



The Health of Immigrants in New York City

*A Report from the
New York City Department
of Health and Mental Hygiene
June 2006*

Dear Fellow New Yorkers:

New York City's Health Department remains committed to improving the health of all the City's diverse populations. Foreign-born New Yorkers are generally healthier than their U.S.-born neighbors, but immigrants often also have special needs. Language barriers reduce health care access, as does undocumented immigration status. The health of some immigrants may decline after they move to the United States and are exposed to “toxic” aspects of our environment, such as unhealthy diet and extensive tobacco company marketing.

We hope this report is useful to our partners in the effort to protect and promote health among foreign-born New Yorkers.

Thomas R. Frieden, MD, MPH
 Commissioner
 New York City Department of Health and Mental Hygiene

Key Findings in This Report

Access to health care is a challenge for foreign-born New Yorkers, and language barriers affect even those who have health care coverage.

- Foreign-born adults under age 65 are less likely to have a regular primary care provider than U.S.-born adults (69% vs. 80%), and foreign-born adults who speak Spanish are less likely to have a regular primary care provider than those who speak English (52% vs. 74%).
- Foreign-born adults with low incomes are less likely to have Medicaid than the U.S.-born (29% vs. 42%). And those age 65 and older are less likely to have Medicare than U.S.-born adults in the same age group (77% vs. 85%).
- Even among adults who have health care coverage, foreign-born adults under age 65 who speak Spanish are nearly twice as likely as those who speak English to report being unable to obtain medical care when needed (15% vs. 8%).

Foreign-born individuals are less likely to utilize preventive care, such as screenings for health conditions like cancer and heart disease.

- Fewer than half of foreign-born adults age 50 and older (44%) have ever received colon cancer screenings, compared to 53% of U.S.-born adults. Among foreign-born adults from certain countries, fewer than 1 in 3 has received colon cancer screenings.
- One quarter of foreign-born women have not received timely Pap tests, compared to 16% of U.S.-born women.
- A higher proportion of U.S.-born adults than foreign-born adults has had their blood pressure (92% vs. 86%) or blood cholesterol (77% vs. 67%) checked recently.

For some behaviors and outcomes, foreign-born New Yorkers appear healthier than those born in the U.S. Yet important disparities exist among foreign-born groups.

- For each of the 10 leading causes of death in New York City, foreign-born adults have similar or lower death rates than U.S.-born adults. Despite this, data suggest that death rates among certain foreign-born subgroups exceed the U.S.-born death rate, and among some foreign-born groups differences are large.
- Overall, foreign-born adults are less likely than U.S. born-adults to smoke (13% vs. 23%), yet foreign-born men are twice as likely to smoke as foreign-born women (18% vs. 9%), and data suggest that foreign-born men from some countries are as likely to smoke as U.S.-born men.

Increased duration of stay in the U.S. may be associated with poor health for foreign-born New Yorkers, even though it may improve access to care and utilization of preventive services.

- Data suggest that foreign-born New Yorkers who have lived in the U.S. for 4 years or more report worse general health than more recent arrivals (24% vs. 17%) and that they are more likely to be obese (16% vs. 12%).
- Foreign-born New Yorkers who have lived in the U.S. for 4 or more years are less likely to be uninsured (21% vs. 31%) and more likely to receive flu shots (57% vs. 45%) than those who have lived in the U.S. for less than 4 years.

Introduction

Overview

Over the past 20 years, there has been rapid growth in New York City's foreign-born population. Foreign-born New Yorkers face a number of unique health concerns, as well as specific barriers to accessing health care services. Immigration to the U.S. can mean changes in social and/or socioeconomic status, language, culture, and many other aspects of life that may affect one's health. Yet there is limited information available about the health of the foreign-born.

In support of improving the health of all New Yorkers, the New York City Department of Health and Mental Hygiene (NYC DOHMH), The Commonwealth Fund, and the Fund for Public Health in New York present this report on the health of foreign-born adults in New York City. This report is informed by NYC DOHMH's citywide health policy, *Take Care New York: A Policy for a Healthier New York City*, which was launched in March 2004. With this public health initiative, the NYC DOHMH outlines 10 priority areas that, if addressed appropriately, could improve the health of all New Yorkers. These priority areas meet the following criteria: they present a large disease burden (killing thousands of New Yorkers and causing hundreds of thousands of preventable illnesses or disabilities each year), they have been proven amenable to intervention and public action, and they can be best addressed through coordinated action by City agencies, public-private partnerships, health care providers, businesses, and individuals. Many of these areas are addressed in this report. For more information on *Take Care New York*, log onto www.nyc.gov/health.

We hope that these data help to inform health promotion and disease prevention programs in New York City.

In This Report

The foreign-born population in New York City is racially and ethnically diverse, and foreign-born individuals have settled here due to a variety of circumstances and under different immigration categories. In this report, we define "foreign-born" New Yorkers as individuals who were born outside of the United States, Puerto Rico, or other U.S. territories. They include: legal immigrants (such as naturalized citizens or "green card" holders); legal non-immigrants (such as diplomats and foreign students); refugees; asylees; and undocumented individuals. "U.S.-born" New Yorkers refers to individuals who were born in the United States, Puerto Rico, or other U.S. territories.

This report is not intended to be an exhaustive examination of the health of foreign-born populations in New York City, nor does it definitively explain the mechanisms (such as culture) through which their health is impacted. Understanding health disparities between foreign-born and U.S.-born populations, however, helps to identify groups that would most benefit from targeted interventions, policies, and programmatic resources. Because the foreign-born population in New York City is diverse, this report examines differences among foreign-born subgroups as defined by country of birth, race/ethnicity, gender, income, language spoken, health insurance status, and duration of residence in the United States. Our ability to present data based on country of birth was limited to only those countries with sizable populations in New York City (see box).

In this report, unless otherwise noted, we examine the health status of foreign-born individuals age 18 and older, regardless of immigration category or citizenship status. Only statistically significant findings are discussed in the text without preface. When we discuss the implications of potentially important findings that are not statistically significant, we indicate this by including the text "data suggest."

Methodology for Country of Birth Analyses. When possible, data were analyzed by country of birth. The leading causes of death are presented for the countries with the largest populations of immigrants in New York City. In the rest of the report, country-specific findings represent the highest or lowest prevalence of the variable of interest. In all cases, restrictions were applied to maximize the stability of the estimates (restrictions were based on the size of the dataset and the prevalence of the condition). Mortality rates are presented for countries with a population of 1,000 or more in New York City, with 50 or more deaths. Analyses using the NYC Community Health Survey are presented only for countries with sample sizes of 50 or more in the survey data. New HIV diagnosis rates are presented for countries that had at least 10 diagnoses and for which country codes could be matched between the HIV/AIDS reporting system (HARS), which provided the numerator, and the U.S. Census, which provided the denominator. Low birthweight data are provided for countries with at least 500 live births. Teen birth data are provided for countries with at least 1,000 teenage girls in the

Overview of Immigrants in New York City

Demographic Profile in 2000

In 2000, an estimated 44% (2.7 million) of the adult population in New York City was foreign-born, up from 33% in 1990. The proportion of New Yorkers who speak only English at home decreased from 60% in 1990 to 53% in 2000. Adults from the Dominican Republic accounted for 12% of the foreign-born population living in New York City in 2000, almost twice as many people as the second-largest group, which was from China. Overall, half of foreign-born New Yorkers were from Latin America and the Caribbean. Among racial/ethnic groups, a larger proportion of Asians were foreign-born than any other group; 91% of Asians in New York City were foreign born, compared to 54% of Hispanics.

The distribution of men and women was approximately the same in the U.S.-born and foreign-born populations. Half of the U.S.-born population was white, compared to one quarter of the foreign-born population. The foreign-born population was more likely to be Hispanic or Asian. Compared to the U.S.-born population, the foreign-born population had a larger proportion of adults in the economically productive age groups (25–64) and a smaller proportion of individuals under 18 years of age. The overall educational attainment of foreign-born adults was lower than that of U.S.-born adults. The household income distribution was somewhat different in these 2 groups, as fewer foreign-born adults had household incomes greater than \$75,000. Most foreign-born adults had lived in the U.S. for 4 or more years.

Sex

	U.S.-born	Foreign-born
Men	45%	47%
Women	55%	53%

Source: NYC PUMS, 2000/NYC Department of City Planning

Race/Ethnicity

Race/Ethnicity	U.S.-born	Foreign-born
White	50%	24%
Black	26%	19%
Hispanic	20%	30%
Asian	2%	21%
Others	2%	6%

Source: NYC PUMS, 2000/NYC Department of City Planning

Leading countries of birth among foreign-born adults

Place of birth	Number*	Percent
1. Dominican Republic	331,700	12
2. China	193,200	7
3. Jamaica	161,300	6
4. Guyana	118,800	4
5. Mexico	108,300	4
6. Ecuador	102,700	4
7. Haiti	90,200	3
8. Trinidad & Tobago	83,400	3
9. Colombia	76,600	3
10. Italy	76,300	3

* Rounded to nearest hundred.
Source: NYC PUMS, 2000/NYC Department of City Planning

Age

Age Group	U.S.-born	Foreign-born
0–17 years	33%	9%
18–24 years	10%	10%
25–44 years	28%	42%
45–64 years	18%	27%
65+ years	12%	12%

Source: NYC PUMS, 2000/NYC Department of City Planning

Education

Education*	U.S.-born	Foreign-born
<High School	22%	35%
High School	25%	23%
Some college	22%	18%
College degree	18%	14%
>College degree	13%	9%

* Among adults 25 and older
Source: NYC PUMS, 2000/NYC Department of City Planning

Income

Household Income	U.S.-born	Foreign-born
<\$25,000	31%	29%
\$25,000–\$49,999	22%	28%
\$50,000–\$75,000	18%	19%
>\$75,000	30%	24%

Source: NYC PUMS, 2000/NYC Department of City Planning

Duration of U.S. residence*

Less than 1 year	4%
1–3 years	9%
4 or more years	88%

* Does not equal 100% due to rounding.
Source: NYC Community Health Survey, 2002, 2003

General Health

Causes of Death

Among adults, foreign-born New Yorkers have remarkably lower all-cause death rates than U.S.-born New Yorkers, as well as comparable or lower cause-specific death rates for each of the leading causes of death. For example, from 2001 through 2003, 350 of every 100,000 foreign-born adults died from heart disease compared to 438 of every 100,000 U.S.-born adults. The death rate due to cancer, the second leading cause of death in both groups, is 40% lower among the foreign-born, and foreign-born adults are 5 times less likely to die from AIDS than their U.S.-born counterparts.

Among the foreign-born, death rates vary dramatically, and some country-specific death rates are higher than the rates among the U.S.-born. For example, while death rates from diabetes are generally lower among the foreign-born than the U.S.-born, data suggest that foreign-born adults from Guyana have a death rate from diabetes that is higher than the U.S.-born rate. AIDS mortality is particularly variable across countries of origin. For example, data suggest that adults born in Mexico are 28 times more likely to die from AIDS than adults from China.

Leading Causes of Death in U.S.-born and foreign-born adult New Yorkers, 2001–2003

Cause of death	Overall Deaths/100,000*		Country of birth (5 largest foreign-born groups) Deaths/100,000*				
	U.S.-born	Foreign-Born	Dominican Republic	China	Jamaica	Guyana	Mexico
All-cause	1,073	768	548	618	785	801	520
Heart disease	438	350	177	206	304	332	146
Cancer	246	175	128	192	199	163	97
Influenza/pneumonia	47	36	28	39	33	32	55
Stroke	31	31	27	37	37	41	21
Diabetes	34	23	24	18	43	58	9
Chronic lower respiratory disease	35	16	10	20	10	10	8
AIDS	41	8	8	0.5	12	10	14

* Age-adjusted and annualized.

Sources: Bureau of Vital Statistics, NYC DOHMH, 2001-2003, NYC DOHMH; U.S. Census 2000/NYC Department of Planning

What is the Healthy Immigrant Effect? The healthy immigrant effect refers to an observation widely-noted in the U.S. and Canada that foreign-born populations tend to have better health outcomes than the native-born population. Although the causes for these patterns are unclear, one potential explanation is that those who migrate to the U.S. may be healthier than those who remain in their countries of origin. This self-selection could mean that only the most able, healthy people move to the U.S. It is also possible that older foreign-born individuals (who may have declining health) return to their countries of origin, leaving the healthiest foreign-born in the U.S. and masking the full extent of illness and death in this group.

Premature Death

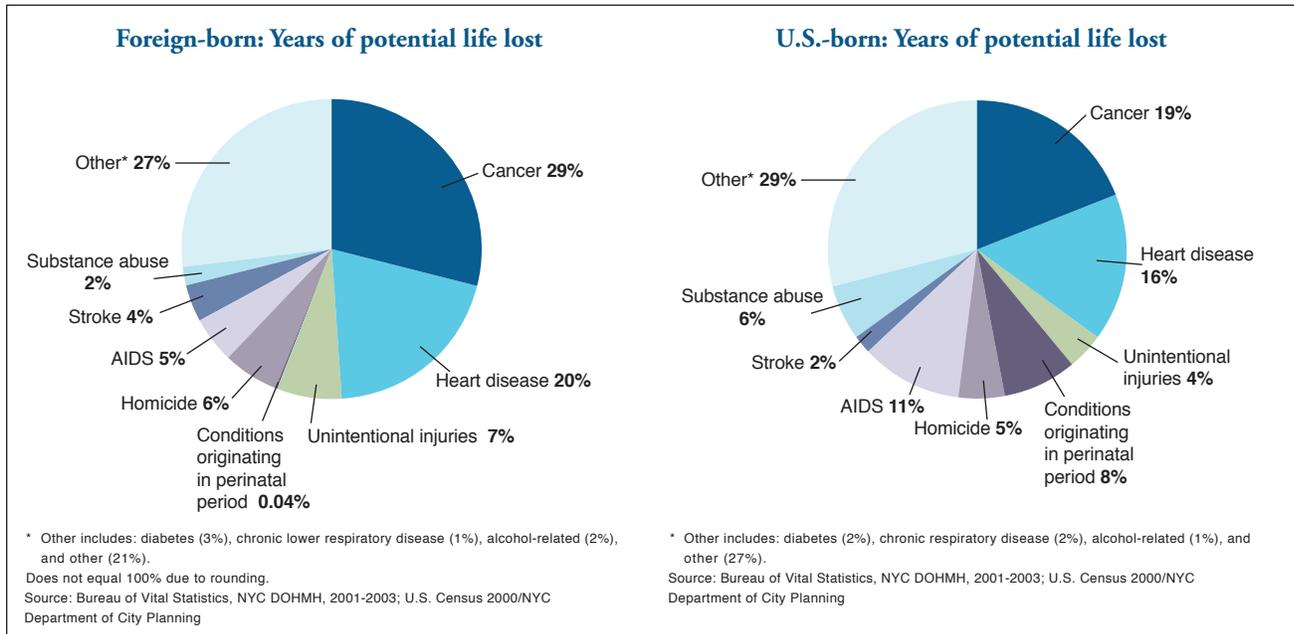
Premature death is defined in this report as death before age 75. One way to measure premature death is to subtract the age a person dies from 75 years. This is known as “years of potential life lost.”

Overall, a smaller proportion of deaths among foreign-born New Yorkers is premature (41% vs. 49%) and fewer years of life are lost for each premature death among the foreign-born, compared to the U.S.-born (17 years vs. 20 years).

The causes of premature death differ between foreign-born and U.S.-born New Yorkers. Among the foreign-born, 29% of years of potential life lost are due to cancer, while cancer is responsible for 19% of the years of potential life lost among the U.S.-born. The years of potential life lost due to heart disease and stroke are also higher among the foreign-born. Substance abuse, AIDS, and perinatal conditions, however, are responsible for a greater proportion of premature deaths among the U.S.-born.

Premature deaths are lower among foreign-born than U.S.-born New Yorkers		
	U.S.-born	Foreign-born
Percent of deaths that are premature (<75 years)	49%	41%
Total years of potential life lost	1,104,338	365,617
Total years of potential life lost per 100,000 population*	8,384	3,864
Total years of potential life lost per premature death	20	17

* Age-adjusted and annualized.
Source: Bureau of Vital Statistics, NYC DOHMH, 2001-2003



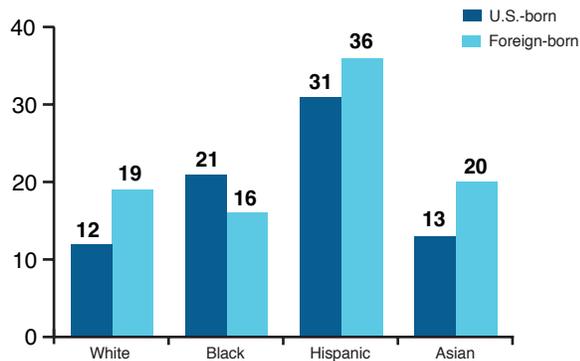
Self-reported health status

Self-reported health status, based on a scale ranging from excellent to poor, is a widely used measure of general health. Overall, foreign-born adults are more likely to report fair or poor health than U.S.-born adults in New York City (24% vs. 17%), but this varies by race/ethnicity. White and Hispanic adults born outside the U.S. are more likely to report fair or poor health than

their U.S.-born counterparts. However, black U.S.-born New Yorkers are more likely than their foreign-born counterparts to report fair or poor health. Self-reported health also varies by duration of residence in the U.S. Data suggest that foreign-born New Yorkers who have lived in the U.S. for 4 years or more are more likely to report fair or poor health than more recent arrivals.

Foreign-born Hispanics are most likely to report fair or poor health

Percent of adults who report fair or poor health



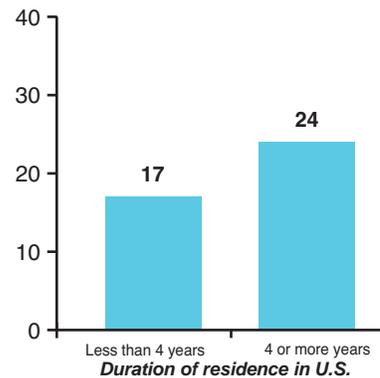
Percents are age-adjusted.

Survey respondents were asked: Would you say that, in general, your health is excellent, very good, good, fair, or poor?

Source: NYC Community Health Survey, 2002, 2003

Foreign-born New Yorkers who have lived in the U.S. for 4 or more years report worse health

Percent of foreign-born adults who report fair or poor health



Percents are age-adjusted.

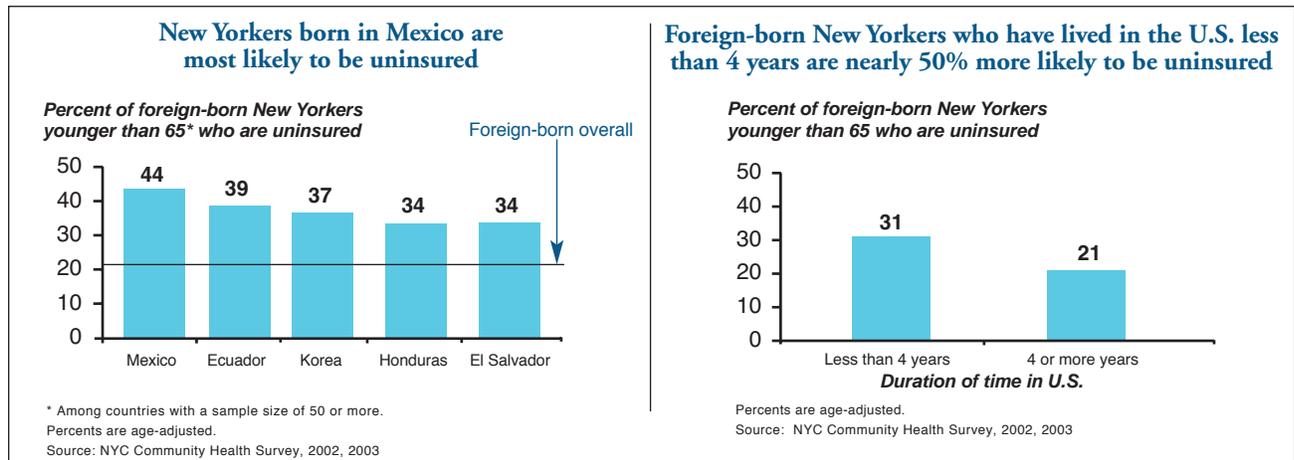
Survey respondents were asked: Would you say that, in general, your health is excellent, very good, good, fair, or poor?

Source: NYC Community Health Survey, 2002, 2003

Access to Care

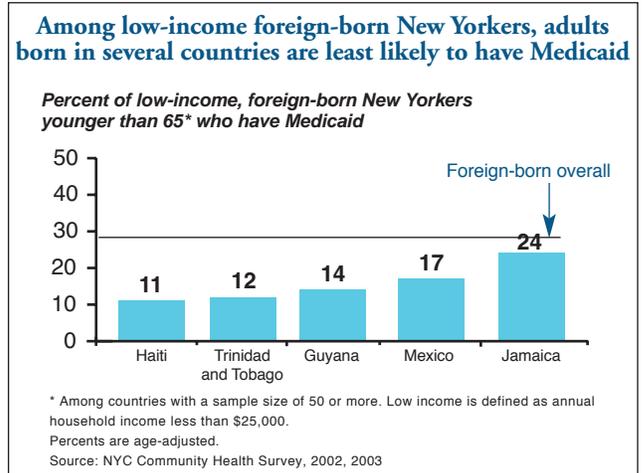
The ability of foreign-born New Yorkers to access health care may be measured by many factors, including whether they have insurance, a regular primary care provider, or a regular place of care. Foreign-born adults younger than 65 are over twice as likely to be uninsured, compared to the U.S.-born (22% vs. 9%). Adults from Latin American countries are most likely to be uninsured.

In fact, the uninsurance rate among adults from Mexico is twice that among all foreign-born. Access to care also varies by length of time in the U.S. Foreign-born New Yorkers who have lived in the U.S. for less than 4 years are more likely to be uninsured than those who have lived in the U.S. for 4 or more years.



Among foreign-born adults younger than 65, those born in Israel have the lowest rate of uninsurance in New York City (2%).

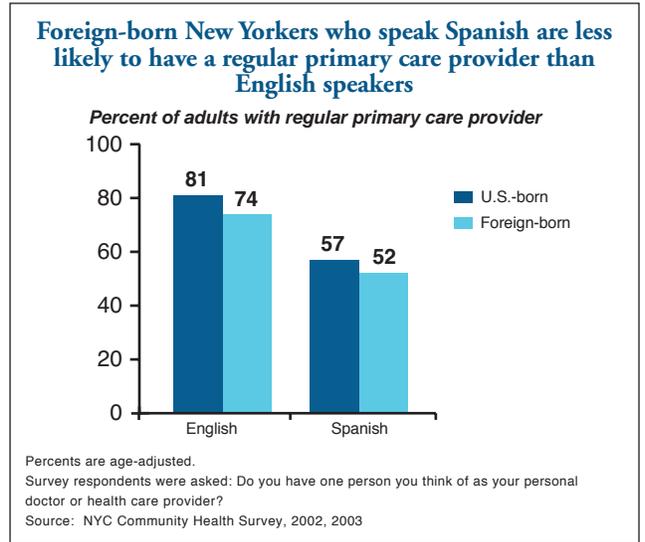
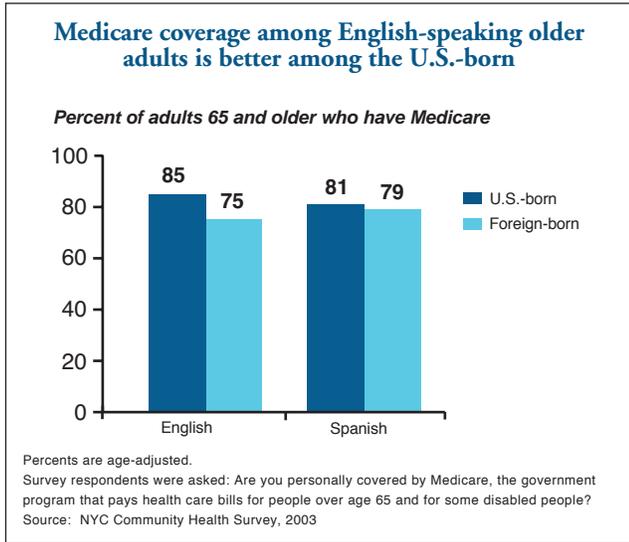
Foreign-born New Yorkers are less likely to have public insurance than the U.S.-born. Overall, among low-income New Yorkers younger than 65, the foreign-born are less likely to have Medicaid than the U.S.-born (29% vs. 42%). Again, disparities exist within the foreign-born population. For example, data suggest that low-income adults from Haiti, Trinidad and Tobago, Guyana, Mexico, and Jamaica are least likely to have Medicaid.



Among low-income foreign-born adults younger than 65, those born in the Dominican Republic have the highest rate of Medicaid coverage in New York City (39%).

As with Medicaid coverage rates, foreign-born New Yorkers age 65 and older are less likely to have Medicare than the U.S.-born (77% vs. 85%), even among English-speakers (75% vs. 85%).

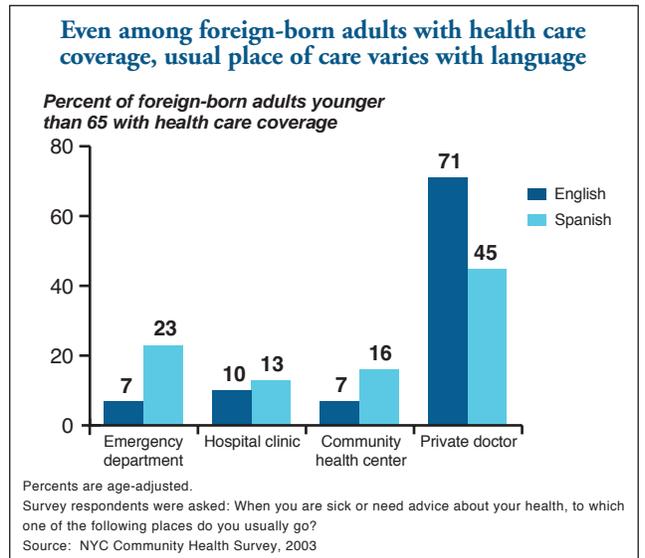
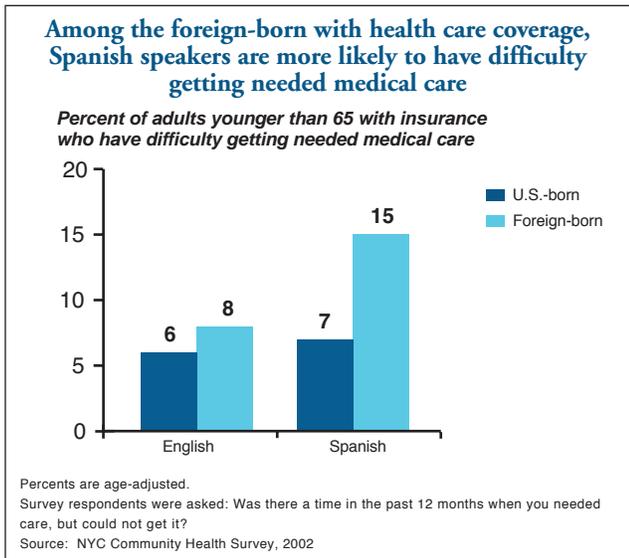
Foreign-born New Yorkers are also less likely to have a regular primary care provider (PCP) than the U.S.-born (69% vs. 80%), and foreign-born New Yorkers who speak Spanish are less likely to have a PCP than English-speaking foreign-born adults (52% vs. 74%). Having a regular PCP is one of the Take Care New York priority areas, and the goal is that 80% of New Yorkers have a primary care provider.



Language spoken was defined by the language in which the NYC Community Health Survey was conducted.

Even among insured foreign-born adults under age 65, those who speak Spanish are nearly twice as likely as those who speak English to report being unable to obtain needed medical care (15% vs. 8%). Among Spanish speakers, data suggest that those who are foreign-born are more than

twice as likely to report difficulty getting needed care, compared to those who are U.S.-born. Further, foreign-born adults who speak Spanish are 3 times more likely than English speakers to use an emergency department as their usual place of care.

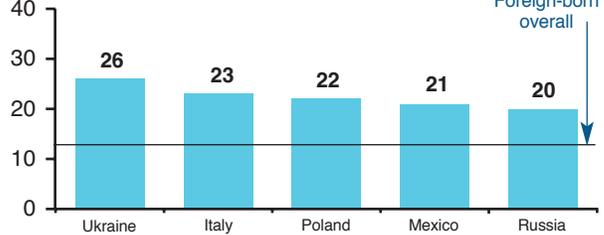


Tobacco Use

Smoking is the leading cause of preventable death in New York City, killing 10,000 New Yorkers every year. Being tobacco free is a Take Care New York priority area. In 2003, approximately 19% of adults in New York City smoked. Foreign-born New Yorkers are less likely to smoke than those who are U.S.-born (13% vs. 23%). However, particularly high rates of smoking, approaching levels in the U.S.-born population, exist among adults from several countries. Data suggest that adults born in Ukraine are most likely to smoke, and they are twice as likely to smoke as foreign-born New Yorkers as a whole. Adults born in Italy, Poland, Mexico, and Russia have high rates of smoking, as well.

New Yorkers born in Ukraine are most likely to smoke

Percent of foreign-born adults* who currently smoke



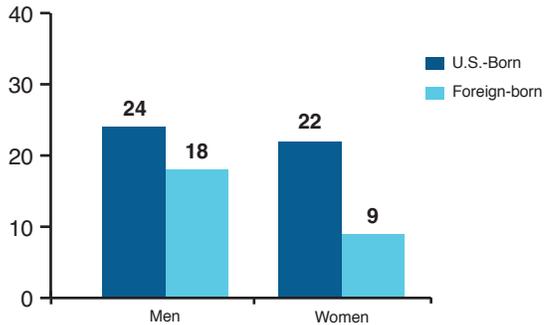
* Among countries with a sample size of 50 or more. Percents are age-adjusted. Survey respondents were asked: Have you smoked at least 100 cigarettes in your entire life? Do you now smoke cigarettes every day, some days, or not at all? Sources: NYC Citywide Health Survey, Fall 2003; NYC Community Health Survey, 2003

Adults born in India are least likely to smoke (5%).

The difference in smoking levels between foreign-born and U.S.-born adults is largely driven by differences in smoking rates among women and less visible among men. U.S.-born women are more than twice as likely to smoke as foreign-born women (22% vs. 9%); the difference among men is smaller (24% vs. 18%). Among the foreign-born, men are twice as likely as women to smoke (18% vs. 9%). Data suggest that men born in Russia are most likely to smoke.

Foreign-born women are half as likely to smoke as foreign-born men

Percent of adults who currently smoke



Percents are age-adjusted. Survey respondents were asked: Have you smoked at least 100 cigarettes in your entire life? Do you now smoke cigarettes every day, some days, or not at all? Source: NYC Citywide Health Survey, Fall 2003; NYC Community Health Survey, 2003.

Differences in smoking between foreign-born men and women*

Percent of foreign-born adults who smoke, 2003

	Men	Women
China	20	4
Ecuador	15	4
Guyana	13	2
Jamaica	17	3
Mexico	21	11
Russia	25	16
Trinidad and Tobago	15	2

* For countries with the highest prevalence of smoking or greatest gender disparity in smoking prevalence and a gender-specific sample size of 50 or more. Percents are age-adjusted. Survey respondents were asked: Have you smoked at least 100 cigarettes in your entire life? Do you now smoke cigarettes every day, some days, or not at all? Sources: NYC Citywide Health Survey, Fall 2003; NYC Community Health Survey, 2003

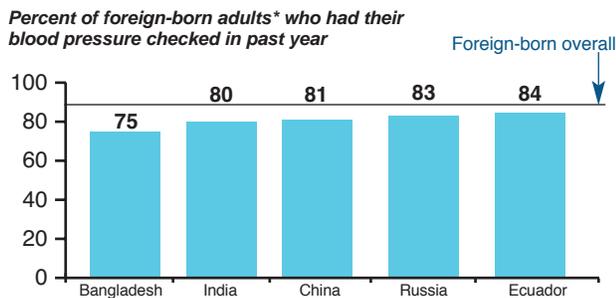
Heart Health

Keeping your heart healthy is one of the Take Care New York goals. Keeping blood pressure, cholesterol, and weight at healthy levels and preventing and controlling diabetes are key components of meeting this goal. Screening rates for high blood pressure (hypertension) and high cholesterol (hypercholesterolemia) are high among New Yorkers, but foreign-born adults are less likely than their U.S.-born counterparts to have their blood pressure and cholesterol checked. While 92% of U.S.-born adults had their blood pressure checked

in the past year, 86% of foreign-born adults report the same. Similarly, 77% of all U.S.-born adults had their cholesterol checked in the past 5 years, compared to 67% of foreign-born adults. Data suggest that foreign-born adults from Bangladesh are less likely than those from other countries to have had their blood pressure checked in the past year. Data also suggest that adults born in Poland and India are less likely to have had their cholesterol checked in the past 5 years, compared to adults from other countries.

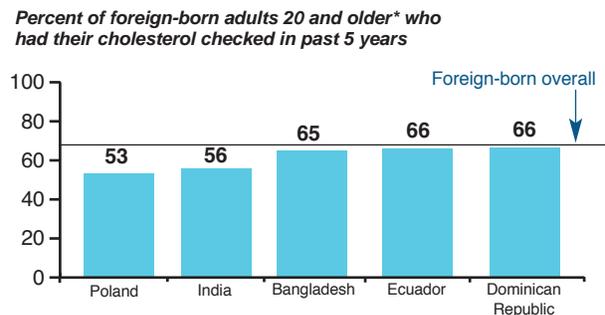
Blood pressure and cholesterol screenings vary by country of birth

New Yorkers born in several countries are least likely to have had their blood pressure checked recently



* Includes countries with a sample size of 50 or more. Percents are age-adjusted. Survey respondents were asked: About how long has it been since you last had your blood pressure taken by a doctor, nurse, or other health professional? Sources: NYC Community Health Survey, 2002

New Yorkers born in several countries are least likely to have had their cholesterol checked recently



* Includes countries with a sample size of 50 or more. Percents are age-adjusted. Survey respondents were asked: Have you ever had your blood cholesterol checked? About how long has it been since you last had your blood cholesterol checked? Sources: NYC Community Health Survey, 2002

Adults born in Haiti are most likely to have had their blood pressure checked (98%).

Adults born in Italy are most likely to have had their cholesterol checked (80%).

Rates of high blood pressure and high cholesterol are similar between U.S.-born and foreign-born adults. However, differences in screening behaviors may mask health variations between the two groups. For example, if the foreign-born who do not receive screening were actually more likely to have elevated blood pressure and cholesterol levels, then the true prevalence of these conditions would be higher among the foreign-born.

Percent of New Yorkers who report high blood pressure or high cholesterol*

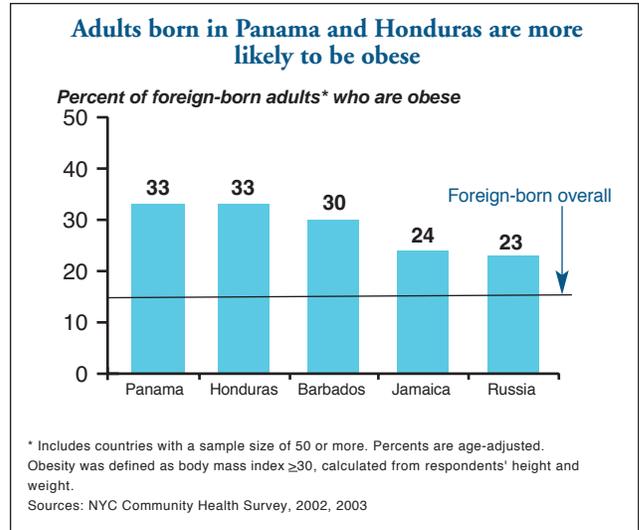
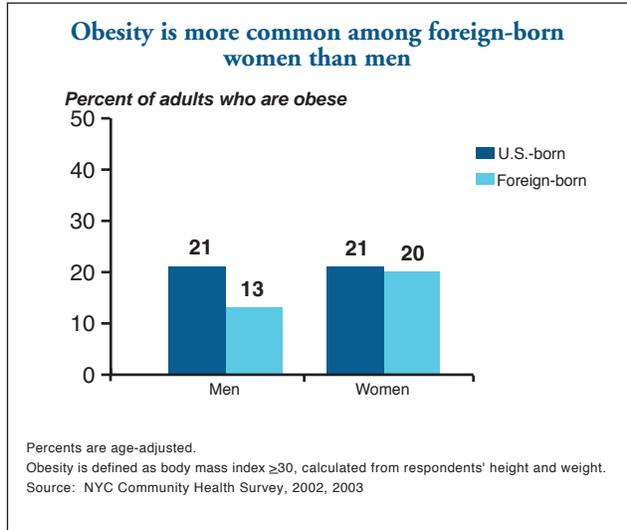
	High blood pressure	High cholesterol
U.S.-born	26	33
Foreign-born	25	32

* Among adults who have been screened for high blood pressure or cholesterol (age 20 and older). Percents are age-adjusted. Survey respondents were asked: Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure? Have you ever been told by a doctor or other health professional that your blood cholesterol is high? Source: NYC Community Health Survey, 2002.

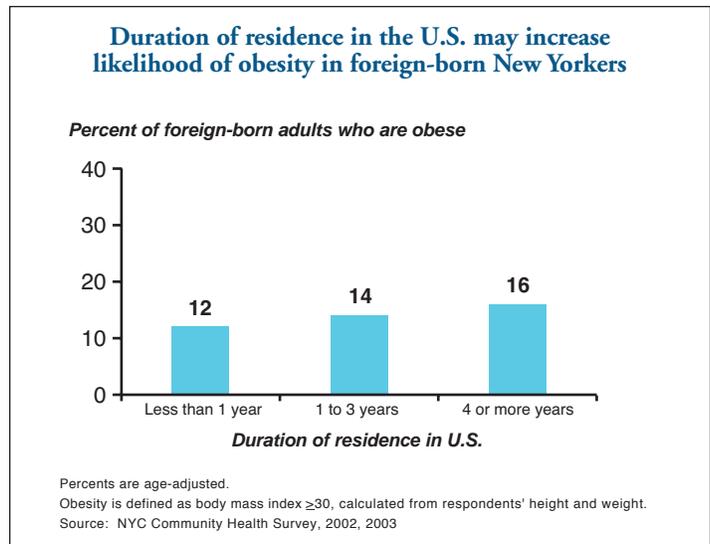
Obesity is defined by a person’s body mass index (BMI), which is based on a person’s weight and height. Adults with a BMI of 30 or more are classified as obese. Obesity increases a person’s risk for several conditions, including heart disease, high blood pressure, stroke, type 2 diabetes, and cancer. In New York City, in 2003, 20% of adults were obese, an increase from 18% in 2002. Foreign-born adults are less likely than U.S.-born adults to be obese (16% vs. 21%). This difference is largely

driven by the lower prevalence of obesity among foreign-born men, who are 35% less likely to be obese than foreign-born women. The rate of obesity among foreign-born women is the same as that among U.S.-born adults.

Data suggest that foreign-born adults from Panama, Honduras, Barbados, Jamaica, and Russia have higher levels of obesity than the overall populations of foreign-born and U.S.-born adults.



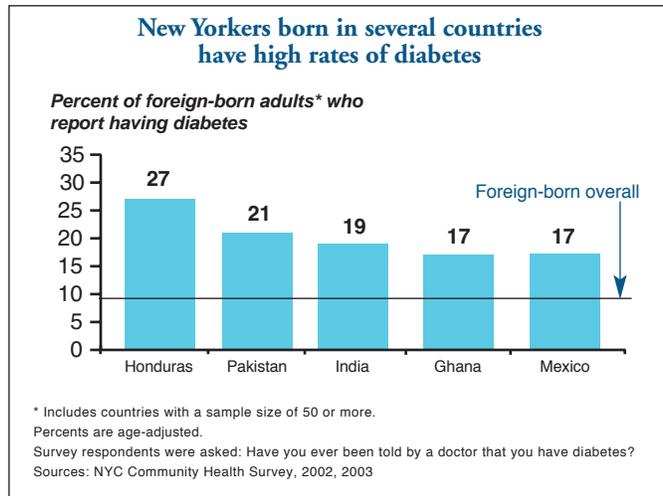
Data suggest that obesity among foreign-born New Yorkers increases with duration of residence in the United States.



Adults born in Korea are least likely to be obese (<1%).

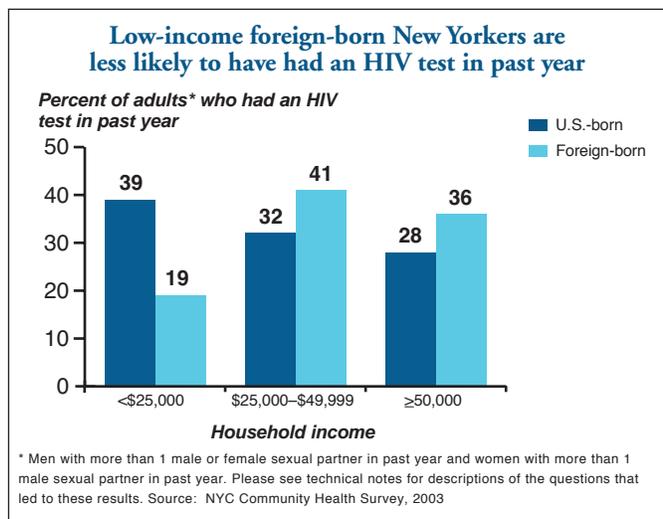
Diabetes is a condition in which the body does not produce or utilize insulin adequately. U.S.-born and foreign-born adults have similar rates of self-reported diabetes (8% vs. 9%), but some foreign-born groups have higher rates of this condition.

Data suggest that adults born in Honduras are 3 times more likely to report having diabetes, compared to U.S.-born adults and the foreign-born population as a whole. Data also suggest that adults born in Pakistan, India, Ghana, and Mexico have higher rates of diabetes.

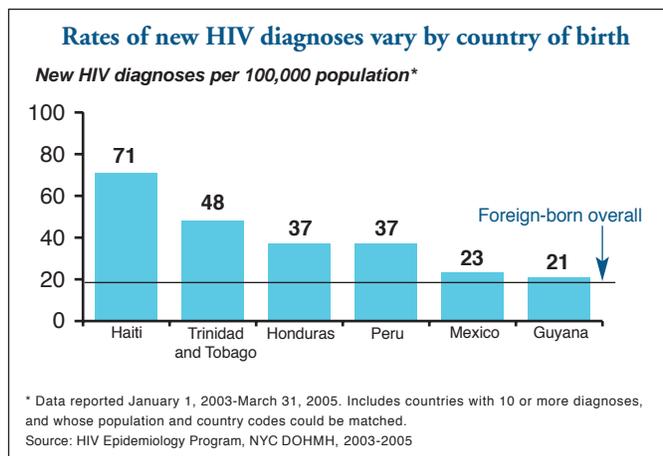


HIV/AIDS

Getting tested for HIV is a crucial step in preventing the spread of HIV, and early treatment can greatly improve long-term health. Knowing one's HIV status is one of the Take Care New York priority areas. Foreign-born and U.S.-born New Yorkers report being tested for HIV in the past year at similar rates (32% vs. 34%). However, there are some differences related to income level. Low-income foreign-born adults are half as likely as U.S.-born adults at the same income level to report being tested for HIV. In higher income groups, however, data suggest that foreign-born New Yorkers are more likely to have had an HIV test in the past year.



Foreign-born New Yorkers are less likely to be diagnosed with HIV than their U.S.-born counterparts (19 vs. 49 per 100,000). However, rates of new HIV diagnoses vary widely by country of birth in the foreign-born population. Adults from some countries have rates of new HIV diagnoses that approach or even surpass the rate among U.S.-born adults. Among adults born in Haiti, the rate of new HIV diagnoses is almost 4 times that of the foreign-born population and nearly 1.5 times that of U.S.-born New Yorkers.



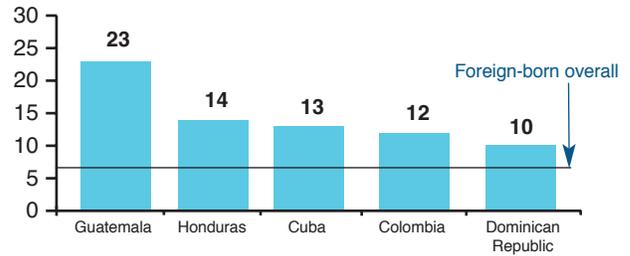
Psychological Distress

Resettling in a new country can present unique mental health challenges. Getting help for depression is one of the Take Care New York priority areas. Foreign-born New Yorkers are more likely to report psychological distress, compared to U.S.-born New Yorkers (7% vs. 5%). In addition, disparities exist among the foreign-born. Compared to adults born in other countries, adults born in some Latin American countries are more likely to report psychological distress. For example, New Yorkers born in Guatemala are more than 3 times as likely to report psychological distress as the foreign-born population as a whole.

Adults born in Barbados and England are least likely to report psychological distress (<1%).

New Yorkers born in Guatemala are most likely to report psychological distress

Percent of foreign-born adults* who report psychological distress



* Includes countries with a sample size of 50 or more.

Percents are age-adjusted.

Psychological distress is measured by Kessler's K6 scale, which asks questions related to feelings of anxiety and depression.

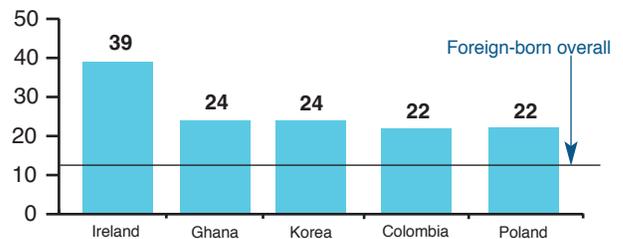
Sources: NYC Community Health Survey, 2002, 2003

Alcohol

Excessive alcohol consumption can lead to injury, chronic illness, and premature death. Alcohol abuse and dependence can be effectively treated with counseling, 12-step programs, and other techniques. Although binge drinking (drinking 5 or more alcoholic drinks on one occasion) is less common among foreign-born New Yorkers than U.S.-born New Yorkers (12% vs. 16%), levels of binge drinking are very high among some foreign-born subgroups. Foreign-born adults from Ireland are 3 times more likely to binge drink than foreign-born adults overall and more than twice as likely to binge drink as U.S.-born adults overall.

Foreign-born adults from several countries have higher levels of binge drinking than foreign-born New Yorkers overall

Percent of adults* who report binge drinking at least once a month



* Includes countries with a sample size of 50 or more.

Percents are age-adjusted.

Survey respondents were asked: Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks on an occasion.

Sources: NYC Community Health Survey, 2002, 2003.

Cancer

Cancer kills nearly 15,000 New Yorkers every year. It is the second leading cause of death among U.S.-born and foreign-born New Yorkers, and it causes the most premature deaths in both groups. The leading causes of cancer deaths among both the U.S- and foreign-born are lung, breast and colon cancers; deaths due to these cancers can often be prevented with healthy behaviors or early identification and treatment. Overall, the top 6

causes of cancer deaths are the same among U.S.-born and foreign-born adults.

There is, however, variation in the leading cancer death rates among the foreign-born. For example, among the foreign-born, adults from Russia have 4 of the highest cancer death rates, while those from the Dominican Republic have 5 of the lowest death cancer death rates.

Top 10 causes of cancer deaths among U.S.-born and foreign-born New Yorkers, 2001-2003¹

U.S.-born New Yorkers	Foreign-born New Yorkers	Foreign-born New Yorkers	
		Highest rate ²	Lowest rate ²
Trachea, bronchus, and lung	Trachea, bronchus, and lung	United Kingdom	Guyana
Breast ³	Breast ³	Russia	China
Colorectal	Colorectal	Russia	Dominican Republic
Lymphoid, hematopoietic, and related tissues	Lymphoid, hematopoietic, and related tissues	Russia	China
Prostate	Prostate	Trinidad & Tobago	Dominican Republic
Pancreas	Pancreas	Russia	Dominican Republic
Liver	Stomach	Korea	Dominican Republic
Stomach	Liver	China	Dominican Republic
Ovary	Ovary	— ⁴	— ⁴
Esophagus	Bladder	— ⁴	— ⁴

¹ Age-adjusted rates.

² For each cancer type, countries with a population less than 1,000 or less than 50 deaths were not included.

³ Among women only.

⁴ There were no countries with a population of 1,000 or more and 50 or more deaths for these cancer types.

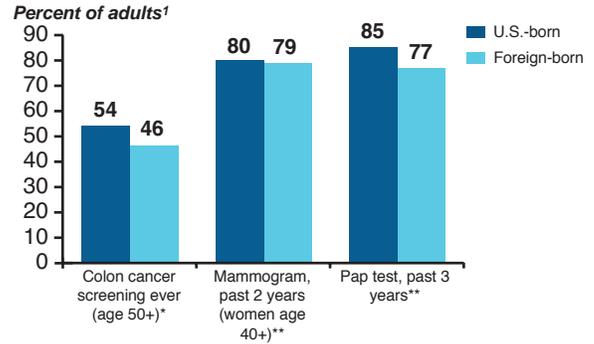
Sources: Bureau of Vital Statistics, NYC DOHMH, 2001-2003; U.S. Census 2000/NYC Department of City Planning

Many cancer deaths could be prevented if individuals at risk were properly screened, and cancer screening is one of the Take Care New York priority areas. The TCNY cancer screening goals are that 60% of adults age 50

or older be screened for colon cancer, 85% of women age 40 or older have a timely mammogram, and 85% of all women receive a timely Pap test.

Foreign-born adults are less likely to receive colon cancer screenings (colonoscopies or sigmoidoscopies) (44% vs. 53%) and Pap tests (73% vs. 84%) than the U.S.-born, and data suggest that foreign-born women are less likely than U.S.-born women to receive a mammogram (74% vs. 79%). Health care coverage increases the proportion of foreign-born New Yorkers receiving screenings. Foreign-born New Yorkers with health care coverage are more likely than the uninsured to receive colon cancer screenings (46% vs. 32%), mammograms (79% vs 48%), and Pap tests (77% vs 62%). But even among individuals with insurance, the foreign-born are less likely to receive colon cancer screenings and Pap tests than U.S.-born individuals.

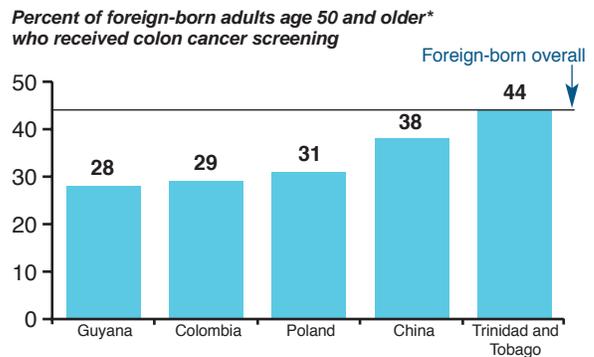
Even among adults with health care coverage, colon cancer screening and Pap test rates are lower in the foreign-born



¹ Among adults who have health care coverage. Percents are age-adjusted. Please see technical notes for descriptions of the questions that led to these results.
 * Source: NYC Community Health Survey, 2002, 2003
 ** Pap test among women who have not had a hysterectomy. Source: NYC Community Health Survey, 2002

Colon cancer screening is particularly low among adults from Guyana, Colombia, and Poland; fewer than 1 in 3 adults age 50 or older from these countries has ever had a colon cancer screening.

Some foreign-born New Yorkers have particularly low rates of colon cancer screening

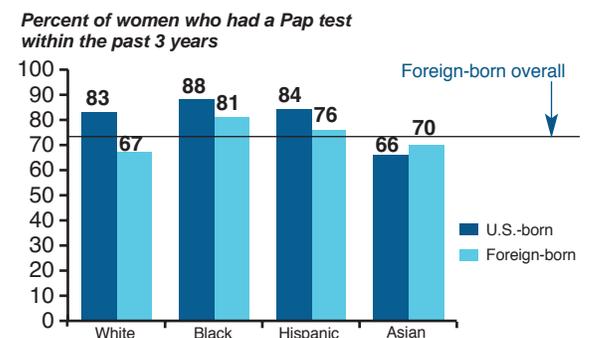


* Among countries with a sample size of 50 or more. Percents are age-adjusted. Please see technical notes for descriptions of the questions that led to these results.
 Source: NYC Community Health Survey, 2002, 2003

Adults born in Germany have the highest rate of colon cancer screening (66%).

White foreign-born women are less likely than white U.S.-born women to have had a Pap test in the past 3 years (67% vs. 83%), and data suggest that foreign-born black (81% vs. 88%) and Hispanic (76% vs. 84%) women are also less likely to have received a timely Pap test.

Many foreign-born women are less likely than U.S.-born women to be screened for cervical cancer



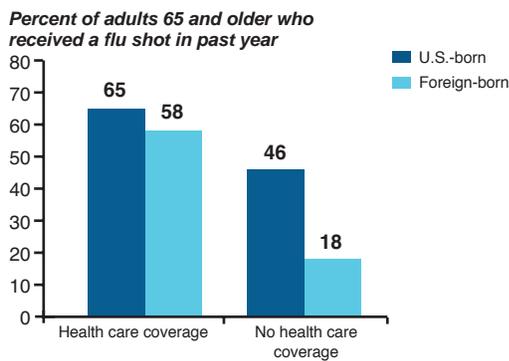
Percents are age-adjusted. Please see technical notes for descriptions of the questions that led to these results.
 Source: NYC Community Health Survey, 2002

Immunizations

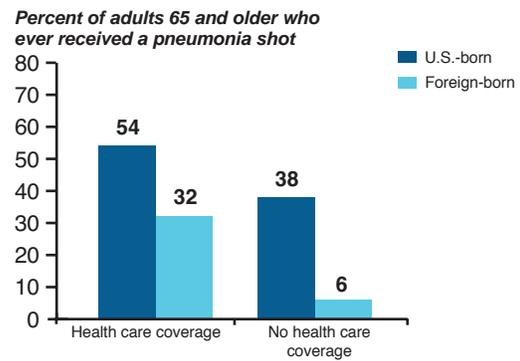
Immunizations can provide personal and population protection from influenza and pneumonia, and having the proper immunizations is one of the Take Care New York priority areas. The Take Care New York goal is that 80% of New Yorkers age 65 and older receive flu immunizations. The flu immunization rate among foreign-born New Yorkers age 65 and older is lower than that of the U.S.-born (57% vs. 65%). Foreign-born individuals age 65 and

older also have low rates of pneumonia immunization compared to the U.S.-born (31% vs. 54%). Having health care coverage dramatically increases flu and pneumonia immunization rates among the foreign-born. Those with insurance are 3 times more likely to have had a flu shot in the past year and 5 times more likely to have ever had a pneumonia shot, compared to those without insurance.

Insurance coverage dramatically increases flu and pneumonia immunization rates among foreign-born New Yorkers



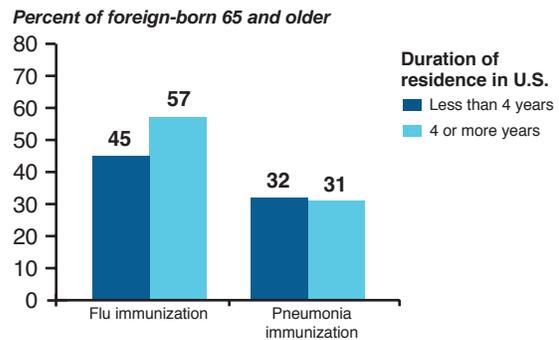
Survey respondents were asked: During the past 12 months, have you had a flu shot?
Source: NYC Community Health Survey, 2002, 2003



Survey respondents were asked: Have you ever had a pneumonia shot?
Source: NYC Community Health Survey, 2002, 2003

Data suggest that foreign-born New Yorkers who have lived in the U.S. for 4 or more years are more likely to have had a flu shot in the past year. Rates of pneumonia immunization do not vary with duration of residence in the U.S.

Duration of residence in U.S. matters for flu immunization

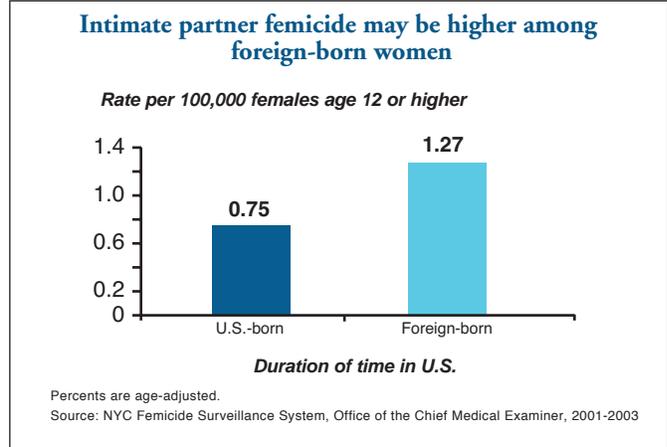


Survey respondents were asked: Have you ever had a pneumonia shot?
Source: NYC Community Health Survey, 2002, 2003

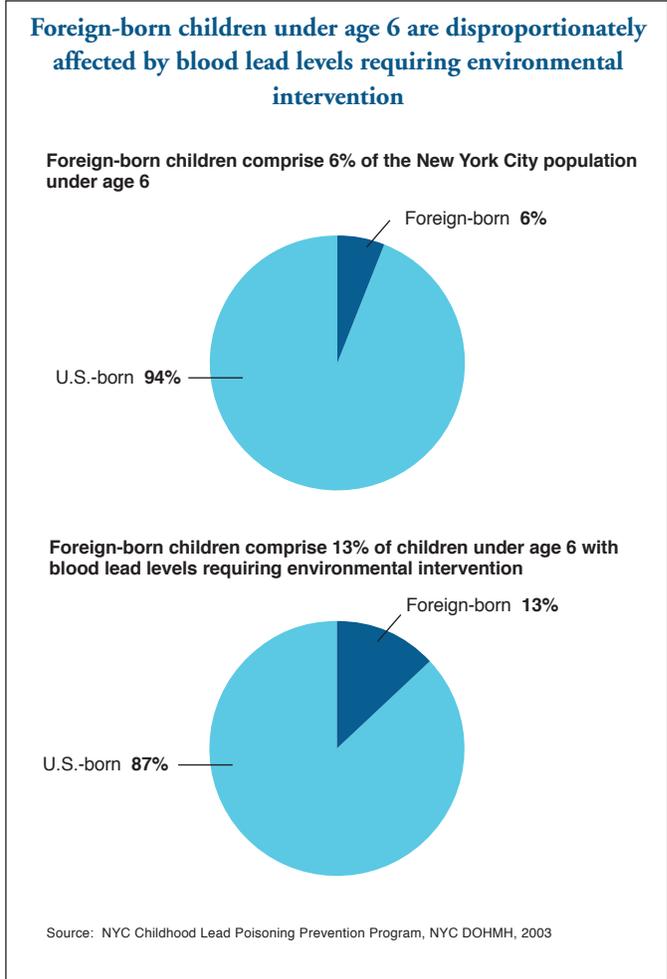
Healthy Home

Having a home free from violence is a Take Care New York priority area. Domestic violence is a major cause of injury and death among New York City women, but effective interventions for domestic violence can reduce assault, injury, and death. The Citywide rate of intimate partner femicide is 1.01 per 100,000 females age 12 and older, but data suggest that the rate is higher among those who are foreign-born (1.27 vs. 0.75 per 100,000 per year).

Femicide is defined as the killing of a female.



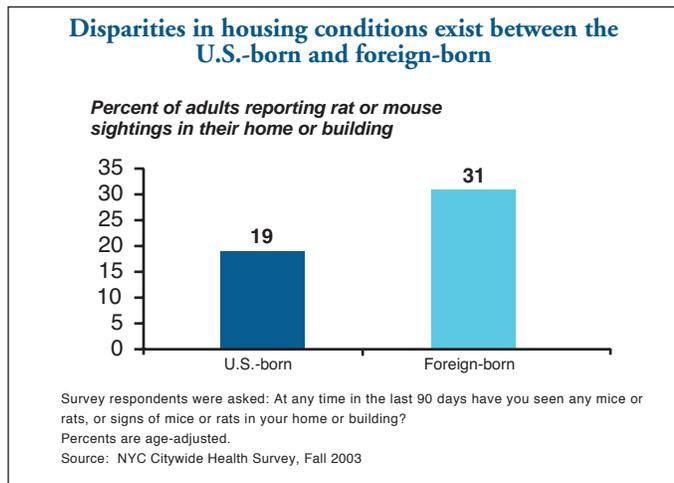
Lead poisoning can impair children’s health, learning, and behavior. The primary sources of lead poisoning in NYC children are peeling or damaged lead-based paint and dust. Other sources of lead exposure include imported food, pottery, cosmetics and traditional health remedies that contain lead. The Take Care New York goal is to reduce the number of children under age 6 with blood lead levels requiring environmental intervention by two thirds by 2008. Data suggest that foreign-born children have disproportionately high blood lead levels requiring environmental intervention. While children born abroad comprise 6% of all New York City children under age 6, they comprise 13% of all children under age 6 with blood lead levels requiring environmental intervention.



Blood Lead Level (BLL) — The concentration of lead in the blood, measured in micrograms (µg) of lead per deciliter (dL) of blood.

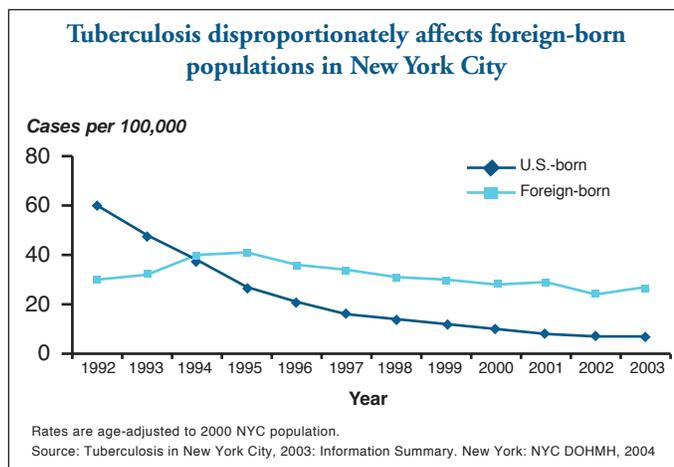
Blood Lead Level Requiring Environmental Intervention — The blood lead level at which NYC DOHMH provides environmental intervention services for poisoned children. In 2003 the EIBLL was one venous BLL ≥ 20 µg/dL or two BLLs of 15-19 µg/dL, taken at least 3 months apart.

Housing conditions affect health, and housing disparities exist between the U.S.-born and foreign-born. U.S.-born adults are less likely than foreign-born adults to see rats or mice in their home or building (19% vs. 31%).

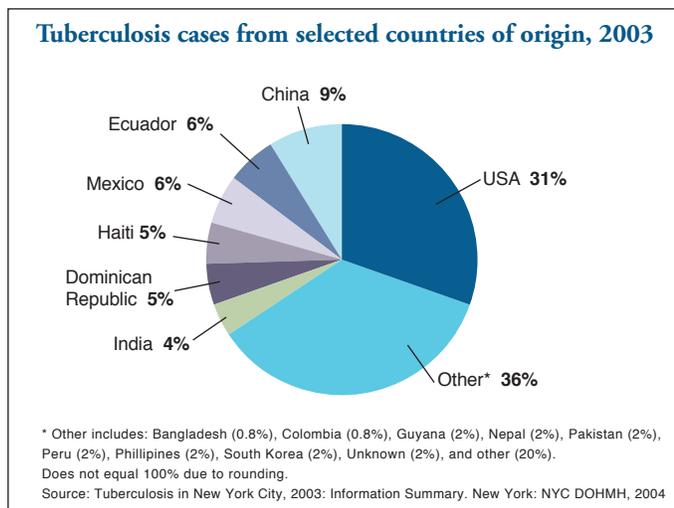


Tuberculosis

Significant progress has been made in decreasing the prevalence of tuberculosis in the U.S.-born population in the past decade, but a similar decrease has not been achieved in the foreign-born population. This has resulted in a widening disparity: an increasing proportion of new tuberculosis cases occurs among foreign-born New Yorkers, despite the fact that the rate of new tuberculosis cases among foreign-born New Yorkers has been stable over time. About two thirds of all tuberculosis cases in New York City now occur among the foreign-born. In 2003, the tuberculosis rate was nearly 4 times higher among foreign-born New Yorkers than among U.S.-born New Yorkers.

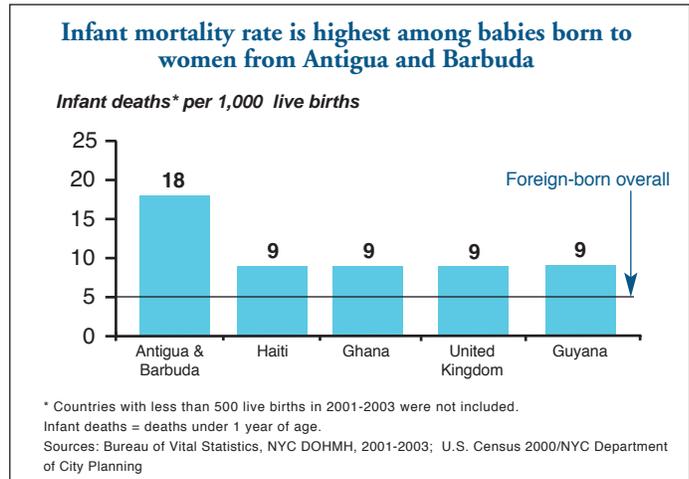


The rates of tuberculosis among individual communities vary greatly, often corresponding to the rates in countries of origin. Among foreign-born New Yorkers the largest number of tuberculosis cases in 2003 occurred among individuals born in China, Ecuador, Mexico, Haiti, the Dominican Republic, and India.



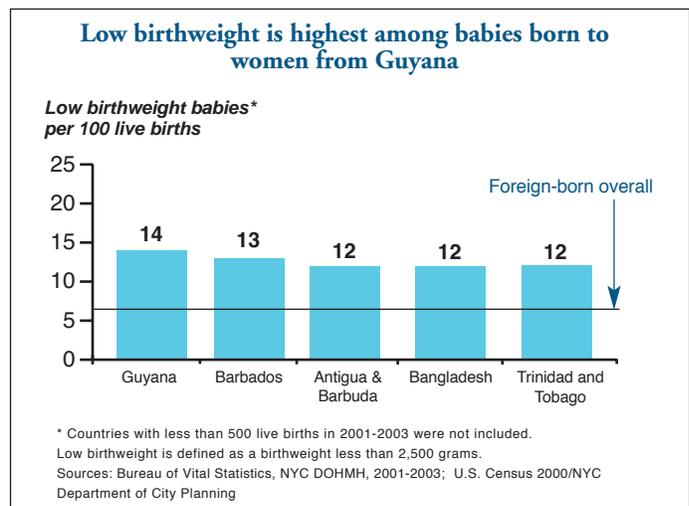
Infant and Maternal Health

Infant mortality is an important indicator of a population's health, and having a healthy baby is one of the Take Care New York goals. The 2001-2003 infant mortality rate was lower among infants born to foreign-born mothers than U.S.-born mothers (5 vs. 7 per 1,000 live births per year). However, differences in infant mortality exist within the foreign-born population. The infant mortality rate among babies born to mothers from Antigua and Barbuda is 3½ times higher than that of the foreign-born population as a whole and 2½ times higher than the U.S.-born population as a whole.



Babies born to mothers from Morocco, Turkey, and Uzbekistan have the lowest infant mortality rates (<1 per 1,000 live births/year).

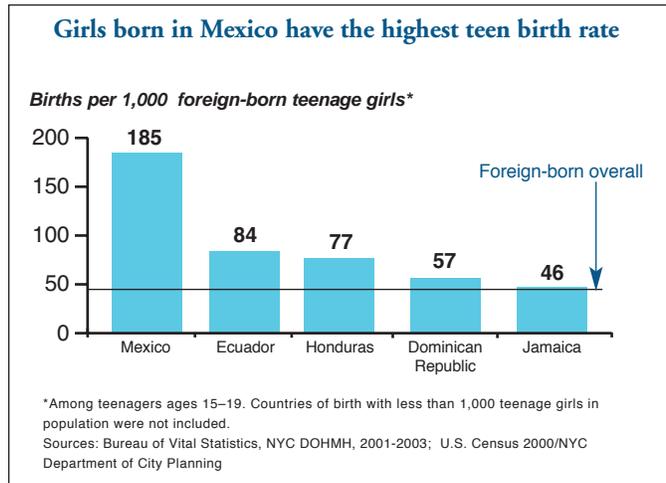
Low birthweight is a weight of less than 2,500 grams at birth. It is a major risk factor for infant mortality, as well as serious health challenges and long-term disabilities. Newborns of foreign-born mothers have lower rates of low birthweight than infants of U.S.-born mothers (7 vs. 10 per 100 live births per year). Data suggest that infants of mothers born in Guyana have the highest rate of low birthweight, compared to infants of mothers born in other countries.



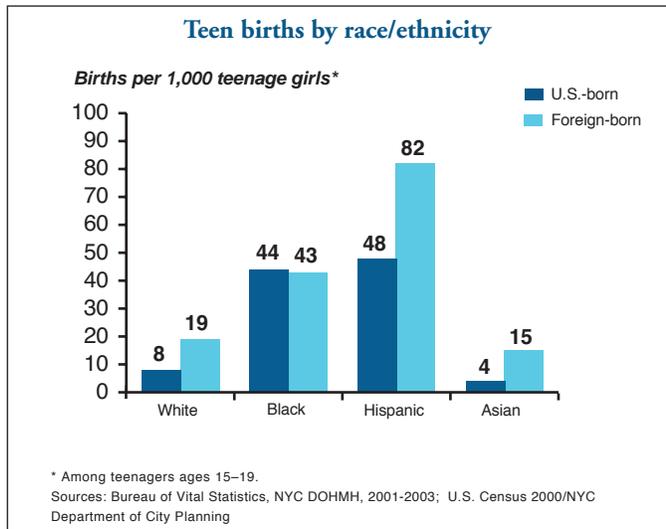
Teen pregnancies and births can indicate unintended pregnancy and less safe sexual behavior, and children born to teen mothers are at increased risk for poor health. The overall teen birth rate continues to decline in New York City, but from 2001 through 2003 the teen birth rate among foreign-born girls was higher than that of U.S.-born girls (45 vs. 32 per 1,000 teen girls per year).

Among foreign-born girls, the highest teen birth rates were seen among girls born in Latin American countries. The teen birth rate was highest among girls born in Mexico, which has a rate more than 2 times higher than the country with second highest rate, Ecuador, and about 4 times higher than the rate in the overall foreign-born population.

Teen birth rates also vary by race/ethnicity. The teen birth rate is highest among Hispanic foreign-born girls (82 per 1,000 teen girls per year), which is higher than the rate among Hispanic girls who are born in the U.S. (48 per 1,000 teenage girls per year). Rates are also higher among the foreign-born for both white (19 vs. 8 per 1,000) and Asian (15 vs. 4 per 1,000) teenage girls. The rates of teen births among black girls do not vary by foreign-born or U.S.-born status (43 vs. 44 per 1,000 teenage girls).



Girls born in Hong Kong have the lowest teen birth rate (<1 per 1,000 per year).



Conclusions

The health of immigrants increasingly characterizes the health of New York City. Forty-four percent of New York City adults are foreign-born, and demographic trends indicate that the number of foreign-born residents will continue to rise. One challenge that many foreign-born New Yorkers face is access to health care. As seen in this report, foreign-born New Yorkers are less likely to have insurance and a primary care provider than U.S.-born New Yorkers. They are also more likely to use an emergency department as their usual place of care and to report difficulty getting needed care, compared to U.S.-born New Yorkers.

While the ability of foreign-born New Yorkers to access health care is linked to health care coverage, improving health insurance coverage does not fully guarantee equal access to care and better health. Findings from this report underscore other factors that also influence access to care among foreign-born New Yorkers, including country of birth, English language use, and duration of residence in the United States. There are many mechanisms through which these factors may influence health, including birth culture, acculturation, quality of care, access to housing, and citizenship status. A more complete understanding of these factors among foreign-born populations can aid in focusing health promotion programs and messages.

In part due to access disparities, foreign-born adults use preventive services less. In particular, foreign-born adults are less likely to receive screening for high blood pressure, high cholesterol, colon cancer, and cervical cancer (Pap tests), compared to the U.S.-born. Foreign-born New Yorkers age 65 and older also have lower rates of influenza and pneumonia immunizations. Heart disease, cancer, and stroke are responsible for the largest number of years of potential life lost. Increasing

the use of preventive care services by this group could reduce avoidable illness and death.

The foreign-born population appears healthier than those born in the U.S. on some measures, including smoking, obesity, infant mortality, low birthweight, and new HIV diagnoses. As this report has shown, however, foreign-born adults are a diverse group, and each subgroup has a distinct health profile. In order to understand the health of immigrants, we must consider not only differences between those who are foreign-born and U.S.-born, but also differences among sub-groups of the foreign-born. For example, death rates from influenza/pneumonia and diabetes are lower among foreign-born adults than U.S.-born adults. However, data suggest that foreign-born adults from Mexico have a higher death rate from influenza/pneumonia, and those from Guyana have a higher death rate from diabetes, compared to the U.S.-born. Similarly, while foreign-born New Yorkers are less likely to smoke than their U.S.-born counterparts, smoking rates among Russian men are comparable to those among U.S.-born men.

Health indicators among the foreign born also vary with duration of residence. Understanding these variations may provide insight into the future health challenges of this population. While foreign-born New Yorkers who have lived in the U.S. for 4 or more years are more likely to have health insurance and receive flu shots than more recent arrivals, data suggest that they are also more likely to report fair or poor health and to be obese. This suggests that health care access and utilization may be easier to improve than health outcomes. The goal of this report is to improve the understanding of the health needs of the foreign-born and move New York City closer to meeting the unique needs of this growing population, both now and in the future.

Recommendations

Improve Access to Health Care

One way to increase utilization of care among foreign-born New Yorkers is to improve their access to care, which can be complicated by citizenship and immigration status. Immigrants, however, may be eligible for many public programs, such as Medicaid, Child Health Plus (CHP), Prenatal Care Assistance Program (PCAP), and Family Health Plus. Additionally, community health clinics treat all patients, regardless of immigration status. City agencies, non-profit organizations, and health care providers must all play a role in helping to connect immigrants to these resources.

Address Cultural and Language Barriers

Multiple outreach strategies are necessary to meet the diverse backgrounds and needs of foreign-born New Yorkers. Culturally appropriate health-related materials in commonly spoken languages should be made available to the immigrant population. Also, language translation, through trained interpreters, should be made available to those who cannot communicate with their providers in English. Local Law 73 mandates that people eligible for social services through City agencies receive them without discrimination based on the language they speak. However, non-City agencies may not have such mandates. All health care providers should be trained to be culturally competent and to access culturally appropriate materials and interpreters. Finally, foreign-born New Yorkers should be educated about how to interact with the local health care system in order to maximize their own health care.

Inform the Undocumented

Because of fears of exposure and deportation, undocumented adults may avoid preventive health care

or refuse to seek necessary treatment. Thus, they may fail to get optimal levels of care. Undocumented immigrants are also at increased risk of coercion by individuals willing to exploit their situation for economic or other gain. Executive Order 41 protects the privacy of immigrant New Yorkers. City agencies and employees are not permitted to ask about immigration status, except in unusual cases. If immigration status is disclosed, it may not be reported to anyone, except when required by law. Educating immigrants about these protections and ensuring compliance with them are essential to engaging all New Yorkers in the health care system.

Target Resources and Interventions

The health of foreign-born New Yorkers can vary widely. By targeting resources and interventions to subgroups of the foreign-born population most at risk, health care providers may have the greatest positive impact on health in this group and citywide. For example, since foreign-born New Yorkers who do not speak English are much more likely to seek health care at the emergency department, improving their access to preventive care may not only improve the care they receive, but also reduce excess burden and cost to the health care system. Another component of reaching those at greatest risk is understanding that sub-groups of foreign-born New Yorkers are at increased risk for different health behaviors and outcomes. Health care and public health professionals should be aware of the risk profiles of individuals whom they strive to serve. For example, Russian and Chinese men are much more likely to smoke than Russian and Chinese women. Targeting messages to these subgroups is likely to increase the chances of improving their health.

Notes

Notes

Technical Notes

For more information

For more information, please call 311, visit nyc.gov/health, e-mail immigranthealth@health.nyc.gov, or write to The Health of Immigrants in NYC, New York City Department of Health and Mental Hygiene, Division of Epidemiology, 125 Worth Street, Room 315, CN-6, New York, NY 10013.

Data sources

Population (sex, race/ethnicity, education, country of birth, age, household income): New York City Department of City Planning/Census data; mortality*, years of potential life lost, births to teens, low birthweight, infant mortality: NYC DOHMH/Office of Vital Statistics; languages spoken in New York City, duration of U.S. residence, self-reported health status, health insurance coverage status, having a regular primary care provider, access to medical care, usual place of care, cancer screening, blood pressure and cholesterol screening and levels, influenza immunization, pneumonia vaccination, HIV testing, obesity, diabetes, emotional distress: NYC DOHMH/Division of Epidemiology/NYC Community Health Survey, 2002, 2003; smoking: NYC DOHMH/Division of Epidemiology/NYC Community Health Survey, 2003, NYC Citywide Health Survey, Fall 2003; tuberculosis: NYC DOHMH Bureau of Tuberculosis Control; new HIV diagnoses: NYC DOHMH HIV Surveillance and Epidemiology Program; domestic violence: NYC Femicide Surveillance System, Office of the Chief Medical Examiner, 2001-2003; lead: NYC Childhood Lead Poisoning Prevention Program, 2003, NYC DOHMH.

* All mortality data include deaths that occurred within New York City.

Prevention/health behavior questions

Mammogram: "Have you ever had a mammogram? If yes, how long has it been since your last mammogram?"

Pap test: "Have you ever had a Pap smear? If yes, how long has it been since your last Pap smear?"

Colon cancer screening: "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted into the rectum to view the bowel for signs of cancer or other health problems. Have you ever had either of these exams?"

HIV test: "Have you had an HIV test during the past 12 months? Do not count any test you may have had as part of a blood donation. During the past 12 months, with how many men have you had sex? During the past 12 months, with how many women have you had sex?"

Country of birth analyses

The leading causes of death are presented for the countries with the largest populations of immigrants in New York. In the rest of the report, the countries chosen represent the highest or lowest prevalence of the variable of interest. In both cases, certain restrictions were applied to maximize the stability of the estimates (restrictions vary depending on the size of the data set and the prevalence of the condition). Mortality rates are presented for countries with a population of 1,000 or more in New York City, with 50 or more events (deaths). Analyses using the NYC Community Health Survey are presented only for countries with sample sizes of 50 or more in the survey data. New HIV diagnoses rates are presented for countries that had at least 10 diagnoses for which the HIV/AIDS reporting system (HARS) and the U.S. Census country codes could be matched. Low birthweight data are provided for countries with at least 500 live births. Teen birth data are provided for countries with at least 1,000 teenage girls in the population.

Language spoken analyses

In the overview section, "only English spoken at home" was defined using the question, "Does this person speak a language other than English at home?" in the 2000 census. In all other sections of the report, language spoken was defined by the language in which the NYC Community Health Survey was conducted.

Analyses and Adjustments

Except in the case of age-specific analyses, all analyses are age-adjusted. Age-adjusted Community Health Survey analyses were standardized to the U.S. Census 2000. Age-adjusted tuberculosis analyses were standardized to the 2000 NYC census population. All other age-adjusted analyses were standardized to the U.S. Standard Population, July 2000. Percentages have been rounded to the nearest whole number. All analyses were conducted by the Bureau of Epidemiology Services, NYC DOHMH, except for analysis of tuberculosis, HIV/AIDS, and lead.

Suggested citation

Kim M, Van Wye G, Kerker B, Thorpe L, Frieden TR. The Health of Immigrants in New York City. New York: New York City Department of Health and Mental Hygiene, 2006.

Acknowledgments

Thanks to the following individuals who contributed to this report: Sonia Angell, Drew Blakeman, Donna Eisenhower, Jennifer Edwards, Jennifer Ellis, Jennifer Fuld, Chris Goranson, Kelly Henning, John Jasek, Deborah Kaplan, Adam Karpati, Elizabeth Kilgore, Kevin Konty, Vani Kurup, Fabienne Laraque, Kenneth Lo, Robert Lopez, Cortnie Lowe, Xiaowu Lu, Catherine Maulsby, Marjorie McMeniman, Tina McVeigh, Farzad Mostashari, Sandra Mullin, Sonal Munsiff, Sara Perl, Chitra Ramaswamy, Lloyd Sederer, Lynn Silver, Tejinder Singh, Catherine Stayton, Parisa Tehranifar, Joyce Weinstein, Ellen Wiewel, and Jane Zucker.

Support for this publication was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff. The Department of Health and Mental Hygiene would like to acknowledge the assistance of the Fund for Public Health in New York (FPHNY). FPHNY is a non-profit organization working in partnership with the New York City Department of Health and Mental Hygiene, enhancing innovation, efficiency, and resources in service of a healthy New York.

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