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Original article

Perceived discrimination and self-rated health in the immigrant population of the Basque Country, Spain

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ABSTRACT

Objective: To examine the effect of perceived discrimination and self-rated health among the immigrant population in the Basque Country, Spain, and determine whether this effect varies according to region of origin, age, sex and education.
Methods: Descriptive cross-sectional study. The study population included immigrants aged 18 and older residing in the Basque Country. Data from the 2014 Foreign Immigrant Population Survey (n = 3,456) were used. Log-binomial regression was used to quantify the association between perceived discrimination and self-rated health before and after checking for the selected characteristics.
Results: Almost 1 in 10 immigrant adults reports perceiving discrimination. In adjusted analyses, the immigrants perceiving discrimination were almost were 1.92 more likely to rate their health as poor (prevalence ratio: 1.92; 95% CI: 1.44–2.56) than those who did not report discrimination. This association did not vary according to region of origin, age, sex or educational level.
Conclusions: Perceived discrimination shows a consistent relationship with perceived health. Moreover, this association did not depend on the region of origin, age, sex or educational level of immigrants. These results show the need for implementing inclusive policies to eliminate individual and institutional discrimination and reduce health inequalities between the immigrant and native populations.

Discriminación y salud percibida en la población inmigrante del País Vasco (España)

Palabras clave:
Discriminación
Inmigrantes
Estado de salud
Encuesta de salud

RESUMEN

Objetivo: Examinar el efecto de la discriminación en la salud percibida en la población inmigrante en el País Vasco y si este efecto es explicado por las diferencias en la región de origen, la edad, el sexo y la educación.
Métodos: Estudio descriptivo transversal cuya población de estudio fue la población inmigrante de 18 años y más de edad, en el País Vasco. Los datos proceden de la Encuesta de Población Inmigrante Extranjera 2014 (n = 3456). Se utilizó la regresión log binomial para medir la asociación entre la discriminación y la salud percibida antes y después de controlar por las características seleccionadas.
Resultados: La discriminación fue referida por casi uno de cada 10 inmigrantes. En los análisis ajustados, los inmigrantes que refirieron discriminación tuvieron 1,92 de probabilidad de tener mala salud (razón de prevalencia: 1,92; intervalo de confianza del 95%: 1,44-2,56) en comparación con quienes no la refirieron. Esta asociación no cambió según la región de origen, el sexo ni el nivel de estudios.
Conclusiones: La percepción de discriminación muestra una consistente relación con la salud percibida. Además, esta relación no depende del lugar de origen, la edad, el sexo ni el nivel de estudios de los inmigrantes. Estos resultados muestran la necesidad de implementar políticas inclusivas que eliminen la discriminación, tanto individual como institucional, para reducir las desigualdades en salud entre la población inmigrante y la autóctona

Introduction

Studies investigating the relationship between racial/ethnic discrimination and health outcomes have increased over the past decade. Most of these studies have been conducted in the United

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States (US) and have focused on discrimination and self-rated health,[1,2] mental health,[2–4] cardiovascular diseases,[5] diabetes,[3] hypertension[6] as well as use and access to health care.[7] Consistently, these studies provide evidence of the negative or detrimental effects of discrimination on health outcomes.[8]

In Europe, the study of discrimination and health status has been steadily increasing over the last decade, especially in the immigrant population, the main source of racial and ethnic diversity in European societies.[9] These studies show that discrimination explains a great proportion of the inequalities observed for health outcomes between the native and immigrant population.[10–13] Over the past two decades, Spain has experience an intense arrival of immigrant population ranking fourth country in the European Union since 2010.[14] Although the economic crisis has affected immigration, this population represent 12.7% of the Spanish population in 2016.[15] In the Basque Country, where immigration has always been lower, the immigrant population represents 8.8% of the total population in 2016.[15] However, it is one of the few regions that has grown in immigrant population during most of the period of economic crisis.[16] The least impact of the crisis and its latest entry of the Basque Country have contributed to this situation. In addition, there have been lower cuts in social policies and less discriminatory towards immigrants, as in the case of the not application of the Royal Decree (RD) 16/2012, which excludes access to health services to immigrants in irregular situation.[17]

The increase of the immigrant population has changed the sociodemographic of Spain and led to an interest on learning about the health effects of migration processes and social factors such as the discrimination associated with the incorporation of this population into the host societies. The latter could lead to discrimination at both the individual (as a result of interpersonal relationships) and the institutional level (due to policies, structures and regulations that may be discriminatory).[18] Recent evidence shows that discrimination is associated with poorer health outcomes, including self-rated health[19–23] in Spain. However, most of these studies used convenience samples or aggregate immigrants regardless of country or region of origin into a single category.

Despite the evidence on the associations between discrimination and health status, it is unclear whether this association varies with the place of origin, gender, age or level of education. Differential discrimination exposures could be expected on immigrants according to place of origin as a result of the attitudes of the host population towards groups more distant culturally and historically. This differential effect could also be affected by contextual factors related to policies for immigrant integration. However, in Europe, a few studies examining the association between perceived discrimination and health taking into account the place of origin showed mixed results. Some studies have found a stronger association in immigrants from particular origins[10,22] while other found an associations regardless of place of origin.[10]

Gender could also determine greater exposure to discrimination, and therefore, have a higher impact on women's health. However, evidence is still inconsistent with some studies reporting poor self-rated health associated with discrimination in women[13,19] whereas others found this association among men.[22] Other important factors such as age[13] and education[13,21] could modify the effect of discrimination on health. However, evidence is inconsistent with some studies suggesting a stronger association between discrimination and poor health among younger and highly educated immigrants,[19,24] whereas other among the least educated immigrants.[25] Therefore, to elucidate these gaps in the literature, this study aims to examine the association between perceived discrimination and self-rated health among the immigrant population in the Basque Country, Spain; and whether this association varies with region of origin, age, gender or education.

Methods

Study design and population

The study used data from the Foreign Immigrant Population Survey 2014 (EPIE). The EPIE is a representative cross-sectional survey of the immigrant population residing in family dwellings in the Basque Country, Spain (N = 5912). This survey has been conducted every four years by the Basque Government since 2010. The EPIE 2014 collected information on the living conditions of the immigrant population and included information on health status and health care utilization. A random sampling design stratified by place of birth and place of residency using information from the 2013 Census data was used. Information was collected via family (5912) and individual (2350) questionnaires. All the interviews used in this study were performed in Spanish. Moreover, the completion rates for family and individual questionnaires were 73.5% and 69.3%, respectively. These analyses are based on the family questionnaires.

Variables

The outcome was self-rated health, a multidimensional measure of physical and psychological health, shown to be a significant predictor of morbidity and mortality and use of health care.[26] Self-rated health was evaluated using the question "How is your health in general?", with answers from very good to very bad. For analytical purposes, self-rated health was specified as good (very good and good) and poor (fair, bad and very bad).[8]

The independent variable, perceived discrimination, was collected through the question "In the past year, have you suffered problems of social rejection because of your social or geographical origin, race, ethnicity, culture, language, religion or administrative status?", with answers of yes and no.

Consistent with previous studies,[23] we considered region of origin (Europe, Africa, Latin America and Asia), age (18-24, 25-34, 35-49, >49 years), gender, educational attainment (primary or less, secondary and graduate or higher), employment status (employed, unemployed and others), administrative situation (permanent resident, non-permanent resident and irregular resident), and length of stay in the Basque Country (<5, 5-10, >10 years).

Of total EPIE participants (n = 5912), we excluded those younger than 18 years of age (n = 1661), those born in countries with a Human Development Index (HDI) very high in 2015 (≥0.83) (n = 302) and those born in the Basque country (n = 493). These exclusions resulted in an analytical sample of 3456.

Statistical analysis

Descriptive statistics for selected characteristics were calculated for the total population and according to region of origin. In addition, prevalence estimates for self-rated health were calculated for each covariate according to region of origin. Chi-square and Cochran-Mantel-Haenszel statistics were used to assess significance associations between each covariate and region of origin and each covariate and self-rated health according to region of origin. We used log-binomial regression to quantify the association between discrimination and self-rated health before and after controlling for selected covariates. We tested interactions terms between discrimination and each covariate considered as effect measure modifier (region of origin, age, gender and education) in the fully-adjusted model.

Data management procedures were carried out using SPSS 22.0. (IBM, Armonk, NY) whereas the statistical analyses were conducted using SUDAAN 11.0.1 (RTI, Research Triangle Park, NC) to take into account the complex sampling design and yield unbiased