



Changes in income inequality and the health of immigrants

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ABSTRACT

Research suggests that income inequality is inversely associated with health. This association has been documented in studies that utilize variation in income inequality across countries or across time from a single country. The primary criticism of these approaches is their inability to account for potential confounders that are associated with income inequality. This paper uses variation in individual experiences of income inequality among immigrants within the United States (U.S.) to evaluate whether individuals who moved from countries with greater income inequality than the U.S. have better health than those who migrated from countries with less income inequality than the U.S. Utilizing individual-level (March Current Population Survey) and country-level data (the United Nations Human Development Reports), we show that among immigrants who have resided in the U.S. between 6 and 20 years, self-reported health is more favorable for the immigrants in the former category (i.e., greater income inequality) than those in the latter (i.e., lower income inequality). Results also show that self-reported health is better among immigrants from more developed countries and those who have more years of education, are male, and are married.

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Introduction

A large literature suggests that upon arrival in the United States (U.S.) immigrants have a health advantage over members of the native-born population (Antecol & Bedard, 2006; Cho, Frisbie, Hummer, & Rogers, 2004; Hummer, Powers, Pullum, Gossman, & Frisbie, 2007; Hummer, Rogers, Nam, & LeClere, 1999). These benefits have been documented in almost every domain of health. On average, immigrants are less likely to smoke or drink, self-report lower levels of chronic illnesses, and have lower risk of mortality from almost all causes of death (Abraido-Lanza, Chao, & Florez, 2005; Abraido-Lanza, Chao, & Gates, 2005; Akresh, 2007; Angel, Buckley, & Sakamoto, 2001; Antecol & Bedard, 2006; Cho et al., 2004; Elo, Mehta, & Huang, 2011; Hummer, Biegler et al., 1999; Hummer et al., 2007; Hummer, Rogers et al., 1999; Jasso, Massey, Rosenzweig, & Smith, 2004; Mutchler, Prakash, & Burr, 2007; Singh & Hiatt, 2006; Singh & Siahpush, 2002). Similar health profiles have been found among immigrants to Canada and Australia (Biddle, Kennedy, & McDonald, 2007; Newbold, 2005; McDonald & Kennedy, 2004, 2005).

While research has documented these advantages for most racial and ethnic subgroups of immigrants (Antecol & Bedard, 2006; Hummer, Biegler et al., 1999; Hummer, Rogers et al., 1999; Jasso et al., 2004), few studies have evaluated the factors that produce variation in health among immigrants. One set of factors that might produce this variation is the conditions in their countries of origin, particularly the level of income inequality. Research suggests that the degree of income inequality faced by individuals in their place of residence is inversely related to health (Kondo et al., 2009; Subramanian & Kawachi, 2004). However, it is unclear whether individuals can improve their health by migrating from places characterized by greater income inequality to places characterized by less income inequality. For example, much of the work that documents this relationship uses variation in income inequality across countries or across time from a single country rather than changes in inequality experienced by particular individuals.

This paper has two goals. First, we evaluate whether country-level measures of conditions in immigrants' countries of origin impact their post-migration health in the U.S. Second, we improve on current research on the relationship between income inequality and health by evaluating whether immigrants who move from countries with greater income inequality than the U.S. report better health than those who migrate from countries with less income inequality than the U.S.

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Utilizing data on immigrants from the 1996, 1998, 2000, 2002, 2004, 2006, and 2008 waves of the March Current Population Survey (CPS) in conjunction with data from the 2009 United Nations Human Development Programme's Human Development Reports, we show that self-reports of health are more favorable among immigrants who are younger, are married, are male, and who have higher levels of education. Models that incorporate country-of-origin characteristics show that immigrants who migrate from countries with greater levels of income inequality report better health than immigrants who migrate from countries with less income inequality. Results also show that immigrants from more developed countries have lower odds of reporting fair/poor health than immigrants from less developed countries.

Background and hypotheses

Selective migration and health

Few papers evaluate the factors that produce variation in health among immigrants. One notable exception is Jasso et al. (2004). This seminal paper proposes a theoretical framework that explains the degree of both labor market and health selection among immigrants in the U.S. The primary predictor of variation in health among immigrants within this framework is differences in the price of skills across countries. Holding other factors constant, Jasso et al. argue that immigrants from countries in which the price of skills is relatively high (measured by GDP per capita) should be more selected on health than immigrants from countries in which the price of skills is relatively low. This proposition is based on the assumption that health is an important determinant of the amount of labor supplied by individuals and of the level of human capital or skills that individuals are able to acquire. Therefore, because immigrants often move to take advantage of differences in wages (skills prices) across countries, immigrants from countries that have higher skills prices should also report better health than those from countries with lower skills prices.

Income inequality and health

A growing body of literature has focused on income inequality and its potential effects on population health (Wilkinson & Pickett, 2010). The central claim made by proponents of this theory is that societies with a more unequal distribution of income pay a penalty in terms of lowered life expectancy, higher rates of stress and mental illness, more crime and imprisonment, and a lowered quality of life (Kawachi & Kennedy, 2006). In short, a society with greater income inequality tends to have more poor people than a more egalitarian society; poverty is causally linked to worse health outcomes (Kawachi, Adler, & Dow, 2010); as a result, societies with greater income inequality will tend to exhibit worse population health status, on average, compared to societies with a more egalitarian income distribution. The theory of income inequality and health makes an additional—and more contested—claim: that income inequality adversely affects the health of both the rich and poor members of society. In other words, greater inequality harms *everybody's* interests, not just the health security of the poor. Within the field of income inequality research, this is referred to as the *contextual effect* of income inequality on population health (Kawachi, 2000).

Kawachi (2000) puts forward two separate mechanisms to explain this contextual effect, both related to negative externalities and spillover effects of living in a society with an unequal distribution of income. First, from the perspective of those in the top half of the income distribution, living in an unequal society increases

their exposure to the “pathologies of poverty,” including more crime and violence, and certain infectious diseases (such as multi-drug-resistant tuberculosis). In theory, some members of the affluent classes could segregate themselves from undesirable contact with the worse-off members of society—for example, by retreating to gated communities. Nevertheless, the theory posits, the affluent may be unable to completely escape the pathologies of poverty. Conversely, from the perspective of those in the bottom half of the income distribution, living in the presence of very wealthy people exposes them to so-called pecuniary spillover effects. For example, when the wealthy move into communities they often drive up real estate prices, compete for scarce places in classrooms, and eventually spur a rise in property taxes, making the area unaffordable to those with more modest means. A different negative externality is caused by the conspicuous consumption habits of the super affluent, which produce invidious social comparisons and lead to positional competition that is both stressful and socially wasteful (Frank, 1999; Kawachi & Kennedy, 2006).

Empirical demonstrations of the contextual effect of income inequality have relied upon multilevel analysis (Kondo et al., 2009). In this approach, researchers examine differences in the health achievement of individuals living in different localities characterized by varying degrees of income inequality, adjusting for confounding variables including individual's own income. For example, within the U.S., researchers have examined variations in the health status of residents living in different states that are characterized by varying degrees of income distribution (Lynch et al., 2004; Subramanian & Kawachi, 2004). Kondo et al. (2009) conducted a meta-analysis of multilevel studies that examined the association between income inequality and health. They identified 27 eligible multilevel studies conducted in different countries (e.g., the United States, Europe, New Zealand, China), representing more than 60 million individuals. According to the meta-analysis, each 0.05 unit increase in the Gini coefficient was associated with a roughly 7% excess risk in all-cause mortality in the population. In other words, the pooled evidence on income inequality and health is consistent with the counterfactual scenario whereby individuals can expect to pay a health penalty consisting of a 7% increase in their mortality risk when moving from a low-inequality locale to a different locale with a 0.05 unit higher Gini coefficient (Kondo et al., 2009). Whether this pooled excess risk represents causality is open to debate, because residual confounding by unobserved characteristics (either at the individual level or the area level) remains a possibility.

Kondo et al. (2009) also noted that the majority of studies conducted to date have considered area variations in income inequality *within* country borders, e.g., variations in the Gini coefficient among the 50 U.S. states. This design may have constrained the potential range of variation in the Gini coefficient. That is, the U.S. (which is currently the most unequal country in the OECD) features a range of distribution in the Gini coefficient that exhibits little overlap with other countries. For example, a cross-national comparison of income inequality in the U.S. compared to Canada demonstrated that the most egalitarian U.S. state is still more unequal (i.e., has a higher Gini index) compared to the most unequal Canadian province (Ross et al., 2000). Indeed, Ross et al. (2000) show that there is not a significant association between mortality and the level of income inequality within Canada. However, this finding might be the result of the distribution of immigrants within the country (Razum, 2000).

Two types of research strategies could be used to overcome the problem of constrained variation. Either one could examine a large cross-national sample with sufficient variation in income inequality, or one could examine a long time series within a single

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