

# Anti-Asian Xenophobia and Asian American COVID-19 Disparities



See also the *AJPH* COVID-19 section, pp. 1344–1375.

As coronavirus disease 2019 (COVID-19) has rapidly spread across the United States, so has xenophobia and discriminatory acts against Asian Americans. From March 19, 2020, to May 13, 2020, more than 1700 anti-Asian hate incidents were documented across the United States, according to reports by the STOP AAPI Hate campaign from the Asian Pacific Policy and Planning Council. In one incident, a trucker threw a drink at an Asian American wearing a mask and gloves and yelled, “Hey Chink, you’re f-ing nasty.”<sup>1</sup>

Although this new rise of racism is alarming, the association between disease, racism, and Asian Americans is not new in US history. “Yellow Peril,” or the fear that Chinese and other Asian immigrants were a threat to America and Western culture, led to the Chinese Exclusion Act of 1882—the first racial-based exclusion law in American history. At the turn of the 20th century, public health officials perceived Chinese and other “Orientals” as infested with disease, subjecting them to undue quarantine, medical examinations, and interrogations. For example, during the 1900 to 1904 bubonic plague in San Francisco, California, a Chinese American man, found dead in his apartment in San Francisco’s Chinatown, was falsely accused of being the

source of this plague; disease transmission was later found to be from rats and fleas. Nevertheless, ungrounded public xenophobia and bias against Chinese Americans resulted in the entire Chinatown area being quarantined and forced vaccinations during this period.

## THE MODEL MINORITY MYTH

Current xenophobic acts against Asian Americans are concerning because racism, a known social determinant of health, can exacerbate health disparities already present in the Asian American population. However, identification and recognition of these racial health gaps have not historically been straightforward. Minority health disparities gained national prominence in the 1985 Heckler Report on Black and Minority Health, which documented racial health disparities at the national level for the first time and led to the establishment of the Federal Office of Minority Health in 1986. However, the report described Asian Americans as healthier than all other racial groups, corroborating the socially reconstructed view of Asian Americans from the 1960s as healthy, wealthy, and with a strong work ethic—the “model

minority” myth. The report did not consider that the aggregated data of good health were largely driven by healthier, affluent Asian American subgroups, neglecting underserved Asian Americans and many distinct Asian American populations, which today consist of more than 50 ethnic and 100 language groups. National Asian American advocacy organizations were founded in direct response to the Heckler report to debunk this “model minority” myth, such as the Asian & Pacific Islander American Health Forum and the Association of Asian Pacific Community Health Organizations. These organizations led the establishment of a national evidence base that disaggregated Asian American racial data by ethnic subgroups and identified health disparities across the heterogeneous Asian American population. Asian American health has since emerged out of the shadows, documenting ethnic health disparities such as

Korean Americans with high uninsurance rates, Vietnamese American women with high cervical cancer rates and low cervical cancer screening rates, and Asian Indian and Filipino Americans with high rates of type 2 diabetes compared with Asian Americans in aggregate, non-Hispanic Whites, and other racial groups.

## COVID-19 ASIAN AMERICAN HEALTH DISPARITIES

Lessons learned from these national initiatives to document Asian American health disparities point us to the need to look further into granular COVID-19 data by Asian American subgroups. Disaggregated data will enable us to fully document COVID-19 Asian American health disparities and the particular Asian American subgroups most affected by this pandemic. Undocumented, low-income, elderly, and limited-English-proficient Asian Americans may be most adversely affected in the current climate, as well as those afraid to seek care because of anti-Asian xenophobia. For example, one out of seven Asian

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immigrants is undocumented, of which Asian Indians (37%) and Chinese (18%) represent the largest proportion.<sup>2</sup> Asians in aggregate are less likely than the general US population to live in poverty (12% vs 15%), but Burmese (35%) and Bhutanese (33%) have poverty rates much higher than the US average.<sup>3</sup> Elderly Asian Americans are particularly vulnerable to COVID-19 not only because of their multiple comorbidities but also because of significant language barriers to health care; 60% of elderly Asian Americans have limited English proficiency, with elderly Cambodians (89%) and Vietnamese (88%) having the highest limited English proficiency.<sup>4</sup>

One place to begin addressing these disparities during this era of COVID-19 would be to understand the unique cultural and language considerations for Asian Americans. For example, Asian American older persons with limited English proficiency are more likely to face social isolation and neglect from the health system. With the current unprecedented stressors on the health system, effective language communication tends to decline in priority, despite being the only lifeline for many Asian American elderly patients. In addition, Asian American communities can be insular, with trusted COVID-19 health information circulating through ethnic community networks such as temples, churches, ethnic newspapers, radio stations, and mobile applications rather than through physicians, government officials, or mainstream American media. It is essential to work with community-based stakeholders who understand these Asian American patients

and their networks, to build trust, conduct testing, and disseminate credible information.

### GAPS IN ASIAN AMERICAN COVID-19 DATA

We can also better understand COVID-19 effects on Asian American populations with more granular data on race/ethnicity. Although there has been a nationwide push for reporting of detailed race/ethnicity data for COVID-19, we have found that Asian Americans are being left out of the conversation. Based on publicly reported data as of June 28, 2020, 86% of states report cases and 82% of states report deaths for Asian Americans. Florida, Missouri, Rhode Island, and West Virginia report COVID-19 data by some racial groups but exclude Asian Americans. No states report data on specific Asian American ethnic subgroups affected by the pandemic.<sup>5</sup>

Asian Americans constitute 5.6% of the US population and currently represent 3.5% of COVID-19 cases (49 481 cases) and 4.3% of deaths (4781 deaths) as of June 28, 2020.<sup>4</sup> California (9724 cases), New Jersey (5140 cases), and Illinois (4119 cases) represent the states with the most Asian American COVID-19 cases. The proportion of Asian American COVID-19 cases is greater than their population representation across 17 US states, including South Dakota (6.2 times), Oklahoma (4.7 times), Nebraska (3.6 times), Iowa (3.4 times), Kentucky (2.8 times), Kansas (2.4 times), Vermont (2.4 times), Minnesota (1.8 times), Maine (1.8 times), and Wisconsin (1.5 times; Table 1).

**TABLE 1—US States With Greater Proportion of Coronavirus Disease 2019 (COVID-19) Cases or Deaths in Asian Americans Compared With Their Population Representation: 2020**

States	Asian American Population, No. (%)	Cases, <sup>a</sup> No. (%) <sup>b</sup>	Deaths, <sup>c</sup> No. (%) <sup>b</sup>
Minnesota	273 126 (4.9)	2 660 (9.0)	47 (3.7)
Iowa	79 971 (2.5)	1 994 (8.5)	23 (3.6)
Ohio	271 762 (2.3)	1 586 (3.5)	30 (1.1)
Oklahoma	84 694 (2.1)	1 086 (9.9)	7 (1.9)
Wisconsin	165 380 (2.8)	1 059 (4.3)	23 (3.0)
Nevada	250 137 (8.2)	885 (8.6)	70 (15.6)
Nebraska	45 779 (2.4)	883 (8.6)	9 (6.6)
Colorado	180 277 (3.2)	794 (3.0)	56 (3.5)
Kansas	82 444 (2.8)	751 (6.7)	9 (3.5)
South Dakota	15 023 (1.7)	700 (10.5)	NA
Tennessee	119 046 (1.8)	556 (1.7)	11 (1.9)
Utah	75 898 (2.4)	469 (2.5)	8 (5.0)
Kentucky	65 300 (1.5)	440 (4.2)	7 (1.3)
Oregon	190 680 (4.6)	303 (4.6)	9 (4.9)
Hawaii	534 479 (37.6)	278 (38.2)	NA
New Hampshire	36 048 (2.7)	146 (3.1)	3 (1.0)
Maine	15 683 (1.2)	63 (2.2)	NA
Idaho	27 026 (1.5)	60 (1.6)	2 (2.2)
Alaska	46 381 (6.3)	60 (8.0)	2 (14.3)
Vermont	11 859 (1.9)	53 (4.5)	2 (3.6)

*Note.* NA = not available. Population data represent Asian race alone from the 2018 American Community Survey 1-year estimates. COVID-19 data are adapted from <https://covidtracking.com/race> and last updated on June 28, 2020. Accurate reporting of US states with greater proportion of COVID-19 cases or deaths is complicated by Arizona, Connecticut, Delaware, Michigan, Oklahoma, Virginia, and Wisconsin reporting Asian as a panracial category, including Asian, Pacific Islander, and Native Hawaiian. In addition, race/ethnicity data are reported separately by New York City and the rest of New York State. New York City reports Asian as a panracial category, including Asian, Pacific Islander, and Native Hawaiian. New York State, excluding New York City, reports a grouping it labels “Asian.”

<sup>a</sup>Seven states did not report COVID-19 cases for Asian Americans: Florida, Louisiana, Missouri, New York, North Dakota, Rhode Island, and West Virginia.

<sup>b</sup>The denominator used to calculate percentage of cases or deaths excludes unknown race.

<sup>c</sup>Nine states did not report COVID-19 deaths for Asian Americans: Florida, Hawaii, Maine, Missouri, Montana, North Dakota, Rhode Island, South Dakota, and West Virginia.

Although these data may highlight disparities for Asian Americans linked to COVID-19 by state, meaningful differences in COVID-19 and associated health risks are being overlooked without granular ethnic subgroup data, in addition to data on

age, gender, language, and other social factors. Therefore, both aggregate and granular Asian American data must be considered in COVID-19 reporting and response. We recommend collecting and reporting Asian American data by a minimum of

seven Asian American ethnic subgroups (Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese, and other Asian) for monitoring COVID-19 incidence, mortality, testing, and treatment following the US Department of Health and Human Services' data collection standards.<sup>6</sup>

This pandemic continues to exacerbate anti-Asian xenophobia and health disparities for medically underserved Asian Americans. For these ethnically diverse populations, greater cultural humility, inclusion, and representation in our COVID-19 response, reporting, and treatment are essential to alleviate the effects of this crisis. As a nation of immigrants, the United States has long-standing roots from Asia as part of its fabric and social history. As one nation, we need to ensure that no one is left out or left behind as we fight this pandemic together. **AJPH**

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## CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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