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Ethnic health inequalities in Europe. The moderating and amplifying role of healthcare system characteristics

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ABSTRACT

Health inequalities between ethnic majority and ethnic minority members are prevalent in contemporary European societies. In this study we used theories on socioeconomic deprivation and intersectionality to derive expectations on how ethnic inequalities in health may be exacerbated or mitigated by national healthcare policies. To test our hypotheses we used data from six waves of the European Social Survey (2002–2012) on 172,491 individuals living in 24 countries. In line with previous research, our results showed that migrants report lower levels of health than natives. In general a country's healthcare expenditure appears to reduce socioeconomic differences in health, but at the same time induces health differences between recent migrants and natives. We also found that specific policies aimed at reducing socioeconomic inequalities in health appeared to work as intended, but as a side-effect amplified differences between natives and recent migrants in self-assessed health and well-being. Finally, our results indicated that policies specifically directed at the improvement of migrants' health, only affected well-being for migrants who have lived in the receiving country for more than 10 years.

1. Introduction

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race … or social condition" (WHO, 1946, p. 1). Research on various European societies and the United States has indicated however that ethnic minorities generally report poorer self-assessed health and have a higher risk of serious illness as compared to ethnic majority groups (Hadjar and Backes, 2013; Missinne and Bracke, 2012; Nielsen and Krasnik, 2010; Smedley et al., 2009; WHO, 2010; Wiking et al., 2004). The two most acknowledged and prominent explanations for these ethnic health inequalities are found in the lower socioeconomic status of migrants and in perceived discrimination of ethnic minority groups (Nazroo, 2003; Safi, 2010; Wiking et al., 2004). Contrarily, some studies showed that ethnic minorities suffer less from certain types of diseases (Darmon and Khlat, 2001; Rafnsson et al., 2013) or have lower mortality rates (Abraído-Lanza et al., 1999; Razum et al., 1998). In addition, there are indications for a so-called 'healthy migrant effect', that suggests that healthier people are physically and financially more likely to migrate (Darmon and Khlat, 2001; Kennedy et al., 2006; Malmusi et al., 2010), whereas others put forward that in times of illness, retirement or unemployment migrants might return to their country of origin, known as the 'salmon bias effect' (Abraído-Lanza et al., 1999; Razum et al., 1998; Wallace and Kulu, 2014).

Despite clear cross-national differences in ethnic health inequalities (Huijts and Kraaykamp, 2012; Safi, 2010) only few studies have tried to identify causes of this cross-national variation. The studies that did, suggested that strict integration policies are associated with poorer migrants' health: ethnic minority groups may experience more health problems, a higher mortality risk, and lower well-being in European countries with stricter integration policies (Hadjar and Backes, 2013; Ikram et al., 2015). Additionally, ethnic minorities seem more disadvantaged in terms of well-being in higher income countries, and less so in countries with a family-oriented welfare system (Hadjar and Backes, 2013).

Studies dealing with alternative explanations for cross-national variation in ethnic health inequalities, however, are still lacking. It is particularly surprising that the role of healthcare systems has

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received little attention. Countries differ in the accessibility and affordability of their healthcare, and in the quality and extent of healthcare provision (Karanikolos et al., 2013; Wendt et al., 2009). Healthcare expenditure has often been linked to social inequalities in health (Fiscella et al., 2000; Mackenbach, 2012). Such inequalities may be smaller in countries with extensive healthcare systems with lower out-of-pocket payments, for this will increase access for all and reduce financial restrictions for the financially deprived (Balabanova et al., 2013). The potential impact of healthcare systems for ethnic health inequalities has been noted as well. For instance, a lack of resources for translators, time pressure on physicians, financing of healthcare, and availability of healthcare institutions affect the health of ethnic minorities more negatively than the health of the ethnic majority (Ingleby, 2011; Smedley et al., 2009).

In this study, we aim to move closer to the underlying mechanisms linking healthcare systems to ethnic health inequalities by examining the role of two specific domains in health policy: policies aimed at the reduction of socioeconomic inequalities in health, and policies targeting migrants' health. First, because of the ubiquity and detrimental impact of socioeconomic inequalities in health (Mackenbach et al., 2008), several countries have implemented policies specifically aimed at reducing these inequalities. Apart from a reduction of socioeconomic inequalities in health, these policies may also diminish ethnic health disparities, given that ethnic minorities are overrepresented among the lower socioeconomic strata. Second, policies specifically targeting migrants' health are usually national policies "that go beyond statutory or legal entitlements" to improve migrants' health (Mladovsky, 2011, p. 186). For example, these policies may provide 'cultural mediators', instruction of health workers in cultural competence, and interpreters (Ingleby, 2011). To our knowledge, no previous study has considered these two health policy dimensions simultaneously to explain cross-national variation in ethnic inequalities in health. All in all, we answer the following research questions: *To what extent is the association between ethnicity and health moderated by a country's (a) healthcare expenditure, (b) policies aimed at reducing socioeconomic inequalities in health, and (c) policies aimed at improving migrants' health?*

To answer these questions, we examine ethnic inequalities in health in 24 European countries, using multilevel regression models to analyze pooled cross-sectional data on 172,491 individuals from six waves of the European Social Survey (2002–2012). Two indicators of health are studied: self-assessed health and well-being. This focus on indicators of self-rated health does justice to the WHO's definition of health (WHO, 1946), which notes that health is "a state of complete physical, mental and social well-being". While these indicators are subjective measures of health, self-assessed health is strongly associated with for instance mortality (DeSalvo et al., 2006). We distinguish recent first-generation immigrants, non-recent first-generation immigrants and second-generation immigrants in dealing with ethnic inequalities, comparing them with native-born citizens of destination countries.

2. Expectations: how healthcare systems affect migrants' health

Previous comparative studies on ethnic and social health inequalities are often undertheorized. Although several studies have shown how ethnic and social inequalities in health vary across countries, little has been done to explain this variation. In this study, we elaborate on theories of socioeconomic deprivation and intersectionality to demonstrate how and why national policies may sometimes have unexpected and unintended effects, focusing on ethnic inequalities in health as an exemplary case.

Theories on socioeconomic deprivation have been derived mostly from notions on material deprivation in the sociology of health, and from notions on human and cultural capital in the social sciences (e.g. Bourdieu, 1986). In short, the most essential implication of deprivation theory is that ethnic inequalities in health are caused by disadvantages in material resources, access to healthcare and information among ethnic minorities. Since ethnic minorities are overrepresented in lower socioeconomic groups (Koopmans, 2010; Van Tubergen, Maas and Flap, 2004), ethnic minorities would be more strongly affected by socioeconomic deprivation than ethnic majority members. Indeed, it has been shown repeatedly that people's socioeconomic position is positively related to health (e.g. Eikemo et al., 2008; Mackenbach et al., 2008; Marmot, 2004). A higher level of education facilitates the understanding of and access to information about healthcare and healthy lifestyles, and higher incomes permit better housing conditions and access to private healthcare.

Based on deprivation theory, we expect healthcare systems to have a vital role in reducing ethnic inequalities in health. After all, affordable and accessible healthcare in a country would mostly benefit people from lower income groups who lack financial resources to pay for high-quality medical treatment. Similarly, health promotion campaigns would have the strongest positive effect for people from lower educational groups who often lack information about healthy lifestyles and healthcare services, and who may need additional support in implementing already available information on health risks. A main strategy to tackle ethnic inequalities in health therefore would be to address the underlying cause for this health disadvantage of ethnic minorities (i.e., socioeconomic deprivation). Subsequently, higher (government) expenditure on healthcare ensures that high quality healthcare is accessible, and especially lower socioeconomic strata are expected to benefit from higher expenditures (Karanikolos et al., 2013). As a result, we expect that higher expenditure on healthcare may reduce differences in health across ethnic groups, since it reduces the negative consequences of socioeconomic deprivation on health. In addition, from deprivation theory it is expected that national policies explicitly aimed at reducing socioeconomic inequalities in health would also be successful in mitigating ethnic health inequalities since they target ethnic minorities' socioeconomic deprivation.

Although it is often readily assumed that policies aimed at reducing socioeconomic inequalities in health would mitigate ethnic inequalities in health, this is not necessarily evident. Based on intersectionality theory we arrive at different expectations. Originating in the field of critical political theory and feminist studies, intersectionality theory was initially applied to intersections of race and gender in describing deprivation and disadvantages among women from ethnic minorities (Crenshaw, 1989). Intersectionality theory revolves around the idea that multiple dimensions of inequality, power and disadvantage cannot be separated or studied in isolation (Bauer, 2014; Kapilashrami et al., 2015). For example, a disadvantage experienced by African American women is not simply the sum of racial inequality and gender inequality, but a unique cumulative position of multiple disadvantages (Crenshaw, 1989; Weber and Parra-Medina, 2003). In the past few years, intersectionality theory has been applied increasingly in research on health, and recently also in comparative studies on health inequality (Bekker, 2003; Hankivsky, 2012; Iyer et al., 2008).

A central argument derived from this theory is that ethnic inequalities in health are caused by more than socioeconomic deprivation alone. After all, intersectionality theory would contend that dimensions of ethnic disadvantage and socioeconomic disadvantage intersect (Bauer, 2014): people from ethnic minority