Enablers of Māori health equity in rural primary healthcare: Insights from Te Tai Tokerau.

Jessica Jane Morgan-French

A research component submitted to

Auckland University of Technology

in partial fulfilment of the requirements for the degree of

Doctor of Health Science (DHSc)

2026

Faculty of Health and Environmental Sciences

Taupua Waiora Centre for Māori Health Research

Abstract

Although Te Tiriti o Waitangi establishes a clear commitment to equity between the Crown and whānau (family) Māori, disparities for Māori and rural whānau have persisted for decades. Despite sustained efforts by primary health providers and commissioners to design equitable health services, these inequities remain entrenched, further compounded by the current government's decision to downplay equity as a priority in Aotearoa New Zealand. Differences in health outcomes, obstacles to access, and reports of cultural unsafety within healthcare delivery indicate Māori health disparities. In response to these issues, this thesis examines how Māori health equity is enabled, implemented, and experienced in rural primary healthcare in Te Tai Tokerau (Northland), Aotearoa New Zealand. The research investigates how rural general practices facilitate equitable care for rural whānau Māori and identifies the practices, processes, models, and systemic policies that are most effective in enabling equity.

This study was grounded in Māori-centred methodology, guided by the ethical principles of Te Ara Tika, and informed by Kaupapa Māori research principles. This methodological approach ensured cultural safety, upheld Māori values, and privileged whānau voices as central to the inquiry. Semi-structured qualitative interviews and focus groups were undertaken with both whānau (n=8) and rural primary care providers (n=8) across Te Tai Tokerau. The interviews and focus groups, generated rich accounts of healthcare delivery, organisational realities, and the relational dynamics that shape the delivery of rural primary health care.

Reflexive thematic analysis revealed four themes: understanding equity and root causes, being aware and culturally safe, establishing partnerships with purpose, and how rural primary health care is delivered. Analysis of the data emphasised the importance of accessible care, whakawhanaungatanga, trust and cultural safety as foundational elements of equity-enabled care.

The findings demonstrate that rural providers can act as sites of innovation and resilience. However, they are also constrained by systemic pressures, including workforce shortages, inadequate funding mechanisms, and structural inequities within the healthcare system. The research highlights the significance of whānau-centred

approaches, alongside the need for affordable, accessible, and culturally safe health services.

The thesis introduces the “Equity Wave” model, a conceptual framework designed to capture how equity can be enabled in practice. The model illustrates the interplay of relational, organisational, and systemic levers, emphasising that equity is not achieved through policy aspirations alone but through everyday actions, structures, and decision-making within healthcare providers. The model highlights a dual axis of cultural worldviews and practice-whānau outcomes, and identifies quadrants that characterise equity-enabled practice, such as Whakawhanaungatanga (relationship-building) and Whakataurite (enacting equity). This framework is a practical tool for guiding the delivery of equity-enabled care.

In this thesis, I argue that equity must be understood as an enabling practice rather than an aspirational ideal, and that rural contexts offer unique insights into how care can be delivered more equitably. The study also outlines practical recommendations for scaling and testing the Equity Wave model nationally, supporting future primary care systems and providers that honour Te Tiriti o Waitangi and embed whānau voices at every level of design and delivery.

This thesis offers both critique and hope: critique of a system that has too often failed rural Māori, and hope in documenting quality practices and models that enable equity providing the opportunity for an evidenced-based approach for providers who influence outcomes for whānau Māori.

Contents

List of figures

List of tables

List of appendices

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.

Artificial intelligence (AI) tools including generative artificial intelligence have not been used to generate ideas or findings, producing content or influencing critical analysis. AI tools have been used for proof reading and administrative purposes.

Jess Morgan-French Date: 29 September 2025

Karakia

Kia kotahi ai ngā pūkenga me ngā whakaaro

Hei tiaki i ngā whānau mā ngā mahi hauora

Me mahitahi tātou, mā te katoa

Haumi e!

Hui e!

Tāiki e!

We come together today to collaborate and share strengths, for the betterment of our whānau and to serve Aotearoa New Zealand through healthcare. Through sharing strengths, wisdom and working together we contribute to a better health system

* This Karakia was developed by the General Practice New Zealand (GPNZ), Ngā Matapihi o te Wairua rōpū in 2022 during the time I was working for GPNZ.

Dedication

To Pania, Jhai, Caine, and Rākaia Morgan-French, and to the tamariki and mokopuna yet to come. This research is for you and your future wellbeing. May you grow old in an equitable health system that honours your identity and serves you as Māori.

Acknowledgements

When they say, 'it takes a village', they really mean it. This research journey has been one of immense growth, challenge, and transformation and I could not have done it alone.

To my husband, Rewiri, though I doubt you'll ever read this thesis, I hope you'll one day know it was for you too. You may not have always known what I was doing, or even what this work is truly about, but your quiet, steadfast support in every other way has meant the world.

Mum, thank you for planting the seeds of values in my heart that this research has now set ablaze. Your strength and your belief in me have carried me further than words can say.

To my supervision team, Professor Denise Wilson and Dr Te Wai Barbarich-Unasa, your wisdom, leadership, mentorship, and unwavering generosity came into my journey at a critical moment. Thank you for holding space for me and showing me what it means to lead, mentor, supervise, listen and educate with integrity and heart.

To my research kāhui, Season-Mary Downs, Carrissa Thompson, Chris Tooley, Rawiri McKree Jansen, Carlton Irving, Kyle Eggleton, and Peter Crampton, you have challenged, stretched, protected, and inspired me. Your guidance kept me culturally grounded and academically sharp. You created a space where I could grow safely, even when it was uncomfortable. Thank you.

I want to acknowledge Whaea Rhoena Davis, an extraordinary Nurse Practitioner, leader, and researcher from Te Tai Tokerau. Throughout my journey, she walked alongside me as a support person, gently guiding, encouraging, and giving me the confidence to carry this work forward. Her belief in me meant more than words can capture, and her wisdom and aroha continue to shape the way I think and act. It is with deep gratitude and love that I honour her memory in these pages.

To Mr Willy T, from the very beginning, when I asked whether I should conduct this research in Te Tai Tokerau or create distance from my home, your reply was simple and powerful: "You do it here, in Te Tai Tokerau. This is your home, do it for our people." Those words became a compass. Thank you.

To General Practice New Zealand (GPNZ) and Collaborative Aotearoa Charitable Trust, thank you for supporting me, my research, and the kaupapa (collective philosophy) at its heart. To my colleagues across both organisations: your belief in me has meant more than you know. Primary care in Aotearoa New Zealand is fortunate to have people like you working with such passion and purpose. The work you do matters deeply.

A special acknowledgement to Sue and Alan Knox who provided thesis formatting and proofreading services and Shoba Nayar who provided transcription services.

To the rural providers I interviewed your commitment to enabling equity is visionary. Being based in Te Tai Tokerau is not a limitation, it is your superpower. Thank you for sharing your insights and standing strong for our communities.

Finally, and most importantly, to the whānau who shared their stories, your voices brought this research to life. You grounded it in truth, in pain, in hope. I carry your words with deep respect. My greatest hope is that this work leads to something meaningful for you, that it helps shape a future where your whānau receive the equitable care you deserve.

Preamble

My comprehension of the lived experiences of Māori, deepened significantly when I formed a relationship with Rewiri, who is now my husband. His enduring struggle within the healthcare system to comprehend the cause of his lower chest pain, address a genetic knee growth issue, and manage numerous inherited health conditions unveiled a stark reality to me.

Throughout our relationship, Rewiri sought assistance from over five General Practitioners across four different medical centres in Aotearoa New Zealand. I bore witness to his disparate treatment compared to mine. I observed healthcare providers asserting the acceptability of enduring pain, expressing helplessness due to restrictions imposed by specialist referral criteria. I experienced the disappointment of denied referral letters. Above all, I witnessed my husband's apprehension about mortality, fearing he might not be there for his children.

I have also worked in the health system for the past 13 years, starting my career in Personal Training, supporting the wealthy to lose weight, rehabilitate injury and find happiness in movement. One day, when I was training one of my favourite clients, Dr Chris Reid (General Practitioner), we shared an insightful conversation about his patients who needed my health coaching services but were not in a financial position to pay for them. We concluded that things needed to change, and as I concluded my master’s in business administration, I landed in primary care, specifically in General Practice. Working for a corporate organisation, we established a health coaching service for the people who needed it the most. This was the start of a life-long commitment to supporting the achievement of health equity in Aotearoa New Zealand.

I share my purākau (story) with you as the motivation behind my research. My research aim is to unpack the enablers within our rural primary health system that improve health equity for whānau Māori, highlighting the things that work. Through provider and whānau voices, stories and dreams, this research aspires to inspire the future health system of Aotearoa New Zealand. Most importantly, my goal is to effect change, ensuring my husband's presence for our mokopuna, his children, and his wider whānau, preserving their wellbeing for the forthcoming generations.

Ethics approval

Auckland University of Technology Ethics Committee (AUTEC): 23/157 8 August 2026.

Chapter 1 Introduction

This thesis aims to highlight the enablers within rural general practice that promote equitable health outcomes for Māori, examining perspectives from both healthcare providers and whānau (families). While extensive research has documented the barriers to equitable care for Māori (Cullen et al., 2023; Dixon et al., 2021; Gibson et al., 2015; Jeffreys et al., 2020; Kidd et al., 2022; Sheridan et al., 2011), establishing a compelling rationale for change, there remains a critical gap in understanding the specific actions and initiatives that effectively enable equity for whānau Māori located in rural communities.

This chapter outlines the rationale, aims and purpose of the research and ultimately presents the central research question. I introduce myself as the researcher, sharing my perspective and context for undertaking this study. Critical terms are defined, positioning their meaning in the context of this work. An overview of Māori health will follow this, outlining significant inequities that rural Māori face. I conclude this chapter by providing an overview of the thesis order and what the readers can expect.

1.1 The opportunity

The persistent health inequities experienced by Māori, the Indigenous peoples of Aotearoa New Zealand, represent a critical challenge in the nation's healthcare system, particularly in rural areas (Minister of Health, 2023; Waitangi Tribunal, 2019). Despite the theoretical guarantees of good health for Māori whānau (families) elevated in Te Tiriti o Waitangi , the practical implementation of the principles recommended by the Waitangi Tribunal in its report of the Wai 2575 claim, has been largely inadequate (Waitangi Tribunal, 2019). This discrepancy between promise and reality underscores the urgent need for research into the enablers of equitable health outcomes for Māori in rural primary care settings.

Māori, the Indigenous people of Aotearoa New Zealand, make up 17.8% of the country’s population (Statistics New Zealand, 2023), which indicates a Māori population increase of 111,657 since the 2018 census data collection. The Māori population is expected to further increase to 20% by 2038 (Te Puni Kōkiri | Ministry of Māori Development, 2018). One in five people in Aotearoa New Zealand, live in a rural

community (Health New Zealand, 2023). Rural Māori, are people of Māori descent living in non-urban areas of Aotearoa New Zealand, and rurality is defined in-depth later in this chapter. Rural Māori, in Aotearoa New Zealand, face significant health inequities compared to both urban Māori and non-Māori populations (Minister of Health, 2023; Sheridan et al., 2024). According to 2023 census data, approximately 21.5% of Māori live in rural areas. This compared to 15% of the Aotearoa New Zealand population (Statistics New Zealand, 2023). This translates to roughly 210,000 Māori residing in rural settings (Statistics New Zealand, 2023). Rural Māori, experience higher rates of all-cause mortality and amenable mortality compared to their urban counterparts; with research showing that living rurally, exacerbates the already substantial health inequities faced by Māori (Jaye et al., 2022). These health disparities are attributed to various factors, including limited access to healthcare services, greater distances to emergency departments, higher levels of socioeconomic deprivation, and systemic issues, including colonisation, specifically within the healthcare system. For instance, rural Māori are more likely to live in areas of high deprivation (Crampton, 2020), have higher rates of multimorbidity, and face challenges in accessing timely and culturally appropriate healthcare (Baker et al., 2019; Crampton, 2020; Eggleton et al., 2022; Sheridan et al., 2024). The combination of rurality and ethnicity creates a compounded effect on health outcomes, highlighting the urgent need for targeted equity-enabled interventions and policy changes to address these persistent inequities.

Given the complex intersection between Māori people and rurality in Aotearoa New Zealand, this research seeks to address the persistent primary health inequities faced by rural communities daily. The intersection refers to the layered and multifaceted relationship of being both being Māori and living in rural areas, which compounds the challenges in accessing healthcare, creating a more complex journey towards equitable health outcomes. For many Māori, rurality is not just a geographic choice but a cultural and spiritual connection to whenua (land), whānau, and whakapapa (genealogy). Yet, rural health systems are often under-resourced, inflexible, and disconnected from these cultural realities, further entrenching inequities.

1.2 Background – Ko wai au?

Nō Holland tōku tūpuna

I tae mai ōku tūpuna ki Aotearoa I te tau 1949

Ko Puhanga Tohora te maunga e rū nei tōku ngākau

Ko Ōtaua te awa e mahea nei aku māharahara

Ko Hankrekis rāua ko Jan ōku mātua tupuna

Ko Lexie Pieters tōku māma

Ko Rewiri Morgan-French tōku hoa rangatira

E noho ana au ki Te Kerikeri me Aku whānau

He Tangata Te Tiriti ahau

Ko Jess Morgan-French tōku ingoa

My journey into this research is a story of connection, commitment, and the pursuit of health equity for rural Māori in Te Tai Tokerau. Growing up in a rural community, I was surrounded by the values of aroha, manaakitanga, and a deep sense of community. These early experiences shaped me. My memories go back to being a student at Karetu Primary School, where I first encountered the cultural richness and resilience within rural Māori communities. Those early interactions taught me the importance of inclusive, community-centred care and left an enduring mark on how I see the world.

My parents played a significant role in this foundation. My mother, a dedicated teacher, had a unique gift for seeing the potential in others. She was a solo mother, and despite the challenges, she was endlessly supportive, always nurturing those around her. My father, a skilled farmer, embodied hard work and resilience. Together, they taught me to value empathy and resilience, qualities that have later guided me both personally and professionally.

My education led me from a small rural primary school to a medium-sized rural private secondary school, a transition that exposed me to stark contrasts in resources and diversity. I began to understand, even then, the systemic inequities that exist within education and beyond. This awareness grew over time, and I carried it forward into my professional life.

My career in health began with a Bachelor's in Sport and Recreation, a path inspired by a passion for physical education. Starting my own personal training business was an eye-opening experience. I quickly learned that those most in need of support were often the least able to afford it. This realisation spurred me toward further education, and I pursued a master’s in business administration (MBA) with a final project focused

on general medical practices in Whangārei. In these general practices, I saw the dedication of primary care providers up close. My knowledge, empathy and respect for general practice deepened, and I knew this was where I wanted to make a difference.

My commitment to this research is also deeply personal. My husband, Rewiri, is of Ngāpuhi descent, with connections to Ōtaua, Hokianga, Rotorua and Maketu. Witnessing his experiences with the health system, experiences that often felt dismissive and inadequate, was both heartbreaking and eye-opening. It exposed me to the privilege I hold as a Pākehā and intensified my drive to work towards evolving the current Aotearoa New Zealand health system, to one that serves Māori equitably. This journey is about creating change and ensuring that future generations, including our children Pania, Jhai, Caine and Rākaia experience a healthcare system that truly meets their needs as Māori.

As a non-Māori, I am deeply committed to being a Tangata Tiriti (Non-Māori person who is committed to upholding Te Tiriti). To me this means that I act with authentic intent to give effect to Te Tiriti o Waitangi and live up to the principles described throughout the Treaty articles.

Today, as Chief Executive Officer of *Collaborative Aotearoa*, I am privileged to work alongside primary health organisations across the country, supporting them in their pursuit of quality and equitable care. I am inspired by the leaders I meet, both Māori and non-Māori, who are equally committed to equity and quality in healthcare. This research is my way of contributing to that vision, seeking to understand the enablers in rural primary healthcare that support equitable outcomes for Māori, honouring Te Tiriti o Waitangi, and working toward a future where all whānau Māori can thrive.

1.3 Research question

The central question guiding this research is: *How can rural primary care service providers in Te Tai Tokerau be enabled to provide equitable services to Whānau Māori?*

Research aim

The overarching aim of this study was to investigate the enablers of Māori health equity in rural primary care. This study aimed to contribute practical insights to enhance equitable health service delivery in Te Tai Tokerau.

This research had two main aims:

1. To explore the experiences and perspectives of rural primary care providers and whānau Māori in Te Tai Tokerau, to understand what activities, actions, systems and/or models best support equitable outcomes for rural Māori people.
2. To seek aspirations from rural primary care providers and whānau Māori in Te Tai Tokerau.

In undertaking this study, I aimed to highlight and celebrate the positive efforts of rural primary care providers working tirelessly to deliver equitable care to Māori communities, focused on general practice services. Too often, conversations about rural health focus on the challenges and systemic barriers, overshadowing providers' dedication and innovative strategies employed on the ground. This research aimed to bring these efforts into the spotlight, recognising the commitment and resourcefulness of rural providers in overcoming obstacles to meet the needs of Māori patients.

By examining what works well within rural general practices, I hope to capture the positive practices, strategies, and adaptations that contribute to equitable health outcomes. These insights can serve as a blueprint for other providers and inform policymakers and funders about the critical enablers that support successful care delivery in rural settings. The work of these providers is not only foundational to their communities but is also a testament to the potential of primary care when it is rooted in cultural understanding, community engagement, and a genuine commitment to equity.

A qualitative research design informed by Māori-centred methodologies and appreciative inquiry methods, underpinned this study. The research comprised five whānau interviews and three whānau focus groups alongside five provider interviews and three provider focus groups. Whānau n=8 and provider n=8 with the total n=16 with 24 individuals involved in the data collection. The blend of perspectives between providers and whānau was essential and enabled balanced insights.

1.4 Māori people in Aotearoa New Zealand

Aotearoa New Zealand is a small country with a population of just over 5 million and consists of two main islands (North and South) and a series of smaller islands. Māori

are the Indigenous people of Aotearoa New Zealand, also known as tangata whenua (people of the land). Māori identity is deeply rooted in whakapapa (genealogy) and whenua (land), which connects individuals to their ancestors and land. This affiliation is expressed through iwi (tribes) and hapū (sub-tribes), which traditionally functioned as the primary social and political units of Māori society.

Māori health inequities in Aotearoa New Zealand are deeply entrenched and persistent, reflecting broader societal and historical factors. Despite Aotearoa New Zealand's universal healthcare system, Māori experience significantly poorer health outcomes compared to non-Māori, including lower life expectancy and higher rates of preventable diseases (Brown & Bryder, 2023). These disparities are linked to systemic issues such as institutional racism, economic disadvantage, and the ongoing impacts of colonisation (Hobbs et al., 2019). Māori are less likely to access healthcare services and, when they do, often receive less effective care, exacerbating health inequities (Waitangi Tribunal, 2019).

1.5 He Whakaputanga o te Rangatiratanga o Nu Tirene

He Whakaputanga o te Rangatiratanga o Nu Tirene (the Declaration of Independence of the United Tribes of New Zealand), holds profound significance for Te Tai Tokerau, as a cornerstone of its cultural, political, and historical identity. Signed in 1835 at Waitangi by 34 northern Māori chiefs, this document asserted the sovereign power and authority of Māori in Aotearoa New Zealand, gaining recognition from the British Crown and establishing a framework for engagement with foreign powers (New Zealand Government, 1835). Its importance extends beyond its historical context, serving as a precursor to Te Tiriti o Waitangi and providing crucial insight into the intentions of the rangatira who later signed Te Tiriti. For many in Te Tai Tokerau, particularly Ngāpuhi, He Whakaputanga remains a living document, continually affirming tino rangatiratanga (self-determination) and informing contemporary discussions on cultural identity, political autonomy, and economic development. As such, it continues to shape the region's narrative, educational curricula, and ongoing negotiations between Māori and the Crown, underscoring its enduring relevance in the socio-political landscape of Te Tai Tokerau.

The importance of He Whakaputanga is critical, as many iwi and hapu in Te Tai Tokerau have always maintained that the Crown must honour both He Whakaputanga and Te Tiriti o Waitangi (Downs, 2019). He Whakaputanga remains an unlegislated document, but many believe that without He Whakaputanga there might have never been a Treaty (O'Malley, 2018).

1.6 Te Tiriti o Waitangi

In the wake of Hīkoi mō Te Tiriti, a moment in Aotearoa New Zealand's political landscape, this section takes on profound significance. This unprecedented demonstration, which unfolded in early December 2024, saw between 40,000 and 100,000 citizens (Radio New Zealand, 2024) from across the nation converge in Wellington, marking it as the largest protest in the country's recorded history. The catalyst for this extraordinary mobilisation was the contentious Waitangi Treaty Principles Bill, a piece of proposed legislation that has ignited intense debate and scrutiny throughout Aotearoa New Zealand. The bill was rejected by Parliament in April 2025.

The scale and passion of Hīkoi mō Te Tiriti underscore the deep-seated importance of Te Tiriti o Waitangi (The Treaty of Waitangi) in Aotearoa New Zealand's national identity and governance structures. This mass movement based on kotahitanga, which saw participants undertaking journeys from the far reaches of both Te Ika-a-Māui (North Island) and Te Waipounamu (South Island), exemplifies the enduring relevance of Te Tiriti and the articles in contemporary Aotearoa New Zealand society.

Te Tiriti o Waitangi is a foundational document in Aotearoa New Zealand that holds significant importance in shaping the country's health system and its obligations to Māori health. Signed in 1840 between Māori chiefs and representatives of the British Crown, Te Tiriti establishes a partnership between Māori and the Crown, guaranteeing certain rights and protections to Māori (Kingi, 2007). Te Tiriti o Waitangi is the Māori text of the agreement between Māori and the Crown and effectively resulted in the British establishing governance over its settlers in Aotearoa New Zealand and affirmed Māori rangatiratanga (sovereignty) over their own affairs (Came et al., 2020). However, the English text differed significantly. Te Tiriti comprised eight of the nine sheets signed, with the majority of Māori signatories endorsing the Te Reo Māori text.

Under the rule of contra proferentem, Aotearoa New Zealand is directed to interpret the agreement according to the Māori text; therefore, this is the version we, as a nation, should uphold. (Came et al., 2020).

In the context of health, Te Tiriti o Waitangi places a responsibility on the Crown to actively protect and promote Māori health and wellbeing. The Waitangi Tribunal's Hauora Report (2019) emphasised that this responsibility extends to "the provision of health services" and requires the health system to "keep itself informed" about the needs of Māori, including achieving health equity.

The principles of Te Tiriti, as interpreted for the health sector by the Waitangi Tribunal (2019), include:

- Tino rangatiratanga (self-determination)
- Equity
- Active protection
- Options
- Partnership

These principles provide a conscientious method of developing and delivering health services to ensure they meet the needs of whānau Māori and work towards eliminating health disparities. The notion of the principles were introduced by the Treaty of Waitangi Act 1975 (Baker et al., 2019). These principles are woven through the Aotearoa New Zealand health system and are referenced in strategy documents such as the He Korowai Oranga – the Māori health strategy (Ministry of Health, 2023).

Despite these commitments, significant health inequities between Māori and non-Māori persist. The Waitangi Tribunal found in 2019 that the Crown had breached Te Tiriti by, failing to design and administer the current primary health care system to actively address persistent Māori health inequities (Waitangi Tribunal, 2019). This tribunal finding underscores the ongoing challenge and urgency in realising the promises of Te Tiriti within the health system.

As we explore the enablers of equitable health outcomes for Māori in rural general practice, it is crucial to consider how these initiatives align with and fulfil the obligations outlined in Te Tiriti o Waitangi. This research seeks to contribute to the

broader goal of achieving health equity for Māori, as mandated by Te Tiriti o Waitangi, the foundational agreement between Māori and the Crown.

Reflection

My connection to Te Tiriti o Waitangi has deepened even further since becoming the parent of a Māori daughter. This profound experience has added a new dimension to my understanding and appreciation of the document's significance.

As a parent, I now view Te Tiriti through the lens of my child's future. It's no longer just about my own relationship with Te Tiriti, but about ensuring that my daughter grows up in an Aotearoa New Zealand that honours its articles, principles and promises. This personal stake has intensified my commitment to upholding Te Tiriti in both my professional and personal life.

Raising a Māori child has made me more acutely aware of the lived experiences of Māori in ways I hadn't fully grasped before. It's made me more acutely aware of the ongoing impacts of colonisation and the critical importance of protecting and promoting Māori rights, language, and culture. I've come to understand more deeply that Te Tiriti is not just a historical document but a living agreement that shapes our present and future.

This new perspective has strengthened my resolve to contribute to a society where my daughter can thrive as a Māori. It has reinforced the importance of ensuring equitable outcomes in health, education, and all aspects of life. I now see more clearly how the principles of partnership, active protection, equity, options and tino rangatiratanga are not abstract concepts, but vital elements that will directly affect my child's life opportunities.

This experience has highlighted the importance of intergenerational knowledge and connection. I feel a greater responsibility to learn and understand Te Tiriti so that I can pass this knowledge on to my daughter, helping her to navigate her identity and rights as tangata whenua (land).

In essence, becoming a parent to a Māori child has transformed my relationship with Te Tiriti o Waitangi from an intellectual understanding to a deeply personal commitment. It's no longer just about honouring a historical agreement, it is about actively shaping a future where my daughter, and all Māori children, can fully express their tino rangatiratanga and cultural identity.

1.7 Waitangi Tribunal hauora claim - Wai2575

The Waitangi Tribunal's Hauora report was released in 2019 as part of the Health Services and Outcomes Kaupapa Inquiry (Wai2575). The Waitangi Tribunal (2019) report, concluded that the Crown had breached the Treaty of Waitangi principles by failing to design and administer a primary health care system that adequately addressed persistent Māori health inequities. The report highlighted systemic issues in the health system, including underfunding of Māori primary health organisations, insufficient data collection, and a lack of proper recognition of Te Tiriti principles in health legislation. The report concluded with recommendations of significant health reforms, including developing a new Te Tiriti clause for health legislation, exploring the establishment of an independent Māori Primary Health Authority, and strengthening accountability mechanisms in the primary health care sector. The Tribunal emphasised that the Crown's failure to address these issues constituted a breach of its Te Tiriti obligations and contributed to the ongoing health disparities between Māori and non-Māori populations. Furthermore, the report called for a more holistic approach to Māori health, recognising the importance of addressing social determinants of health and incorporating Māori health models and practices into the healthcare system. These findings and recommendations challenged the Crown to take immediate and comprehensive action to reform the health system and fulfil its Te Tiriti responsibilities to Māori.

This research was initially motivated by the Wai2575 claim and phase one findings. It aims to highlight enablers within rural primary care services, which in turn supports the delivery of equitable primary healthcare services and, therefore, addresses some of the historical failings within our health system.

1.8 Aotearoa New Zealand primary healthcare system

Since this research began in 2021, Aotearoa New Zealand's primary healthcare system has remained under sustained pressure, shaped by ongoing health reform efforts and political shifts that have slowed the pace of transformation. The significant reforms under the Pae Ora (Health Futures) Act started in July 2022. At the centre of the reformed system is Te Whatu Ora, Health New Zealand (Te Whatu Ora), the country's largest health entity responsible for commissioning and delivering health services

across the motu (country). Te Aka Whai Ora, the Māori Health Authority, was established in July 2022 under the Pae Ora (Healthy Futures) Act as part of major health reforms. Its purpose was to give effect to Te Tiriti o Waitangi, address longstanding Māori health inequities, and strengthen partnership within the health system. The Authority was responsible for commissioning kaupapa Māori services, supporting iwi and Māori providers, embedding mātauranga Māori in service design, and holding the health system accountable for equitable outcomes. Te Aka Whai Ora signalled hope by having Māori determine health service delivery and have an impactful voice in the design and delivery of health services across Aotearoa New Zealand.

Te Aka Whai Ora was disestablished on 30 June 2024 after the National-NZ First-ACT coalition government passed urgent legislation, fulfilling its campaigned pledge to reintegrate Māori health leadership into Health New Zealand and the Ministry of Health. The government argued this would streamline services and create a single health system. But Māori leaders and providers strongly criticised the move as undermining Te Tiriti o Waitangi and Māori self-determination in health (Aspin et al., 2024). The rushed process, limited consultation, and lack of a clear alternative plan drew widespread concern, and later in 2024 the Waitangi Tribunal found the disestablishment breached the Treaty, recommending reconsideration of a stand-alone Māori health authority. This tribunal debate continues today.

Medical primary healthcare in Aotearoa New Zealand is delivered predominantly through general practices, which are typically privately owned and operated businesses. These practices may be owned by individual general practitioners (GPs), groups of GPs, corporate organisations, Māori health providers, not-for-profit trusts, or community-based organisations. This mixed ownership model allows for local responsiveness and community engagement, but also contributes to variability in infrastructure, sustainability, and capacity across the country (Sheridan et al., 2023).

As of 2022, approximately 950 general practices were operating in Aotearoa New Zealand, of which around 400 are considered rural (HealthPoint, 2022). Rural practices often face unique challenges, including workforce shortages, limited access to specialist care, and increased service demand due to ageing or geographically dispersed populations (Crampton & Baxter, 2018). Despite these challenges, rural

practices are critical in delivering comprehensive, community-based care to some of the country's most underserved populations.

General practices are funded primarily through a capitation model (Hau et al., 2022; Sapere, 2022). Under this approach, practices receive a fixed payment per enrolled patient, adjusted for risk factors such as age and sex. Capitation is intended to support population health management and reduce reliance on government-funded fee-for-service payments. A patient co-payment fee remains in place across most general practices operating under a fee-for-service model (Sapere, 2022).

The Primary Health Organisations (PHO) services agreement governs the financial and contractual arrangements that underpin general practice funding (Health New Zealand, 2024). Amendments to this agreement are negotiated through the PHO Services Agreement Amendment Protocol (PSAAP), a collaborative forum comprising representatives from general practice, PHOs, and government agencies. The PSAAP process influences funding allocations, service expectations, and the overall viability of general practice services (O'Keefe, 2007).

PHOs, of which there are currently 30 across the country, are responsible for improving health outcomes and promoting equitable access to care within their enrolled populations (Department of the Prime Minister and Cabinet, 2020). They are a direct result of the Primary Health Care Strategy 2001. Despite major structural reforms elsewhere in the health system, PHOs have remained largely unchanged over the past twenty-three years. However, their future remains uncertain, contributing to a sense of instability and complexity within the primary healthcare sector.

Wider determinants of health care services are often delivered through non-government organisations (NGOs), Māori health providers and Pacific health providers. These providers will usually have a range of services, including social services. Whānau Ora (wrap around service) is a well-known service in Aotearoa New Zealand, launched in 2010. The service was introduced under the leadership of the then Minister for the Community and Voluntary Sector, Hon. Tariana Turia, as a flagship Māori health and social wellbeing initiative (Te Puni Kōkiri | Ministry of Māori Development, 2010). The Whānau Ora approach shifted the delivery focus from individuals to whānau as a collective, empowering families to achieve their aspirations across health, education, housing, and employment. The flexibility within the service delivery enables

community workers to offer flexible services to the whānau (Whānau Ora Comissioning Agency, 2019). The connection general practices have with Whānau Ora providers is variable, with some fully integrated and others with no relationship whatsoever.

In 2024, significant restructuring occurred within the Whānau Ora commissioning landscape, when two of the major commissioning agencies devolved and four new entities were established to take their place. While the political intent of these changes is to strengthen localised commissioning and responsiveness to whānau needs, the systemic effects of this transition remain uncertain. Given the scale of disruption, it is likely that Whānau Ora service delivery will experience short-term impacts as providers, funders, and communities adjust to new commissioning structures and processes (Mathias & Ahuriri-Driscoll, 2025). The extent to which these changes enhance or destabilise existing service provision will become clearer over time, but in the immediate term, such systemic shifts inevitably bring challenges for continuity, coordination, and whānau-centred outcomes.

This section outlines the rapidly shifting landscape of Aotearoa New Zealand's primary healthcare system since 2021, highlighting both structural reform and ongoing pressures. The establishment and later disestablishment of Te Aka Whai Ora illustrate the contested role of Māori leadership in health, with its removal sparking Treaty breaches and ongoing debate. At the same time, general practice remains the cornerstone of care delivery. However, its mixed ownership, reliance on capitation, and challenges in the rural workforce continue to shape variability and inequity in access. PHOs, despite being central to the system since 2001, remain largely unchanged yet face uncertainty in the current environment. Alongside this, Whānau Ora and other Māori and Pacific providers play a critical role in addressing wider determinants of health, though recent restructuring of commissioning agencies has created disruption with uncertain impacts for whānau-centred services. Collectively, these dynamics underscore the fragility, complexity, and contested nature of primary healthcare reform in Aotearoa New Zealand.

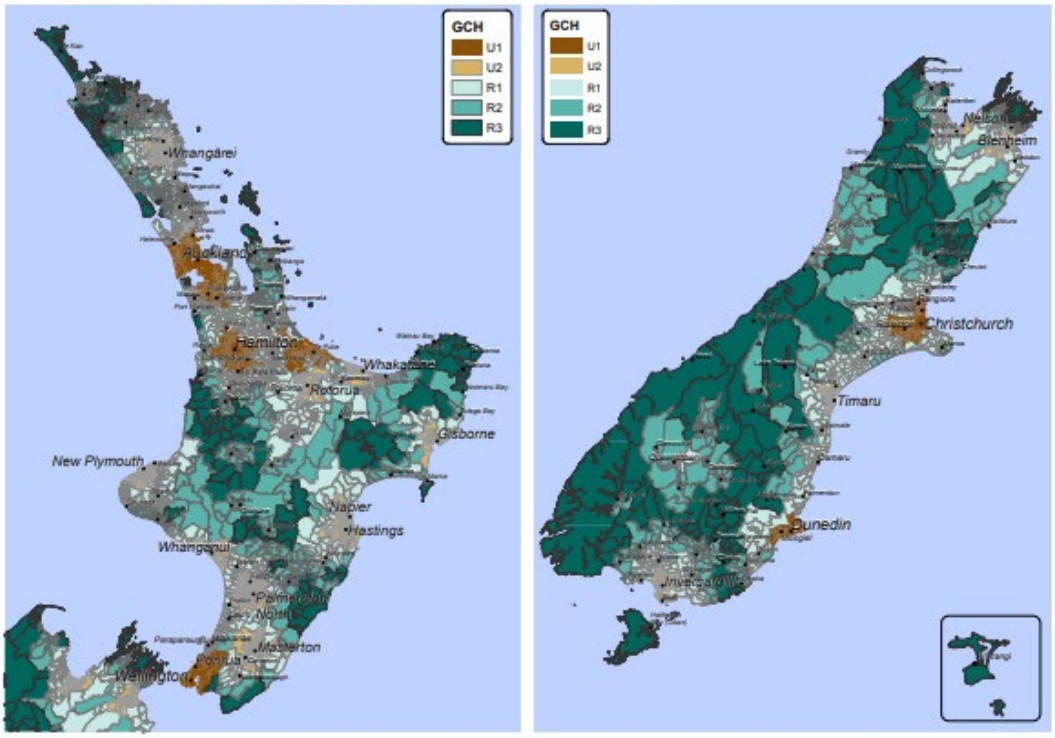
1.9 Defining 'rurality'

Rurality refers to living in areas that are not within the orbit of urban areas. These areas usually have small, spread-out populations and are more isolated than urban areas (Minister of Health, 2023; Statistics New Zealand, 2023). Nixon et al. (2021) emphasise that rurality is more than geographic distance or population size, it is a multi-dimensional concept shaped by community characteristics, access to health services, travel time to referral centres, and local socio-cultural identity. Nixon et al. (2021) claims that generic classifications often misrepresent rural communities, masking inequities in health outcomes. Rurality must therefore be understood as both a spatial reality and a social construct, defined by lived experience as much as by statistical boundaries. The tool developed by Whitehead et al. (2022) is a simple web-based algorithm that aligns areas of Aotearoa New Zealand with rurality classifications. This has been converted into the geographical classifications for health as outlined in the rural health strategy. See Figure 1 Figure 1below.

Figure 1 Geographical classification for health by two factors, distance and population size

Population size thresholds	Drive-time thresholds				
	Urban		Rural		
	Urban (U1)	Urban (U2)	Rural 1 (R1)	Rural 2 (R2)	Rural 3 (R3)
Major urban (Population ≥ 100,000)	≤25min		>25 to ≤60 min	>60 to ≤90 min	>90min
Large urban (30,000 - 99,999)		≤20min	>20 to ≤50 min	>50 to ≤80 min	>80min
Medium urban (10,000 - 29,999)			≤25 min	>25 to ≤60 min	>60min
Small urban (1,000 - 9,999)				≤25 min	>25min

Maps of New Zealand by Geographic Classification for Health



Source: (Minister of Health, 2023, p. 78)

One in four New Zealanders lives in a rural area or small town, making rural areas the minority compared to urban populations (Dalton, 2021). As of 2023, approximately 68,100 Māori people in New Zealand live in rural areas (Statistics New Zealand, 2023). Given the total Māori population was around 887,493 in the 2023 Census, this means that roughly 7.7% of the Māori population resides in rural regions (Statistics New Zealand, 2023). As of the 2023 Census, there were 77,475 people of Māori descent residing in the Te Tai Tokerau Region, representing about 39.9% of the region's total population of 194,007 (Statistics New Zealand, 2023). Te Tai Tokerau as per Whitehead

et al. (2022) rurality classification is majority Rural 3 (R3) with pockets of Rural 2 (R2) (Minister of Health, 2023).

People living in rural communities are also more exposed to transportation unavailability and financial hardship issues, making access for some people in rural areas either unaffordable or simply unattainable (Statistics New Zealand, 2020). When rurality layers on top of ethnicity, inequity can be exacerbated. Therefore, it can be concluded that many rural Māori, face greater health inequities, specifically when accessing health services, compared to urban populations (Smith & Jansen, 2006).

1.10 Defining health equity

Sheridan et al. (2011) and Braveman and Gruskin (2003) describe and define health inequities as "differences in health that are unnecessary, avoidable, unfair, and unjust" (Braveman & Gruskin, 2003, p. 254). The World Health Organization (2010) supports the viewpoint of defining equity as the "absence of avoidable or remediable differences among groups of people" (World Health Organization, 2010, p. 1). These definitions confirm the rhetoric, that is, the unacceptability of health differences between groups of people.

Health equity in this research refers to moving beyond equal access to services and instead ensuring that healthcare delivery responds to the distinct needs of Māori and rural communities. It involves recognising that systemic and structural barriers create different starting points for whānau, and therefore, equity requires intentional action to address these imbalances.

1.11 Defining whānau Māori (in the context of this research)

In this thesis, the term whānau Māori is used to describe people who whakapapa Māori by descent. While the concept of whānau can be broadly interpreted to mean family, extended family, or community, in the context of this research it specifically refers to Māori whānau whose identities, relationships, and wellbeing are grounded in whakapapa. This definition is important as it acknowledges that the lived experiences, values, and health aspirations of whānau Māori are distinct from those of non-Māori, and are shaped by unique cultural, historical, and social contexts. By explicitly framing whānau in this way, the research acknowledges the centrality of whakapapa in Māori

worldviews and ensures that the findings remain aligned with the equity needs and lived realities of Māori communities.

1.12 Rationale for change

It is widely acknowledged that Aotearoa New Zealand's health system has failed Māori; perpetuating systemic inequities that are starkly reflected in health statistics (Crampton & Baxter, 2018; Sheridan et al., 2024). By 2001, Māori already experienced the poorest health status of any population group in the country (Waitangi Tribunal, 2019). Although modest improvements have been observed in recent years, health outcomes for Māori remain unacceptably poor (Ministry of Health, 2023). Standard clinical health indicators, such as obesity rates and smoking prevalence, continue to highlight these disparities (Ministry of Health, 2023). Ministry of Health (2020) reported Māori adults are 1.8 times more likely to be obese and 2.8 times more likely to be current smokers than non-Māori. These indicators point to deeper, long-standing challenges within the health system. Perhaps most notably, life expectancy for Māori remains seven years less than non-Māori (Ministry of Health, 2020; Sheridan et al., 2024). Simpson (2020) emphasised that these inequities persist across the lifespan and are significantly influenced by the social and economic determinants of health. At its core, the ongoing challenge within Aotearoa New Zealand's health system, particularly in rural settings, is the enduring inequity between Māori and non-Māori.

1.13 Thesis outline

This introductory chapter establishes the context, purpose, and significance of the research. It seeks to understand enablers in rural general practice that provide equity for Māori. The chapter highlights the researcher's personal and professional motivations and locates the research within the broader discourse of health inequities, particularly in rural Aotearoa New Zealand. It also outlines the guiding research question and aims.

Chapter Two outlines the strategies for locating and reviewing relevant literature, drawing on international and national sources related to rural Indigenous primary healthcare.

Chapter Three describes the Māori-centred methodological approach, establishing a dual accountability framework that honours both Māori and Western research processes. This methodology chapter introduces and explores Te Kākano, the Māori-Centred model that underpins the research design. It concludes with a reflection on the researcher's positionality, acknowledging the responsibilities and relationships inherent in conducting research within a Māori context.

Chapter Four outlines the data collection methods, with interviews guided by appreciative inquiry elements. The chapter describes a dual data collection approach involving healthcare providers and whānau Māori who access health services. Participants were interviewed individually or in small focus groups, depending on their preference and context. Reflexive thematic analysis was deployed to analyse the data. This chapter outlines the stages of the data analysis process.

Chapter Five opens with three rich and emotive patient stories shared during the data collection phase, offering powerful insights into the lived experiences of Māori whānau in Te Tai Tokerau. These narratives set the context for the findings chapter that follows.

Chapter Six is the findings chapter. Four overarching themes and fourteen sub-themes were identified and are outlined in this chapter. Each theme, along with its corresponding sub-themes, is critically analysed. Participant voices are interwoven throughout the chapter, with quotes of raw data presented alongside interpretive analysis to deepen the understanding of key findings.

In Chapter Seven, the findings are discussed in relation to current literature and broader health system frameworks. The discussion considers implications for rural health policy and practice, especially in ensuring solutions that enable equity for Māori are resourced and respected. In this discussion chapter I introduce the Equity Wave, a model that has been created during this research process to support the applied application of the research.

Chapter eight concludes this thesis. The conclusion chapter summarises the thesis, describes the research limitations and discusses the opportunities for future research.

1.14 Conclusion

There is a pressing need for research that identifies the enablers of equitable health outcomes for Māori in rural primary care settings. This study seeks to explore the factors that currently support successful and equitable service delivery in rural Te Tai Tokerau, a rural region with a high Māori population. By focusing on what contributes to achieving equity, rather than solely examining systemic failures, this research offers a strengths-based perspective that highlights practical, constructive pathways for improvement.

The findings of this study are intended to inform the development and implementation of whole-of-system approaches, that support rural primary care providers in eliminating health inequities for Māori, in line with the principles of Te Tiriti o Waitangi. Through creating space for both providers and whānau Māori to share their whakaaro (thoughts) on effective, equitable service delivery, this research aims to generate insights that will guide future health policy and practice across Aotearoa New Zealand.

In summary, this thesis will investigate the enablers within rural general practice that promote equitable health outcomes for Māori, contributing to the ongoing efforts to improve Māori health outcomes in rural Aotearoa New Zealand.

Ehara taku toa i te toa takitahi, engari he toa takitini

My success is not mine alone, it is the success of the collective.

This whakataukī reflects the kaupapa of this research and embodies the values that underpin my journey through the Doctor of Health Science programme.

Chapter 2 Literature review

2.1 Introduction

The delivery of primary care services to rural Māori communities presents significant challenges, raising important questions about our current understanding of these services. This chapter provides a comprehensive review of national and international literature on this critical topic. A narrative literature review was conducted, focusing on publications from 2014 to 2024, aiming to examine how primary health services are delivered to rural Māori and Indigenous people, with a particular emphasis on enabling and achieving equitable health outcomes. This approach allowed for the synthesis of existing research and empirical knowledge, facilitating a more effective utilisation of research findings.

Health equity is commonly referred to throughout this review. The World Health Organization (2010) (WHO) definition is “equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right and health equity is achieved when everyone can attain their full potential for health and wellbeing” (World Health Organization, 2010, p. 1). This literature review utilises the WHO definition of equity as it was the most commonly referred to definition throughout the literature.

The review is structured first to outline the search strategy used to identify and select relevant literature. This is followed by a presentation of the key findings, highlighting the main themes and insights gathered from the reviewed publications. The chapter concludes with a discussion summarising the findings and identifying gaps in the current literature, providing a solid foundation for understanding the current state of primary care delivery to rural Indigenous communities and highlighting areas for quality improvement and future research.

2.1.1 Search criteria and strategy

To locate literature relevant to the topic, well-defined and specific search criteria were essential. The search strategy was executed in two phases to gather a comprehensive

understanding of existing research. First, national literature was identified using key databases focusing on key words that linked the findings to Māori, the Indigenous people of Aotearoa New Zealand. Second, the scope search was broadened to include key words that linked the findings to international literature on other Indigenous populations such as First Nations and Aboriginal peoples. The search utilised databases including PubMed, Scopus, CINAHL, MEDLINE via EBSCO and PSYCINFO. Keywords, sentences, and advanced filtering techniques were employed in the search process and are outlined in Table 1. The search captured 10 years from 2014 to 2024 and was completed in January 2025.

The literature selection process for this study adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, as outlined by Liberati et al. (2009). The inclusion and exclusion criteria played a crucial role in identifying suitable research for this review, ensuring that the selected literature met specific relevance and quality standards aligned with the review question. These criteria, outlined in Table 1, were instrumental in enhancing the overall suitability of the gathered research. Notably, allied health and hospital sector research was deliberately excluded from the review. This strategic decision was made due to the distinct funding mechanisms for allied health and hospital services within the Aotearoa New Zealand health system, which make them incomparable to primary care services. Graham and Masters-Awatere (2020) support this approach, emphasising that the complexities of healthcare funding and service delivery, particularly in addressing health disparities, require a nuanced perspective, that acknowledges the unique challenges and opportunities within each sector. By focusing specifically on general practice services, the review aimed to provide a more targeted and relevant analysis of the research question at hand.

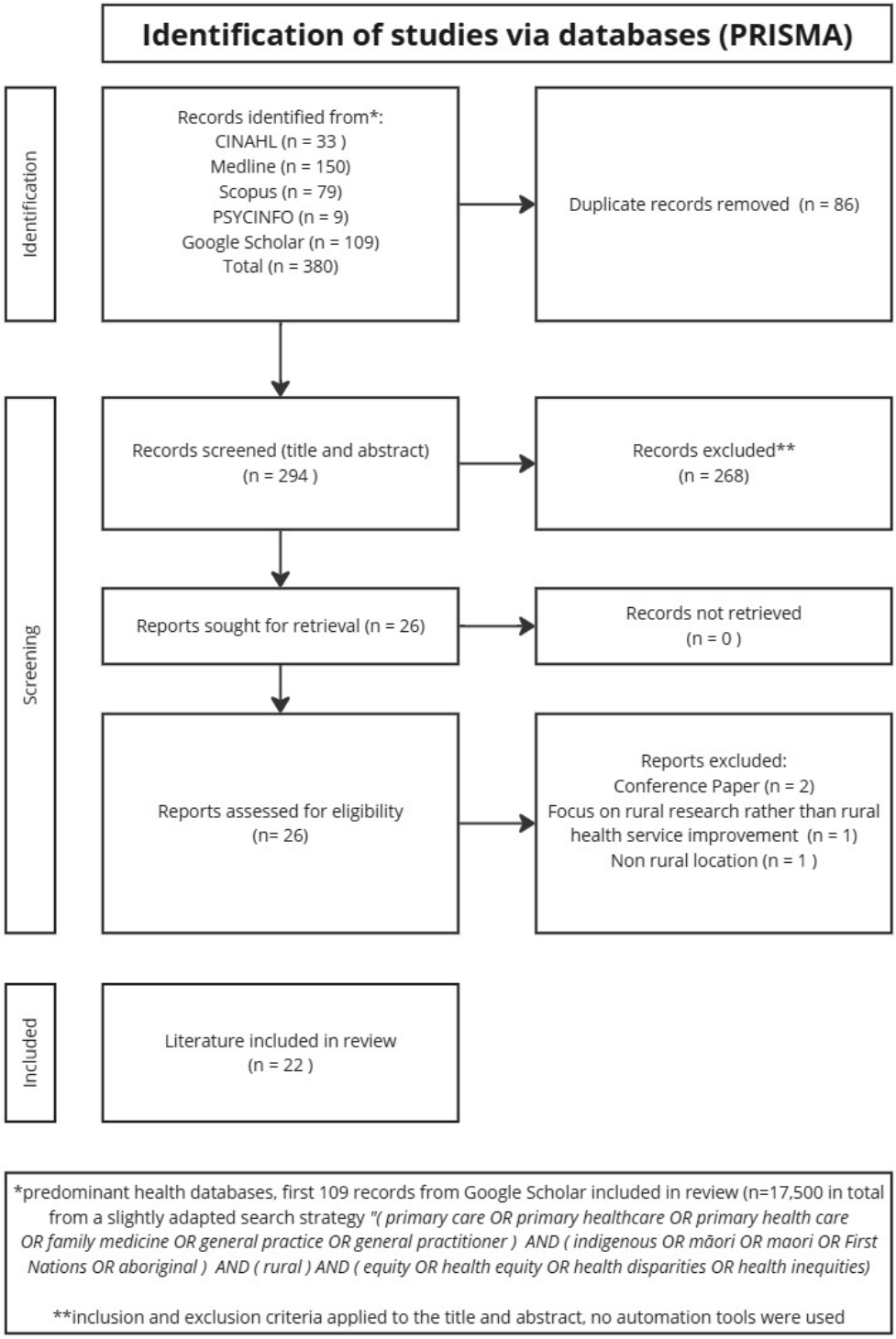
Table 1 Inclusion and exclusion criteria

Inclusion	Exclusion
Written in English	People under the age of 16 years
Primary care/primary healthcare/family medicine/general practice/general practitioner	Allied health services
Adults 16 years and older	Hospital services
Māori/Indigenous/First Nations/Aboriginal	Did not focus on equity for Indigenous populations
Published between 2014-2024	
Enablers to equity	

Note. Table outlines the inclusion and exclusion criteria used during the literature search.

A PRISMA flow chart Figure 2 was utilised to visually represent the systematic review process, detailing the number of records at each stage of selection.

Figure 2 PRISMA flowchart



n = number

The EndNote referencing tool was used to import all the literature from the databases. First, duplicates were removed. The process continued with an initial screening of all article titles against the predetermined inclusion and exclusion criteria (Table 1). Articles that met the inclusion criteria were put into a separate EndNote library. In the second stage of screening, the full text of the remaining articles was reviewed against the same criteria, further refining the selection. At each stage, the number of articles

included and excluded was carefully documented, providing a clear trail of the selection process.

Out of 380 initial articles identified, 86 were excluded due to being duplicates, leaving 294 articles for title and abstract screening. After title and abstract review, 26 articles remained for full-text assessment, of which 22 were ultimately included in the final analysis (Figure 2). This methodical approach ensures a thorough and transparent examination of the relevant literature. The screening and selection process was undertaken by the researcher, with oversight and guidance provided through academic supervision; however, no independent duplicate review by additional researchers was conducted. Key information from the eligible articles was systematically recorded in a literature summary table, and pertinent areas of knowledge were incorporated into the review, providing a solid foundation for the study's findings and conclusions.

The articles were thoroughly analysed, and key information was organised into a literature summary table as introduced above. Table 3 includes essential details such as the source, title, study methods, conclusions, and their relevance to my research.

2.2 Themes from the literature

This review draws on research from various countries with Indigenous populations, including Aotearoa New Zealand, Australia, Canada, and the United States, to identify best practices and common challenges in providing equitable primary health care. The review concluded had three themes, each with sub-themes, that addressed how rural Indigenous primary health services are developed to achieve equity in health outcomes for Indigenous populations. These are outlined in Table 2.

Table 2 Key themes

Theme	Sub-theme
Theme 1: Access, affordability and acceptability	Access Affordability Acceptability
Theme 2: Workforce and models of care	Models of care Team-based care Shift to preventive care
Theme 3: Healthcare policy and funding	Funding

These themes collectively contribute to the overarching discourse required, enabling equitable and timely access to primary healthcare in rural areas. Reviewing the literature provided valuable insights into previous research conducted within primary care, highlighting existing knowledge and accomplishments. It also helped identify gaps in the current knowledge base that this research aims to address.

2.2.1 Discussion

2.2.2 Access, affordability and acceptability

The health of Indigenous populations cannot be understood in isolation from the broader social, economic, and environmental conditions that shape daily life. The literature consistently identifies social determinants, including housing, employment, financial stability, spiritual wellbeing, and social connectedness, as having a profound influence on health outcomes, particularly for Indigenous populations in rural communities (McCalman et al., 2018). These determinants do not sit at the edges of healthcare; rather, they are central to understanding why health disparities persist despite the existence of primary healthcare services.

For rural Indigenous populations, the compounding effect of negative social determinants significantly amplifies barriers to accessing healthcare, creating a cycle that is difficult to interrupt through health service intervention alone (Henderson et al., 2018). The literature highlights that when social determinants are left unaddressed, access to healthcare becomes increasingly difficult, reinforcing existing inequities rather than resolving them (McCalman et al., 2018). This positions social determinants not simply as background context but as active drivers of health inequity that must be accounted for in the design and delivery of primary care services.

The literature identifies several barriers to healthcare access, affordability and acceptability for rural Indigenous populations. When these challenges are effectively addressed, healthcare services become more equitable to these communities. Henderson et al. (2018) conceptualised the concept of equitable access, through the interconnected dimensions of availability, affordability, and acceptability. Equity is not a singular concept but rather a multidimensional one, manifesting differently across access to health services, access to the broader determinants of health, and the achievement of equitable health outcomes. These distinctions are important, as

progress in one dimension does not automatically translate to gains in another (Henderson et al., 2018). A service may be physically available yet financially inaccessible, or accessible yet delivered in a manner that is culturally unsafe. Similarly, equitable access to services does not guarantee equitable outcomes if the underlying social determinants shaping health remain unaddressed (McCalman et al., 2018). Understanding these distinctions is essential to interpreting the findings of this review and the complex interplay of factors that either enable or hinder equity for rural Indigenous populations.

This section identifies and critically analyses the literature associated with each of these critical elements.

Access

Access is referred to as availability and is referred to in the literature as being broader than 'provider availability', spanning out to include geographical accessibility alongside social and physical barriers to receiving services (Henderson et al., 2018). Despite the known challenges associated with access and availability, very few national policies have been implemented to change the status of these healthcare elements. In Aotearoa New Zealand there has been the introduction of a Very Low Cost Access (VLCA) contract, which aimed to enable affordability of general practice services to practices serving mostly Māori patients. This was achieved through providing qualifying general practices with additional funding, conditional on restricting the amount of money they can charge patients as a co-pay for services (Chin et al., 2018). Chin et al. (2018) describe the lack of access and availability as inequitable and have sustained preventive deaths in communities. Drovandi et al. (2022) supports Chin's perspective, discussing the impact access has on the shorter life expectancy of Aboriginal and Torres Strait peoples in Australia. The literature showcases the importance of having services available to whānau when and where they need them.

Comprehensive primary healthcare, which is defined as having services broader than traditional 15-minute doctor consultations and healthcare professionals with a wider range of skills, enables equity by catering to a wider span of healthcare needs (Freeman et al., 2021). Nearly all of the literature reviewed mentioned social determinants and the significant impact that they have on Indigenous wellbeing.

Equitable health outcomes can be achieved by having a wider range of health professionals who offer health service offerings that can meet patients' needs.

Virtual technologies have emerged as potential enablers of healthcare access, particularly in rural areas facing workforce shortages (Gupta et al., 2023), but their implementation requires careful consideration to ensure equitable outcomes and cultural safety, especially for Indigenous patients. The literature emphasises that virtual healthcare should complement, not replace, face-to-face care. This hybrid approach is crucial for building trust among patients, particularly those from Indigenous communities. Fitzpatrick et al. (2023) underscore the necessity of designing virtual healthcare services with Indigenous cultural and ethical safety in mind, aligning with the principles of co-creation and co-design in service development (Bath & Wakerman, 2015).

However, it's critical to note that the primary driver for implementing virtual healthcare has been workforce shortages in rural areas, rather than a proactive approach to improve equitable outcomes. Given this context, a re-evaluation of virtual service delivery is imperative, with cultural and ethical safety prioritised in designing and implementing these services. While the research reviewed generally supports the integration of virtual healthcare options in primary care settings, it also raises essential caveats, including concerns about cultural safety and the potential for digital divides to exacerbate existing inequities if services are not thoughtfully designed with Indigenous patients in mind (Beks, Mitchell, et al., 2022; Fitzpatrick et al., 2023). While virtual technologies offer promising solutions to healthcare access issues, their implementation must be approached with caution and cultural sensitivity, utilising a balanced, patient-centred approach that combines virtual and in-person care, underpinned by principles of cultural safety and equity.

While virtual health care has been a primary focus, the literature identifies additional technologies as potential enablers of equity, including artificial intelligence (AI), drone technology, and point-of-care testing (Causer et al., 2024; Gupta et al., 2023). Artificial Intelligence’s (AI) rapid evolution and its growing potential to disrupt various industries, including healthcare, warrant critical examination. In the healthcare context, AI applications extend beyond clinical decision-making to areas such as resource management and logistics (Gupta et al., 2023). However, implementing AI in

healthcare requires careful consideration of clinical safety and ethical implications, which may limit its adoption rate compared to other industries. The potential of AI to contribute to health equity in rural areas is significant, yet it is crucial to critically assess the readiness of rural healthcare systems to implement and maintain such advanced technologies (Gupta et al., 2023). Factors such as infrastructure, staff training, and ongoing support must be evaluated to ensure that AI implementation does not inadvertently exacerbate existing health disparities for Indigenous people.

Point-of-care testing emerged in the literature as a promising technology for improving healthcare access in rural areas, particularly for Indigenous populations (Causer et al., 2024; Gupta et al., 2023; Lawton et al., 2023).

Integration of point-of-care testing for sexually transmitted infections in rural and remote primary care clinics has demonstrated clinical effectiveness and improved access to diagnostic services. This study by Causer et al. (2024) suggests positive outcomes for point-of-care testing, and it also identified the critical need to consider the broader implications of such technologies. Questions arise regarding the long-term sustainability, cost-effectiveness, and impact on the overall healthcare ecosystem of these solutions in rural areas. While access to diagnostic tools such as point-of-care testing is crucial, it is equally important to ensure that healthcare providers have the necessary skills and support to interpret and act upon the information provided by these technologies (Causer et al., 2024). This was aligned with the work of Lawton et al. (2023), sharing similar findings and conclusions.

While emerging technologies offer promising avenues for addressing healthcare equity in rural communities, a nuanced and critical approach is necessary. Future research should focus on comprehensive evaluations of these technologies, considering their immediate benefits and long-term impacts on healthcare delivery, patient outcomes, and health equity in rural settings.

Affordability

Affordability is crucial in ensuring equitable access to healthcare services across various global contexts. This concept is intrinsically linked to the principle of "leaving no one behind" in India, as emphasised by Gupta et al. (2023), highlighting its importance in achieving universal health coverage. In Australia, the commissioning

planning process prioritises affordability as a strategic objective, aiming to enhance equity of access by locating services in underserved areas and ensuring their affordability, as noted by Henderson et al. (2018). However, maintaining affordable healthcare services presents challenges. Thomas et al. (2014) identified several difficulties in service provision, including recruiting and retaining skilled professionals, maintaining health infrastructure, ensuring service quality and safety, and balancing these factors with the need for affordability, particularly in contexts with small population bases. These challenges underscore the complex interplay between affordability and other aspects of healthcare provision, specifically for rural Indigenous populations. This highlights the need for innovative approaches and careful planning to create healthcare systems that are both affordable and effective while ensuring equitable access for indigenous populations.

Acceptability

The art of delivering primary healthcare relates directly to patient outcomes. Cultural awareness, cultural safety, and cultural competence are terms frequently used within the Aotearoa New Zealand health system to identify the awareness and application of how patients are acknowledged, treated, and respected (Martel et al., 2020). The concept of cultural safety has been evolving since 1991, with Ramsden (2002) bringing it to the forefront in 2002. Ramsden (2002) discussed cultural safety as two key things: firstly, a concept that aims to identify attitudes that may consciously or unconsciously exist towards a different culture; secondly, an attempt to support health professionals in transforming those attitudes and demonstrating actions that enhance the patient's connection with the professional. Although the work of Ramsden (2002) was not directly included in the literature review, the concept of cultural safety was frequently discussed. I have defined it within the context of this literature review, drawing on an Aotearoa New Zealand Indigenous definition and viewpoint.

Several studies have demonstrated the importance of culturally safe and competent care (Barbo & Alam, 2024; Bath & Wakerman, 2015; Blattner et al., 2024; Lawton et al., 2023; Martel et al., 2020). Indigenous people across the world have received healthcare layered with many forms of discrimination and maltreatment, which resulted in adequate and quality care not being received (Barbo & Alam, 2024). This sub-theme directly relates to the acceptability of services, outlining the delivery of

services and how people are treated and cared for when seeking healthcare (Martel et al., 2020). Like many things, without input from lived experience into service design, the outcomes cannot truly connect with Indigenous populations, resulting in many studies recommending Indigenous representation in healthcare policy-making and leadership (Barbo & Alam, 2024).

Culturally safe care is universal, with principles such as kindness, connection, care and respect being commonly understood elements of care and therefore, should be universally understood. “Indigenous people in this review valued safe, accessible and respectful care, aligning with their basic human rights as outlined in the United Nations Declaration on the Rights of Indigenous Peoples” (Barbo & Alam, 2024, p. 148). The literature is heartbreaking, with qualitative stories of Indigenous people avoiding services due to the fear of expected trauma and mistreatment. This behaviour has had a fundamental impact on the health of Indigenous populations. Martel et al. (2020) discuss culturally safe care as a deep understanding of unconscious bias, highlighting the critical reflection health professionals need to carry to enable them to be culturally safe, this is inclusive of people’s values, beliefs and preferences in the provision of health care and critical when aspiring to achieve equitable care.

The evidence suggests a critical relationship between equity for Indigenous people and culturally safe care, indicating that the art form of care delivery will have a profound impact on the quality of service received. Therefore, all health professionals are urged to treat their patients in accordance with universally accepted and well-established principles, such as kindness and respect.

2.2.3 Workforce and models of care

The challenge of recruiting and retaining health professionals in rural areas has been a persistent issue, and was further intensified by the COVID-19 pandemic in 2020 (Blattner et al., 2024). To address this, researchers have explored localised rural innovative care models and alternative working methods, focusing on solutions and enablers arising from workforce shortages in rural locations (Bath & Wakerman, 2015; Lyle et al., 2017).

A key finding from the literature is the importance of community ownership and leadership in service provision, which not only promotes equity in rural healthcare but

also supports the retention of healthcare providers and facilitates culturally appropriate practices (Lyle et al., 2017). This approach, characterised by shared decision-making with communities, enables effective service delivery and implementation changes. The effectiveness of local leadership in rural healthcare is further reinforced by the inherent strengths of rural communities (Jaye et al., 2022). These communities often exhibit strong social connectedness, a sense of intergenerational responsibility, and a feeling of belonging, contributing to the resilience and effectiveness of rural healthcare systems. By leveraging these community strengths and promoting local leadership, rural areas can better address their healthcare workforce challenges and improve overall health outcomes (Jaye et al., 2022; Lyle et al., 2017). This approach recognises the unique characteristics of rural communities and harnesses them to create sustainable and effective healthcare solutions.

Models of care

The literature revealed significant insights into the design and delivery of primary care health services in rural communities. Multiple studies emphasised the importance of locally tailored services that address the specific needs of rural populations (Bath & Wakerman, 2015; Lyle et al., 2017). This approach aligns closely with the concept of cultural safety, which is crucial for achieving equitable outcomes, particularly for Indigenous peoples (Barbo & Alam, 2024). Cultural safety and its alignment to models of care or service design was a consistent theme emerged across the literature (Barbo & Alam, 2024; Bath & Wakerman, 2015; Blattner et al., 2024). The research reinforced that healthcare services designed in collaboration with communities lead to substantially improved quality and equity. While quality remains a central topic of literature (McPhail-Bell et al., 2018), quality improvement demonstrating improvements in Indigenous health (McPhail-Bell et al., 2018). Atmore et al. (2023) made a notable contribution to this discourse by identifying nine principles of healthcare quality for rural settings. Among these, they highlighted that "quality is everybody's job," underscoring the need for health professionals to possess a broad skill set and actively seek opportunities for improvement, particularly to enhance health outcomes for Indigenous peoples. This collective approach to quality aligns with the overarching theme of community involvement and localised service design,

reinforcing the importance of tailored, culturally safe, and community-driven healthcare solutions in rural settings.

Mobile healthcare services, commonly referred to as outreach services, are identified in the literature as a critical model for improving healthcare access in rural communities(Beks, Mitchell, et al., 2022). Rural areas often face significant service shortages, making it challenging for residents to access timely and appropriate healthcare (Thomas et al., 2014). The literature also highlights the complex relationship between social determinants of health such as housing, employment, spiritual wellbeing, social connections, and financial stability and overall health outcomes, particularly for Indigenous populations (McCalman et al., 2018). When negative social determinants are present, access to healthcare becomes increasingly difficult, reinforcing the need for outreach services to bridge these gaps (Henderson et al., 2018; Martel et al., 2020; McCalman et al., 2018). Outreach and mobile clinics address these barriers by bringing healthcare services directly to patients, with health professionals travelling to communities to deliver care closer to home (Beks, Amos, et al., 2022). This model significantly reduces obstacles related to distance, cost, and accessibility, making it easier for individuals to receive necessary care. The literature consistently identifies outreach models and mobile clinics as effective enablers of healthcare access, providing flexible and responsive care that meets the needs of rural and Indigenous communities.

Team based care

The expansion of health professionals' roles within primary care is consistently identified in the literature as a key enabler for improving healthcare access and outcomes (Atmore et al., 2023; Drovandi et al., 2022; Freeman et al., 2021). Over the past decade, general practice has seen the integration of allied health professionals and the extension of practice scopes for traditional roles, contributing to more comprehensive and accessible care (Atmore et al., 2023). This shift reflects broader healthcare reforms aimed at addressing workforce shortages and meeting the complex needs of diverse populations.

Drovandi et al. (2022) specifically highlight the integration of non-prescribing pharmacists into primary care as a strategy that enhances equity in rural communities by increasing service capacity and capability. However, critical analysis of this

expansion reveals several challenges. The integration of new roles into existing healthcare teams may create ambiguity around professional boundaries, potentially leading to fragmented care if not supported by clear governance and collaborative frameworks (Freeman et al., 2021). Additionally, while expanding the workforce can improve access, it does not automatically address deeper systemic issues such as funding constraints, workforce retention in rural areas, or the need for culturally responsive care (Drovandi et al., 2022).

Without targeted strategies to support interdisciplinary collaboration and professional development, extended roles risk becoming transactional rather than transformative (Drovandi et al., 2022). This is particularly relevant in rural and Indigenous communities, where trust, cultural safety, and continuity of care are essential for effective service delivery (Barbo & Alam, 2024). Therefore, while the diversification of roles in primary care holds promise, the literature underscores the need for carefully designed implementation strategies that prioritise integration, sustainability, and equity.

Shift to preventive care

A six-year model of care evaluation conducted in the Fitzroy Valley region of Western Australia demonstrated that targeted interventions and dedicated resources can effectively enhance preventive care (Reeve et al., 2015). The study reported a substantial increase in healthcare assessment uptake, rising from 13% to 61%, indicating significant improvements in preventive healthcare delivery and long-term population health outcomes. Further evidence supporting the value of preventive care is provided by Lawton et al. (2023), who highlighted the life-saving potential of cervical cancer self-swab testing. This method facilitates early cancer detection and timely treatment, underscoring the critical role of preventive measures in improving health outcomes. Additionally, Lawton et al. emphasised the importance of equity in preventive healthcare, noting that self-led testing empowers individuals to control their health decisions, leading to increased participation rates, particularly among Māori people.

2.2.4 Healthcare policy and funding

The literature consistently highlights the critical role of healthcare funding and commissioning in enabling equity, particularly for Indigenous and rural populations (Wakerman et al., 2017). This relationship between financial resources and healthcare outcomes is multifaceted, encompassing aspects of policy, geography, and population demographics (Thomas et al., 2015; Wakerman et al., 2017).

Research conducted in rural Australia demonstrates a significant inverse relationship between population size and per-patient primary healthcare costs in remote communities (Wakerman et al., 2017). This finding underscores the need for funding models that account for the unique challenges faced by smaller, isolated populations. Such models should reflect the higher per capita costs associated with providing healthcare services in these areas, ensuring equitable access to care regardless of geographical location.

A comparative study of healthcare systems in Aotearoa New Zealand and the United States (US) revealed a scarcity of impactful policies explicitly designed to achieve health equity for ethnic minority groups (Chin et al., 2018). However, the study identified two notable enablers for equity in Aotearoa New Zealand:

1. The Very Low Cost Access (VLCA) policy, aimed at addressing healthcare cost equity
2. The establishment of a social investment agency, recognised as a key enabler for achieving equity

These initiatives demonstrate the potential for targeted policies to make significant strides in reducing healthcare disparities.

The literature supports the concept that strategic funding and commissioning can be powerful tools in enabling equity for Indigenous populations (Henderson et al., 2018). Effective commissioning relies on the following key factors: a clear policy framework, engagement and commitment from service providers and consumers and flexibility to adapt to local variations.

This approach allows for the development of healthcare systems that are responsive to the unique needs of diverse communities, particularly those that have been historically underserved. The literature paints a compelling picture of funding and commissioning

as critical enablers of healthcare equity. By recognising the higher costs associated with serving rural and remote populations, implementing targeted policies, and adopting flexible commissioning approaches, healthcare systems can make significant progress in reducing disparities and improving outcomes for all populations, including Indigenous and minority groups.

Despite the well-documented health disparities experienced by rural Indigenous populations, the literature reveals a notable scarcity of policies explicitly designed to achieve equitable health outcomes. This gap is significant, as policy frameworks play a foundational role in shaping how healthcare services are funded, designed, and delivered. Without targeted and enforceable equity-focused policy, gains made at the service delivery level risk being undermined by systemic funding and structural barriers that remain unaddressed.

The literature is consistent in its call for greater Indigenous representation in healthcare leadership and policy decision-making to ensure strategies are both culturally responsive and practically effective. Co-designed policy, developed in genuine partnership with Indigenous communities, is positioned as essential to closing the gap between policy intent and lived experience. Where Indigenous voices are absent from these processes, the resulting frameworks often fail to reflect the complexity of need or the diversity of rural contexts they are intended to serve.

2.3 Conclusion

The literature review provides a comprehensive analysis of the complex and multifaceted factors influencing enablers to equity in primary healthcare for rural Indigenous populations across Aotearoa New Zealand, Australia, Canada, India, and the United States. Three key themes emerged from the literature, each theme contributing critical insights into the development, design and delivery of equitable primary healthcare services.

The review highlights barriers such as limited-service availability, financial burdens, and culturally inappropriate care that persistently hinder healthcare access for rural Indigenous populations. However, when these challenges are systematically and operationally addressed through improving service accessibility, reducing costs, and

delivering culturally safe care, primary healthcare providers can become more equitable, accessible, and responsive to the communities they serve.

Innovative models of care, particularly mobile and outreach services, have been identified as effective strategies for overcoming geographic and social determinants and access barriers to healthcare. These models, alongside the integration of virtual health technologies and point-of-care testing, demonstrate potential in addressing workforce shortages and enhancing service delivery. However, the literature emphasises the importance of culturally responsive and community-driven implementation to prevent exacerbating existing inequities.

Expanding the roles of health professionals and adopting team-based care approaches were consistently recognised as key enablers of improved healthcare delivery in rural environments. These workforce models must be supported by transparent governance, sustainable funding, and workforce development strategies to ensure effective integration and long-term impact. Similarly, preventive care models, when paired with culturally appropriate interventions, have shown promising outcomes in improving Indigenous health outcomes.

The critical role of healthcare policy and funding in driving equity was also evident. Flexible and context-specific funding models, such as Aotearoa, New Zealand's Very Low Cost Access (VLCA) policy, were identified as effective mechanisms for addressing healthcare disparities. The review revealed gaps in policy frameworks and the need for greater Indigenous representation in healthcare leadership and decision-making to ensure services are both effective, culturally safe and enabling of equity.

Collectively, the findings highlight that enabling equitable primary healthcare for rural Indigenous populations requires an integrated approach that combines culturally safe, community-led service design, targeted funding, innovative care models, and a strong focus on preventive care. Addressing these factors holistically will be essential for building sustainable, high-quality primary healthcare providers that truly meet the needs of Indigenous communities. This review also identifies critical gaps in current research, particularly around the enablers from both provider and whānau perspectives, highlighting a crucial opportunity for further research to be explicitly explored in Aotearoa New Zealand, with a direct focus on Māori. Future research should continue to explore enabling strategies and services that empower Indigenous

people and address the complex interplay of factors that influence their health outcomes.

Table 3 Literature summary table

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
1	Atmore et al. (2023)	What is important for high quality rural health care? A qualitative study of rural community and provider views in Aotearoa New Zealand	Aotearoa New Zealand 75 participants and 34 health providers from four different rural communities.	Pragmatic qualitative study. Thematic analysis Focus groups and interviews.	9 key principles: • providing patient- and family-centred care that respected people's preferences for where treatment was provided • providing services as close to home as could be done well • quality was everybody's job • consistent care across settings, with a reduction in unwarranted variation • team-based care across distance, with clear communication and processes between different facilities working together • equitable health care, particularly for Māori, and then for the whole rural community • sustainable service models, particularly for the workforce, as a counterbalance to 'closer to home' • health networks to improve patient flow, and reduce waste • value was more than value for money, and including valuing respectful, timely care.	Principles of quality healthcare that are important to rural communities were identified. The research identified the need for a broader focus on value beyond value for money and a strong focus on equity for Indigenous people.	Quality healthcare, rural verse urban differences and team-based care

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
2	Barbo and Alam (2024)	Indigenous people's experiences of primary health care in Canada: a qualitative systematic review	Canada Systematic review exploring Indigenous people's experiences with primary care services.	• Systematic literature review following the Joanna Briggs methodology • "2503 articles from databases and 12 from grey literature". 22 articles included in the review.	Four themes • "Certain experiences of Indigenous people when receiving primary health care services were considered supportive and respectful"(Barbo & Alam, 2024, p. 145) • "Indigenous people experienced various forms of discrimination and maltreatment that most often resulted in them not receiving adequate and quality primary health care; thus, many adopted coping strategies to face such challenges"(Barbo & Alam, 2024, p. 145) • "Issues related to the primary health care system's structure and practices led Indigenous people to experience inaccessible and incomplete care"(Barbo & Alam, 2024, p. 145) • "Indigenous patients recommended that greater emphasis be placed on culturally sensitive empathic care, recruitment of Indigenous health care providers, accessibility and health teaching and promotion" (Barbo & Alam, 2024, p. 145)	The review highlighted many barriers which in turn could be showcased as what not to do – Cultural safety and racism were identified in the findings.	Cultural safety, racism negatively effects Indigenous peoples overall health

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
3	Bath and Wakerman (2015)	Impact of community participation in primary health care: what is the evidence?	Australia 33 papers included	Literature review with the aim to locate and evaluate evidence of the impact of community participation in primary healthcare on outcomes	Evidenced findings that conclude community participation is linked with improved health outcomes specifically for Indigenous populations.	The voice of health care consumers	Community engagement in design of health services Cultural safety designed by health users Community solutions
4	Beks, Mitchell, et al. (2022)	An Aboriginal Community-Controlled Health Organization model of service delivery: qualitative process evaluation of the Tulku wan Wininn mobile clinic	Australia 19 participants in rural Australia. Both service providers and clients of mobile services.	Qualitative research, interviews with providers and clients. Thematic analysis conducted	Four key themes • "considerations for early implementation • maintaining face-to-face services during COVID-19 • acceptability as a model of service delivery • maintaining the mobile clinic as a service delivery model" (Beks, Mitchell, et al., 2022, p. 4) Mobile clinics address barriers and inequities within rural communities bridging the transport divide.	Enabling equity	Models of cares and community engagement

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
5	Blattner et al. (2024)	He Aroka Urutā. Rural health provider perspectives of the COVID-19 vaccination rollout in rural Aotearoa New Zealand with a focus on Māori and Pasifika communities: a qualitative study	Aotearoa New Zealand To gain insight into factors contributing to the urban-rural COVID-19 vaccination disparity.	Qualitative research. Rural providers participated in interviews and focus groups (n=22)	• "Rural health providers are under pressure yet very resilient"(Blattner et al., 2024, p. 173) • Centrally driven structures are inequitable and are not flexible enough for localised adaption (Blattner et al., 2024, p. 173) • Logistics, workforce and infrastructure in rural communities is real – distances, travel, connectivity and workforce limitations (requires flexibility for unregulated workforce support) • Community owned and driven health services gain best outcomes for whānau and are more equitable.	Evidences the resilience rural providers have and the intentions to provide culturally safe and appropriate services while managing a lean workforce.	Cultural safety and delivery of services Long term sustainable funding for rural providers Solutions to limited health workforce in rural areas

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
6	Causer et al. (2024)	Clinical effectiveness and analytical quality of a national point of-care testing network for sexually transmitted infections integrated into rural and remote primary care clinics in Australia, 2016–2022: an observational program evaluation	Australia First nations people seeking testing for chlamydia, gonorrhoea and trichomonas	Evaluated and monitored trends with monthly point of care testing for clinical effectiveness in rural Australia clinics (n=73)	• POC testing is great in rural communities and can support patients to get results and possible treatment faster. • POC testing has limitations in rural workforces with competency and confidence to administer the tests leaves when someone leaves. • The study suggests that sustainable funding which recognises not only the consumable costs but also costs associated with clinic workforce, new workforce models (including non-clinical staff) and optimisation of the implementation infrastructure including training, quality assurance and connectivity.	Shows programmes in rural communities if funded and resourced can have a clinical benefit to equitable outcomes for patients.	Clinical effectiveness and analytical quality of a national point of-care testing network for sexually transmitted infections integrated into rural and remote primary care clinics in Australia, 2016–2022: an observational program evaluation

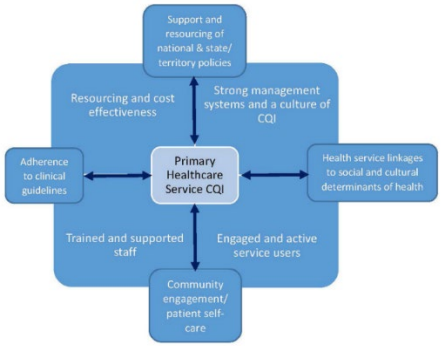
#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
7	Chin et al. (2018)	Lessons for achieving health equity comparing Aotearoa New Zealand and the United States	Aotearoa New Zealand and United States comparison Policy levers and their impact on equity.	Narrative literature review	• Both Aotearoa New Zealand and U.S have relatively few strong policies with support, incentive and enforcement that are explicitly designed to achieve equity for ethic minority groups. • Access to care in Aotearoa New Zealand is stronger and safer compared to the US. However, those with insurance in Aotearoa receive services faster. • VLCA was a policy initiated to address healthcare inequity • The social investment agency in Aotearoa New Zealand is an enabler to equity with a key focus on social determinants and cross agency connection. • Aotearoa New Zealand is recognised internationally for quality ethnicity data in health datasets. • Intrinsic and extrinsic motivation need to be optimised to achieve health equity.	Enablers to equity clearly outlined and recommendations on how a system might design equity policy to see result	Policy design, Access to care, cultural responsiveness, quality, outcomes and payment

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
8	Drovandi et al. (2022)	Enablers and barriers to non-dispensing pharmacist (NDP) integration into the primary health care teams of Aboriginal community-controlled health services	Australia "To investigate enabling factors and barriers influencing integration of NDPs within Aboriginal community-controlled health services delivering primary health care."(Drovandi et al., 2022, p. 3766)	One hundred and four participants informed the findings. NDPs were employed across 20 urban, rural, and remote services in three Australian states and provided pre-defined medication-related roles to adult Aboriginal and Torres Strait Islander Perceptions were elicited from online surveys, interviews, and focus groups.	• NDP integration within primary health care services has potential to enhance medication-related services to Aboriginal and Torres Strait Islander peoples if enabling factors are supported and health systems and adequate resources facilitate the integration of pharmacists within these settings. • Ensuring that Aboriginal and Torres Strait Islander peoples receive quality primary healthcare to meet equity demands requires access to multidisciplinary teams that include pharmacists.	Use of extended care teams to provide equitable care in rural communities to indigenous populations. Cultural safety one of the research key findings.	Australia To investigate enabling factors and barriers influencing integration of NDPs within Aboriginal community-controlled health services delivering primary health care.

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
9	Fitzpatrick et al. (2023)	Understanding virtual primary healthcare with Indigenous populations: a rapid evidence review	Global To understand how high quality Indigenous primary healthcare is defined in virtual modalities.	Rapid literature review from August – December 2021. The following question was used to guide the rapid review: How is high quality Indigenous PHC defined in virtual modalities?	• Four themes were identified o "Limitations and barriers of virtual primary healthcare o Indigenous-centred virtual primary healthcare o Virtual indigenous relationality (building relationships and trust) o Collaborative approaches to ensuring holistic virtual care' (Fitzpatrick et al., 2023, p. 6) • For Indigenous virtual primary care to be of high quality it must be designed with cultural and ethical safety in mind.	Virtual care can be an enabler specifically in rural communities if utilised in partnership with face-to-face care.	Digital divide, cultural safety, trust, develop services in partnership with Indigenous people.
10	Freeman et al. (2021)	The contribution of group work to the goals of comprehensive primary health care	Australia 5-year study Australian primary healthcare services	Review of service reports, interviews with staff (n=123), community assessment workshops (n=65), client survey (n=315), case tracking diabetes (n=184) and client tracking depression (n=95)	• Group work provides many benefits for patients including shifting from transactional to transformational healthcare. • Group work is one strategy to increase the comprehensiveness of PHC services.	Direct links to Alma Alta and improving health outcomes.	Shift to preventive and proactive care, quality of care, community impact and model of care

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
11	Gupta et al. (2023)	Achieving health equity through healthcare technology: Perspective from India	India Review of India experience with health technology	N/A	• The healthcare system can be strengthened by the use of low-cost Indigenous med-tech solutions particularly for screening, diagnosis, and even prognosis. • Healthcare technologies have the potential to reduce health disparities and improve human well-being in India. • mHealth, wearable devices, and point-of-care diagnostics can aid in the early detection and management of diseases. • Primary care providers may make early diagnoses and manage baseline conditions with the use of telemedicine and AI-based techniques.	Looks at how rural inequities can be addressed through the inclusion of cost-effective health technologies.	Technology is an enabler, rural, educate health professionals
12	Henderson et al. (2018)	Commissioning and equity in primary care in Australia: Views from Primary Health Networks	Australia Relationship between commissioning and equity	Interviews (n=55)	• "Equity for PHNs primarily relates to equity of access. Equity of outcomes is viewed as depending upon social determinants of health which are outside of the remit of health services" (Henderson et al., 2018, p. 87) • "Effective commissioning relies on a clear policy framework, engagement by service providers and consumers, and flexibility in responding to changing conditions" (Henderson et al., 2018, p. 87)	How to enable equity through commissioning	Availability, acceptability and affordability of services

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
13	Jaye et al. (2022)	Wellbeing and health in a small Aotearoa New Zealand rural community: Assets, capabilities and being rural-fit	Aotearoa New Zealand. Identify sources of wellbeing and health for members of a small rural community	Qualitative. Patient interviews (n=17)	• Environmental effects on rural communities • Communities connection to rural areas • Intergenerational responsibility in rural communities • Connectedness and belonging are key indicators of wellbeing	Rural research that identifies the enablers within the community and the health concerns of locals	Living rurally, connectedness, environmental effects, asset-based approach, capability approach
14	Lawton et al. (2023)	A Model for Empowering Rural Solutions for Cervical Cancer Prevention (He Tapu Te Whare Tangata): Protocol for a Cluster Randomized Crossover Trial	Aotearoa New Zealand. Clinical community-controlled pathway versus standard in rural area.	Randomised crossover trial. Māori centred research.	• Rural community strengths and whānau approaches enables equity of care • Point of care testing is a good clinical mechanism • Whānau centred models of care provided equitable healthcare service delivery	Enablers to health care services in rural Aotearoa New Zealand.	Rural, models of care, culturally safe models, equitable health outcomes
15	Lyle et al. (2017)	What do evaluations tell us about implementing new models in rural and remote primary health care? Findings from a narrative analysis of seven service evaluations conducted by an Australian Centre of Research Excellence	Australia Centre of research excellence in rural and remote primary care	Narrative synthesis on (n=15) articles	Three key themes • Enabling change • Improving access • Service adaption and sustainability Concluding that capacity for rural and remote health services to improve access to PHC remains variable despite a good understanding of the features associated with successful PHC models.	Rural health care programme review to identify enablers	Shared decision making, locally designed, community led, models of care

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
16	Martel et al. (2020)	Reaching out to reduce health inequities for Māori youth	Aotearoa New Zealand, Te Tai Tokerau Review of youth mental health service – hub and spoke model	Youth mental health inequities	"In a time of increasing GP shortage, youth specialist nurses (YSN) could improve access to care for youth from ethnic minorities, rural and isolated regions, and areas of socio-economic deprivation" (Martel et al., 2020, p. 281) Patient centred care that uses a hub and spoke model to support youth navigate the complexities of seeking help in rural communities.	Rural models of care, addressing barriers and seek model of care solutions that place whānau in the centre	Rural, youth, model of care, cultural safety, bias, unconscious bias
17	McCalman et al. (2018)	Continuous quality improvement and comprehensive primary health care: a systems framework to improve service quality and health outcomes	Australia CQI approaches and a model	CQI model of care that looks to integrate health system (vertically) and across sector (horizontally)	The interplay between health services and other social determinants needs to be addressed through intentional CQI integration approaches. Aiming to address root cause rather than surface intervention. (McCalman et al., 2018, p. 3)  	Indigenous models of care that address social determinants as well as health but not isolated to.	Model of care, social determinants, Indigenous inequities, quality improvement approaches

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
18	McMenamin et al. (2023)	An asset-based evaluation of a novel Aotearoa New Zealand rural health service	Aotearoa New Zealand. Rural health services, evaluation approach	Paper reflecting asset-based approaches to evaluation with the ambition to increase equity for Māori.	The intent of an asset-based approach is to privilege Māori voice, as designing services for Māori unmet needs reflects designing services for those in Aotearoa New Zealand with the most pressing needs.	Rural healthcare evaluation and health outcomes for Māori in rural areas	Evaluation, quality, community-led, empowering Māori voices
19	McPhail-Bell et al. (2018)	An "All teach, All Learn" Approach to research capacity strengthening in Indigenous Primary Health care continuous Quality improvement.	Australia Development of a dedicated CQI-RCS programme which connects network and research programmes to improve health equity through CQI.	Pilot programme	• Model developed based on ethical values and guiding principles • Similar to Te Kākano (Māori-centred methodology) • Addresses power shifts between non-Indigenous and Indigenous • Identify the need for specific CQI models and interventions to address healthcare inequities specifically.	Indigenous quality improvement approaches to make a difference.	Quality improvement, Indigenous leadership, value and principle-based

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
20	Reeve et al. (2015)	Strengthening primary health care: achieving health gains in a remote region of Australia	Australia Rural/remote community	A cross-sectional 6-year retrospective evaluation of the results of a health service partnership between an Aboriginal community-controlled health service, a hospital and a community health service in north-west Western Australia.	This study demonstrates that strengthening primary health care services in remote Australia can lead to significant health gains. Key findings include: 1. Increased primary care access and preventive activities 2. Improved quality of care for chronic diseases 3. Positive trends in health behaviours 4. Decreased mortality rates These improvements resulted from a partnership between community-controlled and government organisations, focusing on comprehensive primary health care	Focuses on enablers that improve primary health services in rural communities	Integration, preventive care, access, culturally appropriate, health promotion and community
21	Thomas et al. (2014)	What core primary health care services should be available to Australians living in rural and remote communities?	Australia	The study used a Delphi method to reach expert consensus on a list of core primary health care (PHC) services and necessary support functions for rural and remote Australia.	The study identified core primary health care services that should be available to all Australians, regardless of location. Key findings include strong consensus on services like care for the sick/injured, maternal/child health, mental health, and public health. Support functions such as management, coordination, and quality systems were also deemed essential. These are the core PHC services that should be available to all Australians, regardless of where they live	Identify key services that should be available in rural communities and links to rural model of care functions	Primary health care, rural and remote, core services, Delphi method, expert consensus, equity of access

#	Author	Title	Setting, Context and Participants	Research Design and Methods	Key Findings	Relevance to what I am doing	Focus/Themes
22	Wakerman et al. (2017)	Equitable resourcing of primary health care in remote communities in Australia's Northern Territory: a pilot study	Australia	Mixed-methods including statistical analysis, cost modelling, comparative analysis and contextual analysis.	The study found a direct relationship between population size and primary health care costs in remote Australian communities. A minimum funding base plus per-capita rate is needed for equitable service delivery. Economies of scale occur in populations over 800. Smaller communities have higher per-capita costs but provide more consultations per capita	Resources in rural communities and its effects on equity	Funding, population, remoteness, equity and sustainability

Chapter 3 Methodology

3.1 Introduction

In planning this research, I was committed to understanding the enablers of equity within rural primary care providers, with a significant focus on general practice. To achieve this, it was essential to identify a methodology that would uphold Māori voice and deliver positive, mana-enhancing outcomes for Māori. Considering my ethnicity and positionality as Pākehā, it was crucial to ensure that the chosen methodology maintained both the cultural safety and appropriateness of the participants and the researcher.

The research required a methodology that centred Māori voices, adhered fully to Māori principles and ultimately created space for Māori voices to be elevated. After wide consultation (refer to Table 5 in the methods chapter) and consideration, I selected Māori-centred research as the research methodology. The taxonomy of Māori research is explained in Cunningham (2000) framework, which categorises research relevant to Māori along a continuum based on the extent of Māori involvement and control. At one end of the continuum is research that does not involve Māori, where Māori knowledge is not sought, a non-Māori organisation or institution controls the research process, and non-Māori methods are utilised. At the other end lies Kaupapa Māori research, where Māori control all elements of the research, and it is conducted by Māori for specific Māori groups. Between these two approaches is Māori-centred research.

It was essential for me to engage with Māori-centred methodology under appropriate mentorship and supervision to ensure that Kaupapa Māori values and principles are upheld throughout the research, acknowledging my gap in lived experience. Smith (2000) discussed in the book *Decolonising Methodologies* that non-Māori can be involved in Kaupapa Māori research, but not on their own. Cunningham (2000) framework provided the same guidance. Māori-centred research is about doing research with Māori, placing priority on their inclusion in the research process, and ensuring the research outcomes benefit Māori people and communities. I believed that appropriate Māori mentorship would vary depending on the individual, their experiences, knowledge, and connection.

For me I grew up in a predominantly Māori community called Karetu. I married into a Māori whānau and have a child who is Māori. Therefore, given my personal positionality and context, Māori mentorship for me will be different to someone who grew up without these experiences. This chapter details the qualitative research design and the Māori-centred methodology employed in this study.

3.2 Positionality

This section articulates my decision to adopt a Māori-centred methodology. Choosing this approach reflects my commitment to ensuring the research is grounded in Māori values, perspectives, and practices. It acknowledges the importance of conducting research in a way that upholds cultural safety, honours Te Tiriti o Waitangi, and creates space for Māori voices to be central in shaping both the process and outcomes of the study.

My research journey

Throughout my research journey, I have had some important and at times challenging conversations about my choice of methodology. These moments of questioning have been critical, prompting deep reflection and clarifying the reasoning behind my approach. I want to take a moment here to explain why I chose a Māori-centred research methodology and what that process looked like for me.

When I first started my Doctorate in Health Science, I came into the process with a genuine desire to learn and understand Māori health outcomes in primary care. My research topic was intentionally open, not because I was unsure, but because I knew the direction needed to be shaped by the very communities the research aimed to support. Being authentically Māori-centred means more than just including Māori voices as participants. It required meaningful involvement from the outset, in the intent, design, and aspirations of the research itself.

I was incredibly fortunate to have a research advisor early on in my journey who supported this view. Rather than pushing me to pin down my methodology too quickly, he encouraged me to take time, proper time, to engage in consultation. We joked that the number of cups of tea or coffee shared was a measure of progress, and in many ways, it was. Over several months, I reached out to Māori leaders, clinicians, health managers, and researchers. Sometimes I shared my broad ideas and simply listened.

Other times, I asked direct questions about what mattered most to them, what gaps they saw, and what kind of research would be truly useful.

This process fundamentally changed the trajectory of my research. It was more than consultation. It was a power shift. It required me, as a non-Māori researcher, to set aside any pre-determined ideas and be led by the voices of those with lived and professional experience in the Māori health sector. This approach can feel uncomfortable for some non-Māori researchers because it challenges the traditional academic view of the researcher as the one who sets the direction. But for me, it was an empowering experience, and in many ways, it felt like I had been permitted to carry on.

Alongside the sense of permission, I also gained what I attribute to be knowledge that changed my thinking paradigms. I heard stories that reflected the day-to-day jobs of Māori leaders. They include a general practitioner who spoke about his patients, their health complexities, and his overwhelming desire to help them, while being stuck in a Western model of delivering primary healthcare. There are Chief Executive Officers who had screens displaying data showcasing inequity, alongside numerous programmes they were delivering to combat these inequities. This demonstrated a commitment to seeking equity and a desire within the sector to understand the enablers of equity. These stories, knowledge sharing, and cups of tea and coffee truly informed the pathway of this research, providing confidence that the topic was worthwhile, meaningful, and needed.

I want to acknowledge everyone who shared a cuppa with me, in person or virtually. Your insights, stories, and guidance had a profound impact on this journey. I hope that when you read this research, you see yourselves reflected in it.

Reflection | Rākaia's welcome to Te Ao

In August 2022, I gave birth to my daughter, Rākaia Morgan-French. I was fortunate to be supported by two Māori midwives who guided me through a natural home birth, allowing Rākaia to enter te ao in a way that honoured elements of tikanga Māori. At this time, I was in the early stages of my research, drafting my proposal. During one of the postnatal visits, I had a kōrero (conversation) with one of my midwives about the profound impact that Māori birthing practices had on my

experience. I expressed deep appreciation for the guidance, aroha, and support that helped me feel both clinically safe and culturally empowered. Practices such as immediate and prolonged skin-to-skin contact with my pepi, using pounamu to cut the umbilical cord, and remaining in our home environment to welcome our taonga into the world, all contributed to a deeply meaningful birth.

As we continued to debrief, the midwife began the standard newborn screening process, which involved collecting blood from Rākaia's heel onto a small card for laboratory testing. She asked if I would like the card returned, and I agreed, assuming this was a routine option. She then shared a story that stayed with me. She told me how, historically, Māori baby placentas, blood samples, and other bodily materials had been collected by health institutions and used in research without consent. These acts often led to misrepresentation, marginalisation, and further erosion of trust in the health system. Stories like this illuminate the ongoing mistrust that Māori communities feel toward health research and reinforce the importance of ethical, culturally safe research practices.

For me, this kōrero was a decisive moment of critical reflection. As a non-Māori researcher, it sharpened my awareness of the legacy of harm that research can cause when conducted without respect for cultural values. It also reaffirmed my commitment to produce ethical research that empowers, uplifts, and authentically represents Māori voices and experiences.

Māori-centred methodology was right for the research

As I continued my research journey, I found myself in a bit of methodology limbo. My research did not quite fit within the established boxes of Western research methodologies, nor did it align fully with a Kaupapa Māori approach, which I respected deeply. I was seeking a middle space, a methodology that could honour both worldviews. I needed a strategy that allowed me to engage with Māori in a culturally safe way, while also staying grounded in the responsibilities I held as an outsider in this space, a Tiriti o Waitangi partner and a māmā of a Māori kotiro.

For a while, I attempted to justify my methodology choice by drawing on Western research theory, exploring frameworks such as critical theory and phenomenology. While these were useful connections, neither quite captured the spirit of what I was

doing. Eventually, I came to realise that the methodology did not have to be predefined by existing Western categories. What mattered more was that it was transparent, ethical, culturally safe, and responsive to the needs of Māori communities. Through a journey of discovery, a Māori-centred methodology gave me the space to conduct research using Māori principles and theory, being guided by tikanga, grounded in respect, and focused on the impact for Māori. It allowed me to honour the people who shaped this work and to do so in a way that felt both accountable and authentic.

Vulnerability in being non-Māori

My position as a non-Māori researcher in this work required me to embrace an often-uncomfortable sense of vulnerability. This vulnerability was layered and complex, reflecting the weight of navigating cultural safety, the realities of historical and systemic inequities between Māori and Pākehā, and the deep responsibility to ensure that my efforts genuinely served the aspirations of Māori communities.

The challenges of being a non-Māori researcher in a Māori-centred space were most evident during moments of uncertainty, times when I questioned myself and thought, “I shouldn’t be doing this.” Yet it was in these moments that I engaged in the deepest reflection, considering the potential impact I could have as a non-Māori to shift the paradigm in how others like me approach primary healthcare delivery in Aotearoa New Zealand. I often liken this feeling to the experience of mum guilt, an emotion that can consume you internally. However, when acknowledged and understood, it can guide you with greater empathy. By engaging with this discomfort, I’ve learned to connect more intentionally with the community and navigate this work with humility, purpose, and respect.

While I am not Māori, te ao Māori is a part of who I have become and who my children are. Being married to a Māori man and being a part of his culture, traditions, and whenua have influenced my lived realities. Sometimes I felt the enormity of treading carefully within the realms of tikanga (Māori values) and kawa (protocol and etiquette), knowing the potential for missteps. These moments humbled me and reinforced the importance of relational accountability to my wider support network. I often leaned heavily on the academic supervisors and the Kāhui for their wisdom, reassurance, and honest feedback. They gave me the strength to remain grounded, the

clarity to navigate complexity, and the courage to carry on. Their support reminded me that this mahi is not done in isolation but in connection with people, with principles, and with purpose. Their guidance kept me aligned with the kaupapa and allowed me to move forward one step at a time.

3.3 The research design

A Māori world view

A Te Tiriti ally and researcher engaging with a Māori worldview (te ao Māori), requires a deep appreciation of its relational, intergenerational, and holistic nature. This worldview does not separate the physical, spiritual, emotional, and environmental domains, but instead weaves them together to shape knowledge, wellbeing, and identity (Cram, 2017; Smith, 2000). Durie (1985) articulated this through the development of Te Whare Tapa Whā, a four-sided model that represents the foundational pillars of Māori health: taha tinana (physical), taha wairua (spiritual), taha hinengaro (mental and emotional), and taha whānau (family and social wellbeing). Durie (2005) then, emphasised that wellbeing is not solely about individual health but is inherently tied to the health of the collective whānau, hapū, and iwi.

Kaupapa Māori research approaches offer a methodological framework that is grounded in Māori values, philosophies, and aspirations. While this study adopts a Māori-centred methodology, it is heavily informed by Kaupapa Māori principles, values, philosophies and aspirations. Kaupapa Māori should be recognised as both a methodology and a way of being (Cram, 2017). Cram (2017) also discussed that Kaupapa Māori health research shifts the focus from deficit-based victim blaming to a strengths-based understanding of the factors influencing the health and wellbeing of Māori people. Therefore, Kaupapa Māori critically examines Western constructs, the impacts of colonisation, and historical societal perspectives. This research has a clear aim, which is to understand the enablers of equity for whānau Māori. The research aim is in response to the Aotearoa New Zealand health sector, which has identified health inequities for Māori but continues to lack evidence on how to enable equity (Kidd et al., 2021; Simpson, 2020; Waitangi Tribunal, 2019).

Cultural appropriation is critically important to Kaupapa Māori research. Smith (1997) highlights the importance of understanding Māori worldviews through the lens of te ao

Māori, which stands in contrast to Western paradigms. These differences lie not only in content but in orientation, where Māori approaches are holistic, relational, and grounded in whakapapa and collective identity. Smith (1997) has devoted his career to Kaupapa Māori research and education during this time, writing widely about Kaupapa Māori research principles and traits. The principles, of Kaupapa Māori theory developed by Smith (2015) have been widely used across educational and health contexts to guide research that centres Māori voices. These principles tino rangatiratanga (self-determination), taonga tuku iho (cultural aspiration), akoranga Māori (culturally preferred pedagogy), kia piki ake I ngā raru o te kāinga (socio-economic mediation), whānau (extended family structure) and kaupapa (collective philosophy) have informed this research (Smith, 2015). The choice to select this principle set was guided by other Māori health researchers who have embraced these principles in their own work (Pihema, 2017). This set has been utilised to inform this research process and is detailed below in Table 4 Kaupapa Māori principles.

For Kaupapa Māori research to remain authentic and effective, it must involve the active participation, leadership, and continuous engagement of Māori throughout the research process (Barbarich, 2019). It is not enough to conduct research on Māori, it must be with and for Māori, guided by the values, tikanga, and aspirations of Māori communities (Smith, 2000). Māori leaders and researchers have created frameworks and pathways that enable critical positioning and reflection of research processes, which have guided this research process, ensuring that the research value for Māori remains the core research priority.

Cram (2017) stated that Kaupapa Māori health research plays a critical role in both disrupting entrenched health inequities and affirming Māori ways of being. She wrote:

> As part of transdisciplinary research teams with Māori colleagues, Pākehā (non-Māori) researchers also have important roles to play in this research. The mission of Kaupapa Māori health research is ensuring that Māori health research informs an agenda of Māori being Māori, being fully human, and living in health and prosperity (Cram, 2017, p. 1).

This research journey has required not only a methodological alignment with Māori worldviews but also a personal and professional commitment to honouring the mana of Māori participants and communities. It is through this awareness that the realities

of whānau Māori rooted in historical, cultural, and collective experience have been more deeply understood and respectfully represented.

Qualitative research design

This study adopts a qualitative research design, as it aims to understand and explore the lived experiences, perspectives, and meanings constructed by participants within their social and cultural contexts. As Braun and Clarke (2013) asserted, qualitative research is fundamentally connected to the use of words as data, rather than numbers, and is oriented toward interpreting how individuals make sense of the world. It is well-suited for exploring complex, contextually embedded phenomena where the richness of human experience is paramount.

Qualitative research is not a singular approach but rather a broad family of research approaches, underpinned by interpretivist and constructivist paradigms (Denzin & Lincoln, 2005). These paradigms acknowledge that knowledge is socially constructed and that the researcher plays an active role in co-constructing meaning with participants. The qualitative research design has been explicit from the start, giving effect to the voices of both those delivering care in the communities and the whānau or patients.

As stated, this research is underpinned by a Māori-centred methodology, which sits within the broader whānau of critical qualitative methodologies. Although this study is not Kaupapa Māori research, the study draws heavily on Kaupapa Māori principles and methods, particularly those that emphasise relationality, accountability, and collective benefit. The approach is strongly influenced by the work of Wilson (2004), who introduced the concept of “relational accountability” through Māori-centred research in Indigenous research, and Mikahere-Hall (2017), who articulates the compatibility of qualitative research with Māori worldviews when conducted with cultural safety and appropriateness.

Qualitative, Māori-centred research is recognised as a suitable research design with its alignment with Māori values, cultural practices, and the need for authentic representation of Māori experiences (Mikahere-Hall, 2017). Qualitative research provides space for participants to articulate their stories in their own words, using language, metaphors, and constructs that are meaningful within their cultural contexts

(Denzin & Lincoln, 2005). This is particularly critical in health research, where Western research has historically marginalised or misrepresented Indigenous voices, values and beliefs (Hudson et al., 2010; Smith, 2000). Considering my research question and aims, as well as the nature of the data to be collected, a qualitative research design was deemed appropriate.

Māori-centred methodology

Māori-centred methodology is the foundation of this research, chosen to serve Māori populations and improve their long-term outcomes, experiences in primary healthcare, and equity. This Māori-centred methodology ensures a strong sense of safety and support for participants, creating culturally affirming spaces for kōrero (discussion) and relationship-building throughout the research process. A research approach that is critical when deploying impactful, meaningful and ethical cross-cultural research.

Māori-centred research positions Māori as central to the research design, implementation, and interpretation. It recognises the validity and legitimacy of mātauranga Māori (Māori knowledge systems) and privileges Māori voices, while still enabling critical engagement with non-Māori theories and methodologies where appropriate (Bishop, 1996; Smith, 2000; Wilson, 2004). This flexible yet principled approach enables the ability to draw upon a range of perspectives while ensuring Māori worldviews remain at the forefront (Wilson et al., 2021). Importantly, Māori-centred research explicitly acknowledges the historical and ongoing impacts of colonisation, and the need for decolonising methodologies that restore mana, agency, and voice to Māori communities (Bishop, 1996; Smith, 2000; Wilson et al., 2021).

Key to Māori-centred research are Kaupapa Māori principles. Like most areas of interest, there are many different sets of principles that can be offered to the research process to guide Kaupapa Māori and Māori-centred research. I chose a grouping of principles from Smith (2015). These principles tino rangatiratanga taonga tuku iho, akoranga Māori, kia piki ake I ngā raru o te, whānau and kaupapa were initially developed within the education sector to explain the conditions that inspired Māori to initiate movements of positive change and transformation. Smith (2015) argued that the presence of these six foundational principles increases the likelihood of achieving transformative outcomes for Māori, an assertion also supported by Hoskins and Jones (2020). This was an aspiration I maintained throughout the research process. While

developed in an educational context, these principles have strong resonance within the primary healthcare sector, where they are increasingly referenced and applied to support culturally grounded, equity-focused research (Durie, 2004; Reid et al., 2014).

Table 4 below presents the six key Kaupapa Māori principles, their definitions, and how they were actively applied in this research.

Table 4

Kaupapa Māori principles

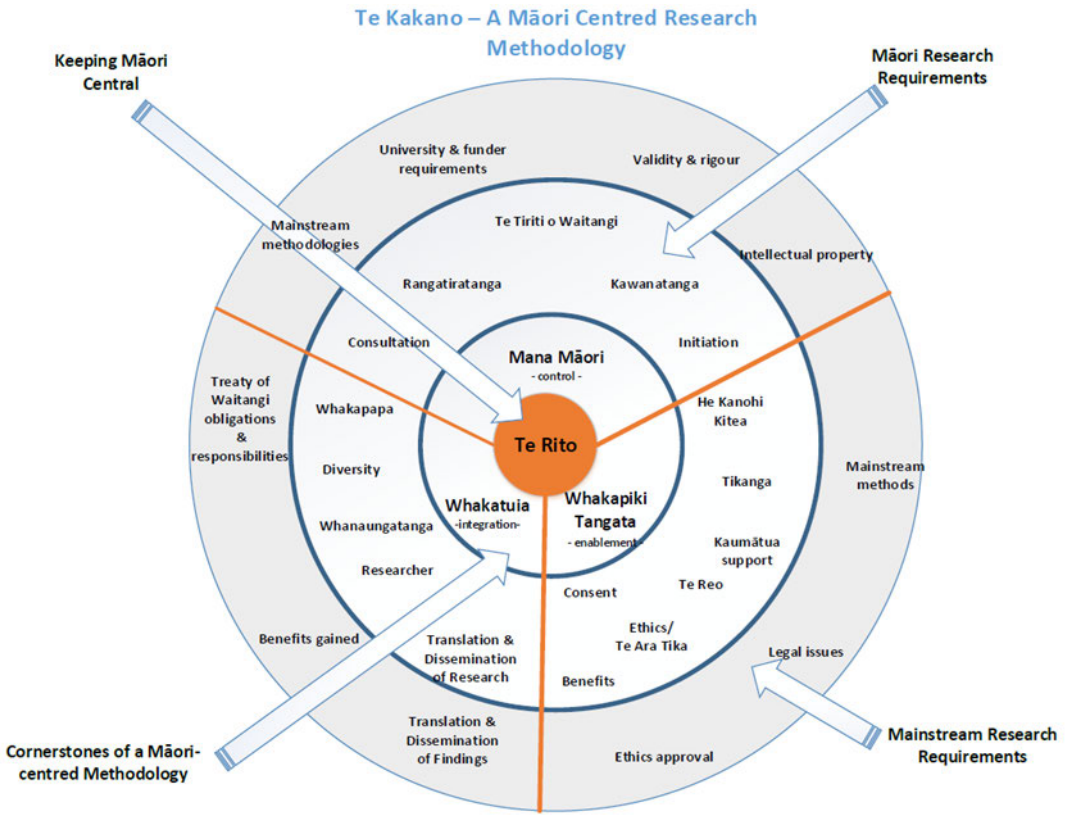
Principle	Definition	Application within the research
Tino rangatiratanga	Self-determination	• The Kāhui informed and guided the research. • Māori were empowered to share their stories and experiences in a way that empowers them.
Ngā taonga tuku iho	Cultural aspiration	• This research was explicitly about understanding what works for Māori. • Te Reo Māori, mātauranga Māori knowledge, te ao Māori culture, and Kaupapa Māori principles were welcomed, nurtured and supported.
Akoranga Māori	Culturally preferred pedagogy	• Data collection was guided by the research • The Kāhui advised on the environment in which data is collected, to ensure it was comfortable for Māori participants.
Kia piki ake i ngā raru o te kāinga	Socio-economic mediation	• This research enabled all eligible participants who wanted to be involved to do so. • The researcher ensured plans were in place to connect with all whānau despite social and economic circumstances. • The researcher acknowledged that some participants may have required more support to be involved than others.
Whānau	Extended family structure	• Whānau focus groups empowered the extended family structure to be involved. • Whakawhanaungatanga (relationship building process)
Kaupapa	Collective philosophy	• The research sought evidence to support improvement in the primary care sector. • The shared vision of equity underpins this research.

Note. These principles have been obtained from the work of (Smith, 2015)

This approach differed from Kaupapa Māori research, which is conducted by Māori, for Māori, and led by Māori. Māori-centred research created a space for both Māori and non-Māori researchers to contribute, provided they do so with cultural safety, accountability, and in partnership with Māori communities (Bishop, 1996; Cunningham, 2000). This dual positioning enables cross-cultural collaboration while upholding Māori as decision-makers and direct beneficiaries of the research. The principles outlined in Table 4 serve as the research navigation, supporting the research in staying connected to the methodology.

A visual way of understanding Māori-centred methodology is through the work of Wilson (2004) who created a model, Te Kākano – A Māori-Centred Research Methodology, displayed in Figure 3. Te Kākano visually displays the interface between Māori and Western research approaches and principles.

Figure 3 Te Kākano – A Māori centred research methodology



Note: This model has been reproduced with permission (Wilson, 2004)

The circular framework focuses on “keeping Māori central,” supported by key elements of a Māori-centred methodology that guided this research. Below, I outline these central elements and explain how they combined to form the overall methodology.

Mana Māori, the element of control, reflects the deeper intent of this research, to ensure that Māori are true partners throughout the research process. For this study, it meant gaining a genuine understanding of the research gap from a Māori perspective, identifying the value this research could add, and, as a non-Māori researcher, committing to a role grounded in Te Tiriti o Waitangi. Honouring Māori research requirements, including meaningful consultation, was important in this process. As mentioned earlier, the “many cups of tea and coffee”, served as a measure of the depth and quality of these engagements. Seeking advice from kaumātua (elders) was a vital part of this journey. Kaumātua, as elders within Māori communities, hold essential knowledge and experience that informs their guidance, support, and wisdom. Their involvement ensured cultural integrity and grounded the research in mātauranga Māori.

Whakatuia represents the integration of the research. Non-Māori can hold whakapapa through relational ties, including marriage, and this was true for me. My husband's whakapapa is Māori, and many of my connections were formed through the relational whakapapa of his iwi. Throughout my life, I have also been intentional in building relationships within the communities I have lived in. I began this research not only with established whānau connections but also with a strong commitment and capacity to form meaningful relationships. These relational skills enabled the research to meet key Māori research expectations, including consultation, whakapapa, diversity, and whanaungatanga.

Whakapiki Tangata, the element of enablement, speaks to the conditions that empower the researcher to fulfil the aims and aspirations of the research in a manner consistent with tikanga Māori. Enablement begins with gaining consent, not merely in a procedural sense, but through the granting of permission by those with cultural authority to proceed. In this research, such permission was supported through engagement with the Kāhui, a Māori advisory group whose presence ensured cultural accountability. The research was guided by Hudson et al. (2010) Te Ara Tika guidelines, an ethical framework grounded in Te Ao Māori, which provided a culturally and ethically sound pathway. This ensured that the research process was aligned with Māori values, upheld tikanga, and prioritised mana-enhancing engagement. Whakapiki Tangata also highlights the significance of kanohi ki te kanohi (face-to-face)

interactions. Given the cultural differences between myself and many participants, such encounters were crucial to building trust, reducing relational distance, and enabling safe, meaningful dialogue.

Research Kāhui

The research kāhui was established as a Māori health and research advisory group, providing cultural and scholarly guidance throughout the research process. The kāhui convened bi-monthly for most of the study, and members were recognised for their contributions through the provision of a koha (honorarium) in the form of Prezzy Cards, distributed upon completion of the research. While formal meeting times were scheduled, in practice, kāhui members offered guidance fluidly and in ways that best suited their availability and expertise.

All engagement with the kāhui was conducted in English, reflecting the linguistic preference of the group's members. Recruitment to the kāhui was by researcher invitation, and many members had been involved in early consultations with the researcher or had provided guidance prior to the commencement of doctoral study. The rōpū included two tauiwi members who had dedicated significant portions of their research and professional careers to the advancement of Māori health.

The contributions of the kāhui were invaluable to this research. Their collective wisdom, guidance, and commitment meaningfully shaped the outcomes and findings of this work, and their involvement is gratefully acknowledged.

3.4 Conclusion

The following quote deeply grounded me as a researcher: “When undertaking research, either across cultures or within a minority culture, it is critical that researchers recognize the power dynamic which is embedded in the relationship with their subjects” (Smith, 2000, p. 229). The primary beneficiaries of this research were, and remained throughout, rural Māori communities. In my experience, having a clear understanding of the stakeholders involved, enabled shared decision-making to feel empowering rather than tokenistic. However, for non-Māori conducting research within Māori-centred contexts, it remained essential to implement culturally safe strategies, to foster genuine community support, and engage in ongoing critical self-reflection.

Chapter 4 Methods

4.1 Introduction

This chapter explains who the research participants were, how they were recruited, the data collection methods and ethical considerations used in this research. As mentioned in the previous chapter, the methodology used is Māori centred. Māori-centred methodology supports the connection and interface between a Māori worldview and a Western worldview.

In this chapter, I explain the information related to how the research was conducted. It includes the research consultation process, data collection processes, participant sampling approaches, and the data analysis approach. The actions taken to ensure research rigour were documented along with my reflexivity in undertaking the research. Ethical, cultural and safety considerations are outlined, detailing my strategies to reduce risk and enhance the quality of the data. The chapter concludes with dissemination strategies that were informed by the participants.

4.2 Consultation

When embarking on my journey towards a doctorate in health science, valuable encouragement was received from Māori mentors and leaders across Aotearoa New Zealand. Their guidance empowered me, as a non-Māori researcher, to courageously pursue studies to enhance health outcomes for Māori. Consultations with respected advisors significantly influenced this decision.

The support of my whānau was paramount in this endeavour. Thorough discussions were undertaken with my husband, seeking his consent and backing for this research journey. Given the substantial time, energy, and resources required for this journey, his approval and ongoing support have been crucial.

Prior to any formal interviews and given my role at the time working in quality improvement in rural general practices, providers and health sector leaders were informally consulted on what they thought about research relating to the enablers that seek equity for Māori. The initial discussions were supportive, with many stating they would like to be involved and recognising that most research focuses on barriers rather

than enablers, so a positive, proactive piece of research was encouraged. This transparent consultation appears to have supported, an inquiry part of the research process supported the data collection process while enabling the principle of whanaungatanga to be activated.

Stakeholder engagement went far and wide with many people contributing to my research in the establishment phase. As described earlier, one of my kāhui advisors called it the coffee era, where many cups of coffee were consumed with people, virtually and in-person, who shared their thoughts, thinking and guidance. These conversations were with Māori and non-Māori leaders health professionals working in predominantly rural Māori communities. Through this consultation period, the researcher was guided and supported to lean into the research question, thinking about the approaches required to ensure the data collected authentically enabled the answer to the research question.

During this consultation phase, the research topic evolved significantly through consultation and reflection. The original research focused on governance-level enablers, shifting to explore practical enablers that providers are implementing or could implement to improve equitable outcomes for rural Māori communities. This shift reflected feedback from stakeholders who emphasised the importance of understanding the real-world challenges and issues experienced within the sector, ensuring the research was framed in a way that responded to genuine problems rather than perceived ones.

This collaborative approach, which combines professional guidance with personal support, has shaped my research path. It reflects a commitment to conducting academically rigorous and culturally respectful research, acknowledging the importance of Māori perspectives in health science research in Aotearoa New Zealand. Table 5 outlines the consultation methods used throughout the research process; this chapter discusses the elements in Table 1 in more detail.

Table 5 *Overview of methods*

Method	Actions
Consultation	• Māori mentors • Whānau • Hui with Māori researchers • Hui with Tauiwi Researchers who have done Māori centred research • Community members • Kaumātua
Networks	• Doctorate in Health Science AUT • Collaborative Aotearoa • General Practice New Zealand (GPNZ) • Hauora Taiwhenua, rural health network • Rural general practice owners and kaimahi • Community members • Hui with rural researchers • Otago and Auckland University rural health researcher symposium 2023
Connection	• Recruitment • Invite letters and social media posts • Initial planning connection with participants over the phone • Networks
Manaakitanga	• Face to face • Whanaungatanga • Information shared • Consent process • Te Reo (not fluent but words used to create connection) • Koha provided • Kai, coffee or tea provided
Analysis	• Reflective thematic analysis • Training in analysis methodology completed • Kāhui members' oversight on data coding • Supervisors' oversight on data coding • Clarification conversations with participants
Cultural Safety	• Māori advisors • Kāhui • Māori supervisors • Peer support • Tauiwi and Māori researchers • Colleagues • Ngā matapihi o te wairua (Primary Health Organisation hauora Māori leaders) • Husband and whānau • Māori-centred frameworks • Community connections and networks

Method	Actions
Dissemination	• Hui • Brief overview of findings and summaries • Conference presentations (Collaborative Aotearoa Ngā Hononga Ora 2025, Rural Health Conference 2025) • Connects with GPNZ, Rural Health Network Hauora Taiwhenua, Collaborative Aotearoa and primary care organisations • Word of mouth • Reports • Social media

Note. Table created to show the research process and the collective engagement with the community.

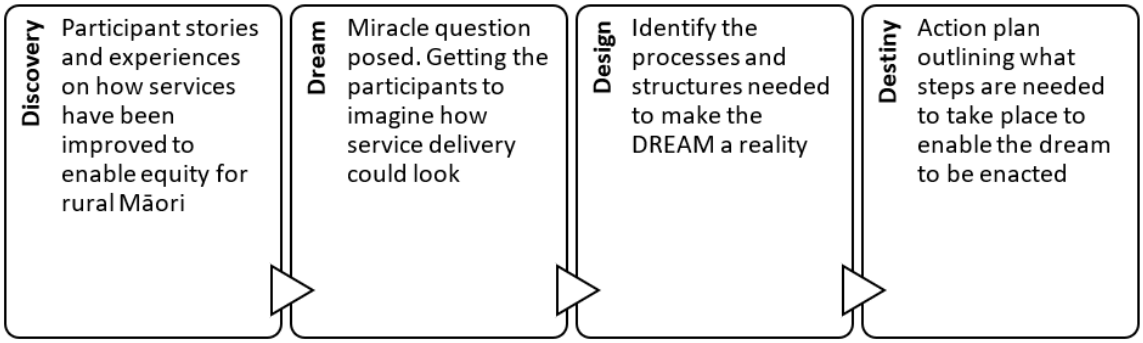
4.3 Appreciative Inquiry

Appreciative Inquiry is a qualitative research approach that seeks to identify and amplify what gives life to individuals, organisations, or communities when they are at their best (Cooperrider & Whitney, 2005). In this context, the term “gives life” refers to the strengths, conditions, relationships, values, and experiences that enable individuals, organisations, or communities to thrive, grow, and function effectively. Rather than focusing on problems or deficits, appreciative inquiry invites participants to explore their values, successes, and aspirations through positive, future-focused dialogue. As a qualitative concept, Appreciative Inquiry facilitates rich, narrative inquiry by creating space for participants to reflect on meaningful experiences and envision preferred futures. Its emphasis on relational dynamics, collective strengths, and appreciative dialogue aligns closely with Indigenous knowledge systems and participatory research traditions. Appreciative Inquiry can inform the tone and structure of various qualitative methods, such as interviews and focus groups, by fostering environments that are inclusive, mana-enhancing, and oriented toward shared learning and transformation.

Appreciative Inquiry emerged as a transformative approach to organisational change in 1986, with its formal publication following in 1987 (Cooperrider & Whitney, 2005). Trajkovski et al. (2013) state that Appreciative Inquiry provides a positive way forward, shifting from problems to solutions and offering a new way of practising in health care and health research. This resonated with the research purpose, which lends itself explicitly to the concept of enablement and improvement, supporting the research in telling a story about possibilities rather than merely highlighting barriers.

The most common version of appreciative inquiry is the 4D cycle: discovery, dream, design, and destiny. This circular process utilises appreciative inquiry principles to gather information by amplifying what is working well and demonstrating practical outcomes (Cooperrider & Whitney, 2005; Trajkovski et al., 2013). The 4D cycle was therefore utilised to support the design of the question and the overall application of the data collection process. This is detailed below in Figure 4. The indicative questionnaire used in the research is included in Appendix A.

Figure 4 4D Cycle with description on how Appreciative Inquiry was implemented into the research design



Significantly, Appreciative Inquiry offers the potential to facilitate change from the ground up through the transformation and discovery of new ideas. This research aims to use Appreciative Inquiry to gather insights from the operational level to inform governance and policy. Appreciative Inquiry is both a theoretical and methodological approach (Bushe & Kassam, 2005). For this research, Appreciative Inquiry is used as a research method and a tool to facilitate the gathering of information and data from participants. Appreciative Inquiry is closely aligned with action research (Bushe & Kassam, 2005; Cooperrider & Whitney, 2005) and continues to be found in many organisational settings, including healthcare environments, making it an appropriate method for research in rural primary care settings.

The Kākano model, rooted in Māori-centred research methodologies, acts as a cultural anchor, ensuring that the research process respects and incorporates Māori values, knowledge systems, and ways of being. By combining Māori-centred methodology with Appreciative Inquiry methods, the research created a "shared third space" where diverse perspectives can coexist and informed each other. This approach acknowledges the historical context and potential barriers faced by Māori

communities in healthcare settings, focusing on identifying strengths and opportunities for positive change.

This Appreciative Inquiry method allows for a nuanced understanding of complex healthcare issues, particularly those affecting Māori communities. It enables the research to address historical injustices and systemic challenges, while simultaneously highlighting and building upon existing strengths and successful practices. By doing so, the research aims to develop more effective, culturally responsive, and sustainable solutions that can enhance mana, connectedness, and overall health outcomes for Māori in rural primary care settings.

4.4 Participants

The two participant groups were providers and whānau. Data collection started with providers in Phase One and continued with whānau in Phase Two. Inclusion criteria for both cohorts are outlined below:

Provider (Phase One) inclusion criteria required participants to be:

- Located in Te Tai Tokerau;
- Primary healthcare professionals, including:
    - the unregulated workforces, such as kaiāwhina. Kaiāwhina is a term used to describe non-regulated roles in the health and disability sector. This encompasses various positions, including community support workers, disability support workers, mental health and addiction support workers and healthcare assistants;
    - Providers who are employed by a Māori Health Provider or Rural General Practice; or
    - Providers who are servicing a majority rural Māori population cohort.

'Rural' was defined using the Whitehead et al. (2022) rural geographic coding, including providers who sit in the rural 2 (R2) and rural 3 (R3) provider groups.

- Whānau (phase two) inclusion criteria required participants to be:
    - Located in Te Tai Tokerau;
    - Patients who self-identify as Māori ethnicity;

- Have accessed primary health services from rural primary health care providers (either Māori Health Providers and General Practices) within the past 3-years; and
- Over the age of 16.

Whānau and providers were excluded if they did/could not consent to participate in the research process. Unfortunately, people who did not speak English were excluded, as the researcher is only fluent in English. Participants were encouraged to use basic te reo Māori words, which were accurately captured and transcribed, throughout their interviews.

In Phase One of this study, the aim was to recruit providers from across Te Tai Tokerau. In Phase Two, the aim was to recruit patients, whānau Māori who lived in Te Tai Tokerau. A total of 16 interviews were completed with a total of 26 individuals participating across the two data collection phases. Some interviews featured more than one person, which enabled the data collection to capture broader views.

An interpreter was not included as part of the research team due to the additional resources required to support this.

4.5 Participant sampling

Purposive sampling was conducted to recruit providers into the research. This means all eligible providers were invited to participate, but only those who chose to respond were included. There were 43 general practices in Te Tai Tokerau, 12 of which were rural mainstream providers, and five of which were rural general practices operated by Māori Health providers. Of the 43 general practices, there were a total of 21 rural general practices in Te Tai Tokerau. In addition, there were four extra Māori providers invited to participate in the research. These providers offer primary care services to the community but do not have a general practice attachment. In total 25 providers were invited to participate in the research. Seven provider organisations agreed to participate. Some of these organisations had more than one group participate in the interviews or focus groups.

The participant selection process for the whānau sample employed a combination of sampling methods to ensure a diverse and representative group. Initially, convenience sampling was utilised, allowing readily accessible individuals to participate. This

approach targeted members via relevant local Facebook groups, providing a readily available pool of potential participants, based on their interest. To enhance the sample's diversity and reach, the study also incorporated snowball sampling, a non-probability method particularly effective for accessing specialised or hard-to-reach populations. This technique capitalised on existing community networks to generate interest and participation in the research.

My longstanding involvement in the Te Tai Tokerau community was crucial in the recruitment process, as I employed whakawhanaungatanga. This Māori concept emphasises the importance of relationships and connections. This approach enhanced the sample's representativeness and aligned with the community's cultural values, fostering trust and participation.

An attempt to include all providers and match these with whānau was initially desired. Guidance from the Ago and Bekele (2022), who suggest a sample size of 5-25 participants for phenomenological studies, alongside Denzin and Lincoln (2005) recommendation of 6-15 interviews for a Master's or Professional Doctorate study, informed the indicative sample size for this research and aligned closely with the nature of the study being undertaken. As reflexive thematic analysis was employed, the researcher was seeking theoretical sufficiency (Braun & Clarke, 2021).

Theoretical sufficiency recognises that meaning in qualitative research is interpretive and emergent, rather than discovered, and therefore does not rely on the point at which no new information arises (Braun & Clarke, 2021). Instead, sufficiency is achieved when the data collected provide adequate richness and depth to support credible and nuanced interpretations aligned with the research aims (Braun & Clarke, 2021). This approach positions sampling decisions as context-dependent and reflexive, privileging the generation of meaningful insights over meeting a predetermined numerical endpoint.

The indicative numbers of 5-20 interviews guided the ethics application and, most importantly, supported the understanding of resources required to complete data collection.

4.6 Recruitment

Phase One

Recruitment for Phase One of the study leveraged pre-existing professional relationships with health providers throughout Te Tai Tokerau, developed through the researcher's previous roles. These established connections facilitated the initial outreach to recruit providers for participation in the research.

Rural general practices and health providers were identified using the HealthPoint website. During October 2023, email invitations were distributed to these providers, accompanied by consent forms (Appendix B) and participant information sheets (Appendix C). Providers were given a two-week window to respond to the invitation (Appendix D) via email. For those who did not respond within this period, a follow-up email was sent to encourage participation.

Providers interested in the study were subsequently invited to participate in either an interview or a focus group. Participants choose which method they would prefer. Data collection sessions were scheduled at a time and location convenient for each provider, with options available from October 2023 to February 2024, to accommodate varying schedules.

All interviews and focus groups were conducted *kanohi ki te kanohi* (face-to-face), an approach chosen to foster trust and connection, and to demonstrate my commitment to improving health outcomes for Māori. This approach was particularly crucial in overcoming initial hesitations in settings where the researcher lacked pre-existing relationships. However, these hesitations were generally resolved by establishing whanaungatanga (relationship-building).

Each data collection session began with an introduction to the research and the researcher, particularly for participants unfamiliar with either. A verbal summary of the participant information sheet (Appendix C) was provided, with an opportunity for participants to ask any clarifying questions. Before proceeding with the interview or focus group, written consent was obtained (Appendix B). The discussion was guided by indicative questions (Appendix A), which differed for providers and patients. These questions were designed to encourage dialogue and apply Appreciative Inquiry principles throughout the data collection phase. The questions for both Phase One and

Two were developed by the researcher through the lens of Appreciative Inquiry; they were tested with the research Kāhui and academic supervision for completeness and cultural awareness.

Phase Two

Recruitment for Phase Two of the study proved more challenging than initially anticipated. Despite establishing relationships within the community, similar to those with healthcare providers, encouraging individuals to commit 45-60 minutes for an interview proved to be difficult. To address this, the recruitment strategy was revised.

Initially, social media was utilised to promote the study. The research poster (Appendix E) was shared on Facebook, LinkedIn and Instagram platforms. The poster was designed by the researcher. The social media sites included my personal pages and community pages, including the Northland grapevine (Northland grapevine is a social media group on Facebook with over 24,000 members). Alongside social media, some health providers also displayed the poster in their waiting rooms, shared it on their social media pages, or distributed it to their consumer focus groups. A consumer focus group is an established patient consumer group coordinated by health providers to gain insights from those with lived experiences. Despite the attempt to socialise the research within the community, limited participant engagement was received. All participants who responded to the community engagement were contacted, and interview dates and times were set.

Given the low response rate from social media, a more direct approach was necessary. Network sampling is a crucial methodology in social science research, particularly for studying hard-to-reach populations and complex social structures (Mouw & Verdery, 2012). Using this technique, the researcher engaged with Māori networks, as well as connections and extended Māori whānau, encouraging them to share the study details within their networks and personally recommend people who might be interested. This method is linked to the research principle of whanaungatanga and enabled more information on the research kaupapa to be delivered to encourage uptake. This approach gradually led to identifying a small but valuable group of participants, most of whom were interviewed individually, with some focus groups also conducted to capture a broader range of experiences.

Once patients (Phase Two participants) expressed their willingness to participate, they were contacted to schedule an interview at a time and location that suited them. All interviews were conducted kanohi ki te kanohi (face-to-face), facilitating trust-building and creating a safe, welcoming environment for participants to share their experiences openly. This approach also helped establish whanaungatanga, critical to fostering a supportive and respectful dialogue.

Just like the provider phase, at the beginning of each interview, the researcher introduced themselves and the research, ensuring that participants had a comprehensive understanding of the research purpose. A verbal summary of the participant information sheet (Appendix F) was provided, and any questions or concerns were addressed. Written consent (Appendix G) was obtained before the interview commenced. Discussions were guided by a series of indicative questions (Appendix A) designed to stimulate *kōrero* (conversation) and facilitate the application of Appreciative Inquiry, enriching the data collection process with depth and meaning.

4.7 Data collection

The data collection process for this study employed two primary methods, focus groups and individual interviews. Both approaches utilised semi-structured questions designed to facilitate an Appreciative Inquiry.

4.7.1 Focus groups and individual interviews

For participants who preferred one-on-one interactions, individual interviews were offered as an alternative to the focus groups. Both the interviews and focus groups lasted up to 60 minutes each and used the same semi-structured question guide as the focus groups, adapted for a one-on-one context. Focus group sessions were conducted with 2-4 participants per group. Interviews were conducted in person one on one.

Data was captured through a handheld audio recording device and later uploaded to the computer through USB and transcribed by an external paid transcriber. The same person transcribed all transcriptions. All transcriptions were verified for accuracy by the lead researcher. All audio-recorded data, transcribed data, and consent forms were stored on the approved AUT OneDrive site and were accessible only to the lead researcher.

As outlined in the participant sampling section, this study was guided by the concept of theoretical sufficiency, which emphasises gathering data of sufficient richness and relevance to enable robust interpretation rather than striving for completeness or redundancy (Braun & Clarke, 2021). In practice, this meant recognising when the data set provided enough depth to meaningfully address the research aims, while also aligning with the reflexive and interpretive values underpinning this study. Given this was the researchers first time using this method, academic supervision helped the researcher to understand and identify where these points were.

Each interview and focus group followed a consistent process and tikanga. All sessions were conducted in person rather than virtually, which, while logistically challenging given the geographical distance between participants and the researcher, was considered essential for establishing and nurturing trust with participants. Participants were given the autonomy to select their preferred interview location, with sessions taking place across a range of settings including workplaces, cafés, and community spaces. This flexibility was intentional, ensuring participants felt at ease and comfortable within the space where kōrero was shared.

Each session opened with the opportunity for karakia, which some participants chose to progress with. This was followed by the researcher guiding participants through the participant information sheet, inclusion criteria, and consent forms to ensure full understanding prior to proceeding. In one instance, a whānau participant, upon engaging with this process, disclosed that their whakapapa was Pacific rather than Māori, meaning they did not meet the research inclusion criteria. As a result, the interview did not proceed. This experience highlights the importance of these procedural conversations in upholding the integrity and scope of the research.

4.8 Data analysis overview

Reflexive thematic analysis

Reflexive thematic analysis (TA) was used to analyse the data. Reflexivity involves the continuous critical reflection on the researcher's positionality (Braun & Clarke, 2022). TA is a qualitative analysis approach that supports flexibility, enabling it to be used across many different data sets (Braun & Clarke, 2006). Through a six-step data analysis process that identifies, analyses themes and reports patterns that emerge

from the data (Braun & Clarke, 2013). Reflexive thematic analysis was selected for several reasons, but primarily to ensure that, regular reflection on researcher positionality was undertaken. Being non-Māori analysing a Māori data set (with support and supervision), the reflexive element of the analysis was necessary.

Reflexive TA is empowered to be flexible and adaptable, enabling the researcher to be critical and responsible for our situatedness within the research and the effect that may have on the setting and the people being studied (Braun & Clarke, 2022). This reflexive approach has been embedded throughout the research. It has occurred not only during this data analysis phase, but also as my critical awareness and heavy responsibility to ensure Māori perspectives, interpretations, and desires are upheld, which has required planned and structured effort.

TA is a method for systematically identifying, organising, and offering insight into patterns of meaning (themes) across a dataset. It enables the researcher to recognise and interpret collective or shared meanings and experiences within the data (Braun & Clarke, 2022). The six phases to TA are outlined below:

Phase 1 - Familiarising myself with the dataset
Phase 2 - Coding the data
Phase 3 - Generating initial themes
Phase 4 - Developing and reviewing themes
Phase 5 - Refining, defining, and naming themes
Phase 6 - Writing up

Despite the six phases being outlined in an ordered and numbered way, there is no expectation that the phases will remain linear (Braun & Clarke, 2013). For this research, the process remained linear, as it made logical and progressive sense.

Reflexive TA provided a comprehensive data analysis method for qualitative research, encompassing theme identification and pattern interpretation. Patterns and themes were essential to the research output as this synthesised the data, enabling the research to meet its aims. Prior to conducting the analysis, the researcher completed a two-day reflexive thematic analysis course at AUT delivered by Terry et al. (2017) whose approaches to reflexive thematic analysis were adopted. The course practically taught Braun and Clarke's 6-phase guide to performing TA.

This method allowed transitioning between phases as needed to ensure a detailed analysis was conducted. As a Tauiwi researcher, who was investigating Māori participants, themes, and concepts required clarification and support to develop. Māori supervision and the Māori research Kāhui supported the identification of these gaps and provided options such as wording for themes and clustering of themes, supporting the analysis of the data.

4.9 Phase 1 - Familiarisation of data

The initial exercise involved situating the researcher within the data. As an engaged leader in the primary and community healthcare sector, listening to providers was found to be deeply compelling. This intrinsic interest, combined with the researchers lived experience of growing up and continuing to reside in Te Tai Tokerau, created a natural connection to both the research topic and its context. Still, it also required reflexivity to mitigate the influence of my aspirations on the analytical process. Braun and Clarke (2022) refer to this as situating the researcher in relation to the data, acknowledging the interplay between personal and academic experiences that are brought into the research.

Familiarisation with the data involved three distinct practices. Firstly, a deep understanding was developed providing an intimate understanding of the dataset. As the researcher conducting all interviews, a replay of the recordings facilitated natural immersion. Second, active engaged with the data through critical reflection, going beyond mere information processing. The employment of an external professional transcription service to ensure accuracy, then reviewed the full transcripts upon their return. This review provided a valuable opportunity to critically engage with the data before initiating the coding phase. Third, employment of systematic notetaking. Immediately following each interview, documentation of the interview context, initial impressions, and notable elements were captured. These notes were formalised during the transcript review by adding detailed comments directly to the transcripts. Additionally, discussing data collection reflections during academic supervision provided a verbal form of notetaking, offering another layer of critical engagement with the data.

The word cloud below in Figure 5 captured the word frequency used throughout the 16 datasets. The word cloud was developed through Nvivo and provided a visual way of looking at the data and coding. It is a compelling visual that reflects the research question and aims, providing confidence that the data aligns with the research objectives.

Figure 4 Word cloud

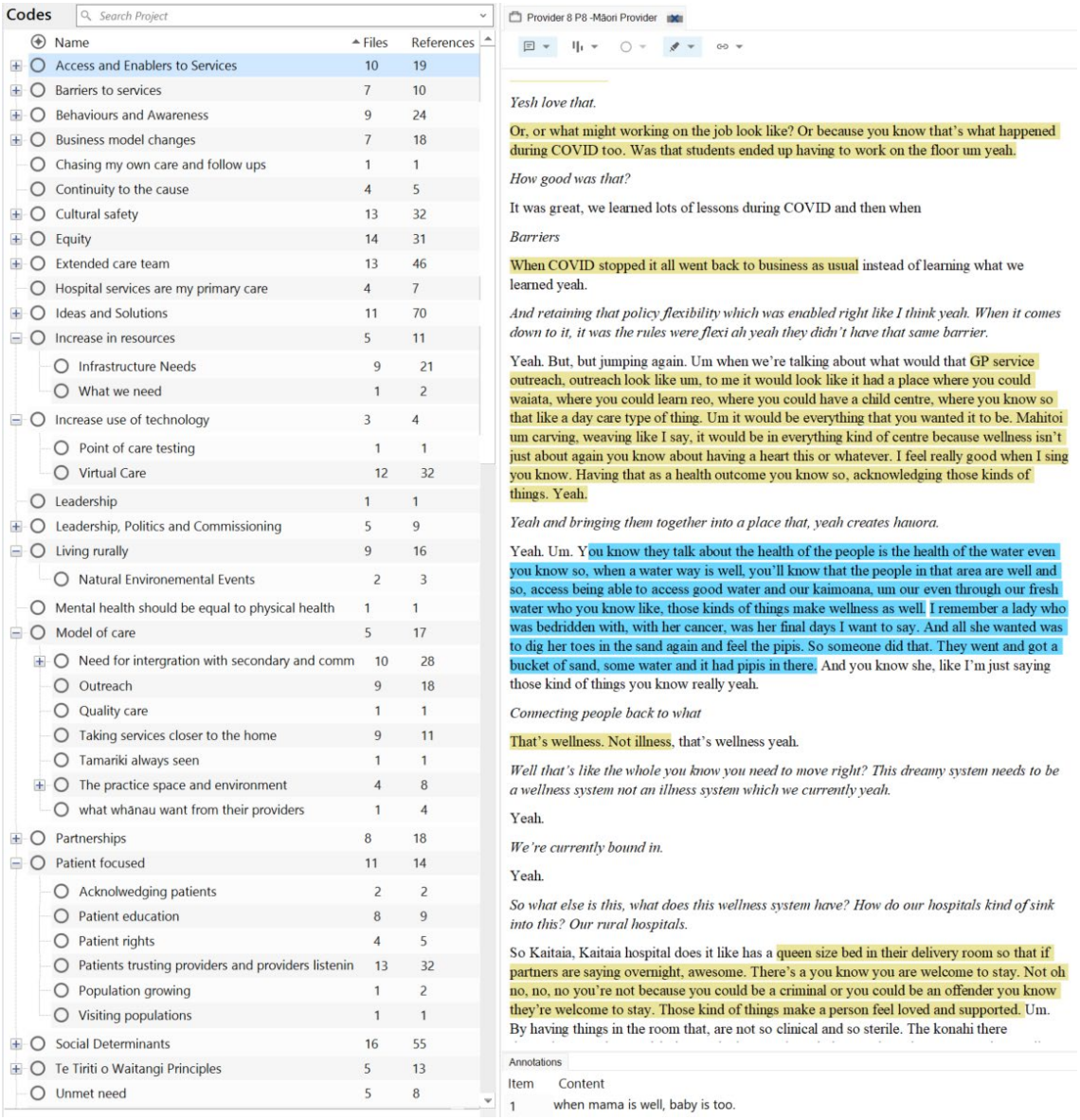
4.10 Phase 2 - Coding

In reflexive thematic analysis (TA), coding is a systematic and iterative process used to identify patterns of meaning across the dataset (Braun & Clarke, 2022). To support organisation and confidentiality, each transcript was categorised by participant group (e.g., provider or whānau) and assigned a unique identifier. Line numbers were applied to all transcripts to enable accurate referencing of where themes and sub-themes originated within the data.

NVivo 14 software was used to support data management, coding, and analysis. Each transcript was read in full multiple times to support familiarity with the data before detailed coding commenced. Segments of text relevant to the research question were systematically coded and accompanied by annotations where appropriate. Initial coding generated more than 100 codes across the dataset. No substantially new codes emerged within the final three whānau interviews and final four provider interviews, indicating sufficient depth and breadth of data to support thematic development (Braun & Clarke, 2021).

Annotations and reflective memos were used throughout the coding process to capture emerging interpretations, identify significant quotations, and document reflections relating to key issues, opportunities, and concerns raised by participants. Consistent with the Appreciative Inquiry approach underpinning the research, a dedicated code relating to ideas, aspirations, and solutions was created to ensure data generated during the Dream phases was distinctly captured and not overshadowed by discussions focused on current challenges and experiences. An example of the coding and annotation process is presented in Figure 6 below, where yellow highlights represent coded data segments and blue highlights represent reflective memos.

Figure 6 Example of data excerpts

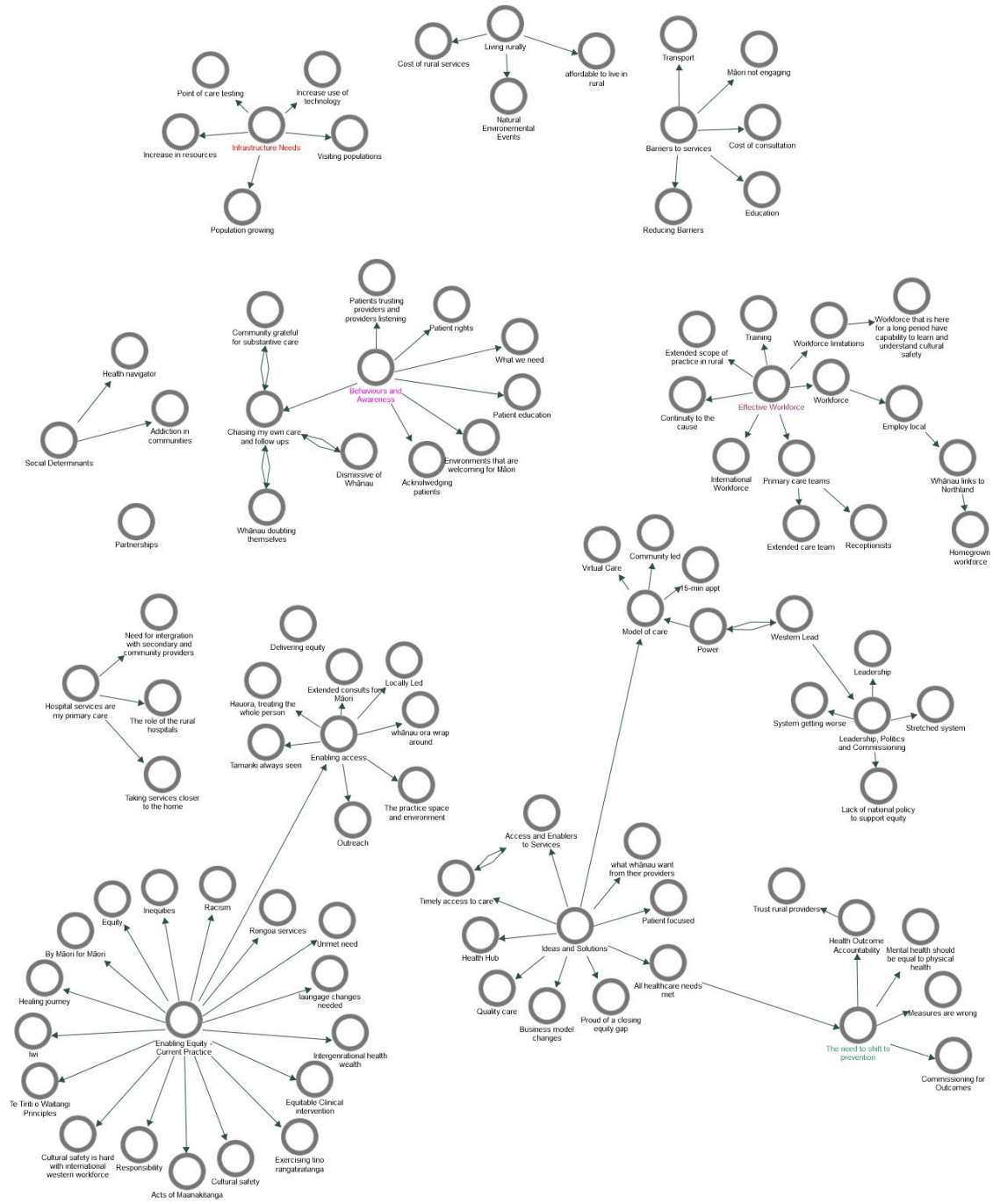


The Kāhui members were informed of the coding process, and meetings with two of the Kāhui members enabled me as the researcher to check elements of the coding and gain advice and insights. Two academic supervision sessions were held during the coding process to provide opportunities for insights. If resource and time allowed the ability to code with participants would have offered an ability to increase the level of decolonisation. Due to resource constraints this was not achieved.

4.10.1 Phase 3 - Generating initial themes

This is the part of the process where analysis scales back out from the micro level to the macro level, shifting codes into themes (Braun & Clarke, 2022). A theme captures the patterning of meaning across the dataset (Braun & Clarke, 2006). For reflexive TA it is about going beyond a topic summary and looking to find elements of shared meaning (Braun & Clarke, 2022). NVivo 14 was again used to support this process. The creation of a visualisation map was completed to think about how the codes and sub-codes related and provided an initial map of the patterns across the dataset.

Figure 5 Findings visualisation map



Thematic maps are working documents used to support the researcher in identifying, organising, and refining patterns of meaning across the dataset, including possible connections, interconnections, and disconnections between themes and sub-themes (Braun & Clarke, 2022). Unlike conceptual maps, which are typically used to illustrate broader theoretical or conceptual relationships, thematic maps are specifically

developed as part of the thematic analysis process to visually represent and explore the structure of themes emerging directly from the data.

4.10.2 Phase 4 - Developing and reviewing themes

A review of the data across the 15 codes was completed, carefully analysing patterns and exploring the underlying meanings. This process required a critical and reflective approach to uncover deeper insights within the dataset. Engagement with academic supervision and the Kāhui was pivotal during this phase, as their guidance challenged the notion to interrogate the data from multiple perspectives and consider alternative interpretations. Through this iterative process, four key themes were identified, these themes encapsulated the core findings of the research.

4.10.3 Phase 5 - Refining, defining, and naming themes

The four themes were developed, organised, and considered in relation to one another, enabling critical thinking about how they might connect and differ from each other. Naming the themes was incredibly thoughtful, and they continued to be developed and progressed throughout the development of the findings chapter.

4.10.4 Phase 6 - Writing up

Writing up the TA findings is a crucial final step that blends together the analytic story and the data extracts into a cohesive, compelling story (Braun & Clarke, 2022). Extracts are sections of data identified from the transcripts. This final part of the six-step process ensured that the story being told accurately reflected the dataset. Given the depth of the dataset, choosing extracts of data to include in the write-up required reflexive critical thinking and consideration.

4.10.5 Phase 7 - Validation of findings

Observations and research notes were kept, supporting the context of the data. Often, after an interview, a voice recording of initial thoughts and feelings was captured. This process helped debrief thoughts and verbally work through thoughts. Many of the interviews were positive and uplifting, and debriefing enabled this energy to be captured. Debriefing in academic supervision and with the kāhui was also a critical part of the process.

Once the data analysis was completed, the preliminary themes were shared alongside the individual coded transcripts were shared to the participants through personalised emails. For those in focus groups the distribution of transcripts was discussed in the focus group, as the groups were small the feedback was agreed to be shared with all people included in the focus groups. Names were not used in the transcripts. The feedback received from the participants was overwhelmingly positive, indicating accuracy of the captured themes.

4.10.6 Ethical considerations and approval

The Auckland University of Technology Ethics Committee (AUTEC 23/157) approved the research on 12 June 2023 (see Appendix H) as a requirement of the University. An amendment had been made on 22 May 2023 to include focus groups (see Appendix I). This amendment was approved on 5 October 2023, and recruitment started shortly after. Recruitment and data collection ended 12 months later in October 2024. Ethical approval for this research was essential but not complicated, and minor adjustments were advised by the ethics committee, including changing the age of whānau participants to 16, not 20 years old, indicating where focus groups will be held and replacing the word ‘anonymous’ with ‘confidential’. Anonymity is not possible with focus groups or interviews, as the participants are known to the researcher.

Informed consent was obtained from all participants before their involvement. Participants were provided with an information sheet outlining the purpose of the research, their rights, and the intended use of data. This included the right to withdraw at any stage prior to analysis and the assurance that participation was entirely voluntary. Consent forms were signed before interviews or focus groups commenced, with processes adapted where appropriate, to ensure understanding and cultural safety.

Information sheets were carefully developed to provide participants with comprehensive details about the research, ensuring they were fully informed about the study and their rights. Participants were informed that they could withdraw from the study at any time, and their contributions would remain confidential, thereby safeguarding their privacy and protecting their role as participants. The information sheets also outlined how and where the data would be securely stored. Participants

were encouraged to retain the information form, which included my contact details, so they could reach out at any stage of the research. Additionally, the participants were assured that their consent forms would remain confidential and accessible only to the researcher. It was emphasised that their data would be used solely for the scope of this research project and would not be utilised for any future or other research without obtaining additional consent.

Data storage and management were undertaken in line with AUTEC requirements and guided by the principles of Māori Data Sovereignty. All digital files, including transcripts and audio recordings, were stored securely on password-protected devices and within the AUT OneDrive system, with access restricted to the researcher. Hard copy materials, such as signed consent forms, were kept in a locked cabinet in the researcher's home office. In recognition that data relating to whānau Māori is a taonga (treasure), the stewardship of these materials was approached with kaitiakitanga (guardianship), ensuring that data use, access, and reporting upheld collective rights and responsibilities. All participants received a copy of their transcript and were provided the opportunity to give clarifying feedback if they felt it was appropriate. Many participants appreciated this opportunity. Only one person provided feedback which was taken onboard.

To further ensure confidentiality, no hard copies of participants' transcripts exist; all transcripts are securely stored electronically on a password-protected computer. In line with ethical requirements, all data, including consent forms, will be retained for six years. After this period, the data will be destroyed in accordance with AUT's processes to uphold ethical standards.

The research ethical standards were guided by Hudson et al. (2010). These guidelines supported the development, design, and delivery of the study, and were actively adopted throughout the research process. Practical examples of this include deliberate engagement, a Māori-centred methodology, and an emphasis on cultural safety. As discussed earlier in this chapter, engagement involved consultation with Māori communities, leaders, and researchers. This was an essential part of the process and ensured Māori participation in the research. The study was also Māori-centred, which Te Ara Tika identifies as good practice (Hudson et al., 2010). By incorporating Māori

values and concepts, the research was able to uphold cultural safety and remain grounded in practices that reflect and respect Māori worldviews.

The academic supervision team supported the researcher in using the CONSIDER statement. The CONSIDER statement (Huria et al., 2019) sets out eight domains and 17 criteria to strengthen the reporting of health research involving Indigenous peoples. It emphasises Indigenous leadership, governance, and knowledge protection, ensuring research is accountable, culturally responsive, and equity focused. By shifting research from being done on Indigenous peoples to being done with and by them, the statement provides a framework that upholds self-determination and supports improved health outcomes. A copy of the CONSIDER statement relevant to this research is provided in Appendix J.

4.10.7 Dissemination

Dissemination of academic research is an essential component of the research process, ensuring that findings are shared in ways that are accessible and meaningful to participants. In this study, all participants were consulted on how they would prefer the research to be shared back with them. Their input was integral to tailoring dissemination strategies that respected their preferences and needs. Various options were suggested by participants, including providing a concise summary of the research findings and organising follow-up meetings to discuss the results in more detail. These approaches were designed to promote transparency, foster ongoing dialogue, and ensure that participants could engage with the findings in a way that supported their understanding and application of the research. This is the continuation of the “cups of tea” approach to connection.

Plans to write journal articles and share the research at conferences is intended to support wider dissemination of the findings, contribute to ongoing academic and sector discussions, and promote practical change that may improve outcomes for rural communities and whānau.

4.11 Research rigour

In applying rigour to the research methods, a systematic approach was employed throughout the study. Research questions were carefully designed, appropriate methodologies were selected, and robust data collection techniques were

implemented. Close attention was paid to sample selection to ensure it was representative and of sufficient size to support meaningful conclusions.

Data analysis was conducted using reflexive thematic analysis, following the six-step process outlined by Braun and Clarke (2022). To further enhance rigour, participants were provided with their coded transcripts for review and verification. Validation of the data coding was also sought through academic supervision and engagement with the research kāhui.

Comprehensive documentation of each stage of the research process, alongside the use of NVivo 14, created a transparent audit trail that enables scrutiny and supports potential replication of the study, thereby strengthening the credibility and trustworthiness of the research.

4.12 Rigor of the research process

The research process was conducted with methodological rigour to ensure the credibility, trustworthiness, and validity of the findings. A Māori-centred methodology guided all stages of the study, ensuring alignment with Te Ao Māori values and reinforcing a commitment to equity and cultural integrity. Data collection involved in-depth, one-hour semi-structured interviews with both whānau and providers, deliberately privileging their voices and creating space for culturally grounded insights to emerge. Reflexive thematic analysis was undertaken systematically, with continuous self-reflection to mitigate researcher bias and uphold cultural safety. The use of NVivo, an electronic qualitative research tool, contributed to analytical consistency, transparency, and traceability. Ongoing consultation with academic supervisors and the research kāhui further strengthened the integrity of the research design and interpretative process.

4.13 Researcher reflexivity

My position within this research has been shaped by my role as a health professional and leader dedicated to improving outcomes for Māori living in rural communities. My professional roles within Te Kaupapa o Mahitahi Hauora, General Practice New Zealand (GPNZ), and Collaborative Aotearoa have centred on primary healthcare

quality improvement and leadership, positioning me as an experienced and connected individual to undertake this research.

While my professional expertise provided a strong foundation, my personal experiences within the Te Tai Tokerau health system were irrelevant to this study. As a non-Māori researcher, I focused on Māori experiences, distinct from mine. Furthermore, I do not have a clinical background and have not worked as a service provider within Te Tai Tokerau, further distancing my personal experiences from the data. This level of disconnect allowed me to approach the research with objectivity. However, I was explicit about my identity, personal motivations for conducting this research, and my professional roles, recognising that these inevitably influenced my positioning within the research space.

My positionality in this study was also informed by my role as a māmā to a Māori daughter, my professional identity as a health leader, and my connection to Māori through my husband and his whānau. These insider connections enabled me to build trust and rapport with research participants while fostering a sense of shared purpose.

As a māmā, I was able to connect specifically with other māmā I interviewed, sharing my commitment to improving health systems for future generations. This shared understanding of responsibility allowed for meaningful dialogue. As a health professional, I remained aware of the potential power dynamics my professional roles could create. I deliberately tried to mitigate any discomfort participants might feel by employing strategies such as *whanaungatanga* and fostering connections to people and places to deconstruct unnecessary power imbalances.

Finally, my role as the wife of a Māori man provided a critical lens for understanding and contextualising this work. I recall a pivotal moment when one of my husband's aunties asked, "Would you be doing this research if you were not married to Rewiri?" This confronting question prompted immediate reflection, and my answer was unequivocal: no. However, my connection to Rewiri and his wider whānau has profoundly deepened my understanding of the systemic inequities Māori face in healthcare compared to my own experiences. This insight has become central to my motivation for this research, driving me to contribute to a health system that serves future generations, including my children and mokopuna, equitably and justly.

4.14 Summary

In this chapter, I outlined the general research approach and specific methods used in the research process. The chapter also outlines the cultural and ethical considerations that have profoundly impacted the research journey, processes, participants, and me as the researcher. Protocols and guidelines have safeguarded the research, ensuring that it is rigorous, culturally safe, and carefully designed to capture the voices of whānau and providers within the Te Tai Tokerau health system and provide an opportunity for their experiences and insights to be captured.

Chapter 5 Whānau stories

This chapter presents three stories shared by whānau during the data collection and interview phase of the research. The stories presented were selected from narratives shared across the data collection process, each chosen for the way in which they authentically reflect the lived experiences of whānau participants. Their inclusion required an additional layer of participant consent, sought and confirmed separately from the primary research consent process, ensuring participants retained full agency over how their personal narratives were represented within this research. These narratives set the context for the findings chapter that follows.

5.1 Justyce

Justyce was a young Māori wahine taken from us too early. Her māmā shared her story with me and consented to me sharing it with you.

Justyce was well known to the Te Tai Tokerau healthcare system. From four months old she experienced seizures that were unexplained and remained undiagnosed for many years. Initially the family believed her seizures were a result of meningitis but later discovered it was due to a mutated kcna2 gene. Her primary care was a combination of the ambulance service and the hospital services with a very rare need to see a general practice. Justyce's condition impacted her developmental stages but that didn't stop her. Her strong-willed personality and embedded character were incredibly contagious.

Justyce's mum had been managing her condition for 18 years, she was the expert in all things Justyce and knew all the signs, triggers and knew what medicines to give. She was Justyce's continuity, enabling her to get the care she needed.

A challenge for the family was when Justyce transitioned from paediatric care to adult services. This transition occurs for many patients aged 16 years old who are under the care of specialty services. With paediatrics, the care was consistent and responsive, adult services weren't so. Being rural, the family often made trips to Starship Children's Hospital (over 350 km away) and Whangārei Hospital (over 90 km away) to see specialists. When Justyce turned 16, her care was transferred to adult services. A transition that Justyce's mum described as detrimental, saying, "There is literally no

one” in a service with limited resources. Mum described times when she was not allowed to go to the hospital with her daughter as she was now an “adult”.

Justyce was 18 years old, and she was at home when she started to have a seizure. The ambulance came and transported her from home to the hospital. For most families, this would be a big event; for Justyce and her mum, it was a monthly experience. Justyce’s mum had rung the hospital and explained what had happened and explicitly outlined the situation and requested specific medicine be given while in the hospital. Simply, this message was not received, the medicine was not given, resulting in another seizure which subsequently ended in Justyce passing away. To this day, Mum asks herself, “Why wouldn’t they just listen to me?”.

Justyce’s primary care was the hospitals, ambulance services and was sometimes supported by her general practice. Her story is devastating and heartbreaking, and I hope all healthcare workers who read this will stop to think about how their actions impact patients and how listening and acting with urgency is critical, in this case, potentially lifesaving.

Figure 6 Painting by Justyce

5.2 Prison in Te Tai Tokerau

The Te Tai Tokerau Region Corrections Facility, commonly known as Ngawha Prison, is located near Kaikohe in Te Tai Tokerau, Aotearoa New Zealand. Opened in 2005, the

facility was designed to accommodate up to 628 male prisoners across various security classifications, ranging from minimum to high security.

Life in a Te Tai Tokerau prison comes with challenges, but for one ex-inmate, the wait for healthcare stands out as one of the most frustrating experiences. 'You've got to wait,' he said, describing the endless delays for even basic care. 'Whether it's a throbbing toothache or something more serious, patience is the only remedy while pain persists. '

Dental care? There's a three-month wait just for a check-up. 'You could have the meanest toothache,' he shared, 'and you still have to wait.' Even general health check-ups are slow. Upon arrival, prisoners are placed on a list, but it might be months before they're seen. 'By the time they call you, most of the fellas are gone.'

Emergency situations don't fare much better. He recalled a time when a friend broke his arm in the yard. Everyone heard it snap, but the medical team only offered Panadol and told him to submit a chit, a form to seek care from a health professional. 'He waited two days before they sent him for an X-ray and surgery,' the ex-prisoner said.

Things have improved slightly with the arrival of a couple of new doctors who seem to care genuinely. 'These doctors actually listen,' he explained. 'They trust us when we say what we need.' For once, there's a sense that someone is willing to act quickly, whether it's prescribing medication for gout or changing a diet without unnecessary red tape.

But the improvements are limited. The system itself is the problem. 'It's the process that takes ages,' he said. A better triage system was suggested that could make a difference, ensuring that people in real pain are seen faster.

Mental health support is another sore point. While some counsellors are available, their focus is narrow, often tied to Accident Compensation Corporation (ACC) claims. 'They just give people sleeping pills,' he said, the standard response to mental health struggles. For those in extreme distress, there's a harsh reality: being placed in a cold, padded unit with minimal comforts is a far cry from the support they need.

In prison, being in pain often feels like being invisible. Yet, this ex-prisoner holds on to hope that the system can change. 'We're not just numbers, 'he said. "We're people

who deserve care.' For now, though, the waits continue, and he can only hope for a day when healthcare behind bars moves faster and treats people with the dignity they deserve.

Figure 7 Drawing by the ex-inmate and whānau participants

5.3 Māmā experiences

In 2005, a health provider began a deeply personal journey that ultimately shaped her professional path and advocacy. Diagnosed with breast cancer, she underwent a transformative surgery where her right breast was replaced using her abdominal muscles. This left her unable to perform full sit-ups, and her body was forever changed into a patchwork of resilience and survival. She didn’t expect to have children after

chemotherapy, fearing it had robbed her of fertility. But to her surprise and immense gratitude, she was blessed with two Tamariki (children).

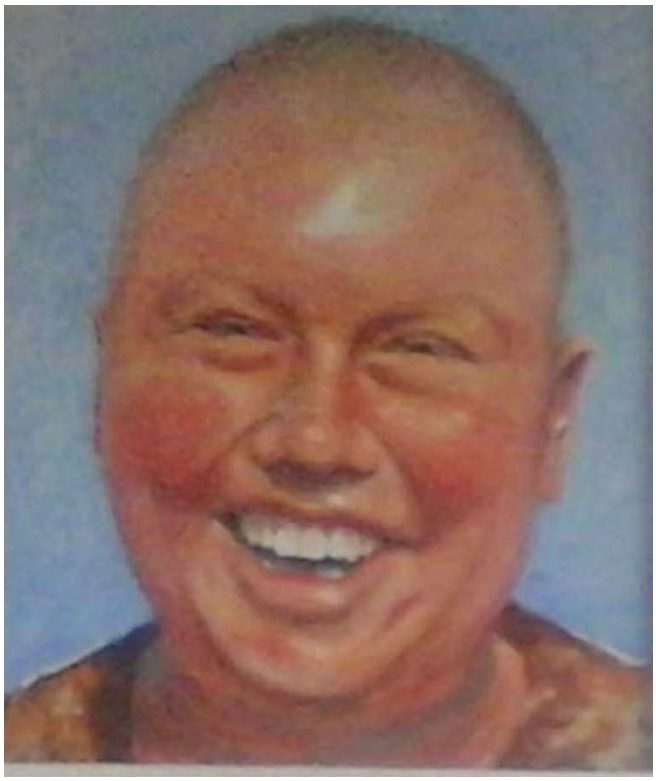
Breastfeeding proved to be a challenge. With only one breast capable of nursing, she navigated the early days of motherhood, determined to provide for her babies. Encouraged by a comment from someone who said, 'If you can breastfeed with one breast, you can help other mums struggling with two.' She found a new purpose. This, coupled with the unwavering support of her midwives, inspired her to advocate for others on their breastfeeding journey.

A few years later, she began working as a breastfeeding advocate. It was there she discovered how something as precious as breastfeeding could be both a gift and a tool for empowering whānau. However, she also confronted the harsh realities of judgment and misconceptions surrounding Māori health and breastfeeding practices. Many assumed that whānau Māori who didn’t breastfeed were disinterested in their health or their babies’ wellbeing, a narrative she knew was far from the truth.

Her approach was grounded in compassion and practicality. While she admired the principles of certain organisations, their rigid, judgmental attitudes didn’t align with the realities faced by many whānau. Instead of condemning formula feeding, she advocated for genuine support, that is, helping whānau access what they needed without shame or barriers. She rejected the paternalistic attitudes some health workers carried, believing that whānau themselves knew best. They simply needed equitable access to the resources and support to thrive.

Her work expanded beyond breastfeeding advocacy. Drawing on her cancer journey, she became a voice for whānau navigating health challenges, always centring the needs and mana of the people she served. Today, she continues to champion the rights of whānau to make informed, supported decisions for their babies and themselves. Her story is one of resilience, empathy, and a relentless drive to transform personal hardship into meaningful change for others.

Figure 8: Painting by Thomas Lauderbach of māmā during her treatment



Note: This was painted at Tapeka Point, where the participant's nana and grandad's ashes are. The feathers around her shoulders are a kahu korowai added by Thomas.

Chapter 6 Findings

6.1 Introduction

Having a destination when out on the water, paddling the waka, is critical to the journey's success. This chapter looks at the research findings and the critical voices of those in the waka (the providers) and the waka (whānau Māori). The whakataukī (proverb) “He waka eke noa” (we are all in this together) (Te Aka Māori Dictionary, 2025) continues to draw a connection to this thesis by bringing the aspirations of both providers and whānau Māori together to ensure equity is enabled in a way that supports both sets of aspirations.

This chapter describes the findings from the analysis of the data collected. The analysis of this research resulted in four central themes, each encompassing several sub-themes that deepen the understanding of the findings. The data were collated and analysed collectively, intentionally bringing together the perspectives of both whānau and providers. This was a deliberate methodological choice, grounded in the understanding that a responsive health system cannot afford to consider whānau needs, wants, and aspirations in isolation from the services designed to support them. Merging these perspectives was therefore not only meaningful but essential to producing findings that reflect the complexity of lived experience and have the potential to inform practical, lasting change.

The first theme, "Understanding equity and root causes," explores the foundational elements contributing to health disparities, including inequities, the importance of enabling equity, and the influence of social determinants.

The second theme, "Being aware and culturally safe," emphasises the need for access to quality services, cultural safety, receptionist awareness, and the voices of unheard whānau, highlighting the importance of culturally responsive care.

The third theme, "Establishing partnerships with purpose," focuses on collaborative approaches that honour Te Tiriti o Waitangi, fostering whakawhanaungatanga, and prioritise health outcomes that are meaningful to communities. Lastly, the theme "Knowing how rural primary healthcare is delivered" addresses the practical aspects of rural healthcare, including the model of care, availability of resources and technology,

costs, and the reality that for many, hospital services function as primary care. These themes and their associated sub-themes are summarised in Table 6 below.

Table 6 Themes and sub-themes

Theme	Sub-theme
Understanding equity and root causes	• Inequities • Equity levers • Social determinants for Māori
Being aware and culturally safe	• Access to and enablers of quality services • Cultural safety • Receptionist awareness • Unheard whānau
Establishing partnerships with purpose	• Upholding Te Tiriti o Waitangi • Whakawhanaungatanga • Health outcomes that mean something
Knowing how rural primary healthcare is delivered	• Model of care • Resourcing • Affordability • Hospital services are my primary care

The stories in the chapter prior are stories that were told during interviews. They provide context, depth and breadth to this findings chapter and should be read prior to this chapter. Quotes in this chapter refer to either provider quotes (P) or whānau quotes (W). All data were collected between January 2023 and December 2023. The average interview or focus group lasted 60 minutes.

6.2 Theme 1 - Understanding equity and root causes

To truly enable equity, we must be able to understand it and the root causes that contribute to both equity and inequity. Equity reflects the notion that everyone starts from different positions in life and seeks to provide additional support to those experiencing poorer health outcomes, enabling them to achieve the same level of wellbeing as others.

Participants described equity in terms of approaches, behaviours, and perceptions, emphasising that it is not about fairness in a general sense, but about allocating resources based on need. Providers in Te Tai Tokerau demonstrated a strong understanding and commitment to equity and its distinct difference from equality.

Many participants shared personal and professional experiences that demonstrated their in-depth understanding of the concept. They described equity as being closely linked to access, life expectancy, and the ability to live to one's full potential, factors that seek long-term outcomes for whānau.

When providers and whānau were asked what achieving equity for whānau meant to them, participants shared perspectives that describe their understanding of equity and the connection that equity has with root causes such as the wider social determinants of health.

> *"It means that they have the wellness that they describe as being their wellness" – P8*

> *"It's about making sure that Māori have the same opportunities as non-Māori to education, to economic development, and to social things. And health has a massive part in that. If people aren't healthy, if they are not living in healthy homes, they're not going to be able to achieve those other determinants to success" – W3*

The provider quote was reflective and affirming, showcasing the provider's desire to uphold the patient's wellness aspirations rather than their own clinical aspirations. The whānau quote was personal, touching on opportunities that many Māori are missing out on due to systemic and societal constructs. Despite their differences in tone and perspective, they are both centred in equity, they both explore the broader determinants of health (not just medical), and they both consider a Māori worldview.

Equity is not just a policy objective. It is a lived experience that shapes the health and wellbeing of individuals and communities. A lived experience highlights the social realities that whānau Māori have when equity is being discussed. The sub-themes of this overarching theme are described next.

6.2.1 Sub-Theme - Inequities

Inequities are a sub-theme of "understanding equity and root causes." Inequities reflect in the disproportionate burden of ill-health among Māori and their overrepresentation in many clinical health indicators. Participants reported inequities as visibly and deeply felt within their communities. Inequities were evident when accessing health services, interactions with clinicians and living rurally. Participants

described the impact of not being listened to, highlighting how individual health professional behaviours impact the ability for equity to be enabled:

> *"So through my journey of cancer, I realised quickly that the doctors who deal with our cancer patients do not listen to us" – W2*

There is another sub-theme, "unheard whānau", presenting later in the findings, that continues the discussion of being whānau unheard by health providers.

Living in rural areas presents additional disadvantages, as distance and travel requirements make accessing health services more challenging. Participants described long journeys to primary healthcare providers, often contingent on tides and weather conditions. The increasing centralisation of health services was frequently raised as a concern, with fears that continued centralisation would further disadvantage rural communities. The limited availability of after-hours care (between 5 pm and 10 pm) was noted as a significant challenge to achieving equity.

> *"It's like an hour away for a broken finger or whatever." – W4*

Participants also reflected on disparities within the public health system, particularly the inequities created by long waitlists for specialist hospital services. While general practice services are fully funded for children under 14 in Aotearoa New Zealand, delays in specialist care meant those without private insurance or the financial means to pay for treatment faced significantly worse health outcomes. This was seen as an unfair and critically inequitable gap in the system:

> *"Well, how come some of these kids have to pay for their operations? But if they can stay in public [public health system], then they're waiting until they die anyway." – W5*

The stark reality of inequities was powerfully captured by this provider's reflection on Māori children dying younger than non-Māori:

> *"We know that our [Māori] children are dying earlier than non-Māori" – P5*

These findings highlight the inequities that participants observe and experience daily. Both providers and whānau demonstrated a strong awareness of the structural and systemic barriers within the health system and their communities. However, it is notable that none of the whānau interviewed expressed these specific concerns about

the rural primary care providers who participated in this research. This suggests that while inequities were deeply felt and understood, there may also be trust and confidence in the care provided locally.

6.2.2 Sub-Theme - Equity levers

The sub-theme "Equity Levers" refers to the mechanisms, strategies, and resources identified within primary health care settings that enable providers to promote and advance equity. Providers described actively seeking opportunities to address inequities, implementing changes such as offering longer appointments for Māori patients, streamlining service pathways, and reducing financial barriers. Many spoke about their journey as an organisation to disrupt traditional general practice models of care, reconfigure business structures, and reshape workplace culture to better serve their Māori patients. One provider reflected on the importance of empowering frontline staff to facilitate access to care:

> *"If you have people in the right spaces who genuinely care, who genuinely want what's best for human beings, they'll [the care team] always get the right people to be seen. They'll [care team] always make sure that they're [whānau] seen, and I love that. So, giving them full control [to help navigate care], giving your receptionist, call handling staff and nurses control to a degree, as they are access points to your GP. I think [this] is one of the best changes we made, you know." – P1*

These findings demonstrate the genuine aspiration that the participants had for enabling equity through levers, such as empowering support staff and building team synergy based on equity.

Te Tai Tokerau providers demonstrated a deep understanding and strong commitment to enabling equity, regardless of their business model. A collective focus on equity was evident from both private clinics and kaupapa Māori health organisations. Some providers described how shifting their business model away from financial incentives allowed for a greater focus on patient needs rather than revenue. Alongside the business model shifts, a practice's operating team culture can also impact and enable equity.

> *"By changing the business model, it took away all of the self-serving measures that the health partnership had. You know a partnership means that a GP is paid based on their contribution to the business, and that's the percentage split. So, when I first started, there was all of this conflict around how many*

> *patients people were seeing, what they were charging, and how often. You know, once you take that out of the equation and you shift the GP's focus or the nurse, the clinician's focus off how their actions are going to impact their back pocket, you can see a real change in their willingness to work. So that was the first kind of major move for us in helping equity." – P1*

Another dominant equity lever for providers was cultural safety. Cultural safety was not an add-on but an embedded part of their work. Their staff lived and breathed Māori health and wellbeing, fostering an environment where enabling equity became second nature. This influenced how health professionals approached their work, bringing energy, passion, and intent, which directly impacted health outcomes for whānau.

"The passion and the energy of our whānau here and the staff." – P4

"The ultimate vision is that whānau are flourishing, that the Ngāpuhi as a tribe, as an iwi, as a hapū, is strong." – P5

This lever effectively articulates the shift that health professionals need to make to enact and enable equity within their roles. Understanding equity is the first step, and then really embedding it into practice through behaviours comes next. This is explored further in the next theme, "Being aware and culturally safe".

Rongoā Māori (traditional healing) emerged as another key lever of equity. Many providers offered rongoā services either within their organisations or through referral pathways. For some whānau, rongoā was critical because it provided care that aligned with their traditions and beliefs.

"Learn waiata, learn karakia and just learn to be part of the space" – W2

Rongoā is a growing service offered in Aotearoa New Zealand, with Accident Compensation Corporation (ACC) pathways being developed and mainstream providers being more aware of the benefits. It was clear from whānau participants that they wanted their health providers to give them the option of using rongoā. Providers in the research all felt confident with rongoā, showcasing their awareness of the impacts traditional healing can have on Māori whānau.

The last lever of equity was trust and relationships. Whanaungatanga (building relationships) was central to whānau experiences of equitable healthcare. Whānau

spoke about the importance of being recognised and understood by their healthcare providers. In some cases, continuity of care was not just about seeing the same doctor but about knowing that the practice, as a whole, understood their needs. The role of receptionists and other non-clinical staff was highlighted by a whānau participant as a crucial first step in enabling equity.

> *"And for me, it's all about relationships, and I know, especially for our Māori men, like dad, they don't like going to the doctors at all. So, one thing I really love is that they [the general practice] they know that. So, if [my dad or husband] were to ring the practice, they know straightaway, "Oh, I need to get this man in here." Not because he's told them he's chopped his leg or whatever, it's because he's actually rung [called]." – W6*

The quote above showcases the levers of equity that providers in Te Tai Tokerau are acting to ensure their Māori patients are exposed to equitable health services.

Overall, the findings of this sub-theme 'equity levers' reveal a strong alignment between providers and whānau on what enables equity. Providers spoke about structural and cultural shifts, while whānau described their experiences in ways that reflected the impact of these efforts. Together, their comments highlighted that enabling equity was about a deep commitment to removing barriers and prioritising Māori health needs, so that all whānau Māori can access the care they are entitled to.

6.2.3 Sub-Theme - Social determinants for Māori

The sub-theme "Social Determinants" refers to the underlying social, economic, and environmental conditions, such as housing, education, income, and employment, that influence health outcomes and shape individuals' ability to access and benefit from primary healthcare services.

Provider participants in this research demonstrated a strong awareness of the social determinants impacting their communities and actively sought ways to address these within health service delivery. Whānau participants, in turn, shared how factors such as housing, education, employment, addiction, and mental wellbeing shape their health outcomes. Providers acknowledged that they could not tackle these challenges in isolation. Instead, they emphasised the need for integration and strong relationships with social service providers. Both provider and whānau participants recognised that social determinants disproportionately affected Māori whānau.

> *"Māori are more likely to be in need of scabies treatment, more likely to need a script for lice, more likely to be in need of nutrition. They are likely to have a nutritional deficit, they'll have some obvious anxieties relating to home life because they live a very challenging life, you know, they'll have sleep deprivation and all of that." – P1*

> *"Yeah, the impact [getting to primary care services] that it has on families when it's, days off from work. If you don't have sick leave or annual leave. It's hard enough to keep jobs" – P6*

> *"Like this area is most deprived in like just about every category, I just think there is a responsibility to fund and fill gaps. The population may be smaller but it doesn't matter. The need is higher" – W6*

Providers discussed their burden as health professionals attempting to address societal challenges that extend far beyond the traditional medical model of care. They reflected on the complexity of their patients' needs, noting that service delivery models often failed to account for the additional resources required to address these complexities. The ongoing concern for their patients' wellbeing after they leave the clinic was evident in their kōrero:

> *"There is worry every day about different people [patients] at different times when they've left the practice and they've gone home, and still the doctors are left with the worry about how that one [patient]? Oh, we should ring you know, or we need some mechanism for checking in." – P2*

Providers highlighted that factors beyond individual behaviour or genetics shape health. Housing instability, education, and economic conditions all play a significant role in shaping health outcomes. Their ability to confidently discuss these issues and provide real-world examples reinforced how frequently they encounter these challenges in their work.

> *"Why are they poor? Because they didn't go to school. Why didn't they go to school? Because there wasn't a belief in school. What we know now is who the 'at-risk' families are. Our children who are at risk are those children who have a parent or both parents who haven't completed [their] education. A parent or both parents who are on social income benefits. A parent or both parents who have got a mental health issue. A parent or both parents who have an addiction. A parent or both parents who've been to prison. Now, if you don't understand that, and you don't understand the science that created that situation, your engagement is all about your own experience. Right? But it isn't necessarily the experience that is going to lift people above where they are." – P3*

One of the most pressing issues raised by providers was the intersection between housing and health. They described scenarios where patients were being treated for respiratory illnesses, only to return to cold, damp, and overcrowded living conditions, rendering medical interventions almost meaningless.

> *"We're seeing people coming in for ventolin inhalers, and then they're going back to a cold, damp, mouldy bedroom with the wind that blows right through and the rain on their head." – P5*

Providers spoke of the challenges brought by decades of underinvestment in housing, compounded by an increasing demand, as whānau return home to reconnect with their whenua and communities.

> *"Homesteads have deteriorated, people have moved on, but you still, you know, we have seen a bit of a return of whānau coming home." – P4*

If all whānau Māori had access to safe, warm and clean housing, the social determinants of individuals would improve. It is becoming increasingly difficult in primary care to manage some of these complex societal shifts that need to occur in order to truly enable equity.

Drug and addiction issues were another primary concern in Te Tai Tokerau, with provider participants highlighting the availability and normalisation of methamphetamine (commonly referred to as P) as a growing crisis. Both whānau and providers spoke with sadness about the devastating impact of addiction on individuals, families, and entire communities.

> *"I was just talking to my whānau the other night about some of the challenges that we have in our communities. About the scourge of (P) in our community, and where we see our whānau, mates and people who have just gone down this dark path into this level of addiction. What's the way out of that? Well, one way out of that is around looking at the socio determinants of health and all the other things that come into play. And who wouldn't want a better life?" – P4*

> *"Methamphetamine. I mean it's oh we saw the water testing results and the Far North is the worst in the country" – P5*

The financial realities of addiction were discussed, with some provider participants pointing out that drug sales provided a source of income for those struggling financially. Addressing addiction, therefore, also required addressing economic

deprivation. This quote below, referencing financial determinants, unpacks so many wider determinants of health elements. Having money enables you to have a warm home, an education, access to prescriptions and other medical services, dental care, healthy food, and the list goes on. These demands on people are challenges, and without addressing the root causes and the financial pressure and challenges that many Māori whānau are facing in Te Tai Tokerau.

> *"Financial determinants of health, which say that only because I have money am I going to have a good life" – P8*

Transport was identified as a significant component of the social determinants of health. In this context, transport refers to the ability of whānau Māori to travel to and from healthcare services. This includes access to a vehicle, obtaining a driver's licence, maintaining vehicle registration, paying road user charges, and affording fuel. These interconnected factors are particularly critical in Te Tai Tokerau, where public transport options in rural areas are virtually non-existent. Participants highlighted transport as a key social determinant factor, and without effective transport, the ability to enable equity for whānau Māori is made more complex.

> *"Because of the isolation, it's very easy for the kaumātua and kuia to become isolated, even more isolated. And, dare I say it, but there's so many of them [kaumātua and kuia] that are bringing up their own moko because you know their family the next generation, are in jail or they're you know [unable to look after their children]." – W7*

Despite the weight of these challenges, a recurring theme in participants' kōrero was the drive to build resilient communities. Whānau and providers shared a vision of empowerment, self-sufficiency, and cultural reconnection as key to overcoming systemic barriers and social determinants of health. Initiatives focused on sustainable food production, job creation, environmental stewardship, and whānau support were seen as pathways to lasting change.

> *"They keep themselves healthy by growing food, by creating jobs, by looking after the environment, by building together as a community. And, we've got a really amazing example where this could really happen through the locality development issue. So that has the potential, if the government doesn't stop it, of really being a by Māori for Māori place where health outcomes can be planned." – W4*

Providers also spoke about the important role of government and social service agencies in enabling equity and addressing the social determinants of health for whānau Māori. Many were already working within contracted services to provide a holistic approach to hauora (health) that extended beyond healthcare, helping whānau reintegrate after incarceration, ensuring food security, and facilitating safe hospital discharges.

> *"We have contracts from supporting whānau who have whānau in te whareherehere [prison] in Ngawha [rural settlement]. So that they can support the person when they're released, but they can also support their whānau as well at the same time. So that maybe when the person is released, their whānau will be on the same page." – P8*

The social determinants of health and their impact on equitable outcomes remain a significant challenge, particularly for rural Māori communities. Participants showed deep care, empathy, and commitment to tackling these issues, offering both stark realities and tangible solutions. Addressing social determinants requires a shift from surface-level interventions to systemic changes that target the root causes. The collective insights from whānau and providers in this research reinforce the urgent need for an integrated, equity-focused approach to health and wellbeing.

This theme, "understanding equity and root causes," is comprehensive, showcasing three sub-themes that detail many complexities within the rural primary health system in Te Tai Tokerau. Understanding inequity is critical to countering it. The next step is to understand all the levers within the system that enable equity to be enhanced, realised or progressed. Finally, the awareness that the root causes or social determinants of health have a profound impact on the real ability to enable equity for whānau Māori.

6.3 Theme 2 - Being aware and culturally safe

Health professional behaviours, awareness, and cultural safety were identified as critical levers for enabling equity for rural Māori communities. This theme really leans into the "how" health professionals deliver care, and the impacts different health professionals' behaviours can have on delivering culturally safe care.

Provider participants demonstrated an awareness of their local population's needs and the requirement to apply culturally safe behaviours in service delivery actively.

Whānau, in turn, shared their positive and negative experiences within the rural primary care environment. Whānau participants identified that the way people feel during healthcare interactions directly influences the outcomes they receive. This theme is explored through four sub-themes: access and enablers, quality services, cultural safety, and the receptionist's role, as well as the experiences of unheard whānau.

6.3.1 Sub-Theme - Access to and enablers of quality services

This sub-theme focuses on access to and enablers of quality services. Access in relation to this theme refers to a patient's ability to schedule an appointment with their healthcare provider. Access to care in this research was closely linked to provider behaviours and awareness. Access was enabled when providers demonstrated an understanding of whānau needs and applied culturally safe behaviours.

A key issue identified by many providers was the ongoing tension between demand and supply within rural primary care. Demand is the number of patients wanting to be seen by a primary care provider, and supply is simply the availability of the health professionals. Providers acknowledged the frustrations caused by appointment delays and limited availability, highlighting the need for innovative solutions to ensure timely access.

> *"Not just turn me away or fob me off or you know that is always the challenge because you've got more demand [patients wanting to be seen] than supply [number of health professional consultations]. And people do feel frustrated that you can't sort them when they wanted to be sorted, and so ideally, we would have some pathways for sorting people in some way, shape or form." – P2*

Whānau appreciated rural providers who made access easy, personalised, and responsive to their needs. Many described positive interactions where providers and practice staff demonstrated a deep understanding of their circumstances, ensuring they were triaged and seen quickly.

> *"Well, GP is handy. Like it's fairly easy to get to and I can normally get an appointment quite quickly." – W1*

While providers remained committed to improving access, they acknowledged that solving the demand-versus-supply dilemma required multiple approaches and systemic

change. The synergy between providers and whānau was particularly evident in this sub-theme, "access to quality service", as both groups shared a collective desire to achieve the same goal, ensuring timely and equitable healthcare access.

This sub-theme, "access to and enablers of quality services," generated significant discussion among participants, reinforcing its importance in achieving equitable outcomes for Māori in rural communities. The shared understanding between providers and whānau suggests that while structural barriers remain, the intent and willingness to address these challenges are strong.

6.3.2 Sub-Theme - Cultural safety

Cultural safety highlights the importance of delivering health services to Māori in a culturally safe way. Cultural safety is a concept and a practice enacted through behaviours and actions that ensure Māori feel heard, are respected, and valued. It fosters a sense of belonging, removes judgment and bias, and strengthens trust between health professionals and whānau.

Participants highlighted the significant role of health professional behaviours in shaping whānau experiences in healthcare settings. The presence or absence of cultural safety directly impacts engagement, trust, and ultimately, health outcomes. A recurring concern raised by the participants, both whānau and providers, was the lack of Māori health professionals, particularly general practitioners, in rural areas. Participants expressed that increasing the representation of Māori within the healthcare workforce would significantly enhance culturally safe health services.

> *"Workforce is a massive issue for all rural areas. A culturally, I won't use the word competent, appropriate workforce for rural areas. Most rural areas are recruiting from outside of New Zealand, which brings very skilled practitioners but not necessarily the local knowledge, the local understanding, or an empathetic view of what needs to be done to look after a person [Māori person]." – P2*

While cultural safety requires systemic change, participants highlighted that small, intentional actions can have a profound impact on Māori, making them feel welcome in healthcare settings. These gestures, whether verbal, behavioural, or environmental, sent clear signals that Māori are valued and safe within the space.

> *"Our front desk staff and call handler's welcome patients with "Kia ora" [Māori greeting for hello]." – P2*

> *"Something as basic as never turning your back to them when you're speaking to them. Especially our kuia kaumātua, they will quickly turn that chair around and readjust the room to how they want, you know." – P6*

A key insight from whānau was the importance of environmental and behavioural cues that indicate how they would be culturally safe. Much like the LGBTQI+ community might look for a rainbow flag to identify a safe space, Māori whānau actively seek signs reassuring them they are welcome and safe. These signs could be the presence of te reo Māori, Māori artwork, or a familiar Māori face at the practice.

> *"It's the "white girl voice" that we use when we meet people who may not be fluent in the te ao Māori way of thinking. But not having to go into that space and have that front in the first place is really great. It takes that level of discomfort away and you can just ask things, without having to edit it in your mind." – W3*

This quote outlines the safety nets Māori whānau are putting up when entering primary healthcare spaces to protect themselves. Simple yet effective ways of combatting this and ensuring whānau Māori feel safe in health providers spaces are to add te reo greetings at reception and Māori artwork on the walls. Also ensure that the provider team have appropriate cultural safety training. The whānau participants were all clear, it does not have to be big; the small things make a positive difference too.

> *"Might be incremental, might be as basic as just trying to help them pronounce someone's name. But that all adds value over time, I think." – W3*

Health professionals who demonstrated cultural safety and respect were deeply appreciated by whānau. Many expressed that when cultural barriers were removed, they felt treated as human beings first and foremost, rather than as outsiders or different from the norm. This sense of familiarity and relational trust made healthcare experiences significantly more positive.

> *"And my daughter doesn't have the easiest name, so, when they come out and they say I'm looking for [her name], I'm like oh wow." – W6*

> *"It's personality. Yeah, it's definitely personality. And even though there are times when someone is culturally different, it's removing that cultural difference and just seeing you as a person. Yeah." – W8*

Cultural safety is not just an ideal. It is a fundamental requirement for delivering effective healthcare to Māori communities. When health professionals prioritise cultural safety in their behaviours and actions, they create spaces where Māori feel comfortable, heard, and able to be honest about their health concerns.

The findings illustrate the impact of cultural safety (or its absence) on healthcare experiences and outcomes. While structural changes are needed to improve the representation of Māori health professionals in healthcare, small, meaningful actions by non-Māori providers can significantly improve the experience for whānau Māori. The ability to engage in a culturally safe way fosters trust, strengthens relationships, and ultimately leads to better health outcomes for Māori in rural communities.

6.3.3 Sub-Theme - The role of the reception team

The role of the reception team is the third sub-theme in this section. It relates to the interactions whānau Māori have with the staff at the reception or administration desk. This includes both physically in the practice and over the phone.

Whānau shared powerful insights into how reception teams influence their healthcare experiences. As the first and last point of contact in a patient's journey, reception staff play a critical role in shaping whānau perceptions of care. Their actions and behaviours can significantly impact access, trust, and overall wellbeing. While non-clinical, receptionists are often under-recognised in terms of training, development, and support, even though their role is fundamental to ensuring a positive and seamless care experience.

One whānau member, who gave birth shortly after the COVID-19 lockdown, described how rigid policies and a lack of flexibility from hospital reception staff added unnecessary stress to an already difficult situation:

> *"The disrespect at the reception was real. They were really hung up on only having two people in the room, and it was after COVID-19. Like it was more relaxed then. Only just out [of COVID-19 lockdown] I get it. But I guess I had a different situation, and I didn't have a partner. And they just added so much stress to me. Oh no. Only two names, so you're only allowed two people ever. And I had a support crew that was kind of larger than that. And I assume some people do. But she was just so horrible." – W1*

This example demonstrates how a receptionist's approach can support or hinder a patient's experience. It underscores the importance of empowering receptionists to apply flexibility where appropriate and ensuring management provides decision-making support at the reception level.

Another whānau member described feeling dismissed when trying to communicate important information over the phone:

> *"You know, the receptionist I called, I had to tell her because they won't give you to people [the doctors] you probably need to talk to. And I still don't think she passed on information." – W4*

While hospital reception experiences often left whānau feeling unheard or dismissed, rural primary care reception teams were viewed more positively. The key difference was the relationships in local, rural settings, where receptionists knew their patients and their families, making access to care more personalised, considered, and welcoming. Whānau expressed appreciation for friendly, warm, and professional receptionists who contributed to a sense of belonging and trust within rural health practices.

> *"Well, just local, knows the family, knows the history. Knew my grandmother, knows my mother and father, so they're local." – W2*

Whānau valued receptionists who acted as guides and navigators within the healthcare system, helping them access the right care at the right time. These receptionists were seen as essential to ensuring patients received appropriate, timely, and compassionate care.

> *"I think having those receptionists that know the patients and can kind of help them navigate, they become like their guidance [system navigators], don't they?". – W6*

Small yet meaningful gestures, such as making eye contact, acknowledging stress, and offering support, were deeply appreciated by whānau. These acts reinforced a sense of care and community.

> *"I noticed that she [the receptionist] had done that [make eye contact]. And I noticed she [the receptionist] put a bit of an extra oomph in there, that was nice. So, I watched when the second person [another patient] came in behind me. She did exactly the same thing, and it was a woman with a child. The child was feeling very unsettled, grumpy and grizzly. She [receptionist] said to mum,*

> *bathrooms are just around the back if you need them, and there's some toys over here that were a couple of little books and things like that if you'd like to use those. I was like oh, that's nice." – W8*

Whānau expressed a strong desire for respect and kindness from reception teams. They wanted to feel that they belonged in the space and that their interactions were heartfelt and genuine. When receptionists were personable, local, and professional, they fostered a warm and trusted connection with patients. A key strength of rural practices was the familiarity between reception staff and whānau, which was not seen as a privacy issue but rather an enabler of culturally safe, equity enabled patient-centred care.

The role of reception teams in shaping healthcare experiences cannot be overstated. They are navigators, connectors, and the first impression of a practice.

6.3.4 Sub-Theme - Unheard whānau

This sub-theme "Unheard whānau" captures the behaviours and interactions that have left whānau feeling unheard within the healthcare system. Providers demonstrated critical awareness of the importance of actively listening and responding to the needs of whānau. However, the experiences shared by whānau revealed a disconnect with their health professionals, which can occur when power dynamics go unaddressed. The hierarchy and authority often placed on health professionals can become unbalanced, leading to the imposition of clinical or scientific worldviews on whānau, without pausing to understand what matters most to them. These moments of disconnection can diminish trust and undermine culturally safe care.

> *"People [health professionals] are so dismissive of whānau, people are so dismissive of Māori" – P1*

Providers and whānau shared kōrero about how patients' persistence and assertiveness can influence the actions of health professionals. The power imbalance between health professionals, who hold access to further care such as specialist referrals, diagnostics, and medications, and whānau, who are requesting support, often results in tension. Navigating the space between accepting clinical advice and advocating for what whānau believe they need is a delicate balance. This dynamic is increasingly being tested as whānau gain greater access to health information through

the internet and artificial intelligence, empowering them to question decisions and push for care that aligns with their understanding and priorities.

> *"I do feel like I've had to be like a squeaky wheel to kind of get to some of the stuff that I've needed for my son. And because I know how to do that, I feel like I get some of the things I need, but I do feel really upset for whānau that won't take that initiative or [don't] know how to do that. Like, I know I'm doing it, and it's horrible because I'm like in the back like, me doing this might put some other child out. I've had this guilt about it but, but it's your child right? So you're like fighting." – W1*

The findings from this research reveal that Māori whānau can feel dismissed by health professionals, and this creates inequities rather than fostering a space for enabling equity. As a result, whānau are compelled to become proactive advocates for themselves and their whānau, persistently pushing for the care they need. Despite their efforts, some whānau still feel unheard and carry the additional burden of navigating the system, often with a sense of guilt, and questioning whether their advocacy is taking resources away from others. This highlights the emotional and systemic challenges whānau face in ensuring equitable access to healthcare.

6.4 Theme 3 - Establishing partnerships with purpose

This theme, "establishing partnerships with purpose," is about meaningful partnerships within our health system that support and enable equity for whānau Māori. Enduring, meaningful change in health outcomes is only possible when grounded in Te Tiriti o Waitangi, strengthened through whakawhanaungatanga, and guided by what truly matters to whānau.

6.4.1 Sub-Theme - Upholding Te Tiriti o Waitangi

This sub-theme is "upholding Te Tiriti o Waitangi" and is about health providers and professionals acknowledging and acting on the principles and articles of Te Tiriti o Waitangi. As outlined in the introduction chapter, Te Tiriti o Waitangi is fundamental to the commitment of Māori health in Aotearoa New Zealand and therefore, when upheld, is a critical enabler of equity for whānau Māori. Te Tiriti o Waitangi promises equity for Māori people. Providers held knowledge on Te Tiriti o Waitangi, and they also understood the importance of embedding it into their workflows. Some whānau did, however, feel that there was an opportunity for improvement.

> *"If the principles of Te Tiriti o Waitangi were adhered to, then that would be achieving equity for Māori in all spaces." -W2*

Te Tiriti o Waitangi, when upheld by providers, creates an opportunity for equity to be enabled. Te Tiriti o Waitangi is about acknowledging Māori people's rights within our health system and the commitment our country made to Māori equity. This statement encapsulates the views of many respondents regarding the importance of being recognised as an equal Te Tiriti partner, across all health system levels. Participants highlighted that Māori health is holistic, deeply interconnected with whānau, whenua, and cultural structures, reinforcing that achieving health equity requires more than just medical consultation. It necessitates acting in genuine partnerships.

It was promising to hear from providers who are actively seeking out opportunities to uphold Te Tiriti o Waitangi.

> *"Our [organisation] is already down that path [giving effect to Te Tiriti o Waitangi]. And people can make a whole community plan to reach those you know, really reach those health outcomes long term, really making an impact. Māori can take control of the health of this little area and plan in a way that's going to, that's going to work." – P4.*

Whānau actively seek to uphold Te Tiriti o Waitangi in their encounters with primary care providers, exercising their rights. Whānau shared they do this by having choice in their care providers, being assertive with the care they require and actively engaging with a series of equity enabling activities that providers offer. This all makes it more accessible for whānau to get the care they require. Whānau also discussed their expectations on providers to deliver this care, as it becomes difficult for some whānau to receive care if equity and Te Tiriti o Waitangi principles alignment are not present.

Providers did discuss the need to uphold Te Tiriti o Waitangi as well. They do this by ensuring their care teams are trained in Te Tiriti o Waitangi and have an understanding of what the document means in relation to primary healthcare, they also use data to make equitably informed decisions. Given the providers were rural, knowing their communities and patients alongside their needs were essential.

6.4.2 Sub-Theme - Whakawhanaungatanga

The sub-theme "whakawhanaungatanga" refers to the process of establishing and nurturing relationships. It aligns closely with the overarching theme of establishing

partnerships with purpose, as it represents the Te Ao Māori practice of forming partnerships grounded in deep connection, shared values, and mutual trust. Whakawhanuangatanga can be to build connection between the provider and the patient or between providers themselves. Acknowledging when there are stronger, more connected relationships in play, outcomes are better for whānau Māori.

Te Tai Tokerau providers spoke to the importance of collective responsibility to whakawhanaungatanga and how their actions impact on others within their community. A particularly compelling insight was taking a whanaungatanga approach to doctor or general practitioner recruitment, recognising that building strong, sustainable teams is not just about filling roles, but about supporting the broader wellbeing of the community.

> *"I've told recruiters so many times lately I won't outbid someone if they're going to [another rural practice]." – P1*

Further to the notion of provider-to-provider whanaungatanga examples, were providers who share resources when required, creating communities that can enable equity rather than just individual providers themselves.

> *"Mobilisation of the resource across the locality. When [a practice] was short, we sent some of our ENs or and our RN across to support them. Then we've got emergency care paramedics here who were all relieving their roster. At the moment another [practice] is down so we've got, three of our team up there." – P5*

Understanding the importance and value of relationships, trust and rapport between health professionals and whānau underpins whakawhanaungatanga. Establishing relationships takes health professionals time to build genuine connections for those they care for. Whakawhanaungatanga is essential for aligning providers' views with those of whānau.

> *"How are we building that rapport? In the moments that are available. Because of course that's going to if you have a good rapport with someone, you're going to get an amazing I think, outcomes from that. You're going to achieve, more I guess rich, service to those people." – W3*

> *"Because they all [the providers] understand, what it's like to get up early in the morning and have to go milk cows or do some things and then try and get to the doctors. So they understand all the struggles." – W5*

Whakawhanaungatanga is a critical enabler of equity. When providers take time to build relationships and connection with whānau, equity can be enabled.

6.4.3 Sub-Theme - Health outcomes that mean something

The sub-theme, "Health outcomes that mean something", is about ensuring that what we are measuring as equitable outcomes for whānau Māori are what whānau Māori expect and not what has been embedded through Western approaches of measuring outcomes.

The provider participants emphasise the need for accountability in healthcare but advocate for a high-level approach rather than focusing on micro-level metrics, such as the number of cardiovascular risk assessments. Instead, providers suggested broader outcome measures, such as life expectancy, to ensure a more holistic, patient-centred approach that prioritises overall wellbeing rather than isolated disease management. Providers stressed the importance of clear structures and defined roles to ensure accountability is shared across the system, rather than falling solely on individuals. This perspective aligns with team-based care models and kaupapa-driven approaches, where collective responsibility and values-based accountability drive success. However, while high-level measures, such as life expectancy, provide a broad view of health outcomes, they may not offer immediate, actionable insights for individual providers.

> *"There definitely needs to be some sort of accountability but I think it needs to be fairly high-level accountability. So rather than the number of CVD risk assessments you do or that sort of thing, it's life expectancy or something quite higher up the chain so that, you're trying to do everything that you can for a patient instead of focussing on or just the Chronic Obstructive Pulmonary Disease (COPD) patients." – P7*

Improved outcomes for whānau requires provider accountability and responsibility. Critical to this is health professionals understanding their roles and the structures and boundaries within which they work.

> *"Just really good, structures or boundaries around what people's roles play are. I don't like this word but, accountability, what is everyone accountable for and what they're going to be successful. Just taking responsibility for those*

> *[patients] who need extra support. I think that's really key because that is going to drive forward the Kaupapa [improved health outcomes for whānau]." W3*

Balancing broad accountability with intermediate indicators is suggested to be necessary to track progress effectively without losing focus on specific, impactful interventions. Whānau wanted providers to be accountable for enabling equity, ensuring that they could receive the care they desired and that when they did, it was culturally safe. Whānau also requested transparency. They wanted to know from their providers who was responsible for enabling whānau to hold the system and providers to account.

6.5 Theme 4 - How rural primary healthcare is delivered

This theme 'how rural healthcare is delivered," addresses the foundations of many primary care providers across Te Tai Tokerau who are privately owned (either through limited liability structures, partnerships or trusts), yet are publicly governed (contractually) and primarily funded. This makes for a complex business model with variable levels of accountability.

There are four sub-headings: *model of care, resource and technology, cost and hospitals serving as people's primary care.*

6.5.1 Sub-Theme - Model of care

This sub-theme, "model of care," is about how the provider operates within their organisation and how that impacts the ability to enable equity for whānau Māori. As outlined earlier, the evolution from individual ownership to collective business models has significantly changed how care is delivered. Individual general practice ownership models are very common, despite the different business approaches that have occurred over the past 20 years. The self-employed model encourages doctors to be insular in their care delivery model, serving only their enrolled patients and avoiding the opportunity to work collaboratively with other healthcare professionals. As described by participants, this approach has the potential to reduce patient access. The shift from a fee-for-service model, where clinicians earned more for seeing more patients, to a capitation model that aimed to improve the quality of care was identified by participants as a mechanism for promoting equity. The funding model is far from

perfect, but as described by participants, it enabled a more collaborative and whānau-centred approach to delivering primary healthcare.

> *"If clinicians have the ability to dictate their access points, you reduce access automatically." – P1*

> *"If you have people in the right spaces who genuinely care, who genuinely want, what's best for human beings, they'll always get, get the right people to be seen." – P1*

The provider comments above reflect the need for primary care business models to continue their maturation journey, enabling them to adopt an equity-based approach to delivering care. Further to the business model, the adoption of acute care clinics within general practices has been an initiative that has enabled same-day access to primary care services. The clinics enable acute care and preventive care to operate in two different ways, maximising the impact of both workstreams.

> *"Having some form of acute service provision and some form of preventative service provision. The acute care arm [people needing same day care], that might be operating a bit like an A&E [accident and medical] type situation if you're in the preventative arm then you might have a different [longer 20min or with a different person in the care team] consultation." – P2*

Other providers focused on the extended care team to deliver services, scaling the skillset of a broader care team. The introduction of kaiāwhina (patient navigation and support roles) has been welcomed by providers.

> *"We're regarded as an integrated health provider. We've got our nine clinics spaced out all through the [area we serve] so people have got easy access to seeing the nurse, seeing the kaimanaakitangata, getting attention." – P4*

A shift toward a collaborative business operating model, one in which working together is normalised and equity for whānau Māori is actively enabled, has the potential to transform the way quality primary care services are delivered and sustained. This way of working is determined by the practices model of care.

6.5.2 Sub-Theme - Resourcing

This sub-theme, "resourcing," highlights the workforce pressures alongside the historical underinvestment in rural primary care. Both workforce and financial resources were highlighted as key challenges by providers and whānau. Although

different, these are closely linked, as financial pay contributes to incentivising doctors to train as general practitioners and other members of the care team to come and work in these rural communities.

> *"We need adequate staffing levels in all areas, which then comes down to money because you need to pay them. That's the short answer to it all." – P7*

> *"But they're seriously understaffed, so there's long wait times of getting into a doctor oh hold on a minute, 6 weeks till the next appointment." – W2*

The workforce shortage is a real concern for both providers and whānau. As with most challenges, the Te Tai Tokerau rural providers and whānau had a range of solutions, most circling back to the concept of a homegrown or trained workforce.

> *"Develop your own workforce or to educate whānau you've got group family group conference rooms." – P5*

Whānau shared similar thoughts about educating and growing their own workforce, highlighting the critical point that patients and whānau are also interested and concerned about the workforce challenges.

> *"Career pathways for our own people. To be in those spaces whether it's nursing, whether it's GPs, whether it's surgeons, specialists, midwives. Connect to our kura or our secondary school where people come in and will say hey, how about coming and helping us out doing this, how about doing that?" – W2*

One general practitioner shared her motivation to work in rural Te Tai Tokerau. Drawing a connection to the area for the health workforce, specifically general practitioners, is critical to sustaining the region's health workforce pipeline.

> *"I'm from the North and from rural places, never liked the city so that was always kind of where I knew I was going to end up being. And I have worked in bigger cities like I did a bit of time in [city] but just the way in rural communities you actually get to know people and be part of the community and feel like you're doing something useful, as opposed to yeah other places where you just feel like you're churning through."- P7*

The workforce shortages extend beyond specific general practitioner roles, affecting access to culturally appropriate care.

> *"I see a counsellor but it was impossible for me to find a counsellor that was kaupapa Māori. Or someone to kōrero with will that I could connect with in*

> *that cultural way. So, I think that [having access to Māori health professionals] would be amazing." – W1*

Rural providers demonstrated resilience in leveraging available resources to meet community needs. Pharmacies are not open for extended hours like in urban areas, which drives rural providers to be creative and forward-thinking with their internal practice resources, such as medicines and access to a centrifuge for spinning blood samples.

> *"Pharmacy you know, we need the medication onsite as well." – P2*

> *"Centrifuge in each clinic, so I managed to get a centrifuge." – P6*

These insights suggest that while rural providers are confident in finding innovative solutions, rural funding remains a challenge to having adequately resourced services. Financial resourcing emerged as a recurring concern, with providers requesting that funding be directed based on actual community needs rather than distributed evenly.

> *"We need to ensure that funding flows to the right area. Investments allocated base you know equitable distribution of resources and that means funding flows to areas that need it. I can't see why or when they look at the poverty map of New Zealand, the greatest areas of need get the least amount of resourcing." – P5*

Others reinforced the argument for need-based investment.

> *"Money because money gets you staff, money gets you equipment, money gets you the facilities. It all boils down to that really." – P7*

Another resourcing challenge was identified. That is, the restricted ability of general practitioners to order diagnostics, which ultimately pushes patients toward hospital services.

> "*The reality is that people feel they get escalated faster [if they go to the hospital]. That they'll get the diagnostics in a timely manner, that they'll get moved on to having the operation or whatever they need, they'll actually be fast-tracked if they front up to the hospital because the hospital doctors have the authority to order all of those things in a timely manner, which a GP does not*." – P2

This restriction on GP-initiated diagnostics inadvertently incentivises hospital visits, contributing to system inefficiencies and reinforcing inequities in care access.

The findings of this sub-theme, “resourcing,” highlights a dual reality on one hand, because rural general practices are struggling with chronic underinvestment and workforce shortages. Yet on the other hand, they are finding ways to optimise the resources available. Without a shift toward equitable investment and regulatory changes to support primary care-led initiatives, including boarding access to diagnostics, rural communities will continue to face delayed care, unnecessary hospitalisations, and worsening health inequities.

6.5.3 Sub-Theme – Affordability

The sub-theme, affordability, specifically the cost of primary care services, emerged as presenting a major barrier to accessing healthcare. Providers highlight systemic inequities, demonstrating how financial constraints lead to delayed or avoided healthcare. Many of the rural providers interviewed offered free services or reduced service costs for their patients, which is a unique approach that comes at a significant cost for these providers.

> *“We have a zero fees policy [both consult and prescription] here for Māori, so that barrier is gone in terms of you need to somebody you can see somebody you know, so that’s pretty massive.” – P2*

> *“We meet the needs of our whānau of [our community] by way of providing a free service [consultations and prescriptions].” – P4*

> *“Everything is free.” – P6*

In contrast, privately owned general practices raised concerns about finances, patients not paying, and the impact this has on patients’ ability to access care. But they have no alternative, given the practice needs to remain financially viable.

> *“There was someone [a patient] yesterday, I had my last hour of the day, had all DNAs [did not attend], and one of them [admin staff] was like “Oh, I think I might know why that one [the patient] didn’t come.” ' Māori lady [the patient]. Because I think I [admin person] sent out her [the patient] bill this morning, and then she [the patient] didn’t show up in the afternoon. She [the patient] might have been whakamā [shy or embarrassed] about it all. And that’s tricky because we know finances are a barrier, and we [the practice] would love not to have that as a thing, but obviously, the climate in general practice right now is that if you don’t chase anyone’s bills, then you can’t keep operating. Money is an issue for a lot of people in rural communities.” – P7*

Whānau contributed thoughts on cost, highlighting its significance across both providers and whānau. This demonstrated the information gaps whānau have on what services are funded, partially funded, or not funded at all.

> *"I don't think that we should get everything for free because someone's got to pay for it, but just more easily yeah, I don't know. Now I don't know how much it costs us $17 to go to the doctor, but someone who isn't registered might be $70. Like, just yeah. Should just be the same." – W4*

> *"And it [no or low cost of consultation] would allow you to go to the doctors more if you were only semi-sick, and not wait until you're sick-sick." – W5*

Some healthcare is free. Participants supported the need for children's health (under 14 years old) to remain fully funded in Aotearoa New Zealand.

> *"Free child healthcare for children anyway" – W5*

The logistical costs of rural healthcare, including transportation and staffing, necessitate a funding model that accounts for geographic disparities. The reference to ambulance and helicopter services illustrates how financial decisions intersect with clinical decisions in emergencies, potentially leading to life-or-death trade-offs.

This sub-theme "affordability" collectively reveals how cost remains a critical determinant of healthcare access and outcomes in Aotearoa New Zealand, particularly for Māori and rural populations. The free services offered in Te Tai Tokerau are contributing to a better provision of equity for Māori.

6.5.4 Sub-Theme - Hospitals serve as people's primary care

This sub-theme, "hospitals serve as people's primary care", highlights the reality for some people. For them, the hospital system is their primary care option or the first place they receive care. Remember the story of Justyce above. This sub-theme was somewhat surprising for me to unfold as a primary care researcher. However, it highlights the realities of some whānau, especially those in Te Tai Tokerau, where the distance to these hospital-level services is lengthy.

> *"I'm just thinking like GP we go to Whangārei a bit for my son. And then we do travel to Auckland as well. So I guess we've got three zones of travel that we're having to, deal with." – W1*

> *"There wasn't really any GP involvement. Just, paeds sort of just stops seeing you [when you turn 16 years old] and they send all your stuff [clinical information] to adult services. And then, you get told to go to a GP if you have any problems. But then with kids that have big problems like she did, it is normalised going direct to specialist services." – W5*

Whānau participants highlight significant challenges in accessing specialist healthcare, particularly for Māori and rural communities. The need to travel across multiple regions for specialist care places a heavy responsibility on whānau, financially and logistically. The transition from paediatric to adult healthcare services also emerges as a gap in care, with young people who have complex conditions struggling to navigate the system change. The expectation that they shift from specialist paediatric care to adult services and general practice without adequate support or handover can lead to delayed treatment and worsening health outcomes.

Some whānau require specialist care as their primary care, so creating space and integrated pathways for this to happen smoothly with transparency, has the ability to enable equity for whānau.

6.6 Conclusion

The findings presented in this chapter illustrate the deeply interconnected challenges and aspirations within the primary healthcare system, particularly for Māori and rural communities.

Just like paddling a waka, achieving equitable health outcomes requires collective effort, shared direction, and awareness of the forces that shape the journey.

Both providers and whānau participants recognised the structural barriers to accessing care. These include whether the practice has the capacity to see patients when they request care. How the very first interaction with the practice enables or hinders equity. Does the health professional adopt whakawhanaungatanga to deepen the relationship between provider and whānau. Equally important is the delivery of culturally safe and responsive care that actively addresses individual provider bias and applies a whakataurite (equitable) approach, ensuring whānau receive the outcomes they desire. These aspirations are layered over challenges such as the cost of consultations, workforce shortages, geographic isolation, and wider social determinants of health;

including housing, education, employment, and addiction, all which compound for whānau while providers are left with limited resources to respond.

Despite these challenges, both provider and whānau participants highlighted the potential to enable equity through culturally safe interactions grounded in whakawhanaungatanga, through services that are affordable, and through care models broad enough to respond to and nurture social determinants, rather than dismissing them.

Whakataukī: He waka eke noa, we are all in this together (Te Aka Māori Dictionary, 2025).

The insights shared by whānau and provider participants, reinforced the importance of understanding root causes, being aware and culturally safe, establishing purposeful partnerships and knowing how rural healthcare is delivered. Together, these elements demonstrate that enabling equity is not just an aspiration, but a responsibility enacted through deliberate action.

While delivery challenges remain, the resilience and determination within these communities offer a pathway forward. Te Tai Tokerau providers in this study have shown that despite the tide being against them, they can navigate the waters when organisations are committed, aligned and execution is done with intent. These providers showcased an understanding of equity and root causes by a combination of their community population knowledge, the equity enabled services they offer, and by their awareness of wider determinants of health. The changes to operating models, enabling fully funded services, embedding cultural safety into operational expectation and designing access systems that enable whānau to be prioritised, are all activities these providers are doing in response to their active awareness of equity.

A critical insight for me from the findings, was that the understanding and willingness to enable equity from providers, was evident. However, the practical application of this for new staff members coming into the providers spaces was limited. If health professionals are non-Māori or have joined the health professional team from international recruitment, the practical resources to educate and upskill new health professionals, is limited. Many providers outlined this challenge in the interviews. The reality of it is, to truly understand a community and their authentic equity needs,

requires whakawhanaungatanga a connection and relationship with the community they are serving. This takes time but is worthy of the investment, as it will have profound impacts on the way that health professionals engage with Māori patients and enable equity in all interactions they have.

Many whānau Māori in this study portrayed a deep gratefulness to many of their providers who they felt were enabling equity for them. They appreciated the culturally safe interactions, the ability to be seen when they were unwell and knowing that they would be cared for in an equitable manner. A few whānau expressed their disappointment with services, where the above was not evident and these interactions resulted in loss of trust in the primary healthcare system.

Strengthening relationships between providers and whānau, embracing Te Tiriti o Waitangi as a foundation, and investing in models of care that prioritise equitable whānau wellbeing, will ensure no one is left behind. Just as a waka reaches its destination through coordinated effort and shared purpose, achieving equitable rural primary healthcare requires a system where everyone plays their part, moving together toward a future where Māori and rural communities thrive.

The Equity Wave was developed as a practical tool to help make sense of the research findings. It offers a model for understanding how every health professional has the ability to enable equity through each interaction they have with whānau Māori. The model is explored and discussed in detail in the following chapter.

Chapter 7 Discussion

7.1 Introduction

I set out to understand what the enablers are in rural general practice, to achieve equity for whānau Māori, to create ideas and solutions, and to celebrate the elements of primary healthcare that are working well. This research also aimed to provide a platform to advocate for policy shifts and funding to follow the enablers, as without them being strengthened, our system risks retaining the status quo or being stuck for solutions.

In this chapter, I examine Māori-centred research and reflect on my learnings of the Te Kākano Māori-centred model as a research methodology. This has been a significant part of my research journey and is critical to reflect and discuss the complexities, the learning and the insights I have gained through the process.

In this chapter I also explore the research findings, discussing the enablers of equitable primary healthcare delivery, and the experiences of whānau Māori in relation to the current literature. Enabling equity factors are discussed in alignment with the four themes identified in the research findings, drawing attention to the similarities, differences, and emergent perspectives. In this chapter I argue that rural general practices in Te Tai Tokerau can demonstrate leadership in enabling equity, and through conscious, active engagement, they can enable improved outcomes for their Māori whānau.

The insights shared by provider participants in this research, deserve considerable recognition, as they demonstrate the ways in which rural general practices can successfully meet the needs of their communities. This chapter concludes by outlining the implications of the study for health professionals, Māori whānau, and policymakers, and closes with a discussion of the researcher's limitations and recommendations for future inquiry.

7.1.1 Enabling equity is not on the current government's agenda

When writing this thesis, enabling equity is notably absent from the government policy agenda. The current National-NZ First-ACT coalition government has made its position clear, emphasising equality and treating everyone the same. But their policies neglect

the critical and nuanced need for equity, which requires recognising and addressing the structural disadvantage, which in Aotearoa New Zealand clearly includes ethnicity. This distinction is not merely semantic. It speaks to the heart of health practice in Aotearoa New Zealand, where unequal outcomes and unmet health needs for Māori are entrenched and well-documented. In choosing to prioritise a 'one-size-fits-all' approach, while disregarding ethnicity as an evidenced element of need, the government risks perpetuating and worsening the inequities, particularly for Māori.

This political stance creates a complex and often uncomfortable paradox for those of us working within the health system. On one hand, we are expected to align with government priorities and demonstrate compliance with national directives. On the other, we carry a professional and moral responsibility to uphold the articles of Te Tiriti o Waitangi, which requires genuine partnership with Māori. Therefore, many health practitioners and leaders are left navigating a space where best practice, guided by a commitment to equity and Te Tiriti obligations, is at odds with the prevailing political discourse. This tension raises essential questions about leadership, advocacy, and the role of health professionals in advancing social justice, even in the face of political resistance.

Reflection

During July 2025, I attended the Royal New Zealand College of General Practitioners (RNZCGP) annual conference in Christchurch (GP25). It was a space filled with energy, ideas, and a shared passion for the future of general practice. During the conference, Minister Simeon Brown announced a series of new primary care initiatives, including long-awaited changes to capitation funding.

I refer to capitation often in this thesis. It is the mechanism through which general practice in Aotearoa New Zealand is publicly funded. Since 2020, work has been underway to ‘re-weigh’ the capitation formula to reflect better population need. Ethnicity has consistently featured in these re-weighting models. The current and historical, formula has only been based on age and sex. Despite the advice from the expert advisory group and the Ministry of Health the Minister announced that ethnicity had remained excluded from the changes to capitation funding. He referenced deprivation, rurality, and multi-morbidity, but not the inclusion of ethnicity.

There was a palpable reaction in the room. People started asking questions. Several audience members, researchers, General Practitioners, leaders, stood up and challenged the omission. They cited evidence, called out the implications, and asked why ethnicity, a well-documented determinant of health equity, had been left out. The room was not divided on this issue. They were aligned in their belief that ethnicity must be included if we are serious about enabling equity and reducing disparities within our health system. Their voices were strong and clear. For me, this was not just a policy moment. It was a lived moment. It was yet another reminder of how easily enabling equity through acknowledging ethnicity can be deprioritised, even when the evidence is strong and the need is urgent. This omission is one of many examples under the current National-NZ First-ACT coalition government, that highlight the ongoing inequities Māori and other marginalised groups face in our health system.

As a health leader and researcher, I remain steadfast in my commitment to enabling equity, particularly for whānau Māori. I believe that achieving equitable health outcomes for whānau Māori is not optional. It is a moral, professional, and a Te Tiriti-bound necessity. In times of political uncertainty, it becomes even more critical to champion research that centres the voices, experiences, and aspirations of whānau Māori and their communities. This thesis is a deliberate act of resistance and advocacy, and in doing so, contributes to the evidence base needed to uphold Te Tiriti o Waitangi and advance meaningful change in our health system.

7.1.2 Māori-centred research

As a non-Māori researcher engaging in Māori-centred research, it was imperative to adopt a methodology that upheld the aspirations of Māori, while also ensuring ethical rigour and personal cultural safety within the research process. Researchers before me have laid important foundations, developing frameworks that honour Māori-centred frameworks within academic research contexts (Barnes, 2013; Eggleton, 2020; Rae, 2024; Wilson, 2004). This study was guided by the Te Kākano Model, a Māori-centred methodological approach that enables a productive interface between Māori and Western paradigms (Wilson, 2004). This interface is central to the research aims to explore equity enablers for Māori, within an entrenched Western rural primary care

system. The methodology did not just support the research process. It created the space in which this research could meaningfully exist.

Cultural support happens in many ways for me. I had significant support around me to successfully deliver Māori-centred research. My whānau, supervisors, the kāhui and extensive network of Māori health colleagues across the health sector contributed to my learning, interpretation and research application. I learnt about myself in these moments, about how I show up as Tauiwi (non-Māori) to support the aspirations of Māori, including how to step back and be guided.

Navigating cross-cultural research as a non-Indigenous researcher requires critical reflexivity and a nuanced approach to understanding cultural dynamics. My experience illustrates the complex interpersonal challenges inherent in conducting research within Māori communities, where historical power imbalances and colonial legacies significantly impacted my interactions. Initial encounters can be marked by scepticism and resistance, as demonstrated by the administrative team member's initial dismissive responses, which reflect deeper systemic tensions surrounding research conducted by non-Indigenous scholars.

Authentic engagement is a crucial strategy for building trust and legitimacy in cross-cultural research contexts. By transparently articulating my research motivations and positioning myself as a collaborative learner rather than an external expert, I learnt how to successfully transform an initially uncomfortable interaction. My approach emphasised the importance of personal narrative, genuine intentionality, and a commitment to understanding and supporting Indigenous aspirations.

Another critical learning experience I gained while activating Te Kākano (the Māori-centred model) and applying a Māori-centred research approach, was through the feedback I received from my kāhui. When I established the kāhui, I took time to lean into relationships with leaders I trusted, those with whom I felt safe, who I knew would challenge my thinking, provide authentic feedback, and guide me on my research journey.

One kāhui member challenged me early on about my assumptions regarding how feedback would be given. This challenge encouraged me to reflect on the kāhui group members practicalities and diverse preferences in offering supervision and support.

Although our meetings were planned, the way I received mentorship and guidance from my kāhui was multi-modal. Some met with me face-to-face, while others met online, either individually or in groups. Some shared written feedback, while others connected through phone calls.

This diverse approach was deeply meaningful. It allowed me to fully embrace the feedback being shared and be intentional about how I applied it to my thinking, engagement, and analysis. Every interaction mattered. This flexible, responsive way of working created a unique and authentic advisory process that truly embodied the values of the Te Kākano model.

7.2 Experiences of whānau and providers in relation to the literature

This section discusses each of the findings' themes and sub-themes in relation to current literature.

7.2.1 Understanding equity and root causes

In this section, the central theme of understanding equity and its root causes is discussed, along with the sub-themes of inequity, enabling equity, and social determinants, as they are deeply interconnected.

The participants articulated a clear and confident understanding of equity that aligned with the World Health Organization's definition of health equity.

> Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and wellbeing**.** (World Health Organization, 2010).

Rural providers interviewed demonstrated a strong understanding of the complexities of equity, including the broader social determinants of health. Their responses reflected a depth of knowledge and awareness, aligning with Roman et al. (2024), who identify such awareness as the first step toward sustainable behaviour change. Participants described equity not merely in terms of resources but as a relational concept, deeply connected to the conditions in which people live. Addressing these

determinants to enable equity requires investment in primary care to expand service delivery, an area participants identified as a persistent resource challenge.

There is both international and national literature that highlights the importance of adequately resourcing primary care to deliver comprehensive services that address the wider determinants of health. Starfield (2011) makes a compelling case for strengthening primary care, arguing that when well-resourced, it can offer accessible, culturally responsive, and population-focused care, moving beyond a narrow, disease-centred approach. This broader scope enables providers to address, rather than overlook, the social and environmental factors that influence health outcomes.

While primary care cannot resolve the structural conditions that create poverty, inadequate housing, or unemployment, primary care is positioned to identify, respond to, and navigate whānau toward support for these determinants, making it a critical connector between clinical care and the broader systems that shape health.

Marmot and Bell (2012) reinforce this position, emphasising that improving health outcomes requires investment in the social determinants of health. Their research establishes clear links between clinical indicators and social conditions, advocating for policy approaches that consider equity from a population health perspective. However, while influential, their work does not fully engage with the role of colonisation as a foundational contributor to inequity.

In the Aotearoa New Zealand context, Came et al. (2020) argues that equitable health outcomes for Māori can only be achieved through structural change, particularly in funding models. She highlights the chronic under-resourcing of kaupapa Māori services. She calls for targeted investment that enables these services to support whānau Māori in addressing challenges related to the wider determinants of health. Her work centres on Te Tiriti o Waitangi obligations and positions, arguing that resourcing both equity and justice is imperative.

Both providers and whānau in this study clearly identified the critical role of social determinants in achieving equitable health outcomes, reinforcing that health extends well beyond clinical or medical care, a view aligned with the work of Starfield et al. (2005). Participants emphasised that to meaningfully advance equity in Māori health, social determinants must be recognised, understood, and actively addressed. While

the previous section discussed the importance of resourcing to support this, the next challenge lies in implementation.

A recent study by Reweti (2023) contributes to this discourse by illustrating how community-based initiatives such as whānau hui, waka ama clubs, and whānau triathlon programmes can effectively address root causes. These include strengthening social cohesion, fostering cultural identity, connecting with the environment, and promoting intergenerational learning. Rather than relying on prescriptive health messaging, these initiatives support equitable health behaviours by cultivating a sense of belonging, purpose, and pride in cultural heritage.

These findings strongly align with this study's observations, particularly in contexts where services failed to engage with the broader determinants of health, or where providers felt inadequately resourced to do so. This is supported by Sheridan et al. (2024), whose research similarly found that neglecting social determinants often led to disengagement from health services and contributed to poorer, inequitable health outcomes among Māori.

Financially resourcing equity is a critical enabler to addressing social determinants of health and achieving equity. Currently, general practice funding in Aotearoa New Zealand is primarily funded based on age and sex demographics, with minimal consideration given to ethnicity, socioeconomic deprivation, or clinical complexity (Health New Zealand, 2024). This funding model is called capitation or population-based funding (Penno et al., 2012) as described further above in my reflection piece. As a result, rural general practices serving predominantly Māori communities, such as those in Te Tai Tokerau, are underfunded relative to the needs of their populations (Sapere, 2022). This misalignment perpetuates inequities by constraining the capacity of practices to deliver care that meets both the social determinants and the medical needs of whānau. Funding policy in Aotearoa, New Zealand is a system-level lever that primary care is subject to, not in control of.

In response to longstanding systemic funding inequities, Te Whatu Ora | Health New Zealand commissioned a national review of the capitation formula in 2022 (Sapere, 2022). The review recommended reweighting capitation to include ethnicity, deprivation, rurality and complexity, alongside the existing variables of age and sex. Implementing these changes had the potential to enhance equity by enabling a more

equitable distribution of resources. However, as outlined earlier, the Minister of Health has announced plans to adopt the reweighting while removing ethnicity from the formula. Implementation has been deferred until 1 July 2026 due to negotiations with providers regarding the effective application and concerns that some practices may experience funding reductions under the revised model. This delay perpetuates inequitable funding structures, particularly in regions such as Te Tai Tokerau, where there are high proportions of rural Māori and significant unmet health needs across both medical care and the broader determinants of health (Love et al., 2021). As many providers and whānau participants in this research observed, wider determinants of health often influence whether individuals seek care at all. The exclusion of ethnicity is likely to exacerbate this, as Māori who do not present to providers will not have key indicators, such as multi-morbidity, captured. Consequently, these needs will remain unrecognised in the revised funding model, representing a missed opportunity to advance equity through effective commissioning and resource allocation.

Timely implementation of the reweighted capitation formula would provide Te Tai Tokerau general practices with the much-needed financial support. Such resourcing has the potential to enable the expansion of local workforce capacity, enhance culturally responsive service delivery, and ultimately, realise equitable health outcomes for Māori whānau, while ensuring rural general practices remain financially sustainable. Love et al. (2021) found significant underfunding that Māori health providers in Aotearoa New Zealand continue to experience, given that their population health needs outweigh their financial resourcing. This finding was also endorsed in work by Sheridan et al. (2024), reaffirming the need for under-resourced Māori providers to be fairly resourced based on their population needs. Equity starts with the ability to do things differently, prioritise, address social determinants, and upskill healthcare workers to apply culturally safe behaviours. Funding is a critical enabler, and equitable funding formulas that account for ethnicity, deprivation, rurality, and clinical complexity must be prioritised.

Importantly, this study has demonstrated that Te Tai Tokerau providers are well-positioned to leverage such investment. Their ability to have the knowledge, capability, and lived experience in advancing equity for Māori was consistently evident across provider interviews. Participants demonstrated a mature, applied understanding of

equity not as a theoretical construct, but as a principle embedded in daily practice. This depth of insight presents a valuable opportunity for scalable system learning and reinforces that the region's capability to drive and sustain equity-focused transformation already exists. Strengthening the resource base would support these efforts and amplify the impact of a workforce already committed to meaningful, equity-oriented care.

Whānau participants in the study, were explicit about their equity needs, aspirations, and desires, many of which they felt were being met by their current providers at a significant and unsustainable cost to many of the providers. While experiences varied across the region and were often shaped by the influence of specific individuals within practices, most whānau expressed that providers in Te Tai Tokerau were delivering equitable care. This was achieved through initiatives such as culturally safe interactions, free or low-cost models of service and care approaches that centred on whānau wellbeing and aspirations. The relationships that providers had with other services addressing the broader determinants of health were evident throughout the interviews. Many providers reported offering internal support, such as emergency housing and Whānau Ora services, enabling more holistic care for whānau.

7.2.2 Being aware and culturally safe

The second theme of being aware and culturally safe sits alongside the sub-themes of access and enablers of quality services, cultural safety, receptionist awareness and unheard whānau. The findings highlighted that equitable care arose from culturally safe, trusting, and meaningful relationships between providers and whānau. Both provider and whānau participants emphasised that trust and relational continuity were equally pivotal in achieving equity. This is supported by recent literature by Curtis et al. (2025) highlighting the importance of cultural safety and its profound potential impact it can have on enabling equity.

The updated 2025 definition of cultural safety offers a precise framing that aligns directly with the way cultural safety is conceptualised in this study.

> Cultural safety requires health professionals to examine themselves and the potential impact of their own identities and culture on their practice. Culturally safe health professionals acknowledge and address their own power, privilege, biases, attitudes, assumptions, stereotypes, prejudices and

> characteristics that may affect the quality of care provided. Cultural safety requires a critical consciousness where health professionals engage in ongoing self-reflection and hold themselves accountable for culturally safe practice as defined by patients and their communities, and as measured through progress towards achieving health equity. Culturally safe health professionals influence healthcare to reduce bias and achieve equity within the workforce and working environment. Cultural safety benefits all patients and communities. This may include communities based on Indigenous status, age or generation, gender, sexual orientation, socio economic status, ethnicity, religious or spiritual belief and disability (Curtis et al., 2025, p. 5).

The sub-themes within this overarching theme are all closely aligned with the definition of cultural safety.

7.2.3 Access and enablers of quality services

When there are more people needing care than health professionals available, how organisations respond becomes very important (Esper et al., 2010). In primary healthcare, “demand” means patients who want or need healthcare, and “supply” is how many appointments or health workers are available. There is limited research on how this balance operates in rural healthcare. However, Ansell et al. (2017) highlight that having enough available care is crucial for a good health system. This gap between need and availability stood out in this research. High demand, combined with workforce shortages and limited appointments, makes it harder for services to deliver fair and equitable healthcare.

These supply and demand pressures often strain the system, resulting in behaviours and responses that fall short of best practice. While practices can adapt internally to manage demand, the root causes of rural workforce undersupply require system-level intervention that sits beyond the remit of individual general practices. Many provider participants shared stories of ongoing recruitment challenges and the persistent demand for primary care services in their communities. These challenges not only raise business considerations but also impact access to healthcare, adding layers of complexity and responsibility to the decision-making of rural health providers.

Although not explicitly related to behaviours, a UK study by Abel et al. (2020) examined general practices at risk of workforce supply and demand imbalance. It found that practices with higher patient-to-GP ratios, greater nurse-to-GP ratios, younger patient populations, and higher levels of socioeconomic deprivation were

significantly more likely to face workforce undersupply. Notably, these higher patient complexity practices were more commonly found in urban areas. In relation to the work by Sheridan et al. (2024), the Aotearoa New Zealand study concluded with similar findings. Her research noted Kaupapa Māori general practices have a higher percentage of Māori patients (52% compared to 12% across all practices). Māori-owned practices also enrolled a higher percentage of children and young people, more deprived population groups and more patients with multimorbidity or complexity (Sheridan et al., 2024). Although this evidence specifically examines practices' enrolment behaviours, the conclusion is that these behaviours shape organisational culture. A linkage between provider workload, organisational structure/ownership and culturally safe care can be drawn. Sheridan et al. (2024) suggest a link between provider behaviours and workload pressures. When a practice faces an undersupply of health professionals, professional behaviours such as customer service are likely to be strained as well. This makes it more difficult for providers to remain critically mindful and deliver culturally safe care, as their capacity to do so becomes compromised under pressure. Further investigation is needed to explore the relationship between health provider workloads and the delivery of culturally safe care, a welcomed opportunity for future research.

7.2.4 Cultural safety

The concept of cultural safety is central to effective healthcare interactions. It extends well beyond basic cultural awareness or sensitivity. Cultural safety was academically defined by Ramsden (2002), a pioneering Māori nurse and has continued to be developed by other academics (Curtis et al., 2019; Curtis et al., 2025). Cultural safety requires health practitioners to engage in critical self-reflection regarding their own cultural identity, the power dynamics at play, and how these factors influence their ability to provide equitable care (Curtis et al., 2025). The findings from this research reinforce the importance of embedding culturally safe practices into the everyday behaviours of general practice staff when delivering services to whānau. This also aligns with the work of Curtis et al. (2019) who similarly identified a strong link between culturally safe practice and the pursuit of health equity. This research resonates with Ramsden (2002) who also highlights the importance of critical self-

reflection. The more critical self-reflection we have, the more able we are to deliver care in a meaningful and equitable way.

Reflection

As a non-Māori researcher, engaging in critical self-reflection has been essential to navigating both the design and delivery of this research. One aspect I continue to find invaluable is my personal and professional network, a group of people with whom I feel safe sharing my naivety, curiosity, and ever-evolving understanding of Māori culture. Equally, and perhaps more importantly, is the critical awareness of understanding our own cultural positioning and biases.

7.2.5 Receptionist awareness

Reception teams occupy a pivotal position within the primary care ecosystem, acting either as gatekeepers or navigators for whānau accessing services (Barbarich, 2019; Litchfield et al., 2017; Neuwelt et al., 2015; Neuwelt et al., 2016; Wilson, 2004). Whānau want kind, respectful, and culturally aware receptionists who make healthcare environments feel welcoming rather than transactional. The receptionist interpersonal interactions, often perceived as routine or administrative, are in fact deeply consequential, shaping both the accessibility and quality of care experienced by patients (Litchfield et al., 2017). The findings of this research reaffirm the significance of receptionists' interactions, revealing that whānau initial engagement with reception staff frequently sets the tone for the entire clinical encounter. In this way, reception teams have a profound influence not only on the immediate emotional response of whānau, but also on their willingness to engage with, trust, and return to healthcare services.

This assertion is supported by Neuwelt et al. (2015), who similarly emphasised the critical role reception staff play in patient outcomes within primary care. This research underscored how receptionists, through their manner, language, and responsiveness, can either reinforce or mitigate systemic barriers to care, particularly for Māori people. In line with these findings, this study contributes further evidence that reception interactions are not merely administrative but constitute meaningful healthcare events in themselves. In considering these findings in relation to enabling equity, it becomes

clear that the reception area is not peripheral to care delivery but integral to it. For many whānau, especially those unfamiliar with medical systems or carrying prior negative experiences, the receptionist may represent the first and most enduring impression of the service. As such, there is an urgent need to elevate the status of reception work within primary care, recognising it as a skilled, relational, and culturally consequential role. This enhancement of status is starting to happen in the UK with Litchfield et al. (2017) discussing the role evolution, which applies to medical receptionists. Alongside the reception role advancement, investment in receptionist training that supports cultural safety, and communication skills is essential if reception teams are to fulfil their potential as enablers of equitable primary healthcare.

7.2.6 Unheard whānau

Healthcare providers must maintain a conscious awareness of the inherent power imbalance embedded within the relationship between health professionals and patients or whānau (Ramsden, 2002). What emerged clearly from the data was that whānau often recognised when their concerns or perspectives were not being adequately acknowledged or responded to, a silence that resonated not just at the individual level but was linked to a broader pattern of disempowerment. For some participants this installed a belief that they were not worthy of services, increased distrust in health systems and therefore they disengaged. For others it created a persistent behaviour that continued to pressure the system to deliver, despite feeling uncomfortable. This sub-theme of feeling unheard was supported in the literature through the work of Wepa (2016), which was framed around the struggle for whānau to be involved in health services. Her research captured the voices of whānau who felt unheard and dismissed, when seeking healthcare services. To enable equity, primary healthcare providers must be supported to develop the skills and systems necessary to genuinely partner with whānau, listening deeply, responding authentically, and disrupting ingrained hierarchies that inhibit relational equity.

7.2.7 Establishing partnerships with purpose

The findings of this study reveal that rural general practice relies on a web of partnerships between patients and healthcare providers, between practices and funders, and critically, between the health system and Te Tiriti o Waitangi. Across

interviews, both providers and whānau described these partnerships not as incidental interactions but as deliberate, values-based relationships with the potential to transform health outcomes for whānau Māori.

This theme, “partnerships with purpose,” reflects the need for deep, sustained, and intentional connections that extend beyond transactional care. Such partnerships are built on reciprocity, trust, and respect, and are grounded in an understanding of the cultural, social, and historical realities that shape whānau health experiences.

The need for partnerships with purpose outlined here, align closely with established Māori health frameworks such as the Hui Process Lacey et al. (2011) and the Meihana Model Pitama et al. (2007), both of which demonstrate how culturally grounded, equity-driven relationships can be enacted in clinical settings to enable equity for whānau Māori.

Within this theme, three interconnected sub-themes capture how partnerships with purpose are established and maintained in rural general practice: upholding Te Tiriti o Waitangi as the foundation for enabling equity, whakawhanaungatanga as the process of building and sustaining genuine relationships which contributes to enabling equity and achieving health outcomes that mean something to whānau as another key enabler of equity.

7.2.8 Upholding Te Tiriti o Waitangi

Te Tiriti o Waitangi is the first form of formal partnership between the monarch and Māori people of Aotearoa New Zealand, yet continues to fall short of exercising the equity promise articulated in Article Three (Sheridan et al., 2024). The partnership between the Crown and Māori has been underserved for decades. The Waitangi Tribunal (2019) Hauora inquiry report recorded breaches in primary and community care, with many rural Māori health providers submitting or supporting tribunal claims. Following the Waitangi Tribunal (2019), there was a noticeable system response to the documented system breaches. Equity was identified across many different elements of healthcare services (Minister of Health, 2023; Ministry of Health, 2015, 2023; Simpson, 2020). If the system objective is to improve Māori health, then building and sustaining partnerships with purpose across all elements of the system from whānau, providers and the wider health system, is critical.

7.2.9 Whakawhanaungatanga

A well-documented relationship-building approach is whakawhanaungatanga, a concept that features prominently across nearly all Māori health models (Wilson et al., 2021). Whakawhanaungatanga refers to the process of establishing and nurturing relationships (Komene et al., 2024). In the context of healthcare, building meaningful connections between the health provider and whānau is critically important (Komene et al., 2024). The initial engagement is often pivotal when windows of opportunity emerge to establish such connections between whānau and providers. This reflects a reality frequently observed in practice and was raised in the findings of this research, where whānau may present with a specific need. They may be reluctant to share personal information or engage more deeply until that need is acknowledged and addressed. This reflects the connection between trust and whakawhanaungatanga. Trust is cultivated through attentive listening and responsive action. Active listening and responsive action often serve as the gateway to deeper, more meaningful connections. As discussed earlier in this chapter, the pain many Māori whānau carry about the health system usually extends beyond the individual provider in front of them. Unless this hurt is acknowledged through acknowledgement, trust is rebuilt through relationships, and authentic connections are formed, the goal of achieving equity will remain out of reach.

As identified above, whakawhanaungatanga is a prominent element within many Māori health models of care.

> Whakawhanaungatanga is paramount and is a priority as part of collaborative healthcare engagement and activities Wilson et al. (2021, p. 9).

This view is reinforced by Komene et al. (2024), whose research concluded that:

> Whakawhanaungatanga was foundational to supporting participants being Māori (p. 1550).

Given these prior findings, it is unsurprising that whakawhanaungatanga emerged so strongly in the current research. Its recurrence across multiple studies underscores its centrality to effective engagement with Māori and highlights the importance of embedding relational approaches within healthcare practice and policy.

7.2.10 Health outcomes that mean something to whānau

A key subtheme that emerged within this broader theme was health outcomes that mean something to whānau. The findings revealed an apparent disconnect between the outcomes whānau valued and those the health system prioritised. Participants, both providers and whānau, frequently described current outcome measures as transactional, focusing on discrete clinical indicators rather than addressing the broader determinants of wellbeing. This reflects a systemic tendency to emphasise disease-specific metrics at the expense of more holistic and meaningful markers of whānau health.

These insights are consistent with the findings of Reweti (2023), who argued that Indigenous-led wellbeing initiatives can significantly improve outcomes when they are grounded in holistic frameworks that reflect whānau values. In particular, the emphasis on Whānau Ora approaches (wrap around services) were seen as critical. These approaches, which are well-established in Aotearoa New Zealand, offer a strengths-based framework that supports whānau empowerment and uplifts collective wellbeing. The findings reinforce the need to reorient outcome measurement in health services towards models that privilege relational, cultural, and holistic conceptions of health, rather than purely clinical or individualised indicators (Reweti, 2023).

7.3 Knowing how rural primary healthcare is delivered

This overarching theme explores and discusses models of care that support and promote equity, alongside the resources required and associated cost implications. Finally, the theme considers the hospital's contribution to primary care, particularly for tamariki with complex and specialised care needs.

7.3.1 Models of care

"Eat-what-you-kill" models, which incentivise practitioners to maximise revenue by increasing patient throughput, come at a significant cost to equity and teamwork (Pullon et al., 2009). This issue was also highlighted in the research findings, particularly in relation to the shift towards collective ownership business models, which encouraged team-based care approaches and models. Such models influence care delivery by supporting a team-based approach, which may better align with equitable and holistic service provision. Team-based care has been a model of care

change that continues to evolve, whereby care for the patients is delivered by a team rather than an individual health professional (Cullen et al., 2023). This model enables different skills to be utilised to ensure best outcomes for whānau are achieved (George, 2023). The findings of this research supported the need for team-based models of care, specifically when addressing the wider social determinants of health. The research by Sheridan et al. (2024) aimed to compare different models of care across Aotearoa New Zealand practices. This research concludes that there is not one better or more equitable model and instead identifying they fall short of delivering and enabling equity for whānau, but as discussed earlier, comparing models based on clinical health measures or outcomes, does not remove the importance of health measures and outcomes that are defined by whānau. Whānau participants in this research indicated that their needs were addressed, and they described experiences involving culturally safe interactions, which contributed to care that supported equity. Having an extended care team allowed for addressing individuals' presenting and underlying concerns with a range of professional skills. Whānau needs will vary. It is the health professionals' and services' responsibility to identify what is important for whānau and act on that before projecting clinical bias and power into the interaction.

7.3.2 Affordability

Funding has been discussed earlier in this chapter and is touched on again here. Financial and other resources are a key challenge in Te Tai Tokerau, with many whānau participants discussing how the fundamentals of a health service are restricted by funding, infrastructure, workforce and limited technology. All these elements are interconnected. Despite the reality of limited resources, the participants had homegrown solutions such as training doctors from within the community. These ideas need to be supported nationally through funding pipelines, enabling rural health providers the autonomy to solve their own resource-restricted problems.

The cost factor of primary healthcare services is well documented in the literature, with studies exploring both the cost of delivering services and the patient co-payments required to access them (Atmore et al., 2023; Chin et al., 2018; Jeffreys et al., 2023; Lawton et al., 2023; Martel et al., 2020; Reeve et al., 2015; Wakerman et al., 2017). In

Te Tai Tokerau, a small number of providers are actively working to reduce cost barriers for whānau accessing primary care. One provider does not charge patients at all, while another offers free general practice services specifically for their Māori patients. These initiatives aim to promote equity by addressing financial barriers to access.

In the grey literature, Loh (2015) presents a compelling argument for providing free primary healthcare services to vulnerable and underserved population groups in Aotearoa New Zealand. She notes that there are 18 practices nationwide offering free care, two of which are located in Te Tai Tokerau. Loh concludes that removing cost barriers can significantly enhance equity and proposes a network of 'safety-net' clinics. These fully funded services, she argues, should be appropriately resourced and work collaboratively with other providers rather than in competition. This research supports the premise that reducing or eliminating cost barriers enables greater equity for whānau. It also highlights a willingness among some existing organisations to deliver such services, provided they are adequately resourced to do so.

7.3.3 Hospital as primary care

For some, hospital specialist services, often located far from home, had become their primary source of care. In these cases, general practice and other local health services were experienced by whānau as offering transactional care for things such as repeat prescriptions.

This pattern echoes findings from Tane et al. (2025), who explored rural Māori experiences in accessing heart health care. Although their focus was on older adults rather than tamariki, the underlying issue was the same, a lack of specialist services closer to home. Cardiologists, for example, were not regularly available in rural hospitals or through primary care providers. The study by Tane et al. (2025, p. 56) identified "access to heart health care closer to home" as a major theme, with rural whānau expressing frustration over travel demands and system barriers that delayed or prevented their access to care.

Similarly, the māmā in this study described the logistical and emotional challenges of travelling to Auckland or Whangārei for their child's care. Like the kaumātua and kuia in Tane et al.'s work, they offered clear, practical solutions, suggesting that health

services should be embedded in the rural communities where they live. When specialist care was occasionally brought into general practices, it was received positively.

These findings reinforce the need for a more integrated model of care where specialist services are accessible within rural communities. Whānau should not have to choose between distance, quality and care.

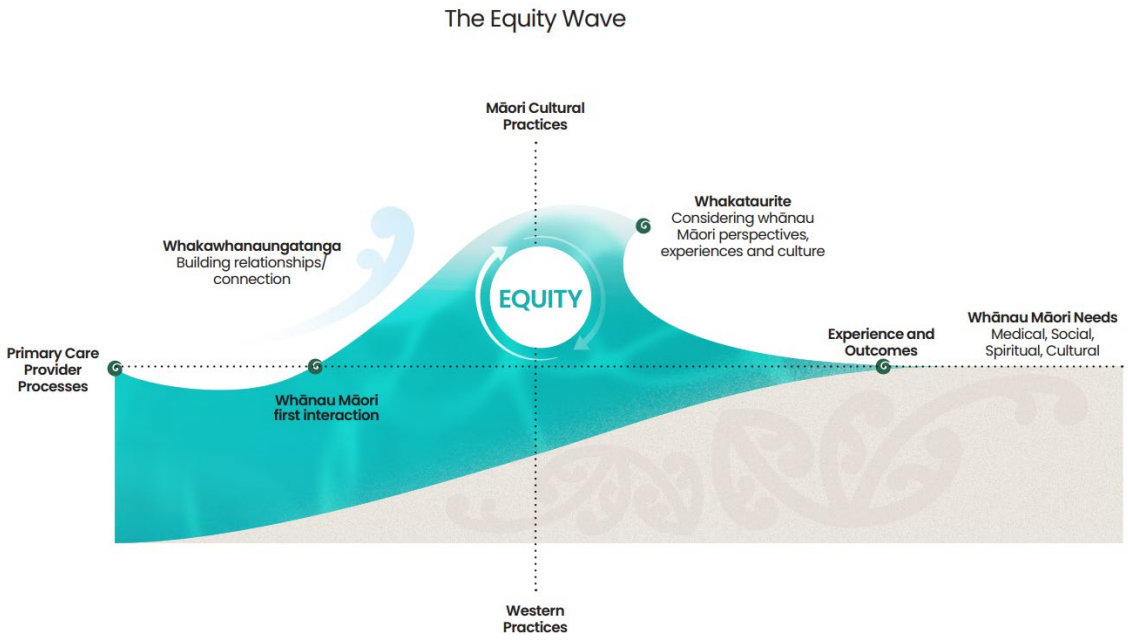
7.4 The Equity Wave - Rethinking engagement with rural Māori

Rural primary care services must expand from equity-focused frameworks to equity-based approaches, implementing their frameworks in practice and applying the knowledge they have gained. For some health professionals, this will take bravery. Applying equitable frameworks to service delivery might be uncomfortable initially, but the more health professionals use them, the easier the application and action will become. As discovered in the findings chapter, enabling equity is an intentional activity.

To support rural primary care providers in delivering equity-based care, I developed the Equity Wave model (Figure 11 The Equity Wave below). Grounded in this doctoral research, the model maps the journey of a whānau Māori interaction with a health professional, illustrating where and how equity can be enabled. Although designed with general practice in mind, it is adaptable to a wide range of primary care settings. The model integrates two intersecting axes that together visualise the conditions necessary for equitable care.

The Equity Wave focuses on what is within primary care's sphere of influence, the interaction between provider and whānau. It does not suggest that equity can be achieved through clinical encounters alone, but rather that every encounter is an opportunity to enable equity within the constraints of a wider system that must also change.

Figure 9 The Equity Wave



Axes and quadrants

The concept of equity can be visualised as the intersection of two axes, one vertical and one horizontal. The four quadrants can represent the different outcomes and or activities required to enable equity.

The vertical axis represents the coming together of different worldviews, specifically Western and Māori cultural practices. This highlights the two different worldviews.

The horizontal axis represents the journey between rural general practice models and whānau outcomes. It can be visualised as a patient pathway, whānau enter on the left through the doors of a general practice and exit on the right with an experience, an outcome, and a sense of whether their needs have been met. This axis travels from left to right, reflecting the interaction whānau have with their provider.

On the far left, the starting point assumes a mainstream general practice model, which typically operates within a Western framework. If the practice were a Kaupapa Māori service, it would begin above the axis line, signalling that its organisational intent, values, and principles are aligned with Te Ao Māori. However, the majority of practices in Aotearoa New Zealand are not Kaupapa Māori, and therefore would begin on or below the axis line.

On the far right of the axis are whānau outcomes. Clinical metrics or system-level targets do not define these, but patient-reported experiences do: whether whānau felt heard, had a positive interaction, and received care that met their expectations. Even when clinical outcomes are technically achieved, if whānau do not feel acknowledged or understood in their healthcare interactions, the result will not enable equity. Health outcomes require more than technical care. They demand relational connection and behavioural intent to be effective and enduring.

This horizontal axis also illustrates the gap between the general practice business model in Aotearoa New Zealand and the patient outcomes and experiences whānau Māori receive from services. These realities encompass not just medical needs, but also social, cultural, and spiritual health dimensions that are intertwined. They must be seen as one, yet are often overlooked in mainstream service design and delivery, where the medical need frequently takes precedence over holistic measures. The visual representation of the gap (the wave) is an illustration of the opportunity we have as health professionals to enable equity for each person with whom we interact.

Figure 10 Quadrants of health equity

Whakawhanaungatanga – Building relationships and connection with whānau Māori	Whakataurite – Enabling equity for whānau Māori through application of culturally safe practices, identification of bias and consideration of wider determinants of health that may not be the presenting concern.
Whānau Māori needs are not met and therefore equity is not enabled.	Whānau Māori needs that are often unseen and unspoken, yet are in existence. The wider determinants of health alongside historical trauma, colonisation effects and other inequitable practices that have impacted the individual.

This quadrant figure (Figure 12 above) illustrates the relationship between Whakawhanaungatanga, the process of building relationships and meaningful connections with whānau Māori, and Whakataurite, the practice of enabling equity through culturally safe approaches, identification of bias, and consideration of wider

determinants of health. When both Whakawhanaungatanga and Whakataurite are present, providers engage in trusted, culturally aligned relationships, while addressing root causes of inequity, resulting in care that truly meets whānau needs. In contrast, when both elements are absent, whānau Māori needs remain unmet and equity is not enabled, perpetuating disadvantage. Where Whakataurite is applied without Whakawhanaungatanga, providers may address some determinants of health, but fail to uncover unseen or unspoken needs, leaving historical trauma, colonisation impacts, and systemic inequities unaddressed. Likewise, focusing solely on relationships without addressing the patients or whānau needs and embedding equity-focused practice, risks maintaining rapport without addressing patients' needs making the structural or systemic changes necessary to achieve equitable outcomes. In essence, the quadrant emphasises that genuine equity for whānau Māori relies on the combined strength of relationship building and culturally safe, equity-enabling action.

Meeting whānau where they are at, along the Māori cultural and Western construct continuum, will enable equity. Providers need to build the capability and capacity to move up and down the axis to ensure that every patient feels heard and listened to. The Māori cultural practices quadrant (top right) is inclusive of and considerate of the Māori cultural practices and values.

7.4.1 The Equity Wave

The equity wave is symbolic. As referenced in the findings chapter, the guiding whakataukī is He Waka Eke Noa (we are all in this together) (Te Aka Māori Dictionary, 2025). This whakataukī speaks to kotahitanga (unity), highlighting the collective effort of paddling in unison toward a shared goal. The wave metaphor connects back to this imagery, reinforcing the sense of being on the water, navigating together. It also grounds the metaphor in our place. Te Tai Tokerau is a region surrounded by water, where the ocean forms an integral part of the landscape, recreation, and way of life. The wave, then, is not only metaphorical but also deeply contextual, reflecting both the kaupapa of the research and the moana (ocean) it emerges from.

The wave concept reflects the individuality of each encounter with whānau. Just as no two waves are the same, each interaction is unique, shaped by different needs, contexts, and relationships. The model offers guidance, insights, and techniques for

navigating these encounters, like learning to bring a waka into shore. However, the balance point while bringing a waka into shore will constantly shift, highlighting the need for health professionals to continuously adapt their approach to the person, the situation, and the aspirations of those they serve.

The wave begins with the patient accessing services and ends with their experience, showcasing the patient's journey and highlighting the opportunities to enable equity along the way. The wave has several steps, as outlined in Table 7 Elements of the equity wave). The middle of the wave is the ultimate element for enabling equity. Equity is enabled through intentional action and resourcing, which is clearly outlined in the findings and throughout this discussion chapter. For some, that action will come more easily than for others, depending on where they sit on the axis. For others, it will require training, support and tools to seek out equity actions, behaviours and initiatives.

Table 7 Elements of the equity wave

Model Characteristic	Explanation	Example
Access (representing the start of the wave)	The ability for whānau Māori to obtain timely, appropriate, and culturally safe health services when needed. For many whānau Māori, seeking care often comes after exhausting all available options within the home and whānau network.	Streamlining booking and appointment systems while prioritising access for Māori whānau. Proactively seeking equity opportunities and being the navigator of health access for whānau Māori.
Whānau Māori first interaction (representing the opportunity to build the wave – the under tow)	The first interaction whānau Māori have with health providers is positive, warm, safe, and provides a connection. He kanohi kitea and kanohi-ki-te-kanohi (Face-to-face) interactions are warm with eye contact and friendliness. These interactions are essential as they build trust for whānau Māori with the health service.	Simple booking systems – if over the phone, having friendly and helpful call handling techniques that support whānau to navigate the system. In-person interactions that involve eye contact and genuine warmth foster a sense of trust and respect, laying the foundation for ongoing engagement with health services.
Whakawhanaungatanga (representing the offshore wind)	Building and sustaining meaningful relationships with whānau Māori.	Connecting beyond the medical transaction. Example "Kia ora [patient name]. My name is [health professionals name] and I am a [role] here at [medical centre name]. Where are you from? Simple greetings and staying on the patient's agenda are critical tips to enacting whakawhanaungatanga.
Whakataurite (representing the onshore wind)	Provider reflective self-awareness, recognising bias and valuing Kaupapa Māori knowledge. How Understands what equity-informed care is, and can apply this in their practice.	Shared decision making and asking the patient, "How can I help you? Is there anything else?" and promoting equity actions such as referral to an extended care team member, funded appointments or longer appointments.
Whānau Māori Needs (represents the sand, the beach, the land)	Feeling heard and listened to while meeting whānau Māori needs within the context of their realities.	Patient-reported feedback enables patient experiences to guide service improvement. Open questions like "How did you find our session today should be promoted with anonymised surveys enabling whānau Māori to be honest.

The Equity Wave provides a practical framework for translating equity principles into everyday action. It offers rural healthcare providers a culturally grounded, evidence-informed guide for delivering care that is both clinically effective and relationally meaningful. By intentionally applying both Whakawhanaungatanga and Whakataurite at each stage of the wave, providers can reduce inequities, strengthen trust, and ensure whānau Māori experiences are central to service design and delivery.

Purākau | A story of the equity wave

Bringing a waka into shore is a moment that demands skill, timing, and unity. It is the culmination of a journey, yet also the beginning of what comes next, rest, restoration, and connection with the land. Navigators and crew would work in harmony with the winds, tides, and the shifting moods of the moana (ocean). Landing a waka was never done alone, it required every hand, every paddle, every voice calling in rhythm.

The waka in this story is a whānau Māori seeking care, the vessel carrying their needs, hopes, and experiences. The paddlers are the primary care team, each with a role in guiding the waka safely to the shore. Some are at the bow, reading the wave and signalling when to paddle harder or hold steady. Others are at the stern, steering with quiet precision. The crew in the middle keep the rhythm and maintains the momentum. Everyone is needed, everyone's effort counts.

In traditional landings, the kaiurungi (steersperson) would read the swell, watching for the right moment when the wave could be harnessed to carry the waka forward. In the context of rural health, this is akin to recognising the conditions that will enable equity, the patient's readiness, the cultural safety of the service, the alignment of resources, and the strength of relationships. Without reading these signals, the waka risks being caught broadside, swamped, or pushed back out to sea.

A skilled crew works with the offshore wind, using it to lift the waka onto the face of the wave. Offshore winds, in this story, represent whakawhanaungatanga, the warm connections, trust, and respect built between the whānau and the health team. Just as an offshore wind shapes the swell into something surfable, these relationships create the right conditions for the journey toward equity. Without it, the wave may close out too soon, leaving the waka stranded.

As the waka nears shore, the onshore wind comes into play. In voyaging history, this wind could help drive the waka forward, but only if harnessed with skill. Too much force could send the vessel off course. Here, the onshore wind is whakataurite, which refers to the deliberate application of culturally safe practices, equity-driven action, and bias awareness. It is the power that propels the waka into the bay, ensuring that momentum is not lost.

In the final approach, bringing the waka into shore, timing was everything. Paddlers had to be in perfect unison, responding instantly to calls from the kaihautū (caller). In healthcare, this reflects the need for the primary care team to coordinate administrators, nurses, doctors, health coaches, each knowing when to act, when to listen, and when to pause. If one paddler stops, the others must adjust. If the rhythm is lost, the waka may drift sideways and land awkwardly, leaving the whānau shaken rather than supported.

The moment the hull slides onto the sand is one of relief and connection. For a patient, this is when their needs have been met, not only in the clinical sense but in the relational and cultural sense. The landing was not just a technical manoeuvre, it was a moment of manaakitanga, of arriving in a place of safety and welcome. If the landing was rough or disorganised, the mana of the voyage could be diminished. In healthcare, this is the difference between a technically correct treatment and an equitable, healing experience.

When the waka is beached, the work does not end. The crew unloads supplies, secures the vessel, and begins the work of connecting with the people and land. In healthcare, the journey continues beyond the appointment. Follow-up care, community connections, and responsiveness to changing needs keep the relationship strong for the next voyage.

The art of bringing a waka into shore reminds us that enabling equity in rural primary care is not about one person’s skill or one moment’s effort. It is about the collective, the rhythm, the reading of conditions, and the commitment to arrive together, safely, every time.

7.5 Limitations of the study

This study invited participation from all rural general practices located within the Te Tai Tokerau region of Aotearoa New Zealand. Eight primary care providers agreed to participate. Significantly, the majority were either owned and operated by Māori health organisations or had established Māori leadership within their governance or management structures. This presented a unique opportunity to explore rural models of care informed by kaupapa Māori values and Indigenous leadership.

However, a key limitation of the study lies in the absence of participation from mainstream general practices that do not have Māori governance or Māori leadership teams. This limitation highlights the need for further research to explore the perspectives and practices of mainstream providers and how they may intersect with or diverge from Indigenous-led approaches to rural health service delivery.

Chapter 8 Conclusion

This thesis has sought to critically examine how equity is enabled, delivered, and experienced within rural primary healthcare in Te Tai Tokerau. At its core, the research was motivated by the recognition that health inequities, particularly those experienced by Māori and rural whānau, remain persistent despite decades of policy attention and reform. Drawing on Māori-centred methodologies and grounded in the ethical principles of Te Ara Tika, this study placed whānau and providers at the centre of the inquiry, privileging their voices in shaping the findings.

The primary aim of this research was to explore how rural general practices enable equitable care for whānau Māori, and to identify what practices, processes, and systemic conditions enhance this goal. Through qualitative interviews with both whānau and providers, the research generated rich accounts of healthcare encounters, organisational pressures, and equity levers. These insights were analysed thematically, leading to the development of the Equity Wave model, a conceptual tool that illustrates how equity can be intentionally enacted during primary care interactions.

This concluding chapter brings together the key findings of the thesis and reflects on their implications for policy, practice, and future research. The researcher closes with a final reflection on the importance of equity as a lived, enacted practice of delivering health services in rural primary healthcare.

8.1 Overview of the thesis

Chapter 1 Introduction

This chapter highlighted the rationale for the study and the systemic inequities that remain here in Aotearoa New Zealand today for whānau Māori living in rural communities. The introduction chapter outlines my positionality as a Tangata Tiriti researcher.

Chapter 2 Literature review

The literature review confirmed that health disparities and inequities for rural Māori are evident within Aotearoa New Zealand and for other Indigenous populations internationally. These inequities require targeted intervention. It also highlighted that

equity can be advanced through health service design and delivery, as well as through commissioning, with the most significant impact achieved when these approaches are combined. This thesis contributes to the existing body of work by addressing inequities in rural communities, specifically for Māori, and aligns with the broader literature already established in this field.

Chapter 3 | Methodology

Applying a Māori-centred methodology offered a rigorous yet culturally safe approach to conducting research as a Te Tiriti ally. In particular, the Te Kākano model provided a framework that upheld Kaupapa Māori principles and methods, while also meeting Western and academic expectations, creating space as a Tangata Te Tiriti researcher to work respectfully in this field. The methodology struck a balance between flexibility, allowing for responsiveness to community needs, and the structure necessary to ensure the rigorous application of research practices. Importantly, this approach ensured that rural Māori communities remained central to all stages of the research process and decision-making.

Chapter 4 | Methods

This study had two participant cohorts: Phase One whānau Māori (patients) and Phase Two providers (health professionals). Both phases were interviewed using Appreciative Inquiry interview questioning. This questioning style facilitated a positive and enabling interview inquiry, allowing the data collection to remain focused on enablers. Reflexive thematic analysis was employed during the data analysis process, allowing the data to form into themes and sub-themes through reflexive processes that included consultation with supervision and the research kāhui advisors.

Chapters 5 and 6 | Findings

Three whānau and one provider stories were captured and shared in Chapter Five. These stories preface the findings chapter and allow the reader to sink deeply into the data collected for this research.

Four themes were explored in the findings chapter. The chapter starts with exploring the theme “understanding equity and root causes”. This theme highlights the importance of understanding and defining equity. Applied or enabled equity is the

intentional use of interventions that prioritise Māori health outcomes. An example of this could be the referral or offering of rongoā Māori (traditional) healing services.

The second theme was “being aware and culturally safe”. This theme brought the application of behaviours into play, highlighting the importance for individual health professionals to take responsibility for their behaviours, actions, and interactions with whānau Māori patients within the primary care setting. It starts with the concept of access (being able to get an appointment), and if whānau Māori cannot easily access the service, they are less likely to attend. When whānau can access their practice or health professional with ease and quickly, it is appreciated.

The third theme is “establishing partnerships with purpose”. This theme highlights the importance of upholding Te Tiriti o Waitangi, Whakawhanaungatanga and health outcomes that are relevant to whānau Māori. An example is the application of whakawhanaungatanga, which relates to building trusted relationships with whānau seeking services by connecting with and understanding whānau Māori on a deeper level. Health professionals have access to more information, enabling them to make better-informed care decisions and provide advice that aligns with the person's goals and expectations. These interactions build and enable equity.

The final theme is “how rural primary healthcare is delivered”. This theme addresses the functional elements of rural primary healthcare delivery that have an ability to enable equity for whānau Māori. This includes resourcing, affordability, models of care and the role of hospital services.

Collectively the findings gather a robust evidence base for equity enabled activity and intervention.

Chapter 7 | Discussion

This chapter discussed the findings in relation to current literature. The findings of this research are aligned with and supported by current literature. This chapter introduces The Equity Wave. It is a model developed from within the research findings that aims to support health professionals in rural primary care to enable equity through every interaction they have with whānau Māori.

The Equity Wave is situated on an axis that follows the patient journey from entering the service to achieving the desired outcomes. The wave formation is strengthened by positive first interactions with the provider, whakawhanaungatanga and whakataurite. During the whakataurite phase, health professionals are invited to reflect on their cultural biases and ensure that they are fully aware. In this moment, we watch health professionals pivot from judgment to empathy, bridging a deeper layer of care for the person they are caring for. The wave arrives on the shore, a place where whānau Māori health outcomes and desires are met. My hope is that this model enables health professionals across Aotearoa New Zealand to rethink every encounter they have with whānau Māori and realise they have the ability to facilitate equity in every interaction they have.

8.2 Review of the question and aim

The central research question guiding this study was, *How can rural primary care service providers in Te Tai Tokerau be enabled to deliver equitable services to Māori?* The study aimed to explore the experiences and perspectives of both rural primary care providers and whānau Māori in Te Tai Tokerau, to identify the activities, actions, systems, and models that best support equitable outcomes for rural Māori.

From this research, the concept of the equity wave emerged, culminating in the development of a new model to support the conceptual delivery of equity-enabled care. This model was shaped by the research findings and further refined through collaboration with my supervision team and the research kāhui. If rural primary healthcare providers apply the equity wave to service delivery for rural Māori, they can enable equity through care provision in every interaction.

The findings from this study reveal a notable and consistent understanding of equity among the providers interviewed. These providers demonstrated a high level of awareness and insight into the principles of equity, and importantly, this knowledge translated into a tangible impact on the care they delivered. Enablers of equity included:

- processes in place to streamline same-day access;
- local receptionists who had connections to whānau and the community acting as navigators for whānau;

- cost barriers removed or mitigated through organisational policies;
- interactions with whānau were based on whanaungatanga, and biases were understood.

Alongside these findings, Māori leadership undoubtedly influenced the ability to deliver localised, equity-enabled care.

This study focused on the enablers of such care, offering valuable insight into what supports equitable service delivery in rural primary care settings. It is essential to acknowledge, however, that while the findings highlight several effective practices and conditions that enable equity, significant barriers and systemic challenges persist. These obstacles continue to create struggles for providers and whānau alike, underscoring the need for ongoing commitment and systemic and structural change.

This research reinforces the need for rural primary care services to move beyond equity as a theoretical framework and towards embedding it as a practical approach in daily operations. Applying equity-based care means acting on the knowledge and frameworks already present, translating them into consistent behaviours, actions, and decisions that improve outcomes for Māori. The research encourages rural primary care providers to continue to or start operationalising their equity commitments, shifting from awareness to applied equity enablement.

Finally, the study provides further evidence to support the argument that eliminating and reducing affordability barriers is a crucial step toward achieving equity. Where fees are reduced or removed, whānau are more likely to access the care they need earlier rather than presenting when their illness is severe or requiring hospitalisation. Encouragingly, some Te Tai Tokerau providers are already demonstrating such affordability models.

Equity is not just a moral imperative. It is also a structural one, requiring funding models and policies that support services to deliver equity-enabled care for whānau.

8.3 Implications for rural whānau

This study amplifies the voices of whānau engaging with primary healthcare services in Aotearoa New Zealand, illuminating both what is valued and what falls short. It reveals the aspirations of whānau for care that is responsive, culturally grounded, and equity-

oriented. If all rural whānau were to receive care aligned with the principles and actions of the equity wave, we would take a significant step toward realising the promise of equity that remains frequently unmet in the current primary healthcare system. This is reaffirmed by Curtis et al. (2025), who outline the critical enablers of culturally safe healthcare, and by doing so, health professionals are enabling equity.

The findings underscore that the behaviours, attitudes, and actions of healthcare professionals are critical levers for enabling equity. While systemic reform is necessary to sustain long-term change, this research also identifies immediate opportunities for individual healthcare workers to respond. The study concluded that equity is not solely a structural issue. It is enacted in each encounter, decision, and act of care. This impact on Māori whānau is further substantiated by Rae (2024), who emphasised the significance of non-Māori behaviours and actions when engaging with Māori, particularly in relation to anti-racism and bias.

While broad systemic reform remains essential for sustainable change, there are immediate opportunities for healthcare professionals to act. The Equity Wave offers a framework for translating culturally safe principles into practical action, ensuring that every interaction can be a step toward equity for whānau Māori.

For whānau Māori in rural Te Tai Tokerau, these findings affirm that equity-enabling providers already exist, practitioners who are culturally attuned, aware of social determinants, and delivering services that go beyond the strictly medical model. These providers exemplify the practices whānau themselves have articulated as essential, that is, flexible care, genuine whakawhanaungatanga, and responsiveness to whānau-defined needs. The Equity Wave model offers an opportunity to strengthen existing practices and bring all primary healthcare providers and professionals on a journey to achieve equity. The path forward lies not in reimagining rural healthcare from scratch, but in amplifying, supporting, and scaling what already works for Māori whānau.

8.4 Implications for policymakers and commissioners

This study highlights some of the most significant equity-enabling activities occurring in rural primary care, particularly within rural general practices. Much of this work is unfunded, adding complexity to the delivery of equitable rural services. Funders such as officials within Health NZ and Manatū Hauora (The Ministry of Health) reading this

thesis should recognise the necessity of resourcing activities that enable equity in rural areas. As discussed throughout, commissioning must fund the expectations placed on service delivery if change is to occur. Policymakers must understand that the challenges facing rural communities require tailored funding approaches, ones that offer equitable depth, flexibility, and responsiveness to the unique needs of each community.

At a strategic level, Aotearoa New Zealand's Rural Health Strategy recommends recruitment and training pathways that reflect Māori community needs, alongside the inclusion of Māori health roles and practitioners to support whānau effectively, in rural settings (Minister of Health, 2023). This aligns with the vision of the Equity Wave, offering a strong foundation for scaling equity-oriented care. Building career pathways into healthcare for Māori is critical to enabling equity for rural communities**.**

Equally important is equipping healthcare workers with the knowledge and skills to enable equity in their everyday practice. Workforce development must include funded education programmes on enabling equity, including the application of the Equity Wave, to improve outcomes for rural whānau Māori.

I urge policymakers, decision-makers and commissioners to invest in strategies and activities that genuinely enable equity for rural Māori communities. This investment should prioritise the affordability of general practice services, developing and educating a rural workforce skilled in equity-based care, and strengthening rural infrastructure to support sustainable, high-quality services.

8.5 Recommendations for further research

The findings of this study highlight both the value and the limitations of the current rural primary healthcare evidence base in Aotearoa New Zealand, offering several opportunities for further research. First, there is a need to investigate whether the patterns observed in Te Tai Tokerau are consistent across other rural regions of Aotearoa New Zealand that have a large Māori community. Comparative studies could determine whether the enablers to equity identified in this research are geographically specific or reflect broader systemic trends.

Second, the intersection between workforce pressure and equity-enabled care delivery warrants deeper exploration. Future research should investigate how workforce

undersupply, particularly in general practice, impacts a practice's ability and capacity to deliver culturally safe, equity-focused care. Understanding this relationship would be critical in informing both workforce planning and service design.

Third, expanding the research to capture the perspectives and operational realities of a greater number of non-Māori-led organisations would enrich the evidence base and provide a more comprehensive understanding of equity drivers and barriers in rural primary care.

Fourth, there is the need to scale and test the Equity Wave model across diverse contexts. While this study developed the model within rural general practices in Te Tai Tokerau, its principles have potential relevance across the wider health system. Testing the model in other rural regions, as well as in urban primary care settings, would provide valuable insights into its transferability and adaptability. Such research could examine whether the model resonates with the experiences of different whānau groups and whether it supports providers to enact equity in practice beyond the Te Tai Tokerau context.

Scaling the model would also involve integrating it into professional development, workforce training, and service design processes. Pilot projects that embed the Equity Wave into clinical training or practice improvement initiatives could assess its utility as a reflective and practical tool. For example, measuring whether its use enhances cultural safety, strengthens provider, whānau relationships, or improves equity outcomes would generate an evidence base for its wider adoption. Ultimately, scaling and testing the Equity Wave model represents an opportunity to transform equity from aspiration into action, ensuring that the lessons learned in Te Tai Tokerau contribute meaningfully to shaping primary healthcare across Aotearoa New Zealand.

8.6 Final words

Equity is everybody's responsibility, and all health professionals must be intentional about it in their everyday care for whānau Māori in rural Te Tai Tokerau. This research has highlighted the depth of knowledge and experience that exists among providers who are already embedding equity-focused practice into their services, demonstrating that there is much to be learned from those leading the way in this space.

Prioritising affordable, accessible, and culturally acceptable care offers a simple yet powerful pathway toward equity. The Equity Wave model was designed to support every interaction whānau Māori have with the health system; when equity is enabled in each encounter, we create the conditions to shift systemic levers.

I close with a Te Tai Tokerau mōteatea that speaks to change, the forward movement of the waters of Te Tai Tokerau, and the enduring desire for unity. These values resonate strongly with the findings of this research. From the equity wave to the shores of Te Tai Tokerau, I leave readers with this challenge: how will you enable equity for whānau Māori?

> Ka nukunuku, ka nekeneke!
> Ka nukunuku, ka nekeneke!
> Titiro ki ngā wai o Tokerau e hora nei ki tua,
> me he pīpīwharauroa, takoto te pai, takoto te pai
> Whitiwhiti, Tatatata
> Whitiwhiti, Tatatata
> Tera ki tua,takoto te pai, takoto te pai
>
> (Whakakai, 2022)

Glossary

Akoranga Māori	Culturally preferred pedagogy
Aotearoa	New Zealand
Hapu	Sub-tribe
Hauora	Health, wellbeing (often holistic)
Hīkoi	March or protest walk
Iwi	Tribe, extended kinship group
Kāhui	Advisory group, cluster of experts/elders
Kai	Food
Kaihautū	Caller
Kaiāwhina	Helper, assistant, contributor, counsel, advocate
Kaitiakitanga	Guardianship, stewardship, trusteeship, trustee
Kaiurungi	Steerer, coxswain, controller, pilot
Kanohi ki te kanohi	Face to face
Kaumātua	Elders (male)
Kuia	Elders (female)
Karakia	Prayer
Kawa	Protocols, customs
Kaupapa	Collective philosophy
Kaupapa Māori	Research, practice, or initiatives grounded in Māori philosophy and principles
Kōrero	To tell, say, speak, read, talk, address
Kōtiro	to be a girl
Koha	Gift, contribution

Māmā	Mother, mum
Mana	Authority, prestige, spiritual power
Manaakitanga	Care, hospitality, generosity
Mana Māori	Māori authority/control
Mātauranga Māori	Māori knowledge systems
Moana	Ocean
Pākehā	Non-Māori (usually European descent)
Rangatahi	Young people
Taonga	Treasure
Tino rangatiratanga	Self-determination
Tāiki e!	Expression of unity and agreement in karakia
Tamariki	Children
Tauiwi	European, non-Māori
Te Ao Māori	A Māori world, worldview
Te Kākano	A Māori-centred research methodology model (“the seed”)
Te Reo (Māori)	Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi (Māori text version)
Tikanga	Customs, correct procedures
Tūmanako	Hope, aspiration
Tūrangawaewae	Place to stand, belonging
Wairua	Spirit, spirituality
Waiata	Song, chant
Wāhine	Women
Waka	Canoe, boat

Whakapapa	Genealogy, lineage
Whakapiki Tangata	Enablement, empowerment
Whakawhanaungatanga	Process of building relationships
Whakataukī	Proverb
Whakataurite	To cause to be alike, imitate, put into perspective
Whānau	Extended family structure
Whānau ora	Holistic family wellbeing, wrap around services
Whenua	Land

References

Abel, G. A., Gomez-Cano, M., Mustafee, N., Smart, A., Fletcher, E., Salisbury, C., Chilvers, R., Dean, S. G., Richards, S. H., Warren, F., & Campbell, J. L. (2020). Workforce predictive risk modelling: Development of a model to identify general practices at risk of a supply−demand imbalance. *Britsh Medical Journal Open*, *10*(1), e027934. https://doi.org/10.1136/bmjopen-2018-027934

Ago, F. Y., & Bekele, W. B. (2022). Sample size for interview in qualitative research in social sciences: A guide to novice researchers. *Research in Educational Policy and Management*, *4*(1), 42-50. https://doi.org/10.46303/repam.2022.3

Ansell, D., Crispo, J. A. G., Simard, B., & Bjerre, L. M. (2017). Interventions to reduce wait times for primary care appointments: A systematic review. *BMC Health Services Research.*, *17*(1), 295. https://doi.org/10.1186/s12913-017-2219-y

Aspin, C., Keenan, R., Muru-Lanning, M., Henare, J., & Lapsley, H. (2024). *Māori Health Authority to be disestablished – Expert Reaction*. Retrieved 20 September from https://www.sciencemediacentre.co.nz/2024/02/27/maori-health-authority-to-be-disestablished-expert-reaction/

Atmore, C., Dovey, S., Gauld, R., & Stokes, T. (2023). What is important for high quality rural health care? A qualitative study of rural community and provider views in Aotearoa New Zealand. *Rural and Remote Health*, *23*(1), 7635. https://doi.org/10.22605/RRH7635

Baker, G., Baxter, J., & Crampton, P. (2019). The Primary Healthcare Claims to the Waitangi Tribunal. *New Zealand Medical Journal*, *132*(1505), 7-13. https://pubmed.ncbi.nlm.nih.gov/31697659/

Barbarich, T. W. (2019). *Tōku reo, tōku whakāetanga, tōku mana : My voice, my informed consent* Auckland University of Technology]. https://openrepository.aut.ac.nz/server/api/core/bitstreams/6b82035e-f633-4c08-a35d-d5dcc7a1a1db/content

Barbo, G., & Alam, S. (2024). Indigenous people's experiences of primary health care in Canada: A qualitative systematic review. *Health Promotion and Chronic Disease Prevention in Canada*, *44*(4), 131-151. https://doi.org/10.24095/hpcdp.44.4.01 (Experiences des Autochtones en matiere de soins de sante primaires au Canada : revue systematique qualitative.)

Barnes, A. (2013). *What can Pākehā learn from engaging in kaupapa Māori educational research?* (978-1-927231-05-0). New Zealand Council for Educational Research.

Bath, J., & Wakerman, J. (2015). Impact of community participation in primary health care: What is the evidence? *Australian Journal Primary Health*, *21*(1), 2-8. https://doi.org/10.1071/PY12164

Beks, H., Amos, T., Bell, J., Ryan, J., Hayward, J., Brown, A., McKenzie, C., Allen, B., Ewing, G., Hudson, K., Clark, R., Morphett, B., Allender, S., Creighton, D., Johnstone, M., & Versace, V. L. (2022). Participatory research with a rural Aboriginal community controlled health organisation: Lessons learned using the CONSIDER statement. *Rural and Remote Health*, *22*(1), 40-52. https://doi.org/10.22605/RRH6740

Beks, H., Mitchell, F., Charles, J. A., McNamara, K. P., & Versace, V. L. (2022). An Aboriginal Community-Controlled Health Organization model of service delivery: Qualitative process evaluation of the Tulku wan Wininn mobile clinic. *International Journal Equity Health*, *21*(1), 163. https://doi.org/10.1186/s12939-022-01768-4

Bishop, R. (1996). *Collaborative research stories: Whakawhanaungatanga*. Dunmore.

Blattner, K., Clay, L., Keenan, R., Taafaki, J., Crengle, S., Nixon, G., Fortune, K., & Stokes, T. (2024). He Aroka Urutā. Rural health provider perspectives of the COVID-19 vaccination rollout in rural Aotearoa New Zealand with a focus on Māori and Pasifika communities: A qualitative study. *Journal of Primary Health Care*, *16*(2), 170-179.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, *13*(2), 201-216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage Publications

Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, *57*(4), 254-258. https://doi.org/10.1136/jech.57.4.254

Brown, H., & Bryder, L. (2023). Universal healthcare for all? Māori health inequalities in Aotearoa New Zealand, 1975-2000. *Social Science and Medicine*, *319*, 115315. https://doi.org/10.1016/j.socscimed.2022.115315

Bushe, G., & Kassam, A. (2005). When is appreciative inquiry transformational? *The Journal of Applied Behavioral Science*, *41*(2), 161-181. https://doi.org/10.1177/0021886304270337

Came, C., O'Sullivan, D., Kidd, J., & Mccreanor, T. (2020). The Waitangi Tribunal's WAI 2575 report implications for decolonsing health systems. *Health and Human Rights*, *22*(1), 209-220. https://www.hhrjournal.org/2020/06/18/the-waitangi-tribunals-wai-2575-report-implications-for-decolonizing-health-systems/

Causer, L. M., Ward, J., Smith, K., Saha, A., Andrewartha, K., Wand, H., Hengel, B., Badman, S. G., Tangey, A., Matthews, S., Mak, D., Gunathilake, M., Moore, E., Speers, D., Persing, D., Anderson, D., Whiley, D., Maher, L., Regan, D., . . . Guy, R. (2024). Clinical effectiveness and analytical quality of a national point-of-care testing network for sexually transmitted infections integrated into rural and remote primary care clinics in Australia, 2016-2022: An observational program evaluation. *The Lancet Regional Health - Western Pacific.*, *48*, 101110. https://doi.org/10.1016/j.lanwpc.2024.101110

Chin, M. H., King, P. T., Jones, R. G., Jones, B., Ameratunga, S. N., Muramatsu, N., & Derrett, S. (2018). Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. *Health Policy*, *122*(8), 837-853. https://doi.org/10.1016/j.healthpol.2018.05.001

Cooperrider, D. L., & Whitney, D. (2005). *Appreciative Inquiry* Berrett-Koehler Publishers

Cram, F. (2017). Kaupapa Māori Health Research. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 1-18). Springer Singapore. https://doi.org/10.1007/978-981-10-2779-6_30-1

Crampton, P. (2020). Oh my. *New Zealand Medical Journal*, *133*(1524), 8-10. https://nzmj.org.nz/media/pages/journal/vol-133-no-1524/oh-my/ad8924d6a8-1696474407/oh-my.pdf:contentReference[oaicite:13]{index=13}

Crampton, P., & Baxter, J. (2018). Rural matters. *New Zealand Medical Journal*, *131*(1485), 6-7. www.nzma.org.nz/journal

Cullen, J., Childerhouse, P., Jayamaha, N., & McBain, L. (2023). Developing a model for primary care quality improvement success: A comparative case study in rural, urban and Kaupapa Māori organisations [Article]. *Journal of Primary Health Care*, *15*(4), 333-342. https://doi.org/10.1071/HC23046

Cunningham, C. (2000). A framework for addressing Māori knowledge in research, science and technology *Pacific Health Dialog*, *7*(1), 62-69.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Curtis, E., Loring, B., Jones, R., Tipene-Leach, D., Walker, C., Paine, S.-J., & Reid, P. (2025). Refining the definitions of cultural safety, cultural competency and Indigenous health: Lessons from Aotearoa New Zealand. *International Journal for Equity in Health*, *24*(1), 130. https://doi.org/10.1186/s12939-025-02478-3

Dalton, S. (2021). Rural health at a crossroads: Tailoring local services for diverse communities. *Association of Salaried Medical Specialists.*(28), 1-15. https://www.asms.org.nz/publications/rural-health-at-a-crossroads/

Denzin, N. K., & Lincoln, Y. S. (2005). *The SAGE handbook of qualitative research* (Third edition. ed.). Sage Publications. http://www.loc.gov/catdir/enhancements/fy0734/2004026085-b.html

Department of the Prime Minister and Cabinet. (2020). *Health and Disability System Review: Cabinet Papers*. New Zealand Government

Dixon, T. W., O'Brien, D. W., Terry, G., Baldwin, J. N., Ruakere, T., Mekkelholt, T., & Larmer, P. J. (2021). The lived experiences of ngā tāne Māori with hip and knee osteoarthritis. *New Zealand Journal of Physiotherapy*, *49*(3), 127-133. https://doi.org/10.15619/nzjp/49.3.03

Downs, S.-M. (2019). *Nga Taumata o te Moana. A return to rangatiratanga over the takutai moana* [Doctorate, The University of Waikato].

Drovandi, A., Smith, D., Preston, R., Morris, L., Page, P., Swain, L., Biros, E., Tremlett, M., Loller, H., Stephens, M., Nugent, A., Vaughan, F., & Couzos, S. (2022). Enablers and barriers to non-dispensing pharmacist integration into the primary health care teams of Aboriginal community-controlled health services [Article]. *Research in Social and Administrative Pharmacy*, *18*(10), 3766-3774. https://doi.org/10.1016/j.sapharm.2022.05.002

Durie, M. (1985). A maori perspective of health. *Social Science and Medicine*, *20*(5), 483-486.

Durie, M. (2004). Understanding health and illness: Research at the interface between science and Indigenous knowledge. *International Journal of Epidemiology*, *33*(5), 1138-1143. https://doi.org/10.1093/ije/dyh250

Durie, M. (2005). Indigenous knowledge within a global knowledge system. *Higher Education Policy*, *18*, 301-312. https://doi.org/10.1057/palgrave.hep.8300092

Eggleton, K. (2020). *Measuring the quality of Māori health providers. A critique of Tauiwi paradigms* [Doctorate Thesis, Auckland University].

Eggleton, K., Anderson, A., & Harwood, M. (2022). The whitewashing of contracts: Unpacking the discourse within māori health provider contracts in Aotearoa/New Zealand. *Health and Social Care in the Community*, *30*(5), e2489-e2496. https://doi.org/10.1111/hsc.13691

Esper, T., Ellinger, A., Stank, T., Flint, D., & Moon, M. (2010). Demand and supply integration: A conceptual framework of value creation through knowledge management. *Journal of the Academy of Marketing Science.*, *38*(1), 5-18.

Fitzpatrick, K. M., Ody, M., Goveas, D., Montesanti, S., Campbell, P., MacDonald, K., Crowshoe, L., Campbell, S., & Roach, P. (2023). Understanding virtual primary healthcare with Indigenous populations: A rapid evidence review. *BMC Health Services Research*, *23*(1), 303. https://doi.org/10.1186/s12913-023-09299-6

Freeman, T., Baum, F., Javanparast, S., Labonte, R., Lawless, A., & Barton, E. (2021). The contribution of group work to the goals of comprehensive primary health care. *Health Promotion Journal Australia*, *32*(1), 126-136. https://doi.org/10.1002/hpja.323

George, J. (2023). *Understanding the complexities of recruitment and retention of allied health professionals in rural health settings* [Doctorate Thesis, Auckland University of Technology].

Gibson, O., Lisy, K., Davy, C., Aromataris, E., Kite, E., Lockwood, C., Riitano, D., McBride, K., & Brown, A. (2015). Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: A systematic review. *Journal of Implementation Science 10*, 71. https://doi.org/10.1186/s13012-015-0261-x

Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: A systematic review of two decades of published qualitative research. *Australian and New Zealand Journal of Public Health*, *44*(3), 193-200. https://doi.org/10.1111/1753-6405.12971

Gupta, P., Choudhury, R., & Kotwal, A. (2023). Achieving health equity through healthcare technology: Perspective from India. *Journal of family medicine and primary care*, *12*(9), 1814-1817. https://doi.org/10.4103/jfmpc.jfmpc_321_23

Hau, K., Cumming, J., Lopez, M. I., Jeffreys, M., Senior, T., & Crampton, P. (2022). *Assessing need for primary care services: Analysis of New Zealand Health Survey data* (Vol. 14).

Health New Zealand. (2023). *Health status report*. https://www.tewhatuora.govt.nz/assets/Publications/Health-status-reports/TWO-5300-Health-Status-Report-Executive-Summary_visuals_P06_V1.pdf

Health New Zealand. (2024). *PHO services agreement*. Website Retrieved from https://www.tewhatuora.govt.nz/assets/For-health-providers/Primary-care-sector/PHO-Services-Agreement-Version-6.6.pdf

HealthPoint. (2022). *Primary Healthcare* Retrieved 18/9/2022 from https://www.healthpoint.co.nz/gps-accident-urgent-medical-care/gp/northland/

Henderson, J., Javanparast, S., MacKean, T., Freeman, T., Baum, F., & Ziersch, A. (2018). Commissioning and equity in primary care in Australia: Views from Primary Health Networks. *Health and Social Care in the Community*, *26*(1), 80-89. https://doi.org/10.1111/hsc.12464

Hobbs, M., Ahuriri-Driscoll, A., Marek, L., Campbell, M., Tomintz, M., & Kingham, S. (2019). Reducing health inequity for Māori people in New Zealand. *The Lancet*, *394*(10209), 1613-1614. https://doi.org/10.1016/S0140-6736(19)30044-3

Hoskins, T. K., & Jones, A. (2020). Māori, Pākehā, critical theory and relationality: A talk by Te Kawehau Hoskins and Alison Jones. *New Zealand Journal of Educational Studies*, *55*(2), 423-429. https://doi.org/10.1007/s40841-020-00174-0

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika Guidelines for Māori research ethics: A framework for researchers and ethics committee members The Pūtaiora Writing Group*.

Huria, T., Palmer, S. C., Pitama, S., Beckert, L., Lacey, C., Ewen, S., & Smith, L. T. (2019). Consolidated criteria for strengthening reporting of health research involving Indigenous peoples: The CONSIDER statement. *BMC Medical Research Methodology*, *19*(1), 1-9. https://doi.org/https://doi.org/10.1186/s12874-019-0815-8

Jaye, C., McHugh, J., Doolan-Noble, F., & Wood, L. (2022). Wellbeing and health in a small New Zealand rural community: Assets, capabilities and being rural-fit. *Journal of Rural Studies*, *92*, 284-293. https://doi.org/10.1016/j.jrurstud.2022.04.005

Jeffreys, M., Ellison-Loschmann, L., Irurzun-Lopez, M., Cumming, J., & McKenzie, F. (2023). Financial barriers to primary health care in Aotearoa New Zealand. *Family Practice*, *41*(6), 995-1001. https://doi.org/10.1093/fampra/cmad096

Jeffreys, M., Irurzun Lopez, M., Russell, L., Smiler, K., Ellison-Loschmann, L., Thomson, M., & Cumming, J. (2020). Equity in access to zero-fees and low-cost primary health care in Aotearoa New Zealand: Results from repeated waves of the New Zealand health survey, 1996-2016. *Health Policy*, *124*(11), 1272-1279. https://doi.org/10.1016/j.healthpol.2020.08.009

Kidd, J., Came, H., Doole, C., & Rae, N. (2022). A critical analysis of te Tiriti o Waitangi application in primary health organisations in Aotearoa New Zealand: Findings from a nationwide survey. *Health and Social Care in the Community*, *30*(1), e105-e112. https://doi.org/10.1111/hsc.13417

Kidd, J., Cassim, S., Rolleston, A., Keenan, R., Lawrenson, R., Sheridan, N., Warbrick, I., Ngaheu, J., & Hokowhitu, B. (2021). View of Hā Ora: Reflecting on a Kaupapa Māori community-engaged co-design approach to lung cancer research. *International Journal of Indigenous Health*, *16*(2), 192-207. https://jps.library.utoronto.ca/index.php/ijih/article/view/33106/27365

Kingi, T. K. (2007). The Treaty of Waitangi: A framework for Māori health development. *New Zealand Journal of Occupational Therapy*, *54*(1), 4-10.

Komene, E., Pene, B., Gerard, D., Parr, J., Aspinall, C., & Wilson, D. (2024). Whakawhanaungatanga—Building trust and connections: A qualitative study Indigenous Māori patients and whānau (extended family network) hospital experiences. *Journal of Advanced Nursing*, *80*(4), 1545-1558. https://doi.org/https://doi.org/10.1111/jan.15912

Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: A framework to enhance the doctor-patient relationship with Māori. *New Zealand Medical Journal*, *124*(1347), 72-78.

Lawton, B., MacDonald, E. J., Storey, F., Stanton, J.-A., Adcock, A., Gibson, M., Parag, V., Sparkes, N. K., Kaimoana, B., King, F., Terry, M., Watson, H., Bennett, M., Lambert, C. S., Geller, S., Paasi, I., Hibma, M., Sykes, P., Hawkes, D., & Saville, M. (2023). A model for empowering rural solutions for cervical cancer prevention (He Tapu Te Whare Tangata): Protocol for a cluster randomized crossover trial. *JMIR Research Protocols*, *12*, e51643. https://doi.org/10.2196/51643

Litchfield, I., Gale, N., Burrows, M., & Greenfield, S. (2017). The future role of receptionists in primary care. *British Journal of General Practice*, *67*(664), 523-524. https://doi.org/10.3399/bjgp17X693401

Love, T., Moore, D., Milkop, A., Woon, L., Young, M., & Comendant, C. (2021). *Methodology for estimating the underfunding of Māori Primary Health Care*.

Lyle, D., Saurman, E., Kirby, S., Jones, D., Humphreys, J., & Wakerman, J. (2017). What do evaluations tell us about implementing new models in rural and remote primary health care? Findings from a narrative analysis of seven service evaluations conducted by an Australian centre of research excellence. *Rural & Remote Health*, *17*(3), 1-9. https://doi.org/10.22605/RRH3926

Marmot, M., & Bell, R. (2012). Fair society, healthy lives. *Public Health*, *126*, S4-S10. https://doi.org/https://doi.org/10.1016/j.puhe.2012.05.014

Martel, R., Reihana-tait, H., Lawrence, A., Shepherd, M., Wihongi, T., & Goodyear-smith, F. (2020). Reaching out to reduce health inequities for Māori youth. *International Nursing Review*(May 2018), 275-281. https://doi.org/10.1111/inr.12565

Mathias, K., & Ahuriri-Driscoll, A. (2025). *Protecting Whānau Ora: Why long-term relationships matter for child health* (2816-1203).

McCalman, J., Bailie, R., Bainbridge, R., McPhail-Bell, K., Percival, N., Askew, D., Fagan, R., & Tsey, K. (2018). Continuous quality improvement and comprehensive primary health care: A systems framework to improve service quality and health outcomes. *Frontiers in public health*, *6*, 76. https://doi.org/10.3389/fpubh.2018.00076

McMenamin, K. E., McMenamin, J. P., & Towers, A. J. (2023). An asset-based evaluation of a novel New Zealand rural health service. *Evaluation Journal of Australasia*, *23*(3), 126-138. https://doi.org/10.1177/1035719x231175874

McPhail-Bell, K., Matthews, V., Bainbridge, R., Redman-MacLaren, M. L., Askew, D., Ramanathan, S., Bailie, J., & Bailie, R. (2018). An "all teach, all learn" approach to research capacity strengthening in Indigenous primary health care continuous quality improvement. *Frontiers in public health*, *6*, 107. https://doi.org/10.3389/fpubh.2018.00107

Mikahere-Hall, A. (2017). Constructing research from an Indigenous Kaupapa Māori perspective: An example of decolonising research. *Wiley*, *15*(3), n/a. https://doi.org/https://doi.org/10.1002/

Minister of Health. (2023). *Rural Health Strategy* M. H. M. o. Health. https://www.health.govt.nz/system/files/2023-06/rural-health-strategy-june-2023.pdf

Ministry of Health. (2015). *Pae ora – healthy futures*. M. H. M. o. Health. https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures

Ministry of Health. (2020). *Key Indicators*. https://minhealthnz.shinyapps.io/nz-health-survey-2019-20-annual-data-explorer/_w_d5f1ab51/#!/key-indicators

Ministry of Health. (2023). *Pae Tū: Hauora Māori Strategy*. https://www.health.govt.nz/publications/pae-tu-hauora-maori-strategy

Mouw, T., & Verdery, A. M. (2012). Network sampling with memory: A proposal for more efficient sampling from social networks. *Sociological Methodology*, *42*(1), 206-256. https://doi.org/10.1177/0081175012461248

Neuwelt, P. M., Kearns, R. A., & Browne, A. J. (2015). The place of receptionists in access to primary care: Challenges in the space between community and consultation. *Social Science and Medicine*, *133*, 287-295. https://doi.org/https://doi.org/10.1016/j.socscimed.2014.10.010

Neuwelt, P. M., Kearns, R. A., & Cairns, I. R. (2016). The care work of general practice receptionists. *Journal of Primary Health Care*, *8*(2), 122-129. https://doi.org/https://doi.org/10.1071/HC15059

New Zealand Government. (1835). *He Whakaputanga o te Rangatiratanga o Nu Tireni - The Declaration of the Independence of New Zealand*. Archives New Zealand. Retrieved August 20 from https://www.archives.govt.nz/discover-our-stories/the-declaration-of-independence-of-new-zealand

Nixon, G., Whitehead, J., Davie, G., Fearnley, D., Crengle, S., de Graaf, B., Smith, M., Wakerman, J., & Lawrenson, R. (2021). Developing the geographic classification for health, a rural-urban classification for New Zealand health research and policy: A research protocol. *Australian Journal of Rural Health*, *29*(6), 939-946. https://doi.org/10.1111/ajr.12778

O'Keefe, B. (2007). De-mystifying PSAAP: A potted history. *New Zealand Doctor*, 37.

O'Malley, V. (2018). *Without He Whakaputanga, there might have been no Treaty of Waitangi*. Retrieved November from https://e-tangata.co.nz/history/without-he-whakaputanga-there-might-have-been-no-treaty-of-waitangi/

Penno, E., Audas, R., & Gauld, R. (2012). *The state of the art? An analysis of New Zealand's population-based funding formular for health services*.

Pihema, C. (2017). *Tūmanako: Kaupapa Māori informed action research with young mothers* [Masters Degree, University of Wellington].

Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand Journal of Psychology*, *36*.

Pullon, S., McKinlay, E., & Dew, K. (2009). Primary health care in New Zealand: The impact of organisational factors on teamwork. *British Journal of General Practice*, *59*(560), 191-197. https://doi.org/10.3399/bjgp09X395003

Radio New Zealand. (2024). *2024 in photos: Hīkoi mō te Tiriti*. Retrieved 17/8/2025 from https://www.rnz.co.nz/news/te-manu-korihi/537875/2024-in-photos-hikoi-mo-te-tiriti

Rae, N. (2024). *Tiriti-based anti-racism praxis of Pākehā critical allies during Aotearoa health system reforms* [PhD thesis, Auckland University of Technology]. Tuwhera. https://openrepository.aut.ac.nz/bitstreams/7d33b630-08a9-42dd-a225-f3a22769ef8d/download

Ramsden, I. M. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* Victoria University of Wellington].

Reeve, C., Humphreys, J., Wakerman, J., Carter, M., Carroll, V., & Reeve, D. (2015). Strengthening primary health care: achieving health gains in a remote region of Australia. *Medical Journal of Australia*, *202*(9), 483-487. https://doi.org/10.5694/mja14.00894

Reid, J., Taylor-Moore, K., & Varona, G. (2014). Towards a social-structural model for understanding current disparities in Maori health and well-being. *Journal of Loss and Trauma*, *19*(6), 514-536. https://doi.org/10.1080/15325024.2013.809295

Reweti, A. (2023). Understanding how whānau-centred initiatives can improve Māori health in Aotearoa New Zealand. *Health Promotion International*, *38*(4), 1-13.

Roman, C. T., Manolica, A., & Ionela Bulat, C. (2024). *Qualitative Analysis of Change Management Models* (Vol. XXIV). University Annals, Economic Sciences Series.

Sapere. (2022). *A future capitation funding approach - addressing health need and sustainability in general practice funding*.

Sheridan, N., Jansen, R. M., Harwood, M., Love, T., Kenealy, T., Group, T. P. C. M. S., Aguirre-Duarte, N., Arroll, B., Atmore, C., Carryer, J., Crampton, P., Dowell, A., Fishman, T., Gauld, R., Hoare, K., Jackson, G., Kerse, N., Lampshire, D., McBain, L., & MacRae, J. (2024). Hauora Māori – Māori health: a right to equal outcomes in primary care. *International Journal for Equity in Health*, *23*(1), 1-20.

Sheridan, N., Kenealy, T., Connolly, M., Mahony, F., Barber, P., Boyd, M., Carswell, P., Clinton, J., Devlin, G., Doughty, R., Dyall, L., Kerse, N., Kolbe, J., Lawrenson, R., & Moffitt, A. (2011). Health equity in the New Zealand health care system: a national survey. *International Journal for Equity in Health*.

Sheridan, N., Love, T., Kenealy, T., Aguirre-Duarte, N., Arroll, B., Atmore, C., Carryer, J., Crampton, P., Dowell, A., Fishman, T., Gauld, R., Harwood, M., Hoare, K., Jackson, G., Jansen, R. M., Kerse, N., Lampshire, D., McBain, L., Macrae, J., . . . Peck, C. (2023). Is there equity of patient health outcomes across models of general practice in Aotearoa New Zealand? A national cross-sectional study. *International Journal for Equity in Health*, *22*(1). https://doi.org/10.1186/s12939-023-01893-8

Simpson, H. (2020). *Health and disability system review: Final report - pūrongo whakamutunga* (978-0-473-51856-1). www.systemreview.health.govt.nz/final-report

Smith, G. (1997). *The development of Kaupapa Maori: Theory and praxis* University of Auckland]. Auckland, New Zealand.

Smith, K., & Jansen, P. (2006). Maori experiences of primary health care: Breaking down the barriers. *NZFP*, *33*(October), 298-300. http://www.nzma.org.nz/journal/115-1167/272/

Smith, L. T. (2000). *Decolonising Methodologies: Research and Indigenous Peoples* (Vol. 29). https://doi.org/10.2307/2653993

Smith, L. T. (2015). Kaupapa Maori research - Some Kaupapa Māori principles *Te Kotahi Research Institute*.

Starfield, B. (2011). The hidden inequity in health care. *International Journal for Equity in Health*, *10*(1), 15. https://doi.org/10.1186/1475-9276-10-15

Starfield, B., Shi, L., Macinko, J., Starfield, B., & Shi, L. (2005). Contribution of primary care to health systems and health *Wiley*, *83*(3), 457-502. https://www.jstor.org/stable/30045625

Statistics New Zealand. (2020). *Urban accessibility - methodology and classification*. https://www.stats.govt.nz/

Statistics New Zealand. (2023). *2023 Census population counts (by ethnic group, age, and Māori descent) and dwelling counts*. Retrieved 17/08/2025 from https://www.stats.govt.nz/information-releases/2023-census-population-counts-by-ethnic-group-age-and-maori-descent-and-dwelling-counts/

Tane, T., Selak, V., Eggleton, K., & Harwood, M. (2025). Rural Māori experiences of accessing heart health care: A Kaupapa Māori qualitative analysis. *Journal of Primary Health Care*, *17*(1), 53-62.

Te Aka Māori Dictionary. (2025). *He waka eke noa*. Retrieved 28 September from https://maoridictionary.co.nz/search?histLoanWords=&idiom=&keywords=he+waka+eke+noa&loan=&phrase=&proverb=&utm_source=chatgpt.com

Te Puni Kōkiri | Ministry of Māori Development. (2010). *Whānau ora: Report of the taskforce on whānau-centred initiatives*.

Te Puni Kōkiri | Ministry of Māori Development. (2018). *Future Demographic Trends for Māori – Part Two*. file:///C:/Users/sfour002/Downloads/46900%20TPK%20Future%20Demographic%20Trends%20Report%20-%20Part%20Two%20(V25)%20FINAL.PDF

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic Analysis *The Sage Handbook Of Qualitative Research In Phychology*

Thomas, S. L., Wakerman, J., & Humphreys, J. S. (2014). What core primary health care services should be available to Australians living in rural and remote communities? [Article]. *BMC Family Practice*, *15*(1), Article 143. https://doi.org/10.1186/1471-2296-15-143

Thomas, S. L., Wakerman, J., & Humphreys, J. S. (2015). Ensuring equity of access to primary health care in rural and remote Australia - What core services should be locally available? [Article]. *International Journal for Equity in Health*, *14*(1), Article 228. https://doi.org/10.1186/s12939-015-0228-1

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Implementing the 4D cycle of appreciative inquiry in health care: A methodological review. *Journal of Advanced Nursing 69*(6), 1224-1234. https://doi.org/10.1111/jan.12086

Waitangi Tribunal. (2019). *Hauora: Report on stage one of the health services outcomes kaupapa inquiry* (9781869563318). www.waitangitribunal.govt.nz

Wakerman, J., Sparrow, L., Thomas, S. L., Humphreys, J. S., & Jones, M. (2017). Equitable resourcing of primary health care in remote communities in Australia's Northern Territory: A pilot study [Article]. *BMC Family Practice*, *18*(1), Article 75. https://doi.org/10.1186/s12875-017-0646-9

Wepa, D. (2016). *Struggling to be Involved: A grounded theory of Māori whānau engagement with healthcare* AUT].

Whakakai. (2022). *Mōteatea -Te Hari o Ngapuhi*. Pou Digital. Retrieved 29 September from https://whakakai.co.nz/te-hari-o-ngapuhi/

Whānau Ora Comissioning Agency. (2019). *Whānau Ora Commissioning Agency - Annual Report*

Whitehead, J., Davie, G., de Graaf, B., Crengle, S., Fearnley, D., Smith, M., Lawrenson, R., & Nixon, G. (2022). Defining rural in Aotearoa New Zealand: a novel geographic classification for health purposes. *New Zealand Medical Journal*, *135*(1559), 24-40. https://doi.org/10.26635/6965.5495

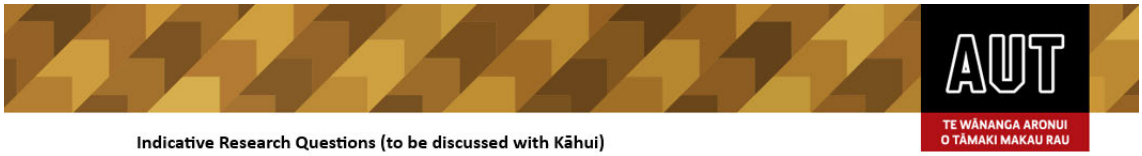
Wilson, D. (2004). *Ngā kairaranga oranga = The weavers of health and wellbeing : A grounded theory study* Massey University]. New Zealand https://mro.massey.ac.nz/items/6a6d841b-8507-4823-8fe2-7d25f1aba09e

Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing*(April), 1-17. https://doi.org/10.1111/jocn.15859

World Health Organization. (2010). *Health Equity*. Retrieved 13/10/2022 from https://www.who.int/health-topics/health-equity#tab=tab_1

Appendices

Appendix A *Indicative Research Questions*



Indicative Research Questions (to be discussed with Kāhui)

Introduction

1. Introduce the researcher and an overview of the study.
2. Discuss research confidentiality.
3. Reassure participants that it is a safe place to kōrero. If participants would like to step out of the session for a break, they are welcome to do so at any time.
4. Explain appreciative inquiry, how the solution-focused method captures what is best, what is working and enables a space to be creative and share ideas around things that could work.
5. Explain the privacy of the data collected and reassure them about how all recordings and transcribed data will be kept confidential.

Provider Pātai:

Discovery	• Please tell me how many years you have been involved in the Northland primary care sector? • What does achieving equity for whānau Māori mean to you? • Tell me about a time where you experienced whānau Māori receiving equitable care?
Dream	• What does an equitable rural primary health service provider look like? • Who is involved in an equitable primary healthcare team? • What resources do you need to be able to deliver this care?
Design	• What are the structures and processes that need to be implemented to make your dream a reality?
Destiny	• What are the next steps?

Patient Pātai:

Discovery	• Please tell me how frequently you visit your primary healthcare provider? • What do you like most about visiting your primary healthcare provider? • What does receiving great healthcare mean to you? • Tell me about the experiences that made you feel good, feel valued and feel heard when you went to a doctor, nurse or other healthcare provider? ○ Think about a provider who made a difference to you. What was it about being with them that made you feel heard and valued?
Dream	• What would a rural primary healthcare service look like that makes you feel welcome and meets your needs? • If your healthcare team did 3 things every time you visited what would they be?
Design	• What are the things that need to be implemented to make this service a reality or great?
Destiny	• What action steps need to take place?

Appendix B *Research Consent Form – Provider*

Research Consent Form – Providers

Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori.

Project Supervisor: Professor Denise Wilson and Dr Te Wai Barbarich-Unasa

Researcher: Jess Morgan-French

- I have read and understood the information provided about this research project in the Information Sheet dated 24.4.2023.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews/focus group and that they will also be audio-taped 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 would like to receive information on the outcomes of the study in the following format (circle one)
- Copy of the full electronic thesis (provide email details below)
    - Copy of a summary findings paper (provide email details below)
    - Other _____(please explain)

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

Email : .....

Phone : .....

Address : .....

Date:

***Approved by the Auckland University of Technology Ethics Committee on type the 8 August 2023 which the final approval was granted AUTEC Reference number* 23/157**

Note: The Participant should retain a copy of this form.

Appendix C *Information Sheet – Provider*

Provider Participant Information Sheet

24.4.2023

Project Title: Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori.

Nō Holland toku tūpuna
I tae mai oku tūpuna ki Aotearoa I te tau 1949
Ko Puhanga Tohora te maunga e rū nei taku ngākau
Ko Ōtaua te awa e mahea nei aku māharahara
Ko Hankrekis rāua ko Jan toku kaumatua
Ko Lexie Pieters toku māmā
Ko Rewiri Morgan-French toku hoa rangatira
E noho ana au ki Kerikeri ki te taha o toku whānau
Ko Jess Morgan-French toku ingoa

I have worked in the primary care health sector for the past ten years. I started as a health coach in general practice, then moved to practice management and primary health organisation service support. I am now working with the General Practice New Zealand (GPNZ) team, a membership-based organisation that advocates for the wellbeing of New Zealanders by supporting high-quality general practice and community-based services.

This is an invitation to participate in research to develop solution-focused concepts based on patient and provider experiences in rural primary care environments to support improvement of Māori health outcomes, access, and equity. This research will involve focus groups and individual interviews to understand rural primary care networks' positive work to enable equitable care for their communities. As a provider I invite you to participate in an interview, sharing your knowledge and understand around what enables equitable service delivery.

This research is a part of my Doctor in Health Science qualification.

The research purpose

The purpose and rationale for this research are to improve health outcomes for Māori within our rural health system. This research can potentially change how rural will seek primary care is delivered through the discovery and advocacy of system fixes. These findings will inform recommendations to Te Aka Whai Ora, Te Whatu Ora, Manatū Hauora, National Primary Care Clinical Leaders and Primary Care Network Support organisations for rural primary care service delivery and service commissioning.

The findings of this research will also be used for academic publications and presentations.

Partcipation

All rural general practices and Māori health providers in Tai Tokerau have been selected to participate in this research. You have received this information sheet as your organisation has been identified as a rural general practice or rural Māori health provider in Tai Tokerau.

If you would like to be involved, contact the researcher. When you make contact, I will organise a time and date that works best for your organisation interviews.

e. jess.morgan-french@gpnz.org.nz

p. 0211615697

Consent forms will be emailed to you prior to the interview date; however, they will be signed on the day with the researcher Your participation in this research is voluntary (it is your choice) and whether you choose to participate 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.

The research process

This research will be capturing qualitative data from both providers and patients. You have been invited to participate in the provider interviews. This involves a 60-minuite one on one or group interview with the researcher. In this interview you will be asked about key enablers within your organisation that create equitable healthcare opportunities for Māori populations. This appreciative inquiry study will also ask you to share ideas and concepts about how you might deliver primary healthcare differently if you had the resources and policy guidelines to do so.

Provider interviews will be held at the healthcare organisation address that the provider associates with. Interviews will be one-on-one, in pairs or in groups depending on what works best for the organisation.

Personal and practice information will be handled with care and stored securely, ensuring participant identities and data remain confidential and protected. Any published results or reports are presented in an aggregated and de-identified manner, preventing individual identification.

You have 3-weeks to consider this invitation to participate.

Risks and discomforts

There are very few discomforts and risks involved in this research. However, if discomforts and risks arise in the data collection process. Referrals to AUT Student Counselling and Mental Health is able. The service will 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 9292.
- 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/student-life/student-support/counselling-and-mental-health

Privacy and partcipation

All data will be stored in a password protected folder on the AUT OneDrive. Only the researcher and the supervisors will have access to the raw data. The data will be aggregated for analysis using pseudonyms to replace organisations names.

It will take up 60 minutes of your time to be involved in this research.

The research thesis, summary of findings and other resources will be available to all participants. You will be asked how you would like this communicated to you during your interview with the researcher.

Concerns about the research

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Denise Wilson, denise.wilson@aut.ac.nz.

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:

Jess Morgan-French
Jess.morgan-french@gpnz.org.nz
0211615697

Project Supervisor Contact Details:

Professor Denise Wilson
denise.wilson@aut.ac.nz
09 921 9999 ext 7392

Dr Te Wai Barbarich-Unasa
tewai.barbarich-unasa@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *8 August 2023*, AUTEC Reference number *23/157*.

Appendix D *Provider Invite Letter*

Kia ora,

Nō Holland toku tūpuna
I tae mai oku tūpuna ki Aotearoa I te tau 1949
Ko Puhanga Tohora te maunga e rū nei taku ngākau
Ko Ōtaua te awa e mahea nei aku māharahara
Ko Hankrekis rāua ko Jan toku kaumatua
Ko Neville Rule rāua ko Lexie Pieters oku matua
Ko Rewiri Morgan-French toku hoa rangatira
E noho ana au ki Kerikeri ki te taha o toku whānau
Ko Jess Morgan-French toku ingoa

I am writing to invite you to participate in an exciting Māori health research project that is taking place in Tai Tokerau (Northland). As a respected rural provider in this region, your insights and expertise are invaluable to the success of this project, and I would be honoured to have your involvement.

This research project aims to explore the operational and governance levers within the rural primary care environment that enables and improves rural health services for Māori. It also aims to explore the health needs and enabling experiences of Māori communities in Northland, and to develop culturally appropriate interventions to improve health outcomes. I believe that this project has the potential to make a real difference in the lives of Māori whānau and communities, and we are committed to ensuring that it is conducted with the utmost respect and sensitivity to Tikanga and Kawa.

Your provider involvement in this project would involve participating in individual provider interviews. Individuals from within your general practice/Māori health provider would self-identify through personal interest and willingness to be involved. The perspectives and experiences captured will help to better understand the enablers and opportunities.

I understand that your time is valuable, and we are committed to ensuring that your involvement in this project is as streamlined and efficient as possible. I will provide necessary support (such as coming to a location that is suitable for you) to facilitate your participation. I am committed to maintaining open lines of communication throughout the project.

If you are interested in participating in this project, or if you would like to learn more about it, please do not hesitate to contact me. I would be more than happy to answer any questions you may have and to provide additional information as needed.

Thank you for considering this invitation, and we look forward to the possibility of working with you on this important project.

Ngā Mihi,

Jess Morgan-French

Appendix E *Recruitment Poster (English)*

AUT
UNIVERSITY

YOUR PATIENT VOICE MATTERS
PARTCIPATE IN RESEARCH

PRIMARY CARE CALL FOR CHANGE
ENABLING RURAL PRIMARY CARE PROVIDERS IN TAI TOKERAU
TO DELIVER EQUITABLE HEALTH SERVICES TO MĀORI.

Kaupapa:

- Self-identified Māori adults aged 16-years and older.
- Participation in a 60-90min whānau face-to-face focus group.
- Share your primary health care experiences and the things that enable you to receive the care you require.
- Koha provided to participants

For more information, contact Jess
e. jess.morgan-french@gpnz.org.nz
p. 0211615697
@ruley.jess (instagram)

Appendix F *Information Sheet - Patient*

Patient Whānau Participant Information Sheet

24.4.2023

Project Title: Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori.

Nō Holland toku tūpuna
I tae mai oku tūpuna ki Aotearoa I te tau 1949
Ko Puhanga Tohora te maunga e rū nei taku ngākau
Ko Ōtaua te awa e mahea nei aku māharahara
Ko Hankrekis rāua ko Jan toku kaumatua
Ko Neville Rule rāua ko Lexie Pieters oku matua
Ko Rewiri Morgan-French toku hoa rangatira
E noho ana au ki Kerikeri ki te taha o toku whānau
Ko Jess Morgan-French toku ingoa

I have worked in the primary care health sector for the past ten years. I started as a health coach in general practice, then moved to practice management and primary health organisation service support. I am now working with the General Practice New Zealand (GPNZ) team, a membership-based organisation that advocates for the wellbeing of New Zealanders by supporting high-quality general practice and community-based services.

This research will seek solution-focused concepts based on patient and provider experiences in rural primary care environments to support improvement of Māori health outcomes, access, and equity. This research will involve focus groups and individual interviews to understand rural primary care networks' positive work to enable equitable care for their communities. As a patient I invite you to participate in a whānau focus group, sharing your knowledge and understanding around what enables equitable service delivery.

This research is a part of my Doctorate in Health Science qualification.

The research purpose

The purpose and rationale for this research are to improve health outcomes for Māori within our rural health system. This research can potentially change how rural primary care is delivered through the discovery and advocacy of system fixes. This work intends to inform and make recommendations to Te Aka Whai Ora, Te Whatu Ora, Manatū Hauora, National Primary Care Clinical Leaders and Primary Care Network Support organisations for rural primary care service delivery and service commissioning.

The findings of this research may be used for academic publications and presentations.

Partcipation

All rural living Māori patients over the age of 16-years old who are able to provide informed and written consent. Whānau focus groups will be held across Tai Tokerau from September to November 2023. Focus groups can be in a quiet private public space such as a library, community building or marae. Wherever the whānau feel most comfortable.

Contact the researcher if you would like to be involved. When you make contact, I will organise a time and date that works best to host a whānau focus group. I encourage you to bring along whānau and friends to the focus group.

e. jess.morgan-french@gpnz.org.nz

p. 0211615697

Consent forms will be emailed to you prior to the focus group date; however, they will be signed on the day with the researcher. Your participation in this research is voluntary (it is your choice) and whether you choose to participate 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.

The research process

This research will be capturing qualitative data from both providers and patients. You have been invited to participate in the patient focus groups. This involves a 90-minuite focus group discussion with the researcher. In this focus group you will be asked about key enablers that support you as Māori to receive health services that meet your needs. This appreciative study (a study that focuses on solutions) will also ask you to share ideas and concepts about how you would like to receive primary healthcare from your rural community providers.

Whānau focus groups will be conducted during September 2023 and January 2024 at a location in Northland that suits the whānau. Groups will be no larger than six people.

Personal information will be handled with care and stored securely, ensuring participant identities and data remain confidential and protected. Any published results or reports are presented in an aggregated and de-identified manner, preventing individual identification.

Risks and discomforts

There are very few discomforts and risks involved in this research. However, if discomforts and risks arise in the data collection process. Referrals to AUT Student Counselling and Mental Health is able. The service will 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 the centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9292.
- 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/student-life/student-support/counselling-and-mental-health

Privacy and partcipation

All data will be stored in a password protected cloud-based environment. Only the researcher will have access to the raw data. The data will be aggregated for analysis using pseudonyms to replace whānau/participant names.

It will take up to 90-minutes of your time to be involved in this research.

The research thesis, summary of findings and other resources will be available to all participants. You will be asked how you would like this communicated to you during your interview or focus group session with the researcher.

Concerns about the research

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Denise Wilson, denise.wilson@aut.ac.nz.

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:

Jess Morgan-French
Jess.morgan-french@gpnz.org.nz
0211615697

Project Supervisor Contact Details:

Professor Denise Wilson
denise.wilson@aut.ac.nz
09 921 9999 ext 7392

Dr Te Wai Barbarich-Unasa
tewai.barbarich-unasa@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *8 August 2023* AUTEC Reference number 23/157.

Appendix G *Research Consent Form - Patient*

Consent Form

Project title: Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori.

Project Supervisor: Professor Denise Wilson and Dr Te Wai Barbarich-Unasa

Researcher: Jess Morgan-French

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 24.4.2023
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the focus group and that it will also be audio-taped 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, while it may not be possible to destroy all records of the focus group discussion of which I was part, 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○
- ○ I wish to receive the researching findings in a different format outlined below.

-

_____

_____

_____

_____

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the 8th of August 2023 which the final approval was granted AUTEC Reference number type the AUTEC reference number **23/157**

Note: The Participant should retain a copy of this form.

Appendix H *Ethics Approval*

Auckland University of Technology Ethics Committee (AUTEC)

8 August 2023

Denise Wilson
Faculty of Health and Environmental Sciences

Dear Denise

Re Ethics Application: **23/157 Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori.**

Thank you for your responses to AUTEC's conditions.

Your ethics application has been approved for three years until 8 August 2026.

Non-Standard Conditions of Approval

1. Amendment of patient Whanau Information Sheet as follows:
    a. Revision of age to 16 years from 20 years in the inclusion criteria;
    b. Inclusion of where Focus Groups may take place;
    c. Replace 'anonymous' with 'confidential' as anonymity is not possible with focus groups (as the participants are known to the researcher);
2. Amendment of provider Information Sheet as follows:
    a. Replace 'anonymous' with 'confidential' as anonymity is not possible with interviews (as the participants are known to the researcher);
3. Amend the Consent Form for the focus groups to use the AUT exemplar for focus groups

Non-standard conditions do not need to be reviewed by AUTEC unless requested but must be completed before commencing your study and the updated documents sent for AUTEC's files.

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.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access 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.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@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: Jess.morgan-french@gpnz.org.nz; tewai.barbarich-unasa@aut.ac.nz

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

Appendix I *Ethics Amendment*

Auckland University of Technology Ethics Committee
(AUTEC)

5 October 2023

Denise Wilson
Faculty of Health and Environmental Sciences

Dear Denise

Re: Ethics Application: **23/157 Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori.**

Thank you for your request for approval of amendments to your ethics application.

The amendment to the data collection protocol (to offer 'provider' focus groups as well as one on one interviews) has been approved.

Non-Standard Conditions of Approval

1. Please use the AUTEC Exemplar that is specifically for focus groups.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed 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.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access 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.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@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: Jess.morgan-french@gpnz.org.nz; tewai.barbarich-unasa@aut.ac.nz

Appendix J *CONSIDER Checklist: Health Research involving Indigenous Peoples*

ITEM		COMMENT	P #
Governance			
1	Describe partnership agreements between the research institution and Indigenous-governing organization for the research (e.g. informal agreements through to MOU or MOA.	Project supported by Kāhui that includes Tai Tokerau manawhenua and individuals who have extensive backgrounds in Māori research. Māori supervision team including Professor Denise Wilson and Dr Te Wai Barbarich-Unasa enagged in Febuary 2023. The researcher is guided by the supervisoary team and the kāhui. A partnership established to support the reseracher and the research with the aim to uphold Te Tiriti o Waitangi, maintain content relvenace for Māori and challenge western pardigms within the research design and application. Māori data will be managed in alignment with the Māori data soveringty principles outlined within the methods chapter.	
2.	Describe accountability and review mechanisms within the partnership agreement that addresses harm minimization.		
3.	Specify how the research partnership agreement includes protection of Indigenous intellectual property and knowledge arising from the research, including financial and intellectual benefits generated (e.g. development of traditional medicines for commercial purposes or supporting the Indigenous community to develop commercialization proposals generated from the research).		
Prioritization			
4.	Explain how the research aims emerged from priorities identified by either Indigenous stakeholder, governing bodies, funders, non-government organization(s), stakeholders, consumers, and empirical evidence.	The study was situated within the literature on primary healthcare inequities and the urgency to change documented in the WAI2575 Hauora report, 2023 NZ Rural Health strategy and academic literature produced in the past 10-years relating to Māori outcomes in rural health, primary care and general practice.	
Relationships (Indigenous stakeholders/participants and research team)			
5.	Specify measures that adhere and honour Indigenous ethical guidelines, processes, and approvals for all relevant Indigenous stakeholders, recognizing that multiple Indigenous partners may be involved, e.g. Indigenous ethics committee approval, regional/national ethics approval processes.	The study received ethical approval, which includes addressing research with Māori. Ethics received on the 8 august 2023. 23/157 Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori.	
6.	Report how Indigenous stakeholders were involved in the research processes (i.e. research design, funding, implementation, analysis, dissemination/recruitment).	The researcher utilised a research kāhui (Māori leadership group) as guidance and reference point throughout the implementation of the study. The kāhui and research kaumatua were involved with supporting the researcher with recruitment of Māori whānau and Māori health organisations where appropriate. Māori whānau groups were asked how they would like to receive the research findings.	
7.	Describe the expertise of the research team in Indigenous health and research.	**Kāhui** – group of Māori leaders and non-Maori researchers who have a particular passion to Māori research have advised and supported the research process. **Supervisors** – Both identify as Māori and are experts in Māori health research. **Primary Researcher** – Non-Māori and therefore supported by the Kāhui and supervisors to conduct the research.	
Methodologies			
8.	Describe the methodological approach of the research including a rationale of methods used and implication for Indigenous stakeholders e.g. privacy and confidentiality (individual and collective).	Decolonisation theory was the underpinning methodological perspective. Māori centred research is the methodology and appreciative inquiry was the primary method.	
9.	Describe how the research methodology incorporated consideration of the physical, social, economic, and cultural environment of the participants and prospective participants (e.g. impacts of colonization, racism, and social justice).	This study uses a Māori-centred research methodology and Māori values and principles. There was an active avoidance on deficit assumptions and the acknowledgement of colonisation has been actively made aware throughout the research process specifically in the background chapter.	

ITEM		COMMENT	P #
Participation			
10.	Specify how individual and collective consent was sought to conduct future analysis on collected samples and data (e.g. additional secondary analyses, third-parties accessing samples (genetic, tissue, blood) for further analyses).	A description of this was outlined in the 'sample' section. Data was only used for the purpose of the thesis and was not identifiable.	
11.	Describe how the resource demands (current and future) placed on Indigenous participants and communities involved in the research were identified and agreed upon including any resourcing for participation, knowledge, and expertise.	All participants received a small in recognition of the value of their contributions and the time taken to participate in the study. The researcher travelled to each of the participants removing travel as a barrier.	
12.	Specify how biological tissue and other samples including data were stored, explaining the processes of removal from traditional lands, if done, and of disposal.	Not applicable	
Capacity			
13.	Explain how the research supported the development and maintenance of Indigenous research capacity (e.g. specific funding of Indigenous researchers).	This study included one researcher working towards her doctorate in health science. The kāhui and supervisors supported the research from an indigenous Māori perspective. The research was self-funded by the researcher.	
14.	Discuss how the research team undertook professional development opportunities to develop the capacity to partner with Indigenous stakeholders.	This is a small study undertaken as part of a doctorate journey. The opportunity for other upcoming non-Māori researchers to learn from the approaches taken will happen once the research is published.	
Analysis and interpretation			
15.	Specify how the research analysis and reporting supported critical inquiry and a strength-based approach that was inclusive of Indigenous values.	This study is grounded in a Māori-centred methodology, led by non-Māori researcher supported by Māori supervisors and a Kāhui.	
Dissemination			
16.	Describe the dissemination of the research findings to relevant Indigenous governing bodies and peoples.	All participants were asked how they would like to receive the research findings. There preferences noted on their consent forms. Most requested a inform meeting one research project complete, others requested a summary of the findings.	
17.	Discuss the process for knowledge translation and implementation to support Indigenous advancement (e.g. research capacity, policy, investment).	Not addressed at this point, however there is intent to share the method process with other researchers and share the findings broadly across the primary and community healthcare sector including to health ministers.	