THE ASIAN-AMERICAN HEALTHCARE MARKET - PROBLEMS AND PROSPECTS

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ABSTRACT

On the basis of an exploratory research study, this paper highlights certain healthcare opportunities and challenges which the rapidly growing Asian American community in the United States creates.

INTRODUCTION

In 1997, the foreign-born population in the United States, as reported by the U.S. Census Bureau, reached 25.8 million. One in 10 American residents, in other words, was born outside the U. S. Of these foreign-born residents; one in four came from Asia. Together with their U.S. born offspring, Asian Americans comprise almost 4 percent of the U.S. population and represent a market of approximately 10 million that is larger than many countries in the world. Because culture affects the way individual approaches his/her healthcare needs, Asian Americans present unique problems and prospects for the healthcare industry, which need to be studied and clearly understood.

To gain insights into this Asian American healthcare market, an exploratory study was conducted. In addition to examining secondary data, 83 healthcare providers and users - both Asian and non-Asians - were surveyed using open-ended questions in personal and telephone interviews. The selection of participants was based on "convenience" sampling. Among the Asian participants were Indians, Chinese, and Filipinos. The healthcare providers included hospital administrators, physicians, technicians, and nurses. This paper highlights some findings of this exploratory research, and sheds light into the nature of the Asian American healthcare market.

MAJOR MARKET CHARACTERISTICS

The Asian American healthcare market continues to grow with the rapidly growing Asian and Pacific Island population, which is expected to be more than 11 million or 4.1 percent of the U.S. population by the year 2000. Over the next 50 years, the Census Bureau expects this population to reach 34 million or 9 percent of the total in the U.S. The growth rate for this community is higher than that of other racial groups including the Hispanic.

This Asian American market comprises at least 22 different national groups, each with its own language, culture, religion, and traditions. In 1996, by country of origin, the Philippines was at the top (1.2 million), followed by China, India, Vietnam and Korea - each contributing at least 500,000 to the U.S. population. However, among the combined foreign and America-born Asian residents in 1990, the Chinese were the largest Asian group (24%), followed by the Filipinos (20%), and the Japanese (12%).

Over 65 percent of Asian Americans aged 5 and over, in 1990, spoke a language other than English at home. Among these native languages were Chinese (1,200,000), Tagalog (840,000), Korean (630,000), Vietnamese (510,000), Japanese (428,000), Urdu/ Hindi (331,000), Thai/Laotian (206,000), and Gujarati (102,000).

Asian Americans represented Christianity as well as many other major religions, including Muslim (1,300,000), Buddhist (1,040,000), and Hindu (502,000).

Nearly 80 percent of the Asian American population aged 25 and over in 1994 had a high school diploma. Almost 40 percent had at least a bachelor's degree, a number much higher than the national rate of approximately 25 percent.

On average, in 1994, Asian families were larger than non-Hispanic White families (3.8 vs 3.1). Sixty percent of the Asian families contained related children under aged 18; almost 80 percent of these children lived with two parents.

One in six Asian Americans aged 25 and over, in 1993, held executive or professional jobs. Between 1987 and 1992, the Asian-owned businesses grew by 56 percent, from 386,291 to 603,439; and the sales generated by these businesses reached $96 billion from $36.5 billion, an increase of 163 percent. In 1992, the Chinese owned the largest number of firms (153,096), followed by the Koreans (104,918), and the Indians (93,340). The median income of Asian households in 1995 was $40,614.

In Texas, where the Asian population tripled over one 10-year period and reached almost half a million in 1995, the median household income was 14 percent higher than that for all Texas households. As reported by Texas Comptroller Sharp (1997), in Harris County that includes Houston, Asian Americans constitute 4.7 percent of the county's population and play a vital economic role. The 36,655 Asian-owned businesses in Texas metropolitan areas generated nearly $5.5 billion in sales in 1992. The presence and influence of Asians in Texas business, government, education, research, medicine, and other endeavors have continued to grow significantly in recent year.

Like Texas, California, New York, Florida, and New Jersey have attracted Asians in large numbers. Other states, too, have experienced some growth of the Asian population.

PROBLEMS & PROSPECTS

With the rising Asian population, income, and influence, there are emerging both challenges and opportunities in the Asian healthcare market in such areas as disease prevention, diagnosis, treatment, and compliance that are primarily due to some unique Asian cultural characteristics. Recent studies - such as Clark (1995), Jecker, Carrese & Pearlman (1995), Commonwealth Fund (1994), Fielo & Degazon (1997), Kemp (1995), Kothari & Kothari (1997), Kohn (1995), McLaughlin & Braun (1998), Pachter (1994), and Yoon & Chien (1996) - provide insights into some of the cross-cultural issues. Our survey participants also provided useful information.

One of the major opportunities exists in cross-cultural medical consulting. Since Asian cultures are characterized by extensive use of herbal and non-Western remedies, a variety of languages and religions, different hygienic practices and diets, beliefs in spirit possession, superstitions, family-based (as opposed to individual) or collectivist decisions, and other cultural traditions and views that influence healthcare practices, there are many cross-cultural medical problems that are not typical for the mainstream medical community. Unless special care is given, these cross-cultural problems could affect the quality of healthcare. Non-Asian physicians, nurses, and other healthcare professionals not familiar with Asian cultural traits thus need training and/or assistance in communication and interaction, diagnosis, treatment (diet, medication, etc.), cultural rituals and taboos, and so forth.

The importance of such consulting services was very much pointed out by several non-Asian survey participants. One small community hospital has managed to have access to those familiar with the Japanese language and culture. Many healthcare providers would prefer to have similar access concerning all different Asian cultures. One physician occasionally refers to the online guidelines for treating Asians provided by the Baylor Medical College (See, Kemp).

Another opportunity remains in preventive care. Most Asian respondents in the survey - particularly women and men 35 years and older - did not worry about any calorie or fat intake, followed no specific diet, exercised little or none, and were relatively indifferent to disease prevention. Although most women and many men did not smoke and consumed alcohol occasionally, this smoking and drinking behavior was attributed to social norms rather than health concerns. There was very little awareness or concern about the higher or rising incidences of diabetes, cancer (especially lung, stomach, liver, and cervical), cardiovascular diseases, tuberculosis, Thalassemia, and Hepatitis B. within the Asian community. Such Asian outlook toward preventive care seems to prevail across the U. S. Since most of the diseases are preventable, there are needs for appropriate educational programs, diet and exercise plans, and periodic medical check-ups. Healthcare providers could meet the challenges of preventive medicine by undertaking creative measures.

By focusing also on other special needs of the Asian market niche - such as mental, geriatric, transportation, financial, funeral - hospitals, physicians, health clubs, and others could gain a competitive edge. Most Asian participants in our survey acknowledged mental stress, but almost all of them were reluctant or unwilling to talk about their feelings or emotional problems. Working female participants felt that they were failing in their "traditional" roles and not meeting

their family's expectations. The performance of their primary physicians was viewed generally by the Asian participants as satisfactory but not outstanding; several found their caregivers somewhat hurried, indifferent, condescending, and largely vague in information or instructions.

Although the survey participants did not clearly identify any specialty healthcare needs, the geriatric needs are evident in the rapidly increasing number of Asians aged 50 and older. The U.S. Census Bureau, for instance, expects the Asian American age group 85 and over to double between 1997 and 2005. Other specialty needs are evident in the study by the Commonwealth Fund (1994), which reports that 40 percent of Chinese Americans (vs 8% for whites) had problems in getting specialty care. Financing healthcare is a major problem for some Asians, because many newcomers, unemployed are often without health insurance. The Commonwealth Fund study (1994) suggests that one in four Asian adults is uninsured. Financial factors, in addition to cultural, prevent many Asian Americans from seeking medical assistance early. Consequently, there are sometimes adverse consequences.

The tendency to delay use of Western healthcare facilities is many times a result of heavy dependence on traditional Asian healthcare practices. Because some of these ancient remedies have recently been proven effective scientifically, they could be combined with Western approaches to appeal to the Asian market. Many Eastern methods have fewer serious side effects and could serve as less expensive alternative. The adoption of Asian techniques also could alleviate the fear of being exploited which may be present due to lack of education or understanding about healthcare practices in the United States.

For female healthcare providers, the Asian community represents additional opportunities because Asian women do not like to be touched by men, nor do they prefer to undress in front of men. Most Asian women are shy also and do not like to talk to men about their health problems. As a result, Asian women prefer female -as opposed to male - caregivers.

Asian religious views about diet, birth, death and dying could offer healthcare prospects. Understanding of such views not only results in better healthcare, but it could provide a strategic marketing direction. For instance, Asians prefer to be with their family at home when dying, and want their remains after death buried in their homeland. To fulfill these wishes requires a considerable amount of empathy and care, which, if done right, could be competitively advantageous for such organizations as home healthcare and funeral homes. Similarly, offering a dietary plan that is culturally compatible makes it easier for the patient to comply and for the healthcare provider to succeed in a competitive environment.

Catering toward rich Asians for services such as hair transplantation and plastic surgery could be rewarding, provided physiological and psychological requirements of the group are clearly understood and met.

CONCLUSION

In conclusion, the growing Asian American healthcare market undoubtedly represents numerous cross-cultural problems and opportunities in relation to disease prevention, diagnosis, treatment, and compliance. Although cultural differences in healthcare create challenges, the healthcare provider with proper concern, understanding, guidance and training could overcome the difficulties. To succeed, however, would require the healthcare provider to perceive these challenges as not problems but as strategic healthcare opportunities. With proactive attitudes and actions, the healthcare provider will be able to deal effectively with the cross-cultural issues.

To improve the quality of Asian American healthcare, several Texas hospitals and clinics in the large metropolitan areas like Houston and Dallas have begun to address the cultural issues and making necessary changes, such as recruiting culturally competent medical staff, hiring full-time interpreters, providing training, serving ethnic foods, accommodating family needs in addition to patient's needs, offering alternatives with traditional Asian treatments, and educating and treating the Asian community with health fairs and other innovative approaches. Preventive medicine is being emphasized. The fears and concerns of older, poor, and uneducated Asian Americans are being carefully addressed first to convince them to enter the mainstream healthcare system. Overall, there seems to be considerable progress in dealing with many cross-cultural problems. As the healthcare industry continues to become responsive to the needs of the Asian American group, it is likely to find more rewarding opportunities.

REFERENCES

Clark, Marta. 1995. "Biomedicine, Meet Ethnomedicine." **Healthcare Forum** 38 (3, May/June): 20-23.

The Commonwealth Fund. 1994. "A Comparative Survey of Minority Health." **Internet:** http://www.cmwf.org/minhlit.html

Fielo, S. and C. Degazon. 1997. "When Cultures Collide: Decision-Making in Multicultural Environment." **Nursing and Healthcare Perspectives** 18 (5, Sept./Oct.): 238-244.

Jecker, N., J. Carrese, and R. Pearlman. 1995. "Caring for Patients in Cross-Cultural Setting." **Hastings Center Report** (January-February): 6-14.

Kemp, Charles. 1995. "Cultural Orientation: Southeast Asian Refugees." **Internet**. http://www.baylor.edu/-Charles_Kemp/ cultural_orientation.html

Kielich, A. and L. Miller. 1996. "Cultural Aspects of Women's Health Care." **Patient Care** 30 (16, October 15): 60-64.

Koening, B. and J. Gates-Williams. 1995. "Understanding Cultural Differences in Caring for Dying Patients." **The Western Journal of Medicine** 163 (3, September): 244-250.

Kohn, Sally. 1995. "Dismantling Sociocultural Barriers to Care." **Healthcare Forum** 38 (3, May/June): 30-33.

Kothari, M. and V. Kothari. 1997. "Cross-cultural Healthcare Challenges: An Insight into Small American Community Hospitals." **The Journal of Hospital Marketing** 12 (1): 23-32.

McLaughlin, L. and K. Braun. 1998. "Asian and Pacific Islanders Cultural Values: Considerations for Healthcare Decision Making." **Health and Social Work** 23 (2, May): 116-127.

Pachter, L. 1994. "Culture and Clinical Care." **The Journal of the American Medical Association** 271 (9, March 2, 1994), 690-694.

Sharpe, John. Texas State Comptroller. (1997). "Lone Star Asians." **Fiscal Notes** (November): 3-5.

U.S. Census Bureau, Dept. of Commerce. Numerous online and offline sources. Washington: The Government of the United States.

Yoon, Eunice and Felix Chien. 1996. "Asian American and Pacific Islander Health: A Paradigm for Minority Health." **The Journal of the American Medical Association** 275 (9, March 6): 736-738.