A young girl with dark hair, wearing a red vest over a white shirt, is smiling and looking out from a window. The window has a traditional wooden lattice pattern. The background is a light-colored wall.

# Health Care for All

Health Access Recommendations for Asian Americans in Illinois  
By Asian Americans in Illinois

October 2005

Prepared by the Asian Health Coalition of Illinois

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The project is funded by IDPH through the initiative of Dr. Eric Whitaker, in collaboration with the South Asian American Policy and Research Institute, the Asian American Institute, and the Asian & Pacific Islander American Health Forum.

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## Executive Summary

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The purpose of this project is to identify the health access needs and disparities facing Asian Americans and Pacific Islanders (AAPIs) in Illinois and to make policy recommendations to reduce these disparities. This project is funded by the Illinois Department of Public Health (IDPH) Center for Minority Health and conducted by the Asian Health Coalition of Illinois in collaboration with the South Asian American Policy and Research Institute (SAAPRI), the Asian American Institute, and the Asian and Pacific Islander American Health Forum (APIAHF).

On-line surveys and in-depth telephone and face-to-face interviews were conducted by SAAPRI with key informants from 20 community-based organizations and service providers. The surveys and interviews addressed client demographics, health access barriers, and policy recommendations. We also asked key informants to provide client stories that illustrate specific health access barriers.

Key informants identified the following health access barriers for AAPIs:

- Language barriers
- Lack of health insurance
- Low income
- High cost of prescription drugs
- Cultural barriers
- Transportation barriers

Policy recommendations include:

### **Access**

- Cover all Illinois residents, regardless of length of stay in U.S., documentation status, and employment status.
- Require comprehensive coverage, including prescription drugs, preventive screenings, alternative medicines, and dental and mental health services.

### **Quality of Care**

- Increase the number of bilingual health care providers who are bilingual and culturally competent.
- Enforce national and local health interpretation requirements.

### **Consumer Participation**

- Include AAPI participation in the Adequate Health Care Task Force.
- Appoint AAPI consumer representatives to Illinois health policy commissions.

### **Small Business Participation**

- Develop affordable coverage options for small businesses.

## **Data**

- Require the collection of disaggregated AAPI ethnic group data by hospitals, clinics, and health systems.
- Require regular review, publication, and dissemination of disaggregated AAPI health data.

## **Suggestions for the future**

The project clearly demonstrated the need to conduct a more comprehensive, detailed, and comparative assessment of the access to health barriers experienced by AAPIs in Illinois. This was obvious from the wealth of information offered by the key informants, the complex nature of the barriers and the recommendations offered.

The primary limitations on the project were the limited availability of time and the lack of ethnic specific and client level information. Working with an aggressive timeline of three months was difficult given the constraints of the service agencies which are understaffed and have multiple demands on their time.

The project relies on the perceptions of the interviewees who are experienced in providing services in the community. However, it is not uniformly grounded in data, which is primarily due to the limited time available to gather the information. For instance, while some key informants reviewed their existing data or research to respond to the questions others used their observations. In order to better quantify the learning from the project, it would be important to follow up with some detailed analysis of data collected by the agencies over a fixed period.

The project relies on anecdotal information through client narrated stories for client specific information. These are important to provide context and reality to the project. However, it would be important to get client level data on barriers to accessing healthcare services through surveys, interviews and focus groups to get a better understanding of the barriers as well as to get some recommendations.

Finally, it is important to review policy and legislation from other states as a benchmark to the recommendations made in this brief. This would provide a compelling argument for policy makers and legislators in Illinois to promote policies that are creative and consider the welfare of minority groups such as AAPIs without compromising the greater good. It is also necessary to flesh out the recommendations that are provided in this brief, to make them more specific. For instance, it would be useful to understand the cost-benefit analysis of some of the recommendations; to look at the geographic areas for filling gaps in specific services such as Federally Qualified Health Care Centers; provide detailed recommendations for targeted areas of funding and so on. To provide this level of detail would mean additional time and information collection and analysis.

## Project Purpose and Overview

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The purpose of this project is to understand and document the needs and the disparities to accessing health care among Asian American and Pacific Islanders (AAPIs) in Illinois.

This project is funded by the Illinois Department of Public Health in collaboration with the Asian and Pacific Islander American Health Forum, and conducted by the Asian Health Coalition of Illinois.<sup>1</sup> Surveys and interviews were conducted with an ethnically diverse group of key informants who represent a wide cross-section of the Illinois AAPI population. This brief, based on their input, is a step in the broader goal to reduce AAPI health access disparities in Illinois through the implementation of the Health Care Justice Act.<sup>2</sup> It will be used to educate AAPI community leaders and service providers on the project findings, and inform public health and legislative leaders on policy recommendations.

The coordinator of this project is the South Asian American Policy and Research Institute. This project was conducted under the guidance of the AAPI Health Access Policy Committee comprised of **healthcare professionals**, researchers, policy advocates and community leaders. They provided input on survey and interview questions as well as on the written report and recommendations generated by this project. Initial findings and key recommendations were presented at the Public Hearing of the state's Adequate Health Care Task Force held on October 5, 2005 in Chicago.

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<sup>1</sup> The project is funded by IDPH through the initiative of Dr. Eric Whitaker, in collaboration with the South Asian American Policy and Research Institute, the Asian American Institute, and the Asian & Pacific Islander American Health Forum.

<sup>2</sup> See Appendix for the Principles of the Health Care Justice Act

## **Methodology and Report Structure**

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On-line surveys and in-depth telephone and face-to-face interviews were conducted by the South Asian American Policy and Research Institute (SAAPRI) with key informants from 20 community-based organizations and service providers based in Illinois. The surveys and interviews probed into client demographics, available programs, health access barriers, and policy recommendations. We also asked key informants to provide client stories that illustrate specific health access barriers. Please see Appendix for the on-line survey, interview questions, and client story form.

Key informant organizations were selected on the basis of their experience in serving AAPI communities and on the basis of ethnic and geographic diversity. While we attempted to reach as broad a spectrum as possible of the AAPI population in Illinois during the time frame of this project, this report is limited to the perceptions of these 20 service providers, which does not include all the AAPI service providers. From all accounts, there is a significant portion of the AAPI community that does not utilize any services, even from ethnic community-based organizations; unfortunately, their voices are not reflected in this report. We did include the voices of AAPI health care consumers in the client stories, which are interwoven into this report narrative.

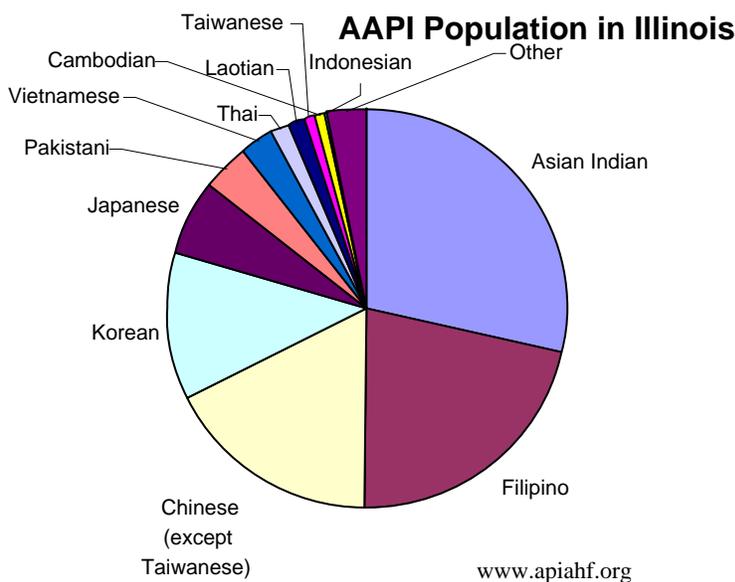
In addition to the survey and interview findings, this report includes a section on national and local AAPI socioeconomic data in order to provide the context for a deeper understanding of the community. The findings were reviewed by the members of the Health Access Policy Committee, who helped further expand upon the policy recommendations made by the key informants.

## A Snapshot of Illinois' AAPI Population

AAPIs are among the fastest growing minority groups in the U.S. population, growing 48% between 1990 and 2000. At present, there are nearly 13 million AAPIs nationwide representing about 4% of the total population. By 2050, they are expected to be about 11% of the U.S. population.<sup>3</sup>

The key demographic feature of the national AAPI population is its diversity. An overwhelming majority of the AAPI population is accounted for by six major sub-groups: Chinese, Filipino, Japanese, Asian Indian, Korean and Vietnamese.<sup>4</sup> But the entire AAPI population is estimated to comprise forty-nine diverse groups and over a hundred different languages.

There is a high proportion of immigrants in the national AAPI population (about 70% are foreign born), and a significant number of them live below the poverty level (14%), are uninsured (17%), and cannot speak English fluently (40%). There is also a high percentage of refugees among AAPIs, especially from southeast Asia.



Both in terms of their demographics and socio-economic profile, the same patterns that apply at the national level are relevant for AAPIs in Illinois.

At the state level, AAPIs represent the second fastest growing minority group in Illinois after Latinos. The Illinois AAPI population is now around the half million mark (485,497 in the 2000 census) and represents 3% of the state's population. (See figure alongside for a breakdown of the AAPI

population in Illinois.)

### *Socio-economic disparities*

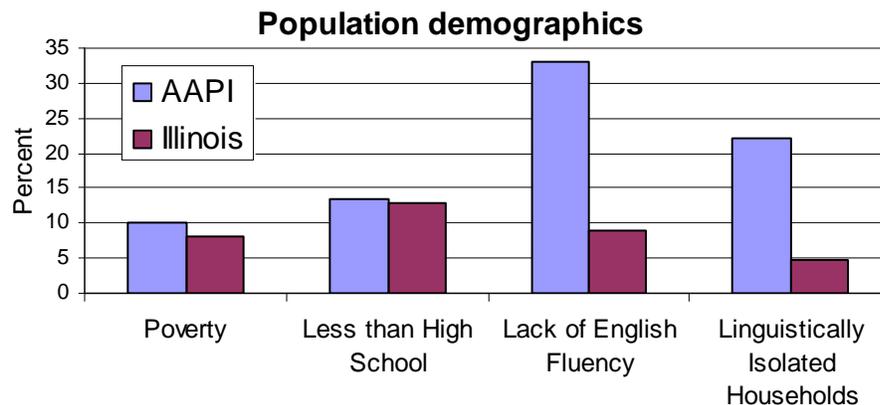
While AAPIs are frequently viewed as a monolithic problem-free “model minority”, in fact this is a diverse population comprised of ethnic groups with very different profiles in terms of income, education, and language proficiency. With regard to income, about 10% of AAPIs and 8% of Illinoisans live below the federal poverty line, but for AAPI groups including Vietnamese, Thai, Koreans, and Pakistanis, the poverty rates are higher, ranging from 13% to 16%. In the city of Chicago, nearly one-third of Koreans live in poverty, the highest rate for any ethnic or racial group. In addition, 7% of Vietnamese

<sup>3</sup> [www.epa.gov](http://www.epa.gov). Website of EPA AAPI Official website of the White House Initiative for Asian Americans and Pacific Islanders.

<sup>4</sup> All these major sub-groups, and more, are represented in this project.

and Cambodians in Illinois are receiving public assistance, more than double the rate of the general U.S. population (3%).

Education data also reveal this diversity. While 13% of AAPIs in Illinois have less than a high school degree, the numbers increase to 16% for Pakistanis, 20% for Chinese, and 34% for Vietnamese, compared to 13% of the white population. Language proficiency also varies widely between AAPI ethnic groups; 44% to 57% of Cambodians, Chinese, Korean, Thai, and Vietnamese speak English “less than very well,” compared to 33% of AAPIs as an aggregate group and 9% of the total Illinois population. About 22% of Illinois AAPIs live in linguistically isolated households, meaning that no one age 14 or older speaks English well.



These data as illustrated by the graph above indicate that certain AAPI ethnic communities are likely to be more vulnerable than the general Illinois population to health access disparities.

#### *Geographic factors*

Geographic concentrations are yet another factor in health access for AAPIs. Many AAPI groups in Illinois including sizeable numbers of Chinese, Vietnamese, South Asians and Koreans reside in neighborhood enclaves in the city of Chicago, so the rise in Chicago’s poverty rate, from 19.3% in 2003 to 21.1% in 2004 is a cause for concern among Asian Americans in Illinois.<sup>5</sup> The poverty rate in Chicago continues to be well above the poverty rate for the entire state. In Cook County (which includes Chicago and suburbs), too, which contains more than 60% of the state’s Asian American population (262,731 AAPIs); poverty rates went up from 12.7% in 2000 to 14.6% in 2004<sup>6</sup>. Because of their geographic concentration in inner city urban areas, which are generally underserved by healthcare professionals, AAPIs tend to be underserved as a group.

Available data reveal that AAPIs both at the national level and in Illinois, experience lack of access to regular health care, are less likely to be satisfied with their care, have fewer preventive services, poorer quality care and higher disease incidence than other sections of the American population. **In Illinois, 17% of the non-elderly AAPI**

<sup>5</sup> U.S. Census Bureau, American Community Survey, 2000-2004

<sup>6</sup> Ibid.

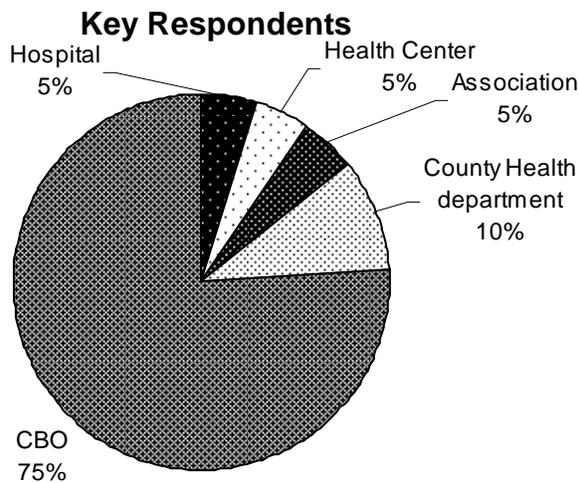
population is reported to be uninsured in comparison to 10% for Whites.<sup>7</sup> The actual number of Asians who have very limited access to healthcare remain to be determined. It is against this background that this project investigates current conditions of AAPI health access disparities in Illinois.

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<sup>7</sup> *Minding the Gap: An Assessment of Racial Disparity in Metropolitan Chicago*, The Human Relations Foundation/Jane Addams Policy Initiative, Chicago, 2003.

## Profile of Key Informants

Twenty key informants were contacted for this report. These sources are a fraction of the number of AAPI serving organizations in Illinois, but include most of the largest AAPI ethnic serving agencies. The majority of the agencies were located in Chicago, with one in Wheaton, two in Rockford, one in Elgin, one in Urbana, and another in Germantown Hills, Illinois. Among the ethnic groups served were Cambodian, Chinese, Filipino, Japanese, Laotian, Korean, Vietnamese, Taiwanese, South Asian (Indian, Pakistani, Bangladeshi, Sri Lankan, Nepalese, Bhutanese,) Middle Eastern, Russian, Eastern European, African, African American and Hispanic. The agencies reported serving a total of 137,665 clients during Fiscal Year 2005. The clients were from the Chicago metro area, including Cook and DuPage counties, and other areas in Illinois, such as Elgin, Rockford, Peoria, Urbana and DeKalb.



### *Programs and Services*

The programs and services most widely offered by the agencies in this project are Health Care and Health Education Services and Senior Services, followed by Immigration and Citizenship services, Employment services, Literacy/ESL, and Legal Aid Services. Other services offered are in the field of elementary education, domestic violence, food distribution, language and vocational training, counseling, homemaker services, family and community, housing, and chef training. The wide range of services offered indicates that there are many other demands besides healthcare that these agencies have to meet with their limited resources.

The healthcare services are generally targeted toward women, children, seniors and people of all age groups who are eligible for Medicare, Medicaid, KidCare and FamilyCare and those without medical insurance. While most organizations said their healthcare programs were used to full capacity, many also said they were underutilized due to lack of personnel, transportation and translation difficulties, and processing problems.

An overwhelming majority of the clients served by these organizations have been in the U.S. ten years or less, and more than half have been here around five years or less. So it is not just the very recent immigrants who are using healthcare and other social services, but even those who have resided in the U.S. as long as 10 years and even 20 years. This would suggest that there is a continuing need for healthcare services in the AAPI population that is not necessarily diminished by length of stay in the U.S.

### *Health issues for AAPIs*

Available studies show that AAPIs have health issues specific to their group. The leading cause of death among AAPIs is heart disease, followed by cancer, stroke and diabetes.<sup>8</sup> They have higher rates of many preventable diseases such as tuberculosis and hepatitis B which are co-occurring factors for more difficult to treat diseases such as AIDS.<sup>9</sup> AAPIs account for over half of the hepatitis B cases and half the deaths resulting from the disease in the U.S. Lung cancer is the leading cause of cancer for Korean, Chinese, and Southeast Asian males, while cervical cancer is commonly reported among Southeast Asian women. AAPIs are 3 to 13 times more likely to die from liver cancer than Whites, with Chinese, Korean and Vietnamese Americans at particularly high risk. Mental health is an emerging concern in AAPI communities with reports of growing numbers of suicides. The stigma associated with mental health issues prevents many AAPIs from seeking care in a timely fashion, resulting in rapid worsening of the problem.<sup>10</sup> Asian American elders are more likely to live in poverty and isolation than their counterparts in the general population. AAPI youth have the highest increase in smoking rates of any ethnic or racial group.<sup>11</sup> These facts underscore the need for better understanding of the health needs of AAPIs.

Our interviews and online surveys of the key informants indicated the health concerns mentioned above are many of the same encountered in Illinois. Almost all of the agencies in this project address the topic of diabetes, heart disease and hypertension, which are the leading causes of death among AAPIs. Most agencies also offer services in the area of nutrition and diet, breast cancer screening and women's health. Cervical cancer screening and domestic violence services are also frequently offered, as are exercise, HIV/AIDS, smoking, hepatitis, and mental health, alcohol and other substance abuse, and prostate cancer. Less than half the agencies offered services in dental care, tuberculosis, and obesity. Other health topics addressed include developmental disability, flu vaccinations, immunizations, osteoporosis, osteoarthritis, arthritis, dementia and Alzheimer's. Given that heart disease, stroke, diabetes, and various kinds of cancers are the leading causes of death among AAPIs, these agencies appear to be focusing on topics that are most relevant and important for their client populations.

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<sup>8</sup> AAPCHO. Association of Asian Pacific Community Health Organizations. [www.aapcho.org](http://www.aapcho.org)

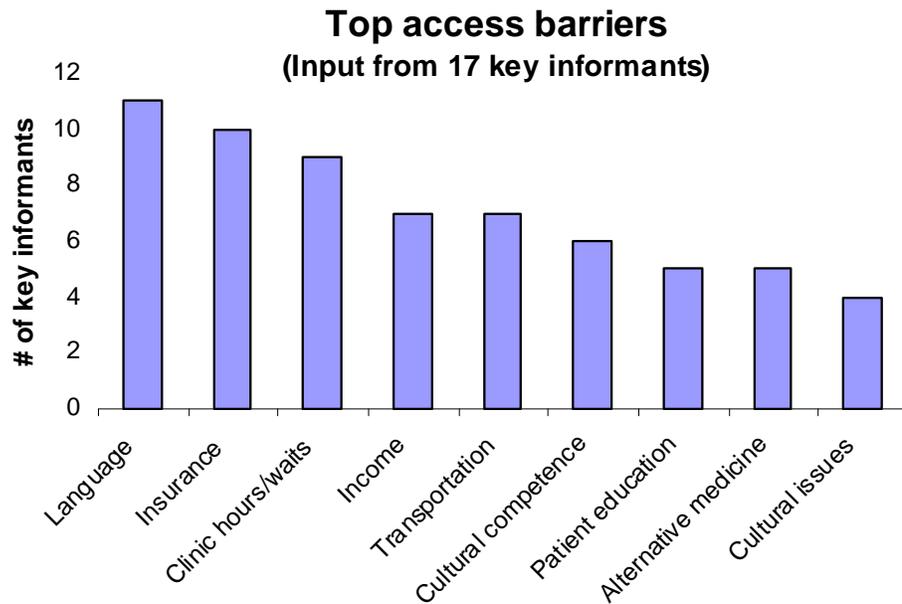
<sup>9</sup> *APIA Health Forum Health Brief*, September 2003, [www.apiahf.org](http://www.apiahf.org)

<sup>10</sup> *Illinois: Emerging Asian American and Pacific Islander Communities. Issues/Needs*, AAPCHO, August 2004

<sup>11</sup> [www.aapi.gov/commission\\_Final\\_Health\\_Report.pdf](http://www.aapi.gov/commission_Final_Health_Report.pdf)

## Findings

The overwhelming majority of the key informants interviewed mentioned **language and cultural competence** as the primary barriers to accessing health care. These were followed closely by **lack of insurance, limited clinic hours, and transportation**. These barriers translate to delayed diagnoses until the situation becomes acute if not terminal in many cases, which results in increased costs for the healthcare system. Many of the people served by the key informants own or work for small businesses, which do not provide health insurance. The employees often have low wages or long hours. Many are reluctant to take time off to attend to their health needs for fear of jeopardizing their employment.



The graph above shows the response to the question regarding health access barriers on interviews, answered by 17 key informants. Each key informant chose three top barriers they encountered which resulted in the analysis indicated by the graph.

*I would like a health clinic that is open on Saturday and had Cambodian interpreter in the health clinic to help me to communicate with my doctor. I usually use my daughter to interpret for me. She born here in the U.S.A. I have problem communicate with my doctor. Transportation also a problem. I can take buses or trains by myself. I fel dizziness, not very comfortable to my surround. Problem I have health. Short memory, stress, trauma, knee pain. Most of all language barrier. I only speak Khmer.*

*---Kheun Kuoy  
60 year-old female Medicaid patient  
Written testimony to Cambodian Association of Illinois  
September 6, 2005*

### *Language Barriers and Interpretation*

Despite federal and state laws that mandate the provision of qualified health interpreter, AAPIs and others with limited English proficiency have greater difficulty communicating with their health care providers than do English-fluent patients. Many AAPIs are not aware of these federal and state mandates, and do not advocate for their own language rights in health care settings. This often results in the use of unqualified interpreters such as relatives and insufficiently trained staff, which can compromise patient confidentiality and quality of care.

All agencies investigated in this project provide services to English speaking populations as well as for their clients who speak the languages of their communities among them Cambodian, Cantonese, Mandarin, Vietnamese, Hindi, Korean, Japanese, Lao, Urdu, Khmer, Spanish, Gujarati as well as 20 other languages and dialects. The linguistic diversity of the Illinois AAPI population is reflected in this variety of language populations served.

On the other hand, the extent and quality of translation and interpretation services provided by health care service providers fall far short of the needs in the community. Most of the organizations we interviewed have the ability to

*There are not enough [interpreters]. South Asian women doctors are available; however the translators are men which make it hard for the Muslim women to talk about their health. Some women bring their children to [interpret] and they are reluctant to talk about issues related to women's health (menstruation, pregnancy). These issues are hard to explain in front of the children.*

*- Sima Quraishi,*

*Executive Director, Muslim Women's Resource Center*

provide interpretation but often do not have the capacity due to the high demand for these services and the limited staff available.

Many AAPIs, especially the elderly and newer immigrants do not understand fully what services are offered, why they are necessary, and where they might go to get them. There are not enough interpreters or literature in Asian languages to explain the services to them. The result is that even where services are available, they might not be accessed.

For our elderly the healthcare situation today is like being in a big river without a bridge. I'm afraid of growing old because there is no quality of care. We need to serve the next group of seniors better.

---Mae Lent

Director for Program Planning, Filipino American Center for Seniors

## Cultural competency

The need for culturally appropriate services is particularly acute in the AAPI community. Going beyond the language and translation barrier, cultural competency has to do with “understanding the diverse attitudes, beliefs, behaviors, practices and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation or generation and acculturation status. Includes an awareness that cultural differences may affect health and the effectiveness of healthcare delivery.”<sup>12</sup>

*A 42 year-old Korean-speaking woman was diagnosed with extensive breast cancer in situ at the end of April 2004. The client had 17 years of formal education in Korea. The client sought her own second opinion from a Korean-speaking surgeon who concurred with the need for surgery and chemotherapy and radiation treatment.*

*The client chose instead to follow an exclusive diet of radish soup she had read about in a book written by a Japanese cancer survivor. She refused western cancer treatment for three months.*

*After three months of the soup diet, the client asked the Breast and Cervical Cancer Screening Program for another surgical opinion which revealed very large breast lump. She believed that the cancer was gone even though the lump was still present and even larger.*

*The Korean doctor later ordered another biopsy, which showed cancer, now infiltrating, and convinced the client of her need for mastectomy and further cancer treatment. All in all, the process of diagnosis to treatment took 7 months.*

*Meredith Ericson,  
Public Health Nurse  
Du Page County Health  
Department*

AAPIs feel that they do not spend enough time with their doctors nor are they involved in decisions regarding their care. Studies have found that AAPIs also tend to underutilize preventive and specialty care and mental health service because they often have little knowledge of the purpose or need for these services. Some Asian American immigrants prefer traditional or alternative medicines, and feel that their doctors do not respect or understand

*What is seen as non-compliance by healthcare professionals may be cultural experience with other remedies. For instance, a pregnant patient experiencing serious back pain refused pain medication. Upon further probing with culturally competence, the patient was provided with a hot compress to ease the pain (a method used in the patient's culture)*

*- Anonymous Key Informant*

them. Lack of understanding between doctor and patient breeds lack of trust and leads to critical delays in delivery of health care.

The need for cultural competency thus works in two ways. One is the need to educate and train health care professionals to understand the health concerns of AAPIs in a culturally competent manner. This includes training them in the uses of alternative medicine. The other is to educate AAPIs in the benefits of western medicine so that they access preventive and screening services regularly and are also amenable to interventions as and when they need them. The key informants in this project saw inadequacies in both these ways as acting as barriers to health access. The stories

show how lack of cultural competency generates frustration, mistrust and fear and create barriers between doctor and patient resulting in total breakdown of healthcare delivery.

<sup>12</sup>Department of Health and Human Services, Healthy People, 2010, Goals and Objectives, January 2000, p. 7-28) as quoted in *President's Advisory Commission on Asian Americans and Pacific Islanders Interim Report to the President and the Nation*, January 2001.

## Poverty and Lack of Insurance

In 2004, many Illinoisans lived without health insurance coverage, a safety net that is integral to an individual's ability to access care and to receive preventative maintenance. The rate of individuals without health insurance for the entire year rose from 13.6% in 2000 to 14.3% in 2003 before dipping marginally to 14.2% in 2004.<sup>13</sup> According to a report published by the Gilead Outreach and Referral Center, there are 1,801,839 uninsured people in Illinois, or 16.2% of the population between the ages of 0-64. Of these, Chicago has 495,251 people or 22.5% of the population, while the metro area has 776,333 people or 14.9%.<sup>14</sup>

Affordability is the reason most often given for lack of health insurance in Illinois.<sup>15</sup> Contrary to popular perception, it is not only the unemployed who lack health insurance. Indeed, the majority of the uninsured are employed, but lack coverage because the cost of health coverage is too high. Many Asian Americans in Illinois are self-employed or employed in small businesses such as restaurants, convenience stores, doctors' offices, and home health care. Newer immigrants are also more likely to be employed in the unorganized sector, which does not provide them with health insurance. Uninsured Illinoisans are often victims of insurance fraud and are targeted by companies that lure them with false advertising.<sup>16</sup> Because of their poor language skills, some AAPI groups are particularly vulnerable in this regard. The uninsured also tend to be the young and low-income population, and both these demographics are high in many AAPI population groups.

The average individual income of the clients served by the agencies selected for this

*Health care is just unaffordable for many adults and seniors who cannot buy supplementary insurance with Medicare; (cost of) insurance is just too high.*

*- Chris Zala,  
Executive Director, Indo-American Center*

report is well below the state level. Almost half of them are unemployed. Even those who are employed tend to be employed part-time or be self-employed. So lack of health insurance is a major issue for them. Low income levels, unemployment rates and lack of health insurance are all important factors in access to healthcare, as borne out by the key informants in the report.

*I have a client who works in a doctor's office. Her employer, as a small businessman does not provide healthcare. Her husband recently got a job in construction and also does not have employer paid healthcare. The couple has two young children. Between them the parents make just over the income limit, not to be able to cover their children under KidCare. They decided they would not get any health insurance for themselves, but get only catastrophic insurance for the kids. They only see the doctor if the children are ill. Neither the kids nor the parents get any routine care, preventive, dental or vision checkups. They are just one family, I have many more such families, who are hardworking but cannot afford routine health care or health insurance.  
-Lien Du, Family Health Education Program Manager, Vietnamese Association of Illinois*

<sup>13</sup> Ibid

<sup>14</sup> ([www.gileadcenter.org](http://www.gileadcenter.org))

<sup>15</sup> Illinois Uninsured State Planning Grant –Small Business Solutions – Novak Report.

<sup>16</sup> Madigan warns of fraud targeting Illinois Uninsured, Press Release AG's office, April 12, 2004.

*Limited clinic hours and long waits*

AAPIs rely on community health care centers to provide them with cost-effective, primary and preventive healthcare, regardless of their insurance and ability to pay. The number of AAPIs served at federally funded health centers grew 48% between 1998 and 2003.<sup>17</sup> Their popularity is due to the fact that they provide culturally appropriate, comprehensive care. But if these and other clinics located in high need areas are not open for service during hours that are convenient to the public, it sets up yet another barrier. For immigrants, especially, who cannot afford to lose pay by taking time off from work, the choice is difficult. They tend to postpone medical care rather than take time off.

*Patient had problems with nose bleed and hearing loss. Long working hours and no insurance delayed seeking help. This was eventually detected as advanced stage of cancer. Early detection using blood and CAT scan would have meant less aggressive treatment and lower cost for the patient and the state.*

*-Dr. Alex Hugh, President,  
Chinese American Association of Greater Chicago*

*Local government can help ensure the viability of public and community health centers, and expand their services and hours to suit working people.*

*-Jing Zhang  
Program Director, Asian Human Services*

*Lack of transportation*

Most AAPIs who are dependent on public transportation find that they cannot access a clinic, which is not conveniently located along public transportation routes or is too far to access. Often, when the patient arrives at the clinic, the lines are too long or services have to be postponed to the point where yet more trips are necessary. This means taking more time off from work, which the patient can ill-afford. Other patients are too old and infirm to travel alone, or unaware of how to use public transportation due to language and cultural barriers.

*Lack of transportation can also be addressed through the rerouting of public transportation to make existing health centers more accessible. Lower fares and relaxation of driver licensing laws would ease transportation difficulties. More funding should be allocated to CBOs so they can provide the service to their clients.*

*-Esther Wong  
Executive Director, Chinese American Service League*

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<sup>17</sup> Fact-Sheet – Health Centers’ Role in Reducing Health Disparities Among Asian Americans and Pacific Islanders, January 2003. [www.aapcho.org](http://www.aapcho.org)

### *Lack of data*

The ethnic and socio-economic diversity within the AAPI population presents unique challenges and requires the collection and analysis of public health data which are disaggregated by AAPI ethnic group. The studies that have been done show that with respect to many socio-economic indicators, such as income, education, language proficiency and poverty levels, all of which are inextricably linked to health status, AAPIs are a mixed group. The wide variations within and across AAPI groups are obscured in average figures for the entire AAPI population. Also, the persistent stereotype of the model minority masks the socio-economic disparities within the AAPI population. More studies are needed to study the impact of these socio-economic factors on each of the AAPI groups.

*We need reliable data on ethnic specific AAPI communities.*

*Jing Zhang  
Asian Human Services*

### *Lack of outreach, advocacy and funding*

Since many of the health access barriers stemmed from lack of awareness, there was a critical need for awareness-raising through outreach and education programs.

*The state can ease the licensure exam difficulties (time limitations) faced by non-native English speakers without lowering the quality standards required.  
-Jean Fujiu, Executive Director,  
Japanese American Service Committee*

Useful collaborations can be developed among the agencies and government, non-profit and faith-based organizations, the media and other institutions to educate the public on the health needs of AAPIs, to develop and implement appropriate standards and guidelines.

The need for medical advocacy on behalf of the patient is important to receiving quality health care. A medical advocate can help guide the patient through the system to effectively utilize their healthcare benefits and at the same time adopt an integrative approach to address cultural competence issues. For instance, the homemaker program is an example where new immigrants are trained not only to assist the elderly with household chores but also take them to see the doctor. This partnership enables both groups to benefit.

More funding is needed to develop much needed programs and services. Mental health programs topped the list of programs that organizations identified as needed. Other programs identified were more screening for various cancers, immunizations and vaccinations, health services for seniors and more education using outreach and interpretation to encourage people to use their services.

## Recommendations

*Healthcare is a human right and should be universally accessible. We need to find resources for people who are hardworking (‘working poor’), for retired seniors who may have worked but may have no healthcare, no social security and no savings.*

*Dr. Alex Hugh, President,  
Chinese American Association of Greater Chicago*

Based on the primary tenets of the Healthcare Justice Act of 2004, the Key Informants and the AHCI Health Access Policy Committee offer the following recommendations –

### Access, Coverage and Benefits:

- Coverage for all Illinois residents, regardless of length of time residing in the US, documentation status, and employment status
- Include more comprehensive preventive dental benefits for adults and children.
- Include coverage of mental health services and preventive health screenings
- Include coverage of alternative medicine technologies
- Include coverage of prescription drugs
- Include coverage of eye care
- Mandate minimum hours of community service for healthcare professionals
- Provide in-service points to health care professionals for community service
- Provide tax incentives to health care professionals for pro bono services

### Quality of services:

- Increase the number of trained healthcare professionals who are bilingual and culturally competent
  - Review and revise certification requirements for those with a foreign degree
  - Review and revise testing requirements for people whose native language is not English
  - Establish training programs for foreign-trained health and mental health providers to help them re-enter the health care workforce
  - Establish health career training and scholarship programs for AAPIs who are underrepresented in the health professions, including Cambodians, Hmong, Laotians and Vietnamese
- Cultural competence
  - Require cultural competency training for State licensure of all health and mental health professionals and provider institutions

- Provide funding directly to Community-Based Organizations for educational outreach
- Make health education and prevention education materials widely available in AAPI languages
- Include cultural competency training as Continuing Education credit requirements for health professionals
- Mandate that hospitals/clinics that receive state funding include cultural competence training activities in their annual reports
- Enforce language rights in health care settings
  - Require health and medical providers to document patients' language requirements in the healthcare setting.
  - Enforce language access as provided by Title VI of the Civil Rights Act and the state's Language Assistance Services Act
  - Mandate that hospitals, clinics, and medical groups have written plans for securing qualified health and mental health interpreters for limited English proficient patients
  - Establish a national 24 hour pool of interpreters who are trained to provide translation specifically for healthcare

Consumer participation:

- Include the participation of Asian Americans on the state's Adequate Health Care Task Force
- Include Asian American consumers on Commissions and policy-making committees in Illinois.
- Include Asian Americans in fund allocation for prevention programs (i.e. cancer screening)

Data Collection:

- Mandate that hospitals, clinics and health systems collect data on AAPI ethnic groups (Cambodian, Chinese, Filipino, Indian, Korean, Pakistani, Vietnamese, etc.)
- IDPH must review the above data annually and regularly issue reports to the public

Affordable options for small businesses:

- Develop affordable health coverage options for small businesses
- Expand options for affordable health coverage for small business to participate in industry networks.

*Health Access Policy Committee Members*

Kathy Chan, Illinois Maternal and Child Health Coalition  
Gem Daus, Asian Pacific Islander American Health Forum  
Diana Derige, Illinois Public Health Institute  
Lien Du, Vietnamese Association of Illinois  
Karen Kim, University of Chicago Hospitals  
Hong Liu, Asian Health Coalition of Illinois  
Ami Shah, South Asian Public Health Association  
Joanna Su  
Ho Tran, Asian Pacific Islander American Health Forum  
Jing Zhang, Asian Human Services

*Key Informants to the Health Care Access Disparities Project*

Apna Ghar, Inc.  
 Asian Women's Alliance  
 Chinese American Service League  
 DuPage County Health Department  
 Evanston Hospital  
 Filipino American Council of Chicago  
 Japanese American Service Committee  
 Korean American Women In Need  
 Muslim Women's Resource Center  
 Vietnamese Association of Illinois  
 YWCA-South East Asia Youth Program

Asian Human Services, Inc.  
 Cambodian Association of Illinois  
 Chinese American Association of Greater Chicago  
 East Central Illinois Refugee Mutual Aid Center  
 Filipino American Center for Seniors  
 Indo-American Center  
 Korean American Community Services  
 Lao American Community Services  
 Rock Valley College  
 Winnebago County Health Department

**Programs and services offered:**      Response Total      14

<b>Services</b>	<b>%</b>	<b>N</b>
Health Care and Health Education Services	79%	11
Senior services	79%	11
Youth services	71%	10
Immigration and citizenship services	57%	8
Employment services	50%	7
Literacy/ESL services	43%	6
Legal aid services	43%	6
<i>Other services</i>	64%	9
<i>Elementary education</i>		2
<i>Domestic violence</i>		2
<i>Food distribution &amp; Filipino language</i>		1
<i>Vocational training</i>		1
<i>Counseling, Homemaker services</i>		1
<i>Family and community, housing, chef training</i>		1

**Language populations served**

<b>Language</b>	<b>%</b>	<b>N</b>
English	100%	14
Chinese Cantonese	71%	10
Chinese Mandarin	64%	9
Vietnamese	57%	8
Hindi	50%	7
Korean	50%	7
Japanese	43%	6
Lao	43%	6
Urdu	43%	6
Khmer	36%	5
Spanish	36%	5
Gujarati	29%	4
<i>Other (please specify) - More than 20 languages</i>	64%	9

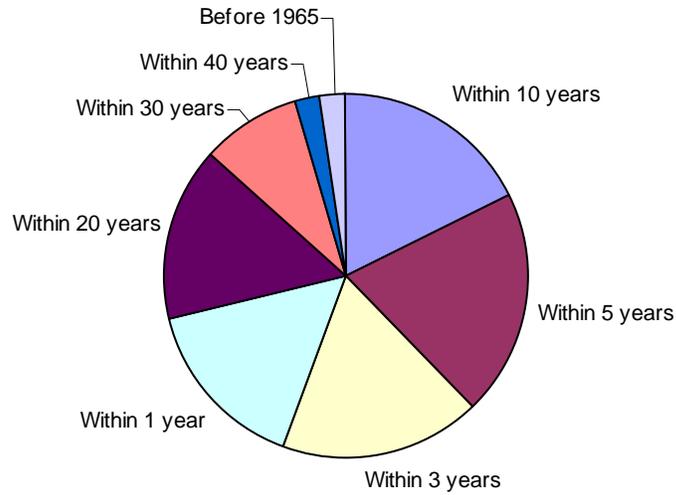
### Health topics addressed

Response total: 14

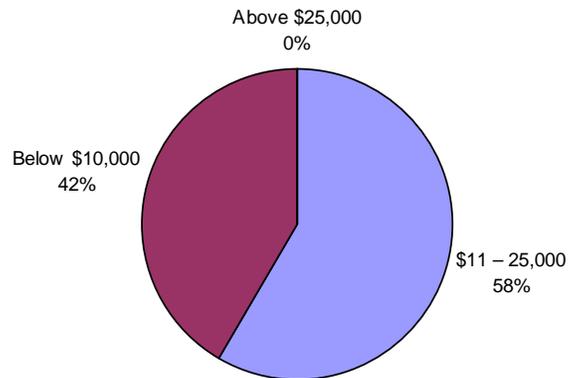
<b>Health Topic</b>	<b>%</b>	<b>N</b>
Heart Disease/Hypertension	93%	13
Nutrition and diet	86%	12
Diabetes	86%	12
Breast cancer screening	86%	12
Women's health	79%	11
Cervical cancer screening	71%	10
Domestic violence	71%	10
Exercise	64%	9
HIV/AIDS	64%	9
Smoking	64%	9
Hepatitis-B	64%	9
Mental Health	57%	8
Alcohol and other substance abuse	50%	7
Prostate cancer	50%	7
Dental care	43%	6
Tuberculosis	43%	6
Obesity	36%	5
<i>Other</i>	50%	7
<i>Developmental disability</i>		2
<i>Flu vaccinations</i>		1
<i>Immunizations</i>		1
<i>Osteoporosis, osteoarthritis, arthritis</i>		2
<i>Dementia, Alzheimer's</i>		1

*Clients Served by the Key Informants*

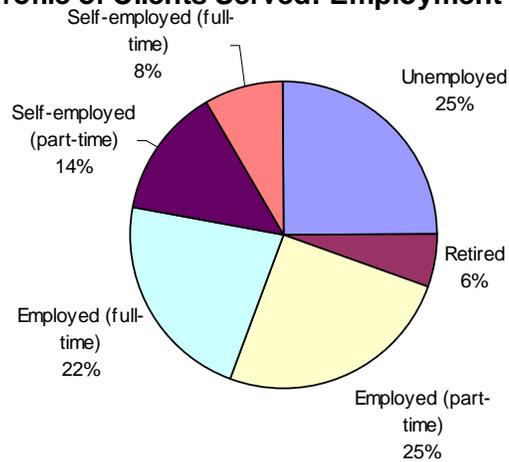
**Profile of Clients Served: Immigration**



**Profile of Clients Served: Income Level**

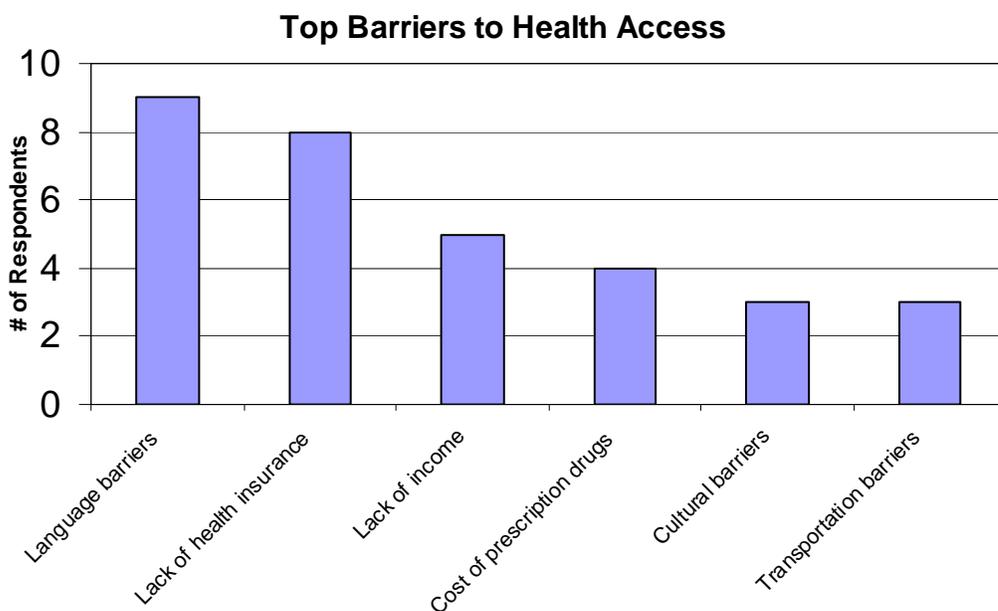
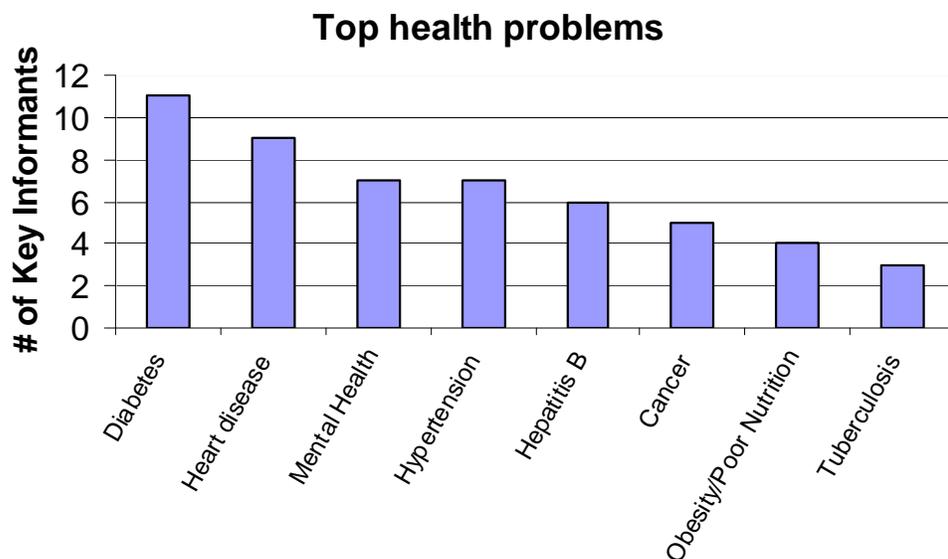


**Profile of Clients Served: Employment Status**



### Summary of Health Disparities and Barriers to Access

The graphs below illustrate the input received from fourteen of the key informants from the online surveys. The results for the barriers are slightly different from those provided during interviews. This is attributed to the fact that most key informants completed the survey before the interview. The questions on the survey limit the informants to fixed responses.



*Principles of the Health Care Justice Act*

- (1) Provides access to a full range of preventive, acute, and long- term health care services;
- (2) Maintains and improves the quality of health care services offered to Illinois residents;
- (3) Provides portability of coverage, regardless of employment status;
- (4) Provides core benefits for all Illinois residents;
- (5) Encourages regional and local consumer participation;
- (6) Contains cost-containment measures;
- (7) Provides a mechanism for reviewing and implementing multiple approaches to preventive medicine based on new technologies;
- (8) Promotes affordable coverage options for the small business

This section includes:

- A copy of the online survey administered during the project
- A copy of the interview questions answered by the key informants
- A copy of the form used to document the client stories.