

Overview of Migrant Women's Health in South Korea: Policy Recommendations

Manka Eunice Fuh

Department of Public Policy and Administration, Yeungnam University, Daegu, Korea

Brice Wilfried Obiang-Obounou*

Department of Food and Nutrition, Keimyung University, Daegu, Korea

Abstract

Every year, the Republic of Korea (Korea) welcomes new immigrants, thereby transitioning from a homogenous society to a multicultural country. Of these immigrants, migrant workers represent the largest group, followed by women who immigrate as spouses to Korean men. One great concern of Korea's policymakers and healthcare providers is how Korea's healthcare system can handle the deterioration of health observed among married Asian female immigrants. The health care system, mediated by the competitive relationship between local clinics and hospitals exacerbate the problem. The authors present possible solutions to the problems through a conceptual model of the relationship between socioeconomic status (SES), Korean healthcare system, food insecurity (FI), and health status. Different policies are proposed including: before you/she come (s) policy, foreign women workforce participation policy, poverty alleviation policy, health insurance policy for migrant women, health professional training policy, food insecurity policy and dietary acculturation policy. More government owned hospitals or private clinics should be built in rural areas. Married migrant women with good income seem to enjoy better health. Developing rural areas through economic empowerment will certainly create job opportunities.

Keywords: Immigrant women health; Health policy; Socioeconomic status; Food insecurity; South Korea.



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1. Introduction

Every year, the Republic of Korea (Korea) welcomes new immigrants; thereby transitioning from a homogenous society to a multicultural country (Im *et al.*, 2014; Jun and Ha, 2015; Kim and Kim, 2013); with an estimated three out of every 100 persons being of foreign origin (Doo-Sub, 2014; Jun and Ha, 2015). Of these immigrants, migrant workers represent the largest group, followed by women who immigrate as spouses to Korean men (Doo-Sub, 2014; Im *et al.*, 2014; Jang and Kim, 2012; Jun *et al.*, 2014; Jun and Ha, 2015; Kim *et al.*, 2013a). Like, most immigrants around the world, these women come to Korea for economic reasons. However, as they settle in their new environment, they lose their health advantage. This has become a serious public health issue. One great concern of Korea's policymakers and healthcare providers is how Korea's healthcare system can handle the deterioration of health observed among married Asian female immigrants. For years, the U.S policymakers have been facing similar challenges with its thirty seven million Latinos that make up roughly 13 percent of the United States' total population. Contrary to other immigrant groups such as migrant workers, foreign students or professionals, these women come to Korea to stay. They are therefore permanent residents with children and a Korean spouse. As their health continues to decline, the same question posed by Reichman (2006) regarding the growing population of Latinos in the U.S applies: "How can it possibly accommodate people who communicate in a different language, come from different culture with different expectations of care, have no insurance coverage, and little or no money to pay, and often delay seeking help until, acutely ill, they rush to the emergency room"?

The poor health experienced by married Asian female immigrants could be multifactorial. Most Korean scholars who examined the issues surrounding the health (mostly mental health) of these women associate them with acculturation or the inability to speak Korean and adapt to the Korean culture (Ahn, 2012; Chae *et al.*, 2014; Choi, 2016; Hyung-Chul *et al.*, 2015; Im *et al.*, 2014; Kim *et al.*, 2010; Kim *et al.*, 2013b; Kim and Kim, 2013; Kim *et al.*, 2015; Lee *et al.*, 2014; Panuncio and Bae, 2012). Acculturation is the process by which a minority group adopts cultural traits of the host country (Abraido-Lanza *et al.*, 2006; Eamranond *et al.*, 2009; Moran *et al.*, 2007; O'Brien *et al.*, 2014; Obiang-Obounou, 2015; Okafor *et al.*, 2013; Rodriguez *et al.*, 2012; Sam and Berry, 2010). Numerous reports associate it to health problems (Hyung-Chul *et al.*, 2015; Jun *et al.*, 2014).

This article presents possible solutions to these problems through a conceptual model of the relationship between socioeconomic status (SES), Korean healthcare system, food insecurity (FI), and health status (Figure 1). By clearly identifying these different interactions and the consequence on health, social and health policies could be translated into programs for the well-being of these women and their children.

2. Socioeconomic Status

The relationship between SES and health is mediated by the healthcare system and food insecurity (Figure 1). SES is a complex phenomenon predicted by a broad spectrum of variables that is often conceptualized as a combination of financial, occupational, and educational influences (Winkleby *et al.*, 1992). Whether assessed by

*Corresponding Author

income or occupation, socioeconomic status is linked to a wide range of health and nutrition problems (Adler and Newman, 2002; Pampel *et al.*, 2010). Married migrant women are often economically challenged and unprepared before coming to Korea, thus find themselves below the poverty line.

2.1. Before You/She Come (s) Policy

Most of the international marriages usually take place through marriage agencies, thus husbands and wives are often strangers to each other (Panuncio and Bae, 2012). For a successful marriage, the need to learn each other's culture and language is to be encouraged. Some researchers recommended a social capital policy as a way to facilitate their assimilation processes (Jun and Ha, 2015). This approach is contrary to the Korean government's willingness to adopt multiculturalism. A multicultural country means that cultural diversity is acceptable. Such cultural diversity is usually not only seen within cross-cultural marriages but also within the broad spectrum of foreigners intermingling with other foreigners within a foreign country; and the different entities are free to keep their own culture. Rural areas in Korea have stronger traditional values such as the male-centered family structure where women are being forced to obey their husband rather than being supported by them Jun *et al.* (2014). The shock of cultures or the inability to quickly adapt may be the reason for the deterioration of health among these women, and consequently a higher divorce rate. As international marriages continue to rise in Korea, blames cannot be solely apportioned to the inability of these women to adapt to the Korean culture. While current policies do not allow a smooth integration of these women, Korean men should as well be prepared to welcome women from a different culture. On this premise, a "Before You/she come (s) Policy" that will prepare both husband and wife for a successful and happier life together in Korea is recommended. The decision by the Korean Ministry of Justice to require foreign spouses to take a Korean language test for a marriage visa is an unpopular one as it delays the bride and groom in starting a family. However, the "Before You/she come (s) Policy", if adopted in partnership with marriage agencies and the Ministry for Health, Welfare and Family Affairs, should give these women the time to learn the Korean language, culture, healthcare system and job opportunities as the Ministry of Justice processes the marriage visa. On the other end, the visa processing time should also prepare the groom to acquaint himself with his spouse food and culture.

2.2. Foreign Women Workforce Participation Policy

An employment for anyone gives a sense of worth. Even though Women have made an important contribution to economic growth in Korea, their labor force participation continues to be dependent upon their childcare responsibilities. In 1998, the East-West Center's Program on Population published a report investigating the links between Asian population change and economic growth in Japan, Taiwan, Singapore, Thailand, Indonesia, and Korea. The Korean woman's (in her late 20s or early 30s) participation in the labor market declines from 54 percent if she has no children, to 40 percent if she has one child, and to 28 percent if she has two children Westley and Mason (1998). Despite Korea's economic growth during the past 40 years, married women are still at a disadvantage in the labor market compared to single women and , not because of productivity (Lee *et al.*, 2008). Without any workforce participation policy reform, the unemployment rate among women will continue to rise and even become worse among married foreign women in Korea. The women who engaged into international marriages for economic reasons are coming to Korea to stay and are likely to also be the breadwinners of the family they left behind. A "Foreign-Women workforce participation Policy" encouraging the hiring of visible minorities, mostly foreign women will be both beneficiary for the country and the multicultural families. The policy will also allow a clear representation of changing demography in Korea. Furthermore, financial strain and/or unemployment are associated with mental health (Cordoba-Dona *et al.*, 2016; Linn *et al.*, 1985; Yoo *et al.*, 2016). Mental health or more precisely depression is a common problem observed among married Asian women in Korea. Almost 1 in 10 (9.7%) of Asian married female immigrants are depressed, a rate that is two to threefold higher than in the general Korean population (2.9-6.7%) (Jun *et al.*, 2014; Kim and Kim, 2013; Park *et al.*, 2016). The Korean Ministry of Justice and the Ministry for Health, Welfare and Family Affairs should work together to implement policies that recognize the education and skills of married Asian female immigrants for a quick insertion into the workforce.

2.3. Poverty Alleviation Policy

In monetary terms, poverty can be defined as levels of income or material wealth below a poverty line (Pinstrup-Andersen *et al.*, 2011). While there is no official poverty line in Korea, a family is considered poor if its income or expenditure falls below the Minimum Cost of Living measured (Park, 2004). There is clear decline of poverty in Korea due its rapid economic growth. The country, which was once known for its large-scale emigration, has recently emerged as a popular destination for immigrants in search of better life (Im *et al.*, 2014; Kim, 2015). In a study investigating factors associated with the mental health of foreign Asian women married to Korean men, women who rated their economic status higher were more likely to have better mental health. A "poverty alleviation policy" is therefore necessary. One way to alleviate poverty among this group is through education, training, skills recognition and acquisition integration and freedom to keep their own culture while they embrace the Korean values. Poverty has a direct association with health. Lack of health, education, and human dignity have been emphasized as key aspects of poverty (Pinstrup-Andersen *et al.*, 2011).

3. Korean Healthcare System

The Korean healthcare system has three arms: the National Health Insurance Program, Medical Aid Program, and Long-term Care Insurance Program (Song, 2009). Like any other country, Korea has a pluralistic medical system that allows patients to choose which treatment suits them best. People can choose between a conventional system of health care known as biomedicine, or a complementary and alternative medicine; the Korean traditional medicine. While the medical technology is well developed such as laparoscopy and robotic operation (Hviid *et al.*, 2015; Hwang *et al.*, 2016), the healthcare system, as designed today seems to present a greater challenge for married Asian female immigrants. First, the majority of these women live in rural and low income places (Hyung-Chul *et al.*, 2015; Kim and Kim, 2013). while most medical facilities are located in urban area with 90% of physicians concentrated in cities (Song, 2009). Second, the Korean Government has authorized the local clinics to handle the treatment of some 52 minor diseases as a way of encouraging patients to utilize these local health services instead of the higher medical facilities (Lee *et al.*, 2014). This policy now requires patients to present a referral slip from a physician in a local clinic in order for the patient to see a doctor in a hospital (Hviid *et al.*, 2015; Lee *et al.*, 2014; Song, 2009). This policy has two immediate consequences. One, married Asian female immigrants are often economically weak and this policy may discourage them from using healthcare services. Two, as mentioned above, most medical facilities are located in urban areas while these women live in villages. The competitive, rather than collaborative relationship between local clinics and hospitals, (Kwon, 2009; Lee *et al.*, 2014; Lee *et al.*, 2016). affects the health of patients, especially in rural places. Physicians' clinics are purchasing expensive medical equipment (Lee *et al.*, 2014). And should therefore be given the opportunity to immediately attend to the need of their patients. Reforms are necessary as evidenced by hospitals and clinics competing over the procession of patients. However, Korea is a world model as the country went from a private voluntary health insurance to government-mandated universal coverage in a short period of time (Lee, 2003).

3.1. Health Insurance Policy for Migrant Women

From the introduction of the mandatory social health insurance for industrial workers in large corporations in 1997 to the entire population in 1989, it took Korea only 12 years to achieve universal coverage of its population (Kwon, 2009). All Korean citizens are required to be insured under the National Health Insurance System. Married immigrants whose husbands are employed can register as a dependent. For these women, mostly living in rural areas with limited income, insurance fees are determined according to different factors (income, property, motor vehicle, age and gender) or 5.08% of the monthly income for those employed (Kwon, 2009). While the contribution does not seem to be much, it appears that household expenditure on health care impoverishes vulnerable families. Kwon reported that when the Korean national poverty line was set at the level of the minimum expenses of living, the proportion of households below the poverty line increased from 10.8% to 12.5% after spending on medical care (Kwon, 2009). The cost of healthcare is becoming an important debate in Korea, however, those economically stable are rarely affected. Because of the cost involved in medical care, migrant women married to Korean men will likely be reluctant to use healthcare services unless it is an emergency condition. While Korea is a model of universal healthcare and the national health expenditure has increased, it is still much lower than that of other OECD countries. A Mobile Clinic for Immigrant Women's Health is an investment that the government should consider. The mobile clinic could reach women in rural place with cultural competent health professionals. The Mobile clinics could also help in reducing health disparity between rural and urban populations.

3.2. Health Professionals Training Policy

Foreigners now represent 3% of the Korean population (Doo-Sub, 2014; Jun and Ha, 2015), mostly immigrants married to Korean spouses (Jun and Ha, 2015); with over 85% of foreign spouses being women (Doo-Sub, 2014; Im *et al.*, 2014; Jang and Kim, 2012; Jun *et al.*, 2014; Jun and Ha, 2015; Kim *et al.*, 2013a). While these women are mainly from China (52.8%), Vietnam (24.1%), the Philippines (5.1%), and Japan (4.1%) (Choi, 2016; Im *et al.*, 2014; Jun and Ha, 2015; Kim *et al.*, 2015), health beliefs due to culture or religion may be an obstacle for Korean health professionals to provide health care that is suitable and culturally acceptable by these populations. Ahn proposed a health care system integrating culture and linguistics (Ahn, 2012). This approach is encouraging for a country adopting multiculturalism. English is commonly used in Korea and many health professionals give treatments to their foreign patients in English. While being culturally sensitive is necessary for nurse and patient interaction, it appears very challenging to change a healthcare system for minority groups coming from different cultures, religions and speaking different languages other than Korean and English. However, the reform necessary for a multicultural society will be in education of nurses, physicians and other health professionals. This research proposes three reforms in healthcare services that could help in transitioning from a homogenous to a multiculturalist society. First, the Ministry of Higher Education should encourage universities to offer mandatory classes in acculturation and health. Cultural Competence allows future healthcare providers to be more culturally sensitive and aware, and to treat patients with more dignity. Second, Korea needs to welcome diversity in its healthcare services. Through its immigration policies, foreign students (mostly from representative minorities in Korea like China, Vietnam, Philippines and Japan) expressing the desire to stay in Korea should be encouraged to study nursing and medicine. Finally, a list of interpreters by region that can assist health providers when dealing with emergency or difficult cases.

4. Food Security

Food security exists when all people, at all times have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life (Choi *et al.*, 2011; Pinstруп-Andersen *et al.*, 2011). Food security incorporates food insecurity as it refers to the probability that a person will not have enough, safe and nutritious food over a specific period of time (Choi *et al.*, 2011; Chun *et al.*, 2015; Pinstруп-Andersen *et al.*, 2011). For married migrant women, especially in rural places, the challenge directly affecting their health is at two levels. First, their low income may not allow them to buy and eat the food of their choice, thus becoming food insecure. Second, coming to a new country means that they have to go through a nutrition transition or dietary acculturation. Dietary acculturation specifically refers to the process that occurs when members of a minority group adopt the eating patterns/ food choices of their new environment (Obiang-Obounou, 2015; Satia, 2010; Satia-Abouta *et al.*, 2002).

4.1. Food Insecurity Policy

Food insecurity often leads to unhealthy diet that eventually results to health risks (Ro, 2014). It is often associated with chronic diseases such as hypertension, hyperlipidaemia, and diabetes among people with lower socioeconomic status (Choi *et al.*, 2011; Seligman *et al.*, 2010). Most married migrant women in Korea fall in that category and are likely to be food insecure. Not having sufficient and nutritious foods, therefore, is possibly due to economic problems or lack of dietary acculturation. The situation is alarming especially for married female immigrants living in rural areas. In Korea, different reports agree that the rate of family food insecurity in rural areas (9.9%) was almost twice higher than the national average (5.4%) (Choi *et al.*, 2011; Kim and Kim, 2009). If these women are to lose their good health due to food insecurity, the government should empower them financially through workforce participation as mentioned in section 2.2.

4.2. Dietary Acculturation Policy

Culture-based food habits are often the last practices people change through acculturation (Kittler *et al.*, 2008). It is possible that the lack of availability of native ingredients will force immediate diet change. However, Kim *et al.* observed that Asian married female immigrants often missed meals at times and had nearly three times higher probability of developing a depressive disorder than those who rarely did (Kim *et al.*, 2015). It will be demanding for these women to master the Korean cuisine upon their arrival in Korea. Dietary acculturation should therefore be both ways in multicultural families. Korean men should be offered support and educational training that will enable them allow their foreign spouses present typical dishes of their home country.

5. Conclusion

Korea has the challenge to address health disparity of its population; mainly for migrant women living in rural areas. The health care system, mediated by the competitive relationship between local clinics and hospitals exacerbate the problem. Most private medical facilities are located in urban areas, and 92.1% of physicians and 90.8% of hospital beds are in urban areas, while 79.7% of the population live in urban areas (Song, 2009). More government owned hospitals or private clinics should be built in rural areas.

Other than that, married migrant women with good income seem to enjoy better health. Developing rural areas though economic empowerment will certainly create job opportunities. These women are in Korea to stay with most of their children born in Korea, and therefore Korean citizens. If women who are often the primary care givers could not properly function due to their health status mediated by their socioeconomic status, the Korean multicultural children are likely to be behind in the society.

Conflict of interest

The authors declare no conflict of interest.

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