

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

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November 2023

Abstract

Elderly Vietnamese immigrants experience unique stressors and healthcare incompatibilities that demand an examination of the quality of their physician-patient interactions. Previous studies on Vietnamese American health disparities demonstrate concerns over stroke rates, heart disease, and reluctance to communicate with health providers. Particular structural, political, cultural, and behavioral effects resulting from forcible immigration from the Vietnam War and communism have exacerbated healthcare complications. To study the depth of these effects, I surveyed and interviewed Vietnamese individuals sixty years of age or older who immigrated to America. These surveys and interviews allowed participants to rate their primary care physicians on different metrics to demonstrate their level of satisfaction with their patient-physician interactions holistically and to connect these ratings to their personal levels of integration within American society and ability to navigate American healthcare systems. The results surprisingly demonstrate an overwhelmingly positive response towards American healthcare, highlighting not the challenges that Vietnamese elderly face in regards to achieving satisfactory levels of healthcare, but rather the means through which they have overcome the difficulties of acculturation and gained access to quality healthcare. My findings indicate success stories in traversing the difficult realm of healthcare for these Vietnamese elderly individuals, whether through their education and information seeking or through caretakers who are capable of providing for them and provide insight into how we can extend this success to others still struggling to find quality healthcare. To expand upon these findings, I suggest conducting similar surveys and interviews, but with a larger sample of Vietnamese Americans, including diversity in education, income, class, employment, and family/home life, as this study was most limited by its small and non-diverse sample.

Introduction

Background

Vietnamese Immigration and Demographics

Vietnamese immigration into America began largely with refugees fleeing from Vietnam during the Vietnam War. After the U.S. left Vietnam in 1975, families fled under political duress during the Communist occupation of Vietnam and came to America often through sponsorship programs. They now constitute the fourth largest Asian American subgroup. As of 2017, there are over 1,343,000 Vietnamese immigrants residing in America.¹ One-third of all Vietnamese immigrants have resided in the greater Los Angeles area, Houston, and San Jose.²

In the Bay Area of California, Vietnamese residents constitute 8.4% of Asian American and Pacific Islander residents.³ In Santa Clara County, the county in which San Jose residents reside, Vietnamese Americans constitute approximately 16% of the AAPI population.⁴

Health Disparities of Vietnamese Americans

Vietnamese Americans face a variety of physical and mental health issues. The Vietnamese American population has the 2nd highest stroke mortality rate among Asian sub-groups.⁵ They also have the highest mortality rates for stroke, liver, lung, and cervical cancer among sub-Asian American groups.⁶ Additionally, Vietnamese American women are

¹ Elijah Alperin and Jeanne Batalova, “Vietnamese Immigrants in the United States,” *Migration Policy Institute* (September 2018): 2.

² Ibid.

³ Rya Jetha, “Ten maps that show where Asian American communities reside in the Bay Area,” *Bay City News*, August 26, 2022, <https://localnewsmatters.org/2022/08/26/ten-maps-that-show-where-asian-american-communities-reside-in-the-bay-area>

⁴ Ibid.

⁵ Hillary Ta, Bryant Lin, and Latha Palaniappan, “Vietnamese and Vietnamese American Health,” *Stanford Medicine Center for Asian Health Research and Education* (March 2020): 1.

⁶ Ibid, 2.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

experiencing increasing rates of diabetes, despite a general decreasing trend for a majority of other racial/ethnic groups. The Vietnamese American population as a whole has a high incidence rate of diabetes.⁷

Vietnamese American populations also show a significant need for assistance with mental health problems, as 21% in a survey of 14,000 Vietnamese Americans reported seeking assistance for their mental health compared to 10% for the American non-Hispanic white population.⁸ However, many Vietnamese Americans are also unlikely to speak to their health providers regarding these mental health struggles, indicating that there may be even more mental health crises that go unanswered within the community.⁹

Structural and Behavioral Causes for Health Disparities

Many possible factors affect the health and healthcare of Vietnamese Americans, including structural, political, cultural, and behavioral practices and events that have shaped the Vietnamese American population in America. Traumatic experiences as a refugee, and language, educational, and political barriers that act as boundaries to assimilation can somaticize into chronic diseases such as type 2 diabetes, cardiovascular issues, tumorigenesis, and more.¹⁰

Structural/Historical/Political

The distinctly traumatic and difficult experience in Vietnamese American immigration history is their shared experience as Vietnam War refugees. Vietnamese migrants immigrated to the USA through three waves: the first sponsorship wave before the communist regime in 1975, the second “boat people” wave fleeing from gross mistreatment under the communist

⁷ Ta, Lin, and Palaniappan, “Vietnamese and Vietnamese American Health,” 2, 4.

⁸ Tim Dang, “Health of Vietnamese-American Refugee Adults: A Summary of Health in the Context of the Vietnam War,” *School Health Research and Evaluation* (June 2012): 3.

⁹ Ibid.

¹⁰ Morgan H. Vien, “Vietnamese American Health, – Chronic Disease and Covid-19: A Discussion of Structural Factors as Health Policies,” *Journal of Asian Health* 2, no.1 (May 2018): 1.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

government around 1978, and the third wave of reunification and humanitarianism in the 1980s and 1990s.¹¹ During these waves, various immigration policies such as the Refugee Act were enacted; though initially, they expanded the immigration cap, they ultimately established a limitation to immigrant numbers.¹² Such programs slowed Vietnamese admission into the USA, as well as extended their time in refugee camps in which they faced difficult living conditions while remaining isolated from the greater society around them.

Weakly-funded resettlement organizations did not provide enough for Vietnamese refugees to build a foundation for their futures in America. Many Vietnamese immigrants lacked immigration plans due to the emergency conditions under which they fled from Vietnam. As a result, these Vietnamese Americans, seeking assistance and comfort from one another, aggregated into the large communities in which they reside today. However, this growth of migratory hubs ultimately disrupted family reunification: the prioritization of finding accessible migrant hotspots often led to splitting refugee families apart.¹³

Another effect of this sudden rush to flee Vietnam was that a majority of lower-class individuals immigrated during the second wave and third wave especially. Their lack of education, working skills, and limited opportunities to learn English, combined with the immediate pressure to be self-sufficient, led to many Vietnamese Americans taking on low-paying and low-prestige jobs that were quickly available. These challenging service and labor jobs further contribute to the population's stressful, harmful, and difficult lifestyles that negatively impact physical and mental health.¹⁴

Traumatic experiences as political detainees, refugee and re-education camps, forcible

¹¹ Ibid, 2.

¹² Ibid, 3.

¹³ Ibid, 4.

¹⁴ Ibid, 5.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

migration through the United States from external pressures, cultural shock and difficulty adjusting, and a stressful political climate are conclusively harmful to the mental health of Vietnamese Americans, while also possibly implicated in the poor health consequences that the population experiences.

Cultural/Behavioral

Many health issues are attributed to the behaviors of Vietnamese Americans surrounding smoking and other cultural practices. 16.3% of Vietnamese Americans are reported to be cigarette smokers, making them the second most prevalent smokers of sub-Asian American groups.¹⁵ Such smoking habits can contribute greatly to the high levels of hypertension and heart diseases.¹⁶ These habits are prevalent in Vietnam, where about 66% of all adult men currently smoke and smoking is responsible for 28% of all deaths, though Vietnamese women typically have rather low rates of smoking in California (as low as 0.4%).¹⁷ Another cultural behavior that can lead to hypertension, heart disease, and diabetes is the Vietnamese diet, which consists of many white rice-based dishes high in sodium and sugar.

Vietnamese Americans' participation in these cultural practices persists largely in part due to residential cultural clustering. They identify more with one another than with America as a whole, which strengthens community bonds but simultaneously causes anxiety regarding alienation in American culture.¹⁸ Additionally, difficulty with language encourages such aggregations of Vietnamese communities: 60% of Vietnamese Americans are reported to not have high proficiency with the English language, which is the highest percentage among all

¹⁵ Ta, Lin, and Palaniappan, "Vietnamese and Vietnamese American Health," 3.

¹⁶ Dang, "Health of Vietnamese-American Refugee Adults." 3.

¹⁷ Ta, Lin, and Palaniappan, "Vietnamese and Vietnamese American Health," 3.

¹⁸ Dang, "Health of Vietnamese-American Adults." 3.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

Asian Americans.¹⁹ In 2019, almost 78% of Vietnamese Americans over the age of five preferred a language other than English.²⁰ This language barrier may further contribute to the inability of Vietnamese Americans to navigate the American healthcare system without assistance.

Cultural health beliefs in Vietnam focus on maintaining a balance of different “vital forces,” which leads to the use of both traditional remedies, such as coining, cupping, pinching, steaming, herbs, and ointments, and Western medicines.²¹ Additionally, Vietnamese medical practices are heavily focused on alleviating symptoms and not on preventative care, which is at odds with many American preventative health practices.²² As a result, Vietnamese immigrants may feel that American healthcare is lacking in homeopathic remedies and adds unnecessary emphasis on medication and preventative checkups.

Asian Americans and Healthcare

Asian Americans as a whole have historically experienced difficulties and dissatisfactions with American healthcare. While the reasons differ greatly between each racial/ethnic subgroup due to the sheer variety of values, cultural practices, immigration experiences, and lifestyles, there are common trends present. For example, Asian Americans report feeling less involved with their own healthcare decisions and not as satisfied with their care compared to whites.²³ They also reported having issues with cultural differences and a lack of physician regard for their mental health.²⁴ Asian Americans rated their overall satisfaction with their primary care significantly lower than whites.²⁵ They scored lower on 10 of 11 Primary

¹⁹ Ta, Lin, and Palaniappan, “Vietnamese and Vietnamese American Health,” 3.

²⁰ Vien, “Vietnamese American Health.” 6.

²¹ Sonia Gordon et al., “Vietnamese Culture: Influences and Implications for Health Care.” *The Molina Institute for Cultural Competency*, 4-5.

²² *Ibid*, 5, 8.

²³ Quyen Ngo-Metzger, Anna T. Legedza, and Russell S. Phillips, “Asian Americans’ Reports of Their Health Care Experiences,” *Journal of General Internal Medicine* 19, no. 2 (February 2004): 111.

²⁴ *Ibid*, 111.

²⁵ Deborah A. Taira et al., “Asian-American Patient Ratings of Physician Primary Care Performance.” *Journal of General Internal Medicine* 12, no. 4 (April 1997): 237–42. <https://doi.org/10.1007/s11606-006-5046-0>.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

Care Scale and Overall Satisfaction dimensions than Caucasians, namely in financial access, organizational access, visit-based continuity, communication, technical skill, contextual knowledge of patients, comprehensive scope of care, interpersonal treatment, integration, and trust.²⁶

The healthcare system in Vietnam relies mainly on out-of-pocket payments, and in America, 8.1% of Vietnamese Americans are uninsured, putting them at second highest for uninsured rates of sub-Asian American groups. The combination of cultural practices from home, as well as language challenges, promotes a lack of integration into US healthcare systems and places Vietnamese Americans at a health disadvantage both somatically and structurally.

Current solutions

Because of the high density of Vietnamese Americans in the Bay Area, there are a great deal of interventions already taking place that aim to improve the quality and accessibility of healthcare for Vietnamese Americans, and to provide culturally competent and connected physicians, assistance in navigating the healthcare system, services overcoming language barriers, and other resources to these large Vietnamese communities. Some important organizations include Asian Health Services—an Oakland-based healthcare provider with the mission to serve Asian populations and emphasize inclusivity and incorporation—and the Vietnamese American Service Center, a Santa Clara based organization that provides health services and community support for Vietnamese Americans ranging from young adults to seniors.

Additionally, clinics, hospitals, and insurance programs offer medical interpreter/translator services to Vietnamese Americans without caretakers or English speakers to assist them through the healthcare process. Such services help empower and build autonomy

²⁶ Ibid, 237.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

for the Vietnamese American community, as some individuals are unable to learn English but still require healthcare. If individuals reside in these Vietnamese American bubbles, they have the option of seeking Vietnamese physicians as well, which erases the issue of language barriers and offers a culturally competent doctor who understands the patient well.

Some physicians and medical institutions have studied Vietnamese culture to provide effective and competent healthcare to Vietnamese Americans. Molina Healthcare of Long Beach, California's Institute of Cultural Competency wrote the paper, *Vietnamese Culture: Influences and Implications for Health Care*, which details Vietnamese world views, religious beliefs, social and family structures, health beliefs, implications for health practitioners, views on women's health, views on death, diet and nutrition, mental health, and other health challenges.²⁷ It highlights the lack of preventative care in Vietnamese culture and the cultural formalities that must be maintained for respectful physician-patient interactions.²⁸

Project Goals

Purpose

Though there are many programs and projects that focus on Asian American healthcare, Vietnamese Americans are a unique group that demands more research in America, with their significant presence and special migratory circumstances. In particular, the elderly Vietnamese immigrants who fled to the USA as adults during the immigration waves are a special demographic that deserves to be highlighted due to their unique hardships and traumatic pressures. Being of an older generation, their healthcare will only become more and more important to their lives. To better understand elderly Vietnamese health, and to ensure a focus

²⁷ Sonia Gordon et al., "Vietnamese Culture," 8.

²⁸ Ibid.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

on the integration of immigrants into a system that so often disregards their care, this research project aims to assess how elderly Vietnamese immigrants in America perceive the quality of their health care and physician visits.

Research Question

Are Vietnamese elderly satisfied or dissatisfied with the quality of their physician visits? What factors contribute to their assessment of the quality of their care, and what can be done to improve healthcare for this demographic group?

Hypothesis

Elderly Vietnamese immigrants experience dissatisfaction with the quality of their patient care and patient-physician interactions. Reasons may include language barriers, an inability to navigate the American healthcare system, distrust of America and its systems, and a lack of cultural understanding.

Methods

Data collection

Data collection was done in the form of surveys and interviews. Some interviews were conducted with the individuals who completed the surveys while others were conducted with their caretakers.

The survey was provided in both online (Google Forms) and printed paper versions, with English and Vietnamese versions for both. The survey questions (in English) are as follows:

Your demographic information:

1. Name

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

2. Age
3. Gender
4. Where are you from in Vietnam?
5. Year of entry into the USA
6. Where are you currently residing?
7. Who are you currently living with (name and relationship)?
8. Does anyone in your household speak English?
9. If you have one, who is your caretaker (name and relationship)?
10. State if someone has assisted you in filling out this form, or if you filled it out alone.
 - a. If you had help, please indicate who assisted you and their relationship to you.

Information regarding your family care doctor:

1. Name
2. Age (estimate)
3. Gender
4. Race/ethnicity
5. What type of institution do you visit them at? (clinic, nursing home, hospital, etc.)
 - a. In what city is it?
6. What language do you use to speak to your doctor?
7. Do you see specialist doctors as well?
 - a. If yes, then which specialties?
8. Does your caretaker go to appointments with you? If yes, then:
 - a. Is your caretaker present in the exam room?
 - b. Does your caretaker translate for you?

c. Does your caretaker speak to the doctor about you?

Please indicate how you feel about your family care doctor by rating each statement 1-5. 1 indicates none/bad, 5 indicates strongly feeling this way/good.

1. Overall satisfaction with doctor:
2. My doctor is knowledgeable:
3. The doctor is kind and caring:
4. I trust my doctor:
5. Quality of care:
6. Cultural knowledge/understanding:

The surveys were collected either through Google form submission, retrieval of the filled-out paper survey, or digital collection of the paper survey via photographs.

The interviews were structured around four major questions:

1. Have you ever wanted to switch physicians? Why?
2. Do you feel well taken care of in America? Or do you prefer healthcare in Vietnam?
Please explain why.
3. How well do you feel you fit into America? Do you feel included in American society?
Please explain why.
4. How difficult was it to join American society? What struggles did you face, and what have you overcome?

In contrast, the interviews were fairly free-form and structured as conversations. They were conducted both in person and over the phone.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

The data was sampled from Vietnamese individuals living in the Bay Area aged 60 and up that previously immigrated to America. To seek out individuals, outreach was performed to high school and college Vietnamese Student Associations, different Vietnamese organizations such as Church groups (Saint Anthony Church school's faculty, students, youth group, and choir), and Bay Area organizations (VAO, VACCEB, VASC), UC Berkeley class announcements, and connections through friends and family. I inquired through email, text, and in person if individuals were interested in participating in healthcare research. There was no incentive offered for the completion of the forms. The final participants were members of my extended family, family friends, relatives of friends, and acquaintances from church.

Analysis of Data

The data was analyzed on an individual, case-by-case basis. Each individual's results from the survey and interview were reviewed and subsequently compared to the integration level that each individual experienced. Integration level refers to the level at which the individual is connected to American culture and society, whether by proxy (through their caretakers) or by their own life experiences (education, career, time spent in America, involvement in Asian American communities, etc.). Though the data from the survey can be quantitatively analyzed, the results are better inspected on a qualitative basis in conjunction with the demographic information provided for each individual. Because the volume of data is small, individual analysis of each data set can be performed, which provides a holistic image and understanding of how varying post-immigration lifestyles can affect the ability of individuals to seek satisfactory healthcare.

Results

Data Tables

ID	Age	Gender	Year of entry into the USA	Where are you currently residing in CA?	Do you have a caretaker? If so, who?	Race/ethnicity of Doctor	What type of institution?	What language do you use to speak to your doctor?	Does your caretaker go to appointments with you?
A	60	M	1988	Antioch	No	VN	Kaiser	ENG	No
B	64	M	1997	Alameda	No	USA	Hospital	ENG	No
C	64	F	1991	Alameda	No	USA	Hospital	ENG	No
D	74	F	1975	Alameda	No	PH	Summit Hospital	ENG	No
E	74	M	1975	Alameda	No	CN/VN	Private office	ENG	No
F	92	M	1980	San Jose	Yes, daughter	VN	Private office	VN	No (only to specialities)
G	72	M	1981	San Leandro	Yes, wife and kids	VN	Kaiser	VN	No
H	73	F	1975	San Leandro	Yes, daughter	VN	Kaiser	VN	No

Table 1.1- Relevant Demographics Information collected from surveys in English and Vietnamese. If data was collected in Vietnamese, I translated it into English. Individuals A-C filled out internet forms. Individuals E-H filled out paper forms. Individuals B+C; D+E; and G+H are married and live together, but filled out surveys individually. Every individual filled out their own survey without caretaker assistance. Individuals G+H live with their caretaker.

Table 1.2- Ratings of Primary Care Physician (1-5 scale, 1 is least 5 is most)

ID	Overall satisfaction with doctor	My doctor is knowledgeable	Doctor is kind and caring	I trust my doctor	Quality of care	Cultural knowledge/understanding
A	5	5	5	5	5	5
B	5	5	5	5	5	5
C	5	5	5	5	5	5
D	5	5	5	5	5	4
E	5	5	5	5	5	5
F	4	N/A	4	3.5	3	4
G	5	N/A	4	4	4	4
H	5	5	5	5	5	5
Mean.	4.875	5	4.75	4.6875	4.625	4.625
StDev	0.3536	0	0.4629	0.5939	0.7440	0.5175

Responses were in regard to their primary care physicians. Individuals F and G did not include a response to “My doctor is knowledgeable,” the reason being that the question was too general/not applicable to their primary care physician. Individual F originally gave responses on a 10 pt scale, and was halved down to a 5 pt scale.

Data Analysis

The ratings of their primary care physicians are extremely high overall. Scores were high for cultural knowledge even for non-Vietnamese physicians, and there are no discernable patterns regarding patient/physician demographics and the scores provided. Even between different cities/years of entry and length of time in America/having a caretaker/institution of care, scores remain high. None of the individuals attend doctor’s appointments with caretakers. Individuals who speak English with their doctor provide slightly higher ratings. The only lower-scoring individual is individual F, who is the oldest and the only individual from the South Bay. All the individuals in this study have achieved a higher level of integration into American society and its healthcare system either by their own means or by access to caretakers/family members who are capable of navigating the healthcare system. They have all

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

found ways to navigate the language barrier, whether it be through having learned English themselves, or by seeking out doctors who speak Vietnamese. They adjusted to their lives in America and did not express discomfort or distaste for American customs, policies, culture, or communities, which are all conducive to social integration and ultimately satisfactory physician experiences.

Interview Takeaways

I interviewed individuals B and C, the caretakers of individuals F, and the caretakers of individuals G and H, with the goal of learning more about their personal experiences and perspectives regarding American society, health care, and culture that could supplement and explain the quantitative ratings they provided. The main topics that emerged were Vietnam vs. America, willingness/ability to change doctors and integration levels.

Vietnam vs. America

According to the caretaker of patients G and H, cultural and knowledge differences (lifestyle and medical) such as certain superstitions and concerns can instill stubbornness regarding following physician orders. However, increased education, such as with individuals B and C, demonstrates an avenue toward becoming flexible and being able to access the search for physicians who are patient and will work through educational gaps with patients.

All individuals agreed that healthcare in America is much more advanced, and regulated, and emphasizes holistic, preventative care compared to Vietnamese healthcare. Ultimately, all individuals reported they preferred American healthcare to Vietnamese healthcare.

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

Willingness/ability to change doctors

Willingness to change doctors varies on a case-by-case basis and is correlated to the personal values of the individuals. Individual C expressed changing doctors frequently to find one that took great care to engage with the individual even when there were difficulties with expressing herself in English. The caretaker of individuals G and H expressed concerns about observing her parents' complaints about their doctors while remaining with the same providers.

Integration levels

From the individuals I spoke to, I found that having caretakers, being able to speak English, attaining education, utilizing healthcare insurance, and fitting into American culture and Vietnamese American communities are all important aspects of integration into American society. Participants in the study were capable of either caring for themselves and did not require intervention (individuals B and C) or had caretakers that were extremely knowledgeable about American healthcare systems and could provide for the individuals wholly (individuals F, G, and H). Notably, those without caretakers have higher levels of American education, in contrast to individuals like Individual F, who have no formal education in America at all. The caretakers of individuals F, G, and H are responsible for managing the individuals' insurance plans as well, while individuals B and C use insurance from employment. Regarding the language barrier, Individual B is proficient in English through education in America, Individual C is slightly proficient but seeks out physicians who are patient and willing to communicate with her, and Individuals F, G, and H have Vietnamese physicians who speak Vietnamese. As for each individual's participation within society, Individual F, though not well engaged in American cultural practices, resides in a densely Vietnamese area and was, up until his more recent years, actively engaged in the Vietnamese parish community in San Jose. Individual B is a proponent of

American society and deeply enjoys the freedom of the culture, and both individual B and C have friends that are of diverse cultural backgrounds, made in community settings such as work and the gym.

Discussion

Revisiting Research Question and Hypothesis

The original hypothesis does not align with the results from this data set. It appears, at least from this small set of data, that elderly Vietnamese immigrants in the Bay Area demonstrate high levels of satisfaction with their patient care and primary care physicians. They have greatly circumnavigated the purported issues of language barriers, an inability to navigate the American healthcare system, distrust of America and its systems, and a lack of cultural understanding.

Individuals have overcome language barrier problems by learning English, having English-speaking family members and caretakers, using translation services, or simply seeking physicians who can speak Vietnamese. The caretaker of patients G and H is very familiar with the state of Vietnamese individuals in healthcare as a former pharmacist for Kaiser Permanente and current insurance agent for Medicare/Medical working to increase Vietnamese awareness of preventative healthcare plans. Upon further discussion with them, they noted that the Bay Area's large Vietnamese communities have actually become quite proficient in navigating American healthcare. Vietnamese communities share information quite liberally through different platforms like Facebook, television news, newspaper announcements, and community gatherings throughout the Bay. Among these platforms, it is common to exchange information on how immigrants can access American healthcare and insurance. Vietnamese immigrants, including undocumented individuals, are frequently informed by other Vietnamese immigrants about how

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

to enroll in insurance programs and take advantage of Medical. There are insurance forms and infographics in Vietnamese as well, alongside access to Vietnamese-speaking agents.

Vietnamese immigrants also do not seem to dislike the American healthcare system. Rather, their experiences with the lower quality of non-preventative healthcare in Vietnam actually aids their current preference for American healthcare and its holistic, preventative nature. Their satisfaction with their primary care physicians is an experience that cannot be translated from Vietnamese healthcare systems, which focus primarily on curing ailments and illnesses once the patient is already experiencing the symptoms, versus performing maintenance checkups. Interestingly, the cultural understanding scores are quite high as well, irrespective of the physician's own ethnicity. There are still many gaps in research-based medical knowledge that the Vietnamese community has, with a lack of education, culturally ingrained knowledge, and superstition forming often non-scientific and stubborn ideas. These issues were highlighted in the insurance agent's anecdotes about Vietnamese patients' reluctance to switch to preventative care plans. Still, the individuals surveyed have managed to seek out physicians who appear to understand them or at least respect their ideas and autonomy as patients.

It should be noted that this sample was very small and incidentally concentrated on individuals who are relatively successful, educated, and have spent a long time in America. This is not a diverse sample and represents the experience of individuals who are comfortable with finding doctors who fit their desires, and have the capacity to achieve satisfaction in their patient care.

Reexamination of research methods

The largest issue in this project is its lack of sampling diversity and size. It pulls from only a few locations in the Bay and has a small sample size. Repeating the project with an

Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

expanded sample would allow for more comparison between cities of current residence, and differing living circumstances, and account for more variability in the immigrant population. More interviews, especially with representatives that demonstrate different current lifestyles as Vietnamese in America, would also allow for a more in-depth examination of each case, creating opportunities to examine other important characteristics that can impact healthcare quality, such as socioeconomic status, education attainment, occupation, and insurance. For example, seeking participants from every major city in the Bay Area, or individuals from different annual income levels, would increase the socioeconomic and geographical diversity. Adding an incentive would also be helpful to receiving more responses. Additionally, the close relation some of the participants had to me could induce possible bias in the honesty of their responses, and reliance on individuals within my own social circle further limits diversity.

Changes in Vietnamese demographics

The contrast between the satisfactory ratings and the initial concerns about Vietnamese immigrants with American healthcare highlights changing patterns within the community as their length of time in America increases.²⁹ One important change is an upward trend of educational attainment through each generation.³⁰ In fact, Vietnamese Americans overall are characterized as high achievers.³¹ Another positive trend is in occupations, where Vietnamese Americans occupy both working-class and professional industries. 34.5% of the U.S. Vietnamese population worked in management, business, science, and the arts in 2017.³² Government resources, such as

²⁹ Abby Budiman, "Vietnamese in the U.S. Fact Sheet," Pew Research, <https://www.pewresearch.org/social-trends/fact-sheet/asian-americans-vietnamese-in-the-u-s-fact-sheet/#length-of-time-in-the-u-s-for-vietnamese-immigrants-2000-2019>

³⁰ Stacy M. Kula et. al, "Vietnamese Americans: History, Education, and Societal Context," *Journal of Southeast Asian American Education and Advancement* 16, no. 1 (2021): 6.

³¹ Ibid.

³² Ibid.

financial aid and relocation agencies, have allowed Vietnamese refugees and their children to focus their efforts on educational attainment.³³ Even when American government support waned, the collective co-ethnic support within the prominent Vietnamese ethnic enclaves provided a sense of societal security and low-barrier employment opportunities.³⁴ This communal support resultantly furthers the upward trend of educational attainment.

Conclusion

The individuals I surveyed and interviewed demonstrated an overwhelmingly positive view of their physician-patient interactions and deemed their primary care physician to be a satisfactory healthcare provider. These results most likely stem from each individual's ability to integrate into American society, namely in their advances in the English language, American education, careers, and caretakers. In my discussion with a Bay Area Vietnamese insurance agent, I learned of additional methods Vietnamese immigrants employ within their communities to achieve satisfactory healthcare, including sharing information with one another and utilizing Vietnamese translation services. Though prior research emphasizes the hardships of Vietnamese immigration and the refugee experience and identifies various health disparities they consequently endure, my study depicts possible improvements in Vietnamese American health. This new positive stance of Vietnamese immigrants towards healthcare may reflect growing provisions for Asian groups in American healthcare institutions or the resilience and adaptability of this demographic and their ability to capitalize on their tight-knit communities.

³³ Ibid, 13.

³⁴ Ibid, 13.

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Quality of Elderly Vietnamese Immigrant Healthcare In the Bay Area

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