Discrimination and Health among Immigrants in Western Europe

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SIGNIFCANCE

Immigration to Europe has rapidly increased in the twenty-first century (Coleman 2009) and the number of immigrants applying for protective status reached a record high of 1.3 million in 2015 (Pew Research Center 2016). Yet recent research examining the well-being of immigrants there has been limited. In this study, we utilize census and survey data to examine the ways in which various social identities impact experiences of discrimination and health among immigrants in Western Europe, as well as the potential mortality and life expectancy differentials between various populations in Italy.

While the countries that compose Western Europe are similar in many of their social and economic realities, there are notable cultural and political differences between nations that could impact immigrants' experiences. Thus, we focus on the case of Italy to provide a more detailed examination of the experiences of immigrants in one specific context. Italy provides an interesting example because it is a relatively new immigrant receiving country. As such, while the experiences of immigrants in France (*e.g.* Guendelman et al. 1999; Alba 2005; Sabatier and Berry 2008; Algan et al. 2010; Larchanche 2012; Moullan and Jusot 2014) and the UK (*e.g.* Marmot, Adelstein, and Bulusu 1984; London 1986; Burnett and Peel 2001; Algan et al. 2010) are relatively well-documented, research examining the well-being of immigrants in Italy frequently involves relatively small sample sizes (*e.g.* Gualdi-Russo et al. 2009; Pezzoli et al. 2009; Favaro et al. 1999), although there are some recent exceptions (Baglio et al. 2010; Moullan and Jusot 2014; Busetta, Cetorelli, and Wilson 2018).

When examining immigrant outcomes in Europe, scholars commonly highlight cultural differences, especially religion, as motivating most anti-immigrant animosity but overlook the contribution of other factors such as racism (Alba 2005; Fekete 2004; Flores 2015). France's 2004 legislation banning headscarves in places of education and 2010 law criminalizing wearing face-veils in public are often highlighted as epitomizing the backlash against religious minorities and symbols in a country devoted to secularism (Grillo and Shah 2012; Hunter-Henin 2012). However, emphasizing religion, and specifically Islam, in politics and in research marginalizes the consequences of racial discrimination (Tiberj and Michon 2013). Moreover, there is emerging evidence that discrimination based on national origins and/or race/ethnicity is more widespread than religious-based discrimination (De la Rica, Glitz, and Ortega 2013; Flores 2015), yet the dominant frameworks used when describing immigrant experiences in Europe do not reflect this reality (Tiberj and Michon 2013).

DATA AND METHODS

This study examines three areas: (1) causes of death and life expectancy, (2) experiences and perceptions of discrimination, and (3) the relationship between social characteristics, experiences of discrimination, and health. For the first objective, Italy's National Institute of Statistics (ISTAT) tracks causes of mortality among immigrants, differentiated by country of citizenship. We use mortality data from 2011, the most recent census year. For the second and third objectives, we use cross-national and cross-temporal surveys that are part of the Eurobarometer Series and collected by the European Commission. In particular, we focus on immigrants in the five largest countries in Western Europe: Germany, France, United Kingdom, Italy, and Spain. This ensures that there is a large enough sample size of immigrants among the respondents in order to run statistical analyses. We combine respondents from three surveys with independent samples, from 2008, 2009, and 2012, which are the three most recent waves that

collected data regarding respondents' place of birth, experiences of discrimination, health, religion and other relevant variables such as gender, age, and occupation.

Mortality and Life Expectancy

For the purposes of summarizing, we use age-specific death rates to calculate standardized crude death rates for immigrant populations from eight different countries of origin, using the Italian composition as the standard. This allows for comparison of crude death rates without the likely differing age structures of the populations influencing the results. This part of the analysis includes people from the countries with the five largest immigrant populations in Italy, in absolute numbers: Romania, Albania, Morocco, China, and Ukraine. In addition, we include immigrants from Pakistan, Nigeria, and India, which were among the five largest sending countries in 2015-2016. Next, we calculate life expectancy for the Italian population by gender and utilize the associated single decrement life table to compare changes in men's and women's life expectancies when the foreign population is excluded from the calculation. If differences in health between the Italian and foreign populations are profound, there may be measurable effects on the entire population's longevity. Lastly, we calculate the change in mortality between men and women by citizenship (Italian and foreign) by decomposing the difference in life expectancies at birth for these populations. This allows for the examination of the contribution of the Italian and foreign populations to differences in life expectancies for men and women in Italy.

Discrimination and Health

A great deal of literature speaks to the role of discrimination in adverse social *and* health outcomes. Yet, as discussed in the significance section, the extent to which race/ethnicity plays a role in experiences of discrimination is underexamined in the European context in favor of religion as the primary motivating factor. We use respondents' answers to the question, "In the past 12 months have you personally felt discriminated against or harassed on the basis of one or more of the following grounds? Was it discrimination on the basis of…? Please tell me all that apply" and "In (OUR COUNTRY), when a company wants to hire someone and has the choice between two candidates with equal skills and qualifications, which of the following criteria may, in your opinion, put one candidate at a disadvantage?" Respondents can choose multiple answers which include skin color or ethnic origin, gender, religion or belief, age, and accent. These questions allow us to observe the patterns of responses between individuals with different immigrant backgrounds and between immigrants from different regions of origin. The former question measures experiences of discrimination while the latter measures perceptions of the motivations for discrimination. The total sample size is 17,765 for the discrimination and labor market disadvantage descriptive statistics.

Next, using the first question above, we recode the experience of discrimination variable as a dummy variable (1=yes, 0=no) and input it into a logistic regression model with another dummy variable, health, as the dependent variable. This variable is based on respondents' answer to the question: "Do you suffer from a chronic physical or mental health problem which affects you in your daily activities?" In addition to discrimination, we examine the impact of religion on this health outcome by modeling each religious denomination as a dummy variable as well. Lastly, we made dummy variables for immigrant populations from each region of origin. Control variables include age, occupational status, and gender. The sample size for the regression

analyses is 17,627 due to the exclusion of respondents that affirmed the “don’t know” option for the chronic health question. All analyses are conducted in Stata 14.

PRELIMINARY FINDINGS

Results indicate considerable variation in mortality between populations from different countries and regions. Overall, immigrants generally have higher mortality rates than the Italian population, once differences in age are taken into account. Additionally, life expectancy at birth for foreigners is lower than Italians. Immigrants report experiencing discrimination in the past year more than those born in France, Germany, the UK, Italy or Spain. In particular, immigrants report experiencing discrimination based on ethnic origin more than any other reason. Immigrants from Asia, Africa, or Latin America are especially at risk of experiencing discrimination. Immigrants and native-born respondents tend to agree which social characteristics put job candidates with equal qualifications at a disadvantage in the labor market. One exception to this is that immigrants more frequently perceive both skin color/ethnic origin and accents as detrimental than native-born respondents. Lastly, compared to native-born respondents citizens, immigrants from all regions have significantly lower odds of reporting a health problem and those from Asia, Africa, or Latin America have the lowest odds of all immigrant groups included. In contrast, Muslims experience 1.34 greater odds of suffering a health problem compared to the Catholic majority in the sample population. These findings add a more comprehensive understanding of the ways in which nationality, and by extension racialized identities, religion, and other social variables affect the health of migrants in Italy and Europe.

REFERENCES

Alba, Richard D. 2005. “Bright versus Blurred Boundaries: Second-Generation Assimilation and Exclusion in France, Germany, and the United States.” *Ethnic and Racial Studies* 28:20 -49.

Algan, Yann, Christian Dustman, Albrecht Glitz, and Alan Manning. 2010. “The Economic Situation of First and Second-Generation Immigrants in France, Germany and the United Kingdom.” *The Economic Journal* 120(542):F4-F30.

Baglio, Giovanni, Catherine Saunders, Angela Spinelli, and John Osborn. 2010. “Utilisation of Hospital Services in Italy: A Comparative Analysis of Immigrant and Italian Citizens.” *Journal of Immigrant Minority Health* 12:598-609.

Burnett, Angela, and Michael Peel. 2001. “Health Needs of Asylum Seekers and Refugees.” *BMJ* 322(7285):544-547.

Busetta, Annalisa, Valeria Cetorelli, and Ben Wilson. 2018. “A Universal Health Care System? Unmet Need for Medical Care Among Regular and Irregular Immigrants in Italy.” *Journal of Immigrant Minority Health* 20:416-421.

Coleman, David. 2009. “Migration and its Consequences in 21st Century Europe.” *Vienna Yearbook Population Research* 7:1-18.

Collins, Patricia Hill. 2015. “Intersectionality’s Definitional Dilemmas.” *Annual Review of Sociology* 41:1-20.

De la Rica, Sara, Albrecht Glitz, and Francesc Ortega. 2013. “Immigration in Europe: Trends, Policies, and Empirical Evidence.” Institute for the Study of Labor (IZA) Discussion Paper No. 7778. Retrieved March 2, 2019 (http://ftp.iza.org/dp7778.pdf).

Favaro, A., M. Maiorani, G. Colombo, and P. Santonastaso. 1999. “Traumatic Experiences, Posttraumatic Stress Disorder, and Dissociative Symptoms in a Group of Refugees from Former Yugoslavia.” *The Journal of Nervous and Mental Disease* 187(5):306-308.

Fekete, L. 2004. “Anti-Muslim Racism and the European Security State.” *Race and Class* 46(1): 4-29.

Flores, Rene D. 2015. “The Resurgence of Race in Spain: Perceptions of Discrimination Among Immigrants.” *Social Forces* 94(1): 237-269.

Grillo, Ralph, and Prakesh Shah. 2012. “Reasons to Ban? The Anti-Burqa Movement in Western Europe.” Max Planck Institute for the Study of Religious and Ethnic Diversity Working Paper 12(5). Retrieved February 19, 2019 (https://qmro.qmul.ac.uk/xmlui/bitstream/handle/123456789/3082/SHAHReasonsToBan2012FINAL.pdf;sequence=2).

Gualdi-Russo, E., A. Zironi, G.V. Dallari, and S. Toselli. 2009. “Migration and Health in Italy: A Multiethnic Adult Sample.” *Journal of Travel Medicine* 16(2), 88-95.

Guendelman, Sylvia, Pierre Buekens, Beatrice Blondel, Monique Kaminski, Francis C. Notzon, and Godelieve Masuy-Stroobant. 1999. “Birth Outcomes of Immigrant Women in the United States, France, and Belgium.” *Maternal and Child Health Journal* 3(3):177-187.

Hunter-Henin, Myriam. 2012. “Why the French Don’t Like the Burqa: *Laicite*, National Identity and Religious Freedom.” *International and Comparative Law Quarterly* 61(3):613-639.

Larchanche, Stephanie. 2012. “Intangible Obstacles: Health Implications of Stigmatization, Structural Violence, and Fear Among Undocumented Immigrants in France.” *Social Science and Medicine* 74(6):858-863.

London, M. 1986. “Mental Illness Among Immigrant Minorities in the United Kingdom.” *The British Journal of Psychiatry* 149(3):265-273.

Marmot, M.G., A.M. Adelstein, and L. Bulusu. 1984. “Lessons from the Study of Immigrant

Mortality." *The Lancet* 1(8392):1455-1457.
Moullan, Yasser, and Florence Jusot. 2014. "Why is the 'Healthy Immigrant Effect' Different Between European Countries?" *European Journal of Public Health* 24(Suppl 1):80-86.
Pew Research Center. 2016. "Number of Asylum Seekers in Europe Surges to Record 1.3 Million in 2015." Retrieved February 19, 2019 (http://www.pewglobal.org/2016/08/02/number-of-refugees-to-europe-surges-to-record-1-3-million-in-2015/pgm_2016-08-02_europe-asylum-01/).
Pezzoli, Maria Chiara, Issa El Hamad, Carmelo Scarcella, Francesco Vassallo, Fabrizio Speziani, Graziella Cristini, Carla Scolari, Barbara Suligoi, Anna Maria Luzi, Daniela Bernasconi, Miriam Lichtner, Giuseppina Cassara, Nino Manca, Giampiero Carosi, and Francesco Castelli. 2009. "HIV Infection among Illegal Migrants, Italy, 2004-2007." *Emerging Infectious Diseases* 15(11), 1802-1804.
Sabatier, Colette, and John W. Berry. 2008. "The Role of Family Acculturation, Parental Style, and Perceived Discrimination in the Adaptation of Second-Generation Immigrant Youth in France and Canada." *European Journal of Developmental Psychology* 5(2):159-185.
Tiberj, Vincent, and Laure Michon. 2013. "Two-Tier Pluralism in 'Colour-Blind' France." *West European Politics* 36(3):580-596.