HEALTH STATUS BY CITIZENSHIP: INSIGHT FROM SURVEY AND REGISTER DATA ON IMMIGRANT HEALTH IN ITALY

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Abstract. This paper analyses the health status of immigrants in Italy, focusing on their citizenship status and the impact of both individual and macro-level factors on their health. We specifically investigate whether immigrants report different levels of health conditions compared to native-born individuals, using measures such as self-rated health, the number of chronic diseases, and functional limitations. Additionally, we evaluate the relationship between citizenship acquisition and health, while also considering the role of family and social support networks.

The study uses a combined dataset of survey and register data from the ISTAT 'Families, Social Subjects, and Life Cycle' (FSS) survey conducted in 2016. By linking FSS 2016 survey participants with citizenship acquisition registers, we ascertain the citizenship status of immigrants in Italy.

Key findings indicate significant health disparities among different migrant sub-groups. Foreigners have higher odds of reporting good or very good self-rated health compared to Italians but significantly lower odds of experiencing functional limitations and chronic diseases, highlighting a potential 'healthy immigrant effect,' where immigrants often arrive in better health compared to the native-born population. Naturalised citizens tend to have health outcomes more similar to those of native-born Italians, suggesting that the integration process, as proxied by naturalisation, may align immigrant health outcomes with those of the host population.

Our study underscores the importance of considering both individual-level factors and broader socio-economic determinants when addressing health disparities among migrant populations. It highlights the need for tailored public health interventions that consider the unique social support structures and integration processes of migrant sub-groups.

1. Background

Although migration brings numerous positive societal effects, such as meeting labour market demands and sustaining welfare models, the recent large-scale population movements require substantial adaptations in public health and health systems (Pottie *et al*., 2017 Trummer and Krasnik, 2017). Health systems must adapt to address the needs of both disadvantaged migrant populations and non-migrant

residents. Consequently, there has been an increasing focus on the health of migrants in host countries, recognizing the unique challenges and health disparities they face.

Migrants' susceptibility to illness is generally comparable to that of the general population; however, significant health disparities exist among different migrant sub-groups, often delineated by their countries of origin (WHO, 2024). A considerable proportion of migrants are part of the working-age population employed in low-paid jobs and are more likely to hold insecure, temporary contracts. Moreover, migrants may find themselves in vulnerable situations due to the reasons compelling them to leave their country of origin, the circumstances in which they travel, or the conditions they face upon arrival. Further, moving from one country to another entails not only a separation from the country of origin but also the challenging process of integrating into a new physical, institutional, and sociocultural environment. The loss of former support networks, or at the very least their transformation, presents immigrants with the need to rebuild their social support systems in the host country, involving an active search for support.

Research shows that people with greater social support, less isolation, and higher levels of interpersonal trust live longer and healthier lives than those who are socially isolated. Support from living arrangements and family members can provide a buffering effect against health deterioration among migrants, making social support a critical factor influencing their health (Yang *et al*., 2023; Salgado *et al*., 2012; Wong *et al*., 2008). Effective social support plays a positive role in promoting and protecting both physical and mental health, significantly alleviating migration-related stress (Fogden *et al*., 2020; Schweitzer *et al*., 2006). This positive impact of social support is also evident among migrants residing in Italy (Novara *et al*., 2023).

Despite the growing recognition of the importance of this issue, gaps remain in our understanding of the relationship between migration and health, especially in countries with a relatively recent history of immigration like Italy.

This study aims to explore whether foreigners residing in Italy report different levels of health compared to native-born individuals. Among the various questions regarding the health of foreigners, we focus on the role of naturalisation, together with the presence of family and social support networks. From this perspective, we examine the health status of foreigners and foreign-born migrants residing in Italy in 2016. A key objective of our analysis is to evaluate the utility of a combined dataset of survey and register data in studying migrant health. The primary dataset comes from the ISTAT 'Families, Social Subjects, and Life Cycle' (FSS) survey conducted in 2016, which represents a cross-section of Italy's adult population (ISTAT 2016). By linking FSS 2016 survey participants with citizenship acquisition registers, we obtain data on the year of naturalisation from 2012. To our knowledge, no previous studies have merged these data sources to investigate migrants' health and family

information. Therefore, this study offers an in-depth view of migrants' health, the role of citizenship, and the influence of family and social support.

2. Method

The study is based on a combined dataset of survey and register data. The primary dataset comes from the ISTAT 'Families, Social Subjects, and Life Cycle' (FSS) survey conducted in 2016, representing a cross-section of Italy's adult population (ISTAT 2016). By linking FSS 2016 survey participants with citizenship acquisition registers and obtaining data on the year of naturalisation spanning from 2012 to 2021, we ascertain the citizenship status of immigrants in Italy.

In this study, we utilised data from the FSS questionnaire to create three dichotomous variables based on specific health-related questions. First, respondents were asked to assess their general health (SRH), with response options being very good, good, neither good nor bad, bad, and very bad. For analysis purposes, we created a dummy variable where 1 represented good or very good health and 0 represented all other responses. Second, respondents were inquired about the presence of chronic diseases or long-term health problems, defined as conditions lasting or expected to last at least six months. Based on the response, a dummy variable was created where 1 indicated the presence of chronic diseases or long-term health problems and 0 indicated their absence. Last, respondents were asked if they experienced limitations lasting at least six months in performing usual activities due to health problems (ADLs), with responses categorised as severe limitations, non-severe limitations, and no limitations. From these responses, we created a dummy variable where 0 indicated no limitations and 1 indicated severe or non-severe limitations.

To achieve the study's objectives, we utilized multivariate logistic regression analysis to investigate the associations between various individual- and macro-level factors influencing immigrant well-being. Key variables include the acquisition of Italian citizenship and the presence of family and social support networks. Specifically, the frequency of personal contacts is assessed using a dummy variable indicating at least weekly personal contact (1) or less frequent contact (0). Social support is measured by two key variables: informal help and formal help. Informal help is assessed by whether respondents received assistance from people outside the household and is categorized as no (0) and yes (1). Formal help is measured by whether respondents received economic assistance from institutions, also categorized as no (0) and yes (1).

As control variables, demographic information includes age (categorised as 18-34 and 35-64), sex, and marital status (categorised as married, never married,

separated/divorced, and widowed). Socioeconomic status is assessed through educational attainment, which indicates the highest level of education completed by respondents and is categorised as tertiary, secondary, and primary education. Perceived economic resources measure respondents' perceived adequacy of economic resources, categorised as very good or sufficient, and insufficient or absolutely insufficient.

In all models, robust standard errors (S.E.) were used, and the data were weighted using normalised ISTAT weights. All the analyses were performed using Stata 18.

3. Results

3.1. Descriptives

Table 1 provides the sample characteristics stratified by citizenship status, based on weighted data from the ISTAT 2016 FSS survey. The sample comprises 17,982 respondents, with 9.8% identified as foreigners, 2.2% as naturalised citizens, and 88% as Italians.

The data reveal significant differences in demographic and socio-economic variables among the three groups. Most of the foreign and naturalised respondents are foreign-born (98.0% and 93.0%, respectively), contrasting sharply with the Italian group (1.5%). A notable proportion of naturalised citizens (50.5%) have held citizenship for over five years, suggesting a significant period of integration and adjustment.

Age distribution indicates a higher percentage of younger individuals (18-34 years) among foreigners (37.2%) compared to naturalised citizens (29.2%) and Italians (28.6%). Conversely, the 35-64 age group is more prevalent among naturalised citizens (70.8%) and Italians (71.4%) than among foreigners (62.8%). This demographic shift might reflect Italy's relatively recent history as a migration-receiving country and the integration phase where younger immigrants either naturalise or remain as foreigners. Gender distribution shows a slightly higher proportion of women among naturalised citizens (58.3%) compared to foreigners (53.7%) and Italians (49.8%).

Regarding family and social characteristics, naturalised citizens are more likely to be married (61.7%) compared to foreigners (51.9%) and Italians (51.5%). This finding aligns with the naturalisation process, where marriage is a common pathway to citizenship (Boyd and Grieco, 2003), with women having a higher propensity to acquire citizenship through marital ties (Boyd and Grieco, 2003; Jasso and Rosenzweig, 1995).

Social support variables highlight that weekly personal contact is significantly lower among foreigners (20.5%) compared to naturalised citizens (28.0%) and Italians (59.9%). This reduced social interaction among foreigners may indicate potential social isolation, a common challenge faced by immigrants (Cacioppo and Cacioppo, 2014).

The proportion of individuals receiving help is relatively similar across the groups, with 13.3% of foreigners, 17.1% of naturalised citizens, and 15.3% of Italians reporting receiving help. Economic help from institutions is more common among foreigners (7.0%) than among naturalised citizens (3.5%) and Italians (1.3%), reflecting potentially greater economic vulnerability among foreigners (Borjas, 1999). Educational attainment reveals that tertiary education is less common among foreigners (13.2%) and naturalised citizens (13.7%) compared to Italians (17.1%). Furthermore, economic resources are perceived as insufficient by a larger proportion of foreigners (54.3%) compared to naturalised citizens (36.6%) and Italians (29.5%). This underscores the economic challenges faced by the foreign-born population, which can be impacted by the disparity in educational attainment affecting employment opportunities and socio-economic integration for immigrants (Chiswick and Miller, 2009).

Table 1 − *Sample characteristics by citizenship status. Weighted data.*

	Foreigners	Naturalised	Italians	Total
n (abs.)	1,231	385	16,366	17,982
n (%)	9.8	2.2	88.0	100.0
Foreign-born	98.0	93.0	1.5	
Citizen for > 5 years		50.5		
18-34	37.2	29.2	28.6	29.5
35-64	62.8	70.8	71.4	70.5
Women	53.7	58.3	49.8	50.3
Tertiary education	13.2	13.7	17.1	16.7
Married	51.9	61.7	51.5	51.8
Weekly personal contact	20.5	28.0	59.9	55.3
Help receivers	13.3	17.1	15.3	15.1
Economic help by institution	7.0	3.5	1.3	1.9
Insufficient economic resources	54.3	36.6	29.5	32.1
Good SRH	82.2	79.1	78.7	79.1
At least one chronic disease	7.9	13.8	14.9	14.2
ADLs	5.2	6.6	7.3	7.1
Severe ADLs	2.4	2.7	2.9	2.9

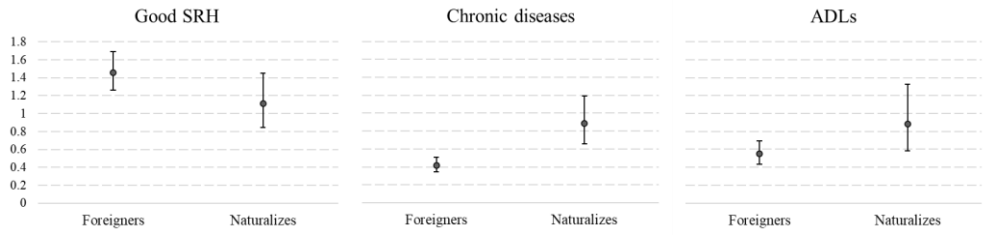
Source: Famiglia e Soggetti Sociali, ISTAT.

Health status indicators suggest that most respondents report good self-rated health (SRH), with slightly higher proportions among foreigners (82.2%) compared to naturalised citizens (79.1%) and Italians (78.7%). The prevalence of chronic diseases is lower among foreigners (7.9%) than among naturalised citizens (13.8%) and Italians (14.9%). Lastly, functional limitations (ADLs) are reported by 5.2% of foreigners, 6.6% of naturalised citizens, and 7.3% of Italians, with severe ADLs being reported by a smaller fraction across all groups. These findings indicate that functional limitations are relatively consistent across groups but slightly higher among Italians, possibly due to an older age distribution in this group.

3.2. Health outcomes by citizenship status

Figure 1 reports odds ratios and robust standard errors from logistic regression models of citizenship status and three health outcomes: good or very good self-reported health (SRH), presence of at least one chronic disease, and severe or non-severe functional limitations (ADLs).

Figure 1 − *Odds ratio (OR) and robust standard errors from logistic regression models for the three health outcomes (good or very good SRH, presence of at least one chronic disease and ADLs limitations) and citizenship status (reference=Italians). Weighted data.*



Source: Own elaboration on Families, Social Subjects and life cycle (FSS), ISTAT, 2016. All models control for age (18-34, 35-64), sex, marital status, contacts with the family, received formal and informal help, education and perceived economic resources (see Table 2).

For citizenship status, foreigners generally report better health outcomes compared to Italians. Specifically, foreigners have significantly higher odds of reporting good or very good self-rated health (OR = 1.458, 95% CI: 1.259-1.687) and significantly lower odds of experiencing functional limitations (OR = 0.550, 95% CI: 0.435-0.694) and chronic diseases (OR = 0.417, 95% CI: 0.345-0.505) compared to Italians. This may reflect the so-called ‘healthy immigrant effect’, where immigrants often arrive in better health compared to the native-born population (McDonald and Kennedy, 2004). Naturalised citizens, on the other hand,

show health outcomes more similar to those of Italians. They do not have significantly different odds of reporting good or very good SRH (OR = 1.109, 95% CI: 0.847-1.452), functional limitations (OR = 0.880, 95% CI: 0.585-1.324), or chronic diseases (OR = 0.888, 95% CI: 0.660-1.193) compared to Italians. This suggests that the integration process, as implied by naturalisation, may influence health status, potentially aligning it more closely with that of native-born citizens.

Overall, family and social networks have a mixed role in relation to health outcomes (Table 2). Weekly personal contact is not significantly associated with the odds of reporting good or very good self-rated health, chronic diseases, or functional limitations. However, receiving help (both informal and formal) is negatively associated with health conditions. These results may reflect the greater need for assistance among individuals with poorer health. Marital status associations are less pronounced, with never married, separated/divorced, and widowed individuals showing varying odds ratios for different health outcomes, but generally not significantly different from married individuals. Notably, widowed individuals have higher odds of experiencing functional limitations and chronic diseases, and lower odds of reporting good or very good self-rated health.

Table 2 − *Odds ratio (OR) and robust standard errors from logistic regression models for the three health outcomes (good or very good SRH, presence of at least one chronic disease and ADLs limitations). Control variables. Weighted data.*

Control variables	Good SRH			Chronic diseases			ADLs		
	OR	95% CI		OR	95% CI		OR	95% CI	
35-64 (ref=18-34)	0.262	0.229	0.299	2.570	2.246	2.943	2.642	2.189	3.189
Women (ref=men)	1.307	1.206	1.416	0.776	0.711	0.848	0.935	0.830	1.054
Never married (ref=married)	1.085	0.977	1.205	0.968	0.863	1.085	1.307	1.122	1.521
Separated/Divorced (ref=married)	0.986	0.867	1.121	1.013	0.878	1.170	1.202	0.996	1.450
Widowed (ref=married)	0.461	0.366	0.581	1.375	1.061	1.782	2.272	1.698	3.040
Secondary education (ref=primary)	1.788	1.639	1.951	0.804	0.730	0.886	0.536	0.470	0.613
Tertiary education (ref=primary)	2.145	1.881	2.446	0.818	0.715	0.935	0.471	0.383	0.578
Weekly personal contact (ref=no)	1.005	0.922	1.096	0.972	0.884	1.068	0.965	0.848	1.097
Receive help (ref=no)	0.790	0.709	0.880	1.602	1.435	1.789	1.737	1.501	2.011
Receive economic help by institution (ref=no)	0.667	0.520	0.856	1.733	1.324	2.270	1.756	1.284	2.403
Very good/good economic resources (ref=bad/very bad)	2.229	2.052	2.422	0.581	0.530	0.637	0.453	0.400	0.512

Source: Own elaboration on Families, Social Subjects and life cycle (FSS), ISTAT, 2016. All models control for citizenship status (Figure 1).

Among the other control variables, all directions are consistent with what is expected according to the literature. Individuals aged 35-64 have significantly higher odds of experiencing functional limitations and chronic diseases, and significantly lower odds of reporting good or very good self-rated health compared to those aged 18-34. Gender differences are notable, with males having lower odds of functional limitations and chronic diseases, and higher odds of reporting good or very good self-rated health compared to females. Educational attainment is inversely related to

negative health outcomes, as are perceived economic resources. Higher educational attainment (secondary and tertiary) is associated with better self-rated health and lower odds of functional limitations compared to primary education. Additionally, tertiary education lowers the odds of chronic diseases compared to primary education. Perceived economic resources, categorized as very good or good, are strongly associated with better health outcomes. Overall, these findings underscore the importance of socio-economic factors in determining health outcomes.

4. Discussion

This study provides a first analysis of the health status of foreigners and foreign-born migrants residing in Italy, with a particular focus on the role of citizenship acquisition and social support networks. Our key findings indicate significant health disparities among different migrant sub-groups. Specifically, foreigners have higher odds of reporting good or very good self-rated health compared to native-born Italians. Conversely, they have significantly lower odds of experiencing functional limitations and chronic diseases. Interestingly, naturalised citizens tend to have health outcomes more similar to those of native-born Italians, suggesting that the integration process, as proxied by naturalisation, may play a crucial role in aligning immigrant health outcomes with those of the host population. Additionally, our results support the 'healthy immigrant effect,' with immigrants exhibiting better health upon arrival compared to the native-born population (Kennedy *et al*., 2006; McDonald and Kennedy, 2004). Given that Italy has a relatively recent history as an immigration country, the immigrant population is predominantly young. This demographic characteristic implies that most immigrants have not resided in the country long enough to experience the well-documented phenomenon where the initial health advantage diminishes with longer stays in the host country. This decline in health, often observed as migrants adapt to the lifestyle and environmental factors of the host country, can be attributed to various factors, including stress associated with the migration process, changes in lifestyle and diet, and barriers to accessing healthcare services (Giannoni *et al*., 2016; Marmot *et al*., 2008; Newbold, 2005; Razum *et al*., 2000). The alignment of health outcomes of naturalised citizens with those of native-born Italians suggests that naturalisation and the associated socio-economic integration play a critical role in mitigating these adverse effects.

Overall, foreigners report diverse configurations of family and social relationships and generally better health conditions, given equivalent socio-demographic, familial, and economic variables. Our analysis highlights the critical role of social support in relation to health outcomes. Weekly personal contact is not significantly associated with reporting good or very good health, chronic diseases,

or functional limitations. However, receiving no help, both informal and formal, is significantly associated with lower odds of reporting good or very good health, chronic diseases, and functional limitations. This likely reflects the greater need for assistance among individuals with poorer health and suggests a need for further analysis of the interaction between family and social support, citizenship, and health outcomes.

Several limitations of the study should be acknowledged. First, the cross-sectional nature of the FSS ISTAT survey limits our ability to establish causal relationships between citizenship status, social support, and health outcomes. Longitudinal data would be more appropriate to assess the long-term impact of naturalisation and social support on health. Second, the reliance on self-rated health measures may introduce reporting bias, as individuals' perceptions of their health can be influenced by various subjective factors. These perceptions may vary significantly across different cultures within the migrant groups. Due to sample size limitations, the study cannot account for the heterogeneity within migrant groups, such as differences in cultural background, migration experience, and length of stay in Italy, which could influence health outcomes in complex ways.

Furthermore, while the linkage of survey data with citizenship acquisition registers provides valuable insights, it is limited to individuals who participated in the survey, potentially omitting important sub-groups of the migrant population. Another limitation is the potential underrepresentation of undocumented migrants or those with precarious legal status, who may face even greater health disparities but are less likely to be captured in official surveys and registers.

Although this study is limited to relatively more integrated migrants, it offers valuable insights and sets the stage for further research. It contributes to the growing body of literature on migrant health by leveraging a unique dataset that combines survey and register data to provide a nuanced understanding of the health status of immigrants in Italy. Our findings underscore the importance of considering both individual-level factors, such as citizenship status and social support, and broader socio-economic determinants when addressing health disparities among migrant populations.

Future research should examine the effect of time since naturalisation (within ±5 years) and assess measures of family and social contact to further deepen our understanding of migrant health. Additionally, developing a social vulnerability index could help identify the most at-risk groups and tailor interventions more effectively.

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