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Healthcare needs and access in a sample of Chinese young adults in Vancouver, British Columbia: A qualitative analysis

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ABSTRACT

Objectives: Immigrants of Chinese ethnicity and young people (between 18 and 30 years of age) are known to access health services less frequently and may be at greater risk for experiencing unmet health needs. The purpose of this study was to examine the health beliefs, health behaviors, primary care access, and perceived unmet healthcare needs of Chinese young adults.
Methods: Semi-structured in-depth interviews were carried out with eight Chinese young adults in Vancouver, Canada.
Results: A content analysis revealed that these Chinese young adults experienced unmet healthcare needs, did not have a primary care provider, and did not access preventive services. Cultural factors such as strong family ties, filial piety, and the practice of Traditional Chinese Medicine influenced their health behaviors and healthcare access patterns.
Conclusion: Chinese young adults share similar issues with other young adults in relation to not having a primary care provider and accessing preventive care but their health beliefs and practices make their needs for care unique from other young adults.

1. Introduction

Young adults, between 18 and 30 years of age, are at greater risk for experiencing unmet health needs [1,2]. The transition to adulthood represents an important period of profound change with significant milestones such as leaving the family home, gaining financial independence, and entering into relationships [3]. Young adults are more likely to change residences and move between provinces than any other age group [4]. High levels of mobility may leave young adults in socially unstable and financially insecure environments compared to other age groups.

Although young adults are generally considered healthy, they are at risk for developing unhealthy behaviours, such as smoking, inactivity, and excessive alcohol consumption; such behaviours have the potential to create health problems later in life [5]. In addition to potentially participating in risky behaviours, the rates of healthcare utilization are also the lowest for young adults compared to other age groups [1,6]. Moreover, one in seven Canadian young adults between the ages of 20 and 34 reported experiencing an unmet healthcare need in the Canadian Community Health Survey [7]. Immigrants also report higher numbers of unmet healthcare needs compared with other members of the population [8]. As perceived by the individual, healthcare needs that have not received attention are considered to be unmet [9,10].

Although immigrants are initially more likely to be in good health, as required by Canadian immigration criteria, they can face challenges in accessing healthcare because of language barriers, differences in perceptions of health and illness, and limited knowledge of the healthcare system [8,11]. It has also been reported that immigrants' relative good health deteriorates with time, becoming equivalent to that of the general population [12–14].

The decline in immigrants' health, known as the healthy

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immigrant paradox, could be in part due to acculturation. Acculturation is the dynamic and complex process where individuals from a differing ethnic group adapt to a new culture, often by adopting its behaviours, attitudes, beliefs, and language [15]. Acculturation extends beyond the immigration period into the second generation; young adults from the second generation of ethnic minority groups demonstrate changes in health beliefs and behaviours over time even when compared with immigrant young adults [16]. It is unclear the relationship between acculturation and health behaviours. Some researchers have found that acculturation positively influences health behaviours while others argue that the process of adaptation to a different culture negatively influences immigrants' health outcomes [17–19].

At the same time, the health beliefs, behaviors, and primary care access of young adults are also heavily influenced by their parents and their cultural values [20]. Past work from the U.S. suggests that Asian-Americans traverse through different and sometimes conflicting cultural realities through school and family life [21] [22]. For example, while Asian-Americans youths in general have lower rates of smoking compared with other non-Asian youth, upon closer examination increased levels of acculturation have been associated with increased rates of smoking for certain subgroups [23]. It is unknown to what degree exposure to Canadian culture through school and language contribute to influencing the health beliefs and practices of Chinese young adults. The amount of time in the new country, degree of fluency in English, and the presence or absence of native 'navigators' demonstrating how and where to access primary care are factors that influence the healthcare utilization of immigrants [24].

The relationship between acculturation and health becomes even more complex when we consider different patterns of acculturation which could take the form of assimilation, separation, integration, or marginalization [25]. Regardless of the form of acculturation, it could be that young adults experience unmet healthcare needs given their context of living within different cultures. Moreover, minority and immigrant groups often experience unmet healthcare needs in the context of primary healthcare, which relate to the accessibility, acceptability, appropriateness of the care received [8,26]. There is also the influence of health beliefs that some Chinese people may ascribe to such as those encompassed in Traditional Chinese Medicine (TCM). It is known that Chinese in Canada are less likely than people from other ethnic groups to consult primary care physicians [27,28]. Even after accessing primary healthcare, satisfaction with the care provided is appreciably lower when compared to the general population [29,30]. It is likely that different patterns of acculturation affect whether or not Chinese young adults experience personal or structural difficulties in accessing healthcare.

Adding to the complexity of the issues around acculturation and health, Chinese in English-speaking countries are often perceived as the "model minority"; a model minority is one whose members are seen to achieve a comparatively higher degree of socioeconomic success than the population average through hard work and determination [31,32]. We hypothesize that alongside the desire to minimize parent-child conflict, Chinese young adults may not want to rupture this social expectation by hesitating to reveal health problems that arise from engaging in risky health behaviours to healthcare providers and their families. This may result in the reduced detection of their mental and physical health problems.

Young adults are known to be at risk for unmet healthcare needs within the context of primary healthcare. Factors such as Chinese ethnicity and immigrant status may amplify differences in accessing health services given differing beliefs and knowledge around health and healthy behaviours. Chinese young adults may have different reasons for unmet health needs when compared to other young adults related to the different patterns of acculturation.

The purpose of this research was to explore the health behaviours, health beliefs, access to primary healthcare, and any perceived unmet healthcare needs of Chinese young adults in the context of primary healthcare in Vancouver.

1.1. Theoretical framework

We examined the factors that contribute to health decision making in connection with accessing health services by utilizing Andersen's Behavioural Model of Health Services Use. The Behavioural Model specifies that health behaviours and health outcomes are predicated upon environmental and population determinants, as well as the enabling resources that are available [26]. This model was selected as the deductive framework for examining the interview data for the qualitative study because it offers a theoretical perspective for studying the factors that lead to unmet health needs, especially for ethnic minorities [33].

2. Material and methods

2.1. Design & procedure

This study was conducted in Vancouver, Canada. Vancouver is a popular destination for Asian immigrants from China, Hong Kong, and Taiwan. According to the 2011 National Household Survey, 18% of metropolitan Vancouver's population were of ethnic Chinese origin [34]. Vancouver has been referred to as the "most Asian city outside of Asia" [35]. Because of the considerable number of young adult Asian immigrants in Vancouver, coupled with a paucity of information about their health behaviours, it is especially important to explore their health beliefs, practices, unmet needs, and access to primary healthcare.

This was a complementary mixed methods study design that employed a secondary analysis of survey data from a larger study (Chinese and South Asians' Preferences and Expectations of Primary Healthcare Survey) and in-depth interviews with ethnic Chinese young adults, between 18 and 30 years of age. The secondary analysis of quantitative data preceded the qualitative interviews. The qualitative interviews were analysed using a deductive content analysis. These interviews allowed for uncovering contextual information around Chinese young adults' healthcare usage, which was not available from the quantitative survey data. The analysis of the qualitative data is reported in this paper.

The interview participants were recruited from the larger study. British Columbian residents 18 years and older participated in a telephone survey about their preferences and experiences in the primary healthcare system. The telephone survey was administered to a representative sample of Chinese-, Punjabi- and English-speaking residents ($n = 1492$) using computer assisted telephone interview techniques (CATI). The research ethics board at the University of British Columbia approved all procedures for the larger survey, secondary analysis, and the in-depth interviews.

For the in-depth interviews, Chinese young adults from the larger survey study, who had consented to being contacted for related research, received telephone calls and were asked to participate in an interview about unmet health needs and health behaviours by the first author. Voice messages were left for those who did not answer if the option was available. Purposive sampling was employed to recruit approximately equal numbers of Chinese young adults based on language preference. Language preference (either Chinese or English) was used as a proxy measure for degree of acculturation in order to capture a range of behaviours that may be relevant for Chinese young adults who may identify more with one culture (i.e., Canadian or Chinese culture) than the other, and

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