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# Demographic and socio-cultural correlates of medical mistrust in two Australian States: Victoria and South Australia



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## ABSTRACT

Studies on medical mistrust have mainly focused on depicting the association between medical mistrust and access/utilization of healthcare services. The effect of broader socio-demographic and psycho-social factors on medical mistrust remains poorly documented. The study examined the effect of broader socio-demographic factors, acculturation, and discrimination on medical mistrust among 425 African migrants living in Victoria and South Australia, Australia. After adjusting for socio-demographic factors, low medical mistrust scores (i.e., more trusting of the system) were associated with refugee ( $\beta = -4.27$ ,  $p < 0.01$ ) and family reunion ( $\beta = -4.01$ ,  $p < 0.01$ ) migration statuses, being Christian ( $\beta = -2.21$ ,  $p < 0.001$ ), and living in rural or village areas prior to migration ( $\beta = -2.09$ ,  $p < 0.05$ ). Medical mistrust did not vary by the type of acculturation, but was positively related to perceived personal ( $\beta = 0.43$ ,  $p < 0.001$ ) and societal ( $\beta = 0.38$ ,  $p < 0.001$ ) discrimination. In order to reduce inequalities in healthcare access and utilisation and health outcomes, programs to enhance trust in the medical system among African migrants and to address discrimination within the community are needed.

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## 1. Introduction

Since the 1940s, countries of the Organisation for Economic Cooperation and Development (OECD) have experienced a demographic transition characterised by the increased immigration that followed the end of the Second World War, the boom and bust of the guest worker migration of the 1960s through to the 1970s, and various waves of refugees and humanitarian entrants associated with global conflicts (Organisation for Economic Co-operation and Development, 2011). Current estimates suggest that the number of international migrants has increased exponentially, growing from 77 million in 1960, to 195 million in 2005, and an estimated 214 million in 2010 (Minter, 2011). This represents 3.1% of the world's population, which does not include the 33.9 million people who are displaced people (i.e., refugees, asylum seekers, and stateless persons) (Pellegrini and Smith, 1998). Australia also has had a long

history of migration, which has transformed the demographic composition of the Australian population.

Until 1973 a "White Australia" policy explicitly excluded peoples of colour. The process of dismantling this policy started in about 1949–1950, following the end of the Second World War, amid fears that uncontrolled migration would result in Australia being 'overrun' by Asians, when the Australian government embarked on policies to populate Australia with European migrants, fearing (Strahan, 1996; Department of Immigration and Citizenship, 2012). By 1949 Australia had allowed 800 non-white refugees to apply for residency and also allowed Japanese war brides to settle in Australia (Department of Immigration and Citizenship, 2012). In 1950, the Colombo Plan was instigated, allowing students from Asian countries access to Australian universities and by 1957 all non-European migrants with 15 years' work experience were allowed to apply for citizenship. From this point onwards things changed quickly: in 1959 legislation allowing the sponsoring of Asian spouses for citizenship was introduced. The conditions of entry for people of non-European backgrounds were further relaxed in 1964, and refugees fleeing the Vietnam War were allowed to settle in Australia in 1966 (Department of Immigration and Citizenship, 2012). Enforcement of racial aspects of the immigration law was effectively abolished in 1973 (Department of Immigration and Citizenship, 2012).

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The removal of the white Australia policy resulted in a more diverse migrant pool, including accepting refugees (i.e., forced migrants) from a wider range of countries (Campbell and Crawford, 2001) in addition to voluntary migration (e.g., economic/skilled migration or family reunion) (Cooke et al., 2004a). The 2011 census revealed that 26% of the Australian population were born overseas, with African migrants constituting one of the fastest growing sub-populations, and representing almost 1% of the Australian population (Australian Bureau of Statistics, 2011). Upon arrival in Australia, most migrants from developing countries including African countries such as Somalia, Eritrea, South Sudan, or Ethiopia often have high social and health needs, as well as experiencing health inequalities arising from their generally poor socio-economic position pre-migration, relative to the average Australian (Salmon et al., 2005; Martin and Mak, 2006). It has been found that even with this increased need, migrants (Kelaheer et al., 1999; Martin and Mak, 2006), including those from Africa, (Cooke et al., 2004b; Caruana et al., 2006; Neale et al., 2007) tend to underutilise available health and social services.

The reason for this underutilisation is unclear and may relate to a lack of integration into Australian society. However, it may be that there is some distrust of government services, as migrants and refugees' home countries were not necessarily concerned with protecting the needs and interests of vulnerable members of their respective communities, and governmental agencies were sometimes, in fact, agents of oppressive regimes (Eidelson and Horn, 2008). For example, around the world there have been cases of forced sterilisation of minority groups whom the 'majority' wishes to control (Presser, 1969; Brown, 1995; Hyatt, 1998; Sills et al., 1998; Benagiano et al., 2004; Holt, 2012). Low health participation rates in some areas could also be related to the way that some health issues such as mental health are seen to be stigmatized in migrants and refugees' home countries (Corrigan and Watson, 2002), thus making migrants and refugees less likely to admit to requiring psychological support in their adopted countries (Gross, 2004). This might partly explain why ethnic minorities such as indigenous and migrant populations report significantly higher levels of medical mistrust compared with the non-indigenous and non-migrant populations (Halbert et al., 2009; Navaza et al., 2012; Cleworth et al., 2006; Newman et al., 2012). Medical mistrust could potentially help explain disparities in health and poor utilisation of health services in host countries. This breach of trust between people and governments is not unique to migrant and refugee communities, for example, the Tuskegee syphilis experiments resulted in significant breach of trust between the health system (and government) and the African-American community, as African Americans were used to investigate the long-term impacts of syphilis without their knowledge or medical intervention (Thomas and Quinn, 1991; Brandon et al., 2005).

Various researchers have argued that trust has both intrinsic and instrumental values (enforceable trust) (Rogers, 1994; Safra et al., 1998; Rhodes and Strain, 2000; Hall et al., 2001). Hofstede (2006) defines intrinsic trust as: "the trust that we may feel for a person 'just like that'. Or, more precisely, at first acquaintance the feeling is 'I think I can trust that person', and also, 'I would like to trust that person'. This feeling relates to the basic needs of human beings to affiliate with one another, to be friends. Then, with time, through being tested time and again and not broken, intrinsic trust can deepen" (p. 16). The intrinsic value of trust lies in the fact that it is the core ingredient of the provider-consumer relationship, giving such a relationship some meaning and importance (Rogers, 1994; Rhodes and Strain, 2000; Hall et al., 2001). In contrast, enforceable trust refers to the "trust that exists precisely because obligations are enforceable, not through recourse to law or violence but through the power of the community" (p. 9) such as community sanctions and ostracism (Portes, 1998). Hendriks (2010) notes that enforceable trust is "the result of individual members' disciplined compliance with group expectations that are

based on notions of good standing and expected benefits or punishment (p. 16). Thus, instrumentally, trust is a determinant of ongoing and sustained medical encounters, and influences an array of behaviours and attitudes associated with service access and utilisation as well as adherence to treatment (Safra et al., 1998; Rhodes and Strain, 2000; Hall et al., 2001).

The variance in intrinsic and instrumental components of trust could potentially explain why a number of studies have found mistrust of healthcare organisations and health professionals to be associated with lower care satisfaction, treatment adherence, and utilization of healthcare services; low levels of blood and organ donation; and low participation in preventive health programs (Boulware et al., 2002; Ward and Coates, 2006; Bickell et al., 2009; LaVeist et al., 2009; Hammond, 2010; Bynum et al., 2012; Irving et al., 2012). The effect of mistrust has been found to be exacerbated by miscommunication of the purpose of the services, for example, cancer screening. Refugees often have a lack of information about healthcare systems and poor knowledge, and are confronted with the use of medical terminologies, as well as facing broader sociocultural and political constraints such as racism and discrimination, cultural factors, or institutions that are poorly equipped to engage with peoples from different cultures and language backgrounds (Bollini and Siem, 1995; Shahid et al., 2009; Navaza et al., 2012).

Given the critical role of trust in facilitating people's engagement with the health system, it is surprising that there are few studies examining the correlates of medical mistrust, especially within migrant and refugee communities. The few available studies have mainly focused on examining differences between ethnic groups (Kirby et al., 2006; Armstrong et al., 2007) and the association between medical mistrust and access and utilization of healthcare services (Boulware et al., 2002; Ward and Coates, 2006; Bickell et al., 2009; LaVeist et al., 2009; Hammond, 2010; Bynum et al., 2012; Irving et al., 2012). However, the effects of broader socio-demographic (e.g., migration status, educational attainment, level of income or religion) and psycho-social (e.g., level of acculturation and discrimination) factors on medical mistrust remain poorly documented. In studies where psycho-social factors have been examined, the emphasis has been on the role played by acculturation and discrimination in the provision of healthcare services to migrant populations in developed countries rather than their influence on medical mistrust (Van der Stuyft et al., 1989). Acculturation, defined as the process of cultural exchanges and the adoption of the beliefs and behaviours of another group that result from two or more ethnic groups coming into contact (Flannery et al., 2001), influences decisions related to accessing and utilisation of healthcare services and is associated with increased use of primary care programs (Wiking et al., 2004; Sussner et al., 2009). Similarly, there is overwhelming evidence that discrimination negatively impacts health and creates associated health disparities (Wiking et al., 2004; Williams and Mohammed, 2009). It is possible that medical mistrust among migrant populations is influenced by the level of acculturation and perceived discrimination. However, very little research has explored how acculturation and discrimination influence migrants' trust of the healthcare system.

To examine these issues this study, using African migrants in Australia as a case study, examined psycho-social and demographic factors as correlates of medical mistrust. We hypothesised that medical mistrust will vary according to the type of acculturation, perceived discrimination faced in the host community, and migrants' socio-economic status.

## 2. Methods

This was a cross-sectional study of sub-Saharan African migrants and refugees living in Victoria and South Australia. The

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