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Older Chinese Migrants' Experiences of Remote Primary Care in England: Interview Study

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Abstract

Background: Over the past decade, remote (non-face-to-face) services are being increasingly used in primary care, including interactions through telephone and online platforms. These services bring potential benefits as well as potential barriers for patients. Older migrants are a population that could face intersectional barriers when accessing healthcare; it is important to understand the impact of remote services on them.

Aim: This study explores older Chinese migrants' experiences of and attitudes to primary care access through remote services.

Design and setting: This is a qualitative interview study. Participants were self-identified ethnically Chinese individuals over 60 years old, recruitment was carried out through community organisations, social media, and snowballing in 2023.

Methods: Participants were purposively sampled for maximum variation in socio-demographics and backgrounds. Data was collected through semi-structured interviews in English and Mandarin. Interviews were recorded and transcribed verbatim; where recording was not consented to, field notes were taken. Transcripts and field notes were analysed using reflexive thematic analysis. Results were shared with participants for verification.

Results: Nineteen participants were interviewed. Many technical and practical barriers exist for the participants when accessing remote primary care. Due to the different levels of access to resources, these barriers impact the most disadvantaged people the most. In addition, participants feel the need for in-person interactions to address concerns and believe remote services should not replace in-person care.

Conclusions: Overall, older Chinese migrants feel few benefits from using remote primary care services. In the current digital context of the NHS, it is crucial to keep multimodal services available while rolling out new service modes and consider the needs of different populations to ensure equity in access.

Keywords: Transients and migrants, aged, primary health care, digital health, health services accessibility, United Kingdom

How this fits in:

Remote services provide a flexible alternative route of access to primary care but also pose challenges in ensuring equity in access and quality of services. This study explores the perspectives of older Chinese migrants, a potentially disadvantaged population in healthcare access, on using remote primary care. The results suggest this population can face many barriers in using remote services, related to the communication and technical challenges as well as emotional needs during medical interactions. Service providers should ensure face-to-face services remain available and minority populations' specific needs (e.g. interpretation services) are considered and incorporated into service design.

Introduction

Remote services, where the patient and the healthcare professional interact without physically meeting are increasingly common in healthcare (1, 2). Remote interactions could happen through a number of channels, including telephone, mobile apps, text messages, websites. Many of these interactions involve the use of the internet and smart devices (e.g. smartphone, tablet computers), but could also happen purely through telephone. These interactions are not limited to consultations but also include other forms of healthcare access, such as appointment making and prescription management. The COVID-19 pandemic prompted an acceleration in the use of such methods in the UK (3). In 2020, 39.0% of NHS (National Health Services) primary care appointments were carried out over telephone or video calls; in 2024, telephone and video consultations still made up a significant proportion of primary care appointments at 30.6% (4).

Remote services are thought to remove practical barriers such as transportation and providing an easier environment for discussing sensitive topics (5-10). However, those who are less familiar with technology or have limited access to digital devices and the internet are at the risk of exclusion (11-15). In addition, other barriers may interact with technical issues to impact remote healthcare access and outcome (16). For example, health mobile apps are considered more useful by people with higher levels of health literacy (17). People's attitudes towards technology may also be affected by emotions associated with changes in healthcare delivery; a study among older rural residents in Sweden found avoidance of remote care as resistance to what they perceived as retrenchment policies (18).

Older migrants represent a population that may face over-lapping factors influencing their access to healthcare, such as mobility, language, and difficulties navigating the healthcare system (19-21). They may face additional technical and/or sensory challenges; however, they could potentially benefit from remote services by avoiding

transportation and using written messages as an easier alternative to verbal communication (22-24).

According to the 2021 Census, there were over 445,000 ethnically Chinese residents in England and Wales (25); of these people, nearly 57,000 were over 60 years old (26). Residents born in China or Hong Kong totalled over 300,000 in England and Wales (27). Chinese migrants, especially older Chinese migrants, are an understudied population in the UK. Previous research on this population had mostly been conducted in the U.S. (28). Older Chinese migrants face migrant-specific difficulties such as language barriers and issues with navigating a different healthcare system; in addition, unique cultural factors, including the use of traditional medicine and agreement with its values, are found to have an impact on healthcare access for this population within high-income countries (20, 21, 29). This study focuses on older Chinese migrants to explore their experiences in their specific socio-cultural context and in the rapidly changing UK healthcare system.

The aim of the study is to understand older Chinese migrants' opinions and attitudes towards remote primary care through their experiences and provide insights into services improvement to ensure equitable access for this population.

Methods

Recruitment

Participants were UK residents who self-identified as ethnically Chinese, over 60 years old, and born outside of the UK. Participants were recruited from community organisations and social media. Snowballing, where participants were asked to spread words about the study to other potential participants, was also used (30). Participants were purposively sampled for maximum variation in socio-demographics and migration backgrounds. The theory of information power was employed to help estimate the sample size (31); based on the research topic, target population, and analytical approach, we initially estimated that 20 interviews may be needed. Recruitment stopped when all major topics of interest had been explored.

Data collection

Data were collected through in-person and telephone semi-structured interviews in either English or Mandarin. Interviews were audio recorded with the participant's consent. Where the participant did not consent to recording, field notes were taken. The interviews were conducted from December 2022 to May 2023.

A topic guide (Supplementary Box 1) was developed based on previous literature, Levesque's access to healthcare framework (32), and input from public and patient

involvement activities; key topics were experiences and opinions of primary care, assistance during healthcare access, alternative medicine, and suggestions for services. As interviews were carried out, the topic guide was continuously modified to reflect new areas of interest.

Data analysis

Recordings were transcribed verbatim into the interview's original language by the interviewer (HG). The transcripts were analysed alongside field notes. We took a constructivist stance and used Braun and Clarke's steps of reflexive thematic analysis as a guide for the analytical process (33). We explored the impact of remote services on primary care through the lens of the healthcare journey proposed by Levesque et al (32); optimal access consists of the whole process from realising healthcare needs to meaningful engagement in care. Although we referred to Levesque's framework for healthcare access to define access and guide the research (32), we employed an inductive approach to data analysis to deep dive into the socio-cultural context.

The transcripts were analysed without translation by a bilingual researcher (HG) and coded directly in English over three rounds at different orders. The codes were categorised and discussed with the research team (GR/RF/FB) for shared concepts and themes; final themes were generated through several iterations of this process. Excerpts of the original transcript were translated into English to aid discussion. In addition to the themes generated, we also mapped out the participants' accounts, as presented in the results, and the respective user or provider characteristics that impacted the healthcare access journey according to Levesque's framework. This map is presented at the end of the results to provide a summary of the results from the 'healthcare journey' perspective while the themes highlight their significances for participants.

A summary of the results with supporting quotes in both English and Mandarin were sent to participants for checking; we did not receive any additional input or request for change.

This study was approved by the research ethics committee at University College London, reference: 23187/001.

Research team and reflexivity

The research team consists of a doctoral researcher, who was the interviewer, and three senior researchers. The interviewer is female, originally from China, and speaks both Mandarin and English. The researcher felt that the common ethnic identity helped to build rapport with research participants, especially female participants. Some

participants particularly shared thoughts from a migration perspective, commenting on whether NHS services make England a better or worse migration destination.

Results

Participant characteristics

Interviews were conducted with 19 participants (Table 1). There were 13 female participants and the median age was 73 years. Where quotes are presented in this article, participant characteristics are summarised in brackets. M or F represents gender, followed by a participant number and the age.

Table 1: Study participants' characteristics

Characteristics	Number of participants (n=19)
Gender	
Female	13
Male	6
Age in years	
60~64	4
65~69	1
70~74	8
75~79	6
Time in the UK	
>40 yrs	11
20~40 yrs	6
10~19 yrs	0
5~9 yrs	1
<5 yrs	1
Education	
Primary school	3
Middle school (years 7-9)	1
High school (years 10-12)	6
College or above	9
Place of Birth	

Hong Kong	6
Mainland China	4
Malaysia	7
Thailand	1
Cambodia	1
Place of residence	
Greater London	16
Birmingham	1
“Small towns” (name not given)	2
Recruitment setting	
Community organisations	12
Snowballing	5
Social media	2
Interview language	
English	11
Mandarin	8
Interview setting	
In person	15
On the phone	4

Theme 1: The practicality of accessing primary care through remote services

Participants described various ways they have interacted with healthcare professionals remotely, including telephone conversations, website-based forms, mobile apps, and text messages. Most participants use a combination of telephone and online services; consultations mainly happened over telephone with complementary online services (e.g. online record of appointments). This theme discusses participants’ general attitudes towards technology, technical skill, as well as the specific challenges in the context of healthcare access.

When asked about their thoughts on smart devices and the internet, participants agreed that they were commonly used and a part of everyday life in society, that *“yeah, smartphone, everybody got phone nowadays, one or two normally, in the pocket, yeah?” (M19, 74 yrs).*

However, participants mentioned that some older people may still have limited access to smart devices or the internet, especially when the cost of smart devices present an additional barrier.

> *"For a lot of people over 60, not everyone has internet all the time… like my dad, he has a landline phone upstairs… there's no internet up there." (F8, 61 yrs)*

Most participants said they were confident with frequently performed tasks, such as contact with family and friends, entertainment, and obtaining information.

On the other hand, accessing healthcare remotely was considered a more complex task. Learning to access healthcare services through remote channels posed a challenge, which could deter people from using certain remote modalities:

> *"Technology, I think sometimes is, also very lazy to learn, I've got an iPad, only I used it for certain things, I'm quite happy with that... I suppose if I wanted to I can Skype the doctor, make an appointment and see the doctor face-to-face, you know, that way I can, but sometimes is so much... I've never tried it, never occurred to me to try." (F12, 76 yrs)*

Answering the call from GP surgeries was not always easy. Several participants mentioned the struggle to be ready all the time due to the uncertainty of call times. They feared missing the call and hence missing their appointment:

> *"Then you have to wait for the doctor's call, they cannot promise you I will ring you in the morning or not, you have to stay, you bring your mobile phone into the toilet, in case…" (F6, 74 yrs)*

Sensory conditions such as declining eyesight or hearing presented additional barriers to using certain devices.

> *"I don't like using the phone, the screen is too small, ahh… when looking at the website on a computer, well maybe my eyes aren't that good now with the age, I could see when the print is large… and the [GP appointment] website is designed to have you read a lot of text first." (M4, 61 yrs)*

Despite the difficulties, the use of remote services was not completely without its merits. Participants noted that being able to access their GP remotely could benefit people who had problems traveling to the GP or were working, although these conditions did not always apply to them.

> *"But also, it will be beneficial for people who live far away, I think. When you have problem travel to your GP, I think communication like this is excellent for them... I'm just aware that it doesn't convenient me, but I also see that it might be convenient for other people." (F5, 74 yrs)*

Theme 2: Widening inequities

For older migrants who already faced difficulties accessing healthcare, for example due to language barriers and difficulties, remote communications exacerbated language problems. It is harder for non-native speakers to communicate without visual cues on the phone, especially with technical terms.

> *"Because for a lot of Chinese they aren't completely fluent in the language... for locals, when they communicate, they don't have any problem on the phone... And because of the local accent, in that scenario, you can't call it language problem, but an accent problem, it's harder to understand." (M4, 61 yrs)*

A participant who acted as an interpreter for the local Chinese community centre mentioned that interpretation was less engaging over the phone compared to in person, especially when the call wasn't appropriately set up for a three-way conversation because it was arranged last minute:

> *"Of course not the same isn't it, not the same in the sense that I can't see what the situation, the patient's at the hospital, yeah, so it's not properly arranged I suppose, if you're proper, like arranged by the hospital, I think there's a 3-way conversation, yeah, but for me because it's last minute things." (F16, 63 yrs)*

With written English, the use of technical terms on websites and the need to write free-text answers also posed a challenge for non-native speakers.

> *"That [online form] feels like composition, maybe it's easier for British people, but for foreigners, like us, although I've been here 30 years, some words you say more, but not for reading or writing, so you know, it feels like composing an article to me." (F8, 61 yrs)*

In addition, many of the practical barriers mentioned in theme 1 require social resources to overcome; remote services hence widened inequities in socio-economic resources. Some migrants can easily mitigate difficulties by seeking help from personal or community networks; however, this source of assistance was not guaranteed for all.

> *"Oh, I'm computer illiterate, everything my children does it for me, I don't have to lift my finger." (F11, 72 yrs)*

> *"Because some family have grandchildren to help, I live on my own, I don't have children, I can't, I don't have anyone to borrow, and my neighbours, they're so busy, they don't offer help, you know." (F5, 74 yrs)*

Another participant pointed out that the different forms and sizes of local communities affected available support and resources. Members of established and larger communities could access more help.

> *"We've been here for a long time, what about some of the new groups, you know? How are they finding the situation, and they won't have community centres to come to… Chinese are considered quite established, yeah. Our network, they contact us and the doctor knows us, professionals know… So we are I suppose stronger in terms of providing support for our community, well established, the network." (F16, 63 yrs)*

The reasons for migration and socioeconomic status add additional layers to the overlapping inequities. Migrants with less education took less skilled jobs and could become more dissociated from mainstream society. For them, learning to adapt to new services were harder as they had little resource for information and learning.

> *"I think there are two groups of people over 60, some came as elites, they were PhD, they came to work in universities, and they have no problem. Others are like me, traditional medicine, restaurants, small businesses, how are you going to learn? Who's gonna teach you?" (F8, 61 yrs)*

Theme 3: Necessity of in-person interaction for medical concerns

Depending on the type of healthcare interaction, and the individual's perception of what is needed to fulfil the purpose of the interaction, in-person interactions may be considered an integral part of care.

The need for healthcare can vary depending on personal beliefs and preferences; these preferences sometimes relate to cultural backgrounds and an individual's level of agreement with them. Some participants mentioned using traditional medicine for their everyday ailments or bruises, and only turning to GPs for serious concerns. In this case, face-to-face interactions are important.

> *"I usually take herbs… and then sometimes it still not working, and that's when I go see GP…it's a psychology, you know, I have to see someone and talk to someone." (F5, 74 yrs)*

Expectations for primary care also relate to personal attitudes towards the internet and the authority of clinicians in healthcare. In contrast to participant F5, another participant said they were comfortable searching for information online and making decisions themselves. They perceived consultation as a way of obtaining referrals and preferred the simplest form of care delivery.

> *"That's my understanding, it's not whether I need you [the GP], I know what's going on, maybe if I spend more time searching it's better. The role of a GP for me now is, well, I have to go through you to get a referral, after GP [consultation], right?…I like, just a voice call is fine, if I want to show the GP something on me,*

I'd do a video call, if it's just description then a voice call, the simpler the better" (M10, 60 yrs).

Most participants expressed that when approaching healthcare regarding new concerns, the GP was needed for care, direction, and reassurance. Trust-building and personal connections were considered necessary for healthcare. The role of the GP was complex and personal; it represented a figure the participant could fully rely on for reassurance. Trust building and human connection in a GP consultation was not always realised when receiving care remotely.

"But for medicine, other things can be remote, like buying stuff, selling food, or other things, there are no emotions involved, these things don't involve feelings, but for doctors, I feel there is, um, there are emotions, other than feelings there's also the issue of trust or not trust, so I don't know, I can't really accept this [remote service]." (F8, 61 yrs)

An in-person visit to the GP offered more certainty of being taken seriously and cared for in the forms of non-verbal cues and physical examinations. This offered further reassurance for patients who may feel unsure about their condition and the next steps.

"At least face-to-face they really can see your problem, like my coughing, when I talk to them at the beginning they don't really got it, I believe they will just say, uh, because all this cold eventually will go away... I must say that when you got a cold you go in and see, then they always listen to your chest." (F14, 76 yrs)

Although the vast majority of participants preferred in-person consultations, they said they would be okay performing repeated tasks online, such as ordering prescriptions with delivery services; this service was considered a more convenient alternative to traditional prescription management.

"It's just that I, my prescription, now I do it online, because for the prescription just saves a lot of time, yeah, and then the GP will send the prescription direct to the pharmacist, then I gotta pick up my prescription, and that's good." (M9, 77 yrs)

Theme 4: A replacement of face-to-face services

During the COVID-19 pandemic, remote services were used more widely because face-to-face interactions were restricted. However, after these restrictions had been lifted, some participants expected face-to-face services to return to pre-pandemic levels.

"I mean the spot of GP is in the surgery, with appointment we turn up and see them, COVID is nearly gone, alright, if they scared, we wear mask, yeah? They can wear mask. But let us go and see them." (F7, 72 yrs)

Instead of becoming an alternative option to face to face services, remote services remained the only option to access care for many participants. The inability to make appointments face-to-face was frustrating for some participants, who often made the journey to the practice because they had encountered difficulties with contacting the practice remotely.

> *"And one morning, I was there, I went to make an appointment, I said help me make an appointment, I want to see the doctor, [they said] call tomorrow morning, I mean, I was there in person! [If I] call them the next morning at 8, the call won't go in, how can they do that? Because they tell everyone to call at 8, everyone is calling, and I am here in person, they just won't make an appointment for me, just no, it has to be over the phone." (F17, 78 yrs)*

Another participant worked for a local community centre, hence often made GP appointments on behalf of older Chinese people who lived in the community centre's charity housing. She was frustrated that she had to complain several times for the surgery to make adjustments:

> *"I got really upset, said look, these are the way I called for the past few days trying to make appointment every time, because I waited 40 minutes, 50 minutes, I give up, you know?…I said maybe may I suggest we forget, I can walk up to make the appointment, maybe it's better than me holding up the phone." (F16, 63 yrs)*

After appointment-making, the first contact with the GP was often a remote consultation: *"I think for this particular surgery, I think they always, the initial, the first time they like to give phone consultation, after that, yeah, they will decide." (F16, 63 yrs)*

While some participants had a smoother experience of seeing their GP face-to-face after an initial remote consultation, others encountered difficulties that made them feel they were being actively prevented from face-to-face services; to those who did not see remote services as an equal alternative to face-to-face services, this meant the NHS did not want them to receive healthcare.

> *"The best is, they hope you don't see any GP." (M4, 61 yrs)*

> *"Stupid, no good, after COVID they will prefer you dying than seeing you." (F6, 74 yrs)*

Notably, the mode of consultation appears to be predominately decided by the GP surgery; few participants mentioned that their surgery would ask for their preference at appointment making, although what they received did not always align with their preference. Overall, they feel passive in deciding the mode of service. *"...how do you*

want to be seen, or do you have a telephone conversation, but sometimes you put to be seen, they'll still put telephone conversation." (F11, 72 yrs)

Overall, the unavailability or limited availability of face-to-face services were received negatively by participants and seen by some as the NHS failing to fulfil their responsibilities.

Remote primary care from a patient journey perspective

We mapped our findings onto the healthcare access journey proposed by Levesque et al. to summarise which provider and user characteristics may influence the use of remote services for primary care, shown in Figure 1.

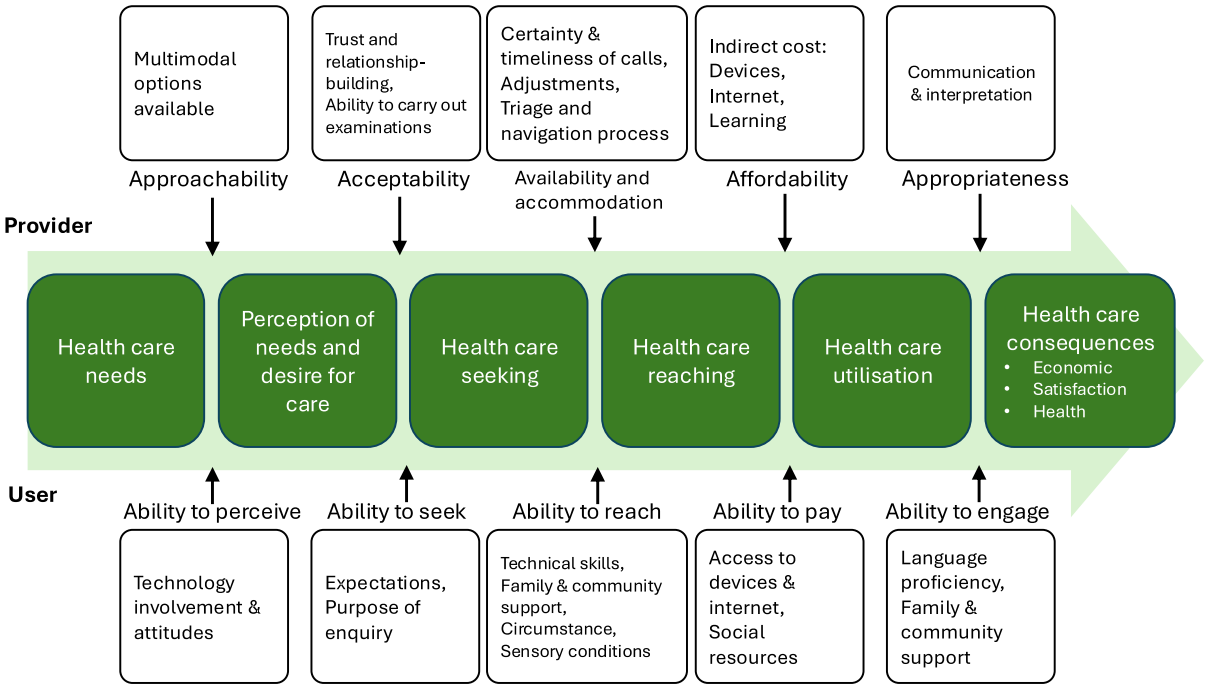

Figure 1 Factors influencing older Chinese migrants' use of remote primary care mapped onto Levesque's framework (32)

A number of provider and user characteristics are shown to impact the journey of accessing remote primary care in the interviews. People will only interact with remote services if they are aware and hold an open attitude towards such modalities; GP surgeries should present multiple channels to accommodate different choices. Remote services may be deemed unacceptable depending on the patient-clinician relationships and the medical nature of the enquiry. An individual's ability to reach the service can be influenced by their technical skills, sources of support, sensory conditions, and personal circumstances. Surgeries that provide reasonable adjustments and adhere to timely delivery of services will make reaching care easier for patients. Although NHS services are free at the point of delivery, several indirect costs can be generated in the process.

During a remote clinical interaction, linguistic barriers are a particular challenge for migrants.

Discussion

Summary

Older Chinese migrants considered remote primary care services a contingency solution during the COVID-19 pandemic; most of them did not think remote services benefitted them. Practically, remote services can be difficult to navigate, and the benefits of such services were not seen as applicable to them. The need for trust building and personal interactions was not always fulfilled during remote interactions. Remote services were perceived as being less good quality compared to traditional face-to-face interactions and exacerbated inequities.

Strengths and limitations

This study covers a population that has received little attention, providing a unique perspective on the role of remote services in primary care access in the UK. The recruitment took a maximum heterogeneity approach. Participants were from different countries, social backgrounds, migration circumstances, and with different English proficiency levels. However, some subgroups of the population might still be missed from the study.

Although efforts were made to reach Chinese communities outside of London, most participants lived in or near London. As a result, most experiences were from urban areas. In addition, London has a large overall migrant population (34), with more community resources and better support for migrants from diverse backgrounds. The findings of this study are hence not as transferable to ethnic minorities and migrants in non-urban settings. Most participants had been in the UK for more than 20 years, there was limited data to explore the experiences of very recent migrants.

None of the participants required assistance for mobility and none spoke about difficulties in physically visiting the GP, hence there was no opportunity to explore how someone with mobility issues may feel about being able to access care without traveling.

The interviews were done in Mandarin and English; although given the option to bring an interpreter, no interviews were conducted with Cantonese-only speakers. Given the wide-spread use of Mandarin in Chinese ethnic migrant groups (from mainland China, Taiwan, Malaysia, etc) (35), Cantonese-only speakers are often early migrants from Hong Kong, representing a potentially more marginalised group (36).

Comparison with existing literature

Many of the concerns and challenges with remote primary care mentioned in this study were shared among older adults and other migrant populations. Studies have shown that remote consultations are favoured by non-migrants, more affluent and educated individuals, and working-aged people; older people may be more likely to encounter technical difficulties (37-42). The concerns over patient-physician relationship were shared across age groups and by both service providers and users (13, 43, 44). A survey with a non-age-restricted sample (17-97 yrs) in the UK showed that people thought remote primary care was convenient but could also generate additional anxiety due to the lack of in-person communication and physical examination (45). In general, remote communications seem to work better with established relationships and for minor issues (22, 24, 43, 46, 47), in agreement with the findings of this study.

Language is a common barrier for non-native speakers that is potentially exacerbated by remote services. Studies in France and the UK have found that non-native-speaking patients can face multiple levels of difficulties in primary care access due to language barriers (48, 49). While remote interpretation can be an accessible solution, careful planning and organisation is required to delivery these benefits (48, 50).

Studies on Chinese migrants often focused on traditional values, cultural preferences, and the use of traditional medicine (20, 28, 29). Findings of this study reflect some of these elements, for example the use of family assistance and traditional medicine; however, there is considerable variability in attitudes towards cultural concepts among participants. While it is important to acknowledge ethno-cultural factors for migrants, it is equally important to avoid harmful stereotypes and alienation of migrants in healthcare and health research.

Implications

Difficulties in navigating remote services and accessing face-to-face care have been frustrating for many older Chinese migrants. These difficulties are likely to apply to other migrant groups, older people, and marginalised communities. Given the variation in digital literacy, device and internet access, language proficiency, and preferences, it is crucial to maintain the availability of face-to-face access and consider what modality is most appropriate for which circumstances.

Our findings highlight the importance of understanding service users' experiences and needs during healthcare service design. Service providers need to acknowledge and find ways to accommodate the needs for different populations to ensure equitable care. For example, language is a particular challenge for migrants who speak English as a second language (51). Policy makers and healthcare providers need to evaluate the current framework for interpretation services and ensure proper communication for both

remote and face-to-face access. Future participatory research that engages underrepresented groups such as migrants and ethnic minorities will be useful for optimising the delivery of inclusive services in a digital era.

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