Access Issues for Chinese People in New Zealand

Final Report

Prepared for Accident Compensation Corporation (ACC)

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Disclaimer: The views of this report might not necessarily be the views of the Accident Compensation Corporation

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Executive summary

Asians are a growing population in New Zealand. By 2016 they are expected to make up 9% of New Zealand's and 20% of the Auckland Region's total population. As such the health and social service needs of Asians must be considered by service providers.

This report details the analysis of data collected through a Chinese Health and Social Services Survey. The survey aimed to identify what barriers existed for Chinese people accessing health and social services in Auckland. The survey was carried out in Chinese and conducted by the Asian Wellbeing Foundation and The Chinese Social Workers group of the Aotearoa New Zealand Association of Social Workers (ANZASW) in 2001. Participants were asked for their views on a number of services and agencies, including hospital services, local government councils, Inland Revenue Department, Police and Accident Compensation Corporation. The survey was opportunistically collected during the 2001 Chinese Health and Social Service Expo and completed by 2,010 individuals attending the expo. Auckland University of Technology (AUT) access to the translated survey data was granted by the Asian Wellbeing Foundation and that data entry and analysis was completed with the support of ACC which has commissioned this report.

Since the survey was conducted there have been further developments in terms of settlement services and these are also discussed in order to contextualise the findings. The report concludes with a section on the implications and recommendations of these findings for the Accident Compensation Corporation (ACC).

The key findings of the research include a lack of English language proficiency leading to communication difficulties and knowledge gaps, for example, being unaware of what services are available; the important role of primary healthy care and General Practitioners (GP's) in particular as a first point of contact and a lack of awareness of the health and civil rights of citizens in New Zealand. The research identified regional differences in terms of the place of birth of respondents and, in particularly, it was noted that Chinese respondents who were born in Mainland China experienced more communication difficulties than those born in Hong Kong or Taiwan. The strengths of this survey were that questions of access went beyond health and well being and were broadened out to incorporate local government services, and that the survey provides information on an area that has not been well researched in the past. The limitations to the research include that the survey was opportunistic and therefore may not be representative of the Chinese population in general; the target population attending the expo may be those with an interest in health issues; and that the questionnaire design is not scientifically robust.

Barriers identified included lack of language proficiency of respondents, lack of knowledge about civil rights and problems accessing GP's.

Recommendations from this report include:

- Recognise English language proficiency as a key settlement enhancer. Strategies are needed to ensure that Chinese migrants are aware of Language Line and encouraged take up their ‘English for Migrants’ language courses.
- Improve responsiveness in the primary care arena. This is often the first point of access to health care.
- Ensure that Chinese clients are aware of the Code of Health and Disability Services Consumers' Rights.
- Improve the capacity and responsiveness of services, by providing access to advocacy services, improve the quality and quantity of interpreter services and provide Chinese-written pamphlets and develop the role of ethnic support workers.
- Support the work of existing community organisations.

With regard to specific implications for ACC relating to access issues, it is recommended that a framework of cultural competence be developed. This includes clinical cultural competence (staff training and workforce development, education of the Chinese community, develop standards); Organisational competence (recruit ethnic workers, form partnerships with ethnic community organisations); Systemic cultural competence (ethnicity data collection) and Linguistic competence (interpreters, language materials).

The authors believe that this report will be a useful resource to inform future policy and practice, the report will be of value to service users, ethnic communities, other agencies, policy makers and academic institutions.

Introduction

The Asian population of New Zealand has increased significantly in recent years so that by 2016 Asians are expected to make up 9% of New Zealand's population and 20% of the Auckland Region's total, of which Chinese comprise a majority group. This has significant implications for health and social service delivery and raises issues that must be considered by providers of such services. This final report provides analysis on data collected through the Chinese Health and Social Services Survey to identify barriers for Chinese people accessing health and social services and issues relating to their migration and settlement experience with implications and recommendations for the Accident Compensation Corporation (ACC).

Data was collected during 2001 and since this time there have been substantial developments in settlement services as well as an increasing awareness of the needs of migrants from non-English speaking backgrounds. A brief overview is provided of developments in the settlement sector.

This final report is an update of the preliminary report and academic and grey literature have been integrated with the research findings which focus on the issues experienced by Asian people in terms of health, treatment and other social and government services. The contextualisation of the research and literature findings as they relate to ACC is then presented. Micro and macro strategies are suggested including a framework of cultural competence and recommendations for future research are made from the authors of this report. In particular the need to not only focus on the problem of access which has been widely researched, but to also research the implementation and assessment of interventions aimed at improving access to services. The report concludes by addressing the limitations of the findings such as methodology and survey instrument design.

Background

Access to services such as health and education, and information are critical for migrants from the time they arrive in the country (Dunstan, Boyd, & Crichton, 2003). Lack of knowledge can prevent people using services to which they are entitled, which is of particular concern when these services can help ease the settlement process. This report provides the results of a survey of access issues for Chinese people in New Zealand which enhances understanding of the needs of Chinese migrants as well as recommending some strategies to address difficulties. This report fills some of the gaps in knowledge about the needs of Chinese people, as previous research has focused on public health and population-wide approaches (Asian Public Health Project Team, 2003) or surveyed people living in a limited area, such as the Asian people and health professionals who were surveyed in North and

West Auckland within the Waitemata District Health Board catchment area (Ngai, Latimer, & Cheung, 2001).

Literature Review

The concept of access has been poorly operationalised, meaning different things in different contexts. This review focuses on access to health services but is intended to be extended to the provision of broader services. In the United States it refers to insurance cover whilst in Europe it is used more subtly to refer to the ability to obtain particular services, of a particular quality "subject to a maximum level of personal inconvenience and cost while in possession of a specified level of information" (Goddard & Smith, 2001, p.1151). According to Szczepura (2005) access is about more than the provision or uptake of services, it is about "equal care" (p. 142). Access is about care that does not vary in quality and the process of accessing that care. Furthermore, other factors impact on access to services, such as income and social factors (Szczepura, 2005) and there is a dearth of peer reviewed literature or published research evaluating the interventions needed to improve access (Atkinson et al., 2001). It is also important to distinguish between equity of access and equality of the treatment or outcome; the latter is defined by Goddard and Smith (2001) as referring to equal services being made available to patients in equal need.

Variations in access arise for several reasons, including availability, quality, cost and information. The personal cost of access can vary between people even when a service is theoretically available to all (Goddard & Smith, 2001). Variations occur too with regard to awareness of the availability and effectiveness of services and these can be related to both language and culture. Three categories of quality in regard to access have been identified in the literature: Structure, process and outcome. All of which have an impact on access (Donabedian, 1980 cited in Goddard & Smith, 2001). Poor quality in terms of process can mean that compliance is jeopardised and clients are dissatisfied, poor quality in relation to structure can result in inappropriate use of the service and poor quality of outcomes can deter future use. The issue of quality intersects with ethnicity and culture, as Asians have needs that are unique to their culture, whilst also having needs that are similar to those of other immigrants and needs similar to those of other patients (Ngo-Metzger et al., 2003). Quality and culture issues include the need to respect patients' traditional beliefs and practices; access to trained interpreters and the availability of appropriate social services.

This brief review considers access issues broadly from the perspectives of the migrant/refugee and the health service provider. For health providers cultural challenges were identified as the primary theme, whereas for migrants/refugees, the following themes recur in the literature:

- Difficulties in communication;
- different cultural understandings of health and illness and health care systems;
- Cost and physical barriers.

Challenges for migrants/refugees

Settlement/resettlement issues

Some of the challenges experienced by Asians are similar to those of other migrants experiencing the process of settlement and resettlement. A study by Walker et al., (1998) found that GP's believed a variety of barriers faced their Asian clients including:

- Cultural problems e.g. language;
- lack of information in appropriate languages;
- lack of understanding of the structure of the system;
- financial and transportation problems;
- poor awareness of availability of entitlements e.g. community services cards; and
- Lack of awareness of health prevention and frustration due to delays.

More recently, Lawrence and Kearns (2005) found in researching the needs of refugees and health providers in the Auckland suburb of Mt Roskill that refugees were faced with issues of resettlement that presented them with greater health challenges and in turn health practitioners were challenged to meet the needs of refugees effectively and in culturally appropriate ways within the context of limited funding. Lawrence and Kearns (2005) found that the resettlement process involves the challenge of beginning life in a new country without a support network. Finding employment and housing are significant and are issues shared to some degree with all migrants. However, in contrast with many migrants, refugees also face anxiety to do with family reunification. This issue of access to services is considered broadly in a one of the earliest reports about the main concerns of immigrant Asians living in Auckland. This report found that health, family and employment were significant (Walker et al., 1998).

Communication difficulties

Language difficulties can extend beyond the medical appointment itself to encompass the full continuum of the health care experience, from making appointments to filling prescriptions and all the steps in between. At many of these stages interpreting services are not available. In particular, they are not provided within primary health care (despite being available in hospitals) (Lawrence & Kearns, 2005). A study in Auckland found that half the study participants were fairly confident about what to do if they or a family member faced a health crisis. However, language was identified as a significant barrier to seeking medical advice when ill followed by finances. Two thirds of participants considered it important that their Doctor spoke the same language (Walker et al., 1998). This finding is similar to an Australian study (Chan & Quine, 1997) which found that respondents had a preference for a GP who was Chinese speaking. The quality of interpreter services was an important finding among Vietnamese- and Chinese-Americans in an American study.

Different cultural understandings of health and illness and health care systems

Asians are less likely to have a usual health practitioner than Māori, Pacific and Pakeha/Others according to a recent Public Health Intelligence occasional bulletin (2004). Asian females in particular were less likely to have seen a nurse or Doctor or used a telephone helpline than females of other ethnicities. A study by Ngo-Metzger et al.,(2003) found that Asians were more likely to use traditional remedies and herbs in tandem with or before seeing a Western practitioner. The study also found that patients were cautious about discussing their usage of traditional remedies with Western practitioners because of previous negative responses. Ngo-Metzger et al., (2003) suggest that many Asian medical beliefs and practices differ from Western approaches and might attribute the causes of illness to imbalances in the body or spiritual factors while treatment paradigms might be based for traditional medicines or acupuncture used alongside Western medicine. In a study in Auckland, Walker et al., (1998) found that 20% of the respondents used traditional medicine. The cost of appointments for primary health care services and a perception of lack of value for money existed unless a prescription was obtained (Lawrence & Kearns, 2005).

Physical barriers

Lack of transportation and lack of familiarity with Auckland's public transport system and, therefore, difficulty finding the location of medical appointments were found to be significant in the study.

Challenges for health providers

Health providers in an Auckland study (Lawrence & Kearns, 2005) found the following challenges when working with refugees:

- medical;
- cultural;
- communication; and
- Operational.

On the whole, Asians are thought to be a young and healthy population (Scragg & Maitra, 2005) so some of these findings are not as relevant for this report. However, perceptions of Asians are significant. The literature varies in terms of health provider's perceptions of Asians. When a survey of 38 doctors in the Auckland region who had Asian clients was undertaken they perceived that their clients were health conscious and accessed their doctors early for help and that they had generally better health than Māori and Pacific people. Conversely, their perception was that Asians generally did not seem to have a regular GP and did not have a good understanding of the organisation of the health system or their entitlements within that system (Walker et al., 1998). This appears to vary according to ethnicity as the research found that 80% of the respondents have a regular GP but Indians had the highest percentage of people with a regular GP and Cambodians with the lowest.

Chatterjee (2004) suggests that another barrier is the misperception of Asians being self-sufficient and well resourced materially and therefore requiring less assistance and that this needs addressing.

Removing cultural barriers

In New Zealand the concept of 'cultural safety' has been a part of nursing education for ten years, developed by Māori nurses in the 1980's. It provides both a conceptual framework for understanding power inequalities structuring relationships as well as practical strategies. It requires that all human beings receive care that takes into account their uniqueness (culture, gender, religious backgrounds). Going beyond a checklist of customs or practices, it is premised on the notion that it is important to understand one's own culture and recognise that one is a culture bearer with associated assumptions about the world which can impact on the care delivered to people who might have different worldviews. Fundamentally, cultural safety aims to improve the health status of New Zealanders by taking account of the Treaty, ensuring access and aiming for health gains of marginalised groups and by enhancing service delivery through having a culturally safe workforce. This is done by addressing power relationships, empowering users, understanding diversity and going beyond tasks to relationships. It also has a broad application and recognises the impact of context (inequalities as a microcosm, impact of history, employment etc, legitimacy of difference, attitudes as barriers, quality improvement and rights) and has a close focus on the individual practitioner (culture bearer, power relationships which favour providers, balancing power differentials, moving towards equitable delivery and minimising risk to marginalised) (Anderson et al., 2003; Cooney, 1994; Coup, 1996; DeSouza, 2004; Jeffs, 2001; Nursing Council of New Zealand, 2002; Polaschek, 1998; Wood & Schwass, 1993). Little is known of how cultural safety education for health professionals (especially in nursing) translates into safe care for migrants in New Zealand because the focus has been largely on the partnership between practitioner s and Māori (DeSouza, 2004). It is theorised that being culturally safe can be transferred into any context.

Strategies

Walker et al. (1998) identified strategies for improving access from the point of view of Asian community members and Doctors. Community members prioritised access to cheap/free health care; more efficient health care and having an Asian Doctor while Doctors in the recommended having a one stop shop; volunteer drivers; increased health screening; free interpreter services; more health professionals who can speak Asian languages; more information and educational material in Asian languages; more education for Asians around prevention, screening, and follow up; providing lists of names of GP's from ethnic communities; making better use of community groups to disseminate information and co-ordination; reduce costs, simplify application systems for community services cards; educate Asians about the health system both before and after migrating.

Chatterjee (2004) identifies both mainstream organisations and agencies and culturally-specific organisations that work to reduce health disparities and inequalities. Her paper recommends a number of workforce development strategies, such as incorporating Asian medical knowledge and practices into training and professional development; recruiting Asian health professionals; employing Asian mentors or elders (link workers) and creating a consultation network of Asian community leaders to interface with mainstream health services.

Conclusion

This literature review demonstrates the need for research about access to services in the broad context of settlement and resettlement for migrants and refugees in New Zealand. Variations in access can arise particularly for members of migrant and refugee groups with regard to awareness around the availability and effectiveness of the service, which can be related to both language and culture. Barriers to access have been identified from research conducted in New Zealand and cultural safety is offered as a possible strategy for improving access, but needs further exploration as it has been mainly oriented to health disparities with Māori. Some groups within the category ‘Asian’ are particularly at risk: Asian females in particular, were less likely to have seen a health professional or used a telephone helpline. Asians in general are less likely to have a regular GP and this has implications for delivering primary health care services as well as for access to secondary and tertiary services.

Methods

A survey was conducted by the Asian Wellbeing Foundation and The Chinese Social Workers of ANZASW in 2001. The survey was translated into Chinese and aimed to look at the issues experienced by Chinese people in Auckland, New Zealand, and the barriers faced by them when they access health and social services. The health and social services surveyed include hospital services, local government councils, Inland Revenue Department, Police, and Accident Compensation Corporation. The survey was opportunistically collected during the 2001 Chinese Health and Social Service Expo and 2,010 individuals attending the expo completed a questionnaire. AUT access to the survey data was granted by the Asian Wellbeing Foundation, with data entry and analysis completed with the support of ACC.

The total sample size of 2,010 means that the prevalence of particular issues, for the population that responded to the survey, can be estimated with an error of approximately ± 2, with 95% confidence and 80% power. However as this was an opportunistic survey of individuals attending the Chinese Health and Social Service Expo, there are potential biases due to the fact that Expo attendees may have particular interest in the Health and Social Services, and may not be representative of the general Chinese population in Auckland or New Zealand.

The statistical methods used to analyse differences between categorical factors was the Chi-square statistic, which detected any significant patterns across the categorical groups. The Cochran-Armitage Trend test was utilised to detect any statistically significant trends across time related factors such as age and amount of time since arrival in New Zealand. The statistical methods were kept at a primarily descriptive level.

Results and analysis

In this section key findings are discussed and the discussion and analysis of the survey findings is then divided into the following sections:

- Demographics
- Main difficulties
- Accessing public services
- Other comments
- Recommendations

The survey results and analysis provided below are primarily quantitative, showing numbers and percentages, examining any statistically significant differences or trends, and highlighting important themes and issues that emerged from the data. There are inconsistent or non-responses to some questions due to flaws in design, therefore the interpretation of some statistical tests of comparisons and trends across groups needs to be treated with caution.

Demographics

Gender

For respondents to the survey Figure 1 shows that females accounted for 55% of respondents and males 45%. There were 53 respondents who did not state their gender.

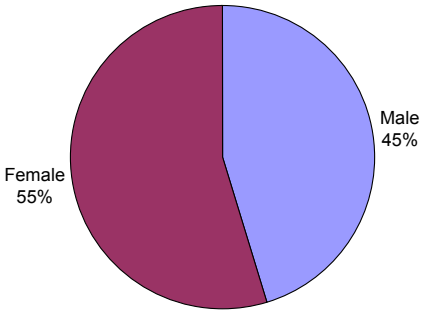

Figure 1: Gender

Age Group

Figure 2 shows the distribution of age for the respondents. Forty five percent of the respondents were aged 45-64, and 28% of the respondents were aged 25-44, and 22% were aged 65 or older. There were 17 respondents that did not state their age group.

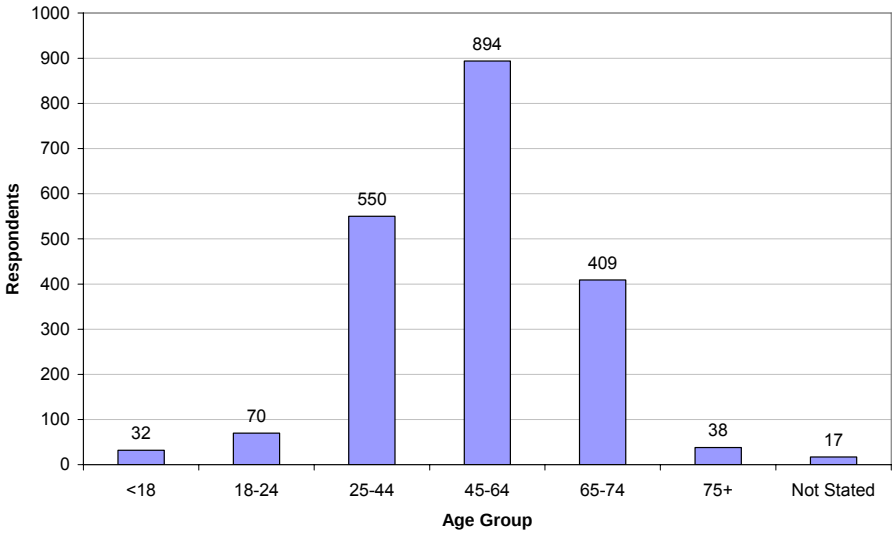

Figure 2: Age Group

Geographical Region

Figure 3 shows where respondents lived. The majority of respondents resided in Central Auckland (36%) or South/East Auckland (37%), in comparison to North Auckland (13%) and West Auckland (13%). There were 32 respondents who did not state where they lived. This distribution is similar to that of the 2001 New Zealand census, Chinese who resided in Auckland were distributed across the region as follows: Central Auckland (45.1%), South/East Auckland (29.2%), North Auckland (14.8%), and West Auckland (10.9%). The

expo was held in Central Auckland, but does not appear to have any major impact on the regional distribution of participants.

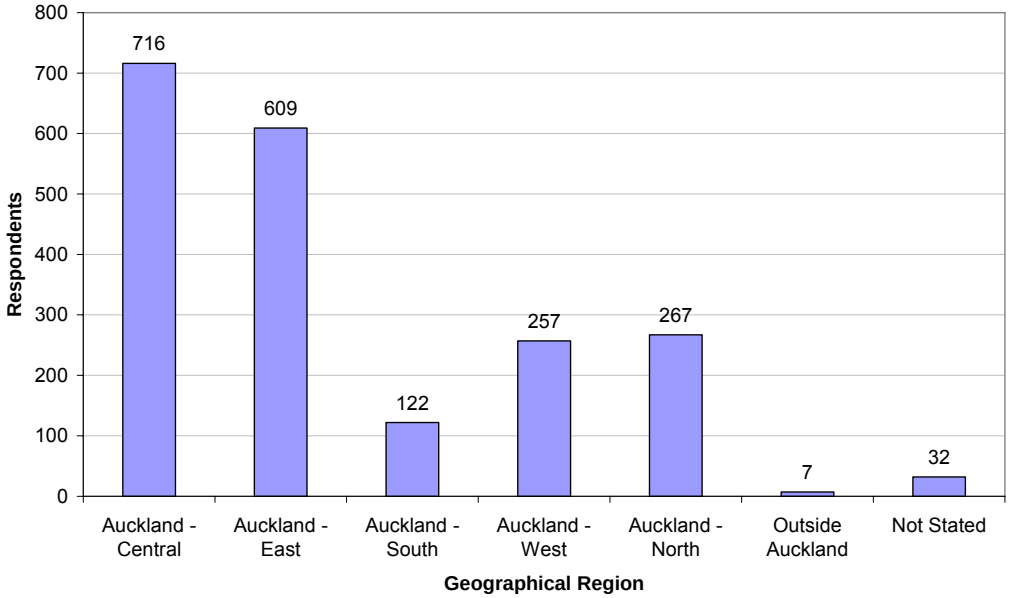

Figure 3: Geographical Region

First Language

Figure 4 shows the first language spoken by respondents. However, 7% of respondents who answered this question responded that they spoke multiple first languages, therefore these numbers represent each mention of a language and so the total is more than the 2,010 respondents. Fifty six respondents did not answer this question.

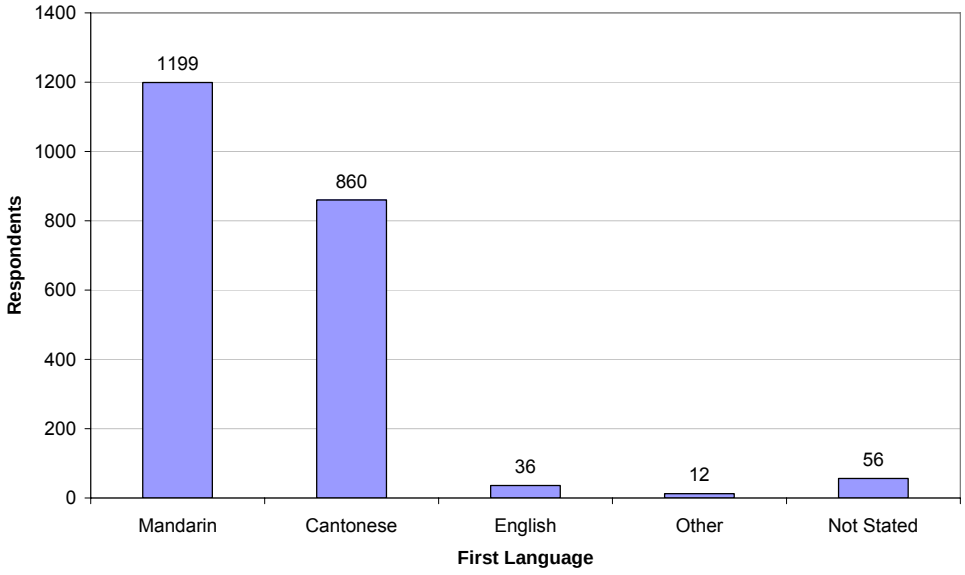

Figure 4: Language

Place of birth

Figure 5 shows place of birth as described by the respondents. It is noted that one respondent selected ‘New Zealand’ as their place of birth but also indicated a date of arrival

in the country. This response has been reclassified as ‘Not Stated’. The category ‘Other’ represents a further 10 locations, which are described in Table 1. Thirty six respondents either did not answer or gave an inconsistent response to this question.

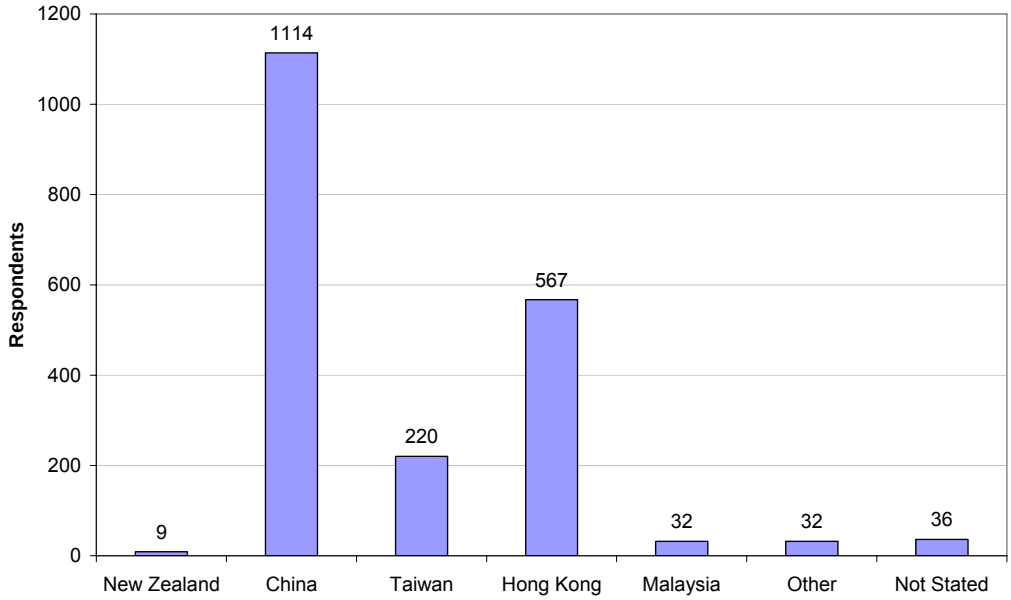

Figure 5: Place of Birth

Country	Respondents
Cambodia	6
Macau	6
Vietnam	6
Singapore	5
Indonesia	4
Brunei	1
Japan	1
Tahiti	1
Canada	1
Not Stated	1

Table 1: Other Countries of Birth

Year of arrival in New Zealand

Figure 6 shows the year of arrival in New Zealand, for which the median year was 1997 and the range was from 1940 to 2001. Because of the wording of the survey form, it is unclear whether respondents were referring to the year of their first arrival in New Zealand or their most recent arrival as a result of a trip overseas. There were nine respondents reliably identified as New Zealand born and 174 did not state a year of arrival in New Zealand.

Figure 6: Year of arrival in New Zealand

Living arrangements

Table 2 presents a breakdown of the respondent's family members who live in the same household as the respondent. Table 3 examines how the age of the respondents may impact on the living arrangements. Table 4 presents a summary of the most common combinations of family members living in the same household. Forty two percent of the respondents live with a spouse and children in the same household. There were 45 respondents who did not answer this question.

	Respondents	%
Living Alone	68	3%
Spouse	1314	67%
Children	1339	68%
Parents	233	12%
Siblings	122	6%
In-laws	20	1%
Grandparents	7	0.4%
Uncle/Aunt	16	1%
Others: relatives*	3	0.2%
Others: non-relatives*	12	1%
Not Stated	45	

* Others include relatives: grandchildren (2) and niece (1), plus non-relatives: home stay (3), friends (7) and not stated (2).

Table 2: Living Arrangements

	<25		25-44		45-64		65+		Not Stated	
	#	%	#	%	#	%	#	%	#	%
Living Alone	7	7.0%	19	3.5%	21	2.4%	21	4.8%	-	-
Spouse	9	9.0%	404	74.3%	634	72.5%	257	59.4%	10	76.9%
Children	5	5.0%	376	69.1%	659	75.3%	290	67.0%	9	69.2%
Parents	76	76.0%	121	22.2%	26	3.0%	8	1.8%	2	15.4%
Siblings	51	51.0%	47	8.6%	19	2.2%	3	0.7%	2	15.4%
In-laws	-	-	8	1.5%	6	0.7%	6	1.4%	-	-
Grandparents	1	1.0%	4	0.7%	0	0.0%	2	0.5%	-	-
Uncle/Aunt	4	4.0%	3	0.6%	7	0.8%	2	0.5%	-	-
Others: relatives	-	-	-	-	2	0.2%	1	0.2%	-	-
Others: non-relatives	5	5.0%	5	0.9%	1	0.1%	1	0.2%	-	-
Not Stated	2		6		19		14		4	
Total	**102**		**550**		**894**		**447**		**17**	

Table 3: Living Arrangements by Age Group

Examining the age groups and also the major combinations of family members, there are the expected patterns where younger respondents are living with parents and/or siblings, and older respondents are living with spouses and/or children. However, there are some apparent inconsistencies in the reported living arrangements, for example, 20% of the respondents reported living with children but no spouse, which appears to be a very high percentage. A possible interpretation may be that a spouse was either unintentionally omitted or working overseas, or alternatively where an older parent is living with their child and possibly their child's spouse and/or grandchildren. In addition, two respondents aged over 65 years of age reported that they to live with their grandparents; a possible interpretation may be that the respondents were actually the grandparents in the household. These inconsistencies could indicate that there are other less obvious problems. Examination of the results in Table 5 presents the major living arrangement combinations and confirms that all these possibilities are very likely, which means the interpretation of the living arrangements may result in inaccurate conclusions. This question could have been designed better as there was room for confusion and perhaps asking about the composition of the household might have yielded more accurate data.

	Respondents	%
Spouse Only	355	18%
Spouse and any other relatives*	33	2%
Spouse and Children Only	829	42%
Spouse and Children and any other relatives*	97	5%
Children Only	392	20%
Children and any other relatives*	20	1%
Parents Only	53	3%
Parents and Siblings	70	4%
Siblings Only	20	1%

* Any other relatives includes parents, in-laws, siblings, grandparents, uncles/aunts, and any other specified, except for spouse and children.

Table 4: Major Living Arrangement Combinations

	<25		25-44		45-64		65+		Not Stated	
	#	%	#	%	#	%	#	%	#	%
Spouse Only	4	1.1%	65	18.3%	173	48.7%	110	31.0%	3	0.9%
Spouse and any other relatives*	2	6.1%	24	72.7%	5	15.2%	2	6.1%	-	-
Spouse and Children Only	3	0.4%	254	30.6%	428	51.6%	140	16.9%	4	0.5%
Spouse and Children and any other relatives*	-	-	61	18.3%	28	28.9%	5	5.2%	3	3.1%
Children Only	2	0.5%	51	13.0%	195	49.7%	142	36.2%	2	0.5%
Children and any other relatives*	-	-	10	50.0%	8	40.0%	2	10.0%	-	-
Parents Only	25	47.2%	20	37.8%	4	7.6%	4	7.6%	-	-
Parents and Siblings	46	65.7%	20	28.6%	1	1.4%	3	4.3%	-	-
Siblings Only	2	10.0%	11	55.0%	6	30.0%	-	-	1	5.0%

Table 5: Major Living Arrangement Combinations by Age Group

Main challenges experienced when living in New Zealand

The survey asked respondents to identify the three main “difficulties” (challenges) that they experienced when living in New Zealand. Forty nine percent of the respondents identified three, 34.9% identified one or two, and 7.9% of the respondents identified none. However, 8.0% identified more than three challenges so it is impossible to identify which were the most important for these respondents. Therefore, all the selected challenges are included in the following analyses. Communication barriers, knowledge about health and civil rights, as well as knowledge about where to seek appropriate services are identified as being the most important for this population in general. The percentages report the importance of each challenge for those that reported any challenges, for example, 58.2% of those that reported any challenges identified that knowledge about health and civil rights was one of them.

	Respondents	%	Rank
Orientation on setting up a business	298	16.1%	6
Employment	612	33.1%	4
Don’t know your health and civil rights	1077	58.2%	2
Don’t know where to seek appropriate service	1038	56.1%	3
Communication barriers during the utilization of health and social service	1193	64.5%	1
Lack of opportunities to learn English	471	25.4%	5
No difficulties stated	159		

Table 6: Main Challenges.

Gender

Table 7 presents the differences across genders for the main challenges that they experienced when living in New Zealand. There were no significant differences between genders.

	Male		Female	
	#	%	#	%
Orientation on setting up a business	146	17.8%	145	14.7%
Employment	258	31.5%	343	34.7%
Don't know your health and civil rights	489	59.7%	562	56.9%
Don't know where to seek appropriate service	439	53.6%	569	57.6%
Communication barriers during the utilization of health and social service	529	64.6%	632	64.0%
Lack of opportunities to learn English	207	25.3%	251	25.4%
No Response	65		85	
Total	884		1073	

Table 7: Main Challenges by Gender.

Age Group

According to the Asian Public Health Report (Asian Public Health Project Team, 2003) over half of the Asian population in the Auckland region are aged between 25 and 65 years, while around 20 percent are aged between 15 to 24 years. In the data, the main challenge among the under twenty five age group was related to finding employment. For many migrants potential routes of economic success are self-employment and working in sectors with high concentrations of owners and workers of the same ethnicity (Logan, Alba, & Stulus, 2003). A possible reason for this is that Labour force participation and employment rates have been shown to rise with duration of residence in New Zealand (Dunstan et al., 2003). The report by the New Zealand Immigration Service found that migrants who had been in New Zealand for 10 or more years had the same levels of labour force participation and employment rates as the New Zealand born population (Dunstan et al., 2003). However migrants from North East Asia had low labour force participation rates (particularly females) and did not achieve parity with the equivalent New Zealand born population until after ten years (Dunstan et al., 2003). The other main challenges among the 25-44 age groups were that they did not know their health and civil rights, closely followed by not knowing how to find the appropriate service.

The main challenges among the 45-64 and 65 and above age groups were communication barriers related to using health and social services. A study by Abbott, Wong, Williams, Au

and Young (2000) found that factors significantly associated with having experienced major adjustment problems included being aged 26-35 years, rejection from locals and having low English proficiency.

Figure 7 presents the trends by age group. The numbers above the bars represent the number of participants, and the percentage represents the percentage of the age group that reported each challenge. The trends show that challenges with employment (Cochran-Armitage Trend Test, $p<0.0001$) and orientation on setting up a business (Cochran-Armitage Trend Test, $p<0.0001$) significantly decrease with age, mainly because as they retire they have less need for employment or business related support. On the other hand, communication barriers (Cochran-Armitage Trend Test, $p<0.0001$), lack of opportunities to learn English (Cochran-Armitage Trend Test, $p<0.0001$), and challenges with knowledge about health and civil rights (Cochran-Armitage Trend Test, $p=0.0006$) all significantly increase with age. Knowledge of where to seek appropriate services is borderline but not a significant trend with age (Cochran-Armitage Trend Test, $p=0.08$).

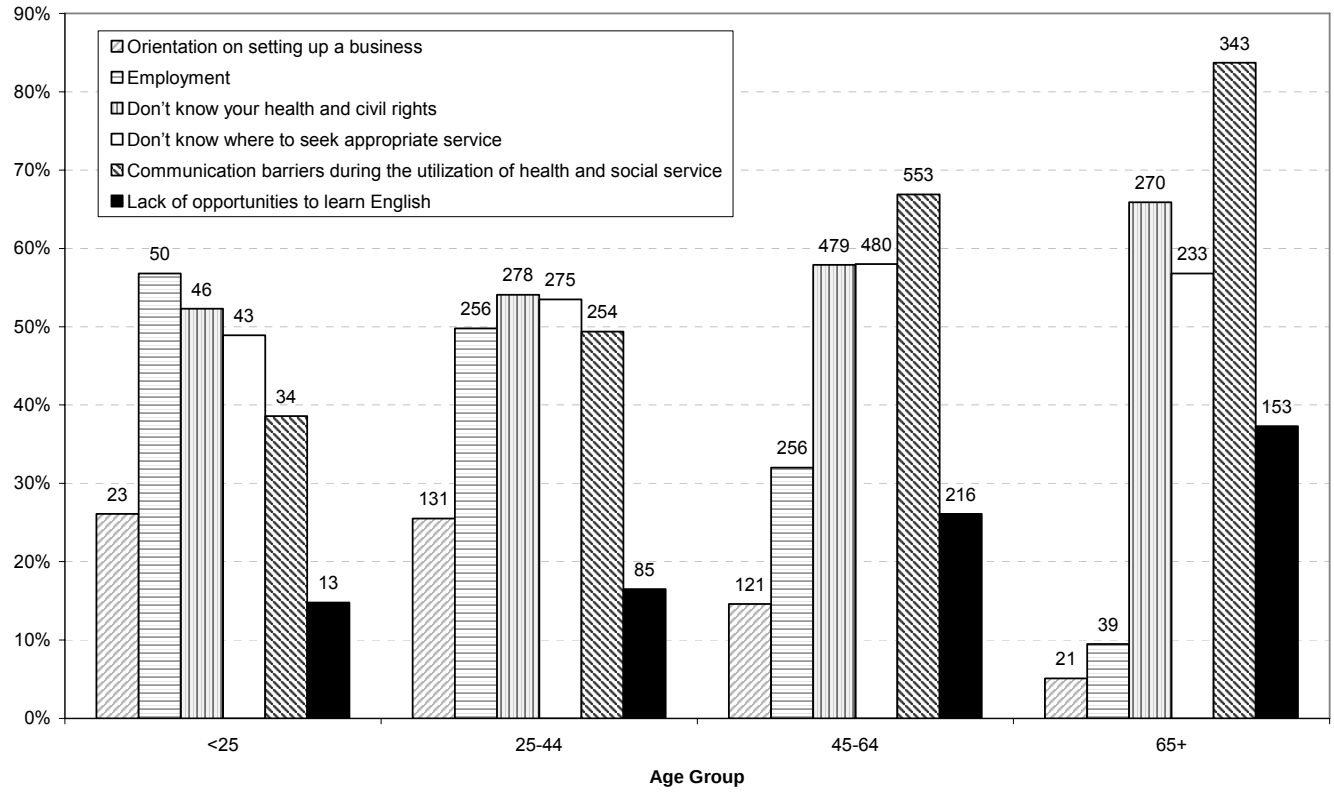

Figure 7 Main Challenges by Age Group

Geographical Region

Table 8 presents the challenges reported by respondents analysed in terms of which part of Auckland they live in. The table highlights challenges with knowledge about where to seek appropriate services (Chi-square, p=0.001). Higher rates were reported in central and southern Auckland compared with those reported in the north and west of Auckland. Communication barriers (Chi-square, p=0.01) also significantly differed by which part of Auckland respondents lived in. None of the other challenges demonstrate significant differences between geographical regions. However, it should be noted that the present region of residence might not be the same as the respondent's initial place of residence in New Zealand.

	Central		East		South		West		North	
	#	%	#	%	#	%	#	%	#	%
Orientation on setting up a business	116	17.3%	98	17.5%	9	9.0%	34	13.8%	35	14.1%
Employment	235	35.1%	178	31.8%	27	27.0%	73	29.7%	92	37.1%
Don't know your health and civil rights	379	56.6%	323	57.7%	62	62.0%	144	58.5%	156	62.9%
Don't know where to seek appropriate service	340	50.7%	323	57.7%	51	51.0%	155	63.0%	152	61.3%
Communication barriers during the utilization of health and social service	399	59.6%	368	65.7%	73	73.0%	172	69.9%	161	64.9%
Lack of opportunities to learn English	163	24.3%	145	25.9%	27	27.0%	64	26.0%	64	25.8%
No Response	46		49		22		11		19	
Total	**716**		**609**		**122**		**257**		**267**	

Table 8: Main Challenges by Geographical Region: Auckland

First Language

Most respondents stated that Mandarin and/or Cantonese was their first language, therefore this analysis focuses only on Mandarin and/or Cantonese language speakers.
Table 9 presents the differences by first language and shows that challenges with employment (Chi-square, p<0.0001) demonstrates significant differences across groups with the higher rates in the Cantonese only language groups. Challenges with knowledge about health and civil rights (Chi-square, p=0.0001), communication barriers (Chi-square, p<0.0001), and lack of opportunities to learn English (Chi-square, p=0.004) demonstrate significant differences across groups, with higher rates in the Mandarin language groups. Challenges with knowledge about where to seek appropriate service (Chi-square, p=0.02) demonstrates significant differences across language groups, with higher rates in the combined Cantonese and Mandarin language group.

	Mandarin Only		Cantonese and Mandarin		Cantonese Only	
	#	%	#	%	#	%
Orientation on setting up a business	157	14.6%	12	11.9%	118	16.5%
Employment	294	27.3%	38	37.6%	258	36.1%
Don't know your health and civil rights	633	58.8%	54	53.5%	345	48.3%
Don't know where to seek appropriate service	569	52.8%	70	69.3%	358	50.1%
Communication barriers during the utilization of health and social service	721	66.9%	65	64.4%	371	51.9%
Lack of opportunities to learn English	290	26.9%	20	19.8%	146	20.4%
No Response	57		6		66	
Total	**1134**		**107**		**781**	

Table 9: Main Challenges by First Language

Place of birth

The place of birth has been restricted to China, Taiwan and Hong Kong for this analysis as these countries account for 96% of the respondents who reported their place of birth.

Consistently all three groups found the lack of knowledge of health and civil rights, knowing where to seek appropriate services and communication barriers to be the most important challenges. However, there are significant differences in the levels reported of challenges across countries of birth, for all challenges except for knowing where to seek appropriate services (Chi-square, p=0.22), which is consistently high across all three countries.

Challenges with language, i.e. communication barriers in accessing health and social services (Chi-square, p<0.0001) as well as lack of opportunities to learn English (Chi-square, p<0.0001), showed significant differences across countries of birth. For both challenges it was highest in the respondents born in China, with decreasing difficulties with those born in Taiwan and lowest rates of difficulties with those born in Hong Kong. This is likely to be related to accessibility to English prior to arrival in New Zealand.

Challenges with employment (Chi-square, p<0.0001) and business orientation (Chi-square, p<0.0001) were significantly different across countries of birth, and are reported to be a more important challenge for respondents born in Taiwan and Hong Kong, in comparison to those born in China. Whereas, challenges with knowing your health and civil rights (Chi-square, p=0.02), was also significantly different across countries of birth, and was reported to be more important for those born in China as compared to those born in Taiwan or Hong Kong.

	China		Taiwan		Hong Kong	
	#	%	#	%	#	%
Orientation on setting up a business	136	12.9%	48	22.6%	104	20.6%
Employment	279	26.4%	91	42.9%	218	43.3%
Don't know your health and civil rights	641	60.6%	124	58.5%	267	53.0%
Don't know where to seek appropriate service	601	56.9%	116	54.7%	282	56.0%
Communication barriers during the utilization of health and social service	762	72.1%	125	59.0%	262	52.0%
Lack of opportunities to learn English	326	30.8%	47	22.2%	80	15.9%
No Response	57		8		63	
Total	1114		220		567	

Table 10: Main Challenges by Place of Birth.

Year of Arrival in New Zealand

Consistently across all groups for year of arrival in New Zealand, the main concern appeared to be communication barriers when accessing health or social services, closely followed by not knowing health or civil rights and not knowing where to seek appropriate services.

Table 11 demonstrates the trends by the year of arrival in New Zealand. The trends show that the reporting of challenges with communication barriers (Cochran-Armitage Trend Test, p=0.0001) and lack of opportunities to learn English (Cochran-Armitage Trend Test, p<0.0001) significantly increase for those that arrived in New Zealand more recently. Also challenges with knowledge about health and civil rights (Cochran-Armitage Trend Test, p<0.0001) and with knowledge about where to seek appropriate services (Cochran-Armitage Trend Test, p=0.0001) significantly decrease with age. However there are no significant trends for challenges with employment (Cochran-Armitage Trend Test, p=0.37) and borderline but not significant trends for orientation on setting up a business (Cochran-Armitage Trend Test, p=0.08).

	<1995		1995-6		1997-8		>1998	
	#	%	#	%	#	%	#	%
Orientation on setting up a business	80	19.5%	91	22.1%	54	11.1%	55	13.9%
Employment	144	35.0%	160	38.8%	139	28.7%	134	33.9%
Don't know your health and civil rights	199	48.4%	230	55.8%	306	63.1%	257	65.1%
Don't know where to seek appropriate service	209	50.9%	231	56.1%	275	56.7%	235	59.5%
Communication barriers during the utilization of health and social service	244	59.4%	240	58.3%	353	72.8%	256	64.8%
Lack of opportunities to learn English	82	20.0%	87	21.1%	144	29.7%	115	29.1%
No Response	56		32		23		13	
Total	**467**		**444**		**508**		**408**	

Table 11: Main Challenges by Year of Arrival.

Living Arrangements

There are a multitude of combinations of possible living arrangements stated by respondents including some inconsistencies in the reported combinations; therefore this analysis will focus on the key components of the family structure, but it needs to be recognised that these may not be accurate categories. It is also important to note that the living arrangements relate to present living arrangements, which may not be representative of the respondents' living arrangement at the time of arrival in New Zealand. It must also be noted that there are some inconsistencies in the reporting of living arrangements, in particular whether the participants answered the questions in relation to themselves or in relation to the household as a whole. For example, whether "children" was interpreted as adult children as well as infants and young children, or "grandparents" was interpreted as the grandparents of the participant or that the household included grandparents of the youngest household member.

Table 12 presents the challenges across members of the household composition. The comparison of respondents that live alone with those that lived with anyone else demonstrated no significant differences for any of the challenges. Comparing living with a spouse with not living with a spouse demonstrated significant higher concern with communication barriers (Chi-square, $p=0.01$) and significantly lower concern with the lack of opportunities to learn English (Chi-square, $p=0.006$). Comparing living with children with not living with children demonstrated significantly higher concern with for orientation (Chi-square, $p=0.01$), employment (Chi-square, $p=0.05$), and communication barriers (Chi-square, $p=0.05$). Comparing living with parent/s with not living with parent/s demonstrated significant higher concern with orientation (Chi-square, $p=0.003$), and employment (Chi-square, $p<0.0001$), as well as significantly lower concern with health and civil rights (Chi-square,

p=0.002), communication barriers (Chi-square, p<0.0001), and lack of opportunities to learn English (Chi-square, p=0.01). Comparing living with sibling/s with not living with sibling/s demonstrated significantly higher concern with employment (Chi-square, p<0.0001) and significantly lower concern for communication barriers (Chi-square, p=0.001).

	Live Alone		Spouse		Children		Parents		Siblings	
	#	%	#	%	#	%	#	%	#	%
Orientation on setting up a business	6	10.0%	207	16.9%	222	17.6%	49	23.2%	23	21.1%
Employment	15	25.0%	403	32.9%	438	34.8%	114	54.0%	59	54.1%
Don't know your health and civil rights	28	46.7%	730	59.5%	721	57.3%	102	48.3%	60	55.0%
Don't know where to seek appropriate service	30	50.0%	692	56.4%	709	56.3%	109	51.7%	60	55.0%
Communication barriers during the utilization of health and social service	38	63.3%	817	66.6%	833	66.2%	100	47.4%	54	49.5%
Lack of opportunities to learn English	17	28.3%	287	23.4%	334	26.5%	39	18.5%	23	21.1%
No Response	8		88		80		22		13	
Total	**68**		**1314**		**1339**		**233**		**122**	

Table 12: Main Challenges by Living Arrangements.

Accessing services

The respondents were asked whether they had utilised any of the services provided by the following organisations.

- Accident Compensation Corporation (ACC)
- Courts
- Child Youth and Family Services (CYFS)
- Department of Internal Affairs (DIA)
- Inland Revenue Department (IRD)
- Local government (Auckland City Council, Manukau City Council, North Shore City Council, Waitakere City Council)
- Police
- Public Hospital (Emergency Department, Outpatients Department, Inpatients Service)
- Race Relations Office[1]
- Tenancy Service
- Work and Income New Zealand (WINZ) [1]

Table 13 provides rates of utilisation for those that responded to this question and the rates of non-response for the respondents. The most commonly accessed service is shown to be IRD, followed by WINZ, DIA, and Emergency Department. The local government organisations have higher levels of non-response than the other organisations, possibly due to the fact that in many cases the respondents live outside the city council regions. Table 14 presents the utilisation rates and non-response rates for the city councils where the respondents are limited to those that live in the relevant regions of Auckland. As it is quite likely that respondents have not always resided in the same region of Auckland, the following analyses will not be restricted to just those in the relevant regions. The high rates of usage of Auckland City Council by those presently living in areas outside central Auckland, suggest that either many have lived for periods of time in central Auckland or that there is some confusion between the services offered by Auckland City Council and the Auckland Regional Council.

[1] Since the survey was conducted the names of some agencies has changed (e.g. WINZ is now Work and Income) and also that some of the agencies listed are in fact subsidiaries of others (e.g. Race Relations Office is a part of the DIA).

	Number	Percent[2]	Rank	Number of Not Stated	Percent Not Stated
ACC	413	22.4%	8	167	8.3%
Courts	110	6.1%	13	194	9.7%
IRD	1138	62.4%	1	185	9.2%
Police	438	24.4%	7	217	10.8%
Emergency Department	561	31.1%	4	204	10.1%
Outpatients Department	512	28.4%	6	209	10.4%
Inpatients Services	357	20.1%	9	236	11.7%
Race Relations Office	26	1.5%	16	238	11.8%
Tenancy Service	332	18.7%	11	234	11.6%
WINZ	675	37.8%	2	222	11.0%
CYF	49	2.8%	15	257	12.8%
Department of Internal Affairs	639	36.2%	3	243	12.1%
Any City Council (Auckland)	538	30.3%	5	237	11.8%
Auckland City Council	332	19.0%	10	265	13.2%
Manukau City Council	332	10.0%	12	303	15.1%
North Shore City Council	104	6.1%	13	305	15.2%
Waitakere City Council	82	4.9%	14	388	19.3%

Table 13: Services Accessed

	Number	Percent[4]	Number of Not Stated	Percent Not Stated
Auckland City Council	187	29.4%	81	11.3%
Manukau City Council	145	23.1%	102	14.0%
North Shore City Council	74	31.5%	32	12.0%
Waitakere City Council	49	23.0%	44	17.1%

Table 14: Services Accessed – Limited to Area of Residence

Gender

Table 15 demonstrates that the most commonly accessed services are the same for males and females, namely IRD, WINZ and DIA. Table 16 presents the full list of utilisation rates of the services by gender.

Examining each of the services for any gender differences demonstrates that there are significant differences for utilisation of Police services (Chi-square, p=0.02) with higher rates of utilisation by males, and Outpatient Health Services (Chi-square, p=0.01) with higher rates of utilisation by females.

[2] Percentage of those that answered this question.

	1st	2nd	3rd
Male	IRD	WINZ	DIA
Female	IRD	WINZ	DIA

Table 15: Top 3 services Accessed by Gender, Excluding City Councils.

	Male		Female	
	#	%	#	%
ACC	190	23.4%	220	22.4%
Courts	53	6.6%	53	5.5%
IRD	494	61.5%	622	63.9%
Police	215	27.3%	216	22.6%
Emergency Department	244	30.6%	305	31.8%
Outpatients Department	203	25.6%	299	31.2%
Inpatients Services	146	18.7%	201	21.3%
Race Relations Office	11	1.4%	15	1.6%
Tenancy Service	156	19.9%	168	17.8%
WINZ	304	38.8%	353	37.0%
CYFS	19	2.5%	28	3.0%
Department of Internal Affairs	297	38.3%	330	35.0%
Any City Council (Auckland)	252	32.2%	273	29.0%

Table 16: All Services Accessed by Gender.

Age Group

Table 17 presents the primary services accessed for each age group, IRD and WINZ were consistently the most accessed organisations across all age groups. Table 18 presents the full list of utilisation of organisation services by age group.

The following services demonstrates significant decreases in utilisation with age: ACC (Cochran-Armitage Trend Test, $p<0.0001$), Courts (Cochran-Armitage Trend Test, $p=0.0002$), IRD (Cochran-Armitage Trend Test, $p<0.0001$), Police (Cochran-Armitage Trend Test, $p<0.0001$), WINZ (Cochran-Armitage Trend Test, $p=0.02$), CYFS (Cochran-Armitage Trend Test, $p=0.010$, DIA (Cochran-Armitage Trend Test, $p<0.0001$), and any City Council (Cochran-Armitage Trend Test, $p<0.0001$). Whereas the Outpatients Health Service demonstrates significant increases in utilisation (Cochran-Armitage Trend Test, $p=0.03$).

	1st	2nd	3rd
< 25	IRD	WINZ	Any City Council
25-44	IRD	WINZ	DIA
45-64	IRD	DIA	Any City Council
65+	WINZ	IRD	Outpatients

Table 17: Top 3 Services Accessed by Age Group, Excluding City Councils.

	<25		25-44		45-64		65+	
	#	%	#	%	#	%	#	%
ACC	26	26.8%	145	28.1%	201	24.2%	39	10.1%
Courts	8	8.4%	48	9.4%	42	5.1%	11	2.9%
IRD	60	63.1%	412	80.0%	507	61.5%	154	40.7%
Police	37	39.4%	176	34.6%	184	22.9%	39	10.5%
Emergency Department	23	24.2%	198	38.8%	220	27.1%	114	30.3%
Outpatients Department	24	25.0%	135	26.6%	223	27.6%	126	33.6%
Inpatients Services	12	12.6%	136	27.3%	134	16.9%	71	19.1%
Race Relations Office	1	1.0%	7	1.4%	11	1.4%	6	1.7%
Tenancy Service	10	10.6%	110	21.9%	130	16.4%	79	21.4%
WINZ	42	44.2%	241	47.1%	225	28.2%	160	43.5%
CYFS	5	5.3%	21	4.2%	16	2.0%	7	2.0%
Department of Internal Affairs	33	34.7%	230	45.5%	289	36.5%	83	22.9%
Any City Council (Auckland)	39	41.1%	183	35.9%	257	32.4%	55	15.3%

Table 18: All Services Accessed by Age Group.

Geographical Region

Table 19 presents the primary services accessed for each geographical region, IRD, WINZ and DIA where consistently the most accessed organisations across most regions, with the exception of the south region where emergency department hospital services was utilised more than DIA services. Table 20 presents the full list of utilisation of organisation services by geographical region.

Examining differences in utilisation rates across the geographical regions demonstrate significant differences for ACC (Chi-square, p=0.003), IRD (Chi-square, p=0.005), and DIA (Chi-square, p=0.008), where there were lower rates of utilisation in south and west regions, with higher rates of utilisation in central and north regions. There were also significant differences in utilisation rates for Inpatients Services (Chi-square, p=0.04), with low rates of utilisation in the north and east regions and high rates of utilisation in south and central regions. While there were low rates of utilisation in the central region, and higher rates of utilisation in the south region of the Race Relations Office (Chi-square, p=0.003). Differences in utilisation of services may relate to the geographical location and convenience of access, particularly in terms of Central Auckland.

	1st	2nd	3rd
Central	IRD	DIA	WINZ
East	IRD	WINZ	DIA
South	IRD	WINZ	Emergency Department
West	IRD	WINZ	DIA
North	IRD	WINZ	DIA

Table 19: Top 3 Services Accessed by Geographical Region.

	Central		East		South		West		North	
	#	%	#	%	#	%	#	%	#	%
ACC	153	23.0%	122	21.7%	16	15.2%	36	16.0%	74	29.5%
Courts	39	6.0%	28	5.1%	5	4.7%	14	6.2%	20	8.2%
IRD	430	66.0%	331	59.8%	50	56.6%	130	56.5%	172	69.1%
Police	165	25.7%	118	21.6%	22	21.0%	61	27.5%	63	25.9%
Emergency Department	214	33.0%	161	29.1%	36	34.6%	63	28.5%	72	29.3%
Outpatients Department	183	28.4%	163	29.4%	35	33.3%	63	28.8%	54	22.2%
Inpatients Services	144	22.6%	89	16.5%	26	25.5%	47	21.4%	43	17.8%
Race Relations Office	5	0.8%	7	1.3%	6	5.8%	4	1.8%	3	1.3%
Tenancy Service	122	19.2%	90	16.6%	20	19.4%	48	21.6%	42	17.6%
WINZ	243	37.8%	191	35.1%	40	38.1%	95	43.2%	91	37.9%
CYFS	16	2.5%	12	2.2%	5	4.9%	4	1.9%	7	2.9%
Department of Internal Affairs	261	41.1%	184	34.2%	28	27.7%	67	30.6%	89	37.2%
Any City Council (Auckland)	198	31.0%	152	18.3%	34	32.4%	63	28.8%	84	35.0%
Auckland City Council	187	29.5%	75	14.2%	13	12.8%	24	11.3%	28	12.0%
Manukau City Council	16	2.6%	116	22.0%	29	28.4%	4	1.9%	3	1.3%
North Shore City Council	11	1.8%	8	1.5%	4	4.0%	4	1.9%	74	31.5%
Waitakere City Council	19	3.2%	6	1.2%	4	4.1%	49	23.0%	3	1.4%

Table 20: All Services Accessed by Geographical Region.

First Language

Table 21 presents the primary services accessed for each age group, IRD was consistently the most accessed organisations across all first language groups, however differences became evident for the next most utilised services. Table 22 presents the full list of utilisation of organisation services by first language group.

Examining differences in utilisation rates across the different first language groups shows significant differences for ACC (Chi-square, $p<0.0001$), IRD (Chi-square, $p<0.0001$), Police (Chi-square, $p<0.0001$), DIA (Chi-square, $p<0.0001$), and any City Council (Chi-square, $p<0.0001$). For all of these services there are lower utilisation rates for respondents whose first language was reported as Mandarin, in comparison with those who reported Cantonese. Also there were significant differences for Emergency Department (Chi-square, $p=0.04$), Tenancy Services (Chi-square, $p=0.0005$), and WINZ (Chi-square, $p<0.0001$). For all these services, there are lower utilisation rates for respondents whose first language is Cantonese, compared to Mandarin. Such differences in utilisation in the language groups could be due to differences in socio-economic status, or length of residence of the respondent, as well as the different perspectives from people with different places of origin.

	1st	2nd	3rd
Mandarin Only	IRD	WINZ	Emergency Department
Cantonese and Mandarin	IRD	WINZ	Outpatients
Cantonese Only	IRD	DIA	Any City Council

Table 21: Top 3 Services Accessed by First Language.

	Mandarin Only		Cantonese and Mandarin		Cantonese Only	
	#	%	#	%	#	%
ACC	163	16.7%	17	17.7%	211	30.9%
Courts	55	5.7%	5	5.3%	40	6.0%
IRD	537	55.9%	53	55.8%	496	72.8%
Police	195	20.6%	23	24.0%	200	30.3%
Emergency Department	315	33.1%	25	26.6%	185	27.5%
Outpatients Department	276	29.1%	32	34.4%	173	25.7%
Inpatients Services	198	21.2%	18	19.8%	113	17.1%
Race Relations Office	13	1.4%	2	2.1%	9	1.4%
Tenancy Service	204	21.8%	18	19.4%	93	14.1%
WINZ	404	42.9%	44	46.8%	194	29.1%
CYFS	27	2.9%	1	1.1%	15	2.3%
Department of Internal Affairs	278	30.1%	28	30.4%	300	45.2%
Any City Council (Auckland)	213	22.9%	21	23.1%	275	41.3%

Table 22: All Services Accessed by First Language.

Place of Birth

Table 23 shows that migrants from all three primary places of origin were most likely to access the IRD. The next commonly accessed service was DIA for migrants from Taiwan or Hong Kong and migrants from China used WINZ with second most frequency. A possible explanation for this is that migrants from China were more likely to be seeking a benefit of some kind than those from Hong Kong or Taiwan.. Table 24 presents the full list of utilisation of services by place of birth.

The lowest utilisation rates of services are for respondents from China compared with those born in Taiwan or Hong Kong. Examining differences in utilisation rates the different countries of birth shows significant differences for ACC (Chi-square, $p<0.0001$), IRD (Chi-square, $p<0.0001$), Police (Chi-square, $p<0.0001$), DIA (Chi-square, $p<0.0001$), and any City Council (Chi-square, $p<0.0001$), where for all of these services there are lower utilisation rates for respondents who reported China as their place of birth in comparison to those who reported Taiwan or Hong Kong. There were also significant differences for Emergency Department (Chi-square, $p=0.03$), Inpatients (Chi-square, $p=0.01$), Outpatients (Chi-square, $p=0.05$), Tenancy (Chi-square, $p<0.0001$), and WINZ (Chi-square, $p<0.0001$). For all these services the highest utilisation rates were for respondents who reported China as their place of birth compared with those born in Taiwan or Hong Kong. Again, such differences in utilisation according to place of birth could be due to socio-economic status, first language or the length of residence of the respondent.

	1st	2nd	3rd
China	IRD	WINZ	Emergency Department
Taiwan	IRD	DIA	Any City Council
Hong Kong	IRD	DIA	Any City Council

Table 23: Top 3 Services Accessed by Place of Birth.

	China		Taiwan		Hong Kong	
	#	%	#	%	#	%
ACC	135	13.5%	56	26.8%	190	35.0%
Courts	48	4.9%	17	8.3%	36	6.7%
IRD	548	55.6%	129	62.0%	405	74.9%
Police	168	17.3%	62	30.4%	180	34.2%
Emergency Department	323	33.2%	58	28.6%	145	27.0%
Outpatients Department	292	30.2%	49	24.3%	135	25.0%
Inpatients Services	215	22.5%	38	18.9%	84	15.9%
Race Relations Office	15	1.6%	1	0.5%	7	1.3%
Tenancy Service	228	23.9%	23	11.4%	66	12.5%
WINZ	491	50.8%	41	20.3%	113	21.4%
CYFS	25	2.7%	5	2.5%	13	2.5%
Department of Internal Affairs	284	30.0%	89	45.4%	242	45.4%
Any City Council (Auckland)	182	19.3%	87	42.9%	231	43.1%

Table 24: All Services Accessed by Place of Birth.

Year of arrival in New Zealand

Inland Revenue was the public service most frequently used by respondents, regardless of their year of arrival. The Department of Internal Affairs and Work and Income also featured prominently amongst respondents as Table 25 shows. Table 26 presents the full list of utilisation of organisation services by year of arrival.

Examining differences in utilisation rates across the year of arrival shows significant trends for ACC (Cochran-Armitage Trend Test , $p<0.0001$), Courts (Cochran-Armitage Trend Test , $p<0.0001$), IRD (Cochran-Armitage Trend Test, $p<0.0001$), Police (Cochran-Armitage Trend Test, $p<0.0001$), Emergency Department (Cochran-Armitage Trend Test , $p<0.0001$), Outpatients (Cochran-Armitage Trend Test, $p=0.0001$), Inpatients (Cochran-Armitage Trend Test, $p=0.001$), Race Relations (Cochran-Armitage Trend Test, $p=0.03$), CYF (Cochran-Armitage Trend Test, $p=0.05$), DIA (Cochran-Armitage Trend Test, $p<0.0001$), and any City Council (Cochran-Armitage Trend Test, $p<0.0001$), with the utilisation rates increasing with length of time since arrival in New Zealand.

Also there were significant trends for WINZ (Cochran-Armitage Trend Test, $p=0.001$), however the utilisation rates decreased with length of time since arrival in New Zealand.

Utilisation rates appeared to increase across all services with the length of stay (except for tenancy services and WINZ), this is obviously linked with awareness and need of services.

	1st	2nd	3rd
< 1995	IRD	DIA	Any City Council
1995-1996	IRD	DIA	WINZ
1997-1998	IRD	WINZ	Outpatients
> 1998	IRD	WINZ	Outpatients

Table 25: Top 3 Services Accessed by Year of Arrival.

	<1995		1995-6		1997-8		>1998	
	#	%	#	%	#	%	#	%
ACC	184	42.0%	101	24.4%	81	17.6%	15	4.0%
Courts	51	11.8%	34	8.4%	13	2.9%	4	1.1%
IRD	332	76.0%	295	71.8%	254	55.5%	175	48.0%
Police	169	39.5%	123	30.6%	88	19.5%	28	7.8%
Emergency Department	166	38.5%	144	35.2%	155	34.2%	56	15.4%
Outpatients Department	153	35.7%	98	24.5%	159	34.6%	64	17.7%
Inpatients Services	110	25.6%	95	23.8%	92	20.6%	38	10.8%
Race Relations Office	9	2.1%	4	1.0%	5	1.1%	1	0.3%
Tenancy Service	81	19.0%	73	18.4%	95	21.2%	48	13.6%
WINZ	134	31.3%	163	40.1%	198	44.1%	132	37.3%
CYFS	17	4.0%	10	2.6%	13	2.9%	4	1.1%
Department of Internal Affairs	213	50.1%	221	55.4%	133	29.9%	32	9.1%
Any City Council (Auckland)	201	47.0%	157	39.6%	103	23.1%	34	9.7%

Table 26: All Services Accessed by Year of Arrival.

Living Arrangements

Inland Revenue was the public service most frequently used by respondents, regardless of their living arrangements. The Department of Internal Affairs and Work and Income also featured prominently amongst respondents as Table 27 shows. Table 28 presents the full list of utilisation of organisation services by living arrangements. It must be noted that there are some inconsistencies in the reporting of living arrangements, in particular whether the participants answered the questions in relation to themselves or in relation to the household as a whole. For example, whether “children” was interpreted as adult children as well as infants and young children, or “grandparents” was interpreted as the grandparents of the participant or that the household included grandparents of the youngest household member.

The comparison of respondents that live alone with those that lived with anyone else reported significantly higher rates of utilisation of Courts (Chi-square, p=0.002). Comparing living with a spouse with not living with a spouse reported significant higher rates of utilisation of IRD (p=0.02), Inpatient (p=0.05), Tenancy (p=0.003), DIA (p=0.001), or any city council (p=0.01). Comparing living with children with not living with children reported significant

higher rates of utilisation of ACC (Chi-square, p=0.05), Emergency Department (Chi-square, p=0.05), Outpatients (Chi-square, p=0.01), and Inpatients (Chi-square, p=0.003). Comparing living with parent/s with not living with parent/s reported significant higher rates of utilisation of ACC (Chi-square, p=0.02), IRD (Chi-square, p<0.0001), Police (Chi-square, p<0.0001), Emergency Department (Chi-square, p=0.03), Inpatients (Chi-square, p<0.0001), WINZ (Chi-square, p=0.0002), CYF (Chi-square, p=0.001), DIA (Chi-square, p<0.0001), or any City Council (Chi-square, p<0.0001). Comparing living with sibling/s with not living with sibling/s reported significantly higher rates of utilisation (Chi-square, p=0.001).

	1st	2nd	3rd
Live Alone	IRD	WINZ	DIA
Spouse	IRD	DIA	WINZ
Children	IRD	WINZ	DIA
Parent	IRD	WINZ	DIA
Siblings	IRD	WINZ	Any City Council

Table 27: Top 3 Services Accessed by Living Arrangements.

	Live Alone		Spouse		Children		Parent		Siblings	
	#	%	#	%	#	%	#	%	#	%
ACC	12	20.3%	287	23.6%	292	23.8%	64	28.7%	29	25.0%
Courts	9	15.5%	69	5.8%	67	5.6%	19	8.6%	9	7.9%
IRD	36	61.0%	783	64.7%	778	64.0%	167	75.2%	76	65.5%
Police	14	24.1%	295	24.9%	288	24.2%	85	39.0%	43	37.1%
Emergency Department	15	25.9%	380	31.8%	393	32.7%	83	37.6%	38	32.8%
Outpatients Department	12	20.7%	335	28.1%	363	30.4%	55	25.2%	25	21.6%
Inpatients Services	7	12.1%	252	21.5%	262	22.2%	66	30.6%	17	14.8%
Race Relations Office	1	1.7%	15	1.3%	19	1.6%	3	1.4%	2	1.7%
Tenancy Service	9	15.8%	239	20.3%	213	18.0%	37	17.1%	14	12.4%
WINZ	19	32.8%	456	38.6%	455	38.2%	108	49.3%	48	42.5%
CYFS	-	-	29	2.5%	33	2.8%	13	6.1%	5	4.4%
Department of Internal Affairs	15	26.3%	453	38.7%	440	37.6%	105	48.2%	44	38.3%
Any City Council (Auckland)	11	19.3%	379	32.3%	355	30.2%	92	41.8%	48	41.0%

Table 28: All Services Accessed by Living Arrangements.

Reasons/Challenges in accessing services

The design of questions addressing reasons for not using a service or identifying "difficulties" (challenges) experienced when using services meant that there was some confusion on the part of the respondents. ACC, IRD, WINZ and DIA have been examined in detail in order to gain a perspective on the services with some of the highest levels of utilisation. An overview of the other services and their reported levels pf reasons/difficulties can be found in the appendices.

Accident Compensation Corporation (ACC)

Table 29 presents some of the issues or concerns identified by respondents with regard to the services provided by ACC. The table shows that a small number of respondents that have utilised ACC services claim to not know that ACC existed or know what services were provided. The former is difficult to explain while the latter could be explained by people who have contacted ACC by phone but were unaware of the services that were offered. A number of respondents who have never used ACC services appear to have an opinion on what ACC does not provide for Chinese immigrants, this could relate to those that have attempted to unsuccessfully utilise ACC services. Lastly there are a number of respondents who have views on why the service was difficult to access but did not state whether they had utilised them. Similar trends can be found in all the other services presented below.

Accident Compensation Corporation (ACC)	Used the service Provided?						Total	
	Yes		No		Not Stated			
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	66	16%	123	9%	12	7%	201	10%
No information in Chinese	53	13%	175	12%	15	9%	243	12%
Not aware of the service existence	3	1%	92	6%	6	4%	101	5%
Don't know the type of services provided	9	2%	176	12%	11	7%	196	10%
No Reasons Stated	330	80%	1,005	70%	133	80%	1,468	73%
Total	413		1,430		167		2,010	

Table 29: Reasons/Challenges in Accessing ACC.

Table 30 presents the reasons or challenges reported with utilising ACC services, compared for the major demographic factors.

Figure 8 and Figure 9 present the key demographics of age and first language in a graphical format to better emphasise the key patterns for these groups. The numbers above the bars represent the number of participants, and the percentage represents the percentage of the group that reported each challenge.

Examining the overall reporting of reasons/challenges with the utilisation of services there are shown to be significant differences

- Gender (Chi-square, p=0.02), where males reported a higher rate of challenges,
- Place of birth (Chi-square, p=0.03) where China was reported as the place of birth reported a higher rate of challenges than Taiwan or Hong Kong.

Examining the individual reasons/difficulties the following was shown:

- For the reasons/challenges “No Chinese speaking staff” the only significant difference was for year of arrival in NZ (Cochran-Armitage Trend Test, p=0.007), where the challenges decreased with length of time in NZ.
- For the reasons/challenges “No Information in Chinese“ there were no significant differences or trends
- For the reasons/challenges “Not aware of the service existence” there were significant difference or trends for
    - Gender had significant differences (Chi-square, p=0.04), with higher rate of challenges reported for males
    - Age had a significant trend (Cochran-Armitage Trend Test, p=0.002), with increasing reporting of challenges with age
    - Place of birth had significant differences (Chi-square, p<0.0001), with respondents born in China reporting higher rates of challenges than those born in Taiwan or Hong Kong
    - Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p<0.0001), with decreased reporting of challenges the longer the respondent was in NZ
    - First language had significant differences (Chi-square, p=0.02), with the reporting of higher rates of challenges for respondents with Mandarin as a first language in comparison to Cantonese
- For the reasons/challenges “Don’t know the type of services provided” there was a significant differences or trends for
    - Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p=0.004), with reported rates of challenges decreasing with the length of time in New Zealand,
    - First language had significant differences (Chi-square, p=0.03), with higher reported rates of challenges for respondents where Mandarin was the first language in comparison with Cantonese.

	Reported Challenges		No Chinese Speaking Staff		No information in Chinese		Not aware of the service existence		Don't know the type of services provided	
Gender	#	%	#	%	#	%	#	%	#	%
Male	261	29.5%	97	11.0%	111	12.6%	55	6.2%	94	10.6%
Female	266	24.8%	100	9.3%	121	11.3%	45	4.2%	96	9.0%
Geographical Region										
Central Auckland	203	28.4%	75	10.5%	94	13.1%	32	4.5%	72	10.1%
East Auckland	154	25.3%	57	9.4%	64	10.5%	32	5.3%	64	10.5%
South Auckland	34	27.9%	12	9.8%	14	11.5%	8	6.6%	11	9.0%
West Auckland	72	28.0%	29	11.3%	36	14.0%	14	5.5%	26	10.1%
North Auckland	71	26.6%	25	9.4%	30	11.2%	14	5.2%	21	7.9%
Place of birth										
China	330	29.6%	115	10.3%	144	12.9%	79	7.1%	119	10.7%
Taiwan	56	25.5%	18	8.2%	18	8.2%	8	3.6%	22	10.0%
Hong Kong	135	23.8%	58	10.2%	71	12.5%	8	1.4%	45	7.9%
Year Arrival in NZ										
<1995	115	24.6%	62	13.3%	60	12.9%	6	1.3%	32	6.9%
1995-6	101	22.8%	39	8.8%	54	12.2%	11	2.5%	40	9.0%
1997-8	150	29.5%	51	10.0%	57	11.2%	39	7.7%	56	11.0%
>1998	133	32.6%	32	7.8%	50	12.3%	35	8.6%	57	14.0%

Table 30: Reasons/Difficulties utilising ACC by Demographics

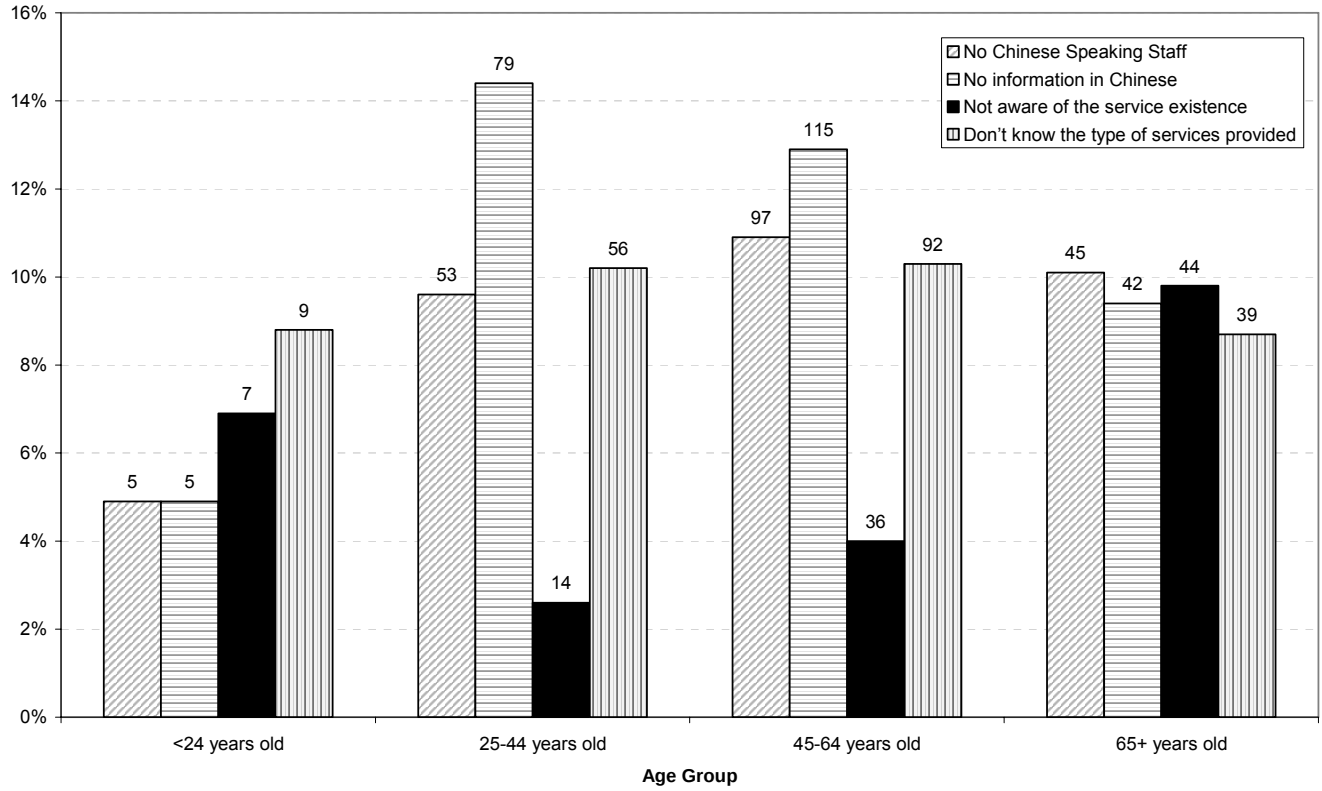

Figure 8 Reasons/Difficulties utilising ACC by Age Group

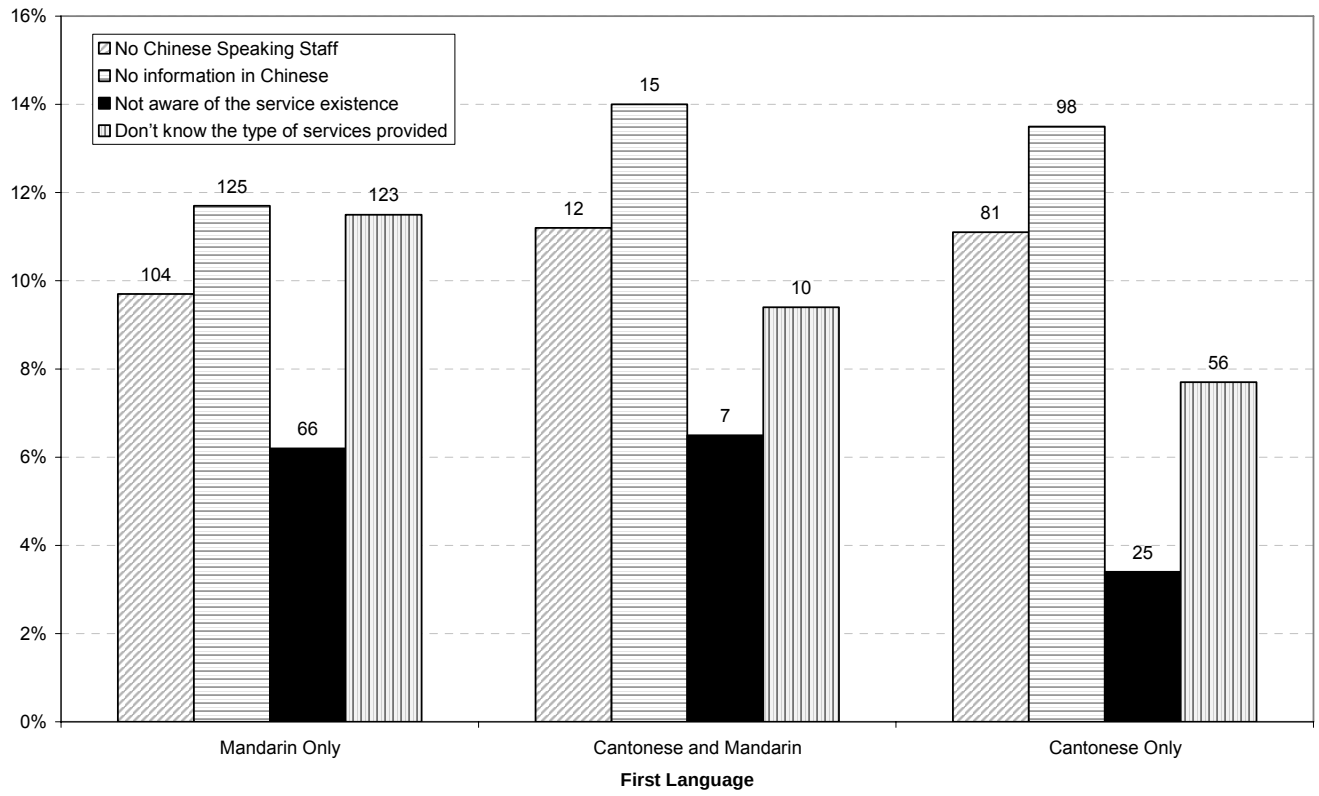

Figure 9 Reasons/Difficulties utilising ACC by First Language

Inland Revenue Department (IRD)

Table 31 presents some of the issues or concerns with regards to the services provided by IRD.

Inland Revenue Department (IRD)	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	193	17%	47	7%	17	9%	257	13%
No information in Chinese	143	13%	65	9%	8	4%	216	11%
Not aware of the service existence	2	0%	19	3%	2	1%	23	1%
Don't know the type of services provided	20	2%	50	7%	2	1%	72	4%
No Reasons Stated	891	78%	539	78%	159	86%	1589	79%
Total	1138		687		185		2010	

Table 31: Reasons/Difficulties in Accessing IRD.

Table 32 presents the reasons or challenges utilising IRD services, compared for the major demographic factors. Examining the overall reporting of reasons/challenges with the utilisation of services there are shown to be significant differences

- Gender (Chi-square, p=0.00), where males reported a higher rate of challenges,
- Year of arrival in NZ (Cochran-Armitage Trend Test, p=0.02), where challenges reported decreased with the length of time in New Zealand.

Examining the individual reasons/challenges the following was shown:

- For the reasons/difficulty "No Chinese speaking staff" there were no significant differences or trends
- For the reasons/difficulty "No Information in Chinese" there were no significant differences or trends
- For the reasons/difficulty "Not aware of the service existence" there were no significant differences or trends
- For the reasons/difficulty "Don't know the type of services provided" there was a significant differences or trends for
    - Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p=0.007), with reported rates of difficulty decreasing with the length of time in New Zealand,
    - First language had significant differences (Chi-square, p=0.007), with higher reported rates of difficulty for respondents where Mandarin was the first language in comparison with Cantonese.

There were no significant age trends, geographical region differences, or place of birth differences. This could be related to minimal engagement at a low level for example everyone who works in New Zealand has to obtain an IRD number which is relatively

straightforward. IRD appeared to have minimal patterns of reported challenges and therefore servicing the Chinese population fairly well across the major subgroups of the population.

	Reported Challenges		No Chinese Speaking Staff		No information in Chinese		Not aware of the service existence		Don't know the type of services provided	
Gender	#	%	#	%	#	%	#	%	#	%
Male	210	23.8%	123	13.9%	108	12.2%	14	1.6%	35	4.0%
Female	202	18.8%	131	12.2%	103	9.6%	9	0.8%	33	3.1%
Age Group										
<24 years old	16	15.7%	6	5.9%	5	4.9%	4	3.9%	7	6.9%
25-44 years old	115	20.9%	73	13.3%	66	12.0%	3	0.6%	17	3.1%
45-64 years old	192	21.5%	122	13.7%	102	11.4%	9	1.0%	32	3.6%
65+ years old	97	21.7%	56	12.5%	52	9.4%	7	1.6%	16	3.6%
Geographical Region										
Central Auckland	153	21.4%	97	13.6%	83	11.6%	5	0.7%	23	3.2%
East Auckland	130	21.4%	77	12.6%	61	10.0%	11	1.8%	26	4.3%
South Auckland	25	20.5%	15	12.3%	15	12.3%	-	-	2	1.6%
West Auckland	60	23.4%	37	14.4%	36	14.0%	3	1.2%	9	3.5%
North Auckland	46	17.2%	29	10.9%	18	6.7%	4	1.5%	9	3.4%
First Language										
Mandarin Only	245	22.9%	93	12.8%	121	10.2%	15	1.4%	51	4.8%
Cantonese and Mandarin	25	23.4%	22	20.6%	17	15.9%	1	0.9%	4	3.7%
Cantonese Only	140	19.2%	135	12.6%	74	10.2%	7	1.0%	14	1.9%
Place of birth										
China	241	21.6%	137	12.3%	128	11.5%	14	1.3%	46	4.1%
Taiwan	50	22.7%	31	14.1%	19	8.6%	4	1.8%	9	4.1%
Hong Kong	114	20.1%	79	13.9%	60	10.6%	2	0.4%	14	2.5%
Year Arrival in NZ										
<1995	85	18.2%	65	13.9%	48	10.3%	4	0.9%	10	2.1%
1995-6	81	18.2%	57	12.8%	41	9.2%	1	0.2%	11	2.5%
1997-8	120	23.6%	66	13.0%	57	11.2%	9	1.8%	21	4.1%
>1998	102	25.0%	53	13.0%	49	12.0%	8	2.0%	25	6.1%

Table 32: Reasons/Challenges Utilising IRD by Demographics

Work & Income NZ (WINZ)

Table 33 presents some of the issues or concerns with regards to the services provided by WINZ.

Work & Income NZ (WINZ)	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	128	19%	61	5%	12	5%	201	10%
No information in Chinese	91	13%	83	7%	16	7%	190	9%
Not aware of the service existence	2	0%	43	4%	3	1%	48	2%
Don't know the type of services provided	11	2%	73	7%	2	1%	86	4%
No Reasons Stated	513	76%	895	80%	194	87%	1602	80%
Total	675		1113		222		2010	

Table 33: Reasons/Challenges in Accessing WINZ.

Table 34 presents the reasons or challenges utilising ACC services, compared for the major demographic factors. Examining the overall reporting of reasons/challenges with the utilisation of services there are shown to be significant differences and trends:

- Gender had significant differences (Chi-square, p=0.0004), where males reported a higher rate of challenges,
- Age had a significant trend (Cochran-Armitage Trend Test, p=0.05), with increased reporting of challenges with age,
- Geographical region had significant differences (Chi-square, p=0.05), with high rates of challenges reported in the west or central regions compared with east or south regions,
- Place of birth had significant differences (Chi-square, p=0.03), with respondents who reported China as the place of birth reported a higher rate of challenges than Taiwan or Hong Kong,
- Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p=0.002), with decreased reporting of challenges reported with length of time in New Zealand,
- First Language had significant differences (Chi-square, p=0.02), with the reporting of higher rates of difficulty for respondents with Mandarin as a first language in comparison to Cantonese.

Examining the individual reasons/challenges the following was shown:

- For the reasons/difficulty "No Chinese speaking staff" the were significant difference or trends for
  - Age had significant differences (Cochran-Armitage Trend Test, p<0.0001), with increased reporting of challenges with age
  - Geographical region had significant differences (Chi-square, p=0.03), with respondents who reside in the west region reporting higher rates in

comparison with central, east, or north regions and the lowest rates in the south regions
    - Place of birth had significant differences (Chi-square, p<0.0001), with respondents who were born in China reporting higher rates of challenges than those born in Taiwan or Hong Kong
    - Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p=0.02), with respondents reporting decreased challenges with the length of time in New Zealand
    - First Language had significant differences (Chi-square, p=0.02) with the reporting of higher rates of difficulty for respondents with Mandarin as a first language in comparison to Cantonese
- For the reasons/difficulty “No Information in Chinese“the were significant difference or trends for
    - Gender had significant differences (Chi-square, p=0.0002), with males reporting higher rates of difficulty
    - Age had a significant trend (Cochran-Armitage Trend Test, p=0.003), with the reporting of challenges increasing with age
    - Geographical region had significant differences (Chi-square, p=0.02), with respondents who reside in the west region reporting higher rates in comparison with central, east, or north regions and the lowest rates in the south regions
    - Place of birth had significant differences (Chi-square, p=0.003), with respondents born in China reporting higher rates of challenges than those born in Taiwan or Hong Kong
    - Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p=0.03), with decreased reporting of challenges the longer the respondent was in NZ
    - first language had significant differences (Chi-square, p=0.02), with the reporting of higher rates of difficulty for respondents with Mandarin as a first language in comparison to Cantonese
- For the reasons/difficulty “Not aware of the service existence” there was a significant trend for age (Cochran-Armitage Trend Test, p=0.05), with decreasing reporting of challenges with age
- For the reasons/difficulty “Don’t know the type of services provided”, there were no significant differences or trends

	Reported Challenges		No Chinese Speaking Staff		No information in Chinese		Not aware of the service existence		Don't know the type of services provided	
Gender	#	%	#	%	#	%	#	%	#	%
Male	209	23.6%	97	11.0%	103	11.7%	26	2.9%	39	4.4%
Female	185	17.2%	96	9.0%	80	7.5%	20	1.9%	42	3.9%
Age Group										
<24 years old	16	15.7%	4	3.9%	1	1.0%	7	6.9%	5	4.9%
25-44 years old	106	19.3%	43	7.8%	48	8.7%	14	2.6%	26	4.7%
45-64 years old	178	19.9%	85	9.5%	90	10.1%	15	1.7%	41	4.6%
65+ years old	105	23.5%	66	14.8%	50	11.2%	12	2.7%	14	3.1%
Geographical Region										
Central Auckland	156	21.8%	70	9.8%	70	9.8%	19	2.7%	40	5.6%
East Auckland	107	17.6%	53	8.7%	48	7.9%	14	2.3%	24	3.9%
South Auckland	19	15.6%	8	6.6%	7	5.7%	1	0.8%	4	3.3%
West Auckland	65	25.3%	39	15.2%	37	14.4%	5	2.0%	9	3.5%
North Auckland	51	19.1%	25	9.4%	24	9.0%	8	3.0%	8	3.0%
First Language										
Mandarin Only	248	23.1%	125	11.7%	117	10.9%	23	2.2%	50	4.7%
Cantonese and Mandarin	22	20.6%	13	12.2%	14	13.1%	3	2.8%	4	3.7%
Cantonese Only	129	17.8%	56	7.7%	54	7.4%	22	3.0%	31	4.3%
Place of birth										
China	259	23.3%	145	13.0%	129	11.6%	25	2.2%	41	3.7%
Taiwan	41	18.6%	12	5.5%	15	6.8%	6	2.7%	12	5.5%
Hong Kong	93	16.4%	35	6.2%	39	6.9%	15	2.7%	29	5.1%
Year Arrival in NZ										
<1995	74	15.9%	34	7.3%	33	7.1%	9	1.9%	19	4.1%
1995-6	79	17.8%	43	9.7%	44	9.9%	4	0.9%	15	3.4%
1997-8	120	23.6%	65	12.8%	54	10.6%	13	2.6%	23	4.5%
>1998	99	24.3%	40	9.8%	42	10.3%	18	4.4%	23	5.6%

Table 34: Reasons/Challenges Utilising WINZ by Demographics

Department of Internal Affairs (DIA)

Table 35 presents some of the issues or concerns with regards to the services provided by DIA.

Department of Internal Affairs	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	99	15%	50	4%	14	6%	163	8%
No information in Chinese	75	12%	69	6%	19	8%	163	8%
Not aware of the service existence	3	0%	42	4%	3	1%	48	2%
Don't know the type of services provided	11	2%	104	9%	6	2%	121	6%
No Reasons Stated	509	80%	901	80%	212	87%	1622	81%
Total	639		1128		243		2010	

Table 35: Reasons/Challenges in Accessing DIA.

Table 36 presents the reasons or challenges utilising DIA services, compared for the major demographic factors. Examining the overall reporting of reasons/challenges with the utilisation of services there are shown to be significant differences

- Gender (Chi-square, $p<0.0001$), where males reported a higher rate of challenges,
- Place of birth (Chi-square, $p=0.005$) where China was reported as the place of birth reported a higher rate of challenges than Taiwan or Hong Kong.
- Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, $p=0.02$), with decreased rates of difficulty with length of time in New Zealand
- First language had significant difference (Chi-square, $p=0.009$), with higher reported rates of difficulty for respondents where Mandarin was the first language in comparison with Cantonese

Examining the individual reasons/challenges the following was shown:

- For the reasons/difficulty "No Chinese speaking staff" the only significant difference was for gender (Chi-square, $p=0.006$), where males reported a higher rate of challenges
- For the reasons/difficulty "No Information in Chinese" there were no significant differences or trends
    - Gender had significant differences (Chi-square, $p<0.0001$), where males reported a higher rate of challenges
    - Geographical region had significant differences(Chi-square, $p=0.005$), with respondents residing in west or central regions reporting higher rates of challenges in comparison with those residing in east, south, or north regions
- For the reasons/difficulty "Not aware of the service existence" there were significant difference or trends for

    - Gender had significant differences (Chi-square, p=0.006), with higher rate of difficulty reported for males
    - Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p=0.0002), with decreased reporting of challenges the longer the respondent was in NZ
- For the reasons/difficulty “Don’t know the type of services provided” there was a significant differences or trends for
    - Place of birth had significant differences (Chi-square, p=0.04), with higher rates of challenges reported by respondents born in China in comparison with those born in Taiwan or Hong Kong
    - Year of arrival in NZ had a significant trend (Cochran-Armitage Trend Test, p=0.0008), with reported rates of difficulty decreasing with the length of time in New Zealand,
    - First language had significant differences (Chi-square, p=0.009), with higher reported rates of difficulty for respondents where Mandarin was the first language in comparison with Cantonese

There were no significant age trends or area differences.

	Reported Challenges		No Chinese Speaking Staff		No information in Chinese		Not aware of the service existence		Don't know the type of services provided	
Gender	#	%	#	%	#	%	#	%	#	%
Male	208	23.5%	89	10.1%	95	10.8%	31	3.5%	56	6.3%
Female	172	16.0%	71	6.6%	62	5.8%	17	1.6%	63	5.9%
Age Group										
<24 years old	20	19.6%	3	2.9%	3	2.9%	9	8.8%	9	8.8%
25-44 years old	106	19.3%	48	8.7%	42	7.6%	8	1.5%	31	5.6%
45-64 years old	174	19.5%	74	8.3%	85	9.5%	17	1.9%	56	6.3%
65+ years old	86	19.2%	37	8.3%	32	7.2%	14	3.1%	25	5.6%
Geographical Region										
Central Auckland	154	21.5%	72	10.1%	71	9.9%	16	2.2%	44	6.2%
East Auckland	105	17.2%	45	7.4%	39	6.4%	17	2.8%	38	6.2%
South Auckland	21	17.2%	10	8.2%	5	4.1%	1	0.8%	7	5.7%
West Auckland	55	21.4%	20	7.8%	29	11.3%	5	2.0%	16	6.2%
North Auckland	44	16.5%	14	5.2%	14	5.2%	9	3.4%	14	5.2%
First Language										
Mandarin Only	240	22.4%	86	8.0%	93	8.7%	27	2.5%	82	7.7%
Cantonese and Mandarin	21	19.6%	14	13.1%	10	9.4%	2	1.9%	6	5.6%
Cantonese Only	120	16.5%	60	8.2%	57	7.8%	19	2.6%	30	4.1%
Place of birth										
China	246	22.1%	94	8.4%	101	9.1%	30	2.7%	81	7.3%
Taiwan	37	16.8%	15	6.8%	12	5.5%	5	2.3%	10	4.6%
Hong Kong	90	15.9%	48	8.5%	43	7.6%	10	1.8%	25	4.4%
Year Arrival in NZ										
<1995	75	16.1%	42	9.0%	36	7.7%	3	0.6%	15	3.2%
1995-6	79	17.8%	46	10.4%	39	8.8%	6	1.4%	15	3.4%
1997-8	105	20.7%	42	8.3%	40	7.9%	14	2.8%	37	7.3%
>1998	99	24.3%	21	5.2%	36	8.8%	21	5.2%	46	11.3%

Table 36: Reasons/Challenges Utilising DIA by Demographics

Services most likely to be utilised in the future

The survey asked respondents to identify the three services that respondents and their families would most likely use within the next five years. Sixty three percent of the respondents identified three services, 15.9% identified one or two services, and 11.4% of the respondents identified no services. However 9.9% identified more than three services, as it is impossible to identify which of the services the respondents were most likely to utilise, all the selected services are including in the following analyses.

The main findings with regard to accessing services were reported as community health, elderly community support, elderly health care, social services and employment skills training. A summary of all responses is shown in Table 37. Where percentages are reported in the following tables these relate to the importance of each service for those that reported any need for future services, for example 70.9% of those that reported any the future access to any service identified that community health would be one of the services.

Employment skills were identified as one of the most important services, however since the survey was completed in 2001, several settlement services and initiatives have been developed in response to difficulties identified by ethnic communities. Two in particular in the Auckland area may have reduced the prominence of these issues. The Chinese New Settlers Services Trust run five multi-service centres providing bi-lingual programmes, seminars and one-on-one case management to meet the settlement needs of local Chinese migrant community. Auckland Regional Migrant Resource Centre (ARMS) provides and Information service and a 'one-stop shop' for migrants that also has designated employment related support services and workshops for migrants seeking employment.

Service	Number	Percent	Rank
Children Health	389	21.8%	6
Family Support	276	15.5%	7
School Social Work	195	10.9%	10
Youth Problems	203	11.4%	9
Elderly Community Support	759	42.6%	2
Elderly Healthcare	600	33.7%	4
Community Health	1262	70.9%	1
Disability Support	94	5.3%	12
Social Services	648	36.4%	3
Counselling	229	12.9%	8
Mental Health	150	8.4%	11
Employment Skills Training	550	30.9%	5
None Stated	229	-	

Table 37: Future Service Utilisation.

Gender

Table 38 presents the services most likely to be used in the future by gender. The services for mental health (Chi-square, p=0.01) and employment skills training (Chi-square, p=0.02) show significant differences across genders, with higher rates for females than males. No other services demonstrated significant differences across genders.

	Male		Female	
	#	%	#	%
Children Health	168	21.4%	214	22.6%
Family Support	111	14.1%	153	16.1%
School Social Work	87	11.1%	103	10.9%
Youth Problems	85	10.8%	112	11.8%
Elderly Community Support	341	43.4%	392	41.3%
Elderly Healthcare	260	33.1%	317	33.4%
Community Health	547	69.7%	683	72.0%
Disability Support	41	5.2%	48	5.1%
Social Services	284	36.2%	345	36.4%
Counselling	105	13.4%	110	11.6%
Mental Health	50	6.4%	92	9.7%
Employment Skills Training	223	28.4%	318	33.5%
None Stated	99		124	
Total	884		1073	

Table 38: Future Service Utilisation According to Gender

Age Group

Table 39 presents the services most likely to be used in the future by age group. Consistently across all age groups community health was most reported as the service likely to be utilised in the next 5 years. When examining the trend across the age groups community health was identified as significantly increasing in perceived future importance with age (Cochran-Armitage Trend Test, p<0.0001).

As would be expected, elderly community support (Cochran-Armitage Trend Test, p<0.0001) and elderly healthcare (Cochran-Armitage Trend Test, p<0.0001) significantly increased in perceived importance with age. Whereas, youth problems (Cochran-Armitage Trend Test, p<0.0001), school social work (Cochran-Armitage Trend Test, p<0.0001), children health (Cochran-Armitage Trend Test, p<0.0001), family support (Cochran-Armitage Trend Test, p<0.0001) and employment skills training (Cochran-Armitage Trend Test, p<0.0001) significantly decreased in perceived future importance, even allowing for the lower rates for children health and family support in the less than 25 year old age group. Mental health (Cochran-Armitage Trend Test, p=0.06) showing a borderline but not significant decrease in perceived importance.

	<25		25-44		45-64		65+	
	#	%	#	%	#	%	#	%
Children Health	25	26.6%	238	47.6%	89	11.1%	35	9.4%
Family Support	10	10.6%	141	28.2%	84	10.5%	36	9.7%
School Social Work	29	30.9%	97	19.4%	50	6.2%	18	4.9%
Youth Problems	22	23.4%	96	19.2%	76	9.5%	7	1.9%
Elderly Community Support	9	9.6%	92	18.4%	375	46.6%	278	74.9%
Elderly Healthcare	13	13.8%	71	14.2%	287	35.7%	222	59.8%
Community Health	53	56.4%	314	62.8%	585	72.8%	304	81.9%
Disability Support	6	6.4%	20	4.0%	46	5.7%	21	5.7%
Social Services	29	30.9%	163	32.6%	328	40.8%	125	33.7%
Counselling	7	7.5%	59	11.8%	122	15.2%	37	10.0%
Mental Health	10	10.6%	46	9.2%	65	8.1%	29	7.8%
Employment Skills Training	52	55.3%	241	48.2%	243	30.2%	12	3.2%
None Stated	8		50		90		76	
Total	102		550		894		447	

Table 39: Future Service Utilisation According to Age group

Geographical Region

Table 40 presents the services most likely to be used in the future by geographical region. Consistently across all regions community health was most reported as the service likely to be utilised in the next 5 years.

Elderly Community Service (Chi-square, p=0.001), Community Health (Chi-square, p=0.04) and employment skills training (Chi-square, p=0.02) show significant differences across geographical regions. No other services demonstrated significant differences across regions.

	Central		East		South		West		North	
	#	%	#	%	#	%	#	%	#	%
Children Health	155	23.9%	103	19.0%	24	25.0%	55	24.2%	46	19.2%
Family Support	91	14.0%	87	16.1%	15	15.6%	34	15.0%	39	16.3%
School Social Work	62	9.6%	69	12.8%	9	9.4%	23	10.1%	28	11.7%
Youth Problems	84	12.9%	57	10.5%	7	7.3%	19	8.4%	34	14.2%
Elderly Community Support	253	39.0%	218	40.3%	44	45.8%	125	55.1%	104	43.3%
Elderly Healthcare	211	32.5%	170	31.4%	38	39.6%	86	37.9%	83	34.6%
Community Health	469	72.3%	364	67.3%	67	69.8%	177	78.0%	165	68.8%
Disability Support	33	5.1%	31	5.7%	8	8.3%	7	3.1%	13	5.4%
Social Services	240	37.0%	206	38.1%	34	35.4%	75	33.0%	81	33.8%
Counselling	85	13.1%	72	13.3%	8	8.3%	29	12.8%	30	12.5%
Mental Health	46	7.1%	45	8.3%	9	9.4%	23	10.1%	24	10.0%
Employment Skills Training	223	34.4%	165	30.5%	20	20.%	57	25.1%	77	32.1%
None Stated	67		68		26		30		27	
Total	716		609		122		257		267	

Table 40: Future Service Utilisation According to Geographical Region

First Language

Table 41 presents the services most likely to be used in the future by first language of the respondent. Consistently across all language groups community health was most reported as the service likely to be utilised in the next 5 years.

There are significant differences in future perceived utilisation for children health (Chi-square, p=0.01), elderly community service (Chi-square, p<0.0001), elderly healthcare (Chi-square, p=0.003), community health (Chi-square, p=0.001), with higher rates for respondents whose first language of Mandarin in comparison with those whose first language is Cantonese.

There are significant differences in future perceived utilisation for youth problems (Chi-square, p=0.0005), social services (Chi-square, p=0.007), with higher rates for respondents whose first language of Cantonese in comparison with those whose first language is Mandarin.

Mental health (Chi-square, p=0.09) shows a borderline difference in perceived future importance. No other services demonstrated significant differences across regions.

	Mandarin Only		Cantonese and Mandarin		Cantonese Only	
	#	%	#	%	#	%
Children Health	228	24.1%	26	26.0%	120	18.3%
Family Support	144	15.2%	21	21.0%	97	14.8%
School Social Work	89	9.4%	14	14.0%	81	12.4%
Youth Problems	86	9.1%	9	9.0%	100	15.2%
Elderly Community Support	453	47.9%	46	46.0%	219	33.4%
Elderly Healthcare	338	35.8%	38	38.0%	184	28.1%
Community Health	703	74.4%	71	71.0%	433	66.0%
Disability Support	45	4.8%	6	6.0%	37	5.6%
Social Services	312	33.0%	38	38.0%	267	40.7%
Counselling	114	12.1%	18	18.0%	85	13.0%
Mental Health	93	9.8%	8	8.0%	44	6.7%
Employment Skills Training	264	27.9%	32	32.0%	240	36.6%
None Stated	127		7		72	
Total	1072		107		728	

Table 41: Future Service Utilisation by First Language.

Place of birth

Table 42 presents the services most likely to be used in the future by place of birth. Consistently across all three countries of birth community health was most reported as the service likely to be utilised in the next 5 years.

When examining the comparisons across place of birth, community health (Chi-square, p<0.0001), elderly community support (Chi-square, p<0.0001), elderly healthcare (Chi-

square, p<0.0001), and children health (Chi-square, p<0.0001), showed significant differences by place of birth. These services were viewed as more important in the future by respondents born in China compared with Taiwan or Hong Kong. Youth problems (Chi-square, p<0.0001), and employment skills training (Chi-square, p<0.0001) also showed significant differences across countries of birth. These services were viewed as less important in the future by respondents born in China compared with Taiwan or Hong Kong. Social services (Chi-square, p=0.05) also showed significant differences across countries of birth, with respondents from Hong Kong identifying them as more important in the future compared to people born in China or Taiwan. Disability support (Chi-square, p=0.01) also showed significant differences across countries of birth, with respondents from Taiwan identifying them as more important in the future compared to people born in China or Hong Kong. Whereas, family support (Chi-square, p=0.08), showed some borderline but non-significant differences.

	China		Taiwan		Hong Kong	
	#	%	#	%	#	%
Children Health	271	27.6%	32	15.3%	72	14.1%
Family Support	159	16.2%	40	19.1%	66	12.9%
School Social Work	96	9.8%	26	12.4%	67	13.1%
Youth Problems	70	7.1%	36	17.2%	85	16.7%
Elderly Community Support	483	49.2%	71	34.0%	172	33.7%
Elderly Healthcare	376	38.3%	53	25.4%	137	26.9%
Community Health	741	75.5%	144	68.9%	328	64.3%
Disability Support	41	4.2%	19	9.1%	28	5.5%
Social Services	337	34.4%	70	33.5%	206	40.4%
Counselling	118	12.0%	26	12.4%	73	14.3%
Mental Health	86	8.8%	23	11.0%	35	6.9%
Employment Skills Training	251	25.6%	89	42.6%	190	37.3%
None Stated	133		11		57	
Total	1114		220		567	

Table 42: Future Service Utilisation by Place of Birth.

Year of arrival in New Zealand

Table 43 presents the services most likely to be used in the future by year of arrival in New Zealand. Consistently across all groups of years of arrival in New Zealand, community health and elderly community support were reported as the services most likely to be utilised in the next 5 years.

When examining the trend across year of arrival in New Zealand, community health (Cochran-Armitage Trend Test, p<0.0001), elderly community support (Cochran-Armitage Trend Test, p=0.0001), elderly healthcare (Cochran-Armitage Trend Test, p=0.03), and children health (Cochran-Armitage Trend Test, p=0.006), were identified as significantly increasing in perceived future importance with age. Whereas, youth problems (Cochran-Armitage Trend Test, p=0.0003), and mental health (Cochran-Armitage Trend Test, p=0.03) have significantly decreased in perceived future importance.

	<1995		1995-6		1997-8		>1998	
	#	%	#	%	#	%	#	%
Children Health	75	18.1%	95	24.1%	87	18.8%	107	29.2%
Family Support	56	13.5%	60	15.2%	61	13.1%	72	19.6%
School Social Work	40	9.7%	54	13.7%	44	9.5%	42	11.4%
Youth Problems	68	16.4%	57	14.4%	41	8.8%	26	7.1%
Elderly Community Support	145	35.0%	155	39.2%	226	48.7%	166	45.2%
Elderly Healthcare	124	30.0%	130	32.9%	166	35.8%	127	34.6%
Community Health	261	63.0%	275	69.6%	365	78.7%	259	70.6%
Disability Support	26	6.3%	30	7.6%	22	4.7%	10	2.7%
Social Services	143	34.5%	145	36.7%	179	38.6%	123	33.5%
Counselling	59	14.3%	44	11.1%	56	12.1%	44	12.0%
Mental Health	47	11.4%	27	6.8%	44	9.5%	23	6.3%
Employment Skills Training	136	32.9%	135	34.2%	128	27.6%	122	33.2%
None Stated	53		49		44		41	
Total	467		444		508		408	

Table 43: Future Service Utilisation by Year of Arrival.

Living Arrangements

Table 44 presents future perceived utilisation for the surveyed services by components of living arrangements. As outlined earlier, there are some inconsistencies in the reporting of living arrangements, in particular whether the participants answered the questions in relation to themselves or in relation to the household as a whole. For example, whether “children” was interpreted as adult children as well as infants and young children, or “grandparents” was interpreted as the grandparents of the participant or that the household included grandparents of the youngest household member.

The comparison of respondents that live alone with those that lived with anyone else reported significant lower rates of future perceived utilisation for elderly healthcare (Chi-square, p=0.08).

Comparing living with a spouse with not living with a spouse reported significant higher rates of future perceived utilisation for family support (Chi-square, p=0.08), and significantly lower rates of future perceived utilisation for Elderly healthcare (Chi-square, p=0.001) lower rate, and elderly community support (Chi-square, p=0.09).

Comparing living with children with not living with children reported significant higher rates of future perceived utilisation for children health (Chi-square, p=0.0002), family support (Chi-square, p=0.07), or youth problems (Chi-square, p=0.08), and significantly lower rates of future perceived utilisation for elderly healthcare (Chi-square, p=0.09).

Comparing living with parent/s with not living with parent/s reported significant higher rates of future perceived utilisation for children health (Chi-square, p<0.0001), family support (Chi-square, p=0.008), school social work (Chi-square, p<0.0001), and employment skills training

(Chi-square, p<0.0001), and significantly lower rates of future perceived utilisation for elderly community support (Chi-square, p<0.0001), elderly healthcare (Chi-square, p<0.0001), community health (Chi-square, p=0.004), and social services (Chi-square, p=0.04).

Comparing living with sibling/s with not living with sibling/s reported significantly higher rates of future perceived utilisation for children health (Chi-square, p=0.005), school social work (Chi-square, p=0.0005), youth problems (Chi-square, p=0.01), or employment skills training (Chi-square, p<0.0001), and significantly lower rates of future perceived utilisation for elderly community support (Chi-square, p<0.0001), elderly healthcare (Chi-square, p=0.009), or community health (Chi-square, p=0.004).

	Live Alone		Spouse		Children		Parent		Siblings	
	#	%	#	%	#	%	#	%	#	%
Children Health	9	14.1%	274	23.3%	296	24.7%	80	37.0%	36	33.0%
Family Support	7	10.9%	191	16.3%	195	16.3%	46	21.3%	19	17.4%
School Social Work	10	15.6%	125	10.6%	137	11.4%	42	19.4%	23	21.1%
Youth Problems	6	9.4%	133	11.3%	150	12.5%	32	14.8%	21	19.3%
Elderly Community Support	33	51.6%	485	41.3%	496	41.4%	62	28.7%	25	22.9%
Elderly Healthcare	28	43.8%	364	31.0%	386	32.2%	53	24.5%	24	22.0%
Community Health	46	71.9%	838	71.3%	849	70.9%	135	62.5%	64	58.7%
Disability Support	1	1.6%	65	5.5%	62	5.2%	14	6.5%	6	5.5%
Social Services	22	34.4%	431	36.7%	422	35.2%	65	30.1%	37	33.9%
Counselling	8	12.5%	157	13.4%	155	12.9%	22	10.2%	9	8.3%
Mental Health	7	10.9%	102	8.7%	102	8.5%	19	8.8%	10	9.2%
Employment Skills Training	18	28.1%	379	32.3%	377	31.5%	96	44.4%	56	51.4%
None Stated	4		139		141		17		13	
Total	**68**		**1314**		**1339**		**233**		**122**	

Table 44: Future Service Utilisation by Living Arrangement

Discussion of the main findings

Some clear barriers to Chinese New Zealanders using services emerged from the survey, which will be discussed below, followed by some issues for further discussion and an elaboration of how settlement services have developed since this survey was conducted.

Barriers

The main barriers to accessing services appear to be related to communication difficulties and knowledge gaps. It is noted that, since the survey was administered a number of services have been developed to address such gaps and these will be discussed later.

Communication barriers

Communication barriers and a lack of English proficiency were identified as the main difficulty experienced by the Chinese survey respondents when living in New Zealand. Lack of English language proficiency impacts on access to health care, employment prospects, income levels and other factors which determine health status (Asian Public Health Project Team, 2003). A study of Chinese Australians found that Chinese migrants preferred to use Chinese speaking General Practitioners (Chan & Quine, 1997). The link between language and accessing health care is further strengthened by the findings of a New Zealand study where self-rated fair or poor health was found to be associated with Chinese-only reading knowledge, residency of more than 5 years and regretting having come to New Zealand (Abbott et al., 2000) and a study of Chinese American women which found that lack of English language ability was a major barrier to access (Liang, Yuan, Mandelblatt, & Pasick, 2004).

Similarly in Auckland language and cultural differences were found to be significant barriers in utilisation of services (Ngai et al., 2001) and the authors recommended the provision of information about services in Asian languages as a strategy to minimise problems related to miscommunication (Ngai et al., 2001). In turn language issues were identified by health professionals as a barrier to providing services to Asians (Ngai et al., 2001). Recommendations of the Asian Public Health report include: reducing language and cultural barriers by providing interpreters, recruiting more Asian health professionals, and developing culturally-sensitive services (Asian Public Health Project Team, 2003).

Unaware of health and civil rights

A second major finding that was alarming in the current consumer focused health and social services environment was that participants did not know their health and civil rights. There is a history of Chinese people in New Zealand being denied their full civil and political rights up till the 1950's (Lunt, Spoonley, & Mataira, 2002) for example the 1898 Old Age Pension Act excluded Asian residents (McClure, 1998 cited in Lunt et al., 2002) and the poll tax which

had been applied to Chinese only was abolished during the Second World War. Every person in New Zealand has rights under the Code of Health and Disability Services Consumers' Rights and when Chinese clients receive health care they need to be advised of their rights and be able to exercise them. In particular Right one includes the right for services to take into account the cultural, religious, social and ethnic needs, values and beliefs of the client (The Health and Disability Commissioner, 1996).

Not knowing where to seek the appropriate service

Not knowing where to find the appropriate service highlights the importance of primary health care, which is seen as a pivotal mechanism for addressing health inequalities as well as being linked with access to other services. Primary health care strategy priority objectives for reducing inequalities are concerned with ensuring that services are both accessible and appropriate for people from lower socioeconomic groups, Māori and Pacific peoples (Ministry of Health, 2001). An English study by Sprostson, Pitson and Walker (2001) found that the self-reported general health status of Chinese people was similar to that of the general population and better than that of other minority ethnic populations. However, it was found that general practitioner (GP) consultation levels were low by Chinese people compared with the general population and with other minority ethnic groups. Factors that enhanced general practitioner consultation were related to gender, self-reported health status and the ability to speak English. The latter being the strongest positive predictor of general practitioner consultations. A community survey of 271 Chinese migrants from Hong Kong and Taiwan aged 15 years and older living in Auckland found that forty-two per cent had consulted a doctor within the past 12 weeks (Abbott et al., 2000). A study amongst Asians in Auckland also found that GP's were the first port of call when Asians found they had a health problem, followed by public accident and emergency centres and seeking help from relatives and friends (Ngai et al., 2001). The issue of cost was found to be significant in the same study (Ngai et al., 2001) with many respondents being more used to free services in their home countries, so it is possible that in this study cost was a factor. Waiting times and the quality of health information were also significant (Ngai et al., 2001).

Other issues

Lack of information in Asian languages

Understanding and accessing services was a key finding in the data and similarly was identified in research conducted some years ago where respondents stated they would have liked information about the health system, accident and emergency services, women's health, dental health, public health and prevention services (Ngai et al., 2001).

City Councils

Respondents referred to four city councils, Manukau City, North Shore City, Auckland City and Waitakere City. A report by Watts and Trlin found that (2000) many central and local

government organisations make effective use of the language skills and cultural backgrounds of their NESB immigrant employees, but many others under-value and under-utilise these resources. The report also recommended that a comprehensive policy framework be developed for planning and managing public sector services to meet the needs of immigrants from different backgrounds (Watts & Trlin, 2000). Of the 157 central and local government organisations that participated in the study 22.3% (35) had explicit policies on the provision of services in languages other than English. Only 8.1% of these were local government agencies.

Complementary therapies

Other studies have found that Chinese migrants used complementary therapies if Western methods failed (Chan & Quine, 1997). While an American study found that alternative and complementary therapies were used at a fairly low rate (6.5%) among Asians (Keith, Kronenfeld, Rivers, & Liang, 2005).

Transportation

Surprisingly this was not identified in the survey as a barrier to accessing health and social services. A recommendation from a Chinese American study was that help with transportation, especially for those living in suburban areas where public transportation is not readily available was a significant asset and improved access to services (Liang et al., 2004).

Regional differences

A study of Chinese Australians found differences in terms of Hong Kong migrants who they found tended to use health care services more than migrants from China (Chan & Quine, 1997). It is significant that this survey found that Chinese born respondents had more difficulty communicating when using health services than Hong Kong born and Taiwanese born, this could be due to different levels of familiarity with English prior to migrating to New Zealand.

Developments in settlement services since the survey

A report commissioned by the New Zealand Immigration service found that migrants had four areas of need: everyday needs, learning English, employment, and supportive connections. They concluded that there were service gaps in all four of those areas.(Ho, Cheung, Bedford, & Leung, 2000). Since then (and since the survey was conducted) a range of settlement programmes have been funded in the Auckland area to assist with these areas of need. These include:

- The Citizens Advice Bureau and Multi-lingual mini-Citizens Advice Bureaux (CAB) within the Auckland Regional Migrant Resource Centre.
- Relationship Services Relating well in New Zealand seminars.
- Shakti Migrant Service (Comprehensive orientation, one-on-one case management and social services support; Employment facilitation, guidance, and job skill training for individuals).
- Auckland Chamber of Commerce New Kiwis website for work placements / job matching; delivery of employment seminars, workshops, and a few one-on-one job seeking sessions when required.
- Migrant Services North Shore (A client liaison service that works across agencies to provide one-on-one settlement services in order to create pathways for positive settlement and employment outcomes for migrants).
- The Refugee and Migrant Service provides refugee re-settlement services including housing, ESOL tuition, social services, education, health and employment, etc to 750 quota refugees annually as well as family reunification and non-quota family reunification. The NZIS provides funding to assist in the training and appointment of volunteers.

It is important to locate these findings in the changing policy context of New Zealand. Not only have new settlement programmes been funded and developed, but initiatives to develop an Immigration Settlement Strategy for migrants, refugees and their families are underway with further activity occurring regionally. The strategy's six goals for migrants and refugees are apposite for consideration here. They are for migrants and refugees to:

- Obtain employment appropriate to their qualifications and skills;
- Are confident using English in a New Zealand setting, or can access appropriate language support to bridge the gap;
- Are able to access appropriate information and responsive services that are available to the wider community (for example housing, education, and services for children);
- Form supportive social networks and establish a sustainable community identity;
- Feel safe expressing their ethnic identity and are accepted by, and are part of, the wider host community; and
- Participate in civic, community and social activities.

Work and Income has developed an Auckland metro migrant and refugee strategy and has enhanced employment services for migrants and refugees in Auckland since 2003, including:

- Integrating Work and Income employment services into community migrant and refugee centres
- Establishing specialist migrant employment programmes and services
- Reducing case loads for specialist case managers to provide more intensive one-on-one assistance.
- An Auckland based multi-lingual call centre with national coverage has been established which offers 11 languages, and complements Language Line, also available for Work and Income clients.

Recommendations: Improving access

There is a dearth of peer reviewed research evaluating the interventions to improve access (Atkinson et al., 2001), this section outlines some strategies for addressing barriers to access and discusses further key themes identified in this report.

English language

Ensure that Chinese migrants are aware of Language line and encourage them to take up their English for Migrants language courses, as proficiency is a key settlement enhancer. The migrant levy that migrants pay when coming to New Zealand entitles migrants to take up English language classes (English for Migrants). The Tertiary Education Commission pays for English language tuition on behalf of migrants to New Zealand who have pre-paid for their training, recent news reports indicate that few migrants take up these classes.

Language line was developed in 2003 by the Office of Ethnic Affairs. Language Line provides telephone-based interpreting support to 10 agencies in 37 languages (including Cantonese and Mandarin) and is available from Monday to Friday 9am - 6pm. This service is free to clients and the process involves phoning or visiting the agency. Then the client needs to ask for the language they want and wait. An Interpreter is usually available within two minutes, to help the client talk to the agency. Several of those agencies are mentioned in this report including:

- Accident Compensation Corporation
- Housing NZ Corporation
- NZ Police
- Tertiary Education Commission (English for Migrants)
- Department of Internal Affairs (Office of Ethnic Affairs, Passports, Citizenship, Births, Deaths and Marriages)
- Department of Labour (Employment Relations Service and New Zealand Immigration Service)
- Ministry of Economic Development (Electrical Workers Licensing Group, Insolvency and Trustee Service, Measurement and Product Safety Service, Ministry of Consumer Affairs – Consumer Line, New Zealand Companies Office)
- Ministry of Social Development (New Zealand Superannuation, Study Link, and Work and Income).

Primary health care

Improve responsiveness in the primary care arena which is often the first point of access to health care. The primary health care strategy was launched in 2001 and has been designed with community involvement in mind so local people can have input into the planning and

delivery of services. It is the role of health workers to work together to reduce health inequalities and to address the causes of poor health status, accessibility, affordability and co-ordination are key. However, there is no mention of Asian populations in the strategy which focuses on the needs of Māori and Pacific populations. The strategy also has a focus on cultural competence, which will be discussed in greater detail later in this report. The Ministry of Health is working with the health sector to progressively implement the Strategy over the next few years. The needs of Chinese in New Zealand need to be considered.

Information about health and civil rights

Ensure that Chinese clients are aware of the Code of Health and Disability Services Consumers' Rights. The Code of Health and Disability Services Consumers' Rights became law on 1 July 1996 as a regulation under the Health and Disability Commissioner Act. Ostensibly as a means of being responsive, accountable to and focused on consumers. A number of rights are conferred on all consumers of health and disability services in New Zealand and it places corresponding obligations on providers of those services. There is a copy available on the Health and Disability Commissioner website. Service providers need to be aware of the need to let Chinese people know that such information is available in Chinese.

Improving services

Improve the capacity and responsiveness of services, by providing access to advocacy services, improve the quality and quantity of interpreter services and provide Chinese-written pamphlets (Sproston et al., 2001) and develop the role of ethnic support workers.

Supporting ethnic organisations

Support the work of existing community organisations. The Asian Public Health Project Team recommended that existing Asian community organisations were resourced in order to facilitating ongoing advocacy and development of better access for Asians (Asian Public Health Project Team, 2003).

Implications for ACC

Having presented the findings of the survey and discussed barriers and recommendations broadly, this section attempts to draw together the findings in relation to the work of ACC.

ACC aims to: “prevent injury, to provide the best treatment and care if injury occurs, and to quickly rehabilitate people back to work or independence at a price that offers high value to levy payers and all New Zealanders”. The survey data suggests that there are sub-groups within the category Chinese New Zealanders who experience difficulties in accessing ACC and thus thwart this aim, in particular men, Chinese born (versus Hong Kong and Taiwanese born), older Chinese migrants and Mandarin speakers (versus Cantonese). Difficulties appeared to decrease with length of stay in New Zealand. In responding to these sub-groups it is noteworthy to review the work being done in regard to improving access and outcomes for Māori and Pacific peoples demonstrated through the application of the principles of partnership, participation and protection in relation to service delivery to these groups (Accident Compensation Corporation, undated-a, undated-b) as there could be implications for Chinese and other Asians. In particular Accident Compensation Corporation’s view that the Treaty of Waitangi is a fundamental aspect of the relationships with these communities and thus Asians too have the rights of equality promised under the treaty to all New Zealand citizens. The report builds and advances on the concepts of cultural competencies which have been outlined in relation to Māori (Accident Compensation Corporation, 2004), and strategies are located within the literature identified in relation to this concept. A caveat on the findings below, is that little is available in the way of peer reviewed articles that identify solutions, as far more research has focused on the definition of the problem of access and that economic evaluations of interventions to improve access are absent (Atkinson et al., 2001). Furthermore, it is hoped that the implications of these findings are extended beyond the Chinese community to the Asian, Migrant and Refugee populations.

Strategies

The implications for ACC are conceptualised around a framework of cultural competence derived from health care literature. This framework has been chosen because of the literature available and with awareness of the use of cultural safety within Nursing as being largely focused on Maori. Cultural competence can be defined as “ the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients social cultural and linguistic needs (Betancourt, Alexander R.

Green, & Carrillo, 2002, pp., v). Betancourt et al., (2002) suggest that cultural competence can help increase responsiveness to communities in three ways. The authors identify the first as clinical competence, which refers to the relationship between health providers and clients (for example training, client education). Secondly, organisational cultural competence refers to strategies that maximise diversity and incorporate leadership and workforce issues (for example involving community representatives), while systemic cultural competence, and is about looking at the structures of the health care system (for example providing health information in the appropriate language, collecting ethnicity data).

Cultural competence is becoming an increasingly relevant concept in health care and The New Zealand Medical Council recently consulted its members on cultural competence (The New Zealand Medical Council, 2005) as a response to the introduction of the Health Practitioners Competence Assurance Act, and in line with its responsibility to ensure the cultural competence of medical practitioners. The consultation document includes a proposed framework and says that cross-cultural doctor-patient interactions are common, and doctors need to be competent in dealing with patients whose cultures differ from their own. It cites the benefits of cultural competence as:

- developing a trusting relationship;
- helping to get more information from patients;
- improving communication with patients;
- helping to resolve any differences;
- increasing concordance with treatment and ensuring better patient outcomes; and
- improved patient satisfaction

Equally other professional groups are developing guidelines for cultural competence for example Physiotherapists (Tinana, 2004). There are a range of frameworks (Other frameworks focus on general recommendations, legal, regulatory and policy interventions, health systems interventions and patient education and empowerment). But this section is structured through the following:

- clinical cultural competence
- organisational cultural competence
- systemic cultural competence

Clinical cultural competence

Staff training and workforce development

Hiring staff that reflect the community that they serve is but one strategy to enhance access to services, equally there is a need to ensure that staff receive education and training in culturally appropriate service delivery at all levels (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). This is in line with a recent ACC document for working with Māori which suggests the need for staff to be familiar with Māori concepts and customs, preferences for care, communication skills, health frameworks, models of health and training (Accident Compensation Corporation, 2004). Communication skills are outlined as being fundamental to client satisfaction with care and acceptability of treatment and establishing effective face to face relationships. It might be appropriate to follow the lead of WINZ which has reduced the size of case loads for specialist case managers, so that they are better able to provide more intensive one-on-one assistance to their migrant and refugee clientele.

Education of the Chinese community

ACC could employ a Migrant liaison officer with an education and training role for the education of the Chinese community. This role could be developed to increase members' knowledge about accessing ACC and improve participation in treatment decisions. Presentations could be done in "plain English" and if possible interpretation to other languages could be accommodated.

Develop standards, measures or indicators

ACC reports six-monthly to Te Roopu Manawa Mai and the Pacific Consultancy Group on progress under each of the key strategies in ACC's business plans (Accident Compensation Corporation, undated-a, undated-b). It is recommended that ACC at this point in its development of a responsiveness strategy to Asian populations could undertake baseline reviews or self-assessments of diversity activities and integrate appropriate measures into internal audits, performance improvement programmes, patient satisfaction assessments, and evaluations. Such an undertaking would result in identifying opportunities for improvement, the development of areas for further action, programmes and activities. Consumer and community surveys could also be developed that are culturally appropriate and other methods of obtaining input will also assist in quality improvement activities. There is a need for ongoing improvement that incorporates "planning, feedback, education, training, review supervision and feedback" (Accident Compensation Corporation, 2004, p.5)

Organisational cultural competence

Ethnic workers

The lack of diversity in health care leadership and the workforce has been identified as a barrier to culturally competent care and studies have shown that health care quality and

racial and ethnic diversity are linked (Betancourt et al., 2002). Guidelines for working with Māori suggest the need for people to receive services from people who are “in tune” with their culture (Accident Compensation Corporation, 2004, p.5). ACC could develop a Migrant Community Liaison Officer role which would have close relationships with Migrant Community Groups and service providers by way of network meetings or presentations in workshops and seminars with a view to increasing public awareness and understanding of ACC.

However, while having an ethnic liaison staff member is commendable, it is also important that staff reflect the client group they serve and organisations should put in place strategies to recruit, retain, and promote diverse staff at all levels (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000) rather than have one member of staff responsible for working with ethnic communities. This can be problematic, as it does not ensure that staff are culturally competent and services can remain mono-cultural with a token nod to diversity. The findings of this study indicate a need for a service to reflect the community it serves, making sure Chinese staff are recruited, supported and developed (Accident Compensation Corporation, 2004),

Forming partnerships with community based organisations

As suggested in the recommendations for working with Māori, there is a need for organisations to understand the communities they serve. This has been demonstrated by ACC through the commissioning of this report (Accident Compensation Corporation, 2004). Other recommendations are to develop relationships with Chinese communities by attending community events, which will help in understanding values and beliefs but also lead to increasing participation a suggestion already identified in the document for working with Māori communities (Accident Compensation Corporation, 2004). Collaborative and participatory partnerships have been identified as a mechanism for facilitating community involvement that takes into account their interests, aspirations, and needs. This could take the form of both formal and informal processes (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). This goes beyond token involvement to defining priorities and strategies for service design and delivery.

Integrating services into community migrant and refugee centres

Transportation was an issue for some respondents as stated in the general comments areas and this could warrant further investigation. A recommendation from a Chinese American study was that help with transportation, especially for those living in suburban areas where public transportation is not readily available was a significant asset (Liang et al., 2004).

Assisting with transportation is likely to not be feasible, however, another option is to follow the lead of WINZ which has integrated Work and Income employment services into community migrant and refugee centres, making them more accessible and visible.

Strategies could involve board participation, ACC already has an external advisory body Te Roopu Manawa Mai to advise on issues related to Māori (Accident Compensation Corporation, undated-a) and a Pacific Consultancy Group to provides advice with regard to Pacific people (Accident Compensation Corporation, undated-b) and it may be necessary to consider developing a board to represent the Asian communities or wider ethnic communities. Other consulting strategies could be community advisory meetings, ad hoc community meetings, focus groups and informal conversations. Involvement and input could also be into policy, marketing, evaluation and communication strategies (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). Partnerships could also be developed for assertive outreach and developing communication strategies with communities.

Systemic cultural competence

Ethnicity data collection

The New Zealand Health Strategy guides the development and provision of new services in the health and disability sector to improve the health of New Zealanders (Ministry of Health, 2000). It aims to reduce inequalities in health status for Māori, Pacific peoples and people from lower socio-economic groups. It focuses on quality to ensure that health outcomes are improved and health disparities reduced through several mechanisms, significantly information management and technology. Improving the quality of information assists health outcomes by providing timely and relevant clinical information. Providing communities with better access to information about their health or health care services can contribute to decision-making regarding local health services. The Strategy cites the example of how ethnicity-related information will ensure Māori communities and the Government are better informed. However, this will not occur unless data is of a high quality and recent research suggests that Māori were under-reported in hospital information systems (Latimer, 2003) and over sampling is one suggestion for remedying this. A standardised national approach to ethnicity data collection is required and Health and Disability sector ethnicity protocols have recently been developed to assist in this (Ministry of Health, 2003). The need for accurate and consistent ethnicity data collection is reinforced as a recommendation in a previous ACC report as a means of planning improvements by comparing access to services and outcomes of care for Māori and (in this case Chinese/Asian) a mechanism for ensuring that disparities

are not maintained (Accident Compensation Corporation, 2004). Furthermore, ethnicity data collection provides a mechanism for monitoring the demographics of clients which in turn can reflect staff recruitment strategies which then reflect the demographics of the community being served (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). Further monitoring of the referral and treatment patterns by provider could also provide useful information to ACC.

Strategic planning

ACC already has a commitment to obtain Māori input into strategic planning through its external advisory body Te Roopu Manawa Mai, and Māori managers (Accident Compensation Corporation, undated-a). While the Pacific Consultancy Group (an external advisory body) provides advice on strategy and policy with regard to Pacific people (Accident Compensation Corporation, undated-b). It is suggested that an external advisory board be developed to help develop, implement, and promote a written strategic plan with clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services to ethnic communities. Implementing cultural and linguistic competence requires targeting of attention and resources to the appropriate population in this case; ACC might wish to do this in response to its Asian clientele. Strategic planning provides a mechanism for defining the activities, policy and goals that are relevant as well as to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission. Such a plan needs to develop with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of ACC that are affected by the strategy. Work and Income have developed an Auckland metro migrant and refugee strategy and have enhanced employment services for migrants and refugees in Auckland.

Linguistic competence

There is a need for policies that focus on linguistic and cultural competence. Linguistic competence could be achieved by providing bilingual /bicultural staff; foreign language interpreting services; having link workers/advocates; materials developed and tested for specific cultural, ethnic, and linguistic groups; translation services including those of: (a) legally binding documents (for example, consent forms), (b) hospital signage, (c) health education materials, (d) public awareness materials and campaigns; and ethnic media in languages other than English, for example, television, radio, internet, newspapers and periodicals (Szczepura, 2005). In the United States health care organisations are required to

both offer and provide language assistance services such as bilingual staff and interpreter services at no extra cost to clients who require it in a timely manner and information about the service should be available in writing (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). Interpreters and bilingual workers should also be credentialed in some way (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). WINZ have developed an Auckland based multi-lingual call centre with national coverage which offers 11 languages, and complements Language Line that is also available for Work and Income clients. It would be useful to investigate how many of migrants take up their entitlement of English for migrants, as the proficiency of English seems a strong indicator for successful settlement.

Strengths and Limitations of the research

The strengths of this survey were that the questions of access went beyond health and well being and were broadened out to incorporate local government services, and that the survey provides information on an area that has not been well researched in the past. As identified in the literature review at the beginning of the report, there is a need for research about migrants to be located in the context of the settlement process.

The research was an opportunistic survey of participants attending the 2001 Chinese Health and Social Service Expo, therefore it is not necessarily representative of the general Chinese immigrant population in New Zealand. In particular, the survey is most likely to have captured the views of respondents who are most motivated in either finding out more about the relevant services or addressing their own personal problems with the services.

The inconsistency in the answers of some questions highlights issues of questionnaire design and whether the respondents fully understand New Zealand services and what organisations/agencies provide these services. The key questions that were not fully addressed by the questionnaire are:

- Awareness of the main service/s or all the services provided by each agency,
- Whether the respondent has had any contact with the agency, and why the contact may not have been satisfactory and/or successful,
- Whether the respondent has successfully utilised the services provided, and whether they were happy with the service provided.

Two of the questions in the survey ask respondents to either choose three “difficulties” or three services. In both cases 7-10% of the respondents choose more than three options, this does raise issues about whether such a question format is appropriate for this population. This inconsistency in how the questions are answered means that there are potential problems in interpretation of results. Either there are some cultural differentials in a group of the participants or that the issues are so large for some individuals that they are unable to limit themselves to only three options.

It must also be noted that the statistical results involve multiple comparisons of the data, and therefore it is possible that a few statistically significant results may have occurred by chance. Despite these limitations, we believe the findings are still valuable and paint a picture of issues faced by members of the Chinese community in Auckland. It is also worth

acknowledging that the survey was developed and undertaken by community members in a voluntary capacity.

Further research

Research issues

Systematic reviews overseas have identified a dearth of research on implementation and assessment of interventions aimed at improving access, instead the focus has largely been on defining problems (Atkinson et al., 2001). It is hoped that this report provides an incentive to develop and evaluate interventions that enhance access to services. Methodological issues have also been identified such as the need to better define dimensions of ethnicity, evaluate outcome measures used as well as the need for long term research that is strategically co-ordinated and developed so that promising projects that have been effective are identified and further assessed and developed with a view to transfer across services (Atkinson et al., 2001). There is also a need to evaluate the effectiveness of cultural safety in the context of migrant communities as the emphasis to date has been on the relationship with Maori (DeSouza, 2004).

Survey issues

Future research could involve exploring the use of alternative methods if Western methods failed for Chinese migrants.

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Appendices

Appendix A: Other Services

The following tables present a summary of the difficulties or reasons for not using services for all the services other than ACC, IRD, WINZ and DIA, which are examined above.

Courts	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	20	18%	128	8%	13	7%	161	8%
No information in Chinese	22	20%	166	10%	10	5%	198	10%
Not aware of the service existence	2	2%	62	4%	2	1%	66	3%
Don't know the type of services provided	1	1%	146	9%	9	5%	156	8%
No Reasons Stated	82	75%	1297	76%	167	86%	1546	77%
Total	110		1706		194		2010	

Table 45: Reasons/Difficulties in accessing Courts.

Police	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	63	14%	110	8%	19	9%	192	10%
No information in Chinese	51	12%	132	10%	15	7%	198	10%
Not aware of the service existence	2	0%	21	2%	2	1%	25	1%
Don't know the type of services provided	4	1%	72	5%	2	1%	78	4%
No Reasons Stated	353	81%	1076	79%	188	87%	1617	80%
Total	438		1355		217		2010	

Table 46: Reasons/Difficulties in accessing Police.

Race Relations Office	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	5	19%	105	6%	13	5%	123	6%
No information in Chinese	6	23%	123	7%	16	7%	145	7%
Not aware of the service existence	2	8%	87	5%	3	1%	92	5%
Don't know the type of services provided	3	12%	158	9%	5	2%	166	8%
No Reasons Stated	18	69%	1365	78%	208	87%	1591	79%
Total	26		1746		238		2010	

Table 47: Reasons/Difficulties in accessing Race Relations Office.

Public Hospital : Emergency Department	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	91	16%	107	9%	23	11%	221	11%
No information in Chinese	71	13%	116	9%	21	10%	208	10%
Not aware of the service existence	2	0%	33	3%	4	2%	39	2%
Don't know the type of services provided	4	1%	82	7%	7	3%	93	5%
No Reasons Stated	438	78%	973	78%	162	79%	1573	78%
Total	561		1245		204		2010	

Table 48: Reasons/Difficulties in accessing Emergency Department.

Public Hospital : Outpatients Department	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	80	16%	105	8%	18	9%	203	10%
No information in Chinese	63	12%	123	10%	22	11%	208	10%
Not aware of the service existence	5	1%	42	3%	3	1%	50	2%
Don't know the type of services provided	11	2%	75	6%	7	3%	93	5%
No Reasons Stated	399	78%	1006	78%	170	81%	1575	78%
Total	512		1289		209		2010	

Table 49: Reasons/Difficulties in accessing Outpatients Department.

Public Hospital : Inpatients Service	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	51	14%	103	7%	21	9%	175	9%
No information in Chinese	41	11%	118	8%	20	8%	179	9%
Not aware of the service existence	1	0%	33	2%	4	2%	38	2%
Don't know the type of services provided	2	1%	94	7%	5	2%	101	5%
No Reasons Stated	287	80%	1133	80%	196	83%	1616	80%
Total	357		1417		236		2010	

Table 50: Reasons/Difficulties in accessing Inpatients Service.

Tenancy Service	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	66	20%	81	6%	14	6%	161	8%
No information in Chinese	39	12%	110	8%	17	7%	166	8%
Not aware of the service existence	2	1%	74	5%	4	2%	80	4%
Don't know the type of services provided	7	2%	119	8%	6	3%	132	7%
No Reasons Stated	250	75%	1127	78%	202	86%	1579	79%
Total	332		1444		234		2010	

Table 51: Reasons/Difficulties in accessing Tenancy Service.

Child, Youth and Family (CYF)	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	6	12%	85	5%	9	4%	100	5%
No information in Chinese	8	16%	111	7%	14	5%	133	7%
Not aware of the service existence	0	0%	81	5%	7	3%	88	4%
Don't know the type of services provided	1	2%	145	9%	8	3%	154	8%
No Reasons Stated	41	84%	1353	79%	225	88%	1619	81%
Total	49		1704		257		2010	

Table 52: Reasons/Difficulties in accessing CYF.

Auckland City Council	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	46	14%	63	4%	12	5%	121	6%
No information in Chinese	36	11%	86	6%	17	6%	139	7%
Not aware of the service existence	3	1%	34	2%	3	1%	40	2%
Don't know the type of services provided	8	2%	125	9%	4	2%	137	7%
No Reasons Stated	268	81%	1144	81%	236	89%	1648	82%
Total	332		1413		265		2010	

Table 53: Reasons/Difficulties in accessing Auckland City Council.

Manukau City Council	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	20	12%	69	4%	11	4%	100	5%
No information in Chinese	19	11%	89	6%	14	5%	122	6%
Not aware of the service existence	0	0%	38	2%	2	1%	40	2%
Don't know the type of services provided	1	1%	132	9%	2	1%	135	7%
No Reasons Stated	142	84%	1249	81%	281	93%	1672	83%
Total	170		1537		303		2010	

Table 54: Reasons/Difficulties in accessing Manukau City Council.

North Shore City Council	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	6	6%	68	4%	11	4%	85	4%
No information in Chinese	7	7%	93	6%	13	4%	113	6%
Not aware of the service existence	0	0%	37	2%	3	1%	40	2%
Don't know the type of services provided	1	1%	127	8%	6	2%	134	7%
No Reasons Stated	94	90%	1314	82%	280	92%	1688	84%
Total	104		1601		305		2010	

Table 55: Reasons/Difficulties in accessing North Shore City Council.

Waitakere City Council	Used the service Provided?							
	Yes		No		Not Stated		Total	
	#	%	#	%	#	%	#	%
No Chinese Speaking Staff	9	11%	68	4%	10	3%	87	4%
No information in Chinese	12	15%	87	5%	13	4%	112	6%
Not aware of the service existence	1	1%	40	3%	3	1%	44	2%
Don't know the type of services provided	1	1%	127	8%	6	2%	134	7%
No Reasons Stated	65	79%	1307	82%	313	93%	1685	84%
Total	82		1590		338		2010	

Table 56: Reasons/Difficulties in accessing Waitakere City Council.

Appendix B: The Survey