



An examination of health selection among U.S. immigrants using multi-national data



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ARTICLE INFO

Article history:

Received 13 August 2015

Received in revised form

1 February 2016

Accepted 19 April 2016

Available online 21 April 2016

Keywords:

Immigrant health

Health selection

Healthy immigrant effect

Multinational data

ABSTRACT

While migrants are widely believed to be positively selected on health, there has been very little empirical exploration of the actual health differential between migrants and non-migrants. This paper explored: 1) the extent of health selection by comparing US immigrants from 19 sending countries to their non-migrating counterparts still residing in the countries of origin; 2) country-level correlates of health selection; and 3) whether country-level health selection accounted for differences in self-rated health between immigrants and US-born Whites. We combined nationally-representative international data with data from US immigrants from the 2003–2007 Current Population Survey. The health selectivity measure was the Net Difference Index (NDI), which compares the distribution of self-rated health between migrants and non-migrants. We calculated Spearman correlation and bivariate regression coefficients between the NDI and economic, health, distance, and migration characteristics of the sending countries. We used generalized estimating equation models to examine the association between country-level health selection and immigrants' current self-rated health. We found immigrants from South America to show the most positive health selection. Health selection was significantly correlated with visa mode of entry, where family networks decrease, but work-related networks increase health selection. There was little evidence that country-level health selection explained differences in the self-rated health of US immigrants relative to US-born Whites. Our findings do not support the idea that country-level health selection underlies the “healthy immigrant effect”.

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1. Introduction

Immigrants have better outcomes than the US-born across a range of health indicators, including obesity, chronic conditions, mental health, self-rated health, and mortality (Antecol and Bedard, 2006; Argeseanu Cunningham et al., 2008; Singh and Miller, 2004; Singh and Siahpush, 2002). There are two main explanations for this immigrant health advantage. The first relies on cultural distinctions between immigrants and US-born. Immigrants may maintain cultural behaviors and social networks that provide certain health advantages, such as healthier diets or abstinence from alcohol and substance use (Lara et al., 2005). The second explanation, which is the focus of this paper, is health selection.

According to this view, there is a minimum level of health in which the benefits of migration outweigh the physical and economic costs. As a result, immigrants are positively selected on health because healthier individuals are more mobile and will benefit the most economically from migration. If immigrants are inherently healthier, they will display more positive health characteristics vis-à-vis the US-born (Jasso et al., 2004).

Despite being widely accepted, our knowledge of the extent of health selection and its role in post-migration health is extremely limited. We are first and foremost limited by inaccurate assessments of health selection; it has traditionally been assessed using US-based data that compares the health status of the foreign born to their US born ethnic counterparts or Whites. For example, Antecol and Bedard (2006) found Hispanic, Black, and White immigrants to have significantly lower likelihood of poor health, health conditions, and activity limitations than respective US-born Hispanics, Blacks, and Whites and attributed the difference to positive health selection. Studies that have used the Current

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Population Survey – the same dataset we utilize in this current analysis – have also found an immigrant advantage in self-rated health among Black and Hispanic immigrants compared to their respective Black and Hispanic US-born counterparts (Acevedo-Garcia et al., 2010; Hamilton and Hummer, 2011). Other studies that have found similar immigrant health advantages in body mass index, disability and self-rated health relative to US-born groups have also proposed health selection as a potential explanation for their findings (Albrecht et al., 2013; Frisbie et al., 2001; Read et al., 2005). A more appropriate comparison, however, requires information about non-migrants who stayed behind in the country of origin. Health selection is present if migrants to the US have better health status than their non-migrating counterparts.

There have been a limited number of studies, all using binational data, to compare US immigrants to non-migrants still residing in the countries of origin. Most of these studies have focused on Mexico and found mixed results for the idea that migrants display better health than non-migrants. Mexican migrants are more likely to be taller (a proxy for early life health) (Crimmins et al., 2005), have better health in childhood (Ullmann et al., 2011), and fewer physical limitations (Bostean, 2013) than Mexican non-migrants. Patterns for health selection in obesity, self-rated health, and mental health are not as strong (Bostean, 2013; Breslau et al., 2011; Guendelman et al., 2013; Ro and Fleischer, 2014; Rubalcava et al., 2008). Research outside of Mexico is limited; one study found Russian immigrants to the US to have lower levels of disability than Russians still residing in Russia (Mehta and Elo, 2012).

Further, health selection is largely discussed as a common feature among immigrants. But the extent of health selection likely varies by sending country characteristics, with some immigrant groups displaying a larger health differential compared to their non-migrating counterparts than others. Jasso et al. (2004) proposed that features of the sending countries that impact the net economic gain of migration should also be associated with health selection. We identify four types of country-level characteristics, economic, health, distance, and migration histories, that can be related to health selection in several ways. First, economic features of the sending country can determine the economic costs and gains for immigrants, which can in turn determine the minimum level of health that makes migration worthwhile. Specifically, immigrants from countries with lower skill prices should have less health selection (Jasso et al., 2004). Lower skill prices are themselves associated with lower country development (ie, GDP, urbanicity) and lower schooling levels (Rosenzweig, 2010). Second, the health status of the sending country should be negatively correlated with health selection (Jasso et al., 2004). Third, greater geographic and cultural distance (ie, language) between the sending country and the United States can produce more health selection, as the cost and physical hardiness required for migration are higher (Read et al., 2005). Finally, existing co-ethnic communities and mode of entry can affect the non-pecuniary costs of migration. A sizeable and vibrant co-ethnic community in the United States can lower the perceived costs of migration, ultimately reducing health selection (Chiswick et al., 2008). Additionally, certain modes of entry into the United States that are more selective on immigrant human capital characteristics, such as occupational skills, should be positively correlated with health selection, as these characteristics are highly correlated with health status (Chiswick et al., 2008).

Despite the multitude of potential links between country characteristics and health selection, there has been very little empirical investigation of such hypotheses. Some research has used US data to compare foreign-born populations from different countries or regions of origin to assess whether one immigrant group has a larger degree of health selection over another (Abraido-Lanza et al., 1999; Read et al., 2005; Son, 2013). For example, Read et al. (2005)

found that compared to white Americans, black immigrants from African nations have better self-rated health while black immigrants from the West Indies have equivalent self-rated health. They proposed that African immigrants had a higher degree of health selection because the costs of migration rise as distance increases and country-level income decreases.

The one study we located that explicitly considered aspects of the sending country associated with health selection is Akresh and Frank (2008), who found health selection to vary by region of origin, visa class of admission, and gender. Yet this study did not directly assess health differentials between migrants and non-migrants; it measured health selection by asking respondents to compare their health to their counterparts still residing in their respective countries of origin. The only comparable study explored country-level educational selectivity by comparing educational levels of US-immigrants to non-migrants and found it to be related to geographic distance and the educational level of the sending country (Feliciano, 2005).

Finally, if we understand health selection to be the differential between migrants and their non-migrating counterparts in the country of origin, this comparison offers us little insight into immigrants' health once they are in the United States. Because the majority of the existing research has only indirectly assessed health selection, the actual extent to which health selection explains the immigrant health advantage over US-born Whites remains unknown. Akresh and Frank (2008) found that immigrants who reported better health than their non-migrating counterparts still residing in their countries of origin had better current health status than immigrants who did not report a health advantage relative to non-migrants. This finding suggests that health selection confers benefits to immigrants' current health status in the US. Yet this study's sample only included foreign-born respondents and could not directly compare immigrants to the US-born. Ultimately, the study was unable to directly test the extent to which health selection explains immigrants' health advantage compared to Whites.

Our current study combined international data and US data on immigrants to explore these research gaps. We assessed the level of health selection for immigrants from 19 sending countries. The first aim of the paper was to determine the extent of health selection among migrants to the US by comparing their health status to non-migrants in their countries of origin. The second aim was to identify country-level correlates of health selection. The third aim of the paper was to compare the current self-rated health of immigrants from countries with high, medium, and low levels of health selection to US-born Whites. If health selection is indeed driving an immigrant health advantage, we would expect that immigrants from the countries with the highest levels of health selection would show the best health relative to US-born Whites. Conversely, immigrants from countries with the lowest levels of health selection should have the worst self-rated health relative to US-born Whites.

2. Methods

2.1. Data

Of the top 30 sending countries to the US, 19 had nationally representative data sources that were publicly available. Collectively, these countries comprise 80% percent of the US immigrant population. We used data that were collected between 2003 and 2005 to best correspond to the 2002–2004 World Health Survey (WHS), which was the data source for the majority of the countries. The WHS is an initiative of the World Health Organization to provide valid, reliable, and comparable sources of international data. The household-based survey provides nationally representative, individual-level data on respondents aged 18 and older from 70

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