Medical Transnationalism: Korean Immigrants’ Medical Tourism to the Home Country

Sou Hyun Jang

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MEDICAL TRANSNATIONALISM:

KOREAN IMMIGRANTS’ MEDICAL TOURISM TO THE HOME COUNTRY

by

SOU HYUN JANG

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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Medical Transnationalism: Korean Immigrants’ Medical Tourism to the Home Country

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Sou Hyun Jang

This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

Medical Transnationalism: Korean Immigrants’ Medical Tourism to the Home Country

By

Sou Hyun Jang

Advisor: Pyong Gap Min

This dissertation examines Korean immigrants’ barriers to formal U.S. healthcare, three distinctive types of healthcare behaviors that they exhibit, contributing factors to their medical tourism, and their experiences and evaluations of medical tourism. Analyzing survey data with 507 Korean immigrants and in-depth interviews with 120 Korean immigrants in the New York-New Jersey area, the study finds that more than half of Korean immigrants have barriers to healthcare in the U.S., the two biggest being the language barrier and not having health insurance. The study also finds that there are three distinctive types of healthcare behavior that Korean immigrants employ to deal with their barriers to healthcare utilization: preference for and dependence on co-ethnic doctors in the U.S., the use of Hanbang (traditional Korean medicine) in the U.S., and medical tours to the homeland. Social transnational ties and health insurance status are the most influential contributing factors to Korean immigrants’ decision to take medical tours to the home country. The vast majority of Korean immigrant medical tourists are satisfied with their medical tourism experiences. This dissertation makes both empirical and theoretical contributions to the literature on immigrant healthcare and immigrant transnationalism by focusing on one immigrant group and by connecting medical transnationalism to other types of transnationalism. The findings of this dissertation imply that
health programs for the most marginalized group—small business owners and their employees—and better support for bilingual Korean-English translators at hospitals are needed.

**Keywords**: New York-New Jersey Korean Community; Mixed-method Approach; Korean Immigrants; Barriers to Healthcare Utilization; Healthcare Behaviors; Co-ethnic Doctors; *Hanbang*; Medical Tourism
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**Introduction**

**Background**

Globalization has brought many new social phenomena, changing many peoples’ lives. One of the new phenomena that have emerged is international medical tourism: trips abroad to obtain medical services. This trips are usually from more developed countries such as countries in North America, Western Europe and the Middle East, to less developed countries such as Mexico, India, Thailand, Singapore and South Korea (Connell, 2006; De Arellano, 2007; Gahlinger, 2008; Ko, 2011; Reed, 2008). Many scholars have pointed out that this worldwide phenomenon has been rapidly growing during recent years (Balaban & Marano, 2010; Connell, 2006; Green, 2008; Mattoo & Rathindran, 2006). Focusing on the U.S. context, Keckley and Underwood (2008) predict that the number of American medical tourists will increase to about 16 million by 2017.

First of all, I need to clarify how I define medical tourism before I examine it. There seems to be no commonly-agreed definition of medical tourism. However, scholars commonly use two conditions to define it: (1) individuals travel from their country to another country, and (2) this trip is intended to get medical care and services. Several scholars (Garcia-Altes, 2005; Goodrich & Goodrich, 1987; Lunt & Carrera, 2010) distinguish medical tourism from health tourism. They consider that medical tourism is derived from health tourism, a broader term including improving, maintaining and recovering individual well-being. Regarding immigrants’ medical tourism, there is also no consensus on how to define it. Their visit to the home country for medical care is also called ‘diaspora medical tourism’ (Keckley & Underwood, 2008; Reed, 2008; Xing, 1998) or ‘medical return’ (Bergmark et al., 2010; Horton & Cole, 2011). However,
in this dissertation, I will use the term ‘medical tourism’ because it is the most suitable term to define the subject of my research: immigrants’ visit to their home country with the intention of medical care or treatment, but not solely for the medical purpose.

Most long-term Korean immigrant visitors to Korea might visit a doctor’s office or a hospital for health care when they suddenly and practically need it. For example, Professor Min, my dissertation advisor, told me that he visited a Korean acupuncture office several times during his stay in Seoul for one month because he had severe back pain caused by his holding two pieces of heavy luggage at the airport. This kind of healthcare treatment cannot be considered as medical tourism. In fact, OECD (2011) refers to these temporary visitors abroad who suddenly ill or have a sudden accident as ‘unfortunate tourists,’ not ‘medical tourists.’ Thus, I consider Korean immigrants as medical tourists when they meet the following two conditions. First of all, they should have intended to get medical care prior to their visits to Korea. Second, the participants should have received major medical treatments in Korea, such as major surgeries, major physical examinations and/or dental care.

It is also important to know how the Korean government defines the individuals who visit Korea for medical care. Officially, the Korean government refers to them as ‘foreign patients,’ not ‘medical tourists’ (KHIDI, 2010). There are three necessary conditions to be considered as a foreign patient by the Korean government’s definition: (1) the individual should not have the Korean citizenship, (2) the individual should not have a Korean national health insurance, and (3) the individual should not be registered as a foreigner\(^1\) at the Korean government. Thus, Korean immigrants who maintain the Korean citizenship with the U.S. permanent residency are

\(^1\) (1) A foreigner, (2) a former Korean who lost the Korean citizenship, or (3) a Korean-born foreigners who are given residence status who intends to stay in Korea for more than 90 days after his entry is eligible for “foreigner registration” to the Korean government. (www.hikorea.go.kr/pt/InfoDetailR_pr.pt)
not defined as foreign patients by the Korean government. However, for my dissertation, I include all Korean residents in the U.S. who include temporary residents, permanent residents, and naturalized U.S. citizens because all these three groups can visit Korean for medical treatment. The Korean government needs to classify Korean immigrants naturalized as citizens of host countries separately from other foreigners. Also, it should collect statistics on Korean residents in foreign countries with Korean citizenship who visit Korea for the medical purpose under the category of “Korean overseas medical tourists.”

As will be documented in detail in the literature review section of Chapter 1, researchers have found that immigrants have shown a greater tendency to visit their home countries for medical care than their native-born children. For example, foreign-born U.S. citizens show a greater propensity for medical tourism than native-born Americans (Reed, 2008; U.S. Department of Commerce, 2005; Wallace et al., 2009). Preliminary research indicates that there are several contributing factors to immigrants’ medical tours to their home country: high medical costs in the U.S., unfamiliarity with the U.S. health care system, and lack of health insurance coverage. In fact, Reed (2008) indicates that health insurance status is one of the major reasons for immigrants’ medical tourism. In Chapter 5, with my own data, I will examine the contributing factors to Korean immigrants’ medical tourism and see if the other immigrant groups’ contributing factors are also applicable to Korean immigrants.

The Need for the Study

Despite a great propensity of immigrants to take medical tourism and the plausible reasons for doing so, researchers have neglected to study immigrants’ medical-tourism experiences systematically. As will be explained later, recently Portes and his associates (2012) used the
transnational theory to explain immigrants’ medical tourism. However, rather than examining contributing factors to immigrants’ medical tourism, their framework of immigrants’ medical tourism was still conceptual; they have not tested their theory based on any quantitative or qualitative data. Moreover, the majority of studies on immigrants’ medical tourism have focus on Mexican immigrants (Bergmark et al., 2010; Brown 2008; Horton & Cole, 2011; Landeck & Garza, 2003), with only a few of them covering other immigrant groups (Fong, 2008; Lee et al., 2010; Xing, 1998).

Korea has become one of the “hot destinations for medical tourism” in the world (CNN, 2009; Horowitz et al., 2007; Ko, 2011), although Korea is not yet competitive with other strong medical tourism countries, such as India, Thailand, and Singapore (Choe, 2008). Regarding the source countries of medical tourists to Korea, Americans seem to be one of the largest medical tourist groups. The 2010 report published by the Korea Health Industry Development Institute (KHIDI) showed that about 82,000 medical tourists visited Korea and that the U.S. medical tourists accounted for 32 percent of them. However, I assume that the number of the U.S. medical tourists might be undercounted because this Korean-government report did not include Koreans who have the U.S. permanent residency or who are the temporary residents of the U.S. Another government report (KOTRA, 2009) indicated that the Korean government and medical tourism agencies have targeted Korean immigrants rather than Caucasians in the United States, although the Korean government has not collected statistics on Korean immigrant medical tourists.

Although the Korean government agencies and the Korean media have paid great attention to Korean immigrant medical tourists to Korea, previous studies include Korean immigrants in only a few English-speaking countries: New Zealand, Canada, and the U.S. Lee et
al. (2010) examined the medical tourism of Korean immigrants in New Zealand. However, the number of foreign patients from New Zealand is negligible. Wang and Kwak (2015) studied the medical-tourism experience of Korean immigrants in Canada, but Canadian patients make up only a very small proportion (2.6%) of total foreign patients to Korea. Oh and his associates (2014) examined the medical tourism of Korean immigrants in the U.S. who comprised the largest overseas Korean patient groups in Korea, numbering 21,338. The U.S. patients are comprised about 32.4 percent of all foreign patients who received medical care in Korea, but their study is restricted to the middle-aged female Korean immigrants who get preventive care such as cancer screening. Thus, this dissertation will contribute to the scarce literature on Korean immigrant medical tourists to Korea, as it analyzes a large-scale survey and in-depth personal interviews with sociological theories.

Main Objectives

This dissertation intends to bridge the gap in research on overseas Koreans’ medical tourism to Korea using relevant sociological theories and research methods. It has three main interrelated objectives. First, it intends to examine how the Korean government’s policy and its close coordination with medical organizations and travel agencies have contributed to the development of medical tourism to Korea since the mid-2000s. It will also examine the extent to which government agencies and medical organizations in Korea have targeted Korean immigrants in the U.S. and other countries. For this objective, it will analyze Korean government reports, studies conducted in Korea, and newspaper articles.

Second, this dissertation intends to answer the following questions regarding Korean immigrants’ healthcare behaviors in the U.S. and the contributing factors to their use of
homeland as the place of medical care. What are the barriers for Korean immigrants to receive medical care in the U.S.? Do these barriers contribute to their distinct healthcare behaviors? How are these barriers and behaviors associated with their decision on medical tour to the home country? What are the other contributing factors to their medical tourism? To answer these questions, I will first probe into their healthcare utilization in the U.S., which is closely related to their decision on medical tourism to Korea for medical care. Then I will examine if Korean immigrants’ transnational ties with home country, their health insurance status, temporary resident status, socioeconomic status, and other demographic characteristics affect their decision on medical tourism.

Third, this dissertation will examine several aspects of their experiences during their medical tourism and their evaluation of medical tourism after they had it. It examines the arrangements and processes of their medical tours to Korea, where they get medical services and the types of medical care obtained in Korea. It also investigates the level of their satisfaction with medical care in Korea compared to the medical costs and medical services obtained in the U.S., and their future plan for revisits to Korea for medical services.

Theoretical and Conceptual Frameworks

Three theoretical perspectives or concepts are useful in understanding Korean immigrants’ medical tours to their homeland. Globalization theory is helpful in understanding Korean government agencies’ and medical organizations’ efforts to attract recipients of medical services globally beyond their national boundary, including the Korean community in the U.S. The transnational theory is relevant to making sense of Korea immigrants’ tours to Korea for medical care. Last, theories of immigrants’ healthcare utilization will contribute to providing a
framework to explain Korean immigrants’ health care in the U.S. and their decisions on medical tourism to the home country.

*Globalization Theory*

There is a long literature on globalization theory, and thus it may be impossible to review it all here. Among many definitions, Held and his colleagues’ definition of globalization (1992: 2) as “the widening, deepening and speeding up of worldwide interconnectedness in all aspects of contemporary social life” seems to be most relevant here. There are different types of globalization: economic, political, socio-cultural, educational, media, social movement and so forth. Among all these, economic globalization has received the greatest academic attention (Brown & Lauder, 1996; Currie & Newson, 1998; Stromquist & Monkman, 2000). There are different forms of global economic activities that include economic integration between two or more countries, international trade and the expansion of global multinational firms.

From the Korean government’s or medical organizations’ point of view, medical tourism is another type of global economic activity that tries to attract recipients of healthcare services globally. However, since global medical services have many non-economic components, we may consider them as another type of global phenomena involving delivery of global medical services. Compared to other forms of globalization, medical globalization, especially medical tourism, is a more recent phenomenon (Bookman & Bookman, 2007; Connell, 2006; Reddy et al., 2010; Reed, 2008). Technological advances that contributed to other types of globalization, including the popularization of international air travel, have made possible transnational healthcare tours. However, the big difference in healthcare costs between Western countries and
newly developed Asian countries, such as India and Korea, is also another important contributing factor to newly emerging transnational healthcare tours.

**Transnationalism Theory**

Second, the concept or theory of transnationalism is useful for examining Korean immigrants’ medical tours to Korea from their own perspective. The concept of transnationalism has a similar meaning to globalization. However, used by immigration scholars, transnationalism or transnational ties refer to the extent to which immigrants or immigrant organizations maintain linkages to their homelands. Some scholars have not made a clear distinction between transnationalism in general and immigrant transnationalism in particular. For example, Portes’ 1999 article placed general transnationalism as its analytic center whereas his 2001 study gives answers to many questions related to immigrants’ transnationalism in particular. In this dissertation, I will focus on immigrants’ transnationalism rather than transnationalism in general.

Social-scientific research on contemporary immigrants’ transnational ties began in the early 1990s. (Basch et al., 1994; Schiller et al., 1992). In 1994, Basch and her colleagues defined transnationalism “as the processes by which immigrants forge and sustain multi-stranded relations that link together their societies of origin and settlement” (Basch et al., 1994: 7). Following their pioneering work, many sociologists and other social scientists have conducted research on immigrant transnational ties (Foner, 1997; Itzigsohn, 2000; Kasinitz et al., 2002; Levitt, 2001; Levitt & Waters, 2002; Levitt et al., 2003; Min, 2012b; Portes, 2003; Portes et al., 1999; Smith, 2005; Smith & Guarnizo, 1998).

Portes and some researchers have applied a narrow definition of transnational ties that includes only “occupations and activities that require regular and sustained social context over
time across borders for their implementations” (Portes et al., 1999; Yang, 2006). However, other scholars have used a broader definition, including immigrants’ economic, political, social and cultural activities with their homelands (Faist, 2000; Itzigsohn et al., 1999; Itzigsohn, 2000). Korean immigrants’ medical tourism to Korea does not belong to the broad definition of medical transnationalism because it does not require regular visits to the home country. Their medical tours to the home country might be a one-time trial. However, it can be still considered as a form of transnationalism because it requires their actual visits to Korea.

Broadly used, transnationalism indicates individual, organizational or governmental cross-border activities. Scholars have distinguished transnationalism with the high and low levels of institutionalization (Schiller et al., 1992; Guarnizo & Smith, 1998; Portes, 2001). According to them, ‘transnationalism from below’ refers to everyday transnational practices or bottom-up grassroots movements at the individual level, whereas ‘transnationalism from above’ means top-down transnational activities at government or corporate level. However, this binary categorization of transnationalism has been criticized by several researchers (Chin & Smith, 2015; Waldinger & Fitzgerald, 2004) because ‘transnationalism from above’ regards nation-states as passive and powerless. Rather, Chin and Smith (2015) argued that nation-states are an essential and active entity that can initiate, promote, and maintain transnational activities. They pointed out that ‘state transnationalism,’ transnational activities that were launched or supported by states, happens when the state seeks its national interests. They also indicated that state transnationalism does not need to be top-down; it includes cooperation between homeland states and diaspora communities. The Korean government’s and other private sectors’ efforts to attract Korean immigrants to the home country for medical care can be considered as state transnationalism because it is initiated and supported by the Korean government in its pursuit of
national economic interests. Thus, the notion of state transnationalism will be applied in Chapter 3 when I explore the Korean government’s strategies to attract ‘foreign patients,’ including Korean immigrants.

Previously, Portes and other transnational scholars have classified immigrants’ transnational activities into the following forms: economic, political, social, and cultural (Itzigsohn, 2000; Kivisto, 2003; Portes, 2001). Some immigration scholars have studied U.S. immigrants’ transnational religious activities, which involve connecting their host cities of settlement and their home cities, both individually or organizationally, as another form of transnational activities (Levitt, 2001; McAlister, 1998; Min, 2010). In contrast to the plethora of research on these types of immigrant transnationalism, there have been only a few studies of immigrants’ medical transnational ties with the home country. For example, Portes, Fernández-Kelly, and Light (2012:16) considered medical transnationalism as one of the coping strategies when legal immigrants have temporary difficulties in getting health insurance for formal health care in the United States. They gave an example of Latino immigrants’ crossing borders for a temporary return to their home country with the intention of receiving medical care. Although they indicated immigrants’ trips to their home countries for medical care as medical transnationalism, they have not explored it with any empirical data.

Considering immigrants only, there are narrow and broad definitions of medical transnationalism. On the one hand, a narrow definition of medical transnationalism includes immigrants’ visiting the home country to get medical care. This form adheres to the narrow definition of medical transnationalism because it requires the physical movement of an individual immigrant to the home country with the intention of getting medical care. Unlike the broad definition of medical transnationalism, which will be explained later, this narrow type is
deeply connected with other types of transnationalism. For example, it is associated with dual citizenship among immigrants, which is a form of political transnationalism. Immigrants who have dual citizenship of both their home and receiving countries might visit their home country more often and more easily. Thus, their chance of getting medical care in the home country might increase as well. Social and cultural transnationalism are also related to immigrants’ medical tourism. Relatives or friends in the home country can help making medical appointments for immigrants even before they arrive the home country so that they can get medical care more quickly and easily, which is directly related to social transnationalism. Moreover, seeing advertisements on ethnic media such as television, newspapers, or radio in the receiving countries can make immigrants more likely to consider a medical tour to their home country, which is an example of associations between medical and cultural transnationalism. On the other hand, a broad definition of medical transnationalism includes all other types that do not require immigrants’ actual visit to the home country. Receiving medicine from the home country or consulting health information from Korea can be considered as examples of the broad definition of immigrant medical transnationalism. In this dissertation, I will not cover this broad type of medical transnationalism.

In sum, immigrants’ medical tourism does not stand alone. Rather, it is connected with other forms of immigrants’ transnationalism. Therefore, the associations between Korean immigrants’ medical tourism with different types of transnationalism will be examined in detail in the following chapters. Particularly in Chapter 4 and 5, I will examine how Korean immigrants’ transnational ties, especially social ties, are connected with their medical tourism to home country with my survey and in-depth interviews with Korean immigrant medical tourists.

Theories and Concepts on Immigrants’ Healthcare Utilization
Since medical tourism is one of the healthcare utilization options, I will apply theories and concepts related to immigrants’ healthcare utilization to examine their medical tourism. Andersen (1968, 1973 & 1995) provided one of the most popular healthcare utilization models for the general population. He (1968, 1995) and his colleague Newman (1973) suggested that there are three factors that determine healthcare services: (1) predisposing factors (e.g. socio-demographic characteristics such as race, gender, and age), (2) enabling factors (e.g. access to healthcare and ability to pay for healthcare such as having health insurance, social relationships involving support from family and community), and (3) perceived and actual need for health service. Applying Andersen’s framework, Akresh (2009) found that the duration of stay in the U.S. had a strong positive influence on immigrants’ health service utilization, after controlling for predisposing factors.

Andersen’s model is one of the widely known models in healthcare utilization for the general population. Akresh (2009) argued that his model is useful to explain immigrants’ healthcare as well. However, there is a limitation to his model because it is not specifically designed for immigrants. Therefore, researchers have modified his model by adding barrier factors that are more relevant to immigrants who are more vulnerable and more likely to show underutilization or delayed utilization than the general population (Carrasquillo et al., 2000; Derose et al., 2007 & 2009; Ell & Castaneda, 1998; LeClere et al., 1994). They have pointed out that we can categorize immigrants’ barriers to healthcare into three categories: (1) structural, (2) financial, and (3) personal barriers. In Chapter 1, I will discuss each barrier and review what kinds of barriers Korean immigrants face in the United States.

Some previous studies have pointed out that immigrants’ barriers to access to formal healthcare utilization contributed to their coping strategies, such as going to free clinics, seeing
co-ethnic doctors (Choi, 2013; Portes et al., 2012; Wang, 2007; Wang et al., 2008), usage of alternative/folk medicine (Akresh, 2009; Han, 2001; Hill et al., 2006; Kim & Chan, 2004; Portes et al., 2012; Pourat et al., 1999; Wu et al., 2007), or medical tours to the home country (Brown, 2008; Landeck & Garza, 2003; Lee et al., 2010; Oh et al., 2014; Wang & Kwak, 2015). Notably, Portes et al. (2012) set the framework for immigrants’ different coping strategies based on their different types of barriers to access to formal U.S. healthcare. According to their categorization, there are four possible situations based on the types of barriers and coping strategies. First, when immigrants lack English proficiency or have cultural differences such as cultural-linguistic barriers, they tend to see co-ethnic healthcare professionals as a coping strategy. Second, when immigrants are uninsured, they tend to seek folk medicine or see unlicensed doctors. Third, if immigrants who recently migrated to the U.S. are not able to access federal health programs, such as Medicaid or Medicare, they tend to go back to the home country for medical care or use free clinics. Lastly, undocumented immigrants tend to seek folk healers, go to free clinics, or receive drugs from the home country. Applying Portes and his associates’ frameworks, Chapter 4 will examine if and how these barriers contribute to Korean immigrants’ medical tour to the home country as one of their coping strategies.

Data and Methods

In this dissertation, I used the following five multiple data sources: (1) public documents, (2) my own survey of 507 Korean immigrants, (3) personal interviews with 20 staff members representing various groups in New York and Korea, (4) audio-taped personal interviews with 100 Korean immigrant participants in medical tourism to Korea and 20 non-participants, and (5) Korean- and local English-language newspaper articles. The first two data sources are
quantitative data while the last three are qualitative data. Use of multiple data sources is one of the major strengths of this dissertation.

Public Documents

I utilized the U.S. decennial census data from 1970, 1980, 1990, 2000 and 2010 to examine the growth of the Korean-American population and Korean immigrants’ settlement patterns in the United States and the New York-New Jersey metropolitan area. I also used the 2009-2011 American Community Surveys (ACS) to analyze Korean immigrants’ demographic and socioeconomic characteristics, occupational characteristics and their rate of health insurance coverage. I chose the 2009-2011 ACS data mainly because the Census Bureau has begun to include the health insurance variables since 2008.

Survey of Korean Immigrants in the New York-New Jersey Area

I conducted a survey of 507 Korean immigrants in the New York-New Jersey metropolitan area to examine Korean immigrants’ medical-tourism experience. The survey questionnaire includes about 40 items. The items can be classified in the following categories: (1) demographic and socioeconomic characteristics and immigration history, (2) their involvement in Korean networks and associations, (3) health insurance and other health-related issues, (4) transnational activity, and (5) medical tourism to Korea (See Appendix A).

The survey participants were recruited in the New York-New Jersey metropolitan area, the second-largest area where Korean immigrants live in the U.S. They were recruited from ethnic-religious organizations, major ethnic festivals (Korean Parade in Manhattan, Korean Thanksgiving, and Folklore Festival in Queens and Korean Festival in New Jersey), other ethnic events at the ethnic community centers, and also personal channels. I did not use a random
sampling technique. However, I used a quota sampling technique to reflect the proportion of Korean immigrants living in the New York-New Jersey metropolitan area based on their gender and age distribution. A survey data will be analyzed in Chapter 4 and 5 where I examine the contributing factors to Korean immigrants’ medical tourism and their experience of it.

*Personal Interviews with Local Staff Members*

I interviewed 20 staff members of various organizations in the Korean community New York and Korea: (1) Korean travel agencies in New York, (2) Korean community centers in New York, (3) The Ministry of Health and Welfare, and (4) three hospitals (Seoul Asan, Yonsei Severance, and Inha University hospitals) in Korea that had received foreign patients and Korean immigrant medical tourists. I asked several questions to these staff members to get background information about when the medical tourism started, how prevalent it is, the proportion of oversea Koreans out of all foreign patients, how the participants are recruited, common types of medical services that the participants have received, how much money they spend and how they pay, what are the strategies of each agency to attract more medical tourists, and other related issues. I also obtained pamphlets, fliers, and other written materials regarding medical tours from these organizations.

*Audio-taped Personal Interviews with 120 Korean Immigrant Participants*

I conducted audio-taped personal interviews with 100 Korean immigrants who had taken at least one medical tour to Korea. I also had chances to talk with 20 non-medical tourists and asked them why they had not taken medical tourism to Korea. I included those non-participants to contrast their decision and experience of medical tourism to the participants. However, my in-depth interviews are mostly focusing on medical tourists who had been to Korea and received
medical treatments or services at least once. I asked them about their medical-tourism experiences in detail. Although I included questions about medical tourism in the survey questionnaire, personal interviews gave me more detailed and nuanced information about their experiences of medical tourism than survey questions.

To recruit interviewees, I first asked the survey participants whether or not they were willing to respond to a further in-depth personal interview. Since I could not obtain enough interviewees through the survey, I used a snowball sampling technique. In order to reduce the bias of having certain group of Korean immigrants as interviewees, I categorized Korean immigrants into five groups: (1) international students, (2) young Koreans who are between 18 and 29 years old, (3) adult Koreans who are between 30 and 44 years old, (4) middle-aged Koreans who are between 45 and 64 years old, and (5) elderly Koreans who are 65 years old or older. I tried to make almost equal numbers of interviewees for each group and balanced numbers of men and women in each group. I believe this categorization helped me to analyze and compare how demographic characteristics (e.g. age, gender, occupation, and visa status) of each group contribute to their medical-tourism experiences.

About 50 questions, mostly open-ended, were asked to the informants. These questions probed into the participants’ background characteristics, including information about their health insurance coverage, the factors that contributed to their decision to take medical tours, the duration of their medical tours, the types of health care received in Korea, their evaluations of the quality of medical services obtained in Korea for the costs, and their plan to continue to use medical tours as a mean for their medical care. Each audio-taped personal interview took about thirty minutes to an hour to be completed. I believe that audio-taped personal interviews are the
central component of data for this dissertation and provide many interesting comments made by the informants. Every name that appears in this dissertation is a pseudonym.

*Korean- and English-Language Daily Newspaper Articles*

Finally, I analyzed newspaper articles published both in the New York-New Jersey area and in Korea as another major data source for this dissertation. *Chosun Ilbo* and *Joongang Ilbo*, two dailies in Korea are chosen because they have the most subscribed readers in Korea. *Koreadaily* and the *Korea Times* are selected because they are the only newspaper companies based in the New York-New Jersey area that produce articles daily.

Researchers (Ko, 2011; Reddy et al., 2010) have pointed out that the media have shown more interest in medical tourism than the academia. Thus, newspaper articles have allowed me to examine how medical tourism has been perceived and how discourses on medical tourism have been changed over time in Korea. Since the Korean government began to promote medical tourism actively in 2009, I expect to find different types of articles regarding medical tourism to Korea from the issues published years *before* and *after* 2009. Therefore, I reviewed articles published in four Korean-language newspaper dailies published in Korea and the U.S. between 2003 and 2013. I analyzed the two local Korean-language daily newspaper articles as well as articles in the two dailies published in Korea to get perspectives of both the Korean community here and the organizations in Korea.

**Organization of Dissertation**

This dissertation is consists of the introduction, six substantive chapters, and the conclusion. The introduction first briefly describes medical tourism and why its study is needed. It then provides the main objectives of this study and its theoretical and practical contributions. It also clarifies
research methods and major data sources. Questionnaires are attached at the end of the dissertation as appendices. Finally, the introduction summarizes the organization of this dissertation.

Chapter 1 (Literature Review of Medical Tourism) reviews literature on medical tourism. The aim of the first section of this chapter is to explore the previous studies of medical tourism in general, such as its various definitions and types. It then examines the previous studies of different immigrants’ medical tourism to the home country. Lastly, it reviews Korean immigrants’ various healthcare patterns in the U.S. and their medical tourism to Korea.

Chapter 2 (Background Information of Korean Immigrants) provides the background information about Korean immigrants in the New York-New Jersey. Based on the existing literature and the ACS data, this chapter covers the history and contemporary trends of Korean immigration to the U.S. and to the New York-New Jersey area, their settlement patterns, socioeconomic characteristics, concentration in small businesses, ethnic attachment, health-related issues, and transnational ties and activities.

Chapter 3 (The Development of Global Medical Tourism in Korea) examines the Korean government’s effort to develop the medical tourism industry in Korea. It investigates the beginning of the development of medical tourism in Korea, the Korean government’s cooperation with the private sector and their strategies to attract more medical tourists. This chapter pays particular attention to government agencies’ and the private sector’s efforts to bring more Korean immigrants to Korea for medical care. In this chapter, I mainly use secondary resources, such as newspaper articles, reports by government agencies, and results of social science research on global medical tourism.
Chapter 4 (Korean Immigrants’ Healthcare Behaviors) examines Korean immigrants’ three healthcare behaviors based on results of a major survey and in-depth personal interviews. There are three major healthcare behaviors that I focus on: Korean immigrants’ preference and dependence on co-ethnic doctors, their practice of Hanbang, and their medical tourism to the home country. I will examine why Korean immigrants show these healthcare behaviors and how the first two behaviors are related to the last one, medical tourism.

Chapter 5 (Contributing Factors to Korean Immigrants’ Decision on Medical Tourism to Korea) shows the prevalence of Korean immigrants’ medical tourism. It then attempts to explain the contributing factors to Korean immigrants’ decision on medical tourism, paying special attention to medical-tourism participants’ transnational characteristics, health insurance status, legal status, life-cycle stage and so on. As a major data source, I use in-depth personal interviews with participants in addition to a survey data.

Chapter 6 (Medical-Tourism Experience and Their Evaluation of It) focuses on medical tourism participants’ experiences during their stay in Korea and their evaluations of it based on personal interviews with participants. It provides information about the arrangement of their medical tourism, the duration of their medical tourism, the types of medical care they received in Korea, and the cities of medical treatments. It also examines Korean medical tourists’ evaluations of medical tourism. I answer the following questions: how much they were satisfied with their medical-tourism experience, whether or not they have any future plan to revisit Korea for medical care, and how their medical-tourism experience changed their lives. Along with Chapter 5, this chapter will be the most important chapter in this dissertation because it indicates new findings on Korean immigrants’ medical tourism based on my own data. The concluding
chapter summarizes major findings, discusses their theoretical and practical significance, and suggests policy implications for the Korean and U.S. governments.
Chapter 1: Literature Review

For a better understanding of Korean immigrants’ medical tourism to the home country, this chapter reviews the existing literature on medical tourism and Korean immigrants’ healthcare behaviors in the U.S. This chapter has three major sections. The first section provides a review of the literature on medical tourism in general. It includes different types and the characteristics of medical tourists. The second section synthesizes the literature on immigrants’ medical tourism to their homeland, mainly on Latino immigrants’ medical tourism because many studies focus on their medical tourism due to the proximity to the homeland. The second section is useful to compare the contributing factors to medical tourism by different immigrant groups. The last section investigates the barriers and difficulties that Korean immigrants have when they utilize healthcare in receiving countries. It also examines Korean immigrants’ several healthcare behaviors: preference for co-ethnic doctors, use of Hanbang, and medical tour to the home country.

Studies of Medical Tourism in General

People have traveled in search of better, cheaper, or more comfortable health care. Thus, medical tourism is not an entirely new phenomenon. However, it is a new term in the globalization era and had not received much attention until recently. Moreover, academic researchers have shown much less interest in medical tourism than the public and private sectors (Ko, 2011; Reddy et al., 2010). In addition to the relative scarcity of academic research, the inconsistent use of definition, a lack of theoretical frameworks and the limited data pose difficulties in studying medical
tourism (Balaban & Marano, 2010; Lunt & Carrera, 2010, Ko, 2011; Reddy et al., 2010; Reed, 2008).

Scholars have categorized medical tourists based on their research purposes. The most common way to do so is to group them by the individual’s motivations to take medical tours, such as the lack of health insurance, expensive medical costs, seeking for a cosmetic care, seeking for a non-FDA approved treatment, seeking for the protection of privacy, and eagerness for travel/leisure in a foreign country (Connell, 2006; Horowitz et al., 2007; Keckley & Underwood 2008). To classify medical tourists, other scholars (Milstein & Smith 2006; Reed, 2008) have used the types of medical care that individuals receive, such as reproductive care, dental care, cosmetic versus non-cosmetic surgery, transplantation, and executive check-ups.

When the direction of travel is considered from Americans’ perspective, medical tourism can be divided into three types (Keckley & Underwood, 2008): (1) outbound medical tourism that U.S. medical tourists go to a foreign country to get medical care, (2) inbound medical tourism that non-U.S. patients come from a foreign country to the U.S., and (3) intra-bound medical tourism that U.S. medical tourist travel across different states. The number of outbound U.S. medical tourists, whom I referred to as medical tourists in my dissertation, are estimated to be about 750,000 in 2007 (Horowitz et al., 2007; Keckley & Underwood, 2008). Keckley and Underwood (2008) reported that only 3 percent of their survey participants actually visited a foreign country to get medical treatment, but that about 27 percent of the respondents answered that they might do so in the future. Regarding the demographic characteristics of outbound U.S. patients, Asians are more likely to visit a foreign country to get elective procedures, which is not directly related to medical emergency, whereas the elderly and those who have Medicare and
Medicaid are less likely to do so. Horowitz et al. (2007) explained that the middle-class Americans without health insurance are the most likely to be medical tourists to a foreign country.

Medical tourism may cause several potential problems. First of all, it could be hard for the medical tourists to find good doctors and hospitals in a foreign country because they have limited knowledge and resources to know that (Horowitz, 2007). Second, it could be problematic for medical tourists to receive a follow-up treatment or a continuous medical care after their medical tour to a foreign country (Horowitz et al., 2007; MacReady, 2007). If there is a side-effect of medical care, it is usually hard for medical tourists to take another trip to a foreign country. The limitation of getting a follow-up treatment is a more serious issue among those who received surgery, especially a transplant surgery in a foreign country (Canales et al., 2006; Terzi et al., 2008). As the doctors in a home country may feel not responsible for doing a follow-up treatment for surgery (Boschert, 2007), the medical tourists may get lost in between two countries.

For the economic benefits, the destination countries try to attract more medical tourists. The development of medical tourism can bring in foreign currency, create more medical-related jobs, produce more tax revenue, and expand the health industry of their own (Bookman & Bookman, 2007; De Arellano, 2007; Garcia-Altes, 2005; Lunt & Carrera, 2010; Reddy et al., 2010; Turner, 2007). In addition to the economic reasons, it can also contribute to the destination countries by preventing a brain drain of doctors and nurses, allowing them to work in their country of origin (De Arellano, 2007). There are several well-known countries for the successful promotion of medical tourists, which include India, Singapore, Thailand, and Malaysia.
Scholars have paid particular attention to the Indian government’s efforts to boost medical tourism (Reddy et al., 2010; Reed, 2008). Notably, the government of India specialized two visas for medical tourists: (1) the Tourist Visa on Arrival (TVOA) for a short-term medical tour and (2) the medical visa for a long-term medical tour. First of all, the individual from any eligible countries, such as Japan, Singapore, Philippines, Finland, Luxembourg, New Zealand, and South Korea and so on can apply, pay, and receive TVOA online and can stay in India for 30 days for short-term medical treatment. Since the individual does not need to visit the Indian embassy to get a visa, he can save time and processes to go to India for short-term medical care. Secondly, in 2005, the Indian government initiated a ‘medical visa’ to attract more medical tourists to India. Once a foreign tourist gets a medical visa, the Indian government allows him to stay in India up to one year, which is not permitted for other tourists with a regular tourist visa. He can also re-enter India up to three times during the year. The Indian government also provides governmental subsidies and reduces tax for the medical tourism industry (De Arellano, 2007).

The government of Singapore, another famous medical tourism country, has established the Singapore Medicine to make Singapore the hub of medical care in Asia (Hurh et al., 2013). Singapore Medicine has established three governmental organizations to promote medical tourism in Singapore: the Singapore Tourism Board (STB), the Economic Development Board (EDB), and the International Enterprise Singapore (IE Singapore). Each organization has shared duties to maximize medical tourism in Singapore. First, the STB contacts medical tourism organizations in other countries, develops various medical tourism programs, and induces cooperation programs between hospitals and travel agencies (Lee & Park, 2013). The EDB
supports medical tourism through investment stimulation and industrial growth in the medical industry. Lastly, the IE Singapore supports health professionals’ overseas activities.

The Thai government has made efforts to promote medical tourism by simplifying visa process for medical tourists, spending more expenditure on healthcare, initiating the “Amazing Thailand” campaign and advertising the excellence of “spas, hospitals and herbal products” in Thailand (Teh, 2007). In particular, the Thai government has set governmental guidelines and the standard for spas and massages in trying to specialize in spa medical tourism (Hurh et al., 2013). To promote medical tourism, the government of Malaysia extends the visa period for medical tourists and supports tax incentives and exemptions to private hospitals. Malaysia also established the Healthcare Travel Council in 2009 to provide information on visa applications, insurance, accommodations, and available medical treatments and locations of medical services. In addition to the countries introduced above, the Korean government has also taken a number of measures to attract foreign medical tourists to Korea. Chapter 3 will examine its efforts and strategies to promote medical tourism.

Studies of U.S. Immigrants’ Medical Tourism to Homeland

More researchers have paid attention to Mexican immigrants’ medical tourism than to any other immigrant group. There are several reasons for this. First, Mexican immigrants make up a large proportion of immigrant medical tourists to their home country simply because they make up about more than 20 percent of total immigrants in the U.S. (Bergmark et al., 2010; Horton & Cole, 2011; Macias & Morales, 2001). Second, due to their unstable job status and a high rate of employment in the informal underground economy, Mexican immigrants have the lowest rate of health insurance among all immigrant groups (Bastida et al., 2008; Bergmark et al., 2010;
Brown, 2008). Third, since Mexico is one of the closest countries to the U.S., Mexican immigrants can easily visit their homeland for medical care.

Horton and Cole (2011) pointed out that Latino immigrants’ medical tour to home country is not just for those who live close to the Mexico border. Yet, researchers have focused on the medical tour experiences of Mexican immigrants who reside in the border states. In other words, due to the physical proximity of California, Arizona, New Mexico and Texas to Mexico, they have shown more interest in medical tours among Mexican immigrants in these border states. Using the 2001 California Health Interview Survey, Wallace et al. (2009) found that Mexican immigrants’ chance of taking a medical tour increases as they live closer to the border. Earlier, Chavez and his associates (1985) found that about 30 percent of Mexican immigrants residing in San Diego had ever visited Mexico for health care since their migration to the U.S. Several studies indicated that about 14 percent of Mexican immigrants in the border states had visited Mexico for the medical purpose. For example, Macias and Morales (2001) conducted a survey of Mexican immigrants who attended a health fair in the city of Lennox, a south Los Angeles County. They found that 14 percent of respondents had crossed a border to Mexico for medical care during the past year. Homedes and LaBrec (1991)’s study shows similar results; 14 percent of 400 Mexican women at the Arizona-Sonora border used Mexico as their regular source of health care. Thompson (1993) also found that 14 percent of 618 Mexican Americans in the Lower Rio Grande Valley in Texas had visited Mexico for the medical treatment.

Researchers have found several contributing factors to Mexican immigrants’ high propensity of medical tourism. First of all, they have indicated that relatively cheaper medical expenses in Mexico is the major contributing factor to Mexican immigrants’ medical tourism to
home country (Brown, 2008; Horton & Cole, 2011; Landeck & Garza, 2003; Macias & Morales, 2001; Thompson, 1993; Wallace et al., 2009). Thompson (1993) found that 83 percent of his Mexican immigrant respondents in Texas chose the low cost as the single most important contributing factor to their health care use in Mexico. Most studies of Mexican immigrants’ medical tourism found that their cultural preference, language, and family custom are less important than the cheaper medical expenses in Mexico. About 70 percent of Mexican immigrant respondents in California also indicated the low cost of medical care in Mexico as the most important reason for their decision to take a medical tour to their home country (Macias & Morales, 2001).

In addition to the lower medical expenses, Mexican immigrants’ uninsured status in the U.S. (Brown, 2008; Landeck & Garza, 2003) and their familiarity with home-country medical treatments (Wallace et al., 2009) are also important contributing factors to their decisions on medical tourism. Horton and Cole (2011) emphasized that there are several attracting features for their Mexican immigrant interviewees to visit home country for medical care. They include the quickness of medical services and the better personal relationships between doctors and patients.

I presume that there are some common motivational factors that contribute to Mexican and Korean immigrants’ medical trips to their home country: lower health care costs, convenience, and familiarity with homeland medical care, and lack of health insurance. There are also differences in medical tourism between the two immigrant groups. For example, it takes longer time and requires more money for Koreans to go back to the homeland because of the longer distance from the U.S. to the homeland. Also, Korean immigrants have a much higher
level of socioeconomic status than Mexican immigrants. Therefore, I will keep these similarities 
and differences in mind when I analyze my survey data and in-depth personal interviews.

Studies of other immigrant groups’ medical tourism are scarce, compared to those of 
Latino immigrants’ medical tourism. Messias’ study (2002) examined medical transnationalism 
with the narratives of Brazilian immigrant women in the United States. She found that her 
Brazilian immigrant women respondents, who were mostly domestic or temporary workers, 
faced economic, and cultural barriers to access to formal healthcare in the United States. Thus, 
they utilized informal healthcare in the U.S. or used transnational health resources, such as 
getting medication from Brazil, relying on other Brazilian health resources, or returning to Brazil 
for medical care.

A few studies have examined Asian countries’ efforts and strategies to promote medical 
tourism (Bookman and Bookman 2007; Lee & Park, 2013). For example, Bookman and 
Bookman (2007) indicated that the development of medical tourism in India began to attract 
participants from Indian diasporic communities. When overseas Indians visit their friends and 
family in India, they also receive medical care or health check-ups because of India’s cheaper 
medical costs and cultural affinity for the Indian styles of medical care.

Fong (2008) examined the unexpected medical return among Chinese sojourners in 
Ireland and the United Kingdom. Although this qualitative study showed the experiences of three 
Chinese sojourners’ medical returns to their home country, its interviewees are limited to 
sojourners who have no children, those who move frequently, and those who have lived in a host 
country for only a limited period of time. These temporary residents have different 
characteristics from most other immigrants. Also, since all Chinese sojourners in his study did
not come back to the receiving country after getting medical care in home country, we cannot consider their behaviors as medical tourism. Emphasizing the effect of cultural affinity on medical tourism, Xing (1998) reported that overseas Chinese visited China for medical care because they believed in traditional Chinese medicine. Most of these overseas Chinese in Xing’s study are from neighboring countries of China, such as Hong Kong, Macau, and Taiwan. Since I found only a few articles on other Asian immigrant groups’ medical tourism to their homeland, my dissertation will contribute to the existing literature on Asian immigrants’ medical tour experiences.

Korean Immigrants’ Healthcare Behaviors and Medical Tourism to Korea

As briefly explained in the introductory chapter, Korean immigrants have a number of barriers to access to the U.S. healthcare, which often causes their underutilization of the U.S. healthcare system. The types of their barriers are structural, financial, and personal. Importantly, these barriers contribute to Korean immigrants’ three types of healthcare behaviors: (1) preference for co-ethnic doctors, (2) practice of Hanbang, and (3) medical tours to the home country. In this section, I provide a detailed review of the types of the barriers and the three healthcare behaviors among Korean immigrants.

Barriers to Healthcare Utilization

Although Korean-Americans have been praised as a “model minority,” most studies of Korean immigrants’ healthcare behaviors have found that they also have various barriers and difficulties in access to the formal healthcare system in the U.S. (Choi, 2013; De Gagne et al., 2014; Jang et al., 2005; Ryu et al., 2001; Shin, 2002; Song et al., 2010). As indicated in the introductory chapter, we can discuss immigrants’ barriers to healthcare by classifying them into the following three: structural, financial, and personal barriers. First, structural barriers include
small numbers of co-ethnic healthcare professionals, geographical proximity to hospitals, locations of hospitals, or the accessibility to public or private transportation to hospitals. Most immigrants have more structural barriers than native-born White Americans because they have fewer chances to meet healthcare professionals such as doctors, nurses, staff members, or interpreters who share the same language or culture. It is partly due to the small number of immigrant healthcare professionals (Kraut, 1990; LaVeist et al., 2003; LaVeist & Nuru-Jeter, 2002; Takada et al., 1998). Other scholars (Cave et al., 1995; Johnson et al., 2004; LaVeist et al., 2003; Ngo-Metzger et al., 2007; Saha et al., 1999; Traylor et al., 2010; Wilson et al., 2005) also pointed out the importance of the linguistic, cultural, and racial concordance between patients and physicians can improve patients’ healthcare utilization through better communications and interactions.

In examining Korean immigrants’ healthcare utilization, researchers have focused on financial or personal barriers rather than structural barriers. There seem to be several reasons for this. First, since Korean immigrants include a much smaller proportion of illegal residents than Latino or Filipino immigrants (Hoefer et al., 2009), researchers have not paid much attention to Koreans’ illegal status as their structural barrier to the U.S. healthcare system. Moreover, since Korean immigrants are concentrated in several metropolitan areas (Min, 2013), they are less likely to have transportation issues to visit the doctor’s offices or hospital than other immigrant groups that are residentially more scattered.

Second, there are financial barriers to immigrants’ healthcare that include poverty, lack of financial resources, or lack of health insurance. Many scholars have found that immigrants’ uninsured status plays a negative role in their healthcare access (Derose et al., 2007 & 2009; Jang et al., 2005). Researchers of Korean immigrants’ healthcare behaviors also have focused on
Korean immigrants’ financial barriers, especially their health insurance status, to investigate their healthcare patterns (Jang et al., 2005; Ryu et al., 2001; Shin et al., 2005). In fact, Korean immigrants show a very low insured rate, compared to other major Asian immigrant groups. Analyzing the 1998 Current Population Survey (CPS), Carrasquillo and his associates (2000) found that more than one-third of Korean immigrants do not have health insurance. When it comes to the private health insurance, only 58 percent of Korean immigrants have private health insurance. Among all major Asian immigrant groups, only Vietnamese immigrants show a lower rate of private health insurance (50%) than Korean immigrants. Chinese (69%), Indian (76%) and Filipino (70%) immigrant groups show much higher private health insurance rates than Korean immigrants.

Using national data, Ryu et al. (2001) also compared Korean Americans and other Asian American groups in the rate of health insurance. The results of their analysis of the 1992 National Health Insurance Survey indicated that Korean Americans show a much lower insured rate (50%) than all Asian ethnic groups (70%). They also emphasized three additional significant results. First, the health insurance coverage is a significant predictor of better healthcare utilization among Korean Americans. Second, the impact of health insurance coverage on healthcare utilization is bigger for Korean Americans than Asian Americans altogether. Lastly, self-employed Koreans are the least likely to be insured.

More recently, several studies have examined the insured rate among Korean immigrants in various regional areas. Shin et al. (2005) found that only slightly more than half of Korean Americans have health insurance in Los Angeles. In Florida, about 70 percent of their elderly Korean Americans are insured (Jang et al., 2005), but this high rate is due to the fact that about a quarter of the sample has Medicare, which is only available for individuals who are 65 years old.
or older. In Baltimore-Washington area, about 60 percent of middle-aged Korean immigrants who have high blood pressure lack health insurance (Song et al., 2010). Lastly, about half of the middle-aged Korean immigrants in North Carolina are not insured mostly because of the high price of insurance (Gagne et al., 2014). Although these four studies have different Korean samples in various U.S. areas, they have one thing in common: health insurance coverage is the key determining factor to Korean immigrants’ healthcare utilization in the U.S.

Previous research found that Korean immigrants’ low health insurance coverage is related to their high concentration of entrepreneurship or ethnic business in the U.S., where one’s health insurance coverage is highly influenced by one’s employment status. Since the vast majority of Korean immigrants are self-employed in small businesses or employed in small Korean firms, they have a lower health insurance coverage than other Asian groups (Ryu et al., 2001; You & Kim, 2008). Among Korean immigrants, self-employed Koreans show a lower rate of health insurance than Koreans who work in the public sector or non-ethnic private sector (Ryu et al., 2001). Korean immigrants in the U.S. with no health insurance have great difficulty in healthcare, especially because they used to be protected by the national healthcare system provided by the Korean government before their immigration to the United States. In Chapter 2, I will compare the differences in health insurance rates by Korean immigrants’ self-employment status by analyzing the ACS data. Later, in Chapter 4, I will examine if self-employed Korean immigrants show a higher rate of underutilization in the U.S. and a higher rate of taking a medical tour to home country for this financial barrier.

Lastly, researchers have examined immigrants’ personal barriers, such as the level of acculturation (Abraido-Lanza et al., 2006; Arcia et al., 2001; Gorman et al., 2010; Salant & Lauderdale, 2003), the level of language proficiency (Hu & Covell, 1986; Jang et al., 2005; Kim
et al., 2011; Wu et al., 2009), cultural differences (Jenkins et al., 1996; Kung, 2004; Wu et al., 2009) and perceived discrimination (Jang et al., 2005; Viruell-Fuentes, 2007; Yoo et al., 2009). Researchers also examined Korean immigrants’ personal barriers to access to healthcare. However, unlike insured status that shows more evident and consistent findings, the influence of personal barriers is often insignificant or inconsistent across different studies. For example, regarding the language barrier, some studies found the positive association between English proficiency and Koreans’ healthcare utilization in the U.S. (Gagne et al., 2014; Juon et al., 2000). By contrast, another study found that English proficiency was found to be not a statistically significant factor to their hospital visits (Jang et al., 2005). The association between acculturation and healthcare utilization is also contradictory. Gagne et al. (2014) showed that there was a positive association between the middle-aged Korean immigrants’ acculturation (the longer period in the U.S) and healthcare utilization. Yet, other studies found that the number of years in the U.S. was not a statistically significant factor to the elderly Korean immigrants’ healthcare utilization in Los Angeles (Sohn & Harada, 2014). Probably by virtue of many Korean social service agencies and elderly centers in LA, new Korean immigrants might have less difficulty in getting access to the U.S. healthcare system than those in other smaller Korean communities.

Preference for Co-ethnic Doctors

As explained in the introductory chapter, the patient-physician concordance is important for the general population and immigrants regarding their healthcare utilization. However, minority members tend to have less chance to have doctors who share the same race, ethnic language, and culture because of a small number of minority physicians. Thus, White Americans show a much higher percent of patient-physician racial concordance (86%) than African Americans (22%), Hispanic Americans (19%), and Asian Americans (52%) (LaVeist & Nuru-
Jeter, 2002; LaVeist et al., 2003). As a minority, immigrants would have less chance to meet the co-ethnic doctors than native-born White Americans due to the small number of immigrant doctors.

Despite a small number of co-ethnic doctors, immigrants still prefer and seek co-ethnic doctors because of language barriers, cultural differences, and their limited knowledge of western medicine (Choi, 2013; Wang, 2007; Wang et al., 2008; Zhang & Verhoef, 2002). In other words, when immigrants see non-co-ethnic doctors, the latter may misunderstand or misinterpret their symptoms. For these reasons, studies showed that various immigrant groups prefer to have co-ethnic doctors. For example, the majority of Chinese immigrants in Toronto prefer to see Chinese-speaking family doctors (Wang, 2007; Wang et al., 2008). However, despite their preference, less than half of them saw Chinese-speaking doctors because of the geographical discrepancy between Chinese immigrants’ living area (suburbs) and the locations of Chinese doctors (downtown).

Another study (Choi, 2013) compared the healthcare behaviors of three Asian immigrant groups in Hawaii (Filipinos, Koreans, and Marshallese) and found that all groups prefer to have co-ethnic doctors with different features in their preference. First, the ethnic community is not the primary source of Marshallese immigrants although they would still choose co-ethnic doctors over non-co-ethnic doctors. Second, Filipino immigrants prefer co-ethnic doctors and actively utilize healthcare in the ethnic community. Lastly, Korean immigrants strongly prefer to see co-ethnic doctors for linguistic and cultural issues, and this decision is reinforced by other ethnic resources, such as co-ethnic media and business directories.
Unlike these studies that emphasized the positive influence of having co-ethnic doctors among immigrants in receiving countries, Lo and Bahar (2013) argued that having co-ethnic doctors is not all good. According to their study, Vietnamese and Mexican immigrants in Northern California feel that their co-ethnic healthcare professionals often overlay additional power to them. Moreover, immigrants themselves also put their co-ethnic healthcare professionals below the White healthcare professionals in terms of racial ranking.

Previous studies reveal that Korean immigrants also prefer Korean doctors because of their language barriers: they believed that they could communicate better with Korean-speaking doctors. For example, slightly more than a quarter of middle-aged Korean immigrants in North Carolina are not able to communicate in English with others. Thus they prefer to see Korean health professionals (Gagné et al., 2014). Another study (Son, 2013) showed that about 30 percent of female Korean immigrants in Wisconsin do not understand well what non-Korean doctors say. Considering this finding, it is not surprising that about half of respondents prefer to see Korean doctors and are willing to travel far to see Korean doctors rather than to see non-Korean doctors nearby.

In addition to language barriers, health insurance status is also related to Korean immigrants’ preference for co-ethnic doctors. Choi (2013) indicated that Korean immigrants often experience a radical change in health insurance status after their migration to the U.S. Unlike Korea that offers a national health insurance program for all nations, the U.S. health insurance is closely related to the individual’s employment status. As will be shown in detail in Chapter 2, Korean immigrants show a high proportion of having own businesses. Thus they tend not to have health insurance. Therefore, they try to seek healthcare in their ethnic community and are more likely to choose co-ethnic doctors over non-co-ethnic doctors.
Use of “Hanbang”

In this section, I examine Korean immigrants’ practice of a non-western form of Korean traditional medicine that has been referred to by various names, such as complementary and alternative medicine (CAM), traditional medicine, oriental medicine, or folk medicine. Han (1997 & 2001) defines it as a traditional medicine that “originated in China and indigenized in Korea.” But many Western researchers have often referred to both Chinese and Korean medicines as “Oriental” or Asian medicine.” Immigrant groups have used traditional medicine partly because they have limited knowledge of the U.S. healthcare system (Kraut, 1990; Kim et al., 2002). As explained in the introductory chapter, Portes et al. (2012) maintained that immigrants use folk medicine as one of their coping strategies when they have barriers to access to formal healthcare in the U.S.

Korean immigrants are no exception to the tendency of immigrants to utilize folk medicine, and many use Hanbang. There are two major types of Hanbang medicine: herbal medicine and acupuncture (Han, 1997 & 2001). Hanbang has both preventive and treatment perspectives in it. First, people who want to regain their vigor take herbal medicine, which is also called as Poyak in Korean. They believe that they can prevent diseases by taking Poyak because it will make them healthier in general. Second, Hanbang can be utilized for treatments of both chronic and acute pain. For example, some people get acupuncture for chronic muscle pain, such as back pain or knee pain. On the contrary, when they have an acute pain from spraining an ankle or lifting heavy stuff, they also get acupuncture to get their muscle back to normal.

Hiller et al. (2006) found that a significant proportion of Korean immigrants use Hanbang as one of their healthcare options; about a quarter of Korean immigrants in California,
as well as Koreans in Korea, use traditional medicine. Although many Korean immigrants utilize *Hanbang*, there are some who seem to solely depend on it. According to Kim et al. (2002), 3.9 percent of elderly Korean immigrants in the Baltimore area utilized Korean traditional medicine *only*, whereas more than half of them utilize only western medicine. These findings suggest that many Korean immigrants mainly depend on western medicine as their primary form of medical treatment and *Hanbang* as alternative medicine once in a while. In fact, scholars have found that Korean immigrants consider *Hanbang* as supplementary treatment, not the main treatment, for their healthcare (Choi, 2013; Kim et al., 2002).

There are several associated factors to Korean immigrants’ practice of *Hanbang*. First of all, the level of acculturation is associated with it, but in a different direction across various studies. For example, with multiple logistic regression analysis, Kim and Chan (2004) indicated that a high level of education, a high degree of acculturation to the U.S. society and a shorter period of stay in the U.S. are positively associated with Korean immigrants’ preference for alternative medicine. Their findings are congruent with the earlier findings by Miller (1990) who showed that more educated and more acculturated Korean immigrants have a greater tendency to seek alternative medicine. By contrast, Hill et al. (2006) discovered that less acculturated Korean immigrants are more likely to see a traditional healer than their more acculturated counterparts.

Health insurance is also associated with Korean immigrants’ use of *Hanbang*. Like acculturation, health insurance status is both positively and negatively correlated with *Hanbang* in different studies. On the one hand, having health insurance is positively associated with the visit to “traditional healers” among elderly Koreans in Los Angeles (Pourat et al., 1999). On the other hand, uninsured Korean Americans in California show a higher prevalence of seeing a “traditional practitioner” than their insured counterparts (Hill et al., 2006). The size of social
network, better mental health status (Pourat et al., 1999), and the type of occupation (Han, 2000) have also contributed to the practice of Hanbang. In particular, Han (2000) argued that Korean immigrants whose job requires a physical movement tend to prefer alternative medicine, compared to skilled migrants or businessmen in Sydney, Australia.

*Medical Tour to the Home Country*

As indicated earlier, the number of social science studies on Korean immigrants’ medical tourism is limited. There are few government-published articles on Korean immigrants’ medical tourism. In 2006, the Korean Ministry of Health and Welfare published a report based on its survey of 271 Korean-Americans who live in Pennsylvania, New Jersey, California, Texas, Virginia, and Georgia. This report showed that about 83 percent of Korean immigrants would go to Korea for cosmetic surgery and that 60 percent would consider going to Korea for dental care, back surgery, or infertility treatment if the cost is appropriate. The report also indicated that due to cheaper medical costs in Korea, it is still cheaper for Korean Americans to get health care in Korea even when their round-trip flight and living expenses during their stay are considered.

Some studies treated medical tourism as one of the healthcare utilization options among Korean immigrants’ (De Gagne et al., 2014; Son, 2013) rather than systematically examining it. Son (2013) explained that the development of technologies and globalization led Korean immigrant women to consider their home country as an option of alternative health care. The majority of Korean immigrant women consider a medical tour to Korea positively because of cheaper, faster, and more comfortable medical care with cultural familiarity. Moreover, De Gagne et al. (2014) found that some middle-aged Korean immigrants do not buy health insurance because they have an alternative place of medical care: home country. In fact, a significant
proportion of uninsured middle-aged Korean immigrants (23%) did not have health insurance because of medical tourism.

There are three major studies of Korean immigrants in three English-speaking countries—New Zealand, Canada, and the U.S.—who engaged in medical tourism. First, Lee and his associates (2010) conducted a study of the use of homeland medical services among Korean immigrants in New Zealand. By interviewing six first-generation middle-aged Korean immigrants in New Zealand who had surgery in Korea, they found that Korean immigrants go back to Korea not only for “effective” reasons, such as better quality doctors, high-brand hospitals with good equipment, and faster medical services but also for “affective” reasons, such as thinking of the homeland as an emotional and therapeutic place for them. Korean immigrants’ higher expectations of medical care services, the lack of cultural and language barriers, the lack of perceived racism, and their subjective feelings of being more accepted in their home country are the main reasons for their decisions to go back to Korea for medical care. Although the authors give plausible explanations for Korean immigrants’ medical tourism from New Zealand to Korea, the interviewees’ demographic characteristics are also restricted to the middle-aged (40 to 55 years old) and to those who had medical surgery in Korea. Thus, their study could not compare how age or the type of medical care are associated with Korean immigrants’ medical tourism.

Second, with transnationalism as their theoretical framework, Wang and Kwak (2015) investigated the barriers to Canadian healthcare and transnational healthcare utilization among Korean immigrants in Toronto. As detailed in the introductory chapter, I argue that there are different types of immigrants’ medical transnationalism: getting pharmaceuticals from home country and visiting the home country to get medical care. Congruent with my classification,
Wang and Kwak (2015) also suggested several types of transnational healthcare: importing medications from Korea, consulting health information from Korea, and visiting Korea for actual medical care. As explained earlier in this chapter, Korean immigrants have structural, financial, and personal barriers to access to healthcare in a receiving country. This study of Korean immigrants in Canada also focused on several barriers that Korean immigrants have when they try to get formal Canadian healthcare. First, it points out that long distance to see a Korean doctor can be a problem. Although Korean immigrants prefer to meet Korean doctors who share the same language and culture with them, it is hard to see them because of this geographic barrier. Second, the insurance coverage is another reason for them to choose the home country for alternative medical care. It is true that the Canadian government offers public health insurance, but its coverage is limited. In other words, Canadian public health insurance does not cover some types of medical care, such as eye care, dental care, and MRIs. Thus, many Korean immigrants take medical tours to Korea, which has relatively lower costs for these types of medical care. Lastly, Korean immigrants have socio-cultural barriers to access to formal healthcare in Canada. As a minority, they have limited social networks and social supports from family and the ethnic community. In particular, those who have children have more difficulty to see a doctor in Canada because they need someone to take care of their children while getting medical care. These barriers contribute to their medical tourism to Korea, although it involves disadvantages, such as travel costs and difficulty of getting after-care.

Lastly, Oh and his associates (2014) conducted a semi-structured focus group with 34 first-generation Korean female immigrants who are over 40 years old in the Washington, DC metropolitan area. They found that cost-effectiveness was the most important contributing factor to Korean female immigrants’ medical tours, especially for cancer screening. Better, faster, and
easier medical services in Korea are other strong contributing factors. Moreover, their barriers to U.S. medical care and other personal reasons, such as visiting family and friends or having more personal time, also influence their decisions to take medical tours. Korean ethnic media’s active marketing is another push factor to Korean immigrants’ medical tours to the home country. The authors pointed out that Korean immigrants were not fully aware of the possible negative aspects of medical tourism, such as the difficulty of timely care and follow-up care.

Although the study by Oh and his associates is a pioneer study that examines the U.S. Korean immigrants’ medical tourism, it has two limitations. First, it used only middle-aged female Korean immigrant participants as a database. Moreover, it focused on their preventive rather than elective care. Therefore, it is hard to know who the medical tourists are, how many of them visit the home country for medical care, and if there are any differences in deciding and experiencing medical tourism by gender, age, and type of medical care they pursue. This dissertation, enriched with both qualitative and quantitative data, will make a significant contribution to the existing literature on Korean immigrants’ medical tourism, overcoming these limitations.
Chapter 2: Background Information about Korean Immigrants

Before examining Korean immigrants’ medical-tourism experiences to the home country, it is useful to know the background information about Korean immigrants and the Korean community in the U.S. and the New York-New Jersey area. This chapter provides the background information in four major sections. The first section describes the history of Koreans’ immigration to the U.S. and their settlement patterns with a focus on the New York-New Jersey Korean community. The second section examines Korean immigrants’ demographic and socio-economic characteristics. It also includes my analysis of the ACS data about their health insurance coverage status. The third section looks at Korean immigrants’ strong ethnic attachment and the contributing factors to it. The last section investigates Korean immigrants’ transnational ties to the home country as it is closely related to their medical tourism.

Korean Immigrants’ Migration History to the U.S. and Their Settlement Patterns

The history of Koreans’ immigration to the U.S. can be divided into three periods (Min, 2005): the pioneer immigration period (1903-1949), the interim period (1950-1964), and the contemporary immigration period (post-1965). The immigration of Koreans to the U.S. began during the period between 1903 and 1905 when about 7,200 Koreans, mostly male workers, arrived in Hawaii to work on sugar plantations (Min, 2005). The widespread famine in Korea was the push factor their migration to Hawaii while the demand for cheap labor in plantations in Hawaii was a pull factor. About 1,500 Koreans, mostly the picture brides of plantation workers and independent movement leaders and students, came to the U.S. between 1905 and 1924. However, Koreans’ immigration to the U.S. had been halted until the early 1950s because the U.S. government passed the Immigration Act of 1924, a conservative immigration law that...
prohibited Asians’ immigration to the U.S. During the interim period (1950-1964), about 15,000 Koreans immigrated to the U.S. The majority of Koreans who came to the U.S. during this period were the wives of U.S. servicemen during and after the Korean War (1950-53) and the orphans adopted by American citizens (Min, 2005 & 2013a). In particular, the McCarran and Walter Act of 1952 and the War Bride Act of 1946 contributed to Koreans’ migration to the U.S., which they allowed American servicemen to bring their Korean wives and children to the U.S.

The vast majority of Korean immigrants came to the U.S. during the contemporary immigration period (post-1965). Since the 1920s, the U.S. immigration system had a national-origin quota based on the Emergency Quota Act of 1921. However, the Immigration and Nationality Act of 1965 abolished this quota system. Since this new law focused on immigrants’ skills and family members of the U.S. citizen, the number of Asian immigrants, including Koreans, had increased rapidly since then. Min (2013a) indicates that more than 95 percent of Korean Americans belong to these “new immigrants” and their descents. The low standard of living in Korea, the lack of job opportunity, political insecurity, and the difficulty in sending children to college were the main reasons for Koreans’ emigration to the U.S. from 1965 to 1990.

Figure 2.1 shows that the annual number of Korean immigrants have increased since 1965. The number was less than 5,000 until 1970. Then, it reached about 10,000 in 1972 and kept increasing until the early 1970s. The peak period of Korean immigration to the U.S. was between 1976 and 1990; more than 30,000 Koreans came to the U.S. annually during this period. The low standard of living, suppression of freedom by the military government, and the military confrontation with North Korea were the contributing factors to Koreans’ massive migration
during this period. Until the year of 1990, the annual number of Koreans who migrated to the U.S. maintained about the annual number of 30,000.

Figure 2.1: Number of Annual Korean Immigrants to the U.S., 1965-2013

![Graph showing the number of annual Korean immigrants to the U.S. from 1965 to 2013](image)


However, the annual number of Korean immigrants declined rapidly in the early 1990s. For example, there were about 26,000 Koreans who migrated to the U.S. in 1991, but their number decreased to about 19,000 in 1992. There was a significant drop in the number of Korean immigrants from about 18,000 in 1996 to about 14,200 in 1997 and about 12,800 in 1999. The improved economic and political conditions in Korea and the decrease in the number of Korean women who got married to American servicemen contributed to the drastic decrease in the
number of Korean immigrants in the 1990s (Min, 2005). Their annual number recovered to about 20,000 per year in 2000 and had maintained the level with the exception of 2003.

Figure 2.2 shows the ten largest Korean population centers in the U.S. The Los Angeles area and the New York-New Jersey area are two dominant Korean population areas in the U.S. About 320,000 Korean Americans lived in the Los Angeles area in 2010, accounting for about 20 percent of the Korean population in the U.S. The New York-New Jersey area is the second-largest Korean population area, with more than 220,000 Korean Americans in 2010. The Washington D.C.-Baltimore area ranked the third largest area for the Korean population in the U.S., followed by Seattle, Chicago, San Francisco, Atlanta, Honolulu, Philadelphia, and Dallas CMSA. About 57 percent of Korean Americans are concentrated in these ten largest Korean population areas.

Figure 2.2: The Ten Largest Korean Population Areas in the U.S.

Source: The U.S. Census Bureau (2010)
The number of the Korean population in the New York-New Jersey area has increased since 1980. Figure 2.3 shows that their number tripled from about 38,000 in 1980 to 118,100 in 1990. The number increased steadily from 2000 to 2010, but the growth spurt has been slowing down, probably due to the financial crisis of 2007-2008. Due to the recession, Korean immigrants might have moved to other areas that have cheaper living expenses than the New York-New Jersey area. The percentages above each bar in Figure 2.3 indicate the percentages of Koreans in the New York-New Jersey area among all Koreans in the U.S. The Korean population in the New York-New Jersey area accounted for about 10 percent of all Koreans in the U.S in 1980, but it has increased over time. They comprised about 14.6 percent of all Korean population in 2010 and about 13 percent in 2010.

Figure 2.3: The Growth of the Korean Population in the U.S. and the New York-New Jersey CMSA, 1970-2010

Note: The Korean population includes both single-race and multiracial Koreans.
In the New York-New Jersey area, Korean immigrants have established two main ethnic enclaves: one in Queens and the other in Bergen County. Before 1970, international students may have comprised the majority of the Korean population in the New York-New Jersey. Most of them lived near Columbia University (Kim, 1981; Min, 2012a). From the late 1970s on, new Korean immigrants had settled down in several areas of Queens Community District 7, especially in Flushing, the largest Korean enclave in New York City. By the late 1980s, they established another ethnic enclave in Queens Community District 11, including Bayside. Flushing and Bayside are the two areas where most Korean Americans were concentrated in Queens.

Korean immigrants have established two suburban enclaves in Bergen County, New Jersey: Fort Lee and Palisades Park. The establishment of these Korean enclaves in New Jersey reflects Korean immigrants’ suburbanization in the early 1990s. Korean immigrants who settled in the initial Korean enclaves in Queens moved to the Bergen County, seeking “suburban amenities,” such as safer and spacious residential area with good schools (Oh, 2007). Also, as Korean corporations relocated from Manhattan to Bergen County, Koreans who worked for those corporations also moved to Bergen County in the late 1980s and the early 1990s (Min, 2012a).

With the Koreans’ suburbanization movement, the number of Koreans in Bergen County has rapidly increased since 1980. Figure 2.4 shows that there were only about 3,000 Koreans who resided in Bergen County in 1980. However, their number increased to over 16,000 in 1990. There was a rapid growth of the Korean population from 1990 until 2010. There were about 60,000 Korean Americans living in Bergen County in 2010. On the other hand, the number of Koreans in Queens had increased drastically from 1980 to 1990, but it has slowed down since
1990. This period overlaps with the Korean immigrants’ suburbanization movement. From 2000 to 2010, the Korean population in Queens experienced a much slower growth rate than in Bergen County.

Figure 2.4: The Growth of the Korean Population in Queens and Bergen Counties (1980-2010)


As noted above, Korean Americans in the New York-New Jersey area are highly centered in Flushing, Bayside, Fort Lee, and Palisades Park. They are also concentrated in Nassau County, Little Neck, Douglaston, Woodside, and Elmhurst/Corona. Therefore, when I conducted my survey of Korean immigrants’ medical tourism, I tried to recruit many respondents from these Korean enclaves. Yet, I also included Korean immigrant respondents and interviewees who did not reside in these ethnic enclaves.

Demographic and Socioeconomic Characteristics

I used the data from the American Community Surveys (ACS) of the U.S. Census to examine Korean immigrants’ demographic and socioeconomic characteristics. I combined the 2009-2011
ACS data from the Integrated Public Use Microdata Series (IPUMS) to increase the sample size. In this section, I compared three: foreign-born Koreans with native-born Koreans and native-born non-Hispanic Whites. The Korean sample includes only single-race Korean respondents.

Table 2.1 compares the demographic characteristics of foreign-born Koreans, compared to native-born Koreans and native-born Whites. There are substantially more female respondents than male respondents among Korean immigrants, whereas native-born Koreans and native-born Whites maintain a more gender balance. About 60 percent of Korean immigrant respondents are female, compared to 52 percent of their native-born Koreans and white counterparts. On average, Korean immigrants are slightly younger (47 years old) than non-Hispanic Whites (51 years old), but older than native-born Koreans (29 years old) when only adult respondents are included in the analysis. Data in the third row of Table 2.1 support my expectation that Korean immigrants are younger than native-born Whites but much older than native-born Koreans: about 15 percent of Korean immigrants are 65 years old and older, compared to 19 percent of native-born Whites and only 1.3 percent of native-born Koreans.

Table 2.1: Demographic Characteristics by Country of Birth and Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Foreign-born Koreans</th>
<th>Native-born Koreans</th>
<th>Native-born Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Female</td>
<td>59.4</td>
<td>52.6</td>
<td>51.9</td>
</tr>
<tr>
<td>Mean age</td>
<td>46.6</td>
<td>29.3</td>
<td>50.7</td>
</tr>
<tr>
<td>% Elderly (65 years old and older)</td>
<td>14.5</td>
<td>1.3</td>
<td>19.1</td>
</tr>
<tr>
<td>% Post-1965 immigration cohort</td>
<td>97.8</td>
<td>-</td>
<td>73.9</td>
</tr>
<tr>
<td>% Naturalized citizen</td>
<td>59.6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>N</td>
<td>25,268</td>
<td>3,839</td>
<td>4,866,205</td>
</tr>
</tbody>
</table>

Source: The ACS (2009-2011)

Notes: Table 2.1 includes respondents who are 18 years old and over. However, the analysis for the percent of elderly includes all respondents (N of all foreign-born Koreans: 27,810; N of all native-born Koreans: 8,237; N of all native-born non-Hispanic Whites: 6,059,816).
The post-1965 immigration cohort has a high level of education. Also, they had white-collar occupations with middle-class urban background prior to their migration to the U.S (Kim, 1981; Min, 1988, 2005 & 2013a; Yoon, 1991). Table 2.2 supports these earlier findings. The vast majority of foreign-born Koreans (91%) are high school graduates, and more than half of them (52%) are college graduates. Their high school and college completion rates are greater than those of native-born Whites but lower than those of native-born Koreans. The variation of the educational level is not huge among Korean immigrants. However, in Chapter 4, I will examine if education is one of contributing factors to Korean immigrants’ medical tourism because the level of education could be a mediating factor to other contributing factors. I will try to answer the following questions. Would more educated Koreans show a higher rate of medical tourism than less educated Koreans because of more transnational ties with the home country through their alumni associations? Alternatively, would they show a lower rate of medical tourism because they have more social networks in the U.S. through their high human capital?

Table 2.2: Socioeconomic Characteristics by Country of Birth and Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Foreign-born Koreans</th>
<th>Native-born Koreans</th>
<th>Native-born Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% High-school Gradates</td>
<td>91.0</td>
<td>98.3</td>
<td>90.6</td>
</tr>
<tr>
<td>% College Graduates</td>
<td>52.4</td>
<td>71.7</td>
<td>30.5</td>
</tr>
<tr>
<td>N (25 years old and over)</td>
<td>22,894</td>
<td>2,187</td>
<td>4,388,241</td>
</tr>
<tr>
<td><strong>Occupational Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Management and professional occupations</td>
<td>49.2</td>
<td>66.7</td>
<td>43.2</td>
</tr>
<tr>
<td>Mean wage and salary income ($)</td>
<td>50,157</td>
<td>68,595</td>
<td>50,557</td>
</tr>
<tr>
<td>N (25-64 years old &amp; currently employed)</td>
<td>12,439</td>
<td>1,624</td>
<td>2,350,749</td>
</tr>
<tr>
<td>% Self-employed</td>
<td>24.3</td>
<td>8.4</td>
<td>11.5</td>
</tr>
<tr>
<td>N (25-64 years old &amp; in the labor market)</td>
<td>13,334</td>
<td>1,752</td>
<td>2,528,633</td>
</tr>
</tbody>
</table>

Source: The ACS (2009-2011)

Note: The analysis of self-employment includes respondents who are 25-64 years old and participate in the labor market (N of Foreign-born Korean: 13,334; N of Native-born Korean: 1,752; N of Native-born White: 2,528,633). The analysis of the management/professional occupations and the mean of wage and salary income include respondents who are 25-64 years old and currently employed. (N of Foreign-born Korean: 12,439; N of Native-born Korean: 1,624; N of Native-born White: 2,350,749).
Korean immigrants show higher rates of managerial and professional occupations than native-born whites. Nearly half of them have managerial and professional occupations. As expected, their native-born Koreans show even higher representation (67%) in these two occupational categories than foreign-born Koreans (49%). Korean immigrants show a slightly lower mean wage and salary income ($50,157) than that of native-born Whites ($50,557), despite their higher engagement in the managerial and professional jobs. Disadvantages in the U.S. labor market, especially their language barrier, are the major contributing factors to Korean immigrants’ higher self-employment rates than native-born whites and other Asian immigrant subgroups (Min, 1984, 1990 & 2008; Min & Bozorgmehr, 2003; Yoon, 1991). Confirming earlier studies, Table 2.2 shows that about a quarter of Korean immigrants are self-employed, whereas only 8 percent of native-born Koreans and 11.5 percent of native-born Whites are self-employed. It should be noted that the census data underestimate the numbers of Korean immigrant entrepreneurs. There are two reasons for this underestimation. First, most small Korean businesses are run by a family; usually a husband and a wife. However, only the husband tends to be the registered owner when they answer to the Census (Min, 2013). Second, there are some Koreans who run businesses illegally. In the New York-New Jersey area, Korean immigrants are concentrated in certain types of labor-intensive businesses, such as grocery and greengrocery retails, dry cleaning stores, and nail salons (Min, 2008).

As a result of their much higher self-employment rate than other Asian immigrant groups, Korean immigrants show a much lower insured rate than other Asian immigrant self-employed groups or native-born self-employed Whites. Table 2.3 shows that Korean immigrants have a much lower insured rate (74.4%) than native-born non-Hispanic Whites (89.4%) or other major foreign-born Asian groups. Moreover, self-employed Korean immigrants are less likely to be
insured (60.1%) than employed Korean immigrants and other self-employed immigrant groups. Self-employed Indian, Chinese and Filipino immigrants have higher rates of insurance coverage than their Korean counterparts because they have higher rates of corporate businesses. Even employed Korean and Chinese immigrants have lower rates of insurance coverage than employed Indian and Filipino immigrants. There are two reasons for Korean immigrants’ lower insurance rates than Indian and Filipino immigrants. First, unlike Korean immigrants who are in labor-intense small business, Indian and Filipino immigrants tend to own and work in professional businesses, such as health or finance fields. Thus, they are more likely to have better benefits, including health insurance. Second, they have higher rates of working in American corporations than Korean immigrants who are more likely to be self-employed. Unlike Koreans who have their own businesses or who work in the ethnic economy, Indian and Filipino immigrants who work in American corporations get better health insurance coverage.

Table 2.3: Percent of Health Insurance Coverage by Self-Employment Status

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Self-employed</td>
<td>60.1</td>
<td>75.5</td>
<td>79.1</td>
<td>78.4</td>
<td>66.3</td>
<td>82.9</td>
</tr>
<tr>
<td>Employed</td>
<td>88.7</td>
<td>89.9</td>
<td>98.3</td>
<td>99.2</td>
<td>91.9</td>
<td>95.9</td>
</tr>
<tr>
<td>All</td>
<td>74.4</td>
<td>82.7</td>
<td>88.7</td>
<td>88.8</td>
<td>79.1</td>
<td>89.4</td>
</tr>
<tr>
<td>Total N</td>
<td>25,268</td>
<td>2,784</td>
<td>43,600</td>
<td>43,303</td>
<td>26,594</td>
<td>5,114,091</td>
</tr>
</tbody>
</table>

Source: The ACS (2009-2011)

Note: Adult (18 years old or older) respondents who had worked within the past 5 years are included in this analysis. Except for the US-born White, all other categories include foreign-born, non-Hispanic and who consider themselves as Asian.
Due to their uninsured status, self-employed Korean immigrants might have a greater tendency to take medical tours to the home country. Or, rather than their uninsured status, their long working hours as entrepreneurs might be a mediating factor to the association between self-employment and medical tourism. In Chapter 5, I will examine if Korean immigrants’ self-employment status, as well as other socio-demographic characteristics, are contributing to their decision on medical tourism. There is no study that has examined how self-employment and insured status contribute to Korean immigrants’ healthcare utilization in the U.S., and further, their decision on medical tourism.

Strong Ethnic attachment

Another distinctive characteristic of Korean immigrants is that they show a higher degree of ethnic attachment and a lower level of assimilation than other Asian immigrant groups. For example, Min (1991, 1998) has shown that those Korean immigrants maintain a higher level of ethnic attachment than other Asian immigrant groups. He discussed three or major contributing factors to Korean immigrants’ ethnic attachments: the degree of group homogeneity, the degree of religious affiliation and practices, and their economic segregation.

First, Korean immigrants are much more culturally homogenous than other Asian immigrant groups. Korean immigrants have one language, compared to other Asian immigrant groups that have several different languages. Also, Korean immigrants have a much lower level of regional differences than Chinese, Indian or Filipino immigrants. In addition, Korean immigrants have a higher level of class homogeneity than Chinese immigrants (Kwong, 1997). Second, about 75 percent of Korean immigrants are Christians, and an overwhelming majority of them participate in ethnic church with great frequency (Hurh & Kim, 1990; Min, 1992; Min & Jang, 2015). High levels of Korean immigrants’ affiliations with and participation in ethnic
churches strengthen their ethnic attachment. Lastly, as pointed out in the earlier section, Korean immigrants show a much higher self-employment rates than native-born whites and other immigrant groups, which further socially isolate them to the ethnic community. Moreover, as a response to conflicts with White suppliers and Black customers, Korean immigrants in the New York City used ethnic collective actions far more frequently than other immigrant groups (Min, 1996 & 2008).

Researchers have found that religion is the significant source of Korean immigrants’ ethnic attachment because religious activities based on the ethnic congregations can help them maintain their cultural traditions and social networks (Hurh & Kim, 1990; Min, 2001; Pang, 1991). Pang (1991) pointed out that Korean ethnic churches provide social supports for the elderly Korean immigrants. Moreover, Min (2001) found that there are about 600 Korean ethnic churches in the New York metropolitan area, and they help Korean immigrants maintain ethnic traditions and ethnic networks. Other types of associations, alumni associations, social service agencies, business associations, and political organizations also played important roles in providing Korean immigrants ethnic networks and social services (Min, 2001). For example, the Korean American Association of Greater New York (KAAGNY) has played a key role in organizing the Korean Parade in Manhattan annually since 1980 and preparing ceremonies for two important Korean national holidays, Independence Movement Day and Independence Day (Min, 2008). In Chapter 3, I will examine how the KAAGNY cooperated with Korean hospitals to attract more Korean immigrant medical tourists.
Chapter 3: The Development of Medical Tourism in Korea and the Related Issues

This chapter aims to provide an overview of the development of medical tourism in Korea and various issues related to it. In the introductory chapter, I argued that the Korean governments’ and other private-sectors’ efforts to attract more foreign patients to Korea could be considered as a type of global economic activity. With the perspective of globalization theory, I examine how it is related to cultural globalization, especially Hallyu, which refers to the worldwide popularity of Korean culture. Also, the notion of transnationalism from above is applied to examine the efforts to promote Korean immigrants’ medical tourism. I use Korean newspaper articles published in Korea and the U.S. for ten years (2003–2013) and documents published by different Korean governmental agencies as two major data sources. In addition, I analyze personal interviews with hospital staff members in Korea and travel agency staff members in the New York-New Jersey area.

This chapter has five sections. The first section examines the development of medical tourism in Korea with the Korean government’s and local governments’ efforts to promote it. In the second section, I investigate the private-sectors’ strategies to attract more foreign patients to Korea. The third section examines the Korean governments’ and private-sectors’ various efforts to attract Korean immigrants to the home country for medical care. The fourth section discusses the consequences of medical tourism, from its economic consequences to social consequences. In the last section, I focus on various problems of medical tourism in Korea.
The Development of Medical Tourism in Korea and Governments’ Promotional Efforts

Before examining the development of medical tourism in Korea, we can consider medical tourism as a global economic activity that mutually influences receiving countries and medical tourists themselves. Lower medical costs comprise one of the strongest factors that contribute to medical tourism to Korea. For example, Koechlin et al. (2010) compared the price levels of hospital services among 12 countries who joined the OECD. The U.S. ranked the first in the price level in various hospital services, whereas Korea had the lowest price level. The U.S. has about three times as high as the price level of inpatient hospital services and about 10 times as high prices of inpatient surgery as Korea. When it comes to real medical costs rather than the price level, Korea still shows significantly cheaper medical expenses for various surgeries and hospital services than other OECD countries. For example, in 2007, a knee replacement surgery costs $14,946 in the U.S., compared to only $9,222 in Korea. Dental treatments show the greatest disparity between two countries; The U.S. has about 15 to 25 times as high dental costs as Korea (Ryu et al., 2015).

With the advantage of cheaper medical expenses, the Korean government has put efforts to develop medical tourism in Korea. Figure 3.1 shows the development of medical tourism in Korea by presenting the changes in the numbers of articles published in Chosun Ilbo and Joongang Ilbo, the two largest daily newspapers in Korea, and in Koreadaily and the Korea Times, the two largest Korean dailies in the U.S., for ten years (January 1st, 2003 to December 31st, 2013). For the content analysis of newspaper articles, I used each newspaper company’s archive website to search articles by a keyword, “medical tourism.” Figure 3.1 confirms that the Korean government’s efforts mainly contributed to the development and the prosperity of medical tourism in Korea. For example, as will be indicated below, the revision of the medical
law in 2009 rapidly changed the dynamics of medical tourism. The numbers of newspaper articles about medical tourism surged from 2008 to 2009.

Figure 3.1: Changes in the Numbers of Medical Tourism Articles by Year and Daily Newspaper Statistics on Medical Tourists in Korea

Figure 3.1 shows the numbers of newspaper articles about medical tourism have declined since 2011. It is probably because medical tourism has received too much media attention during the prosperity period (2009-2011) and it has been stabilized after that. However, the number of foreign patients has increased since 2009 with the Korean government’s and private-sector agencies’ efforts to promote medical tourism in Korea, although their numbers were not collected by the Korean government until 2009 because introducing, arranging and inviting foreign patients were illegal before the revision of the medical law. Based on the official government report, Figure 3.2 shows the changes in the number of foreign patients by year.
(2009-2013). The number of foreign patients who visited Korea for medical care was 60,201 in 2009. Then, the number of foreign patients were more than doubled (122,297) in 2011 and more than tripled (211,218) in 2013.

Figure 3.2: Changes in the number of foreign patients by year (2009-2013)

Various countries have sent patients to Korea for medical care. In 2009, the patients from 141 countries participated in medical tourism to Korea. The number of sending countries increased from 163 in 2010 to 188 in 2012. China sent the most patients among all sending countries in 2013. It sent 56,075 patients, who accounted for 27 percent of all foreign patients to Korea. The Chinese patients also showed a high average annual increasing rate: 63.7 percent between 2012 and 2013. The U.S. ranked the second in the number of patients sent to Korea. About 33,000 American patients came to receive medical care in Korea, comprising about 16% of all foreign patients in Korea in 2013. As indicated in the introductory chapter, the Korean immigrants who maintained Korean nationality were not defined as “foreign patients” by the
Korean government. Thus, the number of Korean immigrants who were naturalized American citizens and visited the home country for medical care were included in statistics of American medical tourists rather those of Korean immigrant patients. In other words, most American patients were highly likely to be Korean immigrants with American citizenship (Jin, 2011; Oh et al., 2014). In 2013, Russia, Japan, and Mongolia sent more than 10,000 patients to Korea, following China and the U.S.

According to the Statistics on International Patients in Korea (2013), foreign patients received medical treatments often in the internal medicine departments (22.4%), check-up departments (10%), dermatology department (9%), plastic surgery department (8.6%), Ob/Gyn department (5.7%) and orthopedics (5.2%) in 2013. About 3.4 percent of foreign patients received Hanbang treatments, and 3.2 percent of them received dental treatments in Korea. The received medical treatments are different by patients’ origin country. Noticeably, Chinese and Japanese patients showed a high prevalence of receiving esthetic-related treatments in Korea. Chinese (67.6%) made up the majority of patients who received plastic surgeries. They (36.5%) also accounted for the significant proportion of those who had skin treatments, along with Japanese patients (17.5%). Japanese patients comprised about half of patients who received Hanbang treatments in Korea. Several newspaper articles reported that Hanbang treatments that Japanese patients received were Hanbang beauty treatments rather than urgent treatments (Lee, 2011; Park, 2012). There was no governmental report that officially indicated reasons for foreign patients’ medical tours to Korea. However, as examined earlier, the Korean government and private-sector agencies tried to connect Hallyu to medical tourism to attract Japanese and Chinese patients who were interested in these elective care. I presumed that Japanese and
Chinese patients’ high chance of receiving plastic surgeries or skin care in Korea were closely related to the Korean Wave.

*Three Different Periods of Medical Tourism in Korea*

We can examine the development of medical tourism in Korea by dividing it into three periods: the pioneer period (2005-2008), the prosperity period (2009-2011), and the maturity period (2012-2013). Figure 3.1 shows that the number of articles about medical tourism was negligible before the pioneer period. Table 3.1 confirms that 2005 was the pioneer year of medical tourism in Korea; the Korean government selected medical tourism as an official national agenda in 2005. Before the year, medical tourism had not received much attention from the media and the Korean government. In 2006, the Korean government began to conduct research on medical tourism to attract foreign patients to Korea. In 2007, it secured a budget for foreign patients and established the Korea International Medical Association (KIMA) to publicize a high level of qualities of Korean medical institutions and provide information about medical tourism to foreign patients and overseas Koreans. But the Korean government’s efforts in the pioneer period were not aggressive, compared to its efforts in later two periods. Also, the newspaper articles published in this period simply introduced major foreign countries (e.g. India, Malaysia, and Singapore) which had successfully promoted medical tourism so that the Korean government could follow them.

It should be emphasized that the year of 2009 was a monumental year for medical tourism in Korea, beginning the prosperity period (2009-2011). The Korean government revised the medical law that made introducing, arranging, and inviting foreign patients legal. After the revision of the 2009 medical law, the Korean government strengthened the basis to attract
foreign patients and to develop the medical tourism industry in Korea. For example, all agencies which dealt with foreign patients were required to register with the government. Also, medical visas were issued so that the medical tourists could come and stay in Korea more easily. The Korean government also opened the Medical Tourism One-Stop Service Center at the Incheon International Airport to help foreign patients who needed medical-tourism information. Moreover, it developed the Korean medical brand, presenting a slogan, “Smart Care, Medical Korea” and established a website (www.medicalkorea.or.kr) to give medical tourism information to foreign patients. Finally, the Korean government introduced several training programs for medical-tourism coordinators and translators.

Since 2010, the Korean government has put spurs to revise laws and has enhanced plans to promote medical tourism in Korea. For example, the authentication system of medical institutions made foreign patients easier to find the medical institutions which registered to the Korean government. The Korean government also tried to build global networks to promote medical tourism through Memorandum of Understanding (MOU) with various countries. In 2011, it also established the law for resolutions of medical conflicts, which made the mediation between patients and medical institutions easier through the Korea Medical Dispute Mediation and Arbitration Agency. Moreover, the Korean government temporarily (for two years) applied a zero tax rate to the corporations that do businesses with medical institutions. It also signed the MOU with UAE, Dubai, and Mongol, and relaxed regulations on Visa (E-7) for special occupations so that foreign healthcare professionals and medical-tourism coordinators could get visas more easily.
Table 3.1: The Korean Government’s Various Efforts to Promote Medical Tourism

<table>
<thead>
<tr>
<th>Year</th>
<th>Contents</th>
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<tbody>
<tr>
<td>2005</td>
<td>• Selected medical tourism as an official governmental agenda</td>
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<tr>
<td>2006</td>
<td>• Implemented research on expansion of global medical services and foreign patients</td>
</tr>
</tbody>
</table>
| 2007 | • Secured budget to attract foreign patients  
• Established the Korea International Medical Association (KIMA) to support medical tourism |
| 2009 | • Revised the medical law: introducing, arranging and inviting foreign patients are legalized  
• Enforced the registration system of promotion agencies who attract foreign patients  
• Issued a medical visa (M visa) to foreign patients  
• Established the “Medical Tourism One-stop Service Center” for foreign patients  
• Developed the Korean medical brand, “Smart Care, Medical Korea”  
• Trained medical-tourism coordinators and translators specialized in the medical tourism area |
| 2010 | • Introduced an authentication system of medical institutions  
• Revised the medical law: the medical institutions who intend to attract foreign patients should be registered with the Korean government |
| 2011 | • Enhanced the “Two Stage Enhancement Plan for Medical Tourism”  
• Applied a temporary zero tax rate (for 2011 and 2012) for commission of companies which do business with medical institutions  
• Signed the Memorandum of Understanding (MOU) with UAE, Dubai, and Mongol  
• Relaxed regulation on E-7 Visa (Special Occupations) for foreign medical professionals and foreign medical-tourism coordinators |
| 2012 | • Enhanced the “Plan for Vitalizing Global Healthcare”  
• Established the Medical Korea Academy Center  
• Introduced medical tourism translation services |
| 2013 | • Enacted the revised electronic visa system  
• Noticed an advanced legislation of Medi-tel (Medicine+Hotel), a specialized building for medical care and accommodation for medical tourists  
• Established a national skills qualification certificate for international medical-tourism coordinators |

Source: Statistics on International Patients in Korea (KHIDI 2013)

While the Korean government actively opened the door to foreign patients during the prosperity period (2009-2011), it continued to enhance plans for the diversification of medical tourism during the maturity period (2012-2013). In 2012, the Korean government diversified the markets by attracting foreign patients from Saudi Arabia, Qatar, Iraq, Kazakhstan, Uzbekistan, Vietnam, Indonesia, and Russia. These countries were not the typical countries, such as the U.S., China, and Japan, which sent their patients to Korea. In 2012, the Korean government also began
to provide translation services to foreign patients so that they could consult about any issues related to medical tourism with staff members at the Korean Medical Dispute Mediation and Arbitration Agency. Translation services were offered in 18 languages, such as English, Chinese, Japanese, Vietnamese, Russian, German, and Spanish. More recently, in 2013, the Korean government improved the overall system to strength medical tourism in Korea. It revised the electronic visa system which allowed foreign patients to get Korean visas much easier and faster through online. Moreover, it pre-announced a legislation of “Medi-tel,” a combination of the medical institution and accommodations for foreign patients. Lastly, the Korean government enforced individuals who wanted to be an international medical-tourism coordinator to take a national examination so that they should study in the areas of public health, tourism, marketing and medical terminology.

Despite the Korean government’s continuous efforts to promote medical tourism, the number of articles about medical tourism decreased from 2011, still maintaining over 200 in 2011, but dropped to 140 in 2013. During this time, the problems of medical tourism in Korea, such as inconsistency in medical tourism terminologies by different governmental departments, several medical laws that hindered attracting more foreign patients, and brokerage problems, appeared in the newspaper articles. In the last section of this chapter, I will discuss the problems of medical tourism in Korea in detail.

Not only the central government but also local governments have tried to attract medical tourists to their regions. They have actively used various strategies since the revision of the medical law in 2009. To compete with other cities, local governments developed specialized medical-tourism programs that represented their cities. Notably, several local governments tried to connect *Hallyu*, a type of cultural globalism, to medical tourism. The contents of *Hallyu*,

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which is also referred to as the “Korean Wave,” include Korean TV shows, dramas, movies, music, and other types of cultural contents. Influenced by the Korean Wave, some foreign patients, especially from neighboring Asian countries, visited Korea for plastic surgery because they wanted to resemble the appearance of Korean celebrities. With increased attention to Hallyu, several local governments have tried to attract foreign patients to their cities, connecting Hallyu to plastic surgeries.

Gangnam-gu in Seoul and Seomyeon in Busan were the two major areas which actively attracted Chinese and Japanese patients to receive plastic surgeries and skin care. In 2012, Gangnam-gu, one of the most affluent and trendsetter districts in Seoul, had 342 plastic surgery hospitals which accounted for about 72 percent of all plastic surgery hospitals in Seoul. To attract more foreign patients interested in receiving plastic surgeries, Gangnam-gu has annually hosted a medical tourism roadshow since 2009 (Sohn, 2012). In particular, Gangnam-gu has tried to attract Japanese and Chinese patients. Since the Korean Wave has been especially popular in China and Japan, people from these neighboring countries have shown a greater tendency to receive plastic surgeries and skin care than patients from other countries. Targeting them, Gangnam-gu established a “medical tourism team” and selected 30 translators who could translate Japanese, Chinese, and Thai language to support hospitals located in Gangnam (Kim, 2009). Moreover, Gangnam-gu was the first local government of Seoul which developed its own medical-tourism package program (Kang, 2013). In 2013, Gangnam-gu introduced a medical-tourism package called “Re-Born,” encouraging foreign patients to “reborn” in Gangnam-gu through medical treatments and spas.

Seomyeon in Busan is another area whose local government tried to connect the Korean Wave and medical tourism, specializing in plastic surgeries and skin care. In particular, Busan,
the second largest city in Korea, established ‘Global Beauty Medical Streets’ in Seomyeon, to attract medical tourists who wanted to receive plastic surgeries, skin care, dental care, and Hanbang treatments. Seomyeon which had more than 100 plastic surgery hospitals and skin care hospitals. In particular, due to the geographic proximity, Japanese patients were the main target of medical tourism in this area. To support medical tourism, the Busan City government established a call center to offer translation services to foreign patients who wanted to receive plastic surgeries in Busan (Shim, 2009).

The Private-Sector Agencies’ Efforts to Promote Medical Tourism in Korea

In this section, I examine the private-sector organizations’ efforts and strategies to attract more medical tourists to Korea. The private-sector organizations include Korean hospitals, travel agencies, and hotels in Korea. As main data sources, I use 10 years of newspaper articles as well as personal interviews with staff members at Korean hospitals and travel agencies in the New York-New Jersey area. In this section, I focus on their efforts to attract general medical tourists from foreign countries. I will discuss the efforts to attract Korean immigrants in the following section.

Korean Hospitals

Among all private-sector agencies, Korean hospitals were most actively engaged in promoting medical tourism through providing various services to medical tourists, such as pick-up services, translation services, and promotional events. Achieving Joint Commission International (JCI) accreditation was another strategy because the JCI was an internationally approved accreditation so that foreign patients could expect guaranteed quality of the hospitals with the JCI. In addition to the JCI, some hospitals used distinct marketing strategies to attract
more foreign patients. One of them is Chaum hospital. Established in 2010, it claimed a high-end medical institution with premium centers, such as the check-up center, the anti-aging center, the cell plastic surgery center, and the spa center. It had a distinct marketing strategy, compared to other hospitals: star marketing (Ko, 2010). In 2010, it invited about 120 world entertainer celebrities, including Kristin Davis, Peter Fonda, Sheena Easton, and Suzanne Somers, to promote their medical services to foreign patients. It was very unusual for foreign celebrities to come to Korea, not for movie promotion but for medical treatment.

Another hospital, Cheongshim, specialized in the Japanese pregnant women’s maternity trip (Chung, 2011b). Although Cheongshim was not as big as Yonsei Severance and Samsung hospital, it held the third rank in terms of attracting foreign patients in 2010. Concentrating on Japanese pregnant women was the key to its success. According to the interview with the staff at the hospital, it costs about $7,300 for delivery of a baby if a Japanese pregnant woman stays for four nights and five days in a hospital in Japan. By contrast, it costs only about one-third if she stays for two weeks for childbirth as well as postpartum care in Cheongshim. As another strategy to attract Japanese pregnant women, the hospital helped issuing birth certificates and passports for the newborns of the Japanese mothers who came to give birth at the hospital.

Connecting medical tourism to the Korean Wave has been recognized as a strategy for several Korean hospitals, especially plastic surgery hospitals and dermatology hospitals. In 2009, six hospitals, including plastic surgery hospitals, dermatology offices, and dental offices, cooperated together to publicize medical-tourism programs in Tokyo, Japan (Kim, 2009). At the medical-tourism fair in Japan, the directors of six hospitals showed the pictures of Korean celebrities to Japanese patients to receive plastic surgeries or skin treatments in Korea. They highlighted the importance of the combination of medical tourism and the Korean Wave because
medical services that they offered were closely related to the trend of Hallyu. In 2011, Dr. Lee, a director of Arumdaun Nara dermatology hospital, received an award from the Korean government to recognize his efforts to attract foreign patients to Korea. In 2011, more than 3,000 foreign patients visited his office to receive skin care. He emphasized the importance of linking Hallyu to medical tourism to attract more foreign patients to Korea (Kim, 2011).

I had a chance to interview staff members at three large hospitals in Korea (Asan Medical Center, Yonsei Severance hospital, and Inha University hospital). As expected, they commonly reported that the number of foreign patients had increased since 2009 due to the revised medical law. Every month, about 100-200 patients visited Asan Medical Center and the Inha University hospital, and 700 patients visited the Yonsei Severance hospital in 2013. Three hospitals had their own specific strategies to attract more medical tourists to their hospitals. For instance, Asan Medical Center held promotional events at the foreign embassies and international schools. It had patients-delivery contract with the United Arab Emirates. The Yonsei Severance Hospital provided translation and accommodation services to their foreign patients. Lastly, the Inha University hospital had offered a pick-up service before and was offering an interpreter to foreign patients.

**Korean Travel Agencies**

Other private-sector organizations were less active in attracting medical tourists to Korea than Korean hospitals. Korean-owned travel agencies in the United States had more promotional activities to send Korean immigrant medical tourists to the home country. Their efforts will be covered in the next section focusing on Korean immigrants. In this section, I will focus on Korean travel agencies’ efforts and strategies to attract general foreign patients. Hana Tour and
Mode Tour are two biggest travel agencies in Korea that promoted medical tourism in Korea. In 2008, the year before the revised medical law was made, Hana Tour developed their first medical-tourism package with collaboration with Korea University Medical Center (Oh, 2009). Another large travel agency, Mode Tour, proposed a medical-tourism package, targeting Chinese patients in cooperation with Gangnam-gu and Ana Clinic, a mega hospital specialized in skin care. The Chinese medical tourists who bought this package spent two days in Seoul for skin treatment and sightseeing and another two days in Jeju Island for sightseeing only (Byun, 2009).

In addition to these two large travel agencies, a new travel agency, MeditourKorea, was established in 2009. This new company specialized in medical tourism to Busan, a second largest city in Korea. It targeted Japanese medical tourists, using the geographical proximity of Busan to Japan. It also tried to use the Korean Wave to promote medical tourism to Korea from Japan (Park, 2009a). For example, to attract more Japanese medical tourists, it held a concert with the original soundtrack (OST) of “the Winter Sonata,” a Korean drama which lit the fuse of Hallyu in Japan in 2009.

**Korean Hotels**

Finally, Korean hotels were another private-sector agencies that have tried to attract more medical tourists. As indicated in the earlier section, in 2013, there was an advanced legislation notice of Medi-tel, a building for medical care and accommodation for medical tourists. However, the collaboration between hotels and hospitals began much earlier than 2013. We can examine their strategies to promote medical tourism in Korea by dividing hospitals into three types. First, some hotels gave discounts to hotel guests if they already received medical care at hospitals that were affiliated with them. For example, a Lotte City Hotel at the Gimpo Airport
area and Wooridul (a hospital) signed an MOU so that medical tourists who received medical care at Wooridul could receive discounts at Lotte hotel if they stayed there (Suh et al., 2012). Hilton Hotel in Seoul gave discounts for a guest room and provided ride services for medical tourists who received medical treatment at Severance hospital (Lee, 2013).

The second strategy used was to invite hospitals or medical offices to their hotel buildings. By doing so, their guests could easily receive medical care while staying in their hotels. Moreover, the medical tourists’ privacy could be protected because their movement could be minimized if the hotel and hospital were at the same location. For example, a Lotte Hotel in Busan invited the Korean Medical Institute (KMI) to its hotel building so that medical tourists could get checkup during their stay in a hotel (Park, 2011). In 2011, the hair plant center of Kyungbook University hospital moved to Novotel in Daegu, which was located in downtown Daegu (Kim, 2012). The center moved to the hotel so that medical tourists could stay at the hotel comfortable and enjoy sightseeing more easily after getting medical care.

The last and most active strategy was to build a special building that had a hotel and a hospital in the same building. This type of strategy may look similar to the second one, but it is not. While a hospital is embraced in a hotel for the second strategy, a hospital and a hotel had an equal importance in the last type. In 2011, there was the first attempt to combine a hotel and a hospital to attract the medical tourists from foreign countries (Park, 2011). The special feature of this ‘hospital-hotel’ was that about half of the building was used as a hospital and another half as a hotel. In 2013, the legislation that allowed the establishment of Medi-tel contributed to the new phase of the medical tourism industry in Korea. As pointed out earlier, there were buildings that had both a hospital and a hotel. However, until 2013, there was no regulation about accommodations for medical tourists. Thus, the building that had a hospital and a hotel needed to
be registered as a “tourist hotel” with the Korean government. However, according to the new legislation of Medi-tel, any medical institutions—hotels or other agencies that had attracted medical tourists—can build a Medi-tel within one kilometer of the hospital. The Medi-tel needed to have at least 20 guestrooms, and at least 50 percent of the guests should be foreigners. With the beginning of this legislation, the number of Medi-tel has increased (Kwon, 2013).

The Efforts to Promote Korean Immigrants’ Medical Tourism

So far, I examined Korean governments’ and private-sector agencies’ efforts to attract the “foreign patients” or medical tourists to Korea. I examine the efforts of various organizations to promote Korean immigrants’ medical tourism in this section. As already pointed out in the introductory chapter, the Korean government does not define Korean immigrants with the U.S. permanent residency as “foreign patients.” Nevertheless, it has made great efforts to bring overseas Koreans back to their home country to get medical care. I also examine in this section the strategies of the private-sector agencies which include hospitals and travel agencies. In addition, I discuss the efforts of the Korean community in the New York-New Jersey area to promote Korean immigrants’ medical tourism to Korea.

The Korean Government’s Efforts to Promote Korean Immigrants’ Medical Tourism

We can consider the Korean government’s efforts to attract Korean immigrant medical tourists as state transnationalism (Chin & Smith, 2015) because their efforts to attract Korean immigrants are highly institutionalized. In order to target Korean immigrants, the Korean government conducted several surveys with Korean immigrants. In 2006, the Korean Ministry of Health and Welfare published a report based on its survey of 271 Korean immigrants who lived in Pennsylvania, New Jersey, California, Texas, Virginia, and Georgia. The results of this survey
showed that about 83 percent of Korean immigrants would go to Korea for cosmetic surgery, with 60 percent of them reporting their intention to visit Korea for dental care, back surgery, or infertility treatments. Later, another governmental report (KOTRA, 2011) found that Korean immigrants, especially those with no health insurance, often had a physical checkup when they visited Korea. They tended to have simple treatments or a cosmetic surgery rather than major surgeries in the home country. In addition to surveys, the Korean government also held exhibitions and conferences to attract Korean immigrant medical tourists. For example, in 2009, in order to promote the advantages of medical tours to Korea, the Korea International Medical Association (KIMA) set up promotional booths at the ‘Music Festival for Korean Immigrants’ in Los Angeles, one of the biggest festivals there.

The Korean government allowed Korean immigrants with a longer residence in Korea to apply for the Korean national health insurance regardless of whether they intended to receive medical care in Korea or not. However, it moderately contributed to Korean immigrants’ medical tours to the homeland because they could receive medical care cheaper with the national insurance if they stay in Korea for a long period. When Korean immigrants plan to take medical tours to the home country, they can apply for the Korean national health insurance with the following steps. First, they should submit the form of Domestic Residence Report² to the jurisdictional immigration office. About two weeks later, they are supposed to receive a domestic residence card. Three months after their admission into Korea, and with the domestic residence card, Korean immigrants can apply for the Korean national health insurance³. Having Korean

³ http://minwon.nhis.or.kr/menu/retrieveMenuSet.xx?menuId=MENU_WBMAA0107
national health insurance would be a major contributing factor to Korean immigrants’ medical
tours to the home country because, with the national health insurance, they could receive medical
care for much lower prices than they could get in the U.S.

Korean local governments also made great efforts to attract more Korean immigrant
medical tourists. Their main strategy was to make the MOUs with Korean associations in the
U.S. so that these associations could send Korean immigrants to the hospitals in “a sister city” in
Korea. Noticeably, Busan Metropolitan City signed the MOU with the Federation of Korean
Associations, U.S.A. in 2009 (Park, 2009b). Based on this MOU, Korean immigrants could
receive a 10-50 percent discount on medical bills when they received medical care in Busan. In
2010, Daegu, the third largest city in Korea, held a business convention for Hansang
(entrepreneurs from Korean diaspora communities). Hospitals in Daegu agreed on the MOU with
many Korean immigrant associations. For instance, Daegu signed the MOU with the Federation
of Korean Associations, U.S.A., expecting for many Korean immigrants to come to Daegu for
medical care because Daegu had about 30 percent cheaper medical costs than Seoul.

The Private-Sector Agencies’ Efforts to Promote Korean Immigrants’ Medical Tourism

Korean hospitals and Korean travel agencies in the U.S. were two major private-sector
agencies who had various strategies to promote Korean immigrants’ medical tourism. Much
lower medical costs in Korea, a substantial proportion of uninsured Korean immigrants, and the
lack of systematic check-up programs in the U.S. were the major important reasons for the
Korean hospitals’ targeting of Korean immigrants (Ahn & Hurh, 2009; Kim, 2011). Several
major Korean hospitals sent staff members to the U.S. metropolitan areas with large Korean
populations to publicize their superior medical services. In 2009, the Hanyang University hospital staff members visited New York, Chicago, Los Angeles, San Francisco, and Seattle to publicize their medical-tourism programs which were designed for Korean immigrants (Choi, 2010a). The Hanyang University hospital also offered discounted flight tickets for Korean immigrants in these five areas in the U.S. so that they could save their medical expenses (Ahn & Hurh, 2009). In addition, the Gangnam Severance hospital offered fast-track services for Korean immigrants who had time pressure. Using fast-track services, Korean immigrants could not have any waiting period for their examinations and treatments. They could also receive the results of their check-ups quickly (Ahn & Hurh, 2009).

In particular, some of the hospitals used a special strategy to attract more Korean immigrants to their hospitals: opening their branch offices in the U.S. The Seoul National University (SNU) hospital was the first one who opened a medical tourism office in the Korea Town of Los Angeles in 2008. Korean immigrants who were interested in receiving medical care at the SNU hospital could consult with the dispatched nurses from Korea. There were 829 Korean immigrants who took medical tours through this Los Angeles office in 2009, and the number of them increased to over 1,000 in 2010 (Kim, 2011). Additionally, the SNU hospital established another branch office in Manhattan in 2012 to attract more Korean immigrants in the East Coast.

During the prosperity period (2009-2011) of medical tourism, other Korean hospitals also established branch offices in the Los Angeles area and the New York-New Jersey area where about 40 percent of U.S. Korean immigrants were concentrated, as reviewed in Chapter 2. Following the SNU hospital, the Catholic University of Korea Seoul St. Mary’s hospital opened a branch office in Los Angeles in 2010 and dispatched Dr. Jang, a plastic surgeon there. About
300 Korean immigrants, mostly from the Los Angeles area, took medical tours to this hospital in 2010. Their ability to consult with the medical doctor prior to their medical tourism is believed to have been the key factor to the success of the hospital in recruiting Korean immigrant clients. Another mega hospital, the Asan Medical Center, also opened branch offices in Los Angeles (2009) and New York (2010) to attract Korean immigrants who were interested in medical tourism to the home country.

Some hospitals stationed staff members at local travel agencies in the U.S. rather than established branch offices. For example, in 2010, the Asan Medical Center sent a staff member at Dongbu Tours in New York so that Korean immigrants who were interested in medical tourism could consult with a member of the hospital. In the following year, Yonsei Severance hospital sent a nurse to Samho Tours in Los Angeles so that she could consult the Korean immigrants’ health issues and build a special medical-tourism program for them.

However, except for the first branch office of the SNU hospital in the Los Angeles area, all other branch offices were shut down due to the low return on investment as of 2013. The demand for Korean immigrants’ medical tourism has decreased naturally over time because some of them already had taken medical tours to the home country. Since they did not receive check-up services or major medical treatments frequently, the number of Korean immigrant medical tourists decreased as time passed. Also, they could have other routes to arrange their medical tourism than contacting hospitals. As will be examined in Chapter 6, only about four percent of my informants reported that their medical tourism was arranged via hospital branch offices or the hospital websites.
Travel agencies in the U.S. were other private-sector organizations who put a lot of efforts to promote Korean immigrants’ medical tourism to Korea. In particular, two large travel agencies in U.S (Aju and Samho Tour) conducted surveys on Korean immigrants’ medical tourism to Korea. Their joint analysis showed that medical-tourism packages successfully settled in the U.S. as one of the tour packages among Korean immigrants for both travel agencies (Choi, 2010a). In 2009, Samho Tour sent 602 Korean immigrants to Yonsei Severance hospital, and Aju Tour sent 143 Koreans to Asan Medical Center. However, a survey conducted in 2011 by Aju Tour, collaborating with the Asan Medical Center, indicated a low awareness of Korean medical tourism among non-Koreans; only 20 percent of about 300 non-Korean respondents have heard of Korean hospitals or medical tourism in Korea, and more than half of the respondents (59%) had no plan to buy medical tour packages to Korea (Chin, 2011).

The big travel agencies, Aju, Samho, and Dongbu tour, aggressively signed the MOU with Korean hospitals. Aju Tour, who introduced the medical tour packages for the first time to Korean immigrants in the U.S., signed MOU with the Inha University hospital (2007) and several other hospitals in Korea. Samho Tour, another travel agency based in the Los Angeles area, made an MOU with The Inha University hospital (2007), Yonsei Severance hospital (2009), Nune eye hospital (2011), and Serion global dermatologic and Aesthetic surgery center (2011). Lastly, Dongbu tour, which was based in the New York-New Jersey area, agreed on the MOU with the Catholic University of Korea Yeouido St. Mary’s hospital (2009) and Asan Medical Center (2010).

In addition to these big tour agencies, other small travel agencies in the New York-New Jersey area did so and so. I interviewed ten employees who worked for these small travel agencies in New York-New Jersey area. I asked them several questions about medical tourism.
Most informants told me that they began to sell medical-tourism packages since 2009 and that the number of Korean immigrant medical tourists reached its peak in 2011 and then declined rapidly. Thus, Korean immigrants’ medical tours to Korea have gone through the same change as non-Koreans’ medical tours to Korea.

Despite the decline in the number of Korean immigrants who bought medical-tourism packages, many travel agency staff members told me that they still had special strategies to send more Korean immigrants to Korea for medical care. For example, one travel agency offered a customized program for each individual. A travel agency employee in his late fifties said:

The price of the regular checkup is fixed (e.g. $480 for women), but you can have an additional physical examination if you pay more. You can choose any examination or treatment if you want. You can choose an airline between the Korean Airline and the Asiana Airlines. You can choose any hospital from the list of 10,000 hospitals that are affiliated with this travel agency. From Yonsei Severance and Samsung hospital to small doctor’s office, you name it. If you choose Yonsei Severance hospital, then I will contact the department of treatment for overseas and make an appointment for you. Then I will receive a confirmation email, and with that email, I can get a discount when I purchase a flight ticket for you. For example, it costs about $1,500 from New York to Seoul if you fly with the Korean Airline, but if you choose a hospital which is affiliated with the Korean Airline, then the flight ticket will be $1,300. (Mr. Kim, a middle-aged employee at a Korean travel agency in Manhattan)
Except for the personalized services, advertising through local Korean newspapers was their only other strategy. A staff at a travel agency located on 32nd street in Manhattan mentioned that usually four or five small travel agencies paid together for the advertisement in a local ethnic newspaper. Under the big advertisement section, each travel agency has its own address, phone number, and medical-tourism packages.

**The Korean Community’s Efforts to Promote Korean Immigrants’ Medical Tourism**

Lastly, the Korean community in the U.S. also tried to promote Korean immigrants’ medical tours to the home country. In particular, the Korean umbrella organizations in different areas in the U.S. played a significant role by signing the MOU with various Korean hospitals to give benefits to Korean immigrants. For example, the Korean American Association of Greater New York (KAAGNY) made an agreement with the Korea Association of Health Promotion (KAHP) in 2004, even before the revision of the medical law. Based on this agreement, the members of KAAGNY could receive a checkup for discounted prices at the KAHP. The year 2009 was a monumental year for medical tourism in Korea, as well as the Korean community in the New York-New Jersey area regarding Korean immigrants’ medical tourism. The KAAGNY signed the MOU with three Korean hospitals in 2009. First, it established the MOU with Hallym University Medical Center, which offered Korean immigrants discounted medical bills and deferred payments for their medical care. Based on the MOU between the KAAGNY and Korea University Medical Center, the members of KAAGNY could receive discounted medical bills. The Wooridul hospital, which signed the MOU with the KAAGNY, provided fast medical services, allowing Korean immigrants to test and see the results on the same day. Lastly, in 2011, the KAAGNY agreed the MOU with the Kyung-Hee University Medical Center so that their members could ask questions to doctors in Korea via Fax.
The Korean Produce Association (KPA) was another organization in the Korean community in the New York-New Jersey area that contributed to Korean immigrants’ medical tourism. As reviewed in Chapter 2, Korean immigrants showed strong ethnic attachment, and the KPA helped them to maintain it through supporting Korean entrepreneurs and providing networks for Korean immigrants. The KPA has annually organized Korean Harvest and Folklore Festival since 1982 to celebrate Chseok, Korean Thanksgiving day, together, transmit Korean folk culture to younger-generation Koreans, and to promote Korean cultural traditions to New Yorkers (Min, 2008: 137). About 250,000 visitors participated in the annual festival during recent years. In 2012, the KPA hosted the Korea Global Medical Tourism Expo at the Korean Harvest and Folklore Festivals for the first time (Kim, 2012). About 50 Korean local governments, hospitals, and travel agencies participated in the expo to publicize their medical-tourism programs to Korean immigrants and the non-Koreans who visited there.

Economic and non-Economic Consequences of Foreign Medical Tourism

As shown in Table 3.2, foreign patients have brought economic benefits as well as economic changes in Korea. Table 3.2 shows that approximately $103,200,000 (USD) were generated as the total medical income profits by foreign patients. Total economic profits brought by foreign patients have increased over time. It was more than doubled between 2010 and 2012. In 2013, foreign patients generated about $393,400,000 of medical income profits to Korea. The average medical expenses per capita also increased over time. On average, foreign patients spent about $1,310 in 2010, but the amount increased to $1,490 in 2011 and $1,680 in 2012. In 2013, foreign patients spent about $1,860 per capita, and they spent about 70 percent more than what Korean patients spent (KHIDI, 2013).
Table 3.2: Total Medical Income Profits and Per Capita Medical Expenses by Foreign Patients

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medical Income Profits</td>
<td>$103,200,000</td>
<td>$180,900,000</td>
<td>$267,300,000</td>
<td>$393,400,000</td>
</tr>
<tr>
<td>The amount each foreign patient spent for medical care in Korea</td>
<td>$1,310</td>
<td>$1,490</td>
<td>$1,680</td>
<td>$1,860</td>
</tr>
</tbody>
</table>

Source: Statistics on International Patients in Korea (KHIDI 2013)
Note: 1 dollar is calculated as 1,000 won

The economic consequences of medical tourism were not just limited to Korea. They also brought various economic changes in several sending countries including the U.S. For example, due to Korean immigrants’ medical tour to the home country, some American health insurance companies changed their policies so that the U.S. medical tourists, mostly Korean immigrants, can utilize their American insurance in Korea. For example, the Blue Cross Blue Shield of South Carolina announced to offer benefits for 10 surgeries performed at the Yonsei Severance hospital in Seoul (Lee, 2009). The UMR, the largest TPA (third-party administration of multiple) company in the U.S., offered the Korean Association Preferred Health Plan, a claim administration to Korean-based companies with 25 or more employees in the U.S. Those who belong to this program could have access to the United Healthcare networks in the U.S., Furthermore, they could compensate for medical care in Korea. In addition, ILWI launched a Health Plan that offered options for no deductible in the U.S. as well as medical tourism to Korea, aiming to help middle-aged Korean immigrants in financial difficulties (Yoo, 2010). In 2011, the Prime Medical Solutions, a medical tourism service company, introduced a new insurance program that included an option of medical tours to Korea (Chung, 2011a).

Several corporations were newly established as the economic consequences of medical tourism. For instance, the Pacific Medline, a medical tourism agency in LA, was founded to send medical tourists from Orange County to Korea (Moon, 2009). In the New York-New Jersey area,
a medical tourism consulting firms appeared. The SK Management Consulting company built a portal website specialized in medical tourism and the Medical Fly Korea was established to connect American medical tourists to Korean hospitals specialized in cancer or spine diseases, received media attention (Choi, 2010b).

Medical tourism has also brought about several social changes, such as introducing new jobs, and government-issued certificates, and new college majors. Notably, a new occupation, ‘medical-tourism coordinator’ has appeared in the newspaper since 2007 and became more visible since 2009, after the revision of the medical law. Each year, newspaper companies have published informative articles about this new job, giving information about how to be a medical-tourism coordinator, how much they earn, and what kinds of work they do. Park (2009a) reported that medical-tourism coordinator was one of the most promising occupations because it became legal to attract foreign patients in 2009. Lee (2011) listed major tasks of a medical-tourism coordinator: “A Medical-tourism coordinator provides medical tourism information for foreign patients in Korea. The coordinator translates the check-in processes, prescriptions, and the follow-up processes. In addition, he/she explains the procedure for admission and discharge at the hospital and helps the post-discharge care. If the foreign patients want sightseeing or shopping, he/she connects the travel agency to them so that they can travel Korea.”

In addition to the appearance of medical-tourism coordinators, several medical tourism majors and educational programs were established by universities, the Korean local government, and the collaboration between public and private-sector agencies. Table 3.3 summarizes new college majors and programs affected by medical tourism in Korea. First, several local governments offered various medical tourism training programs. The medical-tourism coordinator programs were not only introduced by local government but also created by the
collaboration between local government and the private-sector agency. As Table 3.3 shows, some colleges have established the medical tourism major or related programs. Interestingly, Masan University established a department of ‘Medical Tourism and Chinese’ to train medical-tourism coordinators specialized in Chinese patients (Choi, 2012). Students who were admitted to this department need to study Chinese as well as medical tourism. Even a high school began to focus on medical tourism education in addition to colleges and universities; Joogmun high school in Jeju Island assigned students into three classes: medical tourism, medical information, and health nursing (Oh, 2010).

Table 3.3: New College Majors and Programs Influenced by Medical Tourism

<table>
<thead>
<tr>
<th>Sector</th>
<th>Agency</th>
<th>Major/ Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>Daegu</td>
<td>Medical tourism training program</td>
</tr>
<tr>
<td></td>
<td>Jeju</td>
<td>Medical tourism training program</td>
</tr>
<tr>
<td></td>
<td>Gangnam-gu</td>
<td>Medical-tourism coordinator employment program</td>
</tr>
<tr>
<td>Public + Private</td>
<td>Gyeonggi Province &amp; Catholic University</td>
<td>Medical-tourism coordinator program for multicultural family</td>
</tr>
<tr>
<td>Private</td>
<td>Youngsan University</td>
<td>Medical tourism coordination center</td>
</tr>
<tr>
<td></td>
<td>Daekyeung University</td>
<td>Medical-tourism program</td>
</tr>
<tr>
<td></td>
<td>Kimcheon Science College</td>
<td>Medical tourism major</td>
</tr>
<tr>
<td></td>
<td>Hallym University</td>
<td>Medical-tourism program</td>
</tr>
<tr>
<td></td>
<td>Masan University</td>
<td>Department of medical tourism and Chinese</td>
</tr>
<tr>
<td></td>
<td>Mokpo University</td>
<td>Global Medical Academy program</td>
</tr>
<tr>
<td></td>
<td>Yuhan University</td>
<td>Medical Tourism professional training program</td>
</tr>
<tr>
<td></td>
<td>Kyunghee Cyber University &amp; Joongang Joins</td>
<td>Global healthcare professional training program</td>
</tr>
<tr>
<td></td>
<td>Youngsan University</td>
<td>Healthcare management major</td>
</tr>
<tr>
<td></td>
<td>Jungmun High School</td>
<td>Specialized high school focusing on public health and medical-related classes,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>including medical-tourism class</td>
</tr>
</tbody>
</table>

Problems of Medical Tourism

Some problems of medical tourism have emerged despite its development and prosperity. This section examines the problems of medical tourism in Korea in general and those for Korean
immigrants in particular. The problems have received attention from the government and the media mostly during the maturity period of medical tourism in Korea (2012-2013). In the governmental report published by Korea Institute for Industrial Economics and Trade (KIET), Hurh and his associates (2013) pointed out several improvement points for the Korean government to attract more foreign patients. First, they argued that the promotion of medical tourism should be more systematic. Since the Korean government did not investigate the demand for medical tourism by foreign patients’ origin country, it was difficult to promote medical tourism for the different target populations. Second, the numbers of medical-tourism coordinators, medical-tourism translators, and health professionals who could communicate with foreign patients were scarce. Third, better cooperation between two governmental departments (the Ministry of Health and Welfare, and the Ministry of Culture, Sports, and Tourism) in charge of medical tourism was necessary. Lastly, there were too many regulations that prohibited the invigoration of medical tourism. According to Hurh and his colleagues, too strict regulations made it hard for the Korean hospitals, as non-profit corporations, to attract financial investments.

A few newspaper articles reported other more serious problems of medical tourism. The most frequently noted problems are the illegal brokers’ exaggerated advertisements and high commissions (Bae, 2012), and the overcharges against foreign patients (Kim & Kang, 2012). Especially, with the increase of Chinese patients, overcharge against Chinese patients, along with using different rates for Chinese and Korean patients, was singled out as the major problem (Kim & Kang, 2012). “I realized that the plastic surgery cost is different for different people. It is the cheapest for Koreans, then Chinese international students who study in Korea, and the most expensive for Chinese tourists,” an interviewee in the article complained. For the same nose and eye jobs, one of the plastic surgery offices offered $7,000 for Chinese tourists, but only $3,100
for Korean. A KTO staff member in the article argued that “Maybe overcharges contribute to short-term sales, but it will retrogress medical tourism in Korea.” The excessive regulations against medical tourism, non-systematic connections between medical treatment and shopping/sightseeing, the scarcity of English road signs, and overcharge against foreign patients were reported as other problems of medical tourism (Lee et al., 2013).

In addition to foreign patients, Korean immigrants also faced problems during their medical tours to the home country. The most frequently noted problem was that Korean hospitals often forced Korean immigrants to receive unnecessary treatments or extra examinations (Ahn et al., 2009; Kim & Ham, 2012). Since Korean immigrants have been away from the home country for a while, they have become less familiar with Korean medical systems as well. Therefore, when Korean hospitals forced them to get unnecessary medical treatments, it was hard for them to resist. One Korean immigrant couple who participated in medical tourism showed their disappointment with medical-tourism experiences because they paid extra $6,000 for the additional examinations and treatments (Kim & Ham, 2012).

Moreover, it was difficult to mediate any medical disputes between Korean immigrants and the hospitals because Korean immigrants did not usually stay in Korea for long periods of medical care. Due to the difficulty of arbitration of medical conflicts, Korean hospitals preferred to operate simple check-ups to Korean immigrants rather than major surgeries which might cause serious medical disputes (Ahn et al., 2009). Lastly, a few Korean immigrants were misdiagnosed with cancers during their medical tourism (Kim & Ham, 2012). This was particularly important because the cancer screening was the most preferred healthcare that Korean immigrants wanted to receive during their medical tourism (Choi, 2010c). As previously noticed, it was hard for Korean immigrants to ask for compensation of the misdiagnosis to the hospital because most of
them did not stay in Korea for an extended period of time. In Chapter 6, I will examine the kinds of problems Korean immigrants face during and after their medical tours to the home country.
Chapter 4: Korean Immigrants’ Healthcare Behaviors

The three previous chapters have provided the broad reviews and background information about medical tourism, Korean immigrants in the U.S. and Korean government agencies’ and private sector organizations’ efforts to attract medical tourists. This and the following chapters comprise the central part of this dissertation by focusing on the major contributing factors to Korean immigrants’ decision to take medical tourism to Korea and their actual experiences of it. This chapter intends to examine the salient aspects of Korean immigrants’ three distinctive healthcare behaviors, including medical tourism.

This chapter has five sections. The first section examines Korean immigrants’ barriers and difficulties in utilizing healthcare in the U.S. Despite Korean immigrants’ obstacles to healthcare utilization in the U.S., previous studies have paid little attention to how Korean immigrants respond to these barriers. Thus, the following subsections intend to bridge the gap in research on Korean immigrants’ healthcare utilization and their coping strategies, including medical tours to the home country. The second and third subsections investigate Korean immigrants’ preference for and dependence on co-ethnic doctors and their practice of Hanbang. Examining these behaviors are useful because those who entirely depend upon Korean doctors in the New York area or those who use Hanbang more frequently are more likely to take medical tours to the home country than other Korean immigrants. The fourth section presents the prevalence and frequency of Korean immigrants’ medical tourism. Finally, the last section examines the reasons for their medical tourism answered by Korean immigrants who participated in medical tourism.
Korean Immigrants’ Barriers and Difficulties in Utilizing Healthcare in the U.S.

Before examining Korean immigrants’ healthcare behaviors, including medical tourism, it is important to know the barriers to healthcare they encounter in the U.S. As reviewed in Chapter 1, previous studies found that Korean immigrants had various structural, financial, and personal barriers. When I asked the respondents to indicate any difficulties they had experienced related to the U.S. healthcare system, more than half of them answered that they had at least one obstacle. Remarkably, 15 percent of all survey respondents who had received medical care in the U.S. reported that they had more than two barriers in access to healthcare. The most frequently cited two combinations of difficulties were language and having no insurance, followed by language and cultural differences. Table 4.1 shows that about one-third of the respondents had a language barrier in getting healthcare in the United States. When I asked respondents, “How well do you speak English?”, only about 10 percent answered that they speak English very well. More than half of them replied that they do not speak English or speak only a little. Thus, it is not surprising that more than one-third of the respondents reported that they had a language barrier when they accessed medical care in the U.S. Other frequently-cited barriers were having no insurance, cultural differences, and perceived racial discrimination.

Table 4.1: Types of Korean Immigrants’ Barriers and Difficulties to Healthcare in the U.S.

<table>
<thead>
<tr>
<th>Barriers or Difficulties</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>205</td>
<td>44.5</td>
</tr>
<tr>
<td>Language barriers</td>
<td>158</td>
<td>34.3</td>
</tr>
<tr>
<td>Having no insurance</td>
<td>113</td>
<td>24.5</td>
</tr>
<tr>
<td>Cultural differences</td>
<td>45</td>
<td>9.8</td>
</tr>
<tr>
<td>Other barriers</td>
<td>25</td>
<td>5.5</td>
</tr>
<tr>
<td>Total</td>
<td>546</td>
<td>118.6</td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area
Note: The respondents who have never received medical care in the U.S. are excluded in this analysis (N=461). Since several respondents (N=73) gave multiple answers, the sum of the responses exceeds 100%.
Survey Question: “Please indicate below which describes any barriers or difficulties you have when you utilize healthcare in the U.S. (select one or more if applicable)”
According to my in-depth personal interviews, there are four types of language barriers in healthcare: (1) difficulties in understanding medical terminology in English, (2) difficulties in expressing their symptoms in English, (3) difficulties in communicating with non-Korean doctors, and (4) feeling powerless in their interactions with non-Korean doctors. I examine first two types in this section because they have more linguistic aspects, whereas last two types emphasize more interpersonal aspects. I will discuss last two types in the next section when I examine Korean immigrants’ preference for co-ethnic doctors as their preference is related to the doctor-patient relationship.

First, some informants reported that it was hard for them to understand difficult medical terminology in English. They were concerned about their inability to understand English medical terminology at hospitals, and their fear often led them to choose co-ethnic doctors. Second, for some Korean immigrants, the ability to express or describe their symptoms in English was limited. In their view, they did not know enough English adjectives or other words to accurately describe their pain. Min-Seok Kim, a middle-aged employee at a Korean community center, said that he knew various adjectives to describe pain in Korean. Additionally, there are many Korean-language phrases or words to describe certain kinds of pain or other symptoms that simply do not have direct English translations. However, since he knew only one word—pain—to describe his discomfort in English, it was hard for him to elaborate on his pain to American doctors. Since Korean doctors understood his expressions or descriptions right away when they heard it, he preferred to see Korean doctors or to go back to Korea for medical care. When I asked to identify any difficulties or barriers, another informant, who has lived in the U.S. for 40 years, reported a similar problem:
I am confident in understanding and speaking English in my everyday life. But, elaborating symptoms in English is delicate and challenging. For example, regarding a stomachache, I may have a slight pain, a plucking-off pain, or other kinds of pain. However, I can only say “it hurts” in English. A headache is the same. I can say ‘I have a headache, or I have pain in my head,’ but that was it. I cannot describe it in any detail. (Young-Sik Chung, a 67-year-old business owner in Fort Lee, New Jersey)

About a quarter of survey respondents answered that their uninsured status in the U.S. was one of the major obstacles to their healthcare utilization. Since they had lived in Korea, which offers very affordable insurance for all people, many of them revealed their hesitance to pay for more expensive health insurance in the U.S. For example, a 40-year-old non-smoker who earns $30,000 a year needs to pay about $4,500 a year ($372 per month) for the second lowest cost plan in New York state (Cox et al., 2015). By contrast, an employee in Korea who earns about $30,000 has to pay only about $1,800 annually for his/her health insurance, as the health-insurance contribution rate is only about 6 percent of his/her salary (Song, 2009). Moreover, less than 4 percent of total population is uninsured in Korea (Song, 2009), whereas 13 percent of total population is uninsured in the U.S. (Smith & Medalia, 2014). Since Korean immigrants needed to pay large out-of-pocket amounts for medical care due to lack of health insurance in the U.S., they had three coping strategies these barriers: (1) seeing co-ethnic doctors to receive discounted medical costs, (2) practicing Hanbang, as it is relatively cheaper than western medicine, although not covered by insurance anyway, and (3) medical tours to the home country for cheaper medical care. In the next chapter, I will examine how Korean immigrants’ insurance status is associated with their medical tourism. Rather, I will focus on other types of barriers in this chapter.
About one-tenth of survey respondents reported that cultural differences made them feel uncomfortable when they received medical care in the United States. For example, Young-Ja Park, an elderly informant who immigrated two years ago, described how cultural differences made her feel scared at the hospital during the Halloween season:

My family doctor was a first-generation Korean, but I still had to see a non-Korean doctor to take an X-ray and MRI. Immediately after stepping into the American hospital, I became so scared. It was around the Halloween season, and the hospital’s decoration was very scary. At the lobby, there was a statue overloaded with faked blood. Faked blood was everywhere at the hospital. When I saw faked blood, I was freaked out. How could they do that at the hospital, especially in the country of Protestantism? The hospital decoration should make patients feel comfortable. But its decoration created an atmosphere of fear to me. Maybe I did not understand the spirit of Halloween as we did not celebrate it in Korea. (Young-Ja Park, a 72-year-old retired woman in Fort Lee, New Jersey)

Notably, some Korean women pointed out that they felt culturally different and that made them uncomfortable especially when they had Ob/Gyn examinations in the United States. Seong-Sook Kim, a 45-year-old woman who had been in the U.S. for about ten years, recounted her first experience at Ob/Gyn. When the doctor asked her, “When did you have sex for the first time?” she had a cultural shock and felt very uncomfortable telling him about her past sexual experiences. Another female informant in her late 30s also felt embarrassed and upset at the Ob/Gyn:

When I had an abnormal period cycle after arriving in the U.S., I went to the Ob/Gyn. The American doctor had several tests on me. He had an internal
examination on my virginal, and it hurt badly. I could not understand why he did
an internal examination because I told him that I had no sex experience before. In
Korea, doctors did not take an internal examination of a virgin because they were
afraid of causing her to lose hymen. I think Americans undervalue the loss of
hymen than Koreans. I felt very upset for losing it unexpectedly. (Ji-Young Kim,
a 39-year-old woman in Flushing, Queens)

10 of 461 respondents (2.2%) noted that their perceived racial discrimination made them
difficult in utilizing healthcare in the U.S. Some Korean immigrants reported their perceived
discrimination especially by receptionists at the front desk. A 32-year-old female respondent
described her experience of racial discrimination at the hospital. She argued that she encountered
racial discrimination not from white American doctors, but from the non-White staff members
who worked at the counter when she did check-in or check-out processes. One informant even
changed her family doctor because of the attitude of the Latino and Black staff members at the
physician’s office:

I changed my family doctor and my Ob/Gyn doctor not because of the doctor but
because of the attitude of receptionists. They were very unkind and browbeaten
me when I did not understand what they were saying. It might sound racist, but
the horrible receptionists were all Latino and Black. I have never felt that the
doctor disregarded me, but they (receptionists) did. That was the reason for me to
change the doctor. They discriminated against me not only for my imperfect
language but also because of my Asian background. (Tae-Sook Lee, a 38-year-old
housewife in Bronx, New York)
In the following sections, I will examine how Korean immigrants’ barriers and difficulties in utilizing healthcare in the U.S. contributed to their healthcare behaviors, especially three prominent behaviors: preference for co-ethnic doctors, the practice of Hanbang, and medical tours to the home country. As briefly pointed out earlier, these healthcare behaviors were in response to their barriers to the U.S. healthcare utilization. Moreover, first two healthcare behaviors were closely connected to the last one: Korean immigrants’ medical tourism.

Korean Immigrants’ Great Preference for Co-ethnic Doctors and Heavy Dependency on Them

As reviewed in Chapter 1, immigrants prefer co-ethnic physicians due to their shared language and culture and their limited knowledge of western medicine. Korean immigrants also expressed their great preference for co-ethnic doctors and heavy dependency on them in the U.S. Table 4.2 shows that there are over 1,100 Korean medical, dental, Hanbang, and chiropractic offices in the New York-New Jersey area. Of these, about 500 were western-style medical offices, comprising nearly half of all Korean medical offices in the NY-NJ area. 322 dental offices made up about 29 percent of all Korean medical offices, whereas 196 Hanbang offices accounted for about 17 percent. Chiropractic offices accounted for about one-tenth of NY-NJ Korean medical offices. Considering that there are about 250,000 Koreans in the NY-NJ area, there is roughly one Korean medical office per every 200 Koreans in this area. These figures indicate Korean immigrants’ great preference for co-ethnic doctors and their heavy dependency on them.

Table 4.2: Numbers of Korean Medical, Dental, Hanbang, and Chiropractic Offices in the New York-New Jersey Area

<table>
<thead>
<tr>
<th>Numbers of Korean Medical Offices</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western medical offices</td>
<td>488</td>
<td>43.4</td>
</tr>
<tr>
<td>Dental offices</td>
<td>322</td>
<td>28.7</td>
</tr>
<tr>
<td>Hanbang offices</td>
<td>196</td>
<td>17.4</td>
</tr>
<tr>
<td>Chiropractic offices</td>
<td>118</td>
<td>10.5</td>
</tr>
<tr>
<td>Total</td>
<td>1,124</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: The Korea Daily Business Directory (2014)
The analysis of my survey and interview data also supported these earlier findings. The majority of my Korean immigrant informants preferred to see Korean doctors to non-Korean doctors. As Table 4.3 shows, about two-thirds of all survey respondents preferred Korean doctors, whereas only five percent of them preferred non-Korean doctors. About a quarter of them showed no preference for the physician’s ethnicity, and six percent of them answered that their preference depends on the type of medical care. In most cases, they preferred Korean doctors for dental care because they believed that Korean dentists were more dexterous than American dentists. As will be indicated in Chapter 6, their preference for Korean dentists was closely related to the fact that dental care was the second most popular medical treatments that Korean immigrants received in Korea.

<table>
<thead>
<tr>
<th>Preference for Doctor’s Ethnicity</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Korean doctors</td>
<td>327</td>
<td>64.5</td>
</tr>
<tr>
<td>Non-Korean doctors</td>
<td>25</td>
<td>4.9</td>
</tr>
<tr>
<td>No preference</td>
<td>126</td>
<td>24.9</td>
</tr>
<tr>
<td>Depends on the type of medical care</td>
<td>29</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>507</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: My survey with 507 Korean immigrants in the New York-New Jersey Area
Survey Question: Do you prefer a Korean doctor to a non-Korean doctor?

In a previous study, Portes and his associates (2012) mentioned that when immigrants have limited English proficiency or have cultural differences as barriers, they would be likely to see co-ethnic doctors as coping strategies. Previous studies (Choi, 2013; De Gagne et al., 2014; Son, 2013) pointed out that Korean immigrants prefer Korean doctors mostly due to their language barriers. Confirming these findings, Table 4.1 shows that the language barrier was the biggest obstacle for Korean immigrants to get medical care in the U.S., and it strongly affected their inclination to choose Korean doctors. In the first section of this chapter, I discussed two types of language barriers that are more linguistic in nature, such as difficulties in understanding
medical terminology in English and expressing symptoms in English. In this section, I examine
the other two types of language barriers that are more inter-personal and related to their
preference for co-ethnic doctors.

Some Korean informants noted that communicating with non-Korean doctors in English
was often confusing. Since they had difficulty in catching the nuances of a doctor’s words, it was
hard for them to judge if the physician was exaggerating the medical situation or not. Moreover,
difficulties in communication made Korean immigrants endure unreasonable situations at the
hospital. When I asked him if there was any situation that was caused by language barriers, one
male informant in his late forties mentioned that it was hard for him to argue with healthcare
professionals because of difficult conversations with them:

A few years ago, I fractured my rib when I went skiing. I went to the emergency
room to see a doctor, and they took an X-ray. The person who took the X-ray was
a white man. Since he was not able to find the fracture, other medical staff
members came in and took it again and again. After several hours, they finally
found a fracture after taking thousands of X-rays of me. I was very upset at them
because of their incompetence. But I could not argue with them because I had
difficulties in communicating with them. My English proficiency was not good
enough to make them apologize to me, which I thought was a divine right of a
patient. After that experience, I always tried to find a Korean doctor. My doctors
‘have to’ be Korean. (Ji-Hoon Park, a 45-year-old college staff member in
Flushing, Queens)

Lastly, some informants indicated that there were power issues when their doctors were
not Korean. Bo-Hee Kim, a 37-year-old woman who had lived in the U.S. for ten years, said that
she felt inferior to the American doctors when she spoke to them in English. Doctors have more power than their patients because they have better medical knowledge, and she indicated that the power imbalance was even more severe between her and non-Korean speaking doctors because of the language barrier. By contrast, when she spoke in Korean to Korean doctors, she felt that she had almost the same level of power. Another female informant reported that the power imbalance between an immigrant patient and a non-co-ethnic physician became worse when a patient was younger and female. From her experiences with non-Korean doctors, age, and gender, in addition to language barriers, contributed to her feeling powerless in front of native English-speaking male doctors:

When I saw a Korean doctor, I felt that we were equal. I could elaborate all of my symptoms in detail. However, when I saw an American physician, I felt that I was inferior to him. Moreover, since I was a female patient and usually younger than almost all doctors in the U.S., I felt they looked down on me. (Ji-Min Lee, a 34-year-old artist in Manhattan, New York)

In addition to language barriers, having no health insurance was another reason for their preference for Korean doctors. About one-third of survey respondents was not insured in the U.S. I collected my survey data and conducted in-depth personal interviews before the enforcement of the Patient Protection and Affordable Care Act, also known as an ObamaCare. Thus, the percent of uninsured Korean immigrants might be lower now than what my survey data shows. For uninsured Korean immigrants, getting a discounted medical bill by paying cash was a primary reason for looking for Korean doctors. They also felt more comfortable discussing their uninsured status with Korean doctors. A female informant in her late 50s told me that she had seen Korean doctors over 20 years because she had never had health insurance in the United
States. She said that Korean doctors, as immigrants themselves, understood their uninsured situation better than native-born American doctors. When I asked why he chose Korean doctor, Dong-Joo Han, an elderly man who did not have health insurance in the U.S., emphasized that paying a medical bill in cash was a win-win strategy for both Korean patients and Korean doctors:

The language barrier was the first reason for my search for a Korean doctor. The second reason was medical costs. When I went to see a Korean doctor, I could get a discounted medical bill if I paid it in cash. It was a mutual help between a patient and a doctor because he could also have financial benefits by reporting tax if a patient paid a bill in cash. It was a tacit promise between Korean patients and doctors, and it was what I did with my Korean doctor. (Dong-Joo Han, a 67-year-old retired man in Fort Lee, New Jersey)

As indicated in Chapter 1, researchers have (Wang, 2007; Wang et al., 2008) found a discrepancy between Chinese immigrants’ preference for Chinese-speaking doctors and their actual prevalence of seeing them because of the geographical distance between where Chinese immigrants lived (suburbs) and the location of Chinese doctors (downtown). Unlike Chinese immigrants, Korean immigrants in the New York-New Jersey area showed consistency between their preference for co-ethnic doctors and their actual visits to co-ethnic doctors. I asked my survey respondents: “What are the racial/ethnic background and immigrant generation background of your family doctor?” About one-third of respondents (179/507=35%) had no family doctor. As Table 4.4 shows, the vast majority of Korean immigrants had co-ethnic doctors as their family doctors regardless of whether Korean doctors were immigrants or not. Nearly half of them had first-generation Korean doctors, and about 40 percent of them had 1.5 or second-
generation Korean doctors as their family physicians. By contrast, only 14 percent of them had non-Koreans as their family doctors.

Table 4.4: The Ethnicity and Immigrant Generation of Korean Immigrants’ Family Doctor

<table>
<thead>
<tr>
<th>Ethnicity and Immigrant Generation of Family Doctor</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-generation Korean doctor</td>
<td>152</td>
<td>46.3</td>
</tr>
<tr>
<td>1.5 or second generation Korean doctor</td>
<td>130</td>
<td>39.7</td>
</tr>
<tr>
<td>Non-Korean doctor</td>
<td>46</td>
<td>14.0</td>
</tr>
<tr>
<td>Total</td>
<td>328</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: My survey with 507 Korean immigrants in the New York-New Jersey Area
Survey Questions: Do you have a family doctor in the U.S.? What are their ethnicity and immigrant generation?

More informants preferred first-generation Korean immigrant doctors to younger-generation Korean doctors, but they still felt more comfortable with 1.5- or second-generation Korean doctors than with non-Korean doctors, even if they communicated with the younger-generation Korean doctors in English, because of similarities in culture:

I have had an American doctor only once since migration to the U.S. in the late 1990s. I can speak English fluently, but I still feel more comfortable seeing first-generation Korean doctors. However, regardless of the immigrant generation, I prefer Korean doctors to American doctors because of language. Even when I speak to second-generation Korean doctors in English, I feel less embarrassed than speaking to American doctors in English. (Kang-Mi Lee, a 28-year-old student in Brooklyn, New York)

Another informant in her mid-30s indicated that she still felt more comfortable with her second-generation Korean family doctor than with American doctors:

My family doctor was a second-generation Korean American, and he did not speak Korean very well. However, I still felt more relaxed with him than with American doctors. We communicated 85 percent in English and 15 percent in
Korean. When I had to explain my symptom in English, I often spoke in Korean to him, and he understood it most of the time. Of course, he, as a second-generation Korean American, does not fully understand my Korean. However, his understanding of Korean culture helps our communication in Korean. (Mi-Jin Noh, a 34-year-old florist in Flushing, Queens)

Korean Immigrants’ Practice of Hanbang

As reviewed in Chapter 1, health researchers suggested that Hanbang is one of the healthcare options for East Asian immigrants. Table 4.2 in the previous section showed that there were about 200 Hanbang offices in the New York-New Jersey area, comprising about 17 percent of all medical offices. When the number of Hanbang offices was divided by the number of Korean immigrants in this area, there are about one Hanbang offices per 1,100 Korean immigrants. About 15 percent of all survey respondents practiced Hanbang in the U.S. in last five years. This percent was reasonable when the proportion of Hanbang offices (17%) among all medical offices in the New York-New Jersey area was taken into account. Moreover, as reviewed in Chapter 1, the proportion of my survey respondents who practiced Hanbang was similar to that reported by Kim and Chan (2004). In their study, about 15 percent of Korean immigrants preferred Hanbang to western medicine.

In Chapter 1, I pointed out that previous studies commonly found that elderly Korean immigrants were more likely to practice Hanbang than younger Koreans (Chin, 1992; Kim et al., 2002; Pourat et al., 1999). As Table 4.5 shows, my survey results also indicated that older Korean immigrants showed a greater tendency to receive Hanbang treatments than younger Korean immigrants. In particular, middle-aged Korean immigrants who were 50 years old to 64 years old showed the highest percent of practicing Hanbang than all other age groups. In
addition to them, those who were in their forties or those who were elderly also showed a great tendency of utilizing *Hanbang* than their younger counterparts. My results are similar to what Han (2001) found about Korean immigrants in Australia. According to him, middle-aged Koreans who are in their forties and fifties were the majority of *Hanbang* customers.

Table 4.5: Practice of *Hanbang* by Age Group

<table>
<thead>
<tr>
<th>Practice of <em>Hanbang</em></th>
<th>Age group</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-29</td>
<td>30-39</td>
<td>40-49</td>
<td>50-64</td>
<td>65 years old or older</td>
</tr>
<tr>
<td>No</td>
<td>86 (95.6%)</td>
<td>81 (83.5%)</td>
<td>96 (82.1%)</td>
<td>95 (81.2%)</td>
<td>73 (84.9%)</td>
</tr>
<tr>
<td>Yes</td>
<td>4 (4.4%)</td>
<td>16 (16.5%)</td>
<td>21 (17.9%)</td>
<td>22 (18.8%)</td>
<td>13 (15.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>90 (100.0%)</td>
<td>97 (100.0%)</td>
<td>117(100.0%)</td>
<td>117(100.0%)</td>
<td>86(100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey with 507 Korean immigrants in the New York-New Jersey Area

$x^2 (4, N = 507) = 10.17, p = <.05/ \text{gamma} = .18$

I suspect that there are several reasons for older Koreans' greater propensity of practicing *Hanbang*. Most of all, they are more likely to be ill due to their older age, so they are more likely to receive any treatments, including *Hanbang* treatments. Also, *Hanbang* treatments are closely related to geriatric illnesses, such as back pain, knee pain, or arthritis. Lastly, as will be discussed later, middle-aged Korean immigrants had the greatest prevalence of practicing *Hanbang* due to their uninsured status. If they were retired before reaching the age of 65, they were not eligible to receive Medicare. Since *Hanbang* treatment is not covered by health insurance in the U.S., they may choose *Hanbang* as one of the options for their healthcare.

The proportion of Korean immigrants who utilized *Hanbang* is lower compared to those who received any western medical care in the U.S. in the last five years (77%). Nevertheless, a significant proportion of Korean immigrants have utilized *Hanbang* in the United States. According to my in-depth interviews, there are two main reasons for Korean immigrants’
preference for and practice of Hanbang. First, some Korean immigrants preferred Hanbang treatments because they believed that Hanbang understood the fundamental constitution of their body better than western medicine. In their view, Hanbang is a more suitable therapy to cure their illness because it tried to fix the root cause of their illness by changing the physical constitution. For them, the western medicine is just a temporary remedy as it reduces pain temporarily by using painkillers. By contrast, they believe that Hanbang suggests more preventive ways to patients to treat their illness. Hani Kim, a 30-year-old computer designer, asserted, “I trust Hanbang because it understands my constitution. If I go to see a western doctor, he will give me the same medication that he gives to other people. However, if I go to see a doctor who practices Hanbang, he will give me a special treatment effective just for me.” Young-Soo Kim, a college professor, emphasized the preventive aspect of Hanbang treatments:

I prefer Hanbang to the western medicine because it is more preventive than western medicine. Hanbang changes the constitution of your body, whereas western medicine just restrains the pain of the disease by medicine. Since I had had acid reflux for a while, I went to see a Korean doctor who practices western medicine. For five years, he just gave me medicine that suppressed my acid reflux. After five years of western treatments, my reflux still had not been cured. So I went to see the Hanui, a doctor who practices Hanbang. He was surprised by the list of the medications that I took for last five years. Rather than taking medications, My Hanui suggested a special diet for me. He helped me to change my constitution in a more preventive way. After having Hanbang practices, my reflux had been much eased. (Young-Soo Kim, a 70-year-old employee at a non-profit organization in Flushing, Queens)
Second, as expected, more Korean immigrants who indicated that they had encountered any barriers to the U.S. healthcare system used Hanbang in comparison to those who did not have any barriers. About 18 percent of those who encountered barriers practiced Hanbang, while about 11 percent of those who had no barriers practiced it. As Portes and his colleagues (2012) pointed out, though uninsured immigrants are likely to see folk healers as a coping strategy, my informants, especially those who did not have U.S. health insurance, sought Hanbang for financial reasons. As noted in the previous section, about a quarter of survey respondents were found to have no health insurance in the United States. Since Hanui (Hanbang doctors) charge substantially lower fees than Western medical doctors, Korean immigrants with no insurance would rather visit Hanbang offices than Western medical offices. In particular, middle-aged Korean immigrants who were uninsured but not yet qualified for Medicare actively practiced Hanbang. Jae-Young Paek, a middle-aged woman who worked as a dental technician, said that she went to see Hanui several times in the U.S. when she had pain in her knee. She paid about $50 per visit to Hanui because her insurance did not cover Hanbang practice. However, she did not think that it was too expensive because she needed to pay about the same amount of co-pay if she visited orthopedics specialists. Hee-Jin Lee, a 38-year-old employee at a non-profit organization, is another uninsured Korean immigrant. When she had acute pain in her back, she visited an orthopedic doctor first. However, she needed to pay about $200 to meet an orthopedic surgeon and to get an x-ray. Alternatively, she made phone calls to Hanbang offices in the Korean business directory. After talking to several receptionists, she went to the Hanbang office who offered the lowest price to her, $50 per treatment.
Korean Immigrants’ Medical Tours to the Home Country

Korean immigrants’ medical tourism to the home country was significantly related to the first two behaviors that have been examined above: preference for co-ethnic doctors and practice of Hanbang. To see the prevalence of Korean immigrants’ medical tourism, I asked all of my survey respondents, “Have you ever visited Korea for medical care since you migrated to the U.S.?” I asked them to say no to this question if they received medical care accidentally without any plan prior to their trip. Then, I asked a follow-up question to those who said yes to the prior question: “How many times have you visited Korea to get medical since you immigrated to the U.S.?”

Table 4.6 shows that about a quarter of all survey respondents has ever visited Korea for medical care since their migration to the U.S. Among Korean immigrants who participated in medical tourism, nearly half of them engaged in medical tourism just once. About one-third took medical tours two or three times, and about one-fifth had visited Korea four times or more frequently to receive medical treatments. There were four people who took ten or more medical tours to the home country, and all of them led very active and extreme transnational lives. For example, Hyun-Seok Choi, a middle-aged man who runs a fashion jewelry store in Manhattan, had the most frequent numbers of medical tourism visits among all informants. For business purposes, he has to visit Korea at least twice a year. Thus, since migrating to the U.S. in the 1990s, he has visited Korea more than 40 times. Since he had to take business trips frequently and regularly, he applied for Korean health insurance and tried to get as many as medical treatments as possible while staying there. In other words, although he is a U.S. citizen and spends most of his time in the U.S., Korea has been the primary place for his medical care.
Table 4.6: Number of Medical Tours since Migration to the U.S.

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>386</td>
<td>76.1</td>
</tr>
<tr>
<td>Once</td>
<td>51</td>
<td>10.1</td>
</tr>
<tr>
<td>Twice or three times</td>
<td>45</td>
<td>8.9</td>
</tr>
<tr>
<td>Four times or more</td>
<td>25</td>
<td>4.9</td>
</tr>
<tr>
<td>Total</td>
<td>507</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area

Survey Questions: (1) Have you ever visited Korea to get medical care since you immigrated to the U.S.? (2) How many times have you visited Korea to get medical care?

In Chapter 3, I investigated the Korean government’s and other private sectors’ efforts to attract overseas Koreans to the home country for medical care. As pointed out in Chapter 3, 2009 was a turning point year for medical tourism in Korean because the Korean government revised the medical law that made introducing, arranging, and inviting foreign patients legally. To see if these efforts were significant to Korean immigrants’ medical tours to the home country, I asked Korean immigrant medical tourists, “What is the year of your last visit to Korea for the medical purpose?” Table 4.7 shows that only 16 of 121 Korean immigrants who participated in medical tours (13%) took medical tours before 2009. Rather, the vast majority of them made medical tours in 2009 and after. More than half visited Korea in 2012 or later. Although I cannot directly measure the impact of the revised medical law or other efforts to promote medical tourism among Korean immigrants, I suggest that these efforts had a moderate effect on their medical tours to the home country.

Table 4.7: The Year of the Last Visit to Korea for Medical Care

<table>
<thead>
<tr>
<th>Year of Last Medical Tour</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 2009</td>
<td>16</td>
<td>13.2</td>
</tr>
<tr>
<td>2009-2011</td>
<td>39</td>
<td>32.3</td>
</tr>
<tr>
<td>2012-2013</td>
<td>66</td>
<td>54.5</td>
</tr>
<tr>
<td>Total</td>
<td>121</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: My survey of 121 Korean immigrants who have participated in medical tourism to Korea

Survey Question: What is the year of your last visit to Korea for the medical purpose?
Conversations with my informants revealed that Korean immigrants’ decisions to engage in medical tourism were highly or moderately associated with some of their barriers to U.S. medical care and other behaviors related to healthcare. First, as expected, there was a significant association between having obstacles to U.S. healthcare and taking medical tours to the home country. Table 4.8 shows that 84 percent of Korean immigrants with no barrier to U.S. healthcare had never taken a medical tour to the homeland, while 71 percent of those with some barriers had never visited Korea for medical care. The difference between the two groups is more salient among people who took more frequent medical tours. About 17 percent of Korean immigrants who indicated any difficulty in accessing U.S. healthcare had two or more medical tours to the home country; meanwhile, less than 10 percent of those who had no difficulties had taken two or more medical tours. Among my respondents, this clearly shows that those who experienced difficulties utilizing U.S. healthcare were more likely to engage in medical tourism as a coping mechanism.

Table 4.8: Number of Medical Tours by Barriers to the Healthcare in the U.S.

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>Having Any Barriers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Barrier</td>
<td>Any Barriers</td>
</tr>
<tr>
<td>None</td>
<td>172 (83.5%)</td>
<td>214 (71.1%)</td>
</tr>
<tr>
<td>Once</td>
<td>15 (7.3%)</td>
<td>36 (12.0%)</td>
</tr>
<tr>
<td>Twice or more</td>
<td>19 (9.2%)</td>
<td>51 (16.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>206 (100.0%)</td>
<td>301 (100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey with 507 Korean immigrants in the New York-New Jersey Area

Second, I expected to find that Korean immigrants who preferred co-ethnic doctors were more likely to take medical tours to the home country. Confirming my expectation, there was a positive association between a preference for co-ethnic doctors and taking medical tours to the home country. As Table 4.9 shows, 18 percent of the Korean immigrants who did not prefer
Korean doctors in the U.S. took at least one medical tour to the home country, compared to 27 percent of Korean immigrants who preferred Korean doctors. In particular, my survey respondents who preferred Korean physicians were twice as likely (16.8%) to engage in medical tourism twice or more than those who did not prefer co-ethnic doctors (8.3%). However, having Korean family doctors in the U.S. was not significantly associated with their medical tourism experience. In fact, Korean immigrants who had co-ethnic family doctors had a lower rate of taking medical tours to the home country than those who had non-Korean family doctors. This finding suggests that Korean immigrants who had Korean doctors in the U.S. did not need to go back to Korea to get medical care since they could communicate effectively with them in the same language or at the very least, shared culture.

**Table 4.9: Number of Medical Tours by Preference for Co-ethnic Doctors**

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>Preference for Korean Doctors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (81.7%)</td>
<td>Yes (73.1%)</td>
</tr>
<tr>
<td>None</td>
<td>147</td>
<td>239</td>
</tr>
<tr>
<td>Once</td>
<td>18 (10.0%)</td>
<td>33 (10.1%)</td>
</tr>
<tr>
<td>Twice or more</td>
<td>15 (8.3%)</td>
<td>55 (16.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>180 (100.0%)</td>
<td>327 (100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey with 507 Korean immigrants in the New York-New Jersey Area

\[ x^2 (2, N = 507) = 7.17, \ p < .05/\gamma = .24 \]

Lastly, Korean immigrants who utilized *Hanbang* in the U.S. had a higher rate of taking medical tours to the home country than those who did not. Table 4.10 shows that about one-fifth of those who did not use *Hanbang* took at least one medical tour to Korea, compared to about one-third of who used *Hanbang*. This finding is consistent with Xing’s (1998) argument that overseas Chinese’ trust in traditional Chinese medicine contributed to overseas Chinese’ medical tours to the home country. Like overseas Chinese, some of my Korean informants expressed
belief in the effectiveness of Hanbang, and that was often their primary reason for taking medical tours to the home country.

Table 4.10: Number of Medical Tours by Practice of Hanbang in the U.S.

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>Practicing Hanbang in the U.S.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>Total</td>
</tr>
<tr>
<td>None</td>
<td>337 (78.2%)</td>
<td>49 (64.5%)</td>
<td>386 (76.1%)</td>
</tr>
<tr>
<td>Once</td>
<td>37 (8.6%)</td>
<td>14 (18.4%)</td>
<td>51 (10.1%)</td>
</tr>
<tr>
<td>Twice or more</td>
<td>57 (13.2%)</td>
<td>13 (17.1%)</td>
<td>70 (13.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>431 (100.0%)</td>
<td>76 (100.0%)</td>
<td>507 (100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey with 507 Korean immigrants in the New York-New Jersey Area

\(x^2(2, N = 507) = 8.51, p < .05, \gamma = .27\)

Interestingly, a few Korean informants reported that they preferred to receive Hanbang treatments in Korea rather than in the U.S., although they still practiced it here. For them, distrust of Hanui academic credentials in the U.S. was the primary reason for their skepticism or reluctance. They argued that there were only a few universities in Korea, such as Kyung Hee University, which have Hanbang departments. It takes six years to complete a B.A. degree in Hanbang. Moreover, since it is very competitive to get admission to a school and become a Hanui, a doctor who gives Hanbang treatment, they are highly selective in Korea. By contrast, in their view, it is much easier to become a Hanui in the U.S. because there are more universities and two-year colleges which have oriental medicine departments. Also, they indicated that it takes a much shorter period of time to complete the degree in the United States. All of these reasons indicate that the respondents felt that standards were much lower for Hanui in the United States. Most of the Korean informants were aware of these differences, so they preferred to get Hanbang care in Korea rather than in the U.S.
Yong-Gyu Lim, a middle-aged taxi driver, asserted that he visited Korea to receive Chunwha therapy, a particular type of Hanbang treatment because he believed that Hanui in Korea had more reliable academic credentials than Hanui in the U.S.:

A few years ago, I had severe back pain. I even had health insurance in the U.S., but I still went back to Korea for treatments. I wanted to have Hanbang treatments because I believed that Hanbang was better than western medicine. Then, I thought that Hanui in Korea had better ability than Hanui in the U.S. because the majority of them graduated from a competitive university such as Kyung Hee University. By contrast, it was much easier to be Hanui in the U.S. If you spent two years at a community college somewhere in Long Island, you can receive a license to be a Hanui in the U.S. That was the reason why I did not trust them as much as I trusted Hanui in Korea. (Yong-Gyu Lim, a 58-year-old taxi driver in Bayside, Queens)

The Reasons for Korean Immigrants’ Medical Tourism

As previously discussed, Korean immigrants’ barriers to and difficulties with the U.S. healthcare system and their distinctive healthcare behaviors (preference for co-ethnic doctors, and practice of Hanbang) were significantly associated with their medical tours to the home country. In order to assess the reasons for medical tourism besides barriers and healthcare behaviors, I directly asked the following question to 121 Korean immigrant medical tourists: “What factors contributed to your visit to Korea for the medical purpose?” I gave them eight possible answers: (1) lower medical costs, (2) better ability of Korean doctors, (3) easier communication with Korean doctors, (4) shorter waiting time, (5) having no health insurance in the U.S., (6) feeling more comfortable in the home country, (7) simpler procedures at the hospital, and (8) other
reasons that they can freely write. I asked them to choose all applicable, and about half (N=62) respondents chose two or more answers. In other words, multiple reasons simultaneously affected their decision on medical tourism, rather than a single reason.

Table 4.11: Reasons for Medical Tourism

<table>
<thead>
<tr>
<th>Reasons for Medical Tourism</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheaper medical costs in Korea</td>
<td>72</td>
<td>59.5</td>
</tr>
<tr>
<td>Easier communications</td>
<td>43</td>
<td>35.5</td>
</tr>
<tr>
<td>Feel more comfortable in Korea</td>
<td>39</td>
<td>32.2</td>
</tr>
<tr>
<td>Simpler procedures in Korea</td>
<td>34</td>
<td>28.1</td>
</tr>
<tr>
<td>Better ability of doctors in Korea</td>
<td>28</td>
<td>23.1</td>
</tr>
<tr>
<td>A shorter waiting period</td>
<td>24</td>
<td>19.8</td>
</tr>
<tr>
<td>No health insurance in U.S.</td>
<td>22</td>
<td>18.2</td>
</tr>
<tr>
<td>Other reasons</td>
<td>27</td>
<td>22.3</td>
</tr>
<tr>
<td>Total</td>
<td>289</td>
<td>238.7</td>
</tr>
</tbody>
</table>

Source: My survey data with 121 Korean immigrant respondents who have taken a medical tour to Korea
Note: Since several respondents (N=62) gave multiple answers, the sum of the answers exceeds 100%

Survey Question: What was the reason for your visit to Korea for the medical purpose? Indicate all applicable.

The most frequent reason was lower medical costs in Korea. As Table 4.11 shows, about 60 percent of reported that the relatively cheaper medical expenses contributed to their decision on medical tours to the home country. The second popular reason was easier communication with healthcare professionals. About one-third of respondents chose this reason. Another one-third of respondents replied that feeling more comfortable in Korea was the reason for their medical tourism. Simpler medical procedures in Korea and better abilities of Korean doctors were also indicated as important contributing factors to their medical tours to the home country. Moreover, a shorter waiting period, having no U.S. insurance, and other reasons were also noted as reasons for their medical tourism. In the following subsections below, I will discuss each reason separately. I will also cite personal interviews if informants’ personal stories tell what survey data cannot show.
Cheaper Medical Costs in Korea

As discussed in Chapter 3, Korea had much cheaper medical costs than the U.S. Thus, it is not surprising that cheaper medical cost in Korea was the most frequently answered reason for their medical tourism. Personal interviews also support findings of the survey. For example, several informants had the same medical treatments in the U.S. and Korea. When they compared the costs of the same treatments in both countries, and the medical expenses were much cheaper in Korea than the United States. Yeon-Joo Chung, a female informant in her mid-30s, had the same Ob/Gyn surgeries in both countries. For the same treatment, she spent about one thousand dollars more in the U.S. than in Korea although she did not have a health insurance in either country. Sun-Hee Choi was another informant who was surprised by the expensive medical costs in the U.S. for the same medical procedures:

I have a U.S. health insurance through my son’s job. Nevertheless, I still went back to Korea for medical care due to expensive medical costs in the U.S. One day, I fell on the ice in the U.S. I needed to take an X-ray here, and the hospital claimed 4,000 dollars for an X-ray even though my son pays 500 dollars every month for my insurance! I was so surprised by how expensive it was. Because of expensive medical costs, I did not receive further treatments here. Instead, I took an X-ray again in Korea and received treatments there last year. In Korea, the whole medical procedures for the same medical issue cost only about few hundred dollars, even without a Korean national health insurance. (Sun-Hee Choi, a 69 year- old housewife in Palisades Park, New Jersey)

Easier communications and More Comfortable Feelings in the Home Country
As pointed out in the earlier section, about one-third of Korean immigrants had language barriers in accessing the U.S. healthcare system. Previously, I indicated four types of language barriers that gave Korean immigrants’ difficulty in receiving healthcare: (1) difficulties in understanding medical terminology in English, (2) difficulties in expressing symptoms in English, (3) difficulties in communicating with non-Korean doctors, and (4) feeling powerless or having unequal power relates to non-Korean speaking doctors. The language barriers were the main reason for their preference for co-ethnic physicians. In addition to their preference for co-ethnic doctors in the U.S., easier communications by speaking Korean and sharing the same culture with doctors in Korea were important reasons for their medical tours to the home country. Since I discussed the importance of communications with doctors in the earlier sections, I will not repeat it here. My informants indicated that when they received medical care in Korea, they did not face these barriers.

Thirty-two percent of the survey respondents reported that they felt more relaxed and relieved when they received medical treatments in Korea. For them, receiving medical care was not just about the actual practice, but also something emotional. They, especially those who lived alone in the U.S., such as international students, felt comfortable getting medical care in the home country because their relatives and friends gave them emotional support. Kyung-Eun Park, a 56-year-old employee at a non-profit organization in Flushing, said that she became weak-minded and homesick when she was ill. She said that her going back to the homeland for medical care was “like a bird who tries to be nestling in mother bird’s arms.” Not only emotional attachment but also Korea as a homogenous society made Korean immigrants more comfortable in the homeland. Sung-Joon Suh, a middle-aged employee at a Korean firm who took medical tours once in two years, commented, “Unlike in the U.S., I was not a minority member in Korea.
In Korea, a homogenous society, I just looked like one of them. I was not physically distinctive in Korea as I was in the U.S. The fact that I looked just like everybody else made me feel so comfortable when I stayed in Korea for medical care.”

Simpler Medical Procedures and A Shorter Waiting Period

Simpler medical procedures and a shorter waiting period in Korea were often important for Korean immigrants’ medical tourism. More than a quarter of Korean immigrant medical tourists (28%) recognized that medical procedures in the U.S. were more complicated than that in Korea. Since the Korean national health insurance offers the same coverage for all people despite the different insurance rates, they did not need to call the insurance company or the hospital to check if the hospital accepts their national health insurance. By contrast, it felt cumbersome to call American doctor’s office before a visit to check if their insurance would be acceptable. To them, the check-in and the check-out processes were much easier in Korea because the hospital handled everything right after receiving patient’s name and social security number.

Some informants also felt it was very inconvenient to visit different hospitals or doctors’ offices for examination in the U.S, whereas a checkup for the entire body at one hospital was possible in Korea. A 66-year-old male informant, who had been in the U.S. for 35 years and had five medical tours to Korea, complained that it took him several days to get examination at different doctor’s offices in the U.S. By contrast, he spent only three hours for a whole checkup in Korea. Another elderly interviewee told me that he was amazed by the simple and fast the medical procedures in Korea:
The main reason for my medical tours to Korea was convenience. I had a health insurance in the U.S., but medical procedures were too complicated here. I had to make an appointment with each department for a checkup. And I had to make separate visits to different doctors’ offices for an endoscopy or an x-ray. That was very cumbersome. When I had a checkup at Inha University hospital in Korea, I did not stay at the hospital even a day. I checked in at 8 am and was discharged at 11 am, after examining my whole body in one building. (Dae-Sik. Choi, a 70-year-old retired man in Fort Lee, New Jersey)

Along with a simpler procedure, a shorter waiting period in Korea was another attractive factor to Korean immigrants’ medical tourism. One-fifth of medical tourists reported that they decided to go back to Korea for medical care for a shorter waiting period. Joo-Hyun Lee, who had immigrated to the U.S. 20 years ago, took medical tours to the home country for a checkup and other medical care because it took a long time to get her treatments and receive the results in the U.S. She had to wait several weeks to see a doctor for a physical examination, waited another week to see the results and waited another week to get treated. She said, “Since I was quick in temper, I could not bear a long waiting period in American hospitals. I screamed at the receptionists and myself, ‘quickly, quickly’!” She even said that she would go back to Korea if she found any severe disease because of a short waiting time although she had a U.S. insurance. Another informant said that a shorter waiting period was a strong pulling factor to her medical tourism. She compared how long it took for her to make an appointment, get treatment, and see the results for the same disease in the U.S. and Korea:

I had a same Ob/Gyn examination both in the U.S. and Korea. It took several weeks for me to see a doctor to get examined in the U.S. By contrast, doctors in
Korea were more flexible, so I was able to see a doctor right after calling them. Also, it took several months for me to see the results in the U.S., whereas it took only 30 minutes in Korea. (Ji-Won Cha, a 36-year-old accountant in Bronx, New York)

Better Ability of Korean Doctors

About a quarter of survey respondents answered that they went back to Korea for medical care because doctors in Korea had better ability than those in the U.S. They gave two reasons that for this opinion: doctors in Korea used more advanced methods and equipment than physicians in the U.S.; and the academic credentials were more reliable in Korea than in the U.S. First, the respondents identified that Korean doctors knew newer methods and more advanced technologies for medical care than the U.S. doctors. Yang-Mi Kwon, who had a breast cancer surgery in Korea, found that the way of American doctor’s surgery was out-dated than Korean doctor’s, and that was one of the main reasons for her medical tours to Korea:

I was diagnosed with a breast cancer in the U.S. and had several follow-up examinations prior to a surgery. I found that American doctors’ ways of the operation were old-fashioned when I took a biopsy at a hospital in New Jersey. The American doctor used such a big needle to “dig up” my breast tissue. When I contacted my friend, who was a medical doctor in Korea, she told me that the American way was too brutal. That was the reason why I decided to go back to Korea for a breast cancer surgery. Once my doctor in Korea saw how American doctors did a biopsy, he was surprised by American physicians’ outdated operation methods. In Korea, nobody used that old method anymore. (Yang-Mi Kwon, a 50-year-old housewife, Palisades Park NJ)
Second, some Korean informants expressed their doubts about the academic credentials of the U.S. medical schools, not only for Hanui who practices Hanbang, but also for American doctors in general. Young-Chul Doh, a 73-year-old male informant, emphasized that it is harder to get into the medical school in Korea than in the United States. Ji-Hye Kim also argued that American doctors were not as well-educated as doctors in Korea:

American doctors did not seem to be professional because of their academic credentials. In Korea, doctors had to study very hard to enter the medical school and receive their medical degrees. Not everybody can be a doctor in Korea; an only smart person can be a doctor. However, being a doctor is like getting a license in the U.S.; everybody can be a doctor. I did not feel relieved when I saw a doctor in the U.S. because their academic credentials were less reliable than in Korea. (Ji-Hye Kim, a 26 years old employee at a Korean firm, Forest Hill Queens)

*Having No Health Insurance in the U.S.*

While other reasons for medical tourism were “pull factors,” having no insurance in the U.S. was a “push factor” to Korean immigrants’ medical tours to the home country. Nearly one-fifth of respondents (22/121=19%) indicated that having no insurance was the primary reason for their decision on medical tourism. Young-Ho Chung was an elderly man whose medical tourism was exclusively caused by his uninsured status in the U.S. Except for not having health insurance in the U.S., he had no other push factors to receive medical care in Korea; he spoke good English; he knew American culture well for working in U.S. Army Forces in Korea over 30 years; he had two children in New Jersey who could help him to get to the hospital; He had good Korean network in the U.S. for being an elder of the Korean ethnic church. Only the financial
issue caused by uninsured status was a problem for him to receive medical care in the U.S., and that contributed to his medical tourism.

One’s health-insurance status was a complicated issue because it was related to age, occupation, legal status, and other factors. One thing noticeable about Korean immigrants’ health-insurance status was that it was closely related to their occupations. As reviewed in Chapter 1, my survey data confirmed that self-employed Korean immigrants showed a much lower insured rate (60%) than those employed (74%). And this negative association was statistically significant. Not only self-employed Korean immigrants but also Korean immigrants who worked at a Korean firm (74%) showed a lower insured rate than those who worked at a non-Korean firm or public sector (86%). These results suggest that self-employed Koreans and Korean immigrant employees at co-ethnic firms had fewer class resources and more financial barriers to the U.S. healthcare. In fact, many self-employed informants reported that it was hard to see a doctor in the U.S. due to their uninsured status and long working hours. Since I asked the reason for medical tourism only to participants of medical tourism, it was not possible for me to explain the complicated relationship among health-insurance status, employment status, and medical tourism of all Korean immigrants. In Chapter 5, I will examine how their health-insurance status, along with their employment status, contributed to their decision on medical tours to the home country.

Other Reasons

Another quarter of respondents (27/121=22.3%) gave other reasons for their medical tours to Korea. There were three other reasons. The first was to get the second opinion from doctors in Korea. Kyung-Sook Baek, a middle-aged housewife with two children, visited Korea searching for a second opinion after her diagnosis with a thyroid cancer in the U.S. Three years
ago, she was diagnosed with thyroid cancer, and she had surgery in the U.S. Although the surgery was successful, she lost her voice as a side effect. In the U.S., her doctor told her to give up to recover her voice. She was disappointed at her American doctor’s advice, but she did not give up her hope. Then, she suddenly remembered what her friend told her: “When you are diagnosed with cancer, you have to see different doctors for a second, third, and fourth opinions.” To get the second opinion, her sister in Korea made an appointment for her with a famous doctor at Samsung Medical Center. A second opinion from the Korean doctor was positive, and she had her voice back after several treatments at Samsung Medical Center.

The second reason was to receive treatments for diseases which were more prevalent in Korea than in the U.S. Jung-Sook Lee and Kyung-Hee Kim were two medical tourists who wanted receive treatments for diseases that were more common in Korea than in the U.S. Since many Koreans suffer from certain diseases, they believed that frequent operations make expert doctors in these medical fields. An esophageal cancer was one of these diseases. According to Kyung-Hee Kim, an informant in her late forties, esophageal cancer was more prevalent among Koreans, but not among Americans. Consequently, there were many Korean doctors who have operated esophageal cancer. But, it was difficult for her to find a doctor who has performed the surgery many times in the U.S. Also, she thought that American medical technologies for esophageal cancer fell behind of Korean ones. That was the primary reason why she returned to Korea for a better and easier surgery when she found out that she was at the primary stage of esophageal cancer. Jung-Soon Lee, who had hepatitis B, also took a medical trip to the home country for a similar reason:

I was diagnosed with hepatitis B about 30 years ago. Hepatitis B was a rare disease in the U.S., whereas Hepatitis A and C were more common among
Americans. By contrast, it was quite a prevalent disease in Korea. That is the primary reason why I went back to Korea to see Dr. Kim, an expert of the liver at SNU hospital when I knew that I had hepatitis B. (Jung-Soon Lee, a 67-year-old fabric designer in Manhattan, New York)

Lastly, some Korean informants reported that Korean medical facilities and equipment were better and newer than American ones. They complimented the facilities of Korean hospitals. Clean and fancy hospital buildings in Korea, which looked like “shopping malls,” or “department stores,” gave them a feeling of trust in receiving medical treatments there. Soo-Bin Kim, who worked as a dental technician in Flushing, went back to Korea for medical care because she thought that Korean doctors could discover any disease better than American doctors, as Korean hospitals did not hesitate to buy the best and newest medical equipment. Another informant, Eun-Jung Choi described that newest medical equipment was one of the primary reasons for her medical tours to the home country:

Korean hospitals were incomparable to the U.S. hospitals in terms of medical devices. Several years ago, I had a severe pain in my stomach because I had a lump there. When I visited a doctor’s office in the U.S., they just told me that I had a lump in my stomach. They did not specify where I had a lump in my stomach. However, when I saw a doctor in Korea for the same symptom a few months later, he pinpointed out a particular area at a certain membrane of my stomach where the lump was located in. Since my Korean doctor had the best and newest medical technologies, he discovered exactly where I had a problem with my stomach. (Eun-Jung Choi, a 41-year-old employee at a Korean firm in Flushing, Queens)
As summarized above, Korean immigrants took medical tours to the home country for various reasons, such as a lower medical cost, a shorter waiting period, easier communication, simpler procedures, and feeling more comfortable in the home country. They also visited the home country for medical care because of their uninsured status in the U.S. As indicated earlier, about half of them chose more than one reason for their medical tour decision. That is, their medical tour decision was not made by a single factor. Rather, various reasons were simultaneously associated with it. For example, a 64-year-old female informant described the style of her medical tour as “the Trinity style,” because she chose Korea for faster, more accurate, and kinder medical care. Another middle-aged female interviewee, who migrated to the U.S. 20 years ago and who had U.S. health insurance, also pointed out three reasons for her medical tourism: cheaper medical costs, less complicated system, and easier communications with healthcare professionals.

The reasons assessed above were based on the answers of Korean immigrants who only participated in medical tourism (N=121). Although their responses were useful to assess why they decided to take medical tours to Korea, it was not possible to understand the contributing factors to all Korean immigrants’ medical tourism decisions. Thus, in the next chapter, I will thoroughly examine major contributing factors, including all survey respondents (N=507) and as well as my in-depth personal interviews with the participants of medical tourism (N=100) and the non-participants of medical tourism (N=20).
Chapter 5: Contributing Factors to Korean Immigrants’ Decision on Medical Tourism

In Chapter 4, I examined Korean immigrants’ barriers to the U.S. healthcare utilization and their healthcare behaviors: preference for co-ethnic doctors, the practice of Hanbang, and medical tours to the home country. I also assessed reasons for their decision on medical tourism, answered by Korean immigrant survey respondents who participated in medical tourism (N=121). Rather, this chapter intends to analyze the major contributing factors to Korean immigrants’ medical tourism based on my analysis of a survey data and in-depth personal interviews. I use survey data with 507 Korean immigrants in the New York-New Jersey area. I also analyze the in-depth personal interviews with 100 Korean immigrants who participated in medical tourism and 20 Korean immigrants who did not participate in medical tourism.

This chapter has three major sections. The first section examines how Korean immigrants’ transnational ties, especially social ties, contributed to their decision on medical tourism. The second section examines Korean immigrants’ health insurance status as a possible contributing factor to their medical tourism. It also investigates their self-employment status and age as mediating factors to the association between health insurance status and medical tourism. The last section examines the contribution of Koran immigrants’ temporary resident status to their decision on medical tours to the home country.

Korean Immigrants’ Transnational Ties as Contributing Factors to Medical Tourism

In the introductory chapter, I argued that immigrants’ medical tourism does not stand alone. As a type of medical transnationalism, it is closely connected with other types of transnationalism: political, economic, social, cultural, and religious transnationalism. Thus, this section intends to
examine how other types of transnationalism are correlated with Korean immigrants’ decision on medical tourism. This section has three subsections. The first subsection examines whether Korean immigrants’ frequent visit is correlated with their medical tourism. The second subsection investigates the association between social transnationalism and medical tourism, and the last subsection explores the relationship between other types of transnationalism and medical tourism.

The Association between the Number of Visits to Korea and Medical Tourism

Before examining the relationship between medical tourism and other types of transnationalism, it is important to know the frequency of Korean immigrants’ visit to Korea for any purpose because it represents the central aspect of their transnational ties with the home country. Moreover, it is likely to be strongly related especially to their medical tourism as it requires individuals’ physical visit to the home country. The immigrants who visit their country of origin more often for any purpose are more likely to have medical care as well since they need a trip to the home country for it. Table 5.1 indicates the frequency of Korean immigrants’ visit to Korea for any purpose. The majority (78%) of Korean immigrants had ever visited Korea for any reason since their migration to the U.S., but still a substantial proportion of them (22%) had never visited Korea since their immigration. These numbers were similar to what Min (2013) found earlier based on his survey in the New York-New Jersey area: about 85 percent of Korean immigrants have ever visited Korea and more than half of them (54%) have visited Korea three times or more often since their migration to the U.S.

Old timers who had lived in the U.S. for twenty years had a greater propensity of visiting the home country than their newcomer counterparts, who had stayed in the U.S. less than ten years. About one-tenth of old timers and about a quarter of newcomers had never visited Korea
since their migration to the U.S. Perhaps newcomers would not have long enough time to visit the homeland due to their relatively shorter migration periods. Among Korean immigrants who had ever visited Korea (N=395), about the one-fifth had visited their home country for just once. The majority of them had visited Korea twice or more, and about one-third of them had visited Korea four times or more.

Table 5.1: The Number of Visits to Korea since Migration to the U.S.

<table>
<thead>
<tr>
<th>Number Visits to Korea</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never visited</td>
<td>112</td>
<td>22.1</td>
</tr>
<tr>
<td>Once</td>
<td>83</td>
<td>16.4</td>
</tr>
<tr>
<td>2-3 times</td>
<td>132</td>
<td>26.0</td>
</tr>
<tr>
<td>4 times to 8 times</td>
<td>124</td>
<td>24.5</td>
</tr>
<tr>
<td>9 times or more</td>
<td>56</td>
<td>11.0</td>
</tr>
<tr>
<td>Total</td>
<td>507</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area
Survey Questions: Have you ever visited Korea for any purpose (e.g. visiting family and friends, business trip, sightseeing, seeing a doctor, etc.) since you immigrated to the U.S.? If you have done so, how many times?

Table 5.2 shows that the number of visits to Korea has a positive association with the number of medical tours to Korea. Certainly, those who have never visited Korea for any purpose did not take any medical tour to the home country. However, those who visited Korea more often for any purposes also had more medical tours to the home country. The positive and significant association between the number of visits to Korea and medical tourism was probably due to the fact that Korean immigrants’ medical tours were often mixed with other purposes. In other words, the frequent visitors might have other purposes for their visit to Korea along with the medical purpose.
When I asked the 121 Korean immigrants who have ever participated in medical tourism, “Besides getting medical care, what was other purpose(s) of your visit to Korea,” only 6.6 percent of them answered that the purpose of visiting the home country was exclusively for the medical purpose. The vast majority of Korean immigrant medical tourists answered that the purposes of a visit to the home country were mixed with the medical and other purposes. Table 5.3 shows that Korean immigrants who had participated in medical tourism had other reasons, such as visiting family and friends (86%), sightseeing (15%), business purposes (10%) and visa-related issues (6.6%). About 3.3 percent of them reported that attending funerals or weddings in Korea was another reason for their visit to Korea, along with the medical purpose.

Table 5.3: The Purpose of the Last Visit to the Home Country among Korean Immigrants who Participated in Medical Tourism

<table>
<thead>
<tr>
<th>Purpose of the last visit to Korea</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting family and friends</td>
<td>104</td>
<td>86.0</td>
</tr>
<tr>
<td>Sightseeing</td>
<td>18</td>
<td>14.9</td>
</tr>
<tr>
<td>Business trips</td>
<td>12</td>
<td>9.9</td>
</tr>
<tr>
<td>Only for the medical purpose</td>
<td>8</td>
<td>6.6</td>
</tr>
<tr>
<td>To solve the U.S. visa-related Issues</td>
<td>8</td>
<td>6.6</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>127.3</td>
</tr>
</tbody>
</table>

Source: My survey data with 121 Korean immigrant respondents who have taken a medical tour to Korea
Note: Since several respondents (N=29) gave multiple answers, the sum of the responses exceeds 100%
Survey Question: Besides getting medical care, what was another purpose(s) of your visit to Korea? Check all applicable.
Based on the conversations with my informants, there were two groups of Korean immigrants who had visited Korea only for medical purposes: (1) those who needed a major surgery urgently and (2) those who needed follow-up treatments for the prior surgeries which had been operated in Korea. First, some informants immediately went back to the home country for a cancer surgery after they were diagnosed with cancers in the U.S. For example, Jung-Hoon Lee, a middle-aged taxi driver in Queens, went back to Korea about five years ago once he found that he had a thyroid cancer. Yang-Mi Kwon was another person who went back to Korea right after she found that she had a breast cancer in 2006. Korean immigrants who belong to the first type commonly wanted to “have a knife on their body” in Korea than in the U.S. because they, as an ethnic minority, were afraid of receiving paid less attention by non-Korean doctors in the United States. Sung-Ho Lim indeed had a medical tour to Korea for this reason, fear of being an experimental subject during the surgery by non-Korean doctors:

In the U.S., I, as Asian immigrant, often felt racial discrimination. I suspected that American doctors used “us” as “guinea pigs” in the U.S. Last year, I needed to get rid of skin adhesion near my ear, and I wanted to go back to Korea because it was a surgery that puts a knife on my body. I did not want to do it here because I had a stereotype for them to pay less attention to Asian patients. They would do their best to Americans, but not to us, Asians. (Sung-Ho Lim, a 58-year-old taxi driver in Bayside, Queens)

Hyun-Jung Choi, a 37-year-old female accountant, went back to Korea for the follow-up of her surgery in Korea. She received a shoulder surgery in 2005 in Suwon, Korea. Since she preferred to see the same doctor who operated her surgery before, she went back to Korea in 2006 and 2013 for following checkups and treatments for her shoulder. Young-Ho Kim and
Joong-Soo Lim were two elderly Korean immigrants who took medical tours for follow-up treatments of their prior surgeries operated in Korea. Young-Ho Kim, a 78-year-old man who had lived in the U.S. for more than 40 years, visited Korea annually for the last couple of years. He needed eight implants on his teeth. Since he began the first dental implant procedure in Korea, he has visited Korea for follow-up treatments and another implant per each visit. Joong-Soo Lim, a 76-year-old man, also visited Korea annually for the last three years to meet the doctor who performed his heart surgery in the past. During each visit, the doctor checked up if his heart functioned properly. Joong-Soo Lim could see a doctor in the U.S. for the follow-up of his surgery. However, he wanted to be checked by the doctor who had conducted his surgery because he considered that doctor knew his body better than a strange doctor in the U.S.

Recently, researchers have examined a Korean transnational family: a Kirogi family. A Kirogi means a wild goose in Korean. This transnational family is composed of a mother and children staying in the U.S. for mainly children’s educational purpose and a father staying in Korea to support the family financially (Ahn, 2009; Cha, 2010; Jeong et al., 2013; Kang, 2012; Kim, 2009; Lee, 2010; Song, 2010 & 2012). This type of transnational family is often called as a Kirogi family because a wild goose family in the real world and a transnational Kirogi family share similar characteristics. A wild goose couple does not re-marry if a husband or a wife goose dies and the left one dedicates himself or herself raising children alone. It resembles a transnational Kirogi family who has a mother who devotes herself raising children alone in a foreign country (Kim et al., 2014). I hypothesized that the members of Kirogi family would have a stronger transnational tie with the home country. They would have a greater chance to take medical tours to the home country. Unfortunately, the proportion of Kirogi family was not high among my Korean informants. Only 12 of 507 survey respondents answered that they had
spouses in Korea. The vast majority of them were women in their forties and fifties and had children. Most of them were newcomers who have lived in the U.S. less than ten years. Supposedly, they have stayed in the U.S. for a short period of their children’s education. As expected, they showed a much higher percent of taking medical tours to the home country than those who did not have spouses in Korea. During in-depth personal interviews, two Kirogi mothers who explained that they took medical tours frequently because they had to go back to Korea regularly to take care of the left ones: Kirogi fathers. Both Kirogi mothers showed a high degree of transnational lives: they have lived six months in the U.S. and another six months in Korea. Due to their frequent visits to Korea and extended stay there, they did not buy U.S. health insurance and used Korea as the main place for their medical care.

Social Transnationalism and Medical Tourism

In the introductory chapter, I pointed out six areas of transnationalism that are relevant to immigrants –political, economic, social, cultural, religious, and medical. In this section and the following section, I examine the connection between and among medical transnationalism and other types of transnationalism. To measure the level of Korean immigrants’ social transnational ties with the home country, I asked if they have any relatives in Korea and, if so, how often they contacted them. About a quarter had no relative in Korea. Slightly more than half had siblings, and about a half had parents in Korea. As indicated in the earlier section, only a few respondents had spouses in Korea. The elderly Korean immigrants were less likely to have any relatives in Korea probably because their parents were most likely to be passed away. Moreover, most of them had their children in the U.S. rather than in Korea.

The following tables indicate that Korean immigrants’ social transnational ties with the home country are highly associated with their medical-tourism experience. First, Table 5.4
shows that Korean immigrants who have relatives in Korea visit the home country more frequently for medical tourism. For example, 91 percent of Korean immigrants who have no relatives in Korea have never taken medical tours to the home country. By contrast, more than a quarter of Korean immigrants who have any relatives in Korea have taken medical tours to the home country once or more. Moreover, the strength of the positive association between the number of medical tourism visits and having any relatives in Korea was strong.

Table 5.4: The Number of Medical Tours by Having Any Relatives in Korea (N, %)

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>Number of Relatives in Korea</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No relative</td>
<td>Any relatives</td>
</tr>
<tr>
<td>None</td>
<td>119 (90.8%)</td>
<td>267 (71.0%)</td>
</tr>
<tr>
<td>Once</td>
<td>9 (6.9%)</td>
<td>42 (11.2%)</td>
</tr>
<tr>
<td>Twice or more</td>
<td>3 (2.3%)</td>
<td>67 (17.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>131 (100.0%)</td>
<td>376 (100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area

Table 5.4 shows the statistically significant association between having relatives in Korea and medical tourism. Having any relatives in Korea was a mediating factor to the relationship between visiting Korea and taking medical tours to Korea. Korean immigrants who had any relatives in Korea were more likely to visit the homeland. And those who visited Korea more often were more likely to take medical tours to the home country. It is difficult to determine whether having relatives promoted Korean immigrants’ medical tours to Korea because the Chi-square test does not indicate the causality of association. However, many interviewees indicated that having relatives in Korea made it much easier for them to visit Korea for either general or medical purposes because they could stay with their relatives and avoid paying for a hotel or other lodging accommodations. One interviewee in her late thirties told me that having a place to stay for free influenced her decision to get her OB/GYN treatments in Korea. In fact, the
majority of non-medical tourists complained that having no relatives in the home country strongly influenced their decision not to take medical tours because they needed to pay for a hotel in Korea. For example, Min-Ho Park, a middle-aged man who has been in the U.S. for almost 20 years, told me that he had no relatives in Korea because all of his relatives migrated to the United States. Additionally, he married a U.S.-born second-generation Korean woman, so he did not have any in-laws in Korea either. He said that since he did not have any relatives in Korea, he would need to stay in a hotel. Even if he wanted to go to Korea for medical tourism, he was unwilling to pay extra money for hotel accommodations.

Not only having any relatives but also the frequency of contacting them is also important as a type of social transnational ties. Assuming a positive association between frequent contact with relatives and medical tourism, I asked respondents how often they communicated with their relatives if they had any in Korea. I found that there was a positive association between Korean immigrants who contacted their relatives more frequently and those who engaged in medical tourism. Basch, Glick Schiller, and Szanton Blanc (1994) argued that modern communication technologies have promoted transnationalism. This indeed seems to be the case for the Korean immigrants in this study, as email, cheaper or even free international phone service, texting, video chatting, and Kakaotalk (a popular Korean mobile application that offers free message service) has helped Korean immigrants maintain much easier and more frequent contact with relatives in Korea, thus, facilitating social transnational ties.

There were four different types of relatives in Korea: parents, siblings, spouse, and children. Korean immigrants who had spouses in Korea showed the most frequent contacts than those who had any other types of relatives in Korea. However, as noticed earlier, the number of individuals who had spouses in Korea was small. Those who had parents in Korea also showed
frequent contacts, but not as much as those who had spouses. By contrast, having siblings or children in Korea was not associated with frequent contacts.

Noh et al. (2012) found that Korean immigrants in Canada had a strong social transnational ties with the home country; more than half of them have at least one parent in Korea, and about 80 percent of them have talked to them via telephone. Moreover, they found that young and recent immigrants showed stronger social transnational ties than older and old timers. Their findings were similar to what I found with my own survey data. First, young Korean immigrants in the New York-New Jersey area showed more frequent contacts with their relatives in Korea than their elderly counterparts. About two-thirds of non-elderly Korean immigrants had contacted their relatives in Korea a few times a month or more frequent, whereas only about half of elderly Koreans had done so. This was probably due to the fact that elderly Korean immigrants tended to have a fewer number of relatives in Korea as their parents were likely to be dead and as their children were likely to stay in the U.S. with them. Second, newcomers had contacted their relatives in Korea more frequently than their old timer counterparts. About 90 percent of newcomers who had lived in the U.S. less than ten years had contacted their relatives a few times a month or more frequently. About two-thirds of them had contacted their relatives every week or more frequently. By contrast, about half of old-timers who had lived in the U.S. for more than 20 years had contacted their relatives a few times a month or more frequently. About 18 percent had weekly-based or more frequent contacts with their relatives in Korea.

Table 5.5 shows that people who contacted their relatives in Korea more frequently took medical tours to the homeland. About 16 percent of Korean immigrants who contacted their relatives in Korea a few times a year had at least one medical tourism experience. More than a
quarter of Korean immigrants who kept in touch with their relatives in Korea a few times a month had engaged in medical tourism to the home country. Those who contacted their relatives every week or more frequently showed the highest tendency of taking medical tours to Korea (40%); 13 percent took medical tours once, and 27 percent took medical tours twice or more. Contacting their relatives in Korea also affected Korean immigrants’ arrangement of medical tourism. I will examine it in the next chapter as this chapter focuses on social transnational ties as the contributing factor to the decision of Korean immigrants’ medical tourism.

Table 5.5: The Number of Medical Tours by Contacting with Relatives in Korea (N, %)

<table>
<thead>
<tr>
<th>Number of Medical Tourism Visits</th>
<th>Frequency of Contacts with Relatives in Korea</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than a few times a month</td>
<td>A few times a month</td>
</tr>
<tr>
<td>None</td>
<td>88 (83.8%)</td>
<td>91 (72.8%)</td>
</tr>
<tr>
<td>Once</td>
<td>9 (8.6%)</td>
<td>14 (11.2%)</td>
</tr>
<tr>
<td>Twice or more</td>
<td>8 (7.6%)</td>
<td>20 (16.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>105 (100.0%)</td>
<td>125 (100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area
Note: This analysis includes Korean immigrants who have any relatives in Korea (N=376)

\[ x^2 (4, N = 376) = 18.77, p < .01/ \gamma = .36 \]

In Chapter 2, I analyzed the 2009-2011 ACS data and found that Korean immigrants’ educational level was high in general, and the variation of their educational level was not wide. The educational level itself was not significantly associated with Korean immigrants’ medical tours. However, interestingly, the in-depth interviews revealed that respondents’ college education often strengthened their social transnational ties with the home country, playing a mediating factor to their decisions to engage in medical tourism. There were several informants who noted that transnational events organized by their alma maters in Korea influenced their medical tourism. Five interviewees said that they went to university hospitals that were affiliated
with the universities where they graduated. Often, alumni associations invited overseas alumni to Korea for several events, such as a homecoming day. Many of these alumni were eligible for discounted medical bills from the university-affiliated hospitals. These types of financial benefits through social transnational ties were influential factors to engaging in medical tourism. For instance, Yang-Hoon Choi, a 66-year-old man, visited Konkuk University hospital, which was affiliated with his alma mater. Konkuk University hospital offered him a 30 percent discounted medical bill and a 20 percent discounted price for his wife, thus, he and his wife took medical tours to Korea. For Jae-Yong Ryu, another interviewee, strong emotional attachments to his alma mater was another important issue. In his case, medical tourism was deeply associated with an invitation from the alumni association of his alma mater in Korea:

When I visited Korea last time, I went to Chung-Ang University hospital and received a regular checkup because I graduated from Chung-Ang University. The central alumni association of Chung-Ang University in Korea invited all the overseas alumni members. About 40 of us, the alumni members from the U.S., stayed in the university dorm. For three days and four nights, we went sightseeing and attended several university events. The alumni association offered a special rate for a regular checkup at Chung-Ang university hospital for people who wanted to receive it. About half of us had a regular checkup. The alumni association provided lodging at the dorm for extra days for people who needed a longer stay for their checkup. I felt that the university hospital gave us an extra and special care because we were the alumni. Also, I felt very comfortable at the hospital because I had strong emotional attachments to the University. (Jae-Yong Ryu, a 61-year-old business owner, Fort Lee, NJ)
Except for social transnationalism, other types of transnational ties with the home country were marginally related to Korean immigrants’ medical tourism to the home country. My survey data and in-depth personal interviews indicated that Korean immigrants in the New York-New Jersey area had a low degree of political transnational ties with the homeland. Only two informants had political transnational ties with the home country by participating in the political organization to support certain politicians. However, their political transnational ties were not related to their medical tours to the home country.

Interestingly, three elderly interviewees reported that their political transnational ties were closely connected to their medical tourism. In 2010, the Korean government revised the Nationality Act⁴, and it strongly influenced Korean immigrants’ political transnational ties to the home country. Before 2010, Korean immigrants who wanted to attain dual nationality had to give up the other nationality to recover the Korean nationality. However, According to revised Article 9 of the Nationality Act, “a person who had been residing in a foreign country and entered Korea for permanent residency at the age of 65 or older and has attained permission for reinstatement of nationality,” do not need to renounce a foreign nationality to regain their Korean nationality. After their reinstatement of Korean nationality, they have to fulfill the national obligation of tax payment and the Korean national health insurance payment. Also, they can exercise the right to vote if they register as residents with the Korean government. Since the U.S. approves the multiple nationality, they can still receive social security benefits, pension, Medicare, or other welfares from the U.S. Recently in 2014, ten members of the National

⁴ [http://www.law.go.kr/lsInfoP.do?lsiSeq=151992&efYd=20140619#0000](http://www.law.go.kr/lsInfoP.do?lsiSeq=151992&efYd=20140619#0000)
Assembly proposed a revised law that allows overseas Koreans who are 45 years old or older apply for dual nationality (Shin, 2014). The Korean government’s allowance of dual nationality could be considered as state transnationalism as this activity has been initiated by the nation-state in pursuit of national interests.

Dual nationality has promoted some elderly Korean immigrants’ medical tours to the home country because it has allowed them to have easier access to the Korean national health insurance. Ho-Sang Park, a 70-year-old man who recently received dual nationality, described his experience:

As a dual citizen of the U.S. and Korea, it became easier for me to visit the home country. I also had Korean health insurance now. Once you became a dual citizen, you could be fully covered by insurance with only 90 dollars a month. I also had Medicare in the U.S., but I still visited Korea to see a doctor. If I saw a doctor in the U.S., 100 dollars would be deducted from social. In Korea, the co-pay was only three or four dollars with the national insurance. After recovering my Korean nationality, I also felt more attached to my home country. (Ho-Sang Park, a 70-year-old retired man in Palisades Park, New Jersey)

My interview with another Korean senior citizen revealed how political transnational ties as well as economic transnational ties were connected to his medical tourism experience:

I came to the U.S. in 1991 and ran a dry cleaning store before my retirement. I visited Korea last year to recover my Korean citizenship, still maintaining the U.S. citizenship. Last year, I read a local Korean newspaper which was published in New Jersey, and the article reported that Korean immigrants who were older
than 65 years could apply for the dual citizenship. Actually, I did not apply for the dual citizenship for the medical purpose. I did it for the economic purpose. I had an apartment in Seoul, which I bought before migration to the U.S. and wanted to sell it. But the property tax rate was about 70 percent as an American citizen. If I became a dual citizen, then I could pay less tax. After being a dual citizen of two countries, I sold the apartment with lower tax rates. Moreover, I had more chances to visit Korea for the medical purpose. I already had a checkup and dental treatments there because I visited there more often. (Sang-Chul Choi, a 73-year-old retired man, Palisades Park, NJ)

Cultural transnational ties had a mild effect on Korean immigrants’ medical tourism. Only two informants said that advertisements in a Korean newspaper published in the New York-New Jersey area contributed to their decision to engage in medical tourism. Rather, cultural transnationalism influenced the after-effects of their medical tourism. I will examine the influence of cultural transnational ties on medical tourism in the next chapter. Regarding the association between religious transnational ties and medical tourism, three informants who had Won Buddhism as their religion reported that they went to Wonkwang University hospital in Korea, which was affiliated with Won Buddhism. However, other than them, there were no informants whose medical tourism was related to their religious transnational ties with the home country.

Health-insurance Status as a Possible Contributing Factor to Medical Tourism
This section focuses on the relationship between Korean immigrants’ health-insurance status and their medical tourism. In this section, I will answer the following questions. Would uninsured Korean immigrants be more likely to take medical tours to the home country than their insured counterparts due to their financial barriers in the U.S.? Are there any mediating factors to the association between Korean immigrants’ health insurance status and their medical tourism? For instance, would self-employed Korean immigrants, who are known to have a low health insurance rate, be more likely to take medical tours to the home country than their non-self-employed counterparts?

Previous studies found the lack of health insurance coverage was one of the major contributing factors to immigrants’ medical tourism because uninsured immigrants tended to have more difficulties receiving medical care in the U.S. (Brown, 2008; Landeck & Garza, 2003). In Chapter 1, analyzing the 2009-2011 ACS data, I showed that foreign-born Koreans had a lower insured rates (74.4%) than their native-born non-Hispanic Whites (89.4%) and U.S.-born Koreans (78.8%) counterparts. When I asked all survey respondents (N=507) about their health insurance status, nearly 30 percent had no health insurance in the U.S. Thus, I assumed that uninsured Korean immigrants would show a higher chance of taking medical tours to the home country than their insured counterparts due to more financial difficulties to access to U.S. health care.

However, Table 5.6 shows that the association between health insurance status and medical tourism was statistically not significant. 77 percent of uninsured and 76 percent of insured Korean immigrants did not participate in medical tourism. Certainly, for most uninsured Korean immigrants, the home country was the ultimate place of medical care. Due to the expensive medical costs in the U.S. without health insurance, most of them had no choice but to visit the home country for medical treatment. In particular, medical tours to the home country
was an excellent option for middle-aged Korean immigrants who were retired but not yet eligible for Medicare. The home country was the ultimate place of medical care when their U.S. health insurance through their job had been terminated with their retirement and when they were not yet qualified for Medicare because they were younger than 65 years old. There are two reasons for this insignificant relationship between Korean immigrants’ health insurance status and their medical tours to the home country. It is difficult to explain these reasons by quantitative analysis of the survey data. However, fortunately, my in-depth personal interviews with Korean immigrant medical tourists found an interesting phenomenon regarding this insignificant association.

Table 5.6 The Number of Medical Tours by Health Insurance Status

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>Health Insurance Status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not insured</td>
<td>Insured</td>
</tr>
<tr>
<td>None</td>
<td>114 (77.0%)</td>
<td>272 (75.8%)</td>
</tr>
<tr>
<td>Once</td>
<td>13 (8.8%)</td>
<td>38 (10.6%)</td>
</tr>
<tr>
<td>Twice or more</td>
<td>21 (14.2%)</td>
<td>49 (13.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>148 (100.0%)</td>
<td>359 (100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area

\[x^2(2, N = 507) = 0.38, p > .05\]

On the one hand, Korean immigrants who had the U.S. health insurance still took medical tours to the home country. There were four types of Korean immigrants who took medical tours despite having health insurance in the United States: (1) those who viewed Korea as an alternative option for medical care depending on their needs, (2) those who used Korea as a supplementary place of medical care, (3) those who used Korea as a secure place of medical care due to the complicated nature of healthcare in the U.S., and (4) those who viewed Korea as a superior place for medical care. Interestingly, the main reasons for their medical tourism and the
ways of using the home country as the place of medical care were different across the four groups of insured Korean immigrants.

The first type was those who visited Korea for mixed purposes with their U.S. health insurance. For them, Korea was an *alternative* place where they might or might not get medical care depending on their situation. According to my survey, only seven percent of Korean immigrant medical tourists visited Korea only for medical purposes. The vast majority of other Korean immigrant medical tourists visited Korea partly for medical and partly for other purposes, such as visiting family and friends or taking business trips. Eun-Ji Kim, a middle-aged employee at a Korean firm in the United States, explained that her regular visits to Korea contributed to her medical tours to the home country although she had U.S. health insurance: “I had an excellent health insurance through my job, but I tried not to see a doctor in the U.S. unless it was an urgent situation. As I have visited Korea regularly and annually to see my family, I could solve all my health issues in Korea. The medical processes were less complicated, and the medical costs were cheaper there.” Hyun-Woo Park, a middle-aged businessman, visited Korea regularly, primarily for business purposes. He visited Korea at least twice a year and, like Eun-Ji Kim, he used Korea as an alternative place of medical care. Since Korea provided cheaper medical treatments for him, he even canceled his U.S. health insurance. In his case, the home country became an *ultimate* place of medical care rather than an *alternative* place. Korean immigrants who belong to this first type commonly reported that faster medical processes in Korea was the primary reason for their medical tourism.

The second type was those who still visited Korea for medical care because (1) their U.S. health insurance did not cover optical or dental treatment or (2) because their U.S. plans only offered limited coverage. For them, the home country was a *supplementary* place of medical
care. They could have received optical or dental care in the U.S., but cheaper medical costs in Korea were the biggest reason for their medical tourism, as they needed to pay more medical expenses for the same optical or dental treatments in the United States. Ji-Won Kim, an interviewee in her late thirties, had Lasik corrective eye surgery during her last visit to Korea. As an employee at a Korean-American firm, she had health insurance with good coverage for general medical care. However, her U.S. insurance did not cover any optical treatments or surgeries. Although she received all of her other medical care in the U.S., she visited Korea for optical treatments. Many other Korean immigrants in this supplemental category also frequently traveled to Korea to receive dental care. Hye-Young Kim, a middle-aged housewife, said that she had U.S. health insurance with good coverage for general healthcare. For example, it only cost about 20 dollars for her to get an endoscopy with her U.S. insurance. However, her insurance did not cover any dental treatments, so whenever she visited Korea, she made a point to go see a dentist there.

The second type also includes Korean immigrants whose U.S. health insurance offered only limited coverage, which contributed to the need to take medical tours to the homeland. For example, Soo-Jin Bang had a health insurance plan with very limited coverage. Thus, when she had a car accident in the U.S., only a few physical therapy sessions were covered by her insurance. Since she felt that the total number of visits to the physical therapist was not enough in the U.S., she visited Korea regularly to receive supplementary treatment:

Medical tourism means supplementing treatments to me. When the numbers of treatment covered by my U.S. insurance were not enough, I visited Korea for more treatments. For example, I could have only one colonoscopy in every five years in the U.S. But, I wanted to have colonoscopy every year. If I exceeded the
limited numbers of treatments in the U.S., then I needed to pay a huge amount of medical bill here. So, when I wanted to receive more examinations or treatments, I went back to Korea for that. (Soo-Jin Bang, a 58-year-old employee at a Korean firm in Fort Lee, New Jersey)

The third type was insured Korean immigrants who often went back to the home country due to the complicated and confusing nature of the U.S. medical system. Most of all, complicated check-in procedures, long waiting time at the doctor’s office, and having to make an appointment in advance made them use the home country as a secure place of medical care. Kyung-Hwa Chang, a 40-year-old woman who had been in the U.S. for nine years, preferred to go back to Korea for medical care even though she had Aetna insurance here. She felt that it was too inconvenient and complicated to call the doctor’s office to check if they accept her insurance prior to her visits to the office. Also, she felt that making appointments, check-in and check-out procedures, the medical treatment itself, and waiting for results in the U.S. were too time-consuming. Another interviewee also expressed that complicated U.S. medical processes influenced her to go back to Korea for medical treatment:

One day, I had a deep scratch on my knee during exercise. I had a health insurance, Blue Cross Blue Shield, but I needed to make several phone calls to the doctor’s offices to check if they would accept my insurance. After several calls, I finally found a doctor who was willing to take mine, but that office was located too far from where I got injured. After going through all these complicated appointment-making processes in the U.S., I decided to go back to Korea for medical care. (Seo-Yoon Choi, a 30-year-old student, Woodside, Queens)
Additionally, the uncertainty of medical costs was another complication of the U.S. healthcare system that some Korean immigrants wanted to avoid. Min-Joon Yoon, a 36-year-old man who worked at an American bank on Wall Street, pointed out that ambiguity regarding the price of medical procedures made him worried whenever he had any medical issues in the United States. A few years ago, he sprained his ankle while playing soccer. When he visited an orthopedic specialist, the doctors and nurses did not tell him how much he needed to pay for the treatment. A few months after his injury, to his surprise, he continued to receive a number of medical bills. After this experience, he became scared to see a doctor in the U.S. due to the uncertainty of pricing and medical bills. Thus, he tried to receive as many medical treatments as possible whenever he visited Korea. Another interviewee drew an analogy between paying medical bills and buying products in the U.S.:

The U.S. hospitals had such a complicated system, and that did not make any sense. For example, we purchased a product after checking its price. However, we could not know the amount of the expected medical treatments before going through it. Whenever I asked the expected price of the medical care, the receptionist or the doctor said that they could not tell it because it should be negotiated with the insurance company first. (Ji-Hyun Choi, a 40-year-old housewife in Flushing, Queens)

The last type was insured Korean immigrants who had better personal connections with medical doctors in Korea. For them, the home country was a superior place of medical care, as it provided better quality medical services and treatments through better social networks. For example, Min-Sik Choi was an old-timer Korean immigrant who migrated to the U.S. 35 years ago. Although he had a U.S. health insurance plan with good coverage, he still visited Korea for
medical treatment because his youngest sister was a doctor there. Another interviewee described how her higher level of social networks in Korea compared to the U.S. pushed her to go back to Korea despite her U.S. health insurance:

Although I was insured, I felt that there was a limitation for me to search and meet the noted doctors with excellent skills in the U.S. Maybe there were better physicians in the U.S. However, as an immigrant, I had no chance to meet them. In Korea, I had relatives who were doctors, and I had better networks to search and meet the noted doctors. That was the main reason for my medical tourism.

(Ja-Kyung Park, a 47-year-old housewife in Palisades Park, New Jersey)

On the other hand, many Korean immigrants who do not have health insurance in the U.S. were not able to go back to Korea for medical tourism. In other words, there was a mediating factor to the association between Korean immigrants’ health insurance status and medical tourism. One mediating factor was their self-employment status. Self-employed Korean immigrants, who were more likely to be uninsured and thus, more likely to take medical tours, could not visit Korea for medical purposes for several reasons. As previously mentioned in Chapter 1, Korean immigrants were highly concentrated in the ethnic economy either as business owners or employees (Min, 1984, 1990 & 2008; Min & Bozorgmehr, 2003; Yoon, 1991), and self-employed Koreans and Korean employees of co-ethnic Korean businesses were less likely to have insurance coverage than those in the public sector or the non-Korean private sector (Ryu et al., 2001). Thus, I hypothesized that self-employed Korean immigrants would be more likely to go back to Korea to get medical care, assuming that they had less access to U.S. healthcare due to their lower rates of having health insurance. My survey data also confirmed that self-employed Koreans had a lower insured rate (57.0%) than their non-self-employed counterparts
(73.6%).

However, it turned out that long working hours and the necessity of opening their stores every day hindered them from visiting their home country for medical and other purposes. Sang-II Cha, a middle-aged self-employed man, mentioned that he had visited Korea just once (for his father’s funeral) since migrating to the U.S. in the 1990s. Since he had his own business and needed to work all day and everyday, including the weekends, it was impossible for him to visit Korea. Jeong-Sook Yoon, another entrepreneur who runs a laundry in New Jersey, told me that starting up a business totally changed her life, including her insured status and her chance of visiting Korea:

I had visited Korea only three times in last 28 years. The last visit was about 17 years ago before having my own business. Before starting up my laundry, I had a health insurance through my job. Now, as an entrepreneur, I had no insurance and no family doctor. Since I am not insured now, I would love to go to Korea to receive a regular checkup and other medical treatments. However, I could not have any personal time as an owner of a store. Time is so important us, like who have their own businesses. (Jeong-Sook Yoon, a 55-year-old laundry owner in Palisades Park, New Jersey)

However, self-employed Korean immigrants were not the only ones who could not take medical tours to Korea despite their low rate of having health insurance. Employees of Korean firms in the U.S., many of whom are very recent young Korean immigrants, lack any health insurance coverage. As indicated in Chapter 1 and 4, they showed a lower insured rate (74%) than those who work in the public sector or at a non-Korean firm (86%). However, they have difficulty traveling to Korea at all because they typically have trouble affording travel expenses.
In personal interviews, a few employees at a Korean firm indicated that it was hard for them to visit Korea for medical and other purposes because they could not afford travel expenses. Sang-Hoon Choi, an employee at a small Korean-owned store in Flushing, described himself as a “dayfly” as he has lived from hand to mouth. During his 20 years in the U.S., he has only visited Korea once, to attend his father’s funeral. Since his Korean employer only paid him minimum wage without any paid vacation, he could barely make ends meet with his salary. Consequently, although he wanted to receive a medical checkup in Korea, taking medical tours to the home country was just a “pie in the sky.”

Temporary Residence Status as a Contributing Factor to Medical Tourism

In this subsection, I examine how Korean immigrants’ temporary residence status contributed to their medical tours to the home country. In Chapter 1, I pointed out that Korean immigrants’ structural barriers to the health care in the U.S. were not considered much because they were considered to be less undocumented than Latino or Chinese immigrants. Yet, their legal status was found to be one of the most critical structural barriers to their medical tourism because undocumented Korean immigrants could not come back to the U.S. after getting medical treatments in the home country. Legal status was a very sensitive issue among immigrants, especially among the undocumented or people who temporarily stayed in the U.S. Thus, some Korean immigrants were not willing to disclose their past and current legal statuses in the U.S.

About half of the survey respondents (264 out of 507) answered the question of “What is your legal status or visa status at present? (1) temporary visa (student visa, visiting scholar, internee), (2) working visa (H1B, employees of Korean firms), (3) permanent resident, (4) naturalized citizen, and (5) other.” About five percent of respondents answered that their legal
status was “other,” so I presumed that they are most likely to be undocumented Korean immigrants. 29 of 264 survey respondents (11.0%) had a temporary visa, and 11 of them (4.2%) had a working visa. For the analysis of this section, I combined three types of Koreans (1) those who had a temporary visa, (2) those who had a working visa, and (3) those who had indicated his or her visa status as other, calling them as temporary residents. About one-third of the survey respondents were permanent residents, and nearly half of them (128/264=48.5%) were the U.S. citizens.

During the in-depth personal interviews, some Korean immigrants voluntarily disclosed their undocumented status and explained how their legal status influenced their medical tours to the home country. As expected, undocumented Korean immigrants or those who had complicated visa issues did not take medical tours to Korea. In fact, they could not visit the home country for any purposes because they were afraid of not coming back to the U.S. after visiting the home country. For example, a middle-aged male interviewee, who was unemployed and looking for a job, told me that he could not go back to Korea for the medical purpose due to his complicated legal status. Until a few months ago, he had maintained a working visa (H1B). But when I interviewed him, he was staying in the U.S. illegally. Due to his layoff, he did not have health insurance in the U.S. anymore, so he wanted to go back to Korea when he was sick. However, he could not visit Korea for the medical purpose or for any other purposes because he knew that he could not come back again once he left the U.S.

On the other hand, some Koreans discussed how their changed legal status influenced their decision on medical tour. Jung-Ae Kim, a 58-year-old housewife in Palisade Park, had wanted to go back to Korea for medical treatments because she had not been insured since her migration to the U.S. in the late 1990s. However, because of legal status, she could not visit
Korea for 11 years until she became a permanent resident. After “recovering” her status, she visited Korea twice for dental treatments and regular checkups. Another interviewee, Ok-Ja Jin, a 69-year-old retired woman, also indicated that her changed legal status contributed to her medical-tourism experience:

I have been in the U.S. for 15 years. But until recently, my legal status did not allow me to go back to Korea. Five years ago, I was diagnosed with a uterine myoma. I wanted to go back to Korea so badly to get a surgery due to the convenience of hospitalization processes in Korea. However, I could not go back because I was undocumented back then. So, I received surgery in the U.S. A few years later, I received a green card. After then, I regularly went back to Korea every two years to get medical care. (Ok-Ja Jin, a 69-year-old retired woman in Fort Lee, New Jersey)

To examine the association between Korean immigrants’ temporary resident status and the number of their medical tourism, I only included survey respondents who verified their legal status (N=264). However, there were some limitations of this analysis because about half of the respondents who did not answer their legal status were excluded in this analysis. I assumed that they were likely to be undocumented or to have complicated visa issues. Also, some respondents, especially undocumented Korean immigrants, might give a false answer about their legal status. Despite these limitations, Table 5.7 indicates that the association between Korean immigrants’ legal status and their medical-tourism experience was statistically significant. As expected, temporary residents (40%) showed a higher percent of taking medical tours to Korea than their permanent residents (27%) or the U.S. citizen counterparts (16%). In particular, a quarter (25%) of temporary residents took medical tours twice or more, whereas only 8.6 percent of Korean
immigrants with the U.S. nationality experienced two or more medical tourism to the home country.

Table 5.7: The Number of Medical Tours by Legal Status

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>Legal Status</th>
<th>Temporary Residents</th>
<th>Permanent Residents</th>
<th>U.S. Citizens</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>31 (59.6%)</td>
<td>61 (72.6%)</td>
<td>107 (83.6%)</td>
<td>199 (75.4%)</td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>8 (15.4%)</td>
<td>6 (7.2%)</td>
<td>10 (7.8%)</td>
<td>24 (9.1%)</td>
<td></td>
</tr>
<tr>
<td>Twice or more</td>
<td>13 (25.0%)</td>
<td>17 (20.2%)</td>
<td>11 (8.6%)</td>
<td>41 (15.5%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>52 (100.0%)</td>
<td>84 (100.0%)</td>
<td>128 (100.0%)</td>
<td>264 (100.0%)</td>
<td></td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area

\( \chi^2 (4, N = 264) = 13.96, p < .01 \)

Note: This analysis includes Korean immigrants who indicated their legal status (N=264)

There seem to be three factors to the association between Korean immigrants’ temporary-residents status and medical tourism: (1) the U.S. health insurance, (2) the degree of transnational ties with the home country, and (3) the level of assimilation into the U.S. society. First, Korean immigrants who stayed in the U.S. temporarily with student or working visas were less likely to be insured in the United States. Moreover, even if they had health insurance in the U.S., they were more likely to have very limited coverage. Although it was not shown in the table, my survey data confirmed the negative association between being temporary residents and having health insurance in the United States. There are several reasons why temporary residents had a lower insured rate than permanent residents or U.S. citizens. As temporary residents, Korean immigrants cannot receive any public health insurance services such as Medicare or Medicaid. Moreover, they are likely to have less stable employment due to their visa status.

Second, Korean immigrants who were temporary residents showed a much higher level of transnational ties with the home country than permanent residents or the U.S. citizens. In
particular, international students tended to take medical tours to the home country more often. This was due to their higher level of transnational social ties with the home country as they could go back to Korea during summer or winter vacations. Since they go back home during the break by any means, going to see a doctor in Korea was often their primary choice of healthcare. A female international student described:

Every summer, I went back to Korea and had a regular checkup. I received dental care there too because getting a dental treatment was very expensive here with my student insurance. Also, my co-pay was too expensive here, and I could not afford it whenever I visit the doctor’s office. So, when I was sick during the semester in the U.S., I just took some painkillers. Then once the break began, I left to Korea and received medical treatments there. My regular visits to Korea during the vacation and expensive co-pay were important factors to my medical tourism (Hye-Sil Kim, a 25-year-old student in Manhattan, New York)

Another international student stated that his regular visits to Korea during the summer or winter vacation contributed to his medical tourism:

For many reasons, such as language problem and high medical cost in the U.S. I did not go to see a doctor here. Since I visited Korea during the summer or winter breaks anyway, I usually tried to tolerate pain as much as possible when I was sick in the U.S. Recently, I had severe pain on my tooth. I knew a good dentist who attended my church in Flushing. But, I endured pain during the semester and then went home to see a dentist when the summer break began. (Tae-Wook Han, a 24-year-old student in Flushing, Queens)
Not only international students but also employees at Korean firms also revealed strong transnational ties with the home country. Some of them had frequent business trips to Korea as they worked at Korean firms based in the U.S. When they visited Korea for the business purpose, they often received medical care there. Moon-Soo Ha was a 36-year-old employee at a Korean securities company in Manhattan. His company in Korea sent him to the Manhattan office so that he could work there and earn an Executive MBA degree at Columbia Business School. During his two years of stay in the U.S., he visited Korea twice for business meetings in Korea. He extended his stay in Korea so that he could receive dental treatments and a checkup at Korean hospitals.

Lastly, assimilation into the U.S. society mediated the association between the temporary residence status and medical tourism. In general, temporary residents were less assimilated into the U.S. society than permanent residents or the U.S. citizens because they had lived in the U.S. for a shorter time period. Less assimilated immigrants would show a higher preference to take medical tours to the home country rather than to receive medical care in the U.S. due to language barriers or cultural affinity to the home country. Table 5.8 supports this hypothesis by showing the significant and negative association between the duration of stay in the U.S. and medical-tourism experience among Korean immigrants. Newcomers who have lived in the U.S. less than 10 years showed a higher percent of medical tourism. Almost 40 percent had experienced at least one medical tourism. By contrast, old timers who have resided in the U.S. for more than 20 years showed the lowest rate of experiencing medical tourism. Only 5.4 percent of them had taken a medical tour once, and about 10 percent of them took two or more medical tours to the home country.
Table 5.8 The Number of Medical Tours by the Duration of Stay in the U.S.

<table>
<thead>
<tr>
<th>Number of Medical Tours</th>
<th>Duration of Stay in the U.S.</th>
<th>1-9 years</th>
<th>10-19 years</th>
<th>20 years or longer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td>72 (61.0%)</td>
<td>139 (75.5%)</td>
<td>175 (85.4%)</td>
<td>386 (76.1%)</td>
</tr>
<tr>
<td>Once</td>
<td></td>
<td>17 (14.4%)</td>
<td>23 (12.5%)</td>
<td>11 (5.4%)</td>
<td>51 (10.1%)</td>
</tr>
<tr>
<td>Twice or more</td>
<td></td>
<td>29 (24.6%)</td>
<td>22 (12.0%)</td>
<td>19 (9.2%)</td>
<td>70 (13.8%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>118 (100.0%)</td>
<td>184 (100.0%)</td>
<td>205 (100.0%)</td>
<td>507 (100.0%)</td>
</tr>
</tbody>
</table>

Source: My survey of 507 Korean immigrants in the New York-New Jersey area  
$\chi^2(4, N=507) = 27.06, p<0.001/ \text{gamma}=-.375$

My personal interviews with Korean immigrant medical tourists supported the finding; as they assimilated into the U.S. society more, they received medical care in the U.S. than went back to the home country for medical care. Jae-Joon Lim, a 37-year-old government officer, said that he took medical tours frequently during his early migration period:

I have visited Korea seven times since I migrated to the U.S. in 2000. But my medical tours to Korea happened mostly at the beginning of my American life. Back in the early 2000s, I even maintained my Korean insurance so that I could receive medical care whenever I went back to see my parents. After becoming a permanent resident, I did not go to hospitals in Korea anymore because I felt that I needed to see a doctor here to settle down. As I have lived in the U.S. longer, I have become more assimilated into the U.S. society. As a permanent resident, it was the time to solve all my medical issues here rather than going back to Korea. (Jae-Joon Lim, a 37-year-old government officer in Manhattan, New York)

Jae-Joon also said that his preference for Korean doctors had been changed to non-Korean doctors in the U.S. due to his changed legal status and his greater assimilation to the U.S. society.
When I first arrived in the U.S., I was an international student. Back then, I
strongly preferred to go back to Korea to see a Korean doctor. I tried to endure
pain as much as possible since I went back to Korea about once or twice a year.
When medical tourism was impossible, I searched for a Korean doctor in the U.S.
About ten years later, I came to know American medical system better. With
better knowledge and better English proficiency, I was able to receive better
quality of medical care and services from American doctors. So, I tried not to see
a Korean doctor anymore and changed my old family Korean doctor to an
American doctor whose office was closer to my house and who had excellent
reviews on google.

The medical-tourism experiences of Hyun-Joo Kim, who went back to Korea to get
OB/Gyn surgery in the past, were similar to Jae-Joon. Hyun-Joo had been a temporary resident
for several years as she came to the U.S. for further study. After graduating from the university,
she became a school teacher and became a permanent resident. When she was a temporary
resident, she frequently went back to Korea for medical treatments, but she did not do that
anymore as she became more assimilated into the U.S. society:

I have been in the U.S. about 15 years. About seven years ago, I had to have
surgery, so I went back to Korea for that. At that time, I was a FOB (fresh off the
boat), so I had more trust in Korean hospitals. As a temporary resident, I felt
uncomfortable being hospitalized in the U.S. back then. However, I became a
permanent resident, and more assimilated into the U.S. society now. So, I would
not go back to Korea if I need another surgery. Now, I can handle the medical
processes and procedures here. (Hyun-Joo Kim, a 42-year-old teacher in Flushing, Queens)

Old timers commonly indicated that in addition to their greater assimilation to the U.S. society, the increased number of Korean doctors in the New York-New Jersey area was another reason for their no medical tour to Korea anymore. For example, Joo-Young Park, a middle-aged entrepreneur, visited Korea for the medical purpose before. But her visits were concentrated in her early migration days:

I had visited Korea for regular checkups and dental treatments when I first migrated to the U.S. in the late 1970s. Back then, there was no Korean doctor in New Jersey, which was very uncomfortable. So my husband and I often went back to Korea to see doctors. However, there are many Korean doctors in my neighborhood now, so I do not need to go back to Korea for medical care. (Joo-Young Park, a 54-year-old laundry owner in Palisades Park, New Jersey)
In this chapter, I examine Korean immigrants’ medical-tourism experiences and their evaluations of them. I use survey data and the personal interviews with participants in medical tours as the major data sources for this chapter. Previously in Chapter 5, I included data from all survey respondents who have or have not taken medical tourism (N=507). However, to focus on the medical-tourism experiences among medical tourism participants, this chapter includes only data from the survey respondents who have ever visited Korea for medical care (N=121). Moreover, it uses results of in-depth personal interviews.

This chapter has three sections. The first examines the arrangements of their medical tourism. In Chapter 3, I examined the Korean governments (including local governments) and private-sector agencies’ efforts to attract Korean immigrants to Korea for medical care. This section examines if their efforts were influential by looking at how medical tourism was arranged. The second section focuses on the various aspects of Korean immigrants’ medical-tourism experiences: major cities of their medical care, the duration of their stay, the types of hospitals for their medical care, and the types of medical care received in Korea. Finally, the last section probes into their evaluations of medical-tourism experiences, including the degree of their satisfaction with it and their future plan of another medical tourism.

The Arrangement of Medical Tourism

While staying in the U.S., Korean immigrants might have difficulties in arranging medical tourism remotely. Thus, some of them made appointments for medical care when they arrived in Korea. However, their relatives or friends in Korea also arranged their medical tourism. In order
to examine the arrangement of Korean immigrants’ medical tourism, I asked, “Who arranged your medical appointment in Korea?” As Table 6.1 shows, more than half (61.2%) answered that their relatives in Korea arranged it for them. The residents in Korea had more information about the hospitals and easier access to make medical appointments. Thus, many Korean immigrants entrusted their relatives to arrange their medical tourism. As detailed in Chapter 5, social transnational ties were deeply associated with Korean immigrants’ decision on medical tourism. They were also related to its arrangement. In case the Korean immigrants had relatives in Korea and frequent contacts with them, their relatives made an appointment even before they arrived in Korea. For example, Joo-Sang Yang, a 35-year-old librarian in Queens, frequently took medical tours to Korea because he regularly visited Korea to see his family and friends. He usually asked his mother to make an appointment for him before he left the U.S. so that he could save much time. He needed his mother’s help when visiting big hospitals in Korea because the latter usually require a longer waiting period for making arrangements than small private hospitals.

Table 6.1: Person(s) who Arranged Medical Appointments for Korean Immigrant Medical Tourists

<table>
<thead>
<tr>
<th>Who made a medical appointment in Korea?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives in Korea</td>
<td>74</td>
<td>61.2</td>
</tr>
<tr>
<td>The Respondent</td>
<td>48</td>
<td>39.7</td>
</tr>
<tr>
<td>Friend in Korea</td>
<td>7</td>
<td>5.8</td>
</tr>
<tr>
<td>Relatives in the U.S.</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Travel agency in the U.S.</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4.1</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>114.2</td>
</tr>
</tbody>
</table>

Source: My survey data with 121 Korean immigrant respondents who have taken a medical tour to Korea
Note: Since several respondents (N=6) gave multiple answers, the sum of the answers exceeds 100%

About 40 percent of the respondents reported that they made their own medical appointments in Korea. This high proportion was probably due to the fact most Korean hospitals accept walk-in patients. Since it was easy to visit a doctor’s office without an appointment in
Korea, the majority of respondents who made an appointment themselves just went into the doctor’s office when passing it on the street. Ja-Kyung Kim, a 35-year-old employee at a Korean firm in Flushing, had dental treatments, eye treatments, and skin treatments during her medical tour to Korea. She only had to make a phone call to the dental office few hours prior to seeing the dentist. For other treatments, she just walked into the doctors’ offices, and she didn’t wait too long to receive medical treatments. Another informant, a 43-year-old housewife in Bayside, Queens, made the following comment to tell her surprise at how easy it was for her to receive a simple surgery without a prior appointment:

In the U.S., most doctors did not accept the walk-ins. By contrast, in Korea, you could just go to any doctor’s office without an appointment, even wearing a flip flop. Before my medical tour to Korea, I needed to have an operation to remove a sty on my eye. I did not receive a surgery in the U.S. and waited until I visited Korea. To get rid of the sty, I just walked into the eye doctor’s office, and the doctor operated a clearing surgery right away. It was incredible that Korean hospitals accepted walk-ins and that they did not require appointments!

Eight respondents (6%) answered that their friends in Korea arranged their medical tourism. These informants, mostly young female Koreans, showed a high level of social ties with their friends in Korea and a high level of interest in elective treatments popular in Korea. When they wanted to receive plastic surgeries or skin treatments, they tended to ask their friends, rather than their relatives, because their peers were more familiar with the latest trends in Korea. They contacted their friends via email or Kakaotalk, a cell phone application that offers free text messages, voice calls, or video calls. Using these communications methods, they shared the medical information. Once their friends searched and recommended a doctor’s office to them,
the informants asked their friends to arrange their medical tour. For example, Soo-Bin Bae, a 30-year-old hairdresser, wanted to improve her physical appearance. She did not like her square-shaped chin, so she decided to inject a Botox on her chin during her visit to Korea. Before she arrived in Korea, she had talked to her friends via Kakaotalk, and her friends in Korea had made an appointment with a famous skin doctor for her. Another female informant, Eun-Sook Jang, a 40-year-old music teacher, reported that her close friends made an appointment for her skin treatment even before she had asked them to do so. Her friends in Korea were willing to make an appointment on behalf of her because they had more information and easier access to make an appointment.

Only two of 121 survey respondents who participated in medical tourism said that their relatives or a travel agency in the U.S. arranged their medical tours to the home country. Five respondents reported that their medical tourism was arranged by other sources, such as Korean hospital’s internet website. In Chapter 3, I examined the travel agencies’ efforts to promote Korean immigrants’ medical tourism. However, I found that travel agencies arranged only two immigrants’ medical tourism. One of them, Ho-Sik Choi, a 61-year-old man who had been in the U.S. for more than 20 years, purchased a medical-tourism package at a travel agency in New Jersey. Five years before, he saw a medical tourism advertisement in a local Korean newspaper, and he was attracted by the low price. So, he called the travel agency and had a physical checkup at Hanyang University hospital that was connected with the travel agency.

Joon-Sang Park was another informant whose medical tourism was arranged by a travel agency. He had taken two medical tours so far, and the travel agency arranged the first one. However, he did not ask the travel agency to organize his second medical tour because he gained more information through his first one. People who did not use a travel agency pointed out a high
commission rate as the main factor that prohibited them from purchasing a medical-tourism package:

I saw a medical tourism advertisement in the newspaper. However, I would not purchase it. The travel agency is a business that seeks economic profits. So, their medical tour package might not be as cheap as my direct with the hospital. Their commission rate would be high. Also, the numbers of affiliated hospitals with the travel agency might be limited. (Ji-Sun Han, a 40-year-old housewife in Flushing, Queens)

Although it was not shown in the table, Korean immigrants’ social networks influenced the arrangement of medical tourism. First, many interviewees indicated that they could get better information through their relatives or friends in Korea. As they had lived in the U.S. longer, they were more ignorant of good hospitals and doctors in Korea. Second, if their relatives or friends were medical doctors or in the medical industry, Korean immigrants could have a better information channel for their medical care in Korea. However, most informants said that they were likely to know at least one medical doctor in Korea when they expanded their networks to the acquaintances of their relatives or friends.

Some Korean immigrants had advantages when their relatives, especially those who were medical doctors, arranged their medical tourism. Tae-Ho Won, an elderly Korean, regularly visited Korea for the medical purpose once or twice a year, although he had a Medicare. Since he had five medical doctors among his relatives, they arranged his medical treatments in Korea. For example, he received a discounted medical bill or even paid nothing when he saw doctors in Korea. He had no Korean insurance, but he paid nothing when he went to see his nephew, an
internal medical doctor in Korea. His nephew also arranged other medical appointments for him so that he could wait for a shorter time period and receive special attention from other doctors who were his nephew’s friends.

Having better social networks in Korea than in the U.S. also influenced the arrangement of some Korean immigrants’ medical tourism. Most Korean immigrants had high educational levels and white-collar occupations prior to their migration to the U.S. However, many of them experienced downward mobility in the U.S. Moreover, in most cases, their social networks were limited to the Korean community. Jong-Moon Kim, an ivy league university professor, emphasized that his broader social networks in Korea influenced the arrangement of his medical tourism:

I am an Ivy League university professor in the U.S., but I still have narrower networks in the U.S. than in Korea. In Korea, I had broader networks. I even could know the directors of some mega hospitals, such as Yonsei Severance hospital, if I tried to connect them through my networks in Korea. So, I would rather go back to Korea if I have a severe disease. In Korea, I had better connections so that I had better chances to meet the better-quality doctors. When my parents arranged my medical tourism, I had many advantages. I did not even need to queue up for meeting a doctor in Korea. The connections through my parents were extremely valuable. On the contrary, in the U.S., I had to search for a physician or a hospital at Google. In the U.S., I was just “one of the patients.”

(Jong-Moon Kim, 42-year-old university professor in Manhattan, New York)
The Medical-Tourism Experiences

In this section, I will examine the Korean immigrants’ medical-tourism experiences. The first subsection includes major cities where they received medical care and the reasons for their choices of the cities. I will answer the following questions. Would Korean immigrants choose their hometown as the place of medical tourism? Alternatively, as indicated in Chapter 3, would the Korean local government’s efforts affect Korean immigrants’ choices of the cities of their medical tourism? The second subsection examines the duration of Korean immigrants’ medical tourism in Korea. The third subsection examines the types of hospitals where they received medical treatments in Korea. The final subsection examines the types of medical treatments that Korean immigrant medical tourists received in Korea and the U.S.

Major Cities of Medical Treatments

I asked the survey respondents who participated in medical tourism (N=121) where they received medical care in Korea and why they chose that particular city. Table 6.2 shows that about two-thirds of them (67.8%) received medical care in Seoul. There are three main reasons for their high concentration in Seoul. First, Seoul is likely to be most Korean immigrants’ hometown prior to their migration. According to the survey of Park and his associates (1990), more than half of Korean immigrant reported that they had lived in Seoul before their migration to the U.S., although only about a quarter of all Koreans lives there. Second, about 70 percent of my survey respondents (N=121) answered that they chose the city of their medical care because they had relatives in that city. Considering the high concentration of Koreans in Seoul, the capital city of the county, Korean immigrants’ relatives were more likely to live in Seoul. Lastly, Seoul has more hospitals than any other city in Korea. According to a directory of hospitals
made by the Korean Hospital Association (KHA). There were about 335 hospitals in Seoul, compared to 307 in Busan, 168 in Daegu, and 116 in Incheon. The only region that had more hospitals than Seoul was Gyeonggi province, numbering 554 hospitals.

Table 6.2: Major Cities of Medical Care and the Reasons for It

<table>
<thead>
<tr>
<th>Major Cities of Medical Care</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seoul</td>
<td>82</td>
<td>67.8</td>
</tr>
<tr>
<td>Busan</td>
<td>11</td>
<td>9.1</td>
</tr>
<tr>
<td>Incheon</td>
<td>7</td>
<td>5.8</td>
</tr>
<tr>
<td>Bundang</td>
<td>6</td>
<td>5.0</td>
</tr>
<tr>
<td>Daegu</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Kwangju</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Daejeon</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Ilsan</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>12.4</td>
</tr>
<tr>
<td>Total</td>
<td>142</td>
<td>111.7</td>
</tr>
</tbody>
</table>

Source: My survey data with 121 Korean immigrant respondents who have taken a medical tour to Korea
Note: Since several respondents (N=12) gave multiple answers, the sum of the answers exceeds 100%
Survey Question: In what city did you usually get your medical care in Korea? Choose all applicable.

The next commonly reported cities were Busan (9.1%), Incheon (5.8%), and Bundang (5.0%). More than 75 percent of Korean immigrants lived in the five largest cities in Korea prior to their migration to the U.S. (Park et al. 1990; Min 1996). As Busan and Incheon were the second and third largest metropolitan cities in Korea, Korean immigrants were likely to be from these cities and more likely to visit them for medical care. Also, as examined in Chapter 3, Busan was one of the Korean local governments which actively promoted medical tourism. Bundang, a newly-built satellite city of Seoul, may be the hometown of a small proportion of Korean immigrants because this planned city was built in the early 1990s. However, their relatives might live there, as Sungnam, where Bundang was located in, was the 11th largest city in Seoul. Moreover, there were several mega-hospitals in Bundang, such as SNU hospital, Cha hospital, and Jesaeng hospital.
As Table 6.3 shows, about two-thirds of survey respondents (71.1%) answered that they chose a particular city for medical care because they had relatives in that city. In the previous section, I showed that more than 60 percent of Korean immigrants’ medical tourism were arranged by their relatives. Thus, it is not surprising at all that the majority of them chose the city where their relatives lived as the place of their medical care. Moreover, having relatives in the city of their medical care is important because they can provide Korean immigrants with free accommodations. As described in Chapter 5, they can also take care of young children if the medical tourists are responsible for childrearing.

Table 6.3: Reasons for Choosing the Cities for Medical Care

<table>
<thead>
<tr>
<th>The Reasons for Choosing the Cities</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because the city had relatives</td>
<td>86</td>
<td>71.1</td>
</tr>
<tr>
<td>Because the city was the hometown before migration</td>
<td>36</td>
<td>29.8</td>
</tr>
<tr>
<td>Because the city had good hospital(s)</td>
<td>24</td>
<td>20.0</td>
</tr>
<tr>
<td>Because the city had friends</td>
<td>8</td>
<td>6.6</td>
</tr>
<tr>
<td>Because the city promoted medical tourism</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Other reasons</td>
<td>9</td>
<td>7.4</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>136.6</td>
</tr>
</tbody>
</table>

Source: My survey data with 121 Korean immigrant respondents who have taken a medical tour to Korea
Note: Since several respondents (N=34) gave multiple answers, the sum of the answers exceeds 100%.
Survey Question: What was the reason you chose that city? Choose all applicable.

About one-third of the respondents (30%) chose the city because it was their hometown before the migration. My informants indicated that there were two main reasons for their choice of the hometown as the city of their medical tourism. First, they felt more familiar with the city of pre-migration. Second, sometimes, their medical records were still restored at the doctor’s office in the city after their migration to the U.S. Thus, they did not need to discuss all the previous medical histories to the doctors. About one-fifth of informants chose the city because it had good hospitals. As “good-quality hospitals,” they often pointed out several big hospitals in Seoul, such as Samsung Medical Center, Asan Medical Center, and SNU hospital. In Chapter 3, I
reviewed Korean local governments’ various efforts to attract more Korean immigrant medical tourists. However, my survey results showed that only two of 121 survey respondents (1.7%) chose the city due to the promotion of medical tourism by Korean local governments.

**The Duration of Medical Tourism**

To assess the duration of Korean immigrants’ medical tourism, I asked the survey respondents, “How long did you stay in Korea for the medical tour? If you had two or more medical tours to Korea, report the duration of your stay based on your last visit to Korea.” Since I did not ask the duration of medical treatments, but the total period of their stay in Korea, most survey respondents seem to stay in Korea for a long time period. Table 6.4 shows that about two-thirds of them stayed in Korea for one month or longer, whereas about one-third of them stayed in Korea for less than a month. This is a longer period than I expected because the vast majority of informants told me that it took much less time for them to receive medical care in Korea than in the U.S. There seem to be three reasons for their long stay in Korea. First, as indicated in Chapter 5, only 8 of 121 Korean immigrants (6.6%) answered that their visits to Korea were only for the medical purpose. Others had multiple purposes, including the medical purpose. Consequently, it might take longer for Korean immigrants who had other purposes as well as medical purpose than those who had an only medical purpose. For example, Sang-Ho Park, a 53-year-old taxi driver, stayed in Korea for a month. He spent most of the time for sightseeing with his relatives because it only took several days for him to receive a check-up and dental treatments.

Table 6.4: Duration of Stay among Korean Immigrant Medical Tourists by Employment Status
Second, most long-term stayers were students, housewives, the retired, or the unemployed rather than those who had a job. Table 6.4 shows that unemployed Korean immigrants showed a greater tendency to stay in Korea for a longer period than their employed counterparts. Nearly half of them stayed in Korea about a month and about a quarter of them stayed in Korea for a few months or longer period. On the other hand, only 14 of 69 employed Korean (20%) spent a few months or longer period in Korea. Rather, they stayed in Korea for a much shorter time period; nearly half of them stayed in Korea for a few weeks. In other words, unless they were students, housewives, or retired people, it was harder for them to take a long break because they had to work for a living. When I interviewed the non-participants of medical tourism, most of them indicated that they could not stay in Korea for a long time because of their jobs. Hae-Lin Cho, who ran a laundry in New Jersey, could not stay in Korea for a long period because she needed to take care of her store. So, she was hesitant to take medical tours:

I have visited Korea about seven times since I migrated to the U.S. in 1997.

However, I have never visited hospitals in Korea because I only visited there for one or two weeks at maximum. In fact, I have a myoma in my uterus, and I need surgery to get rid of it soon. Since I do not have the U.S. health insurance, taking
a medical tour to Korea is one of the options for me. However, leaving my store for a while would be a burden for me and my family in the U.S. So, I don’t know whether I should take a medical tour or not.

Lastly, it took at least three months for Korean immigrants to access to the Korean national health insurance. As indicated in Chapter 3, if Korean immigrants want to apply for the Korean national health insurance, they first need to receive a domestic residence card, which takes about two weeks. Then, after staying in Korea for three months, they can apply for the national health insurance with the domestic residence card. In general, medical expenses in Korea are cheaper than in the U.S. even without the national health insurance, but it gets much cheaper with it. So, some Koreans, especially those who plan to receive multiple treatments or those who have severe diseases, such as cancer, needed to stay long enough to be eligible for the national health insurance program and to receive benefits from it. They seemed to increase the average duration of stay among Korean immigrants who receive medical care in the home country.

However, staying in Korea for three months or longer was not easy for those who had a job, especially the self-employed. In most cases, taking even a few days off was hard for them. In fact, four Korean informants complained that they wanted to apply for the Korean national health insurance, but they could not do it due to their short stay in Korea. Hye-Mi Choi, a 57-year-old entrepreneur in Queens, said that she regularly visited Korea once every two years for the medical purpose. Since she did not have a health insurance in the U.S., the home country was an ultimate place of medical care for her. However, as an entrepreneur, she could not stay in Korea more than ten days. So, she gave up receiving medical treatments in Korea.
The Types of Hospital for Medical Care

I asked the Korean immigrant medical tourists, “What type of hospital did you go?” when they had their last medical tour to the home country. Table 6.5 indicates that about the one-third of respondents visited small private hospitals (35.5%) or university hospitals (33.1%), and about a quarter of them received medical treatments at mega private hospitals (26.5%) or dental offices (25.6%). Fewer than 10 percent of them answered that they used other types of hospital, such as public health centers or Hanbang offices. Many of them used small private hospitals or dental clinics which they could find easily near the places Korean immigrants stayed. Thus, the primary reason for choosing these types of hospitals was easy accessibility due to the geographic proximity.

Table 6.5 Types of Hospitals for Medical Care in Korea

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Private Hospital</td>
<td>43</td>
<td>35.5</td>
</tr>
<tr>
<td>University Hospital</td>
<td>40</td>
<td>33.1</td>
</tr>
<tr>
<td>Mega Hospital</td>
<td>32</td>
<td>26.5</td>
</tr>
<tr>
<td>Dental Office</td>
<td>31</td>
<td>25.6</td>
</tr>
<tr>
<td>Hanbang Office</td>
<td>7</td>
<td>5.8</td>
</tr>
<tr>
<td>Other Hospital</td>
<td>8</td>
<td>6.6</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>133.1</td>
</tr>
</tbody>
</table>

Source: My survey data with 121 Korean immigrant respondents who have taken a medical tour to Korea
Note: Since several respondents (N=34) gave multiple answers, the sum of the answers exceeds 100%
Survey Question: What type of hospital did you go?

On the other hand, those Korean immigrants who visited university hospitals or mega private hospitals chose them for their popularity or fame. They prefer these hospitals because they are affiliated with good universities or big corporations in Korea. In fact, several interviewees told me that they visited SNU and Yonsei Severance Hospital because they considered those hospitals the most trustworthy due to their affiliations with good universities. Na-Mi Kim, a 40-year-old employee at a Korean firm, said that she would go to SNU hospital if...
she needed medical treatments in Korea. She would do that because, according to her, the
doctors at SNU hospitals were the best as the most intelligent Korean students studied in the
medical school at SNU.

My in-depth personal interviews with Korean immigrants found some interesting
phenomena that survey statistics cannot capture. In many cases, social capital was related to the
selections of the hospitals as well as the arrangements of Korean immigrants’ medical tours, as
detailed earlier. A few informants mentioned that they chose certain hospitals because they had
relatives or friends as medical doctors or the staff members at the hospital. When they know
someone at the hospital, they wait for a shorter time, pay a discounted medical bill, and get better
care from the doctors and staff members. An elderly man who takes medical tours once a year
told me that he went to Samsung Medical Center because his brother was a medical doctor there:

I have been in the U.S. for about 30 years, and I visit Korea once a year. In fact, I
have moved to Korea and the U.S. back and forth for about half and half each
year. My youngest brother graduated from the medical school of Hanyang
University, and now he is a doctor at Samsung Medical Center, which is one of
the best hospitals in Korea. Since I had him there, I chose that hospital. I paid
almost nothing to him because he was a doctor there. Korea is more flexible than
U.S. in that way. (Sang-Bo Kim, a 73-year-old retired man, Palisades Park NJ)

Moreover, if Korean immigrants or their relatives themselves worked for a Hyundai
Group, they chose Asan Medical Center because it is affiliated with the Hyundai Group. Four
informants belong to this case. For example, Hae-Sung Park, a 50-year-old man who was
diagnosed with a thyroid cancer in the U.S. went to Asan Medical Center to get surgery. He
chose that hospital not because of doctors’ ability, but because of the financial benefits through his brother-in-law who worked for the Hyundai Engineering and Construction. He was supposed to pay about 20,000 dollars for the same surgery in the U.S., but he only paid 300 dollars through his brother-in-law. Another informant who had worked for a Hyundai before his retirement said that he also received treatment for a discount price at the Asan Medical Center:

I had physical checkups twice at the Asan Medical Center when I visited Korea in the past. I had worked for Hyundai Group for 30 years and had been a vice president for several years. So, they offered me a huge discount for checkups and treatments. I am not a special case- they usually give discount prices to the former executive members of Hyundai Group. Since I had worked for Hyundai Group for a long time, I knew the director of the hospital and received special treatments from the doctors and the staff members. (Jong-Deok Kim, a 78-year-old retired man in Flushing, Queens)

*The Type of Medical Care Received in Korea*

The government officers and hospital staff members I interviewed said that they did not collect any statistics on the types of medical treatments that overseas Koreans had received in Korea. Thus, I asked the following question to the survey respondents who had participated in medical tourism: “What kind of surgery or treatment did you have last time when you took a medical tour to Korea?” Table 6.6 shows the types of medical care that they received in Korea when they last visited it. These findings were interesting for the following reasons.
Table 6.6: Types of Medical Care Received by Korean Immigrants in Korea

<table>
<thead>
<tr>
<th>Types of Medical Care</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental care</td>
<td>54</td>
<td>44.6</td>
</tr>
<tr>
<td>Checkup</td>
<td>35</td>
<td>28.9</td>
</tr>
<tr>
<td>Endoscopy or Colonoscopy</td>
<td>18</td>
<td>14.9</td>
</tr>
<tr>
<td>Hanbang</td>
<td>18</td>
<td>14.9</td>
</tr>
<tr>
<td>Skin care</td>
<td>18</td>
<td>14.9</td>
</tr>
<tr>
<td>Recuperation</td>
<td>17</td>
<td>14.1</td>
</tr>
<tr>
<td>Eye care</td>
<td>15</td>
<td>12.4</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>9</td>
<td>7.4</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>9</td>
<td>7.4</td>
</tr>
<tr>
<td>Back/Spine</td>
<td>8</td>
<td>6.6</td>
</tr>
<tr>
<td>Mental</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Knee</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Heart</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Cancer</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Other types of medical care</td>
<td>14</td>
<td>11.6</td>
</tr>
<tr>
<td>Total</td>
<td>226**</td>
<td>186.9</td>
</tr>
</tbody>
</table>

Source: My survey with 121 Korean immigrant respondents who had taken a medical tour to Korea
Survey Question: What kinds of surgery or treatment did you receive last time when you took a medical tour to Korea?
Note: Since several respondents (N=54) gave multiple answers, the sum of the answers exceeds 100%

The most frequent medical treatment among Korean immigrant medical tourists was dental care. Nearly half of them received dental care during their last visit to Korea. The most frequently answered reason for receiving dental treatments in Korea was cheaper dental costs in Korea than in the U.S. According to Ryu and his colleagues (2015) who compared the dental fees of Korea, Japan, Germany, and the U.S., Korea showed the lowest dental costs among four countries, much lower costs than the other three countries. In particular, the U.S. showed about 15 times higher dental costs for teeth extractions, about 18 times for amalgam fillings, and about 25 times for scaling than Korea.

Some Korean informants emphasized that they received the same dental treatments for much lower prices in Korea than in the U.S. based on their own experiences. Jung-Hyun Doh, a 46-year-old nail salon owner, has visited Korea every year for dental treatments during recent years. Since her insurance does not cover dental treatments, she needs to pay 1,000 dollars for
only one amalgam filling in the U.S. However, her dentists in Korea charged a half price for the same treatment and gave her dental cleaning for free. Since she needed to have five fillings, she was supposed to pay 5,000 dollars in the U.S. But what she paid for her medical tourism were 2,500 dollars for five fillings and 1,500 dollars for the round-trip flight tickets between Seoul and New York. Thus, she could save 1,000 dollars by taking a medical tour to Korea, while enjoying meeting his relatives and friends there. Jong-Deok Kim, a 78-year-old retired man, saved more money than Jung-Hyun because he had eight dental implants in Korea. While his American dentist claimed 4,000 dollars for one implant, his dentist in Korea charged 1,500 dollars. By taking medical tours, he saved more than 10,000 dollars for it, even after considering his airfare and cost.

In addition to cheaper dental costs, some Korean immigrants indicated that Korean dentists were more dexterous than American dentists due to their physical characteristics. This belief contributed to their dental treatments in Korea. Sang-Mi Lee, a 69-year-old woman who had been in the U.S. for 40 years, visited Korea to see dentists although she had a white family doctor in the U.S. According to her, Korean dentists’ small hands were more suitable for sophisticated dental treatments. Other interviewees also expressed their stereotypical belief in non-Korean dentists’ clumsiness with big hands. Anna Kim, a 27-year-old woman, considered that Korean doctors were more detailed, even for the simple cleaning procedures. Hee-Jae Choi, a 58 years old employee at a Korean firm, argued that the better dexterity of Korean dentists came from their usage of chopsticks. Unlike American dentists, who mainly used forks at the table, Korean dentists could train their hands with chopsticks.

The second and third popular medical treatments were a checkup, and endoscopy or colonoscopy. About one-third of survey respondents (N=121) received a checkup, and about 15
percent of them had endoscopy or colonoscopy during their last medical tour to the home country. They pointed out several advantages of getting these medical treatments in Korea: easier appointment procedures, the convenience of being examined at one building, and the fast-coming-out results. A middle-aged female respondent, an American citizen, who took medical tour three times, answered that it was cumbersome to meet her family doctor prior to seeing a specialist. So, she had an endoscopy and a colonoscopy in Korea because she liked the one-stop service at the hospitals in Korea. Another middle-aged respondent also explained that the one-stop service of Korean hospitals was the major reason that he received a checkup treatment during his medical tours to the home country:

In Korea, you can have one-stop service, so you can do everything once you are checked-in. You can have an endoscopy, blood test, X-ray and other examination or treatments on the same day. However, in the U.S., everything is specialized, so you need to visit each specialized doctor’s office. If you have a stomachache, you need to go to internal medicine doctor. If you have another problem, then the doctor will refer you to another doctor. So you need to make separate appointments to see two or three doctors. Since you have to move from one doctor’s office to another, it is very inconvenient. I think the U.S. healthcare process is too complicated, and that is the primary reason Korean immigrants, including myself, go to Korea for medical treatments. (Yong-Gyu Lim, a 58-year-old taxi driver in Bayside, Queens)

Since I asked the survey respondents to check the medical care that they received in their last visit to Korea, the actual proportion of Koreans who have received a checkup, endoscopy, or colonoscopy is likely to be higher than 15 percent as Table 6.6 shows. My in-depth personal
interviews indicated that they did not receive these medical treatments whenever they took medical tours to the home country. For example, Won-Joon Park, a middle-aged taxi driver, received a checkup in every five years, although he took medical tours every year.

One notable finding is that Korean immigrant medical tourists received more elective medical treatments than urgent and necessary medical treatments in Korea. There were only a few female Koreans who had breast cancer or uterine cancer surgeries and few males who had thyroid cancer surgeries in Korea. Other than these informants, only a few received an urgent or essential operations or surgeries in Korea. As popular elective medical treatments, about 15 percent of Korean immigrant received skin care, and about 12 percent of them received eye treatments, such as LASIK or LASEK surgeries to improve their visions rather than to cure any eye diseases. Receiving cosmetic surgery (7.4%) was another popular elective care among Korean immigrants who participated in medical tours to the home country.

The types of elective care seemed to be different by gender and age. The middle-aged and male Korean immigrants were more likely to receive Hanbang treatments. On the other hand, the majority of respondents who receive cosmetic surgery or skin treatments were young females. For them, Korean skin treatments were leaning towards more esthetic aspects whereas the U.S. skin treatments emphasized more therapeutic aspects. Thus, Korean immigrant women who wanted to receive aesthetic skin treatments preferred to go back to Korea. Also, these aesthetic skin treatments are not covered by most U.S. health insurance policies. Jina Yoon, a 49-year-old housewife, received a laser treatment (IPL, Intense Pulsed Light) during her stay in Korea because her U.S. insurance did not cover any esthetic-related skin treatments. Moreover, for her, Korea had more advanced technologies and easier accesses to the esthetic skin care. Removing a mole and getting a Botox were other frequent elective skin treatments that Korean immigrants
received in Korea. Regarding the plastic surgery, a female informant who had a nose job and double eyelid surgeries maintained that Korea was the most advanced country for the plastic surgery and that it was the main reason for her to receive these types of medical care in Korea:

I have a decent job and health insurance in the U.S. I have no language barriers to access to the healthcare in the U.S. because I came to the U.S. when I was a high school student. However, I visited Korea seven years ago to get the nose and the double-eyelid surgeries in Gangnam. Korea was the best country for the plastic surgery. I met many plastic surgeons in the U.S., but they were not familiar with Asian’s eye shapes. On the other hand, Korean plastic surgeons totally understood “our” eye shapes. Also, plastic surgery hospitals in Korea are very fancy. It even has guest rooms for the patients to stay. It has the most advanced technologies and the best services in the world. I did my surgery on the 7th floor and stayed at the hotel which is located on the 8th floor. It was so convenient for me! When I went there, there were many foreign patients from Japan, China, and Singapore.

Another advantage of getting plastic surgery in Korea is that doctors are skillful because they conduct hundreds of surgeries a day. Also, since there are many plastic surgery hospitals in Seoul, they offer the best services due to the excessive competition. In my case, they even offered me free mole clearing treatments because I had two major surgeries there. (Mi-Jin Noh, a 34-year-old florist in Flushing, Queens)

About 12 percent of respondents answered that they received “other” types of medical treatments in Korea. In most cases, they included uterus treatments for female and prostate
treatments for male respondents. Interestingly, there was one female interviewee who had been in the U.S. for almost 20 years and had medical tours for the reproduction purpose:

I tried to get pregnant for ten years after I got married. After ten years of trial, I became almost 40 years old. So, I was very anxious and worried about not being pregnant. I had an artificial insemination in the U.S., but that did not work. So, I went back to Korea to get an IVF (In Vitro Fertilization). When I did an IVF for the first time, it did not work out. The second trial did not work out, so I took my third medical tour only for the IVF. Fortunately, the third trial was successful. So, I stayed in Korea for six months until I entered the second trimester, which is considered the safest period of pregnancy. When I had an artificial insemination in the U.S., it cost a large amount of money even with my U.S. health insurance. Since the IVF processes were cheaper in Korea and since I had my parents in Korea, I went to Cha hospital that was famous for infertility. I am very happy with my medical tourism because I am a mother of a twin now! (Ji-Yoon Choi, a 46-year-old housewife in Flushing, Queens)

**The Evaluation of Medical Tourism**

I asked Korean immigrant medical tourists if they were satisfied with their medical-tourism experiences and if they had any plan to visit Korea again for medical care. As Table 6.7 shows, about half of them were somewhat satisfied, and the other half were very satisfied with it. The reasons for their satisfaction were similar to the reasons for their decision on medical tourism as discussed in the last section of Chapter 4. The short waiting period, simple medical procedures,
easy communications with healthcare professionals, good services, and cheap medical costs were the main reasons for their satisfaction with their medical-tourism experiences.

Table 6.7: The Evaluation of Medical-Tourism Experience among Korean Immigrants

<table>
<thead>
<tr>
<th>How were you satisfied with your medical-tourism experience?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not satisfied</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Somewhat satisfied</td>
<td>52</td>
<td>43.0</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>68</td>
<td>56.2</td>
</tr>
<tr>
<td>Total</td>
<td>121</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you plan to visit Korean in the future to get medical care?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>71</td>
<td>58.7</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>10.7</td>
</tr>
<tr>
<td>Don’t know</td>
<td>37</td>
<td>30.6</td>
</tr>
<tr>
<td>Total</td>
<td>121</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: My survey data with 121 Korean immigrant respondents who have taken a medical tour to Korea

However, one informant was not satisfied with his medical-tourism experiences. Ji-Seok Kim, a middle-aged who runs a business in Fort Lee, had a back surgery three years ago in Korea. He knew that the medical cost of back surgery was much lower in Korea even without the Korean insurance. Moreover, he had a place to stay with his parents or siblings in Korea. So, he contacted the hospital that specialized in the back surgery and made a surgery appointment by himself. However, unfortunately, he was not satisfied with the processes as well as the results. His back did not get fully recovered. Even worse, his voice became husky as a side effect of the surgery. Unavoidably, he bought a U.S. health insurance policy and had another operation on his back in the U.S. Fortunately, that operation went well, and his back became fully recovered, and his voice went back to almost normal.

Except for him, all other informants were satisfied with their medical tour experience overall, although they still reported several problems. First, like Ji-Seok, some other interviewees pointed out the difficulty of receiving follow-up treatments after their medical tourism as a
problem. Hye-Min Cho, a middle-aged female interviewee, told me that she had a thyroid cancer surgery in Korea because her American doctors avoided giving follow-up examinations and treatments for the surgery that he had not conducted. A staff member at the local travel agency also indicated that follow-up was a significant issue for some Korean immigrant medical tourists who found out unexpected diseases during their medical tourism. Read the following comment:

Let’s say that you discovered a lump in your body while doing a checkup in Korea. Let’s say that you need treatment right away. Then, you have to pay the extra money that might be expensive without Korean health insurance. Let’s say that you need a sudden surgery in Korea. Then you cannot take a flight to back to the U.S. soon. Also, if you have surgery in Korea, then you have to fly back there for aftercare. Only a few of my customers who had bought a medical tour package found out cancers or other severe diseases during their medical tourism. However, when they came back to the U.S. with the examination results of Korea, the U.S. doctors did not accept it. So, they had to spend extra money and time for the same examination. The majority of our customers assumed that they were healthy. So, they did not consider any possibilities of discovering a disease during their medical tourism. Consequently, they were embarrassed when they were diagnosed with the disease. Staying longer in Korea for further treatments or going back to Korea for follow-ups were the problems to them. (a Male staff at the local travel agency in Manhattan, New York)

The follow-up was an issue not just for Korean immigrants who are diagnosed with a severe disease like cancer, but also for those who seek elective care. In particular, most dental treatments needed consecutive treatments and follow-ups, so some Koreans hesitated to begin
dental treatments in Korea. Jin-Hee Chang, a middle-aged who migrated to the U.S. 20 years ago was indecisive about whether she should start a dental implant procedure in Korea or not because it required follow-ups for every six months. Two other informants also showed their indecision to start skin treatments in Korea because frequent follow-up treatments were needed after the first one. Sang-Hoon Baek, a 70-year-old Korean immigrant, was interested in removing spots on his face and body. However, he worried if he could get the proper follow-up treatments after coming back to the U.S. Another female interviewee in her early 40s wanted to have an IPL (a skin laser treatment) in Korea, but she had not decided to do it because she could not visit Korea regularly to take care of her children who attend schools in the U.S.

Besides the difficulty of receiving the follow-up treatments, the informants disclosed their concerns about the short amount of time that Korean doctors spent on the patients. Regardless of their overall satisfaction with medical-tourism experiences, they felt being pressed for time when they received medical care in Korea. According to the informants, the doctors in Korea spent only three minutes to five minutes on them, whereas the physicians in the U.S. spent about 20-30 minutes per each visit. Jung-Soon Lee, who went back to Korea to meet a famous doctor, was shocked by how short the doctor spent on examining on her body:

After I had been diagnosed with Hepatitis B and a high chance of liver cancer, I made an appointment with Dr. Kang, a liver expert at the SNU hospital. It was very hard to make an appointment with him, so I used all of my social networks to do so. When I saw a doctor in the U.S., who graduated from Harvard medical school, he spent over an hour to examine my body. I asked all the questions in my mind, and I discussed everything with him. However, when we met Dr. Kang in Korea, he spent just a minute for me! Dr. Kang touched my tummy twice and
asked me to stand up and sit down. Then he said, “Your liver is hardened.” I took
13 hours of flight to Korea to see him, but that was all I heard from him. That was
it! (Jung-Soon Lee, a 67-year-old fabric designer in Manhattan, New York)

As table 6.7 shows, more than half of Korean immigrant medical tourists were very
satisfied with their medical-tourism experiences. Unlike those who were somewhat satisfied,
they felt that the follow-up was not a problem. Yoon-A Oh, a 41-year-old woman who had a
breast cancer surgery in Korea two years ago, asked her Korean doctor to give her medical chart.
Bringing it to the U.S., she showed it to her American doctor, and he had no problem
understanding it. She even brought a videotape that was recorded during her surgery, and she
watched it with her American doctor. Although the doctors in the video communicated in
Korean, the Korean nurse at the U.S. hospital translated the video to her family doctor. Like
Yoon-A, several interviewees argued that the follow-up by American doctors cannot be the
problem because the Korean hospitals provided all the medical information in the paper as well
as on CDs.

Interestingly, three interviewees pointed out that their strong cultural transnational ties
with the home country positively influenced them to go on additional future medical tourism
trips. There are several Korean TV programs that specialize in health issues, and New York-New
Jersey-based local Korean TV stations broadcast the shows to Korean immigrants. Most Korean
hospitals provided results sheets that indicated specific numeric values/levels for certain kinds of
diseases for Korean immigrants so that they could see if various levels in their bodies were
within normal ranges when they watched the Korean TV programs. As indicated earlier, cultural
transnational ties with the home country promoted Korean immigrants’ medical tourism as some
of them decided to take medical tours after seeing medical-tourism advertisements in Korean
newspapers. Moreover, cultural transnational ties also help the follow-up of medical
transnationalism. Mi-Hee Moon described the association between cultural transnationalism and
the follow-up of her medical tourism:

When I had a checkup in Korea a year ago, the hospital gave me a booklet that
indicated all the numeric values of my body. I also brought a CD that contained
the pictures of my lung. I showed it to my family doctor in Flushing, and he
understood it. Because of the paper and the CD, I had no problem to get follow-up
treatments in the U.S. So, I strongly recommend my friends to visit Korea for a
checkup because I was very satisfied with my experience. The best part was the
booklet that showed all my health information. Whenever I watched Korean TV
program that indicated the normal values of a certain disease, I could compare
those numbers to my numbers in the booklet. Last week, I watched a Korean
health program called a “Vitamin.” The MC presented the level of sodium in a
normal kidney. Since I had a booklet that indicated the sodium level in my
kidney, I compared that number to mine. Like this, whenever I watched the
program, I could compare the figures. I loved the idea of knowing the exact
numbers of my body. (Mi-Hee Moon, a 66-year-old retired man in Bayside,
Queens)

Korean immigrants who were very satisfied with their medical-tourism experiences also
commonly indicated that a trivial thing made them happy about their decision of taking medical
tours to the home country. For example, Joon-Ha Yoon, a 36-year-old employee in the financial
industry at the Wall Street, took an x-ray in the United States. He was shivering with a cold for
half an hour while waiting for his turn. However, nobody came in to check his condition for half
an hour. By contrast, in Korea, a nurse provided a blanket for him while waiting for an x-ray so that he could cover his body. Seung-Ho told me a similar story. During his medical tour to Korea, he had to skip several meals for an endoscopy. What made him surprised was that the hospital provided a bowl of porridge for him after he came back from his endoscopy. The hospital offered a porridge rather than a bowl of rice for his better digestion. A bowl of porridge made him a big fan of Korean medical tourism.

Although almost all survey respondents were somewhat or very satisfied with their medical tour experience, ten percent said that they had no future plan to visit Korea again for medical care. For most of them, their changed insurance status was one of the major contributing factors to their plans for medical tourism. Most of them had visited Korea for medical care when they were not insured in the U.S. But they were less motivated to go back to Korea after they acquired insurance in the U.S. Joo-Mi Park, a middle-aged who came to the U.S. 16 years ago, frequently returned to Korea for a checkup and medical care when she did not have the U.S. health insurance before. However, ever since she was insured, she did not need to go back to Korea for medical care:

About ten years ago, I had no health insurance in the U.S., so whenever I visited Korea, I had a checkup and medical treatments, such as an endoscopy, a blood test, and a gynecology examination. I also had a hemorrhoidectomy, an operation to remove the piles. Five years ago, I was diagnosed with a breast cancer, but I did not go back to Korea for cancer surgery and treatment because I had the U.S. health insurance through my husband’s job. Since I had all relatives in Queens and had no difficulty in speaking English, it was more convenient for me to receive a surgery in the U.S. Moreover, I did not pay much because my insurance
company covered the most of the medical bill, which was originally over 100,000 dollars. So, I would not take medical tours to Korea anymore. (Joo-Mi Park, a 43-year-old employee at a nail salon in Flushing, Queens)

About one-third of respondents answered that they did not know if they would take another medical tour to Korea. As indicated earlier, only about seven percent of Korean immigrants visited Korea only for the medical purpose. Others have different purposes for their visit to Korea, such as visiting family and friends, business trips, sightseeing, and visa issues. Since they did not know when would be their next visit to Korea for those purposes, they also did not know if and when their medical tours to Korea would be.
Conclusion

In this dissertation, I sought to answer the following questions related to Korean immigrants’ medical tours to the home country. First, how have the Korean government’s policies and private-sector agencies’ efforts to target Korean immigrants affected their engagement with medical tourism? Second, what are Korean immigrants’ unique healthcare behaviors in the U.S. and how are they related to their medical tours to Korea? Third, what are the contributing factors to Korean immigrants’ decisions to engage in medical tourism? Fourth, what are their medical tourism experiences like? Fifth, how did they evaluate their medical tourism experiences? To answer the first question, I reviewed Korean governmental reports and newspaper articles published in the U.S. and in Korea. For the other questions, I analyzed data based on 507 surveys that I conducted with Korean immigrants in the New York-New Jersey area, in-depth personal interviews with 100 Korean immigrants who participated in medical tourism, and in-depth personal interviews with 20 Korean immigrants who did not participate in medical tourism.

A Summary of Major Findings

More than half of my Korean survey respondents reported that they had at least one barrier when they received healthcare in the United States. Language barriers and having no insurance were the most frequently cited barriers. Knowing these obstacles is important because they are closely related to Korean immigrants’ healthcare behaviors: preference for co-ethnic doctors and heavy dependence on them, the practice of Hanbang, and medical tours to the home country. As expected, those who had any obstacle to using the U.S. healthcare system were more likely to return to the home country for medical care. Moreover, their preference for co-ethnic physicians
and use of Hanbang medicine in the U.S. were positively associated with their greater tendency to take medical tours to the home country.

I also directly asked the survey respondents who participated in medical tourism what specific reasons led to their decision. Lower medical costs in Korea was the primary reason, followed by easier communication due to lack of language barrier, feeling more comfortable by virtue of being in their homeland, simpler medical procedures in Korea, the better ability of Korean doctors, a shorter waiting period in Korea, and their uninsured status in the United States. Since I only asked those who actually engaged in medical tourism about the reasons for their decision, it was not possible to specify what factors contributed to decisions related to medical tourism among all Korean immigrants. Thus, I synthesized the survey data of all respondents and in-depth personal interviews regardless of whether they did or did not participate in medical tourism to examine the contributing factors to their medical tourism decision. I found that there were three important factors to their decision: transnational social ties with the home country, health insurance status in the U.S., and temporary resident status.

First and foremost, more than any other type of transnational ties, social transnational ties had the strongest positive relation to Korean immigrants’ medical tours to the home country. Social transnationalism is more directly influential on medical tourism because maintaining social ties has the practical benefit of providing Korean immigrants with places to stay in the home country; additionally, their social ties can also help them make medical appointments there. Second, surprisingly, my survey data show that there is no significant association between Korean immigrants’ health insurance status and medical tourism. Korean immigrants’ self-employment status is a mediating factor to the association between health insurance status and medical tourism. Since self-employed Korean immigrants had a lower rate of being insured than
employed Koreans, I hypothesized that they would show a higher tendency to take medical tours to the home country than their counterparts. However, data do not support this expectation. To explain this unexpected finding, I speculate that long working hours and the necessity of operating a store every day may have hindered them from visiting Korea for medical care. Additionally, Korean employees of small co-ethnic businesses also have lower rates of health insurance than Koreans who work in the general economy. Like small business owners, Koreans who work in the ethnic economy also show a low tendency to take medical tours because they have fewer financial resources to visit the home country. Since they, along with employed Koreans, are still more likely to be uninsured and less likely to visit the homeland for medical treatments than their counterparts, they are marginalized from receiving medical care both in the U.S. and in Korea.

Lastly, temporary resident status is a strong contributing factor to Korean immigrants’ medical tourism. Temporary residents are more likely to participate in medical tours to the home country because of several factors. First of all, they are less likely to be insured and to have access to public health insurance services in the U.S., such as Medicare or Medicaid, due to their temporary resident status. Moreover, temporary residents, including international students or temporary employees at Korean corporations in the U.S., have stronger transnational ties with the home country and a lower level of assimilation into American society than permanent residents or U.S. citizens.

Considering all contributing factors, Table 7.1 shows a typology of Korean immigrant medical tourists based on their health insurance status and level of social transnational ties with the home country. Although temporary resident status is another important contributing factor, it is not included in the table because it does not seem to be as influential as health insurance status.
or transnational ties. Moreover, as indicated earlier, it is the factor that eventually influences both the individual’s health insurance status in the United States and transnational ties to the home country, the two axes in the table.

Table 7.1: Types of Korean Immigrant Medical Tourists

<table>
<thead>
<tr>
<th>Level of Transnational Social Ties with the Home Country</th>
<th>Health Insurance Status in the U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Not Insured in the U.S.</td>
</tr>
<tr>
<td>- See co-ethnic doctors or receive medical care in the co-ethnic community in the U.S.</td>
<td></td>
</tr>
<tr>
<td>- Small business owners and their employees</td>
<td>- Receive a checkup in the home country</td>
</tr>
<tr>
<td>- One-time triers</td>
<td>- One-time triers</td>
</tr>
<tr>
<td>High</td>
<td>- Receive most medical care in the home country</td>
</tr>
<tr>
<td>- Temporary residents (e.g. international students, resident employees at Korean firms)</td>
<td>- Receive elective treatments in the home country</td>
</tr>
<tr>
<td>- Professionals, big business owners, and their family members</td>
<td></td>
</tr>
</tbody>
</table>

Korean immigrants with a low level of transnational social ties with Korea and with no U.S. health insurance comprise the most marginalized group. They mostly consist of Korean small business owners and their employees. They show a low tendency to take medical tours to the home country. Rather, seeing co-ethnic doctors and receiving health services in the Korean community are their primary sources of medical care in the United States. However, due to liability issues, most Korean community organizations do not provide any major medical treatments to uninsured Koreans. Instead, several different programs provide cancer screenings, prevention programs, and other low-risk/low-liability services. Thus, when uninsured Korean immigrants with low transnational ties become ill, they are the least likely to receive proper medical care in both the U.S. and the home country.
By contrast, if uninsured Korean immigrants, like international students or resident employees, have a high level of transnational ties, they will often go back to the home country, considering it as the ultimate place of medical care. They will receive as much medical care as they can whenever they have a chance to go there. On the other hand, those who have health insurance in the U.S. and have a low level of transnational ties with the home country are likely to try out medical tourism in Korea just once to see what it is like. They often receive a checkup, which does not require frequent visits to the home country. Lastly, Korean immigrants who have U.S. health insurance and maintain a high level of transnational social ties with the homeland tend to be professionals, big business owners, and their family members, and this group is likely to make frequent visits to Korea to receive elective treatments.

With the exception of one Korean respondent, all of the other informants expressed satisfaction with their medical tourism experiences. Yet, about one-tenth said that they would not take a medical tour again mainly because of their changed insurance status. Since they were now insured in the U.S., they had fewer incentives to go back to the home country for medical care. About one-third of respondents did not know if they would take another medical tour to Korea. Since they were unsure of the next time they would visit Korea, they also did not know if or when they would take another medical tour.

Contributions and Policy Implications

My dissertation has made empirical and theoretical contributions to the literature on immigrant medical transnationalism. First of all, it empirically and methodologically contributes to the literature by focusing on a particular ethnic group’s medical transnationalism with both quantitative and qualitative data. In addition, it makes a theoretical contribution to the discourse
on globalization and transnationalism by trying to connect it to other areas of globalization and transnationalism.

**Empirical and Methodological Contributions**

My dissertation makes a significant empirical contribution to the literature on immigrant medical transnationalism by investigating Korean immigrants’ medical tours to the home country with rich data sets. I practically examined how many Korean immigrants visited the home country for medical care, their reasons for medical tourism, the types of medical care they received in the home country, and their evaluation of it. Second, my dissertation methodologically contributes to the literature on immigrant medical transnationalism. Previous research on immigrants’ medical tourism used mostly quantitative data with a small number of Korean immigrants or qualitative data with a small number of interviewees or focus group participants. Moreover, their interviewees or participants in the focus group were limited to a certain age group or to those who received a particular type of medical care. Thus, my dissertation, which has large-scale survey data with a sample of over 500 respondents and in-depth personal interviews with over 100 Korean immigrants, makes a significant methodological contribution to the literature on Korean immigrants’ medical tourism by utilizing both quantitative and qualitative data.

This dissertation also contributes to the field of Asian American studies as well as the area of minority healthcare behaviors. As a “model minority,” the health issues of Asian Americans have not received much attention. However, my dissertation found that Korean immigrants face various obstacles in accessing and utilizing U.S. healthcare. Seeking medical care in the home country is one of their reactive healthcare behaviors to the barriers. However,
immigration researchers have focused their research on Latino immigrants’ medical tourism experiences. There are some studies that have examined Asian immigrants’ medical tours to the home country, but they often had a small number of interviewees or had no theoretical framework. Thus, my dissertation, which has a large sample of survey respondents (N=507) and in-depth personal interviewees (N=120), in addition to a sociological framework, will also make a significant contribution to the fields of Asian American studies and Asian American healthcare behaviors in the U.S.

_Theoretical Contributions_

My dissertation also makes a theoretical contribution to existing theories of globalization and transnationalism. As indicated in the introductory chapter, there are several types of globalization, such as economic, political, and socio-cultural. According to the globalization theory, the efforts of the Korean government and private sector agencies to promote medical tourism can be considered global economic activity. The competitive price as well as the high quality of medical care in Korea have served to boost this global economic activity. In other words, cheaper medical expenses was a strong financial motivation that attracted international medical tourists, including Korean immigrants in the United States. As reviewed in Chapter 1, researchers have examined the efforts and strategies of several Asian countries (India, Singapore, Thailand, etc.) to promote medical tourism. However, they emphasized the economic aspects of it, rather than finding an intersection of global economic activity with other types of globalization.

My dissertation found that medical tourism in Korea, as a global economic activity, is closely related to cultural globalization: _Hallyu_ (the Korean Wave). As examined in Chapter 3,
the Korean government and private sector agencies actively connected *Hallyu* with the increasing numbers of foreign patients, especially those who were interested in plastic surgery or skin care to look like Korean celebrities. Since Korean cultural content, such as TV shows, dramas, and music, have been popular in several neighboring Asian countries, the Korean Wave has been used as a unique strategy to promote medical tourism in Korea. Plastic surgery has been particularly popular among Chinese or Japanese patients who wanted to look like Korean actors and singers. Consequently, Korean governments, Korean hospitals, and travel agencies have developed medical tourism packages associated with *Hallyu* to attract foreign patients who were interested in it. Only a few studies have pointed out the importance of contemporary cultural globalization, not traditional ones, such as yoga or meditation, on medical tourism. Thus, my dissertation, which emphasized the connection between economic and cultural global activities, will contribute to the literature of globalization.

In addition to the globalization theory, I analyzed Korean immigrants’ medical tourism as a type of medical transnationalism drawing from the transnationalism theory. As pointed out in the introductory chapter, transnational researchers have focused on immigrants’ political, economic, and social transnationalism, but have neglected medical transnationalism. While some researchers (Portes et al., 2012) have given passing statements to medical transnationalism, they have not systematically examined it with empirical data. Rather, they have conceptually suggested it as one of the coping strategies for immigrants’ healthcare utilization in the United States. Thus, this dissertation, which thoroughly investigated medical transnationalism, contributes to the field of immigrant transnationalism.

Most Korean immigrants visited the homeland in 2009 or later to receive medical care. This suggests that Korean immigrants’ medical tourism is likely to have been influenced by the
Korean government’s revision of medical laws in 2009, which legalized promoting medical tourism. Thus, we can also consider it as an example of state transnationalism, which was discussed in the introductory chapter. Moreover, political transnational ties were associated with some older Korean immigrants’ medical tours to the home country. The Korean government’s Nationality Act allowed elderly overseas Koreans to recover their Korean nationality without giving up their foreign nationality, and as a result, some elderly Koreans visited Korea more frequently after recovering their Korean nationality.

My dissertation has also investigated how other types of transnationalism were connected to Korean immigrants’ medical transnationalism. Social transnationalism was the most deeply associated with Korean immigrants’ medical tourism. On the contrary, cultural transnational ties and political transnationalism had less influence on medical tourism. Additionally, economic or religious transnational ties were not closely related to Korean immigrants’ medical tourism. Since there was no previous study that examined the connection between medical and other areas of transnationalism, my dissertation will contribute to the field of immigrant transnationalism.

Policy Implications

Major findings from my dissertation show that Korean small business owners and employees in the ethnic economy are the most marginalized group in my study because they have the most difficulty in getting access to American healthcare system because a large proportion of them do not have health insurance. Moreover, it is difficult for them to take medical tours to the home country due to their long work days and lack of time off. Consequently, they end up receiving inadequate medical care, both in the U.S. and in Korea. However, they actually have many more health problems and high stress due to their lack of
leisure time caused by long work hours (Min, 1990). An implication of this finding is that health programs for this marginalized group need to be initiated to help them receive appropriate and timely medical care in the host country because practically, it is almost impossible for them to visit the home country for medical care because of their obligations to their stores.

I argue that the Korean community in the U.S. should take the first step to making this problem more visible and developing various health programs for small business owners, including both prevention and support programs. For example, since small business owners have virtually no time to exercise outside of their stores or homes, various health prevention programs, such as a specially-designed freehand exercise that they can do in their stores, would be one of the preventive programs. Another possible support program is to connect this marginalized group to Korean doctors who are willing to help them and contribute to the Korean community. The vast majority of my self-employed interviewees indicated that their long work hours and uninsured status prohibited them from visiting the doctor, which entails multiple processes, long hours, and a lot of money without insurance. I suggest that some of the various associations in the Korean community in the U.S. cooperate to build a program that connects small business owners and their employees to Korean doctors so doctors can either visit the stores and perform regular checkups, have more flexible office hours, or give discounts to the uninsured.

My findings also indicate that about one-third of Korean immigrants have a language barrier to U.S. healthcare. Easier communication with medical doctors was the major reason for their preference for co-ethnic doctors and medical tours to the home country. Despite their language barrier, only a few informants reported that they utilized translation services at U.S. hospitals. Those who used them commonly indicated that most translators were not true bilinguals. In most cases, the translators’ Korean proficiency was not good enough to
communicate sufficiently. The lack of fluent bilingual translators has become a significant structural barrier for most Korean immigrants. Greater financial support and training forfluently bilingual Korean-English translators by health policy makers as well as the Korean community in the U.S. are needed.

The Direction of Future Research

This dissertation is only the beginning of more systematic research on immigrants’ medical transnationalism. There is still much to learn about it by conducting research on several different immigrant groups to answer the following research questions. First, what are other U.S. immigrant groups’ medical tourism experiences like? As pointed out earlier, the vast majority of studies on immigrants’ medical tourism have focused on Mexican immigrants, the largest immigrant group in the U.S., but also a group with unique characteristics: overall, they have an extremely low rate of being insured and their home country is in very close geographical proximity to the United States. By contrast, medical tourism experiences of other Asian immigrants have been under-researched. Therefore, it will be meaningful to explore other immigrant groups to see how different demographic, socio-economic, health insurance status, and transnational ties affect or contribute to their medical tourism.

Second, are there any differences in medical tourism experiences between Korean immigrants in the U.S. and those settled in other countries? For example, several cities in the U.S. and Canada (e.g., New York vs. Toronto or Seattle vs. Vancouver) are similar distances from Korea but have totally different healthcare systems. Moreover, the characteristics of Korean immigrants in the U.S. and those in Canada may be different due to the different immigration systems of the two countries. Bearing these similarities and differences in mind, I could examine
how different contributing factors and medical systems in host countries affect immigrants’ decisions regarding medical tourism.

Lastly, further research could be directed at determining how healthcare systems or revised laws of both sending and receiving countries affect immigrants’ medical tours to the home country. There are two possible studies regarding this. One is to see if the Patient Protection and Affordable Care Act, which is better known as ObamaCare, contributed to Korean immigrants’ medical tourism. I conducted most of my surveys and the in-depth personal interviews in 2013, before the enactment of ObamaCare in January 2014. Since ObamaCare enforces all uninsured individuals to be covered by health insurance, it would be great if I could conduct follow-up interviews with the uninsured informants after they registered for ObamaCare. Then I could examine how their changed health insurance status influenced their medical tours to Korea. In fact, at the time of the interviews, some uninsured informants mentioned their interest in ObamaCare and said that they would not take medical tours to Korea once they became insurance beneficiaries of ObamaCare.

The findings drawn from this dissertation indicate that Korean immigrants’ medical tourism was not a simple personal decision on choosing a place of medical care. Rather, it was a complicated phenomenon influenced by various factors, such as their health insurance status, temporary resident status, various barriers to U.S. healthcare, and transnational ties with the home country. It is my hope that my findings will serve as a foundational work in the study of immigrant transnationalism, opening a new door for the under-researched field of medical transnationalism.
Appendix: Survey Questionnaire of Korean Immigrants in the NY-NJ Area

1. Gender: (1) Male    (2) Female

2. How old are you?
   (1) 18-29 years old    (2) 30-39 years old    (3) 40-49 years old
   (4) 50-64 years old    (5) 65 years old and older

3. How many years have you been in the U.S.?
   (1) 1-2 years    (2) 3-4 years    (3) 5-9 years
   (4) 10-19 years    (5) 20 years and more

4. What is your legal status at present?
   (1) Temporary resident (students, visitor to meet family or for sightseeing, visiting scholar/intern)
   (2) Working visa (H1B, employees of Korean firms & temporary business)
   (3) Permanent resident
   (4) Naturalized citizen
   (5) Other (specify:________________________________________________________)

5. Where do you live currently?
   (1) Queens    (2) Manhattan    (3) Other New York City boroughs
   (4) Long Island    (5) Bergen County, NJ
   (6) Upstate New York    (7) Other areas

6. What is your highest educational level?
   (1) Less than high school    (2) High school    (3) 2-year college
   (4) 4-year college    (5) Advanced degree (Master’s, doctoral, or professional)

7. How well do you speak English?
   (1) Not at all    (2) A Little    (3) well    (4) Very well

8. Are you currently married?
   (1) No    (2) Yes, spouse is Korean    (3) Yes, spouse is non-Korean

9. What is your occupation?
   (1) Professional    (2) Business/Finance    (3) Semi-professional (insurance, real estate, travel agency)
   (4) Personal service (dry cleaning, nail salon, secretary)
   (5) Sales (Deli, Grocery)    (6) Other (Transportation, repair)    (7) Student
   (8) Retired    (9) Unemployed

10. If you have an occupation, what does it belong among following examples?
    (1) Self-employed    (2) Korean-owned    (3) Non-Korean-owned
    (4) Government or public sector    (5) Not applicable (student, retired, unemployed)

11. What is your religion? Answer it by choosing one of the following categories.
    (1) Protestantism    (2) Catholicism    (3) Buddhism
    (4) Other (specify:_________________________________________________)    (5) No Religion
12. If you have religion, how often do you go to a religious organization (church or temple)?

(1) Never        (2) 1-2 times a year        (3) every month
(4) once every two weeks    (5) about every week    (6) more often than once a week
(7) Not applicable (no religion)

13. Are you a member of any Korean association (e.g. church, alumni association, business association, international student association, Korean community organization, etc.)? List names of all organizations you belong to. (__________________________)

14. Do you have any of the following family members in Korea? Choose all applicable.

(1) None        (2) Parent(s)        (3) Brother(s) and/or sister(s)
(4) Spouse      (5) Child(ren)

15. If you have one or more of the above, how often do you contact your family members in Korea (by phone, e-mail, skype, facebook, kakaotalk, etc.)?

(1) Never        (2) Once in 2-3 years        (3) 2-3 times a year
(4) 2-3 times in 6 months (5) Monthly        (6) Every other week
(7) Every week    (8) Every 2-3 days         (9) Almost every day
(10) Not applicable (no family member in Korea)

16. How often do you contact your friends in Korea (by phone, e-mail, skype, facebook, kakaotalk, etc.)?

(1) Never        (2) Once in 2-3 years        (3) 2-3 times a year
(4) 2-3 times in 6 months (5) Monthly        (6) Every other week
(7) Every week    (8) Every 2-3 days         (9) Almost every day
(10) Not applicable (no friends in Korea)

17. How often have you visited Korea for any purpose (e.g. visiting family and friends, business trip, sightseeing, seeing a doctor, etc.) since you immigrated to the U.S.?

__________ Times (e.g. none, once, twice, three times, etc.)
The year of the last visit was ___ ___ ___ ___ (e.g. 1996, 2001)

18. In general, would you say your health is:

(1) Poor        (2) Fair        (3) Good        (4) Very good        (5) Excellent

19. How often have you seen or talked to a medical doctor within the last 5 years regarding your health issue?

(1) Never        (2) 1-2 times in 5 years        (3) 3-4 times in 5 years
(4) About once in every year    (5) 2-3 times every year
(6) Every week    (7) More frequent than every week

20. How do you find doctor or hospital in the U.S.? Choose all applicable.

(1) US website (google, yelp, etc.)          (2) Korean website (Heykorean, Naver, etc)
(3) Family/Relatives in US       (4) Friends in US
(5) Coworker in US          (6) People from church, temple in US
(7) Other (specify:__________________________________________)

21. What kind of surgery or treatment did you have in US? Please indicate all applicable.

(1) None        (2) Dental care        (3) Heart surgery/treatment        (4) Cancer
(5) Knee or other joint surgery/treatment       (6) Back disc surgery/treatment
(7) Cosmetic surgery        (8) Skin care        (9) Eye surgery
(10) Oriental medical care (e.g. acupuncture)

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(11) Mental health    (12) General check-up    (13) Recuperation    (14) Otorhinolaryngology  
(15) Endoscopy        (16) Other (specify: ____________________________)

22. How often have you seen or talked to a dentist within the last 5 years regarding your dental issue?  
(1) Never    (2) Less frequent than once a year    (3) About once a year  
(4) A few times a year    (5) About once a month    (6) Every week  
(7) More frequent than every week

23. What is your health insurance status?  
(1) No health insurance    (2) Private health insurance coverage  
(3) Health insurance through employer/union    (4) Medicaid    (5) Medicare  
(6) Korean health insurance        (7) Other (specify: ____________________________)

24. Do you have a family doctor in the U.S.?  
(1) No    (2) Yes, and he/she is a non-Korean.  
(3) Yes, and he/she is a first generation Korean immigrant  
(4) Yes, and he/she is a 1.5 or second generation Korean.

25. Do you prefer a Korean doctor than an American (Non-Korean) doctor?  
(1) Yes    (2) No    (3) No preference  
(4) It depends on type of medical care (specify: ____________________________)  

26. Please indicate below which describes any barriers or difficulties you have when you get medical care 
in the U.S. (select one or more if applicable):  
(1) Having no health insurance    (2) Difficulty/discrimination caused by the language barrier  
(3) Difficulty/discrimination caused by the difference in culture  
(4) Discrimination based on race/ethnicity  
(5) Other (specify: ____________________________)  
(6) I have no difficulties or barriers  
(7) Not applicable (I haven’t had medical care in the U.S.)

27. Have you visited Korea for medical care since you migrated to the U.S.?  
Do not count your medical care received in Korea accidently without your plan or intention 
prior to your visit.  
(1) No  → This is the last question. Thank you for your participation.  
(2) Yes  → Go to Question 28 and further

***********************************************************************
Below is only for those who have made one or more medical tour to Korea
If you have visited Korea to get medical care more than once, then please answer the following questions based on your last visit to Korea.
***********************************************************************

28. How often have you visited Korea to get medical care since you immigrated to the U.S.?  
__________ Times (e.g. none, once, twice, three times, etc.)  
The year of the last visit was ___ ___ ___ ___ (e.g. 1996 etc.)
29. Besides getting medical care, what was other purpose(s) of your visit to Korea? Check all applicable.
   (1) Only medical care purpose  (2) Seeing family and friend  (3) Business
   (4) Changing Visa  (5) Tourism  (6) Other: ________________

30. Who arranged your medical appointment in Korea?
   (1) Yourself  (2) Your family member in Korea  
   (3) Your family member in U.S.  (4) Your friend in Korea  
   (5) Your friend in U.S.  (6) A travel agency in the U.S.  
   (7) A Korean medical office in the U.S.  (8) Other (specify: ___________________________)

31. In what city did you usually get your medical care in Korea? Choose all applicable.
   (1) Seoul  (2) Busan  (3) Daegu  (4) Daejeon  (5) Kwangju  (6) Incheon  
   (7) Ilsan  (8) Bundang  (9) Jeju  (10) ChungJu  (11) Kangreung  
   (12) Other (specify: ________________)  

32. What was the reason you chose that city? Choose all applicable.
   (1) It was your hometown before your migration  (2) You had family member(s)  
   (3) You had close friend(s)  (4) It was good for sightseeing  
   (5) It had good hospital(s)  (6) You were attracted by the medical tourism advertisement provided by the city  
   (7) Other (specify: ________________)  

33. How long did you stay in Korea?
   (1) Less than a week  (2) About one week  (3) One-two weeks  
   (4) About a month  (5) a few months  (6) Longer than a few months  

34. What type of hospital did you go?
   (1) A university hospital (name of the hospital: ___________________________)
   (2) A mega private hospital (name of the hospital: ___________________________)
   (3) A small private hospital (name of the hospital: ___________________________)
   (4) Public health care center  
   (5) Oriental medical clinic (name of the hospital: ___________________________)
   (6) Dental care hospital (name of the hospital: ___________________________)
   (7) Other (name: ___________________________)

35. What factors contributed to your visit to Korea? Indicate all applicable.
   (1) Low medical care cost  (2) Better ability of Korean doctors  
   (3) Easier communication with Korean doctors  (4) Shorter waiting time  
   (5) No health insurance in the US  (6) Feeling more comfortable in home the country  
   (7) Simpler procedures at the hospital  (8) Other (specify: ___________________________)

36. What kind of surgery or treatment did you have last time when you visited? Please indicate all applicable.
   (1) None  (2) Dental care  (3) Heart surgery/treatment  (4) Cancer  
   (5) Knee or other joint surgery/treatment  (6) Back disc surgery/treatment  (7) Cosmetic surgery  
   (8) Skin care  (9) Eye surgery  (10) Oriental medical care (e.g. acupuncture)  
   (11) Mental health  (12) General check-up  (13) Recuperation  (14) Otorhinolaryngology  
   (15) Endoscopy  (16) Other (specify: ___________________________)
37. Did you find anything different between Korean and U.S. regarding medical care or treatment in a hospital?
   (1) No
   (2) Yes (specify: _____________________________________________)
   (3) Not applicable (if you have not had medical care in the U.S.)

38. How were you satisfied with your medical tourism experience?
   (1) Not satisfied       (2) Somewhat satisfied       (3) Very satisfied

39. Do you plan to visit Korea in the future to get medical care?
   (1) No                  (2) Yes                   (3) Don’t know
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There are many difficulties to attract American medical tourists to Korea.


