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The healthy immigrant (migrant) effect: In search of a better native-born comparison group[☆]



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ARTICLE INFO

Article history:

Received 4 March 2014

Revised 30 July 2015

Accepted 24 August 2015

Available online 31 August 2015

Keywords:

Immigrant health

Selectivity

Reference group

Native migrants

USA

ABSTRACT

This paper evaluates whether immigrants' initial health advantage over their U.S.-born counterparts results primarily from characteristics correlated with their birth countries (e.g., immigrant culture) or from selective migration (e.g., unobserved characteristics such as motivation and ambition) by comparing recent immigrants' health to that of recent U.S.-born interstate migrants ("U.S.-born movers"). Using data from the 1999–2013 waves of the March Current Population Survey, I find that, relative to U.S.-born adults (collectively), recent immigrants have a 6.1 percentage point lower probability of reporting their health as fair or poor. Changing the reference group to U.S.-born movers, however, reduces the recent immigrant health advantage by 28%. Similar reductions in the immigrant health advantage occurs in models estimated separately by either race/ethnicity or education level. Models that examine health differences between recent immigrants and U.S.-born movers who both moved for a new job—a primary motivation behind moving for both immigrants and the U.S.-born—show that such immigrants have only a 1.9 percentage point lower probability of reporting their health as fair or poor. Together, the findings suggest that changing the reference group from U.S.-born adults collectively to U.S.-born movers reduces the identified immigrant health advantage, indicating that selective migration plays a significant role in explaining the initial health advantage of immigrants in the United States.

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1. Introduction

Census data show that the number of immigrants residing in the United States grew from roughly 19 million to 40 million between 1990 and 2010, a 110% increase in the immigrant population. Over this 20-year period, the share of foreign-born residents rose from 8% to 13% of the country's population. If these trends continue, immigrants and their descendants will play a significant role in determining the health and welfare of the entire U.S. population in the coming decades.

Scholars have found that immigrants arrive in the United States with an initial health advantage over their U.S.-born counterparts (Antecol and Bedard, 2006; Biddle et al., 2007; Cho et al., 2004; Cobas et al., 1996; Hummer et al., 1999; McDonald and Kennedy, 2005). With a few exceptions (Elo et al., 2011; Landale et al., 2000, 2006, Rubalcava et al., 2008),

[☆] Support for this research was provided by a grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (grant 5R24HD047879). The author would like to thank Robert Hummer, Tiffany Green, and Amos Peters for providing feedback on earlier versions of this manuscript.

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this finding is typically documented by comparing recent immigrants' health to that of representative samples of U.S.-born adults (Antecol and Bedard, 2006; Biddle et al., 2007; Cho et al., 2004; Cobas et al., 1996; Feliciano, 2005; Hummer et al., 1999; McDonald and Kennedy, 2005). Because immigrants are unrepresentative samples of their birth countries, however, this analytic strategy could conflate the relative importance of the two primary mechanisms argued to produce nativity health differences: characteristics unique to immigrants' birth countries (e.g., cultural and dietary practices) and selective migration (e.g., observed and unobserved characteristics correlated with the decision to move).

Using data on immigrants in the United States and nonimmigrants in immigrants' birth countries, researchers have shown that some immigrant subgroups are positively selected on good health (Elo et al., 2011; Kennedy et al., 2014; Landale et al., 2000, 2006). While such studies likely provide the best estimates of the degree of health selection among immigrants, health data are often unavailable for many origin countries, particularly for less developed countries in Africa and Central America. To address this data limitation, I argue that U.S.-born individuals who have made a migration decision—domestic interstate migrants (“U.S.-born movers”)—are a more appropriate comparison group to evaluate nativity differences in health than representative samples of the entire U.S.-born adult population.^{1,2} That is, if the underlying unobserved characteristics associated with selective migration are similar for both immigrants and the U.S.-born, then changing the reference group to U.S.-born movers should produce more accurate estimates of the immigrant health advantage. In turn, this methodological change would diminish the unexplained gap that researchers often attribute to characteristics unique to immigrants' origin countries (e.g., immigrant culture).

Consistent with prior studies (Antecol and Bedard, 2006; Cho et al., 2004), using data from the 1999–2013 March Current Population Surveys, I find that relative to U.S.-born adults collectively, immigrants who have been in the United States for less than one year (“immigrants”) have a 6.1 percentage point lower probability of reporting their health as fair or poor. I then rerun the analysis using recent U.S.-born movers as the reference group and document a 28% smaller nativity health gap than when using models with U.S.-born adults collectively as the referent. I find similar reductions in the immigrant health advantage associated with reference group choice in models estimated separately by either race/ethnicity or education level. Analyses using data on immigrants and U.S.-born adults who both recently moved for the same reason show that immigrants consistently report more favorable health than U.S.-born movers. The smallest immigrant health advantage exists among new job movers (–1.9 percentage points), and the largest immigrant health advantage is among individuals who moved in search of a job (–6.1 percentage points). Together, the findings suggest that selective migration plays a significant role in explaining the initial health advantage of immigrants in the United States.

2. Background

Compared to their U.S.-born counterparts, upon arrival in the United States, many immigrants have lower incomes, are less likely to have health insurance, and live in relatively disadvantaged neighborhoods (Borjas, 1987; Durden and Hummer, 2006; Portes and Rumbaut, 2007). Despite these characteristics, which are typically associated with poor health, a large literature has documented that recent immigrants assess their health more favorably than their U.S.-born adult counterparts. Indeed, researchers have documented this pattern of initial good health for all the racial/ethnic immigrant subgroups (Antecol and Bedard, 2006).

Immigrants' health advantage over natives, however, erodes with increased tenure of U.S. residence (Antecol and Bedard, 2006; Parker Frisbie et al., 2001; Read and Emerson, 2005). The extant literature has offered several noncompeting explanations for immigrants' initial health profiles and subsequent health trajectories, including characteristics unique to immigrants' countries of origin (e.g., cultural practices) and selective migration.

2.1. Cultural buffering

Research has argued that immigrants, particularly Mexican immigrants, have cultural practices that buffer their initial health against a range of social and economic disadvantages faced by many immigrants upon arrival in the United States (Cho et al., 2004; Hummer et al., 1999; Landale et al., 1999; Scribner and Dwyer, 1989). This argument has often been used to explain the favorable birth outcomes of children born to socially and economically disadvantaged Mexican women (Cobas et al., 1996; Collins and Shay, 1994; Scribner, 1996). For example, Scribner and Dwyer (1989) used data from the Hispanic Health and Nutrition Examination Survey to create an index of acculturation measuring the degree to which Mexican immigrants had a more Mexican-orientation (less acculturated) or American orientation (more acculturated) on variables such as language preference and ethnic identification. They found that more acculturated Mexican immigrants faced a higher risk of having a low birth weight baby than their less acculturated counterparts.

¹ Butcher (1994) first used this analytic approach to study nativity differences in labor market outcomes among blacks.

² The convention in this literature is to estimate health models using data on immigrants and natives of the same race or ethnicity. See Antecol and Bedard (2006) and Hamilton and Hummer (2011).

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