

Discrimination and self-reported health for the Spanish Roma

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Abstract

This paper attempts to determine the effect of socio-economic characteristics and personal or ethnic discrimination on the self-reported health of the Spanish Roma. Our analysis reveals that income has a non-monotonic effect: a higher income reduces the probability of having very bad health, but up to a certain level of income, education has no effect on self-reported health, and discrimination, whether it is self-perceived or applies to the Roma community in general, has no effect. However, those who feel discriminated against by social services report a lower level of personal health, possibly because our variable measures not only discrimination, but also the experience of exclusion.

Keywords: Discrimination, health, Roma population

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1. Introduction

The health of the Roma population has begun to receive attention from the EU candidates, following the Copenhagen Criteria, a set of conditions requiring respect for and protection of minorities that must be followed by all candidates for entry to the European Union. Several papers conclude that there exist ethnic health gaps for Roma population, although not all of these studies include the same variables when measuring health.

In 1948, the World Health Organization defined health as “*a state of complete physical, mental and social well-being, and not merely the absence of disease*”. This open characterization expands the concept of health to include such pathological and clinical variables as chronic diseases, accidents, and disabilities, and subjective indicators.

While Zeman et. al. (2003) provide a broad review of the literature, focusing on the pathological and clinical differences in the Roma population, Koupilova et. al. (2001) and Kolarcik et. al. (2009) analyze health considering more dimensions: an individual's physical condition, and self-reported health. This subjective variable, self-reported health, has been included in several studies as one important indicator. Koupilova et. al. (2001) conclude that the health status of the Roma is inferior to that of the non-Roma in the Czech and Slovak Republics, with very few exceptions in the dimensions measured. These authors analyze health measured in different aspects: mortality and life expectancy, perinatal outcomes and reproductive health, communicable and non-communicable diseases, congenital disorders, health behaviors, nutrition and growth, sexual behavior, prostitution and drug abuse, and self-reported health. Kolarcik et. al. (2009) conclude that Slovakian Roma respondents reported poorer health and more accidents during the previous year than non-Roma respondents. The most common explanation for these health gaps is that minority groups have a socio-economic gap, as well as a lesser ability to purchase medications and medical procedures as required. Ethnic minorities often have reduced entitlements in many advanced societies; not only are they exposed to poor working and living conditions, which are per se determinants of poor health, but they also have reduced access to health care. While the former explanation can be applicable to the Spanish Roma population, the later cannot be a justification for lower self-reported health, because all Spanish residents have free access to the national health care services.

However, apart from these factors, there is a growing body of literature providing evidence of the effect of discrimination in health (see Schulz et. al., 2000), confirming that there are institutional and individual forms of discrimination that operate through multiple pathways in the health gap. In this sense, Johnston and Jordan (2012) show that discrimination towards Muslims in Britain worsens self-assessed general health and conclude that discrimination is a potentially important determinant of the large racial and ethnic health gaps observed in many countries. These studies focus on other minorities, but the relationship is also pointed out by Kósa et. al. (2007), who describe the gap in health for the Roma population in Hungary, and show the need for further analysis of the Roma population, comparing socio-economic conditions and ethnic discrimination.

Our aim in this paper is to study the effects of socio-economic and discrimination variables on the health of the Spanish Roma population. Due to the difficulties inherent in measuring health, we study self-reported health as an indicator because it includes physical and mental states, as well as a kind of perceived well-being. Our results show that female and poorer Roma have a higher probability of reporting lower health, although the effect of income is non-monotonic. However, we find no relationship between either general personal discrimination or specific anti-Roma discrimination and the self-reported health of the Roma. This is so because the relationship between perceived ethnic group discrimination and depressive symptoms is mediated by ethnic identity affirmation (see Britian et. al., 2015), that is to say, ethnic identity promotes psychological adjustment in the context of group-based discriminatory experiences. In fact, the Roma population is defined as being proud of their ethnicity and cultural differences. The Spanish Roma have co-existed with the broader population of Spain, under the same laws and regulations, for more than five hundred years, but they exhibit very different social and cultural patterns. The family is the core of Roma social organization; family members usually live very close to each other, family ties are very strong, and traditions appear to matter much more than the market and institutions. However, when different modes of discrimination are considered, and we focus on the discrimination by staff of the social services, a significant and negative relationship appears. Those who feel discriminated against in social services have a higher probability of reporting poorer health, possibly because those who apply for social services suffer exclusion in society, and thus the variable measures not only

discrimination, but also exclusion experience, which decreases the level of self-reported health.

The structure of the paper is as follows. Section 2 presents a brief descriptive analysis of the Roma population in Spain, our empirical analysis is presented in Section 3, and Section 4 outlines our conclusions.

2. Descriptive analysis

Database

Spanish laws covering the protection of data¹ prohibit the incorporation of ethnic variables in the census, making the study of ethnic groups in Spain problematic. The intercultural, social, non-profit organization Fundación Secretariado Gitano² (FSG) has allowed us access to the microdata of a transnational survey, carried out jointly by the Soros Foundation and the Open Society Institute, in 2011³. This database considers the labor situation of the Spanish Roma and contains, apart from income and education, other demographic, sociological, and economic characteristics, making it possible to advance our knowledge of other aspects of this minority ethnic group, e.g. its health patterns. The Spanish Roma Population Survey (SRPS) is based on the same indicators and methodology as Spain's Economically Active Population Survey (EAPS)⁴, which includes the Spanish Roma population residing in the national territory, aged 16 and over (16 being the minimum legal age of employment in Spain). Our sample size is 1,497 interviews of Spanish Roma residents, which allows us to derive results with a 2.53% margin of error. The field work carried out a single interview per household, incorporating questions for all members of the household. The final exploitation of the data applies the appropriate weighting factors to balance the interviewee sample⁵.

¹ Ley Orgánica 15/1999, de 13 de diciembre de Protección de Datos de Carácter Personal. See Appendix III of the report "Ethnic statistics and data protection in the Council of Europe countries" by Simon (2007)

² For more details, see http://www.gitanos.org/quienes_somos/mision_estrategia.html.en

³ See Spanish and Migrant Roma Population In Spain: Employment And Social Inclusion – 2011- A Comparative study, page 203, http://www.gitanos.org/upload/14/10/Situatia_romilor_-_english.pdf

⁴ http://www.ine.es/en/inebmenu/mnu_mercalab_en.htm

⁵ For more details about methodology see Spanish and Migrant Roma Population In Spain: Employment And Social Inclusion – 2011- A Comparative study, pages 205, 212 and 213. http://www.gitanos.org/upload/14/10/Situatia_romilor_-_english.pdf

Some stylized facts

The estimated number of Roma living in Spain is around 700,000 (Council of Europe, 2007), a figure similar to that of Russia, which puts Spain in third place in Europe, in terms of Roma population. There is no homogeneous Roma group in Europe, because five groups are distinguished: Kalderaši, Gitanos, Manush, Romnichal and Erlides. In Spain, the mainstream Roma population group is Gitanos (or Calé). Families in this group are classified as *egalitarian nuclear families*, characterized by independent living arrangements and egalitarian inheritance rules (see Alesina and Giulano, 2013). This group presents strong group cohesion, and the dataset shows that almost 40% of the Spanish Roma primarily have other Roma as their closest friends.

The patterns of the Spanish Roma differ from the mainstream in several key ways; they have more children, they have lower incomes, they participate in the labour market at different rates - almost 26% run their own business or assist in the family business, while this proportion is less than 8% for the broader Spanish population - and their unemployment rate is higher.

Moreover, the Spanish Roma differ in education and in health. Table 1 shows a clear gap in education

Table 1. Percentage of population over 15 years of age in all levels of education, 2011.

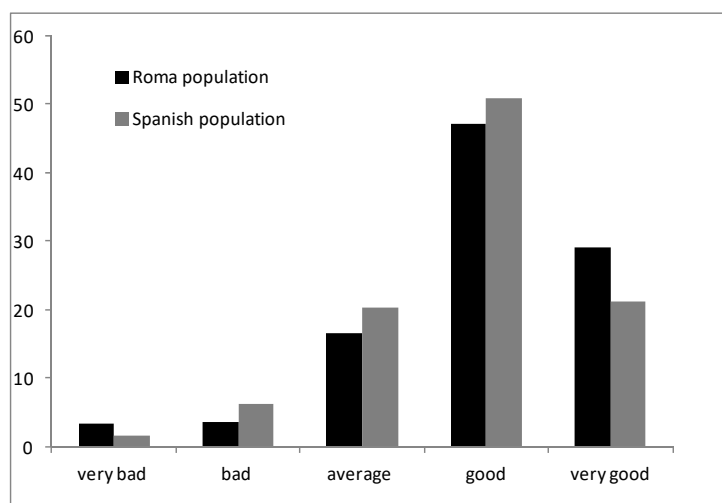
	Roma population	Spanish population
<i>none</i>	17.94	2.22
<i>incomplete or complete primary school</i>	60.24	27.15
<i>incomplete or complete secondary school</i>	19.34	32.31
<i>incomplete or complete tertiary school</i>	2.48	38.33

Source: Own elaboration from SRPS and IVIE (Valencian Institute of Economic Research)

This gap is even higher for young people. The proportion of the Roma population aged between 18 and 30 who have either no education or incomplete primary school is 19% and 43%, respectively, while this is less than 1% in each category for the broader Spanish population.

However, the difference in health cannot be presented as a gap, because, as Figure 1 illustrates, while Roma report very poor health in a higher percentage, they show a similar higher proportion of very good health. Therefore, the variables related to health cannot only be socio-economic characteristics in which Roma appear in a disadvantageous position. Prior literature has related self-reported health to discrimination, but self-reported discrimination is a subjective concept, even though it is widely used in the literature and, contrary to expectations, Kaiser and Major (2006) find that perceived discrimination could be under-, rather than over-reported.

Figure 1. Percentage of population and self-reported health, 2011.

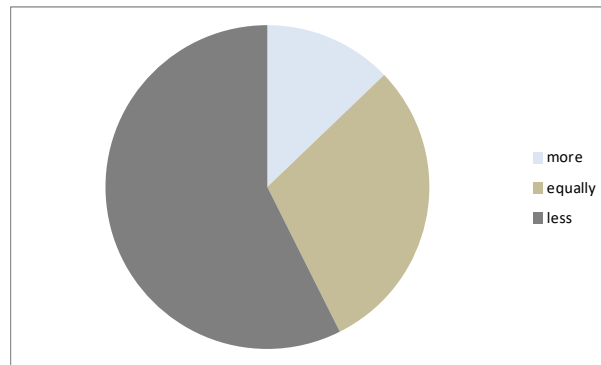


Source: Own elaboration from SRPS and National Health Survey 2011

SRPS incorporates several questions about discrimination, the first being whether the respondent thinks the Roma community is currently more, equally, or less discriminated against than in the past.

Figure 2 indicates that the consensus appears to be that the Roma population feel that they are successfully integrated in Spanish society.

Figure 2: Roma community discrimination, 2011.



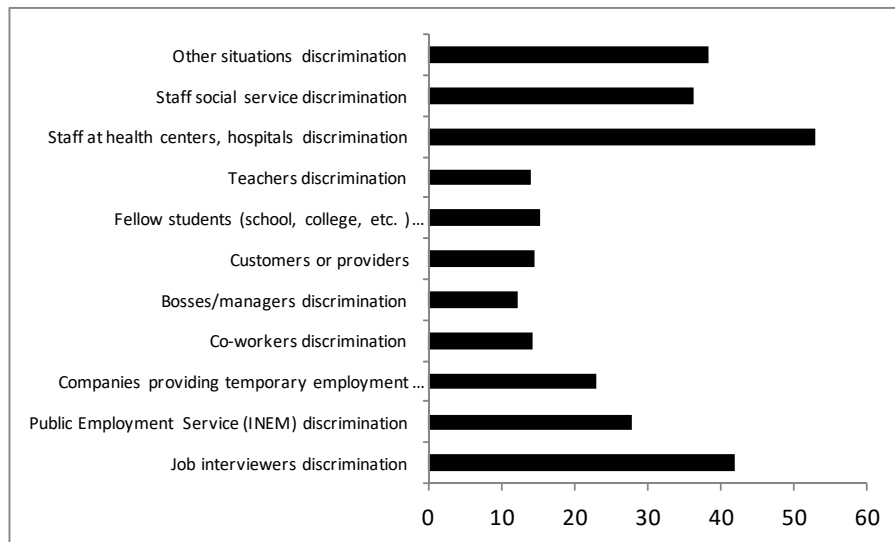
Source: SRPS

The second question is whether the respondent has felt discriminated against at any time in the preceding year. For those who answer yes, the next question is about the specific sources and circumstances of this discrimination (*job interviewers, Public Employment Service, companies providing temporary employment, co-workers, bosses/managers, fellow students (school, college, etc.), teachers, staff at health centers, staff social service, other situation*)

Using data from the Spanish National Health Survey (2006), Gil-González et al. (2013) determined that the frequency of self-perceived discrimination at the national level was 4.2% for men and 6.3% for women. From SRPS, we find that 30% of the Roma interviewed perceived discrimination, with no significant gender differential.

Figure 3 shows, of those with such experience, the percentage of respondents who feel different kinds of discrimination, with the most common experience occurring in health centers and job interviews.

Figure 3: Percentage of Roma community discriminated against, by type, 2011.



Source:

SRPS

Although this descriptive analysis shows a range of different patterns between the Roma and non-Roma Spanish population, the relationships between health and socio-economic or discrimination characteristics cannot be derived from this. An econometric model must be run in order to determine the drivers of the probabilities of having better self-reported health.

3. Econometric model

Self-reported health must be examined using a regression model for ordinal dependent variables, because the variable has five ordered categories. However, the ordered logistic model assumes that each explanatory variable exerts the same effect on each cumulative logit, regardless of the cutoff, and as the hypothesis of proportional odds is violated by our model, we use ordered generalized linear models to explain self-reported health. The Williams (2006) methodology has been applied.

Our explanatory variables are of three kinds: socio-economic characteristics, integration variables, and disabilities and diseases, with the latter being used to control for pathological and clinical problems. In fact, Furner et. al. (2010) conclude that chronic diseases are significant and negatively associated with negative self-reported health.

The socio-economic characteristics include age, gender, number of children, marital status, education, urban residence, income and religion. The integration variables

include the ethnicity of the closest friends, discrimination against the Roma community, the personal discrimination perceived, and the varieties of such discrimination (see Appendix for descriptive statistics).

Table 2 presents two models. In Model I, the personal discrimination perceived has been used in general, and Model II uses the varieties of discrimination in order to provide a more specific and detailed picture of the phenomenon. This Table also presents the marginal effects of Model II.

The sign of the regressors can be interpreted as determining whether self-reported health improves with the regressor, and both models present negative coefficients for age, meaning that an increase in the variable increases the probability of having very poor health. The same result is obtained for those with disabilities and diseases. Other less obvious results are that being female, or having a marital status other than single, increases the probability of having very poor health.

Table 2. OGLM estimation results. Dependent variable: self-reported health.

	Ordered Generalized Linear Model I	Ordered Generalized Linear Model II	Marginal effects very poor health	Marginal effects poor health	Marginal effects average health	Marginal effects good health	Marginal effects very good health
Socioeconomic characteristics							
Age	-0.0633 ***	-0.0735 ***	0.0006 ***	0.0007 ***	0.0087 ***	0.0019 **	-0.0118 ***
Female	-0.4544 ***	-0.4965 ***	0.0038 **	0.0045 ***	0.0589 ***	0.0127 **	-0.0801 ***
Number of children	0.0659	0.1187 **	-0.0009 **	-0.0011 **	-0.0141 **	-0.0031 *	0.0191 ***
marital status (ref. single)							
<i>married</i>	-0.4981 ***	-0.4696 ***	0.0035 **	0.0041 **	0.0544 ***	0.0155 *	-0.0775 ***
<i>cohabiting</i>	-0.4988 *	-0.5587 *	0.0055	0.0065	0.0768	-0.0118	-0.0770 **
<i>widowed</i>	-1.1729 ***	-1.2474 ***	0.0177 **	0.0202 **	0.1963 ***	-0.0946 *	-0.1395 ***
<i>divorced</i>	-0.6056	-0.7746 *	0.0087	0.0102	0.1130	-0.0332	-0.0987 **
<i>separated</i>	-1.0669 ***	-1.1276 **	0.0153	0.0176	0.1758 **	-0.0799	-0.1288 ***
Education (<i>reference > high school</i>)							
<i>no education</i>	-0.3684	-0.3572	0.0031	0.0036	0.0456	0.0013	-0.0536
<i>incomplete primary education</i>	-0.4803	-0.3882	0.0031	0.0036	0.0470	0.0078	-0.0615
<i>complete primary education</i>	-0.5562 *	-0.3771	0.0033	0.0039	0.0481	0.0013	-0.0565
<i>incomplete secondary education</i>	-0.4348	-0.3667	0.0032	0.0038	0.0474	-0.0002	-0.0542
<i>complete secondary education</i>	-0.0699	-0.0247	0.0002	0.0002	0.0030	0.0006	-0.0040
urban	-0.1247	-0.0424	0.0003	0.0004	0.0051	0.0010	-0.0068
Income per adult in household	0.0022	0.0036 **	0.000027 **	0.000033 **	0.000424 **	0.000093 *	0.000577 **
Income per adult in household squared	-0.000004 *	-0.000005 **	0.000000 *	0.000000 *	0.000001 **	0.000000	0.000001 **
Religious	0.0280	0.0933	-0.0007	-0.0009	-0.0113	-0.0018	0.0147
Integration variables							
Ethnicity of closest friends (ref no friends.)							
<i>from my ethnic group only</i>	-1.1728 *	-0.7101	0.0075	0.0088	0.1005	-0.0225	-0.0943
<i>predominantly from my ethnic group</i>	-1.0235	-0.6827	0.0060	0.0071	0.0877	0.0009	-0.1018

<i>the ethnic group does not matter</i>	-0.5366	-0.2672	0.0020	0.0024	0.0311	0.0085	-0.0439
Roma community discrimination (ref. Equal to or less than before)	-0.1031	0.0536	-0.0004	-0.0005	-0.0063	-0.0016	0.0087
Personal discrimination	-0.0209						
<i>Job interviewer discrimination</i>		0.1754	-0.0012	-0.0015	-0.0198	-0.0070	0.0296
<i>Public Employment Service (INEM) discrimination</i>		-0.0747	0.0006	0.0007	0.0091	0.0015	-0.0118
<i>Company providing temporary employment discrimination</i>		-0.0994	0.0008	0.0009	0.0121	0.0017	-0.0156
<i>Co-worker discrimination</i>		0.1590	-0.0011	-0.0013	-0.0180	-0.0063	0.0268
<i>Boss/manager discrimination</i>		-0.2423	0.0021	0.0025	0.0308	0.0011	-0.0364
<i>Customers or providers discrimination</i>		0.1361	-0.0010	-0.0012	-0.0155	-0.0052	0.0228
<i>Fellow students (school, college, etc.) discrimination</i>		-0.1307	0.0011	0.0013	0.0161	0.0019	-0.0203
<i>Teacher discrimination</i>		0.5355	-0.0032	-0.0039	-0.0537	-0.0383	0.0991
<i>Staff at health centers, hospitals discrimination</i>		0.0565	-0.0004	-0.0005	-0.0066	-0.0017	0.0092
<i>Staff social service discrimination</i>		-0.7625 ***	0.0083 *	0.0097 *	0.1093 **	-0.0276	-0.0996 ***
<i>Other situations discrimination</i>		0.2010	-0.0014	-0.0017	-0.0226	-0.0082	0.0340

Disabilities and diseases

Do you suffer from any disability or chronic disease? (ref none)									
<i>Completely incapacitating disability</i>	-2.1732 ***	-1.8620 ***	0.0385 *	0.0420 *	0.3071 ***	-0.2186 **	-0.1689 ***		
<i>Disability precluding work</i>	-2.4153 ***	-2.5057 ***	0.0747 ***	0.0753 ***	0.3858 ***	-0.3450 ***	-0.1908 ***		
<i>Non-incapacitating disability</i>	-1.3320 ***	-1.0351 ***	0.0133 *	0.0154 *	0.1588 **	-0.0657	-0.1218 ***		
<i>Completely incapacitating chronic disease</i>	-3.3145 ***	-2.8503 ***	0.1079 *	0.1009 **	0.3975 ***	-0.4145 ***	-0.1918 ***		
<i>Chronic disease precluding work</i>	-2.8252 ***	-2.5583 ***	0.0800 **	0.0796 ***	0.3887 ***	-0.3588 ***	-0.1895 ***		
<i>Non-incapacitating chronic disease</i>	-1.8675 ***	-1.5505 ***	0.0261 **	0.0293 **	0.2522 ***	-0.1501 **	-0.1576 ***		
Number of obs.	1,336	1,156							
Pseudo R2	0.2005	0.2069							

Having children, or higher income, decreases the probability of having very poor health in Model II. Although the effect of income is non-monotonic, this relationship is maintained up to a certain value of income, and beyond this threshold, higher income increases the probability of having very poor health.

Model I measures discrimination in general - personal and community discrimination - although none of these variables have any effect on self-reported health. The reason is that the relationship between perceived ethnic-group discrimination and depressive symptoms is mediated by ethnic identity affirmation, as mentioned earlier. Ethnic identity promotes psychological adjustment in the context of group-based discriminatory experiences that, in the case of the Spanish Roma, is capable of compensating for any negative effect of discrimination on health. However, as Model II shows, when different discriminatory situations have been considered, the conclusion is not so categorical. Only those who have experienced (perceived) discrimination in Social Services have a greater probability of having very poor health. The reason for this is that the variable measures not only discrimination, but also the experience of exclusion that makes these individuals apply for such services in the first place. This result is in line with Pappa et. al. (2011), who conclude that it is the Roma experience of social exclusion and deprivation that profoundly affects their health.

In fact, the probability of reporting very poor, poor, or average health increases by around 10% for those who have suffered discrimination by the Staff of Social Services, while this percentage is the same – but with the opposite sign - for those reporting very good health (considering the rest of the variables in their mean, or with value zero, if dummies), indicating that the probability of reporting very good health for those who have not suffered this kind of discrimination increase by 10%.

4. Conclusion

The effects of discrimination on the health gap have recently been established in the literature, although very little work has been done to study this link for the Spanish Roma population, who comprise one of the largest ethnic minorities in Spain (close to 2% of the total). One reason for this lack is that Spanish law prohibits the incorporation of ethnic variables in the national census. For our work on this paper, we are fortunate

to have been granted access to an original dataset from the Fundación Secretariado Gitano.

Our analysis is based on an econometric model in which socio-economic and discrimination characteristics are considered as the explanatory variables for self-reported health. Our results are in line with much of the existing literature, and we conclude that female and lower-income Roma individuals have a higher probability of reporting poorer health, although the effect of income is non-monotonic. However, and contrary to the related literature referring to other ethnic groups, we find no evidence of effects on Roma self-reported health from general personal or community discrimination. We propose that this is due to the inter-relationship between perceived ethnic group discrimination, depressive symptoms, and the mediating factor of ethnic identity affirmation. Nevertheless, when specific modes of discrimination are considered, we find that only the discrimination from staff of Social Services has a negative effect on the self-reported health, because this variable measures exclusion, as well as discrimination

Our findings emphasize the need to focus policy interventions more specifically on those in the Roma population (and, by extension, any other ethnic minority) whose self-perceived health suffers from the detrimental effects of discrimination, and who are at risk of social exclusion.

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APPENDIX. Descriptive Statistics

Variable	Obs	Mean	Std. Dev.	Min	Max
Self Reported Health	1494	3.9525	0.9501	1	5
Socio-economic characteristics					
Age	1494	36	15	16	91
Female	1494	0.5181	0.4998	0	1
Number of children	1494	1.7845	1.7808	0	13
marital status (ref. single)					
<i>married</i>	1494	0.5743	0.4946	0	1
<i>cohabiting</i>	1494	0.0576	0.2330	0	1
<i>widowed</i>	1494	0.0462	0.2100	0	1
<i>divorced</i>	1494	0.0214	0.1448	0	1
<i>separated</i>	1494	0.0268	0.1615	0	1
Education (<i>reference > high school</i>)	1494	0.1794	0.3838	0	1
<i>no education</i>	1494	0.1794	0.3838	0	1
<i>incomplete primary education</i>	1494	0.4143	0.4928	0	1
<i>complete primary education</i>	1494	0.1881	0.3909	0	1
<i>incomplete secondary education</i>	1494	0.1191	0.3241	0	1
<i>complete secondary education</i>	1494	0.0743	0.2623	0	1
urban	1494	0.3066	0.4612	0	1
Income per adult in household	1463	159	105	3	700
Income per adult in household squared	1463	36234	59702	10	490000
Religious	1494	0.8541	0.3531	0	1
Integration variables					
Ethnicity of closest friends (ref no friends.)					
<i>from my ethnic group only</i>	1492	0.0784	0.2689	0	1
<i>predominantly from my ethnic group</i>	1492	0.3157	0.4649	0	1
<i>the ethnic group does not matter</i>	1492	0.5985	0.4904	0	1
Roma community discrimination (ref. equal or less than before)	1434	0.1283	0.3346	0	1
Personal discrimination	1424	1.3041	0.4602	0	1
<i>Job interviewer discrimination</i>	1371	0.1327	0.3394	0	1
<i>Public Employment Service (INEM) discrimination</i>	1387	0.0865	0.2812	0	1
<i>Company providing temporary employment discrimination</i>	1336	0.0741	0.2620	0	1
<i>Co-worker discrimination</i>	1324	0.0468	0.2113	0	1
<i>Boss/manager discrimination</i>	1317	0.0402	0.1966	0	1
<i>Customers or providers discrimination</i>	1317	0.0478	0.2135	0	1
<i>Fellow student (school, college, etc.) discrimination</i>	1316	0.0502	0.2183	0	1
<i>Teacher discrimination</i>	1323	0.0461	0.2098	0	1
<i>Staff at health centers, hospitals discrimination</i>	1416	0.1617	0.3683	0	1
<i>Staff social service discrimination</i>	1398	0.1123	0.3159	0	1
<i>Other situations discrimination</i>	1411	0.1176	0.3223	0	1

Disabilities and diseases

Do you suffer from any disability or chronic disease? (ref. none)

<i>Completely incapacitating disability</i>	1493	0.0214	0.1449	0	1
<i>Disability precluding work</i>	1493	0.0261	0.1596	0	1
<i>Non-incapacitating disability</i>	1493	0.0241	0.1534	0	1
<i>Completely incapacitating chronic disease</i>	1493	0.0100	0.0998	0	1
<i>Chronic disease precluding work</i>	1493	0.0174	0.1309	0	1
<i>Non-incapacitating chronic disease</i>	1493	0.0355	0.1851	0	1
