Utilisation of Australian health care services by ethnic Chinese

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Abstract

Australia is a multicultural society in which migrants from non-English-speaking backgrounds may be more vulnerable to illness after their new settlement, and language difficulties and cultural differences may affect their use of health services. The present qualitative study used focus group interviews to explore the health services used by Chinese migrants from Hong Kong and China. The general findings included strong preference for Chinese-speaking general practitioners, insufficient interpreter services, low use of preventive services, and lack of knowledge about the existence and role of ethnic health workers. The paper reports specific differences between migrants from China and Hong Kong, and by age group. It discusses reasons for these findings and notes the implications.

Introduction

The relationship between health and migration has been explored in many studies, highlighting that migrants are more vulnerable to illness and distress (Minas 1990; Schofield 1990). Migrants' use of health care services will also be influenced by many other factors such as cost, accessibility and language. For migrants from non-English-speaking backgrounds, the language barrier will be one of the major factors affecting their use of health care services (National Health Strategy 1993).

With the release of the Galbally Report in 1978, the *Migrant Services and Program* and the *Ethnic Health Workers' Program* were established to improve the accessibility of migrant health services (Galbally 1978). Thereafter, in 1988 there

was a comprehensive investigation of migrant health policy (Mitchell 1988). However, there are still inadequacies and limited funding of language services. There is also minimal research on health service use and the needs of people from non-English-speaking backgrounds, and no national database is available for collection of health service information for ethnic groups (National Health Strategy 1993).

Methodological difficulties in migrant health research

The National Health Strategy stated:

> *The major national data collections of the Australian Bureau of Statistics, such as the National Health Survey, are limited in measuring health status and health service use by people from non-English-speaking backgrounds. Attempts are made to elicit information from respondents on country of birth and language spoken at home, but methodological difficulties reduce the quality of data* (1993, p 128).

Such difficulties may be compounded when questions of interest require the identification of groups of common ethnicity, but with a number of possible countries of birth.

The ethnic Chinese in Australia are a good example. They may have been born in China, Taiwan, Hong Kong, Singapore or Vietnam (Reid & Trompf 1990). According to the National Health Survey, the use of doctors by ethnic Chinese was low; there were problems with access, and some had chosen other sources of health service (Young & Coles 1992). Women from China appeared to have a low utilisation of general practitioner services compared to their Australian counterparts, however, usage by Chinese women from Hong Kong was not established (Young & Coles 1992).

In the 1991 census, out of 10 'Birthplace of fastest growing groups', China came top of the list, while Hong Kong was third. Between 1986 and 1990 the percentage of people who spoke Chinese increased by 90.3 per cent (Ethnic Affairs Commission of NSW 1994). In view of the significant increase in the growth of the Chinese population and the minimal research in health service use, this study explored the utilisation of health care services by Chinese migrants from China and Hong Kong.

The general research question was: What are the experiences of Chinese migrants in utilising Australian health care services (mainstream and ethno-specific)? The specific research question was: Are there differences in this utilisation by Chinese migrants from Hong Kong compared with those from China? This paper refers

to health care services as mainstream (general practitioner, hospital, community health, and so on) or ethno-specific (interpreter, ethnic health worker, Chinese community, and so on), according to the categorisation by Legge and Westbrook (1992, 1994).

Methods

The study is descriptive and exploratory, using a qualitative approach. In order to capture real-life experience and obtain insightful information to answer the research questions, the focus group interview method was used (Stewart & Shamdesani 1991; Krueger 1994). Convenience samples were drawn from existing group members of Chinese organisations which included Chinese community centres, churches and welfare associations.

A total of eight focus groups were conducted in five Sydney suburbs (Campsie, Chatswood, Burwood, City, Baulkham Hills) located in central and northern Sydney, which were selected because of their concentration of Chinese residents. There were four groups of Chinese from Hong Kong and four groups of Chinese from China. Among the Hong Kong groups, two groups consisted of younger females and two of elderly people (males and females). The combination was the same for the four groups from mainland China. In total, there were 45 females and 6 males. The 27 younger females from Hong Kong and China had ages ranging from 25 to 54 years, whereas the 24 elderly people (18 females and 6 males) had ages ranging from 55 to 80 years (see Tables 1 and 2)

Before starting each focus group interview, informed consent was obtained from each group member and strict confidentiality was emphasised. The aim, objectives and the content to be discussed in the session were also disclosed to the participants. Permission was sought from all participants to tape-record and take notes during each session.

Data collection

The focus groups were conducted either in Cantonese or Mandarin by the Chinese author who can speak both Chinese dialects and also English. Each session followed a discussion guide which focused on the following.

1. General practitioner services: When YOU are sick, what do you do? From whom do YOU seek help, and why? Is YOUR general health knowledge obtained from other sources, in addition to doctor's consultation?

Table 1: Summary of sociodemographic information on the younger women's groups from Hong Kong and China

	Hong Kong (n = 14)	China (n = 13)
Age		
25–34	4	6
35–44	6	5
45–54	4	2
55+	0	0
Years in Australia		
0–5	9	7
6–10	5	6
11+	0	0
Birthplace		
Hong Kong	13	0
China	0	13
Other	1	0
Number of children		
0	0	0
1	3	8
2	11	3
3	0	1
4 or more	0	0
Highest education level		
Primary school	0	0
High school	8	7
Polytechnic/vocational training	3	2
University	3	4
Other	0	0
Employment status		
Currently employed:		
Yes	0	2
No	14	11
Previous occupation:		
Professional, technical	4	5
Administrative, executive	6	1
Clerical	1	0
Sales	0	1
Transport, communication	0	0
Tradesmen	0	0
Process/factory workers etc.	0	4
Government servants	0	0
Home duties	2	0
Inadequately described, not stated	1	2

Table 2: Summary of sociodemographic information on the elderly groups from Hong Kong and China

	Hong Kong (n = 12)	China (n = 12)
Age		
25–34	0	0
35–44	0	0
45–54	0	0
55+	12	12
Sex		
Female	10	8
Male	2	4
Years in Australia		
0–5	10	11
6-10	2	1
11+	0	0
Birthplace		
Hong Kong	2	0
China	10	12
Others	0	0
Number of children		
0	1	1
1	2	8
2	2	2
3	4	1
4 or more	3	0
Highest education level		
Primary school	7	1
High school	4	5
Polytechnic/vocational training	0	2
University	0	4
Others	1	0
Employment status		
Currently employed:		
Yes	0	1
No	12	11
Previous occupation:		
Professional, technical	2	5
Administrative, executive	0	0
Clerical	0	0
Sales	0	1
Transport, communication	0	0
Tradesmen	1	2
Process/factory workers etc.	0	1
Government servants	0	3
Home duties	7	0
Inadequately described, not stated	2	0

2. Mainstream services: Have YOU ever used any health care services other than GP services? Why do YOU use this/these service(s)? Do YOU have any problems when using this/these service(s)?
3. Alternative health services: Do YOU use any alternative health services, such as, herbalist, religious healer, acupuncturist or foot reflexologist?

The data were collected over a 12-week period. The length of each session was approximately 45 minutes.

Data analysis

The tape-recordings of the focus group interviews were transcribed and translated from Chinese into English. The Chinese author, a bilingual transcriber, conducted all the transcription. To ensure accuracy in transcription, the tapes were listened to repeatedly. Dialogues on the issues from each session were then categorised into four main areas related to health service use: (i) general practitioner services; (ii) other health care services; (iii) sources of health information; (iv) alternative health services.

The themes from the two groups of younger women from Hong Kong were then compared with those of the two groups of younger women from China. Similarly, the themes from the two groups of elderly (women and men) from Hong Kong were compared with those of the two groups of elderly from China (see Figure 1). These themes are illustrated below with supporting quotations made during the focus group sessions.

Results

Findings from the groups

In total, there were eight groups: four younger women's groups and four elderly groups comprising both males and females. Of the four younger women's groups, two groups consisted of Cantonese-speaking women from Hong Kong, one group consisted of Cantonese-speaking women from China, and one group consisted of Mandarin-speaking women from China. The composition was the same for the four elderly groups.

Mainstream services

In the younger women's groups, the topics covered were general practitioner services, hospital services, early childhood centre services and public health services. In the elderly groups the topic of early childhood centre services was not raised.

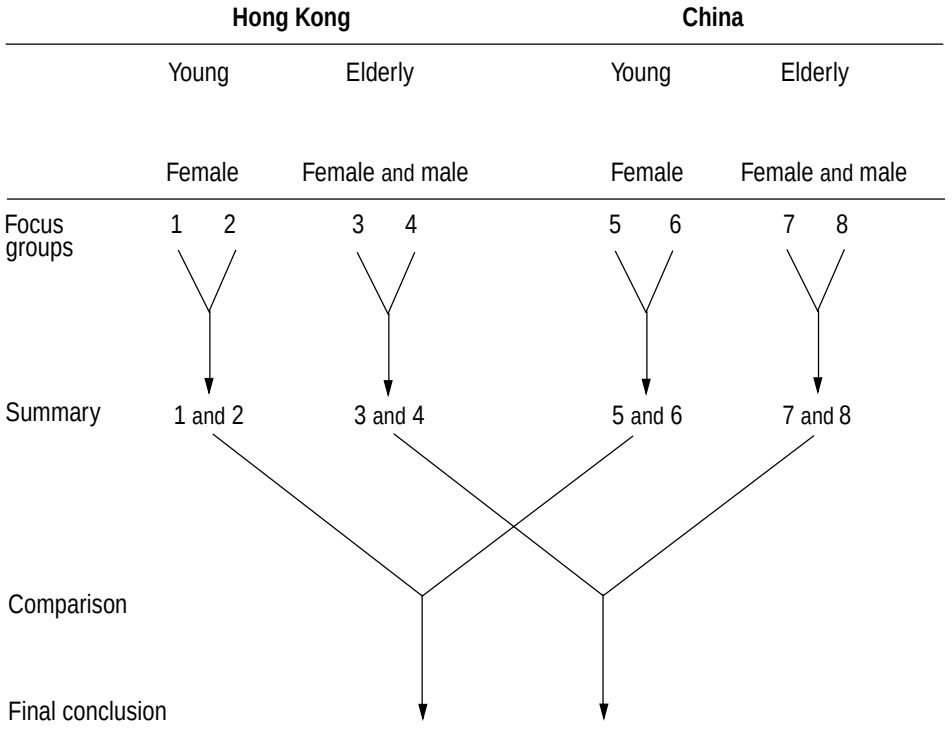

Figure 1: Sequence of analysis of the eight focus group sessions

(i) General practitioner services

Younger women's groups

The general practitioner they chose should be able to speak either in Mandarin (for women from China) or Cantonese (for women from Hong Kong and China). The following themes were consistently found in the four groups: 'If I want to see a doctor, he/she must be able to speak Cantonese/Mandarin.' In case of an emergency, they might need to see a western, English-speaking general practitioner in the medical centre. Most of the younger women from Hong Kong reported that they had no problem in gaining access to and visiting an English-speaking general practitioner, whereas almost all of their counterparts from China could gain access to, but felt uncomfortable visiting, an English-speaking general practitioner: 'If it is at night time, I need to see an English GP in the medical centre. I can understand a little bit of English…my husband's English is better than mine.' All women from Hong Kong and China experienced ease of access to Chinese-speaking general practitioners. All agreed that Australia had a good health care system, with general practitioner services at low cost or free of charge.

Elderly groups

All the elderly from Hong Kong saw Cantonese-speaking general practitioners while they were sick, whereas for most of the elderly from China, the decision to seek a general practitioner for help depended on the severity of their illness. If it was a minor illness, many of these elderly from China would use self-medication: 'Depending upon what kind of illness, if it is just a cold, I have self-medication...if self-medication failed, I would see a GP.'

If the elderly from Hong Kong and China wanted to see a western general practitioner, then the general practitioner should be able to speak Cantonese (for the elderly from Hong Kong and some elderly from China) or Mandarin (for some of the elderly from China). All of the elderly from Hong Kong and China were aware that Chinese-speaking general practitioners were accessible, for example: 'In Chatswood, there are many Cantonese-speaking GPs. It is very convenient. I can walk to the clinic.'

(ii) Health care services other than general practitioner services

(a) Hospital services

Younger women's groups

Many younger women from Hong Kong and China said that the hospital staff were good. Almost all of the women from Hong Kong did not require an interpreter, except under specific circumstances, such as childbirth. However, all of the women from China requested an interpreter during their stay in hospital. Opinions varied over the adequacy of the services provided. The experiences they described reflect their frustration over language and cultural differences.

Elderly groups

While discussing hospitalisation, the elderly from China had scant information since they had not lived in Australia for very long and were in good health. In contrast, although most of the elderly from Hong Kong had lived in Australia for less than five years, they had some experiences to share among group members, especially in relation to interpreter services. An elderly woman from Hong Kong stated: 'As I was admitted to the hospital, I immediately requested an interpreter. I waited and waited, but no interpreter appeared. You know, I couldn't even speak a sentence of English to express my needs, for example: urination and defecation…my communication to the hospital staff was through the paper which my son has written for me. What a pity!' Although the elderly from China did not have any hospitalisation experiences, a few had experience in using the interpreter services, which they felt positive about.

(b) Early childhood centre services

Younger women's groups

The younger women from Hong Kong had no problems gaining access to or communicating with staff when they brought their children to early childhood centres. Those from China also experienced no problems in gaining access to the centres' services, even though all of them had communication problems. One of these women from China said: 'I usually bring my child to the early childhood centre on the specific day which has a Chinese-speaking staff allocated on duty by the centre. I (therefore) have no communication problem.'

(c) Public health services

Younger women's groups

Half of the over-35-year-old informants from Hong Kong had used public health services such as breast screening and pap smear testing. One of these women from Hong Kong said: 'Many women in this women's group have had a pap smear and mammography before. I remembered that some of the group members even encouraged and brought their mother or grandmother to have a mammography and pap smear test too.' However, the majority of the younger women from China had not had a breast screening and pap smear test before.

Elderly groups

Though all of the elderly from Hong Kong and China were aged 55 or over, many of the women had not used breast screening or pap smear testing services before. Some elderly women from Hong Kong and China said things such as: 'I have heard health talks on breast screening and pap smear test in a Chinese community organisation, but I have not used them.'

Ethno-specific services

The information on ethno-specific services related to ethnic health workers, Chinese community services, sources of health information and interpreter services. The interpreter services were closely linked to hospitalisation and have been covered previously. This section concentrates on the remaining issues.

(d) Ethnic health workers

Younger women's groups

Only one group from Hong Kong knew about ethnic health worker services, but the two groups from China had no idea at all and said: 'What do you mean by an ethnic health worker? I don't know.'

Elderly groups

Almost all of the elderly from Hong Kong and China had no idea about the existence or role of the ethnic health worker services.

(e) Chinese community services

Younger women's groups

Half of the informants from Hong Kong and half from China were familiar with the health talks provided by some Chinese organisations. One woman from Hong Kong said: '...in this Chinese women's group, I have heard many health talks such as talks on heart disease, eye disease, women's health issues, and so on.'

Elderly groups

Most of the elderly from China had little idea about Chinese organisations: 'I don't know where other Chinese organisations are. Please tell me.' However, some elderly from Hong Kong did know and had joined activities, such as an English class, dancing club, Tai Chi class, and health talks.

(iii) Sources of health information

Younger women's groups

All of the women from Hong Kong and China reported that their sources were mainly books, friends, family members, newspapers and magazines. Only one woman from Hong Kong and one woman from China suggested the additional source of Chinese health pamphlets. Some of the women also obtained health information from radio and television. One major difference between the women from Hong Kong and those from China was the language of the information sources. In general, the women from Hong Kong could manage to watch or listen to programs on the English-speaking channels whereas their counterparts from China could not.

Elderly groups

The two groups from China reported different sources than those of their counterparts from Hong Kong. The elderly from China obtained health information mainly from books. Other sources included personal experience, friends, family members, newspapers and magazines. As expressed by an elderly person from China: '...in Australia, I also get the health information from Chinese books and newspapers.'

By contrast, most of the elderly from Hong Kong mainly obtained their health information through personal experience, family members and friends, with a few also using Chinese newspapers and magazines.

(iv) Alternative health services

Younger women's groups

Almost all of the women from Hong Kong and China commented that if western treatment failed, they would see a Chinese herbalist, and reported easy access to such a service. The women from China used other alternative health services such as cupping, acupuncture and therapeutic massage, more than did their counterparts from Hong Kong.

Elderly groups

The two groups from Hong Kong and two groups from China reported similar usage to that for the younger women's groups, with the elderly from China using alternative health services more than did the elderly from Hong Kong.

Discussion

Most of the informants from Hong Kong and China (younger women and elderly) would see western general practitioners when they were sick, but preferred one who spoke their language, and such general practitioners were readily available in the areas studied. This preference has been reported for other ethnic groups from non-English-speaking backgrounds.

Despite the Translating and Interpreter Service being well developed and appreciated by some informants, there were also complaints. A substantial difference between the younger women's groups from Hong Kong and those from China was in the utilisation of interpreter services during hospitalisation or in early childhood centres. The women from Hong Kong usually did not require interpreter services, while their counterparts from China did. This is probably explained by the difference in the education systems: English is predominant in the Hong Kong education system, whereas the Chinese language is emphasised in China's education system. However, this difference was not evident for the elderly Chinese.

In the elderly groups, the elderly from both Hong Kong and China usually required interpreter services when using health care services. The interpreter services were described as 'unavailable' and 'not adequate'. These comments are similar to those reported in the National Health Strategy (1993, pp 20, 84) which stated: 'Language services are still inadequate...' and 'TIS (Translating and Interpreter Service) cannot provide the quality of interpersonal communication required for a lengthy, stressful or complicated consultation...'

The majority of the elderly women from Hong Kong and China, and the younger women from China, had not used preventive services such as breast screening and pap smear testing. This issue could be investigated by health promotion units. Also, Mandarin-speaking and Cantonese-speaking general practitioners could convey preventive health information and encourage their patients to use preventive services. Since only the younger women from Hong Kong could manage to read and understand English, it is recommended that health information be made available in Mandarin and Cantonese.

The ethnic health worker may have an important role in bridging the health information gap between the mainstream services and Chinese community, for example, updating health information to the Chinese community and reflecting the needs of the Chinese community to the mainstream services. Since the majority of the participants (from Hong Kong and China) were unaware of ethnic health workers, the promotion of their services could be emphasised in the planning of migrant health services.

Almost all of the study participants reported that if western medical treatment failed, a herbalist was usually the choice. Other alternative health services used by them included cupping, therapeutic massage and religious healing. Most of the younger women and elderly from China showed preference in using various alternative health services compared to the younger women and elderly from Hong Kong, and thus used fewer general practitioner services than did their counterparts from Hong Kong. Such difference may be explained by the different health care systems in both countries. Alternative health services such as cupping, therapeutic massage and herbal medicine are considered different from mainstream health services in Hong Kong (Lee 1981; The Chinese University of Hong Kong 1991) and Australia, but are considered as normal treatment modalities in the hospitals in China (Crozier 1968; World Health Organization 1983; Chen & Zhu 1984).

Conclusion

The present exploratory study has highlighted some similarities, but also some differences, in the utilisation of health care services by ethnic Chinese from two countries of migration. There were also some differences which appeared to be associated with age. Overall, the findings suggest that migrants from Hong Kong utilise available health care services more than do migrants from China. Thus migrants of Chinese ethnic origin should not be treated as an homogeneous group as different needs and health utilisation patterns are evident.

Given the small number involved in the study and the method of selection, no claims of generalisability to all Chinese migrants in Australia can be made. The findings illustrate the opinions of Chinese migrating from two different countries, which are supported by verbatim quotations. These findings may provide some directions for health care providers in planning and implementing health care services for Chinese migrants, for instance, the need for improvement in the quantity and quality of interpreter services; promotion of the availability and role of ethnic health workers; and the importance of producing health information pamphlets written in Chinese languages.

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