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ORIGINAL RESEARCH ARTICLE

Citizenship Status and Chronic Health Conditions among Asians in the U.S.

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Introduction: Studies have shown that citizenship affords people with a range of health benefits and resources. Limited research, however, has explored how citizenship may be tied to the health of Asian Americans, a rapidly growing and increasingly stigmatized social group.

Methods: Drawing on social exclusion theory and the concept of the 'alien citizen', this study uses data from the 2021–2022 California Health Interview Survey to investigate the relationships between citizenship status and chronic health conditions among Asians in the U.S.

Results: After controlling for various sociodemographic factors and health behaviors, the prevalence of having a chronic health condition was significantly higher among Asian U.S. citizens than among their non-citizen counterparts (prevalence ratio (PR) = 1.372, $P < 0.001$). Furthermore, when stratifying citizenship by nativity status, findings indicate that U.S.-born citizens have a greater prevalence of having a chronic health issue, relative to naturalized U.S. citizens (PR = 1.187, $P < 0.01$).

Discussion: Having U.S. citizenship, relatively higher earnings, and access to healthcare services does not exclude Asian Americans from experiencing chronic health issues, which often get masked due to the model minority myth. The findings of this study also underscore the health problems faced by Asians who are born in the U.S., highlighting the importance of examining citizenship by nativity status and raising implications for the social belonging of this population.

Key Words: citizenship ▪ chronic health conditions ▪ social belonging ▪ Asian Americans

In 2022, the U.S. foreign-born population reached 46.1 million people.[1] Compared to 1965, when the U.S. was replacing a national quota system, the number of immigrants living in the U.S. currently has more than quadrupled.[2] While many immigrants who moved to U.S. have become naturalized U.S. citizens, 27% of them remain lawful permanent residents, 5% are in the country temporarily, and almost a quarter do not have state authorization to be in the U.S.[2] Those who have lawful permanent residency, hold temporary visas, or are unauthorized make up the 'non-citizen' category of immigrants and are all legally subject to the threat of deportation.[3] With recent immigration enforcement policies entailing government surveillance, job insecurity, and deportations, researchers have increasingly theorized citizenship as an important marker of stratification in the U.S.[4] As this study will show, these categories of citizenship have important implications for health.

Citizenship refers to some form of community membership, such as membership in a common society, which brings with it certain privileges and rights, including state authorization to be in a country.[5] Scholars have argued that in addition to contributing to processes of social exclusion[5, 6] citizenship status reproduces racial hierarchies, such that even those who carry membership may not enjoy all their rights and privileges, especially if they are part of a group that is routinely targeted for its racial/ethnic background.[7] Moreover, one's social position based on a legal classification, such as immigration status, is still racialized and can serve as a fundamental

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POPULAR SCIENTIFIC SUMMARY

- The prevalence of having a chronic health condition is significantly higher among Asian U.S. citizens than among non-citizens.
- Asians who are born in the U.S. also have a greater prevalence of having a chronic health issue, relative to those who immigrated to the U.S. and became naturalized.
- These findings show how citizenship – which is often associated with health benefits – does not exclude Asian U.S. citizens from experiencing chronic health problems and raise implications for the social belonging of this population.

determinant of health disparities.[8] Studies have shown, for example, that among Latino young adults, non-citizens are at greater risk of all-cause, cardiometabolic, cancer-related, and accidental death than U.S.-born citizens.[9] Limited research, however, has accounted for the experiences of Asian Americans, despite them making up a sizeable portion of the immigrant (and non-citizen) population in the U.S.

Aside from being underrepresented in the immigrant health literature, Asian Americans are important to study for multiple reasons. First, this population has been subjected to a rise in hate crimes during the COVID-19 pandemic, especially from 2020 to 2021, due to their racial/ethnic background.[10-12] However, little is known about the impact of these incidents on Asian Americans, despite being the fastest growing racial/ethnic group in the U.S.[13] Second, between 2015 and 2019, U.S. Immigration and Customs Enforcement arrested nearly 15,000 Asian immigrants,[14] and it is still unclear how these actions have affected Asian non-citizens, as well as their U.S. citizen counterparts. Third, due to the model minority myth – which posits that Asian Americans are highly educated and able to achieve social and economic mobility – there is a false belief that this population is not impacted by larger societal problems.[15] As a result, the health issues faced by Asian Americans often get masked, which has contributed to less scholarly attention on this group.[16] However, recent evidence suggests that Asian Americans *are* experiencing higher rates of health issues than before,[17] underscoring the need to examine how constraints at the structural level might be contributing to these problems.

The present study examines the relationship between citizenship status and chronic health conditions among an ethnically diverse sample of Asians in the U.S. Understanding the nuances of citizenship status is important, as various groups under a broad legal category may experience social exclusion in multiple ways and exhibit different health outcomes. Expanding upon the limited research on this population, this study addresses the following questions:

1. Is the prevalence of having a chronic health condition greater or lower among Asian U.S. citizens than among their non-citizen counterparts?
2. How, if at all, does the prevalence of having a chronic health condition among U.S. citizens vary by nativity status (e.g. U.S.-born vs. foreign-born)?

THEORETICAL FRAMEWORK

A large body of scholarship has found that immigrants who move to the U.S. arrive with better health than their native-born counterparts, which is often referred to as the 'healthy immigrant effect'.[18,19] It has also been established that as immigrants stay in the U.S., many aspects of their health deteriorate, possibly due to acculturation.[20] Acculturation is the process of minority group members adopting new values, beliefs, and behaviors, as a result of prolonged contact with the majority group.[21] Though this phenomenon has been linked to different health outcomes, scholars have increasingly emphasized the need to examine the role of *structural* factors in impacting immigrants' health.[22,23] One such factor is citizenship.

Previous research on other social groups (e.g. Latinos) has found that even if individuals hold U.S. citizenship, they may be concerned about being impacted by punitive laws if they 'look like an immigrant'[24] since cues associated with immigration status are often racialized[25] and can lead to perceptions of citizens still being foreign. This notion of being a 'perpetual foreigner' is experienced by and extends to many communities of color, including Asian Americans.[26] To understand how citizenship status contributes to feelings of (not) belonging and might be linked to health among Asians in the U.S., I draw on Kabeer's[27] framework of social exclusion, as well as Ngai's[28] concept of the alien citizen.

Social exclusion refers to processes driven by unequal power relations that limit people from fully participating in society.[29] Many institutions and the resources they provide can intersect, such that access and participation in one domain (e.g. communities) may be offset by exclusion and/or suspicion through another (e.g. government).[27] One example is the 'alien citizen', who, by virtue of being born in the U.S., is an American citizen but whose citizenship is 'suspect, if not denied, on the account of the racialized identity of their immigrant ancestry'.[28] According to Nakphong et al.,[30] these intersections create both opportunity and disadvantage, resulting in stratification and leading to negative outcomes in various arenas, including health.

Prior scholarship informed by social exclusion frameworks has shown that citizenship is strongly associated with subjective measures of well-being, such

as self-rated health. [31, 32] I build upon this important work by examining how citizenship may simultaneously include and exclude members of the Asian American community and be linked to health, using a more objective measure from a recent dataset.

Even though U.S. citizenship comes with a host of privileges, as well as access to resources that promote health, feeling othered (and being aware of that exclusion) could potentially offset those benefits.[7] Research by Cheryan and Monin,[33] for instance, has found that Asian Americans realize that they are seen as 'less American' compared to other groups, and Asians who are threatened with identity denial (i.e. not recognized as being part of an in-group) feel angrier and more offended. Additionally, within the Asian U.S. citizen population, there may be differences between those who are U.S.-born and those who became naturalized after immigrating to the U.S. For example, since U.S.-born Asian citizens are exposed to social constructions of race and migrant 'illegality' from an early age, they may internalize feelings of social exclusion and exhibit worse health than their foreign-born counterparts. Relatedly, work by Waters[34] has found that West Indians who are born in the U.S. and identify as Black American tend to see more racial discrimination and limit to opportunities for Black people in America. It is possible that this phenomenon extends to Asian Americans as well, warranting the need to analyze health among Asian Americans by nativity status. Guided by social exclusion theory and building upon findings from previous research, I tested the following hypotheses:

1. The prevalence of having a chronic health condition will be greater among Asian U.S. citizens than among non-citizens.
2. The prevalence of having a chronic health issue will be greater among Asian U.S. citizens who are native-born than among those who are foreign-born and became naturalized.

METHODS

Data collection

For this study, data were drawn from the 2021–2022 California Health Interview Survey (CHIS) public use files. CHIS is a comprehensive health survey conducted annually by the University of California, Los Angeles (UCLA) Center for Health Policy Research.[35] Being the largest state health survey in the U.S., CHIS provides representative data on 58 counties in California and covers a wide range of social and health-related topics.[35] Because this study focused on Asian Americans, I limited my sample to respondents who identified as non-Hispanic Asian, which included 7,089 participants. A breakdown of the sample is described later. Since this study relied solely on analysis of de-identified secondary data, approval from the institutional review board was not required.

Measures

Dependent variables

The main dependent variable was the presence of a chronic health condition. To examine this outcome, I referred to questions that asked whether respondents were diagnosed with a chronic illness, including asthma, diabetes, hypertension, and heart disease. In line with previous research that investigated chronic health conditions,[36, 37] these variables were combined into an index, which was then dichotomized. Responses that reflected the presence of at least one chronic health condition were coded as '1'. Those that indicated an absence of a chronic health condition were coded as '0'.

Independent variables

The main independent variable was citizenship status. This variable was assessed by examining the 'citizen2' variable in the dataset, which revealed whether Asian participants were U.S.-born citizens, naturalized U.S. citizens, or non-citizens.

A key covariate was ethnicity. Since Asian Americans consist of different ethnic groups – each with their own historical background and immigration experiences – it was important to see if there were any potential differences in the prevalence of having a chronic health condition by ethnic background. In the sample, participants identified as Chinese (reference group), Japanese, Korean, Filipino, Vietnamese, South Asian, and/or as an 'other Asian' ethnicity. Because there were very few individuals in each of these 'other Asian' ethnicities, the creation of an 'other Asian' category was necessary. Respondents who identified with multiple Asian ethnicities were also combined into this category.

Sociodemographic variables

The sociodemographic variables in this study were age, sex, educational attainment (high school or less, some college or associate's degree, bachelor's degree, or graduate degree), federal poverty level or FPL, which is defined as the household income as percent of the federal poverty line (0–99% FPL, 100–199% FPL, 200–299% FPL, or 300%+ FPL), employment status (working full-time, working part-time, unemployed and looking, or unemployed and not looking), English use and proficiency (speak English only, speak English very well/well, or speak English not well/at all), and health insurance coverage (covered or not covered).

Health behavior and risk variables

Since certain health behaviors and risks can increase the likelihood of developing a chronic health condition, the following variables were taken into account: smoking status (never smoked, quit smoking, or currently smokes), if respondents engaged in binge drinking in the past 30 days (yes or no), and body mass index (BMI) (0–18.49, 18.5–24.99, 25.0–29.99, or 30.0 or higher).

Analysis

StataMP 18 was used to analyze data from the CHIS. Because of the survey's complex sample design,[38] proper weighting and variance calculation through specialized code, including Jackknife estimation, was used before conducting analyses. First, descriptive statistics were calculated and reported in Table 1. Then, since the outcome of interest was shown to be relatively common, I ran a series of Poisson regression models examining the relationship between citizenship status and chronic health conditions, which are reported in Table 2. The results are described as follows.

RESULTS

Table 1 shows the distributions of sociodemographic characteristics, citizenship statuses, and health outcomes among Asians in California. According to this table, 26.97% identified as U.S.-born citizens, 55.25% identified as naturalized U.S. citizens, and 17.77% identified as non-citizens. Regarding ethnicity, 38.54% identified as Chinese, 7.10% identified as Japanese, 11.40% identified as Korean, 13.27% identified as Filipino, 8.01% identified as South Asian, 12.23% identified as Vietnamese, and 9.45% identified as another Asian ethnicity (or multi-ethnic). When looking at poverty levels, 69.06% had an annual household income that was 300%+ of the FPL. With respect to language, 29.81% spoke English only, 55.88% spoke English very well or well, and only 14.32% spoke English not well or not at all. 96.06% had health insurance coverage. Regarding health behaviors, 81.66% never smoked, 14.25% used to smoke but quit, and 4.09% reported being current smokers. While 8.93% had engaged in binge drinking in the past 30 days, 91.07% had not. When analyzing chronic health conditions, 53.56% did not have any chronic health issues, while 46.44% had at least one. Findings from the Poisson regression models are reported in Table 2.

Table 2 shows exponentiated coefficients from the Poisson regression models predicting the presence of a chronic health condition among Asian respondents. The results are presented as prevalence ratios, which show how large the prevalence of an outcome is in one group, relative to another, holding all other variables constant. Values greater than one indicate greater prevalence of having at least one chronic health condition, while values less than one indicate lower prevalence.

According to Model 1, after adjusting for all sociodemographic and health behavior variables, the prevalence of having at least one chronic health condition was significantly higher among Asian U.S. citizens than among non-citizens (prevalence ratio (PR) = 1.372, $P < 0.001$). In Model 2, citizenship was stratified by nativity status to see if there were any differences between U.S.-born citizens and naturalized U.S. citizens. Results showed that the prevalence of having a chronic health issue among U.S.-born citizens was significantly higher than among naturalized U.S. citizens (PR = 1.187, $P < 0.01$).

It is worth noting that the findings also revealed significant differences for certain Asian ethnic groups. In Model 2, for example, the prevalence of having a chronic health condition was significantly higher among Filipino respondents (PR = 1.466, $P < 0.001$) and Vietnamese respondents (PR = 1.191, $P < 0.01$) than among Chinese respondents. For Japanese, Korean, South Asian, and other Asian respondents, however, there were no significant differences (in reference to Chinese participants).

DISCUSSION

The primary objectives of this study were to test whether citizenship status is related to chronic health conditions among Asians in the U.S. and examine whether there are differences by nativity status. After accounting for various sociodemographic factors and health behaviors, the prevalence of having a chronic health condition was significantly higher among Asian U.S. citizens than among their non-citizen counterparts. Furthermore, compared to Asians who became naturalized U.S. citizens, those who were born with U.S. citizenship had a significantly higher prevalence of having a chronic health issue. This finding lends some support to the concept of the 'alien citizen'.[28] One possible explanation is that despite having citizenship from birth, Asian Americans may have earlier exposure to discrimination, be aware of that unequal treatment, and internalize feelings of not belonging. Indeed, work by Lee and Sheng[39] highlights that most Asian Americans do not feel accepted in the U.S. These factors might contribute to poor health among U.S.-born Asians.

Additionally, although ethnicity was not the main focus of this study, I found significant differences among certain Asian subgroups. Specifically, the prevalence of having a chronic health issue was significantly higher among Filipino and Vietnamese participants than among Chinese participants. This heterogeneity in health outcomes is in line with previous research [29, 40, 41] and

Table 1. Weighted Sample Characteristics among Asians in California: 2021–2022 California Health Interview Survey (*n* = 7,089).

Variables	Frequency	Percent
Citizenship		
U.S.-born citizen	1,912	26.97
Naturalized citizen	3,917	55.25
Non-citizen	1,260	17.77
Ethnicity		
Chinese	2,732	38.54
Japanese	503	7.10
Korean	808	11.40
Filipino	941	13.27
South Asian	568	8.01
Vietnamese	867	12.23
Other Asian	670	9.45
Age		
18–34 years	1,393	19.65
35–49 years	1,841	25.97
50–64 years	2,119	29.89
65 years or older	1,736	24.49
Sex		
Male	3,520	49.65
Female	3,569	50.35
Educational attainment		
High school or less	719	10.14
Some college/associate's	1,204	16.98
Bachelor's degree	2,824	39.84
Graduate degree	2,342	33.04
Federal poverty level		
0–99% FPL	649	9.16
100–199% FPL	806	11.37
200–299% FPL	738	10.41
300%+ FPL	4,896	69.06
Employment status		
Working full-time	3,847	54.27
Working part-time	744	10.50
Unemployed + looking	350	4.94
Unemployed + not looking	2,148	30.30
English use and proficiency		
Speak English only	2,113	29.81
Speak English very well/well	3,961	55.88
Speak English not well/at all	1,015	14.32
Health insurance coverage		
Not covered	279	3.94
Covered	6,810	96.06
Smoking status		
Never smoked	5,789	81.66
Quit smoking	1,010	14.25
Currently smokes	290	4.09
Engaged in binge drinking		
No	6,456	91.07
Yes	633	8.93
Body mass index (BMI)		
0–18.49	291	4.10
18.5–24.99	4,154	58.60
25.0–29.99	2,017	28.45
30.0 or higher	627	8.84
Chronic health conditions		
0 chronic health conditions	3,797	53.56
≥1 chronic health condition	3,292	46.44

Table 2. Prevalence ratios from Poisson regression models predicting the presence of a chronic health condition.

Independent variables	Model 1	Model 2
Citizenship		
Citizen (Ref: Non-citizen)	1.372***	
	[1.193–1.578]	
Citizenship + nativity status		
U.S.-born citizen (Ref: Foreign-born U.S. citizen)		1.187**
		[1.059–1.331]
Foreign-born non-citizen		0.765***
		[0.668–0.877]
Ethnicity		
Japanese (Ref: Chinese)	1.171*	1.106
	[1.026–1.338]	[0.966–1.268]
Korean	1.063	1.074
	[0.913–1.238]	[0.924–1.250]
Filipino	1.442***	1.466***
	[1.290–1.613]	[1.311–1.638]
South Asian	1.055	1.075
	[0.907–1.226]	[0.924–1.251]
Vietnamese	1.175**	1.191**
	[1.052–1.312]	[1.069–1.328]
Other Asian	1.142	1.141
	[0.961–1.357]	[0.959–1.357]

Prevalence ratios and 95% CI in brackets.

*** $P < 0.001$, ** $P < 0.01$, * $P < 0.05$.

Note: Models adjusted for age, sex, education, federal poverty level, employment status, health insurance coverage, English use and proficiency, smoking status, binge drinking status, and BMI.

further emphasizes the importance of disaggregating data on Asian Americans.

The results of this investigation should be interpreted in light of several limitations. First, data used were cross-sectional, so I am not able to make any causal claims. Second, this study used three different categories of

citizenship status: U.S.-born citizens, naturalized U.S. citizens, and non-U.S. citizens. Within this last category, I was not able to distinguish refugees, asylum seekers, etc. from other Asians who did not have state authorization to be in the U.S. and may have unique experiences with the legal system. Knowing about pre-migration histories and post-migration encounters is important because they can reveal how certain groups' social struggles and experiences with trauma have contributed to health issues. Third, this paper investigated the association between citizenship status and having any chronic health condition. Examining conditions separately may be beneficial in future research to pinpoint specific health issues that citizens (vs. non-citizens) may have greater or lower prevalence of having. Fourth, regarding health behaviors and risks, only smoking, binge drinking, and BMI were included. Nutritional factors, such as the consumption of highly processed foods, could not be assessed and may need to be included in future work on chronic health problems. Fifth, although I tested interaction terms, ethnicity was not a significant moderator in the association between citizenship status and chronic health conditions. Future research may consider investigating this interaction more in depth with larger samples to better understand potential synergistic effects. Finally, this study was not able to account for geographical differences. It is possible that citizenship may be perceived and operate differently in other parts of the U.S., especially since there are various immigration contexts across states.[42]

CONCLUSIONS

Overall, this study highlights the health problems that Asian Americans may face, even if they are born with U.S. citizenship, raising implications for the social belonging of this highly stigmatized group. Previous research has found that citizenship is strongly linked to subjective measures of well-being, such as self-rated health. [31,32] This investigation provides evidence that citizenship is also associated with more objective measures of health and should be examined by nativity as well. Furthermore, the findings of this study underscore that having U.S. citizenship, higher earnings, and being able to access healthcare services (in ways that non-citizens may not be able to) does not exclude Asian U.S. citizens from experiencing chronic health issues, which often get obscured due to the model minority myth. By focusing more attention on Asian Americans and researching their experiences from a more nuanced perspective, scholars will have a better grasp of the various ways in which social exclusion impacts minority health.

ARTICLE INFORMATION

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