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The Effects of Sociocultural Factors on Older Asian Americans' Access to Care

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Most Asian American elders are immigrants to the United States, and sociocultural factors such as English proficiency and immigration status are prominent factors in their lives. Using data from the California Health Interview Surveys to focus on Asian Americans over age 50, this study seeks to identify interethnic differences, and the effects of English proficiency and immigration status in the way older Asian Americans access healthcare. The results indicated that Asian ethnicity, English proficiency, and immigration status have significant independent effects on older Asian Americans' access to care. Implications for social work's role in addressing access disparities are discussed.

KEYWORDS ethnicity and multicultural issues, older adults, Asian Americans, service use

INTRODUCTION

Background

The rapid growth of racial/ethnic minority groups is changing the United States' population demographic characteristics. Particularly, the Asian segments of the population will increase the fastest due to increasing longevity and new immigration. Seeking economic and social opportunities, Asian ethnic groups have had a long history of immigration to the United States (Kitano & Nakaoka, 2001). Since the immigration reforms of the 1960s, the Asian population has grown exponentially. According to census counts, the

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proportion of Americans who identify themselves as Asians has doubled at each census since 1970 (Kitano & Nakaoka, 2001). In 2000, 801,000 Asians over 65 constituted 2.3% of older adults in the United States (He, Sengupta, Velkoff, & DeBarros, 2005). Both the Asian and Hispanic American population are projected to double in size by 2050, outpacing the population changes for African Americans and non-Hispanic Whites (US Census Bureau, 2008). However, the Asian population in the United States is unique in that trends predict rapid growth of the middle-aged population, which points to large increases in the future proportion of older Asians. The growth of the Asian American population will be spurred by older adults; the number of Asian Americans over 65 will grow five-fold by 2050 (US Census Bureau, 2008).

Despite the changing demographics of the American adult and older population, little physical and mental health research has been conducted on Asian groups (Dilworth-Anderson, Williams, & Gibson, 2002; LaVeist, 1995; Tanjasiri, Wallace, & Shibata, 1995). The lack of empirical research limits the ability of practitioners and policymakers to respond to the changing population. Further, bundling together the various Asian ethnic subgroups into one broad category masks the multiethnic heritage of immigrants from Asian countries. Researchers and service providers will be better able to respond to the physical/mental health needs of racial/ethnic minority adults and older adults by using empirical information on the way adults from immigrant backgrounds use healthcare services now.

Most Asian American older adults are immigrants to the United States (US Census Bureau, 2004). The Asian immigrant experience in the United States is shaped by the pushes and pulls that spur migration (Portes & Rumbaut, 2006). Refugees and asylum-seekers are seen as having little choice but to flee social or political persecution in their country of origin as they are pushed toward life in the United States. Meanwhile, voluntary immigrants, especially among the skilled labor force, choose to come to the United States to seek economic opportunities. US immigration policy facilitates family reunification, and many immigrants and refugees are able to sponsor their immediate and extended families to immigrate.

Portes and Rumbaut (2006) argued that immigrant or refugees' social positions in their country of origin influence their subsequent adaption to life in the United States. This is clearly exemplified by the experience of Vietnamese, who constitute, the largest group of Asian refugees. Although the first wave of refugees was involuntarily resettled, they shared common traits from their life in Vietnam that facilitated adjustment to their new life in the United States; they were proficient in English and highly educated. Although many lost status when they sought employment in the United States, their language skills and prior education enabled them to adapt to the US workforce. This stands in contrast to later Vietnamese refugees, who came with less education, had higher levels of health and mental health

needs, and encountered more challenges (Rumbaut, 2000). There were fewer professionals in later waves, and later refugees experienced additional challenges in securing employment.

Despite the general perception that the Asian American population is a *model minority*, able to overcome obstacles, they have unmet psychosocial needs (Sue, Sue, Sue, & Takeuchi, 1995). Notably, high levels of physical and mental health need have been observed among refugees from Southeast Asia (Beiser, 1988) and among Japanese and Vietnamese older adults (Mui & Kang, 2006). In the context of acculturation, the aging process introduces new psychosocial challenges and exacerbates preexisting psychological distresses (Stoller & Gibson, 1999; Tran, 1992). Variations among Asian Americans with respect to ethnic background, immigration status, and language proficiency affect physical and mental health (Loo, Tong, & True, 1989). The distinction between voluntary and involuntary migration to the United States has been reported to affect the mental health and life satisfaction of older Asian Americans (Mui & Shibusawa, 2008). Furthermore, familiarity with and use of Western medical care in their country of origin has been found to increase the likelihood of using formal medical service in the United States (Chung & Lin, 1994).

Although the research base has established the relationship between English language proficiency and health outcomes (Mui, Kang, Kang, & Domanski, 2007), the construct has been overlooked in the access to care literature. Understanding how older Asian Americans come into the healthcare system is important for social workers and other healthcare providers. The healthcare system is a common point of entry into a broader range of health and social services. Access to care has been defined broadly to encompass having health insurance, seeing a physician, and having a usual source of care. Having a usual source of care is also an indicator of access to preventive health services and screenings for chronic health conditions such as diabetes, cardiovascular disease, and psychosocial well-being that are integral to the overall well-being of older adults (US Centers for Disease Control and Prevention et al., 2009). Having a usual source of care is associated with a decreased number of visits to emergency departments (Petterson, Rabin, Phillips, Bazemore, & Dodoo, 2009), improved linkages with the healthcare system, and more use of preventive services (Xu & Borders, 2008).

Conceptual Framework

Most access-to-care studies have applied Andersen's behavioral model (Andersen, 1995; Choi, 2006). The model seeks to predict healthcare service use through the environment (healthcare system), population characteristics (predisposing characteristics, enabling resources, need factors), health behavior (health practices, use of health services), and outcomes (perceived health status, evaluated health status, consumer satisfaction). Predisposing

characteristics include social demographic variables such as a person's gender, age, racial and ethnic group membership, and health beliefs. Enabling factors include aspects of the individual's personal, family, or community domains that facilitate access to and use of healthcare, including the person's social support and his or her access to healthcare benefits. Need factors include the individual's health status and issues that may precipitate the use of health services. Assessing outcomes of previous health service use and the environmental dimensions is important for analyses of racial and ethnic minority groups who may have negative experiences with the healthcare system or have limited access to resources due to their minority status.

A challenge of using the behavioral model for immigrant populations is conceptualization of cultural variables. Building on Bordieu's original work, Abel (2008) discussed the relative contributions of social, economic, and cultural capital in the development of social class and their subsequent effects on healthcare access and overall health. Cultural capital refers to a group's resources to use and seek out information that enriches their lives. For Asian Americans and other population segments with histories of recent immigration to the United States, the term *group* refers directly to a racial/cultural entity. Within the context of the US healthcare system, however, the concept of cultural capital can be extended to one's ability to navigate and access healthcare, as well as help-seeking behaviors. Therefore, to blend the behavioral model and Abel's description of cultural capital, the enabling factors are divided into economic and sociocultural factors.

Among enabling factors, economic resources have been found to be associated with access to and use of healthcare. Having any insurance coverage and having supplemental insurance coverage are factors associated with increased levels of medical service use (Fitzpatrick, Powe, Cooper, Ives, & Robbins, 2004; M. Jang, Lee, & Woo, 1998).

Although the literature has established a connection between economic factors and access to care, research with immigrant samples has also identified the impact of length of stay in the United States on health care access. One study that compared newly arrived older immigrants with immigrants with longer durations in the United States found that immigrants arriving within the preceding 5 years were far more likely not to have insurance and more likely not to have a usual source of care (Choi, 2006). In their study using nationally representative data, Xu and Borders (2008) showed that immigrants had fewer preventive and nonpreventive visits to physicians than non-immigrants. In addition, more immigrants than nonimmigrants indicated they did not have a usual source of care. Having a usual source of care increased the number of physician contacts for immigrants at a greater rate than for nonimmigrants. Immigrants who had arrived within the preceding 10 years received the least preventative care. Previous research on Mexican immigrants reported differences in access to preventive care by nativity and length of stay in the United States (Wallace, Gutiérrez, & Castañeda 2008).

Research on Asian American samples has focused on the multiple barriers to service utilization, including language access issues, a fragmented healthcare system, lack of insurance, and lack of knowledge about existing resources (M. Jang et al., 1998; Y. Jang, Kim, Hansen, & Chiriboga, 2007; Loo et al., 1989) . In general, limited English proficiency restricts access to care (Ponce, Hays, & Cunningham, 2006). In Ma's (2000) study of Chinese Americans living in Houston, persons with limited English proficiency encountered more barriers to accessing the healthcare system than those with higher levels of English ability. Ma (2000) also reported that facility with the Western healthcare system enabled Chinese Americans to overcome some barriers to care.

Furthering the understanding of English proficiency, M. Jang and his colleagues (1998) found that persons who spoke only Chinese were less likely than English speakers to have health insurance. Among Southeast Asian refugees from Vietnam, Cambodia, and Laos, those with higher levels of English proficiency were more likely to use Western medical services than traditional medical care (Chung & Lin, 1994).

Although researchers have studied minorities' access to care, past research has focused on broad racial and ethnic comparisons. By aggregating Asian Americans into a single racial categorization, previous studies have overlooked the rich diversity within the racial group. The Asian race encompasses more than 30 distinct ethnic groups. However the majority of Asian Americans represent one of six ethnic groups: Chinese, Filipino, Asian Indian, Japanese, Korean, or Vietnamese (US Census Bureau, 2002). To extend the knowledge base on Asian American access to care, this study looks at Asian Americans over age 50 from different ethnic groups. Specifically, this study addresses two specific research questions. First, are there interethnic differences in the way older Asian Americans access healthcare? Second, how do English proficiency and immigration status affect their access to care?

METHODS

This study used publicly available data derived from the 2003 and 2005 versions of the California Health Interview Survey (CHIS; 2005, 2008). Conducted by the Center for Health Policy Research at the University of California–Los Angeles, the CHIS is a cross-sectional study of California residents' health and access to care; it is a random-digit-dial telephone survey that uses a two-stage sampling procedure. More Asian Americans live in California than any other state, and combining two CHIS years enables this study to have the statistical power to focus on interethnic differences among older Asian American adults.

A total of 42,044 adults responded to the 2003 CHIS, and 43,020 responded to the 2005 CHIS. Supplemental sampling strategies were

used during both survey years to increase the number of Korean and Vietnamese respondents. The survey instrument was translated into a number of Asian languages, including Cantonese, Mandarin, Korean, Vietnamese, and Khmer. The overall response rates for the survey years remained low; they ranged from 33.5% in 2003 to 26.9% in 2005, which were consistent with other health surveys (CHIS, 2005, 2008). The local Institutional Review Board approved the protocols for this study.

Study Sample

The study's sample consisted of Asian Americans over age 50. Respondents were included in this study if they identified with the Asian race only and if they were non-Hispanic. This resulted in an unweighted sample size of 3,011. Respondents ranged in age from 50 to 85. To account for the complex sampling methods used in CHIS, jackknife replication methods applying the survey-supplied replicate weights were used to obtain accurate, weighted variance estimates (Rust & Rao, 1996; SAS Institute, 2008).

Measurement of Variables

The dependent variable for this study was whether or not the respondent had a usual source of care. To identify those at risk, not having a usual source of care was coded 1 and having a usual source of care was used as the reference category.

Independent Variables

Anderson's (1995) behavioral model was used to organize the independent variables. Abel's (2008) conceptualization of social class was integrated into enabling factors, which were divided between economic and sociocultural variables. Figure 1 shows the conceptual model.

Predisposing characteristics. To control for differences in work status qualification for government-sponsored insurance, age was used as a continuous measure and as a means of categorizing the preretirement age cohort (50–64) versus those age 65 and older. The sample was subdivided by Asian ethnicity: Chinese, Filipino, Korean, Vietnamese, or Other Asian. The Other Asian category included ethnic groups that were not well represented in the survey, such as Japanese, Cambodian, and South Asian. Marital status was used as a predisposing characteristic. Given the high rate of marriage among older Asian Americans, the sample was divided between the married and the unmarried (widowed, divorced, separated, and never married).

Enabling resources. The enabling resources in this study were divided between economic and sociocultural factors. Economic factors included

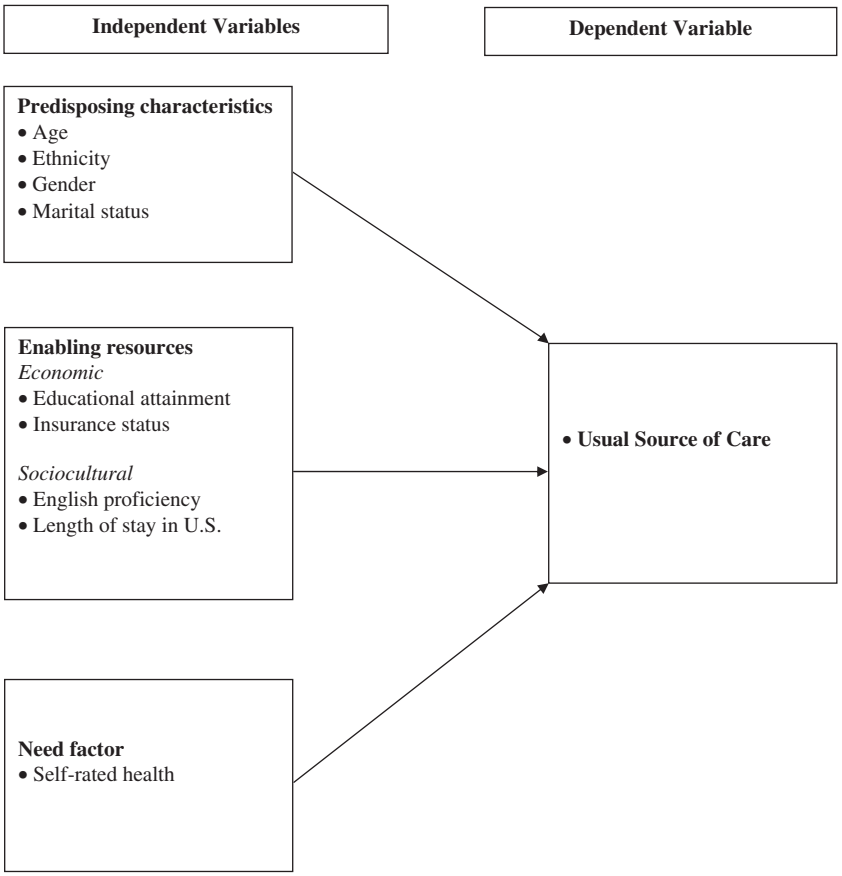

FIGURE 1 Blended conceptual framework for health service use.

educational attainment (less than high school, high school graduate, and some college) and insurance status. Poverty index, a continuous measure calculated by the study authors, was used as an income control. In addition, three sociocultural enabling resources were used: English proficiency and immigration status. English proficiency was measured by a single item: the question "How well do you speak English?" Response options ranged from "not at all" to "speak only English." The *not at all* and *not well* categories were combined into the poor English proficiency category; the *well*, *very well*, and *speak only English* responses were combined to serve as the reference group. Household size was used as a continuous variable as a proxy for social connections.

Need factor. One item, general health, was used as an indicator of health need. The self-rated general health item has been used extensively as a reliable measure of overall health (Sorkin, Tan, Hays, Mangione, & Ngo-Metzger, 2008). Although the item is scored on a 5-point scale, ranging from *poor* to *excellent* health, the *good*, *very good*, and *excellent* categories are

very similar, and are commonly categorized as good health; we used this categorization. The *fair* and *poor* responses were combined in a poor health category.

Analyses

Univariate analyses were used to develop a basic understanding of the predisposing characteristics, enabling resources, and need factors that affect Asian Americans. Additionally, bivariate analyses were used to examine associations among the variables. For multivariate analyses, separate hierarchical logistic regression analyses based on the conceptual model were used to identify the correlates for each dependent variable. All analyses were conducted using *SAS 9.2* software (SAS Institute, 2008).

RESULTS

The weighted sample description is presented in Table 1. The average age of the sample was 63.19 (SE = .17). Chinese Americans composed the largest group, followed by Other Asians. There were more women (57.2%) than men. Most of the sample spoke English well. Roughly one in 10 had arrived in the United States within the preceding 10 years. Nearly three-quarters were married at the time of the survey. Of the sample, 10.6% were uninsured, and 7.8% had no usual source of care.

The results of chi-square tests of selected variables with having a usual source of care are presented in Table 2. Statistically significant differences were observed for a number of predisposing and enabling characteristics. Nearly all Filipino Americans (97%) and more than 90% of Chinese Americans, Vietnamese Americans, and Other Asian Americans had a usual source of care. Korean Americans had the lowest rate of having a usual source of care at 85.2%. The percentage who had no usual source of care ranged from 2.2% for Filipino Americans to 14.8% for Korean Americans.

Although few older Asian Americans who spoke English well had no usual source of care, nearly 10% of those who did not speak English well had no usual source of care. Likewise, less than 5% of older Asian Americans who had been in the United States for more than 5 years had no usual source of care, compared to more than 27% of recent immigrants. Over 30% of the uninsured had no usual source of care, and nearly all older Asian Americans with insurance had a regular place to receive care. Finally, there were no statistically significant differences based on general health.

Very few recent arrivals had a usual source of care. Likewise, differences in having a usual source of care were observed by English proficiency. Among enabling resources, having a usual source of care was associated with having full time work, as well as having insurance.

TABLE 1 Weighted Sample Description for Asian Americans Over Age 50

Variable	*n*	*N*	Weighted %
Age, year (*M, SE*)	63.19 (0.17)		
Gender			
Male	1,266	901,976	42.7
Female	1,745	1,208,192	57.2
English proficiency			
Well	1,804	1,317,182	62.4
Not well	1,207	792,986	37.6
Immigration status			
Less than or equal to 10 years	271	217,381	10.3
Greater than 10 years	2,740	1,892,787	89.7
Asian group			
Chinese	1,050	658,410	31.2
Filipino	464	519,317	24.6
Korean	428	190,228	9.0
Vietnamese	399	263,288	12.5
Other Asian	670	478,924	22.7
Marital status			
Currently married	2,026	1,535,896	72.8
Not married	985	572,273	25.2
Insurance status			
Insured	2,675	1,886,753	89.4
Uninsured	336	223,416	10.6
General health status			
Good	1,922	1,329,070	63.0
Poor	1,089	781,098	37.0
Has a usual source of care			
Yes	2,807	1,988,095	92.2
No	204	122,072	7.8

Multivariate Analyses

The odds ratios from the results of hierarchical logistic regression models, applying the behavioral model to access to care for older Asian Americans, are presented in Table 3. Education and insurance status served as economic enabling resources and were entered at the first step. As expected, the uninsured were far more likely to have no usual source of care.

Predisposing characteristics were entered at the second step. Increased age did not affect the likelihood of a person's having a usual source of care. Women were more likely than men to have a usual source of care, but the significant differences dissipated when health status was controlled. Interethnic differences were noted as Vietnamese Americans were more likely than Chinese Americans to have a usual source of care, even after the introduction of enabling and need controls. The differences between Filipino Americans and Chinese Americans were negated when sociocultural and health controls were entered. In addition, the significant differences between Korean Americans and Chinese Americans at the bivariate level were not observed in the multivariate analyses. Finally, older adults who

TABLE 2 Chi-Square Results for Selected Variables by Usual Source of Care Status

	Have a usual source of care	No usual source of care	χ^2	p
Gender			1.02	.392
Male	42.5	46.4		
Female	57.5	53.6		
English proficiency			57.23	<.0001
Well	64.1	35.5		
Not well	35.9	64.5		
Immigration status			87.10	<.0001
Less than or equal to 10 years	9.0	31.2		
Greater than 10 years	91.0	68.8		
Asian group			65.96	<.0001
Chinese	92.6	7.3		
Filipino	97.8	2.2		
Korean	85.2	14.8		
Vietnamese	95.4	4.6		
Other Asian	95.4	4.6		
Marital status			4.40	.087
Currently married	73.2	65.9		
Not married	26.8	34.1		
Insurance status			495.52	<.0001
Insured	92.5	39.0		
Uninsured	7.5	61.0		
General health status			0.75	.4383
Good	62.8	66.1		
Poor	37.2	33.9		

were not married were more likely than married older adults to have no usual source of care (OR = 2.0).

Two sociocultural factors were entered as enabling resources at the third step. Poor English speakers were more likely than their counterparts who spoke English well to have no usual source of care (OR = 2.3). Additionally, older Asian Americans who had lived in the United States less than 10 years were more likely to have no usual source of care than their counterparts who had lived in the country longer (OR = 2.4). Differences by educational attainment became significant at this step; high school graduates were less likely (OR = .54) to report not having a usual source of care compared with older adults with some college education. The odds ratio remained consistent with the addition of the need covariate.

The final model included general health as a need factor. Those in poor health were more likely to have a usual source of care than their counterparts in good health.

Statistically, predisposing factors explained a significant proportion of the model's variance while controlling for other covariates. The explanatory value of the sociocultural enabling resources was modest, but statistically significant. The introduction of need factors at the final step reduced the variance explained in the model.

TABLE 3 Odds Ratios From Hierarchical Logistic Regression Models of Usual Source of Care

	Step 1 OR	Step 2 OR	Step 3 OR	Step 4 OR
Enabling resources–economic				
Education				
Less than high school	.88	.87	.65	.69
High school graduate	.64	.64	.51*	.54*
Some college (reference)				
Uninsured	19.8****	17.1****	14.3****	14.5****
Poverty index	.94	.90	1.0	.99
Predisposing characteristics				
Age (continuous)		1.0	1.0	1.0
Preretirement age cohort		1.4	1.6	1.5
Female		0.66*	.67	.68
Asian ethnicity				
Filipino		.37*	.47	.45
Korean		1.33	1.29	1.39
Vietnamese		.34**	.33**	.38**
Other Asian		.84	1.18	1.1
Chinese (reference)				
Not married		1.84**	2.0***	2.0***
Enabling resources–sociocultural factors				
English proficiency (not well)			2.1**	2.3**
Less than or equal to 10 years in the U.S.			2.3**	2.4**
Household size			1.0	1.0
Need factor				
General health: Poor				.58
Model statistics				
c at this step	.79	.81	.82	.81
Wald χ^2	250.18 (df = 3)****	366.95 (df = 12)****	428.89 (df = 15)****	476.55 (df = 16)****

*$p < .05$. **$p < .01$. ***$p < .001$. ****$p < .0001$.

Our findings provide support for the study's research questions. This study's findings indicate that there are interethnic differences among older Asian American groups. Additionally, English proficiency and immigration status, common proxies for exposure to American culture, play a significant role in older Asian Americans' access to care.

DISCUSSION

This study used data from the CHIS to examine the effects of sociocultural enabling factors on access to care among older Asian Americans. The results indicated that Asian ethnicity, English proficiency, and immigration status have significant independent effects on older Asian Americans' access to care.

This study reinforces the reality of diversity among Asian Americans as interethnic differences among Asian American groups were found. For

example, Vietnamese Americans were found to be more likely than Chinese Americans to have a usual source of care. This may stem from their past involvement with the healthcare system as recipients of refugee benefits, as well as their higher levels of physical and mental health need than those of members of other Asian American ethnic groups (Mui & Shibusawa, 2008). At the bivariate level, fewer Korean Americans than members of any other Asian American group were found to have a usual source of care. Lacking a usual source of care puts a disproportionate number of Korean Americans at risk for poor health outcomes. Future research to understand the help-seeking differences that separate Korean Americans from other Asian American groups can inform the development of culturally-appropriate interventions to promote access to healthcare.

Although English proficiency and immigration status can vary by Asian ethnicity (Mui, Nguyen, Kang, & Domanski, 2006), this study's results show that the sociocultural factors contribute to having a usual source of care. This extends prior multiracial research on the effects of English proficiency (Ponce et al., 2006) and immigration status (Choi, 2006) by furthering understanding of the way these issues affect Asian American older adults. This study's findings are consistent with prior research that reported higher levels of English proficiency increases the likelihood of having a usual source of care (Ponce et al., 2006). In addition, research that looked at Mexican immigrants reported longer lengths of stay promoted access to preventive care (Wallace et al., 2008). Programs and interventions that empower older Asian Americans with English language skills and education on the US healthcare system have the potential to remedy disparities in accessing healthcare.

Among other enabling resources, the effect of insurance status on access to care has been well established (Choi, 2006). In this study, older adults who had completed high school were at decreased risk of lacking a usual source of care. Although prior research suggests that increased education is associated with positive health and health behaviors (Grossman, 2000), this study's findings may point to the complicated role of education for immigrant older adults. Premigration education can influence the acquisition of English skills, as well as employment opportunities, which in turn can facilitate access to a range of providers and the acquisition of health coverage (Jang et al., 1998).

The differences between married and unmarried older Asian Americans are consistent with prior research on Vietnamese Americans suggesting the facilitative role of marital status on accessing care (Jenkins, Le, McPhee, Stewart, & Ha, 1996). Late-life marital transitions are common among older adults, especially the increased incidence of widowhood (He et al., 2005). Special attention needs to be paid to unmarried older Asian Americans, who may be at elevated risk for health and mental health needs.

Implications for Social Work

American social policies in the wake of the 1996 passage of the Personal Responsibility and Work Opportunity Act curtailed the health and social benefits afforded to recent immigrants and put them at a social disadvantage. The restriction of benefits is but one factor related to their increased vulnerability on the issue of having a usual source of care. As reduced resettlement support is in place, new arrivals have fewer resources to help them learn about the US healthcare system. In addition, the challenges of migration in later life and the immediate needs for work and housing may take precedence over access of healthcare, yet being able to receive timely healthcare reduces treatment delays and improves health promotion.

The passage and implementation of the Patient Protection and Affordable Care Act in 2010 have implications for older Asian Americans. Although the Act extends insurance coverage to a larger percentage of Americans, legal immigrants would still have a 5-year waiting period to apply for Federal benefits. Additionally, social workers need to ensure that older Asian Americans and their communities receive access to the information necessary to comply with the law, and to receive affordable coverage.

At the individual and community levels, strengthening communities by investing in their social resources through enhancement of the new arrivals' English proficiency can bridge the disparity gap while they are waiting for meaningful systemic changes. In addition to improving older Asian Americans' access to usual sources of care, improving their English proficiency can enable them to be fully involved in social (Gellis, 2003), and health (Gellis, 2003; Mui et al., 2007) domains. Greater English proficiency can empower them to access a broader range of service providers and health information. In a culturally congruent context, empowering Asian American communities with the necessary skills to negotiate the current healthcare system can have lasting benefits. Fundamentally, the role of English proficiency has been documented as an important factor in health as well as economic security. For older Asian Americans being proficient in English can affect many health and economic domains.

The stratification among Asian Americans by English proficiency and immigration status reflects Abel's (2008) description of the effects of social class on health. Numerous studies have documented the challenge and barriers to immigrants' access to care due to a lack of knowledge or the ability to deal with challenges associated with interfacing with the healthcare system (Ma, 2000). Within this context, working to improve English proficiency among Asian Americans throughout the earlier periods of their lives can impact their health later in life. Additionally, educating recent arrivals about the healthcare system with the goal of providing them a point of entry can have lasting positive health effects on them.

Limitations

Using the CHIS presents several limitations. Using cross-sectional data from the 2003 and 2005 survey years precludes making definitive causal inferences. The process of combining survey years raises the small possibility of inaccuracy because an individual may have responded to the survey twice. The relatively low response rate would generally limit the inferences to the general population, but the use of replicate weights overcomes some of the nonresponse limitation. Some survey respondents had the option of completing the interview in their native language, but the interview was not translated for all Asian languages. Therefore, certain subgroups, such as the Filipino sample, may have more adults with high levels of English proficiency. Further, the sample was limited to the state of California, which makes generalizations to the general US population tentative at best and raises the possibility of a cohort effect. The analysis did not include interaction terms that may explain some differences among the Asian population. Finally, this use of existing data precludes the examination of health beliefs about Eastern and Western medicine, which could influence access to Western medical care among older Asian immigrants. Further research should be conducted to examine the intersection between Western and Eastern health beliefs across the lifespan to extend the knowledge base on Asian Americans' help-seeking behaviors. The dependent variable for this study did not look at why respondents did not have a usual source of care, or the variations in the type of care, which has been found to differ by race (Gaskin et al., 2007). Future research on Asian American older adults from specific groups that focuses on care provider characteristics can shed light on older adults' help-seeking behaviors as well as strengths and gaps in the healthcare system.

Conclusion

Sociocultural characteristics act as a means of stratification that differentiates who receives care. By reaching out to the underserved using innovative, culturally appropriate methods, social workers can be at the forefront of improving the health of limited-English-proficient and recent immigrant older adults. Building the social resources within Asian American communities can have lasting effects on the health and well-being of Asian Americans throughout their lifespan.

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