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2.9 Immigration and social exclusion: examining health inequalities of immigrants through acculturation lenses

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Introduction

Over the last three decades, the number of people migrating from developing to developed countries has been increasing in stepwise fashion as a result of insecurity, war and poverty. Such mass population movement has resulted in dramatic demographic transformations of most developed countries (Organisation for Economic Co-operation and Development 2007). The latest demographic data indicate that about 4 million new immigrants entered OECD countries on a permanent basis in 2005, an increase of 10 per cent from 2004 (Organisation for Economic Co-operation and Development 2007). In Australia, the 2006 census data indicate that more than one in five Australians (22.2 per cent) were born overseas, a pattern that has remained constant since 1996. The overseas-born population increased in number between 1996 and 2006 by 13 per cent, from around 3.9 million to 4.4 million (Australian Bureau of Statistics 2007d). Although a considerable proportion of Australian residents born overseas (including refugees and humanitarian entrants) come from countries recently affected by war and political unrest (Australian Bureau of Statistics 2007d), at a global level, migration for family reunion is the dominant reason for the inflows, and labour immigration is expanding, while humanitarian migration (including refugees and asylum seekers) has been declining (Organisation for Economic Co-operation and Development 2007).

Regardless of their migration status, cultural differences and different expectations characterise new settlers in Australia and other OECD countries. New entrants experience varying inequalities ranging from difficulties establishing social networks, finding accommodation or employment, learning English, and looking after their general health. However, the level of inequality differs according to the degree of cultural transition. Consequently, acculturation has become a dominant framework used to explain disparities among minority groups. As such, we focus on reviewing the evidence on the relationship between acculturation and social exclusion at structural, group and individual levels. For this chapter, Atkinson’s (1998) notion of social exclusion is used, which emphasises social relations and ruptures in the social contract rather than resource poverty, and identifies three key features of
social exclusion: first, relativity (measuring exclusion by spatially comparing the circumstances of some individuals or communities relative to others at a given time), second, agency (examining the role of some agents and institutions to explain exclusion); and third, dynamics (looking at long-term effects or characteristics of exclusion). Given the complexity of the web to be untangled, we begin by defining the concept of acculturation and examining its historical background. We then move on to examine social exclusion through acculturation lenses focusing on the impact of acculturation on the access to and utilisation of social and health services, and acculturation-related differentials in health outcomes. We finish by examining the implications for public health.

Early research on acculturation emphasised that the acculturation process happens at a group level, with the whole group experiencing structural, cultural, biological, psychological, economic and political changes (for more details see Flannery and colleagues 2001). In addition, it was implied that mutual changes occur in both groups: the dominant group (host society) and the acculturating groups (migrants or refugees). However, due to influences from the host society, most changes occur in the acculturating group (Graves 1967). Nowadays, anthropologists have demonstrated that acculturation occurs at the individual level (Berry 1990a). At this level, acculturation has been termed psychological acculturation, that is, changes in both overt behaviours and covert traits of an individual from a cultural group going through the collective acculturation process (Graves 1967).

However, regardless of the structural level at which the acculturation process occurs, two theoretical models have dominated the literature on acculturation: the unidirectional model (UDM) and the bi-dimensional model (BDM). The UDM assumes that it is not possible to be a fully integrated member of two cultures with two differing sets of cultural values. According to Flannery and colleagues, ‘the UDM describes acculturation as the shedding off of an old culture and the taking on of a new culture ... [and] describes only one outcome of acculturation – assimilation’ (Flannery et al. 2001: 1035). In this respect, the UDM considers acculturation as a linear process where an individual moves from being traditional to assimilating. The problem with this assumption is that the model fails to identify those who are bicultural. Unfortunately, the UDM has predominated research on acculturation and has become the standard view of acculturation (Park and Miller 1921).

In contrast, the BDM measures two cultural orientations – the home and host cultures (Figure 2.3), and assumes that the identifications with traditional and host cultures are independent. This model identifies migrants on four cultural orientations: (1) Traditional, also known as separation (keeps loyalty to traditional culture and does not recognise the host/dominant culture) (Berry and Kim 1988; MacLachlan 1997), (2) Assimilation, also known as ‘cultural shift’ (Berry 1990b) or the ‘melting pot’ theory of acculturation (MacLachlan 1997) (rejects traditional culture and fully embraces the host/
dominant culture), (3) Integration, also known as bicultural orientation or cultural incorporation (retains cultural identity at the same time moving to join the dominant society) (MacLachlan 1997) and (4) Marginalisation (rejects traditional culture and fails to connect with the host/dominant culture by exclusion or withdrawal (MacLachlan 1997).

Questions for constructing the instrument (Berry 1998)

![Bi-directional model of acculturation](image)

Conceptualising the results

![Conceptualising the results](image)

Figure 2.3 Bi-directional model of acculturation
Examining social exclusion through acculturation lenses

Although operationalising and measuring acculturation has become difficult (for example, see detailed discussion of the limitations associated with the application of acculturation theories in Hunt et al. 2004; Rudmin 2006), there are many changes to the social context and structure, networks and social support, and communication and language use that occur when two cultural groups come into contact. The process of acculturation can lead to alienation for certain sectors of migrant communities and this may affect their living standards and access to various opportunities. Because migrants bring with them values and norms that substantially deviate from the norms and values of their host populations, they become subject to subtle forms of social exclusion. The principle of the acculturation theory implies that assimilation and integration may allow migrants to understand the strengths and weaknesses of their new environment while separation and marginalisation are more likely to perpetuate the perceptions of discrimination, alienation or disenfranchisement (Leong and Chou 1994). In this sense, acculturation-related changes may increase the effects of poverty, financial stress and social exclusion in different ways. On the one hand, the process of acculturation pushes certain groups of the migrant communities to the margins of the society (i.e. marginalisation), the consequences of which include limited access to, and utilisation of, services, leading to poor social and health outcomes, and lack of necessary life skills required for full participation in employment opportunities and wider social and community networks (López et al. 2002).

On the other hand, service providers at the systemic level often fail to recognise that they need to acculturate, and their capacity to provide effective health and social services within and throughout the expanded cultural space becomes limited, leading to one or more of three possible scenarios in service delivery: first, cultural destructiveness – a form of forced assimilation whereby there is only one cultural trend that is acknowledged while purposefully outlawing any other cultural approaches; second, cultural incapacity – where service providers put boundaries on cultural requirements in an equal manner, acknowledging their existence but without engaging them and third, cultural blindness – adopting the ‘one approach fits all’ theory, whereby the assumption is that people are all alike and what works for one cultural group should also work for the other (see Cross and colleagues 1989 or Renzaho 2002, 2008 for more information). Obtaining data on patterns of service utilisation, service providers’ community consultation and engagement with ethnic minorities, quality of services and health outcomes for different cultural groups to identify which ones are most affected, and the extent of service providers’ cultural competence would provide information on the level to which a health system is acculturated and the capacity of the health system to meet the needs of all its constituencies. At the individual and group level, migration status and type, population size of the acculturating group, familiarity with host culture, age at migration, personality, and cultural flexibility
and characteristics (e.g. how the acculturating group is willing to alter beliefs and traditions to accommodate demands and needs stemming from coming into contact with a new and different culture) combine to determine migrants’ level of social exclusion. In their new environment, factors influencing social inclusion through cultural integration and adaptation include the degree of racial tolerance and cultural diversity, support systems, and policies and attitudes toward multiculturalism (Coles 2005).

**Some indicators of social exclusion and acculturation: the evidence**

**Access to and utilisation of primary health care**

In Australian primary health care, migrants from a non-English speaking background (NESB) have been found to consistently have longer consultation times, are seven times more likely to attend a medical appointment as a family, and more than twice as likely to attend as a couple, compared with clients of English speaking backgrounds (Renzaho 2007). Increased consultation time, group attendance to an appointment, and increased interpreting cost associated with servicing NESB patients means that this cluster of the population will not receive an adequate level of health care, as these factors are not taken into account in the horizontal fiscal equalisation. Consequently, service providers are not financially equipped to meet these challenges.

However, findings in this area paint an unclear picture. Some studies have reported a negative association between acculturation access to and utilisation of primary health care effect (e.g. Prislin et al. 1998) while others found no association (e.g. Shah et al. 2006; Marks et al. 1987). For example, in their study examining the relationship between the acculturation of Mexican American mothers in Texas and immunisation status of their children between 3 and 24 months of age, Prislin and colleagues (Prislin et al. 1998) found that assimilation (moving away from traditional-orientation) contributed to less positive attitudes toward immunisation, a diminished sense of parental responsibility for getting children immunised, and a stronger perception that cost and time were barriers to children’s immunisation. After adjusting for potential confounding factors, the authors found that in actual fact assimilation contributed to inadequate children immunisation status, but when the parental attitude toward responsibility and perceived barriers for children’s immunisation were added to the model as mediators, the relationship between acculturation and children’s immunisation status became insignificant.

In contrast, Shah and colleagues (Shah et al. 2006) examined whether maintenance of traditional cultural values was a risk factor for the underutilisation of colorectal cancer screening among Hispanic populations in the US. Their unadjusted univariate analysis found an inverse relationship between level of acculturation among Hispanics and the likelihood of not having an at-home faecal occult blood test and not having endoscopy in the
past year, and the trend was consistent when the analysis was extended for ‘the past 5 years’. These results remained consistent when controlling for socioeconomic status (e.g. age, income level, educational level, and poverty threshold) but became non significant when medical history and medical care variables were added to the model. From these findings it is clear that the low use of colorectal screening observed among Hispanics is more due to inadequate access to medical care as a whole rather than their level of acculturation.

Shah and colleagues’ findings are similar to those reported by Marks and colleagues (Marks et al. 1987). They examined whether cultural factors predict the use of screening examinations (e.g. physical examination from a medical doctor, screening for breast cancer, Pap smear) and found that no dimension of acculturation was strongly or consistently associated with the use of screening examinations, except for language. Although use of the English language was found to be most closely associated with increased screening, most of the effects for language were marginal. The study findings strongly suggest that cultural factors may have little influence on health seeking behaviours and use of preventive health care. These findings were further replicated in a separate study by Solis and colleagues (Solis et al. 1990). The latter found that language, but not ethnic identification, was the important predictor of health service utilisation, and that spoken language was the stronger predictor than written language. Nevertheless, the authors caution that the effect of language on screening practices should be considered as an access factor (e.g. improved English ability translates into increased access to services) and not a cultural factor.

Acculturation as a predictor of social issues

Caetano et al. (2007) examined the association between acculturation, acculturation stress, drinking and intimate partner violence among Hispanic couples in the US. The authors interviewed 1,392 couples, and distinguished acculturation from acculturation stress. Acculturation measures were concerned with ethnicity of people with whom respondents interacted at church, at parties, and in the neighbourhood; daily use of and ability to speak, read and write English and Spanish; preference for media (books, radio and TV) in English or Spanish; and a series of questions about values thought to be characteristic of the Hispanic lifestyle. In contrast, the measures of acculturation stress assessed issues related to conflicts with family members and friends because of changes in values, problems with communication in English, and adjustment problems associated with participants’ ethnic culture. Traditionally-oriented Hispanic males reported more stress than those who adopted US cultural norms and values, and there was a positive association between higher levels of stress (but not acculturation level) and intimate partner violence, but none for drinking. For women, there was an inverse association between acculturation level and acculturation stress, as there was for men, but a
positive association between acculturation level (but not acculturation stress) and intimate partner violence, and none for drinking. Although the adoption and adherence to US norms and values translated into less stress, it is possible that the stress accumulated through the process of adaptation to the new country is more likely to explain the increased likelihood of involvement in a violent relationship than drinking.

Hunter et al. (2006) examined the relationship between acculturation and driving under the influence among Hispanic population in California. The authors carried out interviews with Hispanic recidivist offenders driving under the influence immediately prior to sentencing, and two years later. The authors found that the less-acculturated members were more likely to report a repeat driving under the influence conviction at two-year follow-up than their highly acculturated counterparts, even after controlling for demographic factors and drinking severity. However, there was no relationship between acculturation level and driving under the influence arrest rates. The study findings suggest that acculturation level is a risk factor for repeat convictions, and programs geared toward reducing multiple driving under the influence convictions need to specifically target the less acculturated in order to increase program effectiveness.

**Acculturation-related differentials in health outcomes**

Acculturation is associated with changes in chronic disease risk profile. Risk factors and health conditions related to coronary heart disease, cancer, obesity and diabetes differ by acculturation. For example, Kamineni et al. (1999) reported that the incidence of gastric carcinoma among Japanese-Americans was three to six times higher than that of American-born whites, and the highest incidence was among Japanese-Americans born in Japan. Despite the higher incidence of gastric cancer reported among Japanese-Americans, it has been estimated that Japanese migrants residing in Hawaii have lower incidence rates of gastric cancer (Hawaiians experience a 50 per cent decrease in stomach cancer risk post migration) but experience increased risk for breast cancer than Japanese in the country of origin (Tsugane 2005).

Similarly, Reed et al. (1982) studied a cohort of 4,653 men of Japanese ancestry living in Hawaii. Three acculturation dimensions were used: first, culture of upbringing (e.g. degree of exposure to Japanese influences during childhood, years lived in Japan, age at migration, etc.); second, current cultural assimilation (e.g. degree to which an individual had maintained Japanese culture forms, and included information on ability and frequency of reading and writing Japanese) and third, current social assimilation (e.g. degree to which an individual had maintained contact with Japanese ethnic groups in the community, including information about ethnicity of physicians, friends, employers and co-workers). The study found that there was an inverse relationship between total acculturation scores (1 = most Western; 4 = most traditional) and the prevalence of total coronary heart disease, myocardial
infarction and angina. Social assimilation score was also inversely associated with the prevalence of total coronary heart disease, but not myocardial infarction, and angina.

In a critical review of the literature, Perez-Escamilla and Putnik (2007) examined the influence of acculturation on type 2 diabetes and corresponding risk factors, particularly dietary intake, physical activity patterns, smoking and alcohol consumption, and obesity among migrants. Their findings suggest that, among Latinos embracing Western ways, there are both negative and positive outcomes. Negative outcomes include increased obesity risk, suboptimal dietary choices including lack of breast-feeding, low intake of fruits and vegetables, and increased consumption of fats and artificial drinks, smoking and alcohol consumption. Positive outcomes include increased physical activity and a lower likelihood of type 2 diabetes. Other studies have suggested that traditionally-oriented migrants are more likely to have diabetes than their assimilated counterparts (Mainous et al. 2006 and Jaber et al. 2003). In fact, once diabetes is diagnosed, traditionally-oriented diabetic individuals are more likely to have diabetes complications such as peripheral neuropathy compared with their assimilated counterparts (Mainous et al. 2006).

Bhui and colleagues (2005) investigated cultural identity as a risk factor for mental health problems among adolescents in east London’s multiethnic community. This was a cross sectional school based survey of a representative sample of 2,790 adolescents from year 7 (11–12 years) and year 9 (13–14 years) attending schools in east London. All the 42 eligible schools were invited to take part in the study and 28 schools agreed to participate. Of the 2,790 adolescents on which data were obtained, 525 (or 20 per cent) were born outside the UK. The sample was composed of white, Pakistani, Indian, Bangladeshi, Mixed race, Black African, Black Caribbean and Black British. The main finding from this study was that integration was healthy and protective against mental health problems. Importantly, integrated cultural identity based on friendship choices was related to fewer mental health problems among adolescents of all ethnic groups. Similarly integration on the basis of friendship choices remained significantly associated with a lower risk of mental health problems after adjusting for socioeconomic indicators, social support from friends, duration of stay in the UK, religion, age, gender and ethnic group. The authors concluded that cultural identity is a more specific risk factor of importance than ethnicity. Similar findings were reported among Ghanaians in the Netherlands. Knipscheer and Kleber (2007) reported that preservation of traditions and maintenance of cultural affiliation were related to lower level mental health problems. They suggest that there are some domains of cultural adaptation that promote mental health of migrants and others that hinder it. They recommend that mental health professionals working with migrants should assess mental health problems as well as establishing the influence of acculturation stress, cultural affiliations and social and economic disadvantage on mental health.
Marino et al. (2001) examined the relationship between acculturation and oral health status, oral health knowledge and frequency of dental visits in 147 subjects of Vietnamese background, 18 years or older, living in Melbourne, Australia. Oral health was measured using dental status (decayed, missing and filled surface-DMFS index), recentness of dental visits and preventive dental health knowledge. This study found that assimilation (highly acculturated) had a protective effect against deleterious oral health. Acculturation was associated with all three oral health outcomes measured; dental caries history, knowledge of preventive measures for dental caries and frequency of visits to the dentist. Participants who were assimilated had a lower number of teeth affected with caries history, were more likely to have used oral health services in the twelve months prior to the study, and had a better knowledge of ways of preventing dental caries than traditionally-oriented participants. The study also found that overall, Vietnamese migrants had better dental health than the broader Australian population, suggesting that the oral health outcomes of those who are assimilated are, in fact, relatively even better.

Implications for public health

Research on the relationship between acculturation and its long-term effect of social exclusion has produced mixed findings: some studies have linked acculturation to some deleterious health and social outcomes (Prislin et al. 1998; Perez-Escamilla and Putnik 2007); others have reported that acculturation may lead to improved health behaviours and social outcomes (Jaber et al. 2003; Perez-Escamilla and Putnik 2007); while few have found no relationship (Marks et al. 1987). What is clear is that it has been difficult to compare acculturation studies due to the use of different measures. The acculturation measurement has been dominated by surrogate or proxy measures of acculturation such as length of stay and/or generation (a measure that does not take into account pre-immigration history), language and family values. Some studies did not psychometrically derive their acculturation scales, and in most cases, acculturation was considered as a linear process, where individuals move from one end of the axis (traditional) to the other (assimilation) at a different pace. Few of the studies described above considered acculturation as a bi-dimensional process that conceptually allows for the four types of cultural orientation we described in the introduction (assimilation, marginalisation, traditional and integration). This is particularly important as our recent study on acculturation and obesity found that each of these acculturation types have different health risks. However, the dominant finding across these studies, regardless of the acculturation scale used, is that the benefit of preserving traditional values seems to provide superior health outcomes, suggesting that assimilation is detrimental to health. From a public health perspective, it is clear from these studies that there is a need to identify and preserve traditional practices and culture-based positive atti-
tudes that have health benefits, and incorporate them into health promotion programs.

Notes

1 Horizontal fiscal equalisation is a formula used by the Australian Commonwealth to ensure that States and Territories do not experience disadvantage in their financial capacity to offer equal levels of public goods and services commensurate with their contributed tax effort.