

# COMMENTARY

Guillermina Jasso, Douglas S. Massey, Mark R. Rosenzweig, and James P. Smith use unique, newly collected data to look at the health of immigrants and how it changes from the time they decide to immigrate until they are established in the United States. The authors surveyed a sample of new legal immigrants in 2003 and collected detailed data on the legal type of immigration. The new data also contain several health indicators, including self-reported health status (SRHS) at various stages of the immigration process. Finally, the authors' data provide information on health changes during that process.

A number of very interesting conclusions emerge from the analysis. I will comment on several aspects of the paper, starting with issues related to the health measures employed, then moving on to the interpretation of the results, and ending with some questions about the broader implications of this research.

Although the new data improve greatly upon previous data, it is worth noting that the three health measures used in the paper—SRHS, body-mass index (BMI), and depression—have some limitations. For health status, questions are asked both about levels at various points in time and changes between time periods. All of these outcomes are self-reported at a single point in time, shortly after the person has obtained legal entry into the United States.

Self-reported health status can be problematic because it is a subjective measure. Even though it correlates well with more

“objective” measures of health, it is probably subject to many cultural biases, which are likely to be important in this study, given that immigrants come from various countries. SRHS may be a better predictor of underlying health in some countries and for some subgroups. For example, in the United States SRHS is a better predictor of mortality for men than it is for women (Case and Paxson 2005).

Another issue is that these health questions are asked in the context of immigration. Several questions specifically ask the interviewee to rate their health at a given time in the immigration process. The depression question is asked with respect to the visa process itself. Immigrants may therefore be afraid of reporting themselves in poor health. Even if immigrants are not consciously or directly afraid of answering the health questions, their answers may be biased because of the context in which they are asked. For instance, question “D3” asks individuals whether their health has changed since coming to live in the United States. Among those who have recently been admitted to the country, this question is likely to focus attention on a “happy” event (successful immigration); thus, they may be more likely to report improvements in their health. Similar biases have been reported elsewhere, for example, when measuring well-being more generally (Kahneman, Diener, and Schwarz 2003, ch. 4). Finally, it is worth noting that even though the authors collected data on health at various points in time, this information is retrospective and thus subject to the usual recollection biases.

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Although the empirical estimation is clear, I question the authors' interpretation of the results. The first question of interest is the so-called health selection issue, namely, the question of whether immigrants are more or less healthy than the average person in their country of origin. It is not clear to me how one can infer the health of immigrants relative to that of their nonimmigrant counterparts without information on the health of those who did not immigrate.

For example, the authors conclude that men are more positively selected for health than are women. All the estimations compare the health of men and women who immigrated. What the results show is that immigrant men are healthier than immigrant women (according to self-reported health). But this finding does not imply that men are more positively selected on health than are women. For instance, it is well known that women are more likely to report themselves in worse health than men in the United States and elsewhere (see, for example, Case and Paxson [2005]). If in fact the health of men is better than that of women in the country of origin (suppose, for example, that men's distribution is shifted to the right), then immigrant women could be more positively selected than immigrant men and be in worse health than immigrant men. Similar arguments can be made when interpreting the results on the health selection of immigrants by type of visa.

There are additional difficulties in interpreting the findings, due to the fact that immigrants come from different countries and it is not possible to include country-fixed effects. To continue with the example above, we note that it is possible that men and women come from different countries and thus are drawn from different health distributions. Without further assumptions or additional data, it is unclear whether the findings in the paper can shed light on the health selection process.

At a broader level, it would be helpful to relate the specific questions investigated—that is, what is immigrant health? and how does it change over time?—to larger policy or academic questions of interest. For example, why is it important to know

whether immigrants are more or less healthy than their nonimmigrant countrymen? Would the answer to this question, for instance, inform immigration policy? If so, how? There could be many reasons why the selection issue is of interest, but these are not stated.

Similarly, it would be interesting to know why it is important to understand the trajectory of immigrant health. One reason mentioned in the paper is that failure to understand the trajectory of health during migration may lead to erroneous conclusions about the health selection process: because of transitory shocks to health during the immigration process, measures of immigrant health at a given point in time may be biased. However, given that the survey collects data on health prior to immigration and is therefore subject to this bias, more needs to be said about why the health trajectory itself is of interest. For example, do we want to provide special health services to particular immigrants during the immigration period? Do we want to inform them about how their health may suffer throughout the process?

An interesting question that this work starts to address is the assimilation question, namely, does the health of immigrants improve or decline upon reaching the United States? The authors report that for all immigrants, BMI increases with time spent in the United States. But the implications of this finding are not clear. It is not possible to determine whether BMI is increasing because of the various changes in an immigrant's life, including changes in jobs and earnings (which may have been similar in the country of origin), or because of the environment in which the immigrant lives. The environment (which includes, for example, pollution and eating habits) may affect immigrants and natives alike. In order to understand better the mechanisms at work, one has to compare immigrants with natives.

Jasso et al. use new data to begin answering an ambitious set of questions associated with immigrant health. Our understanding of many of these questions will certainly improve because of the extraordinarily detailed data presented by the authors.

## REFERENCES

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