Health differences between migrant and non-migrant elderly in Europe: the role of integration policies and public attitudes towards migration and migrants (2004-2013)

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Introduction

The share of older migrants in Europe is rising steadily. Given the current size of younger migrant populations, it is expected that the share of older migrants in Europe will grow considerably in the future (Lanzieri, 2011). In a context where the public and health discourse aims for equity (Nørredam and Krasnik, 2011), it is highly relevant to study migrant health inequalities at older ages.

So far, most research into migrant health inequalities did not focus on the effects of the context in the country of residence (Castañeda, 2015). In our study, we analyse migrant health inequalities at older ages by considering the effect of integration policies, and public attitudes towards migration and migrants. Since health outcomes may differ according to the health dimension considered, we included measures of both physical (diabetes), and mental (depression) health, plus an additional measures of overall health (self-rated health).

The association between integration policies and migrant health inequalities has only recently been explored (Ikram et al., 2015; Malmusi, 2015); while most studies on the association between attitudes towards migrants and health have focused on a rather narrow view of such attitudes, namely discrimination (Karlsen & Nazroo, 2002; Williams et al., 2003; Paradies, 2006; Borrell et al., 2015).

Our study contributes to the scientific knowledge by providing empirical evidence of the hardly explored association between integration policies and public attitudes towards migration and migrants, and health, with a specific focus at older ages. Our results may allow to detect typologies of policies and attitudes that potentially reduce health inequalities between migrants and non-migrant elderly.

The social determinants of health

Following the WHO model on the social determinants of health (Solar & Irwin, 2010), we studied the association between integration policies and public attitudes towards migration and migrants, and migrant health inequalities at older ages. We understand as integration policies those policies specifically addressed at minorities as a group (Wright & Bloemraad, 2012), but also those policies addressed at migrants (and non-migrants) as individuals (Ersanilli & Koopmans, 2011). More inclusive policies may foster migrants' social and economic integration in the destination countries (Wright & Bloemraad, 2012), which may have a beneficial effect on their health (Ikram et al., 2015). In contrast, policies limiting migrants' rights may have the opposite effect, and even induce stress on the migrants, which may deteriorate their health status (Agyemang et al., 2011). Therefore, we expected that *more inclusive integration policies are associated with better health outcomes among migrants in Europe.*

In our study, we consider both public attitudes towards migration, and public attitudes towards migrants. Public attitudes towards migration reflect the public opinion on the levels of migration that should be allowed in the country, and under which conditions; while public attitudes towards migrants reflect the public perception of migrants who already entered the country, and their impact on society (Ceobanu & Escandell, 2010). Negative attitudes towards migration and migrants, and in particular discrimination, are associated with worse labour market outcomes, and with poor access to social and health services (Johnston & Lordan, 2012), and may even induce stress on the migrants (Bekteshi & Van Hook, 2015), which can potentially worsen their health status. In contrast, positive attitudes towards migration and migrants provide a more favourable context for the social and economic integration of migrants into society, and may even provide support for migrants (Berry, 1997). Accordingly, we hypothesized that *positive public attitudes towards migration and migrants are associated with better health outcomes among migrants in Europe*.

Data and methods

Our study sample is comprised of respondents of migrant and non-migrant origin from the Survey of Health, Ageing and Retirement in Europe (SHARE), a panel survey that collects data on health, socio-economic status and social networks of individuals aged 50 and over in different European countries (Börsch-Supan et al., 2013). We used pooled data from waves 1, 2, 4, and 5 from countries for which data was available in all four waves. Due to small sample sizes after age 80 among non-western migrants, we restricted our analysis to ages 50-79. Migrants were defined as those who were not born in the country they were currently residing (first generation migrants). Furthermore, we classified migrants according to their origin into western and non-western migrants, following the classification by Statistics Netherlands (CBS, 2014).

SHARE data were enriched with two other data sources to test our hypotheses on the importance of integration policies, and public attitudes towards migration and migrants. Data on migration policies was retrieved from the Migrant Integration Policy Index, a multi-dimensional indicator based on more than 140 policy indicators in six policy areas that captures institutional opportunities for migrants to participate in host societies (Niessen et al., 2007). Data on public attitudes towards migration and migrants were derived from the first round of the European Social Survey, which monitors public attitudes and values in different European countries (ESS, 2014). We classified the ten countries in the study according to their relative positioning according to integration policies, and to public attitudes towards migration and migrants.

To assess health differences between migrants and non-migrants at older ages we performed multivariate logistic regression models, for each of the health indicators considered, and separately by sex. We additionally controlled for age, and for length of residence in the country.

Preliminary Results

Table 1 presents the odds ratios to report poor self-rated health, diabetes, and depression for males and females. Western migrant elderly had higher odds to report poor self-rated health and depression than non-migrant elderly. The odds to report poor self-rated health were even higher amongst non-western migrant elderly as compared to non-migrant elderly. The odds to report diabetes were higher

among non-western migrant elderly, but not among western migrant elderly, as compared to non-migrant elderly.

The odds to report poor self-rated health and diabetes were higher in countries with less favourable attitudes towards migration and migrants, and lower in countries with more favourable attitudes towards migration and migrants.

The odds to report poor self-rated health and diabetes were higher in countries with intermediate integration policies, but did not statistically significantly differ in countries with less inclusive integration policies, as compared to countries with more inclusive integration policies.

Although we did not find significant differences in the odds to report depression according to integration policies, and public attitudes towards migration and migrants, the pattern remained similar.

Table 1. Odds ratio to report poor self-rated health, diabetes, and depression, by sex

	Self-rated health				Diabetes				Depression			
	Males		Females		Males		Females		Males		Females	
Non-migrant	(ref)		(ref)		(ref)		(ref)		(ref)		(ref)	
Western migrant	1.187	*	1.360	***	1.096		1.142		1.222	**	1.275	***
Non-western migrant	1.485	**	1.717	***	2.126	***	1.991	***	2.181	***	1.818	***
50-54	(ref)		(ref)		(ref)		(ref)		(ref)		(ref)	
55-59	1.279	***	1.262	***	1.590	***	1.586	***	0.934		0.902	***
60-64	1.525	***	1.409	***	2.167	***	1.853	***	0.841	**	0.894	
65-69	1.676	***	1.734	***	2.820	***	2.619	***	0.862	*	0.873	
70-74	2.244	***	2.511	***	2.861	***	2.983	***	1.027		1.003	
75-79	3.122	***	3.371	***	3.178	***	3.452	***	1.211		1.207	
Length of residence: 10+ years	(ref)		(ref)		(ref)		(ref)		(ref)		(ref)	
Length of residence: 0-9 years	0.493	***	0.688	**	0.619	*	0.758		0.840		0.586	***
Integration policies: more inclusive	(ref)		(ref)		(ref)		(ref)		(ref)		(ref)	
Integration policies: intermediate	1.827	***	2.014	***	1.380	***	1.360	***	1.114		1.319	
Integration policies: less Inclusive	1.069		1.034		1.046		0.825	**	0.939		0.990	
Attitudes: more favourable	(ref)		(ref)		(ref)		(ref)		(ref)		(ref)	
Attitudes: intermediate	1.338		1.287		1.092		1.257	**	0.939		0.958	
Attitudes: less favourable	1.772	***	1.395	*	1.234	***	1.361	***	1.242		1.126	

Data source: SHARE data (2004-2013)

* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$

Discussion

We found evidence that non-migrant elderly, especially those with a non-western origin, were more likely to suffer from poor-self rated health and depression than non-migrant elderly. In line with our expectations, the odds to report poor self-rated health and diabetes increased with more negative public attitudes towards migration and migrants. To a certain extent, more inclusive integration policies were associated with lower odds to report poor self-rated health and diabetes. However, the poorest health outcomes were found in countries with “intermediate” integration policies, which suggests that other country-level policies, such as health or social policies, may be relevant in explaining health inequalities.

Mental health outcomes did not seem to differ in countries with diverse typologies of integration policies, and public attitudes towards migration and migrants. This could be related to the fact that

migrants' poor mental health may be more strongly related to the context and conditions during the pre-departure and movement phases of the migration process (Gushulak et al., 2010), rather than to the context in the country of residence.

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