Discrimination and Health Among Immigrants
in Western Europe

By

Rachel Zajdel

Thesis

Submitted to the Faculty of the

Graduate School of Vanderbilt University

in partial fulfillment of the requirements

for the degree of

MASTER OF ARTS

in

Sociology

August 9, 2019

Nashville, Tennessee

Approved:

Evelyn J. Patterson, Ph.D.

Christy L. Erving, Ph.D.

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INTRODUCTION

Immigration to Europe grew substantially in the twenty-first century (Coleman 2009).

There is an extended history of internal migration between European countries, but large-scale

immigration from other continents is a more recent phenomenon (De la Rica, Glitz, and Ortega

2013). Driven by civil conflict, political instability, and economic hopes, recent immigrants to

Europe are more culturally and ethnically diverse and in vulnerable humanitarian situations. The

number of immigrants applying for protective status in Europe reached a record high of 1.3

million in 2015 (Pew Research Center 2016), with Germany receiving the most asylum

applications (BBC 2018). The number of migrants to the continent has dropped since 2015,

although countries are still grappling with the social and political effects of their changing

populations (Kingsley 2018).

Immigration has not been a pillar of European identity in the same way it has been in

North America (Alba and Foner 2015). Opposite the rise, however shallow, of multiculturalism

in the United States (Jimenez 2009), European integration idealizes cultural homogeneity as a

precondition for social cohesion (Schneider and Crul 2010). The increasing proportion of non-

Christian migrants, of which Muslims are considered a "paradigmatic case" (Conner 2010:377),

has sparked extensive research on Muslim immigrants' experiences in European societies (Alba

2005; Pettersson 2007; Foner and Alba 2008; Strabac and Listhaug 2008; Inglehart and Norris

2009; Croucher 2012). Although prejudice against Muslims is lower in Western Europe than

Eastern Europe (Strabac and Listhaug 2008; Wike, Stokes, and Simmons 2016), Islam is often

portrayed as incompatible with Christian and secular societies (Conner 2010). This

characterization may spur conflict or motivate discrimination against Muslim immigrants, but

religion is not the only social identity that impacts immigrants' experiences in Europe. Specifically, race/ethnicity has an important influence on immigrant well-being.

While the countries that compose Western Europe are similar in many of their social and economic realities, there are marked cultural and political differences between nations that could impact immigrants' experiences. Italy provides a notable example because it is a new immigrant destination. Until recently, Italy was generally more open to immigrants than other European countries (Sunderland 2018; Piser 2018; Nossiter 2019). While the experiences of immigrants in France (e.g. Guendelman et al. 1999; Alba 2005; Sabatier and Berry 2008; Algan et al. 2010; Larchanche 2012; Moullan and Jusot 2014) and the United Kingdom (e.g. Marmot, Adelstein, and Bulusu 1984; London 1986; Burnett and Peel 2001; Algan et al. 2010) are relatively well-documented, research examining the well-being of immigrants in Italy frequently involves small sample sizes (e.g. Gualdi-Russo et al. 2009; Pezzoli et al. 2009; Favaro et al. 1999), although there are some recent exceptions (Baglio et al. 2010; Moullan and Jusot 2014; Busetta, Cetorelli, and Wilson 2018). Racialization of immigrants, and the health effects of such racialization, are particularly understudied in the Mediterranean nation. Thus, I focus on the case of Italy to provide a more detailed examination of the experiences of immigrants, as well as the social processes involved in shaping immigrant experiences, in one unique and underexamined context.

The Case of Italy

Research regarding immigrant well-being in Italy is scarce largely due to Italy's only recent emergence as an immigrant destination. Parallel to the trend in Europe overall, immigration to Italy rapidly increased in the twenty-first century and immigrants to the Mediterranean nation originate from a remarkably large number of countries (Devillanova and

Frattini 2016; Scotto 2017). Italy, along with Spain, experienced the highest annual growth rate of its immigrant population between 2001-2011 (OECD 2014). In addition to the traditional inflow of migrants from eastern European countries like Romania, Albania, and Poland, Italy has experienced a growth in migrants from the Middle East, South Asia, and Africa. Geographically, Italy's southern shore acts as a "gatekeeper to Europe" (Adler 2016). In this way, Italy acts both as an initial entry point into Europe and, purposefully or inadvertently, the final destination for a notable proportion of migrants. In 2014, the number of migrants arriving by sea soared to over 170,000, the highest level on record (International Organization for Migration 2015). Currently, 8.3 percent of the country's population are non-Italian (ISTAT 2017a), but a disproportionate amount of immigrants settle in the traditionally prosperous and industrial north (Comune di Milano 2017) and to a lesser extent central Italy (World Population Review 2017).

Since 2010, the total number of immigrants arriving in Italy annually has decreased (ISTAT 2016a). However, the number and proportion of migrants applying for protective status has greatly increased (UNHCR 2017). In 2016, Italy received 123,370 applications for protective status in addition to the 99,920 pending applications still under review in what the media has dubbed "bureaucratic purgatory" (Asylum Information Database 2018; Nadeau 2015). These protective status seekers constitute a significant proportion of the nearly 301,000 immigrants to Italy in 2016 (ISTAT 2016b). Among European nations in 2017, the number of asylum-seeking children in Italy was second only to Germany (UNHCR 2017). A survey conducted in Italy between April and July 2017 revealed that 88 percent of children and 75 percent of adults who traveled the Central Mediterranean Route (from North African nations and across the Mediterranean Sea to Italy or Malta) responded affirmatively when asked if they had experienced at least one human trafficking or other exploitative practice such as physical and/or

sexual violence (UNHCR 2017). Thus, while the sheer number of migrants to Italy has decreased in the previous decade, a substantial and rising proportion of migrants moving to Italy are in vulnerable humanitarian positions.

LITERATURE REVIEW

Immigrant Reception

Employment-related outcomes are often tied to the host population's receptivity to immigrants. Foreigners are disadvantaged in the labor market across both relatively established (Vour'h, De Rudder, and Tripier 1999; Kalter and Granato 2002; Demireva 2011) and new (Cachon 1999; Campani and Carchedi 1999; Kalter and Kogan 2006) immigrant destination countries in the European Union (EU). Moreover, immigrants in France, Germany, the UK, Spain, and Italy all have higher unemployment rates than the native populations, a gap that is only partially explained by differential educational levels (De la Rica, Glitz, and Ortega 2013) and is particularly large for African and Eastern European immigrants and women (Algan et al. 2010). Both EU and non-EU immigrants also tend to work in less skilled occupations than natives of the same age, education, and region of residence, and such occupational segregation is greater in Italy and Spain than in France, Germany, and the United Kingdom (Dustmann and Frattini 2011). Such differential occupational outcomes are largely ascribed to discrimination by employers, and evidence from audit studies in Germany, Spain, and the United Kingdom support this explanation (Kaas and Manger 2011; Farre et al. 2010; Wood et al. 2009).

Discrimination against religious minorities is one manner in which such structural inequality manifests. Unlike traditional immigrant-receiving countries like the United States and

Canada, religious pluralism is a new and rising phenomenon in Western Europe (Conner 2010).

France, Germany, the United Kingdom, and Italy have the largest Muslim populations in Europe,

in absolute numbers (Hackett 2017). According to one recent poll, over half of Italians and

Spaniards reported having an unfavorable view of Muslims in their country, while less than 30

percent of respondents indicated such a view in France, Germany, and the United Kingdom

(Wike, Stokes, and Simmons 2016). Contrastingly, in another survey, significantly more

respondents reported being unwilling to have Muslims as neighbors than unspecified immigrants

in France and Germany, but there was no statistically significant difference in Great Britain,

Italy, or Spain (Strabac and Listhaug 2008). Lack of openness to Muslim immigrants may be due

to their lack of convergence to the European norm of religiosity, in terms of mean levels of

religious attendance and frequency of prayer (Conner 2010). That is, religion and religious

activity remain salient for Muslim immigrants over time, despite potential pressures to

assimilate, and this pattern is particularly strong in contexts of lower levels of positive immigrant

receptivity (Conner 2010).

One study using data from 1995, a time when immigration to the homogenous country

was in its nascent stages (Andall 1990), found that Italians display the highest level of anti-

immigrant sentiment among Western European citizens (Ceobanu and Escandell 2008). Another

found that anti-immigrant sentiment in Italy significantly increased from 2002 to 2004 (Pichler

2010). More recently, when asked about the quantity of immigrants, the majority of Italian

residents (63.16 percent) responded that there are too many immigrants currently in Italy (ISTAT

2011). Research suggests that hate crimes and anti-immigration right-wing political support are

both historically persistent (Zick, Pettigrew, and Wagner 2008) and currently on the rise in Italy

(Sunderland 2011). This rise in anti-immigrant sentiment impacts legislation, as with the Minniti

Decree (2017), which prohibits an appeal for rejected asylum seekers and bolsters the quicker deportation of undocumented immigrants (Scotto 2017; Open Migration 2017). Characterizing the phenomenon of migration as an emergency or as former Italian Prime Minister Silvio Berlusconi crassly described it, a "human tsunami" (Grant 2011), justifies the passage of legislation that restricts the rights of migrants and reduces provisions for reception centers (Open Migration 2017).

In addition to the portrayal of increased migration as an emergency, migrants themselves are often branded as security problems contributing to terrorism, crime, or illicit activities such as drug trafficking and prostitution. The salience of a small number of crimes committed by migrants has bolstered anti-immigrant sentiment in Italy and across Europe. The perceived size of immigrant populations is associated with anti-immigrant sentiment to a greater extent than actual size (Ceobanu and Escandell 2008). On average, Italians perceive that migrants compose 26 percent of the nation's population but in reality, the migrant population is less than 9 percent (Scotto 2017). Furthermore, Islam, the religion of a growing percentage of immigrants, is often viewed as threatening to or incompatible with the dominant Western culture and Christian majority of Italy (Zanotti 1993). Consequently, anti-immigrant backlash is often coupled with anti-Muslim rhetoric, which has increased across Europe (Rechel et al. 2013). However, Italians may not be as hostile to Islam as often suggested; a plurality (37.1%) of randomly sampled respondents indicated that the religious practice of some immigrants "do not at all" threaten the Italian way of life (ISTAT 2011).[1] An even larger plurality (42.6%) reported "indifference" when asked about their position if a mosque were to be built close to their house (ISTAT 2011).[2]

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[1] In contrast, 17.0% responded "very much," 21.6% said "somewhat," and 24.3% indicated "a little." Questions and answers have been translated from their original in Italian.
[2] 18.4% stated they would be in favor and 39.0% said they would be opposed.

As the previously mentioned audit studies suggest, and will be further discussed, religion is not the only factor motivating xenophobia and discrimination in Europe.

Racialization, Racism, and Xenophobia

Research regarding discrimination in the United States largely explores the role of race and ethnicity; in Europe, the focus is predominantly on discrimination against immigrants and/or religious minorities. "Cultural racism" results when culture or religion is essentialized to the point that followers are viewed as inherently inferior (Foner 2005). France's 2004 legislation banning headscarves in places of education and 2010 law criminalizing face-veils in public spaces are often highlighted as epitomizing the backlash against religious minorities and symbols in a country devoted to secularism (Grillo and Shah 2012; Hunter-Henin 2012). However, emphasizing religion, and specifically Islam, in politics and in research marginalizes the consequences of racial discrimination and reinforces notions of incompatibility between Muslim immigrants' and natives' cultures (Tiberj and Michon 2013). When immigrants in Europe are asked about the perceived main reason for discrimination, race/ethnicity-related responses are often the most frequent (De la Rica, Glitz, and Ortega 2013). Simply put, there is evidence that discrimination based on national origins and/or race/ethnicity is more widespread than religious-based discrimination, yet the dominant frameworks used when describing immigrant experiences in Europe do not reflect this reality (Tiberj and Michon 2013).

Racism is rarely pinpointed as stirring anti-immigrant sentiment in Europe (Flores 2015). Instead, scholars commonly highlight cultural differences, especially religion, as motivating most anti-immigrant animosity (Fekete 2004; Alba 2005; Silberman, Alba, and Fournier 2007). As Alba and Foner (2015:1) assert, "If racial divisions are a defining characteristic of the United

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States, religious cleavages seem their nearest equivalent in Western Europe." Furthermore, in their study of Maghrebians in France, Silberman, Alba, and Fournier (2007) conclude that cultural-based discrimination is the mechanism that spurs downward assimilation, despite only about 5 percent of their respondents reporting religion as a perceived reason why they experienced discrimination. In contrast, about 22 percent of Maghrebian men and nearly 9 percent women reported skin color-based discrimination (Silberman, Alba, and Fournier 2007). Silberman, Alba, and Fournier (2007) interpret the relatively high reports of discrimination based on one's name (26.5 and 18.9 percent for men and women, respectively) as indicative of ethnic, and implicitly religious, discrimination. This interpretation is weak, though, in the absence of understanding if distinctive North African names most strongly signal racial, ethnic, class, or religious associations. In all likelihood, names signal multiple socially meaningful characteristics. Perhaps it is time to reformulate understandings of race and ethnicity in an increasingly diverse Europe.

Emerging evidence suggests that race and ethnicity are central components of anti-immigrant sentiment in Europe. New immigrants to Spain commonly self-report nationality- and race-based discrimination but rarely report religion-based discrimination (Flores 2015). Similarly, this conception of anti-immigrant stigma overlooks an important social fact in Italy; namely, being Italian is conceptualized as being white (Berrocal 2010). Thus, immigrants with darker skin tones and various phenotypes from the Middle East, South Asia, and Africa are typically racialized as internal "others." For example, when reporting a criminal incident, an Italian newspaper described a group of native-born Italian young adults as "Italians but sons of immigrants", "originating from Cape Verde and the Philippines", and "Italians of foreign origin" (Thomassen 2010). In this way, the term "migrants" is often employed as a euphemism for non-

white immigrant groups (Carter 1997). Nevertheless, white racial ascription is necessary but insufficient to acquire racial status as an Italian; historical, social, and political processes continually work to delineate other essential components including genetics, as exemplified by the "intrinsically ethnocentric" *jus sanguinis,* or nationality by bloodline, citizenship principle that mandates longer naturalization wait times for non-EU migrants (Zincone 2010:2). Consequently, claims that cultural differences alone are the basis for anti-immigrant sentiment ignore the ubiquitous racialization of non-white immigrants in Italy.

Italy, like most other European countries, does not collect data regarding race on national surveys like the census. Instead, nationality is the main identifier in categorizing the population and is used as a flawed proxy in the racialization process. Simple racial categorization in Italy is based upon a white-nonwhite binary, but the racial categorization has also been conceptualized as a white to black spectrum (Giuliani and Lombardi-Diop 2013). The white-nonwhite binary closely relates to the Italian-non-Italian distinction, in which ascribed racial status, lingual ability, religion, citizenship status, and nationality are used to determine whether individuals are accepted as Italians or eschewed as foreigners. Compared to the United States, the racial formation process in Italy is undertheorized, in part due to the traditional and relative lack of racial diversity (in the American sense). Thus, the most common way of understanding the racialization process in Italy focuses on the white-nonwhite divide although blackness is also an important social construct that is often overlooked in the literature.

Thus, non-white immigrants are otherized on two fronts: 1) Immigrants are characterized as distinct from and/or inferior to Italians culturally (including religiously) and ethnoracially; 2) Immigrants are dehumanized and their human worth is undermined through criminalization and

portrayals as homogenous masses (i.e. "human tsunami"). Thus, non-white migrants are often

delegitimized both as (future) Italians and as individual humans.

Immigrant Health Advantage

Despite being relatively deprived in terms of socioeconomic status and access to health

care, immigrants often display better health in some important dimensions than the native-born

population (Riosmena, Kuhn, and Jochem 2017). This pattern is known as the immigrant health

advantage. For example, foreign-born individuals in the United States tend to have lower

mortality rates and are less likely to experience circulatory diseases, overweight/obesity, and

some cancers (Singh and Siahpush 2002; Cunningham, Ruben, and Venkat Narayan 2008).

There is evidence that this pattern extends to some European countries as well (Raymond et al.

1996; Razum et al. 1998; Anson 2004; Pacelli et al. 2016), particularly when socioeconomic

status is taken into account (Wengler 2011). The immigrant health advantage is produced by

overlapping mechanisms, most notably the self-selection of healthier individuals into migration

(Landale, Gorman, and Oropesa 2006; Riosmena, Kuhn, and Jochem 2017) and the protection

that social capital in migrant networks offers immigrants (Eschbach et al. 2004; Riosmena,

Kuhn, and Jochem 2017).

The immigrant health advantage does not hold for all health outcomes, though. Many

foreign-born groups exhibit higher rates of diabetes, some infections, and occupational injuries

(Cunningham, Ruben, and Venkat Narayan 2008). Barcellos, Goldman, and Smith (2012) found

that about half of recent Mexican immigrants with diabetes were unaware of their condition until

after their arrival in the United States. While diagnosed prevalence of diabetes and hypertension

was 47 percent lower among recent Mexican immigrants than among native-born Americans,

undiagnosed disease still explained one-third and one-fifth of the immigrant health advantage for

diabetes and hypertension, respectively (Barcellos, Goldman, and Smith 2012). Diabetes

prevalence also increases with length of residence in the United States but reaches a plateau at

about 10 years of residence (Oza-Frank, Stephenson, and Narayan 2011).

Moreover, the immigrant health advantage may not be applicable to all migrant groups.

In the U.S., white immigrants have a persistent health advantage compared to U.S.-born whites,

but black and Mexican American immigrants experience a health disadvantage that increases

with age (Brown 2018). While immigrants overall have lower morality rates than Italians, those

from Sub-Saharan Africa experience significantly higher morality than Italians (Pacelli et al.

2016). Similarly, the immigrant health advantage is evident among immigrants as a whole in

Italy, but immigrants in France and Spain report poorer self-rated health than natives (Moullan

and Jusot 2014). Another shortcoming of the immigrant health effect is that, beyond the few

exceptions noted, it has predominantly been examined in North America and among limited

nation-origin groups, such as Mexican immigrants. Subsequently, the extent to which it applies

to immigrants to Europe is widely underexplored.

Immigrant Health Disadvantage

The health of immigrants increasingly resembles that of the native-born population the

longer their duration of residency (Cunningham, Ruben, and Venkat Narayan 2008). Living in

the United States may lead to declines in both migrants' health and healthy behaviors (Uretsky

and Mathiesen 2007; Ceballos and Palloni 2010; Oza-Frank, Stephenson, and Narayan 2011;

Goldman et al. 2014). For instance, declines in migrants' self-rated health occur quickly, within

about a year after arrival in the United States (Goldman et al. 2014). Eastern European

immigrants to Germany also exhibit an initial health advantage that deteriorates substantially in a period of five years, despite concomitant improvements in socioeconomic status (Ronellenfitsch and Razum 2004). The above findings of a health advantage followed by a rapid decline in health can be explained by the late effect of cumulative inequality (Ronellenfitsch and Razum 2004). That is, disadvantaged socioeconomic environments in both immigrants' place of origin and destination combine with a variety of risk factors including work hazards, unemployment, poor living conditions, and psychological stress to negatively affect well-being (Malmusi, Borrell, and Benach 2010; Rechel et al. 2013).

More specifically, discrimination and marginalization may serve as potential pathways through which the health of immigrants and their descendants erodes (Viruell-Fuentes 2007). For instance, Vargas, Sanchez, and Juarez (2017) recently found that Latino immigrants' perceptions of living in American states with unfavorable anti-immigration laws is associated with reporting poor health and problems related to mental health. Additionally, the prevalence of negative mental health outcomes among undocumented immigrants is higher in localities with anti-immigration policies than in jurisdictions in the same country with neutral or welcoming policies towards immigrants (Martinez et al. 2015). In this way, increased discrimination and stress, deportation and detention, and policies that limit health resources are mechanisms through which anti-immigrant stigma exacerbates racial and ethnic health disparities (Morey 2018).

Immigrant Health in the European Union

In a review of research on mental disorders and their care in immigrant populations in the United Kingdom, Claassen et al. (2005) found that the most consistent result is a higher rate of both voluntary and involuntary hospital admissions for African-Caribbean patients (Harrison et

al. 1997; Takei et al. 1998; Harrison et al. 1999; Coid et al. 2000; Oluwatayo and Gater 2004; Tolmac and Hodes 2004). In particular, Tolmac and Hodes (2004) conducted research in the United Kingdom and found that adolescents who self-identified as black African, black Caribbean, and black British were overrepresented among those admitted with a diagnosis of a psychotic disorder by an odds ratio of 3.7 when compared to adolescents self-identified as white Irish, white British, and white other. This indicates that both black immigrants and black Britons are at a higher risk of being diagnosed with a psychotic disorder due to potential bias in the diagnosing process and/or higher levels of exposure to early life trauma. Notably, adolescents with refugee status were particularly vulnerable to experiencing psychological treatment (Tolmac and Hodes 2004).

The social mobility of immigrants has also been examined (Platt 2005). Social mobility, as a measure of intergenerational work occupation status, is notably limited in Italy and the United States (Pisati 1997; Checchi, Ichino, and Rustichini 1999; Chetty et al. 2014). Importantly, this process affects specific immigrant and ethnic groups differently, with potential implications for access to health care and related health outcomes. In Britain, Indian immigrants who obtained higher class positions in the first generation were able to maintain that status to a large extent in the next generation (Platt 2005). However, black Caribbean immigrants were not able to retain the advantages of more privileged origins or initial upward mobility when present (Platt 2005). These findings indicate that there may be an environment in Britain that is particularly hostile to black immigrant success.

The generalizability of such studies to Italy and other European countries is of concern due to the unique cultures, conceptions of race and ethnicity, socially-constructed racial hierarchies, historical factors, and policies, among other nation-specific features. However, there

may be two key determinants of immigrant health outcomes that span nations: racism and xenophobia. Herzfeld (2007) argues that the world has experienced a globalization of racism, with race-based anti-immigrant sentiment (i.e. intersecting racism and xenophobia) crossing linguistic and other cultural boundaries with ease. Specifically, there has been an increasing globalization of American xenophobia and Christian supremacy (Herzfeld 2007). This phenomenon is exemplified by the utilization of standardized disclaimers such as "I'm not a racist, but…" (*Non sono razzista, ma*…) that have infiltrated the purportedly colorblind rhetoric of citizens in the United States, Italy, and elsewhere (Herzfeld 2007; Bonilla-Silva 2018). According to Herzfeld (2007:270), racial and ethnic animosity "possesses a reassuring feel of global solidarity despite the fact that it has been filtered through the specificities of Italian history and culture."

Immigrant Health in Italy

Despite the rise in immigration to Italy in the twenty-first century, there is a relative paucity of published research regarding immigrant health in the country. Pezzoli et al. (2009) note that, before their study, no data regarding the prevalence of HIV infection in the undocumented migrant population existed. They found an elevated prevalence of HIV among non-European undocumented urban migrants, a large proportion of whom acquired the infection after migration (Pezzoli et al., 2009). Additionally, the prevalence of overweight and obesity among a sample of Moroccan and Kosovar immigrants in Bologna exceeds 50 percent; the mean body mass index (BMI) of female immigrants is significantly higher than that of native-born female Italians (Gualdi-Russo et al. 2009). In contrast, Sole-Auro and Crimmins (2008) found that among those over the age of 50, immigrants are less likely to be overweight than non-

immigrants in Italy. However, they did find that immigrants generally have worse health than the native population in eleven different European countries (Sole-Auro and Crimmins 2008).

Immigrant women experience higher rates of both induced abortion (Medda et al. 2002; Spinelli et al. 2005; Baglio et al. 2010) and spontaneous abortion (Medda et al. 2002) compared to Italian-born women. Infants of immigrant women display higher incidences of prematurity, low birth weight, asphyxia, and neonatal mortality rate than infants of Italian women; these negative outcomes are especially severe for infants born to women from sub-Saharan and West Africa (Bona et al. 2001; Cacciani et al. 2011). Overall, more than half of the acute hospitalizations among immigrant women in the Lazio region are due to childbirth (Baglio et al. 2010). In contrast, the main reason for acute hospitalization among immigrant males in Lazio is injuries, which account for approximately one-quarter of all discharges (Baglio et al. 2010).

Early adolescent (ages 11-15) immigrants in Italy are more often affected by psychosomatic symptoms, less satisfied about their health and life, and less happy compared to Italian adolescents (Vieno et al. 2009). Relatedly, immigrants in Italy experience higher rates of mental health conditions (Favaro et al. 1999; Toselli et al. 2018), which parallels findings among black immigrants in the United Kingdom (Tolmac and Hodes 2004). For example, Carta et al. (2001) compared the prevalence of depressive symptoms between Italians, immigrants from Morocco, and immigrants from Senegal. Compared to Italians, immigrants from Morocco display an increased risk of depression but immigrants from Senegal do not (Carta et al. 2001). Consequently, the researchers conclude that it may not be justified to collapse different nationalities of the African continent or beyond into one homogenized immigrant category.

Research indicates that the health needs of migrants are currently not being met, despite Italy's universal health care system that in principle covers the resident population regardless of

citizenship status. Compared to Italian citizens, the odds of experiencing unmet need for medical care are 27 and 59 percent higher for documented and undocumented immigrants respectively (Busetta, Cetorelli, and Wilson 2018). Undocumented male immigrants and those with chronic illness are particularly at risk for unmet health care needs (Busetta, Cetorelli, and Wilson 2018). Even after adjusting for known risk factors like socioeconomic factors, immigrants are significantly less likely to utilize primary healthcare services but overuse emergency room care (De Luca, Ponzo, and Rodriguez Andres 2013; Devillanova and Frattini 2016). These findings hold for second generation immigrants in Italy (Devillanova and Frattini 2016). Such disparities indicate that differences in health care access and utilization are transmitted intergenerationally, a pattern which has also been illuminated in the United States (Pylypchuk and Hudson 2009). Simply put, there is concurrently equitable legal coverage and inequalities in access of health care in Italy.

DATA AND METHODS

Data on immigrants in the EU are notably poor, despite recent improvements (Coleman 2009). For instance, European countries seldom gather health data by race/ethnicity (Mladovsky 2007). The impact of racialization on health is subsequently underexamined. Data regarding the race and ethnicity of migrants is scarce since nationality is typically used as an immigrant's defining characteristic; yet such a major data limitation does not preclude discussion of its probable effects.

This study examines three areas: (1) causes of death and life expectancy, (2) experiences and perceptions of discrimination and disadvantage, and (3) the relationship between social characteristics, experiences of discrimination, and health. For the first objective, Italy's National

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Institute of Statistics (ISTAT) tracks causes of mortality among immigrants, differentiated by country and region of citizenship. I use mortality data from 2011, the most recent census year. For the second and third objectives, I use cross-national and cross-temporal surveys that are part of the Eurobarometer Series and collected by the European Commission. In particular, I focus on populations in the five largest countries in Western Europe: Germany, France, United Kingdom, Italy, and Spain. The inclusion of multiple countries ensures that there will be a large enough sample size of immigrants among the respondents in order to run statistical analyses. I combine the data from three surveys with independent samples, conducted in 2008, 2009, and 2012, which are the three most recent waves that collected data regarding respondents' place of birth, experiences of discrimination, health, religion and other relevant variables such as gender, age, and occupation.

Mortality and Life Expectancy

For the purposes of summarizing, I use comparative mortality ratios for immigrant populations from eight different countries of origin, using the Italian composition as the standard. This calculation uses a ratio of the actual number of deaths in one population to the expected number based on a second population's mortality rate schedule (Preston, Heuveline, and Guillot 2001). This allows for comparison of crude death rates without the likely differing age structures of the populations influencing the results. A ratio greater than one indicates that the age-specific death rates are generally higher in the first population than in the comparison population (Preston, Heuveline, and Guillot 2001). This part of the analysis includes people from the countries with the five largest immigrant populations in Italy, in absolute numbers: Romania, Albania, Morocco, China, and Ukraine. In addition, I examine the impact on life expectancy

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when separately removing immigrant populations from Pakistan, Nigeria, and India, which were among the five largest sending countries in 2015-2016.

Next, I calculate life expectancy for the Italian population by gender. I use the Coale and Demeny (1983) method to calculate the average person years lived in the <1 and 1-4 age intervals. Typically, associated single decrement life tables are used to measure changes in life expectancy when a single cause of death is excluded from the calculation. However, I utilize the associated single decrement life table to compare changes in men's and women's life expectancies when the immigrant population is excluded from the calculation. If differences in health between the Italian and foreign populations are profound, there may be measurable effects on the entire population's longevity. Lastly, I calculate the change in mortality between men and women by citizenship (Italian and foreign) by decomposing the difference in life expectancies at birth for these populations. This allows for the examination of the contribution of the Italian and foreign populations to differences in life expectancies for men and women in Italy.

Discrimination and Health

A great deal of literature speaks to the role of discrimination in adverse social and health outcomes. Yet, as discussed in the significance section, the extent to which race/ethnicity plays a role in experiences of discrimination is underexamined in the European context in favor of religion as the primary motivating factor. I use respondents' answers to the question, "In the past 12 months have you personally felt discriminated against or harassed on the basis of one or more of the following grounds? Was it discrimination on the basis of…? Please tell me all that apply" and "In (OUR COUNTRY), when a company wants to hire someone and has the choice between two candidates with equal skills and qualifications, which of the following criteria may, in your

opinion, put one candidate at a disadvantage?" Respondents can choose multiple answers which include skin color or ethnic origin, gender, religion or belief, age, and accent. These questions help to illuminate the patterns of responses between individuals with different immigrant backgrounds and between immigrants from different regions of origin. The former question measures experiences of discrimination while the latter measures perceptions of the motivations for discrimination. The total sample size is 17,765 for the discrimination and labor market disadvantage descriptive statistics.

Next, I examine the impact of discrimination, regional background, and religion on health using a logistic regression.

Dependent Variable

The dependent variable is a dummy variable (1=yes, 0=no) based on respondents' answer to the question: "Do you suffer from a chronic physical or mental health problem which affects you in your daily activities?" Respondents that affirmed the "don't know" option for this question were excluded from the regression analysis, which leaves a sample size of 17,627.

Independent Variables

Discrimination is a one factor that can adversely impact individuals' health (Williams, Neighbors, and Jackson 2003), particularly among immigrants (Viruell-Fuentes 2007). Consequently, I recode the above question regarding experience of discrimination (i.e. "In the past 12 months have you personally felt discriminated against or harassed on the basis of one or more of the following grounds?") as a dummy variable (1=yes, 0=no) and enter it into the model.

Religious identity may impact respondents' health through various mechanisms such as differential treatment in health service settings or particular health-relevant behaviors based on

the religion's values. As such, I model each religious denomination as a dummy variable, with Catholics as the comparison group.

The national background of immigrants influences their subsequent reception and treatment in a host country. Immigrants from the EU, European countries outside the EU, and Africa, Asia, and Latin America (combined) are compared to respondents native to the country in which the survey was conducted. Each national background category is a dummy variable, with native respondents as the omitted comparison group.

Control Variables

Control variables include age, occupational status, gender, and year of survey. Health deteriorates with increasing age. I use age categories in order to obtain and compare coefficients across different ages. Inputting age as a continuous variable in the model does not substantively change the results. It is also well-established that socioeconomic status, of which occupation is one component, is associated with health outcomes. Occupational status is an eight-point scale that ranges from unemployed to white collar positions. Some health outcomes, such as chronic conditions, display gendered patterns (McDonough and Walters 2001). In addition, individuals may migrate for different reasons and/or face divergent situations upon migrating that are gendered, which could have implications for their health. Gender is a dichotomous variable (0=man; 1=woman). Lastly, I input survey year in the regression model to account for any large-scale social changes that may have impacted immigrant well-being over the years.

I use Stata 14 for the logistic regression.

RESULTS

Mortality and Life Expectancy

Tables 1 and 2 present age-standardized crude mortality rate ratios and comparative mortality ratios for various immigrant groups in Italy, with the Italian citizen population as the standard. Compared to Italian citizens, foreigners in Italy have a slightly elevated all-cause mortality age-standardized crude mortality rate (Table 1). Age-standardized crude mortality rate ratios indicate a mortality advantage for all regional and national immigrant populations studied, with the exception of those from the European Union. However, this method of comparing mortality rates between foreigners and Italians may overestimate an immigrant health advantage because it relies on the age-specific mortality rates of each immigrant population. Immigrants tend to be in the working ages (15-64 years; UNICEF 2013), and thus the old and young age groups frequently have few or no deaths due to their small overall population. This pattern of low death rates in multiple age categories then results in both lower age-specific and total crude mortality rate.

Table 1. All-Cause Mortality: Immigrant Populations, Deaths, and Age-Standardized Crude Death Rate (ASCDR) Ratios

Citizenship	Population	Deaths	ASCDR Ratio*
Foreigners	4027627	8228	**1.03**
Europe	2136246	4091	**0.76**
Albania	451431	598	**0.41**
Ukraine	178534	259	**0.65**
European Union	1108934	2265	**1.04**
Romania	823100	1166	**0.82**
Africa	845759	1133	**0.35**
North Africa	578285	664	**0.30**
Morocco	407097	386	**0.23**
Sub-Saharan Africa	267474	469	**0.56**
Nigeria	47338	79	**0.65**
Asia	713384	714	**0.51**
China	194510	143	**0.32**
India	116797	157	**0.55**
Pakistan	69877	83	**0.48**
America	328635	460	**0.69**

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author
*Note: Italian citizen population used as the standard for ratios

Table 2. All-Cause Mortality: Immigrant Populations, Deaths, and Comparative Morality Ratios

Citizenship	Population	Deaths	Comparative Mortality Ratio*
Foreigners	4027627	8228	1.25
Europe	2136246	4091	1.23
Albania	451431	598	0.58
Ukraine	178534	259	0.69
European Union	1108934	2265	1.39
Romania	823100	1166	1.41
Africa	845759	1133	0.99
North Africa	578285	664	0.77
Morocco	407097	386	0.56
Sub-Saharan Africa	267474	469	1.64
Nigeria	47338	79	2.26
Asia	713384	714	0.86
China	194510	143	0.74
India	116797	157	1.23
Pakistan	69877	83	1.31
America	328635	460	0.77

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author
*Note: Italian citizen population used as the standard for ratios

In contrast, comparative mortality ratios use the age-specific death rates of the Italian

citizen population, which avoids the above issue. Results indicate considerable variation in

mortality between populations from different countries and regions (Table 2). Overall,

immigrants generally have higher mortality rates than the Italian population. European

immigrants also have higher mortality rates, although Albanians and Ukrainians experience lower mortality. The African population overall does not vary in terms of mortality compared to Italians. Yet, this observation obscures substantial heterogeneity within the continent. North African immigrants have significantly lower mortality rates than the Italian population, but this health advantage does not extend to the rest of Africa. Sub-Saharan African immigrants have higher mortality rates than Italians, and Nigerian immigrants have the most elevated mortality rates of the various immigrant populations examined. Immigrants from Asia generally have lower mortality rates compared to Italians, but populations from South Asia, such as Indian and Pakistan immigrants, have elevated mortality rates. Immigrants from the Americas also tend to have a mortality advantage in Italy.
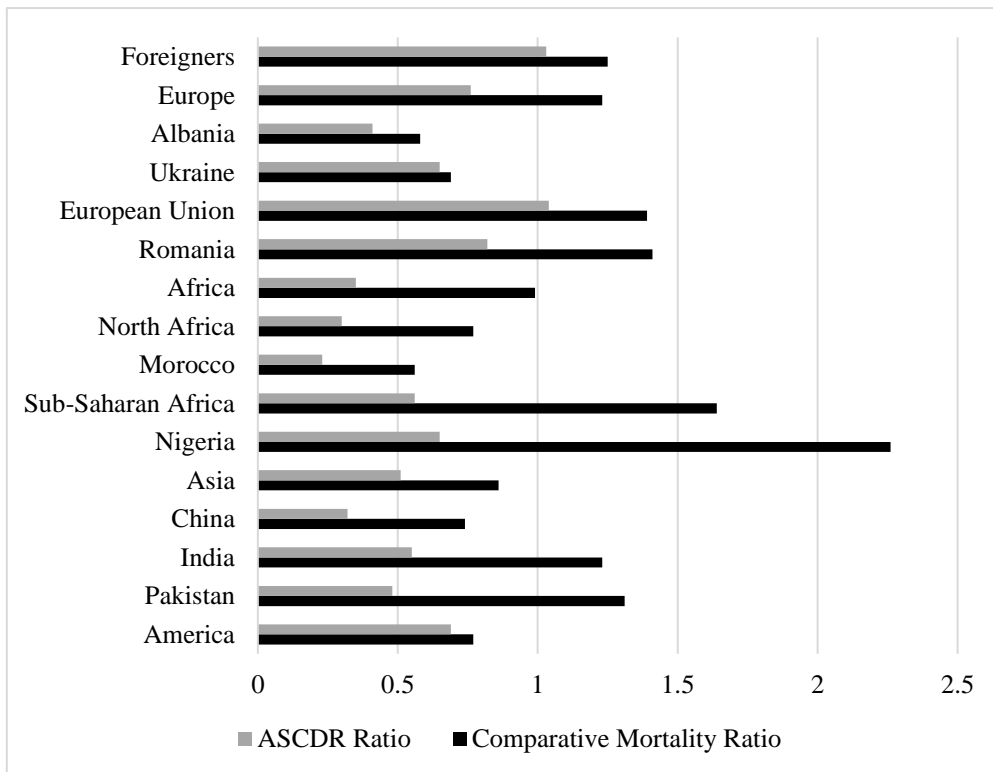
Figure 1. Comparison of Age-Standardized Crude Death Rate (ASCDR) Ratios and Comparative Mortality Ratios for Immigrant Populations in Italy

Given that immigrants generally have higher mortality rates than Italians, it follows that the life expectancy at birth for foreigners is lower than Italians (Table 3). Immigrant men, defined as those who are registered in Italy as citizens of any nation other than Italy, have a life expectancy of under 76 years, while immigrant women have a life expectancy of just over 82 years. In comparison, Italian men and women have a life expectancy of 79.68 and 84.72 years, respectively. Women live substantially longer than men, regardless of immigrant status, but the gender gap in life expectancy is larger for immigrants than for the Italian population. The life tables created to calculate these life expectancies are available in the Appendix.

Table 3. Life Expectancy at Birth by Citizenship and Sex in 2011

Citizenship	Male	Female
Total Population	79.45	84.61
Italians	79.68	84.72
Foreigners	75.95	82.08

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Associated single decrement life tables demonstrate that when immigrants are removed from the calculation of life expectancy, life expectancy at birth increases for the total male resident population in Italy (Table 4). When Italians and foreigners are included in the calculation, life expectancy at birth is 79.45 years. This rises to 80.00 years with the exclusion of foreigners. All men in Italy have a 39.97 percent chance of surviving to age 85, and a 40.51 percent chance when foreign men are excluded. For women, life expectancy increases from 84.61 for the entire resident population to 84.95 when foreign residents are excluded from the calculation. All females in Italy have a 59.19 percent chance of surviving to age 85, and a 59.66

percent chance when foreign residents are excluded. The rise in life expectancy at birth for men

is slightly greater due to the larger difference between foreigners and the total population

compared to women. The difference in life expectancy at birth for all males and females in Italy

is 5.16 years. Italians and foreigners contribute 4.93 and 0.23 years to this gap in life expectancy,

respectively (Table 6). Multiple decrement life tables for Italian citizens and immigrants,

separated for men and women, are available in the Appendix.

Table 4. Associated Single Decrement Life Table for the Italian Resident Population other than Foreigners—Males

Age Class	R-Foreign	lx	npx	nax	ex	*npx	*lx	*nax	*ex
0	0.64760	100000	0.99654	0.0543	79.45	0.99776	100000	0.76970	80.00
1	0.75294	99654	0.99941	1.6412	78.73	0.99956	99776	3.15296	79.18
5	0.80147	99595	0.99952	2.5	74.77	0.99962	99732	4.11227	75.21
10	0.81081	99548	0.99936	2.5	69.81	0.99948	99694	2.98249	70.24
15	0.86182	99484	0.99815	2.5	64.85	0.99841	99641	2.73342	65.27
20	0.78681	99300	0.99706	2.5	59.97	0.99769	99483	2.56948	60.37
25	0.74739	99009	0.99683	2.5	55.14	0.99763	99253	2.52592	55.51
30	0.77803	98695	0.99664	2.5	50.30	0.99738	99018	2.59233	50.63
35	0.84878	98363	0.99582	2.5	45.46	0.99646	98759	2.67604	45.76
40	0.87290	97952	0.99354	2.5	40.64	0.99436	98409	2.73164	40.91
45	0.91003	97320	0.98915	2.5	35.89	0.99012	97854	2.72153	36.13
50	0.93899	96264	0.98261	2.5	31.26	0.98366	96887	2.71076	31.46
55	0.96009	94589	0.97194	2.5	26.77	0.97305	95303	2.69746	26.94
60	0.98163	91935	0.95588	2.5	22.47	0.95667	92735	2.69807	22.61
65	0.98778	87879	0.92713	2.5	18.39	0.92799	88717	2.66329	18.51
70	0.99134	81475	0.88947	2.5	14.64	0.89037	82328	2.66893	14.74
75	0.99417	72470	0.81202	2.5	11.15	0.81301	73303	2.65244	11.23
80	0.99581	58847	0.67917	2.5	8.15	0.68027	59596	2.63070	8.20
85	0.99593	39967	0.00000	5.8173	5.82	0.00000	40541	5.84109	5.84

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 5. Associated Single Decrement Life Table for the Italian Resident Population other than Foreigners—Females

Age Class	R-Foreign	lx	npx	nax	ex	*npx	*lx	*nax	*ex
0	0.63648	100000	0.99702	0.0614	84.61	0.99810	100000	0.06187	84.95
1	0.75714	99702	0.99949	1.5175	83.87	0.99961	99810	1.51758	84.11
5	0.83898	99651	0.99956	2.5	79.91	0.99963	99771	2.50009	80.15
10	0.84848	99607	0.99963	2.5	74.94	0.99969	99735	2.68026	75.17
15	0.85577	99571	0.99926	2.5	69.97	0.99936	99704	2.68570	70.20
20	0.79635	99497	0.99890	2.5	65.02	0.99912	99640	2.53147	65.24
25	0.82524	99387	0.99907	2.5	60.09	0.99923	99553	2.58934	60.30
30	0.81865	99294	0.99852	2.5	55.14	0.99879	99476	2.69200	55.34
35	0.86022	99148	0.99781	2.5	50.22	0.99811	99356	2.73751	50.40
40	0.90597	98930	0.99628	2.5	45.32	0.99663	99168	2.75303	45.49
45	0.93501	98562	0.99358	2.5	40.48	0.99399	98834	2.71985	40.64
50	0.94226	97929	0.98962	2.5	35.73	0.99022	98240	2.68833	35.87
55	0.96319	96913	0.98440	2.5	31.08	0.98497	97279	2.67457	31.20
60	0.97775	95401	0.97667	2.5	26.53	0.97719	95817	2.68982	26.63
65	0.98408	93175	0.96253	2.5	22.11	0.96311	93631	2.69006	22.19
70	0.98948	89684	0.94021	2.5	17.87	0.94082	90177	2.72814	17.94
75	0.99326	84321	0.88970	2.5	13.85	0.89040	84840	2.73617	13.89
80	0.99548	75021	0.78897	2.5	10.25	0.78981	75542	2.50129	10.27
85	0.99625	59189	0.00000	7.3260	7.33	0.00000	59664	7.35354	7.35

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 6. Age and Population (Italian Citizen vs. Immigrant) Decomposition of Difference in Life Expectancies at Birth

Age Class	Male			Female			nΔx	nΔx Italians	nΔx Foreigners
	nmx	nRx Italians	nRx Foreigners	nmx	nRx Italians	nRx Foreigners			
0	0.0035	0.648	0.352	0.0030	0.636	0.364	0.04	0.03	0.01
1	0.0001	0.753	0.247	0.0001	0.757	0.243	0.01	0.00	0.00
5	0.0001	0.801	0.199	0.0001	0.839	0.161	0.00	0.00	0.00
10	0.0001	0.811	0.189	0.0001	0.848	0.152	0.02	0.02	0.00
15	0.0004	0.862	0.138	0.0001	0.856	0.144	0.07	0.06	0.01
20	0.0006	0.787	0.213	0.0002	0.796	0.204	0.11	0.09	0.02
25	0.0006	0.747	0.253	0.0002	0.825	0.175	0.13	0.09	0.04
30	0.0007	0.778	0.222	0.0003	0.819	0.181	0.10	0.07	0.02
35	0.0008	0.849	0.151	0.0004	0.860	0.140	0.09	0.08	0.02
40	0.0013	0.873	0.127	0.0007	0.906	0.094	0.12	0.10	0.02
45	0.0022	0.910	0.090	0.0013	0.935	0.065	0.16	0.14	0.02
50	0.0035	0.939	0.061	0.0021	0.942	0.058	0.23	0.21	0.01
55	0.0057	0.960	0.040	0.0031	0.963	0.037	0.34	0.33	0.01
60	0.0090	0.982	0.018	0.0047	0.978	0.022	0.47	0.46	0.01
65	0.0151	0.988	0.012	0.0076	0.984	0.016	0.63	0.63	0.01
70	0.0234	0.991	0.009	0.0123	0.989	0.011	0.68	0.67	0.00
75	0.0415	0.994	0.006	0.0233	0.993	0.007	0.72	0.71	0.00
80	0.0764	0.996	0.004	0.0472	0.995	0.005	0.63	0.63	0.00
85	0.1719	0.996	0.004	0.1365	0.996	0.004	0.60	0.60	0.00
Sum							5.16	4.93	0.23

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Discrimination and Health

Table 7 presents descriptive statistics for survey respondents. 92.86 percent of respondents are native to the Western European country in which the survey was conducted, while 3.63 percent immigrated from EU member nations, 0.81 percent from European countries outside the EU, and 2.71 percent from Asia, Africa, or Latin America. The majority of the sample identifies as Catholic (50.41 percent), with the next largest proportions identifying as agnostic (16.66 percent) and Protestant (15.99 percent). Only 1.38 percent of respondents identify as Muslim. Respondents are most frequently retired (28.07 percent) or manual workers

(20.91 percent), followed by white collar workers other than managers (10.43 percent). A slight majority of respondents are female (54.48 percent). Respondents are evenly distributed across the ages, with a small overrepresentation of those aged 65 and above (24.29 percent). 10.95 percent of respondents report experiencing at least one instance of discrimination in the past 12 months and 14.59 percent report a chronic mental or physical health problem.

Table 7. Descriptive Statistics for Survey Sample

	N*	Minimum	Maximum
Dependent Variable			
Chronic Health Problem	2,571	0	1
Independent Variables			
Discrimination	1,931	0	1
National Background			
Native of Country	16,369	0	1
Foreign Resident from EU	639	0	1
Foreign Resident from Europe (excluding EU)	142	0	1
Foreign Resident from Asia, Africa, or Latin America	477	0	1
Religion			
Catholic	8,885	0	1
Orthodox	143	0	1
Protestant	2,818	0	1
Buddhist	50	0	1
Muslim	243	0	1
Jewish	27	0	1
Hindu	35	0	1
Sikh	17	0	1
Other Christian	868	0	1
Other Religion	228	0	1
Atheist	1,129	0	1
Agnostic	2,937	0	1
Control Variables			
Occupational Scale	17,627	0	8
Unemployed	1,451		
House persons	1,647		
Retired	4,948		
Manual Workers	3,686		
Self-employed	1,237		
Students	1,229		
Managers	1,591		
Other White Collars	1,838		
Gender	9,604	0	1

Age 15-24	2,120	0	1
Age 25-34	2,596	0	1
Age 35-44	2,980	0	1
Age 45-54	2,940	0	1
Age 55-64	2,709	0	1
Age 65+	4,282	0	1
Survey Year 2008	5,911	0	1
Survey Year 2009	5,914	0	1
Survey Year 2012	5,802	0	1

*N provides the number of respondents that are coded as 1 for each dichotomous variable. Total sample size=17,627 for all variables in table
Data source: Eurobarometer Series 2008, 2009, and 2012 by the European Commission (accessed through the Inter-university Consortium for Political and Social Research)

Unsurprisingly, immigrants report experiencing discrimination in the past year more than those born in France, Germany, the UK, Italy or Spain (Table 8). In particular, immigrants report experiencing discrimination based on ethnic origin more than any other reason. Immigrants from Asia, Africa, or Latin America are especially at risk, with over 30 percent reporting feeling discriminated against or harassed for any reason and 21.17 percent reporting discrimination based on ethnic origin specifically. The next most frequent reasons immigrants from Asia, Africa, or Latin America report as the basis for the discrimination are other (6.89%) and religion or beliefs (5.57%). With the exception of discrimination based on sexual orientation, non-European immigrants report more discrimination in all areas than native-born respondents and European immigrants. Immigrants from within and outside the EU report similar overall levels of discrimination. However, those from an EU member country are slightly more likely to report discrimination based on ethnic origin (11.49%) than those from outside the EU (9.53%), while those from outside the EU are more likely to report discrimination based on religion or beliefs (4.80%) than those from the EU (2.09%).

Table 8. Experiences of Discrimination in Past 12 Months by Region of Origin (%)

	Native	Other EU	Other Europe	Asia, Africa, or Latin America
Yes	10.22	20.09	20.88	30.12
Because of:				
Ethnic Origin	1.96	11.49	9.53	21.17
Gender	3.22	2.90	1.86	3.69
Sexual Orientation	1.81	0.79	3.27	0.85
Religion or beliefs	1.71	2.09	4.80	5.57
Other	3.21	5.22	3.90	6.89
N	16,491	646	148	480

Data source: Eurobarometer Series 2008, 2009, and 2012 by the European Commission (accessed through the Inter-university Consortium for Political and Social Research), calculations by author

Immigrants and native-born respondents tend to agree which social characteristics put job candidates with equal qualifications at a disadvantage in the labor market (Table 9). The most frequently indicated factor is a candidate's look, which includes their dress or presentation. A greater percentage of Italians (50.40%) affirmed the importance of a person's dress or presentation, although immigrants from the EU (44.54%), other European countries (45.79%), and Asia, Africa, or Latin America (44.53%) also affirmed this response more than any other given characteristic. Physical appearance and skin color or ethnic origin are the next most frequently indicated characteristics that disadvantage job candidates. Immigrants more frequently perceive both skin color or ethnic origin and accents as detrimental than native-born respondents. In comparison, a greater percentage of native-born respondents and immigrants from Europe and the EU affirm religion as a disadvantage compared to immigrants from Asia, Africa, or Latin America. Overall, physical characteristics such as dress and presentation, physical appearance,

and skin color are perceived as the most salient for job candidates in Western Europe, although

accent and disability are also frequently reported as important.

Table 9. Disadvantaged Characteristics in the Labor Market (%)

	Native	Other EU	Other Europe	Asia, Africa, or Latin America	Total
Name	13.90	15.47	8.66	15.95	13.97
Address	9.66	8.79	8.17	9.09	9.60
Accent	31.02	35.90	43.79	35.72	31.47
Skin color or ethnic origin*	37.65	41.13	41.24	41.13	37.93
Gender	19.47	18.64	14.13	18.19	19.35
Sexual Orientation	17.86	13.42	14.66	14.21	17.55
Religion	24.43	26.85	30.32	22.82	24.53
Disability	37.48	32.42	34.77	28.98	37.01
Look (Dress or presentation)	50.40	44.54	45.79	44.54	49.96
Physical appearance	38.20	38.94	33.22	37.32	38.15
N	16,491	646	148	480	17,765
N for Skin color or ethnic origin*	10,953	435	92	334	11,814

Data source: Eurobarometer Series 2008, 2009, and 2012 by the European Commission (accessed through the Inter-university Consortium for Political and Social Research), calculations by author

As the regression establishes, experiencing discrimination is a positive and significant

predictor of reporting a chronic physical or mental health problem that affects daily life (b=0.47,

p<0.001; Table 10). Respondents that report at least one experience of discrimination in the past

12 months have 1.60 greater odds of suffering from a health problem (C.I.=1.58-1.62).

Compared to native-born respondents, immigrants from all regions have significantly lower odds

of reporting a health problem and those from Asia, Africa, or Latin America have the lowest

odds of all immigrant groups included (OR=0.65, C.I.=0.63-0.68).

The results for religious populations are varied. Compared to Catholics, respondents that

identify as Orthodox Christian have significantly lower odds of reporting a health problem

(OR=0.38, C.I.=0.64-0.73). Being a member of any other religious group (beyond the ones

listed) is a positive and significant predictor of reporting a health problem. Muslims experience

1.34 greater odds of suffering a health problem compared to the Catholic majority in the sample

population (C.I.=1.28-1.40).

As expected, age is a positive and significant predictor of reporting a chronic health

problem. Compared to respondents aged 15-24, the odds of experiencing a health problem

increases in each subsequent age category and is greatest for those aged 65 and older. As also

expected, occupation predicts odds of reporting a health problem. Respondents higher on the

occupation scale, or those that have positions of greater prestige, have 0.81 lower odds of

reporting a health problem compared to those in positions of lower prestige or the unemployed

(C.I.=0.81-0.81). Lastly, females have greater odds of suffering a health problem than males

(OR=1.04, C.I.=1.03-1.05), although the magnitude of the effect is small.

Table 10. Logistic Regression Model for Discrimination, National Background, Religion, and Health

Variable	Unstandardized Coefficient	Odds Ratio (95% C.I.)
Experienced Discrimination	0.47***	1.60 (1.58-1.62)
Member of EU	-0.16***	0.85 (0.83-0.87)
Other European	-0.10***	0.90 (0.86-0.95)
Asian, African, or Latin American	-0.43***	0.65 (0.63-0.68)
Orthodox	-0.38***	0.68 (0.64-0.73)
Protestant	0.57***	1.77 (1.75-1.79)
Buddhist	0.54***	1.71 (1.58-1.85)
Muslim	0.29***	1.34 (1.28-1.40)
Jewish	0.59***	1.81 (1.62-2.02)
Hindu	0.61***	1.84 (1.65-2.06)
Sikh	0.51***	1.67 (1.42-1.96)
Other Christian	0.90***	2.45 (2.41-2.49)
Other Religion	0.72***	2.06 (1.99-2.14)
Atheist	0.47***	1.61 (1.58-1.64)
Agnostic	0.39***	1.48 (1.46-1.50)
Occupational Scale	-0.21***	0.81 (0.81-0.81)
Gender	0.04***	1.04 (1.03-1.05)
Age 25-34	0.04**	1.04 (1.02-1.07)
Age 35-44	0.58***	1.79 (1.75-1.82)
Age 45-54	1.05***	2.85 (2.79-2.91)

Age 55-64	1.21***	3.36 (3.29-2.43)
Age 65+	1.40***	4.04 (3.97-4.13)
Year of Survey 2009	0.00	1.00 (0.99-1.01)
Year of Survey 2012	-0.02***	0.98 (0.97-0.99)
Constant	-2.32***	0.10 (0.10-0.10)
Pseudo R2	0.08***	

Note: Unstandardized coefficient is listed first and odds ratio is listed below

*p<0.05, **p<0.01, ***p<0.001*

Data source: Eurobarometer Series 2008, 2009, and 2012 by the European Commission (accessed through the Inter-university Consortium for Political and Social Research), calculations by author

DISCUSSION

There is substantial variation in mortality between foreign populations from diverse countries and regions and when using different methods of calculating mortality rate ratios. Age-specific crude death rate ratios result in only a slight disadvantage in health for foreigners and notably lower mortality rates for nearly all immigrant populations compared to Italian citizens. In contrast, comparative mortality ratios demonstrate that only some immigrants have a mortality advantage once the divergent age structures of populations are taken into account. For example, North Africans in Italy have significantly lower mortality rates than the Italian citizen population. In contrast, Sub-Saharan Africans have higher mortality rates than Italians, a finding consistent with previous research (Pacelli et al. 2016). Moreover, results indicate a mortality advantage for Chinese immigrants to Italy but not South Asians. These findings illuminate the need to research immigrant health on national or regional levels rather than on a continental scale, as Carta et al. (2001) also found. When examining mortality rates by continents alone, much of the variation is obscured.

Given the elevated mortality rates for many immigrant populations, life expectancy at birth is lower for foreigners than Italians, and this gap is larger for men than women. While immigrants of both sexes are grossly overrepresented in low-skilled jobs compared to native-born Italians, immigrant men often work in construction and manufacturing and women in domestic service (OECD 2014; Andall 2000). Due to this employment stratification, immigrant men are exposed to greater occupational hazards. This is likely related to the high rate of acute hospitalizations due to injuries among immigrant men (Baglio et al. 2010). Immigrant men also smoke at slightly higher rates than native-born Italian men (32.5 and 31.6 percent, respectively), but immigrant women smoke at lower rates than native-born Italian women (16.2 and 20.0 percent, respectively) (Petrelli et al. 2017), which could contribute to immigrant men's and women's disparities in health relative to the native-born population. Moreover, the economic crisis of 2008 led to a 10 percent drop in the employment rate of immigrant men, more than immigrant women and native-born men and women (OECD 2014). Unemployed individuals are at elevated risk of depression, anxiety, psychosomatic symptoms, subjective well-being, and self-esteem, and people with blue-collar jobs are more distressed by unemployment than those with white-collar jobs (Paul and Moser 2009). Thus, while work-related injuries and smoking may partially explain immigrant men's disadvantaged physical health, unemployment and frequent job loss may impact their mental health.

Immigrants report more discrimination than native-born respondents and European immigrants and those from Asia, Africa, or Latin America are most at risk. Discrimination based on ethnic origin is most frequently reported. This provides further evidence of the salience of race/ethnicity for immigrant experiences in Europe and parallels findings in Spain (Flores 2015) and France (Silberman, Alba, and Fournier 2007). In general, immigrants and natives tend to

agree which social characteristics disadvantage job candidates, with factors relating to physical characteristics being the most frequently affirmed. However, immigrants from all regions more often perceive skin color or ethnic origin and accent as disadvantageous for job candidates than native-born respondents. In contrast, native-born respondents and European immigrants identify religion as detrimental with greater frequency compared to immigrants from Asia, Africa, or Latin America. This suggests that religion is a more salient social characteristic in the minds of Europeans, both immigrants and not, than for individuals from other regions.

As evidenced in previous literature, discrimination is associated with ill health. Although foreigners in Italy overall have a reduced life expectancy and some experience elevated mortality rates, immigrants in Western Europe from Europe and Asia, Africa, or Latin America have significantly lower odds of reporting a chronic health problem. When compared to native-born respondents, immigrants from Asia, Africa, or Latin America have the lowest odds of all groups. This indicates that there may be a morbidity advantage among immigrants that does not necessarily extend to a mortality advantage, if immigrant life expectancy and mortality rates in Italy are any indication.

One factor that could contribute to this discrepancy between a morbidity advantage but mortality disadvantage is healthcare access and utilization. In Europe overall, immigrants experience a slightly higher odds of reporting unmet medical need (Fjær et al. 2017). In Italy, both documented and undocumented immigrants are at much greater risk of experiencing unmet medical needs (Busetta, Cetorelli and Wilson 2018). Immigrants in Italy are also less likely to utilize primary healthcare services, even after adjusting for socioeconomic status (De Luca, Ponzo, and Rodriguez Andres 2013; Devillanova and Frattini 2016). Another possible explanation is that immigrants may be less likely to be diagnosed with a chronic health problem,

as research demonstrates among immigrants in the United States (Barcellos, Goldman, and Smith 2012), and therefore less likely to report one. In this way, immigrants may exhibit a morbidity advantage concomitant with elevated mortality because unequal access to and utilization of healthcare leads to undiagnosed conditions that go untreated and thus result in higher mortality. It could also be that immigrants are healthier overall and when lower life expectancies are observed, as in Italy, it is due to elevated mortality from causes of death that affect younger individuals such as infant mortality, workplace accidents, and homicides, compared to the native-born population.

Lastly, the regression analyses reveal that Muslims have greater odds of reporting a health problem compared to Catholics, who compose a majority of survey respondents. This finding aligns with results from census data in the UK, which illustrates that Muslims have the highest age-standardized rate of reported ill health and disability (Laird et al. 2007). Given that self-reports of discrimination and occupational status are controlled for, these factors cannot explain this finding. Researchers have noted the paucity of studies regarding health and health care disparities between Muslims and majority populations (Padela and Zaidi 2018; Laird et al. 2007). Most explanations relate to the Islamic tradition and health care practices such as patterns of health-care seeking based on Islamic values and adverse health exposures due to having a Muslim identity (Padela and Zaidi 2018). Further research is needed to better illuminate these processes.

Limitations

Due to limitations in Italian census data, the mortality and life expectancy calculations only include immigrants that are citizens of a country other than Italy. Given that Italy does not

grant birthright citizenship, these analyses include both second- and first-generation immigrants. However, immigrants that are naturalized Italian citizens are excluded. It would be worthwhile to examine differences in mortality and life expectancy between immigrants with foreign citizenship, who tend to have immigrated more recently, with naturalized Italian citizens, who tend to have lived in Italy longer. It may be that the health of naturalized Italians more closely aligns with native Italians, as research in the U.S. indicates that the health of immigrants increasingly resembles that of the native-born population the longer their duration of residency (Cunningham, Ruben, and Venkat Narayan 2008). Without the necessary data, though, this trend is yet unknown.

Additionally, the dependent variable in the regression analysis is imprecise in that it refers to either a physical or mental health problem. The survey only asked this one question regarding health. While there is considerable overlap, the factors affecting physical and mental health are distinct and thus, physical and mental health would ideally be examined separately. Relatedly, the survey imprecisely groups respondents by regional background. As the mortality and life expectancy results demonstrate, substantial variation exists between immigrant populations at regional and national levels. The grouping of immigrants from Asia, Africa, *and* Latin America together is particularly problematic. It is possible that the results would vary significantly if each of these regions could have been examined separately.

The survey did not collect data on income, so I could not control for this variable. Instead, I used occupational status as a proxy for socioeconomic status. Despite these limitations, the survey data provided a large sample size that allowed for the examination of discrimination, perceived disadvantage, and health, on a nationally representative sample of native-born and immigrant respondents.

CONCLUSION

The limited amount of research examining the health of migrants in Italy is inappropriate given the scope and type (i.e. large proportion of asylum-seekers) of immigration there (Claassen et al. 2005). The present study adds a more comprehensive understanding of the ways in which nationality, and by extension racialized identities, religion, and other social variables affect the health of migrants in Italy and Europe. The widely accepted explanation of religion as the most salient social characteristic impacting immigrant experiences portrays an incomplete picture. Immigrants to Europe in the twenty-first century are more diverse in terms of religion, race/ethnicity, and national background than ever before. It is time for researchers to consider that the motivations for xenophobia and discrimination extend beyond cultural and religious factors. Results from this study demonstrate that there is significant heterogeneity in the well-being of immigrants in Italy and Western Europe across diverse subsets of the population. Importantly, immigrants themselves say that, in addition to religion, factors such as skin color, ethnic origin, gender, and lingual ability frequently affect their experiences in Europe; it is time for researchers to listen to them.

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Table 11. Life Expectancy for Total Population of Males in Italy

Age Class	Population	Deaths	Avg. Person Years Lived (ax)	Probability of Death (qx)	Survivors (lx)	Years lived (Lx)	Life Expectancy (ex)
<1 year	282221	979	0.054311	0.003458	100000	99673.0213	**79.45214**
1-4 years	1150780	170	1.641232	0.000591	99654.24	398478.122	78.72761
5-9 years	1430608	136	2.5	0.000475	99595.38	497858.566	74.77317
10-14 years	1435035	185	2.5	0.000644	99548.05	497579.878	69.80753
15-19 years	1487573	550	2.5	0.001847	99483.9	496960.16	64.85093
20-24 years	1547963	910	2.5	0.002935	99300.16	495772.184	59.96631
25-29 years	1658118	1053	2.5	0.00317	99008.71	494258.854	55.13547
30-34 years	1946590	1311	2.5	0.003362	98694.83	492644.675	50.30287
35-39 years	2307687	1931	2.5	0.004175	98363.04	490788.511	45.46411
40-44 years	2392699	3100	2.5	0.006457	97952.36	488180.594	40.64424
45-49 years	2316811	5057	2.5	0.010854	97319.87	483958.476	35.89214
50-54 years	1994452	6999	2.5	0.017394	96263.52	477131.668	31.25858
55-59 years	1787615	10174	2.5	0.028058	94589.15	466310.867	26.76765
60-64 years	1833876	16547	2.5	0.04412	91935.2	449535.623	22.4682
65-69 years	1433917	21688	2.5	0.07287	87879.05	423385.975	18.38985
70-74 years	1411746	33033	2.5	0.110528	81475.34	384863.443	14.63874
75-79 years	1075018	44608	2.5	0.187975	72470.04	328293.728	11.14713
80-84 years	734016	56098	2.5	0.320831	58847.45	247037.048	8.148852
85+ years	488531	83,979	5.8173	1	39967.37	232502.148	5.8173

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 12. Life Expectancy for Total Population of Females in Italy

Age Class	Population	Deaths	Avg. Person Years Lived (ax)	Probability of Death (qx)	Survivors (lx)	Years lived (Lx)	Life Expectancy (ex)
<1 year	266283	795	0.06136	0.002977	100000	99720.5477	**84.61315**
1-4 years	1087196	140	1.517468	0.000515	99702.28	398681.669	83.86563
5-9 years	1349760	118	2.5	0.000437	99650.94	498145.831	79.90805
10-14 years	1350317	99	2.5	0.000367	99607.39	497945.689	74.9419
15-19 years	1398736	208	2.5	0.000743	99570.88	497669.405	69.96846
20-24 years	1490294	329	2.5	0.001103	99496.88	497209.977	65.01864
25-29 years	1655403	309	2.5	0.000933	99387.11	496703.775	60.08769
30-34 years	1956682	579	2.5	0.001478	99294.4	496104.982	55.14146
35-39 years	2327831	1023	2.5	0.002195	99147.6	495193.926	50.2194
40-44 years	2425295	1808	2.5	0.00372	98929.98	493729.716	45.32437
45-49 years	2376039	3062	2.5	0.006423	98561.91	491226.946	40.48429
50-54 years	2083816	4347	2.5	0.010376	97928.87	487103.996	35.72984
55-59 years	1892070	5950	2.5	0.015601	96912.73	480783.848	31.07825
60-64 years	1961648	9260	2.5	0.023327	95400.81	471440.43	26.53117
65-69 years	1595034	12183	2.5	0.037475	93175.36	457147.495	22.10514
70-74 years	1672877	20622	2.5	0.059794	89683.63	435011.901	17.86844
75-79 years	1436909	33548	2.5	0.110299	84321.13	398354.348	13.84582
80-84 years	1185394	55933	2.5	0.211032	75020.61	335523.718	10.25239
85+ years	1137850	155,317	7.325985	1	59188.87	433616.8	7.325985

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 13. Life Expectancy for Male Italian Citizens in Italy

Age Class	Population	Deaths	Avg. Person Years Lived (ax)	Probability of Death (qx)	Survivors (lx)	Years lived (Lx)	Life Expectancy (ex)
<1 year	245019	634	0.051945	0.002581	100000	99755.2859	**79.68**
1-4 years	1015236	128	1.643713	0.000504	99742	398849.022	78.88
5-9 years	1304811	109	2.5	0.000418	99692	498353.879	74.92
10-14 years	1326976	150	2.5	0.000565	99650	498109.037	69.95
15-19 years	1377820	474	2.5	0.001719	99594	497540.361	64.99
20-24 years	1410294	716	2.5	0.002535	99422	496482.295	60.10
25-29 years	1480312	787	2.5	0.002655	99170	495193.972	55.25
30-34 years	1710181	1020	2.5	0.002978	98907	493799.514	50.39
35-39 years	2083424	1639	2.5	0.003926	98613	492095.413	45.53
40-44 years	2191588	2706	2.5	0.006155	98226	489616.253	40.70
45-49 years	2182142	4602	2.5	0.010489	97621	485544.945	35.94
50-54 years	1908112	6572	2.5	0.017074	96597	478861.697	31.29
55-59 years	1742200	9768	2.5	0.027646	94948	468176.095	26.79
60-64 years	1809984	16243	2.5	0.043886	92323	451484.599	22.48
65-69 years	1419896	21423	2.5	0.072697	88271	425312.905	18.40
70-74 years	1401364	32747	2.5	0.110391	81854	386680.567	14.64
75-79 years	1069310	44348	2.5	0.187887	72818	329886.855	11.15
80-84 years	731118	55863	2.5	0.320766	59137	248260.478	8.15
85+ years	486862	83,637	5.821132	1	40168	233820.877	5.82

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 14. Life Expectancy for Female Italian Citizens in Italy

Age Class	Population	Deaths	Avg. Person Years Lived (ax)	Probability of Death (qx)	Survivors (lx)	Years lived (Lx)	Life Expectancy (ex)
<1 year	231221	506	0.059127	0.002184	100000	99794.5242	**84.72**
1-4 years	960307	106	1.518678	0.000441	99782	399017.158	83.90
5-9 years	1232009	99	2.5	0.000402	99738	498587.675	79.94
10-14 years	1251292	84	2.5	0.000336	99698	498403.867	74.97
15-19 years	1303690	178	2.5	0.000682	99664	498150.184	70.00
20-24 years	1339355	262	2.5	0.000978	99596	497736.732	65.04
25-29 years	1430931	255	2.5	0.000891	99499	497271.777	60.10
30-34 years	1676182	474	2.5	0.001413	99410	496699.087	55.15
35-39 years	2077304	880	2.5	0.002116	99270	495822.83	50.23
40-44 years	2212329	1638	2.5	0.003695	99060	494382.624	45.33
45-49 years	2212767	2863	2.5	0.006448	98694	491876.484	40.49
50-54 years	1955369	4096	2.5	0.010419	98057	487731.26	35.74
55-59 years	1812471	5731	2.5	0.015686	97035	481371.855	31.09
60-64 years	1917555	9054	2.5	0.023333	95513	471995.158	26.54
65-69 years	1572969	11989	2.5	0.037397	93285	457702.289	22.12
70-74 years	1657851	20405	2.5	0.059703	89796	435578.047	17.88
75-79 years	1429335	33322	2.5	0.110145	84435	398924.918	13.85
80-84 years	1181217	55680	2.5	0.210842	75135	336070.55	10.26
85+ years	1134663	154,735	7.332943	1	59293	434794.36	7.33

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 15. Life Expectancy for Foreign Male Citizens in Italy

Age Class	Population	Deaths	Avg. Person Years Lived (ax)	Probability of Death (qx)	Survivors (lx)	Years lived (Lx)	Life Expectancy (ex)
<1 year	37202	345	0.069891	0.009194	100000	99144.8213	**75.95**
1-4 years	135544	42	1.624885	0.001239	99081	396030.782	75.66
5-9 years	125797	27	2.5	0.001073	98958	494523.879	71.75
10-14 years	108059	35	2.5	0.001618	98852	493858.63	66.82
15-19 years	109753	76	2.5	0.003456	98692	492605.952	61.93
20-24 years	137669	194	2.5	0.007021	98351	490026.836	57.14
25-29 years	177806	266	2.5	0.007452	97660	486481.045	52.52
30-34 years	236409	291	2.5	0.006136	96932	483174.72	47.90
35-39 years	224263	292	2.5	0.006489	96338	480124.991	43.18
40-44 years	201111	394	2.5	0.009748	95712	476229.659	38.44
45-49 years	134669	455	2.5	0.016752	94779	469927.875	33.80
50-54 years	86340	427	2.5	0.024426	93192	460267.855	29.33
55-59 years	45415	406	2.5	0.043722	90915	444639.695	25.00
60-64 years	23892	304	2.5	0.061658	86940	421300.748	21.03
65-69 years	14021	265	2.5	0.090237	81580	389495.379	17.25
70-74 years	10382	286	2.5	0.128864	74218	347181.402	13.71
75-79 years	5708	260	2.5	0.204467	64654	290222.172	10.37
80-84 years	2898	235	2.5	0.337111	51435	213825.129	7.39
85+ years	1669	342	4.880117	1	34095	166389.747	4.88

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 16. Life Expectancy for Foreign Female Citizens in Italy

Age Class	Population	Deaths	Avg. Person Years Lived (ax)	Probability of Death (qx)	Survivors (lx)	Years lived (Lx)	Life Expectancy (ex)
<1 year	35062	289	0.076079	0.00818	100000	99244.21	**82.08**
1-4 years	126889	34	1.509488	0.001071	99182	396463.328	81.76
5-9 years	117751	19	2.5	0.000806	99076	495178.962	77.85
10-14 years	99025	15	2.5	0.000757	98996	494791.836	72.91
15-19 years	95046	30	2.5	0.001577	98921	494214.482	67.96
20-24 years	150939	67	2.5	0.002217	98765	493277.102	63.06
25-29 years	224472	54	2.5	0.001202	98546	492433.548	58.20
30-34 years	280500	105	2.5	0.00187	98427	491677.267	53.27
35-39 years	250527	143	2.5	0.00285	98243	490517.177	48.36
40-44 years	212966	170	2.5	0.003983	97963	488841.669	43.49
45-49 years	163272	199	2.5	0.006076	97573	486384.082	38.66
50-54 years	128447	251	2.5	0.009723	96980	482544.672	33.88
55-59 years	79599	219	2.5	0.013662	96037	476907.029	29.19
60-64 years	44093	206	2.5	0.02309	94725	468158.727	24.56
65-69 years	22065	194	2.5	0.043016	92538	452739.258	20.08
70-74 years	15026	217	2.5	0.069692	88558	427358.432	15.87
75-79 years	7574	226	2.5	0.138838	82386	383333.407	11.87
80-84 years	4177	253	2.5	0.263021	70948	308086.007	8.38
85+ years	3187	582	5.475945	1	52287	286319.913	5.48

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 17. Multiple Decrement Life Table for All Residents and Italian Citizens—Males

Age Class	nDx All Residents	nDx Italians	lx All Residents	nqx All Residents	nqx Italians	ndx Italians	lx Italians
0	979	634	100000	0.003458	0.002239	224	98604
1	170	128	99654	0.000591	0.000445	44	98380
5	136	109	99595	0.000475	0.000381	38	98336
10	185	150	99548	0.000644	0.000522	52	98298
15	550	474	99484	0.001847	0.001592	158	98246
20	910	716	99300	0.002935	0.002309	229	98088
25	1053	787	99009	0.00317	0.002369	235	97858
30	1311	1020	98695	0.003362	0.002616	258	97624
35	1931	1639	98363	0.004175	0.003544	349	97365
40	3100	2706	97952	0.006457	0.005636	552	97017
45	5057	4602	97320	0.010854	0.009878	961	96465
50	6999	6572	96264	0.017394	0.016332	1572	95503
55	10174	9768	94589	0.028058	0.026938	2548	93931
60	16547	16243	91935	0.04412	0.043309	3982	91383
65	21688	21423	87879	0.07287	0.071979	6325	87402
70	33033	32747	81475	0.110528	0.109571	8927	81076
75	44608	44348	72470	0.187975	0.18688	13543	72149
80	56098	55863	58847	0.320831	0.319487	18801	58606
85	83979	83637	39967	1	0.995928	39805	39805
All	288508	283566				98604	

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 18. Multiple Decrement Life Table for All Residents and Italian Citizens—Females

Age Class	nDx All Residents	nDx Italians	lx All Residents	nqx All Residents	nqx Italians	ndx Italians	lx Italians
0	795	506	100000	0.002977	0.001895	189	99053
1	140	106	99702	0.000515	0.000390	39	98863
5	118	99	99651	0.000437	0.000367	37	98824
10	99	84	99607	0.000367	0.000311	31	98788
15	208	178	99571	0.000743	0.000636	63	98757
20	329	262	99497	0.001103	0.000879	87	98694
25	309	255	99387	0.000933	0.000770	77	98606
30	579	474	99294	0.001478	0.001210	120	98530
35	1023	880	99148	0.002195	0.001888	187	98410
40	1808	1638	98930	0.00372	0.003371	333	98222
45	3062	2863	98562	0.006423	0.006005	592	97889
50	4347	4096	97929	0.010376	0.009777	957	97297
55	5950	5731	96913	0.015601	0.015027	1456	96339
60	9260	9054	95401	0.023327	0.022808	2176	94883
65	12183	11989	93175	0.037475	0.036878	3436	92707
70	20622	20405	89684	0.059794	0.059164	5306	89271
75	33548	33322	84321	0.110299	0.109556	9238	83965
80	55933	55680	75021	0.211032	0.210077	15760	74727
85	155317	154735	59189	1	0.996253	58967	58967
All	288508	302357				99053	

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 19. Multiple Decrement Life Table for All Residents and Foreigners—Males

Age Class	nDx All Residents	nDx Foreigners	lx All Residents	nqx All Residents	nqx Foreigners	ndx Foreigners	lx Foreigners
0	979	345	100000	0.003458	0.001218	122	1396
1	170	42	99654	0.000591	0.000146	15	1274
5	136	27	99595	0.000475	0.000094	9	1260
10	185	35	99548	0.000644	0.000122	12	1250
15	550	76	99484	0.001847	0.000255	25	1238
20	910	194	99300	0.002935	0.000626	62	1213
25	1053	266	99009	0.00317	0.000801	79	1151
30	1311	291	98695	0.003362	0.000746	74	1071
35	1931	292	98363	0.004175	0.000631	62	998
40	3100	394	97952	0.006457	0.000821	80	935
45	5057	455	97320	0.010854	0.000977	95	855
50	6999	427	96264	0.017394	0.001061	102	760
55	10174	406	94589	0.028058	0.001120	106	658
60	16547	304	91935	0.04412	0.000811	75	552
65	21688	265	87879	0.07287	0.000890	78	477
70	33033	286	81475	0.110528	0.000957	78	399
75	44608	260	72470	0.187975	0.001096	79	321
80	56098	235	58847	0.320831	0.001344	79	242
85	83979	342	39967	1	0.004072	163	163
All	288508	4942				1396	

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author

Table 20. Multiple Decrement Life Table for All Residents and Foreigners—Females

Age Class	nDx All Residents	nDx Foreigners	lx All Residents	nqx All Residents	nqx Foreigners	ndx Foreigners	lx Foreigners
0	795	289	100000	0.002977	0.001082	108	947
1	140	34	99702	0.000515	0.000125	12	839
5	118	19	99651	0.000437	0.000070	7	826
10	99	15	99607	0.000367	0.000056	6	819
15	208	30	99571	0.000743	0.000107	11	814
20	329	67	99497	0.001103	0.000225	22	803
25	309	54	99387	0.000933	0.000163	16	781
30	579	105	99294	0.001478	0.000268	27	765
35	1023	143	99148	0.002195	0.000307	30	738
40	1808	170	98930	0.00372	0.000350	35	708
45	3062	199	98562	0.006423	0.000417	41	673
50	4347	251	97929	0.010376	0.000599	59	632
55	5950	219	96913	0.015601	0.000574	56	573
60	9260	206	95401	0.023327	0.000519	50	518
65	12183	194	93175	0.037475	0.000597	56	468
70	20622	217	89684	0.059794	0.000629	56	412
75	33548	226	84321	0.110299	0.000743	63	356
80	55933	253	75021	0.211032	0.000955	72	293
85	155317	582	59189	1	0.003747	222	222
All	288508	3273				947	

Data source: Istituto Nazionale di Statistica (ISTAT 2011), calculations by author