

Research paper

Understanding migrants' primary healthcare utilisation in New Zealand through an ethnographic approach

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What is known on this subject

- Disparities in healthcare utilisation exist in international contexts between migrants and host populations.
- Asian migrants have low use of primary healthcare in New Zealand.
- Health inequalities exist between migrants and host populations in New Zealand and internationally, and have been associated with low healthcare utilisation.

What this paper adds

- A greater understanding of why Asian migrants have low use of primary healthcare in New Zealand.
- It describes how health-seeking behaviours create health inequalities for illnesses such as TB through delayed diagnosis and treatment.
- It demonstrates how ethnographic research can contribute towards understanding health behaviours and associated health inequalities.

ABSTRACT

Health inequalities between migrants and host populations in many western countries, including New Zealand, have been associated with low healthcare utilisation. This research used an ethnographic approach based on participant observation and semi-structured interviews to examine Asian migrants' use of primary health services in New Zealand. Participant observations were undertaken in migrant organisations, and clinical and domestic settings. In addition, semi-structured interviews were conducted with 23 migrants from India, South Korea and Mainland China, and six with New Zealand healthcare professionals. Migrants used a variety of strategies to negotiate New Zealand's

healthcare system. These were influenced by their knowledge of it, their experience with healthcare systems in their home countries, language difficulties, structural barriers, divergent understandings of health and the extent of their local support networks. Social networks were found to play fundamental roles in migrants' healthcare strategies and, if promoted through community development, could increase the utilisation of primary health services and reduce health inequalities in New Zealand and other host countries.

Keywords: healthcare utilisation, migrants, New Zealand, primary healthcare, support networks

Introduction

Health systems' abilities to promote health and reduce illness are contingent upon their availability, accessibility and acceptability to all members of a society

(Howden-Chapman, 2005, p.62). In many western nations, certain minority and ethnic groups have limited access to and use of health services, which

contributes to health inequalities (Marks and Hilder, 1997; Howden-Chapman, 2005). Such disparities have been identified in Europe and the USA, where migrant and minority groups have lower utilisation of health systems than native-born populations (Leclere *et al*, 1994; Bollini and Siem, 1995; Chavez *et al*, 1999; Frisbie *et al*, 2001; Keller and Baune, 2005; Huang *et al*, 2006; Cunningham *et al*, 2007; Martinez *et al*, 2008). In a number of industrialised western countries including Germany, France, Italy, Switzerland, the USA and the UK, reduced healthcare access for migrants has been linked to lower levels of health status and increased rates of perinatal mortality, accident/disability, diabetes mellitus, cardiovascular disease, cancer-related diseases and benign prostatic hyperplasia (Bollini and Siem, 1995; Keller and Baune, 2005; Huang *et al*, 2006; Kreps and Sparks, 2008; Martinez *et al*, 2008).

Similar disparities in healthcare use between immigrants and native-born populations occur in New Zealand (NZ). A recent national health survey on Asian populations reported low healthcare service use, particularly for primary healthcare services (Ministry of Health, 2006a; Box 1). Yet to date, no research has been done to explain this gap in health service utilisation by Asians in NZ (Rasanathan *et al*, 2006). Recent epidemiological data also suggest health disparities between Asian migrants and NZ-born populations, with Asian-born people having higher rates of

tuberculosis (TB) (Das *et al*, 2006), mental illness (Abbott *et al*, 2000; Rasanathan *et al*, 2006), cardiovascular disease and type 2 diabetes (Ministry of Health, 2006a) than NZ-born populations. Examining the use of primary health services in NZ by Asian migrants can contribute towards explaining how or why these health inequalities occur. This paper examines migrants' use of primary health services. The research presented here drew on their understandings and experiences of healthcare through an ethnographic approach using participant observation and semi-structured interviews. This allowed for detailed and contextualised analysis of what people both say and do (Emerson *et al*, 1995).

Ethnography

This paper stems from a larger study undertaken in Auckland, NZ, from 2004 to 2007 (Anderson, 2008). The original research used TB as a lens to understand how migration, settlement and support networks influenced migrants' health knowledge and practices, as well as examining more specific characteristics of TB.

Given the comparatively small numbers of people who suffer from TB in Auckland (Das *et al*, 2006), the stigma surrounding the illness (Anderson, 2008), and to ensure reasonable participation rates, three migrant groups were included in the study. Chinese, Indian and Korean migrants were chosen as they are the largest Asian populations in Auckland (New Zealand Census, 2001) and had high incidence of notified TB cases in Auckland at the time of the research. The inclusion, numbers and characteristics of participants differed between those who were formally interviewed and those encountered within ethnographic contexts, but also revealed shared experiences in accessing healthcare.

Ethnography involves 'getting close' to people, observing and participating in their daily routines and lives (Emerson *et al*, 1995, p.1). Thus it provides descriptive accounts of lived events, bringing 'human factors' into the study of health (Foster, 1997, p.527). Ethnography was employed to gain first-hand experiences of how social networks operated for migrants in Auckland, how information about health was exchanged, and what health knowledge and practices were used by migrants.

Participation observation was conducted during the first two years of the research by the author. Organisations were selected on the basis of Indian, Chinese and/or Korean membership. Initially the researcher participated in meetings and activities in the Asian Network Incorporated (TANI), the Auckland Institute of Studies (AIS) St Helens, and the Auckland Chinese Medical Association (ACMA). Once a rapport with

Box 1

In the New Zealand context, the term Asian refers to people from the following ethnic groups (New Zealand Census, 2001):

Afghani	Malayan
Bangladeshi	Malaysian Chinese
Bengali	Nepalese
Burmese	Pakistani
Cambodian	Punjabi
Chinese	Sikh
Fijian Indian	Singaporean
Filipino	Chinese
Gujarati	Sinhalese
Hong Kong Chinese	Sri Lankan
Indian	Sri Lankan Tamil
Indonesian	Taiwanese
Japanese	Chinese
Kampuchean	Tamil
Kampuchean	Thai/Siamese
Chinese	Tibetan
Khmer	Vietnamese
Korean	Vietnamese
Laotian	Chinese

these formal groups was established, the researcher was able to extend social networks and activities to participate in broader social contexts, for example, by attending Chinese film festivals with AIS students, Hindu temple meetings with TANI members and social visits in domestic contexts with members of the three groups. When granted permission by healthcare professionals, participant observation was also undertaken in general practitioners' (GPs') clinics. These included two Korean GPs' clinics, an Indian GP's clinic and a NZ European GP's clinic. Participation observations also included public health nurses (PHNs) from the Auckland Regional Public Health Services (ARPHS) in community TB training sessions and, when patient consent was given, treatment sessions with patients.

Participant observation focuses on both observing and engaging in direct, personal involvement with communities (Jarvie, 1969, p.505; Emerson *et al*, 1995). Whenever possible, the researcher participated in a number of roles and activities within these settings. These included driving participants to community events, giving presentations to the ACMA, recruiting volunteers, and organising and facilitating TB awareness workshops for TANI and PHNs. By being involved with migrant organisations and healthcare services, the research may be favourably biased towards the roles they play for migrants, yet findings from other research in NZ support the author's findings (see for example Chang *et al*, 2006; Morris *et al*, 2007). When possible, descriptions of settings, social networks and informal conversations were recorded in a journal; if this could not be done, field notes were entered as soon as possible after the event.

The presence of an ethnographer in a research context always alters that context, affecting how informants talk and behave (Emerson *et al*, 1995, p.3). An advantage of repeated involvement is that these effects are minimised over time.

Interviews

To supplement observed information sources, semi-structured interviews were employed to provide multiple lines of data (Agar, 1980). Eleven Indian, Chinese and Korean people with TB, and two family members, were interviewed to gain an understanding of the illness experience and issues surrounding TB diagnosis and treatment (see Table 1). Ten people who did not have TB but were members of the same migrant groups were also interviewed, to provide an understanding of migration and settlement experiences, health beliefs and practices. Interviewing six healthcare professionals gained their perspectives on immigrants' understandings of NZ's healthcare system and

factors that facilitated or created barriers to accessing healthcare and treatment (see Table 1).

The strong social stigma surrounding TB meant that the sample for this study was small. Consequently, it is not representative of TB experiences of the three migrant groups in NZ. However, as data for this paper were drawn from the whole sample, including non-TB participants, they can be used to establish a framework for understanding migrants' use of primary healthcare in NZ, which can be built on with future research focused on each migrant group.

TB patients were initially recruited by PHNs who informed patients about the study. If people were interested, the researcher then contacted them and invited them to participate. Non-TB participants were recruited through migrant organisations and GPs and were selected, where possible, to match the age, ethnicity, gender and occupation of TB participants.

Interviews lasted between 30 minutes and an hour and a half, and were recorded with a digital audio recorder. All participants were given the option of using an interpreter from Auckland's Public Health Protection Interpreter Service. These interpreters are qualified and specialise in health-focused contexts. Eight participants chose to use an interpreter.

All the interviews and field notes from participant observations were transcribed and entered into a Qualitative Data Analysis (NUD*IST) 'QSR (N6)' software program, where they were coded under broad conceptual themes, such as 'seeking GPs from country of origin' or 'language difficulties', identified through repeated readings of interviews and transcriptions (Emerson *et al*, 1995).

The Auckland Ethics Committee reviewed the study and issued a favourable opinion in 2003. All data were treated confidentially, and a pseudonym was given to each participant to ensure anonymity both in the transcripts and later in the writing. Any other information that might identify people, such as spatial locations, schools, workplaces and specific ages was omitted, changed or generalised throughout this paper.

New Zealand's healthcare system

In late 2000, NZ's Minister of Health released *The New Zealand Health Strategy* (Ministry of Health, 2000) as a guiding framework for organisations in the health sector to work towards improving health and reducing inequalities in NZ. Following this strategy, in 2001 *The Primary Health Care Strategy* was implemented to improve primary healthcare, particularly in relation to accessing primary services (Ministry of Health, 2001a). Both strategies incorporated methods based on the World Health Organizations's Alma Ata Declaration,

Table 1 Description of participants interviewed in the study (using pseudonyms)

Pseudonym	Type of interview	Ethnicity	Gender	Age (years)
Drezan	TB	Chinese	Male	< 20
Meeta	TB	Indian	Female	30–40
Bina	TB	Indian	Female	< 20
Sachi	TB	Indian	Female	30–40
Vishal	TB	Indian	Male	20–30
Bhadrak	TB	Indian	Male	20–30
Ari	TB	Indian	Male	20–30
June	TB	Korean	Female	50–60
May	TB	Korean	Female	30–40
Yul	TB	Korean	Male	20–30
John	TB	Korean	Male	< 20
Li	Non-TB	Chinese	Female	20–30
Tom	Non-TB	Chinese	Male	20–30
Alex	Non-TB	Chinese	Male	20–30
Jaya	Non-TB	Indian	Female	< 20
Dependu	Non-TB	Indian	Male	50–60
Tushar	Non-TB	Indian	Male	20–30
Jin-Ho	Non-TB	Korean	Female	50–60
Kim	Non-TB	Korean	Female	30–40
Sun	Non-TB	Korean	Female	50–60
Megan	Non-TB (family member)	Indian	Female	50–60
Dani	Non-TB (family member)	Indian	Female	40–50
Madhu	Non-TB	Indian	Female	30–40
Priya	GP	Indian	Female	30–40
Mary	GP	Korean	Female	30–40
Chris	GP	NZ European	Male	50–60
Heather	PHN	Chinese	Female	20–30
Janette	PHN	NZ European	Female	40–50
Sarah	PHN	NZ European	Female	40–50

with a focus on community participation in primary care services (Ministry of Health, 2001a). Following *The Primary Health Care Strategy*, a primary health organisation (PHO) policy was implemented in 2002 (Ministry of Health, 2001b). This was intended to

improve access and provision, by encouraging patients to use GPs as their first point of contact within NZ's healthcare system, and to reduce reliance on secondary public services (Gauld, 2003; Ashton *et al*, 2005). PHOs are formal not-for-profit groups of primary

care providers funded through district health boards (DHBs) on a *per capita* basis (Ministry of Health, 2001b, 2006b). In addition to PHOs, NZ also has independent, non-PHO-affiliated primary healthcare services such as White Cross Accident and Emergency (A&E) clinics. All primary care practices charge for their services (Ashton *et al*, 2005), although patients enrolled with a PHO are eligible for cheaper healthcare services, depending currently on their age, sex, ethnicity and deprivation quintile, as long as they attend the primary care provider with which they are enrolled (Ministry of Health, 2007).

In addition to primary care services, secondary care services are centred on standard public hospitals, and tertiary services include hospitals that provide more advanced services than secondary care hospitals (Gauld, 2003). Both secondary care and tertiary services in hospitals managed by district health boards are free for NZ citizens and permanent residents. Primary care services, private secondary and tertiary facilities can also be accessed through voluntary private health insurance (Ashton *et al*, 2005).

Findings

Seven themes were identified: primary healthcare awareness, transnational understandings of healthcare, referral systems, 'doctor shopping' and returning home, GPs from countries of origin, limited number of Asian GPs, and support networks. Each is discussed below.

Primary healthcare awareness

Participants had varied understandings of NZ's healthcare structure. Knowledge was influenced by age, time spent in NZ and information from friends, family and healthcare professionals. For example, Tushar, a young, well-educated Indian student was undertaking post-graduate studies in Auckland. He had been living in NZ for around six months in a university hostel, when he began to experience flu-like symptoms. Not knowing where to seek healthcare in NZ, Tushar contacted the primary researcher and asked for help. Tushar was asked if he was aware of any local PHO-affiliated GPs close to his hostel, and was advised to seek one out as he would receive subsidised care. Tushar said he was not aware of any such medical practices, had not heard of the PHO system, and asked where he could find a local clinic. After consulting with other students and cultural advisors at Tushar's college, a local Indian GP was found from whom Tushar sought treatment. Tushar's difficulty accessing health services in NZ did not relate to his lack of education, nor to language difficulties, but rather to his lack of awareness of NZ's healthcare system, limited time in NZ, and local social networks, which led to delays in seeking treatment.

Tushar's experience was not an isolated case within the study. Drezan, a young Chinese student, faced a similar situation when he became sick and did not know where to go to receive treatment. Drezan developed pulmonary TB and was experiencing chest pain. As he did not know where to go for help, when his symptoms become severe he contacted his parents in China for advice. His parents encouraged him to find a doctor. However, Drezan did not know where to find a doctor in Auckland and so contacted another Chinese student from his school and asked for help. His friend referred him to a local Chinese newspaper that advertised several Chinese GPs practising in Auckland. After a three-week interval from the onset of his symptoms, Drezan finally found a GP, was diagnosed and began treatment.

Transnational understandings of healthcare

Other participants had no understanding of PHOs, yet knew there were two types of primary healthcare providers in NZ, and evaluated and categorised them according to healthcare systems from their countries of origin. Although all primary healthcare providers operate on a fee-for-service approach, PHO-affiliated GP clinics and sometimes district health board-managed hospitals were classed by participants as public services, while independent non-PHO-affiliated A&E clinics were classed as private.

Sun, a Korean woman in her 50s, migrated to NZ 11 years ago. She joined a local Korean church where she was told she needed to go to a GP clinic for her health needs. Initially Sun went to a PHO-affiliated GP where she described the small clinic with only one practising doctor as 'uncomfortable and suspicious'. Rather than enrol with a PHO, Sun preferred to attend an independent A&E clinic. Her preference was based on experience with Korea's national health insurance programme, where health services are privatised and run like businesses (Kwon, 2003; Oklahoma Medical Research Foundation, 2006). She was also used to large Korean hospitals that employ many medical specialists. For Sun, visible similarities between Korean hospitals and A&E clinics relating to size, inclusion of multiple services, such as radiologists and dentists, and staff wearing professional uniforms influenced her healthcare choice.

As with Sun, Alex, a Chinese man in his 20s, also preferred to attend A&E clinics due to their similarity to large Chinese urban hospitals. In addition, he felt independent services were better because:

'They have independent financial that's why. They have to make money and they have to better themselves. So that's why they react so fast, otherwise they will lose the customer.' (Alex, Chinese man)

Alex's concept of healthcare relates to a market model, where patients are seen as customers and health as a commodity (Kasteler *et al*, 1976; Charny *et al*, 1990). This understanding was strongly influenced by his experience with healthcare systems in China, where there has been a recent increase in private healthcare facilities, and public hospitals function much like for-profit entities (Blumenthal and Hsiao, 2005).

Referral systems

Another aspect of NZ's healthcare system that caused confusion for participants was the system by which patients must be referred by primary care practitioners for hospital or specialist assessment and treatment (Ministry of Health, 2008a), a process that can result in waiting times of up to six months (Ministry of Health, 2008b). Alternatively, private specialists and hospitals can be accessed through private health insurance or direct payments (Ashton *et al*, 2005). Participants found this system to be in complete contrast to the user-pays systems from their home countries, where they could independently seek out the best doctors they could afford (Kwon, 2003; Deogaonkar, 2004; Oklahoma Medical Research Foundation, 2006) without having to wait for long periods of time.

Sashi, an Indian woman in her 30s, worked part-time at a local school. In November 2003, she experienced back pain at work and went to see her local GP. She was diagnosed with back strain, prescribed medication and referred to a physiotherapist. Despite the physiotherapy and pain medication, Sashi's back pain did not improve and she did not want to wait for another referral, so in January 2004 she returned to India to consult with an orthopaedic surgeon who sent her for an X-ray. Sashi's X-ray was normal, so again she was given pain medication and returned to NZ. By February, her pain was so severe she was confined to her bed and could not work, look after her children or perform any domestic duties. Frustrated with her GP, Sashi changed GPs and asked her new doctor to refer her to a specialist, which he did. However, Sashi still had to wait until March for her appointment with an orthopaedic surgeon, when she was given a magnetic resonance imaging scan (MRI) that revealed a TB infection. In March 2004, five months after her initial illness symptom, she was admitted to hospital for surgery and treatment.

'Doctor shopping' and returning home

Sashi's experience with NZ's referral system and her health-seeking choices were common among participants. Four participants also changed GPs due to frustration over long referral times, or not being

referred when their treatment was not working. 'Doctor shopping' or 'frequent changes of doctors' (Sato *et al*, 1995, p.122) has significant effects on patients' health, as it can cause delays in diagnosis through increased consultation times and denying GPs opportunities to assess changing symptoms (Calder *et al*, 2000). 'Doctor shopping' is also in complete contrast to NZ's emphasis on enrolment with one PHO for healthcare.

According to Indian and Korean GPs, another common strategy was for patients to return to their countries of origin for treatment. Priya, an Indian GP, believed that around 50% of her Indian patients returned to India for treatment because of long waiting times to see specialists and the cost of private insurance in NZ. Korean participants returned home because of frustration, confusion, long waiting times, beliefs that Korean medical services were better than those in NZ, and the benefit of greater social support, as explained by Mary, a Korean GP:

'I used to see that happen a lot in my practice [patients returning to Korea for treatment]. Um where you know, especially this waiting list, they couldn't wait and they couldn't afford or if they felt that going privately to solve their medical problem was costly then they would rather spend that money going back to Korea, spend it on the air ticket and have the family support, the medical system that they are familiar with and spend the money there and have their own family look after them in their own language and their own way, cultural way, and then come back when that was dealt with.' (Mary, Korean GP)

GPs from countries of origin

The most common primary healthcare choice among participants was to find a GP from their respective countries of origin who was associated with a PHO. Participants' preferences for GPs from their home countries were influenced by shared languages and cultural understandings of behaviour and health. Difficulties with the English language were common among Korean and Chinese participants. For example, June, a Korean woman in her 50s, was told by her TB clinician, a NZ-born doctor, that her TB could have been due to co-morbidity and reactivated from her diabetes. June did not understand his explanation and asked her Korean GP what it meant. Her GP explained that they were 'sister diseases', as having one would draw the other closer, a metaphor June understood. From observations in clinics, it was evident that Korean GP clinics catered primarily for Korean speakers, GPs and other office staff were able to converse in both English and Korean, and health-information pamphlets and posters were often written in Korean.

Shared understandings of health knowledge were also key to patients' preference for GPs from countries

of origin. Many Koreans believe that the liver is central to well-being as it encompasses metaphysical as well as physical elements of health (Pang, 1990, 1998; Anderson 2008). Korean GPs described how their Korean patients would often attribute their illnesses to liver problems and expected their diagnosis and treatment to conform to their beliefs. Even when the GPs did not believe their patients' conditions were related to liver functions, they maintained sensitivity and understanding of their patients' beliefs, as expressed by Mary:

'The patient might be coming to me presenting with those [gastric] symptoms wanting their liver checked out, but if I went down the path of gastrointestinal investigations then they wouldn't be satisfied you know?' (Mary, Korean GP)

Limited number of Asian GPs

Participants' experiences with their GPs demonstrated how shared understandings of culture could facilitate migrants' health provision and care. Yet one of the key barriers to healthcare for participants, particularly for Koreans, was the limited number of Korean healthcare professionals working in the Auckland area at the time of the research. In 2001, there were 13 266 Korean people living in Auckland (Statistics New Zealand, 2001, p.58), but only three practising Korean GPs, and one of these was part-time. The limited number of available Korean GPs in Auckland created high patient loads and long waiting times, as expressed by Mary:

'You know one of my receptionists actually told me that she could have had me working 24 hours a day if I chose to, if I wanted to, because the demand was that great, yeah. Like I used to have like a week at least waiting list to get in to see me for working appointments. Yeah, so um, the demand is huge for Korean people to seek a Korean-speaking GP.' (Mary, Korean GP)

GPs' high patient loads and waiting times reduced their patients' access to their PHO, and, as a result, Korean patients had to find alternative healthcare options such as A&E clinics, where they might face additional language barriers, or return to their country of origin for treatment. Participants' English language difficulties often resulted in fear, confusion and misunderstandings of diagnosis and treatment. For example, May, a Korean woman in her 30s, received a phone call from her daughter's tennis coach to inform her that her daughter had broken her leg and was taken to an A&E clinic. She did not understand what he was saying and had to wait for her young son to come home to translate for her. When May finally arrived at the clinic, she could not understand why the medical staff had not treated her daughter until her arrival but had waited for her consent, and by this stage she was confused and worried for her daughter.

Limited numbers of Korean GPs also created additional working pressures for the doctors, who described themselves as 'totally overworked and overloaded'. For doctors from migrants' countries of origin, their job encompassed not only healthcare but also additional roles such as acting as interpreters and intermediaries as the gate keepers for secondary and other health services. Mary explained that many hospitals contacted her patients for clinical appointments through letters written in English which they did not understand and, as a result, they did not make the set appointment times. She would have to contact the hospital, reschedule appointments and then contact her patients and translate appointment times and locations. The additional roles GPs played were time consuming and added further to waiting times for their patients. To counter such difficulties, participants would often use local, Auckland-based and transnational networks.

Support networks

Participants created, maintained and used local support networks to gain information on health services, for the provision of resources, as well as for emotional and spiritual support. TANI is a large umbrella organisation for Asian minority groups in Auckland (The Asian Network Inc, 2002). TANI is politically active, and networks with academic researchers to identify inequalities. It then lobbies for policy changes to meet the specific needs of Asian people. TANI has two to four meetings a year, and invites representatives from Asian groups to participate and then disseminate key information back to their respective networks. Along with health topics such as water safety, TANI also actively promotes information about NZ's healthcare system and services. Tushar, who initially arrived in NZ without any close support networks or knowledge of healthcare systems, heard about TANI and was keen to become involved so that he could establish ties to a Tamil group in Auckland. By becoming involved with TANI, he has since joined such a group, found a Tamil family to board with, and has presented seminars on behalf of TANI on health issues. This story illustrates how networks such as TANI can empower individuals and increase migrants' collective agency.

As well as actively disseminating key settlement and health information, local Asian support networks also strove to bridge structural gaps in settlement needs, including access to healthcare. By way of example, Korean churches assisted their members' settlement in NZ in many ways. They provided Korean food, language and cultural activities to create familiarity, help people find homes and employment, and provide English language courses (Chang *et al*, 2006; Morris *et al*, 2007). Mary explained that she would not have

practised medicine in Auckland if it was not for a local Korean pastor who approached her and pleaded for her to open a clinic in Auckland because many of his congregation were struggling to access healthcare in NZ. Not long after this request, Mary opened her practice. The pastor, his wife and members of the congregation have now implemented voluntary rosters to transport elderly members to health services, and also act as informal interpreters when needed.

Discussion

Participants' preferences for A&E clinics demonstrate how lack of understanding of the organisation of primary healthcare, as well as previous experience with healthcare systems from countries of origin, influenced their use of NZ health services. As A&E clinics are open after hours and do not have an appointment system, they are often more easily accessible to patients than their regular health centres. However, consultation and prescription costs are not subsidised for A&E clinics. As only 17% of Asian people aged 15 years and over living in the Auckland region have an income of \$30 000 or more, compared with 31.2% for the whole population (Statistics New Zealand, 2001), increased health costs can economically disadvantage Asian migrants in NZ. In Auckland, following Europeans (56.5%), Asians are the second largest ethnic minority group, making up 18.9% of the population (New Zealand Census, 2001, 2006). PHO enrolments for Auckland District Health Board appear to be consistent with the population demographics; Procure Network Auckland Ltd, the largest PHO in the area, currently has 193 883 (63.1%) NZ European patients and 53 323 (17.35%) Asian patients (Ministry of Health, 2008c). Even though these data suggest Asian people are enrolled with PHOs, participants' accounts in this study demonstrate they are not always attending or receiving the associated benefits.

Although language difficulties created barriers for participants in all sectors of the healthcare system, they were most problematic within the primary sector where interpreting services are often limited or unavailable. In a study of 80 GPs in Auckland, Wearn *et al* (2007) also found that the majority of GPs experienced language difficulties with patients that affected sharing health information and provision of services. The study also supported findings that GPs proficient in languages other than English attract patients within those language groups, and prefer not to use professional interpreters within their practices. Migrants' language difficulties and divergent understandings of illness have also been found to limit healthcare access and influence health outcomes in Europe and the USA (Leclere, 1994; Bollini and Siem, 1995; Eade, 1997;

Kreps and Sparks, 2008; Martinez *et al*, 2008). Along with family, friends and local migrant groups in NZ, GPs from countries of origin were key support people for migrants. GPs were able to bridge language barriers and cultural knowledge of health between their patients and broader NZ healthcare sectors.

Migrants' lack of knowledge of NZ's healthcare system, along with cultural and structural difficulties, created barriers in accessing primary healthcare. Such access difficulties are not unique to NZ. Hahn (1999) found that inadequate translation of public health knowledge is a worldwide problem occurring across and within national borders. In Auckland, there has been a recent emphasis on promoting awareness of NZ's healthcare system. For example, in 2003, Waitemata District Health Board produced information pamphlets available in many languages together with phone services that provided simple descriptions of primary healthcare services (Waitemata District Health Board, 2003). Yet, as demonstrated in this study, most immigrants obtain healthcare information by word of mouth through close community networks and local media such as newspapers. This suggests that, along with general health promotion, local media sources and community groups can be of great importance in promoting awareness of NZ's healthcare systems to immigrants.

Broader local and transnational Asian support networks in NZ were used by migrants to negotiate barriers of settlement and healthcare access. Their effectiveness exemplifies the agency of NZ migrants in their ability to influence local environments and promote health service utilisation through community development. Community participation, sponsorship and guidance are vital elements for successful healthcare programmes (Kerr, 2000). Neuwelt *et al* (2005) demonstrated that community participation within primary healthcare can improve access to resources and community and cultural appropriateness of services. The inclusion and development of migrant community groups within NZ health sectors can, therefore, reduce immigrants' difficulties in understanding and accessing healthcare. In 2005, ARPHS collaborated with TANI to implement a TB awareness project focused on the Indian community in Auckland. The project aimed to provide basic awareness of TB, reduce stigma surrounding TB, encourage BCG vaccinations for infants, and encourage early intervention through providing information about accessing healthcare providers (Miller, 2008).

Within the project, community members were key actors throughout the process, using their extensive local networks to disseminate information about TB to the community through culturally appropriate services such as community presentations in Indian languages, newspapers, radio stations and television. Community dissemination sessions involved outlining where to go if people were experiencing TB symptoms. Additional

topics addressed included the costs of primary and secondary healthcare services in NZ. Therefore, the programme served not only to promote awareness of TB but also to provide more general knowledge about NZ's healthcare system. The programme was intended to develop local community empowerment and was successful in creating ongoing, intersectoral relationships between TANI, ARPHS and Housing NZ, developing the personal skills of participants, and strengthening community action in coping with TB (Miller, 2008).

Conclusion

This paper has addressed some of the reasons why migrants to NZ experience inequalities in access to primary healthcare. Although NZ's PHO policy aimed to improve access to and the provision of primary healthcare to all New Zealanders, this research found that the policy is limited in its ability to facilitate access for many migrants, due to their lack of awareness of the system, previous healthcare experience, and structural barriers such as lack of Korean healthcare providers and interpreters. In addition, their limited access to PHO services means that migrants are not benefiting from the economic advantages of reduced consultation and prescription fees.

However, this paper has also demonstrated that migrants are not passive victims of NZ's healthcare policies. They use local social networks to negotiate and overcome obstacles. Promoting community development within Indian, Korean and Chinese migrant networks in NZ, and in other host countries, can improve health utilisation through culturally appropriate frameworks and further contribute towards reducing health inequalities.

REFERENCES

- Abbott M, Wong WS, Williams M *et al* (2000) Chinese migrants' mental health and adjustment to life in New Zealand. *Disability and Rehabilitation* 22:14–43.
- Agar MH (1980) *The Professional Stranger: an informal introduction to ethnography*. New York: Academic Press.
- Anderson A (2008) Mark of shame: social stigma, tuberculosis and Asian immigrants to New Zealand. In: Littleton J, Park J, Herring A and Farmer T (eds) *Multiplying and Dividing: tuberculosis in Canada and Aotearoa New Zealand*. Auckland: Department of Anthropology, University of Auckland, pp.196–204. <http://researchspace.auckland.ac.nz/handle/2292/2558> (accessed 9 October 2008).
- Ashton A, Mays N and Devlin N (2005) Continuity through change: The rhetoric of health reform in New Zealand. *Social Science and Medicine* 61:253–62.
- Blumenthal D and Hsiao W (2005) Health policy report. Privatization and its discontents: the evolving Chinese health care system. *New England Journal of Medicine* 353:1165–70.
- Bollini P and Siem H (1995) No real progress towards equity: health of migrants and ethnic minorities on the eve of the year 2000. *Social Science and Medicine* 41:819–28.
- Calder L (2000) Tuberculosis: reasons for diagnostic delay in Auckland. *New Zealand Medical Journal* 113:483–5.
- Chang S, Morris C and Vokes R (2006) Korean families in Christchurch: expectations and experiences. *Families Commission Kōmihana ā whānau: Blue Skies Report* 2006;11/06:1–32.
- Charny M, Klein R, Lewis PA and Tipping GK (1990) Britain's new market model of general practice: do consumers know enough to make it work? *Health Policy* 14:243–52.
- Chavez LR, Hubbell FA and Mishra SI (1999) Ethnography and breast cancer control among Latinas and Anglo women in Southern California. In: Hahn RA (ed.) *Anthropology in Public Health: bridging differences in culture and society*. Oxford: Oxford University Press, pp.117–41.
- Cunningham SA, Ruben JD and Narayan KMV (2007) Health of foreign-born people in the United States: a review. *Health and Place* 14:623–35.
- Das D, Baker M, Venugopal K and McAlister S (2006) Why the tuberculosis incidence rate is not falling in New Zealand. *New Zealand Medical Journal* 119(1243):U2248.
- Deogaonkar M (2004) Socio-economic inequality and its effect on healthcare delivery in India: inequality and healthcare. *Electronic Journal of Sociology* 18. www.sociology.org/content/vol8.1/deogaonkar.html (accessed 9 October 2008).
- Eade J (1997) The power of the experts. In: Marks L and Worboys M (eds) *Migrants, Minorities and Health*. London: Routledge, pp.250–71.
- Emerson RM, Fretz RI and Shaw LL (1995) *Writing Ethnographic Fieldnotes*. Chicago: University of Chicago Press.
- Foster GM (1997) Medical anthropology and international health planning. *Social Science and Medicine* 11:527–34.
- Frisbie WP, Cho Y and Hummer RA (2001) Immigration and the health of Asian and Pacific Islander adults in the United States. *American Journal of Epidemiology* 153:372–80.
- Gauld R (2003) Continuity amid chaos: the context of health care management and delivery in New Zealand. In: Gauld R (ed.) *Continuity Amid Chaos*. Dunedin: Otago University Press, pp.13–26.
- Hahn RA (1999) Anthropology and the enhancement of public health practice. In: Hahn RA (ed.) *Anthropology in Public Health: bridging differences in culture and society*. Oxford: Oxford University Press, pp.3–26.
- Howden-Chapman P (2005) Unequal socio-economic determinants, unequal health. In: Dew K and Davis P (eds) *Health and Society in Aotearoa New Zealand* (2e). Auckland: Oxford University Press, pp.51–68.
- Huang ZJ, Yu SM and Ledsky R (2006) Health status and health service access and use among children in U.S. immigrant families. *American Journal of Public Health* 96:634–40.

- Jarvie IC (1969) The problem of ethical integrity in participant observation. *Current Anthropology* 10:505–8.
- Kasteler J, Kane RL, Olsen DM and Thetford C (1976) Issues underlying prevalence of 'doctor-shopping' behaviour. *Journal of Health and Social Behavior* 17:328–39.
- Keller A and Baune BT (2005) Impact of social factors on health status and help-seeking behaviour among migrants and Germans. *Journal of Public Health*, 13:22–8.
- Kerr J (2000) *Community Health Promotion: challenges for practices*. London: Baillière Tindall.
- Kreps GL and Sparks L (2008) Meeting the health literacy needs of immigrant populations. *Patient Education and Counselling* 71:328–32.
- Kwon S (2003) Payment system reform for health care providers in Korea. *Health Policy and Planning* 18:84–92.
- Leclere FB, Jensen L and Biddlecom AE (1994) Health care utilization, family context, and adaptation among immigrants to the United States. *Journal of Health and Social Behavior* 35:370–84.
- Marks L and Hilder L (1997) Ethnic advantage. In: Marks L and Worboys M (eds) *Migrants, Minorities and Health*. London: Routledge, pp.179–209.
- Martinez M, Maislos S and Rayford W (2008) How to engage the Latino or African American patient with benign prostatic hyperplasia: crossing socioeconomic and cultural barriers. *American Journal of Medicine* 121:S11–S17.
- Miller J (2008) An empowerment approach to raise awareness about and reduce stigma around tuberculosis among the Indian community in the Auckland region. In: Littleton J, Park J, Herring A and Farmer T (eds) *Multiplying and Dividing: tuberculosis in Canada and Aotearoa New Zealand*. Auckland: Department of Anthropology, University of Auckland, pp.62–70.
- Ministry of Health (2000) *The New Zealand Health Strategy*. Wellington: Ministry of Health. www.moh.govt.nz/publications/nzhs (accessed 9 October 2008).
- Ministry of Health (2001a) *The Primary Health Care Strategy*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/primary-health-care-strategy-2001 (accessed 9 October 2008).
- Ministry of Health (2001b) *Minimum Requirements for Primary Health Organisations*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/wpg_index/Publications-Minimum+Requirements+for+Primary+Health+Organisations (accessed 9 October 2008).
- Ministry of Health (2006a) *Asian Health Chart Book 2006*. Auckland: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/asian-health-chart-book-2006 (accessed 9 October 2008).
- Ministry of Health (2006b) *Primary Health Care Strategy: primary health organisations (PHOs)*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/primary-health-care-strategy-2001
- Ministry of Health (2007) *Primary Health Care Funding*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/phcs-funding (accessed 9 October 2008).
- Ministry of Health (2008a) *Information about the Management, Referral and Assessment Guidelines*. Wellington: Ministry of Health. www.electiveservices.govt.nz/guidelineinfo.html
- Ministry of Health (2008b) *Information about Patient Flow Indicators (ESPIs)*. Wellington: Ministry of Health. www.electiveservices.govt.nz/indicators.html (accessed 9 October 2008).
- Ministry of Health (2008c) *Enrolment Demographics*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/phcs-pho-enrolment#demographics (accessed 9 October 2008).
- Morris C, Vokes R and Chang S (2007) Social exclusion and church in the experiences of Korean migrant families in Christchurch. *SITES* 4:11–27.
- Neuwelt P, Crampton P, Crengle S *et al* (2005) Assessing and developing community participation in primary health care in Aotearoa New Zealand: a national study. *New Zealand Medical Journal* 118(1218). www.nzma.org.nz/journal/118-1218/1562 (accessed 9 October 2008).
- New Zealand Census (2001) www2.stats.govt.nz/census.htm (accessed 9 October 2008).
- New Zealand Census (2006) www.stats.govt.nz/additional-information/subnat-ethnic-pop-projections.htm
- Oklahoma Medical Research Foundation (2006) *Lessons Learned from the South Korean Health System*. Tulsa: Centre for Health Policy Research. www.coph.ouhsc.edu/coph/HealthPolicyCenter/Pubs/1992/chpr9202k.pdf (accessed 9 October 2008).
- Pang KYC (1990) Hwabyung: the construction of a Korean popular illness among Korean elderly immigrant women in the United States. *Culture, Medicine and Psychiatry* 14:495–512.
- Pang KYC (1998) Symptoms of depression in elderly Korean immigrants: narration and the healing process. *Culture, Medicine and Psychiatry* 22:93–122.
- Rasanathan K, Ameratunga S and Tse S (2006) Asian health in New Zealand – progress and challenges. *New Zealand Medical Journal* 119(1244). www.nzma.org.nz/journal/119-1244/2277 (accessed 9 October 2008).
- Sato T, Takeichi M, Shirahama M *et al* (1995) Doctor-shopping patients and users of alternative medicine among Japanese primary care patients. *General Hospital Psychiatry* 17:115–25.
- Statistics New Zealand (2001) *Census of Population Dwelling: Asian people*. Wellington: Statistics New Zealand. www2.stats.govt.nz/domino/external/web/prod_serv.nsf/html/docs/Population#dwghholdest (accessed 9 October 2008).
- The Asian Network Inc (2002) *About Us*. www.asiannetwork.org.nz/home.html (accessed 9 October 2008).
- Waitemata District Health Board (2003) *Beginners Guide to NZ Healthcare System*. Auckland: Waitemata District Health Board. <http://home.xtra.co.nz/hosts/asianhealth/documents/BeginnersGuide/00-Beginners%20Guide%20to%20NZ%20Healthcare%200504%20-%20Eng%20&%20Chi.pdf> (accessed 9 October 2008).
- Wearn A, Goodyear-Smith F, Everts H and Huggard P (2007) Frequency and effects of non-English consultations in New Zealand general practice. *New Zealand Medical Journal* 120(1264). www.nzma.org.nz/journal/120-1264/2771 (accessed 9 October 2008).

CONFLICTS OF INTEREST

None.

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