

Migrants' access to welfare services: evidence from emergency care

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Abstract

Intense migration flows in Western countries have increased the interest for improving our understanding over migrants' use of welfare services. A major concern is that migrants may crowd natives out of the welfare system and impose a heavy burden on destination countries. Counterarguments contend that the former contribute to financing the system matching up to - or even exceeding- the benefits they receive. While most of the economic literature to date has focused on the labor market, the effects on the health care sector are relatively unexplored.

We study the differences in the use of emergency services between natives and immigrants in Italy using data that cover the population of Emilia-Romagna for the year 2012. We restrict our sample to the population aged 50 or below, as the number of older immigrants is very small. ED attendances are classified according to a 4-level triage coding (I-4L) based on (colour label) categories: red, yellow, green and white codes. *White codes* correspond to the lowest urgency category and are classified as inappropriate. Our analysis exploits the distinction between appropriate and inappropriate Emergency Department (ED) admissions, as this allows to consider differences in ED utilisation due to different underlying health needs, separately from avoidable admissions for minor conditions.

From a theoretical standpoint, we model the relevant decision process in two stages. In each period, the patient is subject to random health shocks: after observing the shock, he decides whether to attend the ED or not (first stage). In the second stage, following a clinical assessment, attenders are assigned the triage code. The empirical strategy is based on a bivariate probit model with sample selection.

We link patient information with the characteristics of his GP, of the GP's list, and with emergency services records. Our control variables consists of patient, physician and list characteristics, in the first place. We also include controls for the organisational characteristics of the GP practice, including proxies for time accessibility and the intensity of professional collaborations. Finally, we account for ED geographical accessibility and technological endowments. We exploit list characteristics as exclusion restrictions to support parameter identification. They are expected to affect the decision to go to the ED, but not to exert any direct effect on the probability of receiving a white code, conditional on attending the ED.

We find that migrants display a higher probability of attending the ED compared to natives, after controlling for a large set of relevant control variables. However, once the attendance decision has been accounted for, the difference in the probability of receiving a white code between migrants and native drops substantially. This suggest that different utilisation pattern are likely due to different underlying severity in health conditions, not by a higher propensity of migrants to use the ED for minor health problems. The effect is even more striking if we unpack the migrant variable according to the macro-area of origin of the patient. In this case, the differences in the probability of being classified as an inappropriate attender is not significant for most groups compared to natives.

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