Medical Anthropology Research and Report in Latin American Immigrants in Saitama and Gunma

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Summary

Objective: To study cultural and health care related issues and living difficulties of immigrants in Saitama and Gunma prefectures.

Materials and Methods: Cross-sectional study with 67 interviews in Saitama and Gunma prefectures, during January and February 2008. The Living difficulty questionnaire was applied to evaluate the level and kind of experienced difficulties by immigrants in Japan. Demographic and clinical variables related with health care were selected as well.

Results: Participants were an average 38 years old. They are living in Japan an average of 11 years. 81% have health insurance in Japan; 14% have it in their country of origin. The first time medical services were needed was 2 years after arrival. Those who don’t have health insurance in Japan -a 33%- is due to a lack of finances. Over-the-counter medicine use was 55%. 45% had experienced hospitalization in Japan. Among the living difficulties causing serious/very serious stress were worries about not getting treatment for health problems, 9.1%; poor access to counseling services, a 12.1%; to emergency medical care, 7.6%; to dentistry care, 7.6%; to long term medical care, 4.5%.

Conclusion: Health care access continues being a problem in spite of long time residence and permanent visa status. There are language difficulties but cultural differences in the outpatient and inpatient settings. Lack of health insurance was due to high cost as well as insufficient information and cultural and language barriers.

Keywords
Immigrants, public health, health and welfare

I. Introduction

Since 1985 immigration visa for Japanese descendants from South America with the concomitant critical socio economical situation of the South American countries has initiated the process of the “ethnicity-based immigration” (Takenaka, 2003). The increasing and growing need of overseas workers in Japan has contributed as well to this factor. This immigration process represents at present 14% of the total amount of foreigners in Japan, being the second largest group in number of importance after Asians (Statistics bureau, 2008). Certain aspects of this immigration process related with the public policies regarding them,
originated the term Japan’s “Guest workers” (Shimada, 1994). The awareness of the potential and real problems of these non-citizens workers has been rising during these 20 years of experienced migration. Even though this phenomenon wasn’t experienced before, local governments have been able to cope with this ongoing process of adaptation, creating new departments into the local governments to face the needs of these new migrants. This is the case of Hamamatsu, Kanagawa, Gifu, Gunma prefectures, to quote some. Based on human rights, three main aspects in which attention is needed and focused are: labor and economic affair departments, boards of education and health and welfare departments (Tegtmeyer Pak K, 1998).

The right to access to health care and welfare is one of the basic human rights. Added to the cultural resettlement experiences, these Japanese descendant workers are facing health care issues that still need to be better understood and supported.

One problem of immigrant’s workers is that only the 40% of them achieve the health care insurance provided by the Japanese government (Tamura, 2005). The main reason is that their monthly salary doesn’t meet the family needs, and the amount of the national insurance coverage is unaffordable for them.

Another reason stated is that “In fact, many newcomers are not included in the social welfare system, even if they are regular residents. Employers of small companies are reluctant to pay half of the insurance premium. Unskilled foreign workers don’t pay it either since they think of returning to their original countries in the future, or the insurance premium and pension have to be paid simultaneously. The Japanese welfare state for newcomer immigrants is immature.” (Kondo, 2007)

In December 1991 a regulation of the Ministry of Health and Welfare denied the National Health Insurance to the undocumented immigrants. In spite of this, under the “Treatment of Travelers Law” some local governments assume part of or all the expenses caused by immigrants for emergency care not covered by any insurance, but that means significant monetary loss to the hospitals, health care services and to the local governments themselves. (Tegtmeyer Pak K, 1998)

In addition to the health insurance and welfare system itself, there are some other problems in the access to the health services. Language barriers, as well as the difficulty in accessing the information itself, are an obstacle to these foreigners to beneficiate themselves from health services. Anthropological research in public health contributes with many clues to the application and evaluation of health programs and policies (Mac Lachlan, 1997). Difference of culture, habits and religion affecting the doctor-patient relationship in this setting remain to be studied in depth, as an aspect that highly influences the level of patient satisfaction in healthcare settings. (Tsuchida, 2003)

Recently, the mental health of immigrant workers all over the world has been paid particular attention. “Fragmentation and erosion of identity, the loss associated with displacement from familiar contexts and support networks, the difficulties of settlement, and the pressures on accustomed family structures and relationships can increase vulnerability to mental illness... addition source of stress on immigrants is that host societies have generally failed to respond effectively to the reality of ethnic, cultural, and linguistic diversity” (Bhugra, 2007).

We decided to conduct this survey in order to have a better understanding of the culture and health care issues of immigrants in Japan, so we may contribute to the improvement of the use and access of health services.
II. Material and Methods

The Institute of Medical Anthropology (IMA) was founded with the purpose of acquiring an anthropological view in the field of health care immigrant’s workers in Japan in 2007. This Institute works in collaboration with the Honjo Waseda Campus of Waseda University. For the first year data collection we designed a survey focused on health care issues. The area selected were the Gunma and Saitama prefectures, due to the increasing population of immigrant’s workers in these areas and the bound and support of the institute members of the Honjo-Waseda Campus of Waseda University in Saitama. Furthermore, there is not previous report published about this topic in this area.

We conducted randomly interviews in that area during the period of January and February 2008. We selected demographic variables as nationality, age, type of visa, living years in Japan, family dependants in Japan, number of children in Japan; variables related to health care, as having or not health insurance in Japan, having or not health insurance in the country of origin, frequency of use of health insurance in Japan during a year; children access to health care services using it for a year; how long after arrival medical services were needed for the first time, explanation for the lack of health insurance in Japan; diseases that required medical assistance, diseases treated at home; having a personal or family experience of hospitalization in Japan, reason for it and questions related with cultural and anthropological habits, customs as, if they were able or not to visit a traditional healer in Japan, what kind of medicines were they taking in Japan and if possible the use and kind of traditional medicine in Japan.

To evaluate the difficulties they have due to protection concerns, access to health and welfare and the resettlement experience, we chose the Postmigration Living Difficulties Checklist (Momartin et al, 2006). The Postmigration Living Difficulties Checklist contains 24 items of postmigration difficulties and is graduated in 5 degree scale from 1 to 5.

1. Not a problem at all
2. A bit of a problem
3. Moderately serious
4. A serious problem
5. A very serious problem

The living difficulties that reached the 4th and 5th degree were considered living difficulties causing serious/very serious stress.

The quantitative data analysis was made using the SPSS, version 13 (SPSS Inc, Chicago, Il, USA).

We had to reassure several times the anonymous mode of questionnaire due to bias in the answers moved by fear; either to be interviewed regarding their visa status, or the uncertainty about the possible interpretation of their answers, being felt as criticism or protest.

III. Results

We did 67 interviews. The statistics summary and the Postmigration Living Difficulties Checklist are shown in table 1 and 2.
<table>
<thead>
<tr>
<th>Table.1 Clinical and demographic variables (n=67)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationality (Peruvian %)</td>
<td>82</td>
</tr>
<tr>
<td>Age(years)</td>
<td>38</td>
</tr>
<tr>
<td>Type of visa (Permanent resident %)</td>
<td>44</td>
</tr>
<tr>
<td>Years in Japan (years)</td>
<td>11</td>
</tr>
<tr>
<td>With family dependants in Japan (%)</td>
<td>58</td>
</tr>
<tr>
<td>More than one child in Japan (%)</td>
<td>43</td>
</tr>
<tr>
<td>With Health Insurance in Japan (%)</td>
<td>81</td>
</tr>
<tr>
<td>With Health Insurance in the country of origin (%)</td>
<td>15</td>
</tr>
<tr>
<td>Frequency of use of health insurance in Japan</td>
<td></td>
</tr>
<tr>
<td>More than 3 times a year (%)</td>
<td>55</td>
</tr>
<tr>
<td>Children’s frequency access to health care under health insurance</td>
<td></td>
</tr>
<tr>
<td>More than 3 times a year (%)</td>
<td>73</td>
</tr>
<tr>
<td>First time need of medical services in Japan (years)</td>
<td>2</td>
</tr>
<tr>
<td>Explanation for the lack of health insurance in Japan (%)</td>
<td></td>
</tr>
<tr>
<td>Lack of finances</td>
<td>33</td>
</tr>
<tr>
<td>Being still in process to get it</td>
<td>20</td>
</tr>
<tr>
<td>Cultural or language barriers</td>
<td>13</td>
</tr>
<tr>
<td>Lack of enough information</td>
<td>13</td>
</tr>
<tr>
<td>Diseases where medical assistance is required (%)</td>
<td></td>
</tr>
<tr>
<td>Work accident</td>
<td>9</td>
</tr>
<tr>
<td>Hypertension/diabetes</td>
<td>9</td>
</tr>
<tr>
<td>Diseases treated at home (%)</td>
<td></td>
</tr>
<tr>
<td>Flu</td>
<td>37</td>
</tr>
<tr>
<td>Had visited a traditional healer in Japan (%)</td>
<td>3</td>
</tr>
<tr>
<td>Medicines taken in Japan (%)</td>
<td></td>
</tr>
<tr>
<td>Over-the-counter Japanese medicines</td>
<td>53</td>
</tr>
<tr>
<td>Medicines from of their country</td>
<td>45</td>
</tr>
<tr>
<td>Use of traditional medicine in Japan (%)</td>
<td>55</td>
</tr>
<tr>
<td>Experience of hospitalization in Japan (%)</td>
<td>45</td>
</tr>
<tr>
<td>Reason for hospitalization in Japan (%)</td>
<td></td>
</tr>
<tr>
<td>Childbirth/Other gynecological reason</td>
<td>35</td>
</tr>
<tr>
<td>Surgery</td>
<td>26</td>
</tr>
<tr>
<td>Accident</td>
<td>13</td>
</tr>
</tbody>
</table>
## Table 2. Postmigration Living Difficulties Checklist

**Living difficulties causing serious and very serious stress**

<table>
<thead>
<tr>
<th>Item</th>
<th>Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication difficulties</td>
<td>9</td>
</tr>
<tr>
<td>Discrimination</td>
<td>2</td>
</tr>
<tr>
<td>Separation from family</td>
<td>14</td>
</tr>
<tr>
<td>Worries about family back at home</td>
<td>18</td>
</tr>
<tr>
<td>Unable to return home in emergency cases</td>
<td>6</td>
</tr>
<tr>
<td>No permission to work</td>
<td>0</td>
</tr>
<tr>
<td>Not being able to find a job</td>
<td>3</td>
</tr>
<tr>
<td>Poor working conditions</td>
<td>8</td>
</tr>
<tr>
<td>Being in jail</td>
<td>0</td>
</tr>
<tr>
<td>Interviews by immigration</td>
<td>0</td>
</tr>
<tr>
<td>Delays in processing your application</td>
<td>3</td>
</tr>
<tr>
<td>Conflict with immigration officials</td>
<td>2</td>
</tr>
<tr>
<td>Fear of being sent back home</td>
<td>2</td>
</tr>
<tr>
<td>Worries about not getting treatment for health problems</td>
<td>9</td>
</tr>
<tr>
<td>Limited access to emergency medical care</td>
<td>8</td>
</tr>
<tr>
<td>Limited access to long term medical care</td>
<td>5</td>
</tr>
<tr>
<td>Limited access to dentistry care</td>
<td>8</td>
</tr>
<tr>
<td>Limited access to counseling services</td>
<td>12</td>
</tr>
<tr>
<td>Scarce government help with welfare</td>
<td>5</td>
</tr>
<tr>
<td>Scarce help with welfare from charities</td>
<td>3</td>
</tr>
<tr>
<td>Poverty</td>
<td>3</td>
</tr>
<tr>
<td>Loneliness and boredom</td>
<td>8</td>
</tr>
<tr>
<td>Isolation</td>
<td>5</td>
</tr>
<tr>
<td>Limited access to the foods you like</td>
<td>2</td>
</tr>
</tbody>
</table>
IV. Discussion

The participants were in average 38 years old. At the time of the survey they had spent 11 years in Japan, so they came being 25, investing the best years of their productive life in the new country. They came from urban middle and lower-middle class, areas like Lima and Sao Paulo in South America. In Japan they were able to have their own houses, and raised their children, who are working in factories and some others are studying hard to the university degree. Some of them have started running their own small business but the majority is working in factories. The time they have been living in Japan could be considered enough to adapt and adjust to the overall experiences of resettlement, including health care access in a foreign country. Also the type of visa they carry was long term resident, named as Japanese descendant, permanent resident, nationality or spouse of Japanese national or permanent resident. Just % carried a short term stay visa.

Almost / of the interviewed people had relatives economically dependent on them in Japan, as well as children in Japan. It can be said that being established they have decided to settle their families here, as corresponding to their visa status.

Health insurance

80% of the interviewed people had one of the 3 possible health insurances in Japan, the National Health Insurance, Welfare Health Insurance or private health insurance. In comparison with the prevalence of the data we got from the Saitama City Hall officer, % of immigrants having either the national health insurance or the social security and the results of Tamura –about 42% of Brazilians immigrants having any kind of health insurance-, our results doubled the expected prevalence of having health insurance in Japan. These results could be due to the longer stay in Japan of the interviewed people and the increased consciousness of the need of health care services since they have family dependents and children living with them.

At the same time near 15% of the interviewed people is currently having private or public health insurance in their country of residence. That could be due to the preference of being treated and having medical checkups in their country of residence, for the difficulties in communication and culture experienced in the medical-patient relationship. Some others, having relatives with illnesses as cancer, they preferred treatment and support surrounded by their relatives at their homeland.

Some examples of what the Latin-American patients experienced at the medical encounters in Japan are the following. “I just understand that everything is right...” It means that they would like to be told what kind of medical test they have done and with which purpose. It doesn’t mean they don’t trust doctors. In Latin-America, the medical-patient relationship has a paternalistic approach. They do trust the doctors, in fact, they continue going to them, but they would like to have a better understanding of their sickness. Another expression, “The doctor didn’t examine by touch...” “I didn’t feel they put interest on me...” I didn’t feel like been cured...” In Latin-American culture the physical touch is part of the communication. Patients many times ask the doctors to touch the part of the body they feel sick. For them this physical way of perception is part of the healing process.

Within the reasons for the lack of health insurance in Japan, the financial one remains as the first cause. The next one is the significant number of immigrants that are still in the process of getting it. There was a case of someone who couldn’t pay since the beginning of his stay in Japan, and now, for her to be able to en-
roll; she has to pay the whole amount since she came
to Japan. The first time she wasn’t able to enroll be-
cause the employers didn’t provide her welfare health
insurance. Even now she doesn’t have the possibility
to have it at work, and the National Health Insurance
is tremendously onerous to her.

Those who lack health insurance because of insuf-
ficient information are 13% the same amount of those
who don’t have it because of language and cultural
barriers. The quantity and quality of the information
regarding health care given to the immigrants in their
own language is the first step to surpass these obstacles
to the health care access. The description of medical
symptoms can be difficult even for those whose share
the same culture and language. Symptoms as dizziness,
headache, stomachache, melancholy..., are hard to ex-
plain in their location, progression, intensity, and qual-
ity, and misunderstandings could even have fatal out-
comes. The efforts of some prefectures and consulates
to provided accurate health information to the foreign-
ers can be exemplified by the medical guide for foreign
people, granted for free in some prefecture websites.
The detailed website of the Brazilian consulate in Na-
goya contains experienced counseling regarding health
insurance and medical care, offering a 24 hour hot line
service to attend the Brazilian immigrants. The health
counseling on the website, advices to maintain the
health care insurance in their country of residence.

Language and cultural barriers represent a great
challenge in the process of health care reform all over
the world. Canadian Health system has a well earned
experience in many years of multicultural immigra-
tion. In the Canadian Health Care System Reform,
the accessibility to a qualified translator in the health
care settings is given for granted. Even further, they are
considering that the health system itself needs to be
modified, taking into account the cultural view of the
patients. (Anderson et al, 2007) Translation should be
done through a qualified translator. The cost of it in
Japan, with the exception of the places where transla-
tion has been implemented and granted for free to the
immigrants, raises considerably the cost of the health
care itself even for those who are paying health insur-
ance. Regarding translation efforts in health care set-
tings by some prefectures, Gunma is giving courses to
prepare proficient medical translators.

To prevent misunderstandings, medical errors, and
lawsuit, due to inaccurate translation in health care
settings in US, since 2000 Medicare and Medicaid
can cover the expenses needed by medical translation
(Flores, 2006).

Those who lack health insurance because they think
they don’t need it, represents a challenge anywhere in
the world. This population cannot be reach easily be-
cause of their lack of awareness, as well as for cultural
reasons. In this survey they are only a small percentage.

**Diseases requiring medical assistance**

Diseases requiring medical assistance are: flu, fol-
lowing in importance work accidents and the gynec-
ological/ obstetrical care. Regarding workers’ accident
compensation, the law doesn’t make a difference
between japanese, foreigners and undocumented mi-
grants. (Del Castillo, 1999)

The coverage would allow them to be compensated
even if they were deported or decide to return to their
countries. This legislation wasn’t known by the im-
migrants since the very beginning of their arrival to
Japan. As soon as they took knowledge of this issue,
the number of work accidents compensation lawsuit
increased yearly. However, I did find miserable cases in
Gunma prefecture of persons that having lost arms or
hands, they did not request their compensation being
afraid of deportation.
Medicines taken in Japan by the immigrants

In their regular consumption of medicines, half are brought from Peru, and half are bought in Japan, even though having an average of 11 years living in Japan. The reason could be the cost, the quantity of dose, the trust on the drug itself, or again language and cultural difficulties. The dose of the drugs available in Japanese drugstores is ordinarily half of the dose available in other countries, because of the difference in the speed of drugs degradation of the Japanese enzyme system.

More than half of the interviewed people are taking traditional medicines from Peru, sometimes available in Peruvian stores in Japan. The Peruvian traditional medicines mentioned by the interviewed people were Chamomile, Lemon Verbena, Anise, Cat’s Claw, Sangre de Grado (Chroton Lechleri) and Chanca Piedra (Break-stone). Chamomile is used because of its sedative properties, Lemon Verbena and Anise because of their digestive properties, Cat’s Claw as a well-known anti inflammatory and anticancer properties in medical research; Sangre de Grado (Chroton Lechleri) is taken in peptic ulcer disease and applied in general wounds improving the process of healing, and Chanca Piedra (Break-stone) is taken in urinary lithiasis and cholelithiasis.

Hospitalization in Japan

Almost half of the interviewed people have experienced themselves or their relatives hospitalization in Japan, mainly due to childbirth, surgery or accident. This fact could explain why these people considered worthy to be enrolled in any kind of health insurance.

Living difficulties causing serious/very serious stress

We found in 9% of the immigrants serious/very serious difficulties in communication after living an average of 11 years in Japan. Serious/very serious worries about not getting treatment for health problems were 9%. Poor mental health access (12%) was the first difficulty felt, followed by dentistry (7.6%) and emergency medical care (7.6%). In comparison with a group of 67 Persian-speakers settled with permanent protection visa in Australia, they felt only 1% of serious/very serious stress regarding worries about not getting medical treatment. Nevertheless 54% of them encountered communication difficulties in the first year of settlement.

Migrants face a broad range of stressors in their process of migration. Some causes and precipitants of mental disorders in migrants are: premigration factors as traumatic events or lack of preparation; cultural factors, as minority status and acculturation stresses; social factors, as social isolation and the loss of social network, family factors, as the partial or total absence of the family; psychological factors, as life changes events or homesickness, or even biological factors as getting old (Mac Lachlan, 1997). Evaluation for mental diseases in immigrants requires a high proficient translation level and a broad cultural understanding.

In this survey, we found out that the access to mental health care for migrants is the highest worry regarding health care the immigrants have in Japan. This topic deserves careful attention and subsequent research.

V. Conclusion

In this survey we concluded that health care access even for those who have health insurance continues to be a problem in spite of the long time of residence and permanent visa status. Language and cultural barriers in the outpatient/inpatient settings deserve to be noticed in order to improve to satisfactory level the doctor/patient relationship. Lack of health insurance is due to high cost as well as insufficient information and cultural and languages difficulties.

Within the worries about getting medical treatment,
mental health is the first one named by the immigrants and in a preventive approach needs to be taken into account.

References