Health Care Needs and Service Delivery for Asian and Pacific Islander Americans: Health Policy

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As the Asian and Pacific Islander American population increases and its demographics change, the need for health care is a subject of much concern. Central to any discussion about health care services for Asian and Pacific Islander Americans is the issue of access. Although access to health care has been a widely researched topic in the United States, and in fact much time and effort has been spent in outlining the barriers to care that face Asian and Pacific Islander individuals, existing health care policies do little to eliminate these barriers. In fact, among the most widely debated policy issues of the day is the reform of the existing U.S. health care system to ensure accessibility for all; but an examination of current proposals reveals that they do not address language and cultural factors in the delivery of care, two factors that affect the use of health services.[1] Because Asian and Pacific Islander communities are relatively new and relatively small, little is known about our health care needs. In the absence of a better empirical basis for policy formation, the requirements for health services for Asians and Pacific Islanders remain difficult to assess.

While the issue of access is critical to any discussion of health care services, it is beyond the scope of this article to provide a complete analysis of this problem. However, indicators relating to access can be measured by

examining Asian and Pacific Islander population characteristics. This article will describe the need for health care services by highlighting certain population characteristics and analyzing the existing health care delivery system in terms of the availability of services for Asian and Pacific Islanders. Finally, this article will conclude with policy recommendations.

Sociodemographic Profile: Key Predictors for Access to Health Services

The context for evaluating current health care services for Asians and Pacific Islanders is the sociodemographic profile of "at-risk" populations (see table 1).

Table 1 lists sociodemographic characteristics which are key indicators and predictors to the use of health services. Factors such as age, sex, race/

Table 1. Characteristics of Population At-Risk
(Indicators of Potential Use of Health Services)*

Predisposing	Enabling	Need
Age	Residence (Location)	Morbidity
Sex	Income	Mortality
Race/Ethnicity	Employment Status	Limited Activity Days
Language	Occupation	Family Health History
Nativity	Level of Insurance	
Education		

* Adapted from behavioral model of health access developed by Aday et al., *Health Care in the United States: Equitable for Whom?* (New York: Sage Publications, New York, 1980).

ethnicity, language, nativity, and education are identified as "predisposing" characteristics. These factors are assumed to exist prior to any recognition of the need for health care. "Enabling" characteristics include such factors as residence, income, employment status/occupation, and level of insurance. They describe the resources available to a population to gain access to services.

Predisposing Characteristics

Table 2 describes the Asian and Pacific Islander population by age/sex breakdown using 1990 Census data. As the table shows, 53.2 percent of females in 1990 are of childbearing age, suggesting the need for reproductive, maternal and child health and other primary health care services.

Table 2: U.S. Asian and Pacific Islander Population by Age & Sex, 1990

	Percent of Population	
Age	Male	Female
75 and over	1.9	2.3
65 to 74	3.7	4.5
55to 64	5.8	7.0
45 to 54	9.8	10.0
35 to 44	16.4	17.7
25 to 34	19.4	19.5
15 to 24	18.0	16.0
5 to 14	16.4	15.2
4 and below	8.4	7.7

Source: U.S. Bureau of the Census, 1990 Census

Projections for the year 2020 indicate a two to threefold increase in the elderly population, suggesting the need for additional attention to elderly needs in the future and more chronic disease prevention services in the present.

Table 3 lists ethnicity and nativity characteristics from the 1990 Census. The 1990 Census currently categorizes up to 17 different Asian ethnicities and eight Pacific Islander ethnicities, in addition to two "other" categories. Although 1990 data is not yet available on language characteristics of ethnic groups, the 1980 Census indicated that 85 percent of Asians and Pacific Islanders spoke a language other than English at home. According to 1990

Table 3. Ethnicity and Nativity Characteristics of Asian and Pacific Islander Americans in 1990

Race/ Ethnicity	Population	Race/ Ethnicity	Population
Chinese	1,645,472	Hawaiian	211,014
Filipino	1,406,770	Samoan	62,964
Japanese	847,562	Guamanian	49,345
Asian Indian	815,447	Tongan	17,606
Korean	798,849	Fijian	7,036
Vietnamese	614,547	Palauan	1,439
Laotian	149,014	No. Mariana Islander	960
Cambodian	147,411	Tahitian	944
Thai	91,275	Other Pacific Islander	13,716
Hmong	90,082	Total Pacific Islander	365,024
Pakistani	81,371		
Indonesian	29,252	**Total Asian Pacific Islander**	**7,273,662**
Malaysian	12,243		
Bangladeshi	11,838	White	199,686,070
Sri Lankan	10,970	Black	29,986,060
Burmese	6,177	Amer. Ind., Eskimo & Aleut	1,959,234
Okinawan	2,247	Other Race	9,804,847
Other Asian	148,111	Hispanic Origin	22,354,059
Total Asian	6,908,638	**Total U.S. Population**	**248,709,873**

Table 4: U.S. PMSA/MSA with the Largest 1990 Asian and Pacific Islander Population

Rank	State	PMSA/MSA	1990 A/PI Population	% of Total PMSA/MSA Population	% of 1990 State A/PI Population
1	CA	Los Angeles-Long Beach	954,485	10.8%	33.5%
2	NY	New York	556,399	6.5%	81.2%
3	HI	Honolulu	526,459	63.0%	76.8%
4	CA	San Francisco	329,599	20.6%	11.6%
5	CA	Oakland	269,566	12.9%	9.5%
6	CA	San Jose	261,466	17.5%	9.2%
7	CA	Anaheim-Santa Ana	249,192	10.3%	8.8%
8	IL	Chicago	229,492	3.8%	80.4%
9		Washington, DC-MD-VA	202,437	5.2%	71.0%
10	CA	*San Diego	198,311	7.9%	7.0%
11	WA	Seattle	135,251	6.9%	64.1%
12	TX	Houston	126,601	3.8%	39.6%
13	CA	*Sacramento	114,520	7.7%	4.0%
14	PA	Philadelphia	104,595	2.2%	76.1%
15	CA	Riverside-San Bernadino	100,792	3.9%	3.5%
		Total of U.S. Asian Pacific Islander Population	4,359,165		59.9%

*Signifies an MSA.

Source: U.S. Bureau of the Census, 1980 & 1990 Censuses.
Asian/Pacific Islander Data Consortium-ACCIS; San Francisco, CA

Census data, Asians and Pacific Islanders had the highest percentage of all persons five years and over who were characterized as "linguistically isolated." In California in 1990, 32.8 percent of all Asian and Pacific Islander households that spoke an Asian Pacific language were "linguistically isolated," as compared to 27.8 percent of Spanish-speaking households and 14.9 percent of households speaking "other" languages, according to data collected and analyzed by the Asian/Pacific Islander Data Consortium.

The existence of many different Asian and Pacific Islander communities means that distinctions in language, practices and beliefs must be taken into consideration in the organization and structure of health services, particularly when coupled with data indicating that the overwhelming majority of Asian and Pacific Islanders will continue to be foreign born up to the year 2020. The need to provide health care services to culturally and linguistically diverse populations presents special challenges now and in the future.[2]

Enabling Characteristics

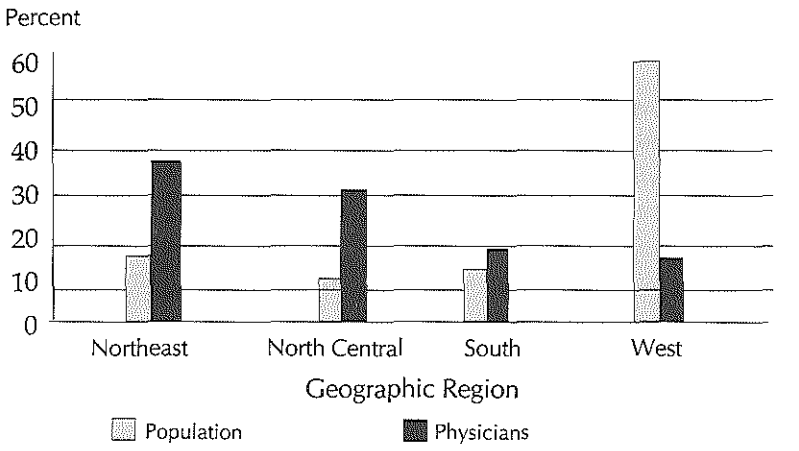
Asian and Pacific Islander Americans in 1990, as in 1980, resided primarily in urban areas, and in the western United States, as indicated by table 4.

Of the top 15 PMSA/MSAs in the U.S. for Asian and Pacific Islander Americans, 11 are in the western region (Los Angeles-Long Beach, Honolulu, San Francisco, Oakland, San Jose, Anaheim-Santa Ana, San Diego, Seattle, Houston, Sacramento and Riverside-San Bernadino), one in the midwest (Chicago), and three are in the eastern region (New York, Washington, D.C., Philadelphia). Among other things, this concentration has significance for physician provider match-ups (see chart 1 showing the distribution of Asian and Pacific Islander physicians).

Paul Ong's population projections for 2020 indicate a 160 percent growth in California's Asian and Pacific Islander population to 7,411,136 in 2020, and a growth in the northeast Mid-Atlantic region (New York, New Jersey, Pennsylvania) population to 2,925,671. Given the current distribution of the physician population, it would appear that unless a major redistribution of physician resources occurs in the next 30 years, Asian and Pacific Islander Americans will continue to experience a physician service deficit in the future.

Educational attainment for Asians and Pacific Islanders represents a bimodal pattern consistent with other socioeconomic indicators. Approxi-

Chart 1: Percent Distribution of Asian Health Professionals & Population by Geographic Region, 1980



Source: Location Patterns of Minority and Other Health Professionals, PHS, HRSA, BHP, Office of Data Analysis and Management, 1985

mately 18.5 percent of Asians and Pacific Islanders 25 years or older in 1990 were high school graduates, 22.7 percent had a bachelor's degree and 13.9 percent had a graduate or professional degree. While this information indicates a high level of educational achievement, 13.7 percent of Asians and Pacific Islanders 25 years or older had less than a ninth grade education as compared to Whites at 8.9 percent. In California, the percentage was 8.7 percent for Asians and Pacific Islanders, second only to "Other Race" (20.3 percent) in this cohort. Level of education, of course, has important consequences for income earning potential, as well as for knowledge of healthy behaviors, service availability and options for acquiring health care.

In 1990, 94.5 percent of civilian Asian and Pacific Islander females and 94.9 percent of males over 16 years of age were employed in the United States. However, this apparently high level of employment does not guarantee health insurance coverage, as 28 percent of Asians and Pacific Islanders in the U.S. were uninsured, compared to Whites at 20 percent.[3] Over 14 percent of Asians and Pacific Islanders lived below the poverty level as compared to Whites at 9.8 percent. In California, per capita income for Asians and Pacific Islanders averaged $13,733, $5,295 lower than per capita

income for Whites. The ability to pay for health care services through direct purchase of insurance is limited for low-income individuals, and for Asian and Pacific Islander Americans, the high proportion of immigrants among the low-income stratum often precludes obtaining care through public subsidy because of limits on eligibility for the newly-arrived.

Health Status

The final category of characteristics which make up the determinants of health care use includes need indicators such as mortality, morbidity, limits of physical activity, and medical emergencies. Although as noted above, little documentation exists to characterize the health status of Asian and Pacific Islander ethnic groups, it is important to summarize some of what is known about the different groups in order to substantiate distinct health needs and service requirements.

Among Asian and Pacific Islander Americans, the distribution of health problems varies among ethnic groups. While heart diseases are more prevalent among the white population, cancer and cerebrovascular diseases are more highly prevalent among Chinese, Japanese and Filipino Americans.[4] Filipinos have a high incidence of hypertension, and Southeast Asian refugees have a high prevalence of tuberculosis infection, hepatitis B, intestinal parasites and anemia. While Filipino females have a lower incidence of breast cancer (41 per 100,000) as compared to Japanese and Chinese (56 per 100,000), they have the lowest survival rates (74 percent) as compared to Japanese and Chinese (85 percent) and to Whites (78 percent). Hawaiians are five times more likely to die of stomach cancer than their white counterparts, and have a higher prevalence of diabetes (48.8 percent) as compared to Whites (7.3 percent). Recent studies reveal smoking rates of 24 percent for Filipinos, 35.8 percent for Koreans in California and up to 72 percent for Lao among Asian males.[6]

Assessing health status by measuring the leading cause of death (LCD) for Asians and Pacific Islanders has recently been the subject of a monograph developed by the Asian American Health Forum in California.[7] This LCD ranking is the only population-based analysis of mortality *by specific ethnic group* to be accomplished to date (see tables 5 and 6).

As table 6 shows, the ten leading causes of death for Asians and Pacific Islanders roughly resembles the same profile as for Whites, and except for AIDS (13th) and suicide (8th), are also similar to other population groups.

Table 5: Leading Causes of Death in California
Number of Deaths and Rank, by Race, 1989

Cause of Death§	Total		Asian & Pacific Islander		Other		Hispanic		Black		White	
	No. of Deaths	Rank	No. of Deaths	Rank	No. of Deaths	Rank	No. of Deaths	Rank	No. of Deaths	Rank	No. of Deaths	Rank
Diseases of the Heart	69,457	1	2,335	1	215	1	4,875	1	5,267	1	56,765	1
Malignant Neoplasms	48,110	2	2,198	2	125	2	3,493	2	3,498	2	38,796	2
Cerebrovascular Disease	15,725	3	833	3	43	4	1,151	4	1,169	3	12,529	3
Unintentional Injuries	10,791	4	496	4	93	3	2,559	3	919	5	6,724	6
Pneumonia and Influenza	10,479	5	394	5	24	7	772	7	620	6	8,669	4
C.O.P.D.*	9,759	6	253	6	25	6	445	12	488	8	8,548	5
AIDS	4,367	7	70	13	12	13	647	9	543	7	3,095	7
Liver Disease***	4,000	8	119	12	41	5	840	6	313	11	2,687	9
Suicide	3,832	9	158	8	20	10	433	13	179	13	3,042	8
Diabetes Mellitus	3,364	10	172	7	22	9	591	10	430	10	2,149	10
Homicide	3,270	11	139	9	28	11	1,091	5	1,068	4	944	11
Perinatal Period**	2,137	12	126	10	19	12	745	8	466	9	781	13
Congenital Anomalies	1,615	13	121	11	13	8	502	11	187	12	792	12
Other Causes	29,024		1,214		155		3,020		2,442		22,193	
Total Number of Deaths	215,930		8,628		835		21,164		17,589		167,714	

* Chronic Obstructive Pulmonary Disease and Allied Conditions
** Certain Conditions Originating in the Perinatal Period
*** Chronic Liver Disease, Cirrhosis

Source: California Department of Health Services
Prepared by: Survey and Research Program of the Asian American Health Forum

Table 6: Rate of Death from All Causes by Race or Ethnicity: California, 1989

Race or Ethnicity	Number of Deaths from All Causes	1990 Population in California*	Rate of Death from All Causes per 100,000 of the Population C/D x 100,000
Japanese	1,558	312,989	498
Other Pacific Islander	85	19,176	443
Samoan	123	31,917	385
Asian Specified**	223	58,058	384
Chinese	2,545	704,850	361
Filipino	2,412	731,685	330
Korean	626	259,941	241
Hawaiian	75	34,447	218
Guamanian	54	25,059	215
Cambodian	130	68,190	191
Vietnamese	450	280,223	161
Thai	47	32,064	147
Asian Indian	221	159,973	138
Asian Unspecified	156	127,087	123
Total Asian & Pacific Islander	8,628	2,845,659	303
Other	835	4,181,234	20
Hispanic	21,164	7,687,938	275
African American	17,589	2,208,801	796
White	167,714	20,524,327	817
Total	215,930	29,760,021	

* 1990 Census population data were used as a denominator since no 1989 population estimates were available.

** Asian Specified includes Lao and others presumed to be Lao.

Source: California Department of Health Services, U.S. Bureau of the Census
Prepared by: Survey and Research Program of the Asian American Health Forum

Table 7: Diseases of the Heart
Primary Leading Cause of Death among
Asian and Pacific Islander Americans in California, 1989

Race or Ethnicity	Number of Deaths from Diseases of the Heart	1990 Population in California*	Rate of Death from Diseases of the Heart per 100,000 of the Population C/D x 100,000
Japanese	447	312,989	143
Other Pacific Islander	22	19,176	115
Filipino	758	731,685	104
Samoan	32	31,917	100
Chinese	694	704,850	98
Hawaiian	27	34,447	78
Guamanian	14	25,059	56
Asian Specified**	30	58,058	52
Korean	133	259,941	51
Asian Indian	76	159,973	48
Asian Unspecified	37	127,087	29
Cambodian	19	68,190	28
Vietnamese	60	280,223	21
Thai	5	32,064	16
Total Asian & Pacific Islander	2,335	2,845,659	82
Other	215	4,181,234	5
Hispanic	4,875	7,687,938	63
African American	5,267	2,208,801	238
White	56,765	20,524,327	277
Total	69,457	29,760,021	

* 1990 Census population data were used as a denominator since no 1989 population estimates were available.

** Asian Specified includes Lao and others presumed to be Lao.

Source: California Department of Health Services, U.S. Bureau of the Census
Prepared by: Survey and Research Program of the Asian American Health Forum

Table 8: Certain Conditions Originating in the Perinatal Period—Tenth Leading Cause of Death among Asian and Pacific Islander Americans in California, 1989

Race or Ethnicity	Number of Deaths from Certain Conditions*	Number of Live Births**	Rate of Death from Certain Conditions Originating in the Perinatal Period per 100,000 Live Births C/D x 100,000
Asian Unspecified	14	1,960	714
Thai	3	637	471
Asian Indian	7	2,333	300
Japanese	10	3,363	297
Cambodian	7	2,525	277
Asian Specified***	13	4,743	274
Other Pacific Islander	3	1,169	257
Chinese	24	9,698	247
Filipino	30	13,679	219
Korean	9	4,261	211
Samoan	2	1,007	199
Vietnamese	12	6,107	196
Hawaiian	0	488	0
Guamanian	0	405	0
Asian & Pacific Islander	126	52,375	241
Other	19	5,037	377
Hispanic	745	211,696	352
African American	466	47,555	980
White	781	252,645	309
Total	2,137	569,308	

* Deaths include infant deaths as well as deaths of the mother; therefore, these rates should not be confused with infant mortality rates.

** No. of Live Births was used as a denominator to determine rate of death.

*** Asian Specified includes Lao and others presumed to be Lao.

Source: California Department of Health Services, U.S. Bureau of the Census
Prepared by: Survey and Research Program of the Asian American Health Forum

The overall crude death rate for Asians and Pacific Islanders (303 per 100,000) is lower than for African Americans and Whites, but higher than Hispanics and "Others." Table 6 presents the death rates for Asians and Pacific Islanders, broken down by ethnicity.

A look at the first and tenth leading cause of death for Asians and Pacific Islanders in California illustrates the importance of disaggregation of data and the implications for health services and intervention (see tables 7 and 8). The overall death rate for Asians and Pacific Islanders due to Diseases of the Heart, the first leading cause of death, is 82 per 100,000, which ranks third highest among all population groups. When broken down by ethnicity, the death rate ranges from a high of 143 per 100,000 for Japanese to a low of 16 per 100,000 for Thai. For the tenth leading cause of death, Perinatal Related Conditions, the overall death rate is 241 per 100,000 for Asians and Pacific Islanders, the lowest of all population groups. When disaggregated by ethnicity, however, a tremendous range is represented, from 714 per 100,000 for "Asian Unspecified" to 196 per 100,000 for Hawaiians. This range graphically illustrates the implications of using aggregated data to develop policy and establish services.

In the past, policies geared towards preventing deaths from these causes have made use of aggregated Asian and Pacific Islander health data, or more likely no data, resulting in programs and services that have had little impact.

The differences in health condition that the above statistics describe indicate distinct at-risk profiles for Asian and Pacific Islander ethnic groups. This information needs to be taken into account in order to formulate policy that will assure the delivery of primary care services and health promotion/disease prevention programs for these populations.

Health Delivery System

The United States health delivery system is quite fragmented, with limited coordination of services. Except for a few models of health delivery programs—for example, community-based primary care and some health maintenance organizations—"mainstream" medicine does not emphasize comprehensive health care programs. Under a comprehensive care program, a person with multiple health concerns can receive the necessary care in a coordinated fashion, including services such as mental health, family planning, nutrition counseling, health promotion and education programs for smoking cessation or weight control. Findings from a recent

survey of health providers involved in bilingual primary care services cited a lack of coordination between various health care facilities in a given geographical area as an impediment for providing access to comprehensive health care.

The availability of appropriate and quality health services is a major factor influencing access to care. This includes providing a range of culturally and linguistically appropriate care: adequately trained translators, bilingual providers and support personnel, culturally sensitive methods of care, and the ability of a patient to obtain care within a reasonable time frame in a supportive environment. According to data from the Association of Asian/Pacific Community Health Organizations (AAPCHO), only eight community health centers among over 400 federally funded centers provide comprehensive, primary care to low-income, limited English speaking Asian and Pacific Islander communities in the United States. These eight centers provide care to over 60 percent of the estimated Asian and Pacific Islander population eligible to receive subsidized care in their service areas, while the remaining 40 percent receive care from one of 86 centers nationwide.[8]

The results from a recent needs assessment conducted by the Association of State and Territorial Health Officers (ASTHO) in the U.S. on state-sponsored bilingual health services reported that only 26 percent of the states responding indicated that linguistically appropriate service delivery is a high priority; 54 percent rated it an average priority, and 20 percent rated it below average or as a low priority.[9] The same report indicated that bilingual/bicultural services were not uniformly offered across all service programs. Overall, the number of bilingual services offered across all state health programs ranged between three and 49, with STD/HIV/AIDS programs having the highest number of bilingual/bicultural services available.[10] Immunization and TB and Maternal and Child Health programs ranked second and third for bilingual/bicultural services. For distribution of educational/information services, 70 percent of respondent states had material in Vietnamese, 52 percent in Cambodian, and 21 percent in Chinese languages. For the various programs, the most utilized method for written or oral translation was to contract individuals as needed.

In a national survey conducted by the Asian American Health Forum of health promotion/disease prevention programs implemented by Asian and Pacific Islander community-based organizations or public entities, 62 percent of respondents indicated some health program in place targeting

Asian and Pacific Islander populations. As with the ASTHO survey, the largest number of programs were HIV/AIDS programs, followed by infectious disease, mental health, nutrition and substance abuse programs. Health Education ranked highest as the type of service delivered, followed by screening, counseling, research and, lastly, primary care.

Very little other data exists to assess the ability of the health care delivery system to respond to the needs of Asian and Pacific Islander Americans. In light of the above attempts to collect national data, however, it is apparent that current community-based and publicly financed attempts to provide health care services to Asians and Pacific Islanders are not sufficient. If, as projected, our population continues to experience exponential growth, then policies and programs will have to see our needs of as a priority.

Equity in Access to Health Care: Policy Recommendations

A more complete analysis of access requires an in-depth study of Asian and Pacific Islander behaviors with regard to health practices, satisfaction with and utilization of services and patient outcomes. Further, the health delivery systems must be examined thoroughly concerning commitment of resources, both public and private, to Asian and Pacific Islander health needs. Much more research and better data collection are needed to adequately formulate policy in this area.

However, even with these stated limitations, the above analysis provides some direction for policy recommendations, assuming that equity in access to health care is a desired objective of policy formation.

The population characteristics presented earlier in this article as indicators of risk, or predictors for service utilization, serve as the basis for our policy recommendations. Immutable, or unalterable characteristics, such as age, sex, race/ethnicity, language, nativity and residence (location), are grouped primarily within the predisposing category and generally cannot be changed through policy intervention. Characteristics that are considered alterable through policy intervention are grouped primarily within the enabling category and include income, employment, occupation and insurance. They also include factors such as education, health practices and attitudes.

Service delivery systems have characteristics which affect access to services but which can be altered and improved. These include organization

(e.g., definition of target populations, patient's waiting time, health plan/program participation) and resources (e.g., types of providers and practices, and supply and distribution of providers and facilities).

It is clear from the sociodemographic profile presented earlier that Asians and Pacific Islanders are at health risk. In order to respond to these needs, health policy development should focus on alterable characteristics in individuals and the delivery system. The following recommendations are grouped by general, individual and system specific categories.

General Recommendations

1. Prioritize the institution of culturally competent health care service delivery in all proposals for health care reform.
2. Modify current national and state data collection methods and reporting systems to codify Asian and Pacific Islander populations by ethnicity and, where appropriate, break down morbidity, mortality, health care use and expenditures by specific ethnic group.
3. Create financial and other incentives for research institutions to conduct community sensitive health services and outcomes research on Asian and Pacific Islander Americans.

Population At-Risk Recommendations

1. Prioritize educational attainment for Asians and Pacific Islanders as a means to ensure gainful employment and access to health insurance coverage; provide employer incentives to improve the health of their workforce through employer-based wellness programs as well as adequate health insurance coverage.
2. Establish universal health care as a means to assure health services access to all Americans, regardless of employment, income or educational status.
3. Expand and fund health promotion/disease prevention

programs targeted towards limited English proficiency populations and newcomer communities that are community based and population specific.

Delivery System Recommendations

1. Increase the number and capacity of community-based primary care facilities to target Asian and Pacific Islander American communities.

2. Modify minority education and training program eligibility to include Asian and Pacific Islander health professionals from ethnic communities that are at-risk and underrepresented.

3. Create financial and other incentives to encourage the development of more primary care providers available to serve the Asian and Pacific Islander community, and motivate a redistribution of providers to better serve population concentrations.

4. Develop standards for health service translation or interpretation through a certification procedure, with reimbursement mechanisms tied to the usage of certified translation services.

5. Coordinate services used by limited English proficient and culturally distinct populations, such as WIC, maternal and child health, immunization services, primary care, as well as social services and mental health services.

Notes

Portions of this paper were adapated from "Health Policy Framework for Asian and Pacific Islander Americans" by Ninez Ponce and Tessie Guillermo, a chapter written for a pending publication of the Asian American Health Forum. The AAHF has granted permission for adapted portions of the chapter to be included in this paper.

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