Provider perspectives on heart healthcare inequities among Māori and Pacific Peoples in Aotearoa New Zealand: A qualitative study

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Abstract

Objective: We explored service providers' views on evidence–practice gaps and inequities in heart health care for Māori and Pacific peoples, alongside solutions to address these issues.

Methods: Employing Kaupapa Māori and Pacific research methodologies, we recruited Māori, Pacific, and non-Māori/Pacific providers, purposively sampled from a range of disciplines. Semi-structured interviews were conducted individually and in focus groups. Differences in perspectives offered by Māori and Pacific providers are compared to those of non-Māori/Pacific providers.

Results: Twenty-three providers, identifying as Māori (6), Pacific (5), or non-Māori/Pacific (12), shared their views of the healthcare system, experiences of providing care, and observations of Māori and Pacific patient and whānau experiences. Results were grouped into three themes: Tikanga Māori and Fa'a Pasifika versus non-Māori/Pacific ways; gaps in the health system for Māori and Pacific patients; and solutions. Māori and Pacific providers emphasised structural determinants, systemic failures and workforce inadequacies underlying inequities.

Conclusions: There is a critical need for equity-focused, holistic and relational models of heart health care that are co-designed with Māori and Pacific patients and whānau, and delivered by a culturally safe workforce.

Implications for Public Health: Adequately resourced services, designed by and for Māori and Pacific peoples, have the potential to achieve equitable heart health care outcomes.

Key words: heart, cardiovascular, Māori, Pacific, Indigenous health, qualitative

Introduction

Cardiovascular diseases (CVD) are the leading contributor to the five- to seven-year life expectancy gaps between Māori and Pacific populations compared with other New Zealanders.[1] Māori and Pacific peoples have a three-fold excess risk of one-year all-cause mortality following a myocardial infarction, with half of this inequity among Māori and three-quarters of the inequity among Pacific peoples linked to modifiable clinical factors that could have been prevented or mitigated in healthcare settings.[2] Yet, Māori and Pacific peoples are underserved across the heart health journey. Our recent systematic review identified extensive and inequitable gaps in CVD risk assessment and management for Māori and Pacific peoples.[3]

Healthcare providers are salient informants regarding systems perpetuating CVD inequities, but the limited research exploring their perspectives suggests variabilities in their awareness of and sensitivities to patient needs and service gaps. For example, a study conducted in the Northland region found that Māori patients' and families' experiences seeking care for ischaemic heart disease diverged substantially from health providers' interpretations of the challenges.[4]

Manawataki Fatu Fatu for ACCESS (Māori and Pacific Hearts in Unison for Achieving Cardiovascular Care in Equity StudieS) is a mixed-

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methods research program examining evidence–practice gaps amenable to interventions that can eliminate inequities in CVD outcomes for Māori and Pacific peoples.[5] We previously published a core study in this program examining the insider knowledge of Māori and Pacific patients and whānau (families) with lived experience of CVD risks.[6] In the present study, we explore service providers' responses to the findings from the patient–whānau study, particularly their views on: (1) the reasons behind the evidence–practice gaps and inequities in CVD care for Māori and Pacific peoples, and (2) implementable solutions that could address these inequities.

Methods

Participants recruited through professional networks were purposively sampled to include a range of disciplines as well as Māori, Pacific, and non-Māori/Pacific practitioners. Semi-structured interviews were conducted individually or in two focus groups by a team of five interviewers–Māori (KB), Samoan (TT-S, CG), Tongan (SH), and non-Māori/Pacific (SA). Where possible, participants were interviewed by a team member of the same ethnicity. Interviews and focus groups were recorded with participants' consent and individual transcripts de-identified by a numbering system. Participants were asked to reflect on challenges their patients face in accessing timely CVD services, identify successful practices that could be scaled up, and suggest improvements. The interview and focus group sessions also included a presentation of themes from the patient/whānau study,[6] followed by a facilitated discussion to elicit participants' reactions, insights, and ideas for potential solutions.

Data analysis was undertaken by the five interviewers and the Māori principal investigator (MH). We began analysis by applying the template analysis framework from the patient and whānau interviews, with its five main themes of: Context, Mana (maintaining control and dignity), Condition, People and Journey. [6]

As we explored the transcripts in depth, it became clear that the existing template did not fit, and there were salient differences between the perspectives of Māori/Pacific providers and non-Māori/Pacific providers on their experiences with Māori and Pacific patients. The difference in responses was strong enough to warrant a change in approach to the analysis. Foregoing the initial template and coding process, we focused on identifying common themes and sub-themes, making a distinction between Māori/ Pacific provider and Non-Māori/ Pacific provider viewpoints.

Results

Participants

A total of 23 health care providers working for a range of provider organisations were interviewed individually or in one of two focus groups (Table 1). They were classified as Māori (6), Pacific (5), or non-Māori/Pacific (12) based on their self-identified ethnic affiliations.

Providers shared their perspectives on the healthcare system, their experiences in delivering care, and observations about the experiences of Māori and Pacific patients and their whānau. Across the three themes and sub-themes identified from the data (Table 2), differences in perspectives were observed between Māori and Pacific providers and non-Māori/Pacific providers. Māori and Pacific providers generally demonstrated greater insight into the lived experiences of patients and whānau.[6]

Theme one: Tikanga and Fa'a Pasifika

Tikanga Māori and Fa'a Pasifika are customary systems of values informing everything from ceremonial activities to everyday relationships, including engagement with health care.[9,10] Many health organisations in Aotearoa have some understanding of tikanga and Fa'a Pasifika and attempt to incorporate elements into healthcare services, e.g. access to traditional medicines and healers and supporting family involvement.

Family

Māori and Pacific clinicians noted increasing recognition of family and communities as integral to an individual's health journey, an understanding implicit in their own practices.

> "*One of the most important things we did was this whakawhanaungatanga [relationship building with the entire extended family] and this establishing of relationships….. getting to know her stories. We [clinicians] involve whānau [family], where we didn't necessarily do that before.*" (prov10-Māori).

Table 1: Study participants including role and ethnic group.

Identifier in quotes	Ethnicity	Workplace role	Provider type
Prov1 M	Māori	GP	Community - Kaupapa Māori
Prov2 P	Pacific	GP	General practice – Pacific provider
Prov3 non-M/P	Non-Māori/Pacific	Cardiac specialist nurse	Public hospital
Prov4 non-M/P	Non-Māori/Pacific	GP	Community – Kaupapa Maori
Prov5 M	Māori	Heart failure specialist nurse	Public hospital
Prov6 M	Māori	Long term condition nurse	Community – Kaupapa Māori
Prov7 non-M/P	Non-Māori/Pacific	Cardiologist	Public hospital
Prov8 P	Pacific	ED doctor	Public hospital
Prov9 P	Pacific	Primary health nurse lead	Community – Kaupapa Māori
Prov10 M	Māori	Heart failure specialist nurse	Public hospital
Prov11 M	Māori	Physician	Public hospital
FGC	6 non-M/P	Focus group of cardiologists	Public hospital
FGEMS	1 Pacific, 5 non-M/P	Focus group of emergency medical service providers	Charitable organisation

GP = general practitioner; ED = emergency department.

Māori and Pacific participants were also more likely to highlight the benefits of including families in healthcare *"No matter how busy we are, we still need to take the time to hear their [Pacific families'] stories and share their concerns, explaining management plans because if we don't, repeat ED presentations and hospital admissions will inevitably* occur." *(prov8-Pacific)*..

All participants described the value of collective-based approaches to education and health promotion activities. However, Māori and Pacific participants endorsed family/whānau-centred approaches, while other providers expected disease-based groups to be key supports:

> *"The support is within your whānau, because we invite the whole families to come along as well. I think that is the key." (prov6-Māori).*
>
> *"Getting a group of heart failure patients together I think would have incredible value in terms of supporting each other."* (FGC).

Non-Māori/Pacific providers tended to prioritise individualised personal care, with one viewing family involvement as a concern: *"Often the children act as carers for parents, so they handle all their medication and treatment information. This leads to the parents not having a good personal health literacy…. have seen this more often in Pacific and Māori communities."*'(FGEMS). Another non-Māori/Pacific clinician focused on cost and efficiencies as overriding priorities for the health system, noting, *"I do agree that building trust at a community level is a very positive thing, and that will have broader benefits; but I am also challenged by this. I personally feel the best bang for the buck is to really engage with the people who actually have the disease." (FGC).* Conversely, some non-Māori/Pacific participants emphasised how talanoa (talking) with multiple family members *"improved patient engagement. It also increased their [the patient's] knowledge and understanding of the care plan and treatment the patient would receive." (prov3- non-Māori/Pacific).*

Mana

Mana, a cultural principle unique to Māori and Pacific peoples, relates to a person's prestige, power and status. Enhancing a person's mana means recognising their strengths as well as their contexts. In this study, mana-diminishing behaviours were noted to be prevalent in heart healthcare. As one participant noted, *"We still commit the same mistakes….. talk down to patients and not talk with patients." (prov7-non-Māori/Pacific).*

Māori and Pacific participants suggested that positive "communication outcomes" for Māori and Pacific patients included mana-enhancement, honouring how people felt as much as the information delivered: "*My Pasifika and Māori patients just want to know that they are being listened to, respected and treated in the same way as other patients." (prov2-Pacific).*

Māori and Pacific providers also highlighted the importance of communicating in the patient's language of choice and being attuned to non-verbal communication to demonstrate respect for the patient's mana, *"I have witnessed people that were unable or didn't have the vocabulary to express the issues that they were feeling, or what their body was going through. … In terms of language barriers, that's both verbal and non-verbal as well." (Pacific member FGEMS).*

Māori and Pacific clinicians described discrimination and racism towards Māori and Pacific patients as the extreme form of mana diminishment in health settings, particularly because negative stereotypes led to unequal treatment, resulting in health inequities. A Māori clinician expressed concern about a patient being bounced around public hospital services with a reputation for being *"a difficult man who probably did not look after himself properly,"* and echoed the patient's despair in feeling that care was denied due to his ethnicity; *"That's what he [patient] said to me, 'what am I supposed to do here? Just wait around to die?' The sad thing though is that those types of things [unequal treatment based on ethnicity] probably happened, and still happens, to lots of Māori and their families but it remains hidden." (prov11-*Māori*).*

Conversely, Māori and Pacific participants also noted that, even when patients from their communities are struggling to get attention, they continue to prioritise caring for others: *"when they turn up at ED and they hear someone screaming, the Māori/Pacific patient will tell us to attend to them first when they [Pacific or Māori] do not realise they are having a heart attack…. O tatou tagata e ave le faamuamua ma le faaaloalo i isi ae mulimuli latou (Our people offer priority and respect to others first and themselves last)." (prov8-Pacific).*

Theme Two: Gaps in the health system for Māori and Pacific patients

Providers recognised multiple service gaps in CVD care for Māori and Pacific peoples.

Completing a CVD risk assessment

Māori and Pacific clinicians described completing a cardiovascular diseases risk assessment (CVDRA) as an important tool for exposing, monitoring and eliminating CVD care inequities. For example, a Pacific clinician (*prov8-Pacific)* who works for a Māori provider serving

Table 2: Themes and sub-themes.

Themes		Māori and pacific providers	Non-Māori/Pacific providers
Tikanga Māori and Fa'a Pasifika versus non-Māori/Pacific ways	*Family*	Central and integrated	Margins and as required
	Mana	Opportunities to enhance and not diminish	"All talk" or hidden
Gaps in health system for Māori and Pacific patients	*CVD risk assessment*	A tool to monitor/drive equity	A clinical tool
	Barriers	Personal, health system and societal	
	Discrimination	Institutional, interpersonal and internal	Interpersonal and internal
Solutions	*Where to intervene*	Wider determinants	
	Optimal CVD care pathways	Into, through and post-acute CVD care	
	Workforce	Leaders and decision makers	Clinicians
	Māori and pacific providers	Integrated	External

CVD = cardiovascular disease.

both Māori and Pacific patients encouraged patients to *"book with the nurse for WOF [health warrant of fitness] and as a birthday gift for themselves to ensure they stay healthy."* This provider also considered solutions to potential barriers: "*Time is a big factor for our people as this prevents them from coming …, it is important to set up clinics during the times they can attend the clinics."* Similarly, a Māori provider offered screening in workplaces with greater numbers of Māori and Pacific workers, "*We're going in [there] and doing the CVD risk assessments with everybody. … And then from there, we refer to wherever we need for that ongoing follow-up, particularly if the CVD risk is up there in the high category*." (prov6-Māori). They also noted that appointment letters should be improved to help patients understand what to expect at the clinic visit.

Community-based Māori and Pacific practitioners emphasised the need to start CVDRA at a much younger age, extend screening settings to workplaces with high proportions of Māori and Pacific people, and expedite referral pathways. *"We cannot keep waiting for our people to react to a life-threatening event for them to seek help. Act before an event!" (prov9-Pacific).*

Some non-Māori/Pacific providers identified several shortfalls in their practice but focused on completing risk assessments: *"I think as clinicians … we need to do a bit better work at doing cardiovascular risk assessments; we need to do a better job at managing our risk factors," (prov4-non-Māori/Pacific).*

Barriers

Providers in both groups acknowledged "upstream causes"[11] to explain CVD inequities but differed in how far upstream they looked.

The non-Māori/Pacific providers focused on "surface level causes"[11] such as *"financial issues, distance, the fear of not being taken seriously and language barriers" (FGEMS),* with cost being postulated as the main factor causing Māori and Pacific peoples to feel "*anxious about the cost of calling an ambulance, this is seen more with Pacific patients." (FGEMS*).

Looking further upstream, Māori and Pacific providers approached CVD as a condition often co-occurring with other chronic diseases (e.g. diabetes) and within the context of multiple conflicting demands imposed by social and structural inequities. They observed intergenerational impacts of poverty compromising access to timely CVD care. "*I know why Māori and Pacific people present late to ED, it is that during the day they look after their grandchildren. They will hold on to the pain until their children come home, which in some cases over 8 hours, hence the late presentation. It is the same when one of the parents is staying home while one works. They will wait until someone comes home as they may have only one car." (prov8-Pacific).*

Māori and Pacific participants emphasised multiple systematic barriers to accessing primary care, with some patients unable to register with a general practitioner (GP) and/or book a timely appointment. The higher fees for unregistered patients "*put the barrier in for a lot of people that can't afford that." (prov6-Māori).*

Non-Māori/Pacific participants were more likely to blame patient-related factors (e.g. age or employment status) for exacerbating systemic issues rather than addressing these issues directly: *"A lot of our patients are served by a model where you can't book… Māori and Pacific people present younger with almost every form of cardiovascular disease, and that might mean a half day, or more than half a day, off work just to see a GP. I am increasingly getting calls from patients to say, 'Can you please fill my script, because I have been trying for three days and I can't get in, and I can't get anyone to answer the phone'". (FGC*).

Both groups commented on long-standing neglect of pervasive barriers:

> "*[Missed appointments] happens quite frequently"* with one supposing "*it is a lot to do with trust for the health system. … no-one really takes the time to figure out why they didn't come." (FGC)*
>
> *"It is still sad to see the same things that were asked to address in decades that have gone, that still exist and thus inequity continues."* (prov9-Pacific).

Discrimination

Institutional biases and racism in healthcare were emphasised, with Māori and Pacific providers concerned about underlying values and structures privileging Pākehā (New Zealander of European descent) aspirations and needs:

> *"There is a cultural difference I think between the way Māori and Pākehā approach health. I think the system has really been designed for Pākehā to succeed, based on medical evidence which is largely in Pākehā population. Lots of our science, the way we practise, is based on essentially white male cohorts. There is an increasing realisation that that's a problem." (prov11*-Māori*).*

A lack of cultural safety[12] was mostly raised as an issue by Māori providers, specifically identifying poor healthcare and inadequate training for health providers:

> "*He wasn't a bad patient at all. It is just cultural competence and cultural safety." (prov1*-Māori*).*
>
> "*Māori providers aren't everywhere, yet. You would also want culturally safe services outside of the kaupapa Māori providers.*" (prov1-Māori) yet "*I felt like there was just not adequate cultural training that was meaningful, that they [providers] could really understand." (prov10*-Māori).

Māori participants felt that cultural concordance contributed significantly to cultural safety in healthcare "*I bring my cultural values into the examination room, it lets the patient relax and share the burden with me knowing that they can trust me to sort it out." (prov11*-Māori).

A non-Māori/Pacific clinician noted the importance of culturally safe relationships, reflecting the efforts of the Māori-led service they worked at to upskill all staff in this area "*If you don't have a good relationship the person is obviously not going to come to see you. … And so, you have to think about what the elements of a culturally safe relationship are and how do primary care physicians build their ability to work in that cultural space." (prov4-non-Māori/Pacific*).

Both participant groups commented on impacts of internalised stigma and fears: *"He [Māori patient] was scared of going to the doctors and getting a diagnosis that would kind of make it real. …but it's not until you get that formal diagnosis. He left it so late because of that fear." (FGEMS)* and *"I think he was in denial, there's a lot of shame, whakamā [embarrassment], denial. He had no money at all to get to the clinic, so he was whakamā." (prov10*-Māori*).*

Theme Three: Improving heart health care for Māori and Pacific patients and families

Both Māori/Pacific and non-Māori/Pacific providers proposed solutions to improve heart health care for Māori and Pacific patients,

but they diverged in the focus of interventions, approaches to workforce development, and the role of culturally concordant services.

Where to intervene

Participants in both groups commented on the impacts of social determinants of health on Māori and Pacific peoples and whānau, especially for patients who are primary income earners for their household. A concerned Māori provider noted, *"He was the main income worker, so he didn't really take on board how sick he was because he had all these other worries." (prov5-Māori)*. A non-Māori/Pacific provider agreed that "*socioeconomic factors are huge. Particularly, accessibility of anything other than primary health becomes very difficult." (FGEMS*)..

Recognising *"There's layers and layers of the social determinants of health that just get piled on and then creates all these extra conditions,"* one non-Māori/Pacific provider endorsed *"always take a public health approach to address these issues, then we need to address the recourses– poverty is a big thing to address." (prov4-non-Māori/Pacific*).

Participants encouraged adequately resourced, community-level efforts, from *"let's start doing health education at events … in the community" (FGEMS)* to health promotion *"that's around community development*" (prov1-Māori). Another participant observed: "*Health promotion grabs the attention and health education leads to actions and lifestyle changes. …Hence more resources are required for our people to get in and have CVDRA before they have heart problems." (prov9-Pacific*).

Optimal CVD care pathways

Participants across both groups called for urgent attention to accelerating care pathways for Māori and Pacific patients into, through, and on to post-acute CVD care. Current processes were considered inadequate, with one frustrated Māori provider describing "*a huge backlog where some people weren't being seen or even just falling off the list at all or not being seen for six to nine months following their event, and no cardiologist eyes over them at all." (prov6-Māori).* To combat this risk, another participant urged "*a special pathway for high needs populations like Māori and Pasifika people– from 111 call through to community follow-up– chest pain is assumed cardiac until proven otherwise as often these groups underplay their symptoms."* (prov2-Pacific).

A Māori provider noted the importance of patients and families in planning the transition from hospital to community in an optimal care pathway *"to ensure that people are discharged on excellent medicine, have got all the follow-ups in place, they know exactly where they're going and what's happening. Again, it came back to that established relationship and spending the time to explain. I do find that things do fall down from the hospital to the community, to the clinics, and there's a big gap there." (prov10*-Māori).

Optimal care also involves various services collaborating to support patients. As evident in one Kaupapa Māori institution: *"It's that liaison with the GP to get these ones that aren't engaging, maybe if they need the medication and whatnot, then it's following up with that, providing all that education as well. The workplaces have now come onboard to do that and allow the time … sometimes we'll be here after hours because we have to wait until they finish work." (prov6-Māori).*

Māori and Pacific providers

Both groups of participants considered Māori and Pacific providers as important to achieving equitable CVD care and outcomes, although these services were often under-resourced: *"The poor people [Māori and Pacific health workers/providers] working in these roles are very busy. They work long and beyond their scope of practice, to provide services to the people. They are drowning in their work and there is more need out there than of them providing the services, therefore require more resources." (prov3-non-Māori/Pacific*).

Māori and Pacific participants advocated for specific funding to integrate these services within the health system, given their contribution and results: *"I think our Māori and Pacific health teams are working really, really hard. Things are getting better and better all the time. We need more Māori health support in hospitals and the kaiāwhina or the navigators." (prov10*-Māori). As Māori and Pacific providers are currently mostly located in community and primary care settings, participants sought more vertical integration of Māori and Pacific providers with hospital-based services: *"I would have way more appropriately resourced, and I would probably focus first appropriately resourced Māori community, but also secondary care based cardiac care teams* because *in terms of the community-based kind of secondary prevention cardiac rehab type things, you'd want kaupapa Māori providers*." *(prov1*-Māori*).*

Participants noted that health services often brought in these providers as an afterthought, when early, meaningful engagement was more effective: "e*ngage meaningfully and effectively with Pasifika community health support workers and providers to make maximal impact.… [and] there is adequate resourcing of services to achieve equitable health outcomes."* (prov2-Pacific)..

Workforce development

Most providers emphasised the importance of increasing the Māori and Pacific workforce, encouraging Māori and Pacific clinicians to pursue speciality training in cardiology and to redress shortfalls in primary care. "I *would address the GP shortage. Acknowledging that GPs can't do everything, I think we need to be looking at the role of clinical nurse specialists, nurse practitioners and getting them to work in primary care as well as secondary care." (FGC*)..

The two groups diverged on leadership development, with Māori and Pacific participants seeking more leaders and decision-makers to advocate for Māori and Pacific health concerns. As one said, "*There needs to be a workforce development, such an important thing in medicine for addressing this. We need more Māori and more Pasifika health care workers, doctors, leaders, managers in the system to really push some of these issues."* As to their mind *"cultural change within medical circles needs to be led from the top."* (prov11-Māori).

Discussion

This in-depth qualitative study, embedded within a multi-disciplinary research program using Kaupapa Māori and Pacific research methodologies, explored healthcare providers' perspectives on the inequities in heart health outcomes among Māori and Pacific peoples

in Aotearoa. Our findings reveal systemic failures in the delivery of heart health care for Māori and Pacific peoples. These failures require attention to the social determinants of health, a radical revision of Western-centric models of care, and expansion of a well-resourced Māori and Pacific workforce, from frontline clinicians to leaders in policy and decision-making. Some distinctions in perspectives offered by Māori and Pacific providers compared with non-Māori/Pacific providers also provide insights into how inequities in healthcare arise. There is a critical need to counter dominant narratives entrenched in the health system that perpetuate the status quo.

By design, this research was informed by our earlier study, which identified the needs and aspirations of Māori and Pacific patients:[6]

- Healthcare providers must be responsive to patients' unique values and strengths, as well as their lived experiences of intergenerational disadvantage and institutional racism.
- The heart holds a special place in Māori and Pacific worldviews, encompassing physical, spiritual, and cultural aspects, making it particularly important for services to uphold patients' mana.
- High-quality care includes accessible information and reciprocal communication.
- More health practitioners from their own communities are highly desired, alongside a culturally safe workforce.
- Importantly, patients viewed the health system as operating in various silos (e.g. prevention, acute care and chronic management), but they valued the whole heart health care journey, i.e. "from getting in to staying in."[6]

Reflecting on these findings, most service provider participants in the present study acknowledged the value of tikanga Māori and Fa'a Pasifika ways at all levels of the patient journey. However, differences in how this was understood and expressed provide insights into how inequities can arise. Māori and Pacific providers emphasised the importance of engaging with families as crucial sources of strength and support when caring for Māori and Pacific patients. They also observed how concerns and responsibilities related to family needs exacerbate the difficulties faced by patients who deprioritise their own health. These providers endorsed family-centred whānau ora principles of care as did patients and whānau participating in our earlier study. While non-Māori/non-Pacific providers in public hospitals acknowledged the importance of families, they were more likely to express concerns about risks to individualised and cost-efficient care. Some suggested Māori and Pacific patients could benefit from engaging with support groups involving people with the same condition. While this is a common support and advocacy model, evidence for this approach in redressing ethnic inequities is lacking. In contrast, Māori and Pacific providers advocated resourcing Kaupapa Māori and Pacific services and health promotion activities involving whānau, churches, cultural and social groups. This aligns with recommendations from patients and whānau,[6] as well as a growing body of evidence.[9,13]

The importance of upholding the mana and dignity of patients and whānau as pivotal to respectful reciprocal relationships was conveyed almost exclusively by Māori and Pacific service providers. The lack of this was considered central to the challenges Māori and Pacific patients face. This is strongly aligned with the experiences shared by patients in our previous study, who noted being looked down upon (as reflected in the Tongan phrase "sio lalo") or feeling that clinicians did not care about their problems.[6] The relative absence of this important aspect of care in non-Māori/Pacific providers' reflections suggests a lack of awareness of what constitutes culturally safe care, and likely impacts of power and privilege. As Lambert et al. assert,[14] non-Indigenous health professionals' limited understanding of lived experiences and health literacy may constrain the extent to which organisational barriers impacting on the care of Indigenous patients are recognised and addressed. Māori and Pacific providers in our study often ascribed their ease with mana-enhancing relationships and sensitivity to Māori and Pacific patients' lived experiences to their shared cultures, a theme echoed in our patient–whānau study.[6] While a recent review of studies conducted in other countries did not find an association between "cultural concordance" and the quality of patient–provider communication,[15] there is increasing evidence of the health equity value of services designed by and for Māori and Pacific peoples,[3,4,9,10,13] including marae-based health and social initiatives.[16,17] Additionally, investment in primary care and systematic screening and treatment programs have been shown to be cost-effective ways to improve outcomes in chronic disease management in Indigenous populations.[18,19]

Strengths and limitations

This study, and the wider program it is embedded in, has unique strengths in the existing literature, being co-led by Māori and Pacific clinicians, underpinned by Kaupapa Māori and Pacific methodologies. It provided novel insights into how service providers' ethnic affiliations and proximity to communities of concern influence what is perceived as underlying problems and effective solutions. The perspectives of Māori and Pacific providers more closely reflected those of their patients.[6] Their comments also reflected high levels of distress, observing biases in care experienced by Māori and Pacific patients and tardy responses from leaders and decision-makers. These are concerning cumulative burdens experienced by Māori and Pacific clinicians who are inadequately represented and resourced in the workforce and subjected to racist and discriminatory practices themselves.[20,21] Our findings must also be interpreted in light of their limitations. We did not canvass nationally representative views of all providers covering all settings. To reduce compromising confidentiality, we did not distinguish ethnic groups within the broad categories of "Pacific" and "non-Māori/Pacific" or identify specific roles or organisations. Underserved intersectional communities, especially rural Māori communities, require further attention.[22]

Implications for public health

Reflecting on inequities in heart health outcomes among Māori and Pacific peoples, most providers participating in this study highlighted gaps in the health system, exacerbated by wider structural and social factors. Māori/Pacific providers explicitly identified institutional biases, racism, and differential access to services influencing evidence–practice gaps and patient and whānau experiences. The New Zealand Government recently issued a circular explaining "that it is the Government's expectation that public services should be prioritised on the basis of need, not race."[23] This is of concern because evidence shows that ethnicity is a marker of need, and targeting by ethnicity is an effective way of allocating resources.[24] The results of the current study support ethnic-specific interventions.

To address inequities, most provider participants advocated for an enhanced, well-resourced Māori and Pacific heart health care workforce in ethnic-specific services, as well as the broader health system. Workforce development initiatives are already in place. Through Manawataki Fatu Fatu for ACCESS, four PhD and three Masters students (all Māori, Pacific or both) received funding and academic support to complete their studies. The cohort included healthcare professionals and researchers. Pūtahi Manawa (https://www.putahimanawa.ac.nz/) runs annual summer studentship programs, for Māori and for Pacific students studying towards health careers. These provide culturally tailored learning and research experiences in heart health. In association with the Cardiac Society of Australia and New Zealand (CSANZ), Te Whare Tukutuku provides a safe space for the Maori and Pacific heart health workforce to connect and provide collegial support.[25] These initiatives are having positive impacts but are currently reliant on funding grants. Secure, sustainable funding for workforce development is needed.

Collectively, this research highlights a critical need for expedited heart health care pathways for Māori and Pacific peoples, addressing the interlocking social and structural inequities. This demands equity-focused, appropriately resourced, holistic and relational models of heart health care that are co-designed with Māori and Pacific patients and whānau, and delivered by an anti-racist, culturally safe workforce.

Ethics

We have previously published the guiding principles and methodology of the Manawataki Fatu Fatu research program.[5,6] In brief, the team, comprising largely Māori and/or Pacific researchers, is co-led by Māori (MH) and Samoan (CG) clinicians and employs Kaupapa Māori and Pacific research methodologies.[7,8] The present study was led by senior Pacific (TT-S) and Māori (KB) researchers and was approved by the Auckland Health Research Ethics Committee.

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Non-financial interests

SH is a member of the Whānau, Consumer and Clinician Digital Council and National Cardiac Clinical Network for Te Whatu Ora Health New Zealand. VS is a member of the Data Safety Monitoring Board for the EQUIT3 clinical trial and a board member of the Auckland Medical Research Foundation and deputy chair of their medical assessment committee. KB is co-director of Pūtahi Manawa | Healthy Hearts for Aotearoa New Zealand. All other authors declare no relevant financial or non-financial interests.

Conflicts of interest

Matire Harwood and Corina Grey report financial support was provided by Heart Foundation of New Zealand. Matire Harwood and Corina Grey report financial support was provided by Healthier Lives National Science Challenge.

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