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Determinants of the variations in self-reported health status among recent and more established immigrants in Canada

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ABSTRACT

Studies have shown that immigrants are normally in better health on arrival compared to their Canadian-born counterparts. However, the health conditions of new immigrants deteriorate after a few years of their arrival in Canada. This phenomenon is popularly termed the "healthy immigrant effect" (HIE) in the immigrant health literature. Although different hypotheses have been proposed to understand HIE, the causes are subject to ongoing discussion. Unlike previous studies, this study explored the possible causes behind the variations in the health status of recent and more established immigrants comparing 2001 and 2010 Canadian Community Health Surveys (CCHS). Four different hypotheses – namely lifestyle change, barriers to health care services, poor social determinants of health, and work related stress – were tested to understand variations in health status. The study concludes that there is a statistically significant difference in the socioeconomic characteristics and health outcomes of immigrants having less than and more than 10 years of residency in Canada. Logistic regression models show that the health conditions of immigrants are associated with age, sex, ethnic origin, smoking habit, Body Mass Index (BMI), total household income, number of consultations made with a family doctor per year and work related stress.

1. Introduction

Every year, about 250,000 immigrants make Canada their new home (CIC, 2011). The share of immigrants in the Canadian population is growing rapidly making the health status of immigrants an increasingly serious public health issue. According to the 2006 Canadian census, about one-fifth of the population of Canada was born outside. New immigrants are relatively young, healthy and economically active because of self-selection, and the introduction of a point system that uses education, age, language, employment experience, arranged employment and adaptability as measures for skilled immigrant selection (Setia et al., 2011). Upon arrival, immigrants typically have better health status compared to their Canadian-born counterparts (McDonald and Kennedy, 2004; Newbold, 2009; Newbold and Filice, 2006), but most of the studies have shown that immigrants health status converges to the average health status of Canadian-born population after few years of arrival (Dean and Wilson, 2009; Newbold, 2009; Newbold and Danforth, 2003; Vissandjeet et al., 2004). This phenomenon has also been observed in the United States, Australia and several Western European countries, and is popularly termed the "healthy immigrant effect" (HIE) (Finnelly, 2005; Kennedy et al., 2006; McDonald and Kennedy, 2004; Setia et al., 2011).

Various hypotheses have been proposed to understand HIE in Canada: lifestyle change, barriers to the use of health services, poor social determinants of health, work-related stress, discrimination and unfair treatment, and health care restructuring to name some of them. A significant number of studies on the HIE have used secondary data, including data from the Canadian Community Health Survey (CCHS) (e.g., Kobayashi and Prus, 2012; McDonald and Kennedy, 2005; Newbold and Filice, 2006), the Longitudinal Survey of Immigrants in Canada (LSIC) (e.g., DeMaio and Kemp, 2010; Newbold, 2009), and the National Population Health Survey (NPHS) (e.g., Newbold, 2006, 2005; Setia et al., 2009; Wu and Schimmele, 2005), but all of these studies have used one particular year or longitudinal survey data based only on two years period and compared the health status of the population based on their time since arrival. Since the immigration system and health care policy of Canada have changed substantially in the last few decades (e.g., Immigration and Refugee Protection Act 2001, restructuring of the Canadian health care system in the 1990s),

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comparison of two different cohorts of immigrants, who arrived in Canada at different periods of time do not tend to take into account the effects of the changes which took place. Therefore, to overcome this problem, this research uses a cohort of immigrants who had less than 10 years of residency in Canada in the 2001 CCHS survey, and a cohort of immigrants who had greater than 10 years of residency in the 2010 CCHS survey (cohort lagged across periods). The cohort of immigrants who reported their residency as less than 10 years in the 2001 survey arrived in Canada sometime between 1991 and 2001 and those who reported their residency as more than 10 years in the 2010 survey also arrived in Canada before 2000. Therefore, both cohorts of immigrants selected for this study represent a group of immigrants most of whom entered Canada almost in the same period of time based on the same selection procedure. Using 2001 and 2010 CCHS data, this study aims to test empirically whether the deterioration of health, as measured by self-rated health status, is associated with lifestyle change, barriers to health services, poor social determinants of health, and work related stress hypotheses. It tries to measure the strength of the relationship between self-reported health status and these hypotheses using different variables to test each hypothesis.

Using the publicly available microdata file of CCHS, the main objective of this research is to answer the following research questions:

1. Are there statistically significant differences in the socioeconomic characteristics and health outcomes of recent immigrants and more established immigrants in Canada?
2. How can we interpret the deteriorating health status of immigrants in Canada?

Understanding HIE is important for two reasons. First of all, immigrants are an inseparable part of the Canadian health care system; understanding immigrants' health helps to understand the overall health status of Canadians and helps to develop population specific health care policy (Laroche, 2000). Secondly, the main objective of Canada's immigration program is to "foster the development of a strong, viable economy in all regions of the country by attracting skilled human resources" from different parts of the world (CIC, 2011). This objective cannot be fulfilled unless the new immigrants are healthy and productive.

2. Background

The HIE is a phenomenon observed in Canada, along with the United States, Australia and many immigrant receiving countries of Europe (Abraído-Lanza et al., 2005; Anikeeva et al., 2010; Choi, 2012; Kennedy et al., 2006). However, the data sources and hypotheses used to understand HIE are different in various contexts. In the Canadian context, studies have shown that the health conditions of immigrants upon arrival are better than their Canadian-born counterparts but their health condition deteriorates after a few years of residency in Canada (Beiser, 2005; Kobayashi and Prus, 2012; Newbold, 2009; Newbold, 2006). Much of the literature has concluded that the health of immigrants is determined by a combination of their sociocultural, political and economic position. "Lifestyle change" is the most frequently used hypothesis to explain HIE. Several studies on HIE have claimed that lifestyles of new immigrants changes through the process of acculturation, defined as the modification of the culture of a group or individual as a result of contact with a different culture, that makes significant changes in the social, cultural, political and economic status of new immigrants in the host society (e.g., Abraído-Lanza et al., 2005; Dean and Wilson, 2010; Newbold, 2009, 2006, 2005; O'Loughlin et al., 2010). Newbold (2009) argues that through the process of acculturation, immigrants adopt a "Canadian lifestyle" that includes unhealthy health behaviors such as increased use of tobacco and alcohol, poor food habits and reduced mobility. But in a study of new immigrants based in Mississauga, Ontario, none of the participants identified lifestyle change as a factor related to health status change but instead, most of the participants believed their improved or constant health status is due to improved living standards in Canada (Dean and Wilson, 2010). In the same study, some participants attributed the stress associated with immigration, and the aging process for their worsening health. Thus, there are controversies about the role of lifestyle change in immigrant health. However, studies have shown that sedentary lifestyles of Canada contribute to increased body mass index (BMI) and negatively influence the health status of new immigrants after a few years in Canada (Newbold, 2006; Setia et al., 2009). Therefore, measuring changes in the lifestyles of immigrants in terms of their smoking, drinking, dietary habits, and physical exercise should be evidence of the role of lifestyle change in determining the variation in health status.

Another body of literature hypothesizes that barriers to health care services is one of the main causes of deteriorating health conditions of new immigrants in Canada (e.g., Kobayashi and Prus, 2012; McDonald and Kennedy, 2005). Inability to communicate in either of the official languages, lack of culturally appropriate treatment, not having a family physician, lack of social networking and lack of belonging to local communities are considered some of the most prominent barriers faced by new immigrants accessing health care services. Because of these barriers they cannot fully utilize the available health care facilities. As a result, it is hypothesized that their health deteriorates within a few years following their arrival in Canada. Newbold (2009) argues that mistrust of the medical system, a culturally less sensitive medical system and culturally inapplicable care may create additional barriers to immigrants accessing health services in Canada. A study by Newbold (2005) using data from the longitudinal survey of NPHS (1994/95 and 2000/01) found that immigrants arriving in Canada between 1990 and 1994 experienced remarkable declines in self-reported health status compared to earlier arrival cohorts, mainly because of the barriers caused by health care restructuring of the early1990s.

Quite a few studies have investigated the impact of immigrants' socioeconomic characteristics on their health. Dunn and Dyck (2000) claim that social determinants of health have a very strong influence on the health of immigrants. Total household income, level of education, housing conditions, social safety networks, employment status, et cetera, are frequently used as indicators of social determinants of health. It has been often hypothesized that immigrants usually experience poor social determinants of health in their early years in Canada (Dunn and Dyck, 2000; Kennedy et al., 2006; Wu and Schimmele, 2005). According to this hypothesis, new immigrants usually are unemployed or underemployed for the first few years, which may lead to low income, poor quality housing and poor social safety networks. As a result, their quality of life is poor, and they usually have deteriorated health status (Kennedy et al., 2006; Newbold, 2009). However, there is no empirical analysis on how social determinants of health differ among recent immigrants who have been in Canada for shorter periods of time compared to those who are more established in Canada.

The role of employment as a determinant of health is well established in the literature (e.g., Dean and Wilson, 2009; Newbold, 2009) but there is insufficient literature on the health effect of work-related stress. Houle and Yssaad (2010) claim that a barrier to finding suitable employment is a key contributing factor