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Understanding the Health Transitions of Immigrants to Canada: Research Priorities

Fernando G. De Maio, PhD

Abstract: Understanding changes in the health of immigrants has been an important area of research in Canadian public health. Recent years have seen important developments, with studies moving away from what might be called ‘sick immigrant’ *versus* ‘healthy immigrant’ debates towards analyzing transitions and how they are influenced by a diverse set of social determinants. The release of data from all three waves of the Longitudinal Survey of Immigrants to Canada has also spurred new theoretical understandings of why immigrants’ initial health advantage is lost over time, with the experience of discrimination becoming an increasingly important predictor. Three research priorities are emerging as particularly important in this area. These are the need for multilevel analyses that incorporate contextual effects, the need for comparative international studies, and the need to refine the conceptualization of race/ethnicity to take advantage of developments in social theory.

Key words: Emigrants and immigrants, Canada, socioeconomic factors, discrimination.

Recent years have seen notable growth in research activity regarding the health of immigrants to Canada.¹ Although the importance of the topic has been appreciated by public health researchers for decades,² developments in the availability of high-quality datasets such as the Longitudinal Survey of Immigrants to Canada (LSIC) as well as an increased acceptance of the social determinants of health model have combined to bring a renewed focus to this area of research. Going beyond descriptions of the so-called *healthy immigrant* effect, wherein the health of immigrants is better than that of the native-born population, recent studies in this area have generated extensive evidence that the health of immigrants deteriorates with increased time in Canada. This pattern is found, with a few exceptions, in studies of self-assessed health status, the presence of a diagnosis for chronic conditions such as diabetes and heart disease, as well as work on mental health and birth outcomes.¹

Results from the most recent studies suggest at least three pressing research priorities. These include the need (a) to expand the explanatory sphere from compositional to contextual factors (and the interaction between them); (b) to develop comparative international studies; and (c) to refine the theoretical underpinning race/ethnicity. Addressing these research priorities would promote a more sociologically meaningful analysis of health inequities in Canada, a country often lauded for its universal health

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care system.^{3,4} Understanding the health transitions of immigrants is a way of examining how the social determinants of health and the formal health care system overlap to produce and sustain population health. This area of research is perhaps uniquely positioned to integrate the unfortunately disparate fields of discrimination,⁵⁻⁸ immigration,^{1,2} social capital,⁹⁻¹¹ and race/ethnicity^{12,13} within the wider programme of the social determinants of health inequities.

From Compositional to Contextual Factors

The majority of studies in this area have been based on individuals as the sole unit of analysis. A consequence of this is that the explanatory sphere has been limited to compositional factors, i.e., characteristics of immigrants and Canadian-born respondents. This is an important limitation; one that could be overcome with the use of more advanced techniques based on multilevel modeling.¹⁴ Such work could incorporate contextual factors as possible explanations for health transitions. For example, are health transitions of immigrants influenced by the level of income inequality in their community? Or are they influenced by the visibility/acceptance of their culture and religion in their area?

Only a few studies in this area have used multilevel techniques,¹⁵⁻¹⁸ and of these not all used multilevel analysis to explicitly model contextual effects. Stafford et al.¹⁷ did so, and their multilevel analyses indicate an intriguing pattern: as the percentage of immigrants in a region increased, the likelihood of depression for immigrants/visible minorities decreased. There is therefore something about *place* that matters to the health of both immigrants and the native-born population. However, much more remains to be done in this area, and area effects are notoriously difficult to ascertain, particularly if the number of areas is relatively small, as is the case with Canadian cities. Nevertheless, future studies should incorporate multilevel analysis whenever possible; not only is it often good treatment of the data,¹⁹ it also opens up possibilities to integrate the immigrant health transition literature with work on the social determinants of health, including the substantial literatures on social capital¹¹ and income inequality.^{20,21} The result could be a complex, nuanced, and useful account of the social determinants of health as experienced by different groups in different places. Researchers working with the long-running Canadian Community Health Survey are perhaps best positioned to work with multilevel models, as the dataset contains identifiers of province and health region and the various years of the survey can be pooled to generate very large sample sizes.

Comparative Studies

Very little work has been done systematically to compare the health transition of immigrants in Canada with that in other countries. This is particularly surprising given that countries such as Australia and the United States have publicly-available data that could be used in combination with key Canadian datasets such as the National Population Health Survey and the Canadian Community Health Survey. Comparative studies could, for example, examine how health transitions of immigrants are influenced by

a country's policy environment, perhaps using a typology of welfare capitalism such as Gosta Esping-Andersen's.²² This may be a way of untangling the complex political economy of health in relation to the health transitions of immigrants. Are transitions improved in social democratic countries? Are they particularly downwardly steep in liberal welfare regimes with higher degrees of commodification? This line of questioning could be particularly important in Canadian/U.S./European studies and would go a long way towards achieving what Paul Farmer²³ calls a *geographically broad* and *historically deep* analysis of health inequities. Such work would blur the boundaries between public health and public policy research and, as a result, generate new insights into the factors driving health inequities among immigrants.

Refining Key Terms

Studies in this area have tended to operationalise ethnicity as birthplace (country or region) or through Statistics Canada's *visible minority* terminology.^{24,25} However, studies are also now beginning to unpack the role of ethnicity as it relates to the health of immigrants,²⁶ and debates continue on conceptual and methodological grounds.^{27,28} Veenstra's¹³ analysis of the CCHS is perhaps the most informative work on this issue; building from critiques of race,²⁹ his analysis calls for the use of a more theoretically-nuanced term *racialized identity*. This term recognizes the social construction that underlies any categorization system for race/ethnicity, and allows us to see such systems as historically and contextually specific identities shaped by relations of power and inequality. For Mullins and Schulz, for example, race should be conceptualized "as relations between groups rather than as something that people of color 'have' and Whites do not. Similarly, gender is considered to be a set of social relations rather than an attribute of individuals."³⁰[p.6] This kind of refinement would generate a shift—from seeing ethnicity as a characteristic of a person to seeing it as an expression of power—a social relation, one that may be underpinned by discrimination.³¹ Distinguishing these effects using regression techniques is a challenge that many of the newest studies in this area are taking seriously.¹ These studies also emphasize the need to move away from a dichotomous understanding of ethnicity (visible minority: yes/no) towards a more nuanced approach that enables researchers to identify differences within the immigrant population. Indeed, studies in this area that have attempted to incorporate a measure of ethnicity suggest that heterogeneity, rather than homogeneity, is likely the pattern at play. However, for this dimension to be fully understood, more research is needed on the interaction between measures of ethnicity and discrimination, and these measures—along with an immigrant's length of residency in Canada—should be incorporated into future analyses.

Conclusion

Research on the health transitions of immigrants to Canada has the potential to develop in theoretically and methodologically nuanced ways, and thereby contribute to wider debates on the social determinants of health and health inequities.³ The growing number of studies published in this area is a testament to the importance attributed

to the topic by public health researchers. As this field of research moves forward, we should see more and more analyses that take advantage of developments in multilevel analysis and thereby expand the explanatory sphere from compositional to contextual factors. Recently published studies also demonstrate the need for engaging with the literature on identities, and call for a move from static classifications of race/ethnicity to relational classifications of racialized identities, which sees categorizations such as visible minority and non-White as expressions of power. Integrating concepts such as these into the statistical modeling that forms the heart of this research programme is a formidable challenge, but one if successfully accomplished that would yield new insight on the health transitions of immigrants to Canada.

Notes

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