Transnational Use of 'Medicines': A Case Study of Returned Ethnic Koreans

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Abstract

This paper is to illustrate how returned elderly ethnic Koreans from Russia and Germany seek medical care by combining the medical resources they have in two countries, Korea and their former host countries. This is a case study to examine how transnational health seeking behaviours, an emerging topic in globalisation and health research, can be applied to Korean transnational migrants. It draws on anthropological fieldwork in the two collective residents of Gohyang Mael(hometown village) and Dok-il Mael(German village) where returned elderly ethnic Koreans from Russia, especially Sakhalin, and Germany live their retired lives, respectively. The paper firstly describes the transnational practices of these two groups of elderly ethnic Koreans in the use of medical systems of both countries in the context of their transnational migration trajectories. Then it discusses the underlying issues associated with being a transnational medical seeker. And finally the implications of the findings will be identified to improve the capacity of the Korean medical system to accommodate transnational migrants including increasing numbers of returned ethnic Koreans.

Introduction

First generation Koreans had migrated to China and the CIS (Commonwealth of Independent States) countries from the early 1900s to the Liberation in 1945. As their descendants began to return to South Korea since the 1990s in addition to other first generation immigrants who went to North America and Europe, especially Germany, between the 1960s and the 1980s, some neighbourhoods in the country have been gradually transformed into collective residential areas of these ethnic return migrants. Parts of Daerim-dong in Seoul and Wonkok-dong in Ansan with Chinese Koreans and regions of Gwangsan-gu in Gwangju with Koreans from CIS countries are few examples of such locations.

In hindsight, however, many of these ethnic Koreans who seemed to return to ‘their

homeland' did not return permanently. Rather, most of them returned alone leaving behind other family members including their children and they themselves and their family members were often coming and going between Korea and their countries of immigration. In this respect, this returning of ethnic Koreans can be seen as a form of transnational migration which has been generalised since the 1990s.

By the now-classic definition, transnational migration or transnationalism of international migrants is "the processes by which immigrants forge and sustain multi-stranded social relations that link together their societies of origin and settlement."(Basch, Glick-Schiller and Blanc 1994) And one of the main reasons why immigrants remain in connection with their countries of origin even after their relocation has turned out to be very practical: they want to combine the resources from both societies to enhance the possibility to survive and thrive. The same story can be applied to immigrants' health seeking behaviours more than any other aspects in the lives of immigrants. There is a huge body of research emphasising immigrants' transnational health seeking behaviours as an effort to find the most suitable ways to increase their health status or to complement their vulnerability as many of them are faced with limited access to host countries' health care systems and declining health status.

This paper is to illustrate how returned elderly ethnic Koreans from Russia and Germany seek medical care by combining the medical resources they have in two countries, Korea and their former host countries. This is a case study to examine how transnational health seeking behaviours, an emerging topic in globalisation and health research, can be applied to Korean transnational migrants.

It draws on anthropological fieldwork in the two collective residents of Gohyang Mael (hometown village) in Ansan and Dok-il Mael (German village) in Namhae where returned elderly ethnic Koreans from Russia, especially Sakhalin, and Germany live their retired lives, respectively. An additional fieldwork was done in Namdong Sahalin (Southeast Sakhalin) Center in Incheon. This current study is based on a research project entitled "Health, Illness and Medical Experiences of Korean Ethnic Return Migrants and Transnational History of Medicine" funded by Korea Research Foundation. The fieldwork was conducted for four months over two separate periods: in Gohayng Mael from November 2016 and February 2017 and Dok-il Mael in August 2017. During these periods, participation observation as well as formal and informal interviews with the participants were done.

The paper firstly reviews the literature on transnational health seeking of international migrants to put this research in context, and then explores the existing body of literature on migrants' medical experiences in Korea to reflect how these studies lack the transnational perspective. Next, it describes the transnational practices of these two groups of elderly ethnic Koreans in the use of medical systems of both countries after briefly looking at their transnational migration trajectories. Then it discusses the underlying issues associated with being a transnational medical care seeker. And finally the implications of the findings will be identified to improve the capacity of the Korean medical system to accommodate transnational migrants including increasing numbers of returned ethnic Koreans.

Literature Review on Migrants' Medical Experiences

Transnational medical seeking can be defined as patients' movements across national borders in search for appropriate solutions for their medical problems and the exchanges of medicines within people's personal transnational networks. Studies on this phenomenon would fall into the following categories: medical tourism, transnational care of chronic diseases, transnational care and cure networks, transnational strategies for enhanced medical treatments, and transnational medicine as a reluctant alternative for marginalised immigrants.

First, a stream of research on medical tourism has been done where people go abroad seeking newly developed medical technologies and treatments that are unavailable or illegal in their own countries. Such movements can largely be identified among middle and upper class people using private medical services in foreign countries. Research in this regard includes transnational medical consumers seeking assisted reproductive technology such as surrogate mothers and in vitro fertilization (Hoof and Pennings 2013) or organ transplantation (Schiano and Rhodes 2013)

Also, the ways in which chronic illnesses are defined and managed in the context of transnational migration has been previously explored. A study on how Pakistani immigrants in Norway respond to signs and symptoms of dementia notes that this immigrant group negotiates dementia in the space between their own imported, culturally defined system of cure and care, and the host society's health-care culture (Naess and Moen 2015). Another study on transnational migrants in Canada receiving cardiac rehabilitation show that these patients hybridize "knowledges from cardiac

rehabilitation, experience with their own bodies and general 'wisdoms' passed on within their own and other immigrant communities" to manage diabetes self-care and to reduce cardiac risk (Seto et al., 2012).

Some studies examine care and cure through transnational networks. Immigrants form transnational social relations with their families, relatives or hometown communities. Even though these may not be on a face-to-face basis, such relationships are mobilized in times of medical emergencies (Baldassar 2014), for example, care for pregnant Bangladesh immigrant women living in New York (Chakrabarti 2010), and medical treatment of Guatemalans in the US (Menjivar 2002) and South Africans living in London (Thomas 2010).

Day-to-day transnational medical seeking among immigrants who have personal networks between the two countries or knowledge of and access to both countries' medical systems is investigated mainly through the cases of Mexican immigrants in the US. A study on Mexican parents living on both sides of the US-Mexican border who cross the border for their children's medical care shows that they do so to achieve desired outcomes in a health-care field employing their transnational cultural capital (Grineski 2011). Another study examines a similar case where once-poor Mexican farmers who obtained economic capital after immigrating to the US return to their home country for high-end private medical services to illustrate that transnational medical strategies are a process of mobilizing available capitals in a transnational space (Horton 2013).

Meanwhile, there are studies which describe transnational medical seeking as a reluctant strategy and suboptimal alternative. South Americans living in London have to adopt transnational medical strategies because of unofficial barriers for immigrants to the public health care system even though they have legal access rights to the system (Gideon 2011). Mexicans in the US who have limited access to the host society's medical insurance due to their legal status have to travel back to their own country for medical treatment or have to rely on various traditional, alternative, folk remedies while they are in the US (Gonzalez-Vazquez et al. 2013).

There have been almost no studies done so far which attempt to understand the transnational medical experiences of immigrants in Korea, including returned ethnic Koreans. The few that are available focus on ways to encourage the participation of overseas Koreans in Korean medical tourism (김동수 2014; 민혜성 2016 등). As for domestic research on migrant health (권구영·박근우 2007; 김윤영·조일동 2016; 김혜련

2010 등), it points to the problems in migrants' access to health services in Korea because of low income and language and cultural barriers, but never succeeds in recognizing migrants' medical experiences as transnational.

Domestic research on the health of returned ethnic Koreans are faced with similar limitations to those of migrant health mentioned above. Most of the research in this area has involved returned ethnic Koreans from China and Sakhalin, Russia. With those from Sakhalin, studies have been conducted on the efficacy of group therapies (박여리 2014; 김경숙·임은희 2012; 황현옥 2004) as well as on the mental health status of the people (김경운·권기창 2015). And with returned ethnic Koreans from China, a greater number of studies have been done including research on their mental health (김한호·우국희·한일숙·이연순·김종례 2010; 백지은·송진희·홍현숙·한혜리·이태경·노성원 2008; 양승민 2008; 문용철 2007; 김옥수·김계하 2003; 김옥수·백성희·김계하 2003; 민성길·이경매·오희철 2004; 허춘영 1999), health promotion behavior (김향란·송미순 2016; 이현경·김정희·유 리·이자인 2016; 김소령·김정순·김동희 2011; 조결자·조미선·박선희 2008) and physical health status (이현경·채덕희·이경은·이민혜 2013; 김선정·이현경·안현미 2010).

Despite the diversity in themes, from risk factors for migrant health, to migrants' responses to these risks, to factors that influence their health promotion, all these pre-existing studies have a common presumption: factors and responses that have impacts on migrant health are limited to a domestic level. Under this assumption these studies argue in unison that health and medical delivery systems in Korea should be improved to be able to provide protection for immigrants who are exposed to the risks of migration. As a result, these studies never consider the fact that the risk factors for migrant health might come from their home countries or that migrants could mobilize resources and capitals from their societies of origin through transnational social relations. However, as implied in a study (감신 2007) which suggests that building a database of sending countries' labour markets and economic and social situations would help make appropriate health policies for returned ethnic Koreans from China and CIS countries, "it is essential to consider migrant health as a truly transnational phenomenon (Duncan 2014: 13)."

Migration Paths of Ethnic Koreans from Sakhalin, Russia and Germany

It was after the year of 2000 that ethnic Koreans from Sakhalin, Russia and Germany began to return to Korea in full scale. Ethnic Koreans from Sakhalin preceded those from

Germany. From as early as 1956, there had been sporadic movements to repatriate around 43,000 Koreans who stayed behind in Sakhalin even after the Liberation of Korea from Japan. They were part of the 150,000 Koreans who had been conscripted into forced labour between the late 1930s and the early 1940s under 'the National Mobilization Act' in 1938. But it was not until the late 1980s that serious efforts were made to repatriate them. By 1994, Korea and Japan agreed on "the Pilot Project of Repatriation Program for Ethnic Koreans in Sakhalin". The program was to build a sanatorium and an apartment complex for "the first generation people" who were defined in the agreement of both governments as "those who were born or moved to Sakhalin before 15 August 1945 and had lived there since then". The Korean government provided the land and the Japanese counterpart the finances for this project. In the meantime 82 households returned to Korea from Sakhalin between September 1997 and December 1998 and settled in Seoul and Incheon. The sanatorium and the apartment complex were built in Incheon and Ansan respectively in 1999, and from 2000 the apartment complex, "Gohyang Mael" began to admit the residents. The repatriation program was expanded between 2007 and 2009: over 2,000 ethnic Koreans returned during this period and "the second generation people", referring to the spouses of the first generation Koreans and their disabled children, were also allowed to return from 2008. The program which was supposed to end by 2009 continued until 2015 as a joint project of both governments and since 2016, it has been carried on by the Korean government alone on a smaller scale of 20 people a year.

As of 2015, 4,368 ethnic Koreans have returned from Sakhalin and 3,035 are living in 22 areas nationwide except for those who passed away and those who went back to Sakhalin. Among these residential areas Gohyang Mael in Ansan is the largest with 655 residents and Nonhyeon district in Incheon is the second largest with 458 returnees. Once settled in Korea they are entitled to the benefits for lower income earners and the elderly, along with some other benefits and one-off financial support for settlement. According to a returnee who works for one of the elders' associations, they receive "about 500,000 won per month." They are also the first grade recipients of the national medical care in Korea. However the benefits are not their sole source of income. One returnee stated that many of them receive pensions from Russia and own properties in Sakhalin or other parts of Russia.

Most of those returning from Germany initially went to the country as contract miners and nurses from the late 1960s until the mid-1970s and settled there before they came

back to Korea after retirement. They returned to resettle collectively in a village called Dok-il Maeul in Namhae-gun, Gyeongsannam-do. Dok-il Maeul was created as a part of the Culture and Art Village Building Project of Namhae-gun in the year 2000. Korean immigrants in Berlin and Hamburg who helped public officials of Namhae-gun purchase grass for a public stadium in 1997 suggested building a village for retired German Koreans in Namhae and this proposal was accepted by the county governor at the time. The project was presented to the Korean immigrants in Germany in 2000, land contracts were made and construction work began in 2001, and the returnees started moving in from 2003. Following the first three households, other returnees in their 60s began to move in. The residents could be grouped into three types of households: single households, Korean couples most of whom married in Germany after they went as single migrant workers, and Korean-German couples where Korean women who were nurses married German men. In 2012 there were 34 households of returnees from Germany but in 2016 the number dropped to 13 as many of them returned to Germany or moved to other places in Korea, according to one returnee. The main income sources of the returnees from Germany are pensions from Germany and earnings from lodging.

These returned ethnic Koreans are in fact not permanent returnees despite the official naming of "permanent return". After returning they are still coming and going between the two countries and many of them own their houses in Russia and Germany. Their children frequently visit them in Korea.

For the returnees from Sakhalin, this shuttling is institutionalized. As a way to soften "the too rigid conditions" for "permanent return" limited only to "the first generation people and their spouses and disabled children" which have been accused of creating "new family separation", a maximum 90 day period "revisitation" is allowed with airfares subsidized. But "the financial support is not enough for the applications" so one can have a chance in three years at best. Many of them, however, visit Sakhalin with their own expenses. Meanwhile their children in Russia frequently come to visit them in Korea, and this is one reason most of them do not want to go to the nursing home despite their ailing health. If they move to a nursing home, there would not be a place for their children to stay when they come to Korea for work.

A similar situation is observed with the returnees from Germany. When these people built their houses in the early 2000s, they did so over years, coming and going between Korea and Germany. After their relocation most of them visit Germany once or twice a year staying for months at a time. Their children also visit Korea frequently. In many

cases married children regularly come to Korea with their own families. Many returnees have their houses in Germany and plan to return when they need to do so.

Personal profiles of the Participants

	Gender(Year of birth/return)	Occupations/ place of residence before migration/year of migration	Reason for Migration	Place of residence before/after return	Education/occupations in the host country	Incomes in Korea	Accompanied (left behind) family members
A	Female(NA/2003)	Public health officer/Busan/1970	To work as a contract nurse	Mainz/Dokilmaeul(GV hereafter)	NA/Nurse	Pension from Germany	German Husband (Four Childrean)
B	Female(1950/2007)	NA/NA/1979	To visit an elder sister working as a nurse from 1970	Hamburg/GV	NA/Running an Asian restaurant	Pension from Germany, lodging	Husband (Two sons)
C	Male(1949/2007)	NA/Taebak/1977	To work as a contract miner	Hamburg/GV	Running an Asian restaurant	Pension from Germany, lodging	Wife (Two sons)
D	Male(1943/2009)	Born in Sakhalin(Chekhov, Noda at the time of birth)	Father from Gyeongsangbuk-do to Sakhalin in 1938 to work as a miner to	Yuzhno-Sakhalinsk/Busan	University graduate/military officer	Pension from Russia and benefits from Korea	Wife (One son and one daughter)

			avoid military conscription				
E	Male(1941/2009)	Born in Sakhalin(Krasnogorsk, Jinnai at the time of birth)	Father from Okaka to Sakhalin in 1927 to look for employment opportunity	Yuzhno-Sakhalinsk/Busan	University graduate/Medical doctor(cardiologist)	Pension from Russia and benefits from Korea	N/A
F	Male(1943/2009)	Born in Sakhalin(Uglegorsk)	Father conscripted into forced labour from Hamgyeongnam-do in 1939	Khabarovsk/Gimhae	University graduate/Medical doctor(neurologist)	Pension from Russia and benefits from Korea	Wife (One son)
G	Female(1949/2009)	Born in Sakhalin(Uglegorsk)	Father moved to Sakhalin in 1941 to look for employment opportunity	Nahotka/Gimhae	University graduate/accountant	Pension from Russia and benefits from Korea	Husband(Two sons)

Transnational Use of 'Medicines' of Ethnic Return Migrants

Given that most returned ethnic Koreans are in old age, it is natural that they are experiencing many health-related problems. As a returnee puts it, "as we are getting old...everyone is sick." A traditional Korean medicine doctor who sees many Sakhalin returnee patients says, "their health status is largely similar to that of native Koreans of

the same age group."

For the returnees from Sakhalin, in-house medical care services are provided within their collective residents. For example, in Gohyang Maeul domiciliary health services are provided where health professionals visit patients of old age and with chronic illnesses in their homes. A traditional Korean medicine doctor resides in the complex offering free of charge consultations and treatments for the residents, along with a few nurses providing basic health services like checking blood pressure or blood glucose levels. Moreover, as these returnees are the first grade recipients of the national medical care, they pay little or nothing at all for their hospital visits.

Despite these measures, however, the returnees from Sakhalin are experiencing difficulties in using Korean medical services. Initially the language and cultural differences were the biggest limitations. But this problem has been mitigated as most large hospitals now have interpreters, the returnees are preparing themselves by "studying with the Korean dictionary" or "asking the nurses in the complex" before seeing the doctors, and according to a health professional, "they are getting a similar level of [medical] knowledge as native Korean elderly people as they have stayed longer and have learned through contacts with Korean doctors."

But the real problem is medical expenses. Even though the returnees are the recipients of the national medical care, they have to pay excess fees when they are treated for serious illnesses or have expensive medical tests done in large medical centers. "In some situations such as cancer operations these fees would be well over 10,000,000won". For these cases, emergency financial support is allocated, and "other budgets such as catastrophic health expenditure, life-long care or emergency aid are also available." However emergency financial support is limited to 3,000,000won and the budget for catastrophic health expenditure is only available between March and September every year. No such expenditure is allocated in the budget between October and February the following year. These means only those with financial support from their children could be treated for serious illnesses in large general hospitals.

Another problem related to serious illness is that patients with those conditions only have few people who can take care of them. Their children are hardly available since they live in Russia. Care giving nurses are only available for 20 hours a week and the cost of hiring private care givers, at 80,000won a day, is financially unbearable. Those without anyone to take care of them could be admitted into the Sakhalin Welfare Centre in

Incheon but not without a long waiting period because only 100 patients can be accommodated. In such circumstances, some elderly returnees "exchange care giving" when they are sick.

Due to the issues mentioned above, returned Koreans from Germany prefer to receive medical treatments there. After all, they are entitled to free care in Germany because all of them pay German public health insurance depending on their pension income even after they returned to Korea. In case of hospitalization no other care giver is needed as the nurses in hospital take care of them. And as most of them have lived in Germany for more than 20 years and many had previously worked as nurses they are used to the German medical system. Moreover, they visit Germany at least once every year and still have their houses there. In this situation they do not see any reason to use Korean medical institutions except for emergent operations, regular check-ups or "simple...outpatient treatments"

In fact using other countries' medical systems was considered as something very unusual and only for the rich and privileged in the past. For ordinary immigrants, medical practices crossing borders were, at best, bringing medications they could easily access in their home countries into the countries they immigrated or vice versa. In less common cases, those who lived in the countries with more advanced medical technologies invited their family members from their countries of origin to have medical treatments that were unavailable or not affordable in their home countries.

These practices are still maintained. Participant B had to bring the medication that she had taken for many years in Germany to Korea because the alternative medication that her Korean doctor had prescribed "did not work". Among the returnees from Sakhalin there are many people who buy particular medication when they visit Russia. Even though identical alternatives are also sold in Korea, they wish to buy those precise products saying the Korean medications do not work. Families and relatives are still being invited over for the purpose of medical treatments. A returnee from Sakhalin invited her daughter and son-in-law to get a colonoscopy done, a test that is not as easily accessible in Russia as it is in Korea.

These transnational medical practices have been normalized since the 1990s as transnational migration began to spread. This means that transnational migrants' selective utilization of the medical systems of both their countries of origin and destination has become a well-established practice. Participant B who had "a big

operation" in 2016 in Germany says that she decided to have the operation in Germany after she was diagnosed in a Korean hospital and found the operation would be "huge and expensive". There are some medical treatments the returnees from Sakhalin seek whenever they revisit the island. The most popular is a natural therapy in the sanatorium in Sinegorsk and patients referred by doctors are able to use this sanatorium for free. Here people receive physiotherapy with the mud and "those who have a stomach trouble" drink "mineral water coming out of the place". Others regularly visit Sakhalin to have vitamin intravenous injections and still others come to the island every summer for the same medical treatment they have been receiving for decades.

The normalization of transnational medical practices was made possible because more transnational migrants were able to join in both countries' public health insurances as more countries began to acknowledge dual memberships to accommodate transnational migrants. Returnees from Sakhalin can benefit from Russian public health insurance when they are in Russia while returnees from Germany can even be reimbursed from their German health insurance, any excess fees they paid in Korea.

However, transnational medical practices do not go without problems. As a returnee from Sakhalin observed, elderly ethnic Koreans from the island are prescribed Korean medications from Korean doctors while they are in the country. The problem arises when they bring back to Korea the medication that was prescribed to them during their revisit to Russia. Those who have had medical treatments in Korea should only follow the Korean doctor's directions, according to the returnee, but instead these people take medications at their whim.

Participant A, a retired nurse, explained another problem associated with transnational medication. She found that, when she took medication brought from Germany, it was impossible for her to check with her doctor how the medication was working and control the administration accordingly, which normally would have been done every four to six weeks. For this reason, she no longer takes medication from Germany. One solution for this problem, according to participant C, is that he takes Korean medication for illness that started in Korea and German medication for ones that he acquired in Germany.

There is a good case which shows that these transnational medical practices are done according to some clear references. As the native Korean elderly people do, the returnees from Sakhalin often use acupuncture by traditional Korean medicine doctors, especially for various musculoskeletal disorders. With these treatments, however, according to a

traditional Korean medicine doctor, nearly all of the patients self-imposedly preset the number of treatments to 10 sessions. When a few returnees from Sakhalin were questioned about whether this was truly the case and their reasons for doing so, they gave the same answers: In Russia doctors say that it should not be done to have electrotherapy for too long. More than 10 to 15 treatments [in one treatment period] are rather harmful. A two or three week suspension is needed before the treatment is resumed. Similar limitations were also being applied to the mud bath or treatments in the sanatorium.

Meanwhile participants E and F who are retired medical doctors gave their explanations of this as followed. (I was informed that in the medical systems of the former Soviet Union and Russia, formally trained and certified biomedical doctors could administer acupuncture treatments upon completion of the six month or one year course provided by the traditional Chinese medical school. Participant E, a cardiologist, and participant F, a neurologist, who had graduated the traditional Chinese medical school said they administered acupuncture treatments in their clinics along with biomedical treatments.) According to participant E, with 10 to 12 repeat sessions, almost all disorders for which the treatment is efficacious "are usually disappeared." For the symptoms that did not show improvements, further acupuncture treatments "will not work because the acupuncture points on the patient's body are not responsive." In this case the treatment should be resumed after two weeks or so. Participant F's explanation is slightly different but points to the same conclusion: treatment with acupuncture directs energy out from one's body and this should not be done excessively. So no more than 10 to 15 treatments should be done at one time and after that suspension is needed to recover one's energy to resume the treatment.

Traditional Korean medicine doctors might not agree with these comments but the point here is that the returnees from Sakhalin tend to be rigorous in keeping this 10-times principle. It should be noted that the former medical doctors from Russia suggests 10 to 15 times with some flexibility. But the patients mentioned above were so strict with the rule that they kept records of each session on a notebook and after their 10 treatments they never came back, the Korean doctor said.

As this case shows, transnational medical practices of returned ethnic Koreans are not provisional alternatives but systematic activities based on transnational evaluation of the two societies. In other words, transnational medical seeking is a very strategic behaviour based on the systematic comparison and evaluation of the experiences in both countries.

This is well shown in the ways they evaluate the medical system and practices in Korea through comparisons with those of their adopted countries.

First of all, the returnees from Sakhalin who had been long used to the socialist medical system of the former Soviet Union reported they were shocked when they first witnessed that people were not given medical exams and treatments if they could not afford them.

> What is difficult is, when you are rushed into the emergency room, you have to be accompanied by a guardian to get treated. Even though you have someone you will not be treated unless they agree on paying the expenses. Even when the person is dying, he or she will not receive care until someone guarantees paying for the patient...I thought this was the way the capitalist society went. (Participant D)

Another aspect of the Korean medical system criticized by the returnees from both countries is the doctors' care practices and attitudes towards the patients. Both the returnees from Germany and Russia acknowledge that in Korea the doctors have well-developed medical skills and the hospitals have cutting-edge medical equipment. But they complained about the biomedical doctors being too dependent on medical exams and equipment, relying on “the machines” to make diagnoses. The returnees say they are especially unsatisfied with the doctors making diagnoses only with information that patients provide without conducting any palpations or auscultations, and most of all only offering very limited consultation time. They then emphasised that Russian doctors make a diagnosis after spending more than 20 minutes thoroughly examining although they are not equipped with state-of-the art medical devices. Participant A from Germany exploded her anger while talking of her frustration when she and her husband in his 90s saw a specialist in a university hospital after waiting six hours. Then the specialist told her to just wait and see after listening to her without any examination: even no auscultation or a blood pressure check. At this she angrily protested to the doctor arguing she will not pay the fees and asking for compensation for transportation. She added that it was unimaginable in Germany.

The returnees from Germany also point to the poor conditions of hospitalized patients. Participant B, who was hospitalized soon after her returning to Korea because of a stomach cramp, was quite shocked at the state of the hospital wards where patients, care givers and visitors were all mixed up "eating, drinking, and laughing and speaking loudly." At night most care givers sleep beside the patients on a makeshift bed. In German hospitals where visitors can only visit patients during designated times, this kind of behaviour is beyond imagination. Moreover, they struggled to understand the

presence of "privately hired care givers". Besides the fact that the expenses to hire such people are burdensome for patients, they were concerned that patients being looked after by these "unprofessional" care givers might be at greater risk if the care giver fails to detect some important changes in patient's state.

Conclusion and Implications

The transnational medical practices of elderly ethnic Korean return migrants from Russia and Germany have been briefly explored so far. Unlike the public images of elderly ethnic Korean return migrants where they are portrayed as home coming people driven by a strong sense of nostalgia, this study features them as active agents who utilize resources of two countries with strategies crossing national borders. As done by most transnational migrants, these elderly people are also attempting to combine the resources from two nation states within their social space which exists between the two societies.

In the context of research on transnational medical seeking, this study could serve as a further case in the exploration of transnational strategies for better medical treatments. And regarding research on migrant health in Korea the present research could be a contribution to it, going beyond the "multiculturalist" approach which mainly focuses on multicultural families and marriage migrants' reproductive health. Also, the existing body of research in Korea fails to recognize migrants' active medical seeking across national borders. Instead, it shows a strong tendency of "methodological nationalism" which refers to "the naturalization of the nation state by the social sciences" (Wimmer and Schiller 2003: 576). Being aware of this fact, the present study illustrates, the present study illustrates that health and medical seeking cannot be contained within national borders, which signifies the needs to enhance the capacity of the Korean medical system to embrace cultural and ethnic diversity.

What the current study also notes is that elderly ethnic Koreans who returned to Korea have rarely been conformed to the country's dominant beliefs or practices on health and medicine. Rather, they negotiate those beliefs and practices with a strong reference of their own. This notion could be further developed into a discussion on medical pluralism. In fact, medical pluralism is not a novice concept especially given that Korea has a long history of institutionalizing both biomedicine and traditional Korean medicine. What is new is that these transnational medical seekers illuminate the possibility of there being many differences within biomedicine itself and these differences could be employed in

improving the effectiveness of national medical system.

This study is in its very early stage. The whole project will take two more years to be completed. During this period, elderly return migrants from the US and ethnic return migrants from China would be sought to obtain a more complete picture of overseas Koreans' transnational medical seeking which I hope will contribute to making the Korean medical system more diverse and effective.

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