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# Factors affecting physician visits in Chinese and Chinese immigrant samples

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**Abstract**

This study examines predictors of Western physician utilization using the Andersen's Behavioral Model of Health Services Use for Chinese elders who reside in Shanghai and immigrant Chinese elders who reside in the US Chinese elders are under-studied relative to their population size and in the US are known to underutilize the healthcare system. Underutilization is highly correlated with poor health and well-being. A unique dataset allowed us to examine predictors of physician utilization for Chinese elders who resided in different countries, in an effort to determine how being an immigrant affects utilization. One hundred and seventy-seven Chinese elders in Boston and 420 Chinese elders in Shanghai participated in the survey. Multiple regression analyses were conducted separately for each sample. Predictors of physician visits for the Boston sample are insurance status, health, and social network, and for the Shanghai sample, use of Chinese medicine, health, and marital status predicted physician visits. We found that access to care variables significantly affects physician utilization for immigrant elders, and that Chinese elders in Shanghai utilize a bicultural system of care. The results indicate that in order to create effective healthcare practices for elder Chinese, alternative healthcare beliefs should be understood by Western physicians.


*Keywords:* China; USA; Immigrants; Older people; Traditional Chinese medicine; Physician visits; Healthcare utilization

## Introduction

Over 12 million Asian Americans live in the United States. Almost one-fourth of US Asians are Chinese (US Census Bureau, 2004). Currently 10% of the Chinese American population is aged 65 or older; this population is projected to increase over 600% in the next 30 years (American Association for Retired Persons & Agency on Aging (AARP), 1996). Despite this projected rapid growth, Chinese elders are under-studied relative to their population size (Andersen, Harada, Chiu, & Makinodan, 1995). As the US experiences increasing population diversity, studies are needed that increase cultural understanding. Cultural competence in particular is a central issue for service and healthcare providers.

Studies have shown that Asians underutilize the healthcare system and have low rates of social service use (Boult & Boult, 1995; Hu, Snowden, Jerrell, & Nguyen, 1991; Snyder, Cunningham, Nakazono, & Hays, 2000; Sproston, Pitson, &

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Walker, 2001; Zhang, Snowden, & Sue, 1998). There is also considerable variation among different Asian ethnic groups, both in terms of level of use (Sproston et al., 2001) and the variables that explain healthcare utilization (Ryu, Young, & Kwak, 2002). Of the studies we reviewed on healthcare use, some aggregated various Asian groups (Boult & Boult, 1995; Ngo-Metzger, Legedza, & Phillips, 2004; Snyder et al., 2000) or aggregated Chinese with other ethnic groups (Wong et al., 1998). Of the limited studies on Chinese Americans, most had sample sizes smaller than 100 (Crain, 1996; Ma, 1999, 2000; Pang, Jordan-Marsh, Silverstein, & Cody, 2003; Wong, Yoo, & Stewart, 2005, 2006; Zhang & Verhoef, 2002), or aggregated age groups, and used age as an independent variable in samples with various age groups (Jang, Lee, & Woo, 1998; Li, Stewart, Stotts, & Froelicher, 2005; Ryu et al., 2002). To avoid making oversimplified assumptions about Asians, researchers recommend studying specific subgroups (Andersen et al., 1995; Gwen, 1997; Ryu et al., 2002).

Researchers have identified access to care barriers and cultural beliefs that may affect the Western healthcare utilization patterns of Chinese Americans. Older Chinese Americans in particular are accustomed to a bicultural system of care. China has a unique healthcare system in that Western medicine (WM) and traditional Chinese medicine (TCM) are often practiced simultaneously in clinical settings. The Chinese government has supported TCM, even establishing a department at the Ministry of Health (Hesketh & Zhu, 1997). It is estimated that 40% of the drugs prescribed by doctors in Western medical settings are traditional Chinese medications (Zheng & Hillier, 1995). In a recent survey of Chinese doctors, Harmsworth and Lewith (2001) found that 98% of doctors received training in TCM. Many doctors prescribed a combination of treatments, preferring TCM for chronic conditions or acute illnesses and WM for life-threatening illnesses.

TCM has been practiced in China for over 2000 years. Contrary to the disease model of Western medicine, TCM focuses on holistic treatment and restoring harmony and balance in body and spirit. Components of TCM include acupuncture, herbal and dietary treatments, and chiropractics. TCM is considered useful in health promotion and in managing chronic conditions (Chan et al., 2003; Lam, 2001; Ma, 1999). Reasons given by Chinese elders for using TCM include an absence of side effects, to maintain health, and to eliminate the health problem instead of just treating the symptoms (Lam, 2001; Li et al., 2005; Sproston et al., 2001). In a study of attitudes towards Western physicians, Chan et al. (2003) found that older Chinese adults were more likely than their younger counterparts to believe in the superiority of TCM over WM and to distrust Western doctors. In the US other non-cultural reasons for not using Western medicine include misunderstanding insurance benefits and affordability (Pang et al., 2003; Zhang & Verhoef, 2002). On the other hand, since most health insurance plans do not cover TCM, it also prevents individuals from seeking TCM. Nonetheless, some studies found that some Chinese persons who utilize TCM also visit Western physicians (Foreman, Yu, Barley, & Chen, 1998; Ma, 1999; Pang et al., 2003). Pang et al. (2003) recommends further research that focuses on understanding the healthcare utilization patterns of Chinese elders.

Currently the healthcare system in China is bifurcated. While the overwhelming majority of rural elders do not have health insurance, in urban areas, all retired employees are covered by Social Medical Insurance which is sponsored by the state. Employers and current employees pay taxes into the system. Social Medical Insurance only covers urban retired employees. Urban elders who have never worked in the past do not have medical insurance. A spouse who has never worked, but is married to a retiree has up to half of their medical costs reimbursed by social medical insurance, depending on the medical services provided. The concept of private insurance is new in China. Only recently, certain types of insurance, such as life insurance and long-term care insurance, have begun to emerge in urban areas. No private medical insurance exists at this point.

In the United States most of the older adults have Medicare, which is a federal government health insurance program. Most people 65 or older are eligible for Medicare hospital insurance (Part A) based on their own, or their spouse's employment. Medicare Part A covers inpatient hospitalization, and Medicare Part B covers physician and outpatient visits. Almost anyone who is 65 or older can enroll in Medicare Part B by paying a monthly premium. In contrast, Medicaid is a publicly financed health insurance program for certain groups of low-income persons. Older adults qualify based on income and asset requirements. Older