

UCLA

UCLA Electronic Theses and Dissertations

Title

In Sickness and in Health: Health Care Experiences of Korean Immigrant Older Adults

Permalink

<https://escholarship.org/uc/item/2gn226kd>

Author

Juhn, Erica

Publication Date

2012

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

In Sickness and in Health:

Health Care Experiences of Korean Immigrant Older Adults

A thesis submitted in partial satisfaction

of the requirements for the degree Master of Arts

in Asian American Studies

by

Erica Young-eun Juhn

2012

© Copyright by
Erica Young-eun Juhn
2012

ABSTRACT OF THE THESIS

In Sickness and in Health:
Health Care Experiences of Korean Immigrant Older Adults

by

Erica Young-eun Juhn

Master of Arts in Asian American Studies

University of California, Los Angeles, 2012

Professor Marjorie Kagawa-Singer, Chair

The purpose of this study was to document the health care experiences of Korean immigrant older adults, 65 years of age or older, living in Los Angeles County, who have health care access through Medicare and/or Medi-Cal, access to a large Korean ethnic enclave, and a diverse social support network. Twelve Korean immigrant older adults were recruited through word-of-mouth via community contacts. Semi-structured qualitative interviews were conducted with individual seniors, with the help of a bilingual, bicultural interpreter. Translated transcripts of the interviews were coded, and domains were identified via a “grounded theory” approach. The themes that emerged were: 1) ambivalence toward Korean primary care doctors, 2) limited health care choices, 3) dependence on a diverse social support network, 4) personal responsibility for one’s health, and 5) the idea of enduring difficulties in life and expected health challenges “old age.” Implications of the findings are discussed for service and policy, with attention to the importance of language and culture for this population.

The thesis of Erica Young-eun Juhn is approved.

Min Zhou

Steven P. Wallace

Marjorie Kagawa-Singer, Committee Chair

University of California, Los Angeles

2012

DEDICATION PAGE

To the Korean ‘halmoni’s (할머니들 – grandmothers) and ‘harabuji’s (할아버지들 – grandfathers) who let me into their lives and shared their history, understanding, and sense of purpose with me. Thank you for all that you are and all that you do and for teaching me more than I can put into words.

TABLE OF CONTENTS

List of Figures	vii
List of Tables	viii
I. INTRODUCTION	1
Problem Statement	3
Background	4
Korean Immigrant Older Adults – Demographics & History	4
Koreatown	9
Purpose of the Study	13
Significance of the Study	13
II. LITERATURE REVIEW	15
Health Care Access and Utilization	15
The Role of the Ethnic Enclave	21
Social Support Networks	28
III. METHODOLOGY	33
Study Design	33
Participants	33
Data Collection	38
Analysis	41
IV. RESULTS	42
Theme 1: Ambivalence toward Korean Primary Care Doctors	44
Main Source of Health Care	45
Superfluous Formality	46
Theme 2: Limited Health Care Choices	48
Theme 3: Dependence on a Diverse Social Support Network	51
Informal Support	52
Formal Support	54
Theme 4: Personal Responsibility for One's Health	56

Theme 5: Enduring	60
V. DISCUSSION AND CONCLUSION	65
Discussion	65
Ambivalence toward Korean Primary Care Doctors	66
Limited Health Care Choices	68
Dependence on a Diverse Social Support Network	70
Personal Responsibility for One's Health	72
Enduring	74
Major Findings	77
Implications	79
Limitations of the Study	83
Concluding Remarks	84
APPENDICES	86
A. Medicare vs. Medi-Cal Basic Background Chart	86
B1. Recruitment Flyer (English)	88
B2. Recruitment Flyer (Korean)	89
C1. Eligibility Screening Consent Script (English)	90
C2. Eligibility Screening Consent Script (Korean)	92
D1. Information Sheet (English)	94
D2. Information Sheet (Korean)	96
E. Interview Guide	99
REFERENCES	103

LIST OF FIGURES

Figure 1	Koreatown, as officially designated by the Los Angeles City Council (map)	11
Figure 2	One version of “Koreatown, Los Angeles, CA,” as defined by Google Maps, with three major freeways shown (map)	12

LIST OF TABLES

Table 1	Demographic Characteristics of Interviewed Seniors	36
Table 2	Language and Health Care Characteristics of Interviewed Seniors	37
Table 3	Themes Chart with Included Domains	43

ACKNOWLEDGEMENTS

It has been a long, difficult journey, but the relationships forged through the process have made it welcome and worthwhile.

I am grateful to my thesis committee members, Professor Marjorie Kagawa-Singer, Professor Steven P. Wallace, and Professor Min Zhou, who have always made themselves available and believed in me, even at the eleventh hour. Thank you for your courses, which inspired me; your detailed comments and edits, which refined my writing; and for the encouragement and support you provided through the years.

To my Committee Chair, Professor Kagawa-Singer, I am indebted to you for all the times you provided a willing ear, even during the most frenzied of times, and for starting me on the path to public health. I cannot imagine my graduate school experience without you, and I'm so glad I don't have to. You continue to amaze me as a professor, a mentor, an advocate, and a friend.

I was blessed to make several friends along the way, but there are six special people who filled my travels through academia with lasting memories of rainbows and laughter. Natalia Yamashiro Chogyoji, Danny Dechartivong, Andrew Jung, Mary Keovisai, Evangeline Reyes, and Christina Suda, I could not ask for a better cohort.

Lindsay R. Gervacio, you will always be my thesis writing partner and kindred spirit, and I'm privileged to count you as my friend and to finish alongside you.

Christine D. Rhee, thank you for being my interpreter and lending your bilingual, bicultural knowledge and time to my little project. More, I am thankful for your 16 years of friendship, which makes sanity possible.

Many other people made completion of this thesis possible. The Asian American Studies Department staff and faculty, both past and present, provided logistic and moral support that went above and beyond. Raina P. Moosa, Noor Puthawala, Jeanne M. Woo, Calvin Lin, Alexander Shearer, Michael S. Huang, Annie Chung, Jen Kira, Wendy Sawasaki, Cathy Kang, friends at Lighthouse Community Church, the MKS office ladies, and many others whose contributions and support remain written on my heart, thank you for your prayers, thoughts, and tough love.

To my beloved family, Mom, Dad, Jennifer, Peter, Alex, and Ajuma (and 할아버지), of all the people on this earth, your love and support have sustained me.

Most of all, I am thankful to my ever faithful God and Father, who was and is my comfort and strength in trials, without whom I would not be who or where I am.

Lastly, I would like to thank the twelve amazing Korean seniors who shared their health care stories with me for this thesis. Thank you for allowing me a glimpse of your lives and personal histories.

I. INTRODUCTION

*Old age is not a disease - it is strength and survivorship,
triumph over all kinds of vicissitudes and disappointments, trials and illnesses.*
—Maggie Kuhn

As Maggie Kuhn¹, an American anti-ageism activist, stated in her quote above, old age is not a disease. There is, however, a tendency in American culture to treat old age as a disease and thus view older adults² as a weak and vulnerable population, expecting little of them and believing they are in constant need of care and protection (Albert & Freedman, 2010). Notably with perceived mental decline or hearing decline, older adults face the burden of being infantilized (Albert & Freedman, 2010). Korean immigrant older adults are liable to be doubly subjected to that view due to their language limitations in English.

Many Korean immigrant older adults living in California's Los Angeles County are monolingual Korean-speaking, relying on the advice and the referral of Korean language resources available to them within the boundaries of Los Angeles' Koreatown to help them navigate the web of health care options. Few venture beyond the ethnic enclave, and if they do, almost never without assistance from an English-speaking relative or friend. Little documentation exists regarding how they are able to utilize needed health care services, and there is much unknown about whether their health care needs are being met.

My aunt and her husband's health care experiences were the impetus for this study. Living nearby Koreatown, they were used to traveling independently by bus to a medical center in Koreatown, with ethnically Korean, Korean-speaking doctors, nurses, and pharmacists to

¹ Maggie Kuhn was an American activist, who, in 1970, founded the Gray Panthers, an organization to address concerns of retirees and counter ageism (Gray Panthers, History). It seeks "social and economic justice and peace for all people" by recognizing the value of different generations and seeing additive value in aging (Gray Panthers, Who We Are).

² "Older adult" can often be a nebulous term, but for the purposes of this paper, "older adult" refers to those who are 65 years of age or older.

handle all their medical needs, from check-ups to filling prescriptions to surgeries. They both had Medicare and Medi-Cal (as Medicaid is called in California) health insurance, which afforded them the ability to seek care at most medical clinics and hospitals throughout Los Angeles County at low to no cost. They did not have knowledge of resources outside of the Korean community, and the language barrier made it unlikely that they would utilize those outside resources. Neither did they have easy transportation to areas beyond the dense crisscross of L.A.'s bus routes near the city center.

But, in March of 2007, due to a complication resulting from a surgery he had had, my aunt's husband went with me to see an English-speaking doctor outside the Korean community he lived in and was used to. I took him outside of Los Angeles' Koreatown to the community and resources that I was more familiar with, the ones I was more comfortable speaking and interacting with as a second generation Korean American, born and raised in Los Angeles, without a fluent grasp of Korean. With my assistance, he was able to communicate with the non-Korean doctor practicing outside of Los Angeles' Koreatown and he eventually had surgery to successfully address the complications. Afterwards, he chose to return to his doctors in Koreatown. He was more at ease there, where he and my aunt knew which bus line to take and his usual doctors and their medical staff spoke and understood Korean and were familiar with Korean culture. This is just one brief example of the varied health care experiences Korean immigrant older adults living in or around Los Angeles' Koreatown have had.

This paper seeks to discover similar and diverse health care experiences of Korean immigrant older adults, presenting stories of strength and survivorship and triumph in old age, even as they face existing language barriers due to their limited English proficiency.

Problem Statement

Often due to their limited English language skills, many Korean immigrant older adults living in Los Angeles County seek out health care options within the borders of Koreatown. Ninety-five percent are estimated to have a usual source of care, and 89% of the Korean immigrant older adult population goes to a doctor's office for their usual source of care, which may include the community clinic or a private medical doctor's office (CHIS 2009). Unlike Korean adults aged 18 to 64, 57% of whom are medically uninsured, 99% of Korean immigrant older adults have health insurance of some sort (CHIS 2009). This is primarily because of Medicare, with 48% insured through a combination of Medicare and Medicaid, referred to as Medi-Cal in California (CHIS 2009). (See Appendix A, Medicare vs. Medi-Cal Basic Background Chart for more information on Medicare and/or Medi-Cal.) These older adults' high rate of being insured within the broader uninsured Korean population, known for its lack of health insurance, makes for an interesting research study into the health care experiences of this often overlooked group.

Of the total Korean immigrant older adult population living in Los Angeles County, 81% are naturalized citizens, many having lived in the United States for 15 years or more (CHIS 2009), which may partially account for their high rate of being medically insured through government programs like Medicare and Medi-Cal. Having been born outside of the United States and immigrating as adults, most of these older adults have limited English proficiency, with 83% stating that they speak English "not well" or "not at all" (CHIS 2009). This may affect their decision to live in metropolitan areas, where there are usually more resources available for recent and long-established immigrants, particularly ones with language barriers, than in the suburbs. Although these Korean immigrant older adults are scattered throughout the major cities

of Los Angeles County, they frequent Los Angeles' Koreatown, an ethnic enclave long associated with the largest concentration of ethnic Koreans outside of the Korean Peninsula.

The ability to access Los Angeles' Koreatown for many of these Korean immigrant older adults is important to procuring the in-language services they may need, such as health care delivered by a culturally Korean, Korean-speaking doctor. Rejecting the traditional living arrangement in Korea, where the older adult often lives with the eldest son's family and provides a sense of social support² (Youn, Knight, Jeong, & Benton, 1999), Korean immigrant older adults do not often live with or sometimes even in close proximity to their adult children (Wong, Yoo, & Stewart, 2005; Wong, Yoo, & Stewart, 2006; Youn, Knight, Jeong, & Benton, 1999). When asked about their household size, approximately 46% of Korean immigrant older adults living in Los Angeles County stated that they lived alone and 54% stated that they lived with only their spouse (CHIS 2009). This modern living arrangement, with the older adult living independently of his or her adult children, creates a situation where other types of social support networks are necessary.

Given the high prevalence of certain cancers and other maladies affecting the Korean population, particularly as they age, it is important that Korean immigrant older adults are aware of their health care options and able to utilize them fully, despite the language barriers they may face or the modified social support networks that they have, and that health care providers and policymakers are equally aware of their needs and experiences.

Background

Korean Immigrant Older Adults – Demographics & History

² This is according to the Korean cultural tradition of filial piety, grounded in Confucianism (Youn, Knight, Jeong, & Benton, 1999).

Currently, there are approximately 31,874 ethnically Korean older adults, 65 years or older, living in Los Angeles County (U.S. Census Bureau, 2010 American Community Survey [ACS]). This constitutes 14.2% of the total estimated population of 224,468 Koreans in the county (U.S. Census Bureau, 2010 ACS). Yearly population profiles since the 2000 U.S. Census show that the overall population of those who identify as ethnically Korean (hereafter referred to as “Korean”) is growing steadily, and so is the percentage of older adults. In 2009, older adults, 65 years or older, made up 13.8% of the total Korean population in Los Angeles County (U.S. Census Bureau, 2009 ACS). In 2005, they were only 11% (U.S. Census Bureau, 2005 ACS). In total numbers, the current number of Korean older adults living in Los Angeles County has grown by 16% from the 2009 American Community Survey (ACS) estimate and 42% from the 2005 ACS estimate.

While the total population of Korean older adults in Los Angeles County includes a minority born in the United States, the majority was born in Korea³ and immigrated to the United States as adults or older adults. There is over one hundred years of history of Korean immigration to the United States, but many of today’s Korean immigrant population arrived after the mid-1970s, with the greatest numbers arriving in the 1980s (Moon, Lubben, & Villa, 1998; Yu & Choe, 2003-2004), as a result of the Immigration and Nationality Act of 1965. Also known as the Hart-Cellar Act, this law lifted the 1924 race-based national origin quotas and instituted a preference system for immigration based on professional skills and family reunification (Warner, 2012; Yu, 1983; Yu & Choe, 2003-2004). The majority of the Korean immigrants who came immediately after, as a result, were self-selected professionals, mostly from the middle class (Bonacich, 1988). Additionally, a provision in the 1965 law allowed for

³ The Korean immigrant older adults, with the youngest being 65 years old by my definition, were born before the 1950 Korean War, and therefore, before the existence of the two Koreas, North and South.

“students-turned-professionals” to apply for permanent residence visas, thus allowing them to sponsor their family members (often, their parents) to immigrate to the United States as well (Yu, Choe, Han, & Yu, 2004). This too contributed to the growth of the Korean immigrant community in the United States. The current Korean immigrant older adult population can therefore be divided into two main groups: 1) those who immigrated earlier as adults and have worked and aged in the United States (Bonacich, 1988; Yu & Choe, 2003-2004; Yu, Phillips, & Yang, 1982), and 2) those who immigrated later as older adults, often sponsored for family reunification reasons by their adult children living in the United States (Kim & Lauderdale, 2002; Moon, Lubben, & Villa, 1998; Wong, Yoo, & Stewart, 2006; Yu & Choe, 2003-2004). There may also be older adults who defy these categories, such as those who immigrated recently as older adults without the assistance of adult children to sponsor them. Whatever their reasons for immigration or the age at which they immigrated, most of the current Korean older adult population are foreign-born immigrants. The following demographic statistics, mostly taken from the 2009 California Health Interview Survey, focus on this majority, the Korean immigrant older adult population, specifically those living in Los Angeles County.

According to demographic profiles, the majority of this population is on the younger end of the older adult spectrum, being between the ages of 65-79, while the remaining 17% of the Korean immigrant older adult population is 80 years of age or older (CHIS 2009). As is common for older adult age groups, since women generally have a longer life expectancy, there are more women (59%) than men (41%) in this Korean immigrant older adult population (CHIS 2009). Also, approximately 55% are married and 45% are not married (separated, divorced, widowed, or otherwise single); among married older adults, 74% are men and 26% are women, and among not married older adults, 99% are women (CHIS 2009). The majority of these older adults live

independently of their adult children, with 50% living in apartment buildings or condominiums, while 41% live in houses; 43% stated that they rent, compared to the 52% who own their home (CHIS 2009).

A plurality of the Korean immigrant older adults in Los Angeles County have up to a high school education, with 42% having attained a high school education and 21% having completed a range of grades up to junior high school; and 22% earned a college degree (either a Bachelor of Arts or a Bachelor of Science, or the equivalent) (CHIS 2009). Most are unemployed and not looking for employment, having retired either while they were still in Korea or in the United States, and live on a fixed income. This fixed income places many of these older adults in range of poverty, with 48% of the population living with incomes below the Federal Poverty Level⁴ (FPL), and an additional 34% of the population having incomes below 300% FPL (CHIS 2009).

According to the Elder Economic Security Standard Index (Elder Index)⁵, the federal poverty guidelines, another term for FPL, drastically underestimate the actual cost of living for older adults, discounting many basic needs and costs based on location and living situation (Wallace & Smith, 2009). Looking at 2007 data⁶, the UCLA Center for Health Policy Research estimated that due to the cost of living, most *healthy* older adults living in Los Angeles County (excluding Los Angeles City) would need at least 160% FPL if single versus 176% FPL for a

⁴ The federal poverty guidelines (also known as the Federal Poverty Level, or FPL) are often used as the measure of eligibility in various federal and state assistance programs, such as Medi-Cal. At the time of the 2009 California Health Interview Survey, the federal poverty guidelines were \$10,830 for a single person and \$14,570 for a couple in the state of California (U.S. Department of Health and Human Services, 2009). The federal poverty threshold, on the other hand, is what the U.S. Census Bureau uses to estimate the actual number of people in poverty, and is based on age and household size but disregards geographical location. In 2009, the threshold was even lower than the FPL, at \$10,289 for a single-person household, for those 65 years and over, and \$12,968 for a two-person household, for those 65 years and over (U.S. Census Bureau, n.d.).

⁵ “The Elder Index is based on the actual cost in each county of the basic expenses needed by older adults to age independently with dignity in their own homes. Those with incomes below the Elder Index are economically insecure” (Wallace & Smith, 2009).

⁶ The 2007 FPL was \$10,210 for a single person and \$13,690 for a couple.

couple without a mortgage, 224% FPL if single versus 223% FPL for a couple renting a one-bedroom, and up to 300% FPL if single versus 280% FPL for a couple with a mortgage to have sufficient income to meet their needs (UCLA Center for Health Policy Research [UCLA CHPR], 2008b). In Los Angeles City, an area that includes Koreatown and the downtown areas that provide bus access to it, the rates were similar to those for Los Angeles County for all categories, except for “single with a mortgage,” which leaped to 327% FPL (UCLA CHPR, 2008a). The overall cost of living would most likely increase for those who get treatment for health problems and must pay for prescription medications.

This is important to note, since 60% of Korean immigrant older adults living in Los Angeles County have at some point received a diagnosis of high blood pressure from their doctor, and of those older adults, 92% take medication to control the condition (CHIS 2009). Also, 28% of the Korean immigrant older adults living in Los Angeles County have at some point been diagnosed with diabetes; 57% of those diagnosed are taking diabetic pills to control blood sugar levels (CHIS 2009). These are just two of the many health conditions that could increase the cost of living for these Korean immigrant older adults living in Los Angeles County. In addition, 83% of Korean immigrant older adults living in Los Angeles County live in the “urban”⁷ or downtown areas of the major cities in the county, one of which is the city of Los Angeles, and roughly 12% of the population live in the “suburban” areas of the county (CHIS 2009). The urban and suburban areas are generally more costly to live in than rural areas farther

⁷ CHIS 2009 employs the Nielson Claritas Urbanization Methodology to differentiate between urban, suburban, second city, and town/rural areas (CHIS 2009). “Urban” areas are designated by population density and contextual density (the density in comparison to surrounding areas) and are usually the “downtown areas of major cities and surrounding neighborhoods,” whereas “suburban” areas have a lower overall density scores and “are not population centers of their surrounding communities” (U.S. Department of Transportation – Federal Highway Administration, n.d.).

away from the city centers; however, they are located closer and therefore may provide increased access to Los Angeles' Koreatown.

Koreatown

Koreatown in Los Angeles is not actually an area where many Koreans reside. But, from the outside looking in, seeing all the Korean signboards and all the shops patronized by Koreans, one would imagine that it is a typical ethnic enclave like New York's Chinatown or even an ethnoburb ("ethnic suburb") like Monterey Park, with members of the cultural majority living there (Li & Skop, 2007). In fact, only about 20.4% of the resident Koreatown population is of Korean descent, with the majority (52.4%) being Latino (Chung, 2004). Yet, most would agree that Koreatown "serves as the hub of the ethnic community" for Koreans in the Los Angeles area (Kitano & Daniels, 1995). The majority of the Koreans who live there are the poor, the elderly, and the recently arrived immigrants, but Koreans living throughout Southern California go there to shop, to eat, and also to access health care options (Chung, 2004).

Koreatown is located "west of downtown Los Angeles and north of South Central" (Chung, 2007), but the boundaries of the actual community (unofficially recognized by the city with "Koreatown" street signs in 1982) were less well-defined⁸ (Kim, 2011). Most would agree that the core of Koreatown, from which everything spread, is still Olympic Boulevard, between Vermont Avenue on the east and Western Avenue on the west (Light & Bonacich, 1988; Yu, Choe, Han, & Yu, 2004), and extending north to Eighth Street (Lee, 1986), or possibly to Wilshire Boulevard, an area formerly known as Wilshire Center (Gold, 2004; Yu, Choe, Han, &

⁸ In 2008, a group of Bangladeshi Americans filed to officially designate an area in the middle of what was known as Koreatown as "Little Bangladesh," thus challenging the unofficial boundaries of the Korean ethnic enclave and leading to debates on the boundaries of the space, as well as an official designation of both communities (Kim, 2011). In 2010, it was decided that a four-block area of Koreatown on Third Street, between South New Hampshire Avenue and South Alexandria Avenue would be designated as Little Bangladesh (Villacorte, 2010).

Yu, 2004). Over the past thirty to forty years, however, with the shifting populations and variations in census tract data collection, the outer limits of Koreatown have been placed as far as Hollywood Boulevard to the north, Hoover Street to the east, Martin Luther King, Jr. Boulevard to the south, and Crenshaw Boulevard to the west (The Koreatown Profile Study Committee, 1984; Yu, Phillips, & Yang, 1982).

Although the boundaries have moved north-south, east-west based on the shifting populations and the accuracy of measurement surveys at different times, the current generally-accepted boundaries of Koreatown seem to fall on Beverly Boulevard to the north, Hoover Street to the east, Pico Boulevard to the south, and Arlington Avenue/Wilton Place to the west, a five-square-mile area containing roughly 250,000 people, most of them not Korean (Lee, 1986; Powers, 2007). As of Friday, August 20, 2010, however, the Los Angeles City Council officially designated a three-square-mile area, bounded by Third Street on the north, Vermont Avenue on the east, Olympic Boulevard on the south, and Western Avenue on the west, including a section of Western Avenue stretching north from Third Street to Rosewood Avenue in East Hollywood, as Koreatown (see Figure 1) (Kim, 2011; Villacorte, 2010).

Despite the official designation, many in the Korean community are likely to go by less formal markers when identifying Los Angeles' Koreatown, such as the location of businesses and organizations with Korean signage and services, resulting in multiple definitions of Koreatown (see Figure 2). There are, for instance, Korean owned and operated businesses, as well as advocacy and social service organizations, media outlets, and health clinics and hospitals geared towards Korean clientele, scattered throughout and beyond the now officially-recognized area of Koreatown (The Korea Times, 2011; UCLA Asian American Studies Center [UCLA AASC], 2008). It is this commercial ethnic enclave (Chung, 2007), a space that no longer

houses the majority of Koreans but still provides linguistically and culturally tailored community services and resources, that may prove key to overcoming immigrant barriers to health, particularly for the Korean immigrant older adult.

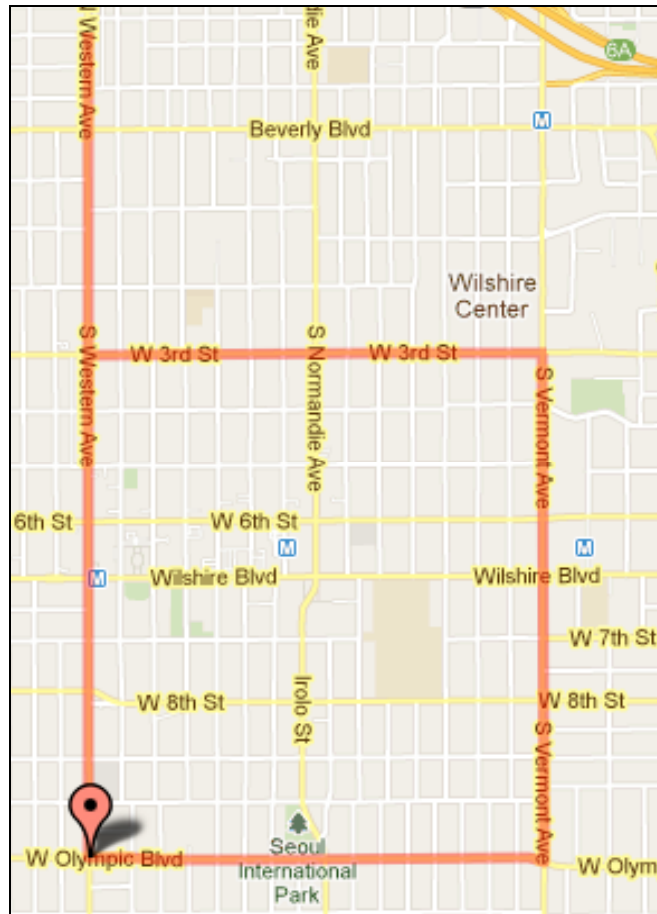


Figure 1. Koreatown, as officially designated by the Los Angeles City Council.
(Kim, 2011; Villacorte, 2010; <http://www.gmap-pedometer.com/?r=5336914>)

Purpose of the Study

This study seeks to start a conversation with the older adults in the Korean immigrant community of Los Angeles County, to see what their health care experiences have been thus far, including what barriers they encounter in accessing and utilizing health care, and to understand how these issues can be improved or resolved. While the community seems to have anecdotal information, passed from person to person, about how or why things are done or what these older adults have experienced, there is a dearth of documentation or published information regarding this growing community. The purpose of this study is ultimately to have a better understanding and documentation of their stories describing the common and diverse problems that Korean immigrant older adults face in navigating their health care, as well as their approach and solution to these problems, given available resources. With the addition of these stories, the hope is that researchers and policymakers will have more robust data, beyond statistics, that is relevant to the Korean elders, to form a more complete picture of this population and its needs.

Significance of the Study

While improving health care access, utilization, and quality for Korean immigrant older adults, given their existing language and cultural barriers and available social support networks, is already important, the current health care situation in this country makes this study all the more urgent and necessary. Passage and implementation of health care laws such as California Senate Bill 853 (SB 853)⁹ (also known as the Health Care Language Assistance Act), in full

⁹ California Senate Bill 853 was passed in California in 2003, but not put into full effect until 2009 (Calvan, 2009). It requires all full-service and specialty health care plans under the jurisdiction of California's Department of Managed Health Care to provide services, materials, and information to members in a language that they speak and understand, based on a needs assessment of plan enrollees (Legislative Counsel of California, 2003). For example, plans with enrollment of 1,000,000 or more must provide translated materials in the top two languages other than English, as well as any additional language if the lesser of 0.75 percent or 15,000 of the enrollee population speak it. The requirements change based on enrollment size for the plan; however, these requirements exclude Medi-Cal enrollees. (Legislative Counsel of California, 2003).

effect since January 1, 2009, and the national Patient Protection and Affordable Care Act¹⁰ (also known as the Affordable Care Act, or referred to colloquially as Health Care Reform), which became law on March 23, 2010 (U.S. Department of Health and Human Services, n.d.), signal many potential changes to state and national health care policy in the coming years (Warner, 2012). There could be more changes slated to come, depending on the outcome of the current U.S. Supreme Court challenge to the Affordable Care Act (with a decision due out in June, following three days of arguments from March 26 to 28, 2012) (Pear, 2012). Combined with looming state and national budget deficits and debates that threaten to erode existing health and safety net services, including Medicare and Medicaid (Medicare (The “Doc Fix” Debate), 2012; Siders, 2012; Warner, 2012), the situation makes it appropriate and pressing to look into the stories of these Korean immigrant older adults. Future policy implications could be affected by learning more about these older adults’ current health care utilization, needs, and concerns, including the resources they depend upon. Recording the varied experiences of Korean immigrant older adults, a population often excluded from the discussion on health care access and utilization due to their limited English proficiency, will better inform the evolving health care reform process and thus contribute to the better health of all communities (Searles, 2012).

¹⁰ The Patient Protection and Affordable Care Act (ACA) attempts to provide a source of health care coverage for all citizens and some non-citizen residents of the United States (Warner, 2012).

II. LITERATURE REVIEW

There are limitations to doing a study of Korean immigrant older adults, since there are relatively few studies to reference that have focused on this subset of the older adult population (Korean immigrants) or on this subset of the Korean population (older adults). As immigrant older adults, they face distinct challenges compared to the average Non-Hispanic White older adult and compared to the average Korean immigrant adult, often due to language barriers, cultural differences, and different forms of social support networks. Therefore, to understand the health care experiences of Korean immigrant older adults, it is necessary to look at three interrelated components: 1) health care access and utilization, 2) the role of the ethnic enclave as a resource and a constraint in addressing cultural and language barriers, and 3) social support networks that these older adults rely upon or turn to.

Health Care Access and Utilization

A common model for looking at health care access and utilization is Andersen's original behavioral model for the use of health services, developed in 1967. This model describes a linear relationship between predisposing characteristics (such as demographic factors like age and gender, socioeconomic status, and health beliefs), enabling resources (personal and community resources, including health insurance and availability of health care), and need for health care (whether perceived or evaluated), with the outcome of increased or decreased use of health services (Andersen, 1995). Updated later, Andersen's new model incorporated the health care system and external environmental factors as inputs and looked at health outcomes (including perceived health status, evaluated health status, and consumer satisfaction) as an output (Andersen, 1995). The logic behind the updated model is that the environment affects the population characteristics (predisposing characteristics, enabling resources, and need), which in

turn affect health behavior (personal health practices and use of health services), leading to certain health outcomes (Andersen, 1995). These models, particularly the latter, are important because they serve to highlight the multiple factors involved in the health care experience as a whole, as well as ways to critique what is seen as the dominant framework for understanding health care for a population.

One of the multiple factors involved is health insurance coverage. Many health care studies on Korean Americans¹¹ note the low percentage of health insurance coverage in the Korean American population overall (Jang, Kim, & Chiriboga, 2005; Ryu, Young, & Park, 2001; Sohn, 2004; Song et al., 2010). This low rate of health insurance coverage is often attributed to the high rate of self-employment¹² (Portes & Rumbaut, 2006) in the Korean immigrant community. Due to the high overhead cost of the business and the use of cheap labor (Bonacich, 1988; Jo, 1999), often employing family members at little or no pay in order to make a profit, the small business owner does not usually invest in health insurance for himself, any of his family members, or for the other employees of the business (Jo, 1999; Ryu, Young, & Park, 2001). While this may be true for working age adults younger than 65, it does not fully explain the situation of most Korean immigrant older adults, who are often retired and have health insurance (CHIS 2009; Sohn, 2004; Sohn & Harada, 2004). Immigrant older adults, 65 and over, who entered lawfully and have been living in the United States, entering before the passage of the

¹¹ “Korean American” is a term that is commonly used to distinguish individuals who are ethnically Korean and live in the United States, regardless of generation or citizenship status, from “Koreans” who live in Korea. In this paper, “Korean American” is used mainly when referencing literature that uses the term. Most Korean immigrant older adults do not use the term “Korean American” when referring to themselves, but rather “Korean,” which is the convention I have adopted for this paper.

¹² Often highly educated, but limited in options due to their limited English ability and lack of transference of Korean credentials for their professional jobs, many Korean immigrants who came in the 1970s and 1980s became “self-employed Korean immigrant entrepreneurs” (Furuto, Biswas, Chung, Murase, & Ross-Sheriff, 1992; Jo, 1999). Thus, the influx of Korean professionals gave rise to a community of ethnic entrepreneurs with its resultant “ethnic enclave economy” (Chung, 2007), where self-employment was the norm.

August 22, 1996 Federal welfare reform law¹³ or after August 22, 1996 and living in the United States for five years, may qualify for Medicare and/or Medicaid, thus providing them with health insurance (Jang, Kim, & Chiriboga, 2005; Sohn & Harada, 2004).

While most Korean immigrant older adults have some form of health insurance (Sohn, 2004), there are those who do not. Some, as Sohn and Harada (2004) posited, may choose not to have health insurance, based on their experiences self-financing their health care in Korea, or due to cultural “Confucian-based health beliefs” such as familism and collectivism or a reliance on traditional (versus Western) medicine. Others may have been self-employed or employees of small businesses where health insurance was not offered, before they retired (Jang, Kim, & Chiriboga, 2005; Sohn & Harada, 2004). Unlike those older adults who have been in the United States longer and qualify for Medicare and/or Medicaid, more recently arrived immigrant older adults who have not met the five-year residency requirement would not be eligible for these public programs for health insurance coverage (Jang, Kim, & Chiriboga, 2005; Sohn & Harada, 2004). Other reasons for being uninsured could be connected to the difficulties in navigating the U.S. health care system due to language barriers or simply a lack of income to purchase health insurance (Song et al., 2010).

Health insurance coverage is often considered the strongest predictor of health care utilization (Ryu, Young, & Park, 2001; Song et al., 2010), since having it eliminates one of the barriers to accessing health care (Jang, Kim, & Chiriboga, 2005; Sohn, 2004; Sohn & Harada, 2004) for the Korean immigrant population. Not having coverage was found to decrease utilization: uninsured Korean Americans had 40% fewer physician’s visits than insured Korean

¹³ This law is also known as the Personal Responsibility and Work Opportunity Reconciliation Act. It included a reform of welfare and Medicaid eligibility, blocking undocumented immigrants from receiving Medicaid and food stamps and requiring documented immigrants to wait five years before applying for Medicaid (Warner, 2012), except for in medical emergencies (Sohn & Harada, 2004).

Americans (Sohn & Harada, 2004). Ryu, Young, and Park (2001) found that the extreme lack of health insurance coverage in the Korean immigrant population prevented access to and use of health care, even in times of need, resulting in delays in seeking care or not seeking it at all. They also found that lack of health insurance coverage was directly correlated with self-employment status and lack of education (Ryu, Young, & Park, 2001).

While health insurance coverage is important, there are other factors beyond health insurance coverage that affect health care utilization for the Korean immigrant older adult population. In two separate studies, time since immigration (referred to also as years lived in the United States and often used as a measure of acculturation) affected health care utilization (Ryu, Young, & Park, 2001; Sohn & Harada, 2004). Those Korean immigrants who had lived in the United States for less time were more likely to utilize health care services, while those who had lived in the United States longer were less likely to utilize health care services even with health insurance coverage. Sohn and Harada (2004) explained this finding by stating that “older Korean Americans who are recent immigrants, contrary to the healthy migrant theory¹⁴, could be a frailer population than older Korean Americans who had lived in the United States longer,” adding that “the need for medical care may also be related to the time period and reasons for immigration.” Those who immigrated more recently as older adults and have been in the United States for fewer years may have immigrated due to health reasons, versus those who immigrated earlier as healthy working age adults and aged in the United States. Also, in the study, those Korean immigrant older adults with less education (in the study, defined as less than high school education) had higher health care utilization (Sohn & Harada, 2004). According to Sohn and Harada (2004), the need for increased explanations and guidance from the physician may

¹⁴ Also known as the “healthy migrant paradox” or the “Latino paradox,” the “healthy migrant theory” states that “immigrants are healthier than individuals born in the United States because they are a self-selected population because of the prerequisite of good health needed to embark on strenuous travel” (Sohn & Harada, 2004).

account for this higher health care utilization by elderly immigrants with fewer years of education.

Based on interactions with Korean immigrant older adults in the Korean community in Los Angeles, however, the actual reason for why recent Korean immigrant older adults utilize health care services more than more established Korean immigrant older adults may be more practical: recent Korean immigrants may have fewer sources of support and therefore, rely on the health care provider for a variety of issues, including acculturation information, versus simply for health care services, thus prompting higher utilization. Many Korean immigrant older adults immigrated primarily for “family reunification” reasons, as mentioned, often following their adult children to the U.S. (Yu, Choe, Han, & Yu, 2004); as such, the age and health status of this population varies greatly depending on time of immigration. In addition, other demographics characteristics, such as education level and circumstances before immigration, contribute to the diversity of this Korean immigrant older adult population, even within the subset of recent Korean immigrant older adults. While there are recent Korean immigrant older adults who are frail or have an illness that may require greater health care utilization, there are also other recent Korean immigrant older adults who are hardy and healthy. Other possible explanations for this unexpected finding exist, including ideas surrounding acculturation, low-income status and Medi-Cal availability and coverage, as well as cultural differences based on time of departure from Korea.

As such, much is unknown, and literature can sometimes seem contradictory, as with Sohn and Harada’s study (2004), which focused on Korean immigrant older adults, and Ryu, Young, and Park’s study (2001), which looked at a cross-section of the Korean American population as a whole, from children to older adults. Contrary to their acculturation hypothesis,

Sohn and Harada (2004) discovered that the Korean immigrant older adults who had been in the country longer actually utilized health care services less than more recently-arrived immigrant older adults, even though those who were in the country longer also had more access to health care through Medicare (Sohn & Harada, 2004). This conflicts with Ryu, Young, and Park's study (2001) finding that an increase in health insurance will show an increased utilization of health care. Likewise, the Sohn and Harada's (2004) finding that Korean American older adults without a high school education were more likely to visit the doctor, dispelling another belief that higher education levels would lead to more frequent health care utilization, does not align with Ryu, Young, and Park's (2001) discovery that Korean Americans with less education are less likely to have health insurance coverage, which would suggest lower health care utilization.

Both are valuable studies because they present different facets of the issue of health care access and utilization for the Korean American population, including the impact of acculturation and language, belief models, and health practices. As with any population, however, health service utilization among Korean immigrant older adults is a complex issue. Moon, Lubben, and Villa (1998) stated, Korean American elders "face multiple adjustment problems in the U.S., such as language barriers, cultural differences, lack of employment opportunities, and unfamiliarity with the social service systems." These multiple problems can affect health service utilization for the Korean immigrant older adult population.

Health care access and utilization, therefore, are simply two interrelated factors that are part of the bigger health care picture for Korean immigrant older adults. To understand this bigger picture—the health care experiences of Korean immigrant older adults—as with the Andersen model of health care, one must look beyond health care access and utilization. Song et al. (2010) suggests that ethnic minority populations, specifically recent immigrants, "often

experience different sets of systematic barriers to obtaining health care” than are accounted for in Andersen’s model; and therefore, a different model, which incorporates the influences of language and culture, is needed to understand health care for these populations and to address their needs. Examining the role that the ethnic enclave plays in addressing additional health care factors such as language, culture, and accessibility and availability of resources provides the beginnings of an alternate health care model.

The Role of the Ethnic Enclave

First, what is a standard “ethnic enclave,” and then, how is Los Angeles’ Koreatown different? Ethnic enclaves depend on the settlement patterns of ethnic immigrants. Located within an urban center, or within a “traditional central city” (Li & Skop, 2007) setting, these enclaves house a concentration of immigrants, usually recently immigrated. Chung (2007) has a more specific definition, stating that ethnic enclaves are bound areas occupied by a certain type of immigrant under a certain type of power structure. These enclaves exist and are often formed as a niche for immigrants who face language barriers in the mainstream spaces.

As seen from the dynamics of New York’s Chinatown, one of the most oft-cited and well-recognized ethnic enclaves, ethnic enclaves are more than a geographical location with the availability of in-language resources; they are often cultural markers of a community, shifting and changing through time. Zhou (1992) writes, Chinatown was first stereotyped as “nothing more than an immigrant ghetto—a rundown residential neighborhood or, at best, a culturally distinctive enclave.” A stereotyped space, much like the immigrants who live there, the ethnic enclave throughout history has been discounted as a place of ill repute, with crowded and run-down conditions, fit only for the immigrants who lived there (Li & Skop, 2007). Zhou (1992) notes, however, that the ethnic enclave was also thought of as a “springboard,” from which

immigrants could transition into the mainstream, and a “cultural center” to serve “ethnic-specific needs.”

In this way, Chinatown, as an ethnic enclave, was a resource for the immigrants who lived there. It was the first stop for new immigrants who arrived in New York, so that they could adjust to American culture and the American way of life, before they moved on to suburbs or elsewhere in the city, whether by providing language or cultural resources, entrepreneurship or other opportunities. Portes and Rumbaut (2006) similarly discuss the notion of an “ethnic community” easing the cultural transition from ethnic to American for the immigrant and offering protection from social and economic factors outside of the community. The ethnic enclave, represented by Chinatown, also served as a cultural center in filling immigrant-specific needs in an “ethnic subeconomy” (Zhou, 1992), with coethnic-run businesses (Li & Skop, 2007). This meant that immigrants within the community or others who had moved to or settled in areas outside of Chinatown would go to Chinatown to obtain certain items or services that could not be had elsewhere. With ethnic-based organizations to provide social services and cultural resources within the bounded space of the enclave, the ethnic enclave fulfills its role as a resource for the immigrant community (Chung, 2007).

As an “economic enclave,” a community supported by a strong ethnic economy (Zhou, 1992), the ethnic enclave, amidst its many advantages and offerings, can also serve as a constraint to the immigrant community. Ethnic enclaves are associated with “low income and cultural isolation” (Furuto, Biswas, Chung, Murase, & Ross-Sheriff, 1992), due to the cheaper cost of living within the space and the tendency of immigrants, particularly those recently arrived, to associate only within their ethnic group (Li & Skop, 2007). While providing a niche for immigrants who may not have the English fluency or business capital to survive in the

mainstream areas, ethnic enclaves also present the possibility of labor exploitation by coethnics, with the immigrant minority as both the oppressed and the oppressor (Bonacich, 1988). Peter Kwong states that ethnic enclaves are sites of “harsh working conditions, low wages, and the violation of labor laws,” under the American capitalist economic system (Chang & Diaz-Veizades, 1999). This can lead to “marginalization,” a state beyond “isolation,” where the immigrant lives separated from the mainstream society, unable to adapt to the new American culture, and also feels detached from his/her own ethnic identity due to the stresses of immigrant life and the mental and physical exhaustion that often accompanies it (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002).

Although Koreatown does have some negative aspects, as noted by KIWA (Koreatown Immigrant Workers Alliance) in their labor struggles against exploitation (Chang & Diaz-Veizades, 1999), as it is now, Koreatown is an economic enclave, serving as a cultural center for the resident and nonresident Korean Americans in and around Los Angeles. Unlike the standard ethnic enclave, few Korean Americans live there, and yet it is the “geographic manifestation of the ethnic networking in Los Angeles that has been, and still is, a major adapting strategy for Korean immigrants in their new country” (Yu, Choe, Han, & Yu, 2004). These ethnic networks include community-based organizations, as mentioned above, as well as in-language stores and services (Chung, 2007). The Koreatown community is so tight-knit and comprehensive that Korean Americans, it has been said, do not even need to know English (Kitano & Daniels, 1995). The presence of a Korean community provides the option of staying and operating within a familiar culture and space rather than facing the task of adapting to the English-dependent American culture and society (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002). It is here that those with limited English language skills go to look for jobs and find support from

organizations of coethnics, either professional institutions or community-based organizations (Furuto, Biswas, Chung, Murase, & Ross-Sheriff, 1992). Koreatown serves as both a symbolic and practical center for the larger Korean American community.

In terms of health care, the ethnic enclave provides a way to bridge the disparities often presented by language and cultural barriers. It was the problem of language that first created the need for an ethnic enclave for immigrants. As Zhou (1992) writes in *Chinatown*, “the main reason why immigrants keep to Chinatown is because they do not know the language.” The ethnic enclave was the transitional space for those who did not yet know English, to adjust to the newness of American culture and eventually learn enough English and migrate out (Jo, 1999). For some, however, the enclave is a stabilizing ground, where language, instead of being a barrier to escaping the enclave, gives them the freedom to be a part of the enclave economy (Zhou, 1992). For instance, immigrant professionals such as doctors, dentists, lawyers, and accountants, who may be unable to communicate well in English and are sometimes unauthorized and unlicensed in the U.S., fulfill a niche in the ethnic enclave, managing to find clientele by offering their services at lowered cost and cash based to those who may not have insurance (Portes & Rumbaut, 2006; Yu, Phillips, & Yang, 1982).

Licensed and unlicensed Korean doctors who both speak the language and know the culture and work within the ethnic enclaves are the ones that the Korean elderly immigrants go to (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Sohn, 2004). In Sohn’s (2004) study, 90% of the 208 study participants (all Korean older adults) reported that their last physician visit was with someone of Korean ethnicity. It is not merely that the doctor is ethnically Korean, but that the doctor speaks the same language and shares the same culture as the older Korean immigrant patient (Jang, Kim, & Chiriboga, 2005; Sohn, 2004; Song et al., 2010). These

participants noted that they had chosen this physician primarily based on the ability to communicate with the physician, rather than the physician's accessibility and medical knowledge (Sohn, 2004). Although having immigrated twenty years ago to the United States, 90% of the elderly Korean participants in Sohn's study felt that they had fair or poor English language skills. Deemed "linguistically isolated" (Hurh, 1998; Sohn, 2004), these Korean older adults would have a hard time obtaining health care services outside of the ethnic enclave, although many of them have health insurance through Medicare and/or Medicaid that allows them to get care at many major medical centers and hospitals.

In the absence of coethnic health care providers who can speak the same language as the immigrant patient, patients and practitioners in the health care setting use multiple alternatives: medical interpreters and medical translation can range from professional interpreters, to illegally relying on untrained staff or patients' family members as interpreters, to the "language line" (a contracted telephone service which provides often flawed interpretation via speakerphone), to nothing at all (Haffner, 1992; Portes, Fernández-Kelly, & Light, 2012). Some practitioners attempt to treat such patients with no intermediaries. This frequently impaired communication can lead to poor health outcomes and poor medical compliance by the patient, who may not have understood the doctor's questions, diagnosis, or instructions for care (Jang, Kim, & Chiriboga, 2005; Lin-Fu, 1988; Mui, Kang, Kang, & Domanski, 2007). Language barriers faced because of limited English proficiency can also become a source of "acculturative stress" (Ponce, Hays, & Cunningham, 2006), affecting health status and quality of life, leading to social isolation and insecurity, and often subjecting the immigrant patient to prejudice, racism, and discrimination (Lin-Fu, 1988; Mui, Kang, Kang, & Domanski, 2007; Ponce, Hays, & Cunningham, 2006; Portes, Fernández-Kelly, & Light, 2012). Language limitations may simply prevent immigrants

from seeking health care, due to inconvenience or embarrassment or shame (Kim, Yu, Chen, Kim, Brintnall, & Vance, 2000; Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Mui, Kang, Kang, & Domanski, 2007). While “language barriers can impede access to health care, lower the quality of care, and result in dissatisfaction with care” (Ponce, Hays, & Cunningham, 2006), it is simplistic to think that addressing language barriers alone, through the ethnic enclave or otherwise, would resolve the health care disparity for the immigrant population.

Immigrants also have cultural beliefs and practices that can affect their health care experience. Coethnic health care providers within the ethnic enclave are often more familiar with these cultural beliefs and folk practices, awareness of which can aid in making a correct diagnosis and also assist in developing the patient-provider trust relationship (Lin-Fu, 1988; Searles, 2012). While health care providers outside of the ethnic enclave may also be fluent in the immigrant patient’s language and familiar with his/her culture, studies have shown that immigrants are typically “more comfortable within the ethnic enclaves” (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002) and that cultural competency is lacking in most medical settings, making it less likely to exist outside of the enclave (Jang, Kim, & Chiriboga, 2005; Lin-Fu, 1988; Moon, Lubben, & Villa, 1998; Mui, Kang, Kang, & Domanski, 2007; Ponce, Hays, & Cunningham, 2006; Portes, Fernández-Kelly, & Light, 2012; Sohn, 2004).

Cultural differences and the presence of an ethnic enclave may impact the type of health care Korean immigrant older adults choose to utilize. Holding on to the Asian cultural perception of illness as symptom-based, some Korean immigrant older adults may not perceive a medical need to seek health care given an absence of symptoms (Pang, 1984; Sohn & Harada, 2004). Alternatively, the Asian cultural belief of “endurance” may cause some Korean immigrant older adults to conceal or suppress their pain or symptoms (Mui, Kang, Kang, &

Domanski, 2007). Meanwhile, with the availability of culture-specific resources within the ethnic enclave, some Korean immigrant older adults may prefer and use ‘hanbang’ (한방), or Korean “traditional” medicine (also called oriental, folk, or alternative medicine), which includes acupuncture, acupressure, or herbal medicines, instead of or in addition to Western medicine (Jang, Kim, & Chiriboga, 2005; Kim, Han, Kim, & Duong, 2002; Pang, 1984; Pang, 1991; Sohn & Harada, 2004). Some Korean immigrant older adults rely on these traditional remedies to treat certain health problems that may not be recognized by Western medicine or which Western medicine cannot cure (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Pang, 1984; Pang, 1991; Sohn & Harada, 2004). Miyong Kim and her colleagues looked at Korean cultural beliefs and how they impacted decisions to utilize Western versus traditional health care practices (Kim, Han, Kim, & Duong, 2002). They recorded the traditional medicine usage by the Korean American participants in their study and recognized the legitimacy of non-Western health practices, showing that participants favored Western medicine over traditional medicine but often used both (Kim, Han, Kim, & Duong, 2002).

In this way, culturally sensitive community resources can be added to the discussion on addressing immigrant-specific barriers to health care access and utilization (Song et al., 2010). The inclusion of cultural beliefs and traditional medicine, in addition to coethnic, Korean-speaking doctors and medical staff, in looking at health care, incorporates the ethnic enclave into the health care model, presenting a more culturally competent version. This new model considers the role of the ethnic enclave, as both a resource and a constraint, in understanding the health care experience of the immigrant population.

Social Support Networks

Social support networks are also an integral part of the health care experiences of Korean immigrant older adults. Wong, Yoo, and Stewart (2005), citing Cohen, Gottlieb, and Underwood, state, “Social support, typically defined in terms of functional domains, refers to any process through which social relationships might promote health and well-being.” These social relationships are operationalized structurally through social networks (Mui & Shibusawa, 2008) and functionally through the types of support given (Wong, Yoo, & Stewart, 2005). There are both informal and formal social networks (or sources of support), with informal networks including adult children, siblings or other relatives, and neighbors, and formal networks including government resources, community-based organizations, churches and other organizations (Moon, Lubben, & Villa, 1998; Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2005). Informal and formal types of support or services exist as well, comprising language, emotional, and tangible support (such as assistance with daily living or financial support), information/advice, companionship, and validation (Wong, Yoo, & Stewart, 2005). The type of social network and support or services that Korean immigrant older adults use depends on the environment they are in (Kim & Lauderdale, 2002; Moon, Lubben, & Villa, 1998; Wong, Yoo, & Stewart, 2005; Wong, Yoo, & Stewart, 2006).

Living arrangements can greatly impact the immigrant older adult’s environment, affecting the resources available to them and the barriers they may face (Kim & Lauderdale, 2002; Wong, Yoo, & Stewart, 2006). As mentioned earlier, the traditional living arrangement in Korea follows the Confucian principle of filial piety, in which the older adults are expected to live with and be taken care of by the eldest son’s family (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2006; Youn, Knight, Jeong, & Benton, 1999). In this context, the older adults are

respected and valued for their life experience and role in the family and retain the symbolic authority as head of household. Upon immigration to the United States, these older adults may continue to live interdependently with their adult children (although not necessarily the eldest son's family), often the sponsors of their immigration, or they may live independently (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2006; Youn, Knight, Jeong, & Benton, 1999).

Whether or not they live with them, Asian immigrant older adults often cite their adult children as their main source of social support (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2006). Culturally, for Koreans, the family is expected to be the primary social unit that takes care of personal matters, with kinship structures forming the basis for trust (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Mui & Shibusawa, 2008; Searles, 2012). As a result, there is a low utilization of "services from non-kin" (Mui & Shibusawa, 2008). The older adults' family can include their siblings and extended family, even distant relatives; but immigration often separates older adults from this larger personal network, resulting in a shrunken social network, with their adult children often as the primary members (Mui & Shibusawa, 2008). It can be problematic then when Korean immigrant older adults live apart from their adult children, particularly if they live far from them.

Korean immigrant older adults do tend to live independently, either by choice or to avoid conflict. Changing notions on filial piety, which may result from acculturation, as well as structural constraints posed by economic factors, contribute to the trend of Korean immigrant older adults living on their own (Moon, Lubben, & Villa, 1998; Wong, Yoo, & Stewart, 2005). Adult children, with their own children to take care of, may not want to take responsibility for their older adult parents; or, in dual-income households, the daughter-in-law, the family member traditionally tasked as the caregiver, may not have the time or the willingness to take care of her

husband's older adult parents (Mui & Shibusawa; Wong, Yoo, & Stewart, 2005; Wong, Yoo, & Stewart, 2006). When interviewed, many older adults stated that they did not want to be a burden to their adult children and that seeking support from them often led to friction or conflicts, hence their desire to live alone (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2006). Alternatively, adult children may live in the suburbs, far from the city's ethnic enclave and the language-specific, culturally relevant resources it has to offer (Kim & Lauderdale, 2002), which can also leave the older adults socially isolated and without adequate social support if they live with their adult children (Wong, Yoo, & Stewart, 2006). For all these reasons, Korean immigrant older adults often live on their own, apart from their adult children (Kim & Lauderdale, 2002). Many may still maintain close relationships with their adult children, however, through visits and telephone calls, thus receiving emotional support from them despite living apart from them (Wong, Yoo, & Stewart, 2006).

Without the day-to-day proximity of their adult children for social support, Korean immigrant older adults who live independently often choose to live in or near a Korean ethnic enclave. In Los Angeles County, for example, Koreatown provides Korean immigrant older adults with a community based on shared language and culture, Korean businesses that can provide familiar services and products, and subsidized housing (an important matter for immigrant older adults to live independently, given often limited incomes) (Kim & Lauderdale, 2002). These independent Korean immigrant older adults must rely on formal support networks and formal support or services, in the absence or decreased interaction with their informal kinship-based networks and support. Understanding the need to be self-reliant and establish a social support network beyond the family unit, they turn to government resources, community-based organizations, and churches, for both services and support (Mui & Shibusawa, 2008;

Wong, Yoo, & Stewart, 2006). They also rely on non-kin social relationships and in-language resources available within the ethnic enclave (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2006). Some Korean immigrant older adults adopt biculturalism, “acquiring skills and traits that [enable] them to become involved with U.S. culture while retaining aspects of their cultures of origin” (Wong, Yoo, & Stewart, 2006). This biculturalism allows these older adults to expand their social network and possibly increase their access to formal social support, a means of adapting to the host culture.

A lack of knowledge of the formal support networks and services available, however, along with language and cultural barriers, often prevents many Korean immigrant older adults from utilizing available formal sources (Moon, Lubben, & Villa, 1998; Mui & Shibusawa, 2008). Given their reliance on family, particularly their adult children, Korean immigrant older adults are also less likely to seek help from formal sources of support (Moon, Lubben, & Villa, 1998). “They do use services known to them” (Moon, Lubben, & Villa, 1998), but they may depend on family members (who may be uninformed themselves or unavailable) to inform them about these formal services or provide language assistance (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2005). For Korean immigrant older adults, often times, the need for language support prevails over all other types of support (Wong, Yoo, & Stewart, 2005) in addressing accessibility, but it has been shown that formal services “must be culturally sensitive to the needs of Korean Americans” (Moon, Lubben, & Villa, 1998) as well to be truly accessible. Those who are connected to Korean community networks through living in an ethnic enclave may have more sources and types of social support available to them, whereas those with small social networks or who are disconnected may have unmet social support needs (Mui & Shibusawa, 2008; Ponce, Hays, & Cunningham, 2006). Additionally, if they are poor in health

and therefore unable to seek services, these older adults may become socially isolated, in addition to having unmet social support needs (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2006).

Referencing Su and Ferraro, Wong, Yoo, and Stewart (2005) state, “The social support gained from a large network can provide individuals meaning and purpose in life, promote a sense of well-being, and allows integration into the larger society, thus influencing health and well-being.” With smaller social networks than many other ethnic groups, Korean immigrant older adults may be at a disadvantage if they live outside of ethnic enclaves (Wong, Yoo, & Stewart, 2006).

The combined factors of health care access and utilization, the presence of an ethnic enclave with its resources and constraints, and the informal and formal social support networks that Korean immigrant older adults rely on, likely, have an impact on their overall health care experiences. These factors, while discussed separately above, may not be readily disentangled in reality. Health care access and utilization for the Korean immigrant older adult may depend upon the presence of a Korean ethnic enclave and the availability of informal or formal social support networks. The Korean ethnic enclave may provide access to formal support and services that may affect health care access and utilization. Health care, while seemingly a simple system of inputs and outputs in the Andersen model, for the Korean immigrant older adult, can be a complex web of interconnected factors involving both language barriers and cultural differences. This study seeks to understand the connections between these interconnected and often invisible and unmeasured factors that Korean immigrant older adults deal with on a daily basis, in order to better articulate their health care experiences for others and view them from a new perspective.

III. METHODOLOGY

Study Design

Participants

This was an exploratory study using qualitative interviews. To recruit participants, per the guidelines of the Institutional Review Board (IRB) at the University of California, Los Angeles (UCLA), I created a two-sided English-Korean bilingual recruitment flyer (see Appendices B1 and B2, Recruitment Flyer, in English and Korean) to place at community organizations, community health clinics, and churches in Koreatown and developed an eligibility screening consent script in English and Korean (see Appendices C1 and C2, Eligibility Screening Consent Script, in English and Korean). I also reached out to my own Koreatown community contacts for help with word-of-mouth recruitment, with the intent of using snowball sampling among the older adults to recruit additional participants after the first round of interviews. The sites where I placed my flyers were Korean-run and had a predominantly or completely Korean audience. I also emailed my flyer to some of my contacts in the Koreatown community. Despite creating the flyer according to IRB guidelines, no one contacted me as a result of seeing it. In the Korean community, it is one's social network—whom you know or who introduces you—that helps with access to the community (Han, Kang, Kim, Ryu, & Kim, 2007). Being ethnically Korean myself, although I do not speak the language fluently, and being identified as a graduate student, I believe, helped me with word-of-mouth recruitment.

This research study was designed to record the health care experiences of Korean immigrant older adults who use Korean as their primary language. Eligibility criteria included: 1) self-identification as ethnically Korean, 2) being 65 years of age or older, and 3) being a resident of Los Angeles County, with access to Los Angeles' Koreatown. Both men and women

were recruited. The choice to interview older adults 65 years and older was to limit the sample of participants to Korean immigrant older adults who likely would have access to some form of health insurance either through Medicare or Medi-Cal or both, thus reducing the barriers to health care and allowing the study to focus less on whether or not there is health care access and utilization and more on quality of care and sources of information. Semi-structured inductive qualitative interviews were used instead of a standardized deductive survey, because the purpose was to collect detailed, nuanced data about personal health care experiences from the perspective of the Korean immigrant older adults in their own words.

I interviewed twelve Korean immigrant older adults, all recruited via word of mouth, either because I had asked them directly or because my contacts had. Seven of the twelve older adults were recruited via a brief presentation of my research topic that I made at a community organization. Since the older adults were all recruited through contacts who had pre-screened the population for me, I did not have to conduct a preliminary eligibility screening. The study participants (“seniors”) ranged in age from 68 to 81 years (see Table 1). Their time since immigration in the United States also had a wide range, from 3.5 years to 51 years. Among the twelve seniors interviewed, there were eight women and four men. Three of the twelve seniors did not live in or near Koreatown, although they had access to and visited the enclave. Five of the seniors owned a car, but the majority of the seniors relied on Los Angeles’ Metro bus system as their main means of transportation. All twelve seniors used Korean as their primary language and were most comfortable interacting in Korean; three seniors, having lived and worked in the United States for several decades, could speak English well, despite preferring Korean (see Table 2). All twelve seniors also stated that they had a regular source of care in a primary doctor and health insurance to cover their health care. Although all twelve had health insurance at the time

of their interview, there was a variety of coverage: two had only Medi-Cal, two had only basic Medicare, four had both Medi-Cal and Medicare, and four had enhanced Medicare for full coverage, either with a Medigap (or Supplemental) policy or with Medicare Advantage (see Appendix A, Medicare vs. Medi-Cal Basic Background Chart for more information on Medicare and/or Medi-Cal.).

The participants each received a \$10 gift certificate to Hannam Chain, a large Koreatown market, at the completion of their interview. The majority of the seniors were thankful that I was interested in their health care experiences and had allowed them to share their stories; they felt that they had done nothing to deserve a “reward” in exchange and were thankful for the gift certificate. Originally, I was going to give a five to ten-pound bag of rice as a “thank you” gift to each senior, but with the interviews not being at their homes and the difficulty of carrying a heavy bag of rice, I opted for the gift certificate to a local market. IRB approval was obtained from UCLA IRB prior to implementation of this study: IRB # 11-003387.

Table 1. Demographic Characteristics of Interviewed Seniors

Age	Total (n = 12)	Males (n = 4)	Females (n = 8)
60-69	3	0	3
70-79	6	3	3
80+	3	1	2
Time in U.S.			
≤10 yrs.	2	1	1
11-25 yrs.	4	1	3
26-40 yrs.	4	1	3
41+ yrs.	2	1	1
Marital Status			
Married	6	4	2
Widowed	6	0	6
Living Arrangement			
Alone	4	0	4
With spouse only	5	3	2
With adult child(ren)	2	1	1
Other	1	0	1
Live in/near Koreatown			
Yes	9	2	7
No	3	2	1
Housing			
House	3	2	1
Low-income housing	3	0	3
Senior housing	6	2	4
Transportation			
Bus only	7	1	6
Car only	3	2	1
Bus & Car	2	1	1

Table 2. Language and Health Care Characteristics of Interviewed Seniors

	Total (n = 12)	Males (n = 4)	Females (n = 8)
English Level - Speaking			
Very well	3	1	2
Good	0	0	0
Not well	7	2	5
Not at all	2	1	1
English Level - Reading			
Very well	2	1	1
Okay	5	1	4
Not well	3	1	2
Not at all	2	1	1
Type of Insurance			
Medi-Cal only	2	1	1
Medicare only	2	0	2
Medi-Cal, Medicare	4	1	3
Medicare w/Supplemental	2	1	1
Medicare Advantage	2	1	1
Deciding Factor for Health Care			
Cost	0	0	0
Proximity	1	0	1
Language Capacity	8	2	6
Cultural Compatibility	1	1	0
Other	2	1	1
Self-Rated Health			
Excellent	1	0	1
Good	1	1	0
Okay (average)	7	2	5
Not good, Bad	3	1	2
Satisfaction w/Health Care			
Excellent	1	1	0
Good	6	2	4
Okay (average)	4	0	4
Less than okay	1	1	0

Data Collection

All interviews were conducted on an individual basis. I conducted all but one of the interviews with the assistance of my friend, who is bilingual in Korean and English and bicultural in her understanding of Korean and American cultural norms. One interview was conducted with the assistance of my father, who is also bilingual and bicultural, at the behest of the male participant who preferred I have an older male chaperone. Eleven of the interviews were conducted in Korean, with the participants responding primarily in Korean, with the interjection of some English words and phrases. The majority of the interviews averaged 45 minutes in length, with the shortest lasting approximately 23 minutes and the longest lasting 1 hour and 40 minutes. The interview location was left up to the participant, to support their comfort in speaking at length with me and the interpreter. The majority of the interviews took place in Los Angeles' Koreatown, either at the community organization where participants were recruited or a public place of business (usually a café). Four interviews took place in residences, three in residences near Koreatown and one at a residence outside of Koreatown. I originally thought the seniors would be more comfortable being interviewed in the privacy of their homes so they could speak candidly and not have to travel anywhere; however, they preferred meeting in public spaces and being out, with two participants specifically expressing that they did not want to be interviewed in their home for reasons of comfort and propriety. Interviews were recorded on a digital recorder without the use of any names or identifying information beyond the content of the interview. Some of the participants were anxious about the interview being recorded, but were put at ease when they saw the questions on the interview guide and after my friend and I repeated what was on the information sheet (that the sole copy of the recording

would be safely kept by me alone, for the purpose of writing my thesis) (see Appendices D1 and D2, Information Sheet, in English and Korean).

I used a printed interview guide that had a total of 19 questions, including demographic, health status, and health insurance-related questions, written in both Korean and English, to conduct informal semi-structured interviews (see Appendix E, Interview Guide). I asked the questions in Korean, following up with additional questions for specifics if needed, but generally allowing participants to share in-depth about their health care experiences. My friend assisted me with asking questions and probing for additional details when I had difficulty with Korean vocabulary or fluency, or if the senior did not understand the question when repeated or read. In this way, since both my friend and I were involved in the interview process, we were both able to develop rapport with the interview participant, and I was able to guide the interview based on the question responses. In fact, many of the seniors perceived us as a team and spoke to both of us, despite my language limitations in Korean. While most of the participants were patient and accommodating of my lack of Korean fluency, I believe it was beneficial to me and to the interviewee to have a fluent Korean speaker to listen and interpret alongside me during the interviews.

Originally, the interview guide was structured with demographics questions regarding birth year (to determine age) and years lived in the United States at the end, since they might be perceived as more personal as identifying information. A second version of the guide, based on feedback during the first few interviews, was structured with the demographics questions in the beginning, which improved the flow of the subsequent interviews, since the answers to the demographics questions provided background context for the longer answers that followed. The interview guide consisted of questions on English language ability, current health status, regular

source of care, factors in seeking and choosing health care, health insurance, and satisfaction with health care. The questions were developed based on a literature review of health care access and utilization studies with Korean American populations, coursework on Asian American immigrant older adults, and the principal investigator's personal and professional experiences working with Korean immigrant older adults in Los Angeles' Koreatown. The interview guide, like the other materials for this study, was translated by a native Korean speaker and then back-translated by another native Korean speaker, and checked for clarity and logic. The interviews, once completed, were transcribed into English from the digital recordings by the principal investigator, with interpreting assistance from the same bilingual, bicultural friend who assisted with the interviews.

There were possible limitations with the translations of the materials developed for the study. The two native Korean speakers who translated and back-translated the materials immigrated to the United States more than 40 years ago, which may have affected their translations. The materials, as a result, may have included some word-for-word literal translations in places, based on an understanding of English, rather than conveying the true sense of the original phrasing. Also, as with any language, Korean has undergone change in the past few decades, both in spelling and usage, with the introduction of many English loanwords and the decreased usage of other words. Therefore, the translators' Korean may be slightly different from the seniors' Korean, depending on the time of immigration. However, the two translators often interact with newer immigrants and read and view media of current day Korea, so their language facility may be more current. While the interview questions were intelligible to all the interviewed Korean seniors, more exact phrasing derived through pilot testing the interview questions with a range of Korean immigrant older adults, both recent and well-established

immigrants, may have helped refine the guide. Additionally, with the interviews and the transcription of the interviews, while the presence and assistance of a native speaker as interpreter helped immensely, certain nuances may have been lost because the principal investigator is not a native speaker of Korean herself.

Analysis

The transcripts for each interview were first read through to get an overview of their content and details. The principal investigator then independently coded the transcripts manually (without a computer program), informed by Glaser and Strauss' "grounded theory" approach to ethnographic interviews (Bernard, 2006; Spradley, 1979) and more specifically referring to Spradley's (1979) step-by-step process of analysis for ethnographic interviews. The codes were developed through a process of reviewing the interview guide questions to determine possible domains and then reviewing salient terms and their meanings within the interview transcript text to refine the taxonomy of the domains. The domains were then analyzed to determine the presence of cultural themes that connected the categories in a manner that would make sense and contribute to answering the research question.

IV. RESULTS

While there were many themes, and even more domains, that emerged from the analysis of the twelve interview transcripts, there were five particular themes that answered the research question on the health care experiences of Korean immigrant older adults, by looking at how these older adults navigate their health care, with respect to the issues of health care access and utilization, ethnic enclaves, and social support networks. The themes were as follows: 1) ambivalence toward Korean primary care doctors, 2) limited health care choices, 3) dependence on a diverse social support network for information, 4) personal responsibility for one's health, and 5) the idea of enduring (see Table 3 below for a chart of the themes with the domains they connect). All five themes reflect the intersection and interconnectedness of language and culture that exists in the Korean immigrant older adult community.

Table 3. Themes Chart, with Included Domains

Theme	Domains
1) Ambivalence toward Korean primary care doctors	<ul style="list-style-type: none">• Availability of choice• Health status• Language (impact/influence)• Limitations• Reasons to go to doctor• Sources of health care• Sources of support
2) Limited health care choices	<ul style="list-style-type: none">• Availability of choice• Health status• Language (impact/influence)• Limitations• Reasons to go to doctor• Sources of health care• Sources of support
3) Dependence on a diverse social support network	<ul style="list-style-type: none">• Language (impact/influence)• Limitations• Sources of support
4) Personal responsibility for one's health	<ul style="list-style-type: none">• Approach to life• Health status• Language (impact/influence)• Limitations• Reasons to go to doctor• Sources of health care• Sources of support
5) Enduring	<ul style="list-style-type: none">• Approach to life• Health concerns• Health status• Limitations

While the participants were very open about sharing their personal details, even going into detail about their various health conditions and primary care doctors' names, the names of the Korean immigrant older adult study participants have been changed to protect their anonymity and privacy. Thus, all the names used to refer to the Korean seniors in the following

interview excerpts are pseudonyms. Each pseudonym is unique, meaning that each name refers to only one participant. The participants' age and years lived in the United States (i.e., time since immigration) are stated within the interview excerpt, at each senior's first mention. For each subsequent reference, only the senior's name is given to introduce the excerpt.

Theme 1: Ambivalence toward Korean Primary Care Doctors

In the course of the interviews, the Korean seniors expressed a range of contrasting beliefs about Korean (Korean-speaking and culturally Korean) primary care doctors, in general, as compared to Korean specialist doctors, and as compared to “American”¹⁵ doctors, stating that Korean primary care doctors were both necessary and unnecessary, competent and unskilled, kind and inattentive, and comfortable to deal with and disagreeable. The two main contrasting attitudes towards Korean primary care doctors, however, were: 1) Korean seniors trust and depend on Korean primary care doctors as their main source of health care, and 2) Korean seniors lack confidence in their Korean primary care doctors, regarding them often as a superfluous formality to picking up their medication.

All of the seniors stated that they had a primary care doctor as their regular source of care. Those of the seniors with Medi-Cal/Medicare (either alone or in combination) (n=8) visited their primary care doctor at least once a month and sometimes more frequently, while those with Medicare Advantage (n=2) visited their primary care doctor on average every three months, and those with Medicare w/Supplemental (n=2) insurance visited their doctor only once a year. The frequency of these visits may coincide with the coverage stipulations of the specific insurance plan the seniors have.

¹⁵ Korean immigrant older adults use the term “American” to refer to English-speaking Non-Hispanic Whites, regardless of citizenship, usually in contrast to “Korean.”

Main Source of Health Care

In the health care system, the primary care doctor is often the first point of contact. The Korean seniors all acknowledged this fact, some of them trusting the primary care doctor to take care of their health care and never questioning the primary care doctor's recommendations.

Mr. Hyun is a 75-year-old man who has lived in the United States for 20 years. He said that his primary care doctor examines and diagnoses him, referring him only if there is a problem. Mr. Hyun continued, "The primary care doctor is the one who sends me. So, it starts from the primary care doctor. If I'm sick, if I tell the primary care doctor, he makes a decision and sends me on the shortest path. That's how treatment is done. The primary care doctor handles everything." He also said that if the doctor told him to take medication to control his blood pressure, he would have to take that blood pressure medication.

Mrs. Cho is 76 years old and has lived and worked in the United States for 38 years. She responded that she just has to follow her primary care doctor's advice when deciding on medical care. "I have to do what he tells me to do."

Other seniors, while initially explaining that they go to their primary care doctors for medical care and adhere to his recommendations, introduced alternatives to the primary care doctor for medical care.

Mr. Min is 78 years old and has lived in the United States for 51 years. He is one of two seniors in the study who are still working and not retired and speaks and reads English very well. He stated that he bases his medical care decisions on the advice of his primary care doctor. But, he added that his decisions to seek medical care also depend on whether he thinks he needs to go and for what diagnosis. He said that when he was having a heart attack, he went directly to the cardiologist and not to the primary care doctor because he knew he had to go to a specialist. Mr. Min explained, "I know that when you have a heart condition that you have to go to the cardiologist. When you don't know, then you have to consult your internist." He said that he does follow the advice of the doctor when it is given, stating, "It's stupid not to follow the doctor's advice."

The Korean seniors in the study all had Korean primary care doctors, some of them staying with the same Korean doctor for years. Loyalty does not equal adherence though.

Mr. Hwang, at 74 years of age, has lived in the United States for 32 years. He said that meeting his primary care doctor was "destiny" and that he counts on him for his medical care. He said that he met him when he went to the hospital and

asked for a Korean-speaking doctor and that they are “growing old together.” Mr. Hwang says that he puts his trust in his primary care doctor, but he has never gotten preventative care because he does not like getting shots or taking medicine. His method for determining whether to follow any course of treatment is to ask “I’m dying, not dying?” If the doctor tells him that he will not die without the treatment, he does not get the treatment. He added that he does not trust his primary care doctor even if he says he will die without the treatment, because “if you’re dying, you die.”

Despite trusting his primary care doctor and depending on him as his main source of medical care, Mr. Hwang put conditions on following his doctor’s recommendations, foregoing preventative care beyond routine exams. Compared to Mr. Hyun and Mrs. Cho, who did not question the doctor’s recommendations, Mr. Hwang, like Mr. Min, used the primary care doctor as a main source of information, but added his own input.

Superfluous Formality

The seniors who had Medi-Cal only, Medicare only, or a combination of the two, were often the ones who expressed a lack of trust or dissatisfaction with their Korean primary care doctors. Unlike Mr. Hwang above, who has had the same primary care doctor for years, some Korean seniors changed their primary care doctors frequently. When asked about their regular source of care, many of these same seniors stated that they see their primary care doctor once a month for routine exams, including blood tests, but primarily to pick up their prescription medicine.

Mrs. Kim is 79 years old and has lived in the United States for 24 years. She said that she has a responsible primary care doctor, an internal medicine doctor. She shared, “Even when I’m not sick, I go regularly once a month to get my prescriptions.” She said that when she is sick, however, she goes to see her “family doctor,” since he is a specialist. She believes that Korean older adults do not have the doctors they want based on how often they switch doctors. She said, “If their friends tell them that this doctor is good, then they go to that doctor. If they hear that another one is good, then they switch to that doctor.”

Other Korean seniors confirmed this practice of frequently switching doctors in their interviews, although it is possible that many Korean seniors simply have multiple doctors instead of relying on their primary care doctor as the main source of care.

Mrs. Chang is a 68-year-old woman who has lived in the United States for 13 years and has been in and out of hospitals frequently during that time for her many health problems. She currently has both Medicare and Medi-Cal insurance, which gives her more flexibility in choosing her health care providers and covers much of the cost. She said that she goes to her primary care doctor once a month to get her medicine. But, she also goes to the heart doctor, the foot clinic, the eye doctor, and the ear doctor, all in separate offices throughout Koreatown, depending on what is hurting or bothering her, because each one is different. She said that she used to tell her primary care doctor about all of her health problems; but, she said, “Others who often go to the hospital said to me, Why do you tell your primary care doctor everything? If there’s an emergency, they’re good at checking you into the hospital quickly, because they make money off of that.” She said these people who go to the hospital often also knew where to go for the best internist and the best heart doctor. Believing that the primary care doctor wants to have everything done at his hospital and not trusting him to give her referrals to specialists, she goes to the primary care doctor first and then seeks out her own specialist care based on whom she knows from the hospital and whom she hears is good or renowned.

Many seniors referred to their primary care doctors as “good” or “kind” people, even Mrs. Chang above, who believes her primary care doctor wants to keep all her medical care at his hospital. Their view of the primary care doctor’s character does not seem to equate to trust in the quality of care or loyalty to the doctor.

Mrs. Lee is 81 years old and has lived in the United States for 31 years. She had not been feeling well during the week of the interview. She said that her current primary care doctor is a “good person,” but that it makes no difference whether or not she goes to see him, since he does not cure illnesses and barely examines her. “He just writes prescriptions if I ask for medicine,” she said. She also stated, “The doctor I have now is the one who gives me my medicine. Frankly, that’s what he is. Then again, they’re all like that.” Mrs. Lee said that she was thinking of changing her primary care doctor and going somewhere else, because her primary care doctor’s office is so far and she has to walk uphill to get there.

This attitude towards primary care doctors that they are easily interchangeable and merely a formality to go through, as the gatekeeper to prescription medicine, is complex. The

Korean seniors who hold this view seem to have various reasons for it, with their distrust or dissatisfaction with their primary care doctors as the primary basis. This contributes to the ambivalence that Korean seniors show toward Korean primary care doctors, ranging from seeing them as trusted medical authority figures within a centralized system of health care, to seeing them as one source of medical care among many, to seeing them as decentralized service providers primarily of prescription medicine.

Theme 2: Limited Health Care Choices

The Korean seniors' ambivalence toward Korean primary care doctors relates to the second theme, the perception of limited health care choices, in that their contrasting attitudes toward Korean primary care doctors affects their perceptions of their health care choices. While there were a range of responses regarding their options for health care, from those who had Medicare and Medi-Cal and felt able to seek medical care at any hospital or doctor's office, to those who felt unable to seek health care for emerging health problems because they only had Medi-Cal, many Korean seniors saw themselves as lacking choices. When asked to identify among cost, proximity, language capacity of the doctor/staff, cultural compatibility of the doctor, or other, how they decide where to go for healthcare, eight of the seniors (who stated they spoke English "not well" or "not at all") chose language capacity, stressing the importance of being able to communicate with their doctors. A ninth senior chose cultural compatibility, because to him, language capacity was inherent in the concept. This idea of health care choice relates not only to health care access, but also quality of care as well as patient satisfaction with care.

The two seniors who are recent immigrants, with only Medi-Cal for their health insurance coverage, see themselves as limited in health care choices until they can attain citizenship status and be considered eligible for access to Medicare.

Mr. Jung is an 81-year-old man who only recently immigrated to the United States 5 years ago. He stated during his interview that he wants to go to the dentist or the dermatologist, but cannot because he only has Medi-Cal. He said that he has no choice but to be unwell. He wants to get Medicare to be able to go to the eye doctor, the dentist, and get the hearing aids he needs. He is waiting, because he does not have Medicare. Right now, he goes to the places that take Medi-Cal. He said that if they say they cannot do anything, then he cannot do anything.

Mrs. Park is 69 years old and immigrated to the United States 3 years and 6 months ago. She only has Medi-Cal. She said that she wanted to get her teeth cleaned, so she asked her primary care doctor if he knew whether or not it was covered. Her doctor did not know. She said that that is the end then, since she cannot go somewhere else and ask. She also said that she did not pick her primary care doctor because she liked him; rather, she saw a pamphlet at an acupuncture clinic and was told to go to that doctor. "Nothing is because I wanted it. It's because I didn't know how otherwise," she said.

As recent immigrants, Mr. Jung and Mrs. Park, besides being limited by the type of health insurance coverage they have, are limited in their health care choices because of their knowledge of which benefits are covered and what other resources exist for them. There are other seniors who felt limited by the quality of the Korean doctors available to them in Koreatown, despite a full range of benefits provided by Medicare and knowledge gained over their long-term residence in the United States.

Mrs. Kim used to go to a very skilled doctor in Korea. She said that here, in the United States, she has to trust her body to the doctor's title and not his skills. Her options are limited because of the language barrier. She said she does not really get to choose her doctor. She has the doctor she does because of her circumstances. It is not because he is the doctor she really needs or wants: "In Korea, I could choose my doctor. But here, there's only one." Since she cannot do what she wants as she wants, she feels her life is limited by those boundaries. She said, "I can't go beyond them, so it's a little frustrating."

Mrs. Lee said that if she could speak English, it would be nice, but she does not have to since she has a Korean doctor. She does not worry, since her hospital has Korean doctors as well. She said that she wants to get an endoscopy because she has been having a lot of gastrointestinal pain, and she is thinking of going to a popular Korean gastroenterologist, despite hearing that he is not very good. She said she does not know anyone else but him.

These seniors face language limitations, which they feel affects the quality of health care they have available to them. They prefer Korean doctors for facility of communication and comfort, but would like to have the option of being able to choose a doctor based on skill or reputation over Korean language ability. Mrs. Kim said that it is difficult to find a good doctor. Those not limited to Korean doctors in Koreatown also felt limited in some respect.

Mr. Hwang can say basic words in English and lives in a Los Angeles County suburb not near Koreatown. He has a Medicare Advantage HMO plan and a Korean-speaking doctor whom he likes and trusts. He sees the long waiting time and difficulty in making appointments as a drawback of his hospital. Sometimes he has had to wait over a month to get an appointment slot. While he does not currently have any specific illness, he said, "For things like cancer, it can progress a lot in a month."

Mrs. Cho worked for a Los Angeles County department office for over 30 years and has a Medicare Advantage HMO plan provided through them. She is comfortable speaking in English, but she prefers having a Korean doctor to prevent any miscommunication about her health care. She said that she is content with her health coverage, but feels inconvenienced by the restriction to in-network doctors. She said that she cannot consult a renowned doctor that she wants to see, since she can only see the doctors belonging to her HMO. While her friends with Medi-Cal and Medicare can request their own treatment, she believes her HMO only gives her the minimum in terms of services and treatments and does not cover things that it may consider "unnecessary."

Both Mr. Hwang and Mrs. Cho are content with their enhanced Medicare plans and their Korean-speaking doctors, but still feel that their health care options are limited. According to Mrs. Cho, though, "everyone has pros and cons," which may influence some Korean seniors to perceive their limitations in choice more as minor inconveniences, a commentary on Korean doctors in Koreatown.

Mrs. Choi is 72 years old and has lived in the United States for 38 years. She is diabetic and rates her health as "so-so," but is in good spirits. She does not have any complaints about her health care, but she finds that Korean doctors in Koreatown are lacking in refinement and attentiveness, compared to American doctors. She stated, "When I went to the American doctor, since I went once every six months when I was in Arizona, they would check the problem area, my

feet, and everything. Korean doctors don't do that, so I feel bad about that. They're not that careful, exact. They're not attentive."

While not seen by Mrs. Choi as a limitation in health care choice, a difference in the quality of care available from the Korean doctors in Koreatown, as compared to elsewhere, may be more than an inconvenience, since Mrs. Choi makes health care choices based on the language capacity of the doctor. She was positive and echoed Mrs. Cho's thought about pros and cons, however, stating, "If one thing's good, then one thing's bad. There's nothing that's all perfect." Korean seniors face limited health care choices on some levels, some finding them to be a major source of stress because of limited access to needed care and others finding them to be minor inconveniences within an imperfect system.

Theme 3: Dependence on a Diverse Social Support Network

The twelve Korean immigrant older adults interviewed for this exploratory study had diverse social support networks, with both informal and formal components, that provided them with information and tangible support to navigate the health care system and living in the United States. Most of the seniors turned to the newspaper, radio, television, and/or the internet, in the Korean language, for independent sources of information. The seniors' informal support networks consisted of their family, primarily referring to their adult children, but also including siblings, extended family, and distant relatives; and the Korean community both within and outside of the ethnic enclave, including church peers and elders, neighbors, classmates from alumni networks, and friends. The formal support networks were composed of community organizations and service providers, the health care provider system (both within and outside the community), and government-related agencies and services. Most seniors depended upon a combination of sources from both their informal and formal support networks.

Informal Support

All twelve seniors, whether having immigrated early or late in their lives, spoke about their adult children during their interviews. These adult children are the main source of informal support within the diverse social support network for these seniors. For some, these adult children may be second generation, born in the United States and raised as Korean Americans; but more likely, they are either part of the 1.5 generation (read as “one point five generation,” these children were born in Korea and immigrated either before or during their adolescence) or part of the first generation, having been born and educated in Korea like their older adult parents. Only one senior, Mrs. Park, did not have adult children living in the United States, since she had immigrated alone at the age of 65 and her two adult daughters lived in Korea. Those who had immigrated later in life had been sponsored by their adult children or had immigrated together with their adult children. Regardless of immigration time, the seniors depend to a certain extent on their adult children as part of their informal family-based or kinship network.

Mr. Jung cannot speak in English at all. His daughter went with him to find a Korean doctor for him to go to when he first came to the United States. He said that if a problem arises where he needs an interpreter, he takes his daughter, his grandson, or his son-in-law to speak on his behalf. His daughter provides financial support for him and his wife, so that they can live in their senior apartment and buy food to eat.

Although he and his wife live apart from their adult daughter, Mr. Jung depends on her and her family for financial and language support, as well as in navigating the U.S. health care system as a recent immigrant who cannot speak English well. Adult children often help their older adult parents as part of their social support network, but some may do so grudgingly, leading to the Korean senior feeling like a burden on his/her children.

Mrs. Baek is 81 years old and has lived in the United States for 25 years. Her eldest daughter, who came to the U.S. as an international student before becoming a citizen, sponsored her for immigration. When Mrs. Baek first arrived in the

United States, her daughter, who speaks English well, went with her to the Social Security office, to help her sign up for Food Stamps and other benefits. Mrs. Baek currently lives alone in a senior apartment near Koreatown and generally takes the bus everywhere. Her daughters live in Southern California and she sees them regularly. She has not had any major illnesses yet, so she has not had to ask for her daughters' help much. She said that her daughters get annoyed when she calls them to come out for her health appointments. They told her that she has to be healthy so that she does not have to be a burden to them. She said that because she is healthy, her daughters are happy.

Mrs. Baek spoke lovingly about her daughters. She conveyed that she could call them if she needed them, but does not need to since she is relatively healthy. Although mentioned jokingly, her desire to not be a burden to her adult children may affect her willingness to depend on them even though they are part of her informal social support network. In contrast, some seniors may have adult children who take up their social support role willingly, but leave the Korean senior too dependent on their support, without the knowledge to do things for himself/herself.

Mrs. Choi immigrated when she was in her thirties with her husband, who spoke English well. Her adult children are part of the 1.5 generation. Her husband set up and managed her health insurance for her; and after her husband passed away, her daughter took over. When she tries to do something herself, her daughter will tell her, "Mom, what do you know? I'll do it." Mrs. Choi said that her daughter does everything for her, so she lacks "development" in certain skills. "Now that I'm trying to do things on my own here [in Los Angeles], I'm struggling. I have to do a little bit at a time," she said. She said that she feels embarrassed to call her daughter in Arizona for simple things, but she does not know anything because everything was and is done for her.

Compared to Mrs. Baek, Mrs. Choi can rely on her adult daughter for all forms of support, from major to minor tasks, without being perceived as a burden. But, the willing support she receives from her daughter still leaves Mrs. Baek feeling ashamed of her lack of knowledge and perhaps more dependent on her daughter than she would like to be. Often times, the seniors' reliance on their adult children is due to language difficulties with English and in navigating an American health care system. Sometimes, it has no bearing on language need.

Mr. Min speaks English well, having lived in the United States for the majority of his life, and was the only senior who preferred to read English-language newspapers (*The Wall Street Journal* and *The Financial Times*) to Korean ones (such as *The Korea Times*, also known as *Hankook Ilbo*) every morning. He lives outside of Koreatown in a house with his wife. Recently, his son and daughter-in-law came to live with them, because his wife has health problems and he cannot take care of her full-time, since he works.

Adult children are an important part of the Korean seniors' informal social support network, but are only one part of the subcategory of family. There are other members of the informal network that come from the Korean community at large. When asked about where they get their health information, including advice on doctors, health insurance plans, and alternative treatments for illnesses, many seniors mentioned their church friends and peers, former and current work colleagues, neighbors in their senior housing complex, and classmates from alumni networks.

Mrs. Hong, a 68-year-old former nurse who has lived in the United States for 45 years, serves on the board of a financial company. She said that she got information about the Supplemental (or Medigap) insurance that she has for her Medicare coverage through her work colleague, who is an insurance agent for one of the plans.

Formal Support

In an effort to find out how Korean immigrant older adults found out about Medicare and Medi-Cal and went through the application process, I included a question on the interview guide on the matter. I expected the seniors to respond with a list of sources of formal support and services, primarily from the community. Many of the Korean seniors seemed confused by the question, most responding that it was “automatic” for Medicare and that they were sent notices for Medi-Cal.

Mrs. Park explained that when you apply for Medi-Cal, when you get your green card, first, “mail” comes to your house. If you don't have any income whatsoever, you have to go to the social worker's office. Everything is in English

there. She said that she could not afford to go to the places that require money, because she had none. So, she went with her husband to sign-up for Medi-Cal, although neither of them speaks English well, since her daughters live in Korea and she could not ask anyone else.

Mrs. Park's account of how she applied for Medi-Cal as a recent immigrant introduces an aspect of the formal social support network within the Korean community that is not often discussed, the "benefits broker." Mr. Hyun elaborated on this concept in his interview.

Mr. Hyun recounted how he had received a call from a social worker about registering for his Social Security benefits, since he had not signed up yet, despite being eligible. The social worker, who spoke in Korean, told him to just come to the Social Security office. She warned him that there are Korean people whom he can bring in to help with interpreting, but he would have to give them one month of what he would receive in benefits as pay. She said that even if he does not do that, there [at the Social Security office], they interpret everything by phone. My Hyun also said, "The woman asked me to tell other Koreans that they don't have to bring anyone."

Apparently a common practice in the Korean community, this "benefits broker" would accompany the Korean immigrant who has limited to no English proficiency to the government agency office and interpret for him/her during the benefits application process. According to Mr. Hyun, the appointment would only take 20 minutes. In exchange for the language assistance during that time, the "benefits broker" would receive one month's pay of the benefit received, which, for welfare, is currently around \$800. This "benefits broker" is a part of the formal social support network, provided by the community, albeit a seemingly exploitative practice.

Another part of the formal social support network for the Korean seniors is the Korean community-based organization, through one of which I recruited seven of the senior participants. It provides multiple forms of support, including civic engagement and companionship through social activities and information through health and legislative seminars. The seniors in the study who were affiliated with the Korean community organization often had a better understanding of Medi-Cal and Medicare and the current issues related to health care, like

spending cuts, due to attending the organization's seminars and getting updates from the organization staff. Various Korean associations also unite seniors around Korean political and national causes.

Mr. Jung said, "When we have a Korean organization seminar or when we had voter registration for parliamentary elections, I go and do everything that I have to and help out." He goes even when his friends say they will not go.

Mrs. Cho mentioned that she had recently gone to a group meeting, where there was a special speaker from Korea, with others from her senior housing apartment complex, because one of the members of the Korean association group lives in her complex.

These formal peer groups provide Korean seniors an alternative to the informal family-based network for information and social interaction. Nine of the twelve seniors live in or near Koreatown, and all twelve seniors regularly (three or more times a week) go there, whether to run errands, go grocery shopping, work, seek health care, attend community events, or meet friends. Four of the twelve seniors lived closer to or with their adult children before, in the suburbs, and then decided to move to the vicinity of Los Angeles' Koreatown for this express purpose. This represents a shift in the priorities of these Korean seniors, to seek out a diverse social support network, which still includes their adult children, but provides access to additional community and government resources, as well as independent living.

Theme 4: Personal Responsibility for One's Health

When asked about how they decide whether or not to seek medical care, some of the Korean seniors responded that they listened to their primary care physician's advice and followed his referrals. Culturally speaking, medical doctors are highly respected within the Korean culture, as is the medical advice they give. Some of the seniors in the study noted,

however, that they had to take care of their own health and figure out their own sickness, so that they could tell their doctors if and how they were sick.

Mrs. Kim said that she needs to be the one to “reveal her sickness” or pains to the doctor, since every doctor’s specialty is different and the doctor does not know everything. Mrs. Kim’s husband suffered a stroke 15 years ago, so she provides care for him. During her interview, she related the story of how her husband was admitted to the hospital for stomach pains and sent home with a diagnosis and treatment for constipation. After three days and no improvement, she said that she did not feel right about the diagnosis and admitted him into the hospital again, whereupon an American doctor came and determined that he needed surgery. He got surgery that day, but his appendix burst because it had been so long and the pus had accumulated. She said that that is why she has to figure out her own illness. If she had just ignored her feelings and had agreed with the first doctor that it was constipation, she said that her husband would have died. She said that it was only because she went to get him re-checked that he’s alive. “I have to be the one to carefully examine myself and see where I’m in pain,” she said. She concluded her interview with a comment on seniors, and not their sons, taking responsibility for their own health, because “daughters and sons are all so busy trying to live their own lives.”

In her interview, Mrs. Kim discussed her proactive approach towards her own health care and that of her husband. She felt the need to take matters into her own hands and take personal responsibility for her own physical health as well as that of her dependent husband, since the doctor cannot know or do everything. While it may seem contrary to Korean cultural norms of respecting and trusting the doctor’s medical advice, taking personal responsibility for one’s health seems to have developed to address practical concerns. Mrs. Kim noted the need for seniors to be personally responsible for one’s health because of the inability to depend wholly on their adult children. Mrs. Park does not have the option of depending on her adult children in the United States either, so she must take care of her own health.

Mrs. Park said that she “runs after” health fairs and health seminars in the Korean community to get health information, after reading about them in the Korean newspaper. She said, “Whatever Medi-Cal provides, I go after.” She thinks it is necessary to be “tenacious” to receive health care. Mrs. Park currently goes to adult school, Monday through Friday, to learn English, studying from morning until evening, partly to get her citizenship and have access to Medicare and other

benefits, and partly because she likes to learn. She said, “When you’re living in America, you can’t just be here, you have to keep trying to learn. You have to learn to read, speak, and keep trying.”

Mrs. Park demonstrates her attitude of independence and personal responsibility for her health with her quest for information in the community. Not content with her current knowledge of health issues, she tries to learn more from multiple sources. She seeks to continuously learn, including learning English, despite her short time living in the United States, compared to many other seniors in the community and in this exploratory study, so that she can take advantage of more health resources and benefits, overcoming her limitations. The unknown for many seniors can be a source of anxiety and also a motivating factor.

Mr. Jung does not consider himself healthy. He currently suffers from painful symptoms related to shingles, among other illnesses. He recounted how he was hospitalized for three days due to stabbing pains in his chest and difficulty breathing because of the pain. He said that his primary doctor did not know what was wrong. So, he told his symptoms to those around him, a bookstore manager whom he knows and his dentist in the Valley, and they told him that it was shingles. He obtained a printout of content in Korean on shingles from the bookstore manager to learn more about the disease, and he carries this around with him so that he can find out additional information.

Although Mr. Jung suffers from many ailments, he exhibits, like Mrs. Kim and Mrs. Park, a desire to understand his health problems and address his health concerns, seeking out health information for himself even when his doctor does not know the answer. Korean seniors’ sense of personal responsibility for their own health may have originated out of a need to adapt to their environment and be resourceful in overcoming the obstacle of living in Los Angeles with English language limitations and health problems.

Mrs. Chang does not live in or near Koreatown, but she travels there by bus almost every day. Since there is no bus service on the weekends at the bus stop closest to her apartment, she walks 30-40 minutes to get to another bus stop, so she can go to church in Koreatown. She has many health problems, including diabetes and gastrointestinal issues that prevent her from eating without nausea. As a result, she has needed medical care many times throughout the years. Before

she qualified and received Medi-Cal and Medicare, she sought medical care at the Los Angeles County hospitals, going often to the large USC County hospital in East Los Angeles and waiting long hours to get seen, first through the emergency room and then getting limited health coverage through the hospital. On two separate occasions, she took four buses to go to the UCLA County hospital, even though it took all day. She went alone each time. She has gone through much trial and error in trying to come up with a diet that she could eat without too many problems. She developed her own combination of herbal medicines to treat her lack of appetite and nausea and sought out vitamin supplements to restore her energy. She also goes to an adult day health care center every weekday by taking the bus and walking, even though there is a car that takes seniors there and back to their homes. She said that she does not need a cane and can walk well and therefore does not need to take the car.

Much like Mr. Jung, Mrs. Chang has had to take personal responsibility for her own health, seeking out medical attention and methods of treatment on her own, since her doctors could not identify what was wrong with her. These Korean seniors utilize existing resources despite challenges in accessing them in order to obtain the health care they need and want.

Mr. Hyun takes an active role in his health. When he chose his primary care physician, he looked at the Korean newspaper's list of Korean doctors and then visited each one in turn to determine which one he liked best. He also sought out his own specialist, a Korean cardiologist in Long Beach, based on his own research, and sees him regularly. He said that he has to take personal responsibility for his health, because, he said, "The doctor doesn't know. Why doesn't he know? I have to go to the hospital for him to know. I know. If I'm sick, I know." Understanding the importance of prevention, he said he guards his health with a proper diet and exercise and not doing things that harm his health, like drinking and smoking.

Mr. Hyun, unlike most of the senior participants in the study, researched his options for his primary care doctor and specialist, meeting them to see if he liked them before making his decision. Most of the seniors in the study exhibit a certain amount of personal responsibility for their health, since it takes a certain amount of personal responsibility for one's health to regularly go to the doctor and follow the doctor's advice for medication or treatment, even without language barriers. Some of the seniors had a more proactive approach to their health, however, like Mrs. Kim, Mrs. Park, Mr. Jung, Mrs. Chang, and Mr. Hyun mentioned above, pursuing

health care in spite of their varying health statuses and levels of knowledge and understanding of the U.S. health care system. In addition to involvement with a community-based organization, seniors who had lived in the United States longer (greater time since immigration) and therefore had higher levels of English speaking and reading comprehension, or were well-educated (having studied and worked as engineers, nurses, or school teachers before immigrating to the U.S.), were more likely to be proactive with their health, seeking preventive care and also not delaying care when coverage and treatment were possible. Not surprisingly, many of these seniors, perhaps due to their involvement with the Korean community organization, also had a better understanding of Medicare and Medi-Cal and the benefits they provide.

Theme 5: Enduring

The cultural theme of enduring, bearing with pain or a negative situation, is one that is common among some Asian cultures (Mui, Kang, Kang, & Domanski, 2007). Most of the Korean seniors I interviewed made mention of their need to “endure” or “bear with” or “let things pass” in a situation. While the seniors used various words to express this cultural idea of “enduring,” the Korean verbs (here, stated in the infinitive form) most often repeated were ‘chamda’ (참다) and ‘gyeondida’ (견디다). Faced with varied limitations, being low-income, having limited transportation, speaking little to no English, not knowing where to go for help, being sick and in pain, or not having access to certain benefits because of insurance coverage, these Korean seniors spoke of their trials and the need to endure.

Mrs. Park does not know whether certain procedures are covered by her Medi-Cal insurance. She said that near her adult school, there is a social worker whom she could ask about her Medi-Cal benefits. But, she feels bad for bothering the social worker with such a small issue and worries that the social worker could get frustrated with her because of it. She also said that it is difficult to meet with the social worker, because she has to make an appointment within the social worker’s limited schedule. So, she said, “I just let it go. The time isn’t right, and I feel bad

for pursuing after him/her.” Later, in describing the ten-page rejection letter in English that she received from one senior housing complex, Mrs. Park said, “I didn’t have the ability to answer them. So, I gave up and I’m bearing with the unfair situation.”

Mrs. Cho, in describing the disadvantage with her Medicare Advantage HMO plan, said that her HMO decides the services offered based on their budget. So, her thought was that “things that might be ‘unnecessary’ are not covered.” She said, “There are things that you just endure. That’s what some people say too.”

While many of the seniors spoke of “enduring” in an individual sense, speaking of enduring their personal frustrations or problems, one senior shared about enduring to keep from burdening her adult daughter.

Mrs. Chang suffers from numerous health problems. She said that she cannot eat and cannot take her medicine. But, she said, “My daughter has to go to work and make money and live on what she makes. She loses money on rent already. If I tell her I’m sick, then she’ll worry. So I don’t say anything ever. I don’t say anything to anyone. If I can’t eat, then I can’t eat.”

This idea of “enduring” alone or in silence is one approach to dealing with health issues and is one that has been noted in other studies of Korean seniors as a cultural value based on the Confucian belief that stresses the importance of the family over the individual and the senior’s desire not to burden his/her children (Pang, 1984; Pang, 1991). Suffering alone to spare their children the burden may be more common among Korean immigrant older women versus men, as Korean folk and contemporary cultures frequently exalt the self-sacrificing love of Korean mothers. Rather than feeling defeated by their obstacles, some seniors spoke of their positive outlook on their life and health and their approach of maintaining this positive attitude despite their health issues, including being thankful for what they have.

When describing her health, Mrs. Kim said currently her health is relatively good because doctors say that she is healthy for her age. She has chronic back pain but she attributes it to being older. She said she is thankful if it only hurts to the degree it is hurting now and if nothing else starts giving her pain. “Just thank you,” she said in English.

Mrs. Kim endures her chronic back pain and feels thankful that she is not worse off. With the simple phrase, “Just thank you,” Mrs. Kim reflects her positive outlook, despite the daily pain she suffers. Some of the seniors were thankful specifically to the United States for providing them with health care coverage and other government benefits, to seek care when needed.

Mrs. Lee said, “I’m not in a lot of pain, but these days, my stomach hurts.” She shared that she wants to go to a large hospital to be examined, since she thinks her primary care doctor is not thorough when he examines her. She said that she does not have to go though if her family is busy and no one can take her. She said, however, that she has a lot to be thankful for. She said, “What more is there to say? I’m so thankful to this country. Who are we to receive this [health care coverage]? We haven’t paid taxes, and they help us. How much do we have to be thankful for, living in this nice place? I think like that. So, I have no problems or complaints. And if I did, that would be a bad thing.”

Many of the seniors, like Mrs. Kim and Mrs. Lee above, felt that it was important to have a positive or thankful attitude and a “cheerful spirit” to be healthy. Several of the Korean seniors shared in detail about their various ailments, including myalgia (muscle pain), neuralgia (nerve pain), chronic back pain, complications from shingles, arthritis, diabetes, headaches, dizziness, loss of appetite and chronic indigestion, high blood pressure, and dental problems. Some spoke of the regular pain they suffer on a daily basis, and most had not had their health concerns addressed to their satisfaction via the health care system. Regardless, seven seniors rated the health care that they have received or can receive in the United States as “good” or better, believing that they have been able to get the health care they need; four rated it as “okay” with reservations; and only one felt that it deserved a barely passing rating.

Some seniors spoke of enduring their conditions alongside mentions of death and their acceptance and preparation for death as part of aging.

Mr. Jung described the pain from his shingles: “Here in the center of my chest, when there’s a jabbing pain, it’s hard to breathe and I break into a sweat. At the

shortest, it lasts for a minute, at the longest for 5 minutes. When it lasts a long time, then it's really difficult." He said that he tries to be positive at those times. "Even though it hurts, I endure it," he said. Mr. Jung said that he tries to stay positive because he does not know whether he will get better or suffer from shingles for the rest of his life. He said he is not scared of dying, since he has lived a full life.

The seniors' comments on death were not stated with a sense of foreboding, but rather with a matter-of-fact attitude, with many stating that they had "lived long enough," like Mr. Min, or "don't want to live that long," like Mrs. Lee.

Mrs. Kim currently lives in a dark ground floor apartment, which does not provide enough sunlight given her husband's health condition. She said that she wants to move to a different apartment in the same senior housing complex, but there are only other ground floor apartments available. She said that she could try moving to another complex, but other places have a 10-year wait. She said, "I probably won't live more than 10 years, and moving is so tiring and burdensome. So, I should just be thankful for what I have and then bear the discomforts."

Mr. Hwang said that his health is "so-so," not good or bad. He said that because he is getting older, although he is healthy, he keeps getting worse, and neither he nor his doctors know why. Laughing but speaking seriously, Mr. Hwang said he told his wife and daughter that he does not want to have a funeral when he dies. He wants to be cremated and have his ashes scattered so that no one can find him. He does not want people to remember him. He wants to be "gone with the wind," he jokes in English. He said he has no fear. He is preparing himself to die. He said he thinks every day, "It could be the end today."

The seniors spoke of enduring many difficulties, big and small, in their life, stemming from the limitations they had or faced. Due to the nature of the questions asked during the course of the interview, many of those difficulties dealt with health concerns. Many of the Korean seniors, even those who professed personal responsibility for their health and took a proactive approach in seeking care in spite of difficulties, recounted instances where they had to endure or bear with a negative situation. They chose to endure these situations with a variety of responses, being silent, positive, or thankful, and accepting that these situations they were enduring were part of their life course, much like death.

To summarize, the Korean primary care doctor plays an important role in the health care of many seniors, both as a trusted source of information and as a means to access their monthly supply of prescription medicine. Many of the seniors felt that they had limited health care choices, however, because they lacked financial resources, had limited or restrictive health care coverage, or were unable to speak English well. Some expressed dissatisfaction with their Korean doctors and questioned the quality of care they were able to receive through them. To address these limitations and meet their health care needs, these seniors utilized both informal and formal sources within their broad social support networks, relying on community and government resources that provided assistance that their adult children could not or did not provide. This shift from the family as the main source of social support tied into the personal, proactive approach to health of some of the Korean seniors, who felt that their health was their responsibility. For many of these Korean seniors, enduring the trials they faced as Korean immigrant older adults was accepted as part of their health care experience and their lives.

V. DISCUSSION AND CONCLUSION

The purpose of this exploratory study was to learn more about the health care experiences that Korean immigrant older adults have, living in Los Angeles County, with access to the largest and most well-known Koreatown in the United States. Specifically, I was interested in understanding how these Korean seniors navigated the U.S. health care system, given their access to Medicare and/or Medi-Cal insurance and a large Korean enclave with the availability of Korean doctors and a network of Korean peers and community resources. The study served to show the diversity of health care experiences, not to mention life experiences, of these Korean immigrant older adults, by recording their individual responses about their health care experiences and viewpoints. It also indicated how issues of language and culture permeate all aspects of the health care experiences of Korean immigrant older adults.

Discussion

The five emergent themes—1) ambivalence toward Korean primary care doctors, 2) limited health care choices, 3) dependence on a diverse social support network for information, 4) personal responsibility for one's health, and 5) the idea of enduring—reflect the wide spectrum of health care experiences for the Korean immigrant older adults interviewed for this study, showing where there are similarities and where there are differences, both within the study and as compared to the existing literature on Korean immigrant older adults. All of the Korean seniors had rich stories and opinions to share about their health care experiences, some choosing to discuss the barriers they face as Korean immigrants and older adults. An understanding of the interconnected components of health care access and utilization, ethnic enclaves, and social support networks contributed to the understanding of the bigger picture of how these Korean

seniors navigate their health care based on their own personality traits and perceptions, as well as external barriers and resources.

While this was an exploratory study with a small sample size, the emergent themes reinforce one of the prevailing points of many of the existing larger studies that were conducted directly with or inclusive of the Korean immigrant older adult population, the importance of language and culture (Jang, Kim, & Chiriboga, 2005; Kim, Yu, Chen, Kim, Brintnall, & Vance, 2000; Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Mui, Kang, Kang, & Domanski, 2007; Sohn, 2004; Sohn & Harada, 2004; Song, et al., 2010; Wong, Yoo, & Stewart, 2005; Wong, Yoo, & Stewart, 2006). Language and culture are inseparable and their influences indispensable in addressing the health care needs and wants of the Korean immigrant older adult community and in discussing their health care experiences. The topics of language and culture weave through and tie together the three components of health care access and utilization, ethnic enclaves, and social support networks that serve as the analytic framework for looking at the health care experiences of the Korean immigrant older adult population through the five themes presented in the results.

Ambivalence toward Korean Primary Care Doctors

A majority of the seniors interviewed had language limitations in English, which they cited as one reason for having Korean-speaking doctors. Limited English proficiency has been shown to limit health care access and utilization, due to an inability (or the fear of being unable) to communicate with English-speaking health care providers (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Kim, Han, Kim, & Duong, 2002; Mui, Kang, Kang, & Domanski, 2007). Many of the Korean seniors looked to Koreatown as a source of Korean-speaking, ethnically Korean medical providers, since many took it as a given that their primary care physician would

have to be Korean in order for them to be able to communicate directly with their doctor. The presence and proximity of Koreatown for many of these seniors presents a means to circumvent their existing language barriers by providing health care that does not require them to know or speak English (Kim & Lauderdale, 2002). All the seniors in the study had a Korean primary care doctor who not only spoke Korean but was ethnically Korean as well, thereby further facilitating patient-provider communication through shared cultural beliefs and hopefully avoiding cultural differences that would exist with a non-Korean doctor outside the ethnic enclave. The three seniors in the study who spoke English moderately to well, who cited something other than “language capacity of the doctor/staff” as the influencing factor in deciding where to go for health care, also had Korean-speaking, ethnically Korean primary care doctors. Notably, even though several had health care insurance provided through Medi-Cal and Medicare and a network of Korean primary care doctors to choose from within and near Koreatown, the Korean seniors still described situations suggesting their health care needs, not to mention quality of care and patient satisfaction, were not being met.

Some of the low-income seniors with Medicare and Medi-Cal, alone or in combination, frequently switched primary care doctors or had multiple doctors they visited regularly, sometimes without telling their primary care doctor, like Mrs. Chang. Several of the interviewed seniors confirmed this pick-and-choose mentality and practice. This practice could be detrimental to the seniors’ health, due to a lack of accountability between doctors and the possibility of conflicting treatments with contraindicated medications. Other seniors mentioned that their doctors were “good” or “kind” people, but they did not trust their ability as doctors, which could likewise affect these seniors’ adherence to the doctor’s advice or the taking of prescribed medicine. Korean cultural beliefs on shame and “saving face” may influence these

practices, because the senior does not want to offend the doctor by questioning his/her judgment (Moon, Lubben, & Villa, 1998; Mui, Kang, Kang, & Domanski, 2007; Pang, 1991). These seniors discussed practices and behaviors to address health care issues that exist despite having Korean-speaking, ethnically Korean doctors. Many simply wanted their doctor to have better “bedside manner,” including being more careful and thorough in examining them and giving them more time and attention during the doctor’s visit. It seemed that they wanted to have a more personal interaction with the doctor. Some of the Korean seniors, despite preferring a Korean doctor, wanted to have the choice of seeing a renowned doctor beyond Koreatown’s borders.

Limited Health Care Choices

While Koreatown provides access to services in the Korean language for this largely monolingual Korean-speaking population, access to care is not the same as quality of care. Some of the limitations to health care choices that the seniors mentioned were due to the lack of certain health care benefits, if a senior only had Medi-Cal vs. a combination of Medicare and Medi-Cal, or because they were restricted by their health care coverage into a particular provider network. Due to cuts in Medi-Cal spending effective July 1, 2009, the care that some seniors wanted and needed most, in the form of dental services, acupuncture, hearing exams, and chiropractic care, is not available to them (California Department of Health Care Services, n.d.). This suggests that having health insurance, while “enabl[ing] access to medical care” (Sohn, 2004), does not ensure that health care needs are met or that there is quality of care.

Some of the limitations, explicit and subtle, were due to the doctors themselves. Many seniors made mention of the low skill or lack of renown or reputation for the Korean doctors that they went to in Koreatown. Some of the seniors had gone to renowned doctors in Korea before

they immigrated to the United States and felt unable to get the same quality of care in Koreatown, whether there was truly a disparity or it was a matter of perception. Many seniors who had Medi-Cal, with or without Medicare, said that they did not choose their primary care doctor. Others, like Mrs. Kim and Mrs. Lee, mentioned that there was only one doctor whom they could go to for certain specialties because he was the only doctor that they knew or had heard about. These issues may account for the frequent switching of doctors mentioned earlier. It is unclear what criteria (aside from the already discussed linguistic and cultural similarity) most of the seniors were using to determine which doctor to see, beyond rumors and advice from friends and other doctors within their social support network. Based on the interviews, there seemed to be only a few doctors that were popular and accepted among the seniors in the Korean immigrant older adult community. A current (2011-2012) Korean business directory produced by The Korea Times (one of the largest Korean newspapers in Southern California) for Los Angeles and Orange Counties listed at least 57 Korean internal medicine doctors with offices in Los Angeles' Koreatown, with additional doctors just outside the borders but nearby Koreatown.

The seniors seemed dissatisfied by the selection of Korean-speaking doctors in Koreatown, so I asked if they would prefer to go to a non-Korean doctor outside of Koreatown, if they did not have the language barrier. Many of the seniors who did not speak English well responded that they would not. They preferred Korean doctors because they felt "more comfortable" with someone who shared their Korean culture and therefore could understand them better. Some seniors mentioned that these culturally Korean doctors knew, without needing to be asked, that they should discuss certain aspects of treatment which might conflict with or be affected by the senior's cultural beliefs. This included addressing the use of traditional herbal remedies in conjunction with prescribed medication, or being more

understanding as a male doctor about the feelings of shame and embarrassment that a Korean immigrant older adult woman may experience during a gynecological exam. These seniors had a certain level of trust in the Korean doctors based on their connection to them through cultural preference and familiarity (Kim & Lauderdale, 2002; Moon, Lubben, & Villa, 1998; Searles, 2012). The seniors' interviews suggest that the issue of health care for Korean immigrant older adults extends beyond the language barrier. The Korean language, for the Korean immigrant older adults, may be a proxy for Korean culture, with language capacity included under the umbrella of "cultural compatibility," as Mr. Hwang said in his interview.

Dependence on a Diverse Social Support Network

This idea of "cultural compatibility" influences these seniors in choosing whom to turn to for social support. Traditionally, the Korean cultural norm recognizes the immediate family as the primary unit of social support, with older adults often living with and depending on their adult children based on the value of filial piety (Mui & Shibusawa, 2008; Pang, 1991; Wong, Yoo, & Stewart, 2005; Wong, Yoo, & Stewart, 2006). The twelve Korean immigrant older adults in the study, however, all had their own independent housing, either in a senior apartment, a low-income apartment, or a house they owned, with ten of the twelve seniors living apart from their adult children. Eight of the twelve seniors chose to live apart from their adult children and live on their own in or near Koreatown, because Koreatown was more convenient and provided them with more activities that were culturally relevant as well as linguistically intelligible. The majority of the seniors interviewed expressed a sense of independence, relying on the bus for transportation and adapting to living on their own in the United States in other ways. These seniors mentioned relying on their adult children from time to time, if their adult children lived nearby or the seniors had an emergency situation; but their adult children were only one part of

these seniors' social support network, and not the primary part. In this way, seniors reduced their dependency and sense of burden on their adult children, as well as their adult children's perceived burden from providing social support or care (Youn, Knight, Jeong, & Benton, 1999). It may be that, as past research has shown, Korean immigrant older adults have adapted to a new cultural norm, the idea of depending on their adult children less and depending more on formal resources (Wong, Yoo, & Stewart, 2006).

The seniors interviewed confirmed previous findings that neighbors, churches, and community organizations play a large part in the social support network, with adult children still present as back-up (Wong, Yoo, & Stewart, 2005). Living in Los Angeles' Koreatown, the largest Korean "economic enclave" outside of Korea, provides these seniors with other options for social support that are also "culturally compatible" to their needs as Korean immigrant older adults (such as providing support in the Korean language, recognizing Korean cultural values, serving Korean food, and engaging in familiar Korean older adult activities), although they are outside their family support network. This enclave provides the means for many of these seniors to live without worrying about the need for language support (Kim & Lauderdale, 2002; Wong, Yoo, & Stewart, 2005) or feel isolated from familiar aspects of Korean culture. Due to the existence and proximity of Koreatown, these seniors have a broader network of formal and informal sources of social support, through ethnic-based community organizations and Korean cultural associations, which recognize the need to have both culturally and linguistically competent services to address the seniors' needs (Moon, Lubben, & Villa, 1998; Portes, Fernández-Kelly, & Light, 2012; Wallace, Villa, Moon, & Lubben, 1996). Addressing both language and culture is important, because for many of these seniors, their notion of being "Korean" commingles Korean language with Korean ethnicity and culture. When stating that

they needed and/or wanted a Korean-speaking doctor, for instance, they assumed that the doctor would be ethnically and culturally Korean as well. Only one of the Korean seniors (Mrs. Hong, who speaks English well and has lived and worked in the United States for 45 years) made the distinction between speaking the Korean language and being culturally Korean, when discussing Korean doctors, citing second-generation Korean American doctors as an example of being Korean but not speaking or understanding Korean well. The availability and knowledge of resources that are linguistically and culturally competent for these Korean immigrant older adults, from medical care to social services to grocery stores and restaurants within the ethnic enclave, leads to increased utilization of those resources (Moon, Lubben, & Villa, 1998), which may affect the seniors' shift to a broader community-based social support network.

Personal Responsibility for One's Health

The Korean seniors' shift from an informal family-based social support network focused on their adult children to one that encompasses the formal resources that the Korean enclave provides may explain the attitude of taking personal responsibility for one's health. Research shows that Korean immigrant older adults felt that they could not rely on their adult children for traditional forms of social support, both for practical and psychological reasons (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2005; Wong, Yoo, & Stewart, 2006). Older adults no longer co-resided with their adult children, so practically, it was harder to rely on their adult children for many things, like meals and errands (Wong, Yoo, & Stewart, 2006). Psychologically, Korean immigrant older adults also felt that depending too much on their adult children would be shameful, given the Western value of independence and autonomy (Mui & Shibusawa, 2008). Although only two seniors in the study explicitly expressed the worry about burdening their adult children, there were others in the study who mentioned that they felt bad

about asking for help. With the cultural expectation of filial piety, the Korean seniors may see their adult children as the accepted source of social support, yet feel guilty about contacting them for help, despite not knowing where else to go for support (Mui & Shibusawa, 2008; Wong, Yoo, & Stewart, 2006; Youn, Knight, Jeong, & Benton, 1999).

Without their adult children to depend on, many of these seniors use their resourcefulness to find culturally-appropriate information through other channels, made easier through the Korean enclave and its resources. There is perhaps also a shift in perception, however, from the notion that they will be taken care of in their old age by their adult children (Mui & Shibusawa, 2008; Pang, 1991), and therefore a need for these Korean seniors to advocate for themselves when it comes to their health care. Since their doctors and some of the medical staff that they encounter in their Koreatown-based hospitals are Korean, these seniors may also feel more comfortable and emboldened in addressing any issues, because of the common language and culture. Despite the presence of Koreatown with the Korean language and cultural resources it offers, the seniors still live within the broader mainstream environment as immigrants with language limitations in English, subject to cultural differences. Some Korean immigrant older adults may be more proactive with their health care as a result within the ethnic enclave, seeking information there because they feel ignorant or at a disadvantage for getting information within the mainstream English-speaking culture (Pang, 1991). While the proactive role that these seniors are taking towards their health and health care may seem like a purely positive attribute, it may be that these Korean seniors see no other option but to take personal responsibility for their own health. They may lack trusted resources or informal support from their adult children, or they may be responding to their perception of limited health care choices, for example, not trusting the skill of their Koreatown doctors. They also may see their health problems as their

own problem, something that they do not want to burden their children with, and therefore take personal responsibility for their own health to endure what they see as their natural burden of aging (Pang, 1991).

Enduring

Enduring is a complex theme, rooted in cultural beliefs on aging and affected by practical access to resources. Korean immigrant older adults show an acceptance of deterioration of health as part of aging (Pang, 1991). Most of the seniors interviewed for the study reflected this acceptance when describing their health problems; they attributed chronic muscle and nerve pain, bone pain, back pain, dental problems, as well as mystery causes of pain to their old age. Many of the seniors had the expectation that their health would decline with age, and so they were thankful that their health was as good as it was. Culturally, it seemed that these Korean seniors had to deal with issues of shame and face-saving as well (Moon, Lubben, & Villa, 1998), and thus endured their pain or negative situations alone. Those who chose to speak of their pain were often ridiculed: Mrs. Baek's friends doubted her severe leg pain and told her she was just trying to get attention when she later said that the pain disappeared with medication. Rather than face ridicule or negative rumors, some seniors chose to mask their illness, like Mrs. Chang, who sought out her own health care, even from the large public County hospitals, and tried out her own folk remedies, but decided that she would endure her pain alone. She also did not want to burden her daughter.

While the idea of enduring may seem contradictory to the previous theme of personal responsibility for one's health, in that the former accepts a negative condition, while the latter seems to reject the negative condition in pursuit of a positive solution, I believe the two attitudes complement each other. Most of the Korean seniors interviewed seemed to share a desire to be

healthy and pursue their own health. Many also stated their need to endure certain situations. The two attitudes do not seem mutually exclusive. Rather, whether the senior is proactive or accepting (enduring) seems to be a question of control and the ability to change one's situation. Without any other solution, the seniors try to have a positive outlook and be thankful for what they have. There also seems to be a cultural belief among Korean immigrant older adults that they should accept their natural course of life, without extreme or extensive life-prolonging measures (Pang, 1991), which may explain the reason some of the seniors had decreased the dosage or stopped taking many of their medications and expressed they were ready to die.

Beyond the cultural explanation, enduring may be in part a response to a lack of access to certain resources. Although the provision of health insurance through public government programs such as Medi-Cal and Medicare does provide Korean seniors with access to health care (Jang, Kim, & Chiriboga, 2005; Sohn, 2004; Sohn & Harada, 2004), the Korean seniors face limitations in the health care they receive. Since many of those interviewed were low-income seniors who did not speak English well, they were reliant on their insurance to provide health care access, the Korean enclave to provide health care providers who shared the same language and culture, and their social support network of peers and community resources to provide insight and advice, as well as additional services. If a health care benefit did not fall within the insurance coverage, as with many needed services after the 2009 cuts to Medi-Cal, or if the Korean-speaking provider did not have a treatment solution, or no one else in the community had any advice, the Korean senior was left with the option to endure or seek out their own solution.

This concept of enduring, along with the underlying responses of being positive and/or thankful, may seem innocuous, but could contribute to additional barriers to receiving quality health care. As immigrant older adults, many of these seniors stated that they needed to "be

positive,” “don’t worry,” “just be happy,” and be thankful, not only for what they have in the form of low-income senior-eligible benefits like Supplemental Security Income and Medi-Cal, but also for their own current health, no matter what the status. Combined with the accepted belief of a natural deterioration of health in old age, the decision to endure a situation may prevent the senior from addressing health problems that may have solutions or treatments, either indefinitely or by delaying care. Enduring may result in misdiagnosis or misrepresentation of severity of illness by affecting pain reporting (Mui, Kang, Kang, & Domanski, 2007).

Enduring health problems and the severe pain associated with them, along with their version of the ageist view that old age is “a time of decline, withdrawal, and vulnerability” (Albert & Freedman, 2010), may influence the Korean seniors to see their old age as a time to prepare for death, since it may be imminent. Accepting that they are at the end of their lives and being thankful for the limited health and time they do have may also have an effect on their health care utilization. Their perceptions of their own negative health may in fact cause them to limit future health care utilization (Jang, Kim, & Chiriboga, 2005), by acknowledging their limitations and the cultural belief that one should live only as long as one is supposed to, without extraordinary measures (Pang, 1991), a notion that may seem contrary to the American pursuit of immortality and eternal youth. Mr. Jung, Mrs. Kim, and Mrs. Chang all mentioned that they were trying to go to the doctor or hospital less often. All three also spoke of death as not far off in their interviews. This theme of enduring, in particular, highlights the dangers of misinterpreting the words and actions of these Korean immigrant older adults due to a lack of cultural awareness or knowledge. As with many of the above-discussed themes, however, more information is needed to determine how much of this belief and practice of enduring is influenced by Korean cultural beliefs and how much is the result of circumstances of being an

immigrant older adult with limited health care options, as well as to see if it ultimately affects the seniors' health care utilization and quality of care.

Major Findings

In addition to the points brought up in the discussion of themes above, there were some additional findings from this study of Korean immigrant older adults that were surprising that I want to highlight. Contrary to the concerns that initiated this research study, all twelve of the interviewed seniors did not see a problem with accessing their health care benefits, since they believed the notification process to be “automatic.” As documented, lawfully-present immigrants, these Korean seniors, from the least informed to the most informed, stated that they received notifications from the government about applying for and receiving their benefits, whether it was Medi-Cal or Medicare, Social Security or Supplemental Security Income (often referred to as “welfare”). The notification letters were in English only. Only one senior stated that she had received a Medi-Cal notification letter in Korean once, but that it was hard to understand. The perception of Medi-Cal and Medicare as “automatic” for older adults may mean that these seniors have the social support or access to resources that enable them to get the English-only letters translated or know where to go despite not understanding the letter, if they have language barriers. The seniors may have learned to navigate the application process to secure health care, with the help of “benefits brokers” in the community or from peers and friends in their networks who have been through the process before.

Being able to apply for and have access to benefits, however, does not imply the understanding of how the health care system works for those with Medi-Cal and/or Medicare. While all the seniors were insured through one or both of the government-sponsored health insurance programs, many did not know the eligibility requirements or the benefits available

through Medi-Cal or Medicare. Consistent with findings in existing literature on health care utilization in the Korean immigrant community, the seniors in the study who had lived in the United States longer (having immigrated earlier) and had a higher level of English speaking and reading comprehension, or were well-educated (in the sample, those who worked as engineers or school teachers in Korea before immigrating to the U.S.) and were connected to a community organization, had a better understanding of Medi-Cal and Medicare. The range in the seniors' knowledge and understanding of resources, as correlated with their immigration and education background, suggests that this population experiences segmented acculturation. Based on the interviews, future studies should look at the influence of education level, English speaking ability, as well as connection to community resources, on understanding the health care system, and possibly better utilization of it.

The existence of coethnic “benefits brokers,” as well as other members of the Korean community perceived by the seniors as exploitative or otherwise negative, is another surprising finding. Perhaps with reason, some of the Korean seniors distrust the Korean community or feel that they cannot rely on it, despite the paradox that these seniors do rely on the Korean community and that this same Korean community enables them to navigate the complex health care system. This recalls the description of the ethnic enclave as both a site of refuge for those who face difficulties in the mainstream society (Chung, 2007; Zhou, 1992) and a stereotyped space where immigrant vulnerabilities are exploited by coethnics (Bonacich, 1988; Li & Skop, 2007). It may be that each senior has a very different idea of what constitutes the “Korean community” and its role in his/her life. This lack of trust in the community as a whole may affect the seniors' utilization of services in the community, as shown with their attitude and practice of frequently switching primary care doctors.

One additional finding that was surprising was the view by many seniors that those who had both Medi-Cal and Medicare had the best coverage. While those with both Medi-Cal and Medicare believed that, as Mr. Hyun stated, “low-income is the very best” because they were able to go to whichever doctor or hospital they wanted, other seniors who had more expensive and more extensive coverage through Medicare Advantage and Medicare with Supplemental also agreed that those with Medi-Cal and Medicare had the best situation. Those who faced in-network restrictions for health care providers under Medicare Advantage or who paid out-of-pocket expenses for Supplemental insurance coverage for the 20% of costs not covered by Medicare expressed what seemed like envy for the joint Medi-Cal/Medicare coverage that low-income seniors had. In general, most people do not want to be considered “low-income” since it has a negative connotation; but with the wider range of health care selection along with the low cost of care that Medi-Cal provides, when added to Medicare, many Korean seniors acknowledged the benefits of being low-income. As Mr. Hyun said, “Since I have Medi-Cal and Medicare, wherever I go, they accept it. I just have to go where I want to go. Whichever doctor, whichever hospital.”

Implications

I believe that better understanding the health care experiences and life experiences of these Korean immigrant older adults makes it possible to better address their needs and take steps to ensure that they not only get access to care, but quality of care and patient satisfaction. While there are clear problems due to a language barrier, the interviews show that it is necessary to look beyond the language barrier, defining and operationalizing cultural components as well, to understand the bigger picture of the health care experience for the Korean immigrant older adult community and in developing culturally competent and relevant health interventions and

health policies. Addressing the language issue by providing professional interpreters at health care facilities and competent and intelligible Korean language translations of Medi-Cal and Medicare notification letters is only a first step towards improving health care access and utilization for Korean seniors (Haffner, 1992; Mui, Kang, Kang, & Domanski, 2007).

There needs to be an integrated approach, one that “recognize[s] that the situation is always bicultural and not merely bilingual” (Haffner, 1992). This necessitates partnerships with the Korean community, often times through churches and community organizations or the medical provider networks within the enclave, to reach the older adult population and conduct health education and health care outreach in a culturally competent manner (Mui, Kang, Kang, & Domanski, 2007; Song et al., 2010; Wallace, Villa, Moon, & Lubben, 1996). In this way, language barriers can be addressed and trust can be fostered (Searles, 2012; Song et al., 2010). Establishing trust between the Korean senior and the health care or social service provider or even the Korean community itself means developing a relationship of reliance that acknowledges the needs and wants, as well as personal histories, of the Korean senior (Searles, 2012).

These personal histories, as with those of the seniors interviewed for this study, may be very different, with a wide range in educational background, socioeconomic status, attitudes, and cultural beliefs and values (as well as adherence to them), among other characteristics. This great within-group variation among the Korean seniors interviewed for the study suggests the need for an “insider” researcher from the community with any future study or intervention, more research (particularly qualitative) on Korean immigrant older adults (and Korean Americans overall), as well as a continued push for disaggregated Asian American data (Kim, Yu, Chen, Kim, Brintnall, & Vance, 2000; Lin-Fu, 1988; Mui & Shibusawa, 2008).

Additional studies and data would help develop a linguistically and culturally appropriate approach that would allow the Korean immigrant older adult to “ag[e] in place” (Kim & Lauderdale, 2002), following Korean cultural norms and customs, living in Koreatown, with all the resources it has to offer, or possibly develop a new idea of “healthy aging” as a Korean immigrant older adult living in the United States (Pang, 1991). In either case, the approach should engage the seniors’ social support networks to improve information dissemination and uptake (Ponce, Hays, & Cunningham, 2006; Sohn, 2004). The small percentage of Korean seniors that are socially isolated, lacking functional social support networks, may require alternative approaches to inform them of health care services or address their need (Wong, Yoo, & Stewart, 2006).

Kim, Cho, Cheon-Klessig, Gerace, & Camilleri’s (2002) health care service program created for the Korean immigrant population in Chicago is one intervention which incorporates many of the suggestions for a linguistically and culturally-tailored approach to health care for Korean immigrant older adults. The study took place in Chicago’s equivalent of Koreatown, Lawrence Avenue, and the study participants were similarly limited in their English language ability and relied on Korean social service agencies located in their community for assistance. Through a collaboration between the Korean community, an academic institution, the local department of public health, and a major foundation which funded the program for four years, the researchers trained bilingual advanced practice nurses to work with community advocates to provide culturally competent primary care services and mental health education. This culturally competent care and education entailed: 1) community outreach by the project staff to inform the community residents about basic self-care and the availability of “American community health services” (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002), 2) bilingual staff to schedule

appointments and see them, 3) appointment times that were set aside in response to community input and availability, 4) community partnerships between the primary care clinic and social service organizations with Korean-speaking staff that facilitated referrals, and 5) three mental health education booklets in Korean developed by Korean bilingual project staff with multiple rounds of input from Korean community members (including patients, mental health professionals, and church pastors). Then they integrated this model of care into the existing infrastructure to ensure sustainability. The study showed that it is possible to respect the culture of the Korean elderly immigrants, while assisting them in acculturating to the United States through provision of health care services. The statement that they “would not attempt to replace Korean values or teach [a] new set of behaviors but to broaden their understanding of how American and Korean cultures differ in some ways, yet seek similar goals in other ways” (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002) well describes the idea of how linguistically and culturally competent health care should be, if incorporated effectively into the Korean ethnic enclave with the support and input of the Korean community.

Another suggestion for a health care program that is linguistically and culturally relevant to this community is to train Community Health Liaisons, who would be Korean immigrant older adults who live in low-income senior housing and act as the health care information specialist or contact person within the housing complex. This approach would allow Korean seniors to access necessary information, provided through fact sheets on health care or health policy, through a local approach, allowing those who may have mobility issues to have access to resources. It would also provide a means for socializing between the Korean seniors in a housing complex, potentially facilitating the formation of new social support networks. Having this health contact person at housing complexes that have a large concentration of Korean seniors would help to

improve the dissemination of health information in the community by utilizing a peer-to-peer network, as well as adapting to the changing nature of the seniors' social support networks.

In summary, in any attempt to address the health care needs of Korean immigrant older adults, it is important to have the proper perspective on older adults and a full understanding of what they perceive as their needs and limitations. In better understanding the experiences of Korean immigrant older adults, it is possible to develop new approaches to reach this underserved population, whether for health promotion programs or in making sure that their opinions are included in discussions on the Korean community and the older adult population, in developing or changing health or language policies.

Limitations of the Study

There are limitations to applying the findings of this study to the broader Korean immigrant older adult population, due to the sampling strategy. The small sample of twelve participants, recruited through convenience sampling, is a biased cross-section of the Korean immigrant older adult community living in Los Angeles County with access to Los Angeles' Koreatown. There was self-selection bias within the sample as well. The majority (7 out of 12) of the seniors were recruited through a meeting at a progressive community-based organization, which precludes seniors who have physical mobility or transportation issues, severe health problems, a lack of interest or engagement in such meetings, or are otherwise isolated from the community. Another limitation to the study is my own identity as a second-generation Korean American woman, born and raised in a suburb outside of Los Angeles' Koreatown, who is conversational but not fluent in speaking or understanding Korean. Although I had translation and interpretation assistance from bilingual, bicultural native Korean speakers for the study, my own language barrier in Korean as well as my second-generation Korean American experiences

may have added to my cultural biases. Additionally, there is a limitation in the single-person coding for the interview transcripts, since there was no other input besides my own as the principal investigator in cross-checking the codes for accuracy or refinement. A final limitation to the study is the lack of demographic questions asked as part of the interview. In a focus on qualitative over quantitative content, I failed to include questions on education level or other socioeconomic questions that would have added a depth of demographic information to the interview content and would have been useful in the data analysis and the formation of future hypotheses.

Concluding Remarks

Based on my experience in certain nonprofit organizations and projects that served Korean immigrant older adults, prior to conducting this exploratory study, I believed that the majority of Korean immigrant older adults were mainly dependent on their adult children or community-based organizations in navigating their health care, and that addressing their language barrier was key to improving their access to health care. I did not expect the range of knowledge and experiences that emerged from my interviews with the seniors, nor the additional limitations and problems that lay beyond the language barrier. After conducting this small study, I can see that the language barrier (with the possibility of “linguistic isolation” resulting from it) is a major problem for many in the Korean immigrant older adult population living in Los Angeles, even with the presence of Los Angeles’ Koreatown to provide in-language, culturally competent services. This study also showed me, however, that the Korean immigrant older adult community is complex and an understanding of it goes beyond a binary representation of whether or not they have health insurance and whether or not they speak English. The interviews reflected the importance of culture as part of the health care model, since culture

influences the behavior of a population, as well as the services provided for and utilized by that population (Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002; Sohn & Harada, 2004).

Most importantly, this study recorded the strengths and the resourcefulness of the Korean seniors in navigating the U.S. health care system, given their language limitations as monolingual Korean-speaking older adults. As Mrs. Kim stated in her interview, “If you look for it, then you can find the health care you need. But, I can’t do it with my own strength. It’s only with someone else’s help that I can find the health care I need.” Future studies should recognize that Korean immigrant older adults are a vulnerable population in need of support, but they, like other immigrant populations, are highly resourceful and able.

Appendix A – Medicare vs. Medi-Cal Basic Background Chart

Medicare	Medi-Cal
<p>Medicare is health insurance for:</p> <ul style="list-style-type: none"> • People 65 or older • People under 65 with certain disabilities • People of any age with End-Stage Renal Disease (ESRD) 	<p>Medi-Cal is California's Medicaid program. Medicaid is state-based health care for:</p> <ul style="list-style-type: none"> • Individuals and families with low incomes and resources, based on varying eligibility requirements
<p>Eligibility:</p> <ul style="list-style-type: none"> • U.S. citizens or lawfully admitted permanent residents 65 years or older, who have themselves or have spouses who have worked and paid Medicare taxes in the U.S. for at least 10 years (or 40 quarters, 4 quarters/year) are automatically eligible. • U.S. citizens or lawfully admitted permanent residents 65 years or older who have not worked and paid Medicare taxes in the U.S. for at least 10 years may purchase Medicare from the government. <ul style="list-style-type: none"> ○ If the lawfully admitted permanent resident entered the U.S. on or after August 22, 1996, s/he must have resided in the U.S. continuously for 5 years or more before applying for and purchasing Medicare. ○ If purchasing Medicare, both Parts A (hospital insurance) and B (medical insurance – doctors), or Part B only, must be purchased. Part A cannot be purchased by itself. 	<p>Eligibility:</p> <ul style="list-style-type: none"> • Limited income • U.S. citizens or lawfully admitted permanent residents (undocumented immigrants may qualify for restricted Medi-Cal for emergency services) • Resident of California • Other requirements include, but are not limited to, being: 65 years or older, blind, disabled, under 21, pregnant, diagnosed with breast or cervical cancer, in a skilled nursing facility or intermediate care facility, refugee status during a limited period of eligibility, OR a parent (or caretaker, if child's parent is deceased/estranged/incapacitated or unemployed as primary wage earner) of a child under 21 <p>Medi-Cal eligibility programs:</p> <p>Those receiving cash assistance under one of the following programs may be automatically eligible for Medi-Cal:</p> <ul style="list-style-type: none"> • SSI/SSP (Supplemental Security Income/State Supplemental Program) • CalWORKS (California Work Opportunity and Responsibility to Kids) • Refugee assistance • Foster care or Adoption Assistance Program • Aged & Disabled Federal Poverty Level (A&D FPL) Program • 250% California Working Disabled (CWD) Program

Medicare	Medi-Cal
<p>Benefits & Services:</p> <p>Medicare has 4 parts:</p> <ul style="list-style-type: none"> • <u>Part A: Hospital Insurance</u> – helps cover inpatient care at hospitals, skilled nursing facilities, hospice, and home health care. • <u>Part B: Medical Services</u> – helps cover doctors’ and other health care providers’ services, outpatient care, durable medical equipment, and home health care; also helps cover some preventive services. • <u>Part C: Managed Health Care</u> – (aka. Medicare Advantage) offers health plan options run by Medicare-approved private insurance companies; generally cover benefits and services provided under Parts A and B and often Part D; may include extra benefits for an extra cost. • <u>Part D: Prescription Drugs</u> – helps cover the cost of prescription drugs; run by Medicare-approved private insurance companies. 	<p>Benefits & Services:</p> <ul style="list-style-type: none"> • Physician visits • X-ray and laboratory tests • Hospital and nursing-home care • Adult day health services • Home health care • Certain prescription drugs excluded as a Medicare Part D benefit • Prosthetic and orthopedic devices* • Hearing aids* • Medical equipment • Ambulance services • Hospice care <p>*Effective July 1, 2009, due to budget cuts, Medi-Cal will no longer pay for podiatry services (initial visit, exam, and/or follow-up appointments) or audiology services (hearing exam or follow-up hearing aid tests), although the devices are covered.</p> <p>Additional benefits no longer covered are: acupuncture, adult dental services, chiropractic services, incontinence cream and washes, dispensing optician services, psychology services, and speech therapy services.</p>
<p>Additional information:</p> <ul style="list-style-type: none"> • A person may qualify for Medi-Cal only, Medicare only, or both Medicare and Medi-Cal. • Medigap is Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare (Parts A & B) coverage. Benefits all Medigap policies must cover include Part A and Part B coinsurance amounts, blood, and additional hospital benefits not covered by Original Medicare. <p>Please note that the above information is a basic summary of the main elements of both Medicare and Medi-Cal, current as of the filing date of this manuscript, and is in no way meant to serve as a comprehensive reference for either type of health care. Please refer to the referenced government websites for that purpose.</p>	

References:

- California Department of Health Care Services, Medi-Cal Frequently Asked Questions
- California Department of Health Care Services, Reduction Medi-Cal Benefits
- California Health Advocates, 2012
- Tamborello, 2010
- U.S. Department of Health and Human Services, Medicare.gov

Appendix B1 – Recruitment Flyer (English)

Are you a Korean adult over the age of 65?

Would you like to discuss your experiences with healthcare to help others better understand how to address your needs?

The purpose of this study is to collect the stories of the healthcare experiences of Korean older adults to see how their health needs are being met and to see what can be improved.

You are eligible if you identify as being Korean and are 65 years of age or older and reside in Los Angeles County with access to Los Angeles' Koreatown.

If you participate, you'll be interviewed about your healthcare experiences, specifically health insurance and decisions to seek health care. If you would like to participate, I will interview you in person. The interview will take about 1-2 hours, and the information you provide will be kept confidential.

The information you provide will help scholars better understand how Korean older adults access and use healthcare and what needs are or are not being met. This may help influence policy to improve healthcare for the elderly in the future.

You will not receive any monetary compensation for your time in this study, but will receive a gift of a 5-10 pound bag of rice OR a gift card upon completion of the interview.

To learn more about this research and set up an interview time, please contact:

Erica Juhn (전영은)
(310) 922-4783
ejuhn@ucla.edu

*If I do not pick up, please leave a message and I will return your call.

Please share this with other Korean older adults who may be interested in this study.

Appendix B2 – Recruitment Flyer (Korean)

어르신 께선 한국인으로 65세가 넘으셨습니까?

어르신께서 보건에 관한 경험들을 의문 함으로서 어르신이 필요한 것들에 대해 다른분들이 좀더 잘알도록 도와주시겠습니까?

이연구의 목적은 보건에 관한 연세가 높으신 한국분들의 경험담을 수집하여 어르신들의 필요되는 것을 어떻게 충족하며 개선할수 있는가를 알기 위함입니다.

어르신께서 65세나 더 높은 연세의 한인으로 LA 카운티에 거주하고 LA 한인타운에 참여 하실수있다면 충분히 참여자격이 부여됩니다.

만일에 어르신께서 참여하시면 보건에관한 경험들 특히 건강보험 과 건강관리를 찾기위한 결정에대해 인터뷰 (면담) 받게 되는데 만일 어르신께서 참여 하시길 원하신다면 제가 직접 인터뷰 (면담) 하도록 하겠습니다.

인터뷰는 한두시간 쯤 걸리며 어르신의 인적사항정보는 일체 비밀로 보장하겠습니다.

어르신께서 제공하시는 정보야말로 학자들로 하여금 연로하신 한인들께서 보건관리를 어떻게 접근 하며 사용하고 어떤 요구사항이 있으며 그요건들이 잘 충당 되는가를 좀더잘 아는데 도움이 될것입니다.

어르신께서 꽤히 이연구에 참여해주시면 그 시간에대한 금전적인 보수는 없습니다. 그러나 인터뷰가 끝나면 5-10파운드 짜리 쌀이나 선물권을 받게 됩니다. 이연구 과정에대해 좀더 알고저 인터뷰 시간을 정하시려면 밑에 적힌 연락처로 연락하시면 됩니다.

전영은 (에리카 전)
(310) 922-4783
ejuhn@ucla.edu

제가 직접 전화를 못받을땐 메세지를 남겨주시면 꼭 전화를 해 드리겠습니다.

부탁드리고 싶은것은 이연구에 흥미가 있는 다른 한인 어르신들이 계시다면 알려 주십시오.

Appendix C1 – Eligibility Screening Consent Script (English)

Eligibility Screening Consent Script
as of: 12/22/11

ELIGIBILITY SCREENING CONSENT SCRIPT

Hello. Thank you for calling. My name is Erica Juhn, and I am an M.A Candidate in Asian American Studies at UCLA. I am conducting a research study on older Korean American adults and their experiences with healthcare options. I would like to ask you a few questions in order to determine whether you are eligible for the study. Before I begin the screening, I would like to tell you about what the research would entail.

If you volunteer to participate in this study, I would ask you to participate in an interview with questions about the type of healthcare you have and how you utilize it, as well as your experiences with accessing healthcare options. The interview would take no more than 2 hours of your time. You would be able to choose the time and location, as well as the pace of the interview. You will have the opportunity to review your interview afterwards and edit it. Once you start the interview, you may also choose to stop the interview and quit the study.

You will receive no payment if you participate in the study, but will receive a gift of a 5-10 pound bag of rice OR a gift card upon completion of the interview. You will not directly benefit from your participation, but the results of the research will increase academic knowledge about the Korean American community, particularly the older adult population and its needs and current healthcare options and experiences.

The screening will take about 5 minutes. You do not have to answer any questions you do not wish to answer or are uncomfortable answering, and you may stop at any time. Your participation in the screening is voluntary. Your answers will be confidential. If you do not qualify for the study or choose not to participate, the information you provided will be destroyed.

Would you like to continue with the screening?
[If no, thank the person and hang-up]

[If yes, continue with the screening]

1. Do you identify as ethnically Korean?
2. Are you currently 65 years of age or older?
3. Do you currently live in Los Angeles County and have access to Los Angeles' Koreatown?
4. What is your primary language?
5. Do you read and understand Korean or English?

Thank you for answering the screening questions. *[Indicate whether the person is eligible, requires additional screening, or is not eligible and explain why.]*

Eligibility Screening Consent Script
as of: 12/22/11

Do you have any questions about the screening or the research? I am going to give you a couple of telephone numbers to call if you have any questions later. Do you have a pen? If you have questions about the research screening, you may call me, Erica Juhn, at (310) 922-4783.

If you have questions about your rights as a research participant or if you wish to voice any problems or concerns you may have about the study to someone other than the researchers, please call the UCLA Office of the Human Research Protection Program at (310) 825-7122.

Thank you for your time.

Appendix C2 – Eligibility Screening Consent Script (Korean)

as of: 12/22/11

참여자격 심사 합의문

안녕하세요. 전화주셔서 감사합니다.

제이름은 에리카 전 입니다. 저는 현재 UCLA에서 동양계 미국인 학과에서 석사학위과정을 밟고있으며 특히 년세많은 한국인 장년을 상대로 보건문제에 관한 경험등을 연구분야로 추진하고 있습니다.

먼저 어르신께서 이분야에 적임이되는지 결정하기위해 몇가지 질문을 준비했습니다. 심사하기전에 이연구가 어떤 결론을 제시할것인가에 대해 말씀드리겠습니다.

이연구에 자진해서 참여 하신다면 제가 제시하는 질문 대답에 하시게 되는데 어떠한 형태의 보건 선택을 하셨으며 어떻게 이용하시고 그 보건문제선택과정에서 있는 경험에 대한 질문을 받으시게 됩니다. 질의과정은 두시간안으로 한정되며 시간과 장소 그리고 질의문답의 속도는 어르신께서 정하게 됩니다. 끝난다음 직접 인터뷰한 내용을 훑어보시고 수정할 기회가 있을뿐만아니라 인터뷰도 도중에 중단하고 또 연구과정을 포기하실수도 있습니다.

이연구에 참여하시면 어떠한 보수도 지급되지 않습니다. 그러나 인터뷰가 끝나면 5-10 파운드 짜리 쌀이나 선물권을 받게 됩니다. 그리고 어르신께 참여하시는 것으로 직접적인 이득은 없을지라도 연구결과로 얻은 학문적인 지식은 물론이고 더 나아가 년로하신 분들이 필요로 하는 현재의 보건문제 선택과 경험에 대해서는 매우크게 보탬이 될것입니다.

심사는 한 5분 정도 걸립니다. 어르신께선 질문에 대해 답하고 싶지 않다던가 불안한 경우엔 꼭 대답하지 않아도 되고 언제든지 중단하실수 있습니다. 심사에 참여하시는것은 자진해서 하는것이고 대답하신것은 비밀로 보장 해드립니다. 만일에 어르신께서 연구화정에 적합하지 않고 참여를 원하지 않으시면 제시된 모든 자료 일체는 지워 버립니다.

심사과정을 계속할까요? [만일 아니라면 그분에게 고맙다고 하고 끊으세요]

[만일 좋다면 심사를 계속하십시오]

1. 어르신께선 이중학적으로 한국사람이라고 생각하십니까?
2. 현재 어르신께선 65세가 넘으셨지요?
3. 어르신께선 현재 LA 카운티 내에 살고 계시며 LA시 한인타운에 가끔 들리시지요?
4. 어르신께서 주로 쓰시는 언어는 무엇입니까?

5. 어르신께선 한국어나 영어를 읽고 이해하십니까?

심사문제에 대답해주셔서 고맙습니다. [상대방이 적격인지, 심사를 더해야 하는지 아니면 적격이 아닌데 왜 아닌지 설명해주세요.]

이심사와 연구에 관해 질문이 있으신지요? 만일에 이따가 무슨 질문이 있으실것을 대비해 전화번호 두개를 드리겠습니다. 펜이 있으십니까? 이 연구심사에 대해 만일 질문이 있으시면 (310) 922-4783 에 전화주십시오. 제이름은 에리카 전 입니다.

어르신께서 이연구 참여에 관한 권리에 질문이 있다던가 연구하는분 외 다른분들께 이연구가 지니는 문제점이라던가 관심에 대해 말씀하시고 싶으시면 UCLA 인간연구보호 프로그램 사무실 (310) 825-7122 로 전화하십시오.

시간을 내주셔서 고맙습니다.

Appendix D1 – Information Sheet (English)

Page 1 of 2

University of California, Los Angeles

INFORMATION SHEET TO PARTICIPATE IN RESEARCH

In Sickness and in Health: Healthcare Choices of Korean American Older Adults

You are asked to participate in a research study conducted by Erica Juhn, M.A. Candidate, from the Asian American Studies Department at the University of California, Los Angeles. You were selected as a possible participant in this study because you identify as ethnically Korean, are aged 65 or older, reside in Los Angeles County with access to Los Angeles' Koreatown, and identify Korean as your primary language. Your participation in this research study is completely voluntary and you may withdraw from it at any time without penalty.

PURPOSE OF THE STUDY

This research study looks at Korean American older adults living in Los Angeles County, in or near Los Angeles' Koreatown, and their healthcare experiences.

PROCEDURES

If you volunteer to participate in this study, I will interview you about your healthcare experiences, including questions about the type of healthcare access (i.e. insurance) you have and how you utilize it. The interview would take at most 1.5 to 2 hours of your time. You may choose the location of the interview and the pace of the interview. You may stop the interview at any time or choose to break it up into two shorter sessions. You will have the opportunity to review your interview material afterwards and edit or erase it.

POTENTIAL RISKS AND DISCOMFORTS

There will be minimal risk or discomfort from your voluntary participation in the study. It will consist of an interview running 1.5 to 2 hours in length, during which you will be asked questions about your experiences with healthcare access and utilization.

POTENTIAL BENEFITS TO SUBJECTS AND/OR SOCIETY

You will not directly benefit from your participation. The results of the research will increase the knowledge about the Korean American community, particularly the older adult population and its needs and current healthcare options.

PAYMENT FOR PARTICIPATION

You will receive no payment for your participation, but will receive a gift of a 5-10 pound bag of rice OR a gift card upon completion of the interview.

USE OF INFORMATION AND CONFIDENTIALITY

The information that you provide in your interviews will be used for the purpose of a Master's Thesis, with the possibility of future use for research by the same Principal Investigator. You have the right to review the audio files made as part of the study to determine whether they should be edited or erased in whole or in part. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Confidentiality will be maintained by the following means:

Data will be collected in handwritten or typewritten fieldnotes that do not include names. Interviews will be recorded on a digital recorder. Fieldnotes, as well as audio data files will be coded, with the code key being kept separate from the notes and data files, in a protected, private location. The data and all materials (except the code key) will be filed and kept in a locked storage box that can be carried from site to site. Digital files will be stored in a password-protected file folder on a personal laptop, as well as similarly backed-up on an external hard drive. Only the Principal Investigator, her interpreter, and her faculty advisor will have access to the data. When research has been completed, the Principal Investigator will maintain the only copy of all files, again in a password-protected file folder only on the back-up device.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Erica Juhn
(310) 922-4783
ejuhn@ucla.edu

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal rights because of your participation in this research study. If you have questions regarding your rights as a research subject, you can contact:

UCLA Office of the Human Research Protection Program
11000 Kinross Avenue, Suite 211
Box 951694
Los Angeles, CA 90095-1694
(310) 825-7122

UCLA
연구참여에 관한 지침서

아프거나 건강할때: 한국계 미국인으로서 연로하신분들의 보건선택

선생님은 UCLA 동양계 미국인 학과에서 석사학위 후보인 에리카 전이 실시하는 연구과정에 참여하시도록 부탁드립니다. 선생님께서 선택된 동기는 인종학상 한국인으로 65세 이상이고 LA 카운티내에 사시며, LA 시내에있는 한인타운에 자주 들리시고 한국어를 주로 쓰고 계시기때문입니다. 선생님께서 이연구에 참여 하심은 완전히 자발적인 것이고 언제든지 사퇴 하실 수 있습니다.

연구의 목적:

이 연구대상은 LA 카운티의 LA 시 안에 사시는 연로하신 한국인과 그분들의 보건관계 경험담 입니다.

절차:

어르신께서 이연구과정에 자발적으로 참여하신다면 어르신의 보건경험에 대해 면담하게 되는데 보험과 같은 보건관리에대한 접촉과 어떻게 이용하셨는지에 대해 질문을 받게 될것입니다. 면담시간은 길게 잡아 한시간반에서 두시간 쯤 됩니다. 어르신께서 면담장소라던가 면담의 속도를 선택하실 수 있으며 면담을 언제든지 멈추거나 또는 짧게 두번에 나누어서 하실수 있습니다. 그리고 끝난다음에 면담한 내용을 검토 하시고 고치거나 지워버릴 수도 있습니다.

잠재적 위험성 과 불안감:

연구과정에 자진 참여함으로 오는 위험과 불안감은 거의 없을것입니다. 면담에 걸리는 시간은 한시간 정도이고 그 내용은 건강관리를 위해 어떤 절차와 과정을 거치시는지 문의하게 될것입니다.

어르신과 사회에 미치는 잠재적인 이득:

어르신께서 이 연구에 참여함으로 얻는 직접적인 이득은 별로 없습니다. 그러나 이연구조사의 결론은 한국인 지역내에서 특히 연로하신 분들이 필요로 하는것과 현재의 보건관계 선택사항에대한 지식을 더해줄것입니다.

연구참여에 대한 지불:

참여하신데 대한 현금 지불은 없습니다. 그러나 인터뷰가 끝나면 5-10 파운드 짜리 쌀이나 선물권을 받게 됩니다.

기밀사항과 그유용관계:

어르신께서 이 면담을 통해 제시하는 정보는 석사학위 논문을위해 쓰일것이고 본연구원의 장래 연구자료로도 쓰일것입니다. 어르신께서는 녹음된 연구자료를 검토하고 전체적 또는 부분적으로 편집 혹은 삭제 하실 권리가 있습니다. 이연구과정에서 나온 정보가 어르신과 관련되었다면 어르신의 허락이나 법의요구가없는 기밀 사항으로 남아있을것입니다.

기밀사항은 다음과같은 방법으로 보관 될것입니다:

자료들은 친필서면이나 타자로 연구기록문집에 이름은 안넣고 수집될것 인데 면담은 디지털 녹음기에 녹음될것이며, 기록문집이나 녹음된 자료는 암호로 될것이며 암호열쇠 노트나 자료철은 기밀장소에 보관될것입니다. 수집된 자료와 모든 관계서류는 (암호 열쇠는제외) 잠을쇠로 잠구는 저장함속에 보관하며 장소에따라 이동하게 됩니다. 디지털 파일은 암호가 보장된 개인 노트북 컴퓨터 파일철에 저장되며 다른 하드 드라이브에도 같은 방법으로 보관됩니다. 이 자료들을 관람 할수 있는 사람은 본연구원이나, 그의 통역관 그리고 대학의 자문교수 뿐입니다. 그리고 이연구과정이 완료 되면 본연구원이 유일한 사본을 암호가 보호받는 철에 입력해서 비상함에 보관할것입니다.

참여와 자퇴:

어르신께서는 스스로 참여 하시던가 아니할것인가를 선택하실 수 있습니다. 만일에 이연구과정에 참여하기로 결정하신 후에도 아무때나 하등의 문제없이 하차하실 수 있습니다.

연구원의 신변:

어르신께서 이연구에 대한 질문이 있으시면 언제든지 자유롭게 저에게 연락 해주시면 됩니다.

제 이름은 전 에리카 (Erica Juhn) 라고 합니다.

전화는 (310) 922-4783

이메일은 ejuhn@ucla.edu

연구대상인의 권리:

어르신께서 이연구과정에 지속적 참여를 원하지 않으시다면 아무
벌칙없이 언제든지 불참 하셔도 됩니다. 이연구과정에 참여하신다고
해서 어르신의 법적권리를 포기 하는것이 아니니깐요. 만일에
어르신께서 연구대상인으로서의 권리에 대해 의문이 있으시면 아래
주소로 연락하십시오.

UCLA Office of the Human Research Protection Program

(UCLA 인간연구보호 프로그램 사무실)

11000 Kinross Avenue, Suite 211, Box 951694

Los Angeles, CA 90095-1694

(310) 825-7122

Appendix E – Interview Guide

면담 내용 Interview Guide

가명 (익명):

Code Initials (for name):

성별 (Gender): 남 (Male) / 여 (Female)

1. 생년:

Birth year:

2. 미국에서 체류 기간이 얼마나 되십니까?

Years in U.S.:

3. 주로 쓰시는 언어가 무엇입니까?

What is the primary language that you speak?

4. 영어쓰시는것이 어느정도 편한하십니까?

How comfortable are you speaking in English?

☐ 불편없이 영어로 의사에게 예기하고 질문할수 있습니다.

Can speak comfortably and ask questions in English to a doctor

☐ 영어로 대화 할수 있습니다.

Can speak conversational English

☐ 잘못하지만 기본적인 단어는 말할수 있습니다.

Can say basic words in English (not well)

☐ 영어는 전혀 못 합니다.

Cannot speak in English (not at all)

5. 영어를 읽거나 이해 하는것은 어느정도 하십니까?

How comfortable are you reading and understanding English?

☐ 영자 신문을 읽을수 있습니다.

Can read a newspaper in English

☐ 광고문 같은것은 읽을수 있습니다.

Can read flyers in English

☐ 간단한 영문 싸인같은것은 읽을수 있습니다.

Can read simple signs in English (not well)

☐ 전혀 읽을수 없습니다.

Cannot read English (not at all)

6. 한인타운 근처에 사십니까?

Do you live in/near Koreatown?

a. 왜 거기 사십니까? 왜 거기에 안 사십니까?

Why or why not?

b. 얼마나 자주 한인타운에 가십니까? 가시면 뭘 하십니까?

How often do you go to Koreatown? What do you do there when you go?

c. 어르신은 어떤 종류의 교통 수단을 사용하십니까?

What kind of transportation do you use?

7. 현재의 생활상태는 어떻습니까? (홀로 사십니까? 장성한 자제분과 사십니까? 양로 시설에서 사십니까?)

What is your living situation now? (Do you live on your own, with adult children, in assisted living, or other?)

a. 홀로 사신다면 양로원, 개인 아파트, 자기집 중에서 어디에 사십니까?

If you live on your own, do you live in senior housing or your own apartment or your own house?

8. 어르신의 현재 건강상태는 어떻습니까?

How would you rate your health now?

9. 어르신께선 주치의나 치료원이 있으십니까?

Do you have a regular doctor or source of care?

a. 만일 있으시다면 얼마나 자주 찾아뵙는지요? 아프지 않을때도 검진차의사를 방문하시는지요?

If yes, how often do you see him/her or go? Do you go to the doctor even when you are not sick (for preventative care)?

b. 없으시다면 병치료가 필요할때 어디로 가십니까? 평균 얼마나 자주 가시나요? 아프지 않을때도 (예방차 치료로) 의사에게 가십니까?

If no, where do you go when you need medical care? On average, how often do you go? Do you ever go to the doctor even when you are not sick (for preventative care)?

10. 의료치료를 받아야 할지 또는 말지를 어떻게 결정 하십니까?

How do you decide whether or not to seek medical care?

a. 어떤 형태의 치료 방법이 필요 하다는것은 어떻게 정하십니까?

How do you decide what type of care you need?

11. 건강보험이 있으십니까?

Do you have health insurance?

a. 왜 있으십니까? 아니면 왜 없으십니까?

Why or why not?

b. 만일 있으시면 어떤종류의 보험을 가지고 계신지요? (개인 / 메디케어 / 메디칼 / 메디케어 와 메디칼 / 긴급한 상황에 대처한 보험 – Catastrophic)

If yes, what type of health insurance do you have? (Private/Medicare/Medi-Cal/Medi-Care & Medi-Cal/Catastrophic)

c. 만일 없다면 어르신께서 어떤 건강보험이 있는지는 아십니까? 예를들면 어떤 종류의 보험이 있는지를?

If no, do you know about the types of health insurance available to you? Which ones?

12. 건강보험을 (안) 가지고 있다는것이 건강치료를 위해서 어느 곳을 가야 하는 것을 어떻게 결정하게 합니까?

How does (not) having health insurance affect where you go for healthcare?

13. 건강치료차 누구한테 갈것인가를 어떻게 결정합니까?

How do you decide **whom** to go to for healthcare?

14. 건강치료차 어디에 갈것인가는 어떻게 결정하십니까?

How do you decide **where** to go to for healthcare?

☐ 비용

Cost

☐ 가까운 거리

Proximity

☐ 의사와 (병원직원)의 언어소통

Language capacity of doctor/staff

☐ 의사와의 문화적 친근감 (양립성)

Cultural compatibility of doctor

☐ 기타 (설명해주시겠습니까?)

Other (please explain)

15. 어디서 건강보험의 종류에 대해 아시게 되었는지요? 혹 개인이나 공공기관에서 의료정보를 찾는데 도와주셨습니까?

Where did you find out about the types of health insurance? Is there anyone (individual or organization) that helped you find out this information?

- a. 만일 누가 도와주셨다면 그 사람이나 기관의 도움을 어떻게 찾았습니까?
그리고 왜 그방법이 꼭 필요하다고 느끼셨는지요?

If someone did help you, how did you find this person/organization to help you, and why did you feel it was necessary?

16. 영어를 자신있게 사용할수 있는것이 건강치료 방법을 결정하는데 어떠한 영향을 줍니까?

How does your confidence in speaking English affect your healthcare-seeking decisions?

17. 미국에서 받거나 받을수 있는 건강관리의 질적인면을 어떻게 평가하십니까?
어르신께서 꼭 필요로 하는 치료방법을 찾으실수 있었는지요?

How would you rate the quality of healthcare that you receive or are able to obtain in the U.S.? Have you been able to find the healthcare you need?

18. 여태까지 저에게 말씀해주신것 가운데 미국에서 보다 나은 치료방법을 위해서 무엇이 필요하다고 생각 하십니까?

Considering all that you have shared with me thus far, what would make you more confident in the quality of healthcare you are able to obtain in the U.S.?

- a. 어르신께서 원하시는 치료를 좀더 쉽게 할수 있는 다른 방법이 있다고 생각 하십니까?

Are there other things that would make it easier for you to obtain the care you would like to have?

19. 어르신과 다른 연로한 한인들이 최선의 건강보호책을 위해서 한인 사회가 어떻게 도울수 있다고 생각하십니까?

How could the Korean community help you and other Korean elders obtain the best possible healthcare?

REFERENCES

2009 California Health Interview Survey [CHIS 2009].

Albert, S. M., & Freedman, V. A. (2010). *Public Health and Aging: Maximizing Function and Well-Being*. New York, NY: Springer Publishing Company.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1), 1-10.

Bernard, H. R. (2006). *Research Methods in Anthropology: Qualitative and Quantitative Approaches* (4th Ed.). New York, NY: AltaMira Press.

Bonacich, E. (1988). The social costs of immigrant entrepreneurship. *Amerasia Journal*, 14(1), 119-128.

California Department of Health Care Services. (n.d.). *Medi-Cal Frequently Asked Questions*. Retrieved February 9, 2012, from <http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFAQs.aspx#whatismedi-cal>

California Department of Health Care Services. (n.d.). *Reduction Medi-Cal Benefits*. Retrieved February 9, 2012, from <http://www.dhcs.ca.gov/services/medi-cal/Pages/ReductionMedi-CalBenefits.aspx>

California Health Advocates. (2012). *Medi-Cal (for People with Medicare)*. Retrieved February 9, 2012, from <http://www.cahealthadvocates.org/low-income/medi-cal.html>

Calvan, B. C. (2009, January 3). It's the law: California patients can have an interpreter at their side. *The Sacramento Bee*, p. 1A.

Chang, E. T., & Diaz-Veizades, J. (1999). *Ethnic Peace in the American City: Building Community in Los Angeles and Beyond*. New York, NY: New York University Press.

Chung, A. Y. (2004). Giving Back to the Community. *Amerasia Journal*, 30(1), 107-124.

Chung, A. Y. (2007). *Legacies of Struggle: Conflict and Cooperation in Korean American Politics*. Stanford, CA: Stanford University Press.

Furuto, S. M., Biswas, R., Chung, D. K., Murase, K., & Ross-Sheriff, F. (1992). *Social Work Practice with Asian Americans*. Newbury Park, CA: Sage Publications, Inc.

Gold, J. (2004, February 4). Koreatown's top 40. *LA Weekly*, Dining section.

Gray Panthers. (n.d.). *Who We Are*. Retrieved March 7, 2012, from http://graypanthers.org/index.php?option=com_content&task=view&id=32&Itemid=45

- Gray Panthers. (n.d.). *History*. Retrieved March 7, 2012, from http://graypanthers.org/index.php?option=com_content&task=blogcategory&id=27&Itemid=17
- Haffner, L. (1992, September). Translation is not enough. Interpreting in a medical setting. *The Western Journal of Medicine*, 157(3), 255-259.
- Han, H.-R., Kang, J., Kim, K. B., Ryu, J. P., & Kim, M. T. (2007). Barriers to and strategies for recruiting Korean Americans for community-partnered health promotion research. *Journal of Immigrant Health*, 9, 137-146.
- Hurh, W. M. (1998). *The Korean Americans*. Westport, CT: Greenwood Press.
- Jang, Y., Kim, G., & Chiriboga, D. A. (2005). Health, healthcare utilization, and satisfaction with service: Barriers and facilitators for older Korean Americans. *Journal of the American Geriatrics Society*, 53, 1613-1617.
- Jo, M. H. (1999). *Korean Immigrants and the Challenge of Adjustment*. Westport, CT: Greenwood Press.
- Kim, J., & Lauderdale, D. S. (2002). The role of community context in immigrant elderly living arrangements: Korean American elderly. *Research on Aging*, 24(6), 630-653.
- Kim, K. K., Yu, E. S. H., Chen, E. H., Kim, J., Brintnall, R., & Vance, S. (2000, September/October). Smoking behavior, knowledge, and beliefs among Korean Americans. *Cancer Practice*, 8(5), 223-230.
- Kim, K. Y. (2011). *Los Angeles's Koreatown*. Charleston, SC: Arcadia Publishing.
- Kim, M., Han, H.-R., Kim, K. B., & Duong, D. N. (2002). The use of traditional and western medicine among Korean American elderly. *Journal of Community Health*, 27(2), 109-120.
- Kim, M. J., Cho, H.-I., Cheon-Klessig, Y. S., Gerace, L. M., & Camilleri, D. D. (2002). Primary health care for Korean immigrants: Sustaining a culturally sensitive model. *Public Health Nursing*, 19(3), 191-200.
- Kitano, H. H. L., & Daniels, R. (1995). *Asian Americans: Emerging Minorities*. Englewood Cliffs, NJ: Prentice Hall.
- Lee, J.-W. (1986). The ethnic enclave as "place": a case study of Koreatown of Los Angeles. (Master's thesis, University of California, Berkeley, 1986).
- Legislative Counsel of California. (2003, October 9). *SB 853 Senate Bill – CHAPTERED*. Retrieved from http://www.leginfo.ca.gov/pub/03-04/bill/sen/sb_0851-0900/sb_853_bill_20031009_chaptered.html

- Li, W., & Skop, E. (2007). Enclaves, ethnoburbs, and new patterns of settlement among Asian immigrants. In M. Zhou & J. V. Gatewood (Eds.), *Contemporary Asian America: A Multidisciplinary Reader* (2nd ed.) (pp. 222-236). New York, NY: New York University Press.
- Light, I., & Bonacich, E. (1988). *Immigrant Entrepreneurs: Koreans in Los Angeles, 1965-1982*. Los Angeles, CA: University of California Press.
- Lin-Fu, J. S. (1988). Population characteristics and health care needs of Asian Pacific Americans. *Public Health Report*, 103(1), 18-27.
- Medicare (The "Doc Fix" Debate). (2012, February 16). *The New York Times*. Retrieved from <http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?scp=7&sq=medicare%20medicaid&st=cse>
- Moon, A., Lubben, J. E., & Villa, V. (1998). Awareness and utilization of community long-term care services by elderly Korean and Non-Hispanic White Americans. *The Gerontologist*, 38(3), 309-316.
- Mui, A. C., Kang, S.-Y., Kang, D., & Domanski, M. D. (2007). English language proficiency and health-related quality of life among Chinese and Korean immigrant elders. *Health & Social Work*, 32(2), 119-127.
- Mui, A. C., & Shibusawa, T. (2008). *Asian American Elders in the Twenty-First Century: Key Indicators of Well-Being*. New York, NY: Columbia University Press.
- Pang, K.-Y. C. (1984). *Everyday Life, Health and Illness of the Elderly Korean Immigrants: Cultural Constructions of Illness*. Ann Arbor, MI: University Microfilms International.
- Pang, K.-Y. C. (1991). *Korean Elderly Women in America, Everyday Life, Health and Illness*. New York, NY: AMS Press.
- Pear, R. (2012, March 9). White House works to shape debate over health law. *The New York Times*. Retrieved from http://www.nytimes.com/2012/03/09/us/politics/white-house-works-to-shape-debate-over-health-law.html?_r=1&hp
- Ponce, N. A., Hays, R. D., & Cunningham, W. E. (2006). Linguistic disparities in health care access and health status among older adults. *Journal of General Internal Medicine*, 21(7), 786-791.
- Portes, A., Fernández-Kelly, P., & Light, D. (2012). Life on the edge: Immigrants confront the American health system. *Ethnic and Racial Studies*, 35(1), 3-22.
- Portes, A., & Rumbaut, R. G. (2006). *Immigrant America: A Portrait*. Los Angeles: University of California Press.

- Powers, K. (2007, July 19). *Neighborhood Project: Koreatown*. Retrieved December 8, 2007, from http://laist.com/2007/07/19/neighborhood_pr_5.php
- Ryu, H., Young, W. B., & Park, C. (2001). Korean American health insurance and health services utilization. *Research in Nursing and Health*, 24, 494-505.
- Searles, C. (2012). Beyond health care reform: Immigrants and the future of medicine. *Ethnic and Racial Studies*, 35(1), 135-149.
- Siders, D. (2012, February 27). Jerry Brown presses Obama on Medi-Cal, meets with labor. *The Sacramento Bee*. Retrieved from <http://blogs.sacbee.com/capitolalertlatest/2012/02/jerry-brown-keeps-pressing-obama-on-medi-cal-meets-with-labor.html#storylink=misearch>
- Sohn, L. (2004). The health and health status of older Korean Americans at the 100-year anniversary of Korean immigration. *Journal of Cross-Cultural Gerontology*, 19, 203-219.
- Sohn, L., & Harada, N. D. (2004). Time since immigration and health services utilization of Korean-American older adults living in Los Angeles County. *Journal of the American Geriatrics Society*, 52(11), 1946-1950.
- Song, H.-J., Han, H.-R., Lee, J.-E., Kim, J.-Y., Kim, K. B., Ryu, J. P., & Kim, M. (2010). Does access to care still affect health care utilization by immigrants? Testing of an empirical explanatory model of health care utilization by Korean American immigrants with high blood pressure. *Journal of Immigrant Minority Health*, 12, 513-519.
- Spradley, J. P. (1979). *The Ethnographic Interview*. San Francisco, CA: Holt, Rinehart and Winston, Inc.
- Tamborello, F. (Ed.). (2010). *The People's Guide to Welfare, Health & Other Services* (33rd ed.). Los Angeles, CA: The Los Angeles Coalition to End Hunger & Homelessness.
- The Korea Times. (2011). Korean Business Directory, 2011-2012. Los Angeles, CA: The Korea Times.
- The Koreatown Profile Study Committee. (1984). *Koreatown Profile Study Report*. Los Angeles, CA: United Way, Inc.
- UCLA Asian American Studies Center. (2008). *Asian American and Pacific Islander community directory: Los Angeles and Orange Counties* (10th ed.). Los Angeles, CA: UCLA Asian American Studies Center.
- UCLA Center for Health Policy Research. (2008a, February). *Elder Economic Security Standard Index, Los Angeles City, CA 2007*. Retrieved from http://www.healthpolicy.ucla.edu/eess0208_pdf/los-angeles-city.pdf

- UCLA Center for Health Policy Research. (2008b, February). *Elder Economic Security Standard Index, Los Angeles County (excluding LA City), CA 2007*. Retrieved from http://www.healthpolicy.ucla.edu/eess0208_pdf/los-angeles.pdf
- U.S. Census Bureau. 2005 American Community Survey.
- U.S. Census Bureau. 2009 American Community Survey.
- U.S. Census Bureau. 2010 American Community Survey.
- U.S. Census Bureau. (n.d.). *Poverty Thresholds for 2010 by Size of Family and Number of Related Children Under 18 Years*. Retrieved February 7, 2012, from <http://www.census.gov/hhes/www/poverty/data/threshld/thresh10.xls>
- U.S. Department of Health and Human Services. (2009). *The 2009 HHS Poverty Guidelines*. Retrieved February 7, 2012, from <http://aspe.hhs.gov/poverty/09poverty.shtml>
- U.S. Department of Health and Human Services. (n.d.). *HealthReform.GOV*. Retrieved March 9, 2012, from <http://healthreform.gov/>
- U.S. Department of Health and Human Services. (n.d.). *Medicare.gov*. Retrieved April 19, 2012, from <http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/medicare-benefits-overview.aspx>
- U.S. Department of Transportation – Federal Highway Administration. (n.d.). *Tract and Block Group Variables (also known as Claritas Variables)*. Retrieved March 8, 2012, from <http://nhts.ornl.gov/2009/pub/UsersGuideClaritas.pdf>
- Villacorte, C. (2010, August 20). Koreatown, Little Bangladesh get actual borders. Retrieved from <http://www.nbcalosangeles.com/news/local/Koreatown-Little-Bangladesh-Communities-Named-101185344.html>
- Wallace, S. P., & Smith, S. E. (2009). *Half a Million Older Californians Living Alone Unable to Make Ends Meet*. Los Angeles, CA: UCLA Center for Health Policy Research.
- Wallace, S. P., Villa, V., Moon, A., & Lubben, J. E. (1996). Health practices of Korean elderly people: National health promotion priorities and minority community needs. *Family & Community Health*, 19(2), 29-42.
- Warner, D. C. (2012). Access to health services for immigrants in the USA: From the Great Society to the 2010 Health Reform Act and after. *Ethnic and Racial Studies*, 35(1), 40-55.
- Wong, S. T., Yoo, G. J., & Stewart, A. L. (2005). Examining the types of social support and the actual sources of support in older Chinese and Korean immigrants. *International Journal of Aging and Human Development*, 61(2), 105-121.

- Wong, S. T., Yoo, G. J., & Stewart, A. L. (2006). The changing meaning of family support among older Chinese and Korean immigrants. *Journal of Gerontology*, 61B(1), S4-S9.
- Youn, G., Knight, B. G., Jeong, H.-S., & Benton, D. (1999). Differences in familism values and caregiving outcomes among Korean, Korean American, and White American dementia caregivers. *Psychology and Aging*, 14(3), 355-364.
- Yu, E.-Y. (1983). Korean communities in America: Past, present, and future. *Amerasia Journal*, 10(2), 23-51.
- Yu, E.-Y., & Choe, P. (2003-2004). Korean population in the United States as reflected in the year 2000 U.S. Census. *Amerasia Journal*, 29(3), 2-21.
- Yu, E.-Y., Choe, P., Han, S. I., & Yu, K. (2004). Emerging diversity: Los Angeles' Koreatown, 1990-2000. *Amerasia Journal*, 30(1), 25-52.
- Yu, E.-Y., Phillips, E. H., & Yang, E. S. (Eds.). (1982). *Koreans in Los Angeles: Prospects and Promises*. Los Angeles, CA: Center for Korean-American and Korean Studies, California State University, Los Angeles.
- Zhou, M. (1992). *Chinatown: The Socioeconomic Potential of an Urban Enclave*. Philadelphia, PA: Temple University Press.