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Health and Health Behaviors of Japanese Americans in California: A Sign of Things to Come for Aging Americans?

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Executive Summary

The Japanese American population is leading the nation in aging. According to the 2010 U.S. Census, the number of adults 65 and older among Japanese Americans (23.6%) was nearly twice the number of adults in that age group in the general population (12.9%). The same trend has also been observed in California. The Japanese American population in California also has the highest proportion among all Asian subgroups of individuals who identify as having mixed-race heritage.^{1,2} Because of aging, acculturation, immigration patterns, and increasing diversity among Japanese Americans, the health status and behaviors of this group today could well be the face of aging Americans in general tomorrow. Health conditions and behaviors among those in the Japanese American community can provide insights into key aspects of the aging population and help the U.S. prepare for the changes ahead.

This report provides a close look at the health and health behaviors of the Japanese American population in California. Using data from the California Health Interview Survey (2003, 2005, 2007, 2009, and 2011-

2012), this report contributes to the understanding of the health status and health-related characteristics of Japanese Americans. The report examines a number of health indicators for Japanese Americans compared to other Asian ethnic groups in the state (Chinese, Filipino, Korean, Vietnamese, South Asian, and other Asian), as well as other racial/ethnic groups (Latinos, African Americans, Whites, American Indians/ Alaska Natives, and other single and multi-ethnic Californians). While Japanese Americans are too often lumped together with other Asian ethnic groups, this report shows that they have unique health concerns and assets relative to other Asian ethnic groups and the general population.

This report looks at 15 indicators related to health status and health behavior. In the first section of the report, we look at health areas of concern for Japanese-only and Japanese-all (explained below), and we then compare health indicators for Japanese Americans to Let's Get Healthy California 2022 targets.³ Health indicators in which Japanese Americans exceed other ethnic groups are also examined.

Definitions of Japanese Categories Used in Report

Japanese-Only	Japanese Multiracial	Japanese-All
(monoracial Japanese) Includes those who report their racial/ ethnic group as "Japanese" and report belonging only to a single race and ethnic group.	(mixed-race Japanese) Regardless of which ethnic group a person identifies with the most, this category includes those who report their racial/ ethnic group as Asian and report belonging to more than one Asian ethnic group (including Japanese).	Includes anyone who identifies as Japanese: respondents who report their racial/ethnic group as Asian and report belonging to a single Asian ethnic group—in this case, Japanese (i.e., Japanese-only). If a respondent reports more than one ethnic group, the respondent most identifies as Japanese; also includes those respondents who respond as multiracial and select Japanese, but do not necessarily most identify as Japanese (i.e., Japanese multiracial).

The second section of this report looks at subgroups within the Japanese American population by specifically looking at the large group of mixed-race people of Japanese descent. As mentioned previously, the Japanese American community is a heterogeneous group that includes not only multiple generations but also a small immigrant population, a larger elderly population, and a rapidly growing proportion of individuals who identify as biracial or multiracial. To this end, this report also presents novel data on several health indicators among Californians who identify as (1) monoracial Japanese (Japanese-only), (2) mixed-race Japanese (multiracial Japanese), and (3) these two groups as a whole (Japanese-all).

Exhibit 1 highlights some of the key findings of the comparison of Japanese American adults (i.e., Japanese-all and Japanese-only) with other racial/ethnic groups and other Asian subgroups.



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Exhibit 1. Key Findings Comparing Japanese Americans to Other Racial/Ethnic Groups in California, Adults 18+ Years

Higher Risk	<p>Hypertension: The prevalence of hypertension was significantly higher among Japanese-only (39%) and Japanese-all (33%) in comparison to the overall Asian population (21%). The prevalence of hypertension among Japanese-only was comparable to all other racial/ethnic groups except Latinos, whose rate was lower (27%). The prevalence of hypertension among Japanese Americans was higher than the national Healthy People 2020 target of 26.9%.</p> <p>Arthritis: Japanese Americans reported the highest prevalence of arthritis (35% for Japanese-all, and 36% for Japanese-only) when compared to all Asian subgroups except for Vietnamese and other Asian.</p> <p>Binge drinking: The prevalence of binge drinking among Japanese Americans was significantly higher (32% for Japanese-all and 28% for Japanese-only) than among Chinese (17%) or Vietnamese (14%).</p>
Moderate Risk*	<p>Diabetes: The prevalence among Japanese-all and Japanese-only was about 9%, which is higher than the Let's Get Healthy California 2022 target (7%) but comparable to California adults in general.</p> <p>Obesity: While the prevalence of obesity was higher among Japanese Americans (~14%) compared to the Chinese community (6%), Japanese adults had a significantly lower prevalence of obesity than all other racial/ethnic groups, especially in comparison to Latinos (30%) and African Americans (35%).</p> <p>Smoking status: The percentages of Japanese-all and Japanese-only who reported being current smokers were 12% and 11%, respectively, which were higher than the Let's Get Healthy California 2022 target (9%) but comparable to the rates for both California adults (14%) and Asians overall (11%).</p>
Lower Risk	<p>Health status: The rate of self-reported fair or poor overall health status was lower among Japanese-all (8%) and Japanese-only (7%) than among the overall Asian population (20.1%), and it was much lower compared to Vietnamese (50%), Korean (31%), and Chinese (19%) respondents.</p> <p>Psychological distress: The prevalence of serious psychological distress was lower among Japanese (5% for Japanese-all and 3% for Japanese-only) than among all other racial/ethnic groups. However, this lower rate among the Japanese was comparable to all other Asian subgroups.</p> <p>Elderly falls: Japanese adults age 65 and older had a significantly lower prevalence of falls (7.8% for Japanese-all and 8.1% for Japanese-only) than adults age 65+ who were American Indian/Alaska Native (31%), other single/multiple races (20%), Latino (15%), or white (14%).</p> <p>Food insecurity: Both Japanese-all and Japanese-only adults had lower levels of food insecurity (21%) compared to Filipinos, whose prevalence of food insecurity was about 41%. The prevalence of food insecurity among Latinos was 40%, and among African Americans it was 43%.</p>

*Does not meet Let's Get Healthy California 2022 targets.

Compared to the general population and often to all other Asian ethnic groups, Japanese Americans seem to be in relatively good health. However, when the three Japanese subgroups defined above are examined, areas of concern emerge. Exhibit 2 highlights some of the key differences in Japanese American health, with Japanese subgroups compared.

Exhibit 2.
Key Findings Comparing Japanese Subgroups in California, Adults 18–64 Years

Higher Risk	Fast food consumption: Multiracial Japanese reported having fast food more often (25%) than respondents who identified as Japanese-only (11%) and Japanese-all (15%).
Lower Risk	Hypertension: Multiracial Japanese had the lowest age-adjusted rate of hypertension (8%) when compared to Japanese-only (22%) and Japanese-all (19%). However, higher consumption of fast food—with its higher sodium content—could exacerbate hypertension risk among multiracial Japanese as they age.

The findings of this study highlight the need to take steps promoting healthy aging, lifestyles, and diets, while also addressing the challenges associated with preventable health conditions and declining quality of life. The findings also highlight the need to ensure that interventions and programs are targeted and culturally competent so that health services are available to meet the needs of the different Japanese subpopulations. As a result, there is also a need for more community-based education and interventions within the Japanese population in California. More data and studies are needed to further improve our understanding of Japanese health and health behaviors, especially for multiracial Japanese subpopulations. These efforts will position the Japanese American community in California as a potential model for the nation in addressing the needs of the aging population, which in the next few decades will likely overburden multiple systems.



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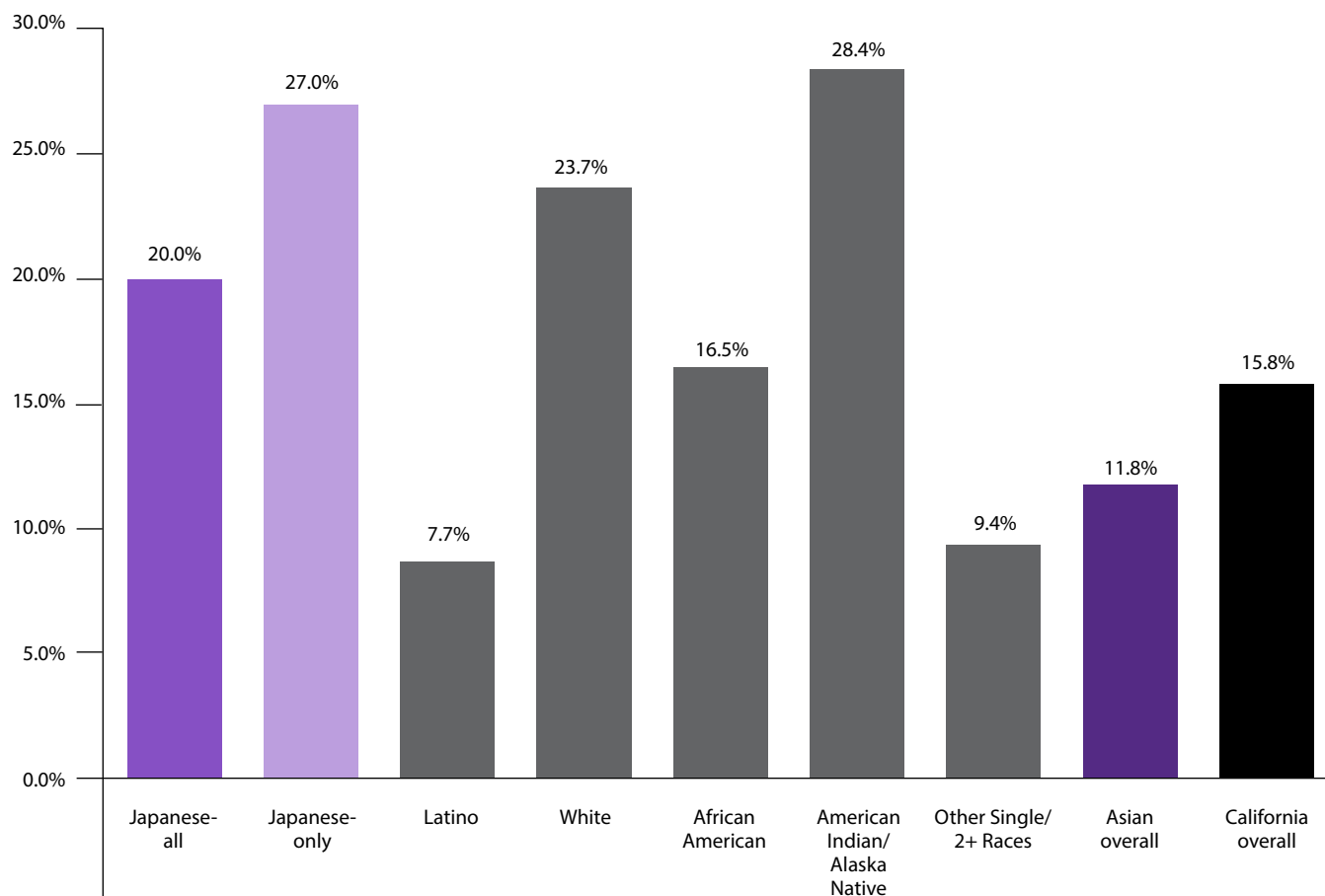
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Introduction

Japanese Americans are leading the nation in aging. According to the 2010 U.S. Census, the Japanese American population had close to twice the number of adults 65 and older (24%) as the general U.S. population (13%). This trend has also been observed in California, where there are nearly twice as many Japanese-only adults age 65 and older as in the general California elderly population (Exhibit 3). The aging of Japanese populations in the United States may be partially due to their longevity, low birth rates, and immigration patterns. When compared to other Asian groups, Japanese Americans

have one of the highest percentages of people who were born in the United States and who primarily speak English as their first language.² The Japanese American population also has the highest proportion of people who identify as having mixed-race heritage, which is significantly higher than other Asian groups.¹ Additionally, among Asian American newlyweds, Japanese have the highest rate of intermarriage.

Exhibit 3.
Distribution of Adults by Race/Ethnicity, Adults 65+ Years



Source: California Health Interview Survey 2011-2012

Based on the 2010 U.S. Census, most people with Japanese heritage are concentrated in the Western states (71%). Thirty-three percent of all Japanese in the United States live in California, followed by Hawaii, at 24 percent. Due to the patterns of aging, acculturation, and increasing diversity among Japanese Americans, an understanding of the health status and behaviors of Japanese Americans today could provide insight and offer help in addressing the issues that older Americans will face in the coming decades. This is especially pertinent considering that by 2050, it is anticipated that the number of Americans 65 and older will be approximately 89 million, or more than double the number of older adults in the United States in 2010.⁴ As Americans continue to live longer and with proportionately more older adults than in previous generations, it is especially crucial to understand the complex issues associated with an aging community.

Using data from the California Health Interview Survey 2003, 2005, 2007, 2009, and 2011-2012, this report presents findings related to the health and health behaviors of the Japanese population in California. The report provides comparisons of the health status and health-related characteristics of Japanese to those of other Asian ethnic groups (Chinese, Filipino, Korean, Vietnamese, South Asian, and other Asian) and other racial/ethnic groups (Latinos, African Americans, Whites, American Indians/Alaska Natives, and other single or multiracial/ethnic Californians). It also provides the first look at novel data on several age-adjusted health indicators among Californians who identify as monoracial Japanese (Japanese-only), those who identify themselves as mixed-race Japanese (multiracial Japanese), and these two groups as a whole (Japanese-all). The health-related issues and behaviors among those in the Japanese American community can provide key lessons for addressing the health concerns of the nation's aging population and help the U.S. prepare for the changes ahead.



1

Japanese-Only and Japanese-All Compared to Other Racial/Ethnic Groups

Japanese Americans Did Not Fare Well in Certain Health Indicators

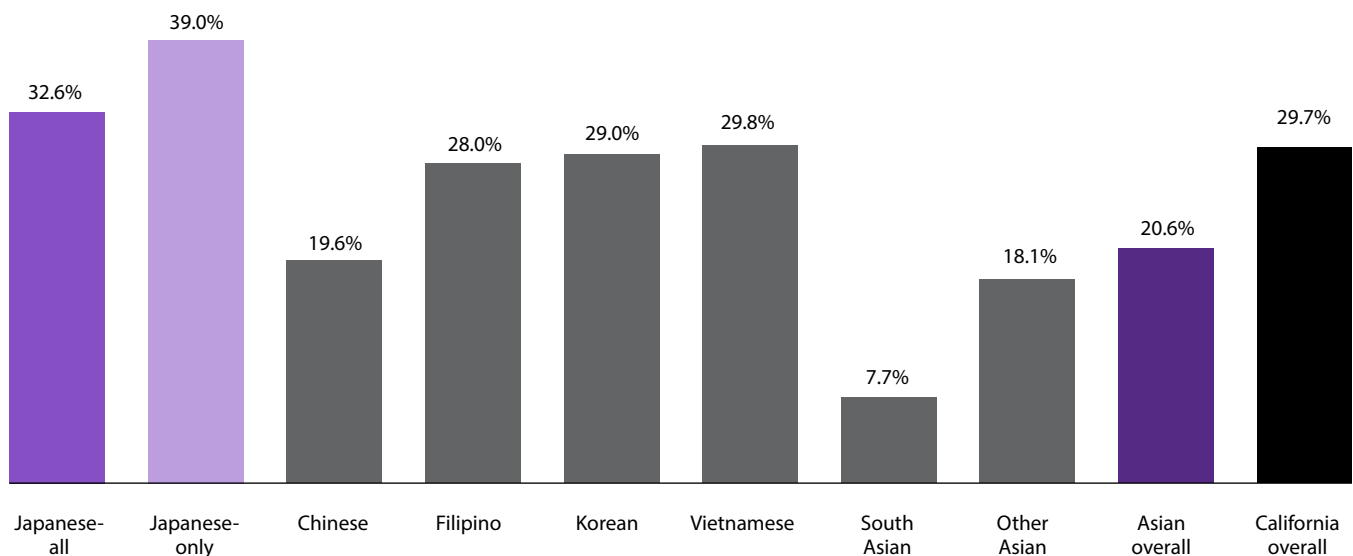
Hypertension, Adults Age 18 and Older (CHIS 2011-2012)

The prevalence of hypertension, or high blood pressure, for those who identify as Japanese-only (39%) is nearly double that of the overall Asian population (21%). Attesting to the idea that Japanese Americans should not be lumped together with other Asian subgroups, the prevalence of hypertension was significantly higher among Japanese adults than Chinese (20%) and South Asians (8%) (Exhibit 4) (see Appendix, Table 1.1). And while the prevalence of hypertension among the Japanese population was slightly higher than among Californians in general (30%), it was significantly higher than the prevalence among Latinos (27%). However, the prevalence of

hypertension among Japanese adults was comparable to rates among African Americans (43%) and American Indians/Alaska Natives (43%) (see Appendix, Table 2.1). Additionally, the prevalence of hypertension was significantly higher among Japanese-only and Japanese-all than the national Healthy People 2020 target of 26.9 percent.

This high prevalence of hypertension—sometimes called “the silent killer”⁵—among Japanese Americans is a major concern. Failure to control high blood pressure through medication or lifestyle changes can lead to a number of major health problems, such as heart disease, stroke, kidney failure, and other health issues. Risk factors for high blood pressure include aging and genetics/family history, in addition to behaviors such as unhealthy diet, alcohol consumption, smoking, physical inactivity, and obesity.⁶

Exhibit 4.
Prevalence of Hypertension, Adults Age 18 and Older



Source: California Health Interview Survey 2011-2012

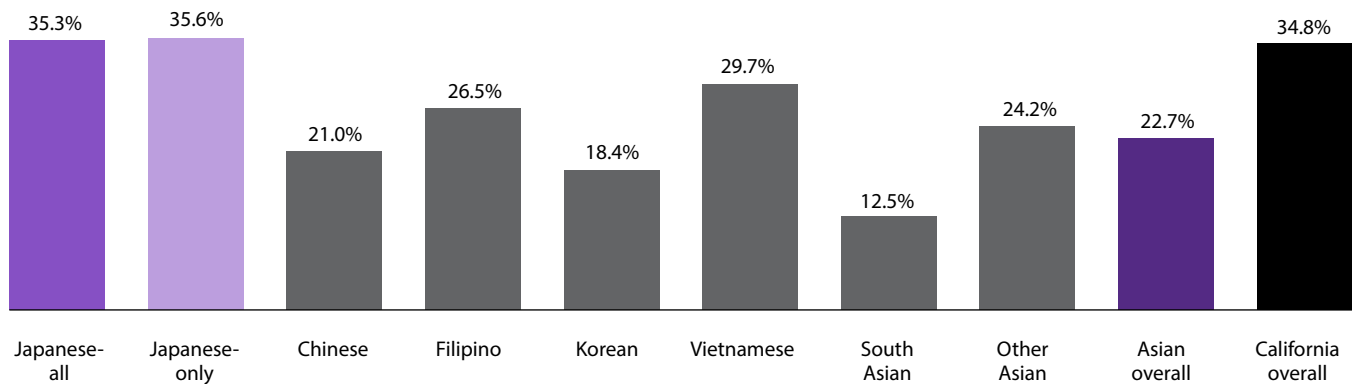
Arthritis, Adults Age 40 and Older (CHIS 2011-2012)

Another chronic condition of major concern among Japanese Americans is arthritis, which may be due to the larger proportion of older people among the population. The Japanese community (Japanese-all 35% and Japanese-only 36%) reported a greater prevalence of arthritis than Asians in general (23%). Compared to Japanese adults, the prevalence of arthritis was also lower among Chinese (21%) and

Koreans (18%). The prevalence of arthritis among the Japanese population is comparable to the overall California population (35%) (Exhibit 5 and Appendix, Tables 1.1 and 2.1).[†] Arthritis is the most common cause of disability among adults in the United States because of its impact on function and mobility. Some of the disabling effects of arthritis include activity limitations, work limitations, and severe pain.

[†] Ranking not possible due to confidence interval overlap.

Exhibit 5.
Prevalence of Arthritis, Adults Age 40 and Older



Source: California Health Interview Survey 2011-2012

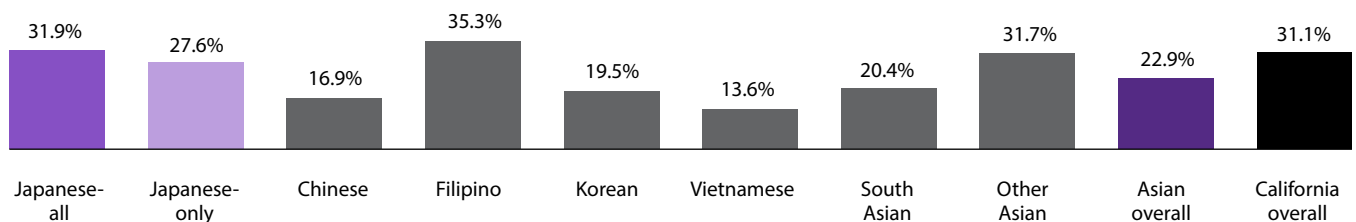
Binge Drinking Past Year, Adults Age 18 and Older (CHIS 2011-2012)

Japanese Americans have the highest percentages of binge drinking (32%) after Filipinos. Binge drinking is defined as having five or more alcoholic drinks on at least one occasion in the past year for men, and four or more drinks for women. Compared to Asians overall, the prevalence of binge drinking among Japanese-all adults in California was significantly higher (32%). More specifically, the prevalence of binge drinking was higher among all Japanese respondents than among those who identified as Chinese (17%) or Vietnamese (14%). It is important to note that binge drinking rates among all Japanese respondents seemed to be more similar to those of Latinos, whites, Filipinos, and the general California adult population (31%) (Exhibit 6; Appendix, Table 2.1).



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Exhibit 6. Prevalence of Binge Drinking During Past Year Among Adults 18+ Years



Source: California Health Interview Survey 2011-2012

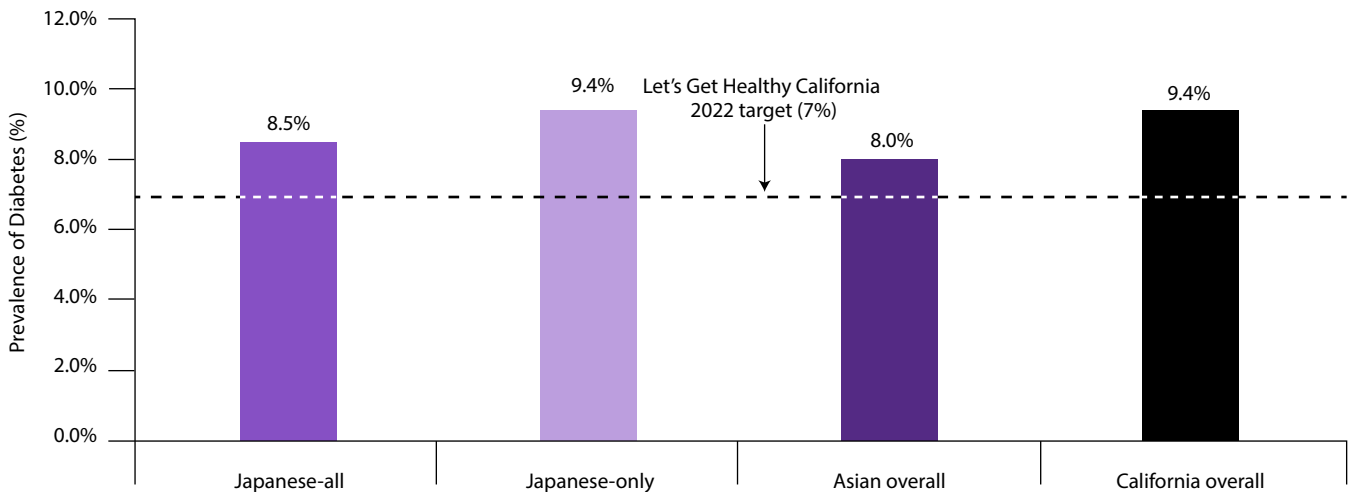
Japanese Americans Still Fell Behind Let's Get Healthy California 2022 Targets

Diabetes, Adults Age 18 and Older (CHIS 2011-2012)

The prevalence of diabetes has been increasing, with a heavier burden felt by many racial/ethnic minority populations.⁷ Acculturation to a diet high in fats,

along with other lifestyle factors, increases the risk of diabetes.⁸ In California, no single major ethnic group has met the Let's Get Healthy California 2022 target of 7% for diabetes prevalence. The prevalence of diabetes among all Japanese (9%) was comparable to that among the general California population (9%), Asians overall (8%), and other racial/ethnic groups.

Exhibit 7.
Prevalence of Diabetes, Adults 18+ Years



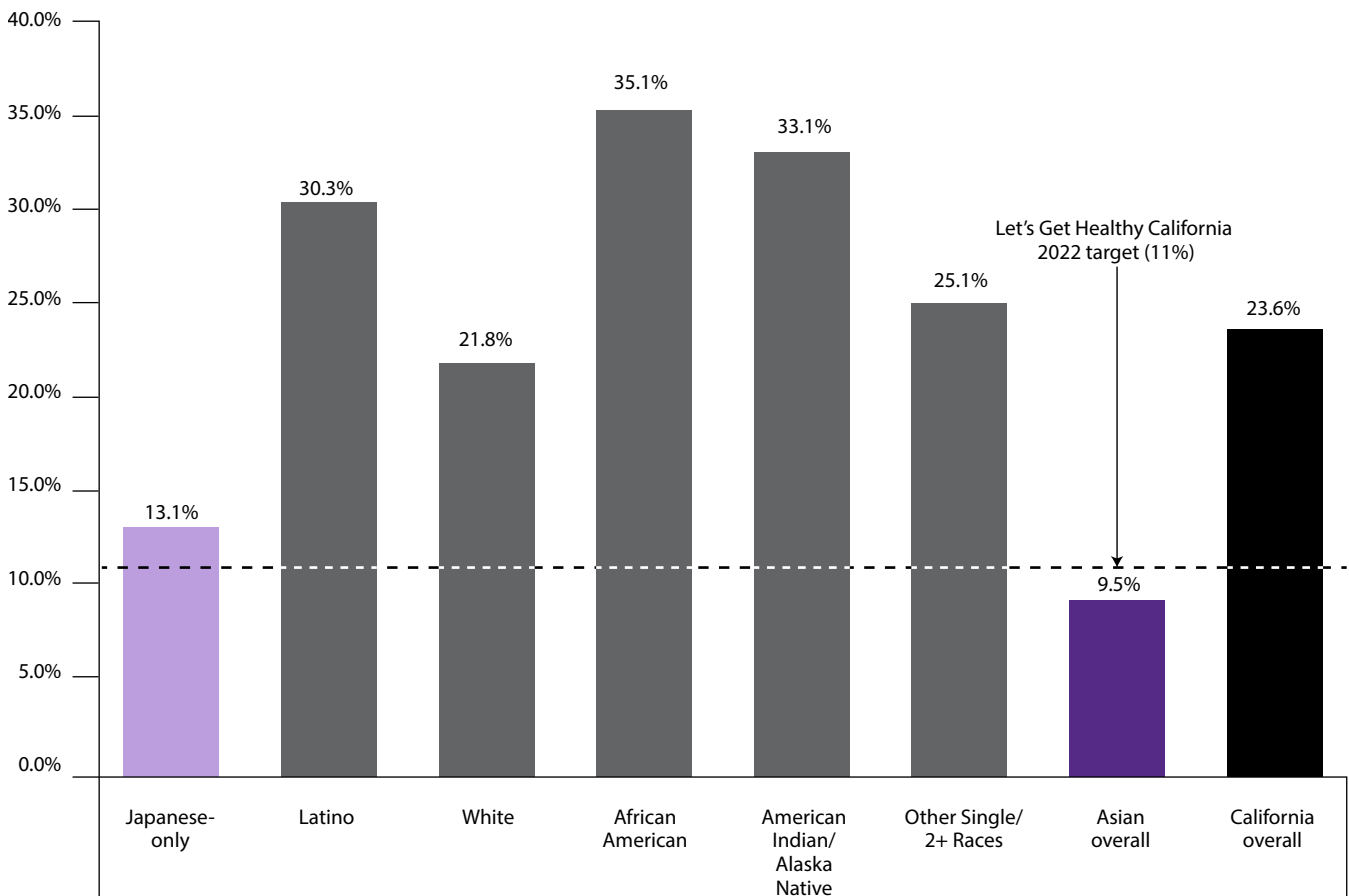
Source: California Health Interview Survey 2011-2012

Obesity, Adults Age 18 and Older (CHIS 2011-2012)

In general, obesity is not a prevalent issue among Japanese respondents compared to other racial/ethnic groups in California. However, Japanese Californians had higher obesity rates (14%) than all other major Asian ethnic groups except Filipinos. Chinese Californians had a significantly lower prevalence of obesity (6%) than Japanese-all (Exhibit 8; Appendix, Table 1.1). The prevalence of obesity among Japanese

adults was also three points higher than the Let's Get Healthy California 2022 target (11%), but it was significantly lower than the prevalence among Californians in general (23.6%). Japanese adults had a much lower prevalence of obesity (~14%) than African Americans (35%), American Indians/Alaska Natives (33%), Latinos (30%), and whites (22%) (see Appendix, Table 2.1).

Exhibit 8.
Prevalence of Obesity, Adults 18+ Years



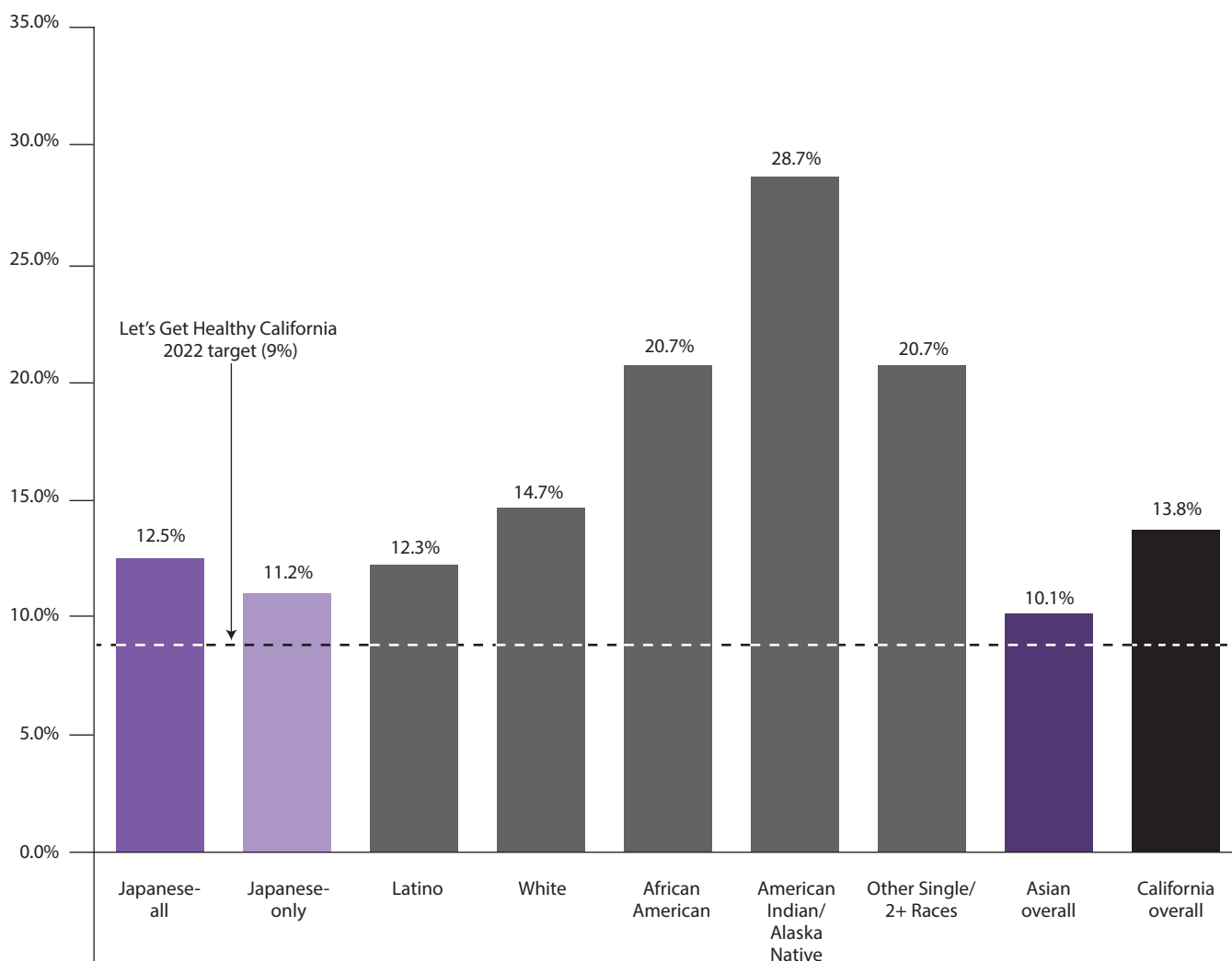
Source: California Health Interview Survey 2011-2012

Current Smokers, Adults 18 and Older (CHIS 2011-2012)

Smoking is a major public health concern, and over recent decades there have been successful efforts to reduce the number of people who smoke. While there have been reductions in general, it is important to consider smoking rates among minority populations. Among Japanese adults, the prevalence of those who reported being current smokers (Japanese-all 13%, and Japanese-only 11%) was higher than the

Let's Get Healthy California 2022 target of 9% (Exhibit 9). The rate of smoking among all Japanese adults was comparable to that of both Californians in general (14%) and Asians overall (10%) (Exhibit 9; Appendix, Table 1.1). However, the proportions of current smokers among both Japanese-all and Japanese-only were significantly lower in comparison to the proportions among American Indians/Alaska Natives (29%) and African Americans (21%) (see Appendix, Table 2.1).

Exhibit 9.
Prevalence of Current Smokers, Adults 18+ Years



Source: California Health Interview Survey 2011-2012

Japanese Americans Lead in Healthy Aging

Ever Diagnosed with Heart Disease, Adults Age 40 and Older (CHIS 2011-2012)

Heart disease is the leading cause of death in the United States.⁹ Certain health conditions and lifestyle factors can increase the risk of developing heart disease. For example, those with high blood pressure or diabetes or who are physically inactive, are obese, have poor diets, currently smoke, or drink excessive amounts of alcoholic beverages are at higher risk of developing heart disease.¹⁰ The prevalence of heart disease among Japanese-all adults was 9%, which was comparable to Californians in general (11%) but lower than the prevalence among white adults (13%). The prevalence of heart disease among the Japanese population was also comparable to other Asian subgroups. While the prevalence of heart disease among Japanese Americans currently may be comparable to other racial/ethnic groups, the higher prevalence of hypertension poses a future concern (see Appendix, Tables 1.1 and 2.1).

Ever Diagnosed with Stroke, Adults Age 65 and Older (CHIS 2003, 2005, 2011-2012)

A major cause of disability among adults, stroke is the fourth leading cause of death in the United States.⁹ In general, certain lifestyle choices—e.g., having a diet high in cholesterol and saturated/trans fats, being physically inactive, being obese, and consuming too much alcohol—can increase the risk of stroke.¹¹ The prevalence of stroke among the Japanese-all 65+ population in California was 7%, which was comparable to Californians in general (9%) and Asians overall (6.5%). And even though Japanese have a larger proportion of older adults, the prevalence of stroke among all Japanese is lower in comparison to African Americans (12%) and American Indians/Alaska Natives (14%) (see Appendix, Table 2.1).



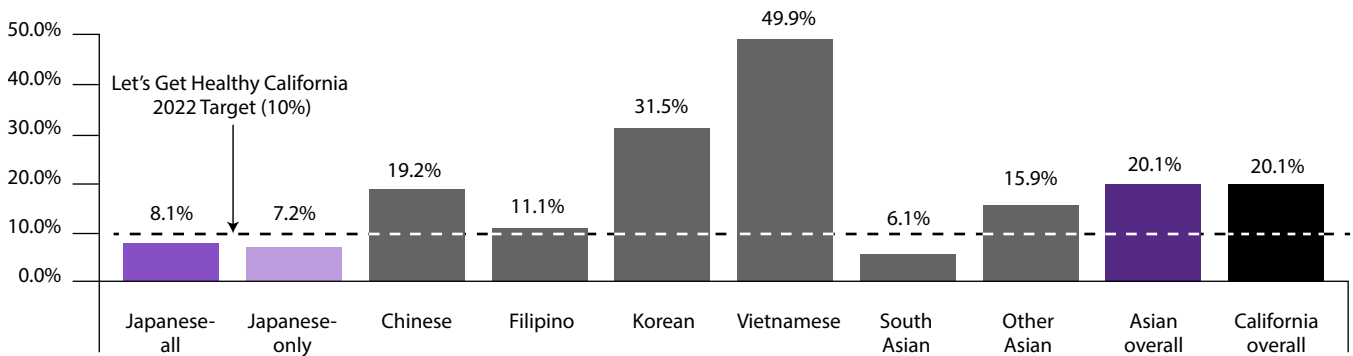
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Self-Reported Fair or Poor Health Status, Adults Age 18 and Older (CHIS 2011-2012)

The rate of self-reported fair or poor overall health was significantly lower among Japanese-all and Japanese-only than among respondents belonging to other Asian subgroups. For example, a significantly greater percentage of Vietnamese (50%), Koreans (32%), and Chinese (19%) perceived their health to be fair or poor compared to Japanese-all (8%) and Japanese-only (7%) (Exhibit 10; Appendix, Table 1.1). These significantly higher rates among other Asian subgroups compared to the Japanese not only show how diverse the Asian minority groups are from each other, but also highlight an opportunity

to further investigate why there is such a disparity. Japanese-all and Japanese-only respondents also have significantly lower rates of self-reported fair or poor health when compared to the California population in general (20%). The Japanese community overall also had a lower rate of self-reported fair or poor health compared to Latinos (29%), American Indians/ Alaska Natives (25%), African Americans (24%), those of other single or mixed race/ethnicity (20%), and whites (14%) (Appendix, Table 2.1). In-depth analysis to understand this health status assessment may provide insights into cultural and other factors that might contribute to perceived good health among the Japanese American community in California.

Exhibit 10.
Prevalence of Self-Reported Fair or Poor Health Status, Adults 18+ Years



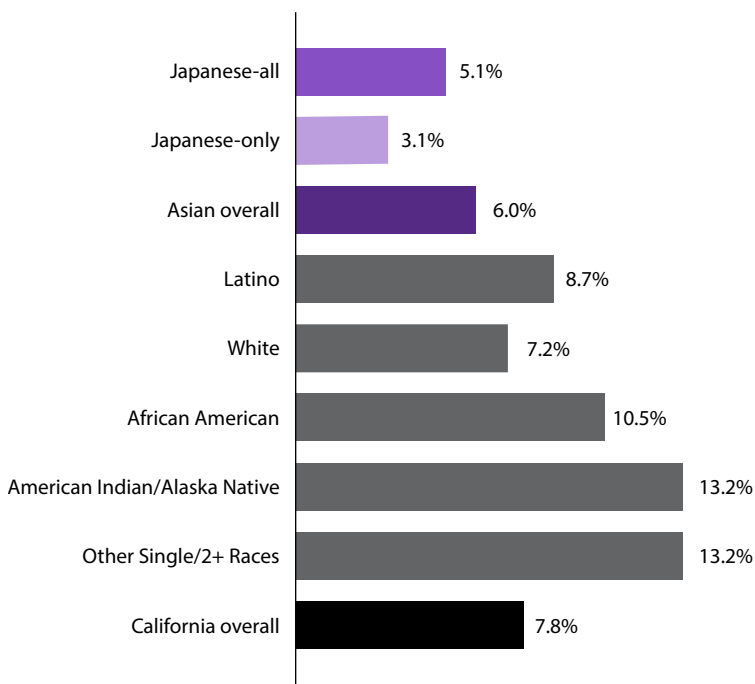
Source: California Health Interview Survey 2011-2012

Serious Psychological Distress, Adults Age 18 and Older (CHIS 2007, 2009, 2011-2012)

In California, about 5% of Japanese-all and 3% of Japanese-only adults reported having serious psychological distress during the past year (Exhibit 11). The prevalence of reported serious psychological distress was lower compared to Californians in general (8%) and all other racial/ethnic groups except for whites (see Appendix, Tables 1.1 and 2.1). The prevalence of psychological distress among

the Japanese was comparable to all other Asian subgroups. It is important to highlight, however, that reporting of psychological distress is dependent on how respondents view issues related to mental illness, which is often associated with stigma or shame. Studies have demonstrated that the unwillingness among Japanese American families to acknowledge psychological disorders may prevent elders who are depressed or experiencing early stages of dementia from getting appropriate needed and preventive care.²

Exhibit 11.
Prevalence of Serious Psychological Distress, Adults 18+ Years



Source: California Health Interview Survey 2007, 2009, 2011-2012

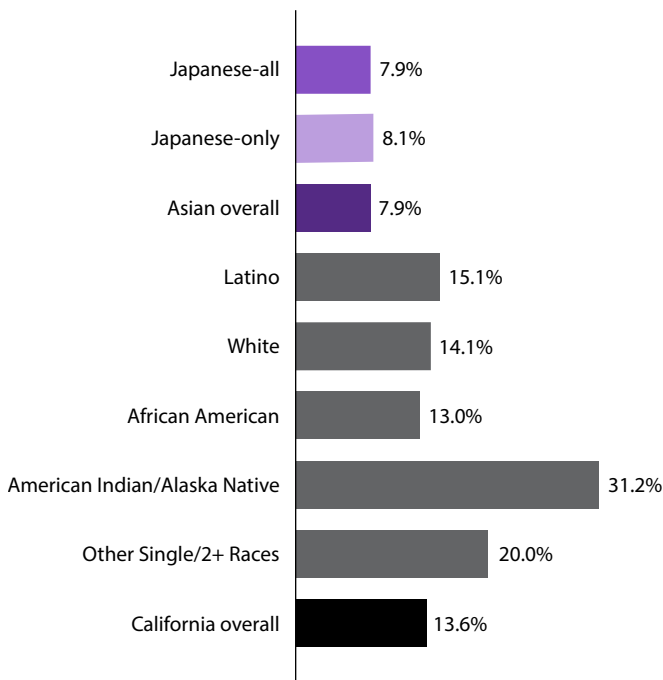
Disability Status, Adults 40 and Older (CHIS 2011-2012)

Twenty-nine percent of Japanese-all and 22% of Japanese-only reported having some form of disability due to physical, mental, or emotional conditions. This rate among Japanese adults was lower than that among Californians in general (40%). More specifically, the prevalence of disability among Japanese-all was lower than that among other single or mixed-race/ethnicity groups (51%), African Americans (48%), Latinos (42%), and whites (40%). American Indians/Alaska Natives had nearly twice the prevalence of disability (60%) as Japanese-all (see Appendix, Table 2.1). However, disability status among Japanese-all and Japanese-only was comparable to all other Asian subgroups except Vietnamese (47%) (see Appendix, Table 1.1).

Elderly Falls, Adults 65 and Older (CHIS 2003, 2005, 2011-2012)

Falls often cause severe disability among the elderly. Injuries from falls can lead to fear of falling, sedentary behavior, impaired function, and lower quality of life. Despite the larger proportion of elderly among Japanese Americans, older Japanese had a significantly lower prevalence of falls than older adults in the general California population (14%) (Exhibit 12). More specifically, the prevalence of elderly falls was nearly four times higher among American Indians/Alaska Natives (31%) than among Japanese-all (8%) (see Appendix, Table 2.2). The rate of elderly falls among the Japanese was similar to that among other Asian subgroups.

Exhibit 12. Prevalence of Elderly Falls, Adults 65+ Years



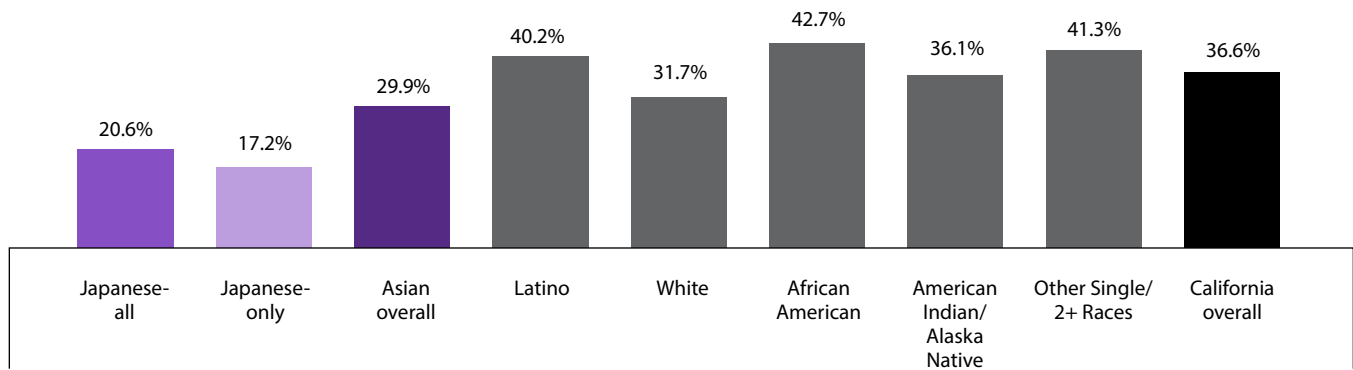
Source: California Health Interview Survey 2007, 2009, 2011-2012

Food Insecurity with and without Hunger, Adults 18 and Older (CHIS 2007, 2009, 2011-2012)

Food insecurity is defined as limited access or uncertain availability of nutritionally adequate food. While food insecurity affects people of every age and race/ethnicity, certain subgroups are especially vulnerable. The California Health Interview Survey (CHIS) collects food security information only from adults with incomes less than 200% of the federal poverty level (FPL).¹² Japanese adults had the lowest

rate of food insecurity of all ethnic groups. However, one-fifth of Japanese-all were still food insecure (Exhibit 13). Among Asian subgroups, Japanese-all and Japanese-only adults had lower levels of food insecurity (with and without hunger) when compared to Filipinos, whose prevalence of food insecurity was about 41%. The rate of food insecurity among Japanese-all was also lower than the overall food insecurity prevalence among California adults, which was 37% (see Appendix, Tables 1.2 and 2.2).

Exhibit 13.
Prevalence of Food Insecurity, Adults 18+ Years



Source: California Health Interview Surveys 2007, 2009, 2011-2012

Civic Engagement, Adults 18 and Older (CHIS 2011-2012)

Japanese-all and Japanese-only adults had a higher prevalence of civic engagement (46% and 48%, respectively) compared to Asians overall (36%), and more specifically to Vietnamese (30%) and Filipinos (32%). And while the level of civic engagement among Japanese Americans was similar to that of Californians in general (41%), the Japanese community had higher rates of civic engagement compared to Latinos (30%). This may be attributable to greater community integration, a higher proportion of older people, and higher voter participation among the elderly (see Appendix, Tables 1.2 and 2.2).

Internet Use to Access Health information, Adults 18 and Older (CHIS 2011-2012)

Overall, 60% of Japanese-all and Japanese-only adults reported using the Internet to access health information. This rate among the Japanese population is comparable to national levels; a nationwide study found that a majority of American adults (approximately 61%) accessed health information online.¹³ Levels of Internet use to access health information are similar across all racial/ethnic groups (see Appendix, Tables 1.1 and 2.2).



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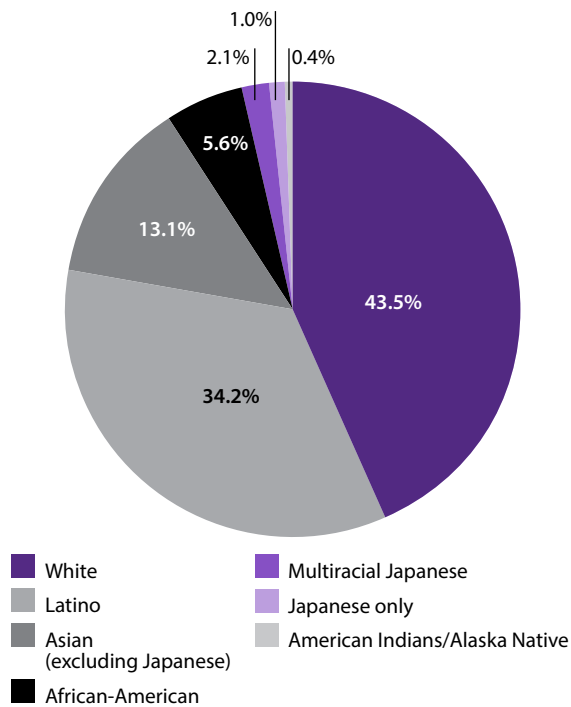
Multiracial Japanese Compared to Japanese-Only and Japanese-All

Multiracial Japanese Americans Differ from Other Japanese in California

A key characteristic that distinguishes Japanese Americans from members of other Asian communities in the United States is the high proportion of people who identify as biracial or multiracial. According to a recent Pew study surveying Asian groups in the United States, Japanese Americans are among the most comfortable with intergroup marriage: 71% of Japanese Americans say they would be very comfortable if their children married someone from another country-of-origin group, and 67% would be very comfortable if their child married a non-Asian.¹⁴ This high rate of intermarriage may be linked to the health and health behaviors of Japanese Americans.

Based on pooled CHIS 2007, 2009, and 2011-2012 data, respondents who identified as multiracial Japanese made up approximately 20% of the Japanese population in California. Multiracial Japanese comprised approximately 2% of the California population, or approximately twice as many as single-race Japanese (Exhibit 14). The demographic analysis of the Japanese subpopulation demonstrated that multiracial Japanese are younger than those who are Japanese-only: the population distribution of those ages 18-34 was 57% for multiracial Japanese, but 14% for Japanese-only (see Appendix, Tables 3.1 and 3.2). As a result, analyses involving multiracial Japanese adults were age-adjusted for those ages 18-64.

Exhibit 14. Racial and Ethnic Distribution in California, Adults 18+ Years



Source: California Health Interview Surveys 2007, 2009, 2011-2012



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Chronic Conditions, Adults 18–64 (CHIS 2007, 2009, 2011-2012)*

- The prevalence of overweight or obesity was 46% among multiracial Japanese. The prevalence of obesity was similar across all Japanese groups, at approximately 29%.
- An estimated 13% of multiracial Japanese adults ages 18-64 reported having either fair or poor overall health.
- Within the Japanese population, multiracial Japanese had the lowest age-adjusted rate of hypertension (8%) when compared to Japanese-only (22%) and Japanese-all (19%). However, higher consumption of fast foods—with their higher sodium content—could exacerbate hypertension risk among multiracial Japanese as they age.

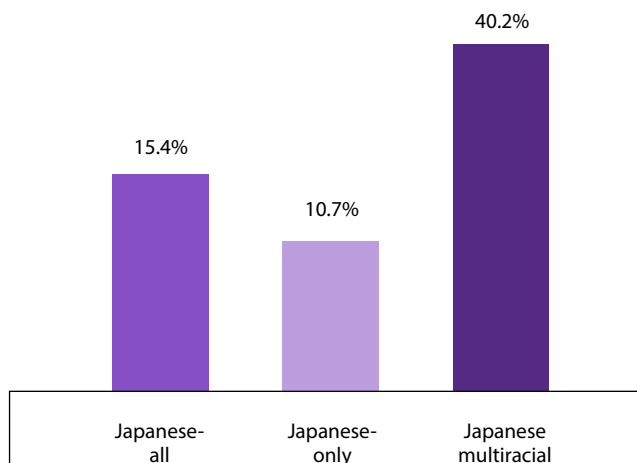
*See Appendix, Table 3.1.

Health Behavior/Neighborhood & Housing/ Food Environment, Adults 18–64 (CHIS 2007, 2009, 2011-2012)**

- Multiracial Japanese in California reported having fast food more often (25%) than respondents who identified as Japanese-only (11%) and Japanese-all (15%) (Exhibit 15).
- The age-adjusted proportion of current smokers among multiracial Japanese adults was 19%.
- Thirty-six percent of multiracial Japanese adults reported binge drinking in the past year.
- In an examination of the age-adjusted rate of flu shots among adults ages 18-64, 22% of multiracial Japanese reported getting a flu shot during the previous year, whereas 31% of Japanese-only adults got flu shots during the past year.
- The level of civic engagement is similar across all Japanese subgroups. The prevalence of civic engagement among multiracial Japanese adults was 62%.

**See Appendix, Table 3.2.

Exhibit 15. Prevalence of Fast Food Consumption 4+ Times in Past Week, Adults 18–64



Source: California Health Interview Surveys 2007, 2009, 2011-12

3

Conclusions and Recommendations

This report highlights the unique status of Japanese Americans as not just the nation's oldest ethnic group, but also a possible portent of America's future aging population. This study shows that for a majority of the indicators (9 out of 15), the Japanese American adult population experiences lower risk. As such, their health and health behaviors may be a source of future study for examining healthy aging, not only in California but also in the United States in general. Although Japanese Americans were often at lower risk than other groups, they did not meet the Let's Get Healthy California 2022 targets in any category except self-reported health status.

This report also paints a very diverse and complex picture of Japanese health and health behaviors when compared to both other Asian groups and other racial/ethnic groups in California. These differences may be attributable to the culture of Japanese Americans and their immigration history. In recent decades, the Japanese American population has had lower rates of immigration compared to immigrant populations from China, Korea, India, the Philippines, and Southeast Asia.² Related to the lower rates of immigration and a more stabilized population, there are more older adults (65 and older) among the Japanese community compared to the overall California population. Compared to other Asian groups in the United States, Japanese have greater rates of acculturation and assimilation, with a high rate of intermarriage. As a result, a large proportion of Japanese in the U.S. identify themselves as biracial or multiracial.¹ This unique mixture of demographics and historical presence in California is reflected in the health status and health behaviors noted in this report. Understanding these issues will provide useful

and important insights for policymakers, senior care providers, and community organizations. The coming impacts on older individuals, their families, and their communities will be far-reaching, with significant implications for public health, social services, and health care systems. Based on the findings of this study, following are some policy implications and recommendations.

A Potential Model of Healthy Aging

Since the Japanese American population is leading the nation in aging, information on key lifestyle and quality-of-life practices that support healthy aging among the Japanese population can help the U.S. prepare for the influx of aging baby boomers. While a significant proportion of Japanese American adults reported a variety of chronic health conditions that can diminish quality of life, such as hypertension and arthritis, more Japanese adults in California reported better physical, mental, and functional health outcomes compared to other racial/ethnic groups. Because Japanese Americans have better health outcomes than most other racial/ethnic groups, it is important to further explore the key biological, behavioral, environmental, and social factors that may be associated with better health outcomes. Understanding the factors associated with the physical, mental, and functional health of Japanese Americans will provide useful and important insights for policymakers, senior care providers, and community organizations catering not only to other Asian groups, but also to the older adult demographic in general. Taking steps now to promote healthy aging, lifestyle, and diet, while also addressing the challenges associated with preventable adverse health conditions and declining quality of life, will position

the Japanese American community as a potential model for the nation when addressing the needs of an aging population that will likely overburden multiple systems in the next few decades.

Targeted and culturally competent interventions and health services for different Japanese subpopulations

This report shows that Japanese American health is not uniform. The outstanding health issues among the Japanese-only subgroup include hypertension, arthritis, and binge drinking. Culturally appropriate diet and physical activity interventions might help members of this subgroup to prevent and control hypertension. Culturally appropriate interventions are also needed for those conditions that appeared to have low prevalence. For instance, the low prevalence of psychological distress may be due to the stigma associated with mental illness within the Japanese culture, with Japanese Americans perhaps reluctant to seek professional assistance or to reveal their psychological distress.¹⁵ It is important to address the stigma associated with mental illness and any barriers that may prevent people from seeking needed mental health-related treatment.

Developing initiatives for community-based primary preventions

Some of the health behaviors or risk factors—such as high rates of binge drinking among Japanese-only, and high consumption of fast food among multiracial Japanese—highlight the need for more community-based primary prevention programs prioritizing different subpopulations within the Japanese population in non-health care settings. These

settings could include the home, school, workplace, and community, such as churches, temples, and community centers. These interventions should focus on promoting health and protecting healthy people from developing preventable diseases or experiencing injuries that may diminish quality of life.

More data and studies to improve our understanding of Japanese health and health behaviors

Given the available data and the stability of the estimates, this report compiles and provides data that depict the health and health needs of the Japanese population in California as best as possible. This report also presents health-related data for the multiracial Japanese American population, for which there is a paucity of information. Data limitations present barriers to better understanding the diverse Japanese population. For this analysis, it was difficult due to the limited sample size to stratify the study population by various health-related factors. Further assessments are needed to examine factors such as age, gender, generation, income level, level of educational attainment, health care utilization, and other behaviors, which ultimately impact health. The multiracial Japanese analysis was also limited; however, the health indicators that were selected provide some key insights into the diverse, multiracial Japanese groups and highlight the importance of more studies on this growing population. Another area of analysis that should be included in future assessments is that of healthy aging indicators. Examples of key indicators to consider are loneliness and social or family support.

Data Sources and Methods

This report utilizes findings primarily from the 2011-2012 California Health Interview Survey (CHIS), but it also pools CHIS years 2007, 2009, and 2011-2012 to stabilize the estimates due to the small sample size of the Japanese American population in the survey. For this study, three categories to define Japanese Americans were created: Japanese-all, Japanese-only (monoracial Japanese), and multiracial Japanese.

To be considered in the “Japanese-all” category, survey respondents had to identify their racial/ethnic group as Asian and report belonging to a single Asian ethnic group (in this case, Japanese). Respondents who identified more than one racial/ethnic group had to most identify as Japanese. Additionally, those respondents who identified as multiracial, and who selected Japanese but did not necessarily most identify as Japanese, were included in the Japanese-all group.

To be considered in the Japanese-only category, respondents had to identify as Asian and then select only a single race/ethnicity (in this case, Japanese).

Lastly, “multiracial Japanese” were respondents who identified as belonging to more than one racial/ethnic group, and who selected “Japanese” as one of the racial/ethnic groups they identified with but not necessarily most identified with.

CHIS is a two-stage, geographically stratified, random-digit-dial (RDD) telephone survey that has been conducted biannually among California’s noninstitutionalized population since 2001. CHIS 2011-2012 interviews were conducted from June 2011 to January 2013. The interviews were conducted in one of five languages: English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, or Korean. CHIS 2011-2012 interviewed approximately 43,000 adults ages 18 or older.

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Appendix

Sample Size Notes

Definitions			
<p>Japanese-All</p> <p>Under this variable, respondents who report their racial/ethnic group as Asian, and report belonging to a single Asian ethnic group, in this case, Japanese. If a respondent reports more than one ethnic group, the respondent most identifies as Japanese. Also includes those respondents who respond as multiracial, select Japanese, but do not necessarily most identify as Japanese.</p>	<p>Japanese-Only</p> <p>Respondents who report their racial/ ethnic group as Japanese and report belonging to a single race and ethnic group only.</p>	<p>Japanese Multiracial</p> <p>Respondents who report their racial/ ethnic group as Asian and report belonging to more than one Asian ethnic group (including Japanese), regardless of which ethnic group he/she identifies with the most; also, the non-Latino prerequisite is removed.</p>	<p>CHIS Health Profile - Japanese</p> <p>Used CHIS constructed variable ASNHP2. Respondents who report their racial/ethnic group as Asian and report belonging to a single Asian ethnic group are assigned to one of eight Asian ethnic groups. If a respondent reported more than one Asian group, that respondent was assigned to the group he/she identified with the most.</p>

	CHIS 2011-2012	Pooled (2007, 2009, 2011-2012)
Japanese-All	404	1459
Japanese-Only	327	1158
Japanese Multiracial	77	301

CHIS POOLED 2007, 2009, 2011-2012	Japanese-All		Japanese-Only		Japanese Multiracial	
	N	%	N	%	N	%
18-34	190	13.02%	76	6.56%	114	37.87%
35-44	208	14.25%	133	11.49%	75	24.92%
45-54	300	20.56%	226	19.52%	74	24.58%
55-64	284	19.47%	255	22.02%	29	9.63%
65 and over	477	32.69%	468	40.41%	9	2.99%

Table 1.1.
Chronic Disease Prevalence for Japanese and Respondents of Other Asian Ethnic Subgroups, Adults 18+, CHIS 2011-2012

Demographics	Japanese-All % Pop. N	Japanese-Only % Pop. N	Chinese % Pop. N	Filipino % Pop. N	Korean % Pop. N	Vietnamese % Pop. N	South Asian % Pop. N	Other Asian % Pop. N	Asian Overall % Pop. N
Age 18-64	80.0 220,277	73.0 148,966	88.7	89.0	77.8	85.7	97.4	94.5	88.2
Age 65+	20.0 55,081	27.0 55,081	11.3	11.0	22.2	14.3	2.6	5.5	11.8
Below 200% FPL	19.3 53,133	19.2 39,245	25.5	19.5	36.8	58.7	19.7	37.9	28.5
Chronic Conditions	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)
Hypertension	32.6 (25.8-39.3)	39.0 (30.9-47.2)	19.6 (16.3-22.9)	28.0 (22.1-33.9)	29.1 (22.9-35.2)	29.8 (24.1-35.6)	7.7 (5.2-10.2)	18.1 (9.3-27.0)	20.6 (18.8-22.4)
Arthritis (40+ year)	35.3 (27.9-42.7)	35.6 (27.8-43.4)	21.0 (16.9-25.1)	26.5 (19.82-33.2)	18.4 (12.8-24.0)	29.7 (23.5-35.9)	12.5 (7.1-17.9)	24.2* (9.0-39.5)	22.7 (20.1-25.2)
Diabetes	8.5 (4.9-12.1)	9.4 (5.3-13.6)	5.5 (3.8-7.2)	9.5 (6.0-13.1)	11.9 (7.3-16.5)	11.4 (7.9-14.9)	5.8 (3.0-8.5)	4.8* (1.9-7.7)	8.0 (6.6-9.3)
Heart Disease (40+ years)	8.7 (5.1-12.3)	9.8 (5.7-13.8)	7.0 (4.1-9.9)	10.1 (5.9-14.3)	4.6 (2.7-6.5)	7.7 (4.4-11.0)	7.0 (3.1-10.9)	8.8* (1.1-15.9)	7.6 (6.0-9.2)
Stroke (65+ years; CHIS 2003, 2005, 2011-2012)	7.0 (3.7-10.4)	‡	5.7 (3.1-8.3)	7.7 (3.3-12.2)	9.3* (3.5-15.1)	7.5 (3.4-11.5)	7.7* (1.3-14.1)	10.0 (6.8-13.1)	6.5 (4.71-8.37)
Serious Psychological Distress (CHIS 2007, 2009, 2011-2012)	5.1 (2.8-7.4)	3.1 (1.4-4.9)	4.4 (3.1-5.6)	7.6 (5.1-10.2)	6.2 (3.5-8.9)	6.1* (2.4-9.8)	4.2 (2.6-5.7)	9.8 (5.2-14.3)	6.0 (4.9-7.0)
Fair or Poor Health	8.1 (4.9-11.4)	7.2 (4.1-10.3)	19.2 (15.7-22.7)	11.1 (7.2-14.9)	31.5 (24.9-38.1)	49.9 (42.6-57.1)	6.1 (3.2-9.0)	15.9 (8.6-23.2)	20.1 (18.1-22.1)
Disability Status Due to Physical/Mental/Emotional Condition	28.8 (22.0-35.6)	22.2 (16.0-28.4)	24.9 (20.4-29.4)	35.1 (27.4-42.8)	26.2 (19.7-32.7)	46.9 (39.9-53.9)	24.1 (15.9-32.3)	31.7 (15.5-47.9)	31.0 (28.1-34.0)
Obese	14.0 (8.8-19.1)	13.1 (7.2-18.9)	5.8 (3.8-7.8)	16.7 (11.7-21.7)	2.2* (0.8-3.6)	6.5 (3.9-9.1)	7.8 (3.9-11.7)	16.4 (6.8-26.0)	9.5 (7.7-11.2)

*Estimate is not statistically stable

‡Estimate is not provided.

Note: See "Sample Size Notes" at start of Appendix for indicator definitions.

Table 1.2.
Health Behaviors and Environment for Japanese and Respondents of Other Asian Ethnic Subgroups, Adults 18+, CHIS 2011-2012

Demographics	Japanese-All % Pop. N	Japanese-Only % Pop. N	Chinese % Pop. N	Filipino % Pop. N	Korean % Pop. N	Vietnamese % Pop. N	South Asian % Pop. N	Other Asian % Pop. N	Asian Overall % Pop. N
Age 18-64	80.0 220,277	73.0 148,966	88.7	89.0	77.8	85.7	97.4	94.5	88.2
Age 65+	20.0 55,081	27.0 55,081	11.3	11.0	22.2	14.3	2.6	5.5	11.8
Below 200% FPL	19.3 53,133	19.2 39,245	25.5	19.5	36.8	58.7	19.7	37.9	28.5
Health Behaviors	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)	(95% C.I.)
Binge Drinking	32.6 (25.8-39.3)	39.0 (30.9-47.2)	19.6 (16.3-22.9)	28.0 (22.1-33.9)	29.1 (22.9-35.2)	29.8 (24.1-35.6)	7.7 (5.2-10.2)	18.1 (9.3-27.0)	20.6 (18.8-22.4)
Elderly Falls (65+ years; CHIS 2003, 2007, 2011-2012)	7.9 (3.8-12.1)	8.1 (3.9-12.3)	5.7 (3.0-8.5)	9.8 (5.5-14.1)	7.6 (4.1-11.1)	13.4 (7.8-19.0)	‡	‡	7.9 (5.7-10.0)
Current Smoker	12.4 (7.7-17.1)	11.0 (5.7-16.3)	7.6 (5.02-10.1)	13.1 (8.6-17.5)	13.0 (7.4-18.6)	14.4 (9.8-19.0)	2.8* (1.1-4.6)	11.8* (2.8-20.9)	10.1 (8.4-11.7)
Flu Shot	36.2 (29.3-43.0)	42.0 (33.7-50.3)	36.5 (32.1-40.9)	33.9 (27.7-40.6)	49.4 (41.7-57.1)	45.9 (38.9-52.9)	34.0 (27.4-40.6)	23.0 (14.6-31.4)	37.2 (34.5-39.8)
Internet Use for Health Information (18 years and over; CHIS 2011-2012)	7.0 (3.7-10.4)	‡	5.7 (3.1-8.3)	7.7 (3.3-12.2)	9.3* (3.5-15.1)	7.5 (3.4-11.5)	7.7* (1.3-14.1)	10.0 (6.8-13.1)	6.5 (4.71-8.37)
Neighborhood and Housing									
Civic Engagement	46.3 (38.6-53.9)	47.5 (38.8-56.2)	38.9 (34.3-43.6)	32.1 (25.6-38.6)	36.8 (29.3-44.3)	29.8 (22.8-36.9)	39.5 (32.7-46.4)	39.5 (28.8-50.4)	35.9 (33.2-38.7)
Food Environment									
Food Insecurity (CHIS 2007, 2009, 2011-2012)	20.6 (12.6-28.6)	17.2 (8.5-25.9)	26.5 (20.9-32.2)	41.0 (31.4-50.6)	17.9 (10.8-25.0)	28.8 (22.5-35.0)	18.3 (10.4-26.2)	34.4 (24.4-44.4)	29.9 (26.1-33.7)

*Estimate is not statistically stable

‡Estimate is not provided.

Note: See "Sample Size Notes" at start of Appendix for indicator definitions.

Table 2.1.
Chronic Disease Prevalence for Japanese and Respondents of Other Races/Ethnicities, Adults 18+, CHIS 2011-2012

Demographics	Japanese-All % Pop. N	Japanese-Only % Pop. N	Latino % Pop. N	White % Pop. N	African American % Pop. N	American Indians/ Alaska Natives % Pop. N	Other Single/ Multiple Races % Pop. N	California Overall % Pop. N
Age 18-64	80.0 220,277	73.0 148,966	92.3	76.3	83.5	71.6	90.6	84.2
Age 65+	20.0 55,081	27.0 55,081	7.7	23.7	16.5	28.4	9.4	15.8
Below 200% FPL	19.3 53,133	19.2 39,245	58.2	20.1	42.3	40.6	31.6	35.9
Chronic Conditions								
Hypertension	32.6 (25.8-39.3)	39.0 (30.9-47.2)	26.5 (24.9-28.0)	32.5 (31.5-33.4)	42.5 (38.9-46.2)	43.2 (32.8-53.7)	24.1 (19.2-29.0)	29.7 (29.0-30.5)
Arthritis (40+ year)	35.3 (27.9-42.7)	35.6 (27.8-43.4)	28.2 (26.1-30.3)	39.1 (38.0-40.1)	42.0 (37.9-46.1)	43.8 (31.8-55.8)	44.1 (37.3-50.9)	34.8 (33.9-35.7)
Diabetes	8.5 (4.9-12.1)	9.4 (5.3-13.6)	11.5 (10.3-12.6)	8.0 (7.5-8.5)	12.9 (10.7-15.0)	16.3 (9.7-23.0)	6.7 (4.3-9.0)	9.4 (8.9-9.9)
Heart Disease (40+ years)	8.7 (5.1-12.3)	9.8 (5.7-13.8)	9.5 (7.9-11.0)	13.3 (12.6-14.1)	9.7 (7.6-11.9)	19.6* (7.2-31.9)	15.2 (10.5-19.8)	11.5 (10.9-12.1)
Stroke (65+ years; CHIS 2003, 2005, 2011-2012)	7.0 (3.7-10.4)	‡	7.8 (6.3-9.2)	9.2 (8.6-9.7)	11.6 (9.2-14.0)	14.2* (5.3-23.2)	10.0 (6.8-13.1)	8.8 (8.4-9.3)
Serious Psychological Distress (CHIS 2007, 2009, 2011-2012)	5.1 (2.8-7.4)	3.1 (1.4-4.9)	8.7 (8.0-9.5)	7.2 (6.8-7.6)	10.5 (8.4-12.6)	13.2 (9.2-17.2)	13.2 (10.7-15.6)	7.8 (7.5-8.2)
Fair or Poor Health	8.1 (4.9-11.4)	7.2 (4.1-10.3)	28.5 (26.8-30.2)	14.2 (13.5-14.9)	23.9 (20.8-27.0)	25.2 (16.4-34.0)	20.3 (15.6-25.0)	20.1 (19.4-20.8)
Disability Status Due to Physical/Mental/Emotional Condition	28.8 (22.0-35.6)	22.2 (16.0-28.4)	42.4 (40.0-44.8)	39.9 (38.9-41.0)	48.1 (43.9-52.3)	61.8 (50.3-73.3)	50.6 (43.4-57.8)	40.2 (39.3-41.2)
Obese	14.0 (8.8-19.1)	13.1 (7.2-18.9)	30.3 (28.7-32.0)	21.8 (20.9-22.7)	35.1 31.6-38.6)	33.1 (24.2-42.1)	25.1 (16.7-30.4)	23.6 (22.9-24.3)

*Estimate is not statistically stable

‡Estimate is not provided.

Note: See "Sample Size Notes" at start of Appendix for indicator definitions.

Table 2.2.
Health Behaviors and Environment for Japanese and Respondents of Other Races/Ethnicities, Adults 18+, CHIS 2011-2012

Demographics	Japanese-All % Pop. N	Japanese-Only % Pop. N	Latino % Pop. N	White % Pop. N	African American % Pop. N	American Indians/ Alaska Natives % Pop. N	Other Single/ Multiple Races % Pop. N	California Overall % Pop. N
Age 18-64	80.0 220,277	73.0 148,966	92.3	76.3	83.5	71.6	90.6	84.2
Age 65+	20.0 55,081	27.0 55,081	7.7	23.7	16.5	28.4	9.4	15.8
Below 200% FPL	19.3 53,133	19.2 39,245	58.2	20.1	42.3	40.6	31.6	35.9
Health Behaviors								
Binge Drinking	31.9 (24.2-39.6)	27.6 (19.0-36.2)	33.7 (31.9-35.5)	32.5 (31.3-33.6)	23.9 (20.6-27.3)	28.3 (19.5-37.2)	37.6 (31.0-44.2)	31.1 (30.3-32.0)
Elderly Falls (65+ years; CHIS 2003, 2007, 2011-2012)	7.9 (3.8-12.1)	8.1 (3.9-12.3)	15.1 (12.8-17.4)	14.1 (13.4-14.8)	13.0 (9.7-16.2)	31.2 (21.2-41.1)	20.0 (14.2-25.9)	13.6 (13.0-14.3)
Current Smoker	12.5 (7.8-17.3)	11.2 (5.8-16.5)	12.3 (11.2-13.3)	14.7 (13.9-15.5)	20.7 (17.7-23.6)	28.7 (19.6-37.8)	20.7 (15.7-25.6)	13.8 (13.2-14.3)
Regular Physical Activity (0-17 years)	54.4 (36.7-72.1)	‡	55.6 (52.1-59.1)	31.5 (28.2-34.7)	46.1 (35.4-56.8)	47.7* (11.8-83.7)	42.9 (32.4-53.3)	43.9 (41.7-46.2)
Flu Shot	36.2 (29.3-43.0)	42.0 (33.7-50.3)	31.3 (29.7-31.9)	41.5 (40.5-42.5)	29.4 (26.2-32.5)	47.2 (36.2-58.1)	32.3 (26.6-38.0)	36.8 (36.0-37.6)
Internet Use for Health Information (18 and older, CHIS 2011-2012)	60.1 (51.3-68.9)	60.0 (49.5-70.5)	54.0 (51.8-56.2)	69.3 (68.2-70.4)	58.2 (53.9-62.5)	53.9 (41.8-66.0)	66.5 (60.0-73.0)	63.7 (62.7-64.7)
Neighborhood and Housing								
Civic Engagement (18 years and over; CHIS 2011-2012)	46.3 (38.6-53.9)	47.5 (38.8-56.2)	30.1 (28.4-31.8)	49.6 (48.5-50.7)	41.6 (37.9-45.4)	40.4 (30.2-50.7)	51.6 (45.3-58.0)	41.3 (40.4-42.2)
Food Environment								
Food Insecurity (CHIS 2007, 2009, 2011-2012)	20.6 (12.6-28.6)	17.2 (8.5-25.9)	40.2 (38.3-42.1)	31.7 (29.5-33.9)	42.7 (38.1-47.4)	36.1 (27.2-44.9)	41.3 (34.5-48.0)	36.7 (35.4-37.9)

*Estimate is not statistically stable

‡Estimate is not provided.

Note: See "Sample Size Notes" at start of Appendix for indicator definitions.

Table 3.1.
Demographic Characteristics and Chronic Disease Prevalence for Californians of Japanese Descent, Adults 18–64, CHIS 2007, 2009, 2011-2012

Demographics	Japanese-All % Pop. N	Japanese-Only % Pop. N	Japanese-Multi % Pop. N
Age 0-17	26.9 111,020	‡	‡
Age 18-34	26.1 77,783	14.0 30,243	57.9 47,541
Age 35-64	50.7 150,063	54.7 117,447	40.5 32,617
Below 200% FPL	15.0 43,971	13.9 (11.0-16.8)	18.0 14,416
Chronic Conditions			
Hypertension	19.1 (15.4-22.9)	21.6 (16.3-26.9)	8.4 (4.2-12.6)
Fair or Poor Health	8.6 (5.8-11.4)	7.1 (4.1-10.0)	12.7 (7.3-18.1)
Obese	14.9 (10.8-18.9)	15.3 (9.2-21.3)	18.6 (11.9-25.2)

*Estimate is not statistically stable.

‡Estimate is not provided.

Note: See “Sample Size Notes” at start of Appendix for indicator definitions.

Table 3.2.
Demographic Characteristics, Health Behaviors, and Environmental Prevalence for Californians of Japanese Descent, Adults 18–64, CHIS 2007, 2009, 2011-2012

Demographics	Japanese-All % Pop. N	Japanese-Only % Pop. N	Japanese-Multi % Pop. N
Age 0-17	26.9 111,020	‡	‡
Age 18-34	26.1 77,783	14.0 30,243	57.9 47,541
Age 35-64	50.7 150,063	54.7 117,447	40.5 32,617
Below 200% FPL	15.0 (12.3-17.8)	13.9 (11.0-16.8)	18.0 (11.6-24.4)
Health Behaviors			
Binge Drinking	33.1 (27.3-38.9)	30.1 (23.2-37.0)	36.0 (28.4-43.6)
Current Smoker	16.7 (11.9-21.6)	13.7 (8.8-18.5)	19.4 (12.3-26.5)
Flu Shot	27.0 (22.8-31.2)	30.7 (24.8-36.7)	21.5 (15.8-27.2)
Neighborhood and Housing			
Civic Engagement	62.2 (53.4-70.9)	53.2 (45.0-61.5)	62.4 (51.0-73.9)
Food Environment			
Fast Food 4+ Times in Past Week	15.4 (11.2-19.6)	10.7 (6.1-15.4)	24.6 (17.0-32.3)

*Estimate is not statistically stable.

‡Estimate is not provided.

Note: See “Sample Size Notes” at start of Appendix for indicator definitions.

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