Background

Skilled migrants make up approximately 67% of the total annual migrant intake into Australia (Australian Government 2017) and are generally in good health when they immigrate (Biddle, Kennedy & McDonald 2007; Jatrana, Pasupuleti & Richardson 2014). Studies recognise that this is due to the healthy migrant effect (migrant health being superior to that of the host population, through selection) and the salmon bias (migrants returning to their home countries due to illness, while the healthiest migrants remain in the country of settlement) (Giannoni, Franzini & Masiero 2016; Jatrana, Pasupuleti & Richardson 2014; Kearns et al. 2017; Rechel et al. 2013; Rivera, Casal & Currais 2016; Vang et al. 2017). However, existing research suggests that skilled migrants face health, particularly mental health, challenges after setttlement and their health can worsen over time through acculturation (Biddle, Kennedy & McDonald 2007; Han & Chesters 2001; Jatrana, Pasupuleti & Richardson 2014; Pernice et al. 2009; Verdonk 1979).

A framework or lens through which to understand how the process of migration interacts with and shapes health would help make sense of this emerging research field. Castaneda et al. (2015) reviewed public health literature on the health of immigrant populations through three frameworks: behavioural, cultural and structural. These researchers noted that the literature is dominated by behavioural and cultural frameworks of immigration and health, and that those who have considered a structural approach often limit their analysis to the issue of health care, instead of considering large scale social factors that impact health.

The literature demonstrates that social determinants of health (SDOH), including socioeconomic status and social exclusion, are implicated in causal pathways relating to the health of migrants (Giannoni, Franzini & Masiero 2016; Marmot et al. 2012). SDOH include factors such as birthplace, living situation, and lifestpa development , as well as the broader systems shaping the conditions of

daily life (WHO 2018). Researchers argue that the act of migration itself is an SDOH, influenced by social structures, systems and norms, policies and resources (Carballo, Divino & Zeric 1998; Marmot et al. 2012; Rechel et al. 2013). However, significant gaps in knowledge about the relationship between SDOH and migration remain, and there is a call for further dialogue between these two research areas. It is because social and structural determinants are upstream, macrolevel factors associated with social and economic policies, that researchers have recommended that this would be an effective framework to understand the relationship between migration and health (Castaneda et al. 2015).

In this paper, we report on the findings of a secondary analysis of data collected for a broader study that explored migrants' experiences of their first two years of resettlement, the resources available to them, and their reasons for deciding to live and remain in their adopted homeland (Harris & Chin, 2017). Primary analyses identified health as a key theme, which, we explore in greater detail. here This paper addresses the research questions: What social factors are skilled migrants exposed to that may impact their health and wellbeing; and how do skilled migrants pursue life conditions that are conducive to health and wellbeing?

Theoretical Framework

We used a contemporary SDOH framework, which includes the role of structures in shaping health outcomes (Dahlgren & Whitehead 1991; Solar O 2010) and Bourdieu's theory of practice (Bourdieu 1990) to explore the research questions. The World Health Organisation (WHO) has differentiated between social and structural determinants. Social determinants are social factors that can promote or undermine health, and structural determinants refers to the socioeconomic and political context which generate social stratification and positions people according to socioeconomic status (Solar O 2010). Structural factors are associated with power, prestige and access to resources, are rooted in

key institutions and processes, and are the key underlying drivers of health inequities (Solar O 2010). In this study, both social and structural determinants were considered.

Bourdieu's theory was also applied in this study for several reasons. His work has been shown to be useful for understanding the relationship between capital resources and structures, and health and health inequities (Huppatz 2015). Further, Bourdieu avoids deficit syndrome by considering the resources people do have rather than those they don't have (Pinxten & Lievens 2014). Bourdieu proposed that people occupy their space in the social world (known as a field) in relation to the likes of others; and that their interactions and use of capital resources contribute to developing class hierarchy, which is associated with life's chances (Bourdieu 1990). Bourdieu identified four types of capital—economic (material and financial resources); social (networks and relationships); cultural (skills and knowledge); and symbolic (power or status gained through honour, prestige or recognition)—that provide people with the resources to navigate social fields (Bourdieu 1990). He also introduced the concept of habitus, which has been described as "those internalised structures, dispositions, tendencies, habits and ways of acting, that are both individualistic and yet typical of one's social groups, communities, family and historical position" (Oliver & O'Reilly 2010, p. 56). A final Bourdieu concept relevant to this study are the 'doxa', also known as the "rules of the game" (Edgerton & Roberts 2014). These include the structural factors that govern the field, (e.g. social, economic and political systems), which can either empower or constrain action and play a central role in determining what is possible (Abel 2007; Cockerham 2013). Resulting outcomes are produced through the interplay of capitals, habitus, doxa and field. Bourdieu's theoretical concepts have previously shown to be useful for understanding migrants' experiences of settling into a new country (Erel 2010; Legido-Quigley & McKee 2012; Oliver & O'Reilly 2010). In summary, we have chosen Bourdieu's theory to compliment the social and structural analysis of migration and health, as it provides additional considerations of capital resources, the habitus, and dynamic navigation of the structural conceptions.

Method

Participants

The Tasmania Government Department of State Growth (DSG) maintains a database of all skilled migrants living in Tasmania . Using the database, the DSG invited expressions of interest from skilled migrants to be involved in the study ; and provided participants with the researchers' contact details, an information sheet, and consent form (Harris & Chin). For the purpose of this study, a skilled migrant in the Tasmanian context is a migrant who has been granted a permanent residence visa which allows him/her to live and work in Tasmania. To be eligible for such a visa, a migrant must be aged under 45 years and meet a range of other criteria including demonstrated skills necessary to undertake an eligible skilled occupation and competent English language proficiency (Tasmanian Government 2018). To be included in the study, participants had to be primary holders of a skilled migrant visa, aged over 18 years, residents of Tasmania for over two years, and currently living Tasmania. Exclusion criteria included spouse/family visa holders. The DSG had no further involvement with the administration, analyses or dissemination of the research.

Data Collection

Semi-structured interviews were conducted face-to-face at a place and time of the participant's choosing, by two postgraduates trained in qualitative research methods (Harris & Chin). Open-ended prompts were utilised as this is most useful for obtaining valid views and experiences from participants (Gall, Gall & Borg 2007). All interviews were conducted in English. There were no language issues as all particiapnts were highly competent in English, wich is a requirement of their visa class.. The semi-structured interviews allowed for the capture of detailed information, and

interviewers to ask further probing and follow-up questions. Interviews lasted 20—60 minutes, and were recorded and later transcribed with the aid of Express Scribe (NCH Software, v. 6.0). All interviews were transcribed twice, by two independent researchers, and transcriptions checked for consistency.

Data Analysis

Data were analysed by a team of four researchers with experience in qualitative research. The researchers used NVivo v.11 (QSR International) software to manage the data analysis process. Thematic analysis was conducted initially by the principal author and used to identify, code and interpret themes from the transcripts (Braun & Clarke 2006). Interviews were evaluated with attention to relevance to the study topic, sincerity, credibility, resonance, and coherent and meaningful themes (Tracy 2010). Final themes were then produced through discussion and consensus of four of the researchers (MV NC FF KH) , to ensure rigour and reliability of data analysis (Lincoln & Guba 1985). The study was approved by the Health Research Ethics Committee (Tasmania) Network (H15739).

Results

Participant Characteristics

Twenty visa holders expressed interest in participating in the study; however, four were found to be ineligible (Harris & Chin). The final sample consisted of 16 participants from eight nations (see Table 1). This was determined to be adequate to ensure suitable saturation of themes related to study aims (O'Reilly & Parker 2013). The majority (69%) were males, most (87%) were from Asia. The participants were employed in a range of occupations.

Table 1. Participant Characteristics

Social Determinants of Health

Skilled migrants reported a wide-range of social factors that impacted their daily living conditions including, cultural factors, education, employment, access to health and social services, housing, income, social support and transport. Table 2 provides example quotes from study participants related to these variables. Study participants drew connections between leaving behind their homeland, transitioning to and building a quality life in Australia, and health; particularly feelings of stress, isolation and anxiety.

Table 2: Social factors affecting skilled migrants and selected quotes

In many cases, it was evident throughout the interviews that social determinants of health were underpinned by macrolevel, structural factors. For example, the stress associated with finding suitable housing or employment, having enough income to meet the cost of living in Tasmania, or accessing health care or transport arose from a complex interplay of socio-economic and cultural ideologies and policies. Numerous study participants identified the role of governments in reducing barriers to accessing the needs for daily living.

Mental Health

Preliminary thematic analyses revealed health as a key theme in migrants' first two years of residency. Follow-up analyses identified mental health as the main perceived health-related outcome. Participants frequently referred to stress associated with the visa process. Participants used terms such as "stressed out," "made me a bit paranoid," and "a bit depressing" when referring to this process. Some also mentioned the effects of migration on the mental health of family members. Several comments related to racism, including its perceived impacts on loved ones: "(my partner) didn't even get an interview…, it made her really depressed." Participants were also likely to mention the overall environment of mostly rural/remote Tasmania, such as finding it "…isolating and

a bit depressing." However, not all statements on mental health were negative. Several participants expressed strong positive outcomes from migrating to Tasmania, with statements such as "happy with my life here," and "quite happy to come back." A number of participants talked about the perceived positive impacts of Tasmania's natural environment on wellbeing.

Resources for Health and Wellbeing

Bourdieu's capitals were used to categorise the resources that skilled migrants drew upon to deal with the challenges and barriers to building a quality life in Tasmania (Table 3). Cultural capital manifested in the form of academic qualifications, cultural skills (e.g. English language), knowledge of host country culture, perceptions of acceptance in the community and experiences of racism, alignment with cultural values, and host and home country similarities. Study participants outlined the experiences of gaining employment, the cost of living, accessing financial resources to navigate visa processes, business opportunities and home ownership, as examples of economic capital. Examples of social capital included family, friends, professional and community networks; and symbolic capital was illustrated through the subjective and objective values associated with job offers.

Table 3: Selected quotes associated with skilled migrants' capital resources

Habitus assists people to find their sense of place in the world, and it is this sense of place that manifests as observable behaviours (Cockerham 2013). Skilled migrants frequently described their disposition to dealing with life's challenges in terms of tenacity and resilience. For example:

> I kind of have that strength, independence; that strength to cope with things…One thing (that) is very important (which) help(ed) me is to connect to new comers and locals to (let them) learn about our culture … I was more out there going to meetings or meeting people.

Accountant, Male, China

Discussion

This study found that migration is a social process that shapes opportunities for migrants to pursue conditions that are conducive to health. These findings are supported by other researchers who have framed migration as a social process, recognising the role of power, policies and resources (structures) in shaping opportunities for migrants to achieve optimal health (Carballo, Divino & Zeric 1998; Castaneda et al. 2015; Ingleby 2012; Marmot et al. 2012; Rechel et al. 2013). Our study contributes to this body of literature using a qualitative approach to provide a richer understanding of skilled migrants' experiences as they participate in the process of migration- specifically focussing on their health.

Some of the unique collective challenges experienced by skilled migrants in this study included language difficulties, recognition of educational qualifications obtained in other countries, accessing medical services that accept temporary visa holders, securing accommodation without an Australian rental history or references, racism, vulnerability to exploitation by employers, obtaining an Australian drivers' license, social isolation associated with geographical isolation (family and friends located in another country) and navigating the migration system. That such social factors impact on health and wellbeing—including mental health—is supported by a large body of evidence (Carballo, Divino & Zeric 1998; CSDH 2008; Marmot et al. 2012; Rechel et al. 2013; Rivera, Casal & Currais 2016). However, few previous studies have reported on these variables in the Australian context (Dantas et al. 2017; Han & Chesters 2001), and we couldn't identify any other studies that specifically included skilled migrants in Australia and applied a social determinants of health framework.

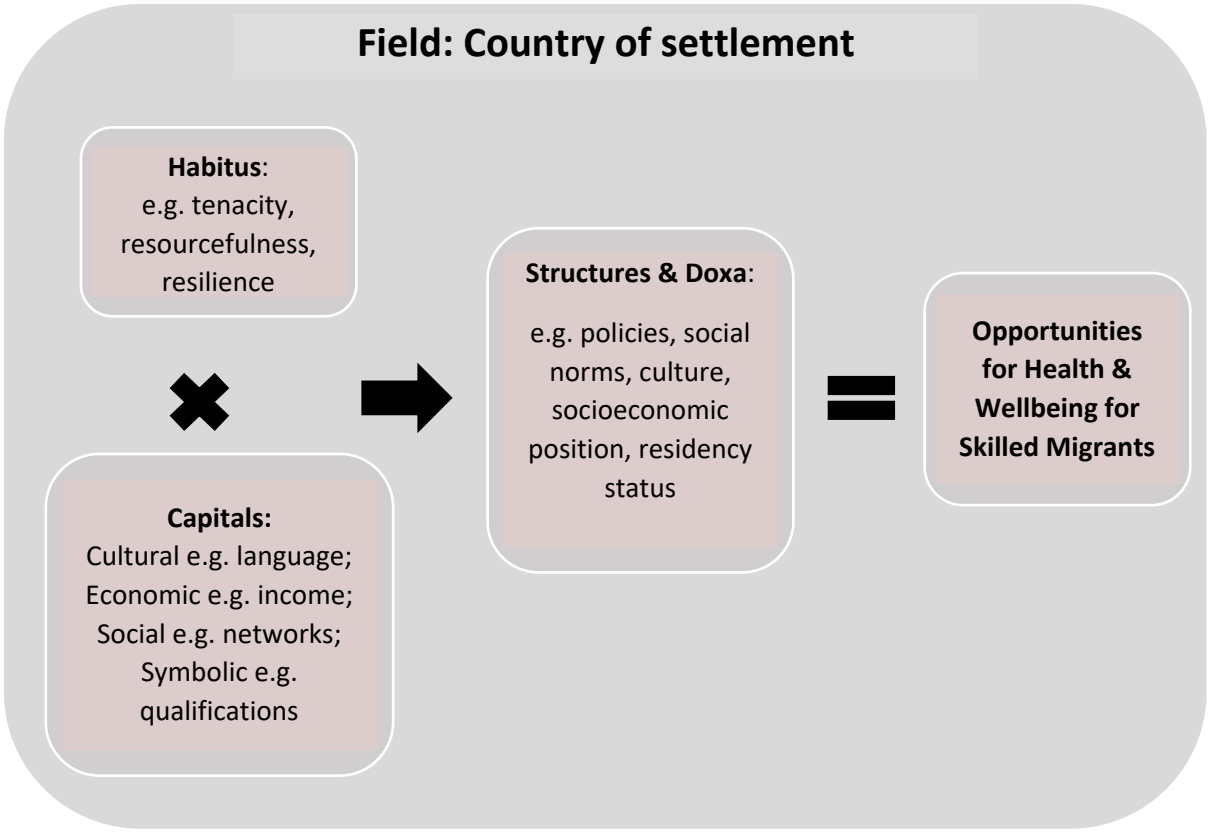
Participants in this study were 'skilled' migrants, which suggests that they possess resources that can assist their international mobility (Ariss & Syed 2011; Erel 2010; Harvey 2009; Nohl et al. 2006; Oliver & O'Reilly 2010). Applying Bourdieu's theory of practice, we found that skilled migrants were able to draw upon a wide range of resources when navigating the social field. For example, many study participants described how social capital (networks, family and friends) enabled them to undertake migration processes, gain employment and participate in community life. Similarly, economic capital enabled skilled migrants to meet housing, transport and cost of living needs. However, while cultural, economic, social and symbolic capitals and the habitus may equip skilled migrants with the resilience, tenacity, and resources to help them purse social conditions conducive to health, their efforts were also constrained by structural factors.

If we consider migration within a SDOH framework, it is apparent that the challenges experienced by skilled migrants are shaped by social, economic and political (structural) mechanisms that are beyond the control of individuals (Crammond & Carey 2017; Giannoni, Franzini & Masiero 2016; Solar O 2010). For example, that skilled migrants experienced difficulties accessing fair work, acceptance by Tasmanian employers of work experience gained in their home country, decent income or secure housing should not simply be seen as a range of social factors that undermine health, rather as a consequence of stratification according to residency status. For example, one study participant described difficulties accessing health services because of their non-permanent residency status; others described problems with securing accommodation because they did not have Australian rental histories. Therefore, no matter how skilled the migrants may be they often found it difficult to navigate the conditions of daily life. The 'struggles' experienced by skilled migrants illustrate the effects of structural power (Cockerham 2013). Numerous study participants described experiences of interacting directly with, or experiencing, the consequences of power that infiltrated many aspects of their daily lives. For example, study participants described stressful interactions with Australia's migration bureaucracy; while others spoke about rejections from

employers despite qualifications and experiences. Such experiences can disempower people and contribute to producing and reproducing social inequalities, and ultimately health inequities (Cockerham 2013; Solar O 2010).

We concur with other researchers and reject the rucksack approach that migrants either fit or do not fit (Clark & Zukas 2013; Erel 2010). Instead, our study illustrated the social complexities challenging the perceived health and wellbeing of skilled migrants as they sought to re-build their lives in Tasmania, and that "the field of the possible is always limited by structures, habitus and capitals" (Oliver & O'Reilly 2010, p. 62). We summarise these key findings by applying them to Bourdieu's theory of practice (Figure 1).

Figure 1: Mechanisms shaping opportunities for health and wellbeing for skilled migrants.



Australia's immigration system should not rely on skilled migrants' disposition and capital resources to overcome barriers to health and wellbeing, at the exclusion of reducing structural constraints. A SDOH approach would likely provide better support for skilled migrants to maintain and improve their health, and enable them to continue to contribute economically, socially and culturally to society.

Strengths and Limitations

This study included a small but adequate sample size, and used individual semi-structured interviews to produce a large quantity of data. The sample was reasonably diverse on ethnicity, age (although not assessed), rural and urban residents, and occupations. The study benefited greatly from multiple researchers reviewing and analysing the data. The group research analyses helped validate the themes that emerged from participants' statements. As with most qualitative studies, the sample did not include all types of skilled migrants, for factors such as ethnicity, occupation, education, etc. It is also worth noting that this study was not aimed at identifying the SDOH found in skilled migration communities. That was a theme that emerged, organically, from the semi-structured interviews. A follow-up study could focus interview prompts on the themes identified here, to provide further details and focus on areas only touched upon.

Implications and Originality

There are unspoken challenges in the migration process, namely the lack of recognition of powerful structural factors, which despite a migrant's strong habitus and extensive capitals, can prevent them from accessing the resources and conditions necessary to maintain and improve health and wellbeing. This is the first known study to link Bourdieu's theory to SDOH in the skilled migrant context. This approach helped reveal the prominence of structural factors beyond the control of migrants but potentially modifiable by the host country. This puts the onus on the hosts to consider

structural reform to modify systems to promote rather than inhibit wellbeing. Innovations could include: new structures in universities; government and industry partners to facilitate employability; improved access to housing; consistent, accessible and supportive information about the migration process; and community-based welcoming programs that encourage social inclusion. Just as importantly, this study revealed how migrants' health, both physical and mental, may be improved through migration. The full experiences of individuals deserve better integration into existing theory and research on health determinants. Previous papers on the topic of migrant health have focussed on the personal attributes and resources of individual migrants, and the effects of specific determinants (Bhugra 2004; Davies, Basten & Frattini 2006; Sundell Lecerof et al. 2016; Widdows & Marway 2015). While they are important, they will never be enough to overcome all the system barriers to good health.

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