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Seeking affective health care: Korean immigrants' use of homeland medical services

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ABSTRACT

This paper explores the phenomenon of migrants returning to their country of origin for health care. Specifically, it examines the case of Korean immigrants to New Zealand making trips to their homeland to obtain medical operations. We situate our inquiry at the intersection of literatures on home, therapeutic spaces and health care consumption. Using semi-structured in-depth interviews we focus on the question of why and how first-generation Koreans in Auckland, New Zealand, seek medical services in their country of birth. Narratives suggest that the immigrants' decisions are shaped by interactions between agency (self) and structure (society) that occur across transnational social fields. Strong preferences for decisive and comprehensive treatment in culturally comfortable settings are revealed. The study highlights a particular link between health and place: that if financially able, immigrant patients will seek not only effective, but also affective medical care.

1. Introduction

This paper examines reasons why first generation Korean immigrants to New Zealand choose their homeland for medical operations. Most literature to date linking health and place for migrants has focussed on everyday practices and the assertion of agency in fostering well-being within spaces of resettlement (Lawrence and Kearns, 2006; Dyck and Dossa, 2007). Invariably, the migrants under consideration have been engaged in a struggle to (re)create health with limited resources and opportunities for travel. Other work has examined interactions between migrant patients and doctors, concluding that styles of communication and underlying discourses can shape relationships and health outcomes (Kokanovic and Manderson, 2007). Our exploratory paper focuses on the health care-seeking behaviour of better resourced migrants whose choices to access hospitals in their homeland require international travel. While there is a limited literature on 'medical tourism' (Connell, 2006; Ramirez de Arellano, 2007; Turner, 2007) and specifically the growing phenomenon of 'transplant tourism' (Cohen, 2009), brief return trips to a home country principally for health care purposes cannot be regarded as tourism *per se*. Rather, deeper reasons must be sought for this utilitarian travel undertaken in search of acceptable medical care in the context of familiar people and places.

Beyond its placement within health and cultural geography there is also an applied aspect to our paper. Given the cultural barriers faced by new immigrants, the study offers insights into the practical and perceptual obstacles faced by new settlers with respect to their host nation's health care services. Hence, we offer a modest contribution to the growing literature on 'cultural competency' which refers to the understanding and empathy needed between health care providers and patients of different ethnic, or cultural backgrounds (Johnston and Herzig, 2006; Betancourt et al., 2005).

The paper is organised as follows. Section 2 provides a contextual overview of the study's sample population and sets the scene by sketching the health care systems of Korea and New Zealand. The third section outlines theoretical perspectives that help *place* the question addressed by the study, drawing on ideas of transnationalism, home, therapeutic landscape and consumption spaces. Section 4 presents the methods and the study population. In Section 5, we present and discuss the findings, exploring various reasons behind Korean immigrants' decisions to return to their homeland for medical operations. We conclude with reflections on the accommodation of affect and consumption spaces into the study of health care behaviour, as well as the study's implications for incorporating diversity and cultural competence within host nation health systems.

2. Context

2.1. The Korean community in New Zealand

Koreans have been one of the fastest growing ethnic groups in New Zealand, with a 'new wave' of migrants arriving in the early 1990s. This wave peaked in 1995, declined in the late 1990s and then increased again in the 21st century (Lidgard and Yoon, 1998;

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Friesen, 2008). This movement has paralleled the emigration of large numbers of middle-class Koreans to other English-speaking countries over this period (Friesen, 2008). In New Zealand, the dramatic increase is illustrated by the fact that only 930 Koreans were enumerated as usual residents in 1991, but by 2006 this number had grown by more than 30 times, to 30,792 (Statistics New Zealand, 1991, 2006). The recent status of this migration means that 94 percent of all Koreans in New Zealand are either first or 1.5 generation migrants and 87 percent have lived in New Zealand for less than 10 years (Chang, 2006). This population is also highly concentrated in the largest metropolitan area, Auckland (2008 population 1.4 million), where about two-thirds of the Korean population of New Zealand reside (Friesen, 2008).

In New Zealand, Koreans are a relatively young and skilled immigrant group. Most came to New Zealand under the 'points system' established in 1991, which prioritised education and experience. Hence high proportions of Korean immigrants are well educated and many were previously employed in skilled occupations in their home country (Lidgard and Yoon, 1998). Despite this, Koreans in New Zealand have experienced one of the highest rates of formal unemployment, which was a surprise to many since they expected that their qualifications would find them work under the points system (Beal and Sos, 1999). However, unable to find formal employment commensurate with their skills, many became self-employed, establishing small businesses such as dairies (aka grocery), restaurants, souvenir shops, cafes, travel agencies and hair salons (Lidgard, 1996). As education and income levels correlate with health status (Curtis, 2006), it is not surprising that the health status of Korean immigrants is not considered problematic at a population level (Rasanathan et al., 2006; Ministry of Health, 2006). However, many Korean immigrants have, and are, experiencing under-employment and this may contribute to mental ill-health (Spoonley et al., 2003; Yoon and Boyer, 1995; Tan, 2008; Ho et al., 2003).

While concerns about health inequalities in New Zealand are primarily and justifiably focused on Maori and Pacific Island people (Dew and Kirkman, 2002), a more recent focus has been on Asian health (Ngai et al., 2001; Ministry of Health, 2006; Tan, 2008). In 2003, representatives of Asian communities in New Zealand launched an 'Asian Public Health Agreement' in order to address the health needs of Asian people (Ministry of Health, 2003). Notwithstanding the problematic nature of the term 'Asian' (a singular category that includes diverse ethnicities and immigrant generations), a major concern in these studies is the inclusion of recent skilled migrants' health status within the same category as longer-term residents (Rasanathan et al., 2006). This 'healthy immigrant effect' has been identified as a problem in several studies because it hides the low health status of many other sub groups such as those of refugee origin (Rasanathan et al., 2006; Ministry of Health, 2006). Although recent migrants' health status is not seen to be as worrying as is the status of New Zealand-born Asians or refugees (Ministry of Health, 2006), inattention to these skilled immigrants' specific health needs risks creating an 'elitism' in health services.

2.2. Korean and New Zealand health care systems

Once in a new country, challenges emerge for providers and migrant-users of medical care. One study, for instance, reported that 'part of the difficulty in servicing Koreans is that they continue to have the same expectations of health care as they had when in their home country' (Han and Davies, 2006, p. 418). First generation Korean immigrants are therefore positioned within a transnational health care structure whereby they have access to the health care information from both their home and host societies. Perceived and actual differences in certain types of health care practices between their home and host nations thus play significant roles in their health-decision making processes.

The health care systems in Korea and New Zealand differ. A recent OECD report shows that there are three distinctive features of health care provision in Korea: the domination of the private sector; paying patients' unconstrained choice of provider; and the limited functional differentiation of providers (Noh et al., 2006). Private sector domination means that most Korean patients are likely to freely choose their medical providers. With respect to 'limited functional differentiation', in Korea, many hospitals are large-scale even if they are privately owned, and they often provide a variety of specialist care within single large hospitals. These large general hospitals, or 'Jong-hap', facilitate easy visits for various check-ups if a patient has multiple conditions (Lee, 1996). If a physician is unsure about their patient's illness, they can refer the patient to a different specialist usually on the same day. This reduces the time involved in visiting another specialist and makes for a quicker general health check-up (Park, 2006; Kang, 2001). Hospitals with known corporate names like Samsung are increasingly present in the Korean medical-market (Noh et al., 2006).

The different character of the health care system in New Zealand, compared with Korea, may well cause confusion for newcomers. Generally a patient visits a general practitioner (GP) as a first point of contact and once the GP has dealt with the conditions within their expertise, the patient is referred elsewhere. While this system can reduce the long waiting list for specialists and direct patients to the appropriate provider, the system has also been criticised for creating anxieties among patients. For this reason, there has been a call for increasing subspecialisation within general practice in New Zealand in the hopes of reducing patient referral. Yet the need for this restructuring is debatable. Should GPs spend time and money to gain specialist training and acquire medical equipment for infrequent use? (Chan et al., 2002). This dilemma is not apparent in Korea because all family doctors are specialised in internal diseases which takes an additional 4-year degree. Also, there are only a small number of family doctors in Korea as the GP referral system has only been recently introduced with little or no success (Park, 2006; Kang, 2001). These differences mean that Koreans making New Zealand their home are likely to carry with them perceptions and expectations generated in their homeland.

3. Linking home, migrants and medical care

3.1. 'Home' and well-being in a transnational context

Home is 'a matrix of social relations' (Valentine, 2001, p. 63) that embraces socially and culturally constructed meanings and provides a sense of belonging. It is generally agreed that home is as much a 'feeling' as a physical place where one experiences attachment and is able to gain a sense of security, belonging and identity (Easthope, 2004). The meanings of home arguably become more complex and multi-dimensional in the context of transnational migration, and are central to migrants' lives (Wiles, 2008). Indeed, living as a migrant, one is often situated such that belonging to the mainstream society is always contested through policy and social norms. In this sense, people's social behaviour or searching for 'homeness' and familiar places is much more dominant within immigrant societies (Jackson and Penrose, 1993).

The participants in this study can be regarded as 'transnationals' because their lives reflect linkages in which immigrants build up and sustain numerous economic, political, social and cultural connections between their home and host nations