Check for updates

Health & Social Care in the Community

WILEY

RESEARCH ARTICLE OPEN ACCESS

Understanding Chinese Late-Life Migrants' Experiences of Healthcare Access and Utilisation in Aotearoa New Zealand

Xi Zhu[1] | Irene Zeng[2] | Priya Saravanakumar[3] | Eleanor Holroyd[1,4]

[1]AUT Migrant and Refugee Health Research Centre, Auckland University of Technology, Auckland, New Zealand | [2]Faculty of Health and Environmental Sciences, School of Nursing, Auckland University of Technology, Auckland, New Zealand | [3]Faculty of Health, School of Nursing and Midwifery, University of Technology Sydney, Sydney, Australia | [4]Faculty of Health and Environmental Sciences, School of Public Health and Interdisciplinary Studies, AUT Migrant and Refugee Health Research Centre, Auckland University of Technology, Auckland, New Zealand

Correspondence: Xi Zhu (em161784@aut.ac.nz)

Received: 1 December 2025 | **Revised:** 17 October 2026 | **Accepted:** 4 November 2026

Keywords: Aotearoa New Zealand | healthcare access and utilisation | recently arrived Chinese late-life migrants

ABSTRACT

Healthcare access and utilisation for Chinese late-life migrants is an important issue in Aotearoa New Zealand (NZ) due to the unmet healthcare needs of this rapidly growing priority population. This study aimed to explore factors influencing healthcare access and utilisation among Chinese late-life migrants, who were aged 65 years and over and immigrated to Aotearoa NZ within 10 years, and to propose actionable recommendations for enhancing healthcare access. The study used a qualitative descriptive approach to conduct semistructured interviews with 12 Chinese late-life migrants (5 males, 7 females; aged between 65 and 78 years; arrived in Aotearoa NZ within the last 10 years). Data analysis revealed four major themes: (1) 'it is the little things that matter the most', (2) fractured patient–practitioner relationship, (3) cultural beliefs and attitudes Toward healthcare access and utilisation, and (4) desire for healthcare information. These findings offer culturally relevant insights to improve migrant healthcare delivery in Aotearoa NZ. Specifically, the study recommends cross-cultural training, bilingual staff, enhanced education, strengthened healthcare equity policies, community orientation and peer-support programmes to reduce barriers, improve inclusivity and enhance healthcare access for Chinese late-life migrants.

1 | Introduction

In Aotearoa New Zealand (NZ), 15% of the population is aged 65 years or older [1], with Chinese late-life migrants making up nearly 6% of this group—a figure projected to double by 2038 [2]. Since 2000, the Chinese population in Aotearoa NZ has grown rapidly, with the late-life group increasing by 3.5% annually [1, 3]. While longer lifespans offer opportunities, they also bring health challenges, especially for late-life adults and migrants [4].

Global and NZ-based research has highlighted that factors such as age, language, cultural background, financial resources, facilities and health conditions significantly influence migrants' healthcare access and utilisation, underscoring the need for targeted support for this rapidly growing population [5–10].

Language competency in participants significantly affects late-life migrants' access to and use of healthcare services [6]. Globally, research showed that migrants with limited English proficiency often struggle to make appointments, locate health facilities, communicate effectively with providers and understand their health conditions [8, 11]. NZ-based recent migrant studies highlighted that language barriers—such as difficulty understanding medical terms, reading healthcare documents and communicating with professionals—pose serious challenges [12–14].

Importantly, late-life adults are more likely to develop chronic conditions such as cardiovascular disease, diabetes and cancer [15]. Consequently, late-life adults, including migrants, are more likely to require and use healthcare services, especially primary

This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

Copyright © 2026 Xi Zhu et al. *Health & Social Care in the Community* published by John Wiley & Sons Ltd.

[16] and hospital care [5]. Consequently, access to and engagement with unfamiliar healthcare services in a new host environment pose considerable challenges for late-life migrants, especially for recently arrived migrants [8].

Migrants have often removed themselves from their familiar social and cultural environment, and the changes in cultures, traditional family expectations, lifestyle and social support systems have been shown to affect health-seeking behaviours in the host countries [17, 18]. For example, cultural beliefs, such as 'we don't want to be a burden', or not replying on filial piety become barriers in restricting late-life migrants from accessing and utilising unfamiliar healthcare services in a new environment [7, 19, 20].

In Aotearoa NZ, many health services, including secondary and tertiary care, are free or subsidised for residents [21]. However, recent migrants without citizenship or residency and with low incomes often face challenges accessing care [22, 23]. These barriers can significantly affect healthcare utilisation for economically disadvantaged nonresident populations [6].

To date, many Aotearoa NZ–based studies have tended to aggregate migrants into ethnic chapters such as Asian or African, which fails to capture the specific and unique cultural beliefs and nuances which pose barriers to accessing services. This study addressed that gap by exploring healthcare access and utilisation among Chinese late-life migrants in Aotearoa NZ, aiming to provide a more comprehensive and culturally informed understanding of their experiences.

2 | Method and Aim

The study employed a qualitative descriptive (QD) approach to explore the possible factors influencing Chinese late-life migrants' healthcare access and utilisation in Aotearoa NZ.

2.1 | Inclusion and Exclusion Criteria

The inclusion criteria were migrants who self-identified as Chinese, were aged 65 years or older, of any gender, had migrated to Aotearoa NZ within the 10 years from the date of interview, held permanent residency or citizenship and resided in the Auckland region. Moreover, no specific exclusion criteria were applied to ensure the utmost fairness and transparency.

2.2 | Sampling Approach and Participant Recruitment

Purposive sampling with maximum variation was used to capture diversity in sociodemographic characteristics (i.e., age, gender, length of residence, migration background and socioeconomic circumstances), allowing the study to encompass a range of experiences among Chinese late-life migrants. This approach enabled the study to explore diverse experiences of adapting to different circumstances while identifying common patterns across participants [24]. Therefore, it broadened the range of perspectives captured and enhanced the depth and transferability of the findings [25]. Potential participants were recruited through multimedia platforms commonly used by Chinese late-life migrants, including WeChat and the SkyKiwi website.

2.3 | Semistructured Interview Guide

A semistructured in-depth interview guide (see Appendix A) was developed to explore participants' experiences in line with the research objective, drawing on an extensive literature review. Sample questions included 'Why did you change the general practitioners (GPs)?' and 'What is the most important factor for you to choose to use or not use such health services?'

2.4 | Ethics and Piloting

Following ethics approval by the Auckland University of Technology Ethics Committee (AUTEC) with the approval number 20/234 (on 24 August 2020), two pilot interviews were conducted. The pilot test refined the semistructured interview guide, assessed clarity and timing, enhanced cultural sensitivity with community feedback and ensured in-depth, inclusive data collection through two purposively sampled practice interviews.

2.5 | Data Collection

A total of 12 key participants were interviewed via WeChat between September 2020 and February 2021, including five males and seven females. Although many late-life Chinese individuals showed interest in this study, we lost contact with several potential participants during the COVID-19–related lockdowns in the Auckland region, highlighting the challenges faced in maintaining participant engagement.

Data saturation was used to guide the final sample size in this study. Recruitment concluded after 12 interviews based on an ongoing assessment of the informational contribution of successive interviews. Data collection and analysis were conducted concurrently, enabling the researcher to assess whether each additional interview generated substantively new codes, concepts or patterns relevant to Chinese late-life migrants' healthcare access and utilisation. As data collection progressed, later interviews predominantly confirmed and elaborated existing codes and themes, while few substantively new insights emerged. The researcher therefore judged that the collected data were saturated, and further interviews were unlikely to meaningfully extend the depth or breadth of the developing themes. Recruitment was consequently discontinued based on the dataset's information power, reflected in the richness, relevance and recurrence of participants' accounts, rather than on a predetermined sample size [26]. This approach provided a transparent and methodologically grounded basis for demonstrating sample adequacy, credibility and dependability.

Besides healthcare experiences, this study also gathered participants' sociodemographic information to provide a clear overview of their personal backgrounds. All participants were born in the People's Republic of China (PRC), were aged between 65 and 78 years, immigrated to Aotearoa NZ between 3 and 10 years prior to the interviews and hold eligible visa (Permanent Resident Visa = 10, Aotearoa NZ citizenship = 2) to use local healthcare services (see Table 1). Participants' other sociodemographic characteristics (see Table 1) included civil/marital status (married = 8, widowed = 2, divorced = 1), accommodation status (11 living with adult children and/or a partner, 1 adult child living nearby), financial status (all had sources of income), health/medical insurance status ($n = 10$), education level (university education and above = 3, secondary education = 9) and

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/3819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

TABLE 1 | Interviewees' sociodemographic information.

No.	Gender	Age	Birthplace	Immigration status	Length of residence in Aotearoa NZ	Civil/ marital status	Living with adult children	Employment status	Health insurance	Highest completed qualification	First language	Language proficiency (English)
1	Male	65	PRC[a]	PR[b]	3 years	Widowed	Lives with daughter and granddaughters	Part time	Medicare insurance	Bachelor degree	Mandarin	Fair
2	Female	71	PRC	Citizen	10 years	Married	Lives with husband. Daughter lives in China	Retired	Medicare insurance	Bachelor degree	Cantonese and Mandarin	Good
3	Female	71	PRC	PR	7 years	Married	Lives with son, daughter-in-law, grandson and granddaughter	Retired	None	Middle school certificate	Mandarin	Poor
4	Female	68	PRC	PR	5 years	Married	Lives alone. Son lives in Auckland	Retired	Medicare insurance	High school	Mandarin	Poor
5	Female	69	PRC	PR	9 years	Married	Lives with husband, daughter, son-in-law and grandson	Retired	Private health insurance	High school	Mandarin	Poor
6	Male	65	PRC	PR	8 years	Divorced	Lives with daughter, son-in-law and granddaughter	Retired	Medicare insurance	High school	Mandarin	Fair
7	Female	65	PRC	PR	6 years	Married	Lives with son and daughter-in-law	Retired	None	High school	Mandarin	Poor
8	Male	68	PRC	PR	8 years	Married	Lives with wife, son and daughter-in-law	Self-employed	Medicare insurance	High school	Mandarin	Poor
9	Male	72	PRC	Citizen	10 years	Married	Lives with wife, son and grandson	Retired	Medicare insurance	High school	Mandarin	Poor
10	Male	70	PRC	PR	9 years	Married	Lives with daughter, son-in-law and granddaughter	Retired	Private health insurance	Bachelor degree	Mandarin	Fair
11	Female	75	PRC	PR	7 years	Widowed	Lives with daughter and granddaughter	Retired	Medicare insurance	Middle school certificate	Mandarin	Poor
12	Female	78	PRC	PR	6 years	Widowed	Lives with daughter, son-in-law and granddaughter	Retired	Medicare insurance	Middle school certificate	Mandarin	Poor
—	69.7	—	—	7.3 years	—	—	—	—	—	—	—	

[a]PRC represents People's Republic of China.
[b]PR represents permanent resident visa.

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/5819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

English language proficiency (three have fair English language proficiency, and one was good).

Understanding participants' sociodemographic characteristics is important because these factors may have shaped their healthcare experiences and, consequently, the perspectives represented in the findings. Existing evidence suggests that gender and family roles may influence expectations of independence, caregiving responsibilities and concerns about becoming a burden [8]. Similarly, limited English proficiency and lower educational attainment have been associated with greater reliance on Chinese-speaking practitioners, family members and social networks to access and understand healthcare [27]. Living with adult children may have provided practical support in navigating healthcare services, while longer residence in Aotearoa NZ may have facilitated greater familiarity with the healthcare system. Collectively, these characteristics may have contributed to differences in healthcare experiences and the range of perspectives captured.

2.6 | Data Analysis Method

Data were analysed using [28] the six-phase approach to thematic analysis: familiarisation, coding, generating themes, reviewing themes, defining and naming themes and reporting. NVivo 20 was used to organise and manage the interview transcripts and coding process.

Following transcription and translation of the audio-recorded interviews from Chinese into English, the researcher repeatedly read the transcripts to develop familiarity with participants' experiences and perspectives. Initial coding was primarily inductive and data-driven. Codes were generated systematically from the data to capture salient meanings, experiences, beliefs and perspectives related to healthcare access and utilisation. Although the research questions and interview guide provided broad areas of enquiry, specific codes were not established a priori but emerged iteratively from participants' accounts. As the example shows in Table 2, participants' preferences for acupuncture over Western physiotherapy generated codes such as 'upbringing' and 'trust', which informed subsequent theme development.

Related codes were then compared and grouped to develop candidate themes. For example, the code 'upbringing' and 'trust' contributed to the candidate themes 'healthcare awareness' and 'patient–practitioner relationship' (see Table 2). Themes were iteratively reviewed against coded extracts and the dataset to assess their coherence and relevance to the research question. Overlapping themes were merged, while conceptually distinct patterns were separated and further refined. Alternative interpretations were considered, and codes or theme definitions were revised where necessary. This iterative process enhanced the credibility and transparency of the analysis while ensuring that the final themes remained grounded in participants' accounts. The findings subsequently informed the development and refinement of the questionnaire.

2.7 | Rigour

To ensure the rigour of this study, several strategies were undertaken to enhance the credibility, transferability, dependability and confirmability of the study [29].

Credibility was supported using a semistructured interview guide, which ensured consistency while allowing participants to elaborate on their experiences of healthcare access and utilisation. Participants were also invited to review their interview transcripts, although no corrections or amendments were requested. To verify the Chinese–English translation, an independent translator back-translated the English transcripts into Chinese for comparison with the original Chinese accounts. During analysis, the researcher remained closely attentive to participants' language and meanings and maintained reflexive notes to identify personal assumptions and potential biases.

Transferability was supported by providing detailed descriptions of the study setting, participant characteristics, sampling, data collection and analytical procedures. Given the culturally specific experiences, values and beliefs of Chinese late-life migrants, the findings are not intended for statistical generalisation; their applicability to other populations or contexts should therefore be considered in relation to contextual similarities and differences.

Dependability was enhanced through systematic documentation of methodological decisions and procedural changes in a research journal, providing an audit trail.

Confirmability was further supported by the audit trail and ongoing reflexivity, which enabled the researcher to critically examine assumptions and ensure that interpretations remained grounded in participants' narratives. Collectively, these procedures strengthened the transparency, consistency and trustworthiness of the findings.

3 | Findings

Four interrelated themes were identified: (1) 'it is the little things that matter the most', (2) fractured patient–practitioner relationship, (3) cultural beliefs and attitudes toward healthcare access and utilisation, and (4) desire for healthcare information. Together, these themes describe how everyday practicalities, relational factors, cultural values and information access shape recently arrived Chinese late-life migrants' healthcare experiences in Aotearoa NZ. The themes were not discrete but reflected recurring and overlapping influences on participants' decisions and engagement with healthcare services. Table 3 summarises these themes.

3.1 | Theme 1: 'It is the Little Things That Matter the Most'

Participants described a range of seemingly minor but consequential factors, such as waiting times, appointment scheduling, location of services and language support, that shaped their use of healthcare services. Four subthemes illustrate these concerns.

3.1.1 | Time Matters

Participants expressed frustration over prolonged waiting times. One participant said '*Getting an appointment (with a GP) at a suitable time is a big problem. It really takes time. Sometimes, I need to wait for a few days until an appointment is available*' (P3, female, 71 years). Another participant reported that delays occurred even with scheduled appointments. '*Even if I did get an appointment, I was never seen on time. This can be inconvenient if I*

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/3819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

TABLE 2 | Example of the thematic analysis process.

Transcript	Code	Potential themes
Participant 8: 'Oh that. I twisted my waist, around my back. My *GP was advising* me to see like *western physiotherapy*, but *to us Chinese*, *we know* that *acupuncture works well on these problems* and *we trust it*. It turned out quite good actually.'	Upbringing Trust	Healthcare Awareness Patient–Practitioner Relationship

have a tight schedule and need to be elsewhere' (P7, female, 65 years).

Meanwhile, the endless waits in secondary and tertiary care heightened their concerns about diagnosis and treatment. Participants complained of unpleasant experiences of using the emergency department (ED) and specialist care services on multiple occasions during their interviews:

> "*I really don't like emergency care here (Aotearoa NZ). If you need to use it, you have to wait a very long time ... I have used emergency care several times. I have to wait for hours. The longest time I have waited was over 6 hours.*" (P6, male, 65 years)

> "*I have been trying for two weeks to get an appointment with a specialist, but no success... the queuing is too long.*" (P5, female, 69 years)

These experiences of waiting for hours in accessing secondary and tertiary healthcare services in Aotearoa NZ, as described by Chinese late-life migrant participants, underscore the emotional and psychological impact these delays have on them. However, the frustration is not merely about the delays themselves. What particularly bothered recently arrived Chinese late-life migrants was the stark contrast between their experiences with emergency care in China and those in Aotearoa NZ.

> "*Once my grandchild was in the emergency for fever. The nurse just took the temperature and asked us to wait ... We waited over 10 hours before the doctor was available. But he just told us to go back to the GP without any treatments. It's unbelievable... It wouldn't happen in China. My grandchild could be given treatment immediately (in China). That's why it is called emergency care, isn't it?*" (P1, male, 65 years)

Such experiences highlighted participants' concerns about how the procedural differences and longer waiting times are not just inconvenient but also contribute to a sense of uncertainty and anxiety. Migrants often feel that their urgent medical needs are not being addressed with the immediacy they were accustomed to in China.

3.1.2 | Location of Services

Many participants emphasised that being close to healthcare services is the main factor affecting their healthcare access and utilisation. For instance, one participant registered with the GP near his workplace because '*it is difficult to take time off work ... But the clinic is very close to my office. So, I can see my GP during my lunch break*' (P1, male, 65 years).

Sometimes, the location of the service, especially GP services, becomes the factor that takes higher priority for Chinese late-life participants. One participant said '*I moved several times and can always find Chinese GPs nearby. But, after moving to my current home, the nearest Chinese GP is about a half-hour drive away, which is too far... I had to start seeing a Kiwi doctor instead*' (P7, female, 65 years).

3.1.3 | Availability of Chinese-Speaking Practitioners

Access to Chinese-speaking healthcare professionals represents a vital factor influencing the healthcare-seeking behaviour. A number of participants express a preference for healthcare practitioners who speak their language fluently. In some cases, participants, who considered service location as a priority factor, still considered the availability of Chinese-speaking doctors an

TABLE 3 | Overview of themes and subthemes.

Themes	Subthemes
(1) 'It is the little things that matter the most'	(a) Time matters (b) Location of services (c) Availability of Chinese-speaking practitioners (d) Difficulty accessing translation
(2) Fractured patient–practitioner relationship	(a) Inefficient communication (b) Conflict in health-related concepts (c) Satisfaction and security
(3) Cultural beliefs and attitudes toward healthcare access and utilisation	(a) 'As the old saying goes' (chang yan dao) (b) 'Don't want to be a burden' (c) Attitudes toward financial costs
(4) Desire for healthcare information	(a) Reliance on publications and media (b) Reliance on social networks

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/3819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

additional factor in choosing a GP service. She said '*I'm still watching for the availability of Chinese-speaking doctors in the area*' (P7, female, 65 years).

3.1.4 | Difficulty Accessing Translation

Many participants mentioned the benefits of utilising translator services. For example, one participant said '*We were pleasantly surprised when the translator met with us early... Half an hour before the appointment. All communications were facilitated through her (translator). It's an impressive experience*' (P6, male, 65 years). However, others mentioned the limited resources and lack of competence of translators. *'I used the translator service once, but it didn't go well ... Despite being fluent in English, I decided to book a translator because medical English differs from everyday language. However, I struggled to secure one due to high demand. When a translator finally arrived, I was worried about her competence. Her English wasn't even as good as mine*' (P2, female, 71 years). Some participants highlighted the difficulty of accessing translation services as a barrier, interrupting their healthcare access and utilisation.

3.2 | Theme 2: Fractured Patient–Practitioner Relationship

Trust and communication were central to participants' healthcare experiences. When these relationships broke down, access and utilisation suffered. Three subthemes capture these dynamics.

3.2.1 | Ineffective Communication

Many participants reported that language and cultural barriers significantly affected their ability to access and understand care. Even those with good English skills found communication easier with Chinese-speaking doctors.

> "*Although my English is good, I find talking to a Chinese doctor easier ... When I had questions or problems related to my diabetes, it was straightforward to describe to the Chinese GP. But when my GP was on leave, and the Kiwi GP took over my regular visits, it became difficult to explain my feelings to him.*" (P1, male, 65 years)

Participants also noted differences in cultural thinking styles, which contributed to misunderstandings. For instance, one participant pointed out that '*Chinese doctors were more understanding and easier to communicate with*', which contrasts with the difficulties she faced due to being a non-native speaker (P2, female, 71 years). Another participant shed light on the challenges posed by '*different ways of thinking between Europeans and Chinese*', emphasising the potential for communication barriers in healthcare settings (P3, female, 71 years).

3.2.2 | Conflict in Health-Related Concepts

Differences in medical norms, treatment approaches and expectations between the participants and their practitioners can create confusion and mistrust. For instance, one participant was troubled by a specialist's vague response, '*preferring the direct diagnoses common in China*' (P1, male, 65 years). Another participant received conflicting diagnoses in Aotearoa NZ and China, raising doubts about '*the accuracy and applicability of NZ medical standards for Chinese patients*' (P7, female, 65 years). These discrepancies/conflicts in healthcare-related concepts, which often stem from differences in traditions, culture and customs, can make it difficult for late-life Chinese patients to fully comprehend their conditions. This may further affect their healthcare decision-making and fracture patient–practitioner relationships.

3.2.3 | Satisfaction and Security

As previously discussed, ineffective communication and differing health concepts can undermine trust, discouraging patients from seeking care. Participants who felt understood and supported reported greater confidence in the healthcare system. For instance, one participant and his family were satisfied with their healthcare practitioners. He stated that '*I'm satisfied overall... We've been through GP, specialist, and hospitalised care. I think they all good for me*' (P10, male, 70 years). Another participant appreciated '*the detailed explanations provided by healthcare practitioners before the surgery*' (P6, male, 65 years).

Moreover, many participants also expressed satisfaction with the respectful treatment received in Aotearoa NZ. For example, one participant appreciated '*being treated with dignity during a hospital stay*', where doctors emphasised consent and patient rights (P12, female, 78 years). This respectful environment enhances satisfaction and encourages continued engagement with healthcare services.

3.3 | Theme 3: Chinese Cultural Beliefs and Attitudes Toward Healthcare Access and Utilisation

Deep-rooted cultural beliefs influenced how participants perceived illness, treatment and responsibility for health. Three subthemes illustrate this influence.

3.3.1 | 'As the Old Saying Goes' (Chang Yan Dao)

Chinese late-life participants frequently referenced traditional sayings, reflecting the deep influence of Chinese culture on their healthcare beliefs and behaviours in Aotearoa NZ. For example, one participant noted the cultural aversion to medication, stating, '*As the old saying goes, any medicine is itself a toxin*', a belief that encourages minimal use of pharmaceuticals (P1, male, 65 years). Another shared a similar sentiment, relying on Chinese herbal medicine for minor illnesses: '*For a mild flu, I just take some Chinese herbal medicine. There is no need to go to a doctor ... I believe Western medicine is more toxic*' (P2, female, 71 years). Moreover, another participant pointed out the different interpretations of diseases in Chinese and Western medicine, expressing a preference for traditional Chinese medicine (TCM). She stated: '*From our (Chinese) traditional point of view, I prefer to use TCM. For example, COVID-19 can't really be treated by Western medicine, but the symptoms can be relieved with TCM*' (P12, female, 78 years). These cultural beliefs strongly shaped their healthcare choices, indicating a shared tendency to rely on personal and traditional assessments over unfamiliar Western approaches, even in a new healthcare environment.

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/3819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

3.3.2 | 'Don't Want to be a burden'

This subtheme highlights how culturally rooted beliefs among Chinese late-life migrants can hinder healthcare access and utilisation. Many participants expressed a strong desire not to burden others, especially family members, which led to reluctance in seeking medical help. For example, one participant hesitated to ask her son for support (P4, female, 68 years), another prioritised caring for grandchildren over his own health (P6, male, 65 years), and another avoided involving his children due to language barriers (P10, male, 70 years). These participants highlight how the cultural mindset of avoiding burdening others can prevent Chinese late-life participants from seeking essential healthcare services. This cultural reluctance significantly influences their attitudes toward healthcare access and utilisation, resulting in avoidance and denial of their own healthcare needs.

3.3.3 | Attitudes Toward Financial Costs

Despite some financial concerns, many Chinese late-life migrants viewed healthcare spending positively, prioritising outcomes over costs. For instance, one participant emphasised that health was more important than expense. He mentioned '*The most important thing to me is the outcome (of healthcare). When it comes to your body and health, the cost is the least of my concerns*' (P1, male, 65 years).

However, dissatisfaction with the effectiveness and value of services often shaped participants' attitudes. Several expressed frustrations overpaying for care that did not meet their expectations, impacting future healthcare decisions. One participant said '*In my opinion, specialists aren't all that great. The session only lasted 15 min, the diagnosis wasn't definitive, and yet I was billed 300 NZ dollars*' (P10, male, 70 years).

Moreover, a key concern was the high cost of medications in Aotearoa NZ, leading many to bring '*familiar and affordable medicines from China*', particularly for common illnesses like colds and fevers (P8, male, 68 years; P11, female, 75 years). This approach reflected both cost-saving measures and trust in Chinese remedies.

3.4 | Theme 4: Desire for Healthcare Information

Access to clear, culturally appropriate health information emerged as both a challenge and an enabler. Participants relied on two main sources.

3.4.1 | Reliance on Publications and Media

Many Chinese late-life participants often relied on brochures, community newspapers and online resources to understand NZ's healthcare system. While some found these materials helpful, others struggled with language barriers or felt that the content was too generic. Specifically, English-based sources posed significant challenges, whereas Chinese-language resources were more accessible but inconsistently delivered.

> *"While English materials were helpful to me, they might not be as beneficial to people with poor English proficiency, such as late-life migrants or recently arrived migrants*." (P1, male, 65 years)

> "*I don't think I see a lot of (health-related) information from mainstream media … The only thing that comes to mind is some pamphlets at a doctor's office.*" (P10, male, 70 years)

As a result, many turned to friends or healthcare professionals for clearer, more personalised information.

> "*Until now, I haven't received any (COVID-19-related healthcare) information from publications and media … I got some verbal information from GP, but not much … I mainly get this by asking my friends*." (P2, female, 71 years)

3.4.2 | Reliance on Social Networks

Social networks played a pivotal role in the lives of Chinese late-life migrants, acting as essential channels for sharing healthcare information and support within the Chinese community in Aotearoa NZ. Friends, family members and community groups often served as primary sources of advice and support:

> "*When I first arrived in Aotearoa NZ, I didn't know where to find doctors. My landlord advised me to see her GP at first*." (P5, female, 69 years)

> "*I'm still figuring out where to seek help with certain health issues, but I have friends who might have some helpful suggestions.*" (P9, male, 72 years)

> *"We have a WeChat group for the Chinese community here, where we share information about healthcare and other services. It's very helpful."* (P6, male, 65 years)

Therefore, social networks played a crucial role in mitigating the barriers posed by language, cultural differences and unfamiliarity with the healthcare system. They empowered recently arrived Chinese late-life migrants to decide about their health and healthcare utilisation, leveraging collective knowledge and experiences within their community.

4 | Discussion

This study identified four interrelated themes shaping healthcare access and utilisation among recently arrived Chinese late-life migrants in Aotearoa NZ. Moving beyond examining these challenges individually, this study demonstrates how structural constraints, patient–practitioner relationships, cultural dynamics and healthcare information needs interact to shape healthcare-seeking experiences.

4.1 | Theme 1: 'It is the Little Things That Matter the Most'

The findings identify waiting times, transport difficulties and language barriers as significant obstacles to healthcare utilisation among Chinese late-life migrants, consistent with previous research in Aotearoa NZ [14], the United States [11] and the United Kingdom [8]. Previous studies have also highlighted language barriers and the importance of bilingual support

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/5819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

networks in facilitating healthcare access [11, 30]. Extending this literature, the present study found that participants could often navigate language barriers in primary care through access to Chinese-speaking GPs and nurses. This suggests that communication difficulties depend not only on patients' English proficiency but also on the availability of linguistically appropriate support within healthcare services. However, these barriers appeared more pronounced in secondary and tertiary care, where specialist referrals, hospital appointments and complex care pathways require greater coordination. In these settings, inconsistent access to language support, combined with long waiting times and transport difficulties, may impede continuity of care, delay treatment and discourage healthcare utilisation.

This study extends existing literature by illustrating how linguistic and structural barriers interact across different levels of healthcare. The findings highlight that the availability of healthcare services does not necessarily translate into equitable access, particularly when patients encounter multiple barriers along the care pathway. Addressing these challenges requires not only improved access to professional interpreting services but also better transport support and coordination between primary, secondary and tertiary care. Such measures may help reduce interconnected barriers and promote more equitable healthcare access for Chinese late-life migrants.

4.2 | Theme 2: Fractured Patient–Practitioner Relationship

The findings suggest that linguistic concordance alone does not guarantee effective communication or the development of trust between patients and healthcare professionals. Consistent with previous research highlighting tensions between traditional health beliefs and Western medical practices [8, 14], participants' experiences indicate that perceived cultural responsiveness plays an important role in shaping their confidence in healthcare professionals and their treatment preferences. When healthcare professionals respected patients' cultural perspectives and preferences, participants reported greater satisfaction and a stronger sense of security. Conversely, perceived cultural insensitivity, particularly in secondary and tertiary care, could undermine trust and reinforce preferences for TCM. These findings suggest that positive healthcare experiences depend not only on linguistic accessibility but also on whether patients feel that their cultural beliefs and treatment preferences are understood and respected by healthcare practitioners.

This study extends existing literature by demonstrating how perceived cultural responsiveness shapes healthcare confidence and treatment preferences, rather than viewing cultural differences solely as communication barriers. The findings also suggest that culturally responsive care may not be experienced consistently across different healthcare settings, highlighting the need to consider how such care is delivered throughout the healthcare system. To strengthen trust and support positive patient experiences, healthcare professionals should engage in respectful dialogue, provide clear explanations of treatment options and meaningfully involve patients in decision-making, regardless of their own ethnic or linguistic backgrounds.

4.3 | Theme 3: Cultural Beliefs and Attitudes Toward Healthcare Access and Utilisation

Consistent with studies conducted in the United States [11], Canada [17], the United Kingdom [8] and Aotearoa NZ [14, 18], the findings highlight the continuing influence of traditional Chinese health beliefs following migration. However, this study extends existing research by demonstrating how these beliefs interact with family obligations, patient–practitioner power dynamics and financial considerations to shape everyday healthcare decisions. For example, respect for medical authority and reluctance to challenge healthcare professionals may discourage patients from asking questions or expressing disagreement, potentially limiting shared decision-making even when language support is available. Similarly, concerns about burdening family members may lead patients to withhold symptoms or delay seeking care, while financial pressures may influence when and where they access healthcare. These findings suggest that culturally shaped behaviours should not be understood as isolated barriers or inherent characteristics of Chinese migrants. Rather, they emerge from the interplay between cultural expectations and the practical circumstances of settlement, highlighting the need to consider both cultural and structural influences on healthcare decision-making.

These findings underscore the importance of culturally sensitive care that recognises patients' cultural beliefs and social circumstances without making assumptions about their preferences or behaviours. Healthcare professionals can support more open communication by creating a nonjudgemental environment in which patients feel comfortable expressing concerns and asking questions, acknowledging traditional treatments respectfully and providing clear information about healthcare costs and entitlements. Such approaches may help reduce barriers to accessing healthcare services and enable Chinese late-life migrants to reconcile their cultural preferences with informed and appropriate healthcare choices.

4.4 | Theme 4: Desire for Healthcare Information

The findings reinforce previous evidence that health literacy and access to health information influence healthcare utilisation among older migrants [5, 31]. Consistent with Tiagi [32], participants experienced difficulties navigating healthcare services. This study extends existing research by illustrating how differences between China's healthcare system and NZ's GP-led model contribute to these challenges, creating uncertainty about where to seek care, how referrals work and how to access specialist services. These findings highlight that recognising a health need does not necessarily equip individuals to identify and navigate the appropriate services. Healthcare utilisation therefore depends not only on service availability and affordability but also on patients' understanding of how the healthcare system operates.

To navigate this unfamiliar system, participants sought information from family members, friends, Chinese community networks, publications and media. These strategies extend research on migrants' adaptive responses to unfamiliar healthcare environments [6] by demonstrating how culturally familiar information sources can help bridge gaps in formal knowledge of the health system. However, reliance on informal sources may also expose migrants to incomplete or inaccurate information, particularly when advice does not reflect NZ referral procedures

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/3819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

or healthcare entitlements. The findings therefore highlight the need to complement community-based information networks with accessible, culturally and linguistically appropriate guidance from healthcare providers. Clear explanations of service pathways, referral processes and entitlements could strengthen health literacy, support informed decision-making and help older migrants navigate the healthcare system more confidently.

5 | Recommendations

This study proposes several actionable recommendations to improve healthcare access and utilisation among Chinese late-life migrants in Aotearoa NZ. Healthcare practitioners should strengthen cross-cultural communication and cultural competence, recruit bilingual or Chinese-speaking professionals and allow longer consultations where needed. Education providers should incorporate intercultural health communication into medical, nursing and allied health curricula. Policymakers should expand interpretation services, provide healthcare-system orientation programmes and promote equitable access to hospital, emergency and specialist care. Community organisations can establish peer-support and health-navigation programmes and codesign culturally and linguistically appropriate health education materials. Together, these strategies could reduce systemic and cultural barriers and promote a more responsive and equitable healthcare system for Chinese late-life migrants and other migrant communities.

5.1 | Strengths and Limitations

The primary strength of the study is that it provides timely, focused and context-specific insights that significantly contribute to the existing knowledge on healthcare access and utilisation among Chinese late-life migrants. While the study is specific to the Aotearoa NZ context, its findings have broader implications. The insights from this research can arguably be transferable to other late-life migrants in similar contexts, such as those in other OECD countries.

The potential limitations of this study relate to its research design, the timing of data collection and resource constraints, which may have introduced bias and limited the transferability of the findings. In particular, data collection took place in Aotearoa NZ between 2020 and 2021, during the COVID-19 pandemic. The pandemic context may have influenced participants' experiences, perceptions and accounts, thereby shaping the findings and potentially limited their applicability to other contexts and periods.

6 | Conclusion

This QD study explored healthcare access among recently arrived Chinese late-life migrants in Aotearoa NZ. The study provides valuable, participant-based insights. Findings are relevant for Chinese communities, healthcare providers, educators and policymakers, offering a nuanced understanding of factors affecting healthcare utilisation. By revealing participants' healthcare access and utilisation experiences, the study contributes a more comprehensive, context-specific perspective, emphasising the need for culturally informed healthcare practices that move beyond language support to address deeper intercultural and structural dimensions of healthcare equity, such as the involvement of a cultural care navigator.

Author Contributions

Xi Zhu, Eleanor Holroyd and Priya Saravanakumar conceptualised the paper. Xi Zhu collected and analysed the data and prepared the manuscript. Eleanor Holroyd (primary supervisor) and Priya Saravanakumar (secondary supervisor) reviewed and edited the manuscript. Irene Zeng, the third supervisor, also contributed to the editing.

Funding

No funding was received for this manuscript.

Disclosure

This work is the qualitative phase of Xi Zhu's PhD thesis.

All four authors (Xi Zhu, Irene Zeng, Priya Saravanakumar and Eleanor Holroyd) read and approved the final manuscript.

Ethics Statement

Ethics approval and consent to participate were obtained. The study was conducted following ethics approval by the Auckland University of Technology Ethics Committee (AUTEC) with the approval number 20/234. Each participant provided written informed consent.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

References

1. Statistics New Zealand, *2018 Census Population and Dwelling Counts Amended* (Statistics New Zealand, 2018), https://www.stats.govt.nz/information-releases/2018-census-population-and-dwelling-counts.

2. Ministry of Health, *Health Practitioners Competence Assurance Act* (Ministry of Health, 2018), https://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act.

3. Immigration New Zealand, *Resident Applications Accepted by Financial Year* (Immigration New Zealand, 2019), https://www.immigration.govt.nz/documents/statistics/statistics-residence-applications-accepted.

4. C. Chew-Graham and M. Ray, *Mental Health and Older People: A Guide for Primary Care Practitioners* (Springer, 2016), https://doi.org/10.1007/978-3-319-29492-6.

5. H. Chen, I. Chi, and R. Liu, "Hospital Utilisation Among Chinese Older Adults: Patterns and Predictors," *Journal of Aging and Health* 31, no. 8 (2019): 1454–1478, https://doi.org/10.1177/0898264318780546.

6. L. Hiam, N. Gionakis, S. M. Holmes, and M. McKee, "Overcoming the Barriers Migrants Face in Accessing Health Care," *Public Health* 172 (2019): 89–92, https://doi.org/10.1016/j.puhe.2018.11.015.

7. J. H. Kim and M. Silverstein, "Are Filial Piety and Ethnic Community Engagement Associated With Psychological Wellbeing Among Older Chinese American Immigrants? A Cultural Resource Perspective," *Research on Aging* 43, no. 2 (2021): 63–73, https://doi.org/10.1177/0164027520937477.

8. V. Peters-Nehrenheim, M. Rommerskirch-Manietta, D. Purwins, M. Roes, and H. Tezcan-Güntekin, "Care Preferences of Older Migrants

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/5819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

and Minority Ethnic Groups With Various Care Needs: A Protocol for a Scoping Review," *British Medical Journal* 12, no. 11 (2022): e061712, https://doi.org/10.1136/bmjopen-2022-061712.

9. World Health Organisation, *Coronavirus Disease 2019 (COVID-19) Situation Report–102* (World Health Organisation, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200501-covid-19-sitrep.pdf?sfvrsn=742f4a18_2.

10. World Health Organisation, *Number of COVID-19 Cases Reported to WHO* (World Health Organisation, 2024), https://data.who.int/dashboards/covid19/cases.

11. W. Y. Mao, J. Li, L. Xu, and I. Chi, "Acculturation and Health Behaviours Among Older Chinese Immigrants in the United States: A Qualitative Descriptive Study," *Nursing and Health Sciences* 22, no. 3 (2020): 714–722, https://doi.org/10.1111/nhs.12718.

12. K. L. Kan, H. Connor, and L. Beddoe, "Accessing Social Service Support: Barriers Experienced by Chinese Migrants Living in Auckland, Aotearoa New Zealand," *Aotearoa New Zealand Social Work* 32, no. 4 (2020): 131–144, https://doi.org/10.11157/anzswj-vol32iss4id800.

13. B. Kanengoni-Nyatara, K. Watson, C. Galindo, N. A. Charania, C. Mpofu, and E. Holroyd, "Barriers to and Recommendations for Equitable Access to Healthcare for Migrants and Refugees in Aotearoa, New Zealand: An Integrative Review," *Journal of Immigrant and Minority Health* 26, no. 1 (2024): 164–180, https://doi.org/10.1007/s10903-023-01528-8.

14. A. Koh, T. Morgan, T. Wiles, L. Williams, J. Xu, and M. Gott, "Older Chinese and Korean Migrants' Experiences of the First COVID-19 Lockdown in Aotearoa New Zealand: A Qualitative Study," *Asia Pacific Viewpoint* 64, no. 1 (2022): 60–71, https://doi.org/10.1111/apv.12364.

15. J. E. Byles, K. Vo, P. M. Forder, et al., "Gender, Mental Health, Physical Health and Retirement: A Prospective Study of 21,609 Australians Aged 55–69 Years," *Maturitas* 87 (2016): 40–48, https://doi.org/10.1016/j.maturias.2016.02.011.

16. Ministry of Health, *Annual Data Explorer 2022/23: New Zealand Health Survey* (Ministry of Health, 2023), https://minhealthnz.shinyapps.io/nz-health-survey-2022-23-annual-data-explorer/.

17. L. L. S. Choi, P. Jung, and K. Zhang, "What Matters Most to Older Chinese Adults," *Journal of Transcultural Nursing* 33, no. 2 (2022): 169–177, https://doi.org/10.1177/10436596211053655.

18. L. A. C. Separa, "Cultural Adaptation Experiences of People in New Zealand," *Review of Communication* 24, no. 2 (2024): 97–113, https://doi.org/10.1080/15358593.2024.2313238.

19. J. Montayre, S. Neville, and E. Holroyd, "Moving Backwards, Moving Forward: The Experiences of Older Filipino Migrants Adjusting to Life in New Zealand," *International Journal of Qualitative Studies on Health and Well-Being* 12, no. 1 (2017): 1347011, https://doi.org/10.1080/17482631.2017.1347011.

20. J. Montayre, P. Saravanakumar, I. Zhao, E. Holroyd, J. Adams, and S. Neville, "Holding on and Letting Go: Views About Filial Piety Among Adult Children Living in New Zealand," *Journal of Clinical Nursing* 31, no. 19-20 (2021): 2797–2804, https://doi.org/10.1111/jocn.16098.

21. Pegasus Health, *New Zealand Health Care System* (Pegasus Health, 2014), https://www.pegasus.health.nz/wp-content/uploads/2018/03/NZ-Health-System-booklet-English.pdf.

22. Ministry of Health, *New Zealand Health Strategy: Future Direction* (Ministry of Health, 2016), https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf.

23. Ministry of Health, *New Zealand Health Research Strategy 2017-2027* (Ministry of Health, 2017), https://www.health.govt.nz/system/files/documents/publications/nz-health-research-strategy-jun17.pdf.

24. M. Subedi, "Sampling and Trustworthiness Issues in Qualitative Research," *Dhaulagiri Journal of Sociology and Anthropology* 17 (2023): 61–64, https://doi.org/10.3126/dsaj.v17i01.61146.

25. L. A. Palinkas, S. M. Horwitz, C. A. Green, J. P. Wisdom, N. Duan, and K. Hoagwood, "Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research," *Administration and Policy in Mental Health and Mental Health Services Research* 42, no. 5 (2015): 533–544, https://doi.org/10.1007/s10488-013-0528-y.

26. K. Malterud, V. Siersma, and A. D. Guassora, "Information Power: Sample Content and Size in Qualitative Studies," in *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*, 2nd ed., ed. P. M. Camic (American Psychological Association, 2021), 67–81, https://doi.org/10.1037/0000252-004.

27. C. Zhu, B. Song, C. A. Walsh, P. C. Ekoh, X. Qiao, and A. Xu, "Barriers to Accessing Health Care of Older Chinese Immigrants in Canada: A Scoping Review," *Frontiers in Public Health* 12 (2024): 1445964, https://doi.org/10.3389/fpubh.2024.1445964.

28. V. Braun and V. Clark, "Using Thematic Analysis in Psychology," *Qualitative Research in Psychology* 3, no. 2 (2006): 77–101, https://doi.org/10.1191/1478088706qp063oa.

29. Y. Lincoln and E. G. Guba, *Naturalistic Inquiry* (SAGE Publication, 1985).

30. X. Y. Liu, G. A. Cook, and M. Cattan, "Support Networks for Chinese Older Immigrants Accessing English Health and Social Care Services: The Concept of Bridge People," *Health and Social Care in the Community* 25, no. 2 (2017): 667–677, https://doi.org/10.1111/hsc.12357.

31. S. Koehn, S. Habib, and S. Bukhari, "S4AC Case Study: Enhancing Underserved Seniors' Access to Health Promotion Programs," *Canadian Journal on Aging/La Revue canadienne du vieillissement* 35, no. 1 (2016): 89–102, https://doi.org/10.1017/S0714980815000586.

32. R. Tiagi, "Access to and Utilization of Health Care Services Among Canada's Immigrants," *International Journal of Migration, Health and Social Care* 12, no. 2 (2016): 146–156, https://doi.org/10.1108/IJMHSC-06-2014-0027.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Supporting Information.** Appendix A presents the semistructured interview guide, comprising open-ended questions and prompts to explore participants' experiences and perspectives.

hsc, 2026, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1155/hsc/3819370 by Auckland University Of Technol, Wiley Online Library on [24/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License