1. Introduction

This paper examines the ongoing discussion of access to health care and health seeking behaviors of Chinese Americans and problems of cultural competence in cross-cultural medical encounters. Through an overview of the current literature as well as my fieldwork in Boston’s Chinatown in 2003, I examine the ethnomedical and biomedical belief systems that inform the misunderstandings between the Chinese patient and medical practitioner, as well as the economic impact present health care coverage has had on the population. Examining socio-historically embedded beliefs such as those revealed in ethnomedical practices has proven fruitful for studies in medical anthropology (from Frake, 1961 to Fadiman, 1997) as such examination reveals the context in which one interprets meaning. I apply this approach to understanding the ethnomedical beliefs of the immigrant Chinese as they pertain to health related beliefs and behaviors at the intersection of two medical systems.

Chinese Americans form a heterogeneous group that has a varied and geographically diverse immigration history. There is a growing corpus of literature discussing the cross-cultural, linguistic, and migratory implications bearing on the efficacy of health care on minority groups in the United States. While stereotyped behaviors of Chinese Americans depict a population that avoids requesting assistance from those outside of one’s immediate family, particularly with respect to mental health issues, it has been demonstrated that Chinese Americans would be more likely to seek formal health care if they had health insurance (Spencer et. al., 2004). This would have a significant impact on alleviating the economic burden of the uninsured through state level health care programs such as Medi-Cal and Mass Health as well as Medicare and Medicaid, and hospital free care.

This paper examines the importance of health care practices and behaviors of Chinese relating to integrated Chinese and western medicine (zhong xi yi jie he) prior to their immigration, focusing on first generation Chinese, or immigrants. It is estimated that two-thirds of the Chinese population in the United States is born overseas. This is significant with regard to culturally particular views of states of health and perceived
avenues of treatment. Since the 1950s, integrated medicine has been an integral part of Chinese health care in China on various administrative levels including the village (Guo, 2000; White, 1999).

Following Pang, et. al. (2003), health seeking behaviors are defined as “those actions that address health related symptoms, including seeking help from health care services and using alternative resources to relieve, prevent, and/or treat symptoms.” The literature, in general, divides health services into two arenas, formal including physician based care, nursing in hospitals and clinics as well as pharmaceutical care, and informal services such as those common to Chinese medicine including acupuncture, herbal medicine, taiqi quan and qigong, as well as home remedies (Pang et. al., 2003, p.865). This dichotomy highlights the structural and ideological context of Chinese folk medicine in the United States.

Additionally, barriers to accessing health care can be divided into the arenas of structural and cultural (for example, see Pang et. al., 2003). Structural barriers include knowledge about services, citizenship, transportation, income, discrimination, and of course, lack of health insurance. Cultural barriers include English language proficiency and indigenous views of health and medicine. It is estimated that 51% of the Chinese population in the United States lacks English language proficiency. The majority of studies focused on Asian and Pacific Islander population in the United States, 20% of which are Chinese Americans, and acknowledge that factors of immigration including fear impact access to resources. Further, language barriers, clashes in cultural expectations and changing social networks form barriers to acquiring health insurance.

2. Acculturation and health care

Successful navigation of the American health care systems is almost always attributed to high levels of acculturation. Acculturation is summarized as English language proficiency, high levels of educational attainment and income (Gomez et. al., 2004; Guo, 2000; Jang et al., 1998; Zhan & Chen, 2004). Acculturation to American society cited as a factor in successful health care encompasses cultural behaviors that include the understanding of doctor-patient relationships (Gomez et al., 2004; Jang et. al., 1998). Culturally particular health seeking behaviors are seen as detrimental to health care by many practitioners of western medicine in the United States and the behaviors form barriers to consistent, regular health care among patients. This is primarily a problem among those patients that are less acculturated to American society. Chinese cultural ideals of respect and face saving interactions often impact the view that the patient is responsible for their health care and acquiring health related information as these cultural attributes imbue the doctor-patient relationship with a level of respect that inhibits patient inquiry and contradiction (Pang et. al., 2003). Acculturation has further implications for health care coverage as it positively affects levels of insurance coverage, which is a significant factor in the dynamic of doctor patient relationships and health care outcomes (Gomez et. al., 2004).
Indeed, acculturation is part of the immigrant experience and impacts the social environment that includes the appropriation of the western views of science and medicine (Ong, 2000; Pang et al., 2003; Zhan & Chen, 2004) as well as structural elements such as racial ideology. In the construction of the “biopolitical subject,” it has been noted that the western medical “regime” socializes individuals to “expected norms of patient behavior” and instructs “patients about the rules and rights that constitute the proper medical …subject” (Ong, 2000).

3. Culturally competent health care

This idea of “culturally competent health care” is now a significant focus of studies on minority health care in the United States. The literature, too broad to summarize here, spans the spectrum of educational concerns and curriculum to the study of clinical practice and health care outcomes. There is no one single definition of “cultural competence” however, the need for health care providers to “adjust and recognize their own culture in order to understand the culture of the patient” (Johnson et al., 2004) may be key to revealing the use of integrated (zhong xi yi jie he) medicine among the Chinese in the United States. Lack of cultural competence and discrimination are often attributed to the practitioner. Studies have revealed that language based discrimination on the part of the practitioner leads to greater use of informal services among the Chinese in the United States (Spencer et al., 2004). Studies have further revealed that “crash courses” in cultures of minority groups has produced few changes in the clinical setting (Thom et al., 2006). The literature that focuses on the discussion of cultural attributes of Chinese Americans most salient to the successful health care interaction include respect and face, family networks, filial piety, yin yang philosophy, and beliefs surrounding death (Chan & Kayser-Jones, 2005). However, it is never made clear how an understanding of these cultural attributes will aid in providing culturally competent health care within the western medical paradigm.

There is a small sector of the literature that attempts to bring to light indigenous beliefs or folk categories that impact views of health, illness and treatment (for example see Keum, 1994 (for Koreans); Lam, 2001; Satia et al., 2000). The articles discuss views of diet and nutrition, mental health and beliefs regarding utilization of health care services. In these instances, it becomes apparent that the folk categories are themselves constructions of the interaction between hierarchical systems of knowledge with regard to health, illness and treatment. As the major problem cited was not simply culturally incompetent actors in the doctor-patient relationship, but access and insurance issues, it should be noted that studies regarding the beliefs of insurance coverage of this population would be fruitful in the ongoing discussion of Chinese American health. Similar to western scientific medicine, insurance is not necessarily a foreign concept to most recent immigrant Chinese.

In a complex web of beliefs and practices both ethnomedical and biomedical, structural and cultural barriers intersect where insurance coverage itself is a barrier to “culturally competent” healthcare. That is, Chinese Americans are limited as to what services are available as insurance companies do not cover the majority of the diverse elements of Chinese medicine. For example, a regional survey of the Northeastern
United States was conducted to determine which complementary and alternative medicine (CAM) modalities were covered (Cleary-Guida et. al., 2001). The results of the survey found that in almost all instances, insurers covered chiropractic services, but “less than half” would reimburse for acupuncture used to treat chronic pain. Massage therapy was minimally covered and other complimentary and alternative medical services were “negligible.” Currently, insurance coverage is limited to chiropractic medicine, acupuncture, and massage therapy. Insurance coverage of CAM is “made confusing by different policies, practitioner requirements, and health plans within each carrier.”

The conclusion of much of the literature is that more has to be done with regard to educating health care practitioners and administrators about “culturally competent” health care as well as developing culturally competent insurance coverage (Jang et. al., 1998; Taylor & Lurie, 2004). As Ong indicates, practitioners are both “agents and objects of biomedical regulation” and reproduce the very socializing structures that confound relativization of medical care (Ong, 2000). Thus, cultural competency should not be understood as simply the study of Chinese culture, Confucian values and yin yang philosophy but rather the complex events of history that have constructed hybrid approaches to healing and healthcare. Chinese folk beliefs regarding the utility of “western” and “Chinese” medicine developed in the past century and half within the context of imperialism and today significantly shape access to healthcare and healthcare seeking behaviors.

4. Downtown Chinese and insurance coverage

Chinese Americans are viewed as one of the most successfully integrated minority populations in the United States (Chen, 1992; Fong, 1994; Kwong, 1996; Wong, 1982). This is the model minority stereotype constructed in the mid-twentieth century and acknowledged in the 1980s under the Reagan Administration. The seachange in America’s view of the Chinese was prompted by the post-1965 immigrants who were better prepared to deal with life in the United States. Since the early years of Chinese immigration beginning in the 1850s, the Chinese had been viewed as a threat to public health (Shah, 2001). However, today the health of the Chinese American population is often viewed as an indicator of successful acculturation. Overall, Chinese Americans have one of the highest life expectancy rates of all groups, including non-Hispanic whites. For example, Chinese American women have a life expectancy of 86.1 years.

Studies over the past twenty years have indicated significant differences within the Chinese American population with regard to socioeconomic status, residence, and cultural patterns. There are the more affluent, professional Chinese, generally from the post-1965 Northern China immigration, and the less affluent laborer from Southern China, mainly today, the Fujianese. The “uptown” Chinese (Chen, 1992) are indeed representative of the model minority. The Chinese arrive in the United States with professional degrees or obtain one in the United States. They are better prepared for life in the United States as they are educated, often Christian, proficient in English, and are employable. Their median income is higher even that of whites, at approximately
$59,000 per year. They live in the suburbs and, through their employment or educational institutions, have medical coverage.

In contrast, the “downtown” Chinese continue to struggle in Chinatowns with unemployment or underemployment, poor English language skills, and limited access to services. This group’s lack of education, which is tied to employment and income, is a factor in the lack of health insurance.

While approximately 21% of all Asian Pacific Islander’s lack health insurance, of the Chinese American population, 20% do not have insurance coverage. However, Chinese Americans overall have relatively high rates of private insurance coverage when compared with public insurance. This may be attributed to the majority of Chinese Americans who fall into the model minority group. Of those Chinese Americans with health coverage, 84.2% had private insurance and 3.8% had public insurance. Chinese Americans who are eligible for Medicaid often do not have it. Studies indicate that only 13% who are eligible for Medicaid are covered. (Spencer & Chen, 2004).

It is evident that married Chinese Americans will have greater access to health insurance if one spouse or both are employed (Takeuchi et. al., 1998). In a focus group conducted in Boston, Massachusetts through the Asian American Civic Association (see below), 60% of those participating that had health insurance were covered through their spouses.

Another population of Chinese Americans, the elderly, is also at risk for impeded access to health coverage. The growing aged population has some of the highest uninsured rates. Language barriers are significant in contributing to the gap in health coverage among this group, as the majority of those elderly are pre-1965 immigrants and are less likely to have successfully integrated into American culture.

5. Boston’s Chinatown study

The Boston Chinatown Study was conducted during the summer of 2003, during which the Severe Acute Respiratory Syndrome (SARS) epidemic threatened Asia and instilled fear throughout the world. This was a particularly informative time as the cultural pattern of racial ideology and fear that had plagued the early years of Chinese immigration during the nineteenth and twentieth centuries was replayed in the twenty-first century. It highlighted the impact of acculturation and the appropriation of racial ideology that informed the social context for health seeking behaviors and practices. Despite Chinese Americans’ distrust of the American health care system highlighted during the SARS epidemic, Chinese Americans continued to seek care from both systems.

The goal of the research was to investigate patterns of health care use with regard to western and Chinese medicine and prescription medications. With the assistance of the Asian American Civic Center in Boston’s Chinatown, a health survey and focus group was conducted. Additionally, interviews with health care providers in a local clinic and in a large hospital were conducted. The focus group and survey were conducted in Mandarin, Cantonese and English with the aid of a Cantonese interpreter. Interviews with
the physicians, all of whom were Chinese American, were conducted in English. While the total number of participants in the study was small (n=50) and generalizations are not possible at this time, the study supports trends presented in other studies and further reveals the importance of folk beliefs of Chinese Americans with regard to health care and attitudes toward western medicine. It further highlights the attitudes of health care practitioners and the conflict between seeking continuity in care and upholding the exclusivity of the western medical paradigm.

The average age of the participants was 40.56 years with a median of 35 years. The male to female ratio was 1:10. Residence patterns revealed that 71% of the sample lives in or near Chinatown. The average length of residency in the United States was 3.9 years, with the time ranging from approximately 12 years to 3 months. Average family size in the United States is 6 people, while in country of origin it was slightly smaller at 4.5 people. The average number of children in U.S. households was 2.57 with the highest being 7 children. The majority of the participants, 71%, were non-citizens. Language use was predominantly Cantonese with 42% being bilingual in Mandarin and Cantonese. English proficiency was limited. Employment levels were low, with 80% being unemployed. Educational levels were low as no one in the group was presently attending college and only one individual possessed a college degree. The median range of income levels for this group was less than $10,000 per year. Health insurance coverage levels were low, with 50% having coverage.

Indicative of the problems inherent in the discussions of culturally competent health care, the Chinese in this study were more likely to agree that western medical doctors were able to understand their particular health concerns. This response may reflect the study population’s familiarity with western medicine in their country of origin as they faced several serious chronic health issues and the majority of the individuals sought health care at the large hospital in Chinatown. However, the folk beliefs of utilization were supported with the participants indicating that the time for western medical treatment is in the case of a serious illness or for surgery. Further, the concern of side effects from western prescription drugs was supported as was the view that Chinese medicines were less likely to cause negative side effects. However, this group was more likely to use over-the-counter drugs such as Tylenol.

Significantly, this population supports the dichotomy separating western and Chinese medical practices on the institutional level as they were more likely to use both systems but less likely to use both services. That is, the Chinese did not use both the hospital and the community health center. This is significant and reflects the health of the study population and folk beliefs of utilization and integration of systems.

With regard to patterns of health care use and attitudes, the majority feels that western medicine is effective and utilize a variety of treatments from both Chinese medicine and western medicine. The sicker the individual, the more reliant on western medicine they were. As demonstrated in other studies, insurance coverage was related to service utilization.
The “health usage” profile of the group is as follows: with regard to medicine use, 71% of the study population used prescription drugs over the past year. Drug use included antibiotics at 42%, prescription pain medications 43%, and insulin at 14%. Illnesses reported were the following, colds, insomnia, allergies, heart disease, lupus, high cholesterol, diabetes, high blood pressure, sore throat, and fever.

With regard Chinese medical practitioners, informants either do not go (bu qu) at 35%, or went four or fewer times over the past year at 65%. This demonstrates an interest in the practice but other factors to be discussed below may hinder the individual’s ability to make more visits. This is significant in comparison to their visits to practitioners of western medicine where we find that only 26% state that they would not go, 53% made four or less visits per year, 9% saw the doctor five to nine times per year, and 12% say the doctor over ten times per year. This pattern is very different than that of those using TCM.

Only 6% of the informants were hospitalized over the past year. The informants in this case had health insurance, used Tufts-New England Medical Center for their health care, saw the doctor more that five times last year, and had incomes of less than $15,000 per year. They used antibiotics in the past year. Fifty percent of this group would not see a practitioner of Chinese medicine.

In sum, attitudes toward western medicine and practitioners were relatively positive. When posed with questions regarding the ability of western medical doctors to understand them, the Chinese in this group responded positively. Seventy-one percent agreed that the seriousness of the illness prompted an individual to seek help from a western medical practice. The percentage of the population that had health insurance sought medical services from formal sources even if they combined it with informal services.

6. Competing systems of knowledge?

As stated above, a significant barrier to health care is the lack of available Chinese ethnomedical services covered under health insurance plans. Many Chinese Americans across the generations use Chinese cultural remedies and treatments. Within the biomedical model, an offshoot of which is the insurance company, these ostensible non-scientific practices are rendered ineffective, hocus pocus, and/or harmful. Spencer & Chen (2004, p. 809) bring to the fore the problems of diagnosis and treatment in systems of competing epistemologies. Further complicating issues of cultural sensitivity with regard to Asian minorities in general, and Chinese specifically, is that Chinese medicine is not a monolithic practice and its traditions have been molded by historical factors such as modernization schemes in the People Republic of China in the 1950s and 1960s (Guo, 2000; Hsu, 1999; Scheid, 2001). In fact, while the Chinese have been labeled as pragmatic with regard to our view of the blending of practices in many realms of life including religions, Chinese culture is more accurately characterized as pluralistic. It is within this context of the shift to nationalism and modernization in the twentieth century that the Chinese practice medicine (Guo, 2000; Hsu, 1999; Scheid, 2001). There are three “schools” or practices in China that have shaped the perceptions of health care among the
Chinese, Chinese may orient themselves toward “Chinese medicine,” “western medicine,” or “integrated Chinese and western medicine” (zhong xi yi jie he) (Guo, 2000; Hsu, 1999; Scheid, 2001). As Scheid (2002:10) states with regard to plurality of health care in China:

Western, Chinese, shamanist, and religious forms of healing not only exist side-by-side, they are also integrated in many different ways. Patients move easily from one doctor, clinic, or hospital to the next if the present one does not deliver the expected results. In time-honored tradition (especially if they can afford the expense), they may consult several doctors and compare their prescriptions before deciding which one’s treatment to follow.

Folk beliefs of western medicine, in contrast or comparison to Chinese medicine, impact immigrants’ perceptions of utility. In the context of globalization and colonialism, many Asian cultures were introduced to western medicine and have developed significant beliefs based on this contact before coming to the United States (see Fadiman, 1997 and Ong, 2000). Throughout the history of contact between the United States and China, competing epistemologies with regard to medical science and practice have colored the developmental trajectory of systems of healing in China. In the early 1990s, this discourse between traditional Chinese healing and medicine and western science persisted in medical institutions in major cities such as Shanghai.

7. Continuity versus orthodoxy in health care

The problem confronting patients and practitioners is complex but not unique. The Chinese arrive with differing expectations with regard to lifestyle and health than what they encounter. While clearly a lack of language proficiency in any instance is a significant barrier, it has been demonstrated that there are significant issues that require additional expenditure of resources including monetary resources to educate both parties as to how to deal with cultural differences. A significant stumbling block is the clash between ideological systems where the difference in focus among health care practitioners such as that of “continuity versus orthodoxy,” comes into play and has major outcomes for culturally competent health care and insurance coverage.

The “continuity versus orthodoxy” dichotomy has important consequences for the health outcomes for the downtown Chinese as it has been demonstrated that a correlation exists between the increase in use of both systems (“formal” and “informal”) and lack of insurance coverage (Zhan & Chen, 2004). The result is an orientation to informal and family orientated treatment (Spencer & Chen, 2004). Concerns with this group regarding health care are not only the lack of insurance coverage, but also a lack of continuity. Many utilize local clinics on a “need only basis” and fail to seek preventative care or follow up care. Within this context is the failure to see the same doctor on a regular basis. In short, the health of Chinese Americans is threatened by infrequent medical visits owing primarily to cultural and linguistic barriers that form the feedback system that contributes to the lack of health insurance.
In the western mindset, there are two distinct systems of knowledge and practice with regard to medicine; folk or ethnomedicine and biomedicine. In most studies of Chinese immigrant health, discussions of utilization are contextualized in “bicultural models” where, if mentioned at all, “integrated medicine” is applied within the very framework of western beliefs of medicine\(^\text{13}\) (Pang et al., 2003). The category of ethnomedicine includes culturally embedded or “traditional” practices and beliefs that are seen as inferior to scientific medicine. Biomedicine, on the other hand, is seen as scientific, objective and efficacious in treatment and cure of states of illness. A significant difference between these two systems is the view that the former focuses on prevention and the latter focuses on cure. In the folk system of belief of Chinese immigrants, this difference is not beyond their understanding or comprehension and in fact plays a significant factor in health care seeking decisions. Health care practitioners on the other hand, had various levels of understanding and/or tolerance of the combination of these two practices. In the local Chinatown clinic, South Cove Community Health Center, interviews\(^\text{14}\) with physicians revealed a cultural understanding of Chinese health seeking behaviors and the combined use of both systems of medicine.\(^\text{15}\) While these professionals were aware of the potential dangerous interactions between herbals and pharmaceuticals, their cultural competence and tolerance with regard to their patients lead to a more consistent care regimen. It was noted by the clinic physicians that patients would simply go elsewhere for health care if their practices were challenged. On the other hand, those physicians in the larger hospital who view these systems as competing and incompatible, forbade the combined use of both systems and as a result did not see patients who would not select the biomedical model exclusively.\(^\text{16}\) This produces a discontinuity in care and potentially eliminates a significant source of healthcare that is otherwise local and accessible.

Interestingly, the growing recognition of “alternative” therapies and the subsequent benefits offered by insurance companies has had a significant impact on the practice of alternative therapies. The appropriation of certain alternative therapies and not others by the dominant biomedical model has continued the perception of these therapies as “alternative” and not of the same quality as those of biomedicine. Most of the folk practices familiar to immigrants continue to exist on a cash basis and under the radar of biomedicine and insurance companies.

8. Folk categories of use

Perceptions of utility between the two systems impact health seeking behaviors among Chinese Americans. The majority of sources report that many Chinese Americans use both systems of medicine and orient their participation or utilization according to perceived areas of strengths (Guo, 2000; Lam, 2001). This reflects the “consumer” view of medicine prevalent in the medical system of China (Scheid, 2000; Lam, 2001). As the use of integrated medicine is not always possible in the United States, and in fact may be discouraged (Guo, 2000), these categories of utility may be further shaped by adaptation to the overseas context and incorporate western notions of Chinese medicine\(^\text{17}\) encountered prior to immigration (Scheid, 2003; Lam, 2001). However, it should be noted that through China’s social history Chinese medicine incorporates western notions of sickness and healing and these are not in a polarized relationship. There is a continuum
between practices and beliefs. Folk categories of utilization are fairly consistent and illuminate the inherent complexities in acculturation and communication between patient and practitioner in the western model. Significantly, for many Chinese the view of Chinese medical practices reflects their experiences with it as a viable and competitive system of treatment and healing. In fact, Flushing, Queens, New York has a reported five integrated medicine practices (Guo, 2000, p.74) that regularly attend to the Chinese in the city. In another study of Chinese in Houston and Los Angeles, it was found that there were “medium rates” for the use of integrated medicine which included health care in country of origin (Ma, 1999). Also to be included here, is the Chinese Hospital in San Francisco that uses a form of integrated medicine (Kim, 1991).

According to folk usage, western medicine is seen as most useful and efficacious in emergency situations or for “identifiable” illness (Wang, 1996). Surgery, a significant component of western medicine is also respected and in China is an integral element in Chinese medicine (Scheid, 2003). However, Chinese medicine is viewed as most effective in treating many chronic and degenerative diseases. Western medicine is accused of masking symptoms, while Chinese medicine offers a cure in many instances. Chinese medicine is holistic and preventative in nature. Notably, western medications are associated with side effects while Chinese medicine is viewed as natural and healthy.

However, barriers to utilizing Chinese medicine effectively are problems of feasibility of lifestyle in the United States. The cultural environment remains elusive and many Chinese feel that they cannot immerse themselves in the necessary daily approach (Satia et.al., 2000). This health concern involves access to foods and daily exercise.

Another area that needs to be investigated more thoroughly is the culturally embedded views of preventative care. This has significant outcomes on health care expenditures as the perceived lack of preventative care attributed to the Chinese prompts the overuse of emergency resources (Jang, 1998, p.142). As the Chinese are noted for their lack of use of regular and consistent health care visits, health problems tend to escalate until treatment by western medicine becomes essential. This is often taken care of in the emergency room. However, the view of many Chinese is to seek “combined” treatment methods and focus on lifestyle as prevention and maintenance. Tied closely with indigenous views of utilization, preventative measures concomitant with Chinese cultural medical practices are viewed as the frontline defense against illness and disease. However, as the attempts to transplant or more accurately translate Chinese health care/lifestyle practices into the American landscape become increasingly frustrated, it has been noted that this approach falls to the wayside (Satia et. al., 2000) and this population is increasingly living within a cultural milieu in a state of flux for interpreting and recognizing viable avenues for treatment.

Within this context, outreach programs to Chinese Americans in ethnic enclaves have been viewed as a failure according to some community church leaders as well as some physicians. For example, a doctor from a local Boston Chinatown clinic states that these outreach efforts are in fact, a “gimmick.” Indeed, while a major hospital in the area spends significant amounts of money and time during the Chinese festivals printing translated pamphlets urging Chinese women to have a mammogram and undergo breast
cancer screening, the attempts to gain the attention of the target population fails. Further studies focused on this dynamic should be undertaken. However, two factors of indigenous beliefs with regard to medicine and preventative care that may bear on outreach outcomes are that intimate discussions of the body and health are privileged to patient-practitioner interaction and that the enclaves have more pressing and population specific health issues.

9. Economics of uninsured Chinese Americans

Today, medical cost on the national level, in general, is estimated in the trillions. As a significant sector of the population, uninsured Chinese Americans should be targeted for outreach and education. There is an estimated $99 billion spent on health services for the uninsured in 2001. The increase in expenditures reveals the threat of the uninsured to health care facilities in high density, minority areas (see for example Takeuchi et. al., 1998). The Institute of Medicine of the National Academies estimates the following subdivision of expenditures: $35 billion for uncompensated care; $23 billion in unpaid hospital bills; $7.1 billion public expenditures for government grants and direct service programs; $5.1 billion in free or reduced cost care; and $23.6 billion in tax dollars to reimburse hospitals that have a disproportionate share of uninsured patients. The Tufts-New England Medical Center, which is located in the small and generally uninsured Chinatown ethnic enclave in Boston, Massachusetts, incurred in 2005 over $2 million in “bad debt write-offs”, and over $2 million in “free care.” Further, as been noted above, in the case of the uninsured there is an increase in emergency department services. The average expenditure for an emergency room visit was $560 in 2003.

There is a general consensus that preventative care and outreach is a cost effective way to address the growing crisis in American healthcare. In one instance, in the Boston area, Tufts-New England Medical Center through its Office of Community Health Programs took an initiative to reach four of its surrounding neighborhoods under a “Community Health Mission” to examine ways to provide “culturally competent” health care and services. Demographically, the hospital estimates that Asian Americans comprised 44% of the total population reached of 502,849. Two of the communities were predominantly Asian or African-American and Hispanic. This mission sought to educate the communities about the hospital, the importance of preventative care and the American health care system. To accomplish this, the hospital sought the alliance of many of the grassroots political, social and educational centers and groups in each neighborhood. The expenditure for the fiscal 2005 year for all four neighborhoods was $13,726,964. The total expenditure for the Community Health Mission in 2005 for outreach per capita was about $28 dollars. This is in comparison to the estimated $2576 per individual estimated for all of health care expenses (AphF website). Chinatown, under the auspices of the Asian Health Initiative Advisory Committee (also involving Tufts-New England Medical Center) composed of “community leaders and hospital representatives” was targeted to address specific concerns of obesity, hepatitis, Tuberculosis, and hypertension, among other health and social issues. Under the Asian Access Program established in 1994, the hospital seeks to educate the growing Asian community in matters pertaining to insurance, social services, disease prevention and availability of services, among other services.
Many studies call for outreach. This can be clearly an effective way to deal with issues of access and utilization of Chinese Americans. However, “cultural competency,” as an integral part of this process, must be broadened to acknowledge folk categories of belief and there must be a greater understanding of the role integrated medicine plays in the lives of immigrant Chinese. Health practitioners of “grassroots” clinics in contact with the poor in the Chinatowns across America recognize the problems of the two systems of thought and how this informs health seeking behaviors and the feedback system affecting barriers and utilization of health care coverage. Structural and cultural barriers are formidable. In order for outreach programs to be successful, and not viewed as “gimmicks,” they must address the views of the target population as closely as possible and further, reflection on one’s own culture will aid in providing new frameworks for analysis of barriers to health care.

Footnotes

1. I use these terms according to convention. However, it is becoming increasingly appropriate to refer to all systems of medicine as “ethnomedical.” This is supported by introductory textbooks in medical anthropology such as Peter J. Brown (1998) Understanding and Applying Medical Anthropology. Mayfield Publishing Company: Mountain View, CA. p.7.

2. California and Massachusetts, respectively.

3. There is a growing corpus of literature on studies utilizing integrated medicine to cure/treat chronic and degenerative illness such as cancer, diabetes, asthma, and heart disease among many others.

4. According to Johnson et. al., 2004, there are eight “content areas” that have been designated central to the education in cultural competence in most curriculums. These areas are general cultural concepts, racism and stereotyping, physician-patient relationships, language, specific cultural concepts, access issues, socioeconomic status, and gender roles and sexuality.


10. The Boston Chinatown Research Project was funded by the Albany College of Pharmacy.

11. As Scheid (2000) indicates, Shanghai was a significant force during the Nationalist Period with regard to the westernization of Chinese medical systems. The author present in Shanghai, PRC in 1990 and 1991 visited hospitals in the city such as Hua Shan Yi Yuan (Huashan hospital) and Shanghai Shi Di Yi Ren Min Hong Shi Zi Yi Yuan (Shanghai First People’s Red Cross Hospital) and found that both hospitals practiced integrated medicine in various forms. Interestingly, in the latter hospital zhong yao was a combination of Chinese and western medicine such as the mixing in various proportions theophylline and herbals as a treatment for asthma.


13. Pang et al attributes this to the levels of acculturation of the study group. Indeed, acculturation involves the appropriation of such metanarratives as modernization and scientization, even racial hierarchy.

14. Interviews were conducted by the author in 2003 in primarily in English.

15. This is not a claim that these doctors practice integrated medicine. The environment in the United States is not conducive to this practice as the dominant medical practice of the biomedical model remains critical of many ethnomedical practices. However, the tolerance of these doctors reflects the interests of their patients who hail from areas of Asia that view integrated medicine as viable.

16. One physician from the hospital noted that she found those patients who used more than one system were “noncompliant anyway.”

17. Further, it is noted that the challenge to Chinese medicine is also a component of the westernization and modernization process in China and elsewhere.


References


