Heath Status of U.S. Immigrants and the Process of Becoming a Legal Permanent Resident Alien

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Using the first round of the 2003 cohort of the New Immigrant Survey, a nationally representative sample of new legal immigrants to the United States, we investigate the relationship between the process of becoming a legal permanent resident alien (the process of obtaining a green card) and the self-reported health status of U.S immigrants. Results from ordered-logitistic regressions indicate that immigrants who felt sad, blue or depressed because of the process of becoming a legal permanent resident in the U.S. were more likely to report a lower health status.

INTRODUCTION

This paper examines the relationship between the process of becoming a legal permanent resident alien otherwise known as the immigration process and the self-reported health status of U.S. immigrants. Host countries value the health set of immigrants in their countries. It is assumed that having a health limitation affects immigrants' earnings (Kossoudji, 1989) and the health care costs of the host country (Smith, 2001). The importance of immigrants' health is reflected in U.S. immigration law as it requires that each prospective immigrant must pass a medical examination before being granted admission to legal permanent residence (or obtaining a green card). While the medical examination, which is one component of the immigration process, plays a positive role in determining the heath set of immigrants seeking permanent residence in the United States, other components of the immigration process such as the availability of immigrant visas and the visa application process have the potential to adversely affect the health of prospective immigrants. In the literature, the set of stresses related to the process of obtaining legal permanent residence is commonly referred to as "visa stress" (Jasso, Massey, Rosenzweig, & Smith, 2005; Saraswati, 2010).

For some prospective immigrants, visa stress may start with either the waiting times for the availability of the immigrant visas once they are approved or the waiting times associated with processing the visa applications. For example, in July 2018 some visa categories had no delay while others had a waiting period of over 20 years (United States Department of State Bureau of Consular Affairs, 2018). According to Jasso et al. (2005), an immigrant visa may be a time of accumulating visa stress. While some prospective immigrants experience no or little waiting time for an immigrant visa to become available, all prospective immigrants experience the waiting period associated with visa application

processing. The waiting period associated with the processing of visa applications may be compounded with the uncertainties related to the approval of the applications. One possible outcome of the visa application process is the denial of the immigrant visa application which is associated with a high probability of deportation for nonimmigrants residing in the host country. Hence, the waiting times and uncertainties confronted by prospective immigrants surrounding visa availability and visa application processing have the potential to adversely affect their mental and physical well-being (Hall & Cuellar, 2016; Lecompte, 2017) which may be reflected in their self-reported health status. This visa stress may not end until the immigrant is granted an unconditional legal permanent residence status (or unconditional green card).

Using the first round of the 2003 cohort of the New Immigrant Survey (NIS-2003-1), we examine the empirical relationship between the process of becoming a legal permanent resident and the health of U.S. immigrants. In contrast to previous studies that have examined the determinants of immigrants' feelings about the immigration process, this study assesses the relationship between immigrants' feelings about the immigration process and their self-reported health status. The motivation for this study is to inform prospective immigrants as well as immigration policy makers that immigrants' health may suffer during the immigration process of obtaining legal permanent residence in the United States. The NIS-2003-1 is a nationally representative multi-cohort longitudinal study of newly admitted legal immigrants and their children to the United States. The sample is based on nationally representative samples of the administrative records, compiled by the U.S. Immigration and Naturalization Service (INS). The advantages of the NIS-2003-1 with regard to this study are twofold. First, it contains a variable that describes the respondents' subjective feelings about their immigration process and a variable representing self-reported health status. Second, the respondents in the sample consist of immigrants arriving in the U.S. with immigrant documents acquired abroad, otherwise referred to as new-arrival immigrants, as well as immigrants who are already in the U.S. with a temporary nonimmigrant visa (or in some cases are in the U.S. illegally) and adjust to lawful permanent residence, otherwise referred to as adjustees or adjustee immigrants (Jasso, Massey, Rosenzweig, & Smith, 2006). This paper exploits the distinction between immigrants to further contribute to the literature by estimating the differential impact of the immigration process on new-arrival immigrants and adjustee immigrants.

The results from ordered-logistic regressions provide evidence that immigrants' feelings about the process of becoming legal permanent residents in the U.S. do affect their self-reported health status. In the model predicting self-reported health status, the coefficient representing the feelings about the immigration process derived from the pooled sample of immigrants is negative and statistically significant. The results also indicate that the self-reported health status of adjustee immigrants are negatively affected by the immigration process while the self-reported health status of new-arrival immigrants are unaffected by the immigration process. The rest of the paper is structured as follows. Section II presents institutional details on immigration and its potential impact on health, Section III discusses the data, while Section IV describes the empirical procedures and results. Section V concludes the paper.

A BRIEF DESCRIPTION OF THE PROCESS OF BECOMING A U.S. LEGAL PERMANENT RESIDENT

The respondents in the NIS-2003-1 sample are U.S. legal permanent residents. According to U.S. Citizenship and Immigration Services [USCIS] (2016) legal permanent residents or green card holders are individuals who have been granted authorization to live and work in the United States on a permanent basis. The immigration process or the steps to become a legal permanent resident in the U.S. or obtain a green card varies according to each applicant's situation. However, the USCIS summarizes the general application process that is applicable to the majority of the applicants in five steps. The first step involves the filing of an immigrant petition with the USCIS for the foreign born individual who wants to become a legal permanent resident. The individual or firm who files the immigration petition for the prospective immigrant is known as the visa sponsor or petitioner. In some cases, the prospective immigrant may be

eligible to file an immigrant petition on his or her behalf. The prospective immigrant may be eligible for a green card under one of the following categories: green card through family, green card through employment, green card as a special immigrant, green card through refugee or asylee status, green card for human trafficking and crime victims, green card for victims of abuse, green card through other categories, or green card through registry.

After the USCIS approves the immigrant petition and there is a visa available in his or her category, the second step requires the prospective immigrant to file either a green card application with the USCIS or a visa application with the U.S. Department of State. If the prospective immigrant is outside of the United States, he or she will file a visa application with the U.S. Department of State and the process is known as consular processing. If the prospective immigrant is in the United States, he or she will file a green card application with the USCIS and the process is referred to as adjustment of status. In the third step, the prospective immigrant attends a biometrics appointment and receives a medical examination. In the biometrics appointment the prospective immigrant provides fingerprints, photos and a signature. The prospective immigrant must pass the medical examination in order to obtain a green card. Jasso et al. (2005) notes that the medical grounds for inadmissibility are grouped into four categories: communicable disease of public health significance (such as tuberculosis or syphilis), lack of required vaccinations (for example, for polio and hepatitis B), physical or mental disorders with harmful behavior, drug abuse or addiction.

Attending an interview and receiving a decision on the application are the fourth and fifth steps respectively. When a decision on the application is made, the prospective immigrant who is residing in the United States will receive a written decision notice from the USCIS. If the prospective immigrant who is residing outside the United States is granted an immigrant visa, the consular officer will give him or her a packet of information known as the "Visa Packet".

Although all prospective immigrants are required to assemble documents and properly fill out forms related to the immigration process, qualifying for legal permanent residency and the varying waiting times associated with obtaining legal permanent residency in some instances create stress (visa stress) that may negatively impact the health of immigrants. For prospective immigrants, in general, there are two periods of the immigration process where the waiting times can be characterized as stressful. The first period occurs after the USCIS approves the immigrant petition and a prospective immigrant has to wait until a visa becomes available in his or her category. This waiting period is only applicable to prospective immigrants whose visas are numerically limited. According to the USCIS (2015) the Immigration and Nationality Act (INA) sets the number of immigrant visas that may be issued to foreign nationals seeking to become lawful permanent residents each year. Numerically limited visas are not always immediately available. When the demand for numerically limited visas is higher than the supply for a given year in any given category or country, a visa waiting list or backlog forms. Prospective immigrants whose visas are numerically unlimited do not encounter this period of waiting stress as their visas are always available. The second period of the immigration process where the waiting times can be characterized as stressful is the application processing period. Similar to the first period, the waiting times vary in length, however, the waiting time in this period generally depends on the current resources the USCIS allocates to processing visa applications. Unlike the first period of the immigration process, all prospective immigrants endure the waiting time associated with application processing. As a consequence of the waiting time associated with obtaining legal permanent residency in the first and second periods of the immigration process, the prospective immigrant may encounter accumulating visa stress.

Visa stress may end before, on, or after the day of admission to legal permanent residence.[1] The day of admission to legal permanent residence marks the end of visa stress for most immigrants. Visa stress may continue after the day of admission to legal permanent residence for a portion of immigrants who were granted permanent resident status on a conditional basis. These immigrants are mainly spouses of U.S. citizens and spouses of legal permanent residences with marriage duration of less than two years and immigrant investors. According to the USCIS (2018) the conditional residents must petition to remove the conditions of the status before the second anniversary of the approval date of their conditional status.

Thus accumulating visa stress associated with obtaining legal permanent residence has the potential to grow more for conditional residents.

THE DATA

To investigate the relationship of visa stress and the self-reported health status of immigrants, we utilize data from the first round of the NIS-2003-1. This data source is a nationally representative sample of new legal immigrants to the United States. The sampling frame for the study is from the electronic administrative records compiled by the U.S Immigration and Naturalization Service (INS). The sample consists of adults and children. 8,573 adult immigrants completed the interviews with a response rate of 68.6% and 810 children immigrants completed the interview with a response rate of 64.8%. For the purpose of this study, we limit our analysis to the adult sample

The data on immigrants who became permanent residents consists of both newly arrived immigrants and adjustees immigrants (immigrants on temporary nonimmigrant visa already in the US). In the survey, immigrants who were admitted as the spouse of a U.S. citizen were undersampled while immigrants admitted as employment and diversity principals were oversampled (Jasso et al., 2005). Immigrants in this first full cohort were sampled from May to November of 2003, covering a seven month-period. This period comprises the final five months of the fiscal year of 2003 and the first two months of the fiscal year of 2004. The immigrants were interviewed in their preferred languages and information on demographics, health, migration history, and social variables were gathered. The interviews were conducted as soon as possible after the immigrant's admission to legal permanent residence. To capture the subjective experiences of the immigration process, immigrants were asked: "During the past 12 months, have you ever felt sad, blue or depressed because of the process of becoming a permanent resident alien?" Respondents who ever felt sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months were coded as 1, and those who did not feel sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months were coded as 0. This variable is the primary independent variable of interest. Also, for health assessment, respondents were asked: "Would you say your health is excellent, very good, good, fair, or poor?" This self-reported health evaluation captures the current health status of immigrants under study at the time of the interview and is the dependent variable for the ordered logit model. The self-reported health variable has a five-point scale in which 1 = poor, 2 = fair, 3 = good, 4 = very good and 5 = excellent.

Several control variables were included in the ordered logit model. The variable representing the class of immigration has four categories, namely family sponsored, employment based, diversity immigrants, and refugees and asylees. Four dummy variables were coded and the dummy variable representing diversity immigrants was the reference category. The variables male, speaks English very well, married, being an adjustee immigrant, reported health problems, doing light physical exercise and suffering harm outside of the U.S. were dummy coded where the characteristic represented by the variable name coded as 1 and 0 otherwise. To create the variable reported health problems, we adapted the methodology in Pandey and Kagotho (2010), where immigrants having any one of the following health problems: high blood pressure, diabetes, cancer, chronic lung disease, heart problem, stroke, emotional problems, arthritis, asthma and pain were coded 1 and immigrants without any of these health problems were coded as 0. The variable country of birth in the NIS-2003-1 data set consists of 22 countries (Canada; Peoples Republic of China; Colombia; Cuba; Dominican Republic; El Salvador; Ethiopia; Guatemala; Haiti; India; Jamaica; Korea; Mexico; Nigeria; Peru; Philippines; Poland; Russia; Ukraine; United Kingdom; United States and Vietnam), 8 regions (Europe and Central Asia; East Asia, South Asia and the Pacific; Other North America; Latin America and the Caribbean, African Sub-Saharan; Middle East and North Africa, Oceania and Arctic Region) and 1 category classified as Unknown. Due to the nature of this variable, we included 21 countries in our ordered logit model. There was one respondent that identified the United States as her county of birth and she was excluded from the sample. The continuous control variables include age (in years) when respondent became a legal permanent resident, education (in years), the duration of the immigration process (in months) and duration in the U.S (in days). After deleting

missing observations, observations from the 8 regions and the Unknown country of birth, the sample size was 4,423 immigrants. Approximately 17 percent of the sample reported ever feeling sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months.

Table 1 displays weighted descriptive statistics by self-reported health status. Immigrants who had ever felt sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months were more likely to be in the poor, fair and good health status groups, 27, 21 and 20 percent respectively. Fourteen percent of the immigrants in the very good health status group and 16 percent of the immigrants in the excellent health status group reported having felt sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months. Immigrants who reported their health status as excellent were more likely to be male, whereas immigrants in other health status groups were more likely to be female. The majority of the immigrants in the sample were married. Each health status group had marriage rates of 70 or more percent.

TABLE 1
SELF-REPORTED HEALTH STATUS BY CATEGORIZED RESPONDENTS

Categorical Variables	Poor		Fair		Good		Very Good		Excellent	
	%	N	%	N	%	N	%	N	%	N
Felt sad during immigration process										
Yes	27	12	21	79	20	244	14	179	16	240
No	73	34	79	297	80	978	86	1098	84	1262
Gender										
Male	31	14	40	150	36	440	42	536	49	736
Female	69	32	60	226	64	782	58	741	51	766
Speaks English very well										
Yes	9	4	7	26	10	122	21	268	28	421
No	91	42	93	350	90	1100	79	1009	72	1081
Class of Immigrant Admission										
Family-sponsored	62	29	60	226	63	770	60	766	50	751
Employment based	2	1	3	11	8	98	12	153	15	225
Diversity immigrant	1	0	1	4	3	36	5	64	7	105
Refugees/Asylees	35	16	36	135	26	318	24	294	28	421
Married										
Yes	71	33	70	263	76	929	75	958	75	1126
No	29	13	30	113	24	293	25	319	25	376
Health Condition										
Yes	94	43	66	248	32	391	18	230	11	165
No	6	3	34	128	68	831	82	1047	89	1337
Light physical exercise										
Yes	61	28	77	290	74	904	76	971	78	1172
No	39	18	23	86	26	318	24	306	22	330
Suffered Harm Outside the U.S.										
Yes	21	10	9	34	7	86	5	64	6	90
No	79	36	91	342	93	1136	95	1213	94	1412
Adjustment of visa status										
Adjustee	59	27	62	233	59	721	60	766	61	916

New-Arrival	41	19	38	143	41	501	40	511	39	586
Continuous Variables	M	SD	M	SD	M	SD	M	SD	M	SD
Age at legal permanent residence (years)	54.3	2.9	47.5	0.9	41.7	0.5	37.2	0.4	35.5	0.3
Education (years)	7.3	0.8	8.5	0.3	10.7	0.2	12.4	0.1	13.2	0.1
Duration of immigration process (months)	55.2	6.1	61.1	2.9	62.8	1.8	57.5	1.6	56.4	1.6
Duration in U.S. (days)	2930.8	509.4	2765.8	157.1	2181.7	77.3	1919.2	67.0	1988.7	67.1

The age of the immigrants when they received their legal permanent residence is inversely related to the percentages in the health status groups. The youngest immigrants belonged to the excellent health status group, and the oldest immigrants belonged to the poor health status group. On average, in all the health status groups 60 percent of the immigrants were adjustee immigrants. Immigrants classified as family-based immigrants had the largest percentages in each of the health status groups, whereas diversity immigrants had the lowest percentages in each of the health status groups. An overwhelming majority of the immigrants in the poor, fair and good health status groups did not speak English very well (between 91 and 93 percent respectively). Twenty-eight percent of immigrants in the excellent health status group and 21 percent of immigrants in the very-good health status group spoke English very well. Immigrants belonging to the excellent health status group were the most educated, they reported an average of 13.2 years of education. In addition, they were the least likely to have a health condition (11 percent) and the most likely to engage in light physical exercise (78 percent) than the other health groups. With the exception of immigrants in the poor health group, 90 percent of the immigrants did not suffer harm while residing outside of the United States. Immigrants belonging to the poor health status group had the shortest immigration process duration (on average 55.2 months) and longest residence duration in the U.S. (on average 2930.8 days).

EMPIRICAL PROCEDURE AND RESULTS

In order to examine the relationship between the immigration process and the self-reported health status of immigrants, we employ ordered logistic regressions and cluster on the immigrants' countries of birth. This analysis is motivated by the following logic: If immigrants reported feeling sad, blue or depressed because of the process of becoming a legal permanent resident alien during the past 12 months or visa stress, they are more likely to identify with a lower self-reported health status than if they did not report experiencing visa stress. Table 2 presents odd ratios for the relationship between the immigration process and self-reported health status of immigrants. Feeling sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months is significantly associated with self-reported health status. Controlling for other determinants of self-reported health status, immigrants who felt sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months were 18.7 percent less likely to report a higher self-reported health status than immigrants who did not feel sad, blue or depressed because of the process of becoming a permanent resident alien during the past 12 months. This result is consistent with our expectations and provides some support for the claim that prolonged exposure to stressful circumstances may have powerful negative effects on a variety of the bodily systems (McEwan & Lasley, 2002).

TABLE 2
LOGISTIC REGRESSION RESULTS

Variables	Odds Ratio		
	Whole Sample (n=4,423)	Adjustee Immigrants (n=2,476)	New-arrival Immigrants (n=1,947)
Age at legal permanent residence	0.9765*	0.9827*	0.9697*
Felt sad during immigration process	0.8130**	0.7893*	0.7915
Male	1.3186*	1.2842*	1.4038*
Eduducation	1.0621*	1.0633*	1.0526*
Speaks English very well	1.6934*	1.7268*	1.9031*
Married	1.0264	1.0985	0.9274
Family-sponsored	0.7254	0.6615	0.6808
Employee based	0.7992	0.6895	1.0334
Refugee/Asylees	0.6682***	0.5744	0.5810**
Heatlh Condition	0.2458*	0.2353*	0.2476*
Light Physical Excercise	1.1305	1.4041*	0.8072
Duration in U.S.	0.9999***	0.9999	0.9999*
Duration of immigration process	1.0005	1.0028	0.9992
Duration of immigration process squared	1.0000	1.0000	1.0000
Suffered Harm Outside of the U.S.	0.7607**	0.7922	0.5639***

*** Result is significant at the 0.1 level (two-sided)
** Result is significant at the 0.05 level (two-sided)
* Result is significant at the 0.01 level (two-sided)

A number of other control variables were also associated with self-reported health status. The relationship between an immigrant's age when he or she obtained legal permanent residence in the U.S. and self-reported health status was negative. For every year increase in age when an immigrant obtained legal permanent residence in the U.S. there was approximately a 2.3 percent odds of reporting a lower self-reported health status. Male immigrants had a 32 percent higher odds of reporting a higher health status than female immigrants. Years of education was also a significant predictor of self-reported health status. An additional year of education resulted in percent increase in the likelihood of reporting a higher self-reported health status. Similar to the results in Okafor et al. (2013), our results on speaking English very well was positively related to self-reported health status. Immigrants who spoke English very well were more than 1.5 times likely to report a higher health status. Compared with diversity immigrants, the predicted odds of reporting a higher self-reported health status decreased by 33.2 percent for refugees or asylees.

As expected, the odds of reporting a higher self-reporting health status were lower for immigrants with at least one medically diagnosed health condition as compared with immigrants without any medically diagnosed health conditions. Immigrants with a medically diagnosed condition were 75.4 percent less likely to report a higher self-reported health status than their counterparts. Similarly, suffering harm outside of the U.S. was negatively related to self-reported health status. Ceteris paribus, compared to immigrants who did not suffer harm outside the U.S., the predicted odds of reporting a higher self-reported health status decreased by 23.9 percent for immigrants who suffered harm outside the U.S. The

results for duration of residence in the United States supports previous research such as Goldman et al. (2014). Although small, the predicted odds of immigrants who had a longer duration of residence in the U.S reporting a higher self-reported health status was 0.01 percent lower than those who had a shorter duration of residence in the U.S. The ratio of new-arrival immigrants to adjustee immigrants in this study's sample was relatively high (0.79), and probably was the contributing factor for the small predicted odds ratio.

The distinction between immigrants as either new-arrival immigrants or adjustee immigrants provides further insights into the relationship between the process of becoming a legal permanent resident and self-reported health status. The predicted odds ratios indicate that the self-reported health status of adjustee immigrants were negatively affected by the immigration process while the self-reported health status of new-arrival immigrants were unaffected by the immigration process. Adjusted immigrants who felt sad, blue or depressed because of the process of becoming a legal permanent resident were 21.1 percent less likely to indicate a higher self-reported health status than those who did not feel sad, blue or depressed because of the process of becoming a legal permanent resident. Since adjustee immigrants are required to return to their home country if they are not approved for legal permanent residence in the U.S., they encounter potential additional financial costs associated with returning to their home country. These potential financial costs may lead to additional stress during the immigration process which may cause the immigrants to have a higher probability of feeling sad, blue or depressed during the immigration process and hence a higher probability of reporting a lower self-reported health status. With the exception of immigrants who engage in light physical exercise, in general, the predicted odds ratios for the demographic characteristics for adjustee immigrants and new-arrival immigrants were similar to the results from the pooled sample of immigrants. Adjustee immigrants who engaged in light physical exercise were more likely to a report a higher self-reported health status (odds ratio = 1.404) than their counterparts who did not engage in light physical exercise.

CONCLUSION

This research paper examines the empirical relationship between self-reported health status and immigrants' subjective feelings about the process of becoming a legal permanent resident alien in the United States. The authors used data from the NIS-2003-1 and the results revealed that immigrants who felt sad, blue or depressed because of the process of becoming a legal permanent resident in the U.S. were more likely to report a lower self-reported health status. Our results from the representative sample of immigrants provide empirical support for previous qualitative studies documenting the relationship between the immigration process and immigrants' health (Lecompte et al., 2017). In addition, exploiting the differences between immigrants who were either new-arrival immigrants or adjustee immigrants showed that the subjective feelings about the immigration process of adjustee immigrants were negatively related to their self-reported health status while the subjective feelings about the immigration process of new-arrival immigrants were unrelated to their self-reported health status. The results inform immigration policy makers and prospective immigrants that the process of becoming a legal permanent resident has the potential to adversely affect immigrants' health. In addition, immigrants residing in the U.S. who are seeking legal permanent residence are more at risk than immigrants applying for legal permanent residence outside the U.S. This higher risk has implications for higher costs such as health care and labor productivity cost in the host country. According to Pandey and Kagotho (2010), investment in English as a second language will not only improve immigrants' job prospects but also their access to health insurance. Similar results arise from our empirical analysis. In all models, speaking the English language very well had the strongest effect on immigrants' self-reported health status. Thus our result on speaking the English language very well adds to the empirical findings on the importance of immigrants' ability to speak the receiving country's language proficiently, it will improve assessment of immigrants' self-reported health status.

ENDNOTES

1. Special rules apply to refugees and asylees and they do not account for a significant portion of immigrants applying for legal permanent residence. For more information see USCIS (2017).

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