

The impact of pre-migration and post-migration socioeconomic status and social integration on immigrant health

Current Knowledge on Immigrant Health

The World Health Organization's social determinants of health (SDH) framework highlights social and structural forces that shape population health around the globe (WHO 2008), but scholars have not commonly applied it to understand how structural factors shape individuals' health in the process of migration (Acevedo-Garcia et al. 2012; Dunn and Dyck 2000). For instance, the literature on immigrant health in the U.S. has mainly focused on two public health concerns: the associations between acculturation and health outcomes, as well as access to health care among different immigrant populations (Castro 2008). But these approaches tend to decontextualize immigrant populations in both the sending and receiving societies (Acevedo-Garcia et al. 2012).

Derived from transnationalism theory and the life course perspective, the "cross-national framework" examines immigrant health from the perspective of population health (Acevedo-Garcia et al. 2012). It considers how immigrant health varies based on immigration push and pull factors, health selection into migration, as well as economic development and health gaps between the sending and receiving societies. For example, the effects of socioeconomic status (SES) and gender can impact both migration and health, especially when an immigrant flow is largely comprised of women (Acevedo-Garcia et al. 2012).

To date, there is limited research about immigrant women's health from a population health perspective (Aroian 2001; Im and Yang 2006). Most research in Western immigrant societies concerns reproductive outcomes and intimate partner violence among immigrant women (Aroian 2001; Raj and Silverman 2003). Since most immigrant women emigrate for family reunions, only a relatively smaller number migrate for marriage. Immigrant women who migrated to reunite with family gauged their health based on their contribution to family wellbeing (Meadows, Thurston and Melton 2001). Unlike other primary immigrants that employers from the host country are involved in the immigration process, marriage migrants might be less well protected, thus the process should be recognized as a significant determinant of health (Meadows, Thurston and Melton 2001). In addition, their health experiences are affected by pre-and post-migration SES, reasons for immigration, and social integration factors such as economic hardships and the lack of social support (Im and Yang 2006).

The traditional categorization of immigrants follows the legal categories of family reunification, employment basis, and refugee status (Pandey and Kagotho 2010). Marriage migration, a growing phenomenon worldwide, does not easily fit into these categories. Merali summarized three factors which potentially determine female marriage migrants' wellbeing: the "gender-insensitive nature" of immigration policies in the receiving country, their lack of awareness of their own rights, and conventional beliefs and norms about gender roles (Merali 2008). Immigration laws in Canada and the U.S. stipulate that spouses rather than the state are responsible for the integration of marriage migrants in the fields of language learning, employment seeking, and adaptation to local lifestyles (Merali 2008). Consequently, maltreatment reported by female marriage migrants is not limited to conventional abusive forms such as emotional, physical, and sexual abuse, but extend to unique forms of immigration- or integration-related abuse (Merali 2008; Raj and Silverman 2003).

Study Context

Transnational marriage migration involves changes both in one spouse's legal status and movement across national borders (Kim 2010). In Asia, the growing phenomenon of transnational marriage migration reflects the movement of females from less developed countries to wealthier countries when they marry men at the destination, many of which were arranged through commercial contacts (Constable 2005; Hugo 2005; Jones and Shen 2008; Piper 2008; Tseng 2010). As one of the new immigrant destinations in East Asia, South Korea (hereafter, Korea) has seen a rapid increase of marriage migrants over the last decade, where the cumulative number has reached 284,000 in 2011 (Chosunilbo 2012). In response to the rising numbers and the integration needs of marriage migrants, Korean government has loosened policies to facilitate their integration, on the basis that they have provided a certain segment of Korean men with opportunities to continue their family line (Lee, Seol and Cho 2006; Tseng 2010).

On the sending end of this immigration flow, marriage migrants from different origin countries entered Korea at different times and were driven by varied incentives. For example, Korean Chinese women began to enter Korea in the early 1990s after local Korean government initiated "marriage tours" to recruit them as the solution for unmarriageable men in rural villages (Kim 2007). On the receiving end, sociocultural contexts and immigration policies play significant roles in immigrant integration and wellbeing. Several characteristics of intra-Asia transnational marriages in Korea may impact the health of marriage migrants, including persisting rigid gender roles, heavy responsibilities of daughters-in-laws, and the cultures of familism and collectivism that push men to seek ideal wives with "traditional virtues" abroad, to fulfill the image of a "filial son" (Chi 2007).

These "East-Asian specific" characteristics of transnational marriage place young immigrant women into a multidimensional disadvantaged position, where they experience disappointments and obstacles as married women, as poorly-educated immigrants, and in situations specific to their immigration, which ultimately impact their health. Existing health literatures on this population either ignore structural factors like pre-and post-migration SES, and central issues of immigrant integration, and have not yet examined their health from the perspective of social determinants (Choi et al. 2012; Kim et al. 2011). Based on the SDH framework and the cross-national perspective which views pre- and post-migration SES as determining factors that shape immigrant health trajectories, we use a recent national survey from Korea to answer the following questions. In the context of intra-Asia marriage migration, how do pre-and post-migration SES impact immigrant women's health? What are the associations between social integration and immigrant women's health? Does ethnicity matter in explaining how SES and social integration impact the health among immigrant women in Korea?

Methods

Data and Analytic Subsample

The 2009 National Survey on Multicultural Families in South Korea was conducted by face-to-face interviews and was designed to study the living condition of marriage migrants. Government officials from the survey agency identified 167,000 married immigrant residents in South Korea including both naturalized and non-citizens, marriage migrants whose spouses are naturalized foreigners or foreigners were excluded in the survey. A total of 130,001 migrants who married Koreans were identified to be

living in Korea in 2009. In the end, the survey received 73,669 questionnaires, a response rate of 56 %. The analytic subsamples of this paper are immigrant women from China and Vietnam since they are the largest groups of marriage migrants: ethnic Koreans born in China (Korean-Chinese) (N=24,561), Han Chinese (N=9,292) and Vietnamese (N=19,363).

Key Variables

The outcome measure in this study is self-rated health. I dichotomized health status as good (very good and quite good) versus the rest (neutral, bad, and very bad). The measure of socioeconomic status (SES) contains variables from marriage migrants and their marital families. Pre-migration SES factors include marriage migrants' education and how they perceive the status of natal families in their home countries, while husband's education and marriage migrants' perception of their marital family are considered post-migration SES.

Five factors represent social integration: Korean language proficiency, length of stay, citizenship status, social relationships in the co-ethnic network, and social relationships with Koreans. Language proficiency is a 3-item scale measuring how fluent the respondents speak, read, and write Korean. Response ranged from (1) very good to (5) very poor. These items were reversed, summed, and averaged to create a Korean language proficiency score. The Cronbach α value of Korean proficiency scale is .94. Respondents were asked whether they have acquired Korean citizenship, and length of stay was coded into four groups.

Two questions in the survey identified marriage migrants' social relationships with others. Respondents were asked "With whom do you spend time when you had an individual or family trouble?" and "who do you spend leisure time or doing recreation activities with?" Each respondent fall into one of the following categories: having zero, one, or two types of social relationships with their own ethnic network, as well as with Koreans.

Analysis

To examine how pre- and post- SES and social integration impact self-rated health, as well as to highlight intra-group variations, I stratified all analyses by ethnic groups: Korean Chinese, Han Chinese, and Vietnamese. Multivariate logistic regression was used to examine the association among key variables in reduced and full models. Likelihood ratio tests were conducted to examine model fit. I excluded those whose information on self-rated health were missing (ranged from 1 percent to 1.5 percent among three ethnic groups).

Key findings

After controlling for covariates, predictors of better health that are consistent across ethnic groups include higher post-migration SES, heightened social relationships with native Koreans, higher Korean language proficiency, shorter lengths of stay, and those without citizenship status. In terms of ethnicity-specific differences, the Han Chinese women who perceived their natal families as wealthy in China had worse health compared to those who perceived their natal families as poorest. On the other hand, Korean Chinese is the only group that shows their health is significantly associated with the education of the husbands. Given that migrants must first adjust to marriage while slowly dealing with other life aspects, it is legitimate to assume that the wellbeing of marriage migrants is, at least initially, largely determined

by the resources of their husbands. However, such effects were not observed among Han Chinese and Vietnamese, a majority of who have just arrived within five years.

As for immigrant women from Vietnam, they were distinctively different from immigrant women from China. First, there is a reversed education gradient in their post-migration health, contrary to the literature on life-course determinants of health (Blane 1999). Second, Vietnamese were the only group showing that having more types of social relationships with co-ethnics had a negative impact on their health. Among our study populations, the Vietnamese had the most interactions with co-ethnics; they also have the least social relationships with native Koreans. Last but not least, our study demonstrates that it is crucial for immigrants to maintain social relationships with native populations, because it not only signals better social integration but also better immigrant health.

Even though intra-Asia marriage migrants share cultural affinity with Koreans under the broader “Asian” umbrella category, they often maintain different religious practices, gender roles, social relationships, and family expectations. The quality and quantity of social relationships that marriage migrants can maintain with native Koreans shows the extent to which marital families and society as a whole accept them. How intra-Asia cultural differences brought by marriage migrants are accepted in Korea will impact with marriage migrants’ social integration and health.

Conclusions

Both pre- and post-migration SES matter for the health of immigrant women and social integration plays a significant role in promoting immigrant health. However, the social and economic circumstances surrounding marriage migration have made Vietnamese women a unique case, compared to the Han Chinese and Korean Chinese. The interplay between pre- and post-migration SES and their effects on immigrant women’s health shows the need for an integrated framework from the family literature and the immigration literature to investigate the health consequence of transnational marriage migration. Intra-Asia marriage migration provides a unique opportunity to investigate the social and political process of immigrant integration where ethnic hierarchies replace the color line and when immigration and integration policy fail to properly address the issue of ethnic discrimination.

Understanding how SES and integration impact immigrant health as well as ethnic differences can inform health policy and immigration policy makers. Since 2006, Korean government has significantly increased its spending on multicultural families. Over the past few years, more than 200 multicultural family centers have been set up countrywide, in order to facilitate the social integration of marriage migrants. Integration policy not only should direct Koreans to respect and appreciate cultures that marriage migrants bring into the society, but also encourage them to reach out and interact with members from “multicultural families,” if a “multicultural society” really is what Korea is heading for. Immigrant integration is especially important because it not only affects marriage migrants but also the developmental trajectories of the “multicultural children.”

Future research should explore how dyadic relationships among transnational couples influence marriage migrants’ health. Socio-demographic dissimilarities such as gaps in age and education between the couple may play a significant role in the wellbeing of transnational marriages, because such marriages were formed under great cultural differences. It is important both in theory and in practice to

examine whether ethnic intermarriages impact the health of immigrant wives in a similar or different way, compared to racial and ethnic intermarriages in other countries.

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