The Nativity Wealth-Health Gradient: The Case of Norway

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Extended Abstract

This study explores the wealth-health gradient in Norway, focusing on how this gradient differs between immigrants and the native-born population. Specifically, we are interested in the following research questions: **(1)** Whether and to what extent does the wealth-health association vary between the immigrant and native-born Norwegian populations? **(2)** To what extent does it differ by region of origin and reason for migration?

The relationship between socioeconomic status (SES) and health is a well-established area of research. Among the various dimensions of SES, wealth stands out as a critical determinant of health outcomes, surpassing income as a predictor of health throughout adulthood (Killewald et al., 2017). Numerous studies have consistently demonstrated that wealthier individuals enjoy better health, regardless of income levels, education, or occupational status. Theoretically, the wealth-health relationship is bidirectional. Greater wealth often leads to better health because individuals with more financial resources can afford better healthcare, adopt healthier lifestyles, and live in better conditions. Conversely, better health can enhance economic potential by increasing work productivity and, consequently, wealth, while poor health can undermine financial stability (Killewald et al., 2017). Importantly, significant disparities in wealth persist, particularly between immigrants and native-born populations (Lewin-Epstein & Semyonov, 2013). That is to say, these inequalities extend beyond other socioeconomic status differences and are crucial for understanding health differences between both populations.

Whereas the body of research on income immigrant assimilation and the association between economic resources and health has become more substantial, wealth is understudied in the health and ethnic and migration studies literature. Following previous studies, we argue

that wealth is a better proxy for an individual's economic standing than education, occupational status, or income. Wealth determines the cumulative and dynamic nature of a person's economic well-being and potential consumption (e.g., Semyonov et al., 2013; Killewald et al., 2017; Semyonov & Lewin-Epstein, 2021). Moreover, it matters specifically within the migration context because wealth is even more unevenly distributed between immigrants and natives than income (e.g., Lewin-Epstein & Semyonov, 2013; Agius et al., 2020). Norway, a recent immigrant-receiving nation with around 15% first-generation (FG) immigrants, faces the so-called "Nordic paradox" (Diaz & Kumar, 2014). Despite low-income inequality and a robust welfare system, socioeconomic inequality in health remains high (Diaz & Kumar, 2014). Wealth inequality is also very pronounced (Pfeffer & Waitkus, 2021), which could further contribute to these disparities.

Despite existing evidence of wealth and health differences related to migration as well as a strong association between the two, there has been limited examination into how this wealth-health gradient specifically affects immigrants compared to the native-born population. To the best of our knowledge, no one has yet studied the extent to which the association between wealth and health varies between immigrants and natives. The current study, therefore, aims to examine whether the wealth-health gradient varies by immigrant status across immigrant groups of different origins and by reason for migration in the Norwegian context. We differentiate between five origin regions: Nordic, EU-15 (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom), other European Union (EU) countries, other Organization for Economic Cooperation and Development (OECD) countries, and all other countries. Additionally, we categorize migration based on four reasons: economic, educational, family reunion, and refugees. We have an additional group for whom the reason for migration

is unknown because they came from Nordic countries, and their reason for migration was not available in the register.

We use data from the Norwegian Population Register, the Norwegian Tax Register, and the KUHR register from 2017 for all Norwegian registered residents aged 27 and older. Our analytical sample includes 599,567 first-generation (FG) immigrants and 2,917,335 native-born individuals. We constructed a *morbidity index* as the dependent variable based on diagnoses from general practitioner consultations. Wealth holdings, derived from individual tax reports, are represented by two key indicators: *gross wealth* and *debts*. To answer our research questions, we predict the morbidity index based on wealth by employing Poisson regression models and compare the wealth-health associations between migrants grouped by their country of origin and their reason for migration with the native-born population.

The findings of this study demonstrate statistically significant differences in the wealth-health gradient between immigrants and native-born individuals in Norway. The observed disparities in the wealth-health gradient are consistent with findings from Semyonov et al. (2013) and Maskileyson (2014), emphasizing the persistent association between wealth and health across different national contexts and healthcare systems. Consistent with existing literature on wealth-health gradients and immigrant health (e.g., Östergren et al., 2023), our results indicate that while wealth is a critical determinant of health outcomes, the relationship is moderated by immigrant and nativity status and reasons for migration. Norwegian natives exhibit a notably steeper wealth-health gradient, with higher wealth strongly associated with fewer health diagnoses. In contrast, the wealth-health gradient is less pronounced among immigrant populations, particularly non-Western immigrants. Similar to Goldman et al. (2006) and Buttenheim et al. (2010), our study confirms that immigrants often face weaker socioeconomic health gradients due to various complex mechanisms, including selective immigration and integration patterns.

Furthermore, our findings align with previous research, such as the work by Östergren et al. (2023), which observed a less steep income gradient in mortality among immigrants compared to natives in Sweden. This pattern suggests a broader trend across the Nordic region, where the migration process and associated socioeconomic challenges are associated with health outcomes.

Age further complicates this phenomenon, with older age groups (57-66 and 67-76) showing the strongest associations between wealth (or debt) and health. Interestingly, contrasts between gross wealth and debt gradients reveal more pronounced debt-health gradients, with a reverse pattern between immigrants and natives compared to wealth gradients. The gap in gradients between these two groups becomes most apparent at older ages, especially at lower wealth levels. This divergence suggests that a combination of factors, including age, migration background, and economic conditions, moderates the association between socioeconomic status and health.

This study contributes to the wealth-health gradient and migration literature by emphasizing the association between wealth, health, and immigrant status. The study's findings underscore the need for targeted policy interventions to address health disparities among different population groups in Norway.

References

Agius Vallejo, J., & Keister, L. A. (2020). Immigrants and wealth attainment: Migration, inequality, and integration. *Journal of Ethnic and Migration Studies*, 46(18), 3745-3761.

Buttenheim, A., Goldman, N., Pebley, A. R., Wong, R., & Chung, C. (2010). Do Mexican immigrants "import" social gradients in health to the US? *Social Science & Medicine*, 71(7), 1268-1276.

Diaz, E., & Kumar, B. N. (2014). Differential utilization of primary health care services among older immigrants and Norwegians: A register-based comparative study in Norway. *BMC Health Services Research*, 14(1), 623.

Goldman, N., Kimbro, R. T., Turra, C. M., & Pebley, A. R. (2006). Socioeconomic gradients in health for white and Mexican-origin populations. *American Journal of Public Health*, 96(12), 2186-2193.

Killewald, A., Pfeffer, F. T., & Schachner, J. N. (2017). Wealth inequality and accumulation. *Annual Review of Sociology*, 43, 379-404.

Lewin-Epstein, N., & Semyonov, M. (2013). Immigration and wealth inequality in old age: The case of Israel. *Research in Social Stratification and Mobility*, 33, 56-71.

Maskileyson, D. (2014). Healthcare system and the wealth–health gradient: A comparative study of older populations in six countries. *Social Science & Medicine*, 119, 18-26.

Östergren, O., Rehnberg, J., Lundberg, O., & Miething, A. (2023). Disruption and selection: The income gradient in mortality among natives and migrants in Sweden. *European Journal of Public Health*, 33(3), 372-377.

Pfeffer, F. T., & Waitkus, N. (2021). The wealth inequality of nations. *American Sociological Review*, 86(4), 567-602.

Semyonov, M., Lewin-Epstein, N., & Maskileyson, D. (2013). Where wealth matters more for health: The wealth–health gradient in 16 countries. *Social Science & Medicine*, 81, 10-17.

Semyonov, M., & Lewin-Epstein, N. (2021). The wealth gap between aging immigrants and native-born in ten European countries. *Sociologicky Casopis*, 57(6), 639-660.