

Unmasking COVID-19 in the Pacific

Standardizing Disaggregated Racial and Ethnic Data Collection and Reporting Practices to Ensure Equity and to Accurately Reflect California's Diversity

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Standardized racial and ethnic data collection and reporting categories are essential for addressing health emergencies such as pandemics and reducing health inequities in California. This data allows policymakers, health agencies, and community-serving organizations to obtain an accurate view of the impact and progression of diseases and health conditions among California's diverse communities. The benefit of having such data across detailed racial and ethnic groups is clear. This data allows for more efficient and equitable allocation of resources to communities suffering disproportionately and tailoring more effective programs that take into account diverse linguistic and cultural needs. This is particularly true for California's Native Hawaiian and Pacific Islander communities which have had the highest COVID-19 case and death rates since the start of the pandemic.

California is home to 337,617 Native Hawaiians and Pacific Islanders (NHPIs), a community that has grown 18% since 2010.¹ The contributions of NHPIs to California have been recognized by both the State Assembly and Senate.^{2,3} NHPIs are often combined with Asian Americans under the obsolete and overly broad "Asian Pacific Islander" data category. A disaggregated NHPI data category allows health agencies to identify health disparities and challenges facing NHPIs that would otherwise not be apparent under the "Asian Pacific Islander" category.

However, the NHPI category itself is too broad and insufficient for designing and evaluating effective health interventions. This is because the NHPI community itself is incredibly diverse and encompasses dozens of distinct Islander communities, each with their own language, culture, and traditions. This means that health interventions tailored for one NHPI community may be largely unsuitable for another NHPI community. For example, data from the California Department of Public Health reveals that NHPIs have the highest cumulative COVID-19 case and death rates of any racial or ethnic group in California.⁴ However, Sāmoan, Tongan, and Marshallese communities, of which a significant proportion speaks a language other

than English at home⁵ had far higher COVID-19 cases and death rates than other NHPI communities.⁶ NHPIs, as a group, have also been diagnosed with diabetes at twice the rate of Asian Americans⁷ but 22.1% of Sāmoan adults have been diagnosed with diabetes compared to 14.2% of Native Hawaiians.⁸

Key Findings

Addressing health inequities rests on the ability to accurately collect and report disaggregated health care information. California has over 3,000 county health departments, private and public medical clinics, insurance companies, and hospital networks that all operate independently. However, there is no mandate requiring their use of standardized racial and ethnic categories or question formats when collecting data.

The lack of standardized racial and ethnic categories in data collection processes resulted in 87% of NHPI cases not identifying an NHPI-specific sub-group in reported data about one year into the pandemic.⁹ As of May 2020, 11.6% (817,260) of cases were missing race and ethnicity data. Also, more NHPIs are being reported as having received the COVID-19 vaccine than there are eligible NHPIs in numerous counties and at the state level.¹⁰ Thus, the ability to identify and address health inequities relies on addressing public health data gaps.¹¹

Recommendations

1. **Racial and ethnic data, including a disaggregated category for NHPIs and NHPI sub-groups, should be standardized across all health care agencies in the data collection and dissemination processes.** This includes utilization of multiracial NHPI categories and, at a minimum, NHPI detailed sub-groups under California Government Code 8310.5 and 8310.7. Forms should incorporate multiple checkboxes for major NHPI sub-groups and a write-in section to maximize inclusive and accurate racial and ethnic reporting. This will allow consistency in reporting health data, help avoid the use of categories that do not inform health policies or programs such as

“multiracial” or “other,” and more accurately capture community needs and inequities as well as inform health interventions and program evaluations. Public health agencies in California should also utilize consistent numbers, ratios, or percentages when analyzing NHPI populations.

2. **Data should be aggregated to the smallest geographic unit possible to preserve precision and minimize data suppression while maintaining compliance with data privacy laws.** For example, if neighborhood-level data is unavailable due to privacy thresholds, the next largest geographic level that meets data suppression thresholds should be publicly reported. At a minimum, NHPI data must be presented at the state level. Standardized reporting practices should also clarify the ability of health agencies at the local and state level to apply flexible privacy threshold standards when extenuating circumstances permit. For example, the lowering of reporting thresholds for NHPI COVID-19 data in Los Angeles County permitted community organizations to recognize immediate and pressing needs for programs to educate various NHPI communities on best practices to reduce community spread and seek resources for testing and vaccination sites.
3. **Precedence for requiring government agencies to utilize a disaggregated NHPI category exists at the federal level as a result of Office of Management and Budget Directive No. 15 in 1997, and the passage of legislation revising CA Government Code 8310.5 and 8310.7. Directive No. 15 mandated the use of an NHPI category at the federal government level and codes 8310.5 and 8310.7 mandates the use of the categories of “Native Hawaiian,” “Guamanian or Chamorro,”**

“Samoan,” “Tongan,” and “Fijian.” There is also precedent for mandating local government agencies to utilize standardized racial and ethnic collection and reporting categories (e.g., AB 953, 2015 Racial Identity Profiling Statistics Act). While the racial and ethnic categories promulgated in AB 953 regulations are intended to capture the race or ethnicity perceived by law enforcement, we recommend that the racial and ethnic categories utilized to collect health data should be self-reported.

Endnotes

1. United States Census Bureau; Decennial Census, 2020 Decennial Redistricting Data (PL 94-171), Table P1; generated by Authors; using data.census.gov; < <https://data.census.gov/cedsci/> > (18 July 2022).
2. California Assembly Concurrent Resolution No. 67 (2011-2012), Furutani, Relative to the Native Hawaiians and Pacific Islanders Communities, https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201120120ACR67.
3. Senate Concurrent Resolution No. 127 (2015-2016), Lara, Relative to the Native Hawaiian and Pacific Islander Community, http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0101-0150/scr_127_bill_20160812_enrolled.htm.
4. UCLA Center for Health Policy Research, Native Hawaiian & Pacific Islander Data Policy Lab, NHPI COVID-19 Data Policy Lab Dashboard; <https://healthpolicy.ucla.edu/health-profiles/Pages/NHPI-COVID-19-Dashboard.aspx> (2 August 2022).
5. United States Census Bureau; American Community Survey 2011-2015, Table B16004; <<https://data.census.gov/cedsci/table?text=B16004&t=-05%20-%20All%20available%20detailed%20Native%20Hawaiian%20and%20Other%20Pacific%20Islander%20races&tid=ACSDT5YSPT2015.B16004>> (2 August 2022).
6. Radhakrishna, R. “Love in the Time of Coronavirus: Advancing Anti-Racism, Resiliency, and Climate Action” (presentation, 23rd Annual Health Equity Symposium, November 2021).
7. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, “2018 Summary Health Statistics”; Table A-4a. (Figures are age-adjusted for adults 18 and over)
8. CDC, 2017. Health Conditions and Behaviors of Native Hawaiian and Pacific Islander Persons in the United States, 2014. Vital and Health Statistics, Series 3, No. 40. Table 9. https://www.cdc.gov/nchs/data/series/sr_03/sr03_040.pdf
9. Radhakrishna, R. “Love in the Time of Coronavirus: Advancing Anti-Racism, Resiliency, and Climate Action” (presentation, 23rd Annual Health Equity Symposium, November 2021).
10. California for All, “Vaccination Data,” last modified July 15, 2022, <https://covid19.ca.gov/vaccination-progress-data/>
11. The Council of State and Territorial Epidemiologists (CSTE), “Addressing Gaps in Public Health Reporting of Race and Ethnicity Data for COVID-19: Findings & Recommendations Among 45 State & Local Health Departments.” https://preparedness.cste.org/wp-content/uploads/2022/04/RaceEthnicityData_FINAL.pdf

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