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Examining Asian Americans' Perceived Barriers to Healthcare Access

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Examining Asian Americans' Perceived Barriers to Healthcare Access

A thesis submitted in partial satisfaction
of the requirements of the University Honors Program
of Loyola Marymount University

by

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Abstract

This research aimed to examine Asian Americans and their perceived barriers to healthcare access. Asian Americans, due to not being a homogenous ethnic group, experience health disparities that are different to those that other ethnic groups experience. Compared to whites in America, Asian Americans are less likely to have job-based insurance coverage and because of this are then less likely to be insured (Brown et al., 2000). Additionally, the most common perceived barriers to accessing healthcare for Asian Americans are cultural attitudes, financial and socioeconomic status, as well as language barriers. These barriers found in the literature served as the primary barriers that were investigated throughout the course of this study. Thus, the goals of the study were to determine whether these perceived barriers are the actual barriers that this large community faces and which of the barriers identified is the most difficult to overcome. This was done through interviews with individuals who identify as ethnically Asian currently living in America. Due to the large number of Vietnamese-identifying participants, this study aimed to also pinpoint barriers that may be unique to this ethnic group. It was found that the most common barriers experienced by participants were financial, transportation, and time barriers. However, the most difficult to overcome were deemed to be both time and financial barriers as is consistent with previous literature. It is vitally important to conduct research on this topic to ensure that healthcare providers and health institutions alike are aware of these disparities in order to better serve this community through the enactment of new policy changes or adjusted procedures and protocols.

This research aims to examine the perceived barriers that Asian Americans face when accessing healthcare. The research questions that served as the framework for this study were as follows: Are the barriers to healthcare access presented in the literature consistent with those experienced by Asians currently living in America and of those experienced? Which barrier is the most difficult to overcome? To fully understand and properly conduct this study, a literature review was conducted.

This literature review seeks first to provide pertinent definitions, current research on barriers, and the implications of key concepts like healthcare access and its effects on minorities in the United States with a specific focus on Asians and Asian Americans in the United States. Finally, this literature review will conclude with the current gaps and challenges found within this area of research which will be used to both develop and justify the current research for pinpointing the most difficult perceived barrier to overcome for Asians and Asian Americans in the United States. Due to evidence presented within the literature, it appeared as though the most prevalent barriers to healthcare access for this minority would be a grasp of the English language, cultural attitudes, immigration status, and the financial burden of accessing care. It was expected that the financial burden of accessing care would be the most difficult to overcome based upon prior case studies.

Healthcare Access

Having access to healthcare is defined as having the ability to “command appropriate health care resources to preserve or improve [one’s] health” (Gulliford *et al.*, 2002). Furthermore, adequate access to healthcare is characterized by four different dimensions, as maintained by Gulliford *et al.*: service availability, utilization of services, relevance, and equity (2002). This means that in order to be considered to have access to health care, there must be

enough services/supplies for those in need of them, patients must be able to use the services available to them, the right service must be able to be utilized when needed, and everyone must have a fair opportunity to use them. Thus, it can be said that examining a group's access to healthcare is a difficult task as all four dimensions must be considered in order to fully understand the degree of lack of access. This lack of access to quality healthcare continues to be a problem that plagues the United States.

One way of providing necessary context to this problem is to examine the number of those living in America without healthcare coverage since healthcare costs are normally too expensive to cover out of pocket. According to the Kaiser Family Foundation, many factors must be taken into account when describing the uninsured population. For example, adults are more likely to be uninsured than children and low-income families as well as those with only one stable income are at a higher risk to be uninsured (Drake *et al.*, 2023). Also, people of color are more likely to be uninsured than whites (Drake *et al.*, 2023). In a fact sheet released by the Center for American Progress, it was revealed that Blacks were the most uninsured minority with over 10% of the population going without healthcare coverage (Carrantala & Maxwell, 2023)

The ongoing pandemic has underscored this grim reality as many minorities and underprivileged populations have not been able to receive the care that they need primarily due to lack of service utilization and relevance (a problem of being able to use the services that may be available to them when needed) as well as equity (a problem of resource allocation).

According to an issue brief released by the California Health Care Foundation, the California homeless population is subjected to a higher risk of both contracting and dying from COVID-19 compared to those who are not housing insecure at the beginning of the pandemic since the focus was on lowering the infection rate of the virus as opposed to addressing the existing health care

issues faced by this population (CHCF, 2021). Additionally, the most recent data made public by the CDC regarding the vaccination status of the adult population revealed that Blacks, Asians, Indigenous Peoples, Hispanics, and Native Hawaiian and other Pacific Islanders were less likely to have completed the first two vaccine doses and the booster than their white counterparts (CDC COVID Data Tracker, 2023).

However, with the help of many government relief programs put in place during the pandemic to increase vaccine availability and efforts to enroll the general population into a state-insured plan, the rate of uninsured people in the United States have recently been reported to be at an all-time low. In most states where legislation regarding the Affordable Care Act was expanded, the rate of uninsured people dropped as much as 2% (Mykata & Conway, 2022). While this is encouraging, many of these newly insured individuals (both adults and children alike) could be at risk for being uninsured once the COVID-19 public health emergency is over as they could be unenrolled from states health programs (Kimball, 2022).

As previously seen, many minorities and marginalized groups within the United States face problems when trying to access healthcare. Asian Americans in this aspect are no different.

Asian Americans, in Broader Context

Asian Americans, while viewed by most as a homogenous group, are anything but. The term Asian American refers to a large heterogeneous community that are often grouped together despite being from three distinct regions of Asia: Southeast Asia, South Asia, and East and Central Asia. Thus, Asian Americans with different ethnicities have distinct cultural beliefs from one another and often differ in demographics from one another as well.

As of the 2020 Census, there are over 20 million people who identify as Asian, Native Hawaiian, or Pacific islander alone in the United States (Monte & Shin, 2022). This figure

accounts for a little over six percent of the country's total population and does not account for those identifying as multiple ethnicities which adds an additional four million people to Asian American community. The subgroups within the Asian American community with the highest populations include the Chinese and Asian Indian communities at over four million each followed by the Filipino and Vietnamese communities at nearly three million and two million respectively (Monte & Shin, 2022).

In terms of income, Indian Americans have the highest reported incomes among the Asian American population while among the poorest are Hmong Americans (Asante-Muhammad & Sim, 2022). These statistics are also dependent upon other factors like education, unemployment, and way they immigrated to the United States where disparities can be seen between each of the Asian American subgroups. At a glance, it appears that over fifty-four percent of Asian Americans over the age of twenty-five in the United States have at least a bachelor's degree. However, looking between different nationalities reveals that over fifty percent of Chinese, Filipino, Japanese, Korean, and South Asians have obtained a bachelor's degree compared to the 29% of Southeast Asians who have not (including data from the Burmese, Cambodian, Hmong, Laotian, and Vietnamese populations) (Institute of Education sciences National Center for Education Statistics, 2019). Similar disparities can be seen while examining other demographic factors.

Most Prevalent Barriers to Healthcare Access for Asian Americans

The most prevalent barriers to healthcare access for Asian Americans include language and culture, a lack of health literacy and health insurance, and immigrant status (Kim & Keefe, 2010). What follows is a working definition for each barrier followed by relevant examples as seen within the Asian and Asian American community in the United States.

It has been made strikingly clear that the most formidable barrier to healthcare access in past literature for Asians and Asian Americans in the United States is the language barrier. The ability to speak English after immigrating to the United States or being born to immigrant parents serves as both a measure of adjustment and a means to adjust to their new environment (Kim & Keefe, 2010). Those who are unable to speak English well may encounter problems like making appointments, locating the appropriate healthcare facilities, as well as communicating with and understanding healthcare providers should there be a lack of language interpretation services available.

Due to the Asian American community being a heterogeneous group as previously discussed, the culture that accompanies each of the different ethnicities can be vastly different from one another. Differences in culture can even be found across different regions of the same countries when considering religious and minority ethnic identities as well. For example, Sri Lanka is home to two dominant populations: the Sinhalese and the Tamils who are distinct from one another regarding religion, minority status, cultural practices, and ethnicities. These differences led to violence in Sri Lanka until the end of the civil war in 2009 (de Silva *et al.*, 2019).

Health literacy is defined as the ability to read health content and understand it in the context of specific health situations (Kim & Keefe, 2010). A review conducted revealed that in the United States, at least 26% of over 31,000 were deemed to have low health literacy and only 20% had marginal health literacy (Paasche-Orlow *et al.*, 2005). This is a barrier experienced not only by nonnative speakers but native speakers of English as well due to the jargon left unexplained that normally accompanies healthcare interactions.

The lack of adequate health insurance has also been a barrier for some Asian American populations. According to the 2021 census data, only 5.8% of people who identify as Asian alone are uninsured (Branch and Conway *et al.*, 2022). This was the second lowest rate as the lowest were whites with 5.7% of those identifying as white alone being uninsured. However, this statistic may be deceiving as some Asian ethnic identities report a higher median income and education rate than others as seen in the disparity between South Asians and the Southeast Asian populations (Asante-Muhammad & Sim, 2022).

Immigrant Status

There are three immigrant status groups into which Asians and Asian Americans can fall into: those who voluntarily left their home country, those who were forced to flee their home country (refugees), and the descendants of both groups (Kim & Keefe, 2010). Immigrant status is an important criterion for many healthcare benefits which can cause undocumented individuals to have a more difficult time accessing the healthcare that they need. This is due in part to bureaucratic restrictions like having to wait five years until they are eligible to receiving healthcare coverage through the government (*HealthCare.gov*). Again, this option is only available for lawful and non-undocumented immigrants in the United States.

One thing to keep in mind about immigrant status and how it may perpetuate certain health disparities in this group is that there is a significant conflict in the discourse surrounding why immigrants have such low rates for utilizing health services.

The first of which is called the “selective immigration hypothesis” which states that those who choose to leave their home country for the United States are often healthier—both mentally and physically—than their counterparts currently living in the country to which they immigrated (Abraido-Lanza *et al.*, 1999). According to this hypothesis then, there should be a lower rate of

healthcare service utilization because there is not a need for them amongst a healthy immigrant population. The contradicting belief is known as the “Salmon bias hypothesis” which maintains that immigrants who are without jobs, unsuccessful, and/or unhealthy may decide to return to their home country, leaving a healthier population in the country they immigrated to (Di Napoli *et al.*, 2021). This means that there would be a low rate of healthcare service utilization because those too weak do not stay in the new country.

Addressing Gaps in the Literature

Throughout the research process of completing this literature review, it became incredibly apparent that there is a large gap in literature when studying the Asian American community. This can be linked to factors previously discussed like how Asian Americans are often treated as a homogenous group despite the many unique subgroups that the umbrella term refers to. For instance, a study conducted to determine the barriers to research participation for minority groups admitted that while there is a large body of literature on this subject regarding African Americans, there is relatively little in terms of data for Asian Americans, Latinos, and Pacific Islanders (George *et al.*, 2014).

Methodology

Sampling and Subject Recruitment

The only criterion for eligible participation within this study was that respondents needed to identify as ethnically Asian. Respondents were recruited to participate in the study through the snowball method. This was done in order to produce a sample of respondents that were biased towards those identifying as ethnically Vietnamese in order to provide a smaller, but hopefully more informative case study.

Twenty total interviews were conducted throughout the data collection phase and occurred in-person, via telephone, and through Zoom meetings. Interview subjects were made aware of the research topic during subject recruitment as informed consent needed to be obtained prior to conducting interviews. Once written consent was obtained, subjects were then scheduled to participate in an interview that lasted no more than one hour. All interview questions were asked in the same wording and manner to each subject. All sampling procedures were approved by Loyola Marymount University's Institutional Review Board.

Data Collection and Analysis

The interview questions were meant to probe at respondents' demographic factors and confirm whether barriers found within the literature were encountered. Additional questions were meant to uncover any additional barriers that may have been experienced but were not explicitly listed within the literature. The nature of the interview questions generated for this study allowed participants to provide simple yes or no answers and an explanation of their answer if they chose to elaborate upon their original answer. This was done in order to protect respondents by giving them the opportunity to disclose or omit sensitive health-related information based on their

personal discretion. In order to ensure information from the interviews were correctly documented, audio recordings were made of all conducted interviews.

Due to the biographical nature of the interviews and the small sample size of this study with no treatment groups, no statistical analyses were conducted. Only qualitative trends and patterns will be discussed throughout the results and discussion of this study. The interview questions used in this study can be found attached in the appendix.

Results

A summary of interview question responses can be found below in Table 1.

Table 1. The table below provides a summary of the respondents’ answers to the questions within the study. For ease of understanding, some questions have been broken into multiple parts. The table below excludes any quotations and is only meant to serve as a summary of the data discussed.

Question	# of Respondents who Replied Yes	# of Respondents who Replied No	# of Respondents who were Unsure
Do you currently have health insurance?	20		
If you were unemployed/are unemployed, would you be able to afford healthcare?	4	16	
Do you believe the length of your residency here in the U.S. has affected how or if you receive medical care?	15	4	1
Do you consider yourself to be proficient in English?	19	1	
Are you able to navigate the healthcare system on your own?	13	7	
Has your proficiency in English affected the healthcare you have received?	16	4	
Have you needed medical matters translated for yourself?	3	17	
Have you needed to translate medical matters for a family member?	11	9	
Has culture affected healthcare previously received?	7	13	
Has culture affected when you reached out for medical care?	8	12	
Has culture affected how you have wanted to be treated in the healthcare system?	5	15	

Respondent Demographics

Respondents were between twenty and sixty-nine years of age. Thirteen respondents were over the age of thirty. Sixteen of the respondents currently live in the state of California, while there were also respondents who lived in Texas (1), Georgia (1), and Arizona (2). In regards to ethnicity, fourteen respondents self-identified as Vietnamese American. Two respondents self-identified as Chinese. There was also one respondent who self-identified as Cambodian, one who self-identified as Taiwanese, one who self-identified as Korean, and one who self-identified as Chinese-Vietnamese.

In regards to employment status, fourteen respondents are currently employed full time. Two respondents are unemployed due to being full-time students in healthcare-related graduate programs. One respondent is unemployed due to a medical condition sustained while working full time. One respondent is currently in the military and one is retired.

Current Healthcare Status

All twenty respondents indicated that they currently have health insurance. Most respondents revealed that their health insurance was linked to their employer (military and most of those employed full time) or their spouse. Some respondents indicated that their health insurance was obtained through their parents since they are under the age of 26. One respondent indicated that their school provided a healthcare coverage plan for their students. One respondent indicated that they paid for their own private health insurance due to being self-employed.

Sixteen respondents indicated that they would not be able to afford out-of-pocket healthcare costs for themselves or their family. Seven of these respondents did say that they would still be insured through spousal support. Two replied that they would only be able to afford

healthcare costs with familial support. Of the four respondents who answered that they would be able to afford healthcare if they were unemployed, two rely on the state for their healthcare as one is retired and the other is a single mom with young children.

Immigration Information

Of the twenty respondents, nine respondents were born in the United States. For the eleven respondents who were born abroad and immigrated to America, the length of their residency ranged from seven years to forty-five years. Ten of these eleven respondents have lived in the United States for over thirty years.

When asked if they believed that the length of their residency in the United States had affected how or if they receive medical care, fifteen subjects agreed that it had. These subjects justified their responses by saying that the longer one lives in the United States, the more educational and employment opportunities one has access to in addition to being under constant pressure to better understand the predominant language spoken. Additionally, one respondent believed that it was easier to assimilate to American culture the younger one is when they first come to this country. Moreover, respondents believed that the longer one stays in the U.S., the more they would know about additional resources available to them and how to access those resources should they be needed. Four respondents believed that the length of their residency did not affect the healthcare they received, but one did mention that health literacy was a problem for them independent of any language barrier. Only one respondent was unable to decide if their residency had affected healthcare received because while they believe that the American healthcare system is accessible, they are also aware that differences in culture, religion, and other beliefs may impede access to traditional western healthcare.

Language Proficiency

Nineteen of the twenty respondents considered themselves to be proficient in the English language. One interesting detail to note was that the singular respondent who did not consider themselves to be proficient in English also had the longest United States residency length.

When asked if they were able to navigate the healthcare system without additional assistance, only thirteen respondents felt comfortable doing so. For some, this was because they had experience in the medical field themselves either as healthcare workers or healthcare providers themselves. For five of the remaining seven respondents, there was a wide variety of reasons pertaining to why they felt more comfortable navigating the healthcare with occasional assistance. These ranged from not knowing how to go through layers of bureaucracy in order to access specialized care to feeling as though they were not entirely health literate. Multiple subjects indicated that being health illiterate to some extent has been cause for them to reach out for additional assistance when selecting new healthcare providers, understanding medical procedures, and even agreeing to different treatment options. Two respondents indicated that they always required assistance whenever they needed to access medical care due to feelings of being completely health illiterate and significant language barriers.

When asked if English proficiency affected the healthcare they had received, sixteen respondents maintained that it did. Many of these respondents believed that by having a better grasp on the language, they were free to choose their own healthcare providers that did not speak their native language, better advocate for themselves and their family members, understand the nuances between different treatment options, and seek additional resources if need be. For those who encountered significant language barriers, they had a much harder time effectively communicating with their provider, either with the assistance of an official translator or a family member. One respondent also revealed that because of the language barrier, they had to spend

more time in order to make sure that they were receiving the appropriate health support at all levels of accessing care (booking appointments, dealing with insurance companies, talking to healthcare providers, and picking up medication/attending in-person treatments like physical therapy). Four respondents stated that their English proficiency did not affect healthcare they had previously received. This could be linked to how they felt comfortable asking for translated documents and translators when needed.

When asked if medical matters needed to be translated for themselves, most respondents (seventeen) replied no. The three respondents who replied yes had unique reasons for why they have needed to utilize translation services/seek the guidance of loved ones who were in the healthcare themselves. One respondent stated they only required additional translations when reaching out for specialist care due to a mental health condition. Another spoke of the recurring issue surrounding health literacy—in this case it was more so to do with understanding test results and medical procedure outcomes. The last respondent who indicated yes maintained that their basic grasp on the English language hindered their abilities to effectively communicate with healthcare providers leading to feelings of discomfort for having to heavily rely on others regarding personal matters.

When asked if they have had to translate medical matters for a family member, nine subjects answered no. For the eleven that have had to translate on behalf of a family member, there were mixed responses on whether or not it had affected their relationship with their family member in any way. Some subjects maintained that it had not affected their relationship in any way because they were able to objectively translate for their family member as was their familial obligation from being a first-generation American who could speak, read, and write the dominant language. Others believed that it had positively affected their relationship because it allowed

them to build empathy and feel as though they were helping their family member make the best decision in regards to their medical care. However, there were also respondents who believed having to translate for a loved one negatively affected their relationship with them. These subjects conceded that they often felt frustrated and stressed when their loved ones were still unable to fully understand their medical information even when lay terms were used or if their loved one was omitting important information due to a deeply instilled belief of stoicism. Having to advocate for someone else in a different language has also created deep frustrations with the healthcare system for some respondents as they believe the system can be extremely inaccessible for those not proficient in English.

Cultural Implications

Thirteen respondents believed that their culture had not affected their healthcare previously received. The seven respondents who maintained they did pointed towards having experiences where medical providers were able to speak native language and some even prescribed them potentially addictive medications with less patient advocacy.

When respondents were asked if their culture had affected when they reached out for medical care, twelve believed that it had not. Many attributed their belief to how they had assimilated to American culture early on and thus felt comfortable reaching out for mental health sources, reproductive health care, and preventative care. Those who maintained they would still be hesitant reaching out for mental health said that they would if it was absolutely necessary since some of them are educated healthcare providers and workers themselves. One individual who was exceptionally hesitant in reaching out for medical care due to a fear of discrimination by healthcare providers due to workers' compensation related injuries. Another individual cited her culture's belief in stoicism that prevents her from immediately reaching out for medical care

when experiencing more minor health issues. Other commonalities between other respondents in the study was the acknowledgement of the stigma surrounding mental health and reproductive health present within the culture that has both inspired feelings of hesitation and anxiousness when reaching out for medical care as well as discomfort while doing so.

When respondents were asked if they believed that their culture had affected how they wanted to be treated, only five respondents replied yes, while fifteen maintained a reply of no. For one individual who responded yes, she maintained that due to her linguistic barriers to understanding English, she often tries to look for providers with the same native language and ethnicity so that she can advocate for herself in her native language. She also believed it was easier to trust these healthcare providers because she believed that they understand her own culture and would cater to her needs best. For the respondent who was a healthcare provider herself, she responded yes due to being more aware of the myths and perceptions of the healthcare field as someone of Asian (Vietnamese) descent. For example, she brought up how some believe Asians to be narcotics naïve due to heavy influences from Eastern medicine or assuming that they are lactose intolerant before clinically determining as such.

All Barriers Experienced by Respondents

Of the twenty respondents, six believed that they had experienced no barriers when trying to access healthcare. One respondent credited to how she had never gotten truly sick in the past and thankfully has not needed to fully utilize the healthcare system. The other fourteen respondents were given the opportunity to list all the barriers they had experienced which led to the ten different barriers seen in Figure 1: finances, language, culture, transportation, bureaucracy, appropriate healthcare, time, childcare, technology, and health literacy. A few of these barriers

may need additional explanation to fully understand what they refer to.

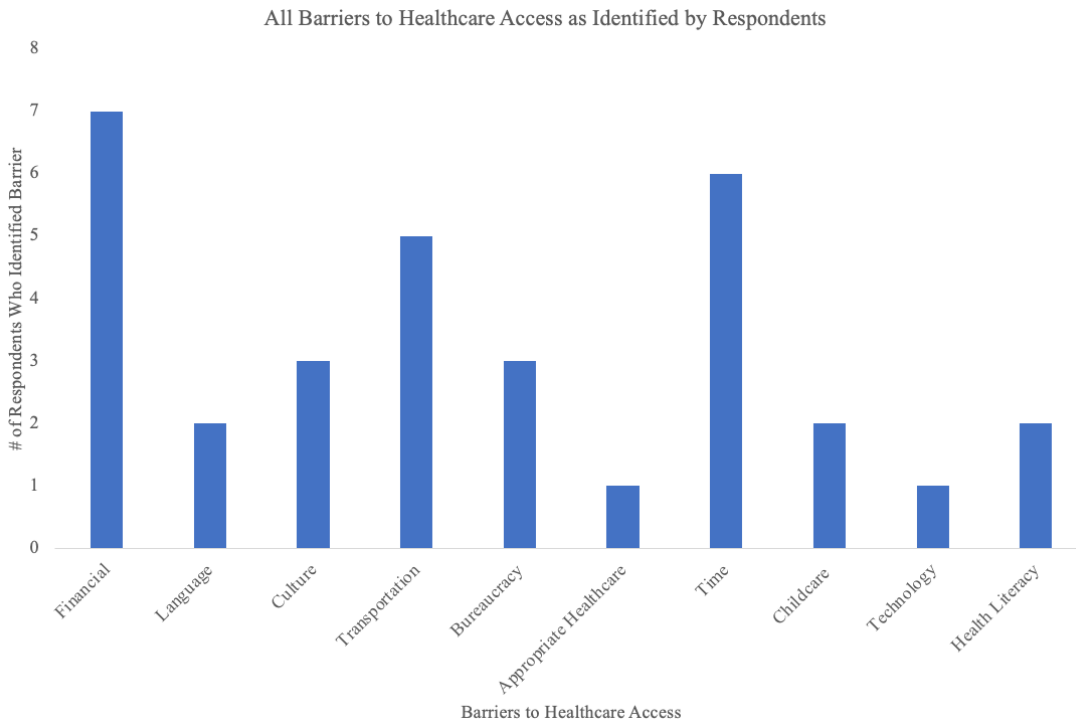


Figure 1. Seen above are all the barriers as identified by fourteen respondents within the study. Respondents were encouraged to list as many barriers as possible with the only requirement being that they have had to experience it. Six respondents responded that they had yet to encounter any barriers and thus have no data to contribute to the above figure. The most common barrier identified was finances with seven respondents followed by time and transportation which had six and five respondents each, respectively.

The time barrier encapsulated problems when trying to find appointments that the respondent would be able to attend and having to consider the time that would be needed to deal with different health issues (future time commitments). Bureaucracy referred to instances when having to go through certain time-consuming, common practices in the healthcare system like having to be referred to a specialist after having been seen by a family medicine doctor. Appropriate healthcare refers to making sure that the healthcare received was the kind of healthcare needed by the patient versus what bureaucratic powers deemed appropriate.

Finances, time, and transportation were among the most commonly encountered barriers.

Then, the fourteen respondents who previously disclosed the healthcare barriers they had encountered were told to choose the hardest barrier to overcome of those they had previously listed. As seen in Figure 2, the most difficult barriers to overcome, as stated by the respondents in this study were time and finance which tied at four counts each.

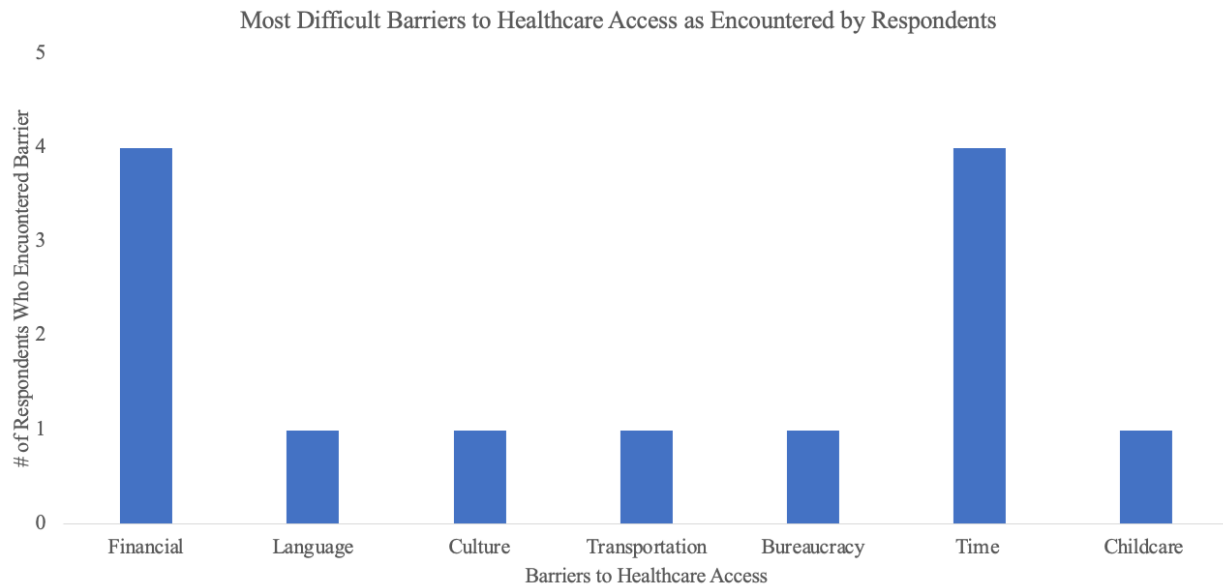


Figure 2. Seen above are the most difficult barriers to overcome as identified by the fourteen respondents featured in Figure 1. The most prevalent and difficult barriers to overcome were time and finances which tied at 4 respondents each.

Discussion

Financial Barriers

While all the subjects within this case study had health insurance coverage of some sort, this is not the case when examining the Asian American community at large. In a study surveying an Asian American population in New York City, it was found that 19% of subjects were uninsured and that disparities existed between the different nationalities (Tan *et al.*, 2018). Southeast Asians were found to be disproportionately uninsured compared to South Asians and Whites. Many respondents also revealed that their current health insurance was tethered to their employment status or their spouse's and that they would not be able to afford health insurance if they were to become unemployed. This is consistent with current literature as many Asian Americans lack healthcare due to lack of employment (Brown *et al.*, 2000).

Immigration Barriers

Respondents who believed that the length of their residency played a role in their access to healthcare cited having a longer time to assimilate culturally and linguistically as well as being able to take advantage of the many educational resources. In a study comparing healthcare utilization between foreign-born and native-born Asian Americans, it was found that foreign-born Asian Americans were more likely to have utilized healthcare resources less than their native-born counterparts (Ye *et al.*, 2012). The respondents from this case study did not adhere to this literature-based trend. While the respondents within this case study were predominantly foreign-born, most of them had resided in the United States for over thirty years which increased their exposure to the English language and allowed for more time to assimilate to American culture. Many had cited their long residency as the reason they felt more comfortable advocating for themselves and accessing healthcare than others.

Linguistic Barriers

For respondents who have needed to have medical matters translated for them, they discussed that the additional use of interpreters and translators were helpful to them. However, in a study comparing limited English proficiency patients who self-communicated with a healthcare provider and those who utilized an interpreter, it was discovered that patients who used an interpreter had more questions about their care than those who communicated by themselves (Green *et al.*, 2005). While this may be due to different factors like comfortability with asking questions in one's native language, the study showed that translators and translated resources may not be enough for those with limited English proficiency. This needs to be considered when deciding what resources need to be improved upon or made available to these marginalized communities that have trouble accessing healthcare. It is important to note that, however, that utilizing professional translators were preferred over family members as seen in past case studies (Ngo-Metzger *et al.*, 2003). Moreover, the same study by Ngo-Metzger *et al.*, found that many of these individuals also needed assistance when navigating the healthcare system (2003). The data from the twenty respondents proved to be consistent with this as those who admitted they did not feel as comfortable advocating for themselves in English also required additional assistance to navigate the bureaucratic healthcare system.

Many respondents who have had to translate medical information for a family member (language brokering) revealed that it had affected their relationship with that family member both positively and negatively, a fact supported by current literature (López *et al.*, 2019). Language brokering is the phenomenon where children become the cultural and linguistic intermediaries for their families due to children being able to assimilate easier than their parents and older family members (Martinez *et al.*, 2009). While language brokering has been revealed

to help with the development of empathy (Weisskirch *et al.*, 2021), it has also been attributed with the development of enhanced anxiety and even depression in adolescents (Shen *et al.*, 2020).

Cultural Barriers

Respondents who maintained that culture had affected the quality of healthcare received and when they reach out for care revealed that being ethnically Asian had both benefits and costs in a healthcare setting. Some found it easier to advocate for themselves due to existing stereotypes, while others found it harder to do so as their health concerns presented themselves differently from their White counterparts. Furthermore, some found themselves hesitant to reach out for mental health resources due to existing stigmas surrounding mental health, preventative care, and reproductive health within the Asian community at large (Kramer *et al.*, 2002). This was consistent with current literature which revealed that Asian Americans access mental health resources at nearly half the rate of other racial-ethnic groups in in the United States (Yang *et al.*, 2020). Additionally, this study also showed that Asian Americans still disproportionately accessed these mental health resources even when there was an identified need for such resources when compared to Whites (Yang *et al.*, 2020).

A common theme for some respondents was the concept of stoicism in the face of illness and suffering that prevented them from sometimes reaching out for medical care at all. Stoicism is the belief upheld by many different Asian communities that acknowledges how pain and suffering are a natural part of life (Stehr-Green & Schantz, 1986). In practice, this means that Asian Americans are predisposed to underreporting their pain levels and symptoms when discussing their health with family members, community members, and healthcare providers alike. Thus, frustrations can arise as seen with some of the respondents in this study who have

had to translate medical matters for family members or admitted to delaying their own treatment in some cases.

Another commonality amongst the respondents was admitting to how themselves or family members were more comfortable trying to utilize Eastern medicinal resources before turning towards Western medicine. This can often complicate patient and physician interactions for providers who are unaware of cultural treatments and side effects caused from such treatments like cupping, acupuncture, and herbal remedies among others. Understanding these cultural practices could allow for more fruitful and open conversations between healthcare providers and Asian Americans who exhibit this preference (Uba, 1992).

Finally, it was revealed that some respondents felt hesitant to reach out for preventive care. This is consistent with literature as Asian Americans were found to have utilized preventative care services like pap smears, colonoscopies, and blood cholesterol checks among other procedures far less than their white counterparts (Wen & Balluz, 2010).

Most Difficult Barriers to Accessing Healthcare

The two most identified barriers to accessing healthcare and the hardest to overcome were finances and time. This finding was consistent with current literature that identified economic reasons and physical barriers (like availability of appointments, childcare, transportation, and etc.) as the most common barriers for the Asian American community at large (Lee *et al.*, 2010). This study stood out amongst the others examined throughout this case study as it contained a large breadth of Asian American subgroups compared to the smaller case studies that were more common.

Conclusion and Future Directions

Thus, it was found that many of the barriers reported by respondents within this study were consistent with current literature findings. Additionally, it was also found that the most difficult barriers to overcome for the respondents within this study were also consistent with those found in the literature.

Scholars with experience in increasing healthcare access and utilization of services by Asian immigrant groups have proposed a few solutions to help Asian communities overcome the barriers outlined in this study. In terms of logistically being able to access health services, a few potential interventions could include the creation and continued support of health outreach programs targeted towards vulnerable populations and increasing access to health insurance and other health-related government programs and resources (Clough *et al.*, 2013). To combat linguistic barriers, Clough *et al.* has also suggested the use of multilingual lay patient navigators, which would help lessen the burden of language brokering on family and community members (2013). To combat existing cultural beliefs about the healthcare system, suggestions have included implementing media and educational campaigns aimed at highlighting the importance of preventative care and utilizing it as well as increasing the diversity of the healthcare workforce to enable patients to select providers who can speak the language they are most comfortable using (Clough *et al.*, 2013).

Due to resource constraints like time and finances, this study featured data from only twenty interviews. To truly have a grasp on the barriers experienced by the Asian American community, the principal researchers would like to implement a nationwide survey aimed at the entire Asian American community in the United States. By having a larger data pool with many different ethnicities featured, it is believed that nuances between the different cultures could be further identified and investigated. A standardized survey would also allow for easier data

collection where statistics could be applied to determine the significance of the results as opposed to a smaller case study like this where only general trends and patterns were identified. This survey should be followed by personal interviews to better understand the barriers experienced by each community, as it should be clearly understood that Asian Americans are not a homogenous group and thus may not experience the same barriers as one another.

To better understand the healthcare access disparities faced by the Vietnamese community, it is the hope of the researchers that similar studies would be implemented throughout places in the country where a large Vietnamese exists like that of Garden Grove and San Jose, California and Houston, Texas. Such a study would also allow for geographical dependent barriers and disparities to be explored as well.

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Appendix

Interview Questions

1. What is your age and state of residence?
2. What is your ethnicity?
3. What is your employment status?
4. How long have you lived in the United States?
5. If you were unemployed/are unemployed, would you be able to afford healthcare?
6. Do you believe the length of your residency here in the U.S. has affected how or if you receive medical care?
7. Do you currently have health insurance? If not, are you able to seek out healthcare if need be?
8. Do you consider yourself to be proficient in English?
9. Has your proficiency in English affected the healthcare you have received?
10. Are you able to navigate the healthcare system on your own or do you require assistance?
11. If a family member has had to translate medical matters for you into your native language, do you think that this has affected your relationship in some way?
12. If you have had to translate medical matters for a family member into their native language, do you think this has affected your relationship in some way?
13. Do you think your culture/ethnicity has affected what kind of medical care you receive, how you have been wanted to be treated, and when you reach out for medical care?
14. If you had to name a few a barriers to you accessing healthcare, what would they be?

15. Of those you listed, what is the most difficult to overcome?