Social Science & Medicine 168 (2016) 93–100

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

First-generation Korean immigrants' barriers to healthcare and their coping strategies in the US

Sou Hyun Jang

City University of New York (CUNY), Graduate Center, Department of Sociology, 365 Fifth Ave, New York, NY 10016, United States

ARTICLE INFO

Article history:
Received 19 January 2016
Received in revised form
29 August 2016
Accepted 7 September 2016
Available online 8 September 2016

Keywords:
United States
Mixed-method approach
Korean immigrants
New York-New Jersey Korean community
Barriers to healthcare utilization
Co-ethnic doctors
Hanbang
Medical tourism

ABSTRACT

This paper examines first-generation Korean immigrants' barriers to healthcare in the US and their strategies for coping with these issues by analyzing survey data from 507 Korean immigrants and in-depth interviews with 120 Korean immigrants in the New York-New Jersey area. It reports that more than half of Korean immigrants have barriers to healthcare in the US, with the language barrier being the most frequent response, followed by having no health insurance. Korean immigrants are not passive, but rather active entities who display coping strategies for these barriers, such as seeing co-ethnic doctors in the US, seeking *Hanbang* (traditional Korean medicine) in the US, and taking medical tours to the home country. However, their coping strategies are far removed from *formal* US healthcare as their behaviors are still restricted to the informal healthcare within the ethnic community or home country. This study methodologically and theoretically contributes to the literature on immigrants' healthcare behaviors by using a mixed-method approach and developing a specific framework for one particular immigrant group.

1. Introduction

Since the 1980s, Asian Americans have been portrayed as a "model minority" by the media and scholars, particularly for their higher educational attainment than the general population in the United States (US) (Chen, 2010; Osajima, 2005; Poon et al., 2015; Suzuki, 1977). However, despite their image of having higher socioeconomic status, Asian Americans fall behind non-Hispanic whites in health fields, including health insurance rates and healthcare utilization rates (Brown et al., 2000; De Alba et al., 2005; Smith and Medalia, 2014; Stella et al., 2004). Moreover, when foreign-born Asians are analyzed separately from US-born Asians, they show even lower rates of health insurance and healthcare utilization than their US-born counterparts and non-Hispanic whites (Brown et al., 2000; Stella et al., 2004).

Korean Americans are not an exception to this model minority myth, particularly in health fields. For example, they have lower health insurance rates (Anderson and Bulatao, 2004; Huang, 2013), which has a negative effect on their healthcare utilization in the US (Derose et al., 2007, 2009; Jang et al., 2005; Ryu et al., 2001). According to the 2009–2011 American Community Survey (ACS) data, about 74% of foreign-born Koreans are insured while 89% of US-born non-Hispanic whites are insured. When compared to other Asian groups, Korean immigrants are still more likely to be uninsured than other Asian immigrant groups (Carrasquillo et al., 2000; Ryu et al., 2001). Analysis of the ACS data confirms that foreign-born Chinese (83%), foreign-born Indians (89%), and foreign-born Filipinos (89%) show higher insured rates than Korean immigrants. In addition to the uninsured status, Korean immigrants' language difficulty is a significant barrier to access to healthcare. For example, some studies have found a negative association between Korean immigrants' poor English proficiency and their healthcare utilization in the US (De Gagne et al., 2014; Juon et al., 2000).

Despite Korean immigrants' barriers to formal healthcare in the US, most earlier studies have focused on explaining the barriers themselves rather than examining how Koreans behave to cope with the barriers. Moreover, previous studies have used either quantitative data or qualitative data to examine Korean immigrants' healthcare behaviors in the US. Thus, using a mixed-method approach, this paper intends to bridge the gap in research on

E-mail address: sjang1@gradcenter.cuny.edu.

http://dx.doi.org/10.1016/j.socscimed.2016.09.007
0277-9536/

Korean immigrants' healthcare utilization and their coping strategies. Traditionally, the term coping strategy has been widely used in the field of psychology, to refer to an effort to solve problems and minimize stress (Lazarus and Folkman, 1984; Zeidner and Endler, 1996). However, in this paper, coping strategy will be construed as immigrants' behavioral strategies to cope with their barriers to formal healthcare in the destination country, as in previous studies on minority health (Torsch and Ma, 2000; Portes et al., 2012).

This paper has five main objectives. First, it examines Korean immigrants' barriers to formal healthcare in the US. Second, it identifies Korean immigrants' various strategies to cope with these barriers, and determines whether different types of coping strategies are associated with different barriers. Third, it investigates whether their coping strategies are inter-related. Fourth, it tests to see whether the previous model of immigrants' coping strategies with respect to healthcare (e.g. Portes et al., 2012) applies to Korean immigrants. Last, based on the findings, it develops a particular framework for Korean immigrants' strategies to cope with healthcare barriers in the US.

2. Literature review

Scholars have commonly pointed out three types of barriers to immigrants' healthcare utilization: structural, financial, and personal. First, structural barriers include limited chances to meet doctors who share the same culture, language, and race/ethnic background. An individual is more likely to choose a doctor of the individual's same race or ethnicity (Gray and Stoddard, 1997; LaVeist and Nuru-Jeter, 2002; Saha et al., 2000), and to feel higher satisfaction with the doctor-patient relationship if the doctor and patient share the same culture and language (LaVeist and Nuru-Jeter, 2002; Saha et al., 2000). However, most immigrants have fewer chances to meet doctors who share their language or culture than native-born white Americans due to the small number of immigrant doctors; this circumstance may lead to misunderstanding and frustration for them (Kraut, 1990; LaVeist et al., 2003; LaVeist and Nuru-Jeter, 2002; Takada et al., 1998). Structural barriers also include geographic proximity to hospitals, locations of hospitals, and access to public or private transportation to hospitals. In addition to these structural barriers, financial barriers to immigrants' healthcare include poverty, lack of financial resources, and lack of health insurance. Many scholars have found that immigrants' uninsured status plays a negative role in their access to healthcare (Derose et al., 2007, 2009; Jang et al., 2005; Yoo and Kim, 2008).

Moreover, personal barriers, such as the level of acculturation (Abraido-Lanza et al., 2005; Arcia et al., 2001; Gorman et al., 2010; Salant and Lauderdale, 2003), perceived discrimination (Jang et al., 2005; Viruell-Fuentes, 2007; Yoo et al., 2009), limited language proficiency (Hu and Covell, 1986; Jang et al., 2005; Kim et al., 2011; Wu et al., 2009), and cultural differences (Jenkins et al., 1996; Kung, 2004; Wu et al., 2009) have been associated with lack of access to healthcare. In particular, previous studies have found that culture and language have a big impact in the provision of health care, such as the doctor-patient relationship (Ferguson and Candib, 2002; Flores, 2000; LaVeist and Nuru-Jeter, 2002) and the use of complementary and alternative medicine (Bodeker and Kronenberg, 2002; Hsiao et al., 2006; Kronenberg et al., 2006; Ma, 1999), especially among minority patients. For example, reviewing articles published from 1966 through 2000, Ferguson and Candib (2002) found that it is more difficult for minority patients to build rapport with doctors and to receive empathic responses from them due to doctors' lack of cultural competence and minority patients' limited English proficiency. Ma (1999) also found that Asian immigrants, including Chinese immigrants, tend to hesitate to openly discuss their cultural practices with Western doctors, making cultural competence one of their major barriers to healthcare. Consequently, Chinese immigrants look for co-ethnic doctors or use practitioners of traditional Chinese medicine.

To cope with these structural, financial, and personal barriers to formal healthcare in the US, immigrants display several behavioral strategies. First, going to free clinics or community health centers has been used as a coping strategy, especially among undocumented or uninsured immigrants, because these clinics offer free (albeit limited) medical care without asking about patients' legal status or insured status (Kamimura et al., 2013; Okie, 2007; Portes et al., 2012). Second, immigrants often seek co-ethnic doctors, especially when they have language barriers, cultural barriers, or limited knowledge of Western medicine (Choi, 2013; Wang, 2007; Wang et al., 2008; Zhang and Verhoef, 2002). Previous studies have pointed out that Asian Americans with limited English proficiency are more likely to see co-racial doctors (LaVeist and Nuru-Jeter, 2002), and Korean immigrants prefer Korean doctors, mostly due to the language barrier (Choi, 2013; De Gagne et al., 2014; Son, 2013).

Using complementary and alternative medicine (CAM) is another coping behavior among immigrants. Although the use of this informal type of medical care is related to a group's own culture (Hsiao et al., 2006), immigrants who have barriers to formal healthcare are still more likely to use CAM (Akresh, 2009; Han, 2001; Hill et al., 2006; Kim and Chan, 2004; Portes et al., 2012; Pourat et al., 1999; Wu et al., 2007). Some Korean immigrants also utilize *Hanbang*, a non-Western form of Korean traditional medicine. *Hanbang* is known by various names, including CAM, traditional medicine, oriental medicine, and folk medicine. Han (2001, p. 146) defines it as traditional medicine that "originated in China and indigenized in Korea." According to Hill et al. (2006), a significant proportion of Korean immigrants (23% of males and 29% of females) have used traditional remedies as a healthcare option in California. Korean immigrants' use of *Hanbang* is associated with barriers to formal healthcare, such as the language barrier, a low level of acculturation, and uninsured status (Han, 2001; Hill et al., 2006).

The last distinctive coping strategy is returning to the home country to seek medical care. Scholars have found that some Mexican immigrants take medical tours to the home country due to the lack of health insurance in the US (Bastida et al., 2008; Bergmark et al., 2010; Brown, 2008). For Korean immigrants, cultural and language barriers, lack of health insurance or limited coverage, and having to take long domestic trips to see Korean doctors within the US have contributed to their decision to engage in medical tourism (Lee et al., 2010; Oh et al., 2014; Wang and Kwak, 2015).

Considering different types of barriers, and especially responding behaviors, Portes et al. (2012) established a framework for immigrants' coping strategies. According to their categorization, four major coping behaviors are based on different types of barriers and situations. First, when immigrants have cultural-linguistic barriers, they tend to see co-ethnic healthcare professionals. Second, when immigrants are uninsured, they are likely to seek folk medicine or see unlicensed doctors. Third, if newcomers cannot access federal health programs, such as Medicaid and Medicare, they tend to go back to the home country for medical care or use free clinics. Last, undocumented immigrants tend to seek folk