

## MIGRANTS' HEALTH IN ITALY: DO THE UNION STATUS AND THE PARTNER'S NATIONALITY MATTER?

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**Abstract.** Being in a romantic union is consistently found to be associated with better health, both because of selection mechanisms and due to virtuous (i.e., healthy) behaviours of coupled individuals. However, the relationship between union status and health status has received considerably less attention among migrant populations, and, to the best of our knowledge, it has never been analysed in Italy. This study aims to fill this gap in the literature, moving one step further: we also explore whether having a partner of migrant or native origin influences migrants' health. Results suggest that migrants in a romantic union have lower risks of experiencing mental health issues, and female migrants fare better in terms of self-rated health and mental health when their partner is of native origin rather than a migrant themselves.

### 1. Introduction

The migration phenomenon in Italy has undergone a well-documented transformation over a history spanning more than forty years (Strozza, 2018): during the '90s it was marked by the presence of pioneering male workers, while over the past two decades, these initial flows were succeeded by family reunifications or the establishment of new families in the host country. As a result, migrants today represent an established and settled population in Italy, numerically relevant, and which contribute to the increasing family diversity. In a similar context, a deep understanding of migrants' life conditions is crucial. In this paper, we focus on migrants' health in Italy, analysing the role played by their union status and by the nationality of their partner – for those who are partnered – in shaping their health.

The protective effect of marriage on individuals' health and mortality has been widely studied on the overall population (e.g., Rendall *et al.*, 2011), while studies on migrants are limited (e.g., Maxwell and Harding, 1998). Generally speaking, the literature shows a positive relationship between being married and having good health. However, despite mixed unions have become increasingly popular over the past years (Lanzieri, 2012), the relationship between the partner's origin (or nationality) and individual health status has been surprisingly disregarded. Some studies demonstrated an association between being in a union with a native and improved economic aspect, indicating that such unions offer migrants some type of

gain (e.g., Elwert and Tegunimataka, 2016). Other studies considered non-economic aspects such as life satisfaction (e.g., Chang, 2016; Potarca and Bernardi, 2021). Only few studies addressed the relationship between having a native vs. a migrant partner and mental health (Eibich and Liu, 2021; Milewski and Gawron, 2019), and we will discuss them in the literature review.

In Italy, literature about migrants' health is limited and recent due to the nature of the migration history of the country, which is relatively recent with respect to all other European countries. The few studies available analyse migrants' mortality (Alicandro *et al.*, 2020; Trappolini *et al.*, 2021), migrants' use of health care services (Devillanova and Frattini, 2016; Trappolini *et al.*, 2020), migrants' health (Loi and Hale, 2019) and gender disparities in health (Trappolini and Giudici, 2021). To the best of our knowledge, differences in migrants' health by marital status in Italy have never been studied, especially focussing on the partner's migration background.

The aim of this study is twofold: first, it analyses whether being in a stable union has a positive effect on migrants' health; second, it explores whether the partner's nationality plays a role in determining individuals' health. In this regard, we refer to exogamous unions to identify unions between an Italian and a foreign citizen, and to endogamous union to identify unions between two foreign citizens.

## **2. Literature review: The link between union status and health**

Demographic literature showed the protective effect of marriage – or, more generally, being in a stable union – on individuals' health and mortality (Carr and Springer 2010; Rendall *et al.*, 2011).

In the literature, there are different mechanisms to explain such a pattern. First, the better health or lower mortality of married individuals is a consequence of the selection of healthy people into marriage (Waldron *et al.*, 1996). The second one focuses on economic resources. Marriage provides economic benefits, including economies of scale and increased earning potential for men, leading to improved living conditions and better access to quality healthcare (Killewald, 2013). Additionally, marriage plays a role in social control, as it is associated with norms discouraging health-risk behaviours like smoking and drug use. When individuals enter marriage, they are more likely to adhere to these norms due to the influence of their spouse and a sense of responsibility towards their family (Fleming *et al.*, 2010). Furthermore, the marital relationship offers significant social support and emotional affection, which can alleviate feelings of loneliness, depression, and improve mental well-being (Peters and Liebroer, 1997).

Although this topic has been extensively analysed on the overall population, there is a scarcity of studies focusing on migrant populations. The study by Maxwell and Harding (1998) suggests that marital status is a key determinant for migrants'

mortality as well: unmarried individuals have a higher mortality than married ones. In another study, Koball *et al.* (2010), analysing the African Americans, show that the links between marriage and health for African Americans vary depending on characteristics, beyond race, of the individual. In a different setting, female marriage migrants in Southeast Asia were found to experience worse health than the native population in their destination countries (for a review, see Yu *et al.* 2019).

Other few researches examine differences in life satisfaction (Chang, 2016; Gawron and Carol, 2022) and mental health (Eibich and Liu, 2021; Milewski and Gawron, 2019) between migrants in endogamous or exogamous unions. The findings indicate that migrants in exogamous unions, after the birth of their first child, tend to report lower life satisfaction in Germany (Gawron and Carol, 2022). In terms of mental health, Milewski and Gawron (2019) suggest that migrants benefit from intermarriages. They observe, across nine European countries, that migrants in exogamous marriages are more likely to report lower levels of depression than their counterparts in endogamous marriages, hypothesising that the non-migrant spouse may operate as a source of bridging interethnic social capital with positive consequences on the migrant partner. The same result is confirmed in the study by Eibich and Liu (2021) on older migrants in Germany. In addition, they find that the size of family networks differs by union type.

Based on this literature, we formulate the following research hypothesis for Italy in order to improve our understanding of migrants' health in the country:

- 1) Migrants in stable unions show better health than their counterparts who are single, widow, or separated/divorced;
- 2) We expect migrants in exogamous unions to have better health than their counterparts in endogamous unions.

In addition, given that health is a typically gendered dimension (and it was proved to be so also in Italy, e.g., Trappolini and Giudici (2021)), we test our research hypotheses separately among men and women.

### **3. Data and methods**

#### *3.1. Data*

We use the unique and most up-to-date Italian survey on foreign citizens, "Social Condition and Integration of Foreign Citizens", conducted by ISTAT during 2011-2012, on a sample of households with at least one member with non-Italian citizenship (hereafter, migrants), providing insights into different aspects of daily life, as well as key socio-economic and demographic information.

The survey collects information on 9,553 households for a total of 25,326 individuals. The data are representative of migrants residing in Italy; therefore, the survey only includes information on migrants regularly settled in the country.

The statistical unit for the analysis is the main respondent. We select only the main respondent (who has to be a migrant, by definition) because in the case of exogamous unions (i.e., a union with a native) the survey does not provide information on Italian individuals. Finally, we exclude individuals below the age of 18 to ensure the reliability of reported health (Bleidablik *et al.*, 2009). Thus, our final sample consists of 9,395 individuals (49.7% women).

### 3.2. *Dependent variables*

We employ three dependent variables: self-rated health (SRH), mental health and physical limitations. SRH is derived from the question ‘How is your health in general?’ with five possible answers ‘very good’, ‘good’, ‘fair’, ‘bad’, ‘very bad’. We dichotomise such variable by coding ‘very good’ and ‘good’ as 0 and 1 otherwise. The information about mental health is included in the Mental Health Index (MHI, see Ware and Gandek, 1994). MHI scores vary between 0 and 100, with higher scores indicating better mental health. We dichotomise the variable by coding 0 scores higher than 65 (the third quartile of MHI distribution). Finally, information about physical limitations is derived from the following question: ‘Do you suffer from limitations in activities usually performed due to health problems?’. We treat physical limitations as a dichotomous variable: 0 ‘no limitations’ and 1 otherwise.

We study multiple health outcomes to better describe migrants’ health and capture different health aspects following previous researches on the same topic (e.g., Alderotti and Trappolini, 2022). SRH should capture the general aspect of health in the short-run, while mental health and physical limitations should capture health problems in the long-run.

### 3.3. *Main explicative and control variables*

We rely on two main explicative variables in order to test each of our two research hypotheses. The first explicative variable is the marital status. We distinguish between ‘single’, ‘divorced or widow’, and ‘in couple’. The second explicative variable is the type of union, as we distinguish between ‘exogamous unions’ (between a migrant and a native), and ‘endogamous unions’ (among co-ethnics).

We control for a set of socio-economic and demographic variables: age (continuous), educational level (‘up to lower secondary education’, ‘upper secondary or tertiary education’), employment status (‘employed’, ‘unemployed’, ‘inactive’), area of origin (‘Romania, Poland and other countries of Central and Eastern Europe that are not in the EU’, ‘Africa’, ‘Asia and South America’, ‘North America, Oceania and the remaining European countries’), duration of stay (‘recent migrants’ – i.e., who migrated less than 7 years before the interview, ‘long-term migrants’ – i.e.,

who migrated at least 7 years before the interview<sup>1</sup>), parity ('childless', 'parents'). Finally, we include information about the reason for migration. When considering the reason for migration, respondents had the option to indicate multiple reasons for their migration. Therefore, we make assumptions in order to identify their primary migration reason. Firstly, if respondents indicate "affective reasons" for their migration, we infer that they have close relatives in Italy, and thus the main reason for migration is categorised as "family reunification," regardless of any other reasons they may have mentioned. Secondly, if respondents do not select "affective reasons" but choose at least one of the following options: "to find a job," "make more money," or "improve life quality," we classify the main reason for migration as "economic/working reasons." Lastly, any remaining migration reasons, such as "study," "war," "persecutions," "to make new experiences," "it was not my choice," or "other," are grouped into a residual category. Descriptive statistics are provided in Table A1 in the Appendix.

### 3.4. Methods

We conduct two separate analyses using logistic regressions. In the first one, we test the protective effect of being in a stable union on each of the three health outcomes considering the overall population. In this regard, the main explicative variable (marital status) only distinguishes among 'single', 'divorced or widowed' or 'couple' (Table 1).

In the second set of analysis, we focus only on couples and investigate differences in migrants' SRH, mental health and physical limitations between exogamous and endogamous unions. In this case, we compute the predicted probabilities with 83.5% confidence intervals<sup>2</sup> both to avoid the incomparability arising from coefficients obtained from different logistic regression models and to enhance the interpretation of results (Figure 1). All the analyses are stratified by sex.

## 4. Results

In this section, we address the relationship between marital status and health among migrants. For space reasons, we only show the results about the relationship between each of the three health outcomes analysed and marital status by sex. Table 1 illustrates the Odds Ratios (OR) depicting such a relationship net of age,

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<sup>1</sup> The choice of 7 years as a threshold ensures subsamples of sufficient size and has been previously adopted in existing literature (e.g., Trappolini and Giudici, 2021, Alderotti and Trappolini, 2022).

<sup>2</sup> Confidence intervals are centred on the predictions and have lengths equal to  $2 \times 1.39 \times$  standard errors. This is necessary to obtain an average level of 5% for Type I errors in pairwise comparisons of a group of means (Goldstein and Healy, 1995).

educational level, employment status, area of origin, duration of stay, parity and reason of migration. Results suggest that men and women in a couple have smaller chances of reporting bad SRH (ORs = 0.84 among men and by 0.91 among women), while divorced/widow individuals have higher risks of reporting bad self-rated health; however, these figures are not significant. On the other hand, relevant differences are detected for mental health. We find that both men and women who are in a union are significantly less likely to report poor mental health than singles (OR = 0.65 and OR = 0.69, p-value 0.000, respectively). No remarkable difference arises with divorced/widow individuals. Finally, men in unions have higher ORs of reporting physical limitations, while divorced/widow women have higher ORs of reporting physical limitations; nevertheless, these results are only weakly significant (p-values between 0.05 and 0.10).

**Table 1** – *Adjusted OR by marital status and sex, in poor self-rated health, poor mental health and has physical limitations. Reference category: single.*

	Men		Women	
	OR	p-value	OR	p-value
<b>Poor self-rated health</b>				
Divorced/Widowed	1.10	(0.571)	1.09	(0.468)
Couple	0.84	(0.290)	0.91	(0.448)
<b>Poor mental health</b>				
Divorced/Widowed	0.89	(0.421)	0.93	(0.470)
Couple	0.65	(0.000)	0.69	(0.000)
<b>Has physical limitations</b>				
Divorced/Widowed	1.03	(0.905)	1.32	(0.060)
Couple	1.39	(0.100)	0.99	(0.969)

*Table notes: Models adjust for age, educational level, employment status, area of origin, duration of stay, parity and reason of migration.*

*Source: Authors' elaboration on SCIF data (2011-2012).*

To address our second hypothesis, we limited our analytical sample to migrants who are in a couple and checked whether there is an association between the partners' migratory background and the respondent's health. Figure 1 displays the adjusted predicted probabilities of reporting bad health for each of the three health outcomes analysed. The figure distinguishes between exogamous and endogamous unions, taking gender into account.

Net of the same set of controls used for the previous analyses, results reveal significant differences for women's SRH and mental health. More specifically, we observe that women in endogamous unions have a 20.0% (95% CI 0.180-0.222) probability of reporting poor SRH, while the same probability for their counterpart in an exogamous union is lower by more than 5 p.p. Similarly, migrant women in a union with a migrant man are more likely to report bad mental health than migrant women in a union with a native man (25% vs. 20%).

As regards men, we do not find significant differences for all health outcomes.

**Figure 1** – Adjusted predicted probabilities by gender and type of union in poor self-rated health, poor mental health and has physical limitations.

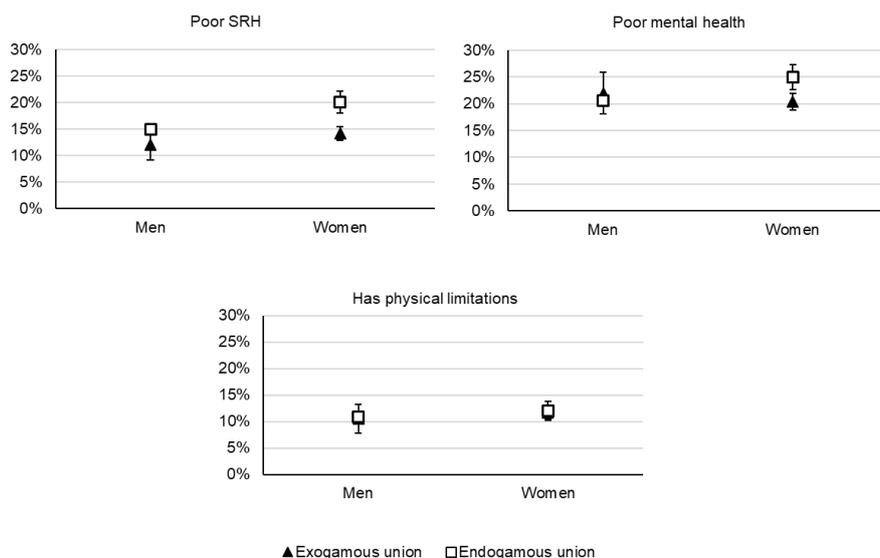


Figure notes: Results from logistic regressions. Models controlled for age, educational level, employment status, area of origin, duration of stay, parity and reason of migration. 83.5% CI. Source: Authors' elaboration on SCIF data.

## 5. Discussion and conclusions

This is the first study in Italy to shed light on the dearth of empirical evidence regarding the link between union status and migrants' health.

Using the Social Condition and Integration of Foreign Citizens (2011-2012), the study analyses differences in health between men and women by marital status. In addition, it specifically examines individuals in unions, comparing individuals' health in exogamous with their counterparts in endogamous unions. By analysing this association, our study contributes to the literature on migrants' health and enhances the comprehension of migrant integration processes within the evolving multicultural environment of European countries.

We tested two hypotheses. In the first one, we assumed individuals in unions to be healthier than their single counterparts. The analyses partially confirmed this hypothesis, highlighting that being in union is especially protective against mental health issues for both men and women. This finding was not unexpected, as being in a stable union is known to have a positive effect on health and mortality (e.g., Carr and Springer, 2010) through various possible mechanisms discussed in the literature review; however, our study proves such an effect holds also for migrants in Italy.

We reasonably posit that selection mechanisms may be especially crucial in the case of migrants in unions, as there may be a double positive selection at play – namely, the positive selection of healthy ones i) into migration and ii) into union.

In the second hypothesis, we expected individuals in exogamous unions to perform better than those in endogamous unions. We found evidence for this hypothesis only among women, who have higher probabilities of reporting poor SRH and mental health if they are in an exogamous union than in an endogamous union. These results agree with previous studies about mental health based on different contexts (e.g., Milewski and Gawron, 2019), thus reinforcing the idea that, for migrants, being married to a native corresponds to some gain in health and/or wellbeing (Potarca and Bernardi 2021). Our findings support the hypothesis that exogamous unions may be beneficial not only for mental health and life satisfaction, but also for SRH. However, as regards men, we did not observe any differences.

These findings suggest that when migrants form unions with natives in the destination country, they have the opportunity to broaden their local family network (Koelet *et al.*, 2017; Martinovic *et al.*, 2009), which can have positive implications. The family networks acquired through marriage, or more generally, unions can contribute to enhancing one's social capital, which in turn has the potential to translate into other forms of capital, including improved health outcomes (Bourdieu, 2018; Eibich and Liu, 2021). Actually, the presence of local family ties allows to alleviate some of the risks factors or challenges migrants face in the destination country, such as language barriers and limited access to services (Arai, 2005), which can negatively affect migrants' health (Robila, 2010). While the literature extensively acknowledges intermarriage as an indication of diminishing ethnic and social boundaries for both immigrants and the host society (Blau *et al.*, 1984), comparatively less attention has been placed on exploring the potential advantages associated with acquiring native family members through unions.

Our results also suggest that such differences disproportionately affect women, who both receive and provide more care (Penning and Wu, 2013), in line with previous studies (Eibich and Liu, 2021; Milewski and Gawron, 2019; Potarca and Bernardi, 2021). Conversely, there is a similarity in SRH, mental health, and physical limitations among men in both endogamous and exogamous unions.

This study has some limitations, which are mostly data-driven. Using cross-sectional data, we cannot observe health variations over time and cannot interpret our results in a causal manner. The survey only provides information for the migrant population, impeding the analysis of the health status of the entire couple as we lack data on native individuals. In addition, the relatively small sample size did not allow us to investigate differences by country of origin or reason of migration.

Bearing the limitations in mind, this paper adds to the literature about the comprehension of increasingly diverse European societies, emphasising the

significance of health as a crucial outcome in migrants' life in the destination countries and its interconnection with life course events.

## Appendix

**Table A1** – Sample characteristics and distribution of the outcome by sex.

	Men	Women
Marital status		
Single	20.80	21.89
Divorced/Widow	13.48	33.86
Exogamous Union	6.28	29.02
Endogamous union	59.44	15.23
Age (mean in years)	40.79	42.31
Educational level		
Up to lower secondary	50.13	31.55
Upper secondary & Tertiary	49.87	68.45
Employment status		
Employed	86.10	69.35
Unemployed	7.32	7.28
Inactive	6.58	23.37
Area of origin		
CEE, No-UE, Romania, Poland	47.27	61.90
Africa	27.27	9.45
Asia, Latin-America, Oceania	20.72	19.60
HDC	4.74	9.06
Length of stay		
Recent migrant (<6 years)	19.91	26.00
Long-term migrant (>=6 years)	80.09	74.00
Parity		
Childless	34.47	35.49
Parents	65.53	64.51
Reason of migration		
Work/Economic	80.79	61.92
Family reunification	8.38	25.85
Other	10.83	12.23
Self-rated health		
Very good / good	84.98	79.95
fair / poor / very poor	15.02	20.05
Mental health		
Good	77.17	74.13
Poor	22.83	25.87
Physical limitations		
Yes	9.70	14.52
No	90.30	85.48
N. observations	4,726	4,669

*Table notes: Percentage should be read in columns.*

*Source: Authors' elaboration on SCIF data (2011-2012).*

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