

*UCLA Center for Health Policy
Research*
(University of California, Los Angeles)

Year 2009

Paper 113

The State of Asian American, Native
Hawaiian and Pacific Islander Health in
California Report

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The State of Asian American, Native Hawaiian and Pacific Islander Health in California Report

Abstract

Despite their reputation as a healthy, successful minority group, Asians in the United States have serious health problems. Using CHIS 2003 and 2005 data, in addition to other data sources, this study compiled data from 25 Asian ethnic groups in California. According to the report, findings include: In total, more than 27 percent of Asians die cancer, the study found. In comparison, cancer claims about 23 percent of whites, 22 percent of blacks and 20 percent of Latinos. Koreans, Vietnamese and Chinese specifically suffer high rates of liver cancer. About 32 percent of Hmong live under the poverty line. Thirty-three percent of Koreans don't have health insurance. This publication was prepared for the Honorable Mike Eng(Assemblymember, 49th Assembly District) and the California Asian Pacific Islander Joint Legislative Caucus and by the UC AAPI Policy Multi-Campus Research Program Health Work Group.

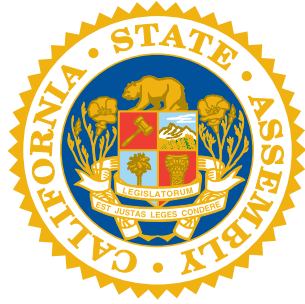


The State of Asian American, Native Hawaiian and Pacific Islander Health in California Report

A report from the California Asian Pacific Islander Joint Legislative Caucus

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The State of Asian American, Native Hawaiian and Pacific Islander Health in California Report

Prepared for the Honorable Mike Eng

Assemblymember, 49th Assembly District

& the CALIFORNIA ASIAN PACIFIC ISLANDER JOINT LEGISLATIVE CAUCUS

By the UC AAPI Policy Multi-Campus Research Program

Health Work Group

Authors

Ninez Ponce, Winston Tseng, Paul Ong,
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April 2009



Honorable Mike Eng

INTRODUCTION

California has the largest and most diverse Asian American, Native Hawaiian and Pacific Islander (AANHPI) population in the United States. In July of 2006, the U.S. Census Bureau estimated that there are more than 5.1 million AANHPIs in California, representing more than 14% of the state's overall population. It is expected that California's AANHPI population will continue to grow rapidly and, as a result, present significant challenges to policymakers at the national, state and local levels. These challenges may be more daunting than originally forecasted because of the shortcomings of existing data on the diverse AANHPI communities. Past practices often aggregated data from the one or two AANHPI racial groups while excluding many of the smaller ethnic groups, giving policy makers a somewhat rosy and homogeneous picture of an extraordinarily diverse population. In fact, the AANHPI population is made up of well over a dozen separate ethnic communities, each with a distinctly unique language, culture, and health profile.

"The State of Asian American, Native Hawaiian and Pacific Islander (AANHPI) Health in California Report" has been commissioned by the California Asian Pacific Islander (API) Joint Legislative Caucus. The purpose of the report is to provide a more accurate snapshot of the social context and health status of AANHPIs in relation to other racial groups in California, as well as in relation to the many AANHPI subgroups. This report is intended to provide the information needed by elected officials, primary and secondary care providers, for-profit and non-profit organizations, school districts, the faith community, law enforcement, and state and local governments in order to provide effective health and mental health services to this emerging and diverse population. The report will hopefully mark the beginning of the development of a body of information whose time has come.

Given the AANHPI community's ethnic and socioeconomic diversity against the backdrop of rising costs of health care, the growing rates of uninsured and underinsured, and the widening chasm of health care disparities, it is imperative that policymakers at all levels of government have access to current data in order to formulate new and relevant health care policies. However, historically, published journal articles and research briefs have broadly documented AANHPIs as a homogeneous community – oftentimes failing to recognize the immense variations between AANHPI subgroups. In addition, very few studies have highlighted the AANHPI community's health status and those that do exist often undergo significant lapses between revisions or updates. It is imperative to develop broader knowledge of the specific illnesses and diseases across new and emerging AANHPI subgroups such as the Cambodians, Laotians, Native Hawaiians and Pacific Islanders and their differences and similarities with other racial/ethnic groups.

It is for these reasons that my office, on behalf of the API Joint Legislative Caucus, and the University of California Asian American and Pacific Islander Policy Multi-Campus Research Program (MRP) decided to collaborate on the development and publication of a report that will fill this void. Specifically, MRP has assembled a multi-disciplinary faculty team with state and national AANHPI health research expertise from the University of California (UC) to gather and carefully assess, through a disaggregated lens, the most recent data available pertaining to the health status of AANHPIs in California.

It is my hope that this report will result in:

- 1) Legislation to mandate the ongoing collection of disaggregated data on AANHPIs and other emerging communities;
- 2) Increased funding for research, especially concerning communities whose needs have been overlooked;
- 3) More effective methods of providing health and mental health education to the myriad AANHPI communities; and, most importantly
- 4) Heightened public awareness to bury the myth of the Asian American “model minority” which masks the serious health needs and concerns of many diverse AANHPI ethnic communities.

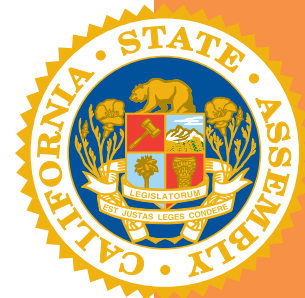
Following the release of the report, the API Joint Legislative Caucus will conduct informational hearings to discuss the findings of the report and develop legislative and non legislative solutions and recommendations for implementation.

On behalf of the Caucus, I would like to express my utmost gratitude to the MRP team, sponsors, and everyone’s contributions that have made this important study possible. I would like to send a special thank you to Paul Ong, Ninez Ponce and Winston Tseng for all their efforts to lead this cause. I would especially like to thank the funders of this project without whose support this work could not have been completed: the California Program on Access to Care, California Program on Opportunity and Equity, University of California Center Sacramento, and Kaiser Permanente.

Sincerely,



MIKE ENG
49th Assembly District
Member, California Asian Pacific Islander Joint Legislative Caucus





Executive Summary

Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs) in California now number over five million and comprise over 14% of the population, making this minority group one of the fastest growing racial populations in the state, as well as in the nation. Because AANHPIs are usually combined into one or two large racial categories, the simplistic image of the “model minority” inevitably emerges, ignoring many of the barriers that may significantly impact the more than a dozen ethnic subgroups that are under the broad “AANHPI” umbrella.

This report examines the health of AANHPIs in California. We examine this diverse population through the lens of socioeconomic factors that differentiate the various AANHPI ethnic subgroups, as well as the social circumstances and health system conditions that may predispose or influence AANHPIs in their health behaviors. Understanding these population characteristics, socioeconomic determinants and health system factors contextualizes the state of AANHPI health in California and thus more effectively guides policy formulation addressing both systemic and specific causes of AANHPI health disparities.

With the diversity of experiences and background characteristics of the AANHPI population, there is a range of ability to access and navigate the health care system. Language, cultural beliefs about health care, and cultural sensitivity of services and providers are some examples of the barriers to health care access and utilization, particularly for recent immigrants who constitute a high proportion of the Asian American population. Other financial and legal barriers include poverty, low-wage employment and citizenship status.

When examining socioeconomic determinants of health access and health status – such as level of education, occupation, income, poverty status, home ownership, use of public programs, and labor force participation – there are marked disparities across Asian ethnic groups. In particular, Asian immigrants in low-wage jobs tend to have the least access to health care partly because of the lack of health insurance, inability to cover the high cost of health care, and the overwhelming demand on their time for work and family obligations.

By far, the most critical element within our health care system is the extent to which people can obtain affordable and effective health care coverage. In California, 6.6 million residents are uninsured, the largest number of uninsured in the nation. Contrary to some beliefs, AANHPIs in California are not only just as susceptible to being uninsured as other populations, but for some groups, even more so. Koreans, Vietnamese, and Native Hawaiians/Pacific Islanders (NHPIs) all have uninsured rates that are higher than the state average.

Differences across AANHPI ethnic subgroups in health behaviors and in the prevalence of cancer, infectious diseases, and chronic conditions support the need to examine health data not only holistically, but by gender and ethnic subgroup as well. For example, cancer is the leading cause of death for Asian Americans, Native Hawaiians and Pacific Islanders as a racial group, but Native Hawaiians have the highest rate of stomach and uterine cancer while liver cancer disproportionately strikes the Vietnamese, Korean, and Chinese populations.

Marked differences in behavioral risk factors also exist across AANHPI subgroups. Some AANHPI ethnic groups disproportionately exhibit negative health behaviors – such as smoking, physical inactivity, and obesity – that raise concerns over the well-being not only of adults, but also of children in these subgroups. For example, Samoan and other Pacific Islander children have the two highest rates among all California children who are overweight or obese, putting these children at heightened risk for cardiovascular disease, Type 2 diabetes, and some types of cancers.

The following are some key findings of our analysis on the health status and health care needs of the AANHPI population by ethnic subgroup:

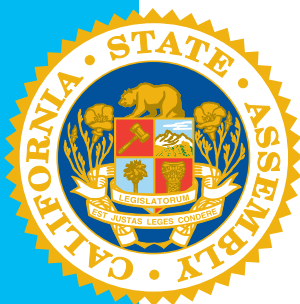
- AANHPIs are the only racial group for whom the leading cause of death is cancer, with higher rates among Asian Americans (27.7%) and NHPIs (25.4%) than for White (23.3%), Latino (20.4%), Black (22.4%) and American Indian/Alaska Native (20.3%) populations in California in 2004.
- Liver cancer disproportionately strikes the AANHPI population at such alarmingly high rates that the cancer burden levied on AANHPIs is unmatched by other racial/ethnic health disparities in the U.S.
- Asian American women have nearly double the rate of non-compliance with cervical cancer screening guidelines as the overall state average, with the lowest rates among Koreans, Vietnamese, Chinese and Other Asians.
- Asian American men also have higher rates of non-compliance with prostate cancer screening guidelines, with Vietnamese and Koreans posting the poorest screening rates among all ethnic groups, and Chinese, Filipinos, and Other Asians also screening at rates worse than the state average.
- AANHPIs account for the largest proportion of all tuberculosis and chronic hepatitis B cases in California, with the majority of cases among the foreign-born population.
- There is an alarming epidemic of overweight and obese children in California’s NHPi communities. In particular, Samoan children have the largest percentage (54%) of all children in the state whose body mass index (BMI) is not within the Healthy Fitness Zone.
- 46% and 70%, respectively, of Filipino and NHPi adults are overweight or obese, compared to the state average of 34%.
- Compared to other racial/ethnic groups, NHPIs have some of the highest rates of diabetes; Filipinos, Vietnamese, and South Asians also have diabetes rates higher than the California average, despite having a generally younger population.
- 25% of adult Filipino males are current smokers, exceeding the state average for adult males of 19%.
- Koreans have the highest uninsured rate (33%) of any racial/ethnic group in the state – far outpacing the state average of uninsured adults (15%).
- Vietnamese and NHPIs experience frequent mental distress at higher rates than other AANHPI groups, yet the Vietnamese represent the highest proportion of insured Californians who are without mental health coverage.

Given the available data for each AANHPI subgroup, this report provides a detailed picture of the AANHPI population, including social and health indicators that are not available in most published reports. However, further data collection and disaggregation efforts are needed, particularly for NHPIs who are typically presented as an aggregate category or for whom estimates are unstable or unavailable because of their small numbers. Further data is also needed to generate estimates for other Southeast Asian groups besides Vietnamese and to disaggregate the South Asian category into Indian, Pakistani, Bangladeshi and Sri Lankan.

As this report shows, examining the Asian American, Native Hawaiian and Pacific Islander population as distinct ethnic subgroups yields a far more complex portrait than that of a successful minority, with unique problems and barriers impacting some subgroups more than others. By understanding the specific health needs of the many AANHPI ethnic subgroups, we are able to formulate more effective policies for this very diverse and rapidly growing population in California.

Explanation of Abbreviations/Terms Contained in the Report and Tables

Abbreviation/Term	Explanation
ACS	American Community Survey
CHIS	California Health Interview Survey
PUMS	Public Use Microsample datafile from US Census
SEER	Surveillance Epidemiology and End Results
AA	Asian Americans
Asian Alone	Includes Asians who identify as single race Asian
Asian Inclusive	Includes Asians who identify as Asian alone or in combination with other races
NHPI	Native Hawaiian and Pacific Islander
NHPI Inclusive	Includes NHPI who identify as NHPI alone or in combination with other races
NH White Inclusive	Includes Non-Hispanic Whites who identify as NH White alone or in combination with other races
AI/AN	American Indians and Alaska Natives
AI/AN Inclusive	Includes AI/AN who identify as AI/AN alone or in combination with other races
Other Asian (CHIS data)	Includes Southeast Asians, other than Vietnamese, and those who identify as multiracial Asian



POPULATION CHARACTERISTICS

Asian Americans are often portrayed as being a successful minority and a number of statistical figures are consistent with this view. However, this portrait hides the complexity and diversity of this population, as well as the problems and barriers they face. Asian Americans in California — and in the nation as a whole — are one of the fastest growing racial populations, with rapid growth continuing into the future. Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs) can be found throughout California, though they are largely concentrated in major metropolitan areas. Although the Census lists nine AANHPI ethnic groups on its forms, there are many more AANHPI ethnic groups that are not listed. In addition, the Pacific Islander population is categorized as Native Hawaiian and Pacific Islander (NHPI) due to its relatively smaller size of the population. This is important to note since the AANHPI population differs in myriad ways, including culturally, linguistically, and religiously. Upon closer inspection, the Asian American population has a high proportion of immigrants with many of the problems related to issues faced by immigrant communities. When looking at indicators such as education and poverty, Southeast Asians are particularly disadvantaged. An examination of socioeconomic factors, particularly in the AANHPI community, becomes even more important since these factors can influence access to health care, health care utilization, health care behavior, and health outcomes.

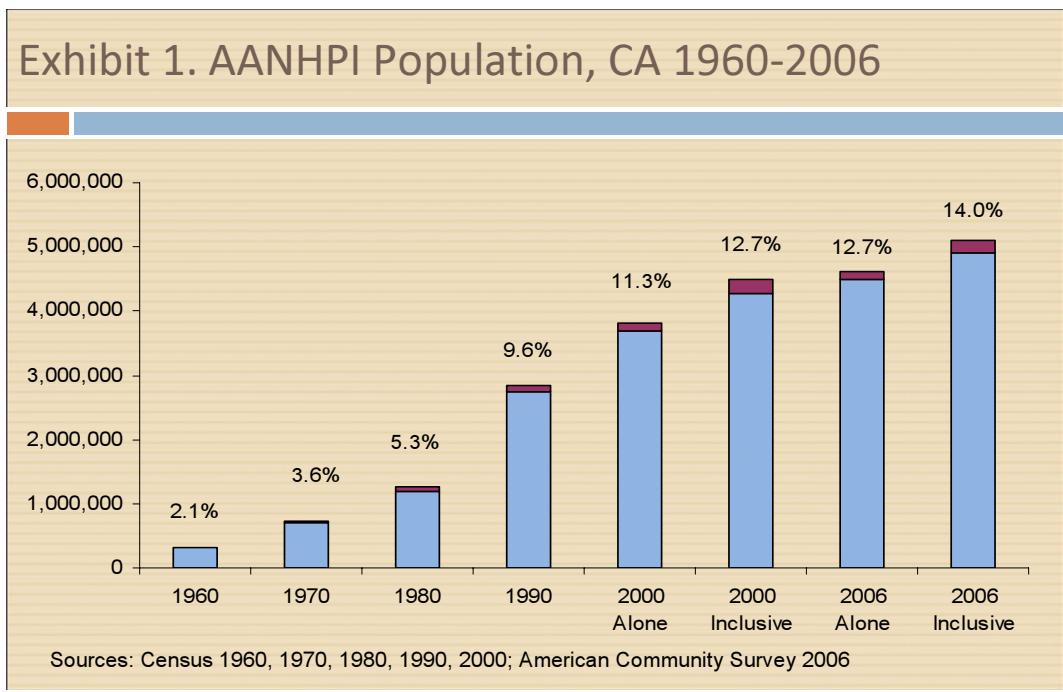
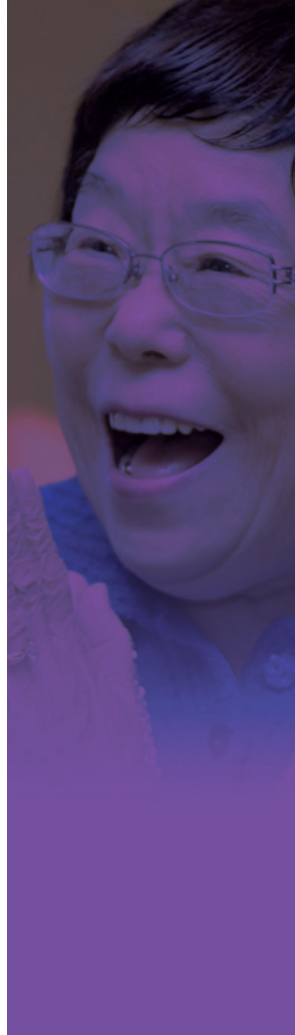


Exhibit 1. AANHPI Population, CA 1960-2006

Exhibit 2. AANHPI Population Projections CA, 2010-2050

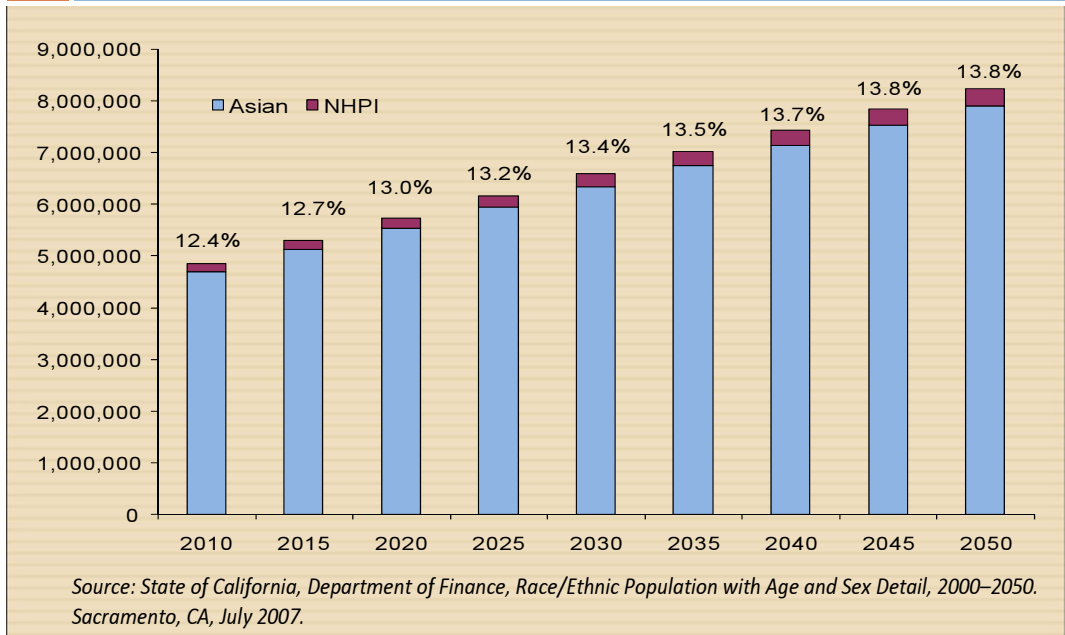


Exhibit 2. AANHPI Population Projections, CA 2010-2050

- The AANHPI population has increased dramatically in California between 1960 (2.1%) and 2006 (14%).
- The California Department of Finance has projected that AANHPIs will continue to grow throughout the first half of the century but AANHPI numbers have already surpassed these projections. For example, the total projection for AANHPIs (which includes both Asians and NHPis) was 12.4% in 2010, yet the “Asian Alone” population already reached 12.7% in 2006.

Exhibit 3. Top 10 Counties with Asian Inclusive Population, CA 2006

Geographic Area	Population	Percent of Population
California	4,896,851	13.4%
Top 10 Counties by Absolute Population		
1 Los Angeles County	1,372,493	13.8%
2 Santa Clara County	546,167	31.5%
3 Orange County	512,189	17.1%
4 Alameda County	378,955	26.0%
5 San Diego County	345,721	11.8%
6 San Francisco County	249,222	33.5%
7 Sacramento County	210,647	15.3%
8 San Mateo County	178,208	25.3%
9 Contra Costa County	154,606	15.1%
10 San Bernardino County	136,569	6.8%
Top 10 Counties by Percentage		
1 San Francisco County	249,222	33.5%
2 Santa Clara County	546,167	31.5%
3 Alameda County	378,955	26.0%
4 San Mateo County	178,208	25.3%
5 Orange County	512,189	17.1%
6 Solano County	68,893	16.7%
7 San Joaquin County	106,239	15.8%
8 Sacramento County	210,647	15.3%
9 Contra Costa County	154,606	15.1%
10 Los Angeles County	1,372,493	13.8%

Source:
American
Community
Survey 2006

Exhibit 3. Top 10 Counties with Asian Inclusive Population, CA 2006

Exhibit 4. Top 10 CA Counties with NHPI Inclusive Population, CA 2006

Geographic area	Population	Percent of Population
California	198,796	0.5%
Top 10 Counties by Absolute Population		
1 Los Angeles County	38,638	0.4%
2 San Diego County	23,529	0.8%
3 Alameda County	17,027	1.2%
4 Orange County	14,942	0.5%
5 Sacramento County	14,380	1.0%
6 San Mateo County	11,488	1.6%
7 Santa Clara County	10,269	0.6%
8 Riverside County	10,058	0.5%
9 San Bernardino County	9,241	0.5%
10 Contra Costa County	6,935	0.7%
Top 10 Counties by Percentage		
1 Yuba County	1,159	1.6%
2 San Mateo County	11,488	1.6%
3 Solano County	5,463	1.3%
4 Alameda County	17,027	1.2%
5 Sacramento County	14,380	1.0%
6 San Diego County	23,529	0.8%
7 San Joaquin County	4,950	0.7%
8 Monterey County	2,910	0.7%
9 Contra Costa County	6,935	0.7%
10 Stanislaus County	3,167	0.6%

Source:
American
Community
Survey 2006

Exhibit 4. Top 10 Counties with NHPI Inclusive Population, CA 2006

Exhibit 5. Age, Marital Status, Fertility Rate

	Age		Median	Marital Status	Fertility Rate
	% <18 years	% 65+ years		Now, married, except separated	Per 100 women 15 to 50 years who had a birth in the past 12 months
Total Population	26.1%	10.8%	34.4	48.5%	5.5
Asian Inclusive	24.0%	10.3%	35.3	56.0%	4.7
Chinese	22.1%	12.2%	37.8	57.8%	3.5
Filipino	25.2%	10.0%	34.8	53.0%	5.1
Indian	26.2%	7.1%	32.5	70.9%	6.7
Japanese	23.1%	16.6%	39.1	49.2%	3.7
Korean	22.5%	9.3%	35.3	55.6%	3.7
Cambodian	31.4%	5.2%	25.5	41.9%	5.5
Hmong	46.5%	3.6%	19.0	43.3%	10.3
Laotian	30.5%	6.6%	27.4	49.8%	6.6
Vietnamese	24.1%	8.5%	35.0	54.4%	4.9
Native Hawaiian and Pacific Islander	31.9%	5.6%	28.1	48.5%	4.1
NH White Inclusive	20.0%	15.7%	41.7	49.5%	4.5
Black or African American Inclusive	31.0%	8.2%	30.5	29.0%	5.0
AI/AN Inclusive	27.4%	7.7%	32.5	38.9%	5.0
Hispanic or Latino (any race)	35.2%	5.0%	26.5	47.1%	6.9

Source: American Community Survey 2006 & PUMS 2006

Exhibit 5. AANHPI Ethnic Breakdown, CA 2006

- The largest numbers of Asians are in Los Angeles County (1.37 million or 13.8% of the population). However, San Francisco County has the largest percentage of Asians (249,000 or 33.5% of the population).
- The largest numbers of Native Hawaiians and Pacific Islanders (NHPIs) are in Los Angeles County (38,638 or 0.4%) and the largest percentage is in Yuba County (1,159; 1.6%).
- There are significant numbers of Asians in at least nine ethnic categories, with Chinese, Filipino and Vietnamese being the three largest groups.
- Asian Americans (AAs) are the 3rd largest racial group in CA.

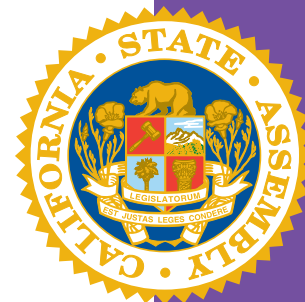
Exhibit 6. AANHPI Ethnic Breakdown, CA 2006

	Alone Population	Inclusive Population
CA Total	36,457,549	
Asian	4,483,252	4,896,851
Chinese	1,165,605	1,302,670
Filipino	1,100,767	1,292,344
Southeast Asian*	861,382	873,066
Vietnamese	533,893	572,296
South Asian*	498,432	515,859
Indian	475,118	506,934
Other Asian*	433,782	486,045
Korean	430,913	468,041
Japanese	300,355	418,696
Native Hawaiian and Pacific Islanders	129,483	198,796
Cambodian	86,700	97,153
Hmong	71,244	72,611
Laotian	65,874	71,183
*Data estimated using PUMS		
Non-Hispanic White	15,600,175	22,826,433
Black or African American	2,260,648	2,533,729
American Indian and Alaska Native	265,963	576,854
Hispanic or Latino**		13,074,155
** Hispanic or Latino (of any race)		

Source: American
Community
Survey 2006 &
PUMS

Exhibit 6. Age, Marital Status, Fertility Rate

- Compared with the overall California population, Asian Americans are slightly older while NHPs are younger.
- Among AAs, Hmongs have the youngest median age and Japanese the oldest median age.
- A majority of adult AAs are married.
- Marriage rates for NHPs are similar to the CA population.
- AANHPIs have a lower fertility rate than CA as a whole.





IMMIGRATION, CITIZENSHIP & LANGUAGE

With the diversity of experiences and background characteristics of the AANHPI population, there is a range of ability to access and navigate the health system as well as public programs overall. Barriers to health care access and utilization include language, cultural beliefs about health care, and the cultural sensitivity of services and providers. Many of these issues are due to the large immigrant population within the Asian American community. Within the NHPI community, health care access and utilization issues may be related to other factors such as cultural norms and perceptions of health care in the U.S. or the lack of health care providers who are culturally sensitive to the needs of the population. The findings point to the necessity of having a health system that can communicate with the immigrant population, which includes having interpreter and translation services available. Unlike the other major immigrant group in California — Latinos — the Asian American population presents a greater challenge because there is no singular language, dominant culture, or dominant religion.

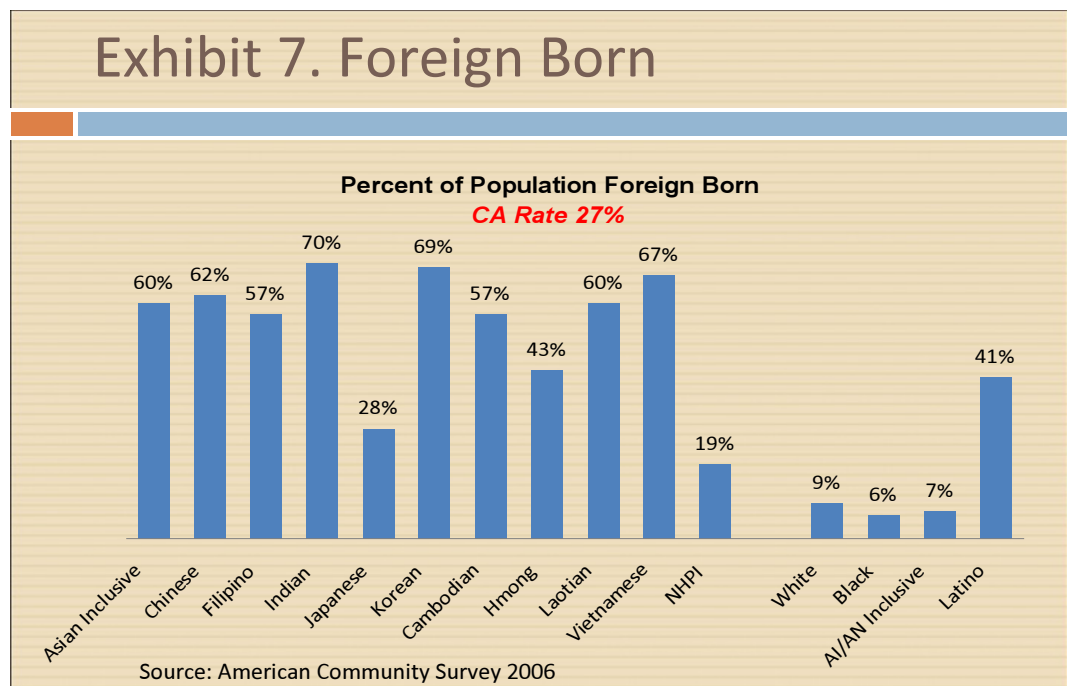


Exhibit 7. Foreign Born

Exhibit 8. Naturalization Rate

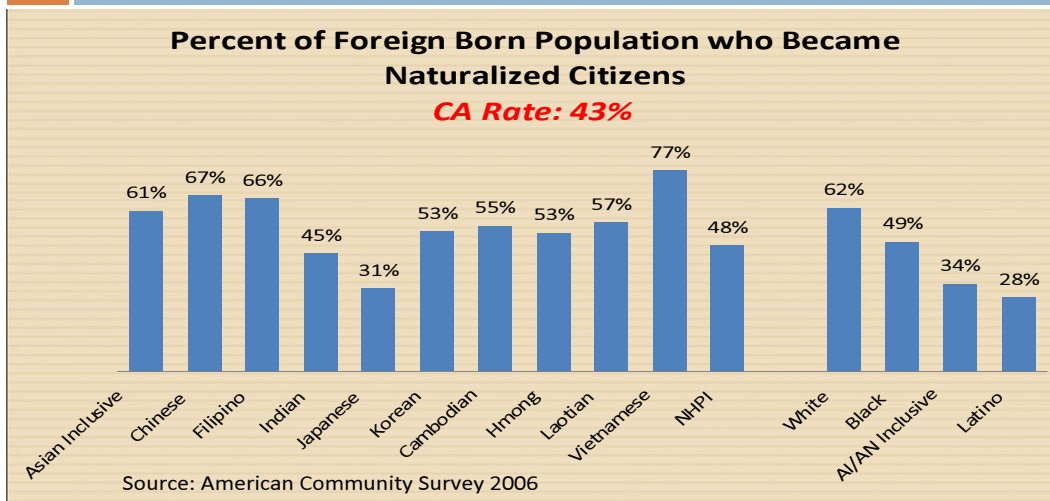


Exhibit 8. Naturalization Rate

- A majority of AAs are foreign-born but NHPi are predominantly U.S.-born. Japanese Americans, who are predominantly U.S.-born, are a notable exception.
- Among foreign-born AAs, a majority have already achieved citizenship.
- There are still large numbers of AAs with limited English proficiency due in part to many being recent arrivals.
- Asian Americans become naturalized citizens at higher rates than the total immigrant population in the state.
- Vietnamese have the highest percentage of naturalized citizens (3 out of 4 become U.S. citizens).

Exhibit 9. Entry into the United States

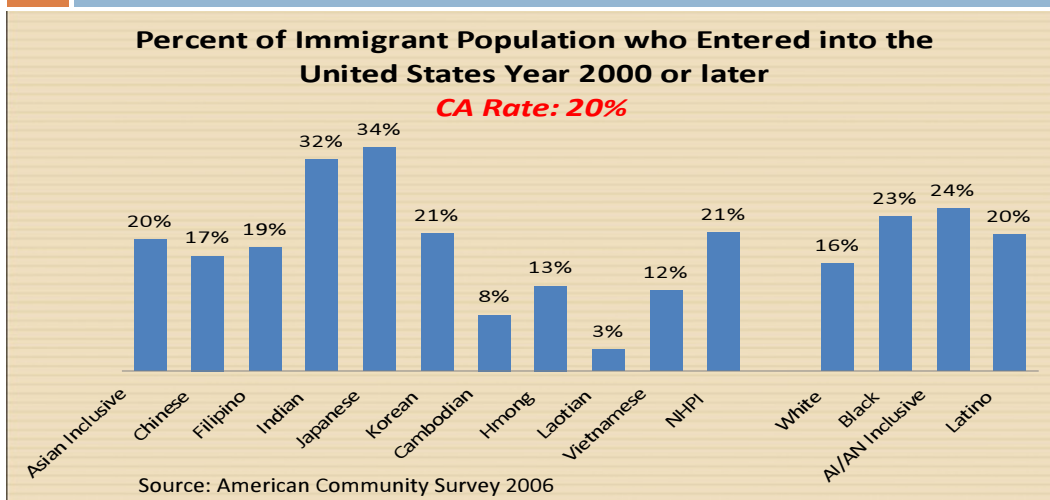


Exhibit 9. Entry into the United States

- Japanese have the highest percentage of immigrants entering the U.S. in the year 2000 or later.
- Japanese, Indians, NHPIs and Koreans have higher rates than Latinos entering in 2000 or later.

Exhibit 10. Limited English Proficiency

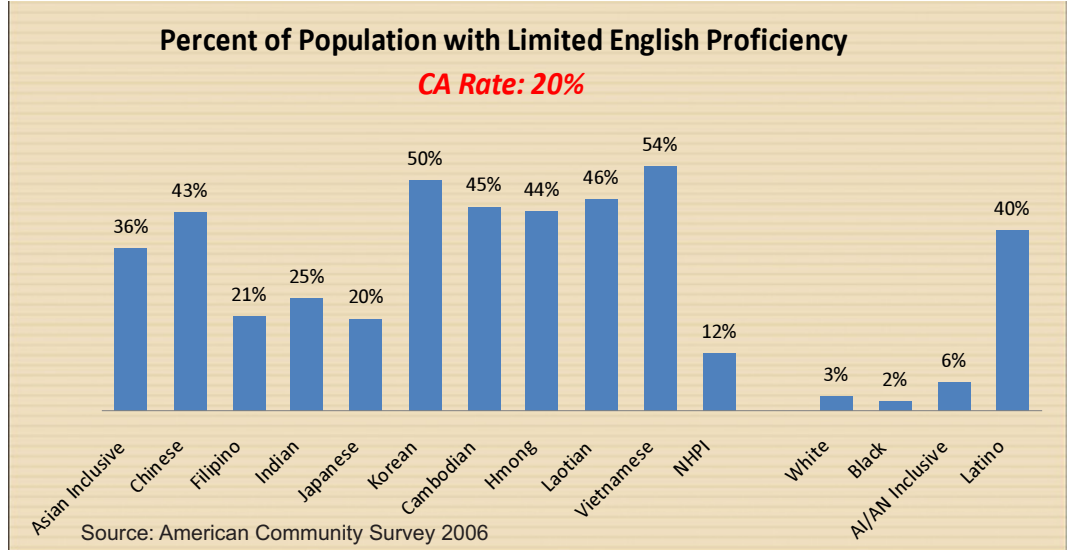
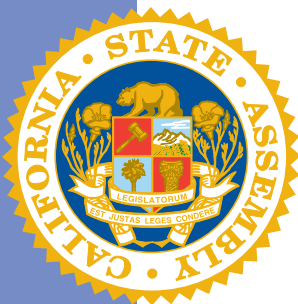


Exhibit 10. Limited English Proficiency

- Many Asian American subgroups have a greater percentage of people with limited English proficiency (LEP) compared with other groups.
- Over half of the Vietnamese (54%) and Korean (50%) communities have limited English proficiency, the highest rates among Asian groups.
- A low proportion of NHPIs (12%) has limited English proficiency.
- Filipinos and Asian Indians, who originate from countries where English is one of the official languages, have fairly low LEP rates (21% and 25%).
- Japanese Americans, many who have been in the U.S. for many generations, also have relatively low LEP rates (20%).



SOCIOECONOMIC DETERMINANTS



Socioeconomic determinants on health access and health status in this report include level of educational attainment, occupation, income level, poverty status, home ownership, use of public programs, and labor force participation. At a cursory glance, AANHPIs would appear to have characteristics that would lead to normative access and health. However, upon closer analysis, variations by racial groups and Asian ethnic groups reveal disparities and barriers across socioeconomic characteristics. There are also unique occupational patterns across racial groups and AANHPI ethnic groups. In particular, Asian immigrants who are in low-wage jobs tend to have the least access to health care partly because of the lack of health insurance, inability to cover the high cost of health care, and the overwhelming demands on their time for work and family obligations.

Exhibit 11. Educational Attainment

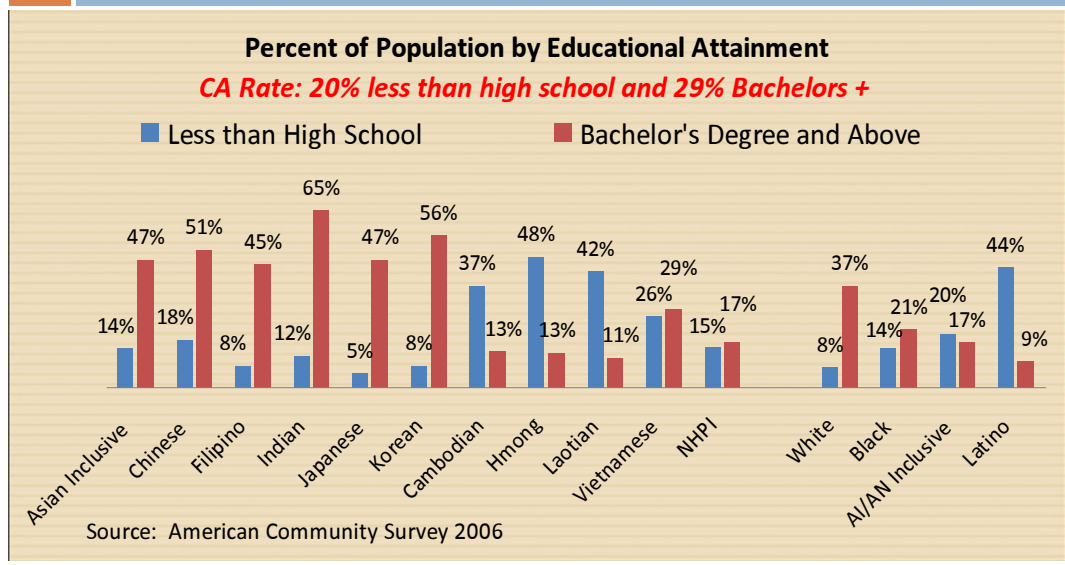


Exhibit 11. Educational Attainment

Exhibit 12. Occupational Types

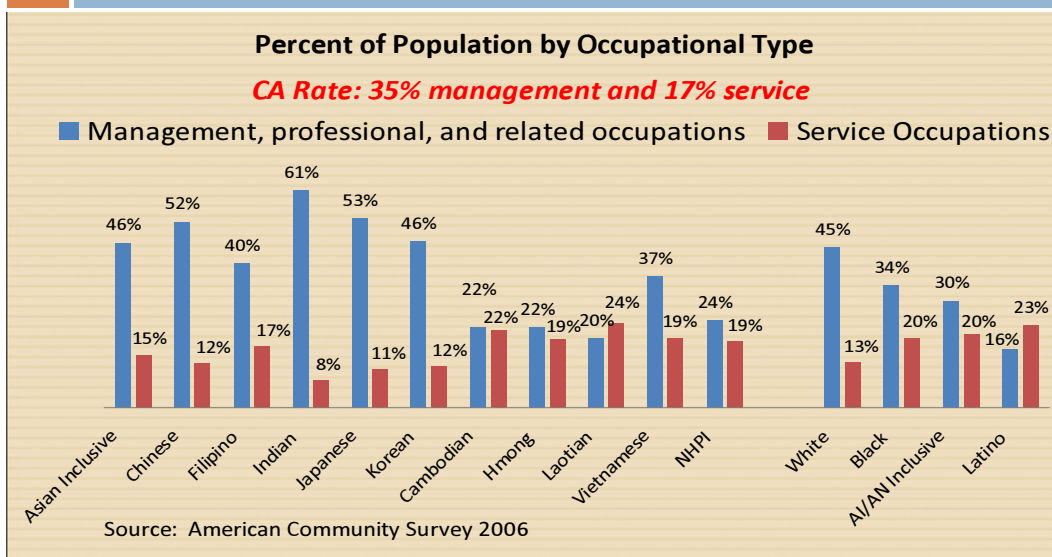


Exhibit 12. Occupational Types

- A large proportion of Southeast Asians have less than a high school education.
- NHPIs and Southeast Asians have proportionately fewer percentages of people who have obtained a bachelor's degree or above.
- NHPIs and Southeast Asians also have a higher representation in service occupations as compared to the overall CA population.

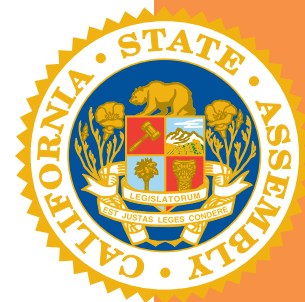
Exhibit 13. Economic Indicators, CA, 2006

	Per Capita Income	Below Poverty	Cash Public Assistance	Food Stamps	Labor Force Participation	Unemployment	Home Ownership Rate
Total	\$26,974	13.1%	3.2%	4.3%	64.5%	4.2%	58.4%
Asian Inclusive	\$27,643	9.8%	2.4%	2.9%	63.7%	3.6%	58.6%
Chinese	\$29,906	10.7%	1.4%	1.6%	61.7%	3.3%	63.6%
Filipino	\$24,991	5.3%	1.8%	2.0%	68.6%	3.8%	64.6%
Indian	\$36,791	6.3%	1.5%	1.2%	66.6%	3.4%	53.8%
Japanese	\$34,174	8.2%	0.6%	0.5%	60.0%	2.8%	64.2%
Korean	\$26,900	11.9%	1.4%	1.3%	59.9%	3.6%	42.4%
Cambodian	\$13,624	21.0%	14.3%	19.7%	58.3%	4.6%	38.8%
Hmong	\$8,470	31.7%	27.1%	39.1%	56.9%	9.5%	37.1%
Laotian	\$13,914	13.4%	8.9%	16.5%	58.3%	5.8%	51.5%
Vietnamese	\$22,507	14.7%	5.6%	7.2%	62.3%	3.7%	57.4%
NHPI	\$19,674	12.4%	4.1%	4.2%	67.3%	5.6%	52.0%
NH White Inclusive	\$37,460	8.2%	1.9%	2.2%	63.5%	3.4%	65.9%
Black or African American Inclusive	\$19,602	20.1%	8.4%	10.3%	60.9%	7.1%	39.3%
AI/AN Inclusive	\$20,663	14.8%	6.2%	8.3%	61.2%	7.1%	52.6%
Hispanic or Latino (any race)	\$14,692	19.1%	4.7%	7.9%	67.2%	5.2%	47.9%

Source: American Community Survey 2006

EXHIBIT 13. ECONOMIC INDICATORS, CA 2006

- The Hmong population's per capita income is more than \$18,000 below that of the total CA population.
- The NHPI population's per capita income is more than \$7,000 below that of the total CA population.
- Southeast Asian communities have a higher percentage of individuals who live below the poverty level compared to the total population.
- The Hmong community has the highest percentage of individuals (32%) living below poverty.
- Southeast Asians (Cambodians, Hmong, Laotians and Vietnamese) also have a higher percentage of people who depend on public assistance and food stamps compared to the total CA population.
- Single-race NHPIs have a higher poverty level than the more inclusive category of NHPIs (those who identify as NHPI alone or in combination with other races).





HEALTH CARE SYSTEM

The following data concentrates on indicators that are integral to the health care system such as *coverage, access and utilization, screening and delivery of care*. How the health care system attends to each of these factors directly impacts its ability to successfully meet the growing health care needs of our communities. Considering the health care system in this manner allows policy makers and health program administrators to more easily identify and eliminate the gaps that often lead to health care disparities and inequality. By creating a more seamless health care system, the goal to deliver high quality health care services to Californians can be realized and, ultimately, result in improved health outcomes and quality of life.

COVERAGE

By far, the most critical element within our system of health care is the extent to which individuals and their families can obtain affordable and effective health care coverage. Nationally, over 44 million Americans are without health insurance and in California, 6.6 million residents are uninsured. Additionally, California has the largest number of uninsured residents and the seventh largest proportion of uninsured in the nation.¹

Numerous studies have shown that lack of health care insurance is a huge risk factor for several preventable diseases such as cardiovascular disease, diabetes, and hypertension. Not having regular access to a primary care provider greatly limits one's ability to be an active participant in one's health and places unnecessary burden and strain on the emergency room delivery system, since the uninsured must obtain health care wherever they can in times of need. Moreover, lack of health insurance has also been linked to diseases that are more easily treatable if detected early such as cervical, breast and colorectal cancer. For the uninsured, being in the precarious position of seeking care only when one 'feels sick' can have detrimental consequences for their health and, in some cases, decreases opportunities for survival.

Health Insurance Coverage

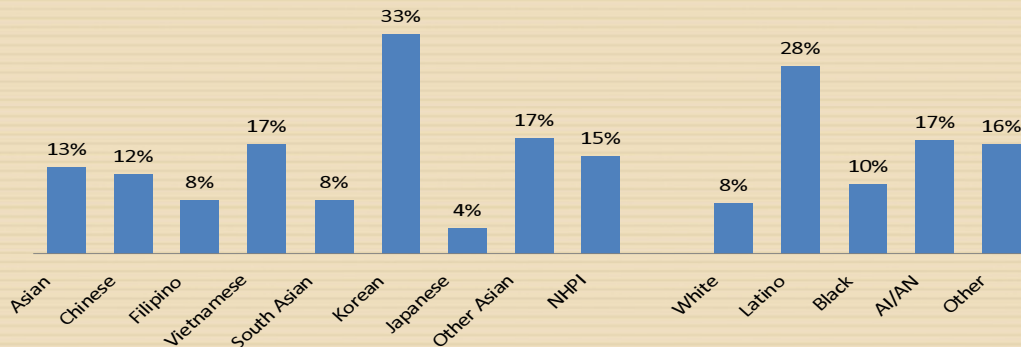
Contrary to some beliefs, Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs) in California are not only just as susceptible to being uninsured as other populations, but for some groups, even more so. While California's state average of uninsured for adults (age 18 to 64 years of age) is 15%, certain groups within the AANHPI community are at or above this average rate.

¹ California Health care Foundation, "Snapshot: California's Uninsured," 2006

Exhibit 14. Health Insurance

Uninsured All Year, Adults, Age 18 to 64

CA Rate: 15%



Source: CHIS 2003 & 2005

"Other" is other single/multiracial individuals

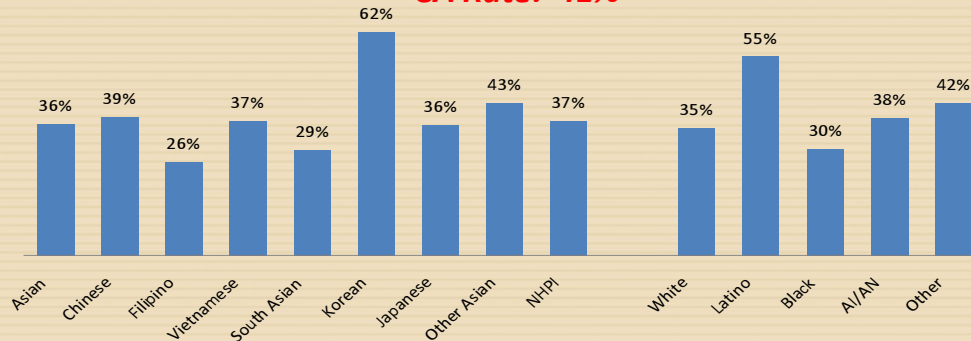
Exhibit 14 Health Insurance

- Japanese nonelderly adults have the lowest uninsured rates (4%) among AANHPI groups.
- 8% of Filipinos and 8% of South Asians were uninsured all year, a rate comparable to Whites.
- 15% of Native Hawaiians/Pacific Islanders (NHPIs) and 17% of both Vietnamese and other Asian groups are without health insurance, comparable to American Indian and Alaska Native uninsured rates.
- Most concerning is that 33% of Koreans in California are uninsured, constituting the highest rate of uninsured within any racial/ethnic group in the entire state. This may be driven by high self-employment among Koreans.

Exhibit 15. Dental Coverage

No Dental Health Coverage, Adults, Age 18 and older

CA Rate: 41%



Source: CHIS 2003

"Other" is other single/multiracial individuals

Exhibit 15. Dental Coverage

- 4 in 10 California adults have no dental coverage.
- On average, 36% of Asians and 37% of NHPIs have no dental coverage — rates that are slightly lower than the state average.
- As in the case for general health care coverage in the state, Koreans have the highest proportion of uninsured for dental care.
- The higher dental coverage rates among Filipinos and South Asians are comparable to the rate for Blacks.

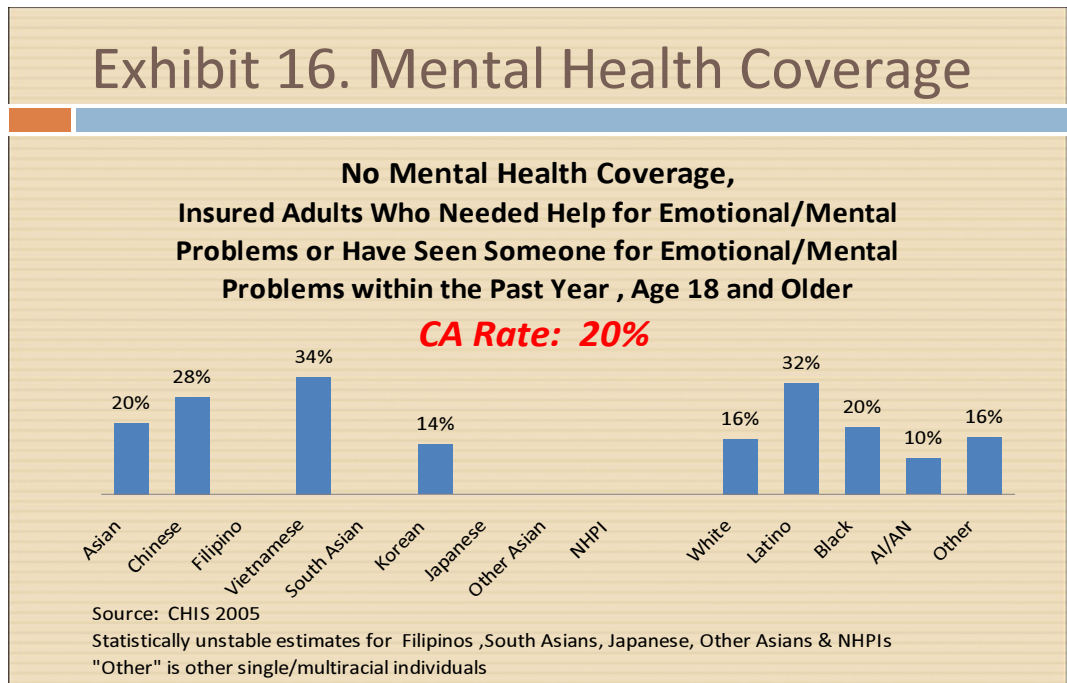


Exhibit 16. Mental Health Coverage

In California, 20% of insured adults (age 18 to 64 years of age) do not have mental health care coverage when seeking help for emotional/mental health care concerns. Accessing mental health care treatment is crucial to overcoming mental health care issues such as depression and anxiety. Another prime concern are the effects of co-morbidity, since other health conditions such as diabetes and cardiovascular disease often exist concurrently with mental health syndromes. For the AANHPI community, mental health care coverage is also an issue:

- 28% of the insured Chinese population and 34% of the insured Vietnamese population are without mental health care coverage.
- Vietnamese represent the highest proportion of insured Californians who are without mental health coverage.
- Mental health non-coverage rates for Vietnamese are similar to rates for Latinos.

ACCESS & UTILIZATION OF PREVENTIVE SERVICES

Having a regular source of medical care – a Healthy People 2010 leading health indicator – and reporting at least one annual visit to a health care provider are two fundamental measures of an individual’s basic connection to the U.S. health care system. Having a basic association with the health care system increases the likelihood of an individual to: 1) Seek timely access to medical care during periods of illness; 2) Receive appropriate and timely preventive care and health screenings for protection against and early detection of disease; and 3) Have some level of continuity of care, which is particularly important for those with chronic health conditions. In addition, having some form of a medical home goes beyond access to primary care by opening pathways to specialty care and other ancillary health services. Several Asian American subgroups report relatively low rates of having a usual source of care and having at least one annual doctor visit as compared to the overall California population. Barriers to having a usual source of health care and/or having a doctor visit in the previous year include limited English proficiency, insurance status, and citizenship status and may be particularly relevant for many Asian subgroup populations.

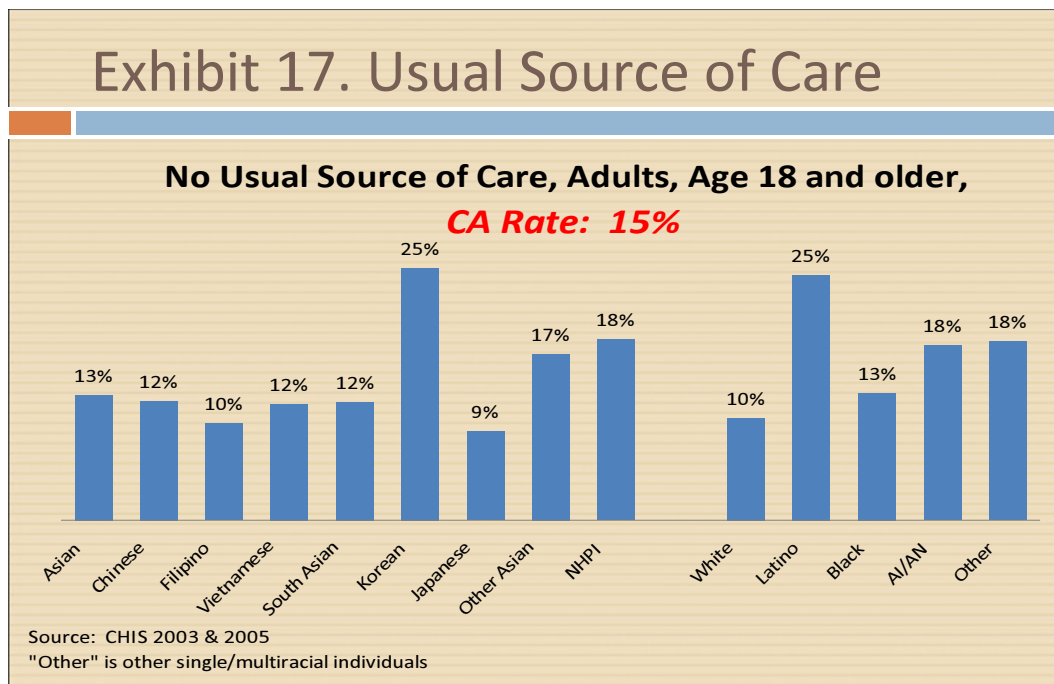


Exhibit 17. Usual Source of Care

- Along with Latinos, Koreans have the highest proportion of adults age 18 - 64 without a usual source of care (25%) in the state.
- 18% of the NHPI and 17% of the Other Asian populations lack having a usual source of health care – rates that exceed the state average.
- Chinese, Vietnamese and South Asians each have 12% of their population without a usual source of care, a rate that is 2 percentage points above the rate for Whites (10%).

Exhibit 18. Annual Doctor Visit

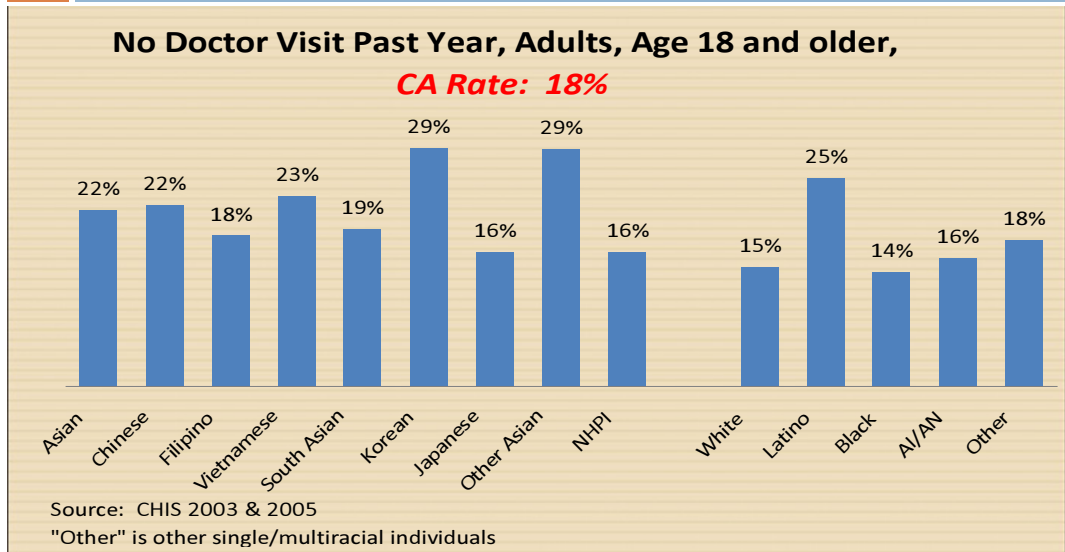


Exhibit 18. Annual Doctor Visit

- Koreans and Other Asian populations have the highest rates (29%) of any adult population (age 18 - 64) who did not visit a doctor within the past year. This is 11 percentage points higher than the state average (18%).
- With the exception of two groups, AANHPI populations have the highest percentage of subgroups who went without a doctor's visit last year. Four of these rates exceed the state average.

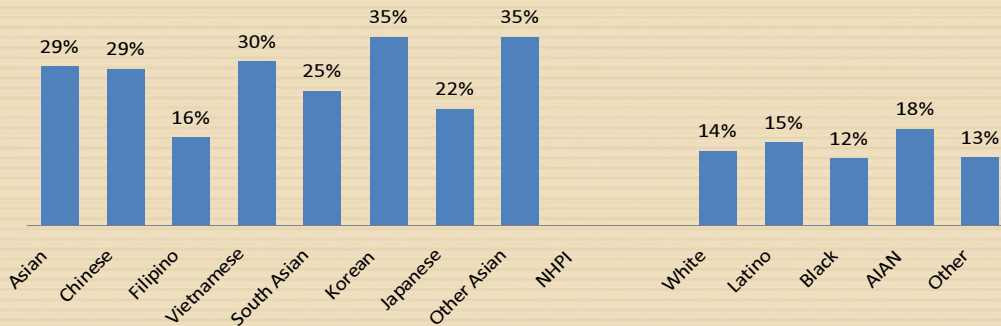
Cancer Screening

Cancer is the second leading cause of death in the United States, accounting for nearly 23% of all deaths in 2005. For Asian Americans, Native Hawaiians and Pacific Islanders, cancer is the leading cause of death. Improvements in both the diagnosis and treatment of cancer have pushed 5-year survival rates to 66% between 1996 and 2003, according to the American Cancer Society (ACS). Cancer screening, through tests such as the mammogram, not only increases the likelihood that cancer is detected earlier when it is more treatable, but, in some cases such as cervical cancer, can prevent the disease entirely. In fact, for breast, colon and cervical cancers, early detection through screening has been shown to reduce mortality rates. Despite the importance of cancer screenings in detecting and preventing cancer, Asian Americans often report screening rates far below that of other racial/ethnic groups. For example, according to the ACS, one of the most treatable cancers, cervical cancer, has a 92% 5-year survival rate if the cancer is detected in its earliest stages. And yet, many Asian American ethnic groups have nearly double the rate of non-compliance with Pap test recommendations as the overall state average, leaving much work to be done in improving rates among these vulnerable populations.

Exhibit 19. Cervical Cancer Screening

Not Compliant with Recommended Pap Test, Women, Age 18 & Older

CA Rate: 16%



Source: CHIS 2003 & 2005

Excludes women who have had hysterectomies

Statistically unstable estimate for NHPI

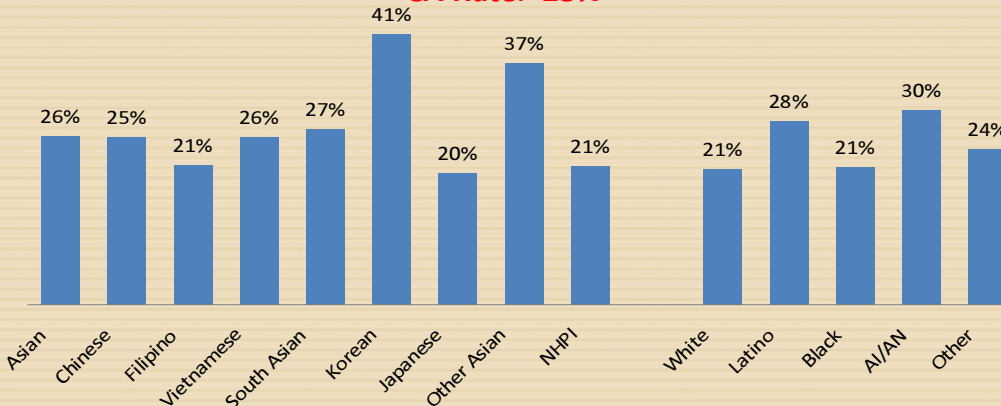
"Other" is other single/multiracial individuals

Exhibit 19. Cervical Cancer Screening

Exhibit 20. Breast Cancer Screening

Not Compliant with Recommended Mammogram, Women, Age 40 +

CA Rate: 23%



Source: CHIS 2003 & 2005

"Other" is other single/multiracial individuals

Exhibit 20. Breast Cancer Screening

- The proportion of Asian women not meeting cervical cancer screening guidelines is much higher than all other racial/ethnic groups.

- Lowest cervical cancer screening rates are among Koreans, Vietnamese, Chinese and Other Asians.
- Chinese, South Asians, Vietnamese and NHPs are also above state average rates in not getting mammograms at recommended time intervals.
- Koreans and the “Other Asian” group have the highest rates of non-compliance with recommended breast cancer screening in the state.

Exhibit 21. Colorectal Cancer Screening

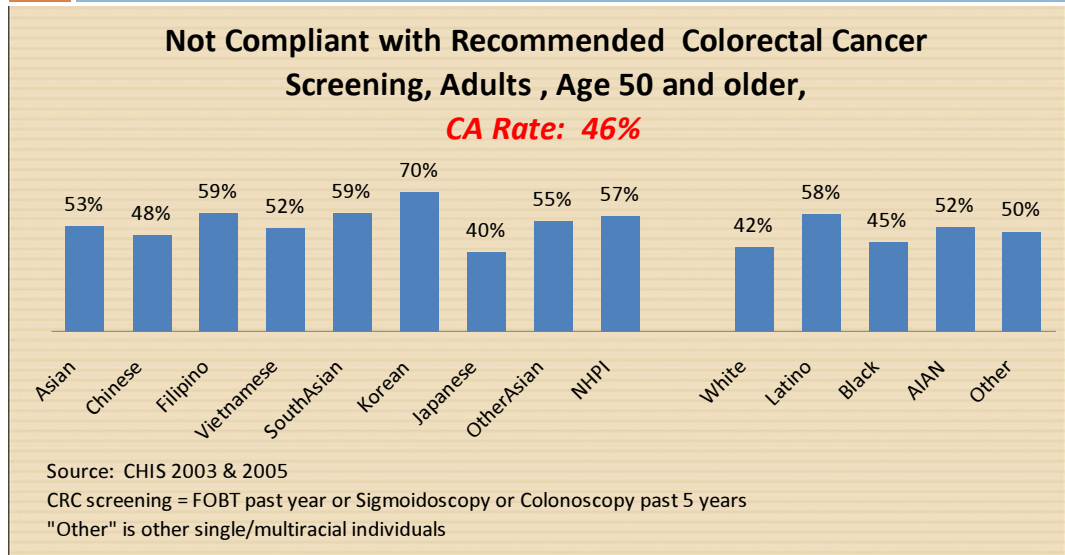


Exhibit 21. Colorectal Cancer Screening

- Most AANHPI groups have poor colorectal cancer screening rates with the poorest compliance among Koreans.
- NHPs, Filipinos and South Asians also have poor compliance rates for colorectal cancer screening.
- Although Japanese have the highest colorectal cancer screening rates among AANHPIs, their rate is still lower than that of the overall CA population.

DELIVERY OF CARE

A wealth of literature shows that racial/ethnic disparities persist in all aspects of health care, from basic levels of access to utilization and quality (*Unequal Treatment*, Institute of Medicine, 2002). Many believe that increased numbers and availability of minority physicians provide one avenue through which to decrease racial/ethnic disparities in care. Racial/ethnic and language concordance be-

tween physicians and patients may provide minority patients in particular with improved outcomes through enhanced cultural competence and sensitivity, better communication between patient and provider, higher patient satisfaction, and decreased perceptions of discrimination. And yet, currently, the composition of the physician population in California does not reflect the diversity of the patient population. This is particularly true for many Asian ethnic groups such as Southeast Asians, whose population numbers far outweigh the availability of racially/ethnically concordant physicians and nurses. Considering that the Census projects that the California and U.S. populations will become significantly more diverse by 2050, the shortage in the number of minority physicians will only be exacerbated in upcoming years. In addition, many Asian ethnic subgroups report high rates of unequal treatment in the receipt of health care which may levy additional barriers to accessing quality, culturally-appropriate health care.

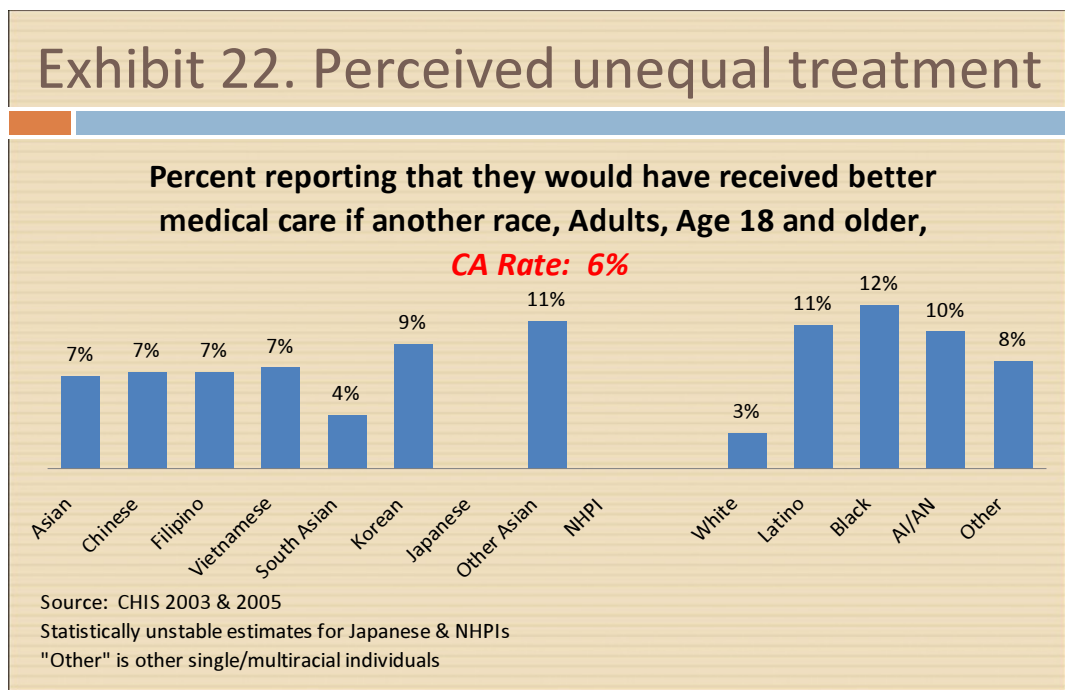


Exhibit 22. Patient Reports of Unequal Treatment

- 4% to almost 11% of all AANHPIs perceive race-based discrimination in medical care.
- Koreans and Other Asians believe they receive unequal treatment at rates comparable with Latinos and American Indians /Alaska Natives.
- South Asians report low rates of unequal treatment in receiving medical care, possibly due to the relatively high proportion of South Asian medical providers in California, which provides more opportunity for South Asians to seek South Asian providers. (see next chart)

Exhibit 23. Healthcare Professionals

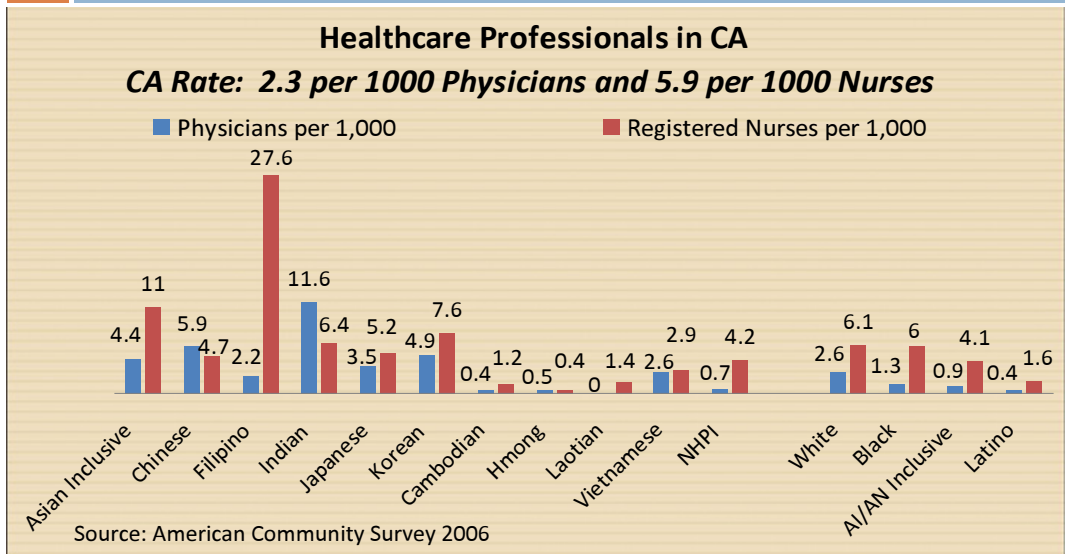
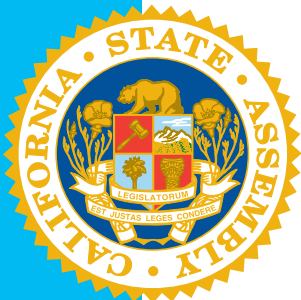


Exhibit 23. Health Care Workforce

The value in examining the health care workforce within the AANHPI community is in identifying the probability of service providers who are co-ethnic and likely to demonstrate a common language and cultural sensitivity. Although some Asian American ethnic groups are well represented in the health professions, there is a severe dearth of physicians and nurses for other ethnic groups. NHPIs and Southeast Asians, in particular, are not adequately represented in the health professions. The findings are not surprising when compared to the educational attainment in both communities.

- Japanese have 11.6 physicians per 1,000 of the population compared to 2.3 per 1,000 for CA.
- Filipinos have 27.6 nurses per 1,000 compared to 5.9 per 1,000 for CA.
- There are 0 physicians per 1,000 in the Laotian community and 0.4 nurses per 1,000 in the Hmong community.



BEHAVIORAL RISK FACTORS



Negative health behaviors such as smoking, physical inactivity, and obesity have been linked to all aspects of health from increased medical expenditures to the development and progression of many types of cancer. Although smoking rates have held steady in recent years, rates of other harmful behaviors such as obesity have risen dramatically in recent decades and have created great concern for the health and well-being of not only adults, but also children who are increasingly at risk for obesity and physical inactivity. Current national figures show that 66.3% of adults age 20 and older are classified as overweight or obese, 21% of all adults smoke, and only 31% and 39.5% of adults engage in regular leisure and non-leisure physical activities respectively.²

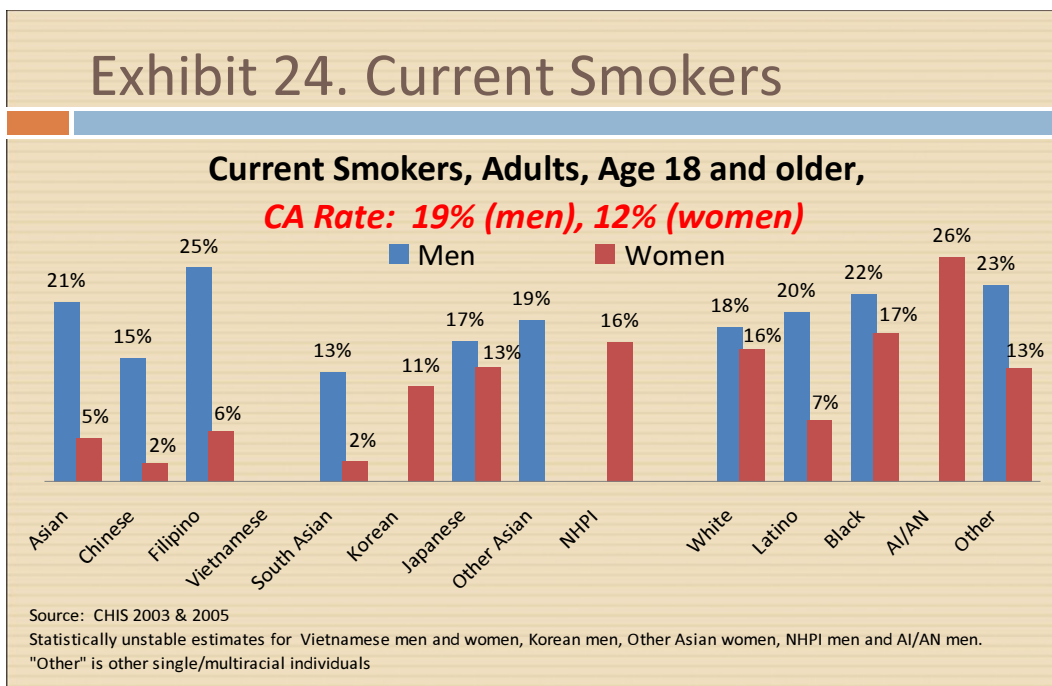


Exhibit 24. Current Smokers

² CDC: National Center for Health Statistics, Health, United States, 2007

- There are dramatic gender differences in smoking across almost all AANHPI ethnic groups.
- Chinese, Filipino and South Asian women are among the least likely to be current smokers.
- While the state average is 12% for adult women (age 18 and older), 16% of NHPI and 13% of Japanese women are current smokers.
- 25% of adult Filipino males (age 18 and older) are current smokers. This exceeds the state average for adult males by 6 percentage points (19%).

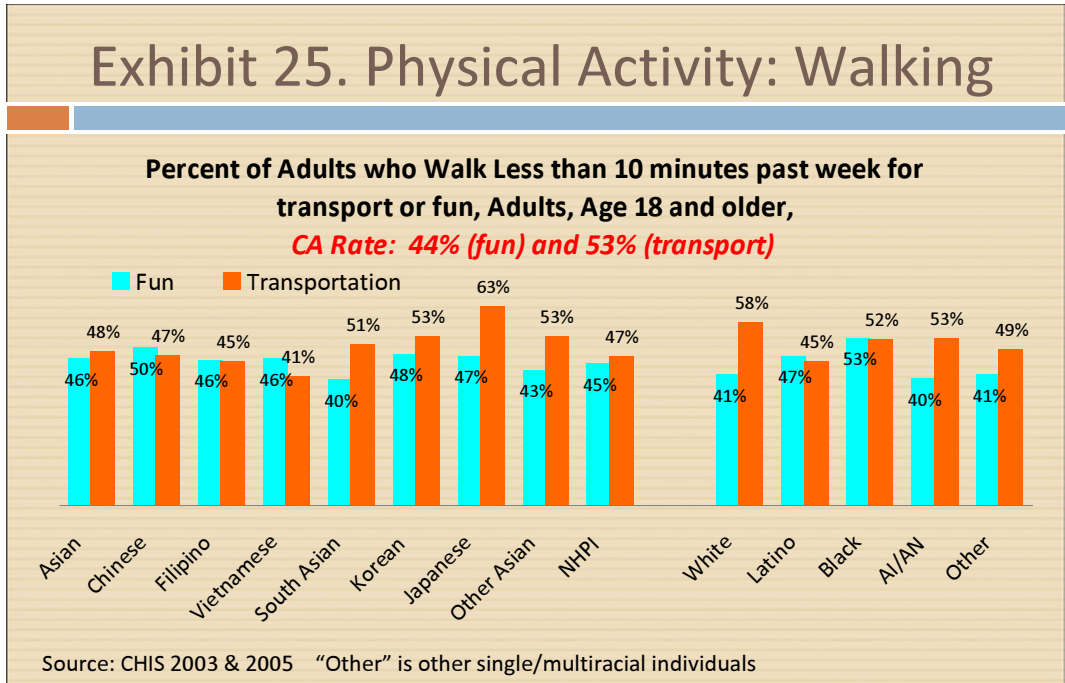


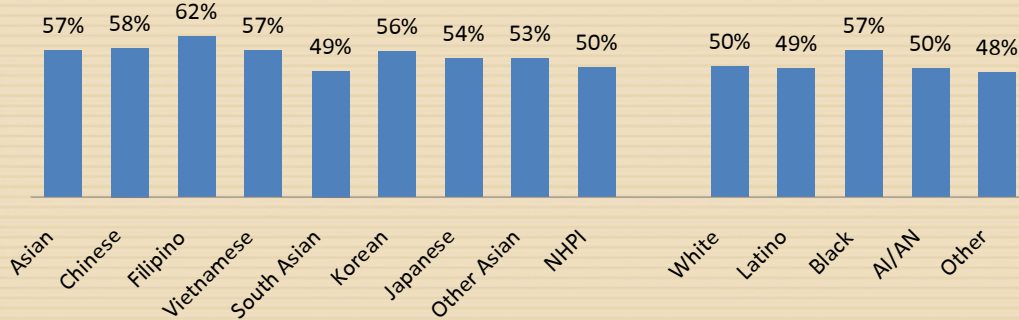
Exhibit 25. Physical Activity

- Higher proportions of Vietnamese, Chinese, and NHPI do not participate in walking for fun.
- Japanese have the greatest spread between leisure and non-leisure walking activity.
- South Asians have the highest rate of engaging in leisure physical activities among AANHPIs, and this rate is comparable to Whites and AI/ANs.

Exhibit 26. Adults: Servings of Fruits & Vegetables

Percent of Adults Who Consume Less than 5 or More Fruits or Vegetables, Age 18 and older,

CA Rate 51%



Source: CHIS 2005

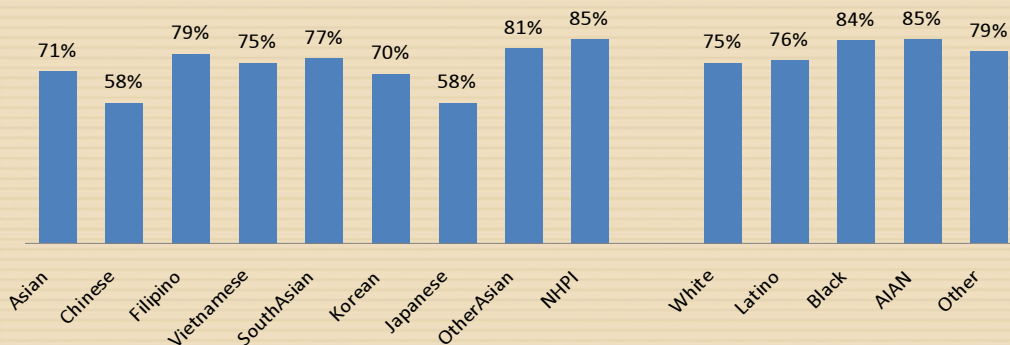
"Other" is other single/multiracial individuals

Exhibit 26. 5-a-day fruit and vegetable intake, Adults

Exhibit 27. Adolescents: Servings of Fruits & Vegetables

Percent of Adolescents Consuming Less than 5 Fruits or Vegetables, Age 12-17,

CA Rate 76%



Source: CHIS 2003 & 2005

"Other" is other single/multiracial individuals

Exhibit 27. 5-a-day fruit and vegetable intake, Adolescents

- Fruit and vegetable consumption rates are fairly comparable across AANHPI adults and other racial/ethnic groups.

- With the exception of South Asian and NHPI populations, all AANHPI groups perform worse than the state average of 51% in not meeting the “5-a-day” nutritional goal.
- With more than 60% of Filipino adults consuming less than 5 fruits and vegetables a day, Filipinos are on the low end of meeting the “5-a-day” nutritional goal.
- Next to Filipinos, Chinese adults are the second largest proportion in the state consuming less than five servings of fruits and vegetables per day.
- Among adolescents, NHPIs, Filipinos, South Asians and Other Asians are more likely to consume less than five servings of fruits and vegetables a day than the state average for adolescents.

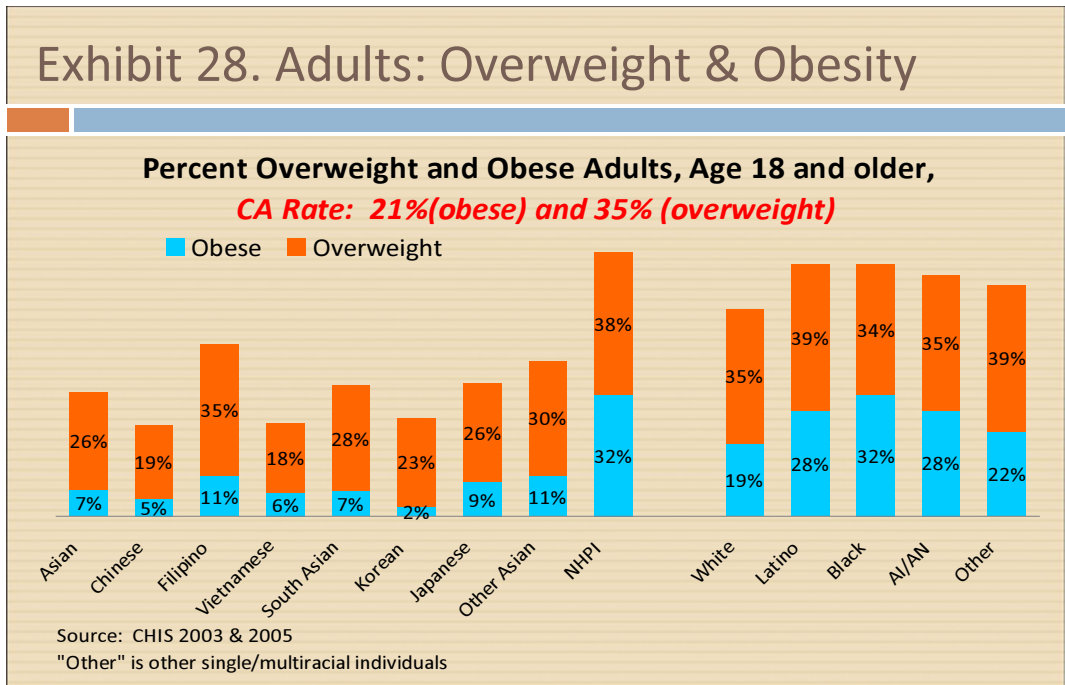


Exhibit 28. Adult Overweight & Obesity

- More than 1 in 3 Filipinos and NHPIs are overweight.
- Among Asians, Filipinos have the highest proportion (46%) of overweight or obese adults.
- 7 in 10 NHPIs are overweight or obese.
- Vietnamese and Chinese have the lowest proportion of adults who are overweight.

CHILDHOOD OBESITY

There is an alarming epidemic of overweight and obese children and adolescents in the United States. Results from the 2003-2004 National Health and Nutrition Examination Survey (NHANES), indicate that an estimated 17% of children and adolescents ages 2-19 years are overweight. Overweight increased from 7.2% to 13.9% among 2-5 year olds and from 11% to 19% among 6-11 year olds

between 1988-94 and 2003-2004. Among adolescents aged 12-19, overweight increased from 11% to 17% during the same period.³

Overweight and obesity is associated with an increased risk of premature morbidity and mortality. Excess weight is associated with a variety of illnesses including cardiovascular disease, Type 2 diabetes, and some types of cancers. Compared to children and adolescents of healthy weight, risk factors for cardiovascular disease (such as high blood pressure and cholesterol) occur with increased frequency in overweight and obese children and adolescents. Moreover, Type 2 diabetes, once thought only to afflict adults, has dramatically increased in children and adolescents. Excess weight can also affect mental health as overweight and obese children and adolescents are more likely to have poor self-esteem and depression (Goodman, 2003).

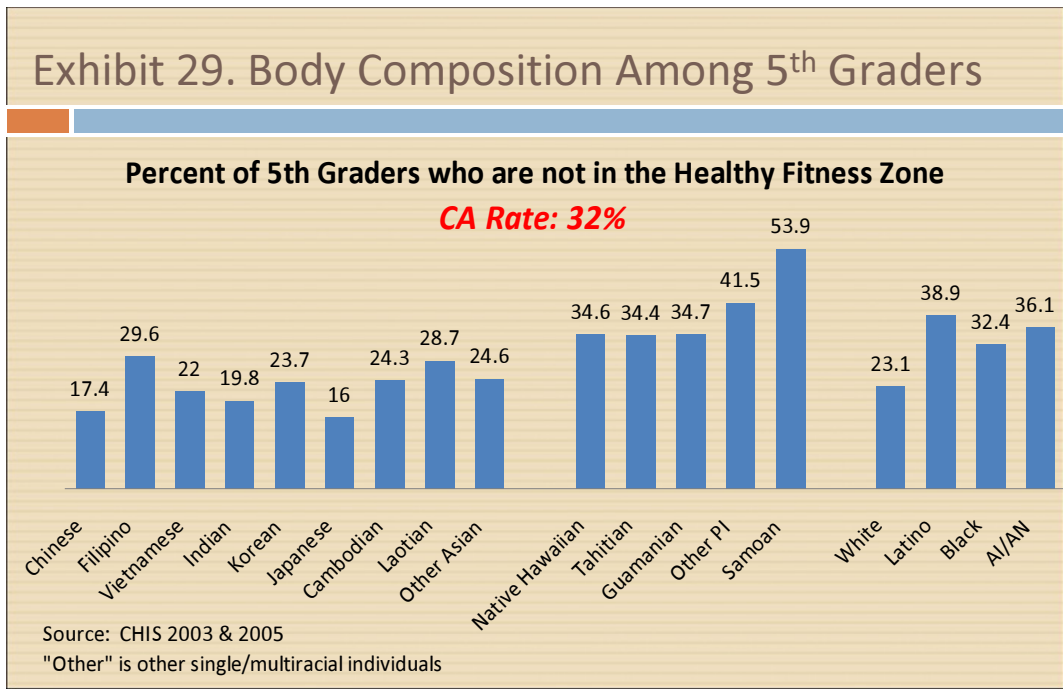
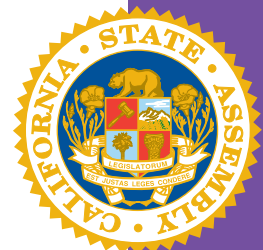


Exhibit 29. Body Composition Among 5th Graders

California schools use Healthy Fitness Zones (HFZ) to evaluate whether a student meets the HFZ goal of physical activity and body composition that offers protection against diseases associated with sedentary living. The problems of overweight and obesity extend into California’s AANHPI children, especially among NHPs.

- Samoan children have the largest percentage (54%) of all children in the state whose body mass index (BMI) is not within the Healthy Fitness Zone.
- Tahitians, Native Hawaiians and Guamanians have BMI percentages higher than the state average of 32%.
- Other Pacific Islanders have the second largest percentage (42%) of all children in the state whose BMIs are not within the Healthy Fitness Zone.

³ CDC 2006: Prevalence of Overweight Among Children and Adolescents: United States, 2003-2004





HEALTH STATUS INDICATORS

VITAL STATISTICS

With the AANHPI population increasing dramatically and faster than the general California population over the past few decades, the vital statistics and disease registries that track the health of these populations – and the state’s capacity to adequately do so – are of growing importance and interest. Vital statistics track births and deaths and represent key indicators that impact the state’s population growth, as well as highlight the critical health/disease outcomes that most impact our diverse populations. Disease registries track health care, health condition/disease, and health professional data and represent vital indicators for assessing the state’s health care system.

Among AANHPIs, the number of live births over the past decade has been increasing at a dramatic pace similar to Latinos, while the number of live births among White and Black populations has been declining. Asian American health challenges are also unique, as Asians are the only racial group with cancer as the leading cause of death. In addition, infectious diseases such as tuberculosis and hepatitis B are of critical concern among AANHPIs.

There are some limitations to the vital statistics and disease registries data on AANHPIs. For example, mortality and natality events for some AANHPI subgroups are too few to provide accurate statistics. Not fully capturing these health statistics among all of California’s language and cultural groups are of increasing concern.

NATALITY

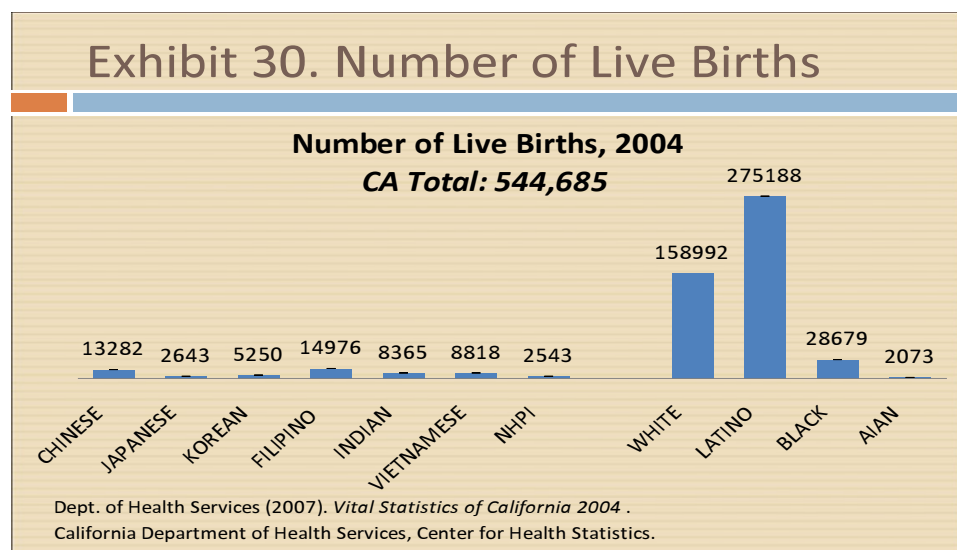


Exhibit 30. Number of Live Births By Race/Ethnic Group of Mother, California, 2000-2004

RACE	2000	2001	2002	2003	2004
Asian	58,876	57,443	59,376	61,525	62,122
NHPI	2,376	2,355	2,411	2,409	2,543
White	168,233	163,777	161,470	162,920	158,992
Latino	257,958	260,996	263,023	269,691	275,188
Black	32,302	30,965	29,807	29,211	28,679
AI/AN	1,975	1,986	1,966	2,004	2,073
TOTAL	531,285	527,371	529,245	540,827	544,685

Data Source: CA Department of Health Services (2007).

Vital Statistics of California 2004.

California Department of Health Services, Center for Health Statistics.

Live Birth Rate (Crude Birth Rate) = (number of live births/estimated total population) x 1,000

- The number of live births for Asian Americans and NHPs from 2000 to 2004 increased by 5.5% and 7%, growing faster than the total number of live births for California (2.5%) during the same period.
- The percentage of total live births by Asian American and NHPI mothers in California increased from 2000 (11.5%) to 2004 (11.9%), while the percentage of live births by White and Black mothers declined during the same period.
- Among Asian American subgroups, Filipino (2.7%), Chinese (2.4%), Vietnamese (1.6%), and Indian American (1.5%) mothers had the highest number of live births in California in 2004.
- Filipino, Chinese, Vietnamese, and Indian American mothers together accounted for 73.1% of all live births by Asian American mothers in California in 2004.

MORTALITY

Exhibit 31. Infant Mortality Rate by Race/Ethnic Group, California, 2004

(Rates are per 1,000 live births in specified group. Age-adjusted rates are calculated using Year 2000 U.S. standard popula-

RACE/ETHNIC GROUP OF CHILD	Total	Male	Female
Asian	2.9	3.3	2.5
NHPI	7.9	9.4	6.3
White	4.6	4.9	4.3
Latino	5.2	5.8	4.6
Black	12.0	13.5	10.4
AI/AN	4.8	6.7	-
TOTAL	5.2	5.7	4.6

tion.)

(Infant deaths are under one year of age.)

(Infant mortality rates are not calculated for fewer than 5 events.)

Data Source: CA Department of Health Services (2007). Vital Statistics of California 2004. California Department of Health Services, Center for Health Statistics.

Infant Mortality Rate = (number of deaths under 1 year of age/total number of live births) x 1,000

- NHPs have a higher infant mortality rate than Asian, White, Latino, and AI/AN Americans in California in 2004.

Exhibit 32. Age-Adjusted Death Rates by Race/Ethnic Group, California, 2001-2004

RACE AND YEAR	2001	2002	2003	2004
Asian	491.6	467.0	456.8	436.6
NHPI	864.1	805.1	776.3	729.9
White/Other/Unknown	803.8	777.7	769.7	743.1
Latino	614.8	579.6	584.5	557.1
Black	1,065.3	1,045.7	1,015.6	971.4
AI/AN	575.7	505.9	470.9	438.1
TOTAL	752.7	723.4	717.2	686.6

(Rates are per 100,000 population in specified groups. Age-adjusted rates are calculated using the direct method and the Year 2000 U.S. standard population.)

Data Source: CA Department of Health Services (2007). Vital Statistics of California 2004. California Department of Health Services, Center for Health Statistics.

- Asian American and NHPI age-adjusted death rates from 2000 to 2004 declined by 12.2% and 15.5%.
- NHPIs have a higher age-adjusted death rate than Asian Americans and the total California population.
- Asian Americans have the lowest age-adjusted death rate across all other racial/ethnic groups.

Exhibit 33. Leading Causes of Death by Race/Ethnic Group, California, 2004

	Asian	NHPI	White	Latino	Black	AI/AN	TOTAL
All Causes	15,886	623	162,083	33,376	18,289	980	232,464
Heart Disease	3,944	173	47,767	7,583	5,049	225	65,002
Cancer	4,402	158	37,809	6,816	4,091	199	53,708
Stroke	1,571	47	11,705	2,139	1,303	53	16,884
Lung Disease (CLRD)	585	15	10,317	820	666	53	12,519
Accidents	652	30	6,348	2,622	791	72	10,614
Influenza & Pneumonia	627	11	5,192	968	475	16	7,331
Diabetes	627	39	3,764	1,817	788	49	7,119
Alzheimer's Disease	229	2	5,868	482	353	12	6,962
Cirrhosis							3,686
Suicide	274	8	2,355	543	132	17	3,364
Hypertension	251	11	1,868	358	350	11	2,860
Assault	122	13	464	1,089	764	19	2,489
Nephritis	201	12	1,370	507	263	8	2,371

Data Source: CA Department of Health Services (2007). Vital Statistics of California 2004. California Department of Health Services, Center for Health Statistics.

- Asian Americans are the only racial/ethnic group for whom the leading cause of death is cancer.
- The percentage of total deaths caused by cancer is higher among Asian Americans (27.7%) and NHPIs (25.4%) than for White (23.3%), Latino (20.4%), Black (22.4%), and AI/AN (20.3%) populations in California in 2004.

- Cancer, Heart Disease, and Stroke combined account for 62.4% and 60.7% of all deaths among Asian Americans and NHPs, rates that are higher than those for White (60%), Latino (49.6%), Black (57.1%), and AI/AN (48.7%) populations in California in 2004.
- Diabetes, hypertension, and Alzheimer’s disease as leading causes of death are growing concerns among Asian Americans and NHPs.

Exhibit 34. Leading Causes of Death by Asian Ethnic Groups, California, 2004

	Asian	Chinese	Filipino	Japanese	Korean	Vietnamese	Indian	NHPI	TOTAL
All Causes	15,886	4,699	4,384	2,271	1,340	1,297	780	623	232,464
Heart Disease	3,944	1,059	1,270	619	296	266	211	173	65,002
Cancer	4,402	1,455	1,120	610	415	391	161	158	53,708
Stroke	1,571	527	434	205	117	121	59	47	16,884
Lung Disease (CLRD)	585	191	166	82	39	45	24	15	12,519
Accidents	652	137	152	77	74	79	54	30	10,614
Influenza & Pneumonia	627	221	120	99	79	56	30	11	7,331
Diabetes	627	163	210	90	50	32	30	39	7,119
Alzheimer’s Disease	229	74	50	56	10	23	9	2	6,962
Cirrhosis		23	29	15	9	17	13		3,686
Suicide	274	62	54	24	58	23	22	8	3,364
Hypertension	251	77	63	38	20	17	15	11	2,860
Assault	122	20	25	5	10	14	15	13	2,489

Data Source: CA Department of Health Services (2007). *Vital Statistics of California 2004*. California Department of Health Services, Center for Health Statistics.

- Cancer is the leading cause of death among Chinese, Korean, and Vietnamese Americans in California in 2004.
- Heart disease is the leading cause of death among Filipino, Japanese, Indian, and NHPI Americans in California in 2004.
- Accidents as a leading cause of death are of particular concern among Chinese, Vietnamese, Indian, Korean, and NHPs in California in 2004.
- Influenza/Pneumonia as a leading cause of death is of particular concern among Japanese, Korean, Chinese, Vietnamese, and Indian Americans in California in 2004.
- Diabetes as a leading cause of death is of particular concern among Filipino, NHPI, Japanese, Chinese, and Indian Americans in California in 2004.
- Suicide as a leading cause of death among Asian Americans is of particular concern among Koreans in California in 2004.

INFECTIOUS DISEASE

TUBERCULOSIS & HEPATITIS B

Infectious diseases overall have been decreasing and are a declining priority for the general California population over the past few decades, but among AANHPIs, infectious diseases such as tuberculosis and hepatitis B are an increasing burden. AANHPIs account for the largest proportion of all tuberculosis and chronic hepatitis B cases in California. The AANHPI burden for tuberculosis has increased over the past decade to almost half of all tuberculosis cases in 2007, with the majority of the AANHPI cases among the foreign-born population. In terms of hepatitis B, AANHPIs account for a majority of all cases of chronic hepatitis B in California. In particular, chronic hepatitis B accounts for a majority of liver cancer incidence and mortality. However, the state and county-level data available on tuberculosis, hepatitis B, and liver cancer among AANHPIs is very limited, due to too few counts to produce accurate statistics on AANHPIs and AANHPI subgroups.

Exhibit 35. Tuberculosis Cases by Race/Ethnicity, California, 1998-2007

YEAR AND RACE	Asian/NHPI	White	Latino	Black	AI/AN	TOTAL
1998	1,527	518	1,401	384	25	3,855
1999	1,415	448	1,340	376	18	3,608
2000	1,367	391	1,198	322	16	3,297
2001	1,399	365	1,252	292	16	3,332
2002	1,285	323	1,273	277	7	3,169
2003	1,351	332	1,281	249	7	3,227
2004	1,287	293	1,173	225	6	2,989
2005	1,274	267	1,126	225	5	2,903
2006	1,223	267	1,068	208	9	2,779
2007	1,262	237	993	218	6	2,725
% Change 1998-2007	-17.4	-54.2	-29.1	-43.2	-76.0	-29.3

Date Source: California Department of Health (2008). *Report on Tuberculosis in California, 2007*. California Department of Health, Tuberculosis Control Branch.

- Asian Americans and NHPIs combined accounted for 42% of all tuberculosis cases in California from 1998 to 2007.
- Tuberculosis cases among Asian Americans and NHPIs combined from 1998 to 2007 declined by 17.4%, while tuberculosis cases among White, Latino, and the total California population declined by 54.2%, 29.1%, and 29.3% during the same period.
- The percentage of tuberculosis cases by Asian Americans and NHPIs combined in California increased from 1998 (39.6%) to 2007 (46.3%), while the percentage of tuberculosis cases by White, Black, and AI/AN Americans declined and Latino Americans stayed the same during the same period.

Exhibit 36. Tuberculosis Case Rates per 100,000 Population by Race/Ethnicity, California, 1998-2007

YEAR	Asian/NHPI	White	Latino	Black	AI/AN	TOTAL
1998	39.7	3.2	13.6	16.9	7.2	11.7
1999	35.4	2.8	12.6	16.3	4.9	10.8
2000	32.7	2.4	10.8	13.8	4.1	9.7
2001	32.2	2.3	10.9	12.3	3.9	9.6
2002	28.7	2.0	10.8	11.6	1.6	9.0
2003	29.4	2.0	10.5	10.4	1.6	9.0
2004	27.4	1.8	9.3	9.4	1.3	8.2
2005	26.7	1.6	8.7	9.4	1.1	7.9
2006	25.2	1.6	8.1	8.6	1.9	7.4
2007	25.5	1.4	7.3	9.0	1.2	7.2
% Change 1998-2007	-35.8	-56.3	-46.3	-46.7	-83.3	-38.5

Date Source: California Department of Health (2008). *Report on Tuberculosis in California, 2007*. California Department of Health, Tuberculosis Control Branch.

- Tuberculosis case rates for Asian Americans and NHPis combined is substantially higher than for White, Latino, Black, and AI/AN Americans in California from 1998 to 2007.
- Tuberculosis case rates for Asian Americans and NHPis combined are 18.2 and 3.5 times higher than the tuberculosis case rates among White and total California populations in 2007.
- Tuberculosis case rates among Asian Americans and NHPis combined declined from 1998 to 2007 by 35.8%, while tuberculosis case rates among White, Latino, and total California populations declined by 56.3%, 46.3%, and 38.5% during the same period.

Exhibit 37. Tuberculosis Cases by U.S.-Born/Foreign Born Status and Country of Origin, California, 2007

	Cases	%
US Born	590	21.7
Foreign Born, Country of Origin:	2,113	77.5
Mexico	603	
Philippines	477	
Vietnam	257	
China	130	
India	102	
Unknown	22	0.8
TOTAL	2,725	100.0

Date Source: California Department of Health (2008). *Report on Tuberculosis in California, 2007*. California Department of Health, Tuberculosis Control Branch.

- Foreign born California residents account for 77.5% of tuberculosis cases in California in 2007.
- The primary Asian countries of origin for foreign born tuberculosis cases include the Philippines, Vietnam, China, and India.
- Foreign born tuberculosis cases from the Philippines (22.6%), Vietnam (12.2%), China (6.2%), and India (4.8%) together account for 45.7% of all foreign born tuberculosis cases in California in 2007.

HEPATITIS B

Exhibit 38. Prevalence and Susceptibility of Hepatitis B among Asian Adults by Age, Sex, and Country of Origin, San Francisco Bay Area, 2001-2006

ASIAN	# Tested for HBsAg	# HBsAg-Positive (Chronically Infected)	%	# Tested for Anti-HBs	# HBsAg-Negative & Anti-HBs-Negative (Unprotected)	%
Age						
< 30	299	16	5.4	172	55	32.0
30 – 59	1,900	201	10.6	973	463	47.6
> 60	922	66	7.2	376	170	45.2
Unknown	42	3	7.1	2	0	0.0
Sex						
Female	1,833	118	6.4	912	418	45.8
Male	1,205	146	12.1	578	252	43.6
Unknown	42	3	7.1	2	0	0.0
Country of Birth						
China	1,016	103	11.1	531	221	41.6
E. Asia, except China	1,072	103	9.6	517	213	41.2
Southeast Asia/Pacific Islands	298	40	13.4	128	60	46.9
United States	153	1	0.7	106	50	47.2
Other	15	0	0.0	6	3	50.0
Unknown	609	26	4.3	235	135	57.4
Total	3163	283	8.9	1523	682	44.8

Data Source: Lin SY, Chang ET, & So SK (2007). Why We Should Routinely Screen Asian American Adults for Hepatitis B: A Cross-Sectional Study of Asians in California. *Hepatology*, 46, 4, 1034-1040.

The regions of the San Francisco Bay Area where the study sample was recruited and interviewed from August 2001 to August 2006 included San Francisco, San Jose, Cupertino, Millbrae, Milpitas, and Sunnyvale as well as at Stanford Hospital.

- 8.9% of Asian adults were infected with chronic hepatitis B in the San Francisco Bay Area from 2001-2006.
- The chronic hepatitis B incidence rate for Asian adult men is almost twice as high as for Asian adult women in the San Francisco Bay Area from 2001-2006.
- Asian adults born in the U.S. had a higher risk of being unprotected from hepatitis B than Asian adults born in East Asia in the San Francisco Bay Area from 2001-2006.

Exhibit 39. Relative Risk of Hepatitis B among Asian Adults by Age, Sex, and Country of Origin, San Francisco Bay Area, 2001-2006

- Asian adults 30 years old or older were three times more likely to be unprotected from hepatitis B than Asian adults under 30 years old in the San Francisco Bay Area from 2001-2006.
- Asian men were twice as likely to be infected with chronic hepatitis B as Asian women in the San Francisco Bay Area from 2001-2006.
- Asian adults born in East Asia, Southeast Asia, and the Pacific Islands were 20 times more likely to be infected with chronic hepatitis B than Asian adults born in the U.S. in the San Francisco Bay Area from 2001-2006.

*** Age < 30, female, and China served as the reference groups for the calculation of relative risk for age, sex, and country of birth.
 Data Source: Lin SY, Chang ET, & So SK (2007). Why We Should Routinely Screen Asian American Adults for Hepatitis B: A Cross-Sectional Study of Asians in California. *Hepatology*, 46, 4, 1034-1040.

CANCER

As noted in the previous sections, for Asian Americans, Native Hawaiians and Pacific Islanders, cancer is the leading cause of death. Nationally, Native Hawaiians have the highest rate of stomach and uterine cancer and the second highest mortality rates for all cancers (Inter-cultural Cancer Council). Because of its small population size in California (less than 200,000), establishing a baseline of information on cancer incidence and mortality per 1,000 population is difficult for the aggregate NHPI category, let alone for the NHPI subgroups. The cancer surveillance data is better for Asian Americans. For example, we know that Asian women in California are the least likely to be diagnosed with cancer – perhaps attributed to the low cancer screening rates we presented earlier in the report. However, in the aggregate and across all sites, compared with other racial/ethnic groups, Asian Americans generally have lower cancer rates. For example, compared to non-Latino whites, Asian men are less likely to have prostate cancer and Asian women are less likely to have breast cancer. However, one study that disaggregated data on five Asian subgroups by cancer site underscores that cancer incidence and mortality rates vary widely across Asian subgroups. Based on five-year average, annual, age-adjusted incidence and mortality rates in California (from 1997–2001), the authors found:

- Chinese
 - ✧ Cancer incidence rates were consistently among the lowest.
 - ✧ Highest mortality rates for lung and bronchial cancer (34.3 per 100,000).

ASIAN	HBsAg-Positive (Chronically Infected)	HBsAg-Negative and Anti-HBs-Negative (Unprotected)
Age		
< 30 ***	1.0	1.0
30-39	1.4	3.9
40-49	1.5	2.5
50-59	1.0	2.8
60-69	0.9	2.8
70 +	0.6	2.9
Sex		
Female ***	1.0	1.0
Male	2.1	0.9
Country of Birth		
China ***	1.0	1.0
East Asia, except China	0.8	1.0
Southeast Asia/Pacific Islands	1.2	1.2
United States	0.05	2.2

- Filipinos
 - ✧ Highest incidence rate for prostate cancer (109.9 per 100,000) and thyroid cancer (10.8 per 100,000).
 - ✧ Highest mortality rates for breast cancer (17.3 per 100,000), prostate cancer (17.5 per 100,000), and thyroid cancer (1.3 per 100,000).
- Japanese
 - ✧ Highest incidence rates for colorectal cancer (57.5 per 100,000), female breast cancer (105.5 per 100,000), and uterine cancer (16.7 per 100,000).
 - ✧ Highest mortality rates for colorectal cancer (20.5 per 100,000) and uterine cancer (2.5 per 100,000).
- Koreans
 - ✧ Highest stomach cancer incidence rate at 37.4 per 100,000.
 - ✧ Highest stomach cancer mortality rate (22.4 per 100,000).
 - ✧ Lowest rate for breast cancer (49.1 per 100,000).
- Vietnamese
 - ✧ Highest rates for liver cancer (33.3 per 100,000) and for lung and bronchial cancers (51.6 per 100,000).
 - ✧ Highest mortality rate for liver cancer (20.8 per 100,000).

Data Source: Kwong SL, Chen MS, Snipes KP, Bal DG, & Wright WE (2005). Asian Subgroups and Cancer Incidence and Mortality Rates in California. *Cancer Supplement*, 104, 12, 2975-2981; California Cancer Registry.

National and state data provide evidence that liver cancer disproportionately strikes the AANHPI population at such alarmingly high rates that the cancer burden levied on AANHPIs is said to be unmatched by other racial/ethnic health disparities in the U.S. In this next section, we focus on liver cancer statistics in California and in the United States.

LIVER CANCER

Exhibit 40. Age-Adjusted Liver Cancer Incidence & Mortality Rates by Race/Ethnicity and Sex, California, 1997-200
(Rates are per 100,000 population in specified groups.)

Incidence	Total Count	Rate	Male Count	Rate	Female Count	Rate
Chinese	657	14.1	507	23.6	150	6.1
Filipino	347	8.8	255	14.9	92	4.4
Japanese	158	7.4	61	7.6	97	7.0
Korean	279	20.2	183	30.4	96	12.7
Vietnamese	465	33.3	360	53.5	105	15.6
Mortality	Total Count	Rate	Male Count	Rate	Female Count	Rate
Chinese	565	12.4	430	20.7	135	5.6
Filipino	228	5.8	163	9.4	65	3.1
Japanese	146	6.6	51	6.4	95	6.5
Korean	212	15.6	131	22.1	81	10.9
Vietnamese	279	20.8	207	32.2	72	11.4

Data Source: Kwong SL, Chen MS, Snipes KP, Bal DG, & Wright WE (2005). Asian Subgroups and Cancer Incidence and Mortality Rates in California. *Cancer Supplement*, 104, 12, 2975-2981; California Cancer Registry.

- Among all Asian Americans in California from 1997-2001, Vietnamese (33.3), Korean (20.2), and Chinese (14.1) had the highest liver cancer incidence rates.
- Among all Asian Americans in California from 1997-2001, Vietnamese (20.8), Korean (15.6), and Chinese (12.4) had the highest liver cancer mortality rates.

Men:

- Excluding Japanese, Asian American men have substantially higher liver cancer incidence rates than Asian American women, ranging from 2.4 times to 3.4 times higher
- Excluding Japanese, Asian American men have substantially higher liver cancer mortality rates than Asian American women, ranging from 2.0 times to 3.7 times higher.

Women:

- Among Asian American women in California, Vietnamese (15.6) and Korean (12.7) women have the highest liver cancer incidence rates.
- Among Asian American women in California, Vietnamese (11.4) and Korean (10.9) women have the highest liver cancer mortality rates.

Exhibit 41. Age-Adjusted Liver Cancer Incidence & Mortality Rates by Race/Ethnicity and Sex in the U.S., 1998-2002

(Rates are per 100,000 population in specified groups.)

RACE	Count	Men	Count	Women
INCIDENCE				
Asian Indian & Pakistani	60	8.7	31	3.9
Chinese	666	24.0	258	8.2
Filipino	413	17.2	150	5.1
Japanese	199	11.4	219	7.9
Cambodian	59	49.1	16	14.1
Korean	319	35.9	164	14.4
Laotian	80	79.4	24	23.1
Samoan	35	54.5	-	-
Vietnamese	493	55.5	146	16.8
White	7,445	6.7	3,689	2.6
MORTALITY				
Asian/NHPI				
Asian Indian	54	5.3	29	2.6
Chinese	761	20.3	308	7.4
Filipino	304	11.3	127	3.9
Japanese	170	9.1	196	6.5
Korean	288	26.3	169	11.7
Samoan	22	32.9	-	-
Vietnamese	335	33.8	102	10.9
White	9,091	6.1	5,546	2.7

The liver cancer incidence data was collected from the period January 1, 1998 to December 31, 2002 from U.S. state and regional population-based cancer registries that participate in NCI's SEER Program. The reporting areas for this analysis included Atlanta, Detroit, Seattle/Puget Sound, and the states of California, Connecticut, Hawaii, Iowa, Kentucky, Louisiana, New Jersey, New Mexico, and Utah. These cancer registries account for 54% of the U.S. Asian American and NHPI population. The liver cancer mortality data from 1998 to 2002 were collected from state vital record offices and consolidated by the National Vital Statistics System of the National Center for Health Statistics. The analysis was limited to the states of California, Hawaii, Illinois, New Jersey, New York, Texas and Washington. These seven states account for 68% of the U.S. Asian American and NHPI population.

Data Source: Miller BA, Chu, KC, Hankey, BF, & Ries LAG (2008). Cancer Incidence and Mortality Patterns among Specific Asian and Pacific Islander Populations in the U.S. *Cancer Causes Control*, 19, 227-256; National Cancer Institute Surveillance Epidemiology and End Results, 1998-2002

- Asian Americans and NHPIs have substantially higher rates of liver cancer incidence than White Americans in the U.S.

- Most Asian Americans have substantially higher liver cancer mortality rates than White Americans in the U.S.

Men

- Laotian (79.4), Vietnamese (55.5), Samoan (54.5), and Cambodian (49.1) men have the highest liver cancer incidence rates in the U.S.
- Among Asian American subgroups by sex, Vietnamese (33.8), Samoan (32.9), Korean (26.9), and Chinese (20.3) men have the highest liver cancer mortality rates in the U.S.
- Liver cancer incidence rates for Laotian, Vietnamese, Samoan, and Cambodian American men are 11.9, 8.3, 8.1, and 7.3 times higher than White men in the U.S.
- Liver cancer mortality rates for Vietnamese, Samoan, Korean, and Chinese American men are 3.3 to 5.5 times higher than White men in the U.S.

Women

- Asian American women also have substantially higher rates of liver cancer incidence than White women in the U.S.
- Most Asian American women also have substantially higher liver cancer mortality rates than White women in the U.S.
- Among Asian American women, Laotian (23.1), Vietnamese (16.8), Korean (14.4), and Cambodian (14.1) women have the highest liver cancer incidence rates.
- Among Asian American women, Korean (11.7), Vietnamese (10.9), Chinese (7.4), and Japanese (6.5) women have the highest liver cancer mortality rates.
- Liver cancer incidence rates for Laotian, Vietnamese, Korean, and Cambodian women are 8.9, 6.5, 5.5, and 5.4 times higher than White women in the U.S.
- Liver cancer mortality rates for Korean, Vietnamese, Chinese, and Japanese women are 2.4 to 4.3 times higher than White women in the U.S.

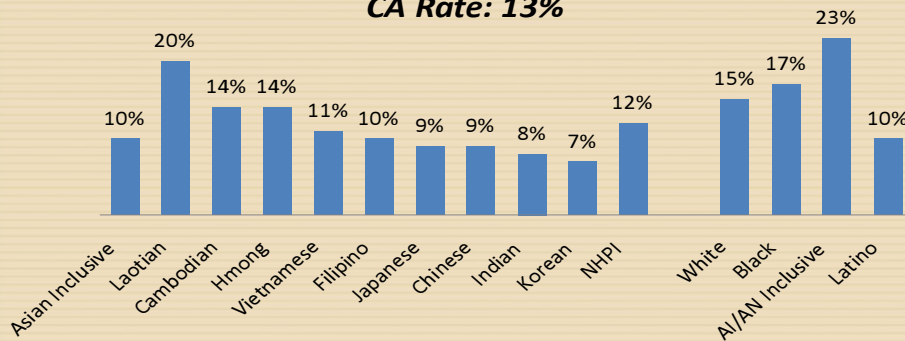
DISABILITY STATUS

The data gathered from ACS on disability are all self-reported indicators. There may be some underreporting in the AANHPI community because of the stigma related to certain types of disability, such as psychological disabilities. Nevertheless, the indicators reveal ethnic diversity within this measure. When examining the disability status of the AANHPI population, Southeast Asians tend to show larger percentages of those who identify as having some form of disability. This may be due to the nature of refugee experiences among the population and trauma from war. The findings about the elderly are not surprising because health problems become more prevalent with age. Another point of consideration with regards to disability is that three of the indicators used in ACS are related to work and barriers to employment.

Exhibit 42. Disability Status

Percent of Total Population with Disability Status

CA Rate: 13%

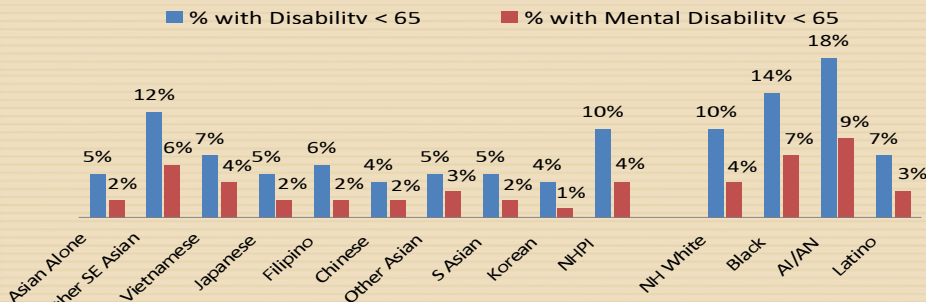


Source: American Community Survey 2006 and PUMS 2006

Exhibit 43. Disability and Mental Disability, CA Adults, Age 18-64

Percent of Population, Adults < 65 Disability Status with Mental Disability

CA Rate: 9% with Disability and 4% with Mental Disability

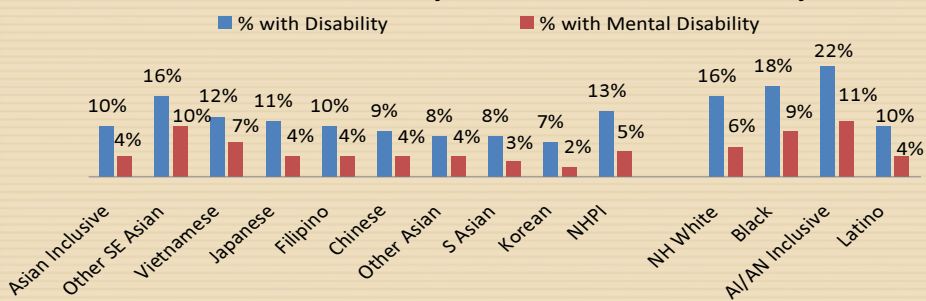


Source: American Community Survey 2006 and PUMS 2006

Exhibit 44. Disability and Mental Disability, CA Adults, Age 65 and Older

Percent of Population, Adults > 65 Disability Status with Mental Disability

CA Rate: 13% with Disability and 5% with Mental Disability



Source: American Community Survey 2006 and PUMS 2006

Exhibit 42, 43, & 44 Disability Status

- Southeast Asians have a higher percentage of the population who have a disability compared to the total population.
- Koreans have a lower rate of disability (7.4%) than the total population (12.9%).
- The NHPI population has comparable disability percentages to the total population.
- Over half of the disabilities reported in the Southeast Asian community included mental disability.
- The Other Southeast Asian population reported the highest percentage of mental disability out of any AANHPI group.
- When taking out individuals aged 65 years or older, similar patterns continue to exist although at lower percentages for each group.

CHRONIC DISEASE

Chronic disease — such as heart disease and diabetes — accounts for seven out of every ten deaths in the U.S. Nearly half of the population in 2005 lived with some type of chronic disease, resulting in major impairments to daily living for many people. In addition to the health burden, chronic disease also accounted for 75% of the nation’s tremendous health care costs. And yet, many chronic diseases are highly preventable through improvements in health behaviors such as decreased weight and smoking prevalence. As compared to other racial/ethnic groups, NHPIs have some of the highest rates of diabetes, due mainly to differences in obesity and overweight. Several other Asian ethnic subgroups also had rates of diabetes that were higher than the California average. Differences in prevalence of other chronic conditions such as heart disease and hypertension can also be seen across Asian ethnic subgroups, further supporting the need to examine the data not only holistically, but by subgroup as well.

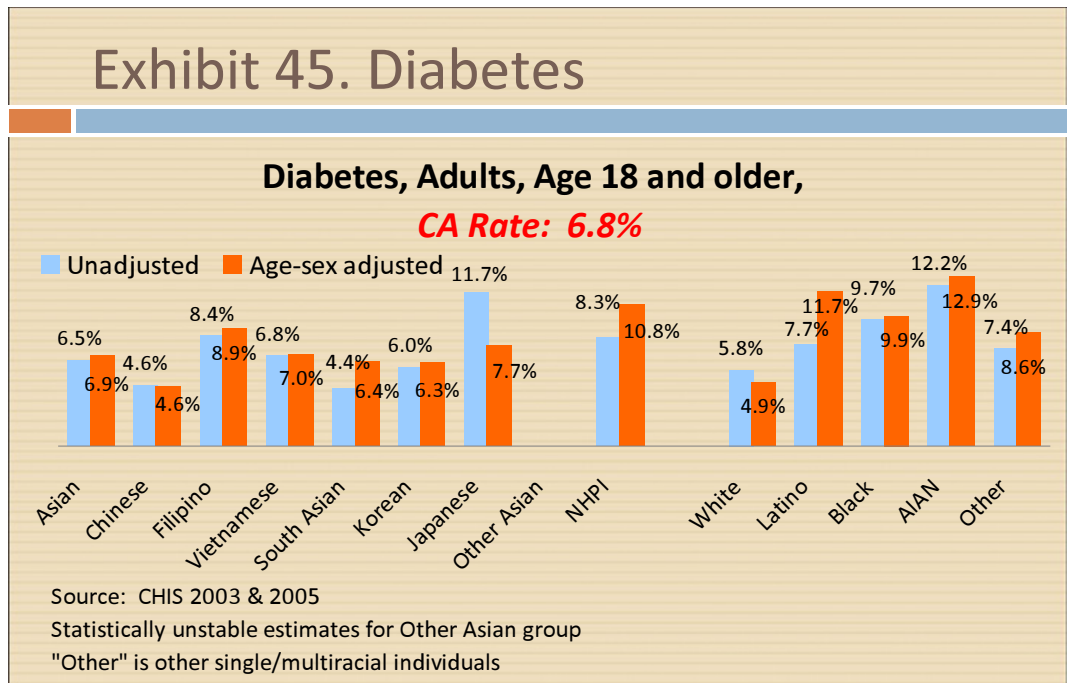


Exhibit 45. Diabetes

- The age-sex adjusted rates allow for comparisons across subgroups that account for the age and sex composition of a population. For example the drop in diabetes rates for Japanese after age-sex adjustment suggests that the higher rate (11.7%) largely reflects an older population.
- NHPIs have high unadjusted and age-adjusted rates of diabetes.
- The NHPI rate is comparable to the Latino rate when accounting for age and sex.
- Filipino age-adjusted rate is higher than the state average and comparable to the Black rate.
- Higher age-sex adjusted rates among Filipinos, Vietnamese and South Asians suggest that diabetes is a problem that strikes these groups, despite having a generally younger population.

Exhibit 46. Heart Disease

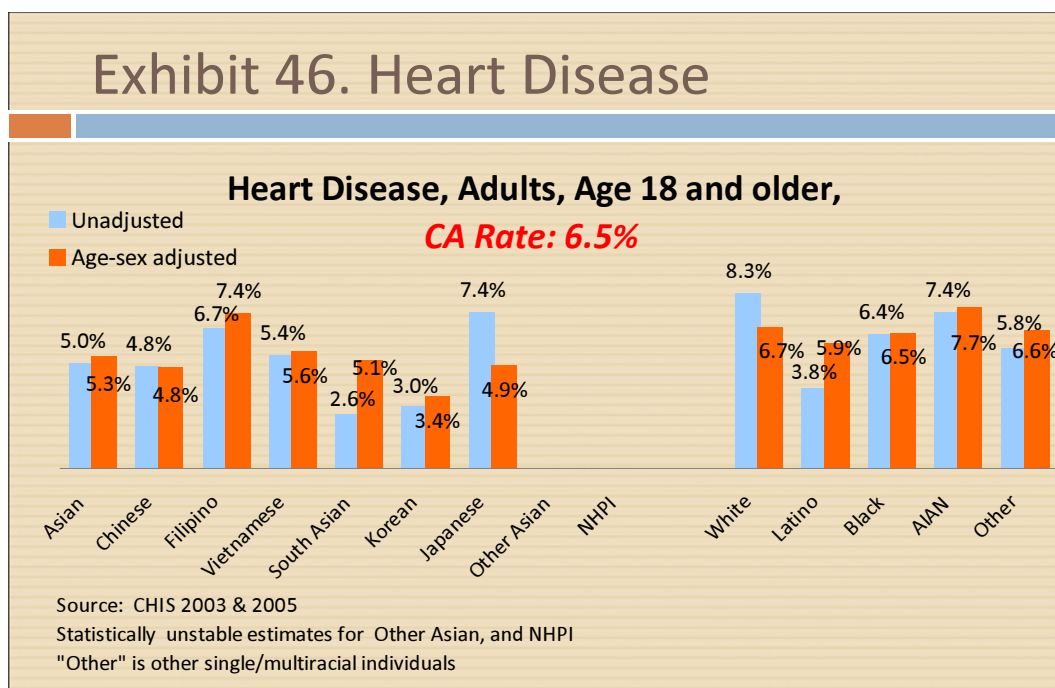


Exhibit 46. Heart Disease

- Filipinos have the highest rate of heart disease among AANHPIs, even after accounting for age and sex.
- Higher unadjusted rates of heart disease among Japanese could be attributed to the fact that the population is relatively older than the overall California population.
- South Asian rates are much higher when adjusting for the age and sex composition of the population.

Exhibit 47. Hypertension

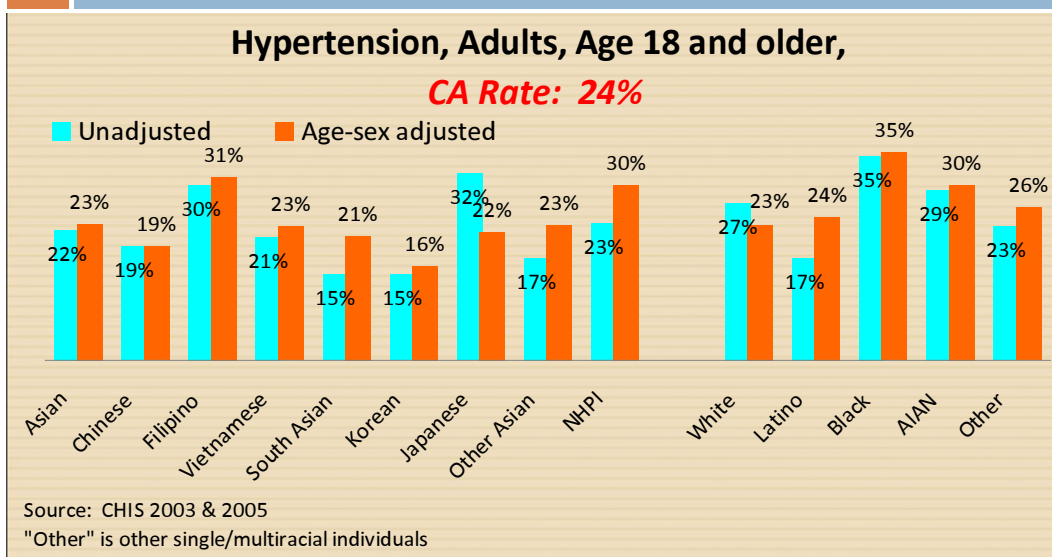


Exhibit 47. Hypertension

- Filipinos, Japanese, and NHPIs have high rates of hypertension.
- Even after accounting for age and sex, Filipinos and NHPIs have high rates of hypertension.
- Hypertension age-sex adjusted rates for Filipinos and NHPIs are comparable to the rate for Blacks.

ASTHMA

One of the most common long-term ailments in children, asthma is a chronic condition characterized by episodes of coughing, wheezing, and breathlessness. The high prevalence of asthma in both adults and children impacts not only individual health and quality of life, but the economy. Millions of health care visits, emergency room visits and hundreds of thousands of hospitalizations are attributed to asthma each year as well as millions of missed school and work days. The incredible impact of asthma on the population has prompted the creation of eight different Healthy People 2010 measures related to the control of asthma ranging from increased patient education to decreased asthma related deaths. Prevalence of asthma among Asian American adults ranges from 3.0% among Koreans to 7.5% among Filipinos – rates comparable to the overall California population. However, rates among AANHPI adolescents are relatively high. In fact, 28% of South Asian and 30% of NHPI youth between the ages of 12 and 17 have been diagnosed with asthma.

Exhibit 48. Adults: Current Asthma

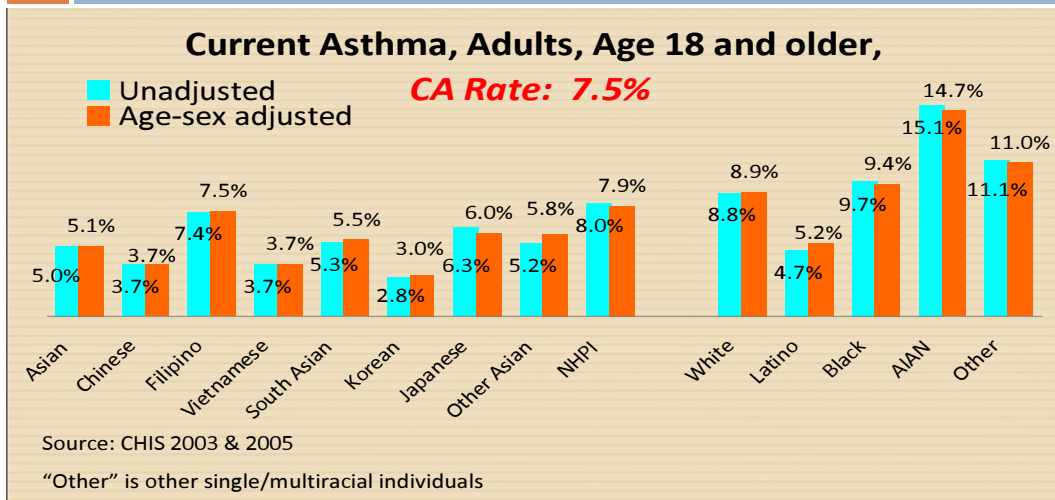


Exhibit 48. Adults, Current Asthma

Exhibit 49. Adolescents: Asthma

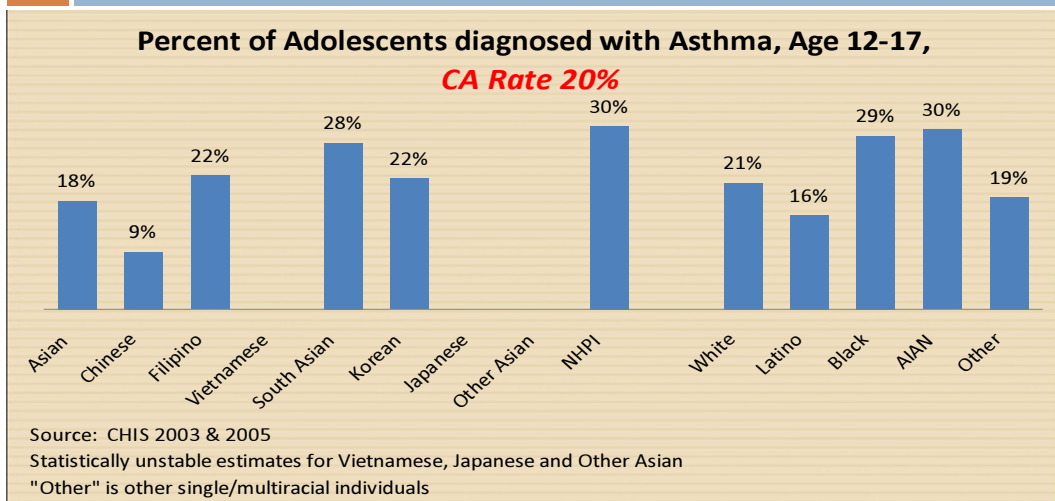


Exhibit 49. Adolescents: Asthma Diagnosis

- Most Asian groups are at or below the state average for current asthma.
- Filipinos and NHPIs have the highest asthma rates among AANHPIs, while Koreans, Chinese and Vietnamese have the lowest rates.
- Among adolescents, Filipinos, South Asians and Koreans have higher than state averages in being diagnosed with asthma.
- The South Asian adolescent asthma rate of 28% and NHPI rate of 30% is comparable to the high rates for Black and American Indian/Alaska Native adolescents.
- Chinese adolescents have relatively low rates of asthma diagnosis (9%).

MENTAL HEALTH

More than a quarter of the U.S. adult population suffers from a diagnosable mental health condition in any given year according to the National Institute of Mental Health. Culture and cultural differences are important not only to the prevalence and diagnosis of mental illness, but in access to mental health services and treatment of conditions. The diversity of experiences and backgrounds of the Asian American population make it difficult to construct any broad generalizations regarding the need for mental health services or the utilization of these services for this group. However, issues such as stress and trauma related to issues of immigration, language barriers, and cultural differences are particularly relevant for the Asian American population as compared to other minority groups in the United States. Overall, research has shown that the disparities in mental health care among Asian Americans are not necessarily a result of stark differences in need or prevalence but in the ability to access quality mental health services. In fact, rates of care-seeking for mental health conditions among the general U.S. population were about double that of AANHPIs. Currently, the need exists for a more diverse mental health workforce to respond to the unique needs of Asian Americans, Native Hawaiians and Pacific Islanders.

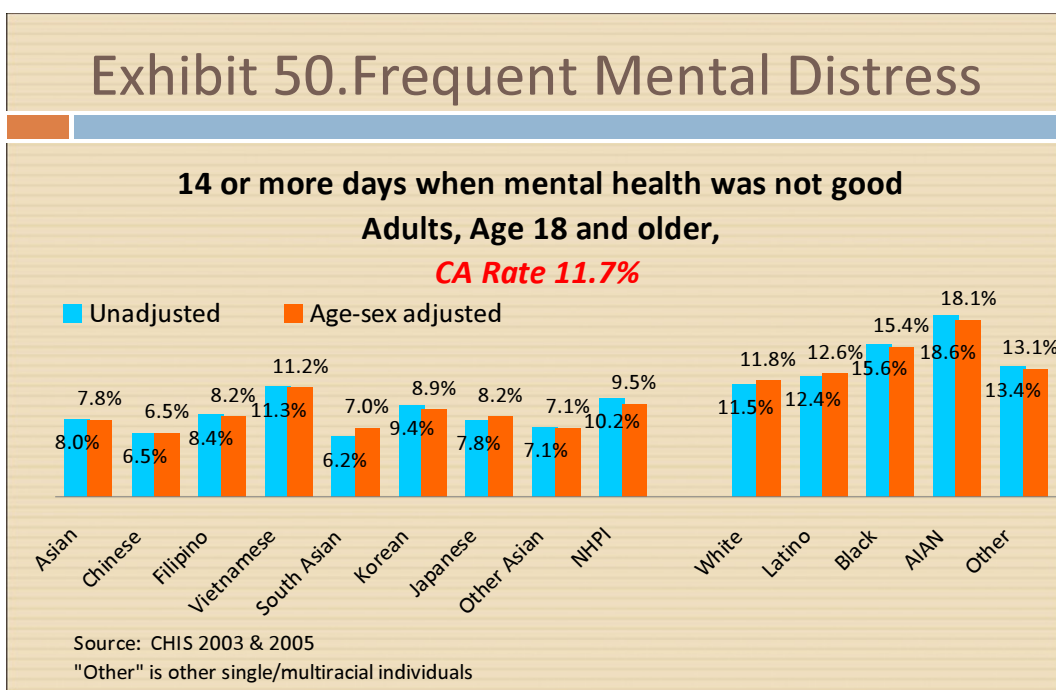
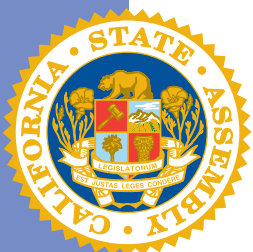


Exhibit 50. Frequent Mental Distress

- Vietnamese and NHPI experience frequent mental distress at higher rates than other AANHPI groups.
- Korean, Filipino and Japanese rates of frequent mental distress are also high, while rates for Chinese, South Asians and Other Asians are lower.
- AANHPIs exhibit generally lower rates of frequent mental distress than other racial/ethnic groups.



REPORT SUMMARY AND POLICY FRAMEWORK FOR LEGISLATIVE ACTION

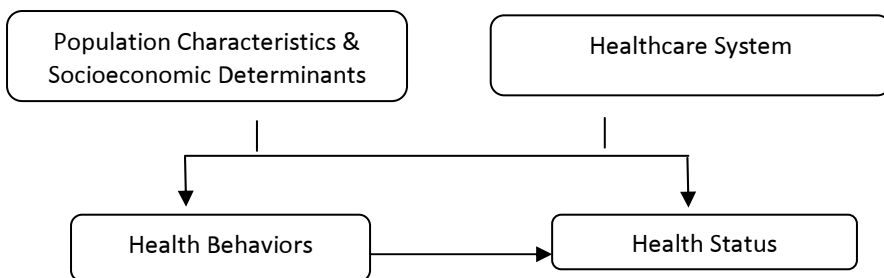


Numbering over 5 million in California, the Asian American, Native Hawaiian and Pacific Islander (AANHPI) population is one of the fastest growing minority groups in California and nationwide with rapid growth projected well into the future. The AANHPI population, with its relatively high proportion of immigrants, differs culturally, linguistically, and religiously from other racial/ethnic groups in California and thus faces its own unique health care needs and challenges.

Complicating this image of AANHPIs in the state is the fact that, although usually combined into one or two large racial categories, many ethnic subgroups exist within the broader population that differ significantly from one another in terms of demographics, socioeconomic status, health status, and health care needs. Thus, the simplistic image of the “model minority” ignores many of the unique and significant barriers faced not only by the broader AANHPI population but, more specifically, by certain ethnic subgroups. This report highlights these concerns by profiling the demographic, socioeconomic, health status, and health behavior differences among Asian American, Native Hawaiian and Pacific Islander ethnic subgroups and by showing these differences in context of the broader California population.

The report’s approach is to examine both the social circumstances as well as health system conditions that may predispose or influence AANHPIs in their health behaviors and that may contribute to disparities that we observe in infectious and chronic diseases (Exhibit 51). Understanding these important population characteristics, socioeconomic determinants and health system factors contextualizes the state of AANHPI health in California and thus more effectively guides policy formulation that addresses both systemic and specific causes of AANHPI health disparities. These policies, in turn, may ultimately reduce the burden of disease and associated health care costs incurred by the state.

Exhibit 51. Conceptual Framework to Guide Policies for Improving AANHPI Health



Population Characteristics & Socioeconomic Determinants

The population characteristics and socioeconomic determinants of health presented in this report — education, occupation, income level, poverty status, home ownership, use of public programs and labor force participation — underscore that certain AANHPI ethnic groups face significant barriers to accessing and utilizing quality health care. Poverty, low-wage employment, citizenship status and limited English proficiency impose financial, legal and linguistic barriers to care. For example, NHPs and Southeast Asians have a higher representation in the service occupations as compared to the overall CA population. Low-wage workers tend to have the least access to health care partly due to a lack of health insurance because they often work for employers who do not offer employment-based coverage. Even in cases where the firm offers health coverage, the employee contribution may be prohibitively expensive. As shown in the coverage section, several Asian subgroups lack coverage, particularly Koreans, who have the highest uninsured rates among all other racial/ethnic groups in the state. In addition, many Asian Americans have a greater percentage of people with limited English proficiency (LEP) compared to most other groups, and a number of studies have established that LEP status among Asians is associated with lower use of preventive services, particularly cancer screening. Finally, permanent residency and citizenship status confer eligibility for some state public coverage and public health programs. California as a state has supported Medicaid and the State Children’s Health Insurance Program (SCHIP) for legal permanent residents in the absence of federal support. With large segments of immigrants who are new entrants and not yet naturalized citizens, California’s AANHPI population would greatly benefit from policies that continue to support access to health care for immigrants.

Recommendations that address Socioeconomic Determinants

- *Support expansion of employment-based coverage through mechanisms that incentivize employers to offer health insurance to their workers. Such policies would benefit a sizable portion of the AANHPI population, particularly those who work in the low-wage sector.*
- *Support policies that increase linguistic access to health care. These include policies that monitor linguistic and cultural competency of both public and private health providers and that reimburse providers for language assistance services, including translation of materials, use of qualified interpreters, and development of multi-language hotlines and websites that facilitate appointment-making and information dissemination.*
- *Support policies that include permanent residents in their eligibility for public coverage programs of Medicaid and SCHIP.*
- *Support policies that include all California residents, including immigrants, in access to public health programs.*

Recommendations that address the Health care System

- *Support expansion of health care coverage to uninsured Californians and ensure that health care coverage includes mental health and dental coverage.*
 - ✧ *Nearly one-third of the Korean population had no health insurance for the entire year, the highest rate of uninsurance in the California population. Korean rates were also the highest in having no dental coverage.*
 - ✧ *Among the insured, Vietnamese represent the highest proportion of insured Californians who are without mental health coverage, yet they also post the highest proportions who report frequent mental health distress among AANHPI groups.*
- *Support continued and expanded funding for community health centers, providers of basic health care for many vulnerable segments of the California population.*

- *Support culturally-appropriate patient education programs that emphasize the importance of having a regular source of care, getting an annual physical exam and getting screened for certain cancers. While the importance of continuity of care and an annual exam is known among the general population, patient education can be targeted to those at highest risk of non-compliance for these preventive services. Targeted resources aimed at increasing screening rates for cervical cancer, breast cancer and colorectal cancer among AANHPIs have the potential to reduce cancer mortality in this population.*
 - ✧ Koreans and NHPIs have higher proportions of individuals without a regular source of care compared to the state average.
 - ✧ Most Asian groups, and Koreans in particular, did not have a doctor visit in the past year.
 - ✧ AANHPI women in general, and across subgroups (except Filipinos), have higher rates of noncompliance in Pap tests than all other racial and ethnic groups. Mammogram noncompliance rates are also particularly high among Koreans.
 - ✧ All Asian and NHPI groups have colorectal cancer screening rates that are much lower than the state average. Asian men also have the lowest prostate cancer screening rates than all other racial/ethnic groups, with non-compliance screening rates exceeding the state average of 57% among Chinese, Filipino, Vietnamese, Korean and Japanese.

- *Policies aimed at increasing the diversity of medical graduates and placement of minority physicians in high need areas will likely result in care for minority patients that is more culturally and linguistically concordant.*
 - ✧ Currently, the supply of racial/ethnic minority physicians in the state does not reflect the incredible diversity of the patient population. This is particularly true for groups such as Southeast Asians whose numbers in the population far outnumber the availability of Southeast Asian health care providers.

Recommendations that address Behavioral Risk Factors

Risk factors for poor health outcomes — such as smoking and obesity/overweight — vary dramatically between AANHPI ethnic groups. For example, smoking rates among Asian American men are particularly alarming, with a quarter of all Filipino men being smokers. Efforts to reduce risky health behaviors among specific groups may improve health outcomes and reduce the prevalence and incidence of preventable diseases such as diabetes.

- *Policies that support patient/consumer education in the following areas and that target the most vulnerable AANHPI groups.*
 - ✧ Smoking cessation programs targeting Asian males, particularly Filipinos.
 - ✧ Healthy eating and food choices, especially among Filipino, Vietnamese, Chinese, and Korean adults.

- *Policies that support nutritional education programs that promote healthy food choices in schools would benefit a majority of AANHPI groups.*
- *Supporting studies that examine the economic factors (e.g. prices of fresh fruit and vegetables and availability of grocery stores in areas) that influence healthy food choices, especially among adolescents.*
- *Policies targeting the obesity epidemic among Native Hawaiian and Pacific Islander adolescents.*

Recommendations that address Health Status and Specific Disease Areas

The data presented in this report provide an initial look at the health status and health care needs of the AANHPI population, by ethnic subgroups. With this picture we see a wide range of experiences within the AANHPI population and the stark differences in each group's health status, ability to access health care and health behaviors. Priority areas for policy formulation are:

- *Reducing infant mortality rates for NHPIs through programs that promote improved access to prenatal and newborn care, including Healthy Start, Medicaid and the State Children's Health Insurance Program (SCHIP) and public health campaigns to prevent child malnutrition.*
- *Reducing tuberculosis (TB) rates among Asian immigrant groups, targeting immigrants from the Philippines and Vietnam by supporting county efforts in health education, surveillance and prevention and control programs.*
- *Reducing hepatitis B rates in the Asian American population by increased screening and vaccination among adolescents and adults. Since July 1, 1999, all California students entering the 7th grade are required to be immunized against hepatitis B. Outreach, screening and vaccination to Asian Americans who do not fall under this policy must continue to ensure protection of California's population against this infectious disease.*
- *Continuing support to counties, community and provider organizations that undertake education and awareness campaigns that reduce the stigma of hepatitis B and TB, and that promote culturally-competent prevention and control efforts.*
- *Legislation that supports the health care system in the prevention and control of diabetes should have a special emphasis on targeting NHPI and Filipino adults, who have diabetes rates that are markedly higher than the state average.*
- *Legislation that supports the health care system in the prevention and control of heart disease and hypertension should have a special emphasis on targeting Filipino adults, who have markedly higher age-sex adjusted rates than all other AANHPI groups, and Japanese American older adults.*
- *Legislation that supports the health care system in the prevention and control of childhood asthma should target South Asian adolescents. Over a quarter of South Asian adolescents have been diagnosed with asthma, and this very high rate is comparable to Black and American Indian/Alaska Native adolescents.*
- *Policies should address diversification of the mental health workforce to respond to the unique mental health needs and mental health access issues of AANHPIs, with special attention to Vietnamese and NHPI adults who report high rates of frequent mental distress.*

Recommendations for Data Development for the AANHPI Population

This report compiles and analyzes various datasets depicting the AANHPI population in California. As best possible, given the available data and the stability of estimates for each AANHPI subgroup, the report provides a detailed picture of the AANHPI population, including social and health indicators that typically are not available in most published reports. Below we highlight the subgroup data available for each of the datasets used in this report and highlight priorities for data needs of the population. (Exhibit 52)

Most of the datasets utilized in this report comply with the Federal Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity

(1997) to separate Asian from NHPI data. Aggregation exists in the TB registry data, but this heeds confidentiality and data privacy reasons. The California Department of Education data includes a 100% count of 5th graders taking a physical fitness exam and therefore reflects the racial/ethnic detail of California 5th graders. The National Cancer Institute Surveillance Epidemiology and End Results (NCI SEER) program also has a number of racial/ethnic categories, owing to a much larger national population, compared to a state population. This allows for cancer incidence and mortality estimates without violating patient confidentiality. For the California Cancer Registry, five-year averages increased the stability of estimates for five Asian subgroups, but no data is available for NHPI subgroups or even NHPIs as an aggregate category. Representation in these disease registries, however, also reflects a population's risk, so that some AANHPI subgroup estimates may not be presented in reports because the disease incidence is very rare for these groups.

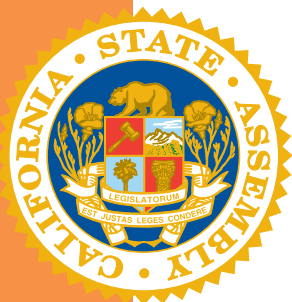
For the California Health Interview Survey, a population-representative sample of households in California, six Asian groups are represented, but the NHPI group estimate is aggregated. In addition, for some indicators, estimates were unstable and were not reported. Combining several years of data increased the number of observations per subgroup, but for some indicators and for some groups, unstable estimates still did not permit reporting for every group, as noted in Exhibit 52. Providing continued support for current data sources such as the California Health Interview Survey and the California Cancer Registry – and initiating new disease registry programs for important diseases such as diabetes and heart disease – ensures continued progress in data collection, research and understanding of the health status and health care needs of this population. Finally, the U.S. Census Bureau's American Community Survey, averaged over three years, provides a sociodemographic picture of nine Asian subgroups, but the NHPI group is also aggregated.

Clearly the data development priority for the AANHPI group is to increase the information for NHPIs. Data development to generate estimates for other Southeast Asian groups besides Vietnamese is also needed. Additionally, data development efforts are needed to disaggregate the South Asian category into Indian, Pakistani, Bangladeshi and Sri Lankan.

Precisely understanding specific AANHPI subpopulation health needs provides a base of evidence to more effectively formulate policies for this very diverse and rapidly growing population in California.

Exhibit 52. Datasets and Availability of AANHPI Subgroup Information

American Community Survey (ACS)	California Health Interview Survey (CHIS)	Vital Statistics	Tuberculosis Disease Registry	Hepatitis B Disease Registry	California Cancer Registry	National Cancer Institute Surveillance Epidemiology and End Results (NCI SEER)	California Department of Education
			Country of Origin	Country of Origin			
Asian NHPI	Asian NHPI	Asian NHPI	Asian/NHPI	Asian	Asian	Asian	Asian NHPI
Chinese	Chinese	Chinese			Chinese	Chinese	Chinese
Filipino	Filipino	Filipino			Filipino	Filipino	Filipino
Vietnamese	Vietnamese	Vietnamese			Vietnamese	Vietnamese	Vietnamese
Indian	South Asian	Indian				Asian Indian & Pakistani	
Japanese	Japanese	Japanese			Japanese	Japanese	
Korean	Korean	Korean			Korean	Korean	Korean
Cambodian						Cambodian	Cambodian
Hmong							
Laotian						Laotian	Laotian
	Other Asian						Other Asian
							Native Hawaiian
						Samoan	Samoan
							Tahitian
							Guamanian
							Other PI



Methodology

This report is a product of secondary data analyses of several data sources, as well as a compilation of information from published administrative reports and peer-reviewed articles. When published data is reported, data sources and research articles are noted directly with the exhibit. This methodology section focuses on the secondary data analyses component of the report, specifically on the use of the Census Bureau’s American Community Survey (ACS), the Decennial Census and Public Use Microdata Samples (PUMS) and the UCLA Center for Health Policy Research’s California Health Interview Survey (CHIS). We highlight the general approach used for each exhibit. Information on the details of each analysis can be obtained from the authors by request. SAS 9.1.3 was used for the Census data analyses (ACS, PUMS) and Stata 10 was used for the CHIS analyses.

Exhibit Title	Data Source(s)	
Exhibit 1	<p>1960 PUMS</p> <p>1970 PUMS</p> <p>1980 – 2000</p> <p>U.S. Census</p> <p>2006 ACS</p> <p>2000 Census – Alone (Table P3), Inclusive (Tables PCT7 and PCT10)</p>	<p>1970 Asian population numbers include other races.</p> <p>1960 and 1970 NHPI numbers are estimates using PUMS.</p> <p><u>1960s and 1970s Native Hawaiians and Other Pacific Islanders</u> The race variable was dummy-coded for Native Hawaiians and Other Pacific Islanders using PUMS 1960 and the Long Form for 1970. In the 1960 dataset, Native Hawaiian was determined by race defined as other and the state of birth as Hawaii. In the 1970 dataset, Native Hawaiian was listed as a distinct code within the race variable. Other Pacific Islander, for both 1960 and 1970, was determined by race defined as other and state of birth as Guam, American Samoa, Pacific Trust Territories, and other Pacific Islands. A separate dataset and variables were created to indicate households as Native Hawaiian or Other Pacific Islander. The datasets were then merged to identify households and individual records, which were Native Hawaiian or Other Pacific Islander. The merged dataset was then examined to identify any records that would be problematic. For example in the 1960 dataset, records that were listed as “other race” but did not fit under Native Hawaiian, Other Pacific Islander, or NHOPI households were excluded in the findings.</p> <p><u>1980 – 1990 Census Data</u> The 1980 and 1990 numbers were taken from their respective Census profiles for the state of California.</p> <p><u>2000 Census Data</u> The 2000 Census was the first time individuals were allowed to identify as one race alone or in combination with other races. In this table, both numbers are reported. Asian and NHOPI alone figures were taken from Table P3. Asian Inclusive figures were taken from Table PCT7 and NHOPI figures form Table PCT10.</p> <p><u>2006 Data from the American Community Survey</u> The ACS utilizes a sample of the population from all counties in the United States.</p>
Exhibit 2	<p>State of California, Department of Finance,</p>	<p>The racial categories used in the projections are mutually exclusive and do not incorporate the new inclusive categorization utilized by the Census. Possible reasons for the underestimation in the AANHUPI projections for California include conservative approaches to calculating the projections, as well as the mutually exclusive categorization of race.</p>

	<i>Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.</i>	
Exhibit 3	2006 ACS	The percentage of each subgroup was calculated by taking the number of Asian Americans or NHOPI and divided by the total population in each county. Please note that the data for the NHOPI population is based on a small sample size and therefore, may not be an accurate indicator of the NHOPI population in each county.
Exhibit 5	2006 ACS 2006 PUMS	The 2006 ACS was the principal data source. South Asian, Southeast Asian, and Other Asian data was derived from the 2006 PUMS. The South Asian category was comprised of Indian, Bangladeshi, Pakistani, and Sri Lankan ethnic groups. The Southeast Asian category was comprised of Vietnamese, Cambodian, Hmong, and Laotian ethnic groups due in part to the shared refugee experience. The Other Asian category was comprised of individuals who identified with ethnic groups other than the ones listed in the table. The inclusive numbers for the AANHOPi population reflect duplicate records due to the ability of individuals to select multiple options in the race category. Also, the Chinese category is inclusive of the Taiwanese population in the published data. The ethnic category, Indian, comprise 95% of the South Asian alone category and 98% of the South Asian inclusive category. Due to these findings, published information on Indians rather than South Asian was used in the estimates using ACS or PUMS.
Exhibit 6	2006 ACS	Percentages were calculated for individuals under 18 years of age, 65 years of age and older, and marital status. The fertility rate was calculated by taking the number of women 15 to 50 years of age who had a birth in the past 12 months, divided by the total number of women 15 to 50 years of age, then multiplied by 100. The fertility rate represents the number of births per 100 women, aged 15 to 50, for each population.
Exhibit 7-10	2006 ACS	The percent of foreign-born people by ethnic groups was calculated by taking the number of foreign-born people divided by the total population within that ethnic group. The naturalization rate was calculated by taking the number of naturalized people divided by the number of foreign-born. Limited English proficiency was classified as those who speak English less than “very well.” Data for racial and ethnic categories (including non-AANHOPi categories) are inclusive, unless otherwise stated.
Exhibits 11-12	2006 ACS	Educational attainment is based on the population age 25 years and over who have received less than a high school diploma. The percent of those who received a bachelor’s degree or higher was calculated by combining the

		number of bachelor's degree recipients and graduate or professional degree recipients. The occupation data were based on percent of the population aged 16 years or over.
Exhibit 13	2006 ACS	The data were taken from published information available from the ACS and 2006 PUMS and utilizes race and ethnic inclusive published data.
Exhibit 23	Census 2000 Summary File	Due to the small sample size in the 2006 ACS, data were taken from a Census 2000 Summary File. The number of physicians and registered nurses per 1,000 was calculated by taking the actual number of physicians or registered nurses divided by the total population in the ethnic group multiplied by 1,000.
Exhibits 42-44	2006 ACS 2006 PUMS	Individuals aged 5 years or older, who had any disability, were recorded in the published data in ACS. Information was gathered for race and ethnic inclusive categories. Data were gathered for the total population in each group then for the population younger than 65 years of age. The racial and ethnic alone data were utilized for the purposes of examining the Southeast Asian population more closely.
Exhibits 14-22 Exhibits 24-28 Exhibit 49	2003 & 2005 CHIS Adult & Adolescent Files	Two years of CHIS data were pooled to increase the number of observations per AANHOPi subgroup. Estimates were weighted to the California population. Specific subsample restrictions (for example age, sex, insured population) for each estimate are noted in each of the exhibits. Estimates with a coefficient of variation (standard error/mean) exceeding 30% were not reported. For some estimates, only one year of data was available—either 2003 or 2005—and this is noted in the exhibit. The racial/ethnic categories reported are mutually exclusive. We employed the UCLA Center for Health Policy Research tabulation of race/ethnicity (racehpr) that uses a “most identified” race/ethnicity question to assign multiracial individuals into single race categories. The “Other Asian” category includes Southeast Asians other than Vietnamese and those who identify as multiracial.
Exhibits 45-48 Exhibit 50	2003 & 2005 CHIS Adult Files	These estimates followed the computation and statistical testing procedures used to generate the previous CHIS exhibits. In addition, we calculated age-sex adjusted rates. We constructed fourteen age-sex cohorts based on CHIS weighted population data, calculated the proportions for each cohort and used these proportions to standardize these chronic disease estimates by age and sex. The 14 cohorts used for standardization were: females ages 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75+ and males 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75+.

California Asian Pacific Islander Joint Legislative Caucus

The California Asian Pacific Islander Joint Legislative Caucus represents and advocates for the interests of the diverse API communities throughout California. It seeks to increase Asian Pacific Islander participation and representation in all levels of government. Additional information can be found at: <http://democrats.assembly.ca.gov/apilegcaucus/>.

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Assemblymember Mike Eng, 49th District Biography

Assemblymember Mike Eng represents the 49th Assembly District, which is located within eastern Los Angeles County and includes the cities of Alhambra, El Monte, Monterey Park, Rosemead, San Gabriel, San Marino, and South El Monte.

Assemblymember Eng chairs the State Assembly Transportation Committee, which oversees the work of the state Office of Traffic Safety, the High Speed Rail Authority, and the Departments of Transportation, Motor Vehicles, California Highway Patrol and Air Resources (for mobile source emissions). Consequently, the Committee develops policies for a broad range of issues such as those related to vehicle license and registration, the State Highway System, local streets and roads, transit, general aviation, fuels, rules of the road, and rail.

Recently, Assemblymember Eng was appointed by Assembly Speaker Karen Bass to the California Transportation Commission (CTC) to serve as one of two ex-officio members. The CTC is responsible for the programming and allocation of funds for the construction of highway, passenger rail and transit improvements throughout California.

Assemblymember Eng has a wide range of other leadership assignments, including membership on the Assembly committees on Business and Employment (of which he previously chaired), Education, Housing and Community Development and Labor Employment.

Assemblymember Eng's top legislative priorities include: addressing California's transportation infrastructure needs, creating "green" jobs, tackling the underground economy by going after tax cheats, advocating for stronger consumer protections, fighting for groundwater cleanup in the San Gabriel Valley and throughout the state, eliminating health disparities among underserved communities, and confronting the growing problem of hate crimes in California and the rest of the nation.

Assemblymember Eng earned his law degree from the University of California Los Angeles. He earned his Bachelor's and Master's degrees at the University of Hawaii while working full-time at a local emergency room. He is also a part-time community college instructor.

University of California Asian American & Pacific Islander Policy MRP

The University of California Asian American & Pacific Islander Policy Multi-Campus Research Program (MRP) promotes and supports applied research on policy issues related to AANHPIs in California, and its faculty affiliates are experts from a wide range of disciplines with knowledge about the complex nature of AANHPI communities. The MRP works with elected officials and their staff, community organizations, and public interest groups. Additional information can be found at <http://www.aasc.ucla.edu/policy/>.

Melissa Gatchell, MPH, is a PhD candidate in the Department of Health Services at UCLA. Melissa's research and dissertation focus on disparities in preventive care among low-income women. She is currently working on a grant that examines the role of safety net clinics in California on cervical cancer screening for low-income women.

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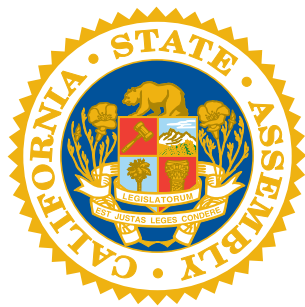
Acknowledgements

The State of Asian American, Native Hawaiian and Pacific Islander (AANHPI) Health in California report was made possible with the support of the following organizations: University of California Asian American and Pacific Islander Policy Multi-Campus Research Program (MRP), UCLA Asian American Studies Center, and the Asian & Pacific Islander American Health Forum.

We are grateful to the following individuals for their assistance and advice: Gary Dymiski, Alex Franco, Christina Aujean Lee, Julio Martinez, Catherine 'Ofa Mann, Andres E. Jimenez, Steve Juarez, and Gil Ojeda.

Several UC faculty members served on the MRP's Health Work Group or participated in the hearing on AANHPI health held in Sacramento on November 13, 2008: Moon S. Chen, Gordon L. Fung, Gilbert C. Gee, Lisa C. Ikemoto, Joel M. Moskowitz, Tung Nguyen, Marjorie Kagawa-Singer, Stanley Sue, Lois M. Takahashi, and Nolan W. Zane.

We would also like to thank Gena Lew Gong for copy editing the report and writing the executive summary, Michelle Sun for doing the typesetting and graphic design, and especially Annie Lam for coordinating and managing this project to its completion.



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