

# Black Immigration and the Health of Adults: Does Country of Origin Matter?

Extended Abstract

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## Abstract

There is limited research on the health of black immigrants. Recent research suggests that black immigrants from majority black regions of the world have better health than black immigrants from majority white regions of the world. However, these studies suffer from relatively small samples of black immigrants and limited data on the country of origin for black immigrants. Using data on specific country of origin taken from the 2000 Census of Population, the American Community Survey, and the March Current Population Survey, this study analyzes the importance of the racial context of an immigrant's home country. The analysis in this study finds limited support for this argument. The results suggest that most of the differences in health among black immigrants are explained by health selection or country specific differences in health production.

**KEYWORDS:** Blacks; Racial Disparities; Health; Immigrants; ethnic groups.

## **Introduction**

Recent U.S. census data show that black immigrants are becoming an increasingly important part of U.S. immigration flows. Recent estimates from the 2005 American Community Survey suggest that black immigrants accounted for one-fifth of the growth in the black population between 2001 and 2006 (Kent, 2007). These data also show that black immigrants accounted for 8% of the total black population in 2005 representing an increase from just 1 % in 1980. The largest group of black immigrants, Jamaican immigrants, accounted for 19% of all black immigrants in 2005. Jamaicans also represented 4.5% of all legal immigrants to the United States in the early 1990s. In recent years, there has been considerable research on the health of Mexican immigrants, a group which represents approximately 30% of the legal immigration flow in the 2000s. However, there has been relatively little research on the health outcomes of black immigrants.

The absence of attention to black immigrants is unfortunate for three reasons. First, if current rates of migration from Africa and the Caribbean continue, black immigrants and their descendants will play an increasingly important role in determining the health of the entire black population in the United States. Second, black natives have worse infant mortality rates, life expectancy at birth, and self-rated health relative to whites in the United States (Hummer et al., 1998; David and Collins, 1997; Singh and Siahpush, 2002). Studies of black immigrants could shed light on the health differences between native blacks and native whites. Third, given the history of poor health among native blacks, black immigrants might not experience the same initial health advantage and assimilation processes as other immigrants (Cho et. al., 2004; Jasso et. al., 2004; Landale et. al., 2000; Antecol and Bedard, 2006; Biddle et. al., 2007; McDonald and Kennedy, 2005).

Read and Emerson (2005) add to the theoretical and empirical literature on the health of black immigrants by introducing the importance of the racial context of an immigrant's country of origin. Read and Emerson argue that black immigrants from majority black countries might have better health than black immigrants from mixed or majority white countries because these immigrants might have limited

exposure to racial discrimination. They also argue that black immigrants from majority black countries might have been privileged to a socialization process that could produce favorable mental and physical health outcomes. Read and Emerson (2005) empirically test the importance of the racial context of origin and find that black immigrants from majority black regions of the world have better health than black immigrants from racially mixed regions, or from regions where blacks are a racial minority. This empirical exercise is an important contribution to the literature on black immigrants.

This paper re-analyzes the importance of the racial context of an immigrant's country of origin by evaluating health differences among black immigrants by region of birth and country of birth. If the racial context of an immigrant's country of origin plays a role in explaining health differences among black immigrants, then health assimilation might also differ among black immigrants by region and country of origin. By pooling data from the 2000 Census of Population, the March Current Population Survey (CPS), and American Community Survey (ACS) to create pseudo panels, this paper estimates assimilation models that separately identify the impact of assimilation/acculturation and cohort quality changes over time to determine if the racial context of an immigrant's home country explains differences in assimilation patterns among black immigrants.

## **Data and Methods**

This paper makes use of cross-sectional data from the 1996, 1998, 2000, 2002, 2004, 2006, and 2008 waves of the March Current Population Survey, a 5% sample of the 2000 Census of Population, and the 2000 to 2007 waves of the American Community Survey. Each of these data sources are extracted from the Integrated Public Use Microdata Series (IPUMS) at the Minnesota Population Center. The March CPS is a monthly U.S. household survey conducted jointly by the U.S. Census Bureau and the Bureau of Labor Statistics. This survey was initially designed to measure unemployment. However, the March CPS also includes a supplement that asks more detailed questions about income and earnings. In 1996, the March CPS was augmented to include expanded measures of disability. One of these variables is self-assessed health. This variable is a subjective measure of health that asks respondents to rate their

current health on a five-point scale as excellent, very good, good, fair, or poor. This variable is utilized in this study.

The 5% sample of the 2000 Census is a random sample of the entire 2000 Census. The United States conducts a decennial census to track demographic, social, economic, and housing characteristics over time. The ACS is nationwide survey that tracks demographic, social, economic, and housing characteristics on a yearly basis. In 2000, both of these data sources started collecting expanded information on disability. These expanded variables include measures of work disability, mobility disability, personal care and physical activity limitations, and a wide range of variables that capture specific physical or mental impairments. This study utilizes measures of physical limitations and personal care limitation taken from these data sources.

Although the measures of disability taken from the 2000 Census and ACS are fairly broad measures of disability, they do provide a general picture of physical or personal care disability. These and similar measures of disability have been used in previous studies on the health of black immigrants (Elo and Mehta, 2008). Additionally, given the relatively small size of the black immigrant population, large samples of black immigrants are needed to study subgroup heterogeneity among black immigrants. Currently, no other dataset provides a larger sample of black immigrants than the U.S. Census and the American Community Survey. Consequently, these data provide valuable insight into the health of black immigrants from different sending countries.

Using data from the March CPS, two sets of models will be estimated. First, using the ordinal measure of self-assessed health, ordered logit regressions of health are estimated. Second, logistic models of poor health are estimated. Using the 2000 Census and the 2000 to 2007 waves of the American Community Survey, logistic regression models of physical and personal care limitations are estimated.

Previous studies have evaluated the health assimilation of immigrants by simply incorporating dummy variables into logistic regression models that account for the number of years an individual has been in the United States. The results from these studies show that the health of immigrants erodes with

increased tenure in the United States. However, these results are misleading because they confound the effect of changes in cohort health over time and the effect of greater tenure in the United States.

By pooling waves of data from the CPS, the 2000 Census, and the ACS to create pseudo panels, this study estimates assimilation models of self-assessed health, poor health, physical limitations, and personal care limitations that separately identify the impact of assimilation/acculturation and cohort quality changes (Borjas, 1987; Antecol and Bedard, 2006).

## **Conclusion**

The results show that almost all cohorts of black immigrants arrive in the U.S. with better health than native blacks. However, the results also show significant variation in initial health among black immigrants by region and country of origin. Additionally, there is significant variation in health assimilation patterns among black immigrants. The estimates in this paper do not find consistent evidence that the racial context of an immigrant's country of origin explains differences in health or assimilation patterns among black immigrants.

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