PART I

Introduction and Research Strategy

Chapter 1

Introduction

THE PROBLEM

The emergence of critical medical anthropology/ sociology in the late 1980s provided a distinct framework to understand how the social, political and economic contexts of society have influenced individual health care utilization patterns (Baer 1997). However, the strands of medical social science following interpretivist social theories such as postmodernism and poststructuralism have continually tended to mystify 'what really affects health care utilization patterns.' Further, although there has been much research about health care use patterns amongst people of developing countries and refugees in Western countries, less attention has been given to recent migrants from newly industrialized countries such as South Korea, which have been through rapid social changes since the end of the Second World War. The small amount of research on the use of traditional medicine amongst recent immigrants in the West which has been conducted has often tended to be dominated largely by interpretivist perspectives, which neglect the political-economic aspects of health and health care.

Medical social scientists agree that cultural factors influence health care use patterns in any society. In developing societies where biomedicine is relatively recent as well as in Western societies where biomedicine has a long history, 'informal' or 'traditional' attitudes towards health care play a complex role in affecting individual health care use patterns. Drawing on these basic assumptions, the aim of this study is to examine the way in which culture mediates individual health care choices when people move from one society to another. The study also examines the extent to which the social location of migrants in the host society alters, restructures and/or eradicates the cultural practices they bring with them.

The research subjects are Korean immigrant men in Sydney. Along with an influx of Asian migrants to Australia since the 1960s, they have brought with them various health practices from their home countries. The major movement of Koreans to Australia started in the early 1970s. Just over 77% of the Koreans in Australia live in New South Wales — largely Sydney (Inglis and Wu 1992: 202, 204). The Korean population in Sydney is known to have reached over 40,000 by 1997 (*Wikŭlli T'op* 1997 May 30: 7).

Since the mid-1980s, as the Korean community in Sydney grew larger, there has been an increase in demand for biomedical health services together with Korean traditional health care and health food. Unlike in most Asian countries, in South Korea there has been a resurgence of Korean traditional medicine during the last couple of decades. This study focuses on the ways in which Korean immigrant men's health care choices are affected by Korean cultural practices, their social location in Australia and other political-economic factors in Australia and Korea.

THESIS ORGANIZATION

Chapter 2 locates the present study in the context of the literature and goes on to review past studies on health care utilization. The research questions, design and strategy are spelled out in chapter 3 and the methodology in chapter 4. Chapters 5 and 6, which form Part II of the thesis, present a brief account of the economic development of postwar South Korea and the way in which these developments influenced Korean migration to Australia and health care use and practice in Korea. Part III, consisting of chapters 7, 8, and 9, presents the analysis of the data obtained from the individual users of health care in Sydney, against the background of Australian immigration policy and the settlement of Korean immigrant men, discussed in chapter 7. Chapter 8 focuses on their work involvement and immigrant life, and the health status and health care use patterns amongst them are discussed in chapter 9. Part IV, comprising chapters 10 and 11, discusses how the providers of biomedical and *hanbang* services have viewed the links between work, health and health care utilization patterns amongst Korean immigrant men. The final chapter summarizes the main conclusions.

DEFINITION OF TERMS

I shall define key concepts at the point where they are introduced. However, there are a few terms that need clarification at this point. Referring to what is known as 'scientifically based' medicine, I have used the term 'biomedicine' rather than cosmopolitan, Western, formal or orthodox medicine. Despite its own problems, the term biomedicine is less problematic in comparison with others. 'Traditional' or 'informal' medicine has been used to refer to what is labelled as 'non-scientifically based' medicine such as acupuncture or herbal medicine.

Hanbang originated from China and has been indigenized in Korea over the last several centuries. Chinese traditional medicine, including herbal medicine and acupuncture, used throughout East Asia is often known as Chinese medicine or East Asian medicine. However, there are significant differences between 'East Asian' medicines used in different parts of East Asia. The major focus in this thesis is *hanbang*, the Korean version of Chinese traditional medicine. *Hanbang* restorative medicine, *hanbang* tonic medicine, Korean traditional medicine, and *poyak* have been sometimes used interchangeably in this thesis. Whereas the word *hanbang* is inclusive of the relevant skills, remedies and knowledge, *hanyak* refers to *hanbang* remedies, i.e., *hanbang* herb medicine (see Diagram G.1). The term '*hanbang* doctor' is used to refer to *hanbang* practitioners in this study as it is in Korean language.

Chapter 2

Literature review

In this chapter, I shall begin by discussing three commonly accepted broad theoretical assumptions of medical social science as they are related to the current study. This will not only locate the present study in the literature but also address its significance. Then I shall state the central conceptual issue of this study deriving from the assumptions, review the relevant studies and foreshadow a theoretical perspective to investigate the central questions of the thesis.

THREE BASIC ASSUMPTIONS: LOCATING THE PRESENT STUDY

The basic assumptions are as follows: (1) Sociologists and anthropologists agree that cultural factors play some role in influencing patterns of health care utilization in *any* society; (2) Even in societies with a long history of capitalism (e.g., most Western or developed societies) where biomedical care has a long history and remains dominant, folk ideas about medicine or 'informal' or 'traditional' attitudes towards health care persist in some complicated fusion with biomedicine; and (3) Furthermore in societies where biomedicine is relatively recent (e.g., developing societies), one might

expect a stronger commitment to traditional medicine because of its common usage for a lengthy period.

Culture refers to 'the distinctive knowledge, habits, ideas, language and ways of living shared by a group of people' (Bates and Linder-Pelz 1987: 26). Anthropologists such as Leach (1982) have pointed out that probably all societies have more than one culture within their borders. Thus, members of most societies are divided up into different social categories based on such factors as age, gender, class, ethnicity, area of residence or rank, and each group has its own distinctive cultural attributes, including linguistic usages, manners, and social activities. Given this, people with different cultural perspectives often have different patterns of health care utilization. In this respect, illness, medicine and health care are regarded as cultural activities and experiences (Lupton 1994: 17).

In Australia, women consult doctors and other health practitioners, both biomedical and alternative, more than men (CDH 1985; Western 1983: 173). They take more medicines of every kind and they spend more days in bed and more time in health care institutions (Bates and Linder-Pelz 1987; Wyndham 1979; Wyndham 1982). The most common reason is obstetrics (CDH 1985; Lugg 1975). Similar tendencies can be found in some other societies, but not in all. For instance, in Cambodia, there is simply no cultural expectation that women seek prenatal care before the eighth month of pregnancy (Kemp 1985). This is likely to reduce the use of health care amongst women in Cambodia.

American Indian healers among the Navajos in Arizona are another example. Their health beliefs and practices are undergoing changes, given the dominant American cultural context. Levy (1983) notes that the rituals of traditional Navajo religion are primarily about health and focused on

enhancing the well-being of the hunter. The central figure in these rituals is the singer, who has learned knowledge of ceremonies for several years under apprenticeship with another practitioner. Levy observed that the number of singers has declined over the years because fewer healers (men) can afford the time involved in learning the chants whilst they also have to earn a living. Levy indicates that the commitments of a wage work economy and the increasing influence of biomedical health practice may eventually eradicate traditional healing rituals among the Navajos.

As indicated, the use of health care is determined not only by physiological factors but also by distinctive cultural aspects of each group and other cultural factors of different societies. Zola (1973) terms the latter, or non-physiological factors, 'pathways to the doctor'. They include the availability of health care; whether the patient can afford it; the failure or success of treatments within the popular or folk sectors; how the patient perceives the problem; and how others around them perceive the problem. Yet other influential factors are the development of scientific technology and the changes in the educational, political and economic environment. These cultural aspects at both the individual and societal levels are not static but changing continuingly. The changes in turn affect health care utilization patterns.

In the West, despite its relatively well-established tradition of biomedicine, traditional, folk or primitive health beliefs persist today even amongst the well-educated and financially well-off patients, not only in those of the less educated or ethnic minorities (Stoeckle and Barsky 1981: 233). Aspects of those traditional health beliefs are not imported but originated within Western culture.

The distinction between biomedicine and so-called unorthodox medicine comes from whether it is based on scientific development. An example of an overlap of the scientific and non-scientific domains is a therapeutic institution called the *Kur* (the cure). As part of a continuing health promoting and curative bathing complex in parts of Europe, the institution maintains a tradition of naturopathic therapies in the contemporary, highly scientific and primarily biomedicine-oriented medical system of West Germany (Maretzki 1987; Maretzki and Seidler 1985).

Maretzki (1987) notes that patients' choice of biomedicine or alternative medicine does not necessarily need to involve an exclusive adherence to one or the other. Rather, there is a range of positions relative to the extremes, i.e., biomedicine and naturopathy. It appears that patients are prepared to explore every possibility to have relief from illness in a given social circumstance so that they can continue to perform their activities including work. It is interesting to observe how such a tendency on the part of patients is met in West Germany. Although naturopathic or alternative therapies are neither taught nor officially recognized by universities, biomedical doctors in private practice commonly prescribe them.

Though the *Kur* involves only about 3% of total health care expenditure in West Germany, it generates large profits through business investments and activities by clinic and rehabilitation centre operators, the hotel and tourist industry, and communities making efforts to obtain formal recognition as '*Heilbad*' or '*Kurort*' (cited in Maretzki 1987: 1062). Despite continuing controversy over the non-scientific nature of the *Kur*, it is established as an eclectic therapy system. Biomedical doctors work as coordinators of therapy and medical monitors (*Badearzt*) for *Kur* patients in *Heilbaeder*. Some of these doctors have been instrumental in developing systematic health care

research on the effectiveness of their treatment regimes in conjunction with university medical faculties (Maretzki 1987: 1064).

Faith healers and other complimentary therapists like chiropractors and folk healers have enjoyed more competing power in the United States than in other countries, like Australia and the United Kingdom, because 'free' medical care is offered in the latter (Wallis and Morley 1976). However, in more recent years, the demand for alternative or folk medicine has steadily grown in most Western societies despite the fact that they are expensive and generally not covered by government health schemes and only partly by private health insurance. It is important to note that biomedicine cannot cure all health problems and persons who are not satisfied with biomedical treatments may seek health care from informal health practitioners (Cockerham 1986: 125).

Many social scientists have observed that in most of the developing countries both biomedical and traditional health care are available and can be used simultaneously by the population (Bhardwaj 1980; Fabrega 1980; Haram 1991; Jaspan 1976; Kleinman 1980; Leslie 1977; Leslie 1980; Pigg 1995; Subedi 1989; Young 1983). Streefland (1985) reports that faith-healing is the most commonly used health care system in Nepal. In Nepali society, traditional health beliefs and shamanism have a significant role. Faith healers (*jhankri/dhami*) enjoy deep-rooted public recognition and contribute significantly to the villagers' health care needs (Subedi 1989).

Similarly, Shah, Shrestha, and Parker (1978, cited in Subedi 1989) found that more than 75% of all illnesses in Nepal are treated by the traditional health care system. The Nepalese are likely to try home remedies initially when ill. If there is then no relief, they seek help from traditional practitioners. If these fail to bring relief, they turn to biomedical physicians (Justice 1981). If

these fail again, patients return to traditional healers. In his study of health care behaviour in Kathmandu, Subedi (1989: 418) found that the wide acceptance and prevailing use of traditional health care in Nepal have significant implications for the use of biomedicine, e.g., delaying the decision to seek biomedical services when necessary.

Subedi (1989: 419) also contends that Nepalese reliance on and use of indigenous health care continues because the traditional medical services are 'readily available, less expensive, and socially closer to the people (in developing countries)' – (also see Chavez 1984a). However, to what extent traditional medicine can maintain its significance in developing countries like Nepal under the continuing exposure to Western thought and culture through the mass media and the heavy influx of tourists is yet to be seen.

The penetration of biomedicine into a traditional society is sometimes more abrupt than at other times, depending on the type of interaction between the host and the incoming culture. For example, in the feudal Malay peninsula, although Western pills and potions are prescribed by the *bomoh* (medicine man or shaman), they do not replace native herbs or biomedical practices. Government-trained midwives were well accepted, but did not replace traditional ones and mothers seem to have no preference for one or the other. They did not have the advantage of surgery, however, since it is against the doctrine of the Kor'an to cut or mutilate the body in any way (Heggenhougen 1980; Wolff 1965). What Wolff argued overall in his study is that the people of the region have accepted the technology but not the ideas behind it. Whether the practices which inform this situation are sustainable over a long period of time is doubtful. Now, thirty years since Wolff's study, it would be safe to say that there has been much change in the links between different kinds of medicine there. This change would take place, not as

Wolff stated through either the Malayanization of Western socio-economic elements or the Westernization of Malay social conditions, but by both.

THE CENTRAL CONCEPTUAL ISSUE

From the discussion of the general assumptions above, yet another question remains to be posed. That is, what changes take place in the way in which *culture* mediates the health care choices people make when they move from one society to another and why? To what extent does the social *location of migrants* in the host society alter, restructure or eradicate the cultural practices people bring with them?

Studies have found that there are differences between immigrants and the native-born in terms of health care utilization patterns, i.e., in the frequency with which they consult health practitioners, or in the types of health care used. There are two broad perspectives explaining the differences for immigrants (Easthope 1989). The first view emphasizes the ethnicity of an immigrant group which structures individual choices. That is, the more an immigrant's ethnic identity is oriented towards the host society, the more she or he is inclined to use the services available in the host society. The second view focuses on the immigrants' disadvantaged position in the host society, which tends to hinder their access to formal health care.

LITERATURE REVIEW

Research with an emphasis on ethnicity and individual choice include studies which utilize (1) the ethnic solidarity model; (2) the social networks model; and (3) the social-psychological model. Until the early 1980s, Suchman's (1965) model, which is centred around the impact of *ethnic solidarity* on medical orientation which in turn affects attitudes to health care, was frequently employed to explain the use of health care among

Mexican-Americans in the United States. For example, Anderson and his associates (1981) found that many Mexican-Americans tend to seek patent medicines, herbs, and teas when sick. If they are not successful in recovering from sickness, they consult members of the family. Next they turn to a *curandero* or folk healer before visiting a physician about their health problems; they may consult both a *curandero* and a physician. Madsen (1973) found in south Texas that even though Mexican-Americans consulted a physician they would not continue the relationship unless there was rapid improvement resulting from treatment. Similarly, pregnant women among Cambodian refugees in the United States waited until the eighth month to seek prenatal care because of the fear of having blood taken, the fact that there was no customary predisposition to seek prenatal care in Cambodia, and because of the sometimes lengthy waiting times in a clinic (Kemp 1985: 48; Mattson and Lew 1992: 53).

A study in Nebraska (Welch, Comer et al. 1973) suggested that the *assimilation* of Euro-American norms and values by Mexican-Americans is accompanied by an inclination towards consulting a biomedical physician. Yet, folk medicine still remains a significant form of health care utilization for lower-income Mexican-Americans (also see Stone 1985). Other studies (Honig-Parnass 1982; Van der Stuyft, De-Muynck et al. 1989) have observed no associations between the tendency to define oneself as ill, service utilization characteristics and length of stay.

As shown in the studies of Mexican immigrants, it is the ethnic solidarity model which has been frequently employed to explain the use of traditional medicine in the immigrant community. Another example of particular relevance to the present study is J. K. Miller's (1988; 1990) research on health care utilization patterns among Korean immigrants in Southern California,

which starts with a hypothesis, not well based, that the more a group of immigrants assimilate to a new society, the more they tend to relinquish their old beliefs, including health services utilization patterns (e.g., the use of herbal medicine or acupuncture). This hypothesis tends to neglect the obvious phenomenon of a burgeoning boom in *hanbang* medicine in Korea as well as overseas, or more generally the increasing popularity of alternative health services in the last few decades. The study also neglects the fact that an important aspect of *hanbang* has been its use as restorative medicine (*poyak*) for many centuries and it is still popular for those Koreans who can afford the high cost. Although the study is enriched by the combined use of a survey method and in-depth interview techniques, other significant issues such as class structure and immigrant involvement in the labour market are hardly considered. It is not surprising that the central hypothesis informing the study, based on an ethnic solidarity model, was not supported by the survey results.

A major problem of most research on the use of traditional medicine amongst immigrants from the ethnic solidarity perspective, is that the use of traditional medicine is often reduced to a mere cultural phenomenon, largely neglecting relevant political-economic aspects (e.g., Bhopal 1986; Brainard and Zaharlick 1989). That is, the decontextualization of traditional health care prevents many medical social scientists from understanding it fully. This is a general problem of most research on ethnomedicine (Heggenhougen 1979; Mathews 1979; Nichter 1991).

In Australia, Greek immigrants have been the subject of research (e.g., Bottomley 1976). However, more than 90% of Greek immigrants were illiterate or semi-illiterate and from peasant backgrounds (Moraitis 1971: 598). It is unfortunate that, despite the large inflow since the 1970s of Asian

migrants to Australia from diverse experiences of urbanization, education, and socio-economic status (Manderson and Mathews 1985: 252), there has been little research about the use of traditional medicine among Asian immigrants in Australia with the exception of the study by Savage (1991). The scope of Mathews' (1979) study of pregnant Vietnamese women is rather limited with an emphasis on traditional medical concepts (e.g., *yin* and *yang*) and dietary behaviour. The decontextualization of study subjects is also a problem, because the study pays no attention to the immigrant experience of the subjects. It is true that most Korean women would be reluctant to shower and wash their hair or get up and undertake light exercise within a few days after delivery of an infant (cf. Manderson and Mathews 1981). However, although the concepts of *yin* or 'cold' and *yang* or 'hot' have been with Koreans for many hundred years, most Koreans today are not likely to classify illness, food and medicine according to the principles of *yin* and *yang*.

Another influential view of health care utilization patterns, emphasizing individual choice, is the *social networks model*, taking many of its ideas from Berger and Luckman (1967). According to this perspective, members of social networks, such as family, relatives, and friends, internalize the interpretation of social reality by significant others. Therefore, the social network is a deciding factor in health care utilization. Research undertaken from this perspective found that the family is the major source providing financial access to health care and that parents socialize children into particular patterns of underlying medical need and health care use (Chrisman and Kleinman 1983; Doherty and McCubbin 1985; Horowits 1978; McKinlay 1973; Sallis and Nader 1988; Schor, Starfield et al. 1987). However, this model largely ignores social and economic factors which are often beyond control by social networks.

The social-psychological model of health care use has focused on the importance of self-perception as it leads to a person's understanding of a particular illness symptom. A particular point of importance is whether or not the patient perceives him/herself to be able to carry out normal social roles (Apple 1960; Baumann 1961; Twaddle 1969). Cancer patients may delay seeing a doctor for fear that their perceptions may be confirmed (Becker and Maiman 1975). The social-psychological model is particularly useful in understanding the decision making process leading up to the seeking of professional health care. However, it does not explain what happens after the contact is established (Wolinsky 1980) and it is not capable of dealing with the areas which are beyond the control of patients and health professionals. It is so focused on health seeking behaviour at the individual level that relevant issues at the structural level are overlooked.

A major shortcoming with the ethnic solidarity model, and to a lesser extent with the social networks model and the social-psychological model, is their decontextualization of health care choices including the access to and the frequency of using various services. Health care does not exist in a social vacuum. That is, it cannot be understood without understanding the social origins of illness and the socio-economic aspects of health care. A predominant emphasis on individual traits in health care use and the numerous shortcomings of the models with an emphasis on ethnicity and individual choice brought about an increasing attention to the causal significance of contextual or structural factors, related to both country of origin and reception (Portes, Kyle et al. 1992: 284). This tendency in recent years particularly, reflects a growing recognition of structural factors in the context of exit and the process of adjustment to a new society in understanding the life of immigrants in general (e.g., Massey, Alarcon et al. 1987; Portes and Böröcz 1989).

Research with an emphasis on structural influences often utilizes what are known as (1) the socio-economic status model or (2) the political economy model. Cockerham (1986) noted that a few large-scale surveys of the use of health care in regard to professional medical services, suggest that Mexican-Americans have the lowest rates of utilization of any ethnic minority in the United States. Anderson and his associates (1981) argued that the under-utilization of biomedical physicians' services amongst immigrants is related to a lack of health insurance or publicly-funded insurance programs to improve primary care (also see Arnold 1979; Guttmacher 1984; Siddharthan 1991). Others attributed it to the lack of knowledge of available services, limited resources and access to care, and cultural differences in illness and health care seeking behaviour (Anderson 1986; Honig-Parnass 1982; Hull 1979; Queseda 1976; Siddharthan 1991; Van der Stuyft, De-Muynck et al. 1989). These studies use what is often known as the socio-economic status model, which focuses on income and education and maintains that socio-economic factors are more influential determining factors of health care utilization than ethnicity. This socio-economic explanation has some validity because recent immigrants are more likely to be poor and, thus, face financial difficulties inhibiting their ability to utilize health care (Chavez, Flores et al. 1992; Jensen 1989; Rumbaut, Chávez et al. 1988). Similarly, other American studies (Chavez 1986; Rumbaut, Chávez et al. 1988; Siddharthan 1991; Valdez, Morgenstern et al. 1993) pointed out that immigrants are more likely to be employed in poorly paid jobs that do not provide health insurance benefits. However, the links between immigrants' work (or production) involvement, health, and use of health care are yet to be explored.

Moreover, several researchers in the United States (e.g., Anderson and Anderson 1979; Sharp, Ross et al. 1983) confirmed that the provision of state-

supported Medicaid to pay the cost of health care for the poor and a federal government-supported Medicare scheme for the elderly diminished greatly the relationship between income and health care use, although people with higher incomes tended to use the 'private' system and those with lower incomes the 'public' system (Cockerham 1986: 96). As the Korean community in Australia has included illegal immigrants, and their number is estimated from a few hundred to several thousand (cf. Han 1994), they might have experienced limited access to biomedical physicians because of the fear to be found illegal. However, every legal migrant in Australia has access to State-provided biomedical service, i.e., Medicare.

A further deficiency of the socio-economic model is that it cannot explain the frequent use of *hanbang* herb medicine and *hanbang poyak* (restorative medicine) in particular amongst Koreans in the United States and Australia. The use of *poyak* is pervasive amongst those Koreans, although it is expensive and not covered by government-supported health schemes. Miller (1988; 1990: 41) finds that the higher the income the more likely the Korean immigrants in California will use *hanbang* medicine and that education was not related to the use of *hanbang*. This phenomenon amongst Korean immigrants is quite different from that which has been found amongst most other immigrants like Hispanics and Cambodians in the United States and Indians in the United Kingdom. Miller's significant finding needs to be explained. It is also problematic to assume that recent immigrants are more likely to be economically disadvantaged. Recent skilled and business emigrants to North America, New Zealand and Australia bring a substantial amount of money with them.

More recent research (Leclere, Jensen et al. 1994; Portes, Kyle et al. 1992; Van der Stuyft, De-Muynck et al. 1989) utilizes a synthesized view of the various

perspectives on health care use. Researchers suggest that, first, predisposing factors such as socio-demographic characteristics (e.g., sex, age, and race) affect the underlying proclivity of a person to seek health care (Portes, Kyle et al. 1992). Consequently, underlying reasons to seek health care, or perceived need, varies from one group to another. Secondly, Leclere, Jensen et al. (1994) and Portes and Rumbaut (1990, ch. 1) point out that the level of adaptation of immigrants could influence their health care seeking, which is a specific aspect of the general process of adaptation. Thirdly, compared to the native-born or those of longer durations of stay, recent immigrants are less likely to use formal health care initially, and have fewer total contacts with a physician (Leclere, Jensen et al. 1994: 381). However, this synthesis tends to utilize existing theories without showing how they can be effectively synthesized to form a theory of health care seeking behaviour and health care utilization. Therefore, the synthesis does not improve the shortcomings of the perspectives mentioned above. More importantly, there was no attempt to explore the links between work, health and use of health care.

If predisposing factors, such as age, sex and race in particular are related to immigrants' work involvement and consequent implications for health care utilization, the studies are likely to be more fruitful. A significant aspect of the recent research is the use of the concept of adaptation. However, the usefulness of the concept is open to further scrutiny. As far as the host society remains little changed in terms of its dealing with immigrants, adopting the concepts of adaptation or acculturation instead of assimilation (which was linked to the implicit anticipation of an eventual merging of immigrants into the dominant culture) as a tool to understand the process of immigrant settlement is not likely to help us better understand health care utilization amongst immigrants. Tripp-Reimer (1983: 101) rightly

contended that the levels of adaptation or high ethnic affiliation of immigrants do not necessarily indicate the retention of traditional health beliefs and health care use.

Although recent studies (e.g., Leclere, Jensen et al. 1994; Portes, Kyle et al. 1992), based on large scale surveys, investigated overall health care use patterns amongst immigrants in the United States, they are not applicable to the Korean immigrant population in Australia, which consists of people from various socio-economic backgrounds utilizing both biomedical and traditional health care. Leclere, Jensen et al. (1994) acknowledged the limitation of their study in regard to the use of traditional health care, saying that they could not measure informal alternatives to medical care and that alternative health care is preferred to formal care because of cultural or financial reasons. This is not an informed view. The use of traditional medicine (e.g., *hanbang* herb remedy) is generally expensive, and it is more than a cultural phenomenon. There is no doubt that the impact of cultural differences in health care utilization does not necessarily fade out with time (Harwood 1981). The question is the level of the significance of *culture* in comparison with other factors such as *work* involvement and its consequence for the demand for health care. However, Leclere, Jensen et al. (1994: 381) suggested a valuable point regarding the purpose of the current study that whilst a sizeable proportion of visits to physicians in the United States derive from 'somatized psychological complaints', immigrants may consult alternative health care for similar problems, which may result in under-utilization of formal health care among immigrants. The point is valuable, because most Koreans perceive herb medicine to be effective for those who suffer from lingering fatigue or a high level of anxiety, which may not be diagnosed in scientific terms and may not usually be cured by biomedicine.

A political economy perspective of health care utilization puts health and health care use in a more fruitful context. This view essentially examines the social origins of illness and the allocation of health resources. The advocates of the view attribute the causes of illness and premature death among working class people to unhealthy working conditions, the nature of production relations, social relations and social reality (Chavez 1986; Doyal 1979; Engels 1968; Frankenberg 1980; Waitzkin 1981). It is also pointed out that although cultural elements of a given subgroup in a community could add to the problem of access to formal health care, cultural beliefs are not the major obstacle (Chavez 1986: 345). Socio-economic circumstances tend to create the obstacles to health care for the lower class population, including immigrants, particularly 'illegals' without medical insurance. This point has contributed to understanding health care use amongst immigrants, but it does not fully explore the links between the consequences of holding low-paying jobs, health status and medical need. Whether the lack of practitioners who speak a relevant foreign language is a problem or not depends upon immigrant communities and their locations. Poor knowledge of English was not a barrier for the Lao in Ohio to access formal health care although most of them required an interpreter (Brainard and Zaharlick 1989).

Although I find the political economy perspective useful and shall draw heavily on many ideas from it, there are some problems with existing studies for the purpose of the current research. Many recent studies have emphasized the low socio-economic characteristics of immigrants and, therefore, argued that they are less likely to access formal health care (Chavez 1986). Relevant to this is that work involvement as a socio-economic characteristic and its consequence for health status and health care utilization are not fully explored. Chavez, Cornelius, et al. (1985: 94),

advocates of the political economy model of health care utilization amongst immigrants, scarcely mention that recent illegal immigrants without health insurance and those who are not eligible for government-supported programs are likely to seek medical care only when they have a *job*-related injury or some other kind of acute health problems. Chi (1985: 40, 44) also briefly mentioned that lack of time was one of the few most important reasons for not seeking health care amongst migrant farmworkers. Lack of time may well be related to work involvement, because workers with low-paying jobs find it difficult to find time to see health practitioners because they are frequently engaged in more than two jobs.

Again most researchers have focused on those immigrants who are in poverty or are 'undocumented'[1] (illegal) (Chavez 1984a; Chavez 1984b; Chavez 1986; Chavez, Cornelius et al. 1985; Chavez, Flores et al. 1992). The studies found that illegal immigrants under-utilized physicians for fear of being found out and that migrant farmworkers expressed a fear of the medical profession or disbelief in it (also see Chi 1985). The former point is likely to be applicable to illegal Koreans in Australia. However, the latter may not be so because most Koreans in Australia would have been familiar with receiving biomedical care prior to coming to Australia. Thus, the above mentioned research from a political economy perspective may not be so applicable to an immigrant community which consists of people from diverse socio-economic backgrounds. As McKinlay (1975) suggests, much confusion over the effect of migration on health status and the use of health care, results from the failure to specify types of migration related to time, place and person. Therefore, it is important to consider types of migration

[1] By the term undocumented, Chavez (1984b: 16) refers to 'the individuals who have migrated to this country [the U.S.] without benefit of documentation from the Immigration and Naturalization Service (INS)'. It appears to me that the term partly recognizes the push/pull factors of migration at a structural level. However, the commonly used term in Australia is 'illegal migrant' which I use in this study.

because they tend to reflect why the immigrants under study left their home country and how they are adjusting to a new society. In short, ethnic groups or members of an ethnic group are far from homogenous with regard to their socio-economic status, education and skills (Uniken Venema, Garretsen et al. 1995: 816). Most of the studies reviewed above are statistically oriented and they provide us with useful observations of trends in health care utilization amongst immigrants. They are often, however, without an elaboration of the relevant social reality, e.g., production involvement.

OTHER SHORTCOMINGS OF THE CURRENT LITERATURE ON THE USE OF TRADITIONAL MEDICINE AMONGST IMMIGRANTS

I would like to discuss other deficiencies of the current research on the use of traditional medicine amongst immigrants. Most researchers who touch on traditional medicine among immigrants have largely focused on health care policy, i.e., how health care practitioners can provide immigrants with culturally appropriate services[2] (e.g., Bottomley 1976; Jenkins, Le et al. 1996; Jezewski 1990; Kemp 1985; Kendall 1987; Manderson and Mathews 1985; Mattson 1995; Mattson and Lew 1992; Yeatman and Dang 1980). This trend is closely related to the prevailing policy of promoting multi-culturalism in general and the trend to promote medical pluralism in particular. Some of the obvious consequences for medical social science include the medicalization and decontextualization of illness and health care, which have led many medical social scientists to detach themselves from the political-economic aspects of illness and health care.

Although there are many insightful studies about the use of traditional medicine in immigrant communities, most focus on immigrants from poor, rural backgrounds in the home country who had lived in a new country for

[2] These researchers have often gained public financial support.

less than five years, and were currently living in poverty (e.g., Brainard and Zaharlick 1989; Kemp 1985). In fact, Brainard and Zaharlick (1989: 848), in their study of traditional health beliefs and practice in the Franklin County Laotian community, excluded from the sampling those who had wealthy, urban backgrounds in Laos, were highly educated, had arrived in the United States relatively early, and were financially well-to-do in the United States. This exclusion seems to reflect the anthropologists' interest in non-urban or economically underdeveloped societies. It may be related to the motive to provide culturally appropriate services for ethnic minority groups. According to Brainard and Zaharlick (1989: 848), of twenty households, very few reported relying on traditional Laotian practitioners and therapies since their arrival in the United States, and several mentioned that they did not know of traditional healers in the local area. Most indicated that they would continue to depend upon biomedicine even if they had access to traditional medicine. Part of the reason was the lack of appropriate herbs in Ohio. However, more importantly, Laotians found biomedicine quicker and usually more effective than traditional medicine.

Brainard and Zaharlick's (1989) study does not offer much insight for the present study primarily because their sample is drawn from those originally of low socio-economic background only. Unlike in their sample, the Korean community in Sydney includes recent Korean men who had high social status and used both bio- and traditional medicine prior to coming to Australia. Further, *hanbang* herb doctors in the Korean community in Sydney seem to have a sufficient supply of herb remedies. If not they would not have advertised their clinics in the Korean ethnic papers and magazines in Sydney. Korean *hanbang* doctors are not only easily available in the overseas Korean communities, they even modify their practices to satisfy

their immigrant patients' expectations under the influence of biomedicine, e.g., using biomedical diagnostic apparatuses (Pang 1989).

With a sufficient supply of traditional remedies and providers in the Korean community in Australia and the United States, Korean immigrants do not choose either traditional medicine or biomedicine, but both. Although some studies report that non-Western traditional health/ non-health beliefs and practices often act as barriers to access to Western health care and utilization of biomedical care amongst Pacific Islanders or Asian immigrants in the West (Harwood 1981; Kleinman 1980; Marr 1987; Mayeno and Hirota 1994; Muecke 1983; Yeatman and Dang 1980), this seems to be not the case in the Korean community. It is even naive to ask respondents which one is preferred (e.g., Bhopal 1986). It seems more important to investigate why both are used, because a preference for traditional health beliefs and practices amongst immigrants does not surface as a major reason for under-utilizing biomedicine (Chavez 1984a: 32; Jenkins, Le et al. 1996). Bhopal (1986) also found in an Indian community in Britain that the absence of local Asian healers and a lack of fresh herbs have contributed to infrequent use of traditional medicine. Hillier (1991: 157) predicts that the practice of traditional medicines such as *Unani* or *Ayurveda* in the Asian community in Britain may continue to decline. Manderson (1985: 252) also reports that Vietnamese immigrants in Australia had limited, though not impossible, opportunities to consult traditional healers, and midwives, and to acquire herbs and medicines.

My review of the literature reveals that among recent immigrant groups in the West the use of traditional medicine is considered to be highly significant among Korean immigrants. Although there has been abundant research regarding the use of traditional medicine amongst Asian and Latin

American immigrants in the West there are fundamental differences between those immigrants and Koreans who have migrated (particularly to Australia) for the last couple of decades. Firstly, there has been an extraordinary economic development in Korea since the 1970s. Secondly, there was a revival of traditional *hanbang* medicine in Korea in the same period and it is a fully accredited medicine though not as much as biomedicine. Thus, it is possible health care utilization among recent Korean immigrants is strongly influenced by the popularity of *hanbang* medical care in Korea since the 1970s.

SUMMARY

In reviewing the current literature on health care utilization amongst immigrants in particular for the purposes of the present study, some useful insights can be gained.

Firstly, most research on health care utilization among immigrants has been fragmentary despite the fact that health care utilization among immigrants is only part of a continuing process of immigrant life: departing from the home country; adjustment to a new society; work involvement; and health status. The research on health care utilization has not paid close attention to its relationship to the experience of immigration or work involvement in particular. More importantly, the links between migrants' use of formal and traditional medicine and employment have not been explored, despite increased acknowledgment of the effects of work on the health status of immigrants.

Secondly, no existing theory can explain the simultaneous use of both biomedical and traditional health care amongst immigrants. This is one of the most serious shortfalls of existing studies of health care utilization

amongst immigrants. It is especially problematic when traditional health practice in the homeland of an immigrant group is enjoying wide recognition not only by the public but also by academic faculties at universities. It is not only the socio-economic and health care context of the host society, but also those of the homeland of the immigrants which influence the use of health care amongst immigrants (cf. Miller 1990).

Thirdly, although research from a political economy perspective (e.g., Chavez 1986) has pointed out the possible links between the social origins of illness and health care utilization amongst immigrants, no empirical study has been carried out to explore the links between health as a capacity to work and health care as a means to sustain work capacity, and the implications for health care utilization. Instead, existing studies from a political economy view focus on immigrants in poverty and are unable to deal with an immigrant community consisting of people from diverse socio-economic backgrounds in the homeland. It is clear that migrants' disadvantage in the labour market (Hillier 1991: 158) needs to be taken into consideration in understanding health status and health care utilization.

Finally, without the provision of traditional practitioners, the use of traditional medicine cannot occur. Accordingly, social and economic characteristics of traditional medicine and practitioners need to be further explored, to more fully understand health care utilization.

Chapter 3

Research questions, design and strategy

RESEARCH QUESTIONS

The literature review has revealed considerable deficiencies in the current research on health care utilization amongst immigrants, especially concerning recent Korean immigrants in Australia. Therefore, the central questions of this study are:

> In what ways does work involvement play a mediating role between cultural attributes and health care utilization amongst Korean immigrant men in Sydney? Apart from work involvement, what other aspects of immigrant life influence health care utilization?

Male Korean immigrants in Australia make a unique case for investigation for the following reasons. Firstly, traditional medicine in Korea is fully accredited and is actively sought by Koreans in contemporary Korea and in Australia. Whether the use of both bio- and traditional medicine amongst Korean men is merely a phenomenon reflecting medical pluralism or is mediated by other factors such as immigration experience and work involvement is an important question. Secondly, Korean men in Australia have come from diverse socio-economic backgrounds and arrived in

Australia at different times. Korean men from lower class backgrounds entered Australia as illegal migrants in the early 1970s, skill-based Koreans in the 1980s, and the small business/ entrepreneurial class in the 1990s. Most activities in the Korean community are centred around first generation Koreans, who are made up of the three groups of immigrants, although their children who were born in Korea and have grown up in Australia are increasingly becoming active. Most of the first generation Koreans are still alive and offer an opportunity to compare the different groups of Korean men in terms of their adjustment to a new country, work involvement, life styles and health care use patterns.

The focus on three different groups of Korean men as the subjects for study was not predetermined by my knowledge about the Korean community in Sydney but evolved out of interviews with Koreans in Sydney in the pilot study. In fact, I was not aware of the 'significance' of the boundaries between three distinctive groups in the Korean community although I knew that Koreans had entered Australia under different categories of migration. It is 'the category under which Koreans have entered Australia' that largely determines who individual Koreans interact with, what they are, and how they feel about other Koreans in the Korean community. It is likely that health status and health care utilization patterns are closely related to the 'category' to which individual Koreans belong.

The primary reason I have focused on Korean men rather than both male and female is because I have experienced difficulty accessing Korean women in the context of Korean culture. I have learned this through my previous research (Han 1994) in the Korean community and it was reaffirmed in the initial stages of data collection for the present study.

Subsidiary questions which would enable us to answer the central questions to be answered are as follows.

Firstly, in what ways have bio- and traditional (*hanbang*) medicine undergone changes in Korea over the last few decades, given that these changes are likely to influence health care utilization amongst recent Korean immigrants?

Both biomedical and *hanbang* health care have been expanding in Korea especially for the last few decades. As in other countries, the increasing popularity of biomedicine in Korea could be understood in terms of Korea's economic development and the influence of Western countries. However, the continuing expansion, in fact revival, of traditional *hanbang* medicine during the period of rapid economic development since the 1960s is rather unique. A notable aspect of *hanbang* medicine in contemporary Korea is that it is most frequently used as a restorative medicine (*poyak*). Whether the predisposition to *hanbang* medicine as *poyak* prior to their migration to Australia has influenced health care utilization amongst Korean men in Australia needs to be examined.

Secondly, what are the social backgrounds of male Korean migrants to Australia? Why did they leave Korea, what did they bring with them which is likely to influence their immigrant life in general?

Thirdly, what have been the experiences of three different socio-economic groups of male Korean immigrants in Australia? The question can be examined with reference to their reasons to migrate, adjustment to Australian society, work involvement, health conditions, and health care utilization patterns.

Finally, examining the consumers of health care explains only half the phenomenon of health care utilization. The demands for health care cannot occur without the provision of health care. How do we understand the synchronic existence of bio- and traditional (*hanbang*) health care in the Korean community in Sydney and its influence on health care utilization patterns among male Korean migrants? How do health practitioners understand the relationships between *work* involvement, health and health care use amongst the Korean men?

RESEARCH DESIGN

The primary data of the thesis were generated by interviewing three groups of Korean men who were admitted to Australia under the different categories of migration, i.e., amnesty, skill-based, and business/investment migration. The primary data also came from interviews with various health care providers such as *hanbang* and biomedical services. A text analysis in Korean ethnic newspapers published in Sydney was also undertaken. Interviews with other Koreans like the former presidents of the Korean Society in Sydney, journalists and religious leaders have provided additional information.

Secondary sources of data (journals, books and newspapers) were used to explore relevant aspects of *hanbang* and biomedicine in Korea and the social backgrounds of Korean migration to Australia.

Generating the primary data through interviews using semi-focussed open-ended questions has resulted in a qualitative study with a minimum use of quantitative methods. Semi-structured interviewing, in which the researcher provides minimal direction and permits considerable latitude for interviewees, is a typical technique of qualitative methodology. Aspects of

this study could have been carried out under the drive of a quantitative methodology. However, quantitative methodology has its own limits just as qualitative methodologies do. For example, statistics show that immigrants are often disadvantaged in the job market for various reasons and suffer frequently from mental illness. Why and how they suffer in their everyday life in a given social context can be better explained and illustrated by qualitative methods. Qualitative methodology is well suited to describe and explain a pattern of relationships and this task can be carried out with a set of conceptually specified analytic categories (Mishler 1990). In other words, an investigation of a social phenomenon in which social reality is realized, to use Roy Bhaskar's terms, can be efficiently carried out by using a qualitative methodology rather than quantitative one (Bhaskar 1978, 1989; Sayer 1992). This is what I intend to do with reference to the phenomenon of health care utilization among Korean men in Sydney.

Other reasons why qualitative methodology is appropriate for this research are as follows. Firstly, one of the key tasks of the study is to investigate the ways in which male Korean migrants live under the influence of socio-economic and political factors. The research necessarily involves understanding the subjective experiences of immigration and this may not be accomplished through a survey questionnaire, using a series of objective concepts and categories in terms of fixed empirical referents.

Secondly, we can better understand events when they are situated in the wider social and historical context. Qualitative descriptions of the social settings and the apparently superficial trivia and minutiae of everyday immigrant life, put the central research issues in their proper social context so that a comprehensive analysis of the events and behaviours under scrutiny becomes possible (Cohen 1978). Thirdly, qualitative methodology

allows a research strategy which is relatively open and unstructured, rather than one which requires in advance a precise plan as to what ought be investigated and how it should be done. In contrast, an open research strategy leaves the researcher's mind open to the new or unexpected findings in the field (Bryman 1988: 66-67). This strategy is particularly desirable because there has been very little research about the Korean community in Australia.

Finally, a pre-determined theory may excessively limit the research and also may cause a disjuncture with participants' experiences. Instead, what is required is 'a general sense of reference and guidance in approaching empirical instances' (Blumer 1954: 7).

EPISTEMOLOGICAL STARTING POINTS

My epistemological starting point is informed by a realist epistemology which relies on the thesis of naturalism, the argument which advocates the essential unity of method between the natural and the social sciences. That is, it is possible to apply the natural science model to the study of social reality. Realists assume that reality in both the natural and social sciences has ontological depth, i.e., it is structured in a hierarchical fashion. Observable events constitute 'surface phenomena and reflect the realisation – at the level of the actual – of generative mechanisms located at the level of underlying relations' (Watson 1986: 8). Generative mechanisms refer to the causal powers of entities, aspects of their nature which cause them to act in particular ways.

There are three levels of reality: first, the empirical, which comprises experienced events; secondly, the actual, which consists of all events, irrespective of whether experienced or not; thirdly, the causal, consisting of

generative mechanisms (Porter 1996: 219). For example, a study of a chemical reaction involves at least two levels of observation: first, surface phenomena, and secondly the scrutiny of generative mechanisms or causal powers located at the level of underlying relations. The surface level of phenomena do not exist independently of deeper underlying factors. Realists argue that a similar method applies to the social sciences where 'tendencies' are the equivalent of generative mechanisms and refer to the emergent natures of particular social relations. These underlying relations for Marxists are 'inner relations' and the observable phenomena at the level of the actual are known as the phenomenal realization of these inner relations (Watson 1986: 8-9).

The major difference between the natural sciences and the social sciences is the ways in which generative mechanisms are understood. In natural science, mechanisms can be apprehended in terms of closed systems so that empirical regularities can be studied through manipulation, repetition of experiments, etc. However, in social science, mechanisms need to be understood in terms of open systems (situations) because the realization of the mechanisms is contingent and the nature of social events in open systems is indeterminate. Generative mechanisms may be apprehended under the construction of closed systems. However within the social sciences, this is usually impossible. This is the limit of naturalism. Therefore in the social sciences, the study of the mechanisms is dependent upon 'historical and comparative analyses and/or practical interventions in basically open systems' (Collier 1994; Jessop 1982: 219; Lovell 1980; Watson 1986).

Regarding the relationship between concepts and reality in the social sciences, realism can be distinguished from positivism/empiricism and

those strands of theory often called conventionalism/ interpretivism/ hermeneutics (Benton 1977; Keat and Urry 1975). Realists share the naturalist thesis with positivists but they reject two particular aspects of positivism. Positivism does not make a distinction between generative mechanisms and observable surface phenomena. Therefore, observable or empirical regularities are the only real phenomena. That is, ontology is reduced to epistemology; '*what is* to *what can be known*' (Lovell 1980: 11). In addition, positivists see abstractions as only heuristic inventions rather than concepts which refer to real entities. Thus positivists reject the ontological depth of social reality and operate with 'a flat ontology' (Watson 1986: 10).

Conventionalists maintain that all knowledge is 'theory laden' and that therefore it is not possible to have 'independent access to the real'. The inevitable result is relativism: knowledge depends on how we look at reality. A conventionalist position argues against the basic realist assumption about an independent and knowable world. However, defending their position, realists acknowledge that knowledge may be 'theory laden' or socially constructed, but it is not 'theory determined' (Sayer 1981). The real world 'cannot be reduced to language or theory, but is independent of both, and yet knowable' (Lovell 1980: 17).

To sum up, realism is both an ontology and an epistemology. It makes assertions about what the nature of the real world is (ontology) and the way the real world can be known on the basis of the ontology. The observable empirical world is causally connected to 'deeper' ontological levels, and it is through these causal connections that we can use sense-data, experience and observation in formulating knowledge of the structures and processes of the real. These causal connections, Lovell (1980: 22) argues,

> cannot themselves be understood through experience, because neither the underlying structures nor the connection between these structures and

> the empirical world are themselves experienced. The connection can only be reconstructed in knowledge. But these connections are vital for the realist theory of knowledge.

Critical realist epistemology combines this realist perspective and historical materialism which emphasizes the significance of the modes of production of life which determine the social, political and intellectual life process in general. It is not the consciousness of the people that makes their being, but on the contrary, their social being that determines their consciousness. The mode of production is critical for our understanding social reality because of our necessary transaction with nature in producing and reproducing our physical existence. This is also the reason why production involvement (i.e., work) is proposed as a significant mediator in health care utilization in this thesis.

STRUCTURE AND AGENCY IN SOCIAL PHENOMENA

Every social phenomenon is produced in the continuing relationship between social structure and individual action. Prior to the occurrence of any individual action, social structure pre-exists. Thus individual action is enabled and restrained by the pre-existing societal conditions (Bhaskar 1989). In this respect, I shall discuss selected aspects of Korean and Australian societies at a structural level as they have influenced Korean migration to Australia, Korean immigrant life and health care utilization in Australia. At the level of the agent, I have interviewed the users and providers of health care in the Korean community in Sydney in regard to the migration experience and health care utilization of Korean men.

Neither individualist voluntarism nor collectivist reification of social entities provide a satisfactory perspective. This is because society does not exist independently of individual human agency. Following critical realism,

I argue that a patient's health-seeking behaviour is enabled and constrained by pre-existing medical systems in the social context and by financial and other kinds of resources available to the patient. The action, in turn, reproduces or transforms the medical systems.

Giddens' (1984) structuration theory shares some common features with a critical realist view: the former stresses the autonomy of social actors, but the latter notes carefully the pre-existence of social forms, thus acknowledging a stronger ontological grounding of structure (Bhaskar 1983; Bhaskar 1989; Porter 1993: 595). In the current study, understanding the structure of the medical system is important. Of course, part of the structure was partially formed by ideas, roles, attitudes, practices which Koreans have brought with them since the early 1970s. Again, this does not imply that individual health care utilization is predetermined by the medical structure to which patients are exposed. That is, the patterns of health care use amongst Korean men is not totally controlled by the types and characteristics of health care systems available in the Korean community and in Australia. Rather, health care seeking behaviour will be influenced by the social position of individuals, in that their social position provides them with the means, media, rules and resources (e.g., past experience of relatives, and friends) so as to enable or encourage the actions (Bhaskar 1989: 3-4). Some Koreans may have more financial resources so that they have relatively easy access to health care. The patterns of health care use might vary from one individual to another, depending upon their life styles and what they do to make a living.

Cultural beliefs Korean migrants were brought up with and their interaction with other Koreans might encourage them to use both biomedicine and Korean traditional health care. This does not mean that, in a place where a diverse range of health care service is available, every patient will utilize all

the available health services. Indeed, every individual action entails the nature of open social systems. For instance, when an individual falls ill, the person's major interest in seeking health services is to recover from illness. The kind of services she or he can pursue depends upon the resources at a personal level, as well as societal level, which existed prior to the former. In seeking the services, the patient (agent) is generally involved in reproducing unintentionally existing health systems.

STRATEGIES OF INQUIRY

This study uses grounded theory method as a tool to analyse the primary data from the Korean community in Sydney. Ideally, grounded theory method involves the concurrent involvement of the three activities: data collection, coding, and analysis. This is why advocates of grounded theory method argue that the use of the technique to analyze data at the conclusion of data collection goes against the principle of the method (Becker 1993: 258). Having collected the primary data for the present study on the basis of social scientific methodological principles not closely linked to a grounded theory methodology, I have not strictly followed grounded theory methodology as advocated by Glaser and Strauss (1967) and Strauss and Corbin (1990). Nevertheless, their suggested method of analyzing data at the conclusion of data collection is often used by qualitative researchers. Strauss and Corbin (1990: 13) indicate that such a strategy is plausible. It is also chosen for the present study for the following reasons. Firstly, the primary task of the research is to generate and explore, rather than to test, ideas about health care utilization among male Korean immigrants in Australia. The data analysis based on grounded theory method is inductive and allows a systematic analysis of data and lessens the inevitable biases, prejudices, and

stereotypical views that a qualitative researcher often brings to the process of analyzing data. These issues are discussed further in the following chapter.

The series of research questions for the current study is derived from my interest in and commitment to a political economy perspective regarding the issues under examination and from a literature review, the course of which was influenced by the above perspective. It is also true that my interview questions were partly influenced by my sociologically informed ideas about health care utilization amongst the study subjects although my questions to the interviewees were as broad and general as possible so that the questions initially remained largely open-ended. No researcher goes to collect data in the field without some preconceived ideas and knowledge about the study subject. This point is well embraced by the grounded theory method (Glaser and Strauss 1967).

My preoccupation with the significance of work involvement in health care utilization and a political economy perspective on the phenomenon is only to assist me to focus the inquiry and to delimit boundaries for comparison so that the development of the theoretical or conceptual outcomes can be conciliated (Morse 1994: 221). Scientific studies always require that 'they be conceived, then elaborated, then checked out' (Strauss 1987: 11). Strauss' preferred terms in grounded theory method are 'induction, deduction, and verification' (Strauss 1987: 11). Induction involves carefully scrutinizing the data and then 'the actions that lead to discovery of an hypothesis – that is, having a hunch or an idea, then converting it into an hypothesis and assessing whether it might provisionally work as at least a partial condition for a type of event, act, relationship, strategy, etc.' Deduction involves 'the drawing of implications from hypotheses or larger systems of them for purposes of verification.' Verification consists of 'knowledge about sites,

events, actions, actors, also procedures and techniques' (Strauss 1987: 12-13). Grounded theory method allows me to test out, not force, my pre-conceived ideas, like the significance of work involvement and my interest in a political economy perspective, and yet to generate theories *grounded in data*.

Secondly, the qualitative strategy used in a study depends upon the purpose of the study, the nature of the research questions, and the skills and resources available to the investigator. The current research deals with the migrant *experience* of Korean men and health care utilization amongst them as part of the continuing *process* of their immigrant life. No aspect of immigrant life can be understood in static terms, but must be considered in active and ongoing terms. Immigrants' values and attitudes change in the process of adjustment to a new society, but they also continue to change depending on their experiences and the changes in the larger society. In this respect, grounded theory method is chosen to analyze the interview data concerning the continuing process of immigrant life of Korean men (Atkinson and Hammersley 1994: 248; Morse 1994: 223).

Thirdly, grounded theory method is appropriate especially when a research is exploratory and where there has not been much research on which further studies can be built. Research into the use of both bio- and traditional medicine amongst immigrants in general and Koreans in particular is still in an exploratory stage. Fourthly, grounded theory is grounded in data, in sociological constructs, and in codes and terms taken from everyday life. The method builds initially from personal experience. The empirical data for the exploration of health care utilization in the Korean community in Sydney have come from interviews where respondents speak about everyday life or their lived experiences. Finally, the data analysis based on grounded theory

method provides a means for transforming data systematically and efficiently into a theoretically dense form.

Chapter 4
Methodology

THE STUDY POPULATION

Most of the primary data was generated from interviews with first generation male Korean immigrants, a few female informants, and health care practitioners in the Korean community in Sydney where a significant proportion of the Korean population reside. As noted earlier, a male researcher would generally have difficulty trying to access female respondents in the Korean cultural context. In my previous research (Han 1994), I largely overcame this problem by accompanying my wife. However, I did not adopt the same strategy for the present study due to a fear that the depth of interviews might be diminished with the presence of a third person. It might have been more difficult to access first generation Korean women than the following generations. I felt comfortable approaching and interviewing those whom Koreans call '1.5 generation' (or those who were born in Korea and emigrated when young) women who might have been more acculturated in Australian society. I also felt that they did not feel uneasy talking to a male researcher. However, given the difficulty of accessing female respondents, even if I had included women in the study,

the extent to which they would have provided the information freely, remains in doubt (Finch 1984). It is possible that their responses would often have been 'sanitized.'

Another important reason for restricting the research to Korean men was that most health care practitioners in the Korean community were male. Of them, only one biomedical doctor and a person providing massage and acupuncture were female, although there were a few more women involved in health food shops. By virtue of this fact male health care practitioners may have had difficulty representing the views of their female clients. Although it was obvious that by not including women some important and worthwhile issues regarding health care use might be neglected, I reached the conclusion that it would be better to research half the population (men) efficiently rather than study the whole (men and women) poorly.

SAMPLING AND PILOT STUDY

The strategy of sampling adopted for this study evolved as the research progressed. Sampling was done purposefully, rather than by some form of random selection from a chosen population (cf. Morse 1994: 230). A few possible strategies of sampling had been considered before I collected the data in the field. It was mainly through a one month pilot study that led me to sample in a particular way.

Although I had some prior knowledge about the Korean community in Sydney, I tried to keep myself open to all possibilities of sampling especially during the pilot study. Despite my clear research interest in health care utilization and its provision in the Korean community, I deliberately met a variety of people and tried to understand the broad social context under

which health care use and its provision occurred. The respondents included former presidents of the Korean Society in Sydney, social welfare workers, journalists, church ministers, the leaders of the Senior Citizen's Association, the members of the Taxi Drivers' Association, various health practitioners, small business owners, overseas students, and virtually any Koreans who were willing to talk to me or who were reputed to be familiar with various issues of the Korean community. I conducted more than 50 interviews for the pilot study.

The interviews were not tape-recorded but I noted down what was being said. Soon after each interview, I recalled what had been discussed and made extensive notes. The pilot interviews led me to modify and improve the research proposal. Before the start of the pilot study, I decided to focus on health care utilization and provision of health care in the Korean community partly because of the increasing popularity of traditional medicine in Korea and overseas. In my interviews, I attempted to make an assessment of their health status and health care use particularly in the context of the Korean immigrant life in Australia. The first couple of weeks of the pilot study was a period of uncertainty. I was preoccupied as to whether or not I was going to obtain sufficient data. Finishing the pilot study and studying the collected data, the central focus of the study became clearer and I was reassured that my chosen theoretical perspective for understanding the central task of the study would prove useful, namely that one could understand health issues only in the context of the wider society, i.e., immigration, work, life style, and the consequences for health status and health care use.

One of the things I learned during the pilot study in regard to sampling was that there were clear divisions between different groups of Koreans in

Sydney. That is, the categories of admission to Australia, the schemes for *amnesty, skilled and business migrants*, significantly influenced the people with whom they frequently interacted, how they have adjusted to and lived in a new society, and consequently their health status and health care utilization patterns.

Sampling the Consumers of Health Services

The experience immigrants have had prior to and during the process of immigration would be likely to affect profoundly their health and use of health services (Easthope 1989: 177). In this respect, it is important to note that Koreans from different socio-economic and educational backgrounds have come to Australia at different moments of both the Korean and Australian capitalist development process. It was assumed that the experiences Koreans had prior to emigration to Australia varied and that the health experience and their use of health services varied accordingly. This was confirmed during the pilot study.

A number of possible ways to sample the users of health care on the basis of probability sampling method were considered prior to and following the pilot study (Polgar and Thomas 1988). It is possible to utilize the Korean Telephone Directory of Sydney published annually by the Korean Society in Sydney. The 1995 edition lists 2,700 Korean men who form 34% of the Korea-born males in the Sydney metropolitan area (7,708 male members, according to the 1991 Census data). Of course, it excluded those who did not have a telephone and those who did not want to be listed in the directory. Nevertheless, the directory may have been a good source from which to sample, considering that I wanted to concentrate on first generation male Korean immigrants. However, its use would present problems. If they refused to participate it would be embarrassing to try to encourage them to

do so. Moreover, given the presence of the three largely different categories of Korean migrants, if I used the directory, I would have liked to ask personal details such as the category to which the potential interviewees belonged prior to meeting them to ensure that people from diverse socio-economic backgrounds were interviewed. However, it seemed rather rude to ask someone over the telephone about their backgrounds, before even meeting them. Although this method could well have been adopted, it might have resulted in unnecessary embarrassment and therefore not proved an adequate method for sampling appropriate representatives from various socio-economic backgrounds. Moreover, an earlier study of the Korean community utilizing the Korean Telephone Directory suffered a very low response rate of 20.25% (*Hanho T'aimjŭ* 1990).

More importantly, after the one month period of pilot study, I came to be preoccupied with questions such as why there are clear differences in adjustment processes, life styles, health conditions and health care utilization amongst a few different groups of Korean men who may be categorized according to their *ways of settling in Australia* or *the ways in which they migrated or were admitted to Australia permanently* (i.e., amnesty, skill-based migration and business/investment migration). At this point, sampling around the *experiences* of a few different groups of Korean men became more important than sampling representatives from the Korean community. The fruitfulness of sampling around *experiences* was reaffirmed while undertaking interviews with the providers of health care. Such a sampling strategy (i.e., a non-probability sampling) was considered to illuminate a relevant situation and to provide insight about the *experiences* under investigation (Wadsworth 1984).

I once considered utilizing various clubs in the Korean community because I was interested in collecting data around the *experiences* of a few groups of Korean men. There are a number of clubs organized on the basis of the places of origin, alumni, hobbies such as sports (body building, golf, bowling, fishing), and business interests. The clubs organized around alumni connections and places of origin are exclusive, in the sense that only those who were born or brought up in a particular place or who graduated from a particular school or university belong to a particular organization. These groups do not best represent the whole population of the Korean community for the purpose of social scientific research. I rejected the idea of using these clubs as the basis for the present study.

However, there are also other exclusive groups. Korean immigrants formed their own individual clubs organized on the basis of *the ways in which they were admitted to Australia* and the life styles which they share to a significant degree (*Hoju Dong-A* 1995 August 16: 17). In fact, I have also learned that the members of each of such groups notably share the ways in which they have been adjusting to their new life in Australia (*Han'guk Sinmun* 1996: 4). These groups are also the ones generally used by Koreans in Sydney when they refer to a Korean in the community. (E.g., He is a computer migrant or he migrated as a cook. He is a business migrant. He worked in the Vietnam War before coming to Australia. He was a migrant to Mexico before.) I utilized the presence of these groups as the basis for sampling in this study. This proved fruitful because the three different groups had distinct migration experiences and health care use patterns.

Many amnesty migrants entered as tourists *mostly* in the 1970s and took advantage of amnesties in 1974, 1976, and 1980. They include, prior to coming to Australia, those who worked in the Vietnam War, those who

migrated to South America, those who worked in the Middle East, those who came directly from Tongduch'ŏn, a base of the United States army in Korea, and those who still remain illegal migrants after the expiration of their visas.

Skill-based and independent migrants have *mostly* arrived in Australia since the 1980s. They include skilled immigrants (who came as cooks, computer workers, motor mechanics, plumbers), independent immigrants selected on the basis of skills and qualifications, husbands of the members of the Nurses Association, and those who worked in West Germany and migrated to Australia as skilled migrants in the 1970s. Finally, there are business/investment migrants who have arrived since the late 1980s

I tried to get the list of the members of each club (group) so as to choose potential interviewees randomly and considered asking the presidents the basis on which they were listed (e.g., by the year of arrival, alphabetical order, etc). I wanted to interview about four or five members from each group or 40-50 members all together. Depending on the size of the total membership of each group, I wanted to include every third or fourth person or so. If the person chosen refused, the next person would have been approached. If the person also refused, the one before the original one would have been chosen. It was not difficult to assume that this sampling method would not always be successful, due to the possible reluctance of potential interviewees to participate. For example, the members of some groups (clubs) are not always proud of belonging to a club made up of those who have experienced frustration in the process of moving from one country to another mainly in search of employment. The experiences which the members of each group share have built up a high degree of mutual understanding amongst

members, but it has also caused a significant degree of exclusivity of the clubs.

I approached the presidents of each social club and discussed the possibility of obtaining the list of the members. Most of them turned down my request and the rest said that they would discuss the matter with individual members in a regular meeting. The only club which sent me the list of members was the Korean Nurses Association in Australia. Before sending me the list, the president made it clear that it was actually my wife who was receiving the list as she is a member. As I met with refusal to access the lists, I asked the presidents of the clubs if they could ring the potential interviewees on my behalf prior to my contacting them (cf. Dean, Eichhorn et al. 1969: 68). This was because I thought it might produce a non-threatening introduction or a supportive attitude. I did not think that the president's involvement would contaminate the quality of the interview. However, at best, only a few presidents gave me the names and phone numbers of a few members of their clubs. However, from these I was able to build up the sample. In the end, 'snowballing' proved to be the most effective method of recruiting interviewees.

In brief, there were two key reasons to utilize 'modes of being admitted to Australia' as the basis of sampling strategy for this study. Firstly, mode of permanent entry was the way Koreans commonly categorized themselves, i.e., the subjective definition of the major groups in the Korean community. Secondly, I suspected that the terms used to categorize Koreans had much to do with their class backgrounds. My pilot study proved that this was true. I thought that class differences of their backgrounds and the consequent impact on their immigrant life would enrich the analysis of the findings of this study.

It may be argued that the sampling method adopted in this study was unsystematic as it was generally based on the class backgrounds of the study subjects. Of course, Koreans in Australia have not only come from a diverse range of backgrounds in Korea but also have led diverse kinds of lives in Australia. Nevertheless, there was little dispute amongst the interviewees as to the different waves of Korean migration to Australia. It proved to be rather surprising that class factors or, to be specific, *the modes of settling (entry) in Australia,* were most significant in dealing with the problems under examination in this study. The adopted sampling method, based on the ways in which they were admitted to Australia, enabled me to collect the data centred around *events* and *experiences* of three different groups of Korean men (i.e., amnesty/illegal, skill-based/ independent, and business/ investment migrants).

Another group of people I interviewed were the elderly people who came to Australia under the category of family reunion. I went along to the centre for the Senior Citizens' Association and asked male members if they had come directly from Korea and if so, whether I could interview them. The reason for visiting the centre rather than contacting them individually was that if they came to Australia directly from Korea, they would not often have been used to making appointments. If they wanted to participate in the study, I could explain what the study is about. These interviews were carried out in the centre.

However, the interview material from the elderly Koreans has not been included in this thesis, but presented elsewhere (Han 1996a), because of the small number of interviews (five people). Those who came under the category of skilled migrants in the 1970s have been incorporated into the group of skilled migrants. The study group of amnesty migrants included

two interviewees who were still illegal at the time of data collection. It is worth noting that family reunion migrants are distinct from 'amnesty' and business migrants in terms of the way they were admitted to Australia. Utilizing 'modes of being admitted to Australia' as the basis of sampling the users of health care, I have excluded family reunion migrants from this study despite their forming a large proportion of Korean migrants in Australia.[3] It is, indeed, rare for Koreans in Sydney to say 'He is a family reunion migrant' despite the large proportion of family reunion migrants in the Korean community.

I should also note that although I utilized snowball sampling and what is known as *theoretical sampling* to a certain degree, I did not use systematically grounded theory method to direct the entire process of data collection.

Sampling the Providers of Health Care and Other Services

From the inception of the study, I wanted to interview the providers of diverse health care services including *hanbang* doctors, in addition to the users of health care services. In most studies of traditional medicine amongst immigrants, the socio-economic context of traditional health care and the practitioners' views are not incorporated with the exception of Pang's (1989) study.

I attempted to cover as many providers of various health services as possible. I interviewed all of the eight biomedical doctors, the two physiotherapists, the podiatrist, three of the ten dentists, seven of the

[3] There is an argument that 'family reunion increases the number of semi-skilled and unskilled NESB migrants' (cf. Collins 1988: 270). This seemed to apply for Korean family reunion migrants who arrived in the 1970s and the early 1980s, but may not well apply for those family reunion migrants who have arrived since the mid-1980s because they are likely to be highly qualified or skilled migrants. However, whether it is true or not is open to further investigation.

fourteen herbal doctors and acupuncturists, a pharmacist, two optometrists, a funeral director, the owner of a deer farm, a Chinese-Australian herbal doctor, a Chinese-Australian ethnic liaison officer whose job involved working with several ethnic groups including Koreans in a community health centre, and five owners of health food shops in the Korean community. Given that I interviewed all practitioners of a few health services such as biomedicine, physiotherapy and podiatry, no sampling strategy was required. Random sampling of the potential interviewees from herbal doctors, health food shops and dentists was not practical. For example, out of the forty health food shops listed in a Korean alphabetical order in *Chugan Saenghwal Chŏngbo* (*The Weekly Korean Life Review* — 1995 February 10), I originally wanted to select every eighth shop. I thought that if the owner refused to participate, the next one would be contacted. If the next did not want to co-operate, the one prior to whoever was originally selected would be chosen. As many of them did not have time or did not want to participate, my desired sampling strategy with health food shops could not be implemented. Eventually I interviewed those who wanted to participate. However, I made sure that the sample was not all from the suburb of Campsie, where a large number of Korean owned businesses are located.

Of all the providers of health care in the Korean community, biomedical doctors were the ones whom I found most reluctant to participate in the present study. I am as grateful to them as I am to other interviewees. I was able to spend about 45 minutes with each of them. I felt that it was not possible to ask for any more of their time largely because they were too busy or because patients were waiting in the reception room. On one occasion, a receptionist asked me to make a 'special' appointment as a patient with the

doctor. However, I did not feel comfortable with the idea because my talk would not be profitable for the doctor.

The names of interview respondents in this study are fictitious. However, I have a personal list which shows both the fictitious and real names of the respondents and informants.

DATA COLLECTION METHODS AND PROBLEMS IN DATA COLLECTION

The data on health care services in Korea is based on secondary sources (journals, books and newspapers) and the data on the users and providers of health services in the Korean-Australian community are based on interviews and Korean ethnic newspapers published in Sydney. As far as data collection from the Korean community is concerned, it largely relied on interview methods, using semi-structured and open-ended interview schedules.

Interview Method

It was crucially important to use open-ended questions for this study because I wanted to listen to the rich and diverse experiences of different individuals without imposing any a priori categorization that might have limited what the respondents had to say. Despite possible misunderstanding between the interviewer and interviewee, interviewing is one of the most powerful ways that social scientists have in attempting to understand fellow human beings. As I used semi-structured open-ended questions, some interviewees complained that the question was too broad or too vague. As a reaction, I generally repeated the question or mentioned that they could say whatever they thought important of various relevant matters from their viewpoints. At other times, I elaborated the questions in general terms.

Given open-ended questions, most interviewees talked freely about their life experiences including health care use. Once the interview began, my important task was to listen to the respondents/ informants carefully and through my body language or verbal prompts encourage them to elaborate. I only occasionally interrupted their talk for clarification. In this respect, the respondents/informants had a great deal of control over what they had to say, but they rarely talked about aspects of their life which seemed entirely irrelevant to my questions. Some interviewees asked me to show them a structured questionnaire which they could fill in. My response was that a questionnaire is one way of understanding people, but I preferred an interview with open-ended questions, because human life is so complex and rigidly structured questions could not possibly accommodate the complexity. I also mentioned at the beginning of each interview that I was interested in listening to their 'happy and sad immigrant life experiences'.

Data Collection

I spent six months in the field at Sydney between January and July in 1995. The field work involved three stages: the first to carry out the pilot study, the second to interview the providers (i.e., biomedical, traditional *hanbang*, allied health practitioners, and health food sellers) and the third stage to interview the users of health services. It should be noted that I had already done some empirical work on a related project in the Sydney Korean community (i.e., Han 1994) and I had been in touch with various printed materials such as newspapers and magazines published in the Korean community. Therefore, I was not researching a community which was completely alien to me, although the area of investigation was a new one. The quality and quantity of the data from each stage of the field work provided me with an abundant source of information, which led me to pursue the following stage. While collecting data in the field, I constantly

examined the overall research design in the light of the collected data and to plan for the following stage.

I was not only able to interview a large number of people, sufficient for the purpose of the study, in six months, but also the information I was gathering soon started to be repetitive or reached the level of *saturation*. Although different groups of people, such as those who settled as amnesty migrants, skilled migrants, and business migrants, shared both similarities and differences regarding their immigrant experiences, there was little difference amongst those belonging to *each* of the three groups.

When arranging the time and place for interviews and at the beginning of each interview, I mentioned to potential interviewees that the project was about the origins of Korean migration to Australia, Korean settlement, health maintenance, and the use of health services and that their participation in the study would be invaluable (cf. Douglas 1985). A consent form, either in English or in Korean, was given and the interviewee was asked to sign it. Interviews took place in a place of the respondents' choice, this being mostly their homes.

During the second stage of field work, I interviewed 25 providers and 10 users of health services. In the last stage, I interviewed 35 consumers of health services. Most interviews lasted about 60-90 minutes. The total number of interviewees for this study reached over 120. Seventy formally arranged interviews which took place in the second and third stages were tape-recorded except one interview with a biomedical doctor because of his reluctance.

When I began the pilot study I was consciously attempting not to let my past knowledge of the Korean community affect the current research. I

maintained a similar stance when embarking upon the interviews with providers of health services as well as with the consumers, since I thought that if field work is properly carried out, the data collected from the three different stages should correspond to each other. Although there was an obvious correspondence between the views from the providers and users of health services, the correspondence was occasionally not as clear cut. For example, some respondents were reluctant to admit that they consumed Korean tonic herbal medicine (*poyak*), despite their admission of using herbs like ginseng for a similar purpose, because the use of *poyak* sometimes indicates their weak health and is viewed as undesirable. The comparison of the perspectives provided by the users and providers of health care has been an important source of cross-checking the data so that the validity has been increased (cf. Minichiello, Aroni et al. 1990: 210). The cross-checking has also served as a stimulus for examining, for example, why such discrepancies are observed rather than merely regarding them as 'distorted' or inaccurate (Silverman 1985). I would also mention here that what I learned from the pilot study was generally confirmed and supported by the second stage; and the second by the third stage.

Interview Opportunities

Firstly, the amnesty migrants who entered Australia with short term visas and immigrated under the category of amnesty were easily available for the interview and they were a more friendly group of people than were others to the researcher. However, those who were currently involved in work were more difficult to access. I was able to meet a small number of those who are still working. The number of people in this 'amnesty' group I interviewed reached 17.

Secondly, the skilled migrants were less accessible than the amnesty migrants. The greater reluctance to participate was largely a reflection of the fact that their immigrant lives had not been experienced as very successful, as well as their busy lives. Some appointments were even cancelled on a short notice. I was able to meet 14 of them. Thirdly, the business migrants tended to be highly restrictive in terms of their availability despite the abundant time they 'enjoy'. I interviewed 9 business migrants.

Part of the difficulty in meeting people is illustrated by the following comments. After interviewing him, I asked Mun Chin-ho who came as a computer programmer and currently runs a key cutting shop,

> *Would you introduce a few of your friends to me?*
>
> I would be quite uncomfortable to do that because they're so busy with their life. To be frank, I just don't feel like doing it. Everyone of them is just extremely busy.

In a Korean church in Sydney, I was introduced to a computer migrant who I learned was a prestigious university graduate from Korea. He was friendly to me when I first met him and he agreed to participate in the study one day. The husband and wife, with seeming kindness, invited me to their place. When the day came they left a phone message for me saying that the husband was supposed to do overtime for furniture delivery, which was his everyday work. The appointment was put off for a few days. I was well prepared to wait and meet his request. However, when the day came I got a message that they wanted me to ring them.

When I returned the call, the wife abruptly told me, despite my explanation as to why I would like to meet them,

> Why the hell are you bothering us? We don't want to have anything to do with you. We aren't having a successful immigrant life.

I didn't intend to disturb your private life. I would be grateful if you would share your immigrant experience, which would help me understand better how Korean immigrants have settled in Australia.

Anyhow, we don't want to see you. There're many other people who are much more successful here in Sydney. You may like to see them. Sorry we can't help you.

I'm terribly sorry and I apologize for any inconvenience I've caused.

Although this experience was a blow to me, I had to appreciate their right to refuse to participate in the study. The kind of dissatisfaction expressed above is prevalent amongst skilled migrants. As I was not able to meet as many people as I wanted I often asked about their friends as well, in order to have a broad view about each group and the whole Korean community.

It was even more difficult to meet business migrants. I asked business migrants why.

Why is it so hard for me to meet business migrants?

There could be many reasons. Why shouldn't they make themselves available? [saying in a cynical tone] As they aren't involved in business even a couple of years after their arrival in Australia, they don't want to say to you that they're doing nothing. You know many Koreans are simply not honest (Min Yong-mo, business migrant).

The so-called business migrants have come with lots of money, whereas the earlier arrivals [amnesty and skilled migrants] came with no money and had a hard time earning enough for their needs. Business migrants came with much more money than what the earlier arrivals earned for more than 15 years. This economic disparity led the earlier arrivals to turn away from the later arrivals. In fact, I felt they [the earlier arrivals] turned away from me soon after my arrival in Sydney. I could feel a sense of jealousy in the way in which they acted and behaved (Kim Tong-sik, business migrant).

This explains why business migrants tend to keep to themselves and do not mix much with those who are not business migrants. Even though I asked those business migrant respondents to this study to introduce me to their friends they were reluctant to do so. The president of the Business Migrant Association would not give me a list of the members, but introduced only

one of his good friends who was a member. Whether I appeared to be trustworthy to them made little difference.

Finding it too hard to meet business migrants, I attended a church, thinking that there should be at least a few of them there. The minister introduced a business migrant to me. As he was busy serving as an elder, I could talk to him only for ten minutes in the church. He gave me his phone number and told me to ring him a few days later. When I rang him he completely refused any kind of participation in the study. He said he was busy doing a part time course in a university. When I asked if I could see him any time at his convenience, I was told that he did not want to spare his time for me at all.

A Korean church minister told me that many business migrants tend to be ashamed of themselves so that they would not like to be the subjects of a study like this. There was little opportunity to meet business migrants at all or to develop a rapport with them (cf. Fontana and Frey 1994: 367).

My difficulty in meeting business migrants is clearly shared by Y. Kim (1995: 70-71), who carried out a major study about small business in the Korean community in Sydney and Melbourne. The representation of business migrants was predominantly low in his sample. This is illustrated by the fact that only 32% of his respondents had business experience prior to coming to Australia.

Whether or not business migrants or any other individual wished to participate in a study is their choice and it should be so appreciated. Although greater cooperation or their help would have enriched this study, I have provided only the evidence available to me with reference to the immigrant life of business migrants and the implications on their health

and the use of health care. Moreover, the proportion of the population of business migrants in the Korean community is relatively low, although the significance of the group's existence in the community cannot be underestimated. Nevertheless, relying on nine business migrant respondents, numerous informants, and health care practitioners, I believe I have been able to investigate the central issues about business migrants satisfactorily.

PRESENCE AND PRESENTATION OF THE RESEARCHER IN THE STUDY

In brief, I decided to present myself as a researcher rather than as a friend, particularly as a Korean researcher who cares for the health of fellow Koreans in Australia. However, I never posed as somebody superior to them. I wore modest but decent dress. I honestly mentioned that my research would not bring about immediate changes in the health of the Korean community in a few years time, but is an effort to have an input in the area. I also mentioned that I am one of very few endeavouring to understand the Korean community in Australia. My comment that I never lived in the Sydney area for a lengthy period led the informants/ respondents to give me detailed information. It also allowed me to ask freely about issues of which I was not aware.

Living mostly in Armidale, which is 600 km away from Sydney, also helped prevent me going 'native' as well. In other words, I was generally able to maintain a balance between boundless intimacy and controlled intimacy (Douglas 1985: 77). I was a 'native-as-stranger' in the field to a significant degree to borrow the words of Minichiello et al. (1990). If I had been a member of the Korean community in Sydney, I would have been able to observe some of its aspects in more detail. However, it would be equally true that I, as part of the community, might have overlooked other important

aspects. As a native Korean speaker, I did not have trouble understanding what the interviewees told me. With the exception of a few respondents who were skilled or business migrants, I did not come across any difficulties establishing a rapport with or gaining trust from the respondents (Fontana and Frey 1994: 367). Following the formal interviews, I was often invited to share meals, snacks or a beverage with them, which allowed informal 'interviews'.

Ever since I became involved in this project, I have felt disturbed in the sense that it is very hurtful to see many fellow Koreans who were enduring dissatisfaction and frustration caused by their harsh immigrant life. I have tried to stand in the shoes of my fellow Koreans. As I worked as one of the lowest paid workers in the health service sector, I, too, have suffered discrimination and problems which were often related to my non-Euro-Australian ethnic background. I have learned that the difficulties I had been through were not as bad as what many of my fellow Koreans have been through.

As I interviewed each respondent and informant I was often saddened by what they have had to experience. I have paid much attention to what they were saying and I have tried to avoid too many analytical or provocative questions, especially when interviewing skilled and business migrants. Had I been provocative, I might have been able to reveal the reality, more efficiently. However, it might also be the case that the interviewees might not have given me the information crucial to this study. It would have further damaged their self-esteem, in addition to what they had already experienced. I made a conscious effort not to dominate the interviews.

In general, my genuine interest about immigrant life and the experiences of the interviewees seemed to enable me to develop trust and confidence from

the interviewees (Finch 1984; Oakley 1981). As the interviewees and I had conversations centred around my research questions, I felt that they regarded the interview as an opportunity to share their life in Australia with a Korean researcher. In general, the respondents who were amnesty migrants shared more happily than other migrants.

DATA ANALYSIS

A constant use of *inductive* and *deductive* thinking and *verification* has been a major principle in the process of analyzing (coding) data from informants and respondents, which makes theory *grounded in data* – (Strauss and Corbin 1990: 111). First of all, open coding was carried out. This involved breaking down and analyzing words, phrases, sentences, and paragraphs and developing their properties and dimensions. The purpose was to identify concepts, events and incidents. They were grouped to form a category(ies), which is a classification of concepts. A category was discovered when concepts were compared one against another and appeared to be closely related to a similar phenomenon. The density of analysis was achieved by the making of comparisons, searching for similarities and differences between incidents, events and other instances of phenomena. This constant comparative analysis was carried out when comparing the immigrant experiences and health care use *between individuals* within each of the three groups comprising the subjects for the study and also *between the groups*. This open coding enabled me to keep myself distant from the data so that the best possible objective analysis of the subjective nature of the data was achieved.

For example, while coding, I discovered that when a Korean falls sick, he consults a biomedical doctor in the first instance because it is 'free'. As I found a few more similar cases, I proposed a tentative statement that Korean

men consult biomedical doctors first when they fall sick. Then, I attempted to verify what I have deduced against data as I compared the cases from one individual with another, i.e., verifying inductively what I proposed deductively. When a proposed statement was supported over and over again in the data, it was regarded as a contributing aspect to the theory under construction. When a proposed statement was not supported, it was discarded. This strategy has been applied to every relevant concept and event found in the data. At the completion of open coding, it became obvious that the data I collected from a few dentists was not relevant to the major themes of the study and thus they were not considered for further analysis.

The next stage of coding I undertook is known as axial coding, which involved making connections between major categories or between a category and its sub-categories by examining under what conditions and context an event occurred and by examining the consequences of any action/interaction that is taken. In my actual coding, open coding and axial coding were carried out alternatively and simultaneously. For example, 'immigrant life' as a whole turned out to be a major category. There are a number of sub-categories such as sŭtŭressŭ (stress), lack of English, work involvement, children's education, the experience of racial discrimination, etc. Whilst analyzing the emerged concepts from the data, which are closely related to these sub-categories, it became obvious that those sub-categories constituted the category of 'immigrant life'.

The discovery and specification of differences and similarities among and within categories is crucially important and they are a core aspect of the grounded theory method of analyzing data. For example, all Korean men seem relatively satisfied with their life in Australia. However, some are more reluctant to take up Australian citizenship. This can be understood not

only by comparing the life in Australia with that in Korea but also by comparing the values and life styles of individuals within each group as well as between different groups such as amnesty, skilled and business migrants.

The final stage of coding was selective coding. This was the process of selecting the core category (the central phenomenon under investigation, i.e., health care utilization) and systematically relating (or integrating) it to other categories. The task involved arranging and rearranging the categories in terms of the paradigm until they appeared to fit a descriptive narrative about the central phenomenon of the study, and to provide an analytic version of the descriptive narrative (i.e., a grounded theory). The final stage of data analysis involved deductively testing out the grounded theory against the data as a way of validating the emerged theory.