

Over-Underserved: Asian Americans As An Invisible Minority

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In the United States, patient care is clearly influenced by income, race, and sex. When adjusted for income, differences in disease management and patient-physician communications persist. Asian and Pacific Islander Americans (APIs) have been viewed as a homogenous model minority that does not suffer from healthcare issues generally affecting minorities in the United States. For example, some might not believe that APIs are affected by the surge in obesity spreading across the nation. In this context, APIs are seen as an academically and economically successful cohort not limited by access to healthcare.

However, health disparities exist between APIs and the general population. Furthermore, the Asian diaspora is composed of more than 20 countries, 60 ethnicities, and 100 languages, and its radically diverse histories and cultures create disparities between Asian ethnicities. As the patient's advocate, organized medicine holds ultimate responsibility for identifying these health disparities and eliminating them.



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Access is a formidable barrier sustaining health disparities in the United States. Roughly 20% of APIs lack health insurance compared to 16% of the general population. When disaggregate data on APIs is produced, a staggering 45% of Korean Americans have no health insurance. In addition, transportation and language barriers pose serious challenges for APIs. Improving access to health care is clearly a multidisciplinary issue requiring

changes in community priorities, public policy, and federal law.

As patients, APIs may find that the medical establishment is unprepared to practice adequate preventative care for common diseases. Hepatitis B virus and liver cancer—entirely preventable diseases—still ravage our communities at rates 20 times greater than the general population. Vietnamese American women fail to get Papanicolaou tests and have the highest rate of cervical cancer of any ethnicity in the United States. Culturally-sensitive preventative care by discerning physicians is a necessary part of the solution. Physicians must be made aware, for example, that APIs are at increased risk of developing metabolic syndrome and diabetes mellitus at lower body mass indices, and that Indian Americans are at tremendous risk for developing cardiovascular disease. To provide the best care possible, physicians need to know that these disparities exist. Additionally, outreach efforts must educate API communities so that individuals can make informed choices.

Health education empowers API

communities to share in medical decision making and practice prevention, but it should also seek to initiate a culturally-sensitive dialogue on stigmatized subjects including mental health and HIV/AIDS. Post-traumatic stress disorder is pervasive in refugee populations such as Cambodian Americans who may not seek treatment for mental illness. Furthermore, psychiatric disorders may have atypical presentations in API patients. In culturally taboo areas such as these, information about APIs is limited. Medical providers should be aware of these subtleties and be prepared to address stigmatized issues.

Firm and accurate data on API health is lacking. Although APIs account for roughly 4% of the nation's population, a mere 0.2% of health-related federal grants directly involve API health. Reasons for this include the perception of APIs as a model minority not subject to the hardships and inequalities of other minorities. In recent past, for example, studies on the nation's health (i.e. NHANES) have pooled APIs into the "Other" category rather than collecting a representative sample as with Blacks and Hispanics. Furthermore, APIs are historically politically insignificant. According to the US Census Bureau, only 33% of APIs are United States citizens. The Census also reports that 13% of naturalized APIs believe they are ineligible to vote. Lack of a cogent voice at the political potluck is undoubtedly related to the dearth of information on API health. Though different Asian ethnicities associate with different political parties, political empowerment is an essential step towards both acquiring accurate data on diseases affecting APIs and eliminating health disparities between APIs and the general population.

Healthcare is complex, and there is no silver bullet that will solve all of the

nation's medical woes. Metropolitan areas with large API populations generally have community clinics and outreach programs catering to the clinical needs and concerns of API patients. Perhaps more challenging is reaching APIs living in areas with little exposure to APIs. Even this article fails to mention the disparities affecting all API ethnicities such as Samoan Americans and Hmong Americans. For our part, APAMSA seeks to address health disparities affecting APIs, particularly through local community outreach and supplemental education for thousands of medical students. However, efforts to date are insufficient. Health disparities persist and go largely unnoticed by those outside of healthcare. Minorities affected by these disparities remain uninformed. For APIs, resolving health disparities requires both obtaining accurate data on disease prevalence and educating patients, providers, and communities.

In the near future, APIs will makeup 20% or more of the practicing physician workforce. APAMSA hopes to educate this cadre of America's physicians about health disparities affecting APIs in order to become our patients' advocates today.

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