New Perspectives on Chinese Immigrants' Experiences under the New Zealand Healthcare System: A Qualitative Descriptive Study

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ATTESTATION OF AUTHORSHIP

I hereby declare that is my own work and that to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: _____

Dated: _____

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ABSTRACT

This research sought to explore the life experiences of Chinese immigrants interacting with the New Zealand healthcare systems; in particular identifying potential difficulties and barriers in accessing and utilising local healthcare services.

A qualitative descriptive methodology was employed. Data was collected via surveys, of 38 Chinese immigrants, aged 30 to 55 years who originated from Mainland China, and semi-structured in-depth interviews with 7 survey participants. Based on data generated from Chinese immigrants' personal encounters in the process of receiving healthcare services and making healthcare-related decisions, a systematic comparative analysis revealed three core findings.

The first major barrier identified towards the effective access and utilisation of New Zealand healthcare services by Chinese immigrants' lies with the differences that exist between healthcare systems in New Zealand and China. Distinctive disparities between the healthcare system structure and standards of healthcare practice caused misalignment between immigrants' expectations in the process of receiving healthcare services and the outcomes of such process. The second barrier arose from communication difficulties between Chinese immigrants and New Zealand healthcare practitioners due to language proficiency, and more importantly, conceptual misunderstandings. In this aspect, New Zealand healthcare practitioners do not seem to fully appreciate the Chinese immigrants' philosophy of health and their healthcare needs; nor do the Chinese immigrants adequately understand how New Zealand healthcare practitioners are trained to provide appropriate care to patients. The third major barrier stems from the lack of Chinese cultural understanding by the New Zealand healthcare industry. While the New Zealand healthcare system is devoted to the recognition and assurance of cultural sensitivity in policy, it appears that such vision has not been effectively translated into cultural understanding at an operational level.

With a rapidly growing Chinese immigrant population in New Zealand and around the world, this study has highlighted the importance of understanding the characteristics of Chinese immigrants in terms of healthcare awareness, attitudes and decision-making process; along with implications for effectively engaging the Chinese immigrant population in the healthcare systems at their destinations of migration.

PERSONAL STORY OF BEING A NEW IMMIGRANT

1st of August 2006 was when my journey began. 40,000 feet above the Pacific Ocean that night, I was nervously sitting through a bumpy flight headed for New Zealand. The boarding pass, I still keep to mark the journey of becoming an immigrant, a journey that both excited and frightened me. For the first time in my life, I had left my home country, China, where I was born and raised. Leaving behind my family, friends and my career, I set out on a new voyage to join my husband in a land I was going to become a resident to, but had never set foot in before.

Settling in a completely foreign environment and adjusting to a new lifestyle was nothing short of a shocking experience. Everyday-life tasks that seemed so simple and trivial before suddenly became immensely difficult and daunting, even though I had the help of my husband pointing me in the right direction. I still remember struggling with myself for half an hour over the hesitation and fear of making one simple phone call to the bank, because I was afraid of not being able to understand a thing they said. Before leaving China, I only had college text-book English education as a second language. Never in my life had I anticipated actually needing to use it to survive. Indeed, I ended up spending another half an hour trying to explain to myself what others might only take a few minutes to do the same.

If talking to a banking officer was difficult enough, then my first encounter with the New Zealand healthcare system was unimaginable. Leaving China's burning hot summer, I all of a sudden, found myself shaking in Auckland's cold southerly winter blow. My immune systems quickly gave way to a serious flu and fever the second week after my arrival. Having been educated and worked as a resident medical doctor in China, I thought visiting the hospital to have these taken care of would be easy. I was utterly wrong; even about the assumption that I was going into a hospital at all. Instead, I ended up in a family doctor's clinic and was quickly stripped down of warm clothing that I had on, lying down with a fan blowing in my face in the middle of a winter night. That was not what I expected would happen. I knew it was probably a viral flu from my professional knowledge and I tried to explain how we treated them back in China. The doctor simply refused to give me an IV (intravenous) line for some fluid, not to mention any anti-viral or antibiotics that I would like to have. "That is how we treat it here" was his final answer, and I was sent home with only a couple of Panadol pills. So I was left

alone feeling helpless with a 39 degree fever to just wait it out, although knowing that I would eventually get better on my own. Being a doctor, I was able to appreciate the different philosophy in medical practices and professional argument over prescription control so that at least I understand where my doctor's decision came from. However, I could not help to wonder if other new Chinese immigrants with no medical knowledge went through the same ordeal, how would they feel about being treated so differently to what it was like back home?

Owing to this experience, my professional background, and my intention of coming to New Zealand to advance my career in the healthcare field, I started paying attention to how the local healthcare system functioned. However, it was not until a couple years later, when I had to personally engage with the system again to give birth to my first child, that I realised there was a lot more to the local healthcare than just the system. I had a difficult pregnancy compared to most first-time mothers, which gave me the opportunity to be involved in almost every aspect of New Zealand's maternity care. During the process I was cared for by a range of professionals from my GP, specialist obstetrician, midwives, educational nurses, hospital surgeon and anaesthetist, to postnatal professionals, lactation consultant and even student doctors. They were all very professional and genuinely tried to do their jobs in helping me, which I appreciated. However, many of them did not know how to provide appropriate care to a culturally differently group of people with traditions like mine. What they believed, and insisted would help me, sometimes only added to my confusion and mental stress. I still remember the strange look from one of the hospital nurses when I refused to take showers after birth and asked to keep all the windows closed. The culture and traditional Chinese medicine practices believed to help new mothers with recovery passed down from generation to generation in China became bizarre actions in the eyes of many New Zealand healthcare professionals.

These rather surprising and often nerve-racking encounters, together with other frustrations that I had to endure in everyday-life, seriously undermined my ability to achieve my potential and what I may be able to contribute to the community and to this country. It is my own such experiences that have provided inspiration for this research project, which is to explore the real-life encounters of Chinese immigrants interacting with New Zealand healthcare systems, in an effort to identify barriers and difficulties relating to the access and utilisation of healthcare services.

CHAPTER 1: INTRODUCTION

This study seeks to understand how the Chinese immigrant population, in New Zealand, makes decisions when seeking help from healthcare services. Within the scope of this study, the Chinese immigrant population is defined as people who were born in the mainland area of the People's Republic of China, or commonly referred as 'mainland China' (i.e. excluding Hong Kong, Taiwan and Macao), and later moved to New Zealand with the intention of taking up residence. Immigration is a term broadly defined as "the movement of people from one country to another, who declare an intention to reside in the latter" (Jary & Jary, 1991, p. 397). This definition has a strong emphasis on the fact that people are 'to join' or 'move into' a new and foreign environment from the one they are accustomed. Going through such a process will inevitably profoundly impact immigrant health and health related decision making (McEwen & Lasley, 2002). There are many potential factors that may influence the utilisation of healthcare services by the Chinese immigrant population including cultural, psychological and behavioural contributions. The links between these factors and their health consequences are at the centre of this study.

This study employs a qualitative descriptive methodology (Denzin & Lincoln, 2000). As far as general research methodological choices are concerned, the qualitative framework differs from its quantitative counterpart in that it does not seek to prove assumptions or hypotheses by 'quantity', or simply numbers. Instead, qualitative methods focus on the 'quality' of the subjects' experiences: that is to describe, understand and explain social phenomena and social reality (Pedersen, 1992). In addition, the descriptive aspect of the methodology requires the research approach to closely adhere to true life experiences of Chinese immigrants, accurately document and summarise everyday events in terms of their own language without unnecessary interpretation from the researcher's perspective (Sandelowski, 2000). In my view, it is particularly useful and important to use this process because the key to understanding the difficulties in utilising healthcare services among Chinese immigrants lies with their real-life experiences, values and beliefs, especially when realities are not in-line with their expectations. To fully appreciate these

contributing factors, and how they may relate to health and well-being, questionnaire-based surveys were collected from Chinese immigrants and follow-up face to face interviews were conducted with selected individuals.

While the chosen methodology provides clear guidelines for conducting the research, a review of the literature revealed a lack of research addressing the issues relating to health and accessing health services by the Chinese immigrant population, especially in the New Zealand context. There is certainly no shortage of immigrant studies in general, but many of them tend to direct attention to certain aspects, thereby covering only a narrow range of perspectives. Refugee studies, for example, are an area in which most of the immigrant research is focused. However, in recent years the proportion of refugees out of the total immigrant population has dropped from 18.5% in 1990 to 7.1% in 2009 (United Nations, 2010). The major driving force of global immigration has switched from socio-political to economic-educational (Bhugra & Decker, 2005). The voluntary group of immigrants, including most of the Chinese leaving for New Zealand, is in search of better education and lifestyle as well as fulfilling their personal goals (Nayar, 2005). This economical-educational driven group of immigrants shares a set of very different needs to those who were propelled by socio-political reasons (e.g. refugees) and ought to be studied from their perspectives such as social-economic status, personal backgrounds and experiences. Furthermore, of the research that did provide new insights and served the benefit of the immigrant group in interest, most only had provisions to cover certain aspects to the issue. For example, a linguistic study may comment on the language proficiency and a cultural sensitivity study may focus only on cultural safety in practice. However, barriers in accessing health services are not separate entities but a series of inter-related elements adversely affecting the utilisation of healthcare services. That is why further research including systematic and strategic analyses is absolutely necessary, hence the aim of this study.

Another important aspect, which may contribute to the significance of this study, is the fact that there are increasing numbers of immigrants moving to New Zealand in recent years (Department of Labour, 2010). Some of the immigrant ethnic groups, particularly Chinese, bring unique cultural value and beliefs. People with such strong sense of

cultural awareness tend to experience increased level of difficulties merging into new cultural environment and adjusting to new lifestyles (Ho, Au, Bedford, & Cooper, 2002). Being able to understand this transition process can significantly help to ease the stresses caused by the loss of cultural norms, religious customs, and social support systems including healthcare (Bhugra & Becker, 2005). Therefore, the effort of this study will contribute to the health and well-being of an important immigrant population.

My personal interest in undertaking this study is drawn from my own experience of being a Chinese immigrant to New Zealand, as well as life stories of many other people who I personally known or spoken with. Before migrating to New Zealand, I obtained a Bachelor's degree in Medicine and completed my hospital residency to become a licensed medical doctor in China. My professional education and work experience in the Chinese healthcare industry have provided first-hand information in understanding the social and cultural background from which Chinese immigrants come. Being one of them, and having experienced much similar difficulties and barriers accessing New Zealand healthcare services, I have become particularly attuned to the concerns and needs of the Chinese immigrant community. Now, as a postgraduate student in the discipline of public health research, these valuable insights have become the impetus of this study, not only to extend my own understanding of the subject but also to explore opportunities to help and promote health and well-being of my fellow Chinese immigrants in this country.

The rest of this chapter will briefly introduce the historical and background of the Chinese immigrant population in New Zealand, followed by some important considerations regarding Chinese health: what gives Chinese immigrants their unique characteristics and what does this mean to the context of this study. The chapter concludes with an outline of the structure of this thesis.

Chinese Immigrants in New Zealand

Chinese people have a long history of migrating overseas that can be dated back as far

as the Ming Dynasty from the 14th century (Liang & Ye, 2001). These first voyages of exploration extended the footprints of Chinese into countries around the South China Sea and the Indian Ocean. But it is not until the 19th century that a small group of Chinese workers started their journey to the western world, and New Zealand was among the earliest destinations. The first record of Chinese immigrants to New Zealand were a small group of gold miners from Canton (now the Guangdong Province of China) back in 1865 following two invitations from Otago's gold mining region (Ritchie, 2003). This group is normally referred as the 'old or first generation Chinese' in New Zealand. Their descendents have thrived in New Zealand and still form a distinct Chinese community in the South Island including Peter Chin and Meng Foon who served as Mayors of Dunedin and Gisborne respectively (Ng, 1993, 1995, 1998). However, during this so-called 'gold rush era', the early Chinese immigrants did not experience warm hospitality. The diversity of the Chinese diaspora, and many other ethnic groups, generated a variety of New Zealand governmental attitudes towards restrictions and discrimination (Nyiri & Saveliev, 2002). These can be seen from many policies and legislations such as the 1899 Immigration Restriction Act and its amendment in 1920, as well as the introduction of 'Poll Tax' on Chinese immigrants (Hutching, 2004; McKinnon, 1996; O'Connor, 1990). As a result, most of the Chinese immigrants at the time were living under legalised discrimination in the desirability of a 'White New Zealand' by the mainstream British society for many decades (Ng, 1998).

After the gold rush era, the second wave of immigrants from China, as well as some other Southeast Asia countries, came during and after World War II; many of them as war refugees. This was an era when most countries were taking a second look at the value of humanity after the global devastation, which gradually led to the disappearance of assumed racial superiorities of the past in New Zealand (Ng, 2001). In 1976, the New Zealand government introduced a general amnesty programme outside the provision of the Immigration Restriction Amendment Act 1920, granting permanent residency to de-facto immigrants (Winkelmann, 2001). This has been seen as an important indication of shift in the country's immigration policy. Consequently, a completely revamped Immigration Act was introduced in 1987 with a fair points system to select immigrants

based on their merit instead of country of origin (O'Connor, 1990). Further, in 2002, the New Zealand government formally apologised to the Chinese community for historical wrongs including racial discrimination and ethnic-specific taxes designed to minimise Chinese immigration (New Zealand Herald, 2002). These much welcomed changes have also marked the beginning of the third and the most intensive influx of education and politically driven Chinese immigrants, primarily from mainland China since the late 1980s (Young, 2005). This group is often referred as the 'new generation' of immigrants. They came with typically higher socio-economic status, education level and greater motivation to seek advancing career opportunities and better lifestyles (Ip, 2003, 2008). The first ethnic Chinese MP (Member of Parliament) in New Zealand, Pansy Wong, and current Labour MP, Raymond Huo, come from this 'new generation'.

In the last decade, the New Zealand Chinese population has increased dramatically; comprising over 40% of the New Zealand Asian population (Statistics New Zealand, 2006a) and are currently the third largest ethnic group of New Zealand (Department of Labour, 2009). At the last census in 2006, Chinese New Zealanders counts for 3.7% of the total population and have risen to 4.07% in 2010, totalling over 150,000 people (Statistics New Zealand, 2010). It is projected by 2026 the Chinese community in New Zealand will further rise to 6.82% of the country's population (Department of Labour, 2009). Out of the whole Chinese population, approximately 75% are born overseas, the majority of which are from China, making the mainland Chinese the most representative sub-group (Statistics New Zealand, 2006a). Meanwhile, the age distribution of the Chinese population shows two bulges in both 15-24 years age and 25-44 years age group (24% and 28.1% respectively), possibly reflecting the large number of young international students and prime age skilled migrant category. Slightly more than a third of Chinese New Zealanders have been in the country for less than five years (Ministry of Health, 2006). Most of the official demographic data were collected at the last census in 2006. Due to the substantial changes in immigration policies since then, it is expected that the make-up of such data will reflect such changes at the next census, still to be decided (The 2011 New Zealand general census has been postponed due to the Christchurch earthquake).

Chinese Immigrant Health and Accessing New Zealand Healthcare Services

While there may be a universally agreed definition of health for all human beings, such as that of the World Health Organisation (WHO, 1948), what health means to different ethnic groups may be quite different. Everyone has a unique background; a collection of ingredients includes one's biological makeup, cultural ties, lifestyles and many more. These variations are unique on the individual level, but more importantly they may be shared as common properties at a group level (Diez-Roux, 2000). This requires public health research to select appropriate grouping methods to suit the research needs. In terms of population health, racial and ethnic grouping is considered one of the most powerful and widely used approaches (Keppel, Bilheimer, & Gurley, 2007). Racial and ethnic grouping is particularly valuable when the subject of research bears strong cultural awareness that can be placed in the same or similar social contexts (Washington State Department of Health, 2010; Whaley, 2003). The Chinese immigrant population in New Zealand is one such group that shares distinctive cultural and social characteristics. These characteristics are closely related to their health and the utilisation of health services in New Zealand system. Therefore, it is essential for this study to explore the underlying cultural and social context in relation to the Chinese immigrant population.

The Cultural Context

The 5000 years of history has made the Chinese cultural traditions one of the richest among all ethnicities in the world, and it is also one of the most extensively studied. But if the question, 'what is the fundamental difference between Chinese and western culture?' is asked, the answer is very hard to come by; there are simply too many. However, as Chinese people started to immigrate to the western world, to live among and come into close contact with local people in the receiving countries, many have arrived at one particular conclusion. That perhaps the most profound difference between the two lies with the Chinese cultural promoting group and family values while the western culture promotes individualism (Ng, 2003a). This may seem somewhat abstract

but when it is translated into everyday-life activities including health and healthcare, the resulting impact becomes apparent.

For the fact that the Chinese people are much more family oriented, they have lower levels of self-awareness than western individuals. This has meant that Chinese individuals care more about their children's health and that of their parents over their own. Low self-awareness means that Chinese people are usually more submissive in nature and have a tendency to avoid confrontation (Ng, 2003a). Therefore when encountering difficulties in seeking health services, they tend to avoid going through the process again with more negative experience, instead of raising the issue and trying to have them solved. In contrast, western culture often means that parents run a much looser family tie. They tend to educate their children how to take care of themselves and let them off on their own at a much earlier age. Further, when encountering problems with healthcare services, western individuals are much more aware of their rights and actively seek solutions and alternatives (Ng, 2003a).

These reserved mentalities and behaviours of the Chinese immigrant population can be interpreted by the two fundamental philosophies of Chinese culture: Taosim and Confucianism. In the context of health and well-being, Taosim provides the philosophical framework of Chinese Traditional Medicine practice (the balance of Yin and Yang), which is highly regarded by the general Chinese population (Ma, 1999; Wang, Rosenberg, & Lo, 2008). Confucianism, on the other hand, is the founding principle of the Chinese cultural value, which greatly impacts the psychology and behaviour of Chinese people when seeking healthcare services (Kwok & Sullivan, 2007). These can be readily seen from examples such as Chinese denial attitude towards death, the disgraceful view of having mental illness, and the unacceptable tradition of female patients being seen by a male doctor. Many of these customs and behaviours are rooted in and influenced by the social reality of their home country. Thus, it is also important for this study to include discussions of the social context of China.

The Social Context

In addition to cultural values and traditions, the social context of China within the scope of health research involves social ideology, political structure and many other social determinants such as economy, education and social welfare system (WHO, 2005). While the social reality of China forms an integral part to the background of this study, such discussion within the context of China alone is meaningless unless they can provide valuable insights to how they may affect the experiences and decision making process of receiving healthcare services by the Chinese immigrant population in New Zealand. The language proficiency of Chinese immigrants is one such typical issue. Most of the recent studies on immigrant health in New Zealand have included language difficulties as one of the major barriers to health services utilisation (Abbott, Wong, Williams, Au, & Young, 2000; DeSouza & Garrett, 2005; Ngai, Latimer, & Cheung, 2001; Wang et al., 2008). In terms of the social context in China, the education system is important. China's education with regards to English language has emphasised reading and writing instead of listening and speaking. This is due to the academic or 'text-book' nature of the system rather than being taught as an essential tool for communication. Worse still, only those with the opportunity to advance to higher education could study English to an operational level. However, even with those well educated individuals who are fortunate enough to become skilled migrants in western countries, their command of the language is far from being able to understand medical terminologies (Ng, 2003b; Walker, Wu, Soothi-O-Soth, & Parr, 1998). Further research in this area has suggested that many Chinese immigrants with language difficulties are finding alternatives to the problem such as turning to a Chinese speaking practitioner, and the issues are becoming a much lesser concern in reality (McPhee et al., 1997; Miltiades & Wu, 2007; Ying & Miller, 1992).

Apart from language barrier, there are many other socially significant factors that may influence the context of this study. The substantial difference between the healthcare services systems in the two societies is another example of important factors. How China's healthcare service system works is fundamentally different to that of New Zealand. A primary healthcare led by the General Practitioner (GP or family doctor)

networks with a referral system that escalates into specialist and hospital care adopted in New Zealand, is virtually unheard of and unimaginable in China (Wang, 2003). Many new Chinese immigrants to New Zealand do not even know what a GP is because the first line of healthcare services in China is provided by public hospitals. It is not uncommon for patients in China to go through several hospitals and a number of doctors before they decide from where to seek help. Often patient-practitioner relationship is more like picking a medical service contract depending on suitability and affordability (Ng, 2003a). With public hospitals in New Zealand turning away 'walk-in patient' without referral, expect for emergencies, there is the potential for Chinese immigrants to be lost in the system and not know where to go. Combined with language difficulties and other frustrations in a foreign environment, the journey of becoming an immigrant can start off on the wrong foot. This study is aimed at hearing these stories in real-life and attempt to find the root to the problems that may contribute to the improvement of New Zealand healthcare policy and delivery to help future immigrant with better access and utilisation of healthcare system.

Drawing from the previous sections, I have presented some examples of important cultural and social considerations towards the health and well-being of the Chinese immigrant population and how they may influence the behaviour, decisions and expectations when seeking and receiving healthcare services in New Zealand. It is the intention and focus of my study to explore these issues. Now I will briefly outline the structure for this thesis.

Thesis Structure

This thesis has seven chapters in total. Chapter One has presented the aim and purpose of this thesis with key concepts explained such as the immigration process, Chinese immigrants and their health, as well as major focuses of the arguments pertaining to this study. Also included in this chapter are a brief overview of the study methodology, significance and the impetus which led to the personal interest in undertaking this project.

Chapter Two is a literature review where relevant research efforts and output to this study are presented and critiqued. In this chapter, key terms and concepts at the centre of interest to this project are explored in more depth including immigration, Chinese identity, health and well-being, cultural and acculturation process, as well as the social context within the scope of this research.

Chapter Three outlines the rationale and justification for the methodological choice in conducting the research. An overview of the qualitative descriptive framework is presented with detailed discussion over sampling, data collection and data analysis methods. Ethical consideration and credibility of the study are also discussed.

Chapters Four, Five and Six focus on data processing and analyses according to data types and thematic categorisation. Finally Chapter Seven draws together findings and discussions in relation to existing literature, their meanings in practice and recommendations for further research are made. The limitations of the study are also discussed.

CHAPTER 2: LITERATURE REVIEW

Since the late 20th century, immigration has become a world-wide phenomenon. Dramatic changes in global social, economical and political environments have propelled many people to leave their countries of origin in search of new places of residence. This trend is most apparent in migrations from Asian countries to the western world (International Organisation for Migration, 2008). As a result of these fast moving immigration trends, and changes in global demographic context, migrant and minority health has become one of the most extensively studied fields in healthcare research, particularly in the past two decades (Loue, 1998).

Within migrant health research, there is ongoing debate regarding healthcare issues of migrant populations, particularly in discrepancies in migrant health status and accessing healthcare services, as well as the contributing factors that might have caused these issues. For example, DeSouza and Garrett (2005) concluded that the major barriers for Chinese migrants accessing healthcare services were language and communication barriers, lack of awareness of health and civil rights and where to seek appropriate service. Alternatively, Scheppers, van Dongen, Dekker, Geertzen and Dekker (2006) explicitly highlighted the importance of cultural, spiritual and behavioural elements specific to ethnic groups as major factors to access issues to healthcare services in migrant populations. The apparent difference in perspectives, on the same subject, suggests the need for further investigations.

The purpose of this chapter is to systematically and critically examine current knowledge in the studies of migrant health status, migrants' health decision making processes and the underlying contributors that affect these issues. This chapter begins with examining the relationships between three fundamental concepts involved in the discussion, namely: immigration, Chinese and health. The second part of this chapter uses current research to illustrate how these three concepts are linked. The third, and final part of this chapter, identifies and critically analyses the conflicts and gaps existing in studies addressing migrant health issues, with a particular focus on Chinese migrant health in the New Zealand context.

Who is involved and what is at stake – Immigration, Chinese, and Health

Immigration, Chinese migrants and health are not simple terms. They are comprehensive concepts with their own theories and each involves complex components, many of which may not apply in the context of this discussion. The purpose of this section is to explore what is relevant between these concepts within the scope of immigrant health, in particular Chinese migrant health, which will help with the later discussion.

Immigration

The term immigration is often confused with words of similar meanings, particularly migration and emigration. The term 'migration', in most literature, is defined as the "movement of persons to a new area or country in order to find work or better living conditions" (Oxford Dictionaries, 2010) and usually serves as a parent term for both 'emigration' and 'immigration'. While emigration focuses on the aspect of migration where people leave their original place of residence; the term immigration refers to people who 'move into' or join a new place of settlement, defined as: "the movement of non-native people into a country in order to settle there" (Collins English Dictionary, 2010). It is clear from these definitions that as a result of the immigration process, immigrants leave their home and way of life to which they are accustomed, and without any transition phase, suddenly find themselves in a completely different environment in which to settle. In this study, due to the mixed usage by academic researchers, the terms 'migrant', 'emigrant' and 'immigrant' will be used interchangeably.

The global trend for immigration continues to rise and is influenced by many driving forces. One widely accepted theory is the push/pull or the reactive-proactive factors of migration motivations (Richmond, 1993). The push factors refer primarily to the motive for 'emigration' from the country of origin (Eurostat, 2000), usually due to the under-development or differences in the social, political and economic systems. The pull factors, on the other hand, are desirable, attractive conditions of the destination country

to ‘immigrate’ into, including employment, education, relationships or even political freedom. Although these driving forces may be different from individual to individual, the overall push and pull factors are largely region or country specific (Head & Reis, 1998). For example, most emigration from New Zealand to Australia is associated with employment opportunities, while emigration from China to New Zealand is predominately driven by education. Therefore, any immigration related studies would need to start with a comprehensive examination of the two societal contexts involved: that of origin and that of settlement (Berry, 1997).

Individuals involved in the migration process will undoubtedly experience multiple stressors that can impact their well-being, including the loss of cultural norms, religious customs, and social support systems including healthcare (Bhugra & Becker, 2005). Not only do changes in physical conditions and lifestyle impact immigrants’ health, prolonged exposure to stressful circumstances has been shown to have powerful negative effects on a variety of bodily systems (McEwen & Lasley, 2002). For example, chronically elevated levels of adrenaline increases blood pressure associated with the human stress response; and the suppression of insulin during periods of stress leads to excessive blood sugar and a greater risk of Type II diabetes (McEwan & Lasley, 2002). Moreover, under such enormous pressure to re-adjust to new social systems, to cope with survival needs, and navigate changes in identity, immigrants’ mental health status may also be stretched to the limit (Bhugra & Becker, 2005). Such mental and physical challenges contribute to highly increased concerns for immigrants’ health, both in short term and long term settlement.

This brief review of immigration has started to reveal some of the complexities of this term commonly used to describe the movement of people between different locations. To appreciate the concept in terms of immigrant health, it is crucial to understand the shock and pressure that immigrants have to endure, both mentally and physically, when immersed in a new environment and the impact this may have on their health conditions. How immigrants cope with these changes and challenges depends heavily on the understanding of social context in their country of origin, as well as in the place of settlement. For Chinese migrants, who are at the centre of this study, many emigrate

from their country of origin and bring with them their customs, values and identity; therefore, it is important to understand the background of this social context and what it means to be Chinese.

Who is 'Asian' and the Chinese Identity

Immigrants from China to western countries, including New Zealand, are typically referred to as Asian (Rasanathan, Craig, & Perkins, 2006); a colloquial term often used due to the lack of understanding and differentiation between the sub-groupings of the Asia continent and its cultures. In New Zealand, for example, the term Asian often describes Chinese and other East and Southeast Asian peoples, where in fact China itself is part of the East Asia region. In this usage, Asian does not include Indian or other South Asian New Zealanders (Rasanathan, Ameratunga, & Tse, 2006). Therefore, to begin to understand the complexity of Chinese migrants, the notion of Asia and what it means in the context of this study needs to be explored.

Colloquially, 'Asian' simply refers to the colony of people who live on the continent of Asia; but the term 'Asia' is academically very loosely defined in a social science and health science research context. The boundaries of 'Asia' and consequently 'Asian' are historically confusing and may refer to largely different geographical areas depending on the research settings. For example, the United States (US) federal agencies defined 'Asian' as "person(s) having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands" (Gimenez, 1992, p. 16; US Government Bureau of Census, 2002). However, the New Zealand Department of Statistics defined the same term as "people with origins in the Asian continent from Afghanistan in the west to Japan in the east, and from China in the north to Indonesian to the south" (Ministry of Health, 2006, p. 1; Statistics New Zealand, 1996). These two definitions are markedly different and strictly speaking are both flawed. The US definition includes the Far East region, which itself does not have clear boundaries and, because the term connotes the 'orientalism' of the 19th century, as described by Edward Said (1978), it is no longer commonly used in recent literatures (Reischauer, Fairbank, & Craig 1960). Meanwhile, the New Zealand definition extends to Afghanistan which

by comparison, reaches into the Middle East region. The US definition also included the Pacific Islands that could stretch into the Oceanic countries as far as New Zealand. This again contradicts the New Zealand definition, which stops at Indonesia. Furthermore, many western countries have their own definitions including the United Kingdom and Australia. Some may exclude what is now commonly referred to as 'Middle East' countries including Afghanistan, while others may include parts of Asian Russia (Ministry of Health, 2006). All these discrepancies suggest that the terms and definitions of 'Asian' are unique to the countries in which the research is conducted and are purposely selected to suit the research context that works best for the researchers (Rasanathan, Craig, & Perkins, 2006). For example, many classifications and definitions of Asian, including the above mentioned US version, are heavily based on genetic and evolutionary research suggesting close genetic relationship and origin of migration between East Asians and native Pacific and Oceania population (Jin & Su, 2000). However, this approach neglects the socio and economic consideration of the recent migration from the western countries to the Pacific and Oceania regions, which makes countries such as New Zealand part of the western world dominated by a non-Asian population. Nevertheless the Asian population, in general, accounts for almost 60% of the total world population (United Nations, 2010) with the richest combination of ethnicities, cultures, languages and religions. Health and welfare are important considerations not only in the Asia continent but also a vital part of many immigrant-taking western countries.

As with the rather mixed concept of 'Asian', discussed above, the definition of Chinese shows similar complexity. Unlike many other names for ethnicity, the word 'Chinese' refers both to a country of origin (China), as well was an ethnic identity. For example, a Singaporean may have a nationality of Singapore but most likely self-identify as Chinese. In fact, 74.2% of all Singaporean have an ethnic origin of Han-Chinese, the largest ethnic sub-group in the Chinese population (Statistics Department of Singapore, 2010). For historic and political reasons, some countries and regions may have a near 100% population rate being 'Chinese' such as Taiwan and Hong Kong (BBC Country Profile, 2010). This particular misunderstanding of 'Chinese identity' has become a

common pitfall found in many research designs and data analyses. For example, the New Zealand Census form is the most extensive population survey in the country, and its data is used in many health research studies. In the 2006 Census questionnaire, participants were asked to identify their ethnic group where only two options (Chinese and Indian) were available for Asian population (Statistics New Zealand, 2006b). Although the option for 'others' was given if appropriate, this design would only add to the confusion for those who have an ethnic origin as Chinese but different country of origin, place of residence and settlement other than China. This group of Chinese may come from completely different background and bear distinctive characteristics. Such mixed data may easily be misused or misrepresented in healthcare studies targeting Asian or the Chinese population. Researchers need to understand that research subjects or participants who identify themselves as 'Chinese' are a heterogeneous group with different set of values, cultural educational and socio-economic backgrounds (Ngai et al., 2001). To address this issue, it has been suggested that the research participants need to be stratified and grouped along the axes of two important dimensions: ethnicity and settlement history (Ministry of Health, 2006).

To further clarify the Chinese identity concerns, in the context of this study, it is also necessary to consider the history and the demographics of the Chinese immigrants in New Zealand, and how they respond to the environment of settlement and exhibit distinctive properties in the health conditions and healthcare decision making process.

The history of Chinese migrants arriving in New Zealand can be traced back to 1865 when the first group of gold miners came to work in the Otago and Southland provinces from Canton, China (Butler, 1977; Grief, 1974). In the following half century, this group and their decedents have suffered legislative discrimination and social prejudice which underline their second-class status, poor living conditions and health (Ip, 2003). The fact most criticised today is that there was virtually no record made by the New Zealand historians or academic societies documenting the lives and health of the Chinese population in New Zealand (Ip, 2003). The limited literature available, for this piece of missing New Zealand history, are those written by the Cantonese themselves. For example, the hand-written documents by Ho Mee who translated for the Chinese

workers during the Otago ‘gold rush’ period and Wong Young Wah who co-authored a narrative titled ‘*The History of Round Hill’s Chinese settlement*’ now being displayed at the Wallace Early Settlers Museum in Riverton, Southland of New Zealand (Ip, 2003). However, due to poor literacy and the extended period of time, very few documents have survived to date.

In the last decade, the New Zealand Chinese population has increased dramatically and is quickly becoming the largest sub-population (Statistics New Zealand, 2006a) and the third largest ethnic group in New Zealand, following New Zealand European and Maori (Department of Labour, 2009). During the same period of time, New Zealand society began to recognise the importance for the Chinese population to integrate into healthcare systems. Consequently, there has been a rapid increase in academic publications concerning Asian and Chinese health such as Walker et al.’s (1998) *New Zealand’s Asian population: views on health and health services* and Ho, Au, Bedford, and Cooper’s (2003) *Mental health issues for Asians in New Zealand*. Although research addresses a range of issues, many studies have very small samples. With such data, not only is their representativeness questionable, it is difficult to generalise whether the results gathered concern the whole Asian population or specific sub-populations such as Chinese. Since 2006, government agencies and some large organisations have started projects on the national level. The most comprehensive one to date is the Asian Health Chart Book 2006 (Ministry of Health, 2006). However, due to the nature and the scope of large scale research, the focus is primarily on cross-group comparisons and specific sub-populations or issues that apply to certain sub-groups are not explored in-depth. For example, the age distribution of the Chinese population shows two bulges at both 15-24 years age and 25-44 years age groups (24% and 28.1% respectively), possibly reflecting the large number of young international students and prime age skilled migrant category (Ministry of Health, 2006). But a recent search of literature has failed to find New Zealand research on the subject of Chinese international student health or young skilled migrant health which is essential considerations of Chinese health in New Zealand.

The identity and demographics of the Chinese population are important characteristics of this unique group and will impact the health and welfare of the Chinese people in

many ways. For example, the much younger age distribution may be closely related to what is known as the ‘health selection effect’ or the ‘healthy immigrant effect’ (McDonald & Kennedy, 2004; Rasanathan et al., 2006) seen in New Zealand healthcare system (and discussed in the following section). To explain these phenomena, such as the ‘healthy immigrant effect’, the fundamental concept of ‘health’, as well as how it may apply to the Chinese population in the New Zealand context, must be explored.

Health and Chinese Health

Health is a universally important consideration for individuals and societies. The most commonly used definition for health was stated by the WHO (1948) as: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (p. 1). Although highly regarded, this 60 year old definition for health has come under criticism. Some argue that this definition is utopian, inflexible and unrealistic (Awofeso, 2005) in that the use of the word ‘complete’ is highly unreasonable to achieve for any individual in real life; while others criticised this definition being too conceptual and lacking operational value for health professionals to work with to promote health (Larson, 1996).

In 1986, the WHO further explained the concept of health in the Ottawa Charter as “a resource for everyday life, not the objective of living. Health is a positive concept emphasising the social and personal resources, as well as physical capacities” (WHO, 1986, p. 1). This definition became the foundation for health promotion in order to strengthen the practicality of the health concept. In addition to the WHO, many researchers have attempted to express their own understanding and perspectives of health. Dunn (1959) raised the difference between health and wellness and emphasised ‘good health’ as a state of being, a passive adaptability to ‘one’s environment’. This view bears close similarity to Maslow’s (1954) concept of self-actualisation where health and wellness are the products of a human being’s interaction with his or her internal and external environments. Both Dunn and Maslow’s concepts highlighted the interaction between people and environment being a vital part of their health. This is

particularly important for immigrants as the immigration process implicitly involves people changing their environment and living in a new place (Nayar, Hocking, & Wilson, 2007).

In the context of this study, Chinese immigrants to New Zealand are more likely to experience the extreme end of the impacts of such environmental change due to the large gap that exists between eastern and western environments, as well as the difference of individual's physical conditions in many different forms. One such example is the obesity rate and related health conditions such as high blood pressure and cholesterol level. A 2002/03 New Zealand Health Survey conducted by the Ministry of Health showed new Chinese immigrants to New Zealand have significantly lower rate of obesity than the generally population. However, after controlling for time spent in New Zealand, the duration of residence was found to be significantly associated with the increased likelihood of being obese for the Chinese population, possibly suggesting acculturation and/or change in environmental factors such as dietary structure (Ministry of Health, 2006). Other researchers have challenged this suggestion and provided their own theories for explanation, such as the 'healthy immigrant effect' (McDonald & Kennedy, 2004; Rasanathan et al., 2006), in which it has been argued that the reason for low rate of some biological risks and diseases are caused by new immigrants having to pass health screening tests before being admitted as new residence. Overtime, this 'healthy immigrant effect' simply wanes off so the rate goes back up again (Rasanathan et al., 2006). Such an example is only one of many on-going debates on the subject. To answer the question of 'who is right?', it is necessary to take an extra step in comparing the status of Chinese immigrant health internationally and explore the bases and evidences supporting these theories (e.g. 'healthy immigrant effect).

Chinese Health in New Zealand and the World – Myth about the 'Chinese Paradox'

To the surprise of many immigrant health researchers, the Chinese immigrant population in New Zealand is showing relatively better health conditions than their counterparts in China or even the general population in their destination countries

(McDonald & Kennedy, 2004; Rasanathan et al., 2006). On the other hand, research also showed that they have numerous difficulties accessing and utilising healthcare services (DeSouza & Garrett, 2005; Ministry of Health, 2006). These seemly conflicting realities are raising questions and this section will attempt to suggest possible answers.

Finding the Root – Health and Accessing Healthcare Services in China

Home to over 1.3 billion people, the People's Republic of China (PRC) is the most populous state in the world (National Bureau of Statistics of China, 2011) and for centuries, the origin of millions of Chinese immigrants worldwide. With such a large population, covering one fifth of the world's total, Chinese health and healthcare services has been the centre of focus for many health researchers. Most of the existing literature and publications are often extremely critical about the history and the current status of China's population health and healthcare services. It is common to come across opinions such as "China faces huge healthcare problems that make those of the United States seem almost trivial by comparison and that constitute a major potential threat to China's domestic tranquility" (Blumenthal & Hsiao, 2005, p. 1165), and "inefficient, prone to the provision of unnecessary care, of poor quality, overly focused on drugs and high-tech care, and insufficiently focused on public health" (Eggleston, Ling, Qingyue, Lindelow, & Wagstaff, 2008, p. 149).

Many of these criticisms, however, target the policy and system level instead of operational level. They tend to emphasise the process and socio-economical factors of healthcare delivery rather than the quality and consequently the outcome on the population health status. A typical adapted logic in these studies is 'the system is failing so the health must also be failing'. Where in fact, during the past 60 years, since the founding of PRC, there has been a dramatic improvement in population health status. For example, the life expectancy has increased from 35 years to 71.8 years and the infant mortality rate has fallen from 200 to 25.5 per 1000 live births in the same period (China Ministry of Health, 2007). It is ironic that some of the latest studies, such as Blumenthal and Hsiao's (2005) *Privatization and Its Discontents – The Evolving*

Chinese Health Care System, are still selectively using life expectancy of 68 years and infant mortality of 34 per 1000 live births. These data were released in *Health Statistics Information in China, 1948-88* from the China Ministry of Public Health in 1989, which was 16-year-old information at the time of publication. Use of outdated and misleading data raises the questionable intention of being politically and ideologically influenced or otherwise biased. There was also research along similar lines of analyses and criticism that recognised the improvements achieved in the health status in China but could not conclusively identify the reasons why. In William Hsiao's (1995) study of Chinese healthcare services, he commented that "In spite of non-system in rural healthcare, defective pricing policy and other problems enumerated above, it seems 'paradoxical' that the measurable health status of the Chinese people has not declined since 1981" (p. 1054). These conflicts in findings and shortage of explanations have caused much confusion for readers and fellow researchers. Numerous critical researchers have brought over the negative stereotypical image of China in their publications to the western academic society. These have led the belief by many readers that the Chinese population was living under sub-prime health conditions with insufficient healthcare services in a socialism dictatorship. But when Chinese immigrants started to arrive in the western world in large numbers since the late 1980s, their health conditions appeared to be far better than earlier believed; although their socio-economical status were at much lower level compared to mainstream population. This phenomenon has mystified many healthcare practitioners and researchers and led to the term 'Asian Paradox' (Ministry of Health, 2006) which closely resembles the well known 'Hispanic paradox' in the US (Markides & Coreil, 1986). The paradox refers to epidemiological findings that showed Hispanic population in the US tend to paradoxically have substantially better health than the average population, despite what their aggregate socio-economic indicators from the country of origin would predict. In an attempt to solve this paradox, some researchers shifted their attention to China's unique social services structure, particularly the healthcare service system, hoping to find plausible explanations.

The social services system, including healthcare in China, is largely different from those

of western countries. Instead of one widely adapted system and set of policies for the whole country, China's urban and rural healthcare systems, along with the access to healthcare services, are distinctively different. In rural areas where most of the critics and concerns are focused, the primary healthcare system including village clinics and township health centres are privately owned after the de-collectivisation of agriculture and the breakdown of the 'iron rice bowl' (Eggleston et al., 2008), a term that refers to the complete state-ownership including healthcare services. The referral system in the rural areas is virtually non-exist and due to distorted pricing and payment system (Wang, 2003), patients are forced to choose basic healthcare wherever they can afford. Furthermore, the quality of health services provided in rural areas and the competency of health practitioners are also far from acceptable. For example, over 70% of rural doctors, or the so-called 'barefoot doctors', had no more than high school qualification with only 20 months of medical training on average (Wang, Xu, & Jiang, 2003). However, the picture looks very different in urban areas. The state and provincial government are leading public funded facilities such as state owned clinics and hospitals, complemented by the government insurance system and the labour insurance system (Grogan, 1995) in large cities and commercial centres. These facilities and policy ensure high level of medical services delivery and referral care (Eggleston et al., 2008) by highly trained and qualified health professionals.

While these differences and improvements seem to be confined to urban areas and certain dimensions of quality (Zhuang & Tang, 2001), it is easily overlooked by immigrant health researchers that most immigrants from China are from urban centres and more developed coastal areas. Major cities such as Beijing and Shanghai accounted for the largest proportion of China's emigrant population, followed by rich east coastal provinces including Fujian, Zhejiang and Guangdong (Liang & Morooka, 2004). The China Population Census data from 1982 to 2000 also calculated that over 70% of emigrations from China originated from these areas (China National Bureau of Statistics, 2002; Lavely, 2001). Such unbalanced demographical distribution effectively means that vast majority of immigrants arriving at their destinations came from the parts of China that had access to high level of healthcare services and thus have much better

health status than rural or the average population of China. Unfortunately, when the research outputs and data about the Chinese population health are used as references in Chinese immigrant health studies, this important factor about the distribution of immigration origins within China is hardly ever isolated and given attention.

Having discussed the background of China's population health and its healthcare system, it seems that the so-called 'Chinese Paradox' as to why Chinese immigrants are exhibiting better health conditions than expected, does have some plausible explanations from the perspective of China's unique social structure. However, Chinese immigrants are still facing great challenges in receiving healthcare services and adapting to new healthcare systems in their new countries at a post-migration stage. Therefore, it is important to explore and understand their circumstances and factors that might contribute to such processes in the countries of their destination, particularly New Zealand as the context of this study.

Trying to Fit In – Chinese Health and Accessing Healthcare Services Overseas

In the 1990s, the population of overseas Chinese exceeded 26.8 million worldwide (Poston & Yu, 1992). According to best recent estimates, in the early 21st century, this number has rapidly grown to nearly 40-50 million (Bruton, Ahlstrom, & Wan, 2003; Li & Li, 2011) scattered around all major continents and over 130 countries. Most of these Chinese immigrants are faced with challenges in accessing and utilising local healthcare services depending on their place of origin and the country of settlement. These challenges may come from many different aspects of life including language, cultural values and personal circumstance. It is difficult to cover all of them but there are some commonly shared concerns among the Chinese immigrants group.

The growth of Chinese immigrants is especially apparent in English-speaking countries (United States, Canada, United Kingdom, Australia and New Zealand), which have led to increased interest in their health and that of their descendents (Kuo & Porter, 1998). English, being one of the official languages used in these countries, is affecting the use of healthcare services by the Chinese immigrants as one of the major barriers. Many

scales used in measuring the health of immigrants typically include measures of language use and proficiency (Salant & Lauderdale, 2003) which targets this weakness for many Chinese immigrants. For example, about 32% of immigrants from mainland China to Canada do not speak English (Statistics Canada, 2001), not to mention more of those with only limited knowledge of the language. Chinese immigrants will almost certainly experience difficulties such as understanding medical terminologies and different ways of interpreting medical symptoms (Ma & Henderson, 1999; Wang, 2007; Zhang & Verhoef, 2002).

Studies in Ireland also found that the Chinese community, as the largest single ethnic group, were particularly concerned about language barriers in accessing essential services and reported difficulties in getting language support, especially out of hours (Dunn & Morgan, 2001). In New Zealand, English proficiency was also indentified as the main difficulty experienced by Chinese immigrants living in the country with a particular impact on health (Asian Public Health Project Team, 2003; DeSouza & Garrett, 2005). These difficulties were most apparent in accessing healthcare services (Abbott et al., 2000; Ngai et al., 2001) especially when communicating with general practitioners (Chan & Quine, 1997); as family doctors do not commonly provide translation services to patients in western countries' primary healthcare system (Wang, Rosenberg & Lo, 2008). Although the adverse impact of language issues is widely accepted, there are others who do not entirely agree. Several studies showed that English language proficiency does not necessarily predict the accessibility and the use of healthcare services (McPhee et al., 1997; Ying & Miller, 1992). Similarly, Miltiades and Wu (2007) in their study on the *Factors affecting physician visits in Chinese and Chinese immigrant samples* used a multiple regression model, which included a measure of English ability. They concluded that English was not a significant predictor of physician utilisation, probably due to the high availability of Chinese ethnic healthcare professionals in the sampling area (Boston, US). This is an interesting, while valid, perspective, but unfortunately not many studies on the subject have considered such an approach. In New Zealand, for example, most research has relied heavily, and sometimes solely, on brief survey responses, typically Yes and No or statistically

quantifiable questions such as measurable socio-economical indicators. However, experiences and opinions such as communication issues (e.g. language) in healthcare require in-depth investigation in comparison to other plausible but often easily overlooked contributors. For instance, a Chinese individual may have had language difficulties with an English-speaking general practitioner in the past thus answering 'Yes' to the question of language barrier. But this may be the reason for this individual to later enrol with a Chinese speaking doctor to remove such barrier, which is not factored in as a follow up question therefore creating bias.

In addition to language barriers, culture issues and acculturation process are other challenges for Chinese immigrants trying to utilise the western healthcare system. Recent studies on immigrant health have highlighted that culture and acculturation influence health outcomes (Salant & Lauderdale, 2003). 'Acculturation' is perhaps a more important term in the context of immigrant health as it emphasises the differences and changes to the culture background to which immigrants are particularly susceptible. As first-time defined by Redfield in his psychology studies, acculturation are "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (Redfield, Linton, & Herskovits, 1936, p. 149). This concept has evolved and been adopted by other disciplines including health and immigrant health research. For example, Berry's (1980) famous stress model of acculturation suggested that individual's initial response to cultural clash during integration may lead to adverse effects on the mental health status, which later improves with acculturation. Other models have suggested declining and deteriorating health status or loss of original culture norms as a result of acculturation.

There is no shortage of theories, however most of them tend to be overly conceptual and lack the consideration of individual cultural values. For example, the Chinese culture bears its distinctive properties, different from other Asian cultures in many ways. When Chinese immigrants bring their cultural values into the western environment, or more specifically the New Zealand culture, the result will be quite different. To understand this further, it is important to realise that the Chinese culture is perceived in different

ways. Many US and Canada researchers treat Taoism (e.g. balance of Yin and Yang) as a highly regarded foundation of the Chinese culture as well as the most important factor for Chinese health and receiving health services (Ma, 1999; Wang et al., 2008). New Zealand and Australia studies often refer to Confucianism in analysing the decision making process in seeking and accepting healthcare services (Kwok & Sullivan, 2007). In fact, both of these two philosophical traditions are integral parts of the Chinese culture that have different effects on the attitude and understanding towards health. For instance, Taoism is the corner stone of the Chinese Traditional Medicine practice believed and trusted by the Chinese population for thousands of years. In China, over 40% of prescriptions given are in the traditional medicine form (Hesketh & Zhu, 1997a, 1997b) and 98% of Chinese doctors received training in the traditional medicine practice (Harmsworth & Lewith, 2001). It is difficult for western trained doctors to communicate with Chinese patients without understanding the difference in health concepts between Chinese and western culture. While Taoism and Traditional Chinese Medicine is more a cultural belief, Confucianism is perhaps the most defining cultural value held by the Chinese people. For example, many Chinese women cannot see male doctors (e.g. gynaecologists) or are deeply concerned at being examined for certain screening process due to such cultural values. As a result, many health conditions are diagnosed late or left untreated.

While these barriers and shortcomings still exist in western countries and Chinese immigrant destinations, it is promising to see that many countries have started to address the issues. New Zealand, for example, has formulated and implemented several strategic directions such as language support framework and cultural competency requirements for health practitioners (St George, 2011). However, whether these initiatives and implementations have effectively served their purpose was inconclusive from current literatures, thus requiring further evaluation and research. This study will attempt to provide answer to this question from the Chinese immigrants' perspectives.

Summary on Current Literature and Finding the Gaps

This chapter has reviewed the current understanding of concepts: immigration, immigrant, and Chinese health in relation to their place of migration destination. The review started with a brief overview of important terms involved in the discussion within the context of this study. The second section shifted the attention to core issues of Chinese immigrant health along both axes of analysing relevant factors in their country of origin as well as those that apply in the environment of immigration destination. The particular concerns over Chinese immigrants' health status and barriers to access healthcare services were highlighted by parallel comparison between literatures reviewing China's healthcare system, international knowledge as well as within New Zealand context. The leading approach employed was to divide and compare eastern and western perspectives on the same issues to demonstrate misalignment on the understanding of Chinese immigrant health.

Overall, the literature reviewed has explored factors to the issue of Chinese immigrant health and under-utilisation of healthcare services from differing perspectives. However, little research has actually attempted to identify potential barriers systematically from the individual perspective. Many survey designs perception and usage of health service in this area tend to use 'statistically quantifiable' type questions. A typical example, from the previously discussed *Chinese Health and Social Services Survey*, used gender, age, geographical region, language, place of birth, time of arrival, living arrangement and choice of problem accessing services; which the research designer assumed were potential factors influencing barriers accessing services. However, questions seeking personal opinion, and values based commentary are typically excluded, usually because they vary from person to person and are more difficult to be quantified for statistical purpose.

Questions about a person's views make more intuitive sense in identifying potential barriers, because barriers arise due to patients' personal expectations, health beliefs or cultural values not being met with the treatment received (Scheppers et al., 2006). Furthermore, when culturally sensitive issues, beliefs and any behavioural and

psychological factors are at the centre of concerns, opinion, open-ended and semi-structured research questions are the only type that may be used to answer them. For example, if a survey result shows that a certain percentage of Chinese people resort to traditional treatment versus going to a local family doctor, it is important to ask “why” questions about the personal concerns, cultural drivers and behavioural patterns affecting such decision; rather than simply trying to correlate it to gender, age group, education, income levels or other pre-determined systematic quantifiable factors.

Another reservation about some research is the focus on certain barriers. For example, a linguistic study may comment on the language barrier and a cultural sensitivity study may focus only on cultural safety in practice. However, it is unlikely that barriers in accessing services are separate entities but rather a series of inter-related elements adversely affecting the utilisation of healthcare services. These barriers can occur at three levels: patient, provider and system. There is a lack of research showing how such potential barriers at different levels can be systematically grouped and therefore addressed strategically to influence policy.

Given the literature reviewed and the gaps identified, this study intends to investigate the Chinese immigrants’ experiences accessing and utilising the New Zealand healthcare system with a more robust approach. The qualitative descriptive methodology framework with combined multiple research methods are selected to provide flexibility in data collection, as well as a more systematic data interpretation. The following chapter discusses the design, implementation and justification of the qualitative descriptive methodology employed by this study, as well as the data collection and analysis procedures used.

CHAPTER 3: RESEARCH METHODOLOGY AND METHODS

The discussion of the methodology and research method in the chapter is divided into three sections. Part one begins with an overview and rationale for choosing a qualitative descriptive research methodology with relevance to the aim, purpose and research questions in the context of this study. The second part presents the procedures and approaches taken to implement the qualitative descriptive methods. Included in this section are strategies and protocols employed in participant selection and recruitment, data collection and analysis, as well as consideration of ethical issues. Finally, the trustworthiness and the rigor of the study are discussed.

Methodological Choice for this Study

Methodology is among the core components of any research process; it is the "strategy, plan of action, process or design lying behind the choice and use of methods and linking the choice and use of methods to the desired outcome" (Crotty, 1998, p. 3). In other words, it is a way to systematically address the research problems (Kothari, 2004). Resolving what is the appropriate methodology for the study, guides the researcher to select and apply appropriate research methods and techniques relevant to the particular research questions and assumptions. Therefore, the foremost step in this chapter is to consider the options available in formulating an appropriate methodological framework.

Quantitative vs. Qualitative

The use of quantitative or qualitative design has stirred much debate in the field of health research. Between quantitative and qualitative, many researchers tend to put the two on complete opposite ends of the spectrum. They promote the idea that quantitative designs are experimental, and focus on the statistical manipulation over numerical data (Leeds-Hurwitz, 1995); while qualitative methods are non-experimental, and use non-numeric natural data to document the world and people studied (Brannen 1992; Hammersley, 1992a; Leeds-Hurwitz, 1995). Other researchers, however, have argued

that such division between quantitative and qualitative approaches are false, and "it is perhaps impossible (and unhelpful) to characterise qualitative research in a way that is completely separate from quantitative research" (Green & Thorogood, 2009, p. 5). The purpose of presenting this argument is not to criticise one methodology framework over the other, but to point out the importance in realising that both offer a distinct set of strengths and limitations (Wolff, Knodel, & Sittitrai, 1991). The appropriateness of the decision in selecting methodological approach is determined by "the purpose of the study, the question being investigated, and the resources available" (Patton 1990, p. 39). The next section discusses the process in choosing appropriate methodology guided by Patton's principle under the context of this study.

Why Qualitative?

Health research covers a wide spectrum of subjects, ranging from microscopic studies on the molecular level to population health on the global scale. Each sub-discipline has its own methodological tradition (Green & Thorogood, 2009). For example, most clinical research such as disease epidemiology or pharmacology studies often relies heavily on quantitative measures (Rice & Ezzy, 1999). On the other hand, recent research in the field of public health and healthcare policies have integrated methodological insights from social science research (Helman, 1984; Kleinman, 1980), which are largely qualitative dominated. Perhaps the most important advantage of incorporating qualitative social science research methodology into health studies is its capability to describe, understand, and explain social phenomena and social reality (Pedersen, 1992), along with the cultural and behavioural aspects under the health context (Green & Thorogood, 2009). In other words, the purpose and nature of qualitative inquiry is to describe, interpret and explain (Denzin & Lincoln, 2005). But rather than doing it from the perspective of the researcher, it is done through the point of view of the people studied (Hammersley, 1992b). The ultimate goal for this process is to "accumulate sufficient knowledge to lead to understanding" (Lincoln & Guba, 1985, p. 313).

This study seeks to identify and understand the sources of potential barriers in accessing and utilising New Zealand healthcare services by Chinese immigrants from their own experiences. The primary focus is to explore personal background, previous overseas experience in receiving medical care and current expectations, cultural beliefs, values and attitudes of the Chinese population and how they may clash with the New Zealand social reality, and consequently affect their utilisation of the local healthcare services. Qualitative methodology provides a framework that is well suited for this purpose. Qualitative methods promote the idea of partnership for exploring different social understandings of reality between two key players (Ulin, Robinson, & Tolley, 2005): the participants who contribute the information (Chinese immigrants) and the researcher who is a listener and guides the process of understanding. Qualitative methodology provides powerful techniques for 'hearing data' (Rubin & Rubin, 1995) and "seeks to listen to participants and build an understanding based on their ideas" (Creswell, 2003, p. 30). In this study, the process of documenting and listening to the participants' experiences is exactly the process of interaction and accumulation of knowledge from descriptive data. Furthermore, the Chinese immigrants participating in this study come from a distinctive cultural environment and many problems central to their healthcare are deeply embedded in their social and cultural context (Ulin, Robinson, & Tolley, 2005), as seen in many qualitative studies. The qualitative methodology is particularly capable of capturing such context in the complex cultural and social world they live in (Grbich, 1999; Polit & Hungler, 1997) and "to generate new understandings that can be used by that social world" (i.e. New Zealand) (Rossman & Rallis, 1998, p. 5).

Why Descriptive?

Unlike some of the more popular qualitative methodologies, such as phenomenology, grounded theory, ethnography or narrative studies, that are based on specific methodological frameworks (Lowenberg, 1993), the qualitative descriptive methodology is not usually shaped or restricted by pre-set conceptual or theoretical systems. It is mostly referred to as a naturalistic or observational technique aiming at describing phenomena or presenting facts objectively for what they are (Lincoln &

Guba, 1985), without too much subjective interpretation from the researcher's point of view. Although one of the most frequently used methods of inquiry in qualitative studies, the descriptive approach is often criticised for having less analytical power compared to its counterparts due to the 'descriptive focused' nature. However, no one method is absolutely stronger or weaker bur rather more or less useful or appropriate in relation to certain purpose (Sandelowski, 2000).

The descriptive approach is indeed less interpretive than it is descriptive, thus not requiring the researchers to move too far away from their data (Sandelowski, 2000). In fact, most of the qualitative approaches including even the most descriptive ones will require some level of interpretation of data. The only difference is to what extent. For example, the same phenomenon interpreted by different phenomenological studies may well be quite different. The point of entry to the analysis on the same data may come from completely different angles shaped by the researcher's point of view, which brings the question of 'interpretive validity' (Maxwell, 1992). The descriptive approach on the other hand, only requires interpretations that are 'low-inference' (Sandelowski, 2000). This does not require the researchers to agree with each other's point of view but rather to agree on the facts contributed by the participants, which seeks 'descriptive validity' (Maxwell, 1992).

In this study, how the data is presented or interpreted will be critical to the overall validity of the research. Similar studies conducted in New Zealand presented findings that largely disagree with each other over often similar data collected, as seen in the literature review chapter. For example, most studies in the area of immigrant health found very similar rate of language proficiency issues across many different countries (Abbott et al., 2000; DeSouza & Garrett, 2005; Ngai et al., 2001). However, the impacts of such language barriers on access issues to healthcare systems are interpreted very differently (McPhee et al., 1997; Miltiades & Wu, 2007; Ying & Miller, 1992), which suggested the need for shifting attention and methods away from interpretive approaches to focus more on the comprehensiveness and the accuracy of circumstances involved. Listening to the participants and understanding what they are experiencing, instead of guessing a causal relationship, is the key to identifying the roots of these

discrepancies.

Another feature of the descriptive approach is that it does not require a conceptual or otherwise highly abstract rendering of data (Sandelowski, 2000). In grounded theory, for example, the data interpretation requires the researcher to develop a theory that has been derived from the data (Chenitz & Swanson, 1986) and interpret data as elements in a "conditional/consequential matrix" (Strauss & Corbin, 1998, p. 181). The descriptive approach does not require the researcher to explain the data in terms of conceptual, philosophical, or other highly abstract framework or system (Sandelowski, 2000), but to accurately document and summarise events in the everyday terms of those events (Sandelowski, 2000). In this study, the majority of data collected are concerned with either actual life experiences of the Chinese immigrants or their opinions towards their healthcare. Personal experiences and opinions vary from individual to individual; the attempt to conceptualise or purposely give philosophical underpinnings to such data may lead to unnecessary over-generalisation bias. A more descriptive approach will help to ensure that every data point is documented 'as it is'. Unique but untypical or minority data entry will be retained and given equal weighting and attention instead of being fed into a model, submerged in the trend of majority, or excluded as outlier in the generalisation process.

In summary, a qualitative descriptive methodology provides a suitable overall design to fit with the aim and purpose of this study. The qualitative aspects of the methodology will accommodate the need to explore social phenomena within a healthcare scope along with the advantages in considering cultural, value and behavioural attributes of the Chinese population. The descriptive approach will help to accurately capture real-life experiences and unique personal opinions from as many perspectives as possible, for comprehensive data analysis. The next section presents the implementation of the chosen qualitative descriptive methods in this study.

Research Design Methods

While research methodology provides the framework and the overall approach to systematically solve the research problem, research methods, sometimes referred to as research techniques, are practical steps, used in performing research operations guided by the methodological framework (Kothari, 2004). The scope of the research methodology is wider than that of research methods which seeks to establish the logics behind the methods for research applications (Kothari, 2004). This section centres on the discussion of the methods used which can be defined as "the steps, procedures, and strategies for gathering and analysing the data in research investigation" (Polit & Hungler, 1997, p. 416). Guided by this definition, included in this section are participant selection procedures, data collection and analysis strategies and ethical considerations.

Ethical Approval

The Auckland University of Technology Ethics Committee (AUTEC) granted ethical approval for this study on 16th September 2010 (Appendix A). All research procedures employed by this study carefully follow the provision and guidelines set by AUTEC. The detailed ethical consideration over the research process will be discussed later in this chapter following data collection and analysis methods.

Overall Sampling Approach

The objective and methods of sampling are fundamentally different in qualitative research than they are in quantitative research (Rice & Ezzy, 1999). Unlike quantitative studies where sampling is to provide statistical generalisation, qualitative sampling is purposive (Rice & Ezzy, 1999). The aim of qualitative sampling is not concerned so much with data 'representativeness' or sample size, but rather the 'richness' of the informants and the in-depth information they can provide (Marshall, 1996). Furthermore, qualitative sampling does not usually require true random sample. Random sampling in population is only appropriate if the data fits a normal distribution.

However, there is no evidence to suggest values, beliefs attitudes and experiences are normally distributed (Marshall, 1996), as often found in qualitative studies.

Considering the context of this current study, and the nature of qualitative sampling, this study takes two consecutive steps with different sampling methods and techniques. There are many different classifications and naming systems to categorise qualitative sampling methods, this study follows Rice and Ezzy's (1999) summary of sampling methods to aid the selection process. The first step is general informative data collection by survey. Instead of random sampling, 'criterion sampling' is used where a set of criteria must be met before participants are selected to take part in the study. The discussion over selection criteria will follow later in the participant recruitment section. The advantage of using 'criterion sampling' methods for the initial survey is to ensure the information collected is relevant to the particular research problem confined by the research boundary. During the second step in the research process, participants are selected from the survey respondents for in-depth interview. For this part of the data collection, a combination of 'typical case sampling' and 'extreme or deviant case sampling' was employed. Both methods were selected because of the sole purpose of filtering 'information-rich' candidates out from the survey data pool for further inquiry. Some may argue that the 'typical case sampling' and the 'extreme or deviant case sampling' seem to sit at opposite ends, because 'typical case sampling' tends to rule out atypical or extreme data point by definition (Patton, 1990). This is theoretically true; however the purpose of categorising these sampling methods is simply to develop a sampling guideline. The actual implementation of these two methods is adjusted to suit this particular study purpose. The word 'typical' in 'typical case sampling' does not necessarily refer to answers similar to each other that forms a majority sub-group in the data set. It is primarily used to select survey respondents from the answers they provided that may typically or potentially yield the richest information for in-depth interview. For example, even if 60% of the survey respondents did not have any previous experiences with New Zealand healthcare system, they are still considered 'atypical' despite the relatively large numbers, because they are not likely to provide worthy information centre to this study focus. Similarly, the 'extreme' or deviant case

does not necessarily mean they are outliers. It is a particular interest of this study to identify individuals with distinctive characteristics that may provide different perspective than typical cases (Rice & Ezzy, 1999).

In summary, the sampling methods selected for this study will combine to extract information that can provide the most insights to the research questions. ‘Criterion sampling’ ensures the right people are asked for the right questions; ‘typical case sampling’ further selects participants with the richest information while ‘extreme or deviant sampling’ provides unique and fresh perspectives for comprehensive understanding.

Participant Recruitment and Selection

Due to the two-step structure of the data collection in this study, the first stage targeting participants is a recruitment process not only for survey but also for the later interview process. Although the recruitment and selection of participants will happen in sequential order along the research timeline, the recruitment process provides the overall domain that embodies both stages, as the interviewees are selected from the survey respondents as a sub-group from the initial recruitment pool. Therefore, it is crucial that the criteria for the recruitment process are carefully set to specifically target potential participants relevant to this study.

Under the above principle, to be eligible for recruitment in this study, participants were required to meet the following criteria:

1. Be a Chinese immigrant to New Zealand who has a country of origin (defined by place of birth) within the People’s Republic of China (PRC; excluding Hong Kong and Macao Special Administrative Regions).

2. Be aged between 30-55 years.

3. Currently live in the Auckland region (defined by Auckland City Council, from Waitakere Ranges to the west, Hauraki Gulf to the east, Rodney District to the

north and Franklin District to the south).

The first criterion ensures participants recruited for this study were deliberately chosen as coming from the mainland of PRC, thus excluding other regions of south-eastern Asia. The purpose of such selection was to target a specific group of Chinese who share similar backgrounds in cultural values and beliefs towards the concepts of health and healthcare. These similarities have been formed over thousands of years in isolation to the western world by the mainland Chinese population. Alternatively, in recent history, other Chinese populated countries and regions, such as Malaysia, Singapore, Hong Kong and Macao, have embraced the modern western system such as the British Commonwealth formation and the implementation of systems. Another important factor is that the mainland Chinese population has experienced a much different social and political environment shaped by communist and socialist system and beliefs since the 1950s. These ex-Soviet Union ideologies, systems and policies fundamentally changed the way healthcare is delivered to the public as part of the social welfare. In contrast, other Chinese dominated countries and regions such as Taiwan have adopted the US systems after the World War II. These differences mean that the Chinese immigrants coming from different backgrounds will respond differently to a new environment.

In setting the second criterion, the target group was chosen for their age because this mid-aged group makes up the largest sub-population among the Chinese community; thus the most representative category. Although representativeness is not the most important consideration in qualitative sampling, having a relatively representative group will help readers who are unfamiliar with the area of the research to better understand the context (Rice & Ezzy, 1999). It will also positively influence the credibility of the study findings. Coincidentally to such selection, this age group will also progress into retirement as New Zealand population peaks into the ‘aging-society’ in the next few decades which puts an unprecedented pressure on the public health system. Therefore, the experiences, views and expectations of this age group should also contribute to the future planning of New Zealand’s healthcare system.

The third criterion defined the geographical boundaries of the recruitment process. This

study was located in the Auckland area for two main reasons. First, Auckland is the largest, most populated city as well as the economic centre of New Zealand. It has become the first choice of destination for immigrants from China in that over 70% PRC Chinese currently live in Auckland with a population exceeding 100,000 (Li, 2010). This is considered a large enough number to generate sufficient information in terms of sample space. Second, the researcher is herself a PRC Chinese immigrant living in the Auckland area and has established relationships and actively participated in a number of local PRC Chinese communities. It was hoped that these experiences and connections would positively contribute to the participant recruitment as well as to other aspects of the research process.

In accordance with the above recruitment criterion, a total of 60 surveys were distributed to participants through a number of channels (see Data Collection section for detail). A total of 38 valid responses were received, out of which 18 individuals indicated consent to participate in the interview process. These 18 individuals consequently formed the pool for the second stage interview participant selection.

The interview participant selection employed the ‘typical case’ and ‘extreme or deviant case’ sampling method, as previously discussed. First, the answers to survey questions about potential participants’ background, personal circumstances and experiences with New Zealand healthcare system were compared with each other. Those that provided the most information-rich were selected, typically with various opinions and experiences interacting with the healthcare services or systems. Individuals who provided little or no such information were generally excluded. However, ‘extreme’ cases were considered if special circumstances were present or new perspectives were involved. For example, one individual has had little experience with the New Zealand public healthcare system or local GP services but expressed strong belief towards Traditional Chinese Medicine. While this individual’s answer was short and limited, he was also included into the selection for further inquiry. In total, 7 participants were chosen for the interview.

Data Collection - Survey

The first step in data collection consisted of a questionnaire based survey. Although survey is more of a quantitative research method than it is qualitative, this does not mean that surveys cannot be used in qualitative studies. Quantitative surveys aim at producing statistical generalisation or describing numerical distributions (Groves et al., 2004). However, there is also a qualitative way that surveys may contribute to the research, especially in population studies in the social context. According to Jansen (2010, p. 3):

> The qualitative type of survey does not aim at establishing frequencies, means or other parameters but at determining the *diversity* of some topic of interest within a given population. This type of survey does not count the number of people with the same characteristic (value of variable) but it establishes the meaningful variation (relevant dimensions and values) within that population.

This qualitative interpretation of survey design theoretically backed-up the practice of using surveys in qualitative studies. However, the researcher of this study does not entirely agree with these statements. From a data analysis perspective, the particular use of survey in this study does involve counting people with the same characteristics. But unlike quantitative counting, the qualitative counting "is a means to an end, not the end itself" (Sandelowski, 2000, p. 338). This was also referred to as "quasi-statistical analysis" by Miller and Crabtree (1992, p. 18). They presented the idea that counting in the qualitative sense is not simply a statistical manipulation of data, but rather a descriptive summary of themes and patterns share by the data, merely confirmed by numerical means (e.g. counting). This is effectively a form of qualitative content analysis. Therefore, the use of survey design in terms of data analysis of this study closely adheres to the aforementioned principle. In addition, it is used more as an observation method not for statistical generalisation, but to present a general image of the cultural, value and behavioural aspects of the target population. This is particularly useful when the subject of investigation is unfamiliar to the general society, within which the study is conducted.

In this study, the survey data collection employed a controlled distribution and collection method where survey forms (Appendix B & C) were distributed to attendees

meeting the selection criteria in a Chinese community centre meeting in October, 2010. The researcher attended this meeting and provided information about the survey. A period of 15 minutes was given to potential participants to read the participant information sheet (Appendix D) as well as the consent form (Appendix E) and to ask any questions. The researcher addressed these questions and concerns and then handed out the survey for those who agreed to give their consent to participate. The surveys were distributed at the beginning of the meetings and a sealed drop-in box at the meeting location was provided for participants to drop in their completed surveys at a time convenient to them within two weeks. The participants were encouraged to use the drop-in box and address-stamped prepaid envelops were provided if the participants chose to take the surveys away and return in two weeks by post. An official at the community centre was appointed to safeguard the sealed box during the two-week period. For privacy reasons, the appointed official did not have access to the contents of the box. The drop-in box was then collected by the researcher after two weeks. It was hoped to receive at least 30 survey responses so that the sample size would be sufficient from which potential interview participants can be chosen. Although a successful collection, the number of valid responses fell marginally short of anticipation at 28 valid responses. To ensure the initial planned sample size was met, the researcher then turned to public facilities including the Auckland City Library and the Auckland University of Technology Libraries where random individuals satisfying the recruitment criteria were asked to participate in the survey. All necessary information and consent were introduced to the participants before the survey was handed out. Participants who agreed to take part in the survey were given the options to complete the survey either at the location or return them in an address-stamped prepaid envelop provided within two weeks. In total, 38 valid survey responses were collected.

Data Collection - Interview

A combination of methods and techniques were employed in the second stage of data collection. During this stage, individual face to face interviews were conducted and audio recorded. Written notes on observations such as participants' body language and

emotional remarks were made. Interviews establish a relationship between the researcher and the participants based on trust, respect and mutual understanding, therefore requires high level skills and care from the researcher (Ulin, Robinson, & Tolley, 2005).

In this study, a semi-structure interview method was used. The semi-structured interview, sometimes referred as non-directive or in-depth interview, is designed with predetermined questions and/or topic areas in mind (Berg, 1995). However, this does not mean questions are asked in exactly the same words following exactly the same order (Bowling, 1997). Instead, they are used to guide the process while the actual speech events are constantly negotiated and reformulated throughout the interaction between the researcher and the participant (Mishler, 1986). This practice allows flexibility for exploring and gathering experiential narratives to develop in-depth understanding of real-life events and experiences (van Manen, 1997).

In total, 7 individuals participated in the interview process that concluded the data collection process. Participants selected from the survey respondents for the interview process were first contacted by telephone and asked their preference for time and location of the interview. Six participants chose their residential homes as the interview venue; one individual requested the interview be conducted at the university campus. Upon arrival at the interview location, the researcher followed a standard process to open the interview. The first step was to offer the participants the option of English or Chinese Mandarin, whichever they felt comfortable with for conducting the interview. The researcher is fluent in both languages. Following the participants' choice of language, the researcher briefly introduced the study purpose, participants' involvements and contribution, and obtained their consent to take part in the interview. The researcher then explained the interview procedure and participants' rights during the course of the interview. Participants were reminded that they were entitled to not answer questions that they did not feel comfortable with, and that they could temporarily break from or terminate the interview at any stage if they did not wish to continue for any reason. All participants were asked to choose a pseudonym for themselves to protect their privacy. The participants then had the opportunity to raise

questions or request further information they might need before the interview commenced.

An interview schedule (Appendix F), containing main questions to cover the major aspects within the research, was used as a guide. Each individual summary of interview questions was slightly different in design according to particular individuals' answers from the survey questions. For example, if a participant's survey answer showed no previous experiences with the New Zealand public hospital system, the questions relating to such topic in the summary of interview were then deleted. Each main question also contained a number of possible follow-up questions. If an individual expressed particular interest or opinions towards a certain topic area, the follow-up questions were re-designed to suit their circumstances. This personalised approach helped to ensure the efficiency of the interview, as well as focusing on the information-rich aspects of the participants for in-depth inquiry. All questions were open-ended to help participants reveal their true experiences and opinions in their own language. For example, questions such as "How did you feel about…?" or "What was it like when…?" were employed instead of "Why did you do this?" or "Was it because of this?". These open-ended questions also helped avoid potential bias when the questions from the researcher maybe 'led' or 'guided' answers.

Each interview took around 60 to 90 minutes and was voice recorded and transcribed word for word by the researcher. The transcript (both in English and Chinese) were then sent to the participants for comments and to request any changes be made if necessary within one week from receiving the transcripts. None of the interview participants responded with change requests or further comments.

During the data collection phase, preliminary data analyses were undertaken. In qualitative studies, the processes of data collection and analysis often take place simultaneously as they both mutually shape each other (Sandelowski, 2000). This phenomenon can be seen in this study as the example of separating information-rich survey responses for interview selection and formulating personalised interview summary questions from the survey data analysis. All survey and interview data were

then arranged and examined by different methods in the more comprehensive data analysis process. For consistency and accuracy, all survey data and interview transcripts used in the following data analysis stage were English versions.

Data Analysis

The ultimate goal for data analysis is for the investigator to "systematically examine data to discover patterns and in some cases, to identify cause-and-effect relationships" (Ulin, Robinson, & Tolley, 2005, p. 139). The underlying question is: how this is done? Between quantitative and qualitative, for example, quantitative researchers apply pre-existing mathematical model to the data (Sandelowski, 2000) to test their hypotheses, because they had expected outcomes in advance even before the data were collected (Ulin, Robinson, & Tolley, 2005). For qualitative researchers, models also apply but "they are generated from the data themselves in the course of the study" (Sandelowski, 2000, p. 338). This study is driven by qualitative descriptive methodology and bears some quantitative characteristics due to the involvement of a survey design.

The practical analysis of survey data began with a qualitative content analysis framework summarised by Kellehear (1993):

1. Develop categories prior to searching for them in the data
2. Select the sample to be categorised
3. Count, or systematically record, the number of times the categories occur

Guided by this framework, the survey answers were categorised into indicators such as age, gender, education and language competency, experiences with various forms of healthcare system and attitudes toward cultural and belief (e.g. tendency of seeking Traditional Chinese Medicine). Individuals were then selected to fit into these categories and their frequencies and correlation counted. This qualitative content analysis by quasi-statistical means has two purposes. First to present an overall picture of the Chinese immigrant population with their unique characteristics, a social

phenomenon better understood and confirmed with the help of numbers. Second, to facilitate the thematic analysis of interview data.

Unlike the complication involved in the survey data analysis, which may include some quantitative numerical manipulation, the analysis of interview data is unarguably typical qualitative. The practical problem lies with how to turn hundreds of pages of transcript, along with numerous other written or media materials, into distinctive layers of truth and understanding of the research questions and context. Simple forms of qualitative content analysis used in the previous survey section did not seem to be appropriate as it required the development of categories prior to examining the data. The complexity of the interview data meant that without comprehensive understanding of the data, it was virtually impossible to develop appropriate categories because all interview data have individual characteristics and were highly versatile. It seemed that the only logical way was to start from the data-end. As suggested by Lincoln and Guba (1985), qualitative data analysis is a process begins where the researcher makes sense of the data. Denzin and Lincoln (1998a) further suggested such process starts with specific observations which later form more general rules. Both these methods imply a strategy of deriving patterns, often referred to as code from the data. According to Charmaz (1983), who worked in the 'grounded theory' tradition:

> codes serves to summarize, synthesize, and sort many observations made of the data…coding becomes the fundamental means of developing the analysis…Researcher use codes to pull together and categorise a series of otherwise discrete events, statements, and observations which they identify in the data. (p. 112)

Although this study does not use grounded theory as its leading methodology, the fundamental data analysis approach derived from this theory, namely the thematic analysis was the method of choice. Using this approach, each survey question was coded for identification of any thematic trends and variations in individuals' circumstance, experiences, problems and general views. The coded data was then used for thematic analysis to identify any patterns (pattern recognition) in seemingly random information (Patton 2002). In preparation, interview data was first transcribed and coded for the identification and extraction of important opinions, statements and

findings related to the research focuses including cultural, beliefs, behavioural and psychological impacts. From then on, the analysis of the interview results took several steps. According to Patton (2002), "the first decision to be made in analysing interviews is whether to begin with case analysis or cross-case analysis" (p. 376).

This research began with cross-case analysis by developing categories and a thematic framework. According to Lincoln and Guba (1985) the essential task of categorising is to bring together into temporary categories those data bits that apparently relate to the same content. The first step in this process is to code individual answers and develop theme or category for grouping. Table 1 is an example of this process.

Table 1: Example of Categorisation Process

Transcript	Code	Category
1-28. 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	Healthcare Awareness
	Trust	Patient-Practitioner Relationship

In the next step, answers and quotes to specific questions are highlighted, sorted and lifted to be re-arranged under newly-developed appropriate thematic content (Rabiee, 2004). Table 2 on the next page is an example of newly developed codes with re-grouped quotes and answers. The numbering such as '1-13' identifies individual interviewee and the location of the quote on the transcript.

Table 2: Example of Re-arrangement of Codes into Themes

Accessing Healthcare Services Delivery (Patient-System)
Primary (Accessing GP Services) [1-13, 4-12, …...]
Secondary (Accessing Specialist Services) [6-9, 6-13, ……]
Tertiary (Accessing Hospital Services) [1-17, 1-18, ...]
Private Sector (Insurance) [1-31, 4-1, ……]
Patient-Practitioner Relationships (Interactions)
Language [1-16, 4-5, ……]
Level of Communication [1-7.1, 4-2, 6-2, ……]
Conceptual Understanding (Context) [1-6, 5-12, ……]
Trust / Respect [1-28, 4-16, ……]
Healthcare Awareness
Internal Source of Knowledge
Upbringing / Mentality [1-28, 4-15, ……]
External Source of Knowledge
Publication / Media Exposure [1-9.2, 4-6, ……]
Friends & Family [4-10, 6-3.5,……]
Healthcare Attitudes
Attitudes towards family health [2-1, 5-6, ……]
Attitudes towards self-care [4-4, 6-3.5, ……]
Attitudes towards financial consideration [5-8, 3-7, ……]

The re-arranged data was then broken down for interpretation to identify the common characteristics as well as differences in views and opinions that individual quotes expressed. The results of this analysis will make sense of the answers and quotes and help to determine if any relationships can be established linking to identified access barriers and if any conclusive or inconclusive answer to research questions can be

deduced. The findings of the analysis will be discussed in details in Chapter Four, Five and Six.

Ethical Considerations

According to Tolich and Davidson (1999) there are five principles of ethical research: do no harm, voluntary participation, informed consent, avoid deceit, and confidentiality. The researcher is committed to ethical research practice and adhered to the above principles which will be discussed in this section. In addition, the researcher also acknowledges the importance and unique value of the Treaty of Waitangi and the implications for Maori in the context of Aotearoa, New Zealand.

Do No Harm

This study was considered to have low risk for both researcher and participants, although minor issues could arise due to the nature of this study relating to the health condition and past experiences in receiving healthcare. Discomfort could be possible depending on individual participant's experiences or views on specific issues relating to questions in the survey or interview. The researcher tried to avoid questions regarding participants' intimate health details. Participants could choose whether or not to answer specific questions. Participants could also choose to temporarily break from or terminate the process at any time if they did not feel comfortable. The researcher could also choose to temporarily break from, or terminate, the process at any time if such risks were present. In these instances, the researcher would advise the participants of pre-arranged free counselling services provided by AUT (Appendix G - Memo from AUT Counselling Services). During the course of this research, no participants raised such concerns or requested counselling services. As the research involved interviewing participants in private homes, researcher safety was ensured by notifying family members or other support persons of the time of arrival/return and location of the interview.

Voluntary Participation

It was anticipated that all participation in this study be voluntary. Potential participants were given information about the purpose and nature of this study, to which they needed to indicate consent before taking part in the study. All participants were informed of their rights to withdraw from this study or to withdraw the complete or in part of any information they provided at any time without any restrictions. No participants withdrew from this study.

Informed Consent

Prior to taking part in this study, potential participants were provided with an Information Sheet (Appendix D) accompanied by the Consent Form (Appendix E). Considering the possible language barriers the participants may have, all of the materials provided to participants were in both English and Chinese to avoid any possible misunderstanding. Participants were encouraged to ask any questions they may have at any stage during the research.

Avoid Deceit

Participants were provided with accurate and clear information regarding all of their involvement in this study. All potential cost, benefits and risks were fully disclosed to the participants prior to the commencement of the study. They were also clearly directed to the contact means of any official contact persons overseeing this study if they needed to raise any concerns.

Confidentiality

The researcher is committed to the protection of participants' privacy and confidentiality. Throughout this study, all record of communication and exchange of information were

only available to the researcher and her supervisors. Pseudonyms have been used to replace any identifying details of the participants in all recordings and transcripts. Participants were advised of their rights in requesting all or any parts of their personal information as well as information provided for this study to be removed and destroyed. All materials relating to this study will be managed, stored and later destroyed strictly in compliance with AUTEC protocol.

Treaty of Waitangi

Although this research does not directly involve Maori participants or particular Maori issues, the principles of the Treaty of Waitangi are relevant not just to Maori/Pakeha relationship but also to relationships with immigrants/minority groups as a whole. The proposed research involves Chinese immigrants as the main target population with a particular focus on how this minority ethnic group may better access New Zealand healthcare system. The Maori population is the single largest minority group in New Zealand. The understanding of health-care utilisation of another ethnicity may well benefit the Maori population over very similar processes. Nevertheless, this research is to be conducted with full respect and acknowledging each of the three principles of the Treaty of Waitangi including partnership, participation and protection, as well as their application and implementation for researcher/researched relationships in general.

Trustworthiness of the Study and Promoting Rigour

Rigour or the trustworthiness of academic research refers to issues that are raised by the terms validity and reliability (Rice & Ezzy, 1999). It describes the procedures that enhance the scientific integrity of the research findings (DePoy & Gitlin, 1998). Some researchers agree that being quantitative or qualitative, the criteria in assessing rigour or trustworthiness are largely the same (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Nolan & Behi, 1995). However, some qualitative researchers argue that it is inappropriate to apply the same evaluation approach to studies that are fundamentally

different in nature and purpose (Dezin & Lincoln, 1998b). It is apparent that there is an ongoing debate without definitive conclusion regarding the issue of rigour amongst researchers (Dezin & Lincoln, 2003; Koch, 1994). While open debates encourages further studies into the issue, the evaluating framework of rigour and trustworthiness developed by Lincoln and Guba (1985), two of the most authorisable scholars in qualitative research proves to be the most acceptable. Lincoln and Guba suggested four criteria for evaluating rigour: credibility, dependability, transferability and confirmability, which this study will follow.

Credibility

According to Lincoln and Guba (1985), credibility of a qualitative descriptive study is dependent upon if the research steps and process can be easily traced and the experiences described by the participants are truly theirs. In this study, the coding process and the re-arrangement of codes into thematic categories can be clearly traced back to original interview transcripts as shown in Tables 1 Table 2 (pp. 45-46). All experiences described by the participants collected from the interview were recorded word for word and presented for what they were with strictly no changes made by the researcher. Credibility also involves other factors such as reflexivity, triangulation and methodology appropriateness.

Reflexivity was maintained in this study as the researcher constantly and honestly evaluated her action and role in the research process. The researcher acknowledges being a Chinese immigrant herself may run the risks of bringing pre-existing values and beliefs into the study as bias, because they may influence the observation and interpretation of the behaviours of others (Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003). To minimise these potential influences, the researcher kept records of thoughts, feelings and ideas, instead of attempting to disguise her role as an instrument of the research. The procedures of data collection and interpretation were also closely consulted and monitored by researcher’s academic supervisors to avoid potential bias.

Credibility can also be achieved through selecting and applying methodology, research

methods and techniques appropriate to the research questions. The researcher employed triangulation, or the use of combining multiple methods and techniques (Rice & Ezzy, 1999). Both atypical and typical qualitative methods, including survey and interview, were discussed from quantitative and qualitative perspectives. This not only helps to compare the advantages and disadvantages of one method with another (Mason, 1996), it also enables the researcher to rise above "the personalistic biases that stem from single methodologies" (Denzin, 1970, p. 300).

Dependability

One strategy for promoting dependability is to include an audit trail analysis over the methodology, data collection and data analysis process. The methodological selection process in this study has been clearly laid out with theoretical and philosophical justifications. All logical steps in forming the reasoning behind the choices and implementations of the methods were structurally valid and show the roadmap of how conclusions are drawn from the logic flow.

Another triangulation method is also used in peer examination. The accuracy of the participants' point of view and accounts of real-life experiences were ensured by sending recorded materials back to the participants for verification and comments including interview transcripts. Although no issues were raised by the participants in regards to the accuracy of interview content and no request for changes was received, the employment of such check and re-check cycle still procedurally helps to ensure the accuracy of assumptions and judgement (Coolican, 1990).

Transferability

Transferability refers to the degree in which the results of a qualitative research can be transferred to other contexts (Polit & Hungler, 1997; Trochim, 2002). This study established clear structure of the methodology and research process with sufficient information provided in terms of research settings, participant selection and data

analysis relative to the nature and purpose of the research topic and questions. This will help the readers and observers of this study to evaluate the transferability and practicality of adopting them in other contexts. However, like many other qualitative descriptive studies, the sample size of this study is not sufficiently large to make generalisation into other contexts without excising careful comparisons and evaluations. The unique characteristics of the Chinese cultural, value and beliefs are also important factors worth noting in terms of applicability to other populations.

Confirmability

According to Lincoln and Guba (1998), confirmability can be assured if the other criteria of credibility, dependability and transferability are achieved. The above discussions have demonstrated every effort has been made to ensure the researcher followed an independent procedure of inquiry with the help of techniques such as reflexivity, triangulation in forming methodological framework, selecting participants, collecting and analysing data to present them in a truly reflective way. However, there is no perfectness in rigour. Other potential aspects contributing to rigour and trustworthiness of this study are openly subjective to criticism.

Summary

This chapter has presented an overview from the choice of methodological framework, research methods and techniques in selecting participants, collecting and analysing data to the ethical considerations and rigour of this study. Theoretical and philosophical implications and justifications for the choices and decisions involved were discussed. In particular, the uniqueness of this study where a combination of multiple data sources, strategies and methods were given special attention which shows the effort made to establish the trustworthiness of this unusual approach. The findings of the research will now be presented.

CHAPTER 4: FINDINGS PART I – SURVEY RESULTS

Introduction

The aim of this study was to uncover the factors that influence Chinese immigrant health and access to healthcare services. The data collection process of this study was divided into two stages: a questionnaire based survey followed by face-to-face interviews with selected participants. Consequently, data collected from these two stages were analysed separately and the findings are presented in Chapters Four, Five and Six

This chapter focuses on the survey data collected from a total of 38 valid responses. According to the design and structure of the survey form, the analyses of answers to survey questions are grouped into three categories: 1) Demographics and general information, 2) Personal healthcare information, and 3) Experiences in receiving healthcare services. The general approach to data analysis in this section involved counting occurrences and frequencies of answers as well as summarising and documenting opinions. The numerical interpretations undertaken in this chapter are employed as a form of qualitative content analysis (Sandelowski, 2000) or as "quasi-statistical analysis" (Miller & Crabtree, 1992, p. 18). They do not involve complex statistical manipulation of data; rather descriptively summarise common characteristics and patterns deduced from the data.

The primary purpose of the survey questionnaire was to gather background information and provide a means to select suitable participants for individual interviews. Therefore, although findings from this section may have important implications beyond simple summaries of numbers and answers, it is not the intention of this chapter to provide ungrounded subjective interpretations without justification. The presentation and analyses of data are focused on accurately reflecting the participants input for what they are, as well as some readily identifiable internal correlations. Findings will be further used in conjunction with interview analyses, from the next two chapters, to aid the overall discussion in Chapter Seven.

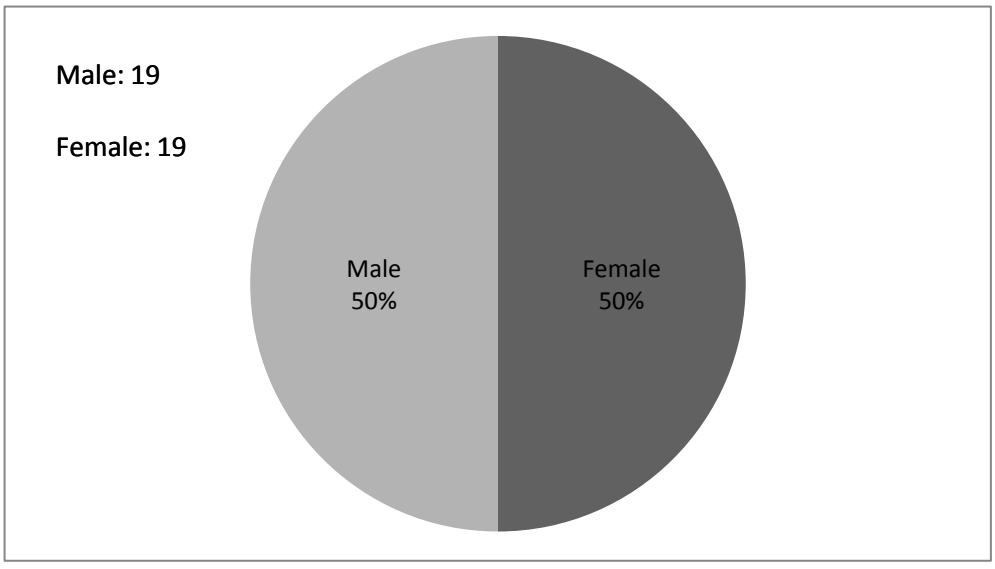
Demographics and General Information

The first section of survey data presentation provides demographic and general information collected from respondents including gender, age, marital status, place of birth, education, language and time of residence in New Zealand. These data offer a clear overview on the personal backgrounds of the survey respondents and establish a baseline for their current social status. Furthermore, they may contribute to making sense of healthcare related findings later in this chapter as well as for interview data analysis in the next chapter.

Gender

Figure 1 shows that there were a total of 38 participants, 19 male and 19 female, each accounted for 50% of the total pool. Survey respondents were not pre-selected for their gender, the 50% even distribution was a random result.

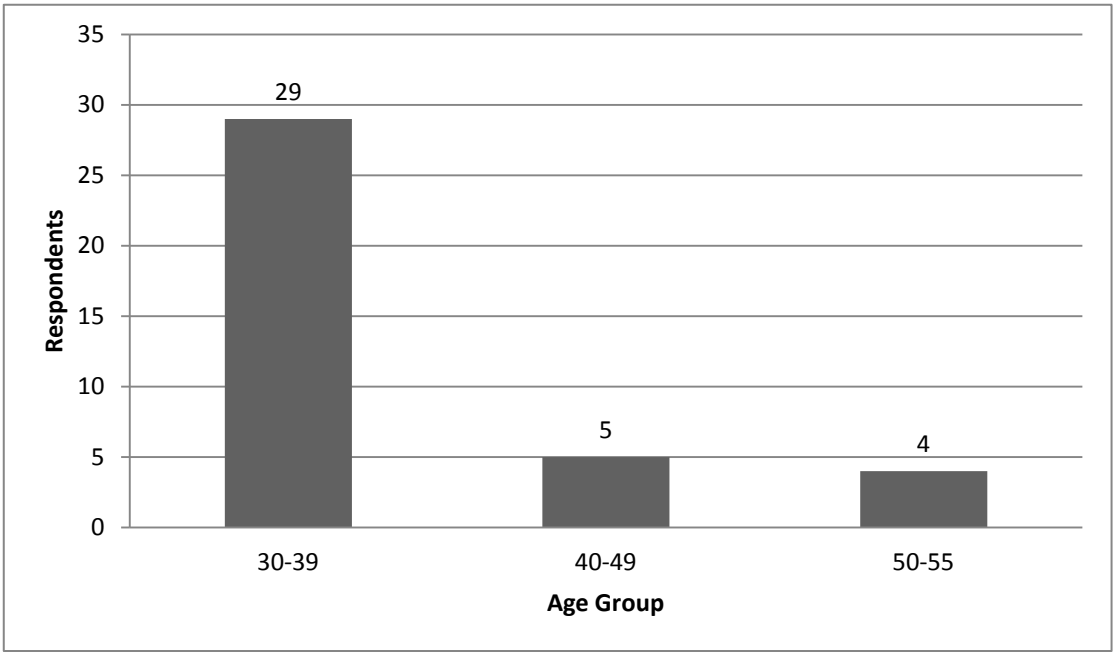
Figure 1: Gender Comparison



Age Group

As previously discussed, participants were required to meet a set of criteria, which included an age limit of between 30 and 55, to be eligible for the study. Figure 2 shows the distribution of age groups within the specified range. Out of all survey respondents, 76.3% were aged between 30 to 39, 13.2% were aged between 40 to 49, and 10.5% were aged between 50 to 55. It is apparent that the age group of 30 to 39 is the single largest sub-group within the specification of this study. This observation possibly reflected the proportion of prime age 'skilled migrant' category among the general Chinese immigrant population. The importance and implications of this age group distribution in the context of this study will be further explored in the discussion chapter.

Figure 2: Age Group

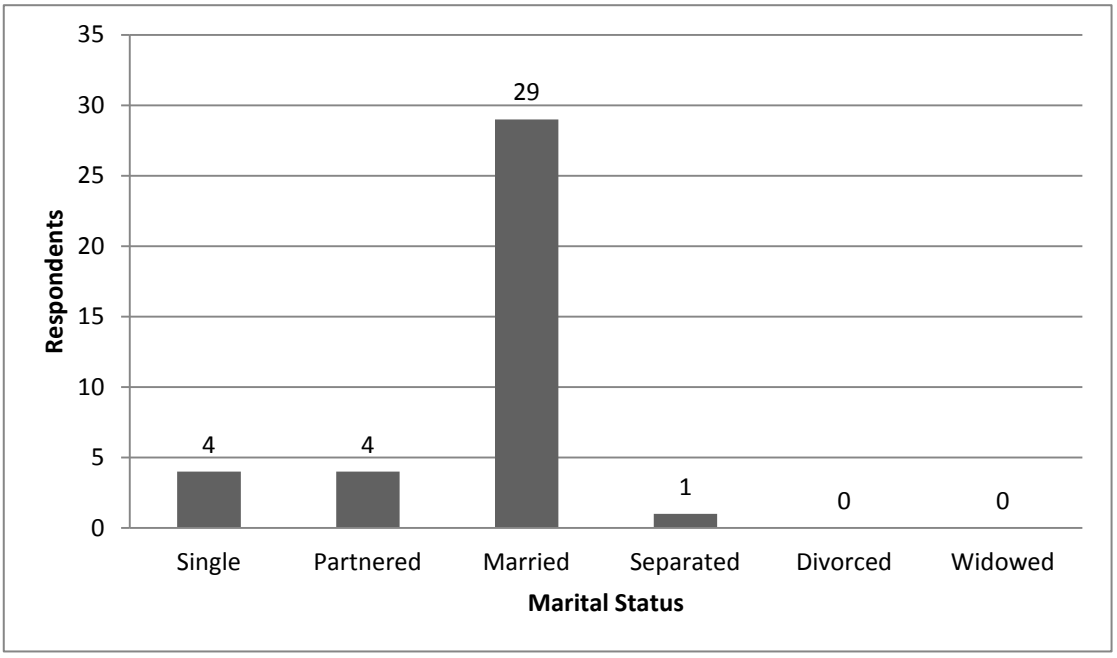


Marital Status

Figure 3 (p. 56) shows the distribution of marital status among respondents. The majority of respondents were married (76.3%), in comparison to being single (10.5%) and in a partnered relationship (10.5%). One respondent reported a separated status and no divorced or widowed respondents were identified. The fact that most of the respondents were involved in stable family structure may have significant impact on

their attitudes and decision makings towards health and healthcare services due to family-oriented Chinese traditions as identified in the literature review. The particular finding will be explored in more depth in conjunction with interview data analysis. There was no evidence suggesting further correlations with other factors at this stage.

Figure 3: Marital Status



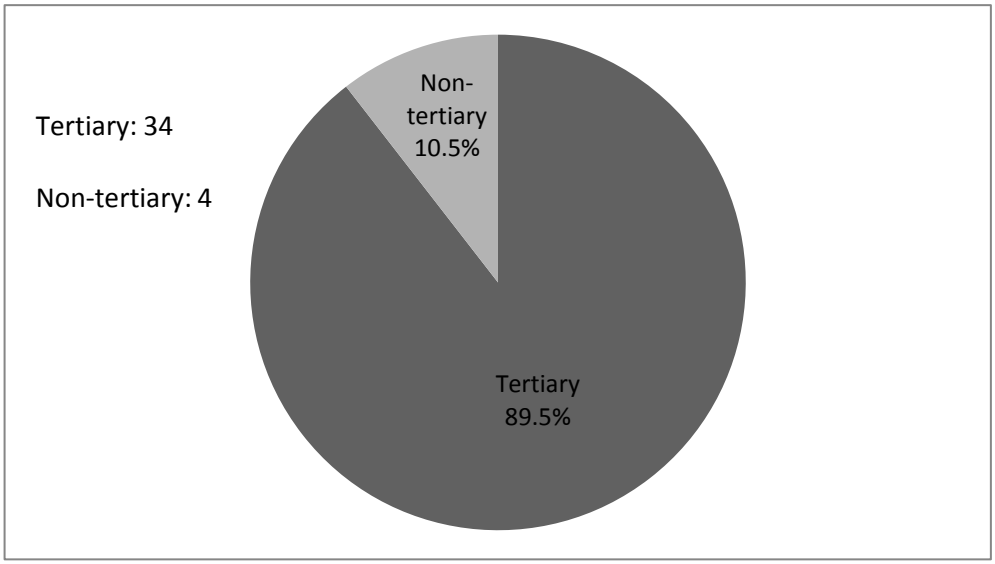
Place of Birth

The purpose of this question was to identify those who fit the selection criteria; which required the participants to have a place of birth within the PRC. All respondents eligible to complete the survey met this criterion. Nine respondents confirmed their eligibility of having been born in China; however, the remainder stated their hometown more specifically. A brief analysis of their places of birth revealed that 86.2% of those respondents originated from coastal provinces and urban centres where the level of economic development and social services are considerably more advanced than the national average in China. In terms of health and healthcare services, this distribution may reflect a potential contributing factor that influences Chinese immigrants' healthcare decisions.

Highest Educational Qualification

Figure 4 shows the proportion of respondents who hold tertiary qualifications. In total, 34 respondents (89.5%) had completed tertiary education and obtained a relevant qualification (national diploma level or above); 4 respondents (10.5%) indicated that they had not attended any form of tertiary education. In addition, when the age group distribution was taken into consideration, high levels of tertiary education achievements were found in the 30 to 39 as well as 40 to 49 sub-group (93.1% and 80% respectively), again possibly reflecting links to prime age skilled migrant category in the Chinese immigrant population. In contrast, only 25% of respondents aged 50 and above had completed tertiary level education.

Figure 4: Highest Qualification



First and Other Languages

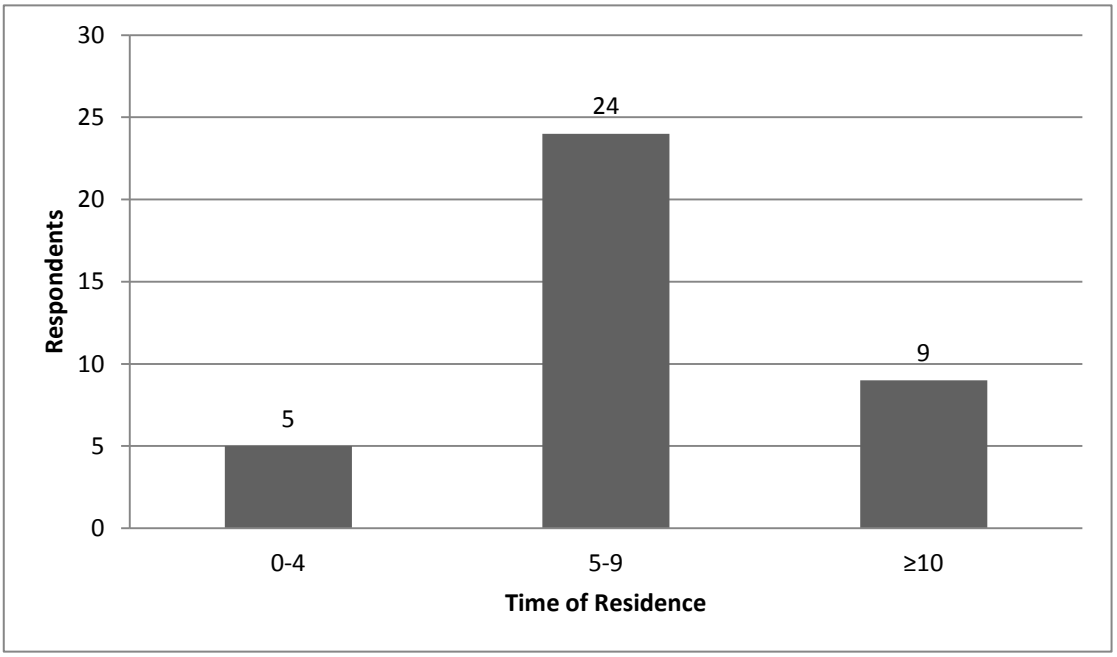
In answering this question, 30 individuals stated ‘Chinese’ as their first language without differentiating between Mandarin, Cantonese, or other local dialects. Three individuals indicated Mandarin as their first language and one individual stated Cantonese. For other languages used by respondents, 25 individuals stated English as their second language and four stated both English and Japanese. Thirteen individuals chose not to answer the ‘Other Language’ option. These answers revealed that at least

65.8% of respondents communicate in both Chinese and English. Of note, were 9 individuals who chose to complete the survey form in English, although they all indicated Chinese as their first language.

Length of Residence in New Zealand

Figure 5 below shows the duration of residence in New Zealand indicated by respondents in number of years. Five respondents (13.2%) had spent less than 5 years in New Zealand, 24 respondents (63.2%) spent between 5 to 9 years and 9 respondents (23.6%) had been in the country for more than 10 years. When duration of residence was broken down into age groups, the older age of respondents did not necessarily translate to longer time of residence in the country. This may suggest a continuing trend of many immigrants coming to New Zealand at older age possibly due to family unification.

Figure 5: Time of Residence in New Zealand



This question concludes the demographics and general information section. The next section personal healthcare information, asks questions about the history and current circumstances, particularly the types of services respondents may have had or are currently having interactions with.

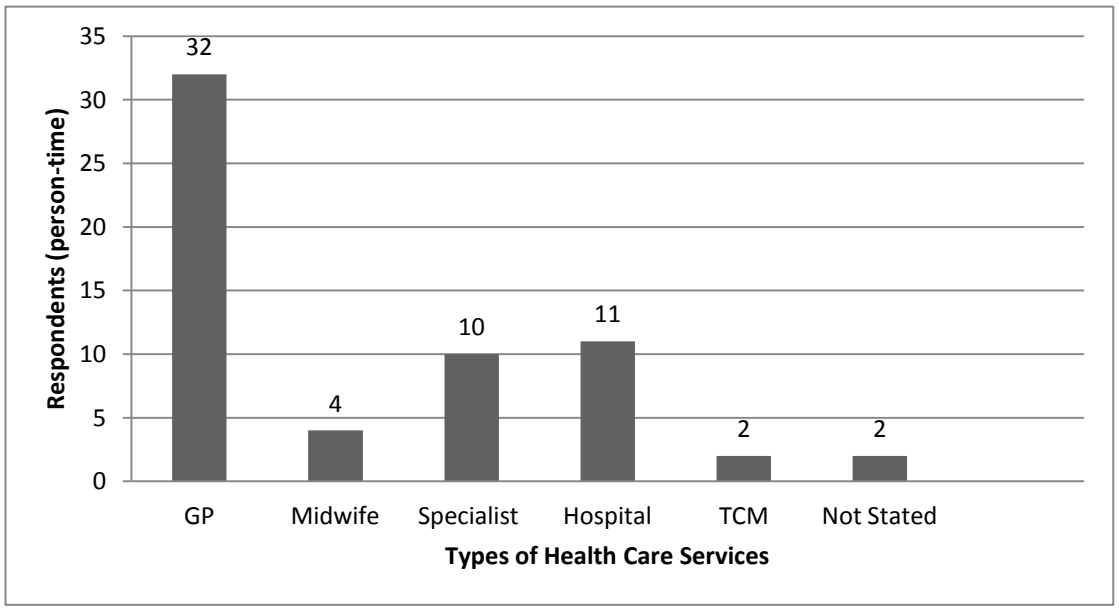
Personal Healthcare Information

From this section on, many questions asked in the survey form allowed multiple choice responses, if deemed appropriate by the respondents. The occurrences counted from these answers are presented in the unit of per person-time (i.e. respondents may be counted multiple times if they have chose more than one option or given more than one answer). These units are also reflected on the graphs.

Question 1: Have you received any healthcare services since your arrival in New Zealand? If yes, please list the type of services you have received in the past.

This question had a 'Yes or No' option, as well as asking respondents to list the healthcare services they had received in the past. Thirty six respondents indicated that they have used at least one form of healthcare services in New Zealand. Two respondents had no experience with local healthcare services. Out of the respondents who answered 'Yes' to the first part of the question, Figure 6 shows a distribution of the different types of services, where GP stands for General Practitioner and TCM stands for Traditional Chinese Medicine.

Figure 6: Types of Healthcare Services Received

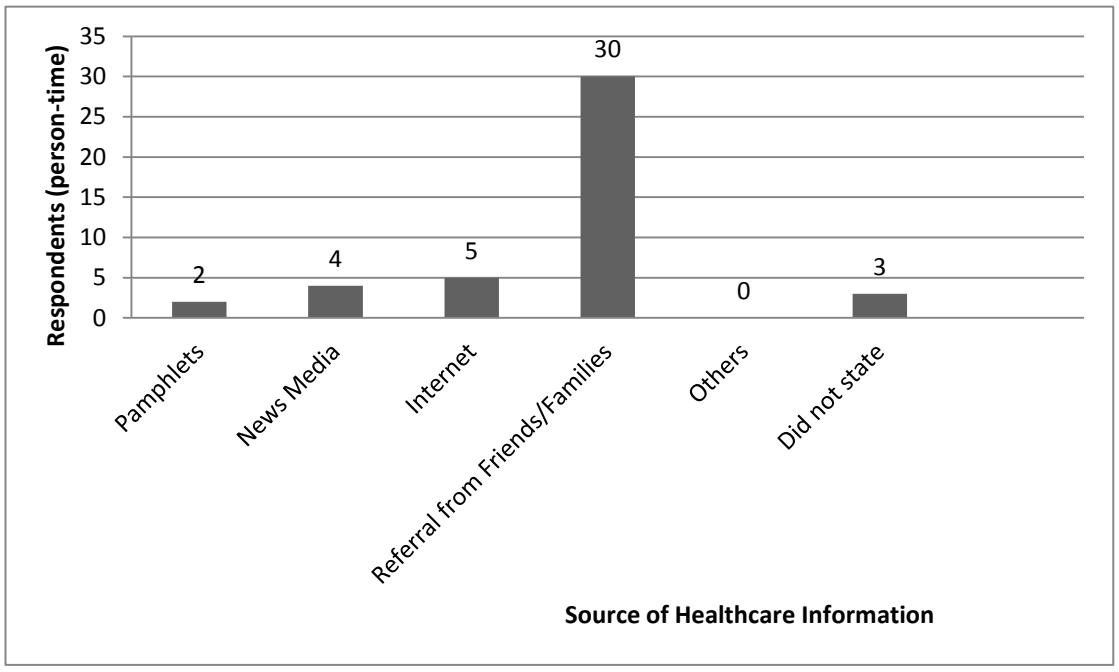


As the graph shows, 32 individuals, (88.9%) stated they have used GP services in the past, 4 individuals (11.1%) have used midwives, 10 individuals (27.8%) have used specialist services, 11 individuals (30.6%) have received hospital care, and 2 individuals (5.6%) have used TCM. Two respondents answered 'Yes' to this question but did not mention the type of services accessed. It is clear that the majority of respondents have visited and received GP services. Further enquiries about these services will be reported in the next few questions. The instances of reported TCM visits however, are lower than expected given that the target group is Chinese immigrants. It is also interesting to note that none of the respondents have listed dental care as one of the healthcare services experienced, although dental services is one of the fundamental forms of healthcare in New Zealand. These observations need to be further explored.

Question 1.1: How are these healthcare services introduced to you?

This follow-up question asked respondents about the source of information through which they were introduced to the healthcare services. Figure 7 below shows the distribution of such sources.

Figure 7: Source of Healthcare Information



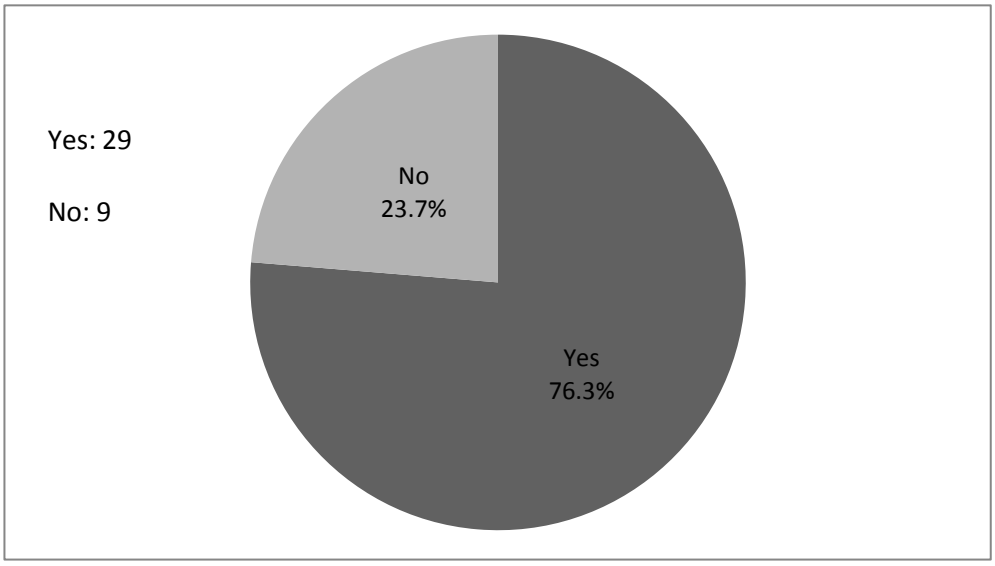
According to choices indicated by respondents, over 78.9% have acquired healthcare

related information from their friends and families as the single largest source. This may well indicate the importance of referrals or 'word of mouth' in social circles within minority immigrant communities. Other channels of information, including pamphlets, news media and internet, are much less used as sources of information, ranging from 5.3% to 13.2%. Three individuals did not answer this question.

Question 2: Do you have a regular GP? If yes, what was the main reason(s) for you to choose your current GP? If no, what was the reason(s) not to have a regular GP and who do you use as your primary healthcare provider?

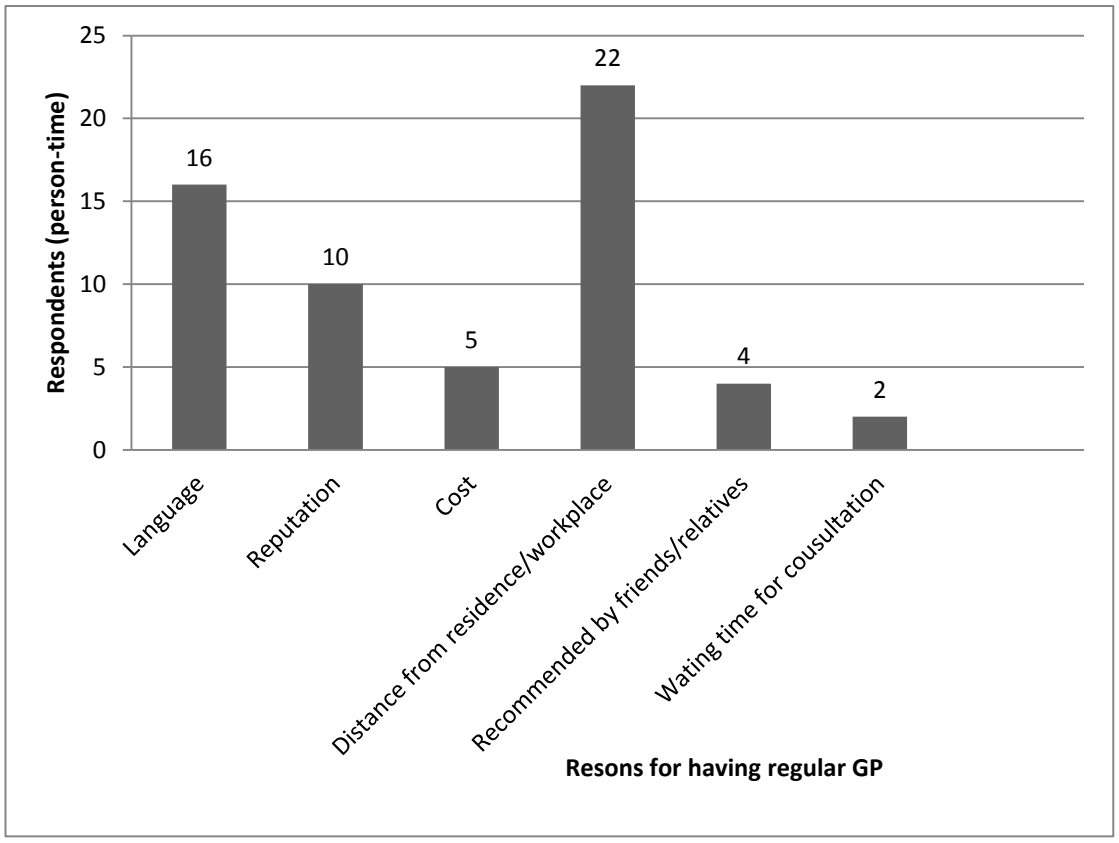
This question follows up on respondents' choices regarding regular GP services. 76.3% of respondents indicated that they have a regular GP for their primary healthcare, as seen in Figure 8 below.

Figure 8: Regular GP Services



For those who chose to visit their regular GP, their reasons for doing so were recorded and grouped into similar categories. Figure 9 (p. 62) shows the frequencies of these answers in per person-time. In answering this question, respondents were not asked to list their reasons in any particular order if there were more than one. Therefore, no additional weightings are given to any particular reason.

Figure 9: Reasons for Having Regular GP



The results indicated that the most frequently mentioned reasons for having a regular GP is the distance from the location of GP practice to the respondents' residences or their workplaces (73.3%). Second, is the consideration over language issues (53.3%). Many respondents stated their desire of having a Chinese speaking GP was for easier communication. In addition, GP's reputation was also considered (33.3%) by the respondents. Other reasons for having a regular GP included the cost of GP services, recommendation from friends or families and waiting time for consultation at GP practice. These reasons appear to be of lesser concern to respondents, ranging from 6.7% to 16.7%. It is worth pointing out that the consideration of a GP's reputation may have some overlap with recommendation from friends and families because reputation may also be part of the reason for recommending. However, in this data set, the potential overlap is not significant enough to alter the overall order of frequencies.

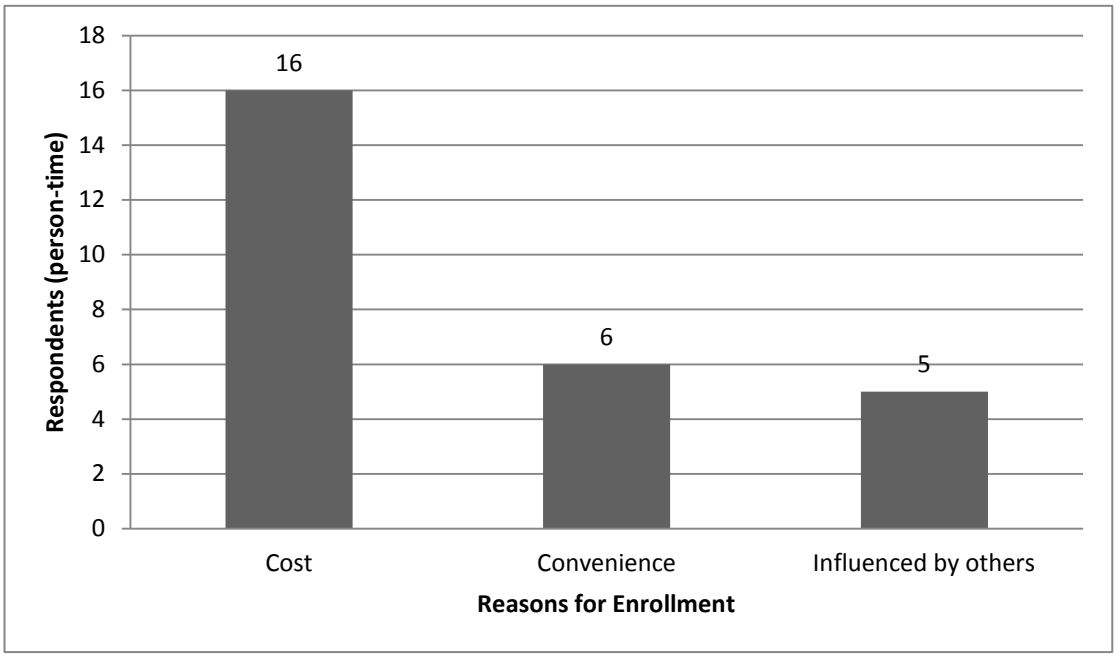
Respondents who indicated not having a regular GP, were also asked their reasons and to state any chosen alternative primary healthcare provider. One individual stated that she used a White Cross clinic near her residence as her primary healthcare provider. In

terms of everyday language, ‘having a regular GP’ mostly described an on-going one-on-one relationship between the patient and the family doctor. However, many GP practices may have more than one doctor in partnership to increase service capacity and coverage. This also means that patients may not be seen by the same doctor every time they visit the practice. White Cross clinics typically employ a number of doctors on rotating shifts to offer enrolled or causal (walk-in) services where appointments may not be necessary. In a broad sense, using a White Cross clinic as a primary health service provider may be considered as having regular a GP practice. But to honour the choices made by the respondents, this individual was still counted as not having a regular GP and her reason given was recorded as such. In addition, two individuals listed having insurance that covered GP services, as their reason for not having a regular GP. It is unclear to the researcher whether having insurance cover presents any consequential relationship to the decision of not having a regular GP. Health insurance may help with the cost of receiving healthcare services but how this may explain the choices of regular GP service requires further inquiry. Other reasons for not having a regular GP included moving residence frequently (one individual) and normally healthy therefore not requiring regular GP (one individual).

Question 2.1: If you have a regular GP, are you enrolled with the Primary Health Organisation (PHO) that your GP practice belongs to? Please specify reason(s).

This is another follow-up question on patient enrolment at GP services. Of the 29 respondents who chose to have a regular GP as their primary healthcare provider, 28 individuals indicated that they were enrolled with their GP practices. Respondents were also asked about the reasons for their decisions and Figure 10 (p. 64) shows the frequencies of positive contributors.

Figure 10: Reasons for Enrollment



Findings revealed that lower cost of services associated with enrolment was the most important factor considered by respondents in guiding their decisions (57.1%). Convenience was the second highest reason (21.4%), and included priority and ease to get appointments for enrolled patients as well as ease with building trusting relationship with the doctors. Some respondents (17.9%) were influenced by others, including their GP, friends, and families, to enrol. The one individual who did not enrol with his GP practice was because he did not know about the enrolment process. This does not necessarily mean that he was not actually enrolled with his PHO through his GP practice. Following the announcement of the Primary Health Care Strategy, by the Ministry of Health in 2001, and the establishment of Primary Health Organisations (PHOs), many patients have been automatically enrolled with the PHO where their GP practice belongs (Ministry of Health, 2001). Seven individuals did not mention any reason for enrolment.

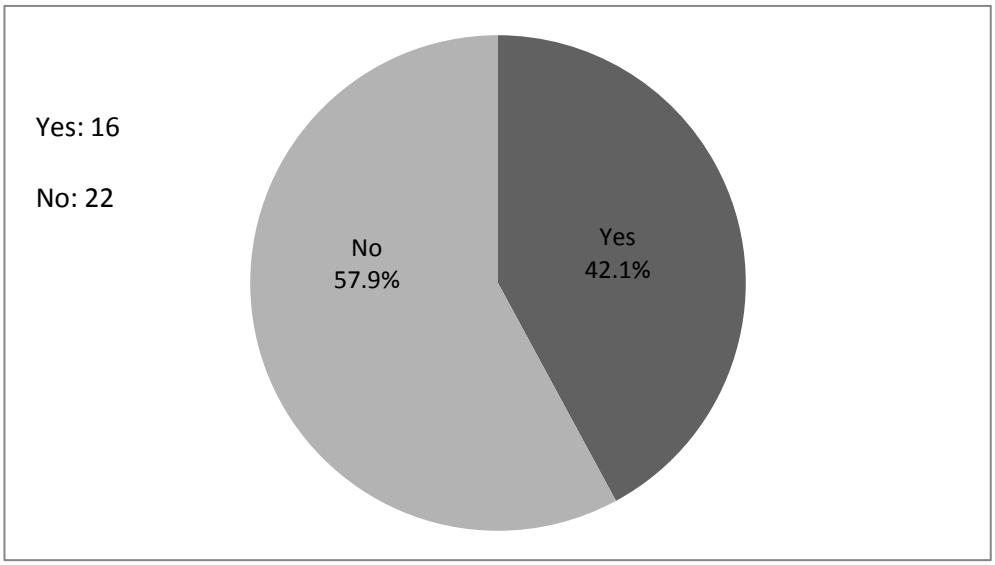
To summarise the previous two questions, on GP services and enrolment, it is clear that majority of Chinese immigrants who participated in this survey have chosen to stay with regular GP and enrol with them for convenience and better service delivery. When choosing their GP, geographical restriction has been identified as the most important

consideration. This is a universal factor as people are usually limited by distances and transportation in accessing any type of social services. Apart from this, it is interesting to note the importance of language issues as considered by respondents when choosing their primary health providers.

Question 3: Have you visited any complementary/alternative medical practices since you have been in New Zealand? If yes, please specify.

When asked about their choices and encounters with any complementary or alternative medical services, in addition to primary healthcare, 42.1% of respondents indicated they have received such services, 57.9% or respondents had not. Figure 11 shows this distribution.

Figure 11: Complementary Health Care



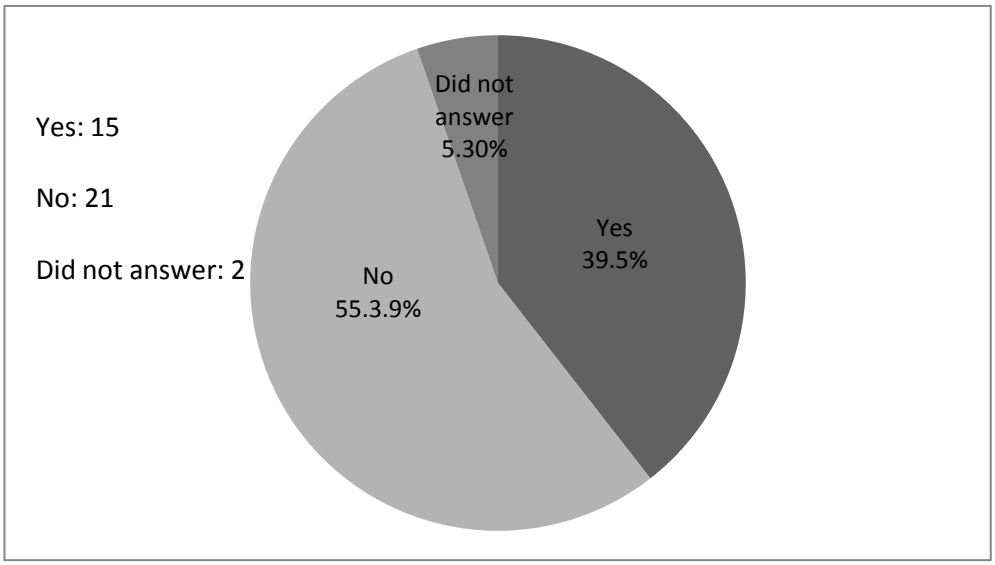
Those who indicated previous visits to complementary or alternative healthcare were asked to specify the type of services they have received. Interestingly, all 16 respondents listed Traditional Chinese Medicine (TCM), including TCM consultation, herbal medicine and acupuncture. No other service types were mentioned. However, this contradicts the previous findings from Question 1 (p. 60) where only 2 individuals reported use of TCM. Upon closer examination, these inconsistencies were most likely caused by survey participants simply forgetting to list TCM and were later reminded by

the further questions. Answers from this question reflected high level of recognition and acceptance of TCM among Chinese immigrants who participated in this survey. This phenomenon is worth further exploration as it may have direct impact on the choice of healthcare services sought by Chinese immigrants in New Zealand.

Question 4: Do you currently have private medical insurance cover? What was your main concern(s) when deciding to have or not to have insurance cover?

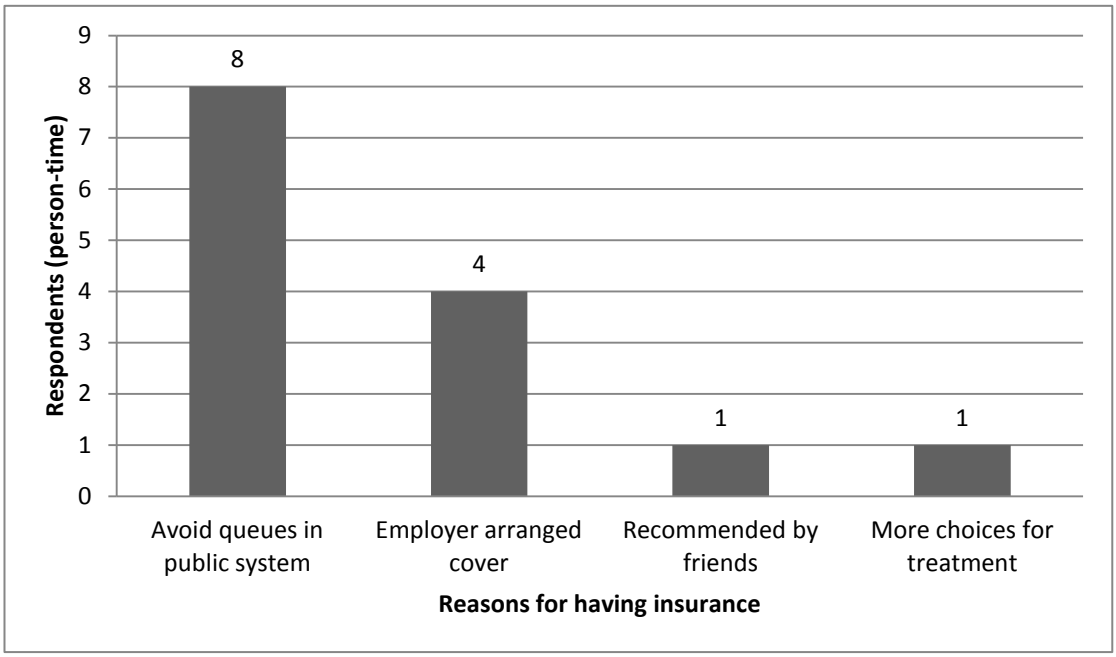
This question was designed to gather respondents' choices and views towards private healthcare insurance in this country. 15 respondents (39.5%) indicated they currently had private health insurance and 21 respondents (55.3%) did not. Two individuals did not answer this question. Figure 12 shows this distribution.

Figure 12: Private Health Insurance Coverage



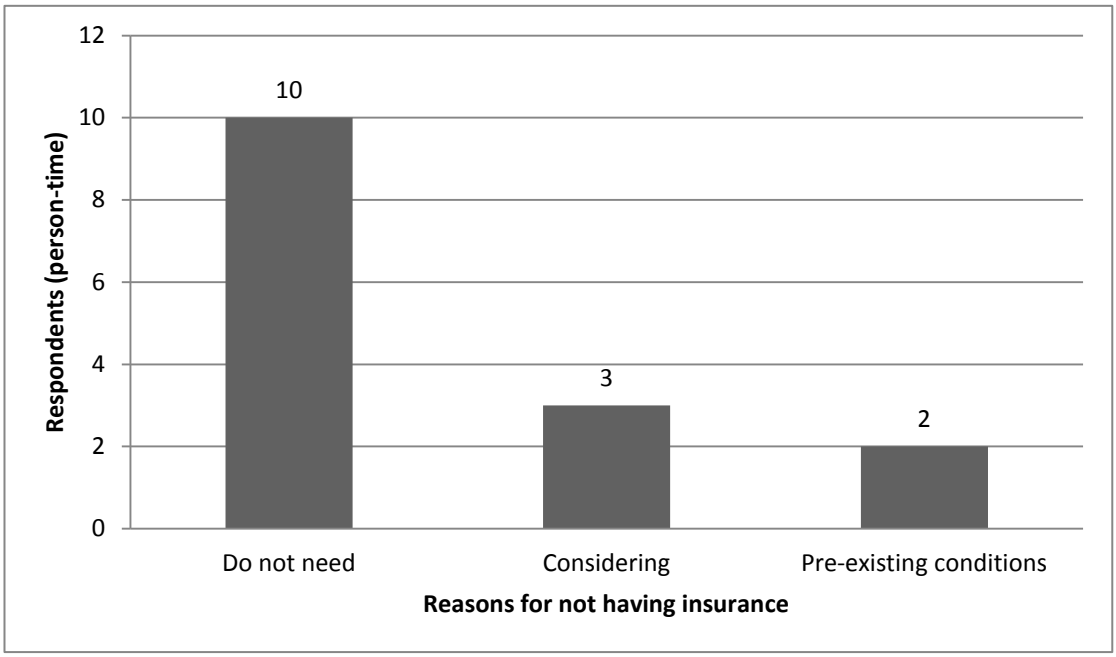
Reasons towards their decisions formed four major categories as per Figure 13 shows on the next page. Eight individuals (53.3%) chose to purchase private health insurance to avoid extended waiting time in public healthcare system. Four individuals (26.7%) were covered by employer arranged or subsidised insurance policies as part of their remuneration packages. One individual was recommended by his friends to purchase health insurance and another individual stated that private health insurance provided him with more alternatives for treatment options if major illnesses were to develop.

Figure 13: Reasons for Having Insurance



Reasons for not having private health insurance are described in Figure 14 (p. 68). Ten individuals (46.7%) stated that they did not need insurance because the public healthcare system covers major illnesses. Interestingly, it is almost the exactly opposite response for the major reason of having insurance. Three individuals (14.3%) considered purchasing private health insurance but had not yet decided. Two individuals (9.5%) were not able to purchase insurance due to pre-existing health conditions. Out of those who did not currently have private insurance (21 individuals), over 25% were either considering making future purchases or at least had the desire to be covered, suggesting potentially a wider coverage if there were changes in circumstances in favour of private health insurance. Six individuals did not state any reasons.

Figure 14: Reasons for Not Having Insurance



This question concluded the Personal Healthcare Information section. Many interesting findings in the section have provided valuable information about respondents' general choices over their primary healthcare services, such as the extremely limited source of healthcare information; reasons for having or not having regular GP; and the high rate of recognition of TCM. Analysis of the information suggests the need of further exploration into the experiences in receiving healthcare services at different levels; which may, in turn, influence Chinese immigrants' healthcare decisions.

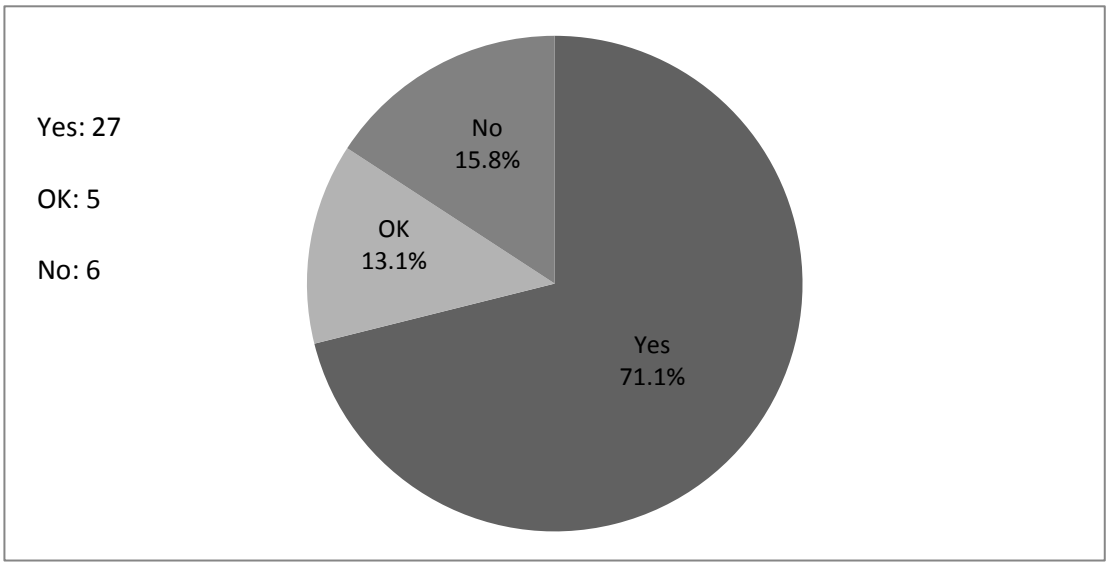
Experiences in Receiving Healthcare Services

In this section, survey participants were asked to describe and value their experiences, not only in primary healthcare (GP services), but extended into secondary and tertiary healthcare systems (specialist, hospital services), as well as complementary or alternative healthcare. Respondents were asked to compare their experiences and comment on how these experiences may differ from previous ones in their home country before migration.

Question 5: In general, are you satisfied with the primary healthcare service experiences? Please specify reason(s).

This question asked the respondents to rate their experiences in receiving primary healthcare services and to comment on the reasons for their opinions. 27 individuals (71.1% of respondents) indicated that overall they are satisfied with their primary healthcare experiences in New Zealand. Five individuals (13.1%) rated their overall experiences as 'OK' and 6 individuals (15.8%) were not satisfied with their experiences. Figure 15 shows this distribution.

Figure 15: Satisfaction over Primary Healthcare Experiences



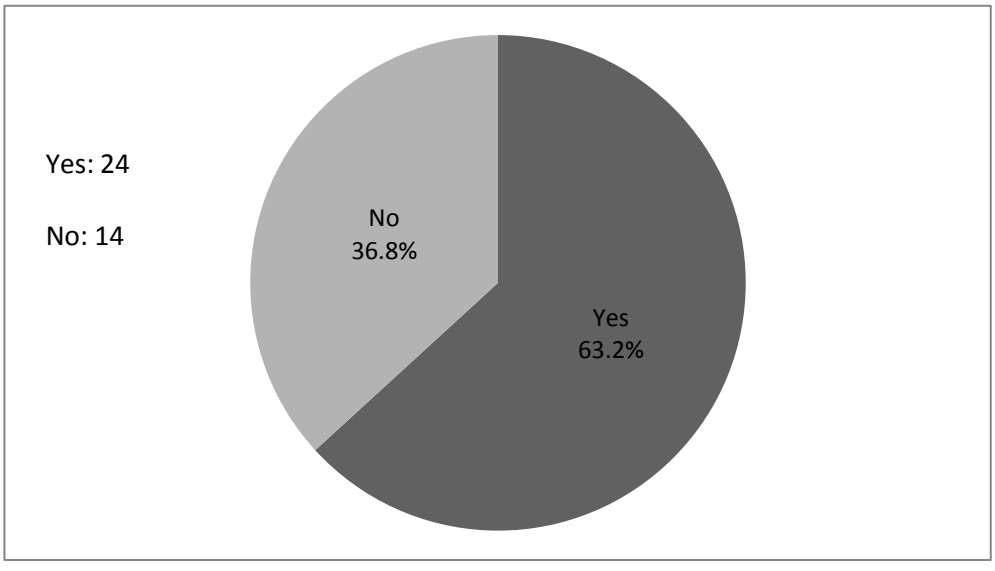
The reasons given for satisfaction were largely focused on the high quality GP services that many respondents (16 individuals, 59.3%) reported. These included professionalism, attitude towards patients, accurate diagnostic and prescription, as well as friendly environment. Two individuals commented on the GP system being very transparent and efficient. For those who rated such experiences being just 'OK' or 'No, not satisfied', 7 individuals (63.6%) reported the services they received being 'low quality', including complaints to waiting time, inexperienced practitioner and unsatisfactory results. Two individuals commented on the GP services charges being 'expensive' and 5 individuals described the GP system as 'inconvenient' to patients including complaints towards opening hours and difficulties getting appointments. Eight individuals did not state any reasons.

These varying answers suggested mixed opinions and attitudes towards primary healthcare experiences. The fact that this survey was completed in a short period of time and answers tended to be short and brief, the crucial details in participants' experiences which influenced and led to these feelings were mostly absent. Therefore, it was essential that such findings were selected and explored further during the one-on-one interview process. Findings from which will be reported in Chapters Five and Six.

Question 6: Have you experienced any difficulties or barriers in receiving primary healthcare services? If yes, please specify.

This question asked respondents to self-report any difficulties or barriers they may have encountered when receiving primary healthcare services. 63.2% (24 individuals) of respondents indicated that they had experienced difficulties or barriers and 36.8% (14 individuals) did not report any such experiences. Figure 16 shows this distribution.

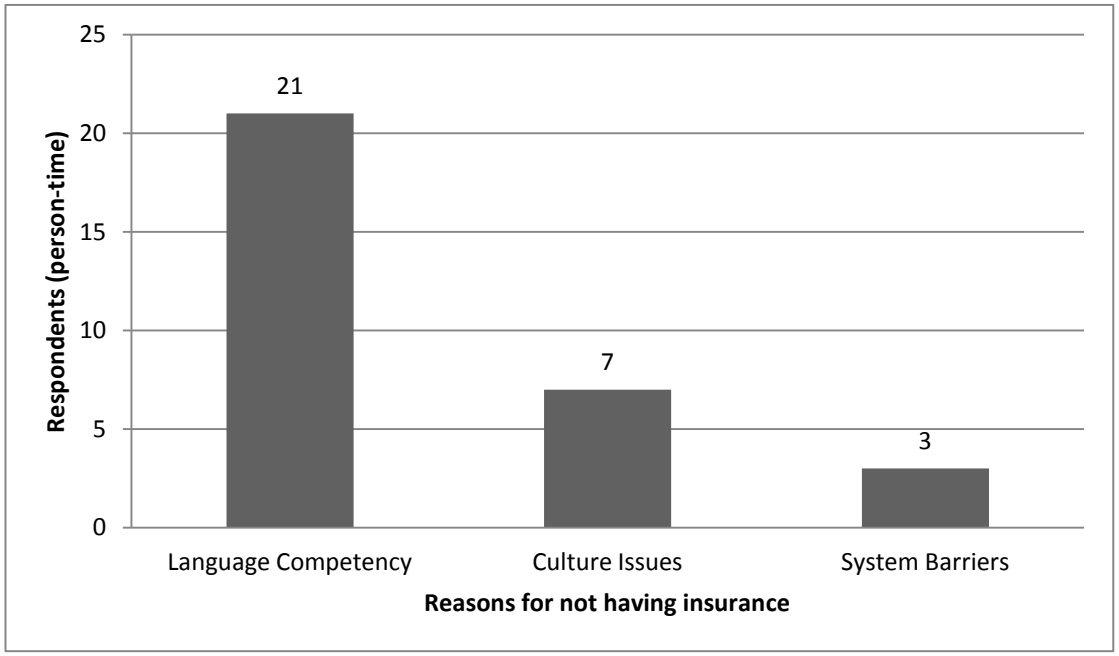
Figure 16: Experiences of Difficulties and Barriers



Among self-reported difficulties or barriers, 21 individuals (87.5%) mentioned language competency related issues, such as not being able to use English or having difficulties understanding medical terminologies. Seven individuals (29.2%) stated culture issues including dietary, traditions and lifestyle were obstacles, and three individuals (12.5%) commented on system barriers where treatments was often delayed by long waiting time.

Figure 17 below shows this distribution.

Figure 17: Identified Difficulties and Barriers



These findings partly confirmed answers from previous questions regarding the major considerations in choosing primary healthcare services. Results clearly suggested that previous experiences in receiving healthcare services influenced subsequent choices and decision-making with regards to language, culture and system barriers.

Question 7: Overall, how do you compare your experience in receiving healthcare services between in New Zealand and mainland China?

In an effort to establish comparable parameters before and after migration, this question asked survey respondents to comment on the different experiences in receiving healthcare services in New Zealand and back in China. Answers to this question were grouped into four categories, each describing the advantages or disadvantages experienced when receiving healthcare services under one of the two contexts. Tables 3-7 (pp. 72-74) summarises respondents' opinions.

Table 3: Advantages in New Zealand

Opinions	Number of Respondents
Humane and professional services	12
Advanced medical equipment	4
Careful prescription management	3
Comfortable environment	2
Trustworthy quality of pharmaceuticals/medication	2
Practitioner's patience towards patients	1
Public and private system meets the needs of different groups	1
Free/subsidised prescription, especially form some expensive medicine	1

Table 4: Disadvantages in New Zealand

Opinions	Number of Respondents
Long waiting time especially for emergency	34
Inexperienced practitioner and inaccurate diagnosis	13
Limited service availability after hours and during weekends	1
Hard to find centralised database of doctors profiles	1
Expensive service charges	1

Table 5: Advantages in China

Opinions	Number of Respondents
Easy access to hospital	8
Short waiting time	8
Cheaper service charges	8
More experienced practitioner	5
Advanced healthcare system	1

Table 6: Disadvantages in China

Opinions	Number of Respondents
Lack of professionalism	3
Expensive	3
Lack of privacy	2
Conflict of interests	2
Rely on personal connections	1
Hard to find personalised services	1

A brief review of the answers revealed that some of these opinions are shared by many respondents while other responses are more individual. On closer examination, many of these experiences refer to similar aspects of healthcare services but on the opposite ends of the scale when put together from the two different countries. Table 7 (p. 74) illustrates some of the comparable parameters when experiences from different countries are paired together.

Table 7: Examples of Cross Comparison

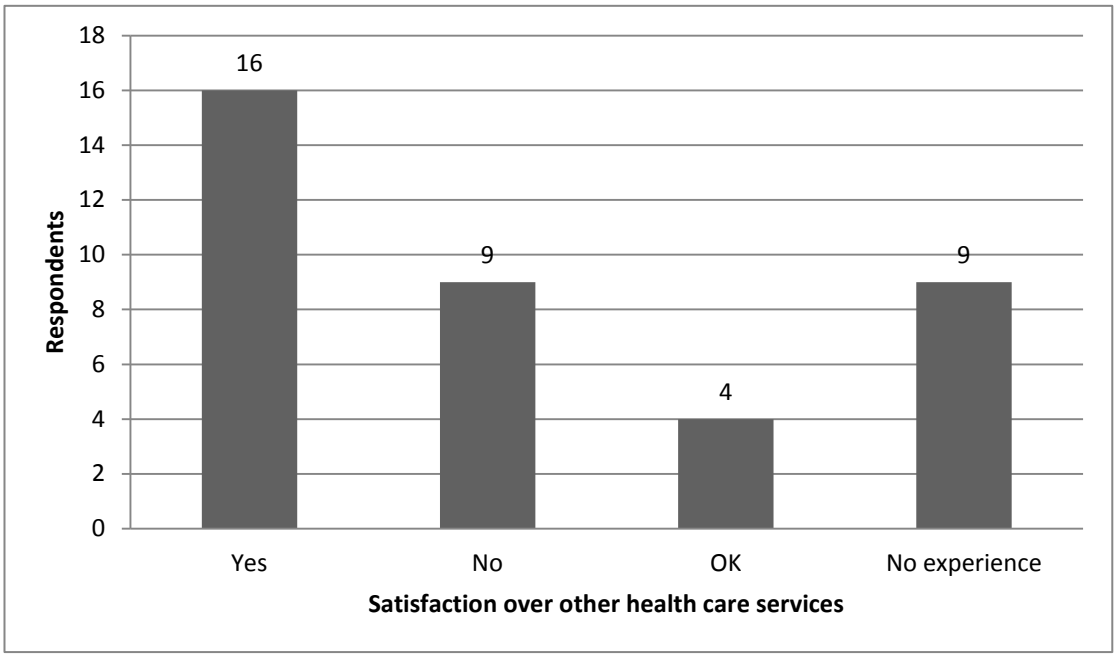
Aspects	**Countries**	
	New Zealand	**China**
Professionalism	Highly professional	Less professional
Waiting time	Long	Short
Environment	Comfortable	No privacy
Experiences of practitioner	Less experienced	More experienced
Cost	Expensive	Cheaper
Accessibility	Limited	Easier

Whether or not respondents' opinions fairly or accurately reflect the realities in either country, it is apparent that many disparities exist in people's attitudes and opinions towards receiving healthcare services. It is more important to understand the potential contributors that are causing these differences rather than the differences themselves. In the following chapters, questions on these differences in experience identified here will become more direct and personalised to explore the underlying factors.

Question 8: Except GP services, are you satisfied with other types of healthcare services experience? Please specify reason(s).

This question asked respondents to rate their satisfaction of experiences of healthcare services received other than GP services, including specialist and hospital care. 16 individuals (42.1%) of respondents indicated that they were generally satisfied with these healthcare services, 9 individuals (23.7%) were not satisfied and 4 individuals (10.5%) rated their experiences as 'OK'. Nine individuals had not had any experience other than primary healthcare services. Figure 18 (p. 75) shows this distribution.

Figure 18: Satisfaction over Other Healthcare Services



For reasons of satisfaction, majority of respondents (11 individuals, 68.8%) reported high quality of healthcare serviced received including specialist and hospital care. Two individuals were satisfied with the results from hospital surgeries. One individual was particularly happy with Accident Compensation Corporation (ACC) providing fully supplemented services as a result of his injury. Another individual was impressed by the advanced medical equipment used in hospital care.

For those who were just 'OK' with, or not satisfied with their experiences, the majority of complaints (11 individuals, 84.6%) were towards the quality of services received, including long waiting list for hospital care, difficulties in getting appointments with specialists, complicated procedures and expensive specialist charges. One individual reported experiencing understanding and communication barriers when receiving hospital care. Four individuals did not provide any reasons.

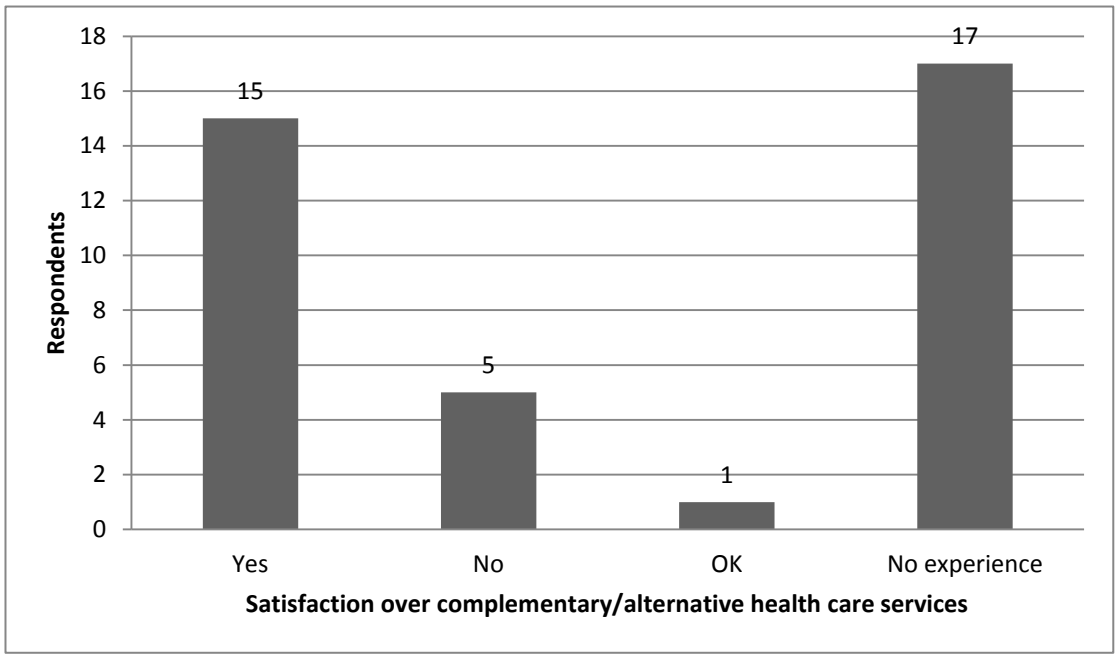
These results bear similar characteristics to Question 5 (p. 69) where respondents were asked to rate their satisfaction level towards their primary healthcare providers. Although the general levels of satisfaction for secondary, tertiary and complementary healthcare services were slightly higher than that of primary healthcare services, the aspects of dissatisfaction were focused along similar lines of concerns such as long

waiting time, difficulties getting appointments and high costs. These suggest common problems throughout the whole system that need further exploration.

Question 9: Are you satisfied with the complementary/alternative healthcare provider that you have used and what was the main reason(s) for choosing their services?

This question asked respondents to rate their satisfaction over complementary or alternative healthcare services they had received, as well as to comment on the reasons. 15 individuals (39.5%) of respondents were satisfied with the services they had received, 5 individuals (13.2%) were not satisfied and 1 individual described his experience as just 'OK'. 17 respondents had not had any experiences. Figure 19 shows this distribution.

Figure 19: Satisfaction over Complementary and Alternative Healthcare



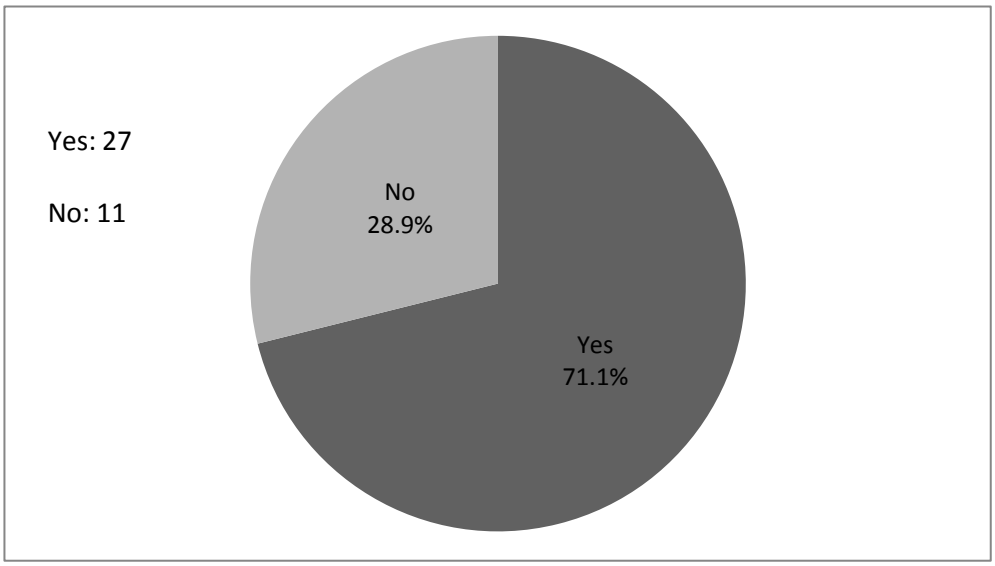
The main reasons for satisfaction were clustered around good results from complementary healthcare services (13 individuals, 86.7%) primarily referring to TCM practices and Chinese herbal medication. Two individuals expressed their belief and trust towards TCM as reasons for satisfaction. One individual was fully supplemented by ACC to cover his Chinese massage and acupuncture treatment. For those who were not satisfied with their complementary healthcare services, 2 individuals (40%) were

only dissatisfied because there was a lack of selection in herbal medicines due to government importation restrictions. The remaining 3 individuals were disappointed with the outcome of TCM practices experienced in New Zealand.

Question 10: Have you ever brought in any medication from mainland China? If so, what kind of medication did you bring in and what were the reason(s) for doing so?

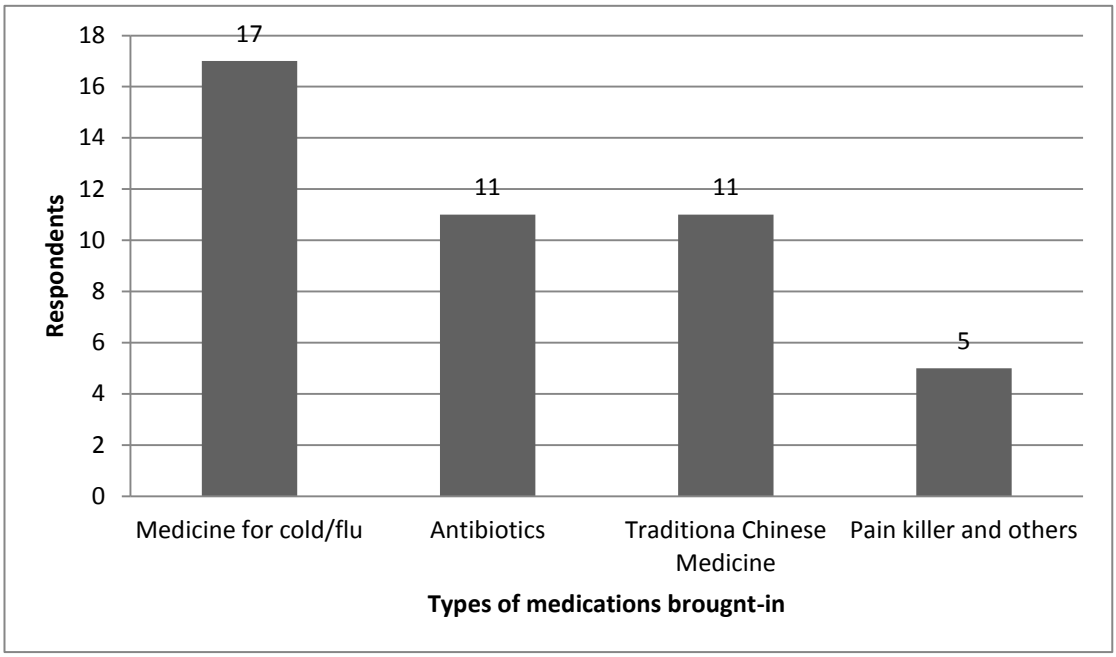
This question was designed to identify Chinese immigrants' attitudes towards medication and self-reported use. In answering this question, 27 respondents (71.1%) indicated they had brought medication to New Zealand from mainland China in the past and the remainder (11 individuals) have not. Figure 20 shows this distribution.

Figure 20: Medications Brought-in from China



For those who had brought in medications, Figure 21 (p. 78) shows a break-down of the types of medications. Common medicine for cold and flu were the most chosen medication to bring from China, followed by antibiotics and TCM. Pain killers and other medication such as ointment were also popular choices. It is worth noting that some of these medications may be controlled or prescription only while others are readily available in the New Zealand market. The reasons and implications of these actions need to be further explored.

Figure 21: Types of Medications Brought-in



For reasons of bringing medications from China, Table 8 summarises major categories of respondents' answers.

Table 8: Reasons for Bringing (or not Bringing) Medications from China

Yes		No	
Reasons	# of respondents	Reasons	# of respondents
Less choice of medicine in NZ	8	Not necessary	5
Convenience	8	Some TCM medicine cannot pass custom	2
Medications in NZ expensive	6	Difficult to keep TCM medicine	1
Good results and low side effects of TCM medicine	5	Some prescription medicine needs Doctors authorisation in China	1
Better results combining TCM with western medicine	1		
Antibiotics not available in NZ without prescription	1		

There were many reasons both for bringing and not bringing medication from China, but two major factors stand out: Prescription medication and TCM medication. Judging from answers, it is more convenient and cheaper to bring common prescription medications from China such as antibiotics, rather than going through the GP system in New Zealand to obtain a prescription. It is also cheaper and easier to bring TCM medicine as they are readily available and easily obtained in China whereas access and selection of TCM medicines is more restricted in New Zealand. Question 10 and its analysis conclude the survey questionnaire and findings for this chapter.

Summary

During this process, three major aspects of the survey have been examined including personal information, healthcare choices, and experiences in receiving healthcare services. The most significant findings arising from the survey responses have centred on the various difficulties and barriers in accessing and utilising New Zealand healthcare services reported by the participants. In particular, issues surrounding the disparities in healthcare system between China and New Zealand, language proficiencies, decision-making towards choosing healthcare providers and the culturally related aspects of healthcare such as TCM were most apparent.

These results have provided interesting and valuable insights to the research objective, while suggesting the needs for in-depth inquiries. The next two chapters will present findings from the individual interview processes. Results from the survey, as presented in this chapter, will be re-visited and referred to in the interview analyses to aid and complement the discussion.

CHAPTER 5: FINDINGS PART II

Accessing Healthcare Services Delivery and Patient-Practitioner Relationship

Introduction

The data for the second stage of analysis were drawn from transcripts produced by face-to-face interviews. While results from the initial survey were valuable for capturing the general tendency towards healthcare decision making by Chinese immigrants, interviews provided a more in-depth and personal perspective.

Four themes emerged from the data analysis: 1) *Accessing Healthcare Services Delivery*, 2) *Patient-Practitioner Relationship*, 3) *Healthcare Awareness*, and 4) *Healthcare Attitudes*. Each theme highlights an aspect of Chinese immigrant healthcare. These themes identified from participants' real-life experiences do not stand in isolation but were systematically re-grouped from a set of inter-related and often re-appearing factors. The purpose of this thematic analysis process is to summarise participants' common experiences and allow understanding of individual variations, to explain their causes and how they may impact healthcare decision-making.

Out of the four themes, the first two were devoted to exploring the interactions between patients and the healthcare system (*Accessing Healthcare Services Delivery*), as well as interactions between patients and healthcare practitioners (*Patient-Practitioner Relationship*). These are the first lines of contact and main interfaces to accessing and utilising New Zealand healthcare services by Chinese immigrants. Alternatively, the latter two themes (*Healthcare Awareness* and *Healthcare Attitudes*), emphasised the internal processes for understanding how personal attributes may influence participants' views and opinions towards New Zealand healthcare services. This chapter discusses the first two themes *Accessing Healthcare Services Delivery* and *Patient-Practitioner Relationship*. Chapter Six will explore the themes *Healthcare Awareness* and *Healthcare Attitudes.*

In presenting the findings, pseudonyms have been used to identify participants. The actual source and location of the information from interview transcriptions will follow

the pseudonym in numerical format; the first number represents the specific interview, the second and subsequent numbers separated by commas indicate where certain passages are situated in the transcripts. For example, excerpts from interview transcripts of Zack, who is the 6th interviewee, are presented as [Zack 6:5.1, 17]. To differentiate between themes, categories and sub-categories where applicable, the thematic names are presented using italics with category names in bolded text and sub-categories un-bolded using upper case first letters (e.g. *Accessing Healthcare Service Delivery*, **Primary**, Time Matters).

An Overview of Themes and Categories

The first two themes *Accessing Healthcare Services Delivery* and *Patient-Practitioner Relationships* embark on the interactions between patients and two most important components of healthcare services respectively: that of the healthcare system and practitioner. The categories and sub-categories applicable within these two themes are outlined in tables 9.1 and 9.2 (pp. 81-82).

Table 9.1 ***Access Healthcare Services Delivery***

Themes	**Categories**	**Sub-categories**
Accessing Healthcare Services Delivery	**Primary (Accessing GP Services)**	Language and Location, Time Matters, How Good Is Good
	Secondary (Accessing Specialist & Hospital Services)	Getting Translated, Being In Emergency, Waiting In Queue Or Paying The Price
	Private Health Insurance	

Table 9.2 ***Patient-Practitioner Relationship***

Themes	Categories	Sub-categories
Patient-Practitioner Relationship	**Level of Communication**	Not Being Able To Explain, Without Explanation
	Conceptual Understanding	
	Trust and Respect	Trust The Practitioner, Respect The Patients, The Chinese Way

Accessing Healthcare Services Delivery captures the first hand experiences of Chinese immigrants accessing and utilising New Zealand healthcare services from a system perspective. Many Chinese immigrants had to go through radical changes in the way healthcare services were delivered when entering a new social environment; that of New Zealand compared to China. These experiences coupled with different levels of local healthcare systems potentially undermine the willingness to seek medical assistance by Chinese immigrants, as well as the outcomes of receiving such services.

The categories under this theme are organised to reflect the basic structures of New Zealand healthcare systems from **Primary** (Accessing GP Services), **Secondary** (Accessing Specialist and Hospital Services) to the **Private Health Insurance** sector. Each of these categories may involve sub-categories for grouping of most frequently mentioned issues.

Primary Healthcare Services Delivery

In New Zealand, **Primary** healthcare refers to General Practitioner (GP) or family doctor, a service that provides the most fundamental healthcare to communities with government contributions in funding and subsidiaries (Ashton, 2005). Most people in New Zealand, including Chinese immigrants and the participants of this study, have had

some form of interactions with the **Primary** healthcare system, as seen from previous survey results. Although a mature system, for over 70 years since its founding regulation of the Social Security Act 1938 was formed, this system has come under many criticisms for not being able to fully delivery its original visions and promises (Ashton, 2002; Easton, 2002); especially in the area of immigrant health, as described by Sharon:

> I don't like the way it (the primary healthcare system) works here at all. Because, one, it is completely different to what it was in China that I just can't get use to or adapt to. When I do get sick and had to visit my GP, it really costs a lot of money. What happened to free healthcare that we were told before? And the worst thing is, it doesn't really always help with my conditions anyway. [Sharon 3:2]

New Zealand healthcare, including the **Primary** system, outlined a vision of free health services for all New Zealanders, regardless of ability to pay (Ashton, 2005). To many immigrants attracted by such promises, like Sharon, they were only partially true. This was one example among many other concerns expressed by interview participants. Although experiences were unique to individuals, three sub-categories of common views and opinions were identified from participants' stories: Language and Location, Time Matters and How Good Is Good?

Primary: Language and Location

People choose where to seek their Primary healthcare or GP services for different reasons. In the previous chapter, survey findings indicated location of GP services and language to be the two foremost considerations (see Figure 6, p. 59). Many of the interview participants elaborated on these reasons:

> Our GP is a Singaporean doctor and he speaks Chinese, that was important… and because his practice is quite close to where we live as well. [Mel 1:13]

> It's close to my home. The GP that I found and the midwife they all have Chinese background and all speaks Chinese. [Yvonne 2: 4]

> The reason for me to enrol with my current family doctor was because his practice is very close to where I work… it is difficult for me to take leave at my work so having him close to my work means that I can simply go see him during my lunch break…. My GP is from Hong Kong and he speaks Chinese. [Sharon 3:7]

> They (doctors at GP service) have Chinese background. One of them is from Shanghai. Old people like my parents, they are over 65 years old, and they surely need and had to have Chinese speaking doctors… [Jacky 5:8]

Most of the interview participants have confirmed the previous survey findings in that being close to the GP services and the availability of Chinese speaking doctors were their main considerations in choosing specific GP services. Although it is difficult to establish which of these two factors takes higher priority, Norman's experience when faced with such a choice may provide suggestions:

> I have lived in quite a few different parts of Auckland and I used to be able to find Chinese doctors quite easily, I didn't think that was going to be a problem, there was always someone around close by. But when we moved into our current home, the closest Chinese doctor that I could find was about half an hour drive away. I wasn't prepared to drive that far every time I need to see a doctor so I had to go with a European doctor for now. I mean wherever possible, I'll still prefer to have a Chinese doctor. And I'm still keeping an eye out in case someone becomes available in the area. [Norman 7:3]

Geographical location and transportation inevitably limited the choices available to Chinese immigrants in accessing **Primary** healthcare services. It is impractical for most people to travel outside their geographical location solely for language preference. However, it seemed apparent that finding a Chinese GP or Chinese speaking GP was not a major issue for most Chinese immigrants. From a healthcare system perspective, there appeared to be sufficient numbers of GPs with Chinese background working in the **Primary** sector. This has significant implications for the Chinese immigrant population in overcoming language and potential communication barriers when utilising healthcare services.

Primary: Time Matters

Choosing a GP practice in the **Primary** healthcare system seemed an easier than anticipated task for the participants; however, trying to understand and cope with how the services are delivered was more difficult. A critical factor impeding the process was getting timely appointments with GP services.

> For example, under the system here you must make an appointment very time before you plan to see your doctor. [Jacky 5:2]

> It really takes a long time, the first problem is getting an appointment and that is difficult. [Sharon 3:3-3]

> To me, getting an appointment with my GP was never easy. My GP always seems to be fully booked. If a health condition develops, often I can't wait for a few days until an appointment is available. So I had to go to like a White Cross clinic or some other private facilities that are more flexible but much more expensive as well. In cases like this, having a regular GP doesn't really help. [Norman 7:5]

Not being able to get appointments with GP services frustrated many of the participants in accessing **Primary** healthcare, especially when most of them came from a country where **Primary** care is provided by public hospitals and appointments are not necessary, "*Like I said, there are quite a bit of differences. In China, people go straight to the hospital, either clinic visit or emergency*" [Well 4:3]. Even when an appointment has been made, the frustration of waiting does not end.

> When you get to your GP for your appointment time, you still have to wait [Sharon 3:3-3].

> I made an appointment for 11 o'clock sharp, but by the time I was actually seen by my GP, it was over 12. [Yvonne 2:7]

> Even if I did get an appointment, I was never seen on time. Half an hour delay is just normal. This can be a hassle if I need to be somewhere else on a tight schedule but after a few times I sort of know what to expect. [Norman 7:5]

The delays in seeing doctors seemed to have become commonplace in GP practices. Interestingly, when it is expected that appointment or session time management may be to blame, some interviewees commented otherwise.

> But some GP's tend to control their appointment time … too overly controlled. Like everyone has a 15 minutes session. Once the 15 minutes are up, they'll like rush you out. But not all GP's are like that, there are some who are quite patient. [Well 4:5]

> Another thing is, it seems like clinics are all very busy, my GP has to see patients practically non-stop, I think it's tiring. I was told that everyone has 15 minutes max and they didn't have much time for consultation. Unlike in China the diagnoses are very detailed and doctors didn't have much of a time issue. Because time here is really limited… consultation doesn't include any test… often after 2-3 days you still don't know what's actually wrong. [Jacky 5:11]

These experiences of the participants suggest that accessing **Primary** healthcare through the GP system was time-consuming with poor efficiency compared to their previous experiences. Participants also suggested the possibility that at least some of the GPs with Chinese background were operating under stretched resources, which implied

the need for more community and system capacity building in **Primary** healthcare for the Chinese immigrant population. In the above comment, Jacky made an interesting point that the delay in time also involves issues around follow-up diagnostics, a view shared by Sharon.

> You usually go see your GP first and your GP will then organise for you to take some testes, then if necessary, a referral to specialist, the time it takes to go through the whole process is very long. [Sharon 3:1]

It seemed that some participants were disappointed in the **Primary** system and worried that delays in diagnostic and treatment may have been caused by a breakdown in connecting the rest of the healthcare system (specialist services or hospital care) to the **Primary** sector. Overall, from getting appointments with the GP, waiting for consultation to receiving treatment or referral, Time Matters to the performance of the **Primary** healthcare system and affects the satisfactory level in receiving these services by the Chinese immigrant population.

Primary: How Good Is Good?

"How Good Is Good" were words Norman used to express his uncertainty towards evaluating the quality of **Primary** healthcare services that he has received.

> It's very hard to say how good is good. From what I know, New Zealand doctors are highly trained and educated. It's hard to get into medical school and seemed even harder to survive it. So I would expect doctors to know what they are doing and what they are talking about, but sometimes that's just not the case. I mean I had good doctors but it really depends on who you get. Some of them just confused me. There were doctors who weren't sure what was wrong with me, and there was one of them actually googling my symptoms on her iPhone. The level of professionalism seems to vary a lot. And out of so many GP practices around, how do you know who's good and who isn't? [Norman 7:8]

Norman acknowledged that New Zealand doctors should have been highly trained and skilled but questioned inconsistency in competency of the GP practices within the **Primary** system. Sharon and Jacky also expressed their doubts over the quality of the services from the perspective of the system itself and its differences to what they have experienced in China.

> When you finally get to see your GP, it doesn't always mean that your problem will get solved. The way it works here is so much different to the system in China. [Sharon 3:3]

> In New Zealand, everyone has to go through their GP first…but in China there is no equivalent to such thing as GP. People go straight to hospitals where doctors are mostly specialists. You have the right and the flexibility to choose to go see whoever you think is best for you… I don't think anyone can really be that multi-skilled, such as a GP, how can they know it all? …the GP's here no matter it is gynaecology, paediatrics or something else, they all need to know. But when you need to know everything, it also means you are probably not good at anything…and that is why I don't have so much confidence in them. For what I have experienced, I think they (GP's) are much less experienced than doctors in China. [Jacky 5:1, 2, 17, 18]

For these Chinese immigrants, getting used to a completely new **Primary** healthcare system that is fundamentally different from what they were previously accustomed to proved frustrating. Many found it hard to comprehend and appreciate the role of the **Primary** GP system as a new layer to their healthcare, where its counterpart does not even exist in the healthcare system of China. With no equivalency to compare to, it is therefore uncertain for many Chinese immigrants to tell How Good Is Good in terms of the quality of **Primary** healthcare services they received. Consequently their faith and confidence in the system are questioned.

Recalling the previous survey results on satisfaction level over Primary healthcare services (Question 5, p. 69), the findings from this section accurately reflected the same concerns participants have expressed including "inconvenience" towards timing, difficulties getting appointments and "low quality" of service delivery. However, while the focus has been on identifying the problematic areas of Chinese immigrants accessing the **Primary** healthcare system, not all experiences are negative. As suggested by survey findings, approximately 70% of respondents were reasonably happy with the overall performance of the system and many interview participants also commented on the positive aspects.

> I think overall it's better here… the most important thing is the GP system… everyone has a GP, all your files, medical history are available when you see doctors, even different doctors. In China, I had to go to hospitals, and may be different hospitals every time. They don't share your medical histories, there's no system linking everything together, doctors don't know what happened before. [Mel 1:10]

> We are quite happy with our GP. Because my wife has quite a complicated condition… he immediately treated us with high priority and a lot of attention… explained things very

> clearly… Also the advantages of having my own GP is that all my medical history are with him. For 8 years, my GP actually gets to know me and my health. All his decisions can be based on all of my previous history. [Zack 6:1.1]

Mel and Zack both prefer the New Zealand **Primary** healthcare system compared to that of China, especially the advantages of having complete and accessible personal medical history supported by the **Primary** healthcare system. These differences in opinions, compared to earlier comments made by the participants, suggest a large degree of variation among the Chinese immigrant population in perceiving and understanding the New Zealand **Primary** healthcare system. The misalignment between participants' personal backgrounds to their experiences and expectations in the New Zealand context seemed to have played a critical role in forming such views and opinions.

The Secondary Healthcare Services Delivery

The **Secondary** component to New Zealand's healthcare system refers to specialist and hospital care where referrals are organised by patients' GPs for the diagnosis and treatment in more complicated health conditions outside the scope of **Primary** healthcare. As defined by New Zealand Public Health and Disability Act 2000, **Secondary** care services are solely funded by the New Zealand government delivered through public hospitals. However, in practice, the **Secondary** system is also complemented by the private sector. From the experiences of interview participants accessing **Secondary** healthcare, three major areas of concerns have been identified as sub-categories: Getting Translated, Being In Emergency and Waiting In Queue Or Paying The Price.

Secondary: Getting Translated

Unlike going through the Primary healthcare system, many Chinese immigrants did not have the flexibility of choosing Chinese speaking practitioners if they had language difficulties when visiting specialist or hospital care. Under the New Zealand **Secondary**

healthcare system, translators can usually be organised for those who may require assistance with language issues. Mel and Zack have both used the translator services.

> I think the translator service is very helpful in hospitals, or other facilities. Especially for my parents or older people who don't really speak English. Like when my mum was seeing specialist and my father-in-law, they told us this service so we used it and it turned out to be very helpful. [Mel 1:30]

> … all communications are through translators… and the translator came to meet us very early with plenty of time to spare in preparation for the surgery on the second day. We were quite impressed. [Zack 6:1.2, 8.1]

While these participants have benefitted from the translator services provided by the **Secondary** system, concerns were also raised about using this service.

> Language can be a problem. Although there are translators but I have come across a few that don't do their job very well. Sometimes I doubt if they are translating exactly what we were saying accurately to the doctors. I worry about this because English in healthcare is not like everyday English. They need to be accurate, like law. Inaccurate translations will directly lead to misjudgement by the doctor or our understanding of doctors' orders. [Zack 6:13]

> I have used the translator service before but it wasn't such a good experience. My mum had a worrying mammography scan result before so we were referred to specialist. I thought my English was good enough to translate for my mum because she doesn't speak any English. But then I was worried there may be certain things like medical terminologies that I'm not familiar with so I decided to book a translator. First it was the problem of not being able to get one for our appointment time simply because they were so fully booked and not enough of them around. After a few booking and re-booking when a translator finally comes around to help my mum, her English was not even as good as mine. What she was translating really worried me and I had to interrupt to correct a few of the mistakes she made. I seriously wonder how she was qualified to be a medical translator. [Norman 7:17]

These criticisms have pointed to either the availability of the translators or quality concerns in delivering the translation services. While providing such services to Chinese immigrants or other ethnic groups may greatly improve the accessibility of **Secondary** healthcare system, it may be a serious threat to the patient's health if the quality of the translation cannot be guaranteed. Furthermore, with increasing numbers of Chinese immigrants coming into the country, the resources that provide the capacity of translation service may be stretched; as has become evident from Zack's experience:

> They knew our English was poor and there simply weren't enough translators around in the hospital especially after hours. So they made bi-lingual sticky notes like "I need to use the bathroom", "I need water" etc. They were stuck on the bedside then all you need to do is to

> point at what you need when you need them. [Zack 6:8.1]

It would seem that some healthcare providers are proactively seeking alternative measures to compensate for lack of resources. However, this is by no means a sustainable solution in the long term for the **Secondary** care system; thus, additional input in capital investment and policy support is required. The shortages in translations services and its negative impact on quality of **Secondary** healthcare delivery was not a standalone factor. The pressures of stretched resources were also widely felt in many other areas throughout the **Secondary** system including emergency care and public system waiting list. Some of these issues were particularly pertinent to the Chinese immigrant population.

Secondary: Being In Emergency

Emergency care is a vital part of public health in the **Secondary** healthcare system. The emergency care in general deals with much more serious and acute health conditions that, in some cases, may be life threatening. Therefore the performance of the emergency care is particularly influential on the views and opinions of the Chinese immigrants towards New Zealand **Secondary** healthcare system and consequently affects the level of service utilisation. The experiences of interview participants accessing hospital emergency care revealed unpleasant surprises, as described by Zack in multiple occasions during his interview.

> I think the only real inconvenience here is emergency care. For example, if you need to visit hospital emergency, you have to wait for very, very long time… The first inconvenience is the emergency care, and that also two parts to it. Number one, waiting time is way too long. We visited hospital emergency three, four times and every single time we had to wait at least 5 hours. Number two is diagnostic or procedure that has to be done in hospitals; again the waiting is way too long. [Zack 6:0, 2]

The consistently long waiting time involved with Being In Emergency has frustrated Zack and his family. But when everyone is subject to the same system and protocol, what seemed to have particularly bothered Chinese immigrants were the differences in experiences between visiting emergency care back in China to that of New Zealand, as commented by Mel.

> Like there was once my child was in the hospital emergency for high fever and temperature. His temperature was like 39, 40 and I was so worried. The nurse came over, took the temperature, have a quick look at the throat and then ask us to wait. From 8, 9o'clock that night to 8 in the next morning, the doctor only came by once. And then when his shift was over, he came again and asked us to go back to our GP without doing anything further. If the same thing happens in China, there would have been plenty of doctors and nurses available and treatment would have been given immediately. [Mel 1:24]

By comparing how the emergency systems may have worked differently in caring for her daughter's condition, Mel has pointed out that in her opinion the emergency care system was seriously under-staffed and under-resourced. It may be that changes in reality from one system to another have a negative impact on accepting the quality of emergency services delivered. On the other hand, another interviewee, Well, although finding it difficult to adapt to the new system due to similar experiences, has attempted to comprehend and explain in his own interpretation as to how these differences between system came about.

> I hear a lot of people complaining about waiting time in the public hospital, but I see it slightly differently. Like my child had a fever over 38 degrees, we went straight to the hospital emergency but we were basically kept waiting from 11 o'clock at night to 5 in the morning, that happens. And when it was 5 in the morning, they offered something like a popsicle to my little one. That was…. I don't know what to say. And we were told to go home. But I think that's because of the system. If it was only a fever, you were told to wait, because there are many others with more serious conditions. Second one, my friend had a fish bone stuck in his throat, he was so worried but still had to wait for at least a couple of hours. And when they get to him, it only took 10 minutes to get that fish bone out. He was furious at the time, but when you calm down and comes to think about it, there are others who had more emergency needs, it's not like they just didn't care about you. They didn't have the resources and they had to follow procedures. They will have to determine an order of emergency. I think that makes sense as well because if you were in a serious condition, you will get treated. That's also a peace of mind. Unlike China, sometimes what's really more important are often confused. [Well 4:1]

Well's rational thinking has helped with his understanding and coming to grips with the nature of the problem. He appreciated the fact that emergency care providers had to follow priority based protocols to cope with demand while under-resourced. However, he also suggested that the protocols and expected timeframe for treatments, depending on the circumstances, were not being effectively communicated to the patients, which may have been the main reason for causing disappointment and complaints.

Overall, Being In Emergency was not an experience positively perceived by Chinese

immigrants. Similarly, in many other aspects of the **Secondary** healthcare, extremely unbalanced demand and resource ratio has been identified by the participants as the main contributor to the issue of accessing healthcare services. While the entire population may be subjected to the same system and quality of service delivery, they posed a particularly negative impact on the participants when compared to their previous overseas experiences. These findings are further confirmed by the previous survey results in the summary of disadvantages of New Zealand healthcare system (see Table 4, p. 72), where long waiting times, especially for emergency, was ranked first on the list by 34 out of 38 respondents.

Secondary: Waiting In Queue Or Paying The Price

While the lack of resources and delays in getting treatment may have caused some issues with the quality of service delivery, the New Zealand **Secondary** healthcare system provides most of these services free of charge as part of the social welfare system. However, some of the participants in this study have questioned such vision and promises of free **Secondary** healthcare by their own experiences.

> …if you are permanent resident, some (treatments) are free of charge… but the referral to specialist has to go through your GP and it takes a very long time. [Sharon 3:1]

> I have been trying two weeks for an appointment with a specialist without success so I had to go with a private one. It was only a 15-minute session but I got charged $300… the queuing at public hospitals is too long and the waiting time is too long. [Jacky 5:1, 9, 19]

> I had some chest pain and my GP recommended me to see a cardiologist. But he warned me from the start that the wait through public system could take up to months and asked me if I consider the option of a private specialist. I didn't want to run the risk of waiting so I agreed. Luckily there was nothing seriously wrong but it was over $1000 out of pocket for me. After that, I decided to take out a health insurance policy. [Norman 7:16]

It seemed that when faced with the choices between endless waiting in the public system and paying for expensive bills for timely private specialist services, many Chinese immigrants had to pay out of their own pocket. Another story given by Mel has illustrated examples of more demanding cases such as hospital surgery also being held up in the long waiting list.

> I know one family friend, he needed a knee replacement I think. He had to wait for over 2 years going through the public system and that was too long for him because he was basically confined to wheelchair the whole time. So he chose to go back to China to do it. He only had to wait for one week there. Here the public system is free, but the waiting is terrible. [Mel 1:31]

This quote reflected the difference between the two systems in New Zealand and China. In this instance, for Mel, the free **Secondary** healthcare here in New Zealand did not offer any real value. Many of the participants in this study who were attracted by the vision of 'universal free healthcare' have found such promises unrealistic when they were forced to pay up for themselves or even go back to their country of origin for treatment. In Sharon's words, "*what happened to the free healthcare that we were told before?*" Norman responded to the issue of 'Waiting In Queue Or Paying The Price' by purchasing private health insurance policy. The next category explores participants' view and opinions on the role of health insurance policies from the private sector.

The Private Health Insurance

The **Private** sector, including private healthcare facilities and private health insurance schemes, are important components complementing mainstream healthcare system in many countries. In New Zealand, there is no compulsory requirement for health insurance, nor does the government regulate or subsidise any health insurance incentives (Ashton, 2005) which have lead to lower policy coverage (Health Funds Association of New Zealand, 2011) compared to other OECD countries. However, many participants in this study expressed strong interest and willingness towards purchasing **Private** health insurances:

> My husband's company paid for insurance policy for our family, including health. For the kids as well… New Zealand social welfare system is quite good… the public system is free, but the waiting (in the public system) is terrible… I think it's money for most people. [Mel 1:30, 30.1, 31, 32]

> I think in New Zealand it (health insurance) is really needed. If you go through the public system in New Zealand, the wait is just too long. But if you have your own health insurance then going to private specialist becomes an option. It doesn't cost you and you avoid the queues. [Sharon 3:18]

> We have private health insurance so we can contact specialist if we need and ask our GP to

> refer us… especially for more complicated conditions. If going through the public system, there will be delays and you had to wait. In fact, this system is quite ineffective and inefficient. That's why private health insurance is so important to us, whenever things go outside what our GP could do, immediate help from private specialist will be available without delay. [Jacky 5:3, 18, 30]

While some participants enjoyed the benefits provided by **Private** health insurance, others were not able to purchase policies despite their intentions, or did not think **Private** health insurance was worth considering.

> At my age, insurance premium is very high. Secondly, pre-existing conditions are usually excluded from cover… that's why we didn't choose to buy private health insurance. [Zack 6:15]

> I did not purchase private health insurance. I used to have basic health insurance (employment based) when I was in China before. But over here I'm self-employed, so I don't have a stable financial or retirement plan backing up insurance policies. But if I'm going to stay in New Zealand in the long term and with my age increases, I think I will do it (purchasing private health insurance). [Evon 2:10]

> Private health insurance, I think that's pretty much the same in all countries. Like my wife has insurance policy that covers GP visits, $80 a week or something, but didn't really use it at all. I think in New Zealand the chances that you develop some illnesses as serious as you would need insurance is quite low, so insurance is not really worth it. [Well 4:18]

Overall, out of the seven participants interviewed in this study, four individuals have purchased **Private** health insurance and three have not. These numbers may not be particularly indicative in their own context but when compared to other relevant information, significant findings emerged.

In New Zealand, **Private** health insurance has about 40% coverage (Blumberg, 2006), which translates into approximately 1.4 million individuals covered nationwide (Health Funds Association of New Zealand, 2011). Recalling the survey findings on **Private** health insurance, about 39.5% of survey respondents indicated having purchased insurance policies while in New Zealand, which was consistent with the New Zealand average. However in China, where participants of this study originally came from, the national coverage for **Private** health insurance was only 6% for urban areas and 8% for rural areas (Zamiska, 2007). The apparent disparity that exists in **Private** health insurance coverage between the two countries might suggest that Chinese immigrants in New Zealand have come a long way to understand the concept of **Private** health

insurance and its position in the healthcare system from their own experiences engaging both the public and private sectors.

Accessing Healthcare Services Delivery (Patients-System): Summary

The immigration process has meant radical transformations in the way Chinese immigrants access and utilise healthcare services under a new and unfamiliar system. *Accessing Healthcare Services Delivery* is the front line of such changes in their experiences. Under this theme, the participants of this study have described their close interactions with all levels of healthcare service deliveries, from accessing GP services in the **Primary** system to accessing specialist and hospital services in the **Secondary** system, as well as sourcing insurance policy covers from **Private** sectors. From analysis of the interviews, many underlying issues concerning and affecting Chinese immigrants' views and opinions towards the delivery of healthcare services, and how they reacted and coped with the changes, have been explored.

Within the most fundamental category of **Primary** healthcare service delivery, Chinese immigrants have expressed their desire towards Language and Location in choosing GP services. As long as geographical location allowed, nearly all participants indicated strong preference over Chinese speaking doctors and most of them were successful in finding such. This has suggested sufficient ethnical diversity amongst the **Primary** health services delivery system in New Zealand. However, many Chinese immigrants have raised their concerns that Time Matters with waiting for the delivery of **Primary** healthcare services. Some of the Chinese immigrants were also struggling to come to terms with a completely new **Primary** healthcare system to what they have experienced before, for which they did not know what to expect in the sense of How Good Is Good towards the quality of **Primary** healthcare service delivery.

Unlike the Primary healthcare system, the participants generally did not have the flexibility to choose healthcare practitioners who speak their own language with services delivered through the **Secondary** system. While Getting Translated offered a

way to assist those who may experience language difficulties, the availability and quality of translations services have come under many criticisms by the participants. Apart from the language issues, Being In Emergency at public hospitals was another aspect of the **Secondary** system that has been identified as particularly problematic. The lack of resources and communication has meant the services experienced by the Chinese immigrants in this study, have been surprisingly unpleasant compared to similar services delivered back home. The emergency care was not the only service that suffered from stretched operational capacity in the **Secondary** healthcare system. The public specialist care and general hospital service deliveries were also heavily pressured which forced many participants needing **Secondary** healthcare to make a difficult choice between Waiting In Queue Or Paying The Price for private healthcare.

To cope with such reality, many participants have started to explore alternative solutions to public healthcare system, considering **Private** health insurances and **Private** healthcare services. Compared to virtual non-existence of **Private** health insurance incentive in their home country, participants have quickly adapted to the concept and necessity of having **Private** insurance policies in New Zealand. The findings here revealed the coverage of **Private** health insurance for Chinese immigrants was almost at the same level with that of the national average in New Zealand, which demonstrated outstanding adjustability of Chinese immigrants in adapting to new environments and new healthcare systems.

Overall, the Chinese immigrants who participated in this study have expressed concerns and identified difficulties when interacting with a new system of healthcare services at various levels in New Zealand. It was also found that most of these concerns and difficulties were caused by the immensity of differences in personal experiences between accessing healthcare systems in China and New Zealand in terms of service delivery and resources allocation. On the other hand, to cope with the radical changes, Chinese immigrants have also exhibited strong resilience and adaptability in adjusting themselves to the new systems and finding solutions to suit their circumstances.

The theme of *Accessing Healthcare Services Delivery* focused on the interactions

between patients and the system and served as the starting point for the analysis of Chinese immigrant accessing healthcare services in a new environment. However, the changes Chinese immigrants have to make during the transition process go far beyond the system level alone. The next theme of *Patient-Practitioner Relationships* explores these intimate and sensitive interactions to reveal how communication, understanding and cultural issues may affect the utilisation of healthcare services by the Chinese immigrants.

Patient-Practitioner Relationships

Patient-Practitioner Relationships is the second layer in the process of Chinese immigrants interacting with healthcare services in New Zealand. Different to the discussions in the previous theme, which centred on interactions that are system related, the relationships between Chinese immigrants and their healthcare practitioners' focused on achieving effective personal communication and understanding while retaining the value and identity of Chinese ethnicity in the process of seeking healthcare services. In analysis of this theme, three major categories: **Level of Communication**, **Conceptual Understanding** and **Trust and Respect** developed (refer Table 9.2, p. 82).

The first category, **Level of Communication**, had two sub-categories: Not Being Able To Explain and Without Explanation. Each of these sub-categories will now be discussed.

Level of Communication: Not Being Able To Explain

Effective communication between healthcare practitioners and their patients involves the exchange of information in both directions: that is, patients need to be able to explain their conditions and concerns to the practitioner; and equally importantly, the practitioners must be able to accurately deliver their opinions and recommendations to the patients. However, during the interviews, many participants expressed their concerns over the **Level of Communication** with their healthcare practitioners, starting with Not

Being Able To Explain themselves.

> Definitely a problem (communication with European doctors). Although my husband has a Masters degree from Auckland University, even he said it is easier to talk to a Chinese doctor. Because Chinese doctors understand what we are saying. If it was a European doctor, it'll be much harder to communicate. For example, I have two kids, both of them born here. My first midwife was Chinese but the second one was European. If I had questions or problems during pregnancy, it's very easy to describe to the Chinese midwife. But when I was having my second one, for example one day I had this extremely tightness on my tummy with pain. So I called up the midwife and she was asking me what type of pain. I didn't know how to explain except just telling her I was having pain. But to my first midwife, I would accurately describe my feelings, what sort of tightness, what sort of pain. [Mel 1:14, 15]

Mel and her husband were confident in their language ability having completed postgraduate tertiary studies in New Zealand, but were still troubled with Not Being Able To Explain their conditions accurately, in a medical sense, to their practitioner. Apart from this difficulty, Mel also commented that cultural issues may have played a role in communicating with their healthcare providers:

> I think there are language issues, as well as cultural. Like the midwife for my first child here used to be a maternal doctor for 8 years in China. My child's position was three rounds inverted and I was worried. She understood my concern and performed a vagina cut earlier on. I think that was such a right decision. Because the midwife for my second child was European and she just wouldn't understand, kept telling me nature, natural is the best way then I had massive vagina bleeding. So sometimes what we think or want is irrelevant to local health practitioners, there are too much cultural difference. [Mel 1:16]

Mel's experiences with two midwives, from two different ethnic backgrounds, resulted in different feelings in terms of **Level of Communication**. While she had no problem with the Chinese midwife, the communication with the European midwife made her feel that she was Not Able To Explain her concerns and the cultural gap led to misunderstanding and consequently her requests being ignored by her practitioner, which she described as 'irrelevant'. Mel's experiences were shared by others.

> Chinese midwives understand my concerns and decisions a lot more, much easier to communicate. Chinese and Europeans are very different in culture and tradition, also in constitution and biology. So I feel that, with a Chinese midwife if I had some doubts or even some things that I may feel sensitive to say, would be much easier to communicate. And I also don't want a third party translator there. [Yvonne 2:4]

> Because we are not native speaker, language can be a problem in communication sometimes. And also the differences in thinking, Europeans and Chinese are just different. For example, if

> you request some medication or different treatment, they (European doctors) don't quite understand why you are asking if they think it's not necessary… these may just be differences in cultural background. [Sharon 3:7]

These experiences highlight participants' concerns over Not Being Able To Explain to their healthcare practitioners, which to some degree have prevented free and honest communication between patients and practitioners. However, this is only half the story. Most of the participants who found it hard to express themselves also felt that the practitioners were not clear with their communication.

Level of Communication: Without Explanation

Effective communication between patients and their healthcare practitioners cannot be one-way. It is equally important, if not more, that healthcare practitioners are able to clearly and accurately deliver their assessments to patient with professional considerations such as cultural sensitivity. From the interviews, participants indicated this has not been achieved to a satisfactory standard.

> I went to see specialist because I had GDM, like diabetes during pregnancy. The specialist gave me a lot of suggestions, quite detailed. But the problem is I don't know if they just don't feel like telling me what it actually is, or how bad it is. Everything is "it's ok". My feeling is that if it is not too serious, it's always just "ok"… They (doctors) think there may be some small problems but not necessarily tell you. If he thinks it's within acceptable range, it's ok… This "OK" here really bothers me. The doctor might think it's only a small problem and I don't have to worry but it is still a problem, otherwise he wouldn't be telling me about it, right? So I still worry and I just want to get to the bottom of it, but they don't help you with that. [Mel 1:6, 7.1, 8]

> I mean for not serious conditions (in emergency care), if they can talk to us, let us know from the start that we might need to wait 4-5 hours. Explain to us, that explanation is important, I don't think that's too much to ask for, instead of leaving the patients without any indication of what's gonna happen, when it's gonna happen. That's the part I don't like… But again, I have to say this again. Like my kid having fever, they really need to try to explain stuff to us. At least making us understand what to expect. Those endless waiting from 11 to 5, if I knew I was going to wait that long, I could have gone home or elsewhere already. [Well 4:2, 5]

From participants' narratives, it appeared that some medical practitioners in New Zealand tended to make decisions on the **Level of Communication** based on the seriousness or the priority of the patient's conditions. Often, in minor cases,

practitioners either did not have the time to fully communicate the process, or chose not to completely disclose the circumstances to comfort their patients from unnecessary worries. In contrast, practitioners' communications to patients, in more serious cases, were much better perceived by the participants, as Zack explains:

> And before the surgery, the doctors explained everything to the last detail, what your condition was, what consequences the surgery may possibly bring, good or bad, how good, how bad, everything so clear and made us fully understand. The skills, the attitude of the doctors here are excellent, and all communications are through translators. We were deeply impressed. [Zack 6:1.2]

Nevertheless, these contrary opinions under different circumstances suggest that the participants tend to seek every explanation when receiving healthcare services. Many of the participants explicitly expressed feelings of being confused, neglected and Without Explanation when their healthcare practitioners exercised discretion in how information was communicated. Apart from these circumstantial differences in communication, procedural and cultural concerns over the **Level of Communication** from practitioners to patients have also been identified.

> Unlike in China… doctors would suggest some possibilities from their experiences and give you a general assessment, here (GP practices) they do not have diagnostic equipment or facilities, they wouldn't give you any conclusions. So, sometimes you have to wait for 2, 3 days without any explanation because they have to wait for test results… My dad had a heart attack once and was transported to hospital by ambulance. But after 8 hours of testing and observation, they still can't give me any conclusions as to what happened. They said they had to wait for a specialist to interpret the results. [Jacky 5:11, 12]

> Your GP has referred you but after a long wait, the hospital tells you that your appointment was cancelled. They tell you it wasn't necessary, I don't know how they come to that conclusion because our GP thinks it is absolutely necessary…Very often the tests that our GP ordered may be refused or cancelled, and the reasons simply conflict with what our GP was telling us. But there's nothing much you can do. [Zack 6:2, 13]

> And other things like they don't really understand Chinese culture about not having cold drinks after birth etc. Even the doctors came in and said that my wife should not be drinking anything for a couple of hours but the nurse later said it was ok to drink. We didn't know who to believe. [Well 4:16]

Such feelings, expressed by the participants, reflect the differences between diagnostic and treatment procedures from previous overseas and New Zealand experiences that can pose significant impact on the perception of **Level of Communication** between patients

and practitioners. The channelling and conduit means of patient-practitioner communication are fundamentally different between the two countries, such as the procedure of medical testing, interpretation of results and the delivery of the doctor's recommendation.

In China, where participants emigrated from, healthcare services are delivered solely through hospitals, including all exchange of information and patient-practitioner communications. In New Zealand, due to the combined efforts from multiple facilities and personnel involved in delivering healthcare services, the passing-on of information and the discontinuous fashion of communication appeared to be a challenge for the Chinese immigrants to comprehend. Combined with differences in cultural values, many participants found themselves in a position of either Not Being Able To Explain their concerns to their practitioners, or were left off Without Explanation by their practitioners. This breakdown in communication may have also been contributed to by other factors such as **Conceptual Understanding** that could potentially undermine the *Patient-Practitioner Relationships* in terms of **Trust and Respect**. The next two categories will explore such issues.

Conceptual Understanding

Within the theme of *Patient-Practitioner Relationships*, the discussion over the **Level of Communication** was aimed at analysing the possible barriers that could potentially prevent effective understanding between patients and practitioners. However, such barriers may involve more than just procedural and cultural differences. From the interviews of participants, the **Conceptual Understanding** was also identified as another influencing contributor to *Patient-Practitioner Relationships*. The category of **Conceptual Understanding** focuses on the difference in perception of healthcare related concepts such as medical standards, treatment styles and other practices.

Recalling Mel's experiences with her diabetic symptoms during pregnancy, which she described in the previous category, she was troubled by her specialist not explaining

what she wanted to know. Another reason for Mel's concern over her condition was not being able to understand the medical standards communicated to her by the practitioner.

> Like my GDM (Gestational Diabetes Mellitus – Diabetes in pregnancy) for example, the specialist was telling me that the standard (of GDM) is different, even between New Zealand and Australia. My blood sugar level at that time was a little high by New Zealand standard but it was normal by Australia standard, so I was told not to worry too much about it… where exactly am I, how high is high, where am I on the scale? In China, doctors give you a figure and a scale, like a range of acceptable values so I can compare for myself… I have another friend went to see specialist about fertility problem. The results failed the China standards, actually by quite a lot. But the doctors here were telling him the results were excellent. I think this is a cultural difference. The information that you get from one country is completely different from another medical standard and this is confusing. I wouldn't know if this is normal or abnormal. I don't know if I have problem or the standard has problem. [Mel 1: 6, 8]

Mel's confusion over the concept of acceptable medical standards has only added to her worries. A confusion shared by Norman in his experience seeking help from a cardiac specialist:

> The consultant cardiologist performed a whole lot of tests but told me there was nothing wrong. So I asked him about my symptoms and I do have symptoms. His answer was yes, there was some abnormities but they were not conclusive enough to make a diagnosis, could just be variations of individual's physiology. I wasn't too happy with that answer; it was like saying yes and no at the same time. So when I had the opportunity going back to China, I had my condition checked up again back home. And this time I was told that I have slightly elevated level of premature beat and mild arrhythmia. I actually needed some medication to control those symptoms. Those made me wonder if the medical standards in use by the two countries actually agree with each other. Or is it the New Zealand standard is not suitable for the Chinese population? [Norman 7:11]

These differences in understanding medical concepts have led to many difficulties for Chinese patients to fully appreciate their conditions, which could negatively impact on *Patient-Practitioner Relationships*. Additionally, another aspect heavily criticised by the participants in terms of **Conceptual Understanding** was the difference in treatment styles and medical practices.

> The cultural difference was simply shocking. And I also remember being given ice cream, cold water and asked to take shower almost immediately after birth and those were unimaginable in China to what we believed as after birth care in China. [Mel 1:20]

> I had a high fever once… doctors asked me to strip down to minimum clothing and told me wearing too much was like cooking myself. But in China for general fever, we were actually told to wear more, drink hot water and sweating can help to cool body temperature. And in

> China you will be given IV drips and works fast. [Sharon 3:9]
>
> If you have a high fever because of flu or cold, they just blow you with a fan, or give you a popsicle. That's near ridiculous to Chinese… It's just people believe in different things. [Well 4: 15]
>
> When I was in China, I do get flu or fever once in a while. But as soon as you have them, you go to the hospital and they give you an IV drip. Usually that works very quickly. Once your temperature is down, you feel much more comfortable. But here, for those things it doesn't make too much difference whether you go to doctors or not… they only ask you to take Panadol. [Zack 6:8]

The different understanding of some common conditions, treatment styles and other healthcare practices may be interpreted as completely different concepts by Chinese patients and their practitioners, such as the concept of providing afterbirth care and treating flu and fever. These gaps in **Conceptual Understanding** are often associated with differences in traditions, culture and customs. As a result, many participants found it hard to establish **Trust and Respect** in their *Patient-Practitioner Relationships*.

Trust and Respect

The **Level of Communication** and **Conceptual Understanding** are among the most important considerations in *Patient-Practitioner Relationships*. However, a fundamental component pertaining to the interactions between patients and their practitioners is **Trust and Respect**. The relationship between patient and healthcare practitioner is much more complex than a simple process of common trade professionals delivering services to their clients. In contrast, the interactions between patient and practitioners involves highly sensitive and emotional issues concerning the health, illness and even life and death of a human being. While the confidence of practitioners lies with their professional knowledge, independence and objectivity, the vulnerability of patients in need of care means they inevitably experience high degree of subjectivity, dependency and uncertainty. This unique, intimate, but unbalanced relationship is delicate and requires both the practitioner to respect the vulnerability of their patients, as well as the patients to trust the professionalism of the practitioners. Failure to establish such **Trust and Respect** will fundamentally undermine the compliance and effectiveness of

diagnosis and treatments. Trust and Respect has three sub-categories: Trust The Practitioner, Respect The Patients and The Chinese Way.

As **Trust and Respect** between patients and practitioners is partly contributed by communication and understanding between the two parties, some of the issues discussed in the previous categories may be revisited.

Trust and Respect: Trust the Practitioner

The trust and faith of patients in their practitioners can be affected by many potential factors. The **Level of Communication** discussed previously is one such factor that may lead to the disappointment and mistrust of practitioners by patients. Revisiting Mel's experience in Without Explanation from her practitioner, she further commented that this breakdown in communication has negatively impacted on her trust in the practitioner.

> I don't think so (practitioner being able to solve her problem). I mean this kind of explanation I sort of understand but not really. It's like the doctor is saying ok and you don't have to worry but you still worry about it. I understand what they are saying but I just feel I can't trust that. [Mel 1:7]

Similarly, the conceptual misunderstanding may also damage the trusting relationship between patients and practitioners, as Norman described after he was diagnosed differently in New Zealand: *"if I take any other similar tests in the future, I don't know if I could trust them anymore"* [7:12]. Issues causing mistrust between patients and practitioners can arise from a number of other factors. Recalling Well's experience during his wife's maternity care, when different practitioners were giving conflicting advice, he commented: *"We didn't know who to believe"* [Well 4:16]. Participants' previous overseas experiences and their own perceptions also played a role in trusting practitioner's knowledge, as Sharon stated, *"Because doctors in China are more experienced, they have seen more patients and more cases"* [3:17]. These perceptions may not necessarily be true but they still reflect various difficulties in trusting healthcare practitioners by the participants.

However, not all relationships between participants and their practitioners were negative. For example, although Mel has expressed her concerns over the **Level of Communication** that consequently affected the **Trust and Respect** with her practitioner, she also admitted that this mistrust can be circumstantial:

> I mean, there are differences but most of them I can adapt to over time. If you choose to trust the way it works here when there are difference, I think they are trustworthy. [Mel 1:27]

Mel has chosen to accept the differences existed in *Patient-Practitioner Relationships* between the two countries and tried to adapt to the New Zealand way of interacting with her healthcare practitioners. On the other hand, Zack and his family were quite satisfied with their interactions with the healthcare practitioners.

> I think I'm overall satisfied. Over the years, common problems have been handled quite well… We've been through most of this system, from GP, to specialist and to hospital, including surgery. They way they work for me, I think it's reasonable. [Zack 6:7, 8.1]

Patients' trust in their healthcare practitioners is one aspect, feeling respected by their practitioners is another key factor in sustaining productive relationships between the two parties.

Trust and Respect: Respect the Patients

New Zealand has well designed and implemented systems for healthcare services governance and the protection of patient rights, including the setup of dedicated government agencies and supporting legislations (Health and Disability Commissioner, 2009). In the Code of Rights, defined under the Health and Disability Commissioner Act 1994, the first right granted to patients when receiving healthcare services is "To be treated with respect". In general, New Zealand healthcare providers strictly adhere to these principles with a high level of professionalism. Despite the various concerns over *Patient-Practitioner Relationships*, expressed by the participants, none of them explicitly complained about being disrespected when receiving healthcare services, as Norman stated:

> One thing I like about New Zealand healthcare is that the practitioners always treat you with dignity and respect. I was in hospitals once for appendix abscess when doctors very kindly

> asked me if I would agree to participate in a training doctor assessment programme. They explained my role and contribution in the programme as well as my rights to raise any concerns that I have. If it was in China, you could get student doctors coming in and watch procedures done on you at any time without even asking for your permission. [Norman 7:21]

Another participant, Well, also commented that *"I think the New Zealand healthcare practices are very reasonable and humane"* [4:1]. These findings resonate with previous survey results in which "Humane and professional services" was rated as the top advantage of New Zealand healthcare services compared to China (see Table 7, p. 74). However, the high level of recognition towards respecting the patients by the practitioner does not mean that there were absolutely no issues, especially when traditional and cultural concerns were involved. Recalling Mel's maternity care experience she commented further about her feelings:

> The cultural difference was simply shocking. And I also remember being given ice cream, cold water and asked to take shower almost immediately after birth and those were unimaginable in China to what we believed as after birth care in China. **I'm still mad thinking back to how strange the nurse was looking at me when I refused to take that shower**. [Mel 1:20]

Although there was no apparent act of disrespect by the practitioner either verbally or physically, the lack of traditional and cultural awareness and sensitivity, combined with miscommunication and misunderstanding, could also lead to feeling of being disrespected by the patients. Apart from the common issues of **Trust and Respect** in general *Patient-Practitioner Relationships*, a unique perspective of the Chinese group has also emerged from the interview findings, which concerns the use of Chinese Traditional Medicine.

Trust and Respect: The Chinese Way

Traditional Chinese Medicine (TCM) practice has been a vital part of the Chinese history, cultural and their healthcare for thousands of years. Even when the Chinese population find themselves in western countries such as New Zealand, the tendency towards trusting and seeking TCM still largely influence their healthcare decision makings, as well as their interactions with healthcare practitioners.

> 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. [Mel 1:28]
>
> I often bring some Chinese medication (to New Zealand) with me that I know work for myself, because I can't buy them here. [Evon 2:11]
>
> If he (my GP) doesn't agree for me to use Chinese medicine, I would still try anyway. Because he's western trained doctor and he would have no idea why Chinese medicine works. [Sharon 3:16]
>
> My husband had muscle injury from gym…he was recommended physio (by his GP) but after about 10 times without any real effect we went back to Chinese acupuncture and massage and that worked really well… I'm actually surprised that even some western doctors are starting to take interest in Chinese Traditional Medicine and wish to learn how it works. [Jacky 5:25, 28]

From these participant comments, it is clear that many Chinese immigrants still insisted on treating certain conditions The Chinese Way. It was also noted that some New Zealand healthcare practitioners remained sceptical towards patients' choice in trusting and seeking TCM practices, which may undermine the **Trust and Respect** and consequently the *Patient-Practitioner Relationship*.

Patient-Practitioner Relationship: Summary

In this second theme, analysis has identified potential contributing factors that may impact on the interactions between Chinese immigrants in this study, and their healthcare practitioners in delivering and receiving healthcare services. The quality of healthcare services delivery and utilisation is critically dependent upon the effectiveness of such interactions. From participants' experiences, three major categories under *Patient-Practitioner Relationships* have been discussed: **Level of Communication**, **Conceptual Understanding** and **Trust and Respect**.

In the discussion involving **Level of Communication** between patient and practitioners, many participants have expressed their concerns of either Not Being Able To Explain themselves to the practitioners or finding it difficult to receive communications from their practitioner Without Explanation. The barriers causing the breakdown of communication have been identified from a number of common factors including language and culture. Further analysis revealed large gaps in **Conceptual**

Understanding also existed between Chinese immigrants' perceptions and New Zealand interpretation in terms of medical standards, healthcare services procedures and the concepts of traditional and cultural values. All these factors combined have led to the negative impacts on the most fundamental component of *Patient-Practitioner Relationships*, which is the establishment of **Trust and Respect**. It is also interesting to note the tendency of Chinese immigrants in trusting and resorting to TCM practices as part of their culture and traditions.

In summary, this chapter primarily focused on the interactions between Chinese immigrants and New Zealand healthcare services on two important levels: the healthcare system and healthcare practitioners. In the next chapter, attention shifts away from external interactions to the internal assessment of personal attributes of individuals and the ethic group as a whole.

CHAPTER 6: FINDINGS PART III

Healthcare Awareness and Healthcare Attitudes

Introduction

The discussion of the previous themes centred on the operational level of seeking and receiving healthcare services where Chinese immigrants interact with various components of the New Zealand healthcare system as well as healthcare practitioners. While the analyses of these interactions capture the real-life experiences reflecting the communication and understanding between patients and practitioners in the context of the system, understanding of the underlying implications requires more than just interpersonal exploration but also intrapersonal analysis (Freshwater, 2002). In this chapter, the individual's self-understanding and how such understanding may impact on the *Healthcare Awareness* of the Chinese immigrants and consequently contribute to their *Healthcare Attitudes* towards seeking healthcare services in New Zealand is discussed.

An Overview of Themes and Categories

In-line with the scope and context of this chapter's analyses, two major themes, based on common characteristics identified from participants' interview transcripts, have developed: *Healthcare Awareness* and *Healthcare Attitudes*. A breakdown of categories and sub-categories where applicable can be found in Tables 10.1 and 10.2 (p. 110) below.

Table 10.1 ***Healthcare Awareness***

Themes	Categories	Sub-categories
Healthcare Awareness	**Internal Source of Knowledge**	There Is An Old Saying, Embedded State Of Mind
	External Source of Knowledge	Publication And Media Exposure, Friends And Family, Healthcare Practitioners

Table 10.2 ***Healthcare Attitudes***

Themes	Categories	Sub-categories
Healthcare Attitudes	**Attitudes towards Family Health**	N/A
	Attitudes towards Self-care	N/A
	Attitudes towards Financial Consideration	N/A

Healthcare Awareness is aimed at exploring participants' awareness and considerations of their healthcare and healthcare services available to them in New Zealand, as well as finding out how participants have come to such awareness from the perspectives of both internal and external sources of knowledge. The second theme, *Healthcare Attitudes*, takes into account the information from *Healthcare Awareness* and attempts to understand participants' attitudes towards healthcare services and the contributing factors that influence such attitudes.

Healthcare Awareness

The term Healthcare Awareness is commonly referred to as Health Education, which by the WHO (2011) definition is "the combination of learning experiences to help

individuals and communities improve their health, by increasing their knowledge or influencing their attitudes" (p. 1). By this definition, the process of raising *Healthcare Awareness* involves the improvement of knowledge and the development of skills in terms of individual's healthcare and healthcare related issues. Such knowledge and skills of personal healthcare may come from various sources, which under the analysis of this theme are grouped into two different categories: the **Internal Source of Knowledge** and the **External Source of Knowledge**. The **Internal Source of Knowledge** refers to healthcare perceptions and interpretations from individual's own self-understanding, often formed as part of their upbringing and mentality; whereas the **External Source of Knowledge** refers to the continuous exposure and acquisition of healthcare related information received from communities and societies throughout the course of life. The analysis of this theme begins with the discussion over the most fundamental component of the **Internal Source of Knowledge**.

In the previous chapter, many concerns emerged, such as conceptual misunderstanding of medical standards and procedure and large gaps in traditional and cultural values. While these findings were informative and valuable in identifying issues relating to Chinese immigrants accessing and utilising local healthcare service, the explanation as to why these phenomena existed remained unclear. There were many underlying questions such as, why did misunderstanding occur? What were the Chinese traditions and culture values? Why did the Chinese immigrants prefer to seek traditional medicine practices? The answers to these questions lie with **Internal Source of Knowledge** of the Chinese immigrants.

Internal Source of Knowledge: There Is An Old Saying

The most rudimentary source of internal knowledge is an individual's upbringing provided by his or her family and surrounding environment which form an intrinsic part of a person's mentality. Healthcare knowledge is no different. "There Is An Old Saying" were the words Mel used during her interview, which accurately reflected the key point of this sub-category. The Chinese way of upbringing is undoubtedly different from that

of New Zealand. All of the participants shared strong links to the Chinese tradition and culture. The old sayings still pose significant impact on their *Healthcare Awareness* as participants described:

> And there are also big cultural differences as well. Like to us Chinese, there is an old saying of "any medicine is itself a toxin". I don't really hear that here… We always try to, especially old people, to take as less medicine as possible. And Chinese have an alternative, to see traditional Chinese doctors. We can sort to Chinese medicine, doesn't have to be western medicine… Chinese medicine may give good results but you don't really understand it… 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. [Mel 1: 11]

> I guess it's because of the (Chinese) traditions, "any medicine is itself a toxin", if my body can heal itself, or let's say everybody knows what their bodies can do to some degree, for example a mild flu, I just take some Chinese herbal medicine, rest a bit and I'll be back on my feet, there is no need to go to a doctor…Flu is most common sickness… I often bring some Chinese medication (to New Zealand) with me that I know work for myself, because I can't buy them here… because medicine is like food, your body get use to some of them… I don't really try anything new (medicine). [Evon 2:5, 11]

> The interpretation of some diseases from the perspective of Chinese medicine is different from the western ways. (The cure of) Some illnesses are slow processes in Chinese medicine practice. So from our (Chinese) traditional point of view, (I would) still choose Chinese Traditional Medicine. Women's irregular period for example, western medicine can't really do anything or any means of intervention by food or nutrition. But generally in China, these can be dealt with Chinese Traditional Medicine. [Sharon 3:14]

These were some examples of the impact of Chinese upbringing towards the use of TCM. In fact, all of the participants interviewed expressed similar thinking. These findings further confirmed the previous survey results where all 16 individual survey respondents who indicated experiences in using complementary healthcare listed TCM as their choice (see Question 3, Chapter 4, p. 66). Nevertheless, it is apparent that this internal healthcare knowledge represented high level of recognition and acceptance of individual's self-understanding and judgement of the best form of healthcare practices for themselves under the strong influence of traditional Chinese upbringing. However, upbringing is not the only factor in the sense of 'old saying'; the Chinese cultural mentality also plays an important role in **Internal Source of Knowledge**, Embedded State Of Mind is one such example.

Internal Source of Knowledge: Embedded State Of Mind

One of the most important attributes of the Chinese culture is the conservative and passive thinking (Ng, 2003). In terms of *Healthcare Awareness*, unfortunately this conservativeness and passiveness often translates into aversion and denial of admitting having certain diseases and health conditions (Ng, 2003). For example, having mental health illnesses or infectious diseases may be regarded as a disgrace in the Chinese culture. These cultural driven mentalities may form specific Embedded State Of Mind affecting individual's own interpretation of health and negatively impact on the utilisation of healthcare services, as been identified from participants' interviews:

> And I know some people just think that (having certain health conditions) wouldn't happen to them. I know it's wrong but some Chinese people still think that way… I really try not to see doctors as much as possible, unless I feel really unwell. [Mel 1:25, 32]
>
> If I need to put this (the importance of healthcare) on a percentage scale, up until now it's only about 20-30%. Because I'm still young, I won't have much health issues. My work and other issues in life are more important… Because I'm still young, I won't need these (medical) services so I never had it (regular GP). [Evon 2:1, 3]
>
> I think in New Zealand the chances that you develop some illnesses as serious as you would need insurance are quite low, so insurance is not really worth it… I think I'm still quite influenced by the Chinese traditions, we don't like to see doctors if not necessary. [Well 4:4, 18]

Some Chinese participants' Embedded State Of Mind, thinking that *"bad things wouldn't happen to them"* [Mel 1:32] and *"I'm still young, I won't need these medical services"* [Evon 2:1] have directly undermined their willingness to actively seek healthcare service. In addition, lack of objective assessment of one's health conditions, such as *"I think in New Zealand the chance that you develop some serious illnesses are quite low"* [Well 4:18] also negatively impacted the level of healthcare services utilisation. Furthermore, the tendency of avoiding doctors seen from many participants, such as *"I really try not to see doctors as much as possible…* [Mel 1:25] and *"we don't like to see doctors if not necessary"* [Well 4:4], greatly undermined participants' willingness to access healthcare services. The **External Source of Knowledge** is another important contributor influencing the *Healthcare Awareness* of Chinese immigrants.

External Source of Knowledge

This category refers to the means of acquiring healthcare related information from their surrounding environment that are valuable to the improvement of *Healthcare Awareness*. From the analysis of participants' interviews, three major sources of such knowledge have been identified: Publication And Media Exposure, Friends And Family, Healthcare Practitioners.

Each of the sub-categories will be discussed for their positions and effects as an **External Source of Knowledge**.

External Source of Knowledge: Publication And Media Exposure

Publication And Media Exposure is one of the most common channels for information circulation amongst the general public. Publications and media include pamphlets, newspapers, television programmes, radio broadcasting and the Internet. In culturally dynamic societies, such as New Zealand, publication and media is also delivered to intended audiences in different languages. Although publication and media has become an integral part of everyday life, the interview participants of this study presented mixed opinions when asked to comment on the role of publication and media as a source of healthcare knowledge and awareness. Some participants were satisfied with Publication And Media Exposure as a valuable source of their healthcare knowledge, as Mel explained:

> There are plenty of medical information or promotion information. In doctor's office, on his table. He'll show you or you can take them yourself… Mostly printed material… all of them in English… I don't really see or hear about them myself (from mainstream media) but I've seen something about Maori people can receive free vaccine, for some … uterus condition, if they are under certain age or something…To me, if I can understand English, they can be quite helpful. But to older people or new immigrants they may not understand the language. I don't think it helps them. I've seen those on the corridor walls in clinics as well…In Chinese newspaper I've seen quit smoking promotions, and it was free. Actually my dad contacted that service, enrolled in the programme and successfully gave up smoking. He had been smoking for decades before that. That organisation was Chinese speaking, I think they are affiliated to public medical facility in Auckland. It's quite well-known in Chinese communities… I think they are well accepted by Chinese. I think there were also something about smear test and vaccines…Of course they were

> helpful. Like those check-ups for breast cancer, smear for people between 40 and 69 I think. Those were very helpful. We didn't know about them until we saw those on the Chinese media. [Mel 1: 9, 9.3; 9.6, 9.9]

Mel's experiences suggested that she was able to obtain healthcare related information and knowledge from various forms of Publication And Media Exposure including printed materials, mainstream media, as well as Chinese media. She was also able to use both English and Chinese based healthcare information to improve the health status of herself and her family, such as taking advantage of free breast and cervical cancer screening, as well as enrolling her father in quit-smoking programmes. This healthcare knowledge, obtained from external sources, has been successfully internalised by Mel to improve her self-understanding of health related issues. However, Mel did point out that part of the reason why she was able to acquire and utilise **External Source of Knowledge** was because of her bilingual ability and some Chinese immigrants who have limited English language competency may experience difficulties with New Zealand mainstream media.

Contrary to Mel's experiences, other participants expressed concerns regarding Publication And Media being a helpful **External Source of Knowledge**:

> Up until now I haven't received any (healthcare information from publication and media). Some verbal information yes (from GP), but basically not much… Usually I do my own research on the internet if I need (healthcare information)… TV programmes may provide a little bit, like teeth cleaning… but all you see on TV is in English… I have seen some (healthcare information) on the Mandarin Page (an Auckland based Chinese newspaper) but they were all some kind of commercial advertisement, like some private clinics, dental care, acupuncture, Chinese medicine etc recommending some checkups to you… Honestly these commercials don't influence me much… To me, there is not enough (healthcare information), I mainly get these (information) by asking my friends. [Evon 2:12, 14, 16]

> Not normally, not that I can remember (from Publication and Media). I think this is what they need to improve on… Mostly in English… but not too much either (from mainstream media). Maybe I didn't pay attention. The ones that I've seen are like telling you what exactly is flu, what caused them, where to get vaccination etc… Yes I have (received information from Chinese media), Chinese ones yes… Of course (the Chinese ones were helpful). Not only just to me, but to old generation migrants, those who don't really speak English well. That would be helpful. [Well 4:6, 10]

> I don't think there is much (from mainstream media)… only that I can remember was some brochure at GP's practice… but there are quite a lot from the Chinese ones. For example the free

> checkups after the age of 45… mainly some Chinese publications, sometimes advertisement… But generally there is not enough (information), if say you need to find some specialist care, don't know where to look. The only way is through your GP's recommendation. [Jacky 5:20, 21, 23]

> I remember there were some. Like information about diabetes, heart diseases, flu etc. They were posted around… Mostly written (material), there are English ones as well as Chinese… I think they are somewhat helpful. Like free breast cancer scans and other checkups for women 45 years old and over… I don't really follow English media, because my English is poor… Chinese media I have, especially AM936 radio station. And websites, I sometimes do go have a look. They were helpful. Like information about dietary health, how to maintain health and wellbeing. I do care about those things. [Zack 6:3, 3.1, 3.4]

These mixed views about obtaining healthcare information from Publication And Media strengthened the understanding that each individual's experience was unique. It was clear that most of the participants have not been able to receive or make use of healthcare related information from mainstream English based Publication And Media; possibly due to their limited command of English language. Although information from Chinese Publication And Media did not pose language difficulties, and was generally much better perceived, the limited amount of information and the lack of systematic knowledge delivery restricted the potential benefits. Some participants also mentioned alternative **External Source of Knowledge** such as asking friends and getting information from their healthcare practitioners, which will be discussed in the next two sub-categories.

External Source of Knowledge: Friends And Family

Chinese immigrants in New Zealand society form closely related communities for socialisation and unification. Additionally, one of the characterising traditions of the Chinese culture is 'family-orientation' (Ng, 2003) which means Chinese immigrants tend to be much closer to their family members and friends when seeking advice. These tendencies were clearly identifiable from the interviews with participants in terms of acquiring healthcare related information from external sources. For example, when Evon found out that she was pregnant, her first response for finding a midwife was to ask her friends:

> To me, there is not enough (healthcare information), I mainly get these (information) by asking my friends... For example, finding a midwife, whether to find a Chinese one or a European one, how to find them, how to get hold of a list of names etc, there wasn't a convenience way. Like when I got pregnant, my first response was to ask my friends who have been pregnant before, who have kids, rather than some already available information... I feel there is enough information (from my friends). [Evon 2:16, 17]

As Evon relied on her friends for referral, so too did Jacky:

> When I first came here (to New Zealand) I didn't even know where to find doctors, didn't know the process at all. It was actually my landlord who told me that I should go see GP first and only when something critical or emergency happens that I can go to a hospital. I thought I could just go to public hospitals and that was ok... I could only ask my friends (if there wasn't enough information). Like last time, I couldn't find any gynaecology specialist who can speak Chinese and there wasn't any female doctor so I had to ask my friends if they know any. [Jacky 5:7, 24]

There were many others who shared similar feelings towards getting healthcare information from friends and families, as Sharon and Zack explained:

> Yes but not much (information from sources other than Publication And Media), I may ask some of my friends... Sometimes I call up my GP but also asking friends. [Sharon 3:12, 13]

> Sometimes you are not sure where exactly to go for help with certain problems but some other friends may know that, and that can be helpful. I also have a few friends and family members work in the healthcare profession where I can get information from. [Zack 6:3.6]

Although most participants in this study have found Friends And Family to be a valuable **External Source of Knowledge** for their healthcare needs, other participants were not completely convinced. When Well was asked about alternative sources of healthcare information such as communities, friends and families, he stated:

> Yeah, there were some. But less comprehensive and less accurate because it's word of mouth only. I think it's better to confirm for myself first... I heard before that some spinal therapy will leave some negative after effects, some negative consequences. Or before the therapy it was actually ok or just a small problem but after the therapy then it develops some serious conditions. That sort of scared me off. I didn't really personally experience any of those. [Well 4:10, 19]

Well was sceptical about 'word of mouth' between Friends And Family as an accurate and reliable source of healthcare information and was concerned that such potential misleading information could cause damaging consequences.

Nevertheless, it is clear from the interview findings that most participants in this study viewed Friends And Family as a primary and trustworthy **External Source of**

Knowledge. In addition to Publication And Media and/or Friends And Family, participants also sought professional advice.

External Source of Knowledge: Healthcare Practitioner

The role of healthcare practitioners is to provide professional healthcare services to the public and promote healthcare awareness and deliver healthcare knowledge. However, the findings from the interviews indicated opposing views towards such role of healthcare practitioners. Some participants highly regarded the practitioner's position as a valuable **External Source of Knowledge**, as Mel explained:

> There are plenty of medical information or promotion information. In doctor's office, on his table. He'll show you or you can take them yourself… Like when my mum was seeing the doctor and he thinks osteoporosis are commonly seen in her ago so he gave my mum a promotion booklet about free check-ups for that… If I needed any specific information, I can always get them from my GP or somewhere else, you'll know where you need to go. This is better than China… He actually referred me to alternative treatment, both western and Chinese. He's leaving the decision up to me. [Mel 1:9.1, 9.2, 12.1, 29.1]

Apart from her GP, Mel has also received healthcare information from other practitioners including Plunket staff and school dentist:

> In New Zealand, from 2 years old I think, Plunket will give information about where is your closest school dental. Like my kids, they drink their milk and go to bed without brushing their teeth. And after a while, the dentist will pick out the build up on their teeth and lecture us on how important it is to prevent things from happening. [Mel 1:26]

While being satisfied with her healthcare practitioners as a valuable **External Source of Knowledge**, Mel also pointed out that there was not enough verbal communication during the delivery of healthcare information, as seen from previous categories:

> (the information is) mostly printed material, I don't really receive any verbal communication on those information, unless on some common conditions… the doctors will briefly explain, well as much as they could. But then it's not really their job so it's still up to us (to make decisions). [Mel 1:9.2, 9.4]

Mel was not the only one who regarded healthcare practitioners as the main source of information. Zack commented: *"I think there are enough. To be honest, my main source of information is actually from my GP for what I need. If I don't feel well, if there's*

anything I need to know, I'll go to my GP. Mostly from him, other channels may be able to supply some additional information" [Zack 6:4].

However, there were many other participants who did not place such trust in their healthcare practitioners as a helpful **External Source of Knowledge**, such as Evon and Well: *"Some verbal information yes (from GP), but basically not much… for some information I'd ask my GP and he'll answer you. But up until now I have not seen my GP to voluntarily provide me with detailed and systematic healthcare information"* [Evon 2:12, 13]. *"From my experiences or my family going to see doctors, I have never received any written information, some verbal, but not much"* [Well 4:6].

Although individual healthcare practitioners may take different approaches to delivering healthcare information and knowledge, it is unjustified to simply conclude these variations in views and opinions expressed by the participants was purely caused by their choice of healthcare practitioners. Such feelings and perceptions were closely linked to many other contributors such as **Trust and Respect**, **Internal Source of Knowledge** and other **External Source of Knowledge**, as previously discussed. For example, Evon who has criticised the role of healthcare practitioner as an **External Source of Knowledge**, relied heavily, if not solely, on Friends And Family as her trusted source of healthcare information. In contrast, Zack viewed Healthcare Practitioner as his main **External Source of Knowledge** and indicated no issues with the **Level of Communication** when receiving healthcare services and a complete **Trust and Respect** between him and his healthcare practitioners.

While the in-depth discussion combining thematic findings under the overall research context will be conducted in the next chapter, the brief analysis above, into the connections among the underlying categories, has revealed some interesting internal relationships between the participants, the external environment and the healthcare information, as well as how they may influence participants' understanding of healthcare knowledge and *Healthcare Awareness*. Such understanding and awareness may come from a number of sources including Publications And Media, Friends And Family and Healthcare Practitioners.

Overall, the general feelings expressed by the participants towards healthcare related **External Source of Knowledge** were divided. Between the three sub-categories, most participants heavily relied on their Friends and Family as their main source of external healthcare knowledge, while many struggled to obtain relevant information from other sources to meet their needs. As Well noted:

> For health promotion there is not enough, certainly can be improved. Especially information about how to keep healthy and information about your well-being. There is a lot of this kind in China. Like how much vitamin you are recommended to take etc. But in New Zealand, I don't see there, not from GP, not from hospitals. [Well 4:17]

However, it is unjustified to simply conclude that the information shortages felt by the participants truly reflected the effort and input of health education and promotion in New Zealand, as the study has also identified large degrees of variation between the individual participant's willingness and ability to actively seek out and utilise **External Source of Knowledge**. Mel for example, has successfully acquired and made use of healthcare information to her advantage from a number of different sources.

This section has uncovered the means through which one may come to the self-understanding of healthcare related issues from both **Internal Source of Knowledge** and **External Source of Knowledge**. The following theme, *Healthcare Attitudes*, will identify personal attitudes affecting Chinese immigrants' healthcare decision-making.

Healthcare Attitudes

The ultimate objective of this research is to uncover Chinese immigrants' perspectives, as a minority group in New Zealand, regarding their level of healthcare services utilisation and consequently their overall health status living in this country. The most critical component to achieve such objective is to identify and understand the contributing factors which may influence the Chinese immigrant's healthcare decision-making; in other words, a process that is driven by their healthcare attitudes. During the analysis of *Healthcare Attitudes*, three major categories emerged including **Attitudes towards Family Health**, **Attitudes towards Self-care** and **Attitudes towards**

Financial Consideration. These will be discussed in turn.

Attitudes towards Family Health

As mentioned in the previous theme, *Healthcare Awareness*, the Chinese population has a defining characteristic of 'family-orientation'. In terms of healthcare, this awareness has led to particular attitudes towards the priorities in decision-making when seeking medical help and services. Interestingly, it was found that almost all participants regarded the health and healthcare of their family members as the greatest importance:

> In my family, I have parents and I have kids, (healthcare services) to them these are very important. Because people at older age, like my parents, my in-laws, they have heart problems, high blood pressure and they have chronic illnesses. They need to visit doctors regularly, every 3 months or anytime if they need or don't feel comfortable… It (healthcare services) is also important to our kids… I mean, these practices maybe it was ok for an adult but when they suggest that we might just have to wait it out for a little child, we'll get so worried… Most of the time, it's me taking my kids or parents to doctors… Like me, I care more about my kids and my parents. [Mel 1:2, 3, 24, 25, 26]

> I think they (healthcare) are extremely important. To us, health is one of the primary concerns, it's something we really care… especially to our family because my wife doesn't have a good health and we are very sensitive to any healthcare changes… I don't see doctors that often but my wife does and she really needs a good GP…My wife is on long term medication, when the prescription runs out, usually about 3 months or so… then we go see the doctor. [Zack 6:1, 6, 7]

Unlike previous analyses where there were certain degrees of variation in views and opinions, all participants under this category uniformly agreed that the health of their families was their top priority in making healthcare related decisions. They were extremely concerned about the wellbeing of their parents, partners and children, in particular. Many participants such as Evon and Well indicated their hesitation in utilising healthcare services unless it was for their family members. Such overwhelming **Attitudes towards Family Health** have raised the question of how does one consider the importance of self-care by comparison?

Attitudes towards Self-care

In contrast to the positive and proactive attitudes towards the health and wellbeing of their families, participants of this study were found to be much less sensitive to their own healthcare needs. A number of reasons that have contributed to the unwillingness of accessing and utilising healthcare services for their own good have been discussed. Some of these attitudes were closely linked and influenced by previously discussed themes and categories, such as participants' interactions with the healthcare system and their self-understanding of healthcare related issues. For example, There Is An Old Saying and Embedded State Of Mind as part of **Internal Source of Knowledge** from *Healthcare Awareness* clearly contributed to the **Attitudes towards Self-care** of participants:

> To myself, I'm still quite young and I don't need to see doctors that often so it doesn't make too much difference for me. But seeing the doctor does provide a sense of comfort, or trust, sometimes… I really try not to see doctors as much as possible, unless I feel really unwell, and it's not getting better for like 3-5 days, then I'll go. Most of the time, it's me taking my kids or parents to doctors. [Mel 1:4, 25]

> Because I'm still young, I won't have much health issues. My work and other issues in life are more important… Because I'm still young, I won't need these (medical) services so I never had it (regular GP)… I guess it's because of the (Chinese) traditions, "any medicine is itself a toxin", if my body can heal itself, or let's say everybody knows what their bodies can do to some degree, for example a mild flu, I just take some Chinese herbal medicine, rest a bit and I'll be back on my feet, there is no need to go to a doctor. [Evon 2:1, 3, 5]

> (Healthcare to myself is) Not that important I think. If I have minor sickness, most of the time I'll just take some cold medicine or antibiotics myself. Unless something serious happens, like my kid got sick, I wouldn't really want to go to doctors, or hospitals. I think I'm still quite influenced by Chinese traditions, we don't like to see doctors if not necessary. I bring common medicines from China and they solve my problems most of the time. [Well 4:4]

It is apparent that some Chinese traditions, cultures and mentalities fundamentally impact on the **Attitudes towards Self-care** by the Chinese participants. Such attitudes were dominated by avoidance and even denial to the necessity and importance to the health and healthcare needs of one-self. Many participants repeatedly mentioned the influence of Chinese traditions such as the tendency of staying away from doctors and hospitals as much as possible, as well as the belief of leaving minor health conditions up to their body systems to deal with in a natural way. In addition to attitudes affected by

participants' *Healthcare Awareness*, their previous experiences interacting with the *Healthcare Services Delivery* and *Patient-Practitioner Relationships* were also found to have contributed to their attitudes in making healthcare decisions from the interviews:

> I don't even consider going to the doctors for small things because it wouldn't help even if I did. My kids often getting fevers when they were young, the GP here wouldn't do much apart from what I just said (ask you to drink water, take rest, etc). Even if it may be some sort of infection, they rarely prescribe antibiotics or anything, unless you strongly ask them to. [Mel 1:23]

> It is completely different to what it was in China that I just can't get use to or adapt to… When I do get sick and had to visit my GP, it really costs a lot of money… it doesn't really always help with my conditions anyway… Generally, if I feel that I can just take some medication myself and be all right then I won't go see doctors. Because in New Zealand, GPs always only give you Panadol anyway, there's no need to spend money getting it from doctors. If I don't get better after taking medicine myself after a while then I may go see doctors. [Sharon 3:2, 8]

> I will deal with it my own ways, use antibiotics that I brought from China and make my own decisions…When you get flu for a while, especially cough for a long time, by the Chinese way of treatment, you need antibiotics. I know it's not always right, you may get dependent on it or develop resistance to antibiotics, but they are effective in daily lives. [Jacky 5:10, 14, 31]

During previous discussions of the interactions between Chinese patients and New Zealand healthcare system, potential barriers such as the **Level of Communication** in the process of service delivery and the differences in **Conceptual Understanding** of how certain conditions are treated have influenced access to and utilisation of healthcare services. These concerns and their impacts on the personal **Attitudes towards Self-care** were consequently reflected in the above statements made by the participants. For example, the differences in treating common conditions such as flu and fever between the two countries have led to the shift in participants' attitudes away from getting prescriptions from local healthcare practitioners to treating themselves using medications brought from China. It seemed to be a common perception that participants were not able to acquire the kind of services they were accustomed to from previous life experiences which resulted in further decreased willingness and desire to seek healthcare services in New Zealand. Furthermore, it was identified that some participants have questioned the value for services from a financial perspective which may negatively impact their **Attitudes towards Self-care** and consequently affect the utilisation of healthcare services.

Attitudes towards Financial Consideration

Throughout the interviews, phrases as *"it really cost a lot of money…", "there is no need to spend money…"* [Sharon 3:2, 3.8], suggested that some participants were concerned about the financial cost of accessing and utilising healthcare services in New Zealand. However not all participants shared this concern; in fact, many of them were quite satisfied with certain aspects of the healthcare pricing systems:

> The enrolment… I think it was because you get cheaper price if you enrol. [Well 4:11].
>
> It is primarily because of a cheaper price (after enrolling with GP). [Jacky 5:8].
>
> Their (GP) charges are quite reasonable as well. [Zack 6:5]

Furthermore, when the financial concerns towards healthcare was first identified from previous survey results (see Question 2.1, Chapter 4, p. 63) and earlier interview analysis, it was suspected that the Chinese immigrants may have been conservative in their attitudes towards healthcare spending. However, a careful review of their opinions relating to this issue revealed otherwise; as Mel explained *"I think the (healthcare) results is what I care the most. To me, if it is something to do with your body, your health, price is the last thing to worry about"* [1:29]. Such findings indicated that the financial considerations of healthcare were not simply caused by pricing issues or conservative spending alone. This raised the question of what was the main contributor that has led to the negative attitudes and dissatisfaction towards healthcare services from the financial perspective. A more in-depth examination of interview transcripts suggested that the cost-effective concern was more dominant in steering the **Attitudes towards Financial Consideration** of healthcare services, as participants described:

> For example, I had some minor scald before and was considering going to the doctors. But I felt that the condition was not worth spending the money and time, so I decided to get some simple cream and handle this myself. [Evon 2: 17]
>
> When I do get sick and had to visit my GP, it really costs a lot of money… And the worst thing is, it doesn't really always help with my conditions anyway [Sharon 3:2]
>
> About specialists, I feel that they are not so good. It was only a 15-minute session (with the specialist) and the diagnosis wasn't conclusive anyway but I got charged $300. [Jacky 5: 10]

From the above statements, it was clear that some of the participants were disappointed at the outcomes and value for money of the healthcare services for which they have paid. These negative experiences have directly impacted the judgement of the cost-effectiveness of healthcare services and consequently affected their future decision-makings in seeking medical help. Again, the driving forces behind such attitudes were closely linked to previously identified barriers in accessing healthcare services such as the misalignment between participants' expectations and the service's delivery of healthcare practices.

In addition to the financial consideration of receiving healthcare services, the cost of prescriptions and medication was also found to be a significant contributor in terms of participants' attitudes and healthcare decision making, as Sharon and Zack described:

> They (medicine brought from China) are mostly flu medicines, for fevers, cough. Sometimes they can be quite expensive here, and you may need prescriptions. Also antibiotics, and something for diarrhoea. Some of these I can't find them here. I bring some Chinese medicine too, also very hard to get in New Zealand but they work really well and very little side effects. [Zack 6:14]

> After seeing doctors in China, I'll bring the medications back (to New Zealand). They are also quite a bit cheaper from a financial perspective, more suitable to yourself as well. [Sharon 3:17]

The high cost of medication in New Zealand was strongly associated with the decisions by the Chinese immigrants to bring their own treatment from overseas, which confirmed the survey results in which over 22% of the 71% of respondents who had imported medications for self-use, indicated the high cost being one of their primary motivations (see Question 10, Chapter 4, p. 77).

Healthcare Awareness and Healthcare Attitudes: Summary

This chapter has presented the analysis of the second layer of contributing factors towards Chinese immigrants accessing and utilising healthcare services in New Zealand. This layer primarily focused on the intrapersonal relationship or the internal aspects of participants in terms of their *Healthcare Awareness* and *Healthcare Attitudes* which formed the two major themes contributing to participants' healthcare decision-makings.

The *Awareness* of healthcare information and knowledge comes from a wide range of sources, both **Internal** and **External**. The traditional Chinese upbringing and mentality are an intrinsic part of the Chinese culture and an **Internal Source of Knowledge** was highly valued by the participants. However, under the New Zealand healthcare context, the misalignments and conflicts between such beliefs, and that of New Zealand reality, have presented challenges for the participants to relate to the local healthcare system. In an attempt to close the gaps, many Chinese immigrants have tried to acquire supplementary information from **External Source of Knowledge**. Unfortunately, barriers and difficulties such as language issues and ineffective communications with healthcare practitioners have undermined their ability to obtain useful advice from the public domain such as Publication And Media or their GPs. Instead, many Chinese immigrants resorted to the narrow social circle of their Friends And Family within the Chinese community.

The shortcomings of *Healthcare Awareness*, combined with the previously identified issues concerning the interactions between Chinese immigrants and the New Zealand healthcare system, were reflected in the negative impacts on the *Healthcare Attitudes* towards the decision-making process when seeking medical services. While the 'family-oriented' Chinese culture values have led to the extreme level of care in **Attitudes towards Family Health**, which positively contributed to the level of access and utilisation of healthcare services, the **Attitudes towards Self-care** together with **Financial Considerations** were seriously impaired by the much decreased willingness in seeking medical assistance. To fully understand the underlying contributors that have caused the denial in attitudes and the under-utilisation of healthcare services, a comprehensive discussion taking into account and linking together findings from all thematic analysis and survey results must be conducted in respect to the context of this research as well as relevant literatures, which will be the primary task of the next chapter.

CHAPTER 7: DISCUSSION AND CONCLUSION

Introduction

In Chapters Four to Six, issues concerning access and utilisation of healthcare services by Chinese immigrants, and the contributing factors pertaining to their healthcare decision-makings, have been explored and analysed using a qualitative descriptive paradigm.

In this chapter, pertinent findings are drawn together to answer the research question and objective. This chapter is divided into three sections. The first section recapitulates the critical findings of the thematic analysis combined with survey results in an attempt to capture their internal relationships and extract the most concerning issues. These issues are addressed in the second section in relation to current literature. The implications within the New Zealand context are discussed. The last section will consider the strengths and limitation of the current study and make healthcare practice, policy and future research recommendations.

Drawing the Findings Together

Guided by the selected methodological framework and chosen research methods, the investigation of this study began with a set of specifically formulated survey questions designed to gather preliminary information about the target population. This information includes their personal background and general opinions towards their experiences when receiving healthcare services in New Zealand. The survey results were reported in Chapter Four where the most concerning issues were extracted to form guidelines for the in-depth interviews. During the survey data analysis, a number of difficulties and barriers to the access and utilisation of healthcare services were identified from the participants' responses and were mainly centred on two major aspects: the participants' interactions with the healthcare systems and interactions with healthcare practitioners.

In the second stage of interview data collection and analysis, participants were verbally given a set of personalised, open-ended questions relevant to their experiences identified from their survey answers. Interview transcripts were examined individually and cross-compared in groups for the systematic classification of common characteristics and the cause-and-effect relationships from the participants' experiences (Ulin, Robinson, & Tolley, 2005).

This process lead to the discovery of the first two major themes of this study: *Accessing Healthcare Services Delivery* and *Patient-Practitioner Relationship* as reported in Chapter Five. Among these findings, a number of particular concerns were expressed by the participants when interacting with various levels of healthcare services delivery throughout **Primary**, **Secondary** to the **Private** sectors of the healthcare systems. Participants raised Language issues when they were Getting Translated; they noted difficulties experienced Being In Emergency and expressed frustrations Waiting In Queue Or Paying The Price where Time Matters in their expectations towards evaluating How Good Is Good of the quality of healthcare services delivered to them.

The **Level of Communication** in a *Patient-Practitioner Relationship* was heavily criticised by the participants. They often found themselves Not Being Able To Explain to their healthcare practitioners or were let off Without Explanation. Such communication barriers were also impacted by the differences in **Conceptual Understanding** between patients and practitioners, which consequently undermined the **Trust and Respect** between the two parties, especially over the Chinese Way of treating certain health conditions.

Upon closer examination of the findings from the first two thematic analyses, it became evident that many of the difficulties and barriers experienced by the participants receiving healthcare services were fundamentally linked to underlying personal attributes specific to the Chinese population. Interview transcripts showed two additional themes arose based on 'intrapersonal' contributors in contrast to the 'interpersonal' interactions from the earlier themes: *Healthcare Awareness* and *Healthcare Attitudes*.

The investigation into participants' *Healthcare Awareness* began with their **Internal Source of Knowledge**, which was aimed at discovering how the Chinese way of upbringing may have impacted participants' frame of mind and their thinking towards healthcare related issues. The Chinese way of upbringing is heavily influenced by the Old Sayings in Chinese traditional education, which led to the conservative and Embedded State Of Mind that consequently affected the recognition and acceptance of a new healthcare system under a new environment.

The **External Source of Knowledge** was also explored from the perspective of Publication And Media Exposure, Friends And Family, as well as Healthcare Practitioners. Large degree of variations have been found in the participants' willingness and ability to utilise different sources of healthcare information along with a strong selective tendency over language preference and reliance on Chinese social circles when trying to acquire such information. The unique cultural and psychological attributes combined with unbalanced sources of healthcare knowledge have consequently affected participants' *Healthcare Attitudes*. It was found that many Chinese cultural beliefs such as 'family-oriented' upbringing have led to positive **Attitudes towards Family Health**.

On the other hand, **Attitudes towards Self-care** and **Financial Considerations** were seriously impaired by the other culturally related attributes such as the conservativeness and low level of self-awareness of the Chinese population.

Each of the four themes addressed one barrier relating to the access and utilisation of healthcare services experienced by the Chinese population. Although presented in a sequential order, these aspects, whether external or internal; interpersonal or intrapersonal, are not stand-alone factors but are inter-related. They share a set of underlying driving forces that ultimately contributes to the outcomes of healthcare decision-making. By examining the findings as a whole, three particular issues have been identified.

Environment and System

The transition from China to New Zealand is not always as smooth as participants expect. When accessing healthcare services, the new system bears little resemblance to what they were accustomed to and creates tension when something goes wrong with their health. The unsettling differences between the two countries are visible in almost every aspect of the healthcare service deliveries.

The first thing to strike participants was a completely new layer of healthcare known as the **Primary** sector which does not exist in China and, therefore, their **Internal Source of Knowledge** is challenged. The role of GPs and the process of referral into the **Secondary** healthcare system puzzled the participants in locating the first point of access to healthcare services. Examples of such confusion were readily seen from participants' experiences Being In Emergency services and the choices they faced between Waiting In Queue Or Paying The Price under the public healthcare system.

Differences were also seen in **Conceptual Understandings** over the perceptions of health status, medical standards and treatment styles in healthcare practices between the two countries. These disparities consequently impacted the **Trust and Respect** between participants and New Zealand healthcare practitioners, *Healthcare Awareness*, **Attitudes towards Self-care,** and **Financial Considerations**. Another heavily criticised aspect of healthcare service delivery by the participants was the lack of resources offered by the New Zealand public healthcare system. This resulted in considerable delays in treatment seen from the sub-category Time Matters.

To cope with such radical changes in healthcare environment and systems, many participants in this study resorted to various **External Source of Knowledge** in an effort to gain better understanding of the New Zealand healthcare systems. Trying to adapt to the changing realities, some participants attempted to make better utilisation of the **Private** sectors of the healthcare system by purchasing **Private Health Insurance**. Others decide to stick with the Chinese Way of healthcare by seeking TCM practices in New Zealand.

Language and Communication

The language barrier can be challenging for Chinese immigrants. Out of all relevant criterions in choosing healthcare service providers, Language becomes the priority consideration. Whether it is seeking a regular GP for **Primary** healthcare or Getting Translated to specialists in hospitals through the **Secondary** care system, having someone who can effectively bridge the language gap is crucial to *Healthcare Service Delivery* and *Patient-Practitioner Relationship*.

The majority of participants were successful in finding alternative solutions to overcome their language difficulties by either turning to healthcare professionals who speak the same language or making use of the translation services offered by the public healthcare system. These attempts bring critical improvements to the quality of receiving healthcare services that are widely recognised by participants.

However, additional language issues are apparent in the frustrations experienced by some immigrants when trying to acquire **External Source of Knowledge** related to healthcare. English-based information from many local healthcare practitioners, and mainstream Publication And Media Exposure, are poorly perceived by the participants due to language barriers. This consequently limits the source of information to their Friends And Family or Chinese community media who speak the same language.

The command of English language is not the only contributor affecting *Healthcare Service Delivery* and *Patient-Practitioner Relationship*. The ability to effectively communicate concerns and expectations across to healthcare professionals also pose significant impact on participants' experiences in receiving healthcare services. Many participants often find themselves Not Being Able To Explain their perspectives fully to healthcare practitioners, that is not simply caused by language competency but rather a combination of differences in **Conceptual Understanding**. The Chinese traditions and upbringing from their **Internal Source of Knowledge** results in the mis-**Communication** which ultimately leads to the negative **Attitudes towards Self-care**.

Participants experienced difficulties obtaining healthcare information and receiving advice from **External Source of Knowledge**, like healthcare practitioners. The feeling

of being left Without Explanation is frequently observed in participants' encountering *Healthcare Service Delivery*.

The unwillingness of the healthcare practitioners to provide detailed explanation due to factors such as time constraints and stretched resources, combined with the submissive nature and hesitation to challenge medical staff from participants' **Internal Source of Knowledge**, subsequently contribute to the mis-**Trust** in *Patient-Practitioner Relationship* and their *Healthcare Attitudes*.

Culture and Tradition

Immigrant populations often bear strong ties to their countries of origin and bring distinctive traditions with them into their lives at the place of re-settlement. Such trends are particularly visible and significantly impact on the Chinese participants in this study.

As with issues discussed as part of the *Environment and System* and *Language and Communication*, many barriers related to receiving healthcare services share underlying *Culture and Tradition* implications. For example, the concerning **Level of Communication** is partly impacted by the conservative culture of Chinese participants where raising questions and disagreement to a professional in the field are considered inappropriate.

Many gaps in **Conceptual Understanding** relating to medical standards and methods of practice are also caused by differences to the Chinese traditional interpretation of health status and philosophy of treatment. However, the most apparent and profound issues with *Culture and Tradition* are seen in the areas of **Trust and Respect** between Chinese patients and local practitioners, **Internal Source of Knowledge** associated with healthcare, and resulting **Attitudes towards Family Health** and **Self-care**.

In terms of **Trust and Respect**, while most participants choose to engage with **Primary** healthcare providers from Chinese or Asian background, who are generally aware of health related cultural issues. The lack of cultural sensitivity from some New Zealand healthcare practitioners in the **Secondary** system is commonly seen, particularly with

hospital services such as maternity care for Chinese families. These differences are apparent from both survey and interview findings on the satisfaction levels of healthcare service deliveries between the two systems reported by participants.

Without appropriate cultural and traditional recognition in practice, the values and beliefs held strongly by the Chinese immigrants that form intrinsic part of their **Internal Source of Knowledge** are challenged.

The misalignment in *Culture and Tradition* between the two countries' healthcare practices undermined participants' willingness to seek medical assistance. As a result, the **Attitudes towards Self-care** taken by many immigrant patients shift away from mainstream healthcare to TCM. However, some local practitioners still remain sceptical of such choice and may even advise against it due to the lack of awareness and unfamiliarity towards the *Culture and Tradition* of Chinese medical practice. This further impairs the **Trust and Respect** between Chinese patients and local practitioners.

While some *Culture and Tradition* issues may negatively influence the *Healthcare Awareness* and **Attitudes towards Self-care**, other aspects of Chinese values and beliefs make positive contribution to the access and utilisation of healthcare services. The participants' **Attitudes towards Family Health** is one such example. The strong 'family-orientated' traditions of the Chinese population are visible from the concerns expressed by most participants of this study. Although their **Attitudes towards Self-care** may be impaired, the desire and willingness to seek medical assistance for their family members takes priority. Comparing the survey results and interview findings, reveals that most participants who were without regular GPs, all decided to enrol with Primary healthcare services when the needs of their family members required attention.

Situating the Findings within the Literature

In Chapter Two, a literature review of previous research concerning immigrant health and accessing healthcare services was conducted. The following sections discuss how the findings fit with existing literature in terms of similarities, disparities and new

insights.

Environment and System

Many studies have suggested that interactions between people and the external environment are a vital part of health (Dunn, 1959; Maslow, 1954). The stress and frustration experienced by the Chinese immigrants in this study supports Bhugra and Becker's (2005) proposition that the changes in the healthcare support system greatly affects the wellbeing of immigrants, both physically and mentally (McEwan & Lasley, 2002). Therefore, the importance of examining the differences in the social realities between the country of origin and settlement (Berry, 1997) is once again confirmed in this study.

In the context of New Zealand and China, the findings suggest many distinctive differences in how the two healthcare systems operate throughout **Primary**, **Secondary** and **Private** sectors. One particularly significant aspect is the differences in referral systems from **Primary** to **Secondary** care. The indistinguishable structure between **Primary** and **Secondary** care within China's healthcare system and the non-existence of referral mechanism seen from Chinese immigrants' previous experiences align with other studies on China's healthcare reforms (Hsiao, 1995; Wang, 2003).

The almost complete lack of **Private** insurance schemes in China (Grogan, 1995) is also confirmed. However, while most of these studies criticise the integrity and operability of China's general healthcare system as being "poor quality", and "insufficiently focused on public health" (Eggleston et al., 2008, p. 149) and "huge health care problems" (Blumenthal & Hsiao, 2005, p. 1165), the views and opinions of the participants in this study diverge. Very few complaints were made by the immigrants towards China's healthcare system.

The fact that most Chinese immigrants come from highly developed urban centres with advanced healthcare services (Liang & Morooka, 2004) supports the argument made by Zhuang and Tang (2001) that high level of medical services delivery are offered

although confined to urban areas and certain dimensions of quality in China. Such findings provide answers to questions regarding the healthy immigrant effect (McDonald & Kennedy, 2004; Rasanathan et al., 2006) and the Asian Paradox (Ministry of Health, 2006).

Instead of differences between system performances, the majority of reported problem areas are concerned with conflict in their **Internal Source of Knowledge** with the reality of New Zealand healthcare structure; the lack of **External Source of Knowledge** from which they can effectively acquire system related information; and the much stretched resources operated by the New Zealand public healthcare system (DeSouza & Garrett, 2005), apparent from findings Time Matters, Being In Emergency and Waiting in Queue Or Paying The Price.

Language and Communication

Language and communication is the key to Chinese immigrants' interactions with New Zealand healthcare services and healthcare practitioners. It determines the effectiveness and accuracy in diagnostic and treatment delivery, the outcomes of which also affect the trusting relationship between patients and practitioners, and consequently the willingness of Chinese immigrants in accessing and utilising healthcare services.

As suggested by Salant and Lauderdale (2003), language use and proficiency significantly impacts immigrant health in English speaking countries. The findings of this current study and other research revealed that a large proportion of Chinese immigrants admit having English language competency issues and find it difficult to understand medical terminologies and interpreting medical symptoms (Ma & Henderson, 1999; Wang, 2007; Zhang & Verhoef, 2002).

However, unlike existing literature which concluded that the language barrier is one of the most influential contributors to the decreased level of healthcare access and utilisation by immigrant population, the findings of this study suggest otherwise, especially in the **Primary** sector. While family doctors in New Zealand do not provide

translation services in **Primary** care which may present language difficulties (Wang, Rosenberg & Lo, 2008), the majority of participants in this study were found to be actively and successfully seeking Chinese speaking practitioners as an alternative solution.

This phenomenon is supported by Miltiades and Wu's (2008) research which found that English was not a significant predictor of **Primary** healthcare utilisation due to the high availability of Chinese speaking healthcare practitioners. Other than the **Primary** sector, language barriers are, however, visible in **Secondary** healthcare (Dunn & Morgan, 2001). This is most apparent from the findings in sub-category Getting Translated, where the quality and availability of translation services was questioned by the Chinese immigrants.

The effective acquisition of healthcare information from **External Source of Knowledge** is also a concerning issue. Due to the poor language proficiency, many Chinese immigrants are not able to obtain sufficient healthcare information from English based mainstream Publication and Media Exposure or from their English speaking Healthcare Practitioners, therefore limiting the source of knowledge within the Chinese speaking Friends and Family. This was also identified by Miltiades and Wu's (2007) study.

Effective communication between immigrant patients and local healthcare practitioners involves more than just speaking the same language. The differences in **Conceptual Understanding** and **Internal Source of Knowledge** over healthcare related practices such as healthcare philosophy and treatment styles meant that Chinese immigrants often found themselves Not Being Able to Explain or left Without Explanation, even when engaged with Chinese speaking practitioners or translators.

While current literature extensively addresses the language issue, in-depth discussions over the **Level of Communication** prove hard to find. Some studies have briefly touched on similar aspects (Abbott et al., 2000; Ngai et al., 2001) but tend to explain such communication issues from a cultural difference perspective. The findings of this study suggest that the main gaps preventing effective communication come from

clashes in understanding the role of healthcare practitioners and the procedural guidelines they follow in delivering medical assistance.

One particularly study conducted by Chan and Quine (1997), investigated the communication between Chinese immigrants and Chinese speaking general practitioners in Australia. The study included the internal knowledge of Chinese immigrants in understanding the role of ethnic health workers and how they operate under the Australian context as being one of the contributing factors. This partly supports the findings of this study.

Culture and Tradition

Among existing literature reviewed on the topic of Chinese immigrant health in New Zealand and internationally, the vast majority recognise culture and traditional considerations to be one of the central processes and underlying contributors affecting the health and healthcare utilisation for the Chinese population (Ngo-Metzger, Legedza, & Phillips, 2004). According to Berry's (1980) stress model, individuals' initial response to cultural clashes during integration may lead to significant adverse effects on immigrant health status.

The findings of this study reveal numerous forms of such culture clash and the negative impacts on the access and utilisation of healthcare services. They are most visible under the category of *Healthcare Awareness* and *Healthcare Attitudes*. When faced with such clashes, previous research suggested the phenomena of 'acculturation' as an outcome which "result when groups of individuals having different cultures comes into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (Redfield, Linton, & Herskovits, 1936, p. 149).

However, the findings of this study show that although some Chinese immigrants began to appreciate the New Zealand way of thinking and reality, and were prepared to compromise to fit in with the system, their core values and beliefs of Chinese culture and tradition remained strong and unchanged. This fits with Berry's (1997) proposition

that while some acculturation models result in declining and deteriorating health conditions and loss of original culture norms, other models may lead to improvement to the understanding of cultural gaps and better health status following the initial response to cultural clashes.

In exploring the origins of the cultural and traditional clashes, existing literature focuses on the two fundamental Chinese philosophies, Taoism (Ma, 1999; Wang, Rosenberg & Lo, 2008) and Confucianism (Kwok & Sullivan, 2007). Both are prominently seen from findings of this study in terms of Chinese immigrants *Healthcare Awareness* and *Healthcare Attitudes*. Taoism embraces the balance of Yin and Yang to form the foundation of TCM practices. Findings in this study clearly suggest the tendency of Chinese immigrants resorting to the Chinese Way of traditional medicine treatment (Hesketh & Zhu, 1997a) when beliefs from their **Internal Source of Knowledge** clashed with solutions offered by local healthcare practitioners, or to bring their own form of medication as alternatives to prescriptions obtained locally.

It was also found that many family doctors with Chinese background in the **Primary** sector hold positive views towards TCM practice. Some may even have related training in the field (Harmsworth & Lewith, 2001) which encourages diversity of healthcare service options and makes positive contributions to the ease of potential culture and tradition issues.

However, the **Secondary** level of healthcare services has seen increased tension in cultural and traditional clashes. This is largely due to the lack of awareness towards Confucianism that is central to Chinese mentality and cultural integrity. Core to Chinese Confucianism is the conservativeness and passiveness which form a set of guidelines in personal value and behaviour such as the ‘family-oriented’ philosophy and sensitivity to culturally related personal feelings (Ng, 2003). Reflected in the findings of this study, such instances are readily visible in the categories of **Level of Communication**, **Trust and Respect** and *Healthcare Attitudes*. Immigrant patients are finding it difficult to communicate their culturally and traditionally related concerns to local practitioners, and are feeling disrespected by some of the actions and responses from healthcare

providers.

The negative impact on the decision making process in seeking and accepting healthcare services due to the lack of awareness and understanding towards Chinese culture and tradition is supported by many high-profile studies including the Asian Health Chart Book (Ministry of Health, 2006) as well as DeSouza and Garrett's (2005) report on *Access Issues for Chinese People in New Zealand.*

Discussion and New Insights Arising from Study

A number of disparities and gaps have been identified for Chinese immigrants accessing and utilising healthcare services within the New Zealand context. Situating the current research results in relation to the literature confirms the fact that findings of this study both support and contradict existing understandings. Pursuing the three most significant areas of discussion presented previously, this study proposes the following new insights.

World class healthcare system does not guarantee accessibility and utilisation

The New Zealand healthcare system is recognised as one of the best in the world and has made remarkable improvements particularly since the 1991 (implemented in 1993) healthcare reform (Hornblow, 1997; Scott, 1994). Although the existing system has largely remained unchanged, it is still competitively comparable to countries such as UK and Australia (Seddon, Marshall, Cambell, & Roland, 2001).

By comparison, the healthcare system of China has been the subject of scrutiny and criticism by the international health research community, clearly evident from previous reviews and discussions. Given such apparently large disparities between the two systems in their quality and availability of services provided, it is reasonable to expect high levels of access, utilisation and satisfaction by Chinese immigrants entering the New Zealand healthcare system. However, the findings of this research showed the opposite. While most existing literatures successfully established links between

utilisation to potential barriers such as language and culture, few attempted to explore the difference between systems as a plausible cause to the problem. The findings of this research provide evidence that such differences indeed play a significant role in determining the level of healthcare utilisation by the Chinese immigrants.

One common misperception that often leads to the ignorance of system differences is the stereotype image of China's healthcare system being in a deficient state and incomparable to that of New Zealand. In fact, while the vast rural areas of China are yet to see functional healthcare systems (Wang et al., 2003), the urban centres in fast developing coastal areas have successfully established reformed healthcare policy framework and quality service delivery to meet regional demand (Zhuang & Tang, 2001). From the findings, it is clear that almost all Chinese immigrant participants come from areas of advanced development with good health status and high expectations of healthcare services and such expectations are key in getting across system barriers.

While the New Zealand public healthcare system has a particular vision for equity where "emphasis is placed on equal access to core services" and "fairness of targeting the government's limited resources to those who have poor health status and limited private resources" (Scott, 1994, p. 38), the Chinese provision for public healthcare system is focused on capacity and efficiency.

To reduce the load of limited public resources, the New Zealand healthcare scheme includes a separate **Primary** sector and a referral system which sometimes leads to considerable delays that may be complimented by the **Private** sector. Whereas in urban China, a centralised hospital system handles all public medical needs.

To boost coverage and efficiency due to the sheer size of population in China, accelerated measures are often employed such as the excessive use of antibiotics and prescription medication (Hsiao, 1995). Both systems have their pros and cons and are designed to accommodate realities in the social context under which they operate. But when Chinese immigrants enter New Zealand healthcare system with the expectations from their previous life experiences, seeking and utilising the new system gives rise to a new type of barrier.

Speaking the same language does not guarantee effective communication

The findings of this study, in contrast to most existing literature, reveal that the English language proficiency may not be a determining factor to the level of access and utilisation of New Zealand healthcare system by the Chinese immigrants. This is especially true in the **Primary** sector due to the high availability of Chinese speaking GPs combined with the translation services offered by the rest of healthcare system. However, the findings also show that speaking the same language does not necessarily translate into smooth and effective communication between immigrant patients and their healthcare services providers. Although this phenomenon is acknowledged by similar studies (McPhee et al., 1997; Miltiades & Wu, 2008; Ying & Miller, 1992), the causes were poorly understood. By examining the findings of this study, two possible explanations become evident.

In terms of immigrant patients finding themselves Not Being Able To Explain their concerns to the healthcare providers, having Chinese speaking practitioners does not mean they fully appreciate the differences in **Conceptual Understanding** relating to the health and healthcare services. Chinese immigrants share a unique comprehension towards the concept of being healthy and unwell, strongly influenced by their **Internal Source of Knowledge** from their earlier upbringing before migration that may be difficult for western trained practitioners to interpret.

Although the practitioners may speak the same language or have Chinese related background, few of them are Chinese immigrants themselves who spent time growing up or being medically trained in China. Even Chinese ethnic doctors from regions like Hong Kong, Singapore and Taiwan who form the majority of Chinese speaking GPs in New Zealand, come from very different environments and do not meet the strict definition of ‘Chinese’ used in this study. As Ngai et al. (2001) stated, people who identify themselves as ‘Chinese’ are a heterogeneous group with different set of values, cultural and socio-economic background.

Additionally, Chinese immigrants also find themselves being left Without Explanation

by their healthcare providers when their expectations are not met. In this consideration, it is the Chinese immigrant patients who do not have a clear understanding of how New Zealand practitioners are trained to respond to patients' needs.

Compared to the Chinese doctors' strong intervention approach, New Zealand healthcare practitioners tend to take preventative measures deemed appropriate to the health conditions without unnecessary over-reactions. Such practices often results in the Chinese immigrants' misperception towards local practitioners being less experienced or even incompetent where in fact, New Zealand doctors are highly trained and follow a rigorous set of procedural guidelines and code of conduct.

On the other hand, the poor English language proficiency of the Chinese immigrants also contributed to the difficulties in getting **External Source of Knowledge** towards the approach taken by New Zealand practitioners which may assist with better understanding and communication in building **Trust and Respect** relationships between the two parties.

Cultural sensitivity does not guarantee cultural understanding

The issue of cultural awareness and sensitivity in medical practice has been extensively researched in healthcare literature nationally and internationally. Recent studies on immigrant health, in respect to the Chinese population conducted in New Zealand, uniformly agree that cultural barriers play a significant role in preventing the effective access and utilisation of healthcare services (DeSouza & Garrett, 2005; Ministry of Health, 2006; Ngai, Latimer & Cheung, 2001). To address the issues, government bodies and professional associations have introduced specific legislation, policy frameworks and guidelines to ensure adequate level of cultural awareness and sensitivity in healthcare practices. These include the Health Practitioners Competence Assurance (HPCA) Act 2003 (Section 118i) and the Core Standards for Doctors in Cultural Competence and Patient-centred care (Chapter Four) by the Medical Council of New Zealand (St George, 2011).

Despite such efforts, evidence of cultural barriers to receiving healthcare services are still visible in everyday practices; reasons for which remain inconclusive. The findings of this study suggest a possible explanation.

While most New Zealand healthcare practitioners are trained to recognise the importance of cultural and traditional issues in practice, it appears that such guidelines do not serve its purpose adequately beyond merely conforming to a simple checklist of ethical conduct. The findings of this study show no apparent act of discrimination or disrespect towards the Chinese culture and tradition by the healthcare practitioners. However, in-depth understanding and appreciation of the Chinese cultural values and beliefs are absent during interactions with immigrant patients, particularly in the **Secondary** sector such as maternity care in public hospitals.

Many healthcare workers do not seem to understand that views and perceptions of health and care may have multiple meanings depending on the cultural and traditional background individuals come from (Davis & Dews, 1999). Nor do they realise the philosophies of Chinese culture such as Taoism and Confucianism means that Chinese individuals make assumptions and interpret the actions of healthcare providers entirely differently under their cultural context. Such misalignment in expectation and lack of true cultural understanding directly leads to the feeling of ignorance and mistrust which may deter further utilisation of healthcare services.

Overall, the new insights arise from this study reflect the most important and significant findings in terms of the three identified areas of concerns. Some of the discoveries support and reinforce propositions from existing literatures but more importantly, new perspectives have emerged contributing to the knowledge of immigrant healthcare while also suggesting the need for further research.

Strengths and Limitations of the Study

In Chapter Three, the rigour and trustworthiness of this study were discussed. The criteria proposed by Lincoln and Guba (1985) in assessing the integrity of qualitative

studies was selected and employed to evaluate the credibility, dependability, confirmability and transferability of this research project. However, this previous discussion was conducted from a research design and methodological point of view. The actual research process including data collection and analysis have brought new aspects of strengths and limitations of the study which will be discussed following the same set of criteria.

Credibility and Dependability

The most important measure of credibility of a qualitative descriptive study depends on ensuring the experiences described by the research participants are truly theirs without pre-assumptive positions taken by the researcher (Lincoln & Guba, 1985).

The initial stage of survey data collection and analysis seemed to suggest the most concerning barriers to access to healthcare services and utilisation are among language, waiting times and practitioner competency. This was in-line with the researcher's assumptions and expectations, as well as existing knowledge drawn from literature reviews before the commencement of the research process.

However, after listening to the participants' case-by-case encounters and exploring the real-life scenarios during the second stage interview process, it became evident that the preliminary survey findings were not entirely accurate. For example, the reason why language was stated by the highest number of participants as a barrier to access and utilisation was not simply referring to English proficiency but rather the troubling **Level of Communication** and differences in **Conceptual Understanding** experienced by the participants.

The simplicity constrained by the short-answer type of survey question design was not sufficient to fully reflect the underlying implications. Similarly, the concerns over waiting time and practitioner competency were later found to be reflections of system barriers and inadequate cultural understandings. The recognition in such development in findings as the research progresses through different stages ensured high level of

reflexivity of the study and avoided potential bias arising from researcher's pre-existing beliefs and expectations (Schneider et al., 2003).

The credibility and dependability of the study was also enhanced by employing multiple research methods and techniques including survey and interview, combining the strengths from both quantitative and qualitative perspectives (Mason, 1996; Rice & Ezzy, 1999), which also avoids "the personalistic biases that stem from single methodologies" (Denzin, 1970, p. 300). Another contributor to promoting credibility and dependability was the honesty and accuracy in documenting participants' life experiences for what they are without subjective interpretation, as well as returning to the participants with research findings for verification and feedback on the accuracy of documentation and understanding.

The extraction and forming of themes, categories and sub-categories were coded with participants own words wherever possible which helped to ensure that they were the true reflection of participants' original views and opinions. When copies of interview transcripts were provided to the participants for review, no report of inaccuracies or misinterpretations were made which further support the dependability of this study.

Transferability and Confirmability

Compared to the relatively strong credibility and dependability, the transferability and confirmability present a certain level of weaknesses of this study. Some may be significant and questionable due to the study design, scope and constrains in resources at the master's level of study.

In terms of transferability which concerns the applicability and validity of study findings when transferred to other context (Polit & Hungler, 1997; Trochim, 2002), the limited sampling size of this research is not sufficiently large enough to be extended into other social contexts. The unique characteristics of the Chinese immigrant population including language, culture and other country-specific background means that making generalisation of the findings from this research into other ethnic immigrant

population may not be a sensible and justifiable practice. In addition, the discussions presented in this research in terms of Chinese immigrants' interaction with the healthcare services were only relevant under the context of New Zealand healthcare system and if given a different social environment may not produce the same results.

However, under the clearly defined settings and methodological framework particularly specified for this study, the outcomes concluded by the research has established sound structure, analysis and justifications which support the validity and make valuable references for similar future studies on immigrant healthcare under different context.

According to Lincoln and Guba (1985), the achievement of confirmability takes into account all previous criteria including credibility, dependability and transferability combined with other contributing factors that may be related to quality of research conduct and validity assurances. In addition to earlier points raised, the confirmability of this study is also affected by a number of practical issues. From a data collection point of view, the researcher's novice experience and skills in conducting survey and interview based studies may restrict the comprehensiveness of the question designs and consequently the density of data collected. The survey and interview techniques only captures past experiences up to the point of data gathering which are not able to predict future development or changes in views and opinions of individuals. This weakness was reflected in the variations seen from participants' awareness and attitudes in the findings of the study.

While every effort is made to randomise the sampling group of participants to ensure fair coverage in demographical characters such as age, gender and other socio-economic determinants defined by the collection criteria, the small sample size still presents questions about the representativeness of the Chinese immigrant population as a whole. Further sampling and extended period in research time span may help to improve the robustness and confirmability for this research.

While the findings and discussions of this study clearly present both strengths and limitations, there is no perfectness in research validity and rigour. The careful consideration and selection of research methods and techniques combined with ethical

conduct of the research process have contributed to the better understanding of issues surrounding the access and utilisation of healthcare. It reveals implications for the study of Chinese immigrant health, policy makings to remove healthcare barriers and guidelines for cultural-specific medical practices.

Implications of this Study

Implications of Chinese Immigrant Health Studies and Future Research

The findings of this study reveal the uniqueness and complexity of Chinese immigrant health and the issues relating to the effective access and utilisation of healthcare services in New Zealand. The results of the research confirms the increasing importance of healthcare needed by the Chinese immigrant population within the context of New Zealand healthcare system and supports previous findings that there exist significant barriers and difficulties for Chinese immigrants in accessing and utilising healthcare services (DeSouza & Garrett, 2005; Ministry of Health, 2006; Ngai, Latimer & Cheung, 2001).

However, the origins of such barriers and difficulties were conflicting within literatures and the reasons remained inconclusive. This study takes into account the inconsistencies in views held by different research and tries to identify the roots to the issues by exploring deep into the mindset and life experiences of the Chinese immigrants and listening to what they had to say for themselves. The argument begins with the healthcare status of the Chinese immigrants and the disparities in healthcare systems between the two countries.

By comparing the findings of this study to that of existing literatures, it becomes clear that a large number of research efforts on Chinese health and healthcare systems were making assumptions and over-generalisation about health and healthcare related realities in China which have led to unexplained phenomenon such as ‘healthy immigrant effect’ and the ‘Asian Paradox’ (McDonald & Kennedy, 2004; Ministry of Health, 2006; Rasanathan et al., 2006). In fact, reasonable explanation may lie with the

unbalanced regional development of healthcare system in China as well as the different approaches taken by policy framework and guidelines to practice. This calls for more independent, comprehensive and in-depth research into China's social context and reality.

In terms of identifying and removing language and cultural barriers, the conclusions drawn by existing literatures were also highly controversial. As the findings of this study suggested, the understanding over how language and cultural related issues may contribute to the access and utilisation of healthcare system involves multiple considerations rather than the simple assessment of English proficiency. The inconsistency of survey results and interview findings in terms of language and cultural issues seen from this study have suggested that the over-reliance on large scale survey based questionnaire with simple "Yes or No" type of design employed by many current research are not sufficient enough to fully investigate the cause of the difficulties and barriers thus requiring combinations of robust research methods and techniques for more comprehensive enquiries in future studies.

Implications of Policy Support, Practice Guidelines and Healthcare Promotion

The New Zealand healthcare system and associated policies has continuously evolved with improvements made to meet the needs of changing environment and social realities (Hornblow, 1997; Scott, 1994; Seddon, Marshall, Campbell, & Roland, 2001). With the recent influx of Chinese immigrants, the local healthcare system has seen challenges in terms of both accommodating the load and meeting the needs of immigrant patients (Department of Labour, 2009; Ho et al., 2002; Statistics New Zealand, 2006a; Walker et al., 1998).

The findings of this research has clearly shown deficiencies in current policy frameworks and standard of practice supporting the effective delivery of healthcare services to the Chinese immigrant population in both **Primary** and **Secondary** sectors. Each of the three most concerning issues identified by this study pertaining to the difficulties in accessing and utilising healthcare services will require changes to be

made to remove such barriers.

In terms of addressing system barriers, local healthcare practitioners need to be trained in understanding the importance of immigrants' backgrounds, previous experiences and the resulting expectations in receiving medical assistance. Filling the gaps in **Conceptual Understanding** and appreciating the patients' **Internal Source of Knowledge** will help to ensure more customised responses to Chinese immigrants and consequently building a better **Trust and Respect** relationship between the two parties.

Multi-lingual support in healthcare practice, particularly within the **Secondary** sector, is also required. While there appears to be a sufficient number of Chinese speaking GPs in the **Primary** healthcare, practitioners with such background should be encouraged to advance into the **Secondary** system where shortages are most apparent. Additionally, Chinese language based healthcare promotional materials requires increased coverage in distribution through the mainstream Publication and Media Exposure as well as frontline Healthcare Practitioners to provide more options of **External Source of Knowledge**, in an effort to boost *Healthcare Awareness* and improve *Healthcare Attitudes* of the Chinese immigrants.

With respect to cultural understanding, changes need to be introduced to how healthcare practitioners are trained to recognise culturally sensitive issues, the impact of changes in cultural context, and more importantly the awareness of underlying cultural values and beliefs held by Chinese immigrants. The current versions of policies and guidelines for cultural competency in practice do not include specific instructions in dealing with any other ethnic group except Maori, which require adjustment to reflect the changes in population diversity and the recognition of 'cultural safety' in healthcare practice (DeSouza & Garrett, 2005).

Summary

This study set out to explore the Chinese immigrants' experiences interacting with New Zealand healthcare systems with the aim to identify difficulties and barriers in accessing

and utilising local healthcare services. It has revealed answers that are founded on the understanding of Chinese immigrants' characteristics including their personal backgrounds, social status and abilities, as well as cultural values and beliefs. By analysing these contributing factors in terms of Chinese immigrants' experiences, awareness and attitudes in receiving healthcare services and how the outcomes of such interactions may impact on their healthcare decision-making process, new insights and perspectives have emerged.

Core to the findings of this study are three most significant considerations: the misaligned expectations due to system differences; the troubled communication due to disparities in language proficiency and conceptual understanding; and the lack of culture recognition and sensitivity in healthcare practice. Such conclusions highlighted the importance of addressing those issues creating barriers to effective use of healthcare services by the Chinese immigrants, and potentially informed us of areas that could be further improved within the New Zealand healthcare systems which may have been previously overlooked.

REFERENCES

Abbott, M. W., Wong, S., Williams, M., Au, M. K., & Young, W. (2000). Recent Chinese migrants' health, adjustment to life in New Zealand and primary health care utilization. *Disability and Rehabilitation, 22*(1-2), 43-56. doi:10.1080/096382800297114

Ashton, T. (2002). Running on the spot: Lessons from a decade of health reform in New Zealand. *Applied Health Economics and Health Policy, 1*(2), 97-106. Retrieved from http://adisonline.com/healtheconomics/pages/default.aspx

Ashton, T. (2005). Recent developments in the funding and organisation of the New Zealand health system. *Australia & New Zealand Health Policy, 2*(9), 1-8, doi: 10.1186/1743-8462-2-9

Asian Public Health Project Team. (2003). *Asian public health project report February 2003*. Retrieved from Asian Health website: http://www.asianhealth.govt.nz/Publications/AsianPublicHealthProjectReport.pdf

Awofeso, N. (2005). *Re-define 'health'* (Bulletin of the World Health Organisation). Retrieved from http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/

BBC. (2010). *BBC country profiles*. Retrieved from http://news.bbc.co.uk/2/hi/country_profiles/default.stm

Berg, B. (1995) *Qualitative research methods for the social sciences* (2nd ed.). Boston, MA: Allyn and Bacon.

Berry. J. W. (1980). Social and cultural change. In H.C. Triandis & R. Brislin (Eds.), *Handbook* of *cross-cultural psychology, Vol.* 5 (pp.211-279). Boston, MA: Allyn & Bacon.

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review*, *46*(1), 5-34. doi:10.1111/j.1464-0597.1997.tb01087.x

Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry, 4*(1), 18-24. Retrieved from http://www.wpanet.org/detail.php?section_id=10&content_id=421

Blumberg, L. J. (2006). *The effect of private health insurance coverage on health services utilisation in New Zealand*. Retrieved from http://www.fulbright.org.nz/voices/axford/docs/axford2006_blumberg.pdf

Blumenthal, D., & Hsiao. W. (2005). Privatization and its discontents: The evolving Chinese health care system. *The New England Journal of Medicine, 353*(11), 1165-1170. Retrieved from http://www.nejm.org/

Bowling, A. (1997). *Research methods in health: Investigating health and health services*. Buckingham, England: Open University Press.

Brannen, J. (1992) Combining qualitative and quantitative approaches: An overview. In Brannen, J. (Eds.), *Mixing methods: Qualitative and quantitative research*. Aldershot, England: Avebury.

Bruton, G. D., Ahlstrom, D., & Wan, J. C. C. (2003). Turnaround in East Asian firms: Evidence from ethnic overseas Chinese communities. *Strategic Management Journal*, *24*(6), 519-540. doi: 10.1002/smj.312

Butler, P. (1977). *Opium & gold*. Martinborough, New Zealand: Alister Taylor Publishing.

Chan, Y. F., & Quine, S. (1997). Utilization of Australian health care services by ethnic Chinese. *Australian Health Review, 20*(1), 64-77. Retrieved from http://ahha.asn.au/publication/journal/australian-health-review-ahr

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R. M. Emerson (Eds.), *Contemporary field research: A collection of readings* (pp. 109-128). Boston, MA: Little, Brown and Company.

Chenitz, W. C., & Swanson, J. M. (1986). *From practice to grounded theory: Qualitative research in nursing*. Menlo Park, CA: Addison-Wesley.

China Ministry of Health. (1989). *Health statistics information in China, 1949-88*. Beijing, China: China Ministry of Health.

China Ministry of Health. (2007). *Ministry of health official document 2007-16*. Retrieved from http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohghcws/s3573/200804/16459.htm

China National Bureau of Statistics. (2002). *Tabulation on the 2000 Population Census of the People's Republic of China*. Beijing, China: China Statistics Press.

Collins English Dictionary. (2010). *Immigration*. In Collins English Dictionary – Complete & Unabridged 10th Edition. Retrieved September 24, 2010, from http://dictionary.reference.com/browse/immigration

Coolican, H. (1990). *Research methods and statistics in psychology*. London, England: Hodder & Stoughton.

Creswell, J. W. (2003). *Research design: Quantitative, qualitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St. Leonards, Australia: Allen & Unwin.

Davis, P., & Dew, K. (Eds.). (1999). *Health and society in Aotearoa New Zealand*. New York, NY: Oxford University Press.

Denzin, N.K. (1970). *The research act: A theoretical introduction to sociological methods*. Chicago, IL: Aldine.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1998a). *Strategies of qualitative inquiry*. Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1998b). *Collecting and interpreting qualitative materials*. Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *The SAGE handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *The landscape of qualitative research: Theories and issues*. Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The SAGE handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Department of Labour. (2010). *International migration outlook – New Zealand 2009/10*. Retrieved from http://www.dol.govt.nz/publications/research/sopemi/2009-2010/imo-2009-2010.pdf

Department of Labour. (2009). *Key findings from the migrants survey 2009: Migrants survey (pilot) – immigration survey monitoring programme*. Retrieved from http://www.dol.govt.nz/publications/research/migrants-survey2009-key-findings/migrants-survey2009-key-findings.pdf

DePoy, E., & Gitlin, L. N. (1998). *Introduction to research: Multiple strategies for health and human services* (2nd ed.). St. Louis, MO: Mosby.

DeSouza, R., & Garrett, N. (2005). *Access issues for Chinese people in New Zealand* (Report prepared for Accident Compensation Corporation). Retrieved from Asian Health website: http://www.asianhealth.govt.nz/Publications/Access_Issues_for_Chinese_people_in_NZ.pdf

Diez-Roux, A. V. (2000). Multilevel analysis in public health research. *Annual Review of Public Health, 21*, 171-192. doi:10.1146/annurev.publhealth.21.1.171

Dunn, H. L. (1959). High-level wellness for man and society. *American Journal of Public Health, 49*(6), 768-792. Retrieved from http://ajph.aphapublications.org/

Dunn, S., & Morgan, V. (2001). *Barriers to access to essential services* (Research for the Equality Directorate of the Office of the First Minister and Deputy First Minister, U.K.). Retrieved from http://www.ofmdfmni.gov.uk/index/equality/equalityresearch/research-publications/barriers.pdf

Easton, B. (2002). The New Zealand health reforms of the 1990s in context. *Applied*

Health Economics and Health Policy, 1, 107-112. Retrieved from http://adisonline.com/healtheconomics/pages/default.aspx

Eggleston, K., Ling, L., Qingyue, M., Lindelow, M., & Wagstaff, A. (2008). Health services delivery in China: A literature review. *Health Economics, 17*(2), 149-165. doi: 10.1002/hec.1306

Eurostat. (2000). *Push and pull factors of international migration: A comparative report*. Luxembourg: Office for Official Publications of the European Communities.

Freshwater, D. (2002). *Therapeutic nursing: Improving patient care through self-awareness and reflection*. London, England: Sage.

Gimenez, M. E. (1992). U. S. ethnic politics: Implications for Latin Americans. *Latin American Perspectives, 19*(4), 7-17. Retrieved from http://lap.sagepub.com/

Grbich, C. (1999). *Qualitative research in health*. London, England: Sage.

Green, J., & Thorogood, N. (2009). *Qualitative methods for health research* (2nd ed.). London, England: Sage.

Grief, S. W. (1974). *The overseas Chinese in New Zealand*. Singapore: Asia Pacific Press.

Grogan, C. M. (1995). Urban economic reform and access to health care coverage in the People's Republic of China. *Social Science & Medicine, 41*(8), 1073-1084. doi:10.1016/0277-9536(94)00419-T

Groves, R. M., Fowler, F. J., Couper, M. P., Lepkowski, J. M., Singer, E., & Tourangeau, R. (2004). *Survey methodology*. Hoboken, NJ: John Wiley & Sons.

Hammersley, M. (1992a). The paradigm wars: Reports from the front. *British Journal of Sociology of Education, 13*(1), 131-143. doi:10.1080/0142569920130110

Hammersley, M. (1992b) *What's wrong with ethnography? - Methodological explorations*. London, England: Routledge.

Harmsworth, K., & Lewith, G. T. (2001). Attitudes to traditional Chinese medicine amongst Western trained doctors in the People's Republic of China. *Social Science & Medicine, 52*(1), 149-153. doi: 10.1016/S0277-9536(00)00124-6

Head, K., & Reis, J. (1998). Immigration and trade creation: Econometric evidence from Canada. *Canadian Journal of Economics, 31*(1), 47-62. Retrieved from http://economics.ca/cje/en/index.php

Health and Disability Commissioner. (2009). *Code of health and disability services consumers' rights*. Wellington, New Zealand: Health and Disability Commissioner.

Health Funds Association of New Zealand. (2011). *Health insurance drops 10,000 in 2010 – HFANZ.* [Press release]. Retrieved from

http://www.healthfunds.org.nz/pdf/2010DecHealthInsuranceStatistics.pdf

Helman, C. (1984). *Culture, health, and illness: An introduction for health professionals*. Bristol, England: Wright and Sons.

Hesketh, T., & Zhu, W.X. (1997a). Health in China: From Mao to market reform. *British Medical Journal, 314*(7093), 1543-1545. Retrieved from http://www.bmj.com/

Hesketh, T., & Zhu, W.X. (1997b). Health in China: The healthcare market. *British Medical Journal, 314*(7094), 1616-1618. Retrieved from http://www.bmj.com/

Ho, E.S., Au, S., Bedford, C., & Cooper, J. (2002). *Mental health issues for Asians in New Zealand: A literature review* (Report for the Mental Health Commission). Retrieved from Mental Health Commission website: http://www.mhc.govt.nz/sites/mhc.govt.nz/files/publications/2003/ASIAN_MH_PAPER.PDF

Hornblow, A. (1997). New Zealand's health reforms: A clash of cultures. *British Medical Journal, 314*(7098), 1892-1894. Retrieved from http://www.bmj.com/

Hsiao, W. (1995). The Chinese health care system: Lessons for other nations. *Social Science & Medicine, 41*(8), 1047-1055. doi:10.1016/0277-9536(94)00421-O

Hutching, M. (2004). *Becoming New Zealanders: Population, immigration and citizenship, 1940-1960*. Retrieved from http://nzhistory.net.nz/dnzb_exhibs/citizen/

International Organisation for Migration. (2008). *IOM's activities on migration data: An overview*. Retrieved from http://publications.iom.int/bookstore/free/IOM_Activities_Overview.pdf

Ip, M. (1995). Chinese New Zealanders: Old settlers and new immigrants. In S. W. Greif (Eds.), *Immigration and national identity in New Zealand: One people, two peoples, many peoples* (pp. 326-333). Palmerston North, New Zealand: Dunsmore Press.

Ip, M. (Eds.). (2003). *Unfolding history, evolving history: The Chinese in New Zealand*. Auckland, New Zealand: Auckland University Press.

Ip, M. (2008). *Being Maori-Chinese: Mixed identities*. Auckland, New Zealand: Auckland University Press.

Jary, D., & Jary, J. (1991). *Collins dictionary of sociology*. Glasgow: HarperCollins Publishers.

Jansen, H. (2010). The logic of qualitative survey research and its position in the field of social research methods. *Forum, Qualitative Social Research, 11*(2), Art.11. Retrieved from http://www.qualitative-research.net/index.php/fqs

Jin, L., & Su, B. (2000). Natives or immigrants: Modern human origin in East Asia.

Nature Reviews Genetics, 1(2), 126-133. doi: 10.1038/35038565

Kellehear, A. (1993). *The unobtrusive researcher: A guide to methods.* St Leonards, Australia: Allen and Unwin.

Keppel, K., Bilheimer, L., & Gurley, L. (2007). Improving population health and reducing health care disparities. *Health Affairs, 26*(5), 1281-1292. doi:10.1377/hlthaff.26.5.1281

Kleinman, A. M. (1980). *Patients and healers in the context of culture*. Berkeley, CA: University of California Press.

Koch, T. (1994). Establishing rigour in qualitative research: The decision trial. *Journal of Advanced Nursing, 19*(5), 976-986. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291365-2648

Kothari, C. R. (2004). *Research methodology: Methods and techniques* (2nd ed.). New Delhi, India: New Age.

Kuo, J., & Porter, K. (1998). Health status of Asian Americans: United States, 1992-1994. *Advance Data from Vital and Health Statistics, 7*(298), 1-16. Retrieved from http://www.cdc.gov/nchs/products/ad.htm

Kwok, C., & Sullivan, G. (2007). Health seeking behaviours among Chinese-Australian women: Implications for health promotion programmes. *Health: An interdisciplinary journal for the social study of health and illness, 11*(3), 401-415. doi:10.1177/1363459307077552

Larson, J. S. (1996). The World Health Organisation's definition of health: Social versus spiritual health. *Social Indicators Research, 38*(2), 181-192. doi:1007/BF00300458

Lavely, W. (2001). First impression from the 2000 Census of China. *Population and Development Review, 27*(4), 755-769. doi: 10.1111/j.1728-4457.2001.00755.x

Leeds-Hurwitz, W. (1995). *Social approaches to communication.* New York, NY: Guilford Press.

Li, P. H. (2010). *New Chinese immigrants to New Zealand: A PRC dimension* (University of Auckland Research Report). Retrieved from International Metropolis Project website: http://international.metropolis.net/pdf/fow_newzealand_immi.pdf

Li, P. S., & Li, E. X. (2011). Changes in the Chinese overseas population, 1955 to 2007. *Canadian Review of Sociology, 48*(2), 137–152. doi: 10.1111/j.1755-618X.2011.01259.x

Liang, Z., & Morooka, H. (2004). Recent trends of emigration from China: 1982-2000. *International Migration, 42*(3), 145-164. doi:10.1111/j.0020-7985.2004.00292.x

Liang, Z., & Ye, W. (2001). From Fujian to New York: Understanding the new Chinese immigrants. In D. Kyle & R. Koslowski (Eds.), *Global human smuggling: Comparative perspectives* (pp. 187-215). Baltimore, MD: Johns Hopkins University Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalist inquiry*. London, England: Sage.

Loue, S. (Eds.). (1998). *Handbook of immigrant health*. New York, NY: Plenum Press.

Lowenberg, J. S. (1993). Interpretive research methodology: Broadening the dialogue. *Advances in Nursing Science, 16*(2), 67-69. Retrieved from http://journals.lww.com/advancesinnursingscience/pages/default.aspx

Ma, G. X. (1999a). Between two worlds: The use of traditional and western health services by Chinese immigrants. *Journal of Community Health, 24*(6), 421-437. doi: 10.1023/A:1018742505785

Ma, G. X. (1999b). *Culture of health: Asian communities in the United States*. Westport, CT: Bergin & Garvey.

Ma, G. X., & Henderson, G. (1999). *Rethinking ethnicity and health care: A sociocultural perspective*. Springfield, IL: Charles C Thomas.

Markides, K. S., & Coreil, J. (1986). The health of Hispanics in the southwestern United States: An epidemiologic paradox. *Public Health Report, 101*(3), 253-265. Retrieved from http://www.publichealthreports.org/

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-526. doi:10.1093/fampra/13.6.522

Maslow, A. (1954). *Motivation and personality*. New York: Harper & Row.

Mason, J. (1996). *Qualitative researching*. London, England: Sage.

Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review, 62*(3), 279-300. Retrieved from http://www.hepg.org/main/her/Index.html

McDonald, J. T., & Kennedy, S. (2004). Insights into the healthy immigrant effect: Health status and health service use of immigrants to Canada. *Social Science and Medicine, 59*(8), 1613-1627. doi:10.1016/j.socscimed.2004.02.004

McEwen, B., & Lasley, E. N. (2002). *The end of stress as we know it*. Washington, DC: The Joseph Henry Press.

McKinnon, M. (1996). *Immigrants and citizens: New Zealanders and Asian immigration in historical context*. Wellington, New Zealand: Institute of Policy Studies.

McPhee, S. J., Stewart, S., Brock, K. C., Bird, J. A., Jenkins, C. H. N., & Pham, G. Q. (1997). Factors associated with breast and cervical cancer screening practices

among Vietnamese American women. *Cancer Detection and Prevention, 21*, 510-521.

Miller, W. L., & Crabtree, B. F. (1992). Primary care research: A multimethod typology and qualitative road map. In B. J. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (Vol. 3; pp. 3-30). Newbury Park, CA: Sage.

Miltiades, H. B., & Wu, B. (2008). Factors affecting physician visits in Chinese and Chinese immigrant samples. *Social Science & Medicine, 66*(3), 704-714. doi:10.1016/j.socscimed.2007.10.016

Ministry of Health. (2001). *The primary health care strategy*. Wellington, New Zealand: Author.

Ministry of Health. (2006). *Asian health chart book 2006* (Public Health Intelligence Monitoring Report No. 4). Retrieved from http://www.moh.govt.nz/moh.nsf/pagesmh/4925/$File/asian-health-chart-book-2006.pdf

Mishler, E. (1986). *Research interviewing: Context and narrative.* Cambridge, MA: Harvard University Press.

Morse, J., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 13-22. Retrieved from http://ejournals.library.ualberta.ca/index.php/IJQM/index

National Bureau of Statistics of China. (2011). *The sixth national population census* (Public Report No.1). Retrieved from http://www.stats.gov.cn/tjgb/rkpcgb/qgrkpcgb/t20110428_402722232.htm

Nayar, S. (2005). *Two becoming one: immigrant Indian women sustaining self and well-being through doing: a grounded theory study* (Master's thesis, Auckland University of Technology, Auckland, New Zealand). Retrieved from http://hdl.handle.net/10292/185

Nayar, S., Hocking, C., & Wilson, J. (2007). An occupational perspective of immigrant health: Indian women's adjustment to living in New Zealand. *British Journal of Occupational Therapy, 70*(1), 16-23.

New Zealand Herald. (2002). *Editorial: Apology to Chinese should be end of it*. Retrieved September 16, 2010, from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=939096

New Zealand Public Health and Disability Act 2000. Retrieved from http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html

Ng, J. (1993). *Windows on a Chinese Past Volume. 1.* Dunedin, New Zealand: Otago Heritage Books.

Ng, J. (1995). *Windows on a Chinese Past Volume. 2*. Dunedin, New Zealand: Otago Heritage Books.

Ng, J. (1998). *Social differences between Kiwi-Chinese and Chinese newcomers*. Paper presented at the 1998 Chinese in Australia and the Pacific: Old and New Migrations and Cultural Change meetings of the Association for the Study of Chinese and Their Descendants in Australasia and the Pacific Islands (ASCKAPI). Dunedin, New Zealand.

Ng, J. (2001). *Chinese settlement in New Zealand, past and present*. Retrieved from http://www.stevenyoung.co.nz/The-Chinese-in-New-Zealand/History-of-Chinese-in-NewZealand/Chinese-settlement-in-NZ-past-and-present.html

Ng, J. (2003a). *Characteristics of Chinese culture and aspects of health care*. Retrieved from http://www.stevenyoung.co.nz/The-Chinese-in-New-Zealand/History-of-Chinese-in-NewZealand/Characteristics-of-Chinese-culture-and-aspects-of-health-care.html

Ng, J. (2003b). The sojourner experience: The Cantonese goldseekers in New Zealand, 1865-1901. In W. Ip (Eds.), *Unfolding history, evolving history: The Chinese in New Zealand*. Auckland, New Zealand: Auckland University Press.

Ngai, M. M. Y., Latimer, S., & Cheung, V. Y. M. (2001). *Healthcare needs of Asian people: Surveys of Asian people and health professionals in the North and West Auckland*. Auckland, New Zealand: Asian Health Support Service, Waitemata District Health Board.

Ngo-Metzger, Q., Legedza, A., Phillips, R. (2004). Asian Americans' reports of their health care experiences. *Journal of General Internal Medicine, 19(2)*, 111-119. doi: 10.1111/j.1525-1497.2004.30143.x

Nolan, M., & Behi, R. (1995). Alternative approaches to establishing reliability and validity. *British Journal of Nursing*, *4*(10), 586-590. Retrieved from http://www.britishjournalofnursing.com/

Nyiri, P., & Saveliev, I. R. (Eds.). (2002). *Globalizing Chinese migration: Trends in Europe and Asia*. Aldershot, England: Ashgate.

O'Connor, M. (1990). *An immigrant nation*. Auckland, New Zealand: Heinemann Education.

Oxford Dictionaries. (2010). *Migration*. In Oxford Dictionaries. Retrieved September 24, 2010, from http://oxforddictionaries.com/definition/migration

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.

Pedersen, D. (1992). Qualitative and quantitative: Two styles of viewing the world or two categories of reality. In N. S. Scrimshaw & G. R. Gleason (Eds.), *Rapid assessment procedures: Qualitative methodologies for planning and evaluation of health related programmes* (pp. 39-50). Boston, MA: International Nutrition Foundation for Developing Countries (INFDC).

Polit, D. F., & Hungler, B. P. (1997). *Essentials of nursing research methods, appraisal & utilization* (4th ed.). New York, NY: Lippincott.

Poston, D. L. Jr., & Yu, M. Y. (1992). The distribution of the overseas Chinese. In D. L. Poston, Jr. & D. Yaukey (Eds.), *The population of modern China* (pp. 117-148). New York, NY: Plenum Press.

Rabiee, F. (2004). Focus group interview and data analysis. *Proceedings of the Nutrition Society, 63*(4), 655–660. doi:10.1079/PNS2004399

Rasanathan, K., Ameratunga, S., & Tse, S. (2006). Asian health in New Zealand: Progress and challenges. *New Zealand Medical Journal*, *119*(1244) (8 pages). Retrieved from http://journal.nzma.org.nz/journal/

Rasanathan, K., Craig, D., & Perkins, R. (2006). The novel use of "Asian" as an ethnic category in the New Zealand health sector. *Ethnicity and Health, 11*(3), 211–227. doi: 10.1080/13557850600565525

Redfield, R., Linton, R., & Herskovits, M. (1936). Memorandum on the study of acculturation. *American Anthropologist, 38*(1), 149-152. doi:10.1525/aa.1936.38.1.02a00330

Reischauer, E. O., Fairbank, J. K., & Craig, A. M. (1960). *A history of East Asian civilization*. Boston, MA: Houghton Mifflin.

Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Oxford, England: Oxford University Press.

Richmond, A. H. (1993). Reactive migration: Sociological perspectives on refugee movements. *Journal of Refugee Studies, 6*(1), 7-24. doi: 10.1093/jrs/6.1.7

Ritchie, N. A. (2003). Traces of the Past: Archaeological insights into the New Zealand Chinese experience in southern New Zealand. In M. Ip (Eds.), *Unfolding history, evolving history: The Chinese in New Zealand* (pp. 157). Auckland, New Zealand: Auckland University Press.

Rossman, G. B., & Rallis, S. F. (1998). *Learning in the field. An introduction to qualitative research*. Thousand Oaks, CA: Sage.

Rubin, H., & Rubin, I. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage.

Said, E. (1978). *Orientalism: Western conceptions of the Orient*. New York, NY: Random House.

Salant, T., & Lauderdale, D. S. (2003). Measuring culture: A critical review of acculturation and health in Asian immigrant population. *Social Science & Medicine, 57*(1), 71-90. doi: 10.1016/S0277-9536(02)00300-3

Sandelowski, M. (2000). Whatever happened to qualitative descriptive? *Research in Nursing & Health, 23*(4), 334-340. doi: 10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice, 23*(3), 325-348. doi:10.1093/fampra/cmi113

Schneider, Z., Elliot, D., LoBiondo-Wood, G., Beanland, C., & Haber, J. (2003). *Nursing Research: Methods, critical appraisal and utilisation* (2nd ed.). Sydney, Australia: Mosby.

Scott, C. D. (1994). Reform of the New Zealand health care system. *Health Policy, 29*(1-2), 25-40. doi: 10.1016/0168-8510(94)90005-1

Seddon, M., Marshall, M., Campbell, S., & Roland, M. (2001). Systematic review of studies of quality of clinical care in general practice in the UK, Australia and New Zealand. *Quality of Health Care, 10*(3), 152-158. doi:10.1136/qhc.0100152..

Singapore Department of Statistics. (2010). *Population trends 2010*. Retrieved from http://www.singstat.gov.sg/pubn/popn/population2010.pdf

Statistics Canada. (2001). *Special tabulated Census data*. Retrieved from British Colombia Research Libraries' Data Services website: http://abacus.library.ubc.ca/handle/10573/41825

Statistics New Zealand. (1996). *Demographic trends*. Wellington, New Zealand: Statistics New Zealand.

Statistics New Zealand. (2006a). *2006 census: QuickStats about culture and identity*. Retrieved from http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/quickstats-about-a-subject/culture-and-identity/asian.aspx

Statistics New Zealand. (2006b). *2006 Census questionnaires – Sample bilingual individual form*. Retrieved from http://www.stats.govt.nz/Census/about-2006-census/2006-census-questionnaires.aspx

Statistics New Zealand. (2010). *National population estimates mean year ended 31 December 1991-2010*. Retrieved from http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/national-pop-estimates.aspx

St George, I. (Eds.). (2011). *Cole's medical practice in New Zealand* (10th ed.).Wellington, New Zealand: Medical Council of New Zealand.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Tolich, M., & Davidson, C. (1999). *Starting fieldwork*. Melbourne, Australia: Oxford University Press.

Trochim, W. M. K. (2002). *Qualitative measures*. Retrieved from http://www.socialresearchmethods.net/kb/qual.htm

Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco, CA: Jossey-Bass.

United Nations. (2007). *World population prospects: The 2006 revision, highlights*. Retrieved from http://www.un.org/esa/population/publications/wpp2006/WPP2006_Highlights_rev.pdf

United Nations. (2010). *World population prospects: The 2010 revision*. Retrieved from http://esa.un.org/unpd/wpp/index.htm

U. S. Government Bureau of Census. (2002). *The Asian and Pacific Islander population in the United States: March 2002*. Retrieved from http://www.census.gov/prod/2003pubs/p20-540.pdf

van Manen, M. (1997). *Researching the lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, Canada: The Althouse Press.

Walker, R., Wu, C. W. D., Soothi-O-Soth, M., & Parr, A. (1998). *New Zealand's Asian population: Views on health and health services*. Auckland, New Zealand: Health Funding Authority.

Wang, F. (2003). Improve rural NCMS in poor areas. *Guizhou Finance and Economics Journal*, 6, 62-64. Retrieved from http://www.ceps.com.tw/ec/ecJnlIntro.aspx?Jnliid=1947

Wang, G., Xu, H., & Jiang, M. (2003). Evaluation on comprehensive quality of 456 doctors in township hospitals. *Chinese Health Resources, 6*(3), 72-74. Retrieved from http://zgwszy.periodicals.net.cn/default.html

Wang, L. (2007). Immigration, ethnicity, and accessibility to culturally diverse family physicians. *Health and Place, 13*(3), 656-671. doi:10.1016/j.healthplace.2006.10.001

Wang, L., Rosenberg, M., & Lo, L. (2008). Ethnicity and utilization of family physicians: A case study of Mainland Chinese immigrants in Toronto, Canada. *Social Science & Medicine, 67*(9), 1410-1422. doi:10.1016/j.socscimed.2008.06.012

Washington State Department of Health. (2010). *Guidelines for using racial and ethnic*

groupings in data analyses. Retrieved from http://www.doh.wa.gov/Data/Guidelines/REGL2010.pdf

Whaley, A. L. (2003). Ethnicity/race, ethics, and epidemiology. *Journal of the National Medical Association, 95*(8), 736-742.

Winkelmann, R. (2001). *Immigration policies and their impact: The case of New Zealand and Australia*. Retrieved from Center for Comparative Immigration Studies, University of California San Diego website: http://escholarship.org/uc/item/2m22d7v8

Wolff, B., Knodel, J., & Sittitrai, W. (1991). Focus groups and survey as complementary research methods: A case example. In D. Morgan (Eds.), *Successful focus groups: advancing the state of the art* (pp. 118-136). Newbury Park, CA: Sage.

World Health Organisation. (1948). *Constitution of the World Health Organisation*. Geneva, Switzerland: Author.

World Health Organisation. (1986). *Ottawa charter for health promotion*. Ottawa, Canada: Author.

World Health Organisation. (2011). *Health education*. Retrieved from http://www.who.int/topics/health_education/en/

World Health Organisation. (2005). *Action on the social determinants of health: Learning from previous experiences*. Retrieved from http://www.who.int/social_determinants/resources/action_sd.pdf

Ying, Y., & Miller, L. S. (1992). Help-seeking behavior and attitude of Chinese-Americans regarding psychological problems. *American Journal of Community Psychology, 20*(4), 549-556. doi: 1007/BF00937758

Young, S. (2005). *The original Chinese in New Zealand in the 21st century*. Paper presented at the Asia in New Zealand Conference, University of Otago. Dunedin, New Zealand.

Zamiska, N. (2007, May 15). Global economy: Medical ills thwart insurers in China. *Wall Street Journal,* p. A8. Retrieved from http://english.cri.cn/2946/2007/05/15/199@227309.htm

Zhang, J., & Verhoef, M. J. (2002). Illness management strategies among Chinese immigrants living with arthritis. *Social Science & Medicine, 55*(10), 1795-1802. doi:10.1016/S0277-9536(01)00311-2

Zhuang, N., & Tang, S. (2001). Application and research on methods of adjustment of medical quality and case mix in measurement of hospital service efficiency. *Chinese Health Resources, 4*(3), 127-129. Retrieved from http://zgwszy.periodicals.net.cn/default.html

APPENDICES

Appendix A

Ethical Approval

MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: John F Smith

From: **Madeline Banda** Executive Secretary, AUTEC

Date: 16 September 2010

Subject: Ethics Application Number 10/166 **New Perspectives on Chinese Immigrants' Experiences under the New Zealand Healthcare System: A Qualitative Descriptive Study.**

Dear John

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 9 August 2010 and that I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 11 October 2010.

Your ethics application is approved for a period of three years until 15 September 2013.

I advise that as part of the ethics approval process, you are required to submit the following to

AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 15 September 2013;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 15 September 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Yi (Sabrina) Wang wangyi_06@hotmail.com

Appendix B

Survey Form English Version

Health Care Service Survey Questionnaire for Chinese People

General Information

Name: ☐ M ☐ F						**Age:**
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Place of Birth:				**Highest Educational Qualification:**		
First Language:				**Other Languages:**		
Time of residence in New Zealand:						

Personal Health Care Information

1. Have you received any health care services since your arrival in New Zealand? (e.g. GP service, specialist service, hospital service, etc.)

☐ Yes ☐ No

If yes, please list the type of services you have received in the past.

_____

_____

_____

_____

1.1 How were these health care services introduced to you?

☐Pamphlets ☐News Media ☐Internet ☐Referral from Friends/Families

☐ Other (Please specify): _____

2. Do you have a regular GP?

☐ Yes ☐ No

If yes, what was the main reason(s) for you to choose your current GP?
(e.g. Language, Distance from your residence, Reputation, Cost, etc.)

_____
_____
_____
_____

If no, what was the reason(s) not to have a regular GP and who do you use as your primary health care provider?

_____
_____
_____
_____

2.1 If you have a regular GP, are you enrolled with the PHO that your GP practice belongs to?

☐ Yes ☐ No

Please specify the reason(s):

_____
_____
_____
_____

3. Have you visited any complementary/alternative medical practices since you have been in New Zealand?
(e.g. Herbal medicine, Acupuncture, Hypnotism, Osteopathy, Homeopathy, etc)

☐ Yes ☐ No

If Yes, Please specify: _____
_____

4. Do you currently have private medical insurance cover?

☐ Yes ☐ No

What was your main concern(s) when deciding to have or not to have insurance cover:

Experiences in receiving Health Care Services

5. In general, are you satisfied with the primary health care service experience? (e.g. GP service)

☐ Yes ☐ No

Please specify reason:

6. Have you experienced any difficulties or barriers in receiving primary health care services?
(e.g. Language, Culture, Religious, etc.)

7. Overall, how do you compare your experience in receiving health care service between in New Zealand and mainland China? (Please describe as detailed as possible)

8. Except GP service , are you satisfied with other types of health care service experience?
(e.g. specialist, hospital, physiotherapy, etc.)

☐ Yes ☐ No

Please specify reason: _____
_____
_____

9. Are you satisfied with the complementary/alternative health care provider that you have used and what was the main reason(s) for choosing their services?

☐ Yes ☐ No

Please specify reason: _____
_____
_____
_____
_____

10. Have you ever brought in any medication from mainland China? If so, what kind of medication did you bring in and what were reasons for doing so?

☐ Yes ☐ No

Please provide details: _____
_____
_____
_____
_____

Thank you for taking the time to fill out our survey questionnaire. Your input is greatly appreciated.

Approved by the Auckland University of Technology Ethics Committee on 16 September 2010

AUTEC Reference number 10/166

Appendix C

Survey Form Chinese Version

新西兰华人医疗保健服务调查问卷

参与者基本信息

姓名: ☐ M ☐ F	**年龄:**
婚姻状况: ☐ 单身 ☐ 同居 ☐ 已婚 ☐ 分居 ☐ 离异 ☐ 寡居	
出生地:	**最高学历 :**
语言（母语）:	**其他语言:**
在新西兰居住时间:	

个人保健信息

1.您在新西兰享受过任何形式的医疗服务么?
(例如. 家庭医生服务, 专科医生服务, 医院提供的医疗服务，健康医疗讲座等.)

☐ 有 ☐ 没有

如果有, 请您列举医疗服务种类。

_____
_____
_____
_____

1.1 您是如何得知这些医疗服务的?

☐宣传单 ☐新闻媒介 ☐Internet 网 ☐亲友的推荐

☐ 其他 (请详细说明): _____

2.你有固定的 GP 么?

☐ 有　　☐ 没有

如果有, 是什么原因您选择现在的 GP?
(例如，语言, 离家近, 好口碑, 价格便宜等.)

_____
_____
_____
_____

如果没有, 是什么原因您不选择固定的 GP，谁是您的基本健康服务提供者?

_____
_____
_____
_____

2.1 如果有固定 CP, 您注册过么?

☐ 注册　　☐ 没有

请详细说明理由:

_____
_____
_____
_____

3.在新西兰您接受过替代疗法治疗么?
(例如. 中药, 针灸, 催眠术, 整骨疗法, 同种疗法等)

☐ 有　　☐ 没有

如果有，请详细说明: _____
_____

4.目前您有医疗保险么?

☐ 有　　☐ 没有

请说明原因:

医疗保健服务经历

5.一般来说, 您对目前的基本医疗保健服务感到满意么?
(例如. GP 服务)

☐ 满意　　☐ 不满意

请详细说明原因:

6.在医疗服务实践中，您觉得有任何的障碍或困难么?
(例如. 语言, 文化, 宗教信仰等.)

7.总的来说, 您如何比较新西兰与中国的医疗保健服务的差别？（请详细叙述）

8.除了家庭医生服务，您对其他形式的医疗保健服务满意么?(例如. 专科医生,医院服务,理疗等.)

☐ 满意　　☐ 不满意

请详述理由: _____

_____

_____

9.您对替代疗法的服务感到满意么？您选择这些服务的主要理由是什么？

☐ 满意　　☐ 不满意

请详述理由: _____

_____

_____

_____

_____

10.您从您的国家带过任何药物到新西兰么? 如果有, 是些什么种类的药物？您为什么带药到新西兰?

☐ 有　　☐ 没有

请详细说明: _____

_____

_____

_____

_____

谢谢您抽出时间完成调查. 再次感谢您的合作。

Approved by the Auckland University of Technology Ethics Committee on 16 September 2010

AUTEC Reference number 10/166

Appendix D

Participants Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

25 May 2010

Project Title

New Perspectives on Chinese Immigrants' Experiences under the New Zealand Healthcare System: A Qualitative Descriptive Study

An Invitation

My name is Yi (Sabrina) Wang (Student ID 0819492), from the School of Public Health and Psychosocial Studies, Faculty of Health and Environmental Sciences at Auckland University of Technology. This study is being conducted as part of my Master thesis. I am interested in your experiences in receiving medical care in New Zealand and how cultural beliefs, values and attitudes may influence your health care decision making process. I would like to invite you to participate in my study to share your experiences. There are two parts of my study: survey questionnaire and interview. Both participation is voluntary. You may withdraw at any time prior to the completion of data collection without any adverse consequences.

What is the purpose of this research?

My study will investigate how the Chinese immigrant population, in New Zealand, make decisions when seeking medical care. It is hoped to make recommendations from the research to support Chinese people generally in making decision regarding medical care in a real-life context and help with health care service planning for Chinese in the future.

How were you identified and why are you being invited to participate in this research?

I will recruit people who are Chinese migrants aged between 30-55, born in the People's Republic of China, living in the Auckland region now. Consent form will be provided to you in addition to this information sheet prior to data collection, where you can leave your contact details if you wish to give consent and participate in this study.

There are two parts of my study: survey questionnaire and interview. I hope to recruit around 40 individuals as the questionnaire participants and up to 10 individuals for in-depth interviews from who have participated in the first part of survey data collection and preference will be given to those providing most detailed responses on the questionnaire.

What will happen in this research?

For the survey, I will give you the survey questionnaire which will take approximately 15-20 minutes to complete. I will provide a sealed drop-in box for you to drop in your completed questionnaires at a time convenient to you if you choose to. I will encourage you to use the drop-in box but address-stamped prepaid envelops will be provided if you choose to take the questionnaires away and post back to me in two weeks.

After all questionnaires are completed, I would like to invite some people for personal interview. If you are happy to be interviewed later, please express your willingness on the consent form.

For the interview, I will arrange to meet you at a place and time that is convenient to you. Our interview will last approximately 1-2 hours, during which I will ask you about general personal information, your perceptions, experiences and opinions on receiving medical care in New Zealand. The interview will be audio taped and typed up. You will receive a copy, which you are welcome to comment on. The information you provide will be used for data analyses in my Master's research thesis.

If you require feedback or any other further information on my findings at the end of my study, my email address will be provided to you for the purpose of requesting such information.

What are the discomforts and risks?

Moderate level of emotional risk is anticipated as you will be sharing your perceptions, experiences and opinions in receiving medical care in New Zealand. There may be potential discomfort given that health issues are discussed which can be sensitive, depending on your personal views and past experiences.

How will these discomforts and risks be alleviated?

You can choose to or not to answer specific questions. You can withdraw any information from the study that you do not wish to have included in the final analysis. You can choose to temporarily break from or terminate the process at any time if you do not feel comfortable. I may choose to temporarily break from or terminate the process at any time if such risks are present. If you wish, free counselling sessions can be arranged through the AUT Counselling Service. The AUT Counselling Services can be contacted at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus**. More information about counsellors and the option of online counselling can be found on website: **http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing.**

What are the benefits?

Your contribution will help me to learn how health care services accessibility and effectiveness for Chinese migrants can be improved and to ensure that there is appropriate support available for the Chinese migrant population under New Zealand public health system.

How will your privacy be protected?

All information collected in this study remains strictly confidential and will only be viewed by me and my research supervisor. The use, storage and destruction of data collected from you will fully comply with AUT Ethics Committee (AUTEC) protocol. You will be asked to choose a pseudonym and any of your information will only be known by that name in any research reports. I will not use specifically identifying details in my study or any presentations or publication.

What are the costs of participating in this research?

For the questionnaire, this will be approximately 15-20 minutes of your time. For the interview, this will be approximately 1-2 hours of your time, plus the time to read and correct the interview transcript and report of findings. I appreciate that your time is given voluntarily.

What opportunity do you have to consider this invitation?

Time will be given in the information session prior to data collection for you to read the information sheet, consent form and questionnaire. You can ask any questions regarding the study that may help your decision as to whether or not to participate, I will be available to answer any questions you may have. If you feel that you need more time to consider this invitation after the information session, you are welcome to take any information material away and advise me of your decision within two weeks.

How do you agree to participate in this research?

Thank you for considering being a participant in my study. If you would like to participate in this study, you need to complete the consent form (accompanied by this information sheet).

Will you receive feedback on the results of this research?

Yes. If requested, a summary report of the findings will be sent to you.

What do you do if you have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Associate Professor John F Smith, john.f.smith@aut.ac.nz, 921 9999 ext 7753*

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz*, 921 9999 ext 8044.

Whom do you contact for further information about this research?

Researcher Contact Details: Yi (Sabrina) Wang

Email: wangyi_06@hotmail.com

PO Box 6549, Wellesley Street, Auckland 1141

Project Supervisor Contact Details: Associate Professor John F Smith

School of Public Health and Psychosocial Studies

Faculty of Environmental Sciences, AUT

Private Bag 92006, Auckland

Email: john.f.smith@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 16 September 2010

AUTEC Reference number 10/166

Appendix E

Consent to Participation in Research

Consent Form

Project title: ***New Perspectives on Chinese Immigrants' Experiences under the New Zealand Healthcare System: A Qualitative Descriptive Study***

Project Supervisor: ***Associate Professor John F Smith***

Researcher: ***Yi (Sabrina) Wang***

- O I have read and understood the information provided about this research project in the Information Sheet dated 25 May 2010.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that I may be asked questions including general personal and/or family information, experiences and opinions about receiving medical care in New Zealand and that I have the opportunity to say no to this if so wished.
- O I understand that the interview will be audio-taped and typed word for word and that the interviewer may make notes during the interview.
- O I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- O If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- O I agree to participate in the survey questionnaire stage of this research (please tick one):

  YesO NoO

  (NOTE: If you select No, please DO NOT proceed with the rest of the consent form)

- O I agree to participate in the interview stage of this research (please tick one): YesO NoO
- O I wish to receive a copy of the report from the research (please tick one): YesO NoO

Participant's signature:

……..

Participant's name:

……..

Participant's Contact Details (if appropriate):

……..

……..

……..

Date:

Approved by the Auckland University of Technology Ethics Committee on 16 September 2010

AUTEC Reference number 10/166

Note: The Participant should retain a copy of this form.

Appendix F

Interview Schedule

Interview Schedule Summary

Note: This interview schedule is designed to assist the researcher with conducting interviews with a group of selected participants, who have completed the earlier questionnaire survey. This summary lists the potential interview questions that may be asked during the interview. Specific questions to be asked in individual interview will depend on the participant's answer to specific survey questions. Not all the questions in the summary will be asked in the individual interviews. Where individual participant's answers to specific questions may lead to other interesting aspects or points that were not prepared, the researcher may develop additional follow-up questions. The question numbering in this summary (q1, q2, etc.) refer to the survey questions.

Greetings and general introduction

Acknowledge participant's time and efforts in taking part in this research and interview. Inform the participant of his/her role and rights in the research. Information sheet and consent forms will be provided. Written consent to be obtained before the interview proceeds to questions.

Interview Questions

1. Tell me about your experiences about access to health care now that you are living in New Zealand?

   We have seen from your survey answers that you arrived in New Zealand at xxx time and have been living in Auckland for xxx amount of time. Since you've been in New Zealand, how important do you rate your health and the quality of health care?

2. We have seen from your survey answers (q1) that you have received xxx and xxx health care services in the past and your experiences with those services were positive / problematic (depending on answer from q5/q6). Can you describe these experiences in more detail?

   OR

   We have seen from your survey answer (q1) that you have not received any health care services in the past or have not received any health care related information via media (q1.1 excluding Referral from Friends/Families), can you tell me the reason(s) of that? Have you experienced any difficulties in getting such information or accessing any services when you needed? If so, what are they?

   Depending on participant's answer, there may be follow up questions to identify such barriers in getting information or accessing services, these may include but not limited to:

   - Have you been provided with relevant health care information (verbal or written) when visiting health care services? If so, in what language was such information provided to you? Was it helpful?
   - Have you seen or heard relevant health care information need from mainstream media such as TV, radio, newspaper and websites? In what languages? Were they helpful?
   - Have you seen or heard relevant health care information from alternative media sources

such as Asian TV channels, Asian radio programmes, Asian websites? In what language? Were they helpful?

- Have you seen or heard relevant health care information from sources such as your employer, local communities, social groups or friends and relatives? In what form and language? Were they helpful?
- Do you feel that you have access to enough health care information in a language (English or Chinese) that you are confident and comfortable with?
- To what extent do you use such information to make decisions when seeking health care services?

3. We have seen from your survey answer (q2, q2.1) that you have / do not have a regular GP and are enrolled / not enrolled with the PHO services. Can you tell me more about your decision to have/not have a GP/PHO? Depending on participant's answer, there may be follow up questions regarding participant's choice and experience of primary health care services, these may include but not limited to:
   - When and under what circumstance did you choose to have a regular GP or enroll with a PHO?
   - Have you changed GP or PHO services? If so, why?
   - Why did you choose your particular GP/PHO?
   - When and under what health conditions will you visit your GP or PHO services? Why? (Note: this question is aimed to find out what health conditions qualify a GP visit and what's stopping participants from visiting GP services: cost, convenience, awareness of one's own health conditions, medical beliefs, past experiences or other concerns?)
   - How satisfied are you with the communication, diagnostic procedures and outcomes of your GP or PHO services visits? Are they in-line with your past expectations of health care service from your experience in China or are there any differences (q6, q7, q10)? (For example, common practice in treating flu with fever in China is a medicinal intravenous drip, in NZ only high-temp cases are treated with physical cooling and oral medication, otherwise patients are usually sent home with paracetamol and recommendation on drinking water and resting. What are your views on such difference and to what extent does this affect your decision making for seeking GP or PHO services? Another example, the NZ time frame for in-hospital post-natal care immediately after birth is usually no more than 3 days in the case of C-section or a matter of hours in normal delivery. Whereas in China, these time frames are usually extended to 10 day and 5 days respectively. In addition, family members are not allowed to accompany and provide care to new mothers and babies overnight in New Zealand hospitals whereas these are common practices in China and are considered necessary family support. What are your views on these differences?)
   - How satisfied are you with NZ's primary health care system and the way it works for you? Is it in-line with your expectations or are there any particular concerns (q8)? (For example, in China, the first point of health care delivery is public hospital for emergency or non-emergency, where in NZ your GP or local community health centre/clinic are the primary provider and referrals are needed before transferring to hospital admission. What are your views on such difference and to what extent does this influence your decision in seeking GP or PHO services?)

4. Your survey answer (q4) indicated that you visit / do not visit complementary or alternative

medical practices. Can you tell me more about this? Depending on participant's answer, there may be follow up questions regarding participant's choice and experience of complementary / alternative health care services, these may include but not limited to:

- Why did you choose to use the complementary/alternative health care practices?
- Under what circumstances would you choose to use complementary/alternative health care practices as oppose to your primary health care?
- How satisfied are you with the communication, diagnostic procedures and outcomes of your complementary/alternative health care practices?
- What are your main concerns about using complementary/alternative health care practices? (For example, Chinese traditional medicine is one of the mainstream health care deliveries in China but generally not the case in NZ and some mainstream medical practitioners may have different opinions towards alternative therapy or treatment. Does this make any difference when you communicate your concerns to your medical provider? What are your views on such difference and to what extent does this influence your decision in seeking medical help?)

5. Are there any other comments you would like to make regarding accessing, utilising New Zealand health care services and system in your experiences including barriers/difficulties, as well as on any other health care related aspects if they have not been covered earlier in the interview? Depending on the participant's individual experiences and personal backgrounds, some further questions may include but not limited to:

   - Other commonly identified access barriers in utilising health care systems such as language, location, cost, availability (waiting time, etc) and awareness of specific services.
   - Any experiences in using health care services other than the primary health care and complementary/alternative health care practices, such as hospital services, specialist services, health care education and issues they may have had.
   - Questions regarding the difference over culturally sensitive issues: For example, post-natal care requires special attention with culturally sensitive common practices which are usually ignored or even promoted against in NZ. What are your views on such difference and to what extent does this impact your decision in seeking medical help?
   - Circumstance, experiences and views on private health insurance in NZ

Conclusion of interview

Thank participants for their time and help with the interview and research. Advise participants of how their responses will be process. Ensure participants have research contact details.

Approved by the Auckland University of Technology Ethics Committee on 16 September 2010
AUTEC Reference number 10/166

Appendix G

AUT Counselling Services Memorandum

MEMORANDUM

TO Sabrina Wang

FROM Kevin Baker

SUBJECT Psychological support for research participants

DATE 21 June 2010

Dear Sabrina

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

'New Perspectives on Chinese Immigrants' Experiences under the New Zealand Healthcare System: A Qualitative Descriptive Study '

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment

- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website: **http://www.aut.ac.nz/students/student_services/health_counselling_and_well being**

Yours sincerely

Kevin Baker
Head of Counselling
Health, Counselling and Wellbeing