

COMMENTARY: PERSISTENCE AND HEALTH-RELATED CONSEQUENCES OF THE MODEL MINORITY STEREOTYPE FOR ASIAN AMERICANS

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Fifty years ago, the term model minority was coined to describe the extraordinary ability of Asian Americans to overcome hardship to succeed in American society. Less well-known is how the model minority stereotype was cultivated within the context of Black-White race relations during the second half of the 20th century, and how this stereotype, in turn, has contributed to the understanding and prioritization of health disparities experienced by Asian Americans. The objectives of this article are to define the model minority stereotype, present its controversies, and provide examples of its social and health-related consequences (ie, implications for obesity and tobacco) across multiple levels of society and institutions. A salient theme throughout the examples provided is the limitation of data presented at the aggregate level across all Asian subgroups which masks meaningful disparities. The intent is to increase the visibility of Asian Americans as a racial/ethnic minority group experiencing chronic disease health disparities and deserving of health-related resources and consideration. *Ethn Dis.* 2016;26(1):133-138; doi:10.18865/ed.26.1.133

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INTRODUCTION

According to the most recent Census data, Asian Americans comprise 5.6% of the United States population, and in metropolitan areas, such as New York City (NYC) or Los Angeles, up to 13% of the city-wide population.¹ The Asian American category includes East Asian (eg, Chinese, Japanese, Korean), South Asian (eg, Bangladeshi, Indian, Pakistani), Southeast Asian (eg, Filipino, Cambodian, Thai, Vietnamese), and sometimes Pacific Islander Americans (eg, Native Hawaiians, Chamorros, Marshallese), denoting a vastly diverse array of sub-populations with unique ethnic, cultural, linguistic and historical profiles, stretching across the entire Asian continent and its millions of islands. Asian Americans were the fastest growing race/ethnic group in the United States in the last ten years;¹ nationally, the Asian American population is projected to double in size to more than 43 million by 2050.

A common stereotype that has been applied to Asian Americans is that they are the model minority. Despite the fact that it is a positive stereotype, stereotypes that are indiscriminately applied have nega-

tive social and health implications, and the model minority stereotype is no exception. The purpose of this article is to define the model minority stereotype and present its controversies, and provide examples of the social and health-related consequences of this label at the broader

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level of the public health and health care sectors. The authors' intention is to increase visibility of Asian Americans as a racial/ethnic minority group that experiences certain

important health disparities, and to raise awareness of the potential detrimental and far-reaching effects of the model minority stereotype.

THE MODEL MINORITY STEREOTYPE: HISTORY AND DEVELOPMENT

The term, model minority, was first coined by two articles published in 1966: "Success Story, Japanese-American Style" in the *New York Times* by William Petersen, and "Success Story of One Minority in the United States" in the *US News and World Report*. Often attributed to East and South Asians, the model minority stereotype posits that Asian Americans are educated, law-abiding, hardworking, and have high incomes, low crime rates, and close family ties.^{2,3} From a broad perspective, this stereotype implies that Asian Americans are not an underprivileged racial/ethnic minority due to their economic success compared with other racial/ethnic groups,⁴ accordingly, Asian Americans merit neither resources nor attention as an ethnic minority group within the American population.

Conversely, the model minority stereotype implies that minorities other than Asian Americans are stereotypically lazy,² driving a wedge between Asian Americans and other ethnic minority groups. The model minority stereotype was incubated, developed and disseminated by conservatives as a way to directly oppose messaging of the Black Power Movement of the 1960s and 1970s, which claimed that "America was a funda-

mentally racist society, structured to keep minorities in a subordinate position."^{2,3} Thus the model minority stereotype was developed by conservatives in the backlash of the Black Power Movement to deny the existence of institutional racism, and to illustrate that individual underperformance explained racial inequality and disparities in American society.³

Supporters of the model minority stereotype have based their argument on three points: 1) despite cultural differences, Asian Americans have overcome structural barriers in American society; 2) labor market discrimination against Asian Americans no longer exists, as evidenced by the high concentrations of Asian Americans in high-paying, professional occupations; and 3) Asian American cultural factors, such as an emphasis on education, a strong work ethic and working to 'save face' keep the unemployment rate low in Asian Americans.^{2,4,5} However, critics of the model minority stereotype have countered these arguments with immigration, economic and education data illustrating the fallibility of the stereotype. For example, no empirical evidence exists to support extraordinary academic abilities in Asian Americans; furthermore, the occupational advantage in professional and engineering and science fields is misleading.^{2,4,5} While Asian Americans may occupy professional positions, they are often more likely to choose support rather than managerial roles or jobs that require minimal verbal expression.² Research also demonstrates the existence of a glass, or 'bamboo,' ceiling for Asian Americans in the workplace,⁶ an is-

sue that is ongoing and documented in current media. Even more fundamentally, critics have demonstrated that the model minority stereotype does not apply equally to all Asian ethnic subgroups, which differ substantially in their cultures, languages, historical patterns of immigration to the United States and level of acculturation within American society.

The Immigration Act of 1965 may be the single most important policy change influencing the inception of the model minority stereotype in 1966, and its development throughout the second half of the 20th century. This 1965 Act ushered in a new era of Asian immigration to the United States by implementing three key changes in immigration policy: 1) abolition of the national origins quota system from Asian countries and the setting of an annual ceiling of 170,000 visas for all countries outside the Western hemisphere (exclusive of parents, spouses and unmarried children); 2) emphasis on family reunification; and 3) employment clearances of certain immigrants, where immigrants with professional degrees were selectively preferred.⁷ As a result of the 1965 Act, hundreds of thousands of Asians immigrated to America, with the proportion of all immigrants increasing from 8% Asian pre-1965 to 43% Asian in the 1980s.⁸ In accordance with the new conditions set forth in the Immigration Act of 1965, many of the Asian American immigrants arriving post-1965 were highly skilled and educated professionals, with a high concentration of those in the medical profession from India and from the Philippines.⁸

These changes in immigration patterns contributed to the perception that Asian Americans were highly educated, fluent in English, successful and hardworking – ie, a model minority, and obscured disparities among Asian ethnic subgroups.

SOCIAL CONSEQUENCES OF THE MODEL MINORITY STEREOTYPE

The image presented by the model minority stereotype is indiscriminately applied to all Asian subgroups, and overstates the success of Asian Americans in terms of resiliency, health, wisdom and wealth. When presented in aggregate, national data show that Asian Americans are more likely to have a college education and higher income than other racial/ethnic minority groups. The Pew Research Center reported that, of adults aged ≥ 25 years, 49% of Asians, compared with 31% of Whites, 18% of Blacks, and 13% of Hispanics had a college education or more.⁹ However, huge variation exists when these data are disaggregated by Asian subgroup: 70% of Asian Indians compared to 26% of Vietnamese adults have a bachelor's degree or more. With regard to household income, the median household income for Asians is \$72,000/year, while the national average is approximately \$53,000/year.¹⁰ When disaggregated by subgroup, Asian Indians have the highest household income at \$95,000, while Bangladeshis have the lowest at \$46,950/year. These numbers further illustrate that both across the 'Asian' category and with-

in a specific Asian subgroup (in this case, South Asian) a bimodal income distribution exists.¹⁰ Demographic data on Asian Americans in the aggregate bolster the model minority stereotype indicating Asians are healthier than other racial/ethnic minority populations, thus giving license to ignore true social disparities.

These education and income data also play out in the college admissions process and affirmative action discourse. While early immigration

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policy favored professional immigrants from Asian countries, elite colleges and universities now limit admissions of Asian American students using a higher admissions standard.^{11,12} Asian American students must outperform (ie, have higher test scores) than their White, Black and Hispanic counterparts to be given the same consideration for admission.¹¹

More broadly, the model minor-

ity myth allows the government to overlook Asian American problems that many, including Asian Americans themselves, may not even realize exist. Arthur Fletcher, the chair for the 1990 Civil Rights Commission on Asian Pacific Islanders, wrote in a letter to President Bush, "Asian Americans suffer widely the pain and humiliation of bigotry and acts of violence...They also confront institutional discrimination in numerous domains, such as places of work and schools, in accessing public services, and in the administration of justice...[the model minority] stereotype leads federal, state, and local agencies to overlook the problems facing Asian Americans, and it often causes resentment of Asian Americans within the general public."¹³ The stereotype undercuts the significance of health and social disparities experienced by Asian American communities and the need to devote resources to mitigate those disparities, and is marked by a dearth of health studies focused on Asian American communities.¹⁴ Both the stereotype and this persistent lack of disaggregated data perpetuate a cycle wherein Asian American populations are excluded from consideration for public service programming and funding.

HEALTH CONSEQUENCES OF THE MODEL MINORITY STEREOTYPE

Because of the model minority stereotype, Asian Americans are commonly believed not to experience health disparities. Owing in part to these beliefs and in part to

making up a small percentage of the national population, Asian Americans are excluded from many national health databases. Additionally, when Asian Americans are included in these surveys, current national survey techniques that utilize random-digit dial and questionnaire administration in English and Spanish only contribute to small sample sizes of Asian Americans.¹⁵ These data are rarely analyzable overall or when disaggregated by Asian subgroup.¹⁵ Other databases that include Asian Americans, such as the Surveillance, Epidemiology and End Results (SEER) cancer registry do not account for the variegated geographic distribution of Asians across the United States. For example, the majority of Asian Americans in the West are Filipino, while Chinese comprise the majority in the East, and Asian Indians comprise the majority of Asian Americans in the South.¹ Furthermore, the SEER registry does not include a site in New York, the city with the largest and most diverse Asian American population.

Two examples are presented below to illustrate how the model minority stereotype impacts the collection and interpretation of health data for Asian Americans and the corresponding allocation of resources and development of initiatives to address Asian American health issues.

Obesity in Asian Americans

Recently, obesity prevalence for the Asian American non-institutionalized adult population using measured body mass index (BMI) values was presented for the first time as 10.8%; an estimate lower compared

with all other racial/ethnic groups, whose values ranged from 32.6% to 47.8%.¹⁶ However the advantage observed between Asian Americans and other groups may be misleading for three primary reasons.¹⁷ First, lower BMI cutoffs may be more appropriate to use in Asian populations in order to meaningfully rank individuals at risk for chronic disease morbidity and mortality.¹⁸ The rationale for modifying these cutoffs is that ethnic Asians tend to have a higher percent body fat for the same BMI as compared with Whites, possibly due to leg length relative to height and/or to smaller body frames – of which Asians tend to have both versus Whites.¹⁹ However, the evidence for formal adoption of these modified cutoffs is limited.¹⁸ Furthermore, application of a lower cutoff would immediately and significantly increase the global obesity prevalence for Asians, and the current limited evidence is not strong enough to justify increases in health care spending and changes to health care policy that would ensue from these new data. Despite the lack of formal adoption of these cutoffs, the modified cutoff may still be useful to consider and/or present for Asian American populations – particularly when reporting prevalence of overweight and obesity.

Second, prevalence of obesity differs by Asian subgroup, with the highest values observed in South Asian Americans,¹⁷ who also have the highest prevalence of diabetes.²⁰ The co-morbidity of obesity and diabetes in South Asian Americans – a specific Asian subgroup – is therefore an issue of public health significance. Third, the prevalence of obesity in

Asian Americans should be placed in the larger context of immigration and globalization through cross-national comparisons and examination of acculturation-related factors, particularly given the increased and substantial burden of diabetes globally in rapidly developing countries such as China and India.²¹ Thus, within the framework of the model minority stereotype, Asian Americans may be excluded from health conversations, policy and planning designed to address the obesity epidemic when they are an at-risk subgroup.

Tobacco Use in Asian Americans

Asian Americans are reported to experience the lowest smoking rates compared with other racial/ethnic minority populations,²² portraying the group overall in a positive light, in line with the model minority stereotype. These findings, however, are largely based on data from surveys that aggregate Asian subgroups, thus masking substantial differences in tobacco use by Asian subgroup. Community-based studies on specific Asian subgroups, as well as local and regional surveys that allow for disaggregating Asian subgroups, have reported elevated smoking prevalence among several Asian ethnic subgroups.²³ In NYC for example, the overall prevalence of current smoking is 18.6% in Whites and 14.1% in Asians.²² However, when disaggregated by subgroup, prevalence of current smoking was 35.5%, 17.7% and 10.1% in Koreans, Chinese and Asian Indians, respectively.²⁴ Partly due to a lack of reliable data and other data-related

challenges, public health and tobacco control movements have not focused on tobacco control issues among Asian Americans.²⁵ The end result is limited capacity and infrastructure to support tobacco prevention and control efforts among Asian American communities.

CONCLUSIONS

The prevailing idea in American society that Asian Americans do not experience poor social and health outcomes undermines the nature and obscures the magnitude of health disparities experienced across Asian subgroups. The model minority stereotype is a myth, based on selective immigration policies favoring skilled, professional workers; the stereotype was created to support the idea that the United States is fundamentally a non-racist society and was perpetuated through the presentation of data that aggregates diverse Asian subgroups. The categorization of Asian Americans as the model minority is pervasive, limiting the access of Asian Americans to important services in financial and educational systems and contributing to a lack of awareness among public health practitioners of how to tackle health conditions and behaviors within the many diverse Asian communities encompassed by the term, Asian American. Ultimately, the model minority stereotype prevents Asian Americans from being considered a racial/ethnic minority deserving of resources at societal, governmental and individual levels.

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CONFLICT OF INTEREST

No reports of conflict of interest.

AUTHOR CONTRIBUTIONS

Research concept and design: Yi, Trinh-Shevrin. Acquisition of data: Yi, Sacks. Data analysis and interpretation: Kwon, Sacks. Manuscript draft: Yi, Kwon, Sacks, Trinh-Shevrin. Statistical expertise: Yi. Acquisition of funding: Trinh-Shevrin. Administrative: Kwon, Sacks. Supervision: Trinh-Shevrin.

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