APIAHF HEALTH BRIEFS

CHINESE IN THE UNITED STATES

HISTORY

Chinese immigration dates back to the mid-1800s. With the decline of the African slave trade and the discovery of gold, Chinese workers were brought to the U.S. to work in mines and on railroads. Later labeled the "yellow peril," the Chinese were barred from entering the U.S. on the basis of race by the Chinese Exclusion Act of 1882. This ban remained in effect until 1943, and it was not until 1952 before immigrant Chinese were able to become U.S. citizens. After changes in U.S. immigration laws in 1965, the Chinese American population quadrupled between 1960 and 1985.[1]

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DEMOGRAPHICS

The U.S. Census Bureau estimates that in 2000, over 2.3 million Chinese lived in the United States[2].

HEALTH STATUS

It is difficult to characterize the health status of Chinese. Many studies do not differentiate between the various ethnicities studied. Small sample sizes make it difficult to generalize research findings. Finally, in some cases, data are just not available. For these reasons, the data contained here provide only a rough estimate of Chinese health status.

MATERNAL AND CHILD HEALTH

Prenatal Care

Starting prenatal care as early as possible during a pregnancy promotes healthier birth outcomes for both the mother and infant. The U.S. Department of Health and Human Services' Healthy People 2010 objectives includes raising the level of pregnant women accessing early prenatal care to 90%.[3] While most Chinese American women in 1992-1993 began prenatal care in the first trimester, over 15% did not.[1]

CHRONIC DISEASES

Cancer

While breast cancer is the most commonly diagnosed cancer among Chinese American women[4], many experience barriers to potentially life-saving preventive screening practices. Studies have shown that among Chinese American women over 60 years of age, insurance coverage for mammography, acculturation, low perceived need and lack of physician recommendation were significant predictors of whether or not they received mammograms.[5] Other studies have also shown that cultural values with respect to modesty and sexuality, especially in unmarried women, pose barriers to breast screening. In addition, institutional barriers such as unavailability of information in Chinese languages, few female physicians, and an absence of educational campaigns also contribute to neglect of breast health.[6]

MENTAL HEALTH

Depression

In a large-scale study of mental health issues among Chinese Americans in Los Angeles, 1,747 adults aged 18-65 years were interviewed regarding rates of major depressive episodes and dysthymia (low-grade depression lasting two years or more). The study found 7% of respondents had experienced an episode of major depression and 5% had had dysthymia in their lifetime. The 12-month rates of depressive episode and dysthymia were 3% and 1%, respectively.[7]

Utilization of mental health services

Barriers to the utilization of mental health services for Chinese Americans include 1) the cultural value placed on the avoidance of shame, 2) the pragmatism that results in the use of both Western and traditional Chinese practitioners and treatments, and 3) the inadequacy of Western-type services to meet the needs of the Chinese American immigrant population.[8]

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Somatization, or the presentation of medically unexplained physical symptoms related to psychiatric disorders, is thought to be more common among Chinese Americans. A comparison of Chinese and White patients referred for psychiatric consultation found somatization to be significantly more common among Chinese American patients, and that complaints were mostly of cardiopulmonary and vestibular symptoms.[9]

HEALTH BEHAVIORS

Diet/Activity

Consumption of saturated fats has been associated with higher risks for prostate cancer among Chinese Americans compared to blacks and whites, and with colorectal cancer when compared to Chinese in the People's Republic of China[10].

Tobacco Use

Chinese American adolescents have a different pattern of smoking initiation than White adolescents. The rates of smoking for Chinese American minors tends to be lower than White minors, but the initiation of smoking continues to rise even into late adolescence. The onset of smoking is also significantly associated with level of acculturation.[11]

ACCESS TO CARE

Lack of Health Insurance

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Like AAPIs overall, Chinese Americans have significantly less access to health care coverage than whites. In 1997, 20% of Chinese Americans (ages 0-64) were uninsured compared to 14% non-Hispanic Whites. The proportion of Chinese Americans in California that did not have health insurance was even higher (28%), twice the national average for whites.[12]

Between 1994 and 1997, the uninsured rate for Chinese Americans in California declined from 26% to 20%, a result of increased job-based coverage. Despite these improvements, Chinese Americans continue to have lower job-based coverage and lower participation rates in Medicaid (2% vs. 6% in Whites) resulting in a continuing disparity in uninsured rates. Lower Medicaid participation rates may be due to widespread concerns among immigrants that enrolling themselves or their children in Medicaid would jeopardize their applications for citizenship. For example, even among U.S. citizens who live in families with children and have family incomes below 200% of poverty (i.e., those who are most likely to be eligible for Medicaid), only 13% of Chinese Americans have Medicaid coverage compared to 24% of whites.[13]

A random survey of over 1,800 Chinese American adults in San Francisco found that use of health services was strongly correlated with income, language, and citizenship status. Of the respondents who reported not having a particular place to go for health care:

- 2 out of 3 were in the lower income group
- 9 out of 10 were monolingual Chinese speakers
- Many cited “no insurance,” “not enough money to pay for care,” and/or “not able to find a doctor who speaks the same language” as reasons.

Low income and monolingual Chinese speaking respondents also suffered from health problems such as heart trouble and high blood pressure significantly more than their higher income and more English proficient counterparts. The lack of access to care was reflected in low rates of preventive care usage. Forty-four percent of female respondents had not had a Pap test in the last 24 months, and 78% of male respondents had not had a prostate exam in the last 24 months.[14]

Linguistic and Cultural Barriers

Cultural issues significantly impact community health. Unfortunately, few programs are designed to build upon cultural assets and community strengths. Chinese place tremendous importance on spirituality, family life, and tradition. Viewing these beliefs as cultural strengths, and, for example, incorporating spirituality or Chinese traditions into a Western healing regimen could be extremely beneficial. In addition, programs which provide culturally competent nutrition education are likely to be successful in reducing risks for diabetes and heart disease, as they have among other populations.[15] Valuing traditional culture and using it to complement Western health practices will help reduce barriers to health care and improve the health of the community.

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