RACE, ETHNICITY, GENDER AND OTHER SOCIAL CHARACTERISTICS AS FACTORS IN HEALTH AND HEALTH CARE DISPARITIES

Edited by Jennie Jacobs Kronenfeld

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RACE, ETHNICITY, GENDER, AND OTHER SOCIAL CHARACTERISTICS AS FACTORS IN HEALTH AND HEALTH CARE DISPARITIES
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PART 1

RACE AND ETHNICITY IN THE US CONTEXT
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Chapter 1

THE IMPACT OF RACIAL DISCRIMINATION ON HEALTH DISPARITIES AMONG ASIAN AMERICANS

Hyunsu Oh

ABSTRACT

Purpose – This study examined the impacts of racial discrimination on the self-reported health among Asian Americans.

Methodology/Approach – This study investigated a subsample of 1,090 Asian Americans from the 2008 National Asian American Survey. Three-category measure of self-reported health was constructed. Racial discrimination experiences encompassed (1) interpersonal discrimination, (2) institutional racism, and (3) hate crime. Ordered logistic regression models were employed to test the association between self-reported health and experiences of racial discrimination among Asian Americans.

Findings – With respect to ethnic origin, South Asians showed lower levels of self-reported health than East Asians/Asian Indians. Although the baseline effect of each discrimination indicator was insignificant, there was an interactional effect between ethnic origin and racial discrimination, indicating the more interpersonal discriminatory experiences, the worse health status for South Asians.

Research limitations – There remained some limitations including data and the measures of racial discrimination.
Despite the limitations, this study revealed that as a risk factor, how experiences of racial discrimination shape health disparities among ethnic groups in the United States, focusing on the heterogeneity within Asian Americans.

**Keywords:** Asian American; racial health disparity; racial discrimination; interpersonal discrimination; institutional racism; ordered-logistic regression

**BACKGROUNDS**

In the United States, health disparities by individuals’ social status are broadly acknowledged. Research shows that disadvantaged and stigmatized populations—women, the older, people of color, homosexuals, and the lower-working class—are more likely to have poor physical and mental health outcomes, compared to the privileged population—men, the younger, Whites, heterosexuals, and the middle-upper class (Arber, 1997; Link & Phelan, 1995; Meyer, 2003; Williams & Collins, 1995; Williams & Mohammed, 2013).

As a consequence of racial inequality regimes of the society, racial disparities in health outcomes, inter alia, are of theoretical and empirical interests to sociologists of health, race/ethnicity, and social inequality. In general, people of color generally show worse health, compared to their White counterparts (Hayward, Miles, Crimmins, & Yang, 2000; Vega & Rumbaut, 1991; Williams, 2012; Williams & Collins, 1995, 2001). Scholars suggest that racial health disparities of the US society reveal the unequal economic, political, and social stratification system of the United States along the line of race and ethnicity (Williams, 2012; Williams & Collins, 2001).

Including the health disparity between racial groups, in order to understand the racial inequality regimes of the United States, a number of sociologists highlight the process of racialization in the US society. These racialized assimilation theorists indicate that racial minorities and immigrants of color and their offspring may have different experiences, compared to Whites and European immigrants, since they would experience various forms of racial discrimination and racism against their body, attitude, and culture. These distinct experiences of discrimination, as minorities, shape individuals’ racial status and assimilation outcomes that significantly affect their social positioning (Emeka & Vallejo, 2011; Golash-Boza, 2006; Telles & Ortiz, 2008; Vasquez, 2010).

Racial health disparities, in this sense, are understood as a result of the process of racialization and racial hierarchy of the society. Studies reveal that experiences of racial discrimination have a significant influence on various physical functioning and mental health problems of racial minorities. For instance, Pascoe and Richman (2009) argued that perceived discriminatory experiences have three pathways for influencing mental and physical health: a direct effect on health, partial mediation from psychological responses, and health risk behaviors as a coping mechanism against discriminatory experiences. Investigating data from migrant farmworkers in Fresno, California, Finch, Frank, & Vega (2004) indicated that discriminatory experiences are associated with higher levels of
depression. Grollman (2012) suggested that multiple forms of perceived discrimination have negative effect on both depressive symptoms and self-rate health among Black and Latino/a youth. Seng and colleagues (2012) addressed that everyday discrimination scale (EDS) frequency score is negatively associated with quality of life among 647 female participants.

Compared to other racial groups, nonetheless, the association between racial discrimination and health status of Asian Americans is still far less investigated in the literature. Indeed, prior studies mainly focus on the cases of African Americans and Hispanic immigrants and their descendants. There are two reasons for little attention to the Asian health status as a racial minority group. First, the Asian population, as compared to African American and Latinx population, has rarely been regarded as a racial minority in the United States. Instead, Asian or Asian American as a panethnic label has been generally accepted as an intermediary racial group between white and non-white (Kim, 1999). During the last decades, higher levels of educational achievements and occupational attainments of Asian population have led the model minority thesis, indicating Asian Americans have nearly approached socioeconomic parity with Whites (Barringer, Takeuchi, & Xenos, 1990; Hirschman & Wong, 1984; Hsu, 2015; Reeves & Bennett, 2004; Sakamoto, Goyette, & Kim, 2009). That is, for researchers who explore health disparities along with the racial hierarchy, the Asian population has not been of interest.

Second, the descriptor Asian may not capture the heterogeneity within the population. According to their ethnic origin, Asian Americans have different experiences in US society. It is broadly acknowledged that Chinese, Japanese, and Korean Americans have achieved a relatively higher educational, occupational, economic outcome than South Asians, such as Cambodian, Hmong, and Laotian Americans (Bonilla-Silva, 2002; Sakamoto et al., 2009; Sakamoto & Woo, 2007). Indeed, due to diversity and variability within the group, it has not been easy to investigate the health status of Asian Americans as one singular panethnic group.

Meanwhile, like other racial minority groups, Asian Americans are also experiencing racial discrimination in the United States (Chou & Feagin, 2008; Goto, Gee, & Takeuchi, 2002; Hsu, 2015; Kim, 1999). Because of their race and ethnicity, accent, and/or immigration status, the Asian population has been racialized in US society and become a target of discrimination (Goto et al., 2002). That is, the framework of racialized assimilation theory which highlights the impact of racialization on racial minorities’ social positioning is applicable to exploring Asian Americans’ health status. In this sense, a growing body of literature indicate that perceived racial discrimination is a significant factor for predicting poor health outcomes among Asian Americans, such as general health, physical functioning, and mental illness (Gee, 2002; Gee, Spencer, Chen, Yip, & Takeuchi, 2007, Gee, Ro, Shariff-Marco, & Chae 2009; Yip, Gee, & Takeuchi, 2008).

Accordingly, this study examines the health status of Asian Americans by investigating data from the 2008 National Asian American Survey (NAAS). Drawing from the prior studies based on the framework of racialized assimilation
theory, I shall ask how experiences of racial discrimination shape the health outcome among Asian Americans.

DATA AND METHODS

Data
Using telephone interviews of respondents who self-identify as Asians/Asian Americans, the NAAS primarily focused on the role of Asian Americans in political elections. In addition to collecting demographic information, the NAAS covered respondents’ political behaviors, attitudes, and personal experiences with immigration to the United States. This dataset was appropriate for the current study because it included a broad sample of Asian/Asian Americans in the United States and information about their self-reported health conditions and experiences of discrimination based on race, ancestry, immigrant status, or accent.

With the exclusion of missing values, this dataset yielded a subsample of 1,090 Asian Americans, of whom 55.0% were men and 45.1% were women. Among the respondents, 32.2% reported China as their national origin versus 26.6% for Vietnam, 26.3% for Korea, 4.3% for Philippines, 3.4% for Taiwan, and 7.2% for others.

Variables
Self-reported Health
To measure the health status of respondents, I used responses to the NAAS question, “How would you rate your overall physical health?” This measurement is broadly used in quantitative research on health disparities of racial minorities because it correlates strongly with other objective measures of health (Finch et al., 2004; Grollman, 2012). Responses were coded as 1 = Poor; 2 = Fair; 3 = Good; 4 = Very good; 5 = Excellent. I recoded these responses as (0) Poor, (1) Fair/Good, and (2) Very Good/Excellent.

Experiences of Racial Discrimination
Based on their race, ancestry, being an immigrant, or having an accent, NAAS respondents answered yes or no to each of the following six questions: “Have you been unfairly denied a job or fired?”, “Have you been unfairly denied a promotion at work”, “Have you been unfairly treated by the police?”, “Have you been unfairly prevented from renting or buying a house?”, “Have you been treated unfairly or badly at restaurants or stores?”, and “Have you been a victim of a hate crime?” I created three indicators of racial discrimination based on the questions: (1) interpersonal discrimination, (2) institutional racism, and (3) hate crime.

Interpersonal racial discrimination encompasses discriminatory interaction between individuals faced by people of color in daily life and at work (Essed, 1991; Karlsen & Nazroo, 2002; Williams & Mohammed, 2013). I measured interpersonal discrimination based on three discriminatory experiences: being
denied a job or fired, being denied a promotion, and being unfairly treated at restaurants or stores. The interpersonal discrimination score ranged from 0 to 3, with the larger number representing more experiences of interpersonal racial discrimination.

Institutional racism refers to racially discriminatory policies or practices ingrained in institutional mechanisms and processes (Karlsen & Nazroo, 2002; Williams & Mohammed, 2013). This form of racial discrimination is typically less overt than interpersonal discrimination; however, it perpetuates racial inequalities by enforcing structural discrimination against racial minorities.

For institutional racism, I used two of respondents’ discriminatory experiences of being unfairly treated when renting or buying home and discriminatory experience by police. Massey and Lundy (2001, p. 452) address “racial discrimination was institutionalized in the American real estate industry during the 1920s and was well established in private practice by the 1940s.” Also, McKenzie and Bhui (2007, p. 650) noted “police policies as a whole resulted in differential treatment for white and black people.” Therefore, racial minorities face institutionalized racism in renting or buying a house and in a relationship with police.

Hate crime indicates unlawful threat and attack directed against a person of color and/or racial minority group, including physical, psychological, and sexual violation, property destruction, and trespassing. As an immediate and violent expression of race-based hostility, hate crime would be an extreme form of racial discrimination and racism (Green, Strolovitch, & Wong, 1998, Green, McFalls, & Smith, 2001). From a question asking experiences of being a victim of a hate crime, I included a dummy variable of hate crime, ranging from 0 to 1.

Ethnic origins
To capture the disparities on experiences of racial discrimination and health status by ethnic origin, I used a dichotomous concept for respondents’ self-identified ancestry or ethnicity. East Asian and Asian Indian denotes ethnic origins as Chinese, Korean, Japanese, Taiwanese, and Indian, while South Asian refers to Filipino, Vietnamese, and other South Asian (South Asian, Burmese, and Asiatic). Within the sample, 64.8% of respondents (n = 706) were categorized as East Asian, while 35.2% were in the South Asian group (n = 384).

Controls
I controlled for several sociodemographic variables, including age in years as well as a dummy variable for female. I also accounted for education level based on the highest degree completed: high school graduate, college degree, and more than college degree, compared to not graduating high school. I included dummy variables for household income based on respondents’ pre-tax household income for the previous year: $20,000–$50,000, $50,000–$100,000, and more than $100,000, compared to less than $20,000. I also used a dummy variable for respondent’s home ownership, with ownership at the time of the survey being coded as 1.
Moreover, to control the extent of assimilation and acculturation into the American society, I added variables for foreign birth and language proficiency. The foreign-born variable was included as a binary dummy, compared to US born. And the NAAS coded how well respondents could speak and read English on a scale of 1–4 each (1 = very well and 4 = not at all). I recoded the items so high values indicated better proficiency, and combined them into one variable, English proficiency. The language proficiency score ranged from 2 to 8, with higher values representing better proficiency in English ($\alpha = 0.927$).

**Analytic Strategy**

To explore the association between racial discrimination experiences and self-reported health status among Asian Americans, I conducted both univariate and multivariate analyses. First, a series of t-tests showed disparities on the levels of experiences of racial discrimination and self-reported health among Asian Americans according to their ethnic origin.

For multivariate analyses, ordered logistic regression models were applied to estimate the impacts of racial discrimination on the self-reported health among Asian Americans. Using maximum likelihood estimation, an ordered logistic regression analysis shows explanatory variables assess the likelihood of being at or above any specified value of the outcome variable that are ordered but without fixed distances between values. The model coefficients, using log odds, show the change in log-odds of being in the highest category by one unit change in the independent variables. In order for identifying the influences of various racial discrimination indicators on the dependent – self-reported health – which is constructed as a three-categorical ordered variable, the statistical technic is appropriate for this study.

**FINDINGS**

Table 1 shows the differences on experiences of racial discrimination among Asian Americans by ethnic origin. For indicators of racial discrimination, it presents that East Asians/Indians had experienced more interpersonal discrimination (0.462 for East Asians/Indians vs 0.281 for South Asians) and institutional racism (0.245 for East Asians and Asian Indians vs 0.167 for South Asians) than their South Asian counterparts. More specifically, Chinese and Japanese origins showed highest levels of both interpersonal discrimination (0.556 for Chinese vs for 0.667 Japanese) and institutional racism (0.274 for Chinese vs for 0.333 Japanese). There is no statistically significant difference on the level of hate crime between ethnic groups.

Table 1 also demonstrates Asian Americans’ levels of self-reported health in accordance with ethnic origins. The average level of self-reported health of East Asians and Asian Indians (1.217) is significantly higher than that of South Asians (1.128). Among East Asians and Asian Indians, Indians reported the highest level of health (1.500). Although Chinese and Japanese Americans had experienced high levels of racial discrimination, it is reported that they showed high levels of