Aging and Health:
Asian and Pacific Islander
American Elders
Second Edition

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SGEC Working Paper Series
Number 3
Ethnogeriatric Reviews

Supported by a grant from the Bureau of
Health Professions for Geriatric Education Centers.
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PREFACE TO THE SECOND EDITION

It is with pleasure that we present this update to our original review of the available literature bearing on the health of older Americans from Asian and Pacific Islander ancestries. Since the time we completed the first edition in 1990, the literature has grown substantially, making it necessary to increase the review from 37 to 91 pages. We were very pleased to have the participation of Dr. Melen McBride in this edition; in addition to her background in geriatric nursing and research, she brings unique expertise in Filipino aging, having worked closely with other Filipino American scholars and health care providers on issues of health for the elders in their community. In this edition, therefore, the amount of information concerning the rapidly growing older Filipino American population, the third largest ethnic group in the Asian Pacific Islander American category, is much more comprehensive than the meager literature we were able to present in the first edition. In addition, we have added several new subject areas, including sections on clinical assessment and ethics.

We would like to express our profound gratitude to two of our colleagues who have supported the production of this review with such dedication. Merry Lee Ellers, MA, Information Specialist of the Stanford Geriatric Education Center (SGEC), has been a major contributor by her diligence in obtaining the literature and tenaciously insisting that the references are correct. Bernadette Serafin, SGEC Program Assistant, has been very helpful in the clerical parts of the production effort. Our sincere thanks also go to Marie Luz Villa, MD, our SGEC Core Faculty colleague, geriatrician, bone specialist, and ethnogerontologist, who contributed the results of her review of the literature and publication on bone density and hip fractures among Asian and Pacific Islander elders in the U.S. and elsewhere.

It is our hope that this review will be useful to faculty, researchers, clinicians, and students in health care disciplines who are struggling with issues of cultural competence and health risks. We would be delighted to have comments on the review or suggestions for other resources that would be helpful.

February, 1996

Gwen Yeo, PhD, Director
Stanford Geriatric Education Center

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# AGING AND HEALTH:
## ASIAN AND PACIFIC ISLANDER AMERICAN ELDERS
### Second Edition

by
Melen R. McBride, RN, PhD, Nancy Morioka-Douglas, MD, and Gwen Yeo, PhD

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PART I

INTRODUCTION

The Asian and Pacific Islander American (APIA) population is the fastest growing ethnic category in the United States. According to census data, the population increased from 1.5 to 3.5 million between 1970 and 1980 and to 6.9 million in 1990 (Paisano et al. 1993; Yu & Cypress, 1982). Not only is the total population growing, but the number of Asian and Pacific Islander Americans 65 years and older more than doubled from 1970 to 1980, from 101,000 to 212,000 and again from 1980 to 1990 when nearly half a million (454,458) people 65+ identified themselves as "Asian" or "Pacific Islander." (Koh & Bell, 1985; U.S. Bureau of the Census, 1992). The Bureau of the Census estimates that in 1995 the APIA population 65 and over is approximately 650,000 (Young & Gu, 1995). The growth in the past few decades is due to liberalization and changes in the immigration laws, inclusion of new groups in the census definition, as well as economic and political changes in the countries of origin which provide the "push factors" for migration, especially for elders who are coming as "followers of children" joining or migrating with adult children. Tanjasiri, Wallace, and Shibata (1995) point out that: 1) in each decade after the sweeping immigration reforms in the 1960s the number of immigrants from Asian and Pacific Island countries grew exponentially from half a million in the 1960s to 3 million in the 1980s; and 2) a larger proportion of legal immigrants from API countries, such as the Philippines, mainland China, Korea, and Vietnam, are over 65 as compared to other immigrant populations.

Asian Pacific Islander American elders comprise 1.5% of all U.S. elders and are projected to grow to 8% by 2050. There are more than 30 national backgrounds represented among the APIA elders, the largest of which are listed individually in Table 1. Countries of origin of these elders span half the globe, including East Asia, Southeast Asia, the Indian subcontinent, Polynesia, Melanesia and Micronesia. One may question the utility of having such a broad category of people who share only a vague geographic continuity, without a common ancestry, culture, or language. Liu and E. Yu (1985, p. 36) explain:

In the strictest sense, the term Asian/Pacific Americans is a meaningful concept only insofar as it identifies the geographic origins of a group of people who are visibly different from the majority white population. . . . [T]he importance of having at least some preliminary baseline information on this ethnic group seems to override the disadvantages of lumping such diverse populations together.

This review is focused on the health of APIA elders and will include: demographics; morbidity and mortality data; health care issues such as access, utilization, and clinical recommendations; and health practices and beliefs. Although an increasing amount is
being written about a range of important topics for APIAs of all ages, the scope of this review has been kept intentionally narrow to focus specifically on health care concerns. It includes information about elders from Chinese, Japanese, Filipino, Korean, Asian Indian, Southeast Asian (Vietnamese, Cambodian, Laotian, Hmong), and Pacific Islander (native Hawaiian, Samoan, Guamanian [Chamorro], and Tongan) backgrounds, since these are the categories for which information is available, although the amount of data about the individual ethnic groups varies considerably.

Asian Pacific Islander Americans share with other ethnic groups the confounding variables of cohort, regional, and acculturation variances. As Valle writes (1989, p. 357):

For example, in the United States, Japanese American first-generation immigrant arrivals, identified as Issei, and their children, the second generation U.S. born Nisei, who were incarcerated and placed in camps at the outbreak of World War II have had a quite different enculturative imprinting than those Issei who did not have that experience but instead came from a postwar, highly technologically oriented, and economically expanding Japan.

Keeping in mind that the characteristics of APIA are very dynamic, it should be emphasized that this paper is not intended to perpetuate ethnic stereotypes of quaint cultural beliefs and practices to which elders of various generations of U.S. residence and levels of acculturation may or may not adhere. Both positive and negative stereotyping have put APIA at a disadvantage in the past. After severe discrimination, exploitation, exclusion, internment, and even violence directed against members of "the yellow peril" during the first half of the 20th century, the perception of APIA groups changed to another type of disadvantage during the latter half. The "positive" stereotype of being the "model minority" (e.g., being self-sufficient, family oriented, educationally oriented, hardworking, and upwardly mobile) has caused them to be excluded sometimes from the same level of concern expressed toward other non-Asian minorities. Wong (1980, p.49) describes an example of this process, "... the Asian American elderly en masse were originally intended to be excluded as minorities from the 1971 White House Conference on Aging and, presumably, from the White House's policy toward the aged, even though extensive preparation had been made to include the non-Asian minorities in a series of lengthy special reports". The anti-Japanese sentiment that became widespread in the U.S. in the late 1980s made many fearful about negative stereotyping directed towards Americans of Asian ancestry in general. An article in the March 18, 1990, San Francisco Chronicle, "The Dark Heart of Japan-Bashing" (Burress, 1990) noted that "[t]he vicious circle of media prejudice and public hostility produce widespread acceptance of the notion that the Japanese are bad people, that they are unprincipled, selfish, racist, and untrustworthy; which kindles resentment that not only threatens Japanese people but can extend to Japanese Americans, and to anyone of Asian descent." Although not directed exclusively
at Asian populations, the anti-immigrant sentiment of the mid 1990s seems to be repeating much of the same cycle.

This paper is an attempt to provide an introductory framework on which health care providers and others can build an increased understanding of the cultural heritage of these ethnically diverse elders. It is hoped that providers will be able to incorporate the information, not to pigeonhole older APIAs, but to recognize the diversity of individuals within the ethnic categories, anticipate needs, to facilitate nonverbal and verbal communication, and to make them comfortable about expressing their own needs and concerns.

DEMOGRAPHIC AND HISTORICAL BACKGROUND

The predominant image that occurs in the review of the demographic data that is available on APIA elders in the U.S. is of immense heterogeneity. Not only have the older Americans in this category come from lands spanning more than half the globe, but within most of the ethnic groups there is vast diversity in level of acculturation to the American way of life, education, income, rural/urban background, and health beliefs and utilization. The sizes and percentages of the older adults in the APIA ethnic groups summarized in the major census tables are presented in Table 1.

The mixture of ethnicities in this category is changing over time, reflecting the increase in immigration from Asia following the 1965 Amendment to the Immigration Act, which allowed 170,000 immigrants per year from the Eastern hemisphere with a limit of 20,000 from any one country (Kitano & Daniels, 1988, p. 16). Moreover, a law passed in 1981 allowed 20,000 people per year to immigrate from Taiwan in addition to the 20,000 per year allowed from mainland China subsequent to 1965. This ensured that the Chinese will continue to dominate the numbers in the APIA category (E. S. H. Yu, 1986).

Currently, the three largest groups among the half million APIA elders are the Chinese, Japanese, and Filipino in that order, which together make up three quarters of all the older APIAs in the U.S. and each numbered more than 100,000 in 1990. After these "big three", the size of the populations drop significantly, with Korean, Asian Indian, and Vietnamese ranging from 18,000 to 35,000 each, followed by a number of smaller groups. It is interesting that the Asian Indian elders with ethnic origins from the Indian subcontinent are the fifth largest APIA population in the U.S., but almost no information is available in the published literature concerning these elders.

Almost all of the APIA ethnic groups had as many or more people in the 55-65 cohort as in all the 65+ age range in 1990, so that the 65+ population is expected to grow dramatically in the next few years. Based on the 1980-90 growth rate, the estimated 1995 population for the total APIA category of elders is 665,699.

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Table 1
ETHNIC IDENTIFICATION OF ASIAN AND PACIFIC ISLANDER ELDERS 65 & OVER, 1990

<table>
<thead>
<tr>
<th>ETHNIC GROUP</th>
<th>NUMBER 65 AND OVER</th>
<th>% OF ASIAN/PI 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Asian</td>
<td>439,723</td>
<td>96.8%</td>
</tr>
<tr>
<td>Chinese</td>
<td>133,977</td>
<td>29.5%</td>
</tr>
<tr>
<td>Japanese</td>
<td>105,932</td>
<td>23.3%</td>
</tr>
<tr>
<td>Filipino</td>
<td>104,206</td>
<td>22.9%</td>
</tr>
<tr>
<td>Korean</td>
<td>35,247</td>
<td>7.8%</td>
</tr>
<tr>
<td>Asian Indian</td>
<td>23,004</td>
<td>5.1%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>18,084</td>
<td>4.0%</td>
</tr>
<tr>
<td>Cambodian</td>
<td>3,724</td>
<td>0.8%</td>
</tr>
<tr>
<td>Lao</td>
<td>3,697</td>
<td>0.8%</td>
</tr>
<tr>
<td>Hmong</td>
<td>2,535</td>
<td>0.6%</td>
</tr>
<tr>
<td>Thai</td>
<td>1,416</td>
<td>0.3%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1,371</td>
<td>0.3%</td>
</tr>
<tr>
<td>Indonesian</td>
<td>1,004</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>5,526</td>
<td>1.2%</td>
</tr>
<tr>
<td>Total Pacific Islander</td>
<td>14,735</td>
<td>3.2%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>10,233</td>
<td>2.3%</td>
</tr>
<tr>
<td>Samoan</td>
<td>2,047</td>
<td>0.5%</td>
</tr>
<tr>
<td>Guamanian</td>
<td>1,523</td>
<td>0.3%</td>
</tr>
<tr>
<td>Tongan</td>
<td>611</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>321</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Sources: U.S. Bureau of the Census, 1992; Young & Gu, 1996.

1 It should be noted that census data, while undoubtedly the most reliable numbers available for the diverse populations of interest, are notoriously inaccurate, especially for the smaller groups and those who have most recently immigrated. Many advocacy groups generally acknowledge the census data to be undercounts of the actual numbers of individuals from Asian and Pacific Island origins residing in the U.S.
The current population of Asian American elders includes: the first and second generations of the "sojourner" immigrants who came to the U.S. in the late 1800s and early 1900s; wives and children who came to join their husbands and fathers after World War II after being separated for decades; and elders who have immigrated with, or to join, their families since the 1965 change in immigration laws, including refugees from the chaos of the War in Vietnam and its aftermath.

Immigrants from China, Japan and the Philippines share a common history in that they were brought over beginning in the late 1800s to provide cheap manual labor. Often, only single, poorly educated males migrated, with the intent of making their fortunes in the United States before returning to their countries of origin or, if possible, bringing their families to the U.S.. Beginning with the Chinese Exclusion Act of 1882, and culminating in the Immigration Act of 1924 barring entry of all Asian populations, however, both discriminatory legislation prohibiting immigration and naturalization of Asian groups, and antimiscegenation laws and informal sanctions preventing Asian men from marrying outside their race, were imposed. The post-World War II era of the late 1940s saw gradual small changes in legal status and one large influx of wives and children, but it was not until 1965 that such laws were finally repealed. As a consequence of the severe discrimination, a large group of single Asian men had been created who were poor, old, and with little social support. This "bachelor society" experience of the mid-1900s greatly affected the overall history of today's older Asian American population (Kamikawa, 1990; Kitano & Daniels, 1988).

Because of the variations in time and circumstances of immigration, different ethnic populations in the APIA category contain very different percentages of older adults. The percentage of people 65+ within the ethnic groups range from a high of 12.5% for Japanese Americans (similar to that in the U.S. as a whole) to 1.6% for people from Thailand. As a whole, 6.2% of APIA population is 65+; the percentages for Chinese and Filipino populations are slightly higher than the average with 8.1% and 7.4%, respectively, and elders in the remaining ethnic populations comprise 4% or less (Paisano et al., 1993; Young & Gu, 1995).

Unless otherwise noted, the remainder of the demographic data presented in this section and in the individual ethnic group sections that follow are based on detailed analyses of 1990 census data from six printed reports and one file tape produced by the National Asian Pacific Center on Aging (Young & Gu, 1995) with a grant from the Administration on Aging. This valuable analysis includes information of the size and demographic and socio-economic characteristics of older Americans from 12 Asian and five Pacific Islander separate ethnic backgrounds.

Almost two thirds of older APIAs in the U.S. reside in two Western states--44% in California, and 20% in Hawaii. The remainder are relatively widely dispersed, with New York having 9%, Illinois, Washington, and New Jersey 3% each, and Texas 2%.
The older APIA population is heavily foreign born; 70% were born outside the U.S., compared to 9% of all older adults in the U.S. and the largest proportion of the four ethnic minority categories. From 83% to 98% of elders in all the Asian ethnic groups were born in other countries except the Japanese Americans, who had only 17% foreign born in 1990. Among Pacific Islanders only the older Tongans reported a majority (99%) to be foreign born, due largely to the fact that the places of origin of most Pacific Island ethnic groups are American protectorates or the state of Hawai'i.

When all the elders in the APIA category are considered together, the majority speak a language other than English (80%) and do not speak English very well (58%); 30% are classified as linguistically isolated. (These language attributes are not found as commonly, however, among native Hawaiian, Guamanian, Japanese, or Samoan American elders.) As a category APIA elders have both higher proportions of well educated and poorly educated than older Americans in general; 13% had a bachelor’s degree or higher, compared to 11% of all older Americans, and 39% (vs. 26%) had less than a 9th grade education. There are also large variations in the income and poverty status of APIA when they are considered as a whole, with those from Southeast Asian backgrounds particularly likely to be disadvantaged. When Liu and E. Yu (1985) looked at five major cities with large concentrations of Asian residents (Chicago, Honolulu, Los Angeles, New York, and San Francisco), one out of every four Filipinos of all ages, and nearly as many Chinese, were receiving public assistance. In 1990 more APIA elders are in the labor force (15.5%) than most older Americans (12%).

Unlike earlier decennial censuses, men are no longer in the majority among older Chinese and Filipino Americans. While in 1970 and 1980 there was still a large number of older males who immigrated in the earlier part of the century and could not marry, the APIA gender ratio of the 1990s reflects a more typical older adult population with 55% female, which is still slightly lower than the total U.S. old female proportion of 60%. Only in the small Indonesian and Tongan groups do men outnumber women. Slightly more APIA elders are married than in the U.S. in general, (79% of males and 43% of the females vs. 75% and 39% for the U.S.); Asian, but not Pacific Islander, elders are a little more likely to live in "households" than older Americans in general (98% of Asians vs. 94.5% for U.S. and Pacific Islanders). It is very clear that Asian elders are much less likely to live in "group quarters" (2.3% vs 5.5% for U.S.) or especially in nursing homes (1.6% vs. 5.0%). These differences are not found among Pacific Islanders; in fact among the small older Samoan population in the U.S. 16% are reported to live in "group quarters" and 13% live in nursing homes (Young & Gu, 1995).

A microsample of 32,726 from the 1990 Census were used by Himes, Hogan, and Eggebeen (1996) to analyze the living arrangements of U.S. residents age 60 and over who reported their ethnicities as Chinese, Japanese, Korean, Southeast Asian, and "Other" Asian. (It is assumed that Filipinos are not included in the "Other" category based on the sample size reported.) Table 2 reflects their analysis.
Table 2
PERCENT 60+ IN LIVING ARRANGEMENTS
ASIAN AMERICANS BY ETHNICITY
Standardized for Age, Sex, & Marital Status

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Alone</th>
<th>W/Spouse Only</th>
<th>W/Spouse &amp; Kin</th>
<th>W/Kin, No Spouse</th>
<th>W/Non-Kin**</th>
<th>Institutionalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Asian</td>
<td>10.0</td>
<td>25.9</td>
<td>33.8</td>
<td>25.5</td>
<td>3.6</td>
<td>1.2</td>
</tr>
<tr>
<td>Chinese</td>
<td>11.9</td>
<td>26.0</td>
<td>33.1</td>
<td>24.6</td>
<td>3.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Japanese</td>
<td>16.8</td>
<td>40.5</td>
<td>23.7</td>
<td>15.3</td>
<td>2.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Korean</td>
<td>9.7</td>
<td>25.5</td>
<td>34.0</td>
<td>26.8</td>
<td>2.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Southeast Asian</td>
<td>4.7</td>
<td>13.9</td>
<td>42.7</td>
<td>32.4</td>
<td>5.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Other Asian</td>
<td>6.9</td>
<td>19.6</td>
<td>38.6</td>
<td>29.7</td>
<td>3.2</td>
<td>2.0</td>
</tr>
<tr>
<td>Total U.S.</td>
<td>24.5</td>
<td>45.7</td>
<td>12.3</td>
<td>11.8</td>
<td>2.6</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Source: Adapted from Himes, Hogan, & Eggebeen, 1996
**Includes non-institutional group quarters.

Some of the major historical background and demographic characteristics of the larger ethnic groups within the APIA category are briefly described below by country of origin.

**Chinese.** Early Chinese immigrants came from the southern province of Kwangtung after the discovery of gold in California in 1850. In 1882, the Chinese Exclusion Act was passed which blocked Chinese immigration. This was extended until 1943, when a small number of Chinese were allowed to immigrate (Kitano & Daniels, 1988). Later immigrants who fled China after the Communist takeover were more educated and spoke the Shanghai dialect and variations of Mandarin, the national language (Chen-Louie, 1983). Between 1989 and 1992, U.S. Immigration and Naturalization Services and other sources reveal that over 23,000 immigrants over 60 came to the U.S. from mainland China, over 3,000 came from Taiwan, and an estimated 780 came from Hong Kong (Young & Gu, 1995). Common languages spoken among older Chinese Americans include Cantonese and Mandarin, but Toisanese, Taiwanese, and other dialects are also found. In 1990, 89% of Chinese elders in the U.S. said they spoke a language other than English, and 73% reported that they did not speak English very well; 46% were classified as linguistically
isolated. Other characteristics of these 134,000 Chinese Americans 65+ reported by Young and Gu include:

- 83.5% were born outside the U.S., and of those 44% have become naturalized citizens;
- 1.4% lived in nursing homes, and 2.5% in "group quarters;"
- 43% had less than a 9th grade education, and 15% had bachelor's degrees or more (with both ends of the educational distribution being considerably higher than the national average for U.S. older adults);
- 13% are still in the labor force;
- 15% of all those 65+ are in poverty, and 47% of those 75+ who live alone, (compared to 12% and 27% nationally, respectively)

A comparison of living arrangements of samples of elders from the 1980 census from California, Hawai‘i, and all other places in the U.S. found that Chinese Americans were more likely than their non-Hispanic white (NHW) counterparts to live in extended family arrangements (with ever-married children, parents, or siblings); for example the ranges for unmarried older Chinese women in the three samples were from 46% to 63%, compared to 18% to 27% for NHWs. Similar but less dramatic differences were found among married females and all males. Those with lower indices of acculturation and lower income were more likely to live in extended families (Kamo & Zhou, 1994).

**Japanese.** Significant events in the history of the Japanese in the United States include the 1924 Immigration Exclusion Act which stopped all immigration to the United States from Japan. In 1942, President Roosevelt signed Executive Order 9066 which authorized the relocation and internment of 112,000 Japanese Americans of whom two thirds were American born citizens (Ishizuka, 1978). Kitano refers to Japanese Americans using "generational" and "chronological" categories. The "generational" category includes the Issei, or first generation, the Nisei, second generation, the Sansei, third generation, the Yonsei, fourth generation, and Gosei, fifth generation. In addition, some Japanese Americans who were born in the U.S. and educated in Japan are referred to as Kibei. The "chronological" category includes the immigration period from 1890 to 1924; the pre-World War II period from 1924 to 1941; the wartime evacuation period from 1941 to 1945; and the postwar period from 1945 to the present (Kitano, 1969).

Because there has been relatively little immigration from Japan in recent years, the older Japanese Americans are the most acculturated of all the APIA elders. In 1990 (Young & Gu, 1995):

- Only 17% of the 104,000 65+ were foreign born, which is dramatically different from other Asian groups; of those 18,000 older Issei, 55% were naturalized citizens.
- Still 62% of all older Japanese Americans reported that they speak a language other than English, and 36% said that they do not speak English very well; 18.5% were classified as linguistically isolated.
They were more highly educated than any APIA group of elders other than the Asian Indian. Only 5% reported their incomes below the poverty threshold, the lowest of any APIA group, and less than half of the national average. They also had the highest percentage (20%) still in the labor force. Higher percentages than in other Asian groups also were in nursing homes (2.4%) and "group quarters" (2.9%), still half of the U.S. rate for elders in general.

Japanese American elders were found to be more likely than non-Hispanic whites (NHWs) to live in extended family households, based on a comparison of three samples from the 1980 census. For example, the percentages of unmarried older Japanese women in the U.S. who lived with extended families ranged from 39% to 54%, compared to 18% to 27% for NHWs. They were less likely than Chinese American elders, however, except in Hawaii (Kamo & Zhou, 1994).

FILIPINO. The earliest recorded Filipino settlement was in Louisiana. The first period of immigration began in 1763 when some crewmen for the Spanish-Mexican galleon trade (1565-1815) escaped enslavement and harsh labor and a few travellers disembarked in the region. These "Manilamen" and their descendants, the Filipino Cajuns, settled in southeastern Louisiana where they introduced the dry shrimping industry (Espina, 1974; Tompar-Tiu & Sustento-Seneriches, 1995). When the United States acquired the Philippines in 1898, after the Spanish American War, Filipinos became eligible to enter the United States as "nationals" without the right to vote and own property or a business.

From 1900 to 1934, the second period of Filipino immigration, was comprised of clusters of immigrants, mostly men (Tompar-Tiu & Sustento-Seneriches). In 1906, fifteen Filipinos arrived in Hawai‘i to work on sugarcane plantations, calling themselves "sakadas" or contract laborers. Many were recruited from 1907 to 1919 to replace the diminishing supply of Japanese laborers. After 1924, an influx of workers immigrated to Hawai‘i as well as California, Washington, and Alaska. Many were poorly educated young bachelors hoping to return to their rural villages. For them, marriage to a Caucasian was illegal (Peterson, 1978; Yeo & Hikoyeda, 1992). Referred to as "manongs" (older brothers) or "old-timers," they aged in the U.S. in social isolation and poverty. In contrast, a small number of government-subsidized scholars or "pensionados" who came in the early 1900s to study returned to the Philippines to positions of responsibility. Later arrivals to the U.S. joined family members or sought economic or educational opportunities. They worked for low wages in California farms, Alaskan canneries, and service industries as domestices in private homes, hotel and hospitals. The discrimination experienced by these "pinoys", an identity these later arrivals gave themselves, led to mainstreaming their families quickly while they formed social organizations as support systems. Seen as a social and economic threat, the Tydings-McDuffie Act was passed in 1934, limiting Filipino immigrants to 50 a year and changing the status of Filipinos in the United States from "nationals" to "aliens". Some of the children of the pinoys are now young-old Filipinos.
who may be their caregivers. Like manongs, many unmarried pinoys live in poverty and isolation.

The third period of immigration from 1945 to 1965 consisted of military personnel and their families, WWII veterans, professionals and students. More women and families were in this group. After 1965, the fourth period of immigration, the number of Filipino immigrants increased dramatically, including many who were well educated and came as family groups (McBride & Parreño, 1996, in press; Orque, 1983a). In Peterson’s San Diego study of 74 elderly Filipinos, two distinct groups were found. One group consisted of single males, and the other of recent arrivals, many of whom were women who lived with their children (Peterson, 1978). The diversity among Filipino immigrants increased as the Marcos regime continued and as living conditions became increasingly difficult. Middle aged immigrants who brought along aging parents are now part of the young-old population (McBride & Parreño, 1996, in press; Tompar-Tiu & Sustento-Seneriches, 1995).

After 1980, a fifth period of immigration has evolved that includes two distinct subgroups of Filipino elders: the "followers of adult children," and the newcomer WWII veterans. There were 26,356 adults 60+ who immigrated to the U.S. from the Philippines from 1989 to 1992, many of whom were "followers of children" who were coming to live with their adult children, large numbers of whom are professionals and paraprofessionals in the U.S. health care system. Many elders became surrogate parents and homemakers for their grandchildren living in households where both parents are employed.

Characteristics of the 104,000 Filipino American elders in 1990 included the following (Young & Gu, 1995):
95% were born outside the U.S., 57% of whom have become naturalized citizens;
89% speak a language other than English, 56% say they do not speak English very well, and 17% are classified as linguistically isolated;
1% lived in nursing homes, and 1.6% in "group quarters;"
43% had less than a 9th grade education, and 16% had bachelor’s degrees or more, which is almost identical to older Chinese Americans, reflecting higher percentages than the national average at both ends of the educational continuum;
18% are still in the labor force;
8% of all those 65+ are in poverty, and 30% of those 75+ who live alone.

The second post-1980 subgroup of older immigrants came after the passage of the 1990 Immigration Act, Section 260, giving immediate United States citizenship to Filipino World War II (WWII) veterans living in the Philippines. However, veterans’ benefits did not come with this legislation. A large number of older Filipinos came to the West Coast to be naturalized in the U.S., as originally required by the law. These are veterans who were recruited by the U.S. Armed Forces in WWII to serve in the Pacific and promised American citizenship for their service. Those who missed the short window of opportunity to become naturalized soon after the end of WWII waited until the 1990
legislation. It is estimated that more than 3,000 veterans, age 62 and older, are now new citizens, many of them residents in urban areas of California and other West Coast cities. The absence of veterans' benefits has led to major economic, social, and health problems creating a group of high risk elders whose quality of life is determined by their ability to access public resources. Many of these veterans immigrated without their families or stable support networks. Their expectations to reunite with family members have been stymied due to lack of understanding of the complex immigration regulations and other public policies associated with health and social services (McBride, June, 1993). Although advocacy groups have formed to seek policy changes to assist these newly immigrated older Filipino Americans, the probability of success in this area is uncertain.

**Korean.** According to census data Korean American elders are the most rapidly growing of all the older APIA ethnic populations in the U.S. and the largest of the middle sized groups; they more than quadrupled their numbers from 1980 to 1990 from 8,600 to over 35,000 and were expected to double again by 1995 (Young & Gu, 1995). Korean migration to the U.S. has occurred in specific phases including: (1) recruited migration (1903-1905) to Hawai‘i of farm workers and families; (2) restricted migration (1905-1924) of picture brides, students, and political exiles; (3) immigration of dependents (1952-1964) including war brides and war orphans; and (4) new waves of settlers (1965-Present), over 20,000 annually, many well-educated, urban professionals, and their extended families (S-Y. Chin, 1993). From 1989 to 1992 alone, over 8,000 elders aged 60 and over immigrated from Korea, many as followers of children (Young & Gu, 1995).

Characteristics that have been found among Korean American families include: a high regard for filial piety; clearly divided family roles; family collectivity and interdependence which frequently overrides individualism and independence; and importance of good education (S-Y. Chin, 1993; Kitano & Daniels, 1988). Korean Americans are heavily Christian, and churches serve as social and educational centers providing group ties, identity, and acceptance. (P.K. Kim & J.-S. Kim, 1992; Lubben, Chi, & Kitano, 1989). Many own businesses unrelated to their professional training because of cultural/language barriers.

Characteristics of the Korean American elders in 1990 include (Young & Gu, 1995):
- 91% were foreign born, 19% of whom were naturalized;
- 80% do not speak English well, and 53% were linguistically isolated;
- 42% had less than a high school education;
- 20% reported incomes under the poverty level, 43% to 48% of those live alone;
- 1.4% live in nursing homes.

**Asian Indian.** The most distinctive characteristic of the literature on Asian Indian elders in the United States is its nonexistence. There is very little information on this population
that began immigrating to the U.S. as early as the turn of the 20th century. For example, the Alienation of Land Act in India under British rule which prohibited certain non-farming castes from owning agricultural land prompted 3,000 people, many from the Punjab region, to move to the West Coast of the U.S. as early as 1908 (Vepa, 1991). The group of Sikh farmers in the Yuba City area of California have preserved their Indian subculture in a cohesive community, which is generally not found in most other immigrant Indian populations in the U.S. due to their own internal diversity (Ramakrishna & Weiss, 1992). Other immigration streams have been through East Africa where Indian traders and business men migrated in the 1920s & 1930s; with the political unrest in Africa in the 1960s, many came to the U.S. There is also a population who came to the U.S. from Fiji after their families had moved there several hundred years ago to work on British plantations (Majmundar, 1990). Although these residents of the U.S. may have come most recently from countries other than India and may in fact be citizens of other countries, they usually identify themselves as “Asian Indian” or “Indo American” (Mazumdar, 1993).

Although in 1990 the over 23,000 older Americans from Asian Indian backgrounds made it the fifth largest APIA ethnic group, there is a serious void of information. The census data indicates that (Young & Gu, 1995):

- Although 83% are foreign born,
- Just over half (51%) say they do not speak English well;
- Only 12% are linguistically isolated,—the smallest of any Asian ethnic group;
- While 39% have educations below 9th grade, 21% have bachelor’s degrees, the highest of any Asian/Pacific Islander group;
- 8% report incomes below poverty;
- 1.4% live in nursing homes.

Many who have come to the U.S. as followers of children find themselves cut off from their social support networks of friends and relatives, from their religious activities, and not respected for their wisdom and guidance as they would be in India (Ramakrishna & Weiss, 1992).

Immigrant populations have also come to the U.S. from other parts of South Asia, such as Bangladesh, Bhutan, India, Pakistan, Nepal, and Sri Lanka, but the numbers tend to be so small that there is neither demographic nor health risk information about the elders among them.

**Southeast Asian.** Since the fall of Saigon in 1975, more than 500,000 refugees from Vietnam, Cambodia, Laos (including Hmong and Mien populations), and Thailand have moved to the United States. Of these, approximately 10% are over the age of 45 years (Muecke, 1983a). Of the 29,456 elders in the U.S. from these ancestries who were counted in the 1990 census, 51% were from Vietnam. In her excellent review article in the December 1983 issue of The Western Journal of Medicine, Muecke, (1983b) described two waves of Southeast Asian immigrants. The first was “generally well educated...,
young...urban dwellers...of Catholic background who were in good health and in the company of family." The second was more heterogeneous in composition but was, in general, "less well educated, less literate, less familiar with Western thought and institutions, less facile in English, and less healthy" (p. 835). Others describe three waves, the last of which arrived in 1979, frequently referred to as "boat people". Individuals in this last group were reportedly sicker and spent more time in relocation camps than their counterparts in the earlier waves (Kamikawa, 1990). Immigration of followers of children in the family reunification program is continuing at a brisk pace, with 16,021 people 60+ arriving from Vietnam alone from 1989-1992 (Young & Gu, 1995). Over 60% of elders in the U.S. from Southeast Asian backgrounds in 1990 were from Vietnam (See Table 1).

As a consequence of their recent arrival in the U.S., virtually all (97%) of the Southeast Asian elders are foreign born; 80% or more do not speak English well, and approximately half are linguistically isolated. The majority have less than a ninth grade education in all of the ethnic populations, including 92% of Hmongs, although 5% of Vietnamese elders have a bachelor's degree. In a recent study of Cambodian elders in San Jose, CA, the mean number of years of school was 1.3, with 68% having none (Handelman & Yeo, 1996, in press). The highest rates of poverty among APIA elders are found in the Southeast Asians, ranging from 18% for Vietnamese to 47% for Hmong.

When the Vietnam war ended, the Hmong people settled in this country to escape retribution from the Communists for collaborating with the U.S. armed forces and for their pro-Western sentiments. As refugees, the painful and difficult experiences of their odyssey increased their need for a close knit community. Their heritage includes the word "Hmong", which means "free men" in their language. These agricultural people have depended on themselves for centuries, migrating in the mountains of Southeast Asia in search of fertile land. Their independence, resourcefulness, and tenacity are traits that enable them to preserve their sense of people-hood as they resettle in new communities. After two decades of living in the U.S., information is gradually unfolding about their culture, values, beliefs, and practices. Numbering 100,000, Hmong refugees traditionally organize into large close knit communities known as clans. The clans headed by male leaders include extended families with the same last name. Respect for elders and authority is emphasized and decisions and problem solving are usually relegated to the clan leader (McInnis, Petracchi, & Morgerbesser, 1990). Adjustment to a high-tech America brought additional stressors to many Hmong families yet their strong work ethic and the strict adherence to the clan system helped with their transition to a new life (Waters, Rao, & Petracchi, 1992). Conversion to Christianity from a belief system of animist and ancestor worship has influenced the way many of the traditional religious rituals are practiced in the U.S. (Bliatout, 1993). As the young Hmong people successfully complete their American education and enter mainstream society, changes in relationships with the clan leaders and elders can be expected (McInnis et al., 1990).
Pacific Islander. Pacific Islanders comprise four percent of the APIA population of all ages, according to the 1990 census, which includes three categories of Pacific Islanders: Polynesians, Micronesians, and Melanesians. Polynesian people include the Hawai’ians, Tongans, Samoans, Cook Islanders, Maoris, and Tahitians. Micronesians comprise the people of Marshall Islands, Kiribati, Guam, and the Federated States of Micronesia. (The Chamorros are the indigenous people of the Mariana Islands and make up 62% of Guam’s population of approximately 100,000 people.) Melanesians are from Fiji, the Solomons, Papua, New Guinea, and Vanuatu (U.S. Bureau of Census, 1990). Of the almost 15,000 older Pacific Islander Americans, 69% are native Hawai’ians; the remainder have immigrated to Hawai’i or the West Coast from other islands in Polynesia (e.g. Samoan and Tongan) or Micronesia (e.g., Guam).

The countries of origin of the three largest groups of Pacific Islander Americans have all been historically politically dominated by the United States. In Hawai’i in 1893, American businessmen overthrew the Hawai’ian monarchy and imprisoned the last Hawai’ian ruler, Queen Lili’uokalani, thus making it a U.S. protectorate (Chang, Durante, Nahulu, & Wong, 1980). Samoa was divided into two distinct entities in 1889; in 1900, the eastern part of the Samoan Islands was declared an American territory. American Samoa was under the administration of the Department of the Navy from 1900 until 1951. In 1951, members of the Samoan Marine Guard were given the option of transferring to the regular United States Navy. Those who chose to do so were moved with their families to Hawai’i and to the West Coast (Holmes, 1974). In 1898, Guam was given to the United States at the end of the Spanish-American War. It has been under U.S. rule continuously except during World War II when it was occupied by the Japanese. In 1950, Guam was made a U.S. territory and its inhabitants were made citizens of the U.S. (Jose et al, 1980).

Although Tongans represent a much smaller subgroup of Pacific Islander immigrants, there is an important difference between them and other Pacific Islander Americans. Tonga is not a protectorate of the United States and Tongan immigrants are not eligible to participate automatically in health or social welfare programs. Also, Tonga has a system of socialized medicine which means that Tongan immigrants are not familiar with the American health care system (Puloka & Palafox, 1980). Although Tongans and Samoans may resemble one another superficially to American providers, it is unwise to mistake one for the other, as there is a long history of rivalry between the two groups.

When considering Asian Pacific Islander Americans, it is tempting to look at Hawai’i as a microcosm of this population group. However, Hawai’i is different from the rest of the United States in that its 65+ population includes 36% Japanese, 28% Caucasian, 17% Filipino, 9% Chinese and 7% Hawaiian. Additionally, for persons 55 and older, despite their predominantly Asian heritage, an overwhelming 73.5% were born in the United States (Executive Office on Aging, State of Hawai’i, 1982).
DEMOGRAPHIC CHARACTERISTICS, ACCULTURATION, AND HEALTH STATUS

As demonstrated in the following sections on mortality and morbidity, health care, and health beliefs and practices, the characteristics summarized above are associated with health status in many ways. Along with nativity (where people are born), length of residence in the United States is also an important factor, since both would be expected to predict the level of acculturation (the degree to which people who have immigrated from their country of origin adopt the culture of the new society). Since the norms of the health care institution in the U.S. are frequently significantly different from those in Asian countries and the Pacific Islands, knowing how to access the services and communicate one's needs may be limited for those less acculturated. Among the majority of those 65 years and older from Asian backgrounds who were foreign born in 1980, 86% of Japanese, 52% of Filipinos, 47% of Asian Indians and 37% of Chinese had immigrated to the United States before 1950 (Liu & E. Yu, 1985). Although duration of residence in this country might be expected to be positively associated with elders' acculturation level, this may not be true for Asian American elders, as illustrated in a 1980 study by Salcido, Nakano, and Jue (1980). Among the 100 low-income Asian subjects aged 55 and over who resided in Asian ethnic communities in Los Angeles, 75% still spoke only their native language although 77% indicated that they had resided in the U.S. for more than 20 years.

Many of the Asian elders who immigrated before 1950 were hampered by the fact that they were predominantly poorly educated, rural, single males, the victims of discrimination, who lived in areas segregated from the majority culture. As Valle (1989, p. 357) suggests:

Clouding the acculturation picture is the discrimination and social-class exclusion from mainstream society often experienced by ethnic minority group members. . .[T]he behaviors and attitudes arising from these experiences must be distinguished from culture-of-origin customs and beliefs. Sometimes the patterns observed relate much more to the effects of discrimination than to a culture of origin. . .

Health care providers would be wise to attend to the demographic characteristics, the heterogeneity, and the historical experiences of the individuals and families from Asian and Pacific Island ancestries they see to provide the most effective care for their older patients.
PART II

MORTALITY AND MORBIDITY

OVERVIEW

Both mortality and morbidity information are limited for most Asian and Pacific Island American elders. While much of the data that is available lumps all "Asian" populations together, some of the more specific studies are based on research with samples from one national ancestry. Information is available about the incidence of different diseases among specific APIA populations only for the largest sub-groups. The overall "Asian" and some comparative findings are presented in this section, followed by a summary of the available ethnic specific literature. Data from research with populations from other countries are presented only when they seem to be relevant for older Americans from that ancestry.

Based on National Center of Health Statistics data available for Chinese, Japanese and Filipinos, Liu and E. S. H. Yu (1985) found that the pattern of deaths for all ages was similar across the three ethnic groups, and that the death rates were lower than those reported for white Americans. Yu and colleagues note that, in comparison to blacks, whites, and American Indian/Alaska Natives, Japanese Americans have maintained the lowest age-adjusted overall mortality rate throughout the past 30 years, while Chinese Americans have maintained the second lowest rate for the past 20 years (Yu, Chang, Liu, & Kan, 1985). They found that "data for Filipino Americans revealed an overall mortality rate for 1980 that is even lower than that found for Japanese Americans" (p. 218). Liu and E. Yu (1985) also found that patterns of morbidity favored APIA populations, with incidence of major diseases all lower than for white Americans.

Nativity and length of time since migration are important variables affecting mortality and morbidity rates for Asian and Pacific Island Americans. For the ten leading causes of death, mortality rates at all ages for foreign born were at least two times the rates for American born Chinese, Japanese and Filipinos across all ages, according to Yu and colleagues (E. S. H. Yu et al., 1985). However, it is not unusual to find that longer time of residence in America increases the risk of certain diseases.

Cancer. For prostate cancer, for example, Whittemore and colleagues found the risk increased with longer residence in North America among older men from Japanese and Chinese ancestry in four cities (Whittemore et al., 1995). The case-control study found that the risk of prostate cancer was strongly positively associated with intake of saturated fats but not to other nutrients, activity level, or vasectomy (John et al., 1995). Another case-control study of breast cancer among young and middle aged women from Chinese, Japanese, and Filipino backgrounds in Los Angeles, San Francisco-Oakland, and Oahu found that in all ethnicities being born in the West increased their risk 1.6 times over those born in Asia; the risk declined with immigration at older ages (Ziegler et al., 1993).
Although there was no information on place of birth, data from the Cancer Surveillance Program of Orange County, California, collected between 1984-1989 from 678 cancer patients, revealed higher risk of squamous cell carcinoma among Asian and Pacific Islander Americans and Hispanics than non-Hispanic whites in age-adjusted analyses. For adenocarcinoma, the incidence rate was highest for APIAs followed by Hispanics and non-Hispanic whites. The highest cumulative age-specific incidence rate for adenocarcinoma was found in APIAs for all age groups above 45. The combined ethnic data showed ages at highest risk for squamous cell carcinoma and adenocarcinoma are 65 to 69 and 40 to 44, respectively (Anton-Culver et al., 1990).

Response to Alcohol. It is important to be aware of potential physiologic and anatomic differences between APIAs and others. While more specific findings related to effectiveness of drugs are reviewed in Section III on health care, the issue of the flushing response to alcohol should be mentioned. A number of studies have found that individuals of Asian ancestry are more likely to respond to alcohol consumption with a marked facial flushing than those with European ancestry. This flushing response, and other associated effects such as headache, nausea, tachycardia, dyspnea, and anxiety, have been found to be related to the acetaldehyde dehydrogenase type I (ALDH-I) "deficiency" in persons of Mongoloid ancestry and are often negatively associated with the amount of alcohol consumed, although this relationship has not been conclusively established in specific Asian populations (Nakawatase, Yamamoto, & Sasao, 1993).

Hip Fracture and Osteoporosis. An example of decreased risk among Asian elders is hip fracture. In spite of methodological difficulties involved in comparing rates of hip fracture across studies, broad conclusions can be drawn regarding differences in hip fracture incidence rates for members of different races and ethnic groups. In their comprehensive review of differences in age-specific incidence rates of hip fracture between racial and ethnic groups in various countries, Maggi and colleagues found that although hip fracture incidence increases with age in all ethnic groups, the increase occurs earlier in non-Hispanic white (NHW) populations than in Asian populations (Maggi, Kelsey, Litvak, & Heyse, 1991). Age- and sex-adjusted incidence rates of hip fracture from the U.S. studies comparing APIA and NHW populations are presented in Table 3. The analysis of the incidence of hip fracture using California Hospital Discharge Data found that incidence of hip fracture among Asian Americans was one half to three fourths that of Anglo Americans and higher than Hispanic and black Californians (Silverman & Madison, 1988).

The authors would like to express their sincere thanks to Marie Luz Villa, MD, a Stanford Geriatric Education Center Affiliated Core Faculty member, geriatrician, and bone specialist, with special expertise in ethnicity, for her major part in writing the information on fracture and bone density throughout this section of the review.
Table 3
AGE-ADJUSTED RATES OF HIP FRACTURE
Per 100,000 Populations

<table>
<thead>
<tr>
<th>Study Site and Date</th>
<th>Asian Female</th>
<th>Asian Male</th>
<th>Non-Hispanic White Female</th>
<th>Non-Hispanic White Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>California, 1983-84 (Silverman &amp; Madison, 1988)</td>
<td>383</td>
<td>116</td>
<td>617</td>
<td>215</td>
</tr>
<tr>
<td>Hawai‘i, 1979-81 (Ross et al, 1991)</td>
<td>224</td>
<td>66</td>
<td>645</td>
<td>205</td>
</tr>
</tbody>
</table>

A very interesting issue in the risk of hip fractures is the finding that although the incidence of fracture is consistently found to be considerably lower among Asians and Asian Americans than non-Hispanic whites the major risk factor, osteoporosis as measured by bone mineral density (BMD) and bone mass, has been found to be similar among Asian and NHWs. Populations with high bone mass are thought to have reduced risk of hip fracture; for example New Zealand Polynesians have relatively high bone mass and a low incidence of hip fracture (Reid, Mackie, & Ibbertson, 1986; Stott, Gray, & Stevenson, 1980). However, Asian Americans have bone mass values close to those of non-Hispanic white Americans, yet have half the incidence of hip fracture (Hagiwara et al., 1989; Russell-Aulet, Wang, Thornton, Colt, & Pierson, 1991; Yano, Wasnich, Vogel & Heibrun, 1984).

One factor that has been found to affect risk for osteoporotic fracture may provide some insight into this seeming contradiction. In analyses of bone densitometry data the simple geometric measurement of hip axis length (HAL) was related to hip fracture risk; longer HAL was associated with an increased risk of hip fracture (Faulkner et al. 1993). In a separate study comparing racial differences in HAL, Asian Americans were found to have a significantly shorter HAL than Anglo-Americans (Cummings et al. 1994), which may contribute to their lower rate of hip fracture. A cross national study comparing Japanese and Caucasian differences in geometric properties of the hip also demonstrated an association between low fracture risk and short femoral neck (Nakamura et al, 1994).

Infectious Disease. Although the rates for older adults in the U.S. are not available, incidence of tuberculosis in 1985 for APIAs of all ages were 8.7 times higher than for the white population. The cases were concentrated almost exclusively (94%) among the foreign born, and almost half of the cases had developed within the first two years of arrival in the U.S. (Gardner, 1994). Indochinese refugees were found to have particularly high rates, about one third of whom had a form of tuberculosis resistant to one or more of the standard medications (R. Hann, 1994).

Likewise, hepatitis B has been found to be much more common among some APIA populations, especially those who are foreign born, although no data is available by age.
Chronic Hepatitis B Virus carrier rates from 5% to 15% have been reported in the Chinese, Korean, Filipino, Southeast Asian, and Pacific Islander American populations (H.-W. L. Hann, 1994). It tends to be asymptomatic until late in the disease when there is a high risk of liver cancer or cirrhosis, frequently in late middle age, so community awareness of the need for screening is important in control of hepatitis B. A survey of Vietnamese in the San Francisco Bay Area, however, reported that 94% of the 215 respondents had never heard of the disease (Mayeno & Hirota, 1994).

Suicide. Diego and associates found poor health and old age to be the most common reasons mentioned in suicide notes of the 48 Asian elders, age 60 and older, whose death certificates were examined in Los Angeles (Diego, Yamamoto, Nguyen, & Hifumi, 1994). Cases include Filipino, Japanese, Korean, and Vietnamese elders, 42% of whom were married and 52% widowed. Overall, the Asian elders chose more traditional methods of suicide, i.e., by hanging (70.8%) compared to the white group who used firearms (45.8%). The statistically significant association between ethnicity and chosen method may be a useful indicator of acculturation for some groups of Asian elders as suggested by McIntosh and Santos (1982).

AVAILABLE INFORMATION FOR SPECIFIC ETHNIC GROUPS

Chinese. Two interesting contradictory sets of evidence are found in the literature on mortality/morbidity among the largest ethnic group of APIA elders in the U.S., —those of Chinese ancestry. One set identifies a trend toward higher risk for foreign born and less acculturated elders, and another finds higher risks associated with increased "Westernization" or "Americanization", especially in cardiovascular disease and cancer. E. S. H. Yu (1986) looked at the effect of nativity on death rates of Chinese elders 60-74 years old, for example, and found that the death rate for foreign born Chinese was almost six times higher than that reported for American born Chinese.

Functional Status and Chronic Illness. Likewise, among a sample of 50 older Chinese Americans in San Diego, lower acculturation levels in language use was associated with higher levels of impairment on the scales of the OARS (Older Americans Resources and Services) instrument translated into Chinese measuring physical, mental, social, and economic function (Morton, Stanford, Happerset, & Molgaard, 1992). A random sample of 203 Chinese elders in Los Angeles reported fewer chronic conditions and better self-rated health than their counterparts in Beijing and Guangzhou, China, but this could be related to the better health of those who choose to immigrate (Kitano et al., 1993).

Heart and Cardiovascular Disease. On the other hand, Chinese Americans show an increased risk of coronary artery disease as they become more "Americanized" (Liu & E. Yu, 1985). In Woo and Donnan’s review of the epidemiology of coronary arterial disease in Hong Kong, Taiwan, and China, they found that in these countries, both the prevalence and incidence of mortality of coronary arterial disease and acute myocardial infarction
were roughly one eighth to one quarter of the average Western figures. However, the prevalence and mortality figures have been increasing in these three large Chinese populations as they become more Westernized (Quock, 1992; Woo & Donnan, 1989).

A study of 346 non-institutionalized Chinese Americans aged 60 to 96 in Boston analyzed their cardiovascular risk factors (Choi et al., 1990). Since 90% of the study population had immigrated from mainland China where there is a higher incidence of stroke mortality and lower cardiac mortality than in the U.S., the authors were interested in exploring the risk factors for stroke. History of hypertension was reported by 32% of the Chinese elders, compared to 39% reported by white elders in the U.S., and elevated blood pressure was found among 28% of the study population in the screening exam. A history of diabetes was reported by 13% of both the Chinese men and women, higher than the national average of 8.8% for older U.S. women, but similar to that of older U.S. men. Cigarette smoking was uncommon in the women and reported by 39% of the men. Other findings indicated that these Chinese American elders: were physically active and seldom obese; consumed a diet high in carbohydrates and low in fat and ascorbic acid; and had lower blood levels of total, low density, and high density lipoproteins. These characteristics resemble those found in the urban population of mainland China, where hemorrhagic stroke is the major cause of cardiovascular mortality (Choi, et al., 1990).

Cancer. Prostate, colon, and breast cancer also seem to increase with residence in U.S. and Canada (Whittemore, 1989; Ziegler et al, 1993). Whittemore compared age-specific incidence rates from 1978-1982 for cancers of the colon and rectum for Chinese Americans, Chinese Canadians, Chinese in Shanghai, and North American whites. She found that Chinese American men had age-adjusted colon cancer rates comparable to those of U.S. and Canadian whites and three times those of men in Shanghai. Rates for Chinese American women were four fifths of the white rates and two times those of women in Shanghai. She suggested that this difference between men and women may reflect the fact that older Chinese men typically migrated decades before the women; thus men may be more Westernized in their life styles and have a longer duration of exposure to Westernized living. Clinically based data confirming this trend come from Chinese Hospital in San Francisco where the most frequently seen malignant neoplasm is colon cancer (Quock, 1992). An examination of dietary correlates of cancer in Whittemore's case-control study of 3,300 individuals in China and among Chinese in North America found that in China colon cancer was positively associated with saturated fat and larger body mass and inversely related with fiber intake; in North America, positive associations were also found with saturated fat, but the inverse association was with beta-carotene intake. Physical inactivity and time lived in North America also showed positive associations with colon cancer incidence (Henderson, 1990).

Malignant neoplasms make up nearly one third of the deaths in Chinese American elders 65-74 years old. Although the leading causes of cancer deaths for white and Chinese Americans are similar, Chinese have lower rates of breast, ovarian, and prostate cancer than whites and higher incidence of liver and esophageal cancers according to
data from 1973 to 1983 from the National Cancer Institute (Jones, 1995; E. S. H. Yu, 1988). In 1994, liver cancer, in fact, was reported to be at least ten times higher among Chinese American men than white men in the U.S. (H.-W. L. Hann, 1994). Nasopharyngeal cancer strikes Chinese men more often than those in other ethnic groups, and the relationship between nasopharyngeal cancer and Chinese salted fish has been well established (Henderson, 1990; Quock, 1992). Cancer of the pancreas is 20% higher among Chinese American women compared to white women (Office of Minority Health, 1988).

Unlike the three city study of Chinese, Japanese, and Filipino women where Chinese women were found to have the lowest incidence of breast cancer at 54 per 100,000 (Ziegler et al., 1993), in a study of breast cancer among five different ethnic populations in Hawai‘i, Chinese women were found to have an incidence of 64 per 100,000, midway between the high for Caucasian (106) and ethnic Hawai‘ian (104) and the low for Filipino women (29) (Goodman, 1991). In age-adjusted data for the San Francisco Bay area comparing white, black, Chinese, Japanese, and Filipino women over 40, Chinese women had the lowest incidence of breast cancer at 78 per 100,000 (Northern California Cancer Center [NCCC], 1993.) For those women who do have breast cancer, Chinese women have a slightly better chance for a five year survival than white women although they had the highest risk for the five ethnic groups in the most advanced stage at diagnosis (NCCC, 1996). Despite some variation in the reported data, attention to breast cancer screening for older Chinese American women is needed.

**Dementia.** The relative prevalence of multi-infarct dementia and Alzheimer’s disease was examined in a Chinese American nursing home and compared to American nursing home populations in general (Serby, Chou, & Franssen, 1987). There was a four to six times greater prevalence of multi-infarct dementia than Alzheimer’s dementia in the Chinese American sample whereas in the general nursing home population there was a relatively low prevalence of multi-infarct dementia. In a probability sample of over 5,000 noninstitutionalized older persons in Shanghai, a team of American and Chinese researchers found a prevalence rate of dementia of 4.6%, 65% of whom were diagnosed as having Alzheimer’s disease. Both cognitive impairment and Alzheimer’s was significantly related to being female and low educational background (E. S. H. Yu et al. 1989; Zhang et al. 1989). Higher proportions of multi-infarct disease than reported with U.S. Caucasian samples were also found in clinical studies in Beijing and Singapore (Chang, Miller, & Lin, 1993).

**Nutrition and Bone Density.** In a study of three groups of Asian American elders in Chicago senior apartments, K. K. Kim and colleagues found that over half the Chinese women (54%) were consuming less than 67% of the Recommended Daily Allowance for calcium. The percent with inadequate levels for Vitamin A was also high (15% of men and 31% of women), but otherwise their dietary intake seemed adequate (K. K. Kim, E. Yu, Liu, Kim, & Kohrs, 1993).
Hu and collaborators, in a dietary study of women in China with similar ethnic backgrounds, demonstrated a wide range in bone mineral density (BMD) depending upon dietary calcium intake (Hu, Zhao, Jia, Parpia, & Campbell, 1993). In this group, although the women with higher calcium intake had higher BMD, the rate of bone loss with age was not affected by dietary calcium, supporting the hypothesis that the differences in bone mass observed in older women were realized earlier in life.

Suicide, Mental Illness, and Alcoholism. Authors have drawn attention to the unusually high suicide rates among older Chinese women (Diego et al., 1994; Liu & E. Yu, 1985). Liu and E. Yu found that for the group 65-74, the suicide rate is three times higher for Chinese women than white women in the U.S.; in the age group 75-80 years, it is seven times higher. Liu and Yu suggest that this pattern of suicide deaths is the result of first generation Chinese women who were brought to the United States as "picture" brides to live in isolated ethnic ghettos, now growing older alone and unable to cope. They cite evidence in unpublished research papers that these elderly Asian women who commit suicide did so "out of despair for their poor health and inability to obtain satisfactory medical care" (p. 48).

The comparison of suicide cases among five Asian groups and whites aged 60 and over in Los Angeles between 1984 and 1989 found that Chinese women were second only to the Japanese men in the number and rates of suicide; most were first generation homemakers from affluent backgrounds who were not U.S. citizens. Diego and colleagues (1994) postulate that the Chinese American women who committed suicide may have held more traditional Asian values about harmony in the home and the role of women that made it difficult to adjust to the American lifestyle. Contrary to the authors' expectation, most (67%) of the Chinese women who committed suicide lived with their children. It was suggested that in this group, filial piety remained strong and family members covered up family tensions even when some suicide notes indicated that the elder did not wish to be a burden to the family (Diego et al., 1994). Contrary to the traditional Japanese view of suicide, the Chinese culture has been described as not tolerant of suicide as an acceptable end, and bringing shame to one's family (Chiles et al., 1989; Diego et al.), which makes the high rate seem even more significant.

A study of alcoholism in Chinese Americans in a New York City Chinatown agency found all but one of their alcoholic clients were men, 53% of whom were over age 50 (Chin, Lai, & Rouse, 1991). About three fourths were born in China and three fourths had been in the U.S. more than 10 years. Almost half had less than a high school education, and most could speak only their Chinese dialect, Cantonese in most cases. None were homeless or in shelters, and 75% worked in Chinese restaurants. The authors found that the restaurant environment was especially conducive to problem drinking, with its long hours, high pressure, and free drinks provided by the employer in many cases. Most of the alcoholic Chinese men were socially isolated and drank alone; many were alienated from wives and children (Chin, Lai, & Rouse, 1991).
Japanese. Health status information about older Japanese Americans has been considerably enhanced by the availability of a large longitudinal data set begun in the 1960s and carefully updated at least six times since. The Honolulu Heart Program and its associated studies in cancer and other diseases have been extremely valuable sources of ongoing epidemiologic research about Japanese Americans. They began with the recruitment in 1965 of 8,006 men of Japanese ancestry living on the island of Oahu in Hawaii born between 1900 and 1919 for the Honolulu Heart Program; this represented 72% of the 11,136 such men who had been identified and located through the World War II Selective Service Registration records. At the time of their initial evaluation between 1965 and 1968, they ranged in age from 45 to 68 (Yano, Reed, & Kagan, 1985). Since that time studies have been added in cancer, osteoporosis, dementia, and caregiving; wives and other relatives of the original subjects have been included; and over 200 articles have been published based on the findings.

Health Status. Although the major emphasis has been on heart and cardiovascular disease, the findings of the Honolulu studies have also included general health status. This population of men has longer life expectancy than men in Japan, who have the longest of any major country. Major activity limitation and living alone are relatively low, and less than 1% rate their health status as poor. In comparisons with those who have chronic diseases of all types, the best predictors of staying healthy with aging are lower blood pressure, less smoking and less alcohol consumption; number of years spent in Japan was positively related to remaining healthy and was the only socio-cultural factor that showed a significant association. Although lower than among U.S. white men, hypertension is the most common health problem, followed by arthritis, diabetes, and gout. (Benfante, Reed, & Brody, 1985; Curb, Reed, Miller, & Yano, 1990).

Heart and Cardiovascular Disease. The prevalence of coronary heart disease (CHD) is twice as great among white males in the Framingham study as it is in Honolulu Japanese American men. The difference could not be explained by differences in baseline levels of serum cholesterol, blood pressure or cigarette smoking (Yano, Reed & Kagan, 1985). Compared with men in Japan, the Japanese Americans had higher risks of CHD and lower risks of stroke. During the first 20 years of the study, incidence of stroke in the Hawaiian Japanese men has declined to half of its original rate of 5.1 per 1,000 person-years to 2.4; the decline may have been attributable to a decrease in blood pressure and smoking. Subjects with diabetes and elevated glucose levels were at higher risk for thromboembolic but not hemorrhagic stroke. Those older men who were physically inactive or partially active experienced a three to four-fold excess incidence of hemorrhagic stroke, compared to those who were active after controlling for other risk factors; for thromboembolic stroke, active older men who did not smoke were at less than half the risk of those who were inactive or partially active, but the differences were not found among men who smoked (Abbott, Rodriguez, Burchfiel, & Curb, 1994; Burchfiel et al., 1994; Curb et al., 1990; Kagan, Popper, Reed, MacLean, & Grove, 1994).
A cross-cultural comparison of coagulation factors to explore possible explanations for the lower coronary heart disease and higher hemorrhagic stroke mortality among Japanese than Caucasian men found that the middle aged Japanese American sample, like their Japanese counterparts, had lower fibrinogen levels than the Caucasian sample, controlling for smoking and other risk factors (Iso et al., 1989).

In the 1979 California Hypertension Survey, the prevalence of hypertension for Japanese women 50 years and older was less than half of the corresponding rate for women of any other ethnic group in that age category (Stavig, Igra, & Leonard, 1988).

**Diabetes.** The study of diabetes among Japanese Americans has been of particular interest to epidemiologists, who have consistently found a higher prevalence of diabetes and impaired glucose tolerance among Japanese Americans than among both the white population in the U. S. and the native population in Japan (Fujimoto, Leonetti, Kinyoun, Newell-Morris et al., 1987). Based on a sample of 229 second generation (Nisei) men in King County, Washington, aged 45 to 74, who were representative of the total Nisei male population in those age cohorts, Fujimoto and colleagues (1987) estimated that 56% of Nisei men in the population have abnormal glucose tolerance and 20% have Type II (non-insulin dependent diabetes mellitus, or NIDDM) diabetes, approximately half of which is undiagnosed. This compares to prevalence rates for white U. S. males from the age cohorts of 45 through 74 from the National Health and Nutrition Examination Survey of 3.5% to 8.5% for diagnosed NIDDM and 3.2% to 9% for undiagnosed NIDDM. The authors cite data from Japan reporting rates of 4.5% for men 40 and over. Fujimoto and colleagues also reported the following complications to be higher among the NIDDM than nondiabetic Nisei men: hypertension, coronary heart disease; retinopathy; neuropathy; and peripheral vascular disease. Of particular interest is the lack of evidence of higher kidney-related complications among diabetics (Fujimoto, Leonetti, Kinyoun, Shuman et al., 1987).

In an effort to explore the causes of this increased risk of diabetes, the diet of the Nisei Japanese men in the Washington state sample was examined. Although there was no difference in overall calorie intake between those with diabetes and those with normal or impaired glucose tolerance, those with diabetes consumed more fat and animal protein (Tsunehara, Leonetti, & Fujimoto, 1990). Those in the sample who developed NIDDM in the 30 months after their initial assessment were compared to the men who did not. Those with diabetes were found to be not only older and with higher serum glucose levels, but they also had higher fasting plasma C-peptide levels and greater intra-abdominal fat. The elevated C-peptide levels represented hypersecretion of insulin thought to reflect a compensatory response to an underlying insulin-resistant state that existed before the development of NIDDM (Bergstrom et al., 1990).

Lipson and Kato-Palmer (1988) similarly report that middle-aged and older groups in Japan have a 3% to 4% rate of adult onset diabetes. In the Los Angeles area, Japanese Americans in the same age groups have a 20% to 22% rate.
Cancer. Data from Hawai’i from 1947 to 1964 revealed that Japanese Americans in Hawai’i had higher rates of stomach cancer than Caucasians or native Hawai’ians (Quisenberry, Bruyere, & Rogers, 1970). In 1988, it was also reported that Japanese living in the United States have a higher incidence of stomach cancer, and Japanese men have a higher incidence of esophageal cancer than nonminorities (Office of Minority Health, 1988). San Francisco Bay Area data show an age-adjusted incidence of stomach cancer for Japanese Americans (19 per 100,000), over twice that of whites, blacks, Chinese, or Filipino populations (NCCC, 1993). The National Cancer Institute reports that Japanese Americans have lower rates of breast, ovarian, and prostate cancer than whites, but slightly higher rates of liver cancer (Jones, 1995). San Francisco Bay Area data confirm this trend, and survival rates for Japanese American women over 40 with breast cancer are the best of the five populations studied (NCCC, 1993).

The longitudinal data from over 6,000 older Japanese American men in Hawai’i allowed predictors of cancer to be studied over the decades of the study. One analysis showed that intestinal metaplasia, which is commonly associated with stomach cancer, was directly related to eating nitrite-rich salty foods (e.g. cured meats) (Stemmermann, Nomura, Chyou, & Hankin, 1990). Another analysis found that men who had impaired lung function were more likely to have developed lung cancer 22 years later, after adjusting for age and smoking (Nomura, Stemmermann, Chyou, Marcus, & Buist, 1991). Lung and colon cancer both were found to be more common in men who had undergone subtotal gastrectomy for peptic ulcers, after adjusting for smoking and alcohol use (Stemmermann, Nomura, & Chyou, 1991).

Bone Density and Fractures. A study comparing hip fracture incidence among native Japanese, Japanese Americans and non-Hispanic white (NHW) Americans reported the lowest rates among Japanese Americans and the highest rates among the NHWs (Ross et al., 1991). This is especially interesting since Japanese elders (as well as Chinese) were implicated in radiographic studies in the 1960’s as being at higher risk for osteoporosis than Caucasian elders (Garn, Pao, & Rihl, 1964; Nordin, 1966). Yano et al. (1984) examined the bone density of over 2,400 older Japanese residents in Hawai’i by single photon absorptiometry and found that they had lower bone mineral content of the radius than comparable U.S. Caucasians. A comparison of bone mineral density (BMD) among U.S. born women of Japanese ancestry and Japanese born women living in San Diego with similar data from women in Japan found higher BMD in U.S. born Japanese American women, but there were no differences after adjusting for age, height, and weight (Kim et al., 1993). Weight, exercise, early menarche, and years of estrogen exposure were positively associated with BMD, while age, smoking, and, contrary to previous findings, percentage of body fat, were negatively associated.

In an effort to shed light on the reason for lower fracture rates among women with equal or lower bone density, Lipsitz and colleagues (1994) compared the muscle strength and fall rates among residents of a nursing home in Japan and a U. S. nursing home.
Average quadricep strength was greater in the Japanese residents, as predicted, and they had about one fourth as many falls during a six month period. Interestingly, however, fall rates for U.S. residents declined with increasing muscle strength, while in Japan this was not the case. (Lipsitz et al., 1994)

Dementia. One preliminary report suggested that, like the Chinese Americans, the prevalence of multi-infarct dementia among the Japanese and the Japanese American populations may be higher than that found among the general U.S. population (Hasegawa, 1989). A difference in the ratio of multi-infarct to Alzheimer's dementia was found for elders in Japan in two studies in which 48% and 70% of dementia patients were diagnosed as having multi-infarct dementia, as compared to 4.4% to 9% in four studies of Caucasians in the U.S. (Chang, Miller, & Lin, 1993).

Suicide. Japanese women 75 years and older and Issei men 85 years and older have also been found to have a much higher suicide rate relative to white Americans (Liu & Yu, 1985). The Los Angeles study found older Japanese men to have higher rates of suicide than any ethnic subgroup of the older Asian women and any other older Asian men (Diego et al., 1994). Contrary to the authors' expectation, the majority were not living alone, and two thirds were U.S. citizens.

Alcohol Consumption. The relationship between the fast-flushing response and alcohol use was explored in a telephone survey of English-speaking Japanese Americans in the greater Los Angeles area, 25% of whom were over 50 (Nakawatase et al., 1993). In the two thirds of the adults who were not total abstainers, nonflushers were 3.6 times more likely to have six drinks or more in a 24-hour period than flushers, holding other factors constant. Being male, single, and 3rd or 4th rather than 2nd generation were also positively related to alcohol use.

A study of attitudes toward drinking among Japanese in the U.S. and Japan found that most felt that it was alright for 60 year old Japanese American men and women to drink a small amount; the Japanese sample was much more tolerant of excessive drinking for an older man but less tolerant for women than Japanese Americans (Kitano, Chi, Rhee, & Law, 1992).

Filipino. Heart Disease and Diabetes. Gerber (1980) found that Filipino men aged 55-64 years who arrived in Hawai‘i before 1931 had a death rate from coronary heart disease that was 61% higher than that of men in the Philippines. In the 1979 California Hypertension Survey, Filipino men 50 and older had a hypertension prevalence rate of 60% and Filipino women 50 and older a rate of 65%, compared to the overall U.S. prevalence rate of 47% for the same age (Stavig et al., 1988). In a 1963 study, Sloan found that among Filipinos in Hawai‘i there was an age-adjusted prevalence of diabetes that was three times that of whites in Hawai‘i.
Cancer. Although the Hawai’i data indicated that Filipino women had the lowest risk for breast cancer at 29 per 100,000, the San Francisco Bay Area cancer registry analysis indicated that Filipino American women over 40 had an age-adjusted risk of 119, substantially higher than comparable black, Chinese, and Japanese women, but lower than whites (Goodman, 1991; NCCC, 1993). They also had the lowest survival rate of the five populations other than black women (NCCC, 1996). Overall age-adjusted cancer incidence at all sites was higher among San Francisco Bay Area Filipino American women than any of the five populations except white women (NCCC, 1993).

Men of Filipino ancestry had the lowest overall age-adjusted incidence of cancer in all sites of the five populations compared in the San Francisco Bay Area, although their rates for prostate cancer were higher than the other two Asian groups (Chinese and Japanese) (NCCC, 1993). Liver cancer among Filipino men and women was second only to the Chinese Americans and three times higher than among whites (NCCC, 1993).

Gout. High rates of hyperuricemia and gout are found, particularly among Filipino males. When Filipinos change from their traditional diet which is low in protein and purines to the typical American diet, there is an increase in hyperuricemia. This prompted Healey and Bayoni-Sioson in 1971 (cited in Torralba & Bayoni-Sioson, 1975) to postulate that some Filipinos may develop gout because of decreased renal ability to clear excess uric acid. However, Torralba and Bayoni-Sioson found in their 1975 survey of gout patients in the Philippines that more than 75% were from low- to middle-income groups who presumably had a fairly modest protein intake.

Dementia. Among the patients of the nine California Alzheimer’s Disease and Diagnostic Centers, Filipinos comprised 0.7% of the total cases screened over an eight year period until 1992 (Yeo & Lieberman, 1993, unpublished data). The data suggest a need for more vigorous case finding in this population. Specific information on the incidence of dementia from various causes among Filipino elders is not available. However, the high prevalence of coronary heart disease and hypertension among those 50 and older (Gerber, 1980; Stavig et al., 1988) could set the stage for cognitive impairment as they age.

Depression and Suicide. A study of clinical depression among Filipinos who live in the San Francisco Bay Area identified geographic separation or alienation from family and financial difficulties to be their most common stressors (Tompar-Tiu & Sustento-Seneriches, 1995). Although most of the participants were less than 65 years of age, similar stressors have been reported for Filipino elders by service providers or family members. In the same study, suicide attempts were made mostly by severely depressed women who later felt remorseful. The relationships between gender, suicide attempts, and successful suicide may be significant issues to investigate in Filipino elders based on the findings of Diego and associates (1994) that older Filipino men committed suicide more than women, a pattern that appears to mimic that of the general population of older
Compared to other Asian groups, the incidence of suicide is low among older Filipino Americans, probably due to the influence of Catholicism.

**Tuberculosis.** In Hawai‘i, the state with the second highest case rate of tuberculosis in the country, 85% of the reported 251 cases in 1993 were among individuals who were foreign born. Immigrants from the Philippines accounted for 62% of the cases, which might be explained by the fact that the Philippines has the highest incidence of tuberculosis of any country reporting to the World Health Organization ("New world order," 1994). The Filipino WWII veterans who were naturalized under the 1990 legislation have been found to be at high risk, and it is thought to be related to the fact that they were not screened for health conditions as other immigrants are because they were granted immediate entry and citizenship. During one year’s screening of the veterans in 1992 and early 1993, 106 cases of tuberculosis were found out of the 1659 screened (Yamada, 1994).

**Korean.** Little published information is available on the health status of the rapidly growing population of older Korean American elders, but some studies are underway which should yield improved data in the future. In a San Jose, California, study of 50 senior center participants and senior apartment dwellers aged 65 to 82, all of whom were born in Korea, 36% reported a history of diabetes, which is approximately four times the rate of older Americans as a whole (J. Lee, Yeo, & Gallagher-Thompson, 1993). It is noteworthy that this population had very low rates of obesity, with only 8% with Body Mass Index scores indicating they were obese; only 30% of those who reported diabetes said that they were overweight at the time they were diagnosed. A comparable 36% reported having high blood pressure, but much lower rates of other cardiovascular-related disease risk factors were found. For example, 8% reported having elevated cholesterol (32% said they did not know their cholesterol levels), 8% were currently smokers, and an astounding 72% were currently exercising on a regular basis. Even though they expressed little interest in, or knowledge of, cardiovascular risk factors, 82% reported they had made changes to improve their health in the last five years. Approximately half reported each of the following: eating less salt, less red meat or eggs, or eating more fiber, fruits, and vegetables (J. Lee et al., 1993).

In a study of close to 7,000 Korean Americans in communities in the Northeast U.S., 5.2% of the females and 7.4% of the males over age 40 were found to be carriers of Hepatitis B Virus. Of the carriers in the study, 42% were found to have chronic hepatitis and 11% had cirrhosis of the liver (H.-W. L. H. Hann, 1994).

A study of nutritional status of residents of senior housing in Chicago found that the nutritional quality of the Korean American elders’ diets was poorer than the other two groups, the Chinese and Japanese Americans. This was due to the large percentage of Korean elders with low intake of calories, calcium, vitamins A and C and riboflavin; 25% of the 60 older Korean women in the study also consumed less than 67% of the Recommended Dietary Allowance for protein (K. K. Kim et al., 1993).
Another study of a potential risk factor for illness explored the drinking behavior of 280 adult Korean Americans in Los Angeles, 12.5% of whom were over age 60 (Lubben, Chi, & Kitano, 1989). The older Koreans were more likely to describe themselves as abstainers than those aged 45 and under; only 20% of those 61+ reported drinking alcohol at all. Heavy drinkers in the study were more apt to be male, and to go to bars or nightclubs.

Fifty Korean immigrants in the San Francisco Bay Area age 60 and over were interviewed in 1981 to identify typical adjustment problems. Ratings of stress and adaptation in five areas of functioning (social, cultural, economic, health, and emotional/cognitive) found that those in greatest risk of difficulty were those with little education, had arrived in the U.S. recently, and lived alone (Kiefer et al., 1985).

**Asian Indian.** A study of insulin resistance compared 22 nondiabetic men and women born on the Indian subcontinent with an average age of 49 who had lived in the San Francisco Bay Area for an average of 10 years with matched controls from European ancestry. The Asian Indian subjects were found to be more resistant to insulin-stimulated glucose uptake and to insulin suppression of free fatty acid levels which are associated with demonstrated risk factors for coronary heart disease (Laws et al., 1994). Although research conducted in the U.S. is not available, studies of Asian Indian populations in the United Kingdom, Singapore, Africa, and Fiji have reported one to four times higher rates of coronary artery disease mortality than the indigenous population in those countries in spite of lower incidence of classic risk factors such as cigarette smoking and a high cholesterol diet (Enas, Yusuf, & Mehta, 1992). Similar findings indicate higher plasma concentrations of glucose, insulin and triglycerides, and low fasting high density lipoprotein (HDL) cholesterol (Laws et al.).

**Southeast Asians.** For Southeast Asians, depression has been reported as a major problem. Muecke (1983b, p. 838) expects that the prevalence of depression will increase for at least two reasons:

...[T]he actual occurrence of depression is probably increasing due to the latency effect of post traumatic stress disorder among refugees, and to an increase in reporting due to greater refugee familiarity with and use of the American health care system.

Unfortunately, despite the increase in prevalence of depression, because of the cultural stigma regarding showing a "weakness of the mind," Nguyen (1985) believes that an extremely small percentage of the Vietnamese will use mental health services. He notes that Vietnamese call psychiatrists either "nerve doctors" or "doctors for the insane" (Nguyen).
In a study of catastrophic stress among Southeast Asian refugees in British Columbia, Beiser, Turner, and Ganesan, (1989) noted that while there were no age-related differences in depression early in the resettlement period of the Chinese, Vietnamese and Laotian refugees, elderly refugees were at risk of developing mental health problems after living in Canada for a few years. The authors reported that this was consistent with prior findings that older migrants develop an increasing sense of isolation as younger members of their families become socialized more rapidly to the majority culture. An unexpected result of their research was that privately sponsored refugees whose religion was different from that of their church group sponsors were at increased risk for depression (Beiser et al.).

Suicide among depressed Vietnamese elders remains unexplored. In Los Angeles County, the incidence recorded between 1984-89 for Vietnamese elders, age 60 and older was exceptionally low compared to other Asian groups (Diego et al., 1994). This may be related to the degree of cultural tolerance of the community. However, there are indications from clinical case reports for this group, that post traumatic stress disorder associated with detention and forced relocation may manifest itself late in life (Chester & Holtan, 1992). Information on depression, suicide, and other mental health issues for this cohort of Vietnamese elders is still evolving.

Older Cambodian refugees in San Jose, California, reported that chronic headache, frequently accompanied by dizziness, was their most serious chronic condition; 51% reported having the condition, and 41% reported it was their worst symptom. The 76 elders who were interviewed also had other symptoms such as respiratory and cardiac complaints, joint and muscular aches, and gastrointestinal symptoms, but headache was considered by far the most bothersome condition (Handelman & Yeo, 1996).

Pacific Islanders. There is little in the published literature about the health status of Pacific Islander elders. This may reflect the comparatively small numbers of elders from the various islands residing on the mainland or in Hawai‘i and their relatively shorter life expectancy. In Hawai‘i from 1930 until the present, for example, life expectancy for native Hawai‘ians has been shorter than all other ethnic groups both at birth and at age 65 (Nordyke, Lee, & Gardner, 1984). Samoan life expectancy at birth has been estimated to be 67 years with only 2.5% of the population over 65 (Mason, cited in Schwitters, 1981, p. 133).

Pacific Islanders are more at risk for diseases that are associated with obesity including cardiovascular disease, hypertension, and adult onset diabetes. In his 1963 survey in Hawai‘i, Sloan found an age-adjusted diabetes prevalence rate of 49% for Hawai‘ians compared to 7% for Caucasians. Fitzpatrick-Nietschmann (1983) notes that increased body weight may no longer be considered attractive after immigration to America; he cites a study in eight O‘ahu communities in which obesity was identified as a sign of unhealthiness by 93% of the immigrant Samoan sample.
In Guam, the Chamorros have an unusually high prevalence rate of two neurologic diseases: amyotrophic lateral sclerosis and Parkinsonian dementia. There is no known reason for these high rates (Reed & Brody, 1975).

Although not related to residence in the U.S., evidence of the effect of migration from Pacific Islands to a "Westernized" country comes from longitudinal studies of adults who migrate from Tokelau (three small isolated Pacific atolls north of Samoa) which has a traditional subsistence economy, to urban New Zealand. Migrants have been found to have increased body mass and increased risk of Type II diabetes among both males and females compared to nonmigrants. In male migrants only, there was an increase in both systolic and diastolic blood pressure, which could not be explained by the increase in weight. Migrants who interacted more with New Zealanders showed significantly higher blood pressure than those who interacted more with Tokelauans (Ostbye, Welby, Prior, Salmond, & Stokes, 1989; Salmond, Prior, & Wessen, 1989).

**SUMMARY**

Unfortunately the health risk profiles for the heterogeneous populations of older Americans from Asian and Pacific Island ancestries that emerge from the available data is full of empty holes where there is a void of information. Table 4 summarizes the differences between health risks for APIA elders and other older Americans based on the current state of knowledge. It should be emphasized that much of the data is the result of small studies which have yet to be replicated or confirmed by well-designed epidemiological studies. Conditions were not included in the Table if there was no evidence that it affected older populations. It is clear from Table 4 that only in the Chinese and Japanese populations do we have much evidence for potential differences in health risks, and even for those groups the range of conditions explored is relatively limited. Although there are no reported studies from the U.S. giving us evidence of the health status of older Americans from Asian Indian backgrounds, the column is included to emphasize the critical need for research.
Table 4
DIFFERENCES IN HEALTH RISKS FOR APIA ELDERS
COMPAARED TO ALL U.S. ELDERS
(= increased risk; - = decreased risk

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NOTES: Chin = Chinese American; Jpn = Japanese American; Fil = Filipino American; Kor = Korean American; As Ind = Asian Indian American; fe. = only established for females, ma. = only established for males; Cham. = Chamorro; HBV = hepatitis B; VN = Vietnamese American; Camb = Cambodian American; Haw = Hawaiian
PART III

HEALTH CARE

USE OF HEALTH CARE

Hospital, Ambulatory, and Community Services. Information on outpatient visits made by Asian and Pacific Island Americans was available for the first time in data collected in the National Ambulatory Medical Care Survey conducted by the National Center for Health Statistics in 1979. Liu and E. Yu (1985) reported that, based on that source, APIA elders 65 years and older visit office-based physicians half as often as white Americans of the same age group. However, APIAs have the highest rate of use of emergency room services compared to any other ethnic group. Liu and E. Yu comment that this finding suggests that they may not have regular providers of care. This may delay seeking medical care which results in increased severity of illness and longer hospital stays; almost three times longer stays have been reported for APIAs than white Americans.

Data from the 1979 California Hypertension Survey confirm the fact that Asian Americans may not have a primary physician. When Chinese, Japanese and Filipino men and women 50 years and older were asked whether they had seen a physician within the prior year, only 63.1% of Chinese women and 58% of Filipino men, as compared to 81.5% of the overall population 50 years and older, had seen a doctor (Stavig et al., 1988). A Minnesota study also found that the 201 Asian elders who responded to a mailed survey (76% of whom had Hmong surnames) had visited a physician significantly less frequently in the past year than the 355 whites, even among those who were at high risk for repeated hospital admissions (Bout & Boul, 1995).

Two other studies confirm the trend with Chinese-only populations.

1). The 106 respondents aged 65 and over attending health care screenings at three Chinese senior centers in Santa Clara County, California, reported: an average of 2.7 MD visits the past year, with 26% reporting no visits; 15% had used an emergency room. It is significant that although they had been in the U.S. an average of 6 years (ranging from less than a year to 20 years) 58% said they had no regular physician, and 31% had no health insurance of any kind (I. Lin, 1995).

2). In Boston, 94 Chinese Americans aged 60, who had been in the U.S. longer than the California sample but were likewise not fluent in English, reported an average of 3.8 MD visits in the past year, and no insurance coverage by 5%. In these interviews, the respondents were also asked about their use of traditional Chinese medicine: 13% had visited a traditional practitioner at least once in the past year, and arthritis was the condition they said would most likely prompt their visit to a Chinese medicine practitioner. (Yee & Chung, 1990).
In 1976, Chan and Chang surveyed 87 respondents with median age range of 45-
50 years in New York City’s Chinatown. They found that only 18% had seen a traditional
practitioner in the prior two years and that more than 80% saw exclusively Western
physicians. Traditional methods were preferred for treating stomach-ache, diarrhea,
itching, anemia, rheumatism and fractures; fractures were treated by traditional healers
with herb paste and wooden splints. Ninety-three percent had used Chinese drugs for
self-treatment. The respondents were more familiar with traditional medicines, but thought
that Western drugs were cheaper and had a faster effect, and preferred them for acute,
episodic problems such as fever, headache, cough, constipation, and hemorrhoids.

In addition to herbs and herb combinations, there are many Chinese patent
medicines that are sold over the counter. These patent medicines are poorly regulated.
In California, the Department of Health Services has collaborated with the Oriental Herbal
Association to identify medicines that contain toxic ingredients or medicines whose
"unproven treatment claims for serious medical conditions divert consumers away from
proper medical attention." Examples are "bezoar antiphlogistic pills" which contain arsenic
disulfide and "cinnabar sedative pills" which contain mercury (California Department of
Health Services, 1988, p. 1).

An example of a successful strategy for increasing utilization of a low cost breast
cancer screening program targeted to older Chinese women was reported by Lovejoy
and her colleagues (Lovejoy, Jenkins, Wu, Shankland, & Wilson, 1989). After planning
carefully with Chinatown-based agencies and businesses for a culturally-appropriate
screening, the bicultural team implemented a one-day program which attracted 108
women; 59% were over 50, 47% had no doctor, 87% were foreign born, and 65% spoke
little or no English.

A study of two sets of residents in congregate housing in Chicago found that
Korean elders had more medical visits for preventive purposes, more contacts with
traditional health providers (called Han Yi), more emergency room visits, and more
hospital stays than their Chinese counterparts, but the reasons for these differences were
not clear. (E.S. Yu, Kim, Liu, & Wong, 1993).

A series of small studies of Filipino American elders provides some insight into their
patterns of use of health care services. A study of 11 frail Filipino elders who are clients
of an Adult Day Health Center (ADHC) in San Francisco reported nonuse of
information/referral, multidimensional geriatric evaluation, placement, and mental health
services, and psychotropic drugs for the past six months. Among these elders 41% had
partial paralysis due to stroke, 64% took hypertensive and anticoagulant drugs; and
cardiovascular problems were the dominant diagnosis for the group, yet it appears the
elders did not receive comprehensive geriatric assessment. Although assistance was
needed by 52% for ADL and 35% for IADL, most elders relied on family members. They
were more cautious and constrained than their white counterparts in seeking medical care
and had longer hospitalizations. However, the Filipino elders were comprehensive users
of services at the ADHC to meet their needs except for the mental health and relocation/placement services (Bautista, 1993).

In a group of clinically depressed Filipino adults, with an average age of 47 years, 60% identified a loved one or close friend as the best person to treat their condition, while 15% picked the family physician. The psychiatrist or psychologist (12%), priest or faith healer (8%), counselor or social worker (5%), and others including prayer group (10%) were acceptable resources. Talking to a loved one or someone who cares was identified as the best treatment for depression by 50%, counseling, psychotherapy and group therapy by 21%, medications by 16%, social and religious activities by 10%, faith healing, employment, marijuana and other by 3% (Tompar-Tiu & Sustento-Seneriches, 1995). For depressed Filipino elders, educating the family on the illness and appropriate therapy is suggested to insure the desired long term effects of the intervention.

Keeping a stock of prescription drugs before immigrating seems to be a common practice for many Filipinos, including the elderly. Many continue to take medications without medical supervision in the U.S. (San Francisco Health Department Executive Report, 1993). Often, supplies are replenished by asking relatives in the Philippines to buy more medications. Sharing drugs with friends and family members who have similar symptoms occur for various reasons such as cost of health care and drugs, avoiding waste, or other personal reasons. This behavior comes partly from easy availability of many potent prescription drugs (e.g., antibiotics) from professionally managed pharmacies in the Philippines.

In Hawai‘i, Braun, Humphrey, and Kaku (1987) studied utilization of three community long term care programs by Japanese and Filipino elders: Japanese-Americans preferred day hospital and comprehensive home care, while Filipino-Americans preferred foster care.

Cox (1986), in her comparison of the variables affecting physician utilization by Vietnamese, Portuguese, and Hispanic elders, reported that the most important predictor of utilization for Vietnamese elders was satisfaction with their medical care; 79% of the Vietnamese sample went to physicians who spoke their own language.

Brainard and Zaharlick (1989) could not account for the differences in utilization of health care among Hmong, Laotian, Cambodian, and Vietnamese refugees by differences in cultural beliefs or health status. They hypothesized that the high use by Laotians was related to the traditional patron-client relationships important in Laotian society; this background allowed Laotian refugees to depend on specific patrons employed in social service agencies to direct them to needed services.
Nursing Homes. As noted in Part I in the demographic section, APIA elders have comparatively low rates of utilization of nursing homes, ranging from .2% for Hmong to 2.6% for Japanese, compared to 5% for U.S. elders as a whole (Young & Gu, 1995). Since a significant number of these elders are immigrants, the low rates may reflect selective health and social support factors that allowed them to migrate and that also reduced the risk of institutionalization. It is also important to remember that most immigrated from countries of origin at a time when the kinship structure was their only well developed long term care resource. It is interesting to note that the Japanese American population, while still half as likely to use nursing homes as older Americans in general, have the highest rates among the APIA populations and also have Japanese-oriented nursing homes built and supported strongly by the Japanese American communities in several West Coast cities (Yeo, 1993).

A study of 1,142 independent Japanese American elders in Seattle explored their preferences for nursing home care under varying scenarios. If temporarily disabled by a hip fracture, 12% intended to use a nursing home, and if permanently demented, 53% intended to use a nursing home. These intentions were positively associated with female gender, lack of social support, and high levels of acculturation into American society. When those who would use a nursing home were asked if their intention would be different if Keiro, the Japanese nursing home in Seattle, did not exist, only 34% would use another nursing home with hip fracture and 39% with dementia (McCormick et al., 1995).

ACCESS AND BARRIERS TO CARE

In considering barriers to care for the older Asian and Pacific Islander Americans, True (1985) identifies four problem areas: language barriers, lack of funds, location of services, and psychological barriers. She notes that the high percentage of the APIA population consisting of recent immigrants will mean continued problems in communication. The psychological barriers to care mentioned by True can include fears of jeopardizing immigration status by using public assistance and also distrust and fear of the government by older Asians who experienced the effects of discriminatory laws and relocation. Kamikawa (1987) also emphasizes the importance of both the nativity factor and the alienation from the larger society, due to the history of discrimination, in explaining the difficulty and reluctance of Asian elders to seek health care in the formalized, bureaucratic Western setting. The lack of bilingual, bicultural staff in health care agencies, as well as the informal traditions of the natural support systems in the primarily rural areas from which elders have immigrated, provide very discouraging barriers for the large population of foreign born elders.

Guttmann’s Washington, D.C. study (1980) found that Asian American elders, used significantly fewer public benefits than Hispanics and blacks. Asian American elders perceived "logistical difficulties," (e.g., lack of transportation, lack of understanding of procedures, and lack of English proficiency) as greater barriers than the other groups.
Traditional Chinese perceptions of dementia are identified as barriers to care for Chinese American elders with dementia and their families by providers and scholars from San Francisco (Elliot, Di Minno, Lam, & Tu, 1996, in press). Rather than seeing it as an illness in the Western sense, perceiving dementia as aging, insanity, a retribution for sins of one’s ancestors or family misdeeds, being possessed by an evil spirit, fate, an imbalance between yin and yang, or the consequence of improper alignment of one’s house or ancestor's graves will decrease the probability that the family will seek the help of Western health care providers or agencies.

Liu and E. Yu (1985) cite a report, based on Asian American Field Study data, that about one half of the sampled respondents of all ages in the Los Angeles area did not have health insurance coverage and only 6% of the Chinese and 6% of the Koreans in that study used MediCal (Medicaid). In 1975, Wong found that in the Oakland, California, Chinese community, only 19% of Asian elders had Medicare coverage (cited in Liu & E. Yu). In a 1968 study of 131 Issei living in Los Angeles' "Little Tokyo," less than half of the 78% of the Issei who had Medicare indicated that they would use the benefits available to them (Hashizume & Takano, 1983). Medicare was new at that time, however, and now that providers automatically apply for available Medicare reimbursements in most cases, use of benefits may be out of the Issei's control.

The needs assessment of Filipino elders conducted by the City of Los Angeles, Department of Aging (1990) found unfamiliarity with services to be a major reason for low service utilization. Lack of knowledge of the benefits and inaccessibility of services contributed to the problem. The weekly social event (dance) at the nutrition site was the primary reason for the Filipino seniors' participation in the nutrition program. Filipinos may delay seeking medical care for an illness until it is quite advanced. Anderson (1983) explains that this occurs because the patients may be trying to adequately characterize the illness in order to ascertain from whom they should seek care.

In addition to the financial and policy barriers, D. L. Yee (1992) emphasizes the barrier contributed by providers that "purport to be colorblind". While providing services that are the same for all elders, regardless of cultural background, they do not understand or value the ethnic, language, and religious differences which impact patient care. Reactions to older immigrant patients that reveal "colorblind" assumptions of the providers can lead the elders to believe that mainstream health care is neither available or acceptable to them (D. L. Yee).

As noted in Part I in the Demographics and Historical Background section, an at-risk subgroup of elders are the Filipino WWII veterans who began to resettle in the U.S. after 1990 when Congress passed Section 405 of the Immigration Act (Chin, 1993b). Because the legislation did not guarantee benefits, the elders are forced to seek social services and health care through the Supplemental Security Income Program and the Medicaid Program. They perceive these supports as "being on welfare" and are sensitive
to being called welfare recipients. Housing and transportation needs and separation from family complicate the adjustment process, especially for those in their 70's and 80's, making them vulnerable to health crises (McBride, March, 1993) and financial exploitation and abuse as reported by Chin (1993a) in the San Francisco Bay Area.

Those who asserted their belief that they should be cared for as WWII veterans learned with great difficulty the limitations of a well intentioned policy. Despite their disappointment, many newly arrived veterans have organized to focus on additional legislation that acknowledges more fully their contribution as U.S. military personnel during WWII and to improve their newly acquired living conditions (Dizon-Gotico, 1995). In the San Francisco Bay Area and other West and East coast regions, support from the Filipino community organizations and individuals and the Filipino media provided: temporary housing for veterans who came from the same Philippine township; donation of money, food, and clothing; scheduling social activities; education on advocacy; funeral arrangements; special multimedia features, and pro bono health, social, psychological, and legal services (McBride, March, 1993).

Modesty has been identified as a barrier to care for older Chinese American women (Mo, 1992), and it likely applies to other ethnic groups as well. Because of the long traditions of strict norms relating to women's role associated with the concept of yin (see Part IV), Chinese women may be reluctant to present themselves for health screening procedures such as mammograms, breast examinations, or Papanicolaou tests, especially if it involves being examined by a male physician.

In attempting to explain the differential risk of institutionalization by ethnic status, Senate hearings were held in 1975 in which testimony of health care providers and family members identified language, social, and cultural issues that isolated APIA when they were in nursing homes as the most important explanations (Moss & Halamandaris, 1977). Chee and Kane (1983) compared small samples of residents and family members from predominantly Japanese and black nursing homes in Los Angeles and found that Japanese respondents were much more likely to rate cultural factors such as ethnic foods, ethnic staff, ethnic activities, and ethnic community involvement as very important. Follow-up interviews confirmed the importance to Japanese residents and their families of the nursing home staff's understanding and adapting to elders' values (such as duty and respect) and of staff's understanding the effect of the elders' unique historical experiences (such as internment).

In a similar New York study comparing black, Chinese, and Puerto Rican nursing home residents, however, Morrison (1983) reports that Chinese residents felt ethnic food and ethnic staff were relatively important but they were the least likely to endorse the importance of celebration of cultural holidays, having traditional church services, music and art, or having staff taught about their culture or having ethnic representation on the nursing home governing board.
Case studies of two Japanese-oriented nursing homes, two Chinese-oriented nursing home, and one "Asian community" nursing home developed by a coalition of Japanese American and Chinese American agencies, examined the degree to which the successful ethnically-oriented facilities incorporated characteristics to increase cultural continuity for the target populations of elders. Most of the facilities preferred to use as many staff from the target population as possible, but there was a substantial variation in the degree to which they were available. All had ethnically-oriented meals available at most meal times and activity programs reflecting cultural preferences, and substantial participation of family members with care and programs. Except in one case, there was little visual imagery in the architecture or decor reflecting the target culture. Most of the nursing homes were not located in densely populated ethnic neighborhoods (Yeo, 1993).

Ishikawa found in his 1978 survey of Samoan elders in San Diego that barriers to health care included the lack of understanding of medical services, the fear and embarrassment of illness which "may mean the admission of personal failure," and use of folk medicine.

ROLE OF FAMILY AND SOCIAL SUPPORT IN HEALTH CARE

Although a strong unifying theme in Asian and Pacific Island cultures is that the family is the most important unit of society, there is great variation in the availability of family support among APIA elders. The lack of family help in getting to a medical facility may be another reason that some elders do not seek care in spite of the traditional ideal in Asian and Pacific Islander societies in which one's children, especially the eldest son, would provide care for the elders. The American Association of Retired Persons Minority Affairs Initiative (1987) reported that, based on the 1980 census, overall only 19% of APIA elders live alone compared to 30% of white elders. However, P. K. Kim (1983, p. 35) reported "26% and 67% of the Chinese elderly men and women, respectively, live alone; 50% of all Japanese households outside of the Western states] are one-person households, and 70% of these are women living alone; 28% of the Filipino elderly have never married"; (many of these are presumed to be older Filipino men who immigrated as laborers in the early part of the century and were not allowed to marry). Among Chinese MediCal (Medicaid) recipients in California, 36% aged 65 to 79, and 48% 80 and over were found to live alone (Lubben & Becerra, 1987).

A California study comparing white, black, Hispanic and Asian (Chinese and Japanese) MediCal recipients found Asians 75 and older had significantly more limited social support networks than white, black or Mexican elders. The authors of the study propose that this could be due to the sample selected, since Asian elders who receive Medicaid may have no other resources; or it might be due to the migration history of Asians early this century which resulted in a cohort of unmarried, isolated, impoverished elderly males (Lubben, Weiler, & Chi, 1989). For some Asian respondents, the desire to remain independent might have led to non-disclosure of their support networks.
Elders who do have children may not be able to rely on filial piety as a way of obtaining housing, and in many cases may prefer not to live with their children. Individual case reports, focus group information, and anecdotal evidence in California have indicated a trend even among recently arriving followers of children to explore living in senior housing as an option to living with their adult children. Some report loneliness from being alone all day and being expected to care for young children as potential negative factors in intergenerational households. It is not uncommon to find followers of children who live parts of the year in the homes of their different children and perhaps even return to their countries of origin for a month or more each year.

Even in Asian countries where older followers of children originate, traditional values are diminishing. As Martin (1988) writes in "The Aging of Asia", "Social changes such as migration, urbanization, and increased female labor force participation mean that generations of a family may live in different places, that they may live in a place where there is no housing to accommodate a multigenerational family, or that the traditionally female caretakers may be working outside the home" (p.110).

Chinese. Among a sample of 60 foreign-born Chinese American elders living in low income housing in Sacramento, 70% of whom spoke no English, 12% lived with their children but 33% preferred to live with them (Cheung, Cho, Lum, Tang & Yau, 1980). Half reported that they had no children living in the same city, and only 27% said that they relied on their children for transportation to the physician and care if they were bedridden. In a study of 259 older Chinese and Korean elders living in congregate senior housing in Chicago, however, Yu and her colleagues found that only 14% of Chinese and 8% of Korean had no children nearby (E. S. H. Yu et al., 1993).

Patterns of filial belief and behavior in the family were studied among four age cohorts of Chinese Americans living in a Midwestern university community. L. C. Yu (1983) reported that less than half of the 510 respondents who completed the questionnaire expressed high filial belief, as measured by agreement with statements indicating that adult children should provide for the welfare of their parents in the areas of health and long term care, financial support, housing, and deference to authority. Among the cohorts aged 36 and over, however, more respondents indicated that they demonstrated high filial behavior than actually expressed the beliefs. She also found evidence of a trend toward more Chinese daughters caring for parents than the traditional pattern of sons assuming responsibility for needed care (L. C. Yu). The same Chinese American data set was used in two analyses (L. C. Yu, 1983; L. C. Yu & Wu, 1985) to examine the relationship between unemployment and level of discomfort in providing financial support and housing to parents and parents-in-law. They found that employment decreased the discomfort level of respondents in providing assistance, especially among the women, 46% of whom were employed outside the home. Among the 297 married respondents, the authors found very few reported that their parents-in-law were living with them or intended to live with them, but 86% of males and 94% of females provided financial assistance to their in-laws.
Japanese. Kitano (1988) reports that Japanese American elders may also not be living with their children. In Osako's 1979 study, only 35% of the Issei lived with their children, although an additional 27% lived in the same neighborhood or apartment.

Filipino. In the United States, many contemporary Filipino families function within an extended family structure with strong emphasis on interpersonal dynamics, particularly group harmony and loyalty, respect for elder and authority, and maintenance of a natural support system by a complex process of interdependent/dependent relationships and family roles (McBride & Parreno, 1996, in press; Superio, 1993; Tompar-Tiu & Sustento Seneriches, 1995). Identified as "the most able social welfare agency" by the National Media Production Center in 1974 (McBride & Parreno, 1996, in press), it is not unusual that biologic, spiritual, and social ties continue to determine membership to many extended Filipino family systems. Intergenerational variations and differences in caregiving expectations range from total reliance on informal resources to full use of formal services. The latter, when considered, is almost a last recourse. Tensions related to prioritizing family needs as perceived through traditional cultural values on child raising and elder care are at the core of many Filipino American homes.

Caregiving roles and responsibilities for a frail Filipino elder may occur by family consensus, self-assignment, or default (McBride & Parreno, 1992; 1996, in press). However, decisions on caregiving issues such as advanced directives, discharge planning, placement, or use of formal services may be made by one or several individuals at various phases of the caregiving process. Family hierarchy and birth order, perceived expertise of family members, power positions within the extended family network (financial, social and education), or feelings of indebtedness are some critical factors to consider when health providers are working with these issues.

For example, it would not be unusual for a primary caregiver to refuse to sign documents until the issue has been discussed with the decision maker in the family who may be living outside the U.S. Titles of respect for the older brother (kuya), sister (ati/ate), uncle (tio), aunt (tia), etc., imply positions of authority and/or power which may guide roles in decision-making and resolving family conflicts (McBride & Parreno, 1996, in press; Medina, 1991; Tompar-Tiu & Sustento-Seneriches, 1995).

In her masters' thesis, Superio (1993) notes that young first and second generation Filipino Americans and older adults who were immigrants felt strongly that children should take care of their aging parents. In contrast, the middle aged first generation adults who may be experiencing the "sandwich generation" syndrome agreed that children should be taught to care for elders, but they themselves did not expect their children to be the primary caregivers when they reach old age. Arranging for proper care, supplementing resources, and giving positive emotional support were some of the specific expectations of this age group.
For some traditional families, using a natural support system may translate to several options. At the Stanford Geriatric Education Center, based on a summary of oral reports from individuals and health professionals, Dr. McBride classified help-seeking patterns among Filipino families involved in elder care into indigenous descriptive categories using Tagalog terms (one of the Pilipino languages). They include: "kayahin na nafin" (rely on ourselves); "magnanap ng paraan" (search for one or more strategies); "tingnan nafin" (let's see how it goes); "magbisitahan" (visit family); "magkuha ng bantay" (get a trusted companion); and "iuwi na" (take elder home, i.e. to the Philippines). Examples of help-seeking actions are: leave a job or ask a young adult to temporarily leave school to be the caregiver; focus the kinship network on the caregiving need; observe the development and quality of relationships with service providers before using other formal services; arrange "short-term" visits by the elder to other family households or vice versa; ask extended family in the Philippines to send a companion/caregiver, usually a poor relative; and mobilize the family to take the elder back to the Philippines.

Some caregiving functions for Filipino children seem to fall within similar help-seeking patterns. It is interesting to note that widowed Filipino grandparents who immigrate to assist their adult children with raising their children, or those who eventually become surrogate parents, seemed to emphasize group or collectivist values while attempting to adjust to the highly individualistic values of the host culture (Valencia-Go, 1989). As Enriquez (1994) points out, the values of interpersonal relationship are deeply embedded in the Filipino psyche, and caring for others is a complex skill that is learned throughout the developmental stages of the Filipino personality.

However, as generations of Filipino American families become acculturated, family support and caregiving in the Filipino community may also change, as is already observed in a small number of families. Medina (1991) asserts that in the Philippines very little change in cultural values and traditions and its influence on families may be anticipated in the future. Thus, Filipino American families who keep kinship ties abroad may choose to blend their cultural heritage with the mainstream culture. For many families, then, biculturism may be more useful as an adaptation model rather than the acculturation continuum model (LaFromboise, Coleman, & Gerton, 1993).

Korean. Interesting insights on expectations and preferences of Chinese and Korean American elders for care comes from the Chicago study of congregate housing residents. Among the Chinese residents, 90% thought in general a nursing home was the best living arrangement when a person becomes old, but with increasing levels of disability, they preferred living with one's children or "other" living arrangements to nursing homes. The Korean response pattern, on the other hand, indicated a strong endorsement of living apart from one's children; 81% preferred living alone if an elder is healthy. With increasing disability, the preference for nursing home residence increased to 70% for those who are incontinent, -- the opposite trend to that found among the Chinese sample (E. S. H. Yu et al., 1993). These differences are an important reminder of the heterogeneity among Asian American elders, even when filial piety is a strong tradition in both cultural heritages.
In the study of Korean elders in the San Francisco Bay Area, in spite of crowding, overwork, and strained relationships in two- and three-generation households, elders in those living arrangements had more positive morale and better self concepts than those who lived alone or with a spouse only. Many who were living with children preferred to live separately with more space and privacy but with rewarding contacts with the children. In the context of traditional Korean values stressing the duties of a son to his parents, less than half of the older Korean American women were satisfied with their sons, whereas about three fourths approved of daughters and sons-in-law (Kiefer et al., 1985).

Southeast Asian. Die and Seelbach (1988) reported the results of a study done on an availability sample of 60 elderly Vietnamese immigrants in Texas. The majority had arrived with the first wave of immigrants and had been in the United States for an average of 11 years. Despite the fact that 75% lived in the same household with their children, 93% reported that they seldom or never had problems with their family. Among Vietnamese families in Hawai'i caring for an elder with dementia is accepted as part of a family responsibility (Braun, Takamura, & Mougeot, 1995).

Pacific Islander. Among traditional Polynesians, caregiving to frail elders and the sick is a primary responsibility of the family. Family ties are maintained, and family visits may last a year or more. In health crises, many would respond by designating at least one family member as caregiver with minimal concern for the individual's personal circumstances. Although most Samoans are at the lower income level, finances are mobilized to support the caregiver's travel and the needs of the elder. For example, a bed may be purchased for an elder who has slept on mats on the floor as is commonly practiced in Samoan communities (King, 1990).

ETHNOGERIATRIC CARE: ISSUES AND RECOMMENDATIONS

Assessment. In providing culturally competent health care services, appropriate techniques of assessment and diagnosis are increasingly being recognized as important (Task Force on Ethnogeriatrics, 1995), although few specific assessment measures have been validated with specific ethnic groups of APIA elders. Three particular issues have been emphasized: use of interpreters; recognizing and incorporating patients' explanatory models of their illness; and diagnosis of depression and dementia.

Language. In view of the heavy majority of APIA elders who are foreign born and the many who are linguistically isolated (see section on demographics in Part I), language issues become immediately paramount in many clinical situations when providers who do not speak the language of the older patient need to take a medical history and description of symptoms. Although a provider from the same ethnic background is usually assumed to be preferable, for many populations they are rarely available, and some disadvantages have been noted (Eng, 1991). The most common solution seems to be use of a family
member to interpret for the elder, but this becomes problematic in many situations. For a child called on to translate, the situation can be extremely traumatic, especially when a grandparent’s health is at stake. For those without a strong vocabulary in both languages, and especially when they are unfamiliar with medical terminology, it is very difficult for the family member and the clinician as well. Because of the family dynamics, older patients may not want to discuss some of their symptoms or concerns. Some Asian and Pacific Island elders, Tongan for example, have strong traditions of modesty or taboos against talking about certain male or female anatomy, especially in front of a family member of the opposite sex, which decreases the likelihood of accurate diagnosis of prostate, breast, vaginal or uterine problems (Llorens, 1990). The stress of immigration and living in children’s household, and especially with more acculturated grandchildren, may be serious concerns of followers of children who would be hesitant to talk about it with providers when family members are their interpreters. Providers are strongly encouraged to advocate for use of professional interpreters on site or telephone interpreter services if at all possible unless the elders express a preference to use their own family members (Task Force on Ethnogeriatrics, 1995).

Health Histories. Taking histories can be problematic for some providers working with elders from different ethnic populations for reasons other than language, including knowing how and when to ask relevant questions and knowing how to interpret the responses.

Respect toward elders is an important expectation of many Asian and Pacific Islander cultures. Respect has been identified as important especially among Filipino elders who should be addressed by their surnames. Older Filipinos in a San Diego study emphasized providers’ attitudes over their professional competence; they wanted providers who respected the clients and were “hindi suplada,” or “without airs” (Peterson, 1978). Young female health care providers should be aware that direct eye contact between an older Filipino man and a young woman usually implies “seduction or anger,” according to Babich and Bush (1985). Care must be taken to protect the elder’s sense of self-regard or “amor propio” especially when the clinician is giving instructions. Personal affront may be felt by the elder especially when deference to the person’s social status, family role, or education is unintentionally overlooked. A strong awareness of one’s status or role in relations to the group may be expected from Filipino elders (Tompar-Tiu & Sustento-Seneriches, 1995).

For Pacific Islander elders, it is also important to show respect. There are topics that are considered shameful or “taboo” to discuss by many Pacific Islanders. Included is anything regarding sexual intercourse, genitalia, venereal disease, and mental health problems (Palafox & Warren, 1980).

One particular area often omitted in a health history is that of herbal or other medications specific to cultural experiences. In view of the widespread use of Asian or Chinese herbal remedies by Americans of Asian and non-Asian backgrounds and the
common availability of herbalists, especially in West and East coast communities, the integration of knowledge about patients' use of these drugs seems important in gaining a clear clinical picture. It seems especially important in the case of remedies to produce specific physiological reactions, such as reducing edema or high blood pressure, to take any possible interactions into account when prescriptions for Western medications may be given. Unfortunately, however, there are no known references that describe the chemical properties of Chinese herbal medications for Western providers to consult, although reference materials are available on the types of medications and their uses (Hikoyeda & Grudzen, 1991). For assistance in interpreting the possible effects of herbal medications one suggestion has been to consult specialists in schools of pharmacy.

Explanatory Models. Explanatory models (EMs) of illness have been identified by Kleinman and his colleagues as extremely important in the understanding of symptoms in Chinese and other Asian populations, especially in relation to mental illness. (See Kleinman, 1980, for an example.) These include the patients' beliefs about the etiology, pathophysiology, and/or prognosis of their illnesses. The incorporation of EMs into the assessment process has increasingly been recognized as important in providing effective health care (Johnson, Hardt, & Kleinman, 1995).

A study among older Cambodian refugees in San Jose, California, revealed that for their most common chronic condition, severe headache frequently combined with dizziness, the terms they used (pruly chil/kit chraen) for the most common explanatory model are translated as "sadness from thinking too much". When explored, this was usually related to recurrent thoughts about family members and friends lost in the tortures by the Khmer Rouge and concerns about living relatives in Cambodia and in the refugee camps in Thailand. Physical stress and the violence endured at the hands of the Khmer Rouge were also cited as explanatory models (Handelman & Yeo, 1996).

Specific suggestions for incorporating explanatory models of illness into the clinical assessment process have been given by Kleinman, Eisenberg, & Good (1978), who recommend at the least using a series of questions to elicit patients' perception of their condition, its causes and effects. Examples are (Johnson et al, p.157):

- What do you call your problem?
- What causes your problem?
- Why do you think it started when it did?
- How does it work---what is going on with your body?
- What kind of treatment do you think would be best for this problem?
- How has this problem affected your life?
- What frightens or concerns you most about this problem and treatment?

A similar strategy is advocated by Berlin and Fowkes (1983) which asks providers to remember the mnemonic "LEARN" to:
Part IV of this review summarizes some of the health beliefs with which providers might be confronted in exploring the explanatory models of illness reflecting non-Western belief systems.

Assessment of Depression and Dementia. Assessment of depression, and more recently, dementia among Asian elders has received considerable attention because of the perceived difficulty in using Euro-centric models of the illnesses and the instruments developed to measure mood and mental status. There have been historical controversies over the relevance of the Western medical conceptualization of depression for Asian populations, especially around the issue of "somatization," i.e., whether or not Asian (especially Chinese) individuals experience or express depression primarily with physical complaints without organic pathology. In addition, in Hong Kong and other parts of China a commonly used diagnosis is neurasthenia, which is defined as weakness or exhaustion of the nervous system giving rise to various forms of mental or bodily inefficiency (Cheung, Lau, & Waldman, 1980-1981; Kleinman, 1982). While neurasthenia is not a diagnosis commonly used in the U.S., Kleinman found that 87% of patients with neurasthenia in Hunan met the criteria used in the U.S. for Major Depressive Disorder. Both the somatization expressions and the conceptualization of neurasthenia are thought to be related to traditional Chinese medicine beliefs.

Segal interviewed 81 physicians and other geriatric health care providers who see elders in Hong Kong and found that the most common symptoms they see in depressed Chinese elders are not depressed mood or dysphoria but the somatic complaints, such as poor appetite, insomnia, and fatigue (Segal, Tam, Yesavage, & Yeo, 1993). This suggests that especially for foreign born Chinese American elders, it is important for providers to be alert to the potential for physical complaints to express depression, even without complaints about mood, as might be expected among Euro-American elders.

A widely used measure of depression in geriatric care and research, developed specifically for older adults, the Geriatric Depression Scale (GDS), has been translated into Chinese and Japanese but has not been validated with an Asian or Asian American population (Yesavage & Gear, personal communication, 1995). Although it intentionally omits the somatic symptoms and as such might be questionable for use with Asian elders given the issue of somatization discussed above, it has been used successfully with Chinese American elders at On Lok Health Services in San Francisco (Der-McLeod, personal communication, 1994).
A Vietnamese Language Depression Rating Scale developed and validated with a Vietnamese population in Oregon (mean age = 33) is available (Kinzie et al., 1982) although no evidence of its use with an older population has been published. The 15 item scale correctly identified 91% of the depressed Vietnamese patients in a psychiatric clinic and 96% of the matched community sample. It consists of three classes of items: common symptoms of physical states associated with depression; symptoms related to depressed or sad mood; and symptoms seemingly unrelated to either lowered mood or the Western concept of depression but found to be significant factors differentiating depressed from non-depressed in the Vietnamese population (e.g. being angry). The authors emphasize the awkwardness of the English words used to translate the Vietnamese concepts in the scale which underline the importance for considering the cultural context (Kinzie et al., 1982).

The assessment of cognitive status and dementia with APIA populations has been a particular concern, given the language and conceptual issues related to culture involved in the traditional measures (Teng, 1996, in press). A team headed by Dr. Evelyn Teng at the University of Southern California has developed a carefully constructed cross-cultural screening instrument for cognitive status and validated it with several Asian and Asian American populations cross-nationally (Teng et al., 1994; Teng, 1996, in press). This multidimensional scale, called the Cognitive Abilities Screening Instrument or CASI, was piloted with dementia programs in Japan, Los Angeles, and Seattle using the English and Japanese language versions. It has also been translated and used with a Chinese population, and has the capability to be adapted for different ethnic populations. Scores for the Mini-Mental State Examination, the Modified Mini-Mental State Test, and the Hasegawa Dementia Screening Scale can be estimated from subsets of the CASI items, and a short version was also found to be comparable in detecting dementia. Especially valuable is a carefully developed training program on videotape for those who will be administering the CASI (Teng et al., 1994).

Physical Examination. It is said that in traditional Chinese medicine, women were examined by using a doll; patients would point to the part of the body that was affected and describe their symptoms. Mo (1992) emphasizes the discomfort felt by many Chinese women in being examined, which likely applies to women from other traditions in which modesty is valued. In a focus group of Filipino doctors in San Mateo County, California, held in 1995, they reported experiences with middle aged and older Filipino women who kept their upper torso covered during an examination, making it difficult to do clinical breast examinations. If the physician suspects great discomfort due to modesty, permission might be asked before the patient is touched.

Treatment. According to Anderson (1983), clinicians should be careful about how they inform Filipino patients about the extent and severity of their disease. Any stress to the patients may cause a loss of equilibrium that may further exacerbate the illness.
Medications. The issue of possible differences in response to certain medications between some Asian populations and Caucasian patients is potentially important for treating older APIAs. Most of the comparative research has involved small groups of younger adults either cross nationally or with Asian subjects from various ethnic backgrounds in the U.S. The interactions of drugs, ethnic diet, and aging metabolic functions is largely an uncharted area for ethnogeriatric research. In Tien's review (1984) of psychotropic drug responses of Asian Americans as compared to non-Asians, she found that Asian patients require a lower dosage and manifest side effects readily with low or medium American doses. Lin- Fu (1986) found that the effective weight-standardized neuroleptic dose for Asian American patients was significantly lower than for whites.

As a part of the National Institute on Mental Health-funded Research Center on the Psychobiology of Ethnicity at the Harbor-UCLA Medical Center, Keh-Ming Lin and colleagues have carefully reviewed the research on ethnic differences in response to specific types of drugs (Lin, Poland, & Nakasaki, 1993). In their review of tricyclic antidepressants (Silver, Poland, & Lin, 1993), they reported several studies which found that among East Asian populations (Chinese, Japanese, Korean, and Vietnamese) smaller doses than usually used to treat depression in Caucasian patients may be effective. Attempts to establish the physiological bases for these differences, however, have had mixed results, with some finding the Asian subjects, (or subgroups of the Asian subjects) as being "slow metabolizers"; other studies have found that when body weight is taken into account, plasma concentrations of the tricyclics were similar, especially in studies with Vietnamese patients. Among Asian Indians, very limited data suggest single doses may produce higher plasma concentrations and more side effects (Silver et al., 1993).

In the review of studies on the benzodiazepines such as diazepam (Valium) widely used for their efficacy in treating anxiety and related symptoms, Lin and colleagues cite a survey of American and Canadian clinicians who regularly treat both "Asian and non-Asian" patients in which the mean dosage levels of the benzodiazepines for the Asian patients were one half to two thirds that of Caucasians. Four kinetic studies in the U.S., Hong Kong, and China exploring this relationship all consistently reported slower metabolism rates for the Asian subjects, suggesting direct or indirect genetic differences affecting the response patterns (Lin, Poland, Fleishaker, & Phillips, 1993).

The psychotropic drug haloperidol (Haldol) is widely used with dementia patients in the U.S., but cross-ethnic studies with older adults are not available. Although interpatient variability was considerable, studies with schizophrenic patients from Caucasian, Chinese, African American, and Hispanic backgrounds have confirmed 40%-50% higher plasma concentrations for Chinese than non-Chinese patients with similar doses (Jann, Lam, & Chang, 1993). The reviewers deduced that dosages greater than 30 mg/day would not be necessary in Chinese patients, compared to 50-60 mg/day for non-Chinese patients.
Surgery. Lin-Fu (1988) notes that lens implantation in cataract surgery has been found to be more difficult in Asian American patients because of the anatomy of their eyes. Successful surgery requires modification of the preoperative medicine dispensed in addition to the surgical technique.

Working with Families. An important resource to health care providers and the ethnic elders’ is the family and social support network. There is little information on assessment of ethnic families, however, the section on the “Role of the Family and Social Support in Health Care” can provide some insights. Some recommendations have been made based on providers’ experiences working with family caregivers of frail APIA elders. In most cases for all APIA backgrounds, remembering that the family is the unit of decision making is crucial for an effective working relationship.

For Chinese American families it is important to understand the cultural mandate for the eldest son and his wife to care for his parents in old age, even if this may seem to be an unfair division of labor from the Western provider’s perspective. In other cases, it helps to understand the intergenerational conflict in families when parents’ expectations are not met (Elliot, DiMinno, Lam, & Tu, 1996, in press). Individuals and families from Chinese ancestry in the U.S. will vary greatly on their degree of commitment to traditional Chinese values, even if they have been in the U.S. decades or even generations. It is recommended that providers evaluate their patients’ place on the continuum of acculturation by identifying their: country of origin; education; and urban or rural background; language(s) spoken; immigration history; kin network; and usual decision-maker in family. Working with the decision-maker and establishing trust (guanxi), and working with linkpersons in the Chinese community infrastructure of service agencies in a respectful way are considered very important for effective relationships (Elliot et al.).

Working with Japanese American family caregivers is facilitated by: understanding the difficulty some have in revealing personal information that might bring shame to the family, such as symptoms of dementia; respecting the need for deference to the father/husband to be preserved; recognizing the importance of indirect, nonverbal, nonstraightforward styles of communicating; and assuring confidentiality in view of the stigma some experience in participating in counseling programs (Tempo & Saito, 1996, in press).

Filipino Americans are usually very protective of their elders. Traditionally, elders expect the family to care for them as a means of paying back a debt of gratitude or utang na loob. Caregiving in a home setting is preferred over institutional care partly to maintain privacy or because of distrust of the system. They may depend heavily on the knowledge and perceived expertise of family members who are health professionals or work in the health field. Because a large number of Filipinos in the United States are in the health field, McBride and Parreno (1995) emphasize the importance of understanding the Filipino American family as a health and social service system so that interventions may be introduced and encouraged at an appropriate stage in the treatment process.
Among Vietnamese families who live in Hawai‘i, it is accepted that the family will take care of their elders (Braun, et al., 1995). Institutional care or aging services may not be part of the immediate resources of the family. However, according to anecdotal reports from service providers, some members of the Vietnamese community in Santa Clara County may be shifting attitudes and expectations in caring for their elders. Use of formal services are being considered to be a priority option, if not the only possible option, in providing care for the frail elder (Grudzen, 1995, personal communication). The regional difference in perspectives raises the question whether it is the tip of the iceberg that is before us that could lead to better understanding of caregiving and acculturation in this community.

ETHICS IN HEALTH CARE

Ethical decision making in health care settings is increasingly being recognized as an important culturally related process which holds the potential for misunderstanding and distrust between Western trained providers and Asian elders and their families, especially in relation to the use of the Western biomedical ethical paradigm emphasizing individual autonomy and informed consent (Orona, 1995; Orona, Koenig, & Davis, 1994; Yeo, 1995). The question has been raised as to whether or not individual autonomy is appropriate as a universal guideline for physicians and other members of the health care team in the face of the following strong traditions among many, if not most, Asian and Pacific Island cultures: 1) the predominance of the family as the unit of value; 2) the importance of filial piety which requires that elders be respected and cared for by their children, and 3) the tradition that families should be involved in health care decisions. A related issue in working with older patients from APIA ancestries is the appropriate method of providing informed consent that is required for major treatment decisions, given the common expectation in many Asian countries that elders should be protected from serious negative information in order to maintain their hope.

A study of 230 patients in a county facility in Los Angeles among eight different ethnic backgrounds examined their preferences for starting and stopping life support in hopeless or terminal situations (Klessig, 1992). Responses to questionnaires in English or their native language reacted to scenarios based on actual situations of patients of various ages. Table 5 compares the responses of the three Asian Pacific Islander American populations in the study and those of the reference group composed of Anglo non-Jewish respondents. The young adult respondents are similar ages to those who might be involved with making decisions about older relatives in the Asian populations where the family members are expected to take responsibility. In this study, there are clear differences between expressed preferences of the Asian groups, even though all favor more aggressive treatment than the reference group of white Californians.
Chinese respondents agreed to terminating life support almost as readily as the reference group, which is not consistent with much of the previous literature. In her discussion of individual groups, Klessig points out that cultural traditions support different preferences among Chinese families, both stopping life support and taking all measures to preserve life, based on the combinations of centuries of influence by Confucianism, Taoism, and Buddhism, emphasizing the heterogeneity and individual differences within ethnic groups that should be expected by providers. In the Korean American population, according to Klessig (1992), it is not unusual for the male head of the family to make life-support decisions about all the members; in order not to bring dishonor to the family and to protect one's parents, this frequently means preserving their lives at all costs. Major influences on the Filipino American preferences for life support include their predominantly Catholic background and traditional respect for elders, which is interpreted frequently as motivation to begin and maintain life support for older family members. Harmony is valued, so that patients' own preferences may be dismissed to avoid conflict in the family.

The consequences of the emphasis on maintaining hope and the reticence to stop life support in the Western health care system was highlighted in a study by Fowkes (1995) in which he analyzed data from 264 patients who had died in a medical practice caring for homebound and nursing home elders in San Jose, California. The Asian patients in the practice were much more likely to die with enteral (tube) feeding than the non-Hispanic white patients in the practice. (Fowkes, 1995).

**Chinese.** Informed consent has been reported to be an especially difficult issue for some providers working with some Chinese American patients. The American requirement that providers give information to patients about their illness, prognosis, and risks and benefits of optional treatments so that they can make informed choices violates the expectation and preferences of some families with traditions similar to those found in many parts of China. Disclosure of a serious diagnosis for an older parent has been identified as particularly difficult for some Chinese families. The following summary of a case adapted from Muller and Desmond (1992) is similar to other anecdotal accounts.

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**Table 5**

PREFERENCES FOR STARTING OR STOPPING LIFE SUPPORT BY ETHNIC GROUP

<table>
<thead>
<tr>
<th>ETHNIC GROUP</th>
<th>PERCENT AGREEING TO START LIFE SUPPORT</th>
<th>PERCENT AGREEING TO STOP LIFE SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese (n=17)</td>
<td>53%</td>
<td>65%</td>
</tr>
<tr>
<td>Filipino (n=28)</td>
<td>80%</td>
<td>14%</td>
</tr>
<tr>
<td>Korean (n=23)</td>
<td>74%</td>
<td>30%</td>
</tr>
<tr>
<td>Reference Group (n=43)</td>
<td>17%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Adapted from Klessig, 1992
CASE EXAMPLE: A Cantonese-speaking woman who had immigrated from mainland China 8 years previously was living with her husband and adult son in a West Coast city when she was admitted to an acute care hospital for pneumonia. Diagnostic studies revealed an obstructing bronchial squamous cell carcinoma, but the youngest son who had become the spokesperson for the family "perhaps because he spoke English better than his siblings" made it clear that he did not wish to discuss his mother's diagnosis with her and that he did not want the physicians to talk with her through another interpreter. She was discharged with antibiotics, and in the ensuing months while diffuse metastases to the spine and brain were confirmed, her primary care physician became increasingly frustrated with the protectiveness of the family members that never allowed the patient to be informed about her diagnosis, prognosis, or treatment options. The family refused hospice care and "do-not-resuscitate" (DNR) orders. Six months after her first admission the patient was readmitted with progressive shortness of breath and shortly became unresponsive. The family refused to consider a DNR order and insisted on extensive and aggressive therapy, including intubation, which the house staff and attending physician refused after long deliberation. When the patient died, the youngest son accused the attending physician of being a murderer (p.323).

The few available studies have pointed to some cultural traditions that differ from the current U.S. medical practice that might help explain the misunderstandings and distress that both the family and the health care team were experiencing in this case.

1. Importance of the Family as Protector. The family is more important in many respects than the individual in many Chinese families, so they may assume that when a person is ill, rather than talking to the patient, health care providers will talk to the family members who are responsible for the sick person. Some writers have described the belief among some Chinese families that one's body belongs to one's ancestors and family, so the decisions should not be left up to the individual, which of course puts those peoples' beliefs in direct conflict with Western assumptions of autonomy. Among the respondents in a pilot qualitative study of cancer patients and their families from different ethnic backgrounds in San Francisco, Chinese relatives defined their duty as protecting the patient, and making their remaining time comfortable and free of distress (Orona et al., 1994). Central to this protection was a need to keep information about the disease and prognosis from the patient. Contrary to the expectations of the physicians and nurses, discussing the prognosis with the patients was viewed by the Chinese families as inviting suffering and sadness.

2. Speaking About Death. According to numerous sources, speaking about death and dying is considered strongly inappropriate among many Chinese American families. In the San Francisco study the Chinese families felt discussion with older parents of their
cancer diagnosis would be rude, disrespectful, and a portent of bad luck (Orona et al., 1994). In addition, a sick adult is entitled to be treated like a child and protected, and telling someone she is dying is seen as likely to make her give up hope, and hasten her death. It also signals that the providers have given up hope. A pilot study interviewing Chinese American elders who did not speak English about their health care preferences in case of incapacity showed that many have a great belief in the potential of medical miracles of the American health care system and think anything is possible (Jump, 1995). This belief, then, would make it even more imperative to maintain hope. Even if the family has given up hope themselves, however, it may be considered much more appropriate not to acknowledge the gravity of the situation openly, although the family and the patient may be aware of the reality but pretend not to (Orona et al., 1994).

3. Good Deaths and Bad Deaths. There is a strong Chinese traditional preference for "good deaths" in which persons die peacefully in old age surrounded by their families and with a full stomach. (P. C.-Y. Lee, 1995; Der-McLeod & B. Yee, 1995; Muller & Desmond, 1992). There is also a shame of "bad deaths". If family members perceive that their parent is not old enough to fulfill the cultural value of longevity, they may insist on any intervention that would prolong life, including nutrition and hydration when providers perceive the situation as "futile". The value of feeding and hydration in the Chinese tradition was emphasized in a cross-cultural study of nurses; Chinese nurses were found to unanimously endorse continuing tube feeding and hydration in cases of non-responsive dementia patients to a much greater degree than nurses in six other countries (Norberg et al., 1994).

Japanese. A study of 48 Japanese American elders in Northern California, half of whom were monolingual Japanese speaking, found that 26% indicated that they preferred their family make decisions about their care in case of incapacity, 15% preferred their physicians, and 50% preferred both. Of the elders who preferred their family members (alone or with the physicians), 76% had not discussed their preferences with family members; 77% thought their family members did not know but expected that decisions would be made by family on behalf of family. For those preferring physicians, 83% had not discussed it with their physician; 72% felt their doctors did not know their preferences but would know what should be done. It was clear that these Japanese American elders had no strong desire to protect their own autonomy and seemed indifferent to controlling health care decision. (Nishimura & Yeo, 1992).

Korean. The use of autonomy and its correlates as a guideline was explored in a study of 200 participants, aged 65 and over, from 31 senior centers in Los Angeles self-identified as European American, African American, Korean American, or Mexican American (Blackhall, Murphy, Frank, Michel, & Azen, 1995). Less than half of the Korean elders (47%) believed that a patient should be told the diagnosis of metastatic cancer, compared to 65% of Mexican Americans, 87% of European Americans, and 88% of
African Americans. Only 35% of the Korean subjects thought a patient should be told of a terminal prognosis. If a decision needs to be made about putting a very ill patient on life support that will prolong life but not cure the illness, 28% of the Korean elders thought the individual should make the decision, and 57% thought the family should. These percentages are roughly the reverse of the responses of the European and African American sample, with the Mexican American subjects falling in between. The Korean elders were found to have "low" scores on an acculturation measure although 66% had lived in the U.S. for more than 10 years. On a stepwise multiple logistic regression for the four ethnic populations, ethnicity was the primary factor related to attitudes toward truth telling and patient decision making (Blackhall et al.)

In light of the evidence reviewed above on use, access and barriers, role of families, health care strategies, and ethics, cultural competence in geriatric health care for Asian and Pacific Island American elders is multifaceted. To add to the complexity, the heterogeneity of health beliefs and practices in the backgrounds of older APIA needs to be taken into account. The available knowledge base is summarized in Section IV.
PART IV

HEALTH BELIEFS AND PRACTICE

In order for health care providers to respond to the needs of elders from diverse cultural backgrounds, it is important to understand the expectations and conceptual frameworks the patients bring to the health care encounter. These explanatory models of illness are heavily influenced in many cases by the traditional cultural perceptions of health and disease elders have been taught in their countries of origin. The following section summarizes some of those cultural beliefs that differ from the Western biomedical model.

CLASSICAL CHINESE BELIEF SYSTEM

The precepts of classical Chinese medicine influenced by Taoist and Confucian philosophies have been incorporated into the traditional health systems in many areas of Asia, including Japan, Korea, the Philippines, and Southeast Asia. Lin (1981) describes the two central concepts in that system as: 1) dynamic balance or harmony, and 2) microcosm-macrocosm correspondence, or the effect on the individual of events and structures in the larger natural and social environment, including the cosmic forces of the universe. From the idea of the correspondence developed three main themes of fundamental importance used in diagnosis and treatment:

1. The Yin/Yang system describes complementary and interdependent opposite forces inherent in the universe that need to be kept in balance to avoid dysfunction. Yin signifies passive, unclear, inward, dark, soft, and cold; Yang signifies active, excited, external, forward, aggressive, volatile, hard, bright, and hot. The balance between these forces is a primary concern in Chinese medicine and is used heavily to prescribe medicines and dietary elements that are seen as "hot" or "cold".

2. Five Evolutive Phases describes the interaction of elements named metal, wood, water, fire, and earth. The phases are progressions of inhibition and facilitation in the interdependence of the elements. Each has its correlates in internal organs, orifices, tastes, colors, and emotions. (e.g. wood is represented by liver and gall bladder, eye, sour, blue, and anger.)

3. Ch'i and the Ching-Lo (Meridian) System. Ch'i is the vital energy and is circulated via the meridian tracts to provide nourishment and vitality to all parts of the body. Blood and the cardiovascular circulation are regarded as part of the ch'i system. Since Ch'i is vital to all functions and is irreplaceable, any loss or obstruction is thought to have grave consequences. The meridians form the basis of acupuncture and other diagnoses and therapies. (For a more detailed description of traditional Chinese medicine, see Lin, 1981, from which this summary was taken.)
Yu and Cypress (1982) suggest that those who have strong beliefs in the Chinese medicine principles would be likely to avoid surgery to the extent possible since it increases the risk of losing one's blood. In maintaining the balance between yin and yang, old people are predisposed to the "cold", and thus can be affected by too many "cold" foods, such as leafy green vegetables (Chen-Louie, 1983).

External forces that cause disease include wind or feng which is a noxious substance that enters the body to cause symptoms such as bloating, flatulence, depression and joint pain (Chen-Louie, 1983).

HEALTH BELIEFS AND PRACTICES FOR SPECIFIC ETHNIC GROUPS

Chinese. Older Chinese Americans in the U.S. would be expected to have been exposed to many, if not most, of the belief systems described above, but the degree to which they accept them and act on them would vary considerably based on their acculturation level to the U.S. society, the urban or rural residence in their countries of origin, educational level, exposure to Western biomedical tenets, and many other factors.

An association between health practices and indicators of acculturation was found in a study of dietary habits among 45 older Chinese American women in the San Francisco Bay Area (Chau, Lee, Tseng, & Downes, 1990). The dietary practice of balancing "hot" and "cold" foods to maintain equilibrium was reported by 49%, and 56% said they believed in the concept. The practice was significantly positively associated with both age and length of time in the U.S. and with immigrating from Hong Kong (as opposed to Taiwan and other sites); the balancing practice was negatively associated with subjects' ability to read English and level of education. The authors speculate that the reason those who were in the U.S. longer were more likely to practice "hot" and "cold" food selection was that the 32% who came from Hong Kong were less educated and immigrated earlier than the 49% who were from Taiwan. One quarter of the sample believed that an older persons' body is "cold" and therefore more prone to "cold" diseases, but 36% said that they were presently avoiding "cold" foods. Chinese staple foods (such as rice, noodles, or dumplings) were consumed by 95% of the sample for lunch and dinner, and 27% chose Chinese staples for breakfast (Chau et al., 1990).

A focus group methodology was used by a team of researchers in Los Angeles to study the health beliefs related to health promotion among elders of four ethnic populations, including both Mandarin- and Cantonese-speaking Chinese Americans. They found that the conceptualization of health among the Chinese participants was more likely to emphasize a positive attitude and spirit, using such phrases translated as having a "good heart", "balance", a "content heart" and "wholeness". Secondarily, the Chinese elders emphasized regularity of activity and habit as important in good health (Frank, Damron-Rodriguez, Levin, Hirsch, & Reuben, 1995).
In their discussion of Japanese American health beliefs, Hashizume and Takano (1983) cite Lock's dissertation which identifies two indigenous belief systems. The first is the Shinto religion:

By nature, humans are thought of as inherently good. Evil is caused by outside spirits who bring retribution on humans because they succumbed to temptation. This state is temporary and can be removed by purification rites...The cleanliness of the Japanese and the use of natural herbal purgatives is thought to originate from this philosophy (p. 225).

The second belief system is the kampo medical system developed around the sixth century, based on the Chinese system. Kampo emphasizes maintaining a harmonious relationship with the universe. Kampo practitioners treat with herbs and restore the flow of energy that is slowed or stopped, resulting in illness. Treatment methods include acupuncture, acupressure, massage and moxibustion which "...are all means to restore the flow of energy through the use of needle, pressure or heat at strategic locations along affected meridians". Lee and Takamura (1980, p. 114) describe moxi-bustion as the practice of burning "small cones from mugwort leaves...at defined points on the skin surface...helpful particularly for ailments of the joints, muscles, bones and back."

Japanese cultural values that influence interaction with health care providers include the avoidance of being in an embarrassing or shameful situation, the passive acceptance of events beyond one's control, and deference to authority. Kitano (1988) notes that Japanese elders may express their submissive attitude towards authority by indirect communication or enryo. An example of enryo is to refuse something the first time despite wanting the offered object, out of a sense of exaggerated politeness. Another example from Hashizume and Takano (1983, p. 224) is "In the hospital a Japanese American patient may not turn on the call light until he is in dire need because he does not want to bother the staff. . . .He perceives his needs as less important than others' needs unless he feels they are urgent."

Other important cultural values are haji or shame; children are not to bring shame to themselves or to their family name. Gaman is self-control, and is one reason that patients may not complain about pain or that the Japanese Americans are reluctant to use community resources. Families and individuals tend to keep problems to themselves and make the best of difficult situations keeping in mind shikata ga nai or "it can't be helped" (Hashizume & Takano, 1983; Lee & Takamura, 1980).

Koko or filial piety is very important. The Issei expect their children will practice oya koko or "care for parents" (Hashizume & Takano, 1983; Lee & Takamura, 1980). In the 1986 study by Osako and Liu of over 100 pairs of Issei mothers and their Nisei daughters, it was found that "the role of filial piety remains strong to counteract the influence of social mobility of the children. . . .The intergenerational cohesion served as a cushion for personal frustrations and old-age social isolation from kin relatives" (pp. 151-152).
During the Meiji era in Japan, which was the historical period in which the Isseis grew up, there was a rigid class system in which rules of language and communication between people of different age, status, and sex were very strict. These values persist in that it is very important to show deference and respect for the Issei, as in never addressing them by their first names (Hashizume & Takano, 1983).

Ishizuka, in her study of Japanese elderly in San Diego in 1978, found that the elderly sought service providers who were "kind persons" (p. 44). This was defined as being sensitive to the hesitation and discomfort which the Japanese American elder experiences when using medical services.

Filipino. Filipinos usually view illness in a holistic framework making little distinction between physical and mental illness. Traditional theories on Filipino health beliefs are grouped into mystical, personalistic, and naturalistic causes (Tan, 1987). However, it is common for a person to cite multiple factors that interlink categories to explain an illness. In a Los Angeles survey, Filipinos gave the following causes for illness: overeating, delayed eating, stress and tension, viruses, pollution, body abuse, intake of incompatible foods, and God's punishment for sins (Tompar-Tiu & Sustento-Seneriches, 1995). Explanatory models of the present cohort of Filipino elders may include traditional theories along with Christian beliefs and Western health belief models.

Mystical causes of illness are associated with an experience or behavior such as ancestors seeking retribution for unfulfilled obligations. Some Filipinos believe in soul loss and a compulsion of the soul to wander out of the body especially when the person sleeps. This syndrome called bangungot characterized by nightmares and sudden death may be attributed to mystical beliefs and also a late heavy meal before bedtime. Personalistic causes may be associated with punishment and retribution by supernatural beings such as an evil spirit, a witch, and a mangkukulam (sorcerer). To counter its effect, a stronger spirit must be summoned, such as a healer or priest. To protect vulnerable persons, using holy oils, wearing religious objects or an anting anting (amulet) may be recommended. Naturalistic causes may include cold, heat, drafts, thunder, lightning, infection, incompatible food and drugs, excessive stress, and familial susceptibility to certain illnesses (Tan, 1987; Tompar-Tiu & Sustento-Seneriches, 1995).

Some authors interpret a Filipino expression bahala na to imply a fatalistic attitude about life closely tied to the belief that suffering and illness are unavoidable conditions, thus illness is punishment for transgressions and health is a reward for good deeds (Baysa, Cabrera, Camilon, & Torres, 1980; Orque, 1983a). More recently, others explain that bahala na suggests taking constructive action coupled with an acceptance of what may come or a sense of resignation, and facing up to the situation with determination despite lack of information. It may also mean taking responsibility for the situation and its consequences. Thus bahala na as a traditional Filipino belief includes recognition of
complex situations, faith in a higher power, courage to take action, and acceptance of one’s limitations (Enriquez, 1994; Tompar-Tiu & Sustento-Seneriches, 1995).

Anderson (1983) provides a review of Filipino cultural characteristics in the special issue of Western Journal of Medicine on cross-cultural medicine. Filipinos may also believe that illness can be the result of an imbalance of “hot” and “cold”. Imbalances can be caused by external factors such as cool drafts or overheating, by personal disorder or by being unwashed, or by psychic factors such as stress, grief or a loss of self-esteem. Orque (1983a) cites Hart in explaining that, historically, hot-cold beliefs probably originated during Spanish rule when the Philippines were administered through Mexico. Mexican-trained Spanish priests introduced Mexican health beliefs.

In Orque’s review (1983a) of Filipino health beliefs, she cites three underlying concepts described by McKenzie and Chrisman: flushing, heating, and protection.

Flushing is based on the assumption that since the body is a container capable of collecting impurities, it should be freed from debris. A complex system of stimulating perspiration, vomiting, flatus, or menstrual bleeding is used... Underlying the heating concept is the belief that hot and cold qualities must be balanced in the body... Protection provides the body with a gatekeeping system to guard against both naturally and supernaturally imposed illness (pp. 162-163).

Cultural healers help to “protect” the body and treat supernaturally caused illnesses by using herbal and medicinal treatments, special beverages, incantations, and offerings (Orque, 1983a). The Hilot, a derivation of the ancient tribal priestess or babaylan, is the most common Filipino folk practitioner and uses three forms of treatment: faith healing through prayer, herbal medicines, and massage and manipulation of bones and body tissues (Baysa et al, 1980). Hilot practitioners usually acknowledge the value of medical care to their clients.

One reason Filipinos may delay seeking health care is that, although they may appear to be Westernized with regard to health beliefs, this might be quite superficial. They may first consult with folk practitioners (Baysa et al, 1980; Orque, 1983a) or family members who are health professionals. In a New York study, 14 Filipino immigrant widows assessed their level of wellness or change in health status by comparing each other’s capacities using their own defined physical and mental health indices. The mental health indices focused on behaviors. They include becoming independent and self-reliant over time, being open to new experiences, nurturing satisfying relationships with family, staying involved in physical activities (household chores or recreation), continuing to practice one’s faith, and learning and adjusting to the host culture. The elders used life experiences rather than formal knowledge to develop their wellness criteria. The study
demonstrates the framework of beliefs and values that guided these elders in maintaining a state of wellness (Valencia-Go, 1989).

Important Filipino cultural values include *utang na loob* which is the obligation to repay any incurred indebtedness, whether money, material objects, or favors (Baysa et al, 1980; Orque, 1983a; Peterson, 1978). The repayment is essential in order to maintain one’s individual and familial respect. Whenever someone does an important favor for a Filipino, an *utang na loob* relationship is created. If one fails to repay a debt or obligation, a Filipino could bring *hiya* or shame to the family. Orque (1983a) notes that, because of a fear of incurring *utang na loob* with the nurse, an elderly Filipino might hesitate to accept the nurse’s services despite her reassurance. Additionally, elderly Filipinos are sometimes hesitant to seek assistance from a source outside the small network with which they are familiar because of uncertainty of the indebtedness which might be incurred with use of an outside system.

According to Enriquez (1994), the Filipino core value *kapwa*, conceptually translated as "shared identity, interacting on equal basis with a fellow human being," may have originated from the need to survive in an agricultural economy where natural calamities are common occurrences. Elements of this core value include: sensitivity and regard for others, respect and concern, helping out, understanding and making up for others’ limitations, rapport and acceptance, and comradeship (Agoncillo & Guerrero, 1987; Enriquez, 1994). Sensitivity to messages from nonverbal behaviors are essential to interpersonal relationships. Traditional psychosocial interactions among Filipinos or *pakitkipakwa* occur in two interrelated domains: the *ibang-tao* or outsider category and the *hindi ibang-tao* or one-of-us category. The first domain consists of 5 levels: *pakitkitungo* (civility, level 1), *pakitkisalamuha* (mixing, level 2), *pakitkilahok* (joining/participating, level 3), *pakitkibagay* (conforming, level 4), and *pakitkisama* (adjusting, level 5). Orque (1983a) suggests that at level 5, *pakitkisama*, a Filipino elder may hesitate to express feelings about treatment that might displease the health provider. The second domain may require additional investment of time and resources. It has 3 levels: *pakikipagpalaga-yang-loob* (mutual trust/rapport, level 6), *pakitkisangkot* (getting involved, level 7), and *pakitkisa* (oneness, full trust, level 8). Beyond level 2, a clinician may be able to establish a working relationship with a Filipino elder and the family (Enriquez, 1994; Pe Pua, 1990).

Filipino beliefs specifically about tuberculosis (TB) were examined in two focus groups in Hawaii conducted in the Ilocano language as part of a study funded by the Center for Disease Control; one group was Filipinos of mixed age from 30 to 77, and the other was WWII Filipino veterans (Yamada, 1994). Participants saw TB as a “wet” disease caused by germs and other factors such as unsanitary conditions, overwork, poor nutrition, cigarettes, alcohol, worrying, and wearing wet clothing. They viewed the disease as highly contagious which could be spread by sharing utensils, beds, or telephones, or by just passing someone on the street or engaging in casual conversation. Those who suffer from TB are stigmatized by society, and the psychological response can border on
depression. Although the most effective treatment was considered to be seeing a physician and taking medication, the groups also mentioned the following as helpful strategies: seeing an albularyo (herbalist) for treatment infusions of eucalyptus or red guava leaves; drinking certain liquids (e.g., Carnation milk, the blood of a pure black dog, large quantities of water); and specific dietary measures (e.g., avoiding salt, sweet, or crab and shrimp). Yamada suggests that a consequence of belief in the extreme contagiousness of TB is stigmatization, which leads those who have the disease to deny it, thus limiting treatment.

**Korean.** Pang (1989; 1991), conducted in-depth interviews with 20 Korean immigrant women between ages 64 and 80 in the Washington, D.C. area about their explanatory models and health practices. She describes the work of Hanui, traditional Korean practitioners, and Hanbang, the traditional Korean medicine. Hanbang is derived from Chinese medicine and is based on balance between um (the same as yin) and yang, and systemic correspondence of the Five Evolutive Phases: fire, earth, metal, water, and wood. It also has an ancient tradition reported in classical Korean literature. (See Pang, 1991, for an excellent description and history of traditional Korean medicine practices). Diagnostic methods used in hanbang are observing the patients, obtaining histories of the illness, listening to patients’ voices, and taking their pulse. The four most common treatment methods are acupuncture, herbs, moxibustion, and cupping. Korean patients may alternate between practitioners of Western and traditional Korean medicine although each type of practitioner may discourage patients from seeing the other (Pang, 1989).

The older Korean women in Pang’s study (1991) conceptualized a number of chronic illnesses as caused by the interruption of the flow of life energy and blood, or Ki (ch’i in the Chinese medicine) due to: lack of regularity and control of daily patterns of living from physical exertion which can cause arthritis, high blood pressure, or other pain; lack of control of food intake, which can cause diabetes or fainting spells; lack of blood caused by “drying blood” which can cause neuralgia or cramps. Coldness, dampness, and/or wind (Pung), which may come from inside the body, also can interfere with the flow of Ki, producing neuralgia, indigestion, or abdominal pain.

The Korean women described spiritual causes of illness if they do not meet their spiritual being’s expectation of them, whether they are related to Christianity, animism, shamanism, or Confucianism. Some were due to failure to pray, others to displeasure of ancestors with their burial place or offenses displeasing folk spirits. A particularly interesting cultural construction of illness found by Pang (1991) was Hwabyung, literally translated as “fire illness”, and related to a failure to keep their emotions from being expressed openly as traditionally required, especially for women. Each emotion affects particular organ systems and influences the flow of Ki in different ways. All of the women were familiar with Hwabyung, and 80% had experienced it, many of whom were well educated. In most cases it was related to difficult interpersonal relationships, or family
problems. The illness can cause a wide variety of symptoms such as gastro-intestinal, cardiac, and respiratory problems, or even blindness and hearing impairments.

**Asian Indian.** Traditional medical beliefs in India vary to some extent, but the primary influence is from the system of Ayurveda (ayur = longevity, veda = science). In this system three of the basic five elements of the universe have analogues in the body as humors: fire (as bile), water (as phlegm), and wind (as wind). A disturbance in the balance between these humors is believed to cause illness. A balance between foods considered “hot” and those considered “cold” is also important for health, and a good digestive system is necessary to transform food into humors and body constituents, such as flesh, bone, marrow, and blood. The key to health in *Aryuvedic* theory is an orderly daily life. Western mainstream medicine is known as “allopathic” medicine and is growing in influence and practice in India (Ramakrishna & Weiss, 1992).

**Southeast Asian.** In Southeast Asian culture, there are three types of medicine practiced (Hoang & Erickson, 1982). Western medicine, introduced by the French in the 19th century, is practiced in large urban areas. Indochinese modern medicine, a variant of traditional Western medicine, is also derived from the French. This school of medicine advocated prescribing medicine for symptomatic relief, which is still identified as the main reason Southeast Asian patients go to the doctor. Nguyen (1985) states that Vietnamese prefer "drastic treatments" and believe that injections are better than medicines given by mouth. He notes that many Vietnamese may ask for "sea water," i.e., an intravenous administration of 5% dextrose in water, as treatment of illness.

All kinds of medicines have been imported from the West to Southeast Asia and are available over the counter. Herb medicines are considered "cold" whereas Western medicines are generally classified as "hot" and are thought to be very potent. This may cause Southeast Asian patients to decrease a prescribed dose, believing that it may be too strong (Tung cited in Muecke, 1983b). This belief may have some credence; as discussed in Section III, some studies have documented a greater sensitivity to medication for Asians as compared to Caucasians. Additionally, practitioners should be aware that water is considered to be "cold" and a sick person may restrict fluid intake to avoid creating an imbalance (Calhoun, 1986).

The third kind of medicine in Southeast Asia is traditional medicine, which includes Chinese and folk medicine. Folk medicine combined folklore with Chinese and medieval French beliefs. Hoang and Erickson (1982, p. 712) comment, "Explanation of disease is either naturalistic (blaming bad wind, for instance), supernaturalistic (influence of gods, demons, spirits) or metaphysical (hot/cold theory) or a combination of all three." Similar to the Chinese, Vietnamese believe that health results from a balance between am (Yin) and duong (Yang) (Calhoun, 1986).
Muecke (1983b) notes that Southeast Asians have traditionally dealt with illness through self-care and self-medication as a result of having had access to most drugs over the counter at low cost, of having few hospitals and physicians, and of the high cost of Western medical care. She describes the four major forms of self-care: offerings to the spirits; maintenance of hot/cold balance; use of herbal medicines; and dermabrasive techniques. Dermal practices include "cupping," in which a cup is heated and placed on the skin: "as it cools, it contracts, drawing the skin and what is believed to be excess energy or wind or toxicity into the cup." Other dermal practices include: rubbing a lubricated coin or spoon over the skin ("coining") to "bring toxic wind to the surface" which also usually produces symmetrical lines of abrasions on the back, pinching, and burning of the skin to compensate for "heat" that is lost (p. 437).

The study of older Cambodian refugees in San Jose found that most of them practice "coining" but few practiced "cupping" (Handelman & Yeo, 1996, in press). Most (79%) combine both Western and Southeast Asian therapies to restore health, including coining, religious ceremonies, acupuncture, and herbs. The 76 older men and women cited both traditional Cambodian beliefs to explain their symptoms such as: "sadness from thinking too much" (see Section III under "Explanatory Models"); imbalance in the four elements of the body--wind, soil, fire, and water; wind illness; Saasey, or a misalignment of the vessels or organs; karma; soul loss; and astrology.

In a small study conducted in Hawai'i to explore Vietnamese attitudes toward dementia, participants indicated that dementia was not a major concern because children have an obligation to care for aging parents under any circumstance. The Vietnamese language provides a range of indigenous terms to delineate the culturally perceived differences in talking about dementia. Participants cited "lang tri" or "dang tri" to describe the slow cognitive decline in Alzheimer's disease, and "mat tri giac" for an episode of acute confusion. These expressions are to be differentiated from "lu lan", the cognitive deficit associated with mental retardation, and "binh tam than," a behavior associated with mental illness (Braun, Takamura, & Mougeot, 1995).

Although the preceding information applies to Vietnamese and Cambodian refugees, Brainard and Zaharlick (1989) distinguish Laotian refugees, particularly the Hmong refugees, from the other groups of Southeast Asians. Unlike the other groups which have health beliefs based on humoral balance or that are naturalistic, the Hmong believe that illnesses are due to "...loss of soul or offence of spirits" (p. 849). Many souls (3-32 according to regional traditions) live in the Hmong body. More commonly, three major souls and three shadows of each major soul is the standard number. A person becomes ill when the soul temporarily departs from the body. In death, one major soul goes directly to heaven and returns to watch over the family; the second eventually reaches heaven and is reassigned to earth as another person or entity; and the third remains at the gravesite (Bliatout, 1993). Because of this belief system, traditional healers would use techniques including blowing to expel evil spirits, or communicating with the spirit world to "bargain" on behalf of the patient. Buddhism is important in Lao
health beliefs, in contradistinction to other Southeast Asian groups. Buddhist monks were consulted to treat broken bones, mental illness, and to prevent illness “by blessing the individual at a ceremony in which strings are tied around the wrist or neck to ward off evil spirits” (p. 847). Another reason that traditional healers would conduct rituals that included tying strings on a patient’s wrist was to bind the sick person’s soul in the body to prevent soul loss (Muecke, 1983b).

Other explanations of illness by the Hmong include: the mandate of life, organic causes, supernatural or metaphysical basis, and magical origins. It is believed that each person has a predetermined existence and illness and time of death is part of this mandate. The Chief of Gods allot time to people and gives them a "paper" to be on earth with a specific clan or family. There are also illnesses resulting from obvious causes such as food poisoning, chicken pox, arthritis, injury, and the like. However, understanding of anatomy and bodily functions is shallow and usually limited to those aspects that are visible. Mental disorders may be associated with nonvisible parts of reality. Violation of a religious or ethical code or displeasing a deity or the spirits may bring about symptoms. The spiritual world consists of ancestral spirits, house spirits who dwell in the home, nature spirits, and evil spirits. These spirits are embedded in the traditional lifestyle of the Hmong. Other illnesses may also be inflicted on a person or oneself when a person learns magical curses. Acquiring the skill is often discouraged because perpetrating it is almost inevitable (Bliatout, 1993; Gupta, 1995; McLinnis et al., 1990; Moua, 1995).

Southeast Asian patients may prefer an Asian service provider even if the provider cannot speak the particular Southeast Asian language. Muecke (1983a) warns, however, that because of political differences, persons from Laos and Cambodia might not want to have a Vietnamese provider.

**Pacific Islanders.** Much of the information in this section comes from Cross-Cultural Caring: A Handbook for Health Care Professionals in Hawaii, (Palafox & Warren, 1980) that was written by medical students at the University of Hawaii School of Medicine. As has been mentioned before, Pacific Islanders have a shortened life span and a long history of domination by Westerners. For these reasons, traditional health care practices may not be as common among the elderly as they are in other APIA groups.

For Pacific Islander elders, it is important to show respect. There are topics that are considered shameful or “taboo” to discuss by many Pacific Islanders. Included is anything regarding sexual intercourse, genitalia, venereal disease, and mental health problems. In ancient Hawai‘i, ill health was considered a punishment for wrong doing and often accepted. In certain cases, priests would intervene using rituals, chants, therapeutic massage, and herbal remedies (Chang et al., 1980). Because of the small number of native Hawai‘ians and their long history of being politically and socially dominated by the United States, traditional health practices generally are not observed and are being forgotten.
Ishikawa found in his 1978 survey of Samoan elders in San Diego that barriers to health care included the lack of understanding of medical services, the fear and embarrassment of illness which "...may mean the admission of personal failure," and use of folk medicine. In Samoa, there are at least two kinds of native healers (Fiatoa & Palafox, 1980; Ishikawa, 1978). The *foma'i* are the "old ladies" of a family who only take care of members of their own families. The *faival* are the medicine men, or "bush doctors" who employ dances, incantations, herbal remedies or therapeutic massage to treat. The generic term for the treatments is *fofo*.

Fiatoa and Palafox (1980) note that the Samoans are a religious people. "Even in the incantations of a *fofo*, the words 'In God's name' are either uttered, repeated, or implied." They explain that in the treatment of illness, first the local remedies are tried, then the bush doctor, the pastor, and finally the doctor. Many times, the decision to call upon professional health personnel is left to the pastor. Treatment consent by a patient or family often first must be approved by the pastor before the family will give its approval. In Samoan thinking, painful experiences are accepted to be "whatever God wills". Death is a natural element of the experience of living. This attitude and the acceptance of eventually replacing family members in their family roles are useful in coping with loss and bereavement (King, 1990).

Tongan traditional folk healers are called *taula tevolo* and are considered intermediaries between spirits and the people. The healers use herbal medicines and rituals to cure disease and pass this information down a single family line (Puloka & Palafox, 1980).

In the Chamorro culture as seen on Guam, the *suruhana* is the traditional healer who also employs both herbal medicine and ceremonial rituals as treatment. Sickness could be caused by possession by ancestral spirits as a form of punishment for violating cultural taboos. *Suruhanas* inherit the ability to communicate with these spirits in order to plead for forgiveness (Jose et al, 1980).

**CONCLUSIONS**

Based on the descriptions above, it is clear that there is both strong overlap among the Asian and Pacific Islander beliefs about health and illness as well as distinctive traditions unique to particular cultures. Although health care providers may feel overwhelmed with the complexity of trying to remember the differences between groups, it may be more important just to try to remember that there may be unique explanatory models of illness operating in one's patients that affect their health care utilization and compliance with treatment recommendations, and remember where the sources of information are for the details when they are needed. Another lesson from the research reviewed in this section is that acculturation is a very important variable to take into account when assessing health beliefs, and one cannot always assume that length of time
in the U.S. is the most important predictor of acculturation, especially among elders who have interacted primarily with others from their country of origin.
PART V

FUTURE IMPLICATIONS

Based on the variability and inadequacy of the information available on the health, health care, and health-related cultural beliefs of Asian and Pacific Islander Americans in general, and elders in particular, many crucial gaps still need to be explored. Although some critics may argue the value of studying the relatively small numbers of older adults that comprise the various subgroups within the APIA category, it is important to keep in mind the fact that these populations are the fastest growing of any of the ethnic geriatric categories.

RESEARCH

At a conference sponsored by the Office of Minority Health of the National Institutes of Health to establish priorities for research and research training with APIA populations in January, 1996, the consensus focused on making community based research a top priority. Emphasis was on full community participation and researchers who come from the ethnic group being studied or who have understanding and sensitivity to the culture. Participants called for developing research designs that accommodate small population size without sacrificing scientific rigor.

New approaches are also necessary to incorporate the cultural perspective of the group being studied. Dr. Neil Kohatsu (1996) points out that most of the health information on APIAs were collected within the context of a Western research design. Understandably, because of its built-in bias, the Western interpretation and conceptualization of data are end results. Such interpretation would naturally lead to Western solutions. This perspective has been expressed in many ethnic communities to explain unsuccessful interventions, which were in some cases, extremely costly.

With the increasing numbers of Asian and Pacific Islander Americans of varying generations of immigration and varying degrees of assimilation, our understanding of their health care needs as they age will be greatly enhanced if we build into our conceptual model a perspective which reflects generation and cohort of assimilation (Yeo & Hikoyeda, 1992). This would allow for an examination of the effects of culture, environment, and biological factors on health status. Although the major longitudinal studies of the prevalence of cardiovascular disease and diabetes among Japanese populations have included these types of analyses, reference to assimilation status is lacking in most of the smaller and/or cross-sectional studies of APIA health.

In ongoing longitudinal studies, attention should be directed to identifying cultural factors that help explain the differences between APIA and white elders in the prevalence of certain diseases, such as various types of cancer, diabetes, vascular dementia, and hemorrhagic stroke. Those studies that are already in progress should be continued and
expanded. The major contributions that the Honolulu Heart Study has made to understanding not only heart disease, but stroke, effects of acculturation on health status, and now cancer, dementia, and caregiving, are convincing evidence for the effectiveness of carefully nurtured and continuing longitudinal research among an APIA population.

Research on effective clinical strategies with different ethnic populations, taking into account their different cultural beliefs and traditions relating to health and health care, would be an important and potentially fruitful method of applied research which could help reduce the identified barriers some APIA elders face. Questions such as the effectiveness of managing chronic diseases incorporating some strategies from APIA traditions, such as herbal therapies or various forms of therapeutic touch would add considerably to the fund of knowledge. Every aspect of ethnogeriatric research should be done always keeping in mind, however, the heterogeneity within the ethnic groups and the different places on the continuum of acculturation occupied by elders from the same ancestry. Support for research projects exploring methods for integrating these approaches into new models of health care delivery, such as managed care, should be a priority.

As consumers of research, educators, providers, and researchers themselves are all encouraged to be vigilant in differentiating and evaluating information when it categorized as "Asian Pacific Islander" or "Asian American" data. Often subjects used in studies may come from one or two groups with little or no representation of other APIA subgroup. Generalizing findings to elders in the whole APIA may lead to misleading and clinically ineffective conclusions.

ETHNOGERIATRIC CARE

In this period of changing health care delivery systems where managed care seems to be the system of choice, emphasis on health promotion through community health services, short hospital stays, and increased dependence on home care could create major difficulties for ethnic elders and their families. As discussed in various sections of this paper, delayed health access, distrust of the formal systems, preference for non-medical approaches to health promotion, and reliance on family support as frailty sets in are behavioral patterns found among some APIA groups which will require thoughtful and innovative interventions.

It is an important value among most APIA families that elders should be cared for by the family if at all possible. Seeking outside help is rarely an option considered for many families. This group orientation serves to maintain the elder’s and family members’ definition of the self in terms of interdependency, in-group sharing, involvement with family members’ lives, or impact of one’s action on the collective, i.e., the family (Triandis, 1994). Collectivism, or group orientation, among traditional APIA communities pose a major challenge to the Western health care system which is highly individualistic in its approach. However, as cost cutting of health care dollars continues and families
are expected to take over where formal care ends, ethnic families' resources may already be exhausted at that point. Thus managed care as it is being designed today could rapidly deplete the limited informal resources of collectivist cultures such as those among APIA ethnic groups. This potential consequence requires an examination and further development of culturally appropriate strategies for supporting APIA families who care for frail elders.

A related issue in this situation, however, is the need for clear and accurate communication between the providers and older patients in the context of an open and trusting relationship. Even if the language barriers could be overcome, it would be very difficult for providers to establish effective communication and trusting relationships without some knowledge of the cultural factors affecting the APIA elders' expectation of the clinical encounter. These include such factors as the importance and the methods of showing respect for elders in greetings and the discussion of symptoms; customs of privacy and touching in physical examinations; the influence on decision making concerning compliance with recommended treatments of issues such as beliefs about the relative power of various forms of medication, or life sustaining treatments.

Methods of approaching the enormous challenges of cross-cultural understanding in the health care encounter need to be tried systematically and used to improve the current model where culture is rarely considered in the encounter. Methods such as those suggested by Johnson, Hardt, and Kleinman (1995) or Berlin and Fowkes (1983) may help to cross the gulf and spin off new and more effective clinical models if they are tried on a large scale. Progress on this front, however, requires rigorous evaluation of the new clinical communication strategies as they are being implemented.

The differential utilization patterns of various types of health care by the various older ethnic populations should continue to be explored in an effort to apply their findings to reduce the massive array of impediments to health care confronting APIA elders, especially the 70% who are foreign born. The large number who report that they have no primary care provider are particularly vulnerable to being ignored for health promotion and disease prevention care and are, potentially, users of high cost emergency care.

Another significant concern is providing the needed levels of appropriate long term care in the decades to come for this growing population. As the traditional cultural values regarding care of the elders by their adult children continue to weaken, the question for planners is whether or not the rates of use of institutional long term care will become similar to those in the mainstream society. The evidence presented in this review suggests that Asian elders find the cultural issues to be significant barriers to nursing home care. While there are a few culturally-oriented long term care services for Japanese and Chinese elders on the East and West coasts, it seems doubtful that most frail elders will have the opportunity to be cared for in a setting targeted specifically to elders from their own background. These tend to be excellent models of care with strong emphasis on ethnic community representation on the governing and administrative structure as well
as in volunteer services in the programs. Even if all communities with APIA elders who need long term care services cannot duplicate these model programs, perhaps general community long term care services can learn from their method of implementing culturally sensitive care.

In the overall future perspective, one of the most important implications for health care providers of the changes that first generation APIA elders are experiencing in their American homeland is the potential for depression and lack of access to care due to unrealized expectation that their adult children will meet all their needs. Since independence of the generations is antithetical to the traditional concepts of filial piety and obligation to one's elders, the assimilation process brings its own risks. It is hoped that the sensitive geriatric providers of the future can be trained to identify these and other potential risks, and, if the promise of future progress in an increased knowledge base is realized, they will also be trained in culturally appropriate intervention strategies for improved health of the future generations of Asian and Pacific Islander American elders.

ETHNOGERIATRIC EDUCATION

In the coming decades, health care providers will need training not only in the traditional aspects of geriatric care, but also on the continuing and emerging issues related to the care of elders of color and their families, including APIAs. Hospitals and other health care agencies are already expected to demonstrate competence in geriatrics as well as caring for ethnically diverse populations in order to be fully accredited, so the need for training in these areas is imminent.

Recommendations for geriatric training in cultural competence were developed as one part of a process to prepare for the future in multidisciplinary geriatric education. The Bureau of Health Professions of the Health Resources and Services Administration in the U.S. Public Health Service chose nationally prominent geriatric educators to work on eleven study groups to identify issues and develop specific recommendations for disciplines and issues in geriatric education. Ethnogeriatrics was one of the study groups which prepared White Papers used as the basis for the National Forum for Education and Training conducted in the Spring of 1995 "to set a national agenda for action on geriatric education for all those who provide health care for older adults" (Klein, 1995). The recommendations for Ethnogeriatrics training include an emphasis on core curriculum knowledge and applications skills such as historical experiences of ethnic cohort groups, assessment of intercultural dynamics, use of translators, and working with ethnic families in medically related decision making processes. Health care professional licensing and accrediting organizations are being advised to incorporate ethnogeriatrics in their requirements to expedite the needed improvement in geriatric services. A copy of the Ethnogeriatrics White paper including the curricular recommendations is available from the Geriatric Initiatives of the Bureau of Health Professions [FAX: (301) 443-1164].
Another dimension of training is multicultural dynamics in many work environments where ethnic diversity among professional and non-professional health providers is fast becoming the profile of a health care workforce. In many long term care settings, the complex interaction of work behaviors, ethnic diversity, and social class can be a prime opportunity to create a culturally responsive setting for APIAs and other ethnic elders. Supportive institutional policies and innovative, culturally sensitive staff development programs have the potential to penetrate the cloak of indifference or denial.

While there appears to be a strong preference among APIAs to train as health professionals, creating a cadre of bilingual bicultural health providers requires additional steps. The Ethnogeriatrics Study Group of the National Forum for Geriatric Education and Training emphasized the need for recruiting and training faculty and providers from diverse ethnic backgrounds to serve the rapidly growing population of elders of color. This is especially true for APIA elders, since they are the category that is increasing most rapidly and have the largest number (70%) of individuals who are foreign born. Bilingual and bicultural faculty and providers trained in ethnogeriatrics can not only improve the care for elders from their own cultural background, but they can also be a major source of positive cross-cultural educational experience for mainstream members of faculty or health care teams to interpret and advocate for ethnic elders and their families. There is a serious need for cultural guides in most educational and health care settings.

Education can also lead to new or modified behaviors that reduce elders' health risks and, potentially, health care costs. As managed care systems expand their visions to the family and community to reduce health crises and hold down health care costs, designing educational programs for APIA elders, their families, and the local APIA community can be expected to increase. Information summarized in this working paper can be useful not only to develop content for professional health care programs but also as a resource for the APIA community. Translating the information into culturally relevant content appropriate to the APIA learner could be an educational process, in and of itself. Although the education we experienced at the Stanford Geriatric Education Center is more than memorable as we worked on this second edition, the power of the information embedded within the pages of this resource can only have far reaching effects through the future if users of this knowledge from different health care disciplines and perspectives work together in partnership to transform and improve the care for APIA elders.
REFERENCES


Moua, H. V. (1995, June 2). Hmong culture, traditions, and beliefs. Paper presented at the conference: Enhancing the Provision of Care for Hmong Elderly, at University of Wisconsin-Eau Claire Davis Center, Eau Claire, WI.


Muller, J., & Desmond, B. (1992, September). Ethical dilemmas in a cross-cultural context: A Chinese example. In J. C. Barker & M. M. Clark (Eds.), Cross-cultural medicine--A decade later [Special issue]. Western Journal of Medicine, 157(3) 323-327.


Northern California Cancer Center. (1996). Greater Bay Area Cancer Registry report: A Publication of the Northern California Cancer Center [Newsletter], 6(1), 1-6.


## CURRENT AND FUTURE ETHNODOGERIATRIC MATERIALS

### A. SGEC WORKING PAPER SERIES AND OTHER PRINTED RESOURCES

<table>
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<tr>
<th>1. Ethnogeriatric Reviews: State of the Literature Summaries</th>
<th>Price</th>
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<tbody>
<tr>
<td>a. Aging and Health: American Indian/Alaska Native Elders</td>
<td>$12.00</td>
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<td>b. Aging and Health: Hispanic American Elders</td>
<td>$12.00</td>
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<td>c. Aging and Health: African American Elders</td>
<td>$12.00</td>
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<tr>
<td>d. Aging and Health: Asian and Pacific Islander American Elders</td>
<td>$12.00</td>
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<th>2. Monographs</th>
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<td><strong>5. Ethnogeriatric Curriculum for Different Disciplines: (1996 New Releases)</strong>&lt;br&gt;Medicine, Nursing, Nutrition, Psychology, Rehabilitation, Social Work and General Health Professions (See Ethnogeriatric Curriculum List)</td>
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<td></td>
<td>2. “The Need for a Culturally Competent Model of Long Term Care,” Lecture by Gwen Yeo, PhD, in AARP Series on Ethnicity and Long Term Care, 1997.</td>
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For additional information about SGEC activities, materials, or bibliographic searches, please call (650) 494-3986 or Fax (650) 494-3617. To order the above materials, circle the item(s) desired, indicate quantity on the line provided, and return with payment to: Stanford Geriatric Education Center, c/o VAPAHCs, 3801 Miranda Avenue, Building 4, (182B-SGEC), Palo Alto, CA 94304.

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<table>
<thead>
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<th>Discipline</th>
<th>Title</th>
<th>Author(s)</th>
<th>Year</th>
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<tr>
<td><strong>A. MEDICINE</strong></td>
<td>Health Care for Ethnic Elders: Health Status, Communication, and Ethics: A curriculum in Ethnogeriatrics for Physicians in Training</td>
<td>Terry Hill, MD</td>
<td>1996</td>
<td>$16.00</td>
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<tr>
<td><strong>B. NURSING</strong></td>
<td>“Ethnogeriatric Nursing in the Context of Rehabilitative Care: Caring for the Emerging Minority,”</td>
<td>Irene Daniels Lewis, RN, DNSc, FAAN and Melen McBride, RN, PhD</td>
<td>1996</td>
<td>$7.00</td>
</tr>
<tr>
<td></td>
<td>“Introduction to Ethnogeriatric Nursing Care Principles, A Curriculum Module for Nurse Assistant, Vocational Nurse, and Associate Degree Nursing Programs,”</td>
<td>Ruth Madalena, MA</td>
<td>1996</td>
<td>$7.00</td>
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<td></td>
<td>“Ethnogeriatric Module for Family Nurse Practitioner and Physician Assistant Programs,”</td>
<td>MaryEm Wallace, PhD, RN, FNP and Melen McBride, RN, PhD</td>
<td>1996</td>
<td>$10.00</td>
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<td><strong>D. REHABILITATION</strong></td>
<td>“Concepts of Eldercare and Ethnogeriatric Rehabilitation,”</td>
<td>Lela Llorens, PhD, OTR, FAOTR</td>
<td>1996</td>
<td>$10.00</td>
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### E. SOCIAL WORK
“Ethnogeriatric Social Work: An Ecological Model for Practice,” Juliette S. Silva, PhD, 1996. $10.00

### F. GENERAL HEALTH PROFESSIONS
“Eldercare in a Multicultural Society, a Model Course for Health Professions Students,” Debra David, PhD, 1996. $7.00

### ADDITIONAL GERIATRIC RESOURCES

| H. Demographics & Health Risks of Ethnic Minority Elders: A Curriculum Module Resource Packet, Gwen Yeo, PhD, 1996. | $10.00 |
| J. Core Curriculum in Ethnogeriatrics, Second Edition. Developed by the members of the Collaborative on Ethnogeriatric Education. October 2000. | $20.00 |
| K. Ethnic Specific Modules for the Ethnogeriatric Core Curriculum Second Edition. | $35.00 |

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