Esteri Löppönen
Veera Rissanen
Maarit Yliruokanen

How Do Chinese Immigrants Experience the Finnish Health Care System and Does it Meet Their Needs

In the Metropolitan Area in Finland

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Metropolia

Abstract

Authors	Esteri Löppönen, Veera Rissanen, Maarit Yliruokanen
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The purpose of our study was to explore the experiences of Chinese immigrants living in the Metropolitan area in Finland on the Finnish health care services and does it meet their needs. The study is part of the LOG-Sote project (Local and Global development in the social and health care), which aims to improve the health care services in Finland towards more immigrant friendly direction. Increasing knowledge about new cultures improves the interaction with patients from different cultural environments and social backgrounds. The Chinese immigrants are the fifth biggest immigrant group in Finland and their experiences on the Finnish health care services have not been explored before.

Fourteen individual interviews were conducted during September and October 2011. All the participants were Chinese who are living in the Metropolitan area in Finland. The participants arrived to Finland between the years 1989 and 2005 and the reasons for the arrival varied. The data collection method was semi-structured interviews with open-ended questions. Data was analyzed by using the inductive content analysis.

The results showed that generally the Finnish health care services are valued and the system is good. The Chinese trusted the Finnish health care workers' professionalism and the quality of the care was high according to the participants. The Chinese immigrants felt valued and equal to the native Finns. Few of the participants said that the access to the services and the care received was better to the immigrants than to the Finns, nevertheless, majority of the participants had difficulties when accessing the care. They did not understand how the Finnish health care system works or where to seek help. Health care workers' lack of facial expressions leaded to feelings that the staff was cold towards the Chinese. Language created problems when accessing the care while communicating with the health care workers. Even though the language was a big problem, participants mentioned that the Finns have a good heart and are helpful in problematic situations.

The results of the study indicate that cultural competence should be increased among the Finnish health care staff in order to respond the needs of the immigrant groups from different backgrounds. Information on the Finnish health care should be provided in multiple languages so that the access and understanding of the system would be easier. The health care workers should encounter the patient with smile and show emotions on their faces.

Keywords	Chinese, immigrants, Finland, experience, metropolitan area, health care, health care services, need

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Tiivistelmä

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Opinnäytetyömme tarkoitus oli tutkia pääkaupunkiseudulla asuvien kiinalaisten maahanmuuttajien kokemuksia suomalaisesta terveydenhuollosta ja vastaavatko tarjotut palvelut heidän tarpeitaan. Työmme on osa LOG-Sote – projektia (Lokaali ja Globaali kehitys sosiaali- ja terveysalalla), joka pyrkii parantamaan suomalaisia terveydenhuoltopalveluita maahanmuuttajaystävällisempään suuntaan. Eri kulttuureista täytyy hankkia tietoa, jotta voidaan parantaa kanssakäymistä asiakkaiden kanssa, jotka tulevat erilaisista sosiaalisista ja kulttuurillisista lähtökohdista. Kiinalaiset ovat viidenneksi suurin maahanmuuttajaryhmä Suomessa, eikä heidän kokemuksiaan suomalaisesta terveydenhuollosta ole tutkittu aiemmin.

Suoritimme neljätoista yksilöhaastattelua syys- lokakuussa 2011. Kaikki haastateltavat olivat pääkaupunkiseudulla asuvia kiinalaisia maahanmuuttajia, jotka ovat tulleet eri syistä Suomeen vuosina 1989–2005. Tiedonkeruumenetelmänä käytimme puolistrukturoitua haastattelua. Kysymykset olivat avoimia, jotta vastauksista saataisiin mahdollisimman paljon erilaista ja arvokasta tietoa, joka ei tarkoin määriteltyjen kysymysten kautta tulisi ilmi. Analysoimme saatua tietoa induktiivisella sisällön analyysilla.

Tuloksista huomattiin, että Suomessa tarjottavia terveyspalveluita arvostetaan ja että käytössä oleva järjestelmä on hyvä. Kiinalaiset luottavat suomalaisen terveydenhuoltohenkilökunnan ammattitaitoon ja hoidon laatu on korkeatasoista. He myös kokevat olevansa tasa-arvoisia suomalaisten kanssa. Pieni osa haastateltavista kertoi, että hoitoon pääsy ja saatu hoito oli jopa parempaa maahanmuuttajille kuin suomalaisille. Kuitenkin suurin osa koki vaikeuksia hoitoon pääsyssä; he eivät ymmärtäneet miten suomalainen terveydenhuoltojärjestelmä toimii, mistä hakea apua tai minne mennä. Kieli tuotti haastatelluille ongelmia hoitoon pääsyssä ja kommunikoinnissa henkilökunnan kanssa. Suomalaisten vähäeleisyys koettiin heikkoutena. Vaikka kieli koettiin suurena vaikeutena, he mainitsivat suomalaisten olevan hyväsydämisiä ja avuliaita kielellisesti ongelmallisissa tilanteissa.

Tutkimuksen tulokset osoittavat, että monikulttuurillista pätevyyttä pitäisi kartuttaa suomalaisen terveydenhuoltohenkilökunnan keskuudessa, jotta maahanmuuttajien tarpeet osattaisiin huomioida tilanteen vaatimalla tavalla. Tietoa suomalaisesta terveydenhuollosta pitäisi tarjota eri kielillä, jotta hoitoon pääsy ja järjestelmän ymmärtäminen olisi maahanmuuttajille helpompaa. Terveydenhuollon ammattilaisten kannattaisi näyttää tunteensa kasvojen ilmeillä ja tervehtiä asiakkaita hymyillen.

Avainsanat	maahanmuuttaja, kiinalainen, Suomi, kokemus, pääkaupunki seutu, terveyden huolto, terveyden huollon palvelut, tarpeet

Content

1 INTRODUCTION

Immigration in modern frames is a fairly new phenomenon in independent Finland. The number of immigrants in Finland has increased since the beginning of 1990's and is still growing. At the end of the year 2009, 155 700 foreign citizens were permanently living in Finland and, in addition, there were 5988 asylum seekers. (Maahanmuuttovirasto 2010.)

In the future social and health care services will take place in a constantly changing society which will propose new challenges to the health care services and working together with patients from different backgrounds and social statuses. LOG-Sote project is a cooperation project between social and health care. The purpose is to acquire information related to the challenges of multiculturism in Finnish health care services and to develop them to respond to the needs of the immigration population. Health care professionals should be able to respond to the challenges of multiculturism in order to provide good quality care. This final project provides knowledge for health care personnel about a specific immigration group, in this case, Chinese people living in Finland.

The purpose of the final project was to explore how the Chinese immigrant group experiences the Finnish health care services and do the services meet the immigrants' health care needs. The services might be tremendously different from the one in their home country. Therefore, there was a need to evaluate the health care needs for a specific immigration population. This way we are able to develop the health care services in Finland towards the immigrations' groups' requirements.

Our study question was: How do Chinese immigrants living in the Metropolitan are in Finland experience the Finnish health care services and does it meet their health care needs?

2 DEFINITIONS OF THE KEY CONCEPTS

2.1 Experience

According to Perttula and Latomaa (2005: 116), humans are creatures that think and have thoughts. When our consciousness chooses its thinking target, we experience. Sometimes, the target is easy to recognize, but the human might be unable to understand where the experience comes from. Nevertheless, it is still a real experience. When researching peoples experiences, the researcher must also think about the life situation of the person. Perttula and Latomaa (2005: 124-132), also state that the life situation is associated with everything the person is connected to. People identify their experiences by understanding them. Understanding can happen through emotions, intuition, knowledge and believes. These ways of understanding are modified by our own experiences. (Perttula & Latomaa 2005: 116, 124-132.)

In this final project, experiences are the main point we are interested in. Our interviewees have a different cultural background, language, possibly religion and even different experiences in health care system in their home country. Kokemus ja Käsitys (2009), argues that experience also has a meaning in people's life; they form opinions, helps us to understand feelings and is created by person´s current life situation. What makes Chinese immigrants experiences interesting in this final project is the fact that their experiences are valuable information to health care professionals and are also unique sources of information. (Kokemus ja Käsitys 2009.)

2.2 Immigrants

The United Nations Refugee Agent (1951) informs that an immigrant is somebody who lives temporarily or permanently in a country where one has not been born but where one has created social bonds. Immigrants can be divided into three categories according to their arrival reason; refugees, migrants and returnees. United Nations (1951) defines a refugee as a person who "owing to a well-founded fear of being persecuted of reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside a country of his nationality, and is unable to or, owing to

such fear, is unwilling to avail himself of the protection of that country…" Returnees are people "who have *voluntarily* returned to their own countries." "*Migrants* make a *conscious* choice to leave their country of origin and can return there without a problem." (The UN Refugee Agency, 1951.)

2.2.1 Current situation

According to Statistics Finland [Tilastokeskus] (2010), in the year 1990, less than 27 000 foreigners lived permanently in Finland. In the same year, first time in the history of independent Finland, more people moved in than moved out. The number is rising constantly. One of the major factors increasing the flow of immigrants was the collapse of The Soviet Union. In the year 1995 Finland joined the EU, which made immigration easier. (Tilastokeskus 2010.)

80% of the immigrants live in Southern Finland and half of the immigrant population live in the Metropolitan area, according to Statistics Finland (2010). Between the year 2008 and 2009, there were 150 different native languages in Helsinki. Besides Finnish and Swedish, the most talked languages were Russian, Estonian, Somali and English. The age structure amongst immigrants differs from the Finnish population. The immigrant population is younger and has a more fertile concentration. The immigration employment reacts more easily to the changes in the labour market because immigrants are over represented in part-time and temporary jobs. Therefore, immigrants are 2,5 times more likely to receive benefits due to unemployment. The longer the immigrant lives in Finland, the better the working life status gets; improvements in language skills, social networking, professional skills and cultural competence. (Tilastokeskus 2010.)

Table 1. Immigrants living in Finland (Tilastokeskus 2010).

Nationality	2008	%	Annual change, %	2009	%	Annual change, %
Russia	26 909	18,8	2,7	28 210	18,1	4,8
Estonia	22 604	15,8	13,0	25 510	16,4	12,9
Sweden	8 439	5,9	1,1	8 506	5,5	0,8
Somalia	4 919	3,4	1,4	5 570	3,6	13,2
China	4 620	3,2	16,1	5 180	3,3	12,1
Thailand	3 932	2,7	13,3	4 497	2,9	14,4
Irak	3 238	2,3	6,7	3 978	2,6	22,9
Turkey	3 429	2,4	7,8	3 809	2,4	11,1
Germany	3 502	2,4	5,5	3 628	2,3	3,6
Britain	3 213	2,2	2,2	3 333	2,1	3,7
Others	58 451	40,8	9,9	63 484	40,8	8,6
Total	143 256	100	7,9	155 705	100	8,7

2.2.2 Chinese Immigrants Living in Finland

As Finnish Immigration Service statistics shows [Maahanmuuttovirasto] (2010), in the year 2010 (1.1.–30.9.), altogether 1076 applications for a residence permit to Finland were made from Chinese immigrants. Reasons why Chinese applied residence permit were for example employed people, students, family tie, marriage etc. Majority of these applications, 586, were from Chinese who arrive to study in Finland. (Maahanmuttovirasto, tilastot 2010.)

In 2009, 5180 Chinese immigrants lived in Finland according to the Statistics Finland (2010). They represented 3,3% and were the 5th biggest immigrant group living in Finland (Tilastokeskus 2010). Residence permit decisions for Chinese immigrants were in the year 2010 (1.1.-30.9.) in total 1137 out of which 991 were positive and 146 were negative decisions. China was the third biggest nationality group in the residence permit statistics. In the year 2009, altogether 1473 residence permits were received from Chinese immigrants; 1248 decisions were positive and 155 negative. (Maahanmuuttovirasto, tilastot 2010.)

To conclude, the majority of Chinese who apply for residence permit get one. The most common reasons why Chinese immigrants come to Finland are study, work or other grounds. Appendix 1 shows that the number of Chinese moving to Finland has increased steadily from the year 1987. In the years 1987-1991, 624 Chinese moved to Finland. By the years 2007-2009 the number of Chinese moving in Finland has quadrupled. (Myrskylä 2010.)

2.2.3 Chinese culture

The World Fact Book (2010) states that, China is a country of 1, 3 billion inhabitants; it has the biggest population in the world. The capital is Beijing, which is located in the North of China. The life expectancy at birth is 73,5 years and 72% of inhabitants are between the age of 15 to 64. Majority of Chinese are Han Chinese (91,5%) and the rest are from other ethnic minorities. (The World Factbook 2010.)

China was for centuries the leading country in science and arts (The World Fact Book 2010). Starvation, foreign occupation and military battles drove this high-end country down in the 19th century. After, World War Two a socialist system was formed by MAO Zedong which caused a strict control of people´s lives. Today, China is a communist state ruled by the President, HU Jintao along with the Chinese Communist Party. Nowadays, the standard of living has improved and possibilities for personal choice has extended, although, the political control still exists and is tight. (The World Factbook 2010.)

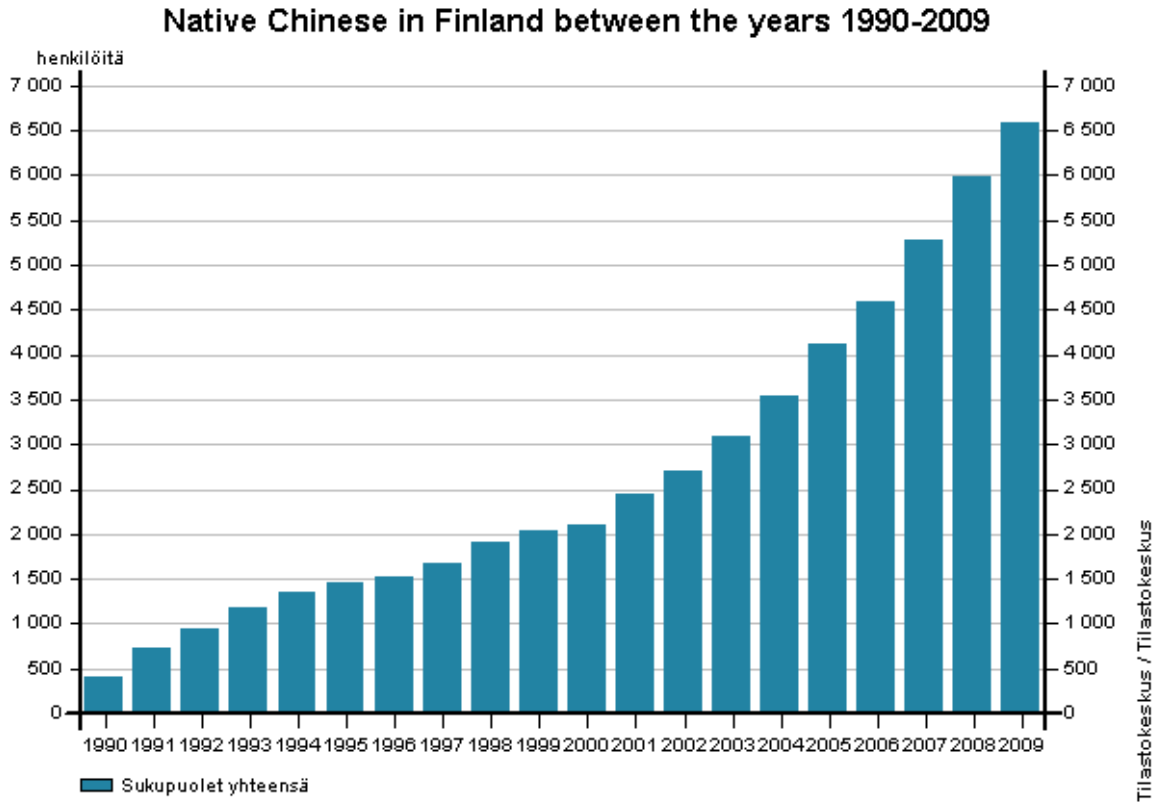
Kuoksa and Turpeinen (2005: 9-23) define the Chinese nursing culture is strongly influenced by the Chinese culture. The family has a significant role in care taking; they look after the nutrition, cleanliness and basic care. The patients are not always informed about their condition or illness if the family thinks it isn't necessary, especially if the illness cannot be treated. The family really has the right to be involved in decision making of the patient´s care. In the Chinese nursing culture, the family is valued and their opinion is respected. (Kuoksa & Turpeinen 2005: 9-23.)

Kuoksa and Turpeinen (2005: 9-23) describe the Chinese medicine is an essential part of the Chinese culture and hospital areas have a specialized setting to practice it. It is often used by itself or together with the Western medicine. Acupuncture, massage, herbs and cupping are the main methods used. (Kuoksa & Turpeinen 2005: 9-23.)

Communication with Chinese can seem quite distant and sometimes even tense, Remes (2005: 79-80) states. Chinese people can behave very politely or then can be ignoring. Nevertheless, they can be considerate, respectful and friendly to other people. Emotions are not strongly expressed to strangers; often behavior is controlled and Chinese try to keep their earned respect. (Remes 2005: 79-80.)

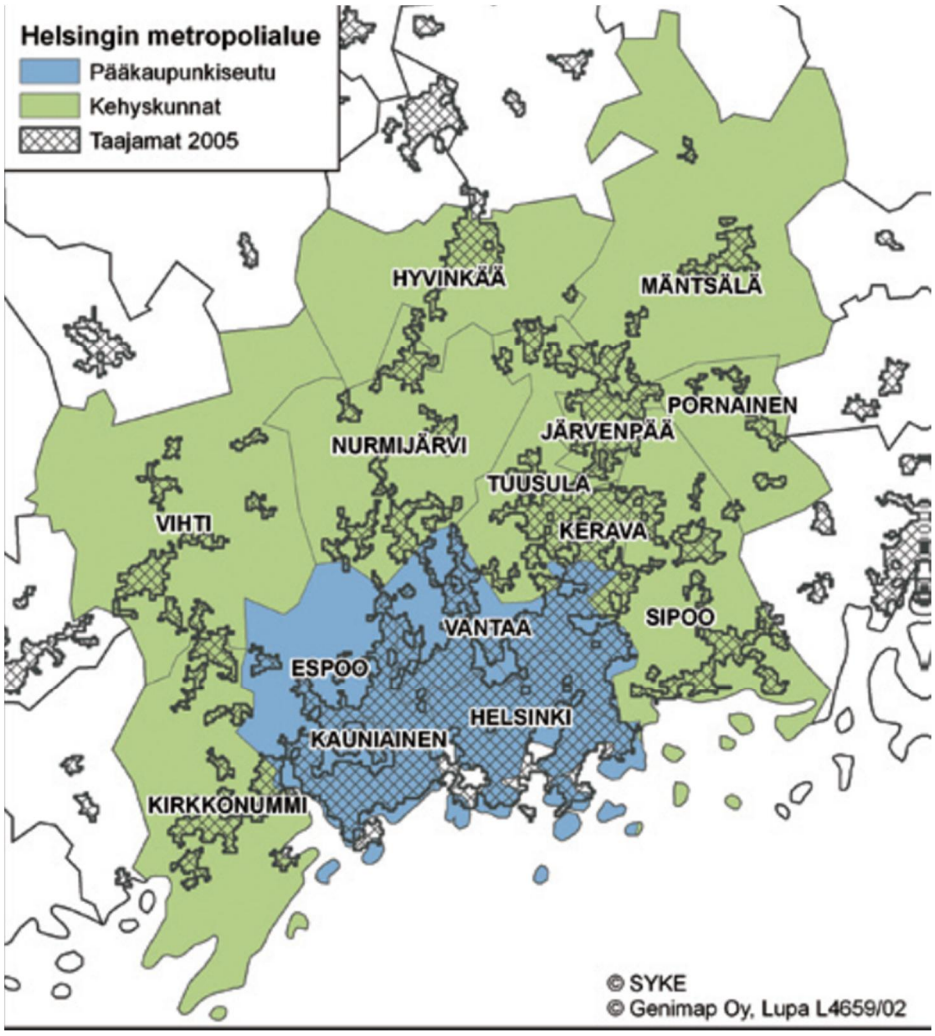
It takes time for Chinese to build new relationships and conversation at first is polite, controlled and conversation topics are cautiously chosen, according to Kuoksa and Turpeinen (2005: 9-23). Older people are much respected and family has a significant role in people's lives. In the Chinese culture discipline is strongly present and the foundation of life is based on family centeredness, traditions and religion. (Kuoksa& Turpeinen 2005: 10.)

Table 2. Native Chinese in Finland between the years 1990-2009 (Statistical Databases, Stat.fi 2010)



2.3 The Metropolitan Area

According to Viren (2007), the Metropolitan means a larger city area. The Metropolitan area is formed by one or more city regions close to each other, which are located around the center city. Not only does it cover urban areas, but also remote regions, which have distinctive commuting connections to the area´s centers. (Viren 2007).



Picture 1. Helsinki Metropolitan Area (Strandell and Harju, 2008: 17)

The picture 1 shows the Helsinki metropolitan area. The greater Helsinki area consists of Helsinki, Kauniainen, Vantaa and Espoo. The Helsinki Metropolitan area also includes Vihti, Kirkkonummi, Nurmijärvi, Hyvinkää, Mäntsälä, Pornainen, Sipoo, Tuusula, Kerava and Järvenpää. (Strandell and Harju, 2008: 17.)

2.4 The Finnish Health Care System

The Finnish health care system is built on three components; public primary care provided by municipalities e.g. health centers, primary and specialist care offered by the private sector which is only partly reimbursed by the National Health Insurance and the

third component is free occupational health care, which is co-funded by the Social Insurance Institution and the employers. (Wahlbeck 2008.)

According to the Ministry of Social Affairs and Health (2003) [STM], the municipalities in Finland, about 450, in total are responsible for organizing the health care. The basic health care services such as health centers should be provided by the municipality. Municipalities can form federations to provide the health services or the services can be bought from other parties as well. To organize special health care every municipality must be part of a health care district. (STM 2003.)

Health care services are being financed mostly by municipality taxes and the government pays their share. Customer fees cover for 10% of the public health care (STM 2003.) The main function of the health care system is to provide and finance basic health care, counseling, maternity services, screenings and dental care (Adjadjihoue 2009:20).

The Ministry of Social Affairs and Health (2002) confirms that The National Health Insurance covers everybody whose primary home and residence is in Finland and spends continually most of one's time in Finland. Public health care system does not cover asylum seekers without a residence permit, short-term foreign workers and illegal immigrants. Emergency care is offered to everyone (STM 2004). The Finnish health care system has raised international attention. Finland is being compared to other European countries by the European Observatory on Health Care Systems. What makes Finnish health care exceptional is the extent of the services compared to a relatively small population. (STM 2002.)

In the year of 2004 started to be valid non-discrimination act [Yhdenvertaisuuslaki] (21/2004) which safeguards equality and provides good quality care for everyone. The aim is to provide everyone equal treatment and prevent discrimination, which is based on citizenship, language, religion, age, opinion, disability, health condition, ethnicity, original nationality, sexual orientation or any other reason related to person. Everyone should be treated equally. (Yhdenvertaisuuslaki 21/2004.)

3 EARLIER STUDIES ON IMMIGRANTS EXPERIENCES IN HEALTH CARE SERVICES

3.1 Experiences in Finnish health care services

We used the following databases; Cinahl, Ebsco, Medic and MetCat. Our keywords were immigrants, health services (in Finland), Finland, statistics, maahanmuuttajat [immigrants], terveydenhuolto [health care], pääkaupunkiseutu [the metropolitan area], terveyspalvelut [health care services] and Suomi [Finland]. Cinahl gave us the biggest amount of results. Therefore, we had to limit our search options; the article had to be linked to a full text, the publication years had to be between 2000 to 2010 and in the English language. MetCat and Medic gave us fewer results and the best materials; six relevant publications.

There has been some research done on immigrants and the Finnish Health Care System. Raija Taavela (1999: 126-127) has interviewed Russians, Ingrians, and Estonians immigrants and their experiences in the Finnish health care system whereas Idehen-Imarhiagbe (2006: 42-52) has interviewed Nigerian's living in the Helsinki region and their experiences in nursing care in the Finnish health care services. In both of the studies, the majority of the participants reported positive experiences; they felt welcomed and received good treatment, trusted Finnish health care staff's professionalism and were grateful of the services they received. Majority had an easy and equal access to health care services but some migrants had practical difficulties; they were not aware where and when to call health care providers, how to book an appointment to the doctor nor how services were allocated among providers. Problems were also raised in culture, religion, body language and taboos. (Idehen-Imarhiagbe 2006: 42-52; Taavela 1999: 126-127; Wahlbeck et al. 2008: 45-51.)

According to Fonseca's (2010: 17-20) study on how ethnic minority students experience healthcare services in Finland, the majority of the results were positive. First, positive experiences were experienced when students got good care and they felt welcomed. Second, they were pleased when receiving care in English. Finally, they felt that the system was better to the one in their home country. (Fonseca 2010: 17-20.)

Fonseca (2010: 17-20) states that negative experiences were mostly due to the language. The staff neither spoke English nor was the English they spoke understandable. In addition Fonseca (2010: 17-20) argues that, none of the participants received an opportunity to have an interpreter. Even though the quality of the care was good, they faced prejudices, stereotyping, ethnocentrism and discrimination. In the beginning of their stay in Finland, they felt that access to the services was difficult since they did not speak Finnish. For this reason, they used the help of a Finnish friend, partner etc. (Fonseca 2010: 17-20.)

According to Ruokonen's (1996: 103-105) research results, the immigrant population does not differ from the Finnish core population when using doctoral services. Immigrants visited public health nurse more often and were sent to laboratory tests more easily than Finns. Native Finns found it easier to get a sick leave certificate for work or to take care of a sick child than immigrants. (Ruokonen 1996: 103-105.)

Wahlbeck's et al. (2008: 45-51) research done over ten years later than Ruokonen's research indicates that the migrants' population uses fewer services than Finnish core population. Exception is the migrant women between the age of 15 and 29; due to pregnancies and childbirths they have more hospitalizations and outpatient visits. (Wahlbeck et al. 2008: 45-51.)

An article by Eklöf and Hupli (2010: 58-60) showed that the increasing number of immigrants in Finland raises the amount of interpreters used in health care. The use of interpreters improves the quality of the care; the patient is understood and information pathway is secured, but employment of translator is expensive and time consuming. (Eklöf&Hupli 2010: 58-60.)

In Korhonen et al. (2010) study, which is also a part of LOG-Sote project, explored immigrant background populations' needs for health promotion, represented by health care staff. According to the health care staff the results were; mental health problems, nonspecific pain, questions about sexual health, dental problems, immobile lifestyle and unhealthy nutrition, overweight and risk of having diabetes, social exclusion, left outside the services and continuous usage of acute appointments. Good practices were centered to one counter, where the services related to immigrant, social and health

care service issues. Coherent working of the service chain, when an immigrant proceeds to municipality's basic social and health care services, was described well. (Korhonen et al. 2010.)

3.2 Experiences in health care services abroad

In the United States of America, Bosnian immigrants experience the USA's health care insurance and services complex and challenging according to Searight (2003: 90). They did not understand the system, accessing the services was difficult and time consuming filled with bureaucracy. The communication was impersonal and the decisions made on care were done on the business side rather than being done in patient centered care perspective. Feelings of frustration, confusion and anxiety rose towards the American health care insurance. Searight (2003: 90) informs that, in the former Yugoslavian system, a health insurance was free to everybody no matter how much was their income. The health insurance system in the United States of America was felt to be very bureaucratic and financially burdening. The Bosnian immigrants felt that they didn't understand the system and very afraid of the medical expenses leaving a mark on their credit records. The American system was felt to be too efficient making the care too brief and less sensitive. (Searight 2003: 90.)

According to Searight (2003: 90-91), the access to the services was stated too be very bureaucratic and slow. The Bosnian immigrants felt they had to do extra work themselves to find out which doctor would take their insurance and the insurance company was naming to the immigrants doctors that wouldn't take them. The struggle to see the doctor could take several months causing even more frustration. (Searight 2003: 90-91.)

While the experiences reported were mainly negative, the advanced technology was given positive feedback. Understanding the system, and the costs of the medical care and bureaucracy were considered the biggest problems. The health care staff was reported to be afraid of getting sued and not offering care without all possible paperwork being done. (Searight 2003: 91-92.)

Same kinds of experiences were reported in Switzerland from African women in Thierfelder, Tanner and Kessler Bodiang's (2005: 87-89) research. The women felt like they were encountered with a shock or a surprise and they wished for more empathetic care and more time from the doctors to discuss during the consultations. They felt their needs were not adequately addressed by the Swiss health care services. (Thierfelder et al. 2005: 87-89.)

Thierfelder et al. (2005: 87-88) describes that the sexual sensations and needs of the circumcised women were not accordingly addressed though the ladies had the need to discuss the matter. The medical examinations were prolonged, painful and patients felt hurt emotionally by the reactions of the health care staff; the circumcised women felt their pride being hurt. During pregnancy the matter of re-infibulation was not discussed with the patient; the physician saw it as a health issue where the patient took it as an ethical issue. To improve the health care services the patients wished more information on what to expect in the delivery instead of information about the baby. (Thierfelder et al. 2005:87-88.)

According to Dastjerdi's (2007: 76) article, "Becoming self-sufficient…", generally immigrants are considered difficult patients because of language and cultural differences. As a result, immigrants avoid contact with health care services, feel frustrated and only seek medical aid when they are acutely ill. Dastjerdi (2007: 76) also states that despite the multicultural society in Canada, health care personnel do not understand the effect of culture to health care. Individuals should be viewed differently and respectfully. In his research the participants had been misidentified and were given information in the wrong languages. (Dastjerdi 2007: 76.)

In Dastjerdi's (2007: 78) research, he refers to Anderson (1991), who interviewed Chinese women living in Canada and their experiences in the health care system. The experiences were negative regarding the fact that the women felt they were not heard considering the care and interaction with the health care professionals and their culture was not appreciated. (Dastjerdi 2007:78.)

Besides problems concerning the language, culture and finances, the fourth identified problem was time orientation. Settling in a new country is overwhelming and excess

energy is used to build up a new life. Health was not considered as a big issue. Due to problems accessing health care services, the immigrants were very sick when they eventually went to the doctor. (Dastjerdi 2007: 78.)

Both in Finland and abroad similar kind of issues were raised concerning the health care services; language barriers, unfamiliarity with the services and culturally related issues. Positive feedback was given on the high level of technology in the hospitals, qualified staff and easy access to emergency care.

4 PURPOSE AND STUDY QUESTION

Our Final Project´s purpose is to explore the experiences of Chinese immigrants living in the Metropolitan in Finland area about the Finnish health care system. The study question is: how do Chinese immigrants living in the Metropolitan area in Finland experience the Finnish health care system and does it meet their needs?

5 METHODOLOGY

According to Silverman (2000: 2), qualitative research is a form of research where instead of concentrating on statistics and numbers, the experience is defined and subscribed as a phenomenon. Nevertheless, qualitative research is a scientific way of evaluation and data collection. It is more often used when doing research on social sciences such as nursing. It is used to move from the personal view to the general and practical perception of things. (Silverman 2000: 2.)

Qualitative data research is more often referred to as the more”humane” approach when doing a research. Quantitative research is mostly numbers and does not apply to our final project work. In Silverman’s (2000) text, Halfpenny (1979) associates such terms as soft, flexible, subjective, political, case study, speculative and grounded with a qualitative method. (Silverman 2000: 2.)

Øvretveit (1998: 116) states that, qualitative research is used to explore experiences on a more general or individual base. Qualitative research is done by different observation methods or interviews (Øvretveit 1998: 116). Our research question and title has to do with Chinese immigrants' experiences; that is why the qualitative approach is more proper in this matter and can offer us data that when only looking at statistics would not be seen. (Øvretveit 1998: 116.)

Øvretveit (1998: 96) states in his book "Comparative and cross-cultural health research- a practical guide", that there are only two ground rules when doing a research: "Do not collect data which someone else has already collected, if you can use their data for your purposes. But always assume such data are unreliable, not valid or comparable, unless you can prove otherwise. These are the two general rules." (Øvretveit 1998: 96). Since there is not previous research done on Chinese's experiences on Finnish health care services there is a need to conduct this kind of research.

5.1 Semi-structured interview and Interview tool

The method we used to collect data in our final project was a semi-structured interview. According to Robson (2007:74-75), a semi-structured interview is more flexible than standardized methods. This allows us to explore emergent themes and thoughts rather than counting only on topics and questions determined in advance. Semi-structured interview enables conversation between the interviewer and the interviewee. This helps the interviewee to relax and it is more likely for us to get more informative answers. (Robson 2007: 74-75.)

The interviews were individual and were conducted under following circumstances: two people participated in the interview, the interviewee and the interviewer. Based on Robson's theory (2007:74-75) the interviews were held in peaceful settings and the interviewer used open-ended questions and a dialogic conversation in order to get a meaningful amount of valuable information. Interview situation was kept stress free and enough time was offered to the interviewee to answer. To keep the interview circumstances smooth, we practiced the situation in advance. A written form of consent was handed to interviewees to read and to be signed before the actual interview. Tape

recorders were used to record the interviews, pen and paper to make notes and drinks were offered to both parties. (Robson 2007: 74-75.)

Robson (2007:74-75) advices in "How to do a Research – A Guide for Undergraduate Students" that the interviewers have to be prepared for the interview situation in advance. Firstly, we need to know what we are asking and we have comprehended our topic. Secondly, we need to know how to guide the interview without leading the interviewee. Finally, we have to be the experts in this phenomenon. (Robson 2007: 74-75.)

By following Robson's (2007:74-75) statements our priority as interviewers is to be engaged and boost the Chinese immigrants, who are being interviewed without the interviewers getting personally involved. This might develop challenges such as following an agenda and possible steering back to the topic without destroying the mutual trust and respect we have built up. (Robson 2007: 74-75.)

According to Tuomi and Sarajärvi's (2002:77) guidelines we chose five main themes that we focused on in the interview. While we were going through the previous studies relevant to our topic, we were able to highlight five different themes; personal background, access to healthcare, communication, need for healthcare and most importantly experiences. Under these themes there were questions made that provided help to us, the interviewers, to discover more detailed data about the themes while guiding the interview situation. The idea was to keep the questions short and get long answers however without guiding the interviewee to wanted answers. (Tuomi & Sarajärvi 2002: 77.)

5.2 Data collection

We collected the data by a semi-structured interview using the interview form (appendix 2). As stated by Tuomi and Sarajärvi (2009: 72-73) the idea is very simple: when we want to know what the other person is feeling or experiencing, we ask them. The benefit of an interview is flexibility. Communication is a keyword hence the questions asked can be repeated, possible misunderstandings can be corrected and the interviewer has the possibility to have a conversation with the interviewee. Questions can be asked in different order depending on the situation and the interviewee. It is crucial

to collect the biggest amount of information, not only what is said but also the way it is expressed. (Tuomi & Sarajärvi 2009: 72-73.)

The interviews took place in our school Metropolia University of Applied Sciences, Department of Health Care and Social Services at Helsinki, Meilahti, Tukholmankatu 10 in one available room. We used the Megora-room which is a resting room for the students between lessons. The Megora room is located on the 4th floor of our school. The setting is very peaceful. The room is acquired with sofas and there is the possibility to make a cup of coffee or tea. The room has a door which can be locked. To avoid possible interruptions the door was kept shut but not locked in order for the interviewees not to feel discomfort. A note informing the usage of the room was placed outside on the door to minimize interruptions. Interviews also took place in various locations around Helsinki area, according to the interviewees' requests. Our goal was to perform 10 to 15 individual interviews with Chinese immigrants. In order to have a contact with the possible interviewees, we contacted the Finland-China association and asked for a possibility to their members to take part in our final project. The interviews took place between the 1.10.2011- 30.10.2011. According to Tuomi and Sarajärvi (2009:74), for the best interest of the participant, the time and place of the interview was scheduled according to the interviewee. In the interview situation there were an interviewer and one interviewee. The interviews were done accordingly to our question form and the answers were acquired in the form of conversation. (Tuomi & Sarajärvi 2009: 74.)

5.3 Data analysis

We used inductive content analysis. Tuomi and Sarajärvi (2009: 108-112) describe the three main steps of the analysis method we chose. To interpret the collected data, first the data is simplified, then the data is categorized and finally theoretical concepts are created. In an inductive content analysis the categories and subcategories rise up from the collected data and are not formed in advance. (Tuomi & Sarajärvi 2009: 108-112.)

By following Tuomi and Sarajärvi's (2009: 109) instructions the interviews were listened through and transcripts were made word by word. After that the transcripts were read and we familiarized ourselves with the content. The data was simplified and essential terms were highlighted so that theoretical concepts were formed on their

basis. Similarities and differences were found and were distributed in different subcategories. From the subcategories main analysis units were formed and from them the general view was established. (Tuomi & Sarajärvi 2009: 109.)

According to Polit and Beck (2004: 578-580), the information under theoretical concepts follows a certain pattern and by analysing the gathered data it is possible to measure whether the results fit into any of the main categories. As all the relevant information we found was put under different subcategories, we were able to see if the same issues were found in the same analysis unit. That way connections and phenomena were found. (Polit & Beck 2004: 578-580.) With the final results the aim was to broaden existing information from previous studies and bring out more ideas and study questions. It can spark up new researches. (Hirsijärvi & Hurme 2009: 137.)

Once we went through the interviews, all data from the transcripts were not analysed. By Kylmä and Juvakka (2007: 112-113) using an inductive content analysis we were searching for information that was valuable to us and to our final project, most importantly did the collected data answer our research questions. The material was separated into parts and all the data which had the same content was put together. This way the data was put into a big picture, answering the research questions and purpose. (Kylmä & Juvakka 2007: 112-113.) In detail, sentences from each transcript formed a paragraph and that built an analysis unit, a result that has a structure. Instead of putting data into very small detailed groups we were looking at things from a broad spectrum. (Janhonen 2003: 25-26.)

6 FINDINGS

Between September and October 2011 we interviewed fourteen Chinese immigrants living in the Metropolitan area in Finland. Twelve of the participants were female and the rest two were male. The interviewees had arrived to Finland during the years 1989 and 2005; the average time lived in Finland was fourteen years.

The reasons for arriving to Finland were education, employment and family. Six of the participants arrived to Finland because of their Finnish partner, four because of studies and the rest four due to employment. At present eight of them are working in Finland in various work environments and six of them are studying in a Finnish educational institute.

All of the interviewees are currently either studying or working in Finland; none of participants are unoccupied. Those who came to Finland due to their partner are presently working or studying. All of the Chinese who came to study to Finland managed to find a job in the capital region.

6.1 Experiences

From the experiences of Chinese immigrants' about the Finnish health care system, six subcategories were found. The main finding showed that the access to the health care was difficult. Encountering the staff was challenging and the interaction was limited due to language barrier. There were cultural differences between the Finns and the Chinese; in body language, in the speed of working and in communication. The Finnish health care staff was seen highly professional and qualified who delivered equal care.

6.1.1 Health care system and services

Almost everybody had positive experiences about the services and the Finnish health care system. Even to some it was a surprise that the quality of the service was so high, as it was first imagined to be low, and there were hardly any difficulties.

"*I really have nothing to complain for the service*"

Experiences were good; the Chinese people were satisfied, grateful and had a good impression of the Finnish health care. The service and the quality of the care were thought to be very good. Some highlighted that the hospitals were the best and the services to the students were splendid and the children were treated very well.

Only a few said that the system was not great and did not have a good feeling about the service they received. Also it was mentioned that the pace of the work should be faster in Finland as it was mentioned to be in China.

Those of the Chinese immigrants, who had stayed in Finland the longest, mentioned that the health care services had changed according to the years; now there are more immigrants living in Finland and also working in the health sector.

6.1.2 Professionalism

In general the staff were said to be really nice, friendly, empathetic and had good listening skills. Many of the participants recognized that the health care professionals were carrying a lot of responsibility and had a challenging job.

> "*Nurse and doctor they really carry their duty and don't want to get any trouble"*

Many of the attendants stated that the health care staff was highly professional and they knew that only licensed personnel were allowed to practice in the health care. They relied on the staff to be well educated, skillful and qualified. A Finnish health care worker was said to work slowly, while sitting in peace and thinking about things before utilizing the care. Nevertheless, the pace of work was thought to be a good quality in the health care staff.

6.1.3 Encountering

> *"Finnish people are bad actors: the heart is in it but the face is not"*

The major factor mentioned when encountering a Finnish health care worker was the lack of facial expression. The staff did not smile or show any other emotions on their

face. Therefore, some took it personally thinking that the staff was little cold towards the participants.

Since the Finnish people have a good heart, according to few interviewees some foreigners demanded too many services and special treatment whereas it was stated that the foreigners should adapt to the Finnish manners. The Finns were said to be too kind therefore they gave easily in to the foreign clients' requests.

6.1.4 Access to health care

Accessing the treatment appeared to be difficult for the attendants; the queues and the waiting times were long, visiting the doctor was hard, especially in the summer and some did not even get their appointments.

> *"Visiting the doctor is harder to get than before, now you just wait with the number in the health center to get an appointment*"

The interviewees thought that a lot has changed, even to the worse, especially in Helsinki. It was quicker to get an appointment in smaller towns and in other cities than Helsinki. Reasons for difficulties accessing the health care were rush, lack of staff and finances.

> *"I thought it would be harder to access the care"*

Minority of the respondents said their access to the health care was easy. Some managed to get an appointment immediately or the next day. Someone even mentioned that because of her foreign background the care was organized quicker.

6.1.5 Equality

"*The service is different to foreigners than to Finns"*

The attendants felt that they were valued and good equality care exists in Finland. Nevertheless, some felt that the service they received was different from the Finns'. No one stated that the care was better to the Finnish people than to the foreigners rather that the service was better to non-native Finns. The participants thought that the system was equal and safe since confidentiality occurs in the Finnish health care settings.

"*If you have money you can get treatment faster in the private sector*"

On the whole, the interviewees acknowledged that accessing to the care was difficult. However, they recognized having money made it easier and quicker. Some had used private health care services and were grateful that Kela, the Social Insurance Institution of Finland, reimbursed some of the expenses.

6.1.6 Language

As can be expected, language and its challenges were highlighted in each interview: for some of the attendants it was a crucial problem which created difficult situations. The language was also said to be a problem if it was not correctly understood, especially when describing symptoms. Not having a shared first language was an issue. On the other hand, the language was not thought to be a tremendous complication.

"When you do not understand, a Finn immediately tries to help you"

The Finns were said to be helpful and the language had never been an insuperable issue. Only knowing one Finnish word was enough to describe the matter and for the health care staff to understand. Some of the interviewees avoided using the telephone when speaking with the Finnish health care staff since they found face-to-face encountering less difficult and faster.

The use of an interpreter was not offered to any of the participants. Consequently, none of them said that they requested for one. A small portion had used their significant other or a friend as a translator even though, a translator with medical background would have benefitted them a lot.

> *"If you have a translator with a medical background it would help much better."*

6.2 Do the services meet the Chinese immigrants' needs?

Overall, the services met the needs of the Chinese immigrants. The care received was good, professional, and the system was well organized. Hardships occurred when encountering a health care worker with Finnish or an immigrant background, and not fully understanding the given information due to the language barrier.

6.2.1 Services meet their needs

All the participants felt that the services met their needs. The system works well and does not exclude the immigrants from the care. The Chinese immigrants get the same treatment as the Finns and feel that the health care services are well organized also for foreigners. Specialized services were particularly mentioned to be a major asset in the Finnish health care system. Occupational health care, maternity clinic, physiotherapy, emergency care and health centers were highlighted.

> *"You can go there anytime and you always get help"*

The care for medical problems is always available no matter if it is acute or chronic. The Chinese immigrants felt that they could access the care at any times. Some felt that the staff was very professional and trusted to the care they received from them. The health care workers were able to meet their needs also by taking into consideration their language skills.

"When I go to this health center, I speak English and those doctors are pretty nice and patient"

Few of the participants expressed that their poor physical condition was taken seriously and due to their immigrant background they were examined and treated thoroughly, almost better than the native Finns.

6.2.2 Services do not meet their needs

"Finnish health care system, I do not understand how it works"

Not all of the interviewees fully understood how the Finnish health care system works and how to seek help. Especially when using the service for the first time, immigrants found it problematic. Accessing the care was difficult and the staff was often so busy that they were hard to reach. Some of the respondents mentioned that they met with the public health nurse and the doctor only in acute cases or when they needed a sick leave certification.

"Many times they had to go back to the starting point, because if you want to go to the hospital for same kind of treatment you received before, you need to go first to your own health care center and start from there. She said, it is really frustrating."

The care that was received did not meet the participants' expectations. Some said that accessing the specialized care was not easy at all and sometimes they had to go back to the beginning of their care. The Chinese immigrants also failed to get the treatment they wanted; it was difficult to request for medication from Finnish doctors. Compared to China, where people seek medical care and even antibiotics for a common cold, they were not able to get the medication they wanted from the doctors in Finland.

Communication and treatment problems were raised when seeking help from the doctors with an immigrant background; half of the interviewees felt that the communication was a big problem and they were not able to fully understand the instructions they received from the doctor. Particularly some of the participants experienced that their

concerns were not taken seriously and instead of examining them, they were sent home or just given pain medication.

> *"I cannot speak Finnish so there is a problem; they are not speaking very much with me."*

For the most part, the language was a problem as stated before. The attendants failed to receive the service in their first language or sometimes even in English. If the client and the staff did not share the same language, the communication stayed limited.

6.2.3 Future development

Excellent ideas on how to develop the Finnish health care system towards immigrant friendly services popped out; the interviewees found ways to improve the Finnish health care system. Firstly, one person came up with the idea of telephone line for foreigners, where people could occasionally call to get their health issues and questions answered by using their first language. Secondly, the answering machines in the health care does not always have English recordings; it would be beneficial to add an English version as well. Thirdly, as mentioned before, not all foreigners fully understand how the Finnish health care system works. An idea of an immigrant focused detailed guide of the Finnish health care services and the reimbursement system in English or other languages would be needed. Finally, due to the globalization in the future the question is; do we need interpreters or services in English in the Finnish health care settings?

7 DISCUSSION

The purpose of our study was to explore the experiences of Chinese immigrants on the Finnish health care system and do the services meet their needs. Our study is part of the LOG-Sote project, which aims to improve the Finnish health care services towards more immigrant friendly direction. The findings of our study can be used for future

purposes, since there does not exist previous data on the Chinese immigrants and the Finnish health care services.

7.1 Results from the findings

From the fourteen interviews, we were able to find useful data, which we separated into two main categories according to the research questions: The Chinese immigrants' experiences on the Finnish health care system and do the services meet their needs. The first main category, the experiences, was put into six different subcategories. The second category, did the services meet the needs, was divided into yes and no.

The experiences of the Finnish health care system according to the Chinese who participated in the interviews were not all that positive. Accessing the Finnish health care services turned out to be difficult to some with long waiting times and challenges to get an appointment to the doctor. Some even noticed that the direction of the health care system in Finland had taken a course to the worse with rush and hurry, financial obstacles and lack of health care personnel, especially in the Helsinki area. The system and the services were thought to be slow and ineffective. Nevertheless, only a few said the system was not great and did not have good feelings of the service they received. The care did not meet the participants' expectations and they did not get the treatment they wanted. In addition, some felt that their concerns were not taken seriously. Also they did not know how the system works or where to seek the help they needed.

Major cultural differences were the lack of facial expressions when encountering the patient; the Finnish health care personnel did not show emotions on their faces, whereas in China the health care staff is required to smile. Furthermore, the language barrier turned out to be a crucial problem creating difficulties in communication and affecting the way they perceived the quality of the care.

However, positive experiences were reported in interacting face to face with the health care staff. Inadequate language skills were not said to be a tremendous problem since the Finns tend to be very helpful with the language; knowing only one significant word and using body language was enough. The Chinese immigrants felt valued and equal or even in a better position in health care than the Finns; the system did not exclude

the immigrants, rather the care was always available for them. Confidentiality was a highly appreciated factor in the Finnish health care. The staff was found to be very professional, taking their jobs seriously and carrying out responsible work ethics. Not only was the staff received as friendly, empathetic and responsible but also educated, qualified and skillful. The Chinese immigrants trusted the care they received and even the language was taken into consideration.

Minority of the participants stated that the access to the Finnish health care was easy. Their physical conditions were taken more seriously and even accessing the health care was quicker than to the native Finns. Almost all of the Chinese were satisfied, grateful and overall had a good impression of the Finnish health care system. To some extend it was even a surprise that the quality of the service was so high and good.

7.2 Validity and ethical considerations

According to Kylmä and Juvakka (2007: 137-138) ethics is an essential part when making reliable research, not to forget that ethical issues are central to the health care profession. Ethics in nursing research is based on three components; confidentiality, autonomy and voluntary participation. In order to have an ethical research we focused on those three components in our interviews. We had done a written form of consent which all of the participants signed (appendix 4). In the written form of consent, we told about the final project so that the participants understood what the study was all about. Also we mentioned that all of the participants' answers were dealt with confidentiality and autonomy was secured. We did not use the answers elsewhere than in our final project and we used the answers as such. Participation was voluntary and the participation could be discontinued if the interviewees felt so. (Kylmä & Juvakka 2007: 137-138)

As interviewers, we had to think ethical issues also when we interviewing the participants, as Kylmä and Juvakka (2007: 137-138) state. We needed to be culturally competent to conduct the interviews, taking into consideration the participants' cultural backgrounds and ensured that discrimination did not occur. Respectful behavior and approach were essential not to forget integrity. In order to avoid bias the interviewers

had to have an objective approach towards the interviewees. (Kylmä & Juvakka 2007: 137-138)

By Kylmä and Juvakka's (2007: 128-129) instructions we also had to think about the validity issues with the intention of having reliable results. The following issues affected the validity of our final project; how trustworthy was our interview tool, was there any indicator that we could use to analyze the answers and how the transcripts were interpreted. It was crucial to notice the connection between the results we got from previous researches done and the results we got from the interviews. Not only did we receive new information but also we extended our results to the existing results. (Kylmä & Juvakka 2007: 128-129.)

According to Kylmä and Juvakka (2007:128-129) in order to have trustworthy qualitative research, we needed to take into consideration the dimension of validities in qualitative research; credibility, dependability, transferability and reflexive. When interviewing we ensured that the results were liable to the outlook that the interviewees had about the research. By making notes and recording the interviews we ensured that all the data was recorded; we used notes and recordings when transcribing the interviews. In the transcribing phase we needed to be aware of our own biases in order to recognize how we affected to the material we got. When the results were in the offing, they had to apply in some other similar situation, as well. (Kylmä & Juvakka 2007: 128-129.)

Our interview tool was a semi-structured interview that allowed the interviewee to express themselves more freely hence the questions were open-ended, as Polit and Beck (2004: 341-342) writes. This created more challenges to the interviewers because the questions need to be carefully thought and the interpretation needs to be objective. In order to have an objective interpretation we had to be aware of our own biases, go through the transcripts several times to avoid misinterpretation and to collect all the relevant data. We could not use any precise indicator because we were the ones to analyze the data in an inductive way. Experience is an individual theme and it could not be measured by any scale. (Polit & Beck 2004: 341-342.)

Our final project was based on all of the ethical considerations. All the data was dealt with confidentiality and no names were reported. The interviews were also autonomous; the participants were allowed to refuse to participate to the study and at any point they could interrupt the interview. All who fitted to the participation criteria could participate and no discrimination occurred. We took a competent approach: we were objective in all stages of the study.

In the interview situation we participated by being active listeners and not letting our personal perspectives reflect on the matter or the interviewee. No one was at risk of identification or was bound to the final project for a longer period of time besides the interview.

Before conducting the interviews we requested permission from the Metropolia University of Applied Science faculty of the Health Care and Nursing's director. The permission was granted in order to interview the students of our school.

Once we started planning our interviews and the data collection, we decided to choose open-ended questions to give the respondents the opportunity to freely answer the questions. The interview tool did not contain any leading questions, which might have altered the results. The interview tool was made by us by using results from the previous studies made on the experiences of immigrants' on health care. From the facts collected from the studies we formed different themes from which we assembled the interview questions.

Before the actual interview, the participants were fully informed on the purpose of the study and where the results would be used. The participation was voluntary; those who were willing to participate signed a written letter of consent. The interviewees did not have a personal relationship with the interviewers. The results were not affected because the opinions of the interviewees on the matter were not discussed later on. During the interviews the participants were free to express themselves. The interviews were conducted in two different languages; Finnish and English. Since neither of the languages were the first language of the interviewees, their expressions might have been partially limited, but in a face-to-face situation these misunderstandings were possible to be corrected and for the interviewees to clarify themselves in other words.

Each and every interview was digitally recorded by using two recorders. Also notes were done during the interviews. All of the interviews were transcribed and afterwards original recordings were destroyed. All of the transcripts were read several times and we familiarized ourselves with the content. We all found key quotes that we separated between the two research questions: what were the experiences of the Chinese immigrants about the Finnish health care system and did the services meet their needs. All the findings were picked up from the interview transcripts. We found connections between the results and compared them to the previous researches.

Since there are no previous studies made on the experiences of the Chinese immigrants living in the Metropolitan area in Finland on the Finnish health care services, the data we collected had to be verified. First we conducted ten individual interviews. In order to have more reliable and trustworthy data we interviewed four more Chinese immigrants to see if there were possible similarities and connections between the results or would new data and experiences arise. The latest four interviews conducted, confirmed the results gathered from previous interviews; it increased the validity of the results.

7.3 Expectations

In the beginning of our final project we had some assumptions on the possible findings; the assumptions were identified from the earlier studies. We were expecting there to exist language problems in the usage of services, communication and understanding the care plan. We knew that the availability for an interpreter was there but we did not have any idea whether this service was being offered or used amongst the Chinese immigrants. Earlier studies indicated that translators were not widely used and accessed.

Since the traditional Chinese medicine has been used in China for centuries and places a big part in the culture, we were assuming that the Western medicine would not play as such a big role as the Chinese medicine. Alternatively, both of them would be used together in harmony. We were expecting the Chinese medicine to be highlighted when talking about any sort of care they received.

As can be expected, foreigners might encounter difficulties when accessing the health care. Imagining from the previous studies, difficulties could occur in knowledge of knowing how are the services allocated, where to seek help and how the Finnish health care system works. Difficulties with the language might restrict seeking help at the early stages of the illness. According to the previous studies, settling down in a new country demanded most of the immigrant's energy and health was not considered as the main priority, so help was only sought when the illness was already in a serious stage.

As far as culture is concerned misfortunes can be expected. Since other immigrant groups, in studies, have experienced cultural related hardships such as discrimination, stereotyping, ethnocentrism and racism, we were also predicting some cultural issues to occur. We expected that possible generalizations would happen, in other words, the immigrants would be encountered as representatives of the Asian culture instead of individuals.

7.4 Conclusions

Our expectations were partially met with the results from the interviews. The Chinese immigrants experienced challenges with the language as we predicted, but surprisingly they found the Finnish people very helpful when encountering dilemmas with the language. The language barrier lead to other problems, such as accessing to the health care, communication with the health care staff and the immigrants were considered generally as difficult patients due to not sharing a common language. To our amazement none of the participants we interviewed were offered the possibility for an interpreter. Never minding the insufficient language skills, the Chinese immigrants performed well in accessing and seeking help within the Finnish health care services. As some of the participants felt that the services and the information should be provided in other languages besides Finnish and Swedish and the occasional English. Therefore, the system should be developed towards an opportunistic approach where people would be able to, in limitations, receive information in their first language or always at least in English.

In the globally developing world body language is vital. Impersonal encountering was said to be a weakness amongst the Finnish health care staff, in conclusion, personal interaction with the client should be improved. The client should be encountered as an individual and the care should be adjusted to meet the individual's needs, but within the qualifications of good care and what is considered as good care in the Finnish health care system. The Finnish health care staff could bring their own personality when facing the client and characterizing the care given. Cultural sensitive care and awareness should be increased for the Finnish health care personnel to respond to the demands of all changing multicultural and global world.

The Chinese immigrants' vision of the care was partly based on medicalization; they expected to get antibiotics for a common cold and minor infections. Cultural competence would require the Finnish health care staff to understand these differences and explain the treatment guidelines. False assumptions of the usage of certain medication should be corrected to differentiate, for the immigrants, bad quality care from the medical guidelines in Finland.

To our surprise, part of the respondents brought up difficulties we had not thought of before. Doctors with an immigrant background were stated to be the weak part of the health care system in Finland. The interviewees had obstacles to communicate with the doctor and were not heard or examined enough. Instead, they only got prescriptions for pain medication or were sent back home. In particular, we noticed a link between the language problem and when visiting the doctor with an immigrant background. Maybe for the future, foreign doctors should be aware of how to encounter clients, not only the native Finns, but also a client whose first language is not Finnish as the doctor's is neither.

In brief to conclude from the interviews, the Finnish health care service despite its minor flaws is a good system providing valuable and specialized care. With professional, competent and devoted staff it is able to provide high end care to everybody: regardless of the clients' background. Yet, there are some areas to develop and improve to the future needs of ever changing Finnish health care.

7.5 Future

The Health care services are constantly and rapidly changing system. In order to provide the best possible care to everybody, change is necessary, compulsory and inevitable. Multiculturism poses an extra challenge in the medical field when creating new evidence- based guidelines. In a constantly more international world the societies should adapt and learn from alternative cultures making the world more united.

The LOG-Sote project is a bigger research formed from different components giving a new and a broader perspective making the Finnish health care system more immigrant supportive. On the whole, we interviewed a new immigrant group that has not been studied as much as other immigrant groups have been. The information we gained from our study offers new and valuable data. Offering the results from this study for public usage, gives the possibility for anybody to develop their cultural competence and giving back information to the health care system that helps them to evolve and serve the needs of growing immigrant population.

For the future the health care services should concentrate on offering more immigrant adapted care. Information should be offered in multiple languages; about the system, the provided services and the access to the care. Some ideas, such as information pamphlet, telephone service line and on-line guides in multiple languages could be offered. Also increasing cultural competence of the students already while studying in the health care and social field; aiming to improve encountering clients from different cultural backgrounds.

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Nationalities that have moved to Finland between the years 1987-2010 (Myrskylä 2010)

	Total	1987-91	1992-96	1997-2001	2002-06	2007-09
Total number of immigrants and returnees	389 398	62 640	66 476	78 350	100 090	81 842
Finns	158 081	32 659	22 735	33 779	42 563	26 345
Total number of Foreigners	231 317	29 981	43 741	44 571	57 527	55 497
EU(27) countries (exluding Finland	77 149	8 841	13 670	13 315	20 702	20 621
Poland	2 895	581	196	193	599	1 326
Sweden	15 723	3 460	2 802	3 521	3 479	2 461
Germany	5 053	720	620	962	1 453	1 298
Estonia	29 013	866	7 117	3 636	8 284	9 110
Rest of Europe	69 564	10 615	16 945	16 372	14 322	11 310
Turkey	5 016	546	932	836	1 484	1 218
Russia	50 372	9 129	11 415	12 166	9 888	7 774
Africa	21 761	3 154	4 078	3 181	5 364	5 984
Somalia	8 532	1 484	2 314	1 376	1 334	2 024
North America	6 398	1 195	1 170	1 391	1 574	1 068
South America	4 137	468	577	762	1 277	1 053
Asia	46 882	3 753	6 597	8 677	13 364	14 491
India	4 529	310	262	605	1 583	1 769
Irak	6 035	171	1 445	1 639	995	1 785
China	7 428	624	947	1 076	2 320	2 461
Thailand	5 551	360	621	883	1 928	1 759
Oceania	1 354	227	164	362	367	234
Australia	1 142	196	146	304	305	191
Unknown, no nationality	4 072	1 728	540	511	557	736

Interview form

Background Would you please, tell about yourself and your background? When did you come to Finland and for what reasons?
Communication Would you please, tell about your language skills? How has it been with the language when you have been using the Finnish health care services? Have you had the need for an interpreter?
Access to the healthcare services Would you please tell how you have been able to access to the Finnish health care system? Faced any problems?
Need for healthcare? Would you please tell have you had the need for the healthcare in Finland? If yes, what kind of?
Experience Would you please tell how have you experienced the Finnish health care (system, staff, quality...)?

Request for a permission to collect data

16.9.2011 Helsinki

Esteri Löppönen
Veera Rissanen
Maarit Yliruokanen maarit.yliruokanen@metropolia.fi
Ylästöntie 16 D 54 01510 Vantaa
Tel. 0408618760

Elina Eriksson
Director of Health Care and Nursing

REQUEST FOR A PERMISSON TO COLLECT DATA

Dear Director Elina Eriksson

We are kindly asking the permission and ethical consent for collecting data for our final project.

We are currently studying in the Degree Programme in Nursing at Metropolia University of Applied Sciences in the group SN08S1. We are working on our final project work which is meant to be published in autumn semester 2011. Our supervisor for the project is Eila-Sisko Korhonen. We are requesting for permission to collect data for our final project.

Our Final Project´s purpose is to explore the experiences of Chinese immigrants living in Finland Metropolitan area about the Finnish health care system. We are doing a qualitative study where our data collection method is semi-structured interviews. We are collecting information and answer the study question, which is: how do Chinese immigrants living in Finland Metropolitan area experience the Finnish health care system?

We are kindly asking for the permission to collect the data by interviewing individually 5-10 Chinese immigrants living in Finland (and possibly Chinese students studying in Metropolia UAS.) Interviews will be digitally recorded and transcripts will be made accordingly of the interviews. We are the only ones to see the material collected from the interviews; recordings, notes and transcripts and they will be destroyed after we have gathered all the data. Identity of the interviewees will be secured and at no point the results will indicate the answerer's identity. An informal written consent will be signed by the interviewees before conducting interviews.

The project is part of the Local and Global Development in Health Care research project which is done in partnership with Metropolia UAS. Our topic for the final project is "The experiences of Chinese immigrants of Finnish Health Care - in Finland Metropolitan area".

Sincerely Yours,

Esteri Löppönen
VeeraRissanen
Maarit Yliruokanen

Letter of information and consent

16.9.2011 Helsinki

Esteri Löppönen
VeeraRissanen
Maarit Yliruokanen

Dear recipient

We are three nursing students from Metropolia University Of Applied Sciences and we are doing our final project as a part of Local and Global Development in Health Care. Our topic is "Chinese Immigrants experiences on the Finnish Health Care Services and Health Care needs – in the Metropolitan area."

We kindly ask You to participate and allow us to use the gathered information in our final project. All answers will be dealt with confidentiality. Interviews will be digitally recorded and transcripts will be made accordingly of the interviews. We are the only ones to see the material collected from the interviews; recordings, notes and transcripts and they will be destroyed after we have gathered all the data. Identity of the interviewees will be secured and at no point the results will indicate the answerer's identity.

Thank You for your participation!

Esteri Löppönen, Veera Rissanen and Maarit Yliruokanen

Nursing Students

Metropolia University of Applied Sciences

Contact person Maarit Yliruokanen, Tel.0408618760

Hereby, I give permission to use all gathered information in "Chinese Immigrants experiences about the Finnish Health Care Services and Health Care needs – in Metropolitan area" – final project.
I have been fully informed about the purpose of the interview and how my answers will be used.

_____ _____

Place and Date Signature