Social Science & Medicine 67 (2008) 1410–1422

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Ethnicity and utilization of family physicians: A case study of Mainland Chinese immigrants in Toronto, Canada

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ARTICLE INFO

Article history:
Available online 9 August 2008

Keywords:
Ethnicity
Health care
Family physician
Toronto
Mainland Chinese immigrants
Canada
Utilization
Language

ABSTRACT

This paper seeks to examine how immigrants in a multicultural society access and utilize culturally- and linguistically-diverse family physicians. It focuses on Mainland Chinese (MLC) immigrants – the most important source of immigrants to Canada since 1996 – in the Toronto Census Metropolitan Area (CMA), Canada. Specifically, the paper aims to explore the choice between Chinese-speaking and non-Chinese-speaking family physicians by MLC immigrants and to determine the underlying reasons for MLC immigrants use of ethnically- and linguistically-matched family physicians. A wide range of data are analyzed including survey and focus group data, physician data from the College of Physicians and Surgeons of Ontario (CPSO) and geo-referenced 2001 Canadian Census data. A mixed-method approach is employed combining quantitative analysis of survey data and Census data, spatial analysis of patient travel behaviour based on the survey and qualitative analysis based on focus groups. The paper reveals an overwhelming preference among MLC survey respondents for Chinese-speaking family physicians regardless of study areas and socioeconomic and demographic status. The focus groups suggest that language, culture and ethnicity are intertwined in a complex way to influence the choice of health care providers and health management strategies in the host society. The paper yields important policy implications for identifying health professional shortage areas for culturally-diverse populations, addressing issues related to foreign-trained physicians and enhancing primary care delivery relevant for immigrant populations.

Introduction

As part of a larger study[1] that investigates the adaptation experience of Chinese immigrants in various socioeconomic domains in Toronto, Canada, in this paper we focus on immigrants' geographical access to and utilization of family physicians who are heterogeneous in their cultural background and language of practice. The ethnic group to be analyzed is Mainland Chinese (MLC) immigrants – the most important source of immigrants to Canada since 1998 – in the Toronto Census Metropolitan Area (CMA). A wide range of data were analyzed including survey and focus group data, physician data from the College of Physicians and Surgeons of Ontario (CPSO) and geo-referenced 2001 Canadian Census data. Specifically, the paper seeks to examine how MLC immigrants in the Toronto CMA utilize family physician resources and their choices between Chinese-speaking and non-Chinese-speaking family physicians; to determine the underlying reasons for MLC immigrants use of ethnically- and linguistically-matched family physicians; and to explore the role of

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[1] See Wang (2003, 2004) and Wang and Lo (2007) for other studies based on this project of Chinese immigrants' consumption experience in grocery shopping, shopping for electronics and using travel agencies.

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doi:10.1016/j.socscimed.2008.06.012

language and culture in health care, health beliefs and health management strategies in relation to MLC immigrants. Here, we use "choice" to describe the process for MLC immigrants to utilize family physicians who are linguistically-diverse, while acknowledging that decision-making regarding family physicians is constrained by multiple factors including availability and in cases where there is a local shortage of family physicians, there is little or no choice for patients in locating their family physicians.

Background and context

The social context of the study is the multi-ethnic city where immigrants can choose to remain distinct in their ethnic identity rather than assimilating to "mainstream" norms. Toronto is perhaps "the most ethnically diverse city in the world" (Hoernig & Walton-Roberts, 2006). Since the early 1990s, over 40% of all immigrants to Canada chose to settle in the Toronto CMA (CIC, 2005; Statistics Canada, 2001a). Despite the availability of a publicly-funded, universal health care system in Canada, immigrants underutilize health services (Hyman, 2001, in Dyck, 2004) and face significant barriers to health care access resulting from a lack of knowledge in the official languages and the Canadian health care system (Leduc & Proulx, 2004). MLC immigrants are the largest recent immigrant group to Canada. They experience strong barriers to health care in Canada. Coming directly from a different culture and health care system, about 32% of them do not speak English (Statistics Canada, 2001b). In China, hospitals provide primary health care to citizens and it is a brand new experience for MLC immigrants to seek primary care from family physicians who act as "gatekeepers" to specialists in Canada. Like many other immigrant groups, MLC immigrants are at a disadvantage in their encounters with health care providers, with their health beliefs and health practices being misunderstood or discounted. Meeting immigrants' health needs is of critical importance to the adaptation and integration of immigrants.

Toronto's ethnic diversity has produced a diverse physician population. In 2005, about 100 different languages other than English and French – the two official languages of Canada – were spoken by physicians and specialists in the Toronto CMA (CPSO, 2005). Nearly 30% of all physicians and surgeons in the CMA self-reported the use of at least one non-official language (CPSO, 2005). Such ethnic and linguistic diversity can have a strong influence on immigrants' utilization of and access to family physicians, particularly for recent immigrants coming from a different cultural background with limited knowledge of official languages.

In this study, we focus on MLC immigrants, the fastest-growing recent immigrant group in Canada. In Toronto, the Chinese have been the largest ethnic minority group since 1996, with a population size of 355,270 and a population share of 7.6% of the CMA's total population. Chinese immigrants in Canada come from various sources including Mainland China, Hong Kong, Taiwan and other countries. Among the various Chinese immigrant sub-groups, Mainland Chinese are the second largest, next to Hong Kong Chinese (HKC). Mainland China replaced Hong Kong as the top immigrant source country to Canada in 1998 when Hong Kong, a former British colony, was returned to the People's Republic of China. MLC are primarily Mandarin-speaking, while Hong Kong Chinese are Cantonese-speaking.

Here, it is useful to provide some information about the Chinese ethnic business activities in Toronto as family physicians are self-employed and can be viewed as a particular type of service providers. The Hong Kong Chinese immigrated to Canada in mass since the 1970s; in Toronto they created the largest and most viable Chinese ethnic economy outside Asia providing a wide range of consumer goods and services to both co-ethnics and the larger population (Lo & Wang, 2007; Preston & Lo, 2000; Wang, 2004). Mass immigration from Mainland China took place after the tragic outcome of the Tiananmen Incident in 1989 when a student pro-democracy protest was suppressed (Lo & Wang, 1997). The growing MLC community has changed the Chinese ethnic business landscape in the city; more and more entrepreneurs that previously targeted Cantonese-speaking populations are providing Mandarin-speaking services to the linguistically-diverse Chinese community and the number of Mandarin-speaking MLC entrepreneurs is also increasing. In this context, many Cantonese-speaking family physicians are now learning Mandarin to attract Mandarin-speaking populations. It is in this context that the paper focuses on the MLC immigrants – the most recent and the most rapidly growing Chinese immigrant sub group in Toronto.

Lo, Wang, Wang, and Yuan (2007) report the lack of English language proficiency as a strong barrier for MLC immigrants in accessing immigrant settlement services in Toronto. Studies (Ma & Henderson, 1999; Wang, 2007; Zhang & Verhoef, 2002) also find linguistic and cultural barriers, such as difficulty of understanding medical terminologies and different ways of interpreting medical symptoms, experienced by immigrant populations in utilizing Western health care systems. MLC came from a country where English is not the language of instruction, the health care system is different from that of Canadas and Taoism is the most fundamental aspect of Chinese culture and traditional Chinese medicine that is widely recognized within China. The linguistic and cultural background likely have an impact on their post-migration health care seeking behaviour, particularly with respect to choosing between Chinese-speaking and non-Chinese-speaking family physicians in Canada. In 2005, about 6.3% of all the physicians and surgeons in Toronto self-reported to speak "Chinese" or at least one of the Chinese languages: Mandarin, Cantonese, Fukien, Hakka, Swatow or Taiwanese (CPSO, 2005). Their last names indicated that they are likely ethnic Chinese, although they may or may not be first-generation immigrants. How immigrants choose between co-ethnic physicians and other physicians is an important question to pursue in understanding what facilitates access to health care or conversely how socio-cultural differences between the mainstream and minority groups create barriers to access and utilizing health care. Khan and Bhardwaj (1994) suggest that in consuming health care services, economic or financial costs are the most important barrier. Canada's health-care system is a group of socialized health insurance