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Practitioner's Essay

Glancing Back, Looking Forward:
Some Comments on Health Research in Asian American Communities

David T. Takeuchi and Seunghye Hong

Abstract

Despite scientific advances that document race and ethnicity as critical factors associated with inequities in health and health care quality, the general political climate has the potential to undermine efforts to improve the quality of life for people in diverse communities. We call for more creative research programs on health issues in Asian American communities to move beyond prevalence and risk factors toward investigating the mechanisms and processes that produce illness and lead to poor quality of health. We emphasize a compelling need to revisit traditional and accepted findings to determine their appropriateness for Asian American communities. We also suggest that as we establish the mechanisms that link social factors and health, we must also place them within the appropriate historical and cultural contexts that are essential for the health of people in their communities.

Empirical research on the social and cultural determinants of health and illness, especially around issues of race and ethnicity, has reached a phase in its scientific development that is both potentially groundbreaking and regressive. Over the past decade and a half, a renewed focus at the federal level has led to an increased attention to race, ethnicity, and health. Federal reports during this time period, such as *Unequal Treatment*, *Measuring Racial Discrimination*, and *Toward Higher Levels of Analyses*, argue that race and ethnicity are critical factors associated with illness and health care quality (Blank, Dabaddy, and Citro 2004; Institute of Medicine 2003; U.S. Department of Health and Human Services 1999). These reports have led to program announcements and request for applications that seek more scientific inquiries on race, ethnicity,

and health. Equally important, scientists from a wide range of disciplines have turned their attention beyond the documentation of race and ethnic differences per se in health to constructing research questions that are substantively richer, more nuanced, and better contextualized.

While more serious and systematic investigations of race, ethnicity and health provide opportunities to improve the quality of life for people in diverse communities, a competing force "the politics of science"has the potential to undermine these efforts. Scientific examinations of race and ethnicity are shaped by the social and political circumstances of an era. For example, biological determinism sees people as belonging to fixed groups based on a set of putative biological features. While still a common perspective of race, it was the dominant scientific ideology during the nineteenth and twentieth centuries. This ideological frame embraces the notion that racial groups can be stratified based on prized traits with whites at the top of this hierarchy forming the superior race. Scientific studies during these times, especially research in the social sciences, did not challenge the existing racial stratification system but rather implicitly or directly helped maintain it (McKee 1993).

Mendel's theory regarding the genetic inheritance of intelligence was used to establish a correlation between skin color and other physical features with intelligence, personality, and individual and national character. Stanley Porteus, a psychologist based in Hawai'i, emerged as an important researcher who helped establish where Asians and Pacific Islanders fit within this racial stratification system. In *Temperament and Race*, for example, Porteus uses intelligence tests to prevailing psychological theories and methods to document the inferiority of non-white races claiming, "[i]nstead of opinions and superficial observations naturally colored by prejudice and racial bias we can substitute statistically treated results founded upon standardized tests" (Porteus 1926:9). In the 1920s, Hawaii became a site for numerous studies on race, intelligence, and personality, largely because of the growing multiethnic population that arose as a result of the immigration of Asian ethnic groups to work on the sugar and pineapple plantations.

According to Porteus, Native Hawaiians were "well-stabilized, docile and patient," but "shallow," "suggestible," and at the "childish stage of development" or the bottom of the social evolutionary scale (32). The Chinese were thought the "least suggestible

and. . .the most dependable group," yet selfish and self-centered (99). The Japanese were the most superior non-white group based on their self-control, but they were believed to be too aggressive and "too ready to seize and turn the white man's own weapons against him" (49). Filipinos were characterized as a race that occupies an "adolescent stage of development" (67). While Porteus statements about different ethnic groups sound like a caricature, these images and beliefs did serve to reinforce the power structure and racial stratification in Hawai'i. Moreover, many of the stereotypes given credence in Porteus' writings are perpetuated in one form or another in the general public discourse. While some social scientists, such as Boas (1931), Ward (1906), and DuBois (1903), did challenge Porteus and his contemporaries, it is clear that the scientific views of race and its link to intelligence and other prized traits was popular since it justified the treatment of racial groups during this period.

Contemporary politics at the federal level influences the science of race, ethnicity, and health in at least two profound ways. First, there is a clear agenda at the federal level for investigating individual biology and behavior to improve health and health care. While the emphasis on individuals are rooted in the medical model, the agenda that springs from this paradigm shapes how resources are allocated to different types of studies. A focus on individual change without a corresponding attention to more macro factors diverts attention from the collective level of interventions that may include community action, environmental modification, and political change. The medical model and investigations on health as individual phenomena are not recent, nor are they unimportant. What is critical is the proportion of resources that are allocated to examining different social *and* biological mechanisms that contribute to health and illness in society.

The second political influence is also not new, but it seems to have created a more poisonous climate in recent years. Some federal agencies and congressional committees have turned their attention to questioning scientific investigations after these empirical studies have already passed peer review scrutiny and been approved for funding by appropriate National Institutes of Health program and administrative committees (Kaiser 2003; Sternberg 2004). Most, if not all, of this recent scrutiny concerns research conducting on issues related to HIV / AIDS and sexuality. In one investigation in 2003, the Department of Health and Human Services, after an

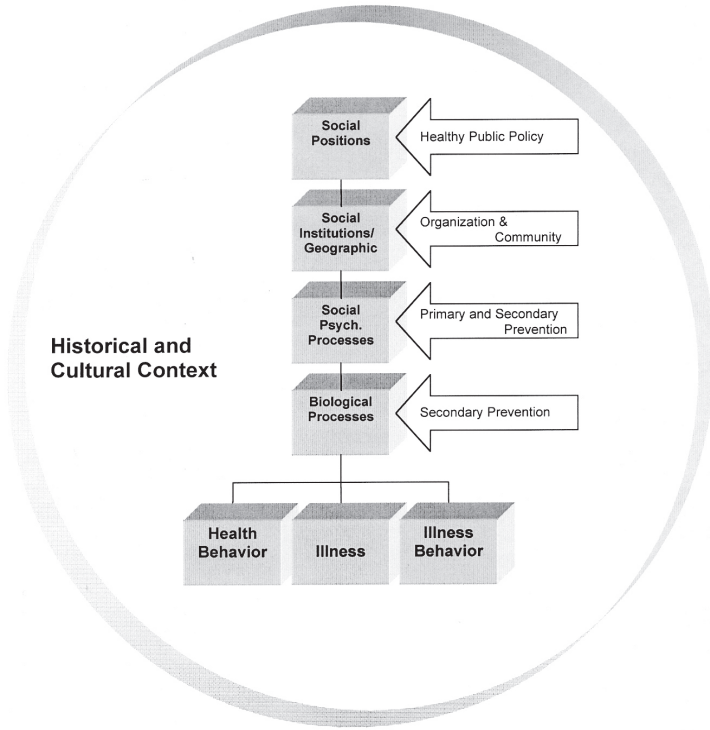
inquiry from Congress, conducted a site visit of a researcher who was examining how HIV infections could be prevented among Asian sex workers. Despite approval of the study by a panel of scientists, Congress felt that the research had a potential to embarrass the White House (Kaiser 2003). This incursion into the scientific process has the real danger of limiting scientific investigations on health to research that conforms to prevailing political beliefs and ideologies.

As tensions play out over these competing directions of opportunities and constraints, research on health issues in Asian American communities can move beyond the documentation of prevalence rates of different health problems toward investigating mechanisms and processes that produce illness, limit access to health care, and deliver poor quality of health care. One means to examine this issue is to frame health research within a hierarchical model. We modify McKinlay and Marceau's framework (2000) for thinking about social contexts and health. This framework is useful, among other hierarchical models, because it specifically maps the types of interventions possible for each level of analysis—from the macro to the cellular. The modification in Figure 1 includes health constructs and incorporates cultural and historical contexts that affect geographic places, institutional characteristics, and individual behavior. Most hierarchical models omit historical and cultural dimensions, but we feel they are essential in examining health issues in Asian American communities. These contexts include cultures and histories of institutions and neighborhoods that help to understand behavior in more meaningful ways. We are absent, for example, a substantial body of research that examines how historical events and power differentials shape the current well-being of groups of people. Each racial and ethnic group has a different history with something indigenous to the country, others voluntarily migrate, and still others seek refugee status to avoid genocide, wars, and political persecution. We do not know how these historical circumstances influence the health of people living in contemporary times. Hawai'i, for example, has one of the healthiest profiles of any state in the nation, but Native Hawaiians suffer one of the poorest health profiles of any ethnic group in the country, despite the million of dollars that have been allocated for different health prevention and treatment programs. Is it possible that the current health status of the Native Hawaiian population can be best under-

stood by examining the oppression of Native Hawaiians in their own homeland? How is the health of a people whose ancestors endured the taking of power within their sovereignty? In a different context, how do the experiences and their associations with health differ from those of people who come as refugees or immigrants to a new country? Answers to these and other complex questions will go a long way in promoting policies and programs that will reduce health inequities in American society.

Beyond the call for more creative research programs that move beyond prevalence and risk factors, there is also a compelling need to revisit traditional and accepted findings to determine their ap-

Figure 1. Levels of Causation for Health and Corresponding Types of Health Interventions



Adapted from McKinlay, J. B., & Marceau, L. D. (2000). Public health matters. *American Journal of Public Health, 90*, 25-33, p. 29.

propriateness for Asian American communities. We illustrate this point with the example of socio-economic status. Education consistently demonstrates a stable direct association with positive health. In many respects education is considered the causal mechanism that leads to economic and social rewards. Progression through the educational pipeline is seen as leading to higher cognitive abilities, better quality and more secure jobs in safe work environments, more opportunities to enhance income, greater capacity to increase wealth, and a wider range of social networks that provide instrumental and emotional support (Mirowsky and Ross 1986). All of these facets are associated with better health and the receipt of better health care (Williams and Collins 1995). On the surface it is reasonable to presume that education operates in a similar fashion in Asian American communities. However, upon closer scrutiny, questions arise about how education may be linked to better health among Asian Americans. Since about 60 percent of Asian Americans are immigrants, many receive their education in another country. In fact, from our National Latino and Asian American Study (NLAAS) data, slightly over 85 percent of our national sample of Asian Americans receive most of their education in another country. When Asians immigrate to the U.S., their education may be undervalued, and they may not receive the same compensation and prestige for their educational accomplishments (Lee 1998). Asian Americans frequently find themselves reaching a glass ceiling in their jobs (Fernandez 1998; Tuan 2002). Moreover, some research suggests that as Asian Americans increase their levels of education, they are more apt to be perceived as threats by other racial groups and, consequently, to receive discriminatory treatment (Goto, Gee, and Takeuchi 2002; Young and Takeuchi 1998). The need to pursue these types of investigations on "established findings" among Asian Americans certainly applies to other types of demographic factors such as gender, marital status and other dimensions of SES.

This issue represents a propitious opportunity to promote a research agenda that builds on the past, but is not bound by it. While there are and will be many obstacles that will deter this agenda from being fulfilled, topics addressed in this issue are no longer at the edges of scholarly investigations on health but are seen as essential scientific domains to consider when studying Asian American communities and other racial and ethnic groups.

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