

Social integration and self-reported health: differences between immigrants and natives

Background. Our paper assesses the relationship between social integration, in terms of social contact and social trust, and one's individual health. While a large body of research already engaged with clarifying this relationship, we know little about the role one's immigration background plays in moderating this relationship. With respect to this, we explicitly focus on how one's immigrant status moderates the relationship between social integration and self-reported health. Previous literature has demonstrably shown that the less socially integrated individuals are, the less likely they are to report good health. Moreover, we know from social capital literature that immigrants have difficulties being socially connected in their host country. *Methods.* With the help of the new MIGHEAL survey, we test this proposed negative relationship. We also compare the results from the MIGHEAL data with findings from the European Social Survey (ESS) round 7. Our analyses follow a thorough approach testing immigrant background as potential moderating factors. We implement logistic regression models and path analysis to reveal the complex interactive relationship between social integration, immigrant status, and self-reported health. *Results/Conclusion.* Our results suggest that immigrant status does play a moderating role in the relationship between social integration and health. This role, however, is limited to the relationship between social activity and self-reported health, which points to a potential endogenous effect.

Introduction

The steady influx of immigrants from within and outside Europe as well as growing inequalities among the population significantly contribute to the difficulties Europe is facing in the aftermath of the economic crisis. While immigration challenges Europe, immigrants themselves face difficulties in their new home countries. The literature on immigrants' health is two-folded: one side supports the 'healthy immigrant hypothesis', which states that immigration is based on a self-selection process in which healthier individuals are more likely to decide to emigrate from their home country; consequently, immigrants should show better health than the average population.^{1,2} The other side, however, has shown that immigrants tend to report lower levels of self-reported health as well as higher levels of mental issues than their native-born counterparts³.

Health status is known to be best explained by individuals' socio-economic status, such as education, occupation and income⁴ – factors that tend to be lower for immigrants and ethnically diverse groups⁵. Rostila, however, identified one's degree of social integration, in terms of social capital, as an additional important determinant of self-reported health⁶. The relationship between social capital and health has been thoroughly analysed in recent years, whereby most studies focussed on the influence of social or generalised trust⁷⁻⁹. Subramanian et al.⁹ reveal that both individual and contextual levels of trust relate to health status¹⁰. In a similar vein, Jen et al⁷ reveal that individual levels of trust are more important than country-level trust in explaining health inequalities.

Yet, following Putnam^{11,12} social capital is composed of a structural and cultural component; that is, social networks and social trust. Prior studies argued that trust generates potential information flows and, thus, should generate better health⁴. At the same time, social integration and social networks are better known to provide important information and a social safety net. In the following, we focus on both social integration and social trust as potential triggers of better health. Our theoretical reasoning relies on two basic mechanisms¹³: (1) social capital renders better access to health relevant information, e.g. where the best and most trustful doctors are, which medical

advice to follow. (2) Structural social capital provides a network of informal health care and general support. Similarly, higher levels of trust invoke feelings of reciprocity, guaranteeing mutual support now and in the future¹⁴.

The literature on the relationship between social capital and health status disagrees on the causal directions between these two concepts. Although recent studies^{15,16} underscored the causal link from social capital to health, there are still doubts. We add an additional factor to this ambiguous relationship: immigrant background. Immigrants are known to show lower levels of both structural and cultural social capital. But more importantly, immigrant levels of social capital, in particular social trust, resemble levels of social capital in their home country¹⁷. According to Dinesen and Hooghe¹⁸, the acculturation of social trust is less likely for first- than second-generation immigrants. A large part of social capital is generated and internalised through both socialisation processes in one's family and the country-specific cultural determinants. With respect to this, social capital evolves in an early life-stage and tends to be rather stable and highly dependent on ancestral factors¹⁹. Immigrants' social capital should thus be antecedent to today's health status.

Social integration, however, may take two forms. First, it may provide information and mutual networks of support and trust as above described; whereas, secondly, social networks may be very homogenous providing only bonding connections. Following Campos-Matos et al.⁴ closed networks may bear negative instead of positive consequences on individual health. These closed or bonding networks are most likely to appear for immigrant groups, that is, immigrants establish rather homogenous networks, which tend to be disconnected from more diverse networks in their country of residence. This missing bridging potential might bear negative health consequences for immigrants, as similar members in a network may not render a diversified network of information. We expect that while social integration fosters native-born health, we might detect that immigrants do not benefit from their enhanced social activity given the composition of their networks²⁰.

This study addresses the relationship between social capital and health status from a different angle than prior research by focussing on differences between first- and second-generation immigrants and native-born citizens. We make use of two different, although related, data sources: a country-specific survey from Greece analysing the societal consequences of the economic crisis as well as data from the European Social Survey (ESS) 2014. Our aim was to broaden the insights on social capital and health by (i) analysing both the effects of the structural, i.e. social networks and activity, and cultural component, i.e. social trust, of social capital on self-reported health and by (ii) focussing on differences between immigrants and the native-born population in the 20 ESS countries in general and Greece in specific.

The combination of these two data sets renders two distinct advantages: first, ESS 2014 did not include Greece, even though Greece has proven to be an extraordinary case concerning its recent history of economic hardship and societal changes; among others, the increased influx of non-Western European immigrants. The MIGHEAL survey was explicitly designed in accordance with the ESS to guarantee valuable comparisons. Secondly, although the situation of Greece seems to be unique in the European context, other countries – mainly Eastern and Southern European ones – already face or will face similar economic and societal challenges as Greece.

Methods

Data sources and variables

Our analyses rests on two data sources. First, we use the MIGHEAL survey, which was designed to capture health inequalities in Greece. More importantly, the survey particularly focusses on the immigrant population in Greece that resulted in an oversampling of immigrants. The Greek survey was established in line with the ESS 2014, which renders the possibility to contrast the findings from Greece with findings from the 20 European countries covered by the ESS.¹ The MIGHEAL

¹ The 20 countries are: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Great Britain, Hungary, Ireland, Lithuania, Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Switzerland, Sweden.

data was fielded shortly after the ESS in 2014. The question design as well as the answer categories resemble each other in both data sets.

The outcome measure self-perceived or self-rated health is based on the question ‘How is your health in general?’. The answer categories range on a 5-point scale from ‘very good’ to ‘very bad’. We recoded the answers to this question to receive a binary indicator, with the categories ‘very bad/bad/fair’ and ‘good/very good’; accordingly, a value of 1 signifies better self-perceived health (Eikemo et al. 2008).²

Social integration is assessed by three different measures. First, social trust is assessed by an additive scale based on following three items: ‘Generally speaking would you say that most people can be trusted, or that you can’t be too careful in dealing with people’, ‘Do you think that most people would try to take advantage of you if they got the chance, or would they try to be fair?’, and ‘Would you say that most of the time people try to be helpful or that they are mostly looking out for themselves’. Answers to the items are captured on an 11-point scale; higher values indicating higher trust. The scale based on the unweighted means of all three variables, ranging from 0-11, shows a good scale reliability ($\alpha=0.74$ in MIGHEAL and $\alpha=0.76$ in ESS7). Further this measure has proven to be adequate for assessing social trust in cross-country comparison²¹. Second, social integration is measured by the respondent’s frequency of social contacts (‘How often do you meet socially with friends, relatives or work colleagues’, ranging from 1 ‘never’ to 7 ‘every day’) and their assessment of their own social activity compared to others (‘Compared to other people of your age, how often would you say you take part in social activities’, ranging from 1 ‘much less than most’ to 5 ‘much more than most’).

Country of birth identifies first-generation immigrants in the Greek data, independent of their current citizenship status. It distinguishes respondent’s born in Greece, Albania or another third

² We repeated the models with the original five-category variable in a linear regression analysis, and the results did not differ.

country. In the ESS, we distinguish between first- and second-generation immigrants as the number of respondents with immigrant background does not allow to distinguish for single countries. We must, however, keep in mind that the immigrant population in the 20 European countries is composed differently than the immigrant population in Greece. For example, countries such as Germany, Sweden or UK have a large number of Western European immigrants. First generation immigrants are identified as being born outside their country of residence and both parents having been born outside the country. Second-generation immigrants were born within their country of residence, but have at least one parent who was born outside the country¹⁸. Additional confounding factors were integrated in the models. Age, gender, educational level (ISCED categories) as well as one's religiosity (not religious at all to very religious) were added.

Statistical analyses

Following the binary structure of the dependent measure, we implemented logistic regression models. In the Greek case, we use simple single-level analysis, whereas the data structure of the ESS demands the implementation of logistic-multilevel models. The ESS consists of 34,409 individuals nested in 20 European countries – Israel was excluded from the analysis. Furthermore, the sample was slightly reduced by missing values on both our main variables of interest and our controls. The MIGHEAL survey includes 1,332 individuals. To assert the effect of social integration on self-reported health by different immigration backgrounds, we make use of interaction models. In doing so, we can reveal whether the predicted positive relationship differs according to one's immigration background. The relationships between the three social integration measures are accounted for by including covariances between these three measures to the models. All analyses were performed using Stata 15.1.

Results

Table 1 gives a first overview over the distribution of our main variables of interest between individuals with and without immigration background. In the Greek sample, Albanian first-generation immigrants show significantly higher levels of self-rated health than native-born Greeks; this also applies to immigrants from other countries. This preliminary finding speaks in favour of the ‘immigrant health thesis’. On the base of the ESS data, we could yet not detect any relevant differences between native- and foreign-born respondents in their levels of self-reported health among the 20 ESS countries. Compared to the Greek sample, however, we see that second- and first-generation immigrants differ in their levels of social contacts and social activity from the native population. Individuals with an immigrant background are less often socially involved than natives. We can only find this difference between Greeks and Albanian immigrants concerning their social activity in the MIGHEAL data.

Table 2 presents the four estimated models for the MIGHEAL data. Model 1 reveals the direct influences of our main variables of interest. Being born in Albania has a positive influence on health compared to those born in Greece. In contrast, if respondents were born in a third country, they are less likely to report good health than their Greece-born counterparts. The differences thereby are the largest between Greek natives and immigrants from third countries: the latter show an average marginal effect of 0.69 on self-reported health, whereas Greek respondents show an average level of 0.77 (average marginal effects are not shown in the tables, but were estimated separately). Out of our three social integration measures, only having regular social contacts with friends or relatives shows a positive and significant relationship with self-reported health. Moreover, this relationship seems to be rather relevant for the explanation of differences in self-reported health: if a person would change his social activity from the lowest (=1) to the highest (=7) frequency of social contacts, his average level of self-reported health would increase by 20 percentage points.

Our main interest, however, was how the relationship between social integration and health status is moderated by immigration background. Models 2 to 4 in Table 2 underscore that immigrant

status does not play a meaningful role in the interaction with social trust or social contact. The only relevant moderation occurs between social activities and country of birth. According to the estimates in model 4, the positive relationship between being socially active and self-reported health will be diminished for respondents born outside of Greece. That is, immigrants' health does not profit from enhanced social activity. The opposite is the case, the more socially active immigrants are, the more likely they are to report bad health compared to native-born Greeks. This is even true for immigrants from Albania who showed higher levels of trust than the native-born respondents.

This finding is further supported by our estimates based on the ESS 2014 data. Table 3 first reveals that like the Greek estimates, immigrants from third countries are more likely to report lower levels of health; whereby the effect is slightly stronger for first- than second-generation immigrants compared to the native-born individuals. Moreover, all three social integration measures show a significant and relevant influence on good levels of self-reported health. Model 8, however, reveals that even in the cross-country comparison, more socially active first-generation immigrants are less likely to report good health compared to the native-born population. In contrast, if first-generation immigrants have enhanced social contact, they are more likely to report better levels of health. Here the negative effect of being an immigrant is outperformed by enhanced social integration through regular social contacts. Figure 1 gives an exemplary overview over the finding reported in model 8. While second-generation immigrants do not differ from native-born individuals, the effect of social activity on a good health status is less positive for first-generation immigrants as well as significantly different from the effect of the native-born respondents.

Discussion

This study aimed to reveal the relationship between immigrant background, social integration, and health status in European countries. We did find support for the general assumption that social integration relates positively to better health status and that immigrants tend to report poorer

health. Yet, this finding holds true only for the cross-national European comparison based on the ESS 2014 survey data. In the Greek case, we cannot replicate the finding that immigrants tend to have poorer health. First-generation immigrants from Albania report better health than both native-born Greeks and immigrants from a third country. This peculiarity may be traced back to the difficult times Greece and the Greek population have been going through and are still suffering from. Our findings support the observation already made by Rocco et al.¹³ that Greece is an outlier in the European context as a result of the economic crisis and its social consequences. Moreover, because of the oversampling of the migrants in the MIGHEAL data, we have been able to give more precise estimates of the difference between migrants and natives compared to the ESS data. Our main interest, however, was the interactive relationship between social integration, immigrant background, and health. Our assumption that immigrant status diminishes the shown positive effect between social trust, social contact, and social activity was supported to some degree by the results; in both the cross-country and Greek comparison. While the relationship between both social trust and social contact and health does not depend on one's immigrant background, the relationship between being socially active and health is diminished for first-generation immigrants. In other words, being socially active does not compensate the negative immigrant effect on health status. This is also true for Albanian immigrants in Greece, even though having been born in Albania showed a sizeable positive effect on health status. The more socially active they become, the less likely they are to report good health.

This negative dependency between immigrant background and social activity could be traced back to the idea of 'bonding social capital'; that is the social interaction in homogenous groups, e.g. ethnically similar groups. In contrast to bridging groups, bonding social capital does not render a large variety of information and diversity of contact. Hence, less positive outcomes may be expected from this kind of social activity^{22,23}. However, we cannot truly analyse the nature of the social activities as our data does not provide more detailed information on the composition of the networks. Future research in this area should concentrate more on the effects of both bridging and

bonding networks on health status. In particular, as other researchers, such as Poortinga²⁴, underscore the positive consequences of bonding social capital on an individual's health status. Moreover, the path-dependency of social integration may be an issue here. Data from prior ESS studies including Albania (ESS6 2012) show that, on average, Albanians are only half as socially active as the average Greek population (Greek data from ESS5 2010). Yet, Albanians show a slightly higher level of self-reported health.

Before discussing the implications of our results, we want to point out that these should be handled with care. As aforementioned, there is a disagreement in the literature on the causal relationship between trust and health status. While there is growing evidence that trust evokes better health rather than that health lowers social capital^{15,16}, we still have to be careful in interpreting results in any causal direction. Our findings showed that the only relevant moderation effect can be detected for the social activity measure. This could be due to a 'health selection process' into social activities, which means that poor health may limit individuals' social activity; for example, by hampering one's mobility or motivation. This argument applies most strongly for older people; and in both samples, the native-born population is significantly older than the respondents with immigrant background.

Our findings imply that there are differences in health status between first- and second-generation immigrants as well as in their level of social integration. The Greek data reveals the most pronounced results as we are able to distinguish between the country of origin of first-generation immigrants. In general, we find larger differences for first- than second-generation immigrants. With respect to this, distinguishing the countries of origin in the ESS might render more pronounced findings as the results by Dinesen and Hooghe¹⁸ already suggest in their analyses based on different waves of the ESS.

In the end, the question arises of what could be done to increase the social integration of immigrants as well as their health status in the European context. The literature often suggests that more extensive welfare states can help 'crowding-in' social integration²⁵. In times of austerity, like

in Greece and most other European countries, an extension of the welfare state seems to be rather hypothetical. It is more likely that we will observe a retraction of welfare measures, which may lead to less social integration of immigrants and consequently larger health inequalities. With respect to this, a suggestion for future research would be to integrate welfare measures to the complex relationship between immigrant background, social integration, and health.

Apart from the welfare state, the attitudinal climate towards immigrants within countries could act as a further mechanism limiting both immigrants' social integration and health status. If immigrants' encounter a hostile surrounding, they may be more likely to retreat to homogenous social networks and will probably be more likely to suffer from bad health – based on the hostility and the decreased social integration. This could be another step towards a more pronounced understanding of health inequalities among immigrants in the European context.

Conclusion

Our findings underscore the role of social integration and social involvement in explaining self-reported health. It is thereby important to distinguish between cultural, here ethnic, backgrounds as social activity is largely driven by one's upbringing and cultural environment. With respect to this, it does not suffice to analyse if a person is an immigrant or not. Our results revealed that it is rather important to distinguish individuals' cultural origins to correctly assess the relationship between social integration and self-reported health. This, however, is only possible by using specific survey data that focus on diverse immigrant populations, such as the MIGHEAL data.

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Table 1: Mean differences

MIGHEAL study			
	Greece (N=798)	Albania (N=320)	Other country (N=213)
self-reported health	0.73 ^b	0.89 ^a	0.78 ^b
social trust	4.07 ^{bc}	4.45 ^{ac}	4.84 ^{ab}
social contacts	3.59	3.52	3.75
social activity	2.60 ^b	2.44 ^a	2.51
European Social Survey			
	native born (N=30,675)	second generation immigrant (N=2,025)	first generation immigrant (N=3,084)
self-reported health	0.66	0.66	0.67
social trust	5.42 ^b	5.30 ^{ac}	5.45 ^b
social contacts	4.80 ^{bc}	4.91 ^{ac}	4.71 ^{ab}
social activity	2.71 ^{bc}	2.64 ^a	2.59 ^a

Note: weighted means in MIGHEAL data; mean effects among 20 countries in ESS data. ^a significantly different to Greek/native population; ^b significantly different to Albanian/second-generation immigrant population; ^c significantly different to other/first-generation immigrant population.

Table 2: Logit regression results – MIGHEAL data

	<i>Self-reported health</i>			
	model 1	model 2	model 3	model 4
country born ¹				
Albania	0.54** (0.25)	0.73 (0.62)	1.27** (0.59)	1.83*** (0.70)
other country	-0.49** (0.24)	0.04 (0.57)	-0.83 (0.55)	0.40 (0.61)
social trust scale	0.05 (0.04)	0.08 (0.06)	0.05 (0.04)	0.05 (0.04)
social contacts	0.25*** (0.06)	0.25*** (0.06)	0.27*** (0.08)	0.26*** (0.06)
social activities	0.12 (0.10)	0.13 (0.10)	0.12 (0.10)	0.25** (0.11)
age	-0.05*** (0.01)	-0.05*** (0.01)	-0.05*** (0.01)	-0.05*** (0.01)
educational level	0.00*** (0.00)	0.00*** (0.00)	0.00*** (0.00)	0.00*** (0.00)
female	-0.17 (0.17)	-0.20 (0.17)	-0.17 (0.17)	-0.21 (0.17)
religiosity	-0.01 (0.03)	-0.01 (0.03)	-0.01 (0.03)	-0.01 (0.03)
<i>interaction effects¹</i>				
Albanian*trust		-0.05 (0.13)		
Other*trust		-0.12 (0.11)		
Albanian*contact			-0.23 (0.16)	
Other*contact			0.10 (0.15)	
Albanian*activity				-0.57** (0.28)
Other*activity				-0.38 (0.24)
intercept	2.26*** (0.56)	2.15*** (0.57)	2.22*** (0.57)	1.97*** (0.57)
N	1146	1146	1146	1146
Pseudo R ²	0.23	0.23	0.23	0.23
AIC	972.57	975.45	973.63	970.76
BIC	1023.01	1035.98	1034.16	1031.29

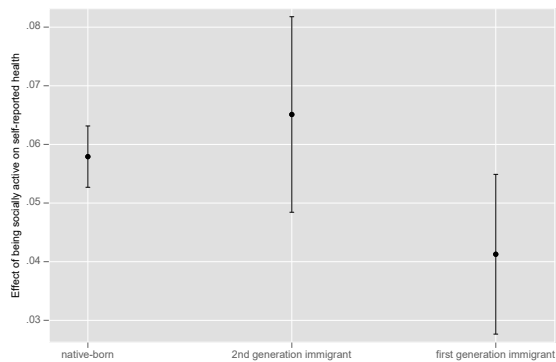
Notes: Standard errors in parentheses; non-standardised regression coefficients presented; survey weights used for estimates; * $p < .10$, ** $p < .05$, *** $p < .01$; AIC=Akaike Information Criterion, BIC=Bayesian Information Criterion; ¹born in Greece as reference category.

Table 3: Multilevel logit regression results – ESS data

	<i>Self-reported health</i>			
	model 5	model 6	model 7	model 8
migration background ¹				
second generation immigrant	-0.11*	-0.24	-0.07	-0.20
	(0.06)	(0.17)	(0.18)	(0.17)
first generation immigrant	-0.17***	-0.06	-0.48***	0.11
	(0.05)	(0.15)	(0.15)	(0.13)
social trust scale	0.15***	0.15***	0.15***	0.15***
	(0.01)	(0.01)	(0.01)	(0.01)
social contacts	0.02**	0.02**	0.01	0.02**
	(0.01)	(0.01)	(0.01)	(0.01)
social activities	0.32***	0.32***	0.33***	0.33***
	(0.02)	(0.02)	(0.02)	(0.02)
age	-0.04***	-0.04***	-0.04***	-0.04***
	(0.00)	(0.00)	(0.00)	(0.00)
educational level	0.15***	0.15***	0.15***	0.15***
	(0.01)	(0.01)	(0.01)	(0.01)
female	-0.19***	-0.19***	-0.19***	-0.19***
	(0.03)	(0.03)	(0.03)	(0.03)
religiosity	-0.02***	-0.02***	-0.02***	-0.02***
	(0.00)	(0.00)	(0.00)	(0.00)
<i>interaction effects¹</i>				
second gen.*trust		0.02		
		(0.03)		
first gen.*trust		-0.02		
		(0.03)		
second gen.*contact			-0.01	
			(0.04)	
first gen.*contact			0.07**	
			(0.03)	
second gen.*activity				0.03
				(0.06)
first gen.*activity				-0.11**
				(0.05)
intercept	0.79***	0.79***	0.82***	0.77***
	(0.13)	(0.13)	(0.13)	(0.13)
variance component	0.22***	0.22***	0.22***	0.22***
	(0.07)	(0.07)	(0.07)	(0.07)
N	34409	34409	34409	34409
AIC	36007.59	36010.31	36006.58	36006.14
BIC	36100.49	36120.11	36116.38	36115.94

Standard errors in parentheses; non-standardised regression coefficients presented; survey weights used for estimates; * $p < .10$, ** $p < .05$, *** $p < .01$. AIC=Akaike Information Criterion, BIC=Bayesian Information Criterion; ¹born in country of residence and not having an immigrant background as reference category.

Figure 1: Interaction between being socially active and immigrant background on health status – ESS data



APPENDIX

Table A1: Descriptive statistics by immigrant status – MIGHEAL data

MIGHEAL		mean	min	max	sd
self-reported health	<i>total</i>	0.78	0	1	0.42
	<i>native-born Greek</i>	0.73	0	1	0.44
	<i>Albanian immigrant</i>	0.89	0	1	0.31
	<i>other country immigrant</i>	0.78	0	1	0.41
social trust scale	<i>total</i>	4.28	0	10	1.84
	<i>native-born Greek</i>	4.07	0	9.67	1.78
	<i>Albanian immigrant</i>	4.45	0	9	1.82
	<i>other country immigrant</i>	4.85	0.67	10	1.96
social contacts	<i>total</i>	3.60	1	6	1.52
	<i>native-born Greek</i>	3.59	1	6	1.54
	<i>Albanian immigrant</i>	3.52	1	6	1.46
	<i>other country immigrant</i>	3.76	1	6	1.52
social activities	<i>total</i>	2.55	1	5	0.92
	<i>native-born Greek</i>	2.60	1	5	0.96
	<i>Albanian immigrant</i>	2.45	1	4	0.82
	<i>other country immigrant</i>	2.51	1	5	0.85
age	<i>total</i>	47.6	15	94	17.6
	<i>native-born Greek</i>	51.9	15	94	19.3
	<i>Albanian immigrant</i>	40.2	15	72	12.2
	<i>other country immigrant</i>	42.6	17	80	12.4
educational level	<i>total</i>	339.4	0	800	187.9
	<i>native-born Greek</i>	354.5	0	800	202.3
	<i>Albanian immigrant</i>	277.6	0	620	135.1
	<i>other country immigrant</i>	375.8	0	800	179.5
female	<i>total</i>	0.51	0	1	0.50
	<i>native-born Greek</i>	0.56	0	1	0.50
	<i>Albanian immigrant</i>	0.43	0	1	0.50
	<i>other country immigrant</i>	0.43	0	1	0.50
religious	<i>total</i>	6.29	0	10	2.74
	<i>native-born Greek</i>	6.17	0	10	2.72
	<i>Albanian immigrant</i>	5.90	0	10	2.77
	<i>other country immigrant</i>	7.30	0	10	2.58
N		1332			

Table A2: Descriptive statistics by immigrants status – ESS data

ESS		mean	min	max	sd
native born/citizenship					
self-reported health					
	<i>total</i>	0.66	0	1	0.47
	<i>native</i>	0.66	0	1	0.47
	<i>second</i>	0.65	0	1	0.48
	<i>first</i>	0.70	0	1	0.46
social trust scale					
	<i>total</i>	5.17	0	10	1.79
	<i>native</i>	5.16	0	10	1.79
	<i>second</i>	5.17	0	10	1.75
	<i>first</i>	5.31	0	10	1.79
social contacts					
	<i>total</i>	4.90	1	7	1.53
	<i>native</i>	4.89	1	7	1.52
	<i>second</i>	5.03	1	7	1.56
	<i>first</i>	4.87	1	7	1.54
social activities					
	<i>total</i>	2.73	1	5	0.92
	<i>native</i>	2.73	1	5	0.91
	<i>second</i>	2.70	1	5	0.91
	<i>first</i>	2.68	1	5	0.95
age					
	<i>total</i>	46.3	14	114	19.1
	<i>native</i>	46.9	14	104	19.4
	<i>second</i>	43.4	15	96	18.4
	<i>first</i>	43.1	15	114	16.0
educational level					
	<i>total</i>	3.40	1	7	1.83
	<i>native</i>	3.37	1	7	1.80
	<i>second</i>	3.52	1	7	1.79
	<i>first</i>	3.58	1	7	2.05
female					
	<i>total</i>	0.51	0	1	0.50
	<i>native</i>	0.51	0	1	0.50
	<i>second</i>	0.54	0	1	0.50
	<i>first</i>	0.50	0	1	0.50
religious					
	<i>total</i>	4.31	0	10	3.12
	<i>native</i>	4.14	0	10	3.06
	<i>second</i>	4.23	0	10	3.19
	<i>first</i>	5.83	0	10	3.14