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Access To Healthcare For Vulnerable Asian Subgroup Populations In The United States

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ACCESS TO HEALTHCARE FOR VULNERABLE ASIAN SUBGROUP POPULATIONS IN
THE UNITED STATES

by

DEBORAH KIM-LU

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

2014

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

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ABSTRACT OF THE DISSERTATION

ACCESS TO HEALTH CARE FOR VULNERABLE ASIAN AMERICAN SUBGROUPS IN THE UNITED STATES

by

Deborah Kim-Lu

Advisor: Professor Christa Altenstetter

Objectives: This dissertation examines the barriers for access to healthcare for the top four most uninsured Asian American subgroups (Bangladeshi, Cambodian, Korean, and Pakistani communities). *Methods:* Combining quantitative and qualitative approaches, this study consisted of: (1) an in-depth review of the Health Services Research literature; (2) qualitative interviews with 24 national health experts and advocates on Asian American health; (3) a survey of a non-probability sample of 107 Koreans in the tri-state region (Connecticut, New Jersey, and New York) using the *Access to Healthcare Survey for Koreans in the U.S.* instrument, which includes a Likert scale with 21 barrier questions and 40 questions capturing demographic, healthcare, health status, beliefs, and civic engagement indicators; and (4) a comparative approach, which draws lessons from other countries facing similar access to healthcare issues, as described in the Comparative Health Policy literature. *Results:* 57% of the Korean sample is self-employed, with 40% having no health insurance at all and 42% having no regular source of care. 67% achieved a Bachelor's degree or above but bivariate analyses show that those who completed their education outside of the U.S. have significantly lower levels of access to healthcare (53%). 63% had resided in the U.S. for more than 20 years and 44% do not speak English well or not at all. *Conclusions:* Structural barriers, such as cost and employment/occupation types, have a significant impact on access to healthcare. Asian American subgroups' increased propensity to

be self-employed or be employed in the ethnic economy cannot be explained as a cultural phenomenon but should be understood as a pragmatic approach to integrating into the U.S. labor market. Due to their high limited English proficiency levels, Asian immigrants face challenges finding employment commensurate with their previous education and job experience. Despite the expected impact of the Affordable Care Act in reducing uninsured rates, future efforts to remedy the barriers to access to healthcare for these Asian American subgroups will require a multifaceted approach that moves towards integrating vulnerable populations, such as immigrants, into the mainstream healthcare system and establishes targeted interventions such as language assistance and comprehensive case management services.

DEDICATION

This work is dedicated to the memory of my father, Hyung Tae Kim (1944 – 2006), for his sacrifice and perseverance as an immigrant in foreign lands, knowing that this day would come.

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I would also like to give a special thanks to Professor Pyong Gap Min for generously providing me with opportunities to conduct research on the Korean community and to be a part of the Research Center for Korean Community at Queens College's Board of Directors. I have learned so much from my short time under his mentorship and appreciate his generosity in sharing his scholarly wisdom with me. Most importantly, without the body of scholarly work on Asian Americans that Professor Min has spearheaded in the last four decades, my dissertation would have been difficult to complete.

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and support. Each and every one of you were reminders of dad's intellectual aspirations and dreams for me, which were a critical source of encouragement, strength, and motivation at times when I felt this dissertation was unachievable.

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Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

- Dr. Martin Luther King, Jr.,

in a speech to the Medical Committee for Human Rights, 1966

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CHAPTER 1: INTRODUCTION

It is well established that health inequities are substantially more prevalent in market-based healthcare systems, such as in the United States (U.S.), than in other advanced industrial countries with mandated national health insurance or national health service models, such as in Canada, Japan, and countries in Western Europe. Universal and equitable healthcare coverage has been a goal for most advanced industrialized countries since the 1950s. The U.S. and South Africa are the only industrialized countries in the world that have not reached universal healthcare coverage (Estes, Harrington & Pellow, 2001). Though the Patient Protection and Affordable Care Act (also known as the Affordable Care Act) is a step toward universal coverage in the U.S. and substantial progress has been made since its passing in 2010, significant risks and insurmountable barriers still exist for underserved communities.

According to the U.S. Census Bureau, close to 50 million Americans were uninsured as of 2010. Congressional Budget Office projections indicate that the Affordable Care Act legislation will decrease the number of uninsured (nonelderly) residents by 32 million, leaving approximately 23 million uninsured U.S. residents in 2019, after the bill's provisions are fully implemented. An estimated one third of these 23 million uninsured Americans will include illegal immigrants. The rest will be composed of individuals who do not enroll in Medicaid, despite being eligible, and who choose to opt out or are exempted from paying the annual penalty (U.S. Congressional Budget Office, 2011). According to the California Academy of Family Physicians, those who are exempt from the requirement include individuals who would,

...pay more than 8% of their income for health insurance, those with incomes below the threshold required for filing taxes (in 2009, \$9,350 for a single person and \$26,000 for a married couple with two children), those who qualify for religious exemptions, those who are incarcerated, and members of Indian tribes¹.

¹ <http://www.familydocs.org/advocacy/health-care-reform/faq>

Without proper representation and better understanding of the structural and cultural barriers to healthcare for vulnerable groups, it is likely that political pressure and desire to improve and extend services will dissipate once the majority of the population is provided with basic medical services. Asian Americans are particularly vulnerable. Contrary to common stereotypes such as the model minority myth, which perceives all Asian Americans as highly financially successful, entrepreneurial, and well-educated, there is convincing evidence that immigrant populations like these have lower rates of access to healthcare than U.S. natives and are more likely to be in poverty, which poses a financial barrier to obtaining healthcare (Lebrun, 2011; LeClere, Jensen, & Biddlecom, 1994). Asian Americans are relatively new immigrants to the U.S., who face numerous other insurmountable barriers because they possess high rates of limited English proficiency, low levels of civic participation and acculturation, and are greatly underrepresented in government in relation to other groups of color. A large percentage of the overall Asian American population is foreign-born, close to 67%, (U.S. Census Bureau, 2010). In sum, these characteristics put them at a higher risk of remaining uninsured and underserved because cuts often occur at a point of least political resistance (Aday & Andersen, 1974; Mechanic, 1978).

Moreover, the purpose of this study was to examine the barriers the most vulnerable Asian American subgroups face in accessing the U.S. healthcare delivery system. Using 2010 U.S. census data, I chose the top four most uninsured Asian Americans: the Bangladeshi, Cambodian, Korean, and Pakistani subgroups. A preliminary analysis confirmed that these Asian American subgroups possess the highest uninsurance rates among all Asian American subgroups, ranging from 24.1% to 20.3%. Table 1.1, provides a preliminary snapshot of these subgroups' uninsurance rates, place of birth, citizenship status, socioeconomic status (i.e., income,

educational attainment, employment) and language proficiency levels. In terms of uninsurance rates, the rates for the Bangladeshi, Cambodian, Korean, and Pakistani subgroups are both significantly higher than the national uninsured rate of 15.5% and the aggregate Asian American uninsured rate of 15.7%. Per capita income for each of these subgroups is less than the national (\$26,059) and aggregate Asian American (\$28,930) groups' per capita income, with Cambodians (\$15,012) and Bangladeshis (\$18,542) earning significantly less.

The top four most uninsured Asian American subgroups are mostly comprised of foreign-born individuals with educational attainment levels that are generally similar to the aggregate Asian American group but significantly higher than the educational attainment levels of the national uninsured group. Employment rates for these subgroups range from 61.9% to 55.0% and unemployment rates range from 9.2% to 5.0%, demonstrating that these subgroups are active participants in the labor market. These employment rates are significantly higher than the national employment rate for uninsured Americans of 17.2%. Lastly, a disproportionate percentage of these subgroups speak another language other than English at home, with Bangladeshis (91.3%) and Pakistanis (85.6%) having the highest rates.

Table 1.1

Snapshot of Preliminary Analysis of Top Four Uninsured Asian American Subgroups

	Total Population	Uninsured	Per Capita	Foreign Born	Naturalized	Not Citizen	H.S. Degree	Some College	B.A. or Higher	Employed	Unemployed	Other
National*	309,349,689	15.50%	\$26,059	34.30%	16.40%	48.30%	19.40%	15.10%	6.80%	17.20%	46.30%	
Asian	14,728,302	15.70%	\$28,930	66.52%	37.92%	28.60%	16.00%	19.60%	29.60%	60.20%	6%	
Korean	1,730,238	24.10%	\$24,786	63.66%	35.53%	28.13%	18.60%	21.50%	34.50%	55.70%	5%	70.20%
Pakistani	393,218	22.70%	\$23,627	65.19%	38.53%	26.66%	17.40%	16.40%	29.80%	56.30%	5.50%	85.60%
Bangladeshi	125,692	22.70%	\$18,542	73.38%	37.92%	35.46%	17.20%	18.10%	25.50%	61.90%	6.30%	91.30%
Cambodian	307,888	20.30%	\$15,012	54.24%	36.26%	17.98%	27.30%	23.40%	11.90%	55.00%	9.20%	77.10%

Data Source: U.S. Census Bureau, 2010. American Community Survey. Accessed on November 25, 2011.

* National figures reflect data for uninsured population only

Of important mention is the fact that several studies at the regional and state levels that exist in the Health Services Research literature on the top four most uninsured Asian American subgroups indicate that in actuality, uninsurance rates may be significantly higher than the U.S. Census Bureau estimates (Brown et al., 2001; Kim, 2004; Shin, Song, Kim, & Probst, 2005; The Commonwealth Fund, 2001; Tirodkar, 2011; Yi, 2003). Several of these studies have consistently reported higher uninsurance rates for Koreans, including estimates from the Commonwealth Fund (2001) at 52%, a rate far above the 24.1% figure provided by 2010 U.S. census data estimates. For example, according to Trinh-Shrevin, Islam, and Rey (2009), Koreans' uninsurance rates across data sets, age groups, and time rank the worst in coverage among all Asian American subgroups and remain high regardless of market conditions or generosity of state public insurance programs. Nevertheless, Andersen, Harada, Chiu, and Makinodan (1994) maintain that the number of studies on Koreans are limited considering their population size. Studies on Koreans in this dissertation appear to be more abundant than the other three Asian American subgroups because the Korean population is much relatively larger than others (1.7 million). As opposed to the size of the Korean population, the Bangladeshi (125,692), Cambodian (307,888), and Pakistani (393,218) are substantially smaller.

In addition, it is important to highlight that socioeconomic status varies widely among Asian Americans. Asian Americans as a whole do perform better in relation to other non-white ethnic groups in several areas, such as income and educational attainment, however, when data is disaggregated within the Asian race category, it shows that there is actually a wide range of economic attainment. According to the U.S. 2010

census, median family income ranges anywhere from \$97,962 for Asian Indian households to \$47,445 for Bangladeshis, whose financial constraints are far worse due to the large number of people that live within a household. The national median family income for Americans was over \$50,000, while the median family income for Asian American households was \$65,469, highest among all racial groups.

In sum, these disparities in health insurance coverage and socioeconomic status indicators suggest that a number of Asian American subgroups, including the subgroups being examined in this study, do not fit the popular notion of a “model minority,” a common stereotype in which all Asian Americans are perceived as highly financially successful, entrepreneurial, and well-educated. Because disadvantaged and medically underserved populations are often the ones that encounter numerous barriers to preventive healthcare, such high rates of uninsurance as well as bleak socioeconomic status that have not been evident in more advantaged Asian American subgroups warrant further examination.

Research Objectives

In efforts to shed light on the healthcare access needs of Asian Americans, the main objectives of this dissertation are as follows. The first objective is to describe the relationship between the top four most vulnerable Asian American subgroups and access to healthcare. This study defines access to healthcare as “the degree fit between characteristics and expectations of the providers and clients” (Penchansky & Thomas, 1981). The second objective stems from the first, which is to closely examine the impact of various structural factors (broadly pertaining to institutional/organizational, socioeconomic, and demographic variables), and cultural factors (including acculturation

related variables) on access to healthcare. Lastly, the third objective is to draw lessons on access to healthcare for vulnerable populations alike from other advanced countries. Learning how they approach the issue of underserved populations highlights policy options for the U.S.

I used both quantitative and qualitative methods to achieve these objectives by employing the following research methods: (1) an in-depth review of the Health Services Research literature; (2) interviews with key national health experts and advocates; (3) a comprehensive survey documenting Korean Americans' barriers in accessing healthcare in the tri-state region (Connecticut, New Jersey, and New York); and (4) a comparative approach, which drew lessons from other countries that are facing similar access to healthcare issues, as described in the Comparative Health Policy literature.

Research Rationale and Significance

Within the context of the policy issue of access to healthcare, this study seeks to debunk the misperception that all Asian Americans represent one common culture and are all part of the “model minority.” The matter of fact is that Asian Americans comprise diverse ethnic subgroups with different cultures and languages and, most importantly, possess varying levels of socioeconomic status. This misconception was left undisputed for many decades after the post-1965 influx of immigration from Asian countries because prior to 2000, there was a profound lack of research on Asian Americans. With the growth of studies published in the Health Services Research literature on the health status and access to healthcare issues of Asian Americans, there has been an increased recognition of the diversity that exists among Asian American subgroups (Bateman, Abesamis-Mendoza, & Ho-Asjoe, 2009; Trihn-Shrevlin et al., 2009).

Nevertheless, there are no empirical studies to date to my knowledge that undertake a “comprehensive approach” to examining the structural and cultural barriers to access to healthcare that exist for the Asian American subgroups examined in this study. Some studies have identified key factors that impede access to healthcare, but they are limited in scope: if they described obstacles these subgroups face, they rarely examined why these Asian American subgroups are facing such obstacles and the effects of broader organizational and contextual factors that fundamentally structures unequal access to healthcare. In addition, the study of cultural factors is generally understudied among Asian American subgroups. This is a substantial gap in the Health Services Research literature because Asian American subgroups each have unique systematic patterns of beliefs, values, and behavior as well as survival mechanisms, which may act to impede or enable access to healthcare. Finally, the majority of existing studies also lack the identification of actionable steps to improve access to healthcare problems and do not take into careful consideration what it takes to enact such change.

Our limited understanding of Asian American subgroups can be explained by the fact that disaggregated data is quite limited across national, state, and local data collections. Due to these data limitations, researchers have found it more practical to conduct studies by themes and issue areas since it is very difficult to find sufficient data sources to base a study at the ethnic subgroup level. As a result, studies have concentrated on access to healthcare themes, examining a large range of Asian American subgroups at a time (Tandon & Kwon, 2009). For example, language access is an important theme that is frequently discussed in the Health Services Research literature since many Asian Americans are foreign born and have high rates of limited English

proficiency. Consequently, because these studies aggregate all Asian American subgroups into one group, findings are often overgeneralized. Lack of attention to the barriers to language access that specific Asian American subgroups experience results in a lack of understanding of the nuances that exist at the subgroup level. Furthermore, organizing studies in this manner makes it very difficult for researchers and policymakers to gain a holistic understanding of any Asian American subgroup.

I argue that as the Affordable Care Act reform implementation moves forward, it is especially critical that researchers and policymakers gain a better understanding of the barriers that the most vulnerable Asian American subgroups face in accessing healthcare so their needs can be addressed appropriately. This study attempted to bridge the gaps that exist in the two major lines of literature on access, which include Health Services Research and Comparative Health Policy by: (1) conducting a comprehensive literature review which provides a one-stop shop for information on the top four most uninsured Asian American subgroups by essentially pooling existing information that is traditionally organized thematically and reorganizes the information by subgroup, (2) generating new knowledge at the subgroup level by collecting data from Koreans in the tri-state region (Connecticut, New Jersey, and New York), a region that is greatly understudied, using the Access to Healthcare Survey on Koreans in the U.S., and (3) identifying practical and actionable interventions that can be implemented among these communities based on strategies employed by other countries, as described in the Comparative Health Policy literature. This study's interdisciplinary approach generates a comprehensive view of the experiences of Bangladeshis, Cambodians, Koreans, and Pakistani in accessing healthcare in the U.S., promoting the notion that studies must

move away from merely documenting the existence and extent of health disparities to explaining why these disparities exist and identifying actionable policy changes.

In sum, because of its comprehensive nature, this study is better positioned to identify targeted solutions for these subgroups with the recognition that a one-size-fits-all approach to addressing access to healthcare issues will undoubtedly result in poor health access and outcomes. This line of inquiry can help inform which policies might be more effective in assuring access to healthcare among immigrant populations. The findings provide policymakers and political leaders with better information and disaggregated data on demographic/socioeconomic and organizational factors associated with Asian Americans' reduced access and utilization of healthcare, therefore improving the visibility of Asian Americans on a national level (Trinh-Shevrin et al., 2009).

A unique aspect of this study is that it identifies valuable opportunities for cross-national learning useful to determine possible alternative approaches to addressing the structural and cultural barriers for one the fastest-growing populations in the country, Asian Americans. To policymakers, studies like these can provide criteria for determining which health policies work best as well as offering a virtual test of different policy options (Stone, 1999). According to Gusmano, Rodwin, and Weisz (2010) (as cited in Marmor, Freeman, & Okma, 2005, p. 341), that "...learning about the experiences of other nations is a precondition for understanding why change takes place, or for learning from that experience". For these scholars, the comparative approach is greatly underutilized in the public health policy space. This study, by contrast, suggests that an interdisciplinary approach such as one comprised of the Health Services Research

and Comparative Health Policy literatures can offer innovative ways to think about healthcare issues.

Lastly, this dissertation generates substantive and a culturally sensitive research methodology and conceptual framework that provides a basis for national or local studies of cultural, political, and socioeconomic aspects of access to healthcare of ethnic minority communities facing similar access to healthcare barriers. This study recognizes that investments must be made to adequately address Asian Americans' healthcare needs since they will continue to comprise the largest subset of immigrants entering the U.S. during the next few decades, retaining the fifth largest subgroup spot for at least another half a century unless some unexpected events take place (Min, 2006). More importantly, policymakers must understand that if investments are not made to mitigate the healthcare access barriers these Asian American subgroups face, the overall costs of providing healthcare for them will exponentially increase in the future.

Dissertation Organization

The remainder of this chapter discusses the theoretical and conceptual framework used to inform this study and describe the methodology used in this study. Chapter Two provides a comprehensive overview of the Health Services Research literature, including in-depth profiles of each subgroup (Bangladeshis, Cambodians, Koreans, and Pakistanis). Chapter Three discusses the results from the qualitative data gathered from interviews with national health experts and advocates and Access to Healthcare Survey for Koreans in the U.S. as well as describes this study's limitations. Chapter Four briefly discusses the case selection criteria that was the basis for selecting Germany and the United Kingdom and provides a comparison of the healthcare systems and description of the organization

and delivery of healthcare in Germany, the United Kingdom and the U.S. to put into context the valuable lessons that exist on access to healthcare for vulnerable populations. Lastly, Chapter Five provides a summary of the key findings, significant contributions and observations, policy implications, recommendations for future study and thoughts on how change in U.S. health policy can be enacted.

Theoretical and Conceptual Framework

This portion of Chapter One describes the theoretical and conceptual framework for this study and defines key terms and definitions. The first two sections define access to healthcare and vulnerable populations in the context of this study. The third section explains the theoretical basis of the study, political economy of health, which emphasizes the importance of societal factors such as economic and political factors in shaping and fundamentally structuring unequal access for vulnerable populations. The fourth section summarizes three leading conceptual frameworks in the Health Services Research literature that are adapted in this study's comprehensive conceptual framework. The fifth section explains the comprehensive conceptual framework for this study, which enables a holistic approach to examining access by incorporating key aspects from the three major conceptual frameworks.

Defining Access

The concept of access to healthcare is central to the study of the organization, financing, and delivery of healthcare services and is also considered an important political symbol and policy goal (Ricketts & Goldsmith, 2005). There are indications that the term access has not been defined clearly in the past and continues to be a challenge

for some studies in the Health Services Research literature. Earlier accounts of this important observation came from Pechansky and Thomas (1981), who maintain that,

Access is an important concept in health policy and health services research, yet it is one which has not been clearly defined or employed precisely. The lack of clarity in defining access is due to the fact that to some researchers and policymakers, ‘access’ refers to entry into or use of the healthcare system, while others characterize access to include factors influencing entry or use (p. 198).

These scholars cite some examples of earlier studies that have limited their definitions of access to entry into the healthcare system, including Fox’s (1972) study of access to medical care for the poor as well as Salkever’s (1975) comparative study of economic class and access to care among healthcare systems.

Despite earlier concerns over the nebulous nature of the concept of access, both researchers and policymakers continue to equate access to healthcare with entry into the healthcare delivery system, using health insurance status as a key determinant of an individual’s access to healthcare. For example, the leading indicators used by the U.S. Department of Health and Human Services (2012) to track the progress of reaching the goal of universal health care under the Affordable Care Act are: (1) the number of persons with health insurance coverage, and (2) the number of persons with a usual primary care provider. While it is clear that the lack of health insurance coverage or other means of access to healthcare results in difficulty of obtaining care, delayed care, and more adverse health consequences as a result, measures such as these are quite limited and problematic. They give the impression that access to healthcare is a one-dimensional problem, essentially equating access to healthcare to the presence or absence of health insurance coverage (Ryu, Young, & Kwak, 2001). The fact that the U.S. healthcare delivery system is highly commodified and lacks social equity values means that

vulnerable populations such as the foreign-born face insurmountable structural and cultural barriers, especially since the system is ill-equipped to meet their cultural and linguistic needs. Gusmano et al. (2010) concur that providing health insurance coverage alone does provide entry to immigrants but does not address the insurmountable barriers they face. Nevertheless, it seems clear that health insurance coverage would reduce disparities in access to primary care by at least reducing the financial barrier to healthcare.

Moreover, while health insurance coverage is a critical step in expanding access to healthcare, this policy issue goes beyond insurance and requires a comprehensive understanding of individuals' ability to obtain needed medical care. In line with the Institute of Medicine's study on Access to Health Care in America (1993), this dissertation defines access to healthcare as Penchansky and Thomas (1981) do: that access reflects the degree "fit" between characteristics and expectations of providers and clients. What does "access to healthcare" mean for vulnerable populations such as the top four most uninsured Asian American subgroups (Bangladeshis, Cambodians, Koreans, and Pakistanis) and what steps must be taken to address the barriers they face?

Defining Vulnerable Populations

The term *vulnerable populations* has been frequently used in studies in the Health Services Research literature, but often, characteristics which make a population "vulnerable" are not clearly defined. In line with the definitions provided by scholars such as Aday (1993) and LaVeist and Isaac (2012), this study defines "vulnerable populations" as groups that experience health and healthcare disparities because of underlying disadvantages related to social status. To clarify, healthcare disparities are

differences in the delivery of healthcare services that contribute to differences in healthcare access for vulnerable populations compared to more privileged groups (Bindman, Grumbach, & King, 2007). Healthcare disparities experienced by vulnerable populations lead to health disparities. Moreover, Aday (1993) maintains that vulnerable populations are,

...at risk of poor physical, psychological, and/or social health because of differences in underlying social status owing to race/ethnicity, gender, and so on. Social status is part of the underlying definition of vulnerability, because differences in social status are made manifest in the differential availability of personal and political power and associated human and social capital resources to different subgroups (p. 5).

Furthermore, inherent in the conceptualization of vulnerable populations is also the lack of equity. In the U.S., vulnerable populations do not have the equal opportunity to achieve their full health potential because healthcare services are not applied according to patients' needs (Braveman, 2006). As a result, vulnerable populations have an increased risk of poor health compared to more privileged groups, underscoring the important notion that health and healthcare disparities are attributable to differences in privilege or social hierarchy that cannot be explained by differences in need for care or preference for care. Therefore, at least in theory, the resulting health and healthcare disparities are modifiable through targeted interventions (Aday, 2001; Shi et al., 2005).

Political Economy of Health Theoretical Framework

A theoretical framework provides a philosophical basis on which research is conducted (Mertens, 1998). This study utilizes the political economy of health theoretical framework that can be traced back to Karl Marx's critique of classical economics. This theoretical framework characterizes healthcare systems from a dynamic perspective and provides a broad context for understanding health issues, which can be defined as,

A critical, historical, and interdisciplinary perspective which examines the political, economic, and social context within which health and illness are defined, treated, and managed (Minkler, Wallace, & McDonald 1994, p. 114).

This theoretical framework goes beyond the notion that issues such as health and healthcare disparities are solely dependent on individuals but, in actuality, are dependent on broader scale issues, including those that stem from the political, economic, and social context of the healthcare system.

This theoretical framework provides a valuable context in which to analyze political, economic, and social factors as determinants of health status and outcomes; and disease, which includes paying close attention to structural barriers preventing people from living healthy lives (Doyal & Pennell, 1979). Considering the unequal distribution of resources, wealth, and power that exists in the U.S., this theoretical framework is conducive to generating an understanding of the barriers that marginalized groups face in accessing healthcare and demonstrating that political economies do indeed structure the context of health. The way in which resources and social benefits are distributed across society shapes the health and healthcare disparities that exist within countries. Embedding a study of the U.S. healthcare system and access to healthcare within political economy extends beyond the common focus on individuals and critically analyzes how external structures and environment impact health behavior.

Leading Conceptual Frameworks for Studying Access

The three most productive theoretical models for understanding and assessing people's health-seeking behaviors include Andersen's behavioral model of healthcare utilization (1995), Shi and Stevens' general framework to study vulnerable populations (2010), and Kleinman's healthcare system model (1978). This study developed a

comprehensive framework for studying access to healthcare among vulnerable populations by isolating and enhancing key components in each of these three models. This section provides an overview of current conceptual frameworks to serve as a backdrop to this study's conceptual framework.

Access as Utilization: Behavioral Model of Health Services and Enhanced Versions

One of the most significant works generated in this field is Andersen's (1995) *Behavioral Model of Health Services*, which examines healthcare access and utilization patterns. For many decades, this model has served as the leading framework in Health Services Research literature and researchers have used this model to create indicators, focused both on process and outcomes. Andersen's original model (1968) was expanded through numerous iterations (Aday & Andersen, 1974; Andersen, 1995; Andersen & Newman, 1973). The key components of the original model remained intact: (1) predisposing factors, (2) enabling factors, (3) need factors, (4) resource factors, and (5) organization factors.

Predisposing factors are generally characteristics of individuals, defined as pertaining to demographic characteristics (e.g., age, sex, marital status, ethnicity, and education) that exist before the presence of an illness. Predisposing factors may also include religion, concepts of health and illness (i.e., cultural perceptions of illness), and norms of help-seeking behaviors among relevant social groups. *Enabling factors* are generally system or structural characteristics, more specifically pertaining to individuals' resources that determine access to healthcare, such as financial resources, health insurance, knowledge of the healthcare system, ability to locate services, and community resources. *Need factors* include health status and may also include individuals'

perceptions of their health conditions or professional evaluations of their health. *Resource factors* relate to the availability of resources in the healthcare system in terms of volume and geographical distribution. Lastly, *organization factors* refer to factors that determine entry or structure.

Scholars have recognized the utility of Andersen's model, generating enhanced versions of their own. A useful example is Phillips, Morrison, Andersen, and Aday's *Enhanced Concept of the Behavioral Model* (1998), which isolates the importance of provider-related variables, such as provider characteristics, methods, or types of services. A more prominent example is Shi and Stevens' *General Framework to Study Vulnerable Populations* (2010). This model demonstrates that the convergence of individual, social, community, and access to care risks lead to vulnerability. Like the behavioral model, Shi and Stevens argue that vulnerability is determined by predisposing, enabling, and need characteristics at both the individual and ecological levels (i.e., system levels). These characteristics converge and interact to make particular populations highly vulnerable. They work together to influence not only healthcare access but also healthcare quality and health status. This model is valuable because it emphasizes that individuals are most vulnerable if they have a combination of health needs, predisposing risk factors, and enabling risk factors. Shi and Stevens (2010) maintain that,

Vulnerability does not represent any personal deficiency of the populations defined as vulnerable, but rather that they experience the interaction of many risks over which individuals may have little or no control. The model also implies an important role for society in addressing the health and healthcare needs of vulnerable populations (p. 20).

Shi and Stevens (2010) focus on three key risk factors among the many predisposing, enabling, and need attributes one can study. This model shows that race/ethnicity,

socioeconomic status, and health insurance coverage are three of the most powerful demographic predictors of poor healthcare access, quality of care, and health status, therefore vulnerability.

Access and Culture: Healthcare System Model

In contrast to the models previously discussed, Kleinman's healthcare system model (1978) allows us to understand how culture impacts the entire spectrum of health, illness, healing, and healthcare behaviors. Other behavioral models do incorporate some cultural factors within their predisposing characteristics, but Kleinman's model goes further by examining the way individuals act in and utilize the healthcare delivery system. More specifically, this framework emphasizes the importance of considering individuals' beliefs as well as patterns of behavior governed by cultural rules of a society that can be influenced by healthcare institutions (e.g., clinics, hospitals, professional associations, health agencies); social roles (e.g., sick roles, healing roles); interpersonal relationships (e.g., doctor-patient relationship, patient-family relationships, social network relationships); interaction settings (e.g., home and doctor's office); and economic and political constraints.

Unique to this model is that it consists of three separate yet interconnected social sectors, each of which has its own set of health beliefs, treatment techniques, practitioners, and methods of evaluation. The first sector is *the popular sector of the healthcare system*. It is the largest sector of any healthcare system, including the family context of illness and care, as well as social networks and communities. According to Kleinman, in both Western and non-Western societies, about 70% to 90% of illness is managed solely within this popular sector, where most decisions are made regarding

when to seek care, whom to consult, and the efficacy evaluation of different treatments. Kleinman maintains that although the popular healthcare system is the largest part of healthcare, it is the least studied and understood. The second sector is called *the professional sector of the healthcare system*, which consists of the organized healing professions. In most societies, the professional sectors of the healthcare system refer to Western medicine. The third sector consists of *the folk sector of the healthcare system*. This sector is composed of nonprofessional healing specialists, including sacred and secular groups and herbalists.

In sum, these models all have unique aspects and commonalities in analyzing how different factors affect healthcare access. However, one significant gap among the behavioral models is the lack of emphasis on cultural factors at the system level. For instance, Andersen's model provides helpful measures of access; highlights the crucial distinction that equitable access is correlated with demographic variables and health needs and on the other hand highlights that inequitable access is an outcome of social structure and enabling resources; and incorporates the role of cultural factors, such as health beliefs, in the predisposing characteristics component. It does not, however, sufficiently take into account nor define the role of cultural factors in access, particularly at the system or "contextual" level. It seems that the incorporation of cultural factors is neither well defined nor measured in the literature and, therefore, is a nebulous concept.

In their critical review of leading frameworks of access, Ricketts and Goldsmith (2005) argue that reconciling models like these should be a priority issue for research. Because not one particular model provides a holistic framework nor adequately defines components to studying vulnerable populations, this study reconciled existing models and

incorporated key aspects into an improved and comprehensive conceptual framework suitable for examining access to healthcare among the top four least insured Asian American subgroups (Bangladeshi, Cambodian, Korean, and Pakistani subgroups).

Towards a Comprehensive Conceptual Framework for Studying Access

This study drew upon and refined the role of key factors identified within existing conceptual frameworks described in the previous section. While each of these frameworks alone is not sufficient in providing a comprehensive framework to studying healthcare access, each framework has valuable aspects that can be used to form a comprehensive approach. These components were integrated into this study's enhanced model, which emphasizes the interaction among *individual level*, *organizational level*, and *contextual factors* in impeding or enabling access to healthcare for vulnerable populations.

I paid particular attention to the role of cultural factors. According to Pasick, D'Onofrio, and Otero-Sabogal (1996), "cultural tailoring"—the development of interventions, strategies, messages, and health materials—should adapt to specific cultural characteristics rather than taking an approach of "cultural targeting," which identifies a specific population subgroup for the purpose of exposure of that subgroup to the intervention. A thorough understanding of the cultural characteristics of the target population and how those characteristics affect individual health behavior is important to ensure the success of intervention. In addition, cultural factors are embedded both at the contextual levels to capture cultural norms that are embedded in societies.

A Venn diagram was selected to demonstrate all possible relations between key variables, intersections, emphasizing the fluid relationships between these variables.

Refer to Figure 1 below for a pictorial interpretation of the model. These factors interact and work together to influence access to healthcare outcomes. The contextual factors component was placed on the top of the figure to emphasize its trickledown effect on both individual and organizational factors. For instance, contextual factors like the politics affecting immigration policies can have a significant impact on individual factors (e.g., enabling variables such as health insurance coverage). This example is illustrated by undocumented immigrants' inability to purchase health insurance coverage in the new health insurance marketplaces under the Affordable Care Act.

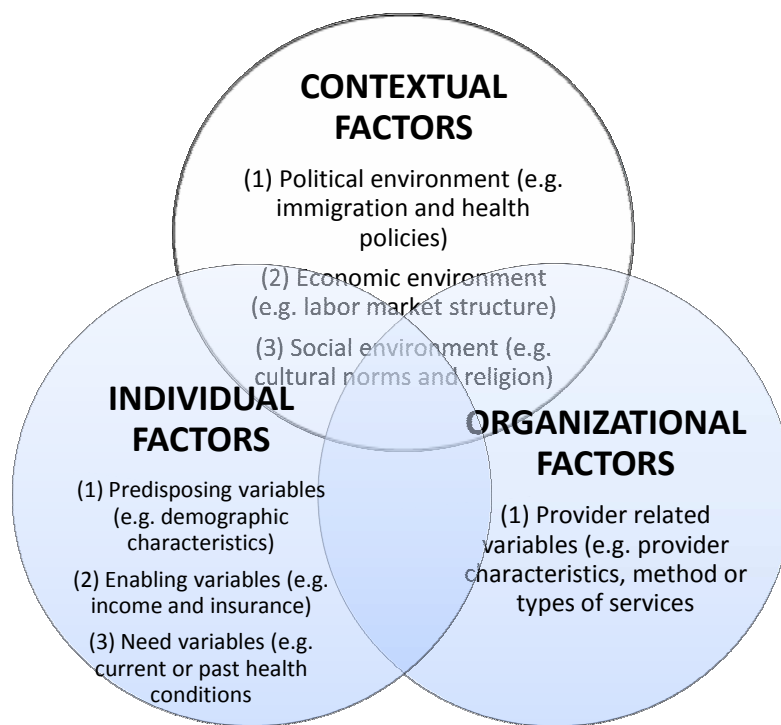


Figure 1
A Comprehensive Framework to Study Access to Healthcare for Vulnerable Populations

Individual Factors

The individual factors in the comprehensive framework include predisposing, enabling, and need variables, drawn from Andersen's behavioral model (1995). While there may be many predisposing, enabling, and need variables that impede or enable

access to healthcare, this study focused on the most relevant factors, including the following variables:

Predisposing Variables

1. Age
2. Gender
3. Marital Status
4. Generational status
5. Cultural beliefs (e.g. religiosity, health beliefs, traditional medicine preference)
6. Civic engagement

Enabling Variables

7. Educational attainment
8. Income
9. Employment status/type
10. Occupational type
11. Acculturation (e.g., language proficiency, length of stay in U.S.)
12. Health insurance coverage status
13. Social networks (e.g., family and community resources)

Generally speaking, individuals have very little control over most predisposing characteristics (Shi and Stevens, 2010). In terms of enabling variables, variables such as health insurance coverage, low income, low educational levels, and language barriers are highly correlated with the presence or lack of access to healthcare. Of particular importance for Asian Americans is the influence of social networks, which comprises faith or community-based organizations. These organizations play a key role in providing

these communities with critical information on the healthcare delivery system, as well as translation, transportation, and free services such as screenings and immunization clinics. Lastly, the comprehensive framework also includes an assessment of the health disparities and needs, variables such as health status. Establishing a solid understanding of the health disparities and needs can help generate a sense of urgency to put in place targeted interventions that will improve access to healthcare so these vulnerable populations can utilize the healthcare services they need.

Organizational Factors

In addition, this comprehensive framework draws on the organizational factors that refer to provider characteristics, method, and types of services, per Phillips et al.'s (1998) model. This study focused on the following variables:

1. Waiting times
2. Healthcare services hours
3. Linguistic competency
4. Transportation
5. Ease of navigation of the healthcare delivery system (e.g., ability to fill out paperwork, resolve insurance coverage issues, and understand care needed)
6. Ease of navigation of the public assistance programs such as Medicaid, Medicare, and others (e.g., ability to fill out paperwork and understand eligibility requirements)

Contextual Factors

Lastly, this comprehensive framework also incorporated contextual factors. Contextual factors refer to barriers that vulnerable populations face at the political,

economic, and social environments. One of the major contributions of this study is to explore in detail how these barriers are critical in the Asian American context, and truly unique to many immigrant minority populations in the U.S. This study focuses on numerous contextual factors central in determining access to healthcare, including the impact of the political and economic environment; immigration and national policies; labor market structure; and national cultural norms and values on vulnerable Asian American populations.

For instance, the political environment in the U.S., including its restrictive immigration and health policies, can create massive barriers that discourage and limit vulnerable populations from accessing health services. There is evidence that immigrants eligible for public assistance programs are not enrolling because they do not want to be viewed as a public charge for fear that it will negatively impact their immigration status (Clough, Lee, & Chae, 2013; Maloy, Darnell, Nolan, Kenney, & Cyprien, 2000). The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which essentially restructured the distribution of federal cash assistance and established a five-year waiting period for public assistance for lawful permanent residents has had a significant impact. Past studies have demonstrated that this particular legislation limited immigrants' access to public benefits and has had unintended consequences of deterring eligible immigrants from accessing benefits (Huang, Yu, & Ledsky, 2006; Kandula, Grogan, Rathouz, & Lauderdale, 2004; Kandula, Wen, Jacobs, & Lauderdale 2006; Park, 2011). For example, Park (2011) explained that the Department of Human Services and the Immigration and Naturalization Service worked together during this time to identify minorities such as Latino and Asian pregnant women enrolled in MediCal, California's

public health insurance for low-income individuals, and forced immigrants to pay for medical benefits on the basis that they will not be given permanent U.S. residency. The economic environment also structures unequal access because a majority of vulnerable populations such as Asian Americans, who are mostly foreign born, do not have the skills to work in the formal labor market and are forced to work in the ethnic economy.

Lastly, the social environment can also impede or enable access. For example, cultural values and norms of the host country may influence vulnerable populations' decisions. Some examples of cultural norms that impact access to healthcare for vulnerable Asian American subgroups include the notion of the "individualism," which consists of independency, individuality, achievements, and autonomy and the "model minority model," which assumes that all Asian Americans are highly successful, educated, and entrepreneurial. For all these reasons, understanding the link between the social, political, economic environmental conditions and access to healthcare is crucial.

Research Methodology

Combining both qualitative and quantitative methods, a holistic approach was used to reconstruct the meaning of the U.S. healthcare environment for the top four most uninsured Asian American subgroups examined in this study (Cambodians, Bangladeshis, Koreans and Pakistanis); and gather and analyze the cultural and structural factors that affect these subgroups' ability to access to healthcare.

My research consisted of three major phases of data collection. The first phase was a comprehensive review of the Health Services Research literature to inform a research agenda developed to guide the fieldwork. The second phase focused on semi-structured qualitative interviews conducted with national health experts and advocates

working with one or more of the top four most uninsured Asian American subgroups. The third phase focused on the design and implementation of the Access to Healthcare Survey for Koreans in the U.S. in the tri-state region of the U.S. (Connecticut-New Jersey-New York). The Korean subgroup was selected as a case study because it is the largest uninsured population of the subgroups being examined in this dissertation and considered one of the most understudied Asian American subgroup in relation to their population size (Andersen et al., 1994). According to the latest U.S. census (2010) 1.7 million Koreans are the fifth largest subgroup out of 28 existing Asian American subgroups. Koreans were also selected because they possess an established immigration history in the U.S. and have a well-known presence in the U.S. economy. Such a comprehensive approach provided different perspectives on access to healthcare issues, confirming the validity, reliability, depth, and scope of the research. The three major phases of data collection are discussed in detail in the following section.

Phase One: In-Depth Literature Review

A comprehensive review of Health Services Research literature on access to healthcare was conducted in 2012 and early 2013. I used PubMed to identify peer-reviewed articles for this dissertation topic. Articles selected met two stringent criteria: (1) empirical studies in which the Asian American subgroups in this study are highlighted; and (2) empirical studies that have generalizable sample sizes (i.e., higher than $N=100$). Key terms such as access to healthcare, access to healthcare for Asian Americans, access to healthcare for “Bangladeshi,” “Cambodians,” “Koreans,” and “Pakistanis” were used. Article titles and abstracts were reviewed and those of potential interest were selected for in-depth review. The bibliographies of located articles were

also reviewed for additional references. The literature search was continued until the articles identified became redundant and cited authors became familiar. In addition, I utilized the Scopus database to track new journal articles that report new findings. The majority of all empirical studies covered in this study's in-depth literature review were published between 1995 to 2014.

In addition, the literature on population statistics and pertinent facts was closely consulted, limited to the most recent national data collections published mainly by the U.S. Census Bureau. Some examples of surveys used in this study include the American Community Survey and Survey of Business Owners. The majority of the data came from the American Community Survey, which provides detailed tabulations for the Asian American subgroups in this study and many other Asian American subgroups. I analyzed the 2010 American Community Survey 1-year estimates and 2007-2011 American Community 5-year estimates which not only includes data on population, but various key socioeconomic indicators, such as age, immigration, language, education, income, employment, housing, and health. Data was accessed via the American Fact Finder search engine periodically throughout 2012 to 2014.

Phase Two: Interviews with Health Experts and Advocates

A thorough review of the Health Services Research literature generated a significant portion of the data that speak to the structural and cultural barriers that impede access to healthcare, however, there were gaps in the literature, which are discussed in detail in the next chapter. One way this study attempted to bridge the gaps identified in the in-depth literature review was by conducting face-to-face interviews with national health experts and advocates from nonprofit organizations as well as various government

agencies throughout the U.S. Interviewees included safety-net providers (e.g., community hospitals and clinics), immigrant organizations (e.g., national, state, and local legal and health policy advocates) and government agencies (e.g., state and county public health and social service agencies). These individuals were best equipped to discuss Asian American access to healthcare issues since they have first-hand experience interacting with these subgroups. These interviews focused on understanding national health experts and advocates' views on the structural and cultural barriers these vulnerable Asian American subgroups face in accessing healthcare in the U.S. The information gathered helped evaluate healthcare programs, health plans, and the overall experiences of the Asian American subgroups in respect to their ability to access basic health services.

Every effort was made to conduct the interviews with “individuals who possess special knowledge, status, or communication skills, and were willing to share their knowledge and skills with the researcher and who have access to perspectives” (Gilchrist & Williams, 1999). I sent letters to potential participants requesting an interview based on an initial pool of key contact information I compiled from the Health Services Research literature. Interested individuals then contacted me to make arrangements for an interview at a mutually convenient date and location (e.g., public settings such as their work place or a conference call). This study also utilized snowballing sampling methods, where I acquired directly from participants recommendations for other potential participants (Bernard, 2000). In total, I conducted 24 interviews during February and May 2013. The majority of the interviewees were health policy directors and senior researchers of community based organizations as well as university scholars based in the

New York, New Jersey, Ohio, San Francisco and Washington, D.C. areas. This number of interviews was necessary to generate emergent themes and patterns.

I obtained consent from interviewees at the beginning of each interview and recorded conversations as digital voice files on a voice recorder. Interviews were conducted in English and lasted from 30 to 75 minutes following a standardized protocol (Refer to appendix B). The protocol contained a set of pre-formed questions that were asked in a semi-structured interview format, based on the key components of the comprehensive framework to study access to healthcare developed for this study (i.e., individual, organizational, and contextual factors), with particular focus on gaining insight into the structural and cultural barriers to access. The open-ended question format provided the informants ample opportunity to offer in-depth explanations to questions as well as identify additional issue areas. Interviews were transcribed and analyzed individually and together as a whole.

I applied a coding process to the notes incurred from these interviews for the purposes of discerning themes, patterns; as well as any similarities and differences among these subgroups (Park, 2011). Atlas.ti 7 was the software package I used for data analysis. The power of the software rests in its flexibility to categorize and arrange data and to organize categories into modes and frameworks that specify relationships between themes emergent from the data. During the coding process, I was guided by Bernard's (2002) inductive method of inquiry, which includes the following steps (p. 463):

1. Read through transcribed texts.
2. Identify potential analytic categories that arise (i.e., coding).
3. Isolate and compare data from categories for comparison.

4. Think about how categories are linked.
5. Use the relations among categories to build theoretical models.
6. Use examples from the data to illuminate the theoretical model.

Phase Three: Access to Healthcare Survey for Koreans in the U.S.

While the comprehensive literature review and qualitative interviews with national health experts and advocates provided key information to establishing an understanding of the top four most uninsured Asian subgroups examined in this study (Bangladeshis, Cambodians, Koreans, Pakistanis), disaggregated data at the subgroup level for one of the subgroups was necessary to further confirm the validity, reliability, depth, and scope of this research. For reasons explained previously in this section, the Koreans were selected. The Access to Healthcare Survey for Koreans in the U.S. was designed to generate granular data that is not sufficiently documented in the Health Services Research literature and is of particular relevance to truly understanding the barriers Korean Americans face in accessing healthcare. The survey was initially drafted in English and then translated into Korean by a professional translation company. It was administered to Koreans working and living in enclaves such as Flushing, New York; and Fort Lee and Palisades Park, New Jersey.

Instrumentation

The instrument created for this study—Access to Healthcare Survey for Koreans in the U.S.— was based on major themes identified in the comprehensive literature review of this study. The survey included two parts. The first part of the survey, Part I: Participant Information, measured variables such as (1) demographic characteristics such as age, gender, marital status, length of residence in the U.S; (2) acculturation; (3)

socioeconomic indicators such as educational attainment, income, employment type; (4) health insurance coverage and regular source of care; (5) health status and healthcare utilization; (6) community healthcare services utilization; (7) political participation; (8) religiosity and other beliefs. The second part of the survey included a Likert scale, Part II: Access to Healthcare, which measured patterns of structural, system, and cultural barriers. The scale assessed different barriers that may prevent people from accessing healthcare, including cost, limited office hours, distrust in the U.S. healthcare system, etc. An example item is: “It is easy to find affordable quality health care.” The instrument was coded on a six-point Likert scale from “Strongly Disagree” to “Strongly Agree”.

Prior to implementing this data collection, the survey instrument was piloted to validate its content and design. The survey instrument underwent internal consistency estimates of reliability including: a split-half coefficient expressed as a Spearman-Brown corrected correlation and Chronbach’s alpha. For the split-half coefficient, the scale was split into two halves such that the two halves would be as equivalent as possible. In splitting the items, sequencing was taken into account. One of the halves included items A1R, A3, A5, A7R, A9, A11, A13, A15, A17R, A19, and A21, while the other half included A2R, A4R, A6, A8R, A10, A12, A14R, A16, A18, and A20. The value for Chronbach’s alpha coefficient was .757 and the split-half coefficient (unequal length) was .784. As they both exceeded .70, each indicated satisfactory reliability (Tabachnick & Fidell, 2007). Before performing any internal consistency tests of reliability on the survey instrument, all items were examined to ensure that the same scale was used and that all necessary reverse-scalings were complete.

Sampling Selection

I collected my sample data from Korean enclaves throughout the tri-state region (Connecticut, New Jersey, and New York) not only because of their close proximity to my residence but for several important reasons. Firstly, the tri-state region has the second largest Korean American population in the U.S., which is understudied in relation to Korean American counterparts in Southern California (i.e., Los Angeles, Orange County). To date, Koreans living in Southern California have been most studied since it has the largest Korean population in the U.S. Secondly, the tri-state region (Connecticut, New Jersey, and New York) is a particularly desirable location to conduct research since, according to Gusmano et al. (2010), it has: (1) higher rates of uninsured residents (about 28% if the population in comparison to about 16% for the U.S. as a whole); (2) highest rates of persons 65 years or older who, because of their recent immigrant status, have not met the eligibility qualifications for Medicare and, therefore, require a stronger safety net; (3) largest public hospital system in the U.S.; and (4) lastly, New York City stands out because its academic medical centers train the largest number of medical residents in the nation. Surprisingly, New York City also has roughly twice the national rate of recent immigrants and twice the rate of children and older persons living below the poverty line (Gusmano, Rodwin, & Cantor, 2007).

My sampling approach consisted of targeting heavily populated ethnic Korean enclaves of Flushing, Bayside, and Little Neck in New York as well as the Fort Lee and Palisades Park in New Jersey. I dropped off surveys at information desks of local religious, immigrant advocacy organizations, ethnic supermarkets, small businesses, and libraries within these areas. Approximately 300 prepaid mail-in surveys were distributed

during the period of August through October 2013. To minimize bias in the survey sample, this study employed a quota sampling method, the nonprobability equivalent of stratified random samples. In other words, I continued my data collection phase until I determined that I had a reasonable sample distribution to answer my study's main research questions (i.e., assess the differences in healthcare access among those with higher education, income, employment statuses, religiosity, and acculturation levels). Other sampling criteria included ensuring that basic demographic variables such as gender and age were reasonably distributed (e.g., approximately 46% of the sample were women and 54% of the sample were men). In total, 107 surveys were collected for analysis, approximately a response rate of 35%. I reviewed each survey individually as they were mailed in as well as conducted an aggregate review at the end of the data collection effort.

Participant Consent

Consent for the Korean Americans participating in the study was waived due to the general belief that "...respondents are more willing to answer sensitive questions about personal behaviors and beliefs when surveys are anonymous than when they are simply promised confidentiality" (Fink, 2003).

CHAPTER 2: COMPREHENSIVE LITERATURE REVIEW

This chapter provides in-depth profiles for the four most uninsured Asian American subgroups in the U.S. being examined in this study (Bangladeshis, Cambodians, Koreans, and Pakistanis). Based on the major components of this study's comprehensive framework discussed in the previous chapter, this literature review describes what is known regarding the most salient structural and cultural barriers that impede each of these Asian American subgroups' ability to access healthcare services. In-depth profiles include descriptions of these subgroups' immigration history, settlement patterns, access to healthcare and health insurance, health disparities and needs, and approaches to healthcare. In addition, these profiles also cover salient factors that are specific to each subgroup, including the role of the ethnic economy on access to healthcare for Koreans, the role of low socioeconomic status on access to healthcare for Cambodians, Bangladeshis, and Pakistanis, as well as the role of traditional medicine and religion on access to healthcare for the Bangladeshis and Pakistanis. Examining a wide range of factors generates an insightful depiction of their experiences.

The degree to which these subgroups have been studied is a reflection of their population size and immigration history. Studies on Koreans are most abundant in comparison to the other three Asian American subgroups because the Korean population is relatively larger (1.7 million). As opposed to the size of the Korean population, the Bangladeshi (125,692), Cambodian (307,888), and Pakistani (393,218) populations are substantially smaller. Nevertheless, according to Andersen et al. (1994) maintain that the number of studies on Koreans are limited considering their population size.

Koreans Americans

Immigration History

Korean immigration in small numbers began at the start of the 20th century and dramatically increased after the enactment of the Immigration Act of 1965, which liberated the immigration quota imposed on foreigners. By 1970, approximately 70,000 Koreans were living in the U.S., consisting mostly of individuals who had held “professional, technical, and related occupations” in South Korea—more specifically, large proportions of healthcare workers—and foreign students (Kim, 1981; Min, 2006). Although Koreans had an early presence in the U.S., they were barely noticeable as a community until the third wave of immigration occurred during the 1980s and 1990s. During this period, approximately 95% of Korean immigrants settled, making them one of the youngest ethnic minorities in the U.S. (Min, 2006).

As of the latest U.S. census (2010), Koreans comprise 15% of the Asian Pacific American population. Scholars, such as Yu et al. (2009), maintain that there are actually many more Koreans living in the U.S. – census data do not account for the estimated 250,000 undocumented Korean immigrants as well as over 800,000 Korean immigrants who arrive each year on non-immigrant visas. Many of these individuals become temporary workers in the Korean ethnic economy or come to the U.S. as international students and often eventually permanently extend their stay. This proportion of Korean “status adjusters” in the U.S. has increased exponentially since the start of the 21st century (Min, 2006, 2013).

Settlement Patterns

The majority of Koreans reside near suburban areas of Los Angeles and New York City (including areas in New York, New Jersey, and Connecticut). Approximately 30% of all Koreans in the U.S. live in California – Koreans are the second largest Asian American subgroup living in Los Angeles (22.9% or 114,140) and the rest (210,446) live in nearby suburban areas, (Min, 2013). Many Koreans work or own small businesses in “Koreatown” in Los Angeles, which is by far the largest Korean ethnic enclave in the country. An analysis of the 2001-2002 Korean yellow pages by Yu, Choe, Han, and Yu (2004) located a large number of Korean businesses in Koreatown, including 34 Korean bookstores, 116 travel agencies, 193 law firms, 184 accounting firms, 410 medical offices, 204 acupuncture/herbal medicine offices, and 41 night clubs/bars.

On the opposite coast, the New York region has the second largest Korean population in the country, with 14.9% of Koreans living there as of the 2010 census count. Koreans are the third largest Asian American subgroup in New York City (8.9% or 102,820) running behind the Chinese and the Asian Indians (Min, 2013). More than 70% of Koreans who live in New York City (numbering 87,000 in 2000) are settled in Queens, with 25% concentrated in Flushing (Min, 2006). Koreans have established ethnic enclaves in Flushing, Queens and in midtown Manhattan (32nd Street between 5th and 6th avenues). In New Jersey, suburban enclaves are located in Bergen County, one in Fort Lee and the other in Palisades Park (Min, 2001). In January 2000, Min (2006) counted 130 Korean stores in the Fort Lee downtown area and another 120 Korean stores in Palisades Park. There are approximately 221,705 Koreans living in Bergen County.

The Korean Ethnic Economy

As described above, Koreans have established ethnic enclaves in major cities in the U.S. with large Korean populations, including California and New York. Not surprisingly, due to the large presence of Korean-owned businesses in these areas, Koreans have developed a reputation as being a highly entrepreneurial immigrant group. This entrepreneurial trend among Koreans has been documented in U.S. census data as well, as early as the 1980s. As shown in Table 2.1, which provides a compilation of U.S. census data for 1980, 1990, and 2000, Koreans had a self-employment rate of 17%, ranking third-highest among all immigrant groups in the 1980s (Min, 2006). Self-employment rates among Koreans then increased in the 1990s to 25% and slightly decreased to 23% in 2000. By 2000, Koreans continued to hold the third-highest self-employment rate among all immigrant groups, after the Greeks and Israelis (Min, 2006).

Table 2.1

Self-employment Rates of the Nine Most Highly Entrepreneurial Immigrant Groups in 1980, 1990, 2000

Ancestry	1980	1990	2000	# of workers in 2000
Greece	15%	26%	26%	99,901
Iran	18%	20%	21%	185,508
Israel	22%	22%	23%	74,645
Hungary	16%	18%	18%	41,627
Italy	14%	16%	17%	252,203
Korea	17%	25%	23%	516,023
Netherlands	14%	17%	16%	57,614
Pakistan	10%	15%	15%	128,386
Taiwan	10%	14%	14%	216,646

Source: Min (2006), p. 239

Sources: U.S. Bureau of the Census, 5% Public Use Microdata Samples of Censuses 1980, 1990, and 2000.

Note: the sample includes individuals who were 25-64 years old and who participated in the labor force in 2000.

More recent self-employment data show that Koreans continue to possess high self-employment rates. For instance, the American Community Survey (2006-2010) 5-year estimates from the U.S. Census Bureau indicate that Koreans make up the second-largest share of business owners, possessing a business ownership rate of 23%. The same dataset indicates that Iranians have the highest business ownership rate at 24.4% and other groups with similar rates include Brazilians at 21% and Italians at 20.1%.

As shown in Table 2.2, the American Community Survey (2007-2011) 5-year estimates from the U.S. Census Bureau on Korean self-employment rates show a slight decrease at 20.6%. This table compares self-employment rates for Koreans in relation to more established Asian American subgroups such as the Chinese (9.6%), Filipinos (4.2%), and Indians (9.8%). When examining self-employment rates within the Asian American context, the Korean rate is significantly higher than other Asian American subgroups. Non-Hispanic native-born white figures were included as a reference point, further highlighting Koreans' unique propensity for self-employment, in contrast to the majority of the U.S. population.

Table 2.2
Self-Employment Rates of Korean Americans aged 18-64

Ethnic Group	Number of Cases	Number	Percent
Korean	25,175	5,191	20.6%
Chinese	70,569	6,791	9.6%
Filipino	59,749	2,481	4.2%
Indian	56,311	5,543	9.8%
Non-Hispanic Native-Born White	4,227,055	431,779	10.2%
Total	4,469,694	456,096	10.2%

Adapted from: Min, P.G. & Kim-Lu, D. (in press). Do Second-Generation Koreans Inherit Their Parents' Businesses? Book Chapter in *Second Generation Korean Experience in North America*. Lexington Books. Forthcoming November, 2014.
Note: 2007-2011 US Census American Community Survey Data. Restricted sample to persons between the ages of 18 through 64 and worked 30 or more hours per week.

Nonetheless, Light and Rosenstein (1995) suggest there is reason to believe that respondents' self-reports in the U.S. Census Bureau surveys underestimate self-employment rates. For Koreans, this underestimation is greater because many family members who work for family-run businesses do not report their work. For instance, although the U.S. census rate for self-employment was 17% for Koreans in the 1980s, Min (1986) found in his study based in Los Angeles and Orange counties that the self-employment rate was actually much higher at 35%. More than half of households owned at least one business and were likely to have several family members working for them. In another study by Min (2009), based in the New York City region, approximately 39% of Koreans were self-employed. He estimates that approximately 80% of Koreans in the U.S. work in the ethnic economy.

Reasons for this heavy concentration of self-employment among Koreans have been studied extensively. There is compelling evidence that their high self-employment rates are not necessarily motivated by the attractiveness of owning a small business but are rather an economic survival strategy. Koreans who have immigrated to the U.S. after the mid-1960s find that entry into professional, technical, and managerial careers is challenging due to their language barriers. According to Kagawa-Singer, Wellisch, and Durvasula (1997), Koreans are reported to have the largest proportions of linguistically isolated persons. Thus, many Korean immigrants who have college educations and white-collar occupations in South Korea decide to enter the small-business sector as an alternative to low-wage and dead-end jobs. Many Korean immigrants start businesses that require a relatively small amount of startup capital and could be operated mostly with family labor (Hurh 1998; Yu et al., 2009). Lastly, Min (2009) attributes the high rates of

small business ownership among Korean immigrants to their high aspiration to achieve economic mobility within a short time.

Yu et al. (2009) explains that in order to overcome resource limitations, Korean communities have built their own institutions and resources. They have established Koreatowns, in which they have built their own communal resources, social networks, and career opportunities, as well as churches, community-based organizations, ethnic media, social, professional, trade organizations, and financial institutions. However, regardless of the strong community infrastructure among Koreans, the reality is that their severe language barriers and high levels of “enculturation” rather than “acculturation” have drastically decreased the number of occupational opportunities for Korean immigrants. According to Yu et al. (2009), whereas the presence of such highly institutionalized Korean American communities may prove instrumental in advancing their economic and political interests, it actually insulates Korean immigrants in the narrow confines of an ethnic community, thus depriving them of further opportunities for development and success. Korean immigrants do not have an equal footing on formal employment opportunities for various reasons discussed above and are more amenable to take on jobs in the Korean ethnic economy where they may already have a network of social relationships and can communicate easily.

Nevertheless, it is important to note that although small business entrepreneurship is generally popular among Koreans, this trend is largely a first-generation immigrant phenomenon (Min, 2006). According to Kim (2009), the outlook for second-generation Koreans is brighter because the majority of them are abandoning the ethnic economy for professional occupations in mainstream economy. Compilation of occupational type data

from the American Community Survey outlined in Table 2.3 corroborates this prediction, demonstrating moderate shifts of younger Korean generations towards professional specialty and management, business, and finance occupations. For example, while approximately 25.7% of Korean immigrants hold professional specialty occupations, the data show that native U.S. born Koreans have higher rates of occupations in this category at 38.2%. Holding professional specialty occupations moderately improves economic conditions. Native U.S. born Korean household incomes are moderately higher than older generations. Figures below show that households in the native U.S. born Korean generational cohort earn \$16,000 more than Korean immigrant households. Korean immigrant households may have a hard time living on an income of \$72,000 because they not only have to cover living expenses for themselves and their families but are also susceptible to catastrophic financial shocks related to self-employment (e.g., unexpected small business costs or repairs).

Table 2.3

Occupational Types of Korean Americans aged 18-64, Compared to Other Groups, by Generational Status

Generation	Number	Occupational Level			Economic Conditions (1,000)	
		Mgmt/ Bus/ Finance	Prof.	All Other	Median Household Income	Median Individual Income
Total	9,761	19.8%	29.9%	50.3%	80	40
First Generation	6,086	18.2%	25.7%	56.1%	72	38
1.5 Generation	2,166	23.3%	36.0%	40.7%	95	47
Native/U.S. Born	1,509	21.5%	38.2%	40.3%	96	42

Notes: 2007-2011 US Census American Community Survey Data. Restricted sample to persons between the ages of 18 through 64 and worked 30 or more hours per week. Analyses based on those full-time workers who reported occupational type².

² Analyses generated but not included in Min, P.G. & Kim-Lu, D. (in press). Do Second-Generation Koreans Inherit Their Parents' Businesses? Book Chapter in *Second Generation Korean Experience in North America*. Lexington Books. Forthcoming November, 2014

Furthermore, looking at occupational type data by generational status demonstrates that older generation Korean immigrants have low rates of holding professional specialty occupations. As shown in Table 2.4, median household income for first generation Korean immigrants (\$72,000) lags behind other Asian American subgroups such as Filipinos (\$98,000), Chinese (87,000), and Indian (\$115,000). High median household income levels for 1st generation Indian immigrants are highly correlated to their very high rates of holding professional specialty occupations in the U.S. (51.6%). This rate is more than twice the rate for 1st generation Korean immigrants (25.7%).

Table 2.4

Occupational Types of Korean Americans aged 18-64, Compared to Other Groups, by Generation

Generation/ Ethnic Group	Number	Occupational Level			Economic Conditions	
		Mgmt/ Bus/ Finance	Prof Spec	All Other	Median Household Income (1,000)	Median Individual Income (1,000)
Total						
Korean	9,761	19.8%	29.9%	50.3%	80	40
Filipino	22,941	12.9%	32.0%	55.2%	99	40
Chinese	19,456	18.7%	38.3%	43.1%	95	45
Indian	19,171	21.6%	50.2%	28.3%	115	62
1st Generation						
Korean	6,086	18.2%	25.7%	56.1%	72	38
Filipino	15,915	11.1%	32.3%	56.6%	98	40
Chinese	12,970	15.6%	37.6%	46.9%	87	40
Indian	15,862	20.7%	51.6%	27.7%	115	65
1.5 Generation						
Korean	2,166	23.3%	36.0%	40.7%	95	47
Filipino	2,663	17.1%	32.5%	50.4%	102	41
Chinese	1,164	24.2%	35.2%	40.6%	97	45
Indian	1,127	26.2%	41.8%	31.8%	121	52
Native/U.S. Born						
Korean	1,509	21.5%	38.2%	40.3%	96	42
Filipino	4,363	16.8%	30.5%	52.7%	100	40
Chinese	5,322	25.0%	40.7%	34.3%	112	55
Indian	2,182	25.3%	44.3%	30.3%	115	50

Notes: 2007-2011 US Census American Community Survey Data. Restricted sample to persons between the ages of 18 through 64 and worked 30 or more hours per week. Analyses based on those full-time workers who reported occupational type³.

Access to Healthcare and Health Insurance

Working in any tertiary ethnic economy is not optimal due to the very informal rules in which employers and employees operate and most importantly because benefits that are traditionally provided to employees in the mainstream economy—including

³ Analyses generated but not included in Min, P.G. & Kim-Lu, D. (in press). Do Second-Generation Koreans Inherit Their Parents' Businesses? Book Chapter in *Second Generation Korean Experience in North America*. Lexington Books. Forthcoming November, 2014.

health insurance, paid vacation, sick days, and retirement funds—are nonexistent. Several studies in the Health Services Research literature on Koreans have found that by far the leading barrier to access to healthcare is the lack of employment-based health insurance (Brown et al., 2000, 2001; Carrasquillo, Carrasquillo, & Shea, 2000; Hill et al., 2006; Jang, Kim, & Chiriboga, 2005; Jang, Chiriboga, & Okazaki, 2009; Jo, Maxwell, Yang, and Bastani, 2010; Kim, 2004; Ryu et al., 2001, 2002; Shin, et al., 2005). Ryu et al. (2001), Ryu, Young, and Kwak (2002) and Kim (2004) attribute low rates of insurance to high rates of self-employment. It is challenging for the uninsured to purchase health insurance due to high premiums. According to Kim & Yoo (2007), many Koreans include working poor families who often do not qualify for public health insurance programs, such as Medicaid, but yet cannot afford private health insurance. Another study examining the social determinants affecting completion of hepatitis B vaccination among Korean immigrant children in Chicago by Kim (2004) found that approximately 70% of the sample was uninsured ($N=116$). The children from working poor families with incomes over \$2500 per month were more likely not to have completed the immunization schedule than children from families with lower incomes. The working poor appeared to face more financial barriers because it is more difficult for them to afford private insurance, and they are unlikely to qualify for public insurance. Because self-employed Americans must pay insurance with after-tax income, the effective price is much higher for them (Skinner, 2009).

Other prominent barriers to access to healthcare for Koreans include severe language barriers (Donnelly & Kim, 2008; Han et al., 2000; Jo et al., 2010; Moon et al., 1998; Shin et al., 2005; Sohn, 2004); lack of understanding of the healthcare delivery

system (Donnelly & Kim, 2008; Kim & Yoo, 2009; Moon, Lubben, & Villa, 1998), social stigma (Ahn, Abesamis-Mendoza, Le, Ho-Asjoe, & Rey, 2007), lack of understanding of public health insurance eligibility due to fear of being seen as a public charge and, therefore, subject to deportation (Jo et al., 2010; Kim & Yoo, 2009). There are two notable items for discussion here. First, it appears that language barriers do not decrease with higher acculturation levels as one would logically expect (e.g., length of stay in the U.S). Sohn (2004) found that most of the elderly sample of the 2000 Korean American Health Survey had severe language barriers even though they reported to have lived in the U.S. for more than 20 years. In many cases, individuals were linguistically isolated, meaning that they lived in households where no single person spoke English and were, therefore, less likely to speak English themselves.

Second, of notable mention is that Koreans not only have low rates of employer-based and private insurance but also possess low rates of public health insurance. Brown et al. (2000) analyzed 1995 and 1996 National Health Interview Surveys and found that Medicaid coverage is generally low among Asian Americans, including Koreans with approximate only 1% of their population participating. In their California-based study, Kim and Yoo (2007) found that one third of the sample ($N = 268$) was uninsured and Korean immigrants, who otherwise would be eligible for programs such as Healthy Families, tended not to apply out of fear that seeking care would jeopardize pending immigration applications or citizenship status.

Some studies have also indicated low public health insurance rates even among the most vulnerable groups such as the elderly. Sohn (2004) analyzed data on Korean elderly collected from the 2000 Korean American Health Survey administered in the Los

Angeles area and found that almost one third of the older sample was uninsured (65 and older) ($n = 208$). Almost 70% of the sample rated their health status as fair or poor.

Considering that those aged 65 or older are eligible to receive health insurance coverage from their previous employers, Medicare, or Medicaid, these rates of uninsurance among the Korean elderly are of great concern. More specifically, Donnelly and Kim's (2008) study on access to mental healthcare for the Korean elderly ($N = 112$) found that they were unable to access the healthcare system due to lack of insurance, lack of knowledge of the healthcare system, and severe language barriers. Scholars such as Moon et al. (1998) who examined the awareness and utilization of community long-term care services by elderly Koreans and non-Hispanic white Americans found that older Koreans had extremely low levels of awareness and utilization of long-term health and social services both relative to the Hispanic population.

Regardless of the critical health needs and vulnerable age groups, it is clear from the studies discussed above that Koreans as a whole face significant barriers to accessing healthcare services because of their high participation rates in the ethnic economy as small business owners and employees. Although many factors affect health status, the evidence in the Health Services Research literature suggesting that Koreans' participation in the ethnic economy has the most significant impact on health insurance and lack thereof is quite compelling. Other key barriers to obtaining health services discussed in this section, such as severe language barriers and lack of knowledge of the healthcare delivery system and public health insurance eligibility, also effectively diminish their ability to utilize preventive services and medical treatments that are likely to reduce their burdens of disease and contribute to improved health status. Koreans possess the lowest

utilization of preventive screenings across cancer types (Ahn et al., 2007; McCracken et al., 2007).

Moreover, the majority of the existing studies on access to healthcare and Koreans do not put into context the overall health needs of this community, especially in a holistic manner. Recognizing this gap in the Health Services Research literature, the following section discusses Koreans' health disparities and needs. The next section covers several studies that examine Koreans' physical and mental health needs, underscoring a truly alarming fact about Koreans' access to healthcare and utilization: they tend to underutilize healthcare services more than other ethnic minorities, despite having significant health risk factors (Kuo & Porter, 1998; Ryu et al., 2001). Therefore, establishing a solid understanding of the health disparities and needs of this community can help generate a sense of urgency for the implementation of targeted interventions that will improve access to healthcare so these vulnerable populations can utilize the healthcare services they need.

Health Disparities and Needs

Koh and Koh (1992) conducted one of the first studies on health issues among Koreans. These scholars found that while Koreans have lower overall mortality rates than the general U.S. population, as an ethnic group, they have specific health needs with respect to stomach cancer, liver cancer, hepatitis, mental health, and other access to healthcare issues, such as lack of health insurance coverage. A description of available studies by major disease type, below, provides a holistic view of the health disparities and needs of the Korean community.

Cancer. Lung cancer is by far the most common cause of cancer incidence among Korean men (Miller, Chu, Hankey, & Ries, 2008). Both Korean men and women have high rates of liver, stomach, and colorectal cancers in relation to other racial groups and among Asian American subgroups (Bateman et al., 2009; Koh & Koh, 1992; Kolonel, 1996). According to Koh and Koh (1992), rates of liver and stomach cancers among Korean men are five to eight times higher than among white men. Korean males experience up to a five-fold increased incidence of stomach cancer compared to the majority of white Americans (Kolonel, 1996). Trend data from the California Cancer registry and Surveillance Epidemiology and End Results indicate that liver cancer ranks among the top five most common cancers among Korean men and women (Bateman et al., 2009).

Although stomach cancer incidence among Asians declines with immigration to the U.S., incidence among Koreans as well as the Japanese and Vietnamese surpasses those other racial/ethnic groups in the U.S. Stomach cancer was among the top five most common malignancies for Korean men and women. Incidence was nearly twice as high in Koreans as in any other population (Bateman et al., 2009). Additionally, trend data from the California Cancer Registry and Surveillance Epidemiology and End Results show that from 1988 to 2001, colorectal cancer incidence increased among Korean men and women (Bateman et al., 2009).

According to Lee, Fogg, and Sadler (2006), among Korean women, breast cancer is the most common cause of cancer morbidity and can be attributed to the fact that Korean women have the lowest rates of cancer screening and early detection rates among all ethnic groups in their study. Han et al. (2000) found that Korean women are more

likely to be diagnosed at a later stage of the disease and, as a result, have higher rates of mortality. This is unfortunate because routine preventive breast healthcare screenings can reduce breast cancer mortality by 40% among women 50 and older (White, Urban, & Taylor, 1993). Han et al. (2000) found that Korean women in an unidentified Southeastern U.S. city underutilized preventive care, such as breast cancer screening, clinical breast examination, and mammograms. Perceived barriers consisted of language, cost, and discomfort resulting from procedures. Language was the strongest barrier. Similarly, Lee et al. (2006) examined the same breast cancer preventive healthcare services in Cook County, Illinois, and found that although rates were improving, the utilization rate was still significantly lower than the national rate. These scholars found that having a primary source of care and being married were strongly related to all these three measures of cancer screening. Furthermore, Sarna, Tae, Kim, Brecht, and Maxwell (2001) highlight that among Korean women, participation in cancer screening are low regardless of their acculturation levels (i.e., length of time in the U.S.). Rates of cervical cancer are particularly high for Korean women as well (Bateman et al., 2009).

Lastly, there is evidence that colorectal cancer rates are particularly high among Koreans. In their comparative study examining how Korean Americans differ from Korean natives from South Korea in their approach to healthcare, Oh, Kreps, and Jun (2013) found that colon cancer rates were 56% higher for Korean Americans than their native counterparts. This study found that Korean Americans have significantly low screening rates for cancer and lack knowledge and information regarding chronic diseases, with limited access to health-related information as one of the core reasons for the gaps in knowledge. In particular, immigration status had a profound influence on

Koreans' health information seeking behaviors. These scholars found that increasing the availability of reliable and valid health information from printed Korean language magazines or newspapers are likely to have a positive influence on increasing awareness and promoting screening behaviors among Koreans.

Cardiovascular Disease and Related Chronic Diseases. A few studies have shown much higher rates of cardiovascular disease. For example, a study of Koreans ($N = 761$) in Maryland showed one third of the sample had hypertension (Kim, Kim, Juon, & Hill, 2000). What was alarming in this study was that only 40% of those with hypertension were taking medications. Another study by the same author also based in Maryland ($N = 205$) found that two thirds of their Korean elderly sample had multiple cardiac risk factors, including high blood pressure (71%) and cholesterol (53%). Besides these two leading risk factors for cardiovascular disease, other factors included being overweight (43%), having a sedentary lifestyle (24%), diabetes (18%), and smoking (7%). Another study by Ahn et al. (2007) finds that utilization of cardiovascular disease preventive screenings is low among Koreans. For instance, while 74% of their sample ($N=100$) received a check-up for high blood pressure, with only 34% receiving one check-up within the last year. They found lower utilization rates for cholesterol screening, with 66% receiving one, with only 28% receiving one within the last year.

Mental Illness. Mental illness is common among Koreans and has been well documented in the Health Services Research literature. Depression in Korean culture is often referred to as “hwa-byung,” which translates into anger sickness. The condition consists of suppressed anger and somatic symptoms (Pang, 1990; Bateman et al., 2009). Jo et al. (2010) conducted a study of Korean health by interviewing numerous leaders in

Korean churches in the Los Angeles area and found that psychological needs were more urgent than Koreans' physical health needs because of the financial and social hardships they face as immigrants. The Korean church leaders explained that over time stressful issues common to immigrant life contribute to "...depression, domestic violence, substance abuse, suicide, and even homicide..." (Jo et al., 2010, p. 159). Common health-related issues among their congregations included "...cancer, heart disease, stroke, high blood pressure, diabetes, lack of exercise, and poor diet" (Jo et al., 2010, p. 159).

In addition, there are numerous studies on mental health that focus on Korean women and the elderly. For Korean women, studies have observed increased depression as well as domestic violence that stem from the increasingly demanding dual roles women are expected to play in meeting both cultural and occupational expectations. Traditionally, Korean women play the role of caregiver in South Korea. Korean men are used to being in control and expect women to be their subordinates. However, gender role expectations change when Korean women enter the U.S. workforce by participating in the husband-wife coordination typical in Korean small businesses or through other jobs in the ethnic economy take on all the domestic responsibilities, including housework and child care (Min, 2006). This pressure creates significant stress and conflict in the Korean family and has been found to increase the occurrence of mental illness in this community (Min & Kim, 2011; Rhee, 1997). Rhee (1997) in her examination of the relationships among acculturation, education level, and other social determinants on the level of depression of Korean married women found that the level of depressive symptoms were highly correlated to their level of labor participation, the extent of their domestic responsibilities, multiple-role strain, and level of acculturation.

The other group that is greatly impacted by mental illness are the Korean elderly (Donnelly & Kim, 2008; Jang et al., 2009; Yi & Tidwell, 2005). Donnelly and Kim (2008) studied access to mental healthcare among the Korean elderly ($N = 112$) and maintain that levels of depressive symptoms among this particular group are more severe than other Asian American subgroups. The Korean elderly sample were reluctant to seek mental healthcare due to the stigma attached to mental illness, their lack of familiarity with U.S. culture, family loyalty, and language problems. Of particular concern is that the study found that a majority of the sample could not access mental health services when they experienced depression or suicidal thoughts because they lacked insurance, lacked knowledge of the U.S. healthcare system, or had severe language barriers. Similar findings were highlighted in a study conducted by Jang et al. (2009). He conducted a survey ($N = 236$) targeting Korean young adults and elderly living in Florida, for the purposes of comparison. These scholars found that both age groups had prominent mental health issues and were not accessing mental health care services likely due to high rates of uninsurance. Contrary to some of the findings from Donnelly and Kim (2008), Jang et al. (2009) argue that the notion that Koreans do not utilize mental health services because there is a stigma around the use of mental health services is misplaced; rather lack of health insurance in accessing mental health services is the most salient factor.

Domestic violence appears to be pervasive in the Korean community as well. Song (1996) conducted a survey based on a non-random sample ($N = 150$) and found that approximately 60% of the respondents (married or divorced women) had been battered by their husband/partner. Another survey conducted by Yoshioka, Dang, Shewmangal, Vhan, and Tan (2000) observed a cycle of violence among Korean American families –

approximately 80% of Korean respondents received some form of physical discipline on a regular basis when they were growing up.

In sum, the previous section suggests that Koreans have many physical and mental health needs that are of great concern. Despite its fast-growing population and contributions to the U.S. economy, it is truly unfortunate that this population as a whole is more likely to be diagnosed at late stages of several types of cancer—such as breast, cervical, and colorectal cancers—diseases that can be detected in early stages with routine screenings and highly treatable in early stages. The studies discussed in this chapter help underscore the important notion that Koreans’ underuse of healthcare services does not imply that they have fewer physical and mental health needs but rather, the lack of health insurance coverage as well as other salient structural and cultural barriers (e.g., cost, severe language barriers and lack of knowledge of the healthcare delivery system) make it impossible to obtain care and are likely to result in either delayed or foregone care (Ryu et al., 2001).

In light of these severe barriers including lack of health insurance coverage, how do Koreans take care of their health needs? The last section briefly describes a few prominent strategies to addressing health needs among Koreans.

Fragmented Approach to Healthcare

In the absence of health insurance coverage, common strategies to managing health may include the utilization of traditional Korean medicine, accessing healthcare services provided by the safety net including free clinics offered by faith-based organizations, and medical tourism. Of particular importance within the Korean community is the use of traditional medicine, known as “Hanbang”. Traditional medicine

is strongly centered on the idea of prevention and common treatments that include acupuncture, herbal medicine, moxibustion, cupping and coin rubbing (Bateman et al., 2009). A study of Korean elderly in Los Angeles County by Pourat, Lubben, Wallace, and Moon (1999) found high rates of traditional medicine utilization, with 42% of their sample ($N = 223$) utilizing traditional medicine within the past year. Furthermore, Kim, Han, Kim, and Duong (2002) in their study of traditional medicine utilization among Korean elderly in Baltimore, Maryland, highlight the wide range of healthcare services that are utilized among this population, including Western healthcare services, the traditional Korean medicine or a combination of both. Considering that the elderly are likely to be covered under Medicare, it is not surprising that most of their sample ($N=205$) depends on Western medicine (54%), some depend on both Western and traditional medicine (26%), only a small portion of the sample depend on traditional medicine (4%), and some do not utilize healthcare at all (4%). Scholars such as Kim and Chan (2004) find that cultural factors such as philosophical congruence greatly influence traditional medicine utilization among Koreans. Participants felt that traditional medicine complemented their "...personal values, world views, spiritual/religious philosophies, or beliefs regarding the nature and meaning of health and illness" (Kim & Chan, 2004, p. 325).

Whereas traditional medicine may be preferred by Koreans because it is more culturally and linguistically competent than Western medicine, some scholars have found that there are harmful effects related to this type of care. For instance, the reliance on traditional medicines can delay sick patients from seeing a Western practitioner in a timely manner, seeking help as a last step that one takes for diagnosis and/or prescription

(Zhan, 2003). More problematic is that often, there is no coordination of care between traditional and Western doctors and practitioners. Bateman et al. (2009) maintain that communication is essentially blocked off by both patients and providers, which can create issues in patient care because traditional medicine is not always the best type of treatment for chronic diseases. Korean patients may share their Western medicine treatment experiences with Hanbang providers, but they often do not talk to Western physicians for fear that Western physicians will ridicule them or discourage them from continuing with the traditional medicine treatment.

There is some evidence of the utilization of medical tourism among Koreans in the Health Services Research literature. A study by De Gagne, Oh, So, and Kim (2014) on the healthcare experiences of Korean immigrants ($N = 125$) living in North Carolina found that close to 50% of their sample had no health insurance because of high costs (75.8%), medical tourism (22.6%), and lack of information (6.5%). In their examination of Korean women's perceptions about healthcare services including routine physical examinations and preventive screening services offered in South Korea versus the U.S., Oh, Jun, Zhou, and Kreps (2014) found that focus group participants ($N = 34$) have better perceptions of the use of these healthcare services in their home country. These scholars observe that participants are willing to travel back to South Korea to obtain these services even in light of having to pay the extra travel costs, as well as possibly take on the risks that go along with delaying healthcare. Taking on these risks are worthwhile since it would provide them with an opportunity to visit their homeland and ensure linguistically and culturally competent services. Lastly, in his study of the health status and health needs of Korean elderly in Los Angeles, Sohn (2004) found that due to the cost of

medications, close to one third of the sample ($n = 208$) had purchased medications out of the country. Almost one third of the older sample was uninsured (65 and older). This finding is of great concern because most are eligible for Medicare and/or Medicaid.

The Korean case is quite unique in comparison to the other Asian American subgroups examined in this study since Koreans have such higher rates of self-employment, which clearly contributes to their low health insurance coverage rates. As the previous section demonstrated, Koreans have their own approach to managing their health needs in a landscape of limited resources. However, I stress that Koreans' fragmented approach to healthcare is ineffective and provides relief in the form of short-term solutions.

Cambodians

Immigration History

Cambodian (also known as Khmer) immigration first began in very insignificant numbers in the 1950s. Most Cambodians immigrated following the Vietnam War, as refugees of the civil war led by the Khmer Rouge regime, whose sole purpose was to erase traditions, elderly people, and family life for the purpose of creating a newly industrialized state. Many Cambodians who survived the genocide sought refuge in other countries, including the U.S. Bateman et al. (2009) identify two major waves of immigration: the first during the period from 1975 to 1977, which included more educated individuals; the second between 1978 and 1980, which included those less educated and less familiar with Western culture than previous refugees. With more political stability in Cambodia by the 1980s, immigration of refugees peaked and consequently declined after 1985.

Not surprisingly, an important factor unique to Southeast Asians, including Cambodians, is their refugee status (Hsu et al., 2004). Whereas the majority of other Asian Americans in the U.S. immigrated by choice, most Cambodian refugees were forced out of their countries of origin, and children were sometimes separated from their larger family units (Bateman et al., 2009). Because men were also systematically killed during the civil war, widows and female-headed households are common in the Cambodian refugee community. It is estimated that approximately 25% of the Cambodian families are headed by a single parent (Fernandez-Kelly and Portes, 2008).

Settlement Patterns

By 2000, a large percentage of Cambodians, approximately 41%, settled in California (U.S. 2000 Census, 5% PUM data). The Long Beach area of Los Angeles County has the largest Cambodian community. Lowell, Massachusetts has the next largest Cambodian community and is the first region in the U.S. in which Cambodians have settled. Koch-Weser, Liang, and Grigg-Saito (2006) indicate that Cambodians initially resettled in several cities and towns across the U.S. upon entry and eventually approximately 10% of the population relocated to Lowell, Massachusetts, near Boston's Chinatown. This area was attractive because there were many manufacturing jobs. Cambodians have established a strong presence in Lowell with temples and Cambodian-owned businesses. Lastly, Cambodians settled in Washington (8%), the third most heavily concentrated state.

Socioeconomic Status

Cambodians are not generally known to have low levels of socioeconomic status in light of their unique mode of incorporation as refugees, which provides easier access to

a series of government benefits and support (Fernandez-Kelly & Portes, 2008). Min (2006) highlights Rumbaut's observation that Cambodians' reception as refugees encompasses a different legal-political entry status, a status that facilitated access to a variety of public assistance programs to which other immigrants were not entitled. Through the Refugee Act of 1980, the U.S. government established special resettlement assistance programs to assist Cambodian refugees. In addition to welfare, housing, and health insurance assistance, resources to family sponsors, who were financially and personally responsible for the refugees, English and American culture training were provided with the goal to ensure their successful adaptation in the U.S.

However, it appears that while Cambodians have been given access to resources to jumpstart their new lives in the U.S., they continue to have one of the lowest rates of socioeconomic status among all Asian American subgroups and the overall U.S. population. In fact, Cambodians generally hold low-status jobs that are labor-intensive and menial. They are less likely than the general U.S. population to be employed in "management, professional, and related occupations." According to the U.S. Census Bureau (2007), out of 94,125 Cambodian civilians that are employed (16 years and over), only 19.8% of Cambodians are in management, professional, and related occupations; 19% in service occupations; 27% in sales and office occupations; 0.2% in farming, fishing, and forestry occupations; 6.6% in construction, extraction, maintenance, and repair occupations; and 27.3% in production, transportation, and material-moving occupations. Min (2006) found that approximately half of Cambodians were at the bottom of the occupational hierarchy, compared to only a third for the U.S. workforce as a whole and less than a fourth of other Asian American subgroups.

Cambodians most likely hold low-level jobs because, generally speaking, they have low levels of educational attainment and literacy rates (Bateman et al., 2009). Rumbaut (1989, 1991) explained that about 55% of Cambodians who immigrated to the U.S. come from rural areas and a vast majority (54%) were farmers and fishers in Cambodia. Their pre-immigration education levels were very low, averaging less than five years of education prior to arriving in the U.S. Due to low levels of educational attainment and occupational status, Cambodians are among the poorest of all Asian Americans. Cambodians have one of the highest rates of poverty with 54% of households living at or below 200% of the poverty line in 2000. More troubling is that among Asian Americans, Cambodian children are among the poorest and are more susceptible to living in poverty (Hernandez, Denton, & Maccartney, 2008).

Access to Healthcare and Health Insurance

There are a limited number of studies that focus on access to healthcare and Cambodians (Koch-Weser et al., 2006; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Wong et al., 2006; Yi, 2003). Opposite to what is observed among the Koreans, most studies on Cambodians suggest that health insurance coverage does not appear to be the most salient barrier that impedes their ability to access healthcare. For instance, a study of self-reported health among Cambodians in Lowell, Massachusetts by Koch-Weser et al. (2006) found that despite very high rates of health insurance, approximately 23% of the sample had to see a physician in the last 12 months but was unable to. Approximately 94% of the sample ($N = 381$) had some type of insurance (e.g., private insurance, Medicaid, Medicare), attributable to widespread access to healthcare in the community. Surprisingly, the most significant barrier to being unable to see a physician was lack of

transportation (45%), forgotten appointment (24%), and lack of time to go (16%). Also, the study found that English proficiency was highly correlated with the increased probability of reporting better health. Similarly, Marshall et al. (2005) found limited English proficiency, unemployment, low levels of formal education, and disabled or retired status as contributing factors for only 70% of their sample seeing a medical provider and 46% a mental health provider (Bateman et al., 2009). Another study by Wong et al. (2006) examining access to mental health services among Cambodians found the most salient barriers to be high cost (80%) and language (66%) (Wong et al., 2006).

On the other hand, Yi (2003) in her study of barriers to access to healthcare in Cambodian women based in Houston found that the lack of health insurance coverage was, in fact, a salient barrier to access to healthcare as well as other factors such as low income, low level of acculturation (i.e., length of stay in the U.S., language fluency), and communication barriers. This study found that actually almost one third of the sample had no form of health insurance due to lack of employer-based health insurance coverage and close to 32% did not have a regular source of care. Being employed and having higher levels of acculturation (i.e., length of stay in U.S. and language fluency) were highly correlated to access to healthcare. Similar to other studies on Cambodians and access to healthcare, one of the more notable findings of this study was the failure of communication. A majority of the sample (84%) indicated that “Understanding what the doctor/nurse is saying and doing” was a barrier as well as “Getting the doctor/nurse to understand you” (Yi, 2003, p. 346).

Another major barrier impeding Cambodians’ ability to access healthcare appears to be low levels of health literacy. In their study of Cambodians’ preparedness for cardiac

emergencies, Meischke et al. (2012) found that although most participants ($N = 667$) indicated 9-1-1 as the first response to a cardiac emergency, a third of the sample expressed that they would contact a friend or family member first instead. Many were aware of cardiopulmonary resuscitation techniques, however, knowledge and training in cardiopulmonary resuscitation was low. They found a strong correlation between higher levels of English proficiency and acculturation levels to predicting cardiopulmonary resuscitation knowledge, training, and intention to call 9-1-1. Low levels of health literacy were also found in a study of Cambodian, Laotian, and Vietnamese immigrants, which found that 94% did not have an understanding of what blood pressure is, and 85% did not have an understanding of how to prevent heart disease (Hong & Bayat, 1999).

In sum, studies on Cambodians help emphasize that health insurance coverage is only the start to improving access to healthcare. While Cambodians may have higher insurance coverage rates in most pockets of the U.S., it is evident they face many more challenges in the healthcare setting due to cost, severe language barriers, lack of transportation as well as their low levels of health literacy.

Health Disparities and Needs

Rumbaut (1989, 1991) found that because Cambodians stayed in refugee camps much longer than other Indochinese, they came to the U.S. with a significantly higher number of chronic health problems. As early as the 1980s, many studies consistently reported higher rates of both physical and mental health morbidity (Catanzaro & Moser, 1982; D'Avanzo & Froman, 1994; Gong-Guy, 1987; Meindhart, Tom, Tse, & Yu, 1985; Molina, Molina, Molina, 1988; Rumbaut, 1985; Welaratna, 1988). According to Pickwell (1999) Cambodians were,

...more likely to have an increased incidence of tuberculosis infection, serologies positive for treponemal infections, multiple intestinal parasitic infestations, a high prevalence of anemia including hereditary hemoglobin E variant, blood smears positive for malaria, hepatitis B surface antigenicity, and more complaints suggestive of what medical professionals consider to be psychosomatic (p. 166).

Furthermore, Pickwell (1999) explained that “Unable to successfully cope with all the forced social change that has occurred to them and unable to express their distress verbally, many of the refugees have developed intractable illness complaints” (p. 165). Consistent with Pickwell’s observation, a few studies have documented low levels of self-perceived health. According to a study in Oakland, California, Gong-Guy (1987) found that a mere 5.8% of Cambodians ($N=589$) reported themselves as healthy. In a more recent study, Wong et al. (2011) found that 90% of Cambodians ($N=511$) in a Long Beach, California, population perceived themselves as having “fair” to “very poor health.” They compared their Cambodian sample to the general population by analyzing data from the California Health Interview Survey and found that Cambodians had much lower health status than both the general population and other Asian American subgroups. More shocking is that nearly 70% of the sample met criteria for probable disability. Their study concluded that Cambodians possessed demographic attributes that make them more susceptible to poor physical health status. More specifically, the individuals with poor health status were “...likely to be female, urban residents, impoverished, and older” (Wong et al., 2011, p. 879). Lastly, Koch-Weser et al. (2006) found similar results in their study of self-reported health among Cambodians in Lowell, Massachusetts. Overall, 44% of the sample reported fair to poor health. Likely to report fair to poor health were females, older, unemployed due to disability, less acculturated, and who needed to see a doctor in the past 12 months but were unable to do so.

Moreover, the following section discusses in detail studies that have documented the health disparities and needs that exist among Cambodians, by major disease type. These studies emphasize Cambodians' significant underutilization of preventive health services regardless of low levels of self-reported health status and high rates of health insurance coverage.

Cancer. For Cambodian men, the highest cancer incidence is lung cancer (Miller et al., 2008). This high incidence of the disease is likely linked to the high rates of smoking among Cambodians, which has roots from the era of the civil war. During the genocide of Cambodians in the 1970s, prisoners of the Khmer Rouge were offered cigarettes as a way to reduce hunger (Bateman et al., 2009). Approximately 71% of Cambodians are still smokers (Bateman et al., 2009). Also, Cambodian men are particularly at risk for liver cancer in relation to other ethnic groups in the U.S. (Kolonel, 1996).

Many studies have focused on hepatitis B infection among Cambodians because of its prevalence among this subgroup and high risks for the disease to cause liver cancer and other serious illnesses (Grytdal et al., 2009; Nguyen et al., 2007; Taylor et al., 2012; Taylor et al., 2013). Hepatitis B infection is a highly infectious disease, which can be transmitted during pregnancy, sexual intercourse, or through close household contact (Nguyen et al., 2007). Taylor et al. (2012) explained that this disease is quite dangerous because although some are affected by acute hepatitis, which is usually followed by immunity, a substantial proportion of the individuals exposed to the disease become chronically infected, meaning that they are highly infectious to others and have higher risk factors for "...liver cancer, chronic active hepatitis, and cirrhosis" (p. 31). Early

Centers of Disease and Control (1991) data indicated that approximately 60% of Southeast immigrants had serological evidence of past hepatitis B infection and 40% remained susceptible to the disease. More recent studies continue to document high rates of infection, vaccination, and low rates of serological testing. Several studies have found very low rates of hepatitis B testing. For example, a few studies found similar results, indicating that only about half of their samples had been serologically tested for hepatitis B (Grytdal et al., 2009; Taylor et al., 2012; Taylor et al., 2013).

Although there is reason to believe that Cambodians are highly susceptible to this disease, awareness of its symptoms, prevalence, and preventive measures—such as vaccination and serological testing—are still lacking. A study based in Seattle, Washington, by Taylor et al. (2002) found that hepatitis B knowledge among Cambodian women was very low with only 56% of participants indicating they knew about the disease. Only 38% of women in the sample knew whether they had previously been serologically tested. What is overwhelmingly shocking is that the majority of the sample was not aware that asymptomatic individuals have the ability to spread hepatitis B as well as that the disease could be contracted via sexual intercourse and worse, the majority of the women were not vaccinated (Taylor, Jackson, Chan, Kuniyuki, & Yasui, 2002).

There are also a number of studies that highlight the underutilization of preventive health services, such as breast and cervical cancer screening, among Cambodian women. According to the American Cancer Society (2003), breast and cervical cancers are the leading cancers among Cambodian women. A major factor explaining why Cambodian women have high rates of cervical cancer are correlated to their low rates of preventive screening services utilization (Ho, 2011; Kelly et al., 1996; Nguyen, 2006; Taylor et al.,

1999; Yi, 1996). Ho (2011) highlights that cervical cancer rates among Cambodian women in comparison to Caucasian women are twice the rate, making it one of the most common types of cancer for this Asian American subgroup. This scholar finds that cultural barriers as well as structural barriers such as cost have an impact on the utilization of cervical cancer preventive screening services. For instance, he finds that some believe they will not get the disease because it is an “American disease,” whereas some are concerned about costs of obtaining a Pap test. More acculturated and English literate Khmer women with regular sources of care are more likely to utilize cervical cancer preventive services (Ho, 2011).

Relatedly, Nguyen et al. (2006) examine the suitability of community health navigators for breast and cervical cancer screening among Cambodians and Laotians ($n=1823$). These scholars observed that community health navigators are essentially bridges between a community and healthcare services, providing assistance at each step of the patient’s experience. Their study revealed that many Cambodians in their sample had unmet cancer needs that could be met through the assistance provided by community health navigators. Their findings show good evidence that future programs with underserved ethnic communities can greatly benefit from the use of community health navigators.

Cardiovascular Disease and Other Related Chronic Diseases. Rasbridge (1997) found that many Dallas-based Cambodians increasingly presented with hypertension, coronary disease, and diabetes. Stroke rates are high among Cambodians, approximately 64 individuals per 1000 individuals experience a stroke, which is much higher than the overall U.S. rate of 27 individuals per 1000 individuals. In particular,

diabetes appears to be an emergent health crisis for Cambodian communities in the U.S. (Bateman et al., 2009). However, there are very few studies that provide reliable data on diabetes and its associated risk factors for these communities. One of the few studies that have been conducted on this topic has estimated that approximately 13% of Cambodians have diabetes (Kinzie et al., 2008). The famine and malnutrition Cambodians' experienced during the civil war has been identified as a possible link to the development of diabetes later in life (National Diabetes Education Program, 2006).

Mental Illness. The mental health consequences of the trauma suffered by Cambodians are well documented (Carlson & Rosser-Hogan, 1993; Gong-Guy, 1987; Gong-Guy, Cravens, & Patterson, 1991; Hinton et al., 2000; Meindhart, 1985; Marshall et al., 2005; Mollica, Poole, & Tor, 1998). Cambodian refugees experience more psychiatric disturbances than other Southeast Asian American subgroups, including post-traumatic stress disorder (Mouanoutoua, Brown, Cappelletty, & Levine, 1991). One study by Grant et al. (2006) found that 62% of their sample of first-generation Cambodian refugee adults in Long Beach, California, experienced post-traumatic stress disorder and as many as 51% had major depression. Another study based in Portland, Oregon, found that 90% of the sample had post-traumatic stress disorder (Kinzie et al., 1990). More surprisingly, studies that focus on acculturation and mental health for Cambodians have shown that the occurrence of mental illness does not decrease even with the presence of higher acculturation levels (Carlson & Rosser-Hogan 1993; Gong-Guy, 1987; LaVeist & Isaac, 2012). For instance, LaVeist and Isaac (2012) highlight high rates of post-traumatic stress disorder, depression, anxiety, and dissociation even among Cambodians that had been in the U.S. for more than 10 years. This particular finding demonstrates that

Cambodians are still struggling to overcome multiple physical and psychological effects of post-traumatic stress disorder, even after many years residing in the U.S.

Like Koreans, domestic violence is also pervasive in U.S. Cambodian communities. Results from the Asian Task Force Against Domestic Violence Survey in Massachusetts indicated that approximately 47% of Cambodian respondents knew a woman who has been physically abused (Yoshioka et al., 2000). A substantial portion of Cambodian respondents (70%) reported receiving some form of physical discipline on a regular basis when they were growing up.

Multilevel Approach to Healthcare

In addition to accessing Western medicine, traditional concepts of folk healing are quite popular among Cambodians. Sickness is often characterized as coming from the will of gods, spirits or karma and therefore the practice of medicine is inseparable from religion (Taylor et al., 1999). Common treatments include acupuncture, coin rubbing, cupping, herbs, pinching, and rituals by spiritual practitioners including Shamans (Yi, 2003). Bateman et al. (2009) explains that Shamans perform "...ceremonies to ask for forgiveness from the gods and ancestors and chase the evil spirits away...." (p. 287).

Cambodians' high levels of health insurance coverage allow them to utilize Western medicine in conjunction with traditional medicine, services that are more culturally familiar to them and much easier to access than Western medicine. Cambodians' help-seeking behavior can be characterized as "multilevel" in nature: essentially they have "...melded all available caring components into a distinguishable multi-tiered system that is acceptable to them, but often difficult for their American providers to understand, accept, and work within" (Pickwell, 1999, p. 166). Pickwell

finds that Cambodians have developed a multilevel approach to healthcare due to their suboptimal experiences with Western medicine. She explained that,

Failure to heal using scientific medicine generates disappointment and prompts the refugees to relentlessly pursue various treatment modalities within the indigenous and professional systems available to them (p.178).

Most of her study's participants perceived Western medicine as ineffective and also expressed dissatisfaction with their experiences with the fragmented approach of healthcare delivery in the U.S. For example, participants were dissatisfied with logistical inconveniences such as long waiting times, lack of transportation, dealing with interpreters, and bill errors.

In sum, the Cambodian case is quite unique in comparison to the other Asian American subgroups examined in this study since Cambodians have been given many resources upon their arrival in the U.S. but are still facing significant barriers accessing health and mental services, possess very low self-perceived health status, and have high incidences of many preventable infectious and chronic diseases as well as mental illness. Wong et al. (2011) sum it up by stating that, "clearly, existing broad-based policies on refugee settlement have been less effective than desired on improving the health of U.S. Cambodian refugees" and rightly point out that "...the reasons underlying the distinctly poor health of Cambodian refugees are not well-studied" (p. 6). Existing studies on Cambodians do appear to unanimously agree that their traumatic backgrounds and ineffective resettlement in the U.S. are two social forces that are significant factors that contribute to their poor health status.

South Asians: Bangladeshi and Pakistani Americans

Due to the relatively recent immigration history and small size of these populations in the U.S., very limited number of studies on Bangladeshis and Pakistanis exist in the Health Services Research literature. The limited number of studies that exist tend to bundle South Asian American subgroups, making it almost impossible to disaggregate or identify any findings specific to individual subgroups (Raj & Silverman, 2002; Tillin et al., 2005). Fortunately, there is increasing recognition within the Health Services Research literature of the importance of ethnic-specific data that are needed to develop more culturally competent interventions. South Asians consist of various ethnicities including Bangladeshis, Indians, and Pakistanis as well as Sri Lankans, and Nepalese that vary sharply in terms of socioeconomic status, linguistic competency, and other factors (Bateman et al., 2009). Therefore to truly understand the barriers they face in accessing healthcare in the U.S, studies must be conducted at the subgroup level.

Moreover, because of this limitation, this study will discuss the Bangladeshi and Pakistani subgroups together in one section since the majority of the information originates from the same studies.

Immigration History and Settlement Patterns

As of the latest U.S. census (2010), there were approximately 3 million South Asian immigrants living in this country. Highly trained professionals comprised the first wave of immigration in the 1960s and 1970s because immigration laws gave preference to highly trained professionals. On the other hand, the second wave of immigration in the 1980s consisted of many working class and poor South Asians (Joshi, 2006).

According to Patel, Rajpathak and Karasz (2012), Bangladeshi immigrants are “...one of the newest and fastest growing...” South Asian subgroups in the U.S. (p. 768). The Bangladeshi population exponentially grew 350% from 1990 to 2000. As of the 2010 U.S. census, approximately 125,000 Bangladeshis were living in this country, with approximately 7% of Bangladeshis residing in California; 49% in New York; 5% in New Jersey; 6% in Texas; 33% in other states (Min, 2006). In New York State, there are high numbers of Bangladeshis residing in parts of the Bronx, Westchester, and Parkchester neighborhoods (Patel, Rajpathak & Karasz, 2012). Kibria (2011) observes that sex ratios, the number of men per 100 women among Bangladeshis is disproportionately high. This is particularly true among the Bangladeshi because single migration of men is dominant in this group (Min, 2006). Moreover, based on 2000 census estimates, Dutta and Jamil (2013) indicate that even at a conservative population growth rate of 20% every year, the Bangladeshi population is expected to increase to 200,000 by 2020.

In terms of the Pakistani community, approximately 393,000 Pakistanis were living in the U.S as of the 2010 U.S. census. The majority of Pakistanis, 21%, live in New York and the rest in California (13%), New Jersey (8%), Texas (12%), and various other states (46%). Min (2006) observes that there are some signs of a possible decline, at least in the immediate future, in rates of Bangladeshi and Pakistani immigration and settlement in the U.S. There have been reports of Pakistanis and Bangladeshis leaving the country following the aftermath of 9/11 to other receiving countries, in particular to Canada (Sachs, 2003).

Socioeconomic Status

Both Bangladeshi and Pakistani subgroups have very low socioeconomic status. According to the 2000 U.S. census, 44% of Bangladeshi households, which on average consist of 4.2 persons, lived on less than \$35,000 total household annual income. Per capita income for Bangladeshis residing in New York was \$10,479, with approximately one third of all Bangladeshis living below the poverty line. More recent figures also corroborate low socioeconomic status. Based on analyses of the American Community Survey (2005-2007) 2-year estimates from the U.S. Census Bureau, the Asian American Federation (2009) found that Bangladeshis were some of the poorest residents in New York City. Jones (2011) explains that low socioeconomic status among the Bangladeshis is the norm because most are low-wage workers in service-related jobs in restaurants, taxi companies, and retail stores. In a study of Bangladeshi immigrants in the New York City area, Dutta and Jamil (2013) found that these jobs are temporary and therefore did not provide any benefits, including health insurance coverage. Lastly, my analyses of the American Community Survey 2007-2011 5-year estimates indicate that the self-employment rate among Bangladeshis is slightly higher than non-Hispanic native-born whites (10.2%), at 12.6%.

Among foreign-born Pakistani men, Min (2006) finds that the percentage of workers who are self-employed is higher at 17.1%. More recent figures include my own analyses of American Community Survey 2007-2011 5-year estimates, indicating a slight decrease in self-employment to 16.2%. While self-employment rates may not be as high as the Koreans (20.6%), Pakistani rates are relatively high, as rates of self-employment

among South Asian Americans tend to be somewhat lower than those reported for non-Hispanic native-born whites at 10.2%.

Access to Healthcare and Health Insurance

Similar to the Cambodians, some studies have found that Bangladeshis and Pakistanis possess high levels of public health insurance coverage. For example, in their study of prenatal care for immigrant mothers living in Brooklyn, New York, McLafferty and Grady (2005) found that more than 80% of Bangladeshi ($n=304$) and Pakistani ($n=611$) women in their sample ($N=2000$) rely on Medicaid. However, although rates of public health insurance were quite high, the study found that their rate of low birth-weight infants was very high, especially for Pakistani mothers. Consequently, poor geographic access to prenatal clinics created massive travel time and cost barriers for these women. Many Pakistani women were unable to obtain the prenatal care they needed. Similarly, in their health needs assessment of a Bangladeshi community in the Bronx, Patel et al., (2012) found high rates of public health insurance coverage (91.6%). The Bangladeshis in their sample ($n=167$) was mostly composed of women (55.1%) who lived under the federal poverty level and possessed high limited English proficiency rates (90%).

In contrast to the results from the studies discussed above, other studies have found low rates of health insurance coverage. In their study of South Asian immigrants' conceptual models of health and disease in Chicago, Illinois, which included Asian Indians and Pakistanis ($N=75$), Tirodkar et al. (2011) found very low coverage rates – approximately 54% had no insurance coverage at all and only 18% had public health insurance. They also found low levels of self-perceived health status, with 23% indicating

that they did not consider themselves to be healthy. Similarly, one of the few studies of breast and cervical cancer screening that exists on South Asian women ($N=98$) in New York City by Islam, Kwon, Senie, and Kathuria (2006) found the lack of health insurance coverage (50%) and low educational attainment to be the most significant barriers. These scholars conducted face-to-face interviews ($N=98$) to closely examine socioeconomic demographic characteristics as well as cancer screening utilization patterns. Islam et al. found that more than one third of the sample of women had never a Pap test and of those who had one, only a little over half of them had the procedure done in the last 3 years; 30% of the sample aged 40 and over never had a mammogram, and of those who had one, little over half of them had the procedure done in the last 2 years; and almost 35% of the sample did not know about breast self-exams and never conducted one.

Nonetheless, limitations in these studies—including the tendency to group several South Asian subgroups in one study and the small sample sizes for the Bangladeshis and Pakistanis—make it difficult to assess whether the trend of low health insurance coverage is generalizable to the Bangladeshi or Pakistani subgroups. For instance, the study by Islam et al. (2006) only included a small sample of Bangladeshi ($n=13$) and Pakistani ($n=5$) women. Also, for the study by Tirodkar et al. (2011), low public health insurance coverage rates may be a result of stricter eligibility rules for programs in the Chicago, Illinois, area or higher socioeconomic status among Pakistanis living in this region.

Other prominent barriers to healthcare access for Bangladeshis and Pakistanis include occupational constraints, limited English proficiency, low levels of health literacy, and difficulty navigating the healthcare system. Dutta and Jamil (2013) provide significant observations on the role of occupational barriers using a culture-centered

approach to examine low-income Bangladeshi immigrants in New York City and their experiences with healthcare. They conducted in-depth semi-structured interviews ($N=20$) and found that Bangladeshi immigrants' experiences were deeply rooted based on their experiences with "inaccess." According to these scholars, "Structure becomes salient in terms of shaping how immigrants go about seeking health care, their use of health services and treatment options, and their likelihood of allocating limited valuable resources to taking care of their health" (p. 180). A majority of the sample worked in temporary jobs at local restaurants, construction, cleaning, taxi, and other low-wage and menial jobs that provided no health insurance. Many of the participants emphasized the role of structural constraints in access to healthcare. For example, due to these occupational constraints, these scholars also found that some Bangladeshis in their sample would ration healthcare visits or delay visits, often seeking care only if it was critical. According to Dutta and Jamil (2013),

The ability to access a hospital therefore is situated in contrast to the ability to work for the day and earn money to feed the family. From a resource-based standpoint, the resources expended in seeking care (in this case time) are rationed against the backdrop of other valuable resources (such as food) that one could procure with one's limited access as a low-income immigrant (p. 177).

Ultimately, for many Bangladeshis and other low-income immigrant groups, seeking healthcare services translates into loss of work wages, which not only impacts the worker's financial survival but his or her dependents as well. Lastly, consistent with the findings from the previous studies discussed in this section, Dutta and Jamil (2013) found that Bangladeshis also faced insurmountable barriers related to language, lack of communication resources and understanding of the healthcare delivery system, and too much time spent waiting for an appointment.

As with Koreans and Cambodians, there is also evidence among the Bangladeshi and Pakistani subgroups that severe language barriers greatly impact their ability to access to healthcare. According to the South Asian Americans Leading Together (SAALT) (2009) organization, approximately 50% of Bangladeshis and 30% of Pakistanis are limited English proficient. Bateman et al. (2009) found higher rates of limited English proficiency among their sample of Bangladeshi immigrants in New York City at 60%. Because many are limited English proficient, they rely on their family members to interpret or even avoid healthcare appointments entirely (South Asian Americans Leading Together, 2009).

Islam et al. (2012) also found high rates of limited English proficiency (92%) and low levels of health literacy of diabetes in their study that documents barriers faced by Bangladeshis accessing diabetes control and prevention services. They conducted both focus groups ($N=47$) and surveys ($N=169$) and found that the majority of the sample had annual incomes of less than \$25,000. Focus group participants indicated high levels of poor health status (67%) in comparison to survey respondents (32%). Some of the most salient barriers faced by this community included language and communication, navigating the healthcare system, and occupational barriers (i.e., low-wage, low-activity jobs). An important finding of this study includes identifying Bangladeshis' willingness to participate in community health worker programs that would promote positive behaviors, provide culturally relevant health information, facilitate social support, and assist them with navigating the healthcare system. Lastly, Patel et al. (2012) found that approximately half of the Bangladeshis in their sample ($n=167$) had incomes at or below the federal poverty level and the majority were limited English proficient (90%).

Approximately 45% of the Bangladeshi women in their study indicated never having a screening for cervical cancer such as a Pap smear.

Health Disparities and Needs

Due to the limited number of studies available on South Asian health disparities and needs, it is challenging to draw observations for Bangladeshis and Pakistanis. To my best knowledge, there are no comprehensive ethnic-specific studies for these subgroups that differentiate their diverse cultural backgrounds, health risk factors, and health status. The limited number of studies that do exist have found very low rates of breast and cervical screening; high rates of metabolic syndrome, diabetes, cardiovascular risk factors; high risk factors for oral, uterine, and ovarian cancers; and high rates of poor self-perceived health status. These conditions and risk factors indicate the critical need for early preventive interventions and health promotion. In the following section, I provide a description of available studies, by major disease type.

Cancer. Overall, among South Asians as a whole, Islam and Zojwalla (2002) have found higher rates of cancer for those that live in the U.S. in comparison to those that live in their native countries. These scholars attribute this variance to the fact that South Asians along with Asian Americans in general have lower screening rates in relation to other groups of color because they face many barriers in accessing healthcare. Barriers to screening they identified include lack of health literacy, education, and cultural beliefs and practices. Some data are available on the examined breast and cervical cancer prevention practices of Bangladeshi and Pakistani populations and generally they show very low rates of screening utilization.

Similarly, as previously discussed in the Access to Health Care and Health Insurance section, Islam et al. (2006) conducted face-to-face interviews ($N=98$) with South Asian women in New York City and found low rates of cancer screening utilization. These scholars found that more than one third of the sample of women had never had a Pap test and of those who had one, only a little over half of them had the procedure done in the last 3 years; 30% of the sample aged 40 and over never had a mammogram, and of those who had one, little over half of them had the procedure done in the last 2 years; and almost 35% of the sample did not know about breast self-exams and never conducted one. In addition, Patel et al. (2012) found that approximately 45% of the Bangladeshi women ($n=167$) in their study indicated never having a screening for cervical cancer such as a Pap smear.

According to Changrani, Cruz, Kerr, Katz, and Gany (2006), there is also a high prevalence of smokeless tobacco use among first-generation Bangladeshi and Indian immigrants ($N=138$) that may increase cancer incidence in these populations. These substances are known as “paan” and “gutka” and are very popular in their native countries, but regular use leads to oral cancer. Their study based in New York City found that 35% of their Bangladeshi sample consisted of regular users of paan, and users were more likely to report having knowledge that using paan would likely cause oral cancer. Paan use was more likely in less-educated Bangladeshi participants. Moreover, these scholars highlight the need to consider “...the cultural, epidemiological, and immigration-related factors that lead to cancer disparities in these communities” (p. 103). Similarly, Patel et al. (2012) found that 17% of their sample ($n=167$) chewed paan.

Miller et al. (2008) also finds that uterine and ovarian cancers are some of the most common cancers among Pakistani women. Pancreatic cancer is the fifth most common contributor to deaths among Pakistani males and prostate cancer is most commonly diagnosed among several Asian American subgroups, including Pakistani males (Bateman et al., 2009; Miller et al., 2008).

Cardiovascular Disease and Related Chronic Diseases. In their study of Bangladeshi men in the U.S., Rianon and Rasu (2010) examined rates of metabolic syndrome "...a combination of risk factors, i.e., dyslipidemia, glucose intolerance, high blood pressure and obesity," which is defined by the presence of at least 3 of these factors (p. 781). Close to 40% of their sample ($N=91$) based in Houston, Texas, had metabolic syndrome and 60% had high blood pressure. These scholars found self-rated health status to be highly correlated with metabolic syndrome.

As previously discussed in the Access to Health Care and Health Insurance section, Patel et al. (2012) study found high rates of cardiovascular risk factors, including diabetes, hypertension, and hyperlipidemia. Shockingly a huge portion of the sample, approximately 75% were either overweight or obese. Over half of the women reported fair to poor health and over 35% of them were identified as having possible risk of depression. Their sample of Bangladeshi women ($n=167$), 55.1% live under the federal poverty level, possess high rates of health insurance coverage (91.6%) and limited English proficiency (90%). Similarly, Islam et al. (2012) also found that their sample comprising focus groups ($n=47$) and surveys ($n=169$) had very low levels of health literacy of diabetes. Focus group participants indicated high levels of poor health status

(67%) in comparison to survey respondents (32%) and as a whole; the sample possessed very high rates of limited English proficiency (92%).

Cultural Approach to Healthcare

Like the Cambodians, traditional concepts of healing such as Ayurvedic and homeopathic medicines are very popular among Bangladeshis and Pakistanis. According to Dutta and Jamil (2013), allopathy (modern medicine), homeopathy, Ayurveda, and spiritual healing are commonly used within the Bangladeshi community. Bateman et al. (2009) explain that traditional concepts of healing such as Ayurveda aim to "...prevent illness, to treat sickness, and to rejuvenate the body for longevity" (p. 286). However, problematic to The Cross Cultural Health Care Program in Seattle, Washington, is that, "If a Western treatment is at odds with the treatment traditional in South Asian communities, the family is likely to ignore the provider and stay with the tradition" (p. 4). This is of particular concern since traditional medical treatments, including Ayurvedic, contain heavy metals such as lead, mercury, or arsenic, which can have dangerous health effects (Saper et al., 2004). Furthermore, greater use of traditional medicine is more common among poorer and less-educated individuals who are more likely to be less informed of the dangerous interactions of using traditional medicine (Bazargan et al., 2005).

While traditional medicine is quite popular, the role of religion also plays a major part in determining how they interact with the healthcare system in the Bangladeshi and Pakistani context. Recently, there has been an increasing interest in understanding models of health and disease among immigrants in the U.S., including relating to the Muslim religion (Curlin, 2008; Tirodkar et al., 2011). Tirodkar et al. (2011) describe South Asian

immigrants' explanatory models of health and disease in Chicago, Illinois, including the role of religion, as a first step to developing culturally appropriate health promotion programs to address the needs of these populations. They conducted semi-structured interviews ($N=75$) with two South Asian subgroups including Asian Indians, who are for the most part followers of the Hindu religion, and Pakistanis, who follow the Muslim faith. These scholars found that one third of the sample of mostly Pakistani participants had a holistic model of health, which integrated spiritual factors. In particular, compared to Hindus, Pakistanis were more likely to express a correlation between religion and good health. The study found that 43% of Muslim participants were more likely to indicate that spiritual factors, such as prayers, contributed to maintaining good health while on the other hand, only about 12% of Hindus indicated religious factors at all. In addition, 12% of Muslims indicated that spiritual factors contribute to disease. No Hindus indicated such correlation.

Nevertheless, Dutta and Jamil (2013) acknowledge the role of religion but maintain that ultimately, structural barriers such as occupational constraints, limited English proficiency, and difficulties navigating the healthcare system are the most salient barriers that prevent Bangladeshis from securing access to healthcare. One of the interviews quoted in this study accurately sums up how Bangladeshis reconcile their financial and healthcare needs, stating that "...if I am sick and can't work for a month or 15 days, no one will help me. No hospital will help.... Even if you die, no hospital with help you" (p. 177)

As demonstrated in the South Asians section of this chapter, the few ethnic-specific studies that focus on these two particular South Asian American subgroups are

very limited in scope. Based on the limited number of existing studies, Bangladeshi and Pakistani cases highlight what the Cambodian case demonstrated: that in this country, access to healthcare begins with health insurance coverage but it does not provide sufficient means to access to healthcare. Currently, studies have found that limited English proficiency, low levels of health literacy, difficulty navigating the healthcare system, and occupational constraints are salient barriers to access to healthcare for these populations. In addition, because of the heavy reliance on public health insurance coverage seen among Bangladeshis and Pakistanis due to their low socioeconomic levels, it is likely that the 5-year waiting period for documented immigrants to access these programs will become an insurmountable barrier to accessing healthcare in itself.

Because addressing health disparities of disadvantaged groups depends in part on the collection of accurate and relevant research data, ethnic-specific studies on Bangladeshi and Pakistani health needs and access to healthcare will play a critical role in the development of culturally and linguistically competent health promotion interventions going forward (Mohanty et al., 2005; Patel et al., 2012).

Addressing Gaps in the Health Services Research Literature

This comprehensive literature review provided in-depth profiles for each of the four Asian American subgroups being examined in this study, underscoring the wide range of information that is available in the Health Services Research Literature. This review was an extensive research effort to provide a one-stop shop for information that helps reconstruct the experiences of the Bangladeshis, Cambodians, Koreans, and Pakistanis and access to healthcare. This effort required me to pool information that is generally organized thematically, covering many Asian American subgroups. For

example, while Trinh-Shevrin, et al. (2009) provide one of the most extensive volumes on Asian and Pacific Islanders and health, including valuable information on Koreans, Cambodians, Pakistanis, and Bangladeshi, the information is organized thematically, making it very difficult to gain a holistic understanding of any particular Asian American subgroup.

The value of conducting a comprehensive literature review like this one is that it provides a holistic view of access to healthcare for each of the Asian American subgroups, which facilitates the identification of the most salient factors that are unique to each subgroup. For instance, after the review, it was evident that the propensity to own small businesses in the ethnic economy is a unique cultural characteristic for the Koreans; unique for Cambodians are their refugee status and extremely low levels of socioeconomic status; and unique for Bangladeshis and Pakistanis are their extremely low levels of socioeconomic status and cultural approach to healthcare. Studies in the Access to Healthcare sections show that the most common challenges to accessing healthcare are cost, lack of insurance, limited English proficiency, low levels of health literacy, difficulty navigating the healthcare system, and occupational barriers (e.g., resource constraints such as long work hours and inability to take off time from work due to loss of wages). More importantly, the Health Disparities and Needs sections highlight the notion that Asian immigrants collectively experience a downward trajectory in health as they adapt to life in the U.S.

Moreover, one major gap in the Health Services Research literature is the absence of ethnic-specific studies that provide in-depth knowledge. To my best knowledge there are no empirical studies on any of the Asian American subgroups being examined in this

study to date that examine a wide range of factors that impact access to healthcare. Existing studies have identified key factors that impede access to healthcare but are limited in their scope: if they describe obstacles these subgroups face, they rarely examine why these Asian American subgroups are facing such obstacles and the effects of broader individual, organizational, and contextual factors that fundamentally structure unequal access to healthcare. Acknowledging this gap, the Access to Healthcare Survey for Koreans in the U.S. will examine a wide range of factors, with special focus on gaining an understanding of how different levels of education, income, employment types, acculturation, and religiosity impact access to healthcare as outlined in Table 1.2 Study Aim, Research Questions, Hypotheses, and Rationale.

In closing, the top four most uninsured subgroups in this study (Bangladeshis, Cambodians, Koreans, Pakistanis) have their own approach to managing their health needs in a landscape of limited resources. However, I stress that these strategies are ineffective and short-term solutions and will be costly to the healthcare delivery system in the long run. Targeted interventions must be established to improve the way in which they access healthcare. The findings from the Access to Healthcare Survey for Koreans in the U.S. will provide useful insights that can help inform health policy and program implementation.

The next chapter provides an overview of the findings and results from the data gathered from interviews with national health experts, Access to Healthcare Survey for Koreans in the U.S. administered in the tri-state region (Connecticut-New Jersey-New York), as well as discusses this study's limitations and strengths.

Table 2.5

Study Aim, Main Research Questions, Hypotheses, and Rationale

Study Aim: Examine the impact of structural and cultural barriers on accessing healthcare for Koreans in the tri-state region of the United States.		
Research Question	Hypothesis	Rationale
RQ1: What is the difference in healthcare access among those with higher education levels?	H ₁ 1: Those with higher education levels will have greater access to healthcare.	Higher levels of educational attainment is correlated with higher income levels, which are expected to reduce structural (e.g. cost) and organizational barriers. The more educated are more likely to be better informed of how the healthcare system operates and therefore better equipped to navigate through organizational barriers.
RQ2: What is the difference in healthcare access among those with higher income levels?	H ₁ 2: Those with higher income levels will have greater access to healthcare.	Higher levels of income will reduce structural barriers (e.g. cost), enabling health insurance coverage.
RQ3: What is the difference in healthcare access between those with different employment types?	H ₁ 3: Those employed in private firms or government organizations will have greater access to healthcare.	Access is expected to be significantly greater for those who work in private firms or government organization since most insurance coverage is generally provided in the formal labor market. Those who are self-employed or working in small businesses are expected to face greater structural, organizational, and cultural barriers due to lack of insurance coverage, occupational constraints, and limited knowledge regarding the healthcare system.
RQ4: What is the difference in healthcare access between those with higher acculturation levels?	H ₀ 4: Those with higher levels of acculturation will not have greater access to healthcare.	Higher levels of acculturation are not expected to be associated with greater access, due Koreans' use of pragmatic strategy of "accommodation without assimilation." Those with longer stays in the United States will not likely to possess higher levels of English proficiency and will face similar structural, organizational, and cultural barriers accessing healthcare.
RQ5: What is the difference in healthcare access between those with higher levels of religiosity?	H ₁ 5: Those with higher levels of religiosity will have worse access to healthcare.	Higher levels of religiosity are expected to be associated with decreased access. Those with higher levels of religiosity may possess fatalistic views that may deter or delay access to healthcare.

CHAPTER 3: RESULTS

This chapter discusses the results from the extensive fieldwork conducted for this dissertation, including qualitative data gathered on the four Asian American subgroups in this study based on interviews with national health experts and advocates, and quantitative data gathered on the Koreans via the Access to Healthcare Survey for Koreans in the U.S. instrument, which was distributed in the tri-state region (Connecticut-New Jersey-New York). As explained in the Research Methodology section in Chapter One, Koreans were selected for the survey because they are (1) substantially larger than the other three Asian American subgroups and the fifth largest Asian subgroup out of the 28 existing subgroups, at 1.7 million (U.S. Census Bureau, 2010) (2) possess an established immigration history, (3) have a well-known presence in the U.S. economy, and (4) because there are very few studies on Koreans in the East Coast region in relation to their population size and economic presence in this area (Andersen et al., 1994).

The results are presented in the following sequence: (1) themes from the interviews with national health experts and advocates; (2) results of the Access to Healthcare Survey for Koreans in the U.S. instrument pilot; (3) descriptive findings and inferential analyses of the Access to Healthcare Survey for Koreans in the U.S. sample, bivariate associations among the major variables, and tests of predictive relationships hypothesized by the current study; (4) overall study's results, and (5) limitations and strengths of the study.

Interviews with National Health Experts and Advocates

Data from interviews are the verbatim transcripts of the interviews. In sum, an iterative process called “joint collection, sampling, and analysis,” described in more detail in the methods section of Chapter One, was the driving force behind the identification of themes. The nature of the semi-structured interviews used to gather interview data were dialectical, allowing me to probe along points and themes that were directly related to the research questions. Content analyses consisted of counting themes’ occurrences as well as eliminating repetition and combining codes (Bryman, 2008).

As discussed later in this chapter, the major findings derived from the interviews were consistent with the findings in my comprehensive literature review described in Chapter 2, and interviewees kindly provided many real-life examples. The interview data was another source of validation of the content and design of the Access to Healthcare Survey for Koreans in the U.S. that was administered to the Korean community in the tri-state region (Connecticut, New Jersey, and New York).

Emergent Themes

The majority of the interviewees (90%) were happy to share their views because they are big believers that Asians in the U.S. comprise of many diverse subgroups, and country of origin is highly important to research, especially in the context of healthcare access. Most interviewees (90%) affirmed the notion that better understanding of the structural and cultural barriers that exist among the Asian communities of this study (i.e., Bangladeshis, Cambodians, Koreans, and Pakistanis) is currently a critical need and considerable gap in the literature. Therefore, studies such as this one are particularly

important to conduct as these subgroup populations are growing rapidly and, more importantly, as healthcare reform is implemented.

Prior to discussing the themes derived from the interviews in detail, it is important to note that the categories in my original framework to study access to healthcare for vulnerable populations including *individual, organizational, and contextual factors* were replaced with *structural, cultural, and system barriers* after conducting the comprehensive literature review discussed in detail in the previous chapter (see Figure 1 on page 25). At this point in my dissertation writing, it became apparent that many of the factors in the original framework would be categorized as individual level factors and would be difficult to decipher the levels of impact between structural and cultural barriers. For example, individual level factors under the original framework included social and cultural variables such as traditional medicine preference, health beliefs, and religion among other variables such as age, income, education, and health status. In addition, organizational level factors in the original framework included only provider related factors but in hindsight, the category was changed to system barriers since these factors are related to the broader level of the entire healthcare delivery system.

Modifying the categories facilitated better identification and categorization of themes, including structural barriers that captured individual factors such as employment type that stem from contextual factors such as the labor market structure, emphasizing that these barriers are beyond one's control and part of the context. Within the original comprehensive framework, it would have been difficult to make the distinction between cultural and system barriers, since cultural barriers would be embedded among individual factors, among a range of other variables such as age and health beliefs. Table 3.1

provides an overview of the emergent themes, based on the revised of structural, cultural, and system barriers.

Table 3.1
Summary of Interview Themes

Structural Barriers	System Barriers	Cultural Barriers
<ul style="list-style-type: none"> • Low health insurance coverage rates • High rates of self-employment or work in the ethnic economy • High cost of health insurance 	<ul style="list-style-type: none"> • Limited hours • Lack of transportation • Confusion or lack of awareness on patient and immigrant rights • HC System is confusing • Lack of awareness of community healthcare services • Enrollment in public insurance is difficult 	<ul style="list-style-type: none"> • Limited English proficiency • Family structure dynamics • Lack of culturally competent providers • Alternative medicine preference • Use of medical tourism • Physical practices connected to religious beliefs and fatalistic views of religion • Distrust of American healthcare system

In terms of *structural barriers* and *system barriers* in accessing healthcare, the most common barriers cited by interviewees included: (1) occupational constraints due to high rates of self-employment or work in the informal ethnic labor market that are not conducive to accessing healthcare (e.g., difficulty accessing healthcare due to long working hours or because of the loss of wages), (2) high costs of health insurance, (3) limited hours, (4) lack of transportation, (5) lack of familiarity with patient and immigration rights, (6) lack of knowledge and resources to navigate a complex healthcare system, and (7) lack of awareness of available public health services provided by the government and community-based organizations as well as public program eligibility rules. The most common *cultural barriers* cited by interviewees included: (1) limited English proficiency, (2) unique family structure dynamics (e.g., reliance on family members to coordinate healthcare and collective decision-making), (3) lack of cultural competency among providers, (4) reliance on alternative medicine, (5) physical practices

connected to religious beliefs such as fasting as well as fatalistic views of illness, and (6) distrust of the American healthcare system.

Occupational Constraints

Almost all interviewees (90%) noted occupational constraints as being one of the major root causes for the poor access to healthcare – most immigrants work in the informal ethnic labor markets making it very difficult to take time off from work or pay for healthcare. In particular, some of these Asian American subgroups (i.e. Koreans and Pakistanis) possess high self-employment rates and often lack of employer-based insurance. The majority of these Asian American subgroups receive healthcare in a piecemeal and fragmented fashion. Preventive care is rare, especially in the case of immigrants who come from countries where prevention and primary care is not emphasized such as Cambodia, Pakistan, and Bangladesh. The Korean case is different from the three other subgroups in this study because most Koreans emigrate from South Korea, a developed country where health prevention and primary care is emphasized. However, some of the interviewees (40%) that had experience with the Korean community explained that while all Koreans are entitled to the National health insurance program; Koreans are aware of how expensive treatments can be in the U.S. due to their experiences with cost-sharing arrangements in South Korea that vary according the type of healthcare treatment and type of healthcare institution. Although the Medical Aid Program in Korea covers medical expenses for those who are unable to pay, some of these interviewees (20%) noted that a very small portion of Koreans are actually eligible for this public insurance.

Interviewees who had experiences with the Korean community (70%) noted that some of the reasons why Koreans often do not access the healthcare system after immigration are because they find the U.S. system very challenging, time consuming, and expensive. By contrast, the Korean healthcare system is known to be very efficient, affordable, and easy to navigate. For example, one interviewee described care in South Korea as well coordinated, where it is very common practice to schedule all necessary routine physical exams on one day to minimize absence from work and other duties.

Information and Resources

A number of interviewees (60%) also mentioned that these communities' awareness of available public health insurance programs and community-based healthcare and social services is generally lacking. They explained that while the mission of many community-based organizations is to provide social services, including education about the U.S. healthcare system, community-based organizations have very little reach because of inadequate funding and resources in relation to their target populations. While these organizations know their populations best, they have very little bandwidth to implement the necessary programs to overcome the barriers to care these populations face. For example, one interviewee mentioned that several nonprofit organizations in the area had established programs to educate small business owners regarding health insurance options and healthcare access, as well as to help them navigate the healthcare delivery system and resolve administrative matters such as billing problems. However, these programs are in fact ineffective at reaching out to the community because of the lack of funding.

Some interviewees (40%) mentioned that nonprofit organizations that serve people of color compete with each other fiercely for funding and are, therefore, underfunded. Asians are the most negatively impacted: one interview noted that while they comprise 13% of the population in New York City, only 1% of the total New York City community healthcare budget is allocated to Asian community-based programs as a whole and the rest allocated to other groups of color. Some interviewees attributed the lack of community-based funding to an absence of strong leadership and lack of political representation of Asians in the New York City region.

Patient and Immigration Rights

Not surprisingly, a good portion of the interviewees (70%) mentioned that because of limited English proficiency and high levels of isolation, these communities also lack knowledge of patient and immigration rights, which greatly impacts the manner in which they seek access to healthcare. In some instances, individuals are unclear of their rights and do not access the healthcare system because they think treatments must be paid in advance or because they fear that if they are unable to pay, the debt will ultimately be carried over to their children. Relatedly, many in these communities do not know they have a right to a translator when seeking care in hospitals and other major healthcare institutions. There is also widespread confusion about public assistance programs and their impact on immigration status, even among the legally documented. Individuals do not want to jeopardize their immigration status and forego seeking public resources to avoid at all costs being classified as a public charge.

Alternative Medicine, Medical Tourism, and Religion

Most interviewees (70%) noted that healthcare tends to become the last priority behind earning a living to cover housing and other basic needs, taking care of family members (including extended family members), and providing educational opportunities for their children. Because of these competing demands of daily life, these Asian American subgroups are at greater risk of developing a habit of seeking alternative methods of treatment because they are cheaper and quicker alternatives to obtaining treatment. One interviewee explained that often times, individuals are not aware that treating health issues with alternative medicine can be quite problematic. In actuality, treating chronic diseases with alternative medicine is frequently incompatible and bigger health issues and risks arise because individuals are not likely to disclose usage of alternative medicines if they seek care from a physician. Also, many may seek Western medicine methods of treatment at later stages of disease when it is too late to treat.

Interviewees also commented on the popularity of medical tourism, especially among those with dual citizenship who return to their home country for low-cost healthcare services and medication. Interviewees (40%) explained that the language barriers mean that many immigrants, even those with intermediate English proficiency, are reluctant to go to doctors outside of their ethnic backgrounds. This issue seems to be closely tied to the fact that many immigrants do not trust the American health system. One interviewee highlighted that even governments are getting into the business of medical tourism. For instance, the South Korean government is actively marketing travel packages with medical care to Koreans in the U.S. However, follow-up care becomes a problem when the primary care physician is in another country.

Some interviewees (40%) indicated that religion may negatively impact healthcare access. For instance, individuals attempt to cure their physical ailments through prayer and believe that only God has the power to heal their ailments. This fatalistic view of their health delays them from seeking treatment for their illnesses. Another interviewee explained that in some instances, individuals go long periods without eating as part of their fasting tradition, a practice that is not compatible with treating chronic diseases such as diabetes and other ailments. Even when they are being treated by Western physicians, individuals may not always disclose their practices and their physicians may be unaware of these dangers.

In addition to the in-depth literature review discussed in Chapter Two, the themes derived from these interviews also helped design the Access to Healthcare Survey for Koreans in the U.S. as well as to define the Korean population more clearly. Results and findings are discussed in the next section.

Access to Healthcare Survey for Koreans in the U.S.

The instrument created for this study—Access to Healthcare Survey for Koreans in the U.S.— is based on preliminary questions on major themes on access from the Health Services Research literature and interviews with national health experts and advocates. This questionnaire was designed to generate granular data at the subgroup level not sufficiently documented in the Health Services Research literature and is of particular relevance to understanding the structural, system, and cultural barriers Korean Americans face in accessing healthcare.

The first part of the questionnaire, *Part I: Participant Information*, measured variables such as (1) demographic characteristics such as age, gender, marital status,

length of residence in the U.S; (2) acculturation; (3) socioeconomic indicators such as educational attainment, income, employment type; (4) health insurance coverage and regular source of care; (5) health status and healthcare utilization; (6) community healthcare services utilization; (7) political participation; (8) religiosity and other beliefs. The second part of the survey included a Likert scale, *Part II: Access to Healthcare*, measured patterns of structural, system, and cultural barriers. The scale assessed different barriers that may prevent people from accessing healthcare, including cost, limited office hours, distrust in the U.S. healthcare system, etc. An example item is: “It is easy to find affordable quality health care.” The instrument was coded on a six-point Likert scale from “Strongly Disagree” to “Strongly Agree”. In this chapter, details of the questionnaire findings will be discussed in the order outlined above, after a brief overview of the pilot of the survey instrument.

Pilot Testing

Before implementing the study’s primary data collection in the Fall of 2013, the English and Korean versions of the Access to Healthcare Survey for Koreans in the U.S. were pilot tested among 20 Koreans 18 years of age and older. Participation was entirely voluntary, and those who participated in the pilot study were not included in the primary study sample. The survey instrument was piloted to validate the content and design of the survey and to assess its construct validity and reliability. For example, the pilot assessed how well Koreans understood the survey questions and helped identify inconsistencies and tendencies to skip certain questions. Some questions were reworded based on feedback received from pilot participants.

Survey Part I: Participant Information

The English and Korean versions of the Access to Healthcare Survey for Koreans in the U.S. were distributed in the tri-state region (Connecticut-New Jersey-New York) in the Fall of 2013. As shown in Table 3.2, which provides an overview of the study sample's demographic characteristics, the total sample consists of 107 Koreans, all of whom identify themselves as ethnic Korean. The sample consists of 58 males (54%) and 49 females (46%) between the ages of 18 and older. Respondents are mostly married (79%), with most living in Connecticut (7%), New Jersey (47%), and New York (46%). Most were born in South Korea (85%). The remaining 15% of the sample were born outside of South Korea, including Argentina, Canada, China, Japan, Paraguay, and the U.S. Overall, the participants are composed of young adults, older adults, and senior citizens who identified themselves as first-generation immigrants (75%).

Table 3.2
Sample Demographics (N=107)

Variable	<i>n</i>	%
Ethnicity		
Korean	107	100
Other	0	0
Gender		
Female	49	46
Male	58	54
Age		
18-25	2	2
26-35	18	17
36-45	23	22
46-55	17	16
56-65	33	31
66 or older	14	13
Marital Status		
Now married	84	79
Never married	16	15
Widowed/Divorced/Separated	7	6
State of Residence		
Connecticut/Other	7	7
New Jersey	48	47
New York	47	46
Country of Birth		
South Korea	90	84
North Korea	1	1
United States	8	8
Other	8	8
Generational Status		
First generation	79	75
1.5 generation	18	17
Second generation	8	8

As shown in Table 3.3, the educational attainment level of respondents is fairly high. Over 60% of this sample have bachelor's degrees and above (master's, professional, or doctorate degrees); 13% have associate's degrees or completed some college, while the remaining 25% have completed high school or less than high school. Over half completed their education in their country of origin, South Korea (53%).

Table 3.3
Educational Attainment

Variable	<i>n</i>	%
Educational Attainment		
Less than high school	10	9
High school or GED	17	16
Some college	11	10
Associate's degree	3	3
Bachelor's degree	36	34
Master's degree	19	18
Professional degree	4	4
Doctorate degree	7	7
Educational Attainment Country Received		
South Korea	57	53
United States	47	44
Other	3	3

The concept of acculturation was measured through simplified indicators that are commonly used in other health studies of immigrant populations, including dichotomous measures of length of stay and language proficiency. As shown in Table 3.4, among the respondents, length of residence in the U.S. ranges from less than five years to more than 40 years. More than half (63%) have resided in the U.S. for more than 20 years. A little over half of the sample speak English well or very well (57%) while a little under half do not speak English well or not at all (44%).

Table 3.4
Acculturation

Variable	<i>n</i>	%
Length of Stay in U.S.		
Less than 5 years	5	5
6 to 10 years	13	12
11 to 20 years	20	19
21 to 30 years	39	37
31 to 40 years	23	22
More than 40 years	4	4
Born in the U.S.	3	3
English Fluency		
Very well	24	23
Well	36	34
Not well	41	39
Not at all	5	5

As shown in Table 3.5, respondents' individual incomes vary significantly, ranging between no income and over \$200,000. Of those surveyed, 17% reported an annual income of \$20,000 or less, 44% reported an income of \$20,000 to \$60,000, 24% reported an annual income of \$80,000 to \$120,000, another 2% reported an income of \$120,001 to \$140,000, and 4% reported an income of over \$200,000. In terms of household income, 12% of households in this sample reported an annual income of \$20,000 or less, 26% reported an income of \$20,000 to \$60,000, 29% reported an annual income of \$60,000 to \$100,000, 20% reported an income of \$100,001 to \$140,000, 5% reported an income of \$140,001 to \$200,000, and 8% reported an income of over \$200,000. 26% of households reported making \$40,000 or less.

Table 3.5
Individual and Total Household Income

Variable	<i>n</i>	%
Individual Income		
\$5,000 to \$10,000	7	7
\$10,001 to \$15,000	4	4
\$15,001 to \$20,000	6	6
\$20,001 to \$40,000	25	24
\$40,001 to \$60,000	20	19
\$60,001 to \$80,000	12	12
\$80,001 to \$100,000	14	14
\$100,001 to \$120,000	10	10
\$120,001 to \$140,000	2	2
\$140,001 to \$160,000	0	0
\$160,001 to \$180,000	0	0
\$180,001 to \$200,000	0	0
Over \$200,000	4	4
Household Income		
\$5,000 to \$10,000	5	5
\$10,001 to \$15,000	3	3
\$15,001 to \$20,000	4	4
\$20,001 to \$40,000	15	14
\$40,001 to \$60,000	11	11
\$60,001 to \$80,000	6	6
\$80,001 to \$100,000	23	23
\$100,001 to \$120,000	16	16
\$120,001 to \$140,000	4	4
\$140,001 to \$160,000	1	1
\$160,001 to \$180,000	1	1
\$180,001 to \$200,000	1	1
Over \$200,000	8	8
Home Ownership		
Own	51	48
Rent	55	52

As shown in Table 3.6, approximately 90% of the sample reported being employed. Generally, while the present patterns of employment had three categories of

“employed”, “self-employed”, or “not employed”, 33% of the informants fall into the category “employed”; 57%, in the “self-employed”; and 1%, in the “not employed.” In terms of employment hours, 83% of the sample work fulltime and 9% work parttime. More specifically, 15% hold positions in private-for-profit companies, 4% in private-not-for-profit organizations, 6% in government organizations, 19% in small business, and 49% report being self-employed. Lastly, only 1% report working for a family small business without pay.

For those who indicated their current occupational type (63%), 10% report having a management, business, and financial occupation; 25% report having a professional occupation; 34% report having a service occupation; and 22% report having occupations in sales, office and administrative support, and construction and extraction. The range of the current occupations held in the U.S. included service-related jobs (e.g., cashier, beautician, and nail technician) and professional-related jobs (e.g., court interpreter, lawyer, and physician).

When queried about previous employment outside the U.S., 11% stated that they had previously held management, business, and financial occupation and 16% held professional occupations. The figure for service occupations held before emigration to the U.S (13%) is much lower than the figure (34%) for service occupations held after emigration. The percentage of service occupations held by Koreans in the U.S. is almost 3 times higher. The range of the occupations specified being held in South Korea were more professional, including occupations in medicine, government employment, and public school administration, among others.

Table 3.6
Employment Type

Variable	<i>n</i>	%
Employment Status		
Employed	35	33
Self-employed	60	57
Not employed	1	1
Looking for work	2	2
Disabled	1	1
Retired	5	5
Employment Hours (PT/FT)		
Full-time	88	83
Part-time	9	9
Employment Type		
Private-for-profit company	16	15
Private-not-for-profit organization	4	4
Government organization	6	6
Small business	20	19
Self-employed	51	48
Working w/o pay in family business	1	1
Occupation in U.S.		
Management, business, and financial	7	10
Professional	17	25
Service	23	34
Sales	5	8
Office and administrative support	8	12
Construction and extraction	1	2
Occupation in South Korea		
Management, business, and financial	10	11
Professional	14	16
Service	12	13
Sales	5	6
Office and administrative support	6	7
Construction and extraction	1	1
Production	1	1
Transportation and material moving	1	1
Armed Forces	1	1

My study used health insurance coverage as one of the socioeconomic indicators in assessing the accessibility to healthcare services. As shown in Table 3.7, approximately 60% of the respondents in the Korean community have some kind of health insurance, most of which was private insurance and some public insurance. In this sample 40% of Koreans report having no insurance. Among those who have insurance coverage, the majority (26%) have insurance through their employers, while a small number of them (8%) are either insured through their spouses and 5% purchase insurance on their own. Informants with Medicare (7%) and Medicaid (19%) coverage are mostly elders, who meet the requirements for dual-eligibility. Dual-eligible individuals include the low-income aged, blind or disabled Medicare beneficiaries who also qualify for the Medicaid program.

In terms of rates in regular source of care, only 58% of respondents report having a regular source of care, most report utilizing private doctors (63%) rather than health clinics (9%) and traditional Korean medicine doctors (5%). Astonishingly, 42% of the respondents report having no regular source of care.

Table 3.7
Health Insurance Coverage and Regular Source of Care

Variable	<i>n</i>	%
Health Insurance Coverage		
Employer-based Insurance	35	34
Individual-purchased insurance	5	5
Medicaid	20	19
Medicare	7	7
Not insured	42	40
Regular Source of Care		
Yes	61	58
Regular Source of Care Type		
Private Doctor	67	63
Health Clinic	9	9
Traditional Korean Medicine Doctor	5	5
None	27	26

Respondents were asked to rate their perceptions of health status: As shown in Table 3.8, 65% of informants rate their health as either very healthy or healthy (19% and 46% respectively), while 29% rate their health as fair, and 7% as unhealthy or very unhealthy. In terms of healthcare utilization trends, 62% of the sample reports having a routine medical check-up within a year, while 22% having their last check-up more than 2 years ago, and 6% having never had one at all. Of the respondents, 30% utilize types of care other than the emergency room for medical emergencies (e.g., traditional Korean medicine doctor, family and friends, and other sources such as the pharmacy). A little under half of the respondents report using traditional Korean medicine (48%) and 37% utilize a traditional Korean medicine provider 1 or more times in the last 12 months. Only 11% of the respondents report traveling to South Korea within the last 5 years to obtain healthcare. Only 8% have traveled to South Korea 1 or more times.

Table 3.8
Health Status and Healthcare Utilization

Variable	<i>n</i>	%
Perceived Health Status		
Very Healthy	20	19
Healthy	48	46
Fair	30	29
Unhealthy	6	6
Very Unhealthy	1	1
Last Routine Medical Check-Up		
Within the last 12 months	65	62
1 year ago	12	11
Variable	<i>n</i>	%
More than 2 years ago	22	21
Never	6	6
Healthcare Frequency (Within the last 12 months)		
0	14	13
1-2	59	56
3-4	17	16
5 or more	16	15
Medical Emergency Care Type		
Emergency room	73	70
Traditional Korean medicine doctor	7	7
Family and friends with medical training	6	6
Family and friends w/o medical training	1	1
Other (e.g., Pharmacy)	3	3
Not applicable	13	13
Traditional Korean Medicine		
Yes	54	52
Traditional Korean Medicine Frequency		
0	66	64
1	15	15
2 – 4	14	14
5 or more	8	8
Medical Tourism to South Korea (Within the last 5 years)		
Yes	11	11
Medical Tourism to South Korea Frequency		
0	96	92
1 or more	8	8

Respondents report very low rates of community healthcare services utilization. As shown in Table 3.9, close to 80% of the sample does not utilize any of the types of healthcare services provided by Korean community health centers in the New York and New Jersey areas, which are commonly situated within Korean ethnic enclaves (e.g., Flushing, Queens). Approximately 17% utilize health clinic services and 4% utilize either language translation assistance, attend health insurance seminars, or support groups.

Table 3.9
Community Healthcare Services Utilization

Variable	<i>n</i>	%
Community Healthcare Services Utilization		
No utilization	83	80
Health clinic	18	17
Language translation assistance	1	1
Nurse hotline	0	0
Seminar (disease prevention)	0	0
Seminar (health insurance)	2	2
Support group	1	1
Social services	0	0

As shown in Table 3.10, more than 60% of the respondents report participation in government elections and identified themselves as Democrats. For the most part, respondents' political engagement is limited to voting in presidential elections (58%). Participation in other political activities include displaying political materials (7%), political party membership (14%), and political party volunteering (1%) are generally low. 87% of the respondents indicated "Yes" or "Maybe" when asked whether political participation improves access to healthcare for the Korean community.

Table 3.10
Political Participation

Variable	<i>n</i>	%
Voting Participation		
Yes	67	63
Political Views		
Democratic	64	62
Republican	10	10
Independent/Other	9	9
None	20	19
Political Engagement		
Vote in presidential elections	62	58
Display political materials at home	7	7
Membership in political party	15	14
Volunteer for political party	1	1
None	43	40
Political Engagement Improves Access to Healthcare for Koreans		
Yes	63	59
Maybe	30	28
No	14	13

As shown in Table 3.11, most of the respondents attend a religious organization on a regular basis, approximately 61% attend either daily or on a weekly basis. More specifically, 12% of respondents report attending a religious organization daily, 49% attend on a weekly basis, 23% attend on a monthly, quarterly, or annual basis, and 17% never attend. When respondents were asked about their religious beliefs in this study, a good portion of the sample indicated that illness is or may be a punishment from God (18%) and illness can or may only be healed by God (17%). A few respondents also included comments on the survey for these questions, noting that illness is or may be present in an individual because of a sin they committed or a result of retribution from God. Lastly, when asked whether illness results in reputational problems for the

individual or family, only 9% of the sample responded “Yes” and 13% responded “Maybe.” Some respondents added comments to further explain why they thought illness can have a negative effect on family reputation, including the stigma of hereditary diseases and fear of the contagious effects of certain diseases.

Table 3.11
Religiosity and Other Beliefs

Variable	<i>n</i>	%
Religious Attendance		
Daily	13	12
Weekly	52	49
Monthly/Quarterly	15	15
Annually	9	8
Never	18	17
Illness is punishment from God		
Yes	6	6
Maybe	13	12
No	87	83
Illness can only be healed by God		
Yes	7	7
Maybe	11	10
No	88	83
Illness results in reputational problems		
Yes	10	9
Maybe	14	13
No	83	78

Survey Part II: Healthcare Access Barriers

In addition to participant information questions in the Access to Healthcare Survey for Koreans in the U.S., respondents also completed a Likert scale with a total of 21 healthcare access barriers—assessing structural, system, and cultural barriers. While the total sample for this study included 107 participants, only 97 were included in the

inferential analyses. Those respondents with 3 or more missing answers to the 21 healthcare access barrier questions were omitted ($n=10$).

The Likert scale ranged from “Strongly Disagree” (1), “Disagree” (2), “Slightly Disagree” (3), “Slightly Agree” (4), “Agree” (5), and “Strongly Agree” (6). To ensure that the survey was balanced, some questions were not worded as barriers but more in a positive way. These questions were recoded and reversed so the analyses generated were consistent. Table 3.12 provides a summary of the mean and standard deviation for all barrier questions. In this context, the higher the mean, the stronger the presence of the barrier. Strong presence of barriers were detected for cost and system barriers, including trouble with paying for insurance ($\mu=3.75$) and the American healthcare system is confusing ($\mu=3.95$). In addition, cultural barriers such as reliance on family to coordinate healthcare ($\mu=4.35$) and feeling more comfortable with Korean doctors ($\mu=3.99$) were strong barriers.

Table 3.12

Summary of Barriers for Access to Healthcare for Koreans in the U.S.

Barrier Question	Barrier Type	N	M (μ)	SD (σ)
I rarely skip medication due to cost (<i>Reversed</i>)	Cost	102	2.98	1.72
I have an easy time communicating with doctors (<i>Reversed</i>)	System	103	2.47	1.28
I have trouble paying for my health insurance	Cost	102	3.75	1.74
I have no problems paying for my medical bills (<i>Reversed</i>)	Cost	97	3.54	1.53
Finding transportation is difficult	System	100	3.26	1.59
I often put off getting medical care due to cost	Cost	99	2.99	2.07
I rarely have to wait a long time to see a doctor (<i>Reversed</i>)	System	98	2.61	1.37
It is easy to find affordable quality healthcare (<i>Reversed</i>)	Cost	99	3.90	1.71
HC facilities in my area have limited hours	System	101	2.48	1.55
HC facilities in my area offer limited services	System	100	3.49	1.81
The American HC System is confusing	System	99	3.95	1.51
Enrolling in public health insurance is difficult	System	98	3.51	1.57
I rely on my family to coordinate my HC	Cultural	101	4.35	1.63
My religious views do not prevent/delay care (<i>Reversed</i>)	Cultural	99	4.35	1.53
Public insurance impacts immigration status	System	97	3.15	1.65
I know I can request an interpreter at a hospital (<i>Reversed</i>)	System	98	2.13	1.28
I prefer conventional Western medicine (<i>Reversed</i>)	Cultural	99	4.83	1.08
Korean media is my main source of information	Cultural	98	3.68	1.63
I feel more comfortable with Korean doctors	Cultural	98	3.99	1.65
Receiving public assistance is disgraceful	Cultural	98	2.62	1.49
I do not trust the American HC system	Cultural	97	3.18	1.55

The next section below discusses the results from the inferential analyses conducted on this study's main research questions discussed in detail in Chapter Two: Comprehensive Literature Review of this dissertation. The bivariate relationships between higher levels of educational attainment, income, employment type, acculturation, and religiosity to access to healthcare are closely examined.

Healthcare Access and Educational Attainment

Research Question #1: What is the difference in healthcare access among those with higher educational attainment levels? My hypothesis was that those with higher educational attainment levels will have greater access to healthcare. Higher levels of educational attainment will be correlated with higher income levels, which are expected

to reduce structural (e.g., cost) and organizational barriers. The more educated respondent is more likely to be better informed about how the healthcare system operates and, therefore, better equipped to navigate organizational barriers.

To evaluate if respondents with higher educational attainment levels had greater access to healthcare, a Pearson correlation was conducted. Pearson correlation evaluates the linear relationship between variables (Field, 2009). Educational attainment level was an ordinal variable categorized into educational attainment levels, where lower numbers represented lower educational attainment levels and higher numbers represented higher income levels. Access to healthcare was the mean calculation of 21 healthcare access questions, where lower values equate to greater access to healthcare and higher values relate to less access to healthcare.

Preliminary tests were conducted to evaluate if the parametric assumptions of the correlation was met. These assumptions include linearity and the absence of extreme outliers. Linearity was assessed using the scatterplot and extreme outliers were assessed using the boxplot. Results indicated that there were no violations in the parametric assumptions of the correlation as the scatterplot was not curvilinear and there were no extreme outliers in the box plot (see Figures 2 and 3).

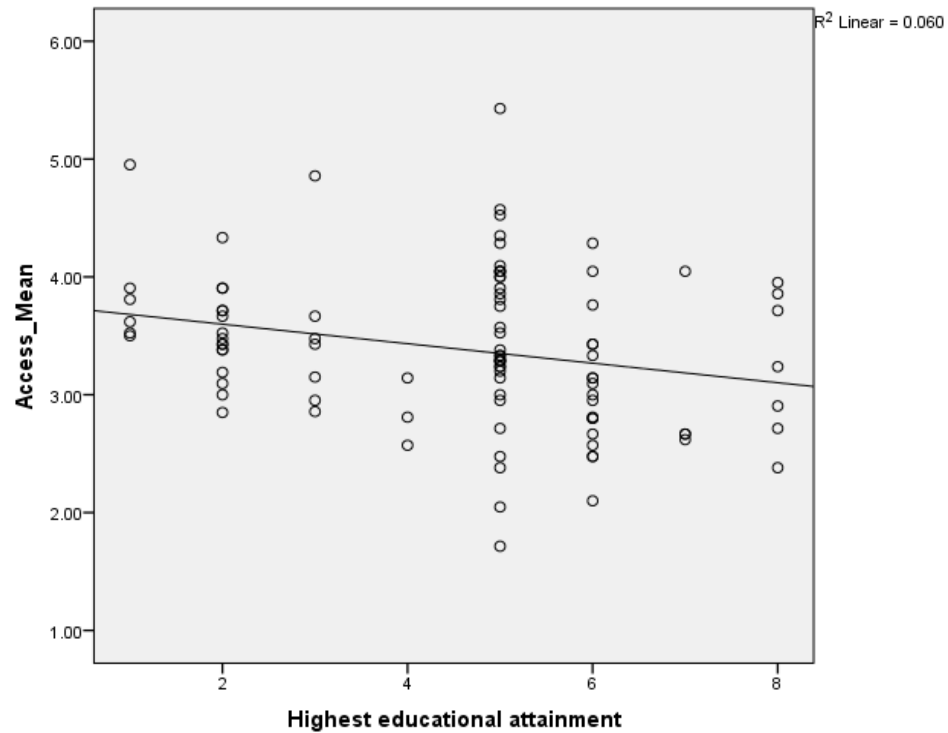


Figure 2
Scatterplot of mean access to healthcare and education attainment level.

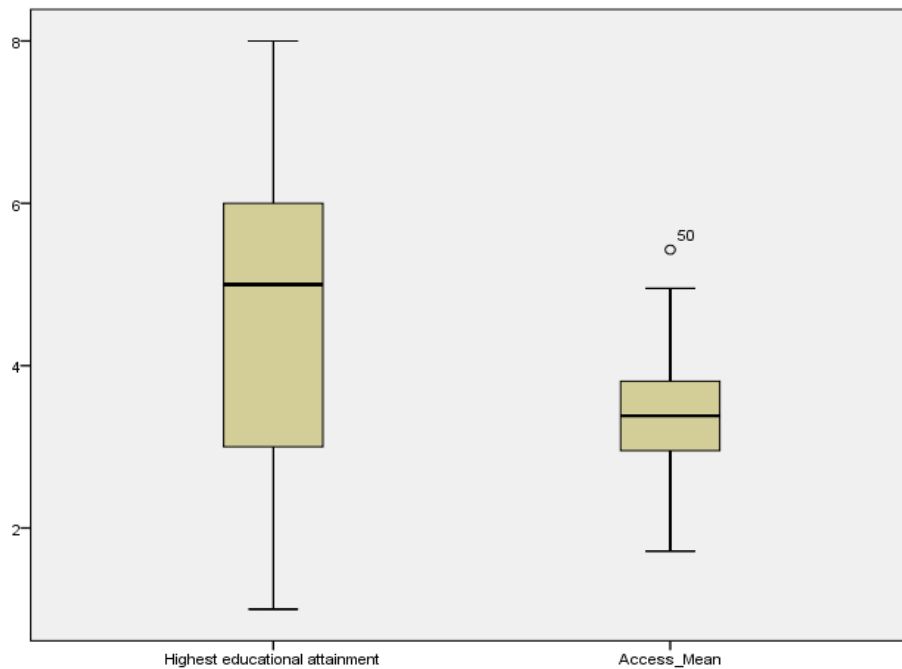


Figure 3
Boxplots of education attainment level and mean access to healthcare illustrate no extreme outliers.

Results of the Pearson correlation indicated that there was a significant negative correlation between educational attainment and access to healthcare, $r = -.244$, $n = 97$, $p = .02$. Based on Cohen's (1988) guidelines, this represents a small correlation. The results indicated that increases in educational attainment were slightly associated with less access to healthcare. This can be seen in the trend line in Figure 2.

Additional Analysis on Educational Attainment

In addition to determining whether respondents with greater levels of educational attainment had greater access to healthcare, I was interested in understanding whether there was a difference between educational attainment and place of education (i.e., U.S. versus outside the U.S.). To evaluate if there was a significant association between educational attainment and place where the respondent received their education, a chi-square test of independence was conducted. The chi-square test of independence is used to determine whether two categorical variables are related. It compares the frequency of cases found in categories of educational attainment across the two categories (South Korea and U.S.) of place of education.

Results of the chi-square test of independence indicated that there was a significant association between educational attainment and place of education, $\chi^2(7, n = 104) = 37.96$, $p < .001$.

Table 3.13

Observed Frequencies and Percentages – Educational Attainment by Place of Education

	South Korea	U.S.
Less than high school	9 (15.8%)	0 (0%)
High school or GED	14 (24.6%)	3 (6.4%)
Some college	9 (15.8%)	2 (4.3%)
Associate's degree	3 (5.3%)	0 (0%)
Bachelor's degree	17 (29.8%)	19 (40.4%)
Master's degree	2 (3.5%)	16 (34.0%)
Professional degree	0 (0%)	4 (8.5%)
Doctorate degree	3 (5.3%)	3 (6.4%)

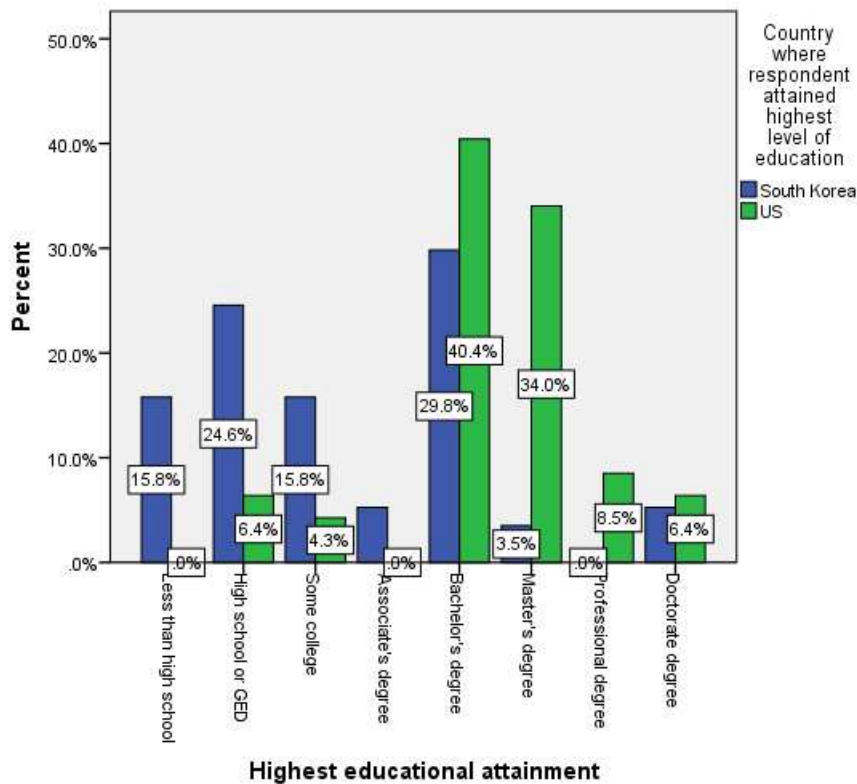


Figure 4

Percent of highest educational attainment by place of education.

Healthcare Access and Income

Research Question #2: What is the difference in healthcare access among those with higher income levels? My hypothesis was that those with higher income levels will

have greater access to healthcare. Higher levels of income will reduce cost barriers, enabling health insurance coverage.

A Pearson correlation analysis was conducted to determine if respondents with higher individual and total household income levels had greater access to healthcare. Mean scores for access to healthcare were used again in this analysis, where low scores represented greater access to healthcare and higher score represented less access to healthcare. Individual and total household income variables were coded, where higher values equated to higher income levels. Preliminary results indicated that both individual income and total household income did not violate the assumption of linearity nor did they contain any outliers (see Figures 5 thru 7).

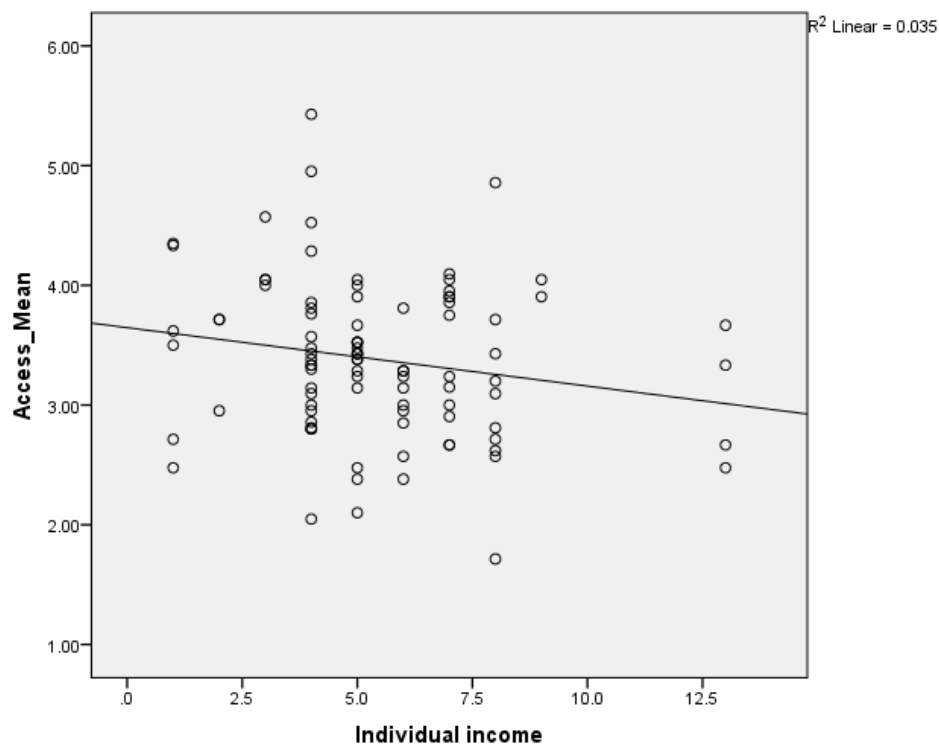


Figure 5
Scatterplot of mean access to healthcare and individual incomes.

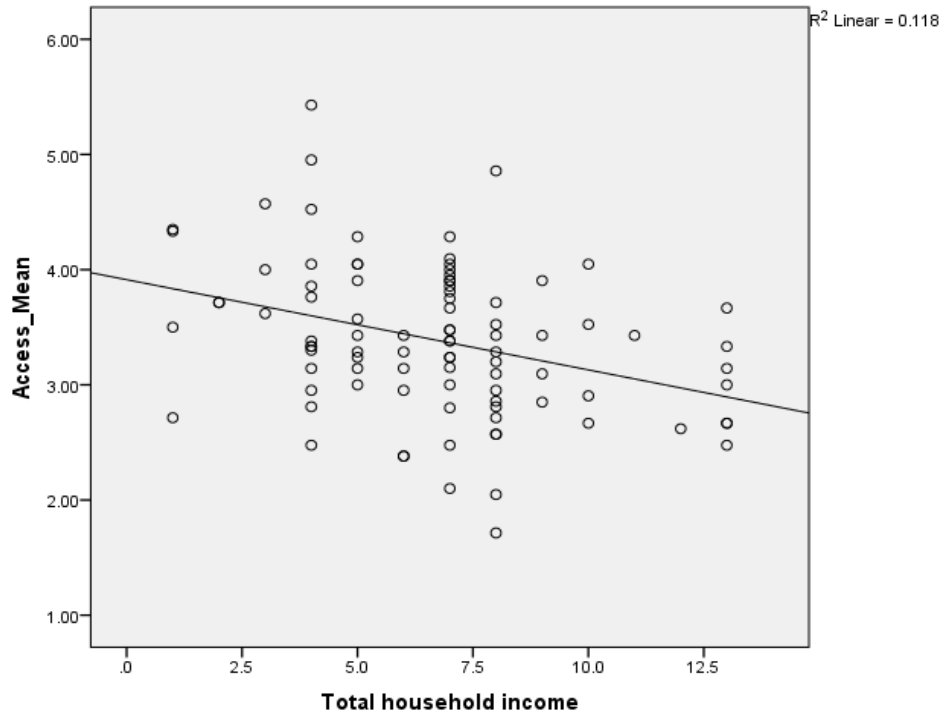


Figure 6
Scatterplot of mean access to healthcare and total household income level.

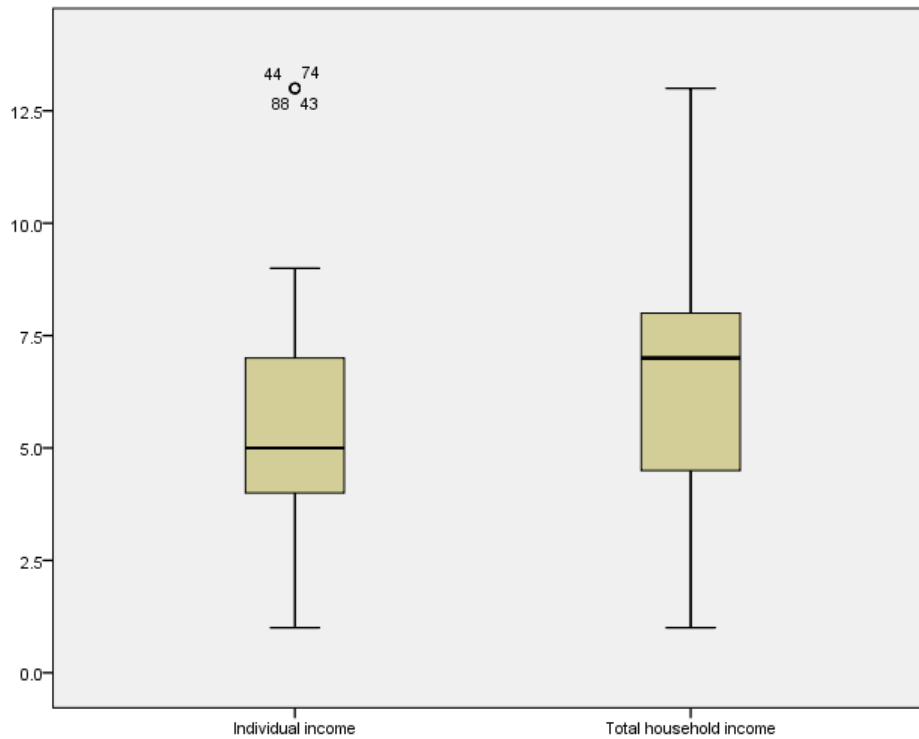


Figure 7
Boxplots of individual and total household income level and mean access to healthcare illustrate no extreme outliers.

Results of the bivariate correlation revealed that there was no significant linear relationship between individual income and access to healthcare mean scores, $r = -.188$, $n = 94$, $p = .07$. Although the correlation coefficient indicates that there is a negative linear relationship between the variables in this study, the p value of .70 indicates that it is unlikely that the correlation coefficient differs from 0 in the real world, or said another way, there is no relationship between these two variables in the real world. The results of the correlation between total household income and access to healthcare mean scores indicated that there was a significant negative linear relationship between the two variables, $r = -.343$, $n = 93$, $p = .001$. The correlation was moderate in size and indicated that decreases in total household income were related to decreases in access to healthcare.

Additionally, the question of what income bracket is more likely to be insured was examined. The analysis of variances indicated that there were no significant differences in healthcare access among the various personal income levels, $F(9, 84) = 1.720$, $p = .10$ (see Tables 3.14 and 3.15).

Table 3.14
Descriptive Statistics ANOVA – Individual Income

	<i>N</i>	<i>M</i>	<i>SD</i>	95% CI	
				Lower	Upper
\$5,000-10,000	6	3.50	.79	2.67	4.32
\$10,001-15,000	3	3.46	.44	2.37	4.55
\$15,001-20,000	4	4.17	.27	3.74	4.60
\$20,001-40,000	23	3.48	.76	3.15	3.80
\$40,001-60,000	19	3.33	.51	3.09	3.58
\$60,001-80,000	10	3.05	.40	2.76	3.34
\$80,001-100,000	13	3.47	.54	3.14	3.80
\$100,001-120,000	10	3.07	.83	2.48	3.67
\$120,001-140,000	2	3.98	.10	3.07	4.88
Over \$200,000	4	3.04	.56	2.15	3.92

Table 3.15
ANOVA Table – Individual Income

	SS	df	MS	F	P
Between Groups	6.15	9	.68	1.72	.10
Within Groups	33.38	84	.40		
Total	39.53	93			

As shown in Table 3.16, the analysis of variances indicated that there were no significant differences in healthcare access among the various total income levels, $F(12, 80) = 1.720$, $p = .05$.

Table 3.16
Descriptive Statistics ANOVA – Total Household Income

	N	M	SD	95% CI	
				Lower	Upper
\$5,000-10,000	4	3.72	.78	2.48	4.97
\$10,001-15,000	2	3.71	.00	3.71	3.71
\$15,001-20,000	3	4.06	.48	2.87	5.25
\$20,001-40,000	14	3.66	.83	3.18	4.15
\$40,001-60,000	10	3.60	.45	3.28	3.91
\$60,001-80,000	6	2.93	.45	2.45	3.40
\$80,001-100,000	22	3.50	.55	3.25	3.74
\$100,001-120,000	15	3.02	.74	2.61	3.43
\$120,001-140,000	4	3.32	.46	2.59	4.05
\$140,001-160,000	4	3.29	.62	2.29	4.28
\$160,001-180,000	1	3.43	.	.	.
\$180,001-200,000	1	2.62	.	.	.
Over \$200,000	7	2.99	.42	2.60	3.38

Additional Analysis on Income

In addition to understanding whether respondents with higher individual and total household income levels had greater access to healthcare, I was also interested in determining at what income bracket respondents of this sample were more likely to be

insured. A chi-square test of goodness of fit was conducted to determine which individual income bracket and household income bracket was more likely to be insured. The chi-square test of goodness of fit evaluates if there are significant differences between the expected and observed category frequencies of a single variable. Results indicated that for personal income, the \$20,001 to \$40,000 group was more likely to be insured with an observed frequency of 25 versus an expected frequency of 10.4, $\chi^2(9, n=104) = 48.5$, $p < .001$ (see Table 3.17). For household income, the \$80,001 to \$100,000 income group was most likely to be insured, having an observed frequency of 23 versus an expected frequency of 7.8, $\chi^2(12, n=101) = 68.3$, $p < .001$ (see Table 3.18).

Table 3.17

Chi-square Test of Goodness of Fit Observed and Expected Frequencies – Individual Income

	Observed N	Expected N	Residual
\$5,000-10,000	7	10.4	-3.4
\$10,001-15,000	4	10.4	-6.4
\$15,001-20,000	6	10.4	-4.4
\$20,001-40,000	25	10.4	14.6
\$40,001-60,000	20	10.4	9.6
\$60,001-80,000	12	10.4	1.6
\$80,001-100,000	14	10.4	3.6
\$100,001-120,000	10	10.4	-.4
\$120,001-140,000	2	10.4	-8.4
Over \$200,000	4	10.4	-6.4

Table 3.18

Chi-square Test of Goodness of Fit Observed and Expected Frequencies – Household Income

	Observed N	Expected N	Residual
\$5,000-10,000	5	7.8	-2.8
\$10,001-15,000	3	7.8	-4.8
\$15,001-20,000	4	7.8	-3.8
\$20,001-40,000	15	7.8	7.2
\$40,001-60,000	11	7.8	3.2
\$60,001-80,000	6	7.8	-1.8
\$80,001-100,000	23	7.8	15.2
\$100,001-120,000	16	7.8	8.2
\$120,001-140,000	4	7.8	-3.8
\$140,001-160,000	4	7.8	-3.8
\$160,001-180,000	1	7.8	-6.8
\$180,001-200,000	1	7.8	-6.8
Over \$200,000	8	7.8	.2

Healthcare Access and Employment Types

Research Question #3: What is the difference in healthcare access among those with different employment types? My hypothesis was that those employed in private firms or government organizations will have greater access to healthcare. Access is expected to be significantly greater for those who work in private firms or government organizations because insurance coverage is generally provided in the formal labor market. Those who are self-employed or working in small businesses are expected to face greater structural, organizational, and cultural barriers due to lack of insurance coverage, occupational constraints, and limited knowledge of the healthcare system.

Two variables comprised employment types: status and work type. Respondents could choose 7 options for employment status—“employed”, “self-employed”, “not employed”, “looking for work”, “disabled”, “retired”, and “other”. Given the small

sample sizes, “not employed”, “looking for work”, “disabled”, and “retired” were combined into not employed and other was excluded from the analysis. The second variable was employment work type, where respondents could choose “government organization”, “small business”, “self-employed”, “working without pay in family business”, and “other”. Due to low sample sizes, working without pay was excluded from the analysis. To determine if there were differences in the healthcare status among groups within the employment status and employment work type variables, an analysis of variances was conducted. An analysis of variances is employed to determine if there are significant mean differences on a continuous dependent variable (healthcare access mean scores) between groups of a categorical independent variable (employment status and employment work type).

The assumptions of the analysis of variance test include exclusion of outliers, multivariate normality (the distributions for all groups of the independent variable should be normally distributed) and homogeneity of variance (the variances of each of the groups of the independent variable should be relatively equal). Results of the preliminary analysis for employment status indicated that there were no violations in any of the assumptions.

Results of the analysis of variances comparing the employment status groups on healthcare status means scores indicated that there was no significant difference in means scores, $F(2, 92) = 1.29$, $p = .28$ (see Tables 3.19 and 3.20). Results of analysis of variance examining mean healthcare access differences among the groups in the employment work type variable indicated there were no significant mean differences between any of the employment work type groups, $F(4, 83) = 1.30$, $p = .278$ (see Tables 3.21 and 3.22).

Table 3.19
Descriptive Statistics ANOVA – Employment Status

	N	M	SD	95% CI	
				Lower	Upper
Employed	31	3.24	.67	2.99	3.48
Self-employed	55	3.44	.58	3.28	3.60
Unemployed	9	3.55	.88	4.23	2.48
Total	95	3.38	.646	3.25	3.51

Table 3.20
ANOVA Table – Employment Status

	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Between Groups	1.07	2	.54	1.29	.28
Within Groups	38.11	92	.41		
Total	39.18	94			

Table 3.21
Descriptive Statistics ANOVA – Employment Work Type

	N	M	SD	95% CI	
				Lower	Upper
Private for-profit company	15	3.28	.752	2.87	3.70
Private not-for-profit organization	4	2.89	.838	1.56	4.22
Government organization	6	3.10	.465	2.61	3.58
Small business	17	3.37	.720	3.00	3.74
Self-employed	46	3.49	.591	3.32	3.67

Table 3.22
ANOVA Table – Employment Work Type

	<i>SS</i>	<i>Df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Between Groups	2.19	5	.548	1.30	.278
Within Groups	35.11	83	.423		
Total	37.30	88			

Healthcare Access and Acculturation

Research Question #4: What is the difference in healthcare access between those with higher acculturation levels? My hypothesis was that those with higher levels of acculturation will not have greater access to healthcare. Higher levels of acculturation are not expected to be associated with greater access because Koreans use a pragmatic strategy of “accommodation without assimilation.” Those with longer stays in the U.S. will not likely possess higher levels of English proficiency and will face similar structural, organizational, and cultural barriers accessing healthcare.

Higher acculturation levels were measured using two different variables, length of stay in the U.S. and English proficiency. Length of stay in the U.S. was measured as an ordinal variable, where higher values represented longer time spent in the U.S. English proficiency was also an ordinal variable, where low values represented a higher level of English proficiency. Two separate correlation analyses were examined to assess if there was a significant linear relationship between the two variables and healthcare access.

Preliminary analyses indicate that there was no violation in linearity and that there were no outliers for either length of stay or English proficiency (see Figures 8, 9, and 10). Results of the correlation between healthcare access and length of stay in the U.S. indicated that there was no significant linear relationship between the two variables, $r = -.196$, $n = 97$, $p = .054$. However, there was a strong positive linear relationship between English proficiency and healthcare access, $r = .544$, $n = 96$, $p < .001$, where greater English proficiency was associated with greater access to healthcare.

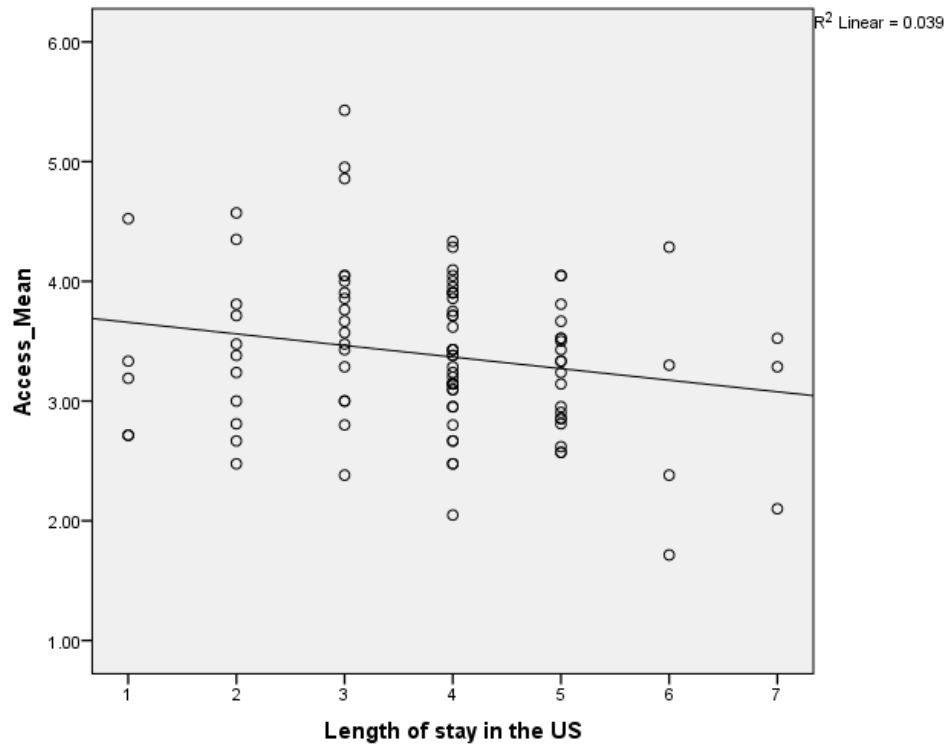


Figure 8
Scatterplot of mean access to healthcare and length of stay in the U.S.

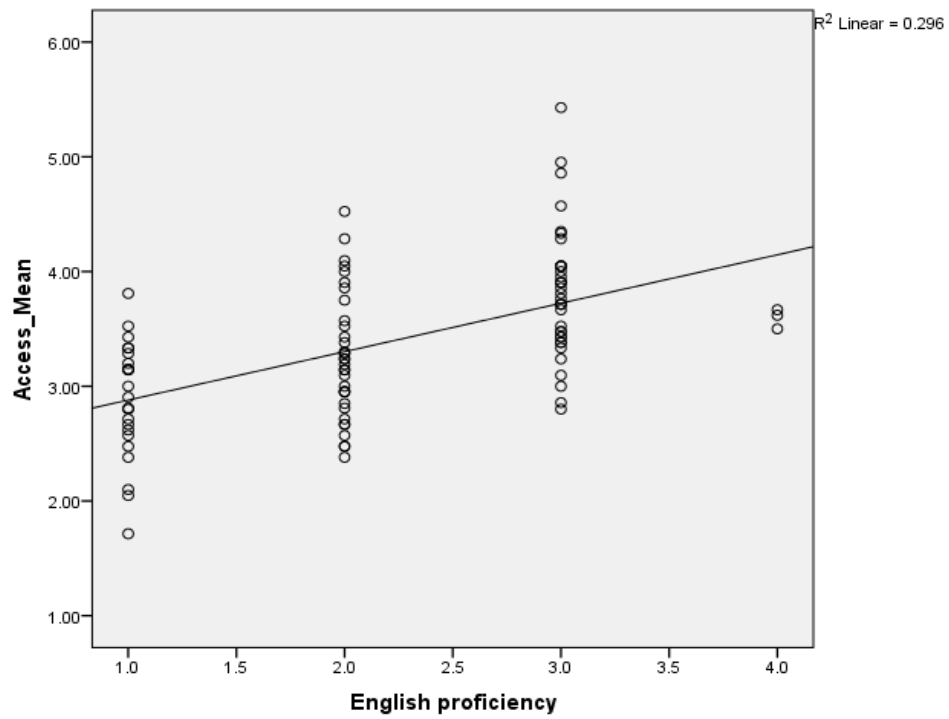


Figure 9
Scatterplot of mean access to healthcare and English proficiency.

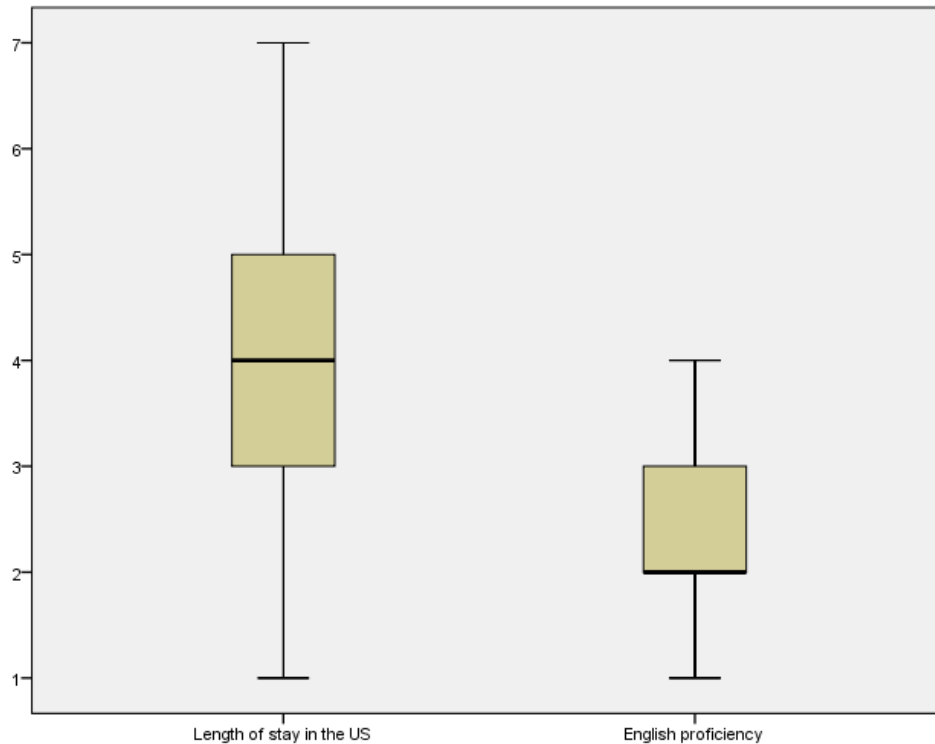


Figure 10
Boxplots of individual and total household income levels and mean access to healthcare illustrate no extreme outliers.

Given the significant correlation between English proficiency and the limited range of English proficiency scores (only 4 categories), an analysis of variance was conducted to determine if there were significant differences in healthcare access among the four English proficiency groups.

Preliminary tests indicated that there was no violation in multivariate normality nor was there a violation in the assumption of homogeneity of variance. Results of the analysis of variance indicate that there were significant differences among the groups, $F(3, 92) = 14.95, p < .001$ (see Tables 3.23, 3.24, and Figure 11). To determine which groups were significantly different from one another, post hoc tests were conducted using the Bonferroni adjustment. The Bonferroni adjustment was used to maintain the studywide error rate at .05 by dividing .05 by the number of post hoc comparisons

(Keselman & Keselman, 1988). Results of the post hoc test indicated that those who spoke English not well ($M = 3.81$, $SD = .570$) had significantly less access to healthcare than both those who spoke well ($M = 3.26$, $SD = .550$) and those who spoke English very well ($M = 2.88$, $SD = .514$). Those who did not speak English at all ($M = 3.60$, $SD = .067$) had significantly different access to healthcare than those who spoke very well, well, or not well (see Figure 11).

Table 3.23
Descriptive Statistics ANOVA – English Proficiency

	<i>N</i>	<i>M</i>	<i>SD</i>	95% CI	
				Lower	Upper
Very well	23	2.88	.514	2.65	3.10
Well	34	3.26	.550	3.07	3.45
Not well	36	3.81	.570	3.62	4.01
Not at all	3	3.60	.086	3.38	3.81

Table 3.24
ANOVA Table – English Proficiency

	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P</i>
Between Groups	13.25	3	4.42	14.95	.000
Within Groups	27.19	92	.30		
Total	40.44	95			

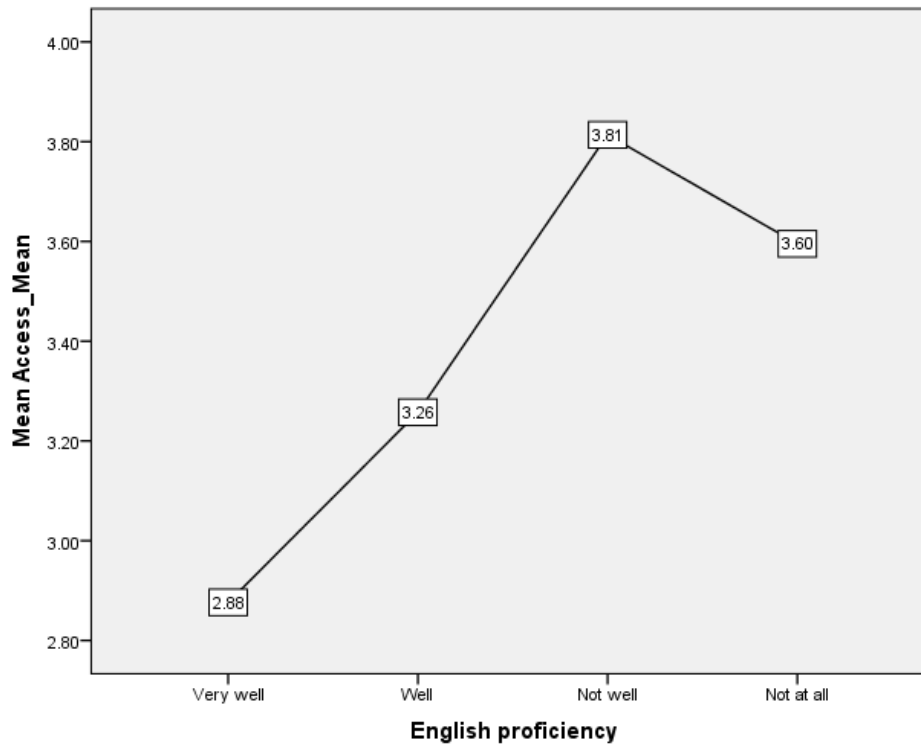


Figure 11
Access to healthcare mean plots by English proficiency groups.

Healthcare Access and Religiosity

Research Question #5: What is the difference in healthcare access between those with higher levels of religiosity? My hypothesis was that those with higher levels of religiosity will have worse access to healthcare. Those with higher levels of religiosity may possess fatalistic views that may deter or delay access to healthcare.

Religiosity was measured using three different variables: religious attendance, illness results from sin, and sickness can be healed only by God. Religious attendance was an ordinal variable, where lower scores represented more frequent religious attendance. Illness results from sin was a categorical variable coded 1 for no, 2 for yes, and 3 for maybe. Sickness can be healed only by God was also a categorical variable coded 1 for no, 2 for yes, and 3 for maybe. A correlation analysis will be used to examine

the relationship between healthcare access and religious attendance. However, because sickness can be healed only by God and illness results from sin are categorical variables, an analysis of variances was used to assess if there were differences among the three groups of the categorical variables and healthcare access.

Preliminary results of religious attendance indicated that there was no violation in the assumptions of linearity and extreme outliers. There were also no violations in the assumption of multivariate normality for either sickness can be healed only by God and illness results from sin. However, there was a violation in the assumption of homogeneity of variance for illness results from sin, but not for sickness can be healed only by God. Given the violation of homogeneity of variance, the Brown-Forsythe robust F test of equality of means was used instead of the standard ANOVA F test.

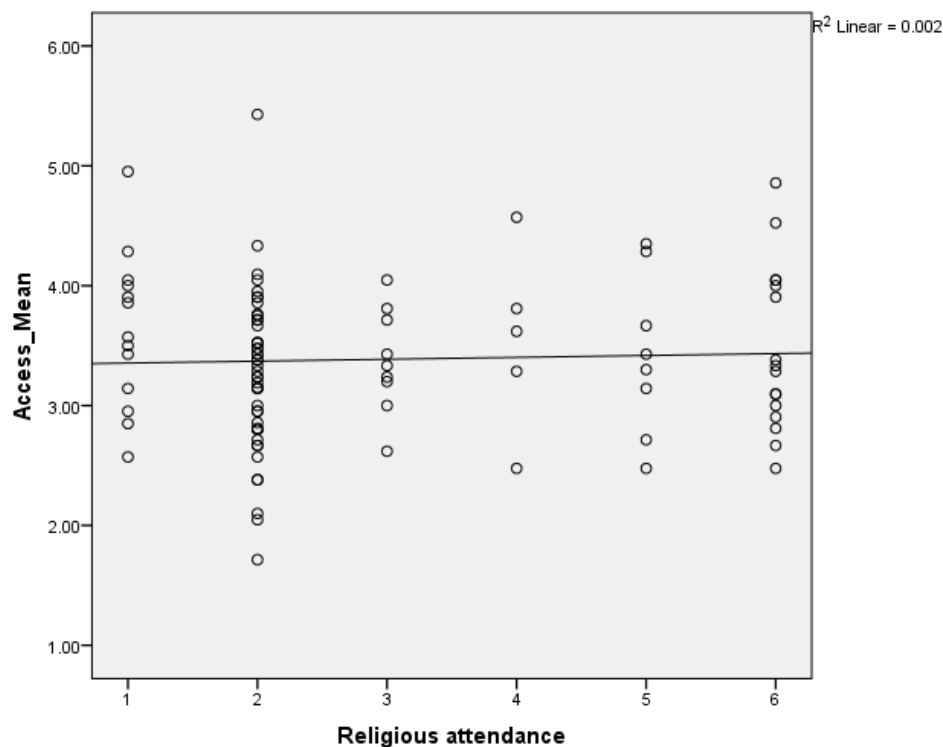


Figure 12
Scatterplot of mean access to healthcare and religious attendance.

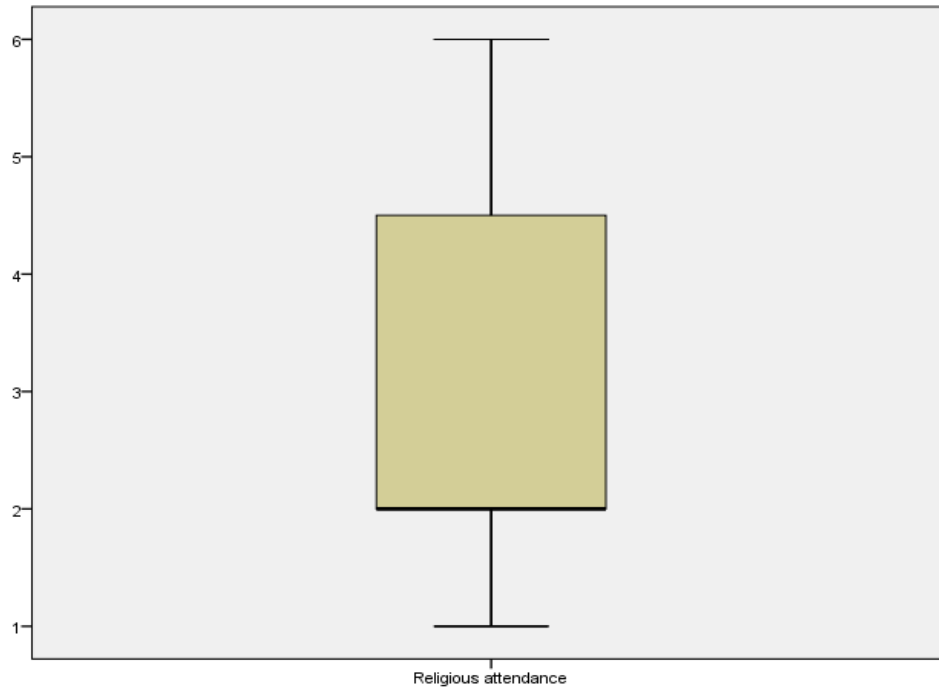


Figure 13

Boxplots of religious attendance and mean access to healthcare illustrate no extreme outliers.

Results of the correlation analysis indicated that there was no significant linear relationship between access to healthcare and religious attendance, $r = .041$, $n = 97$, $p = .687$. Results of the ANOVA using the Browne-Forsythe robust test of equality of means indicated that there were no significant differences among the three groups for the illness results from sin variable, $F(2, 9.24) = 1.474$, $p = .278$ (see Tables 3.25 and 3.26). The ANOVA analysis for the sickness can be healed only by God variable also yielded no significant differences among the yes, no, and maybe groups, $F(2, 93) = 1.12$, $p = .331$ (see Tables 3.27 and 3.28).

Table 3.25

Descriptive Statistics ANOVA – Illness Results from Sin

	<i>N</i>	<i>M</i>	<i>SD</i>	95% CI	
				Lower	Upper
No	78	3.38	.59	3.25	3.52
Yes	6	3.88	1.09	2.73	5.03
Maybe	12	3.12	.66	2.70	3.53

Table 3.26

ANOVA Table – Illness Results from Sin

	<i>F</i>	<i>df1</i>	<i>df2</i>	<i>P</i>
Brown-Forsythe	1.47	2	9.24	.278

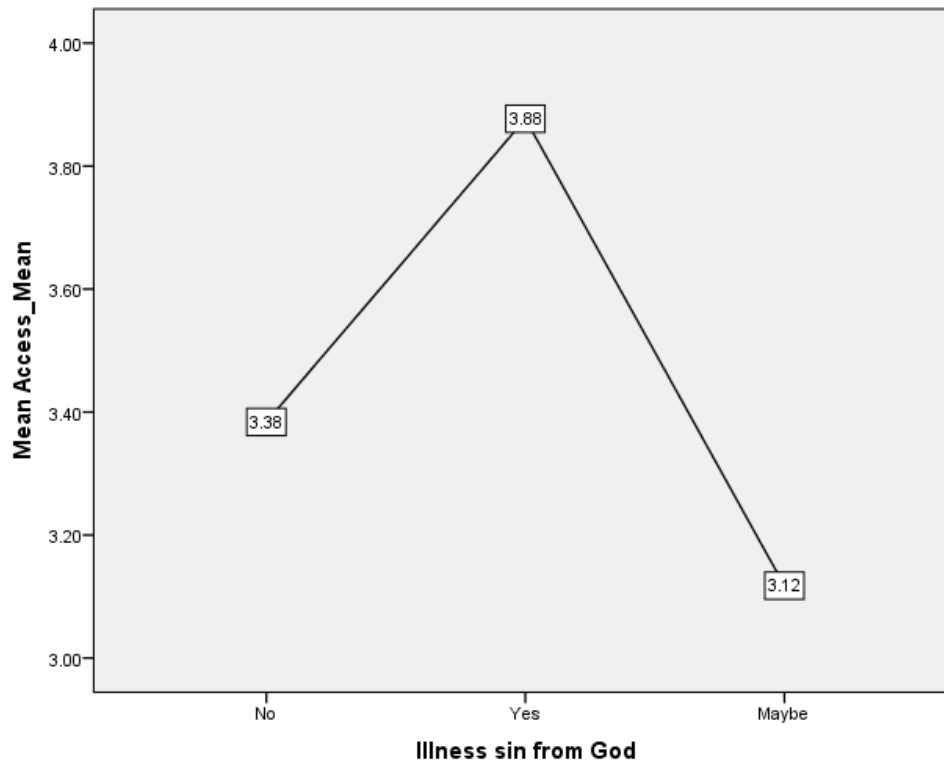


Figure 14

Access to healthcare mean plots by Illness Results from Sin.

Table 3.27

Descriptive Statistics ANOVA – Sickness can be Healed Only by God

	<i>N</i>	<i>M</i>	<i>SD</i>	95% CI	
				Lower	Upper
No	78	3.34	.63	3.20	3.48
Yes	7	3.72	.85	2.93	4.50
Maybe	11	3.44	.69	2.98	3.90

Table 3.28

ANOVA Table – Sickness can be Healed Only by God

	SS	df	MS	F	P
Between Groups	.95	2	.47	1.12	.33
Within Groups	39.31	93	.42		

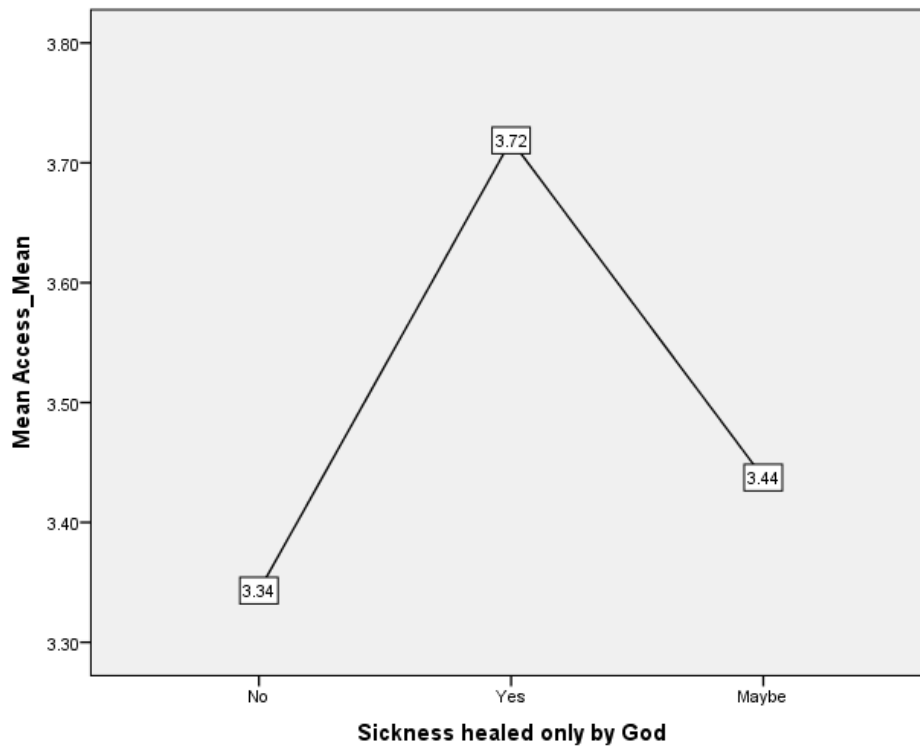


Figure 15

Access to healthcare mean plots by sickness can be healed only by God.

Additional Statistical Analyses

In addition to the five major research questions explained above, a few additional analyses were conducted to determine whether there was a correlation between health insurance coverage and healthcare utilization; as well as to determine the insurance coverage rate for those who were 66 and older in this sample. To determine whether there was a relationship between health insurance coverage and healthcare utilization, point-biserial correlations were conducted to evaluate if there were linear associations between health insurance coverage and healthcare utilization. Health insurance coverage, the dichotomous variable, has been previously defined. Healthcare utilization was defined using two variables; last medical check-up and health visit frequency. Last medical check-up was scored on a 1 to 7 scale where 1 was within the past 12 months and 7 was never. Health visit frequency is simply the number of times respondents reported health visits. Results indicated that there was no significant correlation for employer-based insurance (self), $r = -.108$, $n = 95$, $p = .148$, employer-based insurance (dependent), $r = -.169$, $n = 95$, $p = .051$, individually purchased insurance, $r = -.096$, $n = 95$, $p = .178$, and Medicaid, $r = -.113$, $n = 95$, $p = .138$, or Medicare, $r = -.162$, $n = 95$, $p = .059$. There was a significant positive correlation between health visit frequency and Medicaid, $r = .232$, $n = 96$, $p = .001$, and Medicare, $r = .203$, $n = 96$, $p = .024$, revealing that the more visits respondents reported the more likely they reported insurance coverage. There was no correlation between health visit frequency and employer-based insurance (self), $r = -.046$, $n = 96$, $p = .328$, employer-based insurance (dependent), $r = .036$, $n = 96$, $p = .362$, or individually purchased insurance, $r = -.054$, $n = 96$, $p = .300$. Lastly, as shown in Table 3.29, only 59.8% of those that are 66 and older ($n=14$) in this sample have insurance.

Table 3.29
Frequency Distribution of Those with No Insurance (66 and Older)

	N	%
No	58	59.8
Yes	38	39.2

Discussion of Results

Overview of Key Themes Across Qualitative Interviews and Access to Healthcare Survey on Koreans in the U.S.

Various themes that were highlighted in the qualitative interviews I conducted with health experts and advocates were consistent with the results of the Access to Healthcare Survey for Koreans in the U.S. Major observations are related to Koreans' high self-employment rates, limited English proficiency, low health insurance coverage rates and regular source of care, and various structural, system, and cultural barriers that greatly impede their access to healthcare.

Before delving into detailed discussions of major observations, it is important to note that when comparing Koreans and the general U.S. population, the Korean sample scored higher on socioeconomic indicators such as education. For instance, in terms of educational attainment, a majority of the Korean sample achieved a Bachelor's degree or above (67%). Based on U.S. census data from the 2008-2012 American Community Survey 5-year estimates, close to 29% of the general U.S. population has achieved a Bachelor's degree or above. The relatively high level of educational attainment among this sample is consistent with the Health Services Research literature on Koreans, which explains these high rates as a reflection of cultural values, which emphasize educational attainment as a means of social and economic advancement both in their home countries and abroad (Yoon, 2004; Yu et al., 2009).

Furthermore, consistent with my hypotheses, the inferential analyses on this sample demonstrated that there was a significant negative correlation between educational attainment levels and access to healthcare, most likely due to the fact that those who are more educated also have better jobs with higher income levels, significantly reducing the cost and system barriers they face when accessing the U.S. healthcare system. In particular—education place showed to be very significant, with those who received their education in the U.S. having much higher access to healthcare than those who received their education outside of the U.S. The key distinction here in these inferential analyses is that while Koreans are very educated in general, those that have obtained degrees outside of the U.S. have significantly lower levels of access to healthcare, due to high rates of self-employment or work in the ethnic economy. Conventional wisdom in the Health Services Research literature assumes that higher educational attainment regardless of educational attainment place contributes to higher levels of access – however, results from this survey indicate a critical difference between foreign and U.S. educational attainment and access to healthcare.

High Rates of Self-employment

This study supports the well-established notion that Koreans possess high self-employment rates, with 57% of the respondents indicating that they are self-employed. Numerous studies in the Health Services Research literature have noted that Koreans are self-employed and often work in the ethnic economy, in industries such as retail, restaurants and other service industries (Huh & Kim, 1998; Kim, 2004; Ryu et al., 2001 and 2002; Yoon, 2004; Yu et al., 2009). Nevertheless, my sample's self-employment rate is significantly higher than past studies. For instance, Min's 2009 study in New York City

found that 39% of Koreans were self-employed. Min acknowledges that his study underestimated the self-employment rate of the entire Korean workforce in New York City because his sample had more women (56%). I suspect that this rationale applies in my study sample as well because it included a substantial proportion of women (46%) and therefore the self-employment rate may be underestimated. While many Korean women are participating in the workforce, within the Korean community, men are more likely to be reported as self-employed.

Although Koreans possess higher educational attainment levels, many Korean immigrants adopt a pragmatic strategy of “accommodation without assimilation,” because they are likely to have earned their degrees outside of the U.S. and lack knowledge of English, which forces them to seek self-employment opportunities or work in the ethnic economy. Facing disadvantages in the U.S. labor market, they default to more service-oriented jobs, either by setting up low-startup-cost small businesses or working as low-wage workers in the ethnic labor market. Funding for small businesses is available in small Korean credit borrowing groups or cooperatives often referred to as “kye.”

More specifically, when analyzing the occupation types for the Korean sample, I found a pattern of downward mobility. The figure for service occupations held before emigration to the U.S. (13%) is much lower than the figure for service occupations held after emigration (34%). This significantly lower rate of service occupations held before emigration to the U.S. may be indicative of education being more commensurate with occupation and income in South Korea. Their predicament may be traced to possible

factors such as non-recognition of education obtained outside the U.S., and limited English proficiency.

Exploring trends for educational attainment, income, occupation and industry types for this sample support the argument that high rates of self-employment do not necessarily indicate a cultural propensity for entrepreneurship among Koreans but rather a strategy used to overcome disadvantages they face in the U.S. labor market.

Limited English Proficiency

In terms of the relationship between acculturation and access to healthcare, my hypothesis is consistent with the notion that Koreans become “enculturated” rather than “acculturated” due to their pragmatic approach of “accommodation without assimilation” that has been established in the Health Services Research literature (Park 2012; Yu et al., 2009). Koreans have the largest proportions of linguistically isolated persons (Kagawa-Singer et al., 1997). As hypothesized, despite long years of residence in the U.S., English proficiency is generally low for this sample. The inferential analyses support this notion – the analyses showed no significant relationship for length of stay and access to healthcare. Even those respondents that have lived in the U.S. for prolonged periods of time did not have greater access to healthcare.

Also, a significant positive correlation was observed for English proficiency. This finding underscores the negative effects of “enculturation”. These analyses showed that in fact, those with higher levels of English proficiency had much higher levels of access to healthcare. For example, those that spoke English “Very Well” and “Well” had significantly greater access to healthcare than those who spoke English “Not Well” or “Not at All.” It is likely that those with higher English proficiency are able to assimilate

to the U.S. labor market and possess better paying jobs and have the linguistic ability to navigate the U.S. healthcare system. This finding reiterates the importance of English proficiency and value of bilingualism.

As I will discuss in the next section, Koreans' pragmatic strategy of "accommodation without assimilation" has negative consequences to their access to healthcare. Because of this survival strategy, Koreans face many healthcare disparities, including lack of health insurance coverage, which is the main mechanism in which individuals in the U.S. obtain care.

Low Health Insurance Coverage Rates and Regular Source of Care

While socioeconomic indicators such as educational attainment may paint a rosy picture for Koreans, significantly low health insurance coverage rates reveal their vulnerability to lacking adequate access to healthcare. Approximately 40% of Koreans in this sample had no insurance at all, which is significantly higher than the rates for the general U.S. population, estimated at 13.3% for non-Hispanic Whites, 20.6% for Blacks, 30.7% for Hispanics, 16.3% of Asians, and 25.6% for American Indians/Alaska Indians (the CPS Annual Social and Economic Supplement or ASEC, 2012); as well as much higher than the uninsured rate projected for Koreans in the 2010 American Community Survey of 24%. The uninsured rate for this sample is higher than past rates published in the Health Services Research literature, including one study that found that approximately one third of its sample of Korean elderly was uninsured (Sohn, 2004) . As described in the previous section, high self-employment rates and work in the service-related occupations are some of the key reasons for these high uninsured rates. These findings are aligned with figures included in recent research from the Kaiser Family

Foundation, which found that uninsured rates are much higher in the services/arts entertainment and wholesale/retail industries in contrast to other major industries (refer to Figure 15).

Uninsured Rates Among Selected Industry Groups, White vs. Blue Collar Jobs, 2012

Figure 3

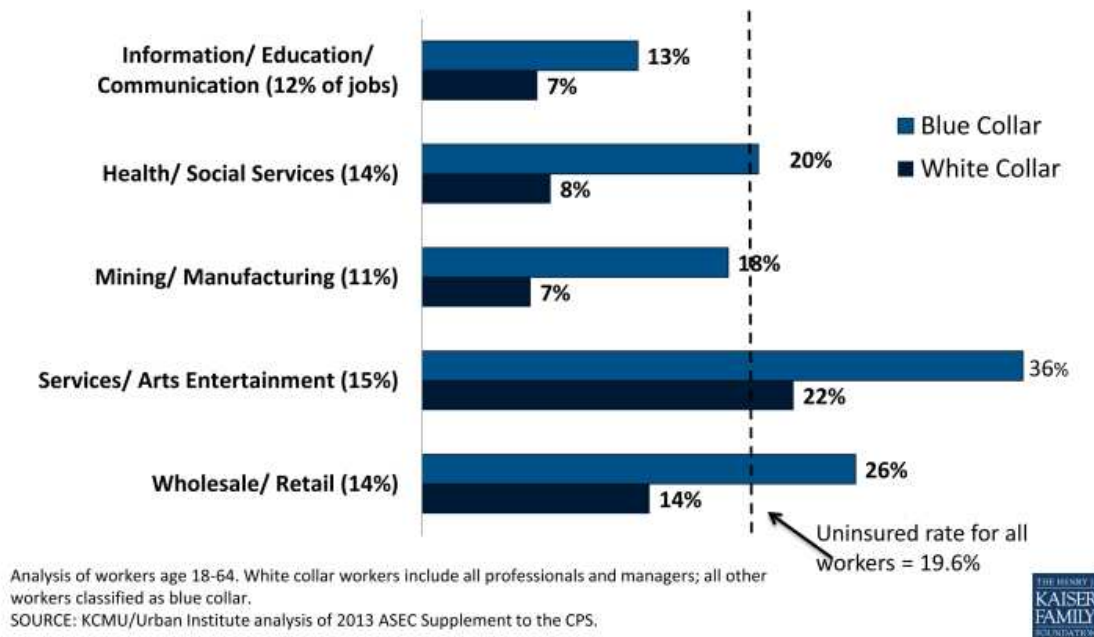


Figure 16
Uninsured Rates Among Selected Industry Groups

Furthermore, 42% of the respondents reported having no regular source of care. Respondents indicated almost nonexistent utilization rates of community health organization services, with only 20% of the sample utilizing mostly health clinic services (18%). This is a surprising finding considering a substantial portion, 36%, perceived their health status as being “fair” (29%), “unhealthy” (6%), or “very unhealthy” (1%).

Given that Koreans have one of the most institutionally complete Asian communities in New York (Min, 2001), one of the most surprising aspects of this study

was the almost nonexistent use of community healthcare services, even in light of the fact that this sample had high uninsured rates (40%). Nevertheless, findings from the interviews with health experts and advocates showed that low rates of community health resource utilization is a reflection of community organizations' lack of reach. These findings are also consistent with other past studies that reported lack of knowledge and utilization of health and social services (Moon et al., 1998). Funding constraints most likely limit the resources these organizations have available to market their services.

High Cost of Health Insurance

One of the most salient barriers to accessing healthcare among Koreans is the high cost associated with health insurance. While the results of my inferential analyses showed that although there was no significant relationship for individual income and access to healthcare, a significant negative correlation was observed for total household income, which ranged from \$5,000 to over \$200,000. Those respondents with higher levels of total household income have greater access to healthcare. In particular, my analyses showed that those respondents with total household incomes between \$80,000 to \$100,000 were more likely to be insured for this sample (23%). Those households that fall under this income bracket are less likely to be able to afford health insurance costs (39%). More specifically, most households in this sample had incomes well below \$80,000, with approximately 23% of households in the sample making \$40,000 or less.

Based on the findings on the income levels of Koreans discussed above, one can argue that Korean households are unable to absorb the high costs of health insurance because insurance costs are likely to be a last priority. Knowing that this subgroup has high rates of self-employment, it is likely that they experience competing financial

demands related to running their small businesses and providing basic necessities such as education, shelter, and food. Some scholars such as Min (2009) have indicated that there is a tendency for Koreans to under-report income but modest income findings of this study demonstrate that while under-reporting may exist, this practice is likely to have a minimal effect on their overall socioeconomic status. Due to the voluntary and anonymous nature of this survey, it is likely that the incomes reported are accurate.

System Barriers

The occupational constraints of self-employment (e.g., long work hours and loss of wages) coupled with the limited English proficiency levels seem to be major contributing factors to why the respondents find that: (1) the U.S. healthcare system is confusing; (2) they have a lack of awareness of community healthcare services; and (3) they find enrollment in public insurance to be difficult. The access to healthcare barriers scale measured factors 1 and 3; both scoring a mean of 4.35 (SD=1.63 and 1.53). In other words, the average response of this sample was “slightly agree” or “agree”. The sample also showed a lack of awareness of community healthcare services, with close to 80% indicating no utilization of community healthcare services. Moreover, these barriers are particularly of concern for Koreans in this sample because a substantial portion of the sample reported their health as being fair or worse (36%), suggesting that underutilization of healthcare is even prevalent despite poorer self-reported health status. So the question is: what strategies are Koreans in this sample taking to stay healthy?

Cultural Barriers

Despite themes of increased medical tourism practices raised during my qualitative interviews with health experts and advocates, the figures in this study do not indicate a trend of Koreans returning to their home country for health treatments. This low rate of medical tourism may be explained because the sample had high rates of self-employment and small business ownership or work, which create significant occupational constraints in terms of taking off time that is needed to travel to South Korea and receive treatment. Because many Korean small businesses are family run (i.e., husband-and-wife operations), receiving treatment abroad would be a significant loss of time and money. On the other hand, utilization of Korean traditional medicine was substantially high for this sample at 48%, with 37% of respondents utilizing a traditional Korean medicine provided 1 or more times in the last 12 months. Utilization of traditional Korean medicine was even higher among uninsured respondents at 80%.

Another important strategy to maintaining health examined in this study was the role of religiosity on access to healthcare. Some scholars believe that greater involvement in religion is associated with better health while others believe that religion actually has a negative impact on access to healthcare (Jo et al., 2010). For this study, religiosity was measured by two indicators – one that assessed whether illness is or may be a punishment from God and another that assessed whether respondents believed that illness can or may only be healed by God. A small part of the sample indicated that illness is or may be a punishment from God (18%) and illness can or may only be healed by God (17%). A few respondents also included comments on the survey for these questions, noting that

illness is or may be present in an individual because of a sin they committed or a result of retribution from God.

While this particular response rate is not significant, it is important to take into account the common religious beliefs that exist within the Korean community, especially because they have very high rates of religious attendance and affiliation. Religion influences individuals' views of the world and their lives, in the context of health and illness. For example, fatalistic religious views may deter or delay individuals from seeking healthcare in a timely manner. However, for this sample, levels of religiosity do not appear to be significant, which is also corroborated in the inferential analyses discussed earlier in this chapter.

Fragmented Approach to Healthcare

The evidence provided by my study suggests that respondents in my sample are taking a fragmented approach to healthcare by utilizing traditional medicine to manage their health needs in lieu of conventional Western medicine. When asked whether the respondents preferred conventional Western medicine versus traditional Korean medicine, the mean response rate was 2.61 ($SD=1.37$). In other words, respondents on average “disagreed”/ “slightly disagree” that they had a distinct preference for traditional Korean medicine. Moreover, these figures suggest that respondents are likely to be utilizing traditional Korean medicine because it is often cheaper, sold by culturally and linguistically competent providers, and more convenient because many providers are located in Korean enclaves and have flexible night time and weekend hours.

Limitations and Strengths

This study has a few limitations. In terms of the data collected from the qualitative interviews with health experts and advocates, one limitation is that the sample of interviewees, which were selected based on the Health Services Literature may not represent a broad range of experience across all the four Asian subgroups studied in this dissertation. To mitigate this risk, I ensured the interviewee sample was distributed evenly across the subgroups so that it was as representative of all four Asian subgroups as possible. In addition, this study has a number of limitations related to the data collected using the Access to Healthcare Survey for Koreans in the U.S. instrument. First, the use of nonprobability sampling limits generalizability of the findings to the entire population of Koreans in the U.S. The findings might have been influenced, at least in part, by characteristics of this particular sample of Koreans, and it is possible that using another sample of Koreans would have yielded different results. Despite this limitation, my study represents the most comprehensive data currently available in the Health Services Research literature, which seeks to understand structural, system, and cultural barriers that impact vulnerable Asian American subgroups' ability to access healthcare (of which the researcher is aware). Second, the sample size for Koreans was relatively small ($N=107$), but large enough to generate statistically significant analyses. Small sample sizes reduce the confidence that one places in the results and associated analyses.

In sum, this study's limitations are outweighed by its strengths. First, this study contributed to the existing Health Services Research literature by comprehensively examining the relationship between access to healthcare and the most vulnerable Asian American subgroups in the U.S., using a wide range of indicators measuring structural,

system, and cultural barriers. Second, and most importantly, the study on Access to Healthcare for Koreans in the U.S. is one of the first comprehensive attempts at documenting the healthcare access, needs, and health status of Koreans living in the East Coast region. This study is one of the first in the literature to document uninsured rates among Koreans living in the East Coast region, expanding the body of knowledge on Koreans in the U.S. Lastly, this study is one of a kind in the literature since it also conducts comparative analyses to incorporate valuable lessons on access to healthcare from other countries around the globe that can be helpful in the U.S. context to illustrate how other countries address the barriers to access that their populations face. This last component of my dissertation will be discussed in the next chapter.

CHAPTER 4: LESSONS FROM ABROAD

Equity in health service provision does not necessarily mean being able to use the same services as everybody else. Existing services may have to be adapted to give migrants and ethnic minorities access to high-quality, appropriate health services.

- World Health Organization (2010)

The purpose of this chapter is to discuss lessons from abroad that can provide insight for the U.S. in terms of improving access to healthcare for vulnerable Asian subgroup populations. I will begin with a summary of the common themes that were derived in this study's data collection efforts as the lessons from abroad will center on how other countries address these common themes.

In Chapter Three, I discussed the results from the qualitative interviews that I conducted with health experts and advocates as well as the results of the Access to Healthcare Survey for Koreans in the U.S. Each of these data sources was key in developing a holistic and thorough understanding of the structural, system, and cultural barriers faced by vulnerable Asian subgroup populations. Building on my revised framework for studying access to healthcare and my interdisciplinary approach, which includes the Health Services Research and Comparative Health Policy literatures, Table 4.1 provides a summary of the key themes derived from these data sources. Common themes across these two data collection efforts are italicized. Examples of common themes include low health insurance rates, high rates of self-employment, high cost of health insurance, confusion with healthcare system, difficulty enrolling in public insurance, lack of awareness of community healthcare services, and limited English proficiency.

Table 4.1

Summary of Key Themes of Interviews and Access to Healthcare Survey

Key Themes Across Interviews and AHCS Survey Results		
Structural Barriers	System Barriers	Cultural Barriers
<ul style="list-style-type: none"> • <i>Low health insurance coverage rates*</i> • <i>High rates of self-employment or work in the ethnic labor market)*</i> • <i>High cost of health insurance*</i> 	<ul style="list-style-type: none"> • <i>Healthcare system is confusing*</i> • <i>Enrolling in public insurance is difficult*</i> • <i>Lack of awareness of community healthcare services*</i> • Confusion or lack of awareness about patient and immigrant rights • Lack of transportation • Lack of culturally competent providers • Limited hours 	<ul style="list-style-type: none"> • <i>Limited English proficiency*</i> • Alternative medicine preference • Distrust of American healthcare system • Family structure dynamics • Physical practices connected to religious beliefs and fatalistic views of religion • Use of medical tourism

Note: Common themes across interviews and AHCS data are italicized and marked with an asterisk.

Contrary to conventional wisdom in the Health Services Research literature, these common themes, in particular in the context of the Korean population, highlight the notion that cultural factors are not prominent barriers but, rather, structural barriers such as employment and occupational type are the most salient barriers. In other words, the way in which vulnerable Asian American subgroups such as the Koreans behave is highly dependent on the way in which the U.S. healthcare delivery system is designed, organized, and implemented. The impact of cultural factors, such as the profound preference for Eastern or alternative medicine, distrust of U.S. healthcare system, religious beliefs, and medical tourism practices to some extent have been overly emphasized. In reality, none of these cultural factors alone can fully explain why vulnerable populations like these experience disproportionate number of barriers to accessing healthcare. Moreover, without conducting an in-depth survey like the one

conducted for the Koreans in this study, it is difficult to draw similar observations for the other three Asian subgroups—the Bangladeshi, Cambodian, and Pakistani subgroups—based on data gathered from qualitative interviews with health experts and advocates alone.

Another valuable aspect of this dissertation is the topic of discussion in this chapter, which is to examine possible lessons from countries like Germany and the United Kingdom to help formulate feasible solutions to addressing the barriers that were identified in this study’s comprehensive literature review and extensive fieldwork. While there are distinct differences in political economies and healthcare system structures, this chapter attempts to derive lessons learned from Germany and the United Kingdom. These countries have identified vulnerable populations with similar access to healthcare barriers as the ones found in the U.S. and have implemented innovative and targeted interventions to address those barriers. The lessons learned from these countries will be discussed in detail after a brief discussion of the importance of cross-national learning in healthcare policy, case selection criteria, overview of the three countries of comparison, and lastly individual country overviews on the healthcare systems and key provisions of care.

The Value of Cross-National Learning in Healthcare Policy

According to Dolowitz and Marsh (1996), the concept of “policy transfer” or what is also known as “lesson drawing” was born as a subset of the comparative politics discipline. These scholars explain that initially, in the 1940s, studies were mainly focused formal institutions of government and by the 1960s emphasis shifted to comparative policy analysis. In their comprehensive literature review, these scholars organized these studies into two major categories: (1) some studies that do not explicitly use the concept

of policy transfer but “...throw considerable light on policy transfer” and (2) studies that explicitly deal with the process of lesson drawing (Coleman, 1994; Walsh, 1994). With globalization, Blank and Burau (2007) indicate that the process of cross-national learning, “...occurs naturally as information about other countries has become more readily available...” (p. 227).

There is general consensus among scholars across social science disciplines that cross-national learning is a valuable tool for social inquiry. Earlier scholars such as Rose (1991) recognized the value of cross-national learning because, simply put, countries share the same social, political, and economic problems, and therefore countries are in a position to learn from each other by studying the way others have responded in similar situations. According to Rose, the value in this technique is rooted on the notion that examining shared problems “...in an unfamiliar setting can expand ideas and inspire fresh thinking about what is possible at home” (Rose, 1991, p. 22).

While there is a general consensus among scholars that cross-national learning is a valuable tool for social inquiry, skeptics like Klein (1997) have rightly pointed out that the rapid growth of comparative studies has generated many studies that suffer from methodological issues. He argues that the comparative health policy literature reflects an overly optimistic and naïve view on the value of cross-national learning. In a similar vein, while they also believe in the value of cross-national learning because “...learning about the experiences of other nations is a precondition for understanding why change takes place, or for learning from that experience”, Marmor et al. (2005) observe that many studies have taken on cross-national learning for the sake of expanding ideas or gaining an understanding of what other countries have achieved without “...further exploration of

the political, social, and economic context required for implementation, this is wishful thinking” (p. 333). Without having a comprehensive understanding of the contextual environment of countries being compared, it is unlikely that lessons can be transferred to another country since similar conditions between countries of comparison are needed to realize such change.

Nonetheless, Marmor, Freeman, and Okma (2009) find that when “...properly done, studies that compare what appear to be similar topics have two potential benefits not available to the policy analyst in a single nation inquiry” (p. 6). In efforts to address the major methodological issues in cross-national studies such as inconsistent terms and definitions, Kieke, Okma, and Marmor (2013) provide useful ground rules that can help mitigate these issues. These scholars have developed five ground rules for comparative studies, which at a high level include establishing: (1) a clear understanding of the purpose for the comparison, (2) organization of the healthcare system (e.g., public versus private) and, (3) values, institutions, and organized interests in the healthcare domain; (4) applying consistent terms and well defined definitions, and (5) providing ample time for in-depth cross-national learning (Kieke, Okma, and Marmor, 2013, p. 491).

Moreover, while some may be skeptical, I argue that lesson drawing is a worthwhile pursuit, regardless of whether aspects of the political, social, and economic context vary among countries being compared. Using the ground rules for comparative studies provided by Kieke, Okma, and Marmor (2013), this chapter will demonstrate that learning from other countries is indeed valuable because examples of others’ successes and failures can serve as illustrations of what can be done better to serve these populations at home. For example, as discussed in detail later in this chapter, there is a lot

that the U.S. can learn from Germany and the United Kingdom, especially in terms of the key underlying principles that must exist within healthcare delivery systems in order to successfully promote and generate greater access to healthcare for vulnerable populations. In sum, at a minimum, lessons from abroad bring insight and should inspire new ideas to approaching challenges we face with the U.S. healthcare system.

To policymakers, studies like these can provide criteria for determining which health policies work best as well as offering a virtual test of different policy options (Stone, 1999). This study, by contrast, suggests that an interdisciplinary approach that includes the Health Services Research and Comparative Health Policy literatures can be truly effective. This study's interdisciplinary approach was conducive to generating a more holistic understanding of the structural, system, and cultural barriers that impact the way that the most vulnerable Asian American subgroups access healthcare as well as offered innovative ways to think about healthcare issues. For instance, drawing lessons from abroad from countries such as Germany and the United Kingdom identified key underlying concepts of their healthcare systems that can be used to spur dialogue and generate new ideas in terms of how we can enact change in the way we provide healthcare for vulnerable populations such as Asian Americans. For all these reasons, policymakers can leverage this interdisciplinary approach to address specific problems that they are facing.

Case Selection Criteria

Germany and the United Kingdom were selected based on three major criteria that have been identified in expert and respected studies in this field such as the Commonwealth Fund. One strict requirement was to ensure that countries selected for

comparison to the U.S. were also part of the Organization for Economic Co-operation and Development. The second case selection requirement was that the countries selected must have significantly sized foreign-born immigrant populations. Both Germany and the United Kingdom have established immigrant populations. For example, based on 2001 census estimates, Iqbal et al., 2012 state that, "...South Asians made up 50% of the UK's total non-white population and 4% of the total UK population..." (p. 5). According to a European Commission report on Germany and the United Kingdom, the former has approximately 15.3 million immigrants (18.6%) and the latter has approximately 3 million immigrants (5.2%) (Huber et al., 2008). According to Passel and D'Vera Cohn (2011), the U.S. is estimated to have 40.4 million immigrants (13%).

Lastly, following Esping-Andersen's typology of welfare states (1990), the last criteria was to include a range of both "liberal" and "conservative" states. The United Kingdom was selected since it is a "liberal" welfare state like the U.S. and Germany because it is a "conservative" welfare state. In addition, Germany was specifically selected because it has both a federated and highly decentralized healthcare system, similar to the U.S., and therefore shares a similar history with the U.S. in terms of its reliance on the labor market to finance and organize its health insurance system (i.e., employer sponsorship). Previous scholars, such as Amelung, Glied, and Topan (2003), acknowledged the similarities between the German and American health insurance systems and have shown the value of looking closely at Germany's evolution to draw valuable lessons for U.S. health insurance.

This last selection criteria has particular significance—the general consensus among comparative studies is that countries with liberal welfare states have greater

inequalities in population health than those with social (i.e., conservative) or Christian democratic welfare states. Liberal welfare states tend to adopt labor market and welfare state policies that lead to greater levels of inequality (Esping-Andersen, 1990).

Examining a range of welfare state types will help assess and predict our country's trajectory, asking: is it possible for the U.S. to overcome the effects of neo-liberalism as it undergoes major healthcare reform or is that effort doomed to fail?

Albeit, this chapter acknowledges the difficulties and limitations in undertaking a comparative analytical approach. Germany, the United Kingdom, and the U.S. widely differ in their financing, provider payment mechanisms, and delivery system organization. With the advent of healthcare reform mandated by the Affordable Care Act, there are already major transformations underway for the U.S. healthcare system and many more through 2019. It seems timely and important to place an emphasis on international learning in the context of health and healthcare and attempt to understand the experiences other countries have already undergone through similar transformations. Despite well-known difficulties in cross-national learning, such as limited data sources, drawing from other countries' experiences is valuable and a source for generating new ideas and best practices. It informs policymakers about possible lessons that can be drawn from other countries facing similar access to healthcare issues with vulnerable populations within their countries.


Brief Comparison of Healthcare Systems

In 2010, the Commonwealth Fund published its performance assessment of the U.S. healthcare system in relation to other countries internationally (Davis, Schoen, & Stremikis, 2010). As Table 4.2 shows, this study examined key indicators of healthcare

system performance ranging from categories of quality care, access, efficiency, equity, long/healthy/productive lives, and health expenditures/capita in 2007. The U.S. along with other countries such as Germany and the United Kingdom as well as Australia, Canada, the Netherlands, and New Zealand, were ranked from 1 (performing the best) to 7 (performing the worst) for each category. Prior to discussing what can be learned from the German and British healthcare systems, these indicators are helpful in gaining an understanding of how Germany, the United Kingdom, and U.S. compare to one another in key aspects of healthcare system performance.

Table 4.2

Performance of the U.S. Healthcare System Compares Internationally

Country Rankings								
	1.00-2.33							
	2.34-4.66							
	4.67-7.00							
		AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)		3	6	4	1	5	2	7
Quality Care		4	7	5	2	1	3	6
Effective Care		2	7	6	3	5	1	4
Safe Care		6	5	3	1	4	2	7
Coordinated Care		4	5	7	2	1	3	6
Patient-Centered Care		2	5	3	6	1	7	4
Access		6.5	5	3	1	4	2	6.5
Cost-Related Problem		6	3.5	3.5	2	5	1	7
Timeliness of Care		6	7	2	1	3	4	5
Efficiency		2	6	5	3	4	1	7
Equity		4	5	3	1	6	2	7
Long, Healthy, Productive Lives		1	2	3	4	5	6	7
Health Expenditures/Capita, 2007		\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: * Estimate. Expenditures shown in \$US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

Source: Davis et al., *“Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally – 2010 Update”* The Commonwealth Fund, June 2010.

More specifically, as shown in Table 4.2, the U.S. ranked as a 6 and above in the majority of indicators, ranking 4 in some subcategories of quality of care (i.e., effective care and patient-centered care), as well as a 5 for timeliness of care under the access category. In relation to the U.S., Germany and the United Kingdom have significantly higher rankings, with the latter performing at the top of the scale. With the exception of a few indicators, such as the patient-centered care subcategory under the quality of care category, the timeliness of care subcategory under the access category and long/health/productive lives, the United Kingdom rankings are relatively higher than Germany's rankings. Among all of the countries in this study, the United Kingdom has received the top rankings along with the Netherlands. Lastly, in terms of health expenditures, the U.S. has the highest costs at \$7290, followed by Germany at \$3,588, and \$2,992 for the United Kingdom. According to Adolino and Blake (2001), possible factors of higher healthcare spending in the U.S. include various reasons such as higher administrative costs due to variety of insurance plans, fee for service, absence of firm global budgets for hospitals, defensive medicine (i.e., expensive tests to protect against potential malpractice law suits), and cost shifting from the uninsured and underinsured to the insured. Higher costs in the U.S. also underscores the absence of national fixed prices or other forms of price controls that are in place in countries like Germany and the United Kingdom.

In addition, Schoen et al. (2010) explored how health insurance design affects access to healthcare and costs in 11 countries as outlined in Table 4.3 ($N=19,000$). This study found that adults in the U.S. fare worse among the 11 countries – approximately 33% went without care because of cost, 35% had out-of-pocket costs that were \$1000 or

more, 20% had serious problems or were unable to pay medical bills, and 31% spent a significant time on paperwork and issues over medical bills or health insurance denials. For the most part, the United Kingdom has significantly fewer access to healthcare issues in comparison to the U.S. and does fairly well when compared to other countries in this study. Some areas of concern for Germany include that approximately 25% went without care because of cost and 23% had problems with health insurance. As shown in Table 4.3, the U.S. clearly lags behind most indicators, with both Germany and the United Kingdom performing significantly better while keeping healthcare costs much lower than costs in the U.S.

Table 4.3
Access, Cost, and Insurance Problems in Past Year

Percent	AUS	CAN	FR	GER	NET	NZ	NOR	SWE	SWIZ	UK	US
Went without care because of cost*	22	15	13	25	6	14	11	10	10	5	33
\$1000 or more out-of-pocket costs	21	12	4	8	9	7	16	2	25	1	35
Serious problem or unable to pay bill	8	6	9	3	4	6	5	5	6	2	20
Problems with health insurance**	14	15	23	23	20	6	9	4	13	5	31

*Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.

**Spent a lot of time on paperwork or disputes over medical bills and/or health insurance denied payment or did not pay as much as expected in past year.

Source: *Commonwealth Fund International Health Policy Survey in Eleven Countries* (Schoen et al., 2010)

Prior to a discussion of the lessons from Germany and the United Kingdom, it is necessary to have a general understanding of how these healthcare systems deliver care to

their populations. This section describes the organization of the U.S., German, and British healthcare systems, including discussions of health insurance schemes, safety net providers for the uninsured, strategies for improving healthcare inequalities, as well as healthcare reform in the U.S. context in light of the major reform that is underway for the Affordable Care Act.

United States

Organization of Healthcare Delivery System and Health Insurance

The organization of the healthcare delivery system in the U.S. consists of mostly private practice physicians; for-profit, non-profit or public hospitals; community-based health centers; and the federal government. According to Frogner and Anderson (2006), these providers are paid through various methods,

The majority of physicians are in private practice....They are paid through a combination of methods: charges, discounted fees paid by private health plans, capitation rate contracts with private plans, public programs, and direct patient fees. Hospitals can be for-profit, non-profit, or public hospitals and are paid through a combination of methods: charges, per admission, and capitation (p. 102).

Furthermore, the U.S. health insurance system can be characterized as a mixed insurance system comprising both public and private insurance (Ellis, Chen, & Luscombe, 2014).

The private system consists of more than 1200 not-for-profit and for-profit health insurance companies that are regulated by states. Public and private providers that are primarily organized at the state and local level (DeLew et al., 1992). As a result of the decentralized organization of health services, there is great variation in the types and availability of healthcare services. Accessibility to services depends on the availability and the type of insurance coverage (Gulliford & Morgan, 2003). In terms of public services, availability and eligibility rules for Medicare and Medicaid coverage vary by

state. These variations result in substantial gaps in the use of these healthcare services for the uninsured.

Most individuals are covered by employer-based health insurance funded by voluntary premium contributions shared between employers and employees. Private health insurance can also be purchased by individuals who do not have employer-based health insurance options, in which case costs are paid solely by individuals. What made it even more challenging in the pre-reform era is that health benefit packages varied widely according to type of insurance, with more comprehensive packages being significantly more expensive. Benefit packages included a range of preventive services, inpatient and outpatient hospital care, and prescription drug coverage. Cost-sharing provisions varied by type of insurance. In 2012, approximately 170.9 million (54.9%) were covered by employer-based insurance (Denavas-Walt, Proctor, & Smith, 2013).

The public health insurance system comprises Medicare, Medicaid, Children's Health Insurance programs, and Veterans healthcare system. Medicare is the social insurance program for the elderly, individuals disabled under age 65, and those with end-stage renal disease. This program is administered by the Centers for Medicare and Medicaid Services, a federal government agency and is financed through a combination of payroll taxes, general federal revenues, and premiums. On the other hand, Medicaid is a federal-state health insurance program covering the poor. Medicaid is also administered by states and operates within broad federal guidelines. In 2012, approximately 48.9 million Americans (15.7%) were covered by Medicare and 50.9 million Americans (16.4%) were covered by Medicaid (Denavas-Walt et al., 2013). The Children's Health

Insurance Program is public insurance for low-income children, which is also administered by states.

Lastly, the Veterans healthcare system is the largest integrated healthcare delivery system for U.S. veterans, their dependents and survivors of disabled veterans, which has been referred to resembling “....a veteran-specific national health service” (Oliver, 2007; Klein, 2011). This system is administered by the Veterans Health Administration, and the federal government owns the medical facilities and employs the healthcare providers. Through sharing agreements, it also provides care for the Department of Defense’s TRICARE program, which provides care to military service members, retirees, and their dependents. According to Percy (2009), the Veterans healthcare system delivered care to 5.1 million veterans in 2008. After undergoing major reforms in the mid-1990s that shifted towards a centrally managed system, the Veterans healthcare system has been viewed as a success story, especially in terms its ability to control costs (Oliver, 2007).

Safety Net Providers

Prior to healthcare reform efforts, market failures were so severe in the U.S. that even with government intervention that provided insurance to the elderly, permanently disabled, and very poor people, approximately 15% of Americans remained uncovered, according to the U.S. Census Bureau’s 2012 American Community Survey. The large percentage of uninsured individuals in the U.S. relies primarily on a makeshift “system” of safety net providers, including public and not-for-profit hospitals, federally qualified community health centers, school-based health centers, municipal/local health clinics, and free health clinics. Out of all these options, if the uninsured seek care, they tend to seek care in community health centers.

In the U.S., community health centers are government-sponsored institutions that provide low-cost care to underserved and low-income populations (Askin & Moore, 2012). Some are designated as Federal Qualified Health Centers, which enables them to receive extra funding from Medicare, Medicaid, and the Children's Health Insurance Program. As of 2014, more than 9,000 locations were providing care to 22 million patients annually (National Association of Community Health Centers). According to the Kaiser Family Foundation, in 2007, 257 of the 1,057 federally funded Federal Qualified Health Centers in the U.S. were located in four states with some of the highest concentrations of immigrants (Florida, New York, Texas, and California).

Lastly, free and charitable clinics also offer care for underserved and low-income populations. Askin and Moore (2012) describe the main differences between community health centers and free and charitable clinics as being that the latter are not government-sponsored and are operated by non-profit organizations.

Comprehensive Healthcare Reform

The Affordable Care Act attempts to address the massive issue of uninsurance and problems associated with social stratification in the U.S. Gaskin, Dinwiddie, Chan, and McCleary (2012) summarize the legislation, explaining that the reform will: (1) provide \$11 billion to expand community health centers, (2) increase payments to primary care providers that take public insurance, and (3) reduce the uninsured population from 49.9 million to 22.1 million through the expansion of Medicaid eligibility to cover individuals below the 133% of the federal poverty level and provide health insurance coverage options for low to moderate wage earners and small businesses via the state health insurance exchanges (Buettgens, Garrett, & Holahan, 2010).

According to Askin and Moore (2012), subsidies for buying insurance through the health insurance market exchanges, in effect starting 2014, are largest for those under 250% of the federal poverty level, though lesser assistance exists for incomes up to 400% of the federal poverty level. Cost-sharing subsidies will be available for those up to 250% of the federal poverty level. In addition, the penalty tax for individuals and employers with more than 50 employees that do not sign up for health insurance will be in effect in 2014 (Ellis et al., 2014). The tax will get phased in, starting at \$95 or 1% of income in the first year and caps at \$695 or 2.5% of income by 2016 (Askin & Moore, 2012). Thereafter, it will increase with cost of living adjustments. Also, employers with 50 or more fulltime employees that do not offer coverage are required to pay a fee of \$2,000 per employee, excluding the first 30 employees. Employers with over 200 employees are mandated to automatically enroll employees into plans they offer and provide employees with the option to opt out of coverage (The Henry J. Kaiser Family Foundation, 2012).

While the Affordable Care Act is fundamentally a groundbreaking plan to reform the U.S. healthcare system, I am not certain how effective the approach of expanding the existing safety net will be on lowering uninsurance rates and addressing other known access barriers such as limited English proficiency, among foreign-born populations. Indeed, we have a long path ahead to close the gap on uninsured rates, especially when it comes to the immigrant population. One major pitfall is that while eligible documented immigrants are eligible for premium credits in state-based health insurance exchanges, those documented immigrants that do not meet the five-year residency requirement are not eligible for public health insurance, as mandated under the Personal Responsibility Work Act (also known as the Welfare Reform Act of 1996). Undocumented immigrants

will continue to be prohibited from public health insurance and are ineligible for purchasing private insurance through the health insurance exchanges (PPACA of 2010, Pub L No. 111-148, 124 Stat. 119). This population is eligible for emergency care but risks getting billed for the services it seeks (The Commonwealth Fund, 2013).

One unintended consequence of excluding undocumented immigrants from public insurance programs and the health insurance exchanges is that it adds many layers of complexity to the eligibility requirements. Complex eligibility rules are a major deterrent to immigrants understanding the system. Scholars, such as Kullgren (2003), find that documented immigrants (including those who have been in the U.S. for five years or more) do not have a clear understanding of state and federal eligibility criteria. Similarly, Sommers (2013) and Parmet (2013) have also indicated that the eligibility requirement for undocumented immigrants has had a major impact on *documented* immigrants. In essence, they argue that immigrants, both undocumented and documented alike, face the same limited access to healthcare options, despite the latter being eligible.

Nevertheless, for documented immigrant pregnant women and immigrant children, the federal government has given states the freedom to choose whether they want to impose a five-year wait period. As seen in Table 4.4, both Connecticut and New York have lifted this ban for children for the Children's Health Insurance Programs and children and pregnant women for Medicaid; New Jersey is slightly more generous in that it has lifted this ban for both children and pregnant women for the Children's Health Insurance Program and children and pregnant women for Medicaid.

Table 4.4

States Providing Medicaid or CHIP Coverage to Lawfully Residing Children and Pregnant Women

State	CHIP	Medicaid
California	Children	Children and pregnant women
Colorado		Pregnant women
Connecticut	Children	Children and pregnant women
Commonwealth of the Northern Mariana Islands (CNMI)		Children* and pregnant women
Washington, D.C.		Children and pregnant women
Delaware	Children	Children and pregnant women
Hawaii		Children and pregnant women*
Illinois	Children	Children*
Iowa	Children	Children
Maine	Children	Children and pregnant women
Maryland		Children and pregnant women
Massachusetts	Children	Children and pregnant women*
Minnesota	Children	Children and pregnant women
Montana	Children	Children*
Nebraska	Children	Children* and pregnant women
New Jersey	Children and pregnant women	Children and pregnant women
New Mexico		Children and pregnant women
New York	Children	Children and pregnant women
North Carolina	Children	Children* and pregnant women
Oregon	Children	Children*
Pennsylvania	Children	Children and Pregnant Women
Rhode Island	Children	Children
Texas	Children	Children*
Vermont	Children	Children and pregnant women
Virginia	Pregnant women** Children	Children and pregnant women*
Washington	Children	Children and pregnant women
Wisconsin		Children and pregnant women

Source: *Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women (2014)*. http://www.insurekidsnow.gov/professionals/eligibility/lawfully_residing.html

Strategies for Improving Healthcare Inequalities

As mentioned in the previous section, one of the major approaches to improving healthcare inequalities is to build up the existing safety net in the U.S. Federal Qualified Health Centers are slated to receive expanded funding through the Community Health Center Fund of \$11 billion under the Affordable Care Act. The funds have been distributed since 2011 starting at \$1 billion and will continue through 2015 when \$3.6 billion will be distributed. Approximately \$9.5 billion of this fund is being allocated for organizational expansion efforts and \$1.5 billion for capital funding, including renovation and construction of community health centers⁴. It is yet to be seen what the actual versus spend estimates for the Community Health Center Fund will be – budget variance due to the dynamics of federalism in the U.S. is likely.

United Kingdom

Organization of Healthcare System and Health Insurance

The healthcare delivery system in the United Kingdom is classified as a national health service. The majority of medical services are provided by government-salaried physicians in publicly owned hospitals and clinics, which are financed by the government through tax revenues (Brown, 2003). There are some private doctors that supplement their incomes from working mainly in National Health Service Trust hospitals but are tightly regulated by the government (Frogner & Anderson, 2006). The National Health Service provides a comprehensive range of services including preventive services; physician services; prescription drugs; dental care; mental healthcare; and rehabilitation. Patients are free to choose their general practitioners and can change general practitioners

⁴ Patient Protection and Affordable Care Act. Pub L No. 111-148, § 10503, Health Care and Education Reconciliation Act. Pub L No. 111-152, §2303, 42 U.S.C. § 254b-2 (2010).

without requiring a reason and are free to enlist with another practice⁵. Cost-sharing is minimal. Individuals can purchase private insurance, which provides a wider range of specialists, quicker scheduling for elective surgery, and other items.

The National Health Service is a centrally funded system with universal eligibility to healthcare based on medical need, thus emphasizing equity in terms of equal access for equal need⁶. This system aspires to comprehensive provision of care “from cradle to grave.” According to Adolino and Blake (2001), this system performs relatively well in terms of cost controls through mechanisms such as fixed global budgets, minimal fee for service reimbursement, salaried physicians, and limits on technology acquisition. Over the last decades of reform, the United Kingdom has been successful in uniting “... specialty care with primary care, primary care with community health care, and all three with social services, so that one ends up with comprehensive, integrated services that are community based” (Light, 2003).

According to Pollard and Savulescu, 2004, explain that immigrants that have been living legally in the UK for 12 months, permanent residents, students in the UK for more than 6 months, refugees, asylum seekers, among other special groups are entitled to National Health Service access (p. 347). National Health Service regulations were reformed in 2004 to implement stricter rules around proof of residency requirements and levied changes for overseas visitors.

⁵ <http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx>

⁶ The British National Health Service consists of 4 diverse health systems for England, Scotland, Wales, and Northern Ireland (Greer, 2004).

Safety Net Providers

Currently, those ineligible for full care include illegal immigrants residing in the United Kingdom. The uninsured are provided with emergency care as in the U.S. and selected care such as sexually transmitted infections, family planning, and compulsory psychiatric treatment (Pollard & Savulescu, 2004). In addition, in his comparison of the healthcare delivery systems in the United Kingdom and the U.S., Llano (2011) finds that uninsured illegal immigrants in the United Kingdom have access to free clinics and other safety net venues. Moreover, the lack of access to healthcare in the United Kingdom context impacts a relatively small number, especially when compared to the U.S. According to a recent study conducted by the London School of Economics, 618,000 illegal immigrants reside in the United Kingdom (Gordon, Scanlon, Travers, & Whitehead, 2009). In contrast, the U.S. has a significantly larger illegal immigrant population, estimated at 11.7 million as of 2012 in a recent report by the Pew Research Center (Passel, 2013).

Strategies for Improving Healthcare Inequalities

According to a HealthQuest country report on the United Kingdom, approximately 3 million (5.2%) immigrants live in this country (Goddard, 2008). They face fewer barriers to healthcare with the presence of the National Health Service, which provides healthcare coverage to all, including immigrants with residency status (Huber et al., 2008). However, it should not be assumed that there are no health inequities in a health service that provides care, free at the point of entry (Smith, Chaturvedi, Harding, Nazroo, & Williams, 2000). Rather, immigrants in the United Kingdom experience health

and healthcare disparities and also face similar structural, system, and cultural barriers that immigrants face in the U.S. healthcare system.

These barriers are well documented in the Health Services Research literature, especially among the Bangladeshi and Pakistani subgroups, which are two out of the four Asian American subgroups examined in this dissertation. According to Nazroo and Williams (2006), out of a total population of over 48 million based on its 2001 census, approximately 707,000 (1.4%) Pakistanis and 275,000 (0.6%) Bangladeshis live in this country. Bangladeshi and Pakistani immigration to the United Kingdom occurred largely in the 1970s and 1980s, and these scholars observe a downward assimilation trend in terms of socioeconomic status among these Asian subgroups. In their analyses of the United Kingdom's General Household Survey data from 1973 to 2003, Berthoud and Blekesaune (2007) found significant socioeconomic disparities among ethnic minorities, including Bangladeshis and Pakistanis. Through the disaggregation of the household survey data, these scholars identified that most minorities had low occupational attainment in comparison with the general white population. In particular, Pakistanis and Bangladeshis males were persistently disadvantaged due to various factors such as lack of educational credentials and unemployment rates. The study found a downward trend among the second generation, who faced labor market disadvantages even worse than those among the first generation (Simpson et al., 2006). This is a striking observation that disputes conventional wisdom – a downward trend is to be expected for first generation populations, however, it is expected that socioeconomic conditions will improve for the next generation. Moreover, these studies underscore a severe downward trend among Bangladeshis and Pakistanis in the United Kingdom.

The downward assimilation of South Asians is also documented in the Health Disparities literature. In their study of morbidity patterns of the largest minority ethnic groups currently recognized in the United Kingdom, mainly the Irish, South Asians, and Caribbeans, Williams and Harding (2004) found disadvantages in labor market participation rates, occupational class, and other indicators are significantly greater among Pakistanis. Another striking feature of South Asian mortality—whether Pakistani, Indian, or Bangladeshi—is excess cardiovascular mortality including both coronary heart disease and stroke mortality, relative to the national average (Balarajan & Bulusu, 1990; Marmot et al., 1984).

In terms of explaining these health disparities, Dixon-Woods et al. (2005) provide a comprehensive overview of 14 studies that report on key barriers to accessing healthcare among ethnic minorities. They found that the prominent barriers were related to the lack of culturally and linguistically competent services. Several studies in the health services literature on immigrants living in the United Kingdom have found that those of South Asian descent face language barriers and experience difficulties understanding health professionals during visits and understanding the National Health Service overall (Chew-Graham et al., 2002; Greenhalgh, Helman, & Chowdhury, 2002; Hussain & Cochrane, 2002; Lawton, Ahmad, Hanna, Douglas, & Hallowell, 2006; Stone, Pound, Pancholi, Farooqi, & Khunti, 2005).

To address the growing evidence of immigrant health and healthcare disparities in the United Kingdom, policymakers have implemented a policy of “mainstreaming”, which, as one formulation puts it, this “...entails rethinking mainstream provision to accommodate gender, race, disability, and other dimensions of discrimination and

disadvantage, including sexuality and religion” (Scottish Council for Voluntary Organisations, 2000). In essence, this approach allows all to participate in the primary healthcare system, providing the same types of health insurance, healthcare services, and providers that are utilized by general population and establishes targeted interventions for vulnerable populations so they can effectively access the system.

In the United Kingdom, the policy of “mainstreaming” can be seen in the widespread availability and effectiveness of linguistic services provided to immigrants, more commonly in the form of “cultural mediators”. Programs such as “Link Workers,” go far beyond just the provision of language services and provide culturally competent and comprehensive case management, including assisting with advocacy and coordination challenges that immigrants face when navigating the National Health Service. In addition, health literacy efforts such as the “Accessing the Inaccessible” program aim to increase health literacy among ethnic communities, helping them become more self-empowered and better equipped to manage their health (Stegeman & Costongs, 2004). Similarly, the “Skilled for Health” project provides health literacy programs for immigrants (Huber et al., 2008). Lastly, the United Kingdom provides NHS Direct, a 24-hour, nationwide telephone health hotline that has available interpreter services for linguistically and culturally competent care, including Bengali and Urdu, which are the official languages for the Bangladeshi and Pakistani populations⁷.

Moreover, the policy of mainstreaming is particularly successful in the United Kingdom because it has an effective governance structure in place that promotes compliance and accountability for population health. Since 2004, all general practitioners

⁷ <http://www.nhsdirect.nhs.uk/en/About/CallingNHSDirect/InterpreterService>

contracting with the National Health Service are assigned to Primary Care Trusts that are responsible for all aspects of healthcare delivery within the populations they serve (Evandrou, 2006). Primary Care Trusts are responsible for having a comprehensive understanding of local health and healthcare needs; and formulate Health Improvement Plans for the reduction of inequalities, a means for policy appraisal, which explicitly assesses impact on cultural and religious groups. Furthermore, Health Improvement Programme Performance Schemes “...recognize health communities making progress from a low base, tackling entrenched problems of ill-health, deprivation and poor and fragmented services” (Department of Health, 1998). The quality of care delivered is also monitored by Health Authorities from the National Health Service. This regulatory institution works with Primary Care Trusts to conduct health equity audits in which they examine access to specific services and geographic areas.

Individual Primary Care Trusts implement health education and care management efforts designed to improve health and tackle health and healthcare inequalities. Local health agreements are another important mechanism used to address health and healthcare inequalities. These agreements set priorities at the local level with support from the central government and the local authority. In terms of funding, grants are allocated to vulnerable populations, based on need. For example, in London, special grants are directly awarded to 10 boroughs with the goal of improving their performance (Gusmano et al., 2010).

Germany

Organization of Healthcare System and Health Insurance

The German healthcare delivery system is characterized as a multi-payer health insurance system where sickness funds provide health coverage. In Germany, health insurance is mandatory and universal for all legal residents, including temporary workers (Ellis et al., 2014). According to the European Observatory on Health Systems and Policies (2004), the “...plural healthcare system of Germany places a high emphasis on free choice of providers and insurers” (p. 9). At the same time, while providing freedom of choice, the healthcare system is able to significantly reduce administrative costs for billing since physicians and hospitals are paid at uniform rates by sickness funds, within a framework of regulation (White, 1994).

Most Germans are covered by the primary social health insurance system referred to as Statutory Health Insurance. Ellis et al. (2014) estimate that approximately 90% of the population belongs to this system, with respective dependents covered free of charge. The remaining 10% include those who earn above this income threshold, including civil servants and self-employed individuals who have the option to stay with the publicly financed scheme or purchase Private Health Insurance, per Ellis et al. Unemployed individuals contribute to Statutory Health Insurance based on their unemployment entitlements (The Commonwealth Fund, 2013).

Statutory Health Insurance offers approximately 200 health plans, also known as “sickness funds.” German healthcare funding relies primarily on an income tax based on a fixed portion of income of approximately 10-15%, which varies by sickness fund. Normand and Busse (2002) explain that health insurance premium contributions are

equally split between employer and employee, in other words, they each pay 50/50, enabling them to share responsibility and control over managing sickness funds. The way in which costs for premiums are shared equally between employers and employees is a reflection of German commitment to social solidarity and collective solutions, including ensuring that businesses' profit motives do not control healthcare (Altenstetter, 2003).

According to the international profile of healthcare systems published by the Commonwealth Fund (2013), individuals who earn less than \$4,874 U.S. dollars per month are eligible to be covered under Statutory Health Insurance. Statutory Health Insurance provides a comprehensive range of services, including physician and hospital services, dental care, vision, prescription drugs, as well as sick leave compensation. Cost sharing is very minimal, limited to €10 per day (\$14 U.S. dollars) and applied to only a few services, such as outpatient prescriptions and hospital stays – overall, the cost sharing does not exceed 2% of household income for adults nor 1% for the chronically ill, including the disabled (Busse, 2008; The Kaiser Family Foundation, 2009). Several populations are exempt from cost sharing including children under the age of 18 years old, individuals receiving state benefits, and individuals with low income levels (Gericke et al., 2004). According to Gericke, Wismar, and Busse (2004), low income levels are considered for incomes per month up to €952/one person (\$1,324 U.S. dollars), €1309/two persons (\$1,820 U.S. dollars) dependent on the insured person's income, and €238 (\$331 U.S. dollars) for each additional dependent⁸.

Physicians generally work in their own private practices and are reimbursed on a fee-for-service basis, which is negotiated between sickness funds and physicians. Since 2002, incentives are available for general practitioners to enroll chronically ill patients

⁸ Based on U.S. dollar currency conversion rate as of March 2014.

into a disease management program. The sickness funds pay general practitioners in an annual lump sum in return for patient training and patient data (The Commonwealth Fund, 2013). Different regional regulations require physicians to provide after-hours care, which is regulated and organized by the regional physician associations. A nationwide telephone hotline also provides after-hours care assistance.

Safety Net Providers

Currently, those ineligible for full care include illegal immigrants residing in Germany. The uninsured, including illegal immigrants are provided with emergency care as in the United Kingdom and U.S. While healthcare restrictions for illegal immigrants in the United Kingdom are not strictly enforced, Castañeda (2009) indicates that Germany has in place, "...unique laws...criminalize health care workers for aiding migrants" (p. 1552). Safety net providers for these vulnerable populations include free clinics and non-profit organizations such as the Berlin Refugee Support Office, which works with healthcare providers in the Berlin area to provide care for refugees and illegal immigrants. This organization also raises their own funds for medical supplies and provides case management services including language assistance (Riesberg & Wörz, 2008). Furthermore, in her study of illegal immigrants and healthcare access in Germany, Castañeda (2009) finds that due to limited safety net providers for illegal immigrants in Germany, most rely heavily on free clinics. However, she finds that the illegality on health in Germany has a significant negative impact on illegal immigrants' health. For instance, illegal immigrants experienced lower quality of healthcare and healthcare access (e.g., delayed care and difficulties obtaining medications).

Moreover, the lack of access to healthcare in the German context impacts a relatively small number, especially when compared to the U.S. According to the Foreigners' Central Register, as of 2007, 445,070 illegal immigrants reside in Germany (0.4 % of the population) (Riesberg & Wörz, 2008). In contrast, the U.S. has a significantly larger illegal immigrant population, estimated at 11.7 million as of 2012 in a recent report by the Pew Research Center (Passel, 2013).

Strategies for Improving Healthcare Inequalities

As in the United Kingdom, fewer barriers to healthcare exist for immigrants in Germany with the presence of Statutory Health Insurance, which covers most of its population. However, it should not be assumed that there are no health inequities in this system. According to Huber et al. (2008), the number of uninsured increased "...from an estimated 0.2% in 2003 (around 188,000 residents) to almost 0.4% (or 300,000) in 2005" (p. 62). More recent estimates have indicated that close to 1% do not have insurance coverage at all (Busse, 2008). Within the European Union, access to German health insurance is considered to be more restricted for unauthorized immigrants and asylum seekers (Castañeda, 2009).

A substantial portion of the uninsured are self-employed individuals who have found purchasing health insurance in Germany too costly. Premium rates for the self-employed have been reported at 40%-50% of income, dramatically higher than what the general population pays at 14% of their income (Schoenfeld, 2005). Amelung et al. (2003) highlight the similarities between the German and American health insurance systems in terms of the labor market structure. In Germany it has evolved over the years, with an influx of workers who have untraditional working arrangements such as "...part-

time jobs, casual jobs, temporary jobs, work at home, and so-called fictitious self-employment (workers who are officially self-employed but perform all their work for a single buyer)” (p. 699). Amelung et al. explain that workers who fall into these job categories do not have employer-based insurance and are not obligated to purchase health insurance. Also, Germans previously covered by their spouse, such as divorced spouses, sometimes remain uninsured – at least for some time. Lastly, elderly widows are particularly vulnerable because spouse benefits are reduced after the death of their retired spouse. Hungerford (2003) explains that, “...if 45 years of age or older, receives 100% of the deceased worker’s benefit for three months and then 60% thereafter” (p. 439). In his comparative study of the economic consequences of widowhood on elderly women in Germany and the U.S., Hungerford (2001) found that elderly German women widows are greatly susceptible to poverty, nearly three times more likely to be poor than elderly women in the U.S.

In addition to the structural barriers discussed above, other studies have found that lack of health literacy and limited German proficiency are major barriers in accessing healthcare in Germany. According to a study funded by the European Commission and directed by the European Health Management Association and European Centre for Social Welfare Policy Research found that prominent barriers to healthcare access in Germany include lack of health insurance coverage as a result of low health literacy levels and lack of ease of navigation in the enrollment process (Huber et al., 2008). For example, one of the reasons for the lack of coverage stems from the lack of health literacy, including instances where individuals failed to sign up with a sickness fund within three months of losing their coverage. Vulnerable populations include individuals

with low educational attainment levels and language barriers, including immigrants.

According to a HealthQuest country report on Germany, as of 2005, approximately 15.3 million (19%) immigrants were living in this country (Riesberg & Wörz, 2008).

To address these barriers, under the patronage of the Minister of State and Federal Government Commission for Migration, Refugees and Integration, Maria Böhmer, Germany has established several innovative programs including the “Migrant for Migrants” (MiMi) project, which aims to integrate immigrants into the German healthcare system, with the vision of providing immigrants with equitable health opportunities in the long term⁹. The MiMi project has been instituted in over 55 locations in 10 states, educating immigrants on various topics such as education around how to use and navigate the healthcare delivery system, health rights, and responsibilities. This project provides multi-language and culturally competent services and it has great reach to ethnic communities since their outreach is conducted by health mediators in easy-to-reach locations in settings that are commonly frequented by immigrants. Health mediators are composed of trained individuals from immigrant backgrounds, who work closely with other community based organizations (e.g., immigration and health services) to ensure adequate access to healthcare among immigrants. In sum, programs like these provide social support and tools to empower immigrants to navigate the German healthcare system and manage their own health.

Lessons for the United States

After examining the organization of healthcare systems, health insurance schemes, safety net providers, and strategies for improving healthcare inequalities within

⁹ http://www.ethno-medizinisches-zentrum.de/index.php?option=com_content&view=article&id=28&Itemid=34

Germany and the United Kingdom, three valuable lessons can be derived for the United States. These lessons are discussed in detail in the next section.

Lesson #1: A “mainstream” healthcare delivery model is the most effective and equitable approach to providing healthcare services to vulnerable populations

The U.S. should strive towards a healthcare system that adopts the United Kingdom’s concept of mainstreaming that “...entails rethinking mainstream provision to accommodate gender, race, disability, and other dimensions of discrimination and disadvantage, including sexuality and religion” (Scottish Council for Voluntary Organisations, 2000). Germany and the United Kingdom demonstrate that vulnerable populations can effectively participate in the primary healthcare system, with the implementation of targeted interventions that address the structural, system, and cultural barriers they face. While U.S. healthcare reform is already underway and unlikely to be reversed during President Obama’s term ending in 2016, this lesson should be considered in the future in the event that the safety net expanded by the Affordable Care Act fails to provide adequate access to healthcare for vulnerable populations, including immigrants.

Currently, the U.S. follows a significantly different model for providing healthcare to vulnerable populations such as the poor and immigrants. Essentially, vulnerable populations are excluded from the primary healthcare system that is utilized by the general population and limited to accessing healthcare services in the safety net. The reasoning behind building out the safety net under the Affordable Care Act is that safety-net providers are seen as a more efficient way for providing care because they know the needs of their communities and are in a better position to care for them. This approach is supported by evidence that community health centers are utilized by the

uninsured or those with public insurance, with large numbers of minorities and immigrant populations (Hicks et al., 2006).

Examining the strategies Germany and the United Kingdom have employed to address healthcare inequities helps delineate several pitfalls in the U.S. model of expanding the safety net. Firstly, building out the safety net creates a separate healthcare delivery system that further isolates and insulates vulnerable populations. Based on the definitions by Healy and McKee (2004), the safety net in the U.S. would be classified as providing parallel services among the other types of healthcare delivery models that exist (i.e., mainstream (collective), integrationist, participatory, and alternative). These scholars explain that,

Parallel services mean a separate but good quality care system that exists to cater for certain groups and that substitute for, rather than complements, mainstream services. The danger with separate services, especially if they cater for a stigmatized group, is that they may become a second-rate service... (p. 359).

Moreover, Abel-Smith, a British economist and leading figure in shaping the healthcare system in the United Kingdom and global health argues that it is important that both the insured and uninsured use the same services – services designed only for vulnerable populations such as the poor are subject to low-quality services, and do not have proper political support to advocate for better services¹⁰.

Nevertheless, it is important to underscore that a mainstream healthcare delivery system is obviously the ideal standard among existing healthcare delivery models defined by Healy and McKee (2004), which has been successful in the cases of Germany, the United Kingdom, and other countries abroad. While it is not a reality in the U.S., the

¹⁰ <http://www.lse.ac.uk/newsAndMedia/publications/books/2013/ThePassionateEconomist.aspx>

mainstream model is what this country ought to aspire to considering that parallel services to vulnerable populations has so many disadvantages, including undermining social solidarity, less accountability from the state, low-quality services, greater stigma for those using services in the safety net among others. Table 4.5 provides an outline of the advantages and disadvantages of a parallel service model.

Table 4.5
Advantages and disadvantages of separate services

Advantages	Disadvantages
Self-determination	Undermining of social solidarity
More control	Less state responsibility, vulnerability
Greater consumer choice	More limited choice of scope and scale
Better access for some	Limited availability to whole population group
Greater quality in terms of responsiveness	Possibly worse quality in terms of clinical effectiveness
Better targeted services	High cost to state
Higher political profile	Greater stigma

Source: Healy and McKee (2004)

Another pitfall of expanding the safety net is that the distribution of federal funding under healthcare reform to community health centers is inequitable. Distribution of these funds is determined based on a grant application process that is quite competitive and resource extensive and therefore, community-based organizations with more resources to develop persuasive grant applications are more likely to receive the funds rather than those organizations with the neediest populations. Thirdly, it is yet to be seen whether safety-net providers will be able to provide the range of services commensurate to those covered by public health insurance programs such as Medicaid or private health insurance providers. According to a report on the uninsured published by the Kaiser Family Foundation (2013), the safety net is not comprehensive and “...such services are unable to substitute for the access to care that insurance provides” (p. 13). Lastly,

considering our nation's history of cutting back social spending, including the welfare reform of 1996, there is reason to be concerned that safety-net providers may be the victims of budget austerity measures, if any arise (Hacker, 2004).

Lesson #2: Health premiums and cost sharing can be affordable

The German and British healthcare systems illustrate that insurance premiums and cost sharing can indeed be affordable. For instance, workers covered under Statutory Health Insurance pay for health insurance premiums in the form of a compulsory contribution, which is automatically deducted from their pay and allocated into sickness funds. Health premiums are affordable at approximately 10-15% of income that is split equally between the employee and employer. Even at the maximum of 15%, a typical German making a gross income of £58,488 (US \$81,148) would pay half of the total annual premium estimated at £8773 (US \$12,172), and another 1 to 2% for cost-sharing items for doctor visits, prescriptions, and other needs (Busse, 2008)¹¹. The United Kingdom has almost zero cost sharing. Unlike the U.S., there are no annual out-of-pocket maximums that impose significant financial liability.

Moreover, if the Affordable Care Act's true objective is to expand health insurance coverage, health premiums and cost sharing should be affordable. Starting with the public health insurance programs, the federal poverty level should be raised to a rate that covers a significant portion of the working poor that are uninsured. As indicated in Table 4.6, Medicaid expansion under this reform expands coverage to very low-income earning individuals below 133% of the federal poverty level, which translates to \$31,721 for a family of four. There is already some evidence that federal poverty levels are too low, including studies such as one by the Asian and Pacific Islander American Health

¹¹ Based on U.S. dollar currency conversion rate as of March 2014.

Forum (2013) on small businesses in California, which found that “Both employers and employees felt that the income requirements to qualify for Medi-Cal (\$15,000 for an individual, \$32,000 for a family of four) are too low and should be raised to allow more people to be covered” (Chin, 2013). In its current state, the access promised by American’s partial system of subsidies for the poor, Medicaid, continues to be deceptive (White, 1994).

Table 4.6

Federal Poverty Level for 48 Contiguous States and the District of Columbia (2014)

Family Size	25%	50%	75%	81%	100%	133%	175%	200%	250%
1	\$2,918	\$5,835	\$8,753	\$9,453	\$11,670	\$15,521	\$20,423	\$23,340	\$29,175
2	\$3,933	\$7,865	\$11,798	\$12,741	\$15,730	\$20,921	\$27,528	\$31,460	\$39,325
3	\$4,948	\$9,895	\$14,843	\$16,030	\$19,790	\$26,321	\$34,633	\$39,580	\$49,475
4	\$5,963	\$11,925	\$17,888	\$19,319	\$23,850	\$31,721	\$41,738	\$47,700	\$59,625
5	\$6,978	\$13,955	\$20,933	\$22,607	\$27,910	\$37,120	\$48,843	\$55,820	\$69,775
6	\$7,993	\$15,985	\$23,978	\$25,896	\$31,970	\$42,520	\$55,948	\$63,940	\$79,925
7	\$9,008	\$18,015	\$27,023	\$29,184	\$36,030	\$47,920	\$63,053	\$72,060	\$90,075
8	\$10,023	\$20,045	\$30,068	\$32,473	\$40,090	\$53,320	\$70,158	\$80,180	\$100,225

Note: Pregnant women count as two people for the purpose of this chart.

Source: Foundation for Health Coverage Education. *2014 Federal Poverty Level*.

http://coverageforall.org/pdf/FHCE_FedPovertyLevel.pdf

In addition, health insurance sold in health insurance market exchanges should be affordable. Currently, even with subsidies, the annual out-of-pocket costs and premiums make insurance very costly even for groups that are theoretically supposed to benefit the most, up to 250% of the federal poverty level. For example, using the Kaiser Family Foundation’s subsidy calculator¹², purchasing insurance for a household of four that includes two adults and two children and earning a gross income of \$59,625 (250% federal poverty level) would pay \$8,290 annually for a Silver Plan in 2014¹³. If eligible for a subsidy, this family of four would receive a government tax credit subsidy of up to

¹² <http://kff.org/interactive/subsidy-calculator/>

¹³ Insurers offer four levels of cost sharing including bronze plans (60% of costs); silver plans (70% of costs); gold (80% of costs); and platinum (90%).

\$3,435 (41% of the overall premium). The total premium cost would be \$4,855 but the significant financial liability is the potential cost related to the annual out-of-pocket maximum of \$12,700. A family of four within the 250% federal poverty level could potentially pay close to \$17,555 (30%) annually for health insurance if they meet or exceed this maximum.

In the Asian context, there is evidence that health insurance costs are not affordable. A recent study by the Asian & Pacific Islander American Health Forum in California found that, “Even with the new subsidies, employees felt that health insurance will still be too expensive. Expanding Medi-Cal would be better” (Chin, 2013, p. 2). This study also found that most small business employers viewed the tax credits as not being helpful in offsetting the costs of purchasing health insurance for their employees. In particular, for families with incomes from small business ownership, these costs can have catastrophic effects on their household incomes due to the (unexpected) operating costs and financial shocks they absorb in running a small business. Such families experience additional loss of income for taking time off for healthcare due to a lack of sick leave compensation.

In sum, while the Affordable Care Act increases the coverage options available for health insurance, health policymakers must reassess whether federal poverty levels adequately cover the majority of the working poor to ensure universal coverage is achieved. Of more urgent nature is the need for policymakers to significantly reduce the out-of-pocket maximums attached to the health insurance sold in health insurance exchanges. They are very expensive compared to what is offered by employer-based

insurance, with some plans not requiring any out-of-pocket maximums for in-network providers.

Lesson #3: Targeted interventions are effective at increasing access to healthcare for vulnerable populations

The Germans and British have established several targeted interventions into their primary healthcare systems that have proven to be successful in mitigating the structural, organizational, and cultural barriers vulnerable populations like immigrants face. The U.S. can learn from several of these interventions, including ones that address occupational and language barriers. Firstly, establishing state level or nationwide health telephone hotlines with interpreter services would significantly enhance healthcare in the U.S. since working long hours is very common among U.S. workers and a barrier to accessing health preventive services (Bateman et al., 2009; Yao et al., 2013). Both Germany and the United Kingdom have established nationwide telephone health hotlines that are accessible 24 hours a day, 7 days a week in efforts to offer both quicker access to care and access to care during afterhours. In the United Kingdom, the national health telephone hotline is called NHS Direct, which consists of nurses supported by clinical decision-support software, provide advice to individuals about the management of their condition and, where required, direct them to the most appropriate healthcare setting to meet their needs (e.g., a general practitioner or hospital accident and emergency department). NHS Direct provides interpreter services that are linguistically and culturally competent care, including Bengali and Urdu, which are the official languages for the Bangladeshi and Pakistani populations.¹⁴ Moreover, by establishing NHS Direct,

¹⁴ <http://www.nhsdirect.nhs.uk/en/About/CallingNHSDirect/InterpreterService>

use of traditional primary care services are avoided either because telephone advice is sufficient or because individuals are immediately directed to alternative services (Beech, 2003).

Secondly, financial incentives for offering afterhours care should be established. Such change will be helpful to immigrants such as the Koreans since many own small businesses and only have one day off, typically Sundays. Germany has gone as far as implementing regional legislation mandating afterhours care along with financial incentives for providers. This mandate is regulated and organized by regional physician associations.

Thirdly, the U.S. can learn from how Germany and the United Kingdom have approached the issue of delivering translation services to immigrant populations. Both these countries have taken great measures to establish linguistically and culturally competent programs that help immigrant populations access their healthcare delivery system effectively and integrate financial incentives for providers across care settings, not just in hospitals. In the United Kingdom, medical providers and local health authorities are responsible for ensuring that their patients have linguistically and culturally competent care. This is monitored by health authorities. In contrast, most states in the U.S. have legislation in place that articulates the right to an interpreter, but these rules vary drastically by state and by healthcare setting. In addition, there are no enforcement mechanisms for these laws, and they are hardly monitored by health agencies in the U.S. (Kao, 2010). Appendix J provides a list of the major state laws and regulations governing language access in healthcare.

In addition, comprehensive case management services provided by “Link Workers,” “Accessing the Inaccessible,” and “Skilled for Health” programs provide templates for strategies that community-based organizations in the U.S. should follow. In particular, these organizations take a very hands-on approach and accommodate to their population’s needs, including in-person outreach for hard-to-reach communities.

In closing, the goal of this chapter was to formulate lessons learned from other countries to inspire solutions to addressing the access to healthcare barriers that immigrants face in the U.S. Immigrants in both the U.S., Germany, and the United Kingdom face disproportionate challenges in accessing care and lessons from the latter two countries demonstrate that it is most equitable to adapt existing services to meet the needs of their vulnerable populations, such as immigrants, but also feasible. One key take away from this chapter is that the ability to successfully integrate vulnerable populations into a mainstream healthcare delivery model is closely linked to the underlying principles of their healthcare systems. Strong social solidarity and commitment from government are the key elements necessary to achieve better health and healthcare access outcomes.

Moreover, trying to adapt any of these lessons learned in the U.S. context will be challenging at best. The “bewildering complex of service and insurance inequalities” that exist in the U.S. makes it much more difficult to address the barriers faced by immigrants in accessing care as compared to Britain’s more centralized and coordinated healthcare system (Light, Portes, & Fernandez-Kelly, 2009b). As Marmor (2011) argued, one of the key lessons derived from the 2010 health reform was that not establishing consensus around the principles and moral implications of the reform produced mixed results. A discussion of how change can be enacted is provided in the next chapter.

The next chapter will integrate these lessons with the study's overall findings, observations, and recommendations for reducing the barriers to U.S. healthcare faced by vulnerable populations, such as the top four most uninsured Asian subgroups.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

Every country has a national health system, which reflects its history, its economic development, and its dominant political ideology.

- Milton I. Roemer (1993)

Summary of Key Study Findings

The purpose of this dissertation was to shed light on the healthcare access needs of the most vulnerable Asian Americans by focusing on the top four most uninsured groups, which include the Bangladeshis, Cambodians, Koreans, and Pakistanis. The main objective was to closely examine the impact of various structural factors (broadly pertaining to institutional/organizational, socioeconomic, and demographic variables), and acculturation/cultural factors on access to healthcare. Lastly, the third objective was to draw lessons on access to healthcare for vulnerable populations alike from other advanced societies. Learning how they approach similar issues highlighted policy options for the U.S. moving forward.

To meet the objectives of this study, I used both quantitative and qualitative methods including: (1) an in-depth review of the Health Services Research literature; (2) interviews with key national health experts and advocates; (3) a survey documenting Korean Americans' barriers in accessing care in the tri-state region (Connecticut, New Jersey, and New York); and (4) a comparative approach, which draws lessons from other countries that are facing similar access to healthcare issues, as described in the Comparative Health Policy literature. Each one of these sources was a critical piece in developing a holistic and thorough understanding of the structural, system, and cultural barriers vulnerable Asian subgroup populations face. As shown in Table 5.1, key insights were derived through the two data collection efforts in this study as well as the lessons

learned from the German and British healthcare delivery systems. Examples of prominent barriers include low health insurance rates, high rates of self-employment, high cost of health insurance, confusion with healthcare system, difficulty enrolling in public insurance, lack of awareness of community healthcare services, and limited English proficiency.

Table 5.1 *Summary of Dissertation Themes and Lessons Learned*

Key Themes Across Interviews with Health Experts and Advocates (all 4 Asian subgroups) and Access to Healthcare Survey for Koreans		
Structural Barriers	Cultural Barriers	System Barriers
<ul style="list-style-type: none"> • <i>Low health insurance coverage rates*</i> • <i>High rates of self-employment (informal ethnic labor market)*</i> • <i>High cost of health insurance*</i> 	<ul style="list-style-type: none"> • <i>Limited English proficiency*</i> • Lack of culturally competent providers • Distrust of American healthcare system • Alternative medicine preference • Use of medical tourism • Family structure dynamics • Physical practices connected to religious beliefs and fatalistic views of religion 	<ul style="list-style-type: none"> • Limited hours • <i>Enrollment in public insurance is difficult*</i> • <i>HC System is confusing*</i> • Confusion or lack of awareness of patient and immigrant rights • Lack of funding and resources among Asian community based organizations • <i>Lack of awareness and reach of community healthcare services*</i> • Lack of transportation
Lessons Learned From Other Countries		
Aspire to move towards a “mainstream” healthcare delivery model		
<ul style="list-style-type: none"> • Insurance premiums and cost sharing can be affordable • A national health hotline with interpretation service lines has reduced the number of preventable medical visits 	<ul style="list-style-type: none"> • Interpretation services can be more effectively mandated, reimbursed, and monitored for compliance • Responsibility for ensuring adequate communication for patients lies with the provider 	<ul style="list-style-type: none"> • Integration of financial incentives for providers to promote after-hours care • There are better access outcomes when more responsibility for the health of the population can be placed on medical providers and local health authorities • Comprehensive case management that is linguistically and culturally competent is more effective and increases access

* Common themes across interviews with health experts and advocates and Access to Healthcare Survey for Koreans are italicized.

These key insights contributed to a lively narrative describing the experiences of accessing healthcare for the most uninsured Asian American subgroups. A key take away from this study is that contrary to conventional wisdom in the Health Services Research literature, the data generated for the Korean population highlights the notion that cultural factors are not the most prominent barriers but, rather, structural barriers such as employment and occupational types are the most salient barriers. In other words, the way in which vulnerable Asian American subgroups such as the Koreans behave is highly dependent on the way in which the U.S. healthcare delivery system is designed, organized, and implemented. Cultural factors that have been commonly thought to be barriers among Asians such as a profound preference in traditional medicine, distrust of the U.S. healthcare system, religious beliefs, and medical tourism practices cannot fully explain why vulnerable populations like these experience a disproportionate number of barriers to accessing healthcare.

In terms of lessons learned from abroad, a close examination of the German and British healthcare systems underscores the importance of moving towards a “mainstream” healthcare delivery model that integrates vulnerable populations into the main system of care along with appropriate and targeted interventions. Both of these countries have shown that insurance premiums and cost sharing can be affordable in addressing structural barriers such as high cost of health insurance and that interpretation services can be effective at addressing language barriers when these services are effectively mandated, reimbursed, and monitored for compliance. In terms of addressing system barriers—confusion with the healthcare system—Germany and the United

Kingdom have shown that comprehensive case management that is linguistically and culturally competent is effective in increasing access among vulnerable populations.

Significant Contributions of Study

This study was designed to generate contributions to the Health Services Research and Comparative Health Policy literatures. My comprehensive literature review on the top four most uninsured Asian subgroups aggregates information on access for these subgroups, pooling existing information that is traditionally spread throughout the literature because most data is collected as part of studies examining multiple racial ethnic groups (Tandon & Kwon, 2009). My literature review delved deep in understanding what is known about access to healthcare in the Asian context, organized at the subgroup level. In addition, this study provides an effective research methodology to generate new qualitative and quantitative data at the disaggregated level, drawing on analytical tools such as qualitative interviews with health experts and advocates and the Access to healthcare Survey for Koreans instrument. This extensive field work is particularly significant since it is the first comprehensive survey on access to healthcare that has been undertaken in the NJ-NY-CT region, generating valuable disaggregated data on Koreans' experiences. Most studies in the past have concentrated in California since it has the most Koreans living in that state.

In some ways, the findings from this study deviate and enhance what is currently known about the top four most uninsured Asian American subgroups in the Health Services Research literature. Firstly, while the link between high self-employment rates and low insurance rates has been well documented, my study deviates from the literature in that it shows that self-employment rates are disproportionately higher (57%). For

instance, Min (2006) reported self-employment rates of 39% in the New York area and the most recent U.S. Census Bureau (2007-2011) figures reported a rate of 20.1%.

Secondly, the findings from the Access to Healthcare Survey for Koreans in the U.S. provides evidence that total household income matters the most in terms of determining access and granular total household income ranges that are likely to be insured (\$80,000 to \$100,000). Total household incomes below this range were not able to absorb health insurance costs (39%). While some studies have identified higher total household income as a major predictor of having health insurance, none have identified specific income ranges in which Koreans would be more likely to afford insurance (Kim 2004; Ryu et al., 2001).

Thirdly, another key insight of this study is identifying the very little utilization of community-based healthcare organizations among Koreans, regardless of evidence that they need the services (20%)¹⁵. Qualitative interviews with health experts and advocates revealed that while the federal government assumes that community health organizations are addressing Asians' needs, in reality these organizations do not have the bandwidth to provide resources because they have very little funding. One interviewee maintained that Asian community health organizations are entitled to 1% of the total New York City community healthcare budget, a very small portion of the budget in relation to other groups of color and their population size (13%). This notion underscores the weak federal/local alignment that exists on access to healthcare. Underrepresented groups such as Asians will continue to go under the radar because they do not have any political leaders bringing light to their social issues.

¹⁵ 40% have no health insurance and 42% have no regular source of care.

Fourthly, this study also debunks the argument that the top four most uninsured Asian subgroups may not need access to healthcare because they are healthy – this study’s extensive descriptions of the health disparities suggest that these subgroups collectively experience a downward trajectory in health as they adapt to life in the U.S. Many studies have found that these subgroups are likely to be diagnosed at later stages of disease – for diseases that can be treated effectively in earlier stages if detected by routine screenings.

In sum, at the micro-level, the most important contribution of this study is providing evidence that supports the argument that cultural factors are not the most salient barriers but, rather, structural barriers such as employment and occupational types are significantly more prominent barriers when it comes to access to healthcare. This study debunks the notion that cultural barriers such as profound preferences in Eastern or alternative medicine, distrust of U.S. healthcare system, religious beliefs, and medical tourism practices are the reasons behind why vulnerable populations like these experience disproportionate levels of access to healthcare. For example, results from the Access to Healthcare Survey for Koreans in the U.S. demonstrate that traditional medicine is actually not a significant barrier among Koreans. Respondents actually report a strong preference for Western medicine. The median response for the Likert scale question “I prefer conventional Western medicine over traditional Korean medicine treatments (for example, Hanbang and Hanyak)” was 4.83 demonstrating that many in the sample responded that they prefer Western medicine (5=Agree). Also, this data source disputes the notion that Koreans’ religiosity negatively impacts their access to healthcare contrary to what other scholars have argued in the past (Jo et al., 2010). Rather, the way

in which vulnerable Asian subgroups behave is highly dependent on the way in which the U.S. healthcare delivery system is designed, organized, and implemented. This study observation is consistent with an interdisciplinary approach that includes the Health Services Research and Comparative Health policy literatures, which emphasizes the significant impact that institutional barriers have in preventing people from accessing healthcare and living healthy lives.

Lastly, this study attempted to show that an interdisciplinary approach consisting of the two key lines of literature on access, Comparative Health Policy and Health Services Research, is best equipped to generate innovative insights as to how we can move away from group-centered problem diagnosis and identify ways to effectively enact structural change. Understanding the theoretical and empirical debates of these fields—including the characteristics of the health system that determine access and the individual variables that influence the decision about seeking care—are crucial determinants (Riebling & Wendt, 2008). The goal of eliminating health and healthcare disparities can only be achieved if we move away from “documenting” health and healthcare disparities to generating studies that inform us how we can realize social change.

Significant Observations

Cost, Employment, and Occupational Types are the Most Significant Structural Barriers

Because health insurance is closely tied to the labor market structure of the U.S., employment and occupation types seem to be the most significant among the structural barriers Asians face in accessing healthcare. Many Asian immigrants are disproportionately engaged in the ethnic economy as either self-employed or low-wage

workers concentrated in service-related occupations.¹⁶ The data collected from the Access to Healthcare Survey for Koreans in the U.S. corroborate these high rates of self-employment among Asian subgroups and find it to be one of the root causes for the low health insurance coverage among this particular Asian subgroup. These high rates of self-employment do not necessarily stem from a cultural propensity for entrepreneurship but rather a pragmatic strategy of “accommodation without assimilation” (Park, 2012).

According to the U.S. Census Bureau Survey of Business Owners (2007), there were approximately 1.5 million businesses owned by Asians, an increase of 40% from 2002, with total receipts close to \$508 billion. Almost half of these Asian-owned businesses are in the service sector, more specifically in repair and maintenance; personal and laundry services; professional, scientific and technical services; and retail trade. Behind Mexicans, Korean immigrants represent the second largest number of immigrant business owners in the U.S. (Farlie, 2008).

Nevertheless, skeptics such as Perry and Rosen (2001) argue that the lack of health insurance coverage among the self-employed is not detrimental to their health. In their analyses of the 1996 Medical Expenditure Panel Survey data, these scholars find that there is no statistical difference in health status between the self-employed and wage-earners and, therefore, argue that the public policy focus on the low rates of health insurance coverage among the self-employed is displaced. On the other hand, the German case discussed in the “lessons learned” chapter clearly supports the notion that

¹⁶ Employment type is defined in this study by the following categories: private-for-profit company, private-not-for-profit-organization, government organization, small business, self-employed, or working without pay in family business. Occupation type in this study includes: management, business, and financial; professional; service; sales; office and administrative support; and construction and extraction.

untraditional labor arrangements such as the self-employed in the U.S. are particularly vulnerable to being uninsured and ultimately have lower levels of access to healthcare.

In terms of cost as a barrier to healthcare access, even with the subsidies provided under the Affordable Care Act, many self-employed or low-wage Asian workers may find health insurance to be too expensive. As highlighted in lesson #2 in the previous chapter, insurance sold in the health insurance marketplaces have very high out-of-pocket maximums that make insurance unaffordable and may force many Asians to opt out of the individual mandate. Those who do not qualify for Medicaid are likely to remain uninsured. Based on individual income, most of the respondents to my Access to Healthcare Survey for Koreans in the U.S. (83%) would fall above the federal poverty line of 133%, not qualifying for Medicaid. Furthermore, a study conducted by Krueger and Kuziemko (2013) further supports the notion that current prices in the health insurance marketplaces are not affordable. A large proportion of their sample of uninsured Americans, most of whom do not have employer-based insurance options, indicates that they are more likely to purchase health insurance with an annual premium of \$2000.

Limited English Proficiency is the Most Significant Cultural Barrier

The biggest cultural barrier among Asians is the lack of English proficiency despite long periods of residence in the U.S. and generally high levels of education in some subgroups such as the Koreans. Data from the Access to Healthcare Survey for Koreans in the U.S. shows that while 63% of the respondents had resided in the U.S. for more than 20 years, 44% of the respondents do not speak English well or not at all. Contrary to conventional wisdom in the Health Services Research literature on the deep

rooted cultural preference and practice of Eastern medicine among Asians, the Access to Healthcare Survey for Koreans data demonstrated that traditional medicine is actually not a significant barrier to accessing healthcare among Koreans (Jenkins, Le, McPhee, Stewart, & Ha, 1996; Jin, Slomka, & Blixen 2002; Kandula et al., 2006; Lee et al., 2010).

Rather, this sample showed a strong preference for Western medicine. For example, the median response for the Likert scale question “I prefer conventional Western medicine over traditional Korean medicine treatments (for example, hanbang and hanyak)” was 4.83 demonstrating that many in the sample responded that they either agreed (5) or strongly agreed (6) that they prefer Western medicine. Also, although the Korean sample had high participation rates in faith-based organizations, with over 60% attending a religious organization either daily or on a weekly basis, fatalistic religious beliefs did not appear to have a major impact on impeding access. When asked whether “Illness can only be healed by God,” only 7% of respondents answered “yes.” In sum, traditional medicine and other health beliefs do not have a major impact on access, suggesting that Asians and other immigrant groups do not prefer different healthcare services outside of what is offered in the mainstream healthcare system in the U.S.

Policy Implications

Cost, employment, and occupation types coupled with limited English proficiency are the most significant structural and cultural barriers Asians face in accessing healthcare in the U.S. It is imperative that cost barriers are addressed by making health premiums and cost sharing affordable, especially for those individuals living in the U.S. that have untraditional employment types in the service industry, including the self-employed. As we see in the German case, individuals that do not fall in traditional

employment or occupation types are more likely to be uninsured due to the high costs of purchasing private health insurance (Amelung et al., 2003).

Most concerning is that while Asian subgroups possess high uninsured rates, the safety net does appear to be utilized by this population to fill their healthcare gaps. Data from my Access to Healthcare Survey for Koreans in the U.S. supports this observation, showing that 80% of the Korean sample had no utilization of community healthcare services despite high levels of uninsured rates (40%) and no source of usual care (42%). The health advocates and experts I interviewed explain that the community-based organizations serving these populations lack federal and state funding and are unable to reach these communities and adequately provide needed healthcare services. Making it more challenging is that most of the community-based organizations serving Asians lack the Medically Underserved Population designation (section 330 or Federal Qualified Health Center and look-a-like), grant-writing expertise, resources, and staff needed to apply for this designation and manage grants.

The reality is that very few Asian community-based organizations have met health center qualifications required for Medically Underserved Population designation but most do provide limited services, including social services as well as special clinical services. In my own search in the Health Resources and Services Administration Data Warehouse, which included the Health Centers and Look-Alike Site Directory, I was only able to locate three community health centers with Medically Underserved Population designation in the New York City area that provide linguistically and culturally competent health services for Asian communities (i.e., Brooklyn Chinese Family, Charles B. Wang, and APICHA community health centers).

Because funding to expand the safety net under the Affordable Care Act is not distributed based on population need and is highly competitive, it is likely that these funds will go to community-based organizations with more resources and who are better equipped to develop persuasive grant applications rather than to those that need it the most. Governance in this sphere is fragmented just like the rest of the healthcare delivery system in terms of how it is designed and implemented – in essence, it is a reflection of this country's culture of individualism and high value on upholding freedom of choice, and preference in organizational pluralism or, in other words, decentralization. This country's fragmented approach to healthcare fuels the structural, system, and cultural barriers vulnerable populations such as Asians face.

As suggested in lesson #1, rather than continue to build out the safety net, which is not a sustainable approach to providing healthcare for vulnerable populations, the U.S. should work towards integrating vulnerable populations—Asian immigrants in particular—into the mainstream healthcare system. In other words, the U.S. should strive to move towards a mainstream healthcare delivery model that adapts its services. Allowing vulnerable populations to access the same services and providers as everyone else in the U.S. will also be crucial in building social solidarity and will be less vulnerable to future political debates that have traditionally generated greater stigma for these groups. According to Moszynski (2008), excluding immigrants from primary care brings no savings to the National Health Service:

It may sound logical to argue that cutting off access to primary care will save money and take pressure off the NHS. But an examination of our findings . . . makes it clear that the opposite is true. Providing early and preventive care through primary care is a means of avoiding costly hospital treatment at a later date. (p. 1095)

In addition, the German and British healthcare systems demonstrate that targeted interventions established to address the barriers faced by immigrants are feasible and successful. Comprehensive case management with interpretation services that can be used in any medical care setting can greatly decrease the barriers Asian immigrants face due to their limited English proficiency as well as help mitigate other organizational barriers they face, including difficulties in enrolling and maintaining health insurance coverage and navigating the healthcare system. Interpretation services have shown to lead to better access to healthcare, including increased efficiency in physician visits, higher levels of patient satisfaction, and better quality of care (Flores, 2005; Hornburger et al., 1996; Jacobs et al., 2006; Jacobs, Shepard, Suaya, & Stone, 2004; Karliner, Jacobs, Chen, & Mutha, 2007). In addition, John-Baptiste et al. (2004) found that limited-English-proficient patients tend to stay in the hospital longer relative to English-speaking patients with similar conditions.

In order to implement such programs, the federal government needs to develop a more uniform system of policies across the states for interpretation services, beyond what is provided in the current legislation.¹⁷ Specific issues, such as funding, are not articulated in these legal obligations and left for states to design and implement (Youdelman, 2011). As a result, states have responded to these federal guidelines, but due to a tremendous state discretion and a lack of oversight and enforcement, a “patchwork” of state language policies has emerged (Chen, Youdelman, & Brooks, 2007; Perkins, 2005; Perkins & Youdelman, 2008; Perkins et al., 2003; Youdelman, 2008).

¹⁷ Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency* (August 16, 2000).

Perkins & Youdelman (2008) show that, to date, although every state currently has policies addressing some aspect of linguistically competent health services, there is tremendous variation across the states. Their study focused on four major types of state policies, including: (1) funding or reimbursement mechanisms for language assistance services; (2) policies on health interpreter competency; (3) requirements for hospitals; and (4) requirements for managed care plans. In their review of state language requirements, these scholars distinguished 31 different policy types, ranging from comprehensive language programs to requirements for specific services (e.g., prenatal care or abortions) or populations (e.g., children, women, persons with disabilities, or older adults). While the sheer number of laws is not indicative of quality, California arguably has the most comprehensive approach, passing more than 150 related laws while in contrast, 17 states have 10 or fewer laws.

Despite availability of federal matching funds under the Medicaid and SCHIP programs, only a handful of states since 2002—Connecticut, New York, Vermont, Virginia, and Wyoming—have developed mechanisms to reimburse providers for the federal matching funds for language services. With the exception of New York, none of the larger immigrant states—i.e., California, Florida, New Jersey, and Texas—have implemented mechanisms to reimburse providers for language assistance services (Kao, 2010). The federal government has attempted to encourage states to participate through the 2009 CHIP Reauthorization Act, which increased the federal match for language services for both SCHIP and Medicaid from 50% to 75% (Perry, et al., 2010). However, establishing incentives alone has proven to be unsuccessful in increasing participation, and therefore the federal government should establish a policy requiring states to develop

funding mechanisms for reimbursing language services and be more sensitive to the fact that states need implementation roadmap frameworks to deliver such services and, therefore, it is key that the federal government take the lead in developing them as soon as possible. Lastly, the federal government must require health insurance companies to reimburse for interpreter services.

Recommendations for Future Study

Regular monitoring of the uninsured and the barriers they continue to face in spite of the reforms implemented by the Affordable Care Act should be part of core health information for policy making. Researchers should conduct long-term monitoring survey studies that keep track, monitor, and study the impact of the Affordable Care Act on health insurance coverage and access to healthcare, with particular focus on employment and occupational type indicators. By doing so, emerging trends of self-employment among the U.S. population can be identified. For example, the “class of worker” question in U.S. Census datasets such as the American Community Survey allows respondents to select whether they are: (1) self-employed in own not incorporated business, professional practice, or farm, or (2) self-employed in own incorporated business, professional practice, or farm. Such indicators can help track insurance-coverage expansion among groups that have high self-employment rates and other groups with sub-par labor participation (e.g., part-time workers and unpaid family workers), taking into consideration health insurance coverage for the household since some are covered by a spouse’s plan or have another job in addition to owning their business. Additionally, studies should monitor the affordability of health insurance coverage including

assessments on which total household income levels are more conducive to the purchase of health insurance coverage.

Deeper knowledge is also needed in developing a comprehensive understanding of the states' policies for interpretation services and associated operational infrastructure and incentive models that work best to address the linguistic needs of the U.S. population. In essence, what types of policies are most effective? It is key to study states that have had success in implementing interpretation services. Researchers should document how having effective policies for interpretation services has drastically enhanced the way limited-English-proficient individuals communicate and interact in the healthcare system. For states with large immigrant populations—California, Florida, New Jersey, and Texas—it is important to understand why, given the availability of federal funding, these states have not implemented mechanisms to draw these funds. A national survey found only 3% of hospitals reported receiving direct reimbursement for language services (Hasnain-Wynia & Baker, 2006). In a national survey of internal medicine physicians, the American College of Physicians (2006) found that 75% of internists were not receiving any direct reimbursement for providing language services to their limited-English-proficient patients (and an additional 24% were uncertain whether their costs were being reimbursed at all). Lastly, researchers should closely examine how other countries deliver these services, including incentives, funding mechanisms, regulation and governance to monitor compliance, which help promote more culturally and linguistically appropriate healthcare.

Enacting Change in U.S. Health Policy

The previous section has demonstrated that the data generated by the interviews conducted with health experts and advocates and Access to Healthcare Survey for Koreans as well as lessons learned from other countries have served as key data points for developing possible solutions that will improve the way immigrants access the U.S. healthcare system. Making these recommendations actionable and operationalizing them, however, is certainly going to be challenging since it will require big change. Wilsford (1994) in his comparison of health reform in Germany, U.S., and the United Kingdom, highlights that big change is difficult, regardless of healthcare system type. He argues that big change is particularly challenging in the U.S. because the political system resembles quite closely a decentralized, non-hierarchical network of autonomous decision-agents. Centralized hierarchies are better at leveraging a wholly new policy path.

While the Affordable Care Act is a monumental change in moving this country towards universal health coverage, in essence, it is not a big change but rather incremental change since the healthcare system continues to be largely profit-driven. On the other hand, ensuring adequate healthcare access for immigrant populations, such as Asians, within the concept of “mainstreaming” proposed in the previous chapter is a big change for this country and would be fundamentally challenging for various reasons. First, the profound value that American culture places on individualism makes it incredibly difficult to persuade the public of the moral imperative and economic tenets of putting in place interventions that will help immigrants, such as Asians, better integrate into the U.S. healthcare system, even by increasing community health centers. As Russell

(2010) argues, social problems such as the low rates of uninsurance among Asians should be better understood as more of a structurally than an individually caused condition. Furthermore, the immigration policy debate underway that centers on whether both documented and undocumented immigrants are “deserving,” inadvertently or not, creates a greater stigma not only for illegal immigrants but documented immigrants as well.

In our individualistic society that fosters limited egalitarianism and government intervention, how can we enact change in U.S. health policy so vulnerable populations such as immigrants do not lack adequate access to healthcare? More importantly, what are the right conditions that will generate exceptional political attention to these issues? One key perspective in the policy agenda-setting literature comes from Green-Pedersen and Wilkerson (2006), who explain in what situations change arises.

Some are structural, emphasizing how institutions are organized to advance some alternatives or issues over others. Some are cognitive, emphasizing how individuals or even institutions process information in ways that limit what will be addressed at any given time. Others emphasize the role of external events or publics, and how they can combine with political incentives to quickly shift attention in a new direction (p. 1041).

It is likely that the role of the public will be of great importance in moving towards integrating Asians and other immigrant populations alike into the mainstream healthcare system. The success in reaching universal coverage within the German and British populations was closely linked to the presence of social solidarity and political will: if public support exists, then politicians have incentives to “connect solutions to problems.”

More importantly, the central idea of equity, which means that everyone should have access to, and be able to use, appropriate, good quality, and affordable healthcare must be embedded very deeply in U.S. culture in order to enact real change within the

healthcare system. To some, equity in the U.S. is an unrealistic claim and it will indeed be challenging to convince others of its importance not just on the basis that it is a human right to have access to healthcare but it is an economic issue that will inevitably impact our society. By framing equity in health in terms of an economic issue and urging others to invest in prevention by committing to an approach of mainstreaming is not only feasible but how we must work to transform our culture in the near term. Moreover, the German case highlights the power that social forces at all levels of society have to influence the design of the healthcare delivery system as well as health policy.

Altenstetter (2003) in her historical analysis of Germany's healthcare system maintains that this system "...has remained relatively intact over the past century..." due to the conservative forces continuous ability to achieve "...political compromise and successful implementation of communitarian values" (p.38). As it is stated,

Germany is above all a story of conservative forces in society. These forces include public and private employers, churches, and faith-based and secular social welfare organizations. They remain committed to the preservation of equitable access to quality medical services, and they form crucial pillars for the delivery of medical services and nursing care (p. 38).

The German case illustrates the power that a broad range of social forces across society can have on the way in which a healthcare delivery system is designed, organized, and implemented. It shows that political compromise can be reached if social forces come together in solidarity. According to Raphael (2010), an effective strategy for change encompasses building citizen coalitions, shifting values and ideology of the public (middle class), and strengthening political parties of the Left and ensuring that they achieve power. Without a strong Left party presence, improvements in health policy for

immigrants, such as Asians, are bleak, especially in liberal welfare states such as the U.S. where only modest benefits are targeted to the least well-off.

As argued by Piven and Cloward (1979), it was not great need caused by the Depression that led to the New Deal Legislation, but the victims of the Depression that mobilized and put pressure on the system to the point of frightening national elites. Moreover, above all, Asian Americans need to put pressure on the system for their right to linguistically and culturally healthcare services within the mainstream U.S. healthcare system. Asian community-based organizations must build strong partnerships with each other, and together engage political leaders using a common language that will ensure political leaders are tuned to the needs of the Asian community. This is particularly important because political leaders have a tendency to deliberately focus on the middle class and ignore ethnic minorities and the poor in fear that power will shift to the Left (Piven & Cloward, 2000).

Moreover, as this dissertation has shown, no single factor can fully explain why vulnerable groups face structural and cultural barriers to healthcare, but rather one must undertake a comprehensive approach to better understand multiple causes. The top four most uninsured Asian subgroups examined in this dissertation demonstrate that low uninsured rates, employment and occupational types as well as limited English proficiency are the most critical determinants of greater levels of access to the U.S. healthcare system. While having health insurance is critical in obtaining healthcare, health coverage is not enough to guarantee access. Moving towards integrating vulnerable populations, such as immigrants, into the mainstream healthcare system and establishing targeted interventions will be critical as these populations are growing

rapidly. According to the U.S. census (2010), the Asian population grew from 10.2 million to 14.7 million between 2000 and 2010 alone, representing a growth rate of 43%. The Asian population consists of mostly immigrants, with just over 66% being foreign-born.

Policymakers must accept that high uninsured rates among immigrants, including Asians, will ultimately harm the nation's economy. Poor health outcomes will not only increase healthcare costs but also negatively impact the economy for many of these vulnerable subgroups are the backbone of many small businesses in major cities in the U.S. For these reasons, the U.S. cannot afford to ignore the health of immigrants. Addressing healthcare inequities of immigrants will most importantly require societal commitment, social solidarity, and political will to implement solutions that are evidence-based as well as be accepted by the public. If public support exists, politicians will have the incentives to "connect solutions to problems." White (1995) maintains that some Americans believe that the U.S. is unique and that it thus cannot learn from other countries' experiences – we as a nation must come to the realization that enacting change is indeed difficult but achievable, regardless of the type of healthcare or political system. Other countries have achieved universal coverage by providing affordable health insurance with quality care for all its citizens but it was not an easy task.

Nonetheless, many of the same forces that are resistant in the U.S. had to be overcome elsewhere, and we must continue to believe that a U.S. healthcare system based on the concept of mainstreaming is possible. Improving the access to healthcare for vulnerable immigrant populations, such as the top four most uninsured Asian subgroups

in this study, is not only a moral imperative but a cost-efficient approach as well as a bridge to a more prosperous country.

Appendix A: Letter and Consent Form for Interviews with Health Experts and Advocates

Date

Dear (*Recipient*):

I am a Ph.D. candidate in the Department of Political Science at the City University of New York Graduate Center conducting dissertation research under the supervision of Professor Christa Altenstetter, Ph.D. My study focuses on access to healthcare and the top four most uninsured Asian American subgroup populations in the U.S. (i.e. Bangladeshi, Cambodian, Korean, and Pakistani subgroups). In hopes to gain a comprehensive understanding of their needs, the central objective of this study is to closely examine what impact various structural and cultural factors have on these subgroups' ability to access care.

In order to provide a robust and detailed analysis of the barriers vulnerable populations face in accessing healthcare, I believe it is vital to capture the perspectives of leading experts of Asian issues like you. I would like to cordially request a meeting with you to discuss any input you can provide for my study. Please feel free to contact me at 347-683-3440 or dkim@gc.cuny.edu if you are interested in participating or have any questions.

The interview will take about 30-45 minutes of your time. All the information you provide will be held in the strictest confidence. No quotations will be included in my dissertation without your explicit consent. I would like to assure you that this study has been reviewed and received Institutional Review Board ethics clearance. Should you have any comments or concerns resulting about your participation in this study, please contact Ms. Barbara Lermant, Associate Director at the Office of Regulatory Compliance Office at CUNY Queens College, 718-997-5415, Barbara.Lermant@qc.cuny.edu.

Thank you in advance for your cooperation in my research.

Yours sincerely,

Deborah Kim-Lu
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dkim@gc.cuny.edu

CITY UNIVERSITY OF NEW YORK

Graduate Center

Department of Political Science

CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Project Title: Access to Health Care for Vulnerable Asian Subgroup Populations in the United States

Principal Investigator: Deborah Kim-Lu
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New York, NY 10016
917-208-0174

Faculty Advisor: Christa Altenstetter, Ph.D.
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Queens College
200 Powdermaker Hall
65-30 Kissena Boulevard
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718-997-5491

Site where study is to be conducted: Interviews with health experts and advocates will be conducted in mutually convenient locations (e.g. interviewee's office, public meeting areas such as coffee shops, etc).

Introduction/Purpose: You are invited to participate in a research study. The study is conducted under the direction of Deborah Kim-Lu, graduate/doctoral student, and CUNY Graduate Center. The purpose of this research study is to better understand the health care access needs of Asian Americans. The results of this study may increase awareness of the existing structural and cultural barriers that hinder access to health care and input received from vulnerable Asian subgroup populations may contribute to a valuable resource for healthcare policy advocates and government as access to health care is expanded in the US.

Procedures: Approximately 24-30 individuals are expected to participate in this study. Each subject will participate in one interview. The time commitment of each participant is expected to be 30-45 minutes. Each session will take place at a mutually convenient location and date to be determined by the principal investigator and interviewee.

Possible Discomforts and Risks: Your participation in this study may involve breach of confidentiality, and other unforeseen discomforts. To minimize these risks, the principal investigator will ensure that every effort is made to keep the information provided during the interview strictly confidential. If any issues arise as a result of this study you should contact Ms. Barbara Lermant, Associate Director at the Office of Regulatory Compliance Office at CUNY Queens College, 718-997-5415, Barbara.Lermant@qc.cuny.edu.

Benefits: There are no direct benefits. However, participating in the study may increase general knowledge of the relationship between access to health care and vulnerable Asian subgroup populations in the United States, information that is necessary to enact change as health care reform expands in this country.

Voluntary Participation: Your participation in this study is voluntary, and you may decide not to participate without prejudice, penalty, or loss of benefits to which you are otherwise entitled. If you decide to leave the study, please contact the principal investigator, Deborah Kim-Lu, to inform them of your decision.

Confidentiality: The data obtained from you will be collected via note taking. The collected data will be accessible to the principal investigator, faculty advisor(s), IRB Members and associated staff. The researcher will protect your confidentiality by securely storing the data and discarding the data in a timely manner after the study is completed. The collected data will be stored on a secure computer. If any content of the interview is considered to be included in a publication, the principal investigator will contact the respective interviewee to obtain written consent to release such information.

Contact Questions/Persons: If you have any questions about the research now or in the future, you should contact the principal investigator, Deborah Kim-Lu, 917-208-0174, dkim@gc.cuny.edu. If you have any questions concerning your rights as a participant in this study, you may contact Ms. Barbara Lermant, Associate Director at the Office of Regulatory Compliance Office at CUNY Queens College, 718-997-5415, Barbara.Lermant@qc.cuny.edu.

Statement of Consent:

“I have read the above description of this research and I understand it. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions that I may have will also be answered by the principal investigator of the research study. I voluntarily agree to participate in this study.

By signing this form I have not waived any of my legal rights to which I would otherwise be entitled.

I will be given a copy of this statement.”

Printed Name of
Subject

Signature of Subject

Date Signed

Printed Name of
Person Explaining
Consent Form

Signature of Person Explaining Consent Form

Date Signed

Printed Name of
Investigator

Signature of Investigator

Date Signed

Appendix B: Health Expert/Advocate Interview Protocol

Date(s): _____

Institution(s): _____

Survey Section Used:

_____ A: Interview Background

_____ B: Institutional Perspective

_____ C: Structural Factors/Barriers

_____ D: Cultural Factors/Barriers

_____ E: Other

Other Topics Discussed: _____

Documents Obtained: _____

Post Interview Comments or Leads:

Administrative Matters

To facilitate my note-taking, I would like to digitally record our conversation today. Please sign the release form. For your information, only I will be privy to the digital recording files which will be eventually destroyed after they are transcribed. In addition, please sign a form devised to meet our human subject requirements. Essentially, this document states that: (1) all information will be held confidential, (2) your participation is voluntary and you may stop at any time if you feel uncomfortable, and (3) I do not intend to inflict any harm. Thank you for your agreeing to participate.

I planned this interview to last no longer than 30 to 45 minutes. During this time, I have several questions that I would like to cover. If time begins to run short, it may be necessary to interrupt you in order to push ahead and complete this line of questioning.

Introduction

You have been selected to speak with me today because you have been identified as a leading expert/advocate who has a great deal to share about Asian Americans and health. My study focuses on access to healthcare and Asian Americans, with particular interest in understanding the barriers and needs of the top four most uninsured Asian American subgroup populations in the U.S. (i.e. Bangladeshi, Cambodian, Korean, and Pakistani subgroups). This study does not aim to evaluate your or your respective institutions' techniques or experiences. Rather, I am trying to learn more about these vulnerable subgroups and hopefully identify ways in which we can improve their ability to access care.

A. Interviewee Background

How long have you been ...

_____ in your present position?

_____ at this institution?

Interesting background information on interviewee:

What is your area of expertise? _____

Do you have experience working with any of the Bangladeshi, Cambodian, Korean, and/or Pakistani communities?

If yes, in which areas/regions in the US? _____

1. Briefly describe your role as it relates to these particular Asian communities.

Probes: How are you involved in Asian American public health issues or advocacy?

How did you get involved?

B. Institutional Perspective

1. Does your institution have a strategy for improving access to healthcare for vulnerable Asian American subgroup populations?

Probes: Is it working – why or why not?

C. Structural Factors

1. What are some of the organizational challenges these subgroups' face in attempting to access healthcare? What are the major opportunities to improve access?

Probes: How can organizational barriers be overcome?

D. Acculturation/Cultural Factors

1. What are some of the acculturation/cultural challenges these subgroups' face in attempting to access healthcare? What are the major opportunities to improve access?

Probes: How can cultural barriers be overcome?

E. Other

1. What are other major challenges these subgroups' face in attempting to access healthcare?

2. What opportunities for improvement do you see emerge in the health advocacy and government sectors to ensure access to healthcare for these vulnerable populations gets better?

Post Interview Comments and/or Observations: _____

Appendix C: Participant Letter for Access to Healthcare Survey for Koreans in the US (English Version)

Date

Dear Sir or Madam,

My name is Deborah Kim-Lu, Ph.D. candidate at the City University of New York Graduate Center, Department of Political Science. I am currently writing a dissertation that explores Asians' experiences accessing healthcare in the United States. One of the subgroups I am studying includes Koreans, who as you may already know from your own experience and others around you, possess high uninsurance rates. To date, very little research on this important social issue for Koreans has been conducted in the New York and New Jersey areas.

I encourage you to please consider taking the time to fill out the enclosed questionnaire, which should only take you about 10 to 15 minutes to complete. You can choose either the Korean or English version of the questionnaire. Please complete all the items to the best of your knowledge. There are no right or wrong answers. **This survey is anonymous so please do not put your name on your questionnaire.** All your answers are confidential. The questionnaire comes with a self-paid postage that you can drop off at any postal office location or postal box to be sent directly to me for collection and analysis. Please feel free to contact me at 347-683-3440 or dkim@gc.cuny.edu if you have any questions.

Sincerely,

Deborah Kim-Lu
Ph.D. Candidate
P.O. Box 405
Belleville, New Jersey 07109

This study was reviewed and approved by the Institutional Review Board of City University of New York. If you have any questions concerning your rights as a participant in this study, you may contact Ms. Barbara Lermant, Associate Director at the Office of Regulatory Compliance Office at CUNY Queens College, 718-997-5415, Barbara.Lermant@qc.cuny.edu.

Appendix D: Access to Healthcare Survey for Koreans in the US (English Version)

Part One: Participant Information

General

1. What is your gender?
☐ 1. Male
☐ 0. Female
2. What is your age group?
☐ 1. Less than 18 years old
☐ 2. 18-25
☐ 3. 26-35
☐ 4. 36-45
☐ 5. 46-55
☐ 6. 56-65
☐ 7. 66 or older
3. What is your marital status?
☐ 1. Now Married
☐ 2. Never Married
☐ 3. Widowed
☐ 4. Divorced
☐ 5. Separated
4. Where do you live?
☐ 1. New York
☐ 2. New Jersey
☐ 3. Connecticut
☐ 4. Other (please specify) _____
5. What is your country of birth?
☐ 1. South Korea
☐ 2. North Korea
☐ 3. United States
☐ 4. Other (print name of country) _____
6. I consider myself as:
☐ 1. 1st generation (born and raised outside of the United States)
☐ 2. 1.5 generation (born outside the United States but spent my adolescent period in the United States)
☐ 3. 2nd generation (born and raised in the United States)
☐ 4. Other (please specify) _____

7. What is your ethnicity?
☐ 1. Korean
☐ 2. Other (please specify) _____
(For example, Chinese, Japanese, Italian, African American, and Dominican)
8. How long have you lived in the United States?
☐ 1. Less than 5 years
☐ 2. 6 to 10 years
☐ 3. 11 to 20 years
☐ 4. 21 to 30 years
☐ 5. 31 to 40 years
☐ 6. More than 40 years
☐ 7. Born in the United States
9. How well do you speak English?
☐ 1. Very well
☐ 2. Well
☐ 3. Not well
☐ 4. Not at all

Education

10. What is the highest level of education that you have completed?
☐ 1. Less than high school
☐ 2. High school or GED
☐ 3. Some college
☐ 4. Associate's degree (for example, AA, AS)
☐ 5. Bachelor's degree
☐ 6. Master's degree (for example, MA, MS, MEd, MSW, MBA)
☐ 7. Professional degree (for example, MD, DDS, DVM, LLB, JD)
☐ 8. Doctorate degree (for example, PhD, EdD)
11. In what country did you receive your highest level of education?
☐ 1. South Korea
☐ 2. United States
☐ 3. Other (print name of country) _____

Income and Employment

12. What is your individual income?

- ☐ 1. \$5,000 to \$10,000
- ☐ 2. \$10,001 to \$15,000
- ☐ 3. \$15,001 to \$20,000
- ☐ 4. \$20,001 to \$40,000
- ☐ 5. \$40,001 to \$60,000
- ☐ 6. \$60,001 to \$80,000
- ☐ 7. \$80,001 to \$100,000
- ☐ 8. \$100,001 to \$120,000
- ☐ 9. \$120,001 to \$140,000
- ☐ 10. \$140,001 to \$160,000
- ☐ 11. \$160,001 to \$180,000
- ☐ 12. \$180,001 to \$200,000
- ☐ 13. Over \$200,000

13. What is your total household income?

- ☐ 1. \$5,000 to \$10,000
- ☐ 2. \$10,001 to \$15,000
- ☐ 3. \$15,001 to \$20,000
- ☐ 4. \$20,001 to \$40,000
- ☐ 5. \$40,001 to \$60,000
- ☐ 6. \$60,001 to \$80,000
- ☐ 7. \$80,001 to \$100,000
- ☐ 8. \$100,001 to \$120,000
- ☐ 9. \$120,001 to \$140,000
- ☐ 10. \$140,001 to \$160,000
- ☐ 11. \$160,001 to \$180,000
- ☐ 12. \$180,001 to \$200,000
- ☐ 13. Over \$200,000

14. How many people live in your household?

Number of children (0 to 17 years old) _____

Number of adults (18 years to 64 years old) _____

Number of seniors (65 years old and older) _____

15. Do you own or rent your home?

- ☐ 1. Own
- ☐ 0. Rent

16. What is your employment status?
- ☐ 1. Employed
 - ☐ 2. Self-employed
 - ☐ 3. Not-employed
 - ☐ 4. Looking for work
 - ☐ 5. Disabled
 - ☐ 6. Retired
 - ☐ 7. Other (please specify) _____
17. If employed, are you:
- ☐ 1. Full-time
 - ☐ 2. Part-time
 - ☐ 3. Not applicable
18. If employed, where do you work?
- ☐ 1. Private-for-profit company
 - ☐ 2. Private-not-for-profit organization
 - ☐ 3. Government organization (federal, state, local)
 - ☐ 4. Small business
 - ☐ 5. Self-employed
 - ☐ 6. Working without pay in family business
 - ☐ 7. Other (please specify) _____
 - ☐ 8. Not applicable
19. If employed, what is your current occupation?
- ☐ 1. Management, business, and financial occupations
(Please specify title) _____
 - ☐ 2. Professional occupations
(Please specify title) _____
 - ☐ 3. Service occupations
(Please specify title) _____
 - ☐ 4. Sales occupations
(Please specify title) _____
 - ☐ 5. Office and administrative support occupations
(Please specify title) _____
 - ☐ 6. Farming, fishing, and forestry occupations
(Please specify title) _____
 - ☐ 7. Construction and extraction occupations
(Please specify title) _____
 - ☐ 8. Installation, maintenance, and repair occupations
(Please specify title) _____
 - ☐ 9. Production occupations
(Please specify title) _____
 - ☐ 10. Transportation and material moving occupations
(Please specify title) _____
 - ☐ 11. Armed Forces

- (Please specify title) _____
- ☐ 12. Other (please specify) _____
- ☐ 13. Not applicable
20. If you worked outside of the United States, what type of occupation did you previously have?
- ☐ 1. Management, business, and financial occupations
(Please specify title) _____
- ☐ 2. Professional occupations
(Please specify title) _____
- ☐ 3. Service occupations
(Please specify title) _____
- ☐ 4. Sales occupations
(Please specify title) _____
- ☐ 5. Office and administrative support occupations
(Please specify title) _____
- ☐ 6. Farming, fishing, and forestry occupations
(Please specify title) _____
- ☐ 7. Construction and extraction occupations
(Please specify title) _____
- ☐ 8. Installation, maintenance, and repair occupations
(Please specify title) _____
- ☐ 9. Production occupations
(Please specify title) _____
- ☐ 10. Transportation and material moving occupations
(Please specify title) _____
- ☐ 11. Armed Forces
(Please specify title) _____
- ☐ 12. Other (please specify) _____
- ☐ 13. Not applicable

Health Care and Health Status

21. What type of health insurance do you have? (Check all that apply)
- ☐ 1. Employer-based insurance (self)
- ☐ 2. Employer-based insurance (for example, you are a dependent on your spouse or parent's insurance)
- ☐ 3. Individual-based insurance (for example, insurance purchased on your own)
- ☐ 4. Medicaid
- ☐ 5. Medicare
- ☐ 6. Other (please specify) _____
- ☐ 7. Not insured

22. Do you have a regular source of medical care? (For example, a primary care physician)
- ☐ 1. Yes
 - ☐ 0. No
23. Where do you go for your regular source of medical care? (Check all that apply)
- ☐ 1. Private doctor
 - ☐ 2. Health clinic
 - ☐ 3. Traditional Korean medicine doctor (for example, hanbang or hanyak)
 - ☐ 4. Other (please specify) _____
 - ☐ 5. None
24. When was your last visit to the doctor for a routine medical check-up?
- ☐ 1. Within the last 12 months
 - ☐ 2. 1 year ago
 - ☐ 3. 2 years ago
 - ☐ 4. 3 years ago
 - ☐ 5. 4 years ago
 - ☐ 6. 5 years ago
 - ☐ 7. More than 5 years ago
 - ☐ 8. Never
25. How many doctor visits did you make in the last 12 months? (For example, routine medical check-up, disease screening, dental, and/or traditional Korean medicine visits)
- ☐ 0
 - ☐ 1
 - ☐ 2
 - ☐ 3
 - ☐ 4
 - ☐ 5 or more
26. Where do you seek care when you have a medical emergency?
- ☐ 1. Emergency room
 - ☐ 2. Traditional Korean medicine doctor (for example, hanbang or hanyak)
 - ☐ 3. Family and friends with medical training (for example, medical doctor or nurse)
 - ☐ 4. Family and friends without medical training
 - ☐ 5. Other (please specify) _____
 - ☐ 6. Not applicable
27. Do you use traditional Korean medicine? (For example, hanbang, hanyak, and/or acupuncture)
- ☐ 1. Yes
 - ☐ 0. No

28. How many visits to a traditional Korean medicine doctor did you make in the last 12 months?
- ☐ 0
 - ☐ 1
 - ☐ 2
 - ☐ 3
 - ☐ 4
 - ☐ 5 or more
29. Have you traveled to South Korea to receive medical care in the last 5 years?
- ☐ 1. Yes
 - ☐ 0. No
30. How many times did you travel to South Korea to receive medical care in the last 5 years?
- ☐ 0
 - ☐ 1
 - ☐ 2
 - ☐ 3
 - ☐ 4
 - ☐ 5 or more
31. Which of the following services provided by Korean community health centers have you attended or used in the past? (Check all that apply)
- ☐ 1. Health clinic (for example, general routine medical check-up, immunization)
 - ☐ 2. Language translation assistance
 - ☐ 3. Nurse hotline
 - ☐ 4. Seminar (for example, disease prevention)
 - ☐ 5. Seminar (for example, health insurance)
 - ☐ 6. Support group
 - ☐ 7. Social services (for example, application assistance, eligibility screening, advocacy)
 - ☐ 8. Other (please specify) _____
 - ☐ 9. None
32. How would you rate your overall health condition?
- ☐ 1. Very healthy
 - ☐ 2. Healthy
 - ☐ 3. Fair
 - ☐ 4. Unhealthy
 - ☐ 5. Very unhealthy

Beliefs and Civic Engagement

33. How often do you regularly attend a religious organization? (For example, church, temple, or other)
- ☐ 1. Daily
 - ☐ 2. Weekly
 - ☐ 3. Monthly
 - ☐ 4. Quarterly
 - ☐ 5. Annually
 - ☐ 6. Never
34. Do you think illness is a result of sin or punishment from God?
- ☐ 1. Yes
 - ☐ 2. No
 - ☐ 3. Maybe (please explain) _____
35. Do you think illness can only be healed by getting forgiveness from God?
- ☐ 1. Yes
 - ☐ 2. No
 - ☐ 3. Maybe (please explain) _____
36. Do you think having an illness will damage your or your family's reputation?
- ☐ 1. Yes
 - ☐ 2. No
 - ☐ 3. Maybe (please explain) _____
37. Do you vote in government elections?
- ☐ 1. Yes
 - ☐ 0. No
38. What best describes your political views?
- ☐ 1. Democratic
 - ☐ 2. Republican
 - ☐ 3. Independent
 - ☐ 4. Other (please specify) _____
39. Which of the following political activities do you participate in? (Check all that apply)
- ☐ 1. Vote in presidential elections
 - ☐ 2. Display political posters/materials at home
 - ☐ 3. Membership in political party
 - ☐ 4. Volunteer for political party
 - ☐ 5. Volunteer in national or local elections
 - ☐ 6. Other (please specify) _____
 - ☐ 7. None

40. Do you think voting in government elections and participating in political activities improves access to quality healthcare for the Korean community?
- ☐ 1. Yes
 - ☐ 2. No
 - ☐ 3. Maybe (please explain) _____

Part Two: Access to Healthcare

Question #	Survey Question	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	I rarely skip taking medication due to cost	1	2	3	4	5	6
2	I have an easy time communicating with doctors and nurses	1	2	3	4	5	6
3	I have trouble paying for my health insurance	1	2	3	4	5	6
4	I have no problems paying my medical bills	1	2	3	4	5	6
5	Finding transportation to the doctor's office is difficult	1	2	3	4	5	6
6	I often put-off getting medical care due to cost	1	2	3	4	5	6
7	I rarely have to wait a long time to see a doctor or nurse	1	2	3	4	5	6
8	It is easy to find affordable quality healthcare	1	2	3	4	5	6
9	Healthcare facilities in my area have limited hours	1	2	3	4	5	6
10	Healthcare facilities in my area offer only limited services	1	2	3	4	5	6
11	The American healthcare system is confusing	1	2	3	4	5	6
12	Enrolling in public health insurance is difficult (for example, Medicaid and Medicare)	1	2	3	4	5	6

Question #	Survey Question	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
13	I rely on my immediate family members to coordinate my healthcare	1	2	3	4	5	6
14	My religious views do not prevent or delay me from seeking healthcare	1	2	3	4	5	6
15	Applying for public health insurance may change my immigration status (for example, Medicaid)	1	2	3	4	5	6
16	I know I can request an interpreter at a hospital, if I need one	1	2	3	4	5	6
17	I prefer conventional Western medicine over traditional Korean medicine treatments (for example, hanbang or hanyak)	1	2	3	4	5	6
18	Korean media is my main source of information (for example, newspaper, television news)	1	2	3	4	5	6
19	I feel more comfortable seeking healthcare from Korean speaking doctors over English speaking doctors	1	2	3	4	5	6
20	Receiving public assistance is disgraceful (for example, disability, food stamps, welfare, Medicaid)	1	2	3	4	5	6
21	I do not trust the American healthcare system	1	2	3	4	5	6

Appendix E: Participant Letter Access to Healthcare Survey for Koreans in the US (Korean Version)

안녕하십니까,

저는 뉴욕시립대학교 대학원센터 정치학과에서 박사 과정을 이수하고 있는 데보라 김 루 입니다. 미국에서 아시아인의 의료 접근권 실태를 보여주는 학위 논문을 준비 중에 있습니다. 제가 조사 중인 소집단 중에 한국인이 포함되어 있으며 주지하시는 바와 같이 이들 중 상당수가 보험 혜택을 받지 못하고 있습니다. 현재까지 이러한 한국인들의 중요한 사회적 문제에 대해 뉴욕 및 뉴저지 지역에서 수행된 연구는 소수에 불과합니다.

저는 여러분들이 시간을 내어 첨부 설문지를 작성해 주실 것을 부탁드립니다. 설문지 작성은 약 15 분에서 20 분 정도의 시간이면 충분할 것입니다. 설문지는 영어본과 한국어본 두 종류가 있으니 둘 중 하나를 선택하시면 됩니다. 작성하실 때 알고 될 수 있는 대로 모든 항목을 빠뜨리지 말고 작성해 주시기를 부탁드립니다. 이 설문지의 질문에 대한 정답이나 오답은 없습니다. 이 조사는 익명으로 실시하고 있으니 설문지상에 성함을 적지 않도록 하십시오. 모든 답변 내용의 기밀은 보장됩니다. 설문지는 우편료 선납 봉투와 함께 제공되오니 우체국 또는 우체통에 넣어 주시면 제가 직접 받아 볼 수 있으며 저는 이를 모두 수거한 후 분석 작업을 수행하고자 합니다.

질문이 있으시면 347-683-3440 또는 dkim@gc.cuny.edu 로연락하십시오. 그럼 안녕히 계십시오.

데보라 김 루

Ph.D. 후보

P.O. Box 405

Belleville, New Jersey 07109

이 연구는 뉴욕시립대학교 기관감사위원회의 검토와 승인을 마쳤습니다. 본 연구 참가자로서의 귀하의 권리에 대한 질문은 쿠니 퀸스 칼리지의 규정준수사무국 부국장을 접촉하십시오: 718-997-5415, Barbara.Lermand@qc.cuny.edu.

Appendix F: Access to Healthcare Survey for Koreans in the US (Korean Version)

의료 접근권에 대한 표본조사

일반 정보

1 **성별**

- ☐ 1. 남성
- ☐ 0. 여성

2 **연령**

- ☐ 1. 18 세 미만
- ☐ 2. 18 세-25 세
- ☐ 3. 26 세-35 세
- ☐ 4. 36 세-45 세
- ☐ 5. 46 세-55 세
- ☐ 6. 56 세-65 세
- ☐ 7. 66 세 이상

3 **혼인 상태**

- ☐ 1. 기혼자
- ☐ 2. 결혼한 적 없음
- ☐ 3. 사별
- ☐ 4. 이혼
- ☐ 5. 별거

- 4 거주지
- ☐ 1. 뉴욕
 - ☐ 2. 뉴저지
 - ☐ 3. 커네티컷
 - ☐ 4. 기타 (지역명 명시) _____
- 5 출생국
- ☐ 1. 한국
 - ☐ 2. 북한
 - ☐ 3. 미국
 - ☐ 4. 기타 (국가명 명시) _____
- 6 아래 중 해당되는 곳에 체크 표시
- ☐ 1. 1 세대 (미국 외의 국가에서 태어나 성장하였다)
 - ☐ 2. 1.5 세대 (미국 외의 국가에서 태어났지만 미국에서 청소년기를 보냈다)
 - ☐ 3. 2 세대 (미국에서 태어나 성장하였다)
 - ☐ 4. 기타 (구체적으로 명기하십시오) _____
- 7 미국 거주 기간
- ☐ 1. 5 년 미만
 - ☐ 2. 6 년 - 10 년
 - ☐ 3. 11 년 - 20 년
 - ☐ 4. 21 년 - 30 년
 - ☐ 5. 31 년 - 40 년
 - ☐ 6. 40 년 초과
 - ☐ 7. 미국에서 태어났다
- 8 영어 구사 능력
- ☐ 1. 매우 잘함

- ☐ 2. 잘함
- ☐ 3. 잘하지 못함
- ☐ 4. 전혀 못함

9 민족 구분

- ☐ 1. 한국인
- ☐ 2. 기타 (구체적으로 명시하십시오) _____
(예: 중국인, 일본인, 이탈리아인, 아프리카 미국인, 도미니카인)

교육 정도

10 최종 학력

- ☐ 1. 고졸 미만
- ☐ 2. 고졸 또는 고졸 학력 인증서 취득
- ☐ 3. 전문대졸
- ☐ 4. 준학사 학위 (예: AA, AS)
- ☐ 5. 학사 학위
- ☐ 6. 석사 학위 (예: MA, MS, MEd, MSW, MBA)
- ☐ 7. 전문학위(예: MD, DDS, DVM, LLB, JD)
- ☐ 8. 박사 학위(예: PhD, EdD)

11 최종 학교 소재지

- ☐ 1. 한국
- ☐ 2. 미국
- ☐ 3. 기타 (국가명 명기) _____

소득 및 고용

12 연소득

- ☐ 1. \$5,000 - \$10,000

- ☐ 2. \$10,001 - \$15,000
- ☐ 3. \$15,001 - \$20,000
- ☐ 4. \$20,001 - \$40,000
- ☐ 5. \$40,001 - \$60,000
- ☐ 6. \$60,001 - \$80,000
- ☐ 7. \$80,001 - \$100,000
- ☐ 8. \$100,001 - \$120,000
- ☐ 9. \$120,001 - \$140,000
- ☐ 10. \$140,001 - \$160,000
- ☐ 11. \$160,001 - \$180,000
- ☐ 12. \$180,001 - \$200,000
- ☐ 13. \$200,000 이상

13 총 가계 소득

- ☐ 1. \$5,000 - \$10,000
- ☐ 2. \$10,001 - \$15,000
- ☐ 3. \$15,001 - \$20,000
- ☐ 4. \$20,001 - \$40,000
- ☐ 5. \$40,001 - \$60,000
- ☐ 6. \$60,001 - \$80,000
- ☐ 7. \$80,001 - \$100,000
- ☐ 8. \$100,001 - \$120,000
- ☐ 9. \$120,001 - \$140,000
- ☐ 10. \$140,001 - \$160,000
- ☐ 11. \$160,001 - \$180,000
- ☐ 12. \$180,001 - \$200,000
- ☐ 13. \$200,000 이상

14 가구 구성원수

- ☐ 1. 자녀수 (0 - 17 세) _____

- ☐ 2. 성인 구성원수 (18 - 64 세) _____
 - ☐ 3. 노인 구성원수 (65 세 이상) _____
- 15 주택 소유 형태
- ☐ 1. 소유
 - ☐ 0. 렌트
- 16 고용 상태
- ☐ 1. 피고용인
 - ☐ 2. 자영업
 - ☐ 3. 실업 상태
 - ☐ 4. 구직 중임
 - ☐ 5. 노동 불능 상태
 - ☐ 6. 은퇴자
 - ☐ 7. 기타 (구체적으로 명기하십시오) _____
- 17 피고용인인 경우:
- ☐ 1. 풀 타임 근무
 - ☐ 2. 파트 타임 근무
 - ☐ 3. 해당 없음
- 18 근무 장소
- ☐ 1. 일반 회사
 - ☐ 2. 민간 비영리 법인
 - ☐ 3. 정부 기구 (연방, 주, 지방 정부)
 - ☐ 4. 소규모 사업장
 - ☐ 5. 자영업
 - ☐ 6. 가업 (무보수로 일함)
 - ☐ 7. 기타 (지역명 명시) _____
 - ☐ 8. 해당 없음

19 피고용인인 경우; 직업 유형

☐ 1. 관리직, 영업 및 재무 관련 직업

(직위를 기입하십시오) _____

☐ 2. 전문직

(직위를 기입하십시오) _____

☐ 3. 서비스 직업

(직위를 기입하십시오) _____

☐ 4. 판매직

(직위를 기입하십시오) _____

☐ 5. 사무직 및 행정직

(직위를 기입하십시오) _____

☐ 6. 농업직, 어업직 및 임업직

(직위를 기입하십시오) _____

☐ 7. 건설 및 채굴 관련 직업

(직위를 기입하십시오) _____

☐ 8. 설치, 유지보수 및 수리 관련 직업

(직위를 기입하십시오) _____

☐ 9. 생산직

(직위를 기입하십시오) _____

☐ 10. 수송 및 운수 관련 직업

(직위를 기입하십시오) _____

☐ 11. 군인

(직위를 기입하십시오) _____

☐ 12. 기타 (구체적으로 기입하십시오) _____

☐ 13. 해당 없음

20 미국 외의 지역에서 과거 직업

☐ 1. 관리직, 영업 및 재무 관련 직업

(직위를 기입하십시오) _____

- 2. 전문직
(직위를 기입하십시오) _____
- 3. 서비스직
(직위를 기입하십시오) _____
- 4. 판매직
(직위를 기입하십시오) _____
- 5. 사무직 및 행정직
(직위를 기입하십시오) _____
- 6. 농업직, 어업직 및 임업직
(직위를 기입하십시오) _____
- 7. 건설 및 채굴 관련 직업
(직위를 기입하십시오) _____
- 8. 설치, 유지보수 및 수리 관련 직업
(직위를 기입하십시오) _____
- 9. 생산직
(직위를 기입하십시오) _____
- 10. 수송 및 운수 관련 직업
(직위를 기입하십시오) _____
- 11. 군인
(직위를 기입하십시오) _____
- 12. 기타 (구체적으로 기입하십시오) _____
- 13. 해당 없음

의료 및 보건 상태

- 21 가입된 보험의 유형 (해당 항목 체크 표시)
- 1. 고용주 기반의 보험 (자신의)
 - 2. 고용주 기반의 보험 (배우자 나 부모의 보험에 따라)
 - 3. 개인 기반의 보험 (자비를 들여 가입한 보험)
 - 4. 메디케이드

- ☐ 5. 메디케어
 - ☐ 6. 기타 (구체적으로 명기하십시오) _____
 - ☐ 7. 가입된 보험 없음
- 22 정기적인 진료를 받을 수 있는 의료 시설 이용 유무 (예: 1 차 진료의)
- ☐ 1. 있다
 - ☐ 0. 없다
- 23 정기적인 진료를 받고 있는 의료 시설 (해당 항목 체크 표시)
- ☐ 1. 민간 의사
 - ☐ 2. 건강 진료소
 - ☐ 3. 전통 한의원 (예: 한방 또는 한약)
 - ☐ 4. 기타 (지역명 명시) _____
 - ☐ 5. 없다
- 24 가장 최근의 건강 검진
- ☐ 1. 지난 12 개월 이내
 - ☐ 2. 1 년 전
 - ☐ 3. 2 년 전
 - ☐ 4. 3 년 전
 - ☐ 5. 4 년 전
 - ☐ 6. 5 년 전
 - ☐ 7. 5 년 이상 경과
 - ☐ 8. 검진한 적 없음
- 25 지난 12 개월간 진료 횟수 (예: 정기 건강 검진, 진찰, 치과 및/또는 전통 한의원 등)
- ☐ 0
 - ☐ 1
 - ☐ 2

- ☐ 3
- ☐ 4
- ☐ 5 회 이상

26 응급상황 발생시 찾는 의료 시설

- ☐ 1. 응급실
- ☐ 2. 전통적인 한의사 (예: 한방 또는 한약)
- ☐ 3. 의학 교육을 받은 가족 및 친구 (예: 의사 또는 간호사)
- ☐ 4. 의학 교육을 받지 않은 가족 및 친구
- ☐ 5. 기타 (구체적으로 명기하십시오) _____
- ☐ 6. 해당 없음

27 한의원 이용 여부 (예: 한방, 한약 및/또는 침술)

- ☐ 1. 있다
- ☐ 0. 없다

28 지난 12 개월간의 한의원 진료 횟수

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 회 이상

29 지난 5 년간 치료 목적의 한국 방문 여부

- ☐ 1. 있다
- ☐ 0. 없다

30 지난 5 년간 치료 목적의 한국 방문 횟수

- ☐ 0

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 회 이상

31 한국 지역사회 보건 센터에서 제공하는 아래 서비스 중 참여한 적이 있는 서비스는 어떤 것입니까? (예: 해당 항목 체크 표시)

- ☐ 1. 건강 진료소 (예: 일반 검진, 면역접종)
- ☐ 2. 언어 번역 지원
- ☐ 3. 간호사 핫라인
- ☐ 4. 세미나 (예: 질병 예방)
- ☐ 5. 세미나 (예: 건강 보험)
- ☐ 6. 협력 단체
- ☐ 7. 사회 복지 사업 (예: 신청 지원, 자격 심사, 권리옹호)
- ☐ 8. 기타 (예: 지역명 명시) _____
- ☐ 9. 없음

32 현재 건강 상태

- ☐ 1. 매우 건강함
- ☐ 2. 건강함
- ☐ 3. 보통임
- ☐ 4. 나쁨
- ☐ 5. 매우 나쁨

신앙 및 시민 참여

33 종교 단체 정기적 참여 횟수 (예: 교회, 절, 기타)

- ☐ 1. 매일
- ☐ 2. 주 1 회

- ☐ 3. 월 1 회
 - ☐ 4. 3 개월에 1 회
 - ☐ 5. 연 1 회
 - ☐ 6. 참여한 적 없음
- 34 질병을 죄의 결과 또는 신의 징벌이라고 생각하십니까?
- ☐ 1. 그렇다
 - ☐ 2. 아니다
 - ☐ 3. 그럴 수 있다 (구체적으로 설명하십시오) _____
- 35 질병은 신이 용서가 있어야만 회복될 수 있다고 믿습니까?
- ☐ 1. 그렇다
 - ☐ 2. 아니다
 - ☐ 3. 그럴 수 있다 (구체적으로 설명하십시오) _____
- 36 질병을 앓게 되면 그로 인해 가족의 평판이 나빠진다고 생각하십니까?
- ☐ 1. 그렇다
 - ☐ 2. 아니다
 - ☐ 3. 그럴 수 있다 (구체적으로 설명하십시오) _____
- 37 정부에서 시행하는 투표 참가 여부
- ☐ 1. 참가한다
 - ☐ 0. 안한다
- 38 다음 중 당신의 정치적 견해를 가장 잘 표현한 것은 어떤 것입니까?
- ☐ 1. 민주
 - ☐ 2. 공화
 - ☐ 3. 무소속
 - ☐ 4. 기타 (구체적으로) _____
 - ☐ 5. 미정

39 다음 중 당신이 참여하고 있는 정치활동은 어떤 것입니까? (해당 항목 체크 표시)

- ☐ 1. 대통령 선거에서 투표한다
- ☐ 2. 정치 포스터/자료를 집에 붙여 놓는다
- ☐ 3. 정당에 가입하였다
- ☐ 4. 정당에서 자원봉사자로 일한다
- ☐ 5. 국가 또는 지방 선거에서 자원봉사자로 일한다
- ☐ 6. 기타 (구체적으로) _____
- ☐ 7. 없음

40 정부에서 시행하는 선거에서 투표권을 행사하고 정치 활동에 참여하면
그로 인해 한국 교민 사회의 의료 접근권이 개선될 것으로 생각하십니까?

- ☐ 1. 그렇다
- ☐ 2. 아니다
- ☐ 3. 그럴 수 있다 (구체적으로 설명하십시오) _____

제 2 부: 의료 접근권

질문 번호	질문	절대 동의하지 않음	동의하지 않음	약간 동의하지 않음	약간 동의함	동의함	매우 동의함
1	비용 때문에 약 복용을 빠뜨리는 경우는 거의 없다	1	2	3	4	5	6
2	의사 및 간호사들과 쉽게 대화한다	1	2	3	4	5	6
3	내 건강 보험을 지불하기가 어렵습니다	1	2	3	4	5	6
4	진료비를 지불하는 데 경제적 어려움이 없다	1	2	3	4	5	6
5	진료를 위해 병원을 찾을 때 교통 수단 때문에 어려움을 겪는다	1	2	3	4	5	6
6	비용 때문에 종종 진료를 미룬다	1	2	3	4	5	6
7	진료를 위해 의사나 간호사를 찾는 일을 미루는 경우는 거의 없다	1	2	3	4	5	6
8		1	2	3	4	5	6

	적절한 의료 시설을 찾아 진료를 받는 데 어려움이 없다						
9	인근의 의료 시설은 이용 시간이 제한적이다	1	2	3	4	5	6
10	인근의 의료 시설은 진료 과목이 제한적이다	1	2	3	4	5	6
질문 번호	질문	절대 동의하지 않음	동의하지 않음	약간 동의하지 않음	약간 동의함	동의함	매우 동의함
11	미국의 의료 시스템은 혼란스러워 이해하기 어렵다	1	2	3	4	5	6
12	의료 보험에 등록하는 일이 쉽지 않다 (예: 메디케이드, 메디케어)	1	2	3	4	5	6
13	의료 서비스를 받고자 할 때 직계 가족에 의존한다	1	2	3	4	5	6
14	종교적 견해 때문에 의료 서비스를 회피하거나 지연하지 않는다	1	2	3	4	5	6
15	공공 건강 보험을	1	2	3	4	5	6

신청하면 이민 지위가
변경될지도 모른다 (예를
들어 메디케이드)

	통역자가 필요하면						
16	병원에서 이를 요구할 수 있다는 것을 알고 있다	1	2	3	4	5	6

	전통적인 한의학 보다						
17	서양 의학을 선호한다 (한방 또는 한약)	1	2	3	4	5	6

	주로 한국의 미디어를 통해						
18	정보를 얻는다 (예: 신문, TV 뉴스)	1	2	3	4	5	6

질문 번호	질문	절대 동의하지 않음	동의하지 않음	약간 동의하지 않음	약간 동의함	동의함	매우 동의함
19	영어로 진료하는 의사보다 한국어로 진료하는 의사에게서 진료를 받을 때 더 안심이 된다	1	2	3	4	5	6
20	공공 지원을 받는 것은 불명예라고 생각한다 (예: 장애, 푸드스탬프, 복지 및 의료지원)	1	2	3	4	5	6
21	미국 보건의료 시스템을 신뢰하지 않는다	1	2	3	4	5	6

Appendix G: Access to Healthcare Survey for Koreans in the U.S. Subscales

Question	Survey Question	Subscale
1 (R)	I rarely skip taking medication due to cost	Cost Barriers
2 (R)	I have an easy time communicating with doctors and nurses	System Barriers
3	I have trouble paying for my health insurance	Cost Barriers
4 (R)	I have no problems paying my medical bills	Cost Barriers
5	Finding transportation to the doctor's office is difficult	System Barriers
6	I often put-off getting medical care due to cost	Cost Barriers
7 (R)	I rarely have to wait a long time to see a doctor or nurse	System Barriers
8 (R)	It is easy to find affordable quality healthcare	Cost Barriers
9	Healthcare facilities in my area have limited hours	System Barriers
10	Healthcare facilities in my area offer only limited health services	System Barriers
11	The American healthcare system is confusing	System Barriers
12	Enrolling in public health insurance is difficult (for example, Medicaid and Medicare)	System Barriers
13	I rely on my immediate family members to coordinate my healthcare	Cultural Barriers
14 (R)	My religious views do not prevent or delay me from seeking healthcare	Cultural Barriers
15	Applying for public health insurance may change my immigration status (for example, Medicaid)	System Barriers
16 (R)	I know I can request an interpreter at a hospital, if I need one	System Barriers
17 (R)	I prefer conventional Western medicine rather than Traditional Korean medicine treatments (for example, hanbang or hanyak)	Cultural Barriers
18	Korean media is my main source of information (for example, newspaper, television news)	Cultural Barriers
19	I feel more comfortable seeking healthcare from Korean speaking doctors over English speaking doctors.	Cultural Barriers
20	Receiving public assistance (for example, disability, food stamps, welfare, medicaid) is disgraceful	Cultural Barriers
21	I do not trust the American healthcare system	Cultural Barriers

**Appendix H: Variables and Measures for Access to Healthcare Survey for Koreans
in the US**

Variable		Definition/Measure	Type
Survey Location	1	Small Business	Categorical
	2	Online	
	3	Church	
	4	Community Organization	
	5	Other	
Survey Language	1	Korean	Dichotomous
	2	English	
Gender	0	Male	Dichotomous
	1	Female	
Age	1	Less than 18 years old	Categorical
	2	18-25	
	3	26-35	
	4	36-45	
	5	46-55	
	6	56-65	
	7	66 or older	
Marital Status	1	Now married	Categorical
	2	Never married	
	3	Widowed	
	4	Divorced	
	5	Separated	
State	1	New York	Categorical
	2	New Jersey	
	3	Connecticut	
	4	Other	
Birth Country	1	South Korea	Categorical
	2	North Korea	
	3	United States	
	4	Other	
Generational Status	1	1 st generation	Categorical
	2	1.5 generation	
	3	2 nd generation	
	4	Other	
Ethnicity	1	Korean	Dichotomous
	2	Other	
Length of Stay in United States	1	Less than 5 years	Categorical
	2	6-10	
	3	11-20	
	4	21-30	
	5	31-40	

	6	More than 40 years	
	7	Born in the US	
English Proficiency	1	Very well	Ordinal
	2	Well	
	3	Not well	
	4	Not at all	
Educational Attainment	1	Less than high school	Ordinal
	2	High school or GED	
	3	Some college	
	4	Associate's degree	
	5	Bachelor's degree	
	6	Master's degree	
	7	Professional degree	
	8	Doctorate degree	
Educational Attainment Country	1	South Korea	Categorical
	2	US	
	3	Other	
Individual Income	1	\$5,000-10,000	Interval
	2	\$10,001-15,000	
	3	\$15,001-20,000	
	4	\$20,001-40,000	
	5	\$40,001-60,000	
	6	\$60,001-80,000	
	7	\$80,001-100,000	
	8	\$100,001-120,000	
	9	\$120,001-140,000	
	10	\$140,001-160,000	
	11	\$160,001-180,000	
	12	\$180,001-200,000	
	13	Over \$200,000	
Total Household Income	1	\$5,000-10,000	Interval
	2	\$10,001-15,000	
	3	\$15,001-20,000	
	4	\$20,001-40,000	
	5	\$40,001-60,000	
	6	\$60,001-80,000	
	7	\$80,001-100,000	
	8	\$100,001-120,000	
	9	\$120,001-140,000	
	10	\$140,001-160,000	
	11	\$160,001-180,000	
	12	\$180,001-200,000	
	13	Over \$200,000	

Number of Household (Children, Adults, or Seniors)	1	1	Categorical
	2	2	
	3	3	
	4	4	
	5	5	
Home Ownership	0	Own	Dichotomous
	1	Rent	
Employment Status	1	Employed	Categorical
	2	Self-employed	
	3	Not-employed	
	4	Looking for work	
	5	Disabled	
	6	Retired	
	7	Other	
Employment Hours	1	Full-Time	Categorical
	2	Part-time	
	3	Not applicable	
Employment Place	1	Private for profit company	Categorical
	2	Private not for profit organization	
	3	Government organization	
	4	Small business	
	5	Self-employed	
	6	Working without pay in family business	
	7	Other	
	8	Not applicable	
Occupation in United States	1	Management, business, and financial	Categorical
	2	Professional	
	3	Service	
	4	Sales	
	5	Office and administrative support	
	6	Farming, fishing, and forestry	
	7	Construction and extraction	
	8	Installation, maintenance, and repair	
	9	Production	
	10	Transportation and material moving	
	11	Armed forces	
	12	Other	
	13	Not applicable	
Occupation Outside of United States	1	Management, business, and financial	Categorical
	2	Professional	
	3	Service	
	4	Sales	
	5	Office and administration support	

	6	Farming, fishing, and forestry	
	7	Construction and extraction	
	8	Installation, maintenance, and repair	
	9	Production	
	10	Transportation and material moving	
	11	Armed forces	
	12	Other	
	13	Not applicable	
Insurance Coverage Type	1	Employment Based (Self)	Categorical
	2	Employment Based (Dependent)	
	3	Individual Based	
	4	Medicaid	
	5	Medicare	
	6	Not Insured	
	7	Insurance Type Specified	
Regular Source of Care	0	No	Dichotomous
	1	Yes	
Regular Source of Care Type	1	Private doctor	Categorical
	2	Health Clinic	
	3	Traditional Korean Doctor	
	4	Other	
	5	None	
Last Medical Check-Up	1	Within the last 12 months	Interval
	2	1 year ago	
	3	2 years ago	
	4	3 years ago	
	5	4 years ago	
	6	5 years ago	
	7	More than 5 years ago	
	8	Never	
Health Visit Frequency	0	0	Ordinal
	1	1	
	2	2	
	3	3	
	4	4	
	5	5 or more	
Emergency Care Type	1	Emergency room	Categorical
	2	Traditional Korean medicine doctor	
	3	Family and friends with medical training	
	4	Family and friends without medical training	
	5	Other	
	6	Not applicable	

Korean Medicine Utilization	0	No	Categorical
	1	Yes	
Korean Medical Utilization Frequency	0	0	Ordinal
	1	1	
	2	2	
	3	3	
	4	4	
	5	5 or more	
Medical Tourism Utilization	0	No	Dichotomous
	1	Yes	
Medical Tourism Frequency	0	0	Ordinal
	1	1	
	2	2	
	3	3	
	4	4	
	5	5 or more	
Community Health Resources Utilization	1	Clinic	Categorical
	2	Translation	
	3	Nurse Hotline	
	4	Seminar on Disease Prevention	
	5	Seminar on Health Insurance	
	6	Support Group	
	7	Social Services	
	8	None	
Self- Reported Health Status	1	Very healthy	Ordinal
	2	Healthy	
	3	Fair	
	4	Unhealthy	
	5	Very unhealthy	
Religious Attendance Frequency	1	Daily	Interval
	2	Weekly	
	3	Monthly	
	4	Quarterly	
	5	Annually	
	6	Never	
Illness is Sin	0	No	
	1	Yes	
	2	Maybe	
Illness Can Only Be Healed by God	0	No	
	1	Yes	
	2	Maybe	
Illness Damages Family Reputation	0	No	
	1	Yes	
	2	Maybe	

Participation in Elections	0	No	Dichotomous
	1	Yes	
Political Party Preference	1	Democratic	Categorical
	2	Republican	
	3	Independent	
	4	Other	
	5	None	
Political Participation Activities	1	Vote Elections	Categorical
	2	Display	
	3	Membership	
	4	Volunteer	
	5	Volunteer National	
	6	None	
Political Participation Impact	0	No	
	1	Yes	
	2	Maybe	
Medical Cost	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Doctor Communication	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Insurance Cost	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Medical Bills	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Transportation	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	

	5	Agree	
	6	Strongly agree	
Cost	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Long Wait	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Cost Affordability	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Limited Hours	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Limited Services	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
System is Confusing	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Enrollment Difficulties	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	

	6	Strongly agree	
Family Coordination	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Religion Delays Healthcare	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Immigration Status	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Interpreter	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Medical Preference	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Korean Media	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
Korean Doctor Preference	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	

Public Assistance	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	
System Trust	1	Strongly disagree	Categorical
	2	Disagree	
	3	Slightly disagree	
	4	Slightly agree	
	5	Agree	
	6	Strongly agree	

Appendix I: Characteristics of the Nonelderly Uninsured Population, 2012

Table 1: Characteristics of the Nonelderly Uninsured Population, 2012

	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total – Nonelderly	266.9	100.0%	47.3	100.0%	17.7%
Age					
Children – Total	78.2	29.3%	7.2	15.2%	9.2%
Adults – Total	188.7	70.7%	40.1	84.8%	21.3%
Adults 19-25	30.0	11.2%	8.2	17.3%	27.4%
Adults 26-34	37.3	14.0%	10.2	21.6%	27.4%
Adults 35-44	39.6	14.8%	8.4	17.8%	21.3%
Adults 45-54	43.4	16.2%	7.9	16.7%	18.2%
Adults 55-64	38.5	14.4%	5.4	11.4%	14.0%
Annual Family Income					
<\$20,000	66.3	24.9%	21.9	46.4%	33.1%
\$20,000 – \$39,999	51.4	19.2%	13.4	28.3%	26.0%
\$40,000 +	149.2	55.9%	12.0	25.4%	8.0%
Family Poverty Level					
≤138%	76.7	28.7%	24.0	50.7%	31.2%
...<100%	56.9	21.3%	18.1	38.3%	31.8%
...100-138%	19.8	7.4%	5.8	12.3%	29.6%
139-400%	99.9	37.4%	18.4	38.9%	18.4%
...139-250%	48.6	18.2%	11.7	24.7%	24.0%
...251-400%	51.3	19.2%	6.7	14.2%	13.1%
>400%	90.3	33.8%	4.9	10.4%	5.5%
Household Type					
Single Adults Living Alone	20.8	7.8%	4.3	9.1%	20.8%
Single Adults Living Together	35.3	13.2%	11.8	25.0%	33.4%
Married Adults	56.2	21.0%	8.7	18.3%	15.4%
1 Parent with children	35.3	13.2%	6.3	13.4%	18.0%
2 Parents with children	105.0	39.3%	12.7	26.8%	12.1%
Multigenerational/Other with children	14.4	5.4%	3.5	7.4%	24.4%
Family Work Status					
2 Full-time	66.0	24.7%	5.2	10.9%	7.8%
1 Full-time	137.9	51.7%	24.8	52.4%	18.0%
Only Part-time	24.5	9.2%	7.3	15.5%	30.0%
Non-Workers	38.5	14.4%	10.0	21.2%	26.1%
Race/Ethnicity					
White only (non-Hispanic)	160.5	60.2%	21.3	45.0%	13.3%
Black only (non-Hispanic)	33.7	12.6%	6.9	14.7%	20.6%
Hispanic	49.9	18.7%	15.3	32.4%	30.7%

Asian/S. Pacific Islander only	15.1	5.7%	2.5	5.2%	16.3%
Am. Indian/Alaska Native	2.0	0.8%	0.5	1.1%	25.6%
Two or More Races	5.5	2.1%	0.8	1.6%	13.6%
Citizenship					
U.S. citizen – native	232.0	86.9%	34.8	73.5%	15.0%
U.S. citizen – naturalized	14.3	5.4%	3.2	6.8%	22.6%
Non-U.S. citizen, resident for < 5 years	4.6	1.7%	1.7	3.6%	37.8%
Non-U.S. citizen, resident for 5+ years	16.0	6.0%	7.6	16.0%	47.4%
Health Status					
Excellent/Very Good	183.1	68.6%	28.1	59.4%	15.4%
Good	60.2	22.5%	14.2	29.9%	23.5%
Fair/Poor	23.7	8.9%	5.1	10.7%	21.3%

() = Estimate has a large 95% confidence interval of +/- 5.0 – 7.9 percentage points. Estimates with larger margins of error or with standard errors greater than 30% are not provided.

Note: The data in the tables is based on analysis of the Census Bureau's March Supplement to the Current Population Survey (the CPS Annual Social and Economic Supplement or ASEC) by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute. The CPS supplement is the primary source of annual health insurance coverage information in the United States.

Appendix J: Selected Health-Related Websites for Germany, United Kingdom, and United States

Germany

Expert Panel for the Evaluation of Developments in the Health System:

www.svr-gesundheit.de

Federal Association of Insurance Fund Doctors: www.bagfw.de

Federal Association of Welfare Organizations: www.bagfw.de

Federal Centre for Health Education: www.bzga.de

Federal Chamber of Doctors: www.bundesaerztekammer.de

Federal Ministry of Health: www.bmgesundheit.de

Federal Ministry of Labour and Social Affairs: www.bmas.bund.de

Germany Hospital Association: www.dkgev.de

United Kingdom

British Medical Association: www.bma.org.uk

Department of Health: www.doh.gov.uk

General Medical Council: www.gmc-uk.org

Healthcare Commission: www.chi.nhs.uk

The King's Fund: www.kingfund.org.uk

National Institute for Health and Clinical Excellence: www.nice.org.uk

NHS Confederation: www.nhsconfed.org

Office of Public Sector Information: www.opsi.gov.uk

United States

Agency for Healthcare Research and Quality: www.ahrq.gov

American Hospital Association: www.aha.org

Center for Disease Control and Prevention: www.cdc.gov

Center for Medicare and Medicaid Services: www.medicare.gov

Department of Health and Human Services: www.hhs.gov

Department of Veterans Affairs: www.va.org

Health Resources and Services Administration: www.hrsa.gov

Institute of Medicine: www.iom.edu

National Center for Health Statistics: www.cdc.gov/nchs

National Institutes of Health: www.nih.gov

National Library of Medicine/National Institutes of Health: www.nlm.nih.gov

International Organizations

European Observatory on Health Care Systems and Policies:

www.euro.who.int/observatory

World Health Organization: www.who.org

World Health Organization, Regional Office for Europe: www.who.dk

Appendix K: Major State Law and Regulations Governing Language Access in Healthcare

Sources: Perkins & Youdelman (2008); Perkins, Youdelman, & Wong (2003); Youdelman (2007).

ALABAMA

Managed Care Mandates

Ala. Admin. Code r. 560-X-37-.01(6)(e), (f), (g)

Regarding Medicaid Managed Care Programs, the state must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees. The state and each managed care entity must make available written information in the prevalent non- English languages. The state must notify enrollees and potential enrollees and require each managed care entity to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages.

Ala. Admin. Code r. 560-X-37-.02(3)(t)

Primary Medical Providers in PCCMs will make oral interpretation services available free of charge to each potential enrollee and enrollee. This requirement applies to all non-English languages.

CALIFORNIA

General

Cal. Gov. Code § 11135

No state agency or state-funded entity shall discriminate against any person in California on the basis of race, national origin, ethnic group identification, religion, age, sex, color, or disability.

Cal. Code Regs. tit. 22, §§ 98211(c), 98210

Recipients of state funds may not discriminate against a person by failing to provide alternative communication services for individuals who are unable to read, speak or write in the English language, except when the state determines that such a requirement would place an undue burden on the recipient.

Funding for Language Assistance

California created the Medi-Cal Language Access Services Taskforce (as required with the passage of SB1405—Soto), charged with developing recommendations for a system to provide language services for California Medi-Cal enrollees. The final report was released in March 2009.

Hospital Mandates

Cal. Gov. Code § 15459.1(d)

Health facilities serving multilingual communities who receive funding to finance construction or modification must post multilingual notices, including statements that the facility has agreed to make services available to all and cannot discriminate against Medicaid or Medicare patients in appropriate areas within the facility.

Cal. Health & Safety Code § 1259

General acute care hospitals must provide language assistance services for language groups that comprise 5 percent or more of the geographical area served by the hospital or of the facility's population and must: 1) develop policies on the provision of interpreter services or bilingual professional staff to LEP patients and review these policies on an annual basis; 2) to the extent possible, must ensure the availability of interpreter services 24 hours a day to LEP patients; 3) post notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter, and directions on how to make complaints to state authorities about interpreter services; 4) notify their employees of their commitment to provide interpreters to all patients who request them; 5) prepare and maintain a list of qualified interpreters; 6) identify and record patients' primary languages in the patients chart, hospital bracelet, bedside notice and/or nursing chart, 7) review standardized forms to determine which should be translated, 8) consider providing non-bilingual staff with picture and phrase sheets for communication with LEP patients, and 9) consider establishing community liaison groups to ensure adequacy of interpreter services.

Cal. Health & Safety Code § 123147

All health facilities and all primary care clinics shall include a patient's principal spoken language on the patient's health records.

Cal. Health & Safety Code § 127410

Each hospital shall provide patients with a written notice that contains information about availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies in English and in languages other than English. Written correspondence to the patient required by this article shall also be in the language spoken by the patient.

Cal. Health & Safety Code § 129065

General acute care hospitals or acute psychiatric hospitals borrowing to finance construction or modification of a health facility must: 1) make available to any interested person a list of physicians with staff privileges at the borrower's facility that includes language spoken, and 2) post notices which shall be multilingual, where the borrower serves a multilingual community, in appropriate areas within the facility. The notices include statements that the facility has agreed to make services available to all in the area and cannot discriminate against Medicaid or Medicare patients.

Cal. Code Regs. tit. 22, § 70707(b)

General acute care hospitals must post notice of patients' rights in English and Spanish.

Managed Care Mandates

Cal. Health & Safety Code § 1367.04, Cal. Ins. Code § 10133.8; Cal. Code of Regs. Tit. 28 §§ 1300.67.04, 1367.07

Department of Managed Health Care and Department of Insurance regulations establishing standards and requirements to provide health care service plan enrollees with appropriate access to language assistance in obtaining health care services (passed in 2003; effective January 1, 2009).

Cal. Code Regs. tit. 22, § 53851(e)

For two-plan managed care counties, each plan shall ensure that information, services or presentations shall be provided in a language that is easy to understand, in the preferred language of the beneficiary, in a culturally appropriate manner, and in a way that is fully accessible to beneficiaries with disabilities.

Cal. Code Regs. tit. 22, § 53876

Each Medicaid managed care plan shall implement and adhere to the cultural and linguistic services requirements of the contract between the plan and the department; at a minimum these contracts will include interpretation, translation of signage and written materials, and referrals to culturally and linguistically appropriate services. In consultation with representatives from contracting plans and community-based diverse cultural and linguistic groups, the department shall develop, and update as appropriate, a set of comprehensive cultural and linguistic requirements which shall be incorporated into the contract between the department and each plan.

Cal. Code Regs. tit. 22, § 53884(b)(3)

In assigning beneficiaries to a Medicaid managed care plan, the Plan's ability to render linguistically appropriate services shall be considered.

Cal. Code Regs. tit. 28, § 1300.67.04

Every health care service plan under the auspices of the Department of Managed Health Care (except Medicaid and Medicare plans) must develop and implement a language assistance program which shall be documented in written policies and procedures, and shall address, at a minimum, standards for: enrollee assessment; providing language assistance services; staff training; and compliance monitoring.

COLORADO

Managed Care Mandates

Colo. Rev. Stat. 10-16-704(9)(e)

All managed care plans must have an access plan that includes the carrier's efforts to address the needs of covered persons with limited English proficiency and with diverse cultural and ethnic backgrounds

10 Colo. Code Regs. § 2505-10 (8.209.4.A[1]), (8.209.4.C), (8.209.7.F)

For each action, a Medicaid managed care organization or pre-paid in-patient health plan must send the member written notice which must be available in English and the prevalent non English languages spoken by members throughout the state

FLORIDA

Hospital Mandates

Fla. Stat. § 381.026(4)(b)(7)

A patient in a healthcare facility who does not speak English has the right to be provided an interpreter if the facility has a person readily available who can interpret on behalf of the patient

Fla. Admin. Code r. 59A-2.55(3)(b)

Each hospital shall develop a systematic approach to educating the patient and family to improve patient outcomes, which includes assessment of cultural practices and language barriers.

Fla. Admin. Code r. 59A-3.255(1)(a)

Each hospital offering emergency services must post notices in English and Spanish stating patients' rights to receive such services.

Managed Care Mandates

Fla. Stat. § 627.419(8)

If an insure advertises a policy in a language other than English, the advertisement shall not be construed to modify or change the policy written in English.

Fla. Stat. § 641.54(5)(e)

Every HMO must provide to subscribers, on request, their policies for addressing the needs of LEP subscribers.

*Fla. Stat. § 636.015, 641.305, 641.421 (2001).

Manage care plans that negotiate contracts in languages other than English must provide non English speaking members with written translations of their contract, approved in advance by the Florida Department of Insurance.

MASSACHUSETTS

Funding for Language Assistance

Mass. Gen. Laws Ann. Ch. 118G, § 11

All rates of payments to acute hospitals and non-acute hospitals under Medicaid shall be established by contract between the provider and the division of medical assistance and shall include reimbursement for the reasonable cost of providing competent interpreter services.

NOTE: Under its requirements for acute care hospitals and their emergency services, federal funds were drawn from the Medicaid program for the reimbursement of language services (from

FY 2002-2005). After 2006, interpreter services were essentially incorporated into the fee-for service payment (as the cost of doing business).

Hospital Mandates

Mass. Gen. Laws Ann. ch. 111, § 25J(a) – (e); ch. 123, § 23A(b)

Every acute care hospital shall provide competent interpreter services in connection with all emergency room services provided to every non-English speaker who is a patient or who seeks appropriate emergency care or treatment.

105 Mass. Code Regs. 128.020

Definitions for hospital licensure include “non-English speaker” – a person who cannot speak or understand, or has difficulty speaking or understanding English, because the speaker primarily or only uses a spoken language other than English.

105 Mass. Code Regs. 130.343(E)

For hospital discharge planning for non-English speaking patients, the hospital shall provide translation assistance to assist the patient and/or as appropriate, the family/patient representative, in understanding the discharge plan.

105 Mass. Code Regs. 130.1101-130.1108

Emergency Room Interpreter Law – to meet licensing standards, acute care hospitals will provide no-cost interpretation in connection with all emergency department services. Interpretation minimally available on an on-call basis 24 hours a day, seven days a week. Written procedures for timely and effective telephone communication with non-English speaking patients shall be established. Each acute care hospital shall develop written policies and procedures, that govern the provision of interpreter services and which include the qualifications for a coordinator of interpret services. Hospitals should be discouraged from using family members and friends and are prohibited from using minor children.

105 Mass. Code Regs. 131.116

Acute hospitals shall translate certain notices into a language or languages other than English if such language or languages are spoken by at least 10% of the residents of the hospital’s service area. These notices should be posted throughout the hospital and copies should be distributed prior to or at the time of admission.

Managed Care Mandates

Mass. Gen. Law Ann. Ch. 1760, § 6(a) (10), (b)(9), 15(k)

Health insurance carriers must provide a statement detailing what translator and interpretation services are available to assist insureds; provided, that the commissioner shall determine in which language other than English such as statement shall be printed.

105 Mass. Code Regs. 128.510

Carriers shall provide insureds, upon request, interpreter and translation services related to administrative procedures.

130 Mass. Code Regs. 508.002(C)(1)(d)

For assigning members to Medicaid managed care plans, the agency assigns a member only if the provider is able to communicate with the member directly or through an interpreter, unless there is no medical care available in the member's service area that meets this requirement.

130 Mass. Code Regs. 515.001, 515.007(l)

The Medicaid agency will inform applicants and members of the availability of interpreter services. Unless the applicant or member chooses to provide his or her own interpreter services, Medicaid will provide telephonic or other interpreter services, whenever the application or member who is seeking assistance has English language proficiency and request interpreter services; or the agency determines such services are necessary.

211 Mass. Code Regs. 52.13(3)(p)

Insurance carriers must deliver, upon enrollment, evidence of coverage which includes a statement detailing what translator and interpretation services are available to assist insureds, including that the carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian, and Spanish.

MICHIGAN

Managed Care Mandates

Mich. Comp. Laws § 333.20194(1)-(2)

All health facilities except emergency medical facilities must display a pamphlet outlining the procedure for filing a complaint against a health facility, agency or individual. The Department of Consumer and Industry Services shall develop the pamphlets in languages that are appropriate to the ethnic composition of the patient population where the pamphlet will be displayed.

MINNESOTA

General

Minn. Stat. § 144.651(4)

The Health Care Bill of Rights states that reasonable accommodations shall be made for those who speak a language other than English.

Funding for Language Assistance

Minn. Stat. § 256B.0625 (18a)(d)

Medicaid medically needy program covers oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency.

Minn. Stat. § 256L.03(3a)

Medicaid covers spoken language interpreter services that assist an enrollee in obtaining covered health care services.

Managed Care Mandates

Minn. Stat. § 62J.72(1)(e)

Disclosure statement by insurance companies describing reimbursement methods must be provided upon request in English, Spanish, Vietnamese, and Hmong, with reasonable efforts made to provide the information contained in the statement to other LEP enrollees.

Minn. Stat. § 62Q.03 (5a)

Health plans must develop a separate risk adjustment system for state-run public programs, including medical assistance, general assistance medical care, and MinnesotaCare. The system must be developed in accordance with the general risk adjustment methodologies described in this section and must attempt to reflect the special needs related to cultural or language barriers.

Minn. Stat. §62Q.5(1)(a)(3), (1a)(c)(2), (2)(b)(2)

If enrollees are required to access services through selected primary care providers for coverage, the health plan company shall prepare a written plan that provides for continuity of care in the event of contract termination between the health plan company and any of the contracted primary care providers, specialists, or general hospital providers. The written plan must explain... The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for enrollees or new enrollees who request continuity of care with their former provider, if the enrollee...does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within 30 minutes or 30 miles.

Minn. Stat. § 256B.69(27)

Managed care contracts must require plans to inform enrollees that upon request the enrollee can obtain a certificate of coverage in the following languages: Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, or Cambodian. Upon request, the plan must provide the enrollee with a certificate of coverage in the specified language of preference.

MISSISSIPPI

Managed care mandates

13-000-003 Miss. Code R. § 6.4(b)

Health maintenance organizations must maintain adequate staffing including appropriate foreign language interpreters and Member materials printed in each language spoken by five percent (5%) or more of the Members in each Service Area. A contractor's annual Diversity Report must show the racial and primary language composition of the Contractor's members by number and percent of total members.

NEW JERSEY

General

N.J. Admin. Code tit. 10, § 90-1.7(f)

All recipients of Federal financial assistance, such any public or private individual in health or social services, must ensure that LEP persons are given meaningful opportunities to participate in their programs, services and benefits. Where language differences prevent meaningful access on the basis of national origin, the OCR Guidance requires that recipient agencies provide oral and written language assistance at no cost to the LEP person.

Hospital Mandates

*N.J. Stat. Ann. § 26:2H-12.8(h)

Any person admitted to a general hospital has the right to expect that within its capacity, the hospital will make reasonable response to request for services, including the services of an interpreter if 10% of more the population in the hospital's service area speaks that language.

*N.J. Admin. Code title 8, § 33-4.10(a)(8)

For approval of certificate of need, hospital must show how the project will promote access for racial and ethnic minorities and must document effective communication between the staff of the proposed project and non-English speaking people.

N.J. Admin. Code title 8, § 33E-1.5(b)(8)

For approval of certificate of need for intensive cardiac care units, hospitals should (to the extent possible) have bilingual clinical personnel available who can overcome language barriers and know and understand cultural differences among patients.

N.J. Admin. Code title 8, § 43A-6.5, 6.6, 12.6(a)

Ambulatory care facilities shall provide printed and/or written instructions and information for patients, with multilingual instructions as indicated and must provide interpretation services when necessary for patients who do not speak English. They must also develop surgical policies and procedures for the provision of written instructions to the patient with multilingual instructions if indicated.

N.J. Admin. Code tit. 8, § 43G-4.1

New Jersey Patient Bill of Rights includes the right to receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the hospital's health care personnel.

N.J. Admin. Code title 8, § 43G-5.2(a)(1), 43H-5.4(f)

As a condition of licensing, hospitals and rehabilitation hospitals shall make written statement of patients rights available in any language that is spoken in the primary language by more than 10 percent of the population of the hospital's service area.

N.J. Admin. Code title 8, § 43G-5.5(c)

As a condition of licensure, hospital shall provide interpretation services when necessary for patients who do not speak English.

N.J. Admin. Code title 8, § 43G-36.6(c)(19)

Satellite Emergency Departments shall have policies and procedures for maintaining a record of hospital employees, medical staff members, and volunteers who can speak languages other than English and can provide interpretive services to patients.

Managed Care Mandates

N.J. Stat. Ann. § 17B:17-20(c)

Any non-English language health or life insurance policy delivered or issued for delivery in this State shall be deemed to be in compliance with this act if the insurer certifies that such policy is translated from an English language policy that does comply with this act.

N.J. Admin. Code title 10 § 77-4.5(c)

For Medicaid/SCHIP individuals who do not speak English or Spanish and who have an established relationship with a physician who speaks their primary language, when there is no available primary care provider in any of the participating managed care plans who speaks the beneficiary's language, the individual may be exempted from enrollment in a contractors' plan.

N.J. Admin. Code title 10 § 11:24-2.2(c)(13)

For a certificate of authority, health maintenance organizations shall include a description of the methods used by the HMO to facilitate access to services for culturally and linguistically diverse members.

N.J. Admin. Code title 11 § 24A-4.2(a)(3)(iii), 24.91(d)(6)

Managed care plans shall disclose which participating providers have the capacity to communicate in languages other than English.

NEW YORK

Funding for Language Assistance

N.Y. Pub. Health Law § 2807-c(k)

Subject to the availability of federal financial participation, the commissioner shall adjust inpatient rates of payment for non-public general hospitals located in a city with a population of more than one million persons to ensure meaningful access to the hospital's services and reasonable accommodation for all Medicaid patients who require language assistance. [\$38 million in FY2008-09]

Hospital Mandates

N.Y. Pub. Health Law § 2807-k (9.a)(e)

As a condition of receiving funds from the Indigent Care Pool, general hospitals shall ensure that application forms are printed in the "primary languages" of patients served by the general hospital.

N.Y. Comp. Code R. & Regs. Title 10, § 405.7(a)(7)

Under patients' rights, hospitals must provide skilled interpreters and translations of all significant forms to ensure effective communication with all persons receiving treatment regardless of language. Hospitals must designate a Language Assistance Coordinator and develop a Language Assistant Program. Interpreters and translations shall be regularly available for non-English speaking groups comprising more than one percent of a hospital's service area. Interpreters must be available in inpatient and outpatient settings within 20 minutes and in emergency rooms within 10 minutes of a request by the patient, the patient's family or representative, or a health provider.

N.Y. Comp. Code R. & Regs. Title 10 § 407.7

For primary care and critical access hospitals participating in a rural health network, requirements for skilled interpreters may be met through effective communication within the network, including telephone, radio or electronic communications.

Managed Care Mandates

N.Y. Pub. Health Law § 4403(5)(b)

When the Commissioner evaluates a renewal application for a health maintenance organization license, consideration should include the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population.

N.Y. Pub. Health Law § 4408(1)(p)

Each subscriber of a health maintenance organization must be provided a description of how the health maintenance organization addresses the needs of non-English speaking enrollees.

N.Y. Pub. Health Law § 4408-a(2)(c)

Each health maintenance organization shall assure that its grievance procedure is reasonably accessible to those who do not speak English.

N.Y. Soc. Serv. Law § 364-j (3)(b)(iv), (4)(e)(iv), (4)(p), (22)(e); N.Y. Comp. Code R. & Regs.

Title 18, § 360-10.15(a)(3)

In managed care plans, Medicaid recipients shall not be required to participate in and may withdraw from a managed care plan if shown that the participant cannot be served by a managed care provider due to a language barrier. A managed care provider shall implement procedures to communicate appropriately with participants who have difficulty communicating in English.

N.Y. Soc. Serv. Law § 369-ee(3)(d)(iv)

Family health insurance plans participating in Family Health Plus program must implement procedures to communicate appropriately with participants who have difficulty communicating in English.

N.Y. Comp. Code R. & Regs. Title 18 § 360-10.8(f)

A Medicaid managed care plan (MCP) must demonstrate that recipients who are eligible to participate in an MCP will be fully informed of how an MCP provides services, and provides enough information in a form which is reasonably understandable to persons of the varying cultural backgrounds represented in the Medicaid recipient population to assure that such recipients can make informed choices of managed care providers and primary care providers.

TEXAS

Funding for Language Assistance

Tex. Human Res. Code Ann. § 32.068 (expires September 1, 2009)

Authorizes Language Interpreter Services Pilot Programs, to be established in five hospital districts across the state to provide Medicaid recipients with oral and written language services in accordance with federal law and Centers for Medicare & Medicaid Services publications. S.B. 376 (2005) directs the Health and Human Services Commission (HHSC) to establish a pilot program to provide Medicaid recipients with oral and written language interpreter services. As of 2007, based on a HHSC report, the program was not implemented.

Hospital Mandates

1 Tex. Admin. Code § 355.8065(c)(3)

Disproportionate share hospitals must prominently post notices of right to charity care in English and Spanish.

Managed Care Mandates

1 Tex. Admin. Code § 353.411(j)(1)-(4)

MCOs must develop a written cultural competency plan describing how the MCO will effectively provide health care services to members from varying cultures, races, ethnic backgrounds and religions to ensure those characteristics do not pose barriers to gaining access to needed services. As part of the requirement to develop the cultural competency plan, the MCO must at a minimum: (1) employ multi-cultural and multi-lingual staff; (2) make available interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history or health education; (3) display to the Health & Human Services Commission (HHSC) through the written plan a method for incorporating the plan into the MCOs policy-making process, administration, and daily practices; and (4) submit the written plan to HHSC for review and approval at intervals specified by the department.

WASHINGTON

General

Wash. Admin. Code 388-472-0005(1)(k)

DSHS applicants/recipients have the right to have interpreter or translator services given at no cost and without delay.

Funding for Language Assistance

Wash. Rev. Code § 74.04.025

The Department of Social and Health Services shall insure that bilingual services are provided to non-English speaking recipients and applicants.

Wash. Admin. Code 388-271-0010

DSHS provides LEP services to applicants/recipients who are limited in the ability to read, write and/or speak English.

Wash. Admin. Code 388-271-0030

DSHS provides fully translated written community in applicant/recipients' primary language.

Wash. Admin. Code 388-502-0010(3)(d)(ii)

For DSHS medical programs, contractors of interpreter agencies are eligible providers and thus eligible for reimbursement of services provided.

Interpreter Competency

Wash. Admin. Code 388-03-010 through 03-176

The provisions establish the rules for certification of Department of Social and Health Services' interpreters/translators, including qualifications and the code of conduct for interpreters/translators and procedures for administering certification examinations.

Hospital Mandates

Wash. Admin. Code 246-453-020(2), (5), 246-453-010(16)

Hospitals providing charity care must prominently display within public areas, provide in writing and explain to the person in any language spoken by more than 10 percent of the population in the hospital's service area, and interpreted for other non-English speaking or limited-English speaking patients a notice that charges for qualified patients may be waived or reduced. Hospitals must take into account any language barriers that may hinder the responsible party's capability of complying with the application procedures for purposes of determining the person's qualification for charity care sponsorship.

Managed Care Mandates

Wash. Admin. Code 284-43-210(4)

All health carriers shall file with the State commissioner an access plan that includes a description of the health carrier's efforts to address the needs of covered LEP persons and persons with diverse cultural backgrounds.

Wash. Admin. Code 284-43-615(2)(b)

Health carriers and health plans must ensure that the grievance process is accessible to enrollees who are limited-English speakers.

Wash. Admin. Code 388-538-110(f)(ii)

For Medicaid managed care, a managed care organization's notice of action must be in the enrollee's primary language and be easily understood as required by federal Medicaid managed care regulations.

Wash. Admin. Code 388-538-130(2)(c)(v), (5)(d)

An exemption to requirements for managed care enrollment exists for a client/enrollee who speaks limited English and the client or enrollee can communicate with a provider who communicates in the client's or enrollee's language is and not available through the MCO and the MCO does not have a provider available who can communicate in the client's language and an interpreter is not available.

WISCONSIN

Managed Care Mandates

Wis. Stat. Ann. § 609.22(8)

If a significant number of enrollees of the defined network plan customarily use languages others than English, the plan shall provide access to translation services fluent in those language to the greatest extent possible.

Wis. Admins. Code Ins. § 9.21(e)(4)

Defined network plans, preferred provider plans and limited service health organization shall provide access to translation services for the purpose of providing information concerning benefits, to the greatest extent possible.

Appendix L: Korean Health and Social Service Non-Profit Organizations in Tri-state Region

Organization Name	Description*	Phone Number	Address	Email/Website Address
AWCA Hankook Senior Center	Offers programs that provide seniors with a wealth of educational, cultural, and health programs. Programs include English classes, a U.S. Citizenship class, a senior chorus, cultural and health education, and exercise.	201-862-1665	9 Genesee Ave., Teaneck, NJ 07666	awca.nj@verizon.net www.awcanj.org
Friends of Grace Seniors Korean Community Center	Offers Culture & Education Services, Youth & Family Services, and Health & Social Services.	201-541-1200	40 Bennett Rd., Englewood, NJ 07631	webmaster@fgskcc.org http://www.fgskcc.org/
Hamilton Madison House Korean Clinic	Offers psychiatric consultation and evaluation, individual, family and group therapy, pharmacotherapy, Marital Counseling, Crisis Intervention, Cultural Activities, Information & Referrals, Case Management, Community Outreach & Education, English & Korean speaking groups, and Parent support group.		78-14 Roosevelt Ave., #204 Jackson Heights, NY 11372	www.hmhonline.org
Immigration Point		718-321-1105	163-03 Northern Blvd., Suite # 206 Flushing, NY 11358	immipoint@gmail.com
Jabiwon Social Services	Offers social and welfare services.	718-460-2019	142-09 37th Ave. Flushing, NY 11354	
Korean American Association for Rehabilitation of the Disabled		718-445-3929	35-20 147 th street, Annex 2F Flushing, NY 11354	
Korean American Community Center of NY, Inc.	Social Services; Citizenship Exam Class; Social Security Benefits Policy and Tax Seminar; Naturalization Application Services; Health Services Information, Support, and Treatment Referrals; Legal Services	718-352-2723	202-16 45th Ave., Bayside, NY 11361	http://kaccny.org/

Organization Name	Description*	Phone Number	Address	Email/Website Address
Korean American Counseling Center	Offers benefit, health, escort services, housing assistance, computer training, palliative care.	718-939-7214	35-26 Union Street Flushing, New York 11354	www.helpneedy.org
Korean American Family Service Center	Legal and Social Service Advocacy; Information and Referral	718-460-3800	P.O. Box 541429 Flushing, NY 11354	contact@kafsc.org http://www.kafsc.org
Korean American League for Civic Action	Provides leadership training and civic education through our Internship Program, Educational Programs, Leadership Development Program, and Voter Education & Mobilization Project.	212-633-2000	149 West 24 th Street, 6 th floor New York, NY 10011	www.kalca.org
Korean American Senior Citizen Association of NY		718-461-3545	149-18 41 Ave., Flushing, NY 11354	
Korean American Senior Citizen Association of NJ		201-945-2400 201-945-2401 201-945-2402	1061 Slocum Ave., Ridgefield, NJ 07657	kscanj@gmail.com www.kscanj.com
Korean Immigrant Service of NY	Immigration Law Counseling and Naturalization Services	718-359-5400	142-01 38th Ave., #2Fl. Flushing, NY 11354	kisny2003@yahoo.com
KSANY		212-695-2029 212-260-2929	286 5th Ave., 2nd Floor, New York, NY 10001	jachung@ksany.com
Minkwon Center for Community Action	Immigrant rights advocacy, civic empowerment, and various legal and social service programs.	718-460-5600	136-19 41 Ave., #3Fl Flushing, NY 11355	ysm@minkwon.org http://www.minkwon.org
The Korean American Association of Greater NY	Coordinates community activities, educational and cultural activities, and social services.	212-255-6969	149 W. 24 St., 6Fl. New York, NY 10011	office@nykorean.org www.nykorean.org
The Korean American Association of NJ		201-592-0000	166 Main St., 2nd Floor Fort Lee, NJ 07024	kaanjoffice@gmail.com www.njkorean.org
The Korean American Association of Central NJ		856-524-8950	218 Thompson Grove, Manalapan, NJ 07726	hyunshin1@hotmail.com

Organization Name	Description*	Phone Number	Address	Email/Website Address
Korean American Behavioral Health Association, Inc. (KABHA).	Provides various referral services for people with developmental, psychological, and behavioral disabilities, including mental illness and developmental delays.			http://www.kabha.org
The Korean American Senior Center		516-938-6135	80-46 Barnum Ave., Plainview, New York	
The Korean Association of Brooklyn		646-541-3300	646 Vanderbilt Ave., Brooklyn, NY 11238	
The Korean Community Service (KCS) of Metropolitan New York, Inc.	Health benefit enrollment site with in-person assistors/navigators. Aging programs; Immigration; Public health advocacy and education; Healthcare case management	718-939-6137	35-56 159 St., Flushing, NY 11358	http://www.kcsny.org/
KCS Korean American Senior Center of Corona	Provides comprehensive care for Asian American Senior Citizens.	718-651-9220	37-06 111th St., Corona, NY 11368	
KCS Flushing Senior Center	Provides comprehensive care for Asian American Senior Citizens.	718-886-8203	42-15, 166 St., Flushing, NY, 11358	
The Korean Family Counseling & Research Center	Legal & Medical Service Referral; Immigration Law Counseling; Welfare Services; Child Health Plan	718-321-2400	35-71 162 St., Flushing, NY 11358	kfccny@aol.com www.kfccny.org
The Korean YMCA		718-961-1177 718-961-6880	138-46 Northern Blvd., Flushing, NY 11354.	http://www.ymcanyc.org
Nodutdol for Korean Community Development		718-335-0419	53-22 Roosevelt Avenue, 2 nd Floor Woodside, NY 11377	www.nodutdol.org
NY/NJ Citizenship Center	Immigration Law Counseling and Naturalization Services	551-574-2015	3000 The Plaza, #3117 Tenafly, NJ, 07670	

Organization Name	Description*	Phone Number	Address	Email/Website Address
Charles B. Wang Community Health Center - Flushing YMCA	Health benefit enrollment site with in-person assistors/navigators.	(718) 886-7355	138-46 Northern Boulevard Flushing, NY 11354	
Charles B. Wang Community Health Center	Health benefit enrollment site with in-person assistors/navigators.	(718) 886-7355	136-26 37th Avenue Flushing, NY 11354	
Women In Need Center		718-539-6546		info@wincny.org http://www.wincny.org/
Wonkwang Community Service Center		718-463-6677	143-42 Cherry Ave., Flushing, NY 11355	nywcsc@gmail.com
YWCA of Queens	Health benefit enrollment site with in-person assistors/navigators.	(718) 353-4553	42-07 Parsons Blvd. Flushing, NY 11355	

Note: Description provided wherever possible.

Adapted from *Korean Social Service Agencies in the New York and New Jersey Area*, by Yun, C. (April 23, 2013),
Retrieved on December 21, 2013 from <http://www.koreanamericandatabank.org/data-bank/item/60-korean-social-service-agencies-in-the-ny-nj-area.html>

Appendix M: Korean Political Representatives in the Tristate region (CT- NJ –NY)

State	Name/ Contact Information	Name/ Contact Information
New Jersey		
Cherry Hill	Susan Shin Angulo, City Councilwoman 820 Mercer Street Cherry Hill, NJ 08002 (856) 665-6500 (O), (856) 488-7893 (F) cherryhilldemocraticcommittee@gmail.com	
Englewood Cliffs	Gloria Oh, Councilwoman Economic Development, Finance, Legal Borough of Englewood Cliffs 482 Hudson Terrace Englewood Cliffs, NJ 07632 (201) 569-5252 (O), (201) 569-4356 (F) info@englewoodcliffsnj.org	
Harrington Park	Joon L. Chung, Councilwoman Borough of Harrington Park 85 Harriot Ave., PO BOX 174 5 Harrington Park, NJ 07640 (201) 768-1700 (O), (201) 768-3038 (F) www.hpboro.net	
Jersey City	Michael Yun, Councilman City Hall, 280 Grove Street Room 202 Jersey City, NJ 07302 (201)547-5485, (201)547-4678 (F) MYun@jcnj.org	
Leonia	Philip (Young Shik) Choi, Councilman 312 Broad Ave. Leonian, NJ 07605 (201) 592-5780 pchoi@leonianj.gov	I. S. (Ick Sung) Pak, Councilman 312 Broad Ave. Leonian, NJ 07605 ispak@leonianj.gov
Palisades Park	Jong Chul Lee, Councilman 275 Broad Ave. Palisades Park, NJ 07650 (201) 941-9401	Jason Kim, Councilman 275 Broad Ave. Palisades Park, NJ 07650 (201) 310-3936, (201) 585-4100 (O) jasonkimpp@gmail.com
Ridgefield	Dennis Shim, Councilman Borough of Ridgefield 604 Broad Avenue Ridgefield, New Jersey 07657 (201) 943-5215 Ext. 431 dshim@ridgefieldboro.com	
Tenafly	Daniel Park, Councilman 100 Riveredge Road Tenafly, NJ 07670 (201) 568-610	

State	Name/ Contact Information	Name/ Contact Information
Wayne	Kevin J. O'Toole, State Senator (Republican) 40th Legislative district Office 155 Route 46 West Wayne, NJ 07470 6 (973) 237-1360 (O), (973) 237-1364 (F) senotoole@njleg.org	
Woodcliff Lake	Jean Bae, Councilwoman 188 Pascack Road Woodcliff Lake, New Jersey 07677 (201)391-4977	
New York		
Albany	Ron Kim, State Assembly member, District 40 136-20 38th Avenue, Suite 10A Flushing, NY 11354 (718)939-0195 Room 429 LOB Albany, NY 12248 (518)455-5411 kimr@assembly.state.ny.us	
Queens	S. J. (Seung Jin) Jung, Democratic District Leader, N.Y. Assembly District 20 163-10 Northern Blvd. Suite 201 Flushing, NY 11358 (718) 353-0304 (O), (718) 353-1226 (F) Sjjung2009@gmail.com	Agnes Kim, District Leader (Dem), NY Assembly district 22 1 Centre Street #835 New York, NY 10007-2341 (212) 669-3910 (O), (212) 669-2707 (F) agnesekim@gmail.com , akim2@comptroller.nyc.gov

Adapted from *Korean American Elected Politicians, Influential Administrative Officials, and Judicial Appointees*, by Yun, C., & Chung, T. (November 19, 2013), Retrieved on December 21, 2013 from <http://koreanamericandatabank.org/images/PDF/New%20Korean%20Politician%20List.pdf>

Appendix N: Summary of Healthcare Information for Korean Immigrants

Newcomers to United States	http://www.uscis.gov/tools/green-card-resources/welcome-united-states-guide-new-immigrants
Health Insurance Market Place	https://www.healthcare.gov/
Public Health Insurance	<p>New York www.nyhealth.gov/health_care/medicaid</p> <p>New Jersey www.state.nj.us/humanservices/dmahs/clients/medicaid www.njfamilycare.org/index.html</p> <p>Community health center directory http://findahealthcenter.hrsa.gov/Search_HCC.aspx</p>
ESL	https://www.literacydirectory.org/
Grants	http://www.hrsa.gov/grants/apply/assistance/nap/

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