I thank Drs. Chang and So for their letter (1). Chang and So were surprised not to find chronic hepatitis B in Asians and Pacific Islanders among the 10 largest US health disparities in my article (2). There are several reasons for this. The studies they cite are based on the prevalence of hepatitis B in urban populations, including large numbers of recent immigrants from Asian countries where hepatitis B is endemic. In contrast, the 10 largest health disparities for Asians/Pacific Islanders are based on indicators corresponding to the Healthy People 2010 objectives (3). The Healthy People 2010 indicators of hepatitis B that were used to identify the largest health disparities are based on the incidence of hepatitis B in the entire Asian/Pacific Islander population of the United States. The prevalence of hepatitis B among recent immigrants in urban areas—that is, the number of persons in specific urban areas with hepatitis B seroprevalence—is substantially larger than the incidence of hepatitis B in the Asian/Pacific Islander population of the United States—that is, the number of persons identified with new cases of hepatitis B. There is one Healthy People 2010 objective based on the prevalence of hepatitis B; however, it is limited to cases of chronic hepatitis B infection in children less than or equal to 2 years of age (3). Data on this objective are not available for different racial and ethnic groups; therefore, this indicator was not included in the identification of the largest disparities.

Healthy People 2010 includes three objectives concerning the incidence of new cases of hepatitis B in the age groups 19–24 years, 25–39 years, and 40 years or more (3). At the Healthy People baseline in 1997, the incidences of new cases of hepatitis B per 100,000 persons among Asians/Pacific Islanders in these age groups were 33.7, 29.3, and 31.0, respectively (4). These rates were 337 percent, 179 percent, and 343 percent higher than the rates for the White non-Hispanic population. In data for 2003, the incidences of new cases of hepatitis B in the Asian/Pacific Islander population had declined to 5.4, 6.3, and 4.9 per 100,000, respectively. In 2003, the Hispanic population had the most favorable rates for the first two age groups (3.5 and 5.4 per 100,000, respectively), and the White non-Hispanic population continued to have the most favorable rate for persons aged 40 years or more (3.3 per 100,000). The reported incidence of hepatitis B for Asians/Pacific Islanders declined substantially, as did the disparity. In 2003, the percent difference from the best group rate was no more than 55 for any of the three age groups.

Drs. Chang and So are quite correct to point out that the prevalence of hepatitis B among foreign-born Asians and Pacific Islanders in urban areas is substantially higher than the prevalence in other racial and ethnic populations (1). The Healthy People 2010 objectives concerning hepatitis B in different racial and ethnic groups do not measure prevalence, and they do not focus specifically on subgroups of Asians or Pacific Islanders. The Healthy People 2010 objectives do indicate, however, that the incidence of new cases of hepatitis B in Asians/Pacific Islanders and the difference between Asians/Pacific Islanders and other racial and ethnic
populations have declined substantially. The rate at which new cases of hepatitis B are occurring in Asians/Pacific Islanders is therefore not among the 10 largest disparities for this population.

ACKNOWLEDGMENTS
Conflict of interest: none declared.

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DOI: 10.1093/aje/kwm262; Advance Access publication September 18, 2007