Exploring Perspectives Affecting Access to Healthcare Among Older Fijian Indian Immigrants in Aotearoa New Zealand

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Abstract

Accessing healthcare in a newly settled country poses many complex challenges for immigrants, especially those of an older age. In Aotearoa New Zealand, immigrants comprise a considerable proportion of the older adult population. It is estimated that 95,000 to 100,000 Fijian Indians live in Aotearoa New Zealand (Narayan, Vakalalabure, et al., 2025). While public health services in Aotearoa New Zealand are free, access to healthcare remains challenging for many, especially older Fijian Indian migrants.

This doctoral thesis in health sciences examines the challenges that older Fijian Indian immigrants face when seeking healthcare services in Aotearoa New Zealand. The study aims to explore various dimensions of healthcare access, specifically how cultural, systemic, and personal factors interact to influence these experiences. The socio-ecological conceptual framework informed the research. The framework recognises that healthcare access is shaped by interacting influences across individual, interpersonal, organisational, community, and policy levels. The thematic analysis, qualitative interpretive descriptive methodology was used to derive insights into the healthcare access experiences of older Fijian Indian immigrants. Purposively, 10 older Fijian Indian immigrants aged 55 and above, comprising six males and four females, were sampled. Participants' experiences were explored through semi-structured interviews to identify barriers to and enablers of older Fijian Indian immigrants' access to healthcare in Aotearoa New Zealand. A six-step thematic analysis enabled the systematic identification of patterns and themes across participant interviews.

Five key themes emerged from the analysis: a lack of trust stemming from experiences of unprofessional behaviour by healthcare providers; insufficient cultural awareness and considerations of ethnicity; longer waiting times; poor patient-centred care; and lack of affordability. Central to accessing healthcare was the development of trust and personal relationships with healthcare providers, but these were frequently undermined by cultural misunderstandings and communication gaps. Participants faced prolonged wait times and limited access to essential specialists, further intensifying their challenges in accessing and engaging with healthcare. Consequently, this was seen to lead to delayed identification and treatment, and deteriorating health outcomes. Furthermore, the findings highlighted insufficient cultural understanding

from healthcare providers, highlighting the pressing need for healthcare practitioner education programmes to develop knowledge and communication skills in cultural understanding, and awareness of beliefs and health practices, as well as safety, to address the needs of increasingly culturally diverse populations in healthcare environments, particularly in Aotearoa New Zealand. The quality of care received was another significant concern, with care frequently seen as being compromised by practices that prioritised efficiency and overlooked patient-centred approaches. This poses a significant challenge for older Fijian Indian immigrants, who require comprehensive, cohesive healthcare strategies to address their unique health needs.

Furthermore, the exorbitant expenses associated with specialist healthcare services created significant obstacles, impeding participants from accessing prompt medical aid, consequently elevating the likelihood of developing chronic health conditions. In the thesis, I advocate for a comprehensive reform approach to ethnic healthcare delivery, endorsing policies that promote cultural competence, patient-centred care, and economic measures to improve healthcare access, particularly for older immigrants.

In summary, the study enhances understanding of structural disparities that affect older Fijian Indian immigrants' ability to access healthcare. It provides significant insights into ways to enhance culturally focused healthcare delivery and systems, as well as policies, to better cater to the needs of this underserved population.

[1]

[1] Coup - A coup refers to the unlawful overthrow of an established government. Fiji experienced military coups in 1987 and 2006, as well as a civilian-led coup in 2000. The 1987 coups, in particular, contributed to political instability, heightened ethnic tensions and increased emigration among Fijian Indians, including migration to Aotearoa New Zealand.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

15/07/2026

Signature | Date

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Ethics Approval

Ethical approval for this study was granted by the Auckland University of Technology Ethics Committee (AUTEC) on 23 November 2021 (Approval Number: 21/408). This approval confirmed that the research had met the required ethical standards for conducting the study. Further details regarding the ethical processes, considerations, and protections for participants are discussed later in Chapter 3.

Chapter 1 Introduction

This chapter introduces research that examines the factors influencing healthcare access for older Fijian Indian immigrants in Aotearoa New Zealand. The aim was to examine the enablers and barriers to accessing healthcare for older Fijian Indian immigrants and how these factors impact their health. The chapter begins with an overview of the historical and contemporary perspectives of Fijian Indians, tracing their historical trajectory from India to Fiji and their subsequent migration to New Zealand. This background information is crucial to understanding the distinct cultural and social factors that shape their experiences with New Zealand's healthcare system.

Additionally, the chapter presents demographic information about the migrant Fijian Indian population in Aotearoa New Zealand. It offers a deeper understanding of their demographic characteristics and emphasises the unique characteristics of this sub-population group within the larger immigrant and host communities. By incorporating these components, the chapter lays the groundwork for a comprehensive understanding of the context in which migration, uniquely Fijian Indian ageing, and engagement with the healthcare system occur among older Fijian Indians residing in Aotearoa New Zealand.

1.1 Historical Background of Fijian Indians

Examining the historical background of Fijian Indians is essential for understanding the social, cultural, and migration-related contexts that have shaped their experiences and identities over time. A brief overview of Fiji as a nation provides an important foundation for understanding the historical experiences of Fijian Indians. Fiji is a small island nation comprising an archipelago of over 332 islands in the Pacific Ocean, in the Melanesian region (Foster et al., 2026; Pacific Community, n.d.). Indigenous Fijians (i-Taukei) were the first settlers, arriving around 3,000 years ago (Kumar et al., 2021). In the 17th and 18th centuries, European explorers encountered the Fiji Islands.

Fiji is a developing state in the South Pacific, made up of dispersed islands, with population and economic activity concentrated on larger islands such as Viti Levu. Its economy has historically relied on agriculture (including sugar production), tourism,

and limited industry, which have contributed to structural vulnerabilities that can intensify migration pressures during periods of political or economic instability (Reddy et al., 2004).

Fiji's population has long been ethnically diverse, including Indigenous iTaukei Fijians, Indo-Fijians, and minority groups (Fiji Bureau of Statistics, n.d.). However, political instability and emigration, particularly after the coups, contributed to significant demographic change, including a decline in the proportion of the Indo-Fijian population over time (Voigt-graf, 2008). Urbanisation also increased, with population growth becoming more concentrated in urban settings while rural regions experienced slower development. Education, employment opportunities, and internal migration patterns contributed to these shifts (Fiji Bureau of Statistics, n.d.; World Bank, n.d.).

Indigenous Fijian society was historically centred on chiefly authority, communal land tenure, and kinship-based governance structures. European colonisation introduced Christianity, new political institutions, and plantation agriculture, reshaping Fiji's social organisation and economic structure (Lal, 2012; Munro & Fraenkel, 2024). These changes created the conditions under which labour migration and ethnic stratification became embedded in Fiji's colonial political economy.

The introduction of Indian indentured labourers under British colonial rule transformed Fiji's demographic and cultural landscape (Prasad, 2005). Indians were recruited primarily for plantation labour, and many remained after indenture ended, forming a permanent Indo-Fijian community central to Fiji's economy and social development (Lal, 2015). Indenture recruitment and labour conditions were often exploitative, and many migrants experienced displacement, hardship, and cultural disruption. These experiences contributed to a resilient diaspora identity shaped by survival, adaptation, and community rebuilding over generations (Buckingham, 2024).

Colonial arrangements and post-indenture settlement contributed to enduring ethnic divisions, particularly around land, power, and political representation. These tensions shaped Fiji's later political instability and, in turn, migration patterns (Ratuva, 2015). Political coups and constitutional changes intensified insecurity among Indo-Fijians and accelerated emigration, underscoring the need to understand migration decisions

within Fiji's colonial history, ethnic politics, and post-independence instability (Munro & Fraenkel, 2024) .

Migration is a deeply human process that extends beyond physical movement from one country to another. People who migrate carry language, culture, beliefs, and social identities that continue to shape how they belong to and participate in the host society. At the same time, migrants often maintain economic (in the form of remittances), emotional and relational ties with their homeland while negotiating new identities and community connections in the receiving country (Boccagni, 2017; Vukojević, 2019). These layered experiences make migration not only a demographic phenomenon but also a lived transition involving shifts in identity, opportunities for social and economic participation, and, at times, experiences of social exclusion and marginalisation. Understanding these intersecting influences is especially important when migration occurs in response to political upheaval, as the decision to move may be urgent, emotionally charged, and shaped by perceived threats to well-being and future security.

In Fiji, due to political instability among the chiefs, a British Crown Colony was established in 1874 (Masaki, 2022). Indians first arrived in Fiji in 1879 through the indentured labour system, known as 'Girmit', a term derived from the word 'agreement' (Munro, 2023). The British leadership established the indentured labour system, which sent Indians to the sugar cane fields without adequate food and basic living conditions. The indentured labourers were subjected to harsh and inhumane treatment, including physical punishment (Kumar, 2024). They were forced to work in sugar cane fields for extra hours, from dawn to dusk, with minimal rest between shifts, and were punished if they slowed down during farm work. The Girmitiyas were living in overcrowded barracks with insufficient food and rations and were denied basic medical care. There was no privacy for families, inadequate bedding or blankets, and unsafe drinking water (Kumar et al., 2023; Wei, 2025, February 28). They were provided with monotonous food items, such as lentils and low-quality rice, and their rations were withheld as punishment (Narayan, Deo, et al., 2025). Even pregnant women were forced to work in the fields and return to work within days of giving birth. Many reports suggest that there was a high rate of infant mortality as mothers were unable to provide care during the postnatal stage (Lal, 2012; Mishra, 2024a, 2024b).

The mothers had to take their newborns into the fields and were even restricted from feeding or attending to their babies when they were crying. They could only attend to their babies during short breaks. With reports describing babies dying in the field, mothers were forced to bury them in shallow graves and resume duties without being allowed any time to grieve (Kumar, 2024; Wei, 2025, February 28).

Together, this caused hardship and endurance; many committed suicide to avoid the hardship of labour (Buckingham, 2024) and there are reports of people hanging themselves to death or jumping into rivers to avoid the hardship and inhuman treatment by the British rulers (Mishra, 2024a). The perseverance of the indentured labourers demonstrate that they transformed their lives, adapted to harsh conditions, and became a driving force in Fiji's economy (Ramesh, 2017). While some Fiji Indians returned to India after the indenture, many settled in Fiji, where they continued to work on leased farms in the sugar cane fields. During the 1940s, the Indian community in Fiji experienced significant growth, and at one point, it outnumbered the Indigenous Fijians (Lal, 2012).

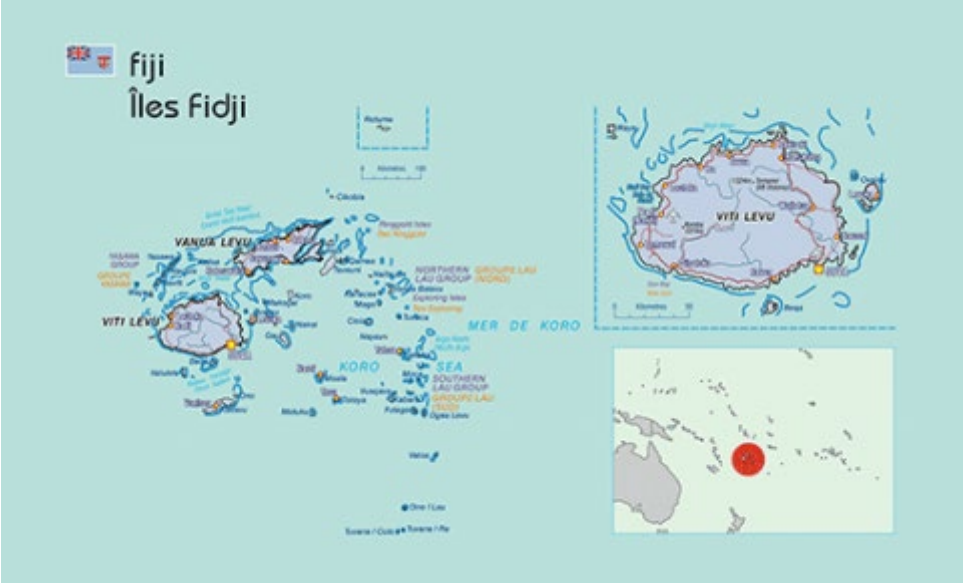
In contemporary times, the social and political landscape of Fiji is shaped by the legacy of colonial rule and by the presence of Indigenous Fijians and Indo-Fijians. It reflects the interplay among these factors and the ongoing challenges of addressing equality, representation, and identity (Mandrika, 2024).

Now, Fijian Indians comprise approximately 37.5% of the Fijian population living in Fiji (Coleman, 2025). Many of them are descendants of the 60,000 indentured labourers who were brought to Fiji from India. Labourers in sub-continental India were diverse in caste systems, linguistic groups, cultural practices, and worldviews (Lal, 2012). An example of this transformation towards greater diversity was the emergence of 'Fiji-Hindi', a unified language incorporating elements of Indian Hindi, Tamil, Telugu, and Malayalam (Lal, 2012). This language also incorporates some terms and phrases from the iTaukei (Indigenous Fijian) community (Mangubhai & Mugler, 2003). According to Hundt (2019), Fiji Hindi is currently the predominant language among Indo-Fijians. Indo-Fijian rituals embody broad representations of India, a significant origin of their culture, identity, and traditions (Voigt-graf, 2008). Over time, the Fijian Indians and their descendants became accustomed to Fijian customs, language influences, inter-

racial marriage, and local ways of living. This has created a unique blended identity that now reflects both Indian heritage and the Fijian cultural values. This fusion has gradually shaped the identity of Indians and their recognition as Fijian Indians rather than simply Indians (Cocom, 2023).

Fiji is an island nation in the South Pacific, comprising numerous islands, of which Viti Levu and Vanua Levu are the two largest. Figure 1 illustrates the geographical location of Fiji and its principal islands, providing context for the country of origin of the Fijian Indian immigrant population examined in this study.

Figure 1. Map of Fiji



Note. Adapted from Fiji map by the Pacific Community, Statistics for Development Division (n.d.), Statistics for Development Division. https://sdd.spc.int/fj

1.2 Emigration from Fiji to New Zealand

For Fiji Indians, Fiji is both homeland and an ancestral landscape of identity formation. Although Indo-Fijians have cultural links to India, generations of life in Fiji produced a distinct Indo-Fijian identity shaped by Pacific history and colonial experience. For migrants, Fiji often remains an enduring emotional and cultural reference point even after resettlement overseas (Lal, 2015; Voigt-graf, 2008).

Indo-Fijians were historically involved in cultivating most of Fiji's cash crops, namely sugar cane and rice, despite not being granted land ownership, as land was primarily held by Indigenous Fijians under the previous colonial policy (Chepulis et al., 2021). Due to economic necessity in the 1950s, Indo-Fijians had to resort to the non-farm

economy. Indians felt they were unfairly treated and deprived of farmland, which forced them to migrate overseas in search of a better lifestyle, better education for their children, and improved healthcare (Narayan, Deo, et al., 2025). There are many reports on the reasons for migration of Fijian Indians to New Zealand, which include the search for a better lifestyle, or better healthcare; however, mass migration from Fiji to Aotearoa New Zealand was driven by political instability following the 1987 military coups in Fiji, which overthrew the elected government of that time (Khan, 2011; Newbury, 2011). Many Indo-Fijian families suffered fear, insecurity, and exclusion following the 1987 military coups. This was when political upheaval disrupted everyday life and contributed to institutional marginalisation and loss of opportunity for ethnic minorities. After the overthrow of an elected government in 1987, discriminatory policies and uncertainty led many to fear that their futures, livelihoods, and children's opportunities were at risk, prompting them to consider leaving their homeland for safer, more stable societies such as Aotearoa New Zealand (Khan, 2011; Leckie, 2024). These experiences, combining political instability, concern for personal security, and a desire for equitable opportunities, were major drivers of migration among Indo-Fijian communities in the late 20th and early 21st centuries (Khan, 2011; Leckie, 2024).

For many Fijian Indian families, however, migration to Aotearoa New Zealand was not solely a reaction to instability in Fiji or a general search for a better future (Gani, 1998). It was also shaped by the availability of work, family-sponsored migration, access to education, and established social networks, which made relocation more feasible (Khan, 2011). Historical accounts show that migrants from Fiji were connected to labour migration pathways, while later migration was increasingly supported through family-based entry and settlement networks. New Zealand's immigration settings, including family and skilled pathways, also helped shape these movements over time (Marlowe et al., 2024). Understanding this broader migration history is important because it highlights that older Fijian Indian migrants may carry diverse migration stories, settlement trajectories, and expectations of life in Aotearoa New Zealand, all of which may continue to influence their engagement with health and social services in later life.

Fijian Indians were historically employed in agricultural and horticultural work (Bedford & Bedford, 2025), but now they work in many diverse areas such as healthcare, education, manufacturing, construction, trades, transport, banking, and finance. The skilled migration category now includes many Fijian Indians working in healthcare and service industries, reflecting long-term settlement beyond work in the primary industry (Khan, 2011; Narayan, Vakalalabure, et al., 2025).

These migration patterns provide an important background for understanding how Fijian Indians became established in Aotearoa New Zealand over time. The following section, therefore, examines the presence and settlement of Fijian Indians in the Aotearoa New Zealand context.

1.3 The Fijian Indian community in Aotearoa New Zealand

The people of Fiji are an expanding community in Aotearoa New Zealand, and Auckland is a key settlement area. The 2013 census (Stats New Zealand, 2015) identified 14,445 people as Fijians. Within the same census report, 10,929 people identified as Fijian Indians, of whom 534 were aged 65 years and over. This population grew over time; the 2018 census report (Stats NZ, 2020) identified 15,240 people as Fijian Indians and 19,985 as Fijians, while the 2023 census (Stats NZ, 2024) recorded further increases to 23,808 and 25,038, respectively. Alongside this overall population growth, the age profile of the Fijian Indian community also shows an appreciable presence of older adults. In 2023, approximately 18.5% of Fijian Indians in Aotearoa New Zealand were aged 55 years and over, and around 8.7% were aged 65 years and over. This suggests that, as the community continues to grow, attention must also be given to the experiences, needs, and well-being of its ageing members. Although census data have long recorded people of Fijian Pacific ethnicity, Fijian Indians were not routinely reported as a distinct ethnic group in publicly available census outputs until more recent Stats NZ reporting (Stats NZ, 2025).

The introduction of a dedicated Fijian Indian ethnic group profile by Stats NZ in 2025 represents an important development, as it enables historical census data to be examined specifically for this population and improves their visibility in demographic and health analyses. The inclusion of ‘Fijian Indian’ as a more visible ethnic

classification in Stats NZ reporting (Stats NZ, 2025) also supports greater recognition of this population in demographic analysis, health planning, and future research.

The data show continuous population growth; however, when the census was conducted in 2023, it did not include a separate ethnicity category for Fijian Indians to select. Therefore, the census report is of debatable value because it does not include a separate ethnicity for Fijian Indians, which could lead to data discrepancies (Narayan, Vakalalabure, et al., 2025). Another reason could be that Fijian Indians are simply identifying themselves as Indians. These statistics may not include the generations born in Aotearoa New Zealand to Indo-Fijian parents. Further, it is estimated that over 100,000 Indo-Fijians live in Aotearoa New Zealand (Narayan, Vakalalabure, et al., 2025). Alongside this demographic backdrop, consideration must also be given to the high prevalence of non-communicable diseases, including diabetes and hypertension, which place many Fijian Indian older adults at increased risk of complex and ongoing healthcare needs (Lin et al., 2016).

Indo-Fijian migration to Aotearoa New Zealand has earlier roots in pathways for education, employment, and family pathways from the mid-twentieth century; however, post-coup migration differed in both urgency and scale (Voigt-graf, 2008). By the early 2000s, Indo-Fijians had established a diaspora community in Aotearoa New Zealand, contributing economically and culturally while also negotiating belonging, identity, and recognition within the host society (Voigt-graf, 2008). These experiences were shaped by structural barriers, such as a lack of opportunities, as well as social experiences, including discrimination and the challenges of cultural adaptation, which influenced integration trajectories and perceptions of acceptance (Bedford & Spoonley, 2014; Narayan, Vakalalabure, et al., 2025).

In Fiji, non-communicable diseases (NCDs), including type 2 diabetes mellitus (T2DM), cardiovascular disease, hypertension, and cancer, are the leading causes of morbidity and mortality across all ethnic groups, including Indigenous Fijians (iTaukei), Fijian Indians, and other ethnic populations (Dearie et al., 2025; Phillips et al., 2018). Indo-Fijians represent a higher proportion of the population with heart disease and diabetes than the general population in Aotearoa New Zealand (Earle et al., 2018; Taylor et al., 2018). Other common diseases affecting the Indo-Fijian population living in Aotearoa

New Zealand include kidney diseases, respiratory diseases, and various forms of cancer (Dearie et al., 2024). Given that Fiji Indians appear to be disproportionately affected by conditions such as cardiovascular disease (CVD), cancer, and kidney disease, understanding the barriers they face in accessing healthcare becomes especially important as they age, as delayed or difficult access may further deepen the health burden experienced by this community. Although published evidence specific to Fiji Indians in Aotearoa New Zealand remains limited, research on migrant-background populations in Aotearoa New Zealand suggests that barriers such as language difficulties, limited familiarity with the health system, and broader access challenges may also affect this community (Bhatia et al., 2025; Kanengoni-Nyatara et al., 2024; Pledger et al., 2024).

Addressing these barriers listed above will require targeted interventions that improve language services, provide culturally appropriate information, and ensure that healthcare services are accessible and affordable for all. While individual studies highlight different health issues, the research reported in this thesis- barriers such as language difficulties, limited cultural responsiveness by healthcare providers, affordability and prolonged waiting times and enablers such as respectful communication and culturally aligned care- complements the *New Zealand Health Strategy* (Minister of Health, 2016) and aligns with its strategic directions. It is particularly focused on culturally responsive care. In this context, culturally safe care means more than recognising cultural difference; it requires healthcare providers to listen respectfully, acknowledge people's lived experiences, and avoid assumptions about their beliefs, language, family roles, or health practices. For older Fijian Indian adults, this includes creating care environments where they feel understood, respected, and able to participate in health decisions without fear of judgment or exclusion.

1.3.1 Aotearoa New Zealand healthcare context and relevance to this study

The healthcare system in Aotearoa New Zealand provides a range of services to New Zealanders. This primarily includes a publicly funded system that provides universal access for all New Zealanders, highlighting the commitment to equitable

access. This system includes Health New Zealand (Te Whatu Ora) for the general public, and Hauora Māori providers who play a critical role in delivering culturally appropriate care for Māori, the Indigenous population. There are other private health service providers, such as private hospitals and GP practices. While Health New Zealand funds GP services, the public has the option to self-fund and choose to receive health services from private hospitals (Ministry of Health, 2026a).

There are many private health insurance options that people choose, allowing them to access health services much more quickly than by waiting for publicly funded care; however, these remain expensive and unaffordable for most of the population (Jeffreys et al., 2024). The Accident Compensation Corporation (ACC) also works in conjunction with Health New Zealand, funding diagnostic and health services for individuals who sustain an injury. ACC covers the costs of diagnostics, treatment, and rehabilitation, and supports income while the person is recovering (Henare et al., 2023). While Health New Zealand has made efforts to protect public health and improve accessibility by funding initiatives, the issues persist because these initiatives do not adequately account for population growth, inflation, and health spending (Irurzun-Lopez et al., 2025).

Primary health care in Aotearoa New Zealand is usually the first point of contact for the general population with health services and includes healthcare provided by general practices. Every New Zealander is expected to enrol with a general practice to get their health needs attended to. Many services, including general practice consultations, nurse services such as health screenings, immunisations, chronic disease management, wound care, cervical smear tests, and sexual health education, are provided by the practice nurses. In addition, there are urgent after-hours medical centres that provide urgent medical and accident treatment. Among the primary care services there are also: community pharmacies; maternity and family planning services; and an allied health team that includes physiotherapists, podiatrists, community mental health services (which include initial counselling and mental health support services) and preventive services (mainly vaccinations, and the promotion of health through various health education programmes and smoking cessation support) (Ministry of Health, 2026a).

Secondary care consists of hospital-based medical, surgical, and mental health care, including services for older adults. These also include funded medical and surgical care, as well as diagnostic services. All these are based at government-funded hospitals in Aotearoa New Zealand (Ministry of Health, 2026a).

Tertiary care is specialised services and complex care for chronic illness and/or life-threatening conditions. These services are provided in acute care hospitals. Examples of tertiary care include cancer treatment, advanced neonatology, specialised burns care, neurosurgery or plastic surgery, and organ transplants by specialised doctors (Ministry of Health, 2026a).

Together, the primary, secondary and tertiary care services form the basis of the continuum of care that underpins health service delivery in Aotearoa New Zealand. It provides a structural foundation that prioritises the principles of the *New Zealand Health Strategy* for all New Zealanders (Minister of Health, 2023).

This healthcare context is directly relevant to the present study because older Fijian Indian immigrants must access and navigate care within the wider Aotearoa New Zealand health system. Although eligible migrants can use publicly funded health services, eligibility alone does not necessarily ensure that care is timely, affordable, culturally appropriate, or responsive to their individual needs. For older migrants, experiences of accessing healthcare may also be shaped by language, cultural beliefs, family involvement, familiarity with the health system, financial circumstances, waiting times, and communication with healthcare professionals (Kanengoni-Nyatara et al., 2024). Understanding the organisation of healthcare in Aotearoa New Zealand, therefore, provides an important foundation for exploring how these wider system conditions are experienced in everyday life. It also helps to explain why this study focuses not only on whether health services are available, but on the barriers and enablers that influence whether older Fijian Indian immigrants can access and engage with care in ways that are respectful, meaningful, and responsive to their needs.

Figure 2 illustrates the organisational structure of the Aotearoa New Zealand health system, showing the relationships among the New Zealand Government, the Ministry of Health | Manatū Hauora, the Public Health Agency, and Health New Zealand | Te Whatu Ora. It also outlines how healthcare services are organised and delivered

through regional and district structures, including hospital, primary care, community, aged care, and disability services.

Figure 2. Structure of the Aotearoa New Zealand Health System



Note. Figure created by the author.

The *New Zealand Health Strategy*, specifically the 2016 strategy (Minister of Health, 2016), serves as the foundation for providing equitable, accessible, and high-quality care. This strategy's central theme is that all New Zealanders live well, stay well, and

get well (Figure 3). To achieve this, five elements of this strategy were developed to support the aim.

Figure 3. Five Strategic Themes of the New Zealand Health Strategy.



Note. Reproduced from *New Zealand Health Strategy:: Future Direction* (Minister of Health, 2016).

The first element, "People-powered," means that the population is empowered to look after their own health through health promotion strategies, and that healthcare providers can educate those with chronic conditions in self-management to reduce the premature onset of chronic diseases, hospitalisation, and premature deaths. The second element, "Closer to home", means providing services such as general practice, home-visiting services, and community health clinics so that they are accessible. "Value and high performance" mean providing evidence-based care and government commitments toward research. Working as "One team" means that all healthcare providers collaborate to achieve better health outcomes for patients. "Smart system" refer to a health system that uses information, technology, data, and innovation to improve service coordination, decision-making, and the quality of care. (Minister of Health, 2016). While these strategies may sound good, it is also important that the

Aotearoa New Zealand health system is informed by Te Tiriti o Waitangi to achieve health outcomes for Aotearoa New Zealand (Came et al., 2016).

Recent reforms in the structure of Te Whatu Ora (Health New Zealand) and the de-establishment of Te Aka Wahi Ora (Māori Health Authority), which aimed to provide integrated, person-centred health services (Reidy et al., 2025), raise concerns about equitable healthcare. While population health and well-being are a focus, the health status of older people remains a concern in Aotearoa New Zealand (Sayat et al., 2024).

1.4 Older Adult Health Services

Older adults in Aotearoa New Zealand, access health and support services through a complex, largely publicly funded system designed to promote well-being, autonomy, and dignity in later life. These services span preventive, primary, community, and specialist care, alongside social and disability support that enable people to remain in their own homes and communities for as long as possible. In everyday practice, older adults and their whānau often engage with multiple providers, including general practice teams, community nursing, allied health services, Māori and Pacific health organisations, aged residential care, and non-government agencies. Although commitments to universal access and equity underpin the system, navigating services can be difficult, particularly for culturally and linguistically diverse older populations whose health experiences are shaped by migration histories and social contexts. Understanding how older adults encounter and use health services is therefore central to recognising both the strengths and the limitations of Aotearoa New Zealand's approach to healthy ageing (Minister of Health, 2023).

The principles of universality, equity, and affordability characterise healthcare access, including that for older adults, in Aotearoa New Zealand. The government provides a wide range of health services, including preventive care, primary care, hospital care, mental health care, and subsidised pharmaceuticals. These services are generally offered free of charge or at a low cost to eligible residents, which is particularly important for older adults who may have ongoing health needs, chronic conditions, and/or limited income.

There are various services for older adults in Aotearoa New Zealand. The comprehensive design of these services provides a holistic approach to care that covers the health and well-being of older adults (Associate Minister of Health, 2023). It aims to provide social support that helps maintain independence, well-being, and a good quality of life.

Services for older people are supported by the *New Zealand Health Strategy* (Minister of Health, 2016), which focuses on promoting healthy ageing among older adults. Due to an ageing population, demand for healthcare services is growing (Sayat et al., 2024). Healthcare services for the ageing population are supported by acute public hospitals, primary care by general practitioners (GPs), and a range of home and community support, including care from district and public health nurses. Examples include Home and Community Support Services, Carer Support Subsidy, respite care, Meals on Wheels, and aged residential care assessment/referral. There is a Needs Assessment and Service Coordination (NASC) that assesses health needs, functional ability, and social support to determine eligibility for publicly funded services. It coordinates personalised healthcare support to promote safety, independence, and quality of life for people aged 65 and above. There are ethnic-based services, specifically for Māori and some Pacific communities (Health New Zealand: Te Whatu Ora, n.d.; Ministry of Health, 2026b), such as Samoan- and Tongan-specific health services, as well as non-governmental organisations. These include aged care residential services, palliative care, and hospice care (Health Navigator Charitable Trust, 2026). In addition, older adults in Aotearoa New Zealand access a continuum of publicly funded support services spanning home-based assistance, needs assessment and coordination, respite and day programmes, specialist dementia and gerontology services, and aged residential care across rest home, hospital, and psychogeriatric levels (Associate Minister of Health, 2023; Ministry of Health, 2026a). The general population is encouraged to enrol in a general practice so that their healthcare needs can be met and the GP can also manage their health and well-being.

While it is the aim, holistic care remains a concern for Aotearoa New Zealand's ageing population (Neville et al., 2022). Despite New Zealand's commitment to providing equitable healthcare, many people continue to experience barriers to timely and appropriate care. These challenges can be more pronounced for older adults, ethnic

minority communities, and other vulnerable populations, who may face difficulties related to language, cost, cultural misunderstanding, limited health literacy, and poor-quality interactions with healthcare services (Ma"U et al., 2022). Healthcare needs to strengthen the continuum of care, address equity gaps, and ensure the care provided is accessible and culturally safe. Access to publicly funded care is based on eligibility rather than income or social status (Health New Zealand: Te Whatu Ora, 2026).

Primary care services are provided by GPs, who often act as the first point of contact and as gatekeepers for the wider healthcare system. Patients can access primary care by enrolling with a GP or attending a walk-in clinic. For older adults, regular contact with primary care is especially important for monitoring long-term conditions, accessing referrals, and receiving preventive health advice. Specialist care is provided through public hospitals funded by the government. Hospital care, including surgery and inpatient care, is free for eligible Aotearoa New Zealand residents; however, some costs may still arise in relation to diagnostic tests, prescriptions, transport, or follow-up care.

Mental health services in Aotearoa New Zealand are provided through a combination of public and private providers. The government funds a range of community-based mental health services, including counselling, therapy, and support groups. Hospitals and mental health clinics also provide specialist mental health services. These services are relevant for older adults, as ageing can be accompanied by social isolation, grief, migration-related stress, and changes in family or community support.

The government also subsidises pharmaceuticals through Pharmac [2]and the Pharmaceutical Schedule. This system makes a range of prescription medicines available to eligible residents at subsidised prices. For older adults, affordable access to medicines is important because many live with long-term health conditions and may require regular prescriptions. However, even within a subsidised system, some people may still experience financial, language, cultural, or transport-related barriers when accessing healthcare and medicines. Overall, access to public healthcare in Aotearoa New Zealand aims to be accessible and affordable. The system is designed to provide

[2] Pharmac is New Zealand's government agency responsible for deciding which medicines and related products are publicly funded through the Pharmaceutical Schedule, helping to ensure equitable and cost-effective access to medicines.

universal coverage and equitable access to all residents, regardless of income or social status. The government has invested in a range of preventive and primary care services, as well as hospital and specialist care.

Although Aotearoa New Zealand has a publicly funded healthcare system, there remains a gap between eligibility for care and the ability to access it when needed. Public funding provides an important foundation for health and well-being, but the system continues to face pressure from resource constraints, workforce shortages, rising demand, and an ageing population. These pressures are reflected in long waits for first specialist assessments, elective treatment, and procedures often associated with long-term conditions, such as hip and knee replacements. Current national health targets aim to ensure that 95% of patients wait less than four months for a first specialist assessment and elective treatment, indicating that timely access remains both a national priority and an ongoing challenge (Ministry of Health, 2026a). Recent research also suggests that the unmet need for secondary healthcare in Aotearoa New Zealand has increased, placing further pressure on general practice and contributing to inequities in access (Bowden et al., 2025).

Access gaps are also evident in osteoarthritis care, where people may require ongoing support, pain management, rehabilitation and, for some, hip or knee replacement surgery. Recent New Zealand research has highlighted concerns about unequal access to osteoarthritis services, including funding pressures, regional differences, and what has been described as “postcode healthcare” (O'Brien, 2023). Stowers et al. (2023) also found geographical differences in access to publicly funded hip and knee arthroplasty, partly due to variations in hospital scoring thresholds for surgical eligibility. This suggests that access to treatment may depend not only on a person’s clinical need, but also on where they live and how local services manage and prioritise demand.

These gaps are particularly important as New Zealand’s population ages and more people live with NCDs, including CVD, diabetes, cancer, chronic respiratory disease, and musculoskeletal conditions (Abey-Nesbit et al., 2023). While longer life expectancy is a positive sign of population health, it also means that more people may need timely primary care, specialist assessment, elective treatment, rehabilitation, and longer-term support. The Organisation for Economic Co-operation and Development (OECD) has

identified NCDs as a major and growing challenge for New Zealand, with important implications for future health spending and service demand (Organisation for Economic Co-operation and Development, 2026). Therefore, while the public healthcare system remains essential, gaps in funding, workforce, and service availability can delay treatment and contribute to unmet health needs. This shows that public healthcare access is not only about having services available, but also about whether people can receive timely, appropriate, and continuous care.

In summary, older adult services in Aotearoa New Zealand play a central role in promoting healthy ageing and supporting older people with varying levels of health and social care needs. Although a wide range of services exists across community, primary, secondary, and residential care settings, equitable access to these services remains an important concern. Differences in culture, language, health literacy, affordability, and familiarity with the health system may influence how older adult migrants experience and use available services. Therefore, an understanding of the available older-adult services in Aotearoa New Zealand is essential for situating discussions of healthcare access and for identifying the structural and social factors that may shape service use among diverse ageing populations.

Fijian Indians represent a minority ethnic population in Aotearoa New Zealand. Older Fijian Indian immigrants may experience additional challenges when accessing healthcare services, as the experiences of migration, cultural and language differences, and the healthcare needs associated with ageing can intersect to create multiple barriers to accessing appropriate care.

1.5 Rationale and Significance of the Study

This study focuses on identifying enablers and barriers to accessing healthcare amongst older Fijian Indians living in Aotearoa New Zealand, given the increasing age of this population and the high prevalence of chronic long-term conditions among older adults in Aotearoa New Zealand. This is a novel study which has not been conducted in Aotearoa New Zealand previously. This study contributes to understanding and providing recommendations on the identified barriers and inequities faced by a minority ethnic group, in this case, older Fijian Indian immigrants living in Aotearoa New Zealand.

In this thesis, the Fijian Indian group is treated as a unique community with its own migration and settlement history. Although Fijian Indians have ancestral links to India, they are not the same as Indian migrants. At the same time, they do not fit neatly into the category of Pacific Islander, particularly because migration, colonial labour histories, and later movements to countries such as New Zealand shape their relationship to Fiji. For many, this has created a complicated sense of belonging, where identity is connected to Fiji, India, and New Zealand, yet not fully contained by any one of them. Older Fijian Indians have a rich history of migration and adaptation, yet face specific challenges and opportunities within the healthcare system that have not been fully understood or effectively addressed in the current literature (Chiang et al., 2021). The convergence of ageing, cultural identity, and immigration created unique circumstances that shaped how these individuals interacted with healthcare services, affecting their overall well-being (Bhandari et al., 2022). This research is timely and significant because chronic diseases, such as T2DM and CVD, are highly prevalent in Fijian Indians and are leading causes of mortality in Aotearoa New Zealand (Dearie et al., 2025).

Fijian Indians have been identified as a high-risk group for CVD and metabolic diseases (Dearie et al., 2024). Language barriers, cultural beliefs, traditional disease self-management approaches, and systemic inequities were identified as obstacles to achieving optimal healthcare outcomes for recent older migrants in other countries (Arora et al., 2019; Mbanya et al., 2019; Tiagi, 2016). A commonly reported lack of cultural competence among healthcare providers exacerbated the difficulties migrants face in their host countries, resulting in inequalities in healthcare accessibility and service utilisation globally and regionally (Mbanya et al., 2019; Raaj, 2016; Tiagi, 2016).

Older Fijian Indian migrants are an important population to study because ageing, migration, culture, and health system factors interact in ways that can shape healthcare access and well-being. National health policy emphasises equitable access to quality healthcare for all population groups, highlighting the importance of understanding the experiences of groups whose needs may be overlooked in mainstream service design (Szabó & Goodin, 2025). Studying older Fijian Indian migrants is significant because broad categories such as “migrants” or “older adults” can overlook the cultural, linguistic, historical, and family contexts that shape this

community's health beliefs and healthcare experiences (Pledger & Cumming, 2024). This becomes especially important in later life, when healthcare needs often become more frequent and complex (Mann et al., 2025). By focusing specifically on older Fijian Indian migrants, this study addresses an important knowledge gap. It provides evidence to support more equitable, culturally responsive, and population-sensitive healthcare policy and practice in Aotearoa New Zealand.

This study aimed to examine the barriers to and enablers of healthcare access and to explore older Fijian Indian migrants' views of their healthcare experiences. An interpretive-descriptive research design was used to examine the cultural, social, and systemic factors influencing these experiences (Thorne, 2016). The findings contribute to broader discussions on health equity and may help inform improvements in healthcare accessibility for other migrant ethnic groups in Aotearoa New Zealand.

The socio-ecological conceptual framework (Chung et al., 2018), applied in the discussion chapter 5, informed by the dimensions of availability, accessibility, acceptability, and quality (AAAQ) (United Nations Committee on Economic, Social and Cultural Rights, 2000), guided the overall study, including the development of the interview approach and the interpretation of findings. The socio-ecological conceptual model was used as an organising framework for the discussion section of the current study (Chung et al., 2018). This model helped examine healthcare access not only as an individual issue, but also as one shaped by family, community, healthcare organisations, and wider social systems. It was particularly relevant for older Fijian Indian migrants in Auckland, whose healthcare experiences may be influenced by migration history, language, cultural expectations, family roles, service affordability, and the accessibility of the New Zealand health system.

1.5.1 Research questions

1. What are the enablers of access to healthcare among older Fijian Indian immigrants, and how do these manifest?
2. What are the barriers, including systemic level and structural inequities, to accessing healthcare, and how do these manifest?
3. What strategic suggestions can enhance access to health services for older Fijian Indian immigrants?

1.6 Definition of Key Terms and Abbreviations

This section outlines the definitions of key terms used in the study, reflecting how these concepts are understood in the context of this research.

- **ACC** – Accident Compensation Corporation. ACC is New Zealand's no-fault accident compensation scheme. It provides support for people who experience injuries, including treatment, rehabilitation, and compensation for eligible accident-related injuries.
- **Acute care** – Acute care refers to short-term treatment for severe, urgent, or sudden episodes of illness or injury. It usually requires prompt clinical intervention and is often delivered in hospital settings.
- **Aotearoa New Zealand** – The combined Māori and English name for New Zealand.
- **Asian Indian** – A term used in some international studies to refer to people of Indian ancestry or origin. In this thesis, it is used only when reflecting the terminology of those studies.
- **Barriers** – Barriers are factors that hinder, delay, or prevent access to healthcare services. In this study, barriers may include structural, financial, linguistic, cultural, and interpersonal obstacles.
- **Cultural safety** – In the Aotearoa New Zealand context, cultural safety is a core expectation of nursing practice and is closely linked to Te Tiriti o Waitangi, Māori health, and reflective, respectful care. In this thesis, cultural safety refers to care that is responsive to people's cultural identities, values, and lived experiences.
- **CVD** – cardiovascular disease.
- **Enablers** – Enablers are factors that facilitate, support, or improve access to healthcare services. In this study, enablers refer to conditions or processes that help participants obtain and use healthcare more effectively.
- **Equitable and culturally appropriate care** – Equitable and culturally appropriate care refers to healthcare delivered fairly and in ways that recognise and respond to diverse needs, values, and cultural contexts. In this study, care is understood as respectful, inclusive, and responsive to the cultural and social realities of older Fijian Indian migrants.

- **Fijian Indians** – In this study, Fijian Indians refer to people of Indian ancestry whose families are historically rooted in Fiji and who later migrated to New Zealand. This term is used consistently throughout the thesis to reflect the historical, cultural, and diasporic identities of the participant group. The term **Indo-Fijians** is used interchangeably, but the meaning remains the same.
- **Girmit** – Girmit is derived from the word "agreement" and refers to the system of indentured labour under which Indians were taken to Fiji during the colonial period. The term is also associated with the historical experiences of those labourers and their descendants.
- **GP** – General practitioner. A GP is a medical doctor who provides first-contact, ongoing, and general healthcare in the community. GPs are often the first point of contact with the health system.
- **Health literacy** – the ability to obtain, understand, and use health information and services to make informed decisions and navigate healthcare systems effectively.
- **Healthcare access** – the ability of individuals to obtain appropriate health services when needed. In this thesis it includes the ability to reach, use, and engage with health services in ways that are timely, acceptable, and responsive to need (Cu et al., 2021). This understanding is consistent with the broader primary health care emphasis on comprehensive, people-centred care.
- **iTaukei** – iTaukei is a Fijian word that refers to the Indigenous people of Fiji. In this thesis, the term is used to distinguish Indigenous Fijians from Fijians of Indian descent.
- **Language barriers** – difficulties in communication between patients and healthcare providers when there is no shared preferred language or when mutual understanding is limited. These barriers may affect navigation of the healthcare system, the understanding of health information, and participation in care.
- **Migrants** – The International Organisation for Migration defines migrants broadly as persons who move away from their usual place of residence, either within a country or across an international border, temporarily or permanently. In this thesis, the term refers to Fijian Indian participants who migrated to New Zealand (Sironi et al., Eds. 2019).

- **Older adults** – In this study, older adults are individuals aged 55 years and over, in line with the study's inclusion criteria. This age range was selected because ageing among migrant communities may be influenced not only by chronological age, but also by migration history, settlement experiences, health status, and access to services. Migrant health research commonly uses flexible age thresholds, including people aged 50+ or 55+, when studying older migrant populations (Bhatia et al., 2024; Kristiansen et al., 2016).
- **Primary care** – Primary care is a key part of the health system that provides promotive, preventive, curative, rehabilitative, and palliative services across the life course. It is commonly the first level of care accessed by individuals and families.
- **South Asian** – A broad term referring to people with ancestry or origins in South Asian countries, commonly including India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives.
- **Talanoa** – Talanoa is a Pacific methodology based on respectful storytelling, open conversation, and relationship-building. It supports the culturally meaningful sharing of experiences.
- **Te Whatu Ora: Health New Zealand** – 'Te Whatu Ora' is the name of Aotearoa New Zealand's national health organisation. It is commonly used alongside 'Health New Zealand'.
- **T2DM** – Type 2 diabetes mellitus.

1.7 Thesis Structure

This section outlines the structure of this thesis. It provides a brief description of each chapter's content in sequential order. This thesis comprises five chapters.

Chapter 1 has provided a comprehensive overview of this research, including the history of Fijian Indians and their migration to Aotearoa New Zealand. Their background, emigration from India to Fiji under the indentured labour system known as 'Girmit', their subsequent migration to Aotearoa New Zealand, and the reasons for this migration, have been outlined. The demographic data on Fijian Indians living in Aotearoa New Zealand have been discussed, including rates of chronic disease. The

chapter has also covered the Aotearoa New Zealand health system and government funding. This serves to provide context for research, which then forms the basis of the research question and the discussion of the study's rationale and significance. The chapter also provides an overview of the socio-ecological conceptual framework and AAAQ dimensions that underpin and guide the exploration of healthcare access among older Fijian Indian migrants throughout the study.

Chapter 2 presents a narrative literature review on access to healthcare for migrants. It covers the existing literature on barriers to and enablers of migrants' access to healthcare. This includes the introduction to the narrative literature review, the search strategy, the dates, the data sources, the inclusion and exclusion criteria, and the themes generated from the literature review. While this comprehensive review acknowledges the relevance of the literature, it also highlights gaps in existing studies among ethnic and migrant populations, and in methods, providing a basis for the research aims and objectives.

Chapter 3 provides a detailed overview of the ontology, epistemology, and methods used in this research. The pragmatism and interpretivism, qualitative, interpretive, and descriptive approach are outlined, including the research design and methods. In the methods section, the approaches to sampling, recruitment data collection, and analysis, obtaining ethics approval, and maintaining rigour are discussed.

Chapter 4 presents the study's findings. The chapter is divided into five themes based on the analysis of the data, with 3 sub-themes for themes 1 to 3, and 2 sub-themes each for themes 4 and 5, and highlights participant quotations aligned with each theme. Each theme covers the experiences of older Fijian Indians accessing healthcare in Aotearoa New Zealand.

Chapter 5 presents a critical discussion of the themes, how they address each research question, and novel insights, drawing on existing global and local literature to highlight or contrast the key findings. It compares the study with Aotearoa New Zealand and global literature on access to healthcare for older migrants, using the socio-ecological conceptual model to frame the discussion.

Also, in Chapter 5, the thesis concludes with a discussion of the study's strengths and limitations, followed by recommendations based on the findings. These recommendations are presented at the macro, policy, and economic levels; the meso, education, healthcare delivery, and health professionals' ongoing education levels; and the micro level to reflect the complex, intersectoral nature of addressing older Fijian Indian migrants' healthcare access. At the macro level, the chapter focuses on Aotearoa New Zealand health policy and broader system-level change. At the meso and micro levels, it considers recommendations for clinical practice, including organisational responsiveness, culturally safe care, communication, and person-centred interactions.

The chapter also includes recommendations for education, covering undergraduate education for both medical doctors and specialised nurses; postgraduate education for health professionals and advanced professional preparation; continuing professional development and workplace learning; academic development and educator capability; and regulatory and institutional oversight. It then provides a summary of the key recommendations, followed by reflection, conclusion, and final remarks. Overall, Chapter 5 draws the thesis together by linking the study findings to practical and policy-relevant directions for improving healthcare access for older Fijian Indian immigrants in Aotearoa New Zealand.

Chapter 2 Narrative Literature Review

This chapter reviews the existing literature on older migrants' access to healthcare both globally and within the Aotearoa New Zealand context. In increasingly diverse societies such as Aotearoa New Zealand, it is important to look beyond general discussions of healthcare access and consider how older migrants, in particular Asian Indian experience health services in everyday life. This literature review, therefore, examines the barriers and enablers shaping healthcare access for older migrants, while also identifying the lack of current research focused specifically on older Fijian Indian migrants in Aotearoa New Zealand. This gap informs the research problem and provides the rationale for the present study.

The global trend of migration and the diversifying ageing population are pivotal to effective and safe healthcare delivery. Similarly, in Aotearoa New Zealand, access to healthcare for migrant communities, especially those who are ageing and frequently experience multiple comorbidities, is a crucial health service delivery issue for addressing health equity, influenced by unique and systematic population-related barriers and enablers (Bhatia et al., 2025).

While access to healthcare remains challenging for the Aotearoa New Zealand population (Williams et al., 2025), the patient experiences, particularly for migrants, also remain highly problematic in relation to communication from healthcare professionals, meaningful person-centred care approaches, clinical skills, overt racism in clinical practice, and the availability of culturally targeted health literacy resources which in turn also remain a challenge for the general population (Rhodes & Douglas, 2025; Uerata et al., 2025). These issues are particularly evident for older migrants, who often have multiple chronic conditions (Abey-Nesbit et al., 2023; Kanengoni-Nyatara et al., 2024; Montayre et al., 2019; Uerata et al., 2025).

This narrative literature review examines current evidence on barriers to and enablers of healthcare access for migrant populations, with particular attention to older migrants and Indian migrants, given their cultural practices that are similar to those of the target population, and, where possible, to Fijian Indians. Older migrants who move from low-resource to high-resource settings may face complex challenges, including

communication difficulties, cultural misunderstandings, loneliness, vulnerability, and concerns about cultural safety (Mukwezwa Tapera, 2025; Simon-Kumar & Sharma, 2025). In Aotearoa New Zealand, migrant health studies have similarly identified barriers to navigating and accessing healthcare services that require further attention (Bhatia et al., 2025; Mann et al., 2025; Xiang et al., 2023).

Within this broader migrant health context, Fijian Indians may experience particular language and cultural factors that shape their access to healthcare. Limited English proficiency can make it difficult to communicate with healthcare providers, understand health information, and participate confidently in care decisions (Pledger & Cumming, 2024). Cultural differences in health beliefs and practices may also influence when and how Fijian Indians seek care (Parackal & Holroyd, 2024). For example, some may use traditional healing practices or delay seeking formal healthcare until symptoms become more serious (Pledger & Cumming, 2024). These factors suggest that healthcare access is shaped not only by individual language, culture, and health beliefs, but also by how services are organised, communicated, and delivered.

This chapter first outlines the literature search strategy and then reviews evidence from Aotearoa New Zealand and international studies on healthcare access among older migrants in the context of the intersecting barriers noted above. It also identifies key gaps in the existing literature and highlights the need for further research focused on the healthcare experiences of older Fijian Indian migrants.

2.1 Literature Search Strategy

This section outlines the literature search strategy. It outlines the databases used and the key terms used to identify high-quality, peer-reviewed scholarly articles relevant to the current study. It also includes outlines of the inclusion and exclusion criteria, as well as the selection criteria used to locate relevant literature.

2.1.1 Key words

PICOT (Population, Intervention, Comparison, Outcome, Timeframe) is an acronym that describes all the elements of a clinical question (Whitehead & Massey, 2025). In this case, it can be set down as follows:

- **Population** – older migrants, migrants, Fijian Indian migrants.
- **Intervention** – access to healthcare.
- **Comparison** – other older ethnic migrants.
- **Outcome** – improved healthcare access, engagement, satisfaction, and reduction in access barriers.
- **Timeframe** – over the last 10 years of literature (10 years due to scarcity of literature on older migrants' access to healthcare).

The following terms were identified and added to the search strategy:

- access to healthcare
- Fijian Indians
- Fiji Indians
- Indo-Fijians
- Indians
- migrants
- barriers to healthcare
- older
- elderly, aged
- access to healthcare amongst Fijian Indians
- access to healthcare amongst Indians in Aotearoa New Zealand
- disparities in healthcare
- accessibility and equity in healthcare

2.1.2 Search strategy

The following search strategy was employed to search the literature. As there was not much literature on access to health on Fijian Indians available, terms were changed from Fijian Indians to:

"Indian migrants" OR "older migrants" OR "ethnic migrants" AND "healthcare access" OR "healthcare barriers" OR "health equity" AND "New Zealand"

To enhance the rigour and comprehensiveness of the search process, the search strategy was developed in consultation with an AUT subject librarian. Guidance was

provided on database selection, keyword development, the use of Boolean operators, and search techniques to ensure that relevant literature was identified systematically.

While these searches identified literature on migration history, identity, ethnic classification, and some broader health-related issues, no studies were found that specifically examined the experiences of older Fiji Indian/Fijian Indian migrants accessing healthcare services in Aotearoa New Zealand. This absence further supports the need for the present study.

The literature review was initially conducted in 2021 as part of developing the current study methodology. At that point, there was limited literature on older migrant populations, particularly on older Indians. However, due to growing recent attention in this field in Aotearoa New Zealand, several recent papers (2016-2025) have been added to the literature review presented here to provide contextual insights into a culturally similar population. Fijian Indians originated in India and share cultural, linguistic, and social practices with the Indian diaspora. Including studies of older Indian migrants provides a contextual understanding of cultural health beliefs, migration experiences, and healthcare access patterns.

This narrative literature review was guided by the following question: What is currently known about the barriers to and enablers of healthcare access for older migrants in Aotearoa New Zealand and comparable (high resource) international contexts? This question helped structure the review of existing evidence and provided a foundation for understanding the more specific healthcare experiences of older Fijian Indian migrants in this study.

Keeping the above research question and criteria in mind, a literature search was conducted across the CINAHL, Scopus, MEDLINE, PubMed, and Cochrane Library databases, as well as the Ovid search platform, following the aforementioned search strategy. These resources were selected to provide broad coverage of the literature on healthcare access among older migrants. CINAHL was particularly relevant for identifying nursing and allied health research, while MEDLINE and PubMed provided access to biomedical and public health literature. Scopus was included for its multidisciplinary coverage, enabling the search to extend beyond nursing and medicine to encompass social and cultural aspects of healthcare access. The Cochrane Library

was considered useful for identifying systematic reviews and synthesised evidence relevant to healthcare services and access. Ovid was also used as a search platform because its advanced search functions supported the use of subject headings, keywords, and combined search terms to systematically identify relevant health literature. This complemented the searches conducted through the other databases and supported a more comprehensive literature search. Together, these resources supported a broader search across nursing, healthcare, public health and related disciplines, reflecting the different factors influencing healthcare access among older migrants.

2.1.3 Inclusion and exclusion criteria

Inclusion

The reviewed literature focused on experiences of accessing healthcare among older migrants, particularly those aged 55 years and over. Studies involving broader migrant and ethnic minority populations were also considered where they provided relevant insights into barriers and enablers to healthcare access. Literature examining healthcare access among older migrants from low-resource countries was considered particularly relevant, given that ageing-related healthcare needs may emerge before the conventional age threshold of 65 years used in Aotearoa New Zealand and other high-resource countries. Studies were therefore considered for inclusion based on their relevance to older migrants' healthcare access experiences, including those involving populations aged 55 years and over.

Exclusion

Articles outside the 10-year timeframe were excluded, as was the grey literature. The search was narrowed to 2016-2025 to provide a contemporary understanding of healthcare access among migrant populations. As the literature review was updated before completion of the thesis, the search was repeated and refined to include studies published between 2016 and 2025, ensuring the review reflected the most recent evidence. Articles that were not in English were also excluded. Studies involving Indian migrants within broader Asian population groups were excluded where findings relating to Indian migrants could not be distinguished from those of other ethnic groups and were therefore insufficiently specific to inform the review.

Following the initial database searches, all retrieved records were imported into reference management software, EndNote, and duplicates were removed. The use of EndNote was supported through workshops and one-to-one consultations provided by AUT Library staff, which assisted with reference management and organisation of the retrieved literature.

The remaining articles were then screened by title and abstract against the inclusion and exclusion criteria and the guiding literature search question. The articles were included if they focused on older migrants, healthcare access, barriers to or enablers of healthcare use, migrant health experiences, or culturally and linguistically diverse communities. The articles were excluded if they did not focus on healthcare access, did not specify the ethnicity of the migrant populations, were not related to migrant or ethnic minority populations, were not available in English, or were not relevant to the Aotearoa New Zealand context or to comparable high-income country contexts. Studies that focused on young adults, non-migrants, and refugees were excluded where their findings did not contribute to understanding healthcare access among the population of interest. Full-text versions of the potentially relevant articles were subsequently assessed for eligibility, resulting in the final selection of studies included in this review.

2.2 Summary of Literature

The narrative literature review drew on 15 sourced research articles. These studies included qualitative studies, quantitative survey-based studies, mixed-methods review-based evidence, a thematic synthesis, a scoping review, and participatory action research. Together, the studies represented a diverse range of older migrant and ethnic minority communities, including Chinese, Indian, Kurdish, Native Hawaiian, Pacific, Pakistani, South Asian, Somali, sub-Saharan African, and Turkish peoples across Aotearoa New Zealand and international contexts. Although the initial literature search conducted in 2021 identified a smaller group of studies, additional recent articles have been included to strengthen the review, refine the thematic groupings, and address the limited evidence available specifically on older Indian and Fijian Indian migrants.

The more recent studies, particularly those published between 2020 and 2025, offered important contextual and comparative insights. The study by Akhtar et al. (2024), conducted in Aotearoa New Zealand, was particularly relevant because it included South Asian immigrants, including Indian and Fijian Indian participants, and examined medication adherence and self-treatment practices. Neville et al. (2022), in their participatory action research with older Pacific peoples, which included Fijian Indians in South Auckland, also provided valuable local insights into how cultural values, family responsibilities, transport, costs, waiting times, and the organisation of services can shape healthcare access for ageing ethnic minority communities. International studies, including Guo et al. (2025) and Ilgaz et al. (2025), who reviewed older Indian migrant research from high-income countries including the United Kingdom, Canada, the United States, and Australia, provided broader comparative evidence on how older migrant groups experience culturally shaped health beliefs, traditional remedies, family support, and healthcare access barriers.

These additional studies were included in the final papers because research on older Indian migrants, and particularly older Fijian Indian migrants in Aotearoa New Zealand, remains limited. For this reason, evidence from Indian, South Asian, and culturally comparable migrant communities was used to provide a broader foundation for understanding how cultural beliefs, language, family expectations, trust, traditional medicine, and health-system navigation may influence healthcare access. While not all studies focused directly on Fijian Indians, they offered meaningful insights into ageing, migration, cultural identity, and healthcare engagement in multicultural health systems.

To synthesise the findings, the literature was analysed using thematic analysis guided by Braun and Clarke (2022). This process enabled the identification, comparison, and organisation of recurring ideas across the included studies into broader thematic categories. The review generated five key themes: cultural safety and discrimination; Indian cultural beliefs, traditional medicine, and health-seeking behaviours; communication and linguistic accessibility; structural and systemic barriers to healthcare access; and health system navigation and health literacy. Together, these themes show that healthcare access for older migrants is multidimensional and shaped by individual, cultural, interpersonal, and health-system factors.

2.3 Cultural Safety and Discrimination

A lack of cultural safety, experiences of discrimination, and patterns of healthcare access and service engagement are closely linked, as healthcare encounters that are perceived as unsafe, disrespectful, or inequitable can discourage ongoing access to healthcare and meaningful engagement with services. Several studies (Guo et al., 2025; Mbanya et al., 2019; Raaj, 2016) have reported that older migrant participants experienced barriers to accessing healthcare, which were exacerbated by a lack of cultural safety understanding among health providers. A quantitative study (Tiagi, 2016), analysing national survey data from Canada on migrants aged 65 years and older, found that older immigrants utilised healthcare services significantly more than Canadian-born older participants. Examples suggest that migrant experiences of healthcare are influenced by culturally mediated expectations of care, communication, and provider responsiveness. When these expectations are not met, service users may experience discomfort, reduced trust, or a reluctance to engage fully with healthcare services. This demonstrates how perceptions of cultural safety are closely connected to healthcare access and service engagement (Tiagi, 2016). However, this study did not explore lived experiences, highlighting the need for a qualitative study to understand healthcare access among older migrant populations.

Comparable findings on factors affecting healthcare access have been reported in other older migrant populations. A qualitative study (Mbanya et al., 2019) in Norway was conducted with sub-Saharan African older migrants (age not specified in detail, however), 47 adults recruited only through community groups and cultural and faith-based organisations, using snowball sampling. The study highlighted participants' perceived lack of cultural understanding, with them preferring healthcare providers, doctors in particular, from their own ethnic background. The participants highlighted that healthcare providers showed little interest in their health concerns, spent too little time, or failed to listen during consultations, leading to a perceived lack of respect and dissatisfaction. A limitation of this study is its focus on sub-Saharan African immigrants, which may limit the transferability of its findings to other migrant populations or geographical settings.

Older migrants experience significant cultural barriers that limit their access to healthcare, particularly in relation to mental health stigma and trust in healthcare providers. These findings were identified in a mixed-methods systematic review by Guo et al. (2025), which synthesised evidence from 33 studies published between 2000 and 2021 on older Chinese migrants across the United Kingdom, Canada, the United States, and Australia. Key barriers included reluctance to discuss mental health conditions because of cultural stigma and a lack of trust in, and support from, healthcare providers. The review further emphasised that more inclusive and culturally sensitive services are needed, and that healthcare providers should acknowledge older migrant patients' beliefs and preferences in a non-judgemental manner. These findings suggest that experiences of healthcare access and service engagement are strongly influenced by whether care is experienced as respectful, supportive, and culturally responsive. A limitation of this study is that it focused only on participants' voices and did not consider insights from healthcare providers. Another limitation is that the studies in the review were from several high-income countries with differences in healthcare systems that may limit generalisability across countries.

The literature indicates that cultural safety, discrimination, and experiences within healthcare encounters are key factors influencing healthcare access and engagement with services for older migrants universally. However, Ilgaz et al. (2025) demonstrated that healthcare access and service engagement are not shaped solely by experiences of discrimination or cultural misunderstanding but can also be strengthened when care is experienced as respectful, equitable, and responsive to patients' cultural values and traditions. A qualitative study by Ilgaz et al. (2025) was conducted in Norway among older Turkish migrants aged 60 years and over, including 15 participants (both men and women) who had lived in Norway for many years (not specified). This study highlighted those older Turkish immigrants in Norway generally described positive healthcare experiences, characterised by equality, respect, and culturally responsive care. Participants reported not experiencing discrimination and that healthcare professionals were supportive and attentive to their cultural values and traditions. For example, one participant recalled that nurses were helpful, understanding, and respectful of the family's culture during a time of bereavement, while another contrasted the Norwegian healthcare system with that of Türkiye, stating that access

to good hospital care did not depend on a person's economic position. These findings suggest that experiences of healthcare access and service engagement are strengthened when care is perceived as equitable, respectful, and culturally safe.

Providing healthcare in line with older migrant patients' backgrounds is important, including understanding the needs of individuals from diverse backgrounds. For example, when educating patients on diet, it is essential to consider their cultural context and staple diet and to communicate in a manner and language they understand (Liu, 2024). However, an in-depth breakdown of these "cultural barriers" is insufficiently explicit to guide healthcare policymakers in implementing ethnic-specific healthcare policies for older adults. For example, Tiagi (2016) stated that efforts must be initiated to promote cultural awareness of how to access services through training and workshops; however, a limitation was that it was unclear which aspects of cultural awareness needed to be changed as part of the recommended training.

Studies examining the older migrant population highlight discriminatory concerns regarding healthcare access. A qualitative study by Browne et al. (2017) examined older Hawaiian migrants living in Los Angeles and San Diego, involving 20 participants and family caregivers. This study also included 10 additional informants, who were community leaders or individuals with knowledge of the healthcare services within the same community group. The study found that discrimination was an important barrier in participants' access experiences, suggesting that healthcare access and service engagement need to be understood within the broader context of marginalisation and social stressors. Browne et al. (2017) further indicated that the needs of older migrants are better addressed when services are accessible, acceptable, and responsive to the cultural and social realities of the communities they serve. A limitation of this study is that it recruited participants from civic clubs, which may have made them more culturally connected, and it was limited to only two communities, limiting its wider applicability to the rest of the Hawaiian migrants (Browne et al., 2017).

Several studies have identified discrimination and institutional barriers as factors shaping healthcare utilisation among migrants. For example, Tiagi (2016) analysed national survey data from 112,203 immigrants in Canada aged 18 years and older to examine patterns of healthcare utilisation across migrant populations. Findings relating

to the older migrant subgroup indicated that some participants avoided or reduced visits to GPs due to perceived discriminatory attitudes from physicians. Although the large sample size strengthened the study's findings, the lack of disaggregated ethnic data limited a deeper understanding of specific migrant groups. Similar concerns were reported in qualitative studies examining migrants' healthcare experiences in Europe. Mölsä et al. (2019) found that older Somali migrants in Finland reported experiences of discrimination and inequitable treatment within healthcare settings, which in some cases led participants to seek religious or traditional healing practices instead of formal healthcare services. Likewise, Mbanya et al. (2019) reported that participants in a qualitative study involving 47 sub-Saharan African immigrants living in Norway often perceived differential treatment compared with the native population. Participants described situations in which healthcare professionals appeared to assume that African patients were carriers of infectious diseases such as HIV. For example, some participants reported that healthcare workers wore double gloves when taking blood samples, which they interpreted as a sign of stigma and disrespect towards them as African patients. Such experiences reinforced feelings of marginalisation and reduced trust in healthcare providers (Mbanya et al., 2019).

In summary, the literature discussed in this section indicates that attention to cultural safety, experiences of discrimination, and the interpersonal quality of healthcare encounters are key influences on healthcare access and service engagement among older migrants. Positive healthcare interactions characterised by respect, equity, and cultural responsiveness can support trust and encourage continued use of services. Conversely, culturally insensitive care, discrimination, and poor recognition of the needs of older immigrant populations may discourage healthcare seeking and reduce meaningful engagement with services (Mölsä et al., 2019). These findings suggest that healthcare access is shaped not only by structural availability but also by whether healthcare environments are experienced as safe, inclusive, and responsive to migrant populations (Arora et al., 2019; Choi et al., 2015; Mbanya et al., 2019; Mölsä et al., 2019; Tiagi, 2016).

2.4 Indian Cultural Beliefs, Traditional Medicine, and Health-Seeking Behaviours

The literature reviewed suggests that specific cultural beliefs about health and well-being, the use of traditional medicine, and culturally shaped help-seeking behaviours, such as access to services, can play an important role in shaping how Indian migrants, and particularly older Indian migrants, respond to illness and access healthcare services. These influences may affect how symptoms are interpreted, when professional care is sought, and the extent to which formal healthcare services are used alongside family support or traditional remedies. However, there appears to be limited research specifically examining the cultural beliefs, traditional medicine, and health-seeking behaviours of older Indian migrants. Accordingly, this theme draws primarily on studies of Indian adult migrants, supplemented where relevant by the broader South Asian migrant literature.

Given the limited literature specifically focusing on older Indian migrants, the analysis of this theme also draws selectively on broader migrant literature, which provides useful comparative insights into different cultural beliefs, traditional practices, and help-seeking behaviours. Similar patterns have been reported in other migrant populations. For example, Guo et al. (2025) found that older Chinese migrants often used traditional healing practices, such as herbal remedies, before seeking formal healthcare and were hesitant to question healthcare professionals because doing so was regarded as disrespectful. Ilgaz et al. (2025) likewise reported that some older Turkish migrants preferred traditional remedies or advice from family members before seeking professional healthcare and felt more comfortable relying on their own cultural community. Similarly, Browne et al. (2017) showed that, among older Native Hawaiian migrants in California, cultural values related to family care, the role of elders, and home-based rather than institutional care shaped the willingness to engage with services. Although these studies were not specific to Indian migrants, they offer useful contextual insights into how culturally embedded beliefs, family expectations, and traditional understandings of care may shape health-seeking behaviours and, in turn, access to healthcare across migrant communities. More specific insight into these issues is provided by studies focusing directly on the Indian migrant population; their findings were later added to the literature review to obtain theme-specific insights.

Healthcare access and health-seeking behaviours are also shaped by how migrants understand, believe in, and value health and illness, as well as their decisions about where to seek help first. Rao (2006) conducted an exploratory qualitative study in a metropolitan city in the United States to examine health treatment choices among Asian Indian migrants. Using in-depth interviews with 21 informants, the study found that participants adopted a pluralistic approach to healthcare, drawing on folk remedies, Ayurveda, homeopathy, and allopathic medicine. Home remedies and Indian medical alternatives were commonly used as first-line treatments for minor ailments, whereas allopathic medicine was preferred for serious or chronic conditions. These findings indicate that health-seeking behaviour and service access among Indian migrants are influenced by culturally grounded beliefs about illness severity, as well as perceptions of the effectiveness and suitability of different treatment systems. A limitation of the study is that it involved a small sample from a single metropolitan setting in the United States, which may limit the transferability of the findings to other Indian migrant populations.

For some migrants, healthcare choices are shaped not only by accessing and interacting with local services but also by ongoing connections with health systems, family members, and trusted providers in their country of origin. Gilbert et al. (2019) conducted a qualitative study in Melbourne, Australia, to explore transnational health-seeking among Indian migrants. Using focus groups with 34 Indian migrants, the study found that participants' help-seeking practices were shaped by culturally embedded expectations of healthcare, particularly in relation to trust, medical authority, and treatment practices. Participants associated Indian healthcare with more decisive doctors, stronger medication, and quicker symptom relief, whereas Australian healthcare was at times perceived as less responsive to these expectations. The study also showed that some migrants continued to seek medicines, advice, or treatment from India, reflecting the continuing influence of transnational ties and culturally familiar forms of care. These findings indicate that Indian migrants' health-seeking practices are shaped not only by beliefs about illness and treatment, but also by the extent to which healthcare systems align with culturally familiar understandings of effective care. A limitation of the study is that it focused on Indian migrants in one

Australian city, which may limit the transferability of the findings to other migrant settings (Gilbert et al., 2019).

For South Asian migrant communities, healthcare use is not only about accessing a doctor, but also about how people understand, trust, and manage prescribed treatments in their everyday lives. Akhtar et al. (2024) conducted a qualitative study in Aotearoa New Zealand to explore conventional medication adherence and self-treatment practices among South Asian immigrants with cardiovascular risk factors. Based on 21 semi-structured interviews, the study included South Asian participants, including Indian and Fijian Indian migrants, who had been prescribed medication for T2DM, hypertension, and/or dyslipidaemia. The findings showed that concerns about side effects, hesitancy to begin long-term conventional medication, and the continued use of herbal and alternative therapies influenced treatment decisions. These findings highlight that treatment practices are shaped not only by biomedical advice but also by cultural beliefs, personal preferences, and prior understandings of illness management. This is closely linked to healthcare access, as it involves more than attending an appointment or receiving a prescription. It also includes whether migrants can understand the information provided, feel confident discussing their concerns, trust the recommended treatment, and use medicines in ways that are meaningful and manageable in their everyday lives. In this sense, medication adherence and self-treatment practices reflect broader issues of access, including communication, health literacy, cultural safety, and the responsiveness of healthcare services to migrant patients' beliefs and lived realities. A limitation of the study is that it drew on a broader South Asian sample rather than exclusively on Indian migrants, which limits the extent to which the findings can be interpreted as specific to Indian migrant populations (Akhtar et al., 2024).

A similar pattern was reported across several studies in the review, where migrants used traditional medicine, home remedies, or family advice alongside formal healthcare. As discussed above, the studies by Rao (2006), Gilbert et al. (2019) and Akhtar et al. (2024) suggest that traditional medicine, familiar health practices, and concerns about prescribed medicines continue to influence health-seeking behaviours and treatment decisions among Indian migrant populations across different countries. Together, these studies suggest that engagement with traditional medicine is not

necessarily a rejection of accessing formal healthcare, but often reflects migrants' cultural beliefs, previous healthcare experiences, trust, and efforts to manage illness in ways that feel familiar and meaningful.

Migrants' access to healthcare is also influenced by how they culturally understand health and illness, and by when professional care is needed. Alidu and Grunfeld (2017) conducted a comparative qualitative study in the United Kingdom to explore beliefs about health among Ghanaian and Indian migrants, alongside a white British comparison group. The study involved 36 participants, including 12 Indian migrants, who took part in semi-structured interviews. The findings identified three broad themes: beliefs about health, symptom interpretation, and self-management and help-seeking. In relation to Indian migrants, the study showed that understandings of health and health behaviour were shaped by cultural and gendered beliefs, influencing how symptoms were interpreted and how care was managed or sought. These findings suggest that help-seeking among Indian migrants is shaped not only by service availability, but also by culturally informed understandings of illness and appropriate responses to it. A limitation of the study is its comparative design and the inclusion of only a small subgroup of Indian participants, which means the findings were not exclusively focused on Indian migrants (Alidu & Grunfeld, 2017).

In summary, the literature discussed in this section of the review suggests that cultural beliefs, traditional medicine, and culturally shaped help-seeking behaviours play an important role in influencing how Indian migrants and, arguably, Fijian Indian migrants interpret symptoms, make treatment decisions, and engage with healthcare services. The studies reviewed demonstrate that Indian migrants often draw on pluralistic models of care combining home remedies, traditional therapies, prescribed medicines, and transnational sources of treatment. Such practices are influenced by beliefs about illness severity, concerns about medication, trust in healthcare providers, and the extent to which healthcare systems align with culturally familiar expectations of care. Evidence from other migrant populations similarly shows that family expectations, traditional understandings of illness, and culturally embedded interaction norms can shape help-seeking, accessing and participation in formal biomedical care. While literature focusing specifically on older Indian migrants remains limited, these findings

provide important insights into the broader cultural factors that may shape healthcare access and service engagement within Indian migrant communities.

2.5 Communication and Linguistic Differences

Cultural and linguistic differences between healthcare providers and older migrants are widely reported as major barriers to immigrants' access to healthcare (Rasi, 2020). All nine of the studies that reported language barriers between the older migrant patients and healthcare professionals dominated as key cultural barriers in accessing healthcare (Arora et al., 2019; Choi et al., 2015; Gazard et al., 2015; Kim & Hocking, 2016; Mbanya et al., 2019; Mölsä et al., 2019; Tiagi, 2016; Tsoh et al., 2016).

Effective communication during healthcare encounters has been widely reported in migrant studies as it plays a vital role in the healthcare experience and service utilisation. A qualitative study conducted in Norway (Arora et al., 2019) examined healthcare experiences among older Pakistani women living in Oslo, focusing on how ethnicity affects access to healthcare in a foreign country. The study included 23 older Pakistani women and 10 informal caregivers aged 48 to 81 years. The study highlighted that a lack of proficiency or limited proficiency in Norwegian hindered interaction with healthcare providers. Instead, these women were criticised by healthcare providers for not learning Norwegian, which led to feelings of exclusion. The participants of this study perceived that their older relatives were treated differently, and they contemplated whether their identity as Pakistani and their immigrant status were the underlying cause for such unpleasant experiences when utilising the healthcare system (Arora et al., 2019). The study's limitations were that it relied on self-reported experiences, which may have been influenced by personal perceptions, and that it was limited to Pakistani women, thereby limiting generalisability.

Difficulty communicating during healthcare encounters has been commonly identified as a barrier affecting the older migrant population. Mölsä et al. (2019) reported that older Somali immigrants in Finland encountered significant communication difficulties in accessing healthcare. This was a quantitative survey design with a matched-pairs comparison, in which participants aged 50 to 85 years completed a questionnaire on healthcare access. The study included 128 older Somali immigrants and 128 Finnish participants as a comparison group. The findings of the study highlighted that the

many older Somali immigrants with limited or no Finnish language proficiency reported difficulty with healthcare providers in accessing healthcare. It also reported that the doctor's inability to understand Somali participants resulted in explaining issues twice or using interpreters, which led to extended waiting times and, at times, critical issues being missed due to the language barrier. Language barriers deter immigrants from fully utilising healthcare. Language and cultural barriers contribute to the low utilisation of healthcare services (Mölsä et al., 2019). Some of the strengths of this study are that it included a matched Finnish comparison group and focused on older migrants, the under-researched group, using various health indicators in the survey. However, the limitation was that it collected data from the two groups at different time points, which could have negatively impacted the study's outcome.

Many studies have highlighted that barriers to effective communication interactions between healthcare professionals and migrant patients can influence healthcare outcomes (Arora et al., 2019; Mbanya et al., 2019; Mölsä et al., 2019; Tiagi, 2016). For example, some migrants reported feeling misunderstood or dismissed during consultations, which affected their willingness to seek care from a GP and, in some cases, led them to rely more on emergency departments (Tiagi, 2016). Misunderstandings were also linked to difficulties in explaining symptoms and interpreting medical advice, which affected continuity of care and adherence to treatment recommendations. Notably, for older migrant populations, effective communication between patients and healthcare providers plays an important role in shaping healthcare utilisation among ageing migrant communities (Arora et al., 2019; Mölsä et al., 2019; Tiagi, 2016).

2.6 Structural and Systemic Barriers to Healthcare Access

Research consistently demonstrates that structural conditions within healthcare systems can significantly shape migrants' ability to access and utilise health services. Studies across several high-income countries report that migrants often encounter systemic barriers such as complex referral pathways, long waiting times, and inadequate understanding of health system structures, which can delay or discourage engagement with healthcare services (Guo et al., 2025; Mbanya et al., 2019; Mölsä et al., 2019). These challenges are often compounded for older migrants who may be

navigating unfamiliar healthcare systems while managing multiple health conditions. Institutional arrangements within healthcare systems, including gatekeeping models and service organisation, may therefore unintentionally create additional barriers that affect continuity of care and access to specialist services. Such findings highlight the importance of considering broader health system structures when examining healthcare access among migrant populations.

Structural inequities and biased practices within healthcare systems continue to influence migrants', especially older and more vulnerable, engagement with health services. Marginal migrant populations, such as disabled, older, poorer and refugees, have often been ignored in health service planning and policy development, which may contribute to unfair healthcare experiences across many countries (Mbanya et al., 2019; Tiagi, 2016). Studies focusing explicitly on older minority migrants and their access to health services remain relatively limited, despite the ageing of the migrant population (Szabó & Goodin, 2025). Gazard et al. (2015) emphasised the importance of disaggregating migrant status and applying intersectional approaches when examining health inequalities, as overlapping social factors, including age, ethnicity, and migration history, shape migrants' healthcare experiences. These perceptions stress the need to examine the structural and institutional factors that shape healthcare access among older migrant populations.

Recent research with older migrant communities in South Auckland, Aotearoa New Zealand, has shown that access to healthcare can be affected by practical and system-level factors, including cost, transport, waiting times, and limited-service availability. In a participatory action research, Neville et al. (2022), involving 104 older Pacific co-researchers aged 52 to 90 years in South Auckland, Aotearoa New Zealand, identified several structural and systemic barriers to healthcare access. Using Talanoa-based focus groups, the study found that participants experienced difficulties related to transport, long waiting times, consultation and medication costs, and limited access to services such as podiatry and physiotherapy. These challenges were further shaped by competing family and church obligations, which sometimes led participants to delay or forgo care. The findings also showed that structural barriers extended beyond affordability and availability to include limited continuity of care, difficulties accessing Pacific healthcare providers, inconsistent interpreter support, and poor understanding

of how the healthcare system operated. These issues indicate that healthcare access is influenced not only by personal willingness to seek care but also by how services are organised and delivered. However, the study was limited by its reliance on recruitment from established community social groups, potentially underrepresenting the perspectives of more socially isolated older Pacific people.

International research also shows that older migrants often face several overlapping systemic barriers when trying to access healthcare, especially when they are unfamiliar with the language, health system, and expectations of care. Arora et al. (2018), in a thematic synthesis of 12 qualitative studies conducted in the United Kingdom, the Netherlands, Norway, and Denmark, examined older non-Western migrants' experiences of accessing healthcare in Europe. The review found that multiple intersecting barriers, including language difficulties, low health literacy, limited knowledge of available services, reliance on family members for navigation and decision-making, and differences in health beliefs and expectations of care, shaped access to care. The synthesis also showed that older migrants often experienced healthcare systems as poorly aligned with their linguistic, cultural, and social realities, leading to confusion, dependence, and, at times, dissatisfaction or mistrust. Notably, the writers argued that barriers to healthcare access should not be understood solely in cultural terms but also in relation to broader vulnerabilities shaped by ageing, immigration, and the organisation of healthcare facilities.

Collectively, these studies highlight the systematic and structural barriers the older migrant population faces, leading to a lack of engagement and poor health outcomes for older migrants.

2.7 Health System Navigation and Health Literacy

Research suggests that difficulties navigating healthcare systems and limited health literacy are important barriers influencing healthcare utilisation among migrant populations. Older migrants may face particular challenges in understanding how healthcare services are organised in host countries, including referral pathways, eligibility criteria, and available support systems (Guo et al., 2025; Mbanya et al., 2019). Inadequate knowledge of the healthcare system, linked with language barriers and differences in health knowledge, a lack of knowledge of internet use or internet

connectivity can reduce migrants' ability to identify appropriate services and follow recommended care pathways (Mölsä et al., 2019; Rasi, 2020). Studies have also highlighted that older migrants may depend on family members or community links to understand health information and navigate services, which can influence healthcare decision-making and service utilisation (Guo et al., 2025). These findings suggest that health literacy and system navigation are interconnected factors that can shape how older immigrants engage with healthcare services.

Limited awareness of available healthcare services and difficulties navigating health services information systems have been widely reported as barriers affecting healthcare utilisation among older migrant populations. Studies indicate that many migrants are unfamiliar with the structure and organisation of healthcare services in host countries, which can influence their ability to identify appropriate services and access care when needed. For example, in a study of 70 Kurdish immigrants and refugees aged 50 years and older living in the United States, Choi et al. (2015) found that many participants were unaware of the healthcare services available to them, leading to underutilisation of these services. Wang et al. (2019), in a scoping review of 31 peer-reviewed Canadian studies, researched older immigrants' access to primary health care and found that health system navigation and health literacy were central challenges shaping service access and use. The review showed that older migrants often encountered linked barriers, including limited health literacy, language differences, cultural beliefs, spatial access, and broader structural factors. Importantly, some older immigrants found the health system confusing and difficult to navigate, while available health information was not always provided in their preferred language or in ways that aligned with their cultural values and traditions. These findings highlight that navigation difficulties among older migrants are not simply individual problems but are closely connected to how healthcare systems communicate information and organise access. However, the review has some limitations, including its restriction to English-language studies, the predominance of qualitative primary studies, limited attention to men's and service providers' perspectives, and the under-representation of some migrant groups and regions.

Other research has also highlighted the role of health literacy in shaping migrants' engagement with healthcare systems. Kim and Hocking (2016) noted that a limited

understanding of healthcare information and services among migrant communities, especially those who were older, can contribute to delayed healthcare-seeking and poorer health outcomes. These findings suggest that improving access to culturally appropriate health information and education may help older migrants navigate healthcare systems more effectively and increase the utilisation of available services. Similar concerns may also be relevant for older Fijian Indian migrants in Aotearoa New Zealand, who may face challenges in accessing and understanding available services or navigating healthcare pathways due to limited access to information in culturally and linguistically appropriate formats or access to the internet. Without adequate knowledge of how healthcare systems operate, older migrants may delay seeking care or have difficulty accessing appropriate services, highlighting the importance of improving health literacy and support for system navigation for ageing migrant populations.

2.8 Summary of Literature Review

While previous research has examined barriers to healthcare access among older migrant populations, and to some extent Indian and other ethnic migrants, very little is known about how ageing Fijian Indians, who differ from continental Indian migrants in Aotearoa New Zealand, experience these issues. The literature reviewed above emphasises several interlinked factors influencing healthcare access among older migrants. Cultural and socio-cultural influences may shape health beliefs, expectations, and help-seeking behaviours among older migrants, especially access (Guo et al., 2025; Mbanya et al., 2019). Communication and linguistic barriers can affect interactions between patients and healthcare providers, influencing understanding of health information and treatment decisions (Mölsä et al., 2019; Rasi, 2020). Structural and systemic factors within healthcare systems, including referral pathways and institutional practices, may further impact migrants' ability to access appropriate services (Mbanya et al., 2019; Tiagi, 2016). In addition, limited health literacy and obstacles to navigating unfamiliar healthcare systems can restrict migrants' awareness of available services and their ability to access care (Choi et al., 2015).

Together, these findings highlight the complex and multidimensional nature of healthcare access for older migrant populations and stress the need for further

research investigating the unique experiences of ageing Fijian Indian migrants in Aotearoa New Zealand. Understanding these experiences is important for identifying culturally appropriate strategies that support equitable healthcare access and for updating services for this growing ageing migrant population.

Chapter 3 Approach to Inquiry, Theoretical Underpinnings, Methodology and Methods

This chapter outlines the philosophical, theoretical, and methodological foundations underpinning the study. It commences with ontology, epistemology, interpretivism, and pragmatism, and discusses the study's interpretivist-pragmatic positioning and qualitative interpretive description. This is followed by the conceptual guiding framework, the socio-ecological model, and the AAAQ dimensions of healthcare access. The chapter then presents the researcher's positionality, research methodology, and methods. Subsequent sections discuss ethics approval, ethical considerations, recruitment, sampling, data collection, transcription and translation, and analysis. Finally, the chapter addresses the establishment of rigour and concludes with a summary.

The study aimed to identify the enablers and barriers to healthcare access among older Fijian Indian immigrants and to provide recommendations to address the barriers. Therefore, it employed a qualitative, interpretive, descriptive research design to explore the healthcare experiences of older Fijian Indian immigrants, as this design allows for an in-depth novel understanding of participants' perspectives regarding access to and utilisation of healthcare. Interpretive description allows for the understanding of complex clinical phenomena, in this case, the experiences of older Fijian Indians accessing healthcare (Thorne, 2025).

3.1 Ontology

This section explains the ontological stance of this research, guiding the study and outlining the assumptions about the nature of the study that support the qualitative exploration of participants' experiences utilising healthcare in Aotearoa New Zealand. Ontology refers to researchers' assumptions about reality and what exists within it (Sweet & Davis, 2025). This study's ontology examines the underlying nature of health disparities in real-world contexts by focusing on access to healthcare among older Fijian Indian immigrants in Aotearoa New Zealand. This statement raises questions about the factors that determine fair access to healthcare and how social, cultural, and systemic factors shape the healthcare experiences of this particular group. A

comprehensive understanding of these processes enables a deeper analysis of obstacles and enablers within healthcare systems. The field of ontology, which examines the fundamental nature of existence and reality, is crucial to understanding theories that affect older Fijian Indian immigrants' access to healthcare. Conceptually, this study must consider the realities and actual experiences of these immigrants, recognising that their lived experiences and world views on healthcare availability are significantly shaped by their cultural heritage, personal backgrounds, and socio-economic circumstances. This ontological viewpoint acknowledges that reality is not a single entity but rather a product of distinct subjective experiences. Within this framework (Chung et al., 2018), the study must demonstrate sensitivity to the diverse aspects of older Fijian Indians' healthcare experiences. These elements include traditional beliefs, social networks, and the influence of immigration on their health-seeking behaviours. Understanding these realities enables the study to provide a more comprehensive and accurate portrayal of the challenges this population faces in accessing healthcare in Aotearoa New Zealand.

3.2 Epistemology

Epistemology, as described by Crotty (1998), is the branch of philosophy that examines the process of acquiring knowledge. Furthermore, Guba (1994) documented that the relationship between the knower and what can be known concerns how data is interpreted. However, the belief is that multiple realities exist, and the knowledge context depends on efforts to improve practice (Thorne, 2016). This study's epistemological framework focuses on comprehending the perceptions and experiences of older Fijian Indian immigrants regarding the healthcare system in Aotearoa New Zealand. The process entails analysing the information gathered from their stories to identify recurring patterns and themes that accurately reflect their experiences. Recognition of the influence of cultural, social, and historical contexts is necessary to understand that knowledge acquired from older Fijian Indians is not solely objective facts but is intricately woven into their distinct cultural viewpoints and life experiences. Hence, the study utilises methodologies that facilitate collaborative knowledge development between me, the researcher, and the participants, recognising participants' real-life experiences as valid sources of knowledge. This epistemological basis for the methodology ensures the study accurately captures

participants' extensive and profound perspectives, leading to a more nuanced understanding of the barriers to and enablers of healthcare access in this community.

The chosen methodology relies on qualitative interpretive-descriptive interviews as the primary means of data collection, ensuring that the insights generated are firmly grounded in participants' experiences and perspectives.

3.3 Interpretivism

Interpretivism assumes that human experiences are socially and culturally constructed, and that individuals actively interpret their realities within particular historical and relational contexts (Crotty, 1998; Lewis, 2015). In health research, this perspective recognises that meanings attached to illness, ageing, and healthcare are shaped by cultural beliefs, migration histories, and social relationships rather than existing as purely objective phenomena (Liamputtong & Rice, 2024; Mangrum, 2026). Interpretivism, therefore, supports inquiry into how people make sense of health and service use within their everyday lives and socio-cultural environments. This orientation is particularly relevant to the present study, which seeks to understand how older Fijian Indian migrants interpret their accessibility encounters within healthcare services in Aotearoa New Zealand. Their experiences of access are influenced not only by the structural availability of services but also by cultural expectations, language, family roles, and prior healthcare experiences shaped in Fiji and through migration trajectories.

3.4 Pragmatism

Pragmatism emphasises the practical value of knowledge and the importance of generating findings that can inform action and improve real-world outcomes (Allemang et al., 2022; Kaushik & Walsh, 2019). Rather than privileging a single epistemological position, pragmatic inquiry focuses on understanding complex phenomena in ways that are useful for addressing applied problems (Allemang et al., 2022; Kaushik & Walsh, 2019).

The philosophical foundations of pragmatism can be traced to the work of Peirce (1878), James (1907), and Dewey (1938). Peirce (1878) emphasised that the meaning of ideas could be understood by considering their practical consequences, while James

(1907) further developed pragmatism by highlighting the importance of experience and the practical value of knowledge. Dewey (1938) extended these ideas by viewing inquiry as a way of understanding and responding to problems encountered in everyday life. These perspectives are relevant to the present study, which sought not only to understand the healthcare experiences of older Fijian Indian immigrants but also to generate knowledge that could inform nursing practice and improve healthcare access. Within the interpretivist–pragmatic positioning of this research, understanding participants' experiences was therefore closely connected to considering the implications of those experiences for healthcare practice.

In nursing and community health research, and particularly within this doctoral study, pragmatism aligns with the emphasis on professional practice, leadership, and socio-cultural change in addressing access to healthcare services. It also supports the aim of producing knowledge that guides culturally responsive care, service design, and equity-focused interventions (Thorne, 2016). This perspective is consistent with the applied intent of the present study, which aims not only to explore the healthcare access experiences of older Fijian Indian migrants but also to inform community and primary care practices about how they can better support ageing migrant populations within the Aotearoa New Zealand health system.

3.5 Interpretivist–Pragmatic Positioning of the Study

Positioning this study within an interpretivist–pragmatic paradigm acknowledges both the subjective, culturally situated nature of healthcare experiences and the practical need to improve service accessibility (Morgan et al., 2024; Thorne, 2016). Although interpretivism and pragmatism are derived from different philosophical traditions, they are complementary within the context of this study. Interpretivism provides the epistemological foundation for understanding how older Fijian Indian immigrants perceive and make meaning of their experiences accessing healthcare (Crotty, 1998). Pragmatism complements this perspective by recognising the importance of generating knowledge that can inform practical improvements to healthcare services and policy (Allemang et al., 2022; Kaushik & Walsh, 2019). Older migrants' interactions when accessing health services are shaped by meanings, expectations, and cultural understandings, and occur within the structural conditions of health systems and

migration contexts (Liamputtong & Rice, 2024; Salman et al., 2025). Integrating interpretivism and pragmatism, therefore, allows for the exploration of lived experiences alongside consideration of their implications for healthcare and service practice, policy, and service equity as per DHSc requirements (Thompson Burdine et al., 2021; Thorne, 2016). This combined stance supports the study's focus on culturally grounded understandings of access while maintaining an applied orientation toward enhancing healthcare responsiveness for older Fijian Indian communities in Aotearoa New Zealand.

3.6 Qualitative Interpretive Description

Interpretive description is a qualitative methodology developed to generate clinically relevant knowledge and bridge the gap between theoretical understanding and professional practice (Thorne, 2025; Thorne, 2016). It combines descriptive and interpretive traditions to provide a rich and contextual understanding of human experiences and the meanings individuals attribute to them (Thompson Burdine et al., 2021). Rather than merely describing phenomena, interpretive description seeks to generate insights that apply to practice and contribute to improvements in health professional practice and healthcare delivery.

The interpretive component focuses on understanding the meanings and significance that participants assign to their experiences within their social and cultural contexts. The descriptive component emphasises providing a detailed, comprehensive account of these experiences, thereby enabling a nuanced understanding of complex health-related phenomena (Thorne, 2025; Thorne, 2016). This combination makes interpretive description particularly suited to nursing and health research, where understanding lived experiences can inform person-centred and culturally responsive care (Wilson, 2025).

Interpretive description is grounded in naturalistic inquiry and informed by constructivist thinking, recognising that experiences are shaped by social, cultural, and contextual influences (Thorne, 2025). Data are typically generated through methods such as in-depth interviews and analysed to identify patterns and meanings that enhance the understanding of the phenomenon under study (Braun & Clarke, 2022; Duggleby Wenzel et al., 2026). The approach aims to move beyond simple description

to produce knowledge that is meaningful and useful for clinical practice, service development, and policy.

Interpretive description was selected for this study because it aligns with the applied focus of the AUT DHSc programme and its emphasis on professional practice and socio-cultural change. The study sought not only to understand the healthcare access experiences of older Fijian Indian migrants in Aotearoa New Zealand but also to generate practice-based insights that could inform culturally responsive nursing care and health service delivery. Unlike phenomenology, which aims to uncover the essence of lived experience, interpretive description offers a flexible methodology capable of addressing clinically and policy-relevant questions and identifying barriers to and enablers of healthcare access among ageing migrant populations (Thompson Burdine et al., 2021; Thorne, 2016).

Interpretive description is congruent with the interpretivist–pragmatic orientation of this study because it seeks to generate clinically meaningful knowledge grounded in participants' experiential accounts while remaining oriented toward practical application (Thorne et al., 2004; Thorne, 2016). This alignment is appropriate for the present study, as it supports the interpretation of older Fijian Indian migrants' experiences of healthcare access in ways that are meaningful for community nursing, primary care, and culturally responsive service design within Aotearoa New Zealand.

3.7 Conceptual Frameworks

This study is informed by two complementary conceptual frameworks that together provide a comprehensive framing for examining healthcare access among older Fijian Indian migrants in Aotearoa New Zealand. The Socio-Ecological Conceptual Framework provides a broad perspective by examining how individual, interpersonal, community, organisational, and policy-level factors interact to influence healthcare access. The Availability, Accessibility, Acceptability, and Quality (AAAQ) framework complements this perspective by focusing on the health system dimensions that shape equitable access to healthcare. Together, these frameworks provide the conceptual foundation for the study and guide the interpretation of the findings.

The socio-ecological conceptual framework, which recognises that health experiences and access to services are shaped by dynamic interactions across multiple levels, including the individual, interpersonal, community, organisational, and broader health system levels (McLeroy et al., 1988). Socio-ecological perspectives are widely used in public health and health services research to understand how social context, structural conditions, and service environments influence healthcare engagement and outcomes (Golden & Earp, 2012; McLeroy et al., 1988; Palmer et al., 2024). Such an approach is particularly relevant for examining healthcare access among older migrant populations, whose experiences are situated at the intersection of ageing, migration history, family structures, and the organisation of the health system.

Within the context of this study, the socio-ecological conceptual framework enables an exploration of how healthcare access for older Fijian Indian migrants in Aotearoa New Zealand is shaped not only by individual health needs and ageing processes but also by family roles, community networks, cultural expectations, and interactions with primary and community health services. Migration experiences, language practices, and culturally shaped understandings of health and care are embedded within these relational and structural environments. A socio-ecological perspective, therefore, supports an understanding of access as a socially situated process rather than solely an issue of service availability, aligning with evidence that migrant health experiences are shaped across multiple levels of influence within receiving health systems (Guruge et al., 2018; Lebrun & Dubay, 2010).

The socio-ecological conceptual framework also provides a coherent structure for approaching the interviews, interpreting and critiquing the results, and examining how organisational and system-level factors within the Aotearoa New Zealand health system influence access for ageing migrant communities. Service navigation, the cultural responsiveness of care, and relationships with primary health providers occur within institutional and policy environments that can either enable or constrain equitable healthcare engagement. Research in Aotearoa New Zealand and comparable migrant-receiving countries highlights that older migrants often experience access challenges arising from system complexity, cultural incongruence, and limited responsiveness of services to culturally diverse ageing populations (Came et al., 2016; Curtis et al., 2019). Viewing participants' experiences across socio-ecological levels,

therefore, supports the identification of multi-layered structural and relational influences on access.

While concepts such as cultural safety, healthcare accessibility, and migrant health equity, as discussed in the literature review in Chapter 2, are drawn upon to contextualise the findings, the socio-ecological conceptual framework provides the primary analytic structure for interpreting the findings. Cultural safety, for example, is particularly relevant for understanding how Fijian Indian elders experience healthcare encounters within a bicultural health system, and also understanding how power, culture, and recognition shape engagement with services (Curtis et al., 2019; Satur & Carrington, 2022). These concepts are used to deepen the interpretation of socio-ecological influences on access. Positioning the study within a socio-ecological conceptual framework, therefore, provides a comprehensive understanding of healthcare access by recognising the interacting personal, relational, community, and health system contexts that shape the experiences of older Fijian Indian migrants in Aotearoa New Zealand.

This socio-ecological conceptual framework provides a foundation for a study that offers a critical perspective for examining the phenomenon of interest, enabling a researcher to interpret relationships among variables, situate the study within existing knowledge, and justify the analytical approach employed. The theoretical framework enhances the research's intellectual coherence, reliability, and depth, ensuring that the interpretation of findings is grounded in established theoretical perspectives (Varpio et al., 2020).

Older Fijian Indians encounter distinct personal, age-related, familial, cultural, generational, and migration-related challenges that require a theory-informed analysis rather than merely descriptive reporting. The incorporation of equity-based and culturally responsive frameworks enhances the credibility and transferability of the current study.

3.7.1 AAAQ framework as a lens for approaching healthcare access

Conceptual understandings of healthcare access in this study are informed by the World Health Organisation's AAAQ framework (United Nations Committee on Economic, Social and Cultural Rights, 2000) which conceptualises access as

encompassing not only the presence of services but also their cultural responsiveness, equity, and appropriateness for populations (United Nations Committee on Economic, Social and Cultural Rights, 2000). The AAAQ model emphasises that health systems should ensure services are sufficiently available, physically and economically accessible, culturally acceptable, and delivered at appropriate quality standards, particularly for marginalised and migrant communities (United Nations Committee on Economic, Social and Cultural Rights, 2000; Varpio et al., 2020). These dimensions are widely applied in health access research to understand how structural and socio-cultural factors shape engagement with services among diverse populations (Levesque et al., 2013; United Nations Committee on Economic, Social and Cultural Rights, 2000).

In the present study, AAAQ concepts support the interpretation of barriers and enablers that influence healthcare access for older Fijian Indian migrants in Aotearoa New Zealand, including service availability, culturally aligned care, communication practices, and perceived provider responsiveness. For ageing migrant populations, access experiences are shaped by migration histories, language, family support, and relationships with primary care and community services within receiving health systems, as highlighted in studies using the AAAQ (Cu et al., 2021; Levesque et al., 2013; Varpio et al., 2020). However, rather than functioning as a standalone framework, the AAAQ dimensions are considered within the broader socio-ecological understanding that healthcare access is shaped by interactions among individual, interpersonal, community, organisational, and health system levels. Positioning AAAQ within this socio-ecological perspective enables a holistic ecological interpretation of older migrant participants' experiences while maintaining alignment with the study's approach to data collection and discussion.

3.8 Researcher Positionality

As this study was undertaken as part of a DHSc programme rather than as a traditional PhD, my position as a practitioner–researcher is important to acknowledge. The DHSc is applied in nature and encourages the integration of professional practice, critical reflection, and research inquiry. This shaped the way I approached the study, as my aim was not only to generate academic knowledge but also to produce findings that

could inform culturally responsive healthcare practice for older Fijian Indian migrants in Aotearoa New Zealand.

As a Fijian Indian nurse researcher, I occupy a culturally embedded position that shapes my understanding of the experiences explored in this study. I was born and raised in Fiji and share linguistic, cultural, and social connections with the Fijian Indian community. My professional background includes nursing education and clinical experience in Fiji and New Zealand, providing me with familiarity with both countries' health systems and with the migration trajectories of many Fijian Indian families. These personal and professional experiences informed my interest in understanding how older Fijian Indian migrants navigate healthcare access in Aotearoa New Zealand.

My insider cultural positioning enabled rapport and trust when engaging with older Fijian Indian participants, particularly through shared language and cultural references. At the same time, shared ethnicity does not equate to identical experience, as participants' migration histories, ageing journeys, and social circumstances differ from my own. I therefore approached interviews with attentiveness to participants' individual meanings rather than assuming shared understanding (Guruge et al., 2018; Lebrun & Dubay, 2010). Reflexivity was maintained throughout the study to recognise how my cultural proximity and professional background could shape interactions, interpretations, and meaning-making (Dinour & Mendez Camacho, 2025). This reflexive stance supported efforts to minimise subjective bias and assumptions and ensure participants' perspectives remained central (Beigi, 2026; Berger, 2015).

My background as a nurse educator also influenced the interpretive lens of this study, particularly in recognising how health system structures, service organisation, and professional interactions shape access experiences. This professional orientation required for a DHSc supported attention to practice implications while remaining grounded in participants' accounts. Throughout the research process, reflexive journaling, the documenting of analytic decisions, and consultation during translation were used to enhance credibility and cultural sensitivity (Finlay, 2002). As a Fijian Indian researcher working with my own community, I sought to balance cultural closeness with analytic reflexivity to ensure the study produced knowledge that is both

trustworthy and meaningful for improving healthcare access for older Fijian Indian migrants in Aotearoa New Zealand.

3.9 Research Methodology

The term ‘research methodology’ refers to the overall approach, theoretical framework, and philosophical assumptions that guide the research process (Lincoln & Guba, 1986), encompassing the principles, concepts, and theories that underpin the research design and methods. The methodology enables researchers to select appropriate research methods, design the study, and effectively interpret the findings. It also encompasses ethical considerations and research paradigms (e.g., positivism, interpretivism, critical theory) that influence the research process (Crotty, 1998).

In this study, methodology is situated within an interpretivist–pragmatic paradigm and informed by a socio-ecological understanding of healthcare access (Thorne, 2025). A qualitative interpretive-descriptive methodological approach was adopted to explore how older Fijian Indian migrants experience and navigate healthcare services in Aotearoa New Zealand (Lewis, 2015; Morgan, 2014). This approach aligns with the study’s aim to generate practice-relevant knowledge grounded in participants’ experiences while recognising that healthcare access is shaped through interacting individual, relational, and health system contexts (Thorne, 2016). The methodological positioning, therefore, provides a coherent foundation for the qualitative methods

3.10 Methods

The term ‘research methods’ refers to the techniques and strategies used to collect and analyse data to answer research questions or test hypotheses (Golden & Earp, 2012; Thorne, 2016). The choice of research method depends on the nature of the research question, the type of data required, and the availability of resources and time. Qualitative research involves collecting and analysing non-numerical data such as text, images, or video to gain insights into social, cultural, or psychological phenomena (Jeffries et al., 2019). Qualitative research employs a range of methods, including interviews, focus groups, and participant observation (Braun et al., 2017). Overall, the choice of research method depends on alignment with the ontology, epistemic and

methodological premises and the drive to address the gap in the research literature (Creswell & Poth, 2018).

In-depth interviews were chosen as they are well-suited to qualitative research, enabling researchers to gain rich, detailed insights into participants' lived experiences, views, and meanings (Ghorbani & Matourypour, 2020).

This method approach helped ensure the reliability, validity, and relevance of the data acquired, as well as alignment with the research question, ontology, and epistemology (Vaivio, 2012).

3.11 Ethics Approval

Ethical approval for this study was obtained from the Auckland University of Technology Ethics Committee (AUTEC) on 23 November 2021 (AUTEC reference: 21/408) (see Appendix A). This study was conducted in accordance with AUTEC requirements and established ethical standards for research involving human participants in Aotearoa New Zealand. Particular attention was given to protecting the rights, privacy, dignity and wellbeing of older Fijian Indian immigrants participating in the study. The ethical considerations and measures undertaken to support participants throughout the research process are discussed in Section 3.12.

Ethics meant ensuring that participants were treated with respect, safety, privacy, and dignity throughout the research process. The study was conducted in accordance with established ethical principles of voluntary participation, informed consent, confidentiality, and respect for participants. Particular attention was given to culturally respectful engagement with older Fijian Indian migrants, including clear communication of study information and allowing participants to choose interview settings and language preferences. Participants were informed that they could withdraw at any time during the interview or after the interview, and that once the data are published, this may no longer be possible. However, all measures were taken to protect privacy, including the use of pseudonyms and secure data storage.

The research was guided by the principles of respect, voluntary participation, informed consent, and protection from harm. Participants received written and verbal information outlining the purpose of the study, what participation involved, and their

right to decline or withdraw at any stage without consequence. Time was provided for participants to consider participation and, if desired, discuss involvement with family. Written informed consent was obtained prior to interviews. Particular care was taken to ensure that study information was communicated in a clear and culturally appropriate manner, recognising that participants were older migrants and may hold differing expectations regarding research participation and authority.

Confidentiality and privacy were maintained throughout the study. Participants were assigned pseudonyms, and identifying information was removed from transcripts and reporting. Audio recordings and transcripts were stored securely on password-protected university systems accessible only to me, the researcher, and the supervisory team, in accordance with AUTEC data management requirements. Findings are reported in ways that protect participant identity while preserving the meaning of their experiences.

Ethical conduct also included attention to cultural respect and relational sensitivity when engaging with older Fijian Indian participants. Interviews were arranged at times and locations chosen by participants, and language preferences were accommodated to support comfort and understanding. The study therefore sought to uphold culturally respectful and safe research practices when working with older migrant communities in Aotearoa New Zealand, consistent with national ethical guidance for health research involving culturally diverse populations (Health Research Council of New Zealand, 2021) (see Appendix A).

3.12 Ethical Considerations

Ethical considerations were an important part of this research, particularly because the study involved older Fijian Indian immigrants sharing their personal experiences of accessing healthcare. The research was guided by the principles of respect, voluntary participation, informed consent, confidentiality and protection from harm. These principles were considered throughout the recruitment, interview and data management processes to ensure that participants were treated with dignity and respect.

Before participating, individuals were provided with written and verbal information explaining the purpose of the study, what participation involved and their rights as participants. Time was provided for them to consider their involvement and, if they wished, discuss participation with family members. Written informed consent was obtained before the interviews commenced. Participants were informed that they could decline to participate or withdraw in accordance with the conditions outlined in the approved participant information sheet.

Confidentiality and privacy were maintained throughout the research process. Participants were assigned pseudonyms, and identifying information was removed from interview transcripts and the reporting of findings. Audio recordings and transcripts were stored securely on password-protected university systems, with access restricted to the researcher and supervisory team, in accordance with AUTEC requirements.

Cultural sensitivity was particularly important when engaging with older Fijian Indian participants. As a researcher from the same cultural background, I recognised the importance of respecting participants' values, customs and expectations. This included showing respect for elders, allowing time for informal conversation before interviews and accommodating participants' preferred language. Interviews were arranged at times and locations convenient to participants, helping them feel comfortable when sharing their experiences.

These considerations helped establish a respectful research environment in which participants could share their healthcare experiences openly while maintaining their privacy, dignity and right to make informed decisions about participation.

3.13 Recruitment

The recruitment was conducted through various religious organisations and community groups in the Auckland region. The participant recruitment flyers (see Appendix C) were available in both English and Hindi and were placed in areas commonly used by Indo-Fijians, for example, temples, churches, mosques, Indian restaurants, and takeaway shops located throughout the Auckland region. They were

displayed for sample recruitment in the following areas, with the permission of the owners or delegates:

- Shri Ram Mandir Charitable Trust, Henderson
- Durga Mandir, Manukau
- Shiv Temple, Manurewa
- Auckland Indian Association, Papatoetoe
- Manukau Indian Association
- Valley Fresh, Papatoetoe
- Auckland Indian Sweets, Otahuhu

In addition to the posters, talking to community members proved highly effective for recruiting research participants. Many smaller social groups, as outlined above, were also contacted as per ethical approval. I shared my research phone numbers and emails with my network and smaller social organisations. I also provided potential volunteers with the opportunity to reach out, in the form of snowballing, as per ethics, to others and let me know about their interest.

3.14 Sampling

The target population for this study comprised older Fijian Indian immigrants aged 55 years or older who had lived in Aotearoa New Zealand for at least one year prior to recruitment. This criterion ensured that participants had sufficient exposure to the Aotearoa New Zealand health system to reflect on experiences of accessing healthcare. Eligibility was restricted to individuals who self-identified as Fijian Indian, recognising ethnic identity as a central aspect shaping cultural beliefs, migration experiences, and healthcare expectations. Participants were also required to hold permanent residency status, as this confers eligibility for publicly funded health services in Aotearoa New Zealand. Limiting inclusion to permanent residents supported the exploration of healthcare access experiences within comparable structural conditions of health service eligibility and entitlement, rather than differences arising from visa-related funding barriers.

A purposive sampling strategy (Ahmad & Wilkins, 2025; Ames et al., 2019) was used to recruit participants who could provide rich, relevant insights into healthcare access

among older Fijian Indian migrants. Purposive sampling is widely used in qualitative health research to select information-rich participants with direct experience of the topic under study (Ames et al., 2019). This approach is consistent with interpretive-descriptive methodology, which seeks experiential understanding from participants who can meaningfully inform practice-relevant knowledge (Shakman et al., 2017). Recruitment, therefore, focused on older Fijian Indian community members with lived experience of engaging with health services in Aotearoa New Zealand.

3.15 Inclusion Criteria

In summary, potential interviewees included in the study were those who

- self-identified as a Fijian Indian immigrant;
- were age 55 years or older;
- had been living in Aotearoa New Zealand for a minimum of one year
- have a permanent residency status visa, to ensure that participants could access government-funded healthcare services; and
- had accessed healthcare services in Aotearoa New Zealand.

3.16 Exclusion Criteria

People excluded from the study were those who

- were unable to communicate effectively,
- were close relatives and friends in the community with whom I regularly associate, who may have felt compelled to participate in the study; or
- cannot communicate in English or in Hindi.

The participants were purposely selected to include a diverse range of religious and gender backgrounds (Thorne, 2016).

I provided each participant with the participant information sheet (see Appendix B) about the study if they were interested. This included the interview process. After reading the participant information sheet, participants were given time to decide and then contact me if they remained interested in participating in the study. An interview time was negotiated with the participant at their convenience. Before the interview, I ensured the participant fully understood the process and signed the consent form (see Appendix E). All participants were given pseudonyms to protect their identities. The

interviews were conducted in both English and the Fijian Hindi dialect, at the participants' choice.

3.17 Approach to Data Collection

Appointments were scheduled at mutually convenient times for the participants, and interviews were conducted in private rooms at their residences to ensure a comfortable, familiar setting. Throughout these home visits, I diligently followed the standards and cultural customs of the Fijian Indian community, including showing respect for the household, for elders, using culturally appropriate greetings, farewells and being mindful of traditional protocols. This includes greetings at the door, asking for permission to enter the house, removing shoes before entering, and engaging in general conversation to get to know each other before the interview. The adoption of this culturally sensitive approach not only enabled transparent and sincere communication but also fostered trust and rapport with participants, allowing them to express their experiences more openly (Ahmad & Wilkins, 2025). With due regard for these cultural customs, I ensured that the interviews were conducted in accordance with ethical standards as approved by AUTEC and that they demonstrated respect for the participants' cultural values. For example, speaking in their preferred language, greeting other family members if they were present, and accepting tea or light refreshments at the beginning of the session as a gesture of respect.

A data-collection safety protocol (see Appendix B) was followed during the interview process to ensure my safety. A WhatsApp group was created for the research supervisors, and they were informed of the agreed date, time, and location for each interview. Before each interview began, a text message was sent to the supervisors to confirm that the interview was about to start. Another message was sent after the interview was completed and I had left the house, to confirm that I was safe and that the interview had ended. This process provided a safety check-in system during data collection.

The sample comprised 10 older Fijian Indian immigrants living in Auckland, Aotearoa New Zealand. In qualitative research, the appropriateness of a sample is determined not only by the number of participants but also by the relevance, depth and richness of the information they provide. In the present study, the sample size was guided by the

assessment of data saturation during the interview process, rather than by a predetermined number of participants. Participants were recruited using specific eligibility criteria, including their Fijian Indian background, age of 55 years or over, and experience of living in Aotearoa New Zealand. These characteristics provided a focused group from which to explore healthcare access experiences in greater depth. Saturation was considered in relation to the recurrence of issues across interviews and the depth of understanding developed about participants' experiences. Hennink et al. (2017) distinguish between code saturation, where recurring issues have been identified, and meaning saturation, which involves developing a deeper understanding of those issues. Within the Interpretive Description methodology, the emphasis was on developing a meaningful understanding of participants' experiences and identifying findings relevant to healthcare practice, rather than achieving statistical representation.

Data saturation was considered throughout the interview process rather than being determined solely by the number of participants. During the initial interviews, similarities began to emerge in participants' accounts of their healthcare experiences. These observations were discussed with my supervisors, and the semi-structured interview guide was reviewed and modified to explore emerging issues in greater depth. Following approximately seven to eight interviews, further similarities were identified across participants' experiences, prompting additional discussions with my supervisors and refinements to the interview questions. These changes helped explore whether other perspectives or experiences had not yet been adequately captured. The later interviews provided further detail about previously identified issues, helping to deepen the understanding of how participants experienced and navigated healthcare services. By the tenth interview, the information shared by participants was largely consistent with that obtained in earlier interviews. Following discussions with my supervisory team, it was agreed that the interviews had provided sufficient information and depth of understanding to address the research questions, with no substantively new issues emerging that required further recruitment. On this basis, recruitment was concluded after 10 interviews. This approach recognises that saturation involves considering both the recurrence of issues and the adequacy of understanding developed from the data (Hennink et al., 2017; Saunders et al., 2018).

This study employed semi-structured interviews to gather comprehensive insights into participants' experiences with healthcare access (DeJonckheere & Vaughn, 2019). Some examples of questions that were further refined iteratively as they proceeded are as follows:

- Would you be able to tell me what health is in your own words?
- If you have to describe your health, what are the things you want to achieve for your own health and well-being?
- How would you rate your health?
- Could you please tell me which healthcare services you used? (Describe what is meant by primary and secondary to the participant.)
- How, if at all, were the services you utilised adequate to meet your needs? Was it easy to access the health services? (Provide examples (prompts) to share barriers and enablers.)
- In your opinion, do you think the healthcare provider has met your cultural needs? If so, could you please describe it? If not, could you please describe what you would have preferred the healthcare provider to improve?
- Were there any unpleasant experiences? If so, please outline them.
- In your opinion, what could be done to avoid such experiences?
- During our chat, you mentioned… Please tell me a bit more about this…
- During any of your encounters with health services, can you tell me whether you were given health education about your health concern?
- Were you given a choice about your treatment?
- Waiting times to see a GP and/or for specialist appointments?

The interview questions (see Appendix D) were designed to guide the process of asking specific, open-ended questions about healthcare access. This included questions about access to all levels of healthcare services. The questions served as a guide, and further probes were added in keeping with the iteration. The interview guides were reformulated after some interviews, as new data emerged, to further extract deeper insights into the essence of the participants' experiences.

Following the consent, each participant was interviewed (DeJonckheere & Vaughn, 2019). The interviews were conducted in the participants' preferred language, either

Fiji Hindi or English. Several participants spoke both English and Hindi; therefore, the interviews were conducted in a mixture of the two. The interviews lasted between 30 minutes and just over an hour. During the interview process, participants' views were carefully considered, allowing them to reflect on and share their experiences of healthcare access (DeJonckheere & Vaughn, 2019). The participants were asked to elaborate on their experiences (Kallio et al., 2016; Vestgarden et al., 2024), and were reminded that they had the right not to answer any questions if they did not feel comfortable and that they could terminate the interview if they decided not to continue. They were also reminded that they could request more information about the process before the interview if needed. Careful consideration was given to participants' body language and expressions to enhance the data (Robinson, 2023). Participants were also asked to complete a demographic data sheet to gather brief contextual information (Adeoye-Olatunde & Olenik, 2021; Demirci, 2024).

3.18 Transcription and translation

The interviews were recorded on a digital recorder and then transcribed. All the interview recordings were first transcribed and translated into English. A total of 10 interviews were conducted. I transcribed and translated three interviews, conducted in Hindi, while the rest were transcribed by a bilingual Fijian Indian schoolteacher who holds a bachelor's degree in Hindi and has completed their education in Fiji. (See Appendix I). The preservation of the original data was facilitated by my proficiency in the language, the translator's proficiency, and their comprehension of the cultural complexities and idiomatic expressions specific to Fijian Hindi (O'Brien et al., 2014).

To ensure translation equivalence across all Hindi transcripts, back-translation was employed (see Appendix H), a rigorous method in translation studies for ensuring the accuracy and semantic equivalence of translated texts (Squires, 2009). This process involves translating a document from the source to the target language, then independently translating it back into the original language. According to a recent study, this technique is valuable in research and clinical settings, where precise language is crucial for maintaining the integrity of the information conveyed (Cruchinho et al., 2024). Back translation helps identify and correct errors and ambiguities, thereby enhancing the translation's reliability.

In this study, back translation was undertaken to ensure the conceptual and linguistic accuracy of participant data collected in Fijian Hindi. As noted above, interviews conducted in Fijian Hindi were first translated into English by me and the transcriber listed above, who is fluent in both languages and familiar with the participants' cultural context. To enhance rigour, a bilingual independent translator then back-translated selected transcripts from English into Fijian Hindi without access to the original recordings. The original Fijian Hindi transcripts and back-translated versions were compared to identify discrepancies in meaning, cultural nuance, and terminology. Where differences were identified, translations were reviewed and refined through discussion to preserve participants' intended meanings and culturally embedded expressions. This iterative process supported semantic equivalence and the credibility of translated data within the analysis (Cruchinho et al., 2024; Ozolins et al., 2020). One independent Fijian Indian community member was involved and assigned only a few paragraphs to complete the back-translation. Back-translation facilitates the identification of common textual words or phrases that require modification to preserve the original intention (Santos et al., 2015).

3.19 Analysis

Thematic analysis is a versatile and widely employed qualitative research method that is particularly suitable for examining diverse viewpoints and complex, conceptual, and nuanced understandings of data (Van Nes et al., 2010). Thematic analysis offers several significant benefits when examining the viewpoints and perspectives that affect access to healthcare among older Fijian Indian immigrants in Aotearoa New Zealand.

The thematic data analysis approach is advantageous for accommodating diverse theoretical frameworks and can be utilised to examine data at varying levels of detail (Braun & Clarke, 2006). Thematic analysis in this study enabled the investigation of data from multiple perspectives, including cultural influences, socio-economic factors, and personal expectations. These factors are crucial in comprehending, obtaining and interpreting healthcare (MacLean, 2025). The following section provides a comprehensive guide to thematic analysis, elucidating its flexibility and systematic approach to analysing qualitative data (Braun & Clarke, 2022).

Thematic analysis identifies the content being expressed and explores how it is conveyed, as well as the broader implications of these perspectives (Braun & Clarke, 2006). This approach fosters an in-depth analysis, delving beyond surface-level explanations to comprehend the underlying causes, motivations, and consequences. This level of depth is essential to effectively address the complexities of healthcare access for underserved, marginalised, or culturally specific populations.

Braun and Clarke (2006) thematic analysis provides a methodical means to reveal and analyse the intricate, often complex realities of individuals' experiences, enabling a comprehensive, detailed understanding of their involvement in healthcare within the specific context of Aotearoa New Zealand.

Although this study was guided by Thorne's (2016) Interpretive Description methodology, Braun and Clarke's (2006) six-phase thematic analysis was chosen as the analytical approach. Thorne's approach emphasises developing an interpretive understanding of participants' experiences and generating knowledge meaningful to clinical practice, rather than prescribing a fixed sequence of analytical steps. Braun and Clarke's approach was considered appropriate because it provided a clear and systematic process for working through the interview data, from becoming familiar with participants' accounts to identifying patterns and developing themes. This was particularly valuable in examining the different experiences of older Fijian Indian immigrants while remaining attentive to the cultural, social and healthcare contexts shaping those experiences. The intention was not to develop themes solely as descriptive categories, but to interpret their meaning and relevance to healthcare access. Therefore, while Braun and Clarke's six phases guided the analytical process, the broader principles of Interpretive Description continued to inform how the findings were understood and their implications for nursing practice were considered.

The process of thematic analysis in this study involved the following steps:

1. *Familiarisation with the Data*: This initial step involved immersing myself in the data to become thoroughly familiar with its depth and breadth. This study included transcribing interviews and reading the transcripts multiple times. I began by thoroughly immersing myself in the facts. I meticulously scrutinised all the transcripts, field notes, and other data sources to gain a comprehensive

understanding of the subject matter. Subsequently, I documented key data and highlighted noteworthy factors, particularly those related to the obstacles and facilitators of healthcare availability (Braun & Clarke, 2006).

2. *Generating Initial Codes*: The second step involved systematically coding the data across the entire dataset. Codes were labelled to identify essential data features relevant to the research question. Creating initial codes is a crucial stage in thematic analysis, as it helps break down the data into more manageable segments. Through systematic data coding, I could identify patterns and themes demonstrating the obstacles and facilitators to healthcare accessibility for older Fijian Indians in Aotearoa New Zealand. This technique facilitates data organisation and establishes a basis for more profound analysis and interpretation (Thorne, 2025; Thorne, 2016).
3. *Searching for Themes*: After the data has been coded, the next step is to collate codes into potential themes. Themes are broader patterns of meaning that combine several codes. In this study, the first patterns were recognised and organised in a tabular structure. The quotations were recorded alongside the initial ideas. The transcripts were arranged in a tabular style. After the preliminary themes were identified, descriptive codes were created. The codes were intricate, necessitating the identification of patterns and themes throughout all the transcribed material (Thorne, 2025; Thorne, 2016).
4. *Reviewing Themes*: Examining themes in a thematic analysis is crucial to ensure they accurately reflect the data and offer significant insights into the research enquiry. This phase involved checking the themes against the dataset to ensure they accurately reflect the data. It involved refining themes by splitting, combining, or discarding them as necessary. Through a comprehensive assessment of the themes, I could guarantee that they were strongly supported by the data, precisely defined, and meaningfully connected to the research topic. This technique employed analytical reasoning and a repetitive improvement process to precisely depict the obstacles and facilitators to healthcare accessibility for older Fijian Indian individuals residing in Aotearoa New Zealand (Thorne, 2025; Thorne, 2016).
5. *Defining and Naming Themes*: After reviewing the themes, the next step was to define and name them. This technique entailed succinctly delineating the

essence of each topic, guaranteeing that each theme encapsulated a unique and logical pattern in the data. By precisely defining and identifying the themes, I ensured that the analysis was well-structured and that each theme appropriately represented the data, resulting in a comprehensive understanding of the obstacles and facilitators to healthcare access for older Fijian Indians in Aotearoa New Zealand (Thorne, 2025; Thorne, 2016).

6. *Producing the Report*: The final step was writing the report, in which the themes were woven together to tell the story of the data. This thesis provides a detailed, coherent, and persuasive account of the experiences of older Fijian Indians in Aotearoa New Zealand (Thorne, 2025; Thorne, 2016).

The thematic analysis enabled me to uncover the fundamental themes and narratives that shape the experiences of older Fijian Indians residing in Aotearoa New Zealand. This approach enabled a thorough analysis of their cultural, social, and personal backgrounds, and provided a deeper understanding of their distinct challenges and contributions to the diverse makeup of Aotearoa New Zealand society (Thorne, 2025; Thorne, 2016). (See Appendix G).

Establishing Rigour

Rigour in this qualitative study was ensured through qualitative methodological strategies that enhanced credibility, dependability, and transferability throughout the research process.

1. Methodological Rigour

The selection of a qualitative methodology was well-suited to investigating the intricate experiences of older Fijian Indians in healthcare settings. Using purposive sampling, participants were deliberately selected according to criteria pertinent to the research enquiry (Nowell et al., 2017). Implementing this sampling technique ensured that participants had first-hand, significant experiences related to the research subject, thereby enhancing the relevance and comprehensiveness of the findings.

2. Data Collection Techniques

A semi-structured interview approach was employed. This interview guide was regularly updated in discussion with the supervision team through an iterative process after each interview, to ensure that all the essential emerging patterns and sub-themes from preceding interviews were covered.

3. Data Saturation

Data saturation was considered in keeping with the principles of Interpretive Description (Thorne, 2016), which emphasises developing sufficient depth and understanding of participants' experiences to generate meaningful insights relevant to healthcare practice. Rather than relying solely on the recurrence of similar information, consideration was given to whether the interviews provided an adequate understanding of the issues being explored. As discussed in the data collection section, emerging similarities and differences were reviewed throughout the interviews and discussed with my supervisory team. When data saturation was achieved, as agreed with the supervision team, indicating that no new information of substantial importance emerged, data collection ceased. This ensured that the results were thorough and that all pertinent parameters of the research enquiry were adequately investigated (Ames et al., 2019).

4. Data Analysis and Interpretation

The data analysis was conducted using a systematic, iterative coding process consistent with thematic analysis, in which initial codes were developed, refined, and interpreted to generate meaningful themes. Using this approach, themes and patterns were systematically and rigorously identified, firmly based on the data.

I consistently upheld reflexivity (Laari, 2025) throughout the research process. Reflexivity entails a researcher critically assessing their position, prejudices, and impact on the research process (Mason-Bish, 2019). The resultant findings were rendered highly objective through my conscious recognition and effective reduction of these biases.

The dataset analysis and interpretation were peer-reviewed and debriefed with the supervisors. Subjecting the research to scrutiny facilitated the detection of any potential biases or omissions, thereby ensuring reliability.

5. Transferability and Dependability

For transferability, the thesis provides comprehensive contextual information and detailed descriptions, enabling readers to assess the relevance of the qualitative results to comparable older research on migrant healthcare accessibility. This increases the transferability of the study's results to different migration contexts and other older migrant groups.

Dependability was ensured by adhering to consistent research procedures and maintaining comprehensive documentation of every phase of the research, and maintaining an audit trail (Blair & Pavlova, 2026). This measure ensured that the study could be reproduced with comparable outcomes, thereby enhancing the reliability of the conclusions (Thorne, 2016).

By implementing these approaches, the study maintained a high degree of rigour, ensuring that the results are credible and valuable additions to the understanding of the healthcare experiences of older Fijian Indians in Aotearoa New Zealand.

Summary

This chapter has outlined the philosophical positioning, conceptual framework, and methodological approach guiding this study. Situated within an interpretivist paradigm and informed by a socio-ecological understanding of healthcare access, the study adopted interpretive description to explore the experiences of older Fijian Indian migrants navigating healthcare services in Aotearoa New Zealand. Consideration of my positionality, ethical clearance and compliance, engagement, and culturally responsive methods has been central to the research design, reflecting both my insider position as the researcher and the relational nature of qualitative inquiry with ageing migrant communities. Together, these theoretical and methodological foundations, along with the methods employed, provide a coherent framework for examining how individual, relational, and health system factors shape older Fijian Indian immigrants' experiences of healthcare access. The following chapter presents the study's findings, illustrating how older Fijian Indian migrants experience and navigate access to healthcare within the Aotearoa New Zealand health system.

Chapter 4 Findings

4.1 Introduction

This chapter presents the findings of the current study, examining the barriers to and enablers of access to healthcare among older Fijian Indian immigrants in Aotearoa New Zealand. The interview data are presented under key themes that address the research questions, providing valuable insight into the community's perceived barriers to and enablers of healthcare access. This analysis serves as the foundation for the next chapter, which explores the discussion and policy implications in depth.

In order to direct the analysis, this chapter focuses on the following research questions:

1. What are the enablers of access to healthcare amongst older Fijian Indian immigrants, and how do these manifest?
2. What are the barriers, including systemic level and structural inequities, to accessing healthcare, and how do these manifest?
3. What strategic suggestions can enhance access to health services for older Fijian Indian immigrants?

The purposive sampling methodology was designed to incorporate cultural diversity in terms of gender and age, aiming to mitigate potential biases inherent in demographically homogeneous samples (Nowell et al., 2017). The analysis relies on data collected through extensive individual interviews that examined participants' perspectives on barriers to and enablers of access to healthcare in Aotearoa New Zealand.

4.2 Summary of Demographics

A total of 10 participants who met the eligibility criteria were interviewed using a semi-structured format. Participants were purposively selected according to the inclusion criteria. These criteria included self-identifying as a Fijian Indian immigrant aged 55 years or older and having been in Aotearoa New Zealand for at least one year. These criteria were considered to ensure that the participants had prior experience of accessing Aotearoa New Zealand's healthcare facilities. All interviewees held a

permanent residency visa and had used healthcare services in Aotearoa New Zealand. The participants' ages ranged from 57 to 74 years. Of the 10 participants, six were male, and four were female. All the participants were married, with one individual stating they were separated from their partner. A total of eight participants identified as Hindu, one as Muslim, and one as Christian. The duration of residency for all participants in Aotearoa New Zealand ranged from 7 to 35 years. The participants' educational backgrounds ranged from primary school to tertiary education, with two having a primary school education, three having a secondary-level education, and four having a tertiary-level education. Two of the participants had comprehensive private medical insurance to cover their healthcare expenses.

The participants were given pseudonyms to protect their identities and maintain confidentiality throughout the study. Table 1 on the next page provides key demographic information about the participants.

Table 1. An Overview of the Key Demographics of the Participants

Participant/ Pseudonym	Gender	Age	Language Used	Employment status	Marital Status	Religion	Duration in NZ	Education Level	Health Insurance
1 Govind	Male	57	English	Employed	Married	Hindu	14 years	Tertiary	Nil
2 Taaj	Male	64	English	Employed	Married	Muslim	15 years	Tertiary	Full medical cover
3 Prakash	Male	74	Hindi	Retired	Separated	Hindu	15 years	Primary School	Nil
4 Kamla	Female	60*[3]	Hindi	Retired	Married	Hindu	7 years	Primary School	Nil
5 Ramesh	Male	70*	English	Retired	Married	Hindu	15 years	Tertiary	Nil
6 Rosie	Female	60*	Hindi	Retired	Married	Christian	35 years	Secondary School	Nil
7 Leela	Female	58	Hindi	Part-time worker	Married	Hindu	12 years	Secondary School	Full medical cover
8 Gopi	Female	70*	Hindi	Part-time worker	Married	Hindu	8 years	Secondary School	Nil
9 Anand	Male	68	Hindi	Retired	Married	Hindu	17 years	Tertiary	Nil
10 Hari	Male	71	Hindi	Retired	Married	Hindu	14 years	Primary School	Nil

[3] *Exact age was not reported by the participant; therefore, the age group reflects the participant's self-reported age range. (See Appendix F).

4.3 Presentation of Findings

This section presents the key findings from interviews with older Fijian Indian participants, focusing on the factors that shaped their access to healthcare services in Auckland. Illustrative quotations from participants support the subsequent presentation of themes, sub-themes, and their connections. By aligning with the research questions and objectives, this thematic approach offers an in-depth exploration of the determinants affecting healthcare access for older Fijian Indians in Aotearoa New Zealand.

Participants ranged in age from 57 to 74 years. Where relevant, contrasting accounts from participants of different ages are presented to illustrate how they experienced barriers and enablers to healthcare access and how they sought or navigated healthcare services. For example, under the theme Longer Waiting Times, a participant in his 50s described difficulties attending appointments because of work commitments, while a participant in his 70s questioned the practicality of booking appointments in advance when illness occurred unexpectedly. These accounts highlight how participants' individual circumstances shaped their experiences of healthcare access. Age and length of residence in Aotearoa New Zealand are considered where they provide relevant context to individual experiences.

Five major themes emerged from the thematic analysis process. Themes 1-3 comprised three sub-themes, while themes 4 and 5 each comprised two sub-themes, as follows.

Theme 1: Lack of trust resulting from experiences of unprofessional behaviour by healthcare providers.

1.1 Loss of confidence in the healthcare providers stemming from inadequate healthcare services.
1.2 Poor professional attitudes and lack of empathy.
1.3 Perceived disregard and culturally insensitive communication regarding health concerns.

The sub-themes discussed participants' struggles to trust healthcare service providers following negative experiences. These struggles were further reinforced by the poor

professional attitudes of the healthcare providers, whom participants felt did not hear them and undermined their health concerns.

Theme 2: Inadequate cultural awareness and considerations of ethnicity.

2.1 Poor cultural understanding.
2.2 Language and communication barriers.
2.3 Ethnic prejudice and discrimination.

Participants discussed how the services are not culturally suitable for Fijian Indian immigrants in Aotearoa New Zealand, who face language and communication barriers. Participants also perceived ethnic prejudice and discrimination.

Theme 3: Longer Waiting Times.

3.1 Inflexible access times.
3.2 Long waiting times and staff shortages.
3.3 Logistic barriers in navigating health services.

Participants discussed access to specialist services, including opening hours in primary care and staff shortages relating to delays in receiving specialist appointments. Other concerns included the geographic distribution of healthcare services, as well as errors and delays within the healthcare system, resulting in delayed access to numerous specialist services.

Theme 4: Poor patient-centred care.

4.1 Feeling rushed during appointments.
4.2 Lack of individualised attention to patients' needs.

Participants discussed issues related to inadequate healthcare services, including rushed appointments and failure to meet their needs. The participants expressed concerns about a lack of follow-up care, which the health system often failed to provide.

Theme 5: Lack of affordability.

5.1 Increased GPs' fees.

5.2 Need to prioritise daily survival over obtaining healthcare.

The participants shared experiences of how the cost affected their ability to access health services due to financial constraints. Their experiences related to the high cost of GP services and poor or no investment in minority ethnic communities' health, where the participants had to prioritise basic needs over their health.

Table 2, below, summarises the themes and sub-themes. The theme and sub-themes are discussed in detail after the table below.

Table 2. Themes and Sub-themes

Main Themes	Sub-Themes
1. Lack of trust resulting from experiences of unprofessional behaviour by healthcare providers.	1.1 Loss of confidence in healthcare providers stemming from inadequate healthcare services 1.2 Poor professional attitudes and a lack of empathy 1.3 Perceived disregard and culturally insensitive communication regarding health concerns
2. Inadequate cultural awareness and inadequate considerations of ethnicity	2.1 Poor cultural understanding 2.2 Language and communication barriers 2.3 Ethnic prejudice and discrimination
3. Longer Waiting Times	3.1 Inflexible access times 3.2 Long waiting times and staff shortages 3.3 Logistic barriers in navigating health services
4. Poor patient-centred care	4.1 Feeling rushed during appointments 4.2 Lack of individualised attention to patients' needs
5. Lack of affordability	5.1 Increased GPs' fees 5.2 Need to prioritise daily survival over obtaining healthcare

Theme 1: Lack of Trust Resulting from Experiences of Unprofessional Behaviour by Healthcare Providers

The participants emphasised that trust was vital in their relationships with healthcare providers and substantially influenced their interactions with healthcare services. The development of trust in medical encounters enabled participants to develop confidence, thereby enhancing their health outcomes and adherence to treatment courses, and facilitating efficient communication, which further improved engagement.

Many participants shared a similar view on trust, specifically a **loss of confidence in healthcare providers stemming from inadequate healthcare services**, which was a recurring theme across multiple interviews. This highlights a lack of confidence in the healthcare providers, which was significantly affecting the health of the older Fijian Indian population. It was highlighted that these participants perceived healthcare practitioners as not taking their concerns and symptoms seriously, which is vital for establishing trust.

Another sub-theme highlighted that participants' lack of comfort during healthcare encounters depended on whether providers showed professionalism, respect, and empathy. In describing **poor professional attitudes and a lack of empathy**, participants perceived negative influences on their trust and comfort levels from healthcare providers' attitudes and behaviours during professional interactions. Some participants shared their previous experiences of encountering an unacceptable demeanour and a lack of empathy from healthcare providers.

Another sub-theme, **perceived disregard and culturally insensitive communication regarding health concerns**, illustrates that the older Fijian Indians, when encountering health professionals, were not taken seriously. The participants reported that healthcare providers treated them as if they were feigning their condition.

Collectively, these sub-themes provide a comprehensive overview of the intersecting factors that influence trust formation in healthcare practitioners' interactions with older Fijian Indians.

Sub-theme 1.1: Loss of confidence in healthcare providers stemming from inadequate healthcare services

Trust is crucial for building patient–healthcare provider relationships; however, many older Fijian Indians reported they could not trust healthcare professionals.

Leela, a 58-year-old woman, stated that

> "what GP could have done was to give me painkillers instead of a steroid injection or send me for further treatment. Just give me painkillers and send me to the foot and ankle specialists, then I can go further and would have known what was wrong with me, but instead, he gave me injection after injection until it popped."

Leela's story underscores the fact that she did not receive a timely referral to a specialist, leading to a situation where her ankle "popped" and causing her to lose trust and confidence in the healthcare professional. This contributed to her physical health demise.

Leela added:

> "So, because of him, I am selling my house now, just because of him, I know I can't be full-time anymore, just because I can't lose my job."

Leela's quote suggests substantial changes in the health and well-being of Fijian Indian migrants, with a particular healthcare provider causing significant pressures. The reference to "because of him" suggests that Leela was significantly restricted in her choices, leading to actions that resulted in the sale of her property. This highlights how Leela lost confidence in the healthcare provider due to inadequate healthcare service.

Govind, a 57-year-old schoolteacher, said he had been formally seeking a referral to a specialist for his condition, but the GP had disregarded his requests:

> "Because it took me quite a few visits to the GP before he referred me to the specialist."

This made Govind feel that the GP did not trust what he told him. Govind's statement attests that healthcare professionals did not trust his shared health information and kept delaying vital treatment for his recovery.

Anand, a 68-year-old retired schoolteacher, shared a similar experience of lack of confidence with his GP, saying:

> "As I was from the teaching field, to me, I felt, they were bit young, not experienced to tackle patients, they wanted to get rid of, they have seen and that's it."

This dismissive approach led Anand to lose trust in the doctor and made him feel less confident in the care he received.

In contrast, Taaj, a 64-year-old male who works in a government department, expressed a positive sentiment towards his GP. He commented:

> "I think they are quite friendly; they are quite helpful. I think the nurses and doctors have been quite good with me."

Furthermore, Prakash, a 74-year-old retired male, shared similar thoughts as he praised his GP:

> "He did a good job in a proper manner … [the] Indian doctor was a very lovely man."

The remarks mentioned above involved utilising a primary care practice. The participant's description shows that trust was strengthened when care was experienced as both professional and culturally familiar. The phrase "proper manner" suggests that the doctor's approach was seen as respectful and appropriate, while describing the doctor as "a very lovely man" reflects a sense of comfort and positive connection. This may indicate that having an Indian doctor helped the participant feel understood, which supported trust and confidence in the healthcare encounter.

Hari, a 71-year-old male, shared similar sentiments. Retired now, he was admitted to acute care, and verbalised that

> "doctor for me was really very good, whenever I used to go and see him for my problem, he used to see me very well and if the more was to be done he used to do it very well, such as x-ray and all, all places he was very good, he was always good, he used to advise me well."

He further highlighted positive words about his GP:

> "Yes, he was a peaceful person, and his talking mannerism was really good."

These excerpts suggest that trust was shaped by the way healthcare providers communicated with participants. Participants felt more supported when doctors listened patiently, responded respectfully, and showed some understanding of their cultural needs.

Sub-theme 1.2: Poor professional attitudes and a lack of empathy

Many participants reported multiple medical encounters with healthcare providers during which their symptoms were disregarded or perceived as psychosomatic, leading to substantial delays in receiving a proper diagnosis and appropriate treatment. The scepticism among healthcare staff was particularly evident in cases involving complex, chronic conditions. Symptoms like pain, coupled with unclear origins, increased mistrust of the GP, as participants' conditions were perceived as potentially psychosomatic. This perception caused feelings of stigma, which resulted in delays in seeking healthcare and receiving a diagnosis and treatment.

One participant, Leela, expressed dissatisfaction with her specialist doctor's unprofessional attitude toward her care. She stated:

> "I thought he must have been very busy that day. I felt that he was just busy, and he doesn't want to take interest, but he is a specialist, he is a big specialist."

This statement highlights a perceived lack of engagement and unmet expectations of a consultant at an acute care tertiary hospital clinic.

Govind, a 57-year-old man, contributed an experience of similar attitudes:

> "I believe they should have asked me more questions, you know, to diagnose it, you know, probably, they should have asked me more from when it is paining, but initially they didn't, they just tried to get rid of me."

This experience underscores the disdain exhibited by GPs in basic healthcare settings towards older Fijian Indian patients, and how the resultant erosion of trust adversely affects their healing process. The consequences of participants perceiving a lack of

attention or disregard from healthcare professionals have a significant impact on their psychological state and ability to build trusting relationships, ultimately affecting the efficacy of their medical treatment.

Ramesh, a 70-year-old retired man, highlighted the behaviour of night-shift healthcare professionals in an acute setting, saying that

> "when the time to sleep and rest, … they were gossiping, it was extra and was loud which was disturbing … the numbness was wearing out since the effect of tablet was getting less, I was feeling uneasy due to loud noise, I am not used to that at home too … you people can talk though you can keep the volume low … it's kind of disturbing, please keep the volume low, like I felt they did not like it, … since at night it's hard to fall off to sleep."

This quote highlights Ramesh's concerning experience while in the hospital, which not only disturbed his sleep but may have hampered his recovery owing to a lack of sleep caused by the healthcare staff's unprofessional attitude. Ramesh further added that:

> "They lack politeness, and they lack respect for the older people."

Consistent with this, Rosie, a 60-year-old woman, shared an experience of a lack of professional etiquette during her eye surgery at a public hospital:

> "Mostly, they were talking about their boyfriends, girlfriends, and at the weekend, where they were going to have dinner and stuff like that, and I don't know whether they were concentrating on me or not."

Poor professional attitudes and a lack of empathy shown by health practitioners illustrate the participants' dissatisfaction with the acute care healthcare setting. They felt that healthcare workers did not meet the participants' expectations for respectful behaviour, whether because of cultural expectations among Fijian Indian immigrants or perceived impoliteness.

Sub-theme 1.3: Perceived disregard and culturally insensitive communication regarding health concerns

Many participants believed that acute and primary care healthcare providers failed to address their health concerns, highlighting the importance of patient-centred communication in building trust and enhancing engagement in healthcare services.

Govind, a 57-year-old male, stated that he had been seeking a specialist referral for his condition, but the GPs had disregarded his requests:

> "I had this pain, you know, they asked me to describe between zero to 10, you know? And I mean, I never had pain. They probably should have asked me more about it when it was painful. They thought I was making up new stories and said that I didn't have a particular pain, and then they referred me to a psychologist."

The above statement highlights how Govind's health concerns were undermined, and that the healthcare provider perceived him and labelled him as an older Fijian Indian, referring him to a health psychologist.

Ramesh, who went to the emergency department with his wife, was advised by the administration team to return to his GP. With some reluctance, he had to battle for his right to see a doctor, arguing that how they could judge their health condition was not severe enough. His tenacity paid off. After being examined by medical personnel, his wife was admitted to the hospital for eight days for acute treatment.

Ramesh stated:

> "I mean, it was a genuine case. She was admitted into hospital for eight days. So just imagine a patient is really sick only, then it'll be admitted for eight days. She did not go there just for nothing."

Ramesh phoned an ambulance to take his wife to the hospital before going himself. She was severely ill, and Ramesh was unable to transport her in his car. After calling the ambulance service, he was told they would not prioritise picking her up. Ramesh verbalised that

> "Ambulance service in New Zealand is one of the worst I have come across. We are explaining unnecessary questions. So finally, I got the phone and said, 'Look, tell me one thing, are you coming?' And she said, 'No, we can't come for that. It's not life-threatening. So, we can't come for that.'"

Ramesh argued that if it was not life-threatening, then why was his wife admitted for eight days with intensive treatment with antibiotics?

Ramesh added that, while at the acute care hospital, the actions of the administration staff in sending him to another emergency department in the community without

knowing the condition presented to the hospital were “frustrating”. He said, “Actually, I was frustrated”.

This highlights that when healthcare professionals disregard patients’ concerns, it impacts their physical, emotional, and psychological health. The acute healthcare provider’s inefficiency was perceived as a neglect of participants’ health concerns.

Theme 2: Inadequate Cultural Awareness and Considerations of Ethnicity

This section examines the access challenges faced by older Fijian Indian immigrants, that focused on cultural misunderstandings, communication barriers, and ethnic discrimination in healthcare settings.

Sub-theme 2.1: Poor cultural understanding.

A lack of cultural sensitivity in healthcare interactions leads to feelings of neglect and marginalisation. Most participants voiced how the healthcare providers failed to provide culturally appropriate care. This included poor understanding by the healthcare providers in both acute and primary care, including instances where the healthcare providers could not relate to the healthcare concerns of the older Fijian Indian immigrants.

Prakash, a 74-year-old retired male, shared an experience while accessing primary health care, stating:

> “They were not as understanding as our home people first. … I think they had a cultural problem.”

The above statement by Prakash implies that the GP was not culturally competent and disregarded the cultural values of this older “Fijian Indian” immigrant. It highlights how the Fijian Indians may be misunderstood in the healthcare settings here in Aotearoa New Zealand, compared to the healthcare provided in Fiji.

Kamla, 60 years old and now retired, added that while accessing a GP service,

> “The Indian doctor was also good.”

Kamla’s statement consolidates her feeling of a deep level of cultural understanding while sharing healthcare information with her GP. It enables a higher level of comfort

when sharing background information, fostering greater trust, communication, and a more positive experience in cross-cultural encounters.

Ramesh shared a similar experience while accessing GP services. He stated:

> "So, there was not, I mean, I can say it was not difficult because he understood, uh, the Fiji Indians. Well, because he himself, our GP was Fiji Indian for our GP's Fiji Indian. So, we had a very smooth, uh, primary care."

Ramesh suggested that he had shared his cultural and ethnic background with the GP, which enhanced his experience, making him feel respected and perhaps at ease when sharing health-related information and receiving culturally safe healthcare.

Ramesh further stated that

> "a lot of GPs don't talk about what you are eating or what you are having for breakfast, or if you have diabetes, what control you should have with your diet and things like that."

Ramesh's concern highlights that the GP's lack of comprehensive education or health promotion has significant health implications. It is a missed opportunity to provide personalised preventative education on chronic conditions tailored to the cultural context of Fijian Indians' food practices. A lack of self-empowerment and self-management contributes to poor long-term health outcomes. This undermines the GP's role, which ideally should be to provide holistic healthcare.

Ramesh further stated that

> "GPs here won't tell you, but this gentleman from Fiji had knowledge of, … there are a lot of things in our own diet that Indian food, there are a lot of, spices that have effects on your body."

Again, this demonstrates that sharing a cultural background facilitates interaction and the sharing of necessary culturally based interventions. This will also enable older Fijian Indians to comply with healthcare interventions, as they can be tailored to their ethnicity and cultural practices.

Taaj, a 64-year-old man, recounted an experience during his acute care admission, stating:

> "Fiji people who go and seek those services, and if their cultural needs are met, then things would be much better."

This statement highlights the unmet cultural expectations in the acute care setting. Taaj's statement suggests that if care is inclusive, culturally aligned, and tailored to meet the needs of Fijian Indians, then health outcomes will improve.

Gopi shared a similar sentiment, stating:

> "Well, for us migrants, the doctors from India I don't prefer; they don't understand us."

Gopis highlights that the cultural accommodation of healthcare service delivery is inadequately addressed for Fijian Indian immigrants in Aotearoa New Zealand. This remark illustrates the cultural distinctions between Indian Indians and Fijian Indians.

These quotations suggest that older Fijian Indian migrants perceive healthcare providers in Aotearoa New Zealand as not fully understanding their cultural needs, leading to dissatisfied health consumers.

Sub-theme 2.2: Language and communication barriers

Effective communication is crucial to delivering high-quality care and achieving optimal healthcare outcomes. However, several participants reported miscommunications and abrupt consultations that hindered their complete engagement in the decision-making process regarding their treatment.

Gopi shared an experience at a clinic in an acute care hospital, stating:

> "The doctor is fast and writes, explains, and finishes off quickly. He will see you and will do his work but will not explain much."

The lack of a clear explanation in a fast-paced scenario limits participants' understanding; in this case, Gopi felt the service was rushed. This limits the opportunity to ask questions and to share in decision-making for better health outcomes, particularly among older Fijian Indians.

Leela, a 58-year-old part-time worker, recalled a consultation where she was left confused, and added:

> "The Doctor came in and said, 'Oh, I didn't give much good information, aye.'"

Leela perceived a lack of seriousness towards her problems that led to the loss of trust in the healthcare system and a reluctance to seek help or adhere to medical advice.

Language barriers also led to discomfort and disengagement. Hari added.

> "Though the interpreter is there, since it's English speaking, they put the interpreters from India who cannot relay the right message."

Fijian Indians speak a distinct Hindi dialect, different from that spoken by Indians from India. Hindi is a diverse language with over fifty dialects. The dialects of India and Fijian Indians are distinct from one another. This resulted in participants not fully comprehending when interpreters from India attempt to translate healthcare issues in a dialect unknown to older Fijian Indians. Besides issues with dialect, the way healthcare providers communicated was identified as an additional issue by the participants.

Hari stated that

> "I do understand the English-speaking doctors, but I do not talk to them much."

This highlights that understanding English did not necessarily translate into active participation in healthcare consultations with English-speaking doctors.

Prakash added:

> "if you are not educated or just speaking English that well, it was hard for them to understand what you were talking about."

It is not only the participants who find it difficult to understand the doctors; Prakash also perceived that the doctors have difficulty understanding what the Fijian Indians are trying to explain.

Patients expressed more comfort with doctors who spoke Fiji Hindi or shared a similar background.

Prakash appreciated being able to speak Hindi. He said,

> "'Oh sure, please do converse in Hindi.' He was good at his work."

These experiences show that linguistic familiarity and culturally attuned communication improve trust and patient satisfaction.

Anand, a 68-year-old male, reaffirmed this while sharing an interaction with his GP, who happened to be Fijian Indian:

> "He did a good job in a proper manner."

Gopi shared an experience of talking to her GP who was a Fijian Indian himself:

> "But the one from Fiji he understood me, I told him see it's high time, my family history is that we have thyroid running in my lineage, on that I just want to know how my thyroid is, function can be judged through the blood."

Again, the doctor from Fiji highlighted the importance of family history in diagnosis and did not dismiss the patient's concern. This highlights the cultural familiarity with the Fijian Indians.

Gopi reinforced this concern:

> "But he thought I did not have a right to speak. But from that time, I would prefer the doctor from my own Fijian Indian doctor, since they do understand much of us."

Despite Gopi's attempts to communicate, the doctor's approach and poor engagement left her feeling helpless. This led her to say that a Fijian Indian doctor would be more understanding, respectful, and culturally aware.

Taaj verbalised the following view:

> "They probably don't have the confidence or knowledge, or they probably can't explain in the language, like what's, what's causing the underlying conditions of the causes of it, or what do you think the cause?"

Although holding advanced medical knowledge for the healthcare profession is crucial for addressing the complex comorbidities of older Fijian Indian patients, cultural understanding is essential to communicate that information effectively. This also

highlights specific cultural barriers to understanding the Fijian Indian population, further complicating communication.

These older Fijian Indian migrants have reported that communication difficulties hindered their interactions with healthcare providers. Besides communication, commonly the language barrier and lack of cultural understanding led to dissatisfaction among the participants.

Sub-theme 2.3: Ethnic prejudice and discrimination

Poor health practices, ethnic prejudice, and discrimination towards the older members of the Fijian Indian community appear to have posed significant barriers to equitable healthcare. Some participants described direct experiences of racial bias that led to delayed diagnoses or the dismissal of symptoms. Participants have highlighted feelings of being disregarded, overlooked, and treated differently from individuals of other races.

For example, while accessing the primary health care service, Govind felt his concerns were being dismissed due to racism and prejudices, stating:

> "Probably because I was an Indian, probably, and it was my skin colour, maybe, you know?"

Ethnicity-based mistreatment, for example, discrimination or culturally insensitive healthcare, can result in a loss of confidence between older Fijian Indian patients and healthcare professionals. This impacts their immediate healthcare encounter and their inclination to pursue medical assistance in the future.

Kamla reinforced this concern"

> "They just don't give a damn; they think if it was someone of their own or white people, then the story would have been different."

Similar concerns were expressed by Gopi, stating that,

> "They don't care at all … these are Indian old women and men, where will they go and report?"

Rosie, a 60-year-old, raised concerns about misclassification:

> "They say its Indians; there they don't know whether we are from India or Pacific … we are struggling in the middle."

Such experiences suggest systemic biases and misrecognition of ethnic identities, which may prevent targeted care or resource allocation. This reflects a broader issue of the misclassification of ethnic identity in the healthcare setting, leading to ethnic prejudice and discrimination against the Fijian Indian population. Rosie's comment was that

> "For us, there is nothing. For Fiji Indians, there is absolutely nothing."

Rosie's comments underscore the perceived neglect of her minority ethnic community within the healthcare system.

The presence of ethnic bias in healthcare settings can have a profound negative effect on older Fijian Indians, resulting in unequal access to high-quality healthcare. These biases might appear as stereotyping, underestimating symptoms, or ignoring culturally unique health conditions, ultimately leading to unfavourable health consequences.

Theme 3: Longer Waiting Times

A recurring theme in participants' accounts was the struggle with long wait times and poor access to healthcare services. This theme emphasises the crucial disparities between healthcare needs and the availability of prompt medical assistance. Participants consistently emphasised the difficulties in obtaining prompt healthcare services, often worsened by extended waiting times for primary health care and specialist treatment. These delays had both physical and psychological effects, especially among those managing chronic illnesses and/or balancing work and family obligations.

Sub-theme 3.1: Inflexible access times

Participants voiced frustration over the limited availability of specialist care. For example, referrals for orthopaedic or eye care were delayed.

Govind, a dedicated school teacher, faced difficulties attending GP appointments during standard hours:

> "I need to go to work … My culture says I am the 'guru' (teacher). They won't understand that."

He stressed the need for more flexible appointment options. Should he need to consult a GP for non-urgent matters, he must take leave from work to attend the doctor's appointments. This highlights the system's inefficiency in making healthcare services accessible after hours. Govind said:

> "You should be able to see any GP, even if it is after hours."

Govind argued that if your GP is unavailable, you should have the option to consult with another GP instead of proceeding to emergency accident and medical centres, which incur far higher costs than GP services. Occasionally, patients may be turned away from the emergency departments if their condition is not critical enough.

Taj added:

> "If you want to go and see your GP today … we do not have any space for you. Oh my God."

Such limitations can delay diagnosis and treatment, forcing patients into more costly and crowded emergency departments or urgent care clinics.

Hari said:

> "One way it is convenient, but on the other hand, how will I know that I will fall sick next week? How will I know on that particular date that I will fall sick on that day, so I can go and make the appointment?"

Similar sentiments were shared by Ramesh, who stated:

> "I don't need to see the doctor, so how do I make an appointment in advance? When we fall sick, then only we have to see the doctor, there, then they won't see us."

Gopi shared the same sentiment:

> "While the appointment system is good that you don't have to wait at some GP for many hours, it becomes a problem when you get sick suddenly, and your GP is fully booked."

These comments accentuate the inefficiency of the healthcare system's appointment and referral system, as it fails to adequately serve older Fijian Indians who fail to schedule appointments when they become ill. The absence of prompt and timely medical treatment options leaves them with no recourse. The sole option available to them is emergency departments, where minor ailments may not be treated or where waiting periods often exceed six hours, discouraging individuals from seeking prompt healthcare. Besides longer wait times, participants reported having to wait extended periods to access specialist surgery.

Appointment availability at GP was a concern voiced by Hari, who stated:

> "The appointment system will work for that person who will want to get their diabetes checked or something, not other kinds of sickness … if someone falls sick all of a sudden, like chest pain, they will say that we won't see them, they will tell us direct, appointment is not good."

Hari believed this becomes a barrier to accessing urgent healthcare due to the appointment system.

Gopi stated:

> "It's good that they have an online booking system now, but for some only, there are two problems; it's hard to get an appointment when I am free, and the other is that I don't really understand the booking system."

Gopi indicates that the online appointment booking system is not user-friendly, especially for older Fijian Indian immigrants. For those who can book appointments, it is challenging to secure timely ones, which delays treatment. This causes frustration and discourages older Fijian immigrants from seeking help.

Gopi explained that she is still waiting for an appointment for her condition, stating:

> "Even now, they have sent a letter, and in it, they are saying they will call at their convenience, and up till now, they have not called me. It is more than a year and six or eight months."

Gopi perceived that the state of the healthcare system, which is delaying treatment and follow-ups, leads to the poor health status of older Fijian Indian migrants. Delays

in care delivery within the health system are a barrier to timely healthcare access and may affect overall health outcomes.

Sub-theme 3.2: Long waiting times and staff shortages

One common concern the participants raised was the longer wait times in waiting rooms or the emergency departments caused by staff shortages, which worsened health conditions and led to frustration. These issues affect not only their physical health but also their emotional well-being and their perception of Aotearoa New Zealand's healthcare system.

Hari reported the waiting time in a drop-in clinic:

> "At my previous GP, it was like three hours, three hours at least, waiting for the doctors."

Furthermore, when he changed his GP within the Auckland region, he encountered even longer waiting times:

> "Where the queue is too long, you have to wait four to six hours."

Hari expressed concern as follows:

> "The longer waiting time that we as sick people have to wait, the longer period of time, the patients get sicker since there is no food and beverages, we sit and wait for two hours, three hours, this should be improved a lot."

Kamla stated she also had a significant delay at an urgent care facility (secondary care). She emphasised:

> "Okay, the waiting time was extremely long, extremely long … the whole night."

In addition, prolonged waiting periods for publicly funded specialised medical treatment (over six months) appeared to have a substantial influence on the well-being of patients, leading to heightened levels of worry and potentially exacerbating health issues as a result of delayed interventions.

Hari shared an experience when he was hospitalised, stating:

> "we go to the hospital … sometimes one or two days after the doctor comes and see you … once the doctors have done their rounds in the morning they will not come during the day, whole day the people are laying there when doctors do not come then who will give the medicines … my treatment should start not only mine but for anyone for that matter, that is what is lacking."

Hari's comment suggests that the shortage of medical care staff in hospitals meant delays in patient recovery. Ramesh further reinforced this sentiment while waiting at an ED, who mentioned that

> "I had to wait for about seven or eight hours. I said, 'Okay, we'll wait.'"

This highlights the critical nature of health problems requiring immediate medical attention, yet older Fijian Indian participants suffered through a wait of seven to eight hours just to get such care. This accentuates the unacceptable waiting times at the acute care treatment facility. The time delay in treatment can substantially impact the prognosis of patients' conditions.

Ramesh recalled an event when he called for an ambulance for his wife:

> "Ambulance service in New Zealand is one of the worst I have come across … and she said, 'No, we 'can't come.'"

Ramesh perceived this as due to staff and resource shortages in the Aotearoa New Zealand healthcare system.

Anand recounted an incident in which he believed the doctors he encountered at the primary care clinic were either interns or trainees who lacked knowledge on what to prescribe and had to consult Google.

In a similar kind of experience, Kamla stated:

> "I had this thyroid issue. I requested it since they don't give you referrals easily … that is the worst part, since they rarely give you referrals, since your condition really deteriorates."

There is not only a longer wait for treatment, but Govind also explained that even after treatment, it took longer to complete paperwork:

> "It took three hours to give the discharge because I had to wait for that, or that was for a while."

This reflects participants' perceptions that prolonged waiting times, including delays in the discharge process, indicated staff shortages.

The findings of this study highlighted that the delays in referrals, possibly due to a shortage of specialists, are a significant healthcare system issue, potentially causing increased anxiety and delayed diagnosis and treatment.

Sub-theme 3.3: Logistic barriers in navigating health services

Some participants expressed concern about the difficulty in accessing services due to logistical barriers. Logistical barriers, such as Auckland's poor public transport system and an unfriendly appointment scheduling system, made it harder for older Fijian Indians to navigate and access healthcare services effectively. Participants highlighted delayed appointments, a lack of transportation, and limited after-hours healthcare facilities.

Ramesh stated that he

> "got discharged and clinic appointments [were] made. How can I go to the clinic if I can't walk. Public transport is unsafe and unreliable. Not on time, I need. ACC hardly pays for this in my wife's case."

This exemplifies the difficulty older Fijian Indians face in attending health clinics, as they are unable to do so due to transportation issues in this case.

Rosie, who had eye surgery, stated:

> "I asked, almost after a year … I asked why I did not get an appointment, and they told me that my folder got shifted."

Despite having surgery a year ago, she is still waiting for an appointment to review, mainly due to medical notes being shifted to another catchment area without her knowledge, resulting in there being no follow-up.

Appointment availability at GP was a concern voiced by Hari, who stated:

> "The appointment system will work for that person who will want to get their diabetes checked or something, not other kinds of sickness …

> if someone falls sick all of a sudden, like chest pain, they will say that we won't see them, they will tell us direct, appointment is not good."

Hari believed this becomes a barrier to accessing urgent healthcare due to the appointment system.

Gopi stated:

> "It's good that they have an online booking system now, but for some only, there are two problems; it's hard to get an appointment when I am free, and the other is that I don't really understand the booking system."

Gopi indicated that the online appointment booking system is not user-friendly, especially for older Fijian Indian immigrants. For those who can book appointments, it is challenging to secure timely ones, which delays treatment. This causes frustration and discourages older Fijian immigrants from seeking help.

Kamla shared that

> "I can't get to clinic appointments; I don't drive and my husband has to work full time to look after the family. We don't get much support even from the government."

The locations of some clinics, which are far from the main residential areas, make it difficult for some people to attend, resulting in reduced continuity of care and delayed follow-ups.

These older Fijian Indians reported being unable to access healthcare due to the occurrence of transport issues, unfriendly clinic times, and not receiving timely appointments, which have a detrimental impact on their health.

Theme 4: Poor Patient-Centred Care

Some participants described poor-quality healthcare encounters experienced, during which they felt rushed, dismissed, or not fully supported by healthcare providers. They felt that the healthcare providers ignored details about their health. Emphasising patient-centred treatment is crucial for improving health outcomes and minimising inequities, particularly among minority populations such as older Fijian Indians.

Ramesh mentioned feeling "the whole system here has become more commercialised" and is lacking in quality patient-centred care.

Sub-theme 4.1: Feeling rushed during appointments

Participants expressed the view that healthcare providers must allow sufficient time for patients. This will enable them to conduct proper assessments and provide the necessary health interventions. However, many participants felt they were not given sufficient time to discuss their concerns. They felt the medical appointments were rushed, leading to unanswered questions, inadequate communication, and their concerns not being addressed.

Ramesh recalls an instance when he visited his GP. He felt they were in a rush, stating:

> "So, within that 15 minutes, you must be able, they must be able to understand what you are talking about."

The 15-minute GP consultation does not provide enough time for Ramesh to discuss his health concerns.

Ramesh added:

> "And then they must be able to diagnose what ailment you have and then start the treatment … a 15-minute allocation in some places is not adequate. So that's the big problem with GPs."

Ramesh further explained that some of the GPs will indicate him to stop talking. He verbalised this as follows:

> "Giving some gestures that you should up finish, stop the conversation … that lady GP will be looking at the clock. As soon as it was 15 minutes, they will start standing up and, you know, sort of indicating that you must, your time is up, you better quit."

This highlights the inadequate holistic care and rushed service Ramesh received during the consultation.

Ramesh believed that

> "they want to attend as many numbers as you can … it is a lot of money-making rather than dealing with health issues and treatment

> or even advising patients on prevention … the big medical centres are more oriented toward making money."

Ramesh reiterated that the prevailing business models in healthcare, which prioritise efficiency, often prioritise maximising output and minimising costs at the expense of patient care quality, negatively impacting the patient experience. These methods can result in hurried consultations, reduced patient involvement, and a lack of comprehensive care, which can be particularly detrimental to groups that require more nuanced and culturally sensitive approaches.

Ramesh said:

> "So I don't think they are much concerned about prevention of diseases in this country."

This statement highlights the lack of focus on disease prevention and health promotion, which are essential to improving the health of the older Fijian Indian population here in Aotearoa New Zealand.

Babu said:

> "I felt they should tell me about my sickness, such as my diabetes and all. They could have seen me, tell me about my sugar level that it was high, the doctors before use to print and give my charts to me, but this one never did that."

Babu felt this was a missed opportunity for self-management and that the GPs prioritised speed over understanding, leaving participants uninformed and compromising the quality of chronic care.

Rosie shared an experience while at an acute care facility, attending a specialist appointment, said that

> "he is just busy, and he doesn't want to, he doesn't want to take interest, but he is a specialist, he is a big specialist."

Rosie's experience demonstrates that this issue is not limited to primary care but also extends to acute care settings, where participants have received rushed care and insufficient attention to their care needs.

The findings of this study indicate that healthcare systems must prioritise integrating patient-centred care and ongoing quality improvement as fundamental principles. This approach will ensure that healthcare practices not only meet clinical requirements but also respect the choices and values of older Fijian Indians, creating an environment in which they feel appreciated and understood.

Sub-theme 4.2: Lack of individualised attention to patients' needs

Some participants felt that their care was not personalised for older Fijian Indians, even though this approach is considered vital to achieving good health. Many participants felt that this was not the case as they verbalised that the "one size fits all" care model does not work with the minority ethnic community. The lack of attention to tailored care leads to poor health outcomes, miscommunication, and diminished trust in the healthcare system.

Ramesh mentioned:

> "The whole system here has become more commercialised and lacking quality patient-centred care."

Anand shared an experience when he went to see his GP for shortness of breath, stating:

> "He didn't even check me well. He didn't check my chest to see what the problem was."

Anand's experience testifies to patients are missing out on individualised care. He added:

> "I think this is not right; the white man could have examined then it would have been better … even if he would have touched me, would have been better; he was slack."

Anand stated that he received poor-quality care, where the GPs did not provide much attention to his concerns, and it also affected the therapeutic relationship.

Govind shared a similar experience when he went to see his GP for chest pain. He stated that they did not do much investigation initially:

> "Initially, they didn't, they just tried to get rid of me."

This shows a lack of quality patient care, with care that feels impersonal and rushed.

Taaj, who was describing an instance when he wanted to see his GP, stated:

> "So I mean, it was like a long wait time, and sometimes the [staff] are not very nicer because they are overworked, or tired and stuff. So that happens on occasions, too."

Taaj added:

> "I think the medical system problem needs to understand the needs of other requirements of people coming from Fiji".

Similar experiences were echoed in the acute care facility by Gopi, describing how

> "I continuously visited hospital, and they gave me Panadol and sent me home. By taking Panadol … the conditions worsened, and my lungs deteriorated. When I was not able to take the condition on the verge of knocking out of my lungs, I was getting cramps, and my fever was persistent, I continuously coughed for one night and a day."

Gopi implies that due to a lack of attention initially in the hospital, her condition worsened.

> "They scanned and told me that my lungs has damaged a lot … and due to pneumonia, your lungs has deteriorated further. They said we can't reverse it."

Gopi described that her lungs could not be treated initially due to a delay in care. This has a lifelong implication for her, deteriorating not only her physical but also her mental health.

These narratives illustrate that participants felt they could not connect with the healthcare providers, showing a lack of attention to individualised care. It highlights the participants felt less satisfaction and reduced trust, that there was limited understanding, and this hindered therapeutic relationships.

Theme 5: Lack of Affordability

Participants indicated that higher costs and exorbitant expenses related to specialist healthcare services significantly impede their ability to obtain necessary care, resulting in delays in seeking treatment and poor health outcomes. As individuals age, they

often face difficulties meeting their healthcare needs, necessitating more frequent access to care, especially specialist care, which currently in Aotearoa New Zealand can cost 300-500 NZD per visit. Financial constraints often force individuals to prioritise their urgent financial needs over crucial healthcare, which can worsen pre-existing health issues and potentially escalate into more serious health emergencies in the long run(Kanengoni-Nyatara et al., 2024).

Sub-theme 5.1: Increased GPs' fees

Increased GP consultation where highlighted as an added barrier for Fijian Indians seeking timely medical attention. Some participants stated that visiting a GP was unaffordable for low-income earners, as the increased cost is a financial burden. As a result of increased fees, participants occasionally postpone or avoid GP visits, which impacts their health and well-being.

Govind, who is on cholesterol medication, has to see a GP every time for the same prescription. He queried this, as follows:

> "I have to go to the doctor every three months, and they don't even get repeats of the other thing. When you're talking about a certain medication, like [for] cholesterol, they know they should be able to give me repeats. But they don't, I have to pay for each visit."

Govind implied that this is an unnecessary cost that can be avoided.

Prakash shared similar sentiments, stating:

> "I think the doctor's fee is a bit too much; before, it was 9 or 10 dollars, 12 dollars; now I have to pay 20 or 39 dollars."

Prakash perceived that the increase in GP fees is significant, making it unaffordable for many.

Ramesh added:

> "The whole system here has become more commercialised."

This showed his dissatisfaction with the cost of GP care.

Hari stated:

> "We always go to the doctor, like both of us are sick people, and we have to pay. It's a lot of cost for us, you see, don't include the transportation cost and other associated costs."

This highlights the difficulty Hari faces in overcoming the financial barrier to seeing his GP.

Gopi shared:

> "I am in problem from everywhere. We don't get any form of financial assistance from the government. All gets deducted."

Gopi explained that she and her husband were not eligible for any government pension despite having residence visas. They had to have been in Aotearoa, New Zealand, for over 10 years to be eligible for a pension. This impacts not only their physical health but also their overall health and well-being.

Gopi said,

> "We are not getting paid anything, and the government is not supporting us on anything, not even taxis. I complained, and they said I couldn't get a taxi fare since it's not 10 years yet, and my husband is still working. He is working since we have to survive; otherwise, how will we survive? Where else, when it comes to us, we don't even get a taxi to go to the hospital. I even complained and asked for it, but it fell on deaf ears. At least they can give us something for our medical needs."

This excerpt highlights Gopi and her family's dire situation in accessing the health services they need in a timely manner. The perceived lack of government support has created a financial burden, leading to poor health and well-being for the entire family.

Sub-theme 5.2: Need to prioritise daily survival over obtaining healthcare

Some participants reported having to prioritise their basic needs over their health.

Hari said:

> "I had to pay rent first, and if any money is left, I will see my GP."

Hari added that utility bills are much higher and very costly during winter. He said:

> "I don't use heaters at night, even if it's cold. It saves us some money."

This describes Hari's sacrifices and staying in a colder house to save money to meet everyday living needs.

Gopi raised similar concerns. She stated:

> "There is hardly any money left after paying rent, bills and groceries. My health is not my priority; feeding my family is."

She added,

> "I had to wait until I saved some money for seeing a doctor."

This illustrates how Gopi manages challenging financial situations and prioritises health over basic needs.

Kamla also had to sacrifice her health, as she stated:

> "I missed my physiotherapy appointments because it was costing me too much. I had to pay every time I saw them. My husband is a builder, and his van broke down. I had to save money and get the van repaired as he gets paid monthly, and he couldn't wait that long."

Kamla tried to normalise her pain so that she could help her husband get back to his job, getting his van fixed rather than prioritising her health.

Anand said he is not always in financial difficulties, but

> "I am more careful now on where and how much I have to spend. Sometimes, I will wait to see if my sickness gets better by waiting at home. Unless I get very sick, I try and avoid seeing the doctors."

Anand's action proves that he delays seeing doctors unless necessary. He tried to normalise the illness, which can lead to slow or no healing at all, and poor prognosis.

Prakash recalled an instance when he had backache:

> "I thought the pain will go away in a few days and took Panadol. I didn't want to go to the doctor, as they will think I come there too often, you know."

Prakash tried to normalise his pain by waiting at home and seeing if that improved, instead of seeing his GP.

Ramesh's statement below indicates that some older Fijian Indians use traditional (herbal) medicines.

> "I try some herbal medicines. When I was growing up, my parents taught me about this, and it's not as expensive as seeing a GP."

Ramesh's action amplifies that he delayed his treatments and sought home remedies while thinking of the cost of seeing a GP. This indicates a financial barrier to accessing GP care.

These examples amplify the fact that basic healthcare needs are not prioritised by older Fijian immigrants living in Aotearoa New Zealand. The participants had to delay seeking medical care due to financial hardship. Healthcare is not considered the most important factor when faced with financial burdens, which influence health-seeking behaviours among older Fijian immigrants.

This theme, related to higher costs and affordability, highlights that older Fijian Indians face substantial financial burdens when accessing healthcare. Increased GP fees led participants to delay or avoid seeking timely healthcare. The cost of living in Aotearoa New Zealand also hindered access to healthcare, and participants prioritised daily survival needs over healthcare.

4.4 Conclusion

The findings reveal how systemic barriers, including the poor cultural competency of health service professionals, racism, language and communication barriers, and inflexible service models, are associated with delays, long waits, staff shortages and high costs, and compound to disadvantage older Fijian Indian immigrants in accessing healthcare in Aotearoa New Zealand. The enablers were generally the reverse of the barriers, and implicit enablers included the development of a trusting patient-provider relationship and culturally responsive and culturally safe healthcare. This also included physician support and effective communication, greater cultural understanding of mental health to reduce stigma and encourage help-seeking.

Addressing these challenges requires targeted cultural training for healthcare providers, structural reforms to improve access, and the promotion of culturally safe and inclusive health services. These results are critically discussed in the following

chapter in relation to globally relevant literature, identifying novel and unique findings, similarities to and differences from other studies, and implications for healthcare access among older Fijian Indian immigrants living in Aotearoa New Zealand.

Chapter 5 Discussion

5.1 Introduction

This chapter reviews the study's key findings and critically examines each theme in relation to existing literature. The participants in this study are older Fijian Indians who migrated from Fiji to New Zealand. The impact of ageing and the process of migration and resettlement to a high-income country delivered benefits and opportunities for older Fijian Indians and their families, while also posing challenges to their health and well-being. The discussion includes the interpretation of findings, which are critically discussed and, in the context of the study's three research questions, compared and contrasted with the current global and local literature. The chapter also includes a consideration of the study's strengths and limitations, implications for health service delivery, the education of health professionals, and cultural safety policy, and recommendations for the future regarding access to healthcare for older Fijian Indian immigrants, as well as prospects for future research.

This study's main questions were:

1. What are the enablers of access to healthcare among older Fijian Indian immigrants, and how do these manifest?
2. What are the barriers, including systemic level and structural inequities, to accessing healthcare, and how do these manifest?
3. What strategic suggestions can enhance access to health services for older Fijian Indian immigrants?

The following discussion provides a summary of the findings, compares them with the existing literature, and outlines the implications of the current study's results.

5.2 Discussion

In summary, the findings of this study indicate that healthcare systems must prioritise integrating culturally safe patient-centred care and ongoing quality systems improvement as fundamental principles. The socio-ecological conceptual model, as referred to in chapter 2, served as a useful lens for framing these findings, highlighting

how healthcare access and experiences are shaped by interacting factors at the individual, interpersonal, organisational, and policy levels.

Figure 4 illustrates how the Social Ecological Context (SEC) and Availability, Accessibility, Acceptability and Quality (AAAQ) frameworks provide complementary perspectives for interpreting the five themes identified in this study. The SEC framework considers the influence of individual, interpersonal, community, and broader healthcare-system factors on healthcare access, while AAAQ provides a framework for understanding the availability, accessibility, acceptability, and quality of healthcare services.

Figure 4. The SEC and AAAQ frameworks are presented as complementary perspectives for interpreting the five themes.

Social Ecological Context (SEC) **Individual, interpersonal, community and healthcare-system influences**	**AAAQ Framework** **Availability, Accessibility, Acceptability and Quality**
↓	
Interpretation of the Five Themes **Frameworks used to interpret findings, not to generate themes**	
↓	
BARRIERS IDENTIFIED	**ENABLERS TO ACCESS**
1. Lack of trust from unprofessional behaviour	Respectful care and trusting relationships
2. Inadequate cultural awareness and consideration of ethnicity	Shared language and cultural understanding
3. Longer waiting times, including difficulty navigating services	Appointment and navigation support
4. Poor patient-centred care	Being listened to and individualised care
5. Lack of affordability of access to healthcare services	Affordable or subsidised healthcare

Participants' experiences showed that healthcare access was not only about the availability of services, but also whether services were affordable, culturally acceptable, linguistically accessible, and responsive to their needs. The socio-ecological conceptual framework further helped explain how access was shaped across multiple levels, including individual health beliefs, family support, community networks, healthcare provider interactions, and wider system factors such as cost, waiting times, and service navigation. Returning to both the socio-ecological conceptual framework and the AAAQ dimensions of healthcare access in the discussion strengthens the study's consistency and demonstrates how the findings connect to the conceptual foundation introduced earlier.

The discussion focuses on how each theme illustrates the barriers to and enablers of healthcare access for older Fijian Indian immigrants living in Aotearoa New Zealand, as well as participants' perspectives on culturally responsive care. The findings are then considered in relation to existing research to examine areas of convergence and divergence, and to identify the challenges that require attention to improve healthcare access.

5.2.1 Analysis of key findings

Ten older Fijian Indian immigrants participated in this study, all aged 57 years or older, comprising six males and four females. The participants were from different faith groups, including Christianity, Hinduism and Islam. The participants identified key barriers to accessing healthcare in Aotearoa New Zealand. Five major themes were identified: lack of trust resulting from experiences of unprofessional behaviour by healthcare providers; inadequate cultural awareness and inadequate considerations of ethnicity; longer waiting times; poor patient-centred care; and lack of affordability. These issues largely posed barriers and, in a few situations, enablers for older Fijian Indian immigrants' access to healthcare in numerous ways. Table 3, below, connects research questions 1 and 2 with the related themes that address each question, and summarises the main barriers to and enablers of healthcare access.

Table 3. Summary of Research Questions 1 and 2, and Related Themes

Research Question	Related Themes	Key Barriers/Enablers
1. What are the enablers of access to healthcare among older Fijian Indian immigrants, and how do these manifest?	Lack of trust resulting from experiences of unprofessional behaviour by healthcare providers	Respectful interactions with healthcare providers that helped establish and maintain trust.
	Inadequate cultural awareness and inadequate considerations of ethnicity	Shared language, cultural understanding and effective communication.
	Longer waiting times	Support with arranging appointments.
	Poor patient-centred care	Attentive healthcare providers, being listened to and individualised care.
	Lack of affordability of access to healthcare services	Access to subsidised GP care.
2. What are the barriers, including systemic level and structural inequities, to accessing healthcare, and how do these manifest?	Lack of trust resulting from experiences of unprofessional behaviour by healthcare providers	Loss of confidence, unprofessional attitudes, perceived disregard.
	Inadequate cultural awareness and inadequate considerations of ethnicity	Cultural misunderstandings, language barriers, perceived discrimination.
	Poor access and longer waiting times	Appointment delays, inflexible clinic hours, difficulty navigating healthcare services.
	Poor patient-centred care	Lack of genuine interest in participants Rushed consultations, limited individualised attention.
	Lack of affordability of access to healthcare services	Higher cost GP fees, competing financial demands.

Theme 1: Lack of trust resulting from experiences of unprofessional attitudes by healthcare providers

This subsection addresses research questions one and two in relation to the first major theme: the lack of trust resulting from experiences of unprofessional attitudes by healthcare providers. Three sub-themes are: *loss of confidence in healthcare providers stemming from inadequate healthcare services; poor professional attitudes and a lack of empathy; perceived disregard,* and *culturally insensitive communication regarding health concerns.* The theme demonstrated how the lack of respectful communication led to a loss of trust. It further highlighted that poor conduct, and the dismissal of participants' concerns directly influenced their willingness to seek or continue care, addressing research question two and identifying the barriers to accessing healthcare, specifically due to trust issues with healthcare providers and those providers' unprofessional behaviour.

Participants' concerns ranged from perceived poor quality of health services to professional conduct, such as a lack of empathy, which further undermined their health-seeking behaviour. Building trust is crucial in doctor–patient encounters, as it facilitates better communication, adherence to treatment plans, and ultimately enhanced patient outcomes (Ahmad & Wilkins, 2025). Distrust between patients and healthcare practitioners can significantly hinder therapeutic partnerships, thereby reducing the effectiveness of healthcare delivery. When trust is violated, patients may be less likely to seek ongoing medical attention, disclose specific health information, or follow treatment recommendations, all of which are critical for optimal health management (Haenssgen et al., 2024). Establishing trust requires a consistent, transparent, and truthful exchange of information, along with professional behaviours that demonstrate a commitment to the patient's welfare. Resolving these trust concerns is crucial to enhancing the overall quality and effectiveness of healthcare services (Henning et al., 2025). Similarly, Pillen et al. (2024) found that sub-Saharan African migrants in Norway reported experiences of discrimination, stereotyping, and cultural misunderstanding within healthcare settings. These experiences contributed to feelings of exclusion and reduced trust in healthcare services, influencing willingness to seek care and engage with providers. A systematic review by Mbanya et al. (2019) on ethnic minority population and access to healthcare had similar findings. This

review assessed the quality and safety of healthcare services provided to migrant ethnic patients.

In contrast to the barriers experienced by many participants, one participant described positive access to healthcare. As mentioned in chapter 4, while being attended by the "Indian doctor", Prakash said the doctor did a "good job in a proper manner, and he was a lovely man". The shared cultural background appeared to strengthen trust and facilitate communication, helping the participant feel more comfortable during the healthcare encounter. This finding suggests that it was not simply the healthcare professional's ethnicity that mattered, but their ability to understand the participant's cultural background, values, and communication needs. Feeling understood and respected appeared to encourage greater trust and engagement with healthcare services. Similar findings have been reported among migrant populations, where culturally responsive care and effective communication have been shown to strengthen trust and support access to healthcare(Reeve & Lavery, 2023).

Overall, findings support the conclusion that the ethnic minority community loses trust in healthcare providers due to the lack of targeted and responsive care being provided. Targeted, responsive care and respectful care can strengthen trust in healthcare services.

Theme 2: Inadequate cultural awareness and inadequate considerations of ethnicity

This sub-section addresses research questions one and two by identifying the enablers and barriers to accessing healthcare. The second theme of *Insufficient cultural awareness and inadequate considerations of ethnicity* has sub-themes of *poor cultural understanding, language and communication barriers,* and *ethnic prejudice and discrimination*. The study's findings indicate that the older Fijian immigrants interviewed, perceived that their care was not culturally appropriate and that no specific considerations were given to ethnicity. Examples included not understanding dietary patterns, such as preferring rice-based diets, not educating on the diabetes diet in relation to staple foods for Fijian Indians, and ignoring expressions of pain, such as disregarding reports of pain. A significant feature of these inadequate cultural considerations was a poor communication style and little or no attention to written

and spoken language support in the Fijian Hindi. Often, interpreters from other countries, such as India, were used, as Hari noted in Chapter 4; however, they did not use the Fijian Indian dialect and were unable to understand the participants' concerns.

Conversely, some participants described positive healthcare experiences when healthcare professionals understood their cultural background and lived experiences. As outlined in chapter 4, Gopi expressed "the Fijian Indian doctor understood me… I would prefer the doctor from my own background since they do understand us". A preference for a Fijian Indian doctor because she felt understood and believed they had a better appreciation of her cultural values and communication style. This finding suggests that participants valued healthcare professionals who recognised and responded to their cultural needs, rather than simply sharing the same ethnicity. Feeling culturally understood appeared to strengthen trust, improve communication, and enhance participants' confidence in engaging with healthcare services. Similar findings have been reported among migrant populations, where culturally responsive care has been associated with improved patient experiences, greater trust, and better engagement with healthcare services(Hodge et al., 2024; Reeve & Lavery, 2023).

Communication is the foundation for equitable healthcare; however, language differences continue to alienate migrant communities, especially those with a complicated socio-linguistic background. One of the participants' statements, "though the interpreter is there since it is English speaking, they put the interpreters from India who cannot relay the right message", suggests they could not get clear communication through the interpreter from the Indian continent, as continental Indians have more than 1900 dialects which are distinct from the Fijian Indian dialect Chauhan et al. (2020). This creates a considerable language barrier despite having trained interpreters. This finding aligns with a study conducted in Ghana, which found that the language barrier led to profound misunderstandings and miscommunication between patients and healthcare providers (Devy, 2014). Furthermore, untrained interpreters confused and eroded trust in the confidentiality of professional communications between Ghanaians and healthcare providers. A recent systematic review (Glover-Meni et al., 2024) on barriers and facilitators to residential aged care in Australia among older migrants reported comparable findings. Of the 14 included studies, all 14 cited the absence of a shared language as a barrier to accessing healthcare. Similarly,

another study in Australia (McGrath et al., 2022) found that language was a barrier to accessing healthcare among older Chinese migrants following the COVID-19 pandemic. This study also reported that older Chinese migrants would not seek medical assistance due to a lack of Chinese-speaking doctors. It further reported that patients would prefer to wait and self-manage at home, which could lead to deterioration in their health.

While sub-theme 2.2 outlines claims about barriers related to language and communication, a UK study by Xiao et al. (2023) supports the claim that using culturally appropriate language as outlined in chapter 4, facilitates understanding of the healthcare being provided and participants' engagement with healthcare, enabling them to respond to healthcare advice when needed. (Paudyal et al., 2025) claimed that using a tailored approach and incorporating participants' views resulted in the production of COVID-19-related health educational resources in participants' languages. By doing so, the study found that the educational resources enabled the older members of the ethnic minority community to understand the health information. It also reported improved communication with healthcare professionals and the effective use of healthcare services.

The lack of effective communication due to a language barrier can worsen health problems, increasing the likelihood of delayed diagnoses and treatments (Paudyal et al., 2025). Additionally, commonly experiencing disregard for the presenting health concerns by healthcare practitioners, stemming from poor communication, can lead to emotional distress and a sense of powerlessness, ultimately resulting in overall patient dissatisfaction and poorer health outcomes (Wallace et al., 2025).

Not only spoken language but also written health information were found to be barriers in the current study. The current study found that participants did not receive any written health information in their language. There was no written health information in the Fijian Hindi dialect in Aotearoa New Zealand. However, some information was available in Hindi, which were not ideal, but still important for the older members of the Fijian Indian and other ethnic minority communities (Wallace et al., 2025). This finding is similar to another qualitative study in Aotearoa New Zealand (Van Rosse et al., 2016), which explored Asian migrants' healthcare access and

engagement with primary care, showing that resources targeted at the migrant ethnic communities were hard to find, as these resources were not in the desired language of those communities, leading to users' frustration as they could not comprehend the resources. This study also found that primary health care websites were not user-friendly for the migrant community, making it difficult to navigate and understand the available healthcare resources.

The other issues identified by current study participants were that the healthcare providers did not provide sufficient information, explaining that the doctors would conduct the consultation, "but will not explain much." Participants' perception of a lack of attention or disregard from healthcare professionals appeared to significantly affect their psychological state and their ability to build trusting relationships, as seen in Chapter 4, thereby affecting the perceived efficacy of their medical treatment. Such findings mirror research (Xiang et al., 2023) highlighting how systemic biases often lead to the neglect of especially older migrants' healthcare needs. Similar concerns have been reported in studies of older migrants in other high-income countries. For example, research with older immigrant patients in Canada found that limited information-sharing and insufficient explanation from clinicians reduced patients' understanding of their health conditions and treatment, contributing to uncertainty and diminished trust in healthcare relationships (Li et al., 2021). Likewise, studies of older migrants in Australia have shown that when clinicians do not take time to explain diagnoses or care processes in culturally and linguistically appropriate ways, older migrants may perceive disregard or a lack of respect, which negatively affects engagement with services and continuity of care (Guruge et al., 2018).

Furthermore, there was a feeling of disappointment among the current study participants regarding how they were treated in their medical encounter with healthcare providers, as they described ethnic prejudice, discrimination and, at times, racism. For example, a participant stated, "Probably because I was an Indian, probably, and it was my skin colour." The perceived presence of ethnic bias in healthcare settings delivery can have a profound adverse effect on migrants, especially those of an older age, resulting in delays and hesitation in regard to accessing healthcare, and correspondingly longer-standing health outcome inequities when compared to the general population. Ethnic bias might appear as stereotyping, underestimating

symptoms, or ignoring culturally unique health conditions, leading to unfavourable health consequences. This perception underscores feelings of marginalisation and inequity experienced by the Fijian Indian community. Two reasonably recent integrative reviews (Renzaho et al., 2016; Ziersch et al., 2017) undertaken in Aotearoa New Zealand, exploring barriers and offering recommendations for equitable healthcare for the migrant refugee population, supported the above claims of ethnic prejudice and systemic racism in migrant service delivery. This review supported the claim of ethnic minorities experiencing race-related stigmatisation from healthcare providers.

The current study's participants also implied that the healthcare providers lacked cultural competence. Participants reported that some interactions did not meet their expectations. For example, one of the participants stated, as per Chapter 4, "They were not as understanding as our home people first. … I think they had a cultural problem." 'Home people' refers to the healthcare providers from Fiji.

An important key enabler was actually receiving culturally congruent care from an ethnic Indian health provider, and was reiterated in a comment from a participant, "The Indian doctor was also good", implying that the care they received from the Indian doctor was culturally appropriate. The participants emphasised the need for culturally appropriate care, as per Chapter 4, ensuring that they are respected and understood, and that they feel safe within the health system. This will also ensure better engagement with healthcare and reduce disparities for migrant ethnic communities. A qualitative study in Aotearoa New Zealand, recruited acute care clinical staff who cared for older adults of ethnically diverse backgrounds (Kanengoni-Nyatara et al., 2024). The study highlighted barriers to delivering safe, culturally responsive care from the staff perspective. It emphasised that the staff members felt frustrated by the lack of formal support from organisations. Another community study, based on district nursing care for culturally diverse older adults in the UK, highlighted the importance of culturally appropriate care (Bonus et al., 2025). That study concluded by urging broader discussion of issues related to culturally competent care, focusing on how the nursing profession can be competent in providing culturally appropriate care scores a range of ethnic populations, rather than on specific migrant groups. The current study concurs with previous research on the importance of

providing culturally appropriate care, highlighting patient-centred care, culturally congruent care, and the use of resources that reflect the needs of ethnically diverse groups.

The current study's participants described culturally concerning communication by healthcare professionals that limited the cultural accommodation of their health concerns and affected their accessibility and engagement experience as patients. Similar barriers were reported among the migrant population in Spain. A study in Catalonia (Reeve & Lavery, 2023) explored barriers to cultural competence from the perspectives of migrant women and healthcare providers. It was highlighted that inequities among migrant communities are persistent due to a lack of ethnic representation in the health workforce, suggesting that both pathways for training more ethnic-background health professionals and mainstream education in cultural competence and the representation of ethnic healthcare providers are necessary. This would serve to improve intercultural communication between the migrant community and healthcare providers.

Of note in the current study are reports that address research question one on enablers, from Fijian Indian participants, who felt better understood by a doctor who shared their ethnic background. Accordingly, participants felt respected and understood in their cultural context. These findings underscore the importance of a diverse, multicultural workforce that reflects population diversity and enables individuals to be understood and engaged with on their own terms, supporting Lurgain et al. (2024) claim that, ideally, migrants lived experiences are incorporated into patient care delivery services. Implementing such inclusive approaches that prioritise culturally safe and respectful care (Curtis et al., 2019) helps ensure that healthcare services are tailored to address the distinct needs of older individuals from the Fijian Indian community.

Participants in the current study alluded to ethnic prejudice and discrimination in their encounters with their healthcare providers. Many Fijian Indian participants reported that, on a number of occasions, they encountered racism stemming from their ethnic background while receiving healthcare services. For example, one participant described an experience when they felt targeted, and the care was potentially delayed

because of ethnicity. Participants in the current study also reported that their health concerns were not taken seriously because of their ethnic background. A participant commented that the healthcare providers do not care about patients from their ethnic background, stating, “They just don’t give a damn; they think if it were someone of their own or white people, then the story would have been different.” This raises concern about the presence of ethnic prejudice in the healthcare system in Aotearoa New Zealand and highlights a need for further mandatory cultural safety training of the healthcare providers. Similar findings were noted in a study done in Ontario, Canada, on Indigenous cultural safety, which identified discrimination and racism within the healthcare system (Lurgain et al., 2024). It highlighted multiple experiences of prejudice, injustice, and maltreatment against the Indigenous people. A study by Webb et al. (2023) suggests the need to incorporate cultural safety into health professional education and training, which can also help further develop cultural safety and healthcare providers' confidence in attending to the care of the ethnic migrant populations.

Participants in the present study described experiences of mistrust, perceived exclusion, and lack of culturally appropriate care within healthcare interactions. Similar patterns have been identified among older migrant populations internationally. A study in Finland, by Webb et al. (2023), investigated the lived experiences of older migrant women. The findings of the study show that the older migrant women faced structural racism and everyday microaggressions, generating mistrust particularly relating to exclusion and the lack of culturally appropriate care. Despite contextual differences, the current study and the study by KC et al. (2024) underscore the significance of recognising racism in healthcare facilities for the ageing migrant population and emphasise the need for culturally inclusive care. A recent scoping review KC et al. (2024), identified 23 papers that examined the experiences and accessibility of palliative treatment for older people from minority ethnic groups. These populations faced cultural disparities, linguistic challenges, health literacy issues, migration-related difficulties, and diminished trust in services and healthcare providers. The results of the review correspond closely with those of the current investigation.

Consistent with previous research (Aker et al., 2024), participants in the current study reported experiences of perceived ethnic discrimination, stereotyping, and a lack of understanding of their cultural and age-related needs. These experiences affected trust, communication, and their willingness to engage with healthcare services. Similar findings have been reported internationally among older migrant populations, where discrimination and culturally incongruent care have been associated with reduced satisfaction, poorer communication, and difficulties navigating healthcare systems (Guo et al., 2025; Wang et al., 2019; Xiao et al., 2023). The findings suggest that culturally responsive communication and an awareness of the diverse needs of older migrants are important aspects of quality healthcare. A comparable study in Australia on migrant women accessing healthcare supports training healthcare providers from the same ethnic groups. One of the study's primary outcomes strongly recommended co-designed, co-delivered staff training with members of the ethnic community group (Guo et al., 2025; Wang et al., 2019; Xiao et al., 2023). In Aotearoa New Zealand, culturally aware healthcare provision necessitates purposefully selecting new entry tertiary students from ethnic communities, such as Māori, Pacific and other migrant and refugee backgrounds for medical school (Rambaldini-Gooding et al., 2024) and for other healthcare professional education programmes, to ensure competence in providing care to various ethnic groups. This must also include respect for their religious beliefs, dietary preferences, end-of-life customs, and general healthy behaviours. These recommendations address research question 3 and are outlined in Chapter 5.

Theme 3: Longer Waiting Times and limited access to specialists

This sub-section addresses the theme of poor access and longer waiting times, which encompassed three sub-themes: *limited access to specialist services and inflexible access times*, *long waiting times and staff shortages*, and *logistical barriers in navigating health services*. It addresses research question 2, identifying key barriers related to poor accessibility and longer wait times, both for appointments and in waiting rooms. The findings indicated that patients faced long wait times to obtain specialist appointments, particularly from a GP and in acute care hospitals. The long wait times had a negative impact on their physical health and emotional well-being. This suggests that the participants experienced greater suffering and dissatisfaction.

Their physical well-being, often with a deterioration in their chronic health conditions, was not only affected by these delays, but they also experienced increased levels of anxiety and frustration, especially when it came to managing chronic health conditions and the need to get back to work or take care of their families. The sense of neglect of Fijian Indian patients in the Aotearoa New Zealand healthcare system is highlighted, suggesting that these patients' concerns might not be addressed with the same urgency as those of other groups, particularly white individuals.

Several studies in Australia examining the experiences of lengthy wait times for allied primary health care appointments found that participants reported experiencing frustration and worry (Crampton et al., 2018; Curtis et al., 2015; Curtis et al., 2012). This acted as a barrier to timely access to healthcare. Another study conducted in Australia found non-English speaking migrant participants were disadvantaged and had to wait longer for admission in the emergency department (Parry et al., 2024). Similarly, a more recent study conducted in Australia on migrants found that participants experienced longer wait times to access healthcare and had difficulty getting appointments (Wong-Castillo et al., 2025). These findings suggest that migrants encounter numerous additional and complex logistical barriers to accessing healthcare, which should be addressed at the governmental level. Another study done in Australia on waiting times for Indigenous women to see doctors after traumatic brain injury highlighted that treatment delays were perceived as disrespect and discrimination that caused prolonged pain and suffering (Manju et al., 2021). That finding aligns with the present study, in which participants reported similar dissatisfaction, unease, and pain due to delayed and restricted access to healthcare. This needs improvement, particularly to alleviate the suffering of older migrant patients. Reduced wait times can lead to better outcomes, thereby alleviating pain, suffering, and dissatisfaction (Fitts & Soldatic, 2024).

In addition to the longer wait times for initial GP care, current study participants reported waiting even longer for specialist appointments. As identified by Kamla in chapter 4, she had to wait; she could not get a referral for her thyroid condition, which led to deterioration in her condition. Delayed specialists' appointments caused significant stress that led to their conditions getting worse. While waiting for the appointment, there was no support provided, which led to even more anxiety. A

mixed-methods study (Harding et al., 2024) conducted in Toronto, Canada, examined the socio-cultural and economic barriers to accessing Canadian healthcare, which are linked to longer wait times, particularly for specialist, surgical, and GP appointments. The participants described delays in obtaining access and in receiving timely treatment. Another study (Czukar et al., 2025) was conducted among older Chinese migrants in the UK to explore their perspectives on the delivery of primary health care services. This study identified longer wait times as one of the issues, a finding similar to that of the current study. A study on migrants in Regina, Saskatchewan, Canada, reported similar findings (Guo et al., 2025). That study highlighted barriers to accessing healthcare, particularly in obtaining specialist appointments. This aligns with the current study's findings, which call for equitable access to specialist care for migrants. All patients, in particular older patients, must receive timely healthcare, as delay has numerous consequences, including frustration due to waiting, depression and anxiety, worsening of patients' conditions, and poor engagement with healthcare services. While some participants found that the appointment system was beneficial, it had its own issues, like not being user-friendly, and the participants were unable to get timely appointments for acute illness, as some of the GPs' wait times could be weeks, as outlined in Chapter 4.

Theme 4: Poor patient-centred care

The following sub-section addresses the theme of poor patient-centred care, with sub-themes being *feeling rushed during appointments* and a *lack of individualised attention to patients' needs*. It addresses research question two by identifying barriers to patient-centred care. This study revealed that participants felt their care was rushed and lacked individualised attention. As evidenced in the current study's narratives, participants perceived that healthcare providers did not provide the detailed, holistic care they expected and implied that their condition worsened due to a lack of attention. They felt the care was rushed, with one participant saying, "As soon as it was 15 minutes, they will start standing up and, you know, sort of indicating that you must your time is up, you better quit"; and they felt the care lacked attention to their individual needs, with another participant commenting, "I think the medical system problem needs to understand the needs of other requirements of people coming from Fiji."

An integrative review (Pandey et al., 2022) reviewed 27 articles on transitional care for older ethnic minority patients. This review identified findings that closely resonate with the current research. The outcomes of the review highlighted the unmet needs of older ethnic minority people, highlighting the significance of providing culturally appropriate patient-centred transitional care between hospital and home. These findings also suggest that the healthcare experiences of minority ethnic groups differed, to some extent, from those of the host population, indicating unmet healthcare needs of the older migrants.

Participants in the present study emphasised the importance of being listened to, respected, and understood in healthcare interactions, highlighting that culturally attuned, person-centred engagement influenced their comfort and trust in care. These accounts suggest that recognising patients' cultural backgrounds and individual contexts is central to effective healthcare relationships for older Fijian Indian migrants. A study conducted in southwest England with residents in aged care homes (Dolu et al., 2023) highlighted the importance of incorporating patient-centred care. It revealed that navigating cultural backgrounds requires a strong person-centred approach to care. It enables working in partnership with the patients, facilitating mutual respect and better patient outcomes. Another study in Sweden, which incorporated patient-centred care, provided valuable insights that demonstrated that respectful, person-centred care was strengthened when residents were recognised as active partners in their own care rather than passive recipients of services. By valuing residents' preferences, encouraging their involvement in care decisions, and fostering collaborative relationships with families and healthcare professionals, care was experienced as more respectful, responsive, and individualised (Hodge et al., 2024). A study in Toronto, Canada (Klysing et al., 2025), on the experiences of migrant women regarding physician behaviours to enhance patient-centred care, highlighted findings similar to those of the current study. It revealed that physicians failed to listen to migrant women's concerns and did not allow time for explanations, nor did they allow time to ask questions. The physicians failed to understand the women's concerns, leading them to avoid seeking healthcare.

Notably, participants did not describe examples of enablers for patient-centred care. Instead, their accounts consistently reflected the absence of individualised, respectful,

and collaborative care. This highlights patient-centred care as an important area for improvement, rather than as an identified enabler in the present study.

To advance patient-centred practices, healthcare organisations should consider adopting strategies such as educating providers in cultural proficiency, enabling longer consultation times for people whose first language is not English, particularly for older migrants with complex health needs, enhancing communication skills, and involving patients and their families in care planning and decision-making. Incorporating patient feedback systems to evaluate and enhance treatment delivery consistently helps provide a more adaptable healthcare system.

Theme 5: Lack of affordability of healthcare services

This sub-section examines the theme of lack of affordability of access to healthcare services, with sub-themes being *increasing GPs' fees* and the *need to prioritise daily survival over obtaining healthcare* due to financial constraints. It answers research question 2 by identifying how higher costs and affordability barriers prevent older Fijian Indian immigrants from accessing healthcare. Participants felt that the cost of accessing GP care had increased steadily, prompting them to consider whether to seek care or delay it. The increased cost of seeing a GP and the cost of living in Aotearoa New Zealand are highlighted when patients choose to prioritise their basic needs over healthcare. One participant said, "I think the doctor's fee is a bit too much," and another said, "My health is not my priority; feeding my family is," as reported in Chapter 4. These statements suggest the dire cost of living for many New Zealanders, particularly Fijian Indian immigrants, who are prioritising basic needs over healthcare due to increased costs. A mixed-methods systematic review (Gagliardi et al., 2020), among older Chinese migrants living in Toronto, Canada, accessing healthcare, they found concerns about cost similar to those in the current study.

A recent cohort study in Aotearoa New Zealand (Guo et al., 2025) investigating unmet needs in primary health care that led to inpatient hospitalisation found that prohibitive costs were a barrier to accessing healthcare, especially for younger adults, females, and the Māori population. While consultation fees vary between GP practices, they further hinder access to healthcare, as demonstrated in (Pledger et al., 2024) study, a finding that aligns with the current research.

Participants in the current study described how financial constraints shaped their decisions about seeking healthcare, particularly when considering service costs and affordability. Although information on participants' income sources was not formally collected, these accounts reflect the broader financial realities of many older adults in Aotearoa New Zealand who rely primarily on superannuation income, a unique, limited, universal Aotearoa New Zealand pension scheme to 65 years old plus, which is below the poverty level. Living on a limited, fixed income has been identified in several studies as a structural factor influencing healthcare affordability among older populations, aligning with the financial barriers described by participants in this study. A study done in West Iran exploring barriers to healthcare and socio-economic inequality, Pledger and Cumming (2024) highlighted that the participants could not access mental health care due to poor socio-economic status. This included the prohibitive cost of health services and transportation; hence, the study reported, health outcomes were poor. Similar outcomes were observed in a study (Meribe et al., 2025) in Australia, where researchers explored the barriers to mental health for African migrants, revealing that one of the factors contributing to these needs was high healthcare costs and limited access to healthcare due to affordability constraints. In line with a previous study, another study in the Midwestern United States (Joo & Lee, 2016) examined barriers and facilitators of diabetes management with elderly Korean immigrants. The research findings revealed that the participants, despite being on social security benefits, felt the high cost of type 2 diabetes care and management. A systematic review (Li et al., 2021) on access to healthcare identified 7 studies (unclear which countries these studies were conducted in) with similar findings, suggesting that migrants faced healthcare access issues related to costs. All the above studies resonate with the findings of the current research, as older Fijian immigrants faced similar healthcare barriers.

The thematic findings from the current study indicate that financial constraints related to healthcare costs, GPs and specialists, as well as the high cost of living, influence healthcare access for older Fijian Indian migrants. Improving affordability within primary and community healthcare services, including reduced co-payments or targeted subsidies for older adults on limited income, may help mitigate cost-related barriers and support equitable access. Approaches that consider fixed-income older

populations have been identified as effective in improving healthcare affordability and utilisation (Galanis et al., 2022).

Summary

This section discussed the findings in relation to the existing literature and explored the healthcare access experiences of older Fijian Indian immigrants in Aotearoa New Zealand.

A key finding was the central and enabling role of establishing trust in shaping healthcare experiences. Respectful communication, active listening, continuity of care, and positive interactions with healthcare providers were identified as important enablers that encouraged engagement with health services. Conversely, experiences of hurried consultations, perceived unprofessional behaviour, and limited provider engagement contributed to mistrust and reduced confidence in healthcare services. Trust was closely linked to participants' perceptions of being valued, heard, and respected within healthcare encounters.

Cultural alignment also emerged as an important enabling factor influencing healthcare access. Participants valued healthcare providers who demonstrated cultural awareness, respect for the participants' beliefs and practices, and an understanding of the unique migration and settlement experiences of older Fijian Indian communities. In contrast, insufficient cultural awareness and inadequate consideration of ethnic-specific needs created barriers to meaningful engagement with healthcare services and affected the acceptability of care.

Organisational and structural factors further influenced access to healthcare. Long waiting times for GP appointments, specialist consultations, and emergency department services were commonly reported as barriers to timely access to care. Affordability was another significant concern, with healthcare costs creating additional challenges for some participants despite the availability of publicly funded services. Participants also highlighted the importance of patient-centred care, expressing a preference for healthcare interactions that demonstrated empathy, genuine interest, and responsiveness to their individual needs.

Overall, the findings indicate that improving healthcare access for older Fijian Indian immigrants requires attention not only to service availability but also to the quality, acceptability, and cultural representativeness and responsiveness of care. This discussion highlights the need for healthcare systems and providers to strengthen culturally responsive practices, foster trusting relationships, reduce barriers to accessing care, and deliver person-centred care that is timely and affordable, which recognises the diverse experiences and needs of ageing migrant populations in Aotearoa New Zealand.

5.3 Implications and Conclusion

This section reflects on the strengths and limitations of the study and considers implications for culturally responsive healthcare practice and policy. Recommendations arising from the current research are discussed, including the contribution of this novel finding to knowledge generation, and its significance for improving equitable healthcare access for older Fijian Indian communities in Aotearoa New Zealand, followed by suggestions for future research on older migrant populations' healthcare access. To conclude the thesis, a reflection on my research journey is added, along with a conclusion and final remarks.

5.3.1 Strengths

A key strength of this study is its novel, culturally specific examination of healthcare access among older Fijian Indian migrants in Aotearoa New Zealand. This population remains under-represented in health research and healthcare delivery services despite its population growth and ageing profile. The qualitative design enabled the gathering of rich, in-depth accounts of participants lived experiences, foregrounding older Fijian Indian voices that are rarely captured in mainstream health research. Conducting interviews in participants' preferred languages and dialects further enhanced cultural safety, depth of expression, and relational trust during data collection.

Another strength lies in the shared cultural and linguistic background of the participants and me as the researcher, which facilitated community access, rapport, and a nuanced understanding of culturally embedded meanings. My insider positioning helped participants feel comfortable discussing sensitive experiences and strengthened the data's authenticity. I facilitated participants' comfort in discussing

sensitive experiences, thereby enhancing the authenticity of the data. Furthermore, being aware of my positionality and potential for bias by critically reflecting on my background and maintaining an ongoing awareness of our shared cultural background helped limit biases and minimise over-familiar interpretation, thereby supporting analytic credibility. Ongoing reflexivity, as outlined in Chapter 3, helped me become aware of my background and how it could shape interpretation and analysis, and reduced the risk of over-familiarisation or misinterpretation of the data. Hence, reflexive engagement with my positionality strengthened the credibility of the research.

5.3.2 Limitations

Several limitations should also be considered. Participants were recruited only from the Auckland region, where the majority of Fijian Indians in Aotearoa New Zealand reside; therefore, the findings may not reflect the experiences of those living in smaller regional or rural areas, where healthcare access structures differ. The study focused specifically on migrants aged 55 years and over and thus does not capture the perspectives of younger Fijian Indian migrants, whose healthcare expectations and ageing trajectories may differ. While participants discussed accessibility experiences across primary and acute care, the study did not examine a single service setting in depth, such as access to clinics or emergency departments; future research could explore specific healthcare contexts, such as community or social care, to provide more detailed system-level insight.

Although participants' private health insurance information was collected on the data collection sheet, the interviews did not explore this issue in depth. Consequently, the study was unable to examine how participants used private health insurance, the extent to which it influenced healthcare choices, or whether it affected access to specialist services and waiting times. Further exploration of insurance use may have provided a richer understanding of the financial and structural factors shaping healthcare access among older Fijian Indian migrants.

The sample size was 10 participants, although data saturation was achieved earlier in the data collection process, which meant the study met the time and budget requirements for a DHSc study with deep emic data representation. However, 10

participants may be considered a small sample size and may yield less transferable results; therefore, future research can focus on a larger sample, possibly using a grounded theory approach or a multiple-interview-phase over-time design. Furthermore, the participants may have had different lengths of residency in Aotearoa New Zealand, which could have shaped their familiarity with the health system and financial acumen, leading to experiences that differed from others'. Living for a longer period in Aotearoa New Zealand could have potentially enabled them to understand health services better and may perhaps have given them more confidence in accessing healthcare.

As the study focused on a single culturally specific migrant group (Fijian Indians), the findings may not generalise to other older migrant populations, whether in Aotearoa New Zealand or elsewhere. However, they may offer transferable insights for understanding healthcare access among culturally diverse minority ageing communities in similar high-resource health system contexts.

Older Fijian Indian migrants are shaped not only by ethnicity, but also by a particular migration history, including movement from Fiji to Aotearoa New Zealand rather than direct migration from India. Their healthcare experiences may reflect a combination of Indian cultural values, Fiji-based lived experiences, and settlement experiences in Aotearoa New Zealand. Language use, family roles, religious or cultural expectations, and help-seeking practices may differ from those of other migrant groups. Their views about ageing, illness, family support, and formal healthcare may be influenced by intergenerational expectations and culturally shaped understandings of care. Other Indian subgroups, Pacific groups, or non-migrant older adults may not share these layered experiences. Therefore, the findings should be understood as reflecting the specific socio-cultural and migration context of older Fijian Indian immigrants rather than migrant populations more broadly. This population may occupy a distinct position at the intersection of ageing, migration, ethnicity, and cultural identity, shaping healthcare access in ways that may not be fully comparable to those of other groups.

5.3.3 Recommendations

Based on the study’s findings, some key recommendations can be made to address the identified barriers to and support the identified enablers of healthcare access. The

research findings inform recommendations on health services, health workforce education, health professional training strategies, and policy adaptation to reflect the healthcare access and engagement needs of migrant ethnic communities. The recommendations presented in this chapter recognise that improving healthcare access requires a coordinated response across macro, meso, and micro levels of the healthcare system.

New Zealand's health policies (macro level)

The research findings provide a basis for health and ethnic community-led policy amendments to strengthen culturally appropriate and accessible healthcare for older Fijian Indians.

Firstly, Aotearoa New Zealand has established an important legislative and policy foundation for promoting equitable access to healthcare. The Pae Ora (Healthy Futures) Act 2022 recognises the importance of improving health outcomes, reducing health inequities and ensuring that healthcare services respond to the needs of different population groups. Its health sector principles emphasise equitable access, culturally safe and responsive services, and the involvement of communities in decisions affecting their health. Similarly, the New Zealand Health Strategy (2023) supports a more people-centred health system that recognises the diverse needs of individuals, whānau and communities. These commitments provide a positive foundation for improving healthcare access, while recognising the particular obligations to Māori under Te Tiriti o Waitangi. However, the experiences shared by participants in this study suggest that challenges remain in translating these principles into everyday healthcare practice. The following recommendations therefore build on existing legislative and policy commitments, with particular attention to improving communication, cultural responsiveness, affordability and the experiences of older Fijian Indian immigrants accessing healthcare.

Secondly, New Zealand's healthcare policies must be updated to reflect the needs of the rapidly increasing multi-ethnic population living here. Policies must include all races, genders, and ages. The one-size-fits-all approach needs thorough scrutiny and a shift toward equity-focused frameworks, including those for migrant groups. This will promote universalism and avoid structural racism (KC et al., 2024).

The third policy aspect to address is the New Zealand Health Strategy (2023) (Ruscitti et al., 2024). The New Zealand Health Strategy explicitly refers to improving health equity for "diverse communities" and groups experiencing poorer outcomes. This policy should be more specific, focusing on the ethnic groups of older migrants rather than treating ethnic diversity as an undifferentiated category. Naming ageing migrant communities will direct healthcare in equity planning, service design, and monitoring.

Services have argued that Asian and ethnic minority populations should be more explicitly named within legislation and national strategies because they are often grouped under 'other populations. Current health reforms increasingly use ethnicity categories, including Māori, Pacific, Asian, and MELAA (Middle Eastern, Latin American, and African) populations, to plan and monitor equity outcomes. However, these categories could be further adapted by ensuring that specific communities, such as older Fijian Indians, are recognised in local health needs assessments, service planning, and culturally responsive models of care.

The fifth policy area to consider is the Government Policy Statement on Health 2024–2027 (Minister of Health, 2024). This policy states the expectations for Health New Zealand in shaping the health plan. It needs to be more specific regarding equity and access, distinguishing populations beyond broad ethnic groups, so that the unmet needs of older migrants are not hidden within larger populations. Migrant-sensitive indicators, including language needs, timely access, use of interpreters, navigation support, and long-term care, should be embedded in performance frameworks to better address the added complexity of older migrant populations.

The Te Whatu Ora Health New Zealand's planning and performance of Te Pae Tata, the New Zealand Health Plan (Health New Zealand | Te Whatu Ora, 2022), is responsible for developing strategies and government priorities. This should include migrant-specific and age-sensitive indicators in implementation and monitoring, rather than keeping indicators broad. These indicators can measure issues identified in the current research, such as culturally responsive communication, language barriers, waiting times to access healthcare, and transport barriers.

While Aotearoa New Zealand does not currently have a dedicated national health policy specifically for migrants, migrant health is addressed within broader health and

settlement policies: "Pae Ora (Healthy Futures) Act 2022" (2022), the *New Zealand Health Strategy (Minister of Health, 2023)*, the New Zealand Migrant Settlement and Integration Strategy (Immigration New Zealand, 2023) and various refugee and ethnic community health initiatives. This study does not advocate replacing existing policies; rather, it suggests strengthening current strategies by making migrant populations more explicit in planning, service delivery, and performance measurement. Future policy development could also adopt co-design approaches that actively involve older migrants, families, communities, and healthcare providers to ensure services are responsive to their cultural values and lived experiences.

Clinical practice (meso and micro levels)

The findings of this study highlight the need for reforms in the delivery of clinical care and in the quality of interpersonal engagement, with changes required at both organisational and patient-facing levels. To strengthen clinical practice engagement for older Fijian Indian migrants and, by extension, other ageing ethnic migrant groups facing similar barriers to access, healthcare organisations in Aotearoa New Zealand need to adopt service models that are more culturally responsive, linguistically accessible, and practically supportive of how people move through the health system. This recommendation is consistent with the current *New Zealand Health Strategy*, 2023 (Minister of Health, 2023), which emphasises a health system that is more people-centred, locally responsive, equitable, and better able to meet the needs of diverse communities, and with the Government Policy Statement on Health 2024–2027*(Minister of Health, 2024)*, which expects timely access to quality care and services that are clinically and culturally appropriate.

At the meso level, one of the most important clinical practice implications is the need to improve ethnic care navigation and access support. The present study showed that access barriers did not arise only at the point of consultation; they also occurred before and between encounters, particularly when participants were trying to make appointments, understand referrals, respond to treatment advice, or navigate between primary care, specialist services, and community support. For older migrant patients, especially those with limited confidence in English or limited familiarity with the Aotearoa New Zealand health system, these steps can be difficult to navigate independently. Current Ministry advice (Health Quality & Safety Commission, 2023) on

the future direction of primary and community healthcare recognises that the system needs to offer people care when, how, and where they need it, and that services should be designed around the needs of local communities rather than relying on standardised, one-size-fits-all models. Against that background, a practical recommendation is that primary care and community services should develop more explicit culturally and linguistically targeted navigation support for older migrant patients.

One way to operationalise this would be to introduce culturally appropriate community health navigator roles for ethnic migrant communities, including the Fijian Indian population. While some groups in Aotearoa New Zealand are supported through navigator or liaison-style initiatives (Ministry of Health, 2020), equivalent roles are not consistently available for the Fijian Indian community. Community health navigators with cultural and linguistic familiarity could assist older adults in understanding healthcare pathways, clarifying referral processes, preparing for appointments, interpreting health information, and communicating more confidently with providers. Such roles could also reduce over-reliance on family members for informal interpreting and system navigation. In practice, these roles could be embedded within local networks, general practices serving high-migrant-density communities, community providers, or NGOs that already work with ethnic minority populations. A navigator model would not replace clinicians, but it could make care more accessible by reducing the everyday system complexity that many participants in this study experienced. This aligns with the broader policy direction toward more integrated, community-linked, locally tailored primary care and services.

Closely related to navigation support is the need for more systematic interpreter access and language-responsive communication. The healthcare system, across both acute and primary care, should continue to support and recruit diverse, multilingual staff, including receptionists, interpreters, nurses, allied health professionals, and clinicians. This will improve communication, trust, cultural understanding, and the navigation of services for older migrant patients with limited English proficiency or unfamiliarity with the Aotearoa New Zealand healthcare system. However, recruitment alone is not enough. Interpreter access should be treated as a routine component of safe care rather than an optional add-on, and services caring for large migrant

populations should have clearer pathways to obtaining trained interpreters in a timely manner. For older Fijian Indian patients, providers should also consider offering written health information in Fijian Hindi where appropriate, particularly for appointments, medication instructions, referrals, and follow-up advice. While not every consultation can be language-concordant, services can still reduce communication barriers by combining multilingual staffing, access to formal interpreters, translated resources, and more deliberate checks of patient understanding. This recommendation is strongly supported by current policy emphasis on culturally appropriate care and by the Health Quality & Safety Commission's guidance (Hayes, 2016; Health Quality & Safety Commission, 2016), which stresses that quality care must acknowledge and support each person's values, beliefs, and worldviews.

A second area of clinical practice reform concerns organisational service delivery, particularly regarding waiting times and limited access to appointments. Participants in the current study highlighted longer wait times and difficulties obtaining care when it was needed. Timeliness should therefore be treated as a core dimension of healthcare access, not simply as a matter of convenience. To enhance access and reduce wait times, primary care services should consider extending GP hours to include weekends and evenings, improving appointment availability processes, and reviewing whether their current booking systems work effectively for older patients who may rely on family assistance, phone-based communication, or transport coordination. In clinics serving high-migrant-density populations, lean-based strategies such as improved care pathways, standardised triage protocols, and bottleneck reviews may help reduce delays in assessment and follow-up. These approaches are particularly important when delayed access leads people to defer care until problems worsen or to seek help through acute services instead. The current Ministry briefing on the direction of primary and community healthcare (Health Quality & Safety Commission, 2016) explicitly notes the need for more accessible, community-focused services and a stronger emphasis on timely access in primary care, providing policy support for these service-level changes.

Alongside changes to appointment systems, organisations should strengthen the routine monitoring of wait times, access barriers, and patient satisfaction.

Incorporating patient feedback systems to evaluate and enhance treatment delivery consistently can help create a more adaptable healthcare system. In Aotearoa New Zealand, this recommendation is particularly relevant because Te Tāhū Hauora Health Quality & Safety Commission already runs national patient experience programmes and identifies patient experience as a useful quality indicator. The Health Quality & Safety Commission states that better patient experiences are associated with being listened to, treated respectfully, and being more likely to follow advice and engage with follow-up care. For older Fijian Indian patients, and for other ethnic migrant groups, services should not rely solely on generic patient satisfaction reporting. Instead, they should seek more targeted feedback on language accessibility, communication clarity, waiting times, trust, and continuity of care. Where feasible, local service evaluation data should be reviewed by ethnicity, age, and language needs so that broader categories do not obscure problems experienced by older migrant patients. This would give patient feedback a stronger quality-improvement function rather than treating it as a passive reporting exercise.

A further clinical practice priority is workforce responsiveness. The healthcare system should continue to support, recruit, and train multilingual and ethnically diverse staff across frontline and clinical roles, but this needs to be planned more intentionally. In services that care for high proportions of migrant patients, bilingual workforce pathways could be developed across reception, navigation, nursing, allied health, and clinical teams. This is not simply about matching the patient's ethnicity with the practitioner's; rather, it is about improving communication, reducing anxiety, and creating services in which older migrants are more likely to feel understood and respected, and to understand and navigate services. Health organisations should therefore consider how recruitment, retention, mentoring, and role development can build a workforce that reflects the communities they serve, especially in Auckland, a super-diverse city. This idea also aligns with the Health Quality & Safety Commission's (Ministry of Health, 2020) consumer engagement quality and safety framework, which links equitable representation and co-design to stronger service delivery and safer care.

Health promotion education programmes for older migrants are also recommended. Service improvement initiatives should be co-designed and co-delivered with relevant

stakeholders, including members of the Fijian Indian community. In addition, staff from diverse ethnic backgrounds within Aotearoa New Zealand's health services can help make health promotion educational materials and service processes more culturally responsive. In clinical practice, this means that healthcare organisations should not make assumptions about what ethnic migrant communities need without involving them in service planning, patient information development, and quality improvement. Leadership roles within the Fijian Indian community are particularly important here. Identifying respected community leaders may support the development of bilingual resources, promote culturally grounded health literacy initiatives, and improve the relevance of care navigation and communication strategies. Current Health Quality & Safety Commission guidance on consumer and whānau engagement supports this direction by treating involvement in service delivery, policy, and governance as a marker of quality and safety rather than an optional extra.

At the micro level, the current study's findings point strongly to the importance of trust-building, respectful communication, and continuity of care. One of the earliest themes to emerge from this study was the lack of trust resulting from perceived unprofessional behaviour by healthcare providers. This is a significant practice issue because trust influences whether patients feel confident returning for care, sharing sensitive concerns, following treatment plans, and seeking help early rather than late. To enhance trust, healthcare services in Aotearoa New Zealand must be delivered more professionally by demonstrating empathy and genuinely addressing patients' concerns. Essential strategies include patient-centred communication, empathetic and responsive listening, transparent, culturally safe communication about diagnoses and treatment, and meaningful patient involvement in care planning and decision-making. These recommendations are not merely interpersonal ideals. They are consistent with the current Aotearoa New Zealand policy (Health Quality & Safety Commission, 2014), which frames care as people-centred and appropriate to patient needs, and aligns with the Health Quality & Safety Commission's position that patient experience improves when people are listened to and treated with respect.

For older Fijian Indian patients, trust in health services may also be strengthened when healthcare professionals recognise the relevance of family relationships, migration

experiences, and culturally shaped expectations of care. This does not mean stereotyping patients by culture. Rather, it means that clinicians should actively explore who should be involved in discussions, whether the patient would like family support present, and whether cultural or language factors affect understanding. Encouraging patient involvement and engagement in decision-making can strengthen the therapeutic relationship and cultivate a sense of value and respect among patients. Strengthening continuity of care is also likely to be important. Seeing the same clinician over time may foster familiarity, rapport, and confidence, particularly for patients who have previously felt dismissed or misunderstood. In this sense, continuity is not only an organisational issue; it is also a relational intervention that may help repair distrust and improve ongoing engagement with care.

Overall, the clinical practice recommendations arising from this study suggest that improving healthcare access for older Fijian Indian migrants requires more than isolated cultural training or general statements about diversity. What is needed is a dedicated coordinated response across care navigation, language access, workforce planning, patient feedback, waiting-time reduction, community partnership, and trust-building at the clinical encounter. Current Aotearoa New Zealand policy already provides a useful framework for this through its emphasis on equitable, people-centred, culturally appropriate, and locally responsive care. However, these policy intentions need to be translated more explicitly into clinical service design and everyday professional practice for older migrant groups whose needs can otherwise remain insufficiently visible. The recommendations outlined here are therefore relevant not only to older Fijian Indian migrants but also to other ageing ethnic migrant populations who experience overlapping barriers related to language, cultural expectations, trust, system complexity, and timely access to care.

Education for health professionals, undergraduate, postgraduate, and continuing professional development (meso and micro levels)

The findings of this study suggest that improving healthcare access for older Fijian Indian migrants cannot be achieved solely through service delivery reform. Educational reform is also required to better prepare current and future healthcare professionals to work with culturally diverse ageing populations whose experiences of health, illness, communication, family support, and healthcare systems may differ from dominant

assumptions in practice. A stronger educational response is particularly important because the barriers identified in this study—limited trust, perceived unprofessional behaviour, inadequate communication, cultural misunderstanding, and uncertainty in navigating services—are not only system issues; they are also workforce capability issues. Current Aotearoa New Zealand policy already supports this direction. The New Zealand Health Strategy, 2023 (Minister of Health, 2023) emphasises the need for a culturally responsive workforce and recognises that inconsistent cultural responsiveness creates barriers to equitable, high-quality care. In addition, the Health Workforce Strategic Framework (Ministry of Health, 2023) identifies education and training as a central lever to address system challenges and strengthen workforce capability. Cultural safety is already embedded within nursing education and practice through the Nursing Council of New Zealand's standards and the recently introduced Pou framework (Health Quality & Safety Commission, 2014; Manatū Hauora Ministry of Health, 2023), which organises nursing competence into six interconnected domains that promote culturally safe, person-centred, relationship-focused, and equitable nursing practice. It emphasises culturally safe practice, critical reflection, partnership, equity, and responsiveness to diverse populations. The findings of this study suggest that these principles can be further strengthened by paying greater attention to the experiences of culturally diverse older migrant populations, particularly communication, trust, family involvement, and health literacy.

Undergraduate education

At the undergraduate level, cultural safety education related to migrant health should be more explicitly integrated across health professional programmes such as medicine and nursing in Aotearoa New Zealand. Undergraduate preparation needs to go beyond generic diversity content and include a stronger understanding of migration contexts, culturally grounded health beliefs, language-related barriers, family roles in care, and culturally responsive communication. This would involve students in nursing, medicine, physiotherapy, medical pharmacy, and allied health programmes engaging in structured learning about how ageing, migration, ethnicity, and language intersect to shape healthcare access and experience. This is not simply an added topic; it is a necessary extension of the wider educational commitment to cultural safety and equitable care. The Nursing Council of New Zealand (2026) updated cultural safety

guidance reinforces that cultural safety is integral to nursing education and practice, while the Medical Council of New Zealand (2021) requires doctors to reflect on how their own views and biases affect clinical interactions and patient care.

A clinical practical-based recommendation is that undergraduate programmes should incorporate culturally centred and responsive learning activities that move students from abstract awareness to applied capability. This could include case-based learning focused on older migrant patients, simulated consultations involving interpreters or family-supported communication, and reflective assessment tasks on cultural assumptions, power imbalances, and communication breakdown. For older Fijian Indian populations, examples could include scenarios involving language mediation, culturally shaped expectations of respect, differing understandings of illness and treatment, and the role of family in decision-making. Such teaching would not be intended to essentialise Fijian Indian patients or other ethnic groups, but rather to help students develop the skills to ask better questions, communicate more respectfully, and adapt their practice to diverse contexts. This would be particularly valuable in reducing unintentional dismissiveness or miscommunication that participants in this study associated with distrust.

Undergraduate programmes should also include robust teaching on transparent, considerate and attentive communication because, for the participants in the current study, communication quality was closely tied to trust, confidence in services, and willingness to engage with care in the current study's cultural safety. Students need to be enabled to communicate information clearly, check understanding, listen responsively, involve family where appropriate, and explain diagnoses and treatment plans in ways that patients can meaningfully use. A curriculum that includes these relational and cultural competencies is more likely to prepare graduates who can provide the respectful, culturally safe practice that older migrant patients and communities need. This recommendation aligns with the broader health system's direction toward people-centred care and improved care experiences.

Postgraduate education

At the postgraduate level, educational preparation should become more discipline-specific, clinically applied, and leadership-oriented. While undergraduate education

provides a foundation, postgraduate programmes and advanced clinical training should deepen capability in working with complex patient populations, including older migrants who may face layered barriers related to language, cultural expectations, chronic illness, family dependence, and system unfamiliarity. Postgraduate education should therefore include more explicit attention to the health of ageing migrant populations, with culturally responsive assessment, shared decision-making, trust-building, and continuity of care.

For example, specialist nursing, specialist NCD medicine, general practice, gerontology, community health, rehabilitation, and public health programmes could include applied teaching on how to adapt care processes for patients who require interpreters, who draw heavily on family support, or who may be less likely to question authority despite not fully understanding clinical advice. This is especially important because postgraduate education shapes future clinical leaders, educators, and advanced practitioners. If these programmes do not address the realities of caring for culturally diverse ageing populations, inequities identified in practice may be reproduced at higher levels of responsibility.

Postgraduate curricula should also prepare clinicians to support service improvement and co-design with community care delivery. At this level, education should not only teach clinicians how to work with individual patients, but also how to partner with communities to develop resources, improve access pathways, and redesign services. This would strengthen clinical leadership for equity and align with current system expectations that services become more responsive to the needs and aspirations of local communities. The Health Workforce Strategic Framework (Ministry of Health, 2023) identifies workforce development as central to wider system improvement, and postgraduate training is one of the clearest avenues through which this can be operationalised.

Continuing professional development and workplace learning

Educational reform should not stop at professional undergraduate qualifications and registration education. Healthcare services should provide ongoing training for registered health professionals to support culturally safe practice with migrant communities and to enhance equitable healthcare engagement. In this study,

participants' accounts made it clear that communication, trust, and the quality of interpersonal care remain critical in real-world encounters. This suggests that continuing professional development should include more than mandatory updates or isolated workshops. Instead, it should provide structured, repeated learning opportunities that help practitioners refine their skills in communication, interpretation support, family-inclusive practice, and culturally responsive care.

Continuing professional development should include at least four elements. First, it should strengthen understanding of migration pathways and resettlement challenges as determinants of health, including how settlement history, language barriers, family roles, and prior healthcare experiences can shape help-seeking and trust. Second, it should focus on relational clinical skills, such as empathetic listening, checking for understanding, explaining treatment clearly, and meaningfully involving patients and their families in decisions. Third, it should address implicit bias, stereotyping, racism and professional conduct, especially where subtle forms of dismissal or rushed communication undermine trust. Fourth, it should provide practical guidance on working with interpreters, translated resources, and culturally specific support roles such as navigators or liaison workers.

An additional recommendation is that senior management of healthcare organisations embed this learning into ongoing workplace education plans rather than treating migrant health as an optional area of interest. In services with high ethnic diversity among clients, departments—and, increasingly, the aged care sector—could incorporate migrant health and culturally responsive practice into orientation programmes, annual competency reviews, case review discussions, and quality-improvement initiatives. This would make educational reform continuous, sustainable, and practice-linked rather than episodic. Such an approach is consistent with the *New Zealand Health Strategy* (Nursing Council of New Zealand, 2023), which argues that structural change alone is not enough and that workforce values, relationships, and ways of working also need to shift.

Academic cultural safety development and educator capability

An additional recommendation is that educational reform should include preparing educators themselves. At medical school, for example, if lecturers, clinical educators,

and preceptors do not feel confident teaching migrant health, cultural safety, and equity-related communication, the content is likely to remain superficial or inconsistent. Tertiary institutions should therefore invest in educator development so that staff are better prepared to teach on migration, language, ethnicity, trust, and culturally responsive care. This is particularly relevant in curricula that already contain cultural safety content but may not yet address the needs of non-Māori, non-Pacific migrants, for example, ethnic and ageing populations, in a sufficiently explicit way.

Educational content should be informed by ethnic communities, service users, clinicians, and educators from diverse ethnic backgrounds. For older Fijian Indian populations, this could include consultations with community leaders, bilingual health workers, and patients or their families with lived experience navigating services. The aim should not be to create static 'cultural facts' on one community, but to ensure that educational content reflects lived realities, avoids stereotypes, and remains responsive to how access barriers actually occur in practice.

Regulatory and institutional oversight

Educational recommendations are more likely to have a sustained impact when supported by institutional and regulatory accountability. The guidelines and expectations for cultural safety should therefore be monitored not only at the programme level, but also by relevant professional and educational bodies in Aotearoa New Zealand. At an institutional level, tertiary education providers should demonstrate how cultural safety, equity, and culturally responsive communication are embedded in curriculum design, teaching, assessment, and clinical placement expectations by setting learning objectives. At a regulatory level, professional councils (the Medical Council of New Zealand, the New Zealand Nursing Organisation, the Nursing Council of New Zealand) and the New Zealand Qualifications Authority could continue to require, revise, and evaluate culturally safe practice, and consider how those expectations are applied in clinical practice among increasingly diverse migrant communities.

The Nursing Council of New Zealand (2023) identifies reflective practice, recognition of bias, and responsiveness to diverse worldviews as professional responsibilities required for safe and effective care. These are important foundations, but based on

the findings presented in this thesis, I suggest that such standards could be operationalised more clearly for migrant ageing health, including communication across language differences, the role of family in care, and equitable engagement with older migrants. For nursing, the Nursing Council of New Zealand has already established a strong foundation through Te Paerewa: Standards of Competence for Registered Nurses, which explicitly links cultural safety, ongoing learning, and professional practice, and provides a basis for further strengthening educational guidance as healthcare needs continue to evolve (Manatū Hauora Ministry of Health, 2023).

Regarding ethnicity data, Fijian Indian ethnicity data is available for the first time in 2025 through Stats NZ reporting, enabling greater use of the disaggregated data in health planning, monitoring, and service development. More explicit use of the recent Fijian Indian data would improve the visibility of this community and support culturally responsive, evidence-informed healthcare planning for older Fijian Indian migrants.

Another recommendation is that institutions and professional bodies should move beyond stating expectations to reviewing implementation. This could involve periodic curriculum review, clearer graduate outcome statements related to culturally responsive care, and stronger scrutiny of whether students and practitioners can apply cultural safety principles to migrant communities as well as to Māori and Pacific peoples. The New Zealand Qualification Authority's programme approval and accreditation guidance provides a framework for tertiary oversight, although it does not itself specify the health of the ageing migrant population. This means institutions still have room and responsibility to translate broad educational and quality expectations into more explicit curriculum commitments.

Taken together, these recommendations indicate that education for healthcare providers in Aotearoa New Zealand needs to be strengthened across the full professional continuum. At the undergraduate level, healthcare training institutions should embed core cultural education into degree programmes to establish a foundation in migration-informed cultural safety, effective communication, and reflective practice. This should include attention to community beliefs, customs, socio-economic barriers, and key language concepts relevant to migrant populations. At the

postgraduate level, this capability should be extended to preparing clinicians to lead equitable service development and culturally responsive care models. Continuing professional development should further reinforce these skills in clinical practice through ongoing cultural safety initiatives that support practitioners to remain responsive to the evolving needs of migrant communities (Hardy et al., 2023). Educator development is equally important to ensure that this content is delivered with confidence and consistency. In addition, institutional and regulatory oversight should move beyond general endorsement towards clearer expectations for implementation, evaluation, and review. Collectively, these measures would better equip the health workforce to respond to the needs of older Fijian Indian migrants and other ethnic migrant populations who continue to experience barriers related to trust, communication, and equitable access to healthcare.

5.3.4 Summary of key recommendations

The recommendations set out above call for a coordinated response across macro, meso, and micro levels. At the policy level, the study recommends strengthening existing Aotearoa New Zealand health policies rather than creating entirely new ones. This includes enabling older migrant communities to be more visible both in co-design and within equity frameworks, embedding migrant-specific and age-sensitive indicators into planning and performance systems, and ensuring that issues such as language needs, interpreter use, timely access, navigation support, and the provision of person-centred, respectful, and culturally enabling long-term care are explicitly monitored rather than absorbed into broad ethnic reporting categories.

At the clinical and organisational level, the study recommends more culturally responsive and practically supportive models of care, especially for medicine, for specialism, and for nursing frontline health professionals. Key proposals include introducing community health navigator roles for Fijian Indian and other ethnic migrant communities, improving access to trained interpreters, expanding multilingual staffing, developing translated written resources, reviewing appointment systems and GP availability, reducing waiting times, and collecting more targeted patient feedback on communication, trust, language accessibility, and continuity of care. The recommendations also stress the importance of stronger workforce planning, diversity and cultural capacity building, community partnership, and co-design with Fijian Indian

community leaders and service users so that lived realities rather than assumptions shape services.

At the educational level, the study recommends reform across the full continuum of health professionals. Undergraduate programmes should embed migration-informed cultural safety, communication, and reflective practice more explicitly. Postgraduate education should prepare clinicians to lead equitable and culturally responsive service development, while continuing professional development should provide ongoing workplace learning in interpreter use, implicit bias, trust-building, and family-inclusive care. The recommendations also emphasise educator preparation and stronger institutional and regulatory oversight to ensure that cultural safety expectations are implemented, reviewed, and applied meaningfully to ageing migrant populations. Taken together, the recommendations argue for a whole-system approach in which policy, service delivery, workforce capability, and education work together to improve healthcare access for older Fijian Indian migrants and similar ageing ethnic migrant communities.

5.3.5 Future research recommendations

Future research could build on this study by including a larger number of older Fijian Indians from different regions of Aotearoa New Zealand. As this study used a small qualitative sample, future quantitative research could help measure the prevalence of specific barriers and enablers within the wider Fijian Indian community. Future research should examine the impact of these recommendations over time using larger population samples and quantitative measures, including patient satisfaction and service access and utilisation indicators. Future co-design approaches involving older Fijian Indian migrants and key stakeholders may also help ensure that future interventions remain culturally responsive and aligned with community needs. Further research could also compare the healthcare experiences of Fijian Indian communities living in other countries, such as Australia, Canada, the United States, and the United Kingdom, to better understand how migration history, settlement context, and health systems shape access to care.

Future research could adopt participatory or co-designed intervention approaches to evaluate culturally tailored strategies that enhance healthcare navigation,

communication, and engagement for Fijian Indian communities in Aotearoa, New Zealand.

Finally, further research is needed to explore the above recommendations at different levels and in greater depth, particularly how system- and policy-level factors affect older Fijian Indian migrants' ability to access timely, culturally responsive care.

5.4 Reflection

Reflecting on this study, it is important to recognise that this research was undertaken as part of a DHSc rather than a PhD. Therefore, the purpose of the study was not only to contribute to knowledge but also to inform change and leadership in professional health practice. The findings have encouraged me to think critically about how healthcare services can better respond to older Fijian Indian migrants through culturally responsive care, clearer communication, and improved access pathways. As it is a DHSc study, the emphasis is on applying research findings to real practice settings and supporting improvements that can make healthcare more accessible, respectful, and responsive for this community.

This study has enabled me to gain a deeper understanding of the cultural needs of Fijian Indians living in Aotearoa New Zealand. I have developed stronger interview skills and critically reflected on my own assumptions about healthcare access while navigating the complexities of participants' healthcare experiences. Engaging with participants' diverse perspectives challenged some of my preconceptions and reinforced the importance of approaching each interview with openness, reflexivity, and a willingness to understand experiences that differed from my own. Furthermore, it has enabled me to build trust in the community, and I feel honoured to share participants' voices so that they can enrich the understanding of policymakers and healthcare training providers. Carrying out this study has helped me to grow as a culturally responsive researcher.

Future co-design approaches involving Fijian Indian community leaders, elders, family members, and carers would strengthen the cultural relevance and acceptability of healthcare access initiatives for this population. Engaging community stakeholders in developing services or support roles, such as culturally specific health navigators,

would ensure that interventions reflect the lived experiences, language needs, and cultural expectations of older Fijian Indian migrants. Family members and informal carers play a central role in supporting older migrants' access to healthcare and should therefore be included in planning and implementation processes.

Through this doctoral journey, I believe I have met the requirements of the DHSc programme by engaging deeply with both the theoretical and practical dimensions of research. My learning has developed through coursework, theory-based learning, workshops, supervision, and the process of undertaking an independent research project from beginning to end. This included developing the research focus, engaging with relevant literature, preparing and gaining ethics approval, recruiting participants, collecting data, analysing findings, and writing the thesis. Each stage strengthened my understanding of research as a careful, reflective, and responsible process. More importantly, this journey has helped me grow as a practitioner-researcher, enabling me to connect academic knowledge with described experiences, cultural understanding, and the wider goal of improving health equity for older Fijian Indian migrants in Aotearoa New Zealand.

5.5 Conclusion

This research examined the enablers and barriers to accessing healthcare in Aotearoa New Zealand, with a focus on older Fijian Indian migrants. The findings identified key, unique barriers to healthcare access for the older Fijian Indian migrant population, highlighted cultural needs, and emphasised the need to improve trust, communication, access, cultural acceptability, and affordability in healthcare, as well as reduce logistical barriers. While this is the first study of its kind to examine the growing and ageing Fijian Indian population in Aotearoa New Zealand, it provides a foundation for future research and for achieving inclusive healthcare services for minority ethnic communities.

The Fijian Indian population has remained largely invisible in health research despite its growth and ageing profile. By foregrounding culturally situated experiences of trust, communication, and access, the study extends understanding of how healthcare systems interact with ageing migrant communities. The findings, therefore, offer insights relevant not only to Fijian Indian populations but also to broader efforts to

improve culturally responsive and equitable healthcare for diverse older migrant groups in Aotearoa New Zealand.

5.6 Final Remarks

The research reported in this thesis examined barriers to and enablers of access to healthcare amongst the older Fijian Indian migrants living in Aotearoa New Zealand. The findings suggest significant barriers related to cultural differences, communication, access, and affordability, and highlight the complexity and limitations of the older migrant population. While Fijian Indians constitute a small proportion of the total population, the estimated number of Fijian Indians residing in Aotearoa New Zealand is between 95,000 and 100,000 (Narayan, Vakalalabure, et al., 2025). Given this significant number, this research aims to inform healthcare providers and educational institutions about the importance of inclusion and diversity within the healthcare system to improve health outcomes for minority ethnic migrant communities. This research may benefit other minority migrant populations and be transferable to them.

Each life matters, and everyone deserves equitable, culturally appropriate care. There is an urgent need for inclusiveness in the healthcare system. The voices of the people who participated in this study must guide policy change and future research, which should include a broader range of age groups, geographical regions and minority ethnic communities to achieve a comprehensive understanding of all age groups and other minority ethnic communities.

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Appendices

Appendix A: Ethics Approval



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

12 November 2021

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Ethics Application: **21/408 Exploring perspectives affecting access to healthcare amongst older Fijian Indian immigrants in New Zealand**

Thank you for submitting your application for ethical review. We are pleased to advise that a subcommittee of the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application , subject to:

1. Provision of the authorising signature in section O.3 of the application;
2. Clarification about whether participants are being recruited using purposive sampling or on a convenience basis;
3. Clarification about the use of the demographic questionnaire and when it will be implemented. AUTEC advises that no information may be collected prior to consent being given;
4. Clarification about how the thank you gift will be given to participants when the interview is by videoconference;
5. Provision of more reflective information about how the researcher and participants will ensure that each other is adequately protected in this research;
6. Clarification about how evidence of consent will be obtained. Obtaining both oral and written evidence of consent for a participant is unnecessarily burdensome for them. AUTEC recommends that the researcher uses an oral consent protocol for the videoconference interviews. An exemplar is included in the current Consent Form Exemplars on the research ethics website.;
7. Provision of a detailed protocol about what level of confidentiality will be provided to the participants and how this will be implemented. Advice about this needs to be included in the Information Sheet;
8. Provision of a revised and consistent data storage protocol, identifying exactly how and where the data will be stored on AUT premises in the post analysis data retention phase of the research;
9. Provision of an assurance that the researcher will not provide any healthcare to distressed participants and that no participant will need to pay for counselling services or GP consultations as a result of taking part in this research;
10. Removal of the reference to the gift of a voucher from the advertisement;
11. Provision of an escalation procedure in the Researcher Safety Protocol for use if the researcher is in at risk situation;
12. Amendment of the Information Sheet as follows:

a. Alteration of the advice about the degree being completed to reflect the qualification that is being sought;

b. Inclusion of clearer advice about how the participant agrees to take part in the research;

c. Removal of the offer of support and guidance from the section on alleviating risks as this is not an appropriate part of the researcher's role;

d. Alteration of the amount of time that participants will have to consider the application to four weeks;

e. Removal of the section on compensation;

13. Alteration of the Consent Form to include reference to video recording if a videoconference is being used;

14. Inclusion of the current AUT logo, the exclusion criteria, and the AUTEC approval statement in the advertisement.

Please provide us with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

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

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

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

We look forward to hearing from you,

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

23 November 2021

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re Ethics Application: **21/408 Exploring perspectives affecting access to healthcare amongst older Fijian Indian immigrants in New Zealand**

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

Your ethics application has been approved for three years until 23 November 2024.

Non-Standard Conditions of Approval

1. In the Researchers Safety Protocol remove the paragraph that states '*The supervisors will escalate this notifying the ethics team at AUT*'. This condition refers to having an escalation plan if the researcher does not make contact with the Primary Supervisor at the conclusion of the interview. Please review this and update accordingly.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: xtm7464@autuni.ac.nz; jagamaya.shrestha@aut.ac.nz

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: xtm7464@autuni.ac.nz; jagamaya.shrestha@aut.ac.nz

Appendix B: Participant Information Sheet

Appendix A:

Participant Information Sheet

Date Information Sheet Produced:

27/11/20

21 **Project Title**

Exploring perspectives affecting access to healthcare amongst older Fijian Indian immigrants in New Zealand.

An Invitation

Hello, my name is Vimlesh Shukla, and I am currently enrolled at Auckland University of Technology pursuing a Doctor of Philosophy. My research focuses on exploring the experiences of older Fijian Indians who have/are utilising healthcare in New Zealand.

What is the purpose of this research?

Access to healthcare for Fijian Indians has never been investigated in New Zealand or anywhere else in the world. The purpose of this study is to determine the factors that facilitate and obstruct access to healthcare. If enablers and barriers exist, what are they, and how do they impact the individual?

Fijian Indians and people of pacific descent are at a higher risk of Type 2 Diabetes Mellitus and Cardiovascular Diseases than the general population. Numerous factors have made it more difficult for the minority immigrant population to achieve good health.

This is the first study to examine the experiences of the Fijian Indian community in New Zealand's healthcare system. The findings from this study may be used in academic publications and/or presentations aimed at increasing healthcare utilisation and lowering barriers to care in this population.

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

You have responded to a community advertisement or personal invitation. Participants in this study must meet the following criteria:

- Self-identified Fijian Indian immigrant
- Age 55 years and older
- Living in New Zealand for over one year.

- Have an NZ Permanent Residency status visa. This will ensure that the participants can access healthcare services funded by the government.

You can't participate in this study if you cannot communicate in either English or Hindi language.

How do I agree to participate in this research?

Kindly contact us via phone, email, or text after you have read and understood the information provided in this sheet. I will contact you after that to organise for an interview date and time that is convenient for you.

The interview will take place either face to face or, if COVID 19 restrictions remain in effect, via Zoom. If you choose to proceed with the interview, I will assist you in this process.

The face-to-face interview will take place at a time and place convenient to you, this may be your in your home with your consent. A consent form has been supplied at the end of this information page if you choose to participate in this study. Kindly finish this and I will collect it prior to the interview.

You do not need to fill the consent form if you are going to be interviewed over Zoom.

If we're doing the interview over Zoom, I'll use the oral consent protocol to get your permission to record the conversation.

Please note that your participation in this research is voluntary (it is your choice), and whether you choose or not to participate, it will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any

data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

Please note that no personally identifiable information will be used to write the summary or in the publication of the research findings.

What will happen in this research?

If you wish to participate in this study, an interview will be scheduled at a time and place that is convenient for you. This interview will last between 35 and 40 minutes.

If there are covid 19 restrictions in place, a zoom call can be scheduled at a time that is convenient for you.

The interview will be recorded. You will be asked a few questions regarding your own experiences with New Zealand's healthcare system. You can inform me about both the positive and negative parts of it, as well as any problems or issues you've had while accessing healthcare.

Finally, your stories will be analysed and transcribed. A summary of what you said during the interview will be provided to you so that you may verify that it was reported accurately. If everything you've said is accurate, the information will be incorporated into my thesis.

Please note that the data collected for this project will be accessible only to my supervisors and me. Only the study's findings will be published; no identifiable personal information will be disclosed.

What are the discomforts and risks?

Recalling and telling the unpleasant experiences while accessing healthcare can be unpleasant. This can bring back memories of the sad times. However, don't be afraid; this is a natural reaction as we view ourselves differently in today's environment. It is natural to develop unpleasant feelings when recalling such events.

This research aims to learn from those experiences and your stories can help us better understand the experiences you had accessing healthcare in New Zealand.

How will these discomforts and risks be alleviated?

If you become uneasy during this interview, I will pause it. You may also choose to end the interview earlier without consequence if you do not wish to continue. If you believe recalling your unpleasant experience is becoming unbearable, you can contact the following services for support.

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/studentlife/student-support/counselling-and-mental-health

If you prefer to seek additional support, you can contact one of the ethnic-based organisations listed below.

You can also contact your General practitioner (GP) for help or advice.

These services are provided free of charge.

Gandhi Nivas – based at multiple locations within NZ and provide counselling and temporary accommodation for needy people.

PH: 0800 Gandhi (0800 4260344)

Sahaayta – is an ethnic-based (south Asian) service for Counselling, Social Support.

PH: 09 280 4064

Asian Family Services - Asian Helpline helps Asian people in New Zealand to access appropriate counselling support PH: 0800 862 342

What are the benefits?

This study's goal is to see if changing healthcare policy can enhance medicine-related outcomes for Fijian Indian migrants in New Zealand. The findings of this study can be utilised to develop future health policies/strategies focused at improving older Fijian Indian migrants' access to quality health care in New Zealand. Other ethnic minority immigrant populations in New Zealand can use the study's findings to explore healthcare access and equity.

Finally, this study will aid in my pursuit of a Doctor of Philosophy qualification.

How will my privacy be protected?

Throughout the study, your privacy and confidentiality will be a top priority. The research will be conducted using numbers rather than names, and any identifiable information will be omitted from the results.

Only my supervisors and I will have access to the gathered and analysed data. All data collected will be securely stored for six years before being deleted (electronic) or destroyed (shredded) (written).

No participant's identifying name will be utilised in any section of the transcript that could be used to identify them.

The original transcripts, audio recordings, consent forms, and all correspondence will be stored in a locked cupboard at the primary supervisors'

office in AUT. All recorded interviews will be stored on a password protected portable hard drive.

According to the Privacy Act 2020, data acquired shall be utilised exclusively for the purposes for which it was collected.

Please be assured that your personal information will not be shared with anybody other than the supervisors. **What are the costs of participating in this research?**

Participation in this study is completely free of charge. However, the interview is expected to last approximately 30 to 40 minutes.

What opportunity do I have to consider this invitation?

Participants who are interested in participating in the study are encouraged to respond within four weeks of receiving information about it.

Will I receive feedback on the results of this research?

All participants will receive a written summary of the study's findings via email or postal mail. You may indicate whether you wish to receive or not receive the summary on the consent form attached.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Professor Eleanor Holroyd on eleanor.holroyd@aut.ac.nz or (09) 921 9999 ext. 5298.*

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz*, (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

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

Researcher Contact Details:

Vimlesh Shukla

Email: xtm7464@autuni.ac.nz

Contact: 02102513446

Project Supervisor Contact Details:

Professor Eleanor Holroyd

Email: eleanor.holroyd@aut.ac.nz

Phone: (09) 921 9999 ext. 5298

Approved by the Auckland University of Technology Ethics Committee on *23/11/2021*, AUTEC Reference number *21/408*

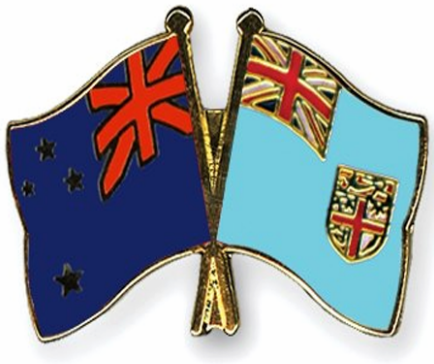
Appendix C: Flyer in English and Hindi

Appendix G

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

- ✓ Are you a Fijian Indian and have permanent NZ residence or citizenship?
- ✓ Are you 55 years or older?
- ✓ Have you utilised a health service in New Zealand?
- ✓ Have you been living in New Zealand for over a year?

Then we would love to hear from you.



You will not be considered to take part in this research if you are:

- Close relative and friend from the Fijian Indian community with whom I regularly associate with.
- If you are unable to speak in English or Hindi.

We are conducting research on Fiji Indians' experience in utilising healthcare in New Zealand.

If you are interested in participating in this research, please contact

Vimlesh Shukla

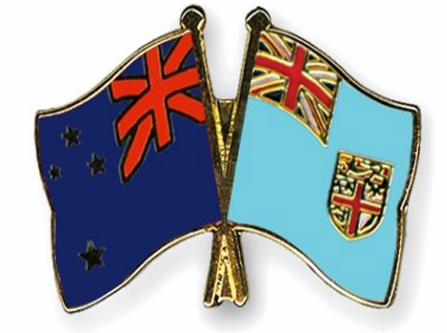
Email: xtm7464@autuni.ac.nz

Ph: 02102513446

We hope to hear from you soon.

Approved by the Auckland University of Technology Ethics Committee on *23/11/2021*, AUTEC Reference number *21/408*.

- ✓ क्या आप फ़ीजी के भारतीय हैं और आपके पास न्यूज़ीलैंड स्थायी निवास या नागरिकता है?
- ✓ क्या आप ५५ (55) वर्ष या उससे अधिक उम्र के हैं?
- ✓ क्या आपने न्यूज़ीलैंड में किसी स्वास्थ्य सेवा का उपयोग किया है?
- ✓ क्या आप न्यूजीलैंड में एक साल से अधिक समय से रह रहे हैं,
  तो हम आपसे सुनना चाहेंगे?



आपको इस शोध में भाग लेने के लिए नहीं माना जाएगा यदि आप:

- फ़ीजी भारतीय समुदाय के करीबी रिश्तेदार और दोस्त जिनके साथ मैं नियमित रूप से जुड़ता हूं।
- यदि आप अंग्रेजी या हिंदी में बोलने में असमर्थ हैं।

हम न्यूजीलैंड में स्वास्थ्य सेवा के उपयोग में फिजी भारतीयों के अनुभव पर एक शोध (research) कर रहे हैं।
यदि आप इस अनुसंधान में भाग लेने के इच्छुक हैं, तो कृपया संपर्क करें

Vimlesh Shukla (भीमलेस सुक्ला)

ईमेल (Email): xtm7464@autuni.ac.nz

फोन:०२१०२५१३४४६ (02102513446)

हमें आप से जल्द ही संपर्क की आशा है।

Approved by the (ऑकलैंड यूनिवर्सिटी ऑफ़ टेक्नोलॉजी एथिक्स कमिटी) Auckland University of Technology Ethics Committee on *23/11/2021*, AUTEC Reference number *21/408*.

Appendix D: Interview Questions

Version 1

Semi Structured Interview Guide Start Time: Finish Time:

1. Could you please tell me which healthcare services you used?
   Prompts:
   - Type of healthcare facilities. (Primary care or acute care)
   - Which part of New Zealand this facility is in
   - What specialty (medical, surgical, mental health or other)
   - How often do you visit/ utilise these healthcare service?
   - Have you accessed health care through the public system or private facilities?
   - If private, did you pay with health insurance or your own funds?

2. Were the services you utilised adequate to meet your needs?
   Prompts:
   - Would be able to describe these needs?
   - What made it a pleasant experience?
   - Please give some examples.

3. Were there any unpleasant experiences?
   Prompts:
   - If yes, would you describe any examples of it.
   - What do you believe caused these unpleasing events?
   - Were you physical and cultural needs met?

4. In your opinion, what could be done to avoid such experiences?
   Prompts:
   - Medical needs
   - Cultural needs
   - Language barriers if any

Follow up questions:
During our chat, you mentioned…. please tell me a bit more about this……
What was the circumstance or context around your experience or comment?
Can you explain a bit more about?

5. Are there any additional comments you wish to make about the healthcare services you used?

Version 2

Semi Structured Interview Guide Start Time: Finish Time:

1. Would you be able to tell me what is health and what it means to you?
2. How would rate your health?
3. Could you please tell me which healthcare services you used?
    a) Primary Healthcare
    b) Secondary healthcare

    Prompts:
    - Type of healthcare facilities. (Primary care or acute care)
    - Which part of New Zealand this facility is in
    - What specialty (medical, surgical, mental health or other)
    - How often do you visit/ utilise these healthcare service?
    - Have you accessed health care through the public system or private facilities?
    - If private, did you pay with health insurance or your own funds?

4. Were the services you utilised adequate to meet your needs?
    Prompts:
    - Would be able to describe these needs?
    - What made it a pleasant experience?
    - Please give some examples.

5. Were there any unpleasant experiences?
    Prompts:
    - If yes, would you describe any examples of it.
    - What do you believe caused these unpleasing events?
    - Were you physical and cultural needs met?

6. In your opinion, what could be done to avoid such experiences?
    Prompts:
    - Medical needs
    - Cultural needs
    - Language barriers if any

Follow up questions:

During our chat, you mentioned…. please tell me a bit more about this……
What was the circumstance or context around your experience or comment?
Can you explain a bit more about?

7. Are there any additional comments you wish to make about the healthcare services you used?

Version 3

Semi Structured Interview Guide Start Time: Finish Time:

1. Would you be able to tell me what is health in your own terms?
2. If you have to describe your health, what are the things you want to achieve for your own health and wellbeing?
3. How would rate your health?
4. Could you please tell me which healthcare services you used?
    a) Primary Healthcare
    b) Secondary healthcare

    Prompts:
    - Type of healthcare facilities. (Primary care or acute care)
    - Which part of New Zealand this facility is in
    - What specialty (medical, surgical, mental health or other)
    - How often do you visit/ utilise these healthcare service?
    - Have you accessed health care through the public system or private facilities?
    - If private, did you pay with health insurance or your own funds?

5. Were the services you utilised adequate to meet your needs?
6. In your opinion, do you think your **cultural** needs have been met by the healthcare provider? If yes, can you please describe it. If no, can you please describe what are the things you would have preferred the healthcare provider to improve on?

    Prompts:
    - Would be able to describe these needs?
    - What made it a pleasant experience?
    - Please give some examples.

7. Were there any unpleasant experiences?

    Prompts:
    - If yes, would you describe any examples of it.
    - What do you believe caused these unpleasing events?
    - Were you physical and cultural needs met?

8. In your opinion, what could be done to avoid such experiences?

    Prompts:
    - Medical needs
    - Cultural needs
    - Language barriers if any

Follow up questions:

During our chat, you mentioned…. please tell me a bit more about this……
What was the circumstance or context around your experience or comment?
Can you explain a bit more about?

9. The health services you have used, can you tell me if you were given health education on your health concern?
10. Were you given a choice about your treatment?

11. Were you explained about the medication you were provided?
    a) How to administer
    b) dosage
    c) Side effects
    d) What to do in case of side effects

12. Were any referrals made or were you given a choice about the referrals to a service related to your health?
13. What is you opinion on telehealth?

14. Are there any additional comments you wish to make about the healthcare services you used?

Version 4

Semi Structured Interview Guide Start Time: Finish Time:

1. Would you be able to tell me what is health in your own terms?
2. If you have to describe your health, what are the things you want to achieve for your own health and wellbeing?
3. How would rate your health?
4. Could you please tell me which healthcare services you used? (Describe what is meant by primary and Secondary to the participant)
    a) Primary Healthcare community based?
    b) Secondary healthcare – hospital

    Prompts:
    - Type of healthcare facilities. (Primary care or acute care)
    - Which part of New Zealand this facility is in
    - What specialty (medical, surgical, mental health or other)
    - How often do you visit/ utilise these healthcare service?
    - Have you accessed health care through the public system or private facilities?
    - If private, did you pay with health insurance or your own funds?

5. How if at all, were the services you utilised adequate to meet your needs?
6. In your opinion, do you think your **cultural** needs have been met by the healthcare provider? If yes, can you please describe it. If no, can you please describe what are the things you would have preferred the healthcare provider to improve on?

    Prompts:
    - Would be able to describe these needs?
    - What was specifically cultural about xxx (prompts language spoken, respect, gender of practitioners etc)?
    - Please give some examples.

7. Were there any unpleasant experiences, if so please outline ?

    Prompts:
    - If yes, would you describe any examples of it.
    - What do you believe caused these unpleasing events?
    - Were you physical and cultural needs met?

8. In your opinion, what could be done to avoid such experiences?

    Prompts:
    - Medical needs
    - Cultural needs
    - Language barriers if any

Follow up questions:

During our chat, you mentioned…. please tell me a bit more about this……

What was the circumstance or context around your experience or comment?

Can you explain a bit more about?

9. During your any of your encounter with the health services, can you tell me if you were given health education on your health concern?
10. Were you given a choice about your treatment?

11. How was medication provision and adherence explained?
    a) dosage
    b) Side effects
    c) What to do in case of side effects

12. Were any referrals made or were you given a choice about the referrals to a service related to your health? What was your understanding about the referrals about referrals?
13. Have you ever been consulted by a healthcare professional using Telehealth (explain what telehealth means to the participant)?
14. What is your opinion on telehealth? What are some of the barrier and enablers of telehealth?

15. Waiting times to see GP and or for any specialist appointments?

16. Are there any additional comments you wish to make about the healthcare services you used?

Thank the participant.

Appendix E: Consent Form



Consent Form

For use when interviews are involved.

Project title: ***Exploring Perspectives affecting Access to Healthcare Amongst Older Fijian Indian Immigrants in New Zealand.***

Project Supervisor: ***Eleanor Holroyd and Jagamaya Shrestha-Ranjit***

Researcher: *Vimlesh Shukla*

- I have read and understood the information provided about this research project in the Information Sheet dated 2021/2022.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped/zoom recorded and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study, then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes☐ No☐

Participants signature:

.....

Participants name:

.....

Participants Contact Details (if appropriate):

.....

..... Date:

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

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

Consent-Form English and Hindi Appendix E page 1 of 2.

This version was last edited in March 2020

Appendix F: Summary of Demographic Data

Demographic Characteristics

Date:

Name: (Pseudonym)	
Age range:	55 - 60 61 - 65 66 – 70 71 – 75 76 – 80 81 – 85 86 and above
Gender	Male Female Gender Diverse Prefer not to say
Marital status:	Single Married Separated/Divorced Widow
Religion	Hindu Christian Muslim Other/prefer not to say
Duration of residence/residing in New Zealand	14 years
Employment status	Retired Full time paid employment Part-time employment Self employed
Family living situation/support	Living alone Living with nuclear family Living with extended family
Education level	No formal education Primary school College Tertiary level Please specify:
Health Insurance	Full medical cover (comprehensive) Accident and injury cover None

Appendix G: Coding Sample

Themes	Sub-Theme	Data supporting the code
Trust versus mistrust ***Perceptions and Trust in Healthcare***	Perception of disbelief Symptoms not trusted by the healthcare professional's (lack of trust) Seen as psychosomatic Considered to be psychosomatic	-I think they were thinking I was making up, because I had this pain, you know, they asked me to describe between zero to 10, you know? And I mean, I had never pain -probably, they should have asked me more from when it is paining - they thought I was making up know stories said that I didn't have the particular pain- And then my referred me to a psychologist.
Access and Waiting Times Increased delays Lack of specialist health professionals ***Quality of Care and Patient-Centeredness:***	Longer waiting time Due to lack of specialists available	-three hours to give the discharge because I had to wait that, or that was for while -Because it took me quite a few visits to the GP before he referred me to, to, to the specialist - Longest wait was an hour or so long as it was an hour
Ethnicity and Cultural Competence (Language Barrier) Ethnic Biasness Ethnic Prejudice	Trust - not having the healthcare professional's confidence	- Because it took me quite a few visits to the GP before he referred me to, to, to the specialist.
Ethnicity and Cultural Competence Ethnic Biasness Prejudice in relation to ethnicity ***Ethnicity and Cultural Competence***	Ethnicity difference – Biased treatment due to ethnicity Poor treatment due to ethnicity Lack of interest in patients Poor assessments and treatments	-probably because I was an Indian probably - it was my skin colour, maybe, you know? - I believe they should have asked me more questions, you know, to diagnose it, you know, - probably, they should have asked me more from when it is paining. - but initially they didn't, they just tried to get rid of me.

Appendix H. Comparison of the Original English, Fiji Hindi Translation, and Back-Translation

Translated English Version	**Fiji Hindi**	**Back-Translated English**
Because it took me quite a few visits to the GP before he referred me to the specialist	Kahe ki GP ke hame specialist ke lage bheje se pahile bahut baar dekhawe jaye ke para.	Because I had to visit the GP many times before I was referred to the specialist.
I believe they should have asked me more questions, you know, to diagnose it, you know, probably, they should have asked me more from when it is paining, but initially they didn't, they just tried to get rid of me.	Hum socha ki u log humme se sawaal kari, puche ke chahi, tab batae konchi bemari hai. U log ke puchey ke raha ki dard kaha hai, lekin shuru mei u log aisan nai karis. U log bas jaldi se hamme bhej dewe ke koshish karat raha.	I believe they should have asked me more questions so they could properly understand what was wrong. They should have asked me when the pain started, but at first, they did not. They just seemed to want to send me away quickly.
They were not as understanding as our home people first. … I think they had a cultural problem	Pahile u log ghar ke log jaise nai samjhe … Hammee lage hai ki u log ke cultural problem hai.	At first, they were not as understanding as the people from my home country. … I think they lacked cultural understanding.
if you are not educated or just speaking English that well, it was hard for them to understand what you were talking about	Agar tum parha-likha nai hai, ya English ṭheek se nai bolta hai, tu u log ke samajhe mei mushkil hoi ki tum ka bole mangta hai.	If you are not well educated or cannot speak English well, it was difficult for them to understand what you were trying to say.
Probably because I was an Indian, probably, and it was my skin colour, maybe, you know	Shayad u log jane ki ham Indian hai, aur shayad humlog ke skin colour ke kaaran, maybe, tum jane.	Maybe it was because I was Indian, and perhaps because of the colour of my skin, maybe, you know.

Appendix I Transcriber Consent Form

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title: ***Exploring perspectives affecting access to healthcare amongst older Fijian Indian immigrants in New Zealand***

Project Supervisor: ***Professor Eleanor Holroyd***

Researcher: ***Vimlesh Shukla***

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name: Arunesh Kumar

Transcriber's Contact Details (if appropriate):

lionkaleja1976@gmail.com

.....

.....

Date: 21/04/2023

Project Supervisor's Contact Details (if appropriate):

Eleanor Holroyd

eleanor.holroyd@aut.ac.nz

.....

Approved by the Auckland University of Technology Ethics Committee on 23/11/2021 AUTEC Reference number 21/408

Note: The Transcriber should retain a copy of this form