Elderly Chinese and Vietnamese Immigrants’ Medicine Use and Attitudes to a Home Medicines Review

**Authors:** Lesley WHITE¹, Professor of Pharmacy Management, BPharm, MCom and Med., and Christiane KLINNER¹, Research Officer, Grad Dipl Mmt, Grad Cert QHR

**Institutional affiliation:** ¹Faculty of Pharmacy, University of Sydney, Australia (at the time of writing)

**Corresponding author:** Professor Lesley White, Executive Dean, Faculty of Business, Charles Sturt University, Bathurst, Heffron Building, Phone 02 6338 4285, Email lwhite@csu.edu.au

**Keywords:** access to primary care; consumer perceptions; focus groups; medication review; medicine use

**Abstract**

There is a paucity of research into the perceptions of elderly Australian ethnic minorities towards public health services related to quality use of medicines. Among the six fastest growing ethnic groups in Australia, the Mandarin-speaking Chinese and Vietnamese constitute the largest elderly populations with poor English skills. This paper investigates the relationships of elderly Chinese and Vietnamese migrants with medicines, general practitioners and pharmacists, and how these relationships influence their awareness and attitudes of the Home Medicines Review (HMR) program. Two semi-structured focus groups were held with a total of 17 HMR-eligible patients who have never received an HMR, one with Chinese and one with Vietnamese respondents, each in the respective community language. Confusion about medications and an intention to have an HMR were pronounced among all participants although none of them had heard of the program before participating in the focus groups. Respondents reported difficulties locating a pharmacist who spoke their native language, which contributed to an increased unmet need for medicine information. The Chinese group additionally complained about a lack of support from their general practitioners in relation to their medicine concerns and was adamant that they would prefer to have an HMR without the involvement of their general practitioner. Our results indicate a distinct HMR need but not use among elderly Chinese and Vietnamese eligible patients with poor English skills. HMR service use and perceived medication problems are likely to improve with an increasing availability of bi-lingual and culturally sensitive health care providers.

**Introduction**

The Home Medicines Review (HMR), a government funded consumer health service, is designed to assist medicine-taking consumers to maximize the benefits of their medication regimen and prevent medication related problems. Eligible for this service are people who live at home and are considered

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¹This is a pre-copyedited, author-produced PDF of an article accepted for publication in the Australian Journal of Primary Health following peer review. The definitive publisher-authenticated version [White L. and Klinner C., *Medicine use of elderly Chinese and Vietnamese immigrants and attitudes to home medicines review.* Australian Journal of Primary Health, 2012. 18(1): p. 50-55.] is available online at:  
http://www.publish.csiro.au/paper/PY10099
to be at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect\(^2\) (for eligibility requirements see table 1). In collaboration with the general practitioner (GP), a specially trained pharmacist comprehensively reviews the patient’s medication regimen in a home visit. After analysis of the pharmacist’s report, the GP and patient agree on a medication management plan\(^3\).

The HMR program has been found to successfully identify medication related problems (Yu et al., 2007), improve patient health (Holland et al., 2008, Castelino et al., 2009) and enhance the relationships between GP, pharmacist and patient (Quirke et al., 2006). It is therefore in the interest of the community that this cognitive pharmacy service is effectively used by those patients at highest risk of medication misadventure. However, recent research has shown that those in greatest need of an HMR, such as people of culturally and linguistically diverse (CALD) background, are often the least likely to receive this service (Campbell Research & Consulting, 2008). In 2006, the Australian government declared people from CALD backgrounds as disadvantaged with regard to gaining access to and using the full range of health care services because of language barriers and a lack of awareness about the available services (Department of Health and Ageing, 2006\(^4\)).

The CALD population in Australia is ageing more rapidly than the Australian-born population and 22.5% of older Australians are forecast to be from culturally and linguistically diverse backgrounds by 2011 (Department of Health and Ageing, 2006). Among the five fastest growing CALD populations, the Mandarin-speaking Chinese and Vietnamese Australians have the poorest English language skills (ABS, 2006), which poses a major barrier to equitable health care access. A study by Liu (2003) showed that Chinese migrants with the poorest English skills, living in the capital district of New York, U.S. A., identified by the study author as “old age recent immigrants”, had the highest health service needs, but a pattern of not using the services due to a lack of awareness of service availability and accessibility. Language limitations were given as the main reason for this perception, followed by the patients’ assumption that they do not qualify for the services. Other U.S. based studies found that language barrier between Chinese/Vietnamese patients and their doctors impeded the quality and safety of their care (Ngo-Metzger et al., 2003, Gadon et al., 2007).

In addition to the language barrier, elderly Chinese and Vietnamese migrants have been shown to struggle with the differences in the health care systems and medicine traditions between their home and their immigration country. Studies on drug use in Vietnam for example have shown that insufficient public health education and inefficient medicine policies were leading to a dependency on self-medication by 40-60% of the population (Okumura et al., 2002, Johansson et al., 2000). Other studies based in Sydney, Australia and major cities in the U.S.A. revealed that 55-72% of Chinese and Vietnamese migrants used Traditional Chinese Medicine in their country of immigration but usually did not discuss this with their providers due to an anticipated or perceived lack of understanding on the part of the prescribers (O’Callaghan and Quine, 2007, Ahn et al., 2006). This often caused confusion among the CALD patients about the effectiveness and safety of combining traditional with prescribed medicines and a tendency to reduce the amount of prescribed (Western) medications upon feeling better as Western medicines were believed to cause an imbalance in the body, unwanted side effects or addiction (Bolton et al., 2002, O’Callaghan and Quine, 2007).

In light of these unique challenges that elderly Chinese and Vietnamese migrants face regarding their medicine management, it is possible that these ethnic groups may belong to those in greatest need of an HMR but among the least likely to receive this service. This paper examines a) how aging HMR-


eligible Chinese and Vietnamese Australians who have never received an HMR manage their medicines, b) to what extent they are aware of the existence of this free health service and c) how likely they are to accept and receive an HMR in the future.

Methods
Seventeen HMR-eligible patients (6 Chinese and 11 Vietnamese speakers), who have never received an HMR, participated in two focus groups, one in each language. The patients were selected on the basis of the Australian Federal Government’s eligibility criteria for HMRs (see table 1). The age of the participants ranged from 55 to 83 years. Participants were recruited through bi-lingual community pharmacists in two suburban areas of Sydney, NSW. Patient information statements and consent forms were presented to participants in the community language. Assurances were given regarding anonymity and confidentiality. All participants agreed in writing to the research content and process, including audio taping of the focus groups. Ethics approval was obtained from the University of Sydney’s Ethics Committee.

Table 1: HMR eligibility requirements

<table>
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<th>Patients who may benefit from an HMR include those:</th>
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<td>• taking 5 or more regular medications;</td>
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<td>• who are confused or worried about their medicines (or forget to take their medicines);</td>
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<td>• taking more than 12 doses of medication per day;</td>
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<td>• who have had a significant change to their medication regime;</td>
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<td>• with literacy or language difficulties, dexterity problems, impaired sight, or those with cognitive difficulties such as dementia;</td>
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<td>• seeing a number of different doctors, including GPs and specialists</td>
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Semi-structured focus group discussions were chosen as the data collection method. Focus groups offer researchers a powerful investigative potential especially in the areas of consumer behavior, patient-provider collaboration, health literacy research, and disease and medication management. The group discussion format stimulates the exchange of ideas and assists participants to refine their individual viewpoints by comparing them to other people’s opinions. It provides a protecting place that gives participants a sense of community, which makes them more comfortable in expressing their opinions (Chan, 2009; Huston and Hobson, 2008).

The focus groups were conducted in the community languages, each moderated by an interpreter, a bi-lingual pharmacist and a member of the research team. The sessions were opened by an invitation to discuss what kind of medicine problems they tend to experience and how they manage these. The relationships of the participants to their pharmacists and GPs were then explored. Respondents were asked if they had been aware of the HMR before being invited to attend the focus group and what they thought this service would entail. The HMR program was then explained and participants were asked about their opinions of this service and whether or under which circumstances they would consider

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using it. Finally, it was investigated if participants would ask their GP for an HMR referral and whether they would recommend the HMR program to friends and family.

People from Chinese and Vietnamese origin were chosen because these constitute, among the six largest ethnic populations in Australia, the two with the poorest self-reported English language skills in the age range over 55 years (Australian Bureau of Statistics, 2006). Participants were defined as belonging to the respective CALD group if they self-identified as belonging to the respective group, spoke their native language at home and had limited English skills.

Analysis

Both focus group discussions were audio taped and transcribed verbatim with tracking of individual speakers. In addition, session notes on seating order and body language were made. The transcripts were coded with NVivo 8, and key themes identified, discussed, categorized and critically examined. An abridged report was completed for each focus group. The transcripts were translated into English and each proofread by an HMR-experienced bi-lingual pharmacist.

Findings

Concerns about medicines

The Chinese participants reported major concerns with their medications and were afraid of taking too many medications. Some of them admitted decreasing the dose or stopping a prescribed medication altogether.

"I take so many medications and few of them are effective. I asked my doctor many times if I could take less and the doctor said no. […] I went to a different doctor […] and the answer was still no."

"Yes. We decrease [the dose] ourselves."

They also reported confusion with generic medicines and feared that they could be less effective than the original brands.

“One [medicine] is the usual one, the other is on special. This confuses me a lot. […] So there are ones that are less expensive. And I am not sure whether they are as good [as the original] or not."

Therefore, the Chinese participants were desperate to obtain more medicine information but often did not know who to turn to.

“What is the little [tablet] once a week used for? Is it ok if I don’t take it?”

“We got nobody to seek for advice and we don’t know where to go.”

Although the Vietnamese participants also reported concerns about their medicines, their worries were not as pronounced as those in the Chinese group and none of them would alter the prescribed dose.

[On prompting]: “No, we are not cutting the doses, we do what the doctor told us, do what is prescribed for.”

Relationship with service providers

Both ethnic groups visited GPs who spoke their community language but found it difficult to find a pharmacist of their language background. In both groups the pharmacist’s role was regarded as being centered on medicine supply issues and GPs were seen as the person who should make medication
decisions, although some participants would occasionally also ask a pharmacist for their opinion. However, neither GPs nor pharmacists were seen as particularly helpful to respond to detailed medication questions.

Chinese: “[The pharmacists] are always too busy to respond.” Second Chinese responding: “They hardly answer any questions. And doctors get annoyed if you ask them.”

The two ethnic groups differed significantly in their reactions to their GP’s prescribing decisions. The Vietnamese described open-minded trusting relationships with their GPs, and they would always follow their GP’s advice.

“The patient is always listening to the doctor, he makes decisions on our medicines, and we cannot change it, neither cutting nor increasing doses.”

In contrast, the Chinese had much more skeptical views of their GP’s medication decisions. They perceived that their GPs prescribed too many medicines and did not take overall responsibility for their care.

[The doctors] just simply put [the medicines] together without taking care of what might happen to us.”

“What can you do about [taking many medications]? The doctor just refused to reduce the dose.”

As a result of their dissatisfaction with their doctors’ medication advice, several Chinese regularly sought advice from family, friends and members of their Chinese association and reduced their medication doses without informing their GP.

“So we are really confused and don’t know what we should do now. All we can do now is to control [the dose] by ourselves.”

“So in the recent years, I only took one tablet [instead of the prescribed two]. But I still tell the doctor that I am taking two each time. Yes, I lie to him. Why? Because my doctor could get angry with me.”

“I try to reduce the dose myself quietly.”

“Also, I consulted my relatives and friends. [They said] yes, you have taken too many medications and the adverse effect has impacted on your kidneys. So in the following half a year, I didn’t take any Diabex.”

**Language barrier**

For both ethnic groups, limited English skills were an explicit barrier to accessing medicine information. Participants either put up with not understanding the available information (including medicine labels), or relied on verbal advice from bi-lingual doctors or pharmacists, or asked their children or members of their community association to help with interpretation.

Chinese: “We just show [the pharmacist] the prescriptions and take what they give us. It’s impossible for us to ask why we should take this medication and what effect it has.”

Vietnamese: “I do not read [the medicine labels], but the doctor told me.”

Vietnamese: “We will ask each other. We have an association where everyone can have a say.”
Awareness and attitudes towards HMR

None of the participants had heard of the HMR program before being invited to the focus group and all of them perceived the program positively and were keen to use it.

Chinese: “This is the first time [that we hear about this program] and we hope that if you have other activities like this in the future, please let us know. We do want to be involved and learn something.”

Chinese: “We really want to have this service.”

Vietnamese: “[The HMR ensures] we have the right medicines.” Second Vietnamese [adding]: “We should be told which medicine to delete, which to take, which to add.”

Both ethnic groups welcomed the HMR being conducted in their home and were, on being prompted, interested to receive a copy of the HMR report.

Chinese: “I’m happy for [the HMR pharmacist] to come [to my home].” Second Chinese [adding]: “I will make a tea for them […] I will pay for her/his travel expenses.”

Vietnamese: “[The HMR pharmacist’s] coming for checking is good for us.”

The participants felt comfortable about being visited by an unknown pharmacist, but - due to their poor English language skills - both ethnic groups wanted the HMR pharmacist to speak their own language or bring an interpreter to the visit as long as they didn’t have to organize this themselves.

Vietnamese: “Any [pharmacist] will do, if we can understand him/her that’s fine. No need to be my own pharmacist.”

Among the Vietnamese participants there was consensus that the best way to promote the HMR program was to feature it on the community radio station SBS Radio Vietnamese.

The GP as HMR barrier

The involvement of the GP in the HMR was seen as a significant barrier to having an HMR, particularly by the Chinese respondents. They were convinced that their GP would be upset if they had their medicines reviewed by a pharmacist. If a GP agreed to an HMR, on the other hand, s/he was perceived as admitting to his/her incompetence in managing the patient’s medications.

 “[The HMR] could bring trouble to the doctor and the pharmacist. The doctor won’t introduce a pharmacist to me. […] [The doctor] won’t be happy, they will feel I don’t trust them, I look down on them. [They will say] ‘I give you this medication, and you ask the pharmacist to double check my work?’ Very difficult to do so.”

[The GP] will think ‘I give you this medication, and you don’t trust me? Instead you go and find a pharmacist to take charge of me?’ [The GP] won’t be happy.”

“If the GP orders an HMR] that seems they don’t even trust themselves.”

The Chinese were however keen to have an HMR without the involvement of their GP.

“If the pharmacist can offer the [HMR] service, on their own initiative that will be good.” Second Chinese [adding]: “We really want to use this service.” First Chinese: “We really want, but not through the doctor.”

Among the Vietnamese participants there were also doubts regarding whether the GP would cooperate in the HMR program but they would still be happy to discuss the service with their GP.

“I am not sure if the doctor is going to agree to [an HMR]. […] He might be upset.”
"I will tell my doctor about [the HMR], there is nothing to hide."

Discussion
The extent to which the Chinese participants desired to have an HMR, but the involvement of their GP is striking. In comparison to the Vietnamese respondents, who also had a distinctive need for more medicine information and a strong desire to have an HMR, the Chinese participants seemed to have greater problems with managing their medicines. Doubts about the effectiveness of prescribed medications and generic brands, fear of taking too many medications, and a lack of medicine information all contributed to pervasive confusion and deliberate medication non-adherence, following family and friends’ advice. In addition, the Chinese had strained relationships with their GPs, dominated by enormous respect of the GP’s authority on the one hand and frustration with and skepticism of the GP’s medication decisions on the other.

A possible cause for the ambivalent relationships with their GPs and the request to have an HMR without GP involvement could lie in the Chinese participants’ unsuccessful attempts to resolve their medication concerns with their prescribers. Unresolved medication worries, in turn, are likely to have caused the Chinese participants’ desire to have an HMR. Explanations for the poor communication between the Chinese participants and their Western GPs and their fear of being prescribed too many medications may be found when consulting previous related studies. Ngo-Metzger et al. (2003) and Ahn et al. (2006) showed that, although Chinese and Vietnamese patients desired to discuss their traditional medicine practices with their western health care providers, only a minority of those patients actually disclosed their traditional medicine use to their providers as most western-trained practitioners were found to know little about traditional Asian beliefs and practices. The reasons given were fear of disapproval or an expected lack of knowledge on the part of the western-trained doctors. Due to the perceived absence of support from their doctors, patients resorted to obtaining advice from family, friends, neighbours and herbalists and reduced the amount of their prescribed western medicines at the cost of increased confusion and uncertainty about the appropriateness and safety of their medicines use (O’Callaghan and Quine, 2007). In contrast, patients who did have discussions about their traditional medicine use were likely to have more confidence and trust in their providers than those who did not (Ahn et al., 2006). These patients valued their providers’ knowledge, inquiry and non-judgmental acceptance of traditional Asian medical beliefs and practices as an important aspect of quality care (Ngo-Metzger et al., 2003). Without discriminating whether patients discussed the use of traditional medicines with their doctors, Bolton et al. (2002) describe a general lack of confidence of Chinese patients in their Western GPs, indicating that the GP as generalist was an unknown concept in China where “most doctors specialise in one field”, whereas the Australian GPs “know a bit about this and a bit about that but nothing in detail” (Bolton et al., 2002).

The second major finding of the study is the lack of awareness of the HMR program among all respondents across both ethnic groups as well as the fundamental communication problems that the participants had, specifically with pharmacists, due to their limited English language skills. Whilst most participants appeared to visit GPs who speak their own language, several of them did not know any bi-lingual community pharmacist. It is likely that Sproston’s (2001) finding that non-English speaking Chinese patients visited their GP significantly less often than those with good English skills could also be true for visiting a pharmacist. Together with the finding of a recent study by Authors (2009) that the majority of HMR-recipients first heard of the HMR Program from their pharmacists, it could be argued that poor English skills, low pharmacist consultation rates and a potential scarcity of bi-lingual pharmacists all contributed to preventing the Chinese and Vietnamese participants from becoming aware of the HMR service.
Although no statistical evidence for a shortage of bi-lingual HMR-pharmacists has been located, the Australian government recently stated, in slightly broader terms, that many health care services are neither staffed by persons who are qualified in personal and community care competencies, nor by persons who can clearly and effectively communicate with their clients in their own languages (Department of Health and Ageing, 2006). It is therefore essential that future health strategies include the provision of cultural competency training for GPs and pharmacists with the aims of increasing the HMR providers’ knowledge about non-western health beliefs and practices, and to become more sensitive, inquisitive and non-judgmental about traditional medicine use. Medication compliance issues need to be negotiated more effectively after carefully evaluating the attitudes of each individual patient towards their traditional values and practices versus the use of western medicine (Yu, 2006). Also, more bilingual health care staff should be recruited to facilitate access to the HMR service for patients whose English skills are limited.

This study is limited by a small sample size and should therefore be treated as indicative. Further research with larger patient populations is needed to verify our findings. In addition, the investigation of the perceptions of other CALD groups and the assessment of correlations between HMR-variables through quantitative research would be of value.

**Conclusion**

Our study shows that elderly Chinese and Vietnamese HMR-eligible non-recipients are among the most vulnerable patient segments with regards to appropriate and safe medication management and in high need of the HMR service. Specifically, poor English language skills and difficulties accessing bi-lingual and bi-cultural health care providers pose a major barrier for elderly Chinese and Vietnamese populations in Australia in obtaining much needed and wanted medicine information and services.

**Acknowledgements**

We thank Stephen Carter for assisting with data collection. We also thank the community pharmacists Giuliano Vaccari and Anh Mai for facilitating access to the Chinese and Vietnamese communities.

This project was funded by the Australian Government Department of Health and Ageing as part of the Fourth Community Pharmacy Agreement Research & Development Program managed by the Pharmacy Guild of Australia.

**Conflicts of Interest:**

No conflicts of interest exist.

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