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Immigrants' health by type of integration policies in Europe. A test with EU-SILC

Davide Malmusi, with Aitor Domínguez-Aguayo, Laia Palència, Carme Borrell

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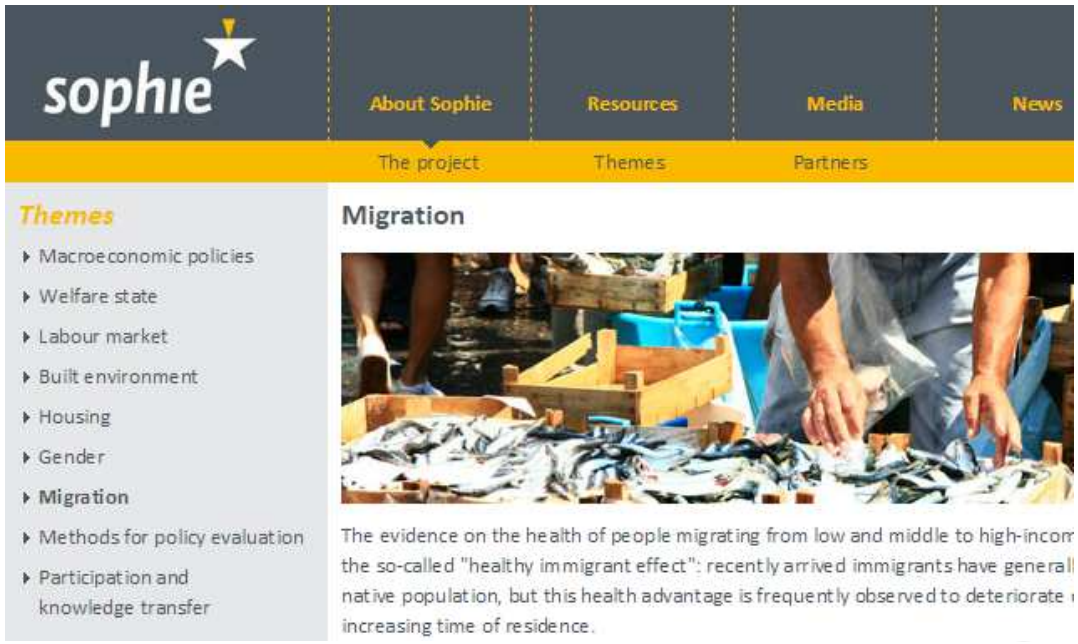
SOPHIE project

Acronym for “Structural Policies and Health Inequalities Evaluation”. Funded by EU FP7 (Nov. 2011 - Oct. 2015). *www.sophie-project.eu*

SOPHIE aims to generate new evidence on the health equity impact of social and economic policies and to develop innovative methodologies for the evaluation of these policies in Europe



Background

“Social determinants of health” and “health inequalities”

The chances of illness and premature death are unequally distributed between social groups: country and area of residence, gender, social class, ethnicity…

These avoidable health inequalities arise from the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

World Health Organization

World Health Organization. Social determinants of health – Key concepts.

Background

Immigrants' health

Immigrants from less to more advanced countries:

- "healthy immigrant effect" vanishing over time…[1, 2]
- … resulting in poorer health than natives, explained by poorer socio-economic conditions and discrimination[3, 4]

Do immigration policies, that influence these factors, have an impact on immigrants' health?

Little knowledge so far – mainly studies on single policy cases, outside Europe, on control policies and undocumented migrants [5]

1 Fernando G De Maio. Immigration as pathogenic… Int J Equity Health 2010
2 Marie Norredam et al. Duration of residence and disease occurrence… Trop Med Int'l Health 2014
3 Vincent Lorant et al. Contextual factors and immigrants' health… Health & Place 2008.
4 Sarah Missinne et al. Depressive symptoms among immigrants… Soc Psychiatry Psychiatr Epidemiol 2012
5 Omar Martinez et al. Evaluating the impact of immigration policies… J Immigr Minor Health 2013

Background

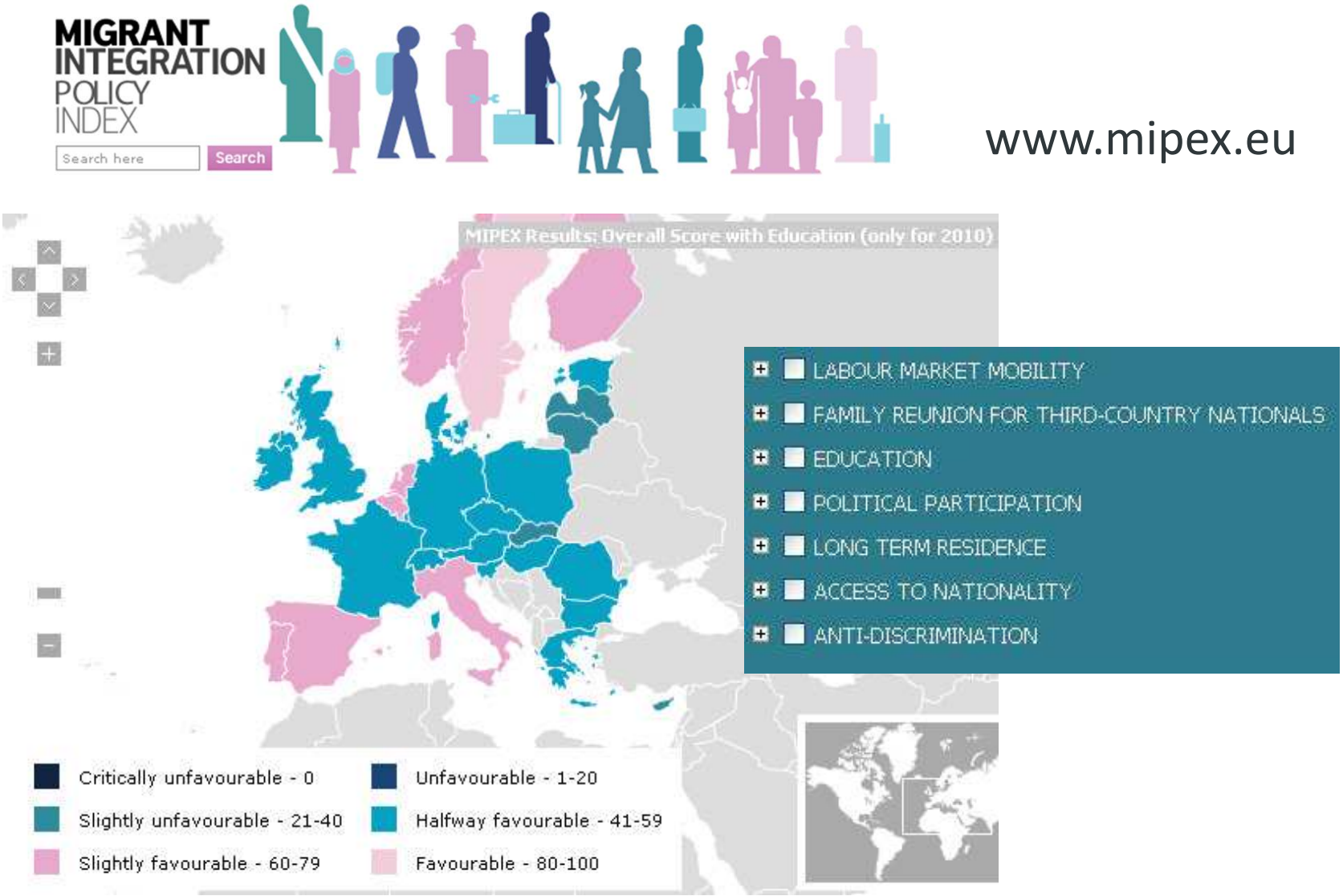
Immigrants' health. Cross-country comparisons

Emerging cross-country analyses of mortality of immigrants with similar origins[1,2] not yet linked to integration policy context

Attempts in maternal[3] and perinatal[4] health using naturalisation rates as integration policy indicator

"Migrant Integration Policy Index" (MIPEX) overall score not associated with immigrants' depression[5]

1 Jacob Spallek et al. Cancer mortality patterns among Turkish immigrants… Eur J Epidemiol 2012
2 Snorri B Rafnsson et al. Sizable variations in circulatory disease mortality… Eur J Public Health 2013
3 Paola Bollini et al. Pregnancy outcome of migrant women and integration policy… Soc Sci Med 2009
4 Sarah F Villadsen et al. Cross-country variation in stillbirth and neonatal mortality… Eur J Public Health 2010
5 Katia Levecque et al. Depression in Europe: does migrant integration have mental health … Ethn Health 2015



Do current scores reflect policies that settled immigrants have experienced? Are all dimensions equally relevant for health?

Background

Integration “regimes”

Three historical policy models have been described based on legal and cultural rights:[1,2]

- **Multicultural**: facility to acquire citizenship (*ius soli*), tolerance of cultural difference. *UK, Netherlands, Sweden*

- **Differential exclusionist**: migrants as “guest workers”, low tolerance, citizenship based on ancestry. *Germany*

- **Assimilationist**: facility to acquire citizenship, but cultural manifestations should be private. *France*

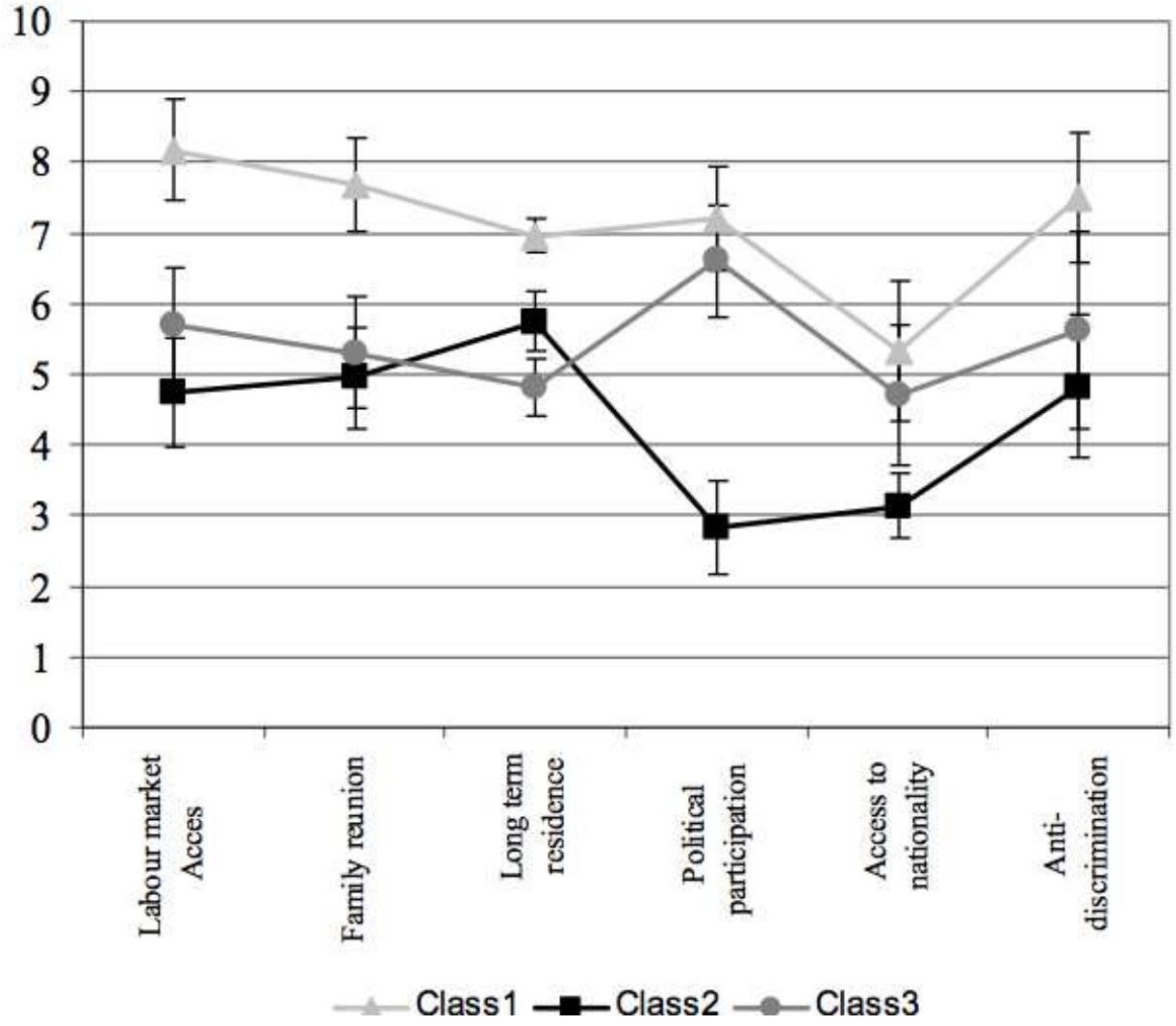
Increasing policy convergence of EU countries with historically different approaches.[3,4]

1 Stephen Castles. How Nation-States respond to immigration… New Community 1995
2 Steven Weldon. The institutional context of tolerance for ethnic… Am J Pol Sci 2006
3 Hans Mahnig et al. Country-specific or convergent? A typology… J Int Migr Integr 2000
4 Friedrich Heckmann et al. The Integration of Immigrants in European … Lucius&Lucius 2003

Background

A “data-driven” policy typology

MIPEX 2007 Latent Class Analysis. Bart Meuleman 2009 (Dissertation)



Inclusive (multicultural)

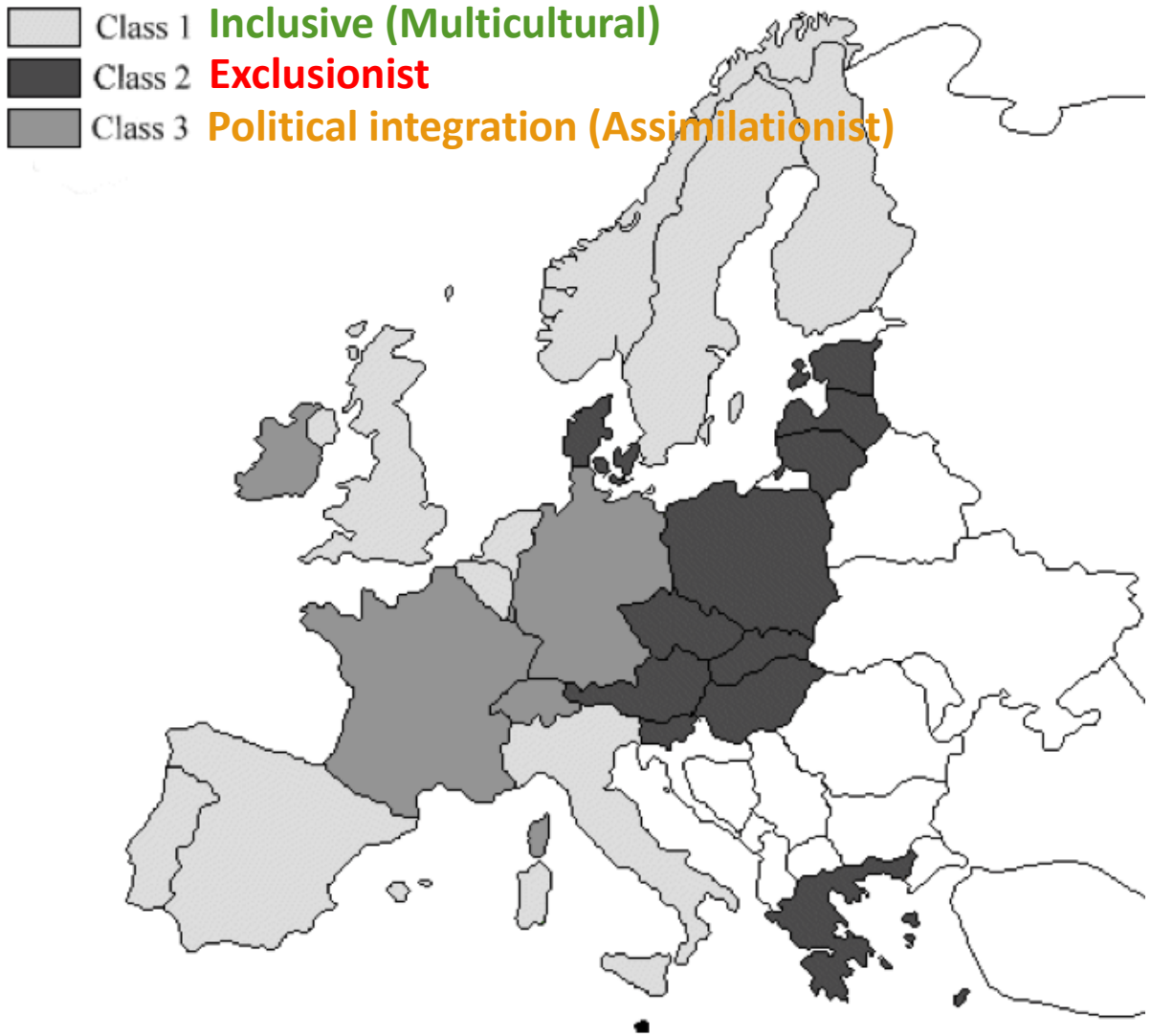
Political integration (assimilationist)

Exclusionist

Background

A “data-driven” policy typology

MIPEX 2007 Latent Class Analysis. Bart Meuleman 2009 (Dissertation)



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doi:10.1093/eurpub/cku156

Immigrants' health and health inequality by type of integration policies in European countries

Davide Malmusi[1,2]

Objective: To analyse the differences across European countries with different integration policies:

- in immigrants' self-rated health
- in self-rated health inequalities between natives and immigrants,

and the contribution of socio-economic conditions to such differences.

Methods

Data source: EU-SILC 2011 cross-sectional database

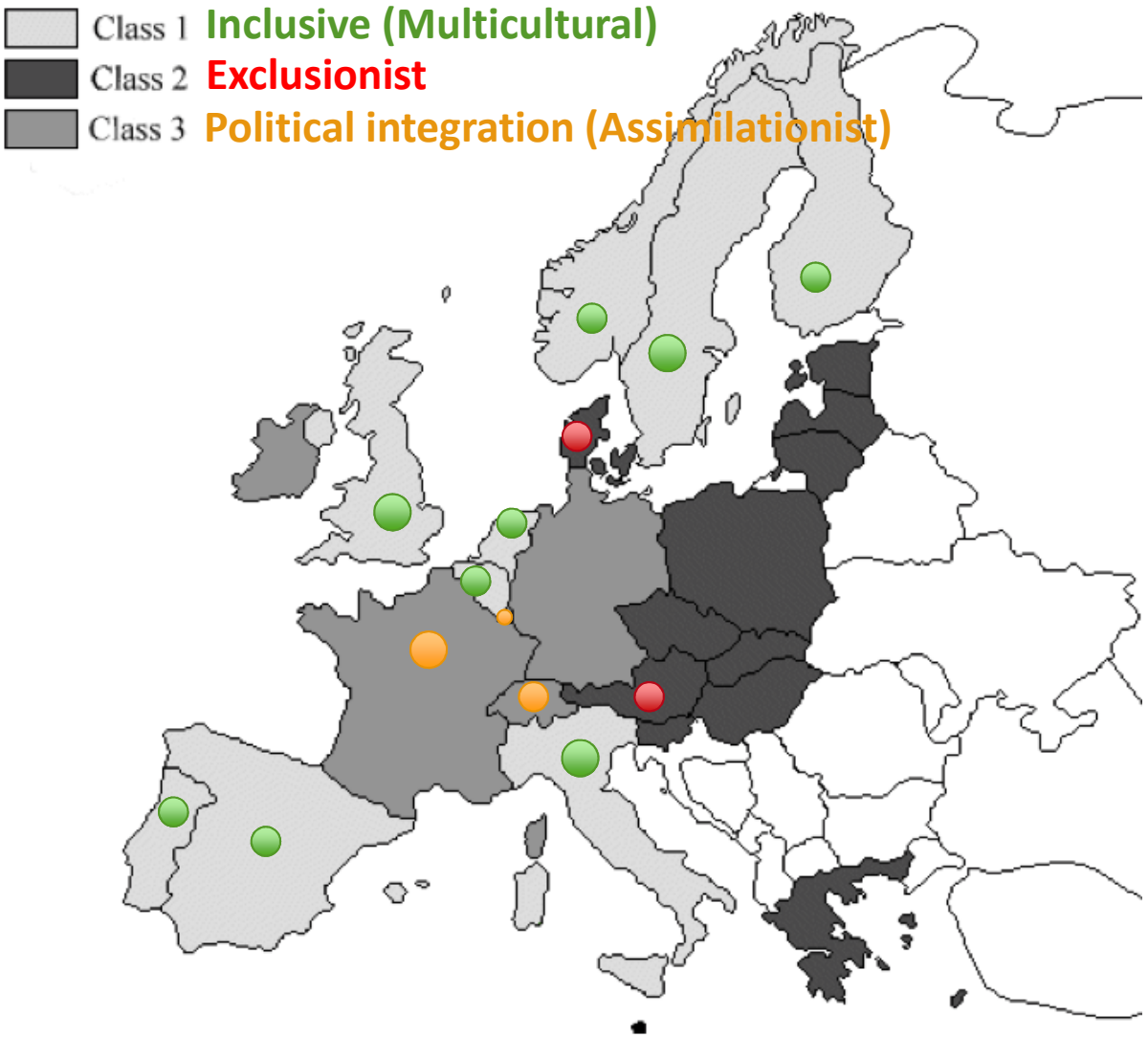
Study population: individuals aged 16 or over

14 countries included: UK NL BE SE NO FI IT ES PT CH FR LU AT DK

16 countries excluded: *No data in the 2013 release:* EL, IE.
Not classified in the typology: BG, CY, HR, RO.
<0.5% immigrants: HU, CZ, SK, PL.
Most "foreign-born" not really "foreign-born": LT.
Not separating EU and non-EU immigrants: DE, EE, LV, SI, MT.

Valid sample: 184,388 subjects (7,088 immigrants)

Countries included by integration regime



Methods. Variables

Dependent variables:

- Self-rated health (very good, good / fair, bad, very bad)
- Limiting longstanding illness
- Activity limitation because of health problems

Independent variables:

- Immigrant status: born in country of residence / born outside the EU with 10+ years of residence in the country (EU and recent immigrants excluded)
- Country of residence integration regime

Explanatory variables:

EU citizenship, Educational level, Occupational social class, Economic situation (equivalised household income quintile, material deprivation, ability to make ends meet, overcrowding)

Adjustment by age, stratification by sex

Methods. Analysis

Description of explanatory variables by integration regime, sex and immigrant status

Description of sample size and age-adjusted prevalence* of poor health by sex, country / integration regime and immigrant status

Estimation of prevalence ratios (PR) of poor self-rated health:**

- between migrants living in each regime
- for migrants versus natives within each regime

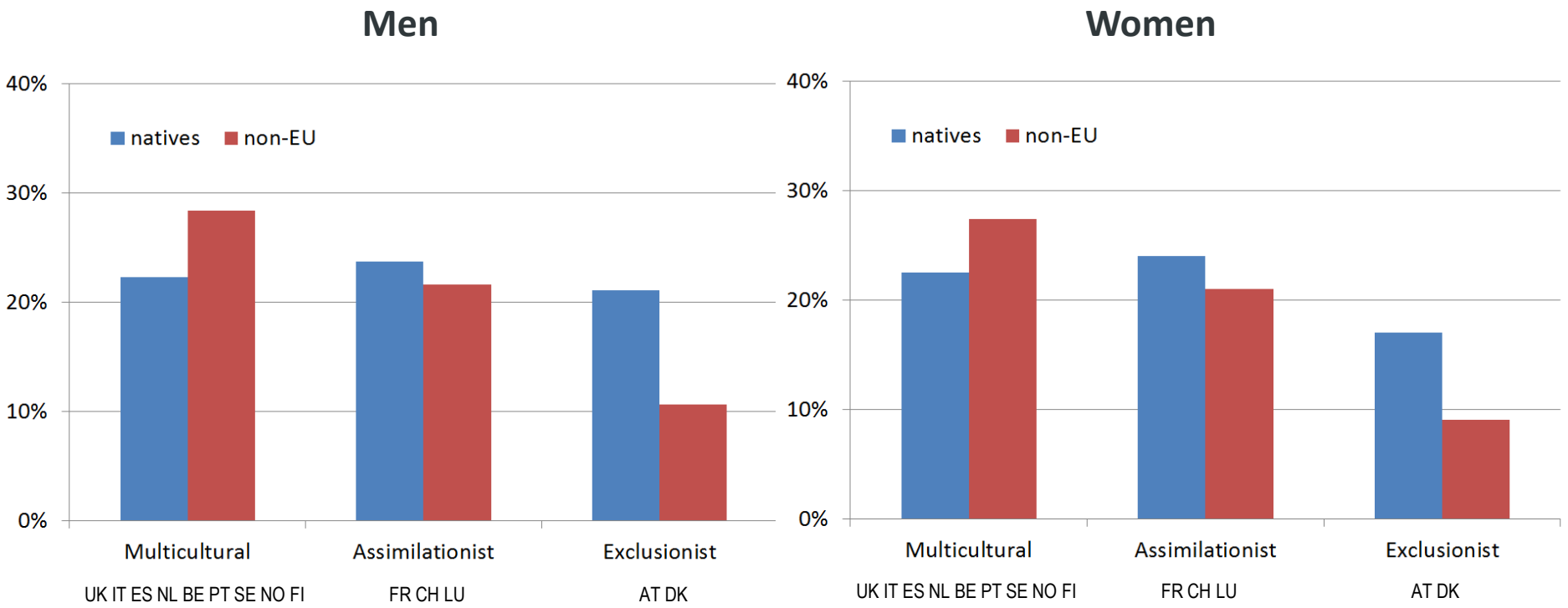
sequentially adjusting for age and explanatory variables

* Predicted probability post-estimation function of logistic regression

** Poisson regression with robust standard error

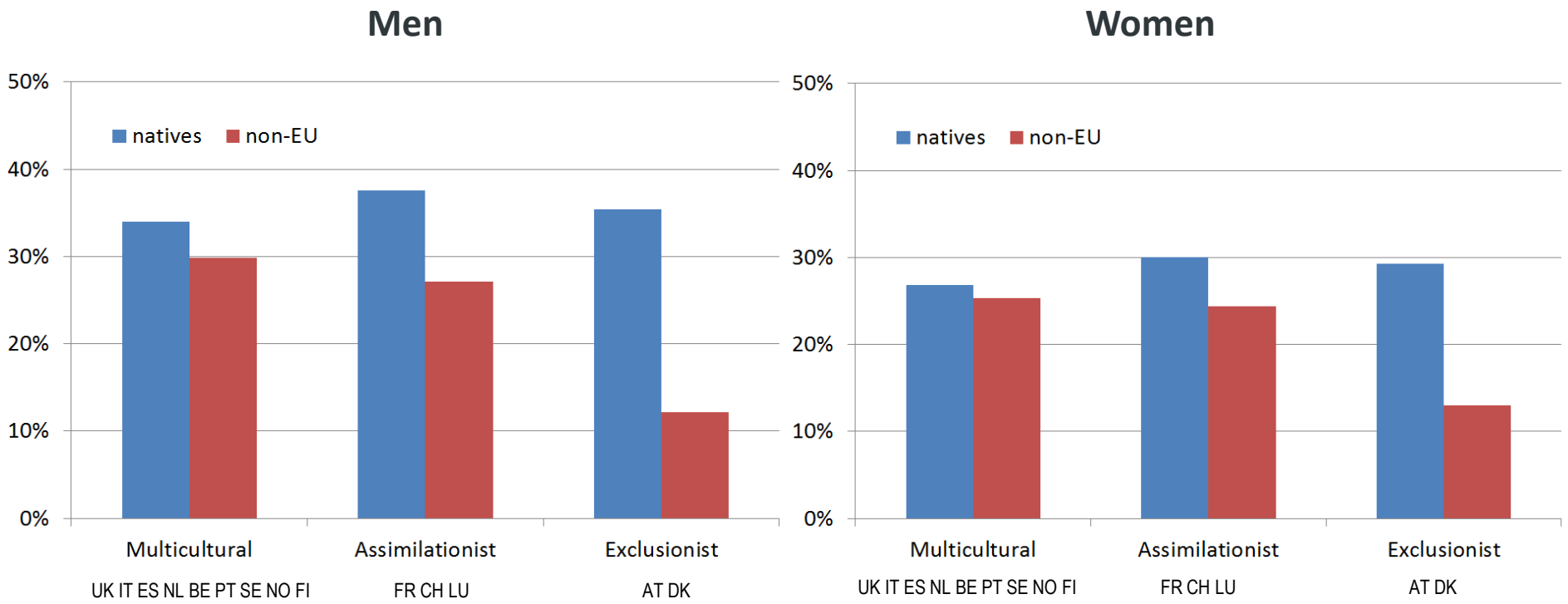
Results

Tertiary education (%)



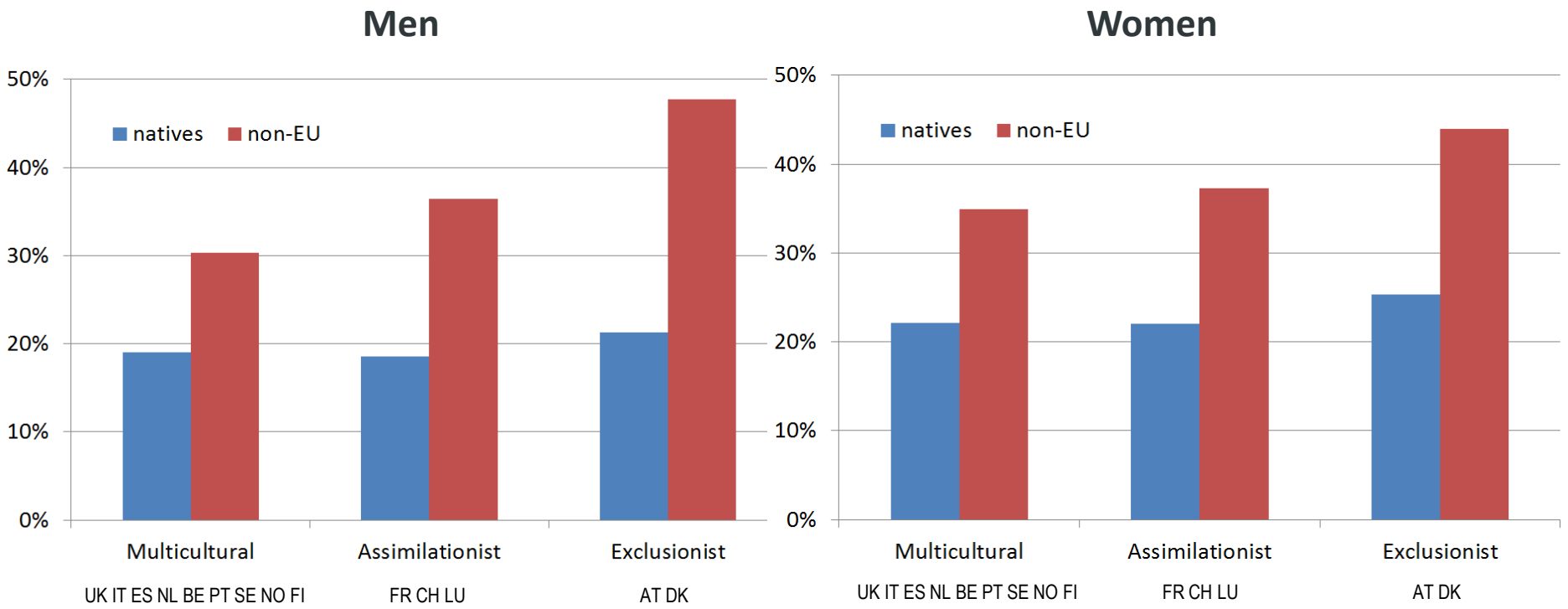
Results

Managerial, professional or technical occupation (%)



Results

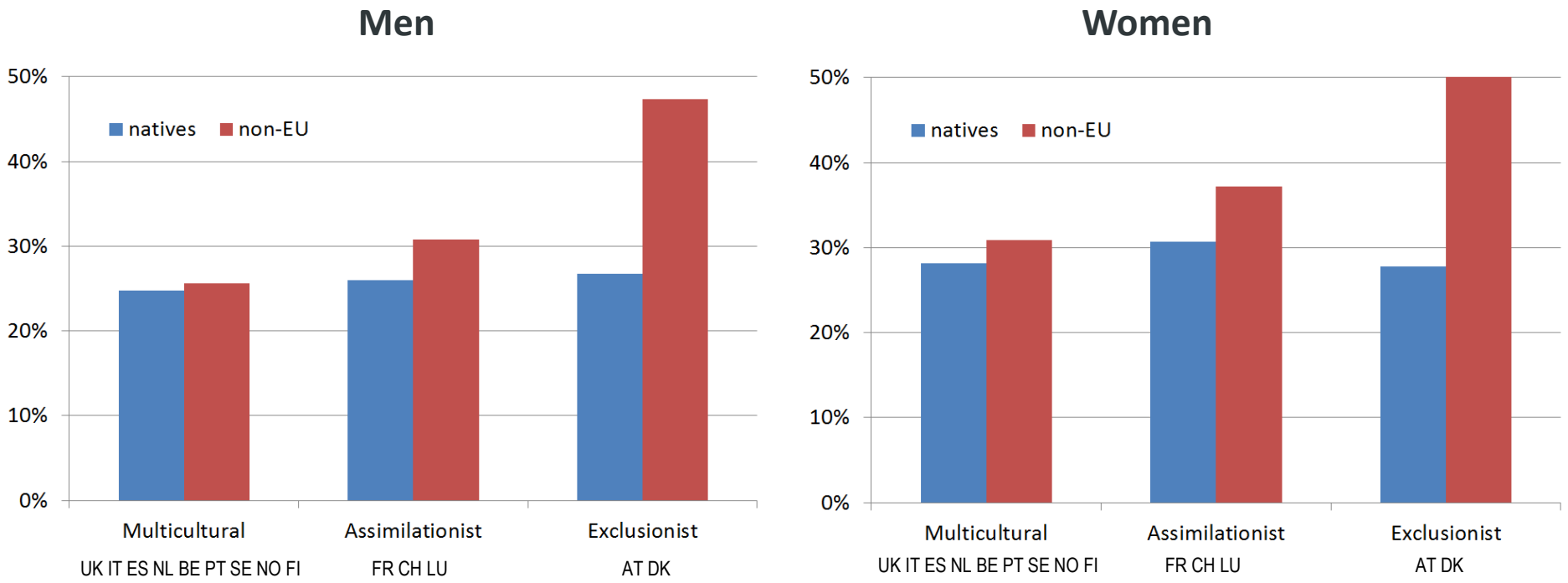
Household in the lowest income quintile (%)



Results

Poor self-rated health

Predicted prevalence at age 50 (%) *

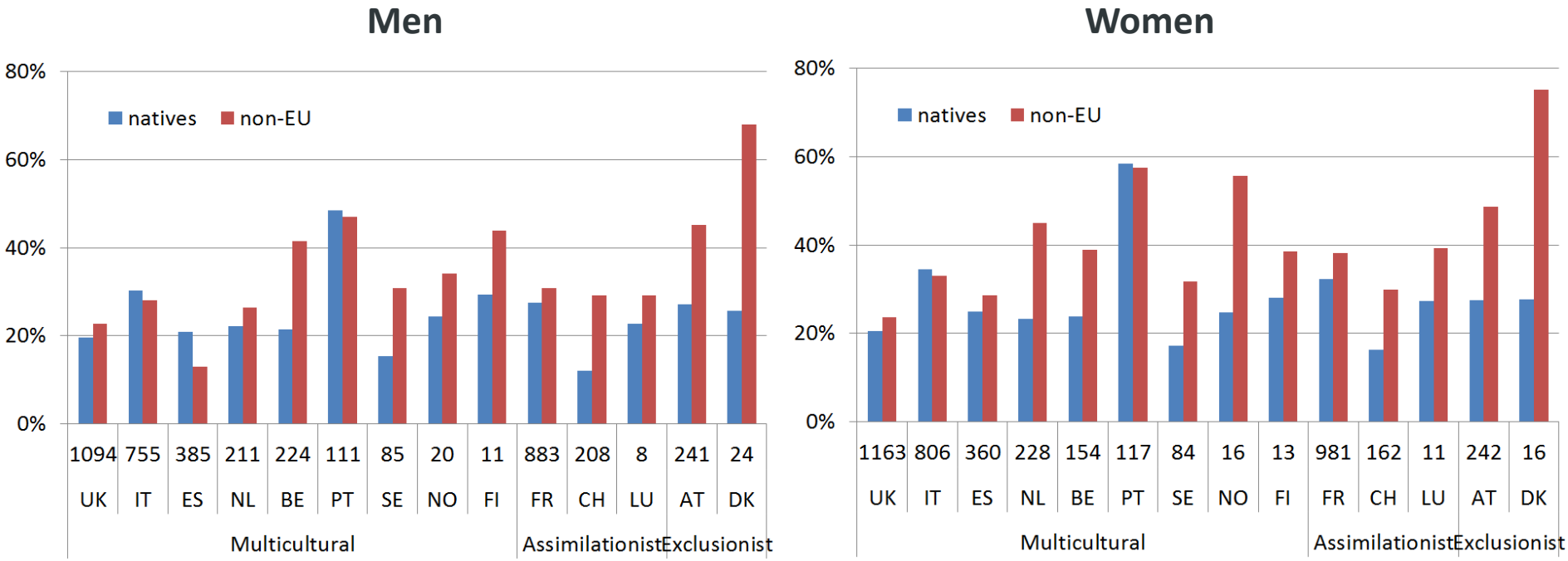


* Predicted probability post-estimation function of logistic regression

Results

Poor self-rated health. Country by country

Predicted prevalence at age 50 (%) *



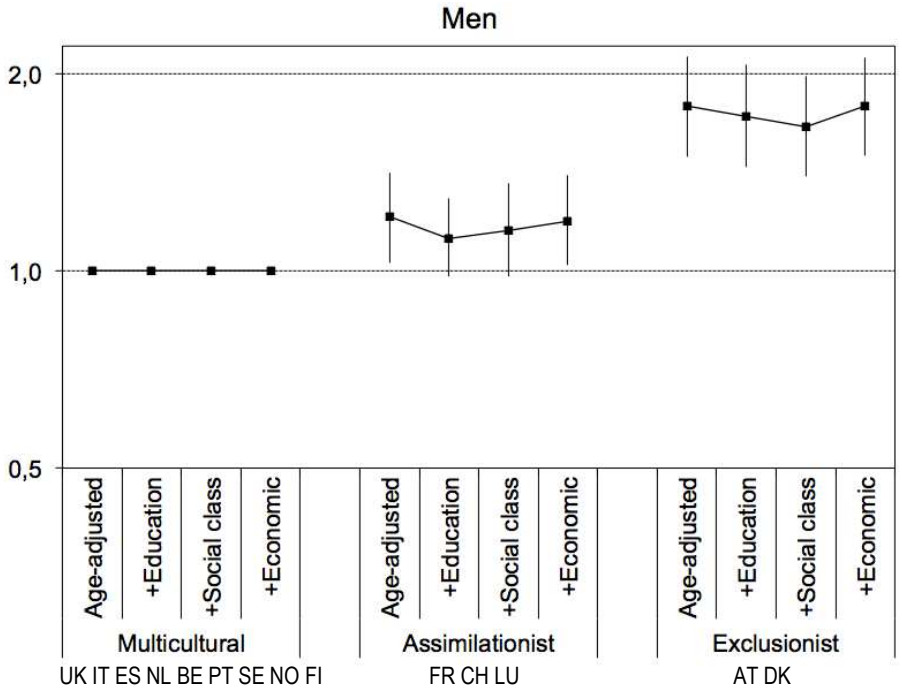
* Predicted probability post-estimation function of logistic regression

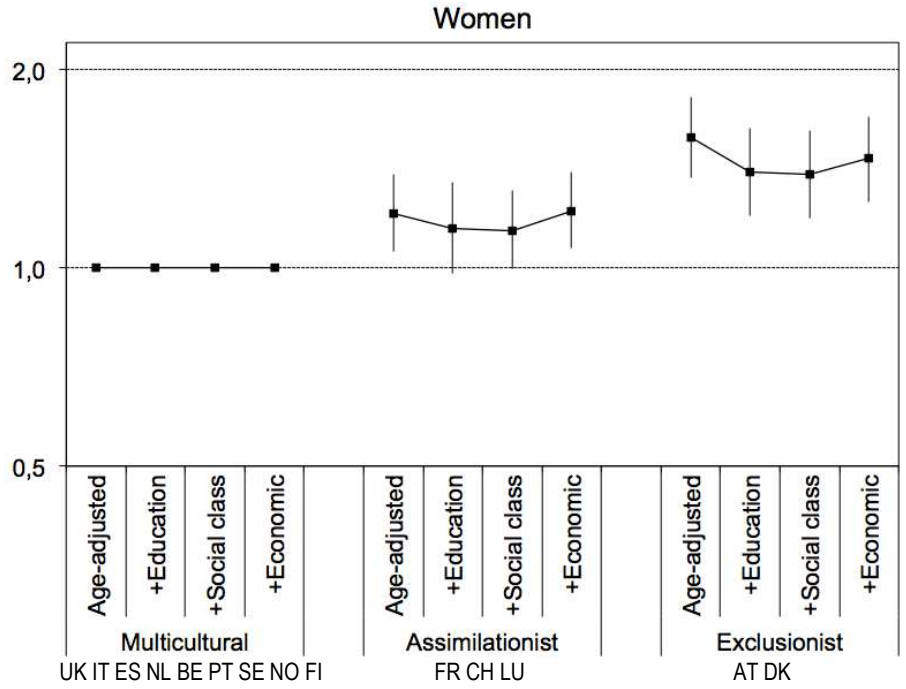
Numbers indicate immigrants' weighted sample size

Results

Immigrants between country types (ref. multicultural)

Poor self-rated health. Prevalence ratio with 95%CI **



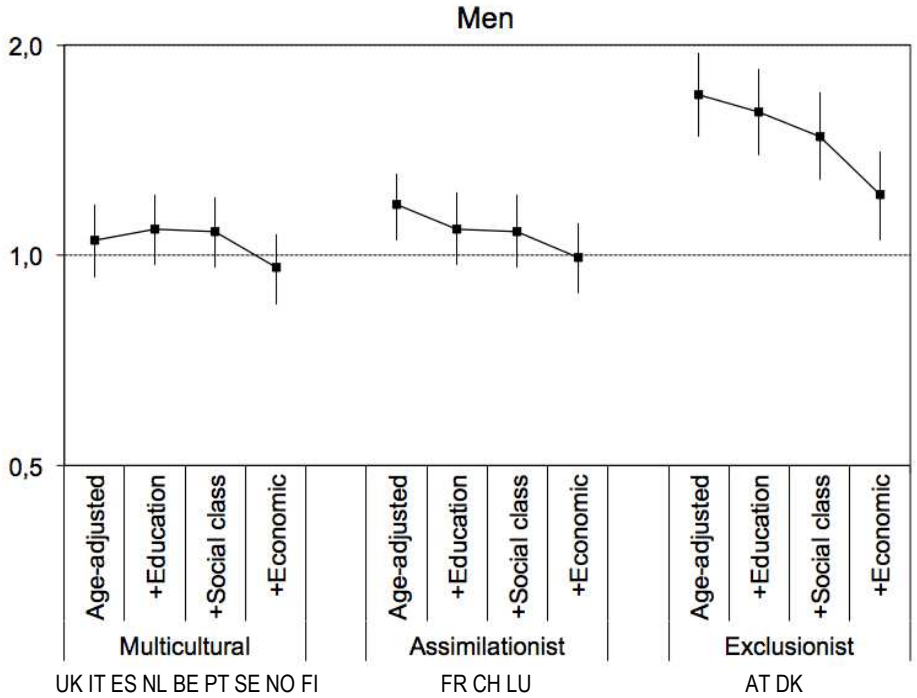


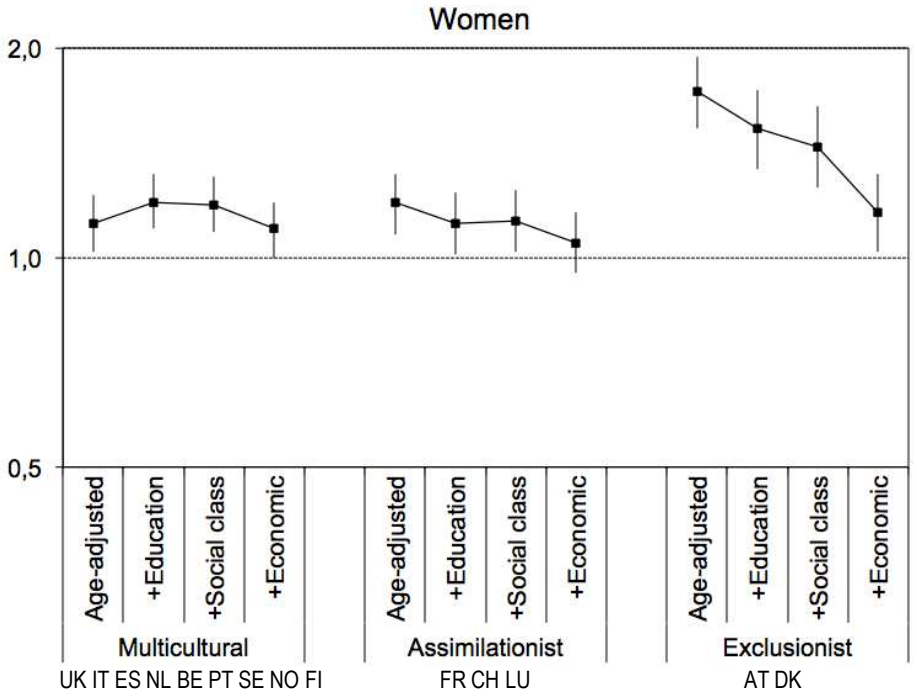
** Poisson regression with robust standard error

Results

Immigrants versus natives

Poor self-rated health. Prevalence ratio with 95%CI **





** Poisson regression with robust standard error

Discussion. Main results

First cross-country comparative study that tests the association of integration policy models with immigrants' health

Immigrants in all country groups experience poorer health than natives, fully or partly explained by socioeconomic conditions

Immigrants in countries with an "exclusionist" model experience worse health and more health inequality than in other countries, beyond what expected for their poorer socioeconomic conditions

Less conclusive* tendency to better migrants' health in "inclusive/multicultural" compared to "political integration/assimilationist"

* Differences reduced when adjusting for education, when omitting recent immigration countries,

Discussion. Limitations

Mixing together all non-EU migrants of different origins and reasons for migration

Single big countries driving results of regimes

Lack of separated data in some countries (e.g. Germany)

Limited participation/representativeness of immigrants?

Comparability of self-rated health across countries and origins

Conclusions

Integration policy models appear to make a difference on immigrants' health across Europe.

Immigrants living in "exclusionist" countries suffer larger socioeconomic segregation and poorer health.

Inclusive policies may have health benefits.

Adequate cross-country samples of migrants with similar origins are needed to confirm these results.

Next studies

Mortality MEHO database: higher mortality rate for Turkish and Moroccans living in DK than in NL and FR[1]

Depression and self-rated health, ESS 2012: inequalities larger in DK, CH. link to some MIPEX dimensions scores[2]

Unmet need for healthcare EU-SILC 2012 *Draft*

Future: Adolescents' health (HBSC), European Health Interview Survey 2013-15…?

1 Umar Ikram et al. Integration policies and immigrants' mortality… EUPHA 2014 conference. j.mp/ikram14

2 Davide Malmusi et al. Integration policy models in Europe… IMISCOE 2015 conference (forthcoming)

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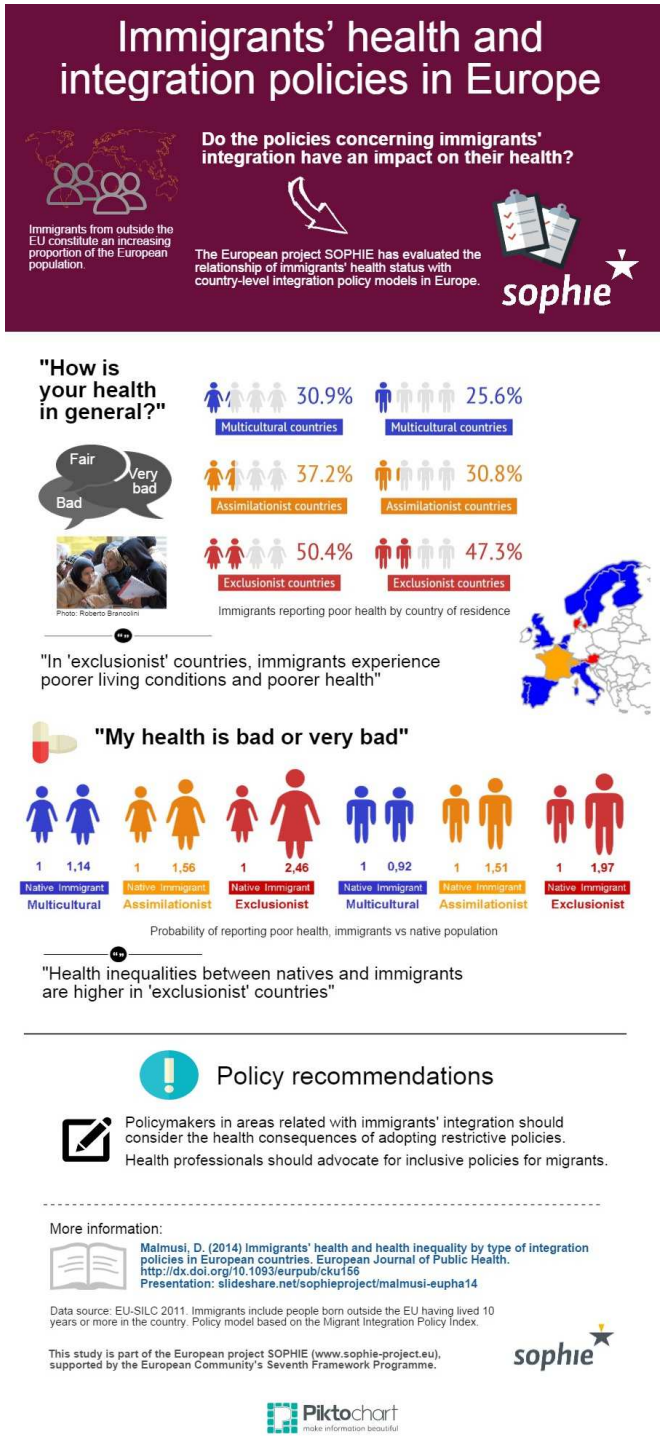


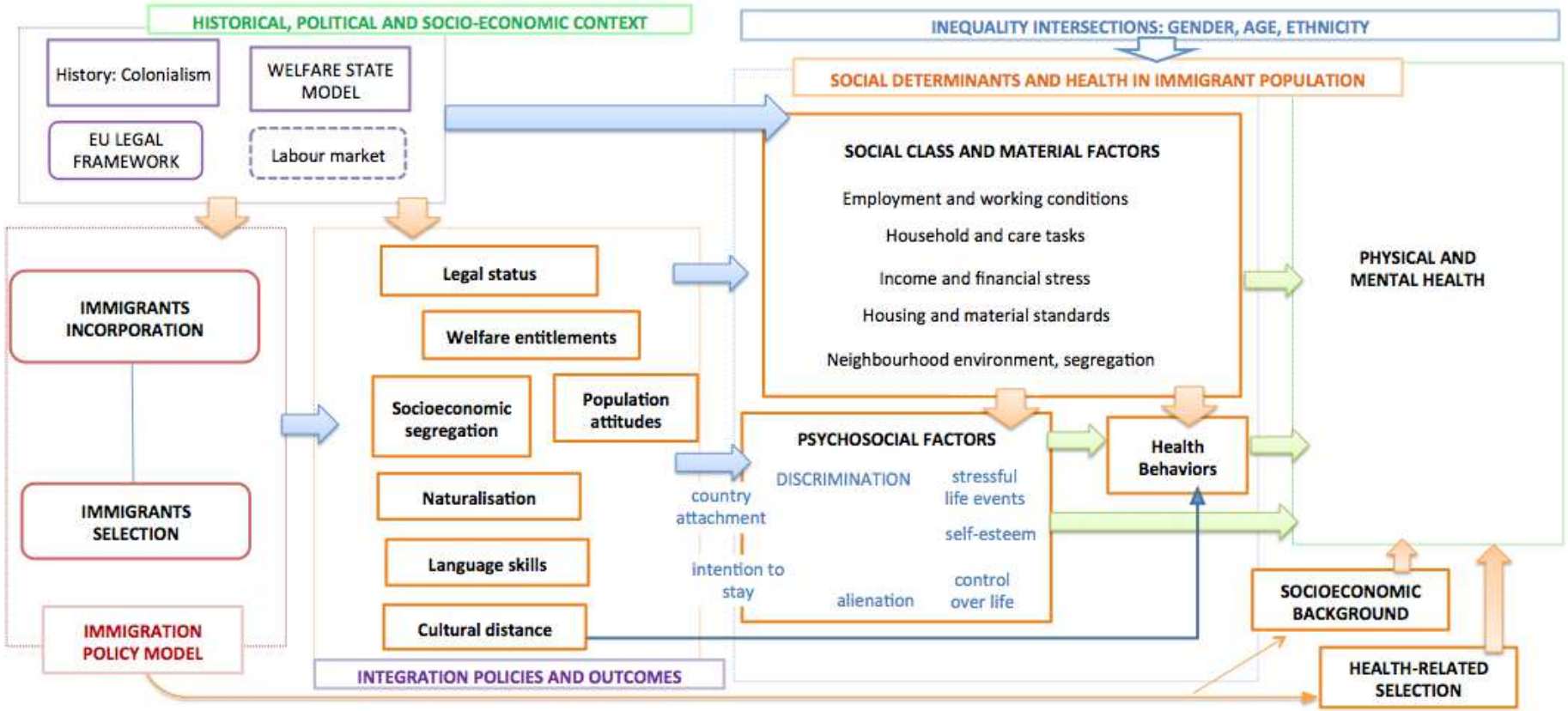
Discussion. Limitations

	% born outside EU	Three most frequent countries of birth and % of total non-EU immigrants			Main reasons for migrating*		EU-SILC Non-response rate**
Multicultural countries							
United Kingdom	7.9%	India 14%	Pakistan 9%	Bangladesh 5%	Work 32%	Family 31%	27.3%
Italy	6.0%	Albania 12%	Morocco 11%	Ukraine 5%	Work 59%	Family 35%	25.0%
Spain	8.9%	Morocco 18%	Ecuador 12%	Colombia 9%	Work 54%	Family 30%	34.4%
Netherlands	8.5%	Turkey 14%	Morocco 12%	Indonesia 10%	Family 48%	Work 17%	14.5%
Belgium	7.8%	Morocco 22%	Turkey 11%	DR Congo 10%	Family 46%	Work 26%	38.2%
Portugal	5.2%	n/a	n/a	n/a	Family 40%	Work 40%	n/a
Sweden	9.6%	Iraq 14%	Iran 7%	Bosnia 6%	Family 46%	Refugee 23%	37.2%
Norway	6.8%	Iraq 6%	Somalia 6%	Pakistan 5%	Family 55%	Refugee 15%	50.7%
Finland	2.9%	Somalia 5%	Russia 5%	Iraq 5%	n/a	n/a	18.1%
Assimilationist countries							
France	8.0%	n/a	n/a	n/a	Family 46%	Work 27%	19.2%
Switzerland	9.9%	Turkey 10%	Serbia 7%	FYR Macedonia 7%	Work 42%	Family 34%	n/a
Luxembourg	5.6%	n/a	n/a	n/a	Work 43%	Family 39%	43.3%
Exclusionist countries							
Austria	9.1%	n/a	n/a	n/a	Family 39%	Work 33%	23.0%
Denmark	6.4%	Turkey 9%	Iraq 6%	Bosnia 5%	n/a	n/a	44.4%

Data extracted from Eurostat > Statistics > Browse / Search database. Population data except for (*) EU Labour Force Survey 2008.

** Overall individual non-response rate in the original sample for the total population. Available at http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions

Conceptual framework: Immigration policy and migrants' health



Background

Which survey data to compare immigrants' health?

European Social Survey[1]: self-rated health, depressive symptoms scale in selected waves; 26 countries, around 60,000 people (3,000 immigrants per wave), too small

EU-SILC: self-rated health, limiting longstanding illness, activity limitation due to health problem; 30 countries, around 400,000 (18,000 non-EU), no country of birth info.

SHARE 11 countries 2004. 27,000 (2,000 immigrants)

EHIS. Limited socio-economic variables. 2006-09 17 MS. 2013-15 all MS

1 Katia Levecque et al. Depression in Europe: does migrant integration have mental health … Ethn Health 2015

Questions for you!

Weighting. RB050, PB060, PB040?

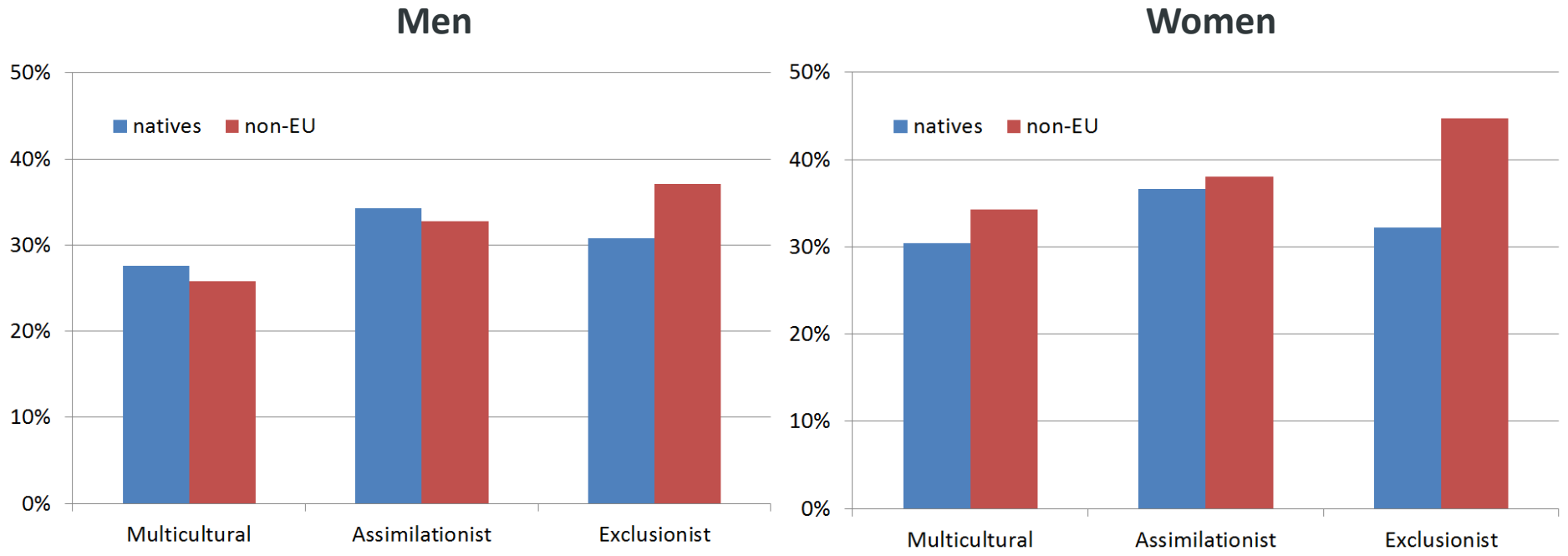
Merging cross-sections e.g. 2007 and 2011

Immigrants' health by type of integration policies

Results

Limiting longstanding illness

Predicted prevalence at age 50 via regression (%)



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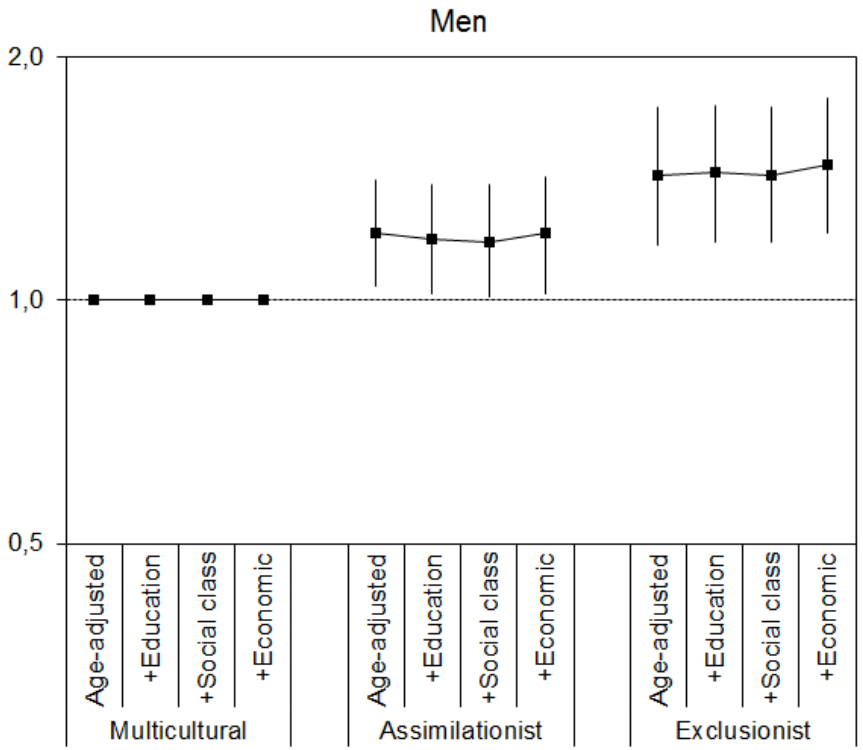
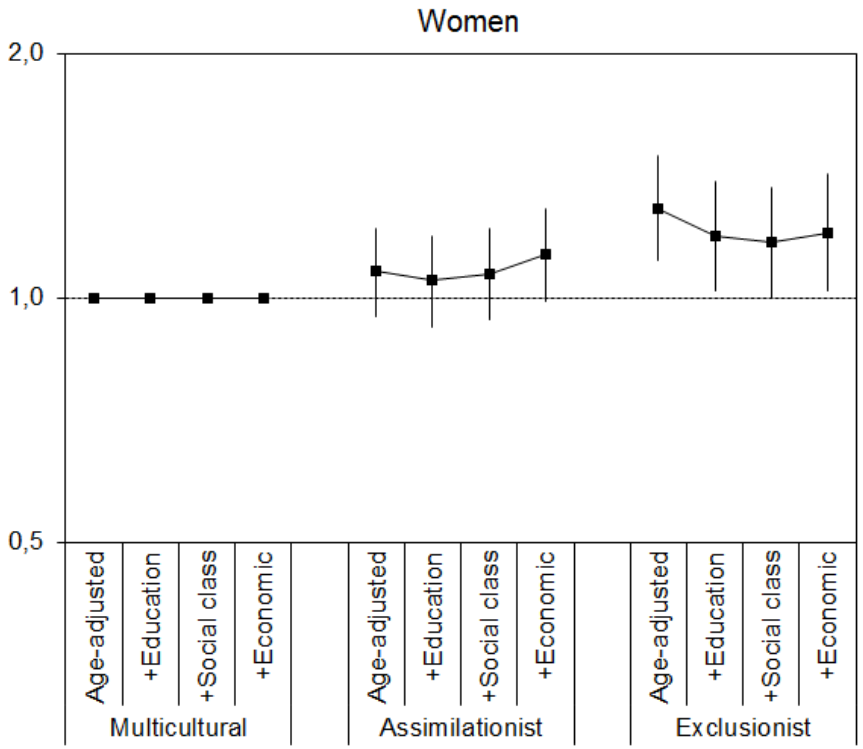
Limiting longstanding illness. Prevalence ratio with 95%CI





Results

Immigrants versus natives

Limiting longstanding illness. Prevalence ratio with 95%CI