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Pacific people in Aotearoa New Zealand and the treatment of long-term conditions: a narrative literature review about Pacific people's understandings of health and wellbeing

Lisa Kitione[A], Debbie Ryan[A,*], Ausaga Faasalele Tanuvasa[B] and Ben Gray[C]

For full list of author affiliations and declarations see end of paper

***Correspondence to:**
Debbie Ryan
Pacific Perspectives Limited, Wellington, New Zealand.
Email: debbie@pacificperspectives.co.nz

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ABSTRACT

Introduction. Long-term conditions data for Pacific people show unchanged outcomes over several decades. Research suggests that models of care that recognise diverse understandings of health and wellbeing have benefits for people with long-term conditions and their families and help address longstanding health disparities. **Aim.** To explore Pacific people's understandings of health and wellbeing and, within this context, to examine concepts related to long-term conditions models of care. **Methods.** A narrative review was conducted using broad search terms in key clinical and social science databases and manual searches of Pacific-focused publications to ensure extensive coverage of topics of interest. The methods were well suited to exploring experiential, conceptual themes often underrepresented in systematic reviews. **Results.** Eighteen studies produced over a more than 25-year period (1997–2024) were included. The studies describe values and beliefs that form holistic conceptualisations of Pacific health, centred around family and grounded in a collective sense of wellbeing. They provide insights about how these understandings intersect with socioeconomic and environmental factors to shape context-specific experiences of care for Pacific peoples. **Discussion.** The reviewed studies highlight the 'lived with' effects of long-term conditions that Pacific people and their families experience. They illustrate how the goals of long-term condition models of care, however desirable, may not seem beneficial or feasible for Pacific families if they neglect other dimensions of wellbeing, or fail to consider constraining contextual factors. Literature that challenges conventional concepts in long-term conditions models of care potentially support appropriate approaches for Pacific people and their families.

Keywords: chronic disease management, health equity, models of care, narrative review, Pacific communities, Pacific health, patient journey, primary health care.

Introduction

Preventing, treating and managing long-term conditions (LTCs) are priorities for the health of Pacific people in Aotearoa New Zealand (NZ). A life expectancy gap of more than 5 years between Pacific people and non-Māori, non-Pacific people (NMNP) has been primarily attributed to inequitable LTC outcomes.[1–4] Available LTC data for Pacific people report unchanged, sometimes worsening, outcomes and disparities with the total population over several decades. Diabetes prevalence is estimated to be three -fold higher in Pacific people than for NMNP, with increases and higher rates of complications, including kidney failure and amputations, forecast within the next 20 years.[1,3,5] Trends in stroke incidence and outcomes similarly show persistent differences in incidence and mortality rates between Pacific people and the rest of the population, and a close to a 15-year age difference between Pacific and NZ/European people's experience of stroke.[6] Multimorbidity is also increasing,[7,8] mirroring international patterns.[9,10]

WHAT GAP THIS FILLS

What is already known: Inequities related to long-term conditions for Pacific people in Aotearoa New Zealand have been reported over several decades. Evidence suggests that when models of care reflect diverse understandings of health, it has benefits for people living with long-term conditions and their families that can help reduce longstanding health disparities.

What this study adds: Health research about Pacific people that offers insight to holistic understandings of health and wellbeing, highlights the potential of family-centred long-term condition models of care designed to look beyond the treatment of single conditions.

LTCs require people and their families to engage with hospital, primary and community care services for treatment, symptom management, disability support and end-of-life care.[11,12] Data relating to enrolment in Primary Health Organisations, attendance for diabetes review, and attempts to improve living environments, indicate that Pacific people are motivated to engage with health services.[13,14] However, a lack of access to services and poor quality of care at all levels of the system drive high unmet need that is reflected in LTCs amenable mortality rates being 2.4-fold greater than those for NMNP.[7] Access barriers to care relating to cost, appointments, transport, communication, health literacy and, increasingly, the ability to enrol with a general practice, have long been articulated.[3,13,15–18] Additionally, treatment gaps for Pacific people reported for conditions like diabetes and gout have contributed to poor outcomes and led to significant differences in hospitalisation by ethnicity.[19,20]

Increases in people living with LTCs has prompted debate about how health is defined. The attainability of the World Health Organization (WHO) definition of health ('complete physical, mental and social well-being')[21] has been questioned in relation to people with LTCs experiencing periods of poor 'health' (as defined by WHO) and deteriorating 'health' as their conditions progress. Huber *et al.* argue that defining health as 'the ability to adapt and to self-manage in the face of social, physical and emotional challenges', more appropriately recognises that interacting with health services is only a fraction of day-to-day 'lived with' effects of LTCs.[22] Models of LTC care, such as the Chronic Care Model, acknowledge these 'lived with' realities by promoting self-management,[23–25] partnerships with multidisciplinary health teams,[26] and consideration of socioeconomic determinants of disease in care delivery.[27,28]

Research increasingly asserts that to meet the needs of people living with LTCs and their families, health systems must recognise the preferences, values and beliefs that shape a person's understandings of health and wellbeing.[29] Services designed to reflect diverse conceptualisations of health and wellbeing have benefits for collaborative care, decision-making, communication, behaviour change, and can help reduce longstanding health disparities.[24,29] As part of a study about Pacific people and LTCs, a narrative literature review was undertaken to: (a) explore Pacific peope's understandings of health and wellbeing; and (b) within this context, examine the literature about four key concepts related to LTC models of care used in NZ.

Methods

Narrative review methods were chosen to produce a 'meaningful synthesis' that critically examined and deepened understanding of the study's topics of interest.[30] The methods enabled us to: (a) incorporate a wide range of evidence to form a nuanced picture about Pacific people's understandings of health and wellbeing; and (b) purposively select key concepts related to LTC models of care used in NZ and interpret the literature about them.[31]

Pacific-focused studies were identified through iterative searches conducted in clinical and social science databases (such as PubMed and Google Scholar) and manual searches of Pacific-focused publications (including Pacific Health Dialog and Pacific Health Review). Search terms were developed to ensure broad coverage of relevant literature that included combinations of: 'Pacific people', 'Pacific patients', 'Pacific families'; 'understanding', 'experience', 'perspectives'; and 'long-term conditions'; 'long-term conditions management'; diabetes, cardiovascular disease, respiratory disease, multimorbidity, 'primary care' and 'primary healthcare'. A snowballing approach was used to track references in sourced articles. Expertise of research team members contributed to identifying other relevant sources.

In 2007, the National Health Committee noted a scarcity of LTC research about Pacific people.[11] Although improving, the ongoing shortage of peer reviewed, published Pacific-focused literature in NZ more than 15 years later prompted us to include grey literature, commissioned research and public sector reporting. We collected over 200 references in the process of selecting the 18 Pacific-focused articles presented in this review. Inclusion criteria encompassed studies that: (1) focused on Pacific populations in NZ, as well as the Pacific region, Australia, and the USA on the basis of shared characteristics with Pacific people in NZ (eg a collectivist way of living, socioeconomic and health status); and (2) addressed patient or family perspectives, cultural models of health, or aspects of LTC management. Exclusion criteria applied to studies that did not involve Pacific participants or populations, lacked relevance to LTCs or care delivery, or did not explore health experiences, beliefs, or culturally informed practices.

Purposive selection of four key concepts relating to LTC models of care used in NZ (complexity, patient and family-centred care, self-management support, and cultural competence) aimed to align with health policy priorities for LTC management over the same time period of the 18 studies in the review.[3,32,33]

Results

Eighteen primarily NZ studies were included in the narrative review. Publication dates range from 1997 to 2024, representing a more than 25-year period of research about Pacific people. Of the 18 studies, three describe Pacific understandings of health on an abstracted, conceptual level.[34–36] The remaining studies cover a range of health conditions, including LTCs such as diabetes, chronic kidney disease, and cardiovascular disease. The majority of studies used qualitative methods – commonly in-depth interviews to collect experiential data from participants (sometimes guided by a Pacific conceptual framework). The majority of the studies were also designed to report ethnic-specific Pacific data. Supplementary Table S1 shows included studies arranged chronologically and provides details of each.

Pacific models of holistic health and wellbeing

Pacific conceptual models of health and wellbeing, such as Pulotu-Endemann's Fonofale Model of Health,[34] show understandings of health that encompass interconnected physical, mental and spiritual dimensions, centre relationships with family and culture, and exist in distinct environmental and temporal contexts. They also depict worldviews and specific cultural and linguistic characteristics of Pacific ethnic groups. The Fonua model, for instance, describes Tongan dimensions of health and wellbeing, translated to English as spiritual, mental, physical, community and the environment.[35] Core to the Fonua model is the concept of tauhi vā, denoting the maintenance of relationships between people and the broader environment.[36]

Pacific people's understandings of health care: key messages in the research

The privileging of collective wellbeing over that of the individual is a common theme throughout the studies reviewed. Pacific people's perceptions of health are described as functional – having the ability to perform tasks of daily living and carry out social roles – where understandings of 'function' are underpinned by the interconnected dimensions and relationships described above. In this context, the perceived role for health services is to fix illness that interrupts such function, rather than to maintain function or prevent illness.[13]

Spiritual beliefs and fatalism (the subjugation of events to destiny) were found in some studies to aid responses of denial or a perceived loss of control to a health condition.[37,38] Others described spirituality as a cornerstone of collectivism and core to holistic wellbeing,[39] suggesting a more nuanced understanding of 'fatalism' as a rational acceptance of possible treatment options in the context of limited resources.[40] Several studies show how understandings of health and wellbeing are affected by difficult to understand health information that constrains active efforts by Pacific people with LTCs to seek care and build knowledge about their conditions.[38,40] Not being able to understand health information can be a source of shame and regret for Pacific families.[41] Insights about missed opportunities or an earlier failure to understand the severity of preventable conditions are often gained late in the trajectory of illnesses.[41]

The centrality of family and the home, particularly during periods of illness, is consistently identified as a source of resilience and meaningful focus beyond illness for Pacific people.[39,42–44] In a study about a secondary care Pacific navigator service, individual perceptions of health and wellbeing were found to be inextricable from those of the wider family. Almost all of the families interviewed had multiple members with serious health conditions, who relied on each other for support.[14] This support is often provided in hospital settings that have been reported as foreign environments for many Pacific families,[45] and during hospitalisations that represent 'the very time [people] most wanted to be at home'.[46] To provide this level of care, families absorbed significant costs relating to employment, transport and childcare.[45]

The literature also highlights intersecting and compounding impacts of culture, identity, socioeconomic status, negative experiences of the health system, and entrenched power imbalances on understandings of health and wellbeing and, subsequently, health outcomes experienced.[46] A study of problem gambling, for example, found that cultural factors such as collectivism, family and community responsibilities, and spiritual beliefs, magnified harms for Pacific people.[47] Similarly, a study about Pacific women's up-take of cervical screening, attributed barriers to the 'cultural' role of Pacific women within their families and communities, socioeconomic circumstances, and the delivery modes of preventive health services.[17] The authors note that rather than women avoiding screening, they are 'prioritising total family care at the expense of their personal care…'.[17]

Other studies have focused on how the pressures of poverty and scarce resources narrow the health choices available to many Pacific families, as well as their ability to prioritise health. Research set in South Auckland, examining the perspectives of people with LTCs (two-thirds of whom were Pacific), found that low engagement with health services was associated with powerlessness and the compounding jeopardy of LTCs, poverty, belonging to an ethnic minority group and aging. Participants wanted a relationship with clinicians who understood their health needs in the context of their lives.[46]

Discussion

A narrative review was used in this study to explore Pacific people's understandings of health and to examine four key concepts related to LTC models of care used in NZ. The flexibility of a narrative review approach allowed for the inclusion of diverse published and non-published evidence, which was important given the long-recognised shortage of published research relating to Pacific people and LTCs. It also enabled the selection of studies produced over a more than 25-year period that has seen persistent disparities in LTC outcomes for Pacific people in NZ. The method was suited to exploring experiential and conceptual themes often underrepresented in traditional reviews, such as family-centred care and cultural values.

The 18 reviewed studies offer insights into expansive and holistic Pacific conceptualisations of health and wellbeing centred around family, grounded in a collective sense of wellbeing and encompassing spiritual and environmental dimensions. The studies highlight that policy interventions focused on the person with the condition, or on models of care designed to look beyond the treatment of single conditions, bring people's values and beliefs, experiences of care, and contexts to the fore. They suggest that improving physical health, though undeniably a desirable goal, may not seem beneficial or feasible for a Pacific person and their family if it occurs at the neglect of other dimensions of wellbeing, or without consideration to contextual factors that constrain such goals. With some exceptions (such as Howden–Chapman's research about housing and health,[48] or Māori health tools such as Hua Oranga),[49] this has not been sufficiently recognised by health or social systems in NZ.[29]

Research attention to multimorbidity is building an evidence base more consistent with the studies in this review. Although the focus remains on physical illness, complex pathways to care, psychological distress, and the challenges of treatment adherence and polypharmacy that people with LTCs experience are increasingly prominent in LTC research.[50–53] Concepts such as syndemics, focused on the biosocial complex that consists of 'interacting co-present, or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction', also challenge conventional understandings of disease and health.[54] Similarly, studies about key concepts related to LTC models of care, such as the four discussed below, accentuate contextual factors in family lives, relational care, and the importance of empowered decision-making, and potentially support more appropriate approaches for Pacific people with LTCs and their families.

The descriptor '*complexity*', for example, is frequently used in LTC research, but not always clearly defined. In a medical framing, levels of complexity are associated with patient characteristics, likely disease progression and required medical care.[55] Alternatively, complexity is also used to encompass ideas about the intersection of characteristics such as ethnicity, gender and class that reflect context-specific and entrenched social power imbalances that affect the experiences of diverse population groups.[56–59] As reviewed studies examining the impact of cultural values,[47] gender,[17] and socio-economic position[46] for Pacific people illustrate, complex groups are more likely to encounter barriers to health and social support, and experience unmet need.[60] Complex problems require a trial-and-error and/or patient and family-centred approach that assesses a person's own priorities for health improvement, as opposed to a single disease 'best practice' guideline or protocol that may oversimplify or not reflect what is important to them.[61]

Patient and family-centred care, a health priority in NZ, is treated in the literature as having both relational and transactional dimensions. A UK review of patient experience measures found that although both relational (compassion, responsiveness, emotional support) and transactional (access, coordination, integration) aspects were part of patient-centred care, systems had overwhelmingly focused on measures for the latter.[62] Mead and Bower argue that patient-centred care involves a broadened recognition of each patient's unique context and a 'therapeutic alliance' between patients and doctors.[63] Other literature recommends the identification of treatment priorities for patients with multiple conditions, and better processes for coordinating care beyond the health sector.[64,65]

Models of integrated care (such as Te Pou's model of integrated primary mental health and addiction care) have long been a focus of LTC management in NZ. However, family experiences show that more work is needed for service approaches to reflect their needs, including the incorporation of cultural practices into models of care and employment of Pacific staff able to support cultural needs.[39] Evidence suggests that Whānau Ora approaches developed to support the aspirations of whānau, hold potential to improve engagement and service delivery for Pacific people.[66]

Also contested in the literature is whether the appropriate focus of *self-management support* (SMS) is relational (eg recognises social environment and prior healthcare experiences) or transactional (eg emphasises the monitoring of clinical indicators, action planning).[67] SMS is generally understood as the support people with LTCs receive from their healthcare team to make decisions that support better health outcomes.[68] Critics argue that over-emphasis on transactional activities without understanding a person's capacity to be engaged in collaborative care, risks 'best practice' approaches being imposed on, rather than co-constructed with, the patient (and patients being labelled 'non-compliant' if they are not achieved).[21,69,70] Sheridan *et al.* found that engagement, power sharing, and the building of long-term relationships by providers, translated into provider, patient and carer trust and concordance, which enabled behavioural changes.[66] As it becomes more common for Pacific families living with multiple LTCs or multimorbidity and being reliant on 'bi-directional' carer support,[41] research argues that families should be the 'final arbiter' of whether effective SMS has been experienced.[66]

In relation to *culturally competent systems*, commonly defined as those that incorporate an '…assessment of cross-cultural relations, vigilance towards dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs…',[71] debate is ongoing as to how culture is defined.[72] The definition of culture by cognitive aspects – traditions, language or other characteristics – has created a cultural competence framework focused on developing cross-cultural knowledge, communication skills, and respecting differences between groups. Critics argue that this approach assumes a static-like culture and group homogeneity that can lead to stereotyping.[73] A broadened approach considers culture in the context of structural and political factors, which influence an person's social status and impact on health behaviours and outcomes. Interventions shaped by this approach focus on addressing power structures, systemic factors and racism.[74,75]

Limitations of the research

This narrative review intended to achieve a contextualised interpretation and synthesis of evidence to address a multifaceted research question. We acknowledge that selection methods may have led to bias and omissions, despite steps taken by the researchers to mitigate this. Additionally, although we cite a persistent shortage of LTC research focused on Pacific populations, narrative review methods did not enable conclusions to be drawn about knowledge gaps to inform future activity in the same way that a systematic review would have.

Conclusion

Pacific people in NZ experience a persistent burden of LTCs and multimorbidity. A small body of research about Pacific people, including the 18 studies in this narrative review, describes holistic understandings of health and wellbeing, and provides insights about the impact of their intersection with socioeconomic and environmental factors. The studies provide insight into the day- to-day 'lived with' effects of LTCs that many Pacific families experience, and highlight the paradigm shift needed to sufficiently value the knowledge required to develop culturally responsive, family-centred LTC strategies. Literature that is challenging conventional concepts in LTC models of care may potentially support appropriate approaches for Pacific people with LTCs and their families.

Supplementary material

Supplementary material is available online.

References

1 Health Quality & Safety Commission. Bula Sautu – A window on quality 2021: Pacific health in the year of COVID-19. Health Quality & Safety Commission, NZ: Wellington; 2021. Available at https://www.hqsc.govt.nz/assets/Our-data/Publications-resources/BulaSautu_WEB.pdf [Accessed 7 October 2024].

2 Ryan D, Grey C, Mischewski B. Tofa Saili: A review of evidence about health equity for Pacific Peoples in New Zealand. Wellington: Pacific Perspectives Ltd; 2019.

3 Minister of Health. Te Mana Ola: The Pacific Health Strategy. Wellington, New Zealand: Ministry of Health; 2023.

4 Walsh M, Grey C. The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand—a decomposition analysis. *N Z Med J* 2019; 132(1492): 46–60.

5 PwC, Diabetes New Zealand. The economic and social cost of type 2 diabetes; 2021. Available at https://healthierlives.co.nz/wp-content/uploads/Economic-and-Social-Cost-of-Type-2-Diabetes-FINAL-REPORT_Secure-5.pdf [Accessed 9 October 2024].

6 Feigin VL, Krishnamurthi RV, Barker-Collo S, *et al.* 30-Year trends in stroke rates and outcome in Auckland, New Zealand (1981-2012): a multi-ethnic population-based series of studies. *PLoS One* 2015; 10(8): 0134609. doi:10.1371/journal.pone.0134609

7 Gurney J, Stanley J, Sarfati D. The inequity of morbidity: disparities in the prevalence of morbidity between ethnic groups in New Zealand. *J Comorb* 2020; 10: 2235042X20971168. doi:10.1177/2235042X20971168

8 Ajwani S, Blakely T, Robson B, *et al.* Decades of disparity: ethnic mortality trends in New Zealand 1980-1999. Wellington: Ministry of Health and University of Otago; 2003. Available at https://www.otago.ac.nz/wellington/otago024494.pdf [Accessed 7 October 2024].

9 Palladino R, Tayu Lee J, Ashworth M, *et al.* Associations between multimorbidity, healthcare utilisation and health status: evidence from 16 European countries. *Age Ageing* 2016; 45(3): 431–435. doi:10.1093/ageing/afw044

10 Barnett K, Mercer SW, Norbury M, *et al.* Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; 380(9836): 37–43. doi:10.1016/S0140-6736(12)60240-2

11 National Health Committee. Meeting the needs of people with chronic conditions. Wellington, NZ: Ministry of Health; 2007. Available at https://www.health.govt.nz/system/files/2016-03/meeting-needs-chronic-conditions-feb07.pdf [Accessed 7 October 2024].

12 Reynolds R, Dennis S, Hasan I, *et al.* A systematic review of chronic disease management interventions in primary care. *BMC Fam Pract* 2018; 19(1): 11. doi:10.1186/s12875-017-0692-3

13 Southwick M, Kenealy T, Ryan D. Primary care for Pacific people: a Pacific health and systems approach. Report to the Health Research Council and the Ministry of Health. Wellington, NZ: Pacific Perspectives Ltd; 2012. Available at https://www.researchgate.net/publication/266318984_Primary_Care_for_Pacific_People_A_Pacific_and_Health_Systems_approach [Accessed 7 October 2024].

14 Pacific Perspectives Ltd. Health care experiences of Pacific families who have children with rheumatic fever: report to Counties Manukau Health; 2009. Wellington, NZ: Pacific Perspectives Ltd; 2009. Available at https://www.nzdoctor.co.nz/sites/default/files/2020-05/2015.06.3%20Pacific%20RhF%20Families%20experience_v1.pdf [Accessed 7 October 2024].

15 Wai KC, Elley CR, Nosa V, *et al.* Perspectives on adherence to blood pressure-lowering medications among Samoan patients: qualitative interviews. *J Prim Health Care* 2010; 2(3): 217–224.

16 McKinlay E, Graham S, Horrill P. Culturally and linguistically diverse patients' views of multimorbidity and general practice care. *J Prim Health Care* 2015; 7(3): 228–235.

17 Foliaki S, Matheson A. Barriers to cervical screening among Pacific women in a New Zealand urban population. *Asian Pac J Cancer Prev* 2015; 16(4): 1565–1570. doi:10.7314/apjcp.2015.16.4.1565

18 Pledger M, Irurzun-Lopez M, Mohan N, *et al.* An area-based description of closed books in general practices in Aotearoa New Zealand. *J Prim Health Care* 2023; 15(2): 128–134. doi:10.1071/HC23035

19 Grey C, Sandford L, Walsh M. Pacific health snapshot in the Auckland region. A report to the Auckland DHB and Waitematā

DHB Community and Public Health Advisory Committee. Auckland: Auckland DHB and Waitematā DHB; 2019.

20 Health New Zealand | Te Whatu Ora. Aotearoa New Zealand Health Status Report 2023. Auckland: Health New Zealand | Te Whatu Ora; 2024. Available at https://www.tewhatuora.govt.nz/publications/health-status-report/ [Accessed 9 October 2024].

21 World Health Organization. Constitution. World Health Organization; 1989. Available at https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1 [Accessed 9 October 2024].

22 Huber M, Knottnerus JA, Green L, *et al.* How should we define health? *BMJ* 2011; 343(7817): 235–237. doi:10.1136/bmj.d4163

23 Bodenheimer T, Lorig K, Holman H, *et al.* Patient self-management of chronic disease in primary care. *JAMA* 2002; 288(19): 2469–2475. doi:10.1001/jama.288.19.2469

24 Carryer J, Doolan-Noble F, Gauld R, *et al.* New Zealand patients' perceptions of chronic care delivery'. *J Integr Care* 2014; 22(2): 71–80. doi:10.1108/JICA-12-2013-0048

25 Grilo AM, dos Santos MC, Gomes AI, *et al.* Promoting patient-centered care in chronic disease. In: Sayligil O, editor. Patient centered medicine. InTech; 2017.

26 Grover A, Joshi A. An overview of chronic disease models: A systematic literature review. *Glob J Health Sci* 2014; 7(2): 210–227. doi:10.5539/gjhs.v7n2p210

27 Rea H, Kenealy T, Wellingham J, *et al.* Chronic care management evolves towards integrated care in Counties Manukau, New Zealand. *N Z Med J* 2007; 120(1252): 2489.

28 Boehmer KR, Abu Dabrh AM, Gionfriddo MR, *et al.* Does the chronic care model meet the emerging needs of people living with multimorbidity? A systematic review and thematic synthesis. *PLoS One* 2018; 13(2): 0190852. doi:10.1371/journal.pone.0190852

29 Askerud A, Jaye C, McKinlay E, *et al.* What is the answer to the challenge of multimorbidity in New Zealand? *J Prim Health Care* 2020; 12(2): 118–121. doi:10.1071/HC20028

30 Greenhalgh T, Thorne S, Malterud K. Time to challenge the spurious hierarchy of systematic over narrative reviews? *Eur J Clin Invest* 2018; 48(6): 12931. doi:10.1111/eci.12931

31 Sukhera J. Narrative reviews: flexible, rigorous, and practical. *J Grad Med Educ* 2022; 14(4): 414–417. doi:10.4300/JGME-D-22-00480.1

32 King A. The New Zealand health strategy. Wellington, NZ: Ministry of Health; 2000.

33 Minister of Health. New Zealand health strategy: future direction. Welllington, NZ: Ministry of Health; 2016.

34 Pulotu-Endemann FK. "Fonofale Model of Health" 2001. Presented to Massey University Health Promotion Forum, Wellington; 2009. Available at https://d3n8a8pro7vhmx.cloudfront.net/actionpoint/pages/437/attachments/original/1534408956/Fonofalemodelexplanation.pdf?1534408956 [Accessed 7 October 2024].

35 Tu'itahi S. Why Pasifika health models? Do they work? (From Fonua to Fonua Ola). Presentation on behalf of Health Promotion Forum of New Zealand and Auckland University of Technology, Auckland; 2015. Available at https://hpfnz.org.nz/assets/Uploads/From-Fonua-to-Fonua-Ola.pdf [Accessed 7 October 2024].

36 Mila-Schaaf K. Pacific health research guidelines: the cartography of an ethical relationship. *Int J Soc Sci* 2009; 60(195): 135–143. doi:10.1111/j.1468-2451.2009.01707.x

37 Paddison CA. Exploring physical and psychological wellbeing among adults with Type 2 diabetes in New Zealand: identifying a need to improve the experiences of Pacific peoples. *N Z Med J* 2010; 123(1310): 30–42.

38 Barnes L, Moss-Morris R, Kaufusi M. Illness beliefs and adherence in diabetes mellitus: a comparison between Tongan and European patients. *N Z Med J* 2004; 117(1188): U743.

39 Mulipola TI, Holroyd E, Vaka S. Using Fa'afaletui to explore Samoan consumers' experience and interpretation of mental health person-centred care in Aotearoa, New Zealand. *Int J Ment Health Nurs* 2023; 32(2): 513–523. doi:10.1111/inm.13090

40 Brewer KM, Taueetia-Su'a T, Hanchard S, *et al.* Māori and Pacific families' experiences and perspectives of cardiovascular care; A qualitative study. *Aust N Z J Public Health* 2024; 48(3): 100149. doi:10.1016/j.anzjph.2024.100149

41 Schmidt-Busby J, Wiles J, Exeter D, *et al.* Understandings of disease among Pacific peoples with diabetes and end-stage renal disease in New Zealand. *Health Expect* 2019; 22(5): 1122–1131. doi:10.1111/hex.12946

42 Kaholokula JK, Saito E, Mau MK, *et al.* Pacific Islanders' perspectives on heart failure management. *Patient Educ Couns* 2008; 70(2): 281–291. doi:10.1016/j.pec.2007.10.015

43 Sheridan N, Kenealy T, Salmon E, *et al.* Helplessness, self-blame and faith may impact on self-management in COPD: a qualitative study. *Prim Care Respir J* 2011; 20(3): 307–314. doi:10.4104/pcrj.2011.00035

44 Bathgate M, Pulotu-Endemann FK. Pacific people in New Zealand. In: Ellis PM & Collings SC, editors. Mental Health in New Zealand from a Public Health Perspective. Wellington, NZ: Ministry of Health; 1997. p. 104–35.

45 Arlidge B, Abel S, Asiasiga L, *et al.* Experiences of whānau/families when injured children are admitted to hospital: a multi-ethnic qualitative study from Aotearoa/New Zealand. *Ethn Health* 2009; 14(2): 169–183. doi:10.1080/13557850802307791

46 Sheridan N, Kenealy T, Parsons M, *et al.* Health reality show: regular celebrities, high stakes, new game: a model for managing complex primary health care. *N Z Med J* 2009; 122(1301): 31–42.

47 Kolandai-Matchett K, Langham E, Bellringer M, *et al.* How gambling harms experienced by Pacific people in New Zealand amplify when they are culture-related. *Asian J Gambl Issues Public Health* 2017; 7(2017): 5. 1–20. doi:10.1186/s40405-017-0026-3

48 Howden-Chapman P, Bennett J, Edwards R, *et al.* Review of the impact of housing quality on inequalities in health and well-being. *Annu Rev Public Health* 2023; 44(1): 233–254. doi:10.1146/annurev-publhealth-071521-111836

49 Durie M, Kingi TK. A framework for measuring Māori mental health outcomes. A report prepared for the Ministry of Health by Massey University, Department of Māori Studies Te Pūmana Hauora; 1997. Available at https://www.massey.ac.nz/documents/513/T_Kingi_M_Duire_A_framework_for_measuring_maori_mental_health_outcomes.pdf [Accessed 7 October 2024].

50 Smith S, Soubhi H, Fortin M, *et al.* Managing patients with multimorbidity: systematic review of interventions in primary care and community settings. *BMJ* 2012; 345: e5205. doi:10.1136/bmj.e5205

51 Kuluski K, Ho JW, Hans PK, *et al.* Community care for people with complex care needs: bridging the gap between health and social care. *Int J Integr Care* 2017; 17(4): 2. doi:10.5334/ijic.2944

52 May CR, Masters J, Welch L, *et al.* EXPERTS 1—experiences of long-term life-limiting conditions among patients and carers: protocol for a qualitative meta-synthesis and conceptual modelling study. *BMJ Open* 2015; 5: e007372. doi:10.1136/bmjopen-2014-007372

53 Smith SM, Wallace E, O'Dowd T, *et al.* Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. *Cochrane Database Syst Rev* 2016; 3(3): CD006560. doi:10.1002/14651858.CD006560.pub3

54 Singer M, Bulled N, Ostrach B, *et al.* Syndemics and the biosocial conception of health. *Lancet* 2017; 389(10072): 941–950. doi:10.1016/S0140-6736(17)30003-X

55 Ham C. The ten characteristics of the high-performing chronic care system. *Health Econ Policy Law* 2010; 5(Pt 1): 71–90. doi:10.1017/S1744133109990120

56 Mechanic D, Tanner J. Vulnerable people, groups, and populations: societal view. *Health Aff (Project Hope)* 2007; 26(5): 1220–1230. doi:10.1377/hlthaff.26.5.1220

57 Richard L, Furler J, Densley K, *et al.* Equity of access to primary healthcare for vulnerable populations: the IMPACT international online survey of innovations. *Int J Equity Health* 2016; 15(2016): 1–20. doi:10.1186/s12939-016-0351-7

58 Lamb J, Bower P, Rogers A, *et al.* Access to mental health in primary care: a qualitative meta-synthesis of evidence from the experience of people from 'hard to reach' groups. *Health* 2017; 16(1): 76–104. doi:10.1177/1363459311403945

59 Gkiouleka A, Wong G, Sowden S, *et al.* Reducing health inequalities through general practice: a realist review and action framework. *Health Soc Care Deliv Res* 2024; 12(7): 1–104. doi:10.3310/YTWW7032

60 Mercer SW, Guthrie B, Furler J, *et al.* Multimorbidity and the inverse care law in primary care: inequalities set to rise as criteria for funding change in the UK. *BMJ* 2012; 345(7867): 10.

61 Gray B. The Cynefin framework: applying an understanding of complexity to medicine. *J Prim Health Care* 2017; 9(4): 258–261. doi:10.1071/HC17002

62 Robert G, Cornwell J, Brearley S, *et al*. 'What matters to patients'? Developing the evidence base for measuring and improving patient experience; project report for the Department of Health and NHS Institute for Innovation and Improvement. Department of Health. NHS Institute for Innovation & Improvement; London, UK: Department of Health; 2011.

63 Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000; 51(7): 1087–1110. doi:10.1016/s0277-9536(00)00098-8

64 Salisbury C. Multimorbidity: redesigning health care for people who use it. *Lancet* 2012; 380(9836): 7–9. doi:10.1016/S0140-6736(12)60482-6

65 Øvretveit J. Evidence: does clinical coordination improve quality and save money? London: The Health Foundation; 2011. Available at: https://www.health.org.uk/sites/health/files/DoesClinicalCoordinationImproveQualityAndSaveMoneyVol2_fullversion.pdf [Accessed 9 October 2024].

66 Sheridan N, Kenealy T, Kuluski K, *et al.* Are patient and carer experiences mirrored in the Practice Reviews of Self-management Support (PRISMS) provider taxonomy? *Int J Integr Care* 2017; 17(2): 8. doi:10.5334/ijic.2483

67 Lau-Walker M, Thompson DR. Self-management in long-term health conditions—A complex concept poorly understood and applied? *Patient Educ Couns* 2009; 75(2): 290–292. doi:10.1016/j.pec.2009.02.001

68 Ahmad N, Ellins J, Krelle H, *et al.* Person-centred care: from ideas to action. London: The Health Foundation; 2014. Available at: https://www.health.org.uk/sites/default/files/PersonCentredCareFromIdeasToAction.pdf [Accessed 9 October 2024].

69 Gray B. Bioethics for New Zealand/Aotearoa. *N Z Med J* 2014; 127(1397): 67–76.

70 Kutner NG. Paradigm tension in management of chronic disease. In: Kronenfeld JJ, editor. Reorganizing health care delivery systems: Problems of managed care and other models of health care delivery (Research in the sociology of health care: Volume 21: 107–123). Leeds, UK: Emerald Group Publishing Limited; 2003. doi:10.1016/S0275-4959(03)21006-1.

71 Betancourt JR, Green AA, Carrillo JE, *et al.* Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 2003; 118: 293–302. doi:10.1093/phr/118.4.293

72 Lo MC, Stacey CL. Beyond cultural competency: bourdieu, patients and clinical encounters. *Sociol Health Illn* 2008; 30(5): 741–755. doi:10.1111/j.1467-9566.2008.01091.x

73 Tualaulelei E, McFall-McCaffery J. The Pacific research paradigm: opportunities and challenges. *Mai J* 2017; 8(2): 188–204. doi:10.20507/MAIJournal.2019.8.2.7

74 Williamson M, Harrison L. Providing culturally appropriate care: a literature review. *Int J Nurs Stud* 2010; 47(6): 761–769. doi:10.1016/j.ijnurstu.2009.12.012

75 Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Serv Res* 2014; 14: 99. doi:10.1186/1472-6963-14-99

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Author affiliations

[A]Pacific Perspectives Limited, Wellington, New Zealand.

[B]Te Hikuwai Rangahau Hauora - Health Services Research Centre, Te Wāhanga Tātai Hauora - Wellington Faculty of Health, Te Herenga Waka - Victoria University of Wellington, Rutherford House, Piptea Campus, Bunny Street, Wellington 6011, New Zealand.

[C]Department of Primary Health Care & General Practice, University of Otago, Wellington, New Zealand.