Doctor of Sociology

Healthy ageing in a comparative perspective: a study of the health of older migrants and non-migrants across Europe.

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Abstract

The aim of this PhD thesis was to analyse health differences between older migrants and non-migrants in Europe. European societies are becoming older and more culturally diverse. However, relatively little attention has been paid to the health of older migrants in Europe. Serious concerns exist whether migrants in Europe are ageing as healthily as non-migrants, because migrants face additional challenges before, during, and after migration. Knowledge about the health of older migrants compared to older non-migrants is needed in light of the growing share of older persons with a migrant background. These insights about the specific health needs of migrants in Europe will prove useful to tailor healthy ageing strategies across Europe.

Previous studies on migrant health rarely focused on the older population, were mainly conducted in a single country, or took a cross-sectional approach. The current study provided crucial new knowledge on the health of older migrants and non-migrants in Europe by focusing specifically on the older population (aged 50 and older), by taking a multidisciplinary and cross-country comparative perspective, by applying both cross-sectional and longitudinal designs, and by taking into consideration the effect of both individual- and contextual-level factors.

The two main research questions assessed in the study were:
1. How does the health of older migrants and non-migrants differ across European countries, and how do these differences evolve over time and with age?
2. To what extent are the health differences between older migrants and non-migrants in Europe explained via individual and contextual factors?

This study focused on older individuals (aged 50 and older) living in northwestern and southern Europe. It focused on non-migrants versus first generation migrants, i.e. those who were born in a different country from their current country of residence. Migrants were further subdivided into two broad groups of origin: western and non-western.

After an introductory chapter that outlines the theoretical approaches on which this study built, the empirical chapters two to five address specific sub questions that will help answer the overarching research questions outlined above. All of the chapters aim to provide an answer to the first research question, chapters four and five additionally aim to provide an answer to the second research question. The empirical chapters cover different dimensions
of health and mortality patterns. The thesis concludes with a chapter that provides an overall discussion of the findings.

Chapter 2 investigated differences in overall and cause-specific mortality between older migrants and non-migrants in Belgium. Data derived from an eight-year mortality follow up of the population living in Flanders and in the Brussels-Capital Region in 2001 (census). The results show that, many years after migration, older migrants in Belgium had an overall mortality advantage relative to non-migrants, mainly due to a mortality advantage from cardiovascular and cancer mortality. However, it was also found that older migrants in Belgium faced higher mortality than older non-migrants from specific causes, such as infectious diseases and diabetes-related causes. Some of the disadvantages for specific migrant groups (lung cancer among western female migrants, or cardiovascular diseases among non-western female migrants) had not been found in previous studies at younger ages.

Chapter 3 examined health differences between older migrants and non-migrants further, by looking not only at mortality but also at general health, while taking a cross-country comparative perspective. Healthy life expectancy at age 50 (HLE50) was analysed in Belgium, the Netherlands, and England and Wales. Mortality data derived from death registers, while general health data derived from either census or health surveys, depending on the country. The results show that migrants could expect to live a smaller number of years and a smaller share of their remaining life expectancy in good health than non-migrants. Inequalities in HLE50 were more pronounced between non-western migrants and non-migrants. Improvements of HLE50 in the Netherlands were mainly attributable to improvements in general health, especially among non-western migrants, and therefore led to a reduction in the inequalities in HLE50 between migrants and non-migrants. In contrast, differences in the trends of mortality and morbidity led to an increase in the inequalities in HLE50 between (non-western) migrants and non-migrants in England and Wales. Moreover, improvements in HLE50 in England and Wales were driven mainly by mortality decreases, which led to a decrease in the share groups.

Chapter 4 incorporated a longitudinal perspective in analysing differences in the health transition patterns of migrants and non-migrants in 10 southern and northwestern European countries: Austria, Belgium, Denmark, France, Germany, Italy, the Netherlands, Spain, Sweden, and Switzerland. Demographic, socio-economic, and health data derived from the Survey of Health, Ageing and Retirement in Europe (SHARE). The results show that older migrants, and especially those of non-western origin, had poorer health outcomes than older non-migrants. Furthermore, migrants also faced higher risks of experiencing a deterioration in health than non-migrants. In our study, socio-economic characteristics (lower levels of education, being unemployed or economically inactive) and lifestyle (poor exercise habits, smoking, obesity) had an important effect in explaining patterns of health deterioration.

Chapter 5 explored differences in overall, physical, and mental health between older migrants and non-migrants in 10 southern and north-western European countries (see above). Data on country-level integration policies (Migrant Integration Policy Index) and
public attitudes towards migration and migrants (European Social Survey) were combined with SHARE data. The results indicate that older migrants, and especially those of non-western origin, tended to be in poorer self-rated health than older non-migrants, and that they suffer more from diabetes and depression. This chapter also investigated how the policy and societal context contributes to health differences between older migrants and non-migrants. Migrants had the worst health outcomes in countries with the least favourable attitudes towards migration and migrants. This association appeared to be stronger for non-western than for western migrants. No clear association between integration policies and migrant health was found in the study.

Overall, the results of the empirical chapters show that older migrants in Europe have poorer health outcomes than older non-migrants, and that they also tend to be at higher risks of experiencing health deterioration. These findings clearly contrast with findings at younger ages, especially shortly after migration, when migrants are often found to be relatively healthy compared to non-migrants.

Steeper rates of health deterioration among migrants leading to a relative health disadvantage at older ages may be explained by the negative effects of a lower socio-economic position over the course of their life, as postulated by the cumulative disadvantage theory. However, the results also show that older migrants in Europe, or at least in certain European countries, retain certain health advantages, mainly in terms of mortality. Given migrants’ generally lower socio-economic status, their mortality advantage has been described in the literature as a paradox, i.e. the migrant mortality paradox. In short, the results of this study show that older migrants tend to be disadvantaged in terms of health when compared to non-migrants, but not in terms of overall mortality. These findings raise concerns whether current healthy ageing policies are adequately targeting the migrant population.

Furthermore, the results of this study also point at some of the mechanisms that explain health inequalities between older migrants and non-migrants in Europe. First, differences in socio-economic status and in lifestyles partly explained health differences between older migrants and non-migrants in Europe. Having lower levels of education, being unemployed or economically inactive, smoking, being overweight or obese, and not exercising frequently partially explain inequalities in health outcomes and transitions between older migrants and non-migrants.

Second, the policy and societal context in the country of residence was also particularly relevant in explaining health inequalities between older migrants and non-migrants across Europe: migrant health inequalities are more pronounced in countries with less favourable public attitudes towards migration and migrants.

In light of the findings, several multi-sectorial policy recommendations can be formulated. To overcome migrants’ generally lower levels of education and to promote healthier habits, efforts should be devoted in promoting health literacy, especially regarding prevention, including healthier diets and exercise patterns. At the same time, language courses or workshops on labour market incorporation could facilitate migrants’ integration and thus also contribute to better health via improved socio-economic conditions. Policymakers will need to pay special attention to the language and cultural sensitivities of migrants when
trying to implement these recommendations. Moreover, action is needed to promote a more favourable view of migrants, especially among the non-migrant population. A more positive climate towards migrants would be not only beneficial for the health of older migrants, but would also help reducing the health care costs among a potentially healthier migrant population. Policymakers need to address their interventions not only at the older population, but also target the younger population, who will eventually become older.

This PhD thesis answered some important questions regarding differences in health between older migrants and non-migrants in Europe. In order to fully understand the genesis of health inequalities between (older) migrants and nonmigrants, future research should aim to incorporate a life course perspective. More insights are needed on the specific conditions and events taking place at origin, during the migration process, and at destination. Therefore, there is a need for studies comparing the health situation of migrants with the health situation of those having not migrated in the country of origin, or studies comparing the health situation of different groups of migrants (e.g. regular and irregular migrants, or forced and voluntary migration), preferably comparing their situation in different countries of destination.