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

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SOPHIE project


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. 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\(^5\)

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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
Emerging cross-country analyses of mortality of immigrants with similar origins\textsuperscript{1,2} not yet linked to integration policy context

Attempts in maternal\textsuperscript{3} and perinatal\textsuperscript{4} health using naturalisation rates as integration policy indicator

“Migrant Integration Policy Index” (MIPEX) overall score not associated with immigrants’ depression\textsuperscript{5}

\textsuperscript{1} Jacob Spallek et al. Cancer mortality patterns among Turkish immigrants... Eur J Epidemiol 2012
\textsuperscript{2} Snorri B Rafnsson et al. Sizable variations in circulatory disease mortality... Eur J Public Health 2013
\textsuperscript{3} Paola Bollini et al. Pregnancy outcome of migrant women and integration policy... Soc Sci Med 2009
\textsuperscript{4} Sarah F Villadsen et al. Cross-country variation in stillbirth and neonatal mortality... Eur J Public Health 2010
\textsuperscript{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?
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

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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
A “data-driven” policy typology
A “data-driven” policy typology

Background

Map showing countries classified into three types:

- Class 1: Inclusive (Multicultural)
- Class 2: Exclusionist
- Class 3: Political integration (Assimilationist)
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

Class 1: Inclusive (Multicultural)
Class 2: Exclusionist
Class 3: Political integration (Assimilationist)
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 (%)

Men

- Multicultural
  - UK IT ES NL BE PT SE NO FI
- Assimilationist
  - FR CH LU
- Exclusionist
  - AT DK

Women

- Multicultural
  - UK IT ES NL BE PT SE NO FI
- Assimilationist
  - FR CH LU
- Exclusionist
  - AT DK
Results

Managerial, professional or technical occupation (%)

**Men**
- Multicultural
- Assimilationist
- Exclusionist

**Women**
- Multicultural
- Assimilationist
- Exclusionist

The graphs display the percentage of individuals in each category (Multicultural, Assimilationist, Exclusionist) for both genders (Men and Women), categorized by their origin (natives vs. non-EU) across various countries.
Results

Household in the lowest income quintile (%)

Men

- Multicultural
- Assimilationist
- Exclusionist

Women

- Multicultural
- Assimilationist
- Exclusionist

EU countries: UK IT ES NL BE PT SE NO FI

Non-EU countries: AT DK
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 (%) *

Men

Women

* 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, with other health indicators
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…?*

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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)
This project is funded by:

sophie-project.eu
slideshare.net/sophieproject
@sophieproject
dmalmusi@aspb.cat

C S B Consorci Sanitar de Barcelona
Agència de Salut Pública

Photos: Roberto Brancolini, Roberto Malaguti
<table>
<thead>
<tr>
<th>Country</th>
<th>% born outside EU</th>
<th>% of total non-EU immigrants</th>
<th>Main reasons for migrating*</th>
<th>EU-SILC Non-response rate**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multicultural countries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>7.9%</td>
<td>India 14%</td>
<td>Work 32%</td>
<td>Family 31%</td>
</tr>
<tr>
<td>Italy</td>
<td>6.0%</td>
<td>Albania 12%</td>
<td>Work 59%</td>
<td>Family 35%</td>
</tr>
<tr>
<td>Spain</td>
<td>8.9%</td>
<td>Morocco 18%</td>
<td>Work 54%</td>
<td>Family 30%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>8.5%</td>
<td>Morocco 12%</td>
<td>Family 48%</td>
<td>Work 17%</td>
</tr>
<tr>
<td>Belgium</td>
<td>7.8%</td>
<td>Morocco 22%</td>
<td>Family 46%</td>
<td>Work 26%</td>
</tr>
<tr>
<td>Portugal</td>
<td>5.2%</td>
<td>n/a</td>
<td>Family 40%</td>
<td>Work 40%</td>
</tr>
<tr>
<td>Sweden</td>
<td>9.6%</td>
<td>Iraq 14%</td>
<td>Family 46%</td>
<td>Refugee 23%</td>
</tr>
<tr>
<td>Norway</td>
<td>6.8%</td>
<td>Iraq 5%</td>
<td>Family 55%</td>
<td>Refugee 15%</td>
</tr>
<tr>
<td>Finland</td>
<td>2.9%</td>
<td>Somalia 5%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
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<td><strong>Assimilationist countries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>8.0%</td>
<td>n/a</td>
<td>Family 46%</td>
<td>Work 27%</td>
</tr>
<tr>
<td>Switzerland</td>
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<td>Turkey 10%</td>
<td>Work 42%</td>
<td>Family 34%</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>5.6%</td>
<td>n/a</td>
<td>Work 43%</td>
<td>Family 39%</td>
</tr>
<tr>
<td><strong>Exclusionist countries</strong></td>
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</tr>
<tr>
<td>Austria</td>
<td>9.1%</td>
<td>n/a</td>
<td>Family 39%</td>
<td>Work 33%</td>
</tr>
<tr>
<td>Denmark</td>
<td>6.4%</td>
<td>Turkey 9%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>


** 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

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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 (%)

Men
Women

<table>
<thead>
<tr>
<th>Type of Integration Policies</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multicultural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assimilationist</td>
<td></td>
<td></td>
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<tr>
<td>Exclusionist</td>
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</tbody>
</table>
Immigrants’ health by type of integration policies

Results

Immigrants between country types (ref. multicultural)

Limiting longstanding illness. Prevalence ratio with 95%CI

[Graph showing prevalence ratios for men and women across multicultural, assimilationist, and exclusionist integration policies, with age-adjusted and additional factors (education, social class, economic) included.]
Immigrants versus natives

Limiting longstanding illness. Prevalence ratio with 95%CI

Results