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The dragon and the snake: health practices among Chinese in the UK from an inter-disciplinary perspective

Joanna Long[a]*, Paula Byrne[a], Mark Gabbay[a], Lucy Frith[a] and Ian Fletcher[b]

[a]*Department of Health Services Research, University of Liverpool, Liverpool, UK;* [b]*Division of Health Research, Lancaster University, Lancaster, UK*

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Objectives. This paper explores how ethnicity has been represented in research on the health practices of Chinese populations in the UK and suggests ways in which such research might be enriched by adopting an interdisciplinary approach.
Design. A systematic literature review of studies was conducted on research with 'Chinese' in the UK.
Results. The review highlighted that research with Chinese populations is frequently grounded in assumptions about the homogeneity of Chinese ethnic and cultural identities, and health practices, which undermines the generalizability of findings and conclusions.
Conclusions. There was a lack of clarity surrounding the term 'Chinese' as an ethnic and national label that can lead to racialised constructions of ethnicity. An interdisciplinary approach is a valuable tool for enriching understandings of culturally-specific accounts of health and illness, and to address ways in which Chinese populations negotiate different health care systems and models of health.

Keywords: interdisciplinarity; critical ethnicity; everyday health practices; medical epistemology; Chinese; migration

Introduction

Health is known to be stratified by ethnicity (Nazroo 1997; Erens et al. 2001; Sproston and Mindell 2006), both in terms of the incidence of particular diseases, such as different cancers (Jack, Davies, and Møller 2009; NCIN 2009), and by the low or late utilisation of health services (Blackman and Masi 2006; Burns et al. 2007; Smaje and Le Grand 1997). Public institutions have a legal and ethical obligation to address such inequalities, to ensure equal treatment for equal need across all population groups (Home Office 2010). However, fulfilling this requirement is difficult in a multicultural society (Bhopal 2009). Moreover, research into ethnic inequalities in health cannot be based on ethnicity alone, as this risks essentialising and racialising genetic and cultural differences between groups (Bhopal 1997; Bradby 2003) and ignores the other causal mechanisms that intersect with ethnicity to influence health, such as class, income and racism (Smaje and Le Grand 1997). Rather, a multi-faceted approach to the issues surrounding ethnic inequalities in health is required. That is, an approach which addresses not only the structural factors

*Corresponding author. Email: j.c.long@liverpool.ac.uk

surrounding ethnicity, but also the flexible, multiple nature of the identities that make up ethnicity and the role of socio-economic class (Nazroo 1998).

This article explores these issues through one particular group: the health practices of 'Chinese' populations in the UK. The inverted commas are intended to encourage caution around uncritical use of 'Chinese' or 'Chinese people', which obscure the heterogeneities among people of Chinese ethnic and national origin (Payne et al. 2005, 2008). Other terms are equally problematic: 'Chinese community' implies a cohesiveness to a local Chinese population that may not exist (Young 1990); 'Chinese-origin' emphasises past over present, and assumes that supposed 'origins' are both straightforward and enduringly influential; 'ethnic Chinese' risks racialising participants as something people *are* rather than an identity to which they relate; 'Chinese-identifying' or 'those who self-identify as Chinese' is fitting but cumbersome (Prior, Chun, and Huat 2000; Waller et al. 2009). We use the term 'Chinese populations' to encompass self-identification as Han Chinese[1] from a range of countries e.g. People's Republic of China (PRC), Taiwan, Hong Kong, Malaysia, etc. The rationale for focusing on Chinese populations is that this group is the fastest-growing ethnic minority population in the UK (Office for National Statistics 2013). But, they are a relatively under-researched group in terms of health practices and experiences of health care. As an interdisciplinary team of researchers, we are also concerned with the social, cultural and historical aspects of Chinese populations in Liverpool and Manchester, due to Liverpool's status as one of the first Chinese communities in the UK and Greater Manchester's large Chinese population (Office for National Statistics 2013). Furthermore, as we will illustrate in this paper, although Chinese populations are often referred to as if they are a homogenous group, the size of the PRC and the variety of nationalities, cultural groups and ethnicities that fall under the label 'Chinese' make this group an excellent exemplar of the complexities of ethnicity and the need to challenge assumptions and stereotypes.

Although there are sizeable Chinese populations in London and Manchester, this group is often framed as 'hard to reach' due to their wider geographical dispersal, something which may be partially explained by socio-economic trends. Chinese populations have historically worked in family-run catering businesses, often established with limited capital and located in places with few or no other Chinese food outlets in order to maximise chances of success (Chau and Yu 2001). This makes finding and providing services for Chinese populations in the UK difficult (Wong 2006; Tran 2006; Watt, Howel, and Lo 1993). There has also been a self-perpetuating misconception of Chinese populations as 'self-sufficient' and 'independent' by UK authorities (House of Commons Home Affairs Committee 1985). However, Chinese populations' migration networks are strongly based on family and village ties to provide funding for and information about job opportunities, documentation and procedures for establishing a business (Pieke et al. 2004). Moreover, poor or absent English-speaking abilities reinforce this reliance on these networks, particularly those with better language skills, to translate official information and liaise with health professionals (Fountain and Hicks 2010). This lack of direct access to information is one explanation offered for Chinese populations' under-utilisation of services, which perpetuates stereotypes of a 'closed', 'self-sufficient' and 'independent' group (Wong 1989, 92). It is more difficult to conduct research in participants' language of choice, as is recommended, because Chinese populations are a heterogeneous group both in terms of language and place of origin (Prior, Chun, and Huat 2000). The cultural sensitivity to certain kinds of health issues, such as mental health, can

also make it difficult to recruit participants (Green et al. 2000). Thus Fountain and Hicks (2010) assert that 'Chinese' are 'hard-to-reach' mainly from the perspective of investigators without the necessary resources of time, language skills and connections to access the desired information. In general, the barriers to research with Chinese populations in the UK are similar to the barriers between public health services and Chinese populations. We reviewed the existing literature on health practices and experiences among Chinese populations in the UK, to explore the following research question.

What are the health practices and experiences of Chinese populations in the UK?

The authors' expertise in the following areas such as human geography, psychology, sociology, primary care and medical ethics facilitated a holistic response to the research question via their interdisciplinary lens.

Methods

Literature review

A literature search of existing peer-reviewed and grey research on the health needs, practices and experiences of Chinese populations living in the UK was conducted (July 2013) through keyword searches of multi-disciplinary electronic databases: MEDLINE, PsychINFO, Anthrosource, SCOPUS and EBSCO Discover. The search was guided by the general principles recommended by the Centre for Reviews and Dissemination (2009) to ensure rigour and transparency. The search combined index terms and free text words based on synonyms of a combination of relevant components: 'Chinese','health', 'UK' or 'Great Britain'. MESH terms and APA headlines were utilised to include relevant subheadings and to ensure that searches were comprehensive e.g. chinese cultural groups, health surveys, England, etc. There were no date restrictions but limits were applied to include only materials in English language. Specific search syntax for each database is available upon request from the authors. Searches were conducted across the following topics: migration and health; health literacy; Chinese medicine; Chinese migration; flexible citizenship and globalisation; Chinese in Liverpool/Manchester/UK. The search for empirical studies was augmented with searches for theoretical discussions of ethnicity, health and migration. Additional hand searches of relevant journals were conducted, followed by a search of the reference lists of all included books with a search of the authors' own files. The results were visually scanned for titles and contents related to the topic of interest. Reference lists of included articles were also examined to determine that no relevant papers were overlooked. A total of 152 resources were identified from the initial searches and all the titles and abstracts or summaries were read to identify articles relevant to the review, with uncertainty being resolved by discussion between the authors. A total of 20 studies with Chinese participants were identified. Of these, 13 studies met the inclusion criteria of: primary data collection (qualitative and quantitative), Chinese populations, data collected in the UK, and were selected for detailed review (see Table 1). Data from each full text paper were extracted by the first author (J.L.), and the findings were verified by a co-author (I.F.) to ensure that appropriate, consistent and matching data were collected. Data obtained from each included study were critically analysed to determine whether they addressed the research question (see Appendix 1). Most studies were relatively small scale (one study >500 participants) and employed a mixture of qualitative and quantitative methods, mainly survey questionnaires, interviews and focus

Table 1. Overview of reviewed studies and key findings.

Published studies	Authors	Findings
(1) Elderly people from ethnic minorities in Liverpool: mental illness, unmet need and barriers to service use	Boneham et al. (1997)	• Low level of service use despite considerable unmet need • Main barriers to service use included lack of knowledge about services and perception of services as culturally inappropriate (language issues)
(2) Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005–2008	Fountain and Hicks (2010)	• Stigma of mental illness a barrier to help-seeking • Taboo among older Chinese people on sharing negative emotions • Language as barrier to help-seeking; opportunities to improve skills limited by working hours • Usage of TCM among Chinese study participants • No preference to be cared for by professionals from the same ethnic background
(3) a. The health beliefs of the Chinese community in England: a qualitative research study b. Health and identity: the case of the Chinese community in England c. Social representations of health and illness: the case of the Chinese community in England	a. Gervais and Jovchelovitch (1998a) b. Gervais and Jovchelovitch (1998b) c. Jovchelovitch and Gervais (1999)	• Social representations of health and illness are related to cultural identity • Chinese community in England exhibits hybrid representation that combines Chinese traditions and Western Medicine • Hybrid representation of health and illness attributable to impact of globalisation on cultural identities
(4) a. Mental health of Chinese women in Britain b. 'We are not completely Westernised': dual medical systems and pathways to health among Chinese migrant women in England c. Is the English National Health Service meeting the needs of mentally distressed Chinese women? d. Chinese migrant women and families in Britain	a. Green et al. (2000) b. Green et al. (2006) c. Green et al. (2002) d. Lee et al. (2002)	• Participants use both Chinese and Western medical systems in order to overcome barriers when accessing health care • Communication between Chinese service users and health care professionals impeded by lack of common language and absence of shared concepts of causes and manifestations of health and illness

Table 1 (*Continued*)

Published studies	Authors	Findings
(5) Barriers to meeting the mental health needs of the Chinese community	Li et al. (1999)	• Delay in contacting health professionals when ill, even if registered with GP • GP not always the first port of call when ill • Majority encountered difficulties when seeking professional help, including language barriers, lack of access to bilingual health professionals, different perceptions of symptoms and lack of knowledge about services • Service users experienced of stigma and ignorance regarding mental illness from other members of Chinese community
(6) Older Chinese people's views on food: implications for supportive cancer care	Payne et al. (2008)	• Chinese participants considered certain foods to be therapeutic/risky for health, as well as and supportive/comforting • Participant concerns about hospital admission linked to a lack of Chinese food provision in hospitals and general poor quality/unsuitability of hospital food
(7) Beliefs and accounts of illness. Views from two Cantonese-speaking communities in England	Prior, Chun, and Huat (2000)	• Cantonese speakers mobilise range of agents (TCM, spirits, demons, food, weather) in order to describe and explain bodily and mental wellbeing • Better to focus on 'accounts' rather than 'beliefs' about health, as former are publicly available and verifiable
(8) a. Medical pluralism of the Chinese in London: an exploratory study b. Health behaviours and the use of Traditional Chinese Medicine among the British Chinese	a. Rochelle and Marks (2010) b. Rochelle and Marks (2011)	• Concurrent use of WM and TCM was common • NHS considered difficult to use due to concerns about language barriers, problems communicating with and trusting health care providers • UK TCM perceived to be aimed at non-Chinese market • Concerns about regulation of UK TCM practitioners

Table 1 (*Continued*)

Published studies	Authors	Findings
(9) a. Health and lifestyles of the Chinese population in England b. The use of primary care services by the Chinese population living in England: examining inequalities	a. Sproston et al. (1999) b. Sproston, Pitson, and Walker (2001)	• Lower-than-average reporting of long-standing illness or disability • Stress considered by many to be main detriment to health • Food considered by many to be main supporter of health • Less likely than general population to consult GP, but English speakers more likely to consult GP than non-English speakers • Few took interpreters to GP consultations and very low provision of interpreter by GP surgery • Use of TCM evident but not widespread or frequent; more common among older age groups, those born outside UK and those with poor English-speaking skills • Majority not involve in Chinese community centres
(10) Health needs of the Chinese in Shropshire and Telford and Wrekin	Tran (2006)	• Language and concepts of health major determinants of how people seek and use health care • Lack of awareness about translation and interpretation services • Lack of awareness about health services • Some participants unable to visit GP because of inflexible surgery hours • Need for culturally aware health care (particularly in mental health)
(11) The health care experiences and health behaviour of the Chinese: a survey based in Hull	Watt, Howel, and Lo (1993)	• Sub-optimal use of health services among participants • Language/communication difficulties cited as main reason for low uptake of services

Table 1 (*Continued*)

Published studies	Authors	Findings
(12) Chinese in Burton and Southeast Staffordshire: a baseline community needs assessment	Wong (2006)	• Health service providers and users find one another 'hard to reach' • Language barriers cited by participants as making services 'hard to reach'
(13) Overseas Chinese students in the UK: patterns and correlates of their use of Western and traditional Chinese medicine	Bishop et al. (2009)	• International Chinese higher education students use TCM and WM • Further research needed

groups. Recurring themes across all the study findings included language as a barrier to health service uptake; low awareness and uptake of interpreter services; the dual use of Traditional Chinese Medicine (TCM) and Western Medicine (WM); an emphasis on the role of food in maintaining health, getting ill and aiding recovery from illness (see Table 1).

Results

The first investigation identified in the review was published in 1993, with only four studies originating in the 1990s (1, 3, 5, 9). The majority of articles were published from 2000 to 2012, with one study overlapping both decades (9). This relatively small body of literature illustrates that research with Chinese populations in the UK remains exploratory in nature. This exploratory phase was apparent from researchers primary focus on the health needs, experiences and health-related behaviour of Chinese populations to gain an understanding of the area, which continues to be an area of interest in recent papers (2, 8). Mental health was an area of health that received attention, particularly the mental health of women from Chinese populations (1, 2, 4, 5).

The 13 reviewed studies exhibited a high degree of consistency regarding issues of language, medical pluralism and food.

Language

Eight studies reported language difficulties acting as a barrier to health service uptake among Chinese populations due to individuals' concerns about their ability to communicate with health care professionals, which led to a lack of common understanding about symptoms, treatment and health concepts. At the organisational-level language barriers manifested as lack of access to interpreters and information about services in Cantonese or Mandarin, resulting in a reduced awareness of the availability of different services (1, 2, 4, 5, 9, 10, 11, 12).

Medical pluralism

Evidence of the dual use of TCM alongside WM was identified across eight studies (2, 3, 4, 6, 7, 8, 9, 13), with 25% of participants reporting personal use of TCM in the UK (13). There were recurrent themes arising from the studies that participants perceived these two health systems as appropriate for differing aspects of health, that is, TCM for emotional and somatic conditions with an expectation that they are not separate entities, whereas the primarly focus of WM is on physiological treatments. There were concerns experessed regarding the regulation and costs of TCM treatments in the UK, in addition to negative perceptions about the cultural appropriateness of WM (2, 3, 4, 7, 8, 9).

Food

Long established traditions that particular foods have health-promoting or health-damaging properties were highlighted by participants in two studies (6, 9). The overwhelming majority (68%) reported that food was the most important factor for maintaining good health in a primacy care study (9). The themes reported from an

investigation focused on food and cancer care highlighted the therapeutic and comforting aspects, as well as potential risks of certain foods and the lack of culturally appropriate hospital meals (6).

However, in addition to these consistencies in findings across the studies, there were some underlying assumptions that limit the generalisability of the findings across Chinese populations, assumptions that centre on the homogeneity of 'The Chinese' in the UK and a lack of engagement with migration history.

Few studies contextualised their research with the histories of Chinese population migration to the UK (4, 5, 9, 11), which developed in earnest after the establishment of Hong Kong as a British colony in 1841 and British shipping merchants' exploitation of this new source of 'cheap, docile and expendable coolie[2] labor' (Pieke et al. 2004, 39; Parker 1998; Skeldon 1996). Hong Kong's Commonwealth membership kept migration routes relatively open to the UK until the Immigration Act of 1962 (Parker 1998). Hence, the majority of Chinese population migrants to the UK are from Hong Kong and the New Territories (Pieke 1998). In the 1960s and 1970s, widespread political changes in Southeast Asia, led to waves of migration including ethnic Chinese populations. PRC's political and economic policies over the last 30 years has seen an increase in political asylum-seekers, undocumented migration from Fujian province, as well as the movement of more affluent, educated urban-dwellers from parts of Northern China (Pieke 1998; Pieke et al. 2004). In addition, since 2000 there has been a worldwide increase in Chinese international students choosing to study overseas e.g. North America, the UK, and Australia. This group of temporary migrants are usually classified as 'sojourners' in the migration literature. Currently the largest category of overseas students in the UK is classified as 'Chinese' with over 90,000 originating from mainland China and Hong Kong.[3]

Although few studies discuss Chinese populations' migration histories in any detail (4, 5, 10, 12), some report on Chinese populations' diversity by noting the different geographical origins of participants e.g. mainland China, Hong Kong, Taiwan, southeast Asia and the UK (3, 4, 6, 8, 11), or by highlighting participants first language e.g. Cantonese, Mandarin, Hakka, Hokkien, Shanghainese, See Yip, Vietnamese and English (2, 4, 6, 8). Indeed, in many of the studies great care was taken to cater for participants' linguistic needs by ensuring a linguistically-appropriate researcher or interpreter aided data collection (1, 3, 4, 5, 6, 8, 9, 10, 11, 12). Valuable as these efforts are in acknowledging and accommodating diversity within the research methodology, they were often undermined by a lack of specificity about dialect (3, 8) and subsequent generalisations about 'the Chinese' or 'the Chinese community' in the analysis and discussion (3, 5, 6, 8, 12). No study questioned why Cantonese was most prevalent among their research subjects, how other patterns of language use had come about or the role of migration history. The implications of ignoring these questions become clear when recruitment methods are considered in more detail.

It can be challenging to access research participants from Chinese populations, particularly for larger-scale, quantitative studies due to geographical dispersal (Chau and Yu 2001). Hence, investigators have generally focused their recruitment efforts in areas where UK Chinese populations are concentrated, via 'community' organisations (1, 5, 6), specific geographical locations (6, 9), and the take-away food industry (10, 11). The first two bias the sample towards those who self-identify as Chinese and participate in 'community' activities (an issue acknowledged by the authors of studies 5 and 6).

Moreover, in focusing on specific geographical locations, some researchers selected 'Chinese surnames' from the electoral registers of areas with large Chinese populations (9). While the authors acknowledged that there is a grey area given the overlap between 'English language' and 'Chinese' surnames (such as 'Lee') and they described their inclusion/exclusion criteria, e.g., May Lee and Edward Lee respectively. This strategy risked excluding those of mixed origin, who may have 'English language' surnames but who nevertheless self-identify as 'Chinese' and whose ideas and practices about health are influenced by this mixed cultural heritage. This strategy would be particularly limiting in port cities with long-established Chinese populations, such as Liverpool where relationships between Chinese seamen and white, local women were commonplace (Wong 1989). The third strategy of recruiting via take-away businesses over-represents Cantonese populations (especially those from Hong Kong) in the research sample, and focussing too heavily on the catering industry over represents Cantonese speakers in research about Chinese populations in the UK. It also skews results towards a particular demographic group with shared cultural, socio-economic and migration backgrounds and leads to 'Cantonese' health practices and experiences being erroneously extrapolated across other Chinese populations whose practices and experiences may differ.

These recruitment issues expose the inadequacy of the basic category 'Chinese' to describe this diverse minority population and highlights the need to engage with differing migration patterns, because historical and recent political/cultural changes have shaped Chinese populations in the UK. The migration stories behind these language differences illuminate significant variations within the UK Chinese population, which potentially limits the generalizability of reports on 'Chinese' health ideas and practices (1, 2, 3, 5, 8, 11, 12).

Discussion

Reviewing existing research into the health experiences and practices of Chinese populations living in the UK from an interdisciplinary perspective, reveals some of the problems surrounding Chinese ethnicity. At the core of this problem lie two things: a lack of clarity and complexity in the meaning of 'Chinese' and a failure to engage with the way in which migration interacts with health-seeking behaviours.

'Chinese' is both an ethnic and national label. However, it is not always clear which way this is being used, either by participants or researchers, and what claims can be made on the basis of either of these about individual practices. According to the PRC's 2000 national census, Han Chinese comprise 91.6% of the population of the PRC, with the remaining 8.4% coming from the other 55 officially recognised ethnic groups (www.gov.cn). Moreover, due to historic trade and migration patterns from southern China, Han Chinese are distributed across the countries of southeast Asia (Skeldon 1996) and therefore may identify as Han Chinese, as nationals of particular southeast Asian countries, or as both. The situation within the PRC is also complicated: first, because the position and sovereignty of Taiwan in relation to the PRC is disputed; second, because Hong Kong was a British colony for 155 years and has only recently become part of the PRC as a Special Administrative Region (SAR); and finally, because significant social, economic and cultural differences exist between north and south, between provinces, between inland and coastal regions, and between rural and urban areas within the PRC (Pieke et al. 2004). Thus the extent to which the population of these different areas

identify nationally or ethnically as 'Chinese' is debatable. Any use of 'Chinese' as a national identifier must therefore come with critical reflection on how much this (as opposed to any other geographical/cultural identification) impacts on participants' health practices. Likewise, if the ethnic label 'Chinese' is short-hand for Han Chinese, then this should be stated. As it stands there is a lack of clarity about what 'Chinese' means to researchers and participants, and a danger that specific cultural and social ideas and practices about health will be erroneously extrapolated across a heterogeneous group of people.

Migration complicates matters further. The UK 'Chinese' population was formed through a diverse set of migration pathways that point towards socio-economic, class, culture and identity differences within this ostensibly homogenous 'community'. Pieke (1998, 6–7) identifies five major trends in 'Chinese' migration to Europe and the UK, beginning with small traders travelling overland in the mid-ninteenth century and Cantonese seamen from the Pearl River Delta, while the major migration pathways of the latter half of the twenteith century have come through the decolonisation of Southeast Asia, economic migration (often by poor and undocumented workers), and the movement of well-educated city-dwellers to Eastern Europe after the fall of communism (Pieke 1998, 6–7). To these five we should also add those seeking political asylum (a significant issue in the last 20 years) and international students, who now form 3.6% of the total student population in the UK (www.hesa.ac.uk). 'Chinese' migration to the UK is thus a highly mixed picture of skilled and unskilled, documented and undocumented, financially comfortable, struggling, poor and impoverished migration, not to mention the diversities within these different groups.

Identification as 'Chinese' among these groups and their descendants is more complex still. Identity is a process of 'becoming' as well as one of 'being'. It is a process in which shared histories, common experiences and cultural codes may provide stable frames of reference whilst being 'subject to the continuous "play" of history, culture and power' (Hall 1990, 225). In other words, identities are dynamic and multiple. They are produced individually and collectively both with and against forces of culture, religion, society and personality. Health practices, like identities, are multiple and dynamic. It cannot be assumed that recent migrants identify more strongly as 'Chinese' than others and pursue 'Chinese' health practices accordingly. Neither can it be assumed that UK-born 'Chinese' nor those with mixed ancestry identify more strongly as British than others and pursue 'Western' health practices accordingly. And why is cultural or ethnic identity given such influence over health practices anyway? Identity may be just one of many factors (money, convenience, habit, curiosity, obedience) why people pursue certain health behaviours. Failing to question 'Chinese' ethnicities, identities and practices can lead researchers to explain their findings through 'cultural factors' based on stereotypes, leading to a racialised view of 'Chinese-ness' (Bradby 2003; Nazroo 1998). It is therefore vital that researchers listen carefully not only to participants' accounts of their health ideas and practices but also to their accounts of the different forces that have shaped and continue to shape these health ideas and practices.

Part of the problem here is the way in which the Office for National Statistics gathers data on UK ethnic groups. The 2001 census[4] organised ethnicity under five main groups, with 16 sub-categories (see Table 2). 'Chinese' was listed in this census under the generic 'Other' category and there were no sub-ethnic categories. Moreover, there was no option for 'White and Chinese' as a mixed ethnic group, meaning that anyone self-identifying as

Table 2. Ethnic groups in the 2001 census.

White	Mixed	Asian	Black	Other
White British	White and Black Caribbean	Indian	Black Caribbean	Chinese
White Irish	White and Black African	Pakistani	Black African	Other ethnic group
Other White	White and Asian	Bangladeshi	Other Black	
	Other mixed	Other Asian		

of mixed Chinese descent was concealed within the category 'mixed other'.[5] In Liverpool, this 'mixed other' group constituted over 8% of the local ethnic minority population and almost 9% of the ethnic minority population on wider Merseyside. Given the history of mixed marriages in Liverpool (Wong 1989), the census figures are likely to underestimate the size of the Chinese population, both in Liverpool and across the UK. This failure of official statistics to acknowledge both the heterogeneity within Chinese ethnicity and the potential for mixed or multiple identities among Chinese populations amounts to a racialised view of Chinese ethnicity (Bradby 2003) and should be cause for both concern and scepticism among researchers (Smart et al. 2008). This oversight was reproduced across many of the studies we reviewed, as only three studies took a critical attitude to the way in which they used the label 'Chinese' (6, 7, 10). Others drew on ONS data to provide an overview of the Chinese population in the UK without reflecting on how it (and by extension their own research) constructs 'Chinese-ness' in particular, simplistic ways (4c, 5, 8, 12). Failing to question Chinese ethnicity can also lead researchers to explain their findings through 'cultural factors' based on stereotypes (Nazroo 1998). It is therefore vital that researchers listen carefully not only to participants' accounts of their health ideas and practices but also to their accounts of the different forces that have shaped and continue to shape these health ideas and practices.

Nowhere is this clearer than in the importance of popular or 'folk' medicine to health practices among Chinese populations. The role of soups and herbal remedies to the everyday maintenance of good health has been acknowledged (6, 7) and the geographical variation of these techniques was clearly articulated by our interviewees, which raises questions about the labelling of these ideas and practices as uniformly 'Chinese' or 'traditional'. Questions also remain about the line between these everyday health practices and more formalised medical treatment from either a Chinese-trained or biomedicine-trained practitioner. In particular, to what extent are everyday practices considered 'medicine' at all, rather than simply 'how one ought to live'? More broadly, thinking about the social and cultural forces shaping health ideas and practices might have implications for public health services regarding equity of access and culturally appropriate care across ethnic groups. It is known that Chinese-identifying service users draw on remedies and practices from different medical models in order to remain healthy and that this has a strong pragmatic element. However, what we have also shown is the possibility that people are also negotiating multiple health care systems – public and private, within the UK and beyond it – in order to obtain the desired treatment and health outcomes. This strategic use of available medical systems includes the way in which Chinese population service users may register with general practice (GP) surgeries that

have Chinese or southeast Asian doctors who speak Mandarin or Cantonese so that their language and their conceptualisations of health and illness will be understood.

In a more fundamental way, researchers might also consider the some of the direct links between migration and health. This includes how migrants may use their mobility to pursue health-seeking behaviours, such as having full health checks during return visits as discussed earlier, as well as the ways in which the experience of migrating affects people's health, particularly their mental health. As new migrants and soujouners from the PRC, Hong Kong and Taiwan continue to arrive in the UK, this relationship between mental health and migration ought to be probed further. Recent research among Hong Kong Chinese families in the UK and Hong Kong has found that many people 'perform' when communicating with their families in order to maintain their relationships in a desired way, such as withholding bad news in order 'not to worry' their relatives (Shardlow, Ng, and Rochelle 2012; see also Madianou and Miller 2012).

This review and focus on the health practices of Chinese populations in the UK have not encompassed some salient issues that are worthy of discussion. Specifically, health inequalities have been documented due to the underutilization of social and health care services by Chinese populations in the UK (Green et al. 2002; Aspinall and Jacobson 2004; Rochelle and Marks 2011). Some of these health inequalities may be driven by differences in approaches to help-seeking between Chinese populations and the broader UK populations. For instance, socio-cultural influences will impact on help-seeking behaviours, such as having a Collectivist approach, whereby family networks are utilised to manage and deal with any health or social care issues, prior to accessing National Health Service (NHS) or other government agencies (Au et al 2013; Rochelle and Shardlow 2013). Authors have reported that individuals from Chinese populations may prefer to manage problems by themselves to avoid issues of embarrassment, and that help-seeking itself may be viewed negatively (Chan and Parker 2004). A key construct in Chinese societies is 'face', the social impressions and worth associated with an individual, and help-seeking has been regarded as having negative impacts on face impressions by others. Hence, face concerns may act to inhibit help-seeking (Mak and Chen 2010). A lack of up-to-date health intelligence data may impact on perceived health inequalities. There is evidence of a hidden population of undocumented Chinese migrant workers who are potentially being missed and under serviced by NHS services (Kagan et al. 2011). Exploitative working practices allied with poor living conditions will also contribute to restricted access to health care for such workers. These documented areas and other socio-cultural issues highlight the importance of adopting a nuanced interdisciplinary approach to obtain a wider understanding of the influences underpinning the health practices of Chinese populations in the UK, to help inform services and facilitate access to appropriate medical care.

Conclusion

In this paper, we have explored how ethnicity has been constructed in research on the health practices of Chinese populations in the UK and the potential for an interdisciplinary approach to improve and enrich such research. Our multi-faceted approach has challenged assumptions made by researchers about the homogeneity of 'Chinese' participants by demonstrating the complexity of migration histories, identities and associated health practices of different Chinese populations. This work has been driven

by a wide range of empirical and theoretical perspectives: from bioethics, primary care and psychology, to history, sociology, cultural studies and cultural geography. These viewpoints have enabled our attention to take into account individual, group, cultural and organisational influences with regard to issues of equity of access and culturally appropriate services, interaction between services users and providers, and how these intersect with patterns and histories of migration, cultural identities and practices in diaspora, and constructions of race and ethnicity among research participants. Our call for more complexity, depth and reflection in the questions being asked about ethnicity and health are unlikely to arise via the lens of a single discipline. In doing so, we have demonstrated the power of an interdisciplinary perspective to critique and dismantle racialised constructions of ethnicity and to address the complexities of researching with Chinese populations. Finally, it was noteworthy that particular topics have yet to be reported in the literature, an example was targeted service provision for Chinese populations, which will be worthy of future investigation.

Notes

1. The 'Han' ethnic group constitute over 90% of the PRC population (www.gov.cn).
2. Historical, racialised term for hired labourer from India and later China (OED: www.oed.com).
3. Higher Education Statistics Agency www.hesa.ac.uk See also, Office for National Statistics http://www.ons.gov.uk/ons/rel/ctu/annual-abstract-of-statistics/quarter-4-2011/chapter-20-education.xls
4. Statistics for the 2011 had not been released at the time of writing.
5. This situation remained the same in the 2011 census, although 'Chinese' was now listed under the 'Asian/Asian British' category.

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Key messages

(1) A need to clarify terminology, e.g., the Chinese when conducting research with Chinese populations.
(2) An interdisciplinary approach is required to improve understandings of ethnicity and health, particularly of culturally-specific accounts of health and illness.
(3) The need to address how Chinese populations negotiate different health care systems, as well as TCM and WM models of health.

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Appendix 1

Table A1. Reviewed studies – strengths and assumptions.

Published studies	Authors	Strengths	Assumptions
(1) Elderly people from ethnic minorities in Liverpool: mental illness, unmet need and barriers to service use	Boneham et al. (1997)	• Matched ethnic backgrounds of interviewers to respondents where possible	• Ethnic categories not questioned • Names from GP patient lists • Names from 'community' lists
(2) Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005–2008	Fountain and Hicks (2010)	• Community-led research projects • Seven Chinese languages/ dialects reported	• Label 'Chinese' not questioned • No sub-ethnic categories for Chinese
(3) a. The health beliefs of the Chinese community in England: a qualitative research study b. Health and identity: the case of the Chinese community in England c. Social representations of health and illness: the case of the Chinese community in England	a. Gervais and Jovchelovitch (1998a) b. Gervais and Jovchelovitch (1998b) c. Jovchelovitch and Gervais (1999)	• Refers to 'established cultural and medical tradition' as influencing Chinese health practices • Acknowledgement of larger cultural, social, economic and political determinants of health • Employed Chinese-speaking research assistant (dialect not specified) • Influence of interpreters on focus group discussion independently evaluated by Chinese speaker • Both Western biomedicine and Chinese medicine referred to as 'belief' (a)	• Western Medicine as 'science', Chinese medical knowledge as 'belief' (b) • Labels 'Chinese', 'the Chinese' and 'the Chinese community' not questioned • Assumes view of over-44s 'traditional' • Erroneous account of Chinese migration histories • Assumes straightforward links between Chinese medicine and Chinese identity • Chinese medicine portrayed as coherent and systematised body of knowledge • Acknowledges and then ignores fact that 'Chinese' encompasses diverse geographical origins

Table A1 (*Continued*)

Published studies	Authors	Strengths	Assumptions
(4) a. Mental health of Chinese women in Britain b. 'We are not completely Westernised': dual medical systems and pathways to health among Chinese migrant women in England c. Is the English National Health Service meeting the needs of mentally distressed Chinese women? d. Chinese migrant women and families in Britain	a. Green et al. (2000) b. Green et al. (2006) c. Green et al. (2002) d. Lee et al. (2002)	• Employed Mandarin- and Cantonese-speaking researcher • Translation process considered carefully, glossary compiled of words not easily translated • Conceptual misunderstanding between patients and health workers due to diverse medical models • Recognises diverse geographical origins of 'Chinese' • Understanding of Chinese migration history	• Complex understanding of Chinese-ness not maintained in analysis, discussion and conclusions
(5) Barriers to meeting the mental health needs of the Chinese community	Li et al. (1999)	• Good understanding of Chinese migration history • Acknowledgement of four different Chinese languages spoken by participants • Cantonese- and Hakka-speaking researcher • Acknowledges recruitment via community organisations biases sample to Chinese self-identify • Recognises cultural differences in how certain illnesses are conceptualised and presented	• Label 'Chinese' and 'Chinese community' not fully questioned

Table A1 (*Continued*)

Published studies	Authors	Strengths	Assumptions
(6) Older Chinese people's views on food: implications for supportive cancer care	Payne et al. (2008)	• Awareness that term 'Chinese people' is problematic • Culturally sensitive recruitment and data collection practices • Interviews conducted in participants' preferred language • Awareness of influence of migration on health ideas and practices	• Continues to use term 'Chinese people' and 'Chinese community' despite awareness that it is problematic • Claims to access health 'beliefs'
(7) Beliefs and accounts of illness. Views from two Cantonese-speaking communities in England	Prior, Chun, and Huat (2000)	• Questions Western 'science' and cultural 'belief' • Questions research of 'beliefs' • Refers to 'those who self-identify as Chinese' • Researched 'Cantonese speakers' not 'Chinese' (although further explanation not given) • Unpacks representations of TCM as coherent and systematised medical knowledge • Considers 'popular medicine' alongside Western and TCM treatment systems • Highlights differences in conceptualising and presenting health issues, particularly mental health	• Introduced as focusing on Cantonese speakers but concludes about 'the Chinese community'

Table A1 (*Continued*)

Published studies	Authors	Strengths	Assumptions
(8) a. Medical pluralism of the Chinese in London: an exploratory study b. Health behaviours and the use of Traditional Chinese Medicine among the British Chinese	a. Rochelle and Marks (2010) b. Rochelle and Marks (2011)	• Respondents described as 'of Chinese-origin', more specific places of origin also given (a) • Misunderstanding between patients and practitioners partly due to different health concepts (a) • Highlighted range of geographical origins and languages spoken among respondents (b) • Self-completion survey provided in English and Chinese (translated & back-translated) (b)	• Cantonese used in focus group but prevalence of this dialect not explained or probed further (a) • Label 'Chinese' and 'the Chinese community' not fully questioned (a; b)
(9) a. Health and lifestyles of the Chinese population in England b. The use of primary care services by the Chinese population living in England: examining inequalities	a. Sproston et al. (1999) b. Sproston, Pitson, and Walker (2001)	• 'Chinese population' not 'Chinese community' • Employed Chinese-speaking interviewers (dialect not specified) • Self-completion survey provided in English and Chinese (translated and back-translated) • Careful construction and wording of questionnaires to facilitate cross-cultural communication • Use of vignettes to access thoughts about use of different medical models • Acknowledged different meanings of 'health' (although unable to explore further)	• Descriptive report with little interpretation (limitation acknowledged by authors) • Sampling via a 'name search' of electoral registers • No recognition of different understandings of psychological and somatic health/well-being/illness • Claims to explore health 'beliefs' (a – chapter 5)

Table A1 (*Continued*)

Published studies	Authors	Strengths	Assumptions
(10) Health needs of the Chinese in Shropshire and Telford and Wrekin	Tran (2006)	• Good summary of Chinese migration history from across SE Asia to different parts of the UK • Focus group conducted in Mandarin and interviews conducted in Cantonese and English • *Questionnaire in English and Chinese (separate versions, not side by side translation)*	• Translation process and quality control not specified • Over-representation of take-away workers in sample due to recruitment methods not considered • *Language of questionnaire not specified*
(11) The health care experiences and health behaviour of the Chinese: a survey based in Hull	Watt, Howel, and Lo (1993)	• Indicates main geographical origins and occupations of local Chinese population • Questionnaires produced in English and Chinese • Cantonese- and Hakka speaker on research team	• Label 'Chinese' not questioned • Reasons for the predominance of Cantonese and take-away workers in study area not considered
(12) Chinese in Burton and Southeast Staffordshire: a baseline community needs assessment	Wong (2006)	• Questionnaires produced in English and Chinese • Interview questionnaires administered by Mandarin- or Cantonese speakers	• Process and quality control of questionnaire translation not explained • Terms 'Chinese' and 'the Chinese community' not questioned • Superficial engagement Chinese migration history
(13) Overseas Chinese students in the UK: patterns and correlates of their use of Western and Traditional Chinese Medicine	Bishop et al. (2009)	• International Chinese higher education students use TCM and WM	• Further research needed