

Comparing migrants' health across Europe: same origins, different destinations

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Introduction

Health plays a crucial role in the integration of migrants, yet understanding migrant health is complex. Multiple factors shape health trajectories before, during, and after migration. Before arriving in the host country, individuals are exposed to environmental, microbiological, and cultural risk factors; migration itself entails profound transformations that may influence physical and mental health through stress, uncertainty, and adaptation. Once settled, living and working conditions, economic opportunities, and access to healthcare become key determinants of wellbeing. Migrants' health therefore reflects the interaction between conditions in the country of origin, the migration process, and the post-migration context at destination.

A growing body of research shows that migrants' health and mental wellbeing vary substantially across European contexts (Aichberger et al., 2010; Moullan & Jusot, 2014). Differences in self-rated health and depression have been linked to structural and individual determinants such as socioeconomic conditions, barriers in accessing healthcare services, housing and working conditions, and exposure to discrimination (Rana et al., 2025; Siddiq & Najand, 2022). However, findings remain inconsistent across countries, reflecting the interplay between selection mechanisms, migrants' origins, and destination-specific factors including welfare regimes, integration policies, and labour market opportunities.

Despite increased attention to these issues, important gaps remain. Most comparative studies focus on destination country characteristics, overlooking how migrants' countries or regions of origin shape health outcomes. A *country-of-origin/country-of-destination* framework offers a more comprehensive understanding of migrants' health by distinguishing compositional influences—linked to migrants' pre-migration conditions, socioeconomic profiles, and cultural norms—from contextual influences operating at destination, and by allowing comparisons of migrants from the same origin groups across different European destinations. Moreover, no studies examine both dimensions jointly across origin groups and destination contexts, despite clear evidence of different health outcomes across migrant populations.

To address these gaps, we apply a *country-of-origin/country-of-destination* comparative framework to analyse differences in self-rated health and depression among four major migrants' origin groups—Eastern Europeans, migrants from the Middle East and North Africa (MENA), Sub-Saharan Africans (SSA), and Latin Americans—across three European macro-regions: northern, continental, and southern Europe, which differ in welfare systems, integration regimes, and social attitudes toward migrants. In this framework, the context of origin reflects cultural norms, health behaviours, and pre-migration experiences that may persist after migration (Milewski, 2007), while the context of destination introduces new social norms, institutional frameworks, and opportunities (Maxwell, 2010) that can facilitate or hinder wellbeing. The interplay between origin and destination factors, mediated by different forms and degrees of integration, may produce distinct self-rated health and depression patterns, reflecting varying opportunities for migrants' adaptation and inclusion.

This study contributes to the existing literature in three ways. First, it analyses self-rated health and depression, offering a holistic understanding of migrants' wellbeing. Second, it explicitly incorporates both origin and destination perspectives, moving beyond single-country analyses. Third,

it examines how regional variation in destination contexts shape health inequalities among migrant groups. Specifically, we ask: Do migrants from the same origin groups report different levels of self-rated health and depression across European destinations, and to what extent do these differences reflect varying forms of integration? Overall, this comparative approach advances understanding of how structural, institutional, and cultural factors interact with migration background and integration processes to shape migrants' self-rated health and depression across Europe.

Data and Methods

We use data from the European Social Survey (ESS) round 7 (2014) and 11 (2023). The ESS is unique in combining standardized measures of self-rated health and depression with substantial samples of foreign-born respondents across a large number of European countries. It provides a representative sample of the general population aged 15 and older living in private households, regardless of language, citizenship, or nationality. ESS round 7 includes 22 countries and round 11 includes 29 countries.

For this analysis, we include northern, continental and southern European countries—representing the main immigration-receiving regions (e.g., Rechel et al., 2013)—and exclude Eastern European countries, which mainly attract immigrants from neighbouring countries (Eurostat, 2025), as well as Israel, to maintain a European focus.

From the initial pooled sample (N = 86,347), we select only migrants, defined by their place of birth outside the country of residence, and retain individuals with complete information on all key variables. The final analytical sample consists of 3,095 migrants. All analyses use the post-stratification provided by the ESS to ensure representativeness.

Our dependent variables are self-rated health (SRH) and depression. SRH is derived from the question “*How is your general health?*” (responses ranging from “Very bad” to “Very good”). We dichotomise the variable, assigning a value of 1 to individuals reporting “Fair,” “Bad,” or “Very bad” health, and 0 otherwise. Depression is measured through the question “*How much of the time during the past week did you feel depressed?*” with four response options ranging from “None or almost none of the time,” to “All or almost all of the time.” The variable takes a value of 1 for respondents reporting “Some of the time,” “Most of the time” or “All or almost all of the time,” and 0 otherwise.

Our main explicative variables capture migrants' regions of origins and regions of destination. We distinguish four migrants' origin regions: Eastern Europeans, migrants from MENA, SSA, and Latin-Americans. The countries of destination are grouped into three European macro-regions based on similarities in welfare systems and integration regimes, and social attitudes toward migrants: northern (Denmark, Finland, Norway, Sweden, and Iceland), continental (Austria, Belgium, Switzerland, Germany, France, Great Britain, Ireland, the Netherlands), southern (Cyprus, Spain, Greece, Italy, Portugal) Europe.

We control for a wide set of variables: *individuals' characteristics* [sex (men, women), age (in years), civil status (single, married, divorced/widowed), and whether ever divorced (no, yes)]; *four indicators of socioeconomic status* [education (up to secondary, tertiary), occupational status (employed in high-skilled jobs, employed in medium-skilled jobs, employed in low-skilled jobs, unemployed, inactive/retired, other), employment history (ever had a job with no unemployment spells, ever had a job with unemployment spells, never worked), perceived income adequacy (adequate, some difficulties)]; *an indicator of physical health* [suffering from physical problems (no, yes)]; *an indicator of migration history* [duration of stay in the host country (<15 recent years, ≥ 15 years)]; and *indicators of social support, exclusion or experience barriers of integration* [perceived

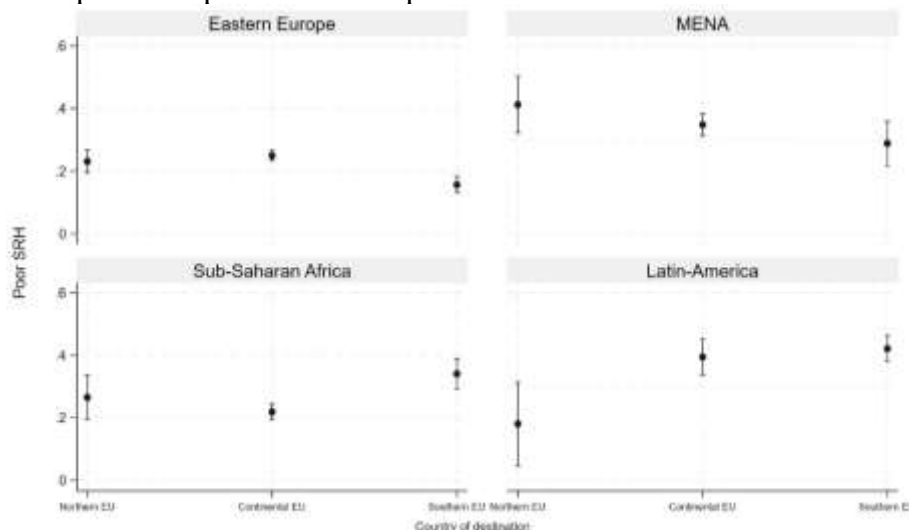
membership of a group which is discriminated against (no, yes), state of the healthcare services in the country (bad, sufficient, good/very good) social support indicated by the presence of someone whom one can discuss intimate or personal matters with (no, yes)].

To address our research question, we estimate weighted logistic regression models for each dependent variable (SRH and depression). Each model includes an interaction term between migrants' regions of origin and regions of destination, controlling for all covariates listed above. We present results as predicted probabilities to enhance interpretability. Confidence intervals are computed at the 83.5% confidence level, to allow pairwise comparisons (see e.g., Goldstein and Healy, 1995)

Preliminary results

Figure 1 shows the predicted probabilities of reporting poor SRH among migrants from Eastern Europe, MENA, SSA, and Latin America across the three destination regions considered. On average, migrants from Eastern Europe display lower probabilities of poor SRH than those from other regions. This pattern is particularly marked among those residing in Southern Europe, who are significantly less likely to report poor SRH than their counterparts in Northern or Continental Europe. Migrants from MENA countries also exhibit the lowest probability of poor SRH in Southern Europe, although the difference with other destination regions is not statistically significant. Interestingly, the pattern is reversed among migrants from SSA: those residing in Southern Europe are the most likely to report poor SRH, with a significantly higher probability than those in Continental Europe (while the difference with Northern Europe is not significant). Finally, migrants from Latin America show particularly low probabilities of poor SRH in Northern Europe, whereas such probabilities are significantly higher in both Continental and Southern Europe.

Figure 1. Adjusted predicted probabilities of poor SRH

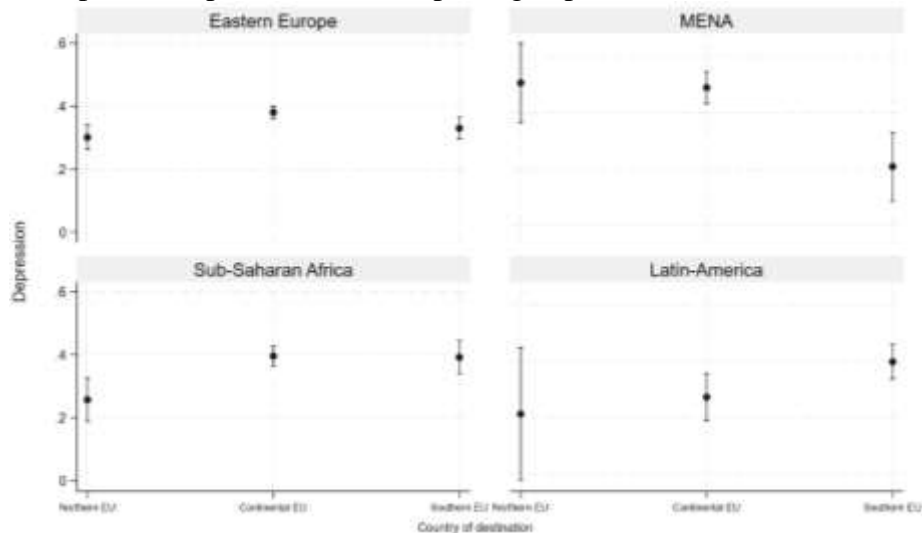


Source: Authors' elaboration on ESS7 and ESS11 data.

Results on depression show some similarities with the patterns observed for SRH, but also notable differences. Among migrants from Eastern Europe, variations in the likelihood of reporting depression are limited; however, they display a significantly higher probability of depression in Continental Europe than in Northern or Southern Europe. Migrants from MENA countries tend to report higher levels of depression in Northern and Continental Europe, while the probability is

significantly lower in Southern Europe. Interestingly, the opposite pattern emerges among migrants from SSA, whose likelihood of reporting depressive symptoms is lowest in Northern Europe (and significantly so). Finally, migrants from Latin America exhibit a slightly higher probability of depression in Southern Europe compared to Continental and Northern Europe.

Figure 2. Adjusted predicted probabilities of reporting depression



Source: Authors' elaboration on ESS7 and ESS11 data.

Further developments

Preliminary results show that migrants from the same macro-area of origin show remarkable health differences across regions of destination that persists after including a large set of socio-demographic, economic, and migration-related controls. In the next steps, we will refine our analysis by employing the eight item-version of the depression scale to capture the frequency of depressive symptoms in the week preceding the interview. The items include: (1) feeling depressed, (2) feeling lonely, (3) feeling sad, (4) feeling happy, (5) enjoying life, (6) feeling that everything was an effort, (7) experiencing restless sleep, and (8) having difficulties getting going. Additionally, we plan to include Migrant Integration Policy Index (MIPEX) as a control variable, which creates a rich, multi-dimensional picture of migrants' opportunities to participate fully in host society.

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