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The self-perceived health status and access to health care services among Korean immigrants in Ottawa, Ontario

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THE SELF-PERCEIVED HEALTH STATUS AND ACCESS TO HEALTH CARE SERVICES
AMONG KOREAN IMMIGRANTS IN OTTAWA, ONTARIO

by

Sang-Mi Suh, BA, University of Toronto, 2008

A Major Research Paper
Presented to Ryerson University

In partial fulfillment of the requirements for the degree of

Master of Arts
In the Program of
Immigration and Settlement Studies

Toronto, Ontario, Canada, 2009

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Masters of Arts
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ABSTRACT

The objectives of this paper were to examine the current self-perceived health status of Korean immigrants and identify their health determining factors, particularly the impact of acculturative stress. Also, the use of primary health care services in Canada and the choice of participants' alternative use of health coping strategies were also under careful scrutiny. A qualitative approach was used based on focus groups and analysis was set within the population health perspective. The results indicated that acculturative stress was a major health- determining factor among participants. High acculturative stress and barriers to using Canada's primary health care system increased patterns of demands for outside of primary health care system, such as access to emergency department services. Also, continuously experienced difficulties in using the regular health care services, the Korean participants chose to utilize their high transnational activities and accessed medical services in their homeland.

Key words: Self-perceived health status; acculturative stress; immigrant health; health care utilization pattern, transnational health care.

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Chapter1: INTRODUCTION

Canada receives roughly 250,000 immigrants each year and over 6 million Canadians (about 19.8%) are foreign born (DesMeules et al., 2004; Census 2006, Statistics Canada). This means that one in five Canadians is born outside the country, and this number in 2006 was the highest in 75 years (Census 2006, Statistics Canada). Among the over 6 million foreign-born Canadians, more than 5 million are members of visible minorities (Census 2006, Statistics Canada). Steadily increasing numbers of immigrants also show a clear pattern of preference for the province to settle in Ontario and it became “the province of choice for more than half (52.3%) of the 1.1 million newcomers during the 2001-2006 period” (Census 2006, Statistics Canada). Ontario also has the highest percentage (28.3%) of population who were born outside of Canada (Census 2006, Statistics Canada). Jasso, by using neoclassical economic theory, explained that health is one of the necessary component to reap the reward of the investment in migration (Jasso, 2003). Thus, researching immigrants’ health is crucial for Canada to ensure the well being of immigrants to maximize the returns to its large-scale immigration program. Moreover, by ensuring the health of immigrants, it will consequently enhance the settlement/immigration experience for immigrants.

The health status of these increasing numbers of recent immigrants immediately upon their arrival in Canada, particularly of economic class immigrants, is generally “healthier than native-born population,” both because they have passed a rigorous medical screening process and because healthy individuals are more likely to choose to migrate (Beiser, 2005; Newbold, 2005). However, many research reports have claimed that this health advantage of recent immigrants diminishes with the increasing length of their residence (Newbold, 2005; McDonald & Kennedy, 2004; Pottie et al., 2008; Ng et al., 2005; Beiser, 2005; Hyman, 2001; et al.). This observation on immigrants’ health deterioration over time is called the “healthy immigrant effect” (Hyman, 2001). The existing literature studied whether immigrants lose their health advantage over time and attempted to provide reasons for immigrants’ health deterioration.

The objective of this paper is to explore two separate but interrelated sphere of self-perceived health status and health care utilization patterns among Korean immigrants in Ottawa Ontario. To conduct this research, four focus groups of 22 Korean economic class immigrants living in Ottawa, Ontario, were used. The main questions that were asked during the focus group discussions were on the topics of self-perceived health status, experiences of using the comprehensive health care system that includes primary health care system (family doctor, walk-in clinics) as well as other levels of care (such as hospitals, emergency room and specialist care) and finally, use of any alternative health coping strategies. I then further explored the self-perceived health status of Korean immigrants by asking questions on acculturative stress (levels of social capital and language skills) and changes in lifestyle (change in eating habits and frequency of physical activity). Acculturation, which refers to the cultural change that is “marked by physical and psychological changes due to the adaptation required in diet, climate, housing, interactional styles, norms, and values to a new culture” (Nwadoria & McAdoo, 1996) was a key theme in exploring self-perceived health status. Acculturation, particularly the acculturative stress and change in lifestyle were reported to be major factors affecting immigrants’ health in the existing literature (Ng et al., 2005; Noh & Kaspar, 2003). The participants’ experiences of using the health care system were collected by asking about positive experiences and any barriers they had experienced while using family physicians, walk-in clinics, emergency rooms and specialists. Lastly, participants’ alternative health coping strategies were explored by asking how participants dealt with the barriers they experienced while accessing health care system. Socio-demographic variables such as age, gender, marital status, living arrangement were taken into consideration in analyzing the data set.

I chose the population health perspective for this research. The population health perspective is commonly used to address a wide range of health issues, suggesting that the major determinants of health status are cultural, social and economic factors rather than medical care input and use (McDonald & Kennedy, 2004). Throughout the paper this perspective will emphasize that socio-

economic status and its related factors of class, gender, race, ethnicity, and age differences have a major influence on health status (Dunn & Dyck, 2000). This paper has six chapters. The first chapter reviews the literature on immigrants' health, particularly on the determinants of health and barriers in utilizing health care system. The second chapter provides a brief overview of the characteristics of the immigrants that the city of Ottawa receives, and of Korean immigrants in Canada. Socio-demographic information on the participants and their current health status will be presented. The third chapter will discuss the methodology of the research, followed by extensive analysis of the data provided by the focus groups in the fourth chapter. The fifth chapter will include findings and results, highlighting the interrelationship between the participants' self-perceived health status, acculturation stress, barriers to accessing health care and alternative health coping strategies. The results will indicate that many participants experienced acculturation stress, which resulted in mental and physical health deterioration and creation of a unique alternative health seeking behaviours. The final chapter will include the policy implications of this research.

Chapter 2: Study area and study population: The Korean immigrants

I chose Korean immigrants living in Ottawa as participants for this study to focus on the health of racialized immigrants who enjoy a higher income and education level. Many existing studies have studied extremely disadvantaged racialized immigrant populations who are suffering from a deterioration of health due to poverty and substandard living conditions (Noh & Kaspar, 2003). Results from researches on less privileged racialized immigrants have already confirmed that socio-demographic characteristics do have an influence on immigrants' health (Dean & Wilson 2009; Dunn & Dyck, 2000; Noh & Kaspar, 2003).

Through this research, I was interested in finding out how highly educated immigrants with high incomes, that is higher than the average Canadian household income of \$52,550 (City of Ottawa, 2009), perceive their health status and also maintain their health by utilizing the primary health care system. I chose Ottawa as the main location of the study because immigrants living in Ottawa are mostly economic immigrants with high education and income levels. Unlike immigrants living in other large immigrant-receiving cities such as Toronto, Vancouver, and Montreal, almost half (49.2%) of all immigrants in Ottawa are economic immigrants, and it has "the highest percentage of immigrants with a university degree among Canada's large cities" (City of Ottawa, 2009). In addition, many immigrants are involved in highly skilled occupations and receive higher incomes than in any other metropolitan city centres in Canada. The recent statistics revealed that, "the average salary of a recent immigrant male aged 25-54 in Ottawa-Gatineau was \$42,344, or 81% of the average \$52,550 for a Canadian-born male in the same age group" (City of Ottawa, 2009). Also, recent immigrant female in the same age group "earned an average of \$27,145, or 72% of the average \$37,587 for a Canadian-born female" (City of Ottawa, 2009). These figures on average earnings of employed males and females in Ottawa are noticeably higher than other metropolitan areas like Toronto where employed male immigrants earns \$35.202 and \$23.405 for female immigrants (City of Ottawa, 2009).

Official statistics on the average income of economic class Korean immigrants in Ottawa are not available, therefore I assume that for this research, Korean immigrants did fall into the high socio-demographic categories, that is immigrants with university education and having a household income ranging between \$80,000 or more for three or more people per house (Perez, 2002). Also, the Korean community is an important one to study, because it is a fast growing community. According to Statistics Canada, there are over 100,000 Koreans living in Canada, and the Korean community is the seventh largest non-European ethnic group in Canada (Census 2006, Statistics Canada). Between 1996 and 2001, the number of Koreans living in Canada rose by 53%, whereas the overall population grew by only 4% (Census 2006, Statistics Canada). However, not much academic research has been conducted on Korean immigrants in Ottawa with their health status as a particular focus of the study.

Table 1. Socio-demographic file of participants vs Korean community in Canada

Participants		All Korean immigrants in Canada	
Gender (Male & Female)	41%, 59%	49.1% , 52.6%	
Age			
Under 15	0	21.9	18.4
15-24	0	21.4	20.5
25-44	45.2	30.4	36.2
45-64	54.5	22.3	20.0
65+	0	4.1	4.9
Marital Status			
Married	73	54	
Single	27	N.A	
Other (lone parent, Common-law)	0	5%	
Education Level			
Less than High School	0 0	16.3	17.9
Completed High School	0 0	9.1	12.7
Some Post-Secondary	0 9.1	18.2	17.6
Completed Post-Secondary	100 90.1	41	33.8

Language Proficiency		
Conversion in English	100	89
Carry a conversation in English	96.4	82
Bilingual in English and French	9.1	6
First language other than English or French	100	85
Employment Status (aged 15 or older)		
Employed	31.8	51
Paid workforce	18.2	52
Self-Employed	13.6	31
Unemployed	68.2	8.9
Household Income		
Low-income cutoff	0%	43%
Average household income	\$80,000-100,000	\$20,114.5

Source: Census 2006, Statistics Canada

Chapter 3: Literature Review

Many researchers have observed the declining immigrants' health with the increased length of their residence and tried to identify the determinants to their changes in health. The following literature review is divided into two subsections to understand the changes in immigrants' health status and their access to health care system. First, by using the population health perspective, I looked at how socio-economic factors and the resettlement stress shaped immigrants' health status. Then, I examined how barriers in accessing health care system and aging factor negatively influenced the health status of immigrants.

3.1 Literature on immigrant health

According to many studies, health and socio-economic position has been affecting non-European immigrants more significantly as more immigrants (30%) are living in poverty during their first 10 years in Canada (Reitz, 2007; Sweetman & Warman, 2008; Bauder, 2003). Also, according to Maclean et al., (2004) "in recent years, differences in health outcomes by socio-economic position have been recognized as a persisting trend in public health" (p.5). It has been studied that the increased mortality risk is associated with low levels of income and education and it has been affecting both immigrants and non-immigrants (McDonald & Kennedy 2004; Newbold, 2004). In fact, Newbold and Danforth (2003) found that the socio-economic and socio-demographic factors were closely associated with the health status of immigrants in a way that was different from non-immigrants. Factors including income, home ownership, gender, social support, working status were significantly affecting immigrants to report their health status to be poorer than non-immigrant populations (Newbold & Danforth, 2003). For instance, the stress that arises from experiencing barriers relating to foreign credential recognition, lack of access to language training programs that results in economic disadvantage were strongly affecting how immigrants perceived their health status, which was not shared by the host population (Newbold & Danforth, 2003). In addition to self-assessed health status of immigrants, marginalized socio-economic status of recent immigrants (post 1980s) also "compromised survival rates in diseases such as cancer" (Beiser, 2005; Kliever,

1997). Furthermore, the socio-economic factor was noted to influence the “quality of care” (Beiser, 2005). Carter’s study examined the impact of the different quality of care between white and black diabetes patients in the U.S. and concluded that “blacks with diabetes have more amputations than whites and diabetes-related mortality is increasing more quickly among minorities than among majority culture populations” (Carter cited in Beiser, 2005, p7).

Although the immigration policy emphasizes the human capitals that immigrants bring into the country, very little attention has been paid to the impact of employment circumstances on the health of immigrants (Dean & Wilson, 2009). Dean and Wilson found that both unemployment and underemployment, which are associated with “lack of income, loss of employment-related skills, and a loss of social status” had negative impact on the mental health of all 22 participants (Dean & Wilson, 2009). The deteriorated mental health negatively impacted their physical health, which resulted in “physical pain and strain, increased in blood pressure and weight loss” (Dean & Wilson, 2009, p189). It was interesting to note that the employment status of the participant was directly linked to the health of family members. For example, the stress from lack of work and income is shared between family members and it subsequently deteriorated the mental health status of the all members of the family (Dean & Wilson, 2009).

There are two crucial contrasting arguments concerning the claim that “employment is correlated with positive health, while unemployment is related to poor health” (Dean & Wilson, 2009, p187). Newbold argued that employment raises the health status (self-reported and physical functioning) compared to those who are unemployed and the low-income individuals, who were more likely to report transition to poor health (Newbold 2009). Cai and Kalb (2006) further claimed that employment improves mental health by raising self-confidence, life satisfaction level and happiness. A contrasting argument to Newbold and Cai & Kalb highlighted the “‘healthy worker effect’, which suggests that individuals with better health tend to seek employment more so than those who are unhealthy” (Dean & Wilson, 2009 p.188).

Resettlement stress had a high impact on the health status and the health system utilization behaviour of immigrants. Beiser calls this study the resettlement stress paradigm and explained the phenomenon called immigrant overshoot; the immigrants' health deteriorates even more than the members of the receiving society (Beiser, 2005). The type of stresses that were related to resettlement included unemployment, poverty and lack of access to services (Beiser, 2005). For instance, new arrivals who are from non-traditional source countries "may feel overwhelmed" from utilizing Western medicine due to their unfamiliarity with the system, language and cultural barriers as well as racism and discrimination that are not experienced with the host population (Newbold & Danforth, 2003).

3.2 Literature on barriers to accessing health care services

McDonald and Kennedy (2004) presented a result that there might be a link between language and cultural barriers and the health status of immigrants. The study compared chronic conditions among immigrants between "English speaking country" (ESB) and "non-English speaking country" (NESB) and concluded that newly arrived immigrants from ESB countries had very similar incidence of Type A conditions to native-born levels without increasing incidence in chronic conditions with additional years in Canada (McDonald & Kennedy, 2004, p.1621). The authors explained that this situation can be explained that because ESB immigrants "come from countries with similar culture and language to Canada, they would be least likely to experience barriers to accessing healthcare after migration" (McDonald & Kennedy, 2004, p.1621).

The study by Wang and her colleagues (2008) conducted focus groups and surveys on ethnic Chinese living in Toronto and confirmed the existence of culture and language barriers in using health care. The overwhelming majority of respondents (59%) from the questionnaire survey indicated that they "feel more comfortable" in communicating with doctors in Mandarin only, and only 3% preferred English speaking physicians (Wang et al., 2008). Further, "culturally specific health care" was desired and used among Chinese immigrants (Wang et al., 2008, p.1418). Medical

terminologies in Chinese and physician knowledge in concepts that stems of Taoism such as “the use of Yin-Yang balance, internal energy or Chi” was strongly desired by Chinese in discussing their medical symptoms (Wang et al., 2008). Furthermore, the report found that there was a discrepancy between preference for Mandarin-speaking physicians (59%) and the actual proportion who had Mandarin-speaking physicians (38%). The report clearly stated immigrant health care seeking behavior and the mismatch between the demand and supply of those language and culture sensitive physicians.

Pottie and colleagues (2008) also used a language as a determinant to self-perceived health status of immigrants by using a cross-sectional analysis of the first two surveys of the Longitudinal Survey of Immigrants to Canada (LSIC). The study looked at the relationships among language proficiency, gender and self-reported health and found that “poor language proficiency more often reported poor health than those with good language proficiency (5% versus 2%)”, even when controlling for a range of characteristics such as health care and job satisfaction (Pottie et al., 2008). Again, surprisingly, the language proficiency did not affect the self-reported health of men (Pottie et al., 2008). Although the research gave an insight to the fact the most frequently reported barriers in accessing health care services are language and culture amongst immigrants and refugees in Canada (Pottie et al., 2008). Limited English proficiency was also found to create barriers to preventive health care by Brennfleck (2001). The report presented a finding that while 63.8% of Korean women who were fluent in English, reported having a mammogram within the previous two years, whereas the figure dropped to 45% among women with limited linguistic proficiency in English (Brennfleck, 2001).

Age was also a contributing factor to the decline in immigrants’ health while in Canada (Pottie et al., 2008). Immigrants of European origin compared to those of non-European origin are more likely to report poor health status, a chronic condition, which attributed to the fact that European immigrants are much older, on average, than non-European immigrants (Dunn & Dyck,

2000). Ali also acknowledged through her study that age increases the probability of illness for everyone, but aging factor affected immigrants more significantly than the native-born (Ali, 2002). The health status discrepancy between the older group (50 or older) and younger group (less than 30) was more noticeable than the difference between older and younger group in the general host population (Ali, 2002).

The literature reviewed highlights that language and cultural barriers, socio-economic status, aging process and the knowledge of utilizing unfamiliar health care system could have a negative impact on the racialized immigrants' health status. Yet there is a gap in the literature of immigrants' health research concerning the impact of immigrants' health when immigrants bring their extremely diverse health behaviours and unique lifestyles, shaped by their places of origin, to their new country (Noh & Kaspar, 2003). Immigrants also arrive in Canada with various pre-migration socio-economic and demographic characteristics such as education and entry status (Noh & Kaspar, 2003). They then go through the process of adaptation and acculturation according to their capacity. These factors also have a different impact on their health status and use of health services. This is especially true when different classes of immigrants (refugees, economic and family immigration classes) are studied and are seen to have different health outcomes from each other (McDonald & Kennedy, 2004). Thus, more research focusing on ethnicity, socio-demographic status and cultural subgroups should be conducted in a future research (DesMeules et al., 2004, p.1).

This research focuses on ethnicity, immigrant status and socio-economic status to explore the two separate, yet interrelated spheres: self-perceived health status of racialized immigrants and their health care utilization patterns. Specifically, the objective of this paper is to observe how health determining factors, particularly, acculturation and use of health care system influence the self-perceived health status of Korean economic class immigrants in Ottawa, Ontario. The findings of this paper will contribute to the existing literatures on immigrant health by highlighting the need to sensitize the health care provisions to specifically correspond and meet the particular needs of

racialized immigrants' health. Also, unlike the literature on the broad trend of immigrants' health by using quantitative datasets (e.g. National Population Health Survey), this paper examines experiences, feelings and views on immigrants' self-perceived health status and identifying their use of health care (Wang et al., 2008).

Chapter 4: Methodology

I used focus groups to explore the two different yet interrelated spheres of the health status of Korean immigrants and the health care utilization patterns of the study's participants in Ottawa, Ontario. Specific questions were used to guide the focus groups' discussions. The questions included the following themes: self-perceived health status, health determining factors, barriers in accessing primary health care system, and health coping strategies. I used a qualitative research approach to capture in-depth information about their health status, experiences, feelings and views on any health-related changes that they experienced while living in Canada, and any factors that affected their health and their access to the medical care system. Self-perceived health status was used in this study to understand the health status of participants, because it is strongly known to be a "good proxy for health status" (Newbold, 2009, p.5) that is closely related to the physical health status of participants (their mortality, symptom reporting and health care utilization) as well their functional status (Dunn & Dyck, 2000; Pottie et al., 2008; Newbold, 2009).

Participants were recruited with the help of two key informants who are deeply involved with the Korean community in Ottawa. They used their social network to recruit participants. Also, the already recruited potential participants were asked to bring any others who might be interested in participating in the research. I confirmed all 22 potential participants, 9 male and 13 female, by phone and grouped them according to certain characteristics as described below. The participants were given a general idea of the discussion; exact questions were not revealed prior to the focus group meetings.

All participants were born in South Korea and were either permanent residents or Canadian citizens who are currently living in Canada. All 22 participants were divided into four groups representing different characteristics. Participants were divided according to their socio-demographic profiles to see whether age, gender, education, living arrangements, length of stay and income have an impact on their self-perceived health status. The eligibility criteria for participants were Korean

economic class immigrants currently living in Ottawa, aged from 19 to 59 with an experience of accessing the Canadian health system for at least a year with an OHIP card.

The first group was composed of six middle-aged (35-45) “astronaut housewives” who came to Canada less than five years ago and are currently living with their children. The so called “astronaut housewives” are members of astronaut family, which represents an arrangement found mostly in migrant Asian households. Astronaut families are “characterized by the head of the household living and working in the country of origin while the remaining family members reside in the host country (Canada)” (Aye & Bernard, 2001). All participants were depending on their spouses for financial support. The findings from this group would allow me to observe whether a living arrangement and a dual health care coverage in Canada and South Korea affects participants’ self-perceived health status and the use of health care system.

The second group was made up of five young adults (25-26). All of the participants in this group were long-standing 1.5 generations young adults immigrants, who arrived as youth (17 years or younger). The finding of this group would be compared with other older immigrants and this will be useful to identify how aging process affects one’s self-perceived health and use of medical care services. Only one female participant was currently working full-time; two male participants were currently unemployed, but with experience of working full time previously, and one male was a full-time student. This group was expected to experience the least aging effect in perceiving their health compared to the other groups that were composed of older immigrants.

The third group included six older (45-59) long-standing female immigrants. Two of the members of this group were employed or were working when this research was conducted. This group was created to observe and identify determinants to the health status of older long-standing female participants. Finally, the last group involved five long-standing 1st generation male immigrants (aged 35-59) to discuss the health status of male immigrants. Also, the findings from this group will explore how full-time working immigrants’ health is perceived differently from that of

unemployed female participants. Two in this group were self-employed, two were employees in the public and private sector, and one was unemployed.

On average, half of the participants fell into an age group of 25 and 44 while the other half was aged between 35 and 59. The majority (73%) of them were married. The education level of the participants was strikingly high: almost all of the participants had completed post-secondary education. While only limited numbers of the participants were employed full-time, the majority of participants nonetheless, had household incomes of \$80,000 to more than \$100,000. This is above the average household income of immigrants living in Ottawa. The employment rate among the participants is lower because 12 of the female participants were stay-at-home mothers. Household income was also distorted because three out of four participants who had less than \$50,000 household income were astronaut housewives who lived in two or three individual in a household and fully depended on financial income from their spouse in Korea. The rest of participants (18 out of 22) lived in a household of four individuals.

The focus groups took place in an office in the workplace of one of the key informants, as it was conveniently located for most participants. I assumed the role of focus group facilitator and each focus group lasted about 90 minutes. The discussions in Korean were audio-recorded and later translated verbatim into English for analysis. I am aware of the shortcomings of the focus group, that the findings may not be representative of all the visible minority groups living in Ontario. Also, there is a risk of facilitator bias, as I am a member of the Korean community group in Ottawa. Objectivity could thus become an issue with the findings from the focus group. However, because I am a Korean Canadian who is familiar with Korean culture and language, I was able to develop rapport quickly with the participants and so allow the research to be culturally competent (Flowerdew & Martin, 2005).

All participants were required to sign a consent form prior to the focus groups' discussion stating that they had agreed to participate in the research; the consent form promised them

confidentiality and anonymity. Participants were also informed that discussions would be recorded so that the material could be analyzed and that they could withdraw from the study at any time. A brief one-page survey was distributed upon the completion of the focus group discussions to collect the socio-demographic background information on the participants. Each participant was given \$15 cash as an honorarium and a light lunch was offered to participants after each discussion. Cash was chosen as the type of honorarium, because the majority of participants preferred it over any other kind of compensation, such as a gift card. Dean and Wilson suggested that “providing participants with compensation has become standard practice in many collaborative and community-based research projects” (Dean & Wilson, 2009 p.192). An excellent rapport was built in each focus group, and participants were very passionate about the discussion topics, which led to lengthy unofficial discussion (not included in the study), which continued after the formal focus group discussions on health and health care services in Canada had ended.

The findings from the focus groups were analyzed by using grounded theory. The grounded theory is used to analyze qualitative data by identifying themes within and across the focus group discussions (Dean & Wilson, 2009; Cope, 2005; Strauss & Corbin, 1998). After coding the transcripts line by line into a specific theme (for example, the language barrier), I identified important inclusive themes (for example, the unmet needs for medical care) that had been repeatedly raised or agreed on by several participants (Dean & Wilson, 2009). In an effort to overcome the limits of audio transcription and improve the subsequent analysis, I constructed a “sketch of group configuration ... indicating participants' names and their position in the room”, a strategy suggested by Flowerdrew and Martin (2005), by associating a number (for example P1 to P6) with each participant during the transcribing process.

Table 2. Socio-demographic profile of participants

	Total	Percent of total (%)
Focus group participants		

Total	22	100
Male	9	41
Female	13	59
Age		
25-34	5	22.7
35-44	5	22.7
45+	12	54.5
Marital Status		
Married	16	73
Single	6	27
Other	0	0
Education Level		
Less than high school	0	0
High school	0	0
Some post-secondary	2	9.1
Post-secondary	20	90.9
Language Proficiency		
Excellent	0	0
Very Good	5	22.7
Good	4	18.2
Fair	11	50
Poor	1	4.6
Employment Status		
Employed	7	31.8
Unemployed	15	68.2
Household Income		
Less than \$50,000	4	18.2
\$50-60,000	1	4.5
\$60-80,000	1	4.5
\$80-100,000	6	27.2
\$100,000 or more	7	31.8

(Headings suggested by Dean & Wilson, 2009).

Chapter 5: Conceptual Framework of self-perceived health status and health care utilization patterns

In this chapter, the following themes will guide the analysis of the focus group findings: self-perceived health status, health determining factors, barriers in accessing primary health care system, and health coping strategies. The conceptual framework will be used to explore how health determining factors and barriers in accessing health care system are interrelated to influence the self-perceived health status among the participants and shape their health coping strategies.

Figure 1. Conceptual Framework of self-perceived health status and health care utilization patterns

The conceptual framework was built upon the literature on immigrant health, particularly the “acculturation and immigrant mental health” by Noh, Kaspar and Hou (1997). This conceptual framework first explains that immigrants land in a new country with diverse pre-migration factors, such as age, sex, education level, professional experience and also experiences of utilizing health care system in their country of origin. Then, those newly landed immigrants face a demand to adapt into the new country and experience acculturation process. An acculturation is “defined as a cultural change that is provoked by the clash of two or more autonomous cultural systems” (Djuraskovic & Arthur, 2009, p.19). Also, acculturation represents “progressive adaptation” in which immigrants experience during their settlement period (Djuraskovic & Arthur, 2009, p.19). There are largely three main areas where immigrants undergo various changes to adapt into their new country and those changes are: cultural adaptation, lifestyle, health behaviour and physical environment and finally, quality of social capital. Both European immigrants and non-European immigrants experience acculturation period, however, the experience of acculturation of non-European immigrants may be more complex in Canada, due to their drastically different pre-migration circumstances, such as language and culture (Djuraskovic & Arthur, 2009, p.19).

The cultural adaptation refers to “the adoption of instrumental traits of Canadian culture such as language, education, skills training, participating in job searches, and learning how to use media and social services” (Noh & Kaspar, 2003, p.329). Along with the cultural adaptation, immigrants also uptake on an “unhealthy north American lifestyle after arrival”, which may involve increased consumption of junk foods and lower levels of physical activities (Ng et al., 2005, p.4). Changes in weather conditions can also have an influence on immigrants’ mental health and their level of physical activity. In addition, the quality of social capital is also another major factor in acculturation process. Social capital is defined as “the network of connections, loyalties, and mutual obligations which induce people to extend favors, preferential treatment and to act in each others’ best interest” (Gold, 1995, cited in George, 2009, p.1). In this paper, the term *social capital*

emphasizes more than a simple form of social network or quantity of social support, but more the quality of the social support in the form of the “availability of someone to provide help or emotional support” during this stressful settlement process (Sherbourne & Stewart, 1991, cited in Wong et al., 2007, p. 3).

While undergoing the process of acculturation, any deficits in cultural adaptation, uptake of unhealthy North American lifestyle and low social capital can translate into an acculturative stress. An acculturative stress refers to a “social isolation, sense of marginalization and perceived discrimination” (Noh & Kaspar, 2003, p.330). In addition to acculturative stress, immigrants encounter barriers to medical access. Barriers in utilizing medical system include long waiting time, culture and language barrier between a patient and a physician (Wang et al., 2008). When immigrants experience both acculturative stress and barriers in accessing health care system, it increases mental and physical stress, such as depression and chronic illnesses, which in turn, may negatively shape the self-perceived health status among immigrants (Noh & Kaspar, 2003). Furthermore, such barriers to medical access and deteriorated self-perceived health status among immigrants may reinforce their use of an alternative health coping strategy, such as traditional Chinese herbal medicine and using medications brought from country of origin (Wang et al., 2008).

As the above conceptual framework of self-perceived health status and health care utilization patterns explained, immigrants migrate with their unique pre-migration factors and undergo acculturation process. Any difficulties experienced by immigrants while adapting into new culture, lifestyle and forming new social relations with others, along with barriers in using medical system, may result in acculturative stress. Such acculturative stress and unmet needs of medical care brings two possible outcomes such as deterioration in self-perceived health status and usage of alternative health coping strategies. In the next chapter, I will illustrate how the data of this paper points to this conceptual framework.

6. Analysis

6.1 Self-perceived health status

In this chapter, the following themes will guide the analysis of the focus group findings in the following order: self-perceived health status, health determining factors, barriers in accessing Canadian health care system, and alternative health coping strategies. In response to the question concerning self-perceived health status, the overwhelming majority of all participants reported their health status to be either “fair” or “good”. Participants across the focus groups, regardless of their length of stay, gender, or a living arrangement, most participants were less likely to report their self-perceived health status to be “excellent” or “very good”. I assume that the health of the participants on their immediate arrival in Canada was in better shape than their current health for two reasons. First, all went through the vigorous medical examination that is required as a “direct health screening” process under the Canadian Immigration Act (McDonald & Kennedy, 2004, p.1614), which determined that they were healthy enough to be admitted to Canada (Gushulak, 2007). Second, in addition to the health screening process, almost all of the participants said that they had undertaken any necessary health check-ups additional to those required by Citizenship and Immigration Canada (CIC), and had been treated for any minor conditions including dental care.

However, there were few participants who assessed their health status to have improved upon arrival in Canada. Participants with working experience in Korea claimed that their health had in fact improved upon arrival in Canada, regardless of their gender or age. Participants with working experience in Korea thought their improvement in health was due to fewer working hours, less work-related stress and more leisure time in Canada, which took care of their health by increasing physical activities. For two female participants, although they experienced somewhat high settlement stress, the absence of work, work-related stress and pressure allowed their perception of their health to improve. However, it should be noted that both participants were recent immigrants who had lived in Canada for less than 10 years. Two male participants also explained that reduced working hours

(close to 12 hours a day in Korea to 9 hours a day in Canada) and less work-related stress along with increased leisure time and more physical activity were reasons to consider their health improved.

P3 from Group 4: I had a really bad back problem as well as my legs (it was so bad that sometimes I had a difficulty walking), due to long working hours in Korea. Frequent business trips worsened my health status too. I spent about 3 months on business trips overseas. The change in environment, the time difference and meeting clients was so stressful. But I started to swim a lot more often during my time off from work and swimming really helped to improve my back. So immigrating here really helped me to stay away from all of those things [work-related stress] and improved my health.

In addition to the participants with working experience in their country of origin, age also evidently influenced the self-perceived health status among participants. There was a big difference between the group with young adults between the age of 25 and 26 and the three other groups, composed of older immigrants aged between 34 and 59, with respect to the likelihood of their health status being perceived as deteriorating upon arrival in Canada. Many older participants (both male and female), especially long-standing immigrants, mentioned specifically that their health had worsened since their arrival in Canada, mostly due to their aging process.

P2 Group4: I think that the aging effect plays a big part in my own health status. I came here when I was 19 and now I'm almost 40. But, due to aging, I'm sick for more days than before [because I'm older] and it takes me a long time to recover from a simple illness like a cold

For younger participants, it was clear that the aging factor was not an issue, and acculturative stress was a major factor causing their health to deteriorate. Younger participants in their mid-20s, who landed in Canada as child immigrants (aged between 8 and 12) on the other hand, were much less likely to report a deterioration in their health. Furthermore, they reported much less frequent use of health services compared to the three other groups and found almost no need for alternative health coping strategies. As for the majority of participants, who reported their declined health upon arrival in Canada, I concluded that they were affected by the following determinants.

6.2.Determinants of health

6.2.1 Cultural adaptation

In the focus group discussions, factors such as language, education skills training and job searches were founded to affect the participants the most during their acculturation process. Overall, the majority of participants could carry a conversation in English. However, female participants who were above the age of 35, mostly stay-at-home mothers, perceived their English skills to be less than average. During the discussion on lack of proficiency in English, it was possible to see how they were affected by their low proficiency in English and link it to their difficulty integrating into the host society. The language barrier affected some participants' ability to feel a sense of belonging, integration, or worth as an equal citizen (Saloojee, 2003). This limited integration into mainstream society reinforced their tendency to find their social activities within their ethnic community and to seek social support from the members of the same ethnic group.

One participant explained how her lack of proficiency in English negatively affected her ability to integrate with others because she experienced difficulty socializing with non-Koreans outside of her Korean community. She said,

P2, Group1: I think we don't feel 100% comfortable or at ease. Unconsciously, I feel tense from talking and socializing with white people. Even being surrounded by white people puts me under a lot of stress, because I feel that they notice or at least think that I stand out from that particular crowd (by being foreign-born Korean).

Another participant also mentioned her experience of difficulty integrating with non-Koreans due to her lack of proficiency in English.

P3, Group3: There is a limit to what you can talk about or share due to the language barrier... I feel like a burden when I'm with them (white Canadians). I don't speak English as freely as they do and sometimes when I don't understand something, I feel like I have to stop them and ask questions. When I do that, I tend to cut the flow of the conversation.

In addition to the language barrier, many unemployed middle-aged female participants were particularly vulnerable to stress from loneliness by being isolated from the society.

P2, Group3: At home, my kids speak English when they're outside [of the house] and they speak Korean at home. They can't really express their feelings freely in Korean to me and I also can't communicate the way I want to to my kids in Korean. I feel like there's a lack of communication there. My husband is working outside, has his own status and career in society. But for housewives like myself, I can't work like I used to in Korea and my social activities are very restricted to things like going to church or going out for a meal with other Korean housewives. I feel isolated from the rest of the society; I can't perfectly blend in with my children nor my husband. I have no other family nor close relatives here in Canada, no close friends, so it makes me very lonely here.

As these quotations suggest, low language ability increases a sense of barrier in integrating into the host society and produces a social isolation that in fact contributes to worse mental health (Noh & Kaspar, 2003).

I was curious to find out whether that sense of isolation and lack of integration was solely based on language, because the participants said they felt limited in sharing or talking to non-Koreans due to the language barrier. Further probing questions were put forward asking participants whether they would like to more actively integrate and socialize with non-Koreans if they could speak English fluently. The answers to this question were somewhat surprising and did not vary much across the different focus groups. The majority of participants said that there were certain cultural barriers that would discourage them from actively associating with others as they would with members of Korean community.

"Ethnic identity has been defined as a person's subjective sense of belonging to a certain group or a culture" (Murphy & Mahalingam, 2004, p.4). This sense of ethnic identity was reported to have an influence on racialized immigrants' psychological well-being when they feel isolated from the main society, because it provides them a sense of belonging (Murphy & Mahalingam, 2004). Participants explained cultural differences more specifically as an absence of connectedness from sharing the same ethnic background. Participants felt that there was a difference in topics of interest among themselves and non-Koreans and thus felt that it was difficult to relate to and integrate with non-Koreans. There was a sense of hierarchy in their preferences for social interaction. The

participants felt most comfortable and thus preferred to interact with other Koreans, followed by other Asian immigrants.

Participants specifically used the example of their husband or children to express how it was not language alone that affected their integration:

P1, Group 3: I think Asians prefer to meet other Asians regardless of their ethnic background. White people make us feel somewhat different. But with other Asians immigrants, we share a sense of being an outsider, so even if we have a language barrier (between Korean immigrants and non-Korean Asian immigrants), we feel much more comfortable with them.

The young adults who had lived in Canada for more than 10 years also experienced this sense of being an outsider. Despite their fluency in English, all the five youth participants explained that all of their close friends were ethnic-Koreans, because they felt more comfortable and connected with them; there was a stronger sense of belonging in a group of members with the same ethnicity. There was a high level of stress among young adults with cultural adaptation: difficulties catching up with education, improving their language proficiency and integrating with Canadian-born friends produced mental stress and led them to assess their health negatively. However, it was interesting to note individuals with low acculturative stress. This was partially explained as the result of their positive outlook and mindset on life, but unlike the other two participants who assessed their health as deteriorated, they were surrounded by peers or co-workers who were also immigrants, and who were experiencing the same acculturation-related difficulties with lower language proficiency in English. They were also studying or working mostly in science and engineering where they were exposed to less acculturation stress.

Mehta found that “greater acculturation is correlated with better mental health outcomes among Hispanics and Asian Indians, respectively, suggesting that a less ethnic orientation was more protective of psychological well-being” (cited in Shin, Han & Kim, 2007). Also, among Mexican Americans, the less-acculturated were at higher risk of depression than less-acculturated Mexican American and immigrants (Murphy & Mahalingam, 2004). Because the close friends and social

contacts of 100% of the participants, regardless of their gender, age, or year of arrival, were ethnic Korean immigrants, and the participants were reported to be not socially well-integrated, it can be speculated that the participants were more likely to be vulnerable to mental stress.

Work undeniably plays a crucial role in affecting immigrants' settlement experience and their health (Ahonen et al., 2007). Work-related fatalities and illnesses that were specific to the occupations that employ a large number of Korean immigrants were mentioned in focus group four with 1st generation male participants. Two male participants who assessed their health to be fair explained their ethnic-business-related stress and physical symptoms of ethnic-business-related stress as a main reason to view their health negatively.

The vast majority of Korean immigrants in Canada find employment in ethnic businesses or run a small-business of their own, such as a Korean-owned convenience store or a dry cleaning business in the "ethnic economy," (Koreatown Immigrant Workers Alliance, KIWA, 2009). Such types of Korean owned small businesses are usually run by family members, require long working hours, and make all family members vulnerable to mental distress and chronic illnesses. According to KIWA, 82% of surveyed Korean immigrant workers in ethnic businesses living in Los Angeles, in the United States, suffer from "some sort of musculoskeletal pain that they thought was related to their work" (KIWA, 2009, p.1). Two participants who previously owned such ethnic businesses (in this case small grocery stores) shared their experience and that of their friends who were also self-employed in small businesses, indicating and how these businesses directly affected their mental and physical health. First, one participant explained the perceived difference between the types of immigrants that Ottawa has compared to other metropolitan cities like Vancouver, Montreal or Toronto.

P5, Group4: In Vancouver, about 90% of Koreans run small businesses. Toronto is very similar to Vancouver. But, Ottawa is very different. Most people living in this city are either private or public sector employees. Those people have time to really enjoy the privileges in the city. So that may have a positive impact on their health. I think most Koreans own grocery stores as a small business and I myself had a grocery store for 7 years in Vancouver.

I never went on a vacation. I always worked late at night too. I was always at the store. You cannot imagine the level of stress you get from running a business that deals with Canadians [English speaking non-Koreans]. Then, my immune system really dropped low and my physical health was starting to get worse.

In addition, it was suggested that dry cleaning businesses, which are also commonly owned by Korean immigrants, also pose a danger to their health due to a constant exposure to toxic chemicals at their workplace.

P5, Group4: So, immigrants who work in places like that get ill very quickly. They may be fine for 4-6 years, but it's almost guaranteed that they are going to develop some kind of illness in 10-15 years at least.

Furthermore, he explained that those people who have long working hours tend not have time to visit a doctor, because they are self-employed full time, and instead they depend on a heavy consumption of pain relievers. Based on his reflection, lack of visit to a physician in conjunction with heavy consumption of pain relievers may have a serious potential to worsen immigrants' health and increase a chance to develop a life-threatening chronic illness. This consequently has a serious impact on their health and can develop into a life-threatening chronic illness. The other participant, who also owned a grocery store in Montreal, strongly agreed and explained that "this is an illness that most first generation Korean immigrants get." He further added that

P1, Group4: About 5-6 years ago in Montreal, I also owned a small business [a convenience store] for about 7 years. Back in 1988, I knew people who owned small businesses [mostly stores] for 15-20 years, so those people came to Canada in 1960s, and I witnessed how they started to die from cancer in the 1990s.

In 3-4 years, I saw 20 people who died from cancers. These people immigrated to Canada about 15-20 years earlier than us. As P5 mentioned, these are grocery stores that open for 24 hours. They have no holidays, no weekends, just work 24 hours all year around. So they make a lot of money and buy buildings worth millions and send their kids to great schools. Now, they have finally made enough money to enjoy life, their spouse falls ill and dies from cancer and the remaining person also falls ill soon after. This is a very common life story for first generation Koreans.

As this quotation explains, it can be speculated that Korean immigrants who own small businesses may be exposed to a health-deteriorating working environment, long hours and stress. This kind of

occupational health hazard for immigrants has received little attention in the literature and is in much need of further research. Study of the occupational health of immigrants has been much more focused on the nature of work involving immediate fatalities, such as direct contact with toxic chemicals, fatal accidents or the safety of the work environment. However, according to two participants, it was evident that their work-related situations are perceived as a major factor that made their health deteriorate over time, and, as both of the participants explained, “those businesses were slowly driving us [Korean-ethnic small business owners] to death.” The health-deteriorating working environment of small ethnic businesses warrants serious attention and further research and policy consideration.

6. 2. 2 *Low quality of social capital*

P4 Group3: I think a lot of immigrants do go through many emotional and mental problems here. We are mentally quite unstable. I'm like that for sure.

As the statement above expresses, many participants felt strongly that their lack of social capital negatively affected their mental health status. Partially due to the participants' strong preference for interacting or bonding with other members of the Korean community and due to their language and/or cultural barriers, I observed that many participants limited their social interactions and activities to their ethnic community. However, the desire to interact mostly with their fellow ethnic Koreans allowed many of them to have many Korean friends and strong involvement and association with them. As a result, half of the participants reported a high level of social support (friends or contacts with whom they had frequent socialization, at least once a week). Another half of them said they had a low level of social support. Social support has been concluded to buffer the settlement stress of Korean immigrants (Noh et al., 2007; Shin et al., 2007; Kim et al., 2005). Interestingly, however, regardless of high or low social support, many participants suffered from loneliness and isolation because they could not use their social support to cope with settlement stress, due to the low

quality of their social capital. Again, this particular stress was mostly reported by stay-at-home mothers. One female participant who claimed to have a low level of social support said,

P1, Group1: I think reminiscing about Korea is the biggest factor in causing settlement stress. I mean, not having many friends like I used to in Korea gives me much stress. There's not many people that I can share my feelings with or who understand what I'm going through, so it gives me much stress, which is followed by real physical symptoms such as headache

Another female participant with a self-claimed high level of social support on the survey mentioned the lack of a friend to share her personal stress.

P5, Group3: Regarding my mental health, I think I'm under a lot of stress. I don't have anyone to share my feelings and personal stories with. I don't have anyone to share those stresses I get from my daily routines. My kids are growing up and I get a lot of stress from them too.

Many female participants, similar to Indo-Canadian women, perceived "loneliness and depression as matters that do not warrant medical attention, but instead viewed them as personal problems" (Newbold, 2005, p.1360). Also, due to reasons of stigmatism and fear of how others might think of their situation in a small ethnic community, none of them preferred to use any services for immigrants' mental health, even confidential, culture-specific mental health centres for Korean female immigrants. Lack of correct knowledge about maintaining mental health among participants is a point of concern, because many researchers have confirmed that loneliness is very strongly linked to a poor psychological condition that is detrimental to well-being.

An important contributor to the settlement stress of the participants I found was that they were suffering from a high level of stress from their own ethnic social networks. Participants explained that this was due to the desperate need to find quality social support among a limited number of social contacts and networks in a small ethnic Korean community; this need caused much conflict, disappointment and stress among and between people. This type of high stress from social relations and social support has been explained as the "paradoxical nature of social activities," so that some social activities may increase, rather than decrease stress (Murphy & Mahalingam, 2004, p.4).

In other words, participants felt a great deal of stress when their expectation of gaining high quality social support failed or they faced difficulties while searching for it within a small, restricted pool of social interaction in the Korean community.

6.2.3 Lifestyle Changes

Numerous social and epidemiological studies have argued that immigrants lose their health benefits over time by “becoming us” (Noh & Kaspar, 2003, p. 325). One of the tangible pieces of evidence of immigrants becoming like the host population is the uptaking of an “unhealthy North American lifestyle after arrival” (Ng et al., 2005, p. 4). To understand the change in health behaviour among Korean immigrants affect, I asked participants about the possible changes in the frequency of their physical activity during their leisure time, their eating habits, smoking, and consumption of alcohol. There were mixed responses to this question on lifestyle acculturation and change in health behaviours. Many middle aged female participants and also some male participants reported decreased physical activity due to frequent use of the car as a major means of transportation (instead of walking), to bad weather that limited physical activities outside, and to low social interaction with others. Surprisingly, smoking and drinking were reduced after landing in Canada. This can be partially explained by the fact that many participants considered drinking and smoking mostly as an opportunity to socialize with friends or co-workers and to build their friendship and trust in a group. Due to the lower quality of their social capital compared to their previous social capital in Korea, their chances of socializing with friends involving drinking and smoking were reduced. Many participants were, however, affected by a change of eating habits since arriving in Canada. Noticeably increased consumption of junk food and coffee was pointed out during the discussion. Consequently, due to factors such as increased inactivity or change in dietary habits, all participants reported experiencing a weight gain, though to a different extent. Weight gain has been found to affect how one perceives one’s health status (Ng et al., 2005), which helps to explain why the majority of participants viewed their health as fair or good.

Another frequently mentioned factor that affected the mental status of middle-aged and older female and young participants were interacting with the changing environment. Many participants were new to Canada's long winter and this resulted in changes in their mood, particularly affecting the recent immigrants.

P6 in Group 1: The winter in Canada is much longer than in Korea. Many Korean immigrants find it difficult to endure (or cope with) a long Canadian winter. Also, shorter daylight affects one's mood and many people feel more depressed. So, many problems arise during the winter. It's not always necessarily a simple stress coming from reminiscing about Korea, but many experience a real mental problem. The environmental factor really counts.

The change in weather also affected young male participants' motivation to study:

P2 in Group 2: I think weather makes a huge difference too. During the winter time, it's so depressing. There were times when I didn't want to go to school because of the poor weather. Like he [the other participant] said, I lost a lot of motivation and got restless.

Based on the observation, for some participants the change in environment negatively affected their mental wellbeing. This deterioration on mental health, in fact, was part of an outcome of acculturation process.

So far, the analysis of the focus group findings pointed out that the use of language, cultural difference, lack of quality in social networks, changes in lifestyle and physical environment were affecting Korean immigrants' self-perceived health status. I emphasize that such identified health determining factors among participants were very similar to the factors that were laid out in the conceptual framework. While analyzing and identifying the health determining factors, I also observed that despite the grouping of different socio-demographic characteristic of immigrants into four focus groups, such as gender, age and length of stay, were not proven to bring much difference in terms of their exposure to a different types of above mentioned health determining factors. However, there was a difference in the levels of responses among participants within the categories of each health determining factors. For example, older male participants (focus group 4) were more at risk of work-related symptoms and illnesses whereas, older female participants (focus group 1 and 3) were more vulnerable to language and cultural barriers and lack of quality in social capital than

any other participants. Younger participants (focus group 2) were exposed to acculturative stress were also affected by difficulties finding work and catching up with the new education system. These factors were also reported to have made a noticeable impact on the participants' physical health. In the section below, more detailed analysis of the physical health outcome affected by these factors will be illustrated.

6.3 Physical outcome of an acculturative stress

The acculturation-related stress that was described above, was mostly psychological in nature, such as a sense of marginalization and loneliness. The high level of mental stress was linked to a declining physical health status. Participants who experienced fair or low settlement stress were more likely to rate their health as excellent or very good. Participants with high or very high settlement stress were more likely to report their health status as only fair. Those participants who experienced a high settlement stress described their experience of deterioration in physical health. For example, astronaut housewives (aged 35 or older) who had a high level of settlement stress and low social support were more likely to develop or worsen their pre-existing allergy compared to other female participants of the same age or older with low settlement stress. An astronaut housewife who said she had a high level of settlement stress in the survey said:

P4, Group1: The first two years after I immigrated to Canada, I had no problem with my health. But I heard from someone that you develop an allergy after 5 years in Canada and that you're a true Canadian after you develop an allergy [laughs]. And I'm convinced that I'm developing an allergy now because I feel light-headed, I sneeze, have a runny nose and red eyes, and a swollen pain in my eyes; but I have no fever and no reason to have a cold.

I speculate that the possible reason to such development of allergy among some participants could be related to a high settlement stress. A recent study by Montoro et al., (2009) explained that stress has a particular repercussion on the immune system, which makes an individual more vulnerable to allergic disease. Although it is difficult to conclude that a chronic stress alone directly relates to a development of an allergy, it was found that a high level of stress is one of the strong contributor to

the development and worsening of an allergy (Montoro et al., 2009). Their research suggested that stress may trigger the “appearance of allergic disease on one hand, and complicate the control of existing allergy on the other” (Montoro et al., 2009, p. 45).

Some participants themselves speculated that the length of stay in Canada may affect how immigrants assess their health status. In fact, among the female participants, those who reported worsened health conditions upon arrival in Canada experienced certain physical symptoms after two years of residency.

P4, Group1: I hear that the settlement-stress-related symptoms, such as headache, extreme sensitivity to insignificant events and insomnia, tend to occur and get worse after two years living in Canada.

As the quotation above suggests, most participants agreed that there is a certain honeymoon period, which lasts about 2 years. However, after 2 years, various different signs of settlement stress, such as loneliness, start to show and start to affect people’s mental and physical health negatively.

P4, Group1: I have a problem with my digestive system, and I guess my settlement process and lack of English skills caused my health to deteriorate. I even arranged a full oral examination from a dentist just before I left Korea, but my gums started to bleed excessively after few months in Canada. Also, I started to have diarrhea for 3 months and I was in a desperate need of seeing a doctor.

While the acculturation process, involving cultural adaptation, change in lifestyle and low quality of social support, affected the mental and physical health of participants, the participants also had to adapt to the Canadian medical system, more especially to accessing and using the Canadian medical system. Many participants praised the public health care system for its free primary health care service, but various barriers to accessing health care became another type of settlement stress that added to the participants’ acculturation process. The reported barriers to using the health care system were a difficulty getting a family doctor, very long waiting time to make an appointment, unmet medical needs, and language difficulties because of the extreme shortage of Korean- speaking physicians in Ottawa.

6.4 Barriers to accessing the health care system in Canada

6.4.1 Difficulty in finding and accessing family physician

More than half of the participants had a regular family doctor. While more recent immigrants, as might be expected, do not have family doctors, quite a number of long-standing immigrants were also still in a lengthy search for family doctors. Those who had family doctors spent 1-3 years looking for one whose office was located within a 30 minute drive from their residence. The majority of the participants had actively tried to find a doctor using the Internet, or their social networks, or by accessing an immigrant service centre, such as the YMCA Newcomers Centre. All of those who still had no family doctor were in the process of searching for one by making inquiries to available physicians and their clinics. Many participants expressed their frustration at the difficulty of finding an available doctor in their neighborhood. One participant expressed her frustration by saying,

P3 Group3: I even saw a TV commercial that encouraged people to sign up for a family doctor as if we were too lazy to apply for one. But that's not true. We're trying our best to get a doctor, but it really is difficult.

Also, the most frequently mentioned barrier that participants experienced was the limited options they had selecting the doctor of their preference. According to the participants, they highly valued doctors who allow them enough time to discuss their fears and concerns about their health, and who give an instruction on how to manage their disease and educates patients on their illness and treatment plan, including written instructions about medications, diet and exercise. Participants explained that doctors with a good reputation found on the Internet were often unavailable or were not accepting new patients. It was a frustrating experience for the participants for not being able to locate a doctor of their first choice. In order to secure a family doctor, they had either to travel a greater distance (longer than 30 minutes), or to be put on the waiting list until a space opened up, or

to settle for a doctor who was accepting new patients, regardless of their preference and needs. Many assumed their difficulty in finding a doctor was due to the shortage of doctors.

One of the most valued factors that they looked for in medical service was a physician from whom they could receive enough medical attention and care. Often participants found it very difficult to find doctors with this particular professional quality. Difficulties in finding such physicians became a frustration, which was expressed as an unmet need for medical care.

6.4.2 Unmet needs for medical care

An unmet need for care, which could involve the cultural and language differences between health care practitioners and patients was founded to have an impact in immigrants' health by delivering an inappropriate care provision (Dunn & Dyck, 2000). During the focus group discussions, it was clearly evident that the cultural and language differences between the physician and participants brought many negative experiences for participants in using health care services.

Although the extent or the degree of the language barrier varied depending on the participants' level of language skills, all had difficulty with communicating effectively with a physician, with explaining their symptoms clearly, and with accurately understanding the physician to some extent. In order to overcome the language barrier and communicate better with the doctor, participants felt the need to put in an extra effort. Prior to seeing a doctor, many explained that they took extra time to write down their symptoms and details of their illness in English so they could clearly explain their problems. Or they would make the visit to the doctor with a translator (often a family member). One participant described a visit to a walk-in clinic where she felt a real language barrier that affected her trust in the doctor and the prescription she received from him, emphasizing her need for a Korean-speaking physician:

P5 Group1: There are so many things about your symptoms or illness that you cannot translate into English. A particular expression that describes a certain illness or pain is very difficult to say in English. So, when you visit Korean physician, you can use your native language and explain all your symptoms in comfortable native language and have the doctor understand you one hundred per cent.

Noh and Kaspar (2003) explain that Asians suffer from language barriers because they “present their somatic symptoms to clinicians as, for example, “fire in the chest” in describing their illnesses. This could increase the language barrier because of the need to translate these terms into medical terms and also creates a difficulty for a physician to understand what those descriptions mean. This kind of language barrier made participants anxious to find Korean-speaking physicians. However, there is only one Korean-speaking physician in Ottawa currently, and none of the participants had the opportunity to use this Korean doctor, despite of their strong preference for a same language physician.

P5, Group4: I think when you first arrive as an immigrant, the very first thing that you look for is a doctor who can speak your native language. But, there is an absolutely limited number of doctors who are Korean and also able to speak Korean fluently.

While the language barrier between participants and their doctors was evident, the cultural barrier requires a little more attention and explanation. The cultural difference in medical care does not refer to any specific culture or traditionally-based ethnic-specific concepts such as a “balance of yin and yang or Taoism” in medical practice (Wang et al., 2008). This study explains how a cultural barrier in medical care may arise when a patient brings an expectation of the health care system and quality of medical care that has been shaped by his or her place of origin. In other words, when the expectation of medical care has been shaped by a previous experience of using a health care system in country of origin and when the health experience gets worse in the new country, unmet expectations become an unmet need for medical care. As explained previously, the participants from all four focus groups explained that the professional attitude of and care from a physician was one of the important elements in a satisfactory health care system. Most of the middle-aged female participants expressed a sense of intimidation and tension when dealing with a physician, and some even felt nervous due to their language barrier even before seeing the doctor. Thus, for those participants, it was very important to find a doctor who could make them feel relaxed and

comfortable by not rushing them during the treatment time. Participants voiced their dissatisfaction with medical care when a doctor rushed, had only a brief treatment time, and failed to explain the diagnosis to them, leaving them feeling poorly served by the medical community.

P6, Group3: I had a very horrible experience with a walk-in clinic doctor once. I prepared three things to discuss with her, and as soon as I tried to ask her my second question, she cut me off and said I could only talk about one thing at a visit. I was offended by her gesture and the tone of her voice and she made me wonder whether she was a racist.

Across the focus groups, participants felt most satisfied with medical treatment when the doctor was sensitive to their health care concerns by listening carefully, asking appropriate questions during the examination, and explaining the diagnosis and the treatment plan, such as the prescription and how to avoid such symptoms by taking precautions in the future. One participant described a situation where she was very satisfied with her physician:

P5, Group3: Those doctors who take their time to explain things are very rare. When you're with doctors like that, you feel so much more comfortable and feel like you're being taken care of even when they don't prescribe you any medications. [Everyone nods in agreement.] But most of the doctors tell you that it's nothing significant and just tell you to go home. Then you don't know why you're sick or feeling the pain, so you have to revisit and ask the same questions to the doctor (because he didn't explain things well in the first place). I wish doctors could be more friendly and explain things more to us so we can feel more comfortable from knowing what's going on with our body.

Most participants also valued doctors' referrals to a specialist for a further thorough check-up and follow-up calls to explain the results and ask about their progress.

P5, Group4: My friend always boasts about his doctor and talks about how his doctor takes care of him so well. His doctor always asked him very detailed questions and referred him to a specialist to get a check up on many things. He felt he was being taken care of and he was so happy.

Such desire to receive more medical attention from their family physician was evident in participants regardless of their physical health status.

In addition to the quality of professional care from a physician, some participants reported incidents of misdiagnosis that damaged the trusting relationship with the doctor. Eight out of 22

participants reported incidents of erroneous diagnosis. The nature of these misdiagnoses varied from minor mistakes to an extreme life-changing case. For example, one participant mentioned that a doctor misdiagnosed shingles as another illness and provided him with a wrong prescription that could have caused him to lose his sight.

P4, Group3: My husband had shingles but they didn't know that it was shingles. The resident couldn't figure out what it was that my husband was suffering from and kept prescribing my husband the wrong drugs and treatments. My husband could have lost his sight from them. While my husband was with his doctor, an experienced surgeon from Montreal walked in and said, "He's suffering from shingles." If we decided to sue the doctor for this, the whole incident could have gotten very ugly... many Koreans are afraid to take further action, even if they have experienced unfair treatment or a medical situation when they were harmed. They don't know who to turn to.

In addition, most participants had experiences when they felt confused over the treatment and about medical advice they received from their doctor. Such confusion was partly related to the participants' previous experience of using the medical care system in Korea. For example, many spoke of a cultural difference in use of pain relievers. They expected the doctor to prescribe a treatment that would give them an effective and immediate relief from a symptom, such as antibiotics or a needle shot. However, when their doctor advised them to take some rest, avoid stress, drink more water or take Advil or Tylenol, some participants felt that doctors were overlooking their symptoms and subsequently questioned the doctor's professional interest in taking good care of them. Some considered such "medical advice" insufficient, especially when the symptoms persisted for a long period of time. Some were even discouraged from going to seek medical advice from their family physician. Thus, instead of consulting with a family physician, many participants preferred to meet with specialists to get a more careful examination of their particular symptoms. One participant explained that

P1, Group4: The best thing is you find a family doctor who can allow you to access the medical services you need [a specialist] and use that service. But how you go about finding that doctor is important and difficult.

However, participants once again felt there were barriers to accessing specialists because their family physician acted as a gatekeeper to a specialist (Wang et al., 2008). A participant who had lived in Vancouver before moving to Ottawa had a Korean speaking physician of Chinese origin, Dr. Hwang. He explained that almost all of his patients were Korean according to Dr. Hwang,

P5, Group4: Too many [Korean] patients want to see a specialist doctor and it becomes very difficult for him to send them all to a specialist as they wish.

6.4.3 Long waiting times and limited access to physician

In addition to a long period searching for a physician, participants also experienced difficulties getting an appointment or contacting a doctor. First, long waiting times before an appointment was problematic because it prevented patients from getting timely treatment. To avoid waiting for days to see a physician, some participants often used a walk-in clinic. However, many said that they had to endure long waiting times at walk-in clinics too.

P5, Group2: I find that one of the most frustrating thing is a long waiting time. So, most of the time, I don't bother going to see a doctor even if I'm sick. It's the same everywhere

A long waiting time to access a physician was a new experience for participants that became another source of a frustration. Another person who pointed out the slow access to medical service in Canada said,

P4, Group3: I find that everything here is slower than Korea. The first thing I noticed about the Canadian medical service system is their slow process in treating patients. While I feel an urgency that requires immediate attention from a doctor, they go with their own system and flow. The process of the Canadian medical service is different from the Korean one, and I think people tend to give up their expectations of getting timely treatment as they reside in Canada for a longer period of time. We are still not used to the process and delays in accessing medical care; it makes us very angry and frustrated.

Long waiting times to access a specialist were also pointed out as a problem. Based on the experience of the participants, the waiting time to see a specialist was between 2 months and up to a year when it involved particular examinations such as Magnetic Resonance Imaging (MRI) or Computer Tomography (CT) scanning. When the time lag after making an appointment to see a

specialist was found to be too long, many reported that they used the emergency room as a faster way to see a specialist. Although many still had to endure a long waiting time to see the specialist, they considered that it was better than waiting months to visit one. The reported average waiting time using the emergency room was 6 hours or more. Again, many made a link between the long waiting time and a shortage of physicians:

P5, Group3: I think the problem is the shortage of doctors that cannot meet the demands of the patients. They can't take a good care of patients because there are simply way too many for them to handle.

From analysis of the barriers to the Canadian primary health care system, it was evident that such barriers have changed and shaped medical access patterns. Difficulty finding a family physician or a long waiting time after making an appointment has led to use of walk-in clinics. Also, frustrated with the long waiting time and unmet medical needs, participants seek access to specialists through the emergency room. Some were discouraged from using medical system and were clearly experiencing much frustration in the process of seeking medical care. Therefore, language, culture and unmet needs of medical care acting as barriers to use of the Canadian medical system partially resulted in under-utilization of the Canadian primary health care system. However, those barriers had only a partial impact on use, because, despite the barriers and difficulties, participants continually sought different ways to meet with a doctor. Also, the overall frequency of use of the medical system by participants, particularly the preventative health practices, was being supplemented by their use of alternative health coping strategies such as using the health system in Korea. Thus, the actual case of under-diagnosis and treatment of health problems or under-use of preventative health screening (McDonald & Kennedy, 2004) was not found.

6. 5 Alternative health coping strategies

The barriers encountered by participants in using the health system were largely based on the unmet needs for medical care that were associated with cultural and language barriers between health care practitioners and patients. These reported barriers are, in fact, not unique to Korean immigrants.

Many immigrants, particularly non-European immigrants, experience cultural and language barriers in accessing the medical system in Canada (Wang et al., 2008; McDonald & Kennedy 2004; Beiser, Chen et al., date; Newbold, 2009; Pottie et al., 2008). However, what differentiates Koreans from other racialized immigrants is the intensity of their perceived frustration with the current medical utilization pattern due to the sharp contrast between their past experience of using medical services in Korea and the current Canadian medical system. DesMeules et al. (2009) note that “health status and health service disparities among immigrants may vary by personal characteristics, experiences of migration and region of origin” (p. 1). Echoing DesMeules et al (2009), the participants in my study were highly dissatisfied with the “new” barriers to accessing physicians and medical care in the host country, because there were no such barriers in Korea. The participants had been exposed to and familiarized themselves with the Korean medical system for a minimum of 15 years for some and up to 45 years for others. To many participants, comparing the two nations’ medical systems seemed unavoidable. By comparing those two different medical service systems and their access, the participants felt a health service disparity in Canada and such a disparity made them feel constrained in their capacity to take care of their health in Canada compared to Korea. The long waiting time to see a physician and a less than satisfactory quality of medical care created some lack of trust and even fear towards the medical system in Canada. More specifically, many participants were worried about the possibility of an undiagnosed condition that might worsen their health status as long as they experienced barriers like a long waiting time to see a doctor and limited access to different types of screening tests.

P3, Group4: I think that’s our ultimate fear. Hypothetically speaking, if I went to see a doctor because I had a problem with my stomach (without any visible symptoms), he could simply overlook my problem and prescribe a medication to help with my digestion. Then I would probably take that medication and wait to get better. But, my symptoms persist (even with the medication). Then you go back to the doctor and he or she suggests the same treatment again. But, in Korea, you go to a doctor and say that your prescribed medication didn’t work, and then the doctor worries and allows the patient to go through a thorough check-up. Then, going through a check-up, you may identify any illness like a cancer at an earlier stage. But when you can’t have access to that kind of thorough examination and experience the lack of

the doctor's attention, you may end up under-diagnosed and your illness may develop into something more serious.

6.5.1 Transnational health care seeking behavior

Comparing the access to medical systems and the quality of care, most participants praised the Korean medical system for a quick and convenient access to a family physician and specialists. First, the waiting time was reported to be usually no more than 30 minutes without an appointment or a referral, and many clinics offer one-stop-service where you can see many different specialists and also get your health examination screening, such as ultrasound, done in one clinic. One participant said, "We are so used to getting timely treatment and easy access to a doctor when we are in need and also to quickly getting medication."

Second, an annual check-up offered by a Canadian physician involves simply tests such as blood-pressure, a pep-test, and height and weight measurements. What Korean participants wanted was a comprehensive, thorough health screening, as many considered that preventative health practice was one of the most important components for an early detection in sustaining their health and wellbeing. They wanted a comprehensive health screening practice involving sophisticated medical tests such as CT or MRI scanning. This desire for thorough health screening check-ups reported by the participants may be shared by many other Korean immigrants living in North America. Understanding such demand and need in many Korean immigrants, the Korea Medical Institute (KMI) Global Marketing Agency has organized the so-called "medical tour to Korea." KMI was created in 1985 to help Korean immigrants living in North America to get the thorough health check-ups they need in seven different locations in South Korea. They offer five different levels of health check-up packages, according to the types of examination and cost: White, White II, Silver, Gold and Platinum. The White and White II (\$310-380 CND) include the following services: blood testing for problems with the liver, kidney, and thyroid gland; tests for diabetes, tumour and hepatitis; colonoscopy, ultrasound on breast, stomach, lung, and cervix; and further checks for bone

density and eye pressure. Higher levels of examination (\$620-\$1620) include testing done at the White II level, plus CT or MRI or position emission tomography-computer tomography (PET-CT) on the whole body and brain. In addition to these services, KMI also offers a referral to dentists, cosmetic surgeons and dermatologists.

Third, many participants raised the issue of some type of immediate pain reliever usually given after the first treatment time in Korea, such as some type of drugs or a needle shot when necessary. While many people regarded easy convenient access to physicians and specialists highly, almost all of the participants were wary of the Korean way of prescription of high doses of oral medications and its impact on their body. Many believed that their exposure to high doses of oral medications such as antibiotics, in Korea have increased their resistance to some medications. One participant told a story of her friend who is a recent immigrant in Canada, noticed his resistance to antibiotics and directly experienced the difference between a Korean doctor's prescription and a Canadian doctor's:

P3, Group1: One of my friends had a problem with his urinary organs so he went to see a doctor here. He was prescribed a small amount of drugs to treat his problem, but he didn't get better after taking the pills for a week. Then, he went back and received another week's worth of drugs. Then, he had a chance to go to Korea soon after. He took the pills [he received from his Canadian doctor] to a Korean doctor and explained why he was given them. Then the Korean doctor said that he [the patient] was supposed to take a dose 4 times as strong to get better. In the end, by following Korean doctor's prescription, he was soon improved.

Many participants noticed that Canadian physicians were more reluctant to give out antibiotics, whereas Korean doctors handed them out more easily for symptoms such as a cold. Participants mostly considered that excessive use of antibiotics or pain-relievers was wrong, but without knowing their pre-migration-related medical experience, the prescription from a Canadian doctor did not work well to alleviate their symptoms quickly. Limited improvement in their illness caused participants to make more visits to a doctor's office and left them in frustration.

P1, Group3: ... Korean immigrants are already so used to having heavy doses of drugs and so have built higher resistance to antibiotics, they [what Canadian doctors would normally

prescribe] may not work for us. I don't usually get better after one antibiotic. I need to take at least two to feel better and Canadians freak out when we tell them how many antibiotics we take.

The pre-migration-related medical experience in their home country, such as quick and easy access to physicians, availability of thorough examinations and an exposure to higher doses of antibiotics obviously affected the participants' expectations of medical service as well as their level of satisfaction with their current experience using the Canadian medical system.

Transnationalism is defined to be "the processes by which immigrants forge and sustain multistranded social relations that link together their societies of origin and settlement, and through which they create transnational social fields that cross national borders" (Basch cited in Schiller & Blanc, 1994, p6). Clearly, all the participants were engaging in a high level of transnational activity in many different ways (Kwak, 2008). All the participants used the Internet on a daily basis, reading up-to-date online news, watching various Korean TV channels through various websites, and listening to music. Also, they exchanged emails, talked on the phone with their close friends and relatives using online calling systems or long-distance calling cards. Making frequent trips back to South Korea was another form of transnational activity. The frequency of making trips back to Korea varied according to the participants' characteristics. The astronaut housewives made the most frequent visits to Korea, going back once a year, and used the health care system more often than any other participants, because their public health cards were still valid due to their husbands who still lived and worked in Korea. Second in frequency were the older stay-at-home mothers with grown up children, who were taking a trip at least once every 2 to 3 years. Young adults and older male participants had limited trips to Korea due to their school and work commitments, going on average once every 3 to 4 years. Many of them reported that it was "essential" for them to use various medical facilities when in Korea, such as visits to physicians, specialists, dentists and cosmetic surgeons.

This alternative health coping method was also possible because the overwhelming majority of participants who traveled were housewives with more time flexibility and financial means to afford the transportation costs as well as the treatment fees. (The Korean public medical system is only partially covered and, for foreigners, there is a considerably high financial cost to using any kind of medical system in Korea). Although the majority of the participants had no medical insurance but some type of coverage for public health (because they were Canadian citizens), they were willing to use the Korean medical services because they considered they were worth it. Also, I speculate that these strong transnational ties and the pattern of use of medical services were intended to produce a positive outcome for their psychological wellbeing and were used as another acculturative-stress-coping strategy. Also, it is important to note that the finding of this alternative health coping strategy is only restricted to this study and is not representative of larger Korean community in Canada. However, not much research has been conducted on the subject of trans-nationalism and health; much more study is needed.

In this chapter, as the conceptual framework suggested previously, I observed how the interrelated relationship between the health determining factors and barriers to accessing health care system resulted in declining participants' self-perceived health status. Again, the analysis highlighted confirmed the conceptual framework model that the acculturative stress including a sense of isolation and barriers to accessing the health care system in Canada, such as unmet needs of medical care motivated participants to increase their health seeking behaviour outside of primary health care system. It was interesting to find out that alternative health seeking behaviour included increasing visits to emergency departments. However, it should be clarified that the increased visits to emergency department among participants were practiced to shorten their waiting time to seek medical attention from a specialist. Unmet medical needs and unmet expectations in Canadian health care system, that has been previously formulated from their homeland, affected the participants' health-seeking behaviours. Such alternative use of health care system was a surprising result that

may become an additional component in developing the existing conceptual framework. I found that the integrating transnational activity and their use of transnational health coping strategy was the partial solution to unsatisfactory experience with Canadian health care system. Some participants explained this health seeking behaviour as an added bonus to their trips to Korea, while some made the trip just for the purpose of getting timely treatment and preventative health care.

Chapter 7: Discussion and conclusions

This study was exploratory in nature that examined the self-perceived health status of Korean immigrants with two approaches. Definition of health is “a state of complete physical, mental and social well-being and not merely the absence of disease” (World Health Organization, 1986). To thoroughly assess my Korean participants’ physical, mental and social well-being, the complex interplay of factors such as acculturative stress, barriers to accessing the primary health care system and alternative health coping strategies were examined.

First, during the focus group discussions, I asked my participants how they perceived their health now compared to their health status immediately upon arrival in Canada. Although there were variations in self-perceived health status depending on their previous working experience, generally the majority of participants in the focus groups considered their health was better immediately upon arrival, and majority of all the participants considered their current health was “good” or “fair”. The survey that was conducted at the end of the focus groups, assessing their participants’ health status, also confirmed the findings from the discussions.

The findings of the paper mostly confirmed the conceptual framework model that was outlined in chapter five. Within the parameters of participants’ settlement experience, factors that might affect participants’ mental and physical health were discussed to identify various determinants of their current health status. The data reflected the health determining factors that were included in the conceptual framework model, such as cultural adaptation, change in lifestyle and low social capital. Low language proficiency and cultural differences (cultural adaptation) that were found comparing participants and mainstream society were barriers preventing participants from integrating into mainstream society. Unable to fully integrate and actively participate in their host society, many participants experienced acculturative stress, such as a sense of isolation, loneliness and marginalization. Acculturative stress was also explained as an outcome of health determining factors as indicated in the conceptual framework model. In order to cope with such mental stress,

participants looked to their ethnic community to find a sense of belonging and social support. However, a lack of quality in their social networks and social capital in fact worsened their settlement stress.

As various settlement stresses caused a high level of mental stress among participants, it was not surprising that this mental stress was developing into physical symptoms. Participants with a high settlement stress level, especially the astronaut housewives, were more likely to develop a debilitating physical condition such as chronic headaches, allergies and insomnia. This stage of worsening participants' mental and physical health based on acculturative stress was explained as deterioration in self-perceived health status as a partial outcome of acculturative stress in the conceptual framework model.

The commonalities in findings from the four focus groups were the participants' exposure to the three health determining factors (cultural adaptation, change in lifestyle and low quality in social capital). However, there was a difference in terms of the level of exposure to certain acculturative stress between different focus groups, which affected their self-perceived health status differently. For example, while the signs of mental stress (e.g. depression and loneliness) were prevalent among female participants (mostly 35 or older in focus groups 1 and 3, both recent, less than 5 years and long-standing immigrants, more than 10 years) male participants (in focus group 4), were more likely to report work-related settlement stress and worsened chronic conditions upon their arrival in Canada. Small businesses run by Korean immigrants tend to be convenience stores or dry-cleaning businesses that require long hours of work, much repetitive physical activity and sometimes handling of chemicals in the work place. These working conditions were given by the participants as the reason for the increased mortality rate among first generation Korean immigrants.

The second approach to examining the self-perceived health status of Korean participants was observing their use of the health care system. It was interesting to find out that their experience of using the Korean medical care system prior to migrating to Canada had shaped their use of and

satisfaction level with access to the Canadian system. The new experience of barriers to using Canadian primary medical system, such as difficulty getting what they considered timely treatment, lack of information or access to thorough physical examinations, disagreements over need for prescriptions, along with language and cultural barriers with their physicians, created a fear of undiagnosed symptoms and illnesses. This data on the types of barriers to medical access helped to better understand what the unmet needs of medical care referred to in the conceptual framework. The result of such, perhaps unwarranted, but perceived fear of their unknown or undiagnosed health status was to seek an alternative health coping strategy.

The data of this paper also confirmed conceptual framework that the existing settlement stress and barriers to accessing the primary health care system in Canada among Korean participants resulted in alternative health coping strategies. The findings indicated that there were two distinct health coping methods. First, barriers to using family physicians and walk-in clinics noticeably increased patterns of demand for access to specialists and emergency department services for non-life-threatening illnesses. Second, as they continuously experienced difficulties in using these alternatives to the regular health care services, the Korean participants chose to use medical services in their homeland.

Korean participants had high levels of transnational activities and these often involved regular trips back to Korea (Kwak, 2008). With their existing frustrations about accessing the Canadian medical system and the quality of the care provided (indicated as the barriers to medical access in the conceptual framework model), many practiced their alternative health coping strategy by combining their transnational activity with their unmet needs for medical care. In other words, many participants were using their frequent trips back to Korea as an opportunity to use preventative health practices such as thorough health checkups including MRI or CT, as well as primary health care and specialists. They were saving their trips to Canadian physicians until they had gone back to Korea and seen a Korean doctor. This desire to see a Korean doctor was not only for the benefit of

using a familiar health system, but for the quality of care, the easy access to care, and absence of language and cultural barriers that might cause misunderstandings between themselves and physicians and so produce inadequate medical care. This finding is valuable in understanding the medical needs of participants and their motivation and reasons for using the alternative health coping strategy and thus should enhance the conceptual framework model further.

It is important to note that the socio-demographic (age, sex, marital status, length of stay in Canada) and socio-economic status (professional experience, household income and education level) of the participants were major factors influencing the findings of this research. All of the participants were economic immigrants with on average a high socio-economic status. About half of the participants were also unemployed housewives. What this indicates is that many of the participants had financial resources and time flexibility to afford such frequent trips back to their country of origin and to resort to an alternative health care system. Thus, the findings of this research may enhance understanding of the determinants of health among racialized economic immigrants with high socio-economic status, however is not representative of the greater racialized economic immigrants (Dean & Wilson, 2009).

Few limitations were associated with the use of focus groups for this research. The relatively small number of participants may have excluded people with a broad range of household incomes. However, I emphasize that the participants for this study had higher socio-economic status than generally expected in Korean communities in Canada. Thus, findings of this research are not meant to represent the entire Korean immigrant community in Ontario, let alone in Canada. There is also a gender imbalance in the study with a slightly higher number of female participants (59%) than male participants (41%). However, having more female participants is perhaps beneficial, because it is more representative of the total gender distribution among Korean immigrants in Canada, where there are slightly more women (51.7%) than men (49.3%) (Lindsay, 2001). Furthermore, the findings are based on the focus group discussions in which participants relied on their memories, which may

have been recent in nature or retrospective over a long period of time and so not always 100 percent accurate (Jimenez, 2009).

The findings of this research on the unique health concerns of a particular group of Korean immigrants have potentially important policy implications. Identifying unique health care needs and provisions, types of unmet needs for care, barriers to accessing the health care system should be known to policy makers so that they can formulate and provide better health care system strategies in policy papers and care provisions in practice. To raise awareness of ethnicity-sensitive health care provision, more research on ethnic-specific health status and immigrant use of the medical system is called for. Better health promotion programs and health care provisions specifically targeting ethno-specific immigrants should also be in place. To provide this ethno-specific program delivery effectively, both public and physicians should be educated. The public should be given correct information about effective health practices, including how to better manage their own health. For example, participants in this study strongly believed that highly advanced preventative health practices were one of the best ways to maintain one's health. It remains unknown, however, that participants were aware of the widespread medical screening tests do involve a downside, such as false positives or false negatives, detection of slow growing cancers that do not require treatment, and detection of deadly cancers that are going to cause fatality anyway (Calonge, cited in Wentz, 2009). Rather than depending on screening tests to maintain their health, immigrants should be given correct information on health practices through more ethno-specific community-based organizations. Also, more physicians should be taught that when dealing with racialized immigrants they need to sensitize their medical provision, particularly focusing on subtle discrimination and communication during the treatment time.

Furthermore, the gaps in primary health care services that were raised during the focus group discussions, such as shortages in human resources and maldistribution of physicians; dissatisfaction on the part of patients from limited provided care can be partially remedied by encouraging the use of

the enhanced physician reimbursement model called, “Family Health Reform”(Glazier et al., 2009). Although there are conflicting findings on the reform of primary health care, the enhanced fee-for-service, Family Health Reform is a blended capitation funding model for physicians that is generally reported to bring better comprehensiveness of care and access to care for patients. Lower morbidity and comorbidity indices, increased after-hour care, less visits to emergency departments were evident for the existing patients for the enhanced fee-for-service than patients in the capitation practices (Glazier et al., 2009). Moreover, this new funding model caused increased “uptake of unattached patients” (Glazier et al., 2009). Therefore, changing the funding strategy to physicians, may positively reinforce their ability to provide medical care for patients, and ultimately enhance the medical experience in Canada for not only immigrants but the general population as well.

More future research should be conducted on the relationship between trans-nationalism and the use of alternative health coping strategies. Conducting more research on the immigrants’ preference for the use of alternative health care over the Canadian primary health care system would reveal the inefficiencies in the existing primary care system and also find ways to meet the hitherto unmet needs for care. Finally, due to the small number of 22 participants involved in this study and the qualitative nature of focus group methods, the analysis only allowed restricted speculations on the possible relationships, between various factors. Thus, a larger random survey is needed for future research to confirm and generalize the relationships and patterns found in this study.

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