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Asian Americans and Pacific Islanders (AAPIs) are an incredibly diverse group of people with distinct histories, cultures, and experiences. AAPIs originate from almost fifty nations and speak over one hundred different languages and dialects. Some populations immigrated to the U.S. in recent decades, while others have resided here for many generations, or are native to what is now the U.S. The 2000 Census counted 11.9 million Asian Americans, and almost 900,000 Native Hawaiians and Other Pacific Islanders (NHOPIs). AAPIs are one of the fastest growing populations in the U.S. and are expected to reach 33.4 million (or 8%) by 2050¹.

The Challenge

Asian Americans and Pacific Islanders (AAPIs) continue to face barriers in accessing health services. Many AAPI populations have high rates of poverty, limited English proficiency, and are unfamiliar with the healthcare system and public programs. These challenges, combined with high rates of uninsurance, have led to disparities in the use of life-saving services. For example:

- Among women have one of the lowest mammography screening rates of any group at only 30%².
- Compared to other women, AAPI women have the lowest HIV testing rates of any ethnicity³.
- AAPI women are less likely to report cases of domestic violence than other women⁴.
- AAPIs are less likely to receive smoking cessation counseling from physicians (68% vs. 79% of total U.S. smokers)⁵.

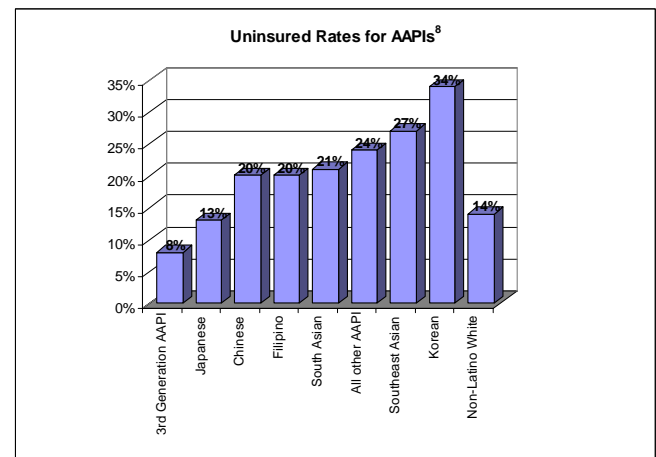
Higher Rates of Uninsurance

Health insurance coverage is one of the most important factors in an individual's ability to access services. Overall, at least 17.7% of all Asian Americans and 21.8% of Native Hawaiians and Other Pacific Islanders (NHOPI) are uninsured, compared to 11.2% of non-Hispanic Whites. This represents a total of 2.3 million AAPIs who are without health care coverage⁶.

AAPI children are also more likely to be uninsured. In 2005, 12.2% of Asian American children were without health insurance, compared to 7.2% of non-Hispanic White children⁶. In 2001, 411,000 AAPI children were uninsured, representing 4.5% of all uninsured children in the U.S.⁷

Differences by Ethnic Group

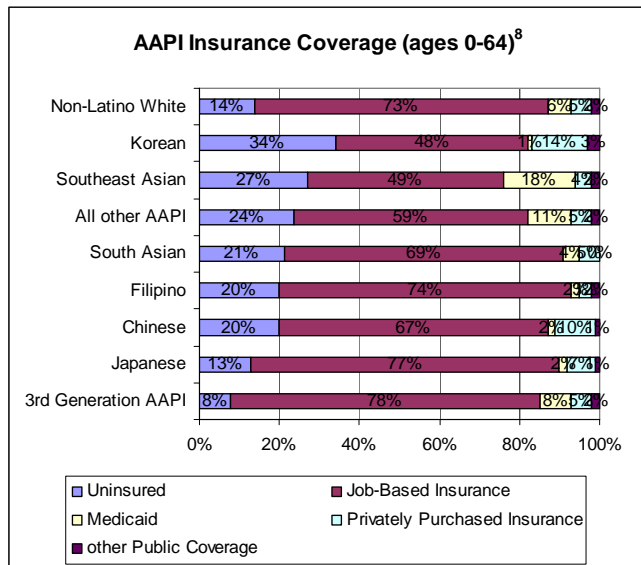
Health care coverage rates vary greatly among the different AAPI populations. Studies show that as many as 52% of Korean American and 32% of Vietnamese American adults aged 18-64 are uninsured, compared to 15% of the total population⁵. Previous data indicates that all AAPI sub-groups, except Japanese and Third-Generation AAPIs, are significantly more likely to be uninsured than non-Latino Whites⁸.



Differences in coverage rates among the various AAPI ethnic groups are thought to be largely related to differences in employment-based coverage. Korean Americans and Southeast Asians, who were the most likely to be uninsured, were also the least likely to have employment-based coverage (48% and 49%, respectively). Korean Americans are more often self-employed or work in smaller businesses that do not provide health coverage. In spite of much higher costs, many Korean Americans are forced to purchase insurance from the private individual market (14% vs. 5% of non-Latino Whites).⁹

Many Southeast Asians and NHOPI populations have high rates of poverty and near-poverty. Often AAPI working families have income levels that exceed the limits for coverage by public programs yet are too low to afford purchasing private health insurance.

Efforts should be made to expand eligibility of existing programs such as Medicaid and State Children's Health Insurance Program (SCHIP) to include more working families. Many states now cover children who live in families that make twice the federal poverty level. In addition, some states now use Medicaid or SCHIP to cover parents of children enrolled in SCHIP.



Lower Rates of Job-Based Coverage

- Asian Americans had lower rates of coverage by private health insurance (70.5%) compared to non-Hispanic Whites (75.5%). This includes lower rates of both employment-based coverage and directly purchased coverage⁶.
- AAPI children are less likely to have private health insurance compared to non-Hispanic Whites (70.4% vs. 79.9%), and less likely to have employment-based coverage, (64.2% vs. 74.1%)⁷.

AAPIs often have lower rates of job-based coverage because of the industries that they work in, the types of jobs they hold and their employer size. Government agencies, consumer advocates and employers need to work together to encourage or require all employers to provide affordable health coverage.

Lower Coverage Rates in Public Programs

- In general, Asian Americans have lower usage of government-sponsored health coverage like Medicaid and Medicare (18.3% vs. 26.1% in Whites)⁶ in spite of higher poverty rates.

- AAPI children are somewhat more likely to have government health insurance (Medicaid, SCHIP, military health care) 22.4%, compared to 18.4% of non-Hispanic White children.⁷
- Southeast Asians tend to be more likely to be covered by Medicaid than the overall U.S. population due in part to their higher poverty rates.⁸
- Non-Hispanic Whites were almost twice as likely to be covered by Medicare as Asian Americans (16.2% vs. 8.8%)⁶. Although the younger age-distribution of AAPIs may explain part of this difference, it does not account for such a large discrepancy.

Many AAPIs who qualify for Medicaid and Medicare coverage are not enrolled due to language barriers, lack of information and fears regarding effects on immigration status. Data shows that half of all uninsured children in California are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP).

Government agencies at all levels need to provide information about public programs to all populations regardless of English proficiency. Agencies should support community-based organizations in providing culturally and linguistically appropriate information and allaying any fears due to misinformation.

Less Access to Care

- NHOPI adults are less likely have a usual source of care, and significantly less likely to have seen a health care professional in the past year compared to the U.S. population as a whole.⁹
- Asian American adults were much more likely to have never seen a doctor or other health care professional (2.4%), or have not seen one in over five years (4.0%), compared to the overall U.S. population (1.4% and 2.5% respectively).⁹
- Asian American children are almost twice as likely to be without a usual source of health care compared to the overall U.S. population (8.0% vs. 4.8%, respectively). They are also less likely to have seen a health care profession in the past six months (65.0% vs. 73.6%), and more likely to have not seen a health care profession in the past five years (3.8% vs. 2.2%).¹⁰
- 37.3% of Asian Americans who are uninsured indicated that they had never had health insurance coverage, compared to 26.6% of the total U.S. population.¹¹

Lack of Accurate Data

Data from national surveys such as the Current Population Survey generally underreport the number of people without health insurance due to methodology

issues.⁶ Furthermore, since these surveys are not conducted in any Asian languages, and since AAPIs are far more likely to be limited English proficient, the true number of uninsured AAPIs is likely to be much higher than reported.

Data on AAPIs as an aggregated group also obscures the often vast differences found between the various sub-populations. National data on Native Hawaiian and Pacific Islanders as a whole is rare and disaggregated NHOPI data is virtually non-existent. APIAHF supports the use of over-sampling, multi-year samples, and other statistical techniques to get a true picture of the status of AAPIs.

APIAHF Principles for Universal Coverage and Access to Quality Health Care

APIAHF supports universal, comprehensive, affordable and accessible health care that ensures cultural and linguistic access for all residents of the U.S. and territories. To achieve this, any effort to reform local, state, or national health care systems should incorporate the following principles:

1. Affordable health coverage should be available to all individuals regardless of nativity or citizenship status.
2. Health coverage should offer comprehensive benefits that include oral, mental, and substance abuse coverage.
3. Any reform that is employer-based must include affordable options for small business employers and self-employed individuals.
4. Systems of accountability should be designed and implemented to monitor and track coverage and access to healthcare by AAPI ethnic subgroups.
5. Health care should be linguistically and culturally appropriate, accounting for the vast ethnic and linguistic diversity among AAPIs.
6. The healthcare workforce should reflect the ethnic diversity among AAPIs.
7. Health coverage and health systems should support evidence-based complementary alternative medicine.
8. Health coverage and health systems should promote prevention and primary care across the lifespan.

Sources

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