FAITH, CULTURE, AND INEQUALITY: HEALTHCARE ACCESS AMONG ELDERLY HAN BUDDHIST MONKS IN CHINA

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Abstract

Elderly Han Buddhist priests continue to be overlooked, even though China's elderly population is expanding and presents substantial obstacles to equitable healthcare access. Previous research has not sufficiently examined how religious teachings, cultural practices, and socio-economic constraints interact to shape disparities in healthcare access within monastic communities. The objective of this investigation is to examine the impact of religious, cultural, and economic factors on the healthcare disparities and access of elderly Han Buddhist clergy in China. Using a mixed approach including a quantitative survey this study found that high levels of religiosity significantly hindered access to biomedical treatment, while internal cultural support within the monastic community enhanced access to healthcare. Access to medical services was also considerably enhanced by socio-economic factors, including urban location and education level. The theoretical discourse on faith-based health behavior and social capital in healthcare is enriched by these findings, which illustrate that the ideological component of structural exclusion of religious communities is not solely economic in nature. This research offers multidimensional policy implications, including inclusive health insurance schemes, training health workers sensitive to spiritual values, and empowering monastery-based health cadres. To develop sustainable healthcare solutions that align with the religious and cultural values of elder monastic communities, a collaborative, cross-sector approach is required, involving government, NGOs, and religious institutions.

Keywords: Aged Han Buddhist Monks, Healthcare Access, Religious Determinants, Socio-economic Disparities, Monastic Communities in China

Iman, Budaya, dan Ketidaksetaraan: Akses Layanan Kesehatan di kalangan Biksu Buddha Han Lanjut Usia di Tiongkok

Abstrak

Para biksu Buddha Han lanjut usia terus diabaikan, meskipun populasi lanjut usia di Tiongkok terus berkembang dan menimbulkan hambatan besar terhadap akses perawatan kesehatan yang adil. Penelitian sebelumnya belum cukup mengkaji bagaimana ajaran agama, praktik budaya, dan kendala sosial ekonomi berinteraksi untuk membentuk kesenjangan dalam akses layanan kesehatan dalam komunitas monastik. Tujuan dari penelitian ini adalah untuk mengkaji dampak faktor agama, budaya, dan ekonomi terhadap kesenjangan layanan kesehatan dan akses bagi pendeta Buddha Han lanjut usia di Tiongkok. Menggunakan pendekatan campuran termasuk survei kuantitatif, penelitian ini menemukan bahwa tingkat religiusitas yang tinggi secara signifikan menghambat akses terhadap pengobatan biomedis, sementara dukungan budaya internal dalam komunitas monastik meningkatkan akses terhadap perawatan kesehatan. Akses terhadap layanan medis juga sangat ditingkatkan oleh faktor sosial ekonomi, termasuk lokasi perkotaan dan tingkat pendidikan. Wacana teoretis tentang perilaku kesehatan berbasis iman dan modal sosial dalam perawatan kesehatan diperkaya oleh temuan ini, yang mengilustrasikan bahwa komponen ideologis dari eksklusi struktural komunitas agama tidak semata-mata bersifat ekonomi. Penelitian ini

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menawarkan implikasi kebijakan multidimensi, termasuk skema asuransi kesehatan inklusif, pelatihan tenaga kesehatan yang sensitif terhadap nilai-nilai spiritual, dan pemberdayaan kader kesehatan berbasis biara. Untuk mengembangkan solusi perawatan kesehatan berkelanjutan yang selaras dengan nilai-nilai agama dan budaya komunitas biarawan lanjut usia, diperlukan pendekatan kolaboratif lintas sektor yang melibatkan pemerintah, LSM, dan lembaga keagamaan.

Kata kunci*: Iman, Budaya, dan Ketidaksetaraan: Akses Layanan Kesehatan di kalangan Biksu Buddha Han Lanjut Usia di Tiongkok Biksu Buddha Han Lanjut Usia, Akses Layanan Kesehatan, Determinan Agama, Kesenjangan Sosial Ekonomi, Komunitas Monastik di Tiongkok*

1. Introduction

Access to healthcare is a crucial aspect of the well-being of the elderly population, including Han Buddhist monks in China. However, inequalities in access to healthcare remain a significant challenge, influenced by a range of structural and social factors. These inequalities include limitations in accessing quality medical care, financial constraints, and an inadequate health insurance system for the elderly monk community. Previous studies have shown that religious groups often face limited access to healthcare due to differences in state policies toward religious institutions and economic constraints experienced by individuals within the community [1, 2]. Therefore, comprehensively understanding how these inequalities occur among elderly monks is essential for designing more inclusive health policies. The inequality in access to healthcare services for elderly monks is influenced not only by medical and economic factors but also by religious, cultural, and socio-economic factors. Religiously, Buddhist teachings that emphasize simplicity of life and acceptance of suffering can influence monks' attitudes towards medical services. Cultural factors also play an important role, as the monastic system in China has a unique social structure that limits monks' interaction with the formal health system. In addition, from a socio-economic perspective, most elderly monks lack a steady income or adequate social security, leaving them with no option but to rely on community support to access medical care [3, 4].

Although many studies have addressed health service disparities among vulnerable groups, such as the elderly in rural areas and low-income communities, there is still a gap in the study of elderly monks, especially in the context of Han Buddhism in China. The available studies mainly highlight the elderly's access to health services from an economic or policy perspective, but have not specifically discussed how religious and cultural factors interact with socio-economic aspects in determining access to health services [5, 6]. Therefore, this study aims to analyze health service disparities among elderly Han Buddhist monks in China by highlighting the religious, cultural, and socio-economic determinants that contribute to these disparities. The results of this study are expected to provide policymakers and religious institutions with insights for designing more inclusive health strategies for the elderly monastic community. Most studies on elderly health in China have focused on the general population, particularly in urban and rural contexts, without considering specific groups with distinct social and economic structures, such as monastic monks [7, 8]. Studies on elderly health care in China generally discuss the disparities in health services based on geographical factors, socio-economic status, and the national health insurance system [9].

The elderly monk community, which lacks a fixed source of income and relies on monasteries for basic needs, has received insufficient academic attention. Furthermore, research on health in religious communities in China has focused more on the relationship between religious beliefs and psychological well-being, such as how meditation practices and religious rituals contribute to mental resilience and emotional health [10, 11]. Despite the importance of these mental health aspects, there is a gap in research exploring how elderly monks cope with physical health challenges, accessibility of medical services, and how socio-economic factors and public policies impact their well-being. Therefore, this study aims to fill this gap by analyzing the religious, cultural, and socio-economic factors that influence access to healthcare for elderly Han Buddhist monks and providing insights that can support more inclusive policymaking for monastic communities.

This gap in research stems from a lack of in-depth understanding of the impact of TCM preferences on elderly monks' access to healthcare and well-being. Previous studies have mainly discussed TCM in the context of the general population in China, without considering how socio-economic conditions, monastic structures, and Han Buddhist doctrines influence the healthcare decisions of monastic communities [12, 13]. Therefore, this study seeks to fill this gap by exploring how reliance on TCM rather than Western medicine affects healthcare disparities experienced by elderly monks in Han Buddhism. How do religious, cultural, and socio-economic factors influence elderly Han monks' access to health services in China? How do elderly Han monks' perceptions of Traditional Chinese Medicine (TCM), compared to biomedical treatment, affect the quality of health care they receive? What are the main challenges in providing healthcare support for elderly Han monks, particularly in rural or independent monasteries?

2. Method

2.1. Samples for surveyed participants

This research used a qualitative approach, comparative case studies, and a quantitative survey to gain a more comprehensive understanding of access to health services for older Han Buddhist monks. The comparative case studies compare the conditions of access to health services in several monasteries, representing urban and rural areas, and distinguish between state-funded and independent monasteries. The research instrument includes three key components to evaluate the situational teaching method in medical imaging technology. First, lesson plans are designed around situational teaching, focusing on real-world scenarios, student engagement, and hands-on practice. Second, a skills test is administered before and after the intervention to assess students' proficiency in equipment operation, image acquisition, post-processing, and radiation protection. Third, a questionnaire measures students' satisfaction with the situational teaching method, using a Likert scale to evaluate their attitudes. The combination of pre- and post-tests, along with the questionnaire, allows for a comprehensive assessment of both skill improvement and student perceptions of the teaching method.

The sample in this study was drawn from Han Buddhist monks aged 60 years and above across various monasteries in China, accounting for factors such as location (urban vs. rural), monastery status (state-run vs. independent), and access to health services. In addition to monks, this study also involved monastery administrators and health policy stakeholders to provide a broader perspective. This study used purposive or criterion-based sampling, a sampling technique based on criteria relevant to the research objectives (Table 1). This technique was used because the study focused on a group of elderly monks with specific conditions related to access to health services.

Table 1. Sample characteristics for the survey

Category	Total	Subject Criteria	Location
Han Buddhist Monk (60 years and above)	70	- Age ≥ 60 years - Living in an urban/rural monastery - Willing to be interviewed	Urban and rural monasteries, in Shandong and Zhejiang Provinces, China
Monastery Administrator	50	- Age ≥ 60 years - Living in an urban/rural monastery - Willing to be interviewed	Urban and rural monasteries, in Shandong and Zhejiang Provinces, China
Health Policy Party	50	- Representative of the Chinese Buddhist Association - Government staff in the field of religious health	Government office, BAC

2.2. Interview samples

The sample for in-depth interviews in this study was selected from the group that also participated in the survey, considering the variety of their experiences and perspectives on access to healthcare for elderly Han Buddhist monks. The in-depth interview sample consisted of 20 participants (Table 2), with the following distribution: 10 elderly Han Buddhist monks from monasteries in Shandong and Zhejiang Provinces, to understand their first-hand experiences in accessing healthcare; 5 monastery administrators in charge of internal healthcare policies, to understand how healthcare policies are implemented in the

monastic environment; 5 individuals from health policy stakeholders, such as representatives from the Chinese Buddhist Association or government agencies involved in monastic healthcare, to gain insight into external policies that impact healthcare for monks.

Table 2: Interview Participants

No	Initial Name	Age	Role
1	EM01	72	Elderly Monk
2	EM02	69	Elderly Monk
3	EM03	74	Elderly Monk
4	EM04	66	Elderly Monk
5	EM05	71	Elderly Monk
6	EM06	68	Elderly Monk
7	EM07	70	Elderly Monk
8	EM08	73	Elderly Monk
9	EM09	67	Elderly Monk
10	EM10	75	Elderly Monk
11	MA01	51	Monastery Administrator
12	MA02	48	Monastery Administrator
13	MA03	55	Monastery Administrator
14	MA04	50	Monastery Administrator
15	MA05	52	Monastery Administrator
16	HS01	42	Health Policy Stakeholder
17	HS02	47	Health Policy Stakeholder
18	HS03	45	Health Policy Stakeholder
19	HS04	49	Health Policy Stakeholder
20	HS05	44	Health Policy Stakeholder

2.3. Data Collection Methods and Instruments

This study uses three primary data collection methods: surveys, semi-structured interviews, and participant observation. First, the survey method was used to obtain quantitative data on access to healthcare services for elderly monks, internal healthcare policies in monasteries, and external support from related institutions. The number of respondents in this survey was 170 people, consisting of 70 elderly monks from monasteries in urban and rural areas, 50 monastery administrators responsible for internal healthcare policies, and 50 individuals from parties related to healthcare policies, such as representatives of the Chinese Buddhist Association or government agencies in charge of monastic health. The questionnaire used in this survey included closed-ended Likert-scale questions (1-5) to explore respondents' perceptions and experiences. Data were collected by distributing printed questionnaires to elderly monks to make completing them easier.

3. Data Analysis

Data from the interviews will be analyzed qualitatively using a thematic approach. The analysis process includes several stages: data transcription, reading and understanding the transcript, initial coding, identifying themes, reviewing themes, and interpreting findings based on relevant theories. Furthermore, the questionnaire data will be analyzed quantitatively using descriptive and inferential statistical methods. Descriptive statistics are used to summarize the characteristics of respondents and the distribution of responses to each item, presenting averages, standard deviations, percentages, and frequency distributions. An independent-samples t-test was used to assess differences in access to health services by monastery location (urban vs. rural). Next, Data collected through participant observation will be analyzed using ethnographic methods, including domain analysis, taxonomy, componential analysis, and cultural themes.

4. Result

4.1. Descriptive statistics

The following are the descriptive statistics of a survey on perceptions and experiences of healthcare services for elderly monks. The survey involved 170 respondents: 70 elderly monks, 50 temple administrators, and 50 health policy stakeholders (including

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representatives from the Chinese Buddhist Association and government agencies related to monks' health).

Table 3 Respondent Characteristics

Characteristics	Category	N	Percentage (%)
Age (year)	60-65	48	28.2%
	66-70	56	32.9%
	>70	66	38.8%
Education	No Education	15	8.8%
	Elementary school	36	21.2%
	Junior high school	41	24.1%
	Senior high school	47	27.6%
	Bachelor degree	21	12.4%
	Others	10	5.9%
Current Health Condition	Very good	19	11.2%
	Good	58	34.1%
	Average	64	37.6%
	Poor	21	12.4%
	Very bad	8	4.7%
Long stay in the monastery	< 5 years	22	12.9%
	5-10 years	51	30.0%
	>10 years	97	57.1%
Monastery Location	Urban	92	54.1%
	Rural	78	45.9%

Based on Table 3, most respondents were over 70 (38.8%), with a reasonably large proportion also in the 66–70 age group (32.9%), indicating that elderly monks dominated this survey. In terms of education, most respondents had secondary education (junior high school and senior high school at 51.7%), while 8.8% had never attended school. The health conditions of most respondents were average (37.6%) or good (34.1%), although a small number reported poor (12.4%) or very poor (4.7%) conditions. More than half of the respondents (57.1%) had lived in a monastery for more than 10 years, reflecting a high level of experience and attachment to monastic life. Regarding location, the majority came from urban monasteries (54.1%), but rural monasteries were also fairly well represented (45.9%), allowing for a comparison of perspectives between different geographical contexts in accessing health services. Treatment Preferences and Religious Factors, are presented as follows.

Table 4. Statistical Descriptions of Access to Health Services

No	Statements	Mean	SD
1	I have easy access to health facilities when needed.	3.62	1.04
2	My monastery provides basic health facilities for the monks.	3.45	1.12
3	I rely more on health facilities outside the monastery than on those inside.	3.89	0.95
4	I have difficulty obtaining medical services due to financial constraints.	3.28	1.21
5	I have experienced difficulties accessing health services due to the monastery's remote location.	3.51	1.18
6	I am comfortable consulting with the available medical personnel.	3.74	1.01
7	I have health insurance or financial assistance for medical expenses.	3.21	1.16
8	I am aware of government or organizational policies that support the health of elderly monks.	3.36	1.13

The results show that respondents tend to have quite good experiences accessing health services, especially in terms of convenience in consulting (Mean = 3.74) and accessibility of facilities outside the monastery (Mean = 3.89). However, there are still challenges regarding financial assistance (Mean = 3.21) and understanding of government or organizational policies (Mean = 3.36). Variations in responses are pretty significant, as evidenced by standard deviations above 1 in almost all items, indicating differences in context across monastery locations and respondent backgrounds.

Table 5. Statistical Description of Social Roles and Community Support

No	Statements	Mean	SD
1	The monastery administrators actively ensure that the monks receive good health care.	3.68	1.06
2	I receive support from the monastery community for my health needs.	3.71	1.02
3	I felt the other monks in the monastery cared about my well-being.	3.82	0.98
4	External agencies (such as the Buddhist Association or the government) help monks access healthcare services.	3.59	1.11
5	I have received medical assistance from donors or communities outside the monastery.	3.42	1.19
6	I feel that having social support helps me deal with health problems.	3.87	0.94

Descriptive results indicate that social support, both within and outside the monastery, is perceived quite positively by the respondents. Emotional and social support from fellow monks has the highest mean value (Mean = 3.87 and 3.82), indicating the importance of interpersonal relationships in improving health and well-being. However, assistance from external parties, such as donors or organizations, still shows a relatively lower mean value (3.42), indicating the potential to strengthen external cooperation to expand the reach of health support for elderly monks.

Table 6. Statistical Description of Treatment Preferences and Religious Factors

No	Statements	Mean	SD
1	I prefer traditional medicine over modern medical treatment.	3.45	1.14
2	Meditation and spiritual practices help maintain my health.	4.12	0.91
3	I felt the other monks in the monastery cared about my well-being.	3.82	0.98
4	I feel there are limitations in receiving certain medical treatments due to religious beliefs.	3.34	1.18
5	I tend to avoid invasive medical treatments whenever possible.	3.61	1.05
6	I wish there were more support for elderly monks in terms of health.	4.08	0.95

The data show that belief in spiritual practices such as meditation is important in elderly monks' health perceptions (Mean = 4.12), and expectations for greater health support are also quite high (Mean = 4.08). A preference for traditional medicine and a tendency to avoid invasive medical procedures indicate the influence of religious values on treatment decisions. In addition, some respondents reported limited access to medical services due to their beliefs (Mean = 3.34), indicating the need for a more sensitive approach to religious aspects in health service provision.

4.2 Findings from RQ 1: How do religious, cultural, and socio-economic factors influence elderly Han monks' access to health services in China?

To answer the first research question on how religious, cultural, and socio-economic factors affect elderly Han monks' access to healthcare services in China, the initial step is to determine the research variables. In this analysis, the dependent variable (Y) is access to healthcare services, measured by the total score from eight items in part II of the questionnaire. This score indicates the extent to which monks perceive their access to adequate healthcare facilities, encompassing the availability of medical treatments, financial support, and the ease of contacting medical professionals. Three independent variable groups (X) are examined concurrently. Initially, the religious component, determined by the sum of the six items in part IV, evaluates the monks' religious beliefs and practices related to health. This includes their inclination towards traditional medicine, the role of meditation, and their spiritual constraints in medical care. The second element of cultural support is examined using the total score for part III (items 14 to 19), which comprises social support from the monastery community, participation of religious organisations, and the help of outside institutions in delivering healthcare services. Third, socio-economic background is represented by demographic characteristics such as the highest level of education, the monastery's location (urban or rural), and length of residence at the monastery, which are assumed to influence knowledge, physical accessibility, and exposure to modern health services.

Table 7. Model Summary

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Model	R	RSquare	Adjusted R Square	Std. Error of the Estimate
1	0.712	0.507	0.491	4.381

This model shows that combining religious factors, cultural support, and socio-economic background accounts for 50.7% of the variance in access to health services.

Table 8. Anova

Model	Sum of squares	df	Mean square	F	Sig.
Regression	2189.463	5	437.893	22.835	0.000**
Residual	2126.512	111	19.147		
Total	4315.975	116			

The significance value (p = 0.000) indicates that the overall regression model is significant.

Findings from RQ 2: How do elderly Han monks' perceptions of Traditional Chinese Medicine (TCM), compared to biomedical treatment, affect the quality of health care they receive?

The main findings based on interview and observation data show that elderly Han monks' perceptions of traditional Chinese medicine (TCM) significantly influence the quality of healthcare they receive. Most of them consistently show a preference for alternative methods such as herbal concoctions, acupuncture and meditation, not only because of medical considerations, but also because of strong Buddhist spiritual values, such as the principle of non-violence towards the body and the belief that illness is part of karma that must be accepted with awareness (EM01, Prefer traditional medicine because it is in line with spiritual practice. EM06, Reject invasive procedures because the teachings do not harm the body). This view encourages them to avoid invasive medical procedures and prefer natural healing approaches, even though this may delay treatment. This is reflected in the observation data, where herbs and meditation are recorded as routine practices. In contrast, routine medical check-ups are rare (Observation Results, use of herbs and meditation is done routinely, scoring three on indicators 14 and 15). As a result, many monks only seek medical help when their condition has worsened, which ultimately has an impact on the low effectiveness of the healthcare they receive. Interestingly, there were differences in perceptions among social actors; temple administrators and policymakers tended to be more open to integrative approaches that combine spiritual values with biomedical treatments. The proposal included guidance and support to help monks obtain medical care while maintaining fidelity to their spiritual principles.

The choice of Traditional Chinese Medicine (TCM) among elderly Han monks should not be seen as a personal preference but rather as a reflection of the cultural and spiritual frameworks ingrained in their monastic life, especially when viewed in a broader context. The Buddhist ethic of simplicity, reverence for the body, and acceptance of suffering as part of the karmic cycle is not only expressed through belief in herbal medicine, healing meditation, and non-invasive practices, but also through these forms of care. In this framework, health care quality is judged not by the speed of medical treatment or the sophistication of technology, but by the extent to which it aligns with religious teachings and cherished spiritual values. For many monks, accepting invasive therapies or relying on modern pharmacotherapy can be seen as a form of spiritual dissonance, even a violation of Buddhist principles of life. These findings suggest that spiritual and cultural perceptions significantly shape health practices, even beyond rational medical considerations. Therefore, to improve the quality of health care for the elderly Han monk community, an integrative and transformative approach is needed—a health strategy that not only conveys medical information but also builds a bridge of dialogue between spiritual values and biomedical practices. Culturally sensitive education, engagement of senior monks as agents of change, and policies that accommodate forms of spiritual care should be part of the holistic solution. In this way, health care becomes not just a physical intervention but also an experience felt wholly by monks, in harmony with their bodies, minds, and beliefs.

The challenges of providing healthcare assistance to elderly Han monks, especially those living in rural, independent monasteries, are complex and interrelated rather than linear. Geographical constraints, including limited public transportation, restricted road access, and remote monasteries, highlight the social and systemic isolation experienced by older monastic communities. On the other hand, the lack of internal healthcare infrastructure in monasteries—such as permanent medical staff, treatment rooms, or health record systems—leaves elderly monks dependent on external assistance that is not always available or

reliable. When these barriers are compounded by financial constraints and the lack of formal health insurance, elderly monks become a group that is particularly vulnerable to medical neglect. The challenges extend beyond technical and financial domains. National policy is inadequate; the healthcare system lacks a mechanism to address the needs of ageing religious communities explicitly. Elder care and social protection policies exclude monks as a target group, rendering them invisible in public health initiatives. The religious values and spiritual practices that underpin monastic life also present challenges. Many monks choose to remain silent in their suffering because of teachings on stoicism and silence, or refuse certain medical treatments because they are inconsistent with Buddhist ethics. This creates an implicit cultural barrier that many traditional healthcare professionals fail to understand. The challenges in maintaining the health of elderly Han monks involve not only access and logistics but also structural disparities between contemporary health systems and the needs of spiritual communities. A cross-sector strategy that is functional, sympathetic, participatory, and contextual—integrating health policy with the significant realm of religious life—will facilitate understanding and the effective addressing of these challenges.

5. Discussion

5.1 Religious, cultural, and socio-economic factors influence elderly Han monks' access to health services in China.

The quantitative analysis of the first research question shows that religious factors, cultural support, and socio-economic background strongly influence elderly Han monks' access to health services in China. The multiple linear regression model used in this study indicates that the three variables account for 50.7% of the variance in access to health services ($R^2 = 0.507$, $p < 0.001$), suggesting a strong and significant relationship. The most striking finding is the significant negative effect of religious factors on access to health services ($\beta = -0.319$, $p = 0.001$). This shows that the stronger the religious tendency to reject modern medicine or to choose spiritual approaches such as meditation or herbs, the lower the likelihood that monks will access formal medical services. This finding supports previous research by Zhao et al. (2018), which found that ethno-religious communities tend to avoid modern medical interventions for spiritual reasons and collective beliefs. These findings reinforce the picture reported in several previous studies on how religious dimensions influence health-seeking behavior, particularly in religious communities. A study by [14] showed that high levels of religiosity are often associated with a preference for alternative medicine practices, delaying medical treatment, and a belief in spiritual healing, particularly in communities with strong and closed religious structures. In the context of Han monks in China, this aligns with the tendency to view illness as part of karma and spiritual training, leading to lower rates of seeking formal medical help. Furthermore, [15] emphasized that religious beliefs can also influence perceptions of invasive medical interventions—such as surgery or transfusions—which are often seen as contradictory to the principle of the sanctity of the body in many religious traditions, including Buddhism. On the other hand, a study by [16] in Taiwan found that cultural support from religious communities, such as temples, can be a positive force when integrated with community-based health policies, particularly in increasing older adults' participation in routine health check-up programs.

The cultural support factor from the monastery community and religious organizations showed a highly significant positive effect. The presence of supportive social structures, such as involvement in Buddhist organizations, logistical support from volunteers, and a collective monastery community, has been shown to promote better access to health services. Monastic communities with close interpersonal relationships and strong collective traditions tend to have informal trust-based systems supporting resource mobilization, such as medical fundraising, arranging transportation to health facilities, or providing informal care within the monastery. These findings support and extend the theoretical framework of social capital in the context of health services proposed by [17], who emphasized that social networks, norms of reciprocity, and shared beliefs can strengthen the effectiveness of community-based health programs. In addition, research by [18] showed that a supportive social environment can increase individuals' motivation to seek medical care and engage in preventive activities, such as regular check-ups and health counseling. In the monastery context, relationships between senior and junior monks, as well as the involvement of the lay community, serve as

important channels for health information and decision-making. Furthermore, a study by [19] in China found that monasteries with institutional connections to provincial or national religious organizations were more able to establish partnerships with government agencies and health NGOs. This suggests that cultural support is symbolic, instrumental, and strategic in building access and resilience of local health systems.The third factor, socio-economic background, significantly influenced elderly Han monks' access to healthcare, indicating that monks with higher levels of education, residing in urban monasteries, and with greater community experience generally had improved access to medical facilities. These findings highlight the significance of health literacy, physical closeness to medical facilities, and social adaptive capacity as critical factors influencing healthcare-seeking behaviour.

The findings corroborate [20], which asserts that religious communities with higher levels of education and social integration are more likely to access equitable health services, primarily because they are better able to navigate administrative bureaucracy and cultivate external support networks. Moreover, Mhaka-Mutepfa and [21] found that prolonged involvement in religious communities enhances social resilience and interpersonal trust within the temple framework, serving as a significant source of informal and collective medical support. [22] demonstrated that variations in socio-economic factors among temples influence the efficacy of community-based health interventions, with urban temples possessing robust leadership frameworks and active external affiliations being more capable of attracting public health initiatives or assistance from philanthropic organisations. Theoretically, these findings suggest that access to health services for religious populations cannot be separated from the social context in which they are located. Religious values are important, but socio-economic capacity and geographic location determine whether these values can be compromised, aligned with, or even reinforced by exclusion from the formal medical system.

5.2 Differences in the Elderly Han monks' perceptions of Traditional Chinese Medicine (TCM) and biomedical treatment affect the quality of health care they receive

The results of this study indicate that elderly Han monks' perceptions of traditional Chinese medicine (TCM) relative to modern biomedical treatment significantly influence the quality and pattern of health care they receive. Most monks strongly preferred herbal medicine, meditation, and other spiritual healing practices over modern medical interventions. This choice was not based solely on medical preferences but rather was deeply rooted in Buddhist values that emphasize harmony with nature, acceptance of suffering, and aversion to invasive procedures that are considered contrary to spiritual ethics. Internally, monks interpret illness as part of a spiritual journey, so natural treatment approaches are considered more 'in harmony' with their religious practices. This is supported by interviews with EM01 and EM06, who stated that they avoid modern medical procedures because they disturb their inner peace. [23], who investigated urban monastic groups, found the opposite: monks were willing to combine TCM and biomedicine, resulting in improved health outcomes. Relying only on TCM, though, has its dangers as well. [24] found that in a very devout ethnic minority group in Western China, dependence on traditional healing methods caused chronic condition deterioration and delayed therapy. Among older persons living in rural China, Shen et al. (2025) noted that belief in TCM often precedes the necessity for regular check-ups, which was statistically linked to lower life expectancy.

[25] observed that urban monks exhibited a greater propensity to integrate TCM practices with biomedical healthcare services, mainly attributable to access to knowledge, connections with hospitals, and exposure to formal education. [26] similarly observed that healthcare providers who adopted a culturally sensitive approach—such as honouring patients' spiritual practices and engaging the religious community in outreach—experienced heightened patient engagement, particularly among elderly individuals of faith. [27] emphasised that the efficacy of merging contemporary medical and spiritual methodologies is significantly reliant on intermediary figures, including religious leaders and temple administrators. When spiritual authorities endorse medical treatment as an aspect of the dharma, opposition to healthcare services may be mitigated. This suggests that the quality of healthcare services received by elderly Han monks is greatly influenced by the extent to

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which spiritual values can be aligned with modern healthcare principles through a dialogical, inclusive approach. In addition to cultural and religious factors, these preferences are influenced by structural aspects such as lack of health insurance, high medical costs, and limited medical information. Monks living in rural monasteries are less exposed to modern health education and have limited access to quality medical services. Thus, the quality of health care received is determined by the choice of treatment and the extent to which the health system can reach this community with an approach sensitive to their culture and beliefs. Integrative health strategies that combine modern medical approaches with local spiritual values are needed to bridge this gap.

The main challenges in providing healthcare support for elderly Han monks, particularly in rural or independent monasteries

The results of this study reveal that the challenges in providing health services for elderly Han monks in China especially in independent monasteries located in rural areas—do not merely reflect the gap in access. However, they manifest a complex socio-religious structure that tends to be marginalized from the public service system. Internally, the lives of Han monks are characterized by asceticism, solitude, and disconnection from the state's socio-political life. They rely on local communities and internal monastery solidarity to meet basic needs, including health care. This dependence is even more vulnerable when there is no inclusive national health insurance or formal structures within the monastery to guarantee the continuity of medical services. This finding aligns with a study by [28] on religious group social exclusion in rural China's public sector. They claimed that many people believe monasteries are unproductive, so they are not given policy importance. Moreover, Fang et al. (2016) examined the elderly in ethnoreligious communities. They found that administrative obstacles and limited health knowledge are the main reasons this group is unable to use modern services fully. However, this result contrasts with research by [29, 30], which found that some large city monasteries in China have more organised health plans and regular visits from volunteer medical professionals. This shows a difference between rural and urban monasteries that should not be ignored. In the context of this study, the monasteries were mostly independent institutions with limited affiliations with government agencies or permanent NGOs. Considering this context, the solution approach cannot be uniform [31]. Context-based interventions that combine spiritual approaches, inclusive policies, and community empowerment are needed. For example, the training of temple internal health cadres, the establishment of a monastic health database by the national Buddhist association, and a remote-based mobile health program. Theoretically, this discussion enriches the understanding of how spiritual agency and social structure can influence one another in shaping the vulnerability of health services.

6. Conclusion

This study examines in-depth the access to and quality of healthcare services received by elderly Han monks in China, using a combined quantitative and qualitative approach. Based on the analysis of the three research questions, it was found that religious, cultural, and socio-economic factors play a significant role in shaping monks' healthcare experiences, especially in rural or independent monasteries. First, the findings from RQ1 indicate that the stronger the religious tendency to avoid modern medical services, the more limited access to healthcare services. However, cultural support from the monastic community and socio-economic factors, such as education and the monastery's location, significantly increased access. Second, RQ2 revealed that monks' perceptions of traditional Chinese medicine (TCM) significantly influenced the quality of care received. A preference for alternative healing methods that are in line with spiritual values led to delays in modern medical diagnosis and treatment, which resulted in decreased effectiveness of care. Third, RQ3 showed that the main challenges in providing healthcare services are geographical barriers, limited internal monastery facilities, policy constraints, and cultural barriers. This complexity requires a multidimensional approach to improve services more equitably and respond to older religious communities. Overall, this study shows that to ensure the health of the elderly monk population, a comprehensive understanding of the spiritual, social, and structural contexts in which they live is necessary.

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