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"Toward Healing and Health Equity for Asian American, Native Hawaiian, and Pacific Islander Populations" – authored by Howard K. Koh, former U.S. Assistant Secretary for Health at the Department of Health and Human Services, Juliet K. Choi, president and CEO of APIAHF, and Jeff Caballero, executive director of AAPCHO.

"The US must stop the hate and move toward healing."

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Toward Healing and Health Equity for Asian American, Native Hawaiian, and Pacific Islander Populations

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Through the COVID-19 pandemic, a long-simmering US national history of prejudice against individuals of Asian descent has surfaced in a spate of xenophobic hate. A pandemic, exposing widespread health inequities that have disproportionately affected racial and ethnic minority communities, has also triggered racist rhetoric blaming COVID-19 on an often invisible, yet vital, community of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) individuals. With recognition that the terms *Asian American*, *Native Hawaiian*, and *Pacific Islander* encompass a multitude of specific racial and ethnic categories and countries of descent, herein, we will refer to these communities under the collective term and abbreviation (*Asian American, Native Hawaiian, and Pacific Islander* [*AANHPI*]). Healing the hate and moving toward health equity for all requires recognizing the special challenges of this rapidly expanding population that represents the fastest-growing racial and ethnic minority group in the US. From 2000 to 2019, the AANHPI population in the US increased by 95%. Now accounting for 7% (23.2 million people) of the US population, it is projected to double by 2060.[1]

US residents of AANHPI descent, who have richly contributed to the nation's social fabric for centuries, are still regularly treated as outsiders, as "them" rather than "us," and as "foreigners" in their own country. Over the past year, substantial increases in the number and intensity of public assaults against AANHPI individuals have included race-based verbal profanities and vandalism as well as unprovoked physical violence. Rising discrimination culminated in the March 2021 Atlanta spa shootings that caused 8 deaths, including 6 AANHPI women.[2] Accompanying many of these assaults have been cries of "you [brought] the virus here" and "go back to where you came from."[3] More than 6600 self-reported hate incidents (March 2020-March 2021)[3] and 1845 hate crimes reported to police (a nearly 150% increase from 2019-2020)[4] harm not only targeted individuals but also the broader AANHPI community. In a national online survey (conducted from April 5, 2021, to April 11, 2021) of 5109 US adults, 81% of the 352 AANHPI respondents said that violence against them is increasing and 45% reported that they have personally experienced an offensive incident tied to their racial and ethnic background during the COVID-19 pandemic.[2]

Future studies with larger samples should track and extend these findings. Such explicit discrimination does not escape AANHPI professionals who also face COVID-19 exposure risks while serving on the frontline of health care; AANHPI individuals represented 21% of US physicians and surgeons in 2017 and 9% of US registered nurses in 2019.[5] An analysis by National Nurses United found that, as of September 16, 2020, individuals of Filipinx background (approximately 4% of US registered nurses) accounted for 31.5% of 213 COVID-19 fatalities among registered nurses.[6]

Hate incidents can be associated with pain, disability, and exacerbation of heart and lung disease. They can also adversely affect mental health, through anxiety, depression, and even suicidal ideation, for a population already among the lowest users of mental health services.[7]

Broader effects of COVID-19 also complicate other aspects of daily life. Hypervigilant AANHPI older adults fear venturing outside alone. Concerned AANHPI parents disproportionately hold their children back from returning to schools. AANHPI-owned businesses (often capitalized by family members and not banks), such as boycotted restaurants, face additional challenges when trying to access Paycheck Protection Program loans.

Understanding health equity concerns for AANHPI individuals requires better data to not only allow critical comparisons with other major racial and ethnic populations but also among AANHPI individuals who identify with more specific racial and ethnic categories or countries of descent. Although AANHPI individuals constitute about 7% of the US population,[1] only 0.17% of National Institutes of Health research funding from 1992 to 2018 was focused specifically on studies involving this group.[7] Too often, potentially relevant data are incomplete, misclassified, aggregated, or simply absent; with no data, too many assume there is no problem and no disparity.

Considering AANHPI individuals as an aggregated group can blur critical within-group differences or prompt misleading extrapolations between subgroups. AANHPI individuals are not a monolithic group, but rather represent a profoundly heterogeneous population that traces its roots to at least 19 countries, from the Indian subcontinent to East Asia, Southeast Asia, and the Pacific.[1] Their heritage is linked to more than 50 different races and ethnicities and 100 languages.[8] Six groups (those of Chinese, Filipinx, Indian, Japanese, Korean, and Vietnamese background) have populations ranging from more than 1 million to more than 5 million individuals in the US and account for 85% of AANHPI people.[1] Nearly half live in the West (one-third in California), nearly 60% are non-US born, and 14% represent multiple races and ethnicities.[1] A total of 27% of AANHPI people live in multigenerational households (compared with 20% of the general population); for some groups, the percentage is much higher (eg, Bhutanese [56%], Cambodian [42%], and Laotian [40%]),[1] potentially raising COVID-19 exposure risk for older adults. In aggregate, AANHPI people do well relative to the general population on socioeconomic indicators, but considerable variation exists among specific racial and ethnic groups and between US-born vs non–US-born populations (eg, median income, poverty rates, educational attainment, home ownership).[1,9]

Aggregate COVID-19 case and death rates among AANHPI individuals appear similar to that of non-Hispanic White individuals in the US. But AANHPI people have disproportionately higher mortality in some states, including Nevada, Utah, and Nebraska.[9] Furthermore, while only 23 states report disaggregated case rate data for Native Hawaiian and Pacific Islander populations, in 18 of those states, Native Hawaiian and Pacific Islander individuals have the highest case rates of COVID-19 among any racial or ethnic group.[10] Limited English-language proficiency, poverty, or both hinder timely access to COVID-19–related public benefits and public health systems. Moreover, concerns related to adverse immigration actions can further dissuade those with noncitizen immigration status (both documented and undocumented) from seeking

necessary services.[9] Such factors could potentially explain some preliminary data suggesting disproportionately high COVID-19 case-fatality rates.

Since 1997, the US Office of Management and Budget has collected data requiring distinction between Asian American individuals vs Native Hawaiian and Pacific Islander individuals. Since 2010, a major advance under the Affordable Care Act has required that all federally funded health surveys of self-reported information collect disaggregated data by the most populous subgroups for Asian American individuals (including Chinese, Filipinx, Indian, Japanese, Korean, and Vietnamese)[1] and Pacific Islanders (including Guamanian or Chamorro, Native Hawaiian, and Samoan). Such granular data could help better define specific needs and set the stage for addressing them.

Current health challenges of AANHPI people include, but extend far beyond, those associated with COVID-19 and pandemic-related hate. Cancer, not heart disease, is the leading cause of death in AANHPI individuals, but some studies have noted lower cancer screening rates than in other populations. Some dedicated cancer registries have highlighted specific outcomes associated with AANHPI groups, such as high rates of liver cancer (driven largely by hepatitis B) and stomach cancer (especially among Korean American men). Oversampling of National Health and Nutrition Examination Survey data has helped identify other special challenges, including finding a high rate of undiagnosed diabetes in AANHPI adults.

The US must stop the hate and move toward healing. An early wave of responses has begun. President Biden's January 2021 executive order addressed hate directed at AANHPI individuals as a top priority. The US Congress, which held its first hearings in decades addressing AANHPI discrimination, passed the COVID-19 Hate Crimes Act, a rare bipartisan proposal, in May 2021. The White House Initiative on Asian Americans and Pacific Islanders was started under the Clinton administration and continues to this day; it must now, in the new administration, explicitly focus on quality data and data disaggregation, language translation, and greater recognition of the needs of intergenerational households. The Biden administration also could build on the accomplishments of the Obama administration. As of 2016, efforts to improve Affordable Care Act–related health insurance coverage—in close collaboration with advocates, navigators, and assisters conducting multilingual written and oral outreach nationwide—essentially closed health insurance coverage gaps (overall and in almost all major AANHPI subgroups) compared with the non-Hispanic White population.[8] Yet, progress remains tenuous.

To add to national progress, medical and public health professionals must denounce hate and routinely include AANHPI individuals as part of diversity, equity, and inclusion efforts. To overcome implicit biases and move toward true patient-centered care, clinicians should also identify and avoid assumptions about AANHPI patients' race and ethnicity, birthplace, first language, socioeconomic position, culture, spouse or partner, sexual orientation or gender identity, disability status, or worldview. Asking about discrimination as part of acknowledging pandemic-related social isolation and financial hardship can signal respect and support. Clinicians can also better educate patients about vaccination and testing for COVID-19 and

other preventable health conditions. National groups, including the Association of Asian Pacific Community Health Organizations and the Asian & Pacific Islander American Health Forum, are promoting efforts to enable trusted messengers and community-based organizations to offer, when needed, translated information, resources, and services. A nation dedicated to health equity for the future can honor those who helped build its past by prioritizing commitment to its most diverse and fastest growing racial group.

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