RESEARCH AND EVALUATION OF BARRIERS TO ASIAN PEOPLE ACCESSING INJURY RELATED SERVICES AND ENTITELMENTS

FINAL REPORT
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Accident Compensation Corporation
(ACC)

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Conflict of interest statement
All members of the research team involved in the present project and production of the Report are employed by The University of Auckland.

The project team declares no conflict of interests to this research project.

Disclaimer
This Report summarises key findings on the topic of barriers to Asian people accessing injury related services and entitlements. Members of the research team have taken all care to accurately capture and interpret the perspectives of research participants while maintaining their privacy and confidentiality. Any view or opinions expressed in this Report are those of the authors and do not necessarily represent the views of ACC.

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EXECUTIVE SUMMARY

BACKGROUND

Accident Compensation Corporation (ACC) data show that Asian peoples[1] under-use their services. The reasons for this are not known but international research shows that people may experience personal, cultural, financial and other barriers to accessing health services. Some are also dissuaded from using injury-related or health services in general because of characteristics of the service itself. For Asian immigrants other reasons such as a lack of familiarity with services and limited additional language skills can also act as barriers to services.

METHODS

The present research assessed reasons why Asian peoples in New Zealand under-use ACC services.

Sample:
By using qualitative research methodology, this project engaged 113 participants in in-depth interviews and focus groups.

14 focus groups consisting of 91 participants (23 claimants and 68 non-claimants), comprising 22 Chinese [3 groups]; 20 Indian [3]; 18 Korean [3]; 10 South Asians [2] e.g. Sri Lankan, Pakistani, Bangladeshi, Nepalese; and 21 South East Asians [3] e.g., Cambodians, Vietnamese, Filippinos.

Individual interviews with 22 individuals comprising 11 claimants, 3 Asian general practitioners, 2 traditional health providers, 3 Asian community leaders and 3 ACC case managers.

Data Analysis:
Data was analysed using a general inductive approach.
The following barriers to accessing ACC services were analysed:

1. Personal characteristics of Asians that contribute to the decision about whether to access ACC services when the need arises:

- Demographic data re: age, gender, general English language competence, specific injury-related language competence
- Information concerning beliefs – worldview - about the nature of injury
- Help-seeking behaviours

2. Logistical and environmental factors:

- Cost of services (e.g. visiting GPs)
- Transport to services

[1] For the purpose of this study, the term "Asian Peoples" is used to denote diversity of people's culture and linguistic origins under the term of "Asian". For details please see, Workshop Organising Team. (2005). *Issues and options paper: The use of the term 'Asian' in New Zealand and implications for research, policy development and community engagement.* Auckland: University of Auckland.

- Availability of services at different times of the day/week
- Child care during treatment and injury prevention programmes
- Availability and promotion of ACC services
- Other matters raised by participants.

3. Institutional factors:

- Knowledge about ACC and entitlements to services
- Sources of information used to learn about ACC
- For participants *who have accessed ACC services*: feelings about contacts with ACC, and aspects of the service provision that made the experience a positive or negative one
- For participants *who have not accessed ACC services* in spite of injury: features of ACC services that contributed to their decision to not seek assistance from the agency

4. Challenges to ACC to help Asians overcome the difficulties and the barriers they perceive:

- Institutional barriers to knowledge about the service
- Cultural barriers caused by differences in beliefs about injury, its meaning and treatment.

RESULTS

Personal Barriers

Demographic data

Age:

- Age is a barrier for old Asian folk who experience difficulties with language and transport and are usually unaware of services available to them.
- Older Indian, South Asian and South East Asian folk do not want to be seen as 'begging', so avoid making claims.
- Some older people may be afraid of western medicine (doctors and needles).

Gender:

- Indian women may sometimes be neglected because they give priority to their families.
- Some women have transport difficulties as many do not drive.

English language competence:

- Indians and South Asians have no problem with general English language competence, except some older folk.
- English incompetence has a huge impact on Chinese, Koreans and some South East Asians

Injury-related language competence:

- None of the groups is competent in injury-related language, despite the general English language competence of the Indian and South Asian groups.
- There are misunderstandings with local European GPs which lead to incorrect diagnoses and difficulties in accessing the full scale of services provided by ACC.
- Ethnic doctors are reluctant to recommend services which can be accessed by the public as they would not be able to speak English.

Information concerning beliefs about the nature of injury:

- Some Asians try to cope with pain as going to the doctor may be seen as a sign of weakness.

- Broken bones and loss of blood and children's injuries constitute serious injuries and need professional help.

Help-seeking behaviours:

- The usual course of action for most Asians for the treatment of injuries and pain appears to be:
  1. self-diagnose and medicate
  2. visit a traditional practitioner (except Koreans and some younger people)
  3. visit a private general practitioner
- The preferred treatment for small injuries sustained in the home is self-diagnosis and medication - treatment with home remedies and medication brought from their home countries.
- Intermediate injuries may be treated by a traditional practitioner such as an acupuncturist, masseur or an ayurvedic doctor.
- For more serious injuries, professional help is sought by all Asians.
- Families support each other in making decisions on the course of action to be taken. Younger family members may make decisions for older members, and husbands for wives.
- Economics and knowledge (i.e. information about New Zealand systems), rather than people, appear to be the main determinants of where help for injuries and pain will be sought.
- All groups prefer private doctors to the public health system
- Majority of Asians prefer to visit doctors from their own ethnic groups
- International students have medical insurance and visit a GP more often.
- Community card holders use services more than others.
- Asians do not always have a permanent family doctor, but if they do, s/he is the gatekeeper and makes decisions about the course of action to follow.

Logistical and Environmental Barriers

Costs of services:

- Cost is a significant problem for all, unless they have a Community Card.
- Asians lack knowledge about ACC subsidised services which would help with costs.
- Most elderly Asians prefer the services of traditional practitioners, but these are more expensive than general medicine, so cannot be accessed.
- Many Indians have a financial responsibility for family in their home country; consequently, cannot afford to visit the doctor unnecessarily.

Transport to services:

- Transport is a problem for some, mainly women and older folk.

Time:

- Time in general is a major problem for all working Asians who work long hours and have no time to go to the doctor or the hospital.
- Asians have a positive work ethic so avoid taking time off work to go to the doctor.
- After hours services usually cost more, which serves as an additional barrier.

Availability and promotion of ACC services:

- This is a significant problem. Promotion is inadequate

Other matters raised by participants:

Discrimination:

- All groups complained about perceived discrimination from ACC service providers, which discourages them from participating in the ACC programme.

Telephone-prompt system:

- Most respondents experienced difficulty with using the telephone-prompts when communicating with the hospital and ACC

Institutional Barriers

Knowledge about ACC and sources of information:

- Most participants have insufficient knowledge about ACC and entitlements to services
- Family and friends who have participated in the ACC programme provide information to community
- Claimants have been informed by their doctors
- Some TPs, such as acupuncturists who are affiliated to ACC, have limited knowledge, while others have no idea about ACC
- All respondents consider sources of information to be inadequate

Perceptions of claimants on their experience with ACC:

Chinese:

- Mixed feelings about ACC ranging from negative to positive
- Feelings determined by level of knowledge of ACC and its services, benefit received, bureaucracy and attitudes of staff

Indians:

- Scored 1-5/10 - not a positive rating
- Feelings determined by level of knowledge of ACC and its services, benefit received, bureaucracy and attitudes of staff

Koreans:

- 7-8/10 - a positive rating
- Most Koreans appear to be unaware of ACC and its services; consequently, are pleasantly surprised to receive any benefit at all

South East Asians:

- Positive ratings
- Like the Koreans, they do not have any expectations in terms of compensation for injuries, hence are pleased at receiving any compensation

Perceptions of non-claimants who have had injuries, and determinants of decision to not seek assistance from ACC:

- Main reason cited by all non-claimants for not seeking assistance, was that ACC claims may affect their employment prospects.

Challenges to ACC

Cultural barriers:

- Asians are experiencing several cultural barriers which include ideological barriers such as differing Asian worldviews, lack of understanding of Asian worldviews and their implications for health-seeking behaviours, and negative attitudes toward Asian claimants. These need to be eliminated.

Institutional barriers:

- Asians are also experiencing institutional barriers such as inadequate promotion of ACC systems and services, poor communication, insufficient Asian service providers for Asians, inadequate translation and interpretation services, lack of Asian-specific services, and systemic barriers which need to be eliminated.

RECOMMENDATIONS

Of the several recommendations made, the most urgent for eliminating barriers to Asian access to ACC services are:

1. Communicating with the Asian community through the Asian media and cultural organisations
2. Training staff in cultural competence and valuing and respect of cultural diversity
3. Employing a client-centred time approach (i.e. people focussed which accommodates individual needs) as opposed to a practice-centred (or agency-centred) time approach to eliminate issues of time.
4. Establishing an ACC Asian language hotline that makes information easily accessible to Asians.
5. Providing information and forms in the major Asian languages
6. Providing the Asian community with wider access to funding to improve their access to culturally appropriate health services, such as those provided by TPs

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CODING and ABBREVIATIONS

Claimants and Non-claimants:
Chinese:
ccm = Chinese claimant, male
ccf = Chinese claimant, female

cnm = Chinese non-claimant, male
cnf = Chinese non-claimant, female

ctpm = Chinese traditional practitioner, male
ctpf = Chinese traditional practitioner, female

cgpm = Chinese general practitioner, male
cgpf = Chinese general practitioner, female

cclm = Chinese community leader, male
cclf = Chinese community leader, female

Indian:
icm = Indian claimant, male
icf = Indian claimant, female

inm = Indian non-claimant, male
inf = Indian non-claimant, female

itpm = Indian traditional practitioner, male
itpf = Indian traditional practioner, female

igpm = Indian general practitioner, male
igpf = Indian general practitioner, female

iclm = Indian community leader, male
iclf = Indian community leader, female

Korean
kcm = Korean claimant, male
kcf = Korean claimant, female

knm = Korean non-claimant, male
knf = Korean non-claimant, female

kgpm = Korean general practitioner, male
kgpf = Korean general practitioner, female

kclm = Korean community leader, male
kclf = Korean community leader, female

South Asian
scm = South Asian claimant, male

scf = South Asian claimant, female

snm = South Asian non-claimant, male
snf = South Asian non-claimant, female

South East Asian
secm = South East Asian claimant, male
secf = South East Asian claimant, female

senm = South East Asian non-claimant, male
senf = South East Asian non-claimant, female

Other:

GP = General Practitioner
TP = Traditional Practitioner
CL = Community Leader
CM = Case Manager
cl = Claimant
non-cl = non-claimant

CHAPTER ONE: OVERVIEW

INTRODUCTION

This study was commissioned by the Accident Compensation Corporation (ACC) to review the existing literature and conduct a survey on barriers that Asian ethnic groups in New Zealand may be encountering in accessing ACC services.

Several studies on barriers in accessing health care services have been conducted in the past in developed countries including New Zealand, and have identified barriers that are somewhat identical irrespective of the nature of health services provided. However, this is the first research to look at the barriers being faced specifically by the existing and potential ACC clients from the Asian community.

BACKGROUND

Injury is a leading cause of premature death and disability in New Zealand. Accident Compensation Corporation (ACC) offers and organises help to anyone in New Zealand in the event of injury which includes financial and other necessary services to support an early recovery of injured people.[1] ACC is mandated to cover injury related costs irrespective of the nature of the injuries and the place of occurrence.[1] ACC deals with 1.4 million injury claims each year and the annual economic cost of injury is estimated to be $6-7 billion.[2] Health services in New Zealand promotes equity in accessing and utilisation of health services among the people in New Zealand.[3] ACC is bound by a similar principle.[4]

Currently Asians are not categorised as a separate ethnic group in the publicly available statistical documents of ACC. However, the data presented by the ACC Research and Corporate Services Division at the request of this project suggests that despite Asians representing about 7% of the New Zealand population, they have had 2% of entitlement claims to ACC. This under-servicing of Asian clients suggests that they might experience more barriers in accessing injury prevention and rehabilitation services than the other ethnic groups in New Zealand.

The ethnic make-up of the New Zealand population has become more diverse in recent years.[5] In New Zealand, ethnicity is broadly divided into five main groups: European, Maori, Pacific Peoples, Asians and other. Generally, however, the term "Asian" covers a group of people who migrated from at least 28 different countries, representing a wide range of cultural, linguistic and social backgrounds.[6] There are differences between different groups of Asian people; therefore, they cannot be considered a homogeneous group. Asians are even regrouped by various authorities according to their own policies.[7] They are also different from the mainstream New Zealand society. Therefore, a clear definition of Asians is hard to find.

Asians are the fastest growing ethnic group in New Zealand. Between 1991 and 2001, the number of people who identified as Asian doubled. They will further double to make up 14.5% of the New Zealand population by 2021.[8] The Asian ethnic group is also the only ethnic group where net migration is projected to contribute more than the natural increase to population growth. Asian health is viewed as an emerging topic

in New Zealand. However, one commonality that has been revealed among the new migrant Asians in New Zealand is that they are highly educated and are relatively under-employed or unemployed.[9] Health needs and the barriers to accessing health services of this group of people have not been assessed systematically so far.

RESEARCH OBJECTIVES

The present study is aimed at discovering the barriers that Asian populations in New Zealand are facing in general in accessing ACC services. The outcome of the study will help in the development of culturally appropriate injury prevention and rehabilitation programmes for Asian people in New Zealand.

RESEARCH QUESTIONS

The following four questions were addressed in this study:

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

Exploration of matters relating to this question involved gathering data on three aspects namely: *demographic characteristics, health beliefs and determinants of help-seeking behaviours*.

- Demographic data re: age, gender, general English language competence, and specific injury-related language competence.
- Information concerning beliefs about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?
- Help-seeking behaviours: Topics including: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.

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

Exploration of matters relating to this question involved gathering data on costs of services (e.g. visiting GPs) as barriers, transport to services, availability of services at different times of the day/week, child care during treatment and injury prevention programmes, availability and promotion of ACC services in public places and other matters raised by participants.

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

Exploration of matters relating to this question involved gathering data on three aspects namely *acquisition of knowledge about ACC, those who use ACC and those who do not*:

- What do participants *know about ACC* and about entitlements to services? What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?

- For participants *who have accessed ACC services*: How they feel about their contacts with ACC, and aspects of the service provision that made the experience a positive or negative one?

- For participants *who have not accessed ACC services* in spite of injury: What features of ACC services contributed to their decision to not seek assistance from the agency?

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

Exploration of this question addressed institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.

Additionally, respondents were asked what they could do to improve their access to ACC services.

CHAPTER TWO: LITERATURE REVIEW

Literature search:

This literature review has looked at the available literature related to barriers in accessing health services in the global context with special reference to minority ethnic communities and Asians. It has followed a three step search of relevant literature on health care access barriers. Firstly, combinations of keywords were used to find related articles published in peer-reviewed journals. In the second step, abstracts of all identified articles were scanned to separate articles relevant to the study. In the next step full texts of a number of selected articles were collected to get further details of those studies. Besides that, a search for grey literature on health care access barriers was also carried out.

Initially a Medline search on peer reviewed medical literature was conducted using keywords 'health care' and 'accessing' and 'barriers' which yielded 173 articles. When this was narrowed down to articles published between year 2000 and 2006, the number of articles dropped down to 132. A further search was conducted with the same keywords plus 'Asians,' which yielded 9 articles, where 4 articles were found when the keyword 'Asian' was replaced by 'New Zealand'. It yielded no article when both 'New Zealand' and 'Asian' along with the other three initial keywords were used. No article was found on ACC's health care access barriers either. The articles were further reviewed on the nature of barriers and the study respondents. Out of 132 articles, 52 reported some kind of barriers faced by patients in accessing health care services in general.

Among the unpublished reports (grey literature), three local reports on Asians' health in New Zealand were accessed and a preliminary review conducted. These reports are: Asian Public Health Project Report, Mental Health Issues for Asians in New Zealand and Access Issues for Chinese People in New Zealand.

Full text reviews of articles:

Once viewed as homogenous, society in developed countries is recently experiencing ethnic and cultural diversity due to immigration from underdeveloped countries, linking them with absolute and relative poverty in a section of the population. Cultural diversity and social class are reported to be important determinants of health status which are associated with access to health services and are predisposed to lifestyles, health promoting and protecting recourses. Health promotion is viewed as an important dimension to preventive health.[10] However, the required resources to health promotion among multi-ethnic populations were reported to be insufficient to deliver an effective health service to these populations.[11] Such resource limitations to health-care settings targeting multi-ethnic populations might create significant barriers in accessing health services and generate ambivalence or negative attitudes towards using health services.

The success or failure of health promotion strategies in developed countries may depend directly on components of cultural factors and diversity among the immigrant populations. These components include variation in disease/injury

incidence/mortality, the risk exposures and the influence of culture on health knowledge, attitudes and behaviours. The behavioural factors may further be influenced by family, institutional and community informational and motivational forces.[12] Significant differences in exposure to risk behaviours among less acculturated ethnic groups have been reported in overseas literature. These risks may be influenced by factors like age, income, education, gender, marital status, place of residence, and region.[13]

Health advocates and health providers play vital roles in influencing policy makers, the media and community leaders promote health services by using professional expertise and institutional resources. The existence of multi-dimensional barriers in health promotional and preventive services is acknowledged by health advocates and providers. These barriers may be related to resource allocations, leadership quality, and the interaction between reluctance to make use of healthcare services until it is absolutely necessary and the variable quality of healthcare services for multi-ethnic populations. The lack of health insurance coverage or support services play a role in access barriers for many low-income and multi-ethnic communities in developed countries.[14] Such barriers negatively affect the health status of these people. The weaker and diverse ethnic communities bear a double edged sword from themselves as well from their service providers. Here beneficiaries receive care with a kind of denigrating self perception of "feel poor, made poor" which disengages them further from accessing health services. Consequently, service providers perceive such clients as less committed who miss appointments, care less about their health and do not appreciate work of health services.[15] Therefore, being a member of a minority group in and of itself constitutes a barrier to access. However, there are significant non-financial barriers, as mentioned above, which would not disappear with the adjustment of financial factors. The US experience suggests that certain sections of nonwhites are facing access difficulties in the healthcare system regardless of insurance and health status.[16] Inadequate supply of physicians of patients' choice has been blamed for such ethnic differences. Another UK survey suggests that Asians are twice as likely to prefer their own practice doctor even if a deputizing doctor is an Asian.[17] However, differences are also reported in egalitarian payment and delivery systems. A review of the access to healthcare system discovered that these patients choose to use emergency departments more frequently than GPs to overcome access barriers. In the UK, almost half of the Asian patients would have direct access to the hospital consultants and over 90% would prefer to be referred to specialists in the hospitals.[17]

It is important to understand the cultural sensitivity and community ownership concepts in health promotion programmes. Health promotion programmes in multi-ethnic groups face numerous barriers which include language problems and awareness of the available services. Involvement of community in health promotion programme development may overcome these potential barriers where health professionals and service providers should have important roles to play in determining health promotion priorities. Community participation is useful in identifying needs and developing health promotion interventions where health professionals would contribute methodical knowledge and expertise to enhance the programme development.

The managed practice which distinguishes frameworks of services between 'practice-centred time' and 'patient-centred time' are considering 'cultural understanding of

patients' by professionals and the necessity of 'patient-centred time' approach.[18] These frameworks highlighted a number of non-financial barriers to accessing GP care, ranging from limited hours of practice opening, traditional appointment systems, practice intolerance of missed appointments, long waiting times,[17] to the inadequate consultation times. It is further revealed that the long waiting time may be greater in those practices operating open access as opposed to appointment system. Wide range of features in 'patient-centred time' such as flexibility and responsiveness, global-view and values of individual clients respecting their choice and level of acceptability were discussed which need to be negotiated with the service providers or practice management to achieve good practise outcome. However, such settlements of changes are not without counter pressures on service providers or GPs to manage individual demands,[19] value of time for money, safeguarding professional power and preserving social control over patients. Therefore, the practicality to meet such demands of 'patient-centred time' would be challenging.

Migrants are reported to be under using the healthcare system. A dated study on Southeast Asian refugees in the US found an unprecedented low proportion (10%) of sick people sought Western medical care and of them a large proportion (73%) avoided follow-up visits.[20] This prompted a wide range of discussions and consultations to identify the cultural reasons behind such under utilisation of healthcare services. Interesting conceptions on health of these people were revealed which explained partly their poor health seeking attitudes. Southeast Asian people viewed suffering and illness as an unavoidable part of life,[21] which inhibited them from seeking medical help in physical pain. There were common beliefs among them that since the length of a person's life is pre-determined, life-saving health care is not going to change anything.[22] Such attitudes and cultural values among Asian people based on stoicism may be a barrier in seeking health care.[23] Spiritual beliefs also hinder Asian people from seeking health care. Some believed that illness is a way of punishment for offending nature, others explained mild illnesses are caused by organic problems and serious illnesses are caused by supernatural events.[24] Such beliefs drive them to traditional healers or often to religious healers as the first choice of treatment. It is, therefore, true that cultural sensitivity has helped them develop mistrust towards the Western healthcare system. Nevertheless, they seek help from Western medicine with high expectations once traditional medicine fails, and often at a late stage of illness. They expect Western medicine will identify and treat their problem with minimum effort and would treat malady instantly.[23] Such beliefs generate several misconceptions about the use and ability of modern medical instruments, which consequently leads to disappointments. These disappointments may exacerbate further with bad experience, neglect and/or adverse outcomes, which ultimately may turn them back to traditional ways of treatment.

Recently a number of common issues were discussed to determine the perceived barriers in accessing the healthcare system among disadvantaged urban populations in a developed country. Most frequently reported barriers were lack of information, cost, childcare facilities, transport, and adverse experiences.[25] Information about healthcare services, especially about free or discounted healthcare services, are important for prospective clients to access healthcare services. However, the survey suggests that an overwhelming majority do not have a clear idea about the different kinds of existing healthcare programmes.[25] This could be due to communication difficulties faced by certain sections of populations. For ethnic minorities in developed countries, language

is an important barrier to communicating properly with healthcare personnel. Lack of effective communications due to language differences may have an important impact on patients and providers as well. Although the extent to which language affects care is not known, it is suggested those who do not speak English are less likely to have a regular source of care,[26] receive fewer health check-ups[27] and their children have worst reported health status.[28] Besides the means of communication, language is also closely related to culture which denotes a functional membership in a particular ethnic group.[29,30] A Canadian study found that non-English speakers are less likely to receive preventive healthcare services. In the same study Asian women were identified as less likely to use screening services compared to Canadian-born women when adjusted for other confounders.[31] Use of language other than English is thought to be related to under utilisation of healthcare services in several ways. Language differences may reflect a proxy to the low socio-economic status, barrier to contact with the healthcare system, marker for cultural differences about the value or acceptance of western medicine and preventive services, and communication barrier. Language may influence the providers' communication with their clients as well.[32] Doctors are reported to be less enthusiastic to discuss preventive services or other service options with non-English speaking patients.[33] However, another study comparing access to services with acculturation as predictors for preventive services utilisation has viewed the influence of language on healthcare services access separately from that of culture.[27] The study argued that irrespective of one's level of acculturation on psycho-social dimensions, variations in language preference seem to be a critical determinant of utilisation of health services and act as an access factor. A large proportion among immigrant populations in developed countries speaks languages other than English. This hampers the distribution of health programmes to this population. Although the communication barriers are remediable[34] by using interpreter services, that could be costly and may not be readily available. Use of untrained interpreters or relatives of patients as interpreters could be an option. However, it is suggested that simply providing untrained interpreters may do little to improve communication.[35]

Demographic variables (e.g. lack of telephone connection) were significantly related to the barrier where knowledge about services is important for the people to access the services. Cost is also an issue in accessing healthcare facilities. A study found 44% avoided visit to a doctor in one year when care was needed which is supported by another study.[36] Most of the cases in this category had no health insurance. This burden was further compounded by low-level jobs which do not provide insurance benefits. Lack of knowledge about the existence of health insurance or other health supports may come from ignorance of ones health. Adults who have children in their care perceived difficulty in accessing childcare facilities at the time of medical care needs. Most young adults who lived in less poverty-dense neighbourhoods would report this as a significant barrier. Cultural orientation may discourage them from relying on baby-sitters. However, some Asian families have extended families and friends to take care of their children. But those who do not have any such alternative support tend to avoid visiting doctors. Most doctors' surgeries operate between official hours, and taking time off to visit a doctor during that period for working adults is also perceived as a barrier. People with more children would report more difficulty taking time off work for healthcare needs, reflecting the complexity of balancing work and family demands and still attending to one's personal healthcare needs. Transport is reported to be a barrier among one-third of people in recent surveys.[25,37] Transport tends to be a problem mostly for unemployed people,

especially in areas where public transport is not so easily available. Difficulties lie in taking time off work to attend healthcare centres. Furthermore, employees are reluctant to report injury and claim compensation for fear of affecting their job situation[38] or reducing future job prospects.

In summary, economically disadvantaged groups and medically underserved people usually perceive more barriers in accessing healthcare. An overwhelming majority of them face more than one barrier. Generally, all genders and ethnicities have equal chances of facing access barriers, but the influence of socio-economic status could transcend inequalities in access above that of ethnic communities and gender.[25] Cultural sensitivity and communication difficulties may in combination or separately act as access barriers. Institutional attitudes and infrastructural shortcomings affect health service utilisation immensely. Ineffective information dissemination and low awareness about the available options on health services are vital for people to access services. In case of injury and illness, relationship and understanding between employer and employee may influence compensation claims and help-seeking behaviour of the community.

CHAPTER THREE: METHODOLOGY AND DESIGN

This ACC commissioned study is designed to assess the reasons why Asian peoples in New Zealand under-use ACC services. In order to best achieve this, the study has followed a qualitative research approach which consists of both individual interviews and group discussions. The qualitative method, which is flexible and has a minimum of prestructuring, provides a narrative description and exploration of social meaning and cultural context of data through rich, detailed, meaning-centred accounts (Foster, 1996).

The individual interviews and group discussions used a set of open ended questions, which were developed through extensive consultation with experts, key stakeholders and the key researchers involved in the study.

ETHICS APPROVAL

This project was approved by the University of Auckland ethics committee prior to commencing any fieldwork (Reference 2006 / 049). Ethics approval has ensured the participants right of confidentiality, anonymity, and liberty to withdraw from the study after commencement. The recruitment methods and data collection procedures outlined in the ethics application were adhered to in this study. .

COMMUNITY SENSITISATION

A number of approaches were undertaken to inform the Asian community about the project to ensure their participation. These were:

- **Press release:** The study team prepared a press release outlining the purpose of the study, recruiting procedure, possible outcomes and positive implications on ACC's services to Asians in the future. This press release was sent to most of the multi-media channels operated by the Asian community and also to community organisations. A number of community media which includes community newspapers, magazines, community radio, etc. gave coverage to the study.

- **Community forums:** The key researchers of the study introduced the study among potential participants in community forums. This facilitated networking with other communities to increase participation.

- **Personal contacts:** A number of community leaders and significant others in the community were contacted to create awareness of the project and to facilitate community participation. Advice was sought from them as necessary.

STUDY MATERIALS AND DEVELOPMENT

The following study materials were developed to facilitate field data collection:

Information sheet:

Two sets of information sheets (see appendices 1 and 2) were developed separately, for:

- Participants of individual interviews
- Participants of group discussions.

Consent form:

Two sets of consent sheets (see appendices 3 and 4) were developed separately, for:

- Participants of individual interviews
- Participants of group discussions.

Guidelines for the study team:

The study team were given a number of general instructions tailored for separate groups of participants on procedures and approaches in conducting interviews and discussion sessions:

- Guidelines for interviewing the General Practitioners (GPs)
- Guidelines for interviewing the Traditional Practitioners (TPs)
- Guidelines for interviewing the Community Leaders (CLs)

DATA COLLECTION INSTRUMENTS

Questionnaire schedules:

Two sets of questionnaire schedules were developed in the broader sense (see appendices 5a-e and 6):

- Individual interview schedules for:
  - General Practitioners (TP)
  - Traditional Practitioners (GP)
  - Community Leaders (CL)
  - ACC Case Managers (CM)
  - ACC Claimants
- Focus Group discussion schedules for:
  - ACC Claimants
  - ACC non-Claimants

Questionnaire development:

The required sets of questionnaires were initially developed by the researchers in the study team. These questionnaires were sent to the nominated research contact person of the funding agency for their feedback. The questionnaires were then sent to the in-house experts for their comments. Finally, these comments were incorporated into the questionnaires by the research team. The questionnaires were also tested in mock sessions among the interviewers. Consultations involving members from the Advisory Group were always available to steer the planning and implementation of the project.

The questionnaires consisted of several sections addressing the objectives of the study:

- Personal characteristics of Asians that may contribute in the decision making about whether to access ACC services when the need arises.
    - Explored matters relating to demographic characteristics, health beliefs and determinants of help-seeking behaviours.
- Logistical and environmental factors acting as barriers to Asians in using ACC services.
- Institutional factors contributing to decision making about whether to access ACC services when the need arises
- Ways in which perceived barriers may be overcome so that better ACC services may be accessed.

Translation of documents:

The documents of the study were drafted in English. Provisions for translation of information about the project, consent documents and vignettes into the first language of each ethnic group were in place and were offered only on request of the participants.

ORIENTATION OF INTERVIEWERS

The interviewers attended orientation workshops on processes and procedures for conducting objective individual interviews and focus group discussions. This included how to approach participants for informed consents and the ethical boundaries and guidelines to abide by during interviews. A mock session of a group discussion was conducted by the interviewers under the supervision of named researchers and the study coordinator. This session helped in confidence building for the interviewers and gave the team an opportunity to review the effectiveness of the procedure.

PARTICIPANTS

Participant Sample:

It was attempted to include 8 – 10 people from different age groups and ethnicities representing both genders in each focus group; however this was not possible for the reasons listed above.

Participants for the study were recruited from the Chinese, Indian, Korean, South Asian and South East Asian communities. Participants were recruited for two groups of interactions: individual interviews and focus group discussions.

Individual Interviewees:

A total of 22 in-depth interviews were conducted. Table 1 below provides details of interviewees:

Table 1: Individual Interviews by Ethnicity

Ethnicity	Participants' Status	No. of persons interviewed
Chinese	Claimants	3
	Asian Traditional Practitioners	1
	Asian GP	1
	Community Leader	1
Indian	Claimants	3
	Asian Traditional Practitioners	1
	Asian GP	1
	Community Leader	1
Korean	Claimants	2
	Community Leader	1
	Asian GP	1
South East Asians	Claimants	3
	ACC Case Managers	3
	Total	**22**

Focus Groups:

A total of 14 focus group discussion sessions were conducted with respondents from the Chinese, Indian, Korean, South Asian (e.g. Sri Lankan, Pakistani, Bangladeshi, Nepalese) and South East Asian (e.g., Cambodian, Vietnamese, Filippino) ethnic communities. Table 2 below shows number of invitees approached and respondents by ethnicity and gender:

Table 2: Focus group sample by ethnicity and gender

Group	No. Invited	No. Attended	Female	Male
1. Chinese claimants	14	6	2	4
2. Chinese non-claimants	7	6	5	1
3. Chinese non-claimants	11	10	6	4
Total	**32**	**22**	**13**	**9**
4. Indian claimants	13	7	4	3
5. Indian non-claimants	9	8	2	6
6. Indian non-claimants	7	5	2	3
Total	**29**	**20**	**8**	**12**
7. Korean claimants	5	5	3	2
8. Korean non-claimants	9	8	6	2
9. Korean non-claimants	5	5	3	2
Total	**19**	**18**	**12**	**6**
10. South East Asian claimants	10	5	1	4
11. South East Asian non-claimants	12	9	4	5
12. South East Asian non-claimants	8	7	3	4
Total	**30**	**21**	**8**	**13**
13. South Asian non-claimants	5	5	5	0
14. South Asian non-claimants	5	5	2	3
Total	**10**	**10**	**7**	**3**
Grand Total	**120**	**91**	**48**	**43**

Recruitment of Participants:

Non-claimants, community leaders and traditional practitioners:

Procuring a sample for qualitative research, which requires a greater input from participants in time and effort than for quantitative research, is much more time-consuming and difficult. Consequently, purposive, snowball sampling was used for recruiting non-claimants, community leaders and traditional practitioners. This included the following two approaches:

- Discussion of the problem and promotion of the research in specific Asian languages on community radio and in community newspapers, and putting up notices at GPs clinics
- Using community networks among Asian researchers working on the project.

The first method was used as a means of promoting awareness of the issues in the community and avoids the so-called "over-research" phenomenon among certain community groups in the Asian communities. The second method helped to speed up the process given the six-month timeframe of the project. It is felt that both of these strategies were effective in reaching individuals who do not use ACC services.

Claimants, general practitioners and case managers:

Participants who had accessed ACC services in the last 3 months were recruited from a database of claimants provided by ACC. General practitioners and case managers were also recruited from ACC databases.

The ACC database proved useful in recruiting claimants for the study; however, the following problems were encountered:

- Apparently the database did not contain the detailed ethnic breakdowns required. It was also not possible to identify ethnicity through names as client names were not always ethnic specific. The coding on the list was not always decipherable e.g. the ethnicity column had code numbers such as 41, 42, 43, 44, which did not always correspond to one particular ethnicity. This made selection difficult and time-consuming.
- It was particularly difficult to identify South East Asian clients for the same reasons, e,g. of the 600 names provided in both lists, only 15 were recognisable as South East Asian. Consequently, claimants had to be telephoned to enquire about their ethnicity.
- Only 20 Korean claimants were identified on both lists of 600.
- Some names were repeated more than once on the list due to multiple claims. This reduced the actual number of eligible claimants.
- Many names had no contact numbers which eliminated these clients, further reducing the sample available to us, e.g. nearly 20% of Indian names on the first list had no phone numbers, so could not be contacted.
- Balancing the required participants by gender and age from the final list available after eliminating incomplete data was not easy.
- Furthermore, many clients, especially young people, appeared to be unwilling to participate in the study despite the offer of petrol vouchers to cover travel costs, and refreshments at the meeting.

Venue and time for interviews and discussions:

For the convenience of participants, focus group discussion sessions were held at the CAHRE, School of Population Health, during the weekend afternoons. This approach helped in overcoming the difficulties of recruiting people who were in the workforce, thereby widening the pool of potential participants.
Individual interviews were conducted at a venue chosen by the respondents, which was usually their home or workplace.

DATA COLLECTION PROCEDURE

The focus group discussion sessions were conducted by experienced facilitators in the first language of the respective ethnic communities participating in the sessions. Since English is widely spoken in the Indian subcontinent and most recent immigrants from that subcontinent typically speak English well, the South Asian and Indian focus groups were conducted both in English and in the language of choice of participants. The South East Asian groups were also conducted in English, except the part of the non-claimant group which was conducted in Burmese. In-depth (individual) interviews were conducted in the preferred language of the participant.

Vignettes describing events resulting in injuries of differing severity were used during focus groups and in-depth interviews, in order to gauge differences in response to barriers when injury is less or more severe. Pamphlets provided by ACC and forms that ACC clients fill in were available when participants discussed ways in which ACC could improve its services to Asian clients.

The individual interviews took between half an hour to one hour each, and group discussions lasted between one to two hours each. The individual interviews and the group discussion sessions were audio-taped with the consent of the participants for reliable transcriptions of data at a later period. Important points discussed at the sessions were immediately noted on flip charts which helped participants to follow the progress of the sessions and avoid any duplication during the course of those sessions. The transcriptions of the data were matched with notes taken during the sessions on flip charts as a proxy for controlling the quality of transcriptions.

DATA ANALYSIS

Data collection and analysis were concurrent and reflexive. Analysis was begun following the first interview and focus group discussion. These early data were analysed as a case analysis and served as an emerging basic framework to identify topics to be covered in more depth in subsequent interviews and focus groups. To lend rigour to the analysis and ensure robustness of the data, the analysis was undertaken in two stages:

First stage of data analysis:

The first stage of analysis included transcribing the recorded individual interviews and focus groups and summarising the transcribed data by questionnaire schedules for each ethnic specific research group. Important quotations made by the respondents

were recorded for use in substantiation of statements made in the results section. This stage was conducted individually by each researcher.

Second stage of data analysis:

The second stage was conducted collectively by the team of researchers during analysis workshops. This involved collation and categorisation of the data summarised in stage one into tables for each ethnic specific research group. A composite analysis of all the ethnic groups was also undertaken to enable a comparison of the ethnic groups. Data were analysed using a general inductive approach to identify key themes relevant to the research objectives. Emerging concepts were linked to themes and sub-themes which were developed from study of the written (transcribed) data. Special attention was given to possible meanings of each emerging theme and sub-theme. Some of the areas of focus for the data analyses included: what personal, logistic and environmental, and institutional factors contribute to decisions about whether to access ACC services when the need arises, and what the challenges and recommendations are in improving Asian people's access in using injury-related services. All these findings were synthesised into a framework to provide an account of barriers to Asian peoples accessing injury related services and entitlements.

Credibility:

To increase trustworthiness and credibility of obtained findings, information was constantly checked by the research team members and also by members of the Advisory Group as an expert check. The details are as follows:

- Weekly or biweekly team meetings were held involving all the researchers to update progress and go through the analysis and interpretation of their own dataset - individual interviews and focus group findings
- The project team discussed and agreed on an analysis framework
- Both verbal and written commentaries were provided to the named investigators of this project
- Draft chapters on results, discussions and recommendations were circulated among all team members for checking the accuracy of findings, or any omission of information or details
- A meeting with members of the Expert Advisory Group was held to discuss the draft findings and any relevant issues related to this project on 4th October.

Where necessary, some participants were consulted after interviews or focus groups to verify the closeness of fit between the information provided by them and our interpretation of that data. This involved taking data and interpretations back to the participants so they could judge the accuracy of the account. This process is usually considered the most critical technique for establishing the credibility of qualitative data (Creswell, 1998).

Recommendations were made for approaches that may lead to the provision of more culturally relevant information and services by ACC, with a view to increasing Asian immigrants' use of ACC services and of the entitlements due to them.

CHAPTER FOUR: ANALYSIS OF RESULTS

This section analyses and summarises the results obtained from the focus group discussions and individual interviews with the five groups of respondents, viz. claimants, non-claimants, general practitioners, traditional practitioners and community leaders. The views of the five ethnic groups, viz. Chinese, Indian, Korean, South Asian and South East Asian, are presented within these analyses and summaries of the respondent groups. A composite analysis of results by ethnic group is also presented.

The chapter is divided into six parts:
Part one presents the results of the discussions with the four claimant focus groups, and the 11 individual claimant interviews i.e. people who had accessed injury related services. These four groups comprised of one Chinese group, one Indian group, one Korean group and one South East Asian group.

Part two presents the results of the discussions with 10 non-claimant groups, i.e. those who had not accessed these services. These groups comprised two Chinese groups, two Indian groups, two Korean groups, two South Asian groups and two South East Asian groups.

Part three presents the results of interviews with three general practitioners: one Chinese, one Indian and one Korean.

Part four presents the results of interviews with traditional practitioners: one Chinese and two Indian.

Part five presents the results of interviews with three community leaders: one Chinese, one Indian and one Korean.

Part six presents the results of interviews with three case managers.

Each part is discussed under the four main questions to which answers were sought in this study. These are:

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

This includes:

- Demographic data re: age, gender, general English language competence, specific injury-related language competence
- Information concerning beliefs – worldview - about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?
- Help-seeking behaviours: Topics including: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting

help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.

2. What logistical and environmental factors are barriers to Asians use of ACC services?

This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, availability of services at different times of the day/week, child care during treatment and injury prevention programmes, availability and promotion of ACC services in public places and other matters raised by participants.

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

This includes data on three aspects:

- What do participants *know about ACC* and about entitlements to services? What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?

- For participants *who have accessed ACC services*: How do they feel about their contacts with ACC, and aspects of the service provision that made the experience a positive or negative one?

- For participants *who have not accessed ACC services* in spite of injury: What features of ACC services contributed to their decision to not seek assistance from the agency?

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

This includes institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.

We added a fifth section which asked the following questions which could provide useful information: What can the community do to improve their access? Who would be the community representative or entry point? Did they have any other information that they wished to provide?

PART ONE: RESULTS OF DISCUSSIONS WITH CLAIMANTS (Focus Groups and Individual Interviews)

Part one presents the results of the discussions with the four claimant focus groups, and the 11 individual claimant interviews i.e. people who had accessed injury related services. The four focus groups comprised of one Chinese group, one Indian group, one Korean group and one South East Asian group. The individual interviews were done with three Chinese, three Indians, two Koreans and three South East Asians.

South Asians did not form part of the claimant group. The results of the focus groups and individual interviews of the claimants are presented together as the issues they represent are very similar and often identical. Presenting them separately would have resulted in unnecessary duplication, especially since all groups and individuals have been asked questions that ultimately answered the same four main questions of the study. The results are presented under the four main questions underpinning the study and are substantiated with significant quotations at relevant points:

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

- *Demographic data re: age, gender, general English language competence, specific injury-related language competence*

Age: All respondents (Chinese, Indian, Korean and S E Asian) perceive age to be a barrier for older people who cannot speak English and are less informed. Older Indian and SE Asian people do not appear to want to be seen as begging or receiving welfare, so this attitude becomes a barrier to accessing services. They also feel that older people, especially women, may be subject to transport problems.

Gender: Only Indians have a gender effect with older women, especially Punjabi women, experiencing language and transport difficulties. Others do not perceive gender as a problem.

English language competence: Lack of English language skills is perceived to be a huge barrier to accessing services by the Chinese, Koreans and South East Asians. It has a huge impact in that it acts as a barrier in several ways such as creating lack of communication, misunderstanding etc.:

> secm: I got no choice (choice of GP); my English is no good, so I have to see him (referring to his GP who can speak Thai).

It is only Indians who have no difficulty with general English language competence; however, they do have problems over accent.

Injury-related language competence: As there are no synonyms and direct translations into Asian languages, all four groups perceive this as a barrier to accessing services; consequently they need doctors who can speak their own languages:

> icf: 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.

- *Information concerning beliefs - worldview - about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?*

Worldviews-cultural beliefs re injuries, accidents and pain: All four groups consider smaller injuries as not serious and prefer self diagnosis and home remedies for this. Koreans prefer over the counter advice and medicines and consider traffic injuries as

serious. S E Asians consider going to the doctor as a sign of weakness and will do that only if they have lost blood, have a chronic illness or broken bones. In cases of smaller injuries, they may visit a TP:

> secm: If I consider this as a very big thing, I will not consider going to Traditional practitioner. If it is not serious, then I will go to traditional practitioner as they are quicker than conventional.

Generally, Asians try to bear pain and not make an issue of it:

> incm: We are more prone to bear pain. 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 at home. Little pain or injuries heal by themselves.
>
> secm: If I can sort it out by myself, I think it is not serious, and vice versa.

- *Help-seeking behaviours: Topics including: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.*

Determinants of help-seeking behaviours: All four groups will self-diagnose and treat first before seeking professional help. Chinese and Indians then prefer to go to their traditional practitioners before accessing general practitioners because they prefer traditional remedies and these practitioners also speak their own languages. If they go to a general practitioner, they prefer one from their own community for language reasons. Although Indians prefer to visit the TP, they often go to the GP first, because the GP is covered by ACC and cheaper. GP's clinics are also closer to the community and accessible. However, younger Chinese and Indians apparently prefer GPs to TPs.

Koreans and SE Asians will self-diagnose and treat first, then prefer to go to a general practitioner, again, from their own community. Few Koreans seek medical treatment unless the injury is serious or after pain gets worse:

> kcm: I haven't given importance to that pain for 2-3 months but it got worse and worse. It was 6 months after I got injured that I went to GP.

For Koreans a traditional practitioner appears to be the last resort, unless they have backache for which they will go to the TP first. SE Asians do not appear to have access to traditional practitioners from their own community which is still comparatively small; hence some may have mixed feelings towards TPs from other communities:

> secm: If I plan to go there, I will definitely ask advice from my GP first.

Moreover, there seems to be very few or no SE Asian GPs in Auckland; consequently, they have to turn to GPs from other ethnicities.

Younger Indians make decisions on where to go for older people. Indian and Korean husbands decide for their wives:

> icf: Some women to some extent are dependent upon their spouse and their children.

Family and friends' experiences may also affect how individuals utilise ACC services:

> secf: Because she (referring to her sister) had a good experience with ACC before me, so I am more willing to use it.

2. What logistical and environmental factors are barriers to Asians use of ACC services?

- *This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, availability of services at different times of the day/week, child care during treatment and injury prevention programmes, availability and promotion of ACC services in public places and other matters raised by participants.*

The cost of services: appears to be a problem for Chinese, Indians and S E Asians, but language, more than money, influences the decisions of the Korean community. Amongst Indians, Community Service Card (CSC) holders access services more, and language is a barrier to applying for a Community Service Card:

> secm: If the GP asked them to do other extra services which will require them to pay for themselves, as they don't know about ACC, they will stop here.

> secm: If the injury is not so serious, they don't want to spend that money and time.

Transport: could be a problem for some Chinese, depending on their circumstances (many do not fit the wealthy stereotype), and could be a problem for some Indian and S E Asian older folk and females, but family usually helps. It does not appear to be a problem for Koreans.

Availability of services at different times: Waiting times are a problem for all groups, especially those who are working. Many have two jobs and no time to waste. However, Indians suggest that time is not an issue if children need attention:

> icm: We came here to settle down. We don't have time.
> I have to work hard to survive. We have to work hard to run a family because here we live in a single family and don't have extended family support system.

> secf: Maybe they have to work, visiting GPs means that they have to take time off work.

> secm: If we have to pay, we will make the claim. If it is small amount, it is not worth going to ACC as it is wasting time.

Child care: this is not a problem for any of the groups as families help out when indisposed, or they take their children along with them to medical appointments if necessary.

Promotion of ACC services: all groups consider this to be a huge barrier to accessing services as they do not know much (sometimes nothing) about ACC. Moreover, they cannot understand that such an agency exists as they have not encountered it in their home countries:

> secf: due to the lack of knowledge of ACC benefit, people from Asian country will think that there is no way such benefits would be covered by the government.
>
> kcm: I thought it was nonsense to cover all injuries no matter who is right or wrong.

Other matters raised by participants: Chinese participants suggested that ACC should now be focussing more on their communities now that their numbers are increasing, and SE Asian participants suggested that ACC should pay equal attention to all ethnic groups (as opposed to European, Maori and Pacific Island). Some participants, especially Koreans, raised the issue of prejudice and discrimination against Asians:

> kcf: Some Kiwis seem to think that Asians overuse ACC service. … They think Asians are always looking for social benefits.

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

- *What do participants know about ACC and about entitlements to services? What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?*

All participants do not know enough about ACC and about entitlements to services. The little some may know, they have learnt from family and friends who may have had some dealings with ACC, from their doctor, and from their own experience after the fact. They have no access to other sources of information.

> secm: Due to the lack of knowledge of ACC benefit, people from Asian country will think that there is no way such benefits would be covered by the government.

- *For participants who have accessed ACC services: How do they feel about their contacts with ACC, and aspects of the service provision that made the experience a positive or negative one?*

Chinese have mixed feelings – depending on outcomes. Indians rated their feelings between 1-5 out of 10 depending on level of knowledge and benefit.
Reasons cited for negative ratings by Indians:

- staff is culturally insensitive
- the ACC system is too complicated
- the case manager is changed too often
- the telephone-prompt system is user-unfriendly
- impatient staff
- busy phones
- long waiting times

Koreans and S E Asians rated their feelings about ACC more positively with Koreans scoring 7-8 out of 10:

> kcm: I was quite satisfied with ACC in that no matter how much the medical cost is, ACC supports it so I could save my money.

However, Koreans pointed out that the lack of translation/interpretation services and complicated systems were negative aspects:

> kcf: I went to hospital to claim ACC but soon I regretted that I came because I found all the application form was in English and I didn't think I could fill it out. I thought I should have put up with such a minor injury.

S E Asians do not have many expectations as they did not have such services in their home countries. They were actually pleased with ACC's generosity and with whatever they got for "free". However they do not like the length of the time that is required for ACC to approve a claim.

> secm: I have no expectation, I just expect they will tell me what to do; this is because I don't know about ACC, and so I have no expectation.

> secm: I know this is sometime difficult in their eyes (ACC) as they need to protect their funds, but if the patients really need the services, there shouldn't be any delay.

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

- *This includes institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.*

All groups agree that ACC should provide more knowledge about their service, translation and interpretation services, information in Asian languages, and employ more ethnic minority case workers and other service providers who understand different worldviews. ACC should train both their staff and practitioners to be more culturally aware of the different needs in different ethnicities:

> secm: Let the GP be aware that they should be sensitive enough to meet the needs of non-kiwi patients, either through training or what's so ever.

Additional information:

What can the community do to improve their access?

All groups agree that there should be more communication from the community with ACC

Who should be the community representative – entry point for ACC?

All groups agree that the community can be reached through cultural organisations and events, the media, churches and temples. This group of Indian respondents are adamant that they do not want religious and community leaders involved individually

as they do not always truly represent the community. The community must be consulted as a whole.

See appendix 7 for table of perceptions for claimant group.

PART TWO: RESULTS OF DISCUSSIONS WITH NON-CLAIMANT GROUPS

The results of the discussions with the 10 non-claimant focus groups, i.e. those who had not accessed ACC services, are presented below. These groups comprised two Chinese groups, two Indian groups, two Korean groups, two South Asian groups and two South East Asian groups. Much of their responses are similar, if not identical, to those of the claimants presented above. These results are presented under the four main questions underpinning the study and are substantiated with significant quotations at relevant points:

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

- *Demographic data re: age, gender, general English language competence, specific injury-related language competence*

Age: Most old Asian folk have an English language problem which acts as a barrier. The Chinese and S E Asians suggest that age is a barrier because although older people are more vulnerable to injuries, they are afraid of needles so apparently avoid doctors. Chinese and South Asians appear to believe that young people are more aware and have Kiwi attitudes which may enable access. For Indians and South Asians age is perceived as a barrier because older folk do not wish to be seen as begging, so will not access ACC services. Consequently, older folk appear to have a negative attitude toward ACC:

> sencf: They don't want to feel like beggars, so they don't go to ACC. They feel they can pay for themselves.

> sencm: In my country, the older people are afraid of doctors, they really afraid of needle. If possible they will try to avoid doctor as much as possible.

Koreans do not appear to consider age as a barrier (apart from language).

Gender: Only for Indians did gender appear to be a barrier for older women who experienced language and transport difficulties as many do not drive.

English language competence: Generally, Indians and South Asians do not have an English language problem, except for some old folk (apparently, especially Punjabi women). Chinese, Koreans and S E Asians do experience language problems which act as a barrier to accessing and communicating with ACC. Many older family members have to depend on their children for interpreting services:

> kncf: My parents might have trouble communicating with doctors without my help.

Injury-related language competence: all groups encounter problems with injury-related language competence. This is solved by visiting doctors from their own community which makes it easy for them to communicate their medical problems. However, they apparently have problems in communicating with ACC. S E Asians have no doctors from their own community, so find it difficult to communicate with other doctors and ACC. Indians and South Asians speak general English fluently; however, they do have limited medical language, so also prefer doctors from their own community:

> sencm: Verbal communication is a huge barrier. Sometimes we don't know our body part in Kiwi language or in medical language. There is the accent difference as well.

> sencf: If the patient can't express himself, the doctor can't really give him the treatment. So it's not so much they are not friendly, it was just that he was a bit frustrated.

- *Information concerning beliefs - worldview - about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?*

Worldviews – cultural beliefs re: injuries, accidents and pain: for all groups health does not appear to be the first priority. Chinese prefer self-diagnosis and home remedies for smaller injuries; for Indians and Koreans health appears to be a 1st priority for children. Children's injuries are apparently considered serious because of possible after-effects. Koreans also consider bone-related injuries as serious. Indians and S E Asians try to cope with pain (see claimants for quotation), and the more educated South Asians are apparently more health conscious.

- *Help-seeking behaviours: Topics including: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.*

Determinants of help-seeking behaviour: all groups report preferring to self-diagnose first and preferring to use medicines that they have brought in from their home country. Apparently, they continue to bring in home medicines every time they visit their home countries. Older Asians follow a traditional health path and visit a traditional practitioner before visiting a GP, except Koreans who go straight to a GP. Younger Asians apparently prefer to see the GP rather than a TP.
Economics and level of education may play a role when deciding on where to seek help. With Indians and Koreans, family may assist with these decisions, especially husbands with wives. Koreans prefer the private system for faster service.

> sencf: When some of us gone back to Thailand, we would buy some traditional medicine and bring it back to NZ.

The environment and the national health system of where the participants came from also affect their help-seeking behaviour here in NZ. For example, many of the South

and South East Asian countries do not support such large scale social health insurance schemes, which may result in fewer South East Asians utilising ACC services as they are not accustomed to such a scheme and have very little or no expectation of it:

> sencf: There is no help back in Philippine. You pay for your own costs. Sometimes even if its just moderate pain, you wouldn't go to the doctor because of the expense. Sometime people carry this kind of behaviour over here to NZ with that high tolerance for pain.

2. What logistical and environmental factors are barriers to Asians use of ACC services?

- *This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, availability of services at different times of the day/week, child care during treatment and injury prevention programmes, availability and promotion of ACC services in public places and other matters raised by participants.*

Costs of services: Cost appears to be a problem for many Asians apart from international students who have medical insurance and are usually wealthy and are not concerned with ACC services. Money may influence the decision to access services unless they have a Community Services Card. Limited English may impede access to the card.

Compensation versus Income: This appears to be a problem amongst many non-claimants from all groups. When the financial compensation from ACC is potentially lower than their income, and cannot sustain the family living expenses, this will prevent South East Asians in particular from accessing ACC:

> sencf: Something happened to my dad's shoulder once, he went to seek compensation but he didn't get as much as what he was working, so he didn't claim ACC the next time he hand an injury.

> sencf: I think the other one is that people may hear stories from others saying that you will earn less money if you claim ACC.

Transport to services: For Chinese people, transport may be a problem for some people, depending on their financial circumstances. Women and older folk from Indian, S E Asian and South Asian communities may experience transport problems. However, Koreans apparently do not have transport problems, but feel bothered about driving to a doctor if injuries are minor, so do not go.

Availability of services at different times: Within all five groups, times at which public services are available is a problem, especially for working people, as many Asians have more than one job, hence work long hours.

Child care: This is not a problem for most people as most have family support.

Promotion of ACC services: Most perceive this to be inadequate; hence this is a big barrier because most Asians do not know much, if anything, about ACC and its services.

Other matters: Most Asians, including those who speak English, experience problems understanding and following tele-prompts at hospitals and other ACC services. They

would prefer an alterative system. Because of miscommunication, many appear to believe that ACC is a Pakeha oriented organisation and does not include them. Many also perceive its treatment of clients to be preferential (discrimination). In addition, they may have misperception about ACC due to misinformation:

> sencm: People heard of the name before, but what is ACC, how does it work? No body knows. What they know is that ACC is a big one (organisation) that can give you trouble if you do wrong. Such as IRD, if you do something wrong, they will give you trouble.

> sencm: If Pakeha got injury, they may get full services. I haven't seen it happen to the Asian people like that. There is a lack of focus on the Asian people. I never have seen that kind of services to Asian in the news.

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

- *What do participants know about ACC and about entitlements to services? What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?*

All participants do not know enough about ACC and about entitlements to services. Some knew nothing at the start of the process and learnt about it through the study. The little some may know, they have learnt from family and friends who may have had some dealings with ACC. They have no access to other sources of information.

> sencf: I have been here for 10 years, I still not quite sure what does ACC do and what you can claim.

- *For participants who have not accessed ACC services in spite of injury: What features of ACC services contributed to their decision to not seek assistance from the agency?*

Most working Asians may be concerned that if they had a record of ACC claims, it may affect their employment prospects as prospective employers ask about their ACC claim status. Those who are self-employed, as in the case of many Koreans, are reluctant to access ACC services in spite of injury because they have the misconception that the more they claim, the higher the ACC levy will be.

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

- *This includes institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.*

To overcome institutional barriers:
Promote ACC more vigorously in the Asian communities and provide more knowledge about ACC services through community media and websites:

> kncf: I have read articles about ACC system in Korean newspapers several times. As I read it, I knew that Koreans do not often use ACC services and thought for the first time I could claim ACC service for my injury.

Make the ACC application form simpler and translate it into each language:

> sencm: My daughter used ACC before. I was filling out the form for her at that time, which is quite hard to fill. It is a long form, and English is my second language. When you are injured you will be worrying about your injury and may not be thinking about filling out the form.

To overcome cultural barriers:
ACC should employ more Asian case workers who understand the worldviews of their clients.

ACC should also promote their services through schools as the English-competent young Asian may learn the information and pass it onto the less English-competent older Asian parents.

> sencf: I think if you are targeting high school and primary school, the kids can also tell their parents about it.

Promote a better patient and GP relationship by enhancing the GP's cultural sensitivity skills. Most of the Asians claim and contact ACC through their GP; by enhancing their relationship, more Asians may be more willing to access ACC.

> sencf: GP and primary health care provider should educate their patients. Tell them what ACC is; explain some of the general stuffs to their patients as they are most likely the first point of contact to the health system.

Additional information:

What can the community do to improve their access?
All groups agree that the community should attempt to communicate more with the ACC

Who should be the community representative – entry point for ACC?
All groups agree that the community can be reached through cultural organisations and events, the media, churches and temples. Indian respondents expressed a concern about being represented by some religious and community leaders who may have self-serving interests and/or insufficient knowledge about their community, hence may not be truly representative of the community.

See appendix 8 for table of perceptions for non-claimant group.

PART THREE: RESULTS OF INTERVIEWS WITH GENERAL PRACTITIONERS

Part three presents the results of interviews with the three general practitioners: one Chinese, one Indian and one Korean.
It was difficult to access these doctors, due to their time constraints. Consequently, interviews were rushed and not all aspects of the interview schedule were covered adequately. Researchers were guided by the time allocated to them and where time was an issue, focussed on the more important questions.

These results are presented under the four main questions underpinning the study and are substantiated with significant quotations at relevant points:

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

- *Demographic data re: age, gender, general English language competence, specific injury-related language competence*

Age: All three doctors agreed that older patients experience difficulties with language and transport.

English language competence: English language is a problem for many Chinese patients. The Chinese doctor suggested that even though doctors do not speak the same language (Mandarin, Cantonese) as some of the Chinese patients, patients come to them because of ethnicity. They feel comfortable with a doctor from the same ethnic group and would avoid going to a non-Chinese doctor, even if that Chinese doctor doesn't speak the same language.

> cgpm: Obviously the language is a huge thing, and I think probably just a familiar face really.

The Indian doctor reported that Indian doctors are available who speak the same language and are from the same ethnic groups as most Indians; consequently, English language is not an issue for Indians. Furthermore, most Indians (except some of the very old) speak English. However, although Indians speak English, they prefer to go to doctors from their own ethnic groups because they can adjust their English to their patients' level and make themselves understood:

> igpf: We come down to our patients' language level. We use their phrases and words to communicate with them, otherwise it is a problem.

The Korean doctor reported that Korean patients prefer doctors who speak their language. Doctors are reluctant to refer them to specialists as they would not be able to speak English with the specialists:

> kgpm: There are more support programs for those who are injured than you would know. For example, if you hurt your back, you can join 'back pain program' from which you can benefit. But the problem is that all of these programs are conducted in English. Most Koreans are not good at spoken English so they cannot even think of participating in those programs. We (Koreans GPs) do not refer our Korean patients to those programs as well.

Injury-related language competence: Injury-related language is problematic for all groups of Asians. This is particularly difficult for Chinese, Koreans and SE Asians.
The Chinese doctor suggested that having doctors from own community makes it easy for patients to communicate their injuries, but they have problems in communicating with ACC.
The Indian doctor suggested that, although Indians have no language problem (except some old patients), they prefer doctors from their own community as this makes communication concerning their injuries easier.

The Korean doctor reported that Koreans are not competent with injury-related language; consequently there are misunderstandings when Koreans go to other non-Korean GPs, which leads to incorrect diagnoses. They then go to Korean GPs for a second opinion to confirm medication and diagnosis.

- *Information concerning beliefs- worldview - about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?*

All three doctors agreed that health is not a priority for their patients as other issues are more important. Health of children does, however, take priority over health of adults. Generally, Asians appear to cope with pain and self-diagnose and treat, rather than go to a doctor. This is reflected in comments such as the following:

> igpm: Asians do not give much importance to their injuries and to their health. They are also afraid to lose their job because of their injuries.

> igpm: Asians are more prone to bear pain than Kiwis.

- *Help-seeking behaviours: Topics including: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.*

Chinese: First self-diagnose and medicate, then visit the GP because they want the GP to refer them to the TP. They shop around for the cheapest rates and could sometimes go to the TP first.

> cgpm: they tend to doctor shop a bit. By the time they come to see you, they have already tried their own medicine, seen other TCMP or GP. I think that in their culture; try everything before they come to you.

The Chinese people reportedly tend to see their doctors quite a bit, much like other people:

> cgpm: I think Chinese cultural tends to see their doctors quite a bit, from what I seen anyway. A lot of them do come to their doctors for multi-problems. In that way, I don't think they are any different from other groups. As long as they find a doctor that they are comfortable, they are quite happy to come along.

Indian: Self-diagnose and medicate first, then prefer to go to TP (especially older people). Older people go to GP later as TPs are not covered by ACC. Younger people prefer GP to TP. Cost is important. Doctors feel the claims process is time-consuming, complicated, and involves too much paper work. Furthermore, ACC pays too little for their effort. Doctors feel it is ACC's responsibility to explain about the service to clients, not theirs. Whether patients choose to use the public or private system is dependent on the patient - doctor relationship.

Korean: Koreans may first self-diagnose and medicate with home remedies, then see a GP, and lastly a TP. Koreans are passive in seeking medical help; they are reluctant to follow Korean GP's advice to get help from mainstream society. No GP system in Korea and people go directly to a specialist, therefore patients would prefer to go to specialist first (like in Korea); however, they are forced to go to GP for referral to specialists. Koreans have an individualist attitude on decision making and do not always depend on family to help them make decisions on what course of action to take, although family does help when necessary. Doctors feel it is ACC's responsibility to explain about the service to clients, and not theirs.

All groups apparently expect to get something substantial from a doctor including a prescription. If not, they have no confidence in the doctor. The medication given by local GPs is too mild – Asians give larger doses and more antibiotics. Some Kiwi doctors have apparently now adapted to their Asian patients' needs:

> kgpm: Kiwi doctors rarely prescribe antibiotics to their patients but some give antibiotics to Asian patients more often. They have learned that Asians are not satisfied if they do not get medication including antibiotics from doctors. They also experience difficulty in explaining to Asian patients. For them, giving medication is the easiest way to treat Asian patients.

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

- *This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, availability of services at different times of the day/week, availability and promotion of ACC services in public places and other matters raised by participants.*

Costs of services: Chinese: Cost is problem, but they are usually family oriented (not as strong as Indians), so help each other. Indians: Cost is also problem, but they are also very family-oriented so help family members with costs. Koreans: cost does not appear to be as big a problem for them. However, they do have a misunderstanding that ACC services are free, but still visit them after discovering that there is a cost and complain about the cost later.

Transport: the Chinese doctor feels that Chinese may have transport problems and that these are linked to age. The Indian and Korean doctors feel their communities do not have transport problems as families help out with this.

> cgpm: If they are older Chinese migrants, who can't speak English and can't travel; I don't think they have good access to any services anyway, because they can't drive. Some do take the bus, but a lot of them depend on their kids, and when their kids are at work, they will be stuck at home.

Promotion of ACC services: all three doctors felt strongly that it is ACC's responsibility to promote their services and that doctors should not have to do this. The media is the best place to do this. This should be done in the various ethnic languages:

> igpm: ACC promotion is poor. Too much time is wasted explaining to patients rather than on communicating or on rapport formation.

Other matters:
Chinese: Not all families are wealthy as stereotype suggests. Most do not know about ACC subsidised services, so do not visit the doctor in the first place. Older families help extended family. Many new/young immigrants are wealthy and may not be concerned with ACC services.

Indian: Health is not a priority for most Indians. Money earning and saving is the priority. Many have financial responsibility for family back in the home country, so money is a problem; consequently, they do not visit the doctor unnecessarily.

Korean: Koreans appear to be usually wealthier than other groups, so costs may not always be an issue for many. Many do not have PR, so believe they do not qualify for ACC assistance. There are a large number of international students here who have medical insurance and are not concerned with ACC services. Korean claimants experience language related difficulty when asked to prove that their injuries are clearly related to accidents. Some claims are rejected by ACC because they fail to prove it. The Korean GP suggests that this could partly explain why they may under use ACC services:

> kgpm: In borderline cases Kiwis write letters or talk to case managers to prove that their cases are closely related to accidents. But who can do it among Koreans? That's why Koreans cannot use ACC service as much as Kiwis.

More minority support is needed.

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

- *What do participants know about ACC and about entitlements to services?*

All three doctors believe that their patients know very little about ACC and its services.

> cgpm: I don't think most new immigrant have any idea what ACC does, and their main roles. I think they do understand they get cheaper treatment, but they don't know anything requires further services. New migrants they are not used to the system, so have no idea of how it works.

- *What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?*

The doctors have acquired their information on ACC and its services from ACC representatives.

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

- *This includes institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.*

Institutional barriers: All doctors agreed that ACC needs to actively promote itself and provide more information.

Cultural barriers: The need for ethnic minority service providers was unanimously voiced. The Chinese doctor felt that culture must not have any influence on services, and the Korean doctor suggested that doctors should give the same importance and cultural sensitivity to all ethnic groups:

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

Other:

What can the community do to improve their access?

All three doctors agreed that ACC information should by delivered to the community by the community.

Who should be the community representative – entry point?
Chinese: Community group/leader.
Indian: Cultural organisations and events, media. Some concern about not being fully represented by some religious and community leaders.
Korean: Ethnic media, Church, Korean Society.

See appendix 9 for table of perceptions for general practitioners.

PART FOUR: RESULTS OF INTERVIEWS WITH TRADITIONAL PRACTITIONERS

Part four presents the results of interviews with the traditional practitioners: one Chinese acupuncturist and two Indian ayurvedic practitioners. The sample required only one Indian practitioner; however, after having gone through a long process of imploring a few to give us an interview, finally two agreed simultaneously, and we felt obliged to conduct interviews with both rather than turn down one. This proved to be advantageous in that it reinforced and triangulated this data which turned out to be identical. Due to time constraints, limited data was provided by these practitioners; however, much of this data, including quotations, is similar to that provided by other respondents.
These results are presented under the four main questions underpinning the study and are substantiated with significant quotations at relevant points:

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

- *Demographic data re: age, general English language competence, specific injury-related language competence*

Age: Both the Chinese acupuncturist and the Indian ayurvedic practitioners agreed that age is a barrier as old people may have language and transport problems that may contribute negatively to their decision on whether to access services.

English language competence: The *Chinese* acupuncturist acknowledged that many Chinese patients have a language problem and suggested that having TPs from their own community helps. Chinese patients feel they will be understood by TPs:

> ctpm: normally they will come to the Chinese practitioners as language is a barrier; unless they have children who lived here for quite some time with good English, they would tell them to ring the GP.

The *Indian* ayurvedic practitioners acknowledged that Indians generally do not have a language problem. Furthermore, there are TPs available who speak the same language and from the same ethnic groups. Although Indians speak English, they prefer to go to own traditional doctors as they are comfprtable with them.

Injury-related language competence: Chinese and Indians have problems with injury related language, but having doctors from their own communities makes it easy to communicate. However, they have problems in communicating with ACC. Although Indians generally have no problems (except some older folk) with general English language, injury-related language is problematic.

- *Information concerning beliefs- worldview - about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?*

For both Chinese and Indians health is not a priority, except for children. They both prefer self-diagnosis and home remedies for smaller injuries, and Indians try to cope with pain.

- *Help-seeking behaviours: Topics including: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.*

Chinese: Self-diagnosis and medication first before going to GP for a referral to the TP as they know that they cannot go to the TP without this if they want to be covered by ACC. However, they do shop around and could sometimes go to TP first, depending on cost.

> ctpm: People who suspect broken bones will go to GP, head injuries too. Sometimes they come here first for advice, and then we will recommend them to go see GP for a CT scan.

> ctpm: For those non-urgent patients, often they just don't want to be troubled and can't be bothered with all the hassle so they don't claim ACC.

Indian: Self-diagnosis and medication first before going to GP. Older people prefer TPs as they are more confident with such treatment. However, they may go to a GP

later as TPs are not covered by ACC and cost becomes a problem. Younger people may go to GP first as many are not accustomed to TPs:

> itpf: They want to come to us because they are confident with our treatment, but cost affects them. If they are covered by ACC or other social system, definitely they will come to us, but less people are coming to us.

2. What logistical and environmental factors are barriers to Asians use of ACC services?

- *This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, promotion of ACC services in public places and other matters raised by participants.*

Costs of services: For many Chinese, cost is a problem. They do know about ACC subsidised services, but do not know that it is only acupuncture that is subsidised and that they need a referral from a GP to be able to make a claim. This creates an additional cost which they would rather avoid:

> ctpm: I do advise my patients to claim ACC; however if it normally only requires only 2-3 times of acupuncture, they wouldn't seek ACC. If it requires 20 or many, then they will go seek ACC as they will do the math and find out they can save $40 a session. So if they have to do 20 sessions, it would cost them $800 without ACC; then, they will go through the process of seeing GP for referral.

The Indian TPs say cost should not be a problem for their patients as the system covers that (although it does not cover ayurvedic medicine):

> itpm: For them cost should not be much of a problem. In NZ there is a very good social support system, but the thing is that people don't know how to get things or how to approach the system. These are the gaps to fill in.

Transport: Some older Chinese folk may have transport problems, but Indian people may not experience this as family help with this.

Time: Time is reported to be a major issue for both Chinese and Indians as most work long hours and cannot afford to waste time waiting for doctors and the application process for ACC services:

> ctpm: The patients may go back home and weigh out the time and cost of going to the GP (for a referral), so they will neglect going to GP after the injuries heal in 2-3 weeks.

> ctpm: they need to pre-book appointment with the GP. It is mostly likely a day later before they can see their GP. It is also going to take time to get ACC to approve the claim. So sometime it is not that the Chinese don't want to claim ACC; it's just that they don't want to wait for all this time.

Promotion of ACC services: all TPs felt that it is ACC's responsibility to promote their services and provide more information and services. The media is the best place to do this. This should be done in the various ethnic languages. However, the Chinese TP stated that he helps his clients with ACC information when he can:

> ctpm: Anyone that can claim ACC, we will provide our patients with the claim form. I also teach them some simple knowledge about ACC.

Other matters:
Chinese: Not all families are wealthy as stereotype suggests. Older families help extended family.
Indian: Health is not a priority for most Indians. Money earning and saving is the priority. Many have financial responsibility for family back in the home country, so money is a problem; consequently, they do not visit the doctor or TP unnecessarily.

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

- *What do participants know about ACC and about entitlements to services? What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?*

Whilst the Chinese acupuncturist has some knowledge about ACC and its regulations, he believes it is ACC's responsibility to explain about the service to clients.
The Indian ayurvedic practitioners do not know much about how ACC works as they are not involved. Both TPs realise that their clients know just as little, and while they may have some knowledge about ACC, they have very little or no knowledge about the application process:

> ctpm: 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.

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

- *This includes institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.*

Institutional barriers: The Indian traditional practitioners do not know the rules governing ACC services as they are not involved in the system. ACC needs to promote itself more. Chinese TPs are familiar with some of the regulations as they are involved in the system, but due to language difficulties, there is a lot some of them do not know. Chinese ACC personnel would help with this:

> ctpm: They 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.

Cultural barriers: Chinese and Indian practitioners agreed that more ethnic minority service providers will eliminate misunderstanding caused by cultural barriers when case workers from other ethnic groups work with Asian clients.

Other:

What can the community do to improve their access?

All TPs agreed that ACC information should by delivered to the community by the community.

Who should be the community representative – entry point?
Chinese: Community group/leader.
Indian: Cultural organisations and events, media. Some concern about not being fully represented by some religious and community leaders.

Additional Information provided by Acupuncturist and Ayurvedic Practitioners:

Acupuncturist:

Acupuncturists believe that they should have the same rights as GPs. They should not need a referral from a GP – they are under the impression that they need this.
ACC only allows them to treat one patient at a time – not a few simultaneously. This reduces the number of patients they can see, and their income.
GPs are also allowed to do acupuncture. This is a specialised field and GPs do not have sufficient knowledge – only superficial, so should not provide this service. Only TPs have specialised knowledge. GPs do not refer patients to them, but do it themselves, so their income is declining.
ACC only recognises acupuncturists registered to two associations. Both these are run by westerners and do not have non-Westerners on their boards, so they do not understand Asian requirements etc. The Asian association is not recognised and cannot claim from ACC.

Ayurvedic Practitioners:

Ayurvedic practitioners believe they do not do a quick fix job and treat just the symptoms as GPs do. They treat the root of the problem and provide an holistic service which even includes counselling, but they are not covered by ACC.
WINS advises their clients to visit them and covers their expenses, so why doesn't ACC?
90% of their clients are Pakeha, which demonstrates that their service is valued and is not just a cultural service for Indians. They need to be included in ACC.

See appendix 10 for table of perceptions for traditional practitioners.

PART FIVE: RESULTS OF INTERVIEWS WITH COMMUNITY LEADERS

Part five presents the results of interviews with the three community leaders: one Chinese, one Indian and one Korean. These results are presented under the four main questions underpinning the study and are substantiated with significant quotations at relevant points:

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

- *Demographic data re: age, gender, general English language competence, specific injury-related language competence*

Age: All three leaders suggested that the older people from their communities may experience difficulties with language and transport which may have a negative impact on their decision to access services. The Indian community leader suggested that the elderly and women in that community may sometimes be neglected, and that there is an inclination for Indian women to sacrifice themselves for their family, which may impact negatively on their decision to access services:

> iclf: Old-aged people or women are totally dependent on their children, and they are neglected. The situation is worse if they can't speak English.

Gender: The Indian Community Leader suggested that women may sometimes be neglected. This may be self-inflicted as they "sacrifice" themselves for their family. Some women (especially older Punjabi ladies) also have language & transport difficulties as many do not drive:

> iclf: 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.

The Chinese and Korean community leaders did not appear to recognise a gender effect in their communities.

English language competence: Generally, most Chinese and Koreans are reported to have problems with English language which impacts negatively on their decisions to access services that are run by doctors that are not from their own ethnic groups. Indians usually speak English well, so do not have this problem (except older folk), but they also prefer to access services run by their own doctors.

Injury-related language competence: Again, according to community leaders, this appears to be a problem for most Chinese and Koreans who work around it by going to doctors and traditional practitioners from their own communities who speak their own language. This may not be much of a problem for most Indians, who still choose to visit their own doctors and traditional practitioners.

- *Information concerning beliefs- worldview - about the nature of injury. What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?*

The Chinese and Indian leaders suggested that older people in particular prefer TPs as they believe they treat the root of the problem and not just symptoms like GPs. This

is inadequate. The Chinese, Indians and Koreans apparently expect to get something substantial from a doctor including a prescription. If not, they have no confidence in the doctor. The medication given by local GPs is too mild – Asians give larger doses and more antibiotics. Kiwi doctors do not do this.
The Indian leader suggested that Indian women's cultural inclination to remain silent and not talk too much can be a barrier to accessing correct services:

> iclf: In our culture women don't speak too much or don't open up easily. That cultural habit plays a roll here – if they can't speak, they can't access things.

- *Help-seeking behaviours: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.*

Chinese: Most may self-diagnose and medicate with home remedies first then visit GP, followed by TP. They go to the GP to refer them to the TP. Many may also shop around and could sometimes go to TP first because of cost. Most prefer TPs, but they do not have the right to refer to ACC and are not covered by them, except acupuncture. When they need a certificate, they go to the GP.

Indian: Most Indians may self-diagnose and medicate with home remedies, then may visit a traditional practitioner, especially the older people who feel more confident with TPs. Cost also influences this choice. These may go to a GP later as TPs are not covered by ACC. When they need a certificate, they go to the GP. Younger people prefer to see a GP as they are not always familiar with TPs here in NZ. Family helps make decision on who/what to access:

> iclf: For women and very young children, their parents and their husband, and if they live in an extended family, then the elderly also take part in making decisions for them in seeking help.

Korean: Koreans may first self-diagnose and medicate with home remedies, then see a GP, and lastly a TP. There is no GP system in Korea and people go directly to a specialist. They would prefer to do this here (like in Korea), but are forced to go to GP for referral to Specialists. Koreans do not have a permanent family doctor. If the patients are not satisfied with one doctor, they seek another doctor.

While the family doctor is important, most Asians do not have a permanent family doctor. If they do, s/he is gatekeeper and makes decisions for them.

2. What logistical and environmental factors are barriers to Asians use of ACC services?

- *This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, availability of services at different times of the day/week, child care during treatment and injury prevention programmes, availability and promotion of ACC services in public places and other matters raised by participants.*

Costs of services:

Chinese: The Chinese leader reported that cost may be a problem for many Chinese. If services are not covered by ACC, they may not access those services. Many do not know about ACC subsidised services, so do not access them.

Indian: The Indian leader reported that cost is likely to be a problem for many Indians who may not access services if they are not covered by ACC. However, because they are family-oriented, they usually help family members with costs. Many have financial responsibility for family back in their home country, so money is a problem; consequently, they do not visit the doctor unnecessarily.

Korean: Many Koreans may have a misunderstanding about ACC services being free. Many do not have permanent residence here, so think they cannot access ACC services. A large number of Koreans are international students who have medical insurance, so do not use ACC services.

Transport : This may be a problem for older Chinese, but they find a way around this. It is not a problem for Indians (although older women do not drive) as family support is available. Koreans do not generally have transport problems.

Promotion of ACC services: All three leaders felt that it is ACC's responsibility to promote their services and provide more information and services. The media is the best place to do this. This should be done in the various ethnic languages.

Other matters:
Chinese: Not all families are wealthy as stereotype suggests. Older families help extended family.
Indian: Health is not a priority for most Indians. Money earning and saving is the priority.
Korean: International students and their parents appear to be usually wealthier than other groups so have fewer cost related barriers.

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

- *What do participants know about ACC and about entitlements to services? What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?*

All participants do not know enough about ACC and entitlements to services. Sometimes some of them know nothing about it:

> kclm: Some Korean International students and visitors do not want to go to hospital even if they are seriously injured because they think hospital fee would be so expensive that they cannot afford to. They know nothing about ACC.

Some of them would return to Korea to seek treatment.
If they do know something at all, they usually get their information from family and friends. This is expressed in the following way by the Indian community leader:

> iclf: Because of ignorance and unawareness people don't know about the public sector and some of them don't have a community card, so they cannot access the doctor.

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

> *This includes institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.*

Institutional barriers: All leaders agreed that ACC needs to: actively promote itself and provide more information; improve translation services; have an Asian helpline; have a service especially for Asians – have the word Asian there - as they believe it is only for Kiwis. The Korean community leader implied that the ACC awareness program should be conducted in a more concrete way:

> kclm: We have had seminars to introduce ACC system but few are interested in them. Most people responded 'nothing's new'.

Cultural barriers: The need for ethnic minority service providers and to translate into Asian languages was unanimously voiced.

Other:

What can the community do to improve their access?

All three leaders agreed that ACC information should by delivered to the community by the community. Asians are not accustomed to telephone prompts, so they need to adapt to this system.

Who should be the community representative – entry point?
Chinese: Community group/leader.
Indian: Cultural organisations and events, media, religious and community leaders.
Korean: Ethnic media, Church, Korean Society.

See appendix 11 for table of perceptions for community leaders.

PART SIX: RESULTS OF INTERVIEWS WITH CASE MANAGERS

Part six presents the results of interviews with three case managers, one of which is of Asian ethnicity. Due to time constraints caused by heavy work loads, some questions have not been answered by some managers, and depth of data has sometimes been compromised. This has, nonetheless, not affected the quality of data provided.
These results are presented under the four main questions underpinning the study and are substantiated with significant quotations at relevant points:

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

- *Demographic data re: age, gender, general English language competence, specific injury-related language competence*

Age: The Asian case manager recognised age as a variable in terms of claimants' English competency and mobility:

> cm2: … they (referring to elderly) found it really hard to find out what is available to them when they had injury. It is because a) they don't speak English very well; b) they are older, for which mobility is a problem.

Gender: The Asian case manager stated that gender may be an issue for an Indian female client:

> cm2: …her GP has to be an Indian, and if possible, an Indian lady. She may not feel comfortable with someone from a different culture because she feels like she has to portray a different image to the person who is from a different culture.

English Language Competency: English competency is a barrier that has been identified by all three case managers that prevent claimants from accessing ACC services and case managers from assessing and helping Asian claimants. However, each of the case managers reported having different experiences and perceptions with regard to interpretation services.

The first European case manager uses language line when dealing with Limited English Proficiency (LEP) claimants on the phone. This manager feels interpretation complicates the consultation and finds the language line of low quality. Colleagues have suggested that the face to face interpretation service is better.

> cm1: It makes it more complicated obviously. On the phone we can access language line; it is very hard, the service is not very good.

> cm1: You ring the language line and say you want a Chinese interpreter, and they find somebody who is on their database to be a Chinese interpreter and she is at home washing her clothes with her two kids.

The Asian case manager thinks speaking to Asian claimants in their local language will help the case manager to relate to the claimants. This manager has not used the language line yet, but has found the face to face translation useful, albeit time-consuming. Normally claimants come with their friends or relatives who act as ad-hoc translators.

> cm2: They usually got a translator with them like a family member or friends. If I speak that language, I would speak to them in that language.

> cm2: I found the interpreter very helpful (referring to professional interpreter). However it does take a lot more time than normal. For example, if we planned for one hour for the visit originally, it might take three times as long.

The second European case manager uses both language line and cultural advisors as the translation aids. This manager considers the language line helpful but difficult to manage. The translator sometimes gives answers to claimants without consulting the case manager first. Having a cultural advisor to interpret produces better results.

Sometimes judgments need to be made on whether or not to provide translation services to providers who do not speak Asian languages. In addition, the lack of language skills hampers the relationship between case managers and their Asian claimants.

> cm3: I can sit there for literally 3-5 minutes with dialogues happening between the translators and the claimants, and I will get a one sentence only reply.
>
> cm3: In some circumstance, the translator gave the answer to the claimants as she thought she knows enough about ACC to answer the question. That is not very good, because she doesn't have the training that I have.
>
> cm3: If I am having a meeting, I will always organise the meeting so that our cultural advisor can comes along as well…I will give 10-15 minutes for the advisor to find out the background and discuss with the problems with the claimants. I will come back after 10-15 and ask the advisor to summarise it for me. I think it is a little bit easier and the cultural advisor agrees with me that this helps to get more information from the claimants.

Injury-related language competency: The Asian case manager is of the opinion that the forms may be difficult for claimants to fill out as they are in English, and there may be lack of direct translation for some injury-related words in some Asian languages. The second European case manager recommends that the forms be translated into Asian languages so Asian claimants can read them.

> cm2: It is difficult as the forms are all in English. Even if they got a translator it would be difficult to fill out the form without speaking the language really well.
>
> cm2: Perhaps there was no particular word for rehabilitation in Cantonese, so the translator tried to use a lot of example to explain the term to the claimant.
>
> cm3: …having all the forms in Asian languages so they can understand them.

- *Information concerning belief s- worldview - about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?*

The case managers recognise that different Asian worldviews about health and injury create barriers for Asians in accessing ACC services and for case managers as they do understand these worldviews; consequently, do not know how best to help their Asian clients:

> cm1: The Indian people are very different when compared to the Oriental people. They have real iconic immerse belief…It is like the world is going to an end.
>
> cm2: …If I do the same thing in the Chinese culture, maybe I would be overstepping on some boundaries. That is always the fear as you don't want to do something that may damage the relationship between the case manager and the claimant.

The first European case manager observed that Asians have the tendency of not wanting to talk to government organisations and do not want to cause any problems, and prefer to handle things themselves:

> cm1: The Asian people are like, I don't want to cause hassle, don't want to talk to the government; I would just work it out myself.

Both the European and the Asian case managers perceive Indians as passive in terms of help-seeking. They prefer to rest after injury rather than engaging in rehabilitation programmes. The case managers agree that Asians tend to think that their family will look after their wellbeing after their injury, which prevents them from accessing welfare benefits, such as ACC:

> cm2: In India, the whole concept of injury is that you have to rest it. The family has the main responsibility to look after the person as there is no such system as ACC in India.

In addition, being not at work and on benefits may be a sign of weakness for Indian males in the Indian culture:

> cm2: For Indian male people, it will be a show of weakness by not working anymore and going to ACC for receiving benefits. So it will be like a show of weakness as the male identity should be working and supplying needs to the family. If you are not able to do that, it would be a barrier.

- *Help-seeking behaviours: Topics including: Where Asian patients first seek help for differing severity of injury and pain? Reasons for getting help from this source. Who decides where to seek help and when other sources of help are accessed? Reasons for this sequencing of choices. Willingness to seek help from private and public health services.*

According to the first European case manager, Asian claimants prefer to handle things by themselves and have doubts about the quality of the health services provided in New Zealand; hence they prefer to go overseas to seek better treatment. Apart from the language issue, Asians prefer to go to Asian practices as they understand each others' perspectives and values better. Another factor that affects their decision to seek ACC services is whether or not they wish to seek help from the government in the first place:

> cm1: …it is not just language; it is about understanding their perspective.

> cm1: I had one Asian client, that they are not so sure the treatment in NZ is the best, and want to go to overseas to find the "best" treatment elsewhere.

The Asian case manager suggests Asians may seek ACC services if they know enough about it. They may prefer self-medication or to go to a TP instead of GP as they do not need a prescription for this. They will go to a doctor only when the injury becomes serious:

> cm2: I think people like to self administer with traditional medicine as you don't need prescription for that. You can get it from India. For Indian peoples its Ayurvedic medicine, which is different herbs.

> cm2: Only when it has been out of control, then they would go to a doctor or specialist. The problem may have become worse by that time.

The second European case manager stressed the point that Asians can relate and express themselves better with Asian practitioners and case managers which will ultimately affect their decision on whether to seek ACC services:

> cm3: You always feel that you have more rapport with someone that is culturally the same as you.

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

- *This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, and availability of services at different times of the day/week, availability and promotion of ACC services in public places and other matters raised by participants.*

Cost of services: This is reported as a problem across the broader population and of people in the lower socio-economic status (SES) group, not just an Asian problem. Managers suggest that the problem is caused by level of fees of individual GP practices:

> cm1: It is subsidised, but the problem is that the amount of the GP subsidisation is not enough to cover the full amount of GP consultation. They have a new scheme with physiotherapists with an agreeable pricing that ACC will fully fund it. If this works out with physiotherapists, I think they are going to try it with GPs as well.

Furthermore, lack of knowledge of subsidised ACC services prevents Asians from accessing GP services:

> cm2: …the awareness kicks in as they may not be aware of that the cost to visit GP is subsidised if it is accident related, even X-ray…etc are subsidised if you are an ACC claimant.

Those who would rather visit a TP perceive visiting a GP as an extra cost just for the purpose of getting a medical certificate, rather than a beneficial necessity:

> cm3: It may be seen as extra cost going to GP by Asians as they may perceive that they are only going there to get an ACC medical certificate, rather than going to GP to get some drugs and signing an ACC medical certificate as well.

Transportation: This does not seem to be an issue in Auckland:

> cm1: Transport is less of an issue in Auckland as there is public transport available… ACC will provide transportation services as well if they ring up ACC saying that they had a broken leg and can't drive to see their doctors.

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

Knowledge about ACC: In general, the case managers agree that Asians know very little about ACC which prevents them from accessing services. Asians are not familiar with the ACC system as there is no similar injury related health insurance system in Asian countries:

> cm3: I think a lot of if 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.

Culturally appropriate services: Case managers consider it paradoxical when they are expected to simultaneously provide culturally appropriate services to claimants and the same services for everyone. However, they agree there is a need to make the communication method more culturally appropriate:

> cm1: 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.

> cm1: 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.

Lack of focus on Asians: It is ACC policy to treat everyone the same, but case managers may often be swamped by large work loads which may leave some passive claimants behind e.g. Asian claimants:

> cm1: 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.

> cm1: The one who reminds me all the time, she sends me e-mail. It works the best.

Others: The Indian case manager pointed out that there is a fear of bureaucracy that may frighten off Asian claimants if they do not know the claim process well:

> cm2: There would be the fear of bureaucracy and asking for something from them. And there is the whole process of supplying medical evidence to your GP and Specialist making your claim accepted here at ACC.

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

- *This includes institutional barriers to knowledge about the service, and cultural barriers caused by differences in beliefs about injury, its meaning and treatment.*

The first European case manager stated that while she is uncertain of what ACC has done to help Asians in accessing ACC services, she acknowledges that the lack of knowledge about ACC is the main access barrier, and ACC needs to promote itself in the community. This can be done by having Asian language advertisements targeting Asian communities, and providing information in different Asian languages.
On the other hand, ACC finds it difficult to recruit Asian case managers due to the lack of Asians in the health sector workforce. However, ACC does provide internal staff training to allow their staff more cultural competence in dealing with ethnic

minorities. Staff training is preferred by case managers to being given guidelines on what to do:

> cm1: They provide training to us so that we can know what is better for them. I like training than clear guidelines. It is important to have the information, but shouldn't have clear guidelines on how to treat certain people as you are putting them into a box, which is not personal.
>
> cm1: The barrier, I think is their knowledge about the system and their wanting to use the system. I guess it is really promoting ACC to the community.
>
> cm1: There are not so many Asian people who are working in the health sector who have these kinds of jobs, so they are not the people getting recruited.

The Asian case manager shares the views of other case managers, i.e. ACC should promote themselves to the Asian community through the Asian media in the local Asian languages, e.g. advertisements on Asian TV and newspapers, and having the option to choose an Asian language in browsing the ACC website. ACC should also target different Asian community groups to promote their services, e.g. Business groups, voluntary groups…etc. However, there is uncertainty about whether or not to recruit more Asian ACC workers as it may reflect reverse racism:

> cm2: It would be a bit strange as you said ACC's main percentage of claimants are European, then ACC would be justified in mainly employing European case managers. This is one of the tricky questions about reverse racism as well. The solution may or may not be just employing a person from that particular culture.
>
> cm2: Our forms at the moment are all in English, and if we put our pamphlet in English, it won't make any difference. It would help if the claim form could be in local languages as well.
>
> cm2: The website can provide the options to be read in different languages as well.
>
> cm2: Indian people do have Indian satellite television, so perhaps ACC can localise the TV advertisement campaign; not just merely advertise on TV 1, 2 and 3 as barely any Asian watches that as they don't understand the language.

Like the others, the second European case manager suggested ACC should promote itself to different Asian communities by holding forum-like meetings to deliver the information and understand communities' problems. Brochures and pamphlets need to be distributed in the local Asian languages. There should be more staff training and cultural advisors should be readily available on site to assist with any cultural issues. In addition, there should be more bilingual case managers and practitioners to overcome the language barrier.

> cm3: I have seen some brochures in English. I think they should be in local languages too. They should be more targeted with practitioners that serve more Asian patients.
>
> cm3: I think there are still some access issues with the cultural advisors, acknowledging the case managers with their availability, how to get them involved. That sort of training for case managers when they first come into the branch. I don't think they have been utilised perhaps as well as it should be.

Additional information:

Asians need to be more assertive to secure their entitlements to prevent being left out of case managers' daily heavy workloads. ACC needs to identify and work with practitioners from whom Asians seek help the most to identify the barriers that these Asian claimants face when trying to access health services. More Asians may access ACC services if they can go straight to acupuncturists without GP referral; however, this needs to be monitored carefully to prevent any fraud claims. ACC should also work with community leaders to understand the different needs within each ethnic community:

> cm3: Probably every sector of the culture should be spoken to, eg. Elderly people, parents, children, university students as they all have different needs, knowledge, awareness, different ability to speak English and supports around them.
>
> cm3: I know that people have been to an acupuncturist for a sore back, and the acupuncturist will file it as an injury and claim ACC. They will make a claim not because they had an accident, but they will make up one.
>
> cm1: The more providers that are registered with ACC, then obviously they are going to get into the system.

See appendix 12 for table of perceptions for case managers.

PART SEVEN: COMPOSITE ANALYSIS BY ETHNIC GROUP

Part seven presents a composite analysis of the general views of the five ethnic groups. These results are presented under the four main questions underpinning the study and are substantiated with significant quotations at relevant points:

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

- *Demographic data re: age, gender, general English language competence, specific injury-related language competence*

Age: Most older Asian folk, apart from the South Asians to some extent, appear to experience difficulties with language and transport and are usually unaware of services available to them. Younger people are apparently more informed in terms of what is going on and what is available to them.
Older Indian and South East Asian folk reportedly do not want to be seen as begging, so avoid making claims. The Indian CL suggested that the elderly may sometimes be neglected as young people are too busy earning a living and have no time to avail to them.
South East Asian respondents suggested that older people may be more vulnerable to injuries. On the other hand, they may be afraid of doctors and needles, which may act as a barrier to accessing services.
Older South Asians may share Indian attitudes of not wanting to be seen as begging and avoiding accessing services that are free. Younger South Asians, on the other

hand, reportedly have Kiwi attitudes which apparently favour utilising whatever opportunities are available to them.

Gender: All groups, except Indian, reported no gender effect. The Indian Community Leader suggested that women may sometimes be neglected. This may be self-inflicted as they "sacrifice" themselves for their family. Some women (especially older Punjabi ladies) also have language & transport difficulties as many do not drive.

English language competence: The Indians and South Asians have no problem with general English language competence, except some older folk (especially Punjabi women). A lack of competence has a huge impact on Chinese, Koreans and South East Asians as many do not speak English and cannot communicate with speakers of English.

Injury-related language competence: None of the groups is competent in injury-related language, despite the general English language competence of the Indian and South Asian groups. Consequently, they all find it difficult to communicate their injury-related problems to English speakers. For this reason, they choose to visit doctors from their own ethnic groups who speak their own languages and will understand them. As the South East Asian community does not have their own doctors, they experience great difficulty in this regard. They find it difficult to communicate with others as there are no direct translation into their languages and no synonyms in their languages. The Korean doctor reported that if they go to local GPs, there are misunderstandings which lead to incorrect diagnoses. Consequently, they go to ethnic GPs to confirm diagnosis and medicine. Doctors are reluctant to recommend psychological or other services which can be accessed by the public as they would not be able to speak English.

- *Information concerning belief s- worldview - about the nature of injury. Topics including: What constitutes light/moderate/severe injury? Cultural beliefs about accidents, the meaning of pain? What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?*

Most Asians, especially the older ones, appear to follow a traditional health path which focuses on treating the root of the problem, rather than the symptoms. Consequently, they appear to prefer to visit a traditional practitioner and to use home remedies for smaller injuries. Some (Indians and South East Asians) try to cope with pain as going to the doctor may be seen as a sign of weakness.
All groups agree that broken bones and loss of blood constitute serious injuries and need professional help. When children are injured, help must be sought from professionals. Koreans consider back pain to be serious enough to warrant professional intervention.

- *Help-seeking behaviours: Topics including: When and where Asian patients seek help for differing severity of injury and pain? Reasons for getting help from this source, reasons for this sequencing of choice, and willingness to seek help from private and public health services. Who decides where to seek help?*

When and where do Asians seek help for injuries and pain? Why?

The usual course of action for most Asians for the treatment of injuries and pain appears to be:

1. self-diagnose and medicate
2. visit a traditional practitioner (except Koreans and some younger people)
3. visit a private general practitioner

For most Asians, the preferred treatment for small injuries sustained in the home appears to be self-diagnosis and medication. Smaller injuries are usually treated with home remedies and with medication brought from their home countries. There appears to be a propensity amongst Asians to bring in familiar and tried and tested medicines from home whenever they go back on vacation. It is considered a waste of time and money to visit a doctor for smaller injuries when they can be treated at home. Most Asians (Chinese, Indians, Koreans, South East Asians and South Asians) report working long hours and not having time to go to a doctor unnecessarily. Most Asians also report getting over-the-counter advice and medicine from chemists.

Intermediate injuries and pain such as backache may be treated by a traditional practitioner such as an acupuncturist, masseur or an ayurvedic doctor. Many Asians, especially older people who prefer to "follow a traditional path", believe these practitioners treat the root of the problem and not just the symptoms like general practitioners do. However, as ayurvedic doctors and Chinese masseurs are not covered by ACC, Indian and Chinese people who prefer to be treated by them are often forced to visit a GP instead, after the first visit to the TP, as they are covered by ACC. Many Asians may go to a GP only because they need a certificate for absence from work. Younger people may prefer to visit a GP rather than a TP. Koreans apparently go straight to a GP only because they need a referral to a specialist. They have no GP system in Korea, but go directly to a specialist. Consequently, they do not have a family doctor and would prefer to go directly to a specialist here. However, if children are injured, all Asians report that they would not hesitate to go straight to a GP or hospital to avoid any possible long term consequences for their children.

For more serious injuries, professional help is sought by all Asians. Injuries are considered more serious by all groups of Asians when they look bad and are very painful, when there is a great deal of blood loss and when there may be broken bones. All groups prefer private doctors to the public health system, and prefer to visit doctors from their own ethnic groups rather than local 'Kiwi' doctors. This is simply because they feel comfortable with them, are understood by them culturally and linguistically, and feel confident that they are getting correct and adequate treatment. Koreans appear to prefer the private system mainly because it provides faster service. Many Asians from all ethnic groups apparently do not feel adequately treated if they are not prescribed medication, and in sufficient quantities. Apparently, 'Kiwi' doctors do not always prescribe antibiotics and other medication, or prescribe them in small doses; consequently some Asians do not have confidence in them.

Who decides where to seek help?

For all Asian groups, except the Koreans, economics and knowledge (i.e. information about New Zealand systems), rather than people, appear to be the main determinants of where help for injuries and pain will be sought. For Koreans, cost does not appear

to be as much of a problem as it is for other groups. The cost of services is a huge barrier for many Asians of all ethnicities who are not as wealthy as stereotypes suggest (especially with regard to Chinese). For this reason some Asians may sometimes go to the public health system even though they prefer the private system. Lack of knowledge about systems and services here is an equally large barrier which determines where help is sought or not sought. The acquisition of this knowledge is determined by English language competence; hence the Koreans suggest that language, not money, influences their decisions.

Asians are generally family-oriented; consequently, amongst all groups, except Koreans, families support each other in making decisions on the course of action to be taken. Often, younger family members may make decisions for older members and husbands for wives. Koreans apparently have an individualist attitude on decision making and do not depend on family. However, husbands do make decisions for their wives.

International students from all groups, but mainly Chinese and Korean, have medical insurance. This determines their decision to visit a GP, apparently very often.
Community card holders use services more than others. Language barriers prevent many from applying for the Community card.
Chinese respondents reported that GPs refer patients to ACC because a huge chunk of their income comes from ACC. They also suggested that Asians do not have a permanent family doctor, but if they do, s/he is the gatekeeper and makes decisions about the course of action to follow.

2. What logistical and environmental factors are barriers to Asians use of ACC services?

- *This includes data on costs of services (e.g. visiting GPs) as barriers, transport to services, availability of services at different times of the day/week, child care during treatment and injury prevention programmes, availability and promotion of ACC services in public places and other matters raised by participants.*

Costs of services: All groups agree that cost is a problem, unless they have a Community Card. This may act as a significant barrier to accessing ACC services. Asians lack knowledge about ACC subsidised services which would help with costs. Most older Asians prefer the services of traditional practitioners, but these are usually more expensive than general medicine, so they cannot be accessed. Most Asians are family-oriented, so family members usually help each other with this.
Cost appears to be a bigger burden for many Indians who have a financial responsibility for family in their home country; consequently, they do not visit the doctor unnecessarily. However, if children are injured, cost is not important.
Although cost is a factor for Koreans as well, this does not appear to be as much of a barrier for them as for other groups.

Transport to services: Amongst all Asian groups, except Koreans, transport is a problem for some, mainly women and older folk, but family usually helps. Indian female claimants and non-claimants perceive transport to be a problem, but their GP, TP and CL do not perceive this as a problem as families take care of this. For Koreans, this is usually not a problem, but some apparently feel bothered about

driving to the doctor if injuries are minor, so they do not go. The perceived difficulties or inconveniences associated with transport could act as a barrier to accessing services.

Availability of services at different times: Time in general is a problem for all working Asians, and can serve as a barrier to accessing services. Most Asians work long hours and many have two jobs and work over weekends and nights to make ends meet, and have no time to go to the doctor or the hospital. Generally, Asians have a positive work ethic and do not like to give up work time for other appointments, so avoid taking time off work to go to the doctor. After hours services usually cost more, which would serve as an additional barrier. They also report not having time for the ACC telephone-prompt system which takes up too much of their limited time.

Child care during treatment and injury prevention programmes: As all Asians are usually family-oriented, child care is generally not a barrier for them as family helps. If family is not available, they take their children with them to appointments.

Availability and promotion of ACC services in public places: All Asian groups agreed unanimously that this is a problem. Much more promotion is needed. All respondents suggested that it is ACC's responsibility to do this. This can be done through the media and cultural gatherings and organisations such as women's groups (Indian suggestion), and in ethnic languages.

Other matters raised by participants:
All groups complained about perceived discrimination from ACC service providers. They reported feeling that some ethnic groups were given preferential treatment which they did not receive. This discouraged them from participating further in the ACC programme.

Most respondents complained about problems relating to following telephone-prompts when communicating with the hospital and ACC. Those who are not proficient in English could not follow these, and those who are generally competent in English also experienced problems relating to understanding and/or time.

SES apparently impacts on Chinese families in that older families may need more financial help and help extended family. However, it may be different with new/young immigrants, many of whom appear to be wealthy and do not need help from family. ACC should focus more on them now that they are growing in numbers.

Indians emphasised that health is not a priority for them. Instead, earning money and saving is the priority.

Koreans are apparently usually wealthier than other groups, so do not appear to experience all the problems of other groups.

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

- *What do participants know about ACC and about entitlements to services? What sources of information have they used to learn about ACC? Where and from whom do participants learn about ACC?*

Most participants do not appear to have sufficient knowledge about ACC and entitlements to services. The little they may know, they have learnt from family and friends who have participated in the programme. In the case of claimants, they have been informed by their doctors. Some TPs, such as acupuncturists who are affiliated to ACC, have limited knowledge, while others have no idea about ACC, so cannot explain much about ACC to their clients. All respondents consider sources of information to be inadequate.

- *For participants who have accessed ACC services: How do they feel about their contacts with ACC, and aspects of the service provision that made the experience a positive or negative one?*

Chinese: Mixed feelings about ACC ranging from negative to positive. Feelings appeared to be determined by their level of knowledge of ACC and its services and the benefit they had received.
Indians: Scored 1-5/10 - not a positive rating. Again, feelings appeared to be determined by their level of knowledge of ACC and its services and the benefit they had received.
Koreans: 7-8/10 which is a positive rating. Most Koreans appear to be unaware of ACC and its services; consequently, it may be that they are pleasantly surprised to receive any benefit from them at all, hence rate them positively.
South East Asians: Their ratings were more positive. Like the Koreans, they did not have any expectations in terms of compensation for injuries as they never had such services back in their home countries, hence may be pleased at receiving any compensation.

There were no South Asian claimants in the study.

- *For participants who have not accessed ACC services in spite of injury: What features of ACC services contributed to their decision to not seek assistance from the agency?*

Apart from other features mentioned earlier such as cost, time, knowledge and discrimination, the main reason cited by all respondents for not seeking assistance from the agency, was that ACC claims may affect their employment prospects. Apparently, prospective employers ask interviewees about their ACC claims status and view claimants negatively. Since employment is so important for Asian immigrants, they will not do anything that will jeopardise employment opportunities.

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

- *This includes institutional barriers to knowledge about the service, cultural barriers caused by differences in beliefs about injury, its meaning and treatment.*

Institutional barriers: There is a lack of:

- Ethnic minority service providers
- Information in ethnic languages
- Adequate translation services
- An Asian helpline
- A service especially for Asians. Asians believe ACC is only for Kiwis.
- Readily available information such as pamphlets about ACC on planes and inclusion in video presentation on NZ on planes.

These need to be provided to overcome the difficulties and barriers perceived by Asians.

Cultural barriers: ACC can eliminate or alleviate cultural barriers by providing:

- Ethnic minority service providers
- More ethnic minority case workers who understand different worldviews
- Cultural competence training to employees and service providers
- Training for inter-ethnic and cross-cultural acceptance and respect

Other:

What can the community do to improve their access?

There should be more communication between the community and ACC.
ACC information should be delivered to the community by the community. The community is not accustomed to telephone prompts. They need to adapt to this system.

Who should be the community representative – entry point?

Chinese: Community group/leader.
Indian: Cultural organisations. Some concern about some religious and community leaders who may have self-serving interests and/or insufficient knowledge about the community, hence may not be truly representative of the community.
Korean: Church, Korean Society.
South East Asian and South Asian: Cultural organisations.

Other Information:

Chinese: the Chinese acupuncturist interviewed voiced the following concern shared by his colleagues: they should have the same rights as GPs and should not need a referral from a GP – they are under the impression that they need this.
ACC only allows them to treat one patient at a time – not a few simultaneously. This reduces the number of patients they can see, and their income.
GPs are also allowed to do acupuncture. This is a specialised field and GPs do not have specialised, in-depth knowledge, so should not provide this service. They are in competition with GPs who do not refer patients to them because they wish to do it themselves, so their income is declining. ACC only recognises acupuncturists registered to two associations. Both these are run by Westerners with no non-Westerners on their boards who do not understand the requirements etc. of Asian

people. The Asian association is not recognised; consequently, their clients are not eligible for compensation from ACC.

Indians: GP says referrals are time-consuming, complicated, and involve too much paper work. Furthermore, ACC pays too little which impacts negatively on referrals by GP.

Recommendation by Ayurvedic practitioners:

Ayurvedic practitioners should be included in ACC's services. They provide a valuable and valued service and do not do a "quick fix job" and treat just the symptoms as GPs do. They treat the root of the problem and provide a holistic service, but are not covered by ACC. WINS advises their clients to visit them and covers their expenses, and, according to them, 90% of their clients are Pakeha, which demonstrates that their service is valued. It is not just a cultural service for Indians, so should be included in ACC.

See appendix 13 for composite table of general perceptions for all ethnic groups.

CHAPTER FIVE: BARRIERS AND ACCESS ISSUES

Chapter five collates and discusses the common themes concerning barriers to accessing services that emerged from focus group discussions and individual interviews with claimants, non-claimants, general practitioners, traditional practitioners and community leaders from the Chinese, Indian, Korean, South East Asian and South Asian communities, as well as case managers from ACC.

It is clear from their recent statements in the current ACC Strategic Directions draft document's strategic response paragraph: "Our aim is to earn the respect of the community", and in strategic priority 1: "People will only engage with us if they trust what we do and how we will deliver service…", that ACC realizes that the community they seek to serve may not fully "respect" or "trust" their organization. The results of this study should confirm and reinforce that realization with regard to the Asian community.

Why do some participants in this study have reservations about services provided by ACC?

Some Asian respondents are dissatisfied with ACC services as they perceive them to be irrelevant to their health and well-being because their needs are not being adequately met. There are gaps in the service and a mismatch between the needs of the people and the services that are currently being provided. Furthermore, communication between the agency and the Asian community appears to be insufficient and/or ineffective. Such resource limitations lead to lower levels of satisfaction amongst many Asians, and, as suggested by Arkin (1990), create significant barriers in accessing health services and generate ambivalence and negative attitudes towards using health services.

Korean and South East Asian respondents rated the organisation more positively in general than Chinese, Indian and South Asian groups because of the unexpected monetary compensation they received from ACC for injuries for which they themselves were responsible. They expressed gratitude for receiving money that they did not expect to be paid. However, they pointed out that the negative conditions listed above negated feelings of satisfaction with monetary benefits. Such dissatisfaction has led to a lack of confidence in ACC and has discouraged many Asians from participating in its programme.

In order to gain the respect and trust of the Asian community and ensure that they have confidence in ACC so that they will engage with them (*Strategic Priority 1: Ensuring New Zealanders have confidence in ACC*), and in that way enable ACC to play the strong leadership role they desire in injury prevention and delivery of services, a number of factors that lead to negative conditions need to be taken into consideration. These factors serve as barriers to access for Asians.

The respondents to this study identified the following *main barriers* to accessing health services provided by ACC. For the purposes of this discussion, these barriers are divided into three broad categories of ideological barriers, institutional and logistical and environmental barriers. However, they are all interrelated with each

influencing and being influenced by the other, so need to be considered simultaneously:

- Ideological barriers include prejudicial and discriminatory attitudes toward Asians, and lack of understanding of Asian worldviews and their implications for health-seeking behaviours
- Institutional barriers include inadequate promotion of ACC systems and services, poor communication, insufficient Asian service providers, inadequate translation and interpretation services, lack of Asian-specific services, and systemic barriers
- Logistical and environmental barriers include knowledge of ACC services, cost of services, issues of time, loss of income, transport, and poor communication

These barriers lead to negative conditions and need to be eliminated if the positive conditions sought by ACC in their Strategic Directions draft document are to be realised. Similar barriers to accessing health services have been identified in other international studies (Neff, 1986). These barriers are discussed below. Quotations supporting the claims made in this discussion can be found in the results chapter.

IDEOLOGICAL BARRIERS

Ideological barriers are significant because they create a mindset that has a huge impact on attitudes and behaviours toward people. Notions of the supposed superiority and inferiority of some groups and the differential value placed on cultures have repercussions for interethnic interactions (Tully, 1995; Sobrun-Maharaj, 2002). In the case of ACC, this plays a significant role in Asian responses to the services provided.

- **Attitudes toward Claimants – Asian perceptions of prejudice and discrimination:**

Prejudice is often expressed and influenced by *stereotypes* which are a powerful element of prejudice (Hall, 1997; Kerlinger, 1984). Popular stereotypes about Asian groups, which are usually negative, may have an impact on the way they are perceived by some ACC staff and may influence their treatment of them. All groups, especially Koreans and SE Asians, complained about perceived prejudice and discrimination from some ACC personnel including injuries service providers, office staff and case managers. They reported feeling that some ethnic groups (European, Maori and Pacific Island) were given preferential treatment which they did not receive. There is a clear sense that the Asian community consequently feels mistreated, denigrated and disrespected by ACC personnel. Such negative attitudes have discouraged them from participating further in the ACC programme. Non-claimants were discouraged by stories of this nature from family and friends.

Negative attitudes are often caused by a lack of knowledge and understanding of the people to whom they are directed, and groups who are different or who challenge the status quo are often viewed with a degree of fear and loathing (Hurwitz & Peffley, 1992). Perpetrators of such attitudes perceive cultural identity and differences as deficits (Hall, 1996), and apparently disregard and disrespect those who possess it. A lack of understanding of Asian worldviews may contribute to these negative attitudes

which create barriers to access for Asians. To eliminate this barrier and to ensure that the organisation is "People-focused with good outcomes" *(Strategic Priority 3)*, ACC personnel need to be provided with the knowledge and cultural orientations required to facilitate positive attitudes.

- **Differing Asian Worldviews (on health, injuries, accidents, and seeking treatment)**

The differing worldviews and natures of immigrant and local peoples and cultures can act as barriers to effective interpersonal communication (Hofstede, 1980; Lambert & Taylor, 1990; Schwartz, 1994; Triandis, 1995). In the case of ACC personnel and Asian claimants, this can lead to feelings of misunderstanding; consequently, the need for understanding of worldviews is paramount. Moreover, the way we view our world impacts on our conception of health and our utilisation of healthcare services. It is clear from interview responses that Asian worldviews do have an impact on their utilisation of healthcare services provided by ACC. Some Asians (Indians and South East Asians in this study), especially males, try to cope with pain and do not seek help as this may be seen as a sign of weakness. This finding is supported by that of a study on South East Asian refugees in the US, cited in the literature review (reference), which found stoicism in these people who viewed suffering and illness as an unavoidable part of life, which inhibited them from seeking medical help in physical pain. This is known to be true of other Asian ethnic groups (Hindus and Buddhists) that are influenced by the concept of Karma which maintains that cause and effect is determined by our own actions, i.e. positive actions bring positive effects and vice versa. This mindset facilitates the acceptance of negative phenomena such injuries and illness as part of life, and encourages endurance of pain. Furthermore, responses from the present study suggested that not working and being on a benefit may be seen as a sign of weakness for an Indian male. These attitudes would serve as a barrier to accessing health care services provided by ACC.

Moreover, Asians are typically collectivistic, therefore family-oriented people. Consequently, the well-being of the family is often considered to be more important than the well-being of the individual. Asians will therefore often make personal sacrifices to help family. This sometimes translates into individuals neglecting themselves to ensure the family is taken care of, as in the case of Indian women who reportedly 'sacrifice' themselves for the well-being of their families. This prevents them from seeing a doctor when they need help. For this reason, several Indians reported that their health is not a priority for them as they need to save money to send back home to their families in India. Visiting a doctor for an injury is therefore considered 'unnecessary'. Families also support each other in making decisions about matters related to their health. Furthermore, many older Asians, especially Indian and South East Asian folk, have a great sense of pride and do not want 'to be seen as begging', so avoid making claims from an organisation that may be perceived as giving to those who cannot or will not take care of themselves.

Where health treatment is concerned, most Asians, especially older ones, prefer to follow a traditional health path which focuses on holistic care and treating the root of the problem, rather than the symptoms. Consequently, they prefer to visit a traditional practitioner and to use home remedies whenever possible. They also prefer rest in the home for rehabilitation as opposed to some of the rehabilitation programmes offered

by Western systems to which many cannot relate. Because these programmes are often considered to be irrelevant to their needs, they choose not to participate in such programmes. This highlights the question of relevance and the issue of the traditional way versus the 'Kiwi' way. Should the traditional way of doing things, i.e. self-diagnosis and medication with home remedies and visiting a TP be retained and included within the ACC system because it is culturally appropriate to Asians, or should it be changed to fit into the 'Kiwi' model? To what extent are cultural differences appropriate or inappropriate? *Strategic Priority 7: Rehabilitation focused on returning to productive life*, aims to "enter into a more direct, productive and open relationship with customers" and "become involved early in their rehabilitation and work in partnership with them and their families" to "minimise delays in treatment or other entitlements to speed an injured person's recovery". In order to achieve this, the questions raised above need to be considered seriously.

- **Lack of understanding of Asian worldviews and their implications for health-seeking behaviours:**

A lack of understanding of the Asian worldview clearly serves as a barrier to adequate service provision by ACC personnel. Whilst there appears to be a little knowledge on the part of one case manager of the Indian worldview, there appears to be little evidence of any broad knowledge of Asian worldviews amongst the three managers interviewed. It is clear from their responses that all three find the cultural perspective a barrier in treating Asian claimants. They acknowledge that they lack understanding and do not know how to treat claimants appropriately. Because they are not understood by service providers of other ethnicities, Asians prefer to interact with providers from their own ethnic groups with whom they feel comfortable, and to avoid those who do not understand them, which impacts on their help-seeking behaviours and access to services. This points to a strong need for the re-orientation and education of ACC personnel on Asian worldviews.

These ideological barriers generate several institutional barriers which are listed below.

INSTITUTIONAL BARRIERS

Inadequate promotion of ACC systems and services, poor communication, insufficient Asian service providers, inadequate translation and interpretation services, lack of Asian-specific services, and systemic barriers are negative conditions within the agency which lead to perceptions of irrelevance and lower levels of satisfaction with ACC services, which act as barriers to accessing services:

- **Inadequate promotion of ACC systems and services[2]:**

There is unanimous agreement from all respondents that ACC services are inadequately promoted and knowledge about the agency and its services is lacking. Consequently, many Asians are unaware of the existence of the agency and most are

[2] It is worth noting a series of nationwide Community Consultation Forums have been organised by the ACC National Asian Services in October 2006. Undoubtedly it can be seen as a beginning of increased promotion of ACC systems and services within the Asian New Zealand communities.

unaware of the extent of the services they provide and entitlements to services. All respondents consider sources of information to be inadequate. This is exacerbated by the apparent lack of communication between the agency and Asian communities. Much more promotion is needed within Asian communities and in their languages. This view is fully endorsed by all three case managers interviewed.

- **Poor Communication:**

Poor communication between ACC and the Asian community is a significant barrier to accessing services. Some non-Asian staff are perceived by Asian clients to have negative attitudes toward them and to be culturally insensitive and impatient and unwilling to communicate with them positively. Consequently, Asians feel discouraged from participating in the ACC programme.

- **Insufficient Asian service providers:**

There are insufficient Asian staff employed by ACC. Asians perceive an urgent need for Asian staff who understand Asian worldviews as this would facilitate the application process and encourage participation in the programme.

- **Inadequate translation and interpretation services:**

The current translation and interpretation service is clearly inadequate, especially from the perspective of case managers. This leads to misunderstanding between staff and client which complicates the process and discourages participation.

- **Lack of Asian-specific services:**

The Asian community strongly believes that services such as an Asian helpline which provides information and help in the major Asian languages are now needed as the Asian community is growing in numbers. This would facilitate accessing of information and services and encourage participation in the programme.

- **Systemic barriers:**

Other barriers related to the systems within the agency cited as exacerbating the situation include the following:

    - Lack of consistency in case managers who are frequently changed
    - Complicated claims system
    - Long waiting times – for service and claims processing
    - Busy phones and user-unfriendly telephone-prompt system

LOGISTICAL AND ENVIRONMENTAL BARRIERS

Knowledge about ACC, cost of services, loss of income, issues time, transport to services and poor English language skills act as barriers to this sample of Asian respondents in accessing services. Transport problems are a by-product of cost and time which are all interrelated. Cost and transport have been identified as frequently

reported barriers in studies of poor populations (Ahmed et al., 2001; Keife & Hyman, 1996). Whilst the respondents of this study may not be categorised as poor, many are struggling to make ends meet to settle into their new country, so may be experiencing similar hardships as discussed below:

- **Inadequate knowledge about ACC:**

Inadequate knowledge about ACC systems and services is a large barrier which determines where, when and how help is sought or not sought. It is clear that most Asians do not know enough about ACC, what services are available to them and how to access those services. In fact, some non-claimants did not know of the existence of the agency till the commencement of the study. The little they may know, they have learnt from family and friends who have participated in the programme. Claimants interviewed have been informed by their doctors. Some TPs, such as acupuncturists who are affiliated to ACC, have limited knowledge, while others, such as ayurvedic practitioners, may have little or no idea about ACC's regulations as in the case of those interviewed for this study.

- **Costs of services:**

Cost appears to be a major problem for most Asians, unless they have a Community Services Card. This may act as a significant barrier to accessing ACC services. For this reason some Asians may sometimes go to the public health system even though they prefer the private system. Most older Asians prefer the services of traditional practitioners, but these are usually more expensive than general medicine and are not covered by ACC, so they often cannot be accessed.
It is clear from the data that Asians lack knowledge about ACC subsidised services which would help with costs. Furthermore, as respondents get their information from family and friends, it is unclear how much of the cost problem is related to suspected cost and how much to real cost.
Cost appears to be a bigger burden for many Indians who have a financial responsibility for family in their home country; consequently, they do not visit the doctor 'unnecessarily'. However, if children are injured, cost is considered to be unimportant.

The stereotype of the wealthy Chinese has led to the myth that cost is not a problem to Chinese. However, Chinese respondents point out that while some new immigrants may be wealthy, there are older Chinese families and those of Chinese origin from other parts of Asia who are not wealthy and need financial assistance.
Those who do fit the wealthy stereotype are some international students who are from all Asian groups, but mainly Chinese and Korean. They have medical insurance; consequently, are not concerned with ACC assistance and visit a GP often. However, even within this group there is a sub-group that is also struggling to survive as some parents back home are over-committing themselves financially to educate their children overseas. Some Chinese parents are even selling everything they own to send their only child overseas.
Others, for whom cost does not appear to be a concern, are community service card holders who use services more than others. Language barriers and the reluctance of depending on state welfare assistance prevent many from applying for the community services card.

- **Loss of Income:**

The main reason cited by non-claimants for not seeking assistance from the agency, was that ACC claims may affect their employment prospects. Apparently, prospective employers ask interviewees about their ACC claims status and view claimants negatively. This may suggest that education about ACC in the employment sector, amongst Asian employers within small businesses, may need to be reconsidered. Since employment is so important for Asian immigrants, they will not do anything that will jeopardise employment opportunities and their ability to earn an income. In addition, people whose income depends on a bonus may be unwilling to stay away from work for rehabilitation. They would rather go out to work than stay at home and rest, which impacts on how Asians interact/cooperate with practitioners and case managers.

- **Issues of Time:**

The issue of time in general is clearly a major problem for all working Asians and serves as a barrier to accessing services. Most Asians work long hours and many have two jobs and work over weekends and nights to make ends meet, and have no time to go to the doctor or the hospital. As revealed in this study, Asians have a positive work ethic and do not like to give up work time for other appointments, so avoid taking time off work to go to the doctor. Consequently, availability of services at different times becomes an issue for them. After hours services usually cost more and will offset any ACC subsidies, which would serve as a barrier to potential users. Long waiting times at hospitals and doctors' rooms are also an issue.

They also report not having time for the ACC telephone-prompt system which takes up too much of their limited time. Most respondents complained about problems relating to following telephone-prompts when communicating with the hospital and ACC. Those who are not proficient in English could not follow these, and those who are generally competent in English also experienced problems relating to understanding and/or time due to the unfamiliarity and complexity of the process.

- **Transport to services:**

Transport can be a barrier in accessing services for some Asians, and this is usually age and gender related, and connected to time and cost. Amongst all Asian groups, except Koreans, transport may be a problem for some women and older folk; however, as Asians are family-oriented, family usually helps with this. Although the wider community, including GPs, TPs and community leaders, do not appear to perceive transport as a problem, it seems like many of the women involved do perceive it as a problem which may prevent them from seeking health services for fear of inconveniencing their families. As alluded to above, families do not have the time to transport older or female members of the family to health services.

For Koreans, this is usually not a problem, but some apparently feel bothered about driving to the doctor if injuries are minor, so they do not go. The perceived difficulties or inconveniences associated with transport could act as a barrier to those involved.

- **Poor English Language Skills:**

The inability of many Asians to communicate with ACC and its personnel, serves as a barrier to access for Asians. This inability to communicate is determined by their general English competence and their injury-related language competence. Communication and lack of knowledge are interrelated because the acquisition of knowledge about ACC is determined by English language competence; hence the Koreans suggest that language, rather than money, influences their access to services.

While most Indians and South Asians have no problem with general English language competence, except some older folk, a lack of competence has a huge impact on Chinese, Koreans and South East Asians as many do not speak English and cannot communicate with speakers of English. It is clear from interviews with case managers that the lack of English language competence of their clients creates problems for them in service provision.

This is complicated further by the fact that none of the groups is competent in injury-related language, despite the general English language competence of the Indian and South Asian groups. Consequently, they all find it difficult to communicate their injury-related problems to English speakers. For this reason, they choose to visit doctors from their own ethnic groups who speak their own languages and will understand them. As the South East Asian community is comparatively smaller and does not have their own doctors, they experience great difficulty in this regard. They find it difficult to communicate with others as there is no direct translation into their languages and no synonyms in their languages. The Korean doctor reported that if Koreans go to local 'Kiwi' GPs, there are misunderstandings which lead to incorrect diagnoses. Consequently, they go to Korean GPs to confirm diagnosis and medication. Doctors are reluctant to recommend psychological or other services which can be accessed by the public as they would not be able to speak English. The lack of injury-related language competence impacts hugely on their ability to access health services.

The communication problem will be eliminated only by having Asian personnel and service providers for the Asian community.

CHAPTER SIX: CONCLUSION

None of the barriers presented in this report can be considered individually as they are all inter-related and require a comprehensive approach when analysing their relationship with ACC utilisation and other factors. However, to facilitate comprehension and easy access to the data, the conclusions drawn from the study are presented in relation to the four main questions addressed in the study and the objectives they were intended to achieve.

From the "inadequacies" discussed above, it is clear that there are several challenges facing ACC if they are to improve Asian access to injury-related services. Several recommendations for optimal outcomes have emerged from interviews with respondents to the study. These are listed below each question, its objectives and conclusions.

CONCLUSIONS AND RECOMMENDATIONS:

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

Objective: To explore *demographic characteristics, health beliefs and determinants of help-seeking behaviours* that impact on Asian access to ACC services.

Conclusions:

Demographic data

Age:

- Age is a barrier for old Asian folk who experience difficulties with language and transport and are usually unaware of services available to them.
- Older Indian, South Asian and South East Asian folk do not want to be seen as begging, so avoid making claims.
- Some older people may be afraid of western medicine (doctors and needles).

Gender:

- Indian women may sometimes be neglected because they give priority to their families.
- Some women have transport difficulties as many do not drive.

English language competence:

- Indians and South Asians have no problem with general English language competence, except some older folk.
- English incompetence has a huge impact on Chinese, Koreans and South East Asians as many do not speak English and cannot communicate with speakers of English.

Injury-related language competence:

- None of the groups is competent in injury-related language, despite the general English language competence of the Indian and South Asian groups.
- They find it difficult to communicate their injury-related problems to English speakers, and choose to visit doctors from their own ethnic groups who speak their own languages and understand them.
- There are misunderstandings with local European GPs which lead to incorrect diagnoses.
- Ethnic doctors are reluctant to recommend services which can be accessed by the public as they would not be able to speak English.

Information concerning beliefs about the nature of injury:

What are the culturally acceptable ways of expressing different levels of pain/reacting to different injuries?

- Some Asians try to cope with pain as going to the doctor may be seen as a sign of weakness.

What constitutes light/moderate/severe injury?

- Broken bones and loss of blood and children's injuries constitute serious injuries and need professional help.

Help-seeking behaviours:

When and where do Asians seek help for injuries and pain?

- The usual course of action for most Asians for the treatment of injuries and pain appears to be:

4. self-diagnose and medicate
5. visit a traditional practitioner (except Koreans and some younger people)
6. visit a private general practitioner

Small Injuries:

- The preferred treatment for small injuries sustained in the home appears to be self-diagnosis and medication - treatment with home remedies and with medication brought from their home countries.
- There appears to be a propensity amongst Asians to bring in familiar and tried and tested medicines from home whenever they go back on vacation.
- It is considered a waste of time and money to visit a doctor for smaller injuries when they can be treated at home. Most Asians (Chinese, Indians, Koreans, South East Asians and South Asians) report working long hours and not having time to go to a doctor unnecessarily.
- Most Asians also report getting over-the-counter advice and medicine from chemists.

Intermediate injuries:

- Intermediate injuries and pain such as backache may be treated by a traditional practitioner such as an acupuncturist, masseur or an ayurvedic doctor. Many Asians believe these practitioners provide holistic treatment and treat the root of the problem and not just the symptoms like general practitioners do.

- As ayurvedic doctors and Chinese masseurs are not covered by ACC, Indian and Chinese people who prefer to be treated by them are often forced to visit a GP after the first visit to the TP, as they are covered by ACC.
- If children are injured, they go directly to a GP or hospital to avoid any possible long term consequences for their children.

Serious injuries:

- For more *serious injuries*, professional help is sought by all Asians. Injuries are considered more serious by all groups of Asians when they look bad and are very painful, when there is a great deal of blood loss and when there may be broken bones.

Who decides where to seek help?

- Asians are generally family-oriented; consequently, families support each other in making decisions on the course of action to be taken. Often, younger family members may make decisions for older members, and husbands for wives.
- For most Asians, economics and knowledge (i.e. information about New Zealand systems), rather than people, appear to be the main determinants of where help for injuries and pain will be sought.

Where is help sought? Why?

- All groups prefer private doctors to the public health system, and prefer to visit doctors from their own ethnic groups rather than local 'Kiwi' doctors. This is simply because they feel comfortable with them, are understood by them culturally and linguistically, and feel confident that they are getting correct and adequate treatment.
- Koreans appear to prefer the private system mainly because it provides faster service.
- Many Asians from all ethnic groups apparently do not feel adequately treated if they are not prescribed medication, and in sufficient quantities. Apparently, 'Kiwi' doctors do not always prescribe antibiotics and other medication, or prescribe them in small doses; consequently some Asians do not have confidence in them.
- The cost of services is a huge barrier for many Asians of all ethnicities who are not as wealthy as stereotypes suggest (especially with regard to Chinese). For this reason some Asians may go to the public health system even though they prefer the private system.
- Lack of knowledge about systems and services here is an equally large barrier which determines whether and where help is sought.
- International students have medical insurance. This determines their decision to visit a GP, apparently very often.
- Community card holders use services more than others. Language barriers prevent many from applying for the Community card.
- Asians do not always have a permanent family doctor, but if they do, s/he is the gatekeeper and makes decisions about the course of action to follow.

Recommendations:

According to the *ACC Strategic Directions draft document*, ACC wishes to "meet changing demands" and "develop a longer term view of the community's needs and actively plan to meet them", and according to *Strategic Priority 4*, it wishes to ensure "open and fair access for all New Zealanders". To realise these goals for the Asian community, ACC needs to:

- Provide culturally appropriate and relevant services which accommodate traditional medicine such as that provided by acupuncturists and ayurvedic practitioners.
- Provide the Asian community with wider access to funding to improve their access to culturally appropriate health services, such as those provided by TPs, if there is to be equity and fairness in access. Although mainstream providers are likely to remain the most common group accessed by and needing to respond to injury events in Asian communities, clients' preference for TPs should also be addressed uniformly.
- Consider utilising TPs as relevant channels through which ACC can communicate information to the community, as well as engage with as culturally relevant and appropriate service providers, as TPs are clearly an important option for Asian communities
- Provide a targeted service for vulnerable groups such as women and the Asian elderly including assistance with transport. One of ACC's priorities is our ageing population. Although families assist with this, older Asian people appear to be experiencing problems with transport and language that other ageing population groups are experiencing, but they do not appear to be getting the help with this that others may be getting.
- Provide information about ACC and its services and entitlements in Asian languages
- Increase Asian health service providers for the Asian community
- Monitor and control the quality of existing translation and interpretation services
- Establish an ACC Asian language helpline/hotline
- Consider establishing a service especially for Asians as Asians believe ACC is only for Kiwis

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

Objective: to explore potential barriers of *costs of services* (e.g. visiting GPs), *transport* to services, availability of services at different *times* of the day/week, *promotion of ACC services* and other matters raised by participants.

Conclusions:

Costs of services:

- Cost is a significant problem for all, unless they have a Community Card.
- Asians lack knowledge about ACC subsidised services which would help with costs.
- Most elderly Asians prefer the services of traditional practitioners, but these are usually more expensive than general medicine, so they cannot be accessed.

- Many Indians have a financial responsibility for family in their home country; consequently, they cannot afford to visit the doctor unnecessarily.

Transport to services:

- Transport is a problem for some, mainly women and older folk.

Time:

- Time in general is a major problem for all working Asians. Most Asians work long hours and many have two jobs and work over weekends and nights to make ends meet, and have no time to go to the doctor or the hospital.
- Generally, Asians have a positive work ethic and do not like to give up work time for other appointments, so avoid taking time off work to go to the doctor.
- After hours services usually cost more, which serves as an additional barrier.

Availability and promotion of ACC services:

- This is a significant problem. Promotion is inadequate and much more promotion is needed.

Other matters raised by participants:
Discrimination:

- All groups complained about perceived discrimination from ACC service providers.
- There is a perception amongst many Asian claimants that some ethnic groups are given preferential treatment which they do not receive. This discourages them from participating further in the ACC programme.

Telephone-prompt system:

- Most respondents complained about problems relating to following telephone-prompts when communicating with the hospital and ACC.
- Those who are not proficient in English could not follow these, and those who are generally competent in English also experienced problems relating to understanding and/or time.

Recommendations:

In order to eliminate the logistical and environmental barriers listed above, ACC needs to:

- Consider increasing ACC subsidies for families in need of assistance to eliminate cost issues
- Work with different agencies (other government departments or NGOs) to provide a transport service for women and the elderly
- Employ a client-centred time approach (i.e. people focussed which accommodates individual needs) as opposed to a practice-centred (or agency-centred) time approach to eliminate issues of time.
- Promote ACC services in Asian languages through the Asian media and cultural gatherings and organisations such as women's groups
- Train staff for inter-ethnic and cross-cultural acceptance and respect
- Establish an ACC Asian language helpline/hotline

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

Objective: to explore the impact of *acquisition of knowledge about ACC* on *those who use ACC and those who do not*:

Conclusions:

Knowledge about ACC and sources of information:

- Most participants have insufficient knowledge about ACC and entitlements to services.
- Family and friends who have participated in the ACC programme provide information to community.
- Claimants have been informed by their doctors.
- Some TPs, such as acupuncturists who are affiliated to ACC, have limited knowledge, while others have no idea about ACC.
- All respondents consider sources of information to be inadequate.

Perceptions of claimants on their experience with ACC:
Chinese:

- Mixed feelings about ACC ranging from negative to positive.
- Feelings determined by their level of knowledge of ACC and its services, the benefit they had received, bureaucracy and attitudes of staff.

Indians:

- Scored 1-5/10 - not a positive rating.
- Feelings determined by their level of knowledge of ACC and its services, the benefit they had received, bureaucracy and attitudes of staff.

Koreans:

- 7-8/10 - a positive rating.
- Most Koreans appear to be unaware of ACC and its services; consequently, they are pleasantly surprised to receive any benefit from them at all, hence rate them positively.

South East Asians:

- Positive ratings.
- Like the Koreans, they did not have any expectations in terms of compensation for injuries as they never had such services in their home countries, hence are pleased at receiving any compensation.

Perceptions of non-claimants who have had injuries, and determinants of decision to not seek assistance from ACC:

Employment prospects:

- Apart from cost, time, knowledge and discrimination, the main reason cited by all respondents for not seeking assistance from the agency, was that ACC claims may affect their employment prospects.

- Prospective employers ask interviewees about their ACC claims status and view claimants negatively. Since employment is so important for Asian immigrants, they do nothing that will jeopardise employment opportunities.

Recommendations:

To eliminate barriers arising from lack of knowledge about ACC systems and services ACC needs to:

- Provide a robust education programme concerning ACC regulations for employers and employees within the employment sector.
- Actively promote ACC and provide information in the major Asian languages about primary care services that are funded by ACC and other primary care services that are not, and differential costs associated with different services.
- Utilise existing health promotion events for promotion so that a wider audience can be reached.
- Utilise multi-media such as a DVD (as opposed to written brochures/ pamphlets) for promotion to reach a wider audience and facilitate people's understanding of ACC.
- Tailor education for injury prevention to the Asian population to make it more accessible to this group

4. What can ACC do to help Asians overcome the difficulties and the barriers they perceive?

Objective: to explore the impact of *institutional barriers* to knowledge about the service, and *cultural barriers* caused by differences in beliefs about injury, its meaning and treatment on Asian access of ACC services.

Conclusions:

Cultural barriers:

- Asians are experiencing several cultural barriers in accessing ACC services which include ideological barriers such as differing Asian worldviews, and lack of understanding of Asian worldviews and their implications for health-seeking behaviours, and negative attitudes toward Asian claimants.
- This has created a chasm between ACC and the Asian community.

Institutional barriers:

- Asians are also experiencing institutional barriers such as inadequate promotion of ACC systems and services, poor communication, insufficient Asian service providers for Asians, inadequate translation and interpretation services, lack of Asian-specific services, and systemic barriers.
- Some Asian claimants feel neglected by ACC as they feel services for them are lacking or inadequate in comparison with provisions made for other ethnic groups**.**

Recommendations:

To ensure that Asian "New Zealanders have confidence in ACC" (ACC's Strategic Priority 1), the agency needs to eliminate, or at least alleviate, ideological barriers associated with attitudes and worldviews by providing:

- More Asian case workers who understand different worldviews.
- Cultural competence training to ACC employees and service providers.
- A targeted service for the growing Asian community, as some Asians believe ACC caters only for 'Kiwis', which identifies injuries and other issues specific to Asians. This may include expanding the Asian focus in each ACC division (e.g. Call Centre, Research and Development), or expanding the Asian Development Unit.

To ensure that ACC is an "efficient, sustainable and flexible organisation" *(Strategic Priority 6)*, the following is recommended:

To eliminate feelings of neglect amongst Asians:

- Conduct rigorous consultations with the Asian community and further research in order to ensure that services are provided that best meet their needs.
- Provide interventions to reduce or eliminate barriers e.g. a local community based programme/ trial where there is a high Asian concentration, and evaluation of outcomes of interventions.

To eliminate barriers arising from poor communication:

- Have communication systems in place between ACC and Asian communities, via the Asian media (newspapers, radio, and television) and cultural organisations, to bridge the communication chasm that currently exists.
- Provide a sound and reliable translation and interpretation service that is constantly monitored and controlled.
- Establish an Asian helpline/hotline – perhaps in partnership with CAB language line.

To eliminate systemic barriers:

- Establish an ACC Asian language hotline that makes information easily accessible to Asians.
- Provide claim forms in Asian languages.
- Ensure transition from one case manager to another is managed properly to save time and misunderstanding.
- Improve the quality of ethnicity data in terms of recording and coding systems.
- Establish links with marginalised Asian populations to include and inform them.

Other Recommendations by Respondents:

The Asian community recognises its responsibility in improving access to ACC services and makes the following recommendations for them:

What can the community do to improve their access?

- Communicate more with ACC
- Disseminate information regarding ACC's services to the community through proper community representatives
- Be familiar with the telephone-prompt system to facilitate accessing ACC services

Who should be the community representative – entry point for ACC?

- Cultural and religious organisations
- Community leaders

PRIORITIES

The following recommendations are considered to be urgent and should take priority:

1. Communicating with the Asian community through the Asian media and cultural organisations
2. Training staff in cultural competence and valuing and respect of cultural diversity
3. Employing a client-centred time approach (i.e. people focussed which accommodates individual needs) as opposed to a practice-centred (or agency-centred) time approach to eliminate issues of time.
4. Establishing an ACC Asian language hotline that makes information easily accessible to Asians.
5. Providing information and forms in the major Asian languages
6. Providing the Asian community with wider access to funding to improve their access to culturally appropriate health services, such as those provided by TPs

STRENGTHS OF THE STUDY

- The robustness of our methodology and research rigour e.g. cross- checking by research team, input from ethnic researchers in data interpretation and checking of accuracy, expert advice from evaluation and injury prevention researcher, applied to handle a very complex project and very diverse population groups.
- Partnership with ACC personnel in the design of the project, recruitment of participants, and feedback to the early draft of the report has added to the rigour and validity of the research.
- The study has identified some potential barriers that were not revealed in other studies.
- The report provides specific and detailed information concerning five heterogeneous Asian ethnic groups and not just general information about a single, supposedly homogenous, Asian group.

- An incidental commonality was observed within the sample, of newness within New Zealand: the discussion revealed that all respondents were immigrants who had been in NZ for less than 10 years, with a vast majority being here for only a few years. This provided consistent data.
- There is a very high level of consistency between findings emerged from this project and the comments or issues raised by members of the public in the recent ACC's Asian Community Forum.

LIMITATIONS OF THE STUDY

- Due to recruitment difficulties, the final pool of participants comprised of individuals recruited from the ACC claimant lists and Asian participants recruited via members of the project team. This could have resulted in some bias in the sampling frame, which could confound the final results. The results may consequently not be generalisable to the whole population from each ethnic group.
- For the convenience of the study, the SE Asian group was studied as one homogenous group. This community is a complex one consisting of many sub-groups with their own identities, characteristics and needs, and should be studied separately if their particular needs are to be met.
- Some participants' demographic profile (e.g. employment status and length of stay in New Zealand) was not sought in the study which limited the ability to draw some conclusions.
- Non-claimants were not engaged in individual interviews which might allow room for more in-depth and personal material to be explored.
- The study did not have the opportunity to compare the present findings with similar ethnic specific studies (e.g. Maori or Pacific populations) on a similar topic to identify in what way Asian peoples' experiences about accessing (or not accessing) ACC differ.

FUTURE RESEARCH

The following issues that have arisen from the study warrant further investigation:

1) Raising awareness about ACC and improving service accessibility

- Examine the best way to communicate with the Asian communities regarding the cost structure (and ACC differential subsidies) associated with injury-related services. Another relevant research area is the extent to which the problem of costs of services is related to the perceived cost (due to unreliable information passed by word of mouth) and to the actual cost.
- Investigate at what point barriers identified in this study 'kick in', and ascertain how much of the barriers can be attributed to the level of referral, i.e. initial consultation versus ongoing rehabilitation services, accessing the full range of injury-related services and compensation covered by ACC, and whether GPs stop at the initial consultation or refer them on for rehabilitation.
- Investigate whether the barriers associated with accessing ACC are the same as those for accessing New Zealand general primary healthcare services.

2) Improving rehabilitation outcomes

- Investigate whether the Asian preferred course of action, i.e. self-diagnosis and medication with home remedies or medication from home country, and visiting a TP *could be harmful,* in that delayed presentation to primary health services may lead to a more serious problem and become more costly. Also it is important to assist Asian people to tell the differences between serious and less serious injuries so they can seek early effective treatment. And what will be the most effective way to pass this message to the communities?
- Examine the extent to which young people facilitate, advocate and manage their parents, who are a marginalized population, to access ACC and health services, and determine the extent to which they can serve as an access point for agencies to disseminate messages to their parents; explore how this channel can be effectively used to pass information to the adult population which is comparatively less adaptable and experiences more barriers.
- The Chinese and Indian communities have highlighted concerns about the services of relevant TPs not being covered by ACC. Investigate the relevance and utilisation of TP services amongst Asians and how TPs can help achieve the ACC broad objectives: 1) raising awareness, 2) improving outcome & 3) promoting injury prevention) given its significance for Asian communities.

3) Promoting injury prevention

- Examine the extent to which language is an issue in promoting injury prevention, to what extent it is an Asian problem, and whether it could be a general problem experienced by all groups.
- Examine the personal accounts, appropriate wordings, images and/or metaphors including Asian cultural concepts (e.g. worldview on injuries, help-seeking behaviours) that could be used by ACC to effectively deliver injury prevention messages to the Asian population.
- Evaluate an existing injury-prevention programme (e.g. Falls Prevention) in terms of how the messages are being perceived and transferred to individual situations and how the programme can be tailored to the Asian population. During the data collection process of the present study, some participants did mention they came across ACC-run education seminars on various injury prevention topics; however, it is unclear how effective those programmes are in terms of making behavioural changes.
- Investigate the most effective ways of delivering the injury prevention message to different Asian targeted groups and for different types of injuries.
- Study ways to reach the "difficult to reach" sub-groups (women, people who are not working, elderly people) within the Asian population promoting injury prevention. Evaluation of the effectiveness of those identified strategies.
- Compare the effectiveness of professionals led health promotion versus integrated approach working with Asian communities in promoting injury prevention. The present study did identify the need (in some cases, reluctance) in working with community leaders and communities themselves.

The primary concern reflected in this study is the barriers faced by members of the Asian community in accessing injury-related services provided by ACC. Whilst it is important that access for this community is improved, of greater significance is the need to prevent injury amongst Asians in the first place. It is encouraging to note that this vision has been newly adopted by ACC which is now "committed to a New Zealand in which people *are free of injury*" (italics added).

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APPENDICES

Appendix 1

Social and Community Health

School of Population Health
Tamaki Campus, University of Auckland
Morrin Rd, Glen Innes
Private Bag 92019, Auckland, New Zealand
Phone +64 9 3737599
Fax +64 9 3737624

Participant Information Sheet

For Individual Interviews
(This form can be translated into your language if necessary)

Title: Research and evaluation of barriers to Asian people accessing injury related services and entitlements

To: The participants, practitioners in injury-related services
Researcher: Dr Samson Tse, Ext 86097, Email: s.tse@auckland.ac.nz

Why is this research happening?
This project is funded by Accident Compensation Corporation to find out what barriers are experienced by Asian peoples in using injury related services.

ACC's own data shows that, at present, Asian members of the community are unrepresented as users of ACC services in terms of making injury-related claims, accessing prevention programmes and using rehabilitation services. In the interests of social justice all members of New Zealand society should have equal access to health services (see the Code of ACC Claimants' Rights), so it is important to find out what barriers are limiting Asians access to services provided by ACC.

This research will involve both community groups and experts (practitioners) – community groups in focus groups and experts by interview. Findings from this research will be used to provide culturally relevant and focused information to Asian ethnic groups so that they can begin to access ACC injury prevention and rehabilitation services in proportion to their representation in society. The information also has potential to save costs for ACC since injury prevention activities which are appropriately focused will result in lower rates of injury among Asian peoples in New Zealand.

Other stakeholders, such as GP's and physiotherapists, will also gain information about barriers to Asian participation in injury prevention programmes and rehabilitation services. Drawing on this information, they can educate Asian patients with regard to ACC services and encourage them to take advantage of health services provided by the state for temporary or permanent residents/ citizens of this country.

Your role
The research approach is based on interviews in your first language (individual interview in your case) and it is expected to take approximately 60 minutes. During the meeting, you will be given discussion topics. We will meet at a place and time that is convenient to you and the researcher (some possibilities are School of Population Health University of Auckland or Community Centres).

Keeping what you share safe and confidential

Your assistance in this matter is greatly appreciated and complete confidentiality and anonymity is promised. Your name will not be used and your data would be identified by codes only. If the information you provide is reported or published, this will be done in a way that does not identify you as its source.

Please note that you do not have to take part in this interview if you do not feel comfortable and that you can refuse to answer any particular question. You can withdraw from the research at any time up to 28 July 2006 and ask any questions about the research at any time during participation.

The researchers will take notes while talking. The interview will also be audio-taped with your consent and even if you agree to being taped, you may choose to have the recorder turned off at any time. The tapes are for our records only and if there is a need for them to be transcribed for further analysis, the researchers will transcribe the tapes with your consent in the Confidentiality Agreement. After the completion of the project the tapes will be immediately erased by the researchers. The transcriptions and any other information will be kept by the researchers in a locked cabinet on University premises.

The researchers are intending to keep the data for up to six years after this research, as they might be used as part of further research of the causes of injuries and barriers in accessing ACC services in the future. During this period the data will be kept by Dr Samson Tse in a locked cabinet on University premises. After this period the transcriptions will be destroyed by shredding.

A summary of research findings will be sent to ACC and the Office of Ethnic Affairs. For your interest, we may also send you a summary of our key findings at your request.

Any Questions?
If you have any queries or wish to know more please contact the principal investigator Dr Samson Tse or one of the personnel listed below:

Head of Department:
Professor David Thomas
Social and Community Health Section, School of Population Health, The University of Auckland
Phone: +64 9 3737599 Ext 85657
Email: dr.thomas@auckland.ac.nz

For any queries regarding ethical concerns please contact:
The Chair, The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Research Office – Office of the Vice Chancellor, Private Bag 92019, Auckland
Phone: +64 9 3737999 Ext 87830

"APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 12th of April, 2006 for 3 years from 12/04/2006 to 12/04/2009 Reference Number 2006/049"

Appendix 2

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES
Social and Community Health School of Population Health
Tamaki Campus, University of Auckland Morrin Rd, Glen Innes Private Bag 92019, Auckland, New Zealand Phone +64 9 3737599 Fax +64 9 3737624

Participant Information Sheet

For Focus Groups

(This form can be translated into your language if necessary)

Title: Research and evaluation of barriers to Asian people accessing injury related services and entitlements.

To: The participants, members of Asian community **Researcher:** Dr Samson Tse, Ext 86097, Email: s.tse@auckland.ac.nz

Why this research is happening?

This project is funded by Accident Compensation Corporation to find out what are the barriers experienced by Asian peoples in using injury related services.

ACC's own data show that, at present, Asian members of the community are unrepresented as users of ACC services, in terms of making injury-related claims, accessing prevention programmes and when they need rehabilitation services. In the interests of social justice all members of New Zealand society should have equal access to health services (see the Code of ACC Claimants' Rights) so it is important to find out what barriers are limiting Asians access to services provided by ACC.

This research will involve both community groups and experts (practitioners) – community groups in focus groups and experts by interview. Findings from this research will be used to provide culturally relevant and focused information to Asian ethnic groups so that they can begin to access ACC injury prevention and rehabilitation services in proportion to their representation in society. The information also has potential to save costs for ACC since injury prevention activities which are appropriately focused will result in lower rates of injury among Asian peoples in New Zealand.

Other stakeholders, such as GP's and physiotherapists, will also gain information about barriers to Asian participation in injury prevention programmes and rehabilitation services. Drawing on this information they can educate Asian patients with regard to ACC services and encourage them to take advantage of health services provided by the state for temporary or permanent residents/ citizens of this country.

Your role

The research approach is based on interview in your first language (focus group in your case) and it is anticipated to take approximately 60 minutes. During the meeting, you will be given discussion topics. We will meet at a place and time that is convenient to you and the researcher (some possibilities are School of Population Health University of Auckland or Community Centres).

Keeping what you share safe and confidential
Your assistance in this matter is greatly appreciated. Your name will not be used and your data would be identified by codes only. Given the nature of the focus group, confidentiality cannot be guaranteed. If the information you provide is reported or published, this will be done in a way that does not identify you as its source.

Please note that you do not have to take part in this interview if you do not feel comfortable and that you can refuse to answer any particular question. You can withdraw from the research at any time up to 28 July 2006 and ask any questions about the research at any time during participation.

The researchers will take notes while talking. The interview will also be audio-taped for the entire session with your consent. You may choose not to participate if you wish not to be taped. The tapes are for our records only and if there is a need for them to be transcribed for further analysis, the researchers will transcribe the tapes under your consent in Confidentiality Agreement. After the completion of the project the tapes would be immediately erased by the researchers. The transcriptions and any other information will be kept by the researchers in a locked cabinet on University premises.

The researchers are intending to keep the data for up to six years after this research, as they might be used as part of further research of the causes of injury and barriers in accessing ACC services in future. During this period the data will be kept by Dr Samson Tse in a locked cabinet on University premises. After this period the transcriptions will be destroyed by shredding.

A summary of research findings will be sent to ACC and the Office of Ethnic Affairs. For your interest, we may also send you a summary of our key findings under your requisition.

Any Questions?
If you have any queries or wish to know more please contact the principal investigator Dr Samson Tse or any of the researchers on the above contact details.

You may wish to contact the Head of Department: Professor David Thomas Social and Community Health Section, School of Population Health, The University of Auckland Phone: +64 9 3737599 Ext 85657 Email: dr.thomas@auckland.ac.nz

Or for any queries regarding ethical concerns please contact:
The Chair, The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Research Office – Office of the Vice Chancellor,
Private Bag 92019,
Auckland
Phone: +64 9 3737999 Ext 87830
"APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 12th of April, 2006 for 3 years from 12/04/2006 to 12/04/2009 Reference Number 2006/049"

Appendix 3

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Social and Community Health

School of Population Health

Tamaki Campus,
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Morrin Rd, Glen Innes
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Consent Form
For Individual Interviews

(This form can be translated into your language if necessary)

Title: Research and evaluation of barriers to Asian people accessing injury related services and entitlements.

Researchers: Dr Samson Tse, Ext 86097, Email: s.tse@auckland.ac.nz

This Consent Form will be stored for six years in a locked cabinet on University premises, before it is destroyed.

I have read the Information Sheet and have had the details of the research explained to me. My questions have been answered to my satisfaction, and I understand I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular question.

I agree to provide information to the researcher on the understanding that my name will not be used.

I agree/do not agree that I will be audio taped and understand that, even if I agree, I may choose to have the recorder turned off at any time.

I understand that the audio-tapes will be only transcribed by the researchers if needed and erased after the completion of the project. The data will be kept for up to six years after this research by the researchers, as it might be used as part of future research projects in the same field.

I understand that I am free to withdraw from the research at any time without giving a reason and that I have the right to withdraw my information/data up to 28 July 2006.

I understand that a summary of research findings will be sent to ACC and the Office of Ethnic Affairs.

I understand that I am entitled to request for a summary of the key research findings.

I agree to take part in this research under the conditions set out in the Information Sheet.

Postal address:

Signed:

Name:

Date:

"APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 12th of April, 2006 for 3 years from 12/04/2006 to 12/04/2009 Reference Number 2006/049"

Appendix 4

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES
Social and Community Health School of Population Health
Tamaki Campus, University of Auckland Morrin Rd, Glen Innes Private Bag 92019, Auckland, New Zealand Phone +64 9 3737599 Fax +64 9 3737624

Consent Form

For Focus Groups

(This form can be translated into your language if necessary)

Title: Research and evaluation of barriers to Asian people accessing injury related services and entitlements.

Researcher: Dr Samson Tse, Ext 86097, Email: s.tse@auckland.ac.nz

This Consent Form will be stored for six years in a locked cabinet on University premises, before it is destroyed.

I have read the Information Sheet and have had the details of the research explained to me. My questions have been answered to my satisfaction, and I understand I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular question.

I agree to provide information to the researcher on the understanding that my name will not be used.

I agree/do not agree that I will be audio taped and understand that the entire session will be recorded.

I understand that the audio-tapes will be only transcribed by the researchers if needed and erased after the completion of the project. The data will be kept for up to six years after this research by the researchers, as it might be used as part of future research projects in the same field.

I understand that I am free to withdraw from the research at any time without giving a reason and that I have the right to withdraw my information/data up to 28 July 2006.

I understand that given the nature of the focus group, the confidentiality in the focus groups relies upon the members not discussing participants or the topics outside the group. The researchers will keep the names of the participants confidential, but the information will be used for the research report and publications supporting it.

I understand that a summary of research findings will be sent to ACC and the Office of Ethnic Affairs.

I understand that I am entitled to request for a summary of the key research findings.

I agree to take part in this research under the conditions set out in the Information Sheet.

Summary postal address:

Signed:

Name:

Date:

"APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 12th of April, 2006 for 3 years from 12/04/2006 to 12/04/2009 Reference Number 2006/049"

Appendix 5a
Guidelines for Individual Interviews
(Asian General Practitioners)

Preamble

The preamble can be presented as the interviewers wish. However, the following 5 points must be made clear to the participant(s). The exact wording delivered may vary depending on the language level of the participants:

Firstly, thank the participant(s) for coming to the interview.
Secondly, the interviewers can provide some background and statistical figures showing that Asians are under-utilising ACC services. For example, only 3% of the ACC claimants are Asians while around 7% of the national population are Asians.
Thirdly, inform participant(s) that this research attempts to identify and evaluate the barriers preventing Asians accessing injury related services.
Fourthly, inform participant(s) that the research results may also help ACC to improve their services to Asian populations.
Lastly, inform participant(s) that the success of this research depends on their involvement and sharing their experiences. Therefore their opinions will be much appreciated.

The following is an example of what could be said:

Thank you for taking part in this study. As we know, ACC provides services for accident injuries to NZ residents. However, their data show that out of 7% of Asian people in New Zealand only 3% of the claimants are Asians. Given this under-utilisation of ACC services by Asian communities, we would now like to identify and evaluate barriers to Asian people accessing injury related services and entitlements. It is also important for ACC to know this information so that they may provide appropriate services to their Asian clients in NZ.

Introductions

-Ground rules: confidentiality, anonymity, note taking and use of data, optional audio-taping
-You are invited to comment on and answer the questions asked, and please feel free to tell us anything you would like to share. The responses are voluntary; you may withdraw from the question anytime.
(At this point, the participants must sign the Consent Form to proceed further)

Discussion

The individual interview guidelines will be in four parts. In part one, the semi-structured interview begins with questions regarding the general information of the participant. In part two, the interview proceeds with the participant's understanding of injuries and accidents specific to their cultural background. Part three examines the participant's experiences and/or perception about barriers, knowledge of services provided by ACC and relevance of services to Asian claimants. The fourth part contains questions about the individual's opinion on "moving forward": what can be done to improve Asian peoples' accessing injury-related services and entitlements.
The following topics are developed as a general guide to facilitate the discussion.

Part ONE

- **Verify the participant's general information**
    - Name of the GP
    - Contacts of the practice– includes physical address, phone numbers, fax numbers and E-mails
    - Local community (ethnic) they are serving
    - How long you have been in practice
    - What dialects can you speak
    - What percentage of your patients are Asian (e.g. Indian, Chinese)

Part TWO

- **Observations**
    - What are the services you provided under the ACC contract?

- Would you kindly explain the nature of ACC services that you encourage your patients to have?
- Continue from the previous question; please briefly describe how you will assist your patients in accessing ACC related services.
- How do you think may your Asian patients' perception and experience of injury related services differ from Kiwis? Please explain why they are different or similar.

Part THREE

- **Barriers and access issues:**
  - Why do you think would Asians prefer to go to you rather than other western GPs?
  - How does speaking Asian dialects help your patients in improving their health status?
  - Why do Asians not claim ACC services in the event of injuries and accidents?

  Prompt:
    - *Personal – language, value, attitude, type of injury…etc.*
    - *Practical – transportation, can't afford a GP visit…etc.*
    - *Environmental – lack of understanding of the ACC system, services provided…etc.*
    - *Institutional – unhelpful attitudes towards Asian people, lack of focus on Asian people…etc.*
    -

- **Participant's awareness and knowledge of services provided by ACC**
  - Has your GP practice ever taken any collective initiative to inform your community about ACC services? If so, can you briefly describe the program and the responses from the community? (Prompt: please refer to newspaper, TV, Radio, and actual community events)
  - How much do you know about ACC services in the following three areas: eligibility, types of services, and claim process? Please indicate your answer on a scale of 5, where 1 is no knowledge at all, 2 is a little knowledge, 3 is average knowledge, 4 is a lot of knowledge, and 5 is knowing everything about ACC. As this is an interview, you do not need to record a number as you have done below; just the response e.g "a little knowledge" etc. will be recorded on the tape.
    - Eligibility to make an ACC claim – _____
    - Types of services provided by ACC – _____
    - The claim process – _____
    - Services for special population (eg. Sexual abuse victims).

  - How much do you think do your patients know about the ACC services in the following three areas: eligibility, types of services, and claim process? Please indicate your answer on a scale of 5, where 1 is no knowledge at all, 2 is a little knowledge, 3 is average knowledge, 4 is a lot of knowledge, and 5 is knowing everything about ACC.

    - Eligibility to make ACC claim – _____
    - Type of services provided by ACC – _____
    - The claim process – _____
    - Services for special population (eg. Sexual abuse victims).

- **Participant's opinions on relevance of ACC services to Asian claimants**
  - How are your patients' needs being met by ACC services?
  - Please identify the gaps between the ACC services provided and the expectations of your patients.
  - Are ACC services provided to Asians appropriately adjusted to their cultural and traditional values? Give examples please.
  - Do you think ACC is a fair and equal service in terms of providing injury related services to everyone in NZ?

Part FOUR

- **Moving forward**
    - Who do you think should ACC be working with to improve your patients' access to your services, and why?
    - If there is one thing that ACC can change to improve its services to your community, what would this be and why?
    - How would you like the results of this research to be disseminated across your community?

Appendix 5b
Guidelines for Individual Interviews
(Asian Traditional Practitioners)

Preamble
The preamble can be presented as the interviewers wish. However, the following 5 points must be made clear to the participant(s). The exact wording delivered may vary depending on the language level of the participants:

Firstly, thank the participant(s) for coming to the interview.
Secondly, the interviewers can provide some background and statistical figures showing that Asians are under-utilising ACC services. For example, only 3% of the ACC claimants are Asians while around 7% of the national population are Asians.
Thirdly, inform participant(s) that this research attempts to identify and evaluate the barriers preventing Asians accessing injury related services.
Fourthly, inform participant(s) that the research results may also help ACC to improve their services to Asian populations.
Lastly, inform participant(s) that the success of this research depends on their involvement and sharing their experiences. Therefore their opinions will be much appreciated.

The following is an example of what could be said:

Thank you for taking part in this study. As we know, ACC provides services for accident injuries to NZ residents. However, their data show that out of 7% of Asian people in New Zealand only 3% of the claimants are Asians. Given this under-utilisation of ACC services by Asian communities, we would now like to identify and evaluate barriers to Asian people accessing injury related services and entitlements. It is also important for ACC to know this information so that they may provide appropriate services to their Asian clients in NZ.

Introductions
-Ground rules: confidentiality, anonymity, note taking and use of data, optional audio-taping
-You are invited to comment on and answer the questions asked, and please feel free to tell us anything you would like to share. The responses are voluntary; you may withdraw from the question anytime.
(At this point, the participants must sign the Consent Form to proceed further)

Discussion
The individual interview guidelines will be in four parts. In part one, the semi-structured interview begins with questions regarding the general information of the participant. In part two, the interview proceeds with the participant's understanding of injuries and accidents specific to their cultural background. Part three examines the participant's experiences and/or perception about barriers, knowledge of services provided by ACC and relevance of services to Asian claimants. The fourth part contains questions about the individual's opinion on "moving forward": what can be done to improve Asian peoples' accessing injury-related services and entitlements.
The following topics are developed as a general guide to facilitate the discussion.

Part ONE
- **Verify the participant's general information**
    - Name
    - Contacts – includes physical address, phone numbers, fax numbers and E-mails
    - How long have you been in NZ?
    - How long have you been in practice in NZ?
    - Were you practising your profession prior coming to NZ?

Part TWO
- **Observations**
    - What kind of services are you offering to your patients?
    - How is your practice different from GPs?

- What percentage of your patients are of Asian descent (Please specify ethnicity, e.g. Chinese, Indian)?
- If you are contracted with ACC, can you please describe what type of ACC services you are providing?
- Where normally do your patients and the community you serve seek help in the event of accidental injuries? Please explain.
- What type of injuries and accidental issues become a serious problem to the community you serve?
- How do you think do your Asian patients' perceptions and experiences of injury related services differ from Kiwis? Please explain why they are different or similar.

Part THREE

- **Barriers and access issues:**

  - Why do you think would Asians prefer to go to you rather than other GPs?
  - Why do Asians not claim ACC services in the event of injuries and accidents?

  Prompt:

  - *Personal – language, value, attitude…etc*
  - *Practical – transportation, can't afford a GP visit…etc*
  - *Environmental – lack of understanding of the ACC system, services provided…etc*
  - *Institutional – unhelpful attitudes towards Asian people, lack of focus on Asian people…etc.*

  - How would your patients' English skills affect them in accessing ACC related services?

- **Participant's awareness and knowledge of services provided by ACC**

  - Has your practice ever taken any collective initiative to inform your community regarding ACC services? If so, can you briefly describe the program and the responses from the community? (Prompt: please refer to newspaper, TV, Radio, and actual community events)

  - How much do you know about ACC services in the following three areas: eligibility, types of services, and claim process? Please indicate your answer on a scale of 5, where 1 is no knowledge at all, 2 is a little knowledge, 3 is average knowledge, 4 is a lot of knowledge, and 5 is knowing everything about ACC. As this is an interview, you do not need to record a number as you have done below; just the response e.g "a little knowledge" etc. will be recorded on the tape.
    - Eligibility to make an ACC claim – _____
    - Types of services provided by ACC – _____
    - The claim process – _____
    - Services for special population (eg. Sexual abuse victims).

  - How much do you think do your patients know about the ACC services in the following three areas: eligibility, types of services, and claim process? Please indicate your answer on a scale of 5, where 1 is no knowledge at all, 2 is a little knowledge, 3 is average knowledge, 4 is a lot of knowledge, and 5 is knowing everything about ACC.

    - Eligibility to make ACC claim – _____
    - Type of services provided by ACC – _____
    - The claim process – _____
    - Services for special population (eg. Sexual abuse victims).

- **Participant's opinions on relevance of ACC services to Asian claimants**

- How have your patients' need being met by ACC services?
- Please identify the gaps between the ACC services provided and the expectation from your patients.
- How the ACC services provided to Asians are appropriately adjusted to their cultural and traditional values? Give example please.

Part FOUR

- **Moving forward**

  - Who do you think should ACC be working with to improve your patients' access to your services, and why?
  - If there is <u>one thing</u> that ACC can change to improve its services to your occupation community, what would this be and why?
  - If there is <u>one thing</u> that ACC can change to improve its services to your ethnic community, what would this be and why?
  - How would you like the results of this research to be disseminated across your community?

Appendix 5c
Guidelines for Individual Interviews
(Community Leader)

Preamble
The preamble can be presented as the interviewers wish. However, the following 5 points must be made clear to the participant(s). The exact wording delivered may vary depending on the language level of the participants:

Firstly, thank the participant(s) for coming to the interview.
Secondly, the interviewers can provide some background and statistical figures showing that Asians are under-utilising ACC services. For example, only 3% of the ACC claimants are Asians while around 7% of the national population are Asians.
Thirdly, inform participant(s) that this research attempts to identify and evaluate the barriers preventing Asians accessing injury related services.
Fourthly, inform participant(s) that the research results may also help ACC to improve their services to Asian populations.
Lastly, inform participant(s) that the success of this research depends on their involvement and sharing their experiences. Therefore their opinions will be much appreciated.

The following is an example of what could be said:

Thank you for taking part in this study. As we know, ACC provides services for accident injuries to NZ residents. However, their data show that out of 7% of Asian people in New Zealand only 3% of the claimants are Asians. Given this under-utilisation of ACC services by Asian communities, we would now like to identify and evaluate barriers to Asian people accessing injury related services and entitlements. It is also important for ACC to know this information so that they may provide appropriate services to their Asian clients in NZ.

Introductions
-Ground rules: confidentiality, anonymity, note taking and use of data, optional audio-taping
-You are invited to comment on and answer the questions asked, and please feel free to tell us anything you would like to share. The responses are voluntary; you may withdraw from the question anytime.
(At this point, the participants must sign the Consent Form to proceed further)

Discussion
The individual interview guidelines will be in four parts. In part one, the semi-structured interview begins with questions regarding the general information of the participant. In part two, the interview proceeds with the participant's understanding of injuries and accidents specific to their cultural background. Part three examines the participant's experiences and/or perception about barriers, knowledge of services provided by ACC and relevance of services to Asian claimants. The fourth part contains questions about the individual's opinion on "moving forward": what can be done to improve Asian peoples' accessing injury-related services and entitlements.
The following topics are developed as a general guide to facilitate the discussion.

Part ONE
- **Verify the participant's general information**
    - Name
    - Age
    - Gender
    - Contacts – includes physical address, phone numbers, fax numbers and E-mails
    - How long you have been in NZ
    - Profession

Part TWO
- **Observations**

- What type of injuries or accidents have become a serious health issue in your community? How do they compare with other ethnic communities?
- Where does your community normally seek help after they have had an injury or accident?
- Please explain why they choose to seek help from those places referred to in the previous question?
- How do you think would the perceptions and experiences of injury related services of your community differ from Kiwis? Please explain why they are different or similar.

Part THREE

- **Barriers and access issues:**
  - Please briefly describe how people from your community make decisions in making ACC claims?
  - What are the difficulties that people from your community face when making ACC claims?

  Prompt:
  - *Personal – language, value, attitude, type of injury…etc*
  - *Practical – transportation, can't afford a GP visit…etc*
  - *Environmental – lack of understanding of the ACC system, services provided…etc*
  - *Institutional – unhelpful attitudes towards Asian people, lack of focus on Asian people…etc.*

- **Participant's awareness and knowledge of services provided by ACC**
  - Was there any community awareness program conducted in your community to discuss injuries/accidents and their related health services? If so, please describe the community responses and the details of such programmes or events. How well are these programmes implemented? (Prompt: please refer to newspaper, TV, Radio, and actual community events)
  - How much do you know about ACC services in the following three areas: eligibility, types of services, and claim process? Please indicate your answer on a scale of 5, where 1 is no knowledge at all, 2 is a little knowledge, 3 is average knowledge, 4 is a lot of knowledge, and 5 is knowing everything about ACC. As this is an interview, you do not need to record a number as you have done below; just the response e.g "a little knowledge" etc. will be recorded on the tape.
    - Eligibility to make an ACC claim – _____
    - Types of services provided by ACC – _____
    - The claim process – _____
    - Services for special population (eg. Sexual abuse victims).

- **Participant's opinions on relevance of ACC services to Asian claimants**
  - How has the health need of your community being met by the ACC services?
  - Please identify the gaps between the ACC services provided and the expectation from your community.
  - How has or has not the services being provided appropriately to your culture and traditional beliefs.

Part FOUR

- **Moving forward**
  - What should be the role of the Asian community be in improving ACC services and uptake rates for the community in the future?
  - Who do you think the ACC should be working with to improve your community access to their services, and why?

- If there is one thing that ACC can change to improve its services to your community, which do you prefer and why?
- How would you like the results of this research to be disseminated across your community?

Appendix 5d
Guidelines for Individual Interviews
(Case Managers)

Preamble
The preamble can be presented as the interviewers wish. However, the following 5 points must be made clear to the participant(s). The exact wording delivered may vary depending on the language level of the participants:

Firstly, thank the participant(s) for coming to the interview.
Secondly, the interviewers can provide some background and statistical figures showing that Asians are under-utilising ACC services. For example, only 3% of the ACC claimants are Asians while around 7% of the national population are Asians.
Thirdly, inform participant(s) that this research attempts to identify and evaluate the barriers preventing Asians accessing injury related services.
Fourthly, inform participant(s) that the research results may also help ACC to improve their services to Asian populations.
Lastly, inform participant(s) that the success of this research depends on their involvement and sharing their experiences. Therefore their opinions will be much appreciated.

The following is an example of what could be said:

Thank you for taking part in this study. As we know, ACC provides services for accident injuries to NZ residents. However, their data show that out of 7% of Asian people in New Zealand only 3% of the claimants are Asians. Given this under-utilisation of ACC services by Asian communities, we would now like to identify and evaluate barriers to Asian people accessing injury related services and entitlements. It is also important for ACC to know this information so that they may provide appropriate services to their Asian clients in NZ.

Introductions
-Ground rules: confidentiality, anonymity, note taking and use of data, optional audio-taping
-You are invited to comment on and answer the questions asked, and please feel free to tell us anything you would like to share. The responses are voluntary; you may withdraw from the question anytime.
(At this point, the participants must sign the Consent Form to proceed further)

Discussion
The individual interview guidelines will be in four parts. In part one, the semi-structured interview begins with questions regarding the general information of the participant. In part two, the interview proceeds with the participant's understanding of injuries and accidents specific to their cultural background. Part three examines the participant's experiences and/or perception about barriers, knowledge of services provided by ACC and relevance of services to Asian claimants. The fourth part contains questions about the individual's opinion on "moving forward": what can be done to improve Asian peoples' accessing injury-related services and entitlements.
The following topics are developed as a general guide to facilitate the discussion.

Part ONE
- **Verify the participant's general information**
    - Name of the Case Manager
    - Contacts of the practice– includes physical address, phone numbers, fax numbers and E-mails
    - How long you have been in practice?
    - What dialects can you speak?
    - What percentage of your clients are Asian (e.g. Indian, Chinese)?

Part TWO
- **Observations**
    - Please briefly describe the services provided by you as case manager?

- Please briefly describe how you will assist your clients in accessing ACC related services.
- How do you think may your Asian clients' perception and experience of injury related services differ from Kiwis? Please explain why they are different or similar.

Part THREE

- **Barriers and access issues:**
  - Why do you think would Asians prefer to go to an Asian case manager than Westerner case manager?
  - What are the barriers that you think may prevent your Asian clients or potential Asian clients coming toward you?

  Prompt:
    - *Personal – language, value, attitude, type of injury…etc.*
    - *Practical – transportation, can't afford a GP visit…etc.*
    - *Environmental – lack of understanding of the ACC system, services provided…etc.*
    - *Institutional – unhelpful attitudes towards Asian* ***people, lack of focus on Asian people…etc.***

  - What are the barriers that prevent you from managing your Asian clients' cases?

  Prompt:
    - *Personal – language, value, attitude, type of injury…etc.*
    - *Practical – transportation, can't afford a GP visit…etc.*
    - *Environmental – lack of understanding of the ACC system, services provided…etc.*
    - *Institutional – unhelpful attitudes towards Asian people, lack of focus on Asian people…etc.*
    -

- **Participant's awareness and knowledge of services provided by ACC**
  - Have you ever taken any collective initiative to inform the Asian community about ACC services? If so, can you briefly describe the program and the responses from the community? (Prompt: please refer to newspaper, TV, Radio, and actual community events)
  - How much do you think do your clients know about the ACC services in the following three areas: eligibility, types of services, and claim process? Please indicate your answer on a scale of 5, where 1 is no knowledge at all, 2 is a little knowledge, 3 is average knowledge, 4 is a lot of knowledge, and 5 is knowing everything about ACC.

    - Eligibility to make ACC claim – _____
    - Type of services provided by ACC – _____
    - The claim process – _____
    - Services for special population (eg. Sexual abuse victims).

- **Participant's opinions on relevance of ACC services to Asian claimants**
  - How are your clients' needs being met by ACC services?
  - Please identify the gaps between the ACC services provided and the expectations of your clients.
  - Are ACC services provided to Asians appropriately adjusted to their cultural and traditional values? Give examples please.
  - Do you think ACC is a fair and equal service in terms of providing injury related services to everyone in NZ?

Part FOUR

- **Moving forward**

- Who do you think should ACC be working with to improve your clients' access to your services, and why?
- If there is one thing that ACC can change to improve its services to Asians, what would this be and why?
- How would you like the results of this research to be disseminated across your working community?

Appendix 5e
Guidelines for Individual Interviews
(Claimants)

Preamble
The preamble can be presented as the interviewers wish. However, the following 5 points must be made clear to the participant(s). The exact wording delivered may vary depending on the language level of the participants:

Firstly, thank the participant(s) for coming to the interview.
Secondly, the interviewers can provide some background and statistical figures showing that Asians are under-utilising ACC services. For example, only 3% of the ACC claimants are Asians while around 7% of the national population are Asians.
Thirdly, inform participant(s) that this research attempts to identify and evaluate the barriers preventing Asians accessing injury related services.
Fourthly, inform participant(s) that the research results may also help ACC to improve their services to Asian populations.
Lastly, inform participant(s) that the success of this research depends on their involvement and sharing their experiences. Therefore their opinions will be much appreciated.

The following is an example of what could be said:

Thank you for taking part in this study. As we know, ACC provides services for accident injuries to NZ residents. However, their data show that out of 7% of Asian people in New Zealand only 3% of the claimants are Asians. Given this under-utilisation of ACC services by Asian communities, we would now like to identify and evaluate barriers to Asian people accessing injury related services and entitlements. It is also important for ACC to know this information so that they may provide appropriate services to their Asian clients in NZ.

Introductions
-Ground rules: confidentiality, anonymity, note taking and use of data, optional audio-taping
-You are invited to comment on and answer the questions asked, and please feel free to tell us anything you would like to share. The responses are voluntary; you may withdraw from the question anytime.
(At this point, the participants must sign the Consent Form to proceed further)

Discussion
The individual interview guidelines will be in four parts. In part one, the semi-structured interview begins with questions regarding the general information of the participant. In part two, the interview proceeds with the participant's understanding of injuries and accidents specific to their cultural background. Part three examines the participant's experiences and/or perception about barriers, knowledge of services provided by ACC and relevance of services to Asian claimants. The fourth part contains questions about the individual's opinion on "moving forward": what can be done to improve Asian peoples' accessing injury-related services and entitlements.
The following topics are developed as a general guide to facilitate the discussion.

Part ONE
- **Verify the participant's general information**
    - Name
    - Contacts – includes physical address, phone numbers, fax numbers and E-mails
    - How long have you been in NZ?

Part TWO
- **Personal experiences**
    - Please briefly describe your last injury that required medical attention?
    - Did you go to a traditional practitioner or GP? Please tell me what made you choose that practice?

- Please briefly describe the type of services that were provided by the Practitioners you visited. Please comment on your experience of that service.
- Please describe what type of ACC services you used in the last injury?
- Does your behaviour in seeking treatments after injuries or accidents differ from what you did in your birth place or country of origin? Why or why not?
- How do you think may your perceptions and experiences to injury related services differ from Kiwis? Please explain why they are different from or similar to you.

Part THREE

- **Barriers and access issues:**
  - Please briefly describe what factors influence you to make an ACC claim.
  - Why would you not make an ACC claim when you are injured or had an accident?
  - Why do you think would other Asians not claim ACC services in the event of injuries and accidents?

  Prompt:
    - *Personal – language, value, attitude…etc*
    - *Practical – transportation, can't afford a GP visit…etc*
    - *Environmental – lack of understanding of the ACC system, services provided…etc*
    - *Institutional – unhelpful attitudes towards Asian people, lack of focus on Asian people…etc.*

  - How have your family members or friends affected your decision in seeking ACC claims?

- **Participant's awareness and knowledge of services provided by ACC**
  - Where, when, and how did you first come across the term ACC and services provided by ACC?
  - Was there any community awareness program conducted in your community to introduce the injury/accidents, and their related health services? If so, please describe the community responses and the details of such programmes or events. (Prompt: please refer to newspaper, TV, Radio, and actual community events)
  - Referring to the previous question, please explain how well you think these programmes are in meeting your needs.
  - How much do you know about ACC services in the following three areas: eligibility, types of services, and claim process? Please indicate your answer on a scale of 5, where 1 is no knowledge at all, 2 is a little knowledge, 3 is average knowledge, 4 is a lot of knowledge, and 5 is knowing everything about ACC. As this is an interview, you do not need to record a number as you have done below; just the response e.g. "a little knowledge" etc. will be recorded on the tape.
    - Eligibility to make an ACC claim – _____
    - Types of services provided by ACC – _____
    - The claim process – _____
    - Services for special population (eg. Sexual abuse victims).
    - Awareness of ACC infrastructure that assist Asian claimants (e.g. Asian cultural advisors, Language lines…etc)

- **Participant's opinions on relevance of ACC services to Asian claimants**
  - How have your needs been met by ACC services?
  - What are the ACC services that you felt satisfied with?
  - What are the gaps between the services ACC provided and your expectation?

- When you were being treated by ACC services, do you think the services provided were appropriate to your Asian culture, background and traditional beliefs? Please describe.

Part FOUR

- **Moving forward**
  - Who do you think should ACC be working with to improve ACC awareness in your community?
  - What could be done to increase the ACC uptake rates for Asian people?
  - If there is one thing that ACC can change to improve its services to your community, what should this be and why?
  - Is there any feedback mechanism you are aware of (e.g. case manager or complaint lines)? Please explain why you have or have not used them. What kind of feedback mechanism do you think will work for you?
  - How would you like the results of this research to be disseminated across your community?

Appendix 6
Guidelines for Focus Groups (Claimants and Non-claimants)

Preamble
The preamble can be presented as the interviewers wish. However, the following 5 points must be made clear to the participant(s). The exact wording delivered may vary depending on the language level of the participants:

Firstly, thank the participant(s) for coming to the interview.
Secondly, the interviewers can provide some background and statistical figures showing that Asians are under-utilising ACC services. For example, only 3% of the ACC claimants are Asians while around 7% of the national population are Asians.
Thirdly, inform participant(s) that this research attempts to identify and evaluate the barriers preventing Asians accessing injury related services.
Fourthly, inform participant(s) that the research results may also help ACC to improve their services to Asian populations.
Lastly, inform participant(s) that the success of this research depends on their involvement and sharing their experiences. Therefore their opinions will be much appreciated.

The following is an example of what could be said:

Thank you for taking part in this study. As we know, ACC provides services for accident injuries to NZ residents. However, their data show that out of 7% of Asian people in New Zealand only 3% of the claimants are Asians. Given this under-utilisation of ACC services by Asian communities, we would now like to identify and evaluate barriers to Asian people accessing injury related services and entitlements. It is also important for ACC to know this information so that they may provide appropriate services to their Asian clients in NZ.

Introduction
-Ground rules – confidentiality, note taking and use of data, optional audio-taping

- Understanding and commitment to consent sheet.
- Understanding as research project not practice audit.
- Be courteous and respectful of colleagues' opinions.
- Maintain respect and confidentiality of all service users – attempt to reflect on process rather than content.
- Although this is a 'participatory process in knowledge building', it is acceptable to pass occasionally.
- One person speaking at a time.
- Omission of all names when reporting the findings.

-You are invited to make comments to the questions asked, but please do not feel you are under any pressure to tell us anything you do not wish to disclose in the group

Discussion
The following topics are developed as a general guide to facilitate the discussion.

Part ONE

- **Using the vignettes to identify when the participants will decide to access ACC related services in terms of the seriousness of the accidents or injuries.**
    - Go through each of the scenarios and ask how many of the participants will access ACC related services in that scenario and why.

Part TWO

- **Asian peoples' worldviews on injuries, accidents, seeking treatment or otherwise and how these differ from "mainstream" views**
    - How does your community perceive injuries and accidents? What type of injuries or accidents is considered as a serious issue in your community? Please explain.
    - Do people from your community behave differently in seeking treatments after injuries/accidents from the way they did in their country of origin? Why and why not?

Part THREE

Barriers and access issues:

- What are the reasons why people from your community do not access or claim ACC services in the event of injuries and accidents?

Prompt 1:

- *Personal – language, value, attitude…etc*
- *Practical – transportation, can't afford a GP visit…etc.*
- *Environmental – lack of understanding of the ACC system, services provided…etc.*
- *Institutional – unhelpful attitudes towards Asian people, lack of focus on Asian people…etc.*

Prompt 2:

- *Please rank the above factors in terms of their effects on your community*

- Please share examples that show that the services provided by ACC are user-friendly; and not so user-friendly.

- **Awareness and knowledge of services provided by ACC**
    - Where have you heard/learned about ACC and/or services provided by ACC?
    - Please discuss the following issues:
        - The eligibility of ACC services
        - The type of services provided by ACC
        - The process of making an ACC claim.

      Prompt 1: participants need to discuss these issues based on their knowledge and experiences.

      Prompt 2: participants need to rank these issues in terms of how well they understand them.
- **Relevance of ACC services to Asian claimants**
    - Please discuss the general level of satisfaction with ACC's services.
    - Please discuss the gaps in ACC's services from Asian people's point of view.
    - Please comment on the appropriateness and effectiveness of current ACC communications.
    - How are the health needs of the community being met by ACC services?

Part FOUR

- **Moving forward**
    - What do you think can the communities do in the future to help Asians access ACC services?

- Whom do you think should ACC be working with to improve access to ACC services for your community, and why?
- If there is one thing that you can do to change the ACC system to improve their services, what would that be?

Both ACC and non-ACC service user groups will cover all the above questions. The user groups will have special emphasis on the "Awareness and knowledge of services provided by ACC" and "Relevance of ACC services to Asian claimants" whereas the non-service user groups will tend to examine the "Barriers and issues" and "Awareness and knowledge of services provided by ACC" items closely.

Appendix 7
TABLE OF PERCEPTIONS FOR CLAIMANT GROUP

Question	Chinese	Indian	Korean	SE Asian
1. Personal characteristics as barriers:				
Age	Older people face a language problem, so cannot communicate – this is a huge barrier to access	Some older people face a language and transport problem – barrier Attitude- they don't want to be seen as begging, so won't make claims.	Older people face a language problem – barrier to accessing services. Young are informed	Older people face a language and transport problem; don't want to be seen as taking welfare – barrier to accessing services.
Gender	Don't believe this has any effect on their ability to access services	Old (Punjabi) ladies have language & transport difficulties – don't drive.	No effect	No effect
English lang. competence	Huge impact – acts as barrier in several ways: lack of communication, misunderstanding etc.	Most Indians speak English well – generally have no communication problems, but accent issues	Same as Chinese	Same as Chinese
Injury-related lang. competence	Incompetent - No direct translation, no synonyms in their language, so cannot make themselves understood.	Same as Chinese, despite their general English language competence – cannot explain injuries adequately.	Same as Chinese	Same as Chinese
Cultural Health beliefs (worldviews) re: injuries, accidents and pain	Prefer self-diagnosis and home remedies for smaller injuries	Same as Chinese Bear pain and don't make an issue of it.	Traffic injuries serious Home injury- not so serious – home remedy. Over the counter advice & medicine	Attending doctor is sign of weakness Visit GP if: loss of blood, Chronic illness, Broken bones.
Determinants of help-seeking behaviour: Sources of help, Why sought, Who decides, Reasons for sequencing,	Preferred/traditional course of action: 1. self-diagnose and medicate with home remedies, 2. TP, 3. GP. Some younger people prefer to go straight to the GP rather than	Same as Chinese, but: 1.Self, 2.GP, 3.TP. Prefer TP to GP, but go to GP because they are covered by ACC and TPs are not. Younger prefer GP. Young make decision for older	1.Self, 2.GP, 3.TP Backaches type pain- TP first. If serious, GP. Husband decides for wife. Prefer private GPs - speak same language. Prefer specialist care	1.Self-diag and home remedy; 2. GP. No TPs in their communities. Family helps make decisions on where to go. Prefer private doctors who

Willingness to seek help from private and public health services	the TP. Go to GP for referral to TP. Family helps make decisions. Prefer private GP who speaks own language	family members, husband for wife. Prefer private GP- speaks same language. Go to public system only because of cost.	as in Korea where there is no GP system.	speak their own language, but few available.
2. Logistical and environmental factors:				
• Costs of services	Cost is a problem. Money influences decision on what service to access.	Problem. Money influences decision. Community services card holders use more services. Language barriers to applying for Com card.	Cost is a problem, but language more than money influences decision to access health service.	Problem. Money determines whether they will visit a doctor.
• Transport to services	Sometimes a problem – circumstantial – older folk and those of lower SES	Problem for females and older folk who cannot drive, but family helps	Not a problem	Yes – females and older folk, but get help from family
• Availability of services at different times	Waiting times are a problem, esp. for working group. After hours services cost more, so act as barrier.	Same as Chinese, but depends on who is injured, e.g. children are more imp.	Waiting times are a problem, esp. for working group. After hours – additional costs.	Waiting times are a problem, esp. for working group. After hours – additional costs.
• Child care	Not a problem – family support.	Not a problem – family support.	Not a problem – family support.	Not a problem – family support.
• Promotion of ACC services	Yes, this is a big barrier -don't know much about ACC	Yes – same as Chinese	Yes– same as Chinese	Yes– same as Chinese
• Other matters	ACC should focus more on Asians now that their numbers have increased. Perceived discrimination	Perceived discrimination in the agency.	Perceived prejudice and discrimination in the agency.	Perceived discrimination in the agency. Expect uniform attention for all ethnic groups.
3. Institutional factors:				
• Knowledge about ACC	Not enough-inadequate or nothing in some cases	Not enough – same as Chinese	Not enough – same as Chinese	Not enough– same as Chinese
• Sources of information	Not enough Some from family and friends, some from doctor.	Not enough Same as Chinese	Not enough Same as Chinese	Not enough Same as Chinese
• For claimants -Feelings about their contacts with	Mixed – depending on outcomes.	Score: 1-5/10 Depends on level of knowledge,	7-8/10 – positive, but lack of translation and	More positive. They don't have any

ACC – positive, negative		benefit and communication with ACC	interpretation service and complicated system are negative aspects.	expectation as they never had such services back at home.
4. What can ACC do to help Asians overcome difficulties and barriers?				
• *Institutional barriers* to knowledge about the service	Provide knowledge about ACC, translation and interpretation services, information in Asian languages.	Same as for Chinese	Same as for Chinese	Same as for Chinese
• *Cultural barriers* caused by differences in beliefs about injury, its meaning and treatment	Employ more ethnic minority case workers and other service providers who understand different worldviews to prevent unsatisfactory communication between Asian clients and case workers, which leads to misunderstanding and unsatisfactory outcomes for both parties. Train both their staff and practitioners to be more culturally aware of the different needs in different ethnic groups.	Same as for Chinese	Same as for Chinese	Same as for Chinese
5. Other:				
-What can the community do to improve their access	More communication between ACC and the community	More communication between ACC and the community	More communication between ACC and the community	More communication between ACC and the community
-Community representative – entry point?	Cultural organisations and events, media, community leaders	Cultural organisations and events, media. Definitely not religious and community leaders	Cultural organisations and events, media + church, community leaders	Cultural organisations and events, media + church and temple.

Appendix 8
TABLE OF PERCEPTIONS FOR NON-CLAIMANT GROUP

Question	Chinese	Indian	Korean	SE Asian	South Asian
1. Personal characteristics as barriers:					
Age	Older – language problem, more vulnerable to injuries, afraid of doctors-needles, unaware of systems	Older people face language problem Attitude- don't want to be seen as begging	Don't think age is a barrier, except for language.	Language problem. Older more vulnerable to injuries, afraid of doctors-needles, don't want to be seen as begging.	Older-older attitudes like Indians. Older-negative on ACC. Some may have lang. problems
Gender	No effect	Old (Punjabi) ladies have language & transport difficulties	Gender makes no difference	Gender makes no difference	No difference in gender
English lang. competence	Language problems - Huge impact – acts as barrier - lack of communication, misunderstanding etc.	No language problem except some older women –Punjabi. Some accent issues.	Huge impact – same as Chinese	Language problems – same as Chinese	No language problem
Injury-related lang. competence	Difficulty with this. Doctors from own community make it easy to communicate, but problems in communicating with ACC	Speak Eng., but medical language is a problem, so prefer doctors from own community which makes communication easier	Same as Chinese because no direct translation, no synonyms in their language	No doctors from own community, so difficult to communicate with others	Same as Indians
Cultural Health beliefs (worldviews) re: injuries, accidents and pain	Health is not 1st priority. Prefer self-diagnosis and home remedies for smaller injuries	Health is not 1st priority, except for children. Try to cope with pain.	Health is not 1st priority. Children's injuries are serious. Bone-related injuries are serious	Health is not 1st priority. Try to cope with pain	Health is not 1st priority. Try to cope with pain. Educated are health conscious
Determinants of help-seeking behaviour: Sources of help, Why sought,	1. self, 2. TP 3. GP Older goes to TP or GP, Younger-GP Seek help from GP who	1. self, 2. GP 3. TP (but prefer TP to GP) Older follow traditional health path. Prefer TP but	1.Self, 2.GP, 3.TP Husband decides for wife	1.Self, 2.GP, 3.TP Older follow traditional health path. Prefer to bring in	1.Self, 2.GP, 3.TP Older follow traditional health path. Prefer to bring in

Who decides, Reasons for sequencing, Willingness to seek help from private and public health services	speaks own language. Int'l students-have insurance-visit GP very often. Prefer to bring in medicines from home country. Economics and education decide	forced to go to GP because of cost – TP not covered by ACC. Prefer to bring in medicines from home country. Economics and education decide. Family support- husband decides for wife.	Prefer private-for faster service. Prefer to bring in medicines from home country. Family support – younger members have familiarity with system	medicines from home country. Economics and education decide. Family support – younger members have familiarity with system	medicines from home. Family support – younger members have familiarity with system
2. Logistical and environmental factors:					
• Costs of services	Problem. Money influences decision unless they have Community Services Card. Limited English may impede access to card. Community Card. ACC Compensation versus income is a consideration.	Problem. Money influences decision unless they have Community Card. Community Card. ACC Compensation versus income is a consideration.	Problem. Money influences decision Community Card. ACC Compensation versus income is a consideration.	Problem. Money influences decision unless they have Community Card. ACC Compensation versus income is a consideration.	Problem. Money influences decision unless they have Community Card. Community Card. ACC Compensation versus income is a consideration.
• Transport to services	Problem for some people, depending on circumstances	Problem for older folk and women who do not drive	No problem, but feel bothered about driving to doctor if injuries are minor, so don't go.	Problem for older folk and women who do not drive	Problem for older folk and women who do not drive
• Availability of services at different times	Times at which public services are available is a problem, especially for working people. Not private GP. Waiting times for services also problem.	Same as Chinese	Same as Chinese	Same as Chinese	Same as Chinese
• Child care	Not a problem – family support	Not a problem – family support	Not a problem – family helps	Family helps with child care	Not a problem – family helps

• Promotion of ACC services	Yes, this is a big barrier -don't know much about ACC	Yes, a problem – don't know about application process.	Yes, this is a big barrier -don't know about ACC	Yes, a problem	Yes, a problem
• Other matters	Problems for hosp & ACC (Tele prompt). Because of communication believe ACC is a Pakeha oriented organisation (some) Preferential treatment (discrimination)	Problems for hosp & ACC (Tele prompt). Preferential treatment (discrimination) Because of communication believe ACC is a Pakeha oriented organisation (some). no such system in home country.	Problems for hosp & ACC (Tele prompt). Because of communication believe ACC is a Pakeha oriented organisation (some) Preferential treatment (discrimination)	Problems for hosp & ACC (Tele prompt). Preferential treatment (discrimination) Because of communication believe ACC is a Pakeha oriented organisation (some)	Problems for hosp & ACC (Tele prompt). Preferential treatment (discrimination) Because of communication believe ACC is a Pakeha oriented organisation (some). no such system in home country.
3. Institutional factors:					
• Knowledge about ACC	Not enough, sometimes nothing.	Same as Chinese	Same as Chinese	Same as Chinese	Same as Chinese
• Sources of information	Not enough – family and friends	Same as Chinese	Same as Chinese	Same as Chinese	Same as Chinese
• For non-claimants - What features of ACC services contributed to decision to not seek assistance?	ACC claims may affect employment prospects (employers ask on ACC claims status)	ACC claims may affect employment prospects (employers ask on ACC claims status)	ACC claims may affect employment prospects (employers ask on ACC claims status)	ACC claims may affect employment prospects (employers ask on ACC claims status)	ACC claims may affect employment prospects (employers ask on ACC claims status)
4. What can ACC do to help Asians overcome difficulties and barriers?					
• *Institutional barriers* to knowledge about the service	Promote ACC Provide more knowledge about ACC Make ACC application form simpler	promote ACC. Provide more knowledge about ACC Make ACC application form simpler	Provide more knowledge about ACC Make ACC application form simpler	promote ACC. Provide more knowledge about ACC Make ACC application form simpler	promote ACC. Provide more knowledge about ACC Make ACC application form simpler
• *Cultural barriers* caused by differences in	Employ more Asian case workers who understand	More Asian case managers.	Employ more ethnic minority case workers	More Asian case managers. Employ more	More Asian case managers.

beliefs about injury, its meaning and treatment	different worldviews	Employ more ethnic minority case workers who understand different worldviews	who understand different worldviews	ethnic minority case workers who understand different worldviews	Employ more ethnic minority case workers who understand different worldviews
5. Other:					
-What can the community do to improve their access	More communication between the community and ACC	More communication between the community and ACC	More communication between the community and ACC	More communication between the community and ACC	More communication between the community and ACC
-Community representative – entry point?	Cultural organisations and events, media, community leaders	Cultural organisations and events, media. Definitely not religious and community leaders	Cultural organisations Ethnic media, Church, Korean Society	Cultural organisations and events, media, church, temple	Cultural organisations and events, media, church, temple

Appendix 9
TABLE OF PERCEPTIONS FOR GENERAL PRACTITIONERS

Question	Chinese=1	Indian=1	Korean=1
1. Personal characteristics as barriers:			
Age of patients	Older experience difficulties (language, transport)	Older experience difficulties (language, transport)	Older experience difficulties (language, transport)
English lang. competence	Eng. lang. a major problem. Patients come to them because of this. Avoid other doctors.	Doctors available who speak the same language and from the same ethnic groups. Although Indians speak Eng. they prefer to go to own doctors.	Patients prefer doctors who speak their language; doctors reluctant to refer them to specialists as they wouldn't be able to speak Eng. with the specialists.
Injury-related lang. competence	No injury-related language. Doctors from own community make it easy to communicate, but problems in communicating with ACC	Injury-related language a problem despite general English proficiency, so prefer doctors from own community which makes communication about injuries easier	Not competent. Misunderstanding with other GPs which leads to incorrect diagnoses and medication. Go to ethnic GPs to confirm medicine & diagnosis
Cultural Health beliefs (world views) re: injuries, accidents and pain	Health is not 1st priority. Prefer self-diagnosis and home remedies for smaller injuries. Put up with pain.	Health is not 1st priority, except for children. Making ends meet is more important, so cope with health issues.	Health is not 1st priority. Children's injuries are considered serious because of possible after-effects. Bone-related injuries are serious, cope with others.
Determinants of help-seeking behaviour: Sources of help, Why sought, Who decides, sequencing, private and public	1.Self-med & diagnosis, 2.GP, 3.TP – want the GP to refer them to TP Shop around – could sometimes go to TP first Don't explain much about ACC to patients due to time constraint.	1.Self-med; 2.Prefer TP (older); 3.Older go to GP later as TPs are not covered by ACC; Younger prefer GP; Time-consuming, complicated, too much paper work. ACC pays too little. Patients influenced by patient - doctor relationship – take advice from doctor.	1.Self-med & diagnosis, 2.GP, 3.TP No GP system in Korea: would prefer to go to specialist first (like in Korea) Forced to go to GP for referral to specialists. Prefer to make decisions individually.
2. Logistical and environmental factors:			
• Costs of services	Cost is problem Family-oriented, so help with this.	Cost is problem Family-oriented so help family members.	Misunderstanding – ACC services are free. Complain about cost, but still visit doctors.

• Transport to services	Yes – linked to age	No- get help from family	No problem
• Promotion of ACC services	ACC's responsibility to explain about the service to the clients. Media – better way In-depth information required in own ethnic language	ACC's responsibility to promote their services to clients Media – cultural gatherings Information in own ethnic language	ACC's responsibility to promote services Media and seminars helpful Information in own ethnic language
• Other matters	SES – not all families are wealthy. Don't know much about ACC subsidised services. Older families help extended family New/Young immigrants are wealthy	Health is not 1st priority Money earning and saving is priority. Financial responsibility for family back in home country so money is a problem – don't visit doctor unnecessarily	Many appear to be usually wealthier than other groups Many international students who have medical insurance, so not concerned with ACC.
3. Institutional factors:			
• Knowledge about ACC	Not enough on patients' part. Doctors may have sufficient knowledge.	Not enough on patients' part. Doctors may have sufficient knowledge.	Not enough on patients' part. Doctors may have sufficient knowledge.
• Sources of information	Doctors get their information from ACC	ACC	ACC
4. What can ACC do to help Asians overcome difficulties and barriers?			
• *Institutional barriers* to knowledge about the service	Need to actively promote themselves and provide information.	Need to actively promote themselves and provide information.	Need to actively promote themselves and provide information.
• *Cultural barriers* caused by diffs in beliefs about injury, its meaning and treatment	Have ethnic minority service providers. Culture must not have any influence on services – equal standard of service.	More ethnic minority service providers.	Have ethnic minority service providers. Doctors should give same importance and cultural sensitivity to all ethnic groups.
5. Other:			
-What can the community do to improve their access	ACC info should by delivered to the community by the community	ACC info should by delivered to the community by the community	ACC info should by delivered to the community by the community
-Community representative – entry point?	Community group/leader	Cultural organisations and events, media, religious and community leaders	Ethnic media, Church, Korean Society

Appendix 10
TABLE OF PERCEPTIONS FOR TRADITIONAL PRACTITIONERS

Question	**Chinese = 1**	**Indian = 2**
1. Personal characteristics as barriers:		
Age of patients	Older experience difficulties (language, transport)	Older experience difficulties (language, transport)
English lang. competence	Huge language problem which acts as a barrier to accessing services. Patients come to them because they can be easily understood and are comfortable with them.	No lang. problem (except some old folk). TPs available who speak the same language and from the same ethnic groups. Although Indians speak Eng. they prefer to go to own traditional doctors as they are comfortable with them.
Injury-related lang. competence	Have problems explaining, but doctors from own community makes it easy to communicate. Problems in communicating with ACC	Not competent with injury-related language, so see doctors from own community which makes communication easier.
Cultural Health beliefs (world views) re: injuries, accidents and pain	Health is not a priority. Prefer self-diagnosis and home remedies for smaller injuries	Health is not a priority, except for children. Diagnose and treat themselves before going to doctor. Cope with pain.
Determinants of help-seeking behaviour: Sources of help, Why sought, Who decides, Reasons for sequencing	1.Self-diagnosis and medication, 2.GP, 3.TP. Go to GP as they want the GP to refer them to TP. Shop around – could sometimes go to TP first	1.Self-diagnose and medicate 2/3.Older people prefer TP – go to TP first, but go to GP later as TPs are not covered by ACC. Younger go to GP first.
2. Logistical and environmental factors:		
• Costs of services	Cost is a problem, but weigh this against loss of time. Know about ACC subsidised services, but don't know that only acupuncture is covered and that they need referral from GP – additional cost.	TP says cost should not be a problem – system covers that. However, ayurvedic doctor is not covered by ACC. Is there some misunderstanding here?
• Transport to services	Yes – older people have problems	TPs don't perceive this as a problem as older folk get help from family (but family perceives this as a problem)
• Time	Time is a major issue – no time for waiting for doctors and for claims process. Most Asians work long hours and avoid taking time off work.	Same as for Chinese.
• Promotion of ACC	ACC's responsibility, but TP tries to help clients.	ACC's responsibility to promote services in own ethnic

services	Media – better way In-depth information and more services required	language; more services required Media – cultural gatherings
• Other matters	Older families help extended family New/Young immigrants are wealthy	Health is not 1st priority. Money earning and saving is priority. Financial responsibility for family back in home country so money is a problem – don't visit doctor/TP unnecessarily
3. Institutional factors:		
• Knowledge about ACC	Knows about ACC as they are involved, but believes it is ACC's responsibility to explain about the service to the clients.	Don't know much about how ACC works as they are not involved
4. What can ACC do to help Asians overcome difficulties and barriers?		
• *Institutional barriers* to knowledge about the service	They do know some of the rules governing ACC services, but ACC needs to promote themselves more – language is a barrier.	They do not know the rules governing ACC services. ACC needs to promote themselves more.
• *Cultural barriers* caused by diffs in beliefs about injury, meaning, treatment	More ethnic minority service providers will eliminate misunderstanding	More ethnic minority service providers will eliminate misunderstanding.
5. Other:		
What can community do to improve access	ACC information should by delivered to the community by the community	ACC information should by delivered to the community by the community
Community rep – entry point?	Community group/leader	Cultural organisations and events, media, religious and community leaders
Other information	Acupuncturists should have the same rights as GPs – should not need a referral from GP – they are under the impression that they need this. ACC only allows them to treat one patient at a time – not a few simultaneously. This reduces the number of patients they can see and their income. GPs are also allowed to do acupuncture. This is a specialised field and GPs do not have sufficient knowledge – only superficial, so should not provide this service. Only TPs have specialised knowledge. GPs don't refer patients to them – do it themselves, so their income is declining.	Ayurvedic practitioners don't do a quick fix job and treat the symptoms as GPs do – they treat the root of the problem and provide a holistic service – even counselling, but they are not covered by ACC. WINS advises their clients to visit them and covers their expenses, so why doesn't ACC? 90% of their clients are Pakeha, which demonstrates that their service is valued – not just a cultural service for Indians. They need to be included in ACC

	ACC only recognises acupuncturists registered to 2 associations. Both these are run by westerners – no non-Westerners on boards – do not understand requirements etc. Asian association not recognised – cannot claim from ACC.	

Appendix 11
TABLE OF PERCEPTIONS FOR COMMUNITY LEADERS

Question	Chinese=1	Indian=1	Korean=1
1. Personal characteristics as barriers:			
Age of patients	Older experience difficulties (language, transport)	Older experience difficulties (language, transport) Elderly and women are sometimes neglected – women sacrifice themselves for family	Older experience difficulties (language, transport)
Gender	No effect	Women are neglected – as above. Some women (especially older Punjabi ladies) also have language & transport difficulties as many do not drive	No effect
English lang. competence	Problem for many, but many go to Chinese speaking doctors and TPs. Even if doctors do not speak the same language, patients go to Chinese doctor because of ethnicity and understanding.	Not a problem as speak English well. Doctors and TPs available who speak the same language and from the same ethnic groups. Although Indians speak Eng. they prefer to go to own doctors.	Lack of English competence has a huge impact, so prefer to go to Korean doctors who speak same language.
Injury-related lang. competence	Huge problem, but doctors and TPs from own community who speak same language makes it easy to communicate, but problems in communicating with ACC	Problem with injury-related language, so prefer doctors and TPs from own community which make communication easier	Poor injury-related competence because no direct translation, no synonyms in other languages – huge barrier.
Cultural Health beliefs (world views) re: injuries, accidents and pain	Mainly older people prefer TPs - believe they treat the root of the problem and not just symptoms like GPs – this is inadequate, Expect to get something substantial from doctor including a prescription. If not, no confidence in doctors. Medication too mild – Asians give larger doses and more antibiotics. Kiwi doctors don't do this.	Older people (mainly) – prefer TPs - believe they treat the root of the problem and not just symptoms like GPs. Expect to get something substantial from doctor including a prescription. If not, no confidence in doctors. Medication too mild – Asians give larger doses and more antibiotics. Kiwi doctors don't do this. Women don't usually speak to strangers much, so can't access services.	Expect to get something substantial from doctor including a prescription. If not, no confidence in doctors – medication too mild – Asians give larger doses and more antibiotics. Kiwi doctors don't do this.
Determinants of help-seeking behaviour:	1.Self- diagnosis and medication - home remedies, 2.GP, 3.TP – want the GP to refer	1.Self-diagnose and medicate- home remedies, 2.Prefer TP (older), 3.Older goes to GP later	1.Self- diagnosis and medication - home remedies, 2.GP, 3.TP

Sources of help, Why sought, Who decides, Reasons for sequencing, Willingness to seek help from private and public health services	them to TP. Shop around – could sometimes go to TP first Family doctor is important, but Asians don't usually have a permanent family doctor. If they do, s/he is gatekeeper and makes decisions. Prefer TPs but they don't have right to refer to ACC and are not covered by them, except acupuncture. When they need a certificate, they go to GP.	as TPs are not covered by ACC. Younger prefers GP to TP. Cost influences decision. Family helps decide. Family doctor is important, but Asians don't always have a permanent family doctor. If they do, s/he is gatekeeper and also makes decisions. When they need a certificate, they go to GP.	No GP system in Korea: would prefer to go to specialist first (like in Korea) Forced to go to GP for referral to specialists. Individualist attitude on decision making – don't always depend on family to make decisions. Koreans don't usually have a permanent family doctor.
2. Logistical and environmental factors:			
• Costs of services	Cost is problem – if not covered by ACC, won't go. Know about ACC subsidised services, but don't know that only acupuncture is covered, so find themselves burdened with unexpected cost.	Cost is problem – if not covered by ACC, won't go. Family-oriented so help family members. Financial responsibility for family back in the country so money is a problem – don't visit doctor unnecessarily.	Misunderstanding – ACC services are free - Complain about cost, but still visit doctor. Many are not PR, so think they cannot use services. Many are international students who have medical insurance, so don't use ACC
• Transport to services	Yes – age related, but will find a way	No- get help from family	No problem
• Promotion of ACC services	ACC's responsibility Media – better way In-depth information required	ACC's responsibility Media – cultural gatherings, women's groups; In own ethnic language	ACC's responsibility Media Seminar helpful
• Other matters	Older families help extended family New/Young immigrants are wealthy	Health is not 1st priority Money earning and saving is priority	Appear to be usually wealthier than other groups
3. Institutional factors:			
• Knowledge about ACC	Not enough, sometimes nothing.	Not enough, sometimes nothing.	Not enough, sometimes nothing.
• Sources of information	Not enough – family and friends	Not enough – family and friends	Not enough – family and friends
4. What can ACC do to help Asians overcome difficulties and barriers?			
• *Institutional barriers* to knowledge about the service	Need to actively promote themselves and provide information. Have ethnic minority service providers and translate information into Asian languages. Improve translation	Need to actively promote themselves and provide information. Have ethnic minority service providers and translate information into Asian languages. Improve translation	Need to actively promote themselves and provide information. Have ethnic minority service providers and translate information into Asian languages. Improve translation

	services. Have Asian helpline. Need to have a service especially for Asians – have the word Asian there - as they believe its only for Kiwis	services. Have Asian helpline. Need to have a service especially for Asians – have the word Asian there - as they believe its only for Kiwis	services. Have Asian helpline. Need to have a service especially for Asians – have the word Asian there - as they believe its only for Kiwis
• *Cultural barriers* caused by differences in beliefs about injury, its meaning and treatment	Employ ethnic minority service providers	Employ ethnic minority service providers	Employ ethnic minority service providers
5. Other:			
-What can the community do to improve their access	ACC info should be delivered to the community by the community. Not accustomed to telephone prompts – need to adapt to this system.	ACC info should be delivered to the community by the community. Not accustomed to telephone prompts – need to adapt to this system.	ACC info should be delivered to the community by the community. Not accustomed to telephone prompts – need to adapt to this system.
-Community representative – entry point?	Community group/leader	Cultural organisations and events, media, religious and community leaders.	Ethnic media, Church, Korean Society.

Appendix 12
TABLE OF PERCEPTIONS FOR CASE MANAGERS

Question	**Case Manager 1** (Australian)	**Case Manager 2** (Indian)	**Case Manager 3** (Local Kiwi)
Case Manager background	5 years of experience (Australia, London and NZ). Speaks English and Spanish 10% Asian claimants	Have been in NZ for 12 years. 6 months of ACC experience. Speaks English, Urdu, Hindi and Bengali 10% Asian Claimants	6 months of ACC experience Speaks English only 5% of Asian Claimants Has more dealing with PI and Maori
1. Personal characteristics as barriers:			
Age		Young people are more conversant in English and information gathering. Age (old) is linked with English competency, mobility and transport	
Gender		Indian ladies prefer Indian lady GP.	
English lang. competence	Will employ interpreter with Limited English Proficiency (LEP) claimants. Interpretation complicates the consultation Low quality of language line Better services with face to face interpretation (heard from colleagues)	The more language a case manager speaks, the more it can help them relate to claimants. Prefer to go to Asian GP as a result. Normally claimants come with ad-hoc translator (friends or relatives) Hasn't used language line yet. Found face to face translation useful; however it takes a lot of time to do one session.	Using language line. Needs to know whether or not the doctor speaks in their language to judge whether or not to provide translation there too. Language line is helpful but difficult to manage. Sometimes the translator gives the answer to claimants without consulting with the case managers. Case managers should get training on how to use translator more effectively. Using ACC cultural advisor during face to face meeting.
Injury-related lang. competence		Forms are in English. No direct translation for some injury words.	
Cultural Health beliefs (worldviews) re: injuries, accidents and pain	Acknowledges the differences in health perspective. Asians don't want to talk to the government and don't want to cause 'hassles'.	For Indian, the whole concept of injury is that you have to rest. The family takes care of the patients. Need to understand their needs and values.	Asians don't have the same relationship with case manager due to language. Asian community tends to think their family will look after them after injury

	Acknowledges the difference between Indian and other oriental Asians in values and practices. o Indians are more passive when injured. o Indians prefer to rest after injury rather than engaging in rehabilitation programmes.	Indian male shows sign of weakness for not working and on benefit.	rather than accessing welfare…etc. Acknowledges that each Asian ethnicity is different to one another.
Determinants of help-seeking behaviour: Sources of help, Why sought, Who decides, Reasons for sequencing, Willingness to seek help from private and public health services	Want to handle things by themselves Asians have doubt in the quality of NZ practice and health services, and prefer to go overseas to seek the "best" treatments. Go to Asian practice due to mutual understanding (same perspective), not just language. Asians need to seek help from ACC registered treatment provider. Depends on whether or not they want to seek help from government	They will seek ACC services if they know enough about it. Like self-medication and TP as you don't need prescription. Will go seek doctor or specialist when it gets serious. TP may work for illness but probably not for injury related issues.	Asian can relate better to Asian practitioners and case managers. TP vs GP – preference for TPs.
2. Logistical and environmental factors:			
• Costs of services	This is a problem across abroad. Most GPs are registered with ACC as it is one of their main source of income. The cost is really to do with the pricing system of individual GP.	Don't think cost is a problem. Lack of awareness that GP visits are subsidised is the problem.	More to do with lower SES rather than Asian problem. Differing perceptions towards the cost of GP visit- some see it as an extra cost just for the purpose of getting a medical certificate, rather than a beneficial necessity.
• Transport to services	Not an issue in Auckland.		
3. Institutional factors:			
• Knowledge about	Asians know little about their eligibility.	Awareness; Apprehension	Lack of knowledge

ACC	Scored 1 -2 on average.	Generally scored 2. (however can only comment on claimants. Don't know about the group that never approach ACC).	No Asian country has similar health insurance to ACC Generally very low on knowledge, scored 1 on average.
• Culturally appropriate services?	Paradox situation. On one hand, need to provide culturally appropriate services; on the other hand, the services provided should be the same for everyone. Different perspective makes it difficult to meet their needs.	ACC treats everyone the same. Don't know what is culturally appropriate in treating them. Afraid of doing something inappropriate	The service itself is okay, but need to work on how it is communicated to Asians. Lack of understanding Different perception towards injury services and values.
• Lack of focus on Asian?	ACC tries to treat everyone the same. High volume of work will result in some passive claimants being left behind.		
• Others		Bureaucracy	
4. What can ACC do to help Asians overcome difficulties and barriers?			
• *Institutional barriers* to knowledge about the service	Case managers don't know much about it. Different language access to ACC Should have Asian advertisements - one of the most important barriers that needs to be dealt with.	Advertisement and pamphlet in local language. Website provided in different languages. Help-lines in local languages. TV advertisement in local Asian network.	Going to different Asian communities for presentations and meetings - Like a forum. Brochures in local languages.
• *Cultural barriers* caused by differences in beliefs about injury, its meaning and treatment	Lack of Asian workforce in health sector which makes it hard to recruit Asian case manager. ACC does provide internal staff training - Prefer training rather than guidelines to tell you what to do.	Not sure whether or not they should employ more Asian workers. Fear of reverse racism	Need more training Should have cultural advisor more readily available to assist case managers.
• *others*		Targeting different community groups e.g. business groups, voluntary groups etc. to promote ACC services.	Need bilingual case managers and practitioners.
5. Other:			
• What can the community or	Claimants need to be more assertive to secure their entitlements.	GP can do acupuncture if they have a postgraduate qualification.	Although there may be more Asians claiming ACC by letting TPs claim, we

claimants do to improve their access			need to monitor the process of how TPs claim. There may be some fraud issues here.
-Community representative – entry point?			- Need to work with Asian GP and specialist. - Community leaders from each Asian ethnic sector.
-Any other information	- ACC should work with who Asians seek help from the most. - Patients can go straight to acupuncturist without going to GP first for referral.		

Appendix 13
COMPOSITE TABLE OF GENERAL PERCEPTIONS FOR ALL ETHNIC GROUPS

Question	Chinese	Indian	Korean	S E Asian	South Asian
1. Personal characteristics as barriers:				*(claimants and non-cl. only in this group)*	*(non-claimants only in this group)*
Age	Older people experience difficulties relating to language and transport, which act as barriers to accessing services.	Older folk experience difficulties with language and transport (especially women). Older claimants and non-cl. don't want to be seen as begging, so won't make claims. (CL)Elderly may sometimes be neglected due to time constraints of younger caregivers (long work hours)	Older experience difficulties - language, transport – same as Chinese.	cl - Older people face language and transport problem. non-cl - Older more vulnerable to injuries, but afraid of doctors-needles. -Attitudes - don't want to be seen as taking welfare.	Older-older attitudes - don't want to be seen as taking welfare, so negative on ACC. Don't appear to have as many language and transport problems as other groups.
Gender	No effect	CL says women are sometimes neglected – women sacrifice themselves for family- take care of their needs first and won't see doctor for themselves.	No effect	No difference in gender	No difference in gender
English lang. competence	Huge impact as many don't speak English - acts as barrier - lack of communication, misunderstanding, avoidance of non-Asian service providers etc.	No language problem, except older folk (esp. Punjabi women) – most Indians speak English.	Huge impact – same as Chinese.	Huge impact – same as Chinese.	No language problem – most South Asians speak English well.
Injury-related lang. competence	Major problem with injury-related language as there is no direct translation and no synonyms in their	Problem with injury-related language despite English proficiency, so go to doctors from own community.	Not competent with injury-related language - No direct translation or synonyms in their	Not competent with injury-related language - No direct translation or synonyms in their	Problem with injury-related language despite English proficiency, so go to doctors from own

	languages. Doctors from own community make it easy to communicate. Even though GP and TP may not speak the same language (Mandarin or Cantonese), patients go to them because of ethnicity – feeling understood and comfortable. However, have trouble communicating with ACC personnel, so avoid them when possible.	Doctors and TPs available who speak the same language and from the same ethnic groups – makes health communication easier. However, have trouble communicating with ACC personnel, so avoid them when possible.	language. Creates misunderstanding when seeing other GPs which leads to incorrect diagnosis. Go to ethnic GPs to confirm medicine & diagnosis. Patients prefer doctors who speak their language. Doctors reluctant to recommend other supports which can be accessed by the public to them as they wouldn't be able to speak English.	language. No doctors from own community, so difficult to communicate with others. Causes reluctance to access services – huge barrier.	community. Doctors and TPs available who speak the same language and from the same ethnic groups – makes health communication easier. However, have trouble communicating with ACC personnel, so avoid them when possible.
Cultural Health beliefs (worldviews) re: injuries, accidents and pain	Broken bones and loss of blood considered serious. Children's injuries serious. Prefer home remedies for smaller injuries. Mainly older people prefer TPs - believe they treat the root of the problem and not just symptoms like GPs – this is inadequate	Broken bones and loss of blood considered serious. Children's injuries serious. Try to cope with pain and not make an issue of it. Prefer home remedies for smaller injuries. Older people prefer TPs - believe they provide holistic care and treat the root of the problem.	Traffic injuries serious. Home injury- not so serious. Children's injuries are serious because of possible after-effects. Bone-related injuries are serious. Backache type pain- can be serious. Prefer home remedies for smaller injuries	Going to doctors is seen as a sign of weakness. (non-cl) -Try to cope with pain. Serious injury: loss of blood; broken bones. Older folk follow traditional health path – prefer TPs - treat the root of the problem. Prefer home remedies for smaller injuries	Broken bones and loss of blood considered serious. Children's injuries serious. Older folk follow traditional health path - prefer TPs - treat the root of the problem. Prefer home remedies for smaller injuries.
Determinants of help-seeking behaviour: Sources of help, Why sought, Reasons for sequencing, Willingness to seek help from private and public health services	1.Self- diagnosis and medication - home remedies, 2.TP/GP, 3.TP – Go to GP as they want the GP to refer them to TP, or they would go straight to TP as second choice – TP endorses this view. Prefer TPs but they don't have	1.Self-diagnosis and medicate, 2.TP/GP, 3.GP. Older folk prefer TP, but are forced to go to GP as TPs are not covered by ACC. Younger folk prefer GP Older follow traditional health path- TPs treat the root of the problem and	1.Self-diagnosis and medicate, 2.GP,3.TP. No GP system in Korea, so they don't have a family doctor. Would prefer to go to specialist first (like in Korea). Forced to go to GP for referral to specialists.	1.Self-diagnose and medicate, 2.TP/GP, 3.GP. Older folk prefer TP, but may go to GP because of cost – TPs are not covered by ACC (only acupuncture). They also cost more, so visit GP later. Prefer home	1.Self-diagnose and medicate, 2.TP/GP, 3.GP. Older folk prefer TP – same as SE Asians. Prefer home remedies. Visit GP only for serious injuries. When they need a certificate, they go to

Who decides, why?	right to refer to ACC and are not covered by them, except acupuncture. Younger folk prefer GP Prefer to bring in medicines from home country. GPs refer patients to ACC because a huge chunk of their income comes from ACC. When they need a certificate, they go to GP. Local doctors- medication too mild – go to Asians - give larger doses and more antibiotics. Kiwi doctors don't do this (CL). Expect to get something substantial from doctor including a prescription. If not, no confidence in doctors. Get over the counter advice & medicine. Economics and education (knowledge) decide. Int'l students-have med. insurance-visit GP very often. Asians don't usually have a permanent family doctor. If they do, s/he is gatekeeper and makes decisions. Family support in making decisions.	provide holistic treatment. Expect substantial treatment and medication from doctor or lose confidence in doctors (as for Chinese). When they need a certificate, they go to GP. Get over the counter advice & medicine. Prefer to bring in medicines from home country. Prefer private, go to GP who speaks same language although they speak Eng. Familiarity with doctor. Go to public system only if private is too expensive. Economics and education (knowledge) decide on course of action. Money influences decision. Younger family members make decision for older; Husband for wife.. Community Service card holders use more services. Language barriers to apply for Community Service card.	Because of English incompetence many Koreans are not interested in ACC as they are not sure what it covers. Kiwi doctors – medication too mild. Asians give larger doses and more antibiotics – Kiwis don't do this. Nowadays some Kiwi doctors give more antibiotics to Asian clients because it is expected. Expect to get something substantial from doctor including a prescription. If not, no confidence in doctors. Get over the counter advice & medicine. Prefer private to public GPs - for faster service. Language- not money influences decision. Individualist attitude on decision making – don't depend on family for this, but husband decides for wife.	remedies. Visit GP only for serious injuries. Visit GP if: loss of blood; chronic pain; broken bones. When they need a certificate, they go to GP. Prefer to bring in medicines from home country - Familiarity with medicines. Get over the counter advice & medicine from chemist before visiting doctor. Economics and education (knowledge) decide on course of action. Family support in making decisions.	GP. Older follow this traditional health path. Prefer to bring in medicines from home country - familiarity with medicines. Get over the counter advice & medicine from chemist before visiting doctor. Economics and education (knowledge) decide on course of action. Family support in making decisions.
2. Logistical and environmental					

factors:					
• Costs of services	Cost is a major problem, unless they have Community Services Card. Some know something about ACC subsidised services, but don't know that only acupuncture is covered by ACC, so burdened by unexpected cost. Family oriented, so sometimes help with costs.	Cost of services is important for Indian people, unless they have a community services card. Family-oriented so help family members. Financial responsibility for family in home country – don't visit doctor unnecessarily. Older people prefer TP but more expensive than GP (TPs don't say this). If chn. injured cost is not important. Don't know much, if anything, about ACC subsidised services.	Cost is a problem GP says - misunderstanding that ACC services are free - Complain about cost but still visit them. Don't know much (sometimes nothing) about ACC subsidised services.	Cost is a problem, unless they have Community Services Card. Family-oriented so help family members. Don't know much, if anything, about ACC subsidised services.	Cost is a problem, unless they have Community Services Card. Family-oriented so help family members. Don't know much, if anything, about ACC subsidised services.
• Transport to services	Problem for some depending on circumstances-linked to age, but will find a way – usually family.	Cl. and non-cl. say transport is a problem for women, but others (GP, TP, CL) say it's not a problem as family helps (differing perceptions)	non-cl -Transport is not a problem, but feel bothered about driving to doctor if injuries are minor, so don't go.	Transport is a problem for some – mainly women and older folk, but family usually helps.	Transport is a problem for some older folk, but family helps.
• Availability of services at different times	Waiting times at doctors are a problem, esp. for working group; also claims processing time and tele-prompts.	Time is a problem – same as Chinese - work long hours and two jobs.	Time is a problem to both cl and non-cl – work long hours – same as Chinese.	Time is a problem – work long hours and two jobs & for hospitals & ACC (Tele-prompt)	Time is a problem – work long hours and two jobs & for hospitals & ACC (Tel prompt)
• Child care	Not a problem– family helps or they take children with them.	not a problem – family helps or they take children with them.	No problem -same	Not a problem - same	Not a problem - same
• Promotion of ACC services	ACC's responsibility to promote services – lacking. Media – better way	This is a problem – more promotion needed. GP, TP, CL feel it's ACC's	This is a problem - ACC's responsibility to explain about the service to the	A problem. ACC's responsibility to promote services	A problem. ACC's responsibility to promote services

	In-depth info required. Because of lack of communication some feel ACC is a Pakeha- oriented organisation and not for them.	responsibility to do this. Media – cultural gatherings, women's groups (CL); In own ethnic language. Because of lack of communication some non-cl. believe ACC is a Pakeha-oriented organisation.	clients. Media and seminar helpful. Because of lack of communication some believe ACC is a Pakeha-oriented organisation and not for them.	Media – cultural gatherings, women's groups; In own ethnic language. Because of lack of communication Some believe ACC is a Pakeha-oriented organisation and not for them.	Media – cultural gatherings, women's groups; In own ethnic language. Because of lack of communication Some believe ACC is a Pakeh-oriented organisation and not for them.
• Other matters	ACC should focus more on them now that their numbers are increasing. Preferential treatment for some (discrimination) Problems communicating with hospital & ACC – cannot follow tele-prompts. SES impacts: Older families help extended family. Different with new/young immigrants who are wealthy and don't need help.	Non-cl. feel treatment is preferential (discrimination). Problems communicating with hospital & ACC – cannot follow tele-prompts. Health is not a priority for Indians who focus on earning money and saving to help family back in home country.	GP and CL say – Koreans appear to be usually wealthier than other groups, so don't appear to experience all the problems of other groups. All not treated the same – prejudice and discrimination. Problems communicating with hosp & ACC – cannot follow tele-prompts.	cl. Expect uniform attention for all ethnic groups. Non-cl.-Preferential treatment for some (discrimination). Problems communicating with hospital & ACC – cannot follow tele-prompts.	All not treated the same – discrimination. Problems communicating with hosp & ACC – cannot follow tele-prompts.
3. Institutional factors:					
• Knowledge about ACC	Not enough – more information required. TP-need more help with regulations from Asian personnel – language problems.	Cl. and non-cl don't have enough knowledge about ACC. TP doesn't know much about ACC as not involved in system.	Don't know much about ACC – more information required.	Not enough. Same as Indians and Chinese	Not enough. Same as Indians and Chinese
• Sources of information	Not enough. Limited information acquired mainly from family, friends, and	Not enough sources of information – same as Chinese.	Inadequate – same as Chinese.	Not enough – same as Chinese.	Not enough – same as Chinese (except claimants).

	doctor for claimants.				
• For claimants - Feelings about their contacts with ACC – positive, negative	Mixed feelings about ACC - Depends on level of knowledge & benefit and communication with ACC.	Score: 1-5/10 not very positive. Depends on level of knowledge & benefit and communication with ACC.	7-8/10 mainly positive, but lack of translation and interpretation service and complicated system are negative aspects.	More positive. They don't have much expectation as they never had such services back at home.	No South Asian claimants.
• For non-claimants - What features of ACC services contributed to decision to not seek assistance?	Mainly: ACC claims may affect employment prospects (employers ask on ACC claims status) + Cost, time, knowledge, discrimination	Mainly: ACC claims may affect employment prospects (employers ask on ACC claims status) + Cost, time, knowledge, discrimination	Same as Chinese and Indians	Same as Chinese and Indians	Same as Chinese and Indians
4. What can ACC do to help Asians overcome difficulties and barriers?					
• *Institutional barriers* to knowledge about the service	Need to actively promote themselves and provide information, and translate into Asian languages. Improve translation services. Have Asian helpline. Need to have a service especially for Asians – have the word Asian there - as they believe its only for Kiwis	Lack of ethnic minority service providers and information in ethnic languages – provide these. Improve translation services. Have Asian helpline. Need to have a service especially for Asians – have the word Asian there - as they believe it's only for Kiwis. Have pamphlets on planes about ACC and include in video presentation on NZ.	Provide more knowledge about ACC non-cl-Make ACC application form simpler GP, CL- Need to actively promote themselves and provide information. Have ethnic minority service providers	Provide more knowledge about ACC and translate into Asian languages. Improve translation services.	Provide more knowledge about ACC. Lack of ethnic minority service providers and information in ethnic languages
• *Cultural barriers* caused by differences in beliefs about injury, its meaning and treatment	Have ethnic minority service providers and/or provide cultural competence training to employees and service providers. Employ more ethnic minority case	Have ethnic minority service providers and/or provide cultural competence training to employees and service providers. Employ more ethnic minority case workers	Have ethnic minority service providers and/or provide cultural competence training to employees and service providers. Employ more	Have ethnic minority service providers and/or provide cultural competence training to employees and service providers. Employ more	Have ethnic minority service providers and/or provide cultural competence training to employees and service providers. Employ more

	workers who understand different worldviews	who understand different worldviews	ethnic minority case workers who understand different worldviews. GP- Doctors should give same importance and cultural sensitivity to all ethnic groups.	ethnic minority case workers who understand different worldviews	ethnic minority case workers who understand different worldviews
5. Other:					
-What can the community do to improve their access	More communication between the community and ACC. ACC info should be delivered to the community by the community. Not accustomed to telephone prompts – need to adapt to this system.	More communication between the community and ACC. ACC info should be delivered to the community by the community. Not accustomed to telephone prompts – need to adapt to this system (CL).	More communication between the community and ACC. ACC info should be delivered to the community by the community. Not accustomed to telephone prompts – need to adapt to this system.	More communication between the community and ACC	More communication between the community and ACC
-Community representative – entry point?	Cl. and non-cl. say cultural organisations GP, TP and CL say Community leader	All agree on cultural organisations. Cl and non-cl say definitely not religious and community leaders	Cultural organisations Church, Korean Society, community leader	Cultural organisations church and temple.	Cultural organisations church and temple.
-Any other information	*Recommendation:* Acupuncturists should have the same rights as GPs – should not need a referral from GP – they are under the impression that they need this. ACC only allows them to treat one patient at a time – not a few simultaneously. This reduces the number of patients they can see and	GP says referrals are time-consuming, complicated, too much paper work. ACC pays too little – impacts on referrals by GP. *Recommendation:* Ayurvedic practitioners should be included in ACC's services – They don't do a quick fix job and treat just the symptoms as GPs do – they treat the root	*Recommendation:* Need to actively promote themselves and provide information. Have ethnic minority service providers and translate into Asian languages. Improve translation services. Have Asian helpline. Need to have a service especially for Asians – have the word Asian there - as they	*Recommendation:* Same as Koreans	*Recommendation:* Same as Koreans

	their income. GPs are also allowed to do acupuncture. This is a specialised field and GPs do not have sufficient knowledge – only superficial, so should not provide this service. Only TPs have specialised knowledge. GPs don't refer patients to them – do it themselves, so their income is declining. ACC only recognises acupuncturists registered to 2 associations. Both these are run by westerners – no non-Westerners on boards – do not understand requirements etc. Asian association not recognised – cannot claim from ACC.	of the problem and provide a holistic service – even counselling, but they are not covered by ACC. WINS advises their clients to visit them and covers their expenses, so why doesn't ACC? 90% of their clients are Pakeha, which demonstrates that their service is valued – not just a cultural service for Indians. They need to be included in ACC. Have pamphlets on planes about ACC and include in video presentation on NZ.	believe it's only for Kiwis.		