IS "ASIAN" A USEFUL CATEGORY FOR HEALTH RESEARCH IN NEW ZEALAND?

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ABSTRACT

This paper examines the increasing use of a novel conception of "Asian" as an ethnic group in New Zealand health research. This definition of "Asian" includes peoples with origins in East, South and Southeast Asia, but not from the Middle East or Central Asia. Potential methodological problems due to this aggregation of a diverse group of peoples are identified. Potential problems that this definition may cause for peoples who are excluded and the general problems of ethnicity in research are also considered. The paper concludes by highlighting some issues that require particular clarification in this nascent field.

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INTRODUCTION

Chinese and Indian peoples have settled in New Zealand for almost 150 years, but historically they have been marginal groups. They have been the subject of xenophobia, resulting in measures such as the poll tax applied to Chinese settlers (Murphy, 2002), and, more recently, they have been constructed as "model minorities" (Ip, 1996). Prior to the last decade, little research has been conducted into their health status.

From 1991 to 2001, the New Zealand census shows that the population of people resident in New Zealand considered "Asian" increased from 99,759 to 237,459 people (Statistics New Zealand, 2004). This significant increase was the result of increased migration from East, South and Southeast Asia as a result of the removal of bias in immigration policy which occurred in 1987. There is also a growing fee-paying student population from Asian countries, which in 2002 was estimated to number almost 70,000 students (Education New Zealand, 2004).

This increased population has provoked interest in investigating the health of these peoples. Much of this research, reflecting varying popular and governmental usage, has grouped a range of minority peoples together as "Asian". The following paper investigates the rationale behind this agglomeration of several peoples, and identifies potential problems with this usage in health research in New Zealand. The discussion concludes by noting particular issues that need to be resolved and providing recommendations for the use of "Asian" as a category in health research.

WHO IS "ASIAN"?

The term "Asian" in its simplest sense refers to someone with origins in the Asian continent. However, in New Zealand, the term is increasingly used to refer to persons with origins in East, South and Southeast Asia – that is, excluding peoples from the Middle East, Russia and Central Asia (McKinnon, 1996). A line is generally drawn at either Pakistan or Afghanistan. Countries north or west of this line are excluded.

This definition is used by Statistics New Zealand and reflected in the census questionnaire – thus the Asian population referred to above does not include Middle Eastern peoples. This definition is also increasingly used in the health sector. Recent reports on "Asian" health in New Zealand (Asian Public Health Project Team, 2003; Ho, Au, Bedford, & Cooper, 2003; Ngai, Latimer, & Cheung, 2001; Walker, Wu, Soothi-O-Soth, & Parr, 1998) use this definition. One of these reports makes the assumptions explicit when it comments that the quota for refugees in New Zealand 'includes a proportion of people from non-Asian countries (e.g. Iran and Iraq)' (Asian Public Health Project Team, 2003, p. 39).

This definition has increasing currency in New Zealand, but it is a novel definition of "Asian". In Asia itself, "Asian" lacks specificity as a term of description. However, the New Zealand definition of "Asian" identified above is dissimilar to other western countries. In the United States, Asian peoples have often been grouped with Pacific peoples as "Asian/ Pacific Islander". East Asians are sometimes described as "Orientals" and Indians as "East Indians" to differentiate from the Native American "Indian" population. In the United Kingdom, "Asian" can denote varying meanings but

often refers to people with origins in the Indian sub-continent (Aspinall, 2003). In Australia, “Asian” is often used to denote peoples from Southeast and East Asia.

The crucial point is that the New Zealand definition of “Asian” is novel and specific in that it excludes some peoples who are palpably of Asian origin (such as those from the Middle East). It also groups together peoples in New Zealand who in the popular perception have traditionally been seen as separate groups, such as Chinese and Indians.

IS “ASIAN” AN ETHNICITY?

Most users of the term “Asian” in New Zealand allow that it includes an extremely diverse group. However, it is currently loosely used to suggest an ethnic group in New Zealand. The website for this conference asserts that “Asians are the fastest-growing ethnic group in New Zealand today” (University of Auckland, 2004) before going on to describe the large diversity within this group.

However, it is problematic to talk of “Asians” in New Zealand as a single ethnic group. Ethnicity is a complex concept, but it is generally agreed that ethnicity is a psychocultural rather than genetic identity. The criteria for ethnicity described in Table One are typical. Ethnic groups are generally conceived as meeting these criteria. It is difficult to see how the diversity of peoples currently included as “Asian” in New Zealand would fit these criteria to form a specific ethnic group. It is highly unlikely, for example, that many Indians would feel part of the same ethnic group as, or feel a “unique collective solidarity” with, Chinese (and vice versa), notwithstanding the fact that even these broad terms – “Indian”, “Chinese” – may not in fact describe ethnic groups in New Zealand given the diversity they themselves contain.

Table 1. Criteria for ethnicity (Ministry of Health, 2001).

- ✓ Sense of shared common origins
- ✓ Common and distinctive history and identity
- ✓ Collective cultural individuality
- ✓ Sense of unique collective solidarity

Ethnicity is not static. It is possible that the continued use of “Asian” in New Zealand will result in the ethnogenesis of an “Asian” ethnic group. Young New Zealanders of, for example, Chinese and Indian origin may begin to identify themselves as being of a common “Asian” ethnicity. It may be argued that a similar phenomenon is beginning to occur within Pacific peoples in New Zealand. However, given the tremendous diversity and difference within the Asian peoples in New Zealand, this may still be unlikely in the future.

THE USE OF “ASIAN” AS A CATEGORY IN HEALTH RESEARCH

“Asians” may not, as yet, constitute an ethnic group in New Zealand. However, it can not be denied that the agglomeration of a range of peoples as “Asian” in New Zealand has facilitated much of the initial research into the health status of these

peoples. In doing so, a critical mass of people has been achieved to warrant funding and interest. The recent reports on “Asian” health have given attention to the health needs of various small communities that may otherwise be ignored, such as the Cambodian, Sri Lankan and Vietnamese communities, let alone the larger Chinese and Indian communities.

However, there are two potential practical problems with the current usage. Firstly, the inclusion of such a diverse group of peoples in a common category may result in an averaging effect such that areas of disparity or need are masked. For example, analysis of Auckland New Zealand Health Information Service (NZHIS) data has shown that “Asians” have lower rates of hospitalisations and death than other ethnic groups, and that causes of death are similar to other ethnic groups in New Zealand (Asian Public Health Project Team, 2003). These findings are not surprising given the relative youth of the populations that make up the “Asian” category.

However, this can give the misleading impression that there are no particular concerns for “Asian” health. This is not the case. More specific research has identified particular issues in particular populations, for example, high abortion rates in Chinese students (Goodyear-Smith & Arroll, 2003). It is not clear how summary statistics for “Asian” people are useful. It is not surprising that averaging a population that includes both affluent and deprived socio-economic groups and includes both recent migrants and long established communities, with varying levels of education and English-speaking ability, will result in statistics not dissimilar to the mainstream. But such an approach runs the risk of ignoring groups with high needs related to ethnicity or culture.

This approach also runs the risk of homogenising the approach to a diverse group of people by implying that they are the same. This is certainly not the case for “Asian” peoples even in terms of crude risk factors. For example, Indian peoples seem to have a greater susceptibility to type two diabetes than many other populations (Liew, Seah, Yeo, Lee, & Wise, 2003). This susceptibility seems to be borne out in higher rates of diabetes in Indian New Zealanders (Simmons, Harry, & Gatland, 1999) than other groups, apparently including Chinese New Zealanders. Such differences can easily be lost if the emphasis is placed on “Asian” as a category.

This problem is compounded by the fact that the increasing use of “Asian” can mean that even studies which identify results on specific populations are encouraged to present their findings in terms of “Asian” as a whole. For example, the aforementioned study on abortion rates (Goodyear-Smith & Arroll, 2003) presents its results in terms of “Asians” despite the report identifying that the majority of women so described were Chinese. In fact, the number of “Asian” women who were not Chinese was negligible (Goodyear-Smith, 2004).

Secondly, if the use of “Asian” is justified by its facilitation of marginal groups, its specificity is problematic. That is, if “Asian” is being used in lieu of “Other” or “Migrant” (these are of course separate but intersecting populations), it would seem strange to exclude some of those who constitute “Other” or “Migrant” groups. The most obvious example is the exclusion of Middle Eastern peoples such as Iraqis and Iranians. It is difficult to argue that Chinese and Indians (both counted as “Asian”)

share some ethnic identity that Pakistanis (counted as “Asian”) and Iraqis (“non-Asian”) do not.

Some of the members of groups included as “Asians” obviously share similarities. But many of these similarities are due to being migrants with different cultures to the mainstream European and Maori cultures of New Zealand. If “Migrant” is the group facing similar problems that is aggregated as “Asian”, it is counterintuitive to exclude other migrants such as Somalis and Ethiopians. These excluded groups often have large refugee populations with particularly high health needs. It is a concern that in the quest for recognition for “Asians”, such peoples may become further marginalised.

There is the further concern that the relative good health of established “Asian” communities (such as some sectors of the Chinese and Indian communities) may divert the focus away from the health needs of migrants if they are all included together as “Asian”. Again, this may occur because the averaging effect of including all of these peoples together may mask the poor health status of some migrant groups.

ETHNICITY IN HEALTH RESEARCH

There is a considerable body of literature which examines the use of ethnicity in health research. The consensus is that ethnicity is an important variable that warrants investigation but that there are particular concerns that need to be accounted for when pursuing such research.

Senior and Bhopal (1994) point out that for ethnicity to be a sound epidemiological variable, it must be able to be measured accurately; it must differentiate populations in some way relevant to health; and that observed differences should lead to aetiological hypotheses or potential changes in health care. The problems of measurement of ethnicity are multitude but relate to the fluidity of ethnicity, the difficulty in collecting data and the temptation to use overly large, but inexact, categories.

To remedy this, an important guideline is the need to define the ethnicity of subjects in health research as specifically as possible (Anonymous, 1996; Aspinall, 2003; Kaplan & Bennett, 2003; McKenzie & Crowcroft, 1996; Senior & Bhopal, 1994). That is, as the British Medical Journal identifies in a style directive, ‘”Asian” [is] less accurate than “UK born individuals of Indian ancestry” or “French born individuals of Vietnamese ancestry”’ (Anonymous, 1996) – data on self-assigned ethnicity, country of birth, and years in country of residence should all be collected and considered. Furthermore, researchers should explain the logic behind their categorisations (Anonymous, 1996; Senior & Bhopal, 1994) and in particular the manner in which participants were assigned to these categories (Kaplan & Bennett, 2003).

A further problem with the use of ethnicity in health research is that it is almost always confounded by socio-economic status (SES) (Senior & Bhopal, 1994). As such, it is important that SES data is also collected so that needs based on SES are not explained by ethnicity. That said, ethnicity of itself has a definite impact on health,

particularly health services access, so it is important that it is considered accurately by adjusting for SES.

The British experience with the use of “Asian” shows the problems of adopting a term for a group of people who do not identify themselves in the same way. As alluded to above, “Asian” in Britain often denotes persons with origins in the Indian subcontinent, but it can also refer to persons deriving from the whole of the Asian continent (Aspinall, 2003). The 2001 census in England and Wales included separate categories for “Asian British” and “Chinese or other”. However, there is little evidence that the multitude of ethnicities in Britain with South Asian origins greatly identify themselves as “Asian” (Aspinall, 2003). Moreover, the conception of “Asian” has fluctuated in even official usage (such as censuses) over the last twenty years.

If we relate this overseas experience to the current state in New Zealand, the guidelines for the presentation of ethnic data seem particularly salient, especially with regard to “Asian” New Zealanders. Few studies justify their choice of the novel New Zealand conception of “Asian” as subject, except to refer to the census categories. Rare justifications for the specific determination of only South, Southeast and East Asia as “Asian” point to the fact that ‘New Zealand “faces” the southern and eastern side of the Asian continent…these are the areas of most substantial population and of greatest contact with New Zealand’ (McKinnon, 1996, p. 82). But even these accounts allow that ‘Indians, the second most populous Asian community, would be called “Indian” more often than they are called Asian’ (McKinnon, 1996, p. 83).

PROPOSITIONS

The above discussion has highlighted some concerns with the current usage of the “Asian” category in health and health research. The intention is not to disparage the pioneering research that has occurred in the last decade into “Asian” New Zealanders (much of the primary research does focus on particular groups and, as such, is exempt from the bulk of the above criticism). The increased population and their collective consideration as “Asian” has certainly played an important part in the recognition of the health needs of “Asian” New Zealanders. The elevation of “Asian” as a category has provided some tangible hope for “Asian” New Zealanders of being considered as full citizens of New Zealand as opposed to marginal “Other” aliens. This inaugural conference itself is an example of the recognition of the health needs of “Asian” New Zealanders that may not have been possible without the consolidation of “Asian” New Zealanders as a large, growing population group that demands attention.

However, this discussion has attempted to identify potential problems that the use of the current conception of “Asian” may pose. This can be identified in terms of two strands. Firstly, there are methodological concerns with the use of “Asian” which may undermine further research if care is not taken with the use of ethnicity as a variable. Secondly, there is the concern that in the desire to provoke attention for a disparate group of marginal peoples as “Asian”, other peoples who are excluded on a questionable basis (such as Middle Eastern peoples), and thus continue to occupy the peripheries as “Other”, may be further marginalised.

This topic requires further debate, and the above discussion is an attempt to propose some of the issues involved. The following propositions identify issues that this author feels warrant particular attention.

“Asian” is not a coherent ethnic identity in New Zealand, but this may change

“Asian” does not describe the lived experience of any ethnic group in New Zealand currently. It is possible that this may change, particularly if the category continues to receive governmental backing. It may become an identity for New Zealand-born Asian New Zealanders whose parents come from a variety of ethnicities. But this is not the case at present, and as such its use for practical purposes should acknowledge the artificiality of the category.

Diversity within peoples must be acknowledged

It is important that the diversity of peoples is acknowledged and that they are not reduced to stereotypes of their ethnic groups. Even beyond the use of “Asian”, ethnic communities such as Chinese or Indian are extremely diverse. India is the origin of as many languages as Europe. There are also significant differences between new migrants and established communities. These differences should be acknowledged and research should not attempt to over-generalise.

Health research into “Asian” peoples in New Zealand should describe the participants involved rather than attempting to use a catch-all phrase

Given the problems with the precision of the term “Asian”, health research, even if focused on “Asian” peoples, should describe in some detail the participants involved. This information should attempt to include self-identified ethnic group, place of birth, length of residence in New Zealand, and proficiency in English. This data is essential in *de novo* studies and should be included in published results. In studies which use existing data, this is more problematic. However, the issue remains, and standard collection sources (such as NZHIS data) should be lobbied to be as precise as is practicable.

Researchers must justify why they are including particular peoples in their studies and why these peoples are included together

As discussed above, there are reasons why “Asian” peoples are considered together. However, the onus is still on researchers to justify why they are including “Asian” peoples together. The above discussion has argued that given the diversity of the populations contained within the current conception of “Asian” in New Zealand, summary findings for “Asians” are not particularly useful. If researchers want to present findings for “Asians”, they need to justify why their findings relate to “Asians” as a whole. Alternatively, they need to specifically identify which particular populations of “Asian” peoples they are referring to.

If "Asian" is to be persisted with in health research in New Zealand, a standard definition may be useful, so that studies are comparable

The current conception of "Asian" as discussed above has growing currency, but its exclusions are debatable. Furthermore, it differs from international usages. As such, it may be useful for debate to produce a standard definition which is adopted by researchers in New Zealand. The current definition follows census usage. There is considerable input into the way census categories are formed, with a review having been recently completed. However, there are particular issues for health research in the use of ethnicity and as such, debate and consensus as to what should constitute "Asian" in New Zealand health research is required – if such a term is adjudged useful at all. Standardisation is important as more research occurs to allow comparison between studies.

Why are these peoples grouped together as "Asian"?

The fundamental question is, why are we grouping these peoples together as "Asian"? It must not only be because these peoples are marginal. To study people's health together, they must have some common experiences that shape their health similarly. Ethnicity shapes health therefore studying ethnic groups is valid. "Asian", however, is not as yet a valid ethnic group in New Zealand. The consolidation of researchers into "Asian" health may provide valuable collegial and logistical benefits. But such pragmatism does not justify the research itself following similar paths. A critical mass of "Asian" health research and researchers in New Zealand can surely be built up without ignoring specific communities and resorting to "Asian" as subject. The aim of such research is surely to inform the health of the range of peoples who, whilst they may be able to be classed as "Asian" New Zealanders, deserve to have health research and, moreover, their health needs unobscured by an expedient construct.

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