

Barriers experienced by Asians in accessing injury-related services and compensations

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ABSTRACT

INTRODUCTION: The Accident Compensation Corporation (ACC) administers New Zealand's (NZ) accident compensation scheme. Asians in NZ are apparently under-served by ACC and may be experiencing barriers to accessing services. This study identifies barriers that Asians in NZ face in accessing ACC's injury-related services and compensations.

METHODS: By utilising a qualitative research design, 113 Chinese, Korean, Indian, and South East Asian participants residing in Auckland, NZ were recruited through maximum variation and purposive snowball sampling. Data were gathered during 2006 through 22 individual in-depth interviews and 14 focus group discussions based on semi-structured interview schedules. Interviewees included Asian general practitioners, traditional health providers, users and non-users of injury-related services, case managers and Asian community leaders. Data were analysed using a general inductive approach.

FINDINGS: Results show that personal/cultural characteristics such as age, gender, English language competence, injury-related language competence, differing Asian worldviews, and consequent help-seeking behaviours act as barriers to accessing services and entitlements. This is exacerbated by logistical and environmental factors such as cost, transport, time, inadequate interpretation and translation services, as well as institutional barriers such as lack of information about services, culturally inappropriate services, discriminatory attitudes and employment risks.

CONCLUSION: It is evident that Asians living in NZ are experiencing several cultural, environmental and institutional barriers to accessing ACC services. There is clearly a need for more culturally relevant information and injury-related services if Asian immigrants' use of such services and entitlements is to be increased.

KEYWORDS: Barriers; access; Asians; injury-related services

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Introduction

This study is part of a larger study which was commissioned by the Accident Compensation Corporation (ACC). It aims to investigate what barriers Asian ethnic groups in New Zealand (NZ) may be encountering in accessing health care services provided by the ACC.

NZ's primary health care system consists of Primary Health Organisations (PHOs) which are not-for-profit structures for delivering primary

health care services. They promote equity in access and utilisation of services amongst New Zealanders. Because injury is a leading cause of premature death and disability in NZ, ACC was established by the Crown to offer help which includes financial and other necessary services to anyone in NZ to assist with injury recovery.¹

The data presented by ACC suggest that despite Asians representing about 7% of the NZ population in 2006, they had only 2% of the 1.4 million

J PRIMARY HEALTH CARE
2010;2(1):43–53.

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injury claims. This under-servicing of Asian clients suggests that they might experience more barriers in accessing injury prevention and rehabilitation services than other ethnic groups in NZ.

Several studies on barriers in accessing health care services have been conducted in the past, mainly on poor populations, in the United States (US) and other developed countries including NZ. Very few studies have been conducted on barriers experienced by Asian immigrants in these countries. These studies have identified barriers that are similar, irrespective of the nature of health services provided, and include culture,²⁻⁷ lack of information, cost, childcare facilities, transport and adverse experiences,^{8,9} age, gender, income, education, language proficiency,⁹⁻¹³ lack of health insurance or support services,¹⁴ attitudes of service providers,¹⁵ and lack of ethnic minority service providers.^{16,17}

Asians are the fastest growing ethnic group in NZ and currently make up 9.2% of the popula-

Asian groups and, therefore, they cannot be considered a homogeneous group. Furthermore, at the time of this study, Asians were not categorised as a separate ethnic group in the publicly-available statistical documents of ACC. Hence, based on the New Zealand usage, in this study the term 'Asian' refers to all peoples from South, South East and East Asia.

The aim of this study was to explore the barriers that Asian populations in NZ face in accessing ACC services.

Methods

Study design

This is an observational study which utilises a framework approach to gather data.²¹ Previous NZ research^{22,23} and anecdotal data from Asian communities have identified three broad sets of factors that act as barriers to Asian integration/interaction in NZ, namely, personal/cultural, logistical/environmental, and institutional. The

In NZ...the term 'Asian' is used loosely to describe a group of people from at least 28 different countries, representing a wide range of cultural, linguistic and social backgrounds. However, there are wide differences between different Asian groups and, therefore, they cannot be considered a homogeneous group

tion.² They are projected to make up 14.5% of the NZ population by 2021.³ Asian health is viewed as an emerging topic in NZ; however, the health needs and the barriers to accessing health services of this group of people have not been assessed systematically yet.

In NZ, ethnicity is broadly divided into five main groups: European, Maori, Pacific Peoples, Asians and other. The term 'Asian' is used loosely to describe a group of people from at least 28 different countries, representing a wide range of cultural, linguistic and social backgrounds.⁴ However, there are wide differences between different

study questions were hence framed around these three sets of barriers.

The study utilised qualitative methods of data collection to provide a narrative description and exploration of the personal views of participants on barriers to Asian people accessing injury-related services and entitlements in NZ. This was achieved through focus group discussions and individual interviews with a varied sample of participants from Asian communities and the health service sector. This design also enabled examination of differences in issues, perceptions and experiences between different Asian com-

munities, age groups and genders, and different service providers.

Data collection and analysis were concurrent and reflexive. This iterative process served to identify topics to be covered in depth in subsequent interviews and focus groups. Focus group discussions and individual interviews were audio-taped with the consent of participants for reliable transcription of data.

Focus group discussions

The focus group discussions were employed to scope and identify significant issues concerning barriers experienced by Asians in NZ in accessing ACC services. These discussions aimed to inform and guide the development of the research tool for the individual interviews. Focus group discussions were conducted by experienced researchers from the ethnic communities being interviewed, in the first language of these communities. This, together with being with people with whom they could identify, provided participants with a sense of security and freedom to express themselves spontaneously, to interact and construct meaning jointly, providing open and rigorous discussion of the topic and the collection of a wide range of data.

Discussions lasted one to two hours each. Important points were noted on flip charts which helped participants to follow the progress of the discussion and avoid duplication. Transcriptions and notes were matched as a proxy for controlling the quality of transcriptions. Interviewers were supported by senior researchers from the University of Auckland who served as facilitators, moderators and note-takers.

Face-to-face interviews

The in-depth, individual, face-to-face interviews aimed to explore and expand upon the issues identified in the focus group discussions. They also allowed participants to discuss issues that they may not have raised within a group setting. Interviews were conducted in the preferred language of the participant (which included English) by ethnically matched researchers, and lasted from half to one hour each.

WHAT GAP THIS FILLS

What we already know: Asian health is an emerging topic in New Zealand (NZ), and the health needs and barriers to accessing health services of Asians have not yet been assessed systematically. However, there is some information on the general health needs and access barriers of Asians in other host countries.

What this study adds: This is the first comprehensive study that investigates the Accident Compensation Corporation's (ACC's) health care access barriers for the wider Asian population in NZ, and provides significant data peculiar to the NZ context. Although the information presented pertains to barriers experienced by Asians in accessing ACC services, much of the information also applies to general medical services and can be useful to all medical practitioners.

Recruitment and sample

The study utilised maximum variation sampling to engage 113 participants from a wide range of groups involved in ACC, including claimants of ACC services, non-claimants, community leaders, traditional practitioners, general practitioners and case managers. This range of respondents provided a wide variety of perspectives on access issues in different settings and at different times.

Purposive snowball sampling was used for recruiting non-claimants, community leaders and traditional practitioners. Claimants who had accessed ACC services in the previous three months, general practitioners and case managers were recruited from a database provided by ACC. The sample is therefore not representative of the whole Asian population.

Data collection

Demographic data collected included ethnicity and gender. Data were collected from 22 in-depth individual interviews and 14 focus group discussions. These included *individual interviews* with Chinese, Indian and Korean general practitioners (GPs); Chinese and Indian traditional practitioners (TPs); Chinese, Indian and Korean community leaders (CLs); Indian and European ACC case managers (CMs) and claimants of services from Chinese, Indian, Korean and South East Asian groups. *Focus group discussions* were held with claimants from Chinese, Indian, Korean

and South East Asian communities, and non-claimants from all these groups as well as South Asians. South Asians were not included in the claimant focus group discussions as ACC had no records of claimants from this group.

Interview guidelines were developed by the researchers and confirmed by the Funder and in-house experts. They were tested in mock sessions with the interviewers. The guidelines covered personal/cultural, logistical and environmental, and institutional factors that may contribute to decisions of Asians about accessing injury-related services.

Vignettes describing events resulting in injuries of differing severity were used during focus groups and in-depth interviews to gauge differences in response to barriers when injury is less or more severe.

Documents were drafted in English and provisions for translation into the first language of each ethnic group were in place and offered on the request of participants. This service was utilised by all Chinese, Korean and South East Asian participants and a few Indians in focus group discussions and individual interviews. South Asian interviews and focus group discussions were conducted in English.

Focus group discussions and individual interviews were conducted by ethnically-matched researchers who could speak the language of the participants which included Mandarin, Cantonese, Hindi, Punjabi, Korean and Burmese. These researchers transcribed their interviews and translated these and other documents into English.

Data analysis

The qualitative data generated through the focus group discussions and individual interviews were analysed using a general inductive approach,⁵ that enables the identification of themes, clusters and categories relevant to the research objectives.

To lend rigour to the analysis and ensure robustness of the data, the analysis was undertaken in two stages. Stage one included transcribing recorded individual interviews and focus group

discussions, summarising this data for each ethnic-specific group, and recording important quotations to substantiate statements made. Stage two (conducted collectively by researchers) included collating and categorising data summarised in stage one into tables for each ethnic-specific and service provider group; undertaking a composite analysis of the groups for comparison; analysing data to identify key themes relevant to the research objectives; linking emerging concepts to themes and sub-themes, and synthesising findings to provide an account of barriers in accessing injury-related services.

Trustworthiness and credibility

To increase the trustworthiness and credibility of the findings, the researchers agreed on the analysis framework, and information was checked by the research team and by members of the Advisory Group. Draft chapters on results, discussions and recommendations were checked by all researchers for accuracy of findings or omission of information. Where necessary, participants were consulted after interviews to verify the closeness of fit between their information and our interpretation of it.

Ethics approval

This project was approved by the University of Auckland ethics committee on 26 March 2006 (Reference 2006/049). Ethics approval ensured participants' right of confidentiality, anonymity, and liberty to withdraw from the study after commencement.

Findings

Apart from two case managers who were of European ethnicity, all participants were from Chinese, Indian, Korean, South Asian and South East Asian ethnic communities which represent the largest Asian ethnic groups in NZ (see Table 1).

The results obtained from the analysis of the focus group discussions and individual interviews are presented together as the data from these are similar. This includes data from the five groups of respondents, viz. claimants, non-claimants,

general practitioners, traditional practitioners and community leaders from the five ethnic groups of Chinese, Indian, Korean, South Asian and South East Asian. These results are presented under the three main questions underpinning the study and are substantiated with a selection of quotations from respondents.

Significantly, the responses of both clients and service providers regarding access barriers of Asians are almost identical. The only significant difference in response related to Asian perceptions of discrimination against them by ACC service providers, where non-Asian service providers perceived this to be a workload issue rather than attitudinal.

Question 1: What personal characteristics of Asians contribute to the decision about whether to access ACC services when the need arises?

Personal characteristics included age and gender as well as cultural characteristics such as English and injury-related language competence, worldview and help-seeking behaviours. All five categories of respondents from all five ethnic groups considered these, especially cultural characteristics, to be barriers for Chinese, Indian, Korean, South East Asian and South Asian peoples in accessing ACC services.

Age

All participants were of the opinion that elderly Asians from all five ethnic groups experience access difficulties more, possibly due to cultural differences. This is often exacerbated by their fear of Western medicine as illustrated by the following quotation:

In my country, the older people are afraid of doctors, they're really afraid of needles... they will try to avoid doctor as much as possible. (Community leader)

Furthermore, Indian, South Asian and South East Asian participants reported that the elderly in their communities do not want to be seen as 'begging', so avoid making claims:

They don't want to feel like beggars, so they don't go to ACC. They feel they can pay for themselves. (Non-claimant)

Gender

Gender did not appear to be a barrier for Chinese, Korean, South East Asians and South Asians. However, Indian participants reported that many women from their communities are disadvantaged. Many cannot drive, often neglect themselves for their families, and will not seek treatment unescorted by male family members:

Table 1. Focus groups and individual interviews by ethnicity and gender

	Focus groups (N=14) (91 participants)							Individual interviews (N=22)															
	Claimants (4 groups)			Non-claimants (10 groups*)			Total (for each ethnic group)	Claimants			TPs			GPs			CLs			CMs			Total (for each ethnic group)
	N	F	M	N	F	M		N	F	M	N	F	M	N	F	M	N	F	M	N	F	M	
Chinese	6	2	4	16	11	5	22 (24%)	3	1	2	1		1	1	1	1	1	1					6 (27%)
Indian	7	4	3	13	4	9	20 (22%)	3	2	1	1	1		1	1		1	1		1	1		7 (32%)
Korean	5	3	2	13	9	4	18 (20%)	2	1	1				1		1	1	1					4 (18%)
SEA	5	1	4	16	7	9	21 (23%)	3	1	2													3 (14%)
S Asian				10	7	3	10 (11%)																
Euro																				2	1	1	2 (9%)
Totals	23	10	13	68	38	30	91	11	5	6	2	1	1	3	1	2	3	1	2	3	2	1	22

TP = Traditional practitioner, GP = General practitioner, CL = Community leader, CM = Case manager, N = Number, F = Female, M = Male

* Two non-claimant focus group discussions were conducted in each ethnic group.

Mostly, women cannot drive, and if they drive, they cannot read a map or are not confident to drive. If they are, they have never been out of South Auckland. If they have to go out, then they have to rely totally on their adult children and husband, but they work and come in the evening. If they are serious (their condition), their husband has to leave work, which the women don't want them to do. They try to sacrifice for their family—keep silent about their injuries and stay at home. (Community Leader)

English and injury-related language competence

Both service providers and ACC clients reported that limited English creates difficulty in communicating with health care personnel for the elderly from all ethnic groups and for the Chinese, Korean and some South East Asian communities. For this reason, Asian doctors are apparently reluctant to recommend services to Asians with limited English:

When it comes to explain extent of injury, whether it is private doctor or ACC doctor, it is a problem unless doctor can speak our language or understand what we are trying to explain. (Claimant)

Indian and South Asian claimants and non-claimants did not report difficulties with English language proficiency.

However, all ethnic groups reported lack of injury-related language competence. This apparently creates misunderstanding with NZ European GPs and other service providers, which sometimes leads to incorrect diagnoses and difficulties in accessing services:

Verbal communication is a huge barrier. Sometimes we don't know our body part in Kiwi language or in medical language. (Non-claimant)

Koreans are not competent with injury-related language; consequently, there are misunderstandings when Koreans go to other non-Korean GPs. This sometimes leads to incorrect diagnosis. (Korean GP)

Hence, according to claimants, non-claimants and Asian service providers, most Asians prefer doctors from their own community because it

makes it easier to communicate their injuries. However, they are still left with problems in communicating with ACC personnel and other service providers.

When it comes to explain extent of injury, whether it is private doctor or ACC doctor, it is a problem unless doctor can speak our language or understand what we are trying to explain. (Claimant)

Worldview

Responses from both clients and service providers suggest that Asian worldviews can be a barrier to accessing services amongst all Asian communities. Many participants from both these categories reported that seeking help when in pain is seen as a sign of weakness in their communities; hence, some try 'to bear pain'. Not working is also seen as a sign of weakness for a male:

For Indian male people, it will be a show of weakness by not working anymore and going to ACC for receiving benefits... the male should be working and supporting the family. (Case manager)

Help-seeking behaviours

All respondents from all five categories and ethnic groups suggested that most Asians would follow this help-seeking behaviour:

1. Self-diagnose and medicate;
2. Visit a traditional practitioner (except most Koreans and some younger people);
3. Visit a private general practitioner.

The preferred treatment for small injuries would be using home remedies and medication brought from home countries:

For little injuries we don't go anywhere and don't tell anybody because we think that for such injuries going to a doctor is a waste of time. Then we do home remedies. Little pain or injuries heal by themselves. (Claimant)

All ethnic groups reported that intermediate injuries may be treated by a traditional practitioner, but serious injuries such as broken bones, loss of blood and children's injuries are treated by professionals:

People who suspect broken bones will go to GP, head injuries too. (Traditional practitioner)

Where the course of action for treatment is concerned, all Asian respondents were of the view that most Asian families decide collectively on help-seeking behaviour. Usually, younger members make decisions for the elderly, and husbands for wives:

For women and very young children, their parents and their husband... take part in making decisions for them in seeking help. (Community leader)

Furthermore, economics and knowledge about systems reportedly also determine where Asians seek help for their injuries. International students with medical insurance and community card holders are reported to visit GPs more. All Asian groups have a clear preference for private doctors from their own ethnic groups, and preferably of the same gender:

...her GP has to be an Indian, and if possible, an Indian lady. She may not feel comfortable with someone from a different culture... (Case manager)

Question 2: What logistical and environmental factors are barriers to Asians' use of ACC services?

Logistical and environmental barriers for all five Asian groups, as reported by all five categories of respondents, include cost, transport, time, and interpretation and translation services.

Cost

All respondents reported cost to be a significant problem for most Asians. Some respondents, especially Koreans, reported that there was a misunderstanding by many that ACC services are entirely free, hence they did not expect to have to pay towards the cost of services. Many Asians, especially Indians, have financial responsibility in their home country and, consequently, cannot afford medical help:

If the GP asked them to [access] other extra services which will require them to pay for themselves, as they don't know about ACC, they will stop here...

If the injury is not so serious, they don't want to spend that money and time. (Claimant)

Moreover, when the financial compensation from ACC is potentially lower than their income, and cannot sustain the family living expenses, this will prevent some Asians from accessing ACC:

Something happened to my dad's shoulder once. He went to seek compensation, but he didn't get as much as when he was working, so he didn't claim ACC the next time he had an injury. (Non-claimant)

Most Asians apparently prefer to visit traditional practitioners; however, they are usually expensive and not subsidised, which prohibits access:

They want to come to us because they are confident with our treatment, but cost affects them. (Traditional practitioner)

Transport

According to all respondents, transport is a barrier for the Asian elderly and women who cannot drive. A doctor explained:

...they can't drive. ...a lot of them depend on their kids, and when their kids are at work, they will be stuck at home. (Doctor)

Time

All respondents reported that time is a major problem for all Asians who are in employment, many of whom work long hours and avoid taking time off work, as shown below. Furthermore, after-hours services cost more, so are less accessible.

We don't have time... We have to work hard to run a family because here we live in a single family and don't have extended family support... Visiting GPs means that they have to take time off work. (Claimant)

Interpretation and translation services

All participants, including rehabilitation case managers, considered interpretation and translation services to be a barrier because methods and quality of these services are apparently inadequate:

I can sit there for literally three to five minutes with dialogues happening between the translators and the claimants, and I will get a one sentence only reply... In some circumstance, the translator gave the answer to the claimants as she thought she knows enough about ACC to answer the question... (Case manager)

Question 3: What institutional factors contribute to decision about whether to access ACC services when the need arises?

Institutional barriers to accessing ACC services included lack of information and communication, culturally inappropriate services, perceived discrimination, and employment prospects/risks.

Lack of information and communication

The main institutional barrier experienced by all Asians is lack of information. Both clients and service providers reported that information about injury-related services and compensations in NZ is lacking; hence, most Asians have insufficient knowledge or misinformation about services which prevents them from accessing services:

The most they know is that ACC may cover your injury, but don't know how to make a claim, the process to have the claim approved and so on. (Traditional practitioner)

I think a lot of it has to be with knowledge. I travelled a bit through Asia; there is no system like ACC in most Asian countries, or probably all Asian countries. I can imagine something like ACC is foreign to most Westernised people, let alone Asian people. (Case manager)

This also impacts on doctor-patient relationships as reported by a practitioner:

ACC promotion is poor. Too much time is wasted explaining to patients rather than on communicating or on rapport formation. (Doctor)

Some ethnic minority service providers complained of a lack of appropriate communication from ACC which results in inadequate knowledge about their services:

They [ACC] do communicate with us, but only by a book full of regulation once in two years. This is

not helpful especially to the practitioners who can't speak good English. There should be some more Asian ACC employees to work there for better communication with us. They can contact us and visit our regular association meetings to keep both parties updated. (Traditional practitioner)

Culturally inappropriate services

All respondents stated that ACC services are culturally inappropriate for Asian clients and unanimously voiced the need for culturally appropriate services and ethnic minority service providers.

There should be multilingual staff to serve ethnic minority claimants. It is prerequisite. Even if someone can speak English well and has no problem in communicating with staff, he/she might feel daunted by a huge bureaucratic organisation. Asians show this tendency more clearly because they are accustomed to hierarchical order. (Doctor)

However, case managers appeared frustrated by the paradox inherent in the expectation to simultaneously provide *culturally appropriate* services to claimants and the *same* services for everyone. Nonetheless, they agreed there is a need to make the communication method more culturally appropriate:

On one hand, we were told to provide culturally suitable services; on the other hand, we were told that these are what the entitlements are, and they are the same for everyone. (Case manager)

The way you do things and how you interact with them, which you can adjust; for example, the way to communicate, face to face... etc. There is a line, we can try to adjust the way we communicate, but in terms of the services we provide, we got to follow the guidelines. (Case manager)

Discrimination

Asian claimants, as well as some non-claimants (who had received such reports from claimants), perceived themselves to be discriminated against by ACC service providers who apparently have negative attitudes towards them and do not provide them with equitable services. This, they reported, discourages them from using services:

If Pakeha (European New Zealander) got an injury, they may get full services. I haven't seen it happen to Asian people like that... (Non-claimant)

However, this was explained by a case manager of European ethnicity as being the result of a high volume of work:

The problem we have is the volume that comes through. When you have the high volume, you do as much as you can for everyone you can. If somebody is really difficult to do things with or they are just very quiet (passive seeker), they are forgotten very easily. I notice that Asians are the people that are being forgotten easily. (Case manager)

Employment prospects/risks

Non-claimants cited jeopardising employment prospects as the main reason for not seeking assistance from rehabilitation services:

People hear stories from others saying that you will earn less money if you claim from ACC. (Non-claimant)

Discussion

The data presented by Asian respondents illustrate that there are gaps in injury-related services and a mismatch between their needs and the services being provided. Furthermore, communication between service providers and the Asian community appears to be insufficient and/or ineffective. Such limitations apparently lead to lower levels of satisfaction, create significant barriers in accessing health services, and generate ambivalence and negative attitudes towards using them, resulting in low utilisation of ACC services amongst Asians in NZ.

Analysis of the data suggests that low rates of utilisation may be due, to a large extent, to cultural factors. For example, Asian responses show that they feel discriminated against by some service providers, which creates access barriers for them. Discrimination occurs as a result of a clash of cultures—cultural differences such as differing worldviews and natures of immigrant and local peoples, as well as language differences, can act as barriers to effective interpersonal com-

munication.⁶⁻⁹ For Asian claimants, this apparently leads to feelings of misunderstanding and perceptions of discrimination. This is exacerbated by the limited English language capability of many Asian clients which could contribute to their perceptions that some ACC personnel are impatient and unwilling to communicate with them because of their cultural insensitivity and negative attitudes towards them.

Whilst the culture and language of Asian clients may contribute to perceptions of discrimination, it is acknowledged that ideological barriers exist between groups—such as notions of the supposed superiority and inferiority of some groups—and the differential value placed on cultures has repercussions for interethnic interactions,^{10,11} including services provided. They generate institutional barriers such as inadequate promotion of services, insufficient Asian service providers, inadequate translation and interpretation services, lack of Asian-specific services, and systemic barriers. These create negative conditions which lead to perceptions of irrelevance and discrimination and lower levels of satisfaction with services, and act as barriers to accessing services. This points to a need for the re-orientation and education of personnel on Asian cultures and worldviews to facilitate positive attitudes and interactions and eliminate perceptions of discrimination.

Furthermore, Asian worldviews have an impact on their conception of health which in turn impacts their utilisation of injury-related services.⁵ In the present study, many Asian men avoid seeking help and endure pain. This is likely a consequence of their worldview which includes concepts and principles such as that of the concept of Karma which guides many Asian ethnic groups. This principle advocates the acceptance of negative phenomena such as injuries and illness as part of life, and encourages the endurance of pain. These perceptions serve as a barrier to accessing health care services and may need to be addressed appropriately.

The Asian culture is also typically collectivistic and family-oriented,^{28,29} which appears to act as a barrier to accessing services. This orientation encourages Asians to make personal sacrifices

to help family, which sometimes translates into individuals not seeking medical help—as in the case of Indian women in this study—and to support family rather than depend on external help.

Moreover, Asian peoples are generally traditional and, where treatment is concerned, most prefer to follow a culturally traditional health path which focuses on holistic care and treating the root of the problem rather than symptoms, as shown by this data and other studies.^{5,17} Consequently, many cannot relate to the Western system of health care and consider it to be irrelevant to their needs. This highlights the question of relevance and the issue of the traditional way versus the Western way.

Logistical and environmental barriers of cost, time, and transport, which are all interrelated, exacerbate the problem. Whilst most respondents of this study may not be categorised as poor as in overseas studies,^{12,13} many are struggling to make ends meet to settle into their new country and are experiencing similar hardships. Fear that injury-related claims may affect their employment prospects prevents many from seeking assistance. This may suggest that education in the employment sector may be required to eliminate this barrier.

The issue of time is a major problem for many Asians who work long hours to make ends meet. After-hours services usually cost more and will offset any subsidies. Long waiting times at hospitals and doctors' rooms are also an issue. It is suggested¹⁴ that the necessity of a 'patient-centred time' approach as opposed to a 'practice-centred time' approach needs consideration by professionals to eliminate these problems. Additional features in 'patient-centred time'—such as flexibility and responsiveness, global-view and values of individual clients, respecting their choice and level of acceptability—will also help to achieve good practice outcomes.

Strengths and limitations

The strengths of this study lie in its setting and design. It involved individuals from multiple ethnicities, and from various Asian countries. In addition, collecting data from a variety of people,

such as consumers, non-consumers and service providers, reduced the possible bias of people's experiences and views on the topic.

Like most research, this project is subject to limitations:

- Specific demographic data of participants was not sought in the study which limited the ability to draw some conclusions; for example, what impact did the age, type of employment or length of stay in New Zealand of the participant have on the significance they placed on ACC services?
- Non-claimants were not engaged in individual interviews, hence it was not possible to gather in-depth data on why they do not participate in the ACC programme.
- The data presented by participants are their perceptions or representations of phenomena and may or may not be causal explanations of the barriers they experience.
- The study did not have the opportunity to compare these findings with similar ethnic specific studies (e.g. Maori or Pacific) to identify in what way Asian peoples' access experiences differ.

Policy and practice implications

The results of this study have the following implications for policy and practice in relation to improving access to health services for the Asian community:

1. Wider access to funding is needed to improve access to culturally appropriate health services, such as ethnic minority case workers who understand different worldviews, Asian health providers and traditional practitioners.
2. More funding is needed to increase the output of information about services and entitlements in Asian languages. This has improved significantly since this study was undertaken, with major Asian languages now being catered for; however, languages of smaller groups need to be included.
3. The quality of existing translation and interpretation services needs to be monitored and controlled. Some work is now being done in this area (e.g. the Waitemata District Health

Board), but further development and extension to other areas is needed.

4. Cross-cultural competence training is required for service providers. While this is now being undertaken to some extent, gaps still exist in appropriate curricula and personnel for training.
5. A targeted service for vulnerable groups such as women and the ageing Asian population is needed. This has now been initiated in some Asian communities, but requires further development and extension to other communities.

Future research may:

1. investigate whether the Asian-preferred course of action—for example, self-diagnosis and medication with home remedies or medication from their home country, and visiting a traditional practitioner—could be harmful, in that delayed presentation to primary health services may lead to a more serious problem and become more costly;
2. examine the relevance and utilisation of traditional practitioner services amongst Asians and how traditional practitioners can help raise awareness, improve outcomes and promote injury prevention, given its significance for Asian communities.

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ACKNOWLEDGEMENTS

The authors would like to thank the following people for their contribution: The participants of the study; the Asian researchers, Dennis Hsu, Bon-Giu Koo, Yanbing Li, Neerja Rana, and Dr Htut Myint; our advisors and colleagues, Associate Professor Toni Ashton and Associate Professor Shanti Ameratunga for their expert advice and support; Vishal Rishi for administrative assistance, and Ms Vivian Cheung and Mr Justin Ward of ACC for their input and feedback.

FUNDING

We thank the Accident Compensation Corporation for their funding of this project.

COMPETING INTERESTS

None declared.