



Invited Commentary | Public Health

Asian, Native Hawaiian, and Pacific Islander Populations in the US— Moving From Invisibility to Health Equity

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The important article by Sumibcay et al¹ highlights the problem of invisibility for small minoritized populations in the United States.² Examining 4 surge periods of high COVID-19 mortality in 2020 to 2021, they found that non-Hispanic American Indian or Alaska Native individuals and Native Hawaiian or Pacific Islander individuals had consistently higher COVID-19 mortality than other racial and ethnic groups.¹ However, if Native Hawaiian or Pacific Islander individuals were combined with Asian individuals, the aggregated Asian–Pacific Islander group would have the lowest mortality rates.

Native Hawaiian or Pacific Islander individuals are invisible statistically when aggregated with more numerous Asian individuals; and Native Hawaiian or Pacific Islander individuals are invisible as people when a historical health policy ignores the colonialism and structural racism that led to today's social disadvantage and health inequities. Disaggregating data is just an initial step in advancing health equity. Heterogeneous Native Hawaiian or Pacific Islander and Asian populations need to be truly valued and seen for their diversity, rather than being othered to aggregate categories that do not make sense and dehumanize.^{3,4} In this Commentary, we discuss how the histories of colonization and structural racism impact health inequities for Native Hawaiian or Pacific Islander and Asian individuals; biases in racial and ethnic categorizations and quantitative data that flow from these histories; and the need for complementary quantitative data analysis, qualitative methods, and culturally appropriate narrative and storytelling to hear the voices of minoritized communities and understand their histories of oppression.

History represents what happened, typically from the perspective of the dominant group, and provides insights into the societal structures and institutional biases that contribute to today's health inequities. By the 18th century, European colonizers were exploiting the Pacific islands and their peoples for natural resources and labor and introducing diseases that killed much of the populations.^{5,6} The United States militarized many islands and, after World War II, conducted nuclear bomb tests in the Marshall Islands, destroying the ecosystem and way of life. Today, compared with other racial and ethnic groups in Hawaii, Native Hawaiian individuals have worse economic status, are more likely to experience homelessness, and have health inequities.⁵ Sumibcay et al¹ note likely relationships among structural racism, colonialism, and COVID-19 health inequities for Native Hawaiian or Pacific Islander individuals. Compared with White individuals, Native Hawaiian or Pacific Islander individuals have more poverty, more barriers to accessing health care, more comorbidities, larger households, and a higher percentage of the population in essential worker jobs.^{5,6}

Citizenship status and access to benefits such as health insurance vary across Native Hawaiian or Pacific Islander individuals.^{5,6} Residents of Hawaii are US citizens, whereas Pacific Islander people from Samoa are noncitizen immigrants to the United States. Three Micronesian nations are members of a Compact for Free Association (COFA), receiving financial and security assistance from the United States in return for military bases. Despite being required to pay taxes, migrants from COFA nations have had varying eligibility for Medicaid depending on the political winds. COFA migrants lost eligibility for Medicaid as part of welfare reform in 1996, and Congress reinstated eligibility in December 2020. Thus, colonialism and structural racism have directly led to social and health inequities for Native Hawaiian or Pacific Islander individuals; moreover, legal status and access to health insurance vary across Native Hawaiian or Pacific Islander individuals in the United States based

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on this history, making monolithic approaches to advancing health equity for Native Hawaiian or Pacific Islander individuals nonsensical.

The problem of invisibility extends beyond Native Hawaiian or Pacific Islander individuals to Asian individuals, where grouping heterogeneous populations into a monolithic Asian category erases evidence of inequities and identification of subgroups that need more resources.^{2,3} Race and ethnicity categories often represent concepts of the dominant group and are sometimes arbitrary and illogical. For example, Asia is a European concept that aggregates culturally and linguistically diverse lands beyond the eastern border of Europe, making monolithic and invisible more than 50% of the world population.² The 2020 Census indicates Asian individuals constitute 6.3% (19 million) of the total US population, including the 6 largest subgroups of Asian Indian (1.33% alone; 1.44% alone or in any combination), Chinese (1.25%; 1.57%), Filipino (0.93%; 1.57%), Vietnamese (0.59%; 0.69%), Korean (0.46%; 0.60%), and Japanese (0.22%; 0.48%) people, with vast subgroup heterogeneity.⁷

Beginning in the 19th century, the United States enacted anti-Asian immigration laws. The Immigration and Nationality Act of 1965 increased immigration from Asian countries, prioritizing categories including professionals and people with specialized skills. Thus, statistics showing that Asian individuals in aggregate have higher income and better health reflect the selection effect of prioritizing educated, skilled professionals in immigration. The challenges of Asian individuals who do not have those advantages are lost in aggregate statistics.

For example, many Southeast Asian immigrants suffered directly from the Vietnam War, and family harm continues through intergenerational trauma; they frequently experience social and health inequities.^{2,4} Chinese immigrants without professional skills and with limited English proficiency often work in low-wage service jobs without health insurance benefits. Their challenges are invisible when they are lost in aggregate data and their stories are not heard. Averaging makes Asian individuals at the margin invisible. They are not labeled a priority population, and thus too often Asian subgroups facing major challenges do not qualify for resources and support intended to support disadvantaged minority groups. It is critical to analyze intersectional factors, such as socioeconomic status, immigration status, gender, and English language proficiency, beyond broad aggregate racial and ethnic categories.

Quantitative data for numerically small, marginalized populations are especially subject to biases, including for Asian individuals and people with limited proficiency in dominant languages. Some bias likely results from historical and current racism. For example, the finding of Sumibcay et al¹ that Asian individuals had low COVID-19 mortality rates might reflect underreporting of COVID-19 cases in Asian communities. Yan et al³ summarized data around the same time period indicating that Asian individuals had 53% higher COVID-19 case fatality rate, 2.1 times higher percentage of deaths attributed to COVID-19, and 3.1 times higher excess all-cause mortality than non-Hispanic White individuals. The high case fatality rate is consistent with being tested less frequently but being more likely to be positive and presenting with more severe illness and being more likely to die. Yan et al³ note that COVID-19 testing sites were less available in Asian neighborhoods and anti-Asian racism might have deterred Asian individuals from seeking testing. Thus, Asian communities may have been disproportionately harmed by COVID-19.

To move from invisibility to action, we need accurate data. The medical and social needs of Native Hawaiian or Pacific Islander and Asian subgroups are often hidden in aggregate quantitative data and dominant narratives of history. These needs should be recognized, affirmed, and addressed. Language and mistrust can be barriers to accurate data collection. Trauma, including structural racism and catastrophes such as war, also makes data collection harder. Using only available data too often makes the marginalized invisible.

Qualitative, storytelling, and humanistic data collection approaches must complement disaggregated quantitative data. Research that focuses on concentrated geographical communities is powerful. However, minoritized populations are not solely clustered in visible, vocal ethnic enclaves.² Some isolated minoritized people face enormous minority stress and will try to assimilate

into their surrounding communities and not stand out to survive. We also need to capture their experiences in data collection, and we need to increase the research workforce from minoritized communities who understand these lived experiences and perspectives.⁴ Clinicians, public health leaders, and policymakers must understand these factors to design and implement interventions and policies that will most effectively reduce Native Hawaiian or Pacific Islander mortality from COVID-19 and advance health equity.

All people from small, minoritized racial and ethnic groups are important and should be recognized. We need to make the invisible visible, advocate for intersectional perspectives, and truly value the voices and needs of minoritized populations in the context of their life course and lived experiences.²

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