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Health of newly arrived immigrants in Canada and the United States: Differential selection on health

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ABSTRACT

Canada and the U.S. are two major immigrant-receiving countries characterized by different immigration policies and health care systems. The present study examines whether immigrant health selection, or the "healthy immigrant effect", differs by destination and what factors may account for differences in immigrant health selection. We use 12 years of U.S. National Health Interview Survey and Canadian Community Health Survey data to compare the risks of overweight/obesity and chronic health conditions among new immigrants in the two countries. Results suggest a more positive health selection of immigrants to Canada than the U.S. Specifically, newly arrived U.S. immigrants are more likely to be overweight or obese and have serious chronic health conditions than their Canadian counterparts. The difference in overweight/obesity was explained by differences in source regions and educational levels of immigrants across the two countries. But this is not the case for serious chronic conditions. These results suggest that immigration-related policies can potentially shape immigrant health selection.

1. Introduction

Immigrants are a rapidly growing segment of the U.S. and Canadian populations. By 2010, 12.9% of the U.S. and 20.6% of the Canadian population were foreign-born (Camarota, 2011; Statistics Canada, 2013). Characteristics of immigrants upon arrival, including health, are crucial in shaping their subsequent well-being and incorporation in the destination society. Previous research documents that immigrants in both countries are positively selected on health such that they have better health than native populations upon arrival (Abraido-Lanza et al., 2005; Antecol and Bedard, 2006; Lara et al., 2005; Palloni and Arias, 2004; Kennedy et al., 2014; Akresh and Frank, 2008; Nauman et al., 2015; McDonald and Kennedy, 2004; Rubalcava et al., 2008; Siddiqi et al., 2013). An important yet underexplored question is whether the "healthy immigrant effect" varies across destinations characterized by different immigration policies and health care systems. Cross-national comparative research allows us to investigate this question.

We examine whether there are systematic differences in immigrant health selection in Canada and the U.S., by comparing the health of new immigrants in their *first year of arrival*. The US-Canada comparison is inspired by the similarities and differences between the two countries. Canada and the U.S. both have federal state structures and capitalist economic systems. They have also received large numbers of immigrants based on family ties, skills, economic contribution, and other channels. However, the relative magnitude of these immigration categories varies substantially (2008; Government of Canada, 2012). Canada has instituted an explicit points-based immigration system since the 1960s that selects on human capital characteristics (Greenwood and John, 1991). The U.S., by contrast, has adopted an immigration system that primarily emphasizes family reunification. Primarily as a consequence of this difference, Canada draws a higher proportion of skilled immigrants than the U.S., even among immigrants from the same source country (Kaushal and Lu, 2014). Other destination factors such as immigrant health screening policies and health care systems may also shape immigrant health selection. Both countries adopt health screening as a formal part of the immigration process, albeit with some differences in what constitute health grounds for rejection. As for the health care system, Canada has mostly universal health insurance, whereas the U.S. healthcare system has been largely based on private insurance.

Such contextual differences provide an interesting contrast to

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examine the relative health selection of immigrants. For example, although health is not explicitly assigned a point value in Canada's point system, insofar as the system positively selects on human capital and human capital is positively associated with health, relative health selection is likely to favor immigrants to Canada. Or, to the extent that destination welfare systems factor into immigrant decision-making, individuals with health impairments may find Canada's universal health care system more appealing than the U.S. private-based system.

We use comparable national data over the period of 2001–2012: the National Health Interview Survey (NHIS) in the U.S. and the Canadian Community Health Survey (CCHS). We study post-2000 immigration, a period during which over 15 million legal immigrants entered the two countries. We focus on very recent immigrants, defined as those who arrived within 1 year of the survey, because their health would best capture health status upon arrival (selection) and is least conflated with health assimilation or return migration. In addition, we compare immigrants in the two countries rather than with the respective native population in each country. The latter, albeit an important comparison in its own right, tends to obscure immigrant health selection with the general health profile of the native population. This could be especially problematic since Canadians are healthier than Americans in general (Lasser et al., 2006; O'Neill and O'Neill, 2007).

2. Background and hypotheses

2.1. Immigrant health selection

Studies of immigrant health, including those on immigrants to Canada and the U.S., commonly document a better health profile of immigrants than that of the native-born populations in host societies, even when they come from countries with a high rate of mortality and morbidity (Cunningham et al., 2008). Immigrants' health advantage is manifested in a wide range of health outcomes including mortality, chronic conditions such as hypertension and heart disease, mental health, and health risk behaviors such as smoking (Abraido-Lanza et al., 2005; Antecol and Bedard, 2006; Lara et al., 2005; Palloni and Arias, 2004; Kennedy et al., 2014; Akresh and Frank, 2008; Nauman et al., 2015; McDonald and Kennedy, 2004; Rubalcava et al., 2008; Siddiqi et al., 2013).

The primary explanation advanced for the "healthy migrant effect" is that immigration is a selective process. Because the process of migration and adjustment to a new environment is often arduous and stressful, a minimal health level is required to make migration feasible and worthwhile (Lu, 2008; Rubalcava et al., 2008). This can operate at different stages of immigration. First in the decision-making phase, those with better health are more likely to contemplate international migration, as they perceive a greater chance of admission and a better prospect of settling in the destination. Second in the selection stage (for legal immigration), prospective immigrants with good health are more likely to gain admission while those with poor health may be deemed as inadmissible.

An understudied question is how immigrant health selection varies across destinations characterized by different immigration policies and health systems. To address this question, research needs to focus on newly arrived immigrants to avoid conflating health selection at arrival with health assimilation after arrival. Also, such research should compare immigrants at various destinations, rather than comparing immigrants with the respective native population in each destination (unless native-born populations across different countries share similar health profiles, which is often not the case). Furthermore, studying relative immigrant health selection at the two destinations helps circumvent the prevailing data limitations regarding the availability of information on health of non-migrants among the origin population. In a cross-destination comparison, direct comparisons of health of immigrants at different destinations can be carried out without data on the health of population in the origin country, insofar as we compare immigrant streams from the same source region or country.

2.2. Immigration policy, health screening, and health system in Canada and the U.S

We now discuss several notable institutional differences between the two countries and how each dimension may affect immigrant health selection.

2.2.1. Immigration policy

Canada has implemented an explicit point system to screen workers with special skills or high levels of education (Boyd, 1976; Greenwood and John, 1991). The system seeks to enhance skilled immigration using educational attainment, English/French language proficiency, and occupational experience as markers of skills (Hiebert, 2006). There has been an increasing emphasis on education and language proficiency over time. For example, since the early 2000s, prospective immigrants with a bachelor's degree received 20 points, double the points allocated to college and advanced degrees in the 1990s. Canada has other categories of immigration, including an employer nomination preference category via the Provincial Nominee program and the Canadian experience class (Pandey and Townsend, 2011; Baglay, 2012). This allows provinces to nominate immigrants, mostly workers with specific skills, to meet provincial needs. Despite prioritizing economic-based immigration, the Canadian immigration policy also seeks to preserve family unity by admitting family-based immigrants (Greenwood and McDowell, 1991; Challinor, 2011). While the majority of immigrants to Canada are admitted as economic class migrants, still about 25% are admitted based on family ties (under the family class). The relevant family policy uses narrower definitions of eligible family members than in the U.S., especially for extended family members. In Canada, citizens and permanent residents may sponsor spouses and common law partners; dependent children under the age of 19; and parents and grandparents, if they show no need for social assistance from the government (Kelley and Trebilcock, 2010). Only in rare instances can they sponsor other relatives. Different categories of family-based immigrants are subject to annual target levels set by the government.

The U.S. immigration system emphasizes family reunification, with unlimited admittance for immediate relatives of U.S. citizens, including spouses, unmarried children under 21, and parents (if the citizen is at least 21 years old). Further family-based preference is given to unmarried children of U.S. citizens and their children; spouses and children of legal permanent residents; married children of U.S. citizens and their spouses and children; and the siblings of U.S. citizens and their spouses and children, under fiscal year numerical limitations. The U.S. also allows employer-sponsored immigration, although the proportion of immigrants admitted under this mechanism has remained quite low. The U.S. Immigration Act of 1990 doubled the annual quota of employer-sponsored permanent resident immigration; it also created and expanded temporary immigration (H-1B and F1 visas) for specialized high-skilled workers (i.e., scientific research, information technology, and engineering) and students pursuing higher education (Vialet and Eig, 1990). However, despite the increase in skilled immigration, family reunification remains the central pillar of the U.S. immigration policy.

The proportion of immigrants admitted based on skills or employment is remarkably higher in Canada than in the U.S. In 2010, over 66% of all new legal permanent residents in the U.S. were admitted for family reunification, compared to only 14% issued for employment. In Canada, by contrast, economic-class immigrants accounted for 67% of all legal immigrants in 2010, while family-class immigrants made up 21% (Government of Canada, 2012).

One difference to note is that the U.S. has had a large-scale undocumented immigrant population, primarily from Mexico (Passel and Cohn, 2012; Hoefer et al., 2006). This stream of immigrants has expanded dramatically since the mid-1990s. Estimates suggest that a little over a fourth of all immigrants are undocumented (about 11.7