

# Keeping healthy! Whose responsibility is it anyway? Vietnamese Canadian women and their healthcare providers' perspectives

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## Keeping healthy! Whose responsibility is it anyway? Vietnamese Canadian women and their healthcare providers' perspectives

Understanding how healthcare responsibility is distributed will give insight on how health-care is delivered and how members of a society are expected to practice health-care. The raising cost of health-care has resulted in restructuring of the existing Canadian healthcare system toward a system that controls costs by placing more healthcare responsibility on the individual. This shift might create more difficulty for immigrants and refugees to obtain equitable health-care and put blame on them when they experience illness. This paper is drawn from the results of a larger qualitative study exploring Vietnamese Canadian women's breast cancer and cervical cancer screening practices. Interview data were gathered from 15 Vietnamese Canadian women and six healthcare providers. We will demonstrate that (a) despite the strong influence of individualism, Vietnamese women and their healthcare providers value both individual liberty and the interrelationship between individual and society; (b) limited funding and unequal distribution of healthcare resources impacted how immigrant and refugee women practice health-care. Thus, motivating and fostering immigrant and refugee women's healthcare practice require both individual and institutional effort. To foster immigrant and refugees' healthcare practices, healthcare policy makers and providers need to consider how to distribute healthcare resources that meet immigrants' and refugees' healthcare needs in the most equitable way.

**Key words:** healthcare policy, healthcare responsibility, immigrants' and refugees' health-care.

The ways in which individuals, healthcare professionals, and healthcare policy makers view healthcare responsibility influence how healthcare services are delivered and how members of a society practice health-care. Perspectives on healthcare responsibility have not only determined who is responsible for doing what, but also who is to blame for not being healthy (Cheek 1997). At present, discourse on who is responsible for maintenance of health and prevention of diseases often focuses on individuals, despite the Canadian ideology that health-care is a shared responsibility

of both individuals and society. The restructuring of healthcare systems with its emphasis on the reduction of healthcare costs has placed even more healthcare responsibility on individuals. With this shift of emphasis on societal responsibility for health, institutional support for individuals might be overlooked. The present study, which investigated Vietnamese Canadian women's experiences of breast cancer and cervical cancer screening revealed that increased pressure on individuals' responsibility for their own health-care might create more difficulty for immigrants and refugees to obtain equitable health-care. Furthermore, this direction might compromise the fundamental societal value that people should have equal opportunities to achieve health and well-being.

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It has been pointed out that western psychosocial theories of coping with and preventing illness often reflect ideologies and discourses that value individualism, rationalism, and objectivity (Young 1980; Newton 1995; Mulhall 1996; Donnelly and Long 2003). Ideology is viewed in this paper as a form of consciousness that organizes 'material signifying practices that constitute subjectivities and produce the lived relations by which subject are connected' (Lather 1991, 112). Discourses are sets of experiences that are displayed and arranged through language. They are 'ways of referring to or constructing knowledge about a particular topic of practice' (Hall 1997, 6). The ideology that keeping healthy is the individual's responsibility has been broadly popularized in the media (television, magazines, popular self-help books) and frequently expressed in professional healthcare discourses. Often, individuals are told they can prevent illness by appropriately managing their life — by delegating, prioritizing, and learning to use methods developed to reduce health risks (Newton 1995; Donnelly and Long 2003). These ideologies and discourses reflect dominant western values for individualism, which, in turn, influence the direction of healthcare practice and the distribution of responsibility and role expectancies between individuals and institutions. Individualism has also influenced how responsibility for health is viewed, and thus how health-care is being provided and practiced, and the ways in which people manage pervasive issues of blame and accountability (Donnelly and Long 2003).

Recent rhetoric about health and health-care has focused much more on the interrelationship between individuals and the social context in which they live, and on how specific circumstances affect an individual's healthcare behaviours (Green, Richard and Potvin 1995; Hamilton and Bhatti 1996; Shah 1998; Sallis and Owen 2002; Vollman, Anderson and McFarlane 2004; Stamler and Yiu 2005). However, staying healthy and taking action to prevent illnesses are still often considered the responsibility of an individual. The danger of such discourse is that it might encourage people to self-blame, accept their losses, and silence their complaints.

It has been pointed out that, by heavily placing responsibility for staying healthy on individuals in terms of modifying behavior to reduce risk factors and increasing compliance with medical regimens, healthcare providers might fail to address other social determinants of health that shape people's healthcare behavior (Good 1994). For example, in the prevention of breast cancer and cervical cancer, the message is one that emphasizes the important role that women play in its early detection. Women are told that cervical cancer can be prevented and breast cancer can be cured if they take

the responsibility to engage in preventative measures (Lupton 1994c). Even though this message has encouraged women to participate in breast and cervical cancer screening, it not only places responsibility mostly (if not all) on women, but it also overlooks other contextual factors such as socioeconomic status, gendered roles and expectations, social support networks, and accessibility of healthcare services. All of these may influence women's healthcare behavior. It pays inadequate attention to the impact of race, gender, and class in shaping health-care provided to women of different ethno-cultural backgrounds.

On examining the associations between women's characteristics and whether or not they get a Pap test, Gentleman, Lee and Parsons (1998) state:

Non-compliance does not imply personal responsibility. Women may or may not get a Pap test for a variety of reasons, including awareness, belief in its effectiveness, promotion by health care providers, and access to programs and services (12).

The ways in which Canadians view healthcare responsibility influence how the Canadian healthcare system operates and delivers its services. How healthcare responsibility is viewed, for the most part, reflects what people of a society value. It follows that, to understand how healthcare responsibility is to be understood and operationalized to shape the Canadian healthcare system, we need to pay attention to the Canadian fundamental social values that underlie its healthcare system. Drawing from the results of a larger study, this paper will report findings related to the topic of discussions. Other findings are reported elsewhere (Donnelly 2004, 2006a, 2006b). The next parts of this paper discuss the fundamental values of the Canadian healthcare system, the research method, and the Vietnamese Canadian women and their healthcare providers' perspectives. We will also suggest implications for healthcare practice as it relates to Vietnamese Canadian women.

## FUNDAMENTAL VALUES UNDERLYING THE CANADIAN HEALTHCARE SYSTEM

In theory, liberal egalitarianism provides fundamental social values that underlie the Canadian healthcare system (Stingl 1996). According to Stingl, liberal egalitarianism values the coexistence of the individual and the society at large. Individuals and others in society engage in a joint partnership that is both co-operative and participatory in nature. Under liberal egalitarianism, an individual can exercise liberty such as freedom of speech, association, conscience, and the ability to pursue one's own personal good. An individual's liberty, however, is also limited to ensure the good of others.

The value of individual liberty, Stiglitz posits, is that individuals have the ability to think about and make decisions based on the ways in which they conduct their lives. They are free to choose the result toward which they will act to achieve personal goods such as material wealth, knowledge, love, social power, and prestige. In other words, individuals are granted the ability to make choices and the right to have options available to them. The implicit ideology imbued within the value of individual liberty is that the individual is responsible for the outcomes of their actions and life structures. How an individual's life turns out depends upon that individual's ability and effort.

In health-care, however, this ideology is problematic when applied to immigrants and refugees (especially the female population) because their healthcare choices are not voluntary, nor are they autonomous. Immigrant and refugee women cannot freely decide on their healthcare actions because they are among those who have the least control over their lives. Even though we recognize that women who come to Canada as immigrants might have different experiences than women who come as refugees, and that women of these two groups are not homogenous, many of them experience structural constraints such as low income and socioeconomic status, and limited social support networks. Thus, by not examining the structural conditions that constrain immigrants' and refugees' healthcare-seeking behaviour, we would overlook much of what happens in their lives and why they choose to participate or not in certain health-care programs. Furthermore, if we are relying only on the individual's ability and effort as indicators for an explanation of how individuals practice health-care, we are reinforcing assumptions that individuals who get sick are weak, submissive, or irresponsible (Good 1994).

Liberal egalitarianism views individualism as the most fundamentally important value, but it also views societal collectivism as important. That is:

[Liberal egalitarianism] values individual choice ... it [also] gives independent value to the ongoing social relationships that link the choices of one person to those of the next. It recognizes that although each of us may choose the course of our own life, none of us chooses the background of ongoing social cooperation that makes such a choice possible ... [it] sees society as having an independent existence and value of its own (Stiglitz 1996, 9).

Based on liberal egalitarian values of a society, the existing Canadian health-care system is a federal-provincial system of public reimbursement for the costs of hospital and medical care. Medicare — the Canadian health-care insurance system — is a federal-provincial joint partnership because the federal government contributes a certain percentage (in the past, around 50 per cent) toward the costs of provincial health

insurance. However, provinces have both authority and responsibility to administer the system as they see fit. At present, in the majority of Canadian provinces, private medical practitioners and not-for-profit hospitals provide most health-care services. The private medical practitioners are paid fees for their services. The not-for-profit hospitals are paid by annually negotiated national budgets (Barer, Evans and Labelle 1988). As pointed out by Storch (2003), the existing Canadian health-care does have a mix of both public and private for-profit health-care services. However, the private for-profit segment, which only constitutes 30 per cent of total health expenditure, is for certain services such as dental care, complementary medicine, and nursing homes.

Canada's state-run, tax-financed universal health insurance programs, as observed by Lewis (2004), have fostered social justice and administrative efficiency because they allocate services on the basis of need, not on ability to pay. Operating under the principle that health-care is accessible to everyone, health-care in Canada is a public good, not a market-driven commodity.

However, the Canadian health-care system is undergoing changes as the result of the escalating health-care costs and decreasing federal funding cash-transfer for provincial health-care. According to Lewis (2002), the federal government has reduced its contribution from 50¢ of every dollar spent to 30¢, leaving each province to come up with the rest of the revenue to operate its health-care services. Some provincial government officials state that a publicly funded health-care system might not be maintained unless more revenue can be generated and health-care costs can be lowered. Financial pressure also leads to the questioning of the efficiency and effectiveness of the existing universal health-care programs, with more health-care decision-makers calling for increased individual responsibility in controlling the health-care dollars, and for costs to be shifted from the public sector to the private sector (Vail 1996).

It is anticipated that better utilization of health-care services and increasing individuals' responsibility for health-care will increase the efficiency of the health-care system and decrease the health-care bill (British Columbia Royal Commission on Health Care and Costs 1991; British Columbia Ministry of Health 1993; ManZanKowski 2002). However, many concerns have been raised over the results that such health-care restructuring might produce (Anderson, Blue and Lau 1991; Anderson 1998; Swartz 1993; Rachlis and Kushner 1995; Stiglitz 1996; Storch 1996, 2003). For example, 'self-care' is currently emphasized by policy makers and health-care professionals as one of the important aspects of restructuring the current health-care system. Self-care refers

to 'the decisions taken and the practices adopted by an individual specifically for the preservation of his or her health' (Epp 1986, 7). This focus upon 'self-care' may create further problems for the immigrant/refugee patient seeking health-care services (Stingl 1996). Shortened hospital stays, for example, cost the hospital and hence the government less but result in additional costs for the patient for home care and lead to higher demands on the time and energy of family members. This is especially so for women, as they are often the main care-giver of the family.

Because immigrant and refugee women are among the most economically disadvantaged individuals, this situation adds another burden to their already tenuous economic and family situations, thus fostering further social inequality (Donnelly 2004). According to Statistics Canada (2001), approximately one-quarter of all Vietnamese women living in Canada had an income of less than \$9999 per year. As argued by Anderson, Blue and Lau (1991), self-management can give people a great deal of control over their lives. However, it has become evident from their study of immigrant women that healthcare providers often do not adequately prepare people to take on the responsibility for self-care. Anderson et al. (1991) also stress that self-reliant expectations can shape patient-practitioner interactions in ways that make it difficult for patients to get the help they need from healthcare professionals to manage their care. Furthermore, as Anderson (1996) points out, the potential pitfall of this ideology and discourse is that 'we risk glossing over the institutionalized practices that perpetuate inequity and that are barriers to health and well being' (699). If we are focusing solely on empowering the individual to take responsibility for his/her own health, we risk overlooking 'how class and power differentials will be addressed'. Also, it is not clear:

How people who live in poverty, or have the marginal existence that a job in the lower echelons of the workforce provides, will acquire the resources to become empowered to assume greater responsibility for their health and health care (Anderson 1996, 699).

It has been suggested that creating private market-driven health-care will reduce the healthcare bills by shifting costs for health-care from the public system to the individual. Furthermore, it will give people who have the ability to pay 'better' healthcare services (McArthur, Ramsey and Walker 1996). However, opposition to this suggestion points out that the impact of this direction on the poor is considerably greater than the benefit experienced by the more healthy, and more wealthy tax payers (Evans, Barer and Stoddart 1993; Moorehouse 1993; Vail 1996). There are value conflicts as well. Various provincial commissions reviewing

health-care in Canada over the past decade have revealed that equity remains the most important value held by Canadians with respect to health and health-care. Canadians feel they should have equal opportunities to achieve health and well-being, and equal opportunity to receive health services according to their need, not on their ability to pay (British Columbia Royal Commission on Health Care and Cost 1991; Rachlis and Kushner 1995; Romanow 2002). Shifting cost to the individuals by creating private market-driven health-care might violate those essential values because individuals who are able to pay will get the 'better' and 'faster' services they require (Storch 2003).

The data analysis of the present study, which investigates Vietnamese Canadian women's experiences of breast cancer and cervical cancer screening (Donnelly 2004), revealed that, despite the strong influence of individualism, the female participants and their healthcare providers valued both individual liberty and the interrelationship between individual and society. Furthermore, limited funding as the result of unequal distribution of healthcare resources impacted how immigrant and refugee women practice health-care.

Arthur Kleinman's (1978, 1980) Explanatory Model of Health and Illness and a postcolonial-feminist perspective (Anderson 2002; Anderson and Kirkham 2002) informed this study. The primary researcher's unpublished dissertation and previously published paper (Donnelly 2004, 2006a) addressed the ways in which these theoretical frameworks guided the study. The larger qualitative study was conducted in one of the western Canadian metropolitan cities where the immigrant population makes up 38% of its population of two million. All participants' names used in the study and this paper are pseudonyms. Ethical approval was obtained from the University of British Columbia Ethics Board.

## RESEARCH DESIGN

Participants were recruited using maximum variation purposive sampling; this is 'the process of deliberately selecting a heterogeneous sample and observing commonalities in their experiences' (Morse 1994, 229). In-depth interviewing using a semistructured questionnaire with open-ended questions was conducted with 15 Vietnamese Canadian women and six healthcare providers participating in this exploratory qualitative study. These women were between 46 and 78 years old, and all spoke Vietnamese; five came from the north and 10 came from the south of Vietnam. Their education level ranged from grade 2 to university graduate in Vietnam. The average number of years living in Canada for female participants was 22.7 years (range: 9–26 years).

Among the female participants, one woman had had cervical cancer in Vietnam, and one woman had a daughter who had died of breast cancer at the age of 40 in Canada. Four Vietnamese physicians and two community health nurses also participated in the study. The physicians' years of working in Canada ranged from 4 to 21 years. One community health nurse had worked with Vietnamese women for 4 years; the other had worked with Vietnamese women for more than 15 years. All healthcare providers, except one community health nurse, spoke Vietnamese fluently.

The interviews with female participants lasted between 3 and 4 hours. However, interviews with the healthcare providers only lasted between 30 minutes to 1 hour due to the physicians' time constraints and busy schedule. All interviews were conducted in Vietnamese, with the exception of two interviews with healthcare providers, which were conducted in English. The data obtained from interviews were transcribed and analyzed in the primary language of the participants by the researcher. Questions were asked regarding Vietnamese women's healthcare knowledge, attitudes, past and current practices about clinical breast examination (CBE), breast self-examination (BSE), mammogram, and Pap testing. The interviewers also investigated what the women and the healthcare participants perceived as factors motivating women to engage in preventive cancer screening practices, what they perceived as barriers, and what they perceived as the best possible strategies to promote breast cancer and cervical cancer screening among Vietnamese women.

Data collection and analysis occurred concurrently. Data analysis was an ongoing process that involved specific steps. The details of these steps are reported in a previously published paper (Donnelly 2006a). To ensure rigor, the researcher validated the preliminary findings with six participants (two Vietnamese women, three physicians, and one community health nurse) whom they believed could give the most feedback based on their level of articulation from the first interview. This process also helped the researchers to develop a deeper understanding of the data and gain more insight into the social processes and structures that influence Vietnamese women's breast cancer and cervical cancer screening practices.

The data analysis shows that female participants place emphasis on themselves as responsible and accountable for their health-seeking behaviours, and on others when they stress that doctors are also responsible for giving advice and encouraging women to seek health-care. Similarly, physician participants place responsibility for seeking health-care and for having breast and cervical examinations upon both the women and themselves as physician. It is important to note

that, although the physicians readily acknowledge their responsibility for giving good health-care to the patients, they often attribute women's failure to have regular check-ups to their unwillingness to having these tests done, and to limited support from government institutions.

## FINDINGS

### *'It is up to us, but the doctor is responsible too'* *– the Vietnamese Canadian women's perspective*

Female participants often emphasized that the individual woman is responsible for her own health-care, including obtaining regular check-ups. Discourse around whom is responsible and accountable for health-care is often linked to what women think about their present health-care and their comparison of the existing Canadian healthcare system with that in Vietnam. The advancement of medical technology and the ability to get a medical examination without paying from one's own pocket were often cited as the most important factors to consider in their definition of good health-care, and their opinion of how responsible the government is toward its citizens.

Those who assume that the Canadian healthcare system is much more advantageous than the one they experienced in Vietnam, and emphasize that one does not pay to go to a doctor, feel that going for mammogram and Pap smear test is the woman's responsibility. Female participants such as Mrs Chi, Mrs Phi, and Mrs Minh have been living in Canada for more than 20 years:

**Mrs Chi:** Here, the doctors are very good. If you have the disease, they would know. You don't go to see them, so you are late, that's your fault. When you go to see the doctors, it didn't cost you anything. So if you have time, you should see them.

Not only is an individual responsible for seeking health-care but she is also responsible for monitoring her own health and to work with a physician to keep herself healthy:

**Mrs Phi:** We have the responsibility to keep an eye on our own conditions. If anything changes, we notified the doctor so that he could adjust the medication. If the medication doesn't work, the doctor would change the medication.

Failure to follow the doctor's advice or to go for tests and check-ups was seen by some female participants as the individual's lack of effort to take care of their own health; thus, it is the patient who loses:

**Mrs Minh:** It is up to the patient to avoid all those things (breast cancer and cervical cancer). Whether or not the disease is reduced, it partly depends upon the patients. The doctor is one thing. But if we have the disease, it depends upon whether or not we follow the doctor's advice. It

depends upon the patients. If the patients don't follow doctor's advice, then the disease might not be reduced. So the major thing, I am not talking about disease, which cannot be cured, but for the diseases that can be cured by avoiding this and that, by [doing] certain things then it is the patients' decision. If they are not doing it, then nothing can be done ... If we don't follow what they [doctors] say, we would not be cured ... That would be the patient's loss.

Similarly, Mrs An, who has had a Caucasian family doctor and several encounters with the Canadian healthcare system, including her daughter's breast cancer treatment, praises doctors and nurses. She sees the individual woman as accountable for looking after herself:

**Mrs An:** We have to look after ourselves first because it is our body ... Our body, we have to look after it. Doctors are very good here. They are more than willing to look after us, but if we do not look after ourselves then the doctors cannot do anything. We need to look after ourselves first. Sometimes we have difficulty because we left it too long.

Although many women stress individual responsibility and accountability by emphasizing that women are responsible for going to doctors for check-ups, mammograms and Pap tests, they see that doctors have responsibilities in reminding women to take these tests. Mrs Ha, a 70-year-old woman who has been living in Canada for 26 years attributes her regular mammogram and Pap smears to her family doctor:

**Ms Ha:** Yes, it is up to us, but the family doctor is responsible too. The family doctors have to pay attention to their patients and send them to these examinations. They have to tell the patients what to do. Like me, I didn't know about these things. My family doctor sent me, otherwise how would I know about these things? ... If the doctors don't pay attention and don't tell the women then the women wouldn't know ... It is very important to encourage the Vietnamese doctors to talk to their patients and to tell them [the women] what to do ... If the doctor is a man then he needs to tell his [female] patients to go to any other female doctors.

To some women, an individual's determination to fight off disease is important, but the doctor has an important role in motivating the patients to take care of their health. For Mrs Minh, motivating an individual to take care of his/her own health is a shared responsibility of both the patient and the healthcare provider — a collaborative process that works only when both patients and doctors are willing to take part:

**Mrs Minh:** First of all, the patients had to have the determination to fight their diseases. Second, the doctors, they should talk to the patients about the importance of their health ... That is, the patients should try to take care of themselves. The doctors, they can only give you treatment. It is up to the patients ... On the other hand, the doctor should gently tell the patients the importance, the consequences if they don't follow the doctor's advice and prescriptions. They need to tell the patients that their diseases will not be cured.

It was recognized by several research participants that lack of healthcare information is one of the major barriers to accessing the available healthcare services. It is because of this fact that much information about breast and cervical cancer, together with screening for these cancers, does not reach Vietnamese immigrant women. Mrs Thanh has lived in Canada for 28 years, yet she was not able to access institutional support owing to lack of awareness of the available resources:

**Mrs Thanh:** For many years I just work ... I have never investigated other supports. I did not know. Well, if nobody tells you, how would you know about any other things ... If there is so much help out there, they need to let the people know about it. Otherwise, we would not know. I don't know about any organizations or how they can help.

Institutional support is very limited for Vietnamese women who do not speak English or who are isolated at home. For these women, institutional support is 'out of reach'. Unfamiliarity with the society's organizational structure and services coupled with the inability to speak the host language have made it very difficult for them to access available healthcare services and institutionalized support networks. Mrs Hai, who has been living in Canada for 22 years, states:

I still don't know much about the healthcare system. I just go to the doctor. Some time, we go to the hospital if it is emergency ... I don't know about other things. Also, any social resource or support, social organisations, I don't know ... For example, if you are sad or depressed, you can call for help. But I didn't know.

For more than 8 years a group of Vietnamese women and men have been working together as volunteers to broadcast in Vietnamese for 2 hours on a radio station in the city. For many older women, this program is the main source of connection to the world outside their homes. According to one of the station's founders, it is difficult for Vietnamese women to access healthcare information and giving information via radio is effective because of its easier access. The problem, however, is that there is not enough airtime to address topics such as health and health-care in great detail. Because of the large amount of information and issues that need to be addressed, each month there is only 15 minutes of airtime allocated for healthcare topics; however, with only 2 hours a week, this is the best that they can do. Finding enough money to run the program is a constant struggle for this group of volunteer women:

**Mrs Phi:** The program does not receive any funding. We have to fund raise to run the program, except that there were a few law projects that we were able to ask for some small funding, all services are voluntary. None of us get paid, not even a dollar. We have about 14, 15 volunteers ... Airtime has to be paid ... \$200 for 1 hour

plus tax. For 2 hours, we pay more than \$400. So we need two thousand dollars a month to pay for the airtime. To get this two thousand dollars, we have to do fund raising. We have to do several small projects in order to apply for some small funding. They don't give us any big funding. They don't have any money. So, when one project is nearly finished, we would have to do another application for another project. We, several women, have to get together to do this in order to have money to pay for the airtime. It is very difficult.

When asked if they had approached the government for funding support, Mrs Phi sadly revealed:

[The governments] don't support us with any funding. Yes, we did approach them ... Our women are mainly volunteering. You know, it involves so many things. When you are doing these programs, you have to contact people and you have to pay for people who do not work as volunteer. So the main force that keeps this radio program functioning is voluntary work [from the women in the Vietnamese community].

Mrs Phi is hoping that the radio station, now in its seventh year of operation, will eventually get continuous funding from the government to pay for the airtime and for the many people who have worked as volunteers for the past 7 years.

### *'It is up to the women, but we are not doing enough' – the healthcare providers' perspective*

Some physician participants thought that most Vietnamese Canadian women know about the importance of Pap smears and mammograms and that the main reason for low participation in breast and cervical cancer screening lies within the individual women:

**Dr Think:** The best thing is to talk to the women, to advertise in the newspaper, or to organize meetings. If we talk to them, they will understand. But I think that nowadays these issues [breast and cervical examination] are quite normal. Just put it in the newspaper several times and everyone would know about it. However, it is up to the women, whether or not they would go for these check-ups voluntarily. Now, you ask any women about Pap smear or mammogram, all of them would know what it is. You ask 10 persons, nine of them know what it is all about. They just don't want to go for these check-ups.

The majority of healthcare provider participants were aware that Vietnamese women are very hesitant and embarrassed about breast and cervical examination. Nonetheless, these healthcare providers feel a responsibility to talk to the women about these tests:

**Dr Tien:** The mentality of the Vietnamese women is that they don't like touching. They don't even want to have these kinds of examinations with the Vietnamese female physician ... even though I know that is what's going on, as the physician, I still have the responsibility to talk to them about it. I do know that the women don't like to talk about it, but because of my responsibility, I still talk to them.

Other doctors, however, see healthcare providers' roles and responsibilities as much more involved. Healthcare providers' responsibilities, to some physicians, consist of educating women about health-care and finding ways to assist them to seek help. To Dr Dau, healthcare providers could help Vietnamese Canadian women seek health-care by providing flexible hours of operation for the healthcare clinic, physicians reminding women of their check-ups, and having more accessible educational materials for women. Educational material should be simple and to the point with clear explanations of the dangers of these diseases, and it should be written in Vietnamese. Educational material should also include information about cancer testing, and information about breast cancer and cervical cancer including the stages, treatments, and the prognosis:

**Dr Dau:** With breast cancer, there are different stages. The success of the treatment depends upon which stage the cancer is discovered. Sometimes the success rate is over 90%, but at some stages it is only 2–4%. So we should educate the women with that kind of information. Not only do we have to educate the women; we have to make it easier for them to seek health-care. For example, in all places that do mammography, the hours of operation should be more flexible because present office hours are not easy for these women. The women can only come at 3, 4 o'clock in the afternoon. The reason is the language problem; they have to depend upon their husband. Also, if the husband is working, they cannot leave their children at home alone. Transportation is a problem. Second, they also forget about these things and have to be reminded. If we remind them, they would go.

Another physician, Dr Tien, who has been providing health-care to Vietnamese women for more than 7 years, indicated that, although he has made an effort to promote breast and cervical examinations to Vietnamese women, it is not enough. He attributes women's low participation in preventative cancer screening to the lack of healthcare institutional support:

**Dr Tien:** When you walk into my office, you saw that I have a poster right on the counter. This poster recommends that women should go for breast and cervical examination regularly. The reason that I have the poster there is that Vietnamese women, actually Asian women in general, they don't pay attention [rat la tho o] to breast and cervical cancer. Only when they have the disease, then they worry about it. It might be because they hesitate [ngai], or even don't trust, or are afraid of the results after examination. So I think that health departments and healthcare providers should push more. They should have a stronger program — a better advertisement program that promotes the need for Vietnamese women to go for these tests. It should tell them the importance and danger of breast cancer. We should have a more active, stronger program. Right now, I think we are not doing enough ... I have written a lot of information in Vietnamese. I had prepared lots of information but I don't have the time and the support. If the government

healthcare organizations support by helping with funding, you can invite physicians and others workers to participate.

The lack of government funding for the promotion of cancer screening and specifically for the distribution of breast and cervical cancer screening information to the Vietnamese was identified by another healthcare provider as the most significant barrier to screening services:

**Mrs May:** It is the funding ... it's really frustrating because I may have a piece of written material that I could have the interpreter translate. But through our organization, we are not allowed to do that now. It all has to go to a very structured process to have material translated. So sometimes professionals, nurses ... are just like, oh it is just so much work to have to go through that process. There is no funding ... That is a big, big problem.

Thus, as pointed out by Anderson (1998),

The very structure of the health care system compromises the care a woman receives, and health care professionals are sometimes caught in a moral dilemma as they try to provide a service to women without the adequate resources to do so. This calls into question how resources are allocated within different institutions, what is seen as a priority, and what groups are seen as meriting services (203).

## DISCUSSION AND IMPLICATIONS FOR HEALTH-CARE

As discussed, both the women and their physicians indicate that they are willing to take responsibility for the promotion of women's health and be accountable for their healthcare activities. This, coupled with their recognition that breast cancer and cervical cancer screening is necessary, should foster women's participation in these cancer preventive programs. However, data from my study and studies from the United State and Australia suggest that Vietnamese women do not fully utilize breast and cervical cancer screening services (Yi 1994; Jenkins et al. 1996; McPhee et al. 1997; Cheek, Fuller and Ballantyne 1999; Lesjak, Hua and Ward 1999; Sadler et al. 2001; Donnelly 2004). It begs the question, why, then, do these Vietnamese women feel reluctant to participate in cancer preventive programs? A previously published article (Donnelly 2006a) has reported on how cultural knowledge and values influence Vietnamese Canadian women's breast and cervical cancer screening practices. However, our data analysis also revealed that being an immigrant influences the accessibility of these cancer-screening services.

Immigrant women's social position within a society might have negatively affected how they participate in healthcare programs. In this historical moment, when there is a great concern regarding limited social and healthcare resources, in some provinces, services for immigrants have

suffered the biggest funding cut backs. For example, in the British Columbia budget for 2003–2004, the biggest area of reduction was multiculturalism and immigration services, which was reduced by 37%. In the same budget year, women's services, which provide grants to private and non-profit agencies for the provision of counseling programs and women's centre services, suffered a budget reduction of 5.7% (British Columbia Budget 2004).

As previously discussed, it is perceived that appropriate utilization of healthcare services will reduce healthcare costs. Appropriate utilization of healthcare services, as defined by Rachlis and Kushner (1995), is 'the right services, at the right time, delivered by the right person, in the right place' (96). This definition implies that tests, treatments, and services provided to immigrants and refugees should be founded on the best scientific evidence that services would be of benefit to them and that the services are in fact needed. However, this emphasis on consumer demand may indirectly create unequal access to health-care for immigrants and refugees. For Vietnamese immigrants, this means that unless Vietnamese immigrants (or any other groups of immigrants) are visible enough in Canadian society and unless their concerns are heard, there will be limited health-care services or institutional government support for them. Not only is it difficult for immigrants to voice their concerns, but their concerns also might not be taken as adequate evidence.

Lack of institutional support creates inadequate and inaccessible healthcare services for immigrants. One study shows that accessibility to healthcare services is the strongest predictor of whether or not an individual will received cancer preventive health-care among Vietnamese women (Jenkins et al. 1996). Reduction in funding of community-based health and social services has broad effects on the health of immigrants. A recent study in Canada revealed that policy changes that resulted in healthcare and social service losses for immigrants created increased barriers to access, and increased stress for providers and housing problems for immigrants (Steel et al. 2002). Thus healthcare professionals must consider the ways in which unequal social relations lead to unequal distribution of healthcare and social resources, and shape how health-care is being provided to marginalized groups.

The individualistic approach encouraged in current illness interventions has helped individuals prevent disease and illnesses. However, if not considered carefully, health-care providers might not pay adequate attention to the social relations that contribute to and define illness. In promoting health and preventing diseases among immigrants and refugees, we should be concerned with both the promotion



of what individuals should do to stay healthy, and how individualistic, rationalistic, and objectivism discourses shape the social connection that influence healthcare theory and practice (Newton 1995).

Because health-care requires an emphasis on individuals and their interrelationships within society, motivating and fostering immigrant and refugee women's healthcare practice require both individual and institutional effort. Healthcare professionals should develop a discursive approach that emphasizes the roles of social, cultural, political, and economic factors at the intersection of race, gender, and class in framing our social organizations, human relations, and healthcare practices. More attention should be directed toward examination of system barriers that shape how clients experience and manage health risk. Health promotion and disease prevention approaches should seek to foster social equity and accessibility to health and health-care. From this perspective, the question of who is to blame and who is responsible might then be answered from a different perspective that disrupts and challenges the individualistic dominant discourse.

It is also important for healthcare providers to be aware that, even though we might not see immigrant women seeking help from professional healthcare providers, we should not assume that these women are not interested in looking after their health or are irresponsible toward their healthcare. In the prevention of breast cancer and cervical cancer, Vietnamese women should not be blamed for their 'non-compliance' to engage in preventative measures. Immigrant women's low participation in healthcare programs might not be an indication of their unwillingness to prevent illness and diseases. Other contextual factors such as their low socioeconomic status, gendered roles and expectations, diminished social support networks, and inability to access healthcare services, which is the result of societal inequity, influence these women's healthcare behaviours.

Finally, as healthcare providers, it is important for us to critically examine whether or not shifting costs to individuals by making them assume more responsibility for their healthcare would result in decreased healthcare bills. Studies have shown that, in Canada, where a predominantly publicly funded healthcare system is in place, making poor and elderly patients pay for part of their health-care has not resulted in decreasing healthcare costs. Rather, there has been an unintended effect of a higher rate of serious adverse events, frequent visits to emergency departments, and increased hospital admissions (Tamblyn et al. 2001; Anis et al. 2005). Furthermore, this direction might also have an undesirable impact on the health and well-being of immigrants and refugees. As evidenced by Lynam et al.'s (2003) study, fiscal

restraint, necessitating restructuring of healthcare organizations to enhance efficiency of the provision of medically necessary services, has had unintended consequences for patients of different ethnocultural groups and for nurses. These consequences have created a context for inequities in care delivery for these patients. Thus, healthcare-restructuring rhetoric should put more emphasis on how and where to distribute healthcare dollars to meet the needs of those most vulnerable in the most appropriate and equitable way. As healthcare providers, we need to become more vigilant and advocate more for clients who are located within socially disadvantaged groups.

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