

HISTORY

Korean immigrants began entering the United States via Hawaii in 1902 to work as immigrant laborers on sugar plantations. Over the next decade, churches and independence movements were established in Hawaii and California. 1910 saw picture brides coming to the U.S. from Korea. In 1919, the first Korean Liberty Congress was held in the U.S. to draw attention the plight of Koreans in then Japanese-dominated Korea. Other political actions were captured via journalism, music, and public demonstrations. On December 4, 1943, Military Order No. 45 was issued, exempting Koreans in the U.S. from enemy alien status. In 1945, the 38th parallel was set, dividing Soviet-occupied North Korea from American-occupied South Korea. The Korean War was fought from 1950 to 1953. In 1956, the first U.S.-Korean adoption agency was established, starting a trend of thousands of Korean orphans entering the U.S. Nearly 2,500 Korean businesses were damaged and destroyed in the L.A. Riots of 1992 (Chow, 2003).

DEMOGRAPHICS

The 2000 U.S. Census estimates that nearly 1,077,000 Koreans live in the United States and are the fifth largest Asian American ethnic group (U.S. Census Bureau, 2001). The Korean population of the U.S. in 2000 was nearly 78% foreign-born. Post-1965 Korean immigrants tended to come to the U.S. as families. Many of the immigrants were well educated but were unable to find employment in the U.S., sometimes due to their lack of fluency in English, and opened small businesses instead.

ENGLISH LANGUAGE PROFICIENCY

The ability to speak English has a tremendous impact on access to health information, public services (i.e. Medicaid, Medicare, SCHIP), effective communication with providers and emergency personnel, and the ability to understand and utilize medications properly.

Seventy-six percent of Koreans speak a language other than English at home, compared to 17% of white households. Forty-six percent are limited English proficient (LEP), compared to 8% of whites, and 39% are linguistically isolated vs. 4% of whites. Individuals who

are LEP are less likely to be insured, and less likely to receive key preventive health measures, such as immunizations, mammograms and routine checkups (APIAHF, 2005).

Most Korean Americans visited Korean-speaking doctors (76%), especially more recent immigrants and those less fluent in English (Han, et al, 1996).

Elder Koreans who have extreme difficulty with English often report using traditional Korean medicine, hanbang, and other over-the-counter Korean home remedies rather than going to physicians in the U.S. They avoid going because of communication and cultural difficulties (NIH, 2006).

POVERTY/INCOME

The relationship between income and health has been well established over the years. Poverty and lower income have been correlated with high rates of death and disease while higher income has been correlated with better health status. Large disparities in income have been linked to lower life expectancy in cross-national comparisons as well as higher mortality and obesity rates at the state level.

The per capita income for Koreans is \$18,027 compared to almost \$25,000 for the white population. Fourteen percent live below the federal poverty level and 30% live below 200% of the federal poverty level compared to 8% and 22% for whites (APIAHF, 2005).

Many Korean Americans reported using traditional healing practices, with 30% of medical services being provided by traditional doctors. This was particularly true among those with family incomes under \$10,000 (3.3 visits per year) compared to 0.7 visits for those with family incomes greater than \$50,000 (Han, et al, 1996).

EDUCATIONAL ATTAINMENT

According to the Institute of Medicine (IOM), the likelihood of being insured rises with higher levels of educational attainment. Having a college degree is strongly associated with multiple factors that increase the likelihood of being insured—employment in sectors that are more likely to offer coverage, higher income, and a greater likelihood of choosing employment-based

coverage if offered. Previous studies of Census data have shown that adults who did not graduate from high school were almost twice as likely to be uninsured as those with a high school diploma (38.5% compared to 19.6%) (APIAHF, 2005).

Koreans rank in the top five Asian ethnic groups that did not complete high school, with 14% having less than a degree. Koreans have a lower percentage of completing high school at most (37%) than the White population (52%), and a higher percentage of completing a college education at most (29%) than the White population (17%)(APIAHF, 2005).

IMMIGRATION/CITIZENSHIP STATUS

Citizenship status also has significant and widespread affect on an immigrants' ability to access health services and obtain insurance coverage. While an estimated 15% of Korean American citizens lack health insurance, 42% to 51% of non-citizens lack health coverage.

With 70% of Koreans foreign-born and 51% naturalized citizens, this ethnic group ranks in the top five of Asian groups who are foreign born (APIAHF, 2005).

HEALTH STATUS

It is difficult to characterize the health status of Koreans. Many studies do not differentiate between the various ethnicities studied. Small sample sizes make it difficult to generalize research findings. Finally, in some cases, data are just not available. For these reasons, the data contained here provide only a rough estimate of their health status.

ACCESS TO CARE

Having health insurance has a significant impact on the ability to get care, as well as the kind of care people receive. Until recently, few studies have provided insurance information on specific Asian American ethnicities.

Analysis of Current Population Survey data by the UCLA Center for Health Policy Research has found that Korean Americans had one of the highest rates of uninsurance among all racial or ethnic groups (34%), almost two-and-a-half times higher than the rate among non-Latino whites (14%). Much of this difference may be accounted for by the low rate of health coverage that Korean Americans receive through employment (48% compared to 73% among whites). This low employment-based coverage is thought to be due to a high degree of self-employment and employment in small businesses,

which are less likely to offer health coverage. In spite of the higher costs, more Korean Americans (14% compared to 5% among whites) purchase private insurance, yet this is unable to compensate for the lack of employment-based coverage. Additionally, only 1% of Korean Americans compared to 6% of Whites were covered by Medicaid (Brown, et al, 2000).

In 2003, 34.1% of Koreans in California aged 0-64 were without health insurance and only 37.2% received coverage through their employment (Brown, et al, 2005).

A 1999 study in Los Angeles County, California found that 49% of Korean-American residents under 65 years of age and 24% of those 65 years of age and older had no health insurance. Also, among Asian ethnic groups in the state of California, Koreans are more likely to be uninsured (45%) than Hispanics/Latinos (36%)(NIH, 2006).

According to a study in Los Angeles County, Korean Americans were found to have a lower annual number of doctor visits. On average, Korean Americans reported (NIH, 2006):

- 2.78 visits per year to MDs and doctors of traditional medicine compared to 5.92 visits among Whites, and 3.70 among African Americans and 3.75 among Hispanics.
- Korean Americans made far fewer visits than their counterparts in the Republic of Korea (10.7 visits), which has mandatory national health insurance coverage for all citizens.
- Women made more frequent visits to a doctor, compared to men; those over 65 years of age made the most number of visits (11.7).

In Korea, doctors are the authority and Koreans by and large trust doctors to make treatment choices. Therefore, Korean immigrants may be uncertain when faced with informed consent and must adjust to the idea of having the ultimate choice in their course of medical treatment (NIH, 2006). A study of older Korean Americans indicates that a higher satisfaction of healthcare utilization was observed for those with health insurance, better English-speaking ability, and trust in Western medicine (Jang, et al, 2005).

Overall, health insurance is the strongest predictor of Korean American utilization of health services (Ryu, et al, 2001).

CHRONIC DISEASES

HEART DISEASE & STROKE

The risk of hypertension varies by Asian subpopulation. In 2001, 18% of all Koreans specifically reported having ever been diagnosed with hypertension (NIH, 2006). A 1998-1999 study of 761 Korean Americans in Maryland showed one-third with high blood pressure (HBP), which was more common among men than women and those older than 50. Forty-percent of those with HBP were taking medication (Kim, et al, 2000). Nationally, 30.2% of persons aged 20 and older have hypertension or are taking hypertension medication (DHDSP, 2006). Family history of HBP, gender, level of education and acculturation, regular exercise and being overweight are risk factors for Korean rates of cardiovascular disease (Kim, et al, 2000).

Lack of insurance is the strongest barrier to receiving adequate care for high blood pressure, followed by not having a Korean doctor or a regular medical checkup (Kang, et al, 2006). More specific interventions need to be developed to assist the Korean subpopulation in managing their HBP, such as communicating in the Korean language (Kim, et al, 2005).

CANCER

Breast cancer is the most common cancer among Korean women (NIH, 2006). However, racial and ethnic minority women underutilize mammography and clinical breast examinations. In California, 53% of Korean American women aged 40 and older reported receiving a mammogram in the past two years (NIH, 2006). A survey of 1,090 Korean American women in two California counties revealed that only 34% of those aged 50 and older had a mammogram in the past two years, and only 32% had a clinical breast exam in the past two years. Those who had regular medical checkups were much more likely to have been screened (Wismer, et al, 1998).

Among Korean American women, English language proficiency is associated with receiving mammograms (Juon, et al, 2000) as is English proficiency and physician recommendation (Juon, et al, 2004). Data suggests that Asian grocery store-based cancer education programs have been effective in motivating Korean women to schedule a breast cancer screening (Sadler, et al, 2001). Other culturally responsive programs that are community focused (i.e. Korean grocery stores, churches, senior housing) need to be considered to provide viable strategies to reach Korean women (Kim & Sarna, 2004).

Cervical Cancer

The incidence of cervical cancer among Korean women exceeds 15 per 100,000 (NIH, 2006). In 2002, 12,085 women in the U.S. were diagnosed with cervical cancer (DCPC, 2006). While cervical cancer is common in Korean American women, only about 50% of Korean American women age 18 and older have had a Pap test. Women who have spent a larger part of their lives in the U.S. are more likely to have been tested (Wismer, et al, 1998). According to one survey of Korean American women, 26% of respondents had never heard of a Pap test, and the most common reason for not having been tested was the absence of disease symptoms (Kim, et al, 1999).

The 2000 Korean American Health Survey in Los Angeles County found that being married and insured increased the likelihood of having a pap smear within two years, a physical exam within one year and performing a self-breast examination (Sohn & Harada, 2005).

Focus groups indicate that economic barriers (such as lack of health insurance), time factors (working long hours) and language problems affected whether or not Korean American women were screened. Also, psychosocial barriers such as fear/fatalism, denial, embarrassment, and discomfort requesting the procedure from the physician have been documented. Focus groups also revealed misinformation and lack of knowledge about cervical cancer. Therefore, medical advice and education are important to influence women to undergo a Pap test and take preventative steps related to cervical cancer (Lee, 2000).

Focus group discussions also revealed that there was misinformation and a lack of knowledge about cervical cancer. The women were confused about the causative factors and preventive strategies related to cervical cancer. Many participants were recent immigrants with no medical insurance and long work hours. Participants stated that medical advice and education would influence them most to undergo a Pap test (Lee, 2000).

In 1994 and 2002, in Santa Clara County, California, Korean women are less likely to receive any preventive screening (i.e. Pap tests, breast self-exams, mammograms, etc) than all women in California (Moskowitz, et al, 2004).

A study of Korean American women in Alameda County, California indicated that having a non-Korean doctor was associated with an increased likelihood of having a Pap

smear, clinical breast examination and mammogram compared to having a Korean doctor. Study authors speculated that Korean doctors may not emphasize preventive health services (i.e. screening). Such a strong correlation was not made for other non-female related exams (Lew, et al, 2003).

Colorectal Cancer

While colorectal cancer is the second most common type of cancer among Korean American women and third among Korean American men (NAACCR, 1999), screening practices such as digital rectal exam (DRE) and fecal occult blood tests (FOBT) are greatly underused. Rates of DRE in Korean Americans aged 40-69 years were only 14% in men and 11% for women. Rates of FOBT were even lower: 11% for men and 9% for women. Similar to cervical cancer screening, length of residence in the U.S. was found to be associated with receiving screening (Kim, 1998).

Stomach Cancer

Stomach cancer incidence among Korean Americans is reported to be much higher than among other ethnicities in the U.S. Korean men have the highest rate of stomach cancer of all racial/ethnic groups (48.9 per 100,000) and a five-fold increased rate of stomach cancer compared to White men (Miller, et al, 1996).

INFECTIOUS DISEASES

HEPATITIS B

A study in Western Washington indicates that Koreans, Vietnamese and Chinese are affected by liver cancer more than other racial/ethnic groups. This risk is attributed to high rates of hepatitis B viral (HBV) infection and low rates of vaccination among Asian immigrants (Choe, et al, 2005). One study has indicated that immigrant parents need to have information on how it affects their children, how their children will recover, and how they will pay for the immunizations in order to increase vaccination status; in essence, there needs to be a social support network (Kim, 2004).

DOMESTIC VIOLENCE

In a 1993 study of 256 Korean men from randomly selected Korean households in Chicago and in Queens (which then had the largest Korean population on the East Coast) (Kim & Sung, 2000):

- 18% of the respondents reported committing at least one of the following acts of physical violence within the past year: throwing something, pushing, grabbing, shoving, or slapping their wife.
- 6.3% of the men committed what the researcher

classified as "severe violence" (kicking, biting, hitting with a fist, threatening with a gun or knife, shooting, or stabbing).

In a survey of a convenience sample of 214 Korean women and 121 Korean men in the San Francisco Bay Area conducted in 2000 by Shimtuh, a project serving Korean women in crisis (KCCEB, 2002):

- 42% of the respondents said they knew of a Korean woman who experienced physical violence from a husband or boyfriend.
- About 50% of the respondents knew someone who suffered regular emotional abuse.

A study of Korean American vs. European American male batterers showed that Korean batterers experienced more anger, controlled their anger less, were less independent, more avoidant and less anxious than European American male batterers (Kim & Zane, 2004).

MATERNAL AND CHILD HEALTH

Starting prenatal care as early as possible during a pregnancy is believed to promote healthier birth outcomes for both the mother and infant. A 1992-1996 study of Chinese, Japanese, Korean, and Vietnamese women in the U.S. showed that Korean Americans had a higher risk of beginning care late and even when beginning care early, were at a higher risk of receiving inadequate care. Having the same race as the father increased the risk of a late initiation of care for Korean Americans, and the cultural influences of this need to be studied more. Also, the two groups with the highest proportion of foreign-born women, Korean and Vietnamese Americans, indicated the greatest risk of receiving no care (Yu, et al, 2001).

In California, between 4 and 6.5 % of Korean, Japanese, and Chinese mothers had low-birth weight babies (NIH, 2006), compared to the U.S. average of 7.9% (NCHS, 2006).

API teens as a group are less likely than other female teens to become pregnant and give birth. However, Chinese, Asian Indian, and Korean teen females in California had rates around 10 per 1,000 (NIH, 2006). Although this is small compared to the 2003 U.S. teen pregnancy rate for teens aged 15-19 at 41.6 pregnancies per 1,000 females, specific materials targeting this group are needed (NCHS, 2005).

MENTAL HEALTH

Depression is more common among Korean Americans than it is among Chinese, Japanese, or Filipino Americans. However, depression levels among Korean Americans decrease among those with higher levels of acculturation (measured by language use) but also increase among those whose greater assimilation into U.S. culture has resulted in some loss of a connection with traditional Korean culture and identity (NIH, 2006).

A study of Korean immigrants found that a person's cognitive control (an individual's perception of control over life) is helpful in decreasing a possible detrimental effect of being exposed to stress (Kim, 2002). Another study of immigrants indicates those who report abandonment of Korean identity, traditions and values score higher for depression (Oh, et al, 2002).

SUBSTANCE USE

While few studies have been done on drug and alcohol use among Korean Americans, there is evidence that some Korean American adolescents do misuse alcohol, and are influenced by similar social factors as other adolescents (Nakashima, 2000).

TOBACCO USE

A California statewide survey estimated that lifetime smoking prevalence among Korean Americans is 16% (Chen, 1999). The 2001 Surgeon General's Report on Women and Smoking indicates the smoking prevalence among Korean women aged 18 through 24 years is 19.9% (Office of Women's Health, 2001).

However, in a study of Koreans in Chicago, Illinois, almost 90% of the women have never smoked, compared to 38.5% of the men who were current smokers. Respondents with a non-Christian background were 16.5 times more likely to smoke (Kim, et al, 2000). A study in Alameda County, California had very similar results with 39% of men versus 6% of women smoking and those who attended religious activities were less likely to smoke.

Smoking is more common in social circles in Korea, but is more stigmatized in the United States. This prevalence of smoking among Korean men places them at risk for smoking-related diseases and more attention must be placed to this specific subpopulation. Health messages related to secondhand smoke are also an important step (Lew, et al, 2001). Smoking has also been linked to acculturation levels. Korean American men who were categorized as "bicultural" were least likely to smoke, while among women, those who were

"acculturated" and "bicultural" were more likely to smoke than "traditional" women (Lee, et al, 2000).

A study of smoking cessation indicates that California residents of Korean descent are more likely to quit smoking for 90 days if they have lower acculturation, higher body mass index, a social network discouraging smoking, home smoking restrictions, correct beliefs about smoking harm, and significant concerns about their health. Such social and situational conditions need to be included in designing smoking cessation programs for Korean Americans (Ji, et al, 2005).

NUTRITION, WEIGHT AND PHYSICAL ACTIVITY

A nutrient intake study of immigrant Korean American women ages 40-69 in Chicago, Illinois indicates that their diet had not changed substantially from Korea to the United States. However, Western food has been incorporated with 60% of calories coming from carbohydrates and 16% from fat (Park, et al, 2005). Recommended intake is 20 to 35% of calories from fat and 45 to 65% for carbohydrates (USDA, 2005). Dietary interventions need to be culturally competent, including cultural foods as well as healthy incorporation of Western foods (Kim, et al, 2000). Another study of Korean Americans born in the U.S. vs. Korea found that obesity and nutrient intake varied. 31.4% of U.S.-born Korean women were overweight or obese, compared to 9.4% Korean-born women. U.S.-born women had higher intakes of fat, grains, and red meat and lower intake of fruits and vegetables. Neither group met recommendations for dietary intake. Therefore, acculturation to a Western diet may increase risk for a myriad of chronic diseases (Park, et al, 2005).

An exercise program in Seattle, Washington for Korean elders, ages 67-86 in senior housing was proven to be effective when taking into consideration how Korean values and beliefs influence health management behavior (Sin, et al, 2005). A study of Korean women in Texas indicates that physical activity is connected to health, but physical activity is seen as the opposite of death. However, women stated they rarely participate in exercise because of their busy lives (Im & Choe, 2004).

RESOURCES

The following agencies are able to provide additional information regarding the Korean American community:

Korean Health Education, Information, and Research (KHEIR)

266 South Harvard Blvd. 3rd Floor
Los Angeles, CA 90004
Tel: (213) 637-1070
Fax: (213) 251-8647
Website: <http://www.koreanhealth.org/>

Korean American Community Services
4300 N. California Avenue
Chicago, IL 60618
Tel: (773) 583-5501
Fax: (773) 583-7009
Email: info@kacschgo.org
Website: <http://www.kacschgo.org/>

Asian Health Coalition of Illinois
4753 N. Broadway, Suite 614
Chicago, IL 60640
Tel: (773) 878-3539
Fax: (773) 878-0783
Email: hong@asianhealth.org
Website: <http://www.asianhealth.org/>

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ABOUT THIS SERIES

This health brief is part of a series of that includes Cambodian, Chamorro, Chinese, Filipino, Hmong, Japanese, Korean, Native Hawaiian, Samoan, South Asian, and Vietnamese. All are available for download at www.apiahf.org.

Purpose

The purpose of the series is to summarize published research findings of disparities in the health and healthcare of the selected group. The data presented is meant for community health advocates, grant writers, evaluators and students as a tool to raise awareness, guide program development and spark future research for the well-being of Asian American and Pacific Islander populations.

Methods

This brief was updated after a PubMed literature review. In order to find the latest information, the Pubmed literature search focused on the years 2000-present and each ethnic group was cross referenced with these focus areas: access to quality health services, arthritis, osteoporosis, and chronic back conditions, cancer, chronic kidney disease, diabetes, disability and secondary conditions, education & community-based programs, environmental health, family planning, food safety, health communication, heart disease and stroke, HIV, immunization, infectious disease, injury & violence prevention, maternal, infant & child health, medical product safety, mental health & mental disorder, nutrition & overweight, occupational safety & health, oral health, physical activity & fitness, public health infrastructure, respiratory disease, sexually transmitted disease, substance abuse, tobacco use, and miscellaneous topics. For the Korean health brief, the search cross-referenced the term Korean American with the aforementioned areas.

Limitations

It is difficult to characterize the health status of specific Asian American or Pacific Islander ethnic populations. Many studies do not differentiate between the various ethnicities studied. Small sample sizes make it difficult to generalize research findings and in some cases, data are just not available. For these reasons, the data contained here provide only a rough estimate of health status and are not an exhaustive presentation of the findings, nor are they meant for medical decision-making.

Contributors

This series was revised in 2006 by Gem P. Daus, MA, Mona Bormet, MPH, and Sang Leng Trieu, MPH, with research assistance from Doris Chen. You may send comments and questions to healthinfo@apiahf.org.