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

Edited by Jennie Jacobs Kronenfeld

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EDITED BY

JENNIE JACOBS KRONENFELD
Arizona State University, USA

United Kingdom – North America – Japan
India – Malaysia – China

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ABOUT THE AUTHORS

Annika Y. Anderson, PhD, MA, is an Assistant Professor in the Department of Sociology where she teaches classes on deviant behavior, criminology, and race and ethnic relations. She received her BA in Public Relations from Pennsylvania State University and her MA and PhD in Sociology from Washington State University.

Dr Roksana Badruddoja, PhD, MBA, is a mother and a Associate Professor of Sociology and Women and Gender Studies. She is the author of *Eyes of the Storms: The Voices of South Asian-American Women*, the editor of *New Maternalisms: Tales of Motherwork*, and a contributor of *Good Girls Marry Doctors: South Asian Daughters in Obedience and Rebellion*.

Dr Matt Thomas Bagwell, PhD, MPA, is an Assistant Professor in the Public Administration Division at Tarleton State University. He has worked extensively in public health policy and research; his current interests include broadly public policy analysis, budgeting, ethics, organizational theories, human resource management, public health, and administrative leadership.

Dr Sangeeta Das Bhattacharya MD, MPH, is working in the area of evidence-based health policies, internal medicine, pediatrics, HIV/AIDS, and college mental health programs, and global health. She is a professor in the School of Medical Science and Technology, IIT Kharagpur. Prof Bhattacharya is an alumnus of John Hopkins University and authored several research papers in international journals.

Tulika Bhattacharyya is a Sociologist, Psychologist, and Gerontologist by training. She has been interested in understanding the distinctive contributions institutions of higher education can make in responding to the interests and needs of the aging population, especially in the context of research poor countries.

Dr Debolina Chatterjee is Assistant Professor in the Department of Human Development, J.D. Birla Institute, Kolkata, affiliated to Jadavpur University. Her research interests are in prison studies, sociology of health and illness, gender and ageing.

Prof. Suhita Chopra Chatterjee teaches Sociology of Ageing and Gerontechnology at IIT Kharagpur. Recently she published a book titled *Death and Dying in India: Ageing and End-of-Life Care of the Elderly*. She is a life-long writer and has a uniquely wry voice that glows through her writings.

Claudia Chaufan, MD, PhD, is Associate Professor of Health Policy and Global Health and Director of the Graduate Program in Health at York University, Canada. Prof Chaufan's background spans clinical medicine, sociology, comparative political economy, and philosophy. She teaches about and conducts research on health issues in relation to capitalist globalization, medicalization,

language/power/discourse, and the scholarship of teaching and learning; has published widely; is board member and reviewer of refereed journals; and a long-time supporter of grassroots organizations opposing imperialism and war.

Patricia Drentea, PhD, is professor of sociology at the University of Alabama at Birmingham. Her recent book, *Families and Aging* (Rowman & Littlefield) examines how social trends in families in the US will affect the aging experience. She has published widely in areas of family, gender, race and mental health.

Kelsey E. Gonzalez is a PhD student in the School of Sociology at the University of Arizona. Her research focuses on quantitative methodology, the social determinants of physical and mental health and illness, racial and panethnic identities, and discrimination.

Nicole Henley, PhD, MBA, is an Assistant Professor in the Department of Health Science and Human Ecology. She received her PhD in Health Services from the University of California, Los Angeles. Her research focuses on social determinants of health and access to health care for vulnerable populations.

Terrence D. Hill is an Associate Professor in the School of Sociology and a Scientific Member of the Arizona Center on Aging at the University of Arizona. His research examines the social distribution of health and health-relevant behaviors.

Kimberly R. Huyser, PhD, is an Associate Professor of Sociology at the University of British Columbia, Vancouver. Her research seeks to gain a deeper understanding of the social conditions that undermine health and to identify the cultural and social resources leveraged by racial and ethnic groups in the United States.

Fabrice Julien, MPH, MA, is a doctoral candidate in Medical Sociology at The University of Alabama at Birmingham. His research interests include immigrant health, adolescent mental health, race and discrimination, global health, aging, and social stratification and mobility. Julien is currently funded by the Agency for Healthcare Research Quality (AHRQ).

Maureen Walsh Koricke, PhD, is Assistant Professor in Health Administration and Director of the Master of Health Administration Program at Queens University of Charlotte. Her research focuses on patient safety and quality improvement in health care delivery.

Rajeev Kumar, MSW, MPhil, PhD, completed his doctoral research on HIV/AIDS availing UGC Senior Research Fellowship from the Indian Institute of Technology Kharagpur (India). Dr Kumar is an alumnus of the Tata Institute of Social Sciences, Mumbai, and Central Institute of Psychiatry, Ranchi (India). He is a mental health professional and published several research papers in reputed international books and journals on mental health, community health, and gender rights.

Jessica L. Liddell, MSW/MPH, is a PhD candidate in Social Work at the University of Tulane. Her research focuses on sexual and reproductive health, reproductive justice issues, making health services more responsive to community needs and input, and harm reduction service models.

Andrew H. Mannheimer is a Lecturer in Sociology at Clemson University. His research interests are education, culture, and race and ethnicity. His work

examines the ways social institutions reproduce racial and ethnic inequalities. Recently he won the Phil Prince Award for Innovation in Teaching.

Spero M. Manson, PhD, is a Distinguished Professor of Public Health and Psychiatry and directs the Centers for American Indian and Alaska Native Health which includes 10 national centers engaging with 250 Native communities. He is widely acknowledged as one of the nation's leading authorities on Indian and Native health.

Adrienne N. Milner is a Senior Lecturer in the College of Health and Life Sciences and a member of the Institute of Environment, Health and Societies at Brunel University London. Her research addresses issues of health equity in terms of race and ethnicity and sex and gender.

Joan O'Connell, PhD, is a Health Economist at the Centers for American Indian and Alaska Native Health at the Colorado School of Public Health, University of Colorado. She is Director of the Indian Health Service Improving Health Care Delivery Data Project; data from this project were analyzed in this study.

Hyunsu Oh is a PhD candidate in Sociology at University of California, Merced. His research broadly examines experiences of Asian immigrants and their descendants in various areas, including education, health, and the labor market. He is the recipient of the 2017 Distinguished Graduate Student Paper Award, Pacific Sociological Association.

Jennifer Rockell, PhD in Human Nutrition, University of Otago, is a Lead Health Data Analyst with Telligen, Inc. Her work examines Medicare care transitions, chronic disease management, behavioral health, and vulnerable populations. For 10 years, her research informed health care policy and service delivery for American Indian and Alaska Native communities.

Teresa L. Scheid is a Professor of Sociology and Public Policy at the University of North Carolina at Chapel Hill. Her research focuses on the organization and delivery of health care services with the majority of her research focused on mental health. She is senior editor of *The Handbook for the Study of Mental Health* (Cambridge University Press) and the author of numerous publications including peer-reviewed journal articles and books.

Dr Sanjay Kumar Singh, MD, is a Professor in the Department of Medicine, Rajendra Institute of Medical Sciences (RIMS), Ranchi (India). As a Nodal Officer of Anti-Retroviral Therapy (ART) Centre of RIMS, Dr Singh supervises the therapeutic management of persons infected with HIV/AIDS. Dr Singh has published several research papers in journals of national and international fame.

Damodar Suar, PhD, is a Professor at the Indian Institute of Technology Kharagpur (India). He is the Editor-in-Chief of the journal, *Psychological Studies* (Springer). His research focuses on leadership, business ethics, cognition, post-disaster trauma, and HIV/AIDS. He has authored over 125 scientific/professional articles, 17 book chapters, one book, and co-edited four books.

Dr Thomas T. H. Wan, PhD, MHS, is a Professor of Public Affairs, Health Management and Informatics, and Medical Education at University of Central Florida. His extensive research expertise includes health care informatics, health

systems analysis and evaluation, long-term care, artificial intelligence applications in health care, and clinical health services research.

Charlton Wilson, MD, is a Consultant and Physician Executive who has extensive leadership experience in medicine, public health, and health policy with an emphasis on the populations served by Medicare, Medicaid, and the Indian Health Service programs.

LIST OF CONTRIBUTORS

Annika Y. Anderson	Department of Sociology, California State University, San Bernardino, USA
Roksana Badruddoja	Department of Sociology and Women and Gender Studies Program, Manhattan College, USA
Matt T. Bagwell	Division of Public Administration, Tarleton State University, USA
Sangeeta Das Bhattacharya	School of Medical Science and Technology, Indian Institute of Technology Kharagpur, India
Tulika Bhattacharyya	Department of Humanities and Social Sciences, Indian Institute of Technology Kharagpur, India
Debolina Chatterjee	Department of Human Development, J. D. Birla Institute, India
Suhita Chopra Chatterjee	Department of Humanities and Social Sciences, Indian Institute of Technology Kharagpur, India
Claudia Chaufan	School of Health Policy and Management, York University, USA
Patricia Drentea	Department of Sociology, The University of Alabama at Birmingham, USA
Kelsey E. Gonzalez	School of Sociology, The University of Arizona, USA
Nicole Henley	Department of Health Science and Human Ecology, California State University, San Bernardino, USA
Terrence D. Hill	School of Sociology, The University of Arizona, USA
Kimberly R. Huyser	Department of Sociology, The University of British Columbia, Canada
Fabrice Stanley Julien	Department of Sociology, The University of Alabama at Birmingham, USA
Maureen Walsh Koricke	Blair College of Health, Queens University of Charlotte, USA
Jennie Jacobs Kronenfeld	Arizona State University, USA

Rajeev Kumar	Department of Humanities and Social Sciences, Indian Institute of Technology Kharagpur, India
Jessica L. Liddell	School of Social Work, Tulane University, USA
Andrew H. Mannheimer	Department of Sociology, Anthropology, and Criminal Justice, Clemson University, USA
Spero M. Manson	Centers for American Indian and Alaska Native Health, University of Colorado, USA
Adrienne N. Milner	College of Health and Life Sciences, Brunel University London, UK
Joan O'Connell	Centers for American Indian and Alaska Native Health, Colorado School of Public Health, University of Colorado, USA
Hyunsu Oh	Department of Sociology, University of California, USA
Jennifer Rockell	Telligen, Inc., USA
Teresa L. Scheid	Department of Sociology, University of North Carolina at Charlotte, USA
Sanjay Kumar Singh	Department of Medicine, Rajendra Institute of Medical Sciences, India
Damodar Suar	Department of Humanities and Social Sciences, Indian Institute of Technology Kharagpur, India
Thomas T. H. Wan	Department of Health Management and Informatics Doctoral Program in Public Affairs College of Community Innovation and Education, University of Central Florida, USA
Charlton Wilson	Consultant, Mercy Care, Phoenix, AZ, USA

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 ain. 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.*

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Originality/Value of Paper – *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, heath 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 onthe 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