

Ethnic neighborhoods and health among Asian Americans: Can we generalize?

Emily Walton, University of Wisconsin

Classic assimilation theory predicts one type of ethnic neighborhood, the *immigrant enclave*. An immigrant enclave is composed of individuals who migrate to the United States with poor English skills, and low educational attainment, income, and occupational prestige (Alba and Nee 2003). Living among other recent immigrants who share a common culture and speak the same language can be a source of employment opportunities and provide a familiar social setting, assisting individuals with the transition to life in the United States (Zhou 1992). I hypothesize that immigrant enclaves are comprised mainly of foreign-born individuals and are lacking structural resources; however, these neighborhoods may concentrate social advantages, so the association of ethnic neighborhoods with health is both positive and negative.

Place stratification theory describes a second type of ethnic neighborhood, the *ethnic ghetto*. This perspective contends that if human capital and group social position are low, discriminatory actions by advantaged individuals and institutions place constraints on the residential choices of racial and ethnic minorities with limited resources (Massey and Denton 1993). One consequence of these limited opportunities is that, rather than spatially assimilating into middle-class, suburban neighborhoods, the children of low status immigrants may continue to live in poverty. With time these immigrants and their children are less likely to residentially integrate, but instead may experience downward assimilation in which they are obliged to live in a neighborhood comprised of poorer, native born co-ethnics and other racialized minorities (South et al. 2005). I hypothesize the ethnic ghetto to be comprised of a mix of native and foreign-born individuals, lacking in both structural and social resources, and the association of ethnic neighborhoods with health is negative.

A final ethnic neighborhood type, the *ethnic community*, is predicted by resurgent ethnicity theory. In this scenario, Asian Americans with high socioeconomic status understand that they may have little to gain by spatially integrating and there is an element of choice present in the decision to live in residentially segregated communities (Alba et al. 1999; Logan et al. 2002; Wen et al. 2009). The current picture of Asian Americans living in resource-rich ethnic communities is consistent with work finding that Asian American suburban enclaves provide a relatively high-status setting in which to live, even when spatial assimilation is otherwise possible (Logan et al. 2002; Wen et al. 2009). Instrumentally, these strong ethnic residential communities may serve to maintain cultural identity and can offer social mobility benefits, such as supplemental ethnic educational institutions and ethnic social networks (Zhou 2007). I hypothesize that the ethnic community is comprised of both native- and foreign-born individuals but also contains substantial structural and social resources that residents can use to protect their health.

As the racial fabric of the United States continues to diversify in the context of immigration from Asia and Latin America, researchers are compelled to deepen our understanding of the ways in which residential

experiences of these growing racial groups relate to current theoretical predictions about the effects of place on well-being. Using three prominent theories of community formation – classic spatial assimilation, place stratification, and resurgent ethnicity – this study seeks to broaden the framework through which we investigate the effects of Asian American co-ethnic neighborhood concentration on health.

I have three main goals for this paper. First, I use spatial autocorrelation to define the boundaries of Asian American ethnic neighborhoods in California, focusing on six ethnic subgroups with substantial populations – Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese Americans. Second, using neighborhood characteristics related to nativity, socioeconomic status, and linguistic isolation, I place each ethnic neighborhood within a theoretical typology (immigrant enclave, ethnic ghetto, and ethnic community). Finally, I investigate whether health status of Asian Americans systematically relates to living within different types of ethnic neighborhoods.

Methods

Data for this study come from sources at two levels of analysis and are merged based on each individual respondent’s census tract of residence. I merge tract- and individual-level data from two sources – the 2000 U.S. Census and the combined 2007-09 California Health Interview Survey (CHIS). At the neighborhood level, I use Census 2000 Summary File 2 (SF2) data on racial and ethnic census tract composition to define ethnic neighborhood boundaries using spatial analysis. In addition, I append aggregated tract-level socioeconomic and nativity data from the Census 2000 Summary File 1 (SF1) to individual demographic and health records from the CHIS.

I use spatial analytic techniques to quantitatively define the boundaries of ethnic neighborhoods. Using spatial autocorrelation, I identify geographic “hot spots” consisting of clusters of census tracts with high ethnic density for each Asian subgroup-county combination. The final sample includes 6 Asian ethnic subgroups and 27 California counties with substantial populations of the Asian ethnic subgroups of interest. Within a given county, an ethnic subgroup is included in the sample if there were at least 5 census tracts with over 100 subgroup residents in the Census 2000 SF2. From the county-subgroup maps, I assign all tracts with high-high correlation to be part of an ethnic neighborhood cluster. In this way, each census tract in all included counties is assigned a designation of “in an ethnic neighborhood” (1) or “not in an ethnic neighborhood” (0). The ethnic neighborhood maps are then merged with the CHIS individual-level data, using the census tract as the merging variable. Only census tracts belonging to ethnic neighborhoods (and individuals from the CHIS residing in them) are included in the present analyses. I aggregate tract level data to the level of ethnic clusters in order to broadly categorize the type of ethnic neighborhood each cluster represents: immigrant enclave, ethnic ghetto, and ethnic community. Classifications in the typology are based on each cluster’s constellation of the following variables.

Linguistic isolation	a cluster is considered to be high in linguistic isolation if at least 30% of households that speak primarily an Asian language are linguistically isolated (all members fourteen
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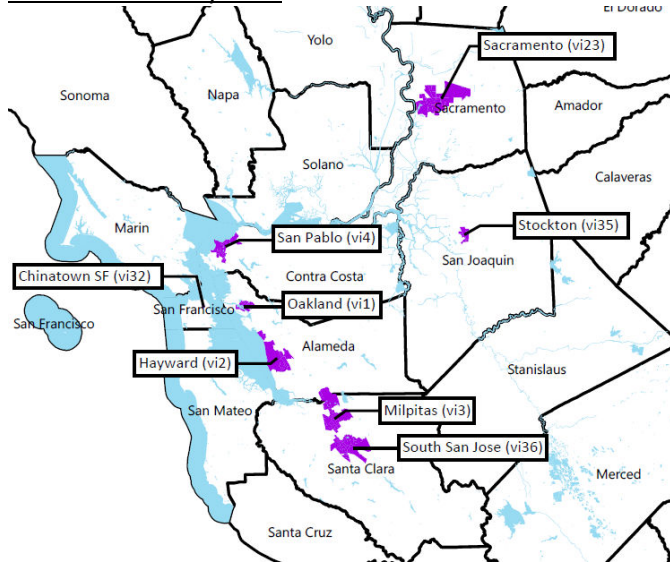
	years old and over have at least some difficulty with English).
Nativity	a cluster is considered to be highly foreign born if at least 30% of individuals are foreign born.
Education	a cluster is considered to have high educational attainment if at least 22% of adults (age 25+) have a bachelor's degree.
Poverty	a cluster is considered to be poor if at least 10% of individuals are below the federal poverty line in 1999.
Median family income	a cluster is considered to be high income if median family income is greater than \$50,000 in 1999.

After mapping, categorizing, and describing each cluster of census tracts, I utilize linear multilevel modeling to assess whether ethnic neighborhood types are associated with individual differences in health status, accounting for individual demographic characteristics.

Results and Discussion

Results presented here are descriptive, and lacking health-related information (due to the sensitive nature of the CHIS data, I am unable to attach health information at this time; however, I will be able to integrate the data well before this presentation in May 2012). I focus on one ethnic group, Vietnamese Americans, for the sake of brevity, but the final paper will include all six ethnic groups analyzed separately. The spatial autocorrelation technique allows for a large-scale, quantitative definition of Vietnamese American neighborhood clusters in California (see Figure 1 below), which not only provides a visual representation of clear cluster boundaries but permits a parsimonious integration of contextual and individual data.

San Francisco Bay Area



Greater Los Angeles Area

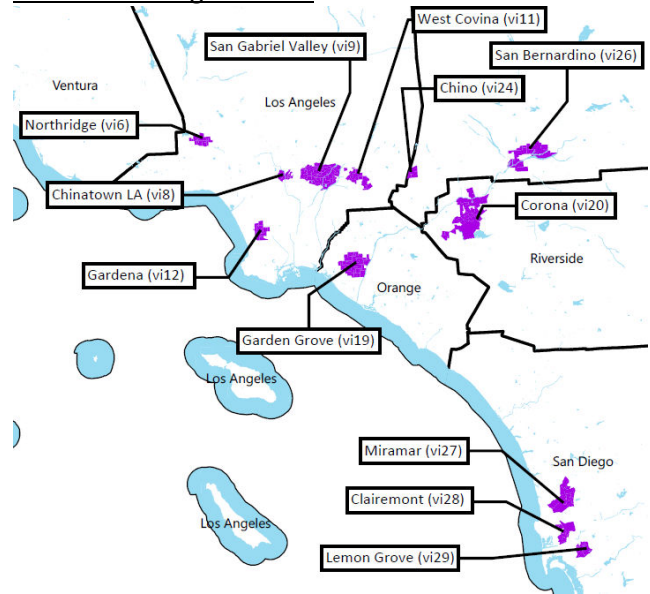


Figure 1. Vietnamese clusters

Figure 1 shows that Vietnamese neighborhood clusters are geographically centered in two areas, the San Francisco Bay Area and the Greater Los Angeles Area. These ethnic neighborhoods vary considerably in their distribution of linguistic, educational, and financial resources, with most being considered immigrant enclaves and

ethnic communities (see Table 1 below). Among those neighborhoods considered classic immigrant enclaves, linguistic isolation and foreign birth are high, while educational attainment, poverty, and median family income are generally low. There are some exceptions, such as the high educational attainment evident in San Francisco’s Chinatown (30.4% of adults have at least a bachelor’s degree), but the extreme linguistic isolation and high percentage of foreign born individuals in this area, combined with high poverty and relatively low family income, make it otherwise fit well in this category. San Bernardino is perhaps the most extreme case of an ethnic ghetto. The community-level characteristics of low educational attainment, high poverty, and low percentage of foreign born, mean that this ethnic neighborhood is comprised mainly of second generation individuals who likely have witnessed blocked upward mobility due to discrimination and labor market constraints.

Table 1. Descriptive statistics for Vietnamese clusters

Ethnic Cluster	Linguistic Isolation	Foreign Born	Bachelor’s Degree	Poverty	Median Family Income	Neighborhood Type
Oakland	48.3%	41.4%	18.2%	21.6%	\$37,486	Immigrant Enclave
Northridge	29.3%	40.9%	20.6%	14.7%	\$49,443	Immigrant Enclave
Chinatown LA	56.4%	55.1%	10.0%	32.8%	\$25,184	Immigrant Enclave
San Gabriel Valley	56.4%	55.1%	10.0%	32.8%	\$25,184	Immigrant Enclave
Garden Grove	45.1%	32.6%	17.2%	12.6%	\$49,145	Immigrant Enclave
Lemon Grove	46.6%	36.3%	12.7%	29.8%	\$28,320	Immigrant Enclave
Chinatown SF	58.1%	45.3%	30.4%	25.1%	\$31,002	Immigrant Enclave
Stockton	30.4%	30.8%	8.7%	28.0%	\$34,327	Immigrant Enclave
Gardena	32.2%	30.9%	15.5%	14.7%	\$43,251	Immigrant Enclave
Sacramento	29.8%	22.6%	15.0%	15.1%	\$42,999	Ethnic Ghetto
Chino	28.1%	23.6%	10.9%	14.9%	\$43,334	Ethnic Ghetto
San Bernardino	19.8%	14.7%	9.5%	27.0%	\$32,762	Ethnic Ghetto
Clairemont	33.8%	25.7%	22.4%	14.2%	\$42,339	Ethnic Ghetto
Hayward	21.6%	44.9%	28.9%	6.8%	\$74,678	Ethnic Community
Milpitas	30.2%	46.3%	33.4%	6.4%	\$83,319	Ethnic Community
San Pablo	17.2%	18.0%	19.2%	7.8%	\$58,921	Ethnic Community
West Covina	23.7%	24.1%	18.2%	9.9%	\$52,488	Ethnic Community
Corona	20.6%	16.8%	14.4%	9.4%	\$51,378	Ethnic Community
Miramar	18.8%	34.3%	39.1%	5.8%	\$71,376	Ethnic Community
South San Jose	35.5%	48.7%	20.3%	9.9%	\$72,465	Ethnic Community

The most consistent message from these descriptive analyses is that there is great variation in social and economic resources associated with ethnic neighborhoods, which has implications for the ways that individual well-being can benefit or suffer as a consequence of co-ethnic residence. I suggest that this variation is systematically related to health for Asian American individuals who live in segregated ethnic neighborhoods. Research on place and health that fails to account for the clear complexity among Asian American communities may be underestimating the ways that individual health is affected by their neighborhood context.