4. Health among older populations of migrant origin

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4.1 Health of older migrants: an introduction

According to the WHO, health can be defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948). This implies that studying health includes different dimensions that will be addressed in this short report. On the one hand, health refers to the physical dimension of being able to perform activities of daily living, having objectively diagnosed chronic diseases, as well as self-assessed health. On the other hand, it also includes mental health issues and other problems in social relations that may lead to social isolation and loneliness (see also Carballo Divino, & Zeric, 1998; Mladovsky, 2007). These different dimensions of health are also clearly related and simultaneously influence each other. For example, a chronic disease like obesity tends to be linked to poorer physical and mental health, as well as low psycho-social wellbeing (Bollini & Siem, 1995; Cunningham & Vandenheede, 2017; Jatrana et al., 2017). Health outcomes are sometimes triggered by one event but may also be the result of an accumulation of health disadvantages over the life course. In all cases, the current health situation of a(n older) person needs to be understood from a life course perspective. In light of the growing diversity of European populations it has been more and more acknowledged that research should address the potential different health situation and paths (Carballo et al., 1998; Carballo & Nerukar, 2001; Rechel et al., 2013).

Although upon arrival, migrants are often found to be healthier than the average resident in the host country (which has been referred to as the healthy migrant paradox), research has shown that health and mortality of migrants converges to that of the host country over time and generation. The initial "healthy migrant paradox" seems to hold true even though the socioeconomic position upon arrival tends to be worse for some migrant groups than for the majority population. Originally, this effect was found in the United States, but in the meantime, it has also been documented for many other countries, including European destination countries. However, over time and with subsequent generations, this health advantage tends to change into a health disadvantage in many cases. There is however a wide variety in health outcomes for different migrant origin groups making generalizations so far rather difficult to make. Clear causal explanations are so far also difficult to reach as most studies rely on cross-sectional data, and thus compare migrants of different ages but do not follow migrants and their health situation longitudinally (Rechel et al., 2012). This clearly hampers the conclusions that can be drawn and prevents researchers from getting a better insight into health and its determinants among migrants as an inherently dynamic and heterogeneous group (Jatrana et al.,2017).

Health differences among migrants compared to non-migrants are mainly ascribed to a set of factors, which are primarily at the individual level and have been associated with a range of health dimensions. These include the selectivity of migrants (both upon arrival and via selective return), migrant-specific risk behavior and life styles, dietary habits, socioeconomic position, as well as health care access and utalization (Brussaard et al. 2001; Gilbert & Khokhar 2008; Kolmboe-Ottesen & Wandel, 2012; Mladovsky 2007; Lindert et al., 2008; Solé-Auró & Crimmins 2008). At the group level, related aspects like the different stages of the health transition migrant origin and destination countries are in as well as the role of networks as a potential continuation of (un)healthy behavior but also as resource for

support have been thematised (Reus Pons et al., 2017; Vandenheede et al., 2015). However, most studies, which address the full migrant population, have not assessed the differential impact that each of these factors may have for older migrants in Europe. Neither have the relative importance of the different health dimensions and their interaction sufficiently been explored (Malmusi, Borrell, & Benach, 2010).

This report gives a short overview of the existing European literature on the topic of migrant health and ageing published in English with a focus on older migrants. A distinction is made between studies on physical health, mental health and loneliness, as well as mortality. There is some obvious overlap but this differentiation helps to provide insight into the different dimensions of health among older migrants. It goes without saying that this short report cannot provide an exhaustive analysis but focuses on some major issues that have been studied. The final section also points to the main research gaps and needs for advancing knowledge about the growing migrant elderly population across Europe.

4.2 Physical and self-perceived health

Most large scale survey studies on physical and self-perceived health among migrants do not specifically focus on older migrants (Rechel 2011). On the one hand many studies do not allow studying the migrant population at all as they target the population at large often implying too few migrants are included for meaningful analyses and no specific migration related questions are posed. On the other hand studies that focus on migrants often do not allow studying the group of older migrants as often these surveys do not include sufficient elderly. Many existing studies on migrants in the European context rely on more small-scale, in-depth studies that are focused on a specific migrant origin group, country of settlement or health intervention (e.g. Bermúdez Morata et al., 2009; Gotsens et al., 2015 for Spain; Public health service Amsterdam 2015; Venema, Garretsen & Van der Maas, 1995 for the Netherlands; Nolan, 2012 for Ireland; Weishaar, 2008 for Scotland; Sharareh, Carina & Sarah, 2007 for Sweden). The more limited research based on more large-scale datasets builds regularly on datasets that are not specifically aimed at migrant populations and, therefore, have significant limitations, e.g. not providing detailed information on migration-specific determinants or migrant groups with a specific migration history. As a result, health is often analysed by e.g. looking at general determinants of health (like socio economic status) rather than migrant specific aspects which many of these population broad surveys do not capture (like length of residence, language knowledge, acculturation, culturally specific health behavior etc.) For example, the SHARE (Survey of Health Ageing and Retirement) data focus on the elderly population across Europe but have no specific aim to target migrant elderly. Studies based on these data that do analyses the migrants in the sample show that migrants are more likely to have lower self-rated health compared to the majority group (e.g. Lanari & Bussini, 2012; Moullan & Jusot, 2014; Reus-Pons et al., 2017; Solé-Auró, Guillen, & Crimmins, 2011). Using European Social Survey data, subjective well-being among migrants has also been shown to be lower than among non-migrants (e.g. Arpino & de Valk, 2017; Sand & Gruber, 2016) but these studies also indicate that this is more valid for certain regions or countries of origins and for certain destination countries. However, although these data can give some indications on how migrants are faring compared to the majority group, the fact that the numbers of migrants in both types of datasets are limited, make it hard to draw far-reaching conclusions. In addition, the ways, in which different migrant origin and destination countries interact, is impossible to explore in detail with these surveys due to limited numbers.

Country-specific studies indicate that, overall, migrants tend to have poorer physical health than the

majority group, but they also stress the large heterogeneity between origin groups (e.g. Carnein et al., 2014; Leão et al., 2009; Vaillant & Wolf, 2010). In England and Wales, European migrants are reported to have better health while a comparative study across Europe found that some European origin groups are worse off than the native majority group, e.g. in the Netherlands, Germany and France. Looking at some specific diseases, existing findings are again mixed by country of settlement and origin. For example, when it comes to heart disease, a Swedish study found that immigrants are worse off in Sweden but still fare better than peers in their country of origin (Gadd et al., 2003; Sundquist et al., 2006). A comparison of self-rated health across Europe overall shows that this is lower among migrant than non-migrant populations (Nielsen & Krasnik,2010). Another European comparative study showed that, for Activities of Daily Living (ADL), immigrants were doing worse than the majority group. This applied to a range of countries including France, Germany, the Netherlands, Sweden and Switzerland (Solé-Auró & Crimmins, 2008). The respective authors also acknowledged the large differences in ADL functioning and self-rated health among the majority group across European destination countries. This implies that the comparison group for migrants is different depending on the country of residence. So in a country where the majority group reports more health problems the reference level is higher than it is for countries where fewer health issues are reported by the majority group population. The choice of the correct reference group for migrant populations and their descendants should therefore always be carefully chosen and reflected upon when drawing conclusions (Solé-Auró & Crimmins, 2008).

The factors often brought up for explaining migrant health differentials include on the one hand general mechanisms that apply to all irrespective of migrant status. These cover for example educational attainment and income (often captured in indicators for socioeconomic status SES), where those with higher educational attainment, income and housing conditions are better off than those, who are doing less well on these dimensions (Jatrana et al., 2017; Silveira et al., 2002; Vacková & Brabcova, 2015). Yet, the relationship between health and SES is not always easy to assess in causal terms as there are complex interactions between the different factors. On the other hand, a range of migrant-specific factors has been identified as potentially relevant. Debates are inconclusive whether these are migrant culture specific, whether they are linked to the minority status or ethnicity and the role of the host society e.g. in terms of discrimination (Marks & Worboys 1997). Overall findings are rather mixed again for different groups and settlement countries. Hence, limitations may arise from sample selection issues: For example, in case data are collected in the language of the majority group, only a selected share of the migrant population will (be able to) participate in a survey. Overall studies mention citizenship and duration of stay, for example, as potential key aspects, where poorer health tends to be linked to those, who have already stayed longer in the country and those who do not hold citizenship (Bolzman et al., 2004; Lanari & Bussini 2012). However, the effect of duration of stay may actually point to very different mechanisms at play: An accumulation of health disadvantages over time in the settlement country, or an acculturation to the host society health levels, norms and behavior, which again may lead to opposite effects when it comes to health outcomes.

Adaptation to the host society in terms of health (risk) behavior, diet and health norms has been suggested to play an important role in migrant health across the life course (Darmon & Khlat, 2001; Ratjana et al., 2017; Solé-Auró & Crimmins 2008). This would undo the initial health advantage migrants may have and explain the health changes observed over time and generations. Since most available data do not include information of migrants' health situation upon arrival, it is difficult to assess the acculturation effect or health development across the life course. Also the role of potential

acculturative stress for both physical and mental health has been mentioned in the literature, but so far limited research has been done due to a lack of suitable longitudinal data that follow migrants from the moment of arrival in the country of settlement (Kristiansen et al., 2007; Ratjana et al., 2017; Solé-Auró & Crimmins, 2008). Finally, access to health care and the role of language have been used to explain differences in health outcomes, also of older migrants (Lanari & Bussini, 2012; Solé-Auró Guillen & Crimmins, 2011). Access to health care not only relates to knowledge on health care systems and potential care that can be obtained but also relates to insufficient health care coverage due to a lack of knowledge on the routes in the national health care systems that widely differ between countries in Europe. Another dimensions is that in case health care systems are not used by migrants to the same level as non-migrants, diseases may go unobserved and as such the prevalence of certain health issues may simply be underestimated for the migrant population (Solé-Auró & Crimmins, 2008).

4.3 Mental health and loneliness

In the field of mental health, there is a longstanding interest in the relationship between migration and (symptoms of) psychological disorders. Numerous studies, conducted mainly in North America (the U.S. and Canada), provide evidence that newcomers have, on average, a better mental health profile than their native-born counterparts (Cunningham et al., 2008; Vang et al., 2017). This "healthy migrant effect", like in the case of physical health, is usually found to be a temporary phenomenon: Migrants' initial mental health advantage disappears and often even deteriorates the longer they live in the host country (Acevedo-Garcia et al., 2010; Wu & Schimmele, 2005).

These studies, however, have focused on other (symptoms of) psychological disorders than loneliness, e.g. depression, anxiety. Depression is reported as a common disorder among a large share of in particular migrant populations (Carta et al 2005). This has been related, in particular, to the cultural shock and the changes that migrants face in terms of their position in society or their social networks (Bhugra, 2004; Carta et al., 2005). Furthermore, studies have suggested that mental health challenges may also result from the interaction with the host society and feelings of rejection, social exclusion and discrimination that migrant populations may face (Warnes et al., 2004). A recent comparative European study on subjective well-being has also pointed to the relevance of the host country's integration policies for explaining the lower levels of subjective well-being of migrants in countries with more restrictive policies (Sand & Gruber, 2016).

Loneliness, commonly defined as unpleasant feelings arising when one perceives a discrepancy between desired and actual number and quality of social relations (Perlman & Peplau, 1981) is still less often studied for migrant populations across Europe. So it remains to be seen whether a "healthy migrant effect" also applies with regard to loneliness, yet there are reasons not to expect that: Migrants experience a discontinuity in their life course, leaving behind the socio-cultural contexts they belonged to, which previously provided a safety net and meaning in life (Ciobanu et al., 2017). Moreover, insecurity about how to socialise and about social expectancies in the new country will initially hinder the development of a new social network (Watt & Badger, 2009). Empirical evidence suggests that there is, at least, a positive relationship between "being migrant" and loneliness in the longer run: Regardless of host country, quantitative studies show that, on average, older migrants are more likely to be lonely than their native peers (de Jong Gierveld et al., 2015; Fokkema and Naderi, 2013; Victor et al., 2012; Wu & Penning, 2015).

To explain the above-average prevalence of loneliness among migrants over time, prior work has examined the impact of general and migrant/culture-specific risk factors. With regard to general risk

factors, the focus has been primarily on migrants' poorer physical health and lower socioeconomic status (e.g. a low level of education and income, living in deprived neighbourhoods) relative to individuals in good physical condition or from higher socioeconomic classes that are better positioned to be in contact with others and to be engaged in health-promoting activities (Fokkema et al., 2012). The studied migrant/culture-specific risk factors include, among others, length of residence, language and cultural barriers, lack of migrant-specific social meeting places and culture-sensitive care, taboo to talk about intimate matters, strong filial norms, discrimination, stigmatization and other negative reactions from the outside world. Until recently, qualitative case study research has been the dominant approach to study the role of both types of (general and migrant specific) risk factors (e.g. Cela & Fokkema, 2017; Choudhry, 2001; Dong et al., 2012; Ip et al., 2007; King et al., 2014; Lee, 2007; Park & Kim, 2013; Treas & Mazumdar, 2002). With the increasing availability of suitable survey data, the interest in this topic also increases among quantitatively oriented scholars (de Jong Gierveld et al., 2015; vanCluysen & van Craen, 2011; Visser & El Fakiri, 2016; Wu and Penning, 2015). For instance, in the first quantitative study on differences in loneliness between older adults of Turkish origin and their German counterparts, Fokkema and Naderi (2013) showed that the higher level of loneliness among Turkish older adults is entirely attributable to their health and socioeconomic disadvantages.

Notwithstanding their valuable contribution, these studies have some limitations. The first one is that they tend to probletamise and stigmatise all migrants overall, overlooking heterogeneity and inequalities between and within migrant groups and ignoring changes in circumstances over the life course (Ciobanu et al., 2017; Zubair & Norris, 2015). For example, the focus of European studies has almost exclusively been on the main non-Western migrant groups, coming from former colonies or guest worker countries, i.e. the groups culturally most different from the native-born population and ranked by Warnes and colleagues (2004) as the most vulnerable group. Despite their vulnerability, however, the few quantitative studies show that there are, indeed, differences in loneliness across ethnic groups: For example, older adults originating from India indicate low rates of loneliness compared to those from Pakistan, Bangladesh, the Caribbean, Africa and China in the United Kingdom (Victor et al. 2012). In the meantime, older adults originating from Turkey show high rates of loneliness compared to migrants from Suriname and/or Morocco in the Netherlands (Klok et al., 2017; Uysal-Bozkir et al., 2017; Visser & El Fakiri, 2016). Moreover, a significant proportion within each of these ethnic groups does not report feeling lonely at all, which may suggest that many migrants possess resources they can mobilise to manifest agency and develop strategies to prevent, cope with, and overcome loneliness (Ciobanu et al., 2017). To avoid the potential pitfall of problematizing and stigmatizing the migrant population, researchers have more recently turned their attention to those factors that may counteract or mediate loneliness. The most common protective factors that have been studied so far include social embeddedness within the family (Fokkema & Naderi, 2013 – no empirical evidence), belonging and participating in the ethnic community and larger society (Klok et al., 2017; Visser & El Fakiri, 2016 – empirical evidence), and religion (Ciobanu & Fokkema, 2017 – empirical evidence).

A second important limitation of previous studies is the exclusive focus on factors at the destination (a notable exception is Klok et al., 2017). It is well known that migrants' lives are often not confined to the place of residence; part of their practices and affinities transcend national boundaries (Basch et al., 1994; Glick Schiller et al., 1992). Therefore, more research is needed to get insight into the consequences of their transnational way of living and belonging on loneliness. In the (mental) health literature, conflicting theoretical arguments have been developed regarding the implications of

transnational ties – as either protective or risk factors – on migrants' well-being (Boccagni, 2015; Torres et al., 2016). On the one hand, transnational ties may improve the migrants' self-esteem and contribute to retaining his or her ethno-identity (Mossakowski, 2003; Torres & Ong, 2010). Transnational ties further serve as reference points, which enable migrants to adopt a favourable status through comparisons with those left behind (Alcántara et al., 2014; Jin et al., 2012; Nieswand, 2011). Finally, transnational ties provide migrants with an alternative space of belonging (Viruell-Fuentes & Schulz, 2009) and source of social support (Baldassar, 2007, 2008; Carling, 2014; Wilding, 2006). This might be particularly relevant when experiencing discrimination/social exclusion in the destination country. If these effects dominate, then transnational ties lead to a lower likelihood of loneliness. On the other hand, transnational ties stir the emotions of long-term separation from family members and friends and nurture feelings of loss, longing and missing through the recurring awareness of one's absence (Dito et al., 2016; Dreby, 2010; Parreñas, 2001). At the same time, they amplify feelings of financial and social obligations putting pressure on migrants to act according to their transnational families' expectations (Baldassar, 2014; Krzyzowski & Mucha, 2014; Mazzucato, 2008). Moreover, keeping transnational ties causes feelings of "uprootedness" and "identity crisis" ("betwixt and between" identities, "double absence"; Grillo, 2007; Sayad, 1999) and therefore a decreased sense of belonging. If these effects dominate, then transnational ties lead to a higher likelihood of loneliness.

4.4 Mortality

In line with studies on physical and mental health, foreign-born migrants tend to have lower mortality levels than the native group in many countries (e.g. Boulogne, 2012; Deboosere & Gadeyne, 2015; Razum et al., 1998; Reus Pons et al., 2016). This also applies despite the lower socioeconomic status many migrants face. In general, studies find that, especially first-generation, migrants have lower levels of all-cause mortality than the majority population in the host country even after controlling for differences in socioeconomic conditions (Vandenheede et al., 2015). Again this has been related to the fact that in particular, those who are relatively healthy will migrate, and migration is, therefore a selective process towards healthier individuals. However, the fact that first-generation migrants have lower mortality could also be due to the fact that in the event of a (life threatening) illness, migrants return to their country of origin and are, therefore, not registered as being ill in the country of destination (referred to as "the salmon bias hypothesis") (Wallace & Kulu, 2014). However, an increasing number of studies claim that due to acculturation, migrants that arrive from less industrialised countries in Europe will make a faster health transition from infectious to chronic diseases, which is why related mortality tends to become more common (Vandenheede et al., 2015).

Studies for Belgium based on full population data found that first-generation migrants of Western and non-Western origin do have an advantage in mortality compared to the majority group population and later generations (Vandenheede et al. 2015). For the Netherlands similar findings are reported on the full population register data. These studies however relate the findings also to issues of registration and salmon bias effects (Uitenbroek & Verhoeff, 2002). Despite the lower levels of mortality, migrants are not necessarily in a better health situation: Some chronic diseases or mental disorders may not lead to death, but have a long-lasting effect on the health condition of the individual. In turn, this may have major impacts on the life of the individual and the care needs over the life course including old age.

Looking at mortality causes, studies find different levels of mortality from most cancer types whereas cardiovascular mortality is higher among certain origin groups (e.g. South Asia) (Arnold et al., 2010;

Deboosere & Gadeyne, 2005; Ikram et al., 2016; Khlat & Darmon, 2003; Landman & Cruickshank, 2001). So far no studies in Europe exist that exclusively focus on mortality among older migrants. The patterns observe relate to the full population of migrants. One of the few exceptions is a recent study by Reus Pons et al. (2016) that focuses on Belgium using full population data. They find that part of the mortality disadvantage for some groups of older migrants is due to their socio-economic position. At the same time they report important differences in mortality patterns between different origin groups and for men and women. This clearly calls for attention to the variety in life paths of various migrant groups when wanting to understand mortality differences at later age.

4.5 Research gaps and needs

Research indicated that despite the potentially healthier starting point of migrants in a country upon their arrival, various health dimensions tend to become worse than that of the majority group population. However, the consistency of this effect across different countries of origin and destination, and the underlying mechanisms are not yet well understood. Studies have acknowledged the cumulative life course effects for health among migrants but, so far, longitudinal studies of health among sufficiently diverse samples of elderly migrants are still limited.

The diversity of the migrant population points to another gap in the existing literature: So far, most studies address rather broad categories of migrant origins or migration reasons. Going more into detail in terms of the causes of migration, as well as the specific situation in the country of origin would be an essential route to advance the general knowledge. After all, “the” older migrant does not exist. This becomes even more evident in the current situation of migration in Europe that covers many different forms of migration and mobility, e.g. labour migrants, refugees, or family migrants among many others.

Health outcomes are sometimes triggered by one event but may also be the result of an accumulation of health disadvantages over the life course. In all cases, the current health situation of a person needs to be seen in a life course perspective, and a cross-sectional analysis seems ill-suited to answer the open questions on health issues and care needs of the increasing population of migrant origin across Europe. This calls for studying risk behaviors and life style over the life course and it also requires a better recording of stressful events, which may turn into later-life health outcomes. Finally, also the timing of the move as well as repetitive moves, circular migration, and settlement at different stages in the life course have not yet been well-understood in relation to general health and late-life health, in particular.

Furthermore, so far, studies on mental and physical health have largely been separate spheres of study. Although it is acknowledged that different health dimensions interact in the life course of a person, research seems somewhat underdeveloped in this regard. The linkage of different health dimensions and analyses of the accumulation of adverse health issues among certain groups would be extremely relevant in terms of prevention and care. A related barrier to advancing our understanding of how migrant populations age and what factors may contribute or hinder healthy ageing has been the division in research between formal and informal care. These different dimensions should be integrated much more to understand how these two forms of care may go hand in hand and how they may contribute to healthy ageing. This is even more valid in view of the debates about the financiability of the health care systems of Europe’s ageing societies. Also in Northern European countries that traditionally have high levels of state care, emphasis has been put on the importance of informal care by family members or alternative care arrangements via individual care takers. Although these trends

apply to the total population, insights into the specific care needs and care options of the heterogeneous migrant population have been largely overlooked so far. Moreover, questions of how the use of care in the country of origin and country of destination is combined in the wake of (late-life) health issues need more attention in research and will also help policymakers and care practitioners.

With regard to data, the identified research gaps imply the need for more suitable large-scale data, and also call for better exploration of the existing data. Data collection efforts should aim for, at least, a certain level of international comparability to better capture effects related to the country of residence and thereby learn from country-specific best practices. Using also population register data, for countries where these are available, and linking them to surveys is a fruitful avenue for future studies. Furthermore, longitudinal data have a greater potential to satisfy the complex interactions of health and migration (either by prospective or retrospective longitudinal designs). Only under these conditions, it will be possible to advance knowledge about the health situation of elder migrants and their care needs now and in the future. More complete information on the health situation upon arrival would, in addition, allow for observing the key turning points in health status for the individual. And as many migrants arrive when they are young, and start ageing in the settlement country, following these men and women over their lives really can bring our knowledge on health ageing among a diverse population further.

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