Health Disparities: The Case of Arab/Middle Eastern Immigrants in The United States.

Extended Abstract:

Constituting only a small fraction of immigrants living in the U.S., Arab/ Middle Eastern

immigrants have been overshadowed in the academic literature on migration, health and religion by other

immigrant groups such as Latino and Asian immigrants. Published literature regarding health

status/profile among Arab-American populations is essentially lacking. Due to the dearth in Arab/Middle

Eastern immigrants in the nationally representative data, the majority of studies on health among this

group used small scale data such as community-based studies to examine this particular ethnic group

(Jaber et al. 2003; Hassoun 1999; Dallo and James 2000; Amer and Hovey 2007; Jamil et al. 2008;

Wrobel et al. 2009; Aroian et al. 2010; Arfken et al. 2011). There is a very small number of studies

examined health among Arab immigrants relying on nationally representative data (Dallo and Borrell

2006; Read 2005).

Immigrant health research consistently shows that some immigrant groups tend to have better

health statuses than their US-born counterparts (Chen et al. 1996; Hummer et al. 1999; Landale et al.

2000; Singh and Siahpush 2002). The health advantage among some immigrant groups is due not only to

a healthier lifestyle in the region of origin, but also to the selective migration of healthy immigrants

(Hummer et al. 1999; Landale et al. 2000). Length of stay in the U.S. is negatively associated with

immigrant health outcome and positively associated with prevalence of obesity and being overweight

(Singh and Siahpush 2002; Himmelgreen et al. 2003; Goel et al. 2004; Dallo and Borrell 2006; Akresh

2007).

Studies on the Arab population in the Arab region show that they experience poor health

outcomes. Although there is a great reduction in commutable diseases, non-commutable diseases such as

stroke, CVD, diabetes, obesity, and cancer have increased dramatically in the Arab region (Benamer and

Grosset 2009; Salim et al. 2009; Musaiger et al. 2011; Zaghloul et al. 2011). Similarly, most studies on

Arab Americans show that they tend to have high rates of diabetes, hypertension, and obesity (Jaber et

al.2003; Hassoun 1999; Dallo and James 2000; Khosla and Fungwe 2002). On the contrary, Read (2005), using data from the 2000 and 2001 NHIS, found no significant differences between Arab Americans and their counterpart non-Hispanic whites in terms of their self-rated health.

Theoretical framework:

This study evaluates the degree to which selection explains variation in self-rated health, and activity/functional limitation among Arab/Middle Eastern immigrants using data from the 2005 to 2010 NHIS. It will compare Arab immigrants with US-born, non-Hispanic Whites on two health measures. Following this conceptual frame work, the following set of research questions guiding this study are: 1) Is there a significant difference between the health outcomes of Arab immigrants and US-born, non Hispanic whites? 2) To what extent does health behavior influence the self-rated health, functional limitation, and the prevalence of chronic diseases among Arab immigrants in the U.S.? 3) To what extent does health selectivity account for the variation in Arab immigrants' health outcomes?/ Do Arab immigrants fit in the selection theory based on their health?

Data and Method:

In order to examine the Arab/Middle Eastern immigrants' health profile, I will merge data from the 2005-2010 National Health Interview Surveys (NHIS). The NHIS is a multipurpose health survey conducted annually since 1957 by the National Center for Health Statistics and Centers for Disease Control and Prevention, and administrated by the U.S. Census Bureau. The NHIS is a multi-stage, stratified, cluster sample that is designed to manage information on the non-institutionalized, civilian population in the U.S (National Center for Health Statistics 2012).

A unique feature in the NHIS is that starting from 2000; the NHIS included a question about the global region of birth. The respondents are to choose from 12 categories. This in turn helps to distinguish the Arab/Middle Eastern American population. Due to the small number of Arab/ Middle Eastern immigrants interviewed in any given year, I will combine six years of data from 2005-2010. The analyses will mainly

draw data from the sample adult files and then link them with corresponding person, household, and family files when necessary.

Preliminary Results:

Table 1 displays key comparisons between the two population of interest, the US-born, non Hispanic Whites and Arab immigrants. Consistence with Read et al. (2005), Arab immigrants tend to report their health as "fair or poor" compared with US-born Whites with 12.09 % and 9.71 %, respectively. On the other hand, they were less likely to report experiencing functional limitation with 26.93% and 36.82 %, respectively. The differences between the two groups are statistically significant at the p-value of <.001.

On average, Arab immigrants are more likely to report being overweight but less likely to experience obesity with 10.55%, 8.88% and 5.6% and 8.49%, respectively. Compared with their US-born, non Hispanic Whites, Arab immigrant are more likely to have an advanced degree and less likely to report having less than HS degree with 23.69 % and 9.54% and 3.72% and 8.8%, respectively. Moreover, Arab immigrants tend to report higher annual income, $45.000-$75.000 and over, compared with US-born Whites, with 41.18% and 37.67%, respectively. 65.29% of the Arab immigrants in the sample reported having a citizenship and 57.36% reported being in the US for 15 years or more. Finally, the two groups have similar sex composition with 51.68% US-born Whites females and 47.6% Arab immigrant females. The difference between the two groups is statistically significant at a p-value of <0.01.

Analysis:

My multivariate analyses will encompass two components. First will be a series of ordinal logistic regression models predicting current self-rated health among both groups. Second will be a set of binary logistic regressions predicting functional limitation.

Note: This paper is still a work in progress

*Table 1.*Characteristics of Arab/Middle Eastern Immigrants and US-born Whites Populations NHIS 2005-2010:

	US-born Whites	Arab/Middle Eastern Immigrants	
	N= 372504	N= 1374	
Self-Rated Health			
%Fair/poor	9.71	12.09	*
%Good	23.97	23.74	*
%Excellent/very good	66.32	64.17	*
% Activity/Function Limitation	36.82	26.93	***
Health Behaviors			
Smoking			
%Current smoker	21.76	19.85	*
%Former smoker	22.96	18.59	*
%Never smoked	55.29	61.56	*
Physical Activities			
%Active	84.11	82.7	
%Not Regularly active	5.5	5.18	
%Not Active	10.39	12.12	
BMI			
%Under weight (BMI<.18.5)	73.44	71.54	***
%Healthy weight(18.5<BMI<25)	9.19	12.3	***
%Over weight (25<=BMI<30)	8.88	10.55	***
%Obese (BMI>=30)	8.49	5.6	***
% Female	51.68	47.6	**
Marital Status			
%Married	49.39	67.23	***
%Widowed	5.76	4.87	***
%Divorced & Separated	10.16	7.42	***
%Never married & living with parents	34.69	20.48	***
Education			
% Less then HS, No diploma	8.8	3.72	***
% HS Graduate	48.86	44.16	***
% College Degree	32.8	28.43	***
% Advanced degree	9.54	23.69	***
Income			
% $ 1.000-$ 19.999	29.88	30	***
%$ 20.000-$ 44.999	37.45	28.82	***
%$ 45.000-$ 75.000 and over	32.67	41.18	***
% Health Insurance	87.31	80.87	***
Duration			
% in the US < 5 years	-	14.34	
% in the US 5-9 years	-	16.97	
% in the US 10-14 years	-	11.34	
% in the US >= 15 years	-	57.36	
% US Citizen	-	65.29	

*+p= < .10 *p=<.05 **p=<.01 ***p=<.001.*