aapi nexus Vol. 4, No. 1 (Winter/Spring 2006): 81-96

Resource Paper

Measuring State-Level Asian American and Pacific Islander Health Disparities: The Case of Illinois

Laurent S. Tao, Jini Han, and Ami M. Shah

Abstract

Illinois is home to the sixth largest Asian American and Pacific Islander (AAPI) population nationwide. AAPIs suffer higher incidence, morbidity, and mortality rates from certain cancers, infectious, and chronic diseases. Despite the exponential growth of the AAPI population, few state-level data sources exist that provide detailed and accurate information regarding AAPI health disparities and needs. Efforts to improve health care for this population will require improved data collection and funding for research on AAPI ethnic groups.

Introduction

In the United States racial and ethnic disparities in health status, disease burden, morbidity, and mortality persist (Department of Health and Human Services 2000a). A recent report to the Department of Health and Human Services (DHHS) concluded that while overall health status may be improving for all racial and ethnic groups, some groups continue to suffer disproportionate rates of death and disability (Department of Health and Human Services 2002). One of the primary goals of the DHHS' Healthy People 2010 Initiative is to eliminate these racial and ethnic health disparities by the year 2010 (Department of Health and Human Services 2000b). Furthermore, the Institute of Medicine (IOM) documented that definite racial and ethnic disparities in the provision of numerous medical services exist. The IOM investigation revealed that minority populations such as African Americans have lower rates of coronary artery revascularization procedures, kidney transplan-

tation, and antiretroviral treatment for HIV infection (Institute of Medicine 2003). Less is known about Latino populations, and even fewer studies involve Asian American and Pacific Islander (AAPI) communities. The lack of health data is particularly pronounced at the state level.

Hawaii, New York and California, with their larger AAPI populations, have relatively more AAPI health data from administrative sources and surveys, but most other states fare poorly in terms of collecting and publishing AAPI health information. Data from these states are often used to make generalizations about AAPIs residing throughout the US. However, given that migration and ethnic distribution patterns of AAPIs differ in the rest of the country, it is likely that health status and needs also differ significantly by region. There is, therefore, a critical need for state-specific information. The situation in Illinois provides insights into what is available and not available, and the implications of the paucity of data. In Illinois, home to the sixth largest AAPI population nationwide, AAPIs increased by 45 percent between 1990 and 2000 (Department of Commerce 2002). Despite the growing AAPI community in the state and particularly in the urban Chicago area, few data sources exist that detail local health outcomes and needs. We present a discussion of the current status of AAPI health data in Illinois, existing deficiencies, and the challenges in gathering and using local and state-level health data. In the conclusion we introduce policy recommendations to improve the quality and accessibility of AAPI health data.

AAPI Health Disparities

Compared to other racial and ethnic populations, AAPIs bear higher incidence, morbidity, and mortality rates of several diseases. Trends in the burden of cancer among AAPIs are especially striking. AAPI women were the first U.S. population to have cancer as the leading cause of death, and cancer is the second leading cause of death in AAPI men. Between 1980 and 1993, mortality from cancer increased by 240 percent for AAPI women and 290 percent for AAPI men, the greatest increases reported for any ethnic group in the U.S. (Miller 1996). There is also emerging evidence that infectious and chronic diseases such as diabetes mellitus and hypertension may disproportionately affect the AAPI population (Chen 1993; Jin 2002).

Colorectal Cancer

While incidence of colorectal cancer (CRC) among non-Hispanic Whites has been decreasing since 1985, the incidence among AAPIs has remained virtually unchanged. Japanese men have the second highest incidence rate of CRC of all ethnic groups, Japanese women have the third highest rate, and Filipinos have the second lowest five-year survival from CRC (Miller 1996). State-level cancer data reveal that in Illinois, CRC affects individual AAPI subgroups differently, variability that can only be documented by disaggregating AAPI data. For example, a study performed by the Illinois Department of Public Health (IDPH) found that CRC ranks as the second most commonly diagnosed cancer among AAPIs as a whole, compared to being ranked fourth in Whites. In subgroup analyses CRC is the most common malignancy in Japanese and Chinese Americans and the fourth most common in Asian Indians/Pakistanis (Dolocek 2000). These statistics suggest that such subgroup-specific information may be crucial in identifying patterns of disease and addressing cancer prevention and treatment needs within ethnically different AAPI communities.

Screening for CRC with interventions such as fecal occult blood testing (FOBT) is an important part of decreasing overall mortality. CRC is often diagnosed at a later stage in African Americans, and studies have shown that this may be due in part to race, socioeconomic status, insurance status, or lack of use of screening procedures (Chen 1997; Mandelblatt 1996; McMahon 1999; Roetzheim 2000). It is noteworthy that AAPIs have not been adequately represented in any of these studies, nor have the studies been replicated with different AAPI subpopulations. In fact, due to small sample sizes in Behavioral Risk Factor Surveillance Survey (BRFSS) data, reliable estimates of CRC screening utilization among AAPIs in Illinois are unavailable (Dolocek 2000). However, there is evidence of a significant difference in utilization by AAPIs. Although national rates of screening are almost equal when comparing non-Hispanic minorities to Whites, AAPIs have the lowest FOBT screening rate—more than two times lower than that of Whites and African Americans (American Cancer Society 2003a). Furthermore, data from the California Health Interview Survey highlights disparities in colorectal cancer screening rates for AAPIs, with almost all ethnic AAPI subgroups reporting significantly lower rates of recent screening compared to the rest of the state population (Ponce

2003). Because of the limitations of Illinois's BRFSS data, we are forced to speculate.

Breast Cancer

National data indicates that AAPI women have a lower incidence rate of breast cancer (97.2 per 100,000) compared to their non-Hispanic White counterparts (140.8 per 100,000) and also experience relatively low breast cancer mortality rates (Miller 1996; Ward 2004). However, breast cancer continues to be the leading cancer diagnosed in AAPI women, and it is likely that the burden of breast cancer morbidity and mortality may be increasing rapidly within the AAPI population (Miller 1996). Epidemiological evidence indicates that when women immigrate to the U.S., their risk of breast cancer rises to six times that of women in their native countries over the course of their time in the U.S. (Ziegler 1996). This concept is illustrated in the higher rates of breast cancer seen in Japanese American women, an ethnic group that immigrated to the U.S. earlier than most other AAPI groups. Breast cancer incidence for Japanese American women has increased persistently since 1988 and is now approaching rates for non-Hispanic White women (Deapen 2002). In addition, subgroups such as Native Hawaiian women have the second highest breast cancer incidence rate in the U.S. (Miller 1996). Subgroup analyses further reveal that several AAPI subgroups experience increased risk of advanced stage of cancer at diagnosis, higher rates of inappropriate treatment, and worse survival rates after breast cancer diagnosis (Hedeen 1999; Li 2003). A report by the IDPH documents that AAPI women in Illinois are less likely to be diagnosed at an early (and more curable) stage of invasive breast cancer compared to their White counterparts, potentially reflecting suboptimal breast cancer screening among AAPI women in Illinois (Dolocek 2000).

National data indicate that AAPIs have lower rates of recent breast cancer screening when compared to every racial/ethnic group other than American Indians/Alaska natives (American Cancer Society 2003b; Kagawa-Singer 2000; Ward 2004). However, data about AAPI mammography utilization is poor, and in many states, state-specific mammography rates cannot be determined due to insufficient data. For example, mammography use by AAPIs in Illinois remains poorly documented because fewer than fifty AAPI respondents were represented in the state's BRFSS (Bolen 2000).

When available, state and community-based research have revealed the presence of significant disparities in screening mammography among specific AAPI populations. Particularly low rates of mammography utilization have been documented among Chinese, Vietnamese, Korean, and Filipino women. For example, among multiethnic women in San Francisco, 73 percent of Chinese and 46 percent of Vietnamese women reported prior mammography, compared to 93 percent of White women (Hiatt 1996). The California BRFSS and Korean Health Survey show that Koreans are under-screened, with 45 percent to 52 percent of Korean women reporting no previous lifetime mammogram; only 10 percent of the state's general female population has never had a screening mammogram (Centers for Disease Control 1997; Wismer 1998). Low rates of recent mammography use have also been demonstrated among Cambodian women (12 percent to 40 percent) and Filipino women (55 percent) (Kelly 1996; Maxwell 2000; Tu 2000). Less is known about Asian Indian women's screening rates, although aggregated National Health Interview Survey (NHIS) data suggests significant under-screening, with 68 percent of Asian Indian women reporting no prior mammogram (Sadler 2001).

Cervical Cancer

In the United States the age-adjusted incidence rate of cervical cancer is almost five times higher among Vietnamese women (43.0 per 100,000) than among non-Hispanic White women (7.5 per 100,000) (Miller 1996). Korean and Chinese women also have incidence rates (15.2 per 100,000 and 12.3 per 100,000, respectively) almost twice that of non-Hispanic White women (Parkin 1992). Furthermore, AAPI subgroups tend to present with more severe disease. Twenty-one percent of Chinese women presented with an advanced stage of disease, whereas only 8 percent of non-Hispanic Whites were similarly staged at the time of diagnosis (Jenkins 1994). Pacific Islanders also presented with a more advanced stage of disease (75 percent vs. 25 percent for non-Pacific Islanders), more lymph node involvement (23 percent vs. 7 percent) and poorer five-year survival rates (32 percent vs. 71 percent) (Robison 2002).

These findings suggest that the AAPI population is not optimally utilizing or being offered access to cervical cancer screening tests. A low ratio of in situ to invasive squamous cell neoplasms

among AAPIs further supports the hypothesis that these populations are not diagnosed or treated at an early preinvasive stage (Frisch 2000). Despite the fact that regular screening can decrease cervical cancer mortality, AAPIs constitute the group that has the lowest rate of use of the Papanicolaou screening test (American Cancer Society 2003b). Rates of cervical cancer screening among Vietnamese women are consistently lower than in the general population (Kagawa-Singer 2000; Ponce 2003; Taylor 2004). It is concerning that despite their high-risk status for cervical cancer, screening rates among Illinois AAPI women are not known due to insufficient representation in the state's behavioral health survey (Bolen 2000). However, the state's cancer registry indicates that AAPI females are less likely to be diagnosed with early and local stages of invasive cervical cancer in comparison to White women, further supporting the likelihood of under-screening in this population (Dolocek 2000).

"Signature Cancers"

As a group AAPIs suffer a disproportionate burden of morbidity and mortality from specific cancers that are unique compared to non-AAPI populations. For example, AAPIs have the highest incidence and mortality rates of all racial and ethnic groups of nasopharyngeal, gastric, liver, and intrahepatic bile duct cancers (Centers for Disease Control 2003; Ward 2004). Vietnamese men have an incidence rate of liver and intrahepatic bile duct cancer that is more than 10 times higher than in non-Hispanic White men (41.8 per 100,000 vs. 3.3 per 100,000) (Miller 1996). AAPI women also have the highest incidence rates of endocrine and thyroid carcinomas (Miller 1996; Centers for Disease Control 2003). Illinois statistics confirm the increased incidence of these AAPI-prevalent cancer sites when compared to Whites. For instance, gastric cancer was the number one site for cancer mortality among Koreans in Illinois, and thyroid cancer was the fourth most common site of malignancy in AAPI women, whereas it was not even among the top ten sites in White women (Dolocek 2000). Although the increased incidence of these "signature" AAPI malignancies are well documented and frequently screened for in other countries, guidelines for prevention and early detection are lacking in Illinois, as well as in the greater U.S.