Chapter 4

Health status and access to health care

Socio-demographic characteristics such as sex, age, participation in risky behaviour (i.e., drinking alcohol, smoking), as well as living and working conditions are among the most important determinants of an individual's health. A "healthy migrant effect" is expected to be found in countries where the bulk of migration is composed of recent migrants, younger on average than the native-born population. This positive effect is expected to diminish as the duration of residence grows longer.

The origin country of migrants and the conditions of the migration may nuance the positive impact of the "immigration self-selection" on health outcomes. Some migrant groups, such as refugees, are particularly vulnerable and may be more likely to suffer from specific diseases or mental disorders. More generally, the migratory experience can lead to stress which may affect migrants' health outcomes in different ways down the line, depending on socio-economic and health conditions in the country of origin and on the extent to which they settle in the receiving country. Finally, a positive correlation generally exists between both educational attainment and income level, on the one hand, and health status, on the other.

This chapter analyses several aspects of self-reported health status for both the native-born and immigrant populations (Indicator 4.1) as well as unmet medical needs (Indicator 4.2). For a discussion on these indicators, refer to the section "Measurement" at the end of this chapter.

4.1. Perceived health status

Background information

Perceived health status reflects a broad perception of one's health, including its physiological and psychological dimensions. Three different aspects are covered in this section: 1) the overall health status; 2) the existence of chronic or long-standing illness or health conditions; and 3) the existence of health-related limitations (limited or strongly limited) which is one definition of disability. Although perceived health status is measured in five levels in all surveys, responses in the Australian and EU-SILC questionnaires range from "very bad" to "very good", centred on "fair", while responses in the American, Canadian and Swiss surveys range from "bad" to "excellent", centred on "good". This section provides figures on the proportion of people rating their health as "good" or better. The existence of chronic health conditions and health-related limitations are covered in much more detail in non-European questionnaires than in those of the Swiss and EU-SILC. This may tend to bias the international comparisons, as there are more opportunities to report to be suffering in non-European questionnaires. Each indicator for the immigrant population is adjusted, predicting what it would be if the foreign-born population had the same age, educational and income characteristics as the native-born population.

On average across OECD countries, 70% of immigrants reported having good health or better in 2009 (72.2% of males, 68.1% of females). This average is comparable to that of the native-born. Over 85% of immigrants in Canada, Ireland and the United States, and less than 45% of immigrants in the Czech Republic, Estonia and Slovenia reported that they were in at least good health (Figure 4.1).

In southern Europe (Greece, Italy, Portugal and Spain) as well as in Finland, Ireland and the United Kingdom, immigrants tend to be healthier on average than their native-born counterparts. In those countries, recent migrants, younger on average than the rest of the population, represent a large proportion of the immigrant stock. In Portugal, the trend is driven by the comparatively low proportion of native-born reporting to be in good health or better. In all other countries, including settlement countries (Australia, Canada), immigrants are on average less likely than native-born to report being in good health or better. In Central and Eastern European countries, with the exception of Hungary, the differences compared with the native-born are large (between a –31.6% points gap in Estonia and a –12.9% points gap in Slovenia).

However, after adjusting for age, education and income level, the differences in health status between immigrant and native-born decrease or become negligible in most countries. Notable exceptions are Norway, where the gap with native-born increases, and to a lesser extent Australia, Canada, Sweden, Switzerland and the United States where the adjustment has little impact. The presence of vulnerable groups, such as humanitarian immigrants, may affect the results for Nordic countries.

Similar results are observed for the other two indicators. Immigrants to Ireland, the United States and southern European countries are significantly less likely to suffer from either a chronic condition or to report health-related limitations than native-born persons (Figures 4.2 and 4.3). After adjustment, immigrants become less likely to suffer from chronic health conditions in Australia, France, Germany than the native-born. In most other countries, differences with the native-born in this category decrease or become statistically insignificant. However, in Canada, Luxembourg and the United States, differences between immigrants and the native-born, in terms of the prevalence of chronic health conditions, seem unrelated to socio-economic factors. While the percentage of immigrants reporting health-related limitations is substantially reduced after adjustment in central and eastern Europe, France and Germany, it remains unchanged after adjustment in Denmark and Switzerland and tends to increase in the Netherlands and Norway (Figure 4.3).

Figure 4.1. **Percentage of foreign- and native-born adults reporting to be in good health, 2009**


StatLink ᘑᔍᔈᛝ *http://dx.doi.org/10.1787/888932734913*
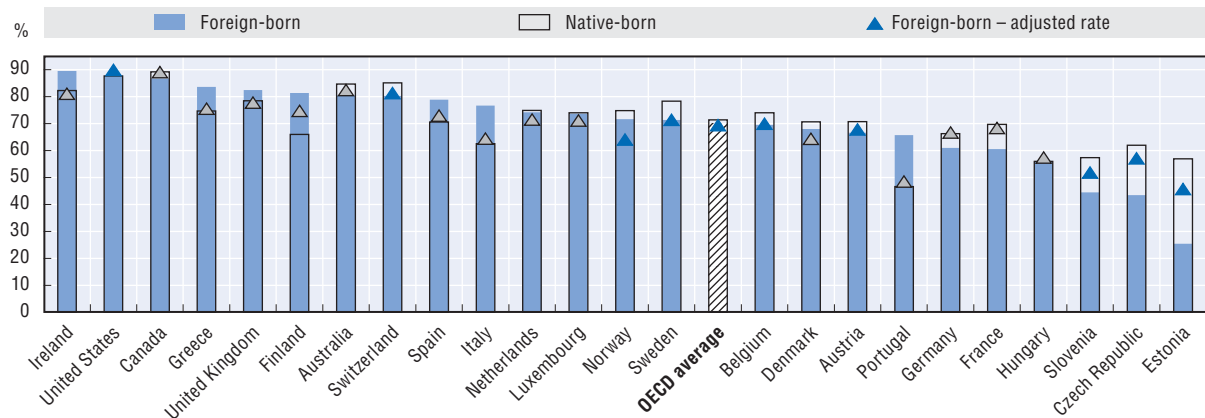
Figure 4.2. **Percentage of foreign- and native-born adults reporting to suffer from chronic health conditions, 2009**

StatLink ᘑᔍᔈᛝ *http://dx.doi.org/10.1787/888932734932*
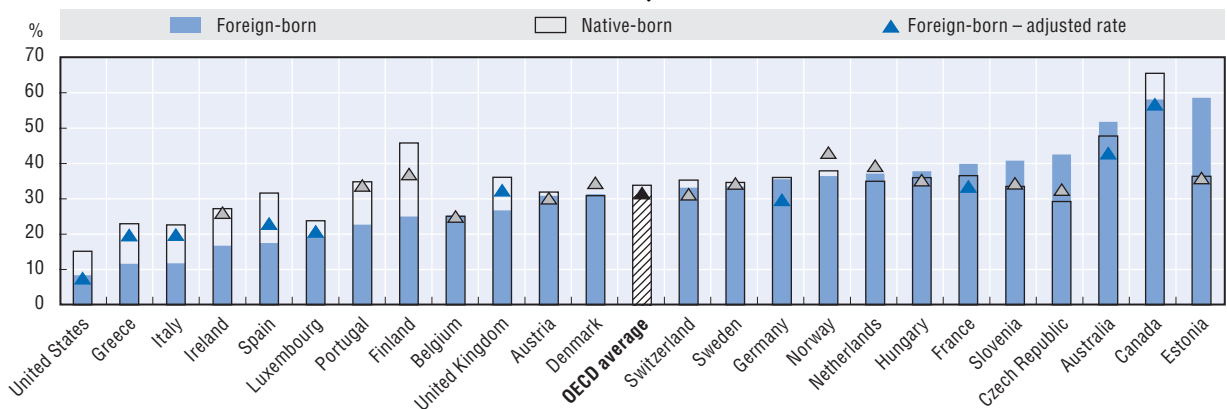
Figure 4.3. **Percentage of foreign- and native-born adults reporting health-related limitations, 2009**

StatLink ᘑᔍᔈᛝ *http://dx.doi.org/10.1787/888932734951*
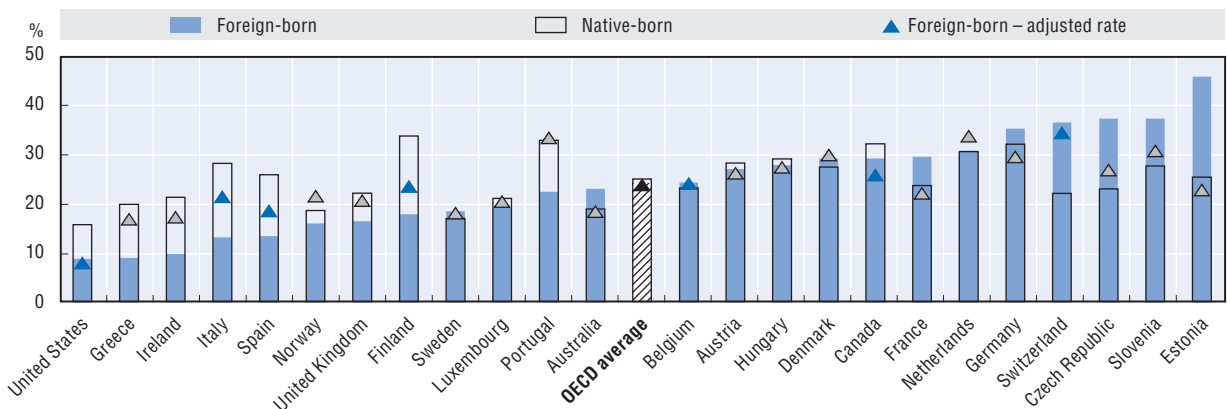
Notes and sources are at the end of the chapter.

4.2. Unmet medical needs

Background information

This indicator reports on whether there was a time in the previous 12 months when the respondents felt they needed health care services (excluding dental examination or treatment) but did not receive them. Of the 20 countries in the EU-SILC survey analysed in this report, only sixteen presented adequate sample sizes for an analysis of the unmet medical needs of immigrants. Furthermore, sample sizes are generally too small to permit a detailed account of the reasons why medical need was unmet.

Among other OECD countries, data on immigrants' unmet health needs were available only for the United States. However, such data referred more specifically to unmet medical needs resulting from cost, as opposed to all possible reasons, and should therefore be compared to EU data with caution.

The indicator for the immigrant population is adjusted, predicting what it would be if the foreign-born population had the same age, educational attainment and income characteristics as the native-born population.

On average across OECD countries, 7.1% of immigrants reported having an unmet medical need over the past year, compared to 5.6% of the native-born population. This difference was not found to be statistically significant.

Differences in the prevalence of unmet needs between the foreign-born and the native-born are significant for approximately half of the countries for which data can be published (Figure 4.4). In all such countries, the foreign-born are more likely to have unmet needs than the native-born. Immigrants in Scandinavian countries were the most likely to report having unmet needs (16.4% in Sweden, 12.6% in Denmark), while those in Belgium, Luxembourg and the United Kingdom were the least likely (less than 4%). Around 9% of immigrants in the United States reported an unmet medical need as a result of cost alone.

After adjusting for age, education and income level, immigrants in both Spain (–2.0% points) and the United States (–0.7% points) were less likely to report unmet medical needs than the native-born. However, immigrants in Austria, Estonia, Portugal and Sweden were still between 4.1% points and 1.2% points more likely to report unmet medical needs than the native-born.

Similar reasons among the native-born and immigrants were reported for unmet medical needs across European OECD countries: cost, waiting to see whether the problem would get better on its own, busy schedules, and waiting lists. However, immigrants (at 31%) were more likely to report cost as the reason behind an unmet medical need than were the native-born (23%).

Figure 4.4. **Percentage of foreign- and native-born adults reporting unmet medical needs, 2009**

StatLink ᵃᵍᵖ *http://dx.doi.org/10.1787/888932734970*
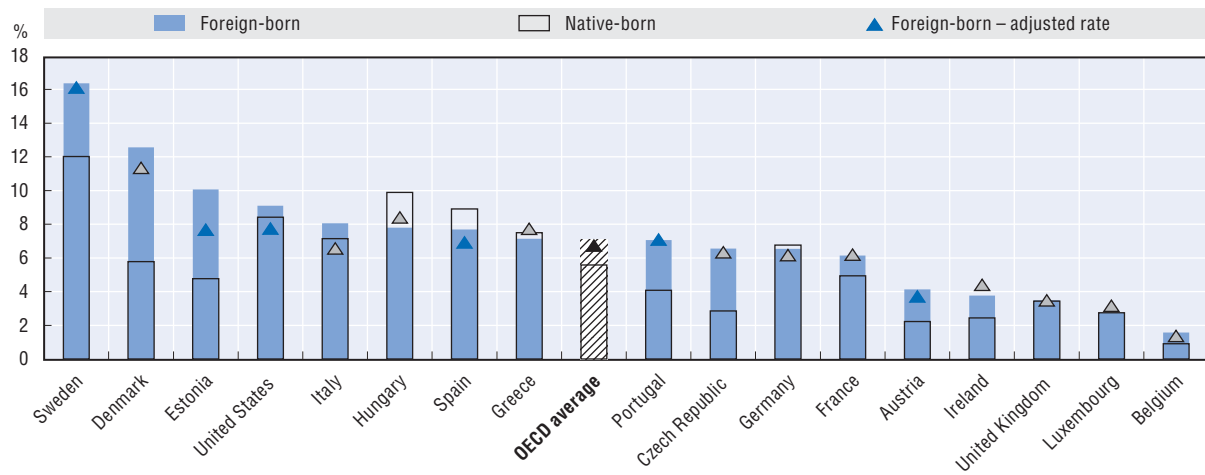
Notes and sources are at the end of the chapter.

Measurement

An ideal set of immigrants' health indicators would report on objective health status as well as describe factors that lead to poor health. However, indicators that are available and easily measurable are static and tend to only report on current health outcomes and not on risk factors that may affect trends in health outcomes. Commonly used health indicators, such as infant mortality and life expectancy, are either inapplicable or unavailable for immigrant populations. Health examinations such as medical tests (blood check-ups, reports of chronic diseases, etc.) would be ideal but require specific surveys, which are implemented infrequently in countries, if at all.

This chapter analyses several aspects of self-reported health status for both the native-born and immigrant populations (Indicator 4.1). Some caution is recommended in interpreting the self-reported replies to the survey questions, since social and cultural differences in self-perception and in self-reporting across countries and between native-born and immigrants within a country may limit the validity of comparison.

Preventative and curative visits to the doctor and medical check-ups (cancer screening, in particular women's breast cancer screening, children vaccination, etc.) are key indications of the equity of access to medical care. However, sample sizes of national health surveys do not allow for robust results for immigrants. Another method of gauging equity of access to services is by assessing reports of unmet needs for health care. In order to determine unmet medical needs, individuals are typically asked whether there was a time in the previous 12 months when they felt they needed health care services but did not receive them, followed by why the need for care was unmet (Indicator 4.2).

Notes, sources and further reading

Notes

Grey diamonds in all figures indicate differences between adjusted rates for immigrants and rates for native-born not statistically different from zero to a probability of 0.05.

All panel designs tend to under represent recent arrivals. In the case of EU-SILC the panel is renewed every four years. The samples are cross-sectionally representative only for the first wave of a new panel: only newly arriving immigrants who join a resident household, *e.g.* through family reunification and formation, are captured. In HILDA, new arrivals after 1999 are only included if they are in previously resident households. As Australia had significant intakes of migrants between 1999 and 2009, and has had an increased focus on highly educated labour migrants since the mid-1990s, the estimates thus tend to be biased.

Sources

European Union Statistics on Income and Living Conditions (EU-SILC) 2009; Swiss Household Panel (SHP) 2009; Household, Income, and Labour Dynamics in Australia (HILDA) 2009; Canadian Community Health Survey (CCHS) 2007-2008; US National Health Interview Survey (NHIS) 2010.

Further reading

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