Healthy People 2010 and Asian Americans/Pacific Islanders: Defining a Baseline of Information

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Objectives. *Healthy People 2010: Understanding and Improving Health* lists 6 areas of disparity in minority health services: infant mortality, cancer, cardiovascular disease, HIV/AIDS, diabetes, and immunizations. This study compiles existing Asian American and Pacific Islander (AAPI) health data to establish a baseline.

Methods. For federally-sponsored research (1986–2000), the Computer Retrieval of Information on Specific Projects (CRISP) database was analyzed. AAPI initiatives were divided by subpopulation and disparity area. MEDLINE articles (1966–2000) were similarly scrutinized.

Results. Few federal health-related grants (0.2%) and MEDLINE articles (0.01%) mention AAPIs. For the 6 disparity areas, significant AAPI data gaps remain.

Conclusions. To reach the *Healthy People 2010* goals and have useful data, researchers and grant makers must focus on obtaining baseline data for disaggregated AAPI subgroups. (*Am J Public Health.* 2003;93:2093–2098)

The Asian American/Pacific Islander (AAPI) population is the fastest growing of America's ethnic groups. Currently at 10.6 million people (about 4% of the total US population), AAPIs are projected to reach 41 million US residents (11% of the total US population) by the year 2050 (Figures 1 and 2).[1–3] Because of these demographics as well as the progressive history of AAPIs in America and the strong activism by effectively organized AAPI organizations, President Clinton signed Executive Order 13125 in 1999; it was intended

> to improve the quality of life of Asian Americans and Pacific Islanders through increased participation in Federal programs where they may be underserved (e.g., health, human services, education, housing, labor, transportation, and economic and community development). . . .[4]

President Bush amended and extended this order with Executive Order 13216 on June 6, 2001.[5] To address health needs specifically, Clinton also commenced his Initiative on Race to eliminate health disparities in and among all racial and ethnic groups.[6] Six areas for concentration of efforts were chosen specifically because of their impact on minorities: infant mortality, immunizations, diabetes, cardiovascular disease, HIV/AIDS, and cancer. For these 6 areas, the focus on minority groups was codified into *Healthy People 2010: Understanding and Improving Health,*[7] the document that addresses this country's goals for better health by the end of the present decade. The goal of Healthy People 2010, to eliminate health disparities, stood as a fundamental shift from *Healthy People 2000: National Health Promotion and Disease Prevention Objectives,*[8] which was based on distinct health targets for separate ethnic groups.

AAPI Demographics

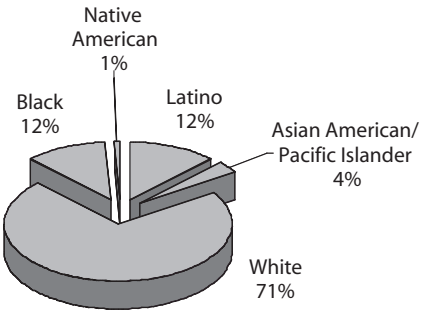
AAPIs have roots in at least 29 Asian countries and 20 Pacific Islander cultures.[9] Members of this group speak over 100 languages and belong to numerous religions; most (95%) are of Asian origin, while the rest (5%) are Pacific Islanders. The 1990 census shows the largest of the AAPI subpopulations to be Chinese Americans (23%), followed by Filipino Americans, Japanese Americans, and Asian Indian Americans.[10] The 2000 census states that Chinese Americans and Filipino Americans remain the first and second largest subpopulations, followed by Asian Indian Americans and Korean Americans (Figure 3).[11,12] A direct comparison of these census data remains problematic because the 2000 census divides the "Asian origin" category into the numerous Asian ethnicities, which allows for a much more detailed and accurate count of these particular populations.

As a group, AAPIs have many social and demographic characteristics that may affect their health status. For example, more than 2 million AAPIs remain uninsured (about 17%).[13] The household poverty rate for AAPIs (14%) is higher than for non-Hispanic Whites (8%).[14] Moreover, the AAPI population includes a larger percentage of immigrants than any other minority group (66%).[15] Many have limited English language proficiency (40%).[9] Also, large education differences exist among various AAPI subpopulations. For example, 88% of Japanese Americans have a high school diploma compared with only 31% of Hmong Americans, and 58% of Asian Indian Americans have a college degree while only 6% of Cambodian Americans or Laotian Americans do.[14]

The diversity of the AAPI population points to variable health burden among the subpopulations. For example, the Northern Mariana population has adult diabetes rates greater than 5 times the US rate.[16] For infant mortality, all Pacific Islander groups have rates higher than the US average; some, such as those in the Northern Marianas and in Palau, for example, have rates as high as twice the average.[16] For cancer, the Chinese have the highest rates of nasopharyngeal carcinoma of any American ethnic/racial group.[17] Vietnamese women have cervical cancer at rates five times those of White American women; moreover, Vietnamese have liver cancer rates at 11.3 times those of White Americans.[17] For infectious disease, AAPIs have greater incidence rates of tuberculosis and hepatitis B than any other ethnic or racial group.[18,19]

Combining Goals

There must be a defined baseline of what health status data currently exists for AAPIs in order to satisfy the combined goals of the Ini-



Source. Data are from the US Bureau of the Census.[1]

FIGURE 1—US Population by Race/ Ethnicity: 2000.

tiative on Race and *Healthy People 2010*. Once this baseline is determined, grant makers and researchers will know where to concentrate efforts in order to close knowledge gaps. Unfortunately, *Healthy People 2010* remains a poor reference for current data regarding AAPIs because it relies solely on data collected at the national level and because of small sample sizes caused by the geographic concentration of AAPIs in certain states only. For the first time, the US Department of Health and Human Services (DHHS) provided details about data gaps with much of the baseline data listed as "Data Not Collected," "Data Statistically Unreliable," or "Data Not Analyzed." Also, AAPIs are treated generally as an aggregate group, although DHHS followed 1997 Office of Management and Budget standards and used subcategories to separate "Asian" from "Native Hawaiian and other Pacific Islander." This treatment fails to convey useful health information because of the heterogeneity of AAPIs. A statistic for the full group may mask a disparity in a subpopulation: the age-adjusted death rate for AAPIs is 350 per 100 000 (compared with 524 for the total American population), but for Native Hawaiians, the rate is 901 per 100 000.[20]

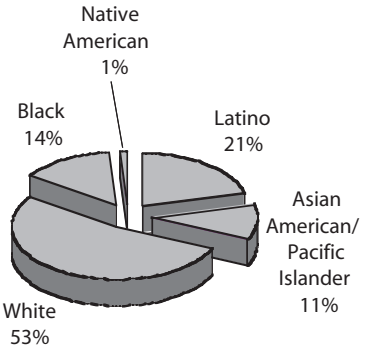
Investigators, however, must acknowledge that AAPI health data remain limited for a number of reasons. First, the relatively small number of AAPIs, even when aggregated, often precludes large representation in studies. There are few consistent efforts to oversample or use alternate methodologies to study AAPI health. Second, AAPIs generally have been considered "model minorities." Because of this, there is a perception that AAPIs obtain uniformly good medical care and, thus, their health status remains invulnerable. Third, because AAPIs are considered overrepresented in health care delivery fields, there is a belief that AAPIs have dealt specifically with their health problems and needs. Fourth, AAPIs had the fewest number of *Healthy People 2000* goals, which has led to less data being collected on them.[21]

METHODS

To obtain an overview of all available data, numerous sources must be evaluated, including grants and initiatives from the government (federal, state, local), organizations (e.g., community, trade, professional), and foundations, as well as research publications. This study looks only at the largest contributors of information on AAPI health: (1) federal government grants and initiatives and (2) research publications.

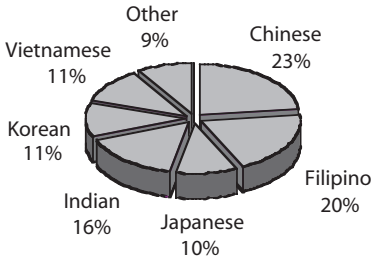
To find the majority of federal grants awarded for AAPI population research, the Computer Retrieval of Information on Specific Projects (CRISP)[22] database was used. This database contains all federal health-related grants given by 7 agencies: the National Institutes of Health, Centers for Disease Control and Prevention, Health Resources and Services Administration, Food and Drug Administration, Substance Abuse and Mental Health Services Administration, Office of the Assistant Secretary for Health, and Agency for Healthcare Research and Quality. The National Library of Medicine's MEDLINE[23] was used to find data from research publications. At the time of this study, only grants from 1986 through 2000 listed in CRISP and published data from 1966 through 2000 from the National Library of Medicine's MEDLINE were used. Both CRISP and MEDLINE were searched per year for 22 specific AAPI countries or cultures of origin and the 6 health disparity areas. Cambodia/ Cambodian (note that both country name and adjective were used), Japan, Korea, Vietnam, Thailand, India, Laos, Indonesia, Malaysia, Bangladesh, Pakistan, Burma (Myanmar), Afghanistan, China, the Philippines, Hawaii, Guam, and Samoa as well as Hmong, South East Asia, Asia, and Pacific Islander were checked. Each was cross-referenced with the 6 health disparity areas: diabetes, immunizations, infant mortality, cardiovascular disease, cancer, and HIV/AIDS. All studies for which the AAPI population as a whole or any subgroup was included in the recruitment process or in a subsequent analysis were selected. Grants and publications were evaluated for possible data they could supply to form a baseline for specific *Healthy People 2010* goals with regard to the 6 health disparity areas.

Because full grant proposals are unavailable, CRISP abstracts were analyzed, whereas the full articles from MEDLINE were read. Any abstract or article which on close examination did not truly seem to be even partially concerned with AAPI health was eliminated. Thus, studies which concentrated only on people within the Asian/Pacific Island coun-



Source. Data are from the US Bureau of Census.[3]

FIGURE 2—Projected US Population by Race/Ethnicity: 2050.



Source. Data are from Barnes JS, Bennett CE.[11]

FIGURE 3—US Asian American and Pacific Islander Population by Race/ Ethnicity: 2000.

tries themselves were not included. The CRISP database no longer provides the dollar amount of each grant, so no comparison could be made with regard to the perceived importance of the data.

RESULTS

Federal Grants

According to the CRISP database (1986–2000), the federal government funded 150 369 health-related grants. Of this number, 342 directly involved AAPI health, or 0.2% of all grants. In the 6 health disparity areas, 83 grants were sponsored.

For each of the 6 specific health areas, *Healthy People 2010* lists multiple goals for the nation to achieve by the year 2010.[24] Data were aligned with the goals and the following results were noted.

Infant mortality. To reduce infant mortality, *Healthy People 2010* lists 23 goals. The 5 federal grants found that addressed this category among AAPIs help to provide data for 3 of the 23 goals, but the data are only specific for certain AAPI subpopulations. The *Healthy People 2010* goals and subpopulations addressed are: (1) Objective 16–1, "Reduce fetal and infant deaths" (provides data for aggregated AAPI, Chinese Americans, and Filipino Americans); (2) Objective 16–10, "Reduce low birthweight (LBW) and very low birthweight (VLBW)" (aggregated AAPI, Chinese Americans, and Filipino Americans); and (3) Objective 16–19 "Increase the proportion of mothers who breastfeed their babies" (Malaysian Americans).

Immunizations. To increase immunization status of the population, *Healthy People 2010* lists 31 goals. The 1 federal grant found that addressed this category among AAPIs helps to provide data for 2 of the 31 goals: (1) Objective 14–2, "Reduce chronic hepatitis B virus infections in infants and young children (perinatal infections)" (Vietnamese Americans), and (2) Objective 14–3, "Reduce hepatitis B in adults and high-risk groups" (Vietnamese Americans).

Diabetes. To reduce diabetes, *Healthy People 2010* lists 17 goals. The 9 federal grants found that addressed this category among AAPIs help to provide data for 3 of the 17 goals: (1) Objective 5–2, "Prevent diabetes" (aggregated AAPI); (2) Objective 5–3, "Reduce the overall rate of diabetes that is clinically diagnosed" (aggregated AAPI); and (3) Objective 5–5, "Reduce the diabetes death rate" (aggregated AAPI, Cambodian Americans, Filipino Americans).

Cardiovascular disease. To reduce cardiovascular disease, *Healthy People 2010* lists 16 goals. The 7 federal grants found that addressed this category among AAPIs help to provide data for 3 of the 16 goals: (1) Objective 12–1, "Reduce coronary heart disease deaths" (aggregated AAPI); (2) Objective 12–7, "Reduce stroke deaths" (aggregated AAPI); and (3) Objective 12–10, "Increase the proportion of adults with high blood pressure whose blood pressure is under control" (aggregated AAPI).

HIV/AIDS. To reduce HIV/AIDS, *Healthy People 2010* lists 17 goals. The 9 federal grants found that addressed this category among AAPIs help to provide data for 5 of the 17 goals: (1) Objective 13–5, "Reduce the number of cases of HIV infection among adolescents and adults" (aggregated South Asian Americans [Indians, Bangladeshis, Pakistanis, and Sri Lankans], aggregated Pacific Islander Americans); (2) Objective 13–6, "Increase the proportion of sexually active persons who use condoms" (aggregated South Asian Americans, aggregated AAPI); (3) Objective 13–7, "Increase the number of HIV-positive persons who know their serostatus" (aggregated South Asian Americans); (4) Objective 13–8 "HIV counseling and education for persons in substance abuse treatment" (aggregated AAPIs, Filipino Americans, Chinese Americans, Vietnamese Americans); and (5) Objective 13–13, "Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines" (aggregated AAPI, Chinese Americans, Japanese Americans, Filipino Americans).

Cancer. To reduce cancer, *Healthy People 2010* lists 15 goals. The 52 federal grants found that addressed this category among AAPIs help to provide data for 9 of the 15 goals: (1) Objective 3–1, "Reduce the overall cancer death rate" (aggregated and disaggregated AAPI, Chinese Americans, Filipino Americans, Japanese Americans, Native Hawaiians, Vietnamese Americans, Cambodian Americans); (2) Objective 3–2, "Reduce the lung cancer death rate" (Vietnamese Americans); (3) Objective 3–3, "Reduce breast cancer death rate" (aggregated AAPI, Korean Americans, Chinese Americans, Japanese Americans, Native Hawaiians, Filipino Americans, Vietnamese Americans, Asian Indian Americans); (4) Objective 3–4, "Reduce the death rate from cancer of the uterine cervix" (Korean Americans, Cambodian Americans, Chinese Americans, Filipino Americans, Japanese Americans, Native Hawaiians, Samoans); (5) Objective 3–5, "Reduce the colorectal cancer death rate" (aggregated AAPI, Chinese Americans, Vietnamese Americans, Asian Indian Americans); (6) Objective 3–7, "Reduce the prostate cancer death rate" (aggregated AAPI, Chinese Americans, Japanese Americans, Vietnamese Americans, Asian Indian Americans); (7) Objective 3–10, "Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening" (aggregated AAPI, Korean Americans, Japanese Americans, Chinese Americans, Filipino Americans, Native Hawaiians); (8) Objective 3–13, "Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years" (aggregated AAPIs); and (9) Objective 3–15, "Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis" (Chinese Americans, Filipino Americans, Japanese Americans, Native Hawaiians).

Research Publications

In the MEDLINE database from 1966 through 2000, there are about 10 million articles, of which 1499 directly involved AAPI health, or 0.01% of all published research contained in MEDLINE. In the 6 health disparity areas, 332 articles were found. For each of the 6 specific health areas, *Healthy People 2010* lists multiple goals for the nation to achieve by the year 2010. The data found were aligned with the goals and the following results were noted.

Infant mortality. To reduce infant mortality, *Healthy People 2010* lists 23 goals. The 21 studies found that addressed this category among AAPIs help to provide data for 4 of

the 23 goals. The data are only specific to certain AAPI subpopulations. The *Healthy People 2010* goals and subpopulations addressed are: (1) Objective 16–1, "Reduce fetal and infant deaths" (provides data for aggregated AAPI, Chinese Americans, Japanese Americans); (2) Objective 16–6, "Increase the proportion of pregnant women who receive early and adequate prenatal care" (Japanese Americans, Native Hawaiians, Filipino Americans); (3) Objective 16–5, "Reduce maternal illness and complications due to pregnancy" (Cambodian Americans); and (4) Objective 16–10, "Reduce low birthweight (LBW) and very low birthweight (VLBW)" (aggregated AAPI, Chinese Americans, Filipino Americans, Asian Indian Americans, Japanese Americans, Samoans, Native Hawaiians).

Immunizations. To increase immunization status of the population, *Healthy People 2010* lists 31 goals. The 23 studies found that addressed this category among AAPIs help to provide data for 4 of the 31 goals: (1) Objective 14–1, "Reduce or eliminate indigenous cases of vaccine-preventable disease" (aggregated AAPI, Chinese Americans, Laotian Americans); (2) Objective 14–2, "Reduce chronic hepatitis B virus infections in infants and young children (perinatal infections)" (aggregated AAPI, aggregated Southeast Asian Americans, Chinese Americans, Vietnamese Americans); (3) Objective 14–3, "Reduce hepatitis B in adults and high-risk groups" (aggregated AAPI); and (4) Objective 14–1, "Reduce Tuberculosis" (aggregated AAPI, Vietnamese Americans, Filipino Americans, Chinese Americans, Korean Americans).

Diabetes. To reduce diabetes, *Healthy People 2010* lists 17 goals. The 43 articles found that addressed this category among AAPIs help provide data for 6 of the 17 goals: (1) Objective 5–2, "Prevent diabetes" (aggregated AAPI, Japanese Americans); (2) Objective 5–3, "Reduce the overall rate of diabetes that is clinically diagnosed" (aggregated AAPI); (3) Objective 5–4, "Increase the proportion of adults with diabetes whose condition has been diagnosed" (Japanese Americans, Chinese Americans); (4) Objective 5–7, "Reduce deaths from cardiovascular disease in persons with diabetes" (Japanese Americans, Asian Indian Americans); (5) Objective 5–8, "Decrease the proportion of pregnant women with gestational diabetes" (aggregated Pacific Islander Americans, Filipino Americans); and (6) Objective 5–9, "Reduce the frequency of foot ulcers in persons with diabetes" (Japanese Americans).

Cardiovascular disease. To reduce cardiovascular disease, *Healthy People 2010* lists 16 goals. The 51 articles found that addressed this category among AAPIs help provide data for 7 of the 16 goals: (1) Objective 12–1, "Reduce coronary heart disease deaths" (aggregated AAPI, Japanese Americans, Filipino Americans, Chinese Americans, Native Hawaiians, Samoans, Asian Indian Americans); (2) Objective 12–3, "Increase the proportion of eligible patients with heart attacks who receive artery-opening therapy within an hour of symptom onset" (aggregated AAPI); (3) Objective 12–7, "Reduce stroke deaths" (aggregated AAPI, Japanese Americans, Chinese Americans); (4) Objective 12–10, "Increase the proportion of adults with high blood pressure whose blood pressure is under control" (Japanese Americans, Filipino Americans, Native Hawaiians); (5) Objective 12–13, "Reduce the mean total blood cholesterol levels among adults" (aggregated AAPI, Japanese Americans, Chinese Americans, Filipino Americans); (6) Objective 12–14, "Reduce the proportion of adults with high total blood cholesterol levels" (Japanese Americans); and (7) Objective 12–16, "Increase the proportion of persons with coronary heart disease who have their LDL-cholesterol level treated to a goal of less than or equal to 100mg/dl" (aggregated AAPI, Filipino Americans).

HIV/AIDS. To reduce HIV/AIDS, *Healthy People 2010* lists 17 goals. The 9 studies found that addressed this category among AAPIs help provide data for 7 of the 17 goals: (1) Objective 13–1, "Reduce AIDS among adolescents and adults" (aggregated AAPI); (2) Objective 13–2, "Reduce the number of new AIDS cases among adolescent and adult men who have sex with men" (aggregated AA, aggregated PI, aggregated Southeast Asian Americans, Japanese Americans, Filipino Americans, Chinese Americans); (3) Objective 13–5, "Reduce the number of cases of HIV infection among adolescents and adults" (aggregated AAPI); (4) Objective 13–6, "Increase the proportion of sexually active persons who use condoms" (aggregated AAPI, Vietnamese Americans, Filipino Americans, Cambodian Americans, Korean Americans, Chinese Americans); (5) Objective 13–7, "Increase the number of HIV-positive persons who know their serostatus" (Chinese Americans, Filipino Americans, Asian Indian Americans, Vietnamese Americans, Korean Americans, Japanese Americans); (6) Objective 13–11, "Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV" (aggregated AAPI); and (7) Objective 13–13, "Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines" (aggregated Asian Americans).

Cancer. To reduce cancer, *Healthy People 2010* lists 15 goals. The 185 studies found that addressed this category among AAPIs help provide data for 13 of the 15 goals: (1) Objective 3–1, "Reduce the overall cancer death rate" (Chinese Americans, Filipino Americans, Japanese Americans, Native Hawaiians); (2) Objective 3–2, "Reduce the lung cancer death rate" (aggregated AAPI, Vietnamese Americans, Japanese Americans, Chinese Americans, Samoans); (3) Objective 3–3, "Reduce the breast cancer death rate" (aggregated AAPI, Pakistani Americans, Asian Indian Americans, Filipino Americans, Chinese Americans, Japanese Americans, Vietnamese Americans, aggregated South Asian Americans, disaggregated Asian Islamic Americans, Samoans); (4) Objective 3–4, "Reduce the death rate from cancer of the uterine cervix" (aggregated AAPI, Korean Americans, Cambodian Americans, Chinese Americans, Filipino Americans, Vietnamese Americans, Native Hawaiians, Samoans); (5) Objective 3–5, "Reduce colorectal cancer death rate" (aggregated AAPI, Chinese Americans, Japanese Americans, Korean Americans, Native Hawaiians, Samoans); (6) Objective 3–6, "Reduce the oropharyngeal cancer death rate" (Korean Americans, Chinese Americans, Samoans); (7) Objective 3–7, "Reduce the prostate cancer death rate" (aggregated AAPI, Chinese Americans, Japanese Americans, Vietnamese Americans, Asian Indian Americans); (8) Objective 3–8, "Reduce the rate of melanoma cancer deaths"

(Samoans); (9) Objective 3–9, "Reduce sun exposure" (Japanese Americans, Chinese Americans, Filipino Americans, Native Hawaiians); (10) Objective 3–11, "Increase the proportion of women who receive a Pap test" (aggregated AAPI, Korean Americans, Chinese Americans, Vietnamese Americans, Cambodian Americans); (11) Objective 3–12, "Increase the proportion of adults who receive a colorectal cancer screening examination" (aggregated AAPI, Chinese Americans, Japanese Americans, Native Hawaiians); (12) Objective 3–13, "Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years" (Filipino Americans, Korean Americans, Vietnamese Americans, Chinese Americans, Cambodian Americans, aggregated South Asian Americans); and (13) Objective 3–14, "Increase the number of states that have a statewide population-based cancer registry that captures case information on at least 95% of the expected number of reportable cancers" (Vietnamese Americans).

DISCUSSION

From these results, there remain large gaps in baseline information with regard to AAPI health data. For each of the 6 health disparity areas, only a few of the *Healthy People 2010* objectives even have data to form a foundation from which research can stem. The data that does exist only seem to be either for aggregated AAPIs or for a few specific AAPI subpopulations. Again, data for aggregated AAPIs have little usefulness, as this population remains the most diverse of the minority groups.

The data for this study may mislead some into thinking that certain key areas are well researched. Closer inspection shows the reverse to be true. For example, the diabetes category of research publication results has articles that could supply data for 6 of 17 *Healthy People 2010* goals. Approximately 80% of the studies published were from the Honolulu Heart Program, which studied Japanese American men. Thus, the medical community has important data on Japanese American men but almost none on any other AAPI subpopulation. Also, the cancer categories for both the CRISP and the MEDLINE databases seem to be comprehensive, with the majority of *Healthy People 2010* goals addressed. *Healthy People 2010*, however, does not even mention cancers such as gastric and liver that affect AAPI subpopulations to a greater degree than they do any other minority group.

Finally, the fact that only 0.2% of all federal health-related grants in the CRISP database and only 0.01% of studies found on MEDLINE even mention AAPI as a studied group shows that the pool from which AAPI baseline data can be gathered continues to be minute.

CONCLUSIONS

This study shows that health data research for AAPIs remains inadequate. In order for this country to try to realize *Health People 2010* goals for AAPIs, research must be directed toward an understanding of where AAPIs currently are with regard to their health. This view has been echoed for years in the public health arena. The rapid growth of the AAPI population has made the situation critical at this point. To have truly meaningful and useful health data, the medical community requires information on the individual AAPI subgroups. AAPI is a political and not a cultural or biological term. Thus, the diversity of diseases and disease burdens found in AAPIs is expected. To be able to collect subpopulation data, researchers should look closely at demographic information and conduct studies in the geographic areas where subpopulations are concentrated. Special attention must be given to be sure the largest AAPI groups are studied completely as to each of the 6 health disparity areas. Focus could also be given to diseases such as tuberculosis that, while prevalent in AAPI communities, are not emphasized among the 6 health disparity areas.

President Clinton laid out the 6 areas in order to end health disparities, and the US Department of Health and Human Services has codified them into its *Healthy People 2010* goals. Grant makers thereby are given a guideline to follow when making funds available for research. For AAPIs, projects that serve to fill in gaps in *Healthy People 2010* data must be funded. Other data sources should be investigated as well. This study only looks at most federal government grants and research publications. State and local government initiatives and those from organizations and foundations should be culled. Also, this study looks at the existing *quantity* of AAPI data. The next step must be to scrutinize the *quality* of this data.

Executive Orders 13125 and 13126, which showed presidential support for AAPIs, as well as the increasing voice of AAPI groups and the growing AAPI population make this an opportune time to concentrate research efforts on this neglected and soon-to-be sizable minority group. Without more data, in 50 years, when AAPIs reach 11% of the US population, the medical community will be floundering over how to provide care for this group. If subgroup analyses are not performed, the United States runs the risk of creating a health policy on the entire AAPI population based upon data from a few of its subpopulations. ■

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Human Participant Protection

No protocol approval was needed for this study.

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