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Article

Immigrant health trajectories in historical context: Insights from European immigrant childhood mortality in 1910

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ABSTRACT

Recent studies of immigrant health have focused on an apparent paradox in which some new immigrants arrive healthier than expected but exhibit poorer health outcomes with duration of residence. Although a variety of explanations have been put forth for this epidemiological pattern, questions remain about the socio-historical generalizability of the empirical findings and accompanying theoretical explanations. By examining childhood mortality patterns of European immigrants to the United States in the early 20th century, this study tests hypotheses from current immigrant health literature in a previous era of immigration. In contrast with post-1965 immigrant groups, European arrivals did not have better outcomes than their U.S.-born white counterparts. Rather, their rates corresponded to a "middle tier" status in between U.S.-born black and white populations. Analysis of post-migration trajectories returned mixed results that similarly differ from contemporary patterns. Many new immigrant groups had higher rates of excess childhood mortality than their U.S-born counterparts, but outcomes appear to have improved with duration of residence or among the second generation. These findings suggest socio-historical variation in the context of reception may act as a "fundamental cause" of immigrant health and mortality outcomes.

1. Introduction

Recent research on the health of immigrant populations to the United States has focused extensively on two empirical patterns. First, many new immigrants exhibit better-than-expected health outcomes upon arrival (Antecol & Bedard, 2006; Dubowitz, Bates, & Acevedo-Garcia, 2010; Landale, Oropesa, & Gorman, 2000; Lariscy, Hummer, & Hayward, 2015; Ruiz, Steffen, & Smith, 2013). This finding has been dubbed a "paradox," in part because health advantages are often observed despite other determinants of poor health, such as low socioeconomic status and experiences of discrimination. Second, the health status of new immigrants often worsens—or health advantages fade—with greater duration of residence in the United States (Cho, Frisbie, Hummer, & Rogers, 2004; Hamilton & Hummer, 2011; Rumbaut, 1997). The second and third generations are often less healthy than the first, and even within the population of first-generation immigrants, health status may deteriorate after migration.

Despite extensive research on this topic, it is still unclear how these patterns vary for different immigrant groups or across social, economic, cultural, and political destination contexts. Although this research originated in studies of Hispanic migrants, researchers have also found evidence supporting the "immigrant health advantage" for Asian and Pacific Islander immigrants (Frisbie, Cho, & Hummer, 2001), West Indian and African blacks (Hamilton & Hummer, 2011; Read & Emerson, 2005; Read et al., 2005), and other immigrant populations (Singh & Hiatt, 2006; Singh et al.,). However, scholars have also found considerable heterogeneity within pan-ethnic Hispanic and Asian categories (Camacho-Rivera, Kawachi, Bennett, & Subramanian, 2015; John, de Castro, Martin, Duran, & Takeuchi, 2012; Subramanian, Jun, Kawachi, & Wright, 2009), as well differing trends for immigrant populations that have received less empirical attention, such as Arab and Middle Eastern immigrants (Abdulrahim & Baker, 2009; Reynolds, Chernenko, & Read, 2016). Such variation raises questions about the generalizability of the mechanisms involved in the immigrant health paradox in relation to group-specific and context-specific social conditions.

Although scholars have begun expanding the scope of comparison to include a wider range of immigrant groups and destination contexts, the focus has remained on the post-1965 wave of immigration to the United States. This paper offers a comparison case by examining the childhood mortality outcomes of European immigrants to the United States in the early 20th century. Prior to the National Origins Act of 1924, immigrants represented nearly 15 percent of the U.S. population, yet little is known about the health and mortality patterns of immigrants during this period. Testing hypotheses from contemporary immigrant health research in a previous era of immigration can be

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valuable for contextualizing empirical patterns and theoretical explanations in the literature. Specifically, finding evidence of the paradox in a drastically different historical context would support the generalizability of the selection and acculturation mechanisms that dominate the research. However, health patterns that differed from the expected pattern—of healthy arrivals followed by deterioration with duration of residence—would direct attention toward alternative explanations and highlight the importance of contextualizing research and theory about the causes of immigrant health trajectories.

The findings of this study suggest early immigrants followed a very different trajectory than contemporary migrants—new immigrants had higher childhood mortality rates than the U.S.-born white population and saw improvement with duration of residence. There was also considerable heterogeneity in outcome patterns within the European immigrant population tied to region of origin, likely shaped in part by selection effects and consequences of contemporaneous ethno-racial boundary hierarchies. The paper concludes with a discussion of how historical comparison can contribute to contemporary immigrant health research by shifting causal questions further "upstream." Many explanations for patterns of immigrant population health focus extensively on risk factors for disease, such as stress experiences, behavioral changes, and similar post-migration exposures. Historical comparison can explicitly highlight the variable upstream social conditions that shape immigrants' ability to avoid such risks or minimize the consequences of disease after migration. For early European immigrants, childhood mortality patterns corresponded both to contemporaneous ethno-racial boundaries and a process of linear assimilation that was unique to the era. I argue that such social and political characteristics in the context of reception can be conceptualized as a fundamental cause (Link & Phelan, 1995) that shapes access to resources for new immigrants across eras of differing risk factors and diseases. This insight can be applied to contemporary research on immigrant health as well.

2. Background

2.1. Explaining immigrant health trajectories

Existing explanations for the "immigrant health paradox" include both generalizable and contextualized theories. Studies have often explained the initial better-than-expected health outcomes of new migrants as a result of selection during the migration process, selective return migration, or cultural differences that shape health behaviors (Dubowitz et al., 2010; Palloni & Arias, 2004). At least a portion of the selection effect is thought to be inherent to the migration process—i.e., it is more difficult for the critically and chronically ill to migrate long distances, thus any immigrant sub-population will under-represent the less-healthy tail of a population distribution (Jasso, Massey, Rosenzweig, & Smith, 2004). In theory, these selective barriers to migration would also be present for European immigrants undertaking long journeys by ship in the early 1900s.

Other explanations are more context-specific and might not apply across eras. Proponents of the "cultural buffering" explanation note that many immigrant groups, particularly Hispanic migrants, share cultural norms that promote better diets, stronger social ties, and lower rates of smoking and alcohol abuse, relative to the U.S.-born population (Antecol & Bedard, 2006; Blue & Fenelon, 2011; Fenelon, 2013; Singh & Siahpush, 2002). This process inherently depends on characteristics of origin-group culture, as well as the links between behaviors and major risk factors for disease. Infectious diseases were a larger cause of overall mortality in the early 1900s, which would suggest a different set of risk factors tied less to long-term patterns of diet and exercise. Similarly, although contemporary mortality data are possibly skewed by return-migration of older migrants—known as the "salmon bias" (Palloni & Arias, 2004; Turra & Elo, 2008)—such reverse selection depends on contextual factors, such as feasibility of return migration. Although transnationalism and return migration played a role in migration patterns in the early 1900s (Wyman, 1996), return trips were less feasible and less common than they are today.

Of particular interest to scholars of health inequalities is how and why the initial better-than-expected health outcomes for new migrants tend to disappear with duration of residence. The prevalence of many health conditions increases across generations for minority immigrant groups to the United States, and often morbidity and mortality risk can increase for the first generation with 10 years or less (Cho et al., 2004; Hamilton & Hummer, 2011; Rumbaut, 1997; Teitler et al., 2015). This pattern of declining health advantages has not only been observed for adult mortality and major disease categories, but it is also found for infant mortality (Hummer, Powers, Pullum, Gossman, & Frisbie, 2007; Landale et al., 2000; Singh et al.,) and other indicators of maternal and infant health, such as preterm and low birthweight births (David & Collins, 1997; Osypuk, Bates, & Acevedo-Garcia, 2010; Teitler, Hutto, & Reichman, 2012).

One of the most common explanations for these patterns of worsening health is the "acculturation hypothesis," which attributes changes in immigrant health outcomes primarily to the adoption of unhealthy behaviors, such as smoking, a sedentary lifestyle, and unhealthy diets (Dubowitz et al., 2010, 2007). However, researchers increasingly note the importance of understanding how "upstream" social conditions shape such acculturation patterns and processes. For instance, health effects of duration of residence vary by race and experiences racism in both sending and receiving contexts (Brown, 2018; Read & Emerson, 2005). Changes in behavioral patterns also often occur in conjunction with material hardship and processes of cumulative disadvantage (Allen et al., 2014; Riosmena, Everett, Rogers, & Dennis, 2015), suggesting either segmented trajectories or multicausal mechanisms that extend beyond cultural change. Assimilation may even protect against poor health or mediate the relationship in neighborhoods of relatively low disadvantage (Akresh, Do, & Frank, 2016; Finch, Lim, Perez, & Do, 2007). Although the acculturation hypothesis is often tested as a generalizable linear process, a growing body of research finds that it is not acculturation alone, but the context of acculturation, that influences post-migration trajectories.

2.2. Fundamental causes of immigrant health

Immigrant health research to date has broadly been characterized by attention to proximate risk factors and determinants of population health, such as health behaviors, acculturative stress, stress from discrimination, and social ties. Yet scholars of immigrant health have increasingly called for greater attention to the contextual factors that shape post-migration trajectories, such as structural inequality, institutional racism, and experiences of discrimination (Acevedo-Garcia, Sanchez-Vaznaugh, Viruell-Fuentes, & Almeida, 2012; Finch, Frank, & Vega, 2004; Holmes, 2006; Yoo, Gee, & Takeuchi, 2009). Such work has the potential to push immigrant health research further "upstream" toward investigating the social conditions that shape migration, integration, and associated exposure to risk factors or access to resources that affect health.

Currently, one of the most influential theoretical perspectives in fields studying health and health inequalities looks at social conditions broadly as a fundamental cause of disease (Hankin & Wright, 2010). Link and Phelan (1995, 1996) argue that social conditions can be considered a fundamental cause because they shape access to resources—both material and symbolic—that can be used to avoid risks or to minimize the consequences of disease after it occurs, even as the more proximal risk factors, linking mechanisms, and diseases change. In this sense, social conditions act as a "cause of causes" or "risk of risks" that can persist across various risk factors and disease outcomes (Link & Phelan, 2010).

Research on immigrant health has remained remarkably disconnected from the fundamental cause literature. A "Web of Science"