

**What are the experiences of older Mandarin-speaking migrants  
in Auckland when accessing health and support services  
in New Zealand?**

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**A thesis submitted to the Auckland University of Technology in fulfilment of the  
requirement for the degree of Master of Arts (MA)**

**2017**

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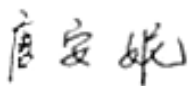
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## Attestation of Authorship

I hereby declare that this submission 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 (except where explicitly defined in the acknowledgments), nor material which to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed..........

Date.....02/06/2017 .....

## **Acknowledgements**

I would like to thank my supervisors, Associate Professor Ineke Crezee and Associate Professor Valerie Wright-St Clair, for their dedication in the guidance and supervision throughout my research journey. My first supervisor Associate Professor Ineke Crezee considerably provided me with detailed information concerning each stage of the research, and always offered valuable advice when I was in a quandary. She always encouraged me when I could not make progress, and carefully revised every paragraph of my drafts, even if there were a number of mistakes. She always gave prompt answers to my questions through emails or text messages, and was prepared to help me with my thesis on weekends and public holidays, and even during annual leave. I also want to express my gratitude to Ineke for her recommendation of Associate Professor Valerie Wright-St Clair as my second supervisor. Valerie guided me with her experience on phenomenological research by providing explicit explanations and examples, and revised my thesis in an informative way even during her sabbatical leave. She always provided a number of references for me to look at, and kindly instructed me on the understanding of key points. My two supervisors showed me how to be a researcher, and inspired me with qualities much deeper than just knowledge and skills pertaining to academics and teaching.

I would like to thank the participants in this study, as this research would never have been finished without their support and trust in me. They regarded the interviews with me as a chat between friends instead of a task that had to be completed, and were always willing to give me advice before or after interviews from their position as experienced migrants. Their caring attitude touched me during the research process.

I would like to thank my proof reader Dr. David Peter Atkinson, who used weekends and public holidays to read my work, and polished the thesis like an artist with his language skills.

I would like to thank my parents, who supported me emotionally and financially throughout my master study in New Zealand. I want to thank my partner Royce Qian, who cooked for me when I was busy studying, and cheered me up when I felt depressed.

I would like to thank all my friends who regularly inquired about my thesis, and provided valuable advice as Chinese migrants. My special thanks go to Jack Chang, who is a professional healthcare interpreter and broadened my knowledge of the New Zealand healthcare system.

Finally, I would like to thank AUT University for supporting me and other postgraduates by providing academic consultation services, regular academic workshops and assistance in each stage of this research. This thesis is a combination of many people's efforts.

## **Abstract**

This study focuses on older Chinese migrants aged 65 years old and over, and explores their experiences of accessing health and support services. The research was informed by guidelines in interpretive phenomenology, and elicited themes related to the health system and service providers, based on participants' lived experiences.

Ten participants in this study, four men and six women, were recruited from two community centres in Auckland, New Zealand. Their time of arrival in New Zealand ranged from 2001 to 2012, and they had encounters with health or support service providers within the past three years. As the methodology requires rich data from participants, semi-structured interviews were employed to carry out in-depth conversation. Interview data were transcribed verbatim and translated by the researcher, and were further rewritten as anecdotes according to recurring themes.

Findings of this study revealed main themes as "being sick" and "being vulnerable", which demonstrated older Chinese participants' risks and sources of support in their daily lives. The subthemes under "being sick" were participants' feelings and barriers when accessing health services, which comprised participants' experiences with General Practitioners, publicly funded hospitals, emergency departments and other primary healthcare services. The subthemes under "being vulnerable" revealed health conditions and accidents which participants were at risk of. Participants' experiences with government services, non-government organisations, family members, acquaintances, and strangers were also discussed.



This study concluded that participants had not only experienced insecurity and vulnerability when accessing health and social services, but also experienced satisfaction and obtained generous help during encounters with various service providers. Meanwhile, the lack of awareness of the nature of different services provided in New Zealand influenced participants' choices of service and assistance providers, and may have caused them to be at risk as they lack the information of making informed decisions.

## Chapter 1 Introduction and Background

*Now when I think back, I have lived a happy life...my friends and I are all over eighty years old now, so we always gather when I go back to China. We gathered once a month, quite enjoyable...we used to gather every other month, then someone suggested that since we were all at an older age, we should gather once a month, someone might pass away tomorrow, who knows? Therefore, we gathered a lot when I went back to China. We were teenagers when first met, now we are over eighty years old.*

The paragraph above is a quote from my first participant, who is an older Chinese migrant living alone in New Zealand. Though these words were presented with constant laughs and a casual tone, the content made me feel sad.

Over the period from 1986 to 2006, the Chinese population soared from below 22,000 to over 140,000 (Liu & Lu, 2008; Xue, Friesen & O’Sullivan, 2012), and has “remained the second largest migrant group in New Zealand, after Great Britain” (Liu, 2015, p. 298). According to Statistics New Zealand (2013), 124,494 Chinese were born overseas, while 3,657 of them were aged 60 or older. Older Chinese migrants, as a category of Chinese migrants, possess their own characteristics. An influx of older Chinese migrants arrived in New Zealand, with a considerable percentage as “follower migrants” of their adult children (Wohlfart, 2014). Older migrants who are over 65 years old can experience more serious language barriers than younger generations, while collecting welfare or seeing doctors requires encounters with other ethnicities, as these older migrants frequently access health and support services.

Considering language and cultural differences in public services between China and New Zealand, ageing in a foreign country presents great challenges for this growing group of older Chinese migrants. In 2006, people from Asian ethnic groups aged 65 or older accounted for less than 5% of the Asian population in New Zealand. This number is anticipated to grow to more than 10% in 2026 (Statistics New Zealand, 2009). As the number of older Chinese increases, their thinking and behaviour can have an impact on their family and acquaintances, as well as on the overall perspectives towards ageing in the communities they clustered. It would be good if the voices of this growing group of older Chinese could be heard within the wider New Zealand community.

This chapter will talk about some shared characteristics of older Chinese migrants, the rationale of choosing my research topic, and ways in which my research answered the research questions. I will then give a glossary of acronyms that frequently appear in the thesis, and explain the outline of the thesis.

### **1.1 Who are the older Chinese in New Zealand?**

The language barrier of current older Chinese has its own historical causes. Most young Chinese migrants came to New Zealand for study or work, and under the requirements for Skilled Migrant Category Resident Visa, their English skills should surpass the level of daily communication (Statistics New Zealand, 2006b; Immigration New Zealand, n.d. a). Their parents, on the other hand, were the generation born before the 1960s. After the foundation of the People's Republic of China (PRC) in 1949, "political events rendered English unpopular" (Adamson, 2004, pp. 35-36), and Russian became the dominant foreign language in schools until "the breakdown of Sino-Soviet relations in the early 1960s" (Gill & Adamson, 2011, p. 28).

Soon afterwards, the Cultural Revolution started, in 1966, and school education was interrupted on a large scale until university began to admit students again in 1977 (Meng & Gregory, 2002). The generations born and raised during these three decades (1950s to 1970s) were affected, as English learning was discouraged. Therefore, English is generally a new subject for older Chinese migrants to cope with when they come to New Zealand. English and Te Reo Māori are the de facto languages in New Zealand (Immigration New Zealand, n.d. b), and the lack of ability to communicate in these languages severely disadvantages people who wish to have equal access to public services.

Age- and migration-related factors result in older migrants accessing health and support services. Firstly, illnesses such as cancer, depression, anxiety and other chronic diseases are more likely to develop with ageing (Byles et al., 2016; Chew-Graham & Ray, 2016; Moussavi et al., 2007), and thus older people are more likely to use health services. General Practitioners, as part of the public health system, are therefore more frequently accessed by older people compared to younger individuals. Secondly, older adults are commonly under the adverse influence of falls and mobility problems (Rubenstein, Powers & MacLean, 2001), which can lead to loss of basic independence and needs of caregivers or support services. Thirdly, being a New Zealand citizen or permanent resident with no income can mean that such a person can claim a range of welfare, subsidies, benefits, as well as a pension when over 65 years old. Older Chinese migrants need to frequently access government and social services to see whether they are eligible for government support to help them pay for daily necessities, including food, accommodation, transport, utilities and health services.

Studies suggest that Asian patients may be overrepresented in certain health statistics, particularly when it comes to diabetes (Raymond et al., 2009) and eye conditions (Quigley & Broman, 2006) such as cataracts. Besides, Chinese migrants may be more likely to suffer from mental health issues, including depression (Abbott et al., 2003; Mui, 1996) and elder abuse (S. Wong, personal communication, 22 November, 2015), which can also impact people from within the immediate family. When unexpected accidents such as theft and emergency medical conditions occur, or when their family or friends are unable to support them, older Chinese migrants have to look for help from other sources. On the other hand, social services are utilised because older migrants are eligible for a range of welfare such as pension, subsidies and benefits. According to statistics collected by the Department of Labour in 2007, Chinese migrants were the second largest migrant group in New Zealand, and received benefits most frequently as recorded on the list (Department of Labour, 2007).

Family members do not always provide support when older migrants are at risk. Though participants arrived in New Zealand by following their adult children, their adult children have the responsibility of working full-time and taking care of their own families, which means older Chinese sometimes have to deal with many issues by themselves. Among all kinds of public services, healthcare services can have great impact on older adults' wellbeing. Sometimes older adults access the services urgently, which allows no time for any assistance providers to come along and help resolve issues. There are also older adults who followed their children when they first came to New Zealand, but were left alone after their children went back to their home countries thus becoming what Wang (2013) terms "abandoned parents". In this case, interpreters and/or Mandarin speakers are their only sources of help.

When older Chinese migrants have encounters with healthcare service providers or interpreters, they intend to give comments from their own perspectives. As health or social services involve face to face communication, patients' satisfaction level could impact the efficiency and eventual effects of services. In present day New Zealand society, quality services are essential to the competitiveness of private service providers (Brunton, 2009). This factor may also have an influence on services provided in public sectors, as the New Zealand Office of Health and Disability was founded with the aim of effectively addressing complaints from health consumers. In addition, District Health Boards need to meet targets set by the Ministry of Health in terms of length of time patients have to wait in Emergency Departments, length of time between referral and diagnosis, and so on (Ministry of Health, n.d.). Therefore, service users' voice matters and can even cause changes in the public health system. According to statistics presented in the previous section, older Chinese migrants are an indispensable part of public health service users, and thus their comments should be of value for service providers and policy makers.

Since its foundation, the New Zealand Office of Health and Disability has received a growing number of complaints each year (Paterson, 2002), while increasing funding cuts have resulted in fewer medical staff, and led to increased workloads and burnouts. This can affect the waiting time and health professionals' attitude towards patients, as there is inadequate capacity for the large number of patients in public hospitals and emergency departments every day. In consequence, service consumers, including older Chinese migrants, can suffer from long waiting or lack of caring before they receive diagnosis or treatment from specialists.

Even though public healthcare service can be accessed by New Zealand citizens for free, there are still other needs that need to be fulfilled. For patients with LEP (limited English proficiency), expressing their requirements involved more work such as seeking help from healthcare interpreters and other sources. Considering the changing expectations of service consumers, it would be challenging to achieve mutual satisfaction from both consumers and healthcare providers (Ramseook-Munhurrin, Lukea-Bhiwajee & Naidoo, 2010). Requirements of safer working hours and higher salaries have caused recurrent strikes among junior doctors even until now, and the shortage of medical staff could not be solved due to limited investment (Radio New Zealand, 2016; Robinson, McCann, Freeman & Beasley, 2008). Cost cutting in the public service could force public officials to look for innovative solutions different from conventional measures (McClintock, 2015). By looking into older Chinese participants' experiences with the New Zealand public healthcare system for this study, I attempt to understand their needs and expectations at the present time.

Older Chinese migrants normally provide care for their grandchildren and/or undertake housework in their adult children's houses. It should be noted that multiple aspects of caregivers' lives can be affected when demands for caregiving are high, including free time, social life, emotional and physical health, and personal development, which are regarded as caregiver burdens (Lu, Liu & Lou, 2015). When fulfilling duties as caregivers, older adults' own physical or psychological issues will be more likely to be neglected.

## **1.2 Why I chose the research question**

This study focused on two research questions which guided the interviews:

1. What are the experiences of older Chinese-speaking migrants in Auckland when accessing health and support services in New Zealand?
2. What kind of language and culture support do participants feel would be best for them?

The previous sections in this chapter have shown the close connection between my research questions and the shared characteristics of older Chinese migrants and the various barriers to accessing health and social services they may encounter in everyday life. On the one hand, older Chinese migrants are connected with their grandchildren, their adult children, and other family members through their children's marriages. Since Chinese migrants have "remained the second largest migrant group in New Zealand" (Liu, 2015, p. 298), the impact of research on older Chinese migrants has great social significance considering the number of people involved. It is hoped that this study may throw more light on the way older Chinese migrants experience health and social services in New Zealand, so as to enable service providers to take this into account when developing services for this specific section of the ageing population. On the other hand, older Chinese migrants are often not equipped with the language skills needed for living in New Zealand, and their needs for utilising health and support services are prerequisites for normal lives, meaning that they are quite likely to have experienced difficulties or obstacles when having encounters with service providers.

### **1.3 How I will answer the research question**

This research was conducted underpinned by the philosophy of phenomenology. As phenomenology is a philosophy that emphasises looking at experiences as they are (Crotty, 1996), it "studies phenomenology as they exist in the world" (Wright-St Clair,



2014, p. 54) and best serves my research questions. The study aimed to uncover the lived experiences of my older participants as recounted by them. The ensuing rich data allowed participant voices to be heard.

Participants' experiences of health and support services are discussed across several subcategories: General Practice (GP) care, public hospitals, emergency departments, other forms of primary care, healthcare interpreters, government services, community services, and other service providers. Each subcategory was further divided into strengths, limitations, expectations, and other opinions. An overall conclusion summarising my findings across all services follows at the end of the thesis.

Participants' opinions and expectations of language and culture support are part of the findings uncovered by the first research question. The difference lies in the addition of my own experiences and opinions, along with a comparison with the literature.

#### **1.4 Common acronyms used in the thesis**

ADHB: Auckland District Health Board

CALD: culturally and linguistically diverse

DHB: District Health Board

ED: Emergency Department

GP: general practitioner/general practice

LEP: limited English proficiency

TANI: The Asian Network Incorporated

\* “Foreign” used in this thesis refers to places or people different from speakers’ birth countries or ethnicity, in other words ‘non-Chinese’.

## **1.5 What I will discuss in the thesis**

In this chapter, I have talked about the background and rationale for this study. I have indicated the importance of research questions and how I relate to them. The connection between research questions and the methodology I chose is also briefly explained. Next, I set out how the findings chapters are structured. After a definition of common acronyms in the thesis, I have provided this outline to provide an overview of the thesis.

In Chapter Two I will review the existing literature, look critically at the literature, synthesise the results, and consider the gap in knowledge that my study hopes to address.

In Chapter Three I will talk about the methodology and corresponding research design. A definition of the methodology is given, followed by the connection between the methodology and my research. I also describe the whole process of the research, including research design, participants in this study, interview questions, and inclusion criteria designing, recruitment, data collection, and data analysis.

The research findings are presented in Chapters Four and Five. Chapter Four provides findings on participants’ views and expectations of health and support services, while Chapter Five presents findings on participants’ choices and sources of assistance providers. These two chapters contain accounts of participants’ lived experiences that are related to research questions, and my understanding of the underlying meaning.

Chapter Six is the Discussion and Conclusion chapter, in which I discuss preceding chapters, and explore the meaning of participants' experiences. Based on participants' feelings during and after their experiences, I try to explain the meaning underneath their encounters with health and support services.

## **Chapter 2 Literature Review**

### **2.1 Introduction**

This chapter will look at three areas of literature: history of Chinese people's immigration into New Zealand and older Chinese migrants, importance and barriers to health and support services for older people, and studies investigating the views of older service consumers by using different research methods. As the research topic of this study focuses on older Chinese migrants, literature on the topic of older migrants is necessary to be covered. Strengths and limitations of previous studies can also provide valuable instructions for this study, as researchers have employed a range of research methods to explore experiences of older migrants. As this study will explore participants' perspectives on health and support services, it is necessary to have a general idea of other studies which have examined migrants' main interactions and obstacles with the healthcare system and social services. In order to explain why I chose phenomenology as my research method, I will review studies which used quantitative or qualitative methods and which are relevant to my research topic. I will discuss the benefits and limitations of each method, and then focus on studies that used phenomenology as their methodological approach. The above areas should give a general overview of the previous findings concerning this research topic.

### **2.2 Immigration**

According to Norris et al. (2010), New Zealand patients' ethnicity information is recorded in the healthcare datasets and is based on self-identification. Ethnic heredity determines a person's ethnicity; albeit it is cultural belongingness and place of upbringing that shape perspectives and opinions. Therefore, migrants should be considered as Chinese migrants only when they self-identified as Chinese.

New Zealand Superannuation regulates that people at a minimum age of 65 can receive pension (Statistics New Zealand, 2013), and thus it should be reasonable to consider being aged 65 and over as a criterion for identifying ‘older’ adults.

There are two turning points in the history of Chinese emigrating to New Zealand. Ever since the arrival of Chinese gold seekers in the 1860s, mass immigration of Chinese was inhibited by government policies, and did not occur until the early 1990s, when people from Hong Kong and Taiwan accounted for a large portion of immigrants (Spoonley & Bedford, 2012). In 1997, the sovereignty over Hong Kong was transferred from the United Kingdom to the People’s Republic of China, which caused feelings of uncertainty among some Hong Kong residents (Xue, Friesen & O’Sullivan, 2012). Quite a few Hong Kong movies produced before the handover also revealed fear or even anger towards the unknown future, and this kind of feeling may have been a ‘push factor’ (Wohlfart, 2014) resulting in emigration. Meanwhile, Taiwan was experiencing an improved economy, a relaxed political environment, business migration programmes, and favourable views of New Zealand, which could have contributed to the wave of Taiwanese migrating to New Zealand during the late 1980s and early 1990s (Xue, Friesen & O’Sullivan, 2012; Museum Victoria, n.d.). After 2000, migrants from China and India were the top ethnic groups arriving in New Zealand (Spoonley & Bedford, 2012). Over the period from 1986 to 2006, New Zealand’s Chinese population soared from less than 22,000 to over 140,000 (Liu & Lu, 2008; Xue, Friesen & O’Sullivan, 2012), and Chinese “have remained the second largest migrant group in New Zealand, after Great Britain” (Liu, 2015, p. 298).

New Zealand policies concerning Chinese migrants have also undergone several changes during the period. In 1881, a Chinese Migrants Restriction Act was passed to

charge a poll tax of £10 on Chinese, as well as implementing tonnage restrictions against Chinese (Wei, 2007). From 1936, Chinese were entitled to receive a pension; from 1938, all social security benefits were open to Chinese people (Spoonley & Bedford, 2012). The policy change in 1986 abolished preference for particular source countries, followed by the introduction of a points selection system in 1991 (Spoonley & Bedford, 2012; Wei, 2007). In general, migrant families tend to maintain strong family links even when they are in other countries, and methods of support include sending remittances overseas and family reunion sponsorship (Statistics New Zealand, 2006a).

From 1 July 2003 to 30 June 2013, 'follower' parents accounted for 21.3% of all Chinese residence approvals (Bedford & Liu, 2013), while from 2013 to 2017, 2,157 older Chinese were granted residency under parent category (including parent, family parent, family parent tier 1 and family retirement) among 10,257 Chinese residence approvals (Immigration New Zealand, 2017), accounting 21.0%. The high rate means that this group's needs and ways of living not only impact their children, but also on the wider New Zealand community. According to 36 articles that Lin, Bryant, Boldero & Dow (2015) studied in the literature review, they found that for older Chinese migrants, their age at the time of migration and their length of stay in the host country both had an impact on their living arrangements, which could in turn influence their feelings about living in New Zealand and level of support received.

Research studies normally define older Chinese migrants as a homogeneous group; however, Liu (2003) divided them into four subgroups. The subgroups are migrants who have stayed a short period in the host country after 60 years old, migrants who have stayed a long time in the host country after 60 years old, retired professionals

who arrived in the host country at a young age, and retired non-professionals who arrived in the host country at a young age. Due to different degrees of influence from and familiarity with the host country, people from different subgroups may have different opinions towards the same service.

Immigration New Zealand (2016) reduced the number of places for the capped family categories in 2016, and temporarily closed the Parent Category, resulting in no Expressions of Interest being selected from the Parent Category Pool from 12 October 2016 onwards. This policy will directly restrict the number of older Chinese coming into New Zealand, and change the structure of older adults' subgroups as time goes by.

## **2.3 Health and support services**

In order to explain the connection between older Chinese migrants and health and support services, I will first explore the connection between age and health conditions from findings of previous studies.

### **2.3.1 Age and health**

Ageing is accompanied by a greater likelihood of cancer, depression, anxiety and other chronic diseases (Byles et al., 2016; Chew-Graham & Ray, 2016; Moussavi et al., 2007), which can influence older people's perception of life experiences. Moreover, falls and mobility problems are ranked among the top two most common and serious concerns that older adults face (Rubenstein, Powers & MacLean, 2001), which can deprive older people of basic independence and result in the need for the assistance of caregivers or support services.

According to Byles (2007), during the ageing process, even older adults who maintain fitness and age positively will experience declining health. Furthermore, middle-aged and older people tend to associate detrimental changes in their physical condition with

ageing (Wurm & Benyamini, 2014), making it more difficult for them to take positive measures and recover from setbacks. For people experiencing changes from working life to retirement, the time and circumstances of the adjustment can also relate to physical and mental health (Byles et al., 2016). From previous studies, Schroyen et al. (2017) conclude that ageism from within the wider community will have a negative impact on older adults' physical and mental health as well as reducing their chance of survival. There is also increased risk of declining activities relating to daily living function with ageing (Covinsky et al., 2003).

Cancer occurrence is prevalent among older people (Smith, Smith, Hurria, Hortobagyi & Buchholz, 2009), which can have an impact on other aspects of their daily lives. As a “disadvantage in one life domain increases the probability of exposure to additional disadvantages in the same domain” (Heap & Fors, 2015, p. 412), older adults with cancer or other chronic physical illnesses are more likely to suffer from psychological health problems, mobility limitations, and lack of financial resources. For older patients with acute disease, hospitalisation can also have a negative impact, as adverse functional changes can occur on many patients at the time of discharge (Covinsky et al., 2003).

For older Chinese migrants, their reasons for immigration can have a great influence on the way they feel about settling in a country outside of mainland China. During interviews conducted by Wang (2013) with community service providers, who had encounters with older Chinese migrants that suffered from abuse or neglect, social isolation was identified as a risk factor that results in powerlessness and refusal of seeking help (p. 50). Even for migrants of the same ethnicity and around the same age, different waves or types of immigration, which are referred to as “generation waves”



by Trang (2008), contribute to differing attitudes towards the same kind of health and support services. A study carried out in Auckland found that though migration could not be counted as a uniform phenomenon (Abbott, 1997), “people migrate at an advanced age constitute one of these high-risk groups” (Abbott et al., 2003, p. 445). It was also found that among those participants, none of the new migrants (who had migrated within one year) showed signs of depression (Abbott et al., 2003). When Steunenberg, van der Mast, Strijbos, Inouye & Schuurmans (2016) were exploring views of Chinese service users, both medical professionals and patients mentioned patients’ feelings of loneliness when staying in the hospital, especially among those who had little company other than doctors and nurses. Meanwhile, Heidenreich, Koo & White (2014) focused on Chinese migrant women who fully devoted their personal time to caring for terminally ill relatives, and tried to identify barriers in accessing palliative care support services. Therefore, variables influencing health issues not only include age and quality of services provided, but also involve the length of immigration and level of emotional satisfaction. Besides, older migrants’ relationships with family members (Shih & Pyke, 2008) and each person’s personality (Schroyen et al., 2017) also have an impact on their physical and mental health. Ho, Au, Bedford & Cooper (2002) further listed factors that affect Chinese people’s utilisation of mental health services in New Zealand, including language ability, knowledge of the service provided and cultural differences. Besides subjective factors, older patients’ habits of treating illnesses also have an impact on the utilisation of health services; for example, self-medication is a popular treatment among older Chinese migrants when illnesses are not severe (Chan & Quine, 1997). As there is no general practitioner (GP) in China, self-medication is common when medical conditions are not serious, as patients can avoid standing in long queues for registration and waiting for diagnosis.

However, if patients are seriously sick, self-medication can delay treatment and result in serious negative consequences.

### **2.3.2 Health and support services in New Zealand**

As a culturally diverse society, New Zealand provides a variety of health and support services targeted at people from different ethnic backgrounds. The health sector involves services by healthcare providers, government organisations, and communities.

The Auckland District Health Board (ADHB) provides a range of services and programmes for culturally and linguistically diverse (CALD) communities. Qualified interpreters are recruited by ADHB in different regions and assigned to public hospitals, and patients can apply to use an interpreter for free in these hospitals through their GPs. Within Waitemata DHB, Sue Lim started an organisation named Asian Health Support Services to provide a variety of support to Asian patients, and also ensured that WDHB staff were trained to better work with the CALD population (Waitemata District Health Board, n.d.). Online resources and courses, developed by Waitemata DHB and funded by the Ministry of Health, are also used to teach health professionals how to work with CALD communities (eCALD, n.d.).

Asian Family Services is an organisation that provides information, education and support on a range of issues affecting Asian families (Asian Family Services, n.d.). Aimed at providing opportunities for Asian communities to be heard in the public arena, The Asian Network Incorporated (TANI), which evolved from The Asian Network Steering Committee, holds workshops and develops programmes constantly for the benefit of Asian communities (TANI, n.d.). The Bhartiya Samaj Charitable Trust offers a wide range of services through Senior Citizens Wing, Children and

Youth Wing, New Migrants Support Wing and Social Services Wing, and cooperates with other Community Welfare organisations that are operating in the Auckland region (Bhartiya Samaj Charitable Trust, n.d.). The Chinese Positive Ageing Charitable Trust is a non-profit organisation established by a group of professionals for the physical and psychological wellbeing of the Chinese older adults in New Zealand, aiming to promote the quality of life for older Chinese in New Zealand through psychological, physical and social activities (Chinese Positive Ageing Charitable Trust, n.d.). The Chinese New Settlers Services Trust provides services that help Asian migrants to successfully settle in New Zealand and to help their children maintain connections to their cultural heritage (The Office of Ethnic Communities, n.d.). Bo Ai She (a Chinese mental health peer support organisation) is a volunteer organisation that provides group support to Chinese mental health service users and their families, initiated by a team of Chinese Mental Health Professionals (Bo Ai She, n.d.).

Auckland University of Technology has developed an active ageing programme named Never2Old since 2002, which gives people aged 60 and over a set of easy-to-follow exercises, and helps them achieve and maintain an active and independent lifestyle (AUT, 2016).

Social services in New Zealand are mainly provided by the government and non-profit organisations. As new migrants are likely to obtain information from earlier arrivals, their choices of social services can overlap and focus on just a few service providers.

Citizens advice bureaus provide people with support and useful information through volunteers, aiming to help people understand their rights and obligations (Citizens Advice Bureau, 2016).

New Zealand Work and Income (WINZ) offers superannuation for people who have lived in New Zealand for at least 10 years since they turned 20, and five of those years must be since they turned 50 (Ministry of Social Development, 2016). Social services in New Zealand that are targeted at older people include GreyPower, the Returned Services Association (RSA), Age Concern and Presbyterian Support organisations. GreyPower is a voluntary organisation that aims to advance, support and protect the welfare and wellbeing of older people (GreyPower, n.d.). The RSA was formed by returning Anzac soldiers in New Zealand in 1916 to provide support and comfort for service men and women and their families, and its National Office helps local RSAs to provide financial assistance and create support networks (RSA, n.d.). Age Concern organises activities and workshops to ensure older people stay connected with their family, friends and community (Age Concern, n.d.). Presbyterian Support organisations, which provide services under the name “Enliven” in recent years, are operated on a “not-for-profit” basis. Most of them provide in-home support to older people, and there are retirement villages available in some regions (Enliven, n.d.).

### **2.3.3 Barriers to accessing health and support services**

Though governments and communities across the globe provide a range of services for the benefit of their citizens, barriers and limitations can still exist when taking into account cultural needs, physical conditions and emotional differences. Difficulties may occur at any time during the process of locating the right type of services, getting to the destination, waiting for treatment, and during diagnosis. Therefore, it is crucial

to identify barriers in health and support services in order to understand participants' experiences.

The team leader at TANI stated that language issues are not the sole barrier when accessing healthcare services; other issues can include different concepts of health and wellbeing, lack of knowledge regarding the service's nature, different expectations, lack of preventive behaviour and cultural issues (S. Cho, personal communication, 14 December 2016). As TANI focuses on the Asian groups in New Zealand, some barriers mentioned here align with some common issues among new migrants, such as a lack of knowledge about the service's nature and language issues.

A small number of studies have been conducted as to the experiences of (older) migrants trying to navigate health and social systems in New Zealand. Wright-St Clair and Nayar (2017) used focus groups to explore Chinese, Indian and Korean late-life immigrants' community participation. They found the participants' limited English language proficiency restricted their participation in mainstream social activities.

Perez (2012) found that migrants from Latin America found it difficult to navigate the New Zealand health system, and main reasons were the lack of information and cultural differences. When exploring the experiences of older Chinese migrants on New Zealand health system, Wang (2011) found that they have a great tendency of relying on Chinese social circles for healthcare information. Nayar and Hocking (2006) found out that well-educated Indian migrants could have difficulty when using an ATM machine or finding their way towards a supermarket, which shed light on older migrants' potential barriers.

A study (Ma & Coyle, 1999) summarised barriers that native Americans faced when accessing disability services such as lack of a specific agency, inconsistent policy implementation, lack of cultural awareness, time lag between referral and diagnosis, lack of long-term planning in service providers, lack of well-trained professionals, geographic isolation, and transportation inconvenience, as well as lack of community involvement. As there were only a few studies concerning the barriers that older Chinese migrants face when accessing health system in New Zealand, I included the study of native American Indians to have some idea about possible barriers when accessing the health system. As an ethnic group in the United States, American Indians reveal obstacles that can apply to the whole population, while the lack of specific services for an ethnic group can apply to any country.

When it comes to older Chinese in the United States, lack of mobility and language barriers were two main limitations when they accessed health services (Pang, Jordan-Marsh, Silverstein & Cody, 2003). A previous study on older Chinese migrants in the United States highlighted participants' lack of awareness concerning available social services, while poor location of service providers, complex procedures and lack of medical staff comprise the additional barriers (Tsai & Lopez, 1997). Lack of mobility is common among older adults, as age-related muscle loss and chronic diseases are usually accompanied by walking problems. When older Chinese have restricted mobility while having no one to turn to, even accessing health services can be challenging.

In a study carried out on older Chinese migrants in Canada, language barriers and long waiting lists were the top two difficulties that participants faced, while lack of awareness of existing health services and cultural or ethnic differences also ranked

high in participants' answers (Lai & Chau, 2007). Blignault, Ponzio, Rong & Eisenbruch (2008) discovered striking shortages of knowledge about health systems and sources among Chinese-born migrants in Australia; additionally, language barriers and cultural differences impacted all informants to varying degrees.

Dong, Chang, Wong, Wong & Simon (2011) noted that participants in their study avoided visiting healthcare professionals for elder mistreatment/abuse, attributing the behaviour to insufficient understanding of health professionals' roles, cultural and linguistic barriers, and probable time constraints during medical appointments. Based on their finding, I decided not to include focus group in the data collecting phase, as one on one interview can be less threatening and thus drawing out more details. Through participants' words and their own knowledge, Dong et al. (2011) deduced a barrier that most studies fail to discuss: emotional support is a major factor that migrants seek besides medical treatment. Language barriers largely reduced patients' communication channels with healthcare professionals, and thus empathy and comfort could not be felt by patients when they genuinely needed them. After conducting interviews with community social workers on the topic of elder abuse in New Zealand, Wang (2013) concluded that the three main barriers to service utilisation in Auckland are lack of language skills, inadequate knowledge of services and systems, and lack of transportation.

## **2.4 Approaches on older service consumers' views**

Before starting research, researchers need to choose a method that fits their aims and helps to answer their research questions. When collecting the views of older health consumers on health and support services, some researchers use qualitative methods such as observation, focus groups, and interviews to explore participants' individual

views and experiences in detail, while others use quantitative methods such as questionnaires to acquire views from a range of participants and make conclusions that can be generalised to a wider population. By using different methods, researchers summarise findings from diversified dimensions, which can help reduce limitations existing during the data-collection phase.

#### **2.4.1 Qualitative research**

Taylor, Bogdan and DeVault (2016) considered phenomenology a principle part of qualitative methodologies. With the phenomenological approach, researchers conduct interviews or focus group discussions to understand the meaning of an experience rather than drawing conclusions or making generalisations.

For studies using focus groups, perspectives and understanding of participants can be more thoroughly understood by researchers through group interaction, and the needs of older people can be identified through group discussion (Gallagher & Truglio-Londrigan, 2004). In one study, medical staff were included in focus discussion groups, in which older health consumers discussed their needs, concerns, and expectations, while health professionals put forward suggestions in the final phase of the study, and such suggestions were counted as practical outcomes of the study (Woo, Mak, Cheng & Choy, 2011). According to analysis by previous researchers, research participants mostly come from either a specific socioeconomic group or organisations with similar characteristics, and thus it may be difficult to generalise to the whole population (Woo et al, 2011; Sixma, van Campen, Kerssens & Peters, 2000). Additionally, members in focus groups are more likely to have an impact on each other (Gallagher & Truglio-Londrigan, 2004), and thus interviews can better suit the aim of collecting individual experiences and opinions. Through studying focus groups



comprised of older Chinese migrants in Australia, researchers found that older migrants from mainland China preferred Chinese-speaking medical staff (Chan & Quine, 1997). By conducting focus groups among older service users as well as health and support service providers in Hong Kong, researchers were able to elicit a variety of attitudes and views from participants, including issues with long waiting times for treatment, expensive medications, and doctors' preference for prescribing cheap medications because of cost constraints (Woo et al., 2011). Regardless of insufficient knowledge of the health system, older users of community support were able to learn from one another and their own life experiences, while caring connections between supporters and older users also helped to facilitate supportive intervention (Gallagher & Truglio-Londrigan, 2004).

A number of previous studies conducted semi-structured interviews with older migrants, and gained rich data from each participant's unique healthcare experiences and perspectives; a range of themes can be elicited during the process as well (Considine et al., 2010; Grimmer, Moss & Falco, 2004; Way, 2008). For example, Considine et al. (2010) identified four themes based on older people's experiences of accessing emergency care and triage processes; Grimmer et al. (2004) also identified eight key themes concerning patients' return to sustainable independent living by their participants' perspectives. Further, participants' individual attitudes towards healthcare services can be observed more clearly through one-to-one interviews. For example, Themessl-Huber, Hubbard and Munro (2007) discovered that older people appeared to be ambivalent when commenting on the admission process and concerning healthcare professionals, and this is often deduced from word usage and manner of speaking. However, since interviewers have a leading position in the interviews, researchers' lack of training may cause failure to fully explore

participants' ideas or interpret data (Bridges, 2008). When faced with more than one interviewee at the same time, interviewers may go off topic and recordings can become difficult to transcribe (Way, 2008).

#### **2.4.2 Quantitative research**

Some studies employed survey to gather data from participants about “who they are, how they think and what they do” (Balnaves & Caputi, 2001, p. 76), in order to gather views from a large quantity of older migrants. For example, Nolin et al. (2006) created a mail survey to collect responses from potential respondents, and received responses on seven main categories from 372 respondents. Grimmer et al. (2004) conducted semi-structured interviews with 100 older patients, and collected both qualitative and quantitative data. Sixma et al. (2000) obtained empirical statistics on experiences and opinions of 338 older people, also combining qualitative and quantitative methods.

By conducting a survey on older Chinese people's choices of using senior centre services in Canada, Lai (2001) found out that 73.5% of older Chinese knew about the services through relatives or friends. Wang (2011) also found that older Chinese migrants in New Zealand have a great tendency of relying on Chinese social circles for healthcare information. From these findings, I would say that the utility of public services not only depends on promotions targeted at older Chinese, but also relies on the promotion of such services among members of older Chinese people's social networks. Participants also expressed their own opinions concerning health services, such as inconvenient office hours, worries about being regarded as having problems, young age of professionals, and annoying weather conditions; additionally, other people's bad experiences also had negative influences on their choice of services (Lai

& Chau, 2007). When Ho, Lewin and Muntz (2010) asked older Chinese in New Zealand about health issues, most participants identified health as the key factor that effects their community involvement, and most intended to maintain independent living for as long as possible.

The above studies showed what kind of answers that quantitative studies could come out with on the topic of older Chinese accessing a health system outside of mainland China. Given that my research questions focus on the lived experiences of participants, survey is not a suitable research method for delving life stories. I will explain in the next section why one on one interview is more appropriate for the purpose of this study,

### **2.4.3 Phenomenological method**

Among studies that used qualitative methods to study older migrants, researchers who employ phenomenology could focus on participants' accounts of particular moments and try "to understand something as an event" (van Manen, Higgins and Riet, 2016, p. 6). Participant-focused methods help researchers explore what happens as it is instead of drawing a conclusion. Therefore, using phenomenology can serve the purpose. Semi-structured interviews adjust questions based on participants' statements, and enable participants to reflect on that particular point in time, meaning that more details can be elicited than in survey or mail questionnaires. Moreover, researchers can immerse in the research data by doing verbatim transcription on their own, which enables them to reflect on participants' stories in depth, and make conclusions with comprehensiveness. In this section, I will briefly examine the strengths and weaknesses of studies that use interviews as a data-collection method.

In contrast to other migrant studies, Stephens, Flick, Tan, Ward and Ziaian (2010) conducted interviews in English with non-native speakers. This method not only met their purpose of “extending the research beyond the general Chinese population” (Stephens et al., 2010, p. 700), but also enabled researchers from other cultures to have direct conversation with under-researched ethnic groups. It should be noted that in the study conducted by Stephens et al. (2010), 85.7% of Chinese participants chose English as their preferred language spoken at home; thus, they are less likely to participate in activities held in Chinese. Therefore, instead of involving organisations specifically targeted at Chinese, researchers can expand recruitment sources to include general community activities or public events.

Unlike most phenomenological studies that use semi-structured interviews, Chan and Lai (2015) used unstructured individual interviews to suit their research topic. This method may affect the outcome of interviews, since random talk can lead to irrelevant themes, and may consume much time when extracting useful data in the analysis stage. Instead of pure unstructured interviews, Peterson and Minnery (2013) conducted interviews by referring to an interview guide to maintain the same topics for each interview. Therefore, although some of the interviews were unstructured to allow elaboration from participants, the base of the interviews remained roughly the same.

There are studies that aimed to obtain rich data by interviewing separate groups of participants—however, the recruitment process could turn out to be different from that intended in the research design. For example, Szu-Yao (2011) aimed to recruit nurses, aged-care residents, and family caregivers, but only nurses and family caregivers participated. In such cases, the researcher should offer an explanation

about the change in the methodology or limitations section, as well as providing possible solutions to future researchers.

Tan, Loi and Yong (2015) regarded data saturation as the criterion for stopping interviews. I agree with the method, since gathering and analysing repetitive data may not reveal any new understandings. However, Tan, Loi and Yong screened, recruited and interviewed twelve participants in a process that did not involve checking whether data saturation was reached. In addition, it was not clear whether recruitment ended before interviews started or after data were saturated, making it difficult to validate the application of this method.

Sometimes participants may refuse to sign consent forms or have interviews recorded, and this sometimes only becomes obvious just before interviews are about to take place (Lo & Russel, 2007; Chan & Lai, 2015). I informed potential participants about the use of consent forms when I talked to them during briefing appointments instead of just before interviews. Participants only met the inclusion criteria when they agreed to give written consent, and those who gave oral consent for interviews but refused to sign consent forms were excluded. As for recording, if the research question requires transcription of interviews, researchers should only select participants who are willing to be recorded.

According to Wright-St Clair (2014), asking phenomenological questions is a pre-stage of gathering phenomenological data. If researchers have not received proper training on phenomenological inquiry, interview questions can stray from the claimed methodology. In a study done by Stephens et al. (2010), the majority of interview questions inquired about participants' opinions and anticipation of ageing rather than their lived experiences, resulting in a lack of description in the analysis section.

Todorova, Guzzardo, Adams & Falcón (2015) interviewed 50 participants and selected 20 of them, which ensures the variety and generality of the data. Nevertheless, considering that each interview lasted one to four hours, it would have been more efficient to conduct a survey before interviews, so as to gather demographic information.

This literature review has identified a gap in the literature, in that no previous study has explored the lived experiences of older Chinese migrants with New Zealand health and social services by exploring their lived experiences. The study reported on here asked older Chinese migrants about their lived experiences in the course of one-on-one interviews.

## **2.5 Conclusion**

This chapter has given an overall picture of older Chinese migrants' situations and opinions. In the previous decade, a great number of older Chinese migrants arrived in New Zealand as parents, demonstrating significance for research. As a vulnerable group facing language and other barriers, Chinese migrants arriving in New Zealand at an old age can encounter various difficulties, which may also have an impact on their adult children, grandchildren, and neighbours as well as members of wider communities.

Ageing is commonly accompanied by a deterioration in physical health, while isolation and loneliness can lead to emotional problems. Therefore, older Chinese migrants frequently utilise health and support services, which are provided by a range of publicly funded services, organisations, and communities. Previous studies (Lai & Chau, 2007; Pang et al., 2003; Tsai & Lopez, 1997) concluded that older service consumers mainly experienced barriers including language and ethnic differences,

administration and policy issues, long waiting lists, and transportation inconvenience, while older people's inadequate knowledge of existing services and the nature of these services were also major limitations. However, past literature regarded health services or social services as a whole, failing to investigate the characteristics of each service provider and relevant barriers.

Qualitative methods, quantitative methods, and a combination of the two methods have all been used to collect older service consumers' views. Qualitative research has been used to gather rich data through group discussion or individual interviews, focusing on potential themes and broader topics that participants might talk about. However, there were also unavoidable limitations: firstly, participants could go off topic during interviews or focus group discussions; secondly, a small number of participants and specific sources of recruitment made it hard to generalise conclusions to the whole population; thirdly, transcribing interviews involved a lot of time, and data analysis was based on researchers' own opinions, which could be subjective. Quantitative research uses large samples to reach conclusions, and can reach people from a range of backgrounds by doing mail surveys or creating online questionnaires. Limitations of quantitative research include: limited options to choose from, and difficulty for researchers to sort out influencing factors during data analysis. Phenomenology employs the method of story-telling, as researchers endeavour to deduce participants' views through their experiences at a particular point in time. By collecting participants' own stories on the same topic, researchers can compare differences and elicit similarities, and analyse a single story in various dimensions.

## **2.6 Summary of chapter**

This chapter has provided a brief overview of immigration history and some background information on the arrival of older Chinese migrants in New Zealand. It has reviewed previous studies which explored the importance of and barriers to health and support services for older people, and older service consumers' views gathered through different research methods. It has identified a gap in the literature, in that no previous study has explored the lived experiences of older Chinese migrants with New Zealand health and social services by exploring their lived experiences. The next chapter will outline the methodological approach used for this study in more detail, including the rationale, research questions, ethics approval, participant recruitment, data gathering and data analysis.



## **Chapter 3 Methodology and Methods**

### **3.1 Introduction**

This study employed interpretive phenomenology to collect older Chinese migrants' experiences of accessing New Zealand health and support services, in order to develop an understanding of their lives in New Zealand. The project was approved by the Auckland University of Technology Ethics Committee (AUTEC) prior to commencement, which ensured that participants' rights were protected, and that data were kept private and secure during the research.

In this chapter, I will look at the methodology of this thesis, and the reason why this approach was suitable for this study. Then I will talk about the methods used during the research process, including participant recruitment, data gathering and data analysis.

### **3.2 Methodology**

As the methodological approach of this study, interpretive phenomenology guided the research design and methods used. In order to design and conduct an inquiry that suits the research aim, phenomenological researchers should have an understanding of the underpinning philosophy (Wright-St Clair, 2014). I will consider the philosophical ideas and explanations concerning phenomenology in this section, and describe how I used them as the guideline for this study, so as to give a clear picture of how I planned to collect and analyse the data.

#### **3.2.1 What is phenomenology?**

By looking at Aristotle's philosophy with phenomenological interpretation, Heidegger (2010) initiated a move from descriptive phenomenology to interpretive phenomenology. Based on specific methodological frameworks, phenomenology is

considered a qualitative methodology along with grounded theory, ethnography, and narrative inquiry (Lowenberg, 1993). Subjectivity could be considered a major limitation of qualitative methods, as participant data are potentially influenced by researchers' views and background. However, Crotty (1996) suggested objectivity still existed in phenomenological studies as researchers studied individual experiences of participants, which can be counted as things that have existed. To explain this colloquially, participants' experiences and underlying meanings are things that exist and will always exist, though researchers bring their own perspectives during the interpretation process. The study of phenomena, or things in themselves, brings a particular perspective to this mode of qualitative research.

Chan and Lai (2015) asked participants to validate the contents of the tapes at the end of each interview. If audio recorders were functioning in the right way, then the content of the tapes would indicate no changes to their previous interviews. It is the analysis phase that involves subjectivity, since researchers' preconceptions may cause them to misinterpret what participants have shared. I would suggest researchers presenting part of the transcribed and processed material for participants to validate.

Chan and Lai (2015) carried out a carefully controlled analysis method to avoid misinterpretation, and I consider it a model for interpreting data gathered using the phenomenological method. Through replacing subjects and objects in the narration section, Chan and Lai paraphrased participants' experiences in the form of indirect quotations. Then theme clusters were summarised to produce themes, which greatly restricted the influence of bias. Another study used two researchers to analyse data separately in the hope of enhancing rigor (Zhang, Shan & Jiang, 2014). I would say that through employing this method, themes identified are more likely to be free of

personal bias, thus remaining truthful to the data. For the purpose of this Master's thesis, I analysed the lived experiences by myself. If I had undertaken a larger-scope research project, e.g. at doctoral level, I would have involved a panel of raters to ensure added rigour. However, I did doublecheck all recurrent themes emerging from the rich data collected with my supervisors.

Phenomenology is considered “part of the social action or interpretivist perspectives in sociology” (Hallebone, 2001, p. 88), and is used to explore daily social lives in the social science sector. By focusing on the nature of something rather than meaning obtained by reflection, phenomenology studies a thing as it is by exploring experiences that are overlooked in daily lives. Phenomenology represents a way of thinking, and thus van Manen (1990) talked about his methodological text “as a *methodos* (a way) to do qualitative research rather than a method” (p. 29). Aligned with this view, Crotty (1996) warned about the misuse of phenomenology, as phenomenologists have to engage with philosophical views. Wright-St Clair (2014) further explained stating that phenomenology is more like a philosophy rather than a research methodology. I prefer to consider phenomenology also as a methodology, as its principles instruct researchers in each part of the research process, and its subcategories have been employed by researchers (Chan & Lai, 2015; Dorrestein, Wright-St Clair & Broom, 2015; Peterson & Minnery, 2013; Szu-Yao, 2011; Todorova et al., 2015) as research methods in their research practice. Gadamer (1989) showed that human understanding can be influenced by history and language in different ways, so the native languages and past experiences of researchers will have an impact on the data analysis (Sharkey, 2001).

### **3.2.2 Why use phenomenology?**

Phenomenology is “the study of human experience and of the ways things present themselves to us in and through such experience” (Sokolowski, 2000, p. 2). As my study focuses on the experiences of older Chinese participants, I considered phenomenology to best serve my research aim. Through using phenomenology, I can come closer to understanding how it is for older Chinese to engage with New Zealand health and support services, which as an international student I myself have barely experienced. Participants may also obtain a more profound understanding about their lives in New Zealand compared with their understanding before having an interview, as one participant (Andrea) reflected at the end of the interview that “I have hardly ever shared with others the things that I have just told you”.

Inclusion criteria and recruitment processes should align with the requirements of phenomenology, meaning that participants should have the ability of recounting their stories to researchers, and researchers need to note down their feelings and thoughts before experiences fade away. Therefore, participants should have rich experiences concerning the research topic, and be able to remember and express them in an organised way. Researchers, on the other hand, need to have an interval between interviews to interpret their data, which is called the “rolling recruitment method” (Wright-St Clair, 2014, p. 58).

When conducting interviews using phenomenology, the inquiry style differs from other methodologies, as researchers need to focus on what was experienced in the moment. Gadamer (1989) suggested that conducting phenomenological interviews feels like having conversations, with information coming out in a predictable way, explaining that no one should feel that they are being led or leading the other

conversation partner. Therefore, semi-structured interviews or even unstructured interviews suit the purpose of this methodology. Questioning styles also largely influence the interviewing outcome, as close-ended questions will result in fixed opinions, and it will prevent researchers from looking at research questions from a broad perspective (Gadamer, 1989). During the data-collection phase, Wright-St Clair (2014) asked questions starting with “what” or “how” in order to elicit participants’ significant moments or hidden aspects to their lives, and always encouraged participants to continue and to finish telling their stories.

During the data analysis phase, the method of drawing coherent stories about experiences, as they were lived, from each transcript was suggested by Wright-St Clair (2014). Van Manen (1990) suggested that many phenomenologists tend to take alternative approaches to elicit taken-for-granted meanings about their research topics, and come across new meanings during the writing process. I agree with this opinion, as new themes came up when I was writing the findings chapters, and these threw light on previous studies. For data analysis, Gadamer (1989) considered interpreting participants’ data as a productive activity; as the interpreter added his/her own horizon of understanding to make sense of the participants’ stories, meaning that his/her work was imbued with meaning co-determined by the interpreter and the participant. The meaning obtained from participants’ data is connected to the process of understanding, and is shaped by the data interpreter’s values, views and attitudes (Brearley, 2001). As for participants’ momentary self-reflection when experiences were ongoing, researchers should examine the process of thinking about something, as the process presents a non-reflective self-awareness (Goldman, 2015). During the interviews, I normally asked questions such as “What were you thinking at that moment?” or “Is

this your current thought or your thought back at that time?” to ensure participants’ stories were not reflective.

### **3.3 Methods**

In this section I will discuss my research questions, research design, ethics approval, inclusion and exclusion criteria for recruitment.

#### **3.3.1 Research questions**

Before the study was conducted, I was aware of some barriers encountered by older Chinese migrants in their everyday lives. Such barriers included LEP, age related illnesses, limited social relations and cultural differences. I hope my research will ensure that the voices of older Chinese migrants in New Zealand are heard, and this may in turn lead to recommendations aimed to improve their experiences with New Zealand health and support services. What had happened to participants in this study when they accessed health and support services was collected as predominant data, and I designed indicative questions for interviews to gather stories in an organised way. In order to have participants recount their stories in as detailed a manner as possible, I also asked questions relating to their narration during interviews.

Two research questions were put forward for this study: Firstly, what are the experiences of older Chinese-speaking migrants in Auckland when accessing health and support services in New Zealand? And secondly, what kind of language and culture support do participants feel would be best for them?

Interview questions surrounding the topics were raised with participants, thus delving into relevant experiences and perspectives as much as possible. Previous studies have also revealed that language or culture barriers ranked among the top barriers that older migrants face in health and support services (Blignault et al., 2008; Dong et al., 2011;

Lai & Chau, 2007; Pang et al., 2003; Wang, 2013). Therefore, participants' opinions and expectations of language and culture support are included as research aims.

### **3.3.2 Research design**

This study used a qualitative phenomenological approach to uncover older Chinese migrants' lived experiences by conducting semi-structured interviews, and seek their perspectives on possible improvements to health and support services.

### **3.3.3 My knowledge of potential participants**

Because of my parents' similar age to my potential participants, as they had both retired in China by the time I conducted this research, their perspective towards life and growing background can be similar to participants as well. I have been listening to their life stories since my childhood, and their tendency of reflecting on their earlier lives as young adults has increased since their retirement. Through their life experiences, I got familiar with what happened in China during the 1960s and 1970s, as well as the impact of historical events on ordinary people.

As I have been an interpreter and translator throughout university and my working life, I tend to look at the question from a view more related to language and culture. In other words, when I look at older Chinese migrants' experiences of accessing health and support services, I tend to analyse these from language and cultural perspectives, striving to discover new perspectives relating to my field of expertise.

Notwithstanding my limited experiences of accessing New Zealand health and support services, my knowledge acquired from university studies and volunteer experiences provided diverse perspectives. I have gained basic knowledge about older adults' health problems and their consequences, through reading the literature and attending classes on health interpreting. Meanwhile, anecdotes and remarks from

older Chinese migrants were obtained during my volunteer activities at The Asian Network Incorporated (TANI), the Never2Old programme and church English classes. This enabled me to have some understanding on older Chinese migrants' lives in New Zealand before this research, and bring my own thinking to the study.

However, as I arrived in New Zealand with adequate English skills for daily communication, and as most individuals at my age usually do not require regular visits to doctors, it would be difficult for me to assume what older Chinese migrants experience or feel when accessing health and support services in New Zealand.

### **3.3.4 Ethics approval**

Ethics approval was initially granted with conditions from Auckland University of Technology Ethics Committee (AUTEC) on 14 April, 2016, with full approval obtained on 3 May, 2016. The approval for extended inclusion criteria was granted on 2 December, 2016.

The copy of the initial approval is attached (Appendix A1), with the approval number of 16/89. AUTEC advised a few amendments concerning the application and English version of the information sheet, suggesting clarification on exclusion criteria, recruitment process, possible discomfort caused to participants, and employment of the phenomenological method. After meeting with my primary supervisor, we decided to use phenomenology only as the methodology, and revised expressions that may have caused confusion. Responses corresponding to the advice can be found on the letter of response sent to AUTEC on 28 April, 2016 (appendix A2). Along with the letter are the revised version of the application, information sheet and the translated version of the recruitment advertisement, indicative questions, information sheet, and the consent form.



Regarding AUTECH's conditions, the interview language was amended from Chinese to Mandarin, as there are different Chinese dialects such as Cantonese and Shanghainese. Only Chinese versions of recruitment advertisements, information sheets, and consent forms would be sent out, as a test of potential participants' language proficiency. Exclusion criteria were also adjusted, as participants would need to be in a quiet state of mind and recall past experiences. Possible discomfort that may have arisen in participants during interviews was reconsidered, and was addressed with a coping plan. Final approval is attached in Appendix B.

Application for extended inclusion criteria was sent in November 2016. In order to recruit enough participants for my study, I applied for approval to extend participants' time of residence in New Zealand from no more than ten years (arrival age no younger than 55 years old) to no more than fifteen years. As some participants were well over 65 years old, this change still ensured that participants had been over 55 years old when they arrived in New Zealand.

### **3.3.5 Inclusion and exclusion criteria**

The inclusion criteria for this study related to older Mandarin speakers aged 65 or older who resided in Central Auckland or the Northcote/Glenfield region. Potential participants had to self-identify as Chinese, be fluent in Mandarin, and able to recall experiences up to three years ago. They also needed to have had health and/or social service interactions in New Zealand during the last three years.

In the study, I planned to interview ten to twenty participants who had arrived in New Zealand no earlier than fifteen years ago (2001). As Mandarin is the only official spoken language all over mainland China (The National People's Congress of the People's Republic of China, n.d.), where the healthcare system and support services

are entirely different from those in New Zealand, I considered that migrants speaking Mandarin were more likely to encounter barriers when they accessed these kinds of services. Besides, I am also a Mandarin speaker, so I chose Mandarin as the language used when interviewing participants. According to Statistics New Zealand (2013), the minimum age of a person receiving New Zealand Superannuation is 65 years old; therefore, I define older people as those with a minimum age of 65.

The exclusion criteria for this study also stated that potential participants should be in a quiet state of mind, which means that they should have the ability to recall their experiences as accurately as possible. I asked participants to choose a location of their reference to be the interview venue, and by ensuring the place was a quiet environment, I tried to make sure that participants were in a quiet state of mind during interviews. Since the study focused on the experiences of participants, it would be impossible to collect data if participants could not tell what had happened earlier when they were using health and support services.

### **3.4 Research instruments**

Research instruments included indicative questions for interviews, and approaches aiming to protect the privacy of participants, which I will discuss in more detail below.

#### **3.4.1 Indicative questions**

Indicative questions (Appendix C) were designed prior to the interview phase, with the purpose of eliciting experiences from participants in as detailed a manner as possible. Questions focused on the particular experiences and moments of accessing health and support services in different contexts. For example, I would ask about participants' first and most recent experiences of using the services, their experiences

with and without an interpreter, their best and worst experiences and their suggestions as to improving current services and service providers.

The interviews aimed to elicit experiences related to the research topic and to encourage them to be as detailed as possible; therefore, extra probing questions relating to participants' experiences were also presented throughout interviews. As this study followed a phenomenological approach, any conclusions about participants' preferred characteristics relating to health and support service providers were deduced from their lived experiences, rather than elicited through direct questioning. Most questions were based on the following list: "What did the healthcare professionals do?" "What were you doing when it happened?" and "Could you illustrate the opinion with an experience?"

### **3.4.2 Privacy**

In general, interviews can involve sensitive personal experiences that participants do not want to share with people they know. Therefore, people's names were replaced by pseudonyms, and information that might reveal their identity was removed from the written stories adapted from transcripts. Completed consent forms with participants' full names and contact details were stored separately from the research data, in a locked filing cabinet in my primary supervisor's office, and were only accessible to my supervisors and me.

Interviews were conducted either in an independent room in the community centre, in a café or food court near a library, in a park, or at participants' homes, with the purpose of making participants feel relaxed and comfortable. This was done to help ensure participants were in a "quiet state of mind". Participants' privacy was ensured by not allowing people to enter the room during interviews, or sitting at a table where

confidentiality could be preserved. A safety protocol (Appendix D) was designed to protect my safety if I were to interview participants alone on private premises.

### **3.5 Participants**

#### **3.5.1 Recruitment**

Various organisations were contacted to recruit the quantity of participants needed. These organisations included: the Chinese Community Centre in Northcote, the Chinese New Settlers Services Trust, the Chinese Positive Ageing Charitable Trust, the Citizens' Advice Bureau in Takapuna, the Positive Ageing Centre in Takapuna, The Asian Network Incorporated (TANI) as well as public libraries in Northcote, Takapuna, Glenfield and Onehunga.

The original inclusion criteria stated that participants should reside in Central Auckland or the Northcote/Glenfield region, so I could easily reach them. In fact, most participants were interviewed near the venue in which they participated in activities, so their residence was no longer a relevant criterion.

After posting the Chinese version of recruitment advertisements outside libraries and activity venues for older adults, I realised it was not a good way to attract potential participants, since no one contacted me through this recruiting method. Later I wrote emails and made phone calls to the Chinese New Settlers Services Trust and Positive Ageing Centre in Takapuna, and promoted the programme with generous help from coordinators and librarians of the Chinese Community Centre in Northcote, the Chinese Positive Ageing Charitable Trust, the Citizens' Advice Bureau in Takapuna, the Positive Ageing Centre in Takapuna, the Asian Network Incorporated (TANI), and public libraries in Northcote and Glenfield.

These organisations were selected because they constantly organised activities targeted at older Chinese people, and there was a large pool to draw from. I made contact with the chairperson or organisation leaders first to acquire their approvals for interviewing organisation members. Leaders were provided with both English and Chinese versions of the recruitment advertisement (Appendix E), information sheet (Appendix F) and consent form (Appendix G). Those who approved of my research provided the time and place of their organisations' regular meetings, and spared five to ten minutes for me to outline the research topic and inclusion criteria. Normally organisation leaders would encourage members to take part in my research after the introduction, or recommended a few potential participants for me to talk to after the meeting. After the meetings, I would talk with people who asked questions or showed a willingness to participate, and gave out the Chinese version of information sheets and consent forms for them to read and make a decision on. As meetings or activities were held weekly, potential participants could give me their signed consent forms whenever they decided to join during the recruitment period. By observing dancing sessions, English classes, and healthcare presentations and assisting some organisation members to communicate with English speakers, I established a rapport with older people. Besides purposive recruitment, this study also involved snowballing, as some of the potential participants actively helped me to recruit others during the recruiting process. Participants told me they were happy to assist in this way as they regarded me as a way of getting their voices heard by the government.

Potential participants who agreed to be interviewed would then receive a phone call from me, and provided their demographic information relating to inclusion and exclusion criteria.

Lastly, all participants were recruited from the Chinese Community Centre in Northcote and Positive Ageing Centre in Takapuna, and it was through snowball sampling of existing participants that I succeeded in obtaining enough participants. From the ten participants interviewed, half were recruited from the Chinese Community Centre, while the rest were from the Positive Ageing Centre in Takapuna. Participants either signed the consent forms and brought them with them or signed the consent forms prior to interviews commencing. I would read out the statements on the consent forms again before the interview, in case some participants needed further explanation.

Table 1: Participants' Profile

Pseudonym	Age	Gender	Arrival Year in New Zealand	Age at Arrival
Andrea	81	F	2001	66
Barnett	72	M	2001	57
Cal	70	M	2012	66
Daisy	74	F	2006	64
Edlyn	72	F	2005	61
Felicia	73	F	2001	58
Georgia	76	F	2006	66
Han	66	M	2011	61
Ivan	67	M	2010	61
Jane	68	F	2008	60

### 3.5.2 Participants

Among the ten eligible participants, there were six women and four men, within the range of 66 to 81 years old. In terms of age of arrival in New Zealand, seven participants had been between 55 and 65 years old when they started to reside in New Zealand, while three participants had been older than 65. All participants resided in Auckland, and all of them were active in participating in community activities, such as English classes, healthcare presentations, or weekly dancing.

### **3.5.3 Data gathering**

One-to-one semi-structured interviews were conducted based on the indicative questions designed beforehand. All interviews were recorded with a digital recorder except for my interview with one participant, who was particularly cautious about not wishing to leave any traceable evidence. Recordings were transcribed verbatim by me soon after each interview to allow for reflection and improving on my questions and interview method. In addition, participants' answers also gave me an understanding of their context, and helped me to focus on specific experiences in the following interviews.

When two or more people were waiting to be interviewed, I would inquire in advance about their available time and preferred venue by telephone, and confirm with them about their availability one day before the interview. Interviews were arranged with intervals in between, enabling me to spend time reflecting on the interview questions and participants' answers in relation to these. Of all participants, one chose to be interviewed in her own home, six preferred to have the interview at the venue where they normally attended activities, while the rest regarded the library as an ideal place for talking. Considering the opening hours and quiet atmosphere of libraries, a few interviews were changed to other venues afterwards, such as a dining place or open space nearby.

Participants were assigned pseudonyms that were only meaningful to me. I took notes concerning participants' experiences or suggestions during interviews or immediately after the interviews, including the emotions they appeared to be feeling when narrating the experiences, their facial expressions and any new themes uncovered

when they were recounting their experiences, to help me understand the underlying meaning.

### **3.5.4 Data analysis**

This method corresponds with the requirement of exploring what happens as it happens, instead of drawing conclusions (van Manen, Higgins & Riet, 2016). I recorded interviews using a digital recorder, then started transcribing them verbatim during the data-collection phase, aiming to improve my questioning skills and discovering universal themes before all interviews were conducted. In this way, I strived to avoid inquiring directly about participants' opinions as previous studies had done (Stephens et al., 2010). When transcribing interviews, I normally had to play recordings several times to obtain a complete sentence, as some participants used words from their local dialects without noticing it. I also sought help from friends who came from regions in China similar to those the participants originated from, by repeating participants' phrases or sentences and inquiring about the meaning. Participant confidentiality was preserved at all times. After I finished transcribing all interviews, my brain would automatically recall the participants' voices and accents when I read words in their transcriptions. This is a good way of familiarising myself with participants' stories and preparing for further interpretations. I recognised themes that could be used for drawing out anecdotes, which were deduced from questions that I asked and irrelevant answers that went off the topic (Table 2). The process used for drawing out coherent stories from the transcripts is explained in more detail below.

By comparing transcripts, I completed the initial analysis and identified recurring or common experiences. I coded participants' answers according to recurrent themes, and integrated them into individual stories. I drew a graph (Appendix H) similar to a



mind map, in order to list major themes and their subthemes. Unexpected themes also appeared during the process, and were marked with different font size compared with themes related to the research questions. Following this, I read through transcripts to uncover recurring themes, and grouped relevant themes (Appendix I) together. I started the second phase of analysis prior to starting to write up my findings chapters, as I read relevant stories from different participants, and then picked out themes which ran through participants' stories. Participants' narration in the transcripts was selected and rearranged according to the content and frequency of relevant themes. On the basis of edited transcripts, I translated sections that will be used as quotes into English, and revised them into coherent stories, which are called anecdotes. I interpreted anecdotes by reading between the lines and spotting statements corresponding to previous studies. The final analysis evolved during the writing phase, when I discovered potential meanings by reading between the lines, and finding linkages between individual stories. Some themes were combined, some themes were divided into more specific subthemes, while the rest were discarded, or were mentioned as recommendations for future work. Further analysis was made during the writing-up process, as my interpretation of participants' anecdotes may be impacted by my own experiences and opinions on older Chinese migrants and service providers.

Table 2: Thematic Analysis

Original Themes	Branches	Combined	Divided	Discarded	Final themes
Experiences with health services (GP/hospital staff/interpreters and other helpers) and public services (service	Experience subjects & participants' feelings		√		1. Health services mentioned were GP care, public hospitals, emergency departments, and other sources. 2. A range of accidents impacted participants' physical and

providers/ helpers)					psychological wellbeing. 3.Social services mentioned were healthcare interpreters, government and community services, non-government services, and other sources.
Leisure activities	Barriers of participating in leisure activities			√	
Language learning	English learning methods	√			4.Language issues appeared throughout the above three themes, and were discussed with other factors as barriers.
Being a contributor (community services & environmental protection/family)	Contribution to community and families			√	
Being a recipient (government financial support/ community activities & helpers & classes/ family financial & daily life support)	Received support from the government, community, and family members.		√		5. Participants receive help from support service providers, strangers, family members and friends
Opinions related to self-identity (medical services, public services and daily lives)	Comparison of New Zealand and China, transition in belongings and confusion in self-identity.	√			6. The comparison of New Zealand and China is discussed along with medical system or public services.

In order to recruit a relatively homogeneous range of participants, inclusion criteria involved those older people who self-identified as Chinese speakers of Mandarin, who had arrived in New Zealand within the past fifteen years and who had experienced interactions with health and/or support services. I contacted various organisations and networks from various parts of Auckland City. However, in the end all participants were recruited through the Chinese Community Centre in Northcote and the Positive Ageing Centre in Takapuna. I contacted those who had volunteered to be interviewed, asking them to choose a time and place for an interview. Before commencing the interviews, I obtained participants' Informed Consent using written consent forms, thus preventing the situation in other studies (Lo & Russel, 2007; Chan & Lai, 2015) where participants refuse to sign consent forms.

### **3.6 Summary of chapter**

This chapter has outlined my methodological approach and methods used, proving a rationale and detailing the recruitment and interview and iterative analysis process. The next two chapters will discuss my findings. Chapter Four will talk about participants' views and expectations of health and support services, while Chapter Five will discuss how participants demonstrated vulnerability when living in New Zealand, and sources of assistance that they received or obtained.

## Chapter 4 Being Sick

### 4.1 Introduction

My findings are divided into two chapters, and this chapter provides findings on participants' views and expectations of health and support services. By listening to my interviewees as they recounted their fortunate or painful experiences when they were unwell enough to seek treatment, I learned about their lived experiences concerning advantages and disadvantages of public hospitals and other publicly funded health services.

As follower migrants who came to New Zealand through the family reunion policy, most participants had limited financial capacity. Only four of them were eligible for NZ superannuation, while the remaining six participants relied on pensions from China and their children's support. When the currency exchange rate was taken into account, even those who were considered upper middle class in China had to think of their budget when doing everything in New Zealand. Moreover, all participants were over 65 years old, and their adult children had their own families and children to take care of.

For example, a participant of this study, Jane, named financial matters as the main cause of her dissatisfaction, and called it a dilemma:

*Without a referral from the GP, you can't go to public hospitals; after the GP has made a referral, you have to wait for the letter being sent to your place; then you have to see a doctor on the day set out in the letter. That's it, you have no other medical choice... If you have the money, you can see a doctor in private clinics, it will be rapid... However, currently my financial situation is disadvantageous. I have to face the fact that I need to wait for a long time. Dealing with my dissatisfaction is a tricky problem. [Jane]*

What Jane said here reveals the situation of older Chinese migrants when being sick. Jane attributed waiting to the referral process, emphasising that *the day set out in the letter* was a time she had to follow rather than her own choice. Jane also provided her own reason for not seeking treatment in private clinics—her financial situation. On the one hand, Jane was dissatisfied with the long wait, which she perceived as an inevitable result of the referral system; on the other hand, she had no money for private clinics, through which she could solve her problem. Therefore, she summarised this as *a tricky problem*.

From Jane's other description in the interview, we can assume that her family could be categorized as well-off. However, her choice of having "*to face the fact that I need to wait for a long time*" demonstrated her perhaps life-long habit of thriftiness. Jane's thriftiness harks back to her time as a child in mainland China. As a concept promoted by the Chinese Communist Party in 1950s, thriftiness became popular in the areas of politics, occupational activities and daily life (Gao, 2007). The Great Leap Forward, starting from 1958, caused deficiency in crop production, which continued years after the campaign ended in 1960. Before the interview started, Jane told me that she rarely had meals in restaurants or had food delivered to her house, and always took part in free activities. For Jane, as for other people born or brought up during this period, using money only when it was needed most was a tradition that impacted her whole life.

This chapter will discuss participants' experiences of health service providers. To do this, their experiences are illustrated under four ideas: experiencing satisfaction when being sick, waiting when being sick, experiencing insecurity when being sick, and

experiencing communication barriers when being sick. I will then present conclusions concerning participants' experiences and opinions.

## **4.2 Experiencing satisfaction when being sick**

Throughout participants' stories of being sick, the most outstanding theme is their satisfaction with health service providers. As much as they suffered from chronic diseases or language barriers, they still experienced great satisfaction from caring actions and a caring manner during diagnosing and/or treatment.

My respondents were generally impressed by the attitude shown by health professionals when they interact with patients in New Zealand. According to participants' description, this 'attitude' involved manner of speaking, actions beyond treatment, the way professionals delivered health services and the patience they showed. However, according to a study by Bautista & Tangsoc (2016) which involved hospital services being assessed by service recipients, management staff and health professionals at the same hospital service could be judged as unsatisfactory by medical staff while simultaneously assessed at a level above the satisfactory standard by patients. I have taken into account that participants may have compared the services they received with past experiences, and perceived them as outstanding when these services exceeded their expectations.

### ***Being satisfied with actions***

In this section I will cite interviewees' accounts to illustrate the nature of their being satisfied with health professionals' caring actions. Andrea described a story about her husband being treated in the public hospital for cancer, and how she was impressed by the doctor's caring actions:

*In China, seeing a nurse is terrifying, [they were] very bad-tempered... Here, when they treated my husband, their friendliness was beyond measure. Doctors' and nurses' actions sometimes really touched me... However, after 7 months, he was dying. Doctors were really nice, and asked my younger daughter and me – my elder daughter was not here by then – and the interpreter to go to the hospital. The attending doctor opened the door. He took in chairs for us to sit, and helped us to take chairs inside; wow, I was so moved. My husband was still lying in bed. The doctor said my husband was already 73 years old, if treated with chemo, the therapy level must be enhanced. He said that if we decided to treat, the enhanced level of chemotherapy might be bad for my husband's body. He was getting older, and the treatment had undergone a long time. Then the doctor said, "The gate of our hospital would always be open for you, you could come whenever you like." At that time, I had the feeling that doctors and nurses here were so nice. [Andrea]*

Andrea considered the friendliness of health professionals as *beyond measure*, which indicates that she had tried to make sense of the level of friendliness. Her compliment of the New Zealand professionals is set against her critique of her experiences in China, describing the nurses as *terrifying* and *very bad-tempered*. It could be inferred from this comparison that Andrea's level of prior expectation had been somewhere in between the levels of friendliness shown by professionals in China and those in New Zealand. Given her bad experiences in China, Andrea might have had a lower level of anticipation when it came to the attitude she expected New Zealand healthcare professionals to show.

In Chinese hospitals, attending doctors and nurses have a tendency to demonstrate their powerful position, and mainly focus on the role of providing treatment. When I went to see doctors in hospitals of mainland China, especially when I was a child back from 1990s to 2000s (before participants in this study moved to New Zealand), sometimes I had a feeling that doctors and nurses saw me as a moving body rather than a living human being, as they spoke only when inquiring about case history or

needing to do further examinations. This is partly because “nursing education in China rarely involved caring theories and how to practice caring in nursing” (Jiang, Ruan, Xiang & Jia, 2015, p. 431). In addition, hospitals and clinics in China functioned by following a task-oriented pattern (Melia, 1987), thus patients’ emotional needs ignored more often than not. In contrast, nursing training in New Zealand, the United States, the United Kingdom and many European countries emphasises the holistic approach, the patient-centred approach and the family-centred approach, which originated from the early forms of hospitals provided by people in monasteries and convents who had dedicated their lives to serving God by helping others (Crezee, 2013). A New Zealand couple encountered this culture-specific gap in expectations, when the wife Amy “gave birth to her daughter Lily in a Chinese hospital without access to interpreters”, and felt that “as a new mother in China I had very few rights but many responsibilities” (Crezee & Ng, 2016, pp. 30-31). The actions that impressed Andrea was something usually carried out by lower-placed health assistant staff in China. When powerful parties, such as doctors and nurses, served the less powerful ones, in this case the patients, it would stir the recipients’ emotions.

Similar to Andrea, Ivan also experienced caring actions that impressed him as a patient receiving treatment:

*When it was time to do the operation, the health professionals helped me to get on the operation table and put my shoes away. Their attitude of service was really – I was overwhelmed. I felt that I was there for convalescence rather than treating an illness. Therefore, the attitude of doctors and nurses was outstanding. [Ivan]*

In this reflection, Ivan expresses his surprise that his treatment was like a convalescence. This is possibly because he knew or experienced this kind of service



only in the context of convalescence. From his description, I could tell that Ivan was flattered when the action took place, and even experienced diffidence when receiving it. The reason may lie behind the statement *rather than treating an illness*. Ivan had received treatment in China, and that was how he perceived treatment should be.

Bringing in an understanding of the health system in China, when a surgery is about to take place in an operating room in China, surgeons normally emphasise their professional status and efficiency by establishing dominance over the patients (Zhou & Grady, 2016), such as giving instructions or communicating only when necessary. With no comforting words or emotional interaction, it would be normal for patients to feel a lack of communication or intuitive care.

Apart from a serving attitude, health professionals' quick responses towards emerging needs also touched Edlyn, another participant in this study:

*My knees were swelling up and I was in great pain, so my son drove me to the emergency department. When it was my turn, the health professionals asked me to walk to the doctor's office. I stood up but couldn't walk, and held on to my son. Health professionals pulled over a wheelchair to me right away, very nice. [Edlyn]*

Edlyn was touched when health professionals cared for her and provided health equipment even though she did not say anything about it. She preferred to seek help from family members (*my son drove me to the emergency department/ held on to my son*) rather than asking health professionals to give her a hand. As for Edlyn's case, health professionals demonstrated a holistic attitude with intuitive understanding of patients' needs and immediate response when sensing such a need.

Hofstede & Hofstede (2001) included the power distance index (PDI) as an aspect of how national culture influences values in the workplace, and explained high Power

Distance as a hierarchical order in which everybody has a place. New Zealand has much less emphasis on power differential than China, and health professionals tend to provide services with a holistic attitude. In medical practice, a holistic and patient-centred approach is emphasised and modelled in training (Morton & Fontaine, 2013), and therefore health professionals, such as trainee nurses, doctors, physiotherapists, and occupational therapists, learn from observing practising professionals in their fields. As part of health services, nursing is defined as caring with love and patience, as nurses should present, be available, and have a genuine desire to help patients (George, 2011). Nurses are also encouraged to reflect on their practice and use mindfulness in their relationships with patients (Johns & Burnie, 2013).

In western countries such as Britain, family caregivers supplement hospital care, and are even given emotional support or respite from caring when they need it (Barber, 2012). In China, there are very limited professional social services to individual older people, and around half of older individuals in both urban and rural areas have a need for more advanced social services (Feng, Wang & Jones, 2013). Family acts as the primary support within the care setting, and also provides the primary financial support (Zhang & Liu, 2007). The differences in health system development between modern China and western countries can be regarded as a main reason for the contrast in health service providers' attitude. Western health systems evolved from monasteries and convents providing health care services from the Middle Ages, where believers served God by devoting themselves to the service and care of others, and therefore there is a long tradition of nursing 'brothers' and 'sisters', providing selfless care to people in need (Crezee, 2013). Moreover, the 1987-1988 Cartwright Inquiry triggered a government inquiry, the findings of which resulted in a profound shift of patients' status and rights (Bunkle & Coney, 1987; Cartwright, 1988; Else, 2010). The

health system in the People's Republic of China, on the other hand, developed from state-owned hospitals in the form of the centrally-planned economy (Zhou, Bundorf, Chang, Huang & Xue, 2011), and therefore carries a feature of maintaining emotional distance from their clients, which is shared by government officials in the nation. However, compared with mainland China, the Taiwanese healthcare system is also publicly funded but is based on caring with a smile, and is incredibly patient-friendly. Therefore, Taiwan can be a role model for other Asian countries in this respect (S. Bennett, personal communication, 8 September, 2015; Crezee, personal communication, 26 April, 2017).

### ***Being satisfied with caring manner***

When describing her experience with the General Practitioner (GP), Georgia explained the GP's caring manner as a reason for not transferring to another family doctor, even though she had moved to a place far away from the clinic:

*I used to live in west Auckland district – I lived separately from my daughter for some time – in New Lynn. I went to the clinic in that place. Besides, doctors [Chinese GPs] in that clinic were attentive and friendly; they were quite conscientious when treating me, and gave me tips on how to live in a healthy way. Therefore, I haven't transferred to another GP since three or four years ago. I visit the doctor every three months, and normally there is no big problem. [Georgia]*

Georgia uses three complimentary words *attentive*, *friendly* and *conscientious* to describe the GPs in the clinic. By adding *quite* before *conscientious*, Georgia wants to stress her genuineness in giving this comment, with an expression of gratitude as well. Even though she has not illustrated the statement with examples, it can be deduced that these qualities are all related to work ethic. Georgia also sensed the GPs' dedication to their patients and extra care in preventing illnesses, and therefore she

continued visiting this clinic even after she moved away from West Auckland to North Shore. She was willing to travel a long distance every three months to see her GP, proving that she was contented with the present GP and his/her services.

Compared with Georgia's comment on the caring manner and treatment advice provided by GPs, Felicia highlights how the GP's words demonstrate his caring attitude:

*He [foreign GP] asked me to take off my clothes to examine the haemorrhoid; I said no, it was too dirty. He replied, "We doctors don't take the so-called dirtiness into account, this is our obligation." I think foreign doctors are more dedicated to their job. [Felicia]*

In this case, Felicia emphasised the reply of her GP rather than his action during the examination. Felicia used the Chinese word *waiguo* (外国) to indicate that her GP was a foreigner, i.e. non-Chinese. The word *waiguo* is slightly negative, with the connotation of a stranger or outsider, and Chinese sometimes use this word to refer to people (even including Chinese people) who cannot understand them or are unfamiliar with Chinese culture (I. Crezee & W. Teng, personal communication, 01 November 2017). The famous translator Yan Fu also demonstrated this connotation in his theory, suggesting the use of Confucianism (Chinese theory) in the translation of foreign works is more trustworthy than ideas delivered through a foreign voice (Teng, in progress).

In this story, Felicia held the opinion that *foreign doctors are more dedicated to their job* was more concerned with how the GP reacted to her refusal. Dr. Watson defines actions that support patients with personal emotions as expressive activity, which "allow for expression of feelings, authentically listening and holding another person's story for them" (Watson, Watson & Human, 2012, p. 47). The other component that

belongs to caring behaviour is operational activity, which provides actual services to meet patients' medical needs (Watson, 1979; George, 2011). The requirement for a holistic approach in clinical nursing also has a great impact on the caring manner of nurses (Morton & Fontaine, 2013; George, 2011). On the other hand, as Chinese people normally value actions more than talking, Chinese health professionals care less about communication, and pay more attention to solving patients' physical problems (Jiang et al., 2015). Therefore, even if doctors in China performed the same operational activities, New Zealand doctors would still do better in terms of expressing their care for their patients.

Concerning this issue of caring for patients, Daisy understood it as giving detailed information with a sincere manner of speaking:

*A Chinese-speaking employee told us that the doctor was not in the clinic at that moment, and would return by Tuesday. He had been seconded somewhere else. She said it quite earnestly... She said we needed to wait until the following week, so we agreed to see the doctor in the following week. Her attitude was really nice. [Daisy]*

Daisy recited the employee's words in great detail, showing that they really stuck in her mind. Unlike institutional employees in China who only give the result without further explanation, the employee not only revealed why the doctor was away, but also provided an alternative solution (i.e. make an appointment for patients). The behaviour represented a mixture of medical service and customer service, as well as a patient-oriented approach (Al Sharif, 2008; Schulz et al., 2014).

Based on participants' accounts of what happened and how they felt, I have tried to define the quality of "good attitude" they mentioned in relation to how health professionals delivered customised medical services through caring actions and a

caring manner, which normally far exceeded the caring behaviours in the participants' home country, as well as their expectations.

### **4.3 Waiting when being sick**

Participants complained about the lengthy process they had to endure before finally receiving medical treatment. As the reform of the New Zealand health system in 1991 caused tremendous changes, waiting lists rose sharply by up to 50% in three years and evoked turmoil (Hornblow & Barnett, 2000). Meanwhile, there were insufficient staff to deal with emergency calls, and emergency rooms in hospitals were at full capacity (Brunton, 2009), due to funding cuts in the healthcare sector.

Most people sought alternative treatment during the waiting period, and gave their own opinions on the long waiting list.

Andrea talked about her experience of waiting for treatment, and how the long period made her worried:

#### ***Waiting for treatment from public hospitals***

*Waiting in line takes too much time. Therefore, many of those with acute diseases go back [to China] to treat their conditions... There was one time when my blood pressure surged up, and led to discomfort in my heart. Dr. Yao, my GP, wrote a referral letter for me, which [sigh] didn't get a response to until three months later... I got through the condition by taking medication. I joked about this, saying that I would be dead long ago, then the response would be of no use. [Andrea]*

Andrea mentioned that by the time the letter of response arrived, she had already managed to address the risky situation by taking medicine. Andrea expressed her helplessness with a joke, though she neither complained about the process nor described her feelings during the waiting period. She also talked about a common

solution for other patients with acute diseases, which was *to go back to China* and see doctors there.

It should be noted that some conditions could not be cured merely with medication, and a long flight could also incur the risk of fatal outcomes when acute diseases are involved. Previous studies showed that the time lag between referral and diagnosis is not a feature typical of only the New Zealand health system, but also existed in other countries such as Canada and the United States (Lai & Chau, 2007; Ma & Coyle, 1999). One participant even talked about the benefit of useful connections (*guanxi*) in China and people who illegally resell appointment vacancies when in need of urgent treatment, feeling relieved that giving bribes and paying extra money as red pocket money (*hongbao*) could speed up the process

Similar to Andrea, Ivan also described how he endured the wait time, along with his opinion of the waiting list:

*I went to see the GP last year; it took around four or five months before I received treatment in the hospital. I suffered a lot during the four or five months. Though the illness was not so serious, it tortured me...I think the wait is too long when it comes to treating chronic diseases in New Zealand... When my worst symptoms occurred, I could not go out. I could only lie prone, not even being able to lie face up. [Ivan]*

Ivan used *suffer* and *torture* to describe his experiences during the time he spent waiting. Though the condition *was not so serious*, the symptoms still impaired Ivan's physical mobility, and deprived him of the ability to look after himself. Since Ivan could not even get onto the ground, his quality of life was reduced to the point where he required a full-time caregiver. This would have a negative impact on the lives of his wife and daughter.

As hospitals assess the impact of illnesses on patients' quality of life, and prioritise life-threatening illnesses in the waiting list, people with less serious conditions and/or chronic diseases cannot be provided with immediate treatment (Waikato DHB, 2015). However, as Ivan described above, these patients' quality of life was greatly reduced. Several month's wait time affected not only the patients themselves, but also their families.

Georgia compared the advantages and disadvantages of the referral system, and named her husband as an example:

*My husband first went to the GP, who was not good; then he went to see an ophthalmologist. The ophthalmologist said he needed an operation, then he waited in line for a lengthy period of time – for one year – so this is the inconvenient part of seeking treatment... Speaking of GP referral to the hospital, it was normally convenient. However, the waiting time was too long. The endoscopy examination, if I have it right, was arranged at least half a year after the referral. [Georgia]*

Georgia considered the referral as *normally convenient*, which refers to the referral process arranged by the GP. In contrast with this convenient process, the waiting list is quite long. The waiting time mentioned here varies from half a year to one year, largely surpassing the waiting time for routine cases. According to clinical guidelines, referrals of patients who neither have “likely malignancy, or life or organ threatening disease” nor with “new significant problems and/or most likely to benefit” are classified as routine cases, and the waiting time is four months (Waikato DHB, 2015). Though the diseases are not fatal, illnesses such as cataracts could have a severe impact on the patient's quality of life. In particular, when age-related cataracts cause visual impairment, patients' mental health will also be negatively impacted (Zhu, Yu, Zhang, Yan & Liu, 2015).



*Here [in New Zealand], you have to wait in line. When you wait in a line, can you survive cancer? Wait for two months, three months or even half a year. You may die within half a year. Are they [hospitals] so busy? I can't understand it. [Felicia]*

Felicia showed concern about the whole waiting system. She was not sure about the priority rules, nor did she count on the system to diagnose a cancer before the disease ended a patient's life. Besides, ignorance (*Are they [hospitals] so busy? I can't understand it*) regarding the New Zealand health system made her irritable and even desperate about the referral process. If there were data available about the number of people on the waiting list, the minimum and maximum time among waiting patients, as well as the average number of patients that public hospitals receive each year, patients would feel informed and empowered rather than helpless.

Jane had cancer as a pre-existing condition, and fell into a panic when found herself spitting blood one morning. She described her feeling when waiting for the final diagnosis:

*Therefore, when I came back to New Zealand this time, it was not until another three months after I did CT that the respiratory specialist contacted me for an inquiry... S/he read all the documents, and asked me about how I felt. At last s/he said "You are fine, everything is fine", and asked me to go home in less than ten minutes since the meeting started. I was tortured, from last December to this August, for such a lengthy period. You tell me, who can keep calm as usual? For me, I could only control my emotions and tried not to think about it. However, as long as there was no diagnosis, I could not feel relieved. [Jane]*

She talked about her solution for her fear and uncertainty: *control my emotions and try not to think about it*. Since there was no alternative but to wait, she converted the treatment of physical illness into managing her emotions. I perceived her response as a warning to the health system, which can be compared to a person persuading

himself/herself not to feel hungry during a famine. Even though she was proved to be fine, the process of repeated referrals and waiting was mental torture for her.

According to the 2016 national review, health expenditures account for only about 9.7% of GDP, and “access to sanitation, water, and health care is considered to be excellent” (New Zealand Country Review, 2016). The distinctive comments of Jane and the national review show that there is a gap between a government report and patients’ personal experiences, as the government reported on healthcare access as being excellent while the patient had to try and avoid thinking about her illness because the thought of the long waiting list would only make her depressed. An accurate and effective exchange of information is necessary to deepen the understanding of both parties, so that patients could be informed about the nature of and reasons for the waiting time and treatment of various illnesses, while government officials should take into account patients’ feelings and views concerning the health system.

### ***Waiting for treatment from the emergency department***

Emergency departments implement a triage system whereby patients are assessed as to the degree of severity of their conditions or injuries, and a clerk who registers patients can call the Registered Nurse if a patient needs immediate medical attention (Crezee, 2013). Severity levels will decide the triage time and performance benchmark (Ministry of Health, 2011). After participants enter the emergency department, they will first be triaged by staff at the reception counter, and only receive immediate treatment if the latter regard this as necessary and contact doctors (Crezee, 2013). Therefore, even though some patients are suffering from painfulness

or bleeding a lot, they still have to wait for long hours until patients with more severe conditions have received treatment.

Among all the participants, Georgia and Jane had had the worst experiences in the emergency department, and they described their emotions during interviews with me:

*That day he arrived at the hospital at around ten to ten thirty, and waited until four or five in the afternoon for someone to treat him, before the staff were off work... The treatment was rather quick; the problem was that they didn't have sufficient time, so we could do nothing but worry. We felt awful at that time. [Georgia]*

Georgia's husband had a deep cut in his chin and bled a lot. However, when patient numbers, injury severity, and insufficient medical resources were taken into consideration, Georgia and her husband had to wait six to seven hours before receiving treatment. Their feeling of *we could do nothing but worry* showed the conflict between patients' needs and the guidelines of ED.

The condition of Georgia's husband could only be classified as triage category 5, which is "less urgent, or dealing with administrative issues only", and the maximum appropriate triage time for this is 120 minutes (Ministry of Health, 2011). A study of emergency departments found that "acutely ill patients find nursing care more satisfying than those with less urgent needs", and also explained that older people attended the emergency department largely because the scarcity of information channels (Dahlen, Westin & Adolfsson, 2012, p. 1). Auckland DHB has carried out a multilingual media campaign "Healthcare – where should I go?" to increase awareness of appropriate healthcare options, as well as informing patients about when to seek emergency care in hospital EDs (TANI, 2016).

As distinct from Georgia's husband, Jane was seen by ED staff relatively quickly, but waited between procedures, which added up to a whole day:

*The next day I was so scared that I went to the hospital's emergency department. I waited in line for how long; I waited for several hours, three or four hours. I went there at ten in the morning and finished at six or seven in the evening... just waited there, just waited. Therefore, when it comes to acute diseases or major illnesses, these patients will be in a really disadvantaged position here, right? [Jane]*

Jane used *wait* four times to emphasise her displeasure. Unlike Georgia's husband, who received treatment as soon as it was his turn, Jane met five medical staff before she was told about her condition. Jane felt powerless and neglected during the whole process in the emergency department, which concurs with the finding that nursing staff do not give sufficient attention to low priority patients in emergency departments (Dahlen, Westin & Adolfsson, 2012).

The team leader at The Asian Network Incorporated (a social service described in section 2.3.2) mentioned that through activities, staff educated the Asian community to choose the appropriate services when they felt unwell: if the illness had not reached the level of seriously unwell and did not need emergency care, patients should visit their GPs or services like after-hours accident and medical clinics (S. Cho, personal communication, 14 December 2016). Auckland DHB even provides a Chinese telephone consulting service (TANI, 2016). However, it should be emphasised that most of the participants in this study did not appear to have access to such information, as their main sources are acquaintances and the Chinese media.

Hunter, Franken and Balmer (2015) studied how knowledge relating to care and health was passed to patients, and concluded that sending pamphlets or transmitting educational information was not an effective method; it is important to employ

approaches that consider learning as a social activity. They also emphasise that information should be mediated and that it is not enough to give people information in writing.

#### 4.4 Experiencing insecurity when being sick

Participants have experienced inaccurate diagnosis or treatment when visiting doctors, and learned during community events or other activities about other migrants' stories about unskilful health professionals. Therefore, there are occasions when they feel insecure when receiving health care in public hospitals or GP clinics. It is worth noting that all GPs but one mentioned by participants had originally immigrated from China, and participants used their experiences to illustrate what they understood to be both the advantages and disadvantages of seeing Chinese GPs.

Andrea talked about how she was affected by the ignorance of her GP:

*The ulcer occurred whenever I was busy. It was something white, forever touching my teeth and it could not heal. Before I went back [to China] I told my GP, but he said it didn't matter. After I came back, I went to pick up my drugs in December, and he still said it didn't matter. It was not until March... when I mentioned it again; he figured nearly one year had passed, and took a picture for me. [Andrea]*

Andrea is not a pushy person when making a request, and her gentle approach to life probably led the GP to underestimate her health status. The GP did not take Andrea's ulcer seriously for nearly a whole year, suggesting his lack of expertise in this field. Andrea described the ulcer as *forever touching my teeth* and *could not heal*, suggesting that she had pain and other related symptoms caused by the ulcer. When the GP *said it didn't matter* again, Andrea used *still* to express her dissatisfaction.

As GPs are the gatekeepers to the New Zealand healthcare system (Crezee, 2013), their ability to accurately assess a patient's condition is of vital importance in the healthcare system. Therefore, their risk judgement is vital to the health outcomes for patients. Besides medical expertise and experience, 'in-between strategies' such as intuition, emotion or trust can also be factors involved in making a decision (Zinn, 2008). Abel and Thompson (2011) further concluded from their study that GPs' decisions of making referrals involved intuition along with their knowledge of the patients. Barnett also talked about this issue, saying that:

*When someone needed to have examinations, he refused, he refused to refer for you. Not because he was busy, I have no idea why. Many people discovered [this phenomenon] ... There was an older Chinese doctor, he could diagnose his own disease, but to ask the GP to refer for him, no way. He had no choice but to go back to China. The GP refused to refer him. The GP refused to make a referral, so he had no choice but to return to China (Wife: It seemed that the GP had a different diagnosis). [Barnett]*

Barnett blamed a GP for refusing to refer patients, claiming that he deliberately ignored patients' health and wellness. Barnett's wife, on the other hand, considered the difference in diagnosis as the underlying reason. It was either the in-between strategies or the GP's lack of expertise that made him refuse to make a referral, which later proved to be a misjudgement, since the patient's self-diagnosis was correct.

Referral behaviours and habits have been studied by various researchers in recent years, from the influence of social networks (Hackl, Hummer & Pruckner, 2015) to the pattern of referring patients with cancer (Delva, Soubeyran, Rainfray & Mathoulin-Pélissier, 2012) or other medical conditions (Aldrees, Tashkandi, AlWanis, AlSanouni & Al-Hamlan, 2015; Jung, Luck-Sikorski, König & Riedel-Heller, 2016; Wardle, Adams, & Sibbritt, 2013).

Cal described the lack of competence of a nurse when giving an injection:

*Then the nurse looked for blood vessels – just wait and see, as the Chinese phrase describes – it was like she was stitching a shoe sole, ping ping ping, but still couldn't find it; she lacked the skill... That was killing us, as the injection went on forever. Later, when she proved incapable of completing the task, another person came to help, an old nurse. The nurses couldn't find it when the blood vessel was slightly narrower than normal... Anyway, generally speaking, their skills were pretty bad in terms of drawing blood from veins or giving injections in veins. [Cal]*

During the interview, Cal's high-pitched voice reflected his nervousness and fluctuating emotions, and his descriptive narration gave away how deeply the experience had impacted him. The simile *like stitching a shoe sole* vividly reproduced the scene in which the nurse inserted a cannula into the blood vessel, and the onomatopoeic word *ping ping ping* demonstrated the movement and strength she used. Cal explained the hospital's solution *another person came to help*, and complained about nurses' lack of skills generally concerning *drawing blood or giving injections*.

Daisy, being a Chinese doctor, developed an attitude of suspicion towards New Zealand health professionals based on other people's encounters in hospitals:

*It's not that I don't trust doctors here; it's because major accidents can happen if you don't pay attention... There was a person with lung cancer; they failed to diagnose it and the person died. Another person suffered from hepatomegaly, and had his liver removed. Another case was to draw blood every day until [onset of] anaemia, then give transfused blood; this is dangerous, extremely dangerous. [Daisy]*

Daisy stated that *major accidents can happen* unless patients paid attention, which demonstrated her perception of doctors' medical skill. By citing three examples as evidence, Daisy demonstrated that her perception was based on experiences which they had shared with her. As a doctor back in China, Daisy used her expertise and

experience to analyse New Zealand doctors' examination results and decisions, and refused further procedures until she had received elucidation in response to her questions. Though Daisy said that she trusted doctors in New Zealand, her perspective and actions revealed her lack of trust in their medical knowledge and skills. She also believed that accidents and dangerous situations were waiting to happen if doctors were allowed to do whatever they wanted.

Regarding misdiagnosis, another participant, a lady called Felicia, also expressed her views:

*There were quite a few cases of misdiagnosis. Why is that? They started with catching a cold, coughing and headache, and doctors usually treated them as a common cold. Later their coughing didn't get better; it turned out that quite a few had lung cancer, and they missed the optimal time for treatment. Therefore, the disadvantages of GPs are serious... Anyway, I think GPs are generally unqualified. [Felicia]*

Initial symptoms of various illnesses can be quite similar. For GPs who are not experts in all fields, an incorrect assessment/evaluation of patients' medical conditions can be fatal. Based on this perspective, Felicia considered that GPs were generally unqualified. What remains unknown to patients is that referrals to surgeons can be used for not only operations, but also specialist advice. In a study conducted by Raymont et al. (2008), 53% of the referrals in New Zealand were sought for diagnostic opinion or specialist consultation, which helped GPs to confirm the degree of seriousness of a patient's condition. GPs should not be criticised for limited knowledge; however, GPs should seek help from specialists whenever they feel uncertain and to confirm any provisional diagnoses.

Barnett experienced a worsening condition which he attributed to his GP, though it was unclear whether he was at different phases of the illness:



*A foreign doctor treated me. I used a cotton pad to wipe [my nose]; however, the more often I wiped, the more serious [my] nosebleed became... later it became an allergy. This allergy developed into allergic rhinitis. I shouldn't have wiped it, shouldn't have wiped it with the cotton pad... The GP treated it. It might have healed if I had gone to a specialty [clinic] for my nose. [Barnett]*

Barnett's condition worsened after he had gone to the GP for treatment. He used *shouldn't have* and *it might have healed if I had gone to a specialty [clinic]* to express his regret. He also thought that the non-Chinese GP was to blame as a minor condition developed into allergic rhinitis, but it is now impossible to explore whether his nosebleed was caused by allergic rhinitis or other conditions.

Abel and Thompson (2011) argued that people's recognition of depth rather than breadth had marginalized generalist (i.e. primary care physician or GP) medical work, and made their worth poorly understood. This could explain my participants' preference for specialists' professional skills in terms of diagnosis and treatment, rather than for generalists' broad medical knowledge and role in early diagnosis and referral. Barnett's comment suggested that in his view specialists had more skills, and were thus a safer option for him when treating his illnesses.

Edlyn expressed her preference and trust of Taiwanese doctors, and stated her opinion of New Zealand doctors:

*I deliberately went back [to Taiwan] to find an orthopaedist, and felt quite relieved to see a doctor there. Doctors in New Zealand are equipped with a wide range of knowledge, but they are not specialised. It was not the doctors' problem, but the level of medical care in New Zealand. [Edlyn]*

Edlyn perceived that doctors in New Zealand *are equipped with a wide range of knowledge*, but *are not specialised*, which might suggest that she misunderstood the role and responsibilities of GPs. In China's healthcare system, there are no GPs functioning as family doctors, and health professionals are normally classified into doctors and nurses. Doctors refer to specialists as well as other professionals who can make a diagnosis, which might have made it difficult for Edlyn to understand the difference between GPs and specialists.

If GPs are the gatekeepers (Crezee, 2013) that prevent further damage to the human body by deploying generalist knowledge in relation to a range of medical fields, then specialists are problem solvers who use expertise in one field to treat certain conditions. However, this viewpoint also reflects the problem of long waiting times. Edlyn had visited GPs and emergency departments, which were not specialists in any particular field, and it was several months after she had treated her illness with traditional Chinese methods that she was able to meet the specialist.

To summarise, GPs have a different role to specialist physicians and nurses, and can seek diagnostic advices from these specialists when necessary. Meanwhile, patients should be informed about the unique role of GPs so as to reduce misunderstanding caused by divergences between the Taiwanese or Mainland Chinese and New Zealand healthcare systems.

#### **4.5 Experiencing communication barriers when being sick**

During the time participants asked for a diagnosis or received treatment, they were eager to communicate with health professionals. However, as they did not have English skills, they were unable to find a person to interpret for them on some occasions, and they therefore experienced anxiety and helplessness.

Georgia accompanied her husband when he was hospitalised as an inpatient, and could not even answer simple questions from doctors and nurses:

*By that time my husband's life was no longer in danger, so he [my husband] was hospitalised for three days. Trouble occurred at that time. There was no interpreter, and my child couldn't stay with us all the time, nor could I speak English. It would be all fine if there was a Chinese interpreter... During the period when my husband was in hospital, hospital staff asked my daughter to interpret on the phone [when they wanted to communicate with us]. My daughter felt it was quite burdensome as she needed to work; maybe she had a bigger workload at that time. Therefore, our daughter asked us to go back to China, because it was convenient [to communicate] in China. [Georgia]*

In current New Zealand, medical appointments, examinations and surgeries are all arranged with interpreters, which greatly assists LEP patients. However, with no interpreter during hospital stay, there may be little communication taking place between hospital staff and inpatients like Georgia's husband. Fortunately, Georgia's husband had the time and financial capability to go back to China to have his health condition managed there; for people with no other choices, having no one to communicate with during hospital stay can cause adverse effects both physically and psychologically.

Interpreters were arranged for outpatient appointments with hospital doctors, but not for patients who were hospitalised. During their stay, it is difficult for them to report on their condition or answer routine inquiries during the course of the day. Studies showed that in the United States and other countries other than New Zealand, the services of interpreters were not commonly utilised during clinical health professional encounters with LEP (Limited English Proficient) inpatients (Flores, 2005; Karliner, Jacobs, Chen, & Mutha, 2007; López, Rodriguez, Huerta, Soukup & Hicks, 2015; Schenker, Pérez-Stable, Nickleach & Karliner 2011). López et al. (2015) reveal that

when diagnosed with the same kinds of conditions, LEP inpatients without an interpreter stayed in the hospital shorter than English speakers. This may result in recurring illnesses or inpatients leaving without having duly recovered.

Apart from during hospitalization, language barrier is also an issue that put patients in a vulnerable situation when they visit the ED. Current research found that in the United States, due to the fact that staff in emergency departments underestimate the importance of interpreting services to patients, professional interpreters may be underutilised (Ramirez, Engel & Tang, 2008). In the above experiences mentioned by participants, medical staff might find it unnecessary to have an interpreter present. For government-funded organisations, the issue of cost effectiveness should also be taken into account. Compared with patients referred by GPs, it is almost impossible to predict which patients will seek emergency services on a given day. If interpreters of a range of language pairs were arranged to stay in the emergency room during opening hours, it would be a waste of resources and taxpayer money. Considering there are fifteen commonly spoken languages in Auckland (Statistics New Zealand, 2013) out of a total of close to 200 community languages used, the number of patients speaking each language is limited, and there are also other settings in need of medical interpreters. Those issues lead to the lack of professional interpreters in the ED, and also make it understandable for some of the participants in this study.

Another experience of such a communication barrier shared by Georgia related to when her husband fell on the street and visited the emergency department:

*He suffered a lot at that time. The main problem was not having an interpreter. We called our daughter, but she was busy and didn't arrive right away. He suffered so much. He went there without prior notice, so they didn't arrange an interpreter. Therefore, it would be much better if the*

*emergency department could prepare a Chinese interpreter. However, people who go to the emergency department speak many different languages, and it will be difficult for them to arrange an interpreter for every ethnicity. [Georgia]*

Georgia emphasised that her husband suffered a lot in the ED by repeating key words in her account. On the one hand, Georgia is aware that having an interpreter present in the emergency department for every language was not feasible; on the other hand, not being able to explain what had happened during an emergency made her feel anxious and helpless.

Another respondent, Jane, also mentioned the need for permanent Chinese interpreters in the emergency department, fearing that people with major accidents may be placed in jeopardy:

*Even for emergency departments in each district hospital, I hope they can distribute one or two Chinese interpreters there, at least one interpreter there from morning till night. For example, if I go to North Shore hospital but there is no other Chinese, in case I have a seizure and no one is around me, what can I do? Who can help me? This is the key issue... Therefore, I suggest allocating more Chinese interpreters in the healthcare institutions, especially in places where Chinese cluster; is it possible? In North Shore hospital, there are quite a lot of older Chinese; is it possible to arrange Chinese speakers in North Shore hospital? Best to do so, since this group will be around for quite a while yet, I tell you. [Jane]*

Jane stated that interpreting services were not available in emergency departments, and gave as an example *in case I have a seizure and no one is around me*. However, professional interpreters do receive phone calls from New Zealand public hospitals and deliver interpretation for LEP patients, sometimes even in the middle of the night (N. Ahankoob, personal communication, 15 October, 2015; J. Chang, personal communication, 10 September, 2016). The reason that some older Chinese are not

provided with interpreters is probably related to the level of seriousness of their emergency.

Jane also suggested distributing interpreters for *emergency departments in each district hospital*, especially an interpreter *from morning till night* where Chinese cluster. However, a previous study in New Zealand showed data on ethnoburbs containing Mainland Chinese, and in 2006 the ethnoburbs were “the North, Central Business District and especially Central West”, and that 50% of people from mainland China settling in Auckland clustered there (Xue, Friesen & O’Sullivan, 2012, p. 588). Therefore, if interpreters were to be allocated to public hospitals in all three areas, it would be a huge cost to the taxpayer.

Apart from a request for Chinese interpreters, Jane also expressed her desire for Chinese-speaking doctors:

*Is it possible to increase the number of Chinese doctors a little bit – it doesn’t matter where they are from, as long as they are Chinese... To be frank, we don’t need an interpreter if there are Chinese doctors, they just need to understand Chinese... National funding can be reduced, and there will be less burden for the country, right? [Jane]*

Jane talked about increasing the number of speakers of a language other than official languages in the hospitals, saying that talking to Chinese-speaking specialists directly could improve communication and reduce cost to the taxpayer. It was also suggested that bilingual providers had fewest interpreter errors and optimal outcomes, which is supported by an analysis of the effects of using trained professional interpreters in a comprehensive literature review in relation to the United States (Flores, 2005).

However, even Chinese-speaking specialists can experience language barriers with patients, as in a case experienced by one professional medical interpreter. When the

interpreter was performing an interpreting assignment in an Auckland hospital, the specialist could understand patients' words but refused to talk with patients in Chinese, since he was unfamiliar with most of the medical words in Chinese (J. Chang, personal communication, 30 November 2016). Currently all healthcare professionals in New Zealand are fluent in English (ExpatFocus, n.d.), which indicates that recruitment requirements consider English fluency a prerequisite. However, there can be language barriers even between Chinese-speaking medical staff and patients, as some people only speak one Chinese dialect such as Mandarin or Cantonese. Some people arrived in New Zealand as international students when they were still teenagers, and have become accustomed to using English in daily life. As lecturers teach medical courses in English, it is also possible that Chinese-speaking doctors do not know healthcare terminology in Chinese. If any misunderstandings occurred during history-taking (Crezee, 2013) or when prescribing medication, the flow-on effects could be disastrous.

Barnett expressed his wish for Chinese-speaking specialists based on another reason:

*I prefer to see Chinese [doctors] ... It depends on interpreters' skills. He needs to be responsible, experienced, smart or flexible in order to interpret accurately. Just take senses as an example; sometimes they are hard to tell. Pain is easy to describe; some other senses can't be expressed directly. There are doctors from north China, and we have some common dialects, so it's easy to understand. [Barnett]*

Barnett preferred to have Chinese-speaking specialists rather than interpreters, which was relevant to the description of medical symptoms. When doctors are faced with patients in the hospital, patients' statements of their condition become the first source of information for judging the severity and possible causes of diseases, before any further examination is taken. As an opportunity for delivering information to

specialists directly, patients want to express themselves as clearly as possible. Barnett mentioned that whether patients' descriptions can be interpreted accurately depended on interpreters' skills, which was the reason that he preferred Chinese specialists. However, since *some other senses can't be expressed directly*, even understanding Chinese is not enough for communication. In order to deliver his feelings, Barnett chose specialists from the same geographical district as he came from. More specifically, he preferred specialists who spoke similar dialects.

Distinct from previous experiences told by other participants, Daisy was able to talk to Chinese-speaking medical professionals:

*They are really nice. First I told them I wanted to sign in, I said it in Chinese and they didn't understand [chuckle], then I corrected and said "Chinese speaker, Mandarin speaker also OK", and a nurse came out... Then the ambulance took us to a hospital in South Auckland. The hospital was rather large; when we arrived I said that we couldn't speak English. Ah, also a Taiwanese, a young doctor [came]. He said "I can speak Chinese", then I said "Sorry to trouble you; please help me with a few things. Please help me do a CT scan or other examinations on him; we can only feel relaxed when his conditions are diagnosed." [Daisy]*

Daisy was fortunate to have Chinese-speaking staff every time she visited a clinic or hospital. She was also able to speak a few English words, which helped her to answer questions from staff on the ambulance. As Daisy chuckled during the story-telling, it could be deduced that she was confident enough to deal with problems with the English words she learned. Similarly, asylum seekers in Europe preferred to mediate for themselves, even if their language skills were quite limited (Pym, 2017). As a doctor back in China, she was more empowered than other participants were, and even used her expertise to advise doctors.



## **4.6 Summary of chapter**

This chapter has discussed participants' experiences with health service providers, from which I elicited their views and expectations of different health service providers. Participants were unanimously satisfied with the attitude of health professionals in public hospitals, while there was divergence of views concerning the attitudes of GPs and emergency department staff. Being on a waiting list for health services caused physical and psychological suffering among many participants, and experiences focused on the time lag between referral and diagnosis as well as waiting in emergency departments. There are also experiences concerning the incompetence of health professionals both in public hospitals and GP clinics, as participants encountered or heard about misdiagnosis, surgery failure and intravenous injection failure. The language barrier is a topic that was touched on by all participants, and also has a great impact on their choices of health services. Though participants' complaints concerning GP care involved various aspects, they still go to Chinese GPs, as they can have relatively unimpeded communication with Chinese speakers. Emergency departments are a place some participants were afraid to go, as they could neither communicate nor find a language service provider promptly when an emergency occurred.

The barriers identified in health and support services involved the time that elapsed between referral and diagnosis, language differences, a lack of knowledge about available services and the nature of existing services, and health professionals' lack of skills. Chapter Five will discuss the situations in which participants were vulnerable, and how they overcame risks by receiving help from various sources.

## **Chapter 5 Being Vulnerable**

### **5.1 Introduction**

This chapter focuses on participants' experiences of being a vulnerable older migrant in New Zealand, and how they received help from different service providers as well as people they were acquainted with. Language barriers and old age are two main reasons that made participants vulnerable, while the unfamiliarity with New Zealand culture and lack of social connections put them easily at risk.

On the one hand, political events during the 1950s to 1970s affected participants in this study and resulted in the predominance of LEP, as all interviewees were born in China before 1951. Of the ten participants interviewed, one possessed English skills before entering New Zealand, another took part in English training courses in China before leaving for New Zealand, while eight participants only started learning English when they commenced residing in New Zealand. The lack of ability to communicate in the official languages in New Zealand (Immigration New Zealand, n.d. b) severely disadvantages people who wish to have equal access to public services.

On the other hand, because of chronic diseases and other accidents associated with old age, participants in this study regularly accessed health and support services with the assistance of professional interpreters, institution employees, family members, friends or even complete strangers. In these scenarios, older migrants played the role of recipients of assistance, and described how they thought and felt throughout the incidents, along with further reflection.

In this chapter, I have divided participants' sources of support into three categories: receiving help from interpreters, receiving help from strangers, and receiving help

from family members and friends. By looking into each participant's reasons for seeking help, their underlying attitudes and potential needs, I aim to uncover how existing services could benefit older Chinese migrants in the most efficient way.

## 5.2 Receiving help from support service providers

Most participants had experience with health interpreters in public hospitals. On the whole, their GPs helped them apply for interpreting services when these interviewees were referred to specialists. Jane talked about her opinion of changing medical interpreters during follow-up appointments, and described how succinctly interpreters relayed specialists' instructions:

*In the hospital, interpreters explained what specialists said. It is very likely that they didn't explain clearly; it depends on their expertise. The interpreter was different every time, you couldn't choose, and had to use whoever was assigned to you... therefore, no one can share my trouble... they answered my question with a very short sentence, what was going on and that was it. When the doctor finished talking, s/he explained a bit. What [the doctor] said, yes or no. Even the precautions were explained roughly, with one sentence. [Jane]*

In this story, Jane reflects on her dissatisfaction with what she learned about her medical condition. She experienced the explanations and precautions as being brief and lacking detailed elucidation. Yet, as she reflects on her experiences over time, she starts to wonder whether it was the interpreters, the *they* she speaks of, who may not have put the words and meanings into the language she understands. She is heard wondering what was left out as she recalls things being *explained roughly, with one sentence*. Perhaps most revealing are her words *no one can share my trouble*. These words announce, in the absence of one consistent interpreter for her, the importance of her understanding what is going on and what is lost. As interpreters kept changing, they had to check her conditions with the specialist and asked her similar questions during every appointment, while no one was familiar with the whole story. *Share my*

*trouble* indicates the appeal for empathy, as well as a comprehensive understanding of her medical conditions. As the interpreters always gave brief answers, she reasons that it could be that interpreters lacked interpreting expertise, or had not interpreted clearly. However, as Jane did not understand English, she could not tell whether doctors originally gave short answers or interpreters interpreted doctors' words as short answers. Jane's vulnerability shows in her uncertainty about how much of what the medical specialist said was conveyed to her.

Jane has a good reason to expect a full delivery of what the doctor said. Looking to the practice context, the New Zealand Society of Interpreter and Translators (NZSTI) code of ethics requires interpreters to "preserve the content and intent of the source message or text without omission or distortion" (NZSTI, 2013, p. 3). What Jane assumed was that the interpreter had omitted information during the interpretation, and she could only be informed with brief summary rather than a complete message. In a literature review concerning older patients with mental health problems, Farooq, Kingston and Regan (2015) stated that omission could occur as interpreters deleted part of or even all of the message delivered by the patient. Jane expressed her supposition of this possibility, and hoped that she could choose interpreters according to her preferences.

Another participant, Georgia, based on her own experience, attributed the causes of interpreters not answering her question to herself:

*We met many interpreters here. Normally they just did interpretation, one sentence by one sentence... I think some girls were attentive; some men were also nice, just a few might consider us nagging. That was no big problem, still OK. He [my husband] likes to ask questions: What is*

*this issue? What does that doctor say? S/he [the interpreter] was reluctant to ask the doctor, and didn't explain any further. S/he thought s/he was saying what the doctor said. When my husband went along, he wanted to know more information. [Georgia]*

Georgia's story, like Jane's, shows she encountered a number of interpreters during her consultations with her doctor. Similarly, her words hint towards her feeling of being left wanting every sentence to be conveyed to the doctor by her interpreters. In saying *they just did interpretation* she suggests that her expectation was more than receiving interpretation from interpreters. In hearing the doctor's words *one sentence by one sentence*, Georgia suggests that interpreters were only doing their job in a mechanistic way without more considerations. Further, in explaining her and her husband's questioning as *nagging*, Georgia suggests their requests for more explanation from the doctor are unwanted, and even irritating to this particular interpreter. Perhaps another explanation from her perspective is that their questioning already made the interpreter feel impatient, and the interpreter's rendition may not have reflected the illocutionary intent of their questions (Morris, 1999). Georgia suggests that this particular interpreter understood her and her husband's request, but was reluctant to ask the doctor or explain any further. By saying it was *still OK*, Georgia's story exemplifies that she is somewhat grateful for the service, or simply reluctant to voice her complaint. Alternatively, perhaps she and her husband understood the medical condition enough, but not in much detail. In this moment, it suggests the New Zealand welfare system was good enough; the interpreters did their job, so Georgia and her husband had no reason to complain about the interpreters' attitudes. At the same time, Georgia and her husband did not experience a satisfactory result. Georgia's husband did not feel that he was fully informed as he was not able to

understand his medical condition to the full degree, and was put in a vulnerable position as he could not communicate directly with the specialist.

Turning to the literature, interpreters are still taught to mostly follow the conduit model during interpretation, and are not allowed to engage in tasks such as advocating or taking sides with clients (Angelelli, 2004; NZSTI, 2013). Therefore, medical interpreters should only interpret conversations between health professionals and patients, while ignoring requests directly made to themselves. There are already appeals to a less mechanistic role for interpreters from scholars and practitioners, as community interpreting settings differ from monologic interpreting (Bowen-Bailey, 2016; Pym, 1999). Patients or other clients should be able to achieve literacy of the type involved in the specific interpreting setting (Pym, 2017), and thus Crezee (2014) proposed to the New Zealand Ministry of Health the introduction of bilingual patient navigator role in the public hospitals, in order to fulfil patients' needs while not violating the interpreters' code of ethics.

In contrast to Georgia's experience, Cal encountered an interpreter who attended to details, and fully rendered specialists' explanation of data and examples. Even though the surgery had been carried out over two years ago, Cal could still recite interpreters' words with great accuracy:

*After I entered the room, the surgeon arranged for me to lie on the operation table, and I just followed whatever s/he asked. I think after I lay down on the operation table, the interpreter told me not to be nervous, and that everything was fine. S/he gave a relatively detailed interpretation of the explanation, saying that the safety percentage of enteroscopy is generally high, that the success rate is over ninety percent.....the failure rate is 0.2 percent, which means the success rate is very high. For example, some people's bowels have already ulcerated, and the accident happened. This case occurs a few times in one thousand surgeries, the rate is very low. S/he*

*conveyed everything to me, and told me not to be afraid if unexpected conditions occur, that they could securely handle it. After they comforted me they gave me an injection, a local anaesthesia injection. After that the surgery was completed, and within very short time the interpreter left. It didn't feel long, but left when s/he should because interpreters charge fees based on hours. They wouldn't stay with you. When they said the job was finished, they left... Here is different from China, very few people have time for chit-chat. [Cal]*

Cal's story suggests he was contented with the dedicated role of his interpreter when he had his enteroscopy done. Interestingly, he has already explained that the procedure had been carried out two years ago, yet he recounts the specific data of its *over ninety percent* success and *0.2 percent* failure rates, and retells the examples explained by the interpreter. In recounting this level of detail, this story illustrates how attentive Cal was to the interpreter, and how well-informed he felt through the interpretation. Unlike Georgia and her husband, who expressed wanting to know more information from doctors, Cal was happy that this interpreter ensured he was well-informed. His words suggest he was satisfied with the specificity of the detail; he was grateful. As a migrant with no English skills as well as a patient with an operation performed by English-speaking surgeons, Cal was vulnerable in both physical and emotional states. It was with the help of medical interpreters that he was able to feel as informed as native speakers.

Cal's words reveal that he was aware that his interpreter had a tight schedule, and even knew that they were paid by the hour. When Cal was talking about his interpreter, a busy image was depicted. The person's work was assigned based on hours, they had no time for small talk, and they left as soon as the work was done. Much as Cal complimented on their professional skills, when reading between the lines, there was a sense of disapproval as he kept emphasising their fast pace.

As interpreters are participants in the interaction with doctors and patients, their “social baggage (their beliefs, attitudes, and cultural norms)” is also brought to the interaction (Angelelli, 2004, p. 26). Even though a business-like approach may be a feature demonstrated by only a few medical interpreters, Cal still regarded this characteristic as shared by most interpreters.

Andrea’s story shows that Cal’s statement was an instance of generalising, and how she was comforted by her talk with interpreters:

*When I had the cataract treated I met several interpreters – the interpreter would inform me about changes of my disease; s/he would call me. S/he first told me on the phone that “I’m the interpreter, here is the date for meeting”, I said “okay, thank you”. When it was the day s/he would come [to the hospital]. Sometimes I felt it was good, to chat with him/her and get known. I said “you are so young; do you work as well?” S/he said s/he didn’t work, yet this interpreting was her/his work. Later we met again and got familiar. I felt wonderful, really... With the anaesthesia, I couldn’t feel what the surgeon was doing, the doctor kept performing the work, and I kept listening to the interpreter. During the process, I said “You need to speak louder”. At that time the interpreter was sitting there, and I said I couldn’t hear. Then s/he stood beside me, quite nice. The interpreters were all nice. [Andrea]*

In contrast to what Cal’s story indicated, Andrea felt there was time around this procedure for her and her interpreter to *get familiar* with each other. In saying *it was good, to chat*, Andrea revealed feeling cared about by her interpreter. It felt nice to just chat. In noticing her interpreter was *so young*, Andrea’s words suggest she was concerned about her interpreter, and cared about how the interpreter manages to work as well. Her story suggests that Andrea assumed that interpreters should have another job apart from interpreting assignments, and being an interpreter was not considered an occupation. With people from all walks of life helping Andrea to overcome the language barrier (which became clear during my interview with her), it is normal for



her to treat interpretation as a part-time job. Andrea's encounter with interpreters was pleasant and uplifting, and this could improve her experience of being a patient to some extent.

Ideally, interpreters ensure that patients have equal access to services (Roat & Crezee, 2015) and that the disadvantageous situation created by language barriers is removed. When patients and interpreters maintain a good relationship, as in Andrea's case, patients can also have some emotional comfort in their encounters with medical staff when facing a serious health problem. Participants' requests for a high voice volume was common during my data-collection phase. Many participants were experiencing hearing loss, and it had been difficult for me to talk with them using normal volume, especially on the phone. As an older migrant living alone in New Zealand, Andrea was in a vulnerable position as she was exposed to loneliness and language barriers, but with the help of this interpreter she felt content and *wonderful*. Andrea talked about her request for the interpreter: *I said, "You need to speak louder"*. This corresponded with what I observed during the research, as most participants were suffering from some degree of hearing loss. However, as hospitals require silence, speaking at a loud volume is not encouraged. Besides, as my experience reveals, there is a great difference in the speaking volume between mainland China and New Zealand, so the requirement for higher volume can also be a cultural issue. Therefore, the interpreter shortened the physical distance between her and Andrea, which is a considerate action perceived as *quite nice* by Andrea.

In 2013, 18.6% of people in New Zealand stated that they were able to speak more than one language, while 51.2% of all multilingual speakers were in the Auckland region (Statistics New Zealand, 2014). The high percentage of multilingual people in

Auckland may explain why Andrea failed to recognise interpreting as an occupation. From results of previous studies, professional interpreters are found to have increased the quality of communication and clinical outcomes among LEP patients (Karliner et al., 2007). The requirement of maintaining professional relationships between interpreters and people who interpreters work with (NZSTI, 2013) has ruled out the supporting role of interpreters in the healthcare settings, while it is clear from the experiences of my interviewees that some still regard interpreters as their advocates and expect more than just language services. Concerning New Zealand sign language interpreting services, none of the interviewees in Magill's study (2016) described their interpreting practice as following the conduit model, which requires interpreters to maintain non-involvement strictly. There is also a trend in expecting interpreters to focus on interpreting consequences and collaborating responsibility, which contradicts with the restriction of interpreters providing advocacy, guidance or advice (Bowen-Bailey, 2016; NZSTI, 2013). Whether interpreters' code of ethics will mediate with stakeholders' evolving needs is a question that awaits further research.

Another interviewee raised the issue of interpreters failing to be part of the healthcare support services, and attributed it to passiveness:

*Some interpreters are not good, just individual cases, as interpreters do not show proactivity... However, I could not understand what the doctor said, nor did the interpreter present it clearly. I couldn't understand the interpreter. After everything was finished, I went home and thought, "I have done cardiography, but what was the problem? [There was] congestion, how did the symptoms occur?" Because the cardiogram showed something was wrong with me, but there was no definite index... It is significant for the interpreter to be proactive. Take this examination as an example, he should have thought [about checking the result] for me if he has a strong sense of responsibility, right? I spent so much time on cardiography, started from morning and finished in the afternoon... If the interpreter put himself in others' shoes, if*

*someone had done an examination and asked what happened, then he should know it was about heart conditions, [the patient was asking] what was the current situation. [Barnett]*

Barnett regarded some interpreters as being passive at work, because they did not think of checking the examination result for him. Barnett's words suggest that he expected feedback after several hours of examinations. He asked about the index produced from the examination, but *couldn't understand the interpreter*. Either Barnett had a problem describing the question, or the interpreter had a problem understanding the meaning of the question; nevertheless, neither party managed to sense the divergence in expectation during the communication. It was not until Barnett arrived home that he experienced the vulnerability of being confused and displeased. Extra expectation is something that caused Barnett to feel *he should have thought [about checking the result] for me if he has a strong sense of responsibility*. It is very likely that Barnett had not been told about the interpreters' role before, and his definition of interpreters' duties was established through supposition or personal experience.

For interpreters who give advice and provide their own opinions on medical conditions, the role overlaps, as they provide services as both a co-diagnostician and an interpreter. This is contrary to the New Zealand Society of Interpreters and Translators Code of Ethics (2013), which prescribes more of an impartial conduit role, with interpreters conveying what is said, without providing their own opinions. Hsieh (2007) attributed the demonstration of different roles as the impact of interpreters' understanding and other parties' expectations; hence it is too complicated to define a universal role for medical interpreters. Some duties are not included in the interpreters' role; nevertheless, patients and even some health professionals expect interpreters to offer help and assistance beyond the interpreters' duty limitations. For

the benefit of fewer risks for both patients and interpreters, it would be necessary for interpreters to explain the duties of their role before appointments. Briefing and debriefing can help patients and healthcare professionals work better with interpreters; however, a previous study discovered that health professionals rarely took time to explain matters to interpreters before medical appointments (Crezee, 2003). Besides, a recent study found that interpreters tended to explain their role to health professionals (four out of five) more frequently than to patients (two out of five), which was based on answers from healthcare interpreters during one-to-one interviews (Magill, 2016). The mutual understanding between the interpreter and the patient was absent in Barnett's case, and led to dissatisfaction that could have been avoided through role clarification.

Misunderstanding about duties of service providers is also demonstrated in Georgia's story, as she perceived arranging appointments with specialists as the duty of health interpreters:

*Another thing is that my knee joint does not function well. I visited the GP clinic several times to check causes and took X-ray examination, several times for the condition. The GP referred me there, and there was an interpreter explaining what conditions I had and which examinations I should take... the interpreter was quite nice, and wrote letters to make appointments, but we couldn't understand. There is a Citizens Advice Bureau, right? They have interpreters there. The day before we went to see the doctor, a Chinese interpreter called us, and asked if we could make it at 10 am or 1 pm. We replied that we could go and confirmed. Then I went to the hospital, this was how it went... [Georgia]*

Georgia mistakenly assumed that English letters were written by interpreters, while they were actually sent by employees of the Ministry of Health. The lack of knowledge about New Zealand healthcare system reveals Georgia's vulnerability when encountering illnesses. The unfamiliarity of the service nature had impacted her choice of seeking healthcare as well as her behaviour during treatments.

After patients give feedback on the date and time of medical appointments, their information will be given to interpreters. This will be the first time that interpreters contact patients, when they confirm the appointment over the telephone. Another source of support and assistance mentioned by Georgia was the Citizens Advice Bureau, which helped her to translate letters and formulate replies. As an organisation run by volunteers, the Citizens Advice Bureau aims to help individuals with questions and assists with their access to various social services (Citizens Advice Bureau, 2016). Chinese-speaking volunteers are arranged by Citizens Advice Bureau to help LEP Chinese solve problems, and the service had also been utilised by Andrea:

*Whenever I have an English letter or other needs, I go to the Citizens Advice Bureau. There's also a Home for Chinese here. Normally I go to the Citizens Advice Bureau, because the Home for Chinese has an inside room for consultation, while the outside room is filled with Chinese people playing mahjong every day. I don't like it. It doesn't charge, I have been there once and no more. I thought since people outside were playing mahjong while the door was open, it seemed that everything you said could be heard by the outside; that was uncomfortable. [Andrea]*

In this story, Andrea compares two kinds of social service providers through her experiences: the Citizens Advice Bureau (CAB) and the Home for Chinese. Both services are free, and both provide a Chinese-speaking service. Andrea went to the Home for Chinese only once, and instantly felt uncomfortable. The place was crowded and impersonal, which was common for Chinese people's meeting places. As liveliness is preferred by Chinese shop owners as a symbol of good business, stores and restaurants choose to yell at passers-by and play pop music with loudspeakers. Customers, on the other hand, talk loudly to or even shout at their companions to cover the noise or express their emotions. When friends are drinking tea or having meals, gossiping about others' personal details is considered an

entertainment activity, through which they can outperform their peers or enjoy sharing gossip about secrets they know (a Chinese idiom calls it “cha yu fan hou”). Gossip topics can involve income, age, property, relationship status or children’s grades, conducted in places including but not limited to restaurants, buses, trains, parks, squares or on the phone (Y. Hu, Y. Nan, & X. Wang, personal communication, 25 February, 2017). Though grace and silence have become more widely accepted with the introduction of cafes and foreign restaurants, when friends gather in Chinese restaurants, teahouses or game lounges, or when they were holding events, toasting or playing mahjong/chess/cards, speaking volume is still a measurement of sincerity, confidence and enthusiasm. What made Andrea feel vulnerable was that the language barrier led to her talking about her private issues in public, and privacy was not considered by service providers in the Home for Chinese.

Based on my limited translating and interpreting practices in New Zealand, older Chinese migrants who seek translation service or advice commonly request confidentiality. As for consulting subjects, family affairs and medical conditions are most frequently involved, which are sensitive and private. The Home for Chinese left the door open and created an open space, causing insecurity and distrust among those who asking for help. The reasons for leaving the door open could be various: one person in charge of multiple tasks as the number of staff is limited, no waiting area for visitors outside the room, or the concept that a closed door is not appropriate. If public service organisations intend to meet the needs of the general public, they need to spend the minimum possible and offer quality services that meet users’ expectations (Scutariu & Bilouseac, 2016). In this case, I suggest that the staff create a signboard with words “Open, knock before entering”, and hang it on the door when providing

consultation services. It is also feasible to ask people about their preferences before the inquiry starts.

When collecting pensions at the Work and Income office, Felicia recited her conversation with an employee to show her praise for government services:

*Another strange thing is that people here put themselves in your shoes all the time. I used to collect benefits once a week, while pensions were collected every other week. As there is an interval of two weeks, the officer asked me “what could you do in the second week?” He then said, “you could apply for subsidies in here in the second week; we can give you subsidies”. In New Zealand, if you spend too much money in the first week, you can apply for extra subsidies; they wouldn’t let you starve. [Felicia]*

Felicia found it strange that staff of public services were so caring and considerate. By using the word *strange* instead of “moving” or “good”, her perception and expectation of public services is explicit: the service provided was beyond her imagination, thus she considers it unusual. Staff not only provided what she requested, but also gave extra information and offered to help in case she had a need in the future. The staff’s sincere consideration of her vulnerability involved in living expenses made her grateful. There is a Chinese idiom which says that “ordinary people regard food as their priority”; by saying *they wouldn’t let you starve*, Felicia expresses a secure feeling and shows gratitude towards public service providers’ concerns.

Non-government organisations also provided assistance for the participant Andrea, which had not been expected at all:

*There was an institute specifically designed, [people there were] also Chinese. My husband’s name was selected [during sampling], then they interviewed us, just like you... we answered her questions, and later she came a second time. We told her my husband was sick, and had quit studying by then. Wow, that lady, really, I still remember her. I don’t even know*

*what her last name is. We weren't studying anymore, so there was no money [as subsidies], we didn't think of it at all. Then she came here and told us that she would contact Work and Income. After it was finished, she told us the time and place for collecting money, saying "I have solved the problem for you, they will approve your application." It was at that time that I was so moved. This person was so nice, so caring, I was really touched, really touched. [Andrea]*

Andrea's husband was diagnosed with a serious illness when he was studying English. The couple had to face hospitalisation and frequent treatment for a life-endangering illness in a country that they had lived in for less than a year, which put them in a vulnerable situation both physically and emotionally. However, as they were not under financial stress, they did not search for information relevant to subsidies, benefits or payments. Their relationship with the person providing support (hereafter referred to as "The Female Researcher") was established only through a research assignment, and The Female Researcher became familiar with their situation merely through interviews. Even though The Female Researcher only met them twice, she kept their problem in mind and found a solution that suited them. The Female Researcher not only completed the task proactively, but also kept a low profile by understating her time and effort. Andrea stressed that she was touched by The Female Researcher's caring character, and praised the service she received. By saying *we didn't think of it at all*, it showed that unexpected actions and extra care for service recipients can raise satisfaction to a large degree. When a service is provided for people in need when those people have not yet requested it, it will bring a high return to providers.

Barnett's experience with Asian Health Support Services also indicated the connection between satisfaction and expectation:



*I called the Asian Health Centre, no, there was a form collecting feedback. It was sent by mail. I filled it, and the centre appointed an interpreter right afterwards. I visited the older doctor – the specialist – again. This time I only asked about one thing, how far had the congestion reached? They told me that the percentage was just twenty to thirty [percent]. The issue was solved as soon as I got the data, so I left after a very brief conversation. [During that appointment] I met the same doctor and a different interpreter, that was about six months after [the initial examination] ... I just wanted to hear the data, one sentence was enough. After that appointment I was clear. The feedback – I think Asian Health [Support Service] is really good at this work. [Barnett]*

Notwithstanding a whole day's examination in the hospital, Barnett was not informed of the detailed result. When Barnett recalled the moment, at first he thought the problem was solved on his part; later he corrected himself and pointed out that the good deed should be attributed to the Asian Health Centre, a public service provider. Barnett's answer indicated his urgent need for contacting the Asian Health Centre; however, he failed to put his thought into practice and only gave his feedback by mail about six months later. It is possible that Barnett would have neither sought help from general public services nor asked for clarification from the GP to obtain the examination result he wanted. The lack of knowledge about services for complaints or requests made Barnett vulnerable to obtain the information he wanted. Fortunately, he seized the opportunity to participate in the survey performed by the Asian Health Centre, gave his feedback and had his problem solved. Features he appreciated in relation to this particular service provider included short response time, attentive arrangement and sincere care. By using *right afterwards*, Barnett complimented the organisation on their efficiency and efforts during the process. Barnett was clear about what kind of information he wanted, and felt he had received timely assistance for his concern.

Felicia's actions in asking for help differed markedly from Barnett's passive behaviour, as she was frank and confident:

*For example, I went alone to deal with the application form for pension. I talked with them in English; I could communicate in these easy words... I knew how to fill in the form. However, to make it simple, I went to the immigration office and said "sorry, I don't know how to fill in this, can you help me with this?" They would help. In fact, we filled it together. I was sitting next to him. He asked about every blank and I answered. I sat beside his office desk. He didn't show impatience, but was quite joyful. He felt that "I could do something for you", and helped selflessly. New Zealand people are so noble. [Felicia]*

Felicia asked the immigration office to do her a favour and help her fill in a form, and she was plain about her English level. *To make it simple* was her reason for seeking help, which led to a conclusion that *New Zealand people are so noble*. It should be noted that Felicia used to be an English teacher at high school in her 30s, and had the capability to complete the application form. Instead of being suspicious of Felicia's request for help or choosing to prioritise other tasks on hand, the immigration officer offered support joyfully and selflessly. The appeal was replied to with friendliness and patience, and thus Felicia appreciated the whole nation and considered that those glorious qualities were shared by everyone.

There is also an example of accessing social services without language support, though the presence of Chinese-speaking staff facilitated the process:

*As for services concerning the government, I have opened account in the bank as well as taking a driving test, both on my own. The bank happened to have a Chinese customer service provider, while the driving test [examiner] spoke simple English, just saying left or right. I can communicate in simple words. [Han]*

Among participants in this study, seven could speak no English at all or only several words. Unlike them, Han could communicate with native speakers *in simple words*. From the phrase *happened to*, Han suggested that he had no idea that he could turn to Chinese staff before entering the bank, yet he still went there on his own. It could be inferred that he had confidence of handling the issue alone, while having a Chinese-speaking person by his side was a bonus.

Han is a relatively new migrant who arrived in New Zealand in 2011, and has talked about his English-learning courses in China. Han's experience could be a hint for the characteristics of new migrants, who have obtained language and driving skills in China, and arrive in New Zealand with more confidence and independence compared with migrants arrived fifteen years ago. With the popularisation of English teaching in China, three million people were learning English when a study took place in 2010 (Song, 2010). If future new migrants are equipped with competent language skills, there could be a variation in requirements and expectations concerning service providers.

### 5.3 Receiving help from strangers

*I was looking all over the room to see if there were any Chinese. Sometimes there were people who could speak [English], but they told the staff a few words and left again, that was it. A few words didn't help; they [hospital staff] were still busy with their work... Ever since we moved here [New Zealand], other aspects concerning language could be more or less dealt with; healthcare is an exception, it is the most difficult part. You have to wait, and there are also other problems. We could choose not to speak on other occasions, but healthcare was emergent affair, talking was indispensable... if I encounter a problem now, two students [who live here] can help me, that's good. [Georgia]*

Georgia accompanied her husband to the emergency department after he tripped over on the street and ripped open his chin. Neither of them could speak English, and their

daughter was busy working. With no interpreters in the emergency department, Georgia had to ask strangers acting as *ad hoc* interpreters. Since both patients and medical staff were occupied with their own duties, this coping strategy also failed. The combination of a language barrier, an emergency and a lack of familiarity with New Zealand health services made Georgia and her husband vulnerable when seeking medical treatment, and they suffered due to anxiety and the time they spent waiting. Georgia had rented out vacant rooms to two Chinese students for two reasons: on the one hand, the weekly rent added to their pensions and allowances, and this could relieve their financial pressure; on the other hand, the students were equipped with English communication skills, and would be able to lend a hand when an emergency happened.

Studies showed that compared with professional medical interpreters, errors potentially causing clinical consequences occurred more frequently with *ad hoc* interpreters (Flores, Abreu, Barone, Bachur & Lin, 2012). When patients or their supporters function as interpreters, they tend to lose focus easily as their attention is focused on their or another person's medical condition. It is also possible that medical concepts and terminology are beyond their language skills, and major mistranslations or omissions may occur. Insecurity and powerlessness lay at the root of Georgia relying on strangers rather than family members, as was revealed through the constant recurrence of the concept of "*busy*" when Georgia talked about her daughter during the interview. Abbott and colleagues summarised from previous studies that variations of depression are influenced by the absence of other people's tangible support as well as "emotional support and satisfaction with social support" (Abbott et al., 2003, p. 450). Since Georgia's daughter had been working overseas for a long period, Georgia's main source of help within the family was unable to offer

substantial assistance when she was in trouble; asking for assistance from strangers turned out to be her alternative solution.

*When I had moved to South Auckland for just one week, I was carrying a bag containing the oil I bought, a list of members who had paid membership fee, documents and rosters, everything was in there. All at once the two bags were stolen, just in the bus station in the southern district. There was only one bus I could take, and I was waiting there. After a while I went to see the sign board, when I walked back, they were gone. I was worried but had no solution; I felt so agitated that I jumped on the ground. There was a police station across the road, others said “you should call the police”, so I called the police at once... At first I called 111, they asked me what happened, I said “it is hard to describe now”. I was trembling, and they were not speaking Chinese. Later [an employee of] a restaurant selling roast duck in that district helped me to interpret; he was a Cantonese and understood Chinese. Later the police came on the scene and asked me to explain how it was lost. [Daisy]*

In this story, Daisy depicted the scene and her mood when she had her shopping stolen. By obscuring the number of bags and the sequence of events, she reveals that she was in an extremely distraught state of mind when the unfortunate event happened. Whether she was carrying one bag or two bags, it was not the value of the things stolen that worried her (this will be explained in the following quoted text), but the significance of lost documents and name lists. The bags were stolen during the time Daisy *went to see the sign board*, which was a short period of time, and thus the thieves had targeted her intentionally. The suddenness of it struck Daisy, leading her to *no solution* but to *jump on the ground*. When faced with this kind of accident, the common reaction was to inquire to people nearby; however, the language barrier impaired Daisy's communication ability, and she had to release her annoyance to the floor.

Daisy had learned some basic English through participating in weekly English classes in the Chinese community, which enabled her to call the police and understand simple dialogue. However, she was emotionally unstable at that time, and failed to respond as normal. She has not clarified whether she asked for help or the restaurant employee offered help, but from *at first I might have called 111 and I was trembling*, her vulnerability could be felt during this incident, and it can be deduced that she was too upset to clearly remember what had happened.

A study on variables causing depression on Chinese and Korean migrants summarised that separation from children or victimisation such as robbery and burglary related to “major emotional, psychological, relational, and social losses” (Mui & Lee, 2014, p. 285). For people who have limited English competency and insufficient ability to cope with emergencies, to have a stranger’s help when in need can support them both physically and psychologically.

*Later I – since I took buses there every week, a lad in the shop [nearby] came out. He thought I had lost everything and had no money for the bus ticket back home, and insisted on giving me a dozen bucks or so to take a bus. That was so kind. Later I dare not accept [the money], telling [him] that I didn’t lose my card or money. Therefore, I didn’t take the money. [Daisy]*

Daisy had her bag stolen, acted rather anxious and called the police, which demonstrated to strangers that all her belongings were very likely stolen. As Daisy manifested deep disturbance, she received a donation from a stranger who barely knew her, which surprised and moved her. She assumed the young man gave her money as an outcome of her passing by every week, and considered him *so kind*. However, as Daisy had moved to the district only one week prior (mentioned in the previous quote), the young man probably had not even got to know her. I assume the young man would lend a hand to anyone stuck in this kind of quandary, which

presented evidence to support Felicia's statement that *New Zealand people are so impressive*. From *I dare not*, Daisy demonstrated honesty and integrity when offered something that she believed inappropriate to accept. The assistance provider's earnestness when helping strangers interacted with Daisy's cautious choice concerning whether it was necessary to accept the precious help, exemplifying a caring community that looks after migrants. Therefore, Daisy's vulnerability was greatly reduced through the assistance of community members.

#### **5.4 Receiving help from family members and friends**

Of the ten participants, seven mentioned their family members frequently and affectionately, while a few only talked about them when answering questions. The reason hidden behind might be their defensiveness when talking about family affairs with a stranger, or a problematic situation within the family. Previous studies have suggested that older Chinese migrants may be more likely to suffer from mental health issues, including depression (Abbott et al., 2003; Mui, 1996) and elder abuse (S. Wong, personal communication, 22 November, 2015). If participants feel events that have happened among family members are private and sensitive, they would incline to avoid talking about them and only mention them when answering specific questions. An example was a study carried out in day-care and senior centres, where older adults were asked to tell their life stories for the purpose of achieving self-value and self-importance; however, as a consequence of psychological and cultural issues, some older Chinese declined to tell personal stories, where "the centrality of the family" was considered the predominant driver (Chan & Lai, 2015, p. 1662). Since participants' relationships with their families were not included in the indicative questions, and the nature of semi-structured interviews followed the topics raised by

participants, the reasons why participants did not talk about their family members were under-investigated in this study.

Jane talked about her experience of emergency and how her daughter accompanied her:

*I live separately [in my own place], I don't live with my daughter. It was only seven o'clock in the morning when I called my daughter, telling her "hurry up and come here, I coughed blood". She was so scared that she didn't even brush her teeth or wash her face, and took me to the emergency department. I was extremely terrified and didn't know what to do. I said I didn't know what was the problem until then. I was very scared, as any patient in this situation would not maintain calm. [Jane]*

Jane was living alone with other tenants in a different place from her daughter, which is rare among all participants. Even though the living situation could indicate impiety in Chinese ethics, Jane's daughter was quite supportive and concerned about her. *She didn't even brush her teeth or wash her face* explicated the daughter's sincere devotion to her mother, as her mother's health prioritised all other aspects, including personal appearance and work. Jane announced that *any patient in this situation would not maintain calm*, indicating that living alone also added to her anxiety, revealing her vulnerability when faced with sudden illness.

Based on limited literature (Shih & Pyke, 2008) on Chinese migrants' relationships with their children, I conclude that daughters-in-law or sons-in-law will impact the son/daughter of older migrants to a great extent, thus influencing the overall relationship. In Jane's accounts throughout the interview, her daughter was the only family member she sought help from, and thus I could deduce that she did not have deep connection with her daughter's family and was perhaps trying to avoid frequent conflicts.



In contrast, Georgia's husband chose to keep the illness hidden and only sought help from family members when he could no longer endure it:

*His [the husband] belly bloated hugely. It started on Sunday, and he endured it until Thursday. At first he refused to go to the hospital, worrying that it could impact our daughter's/son's work. [Our daughter/son was] very busy. On the fourth day, I said "your belly will explode if you don't see a doctor". His belly swelled and shone like a balloon, so I was quite upset. Normally we don't go to our daughter/son [for help]. Our daughter/son came and had a look, and became upset. S/he drove him to the GP right away. [Georgia]*

Georgia's husband developed a symptom that put him in critical condition, and the reason for delaying treatment was so as not to trouble their daughter/son. It is difficult to determine whether Georgia and her husband originally considered seeking help from their adult child as a bad impact on her/his job or based on previous experiences. In the latter case, Georgia and her husband might have asked their adult child for help concerning healthcare or household chores now and then, but was rejected due to being busy at work. As family was no longer regarded as a source of support when an emergency happened and the language barrier prevented them from seeking help on their own, they had to either resort to other sources or tolerate pain and sickness. Minor symptoms can develop into serious illnesses, which placed Georgia's husband at great risk.

In a study conducted among Chinese and Korean migrants, some types of actions were identified as elder neglect, peculiarly in Asian cultures, including "half-day abandonment, the placement of an elder into a nursing home by their adult children, and the unwillingness of adult children to live with their frail elderly parents" (Lee, Kaplan & Perez-Stable, 2014, p. 20). For adult children who fail to provide timely care for their parents, even though the reason can be work or family issues, their older

parents will still experience a sense of neglect as the trust is betrayed. For older adults who immigrated to a foreign country at an old age, their daughters/sons are their primary backup when accidents happen. Older migrants can be trapped by limited transportation options and the habit of saving money, waiting for the moment when they cannot bear it any more.

The same happened to Daisy's husband, who delayed treatment for nearly one month. An ambulance was involved as a result, when he could have initially gone to the GP for an examination:

*That time my husband had a fever for one month. He didn't tell me, and I was busy... I was home only two or three days every week, so he didn't tell me, and I didn't pay enough attention. I asked "How is it going?" He said he recovered. [Sign] I touched him and measured his temperature, he did not have a fever. However, that was because he found some antipyretic medications brought from China and took them by himself. At last I had no choice, so I called XX, who gave lectures in our place [Chinese community centre]. She cared about me, and had told me "call me if you have any problem". Therefore, I called her, and she said "tell your husband to rest at home, I will call 111 for you right now". Later the 111 [ambulance] came. [Daisy]*

Daisy moved to the southern part of Auckland at the request of her daughter, as her daughter wanted to take good care of Daisy and her husband. However, when an emergency occurred, Daisy did not even think of her daughter; instead, she regarded a community lecturer as her last hope, even though all she needed was a phone call to the emergency line. Daisy's husband had the same mindset, which was keeping trouble to himself and causing as little disturbance to the family as possible. To reassure Daisy, Daisy's husband even used antipyretic medication to conceal his fever and his sickness. However, this action put him in a vulnerable situation, as his illness was not treated early enough, and developed into an emergency.

Although there is no way of deducing the underlying reason, I assume that each member within the family was aware of others' tight schedules, and endeavoured in their own way to try not to become a burden. On one hand, Daisy's daughter bought a house for them near her own, assuming they could be looked after better. On the other hand, Daisy avoided troubling her daughter, and sought help from strangers or friends. Daisy's husband also avoided sharing his problem, pretending he was healthy. A Chinese idiom "reporting only what is good while concealing what is unpleasant" could be used to describe their psychology. When someone acts like this, normally s/he wants to show the positive side of things, thus not causing concern. If older migrants are capable of accessing public services on their own, concerns for families can be solved through a third party, while sicknesses can be dealt with at the initial stage.

Andrea asked for the company of her friend when going to the hospital, seeking help concerning both language and wayfinding:

*Treating cataracts? It was also a friend who accompanied me to the hospital. That was a long time ago, I had been going for cataract treatment for two to three years! It was two or three years ago, then I was familiar [with the place] and went alone for re-examination. The first friend [who accompanied me] had very good English, since I couldn't speak English; she also had a good sense of direction, while I couldn't find the way. That friend accompanied me there twice altogether. The first time we went there she told me that "two doctors both said your teeth rub [your tongue], you need to abrade your teeth in the dental clinic". [Andrea]*

By announcing that *I couldn't speak English* and *I couldn't find the way*, Andrea demonstrated her vulnerability while residing in New Zealand. She was living alone in New Zealand with no other family members, and coping with everyday life could have been difficult for her. Fortunately, she had many friends to turn to when needing

assistance. From my limited contact with Andrea through recruiting and interviewing, I concluded that Andrea was a cheerful and warm-hearted lady, quite approachable even for strangers. Her companionability was probably the reason that she made a lot of friends and obtained help from them. She was good at complimenting other people, while admitting her weaknesses and the great value of her friends. She remained positive about problems and life, and was also independent as she went alone for medical appointments after she followed her friend twice and got familiar with the location and basic process. The above favourable characteristics enabled her to have a satisfactory lifestyle without extra worries about being alone or having no one to turn to for support.

Feelings of control seem to have a positive function on older migrants' adaptation, and thus they can avoid mental health problems (Lin, Liu & Jang, 2014). Since Andrea could overcome accidents confidently with no family around, she had control of her life even though she lacked language skills. An older migrant also talked about the influence of personal character in a foreign country when participating in the TANI healthcare workshop, speaking of an introverted older migrant who always refused event invitations from community organisations and developed depression. Previous study discovered that when older Chinese migrants lack proficient language skills and their resources of coping with social realities are insufficient, any trauma can be too difficult for them to endure (Mui & Lee, 2014), which can lead to mental illnesses such as depression.

Ivan described the vulnerable situation he experienced when having an illness, and how he felt fortunate to have his wife as a carer:

*In the worst situation, I could not go out; even when I was on bed, I could only lie prone. I could only lie prone; I couldn't even lie face up. Only my wife looked after me, our daughter was working. It was convenient with my wife there, as I could ask for her help. If I was alone, it would be very difficult. When you were in such great pain, you could not make food by yourself, you could not get off the bed. [Ivan]*

Ivan suffered after an unsuccessful operation on his haemorrhoids, and the GP transferred him to the emergency department straight away. Nevertheless, the problem was not solved immediately, and Ivan had to wait for around half a year for another operation. Ivan described his pain by stressing lying prone, presenting an image that he lacked independent living skills. For older migrants who have poor English skills, hospitalisation or nursing is not a good option, considering their tight budget. Fortunately, Ivan's wife acted as his caregiver, and thus cooking and housework were not a concern. If an older migrant living alone were put in this kind of position, the effects would be significant.

Apart from the requirement for physical care, Ivan also needed language assistance when collaborating with public service providers, especially in healthcare settings:

*My daughter accompanied me when I went to do the surgery; [she] waited outside. My daughter also accompanied me when I went to the emergency department, as there was no interpreter in the emergency department, because we didn't make an appointment. My daughter interpreted for me. [Ivan]*

Ivan's daughter gave him good support both when he did not have an interpreter and when he urgently needed one. Being accompanied and assisted by a family member gave Ivan comfort both physically and psychologically, and a family member was also the most accessible aid for him. Ivan attributes not having an interpreter in the emergency department to getting no appointment, revealing that he still has no idea about how emergency departments provide services. Interpreting services have access

to a limited number of interpreters and normally try and book interpreters in advance. When patients turn up to emergency departments unexpectedly, it may not be possible to find an interpreter at short notice. Ivan's lack of knowledge about the New Zealand healthcare system could result in him finding himself in a disadvantaged position, as he may go to an emergency service when a community pharmacist might be able to assist him, and in fact he waited in pain for an unnecessary long period of time.

In Asian countries, adult children's monetary support is considered to have a vital impact on older adults' psychological wellbeing, as evidenced by findings from research conducted in Myanmar, Vietnam and Thailand (Teerawichitchainan, Pothisiri & Long, 2015). As participants in this study have spent most of their lives in China, and are now living in New Zealand, they may have similar beliefs. In other words, they may expect their adult children to support them. Meanwhile, other kinds of intergenerational support such as emotional support and timely responses may also have contributed to participants' levels of satisfaction in my study, as they are separated from their familiar cultural context and need much more than just financial support. Furthermore, I consider it necessary for Chinese communities to have a comprehensive understanding of the New Zealand healthcare system, as older migrants will be able to reduce risks by choosing appropriate health services. As supporters and family members, older Chinese migrants' adult children also need to demonstrate more emotional care rather than only focus on the physical and financial needs.

Cal expressed his opinion regarding why family members are not allowed to act as interpreters, and how his daughter provided assistance for him:

*My daughter lived with me, and translated English letters for me as well as accompanying me to see doctors. The rule of New Zealand hospitals is that even if you could speak the language or use the language to communicate, you couldn't act as an interpreter. As there is some medical jargon, they [staff] fear that you cannot explain it explicitly. [Misinterpretation could cause] medical accidents, so they must assign an interpreter for you, that's the advantage... To collect subsidies, you must go to Work and Income in person; my child accompanied me there. [Cal]*

Cal received help from his daughter in the same way as Ivan: she provided language support and accompanied him to see doctors. With his daughter's assistance, Cal talked about making medical appointments, suggesting that there was a gap between his daughter and professional healthcare interpreters. By enforcing a rule concerning the choice of medical interpreters, the DHB (District Health Board) reduces the potential vulnerability that Cal may face when using *ad hoc* interpreters. Though Cal did not comment on his daughter's proficiency in English, his satisfaction towards assigned interpreters manifested his preference.

In some Asian countries, the impact of intergenerational co-residence (i.e. several generations living together) and residential proximity to adult children differs remarkably from other forms of living arrangements, as the older adults are more likely to benefit psychologically (Teerawichitchainan, Pothisiri & Long, 2015). In Cal's case, older migrants prefer family members acting as their supporters when in need of psychological support, but are more likely to resort to support services when involving professional areas.

## **5.5 Summary of chapter**

In this chapter, I have presented and interpreted scenarios where older Chinese migrants encountered tricky problems or emergencies, and their sources of help when seeking assistance. Problems that evoked their vulnerability included first and

foremost the language barrier, followed by difficulty in using transportation methods, and chronic illnesses, in that order, as well as unexpected accidents. Most participants in this study tended to seek to diminish their vulnerability by seeking assistance from their family members and acquaintances, through whom they further obtain assistance from public service providers. This can be attributed to the influence of acquaintance networks, which is part of Chinese kinship culture, which was a concept evidenced by previous qualitative studies (Chen, Zhang & Li, 2014). As for assistance from strangers, my participants regarded it as their last choice when they were in need, and the only assistance sought was interpretation, though my participants did report situations in which strangers were willing to offer more than expected.



## **Chapter 6 Discussion and Conclusion**

### **6.1 Introduction**

This study was designed and conducted for the purpose of answering two questions: firstly, to explore the lived experiences of older Chinese-speaking migrants living in Auckland when accessing New Zealand health and support services; secondly, to explore older Chinese patients' preferred type of language and cultural support—specifically, the roles and duties of support providers. In view of the above, indicative questions for older Chinese participants focus on their experiences with services and service providers in healthcare settings, while support services are discussed and analysed as complementary topics. Participants' experiences with health services mainly relate to interactions with general practitioners (GPs), nurses, specialists, emergency department staff, and professional healthcare interpreters. Common themes emerging from participants' lived experiences are discussed in the findings chapters. Though attempts were made to elicit participants' momentary reflections at the time when experiences took place, conclusions were backed by personal accounts, which were more powerful than answers to direct interview questions.

This study adopted a phenomenological framework underpinning its design, in order to gather rich data from participants' encounters with public services in New Zealand. This involved designing and conducting one-to-one interviews, and preparing indicative questions regarding health services for semi-structured interviews.

In this chapter, I will first revisit literature I have reviewed and discuss how my findings are related to them. Then I will summarise findings related to my research questions and related themes. I have classed the themes under the headings of participants' healthcare choices, barriers they face when accessing health and support

services, sources of assistance that they seek, and their opinions and expectations towards public service providers. I then make statements about insights appearing in this study. After stating the limitations and strengths of this study, I then turn to implications for practice, future work, and further research, followed by a general conclusion.

## **6.2 Revisiting the literature**

In this study, all my participants are migrants who came to live in New Zealand through the Parent Category. This aligns with the high percentage of parents among all Chinese who were granted residence from 2003 to 2013 (Bedford & Liu, 2013).

The factors that put my participants at risk physically mostly involved health conditions and accidents related to age, but also language and cultural barriers they experienced when accessing services in public hospitals. Long waiting times resulting from chronic diseases, and mobility problems played a role in my older participants' inabilities to undertake independent daily activities. These risks are aligned with the literature discussing problems associated with ageing (Byles et al., 2016; Chew-Graham & Ray, 2016; Moussavi et al., 2007.; Rubenstein, Powers & MacLean, 2001). Besides, in line with Covinsky's (2003) findings, because of adverse effects caused by chronic diseases or accidents, some of my participants could not participate in social activities for a long period of time. However, this study has not uncovered evidence of older people attributing age to existing detrimental changes, such as those described by Wurm and Benyamini (2014).

Participants' choices of health services reflected their health care habits to some degree (Chan & Quine, 1997), as they generally visited the GP for treatment rather

than for prevention, and this may in turn have increased their utilisation of emergency departments for care.

Among the health and support services that I introduced in the Literature Review chapter, services from ADHB, activities and workshops held by Chinese community centres and Age Concern organisations, New Zealand Work and Income and Citizens Advice Bureaus were among the ones most frequently accessed by participants.

Barriers to accessing health and support services identified in this study include the time lag between referral and diagnosis (Lai & Chau, 2007; Ma & Coyle, 1999), language differences (Pang et al., 2003; S. Cho, personal communication, 14 December 2016; Wang, 2013), lack of knowledge about available services and nature of existing services (Blignault et al., 2008; Dong et al., 2011; Lai & Chau, 2007; S. Cho, personal communication, 14 December 2016; Wang, 2013), not being assisted by the same health interpreters across medical appointments and health professionals' perceived lack of skills (Lai & Chau, 2007; Ma & Coyle, 1999). Participants' complaints about having different interpreters for medical appointments concerning the same illnesses was a new finding, which has not yet been reported by previous studies, although anecdotal evidence suggests that interpreters themselves have informally mentioned this as a potential issue for both them and the patients they interpret for (Crezee, personal communication, 24 March, 2017).

In order to avoid the lack of vivid description of life experiences described by Stephens et al. (2010), my interview questions tried to elicit participants' lived experiences instead of their views or conclusions. However, some participants still tended to express their opinions and suggestions rather than recounting their experiences in detail. While participants' interpretations of events are congruent with

interpretive phenomenology, the primary focus is on eliciting in-depth stories of experiences concerning the research topic (Wright-St Clair, 2014).

This study explored older Chinese migrants' experiences of accessing health and support services in Auckland, and their accounts were analysed according to different service providers. Previous studies have tended to report on health services in general, without differentiating the characteristics of each service category. By identifying participants' views and preferences of different services, this thesis has made a contribution to improving the understanding between health providers and a small group of older migrant health consumers.

### **6.3 Exploring the findings as a whole**

#### **6.3.1 Healthcare choices of older Chinese migrants**

In most previous studies focusing on older Chinese migrants, health services are regarded as a whole, as researchers summarised barriers without looking at the characteristics of each service provider (Dong et al., 2011; Lai & Chau, 2007; Pang et al., 2003; Tsai & Lopez, 1997; Wang, 2013). Based on the frequency of health services that have been mentioned by participants, I have summarised participants' views and analysed them based on five groups. Healthcare services that participants commonly accessed included GPs (general practitioners), public hospital departments, emergency departments, other primary healthcare services, and health services in their home country. As District Health Boards (DHBs) provide a range of services and programmes for culturally and linguistically diverse communities, most health services mentioned here are under the management of the local District Health Board. Therefore, findings and suggestions in this study could be of great value for District

Health Boards, in helping them understand the perspectives of older Chinese health consumers.

GP care was the most frequently mentioned type of healthcare during interviews. Participants felt that talking to a doctor in their native language was comforting and convenient, while only one participant had experience of seeing a non-Chinese GP. Besides, the GP is the gatekeeper to the New Zealand healthcare system for New Zealand citizens (Ministry of Health, 2013), and refers patients to specialists in the public healthcare system. However, in this study, interviewees often complained about GPs' perceived incompetence, as they are not specialists in any field, and patients were unclear about their role and responsibilities. The lack of knowledge about health professionals' roles is a barrier which most commonly appears in studies about migrants (Blignault et al., 2008; Dong et al., 2011; Lai & Chau, 2007; S. Cho, personal communication, 14 December 2016; Wang, 2013). Misdiagnosis of major illnesses and ignorance of minor symptoms were the two main themes that kept coming up in participants' accounts. Other sources of dissatisfaction involved GPs showing a poor attitude or being inconsiderate, and the action of accepting gifts from patients as extra payment (which is an unspoken rule in Chinese hospitals yet forbidden by the Chinese government). Different from some doctors who are self-employed or employed in private clinics in China, GP care in New Zealand is subsidised by the government. In the New Zealand healthcare system, health professionals' conduct concerning accepting gifts from patients is considered a conflict of interest and a violation of the code of ethics for medical practitioners (Medical Council of New Zealand, 2013).

Participants with conditions that required specialist care were also familiar with publicly funded hospital services. The reason for its popularity among interviewees was that it is primarily free of charge; additionally, most of the participants praised the good attitude shown by members of public hospital staff. Almost all participants who had had encounters with public hospital services described their physical and psychological suffering resulting from having to wait for a long time. A few stories drawn from interviews with participants showed that some of them also felt that public hospital staff were incompetent. One participant who used to be a doctor in China even warned people to be cautious when receiving treatment in public hospitals in New Zealand. These findings align with barriers that some ethnic groups share when accessing services: time lag between referral and diagnosis, lack of well-trained professionals (Lai & Chau, 2007; Ma & Coyle, 1999), as well as different expectations (S. Cho, personal communication, 14 December 2016).

The emergency department (ED) was among the top three choices preferred by participants. Compared with public hospitals, this option is more rapid with the equal advantage of incurring no charge. Consequently, participants tended to seek assistance from emergency department staff, regardless of whether their injury severity and urgency level were within the regulated range. Data from 2014-2015 showed that over half of all ED events (more than one million) in New Zealand were determined as immediately, imminently or potentially life-threatening (Ministry of Health, 2016), revealing that a large quantity of events were not at emergency level. When the number of patients exceeds ED capacity, ED staff will feel overworked and experience high levels of work stress. Ma and Coyle (1999) also mention insufficient medical staff in a previous study. There are also hospital staff complaining about misuse of the ED service, saying that migrants treat the ED as free GP care. Given the

circumstances, it is understandable that participants complained about the waiting period in the waiting room, commenting that “emergency departments are slow”. They were obviously not aware of the tax-payer funded nature of these services. Other disadvantages include not having interpreters and staff allegedly showing a poor attitude, however this may conceivably be due to staff feeling that participants should not have presented to ED with non-urgent problems, or staff being overworked.

Other primary healthcare services encountered by my participants included regional screening and physical examination, national screening and physical examinations, vaccinations, presentations and workshops organised by DHBs, and assistance provided by researchers from non-government organisations. When commenting on these services, a few participants expressed gratitude, as regular checks can uncover hidden illnesses and save lives. One participant recommended that it would be good to offer a general physical examination for older people, since current screenings and examinations only focus on a few possible conditions such as cervical, breast, or colon cancer.

When it came to seeking treatment from health services in their home country, only one participant went back to Taiwan, which has an excellent publicly funded health system, quite different to the ‘user pays system’ in mainland China (S. Bennett, personal communication, 8 September, 2015). Regardless of what system they used, all participants who used this kind of service praised the rapidity of health services, no matter whether it was publicly funded (as in Taiwan) or a private service. As hospital expenses in mainland China are charged in RMB, participants did not need to worry about the exchange rate; besides, most participants had medical insurance accumulated over the years, which enabled them to pay fees directly from their

insurance accounts in China. Participants also regarded their familiarity with the health system as an advantage, and praised Chinese doctors and nurses for their skilful practice. One participant even praised Chinese health system because of the possibility of using bribery to speed up waiting process. In spite of the fact that disadvantages were not clearly stated in the interviews, it can be deduced from participants' stories that the separation from their children and lifestyle in New Zealand was also a challenge they faced. In addition, there were factors such as fatigue caused by adapting to another country and jetlag from international travel (as an example, one participant had been ill ever since she arrived in China, and did not show signs of recovery until she left). In addition, participants felt they could not be as mobile as they wished, also due to the immigration policy's requirement regarding length of stay in New Zealand each year (according to participants' statements, time spent overseas can influence superannuation and citizenship in New Zealand)—thus seeing a doctor in the home country was normally considered a backup plan.

### **6.3.2 Risk category and assistance-seeking behaviour**

Health conditions and accidents were two common categories that had made participants feel as if they were being at risk. When participants only showed mild symptoms of certain health conditions or when they were still in the primary stage of chronic diseases, participants tended to face at least a three-month waiting list for specialist consultation. As participants suffered physical discomfort during this waiting time, their mobility and ability to live independently were impaired to varying degrees. New symptoms or illnesses may develop during this time. Accidents or emergencies, on the other hand, happen unexpectedly and require treatment within a significantly shorter time. Under these circumstances, participants preferred to access services such as ambulance services, or care provided by emergency departments or



ACC providers (such as physiotherapists). Nevertheless, most conditions mentioned by participants in this study did not meet the criteria for urgent treatment set by District Health Boards for treatment at their emergency departments, and thus participants still had to wait in the emergency room for around three to six hours. Only one participant revealed his awareness of ACC services such as emergency insurance for travellers and visitors, and described how he used acupuncture to relieve his pain during the waiting period for public hospital services. Participants' lack of knowledge about available services (Blignault et al., 2008; Lai & Chau, 2007; Tsai & Lopez, 1997; Wang, 2013) appeared to be a major reason for their complaints as mentioned here, as the number of people using a service and the amount of funding available by the New Zealand Ministry of Health determines the waiting time for this taxpayer-funded service.

When assistance-seeking behaviour is mentioned, some participants were not the proactive party, as they passively received help from service providers or other people who offered assistance. Participants most commonly approached government services such as public hospitals, the Asian Health Support Services, Work and Income or Immigration New Zealand through one-to-one appointments, made via Chinese-speaking staff through letters or phone calls. Non-government organisations (e.g. The Asian Network Incorporated – TANI), on the other hand, appeared to have more direct interaction with older Chinese migrants through workshops and casual chats, hence creating more opportunities for migrants to discuss their problems in person and locate assistance providers.

Most of participants in this study utilised community services for language assistance, and this involved having English letters that they received in the mailbox translated,

making phone calls to English speakers or daily activities that required English skills, e.g. visiting government offices or using devices with English instructions. Organisations such as Chinese community centres, the Chinese Positive Ageing Charitable Trust, the Citizens Advice Bureau and the Positive Ageing Centre all contribute to help older Chinese migrants adapt to their life in New Zealand. Through clustering people with similar problems together and discussing prevalent difficulties, community services help reduce loneliness and increase migrants' understanding of their own situation and medical conditions.

According to participants' stories, family members and acquaintances were the major providers of assistance. Most participants relied on their adult children when they had health conditions or accidents, while a small portion showed great independence and lived a life more independent from their children. Spouses were main caregivers when participants lost their mobility or suffered from chronic diseases; in return, participants were also the first to offer support when their spouses faced emergencies or acute conditions. Where adult children were less available because they were working or needed to attend to their own nuclear families, spouses were able to respond more quickly and more favourably and may therefore be preferred companions to health and public services, notwithstanding their own limited English skills. Acquaintances who might also provide support or assistance were either younger or might have lived in New Zealand for longer, possessing better English skills than the interviewees. Acquaintances quoted as helpers in the interviews can be categorised as follows: people participants met in community workshops, flatmates staying in houses owned by participants, owners of nearby shops, or friends they met elsewhere. On very few occasions, participants reported having sought help from

strangers, and on those occasions language assistance was the only type of support requested.

### **6.3.3 Opinions and expectations towards service providers**

When participants see GPs for primary care, they expect to receive a precise diagnosis, while the role of GPs usually involves giving a provisional diagnosis (see Crezee, 2013). Though language was their major reason for choosing a Chinese GP, participants were dissatisfied with the expertise of Chinese GPs, as they felt that Chinese specialists acting as GPs in New Zealand resulted in misdiagnosis. I regard this as a result of differences in the medical system and school education between China and New Zealand, as there are no GPs in China. In China, when patients want to seek medical help, they see a doctor at the hospital, and this may have contributed to participants' confusion about the role of the GP. Some participants also expressed their desire of receiving friendlier interactions, since the contrast in attitude between Chinese GPs and New Zealand health professionals they visited was evident. There were also suggestions from respondents regarding combining GP clinics and laboratories for routine examinations, giving information on how to maintain good health, regular follow-ups, and checks on GPs' medical knowledge by administrators.

Public health services were most often the subject of complaints relating to the long waiting times. A few participants also said they wished that doctors and nurses in public hospitals could improve their skills in surgery and/or accuracy when giving injections. There are also participants who said they would prefer to have Chinese-speaking doctors rather than communicating with New Zealand doctors through healthcare interpreters, and their opinions can be summarised into three categories: firstly, hospitalised patients cannot be assigned an interpreter at all times, which

causes significant issues when communication is needed between doctors and patients; secondly, the accuracy of information delivered by interpreters is wholly dependent upon the interpreters' skill and understanding, which worries some participants; thirdly, using Chinese-speaking doctors is both convenient and economical for the government, meanwhile eliminating the process of recruiting and assessing interpreters.

Concerning staff at the emergency department, attitudes and waiting time were the two main issues reported by respondents. As participants were unaware of the triage process implemented by staff at the emergency department, they regarded the perceived ignorance of receptionists or nurses towards their repeated requests for earlier treatment as an attitude issue. In fact, staff were bustling around treating patients with more severe conditions, based on triage, which means the most urgent cases were treated first. Participants all felt that the emergency department should have interpreters of common languages arranged on ambulances and in waiting rooms.

Almost every participant had experienced using healthcare interpreter services; however, comments varied greatly. One participant felt that interpreters lacked proactivity, as he expected that obtaining diagnoses and explanation would be part of interpreters' responsibilities, when in fact it is not (NZSTI, 2013). Some participants felt that interpreted renditions were too brief and that doctors' diagnoses and precautions were explained too generally. Reluctance to ask questions on behalf of patients also accounted as a constraint of utilising healthcare interpreters, when in fact patients are supposed to ask their own questions through the interpreter. Common expectations for professional healthcare interpreters were: detailed delivery of doctors' every word, full interpretation of patients' questions regardless of repetitions,

companionship and chat beyond professional boundaries, patience, and using elevated voices during interpreting assignments, as some of the participants suffer from hearing problems. Concerning follow-up medical appointments with specialists, participants also requested having the same interpreter stay with them, so that the interpreter could get to know the participant's case history. From participants' perspectives, this measure can save briefing time, reduce risks of interpreting errors, improve interpreters' understanding of patients' needs as well as providing increased emotional support.

Government staff whom participants had contact with were officers of the immigration office and Work and Income. Community workers mentioned in interviews included researchers from community institutes, staff in community centres and Citizens' Advice Bureaus. Feedback from participants was unanimously positive, and one participant even considered the government staff to be wonderful. The actions performed by the above service providers outweighed participants' expectations, and therefore nobody felt that any further improvements were needed in terms of providers' attitudes or services.

#### **6.4 Key insights from the study**

Findings of this study show that considerable numbers of participants' complaints resulted from unfamiliarity with the healthcare system or health professionals' roles. Older Chinese migrants tended to compare everything in New Zealand with that in China, and came to conclusions based on the standards or procedures and systems they were familiar with in China. When the quality of subjects or services was higher than what they had experienced in China, they considered it satisfactory or even heart-

warming; conversely, they were likely to suggest improvements if they considered the quality less than that in China.

A new finding consisted in participants' suggestion of always arranging for clients to have the same interpreters for medical appointments. It is already known that having different interpreters across medical appointments could cause barriers for migrants when using health services (Lai & Chau, 2007); however unfortunately, it is impracticable to appoint a specific interpreter for each patient in view of logistics, administration workload and funding issues. If DHBs adopt the suggestion of assigning the same interpreter for follow-up appointments in public hospitals, it would be efficient for them to first decide which patients (e.g. with chronic or acute diseases, need major surgeries or stay in hospitals) need fixed interpreters. Funding issues also play a role, and it appeared participants were largely unaware of those and the fact that public services are paid from tax income.

## **6.5 Limitations and strengths**

### **6.5.1 Limitations**

Participants were from areas in Auckland which have quite a high number of Chinese residents, which may have had an impact on their ways of living and opinions about service providers. During the recruitment process, I only sent posters to and contacted leaders of Auckland organisations. According to statistics collected in 2013, 23.1% of people living in the Auckland region belong to Asian ethnic groups, among which 36.3% were Chinese (Statistics New Zealand, 2014). With a high proportion of Chinese living in Auckland, the service system may be significantly different from that in other regions in New Zealand. Although I contacted organisations in southern, central, and northern Auckland, participants in this study all came from two

organisations on Auckland's North Shore: Positive Ageing Centre in Takapuna and Chinese Community Centre in Northcote. This could be considered a limitation, as these two suburbs are generally considered to be more affluent. However, given participants' similar extracurricular activities and overlapping networks of acquaintances, it is also likely that this homogeneous group expressed opinions that were quite transferrable to other older Chinese in these two areas.

In the course of the recruitment process, I extended the recruiting criteria from less than ten years of stay in New Zealand to less than fifteen years, with the purpose of obtaining enough participants. Among the ten participants I interviewed, four had arrived in New Zealand before 2006, while the remaining six had arrived in 2006 or later. Participants were aged from 66 to 81 years. The heterogeneity of participants' demographic profiles could be a disadvantage for data analysis, considering the influence of numerous potential variables.

This study was conducted in accordance with the principles of phenomenology, and used semi-structured interviews to explore participants' lived experiences. As interviews followed the direction of participants' answers, some themes only came to the surface during the data analysis period. As a result, it is impossible to further probe the reasons uncovered by some specific questions, e.g. the relationship between participants and their adult children, participants' satisfaction levels concerning entertainment activities, or how some participants felt about living in New Zealand without their adult children.

As a novice researcher, I have limited experience in gathering stories through ongoing questioning, and thus answers collected may lack specificity. However, I have been improving my interviewing strategy throughout the research process, as well as my

ability to provide feedback and maintain objectivity. In fact, all of the above varied in each phase due to the need for continuous adjustment to participant responses. The stages of data collecting and analysing overlapped, due to some initial recruitment problems and the limited time available for me to complete the study in. Additionally, as a young adult I have limited life experience; hence inquiring about participants' relationships with their children or issues related to abandonment may be superficial as I sometimes felt uncomfortable exploring such topics, or asking what I would consider more 'probing' questions.

### **6.5.2 Strengths**

The characteristics of the methodology employed in this study enabled a deeper exploration of my research questions. Phenomenology requires asking in-depth questions when interviewing participants, and gathering descriptions as energetic and specific as possible. By conducting semi-structured interviews, participants were able to depict stories and opinions that extend beyond the research questions, and thus relevant themes may emerge during analysis. Analysis of these themes helped me to think outside of the box and connect other areas of study to this research field.

I mentioned the variation in age and length of stay in New Zealand as limitations in the above section—nonetheless, they can also be considered as an aspect of strength in this study. Given the heterogeneity in participants' time spent in New Zealand after retirement, I was able to access a range of older Chinese migrants' critiques of New Zealand public services, and to gather a variety of information on older Chinese migrants' daily problems. Additionally, people of different ages reflected on experiences from various perspectives, which broadened the scope and deepens the interpretation of themes.



Data analysis kept developing during the research process, as I was searching for a suitable approach to categorise scraps of information provided by participants. After primary processing of overall transcriptions, I summarised recurring themes and organised them by way of answers to my research questions. Throughout the findings section, I further refined themes and only discussed the ones I felt contributed to my research findings. The findings section divides themes by types of service providers, and uses participants' experiences as evidence. In the discussion section, data are rearranged differently when compared to the findings section, and is divided by participants' types of choices and expectations. Through repeated reading and pondering, I became immersed in participants' thoughts, and tried to make conclusions as unbiased as possible.

## **6.6 Implications for practice**

From the findings of this study, I can conclude that older Chinese migrants are most attached to acquaintances and family members, suggesting that their social network influences them more than government or authorities. Accordingly, workshops that target older Chinese should be advertised through channels such as leaders of older adults' organisations and organisers of community events for active members, who can promote the events unofficially during group chit-chat or at friends' gatherings.

Social workers or organisations can disseminate booklets relating to Chinese older adults' health in various places, where acquaintances and family members of older Chinese migrants are situated. I got this idea when taking part in a health promotion event organised by TANI. Among Asian faces, I noticed two local ladies taking Chinese flyers that conveyed health information for older adults. They explained that they were kindergarten teachers, and Chinese children were often looked after by their

grandparents, and thus older Chinese could read those flyers when visiting the kindergarten or waiting for their grandchildren. By checking participants' stories, I verified that most participants had in fact been taking care of their grandchildren. One participant, Jane, even described the percentage of older migrants involved in such responsibilities being as high as 90%:

*As for travelling here...older adults like us from China, eight to nine people out of ten need to take care of the grandchildren, cook for sons and/or daughters, and do some housework. From my perspective, 90% of the adult children ask older adults to come over to help instead of bringing their parents for enjoyment, absolutely not for enjoyment.*

When older adults take on the role of caregivers, their own physical and emotional wellbeing is more likely to be ignored. Bringing these people together through programmes can be beneficial, as they have peers to talk about their worries and psychological problems. Programmes can arrange for tutors to instruct older people on health care tips, or provide tailored appointments for them on a one-to-one basis. During my visits to sessions of a similar programme called Never2Old at the Auckland University of Technology, I observed how older people received support from each other and faced daily lives with more confidence. If this type of programme can be promoted to Chinese communities, older adults can have access to more options of leisure activities while communities can create new jobs for those who facilitate those sessions.

Waiting time is an issue that cause physical suffering and anxiety among most participants in this study. If there were data available about the number of people on the waiting list, the minimum and maximum time among waiting patients, as well as the average number of patients that public hospitals receive each year, patients would feel informed and empowered rather than helpless.

Based on participants' expectations concerning health service providers in this study, I would suggest that healthcare interpreters and GPs provide a briefing on their responsibilities and range of expertise when meeting a patient for the first time. Briefing can be an effective way of setting out role boundaries and indicating reasonable expectations, thus decreasing issues due to a misunderstanding of the provision and nature of certain services.

### **6.7 Recommendations and implications**

In 2016, the immigration office temporarily closed the Parent Category, announcing that “no Expressions of Interest will be selected from the Parent Category Pool from 12 October 2016” (Immigration New Zealand, 2016). This means older Chinese who are non-citizens have to find medical options other than those provided by the public healthcare system, which could cost them extra money while making it impossible for them to access publicly funded interpreter services. Older Chinese may stay a longer period of time on visitor visas or student visas for language learning purposes, while waiting for the reopening of the Parent Category, and this may lead to more financial pressure on their adult children. Future researchers could investigate the medical choices of non-residents among older Chinese, while also exploring whether increased financial support from adult children has a significant impact on the relationship between them and their parents.

As the most recent tide of Chinese immigration has occurred since 1986 (Xue, Friesen & O'Sullivan, 2012), most of the migrants who entered New Zealand as students have not reached the age of retirement. Participants in this study are parents of the generation of young migrants, who will retire in a dozen of years' time. Some of participants in this study complained about the monotony of their lives in New

Zealand, and leisure activities mentioned included sports, religious gatherings, and volunteer work. It would be interesting for future researchers to compare the recreational activities of migrants who grow old in New Zealand and migrants who arrive in New Zealand after 55 years old like participants in this study. Communities and businesses can use the research findings as a guide when holding events or setting up classes, benefiting the whole community socially and economically.

From the narratives of my participants' help-seeking experiences with their adult children, I could have examined the relationship between young migrants and their parents; however, this topic did not emerge during the data-collecting phase. Distance causes lengthy periods of separation, while experiences with life in different cultures will affect the way parents and children communicate or get along. A previous study reported on elder abuse among Chinese migrants, revealing a phenomenon that "the adult children work overseas and leave their parents alone in New Zealand to the care of social services" (Wang, 2013). This statement was echoed by an organiser of singing teaching when I participated in a weekly activity at the Positive Ageing Centre in Takapuna, who stated that "we came here at an old age, and then our adult children left us here". Future research could focus on the issue of elder abuse and neglect, in combination with an exploration of traditional Chinese family values and consideration for the financial situation of older Chinese migrants.

## **6.8 Summary**

Participants in this study had most of their health and social service encounters with GPs, publicly funded hospitals and emergency department services. Other health services they used included regional bowel screenings and physical examinations, national screenings and physical examinations, vaccinations, presentations and

workshops organised by DHBs, and assistance provided by researchers from non-government organisations. Health services in their home country of China were considered as a backup plan due to the need for long-haul flights and the Immigration New Zealand requirements that “everyone else included in the residence application has been living in New Zealand for at least 184 days in the 2 years before applying for permanent residence” (Immigration New Zealand, n.d. c).

Issues that put participants at risk were certain health conditions and accidents. For referral of conditions such as chronic diseases, patients normally faced at least three months of waiting time, and could experience immobility or even develop new symptoms, which can apply to all other people in a similar age group in New Zealand. Accidents or emergencies that participants had been confronted with included acute symptoms of disease, falls and theft. To address such situations, participants said they had sought assistance from various support people, and the resources provided by government services, community services, families and friends, non-profit organisations and acquaintances. Only a few participants stated having sought help from strangers when they urgently needed language support.

As for participants’ views on service providers, I will summarise these by mentioning five aspects. Firstly, Chinese GPs were considered unprofessional - even though all but one participant utilised the services of a Chinese family doctor - and participants suggested these should provide suggestions for maintaining good health, regular follow-ups. Participants also felt that there should be audits by ‘administrators’ to check GPs’ medical knowledge. I can only assume that participants kept visiting their Chinese GPs because there were no language barriers as they could speak their own language. Another suggestion from interviewees involved combining GP clinics and

laboratories for routine examinations, as older people tend to have mobility difficulties and may find it hard to get from one service to another. Secondly, long waiting times and the perceived incompetence of New Zealand health staff in relation to carrying out surgeries or giving injections were regarded as barriers when accessing public health services. Because of the language barrier, Chinese-speaking medical staff were also preferred by some participants. Thirdly, staff attitudes were an issue that dissatisfied participants who perhaps erroneously utilised the emergency department services with minor ailments, rather than presenting to their family doctors or after-hours accident and emergency clinics. However, participants' lack of awareness of the fact that emergency department staff might have considered that they were misusing the emergency department for issues they should have seen their GPs with was a significant factor that should be taken into account. A universal suggestion made by respondents was to arrange interpreters of common languages in waiting rooms and on ambulances. However, as ambulances have limited space and are sent out at a short notice, it is better to have Chinese speakers trained as paramedics, e.g. studying Paramedicine programmes. Furthermore, there is a cost involved in having interpreters on standby, when they may not be needed at all during a given period of time. Fourthly, comments on health interpreters varied as participants had different expectations, which mainly included the fact that interpreters should provide a detailed rendition of doctors' every word, repeat all of a patient's questions and raise their voices during interpreting assignments. Participants also hoped the same interpreter could be assigned to them in follow-up appointments to ensure awareness of their previous history resulting in increased accuracy of interpretation. Last but not least, government and social services received unanimously positive remarks from participants, as they exceeded participants' expectations.

## 6.9 Conclusion

This study explored older Chinese migrants' experiences when accessing health and support services. In this thesis, I have divided my findings as to these lived experiences into two categories: experiences with health service providers and other assistance providers.

Participants' narratives showed that health service providers were considered as presenting a good attitude on most occasions. However, interviewers recounted that the time lag between referral and diagnosis had caused them much suffering. Health professionals' perceived incompetence was also highlighted, while Chinese GPs constituted a category that was most frequently complained about. Participants requested arranging for Chinese-speaking staff in medical settings, and had a preference for Chinese-speaking health professionals over interactions with New Zealand health staff mediated by Chinese interpreters, yet all but one participant had a Chinese family doctor. Presumably, participants' need for language access (Roat & Crezee, 2015) overrode other considerations.

Participants experienced barriers including language differences, inconvenient transportation, chronic illnesses as well as unexpected accidents, among which the first three were reported most frequently. Families and acquaintances were two major sources they turned to when in need of assistance, while strangers were their last choice. Government services and community support were also utilised, which they mainly learned about through everyday chatting and community workshops.

Findings of this study indicated the influence of Chinese culture and the Mainland Chinese health system on participant responses, and participants' lack of awareness of the taxpayer funded nature of different services provided in New Zealand. A good

suggestion to improve their knowledge would be to promote health services among members of their networks, and to have service providers give briefings about role boundaries, funding constraints and so on, as this may help older Chinese migrants realize the reason for waiting times.

This study has discussed participants' lived experiences with health and support services in New Zealand. Though barriers and limitations have been discovered, overall participants regard their lives here as promising. I would like to use a comment from my participant Daisy to wrap up the thesis:

*New Zealand is good overall. I shall say it is fortunate for us  
Chinese to come to New Zealand, really fortunate.*



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## Appendices

### Appendix A1: Initial Ethics Approval

14 April 2016

Ineke Crezee

Faculty of Culture and Society

Dear Ineke

**Ethics Application: 16/89 What are the experiences of older Chinese-speaking migrants in Auckland when accessing health and support services in New Zealand?**

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 11 April 2016, subject to the following conditions:

1. Reconsideration of the inclusion and exclusion criteria to more clearly indicate what language skills participants need to take part in the research. AUTEC noted that on the evidence provided in the application, it may be clearer for participants if 'Chinese' in the title was altered to 'Mandarin';
2. Clarification of how the language proficiencies of potential participants will be managed in the recruitment process and provision of all translations that will be used;

3. Clarification of the responses to section A.5.1 of the application and especially of how phenomenology and talanoa are being used as research instruments;
4. Amendment of the Information Sheet as follows:
  - a. Careful checking of the grammar;
  - b. Reconsideration and revision of the sections on discomforts so that they better reflect the nature and context of the research being undertaken.

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach.

AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six

months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz).

I look forward to hearing from you,

Yours sincerely

A handwritten signature in black ink, appearing to read 'K O'Connor', written in a cursive style.

Kate O'Connor

Executive Secretary

**Auckland University of Technology Ethics Committee**

Cc: Anni Tang [sherlly\\_tan@outlook.com](mailto:sherlly_tan@outlook.com), Valerie Wright-St Clair

## Appendix A2: Letter of Response

Dear Erin

Thank you for your response to Application Number 16/89. We have addressed the conditions outlined by AUTECH as follows:

- a. Both the researcher and participants will use Mandarin Chinese during the research. “Chinese” has been altered to “Mandarin” in sentences that involve language skills. (Revised relevant documents are attached, with changes shown in red.)
- b. All translations that will be used are provided. (Translations of participant information sheet and advertisement are attached.)
- c. Responses to section A.5.1 of the application have been clarified. Talanoa will not be used as a research instrument. (The revised ethics application (EA1) has been attached, with changes shown in red.)
- d. Sections on discomforts have been reconsidered and revised so that they better reflect the nature and context of the research being undertaken; grammar mistakes of the information sheet have also been corrected. (Revised participant information sheet is attached, with changes shown in red.)
- e. By only posting advertisements written in Chinese, language proficiencies of potential participants can be tested. Mandarin will also be the only language used in the recruitment process, by email or call as per potential participants’ preference. (Clarification of how the language proficiencies of potential participants will be managed in the recruitment process.)

Thank you again for your careful consideration of this proposal. We look forward to your response.

Ineke Crezee

Valerie Wright-St Clair

Anni Tang



## Appendix B: Final Ethics Approval

3 May 2016

Ineke Crezee

Faculty of Culture and Society

Dear Ineke

Re Ethics Application: **16/89 What are the experiences of older Mandarin speaking migrants in Auckland when accessing health and support services in New Zealand?**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 2 May 2019.

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/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 2 May 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 2 May 2019 or on completion of the project.

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 responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application. AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz).

All the very best with your research,



Kate O'Connor

Executive Secretary

**Auckland University of Technology Ethics Committee**

Cc: Anni Tang [sherlly\\_tan@outlook.com](mailto:sherlly_tan@outlook.com), Valerie Wright-St Clair

## Appendix C: Indicative Questions Guide

For older Mandarin-speaking migrants' interviews

*Tell me about a time you accessed health or social services in New Zealand.*

*Probe: What about the first time?*

*Tell me about the most recent time.*

*Can you describe a moment when accessing health or social services in NZ when you experienced being treated respectfully, or when things went well?*

*Probe: What made it respectful/go well for you?*

*What about a moment when you thought you were not treated respectfully, or something went wrong?*

*Probe: How did you feel during the process?*

*Tell me about an occasion when the interpreter was present.*

*Probe: What happened to influence your understanding of what he/she was talking about?*

*Tell me about an occasion when no one was interpreting for you.*

*Probe: What would have helped/made it better?*

*What things matter the most when you access New Zealand health and social services?*

*What types of qualities, training and role do you think service providers ought to have?*

## 指示性问题

用于访谈使用普通话的移民

说说您以前使用新西兰的医疗或社会服务的情况。

追问：第一次使用这些服务的情况是怎样的？

说说最近一次的情况。

您能描述一下以前使用新西兰的医疗或社会服务时感觉很受尊重或一切都很顺利的那一刻吗？

追问：是哪些细节让您觉得受尊重或事情很顺利？

您能描述一下以前使用新西兰的医疗或社会服务时感觉不受尊重或出问题的那一刻吗？

追问：当时您有哪些想法和感受？

说说您使用这些服务时有译者在场的情况。

追问：当时发生了哪些事影响您对译者的理解？

说说您使用这些服务时没有译者在场的情况。

追问：当时您需要哪些东西/人帮助您？您觉得怎么做会让当时的情况更好？

您在使用新西兰的医疗或社会服务时，哪些方面/东西是最重要的？

您觉得提供这些服务的人员应该具备什么特点/品质？接受什么样的培训？扮演什么样的角色？

## Appendix D: Researcher Safety Protocol

*Project title:* What are the experiences of older Mandarin-speaking migrants in Auckland when accessing health and support services in New Zealand?

*Name of applicant:* Ineke Crezee

*Name of primary researcher:* Anni Tang

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1. I will give my primary supervisor a list of names, contact details, addresses, dates and times of interviews.

2. I will text my primary supervisor as soon as I have left the interview location, and she will text me back to confirm she has received my text message.

If my supervisor does not receive a text message within 10 minutes of my supposed finish time, she will text me. If I am still at the address and okay, I will text back. “Still here, okay. Out in 10” (if I think I will have left the address in 10 minutes, or: “Out in 15” if I think I will have left the address in 15 minutes).

When my supervisor receives this text message, she will await a further text within the designated timeframe. If she does not receive this text message, she will ring me.

*Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEK Reference number type the AUTEK reference number*

## Appendix E: Recruitment Advertisement

*For older Mandarin-speaking migrants.*



*Project title:* What are the experiences of older Mandarin-speaking migrants in Auckland when accessing health and support services in New Zealand?

*Project Supervisors:* Dr Ineke Crezee and Dr Valerie Wright St Clair  
*Researcher:* Anni Tang

---

My name is Anni Tang, a Master student interested in your experiences with New Zealand health and social services. Please contact me if you meet the following criteria and are willing to be interviewed to share your experiences:

- aged 65 or older, self-identifying as Chinese, fluent in Mandarin;
- migrated to New Zealand within the last 15 years;
- had health and/or social service interactions in New Zealand in the last 3 years;
- able to recall stories up to 3 years ago;
- and residing in the central Auckland region or Northcote/Glenfield region.

I hope we can meet soon!

**Researcher Contact Details:**

*Anni Tang, Mandarin-speaking interpreter and researcher: (on a specially designated temporary number that will divert to her mobile phone)*

**Project Supervisor Contact Details:**

*Dr Ineke Crezee, [icrezee@aut.ac.nz](mailto:icrezee@aut.ac.nz), Phone: 09 921-9999, ext. 6825*

*Dr Valerie Wright St Clair, [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz), Phone: 09 921-9999, ext. 7736*

***Approved by the Auckland University of Technology Ethics Committee on***

***03/05/2016***

***AUTEC Reference number 16/89***

## 招募信息

招募使用普通话的老年移民



项目标题:

奥克兰地区使用普通话的老年移民使用新西兰医疗及支援服务时有哪些经历

项目指导: Ineke Crezee 博士、Valerie Wright St Clair 博士

研究员: 唐安妮

---

我是在读硕士唐安妮，非常希望能了解您在新西兰使用医疗及支援服务的经历。如果您符合以下条件，也愿意通过访谈的方式和我分享您的经历，请和我联系：

年龄为 65 岁或以上，认为自己是中国人，普通话流利；

于过去 15 年内移居到新西兰；

过去 3 年内使用过新西兰的医疗和/或支援服务；

能回忆起 3 年内的故事；

住在奥克兰中心区 (City) 或北岸 (Northcote) 或格伦菲尔德 (Glenfield) 地区。

希望能早日见到您！

研究员联系方式：

唐安妮，普通话使用者、口译员、研究员

0211662867          sherlly\_tan@outlook.com

项目指导联系方式：

Ineke Crezee 博士

邮箱： [icrezee@aut.ac.nz](mailto:icrezee@aut.ac.nz)

电话： 09 921-9999 转 6825

Valerie Wright St Clair 博士

邮箱： [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz)

电话： 09 921-9999 转 7736

*奥克兰理工大学伦理委员会于 03/05/2016 批准参考号为 16/89 的申请*



## Appendix F: Participant Information Sheet

Date Information Sheet Produced: 27 November 2016

### Project Title

What are the experiences of older Mandarin-speaking migrants in Auckland when accessing health and support services in New Zealand?

### An Invitation

My name is Anni Tang, and I am a Mandarin-speaking student completing my Master of Arts (Applied Language Studies) at Auckland University of Technology. I am interested in learning more about the experiences of older Mandarin-speaking migrants who access health and social services in New Zealand, and searching for ways that can better address problems encountered by these older migrants.

I invite you to consider volunteering for this research. Interviews will involve me asking questions about your experiences when accessing health and support services in New Zealand, so that I can learn more about what went well and what problems you experienced (if any). I will take notes during the interview and record the process with a digital device, but you do not need to answer questions that you find too personal or that might be embarrassing for you.

Your participation in this research is voluntary, and you can withdraw at any time up to one month after your interview. You will not be disadvantaged in any way if you do not choose to participate in this research. My aim is to learn more about the problems that older Mandarin-speaking migrants face so that future health and support services can be better aligned with the needs of older Mandarin-speaking migrants.

### What is the purpose of this research?

My aim in doing this research is to learn more about what went well and what problems you experienced when accessing health and support services in New Zealand, so that future support services can be better aligned with your needs. This research will be used in the course of, and lead towards the completion of, my master degree. I may want to apply the information I learn to future conference presentations or journal articles.

### How was I identified and why am I being invited to participate in this research?

You may be reading this after seeing the advertisement placed on the website of a support agency or because your friends or acquaintances have participated in my interviews and told you about my research.

You are invited to participate in this research if you: are 65 or older; self-identify as Chinese; are fluent in Mandarin; migrated to New Zealand within the last 15 years; had health and/or social service interactions in New Zealand in the last 3 years; able to recall stories up to 3 years ago and reside in central Auckland or Northcote/Glenfield region.

### What will happen in this research?

Data collecting period of this research project involves me interviewing you and up to 19 other older Chinese migrants. I will contact you to set a time for your interview if you agree to participate in the study. Your interview will focus on your experiences accessing health and social services in New Zealand.

I will record the interviews with a digital device, and take notes to help me remember what happened. I will also send you a summary of the experiences you told me, to see if you agree.

What are the discomforts and risks?

You might have emotional disturbance when you are recalling experiences during the interview. I hope that the discomforts and risks caused to you will be minimal since the interview will be in a form that is similar to daily conversation and causes little pressure.

How will these discomforts and risks be alleviated?

You are encouraged to ask the researcher to stop the interview process at any time and to resume it when you are ready. You can also refuse to answer questions that you find too personal, and I will choose a fictitious name for you to use in my research report. If you feel any discomfort or risk, you can choose to discontinue the interview or withdraw from the study up to one month after your interview date. You will not be disadvantaged in any way if you do not choose to participate in this research.

What are the benefits?

You may benefit from thinking and talking about your experiences of accessing health and support services. Your contribution may influence other older Mandarin-speaking migrants' experiences in the future. As an older Chinese migrant, if you can have a deeper understanding of your needs, you might experience less miscommunication or cultural barriers in your future contact with health or social services in New Zealand. The wider community of older migrants may also benefit as the researcher may identify services that are beneficial to older migrants with participants' help. A community with happier older Chinese migrants will be a happier community; besides, I may learn things from this research that could help older migrants in general. It is hoped that by listening to older Mandarin-speaking migrants, I can have a deeper understanding of the field, improve my expertise during the research as well as completing my Master qualification.

How will my privacy be protected?

I will assign a code name for you and only my supervisors and I will know your real identity. One of my supervisors will keep this information in a locked filing cabinet in her office at the university.

What are the costs of participating in this research?

There will be no direct cost to you during the research. It will take up to 120 minutes of your time, including up to 90 minutes for your interview and 30 minutes to read the summary of your story after the interview.

What opportunity do I have to consider this invitation?

You have two weeks to consider whether to allow me to interview you. I will contact you after this time and check if you are interested in participating.

How do I agree to participate in this research?

Contact me, Anni Tang, if you are interested in participating in this study. My contact details are given below. I will invite you to sign the consent form before your interview begins.

Will I receive feedback on the results of this research?

Yes, I will send a copy of the report from the research if you are interested.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors, Dr Ineke Crezee, [ineke.crezee@aut.ac.nz](mailto:ineke.crezee@aut.ac.nz), 921 9999 ext 6825

Dr Valerie Wright St Clair, [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz), 921 9999 ext 7736

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTECH, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Dr Ineke Crezee, [ineke.crezee@aut.ac.nz](mailto:ineke.crezee@aut.ac.nz), 921 9999 ext 6825

Dr Valerie Wright St Clair, [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz), 921 9999 ext 7736

Researcher Contact Details:

Anni Tang, [sherlly\\_tan@outlook.com](mailto:sherlly_tan@outlook.com), (a specially designated temporary number that will divert to her mobile phone)

Project Supervisor Contact Details:

Dr Ineke Crezee, [ineke.crezee@aut.ac.nz](mailto:ineke.crezee@aut.ac.nz), 921 9999 ext 6825

Dr Valerie Wright St Clair, [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz), 921 9999 ext 7736

# 研究计划说明书

## 研究计划说明书撰写日期

2016 年 11 月 27 日

## 项目标题

奥克兰地区使用普通话的老年移民使用新西兰医疗及支援服务时有哪些经历

## 研究邀请

本人是普通话使用者唐安妮，目前就读于奥克兰理工大学文学硕士学位（应用语言研究）。本人有意了解使用普通话的老年移民在使用新西兰医疗及支援服务时的经历，并寻求方法以更好地解决这些老年移民遇到的问题。

本人邀请您考虑无偿参与该研究。本人会在访谈中问您有关使用新西兰医疗及支援服务时的经历，以便了解经历中顺利的方面和遭遇的问题。本人会在访谈期间做笔记，并使用电子设备记录该过程。如您认为部分问题涉及隐私或让您感到尴尬，可选择不回答这些问题。

您是否参与该研究完全由您自由决定，可在访谈结束满一个月前随时要求退出该研究。如您选择不参与该研究将不会受到任何不利影响。研究目标是多了解使用普通话的老年移民面对的问题，以便医疗及支援服务能在将来更好地满足使用普通话的老年移民的需求。

## 研究目的

本人进行该研究的目的是了解您在使用新西兰医疗及支援服务时的经历，找出经历中顺利的方面和遭遇的问题，以便支援服务能在将来更好地满足您的需求。该研究属于本人硕士学位的最终阶段。本人将来可能将研究内容用于会议演说或期刊文章。

## 我是如何被发现并邀请参与此项研究的？

您可能之前看到支援机构网站上张贴的广告，或您的朋友或相识的人接受本人的采访后向您提及本人的研究。

如果您满足以下条件，则将受邀参与该研究：年龄为 65 岁或以上；认为自己是中国人；普通话流利；于过去 15 年内移居到新西兰；过去 3 年内使用过新西兰的医疗和/或支援服务；能回忆起 3 年内的故事；住在奥克兰中心区(City)或北岸(Northcote)或格伦菲尔德(Glenfield)地区。

## 这项研究的将如何进行？

在这项研究计划的数据收集阶段本人会采访您和（至多）另外 19 名老年中国移民。如果您同意参与该研究，本人会联系您约定访谈时间。访谈内容会关注您在新西兰使用医疗和社会服务的经历。

访谈将利用电子设备记录，本人还会做笔记提醒自己访谈的过程。本人会将您的的经历总结后发回给您并征得您的同意。

## 访谈是否会造成风险或不适感？

您在回想经历时可能有情感波动。由于访谈形式接近日常对话，本人希望将您可能经历的不适和风险降到最低。

## 如何降低风险和不适感？

您可以随时要求研究员暂停访谈，待准备好后再继续。如您认为部分问题太过私人也可拒绝回答，在研究报告中本人还会使用昵称代替您的名字。如果您感到任何不适或认为造成任何风险，可选择终止访谈或在访谈日期后一个月内退出研究。如果您选择不参加该研究，不会受到任何不利影响。

## 研究有何益处？

通过思考并谈论您使用医疗和社会服务的经历，您可能从中获益。您的贡献可能在将来影响其他使用普通话的老年移民的经历。对包括您在内的老年中国移民有更深入的理解后，您可能在将来使用医疗或社会服务时更少体验交流不畅或文化障碍的情况。

由于通过受访者的帮助，研究员可能识别出对老年移民有益的服务，整个老年移民集体都可能受益。如果老年中国移民的幸福感和整个团体的幸福感都会随之提高。本人也可能从研究中学到有助于所有老年移民的知识，并希望通过使用普通话的老年移民叙述的经历，在研究中更深刻地理解该领域并提升专业知识，完成硕士学位。

#### **我的隐私会怎样得到保护？**

本人将为您分配一个代号名称，只有本人和本人的导师们知道您的真实身份。本人的一名导师会将资料锁在她大学办公室的文件柜里。

#### **参与该研究需要付出什么？**

研究过程中无需您直接付出任何项目。参与该研究最多会花费您 120 分钟，其中采访最多花费 90 分钟，另外 30 分钟用于阅读您在采访过程中分享的故事。

#### **我有多长时间考虑是否参与该邀请？**

您有两周的时间考虑是否让本人采访您。两周后本人会联系您，看您是否有意愿参与该研究。

#### **我如何同意参与该研究？**

如果您有意愿参与该研究，请联络本人（唐安妮），本人的联络方式在下面一栏。在采访您之前，本人会邀请您签署同意书。

#### **我会收到研究结果的反馈吗？**

会，如您有兴趣，本人会将研究报告的副本发送给您。

#### **如果我对该研究有担忧应怎么做？**

如果对该项目本身有任何担忧，应立即告知项目指导

Ineke Crezee 博士  
9999 转 6825

邮箱: [icrezee@aut.ac.nz](mailto:icrezee@aut.ac.nz), 电话: 09 921-

Valerie Wright St Clair 博士  
9999 转 7736

邮箱: [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz), 电话: 09 921-

对研究过程中行为的担忧应告知奥克兰理工大学伦理委员会执行秘书

Kate O'Connor  
转 6038

邮箱: [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), 电话: 921 9999

#### **如果我想取得有关该研究的更多信息应联系谁？**

请保存这份《研究计划说明书》和《同意书》的副本，以便以后查阅。您也可联系下方的研究团队：

Ineke Crezee 博士  
9999 转 6825

邮箱: [icrezee@aut.ac.nz](mailto:icrezee@aut.ac.nz), 电话: 09 921-

Valerie Wright St Clair 博士  
9999 转 7736

邮箱: [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz), 电话: 09 921-

#### **研究员联系方式：**

唐安妮

邮箱: [sherlly\\_tan@outlook.com](mailto:sherlly_tan@outlook.com), 电话: (可

转接至手机特别设定的暂时号码)

#### **项目指导联系方式：**

Ineke Crezee 博士  
9999 转 6825

邮箱: [icrezee@aut.ac.nz](mailto:icrezee@aut.ac.nz), 电话: 09 921-

Valerie Wright St Clair 博士  
9999 转 7736

邮箱: [vwright@aut.ac.nz](mailto:vwright@aut.ac.nz), 电话: 09 921-

**奥克兰理工大学伦理委员会于 03/05/2016 批准参考号为 16/89 的申请**

## Appendix G: Consent Form

For use when interviews are involved.

*Project title:* What are the experiences of older Mandarin-speaking migrants in Auckland when accessing health and support services in New Zealand?

*Project Supervisors:* **Dr Ineke Crezee, Dr Valerie Wright St Clair**

*Researcher:* **Anni Tang**

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 29 April 2016.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ 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.
- ☐ I agree for the Mandarin-speaking migrant to be interviewed by the researcher who will use a digital device to record the interview.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one):  
Yes ☐ No ☐

Participant's Signature :

Participant's Name :

Participant's Contact Details (if appropriate) :

Date :

***Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEK Reference number type the AUTEK reference number***

*Note: The Participant should retain a copy of this form.*

## 同意书

### 用于访谈相关内容

项目标题：奥克兰地区使用普通话的老年移民使用新西兰医疗及支援服务时有  
哪些经历

项目指导：Ineke Crezee 博士、Valerie Wright St Clair 博士

研究员：唐安妮

- 我已阅读并理解日期为 2016 年 4 月 29 日的研究计划说明书中所述内容。
- 我有机会提出问题并获得解答。
- 我知晓在数据收集阶段结束前，我可退出研究或撤回为该项目提供的信息，但不会受到任何不利影响。
- 我同意该名使用普通话的移民接受研究员的访谈，并同意研究员使用电子设备录制访谈内容。
- 我同意参与该研究。
- 我希望获得研究报告的副本（请选择一项）：是○否○

受访者签名：

受访者姓名：

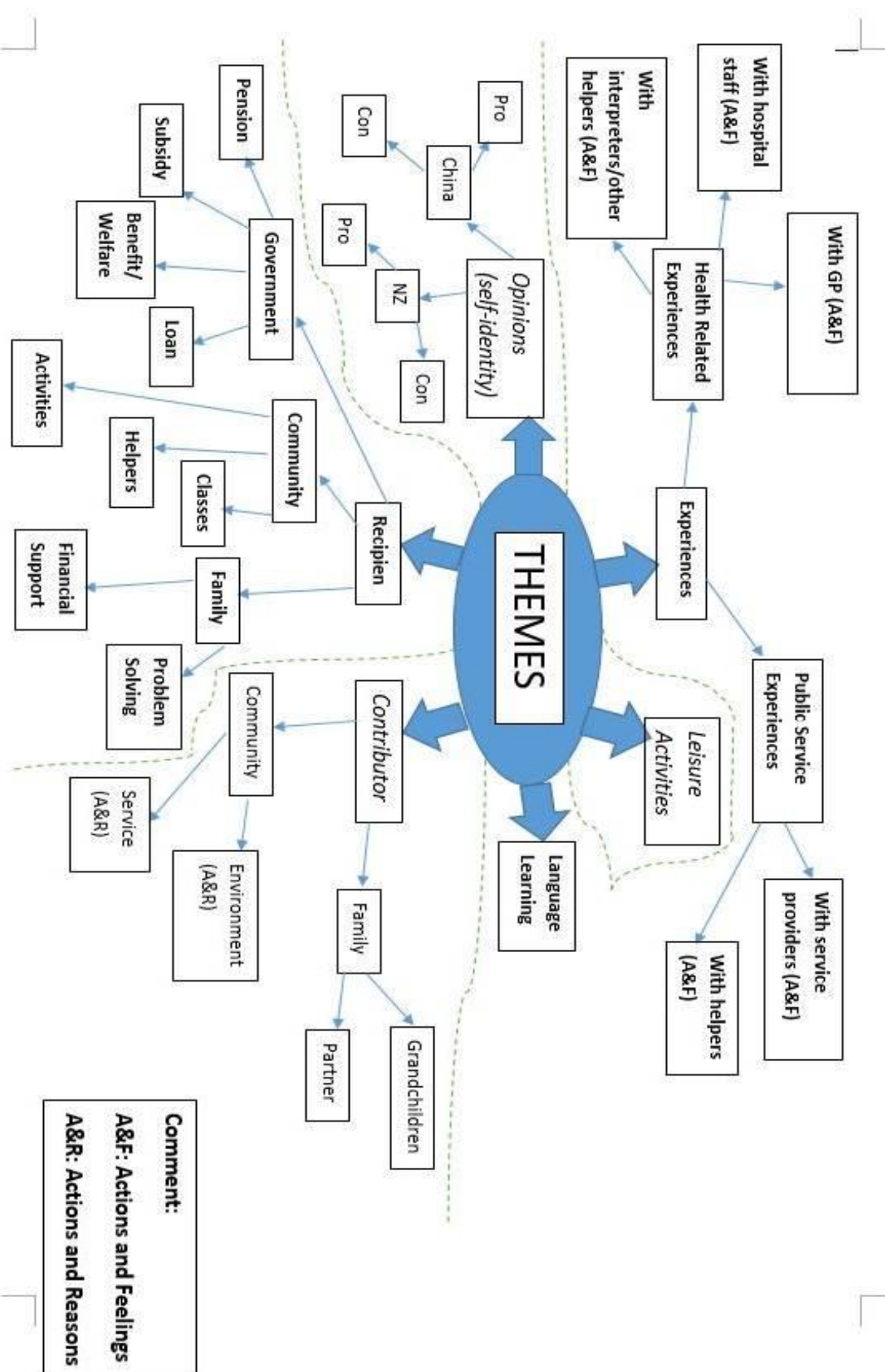
受访者联系方式（如适用）：

日期：

**奥克兰理工大学伦理委员会于输入最终批准日期批准参考号为输入参考号的申请**

备注：受访者需保存该同意书的副本

## Appendix H: Interviews Mind Map





- Participants were aged 65 or older, and no longer worked as taxpayers. They received support from the government, community, and family members. Experiences concerning this field were also frequently mentioned.
- Some participants were not content with merely receiving. They also contributed to the community and their families in various ways.
- Language proved to be a great barrier. Most participants expressed difficulty in learning English through various learning methods.
- Participants compared advantages and disadvantages of living in New Zealand and China, showing a transition in belongingness and confusion in self-identity.
- Participants were keen to take part in leisure activities, but sometimes failed due to various reasons.

Themes that were chosen for the Findings chapters were the following:

- Health services that participants mainly utilized were GP care, public hospitals, emergency departments, and other sources. Participants expressed their own views about each service's strengths and limitations, and also gave suggestions.
- Social services that participants mainly utilized were healthcare interpreters, government and community services, non-government services, and other sources. Participants also sought assistance from family members, acquaintances, and strangers.
- Language issues appeared throughout the above two themes, and were discussed with other factors as barriers when accessing services, rather than a separate topic.
- Participants were put at risk by a range of accidents, which impacted their physical and psychological wellbeing.