If names be not correct, language is not in accordance with the truth of things. If language be not in accordance with the truth of things, affairs cannot be carried on to success.

—Confucius

As we enter this new decade, having prioritized health reform and amid increasing calls for immigration reform, we face an important choice: we can either redress current inequities or further institutionalize them. It is imperative for emergent and immigrant populations, such as Asian Americans, Native Hawaiians, and Pacific Islanders, to participate in the debates and have a place in decision making.

The contributions of Asian Americans, Native Hawaiians, and Pacific Islanders to the continental United States date back to the 1840s. Today, the 15.4 million Asian Americans and 1.1 million Native Hawaiians and Pacific Islanders (identified by single race or in combination with other races) participate in all domains of American life, including the military, government, industry, and service sectors. Third- and fourth-generation Asian Americans, Native Hawaiians, and Pacific Islanders are increasingly common, and by 2030, it is projected that almost 50% of approximately 25 million Asian Americans, Native Hawaiians, and Pacific Islanders in the United States will be native born.1

This special issue of the Journal, devoted to Asian Americans, Native Hawaiians, and Pacific Islanders, is emblematic of the progress that has been made in recognizing and addressing the health needs of this unique grouping of racial and ethnic identities. It is the result of decades of work by activists, researchers, scholars, and leaders who understood that remaining nameless or being defined as “other” diminished the political power of these communities. The identification and categorization of Asian Americans, Native Hawaiians, and Pacific Islanders as specific racial groups allows for disparities and inequities to be detected and documented, provides the basis for allocation of funds and resources that support health programs and services, and supports the monitoring of progress toward equity.

Numerous scholars have documented the bimodality of Asian Americans with regards to socioeconomic status and the heterogeneity of Asian Americans, Native Hawaiians, and Pacific Islanders by ethnicity, religion, and nativity. Two recent texts—one edited by Trinh-Shevrin et al.2 and the other by Bateman et al.3—have provided compelling evidence of Asian American health disparities while also providing the most comprehensive review of Asian American health issues to date.

Still, there is a scarcity of basic health research on Asian Americans, Native Hawaiians, and Pacific Islanders. The data and research available for Native Hawaiians and Pacific Islanders is almost nonexistent. The aggregation of Asian American, Native Hawaiian, and Pacific Islander data continues to mask Pacific Islander disparities, making them a minority within an already “invisible” minority. Furthermore, there continues to be little to no research that accounts for the ethnic diversity within these 3 populations.

RESEARCH AND DATA AS PATHWAYS TO EQUITY

With President Barack Obama’s commitment to strengthening research, an opportunity exists to address the dire need for data and research related to Asian American, Native Hawaiian, and Pacific Islander health. There is critical need for research based upon an ecological framework taking into account the complex multilevel factors that result in disparities and inequities among Asian Americans, Native Hawaiians, and Pacific Islanders. In addition, more health services research is needed to understand how these populations access and use health services, as well as research that builds the evidence base on effective health programming.

As a first step, a fundamental improvement would be the consistent disaggregation of data on Asian Americans, Native Hawaiians, and Pacific Islanders in acknowledgment of the political, cultural, and social differences between these diverse populations. In particular, we must recognize the unique status of Native Hawaiians as indigenous people and the political status of certain Pacific Islands. We must understand how the complex political relations of the Pacific Islands with the US government affects migration, the rights and privileges afforded to Pacific Islanders, and ultimately their health and well-being.
A second step to improve the data on these groups is to expand the application of community-based participatory research (CBPR), which has proven promising in accounting for the ethnic, gender, and class diversity of Asian Americans, Native Hawaiians, and Pacific Islanders. To date, the bulk of CBPR research among these groups has focused on cancer, with a limited number of studies focused on a few ethnic subgroups (e.g., Chinese, Vietnamese, Cambodians, and Koreans). There is tremendous opportunity and need to conduct CBPR with other ethnic groups (e.g., Asian Indians, Bangladeshis, Hmong, Samoans, Tongans, and others) to address critical health issues such as diabetes, cardiovascular disease, behavioral health, HIV/AIDS, and oral health.

A third step is to increase research that examines the cultural, social, economic, and political forces that impact the health of and health care for Asian Americans, Native Hawaiians, and Pacific Islanders. For instance, analyses of data from studies such as the National Latino and Asian American Study are just beginning to probe critical issues of discrimination and identity in health. In their 2003 report, the Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care identified discrimination as a critical factor leading to racial and ethnic health disparities.4 Hopefully, future studies will answer other lingering questions, such as what are the direct and indirect costs associated with a lack of appropriate translation services for the more than 4 million Asian Americans, Native Hawaiians, and Pacific Islanders who have limited English proficiency? What are effective strategies to assure adequate diversification of the health care workforce, given that certain subgroups of Asian Americans (i.e., Southeast Asians), Native Hawaiians, and Pacific Islanders are underrepresented? These and many other questions are in dire need of answers.

ADVOCATING FOR EQUITY

For Asian Americans, Native Hawaiians, and Pacific Islanders, data and research are intricately linked to moving social agendas for equity forward. Research and data alone are not enough. Advocacy is essential given the lack of adequate care and services, particularly for the most vulnerable segments of Asian Americans, Native Hawaiians, and Pacific Islanders (i.e., low-income, limited-English proficient, and immigrant groups).

During the recent debate over health care reform, there was much discussion of what it will cost to increase access to coverage. There are differing opinions on how to control cost, but we do know that denying needed health care services, including primary and preventive care, is costly. According to a recent study by LaViest et al.,5 Asian Americans accounted for $11.4 billion (about 5%) of excess direct medical expenditures between 2003 and 2006, and for 0.03% ($100 million) of all indirect costs attributable to health inequalities.

Until we have a health system that serves all, we must assure that an adequate safety net exists. Community health centers and nonprofits fill the gaps in the health delivery system and serve nearly 500,000 Asian Americans, Native Hawaiians, and Pacific Islanders.6 As these populations grow, there are increasing opportunities to explore whether having health centers focused on Asian Americans, Native Hawaiians, or Pacific Islanders is feasible. Where health centers do not exist, Asian American, Native Hawaiian, and Pacific Islander nonprofits play a critical role in health promotion, health education, and the provision of wrap-around services (i.e., patient navigation, social support, and immigration services). These organizations may also provide basic preventive services. During this economic downturn, support for these nonprofits is crucial.

Policy advocacy must be directed not only at local, state, and federal governments, but also at other funding sources. One indicator demonstrating the disparate resources dedicated to Asian Americans, Native Hawaiians, and Pacific Islanders is foundation funding. Although these groups comprised 4.5% of the US population in 2004, only 0.4% of all US foundation funding was directed at them. This was a slight increase from 0.2% between 1983 and 1990.7 Greater support and targeted resources are needed to assure that there are culturally appropriate health programs and services.

Ultimately, health equity can only be achieved if all individuals have access to necessary services that include preventive and primary care. According to the 2000 Census, more than two thirds of all Asians and one fifth of all Pacific Islanders were foreign born,8,9 bringing forward the issues of justice and equity for our communities as related to health. In the recent debates, Asian American, Native Hawaiian, and Pacific Islander advocates have joined forces with other immigrant advocates in calling for equity in coverage and the removal of barriers to health care for legal and undocumented immigrants.

OUT OF THE SHADOWS

The health reform debate and the debate on immigration reform are tests of this nation’s mettle and conviction to justice and equity. Each of us has a role to play in these debates and in moving these agendas forward. Public health researchers play a critical role in building the evidence base for change. Advocates, health providers, and policymakers must continue to fight for equitable policies that support health communities and ensure an individual’s access to health care. Our collective effort to bring “invisible” populations—such as Asian Americans, Native Hawaiians, and Pacific Islanders—out of the shadows is paramount to achieving equity.

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