



The effect of immigrant generation and duration on self-rated health among US adults 2003–2007[☆]

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ABSTRACT

Global self-rated health (SRH) is increasingly a key indicator in the assessment of immigrant health. However, evidence of the impact on SRH of generational status, duration of residence in the US, and socioeconomic status (SES) among immigrants and their offspring is limited and inconsistent. We overcome limitations in existing research on this topic by using a uniquely large and diverse data source, the March Annual Social and Economic Supplement of the Current Population Survey (CPS; 2003–2007) ($n = 637,209$). As a result, we are able to disaggregate results by race/ethnicity, account for country of origin, and consider the role of multiple dimensions of SES. We find that overall first-generation immigrants in the US have lower odds of poor/fair SRH compared to the third-generation. This association is particularly strong for blacks and Hispanics but not significant for Asians. Among first-generation Asians and Hispanics, longer duration of residence is positively associated with poor/fair SRH. Finally, socioeconomic gradients in SRH tend to be less pronounced among the first-generation (versus the third) and, within the first-generation, among recent arrivals (versus those with longer durations). Our results highlight the importance of explicitly accounting for multiple immigration-related variables and their interactions with race/ethnicity and SES. Otherwise, studies may misestimate SRH differences by race/ethnicity and socioeconomic status. The continued growth of the US immigrant population and the second-generation underscore the need to examine patterns in immigrant health systematically.

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Introduction

Interest in immigrant health has heightened due to the demographic significance of the US immigrant population, and documented health differentials by immigrant status, suggesting an “immigrant health advantage” (Acevedo-Garcia & Bates, 2007). Research in other countries (e.g., Canada, Australia, and the UK) also finds support for a healthy immigrant effect, as well as for erosion of immigrant health with time since migration (Kennedy et al., 2006). Three reasons may account for this apparent advantage. First, immigrants may be healthier than their non-immigrant

counterparts in the country of origin (health selection). Second, immigrants may converge to the health profile of the host country's residents due to the adoption of health-related norms and behaviors (acculturation). Third, immigrants of racial/ethnic minority groups may experience discrimination and blocked social mobility and assimilate intergenerationally into disadvantaged segments of the US population (downward assimilation) (Acevedo-Garcia & Bates, 2007). The latter suggests immigrant status effects on health may vary by race/ethnicity. In addition, studies have documented that for some health outcomes, socioeconomic gradients appear to be less pronounced among immigrants than among non-immigrants (Acevedo-Garcia, Pan, Jun, Osypuk, & Emmons, 2005; Acevedo-Garcia, Soobader, & Berkman, 2005; Goldman, Kimbro, Turra, & Pebley, 2006), also suggesting important interactions between immigrant status and processes of social stratification.

In this analysis, we contribute to the empirical evidence on these patterns using a unique national survey representative of the immigrant population, the *Current Population Survey* (CPS; 2003–2007). In contrast with other work, we distinguish immigrants by generation (i.e. first, second and third/higher), instead of

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distinguishing only the foreign-born from the US-born. A large body of sociological research indicates that the second-generation (i.e. children of immigrants) differs from third and higher generations as a function of socialization processes and protective factors present in immigrant families and communities (Portes & Rumbaut, 2001; Rumbaut & Portes, 2001). We also disaggregate results by race/ethnicity and, among the foreign-born, by residential duration. These data also provide access to an uncommonly comprehensive set of socioeconomic status indicators (e.g., income, education, occupation, and homeownership) with which to test whether social gradients vary by immigrant generation and duration. The CPS therefore allows for a more thorough examination of patterns in immigrant health by immigration status, race/ethnicity, and socioeconomic position than is typically possible in one dataset.

Two complementary theoretical perspectives inform our analysis. The segmented assimilation model of the “new sociology of immigration,” expands on traditional assimilation theory and posits that immigrants’ adaptation trajectories will vary depending on the combination of human capital they possess (e.g., education) and the social context in the receiving country (including the prevailing regimes of social stratification) (Portes, 1996; Portes & Rumbaut, 2001). The model highlights heterogeneity among immigrant groups, and the importance of considering the role of social factors and their interactions over time in generating immigrant outcomes. Compatible with this approach, the concept of intersectionality highlights the ways in which interactions between individuals’ dynamic locations in multiple social hierarchies produce differential patterns of outcomes (Crenshaw, Gotanda, Peller, & Thomas, 1995). In recent years, researchers have begun to apply intersectionality to the study of health outcomes (Hankivsky & Christoffersen, 2008; Schulz & Mullings, 2006; Weber & Parra-Medina, 2003), including, although to a lesser degree, among immigrants (Guruge & Khanlou, 2004). We operationalize the intersectional paradigm using an “intercategorical” approach, which strategically employs existing analytic categories to explore the effects of interactions among them (McCall, 2005).

Global self-rated health (SRH) is increasingly used to assess immigrant health because it: a) captures overall health status and is predictive of mortality; b) applies to populations with young age distributions; and c) is easily and uniformly ascertained, facilitating comparisons across datasets. However, evidence of associations between immigrant-related variables and SRH is less consistent across studies and countries than that pertaining to other outcomes such as chronic conditions and disability (Biddle, Kennedy, & McDonald, 2007; Gee, Kobayashi, & Prus, 2004; Kennedy et al., 2006; McDonald & Kennedy, 2004; Newbold, 2005), which reinforces increasing concerns about the validity of the measure across population subgroups (Dowd & Zajacova, 2007). The less robust findings for SRH may be due to variation in modeling approaches, age- or gender-specific effects (Gee et al., 2004; McDonald & Kennedy, 2004), measurement issues, or patterns unique to the US (Kennedy et al., 2006). Nevertheless, we justify the focus on this indicator because of its comparability to other studies and because the CPS dataset offers a unique opportunity to contribute to the evidence base; a limitation of most previous studies of immigrant SRH is the focus on a single racial/ethnic group and/or a single geographic area (e.g., Finch, 2003; Franzini & Fernandez-Esquer, 2004; Frisbie, Cho, & Hummer, 2001).

In sum, we propose to (i) assess the effect of immigrant generation/duration on SRH by racial/ethnic group, (ii) determine whether demographic and socioeconomic factors (i.e. education, occupation, household income, homeownership, health insurance) account for the effect of immigrant generation/duration on SRH;

and (iii) assess if socioeconomic gradients in SRH vary by immigrant generation/duration.

Methods

Study data

We used data from the March ASEC Supplement of the CPS, a monthly survey of 99,000 households, which provides reliable data on the foreign-born population at the national/state level (90% level of confidence) (Schmidley & Robinson, 1998). Households are surveyed for eight months; at least one interview is in the home. The CPS is administered in English or Spanish; if needed, an interpreter is provided for other languages. To maximize statistical power, we combined data for five years (2003–2007; response rate: 82.6–85.0%) (U.S. Census Bureau, 2006).

We accounted for the CPS multistage sampling design by applying (i) the March Supplement person weights to obtain design-based regression coefficient estimates (U.S. Census Bureau, 2007); and (ii) standard error adjustment factors provided by the Census Bureau. We performed all analyses using Stata 9.0 (College Station, TX: Stata Corporation).

Data exclusions

We limited the sample to adults 18+, and excluded those in group quarters, those with imputed data, Native Americans (small sample size, $n = 8726$), and those reporting multiple races ($n = 13,259$). The final sample size was 637,209 (unweighted); 70.3% (non-Hispanic) white, 10.8% (non-Hispanic) black, 4.9% (non-Hispanic) Asian, and 14.0% Hispanic/Latino (of any race).

Self-rated health

The outcome variable was assessed using a standard question “In general, would you say your health is excellent, very good, good, fair, poor?” We collapsed the five categories to form a dichotomous measure: excellent/very good/good versus fair/poor (Idler & Benyamini, 1997; Subramanian, Acevedo-Garcia, & Osypuk, 2005).

Immigrant generation

Immigrant generation comprises three categories: third/higher-generation (US-born of US-born parents), second-generation (US-born of at least one foreign-born parent), and first-generation (foreign-born). Although they are US citizens, individuals born in Puerto Rico were grouped with the foreign-born because their process of adjustment to the US mainland is similar to that of international immigrants (Duany, 2002).

Duration

For the foreign-born population, we used year of arrival to classify duration of residence into four categories: 0–4, 5–9, 10–14 and 15+ years.

Country of origin

We included countries/regions of origin in sensitivity models, based on the top twelve countries of origin for the adult foreign-born population (2005 CPS), each of which had a weighted population of at least 600,000 (2000 unweighted cases). For whites, the countries include Germany, Canada, and “Other Europe”; for Hispanics, Mexico, Puerto Rico, Cuba, El Salvador, Dominican Republic, and “Other Latin American/Caribbean”; and for Asians,

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