

The health migrant effect applied to australia



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Essay Topic: Multiple theories have been expounded to explain the “ healthy migrant effect”. Outline and critically examine these explanations with reference to evidence about refugee and non-refugee migrant groups in Australia.

The “ healthy migrant effect” is a widely disputed concept among the medical community. It is argued that the migrants from many countries have mortality and morbidity advantages over those in the host country. This is an important concept in Australia particularly, since ‘ 29% of the total population of Australian’s is born overseas as of 2019’. (Australian Bureau of Statistics 2019) There are three main theories that are used to explain the “ healthy migrant effect” (HME) including; selection bias, salmon bias and the convergence theory. However, many factors must be considered when determining the reality of the HME (e. g. refugee and non-refugee migrants), since these can have adverse affects on the evidence provided. It is important to understand all of the theories that explain the HME, since this provides reasoning to give further focus on the health inequities among migrant groups in Australia, which in turn while improve Australia’s overall health.

The selection bias theory argues that the “ healthy migrant effect” exists. It’s based on the idea that only ‘ healthy’ migrants are selected and approved by the government to enter the host country or that only the ‘ healthy’ migrants survive the trauma of migrating to other countries (Namer & Razum 2018). Since the introduction of the *Migration Act 1958* (Cwlth), the process for approval for immigrants requires a rigorous medical examination with strict guidelines on what diseases are and are not permitted into the country. This

means that only those who are deemed 'healthy' by the Australian Immigration Health Services are approved for permanent residency (Paxton 2018). 'Death rates declined by 64% for males, from 1900 to 2000, and 72% by females from 1900 to 2000' (Magnus & Sadowsky 2006). Fittingly the net overseas migration (NOM) of Australia exponentially increased from 2,959 in 1901 to 277,700 in 2009 (Phillips, Klapdor & Simon-Davies 2010). Based on this data it seems adequate that as the NOM increased the mortality rates of Australia decreased as well. However, since factors such as improved health policies, new health technology and more have been developed throughout these years it's hard to determine whether the decrease in mortality rates is purely because of the increase in NOM in Australia. This means that the selection bias theory is nearly impossible to prove since there isn't extensive data solely based on the mortality rates of migrants from before the pre-screening policy of immigrant's introduction to Australia.

In terms of only the fittest migrant's surviving the transit between their original country and their host, this differs between refugee (forced) and non-refugee (voluntary) migrant groups. For example, an English family migrating to Australia will have an easier means of transit compared to that of a family of refugees escaping a war torn country such as Sri-Lanka. As of the 2016 census Australia's leading voluntary migrant population were British (1,087,756) and leading refugee population were Sri-Lankan (109,850) (Simon-Davies 2018). This shows that the intake of voluntary migrants is far higher than that of refugees in Australia. In turn, this could be due to the lower chance of surviving transit between a refugee country and Australia. Therefore, supporting the selection bias argument, however there

are limitations to this including the difference could be due to strict Australian refugee policies, which create slower fluctuations of refugees coming into Australia compared to voluntary migrants. Nevertheless, there is not enough research on Australian migrant groups to back up the claims of the selection bias theory explaining healthy migrant effect.

Similarly, the convergence theory supports the healthy migrant effect but only temporarily. This theory essentially states that as a migrant acculturates even if they do have a health advantage they will either lose or gain this over time (Namer & Razum 2018). For example, a Japanese family who migrate to Australia may change their diet to a more 'Westernised' one to fit in with the societal norms, so they can be socially accepted. This diet would contain more sugar and processed foods than their diets previously had and would therefore increase their likelihood of getting a diet related disease such as Type 2 Diabetes, which is an obvious negative impact on their health. Given the impact of diet-related acculturation alone, the Australian government could improve this by having free nutrition education sessions in multiple languages and provide more frequent follow ups with resettled refugees (Altshuler, Scott & Careyva 2011).

The convergence theory is also a way of explaining the trends in decreased health of migrants in Australia over time. Many studies show that 'migrants who come to Australia often experience weight gain and even obesity following migration after a general length of six months to ten years'(Delavari et al. 2015). However, a case study on Iranian immigrants to Australia showed that the 'pattern of acculturation' as a cause of obesity was not followed by this sub-group instead it was 'linked to the migrant's

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perception' of health (Delevari et al. 2015). These studies show that the convergence theory is only applicable for specific migrant groups in Australia and can't relate to all overseas born Australians. Acculturation in a country such as Australia can also lead to increased risk of migrants developing lung cancer either through passive or direct smoking, since cigarettes are readily available throughout the country (although they're taxed and very expensive and not seen as a socially acceptable activity by most). They could also be more inclined to smoke for the perceived benefits of being a de-stress method to cope with the stress of migration. To prevent this rising level of morbidity and mortality rate among migrant Australians, services must be made readily available in local communities to provide migrants with nutritional and health safety knowledge. Due to the language barrier however, they may need to develop programs and have travelling educators who are able to use the migrant's pre-dominant language to convey what is and is not risky behaviour, thereby promoting healthy ageing. Therefore, the convergence theory doesn't work for all cases but does generally support the idea of the ' healthy migrant effect', even the proposed health advantages don't last.

A theory that conveys the ' healthy migrant effect' doesn't exist is the salmon bias theory. This theory essentially hypothesises that those migrants who end up becoming sick or fatally ill reside back to their heritage country and therefore the data for those people is not included in the overall health of migrants in host countries (Puschmann, Donrovich & Mathijs 2017). This theory doesn't necessarily work for all migrants though. For example, refugee migrants in Australia who have migrated from a war-torn country

would be highly unlikely to go back to their home country when sick. Whereas voluntary migrants would be more likely to go back to their heritage country for familial reasons and comfort, because it's safer, easier and more achievable for this group of migrants (F. Abrafo-Lanza, Dohrenwend, S. Ng-Mak & Turner 1999). From these examples it's evident that the salmon bias theory has limitations, since it relies heavily on the hypothesis that the methodological process of data collection on migrants being inaccurate and inconsistent. Since the salmon bias theory is hard to prove minimal studies have been undertaken to assess its validity. Therefore, it's not accurate to say the salmon bias theory occurs for all migrant groups.

One study however by Turra and Elo (2008) shows that the salmon bias theory is consistent among Hispanics in America. This in turn proves that the salmon bias theory does hold merit in its argument against the 'healthy migrant effect'. Due to its limitations of not having been studied rigorously as its counter theories it's unable to be a definitive proof that the 'healthy migrant effect' does not exist. Since this is the most reasonable and highly regarded argument against the HME it does increase the likelihood of the existence of the 'healthy migrant effect'. However, since it's been shown to occur among sub-groups of migrants it does mean that government policies must entertain the possibility that their data is inaccurate and that migrants aren't as healthy as appears, which will allow a greater focus on the health of migrants to occur.

To conclude, the two theories that support the existence of the 'healthy migrant effect' (selection bias and convergence theory) are true in some

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cases however not for all. The salmon bias theory, which argues against the 'healthy migrant effect', is a fair assumption but is difficult to prove as it relies heavily upon data that doesn't exist. Since health is not just physical but includes aspects such as mental health as well, I don't agree with the existence of the HME. While some migrants do fit into the category of having lower mortality rates, others suffer greatly with the mental stress of migrating to a foreign country. For example, Syrian refugees who don't speak English are unable to communicate effectively with not only health professionals but also those around them in their provided community, thereby negatively affecting their social health. Therefore, I acknowledge that the 'healthy migrant effect' does hold some merit but its not an accurate representation of migrant health in Australia. Moreover, it's been shown that voluntary migrants are more likely to fit the 'healthy migrant effect' than refugees. Since Australia takes in more voluntary migrants than refugees it does appear that the healthy migrant effect is an accurate representation. However, if the Australian government continues to generalise the voluntary and refugee migrants alike then minority sub-groups of overseas born people's health needs are not being met, since more health expenditure goes to those seen as a higher health priority issue. Perhaps further funding in the future should go into improving the health of migrant Australians, especially those of refugee status, to improve Australia's overall health. Therefore, the concept of the 'healthy migrant effect' should not be considered by public health policy makers as this could be detrimental to the health of migrants who fall under the minority category, as their health issues will continue to be overlooked.

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