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Why more sophisticated data collection and tracking is needed for Asian Americans and Pacific Islanders

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<https://www.chartis.com/insights/why-more-sophisticated-data-collection-and-tracking-needed-asian-americans-and-pacific>

The Buzz This Week:

May is Asian American and Pacific Islanders (AAPI) Heritage Month in the United States, celebrating the history and culture of the AAPI population. This year's theme is "Advancing Leaders through Collaboration" and is part of a 4-year Advancing Leaders series for AAPI Heritage Month, with the goal of increasing diversity of leaders. The administration and U.S. Department of Health and Human Services have also stated that advancing health equity and improving health outcomes in this population is a key commitment for AAPI Heritage Month and beyond. However, measuring improved diversity and health equity across this population is not straightforward.

The AAPI terminology encompasses an extremely broad and diverse group of Americans with lineage from all of the Asian continent in addition to the Pacific Island regions of Melanesia, Micronesia, and Polynesia. Collectively, this wide-ranging group makes up more than 25 million AAPI persons and is the fastest-growing demographic group in the country. The AAPI population comes from diverse backgrounds, socio-economic statuses, and cultures. The AAPI population speaks different languages and has varied health status. Yet the U.S. data infrastructure systems do not fully account for the diversity of experiences.

Why It Matters:

Reporting health disparities in aggregate among AAPI people masks real and different health concerns for the various populations. AAPIs are the only ethnic group in which cancer is the leading cause of death, but disaggregation of the data shows cancer is the leading cause only for Asian Americans. Among Pacific Islanders, the leading cause of death is heart disease. Breaking down the data also reveals differences in access to care and uninsurance rates. More than 25% of Pacific Islanders report difficulty paying medical

bills, compared to 16% of white Americans and less than 10% of Asian Americans (with significant differences between subgroups of Asian Americans). Screening, prevention, treatment, and funding for programs must be able to take differences and unique characteristics that impact AAPI health into account in order to improve health outcomes broadly and across each distinct group.

Research on health equity has shown that representation improves health outcomes and access for underserved populations. It is important that all racial and ethnic groups within the larger AAPI designation are represented in health settings and the provider workforce. As demographics shift, it is vital that those changes can be measured and there is knowledge and awareness of where underrepresentation remains within the healthcare workforce.

The Patient Protection and Affordable Care Act (ACA) developed initial standards for disaggregation of AAPI data. The categorization breaks “Asian American” into 7 subgroups and Pacific Islanders into 4 subgroups. However, broad categories of “Other Asian” and “Other Pacific Islander” remain, and many states have not followed suit in expanding their data collection categories. Additional work is needed to collect, compile, and report health data at a more granular level in order to understand the prevalence of diseases and disparate needs for these populations, improve health outcomes, increase representation in the provider workforce appropriately, and ensure culturally competent practices and training for providers.

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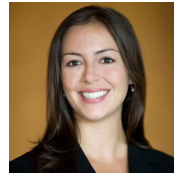
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