Literature review

Readying nursing students for culturally grounded practice that supports a new vision of older persons' healthcare environments

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1 | Introduction

This literature review comprises part of the final project outcomes from the 2024 Ako Aotearoa Research and Innovation Agenda (AARIA) and Toi Ohomai Institute of Technology co-funded inquiry into strategies that equip nursing students for culturally grounded practice in older persons' healthcare provision. The review draws on published studies and publicly available policy, reports and opinion pieces from New Zealand and overseas with a particular focus on two distinct population groups. Māori, as tangata whenua, and Chinese New Zealanders, representing this country's growing multicultural diversity, have in common that they are both traditionally non-western ethnicities. Many of the studies referred to in this review attest to experiences of ageing in which provision was not always well-aligned with cultural preferences or expectations. The ultimate purpose in overviewing such accounts of lived experiences, alongside more general discussion of healthcare and ageing, is to guide the development of culturally-responsive teaching and learning resources and prepare our nursing graduates for the realities of practice in present-day Aotearoa New Zealand.

An integrated, iterative review methodology

The literature review process and the selected presentation which appears in a publication is an important part of any scientific paper or research (Kosztyán et al., 2021). It provides readers with an overview of current knowledge on a topic, identifying relevant theories, themes and gaps in a synthesised summary, providing context for the research being presented. The current review uses an integrated approach to summarise empirical or theoretical literature and commentary from diverse sources, including published and 'grey' (non-academic) literature, such as government and agency documents, and media reports. Integrative reviews also use a range of tools and descriptive methods, including transparent and reproducible search records, and content analysis (Broome, 2000; Whittemore & Knafl, 2005). Adding the concept of iterations allowed the researchers to build this review across the timespan of the project, reconsidering original classification of sources and the review's structural framework as new material was identified and incorporated.

The literature search process commenced via key databases available through the researchers' institute's subscriptions and library memberships, initially through the *EBSCO Discovery* search engine, which incorporates multiple specialist databases and individual e-journal subscriptions. Other databases available included: *Biomedical Reference Collection: Basic* (Ebsco), *Cumulative Index to Nursing and Allied Health Literature CINAHL Complete* (Ebsco), *Cochrane Library*, *DynaMed Plus* (Ebsco), *Health Source: Nursing/Academic* (Ebsco), *Joanna Briggs Institute (JBI)*, *Nursing and Allied Health (ProQuest)*, *PubMed Central*, *ScienceDirect (esp for IPC)*, and *ERIC*. The most useful of these were *Cochran* and *Joanna Brigs Institute (JBI)* with their long history and reputation as repositories of nursing and nursing education research. *Google Scholar* was used to find full text articles and others were sourced through our organisation's library inter-loan system.

Key words which guided the search included combinations of "culture/cultural/biculturalism", "Māori" and "Chinese/Chin*", "nursing" and "nurse education", with descriptors such as "wellbeing"; "well-being", "aged health", "ageing", "aged care", "elderly", "older persons", "older adults", "retirement" and "good practice". Most of the data found were from nursing and allied health sources, yet also identified medicine, gerontology

and social work research. Adding the word "care" to the search words produced large numbers of hits, but often outside the scope of this research. As a preference, search parameters specified sources from 2010 and later.

A well-used framework for managing source material during the data-gathering phase of a qualitative literature review is the SPICE tool (NCCMT, 2018), using a series of headings suggested by the acronym: *Setting; Perspective; Intervention; Comparison; Evaluation*. Using an Excel Spreadsheet, it was relatively straightforward to organise the content, for example, "*Setting*" included "country", "population/ethnicity", "research site"; and "*Perspective*" included sub-headings such as "nurses", "other practitioners'', "educators", "students", and "clients/older people". "*Intervention*" was where we recorded aspects of culture and "*Comparison*" noted sources related to "Māori" and "Chinese" in particular. "*Evaluation*" allowed us to mark sources with interventions, initiatives and strategies which appeared relevant or transferable to our context. We found that using this tool enabled our synthesising of sources, themes and placement, as well as assisting with decisions related to inclusion and exclusion of materials.

Four cornerstones

In the interests of transparency, a critical acknowledgement of four key sources is offered ahead of the following content review.

1. Honeyfield, J., Fraser, C., & White, M. (2021). *What is good practice in aged healthcare provision? A literature review of international studies informed by cultural context: The Aotearoa New Zealand perspective*. [Report]. Sino-New Zealand Aged Healthcare Association & Te Pūkenga – New Zealand Institute of Skills and Technology. Available from: static1.squarespace.com › SNZAHC+Lit+Review_June17

This is a large meta-review conducted by the researchers, which underpins the current study. The focus here was on identifying good practice reports regarding aged healthcare provision, seeking to reposition healthcare of older people as an attractive and valued career choice. While this review also utilised cultural lens theory, the scope was somewhat broader than the current study, and included three strands: Wellness and positive ageing; Culture and indigenous populations; and Education.

2. Mumme, K., Davey, J. & Kerse, N. (2023). *Research on ageing and older people: An Aotearoa New Zealand bibliography (2015–2022).* New Zealand Association of Gerontology: Auckland.

An extensive annotated bibliography, arranged alphabetically in categories which reflect social and economic aspects of ageing in New Zealand, such as the care of older people, maintaining independence and ageing in place, social involvement, and ethnicities.

3. Kerse, N., Teh, R., Moyes, S. A., Broad, J., Rolleston, A., Gott, M., Kepa, M., Wham, C., Hayman, K., Jatrana, S., Adamson, A. & Lumley, T. (2015). Cohort profile: Te Puāwaitanga o Ngā Tapuwae Kia Ora Tonu, Life and Living in Advanced Age: A cohort study in New Zealand (LiLACS NZ). *International Journal of Epidemiology, 44*(6): 1823-1832. doi: 10.1093/ije/dyv103

The LiLACS NZ study and numerous publications 2014 – present day, represented by this early publication cited above, derive from a longitudinal cohort study of Māori and non-Māori, aged 80 years and over. Situated in the Faculty of Medical and Health Sciences, University of Auckland, the large number of reports and articles are a rich source of quantitative and qualitative data and analysis related to health, wellness and healthcare in advanced age.

4. Hokowhitu, B., Oetzel, J. G., Simpson, M. L., Nock, S., Reddy, R., Meha, P., Johnston, K., Jackson, A. M., Erueti, B., Rewi, P., Warbrick, I., Cameron, M. P., Zhang, Y. S. & Ruru, S. (2020). Kaumātua Mana Motuhake Poi: A study protocol for enhancing wellbeing, social connectedness and cultural identity for Māori elders. *BMC Geriatrics, 20*(1): 15. doi: 10.1186/s12877-020-01740-3

"Kaumātua Mana Motuhake: Empowering older Māori to navigate life's challenges through peer education" is a University of Waikato/Rauawaawa Kaumātua Charitable Trust partnership project examining a peer-mentorship programme — "for kaumātua, by kaumātua", funded through the Ageing Well National Science Challenge. This strength-based approach leverages kaumātua knowledge and skills and emphasises mana motuhake (autonomy and self-actualisation) and Māori worldviews and has resulted in multiple publications.

2 | Defining Culture

There are almost as many definitions of culture as there are research publications which report on it, disciplines to which it is central, initiatives designed to protect it and activities which celebrate it. An earlier literature review (Honeyfield et al., 2021) identified four distinct approaches, largely directed by the drivers and interests of the groups which generate them. First, is the view of culture from the founding fields of anthropology and psychology, initially related to visible geographic, national, racial and linguistic differences, and then expanded to shared experiences and social influences such as religion, gender, sexual orientation, (dis)ability, and social class/caste (Hardin et al., 2014). A second definitional grouping is from organisations such as the United Nations (2012) and the World Health Organisation (2016; 2020) which see culture in social, political and economic terms, including concepts like social inclusiveness and rootedness, resilience, creativity and the use of local resources, skills, and indigenous knowledge. Third is a view of culture determined more by research and policy about a particular way of life separating particular groups and populations according to the objectives of the authors, and which has given rise to common-use variants, such as mono-, multi-, inter-, or trans-cultural (Soini and Dessein, 2016). Fourth, and most useful as a framework for this review, is that generated by the country in which the researcher and the researched are situated, and which is immediately recognisable by those whom the research is primarily intended to inform or benefit.

Accordingly, the local, and official definition of culture provided by Statistics New Zealand (2009) which guides this project is:

> Culture can be defined as a general way of life that contributes to national identity and society. Culture can also be defined as the shared knowledge, values, and practices of specific groups…Cultural expression and participation contribute to individual well-being and sense of belonging. The expression of, and respect for, cultural practices, language, and beliefs is part of a socially cohesive society. These expressions of culture are sustained by being passed down generations, and through the protection of heritage. (p. 127)

Biculturalism and te Tiriti o Waitangi/the Treaty of Waitangi

As encapsulated in its name, Aotearoa New Zealand is a bicultural, or dual heritage nation. Biculturalism refers to the equal rights, protection and status of Māori and non-Māori. The basis of our country's societal and legislative model of biculturalism and thus the inclusion of indigenous people as partners in public policy was established in 1840 with the signing of te Tiriti o Waitangi between the Māori and the Crown. Today this treaty is fundamental to the guarantee of the "official recognition of Māori language, culture and modes of social organisation, and their incorporation into government protocols, discourses, administration and policy considerations" (McCormack, 2012, p. 285). While there is some criticism that Māori culture is often "caught in the crossfire", "objectified", or risks being reduced as "a means to an end – i.e. … being appropriated by Pākehā (people of European descent) for political and ideological interests" (Meier & Culpan, 2020, p. 222), most New Zealanders would likely acknowledge that while full realisation of biculturalism is not yet achieved, it is an important, shared national aspiration (Fraser et al., 2020).

Māori, as *tangata whenua* (the people of the land) have a special relationship with the land, and the future of our country. And while New Zealand's overall population growth is slowing, the Māori population is growing: in 2018, Māori comprised 17 percent of New Zealand's population, projected to increase to 21 percent nationally by 2043 (Statistics New Zealand, 2021). Hence, the focus of research, such as the project attached to this review, which intentionally seeks to consider the needs of Māori in order to inform and equip educators and workforce to ensure these are better met.

One area of public life in which biculturalism has played a pivotal role is in our public health policies and a more holistic understanding of wellness, especially related to positive ageing. The Māori concept of *hauora* is not only now a term in common parlance, it is also an integral keystone in support provision.

Multiculturalism

Over the last two decades, "New Zealand has become one of a small number of culturally and linguistically superdiverse countries [indicating] a level of cultural complexity surpassing anything previously experienced" (Royal Society of New Zealand, 2013, p. 1). New Zealand is now home to 160 languages, and multi-ethnic population growth is forecast to continue (StatsNZ, 2021). With 25% of New Zealanders now born outside this country, many of these migrants include older family members coming to join adult children who have made a life here. Following England at 4.5%, the birthplaces of people normally resident in New Zealand showed China (2.9%) as the next largest country of origin (ibid).

Alongside this shift in ethnicity demographics, we are beginning to see a corresponding recognition of various sub-groups being recognised in research studies and think pieces. For example, Russell Bishop, Emeritus Professor of Māori Education at the University of Waikato and advocate for policy and practices that support Māori, has long held that "What is good for everyone is not always good for Māori; but what is good for Māori is good for everyone" (The Education Hub, n.d.). A general extrapolation was that initiatives which support Māori will also assist other marginalised groups (ibid). However, Bishop's latest book *'Teaching to the North-East: Relationship-based learning in practice'* (Bishop, 2019) talks about how education needs to respond to diversity, under which he includes indigenous, migrant, refugee, faith- based students, students with learning difficulties, and students of difference.

Such a multicultural perspective to national service provision takes time to move into policy and practice, and this is certainly evident in health care provision generally, as well as specifically related to services for older adults. The project report to which this literature review is attached contains accounts of varied understanding of cultural good practice from students, educators and managers, as well as a range of experiences shared by older adults from different ethnicities related to their own interactions with healthcare professionals - and nurses in particular. Similar inconsistencies, as well as pockets of good practice in supporting cultural identity were also noted in the literature (e.g. Mumme et al., 2023) and are covered in later sections of this review.

3 | Defining age

Population ageing has been called one of the most significant trends of the 21st century; by 2030, one in six people in the world will be aged 60 years or over (WHO, 2024). Improvements in health and education, nutrition, sanitation, poverty alleviation – and reduced fertility rates in some countries – all contribute to increasing longevity and a change in population distribution. For governments, including our own, there are societal and economic implications, or, as Fried et al. (2022) put it, two challenges which need to be understood, and met:

> (1) How to maintain health and function across our longer lives such that lengthening lifespan is not also a lengthening of illness span, and (2) how we can realise the opportunities offered by a long-lived and healthy population (p. 1080).

Definitions and terminology play an important role here. Internationally, the United Nations (UN) (2015) defines the older person as anyone over the age of 60; for the World Health Organisation (WHO), geography is a key determinant, and you are officially categorised as 'older' when your age has passed the median life expectancy at birth – in sub-Saharan Africa, old age begins at 50 (WHO, 2015). Depending on culture, people might also be considered as old when they become grandparents or when they begin to do less or different work in retirement.

In New Zealand, as in many western countries, older age is considered to begin at 65, the age at which individuals are eligible for the state pension, or the 'superannuation' benefit. Government statistics, policies and legislation generally use this chronological demarcation as a single demographic category, although in some fields, such as gerontology studies and practice, there are sub-categories within this: the young-old (65-74 years of age), the middle-old (75-84 years of age) and the old-old (85 years plus), (Hamlin, 2023). Other gerontologists (Phillips et al., 2010) offer a framework of dimensions: chronological, biological, psychological, and social, noting that chronological age may differ considerably from a person's functional age. It is important, they advise a healthcare audience, to note that "the distinguishing marks of old age normally occur in all five senses at different times and at different rates for different people"".

Perceptions of the hallmarks of ageing are also changing. In the 1950s and 60s, Erikson posited a series of eight psychosocial crises which determine personality development. For Erikson, "old age" from 65 onwards, was marked by "Integrity versus despair", as individuals assessed their contributions and made sense of life in general (Mumme et al., 2023). An accompanying medicalised discourse included descriptors of frailty, increased disability and dependency (Foster, 2020). Today, documents such as the 2017 WHO *Global Strategy and Action Plan on Ageing and Health,* the *New Zealand Health Strategy – Future Directions* (MOH, 2016) and *Better Later Life - He Oranga Kaumātua 2019 to 2034* (MSD, 2019) focus on support which allows people to 'live well, stay well, get well' in later years, and adopt terms such as "ageing well", "healthy ageing", "positive ageing", and "thriving in later life".

Understanding ageism

Terminology matters, and changes in attitude can be slow. Amundsen's (2022) and Foster's (2020) studies of how older age and "the elderly" are constructed by, respectively, online news media and nursing education textbooks, showed evidence, with numerous examples, of disempowerment and negative framing. Stereotypical messages about older adults associated being "elderly" with being vulnerable, declining, and presenting an individual or societal burden. Amundsen's point is that by lacking specificity, "elderly" connotes generalizations and assumptions of older adults as a homogenous group, thus contributing to ageism.

Ageism therefore can be defined as judging an entire population group on the basis of one shared characteristic, and like any of the 'isms', means viewing this group as 'other' (Fisher, 2018). Ageism is experienced as a general disparagement related to age, and might include:

disrespect; being ignored and patronised; assumptions about health related to age; neglect; of consultation; and problems with access to treatment. There can be the use of inappropriate and unnecessary childlike speech to communicate with a patient with hearing loss, or infantilising individuals with generic naming 'love' or 'dear'. The impact on the older people is frequently a sense of powerlessness (Honeyfield et al., 2021).

The effect of ageism can be devastating. Amundsen (2022) cites the WHO's (2021) *Global Report on Ageism* which identifies how widespread ageism is globally, (across institutions, laws, policies) and how damaging this can be to individual health and dignity: "Among older people, ageism is associated with poorer physical and mental health, increased social isolation and loneliness, greater financial insecurity, decreased quality of life and premature death" (p. 3). Further, she notes, a compounding disadvantage can be seen when ageism intersects with ableism, sexism, and racism.

Fisher (2018) also discusses the social construction of age and ageism, but allows for contrasting perspectives of old age, either from a positive paradigm of wisdom, influence and worthy of respect; or from a perspective of ageing as a deficit with significant physical and mental deterioration that is irreversible and undesirable" (p. 61). Within a Western cultural context, ageing is frequently associated with illness, loneliness, loss of physical and cognitive function, and in fact, a person's age is often the foremost characteristic in describing an individual. However, in other cultural groups, including China, Taiwan, Turkey and Sri Lanka, with a more 'collectivist' culture (Hofstede et al., 2010) there appears to be a lesser level of ageism. Where people live with older family members, suggests Fisher (2018), they are less likely to be seen as 'others' but as a diverse and varied population group like any other age group.

What all the authors cited in this section have in common is the call for perceptions of age and ageing to be reframed. In the past, this might have focused on changing the lexicon, with various synonyms and euphemisms for 'elderly' suggested, such as 'senior citizen', 'senior', ' old age pensioner or pensioner', 'retiree', 'elder', 'old/older adult/ person'. Generally, most contemporary authors and commentators adopt the language used in official policy in their own jurisdictions. Combating ageism is less about the use of particular identifiers and more about education and understanding the worldviews and different lenses of others, recognising that growing older means a cultural shift in and of itself (Honeyfield et al., 2021). This begins when students are explicitly guided to recognise their own, and others' ageist attitudes, unconscious bias and the potential impact of these in the workplace on the older adults with whose care they are being charged.

4 | Cultural lens theory

As explained earlier, one of the cornerstones for the current project which this Literature review supports is previous work undertaken by the authors, and the following description of cultural lens theory is reproduced from Honeyfield et al., 2021, pp. 19-20.

The cultural lens approach hails from the domain of psychology, and offers a way to evaluate how theories, practices or phenomena apply across cultural groups (Hardin et al., 2014). The 'cultural validity' of outcomes and/or models is therefore about "the extent to which aspects of theories are generalisable across, equally relevant to, or equally useful to diverse groups" (Hardin et al., 2014, p. 656). Ryan (2017) offers a visual description: Culture acts like the coloured lens that a photographer uses to see a landscape in a particular way, or the wide-angle lens that both captures and distorts reality. The universal behaviour patterns remain, but they are coloured and bent by the cultural environment (para. 5).

The five steps of the cultural lens approach are therefore designed to help researchers metaphorically look through different cultural lenses to view the object of their inquiry in a different way. The five steps, paraphrased from the work of Dik et al. (2019) and Hardin et al. (2014) are:

1. *Articulate how central constructs have been defined (implicitly or explicitly) and thus operationalised in past research.* This step is about stating and exploring conceptual definitions and processes related to the topic.
2. *Identify the groups (a) from which these definitions have been derived and (b) to which the constructs have either not been applied or with which surprising results have been found.* This step identifies the cultural group(s) of interest and the group(s) from which the theory was originally derived. It considers previous studies and unanswered questions.
3. *Identify relevant dimensions underlying cultural variability: What do we know about the cultural contexts of Groups A and B?* This step begins by acquiring basic cultural knowledge and considers sources of cultural variability without yet making conceptual connections to the theory, avoiding easy, or 'intuitive' assumptions.
4. *Evaluate the definitions/operationalisations of the central constructs (from Step 1) in the context of broader cultural knowledge about those groups (from Step 3): What do we know about Construct X within the cultural context of Group B?* This step entails a synthesis of the previous steps, seeking to connect and explain differences. What do these differences mean? At this point researchers move from knowledge to implications.
5. *Derive research questions and specific hypotheses based on the questions and answers from Step 4.* This final step seeks to develop directions for new research based on the insights gained from the cultural lens approach process.

The cultural lens theory builds on multiple antecedents in the field of social psychology; one of the most cited and internationally recognised names (Jones, 2007) is that of Geert Hofstede who developed his cultural dimensions theory in the 1960s-70s, and remained active in organisational culture research until the early 2000s. *Cultural Dimensions Theory* is a framework based on factor analysis from what Jones (2007) calls a "gargantuan research effort" and "the most celebrated of its kind…[which]

comprised 116,000 questionnaires, from which over 60,000 people responded from over 50 countries" (p. 3). His contribution was a mechanism for measuring the effects of a society's culture on the values (and hence behaviours) of its members (Hofstede et al., 2010).

Today, the Hofstede Insights Group (hofstede-insights.com) is an international organisation offering cross-cultural management training and consultancy, as well as an open access tool for broad country comparisons. Entering the countries you wish to compare provides a factor score (not a percentage) for each dimension, as shown in Figure 2.

The Hofstede Insights Group describe culture as "the collective mental programming of the human mind which distinguishes one group of people from another" (Hofstede Insights, n.d.). They point out that the model is not suggesting everyone in a given society thinks or acts the same way; country scores are based on 'the law of big numbers', and on the impact of social control. The scores in Figure 2 below are therefore generalisations – and intended to be so.

As a quick precis of the Hofstede Index dimensions, *Power Distance* is defined as the extent to which people accept that power is distributed unequally. In China, for example, subordinate-superior relationships are more accepted than in New Zealand which aspires more to egalitarianism.

Individualism is about people´s self-image as "I" or "We". In contrast to New Zealand, China is a highly collectivist culture where people act in the interests of the group and not necessarily of themselves.

Masculinity is used to describe societies driven by competition, achievement and success, a value system that starts in school and continues throughout organisational life. People will sacrifice work-life balance, and are motivated more by being the best at what they do, than by liking what they do.

Uncertainty Avoidance describes how a society responds to the unknown future. While New Zealand's score is neutral, China's lower score indicates comfort with ambiguity and an adaptable and entrepreneurial mindset.

Long term orientation is about views of societal change and the importance of tradition. According to the Hofstede Index, New Zealanders are normative in their thinking: respecting established systems, seeking quick results, and with a relatively low commitment to saving for the future. China is a more pragmatic culture, adapting traditions easily to changed conditions, with a focus on saving and investing, thriftiness, and perseverance.

Indulgence is "the extent to which people try to control their desires and impulses, based on the way they were raised" (Hofstede Insights, n.d.). Compared to China, this index score suggests New Zealand is a more indulgent society: optimistic, focused on enjoying life, having fun, acting as they please and spending money more freely.

As acknowledged in the shaded text from Honeyfield et al., 2021, the country comparison shown in Figure 2 is generalised and represents tendencies, mindsets and behaviours in very broad brushstrokes. With New Zealand's population over 80% non-

Māori, the national rankings above can be taken as primarily representative of pakeha New Zealanders. What is valuable for this project is the framework for considering how a collective Chinese mindset, for example, differs from a westernised pattern of thinking, and how many of these differences will be evident in the way older people think about, and respond to healthcare services.

Hallmarks of Chinese culture related to ageing and healthcare

The importance of home and community

In 2011 a group of researchers from Auckland University's School of Population Health interviewed older Chinese migrants living in Auckland about what they considered the ideal place to grow older, and what made positive ageing possible (Wild & Wiles, 2011). Participants in this study were unanimous in their desire to remain independent and live in their own home. They found retirement villages too expensive for most people to afford, and sufficient domestic help (in the form of a maid) was also considered to be too costly in New Zealand.

One aspect which differed from what they had been used to in China related to neighbourhood. They would have liked living in closer co-ethnic communities with other Chinese – to socialise, share activities, take care of one another and offer security – many had experienced petty crime and racism. This preference for community living speaks to the collectivist mindset indicated in the low Hofstede score for individualism (Figure 2). Social cohesion and the experience of loneliness in its absence was also noted in several studies which included, or centred on, Chinese participants cited in Mumme et al.'s (2023) bibliography.

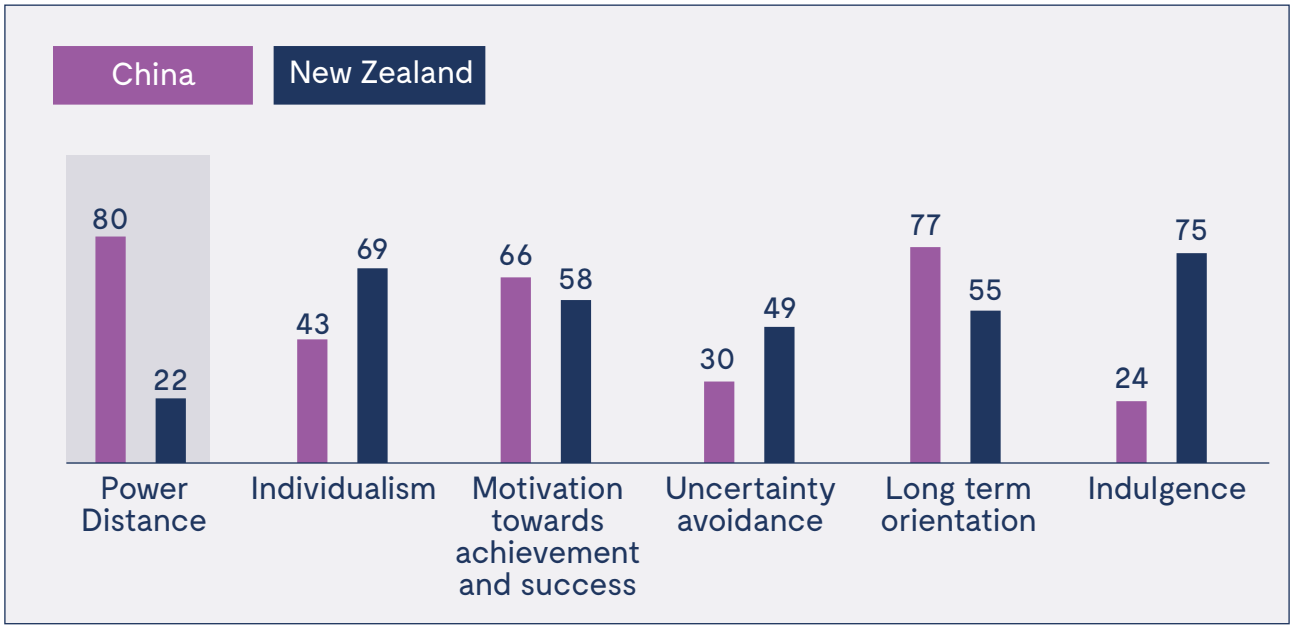

Figure 2. *China-New Zealand cross-cultural comparison using the Hofstede Index. (Hofstede Insights, n.d.). Reproduced under academic articles permission,* https://hi.hofstede-insights.com/faq

Findings in the Auckland University study also support a strong Chinese respect for authority (Power distance) and a lower prioritisation of Indulgence. Participants highly valued government superannuation and/or other WINZ/MSD benefits, and said that this financial support was a great aspect of growing older in New Zealand: "If elderly in China saw this … they all would like to move here!" (Wild & Wiles, 2011, p. 15). However the need to organise their own ethnic societies had been a surprise for some, who said that in China a party secretary, or a director of a department would organise it. Overall, they said, learning, friendship and family were more important than material wealth.

Some recent studies are noting that despite the Chinese population being the largest Asian ethnic group in New Zealand (4.9% of total population), little is known about the lived experience of particular conditions which are comparatively well-documented in other groups. One example is Cheung et al.'s (2022) exploration of how Chinese New Zealanders are coping with dementia. Themes the researchers found common across participants included a lack of understanding of the condition, tension between cultural obligation and carer stress, and the stigma attached to dementia. They conclude:

> It is likely that different psychosocial and cultural issues are at play for Chinese [people living with dementia] in Zealand, where there were historical discrimination and maltreatment issues against Chinese from the late 1860s through the 1950s [10], recent waves of immigration from Hong Kong and China in the past three decades, and dementia services that were developed mainly for Europeans using a westernised model of care (para. 3)

Yu's (2015) examination of how older Chinese responded to a diagnosis of Type 2 diabetes showed similar themes related to cultural preferences, priorities and the divide between traditional and modern medical practices:

> 1) culturally unique perceptions and knowledge of diabetes; 2) lifestyle modification by incorporating Western diabetes regimens into Chinese lifestyle; 3) cultural needs including maintaining harmony and family roles; 4) their views and practice of Western and traditional Chinese medicines; and 5) their experiences of the healthcare service (p. 1)

Both articles end similarly: with a call for providers and educators to have a more holistic focus when planning care and education services that are culturally appropriate and responsive to the needs of the growing number of older Chinese and their families in New Zealand. Similar recommendations are made in several other publications included in Mumme et al.'s (2023) bibliography, in which Chinese are one of several sub-population groups included in various research fields (such as loneliness, frailty, access to health services, and integrated/complementary medicine).

Family and filial responsibility

Articles which include a discussion of psycho-social factors almost always discuss the importance of family and the traditional model of intergenerational living – which may be changing in modern China, but is still held as the ideal by older Chinese immigrants.

A good example here is Liu's (2016) description of transnational Chinese migrant families and the impact of government policy. She explains:

> In July 2012, a significant policy change regarding the Family Sponsorship Stream (Parent Category) took place in New Zealand, which raised the bar for migrants' elderly parents on entering New Zealand as permanent residents. This policy change has a significant impact… [as] filial piety is an important part of traditional values and the state provides very limited ageing support to the elderly. (p. 216)

Even with this change, China has the greatest number of residence approvals under the Parent Category (21.69%) amongst all the top ten immigrant source countries. Other older Chinese gain residence approvals under the business category, some to retire, but many to support their adult children's career progression by providing care for their grandchildren. This then becomes two-way caregiving, as grandparents age, need help with linguistic barriers and cultural dissonance – especially related to healthcare (Ran & Liu, 2020). The research into cultural identity which this literature review accompanies found exactly this expectation among older Chinese: that their family would manage their care, and health services, and that ageing in place was far preferable to retirement complexes or residential care.

A key takeaway from the above discussions related to aged care for older immigrants is that this emerging research area intersects health, migration, family and gerontological studies – and that culture is the common connector.

Hallmarks of Māori culture related to ageing and healthcare

In contrast to the relative scarcity of research relating to the ageing and health of older Chinese in Aotearoa, there is a burgeoning scholarship of Māori health studies related to wellness, *hauora* (the holistic Māori concept of health), longevity determinants, specific conditions, barriers and enablers to accessing services, cultural preferences, *Rongoā Māori* (traditional medicine), case study initiatives, intervention pilots, and more (Hokowhitu et al., 2020; Mumme et al., 2023).

Two key cultural understandings underpinning the literature related to Māori healthcare

1. Hauora
   Hauora is a Māori word for wellbeing and a philosophy of health unique to New Zealand and Māori culture. It includes physical, mental, social and spiritual health, and is based on the *te whare tapa whā* (the four-sided house) model developed by Emeritus Professor Sir Mason Durie (2003). In a Māori world view, the concept of hauora has multi-layered meanings:

   > HAUORA comes from two words *hau* and *ora*. Hau can mean wind, air, breath, dew, eager or brisk, famous, vitality of people/person, or the presentation of a gift in acknowledgment of a gift received. Ora means alive, well in health, safe, survive, recover. Thus, HAUORA can mean breath of life, being alive, vital essence or gift of life, eager survival etc. (Ross, 1998, cited in Meier & Culpan, 2020, p. 223)

Hauora is included, and fundamental to health and education programmes across New Zealand, and in government policy and strategy.

2. Kaupapa and tikanga
   Distinguished Professor Graham Hingangaroa Smith (2012) describes *Kaupapa Māori* as: Related to 'being Māori'. *Tikanga Māori* is about how this is enacted in practice, the Māori way of doing things, or custom. Kaupapa Māori theory, and kaupapa Māori research, means work that is undertaken by Māori, for Māori, with Māori. Cram (n.d.) explains:

   > First, researchers need to affirm the importance of Māori self-definitions and self-valuations. Second, researchers need to critique Pākehā/colonial constructions and definitions of Māori and articulate solutions to Māori concerns in terms of Māori knowledge. These dual agendas are intertwined; for example, the critique of Pākehā commonsense makes space for the expression of an alternate, Māori commonsense.

   In much, if not all recent literature related to Māori healthcare, the underpinning position is the safeguarding of cultural identity and the drive for social transformation and the reduction of inequity.

Evidence relating to the centrality of hauora and kaupapa in Māori ageing

In 2010, a team of researchers began a longitudinal cohort study of Māori aged 80 to 90 years and non-Māori aged 85+ years who agreed to take part in a detailed interview and physical assessment, with follow-up annual interviews over the next five years. The 'Life and Living in Advanced Age, a Cohort Study' (LiLACS) has generated dozens of long and short reports, factsheets, journal articles, conference presentations and keynote addresses – nationally and internationally (e.g. LiLACS 2015; 2016). Findings have been reported in broad trends across the years of the study, as well as by topic, such as dementia, income, independence in daily activities, relationships and emotional support, alcohol use, oral health, medication, and participation in Māori society (Honeyfield et al., 2021).

This longitudinal study has also clearly established the importance of culture to older Māori, as holders of heritage, knowledge and tikanga. Specific findings reported by the LiLACS NZ team in 2015 were:

- almost all Māori had been to a marae in the last 12 months (82%). Māori in advanced age living in areas of higher socioeconomic deprivation were significantly more likely to attend marae
- half (51%) of Māori in advanced age have a complete understanding of their tikanga
- forty-seven per cent of Māori reported that their contacts were mainly with other Māori.

Culture was also a key aspect of work establishing and evaluating a peer education programme for Māori elders by Oetzel et al., with multiple publications between 2019 and 2021, cited in Mumme et al. (2023). The study emphasised contextually based and culturally safe age-friendly environments, with data showing positive associations in health outcomes for 'strength of tribal identity', 'importance of whānau' and 'knowledge of tikanga'.

Dawes et al.'s (2021) study (summarised in Mumme et al., 2023) investigating the impact of COVID on older Māori emphasised the importance of tikanga as kaumātua related their concerns and reactions to infection control linked to the tapu of the body. And Gomes (2022, ibid) investigating the interconnectedness of indigenous culture, health and wellbeing, and landscape found that all must be balanced to reduce Māori health inequalities.

Ageing in place – the role of whanau and community

Two further publications included in Mumme et al.'s (2023) Bibliography talk specifically to the importance of place in Māori culture to maintain wellness across all hauora dimensions. Butcher and Breheny (2016) note that place is integral to the identity of Māori elders and therefore to their experiences of ageing. Simpson et al. (2022) consider the application of these concepts to a kaumātua village and the important features of a codesigned and culture-centred housing community.

The importance of 'ageing in place' to older Māori was also an area of focus for the LiLACS NZ team. They found this to be an area of significant difference in the pattern of living arrangements between Māori and non-Māori. For those with 'critical' needs, requiring assistance multiple times daily, less than half of Māori (36% of women, 50% of men) were living in residential care, compared to three-quarters (76%) of non-Māori men and women with this level of need. For those with a 'short' interval of care (requiring daily assistance), 33% of Māori lived in residential care, compared with 51 per cent of non-Māori (LiLACS NZ, 2016). The enabling factor supporting Māori to remain living in the community rather than in aged care facilities, was the role of family and whānau caregivers, in the home, or living nearby – central to a collectivist-oriented social order (Podsiadlowski & Fox, 2011) and intergenerational connectedness (Hokowhitu et al., 2020).

Just as for older Chinese, the cultural pattern of whanau caring for whanau is marked by reciprocity. As numerous discussions resulting from the LiLACS NZ study aver, Māori kaumātua prefer culturally appropriate and whānau-centred services which respect their cultural identity, maintain their cultural links, and respect the significant obligations and connections that sustain their whānau, hapū and iwi. Cultural identity includes, and is bolstered by levels of marae participation, the use of Māori language, access to Māori resources (such as land) and involvement with whānau (LiLACS NZ 2015; 2016).

The importance of a close connection to te ao Māori for positive ageing was a main finding in Waldon's 2004 research in which almost all (98%) respondents identified their iwi and 85% identified their hapū, most (84%) were able to speak Te Reo Māori and 68% were involved in marae activities to different extents. Two thirds considered they were regarded favourably by their people as kaumātua. In this research, over two thirds of participants offered an optimistic self-assessment of their own health that didn't always tally with their medical history. The conclusion was that the roles that older Māori undertake related to their cultural identity constituted both a risk and a benefit to their health and wellbeing determined by the particular demands and circumstances of their individual context (p. 178 (Waldon, 2004). Therefore, "The Government has an obvious and ongoing role to support the health needs of older Māori in ways that meet their social needs, and recognise the cultural contribution they are making to the health and wellbeing of the whole of Māori society" (Waldon, 2004, p. 178).

Edward's (2010; 2018) work on positive ageing as Māori also focuses on the holistic and cultural contributors to wellbeing. He argues that quality relationships, intergenerational relations and regular positive interactions compensate for, and can override the impact of health disparities and disadvantage on satisfaction with quality of life in older age.

For Emery et al. (2021) too, maintaining *whanaungatanga* (relationships) and undertaking iwi cultural roles and duties are vital for Māori positive ageing. As Cram (n.d.) notes, te ao Māori is a relational world, and 'whanaungatanga', building and strengthening of authentic, trusting and reciprocal relationships, is the way in which members of a community become increasingly culturally-connected. Common to Waldon, Edwards and Emery et al., older Māori ageing in place in their own maraes and communities take on multiple roles. There were governance and leadership roles, and fulfilling the obligations of being a spokesperson, host and arbiter as a tribal elder. Older Māori were often guardians and teachers of 'the old ways' (Emery et al., 2021), passing on *taonga* (cultural and ancestral knowledge and treasures) and *mātauranga* Māori (Māori knowledge). Three of the videos produced as teaching resources to accompany this project showcase a local kaumātua doing exactly this, as he shares local legends and traditional Māori medicines in his kōrero about health and ageing.

Viewed from a cultural lens, this embeddedness in, and interconnectedness with whānau and iwi are hallmarks of a Māori societal collective orientation, less observable among New Zealand Europeans (Podsiadlowski & Fox, 2011). As well as the positive self-assessments of health mentioned above, there is a clear connection to the lower levels of social isolation and loneliness reported by older Māori in several studies cited in Mumme et al. (2023).

Image next page - project participants Aneeta and Mike, narrative 1, taken from "Teaching resource: Older adults' narratives of health and wellbeing."


SURVIVED
50
YEARS OF
MARRIAGE

5 | Supporting cultural identity in healthcare provision for older Chinese and Māori

Acknowledging inequities and reclaiming cultural continuity

Many of the authors in this review so far call for strengths-based and culturally responsive initiatives, yet preface their own reports by backgrounding the health (and other socioeconomic) disparities and cultural dissonance between Indigenous and non-Indigenous populations. Many authors (e.g. Hokowhitu et al., 2020; Podsiadlowski & Fox, 2011) explicitly connect these outcomes to the negative impact of colonisation.

Hokowhitu et al. (2020) suggest that the counter to this divide might well be what different studies term 'cultural continuity' or 'cultural revitalisation'. They cite a number of studies, including Waldon (2004) which demonstrate that *whakawhanaungatanga* (social connecting) and marae-based programmes influenced Māori participation rates and programme effectiveness for Māori in health rehabilitation – even in the face of long-term or multiple health problems. Hokowhitu et al.'s own research looked at the association between kaumātua culture and health through two initiatives: learning te reo Māori and mātauranga; and *tuakana/teina* (peer support/education/mentoring underpinned by kinship). Their rationale is that employing cultural concepts will help shift the public discourse surrounding ageing and build kaumātua health knowledge so that, firstly, the ageing population is seen to be valued and, secondly, the ageing population is given mana Motuhake - self-determination and control over one's own destiny.

New Zealand's Chinese population may not have experienced the impact of colonialism felt by Māori as tangata whenua, but as a sub-population group, have certainly encountered racial and other forms of discrimination like ageism which are widespread in multiple domains across this country – versus the continued dominance of Western worldviews. International studies such as Williams and Mohammed (2013, cited in Honeyfield et al., 2021) have shown that racism adversely affects the health of targets, consciously or not, through: non-inclusive policies and procedures; the perpetuation of stereotypes; and creating psychosocial stressors that can lead to adverse changes in health status and health behaviours.

Chinese culture, like Māori culture, venerates its elders. They too are seen as the guardians of knowledge about traditions and custom, and want to live in communities where they can take an active role in cultural continuity and building a quiet pride in cultural identity (Liu, 2016). The participants in Wild and Wiles' (2011) research into older Chinese in Auckland's plans and preferences for ageing in place did not define themselves in deficit terms – lonely, frail, vulnerable, and a burden on the socio-economic system, and/or a problem to be fixed. They, like kaumatua, want to contribute as valuable members of society and see policies and services which ensure that their potential at the end of the life cycle is fulfilled.

Education and cultural consciousness

Literature from the past two decades included in this review, as well as the meta-analyses of Honeyfield et al. (2021) and Mumme et al. (2023) generally concur that combating ageism, racism and negative stereotypes in aged healthcare begins with education. Student nurses and healthcare assistants' attitudes are impacted by learning *and* experience, theory *and* practice. If students need good experiences in both nursing education related to gerontology and in aged healthcare clinical placements, it is the responsibility of training providers to ensure these occur.

The concept of cultural safety is an important component of the nursing curriculum, but also a requirement for subsequent registration (Honeyfield et al., 2021). Cultural safety calls for students to reflect on "interpersonal power differences (their own and that of the patient), and how the transfer of power within multiple contexts can facilitate appropriate care for Indigenous people and arguably for all patients (Curtis et al., 2019, p. 12). The Nursing Council of New Zealand's (2024) *Registered nurse standards of competence* makes clear that this is mandatory:

> The nurse delivering the nursing care will have undertaken a process of reflection on their own cultural identity and will recognise the impact that their personal culture has on their professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (p. 13)

Another related term is 'cultural competency' which Curtis et al. (2019) describe as "improving the provision of healthcare to ethnic minority groups with the aim of reducing ethnic health disparities" (p. 3).

New Zealand is officially a bicultural nation, but it is also a multicultural one, and this is becoming increasingly acknowledged in healthcare education, research and policy – just as the current project has included Chinese *and* Māori sub-populations for a cultural identity inquiry. In another example, at least a third of the studies about loneliness/social connection cited in Mumme et al. (2023) explicitly discuss inclusivity of cultural diversity in the multicultural New Zealand context.

Image next page - project participant Ivan, narrative 3, taken from "Teaching resource: Older adults' narratives of health and wellbeing."


MEMORIAL CEREMONY AT THE CRASH SITE
Germany 2023

6 | Conclusion

Worldwide, there is a growing call for a paradigm shift in the re-alignment of aged healthcare - in philosophy, policy, procedural guidelines and a desire for individualised, holistic, quality care for those in the later stages of life. Aotearoa New Zealand, with its bicultural heritage, and multicultural modernity, is ideally placed to contribute. Our country already has a 'wellness' orientation, with a vision for all New Zealanders to live well, stay well, and get well (MOH, 2016) and to ensure New Zealand is a great place to age (MSD, 2019). Overall, New Zealand's health system has many strengths, and our people are living longer and healthier lives, census by census. It is when we look beneath the national statistics to the findings of studies and analyses such as those cited in this review, that the persistent, albeit often unconscious, traces of ageism, racism and a western-centric worldview are unveiled.

Moving culture to the centre of the stage in re-imagining how healthcare provision for older adults might do better, starts with research inquiries like the one to which this review is attached. It begins with learning what others have already documented and then testing such findings by checking in with those who know best – representatives of the target population. In this study, interviews generated case-study narratives from older New Zealanders from a range of cultural backgrounds, including but not limited to, Māori and Chinese, offering firsthand accounts. The resultant text and video resources designed for use in nursing education, allow these spokespeople's voices to resonate with the rest of us. We hear the lived experiences and cultural wisdoms that lie behind statements of vision, such as the *Toi Ora Strategy of Te Rūnanga Hauora Māori o Te Moana a Toi*, (Keelan & Porter, 2019), endorsed by the Bay of Plenty District Health Board – and there are many other examples all around the country. People are speaking - Māori, Chinese, and New Zealanders of all ethnicities – we just need to listen.

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