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Visual description: A purple Whaikaha logo with a QR scan for the NZSL name.

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Key issues and opportunities for disabled people's health

Purpose

- 1 This paper outlines key issues and opportunities for lifting the health of disabled people and tāngata whaikaha Māori and their whānau in Aotearoa New Zealand. It is part of a suite of papers examining strategic issues and opportunities to steward better outcomes for disabled people across government and to inform the development of the New Zealand Disability Strategy 2026 – 2030.
- 2 These papers are intended to provide a starting point for the Working Groups that will consider each outcome area in more detail, and propose a prioritised set of well-defined, achievable actions for inclusion in the strategy.

Executive summary

- 3 Good health is fundamental to wellbeing. We all have a right to the highest attainable level of health. All New Zealanders should expect health services to and enables us to thrive, grow and enjoy lives that we value.
- 4 However, disabled New Zealanders experience poorer health and have higher unmet health needs compared to non-disabled New Zealanders. This reflects global data and encompasses physical, mental and social wellbeing.
- 5 The relationship between health and disability is intricate and can be bi-directional. Determinants of health impacting disabled people include income levels, housing, and employment. Often disabled people require high health service use but are prevented from enjoying the highest level of health attainable due to systemic barriers.
- 6 Disability can also be a risk factor for developing mental health conditions, and mental health conditions a risk factor for developing disabilities. Being active, eating and sleeping well, maintaining positive relationships, and engaging with the natural world are key to health and wellbeing but public health messages are often not delivered in an inclusive way that addresses the logistical

and systemic barriers that are the lived reality of disabled people.

7 Disabled people experience a range of barriers accessing the health services they need. These can include:

- systems that remain inaccessible across multiple domains – including physical, technological, financial, and social
- information that does not meet the needs of disabled people including NZSL Interpreters, alternative formats, and knowledge about communication styles and communication equipment
- mistrust of the health system
- the health workforce being undereducated about disability issues and how best to meet the needs of disabled people
- disabled people being under-represented in many areas of the health workforce, and
- healthcare modes such as virtual health care being difficult for people with communication difficulties or self-test screening (eg. for cervical cancer) being inaccessible for someone with vision impairment.

8 The breadth and diversity of issues and drivers of health inequities for disabled people suggest action will be

needed on a number of levels. Several strategic documents such as the Provisional Health of Disabled People Strategy set clear goals for disabled people's health, and initial work programmes have been established in the Ministry of Health and Health New Zealand for the next two to three years. This paper outlines those areas. Other key areas for the NZDS Health Outcome Working Group include:

- governance, leadership and oversight for disabled people in the health system
- building workforce competence in disability and increasing the representation for disabled people working in health
- prioritising supported decision making so disabled people can make more informed choices and where their rights are upheld
- accessible and targeted health promotion work to encourage disabled people to make positive health and wellbeing decisions
- accessible and inclusive health services, including health facility infrastructure and information
- making disability a core part of data collection.

9 The above steps will improve the overall health and wellbeing of disabled New Zealanders, their whānau and communities.

Background

The right to health is a fundamental human right – everyone has the right to enjoy the highest attainable standard of physical and mental health

10 The right to health appears in a number of core international treaties,¹ and in domestic legislation. This right encompasses complete physical, mental, and social wellbeing and equitable health outcomes; access to timely and appropriate healthcare; and underlying social and economic determinants of health, such as work conditions and adequate food and shelter.²

11 With the ratification of the International Covenant on Economic, Social and Cultural Rights (ICESCR) the New Zealand Government agreed to protect the health of its citizens and provide the services, policies, and budgetary means to promote good health and ensure the elimination of health-based discrimination.¹ This

¹ The concept of 'progressive realisation' allows for compliance to happen incrementally. However, in order to determine the rights are being realized over the time the state is obliged to demonstrate that they are: respecting, protecting and fulfilling the rights where possible.

commitment is further cemented by Article 25 of the UNCRPD, ratified by New Zealand in 2008.

Recent health system reforms include legislative change focused on achieving equity in health outcomes, particularly for Māori, Pacific and disabled people, while promoting the health and well-being of all New Zealanders

12 The Pae Ora (Healthy Futures) Act 2022, part of the health system reforms, has as its purpose to:

- protect, promote, and improve the health of all New Zealanders
- achieve equity by reducing health disparities among New Zealand's population groups, in particular for Māori
- build towards pae ora (healthy futures) for all New Zealanders.

13 The health sector principles in the Act (section 7) guide health entities in how to carry out their functions and incorporate key outcomes and behaviours including principles derived from Te Tiriti o Waitangi. The principles require the health system to:

- be equitable
- engage with Māori, population groups, and others to reflect their needs and aspirations

- provide opportunities for Māori to exercise decision-making authority
- provide choice of quality services to Māori and other population groups
- protect and promote people's health and wellbeing.

Disabled people have significantly poorer health outcomes compared with non-disabled people, across physical, mental health and social wellbeing measures.

14 New Zealand's disabled people experience worse health outcomes than its non-disabled population, with the deepest differences among tāngata whaikaha Māori, Pacific disabled people and intellectually disabled people (people with learning disability)ⁱⁱ.

The links between health and disability must be addressed in order to achieve equity of health outcomes

15 The relationship between health and disability is complex, with each impacting the other in significant ways. Often disabled people are prevented from enjoying the highest level of health attainable, not because they are disabled, but because systemic discrimination and

ⁱⁱ Learning disability is the preferred term of many in New Zealand including People First New Zealand, this paper uses the term 'intellectually disabled' to reflect the language used in the UNCRPD.

disadvantage compounds the impact of their disability across a range of health-related and wider determinants of health including income levels, housing conditions, employment, and education.³

16 Disabled individuals often bear a double burden in that they have an increased risk and incidence of chronic health conditions (compared to non-disabled people) but must seek treatment in a health system that for many disabled people remains inaccessible.⁴

17 A well-functioning healthcare system must recognise this interplay, and ensure that services are inclusive, accessible, and tailored to the diverse needs of disabled individuals.

Issues

The reasons for poorer health outcomes for disabled people are complex, systemic, and multi-layered

18 As noted earlier, physical and mental health can be impacted by a wide range of determinants including socioeconomic deprivation, housing, social and cultural issues, education, income and employment, digital exclusion, social exclusion, violence (particularly family and sexual) and discrimination. The links between these

determinants and health outcomes are well-knownⁱⁱⁱ and all play a role in ensuring that an individual can enjoy the highest attainable level of physical and mental health. Many of these issues will be explored in more detail in other working papers⁵ as part of the NZDS refresh. This paper will focus on how these issues interact with the health system.

Disabled people have poorer health outcomes than non-disabled New Zealanders, and are known to have higher levels of unmet health needs

19 Disabled people, like all communities, have diverse lives and equally varied health needs. However, when compared with the general population disabled New Zealanders tend to have poorer levels of health, and greater unmet needs. Appendix A provides a detailed comparison.

Māori, Pacific people, and the disabled population experience deeper disparities in health outcomes

20 Māori, Pacific people and the disabled population experience inequity and poorer health outcomes compared with the general population.⁶ Over the past decade, the amount of disability data collected in surveys has increased significantly, however, it is often

ⁱⁱⁱ For further information about determinants of health see page 12 -13, *Provisional Health of Disabled People Strategy: 2023*.

hard to break down this data by both ethnicity and disability due to the size of the survey samples.

Disability status is also not routinely collected in health-related administrative data, making it difficult to compare outcomes across the wider population. The recent addition of data from the 2023 Census and Household Disability Survey into the Integrated Data Infrastructure (IDI) provides an opportunity to drill down further into the available data to better understand outcomes for tāngata whaikaha Māori and Pacific disabled people.

- 21 The complex interplay between colonisation, ableism, structural racism, and socio-economic disparity may result in disproportionate impacts for Māori.⁷ These issues are currently being considered as part of Stage Two of the Health Services and Outcomes Inquiry (Wai 2575) being carried out by the Waitangi Tribunal. A research report commissioned for Wai 2575 found that:

The Crown does not collect adequate data to monitor its performance for Māori with lived experience of disability. There are large knowledge gaps where the Crown simply does not collect data, or where it does collect data, it does not interrogate the data that it has. The impact of this is that the Crown is not able to

*fund, plan and design services based on real time data and insights that would address demonstrated Māori health and disability support needs.*⁸

22 These issues need to be considered both in the context of the UNCRPD as an individual rights-based framework and Te Tiriti o Waitangi as a founding document of Aotearoa New Zealand that recognises Māori in the context of their whānau, hapū and iwi.

23 It is difficult to establish good data about Pacific disabled people in New Zealand, as datasets are often unreliable at this level of granularity. However, of all ethnic groups in New Zealand, Pacific peoples have been found to experience some of the highest rates for severe housing deprivation, unhealthy housing (defined as damp, mouldy or cold homes),⁹ unemployment, and low income status, all of which are important socioeconomic determinants of health.¹⁰ It is well established that these factors contribute to poorer health outcomes for Pacific people,¹¹ and who, when adjusted for age and gender, are 1.4 times as likely to rate their health as poor or fair than the general population.¹² Disabled people also have poorer outcomes across many of these factors, meaning it is likely that experience of disability will further these

impacts so that Pacific disabled people are likely to have even poorer outcomes.

People with intellectual disability are high users of health care, but their health care outcomes are poorer on average than those of people without intellectual disabilities

24 The Ministry of Health reported on the health indicators of New Zealanders with intellectual disability in 2011.¹³ The overall result of that report as that across all indicators...

...people with intellectual disability were more disadvantaged, in terms of their health and life expectancy, compared to people without intellectual disability. The group with intellectual disability experienced higher rates of specific health conditions, and they also used health services more (apart from preventive screening services). These results are consistent with those from similar overseas studies.¹⁴

25 This included significant differences in life expectancy rates for those with intellectual disability. Males with intellectual disability have a life expectancy more than 18 years less than all New Zealand males. For females, that figure is almost 23 years below the life expectancy of all New Zealand females.¹⁵

26 Findings in the *From Data to Dignity Report*¹⁶, indicate that people with intellectual disability are more likely than people without intellectual disability to have coronary heart disease, chronic obstructive pulmonary disease, and diabetes, and significantly, potentially avoidable hospitalisations. The results also point to people with intellectual disability being more likely than people without intellectual disability to have high mental health needs, mental disorders, and dementia.

Experiencing mental distress and disability are bi-directional in their impacts; those who experience one may be at a higher risk of developing the other

27 World Health Organisation reporting from 2012¹⁷ has identified disability as a risk factor for developing a mental health disorder, and inversely, mental health conditions as a risk factor for developing disabilities. The report provides the following insights into the relationship between mental health disorder and disability:

In health terms, the onset or presence of a mental disorder raises the chance of disability and premature mortality from other diseases, including cardiovascular disease, diabetes, HIV/AIDS and other chronic conditions. The higher than expected occurrence of these diseases in persons with mental disorders can be

*attributed to a range of factors, including general neglect of their physical health (by themselves, families or care providers), elevated rates of psychoactive substance use in this population, diminished physical activity, an unhealthy diet and, in many cases, side-effects of medication. Health outcomes for persons with comorbid mental and physical conditions are markedly worse, due to diminished health-seeking behaviour, adherence and follow-up for these cases.*¹⁸

28 More recently research findings from the Australian Government have examined the relationship between disability and mental health conditions and found that almost 1 in 2 people with severe or profound disability self-reported anxiety disorders, compared with 14 percent of people without a disability.¹⁹

Disabled people can be excluded from health services by physical, digital, financial, communication and/or attitudinal barriers

29 Accessibility is a key issue for disabled people interacting with health services and remains a key driver of inequity between disabled and non-disabled groups. The access needs of disabled people can be specific to

their impairment(s) and sometimes an access need of one person can conflict with those of others.

30 The definition of accessibility is that disabled people should have access to society and government-funded services on an equal basis with others, including to the physical environments, information, communications and technology systems, and all facilities and services available to the public.

Barriers are commonly experienced by disabled people and are a long-term source of frustration for the community

31 Barriers to infrastructure, equipment and services exist across all levels of health service and often prevent or delay disabled people from accessing the healthcare they need.

32 Physical barriers can take many forms but are still common and can prevent access to many health services, ranging from hospitals to GP clinics and cancer screening services.

33 Restrictive opening times coupled with the location of some services can require costly and complex arrangements to organise transport, childcare and/or time off work. This adds complexity and cost for disabled people who are often reliant on others to get to

appointments and can lead to delays in scheduling non-urgent appointments.

- 34 Short appointment slots (such as 15-minute GP appointments) can prevent disabled people from effectively communicating their needs, leading to misunderstanding and confusion about treatment and follow-up actions.

Communication barriers exclude disabled people from the health system

- 35 Disabled people have a range of communication needs, but fully accessible information is often not available. This can include basic information such as treatment information, follow-up care, and medicine labels, but extends to information about other health promoting behaviours including about free screening services and public health information campaigns, such as COVID-19.
- 36 In situations where NZ sign language interpreters are not available, Deaf people may rely on a friend or family member (including children) to interpret. This creates the risks of miscommunication and misunderstandings. It may also result in Deaf people not being able to express themselves honestly in health settings, or in appointments being postponed or cancelled.²⁰

37 There is often a lack of information sharing between services about an individual's disability. This can mean that no arrangements have been made prior to arrival that will enable full participation by the individual (i.e. access to equipment or accessible information) but it can also require the disabled person to have to repeat their medical history which can mean the disabled person must first 'justify' their disability which can sometimes relive traumatic experiences.

Financial barriers prevent disabled people from accessing healthcare services.

38 Disabled people are much more likely to experience financial pressures than non-disabled people. Over half of disabled people (53 percent) did not have enough income to meet basic needs or had only just enough, this contrasts with 33% of non-disabled people (HDS 2023).

39 Disabled children were almost twice as likely to live in households with severe material hardship^{iv} when compared with non-disabled children. Children in disabled households were 3.2 times as likely to live in

^{iv} DEP-17 is the index used by Stats NZ to measure material hardship in New Zealand. A DEP-17 score of 9 or more is the threshold used to identify severe hardship.

households with severe material hardship, when compared with children in non-disabled households.²¹

40 The cost of healthcare can also present financial barriers for people with disabilities. For many individuals these costs will be covered by ACC, government subsidy (i.e. Community Services Card or Disability Allowance), or private health insurance (21.3 percent of disabled adults had private health insurance, compared with 36.5 percent of non-disabled adults).²² However, disabled people who do not qualify for this assistance will need to self-fund health care such as prescriptions, allied health services and oral healthcare, alongside ancillary costs such as transport and childcare. Affordability of medicines can also create financial barriers for many disabled people, especially where the medicines they wish to access are not publicly funded. These costs put additional pressure on disabled people, who in the June quarter 2024 Household Labour Force Survey had a median weekly income from all sources of \$523, less than half the income for non-disabled people (\$1,141).²³

41 These factors strongly influence health inequities. In the 2023/2024 NZHS after age and gender adjustment, disabled adults were nearly twice as likely as non-disabled adults to have unmet need for a GP due to cost.

Disabled people were also more likely than non-disabled to have an unmet need for a GP due to lack of transport (8.4 percent compared with 2.9 percent).²⁴

'Virtual' delivery of services can present new and different barriers for disabled people

42 Health care delivered virtually (by phone or online services), can improve access for people with mobility issues, effectively removing transport barriers, so saving time and money. However, it can present new and different barriers to accessing care, difficulties included people unable to show their physical symptoms, some found it more difficult to explain themselves compared with when they had an in-person appointment, and some found it harder to hear or understand their GP.²⁵

43 During the COVID-19 pandemic, disabled people accessed virtual health care at higher rates than non-disabled people.²⁶ However not all will have been able to do so. Estimates suggest that around 17 percent of disabled people do not have internet access, compared to 5 percent of the general population.²⁷

Disabled people experience high levels of discrimination in the health service, increasing mistrust of the system, which can lead to further disengagement and delays in treatments.

- 44 Disabled people regularly report experiencing discriminatory attitudes from health workers. Health professionals often lack adequate training in disability-inclusive care, leading to biases and inadequate service provision. Some healthcare providers may assume that all disabled individuals have the same need or fail to include them in decision-making about their care. Additionally, disabled people have reported they feel that there is a shortage of disability trained professionals across all of the health sector.²⁸
- 45 Availability of professionals trained to work with people with intellectual disability is particularly limited. People with intellectual disability at risk of diagnostic overshadowing, where health conditions are overlooked or wrongly attributed to their previously documented impairments. In a recent study from the Donald Beasley Institute,²⁹ interviewees reported experiencing diagnostic overshadowing and discrimination³⁰ which led to misdiagnoses or late diagnosis of secondary conditions.
- 46 Diagnostic overshadowing has also been found to be an issue experienced by patients with mental health and substance use conditions in New Zealand. Recent research undertaken in New Zealand reported that 20

percent of respondents reported diagnostic overshadowing.³¹

Adopting health promoting behaviours can be difficult for disabled people

47 Being active, eating and sleeping well, maintaining positive relationships, and engaging with the natural world are actions that people can take to benefit their overall health.³² For many disabled people these are more complicated choices than for non-disabled people.

48 Exercising in inaccessible environments and facilities, needing a support person to be active or requiring different activities than are commonly taught can prevent a disabled person from being as active as a non-disabled person. Some disabled people may also need to be careful of their energy expenditure or certain activities to avoid a condition worsening.³³

49 Navigating healthy food choices can be difficult for all of us but disabled people are at 1.3 times the risk of obesity compared with non-disabled people.^v

Understanding the role that nutrition plays in health and wellbeing can be complex. Well-meaning health messaging is easily overwhelmed by the budgets of the food industry, particularly in lower socio-economic

^v See Appendix A for further detail

neighbourhoods. These issues are particularly astute in areas of New Zealand where accessing affordable and healthy food can be difficult. Disability can further compound these issues and can lead to reliance on ultra-processed foods and other unhealthy food choices.

50 Strong social connections and regular interaction with other people are well-known as having a positive impact on an individual's physical and mental health. In the 2023/2024 NZHS, disabled people were more than six times more likely than non-disabled people to report feeling lonely most or all the time.³⁴

Cultural responsiveness is important to disabled people's ability to engage with the health system

Deaf people may identify as a separate cultural-linguistic group and not as 'disabled' and they experience high rates of mental health issues.

51 International research shows that people who are deaf (culturally Deaf people as well as those who are hard of hearing) experience mental health issues at two to three times the rate of the general population³⁵. In New Zealand factors have been identified to support wellbeing of Deaf people. These include education of health professionals about Deaf culture, New Zealand Sign Language (NZSL) and identity such as impacts of being

Turi Māori (Māori D/deaf) in a hearing world with few or no identity supports.

52 The lack of trilingual interpreters (people who are fluent in te reo Māori, NZSL and English and who are familiar with Māori, Pākehā and Deaf cultural contexts) is a longstanding challenge for the Turi Māori community. Access to culture and identity is important to positive health outcomes.

Tensions exist for some tāngata whaikaha Māori accessing a healthcare system which is based on values that differ from their own culture.

53 Te Ao Māori perspectives on disability see people in a holistic way, as part of a collective, locating disabled people within their whānau and community. This can create tensions with narratives that are individualistic or use language that defines someone by a deficit of ability.

54 Evidence from claimants participating in the Waitangi Tribunal's inquiry into health services and outcomes (Wai 2575) has highlighted structural and cultural barriers across the health system. There are limited options for te ao Māori, whānau and tikanga grounded models of healthcare and the intersection between being both Māori and disabled creates population-specific challenges for tāngata whaikaha Māori.

Pacific disabled people benefit from health practitioners who are culturally competent.

55 Building relationships based on Pacific values is important in connecting with Pacific people and can take time. When disabled Pacific people and their aiga/family are connected into a system based on collective wellbeing, spirituality and cultural competence then health literacy is likely to be better received and shared more readily. Decreasing stigma of disability through the church, and working with existing organisations that have established trust and connection in their local community has been considered one way to grow the wellbeing of Pacific disabled people and aiga. Many of these are community-based organisations outside the church, whose programmes and services are customised to local Pacific communities, and Pacific disabled people. Many of these organisations are making both a physical impact on people's health, and helping to change people's mindsets in terms of how they view their health and their bodies.

56 Developing a health workforce that reflects the community has been identified as a priority in the Health New Zealand's Health Workforce Plan 2024³⁶ which

includes actions to strengthen the Pacific workforce, and the disabled workforce.

57 The Ministry of Disabled People – Whaikaha will shortly be publishing: '*Atoatoali'o, the National Pacific Disability Approach*'. This reflects the voice, experience and aspirations of the Pacific community, Pacific disabled people and their aiga and families. It is an important guide for government agencies.

Limited data makes it difficult for people (and the health system that serves them) to make good, evidenced-based decisions

58 Data collection for disabled people in healthcare is improving. There are now large scale and repeated data collection exercises designed to track and trace the health needs and outcomes of disabled people (i.e. Household Disability Survey). However, there are still many areas where gaps in data collection and analysis mean disabled people are invisible. Robust data collection and analysis about disabled people's access and outcome experiences is important for evidence-based decisions and policies in pursuit of better outcomes for disabled people.

59 Disabled people also want to see their own data curated properly and available to help them with their health

care. Disabled people report that it is frustrating to have to retell their stories every time they engage with a new piece of the government-funded service puzzle. They want providers to be adequately prepared for their appointments; this means accessible environments and appropriate accommodations in place, and well-trained staff who have an appropriate amount of time set aside.

COVID-19 put disabled people at higher risks of negative health outcomes than non-disabled people.

60 The Royal Commission of Inquiry into COVID-19

Lessons Learned (RCOI) released its Phase One Report in 2024. That report calls COVID-19 an “all-of-everything” crisis and provides clear evidence that disabled people experienced the pandemic differently from non-disabled people.

61 The RCOI report notes that although some experiences were positive for some disabled people (e.g. shift to online health provision making it easier for some disabled people to access services, community provision of testing and vaccinations), there are numerous examples of negative impacts on disabled people, as well as impacts that were ‘unpredicted’ by those setting policies (e.g. Personal Protective Equipment shortages preventing carers from accessing clients). There are

numerous findings, lessons and recommendations that are relevant to the lives of disabled people, that cover a range of areas including welfare, justice, immigration, and education.

62 Many of the issues experienced during COVID-19 were unique to a pandemic environment: the consequences of a full lockdown, the isolation of 'bubbles', the shortages of goods and services, and frequently changing rules and regulations of public health orders. The 'new normal' for disabled people often meant living with even greater limitations, many taking extra precautions to protect their health and where there were higher risks to their health, while navigating accessibility issues exacerbated by the pandemic and the actions taken in response.

63 The Ministry of Health is currently undertaking national pandemic planning and preparedness for future pandemic responses in concert with other government agencies. The findings, lessons and recommendations of the Royal Commission of Inquiry into COVID-19 Lessons Learned will be a key input into this work.^{vi}

^{vi} UNCRPD Concluding Observation 20 recommends that the state should closely consult with and actively involve organizations of persons with disabilities in COVID-19 recovery measures.

Demographic projections suggest there will be increasing demand for health services from disabled people.

64 Findings from the 2023 Household Disability Survey reflect the well-known correlation between age and disability.³⁷ 52 percent of those aged 85 and older were identified as disabled, compared with only 17 percent of the general population. Demographic modelling expects that the number of people in the 85 and older age group will double by 2040.³⁸

Work underway

Strategic direction

65 New Zealand's healthcare delivery is set out in several documents that together direct how services will be funded and delivered. The Health and Disability System Review (2019)³⁹ concluded that the health system was not working for disabled people. This resulted in structural reforms to the system that included the Pae Ora (Healthy Futures) Act 2022. This new legislation requires the publication of six health strategies. All strategies have now been published and include:

- New Zealand Health Strategy
- Provisional Health of Disabled People Strategy
- Pae Tū: Hauora Māori Strategy

- Te Mana Ola: Pacific Health Strategy
- Women's Health Strategy
- Rural Health Strategy⁴⁰

66 A 2024 amendment to the Pae Ora Act adds one more strategy for mental health and wellbeing.

67 The intersectional nature of disability means that all the Pae Ora strategies consider disability in their analysis and approach. Other strategies also outline expectations for how the health system performs for disabled people, including the Rare Disorders Strategy and the Healthy Ageing Strategy.

Provisional Health of Disabled People Strategy

68 This strategy is the first dedicated, health system-led strategy for disabled people in Aotearoa New Zealand. Alongside the other Pae Ora strategies, it sets the direction and long-term priorities for achieving equity in disabled people's health and wellbeing outcomes over the next 10 years.

69 The Pae Ora legislation also required shorter term strategic directions in the form of Government Policy Statements⁴¹ and Health Plans,⁴² the latter outlining a three- year plan for how Health New Zealand would deliver on the Government Policy Statement and

strategies. In their current form, these documents commit to ensuring delivery of care is integrated, equity-focused and addresses longstanding disparities facing disabled people.

Government Targets

70 The Government has set nine Government Targets^{vii} to focus the whole of the public sector on achieving improved results in health, education, law and order, work, housing, and the environment. Two of the nine targets focus on achieving improved results in relation to healthcare:

- *Target 1:* Shorter stays in emergency departments; 95% of patients to be admitted, discharged, or transferred from an emergency department within six hours.
- *Target 2:* Shorter waits for elective treatment; 95 percent of people wait less than four months for elective treatment.⁴³

^{vii} More information can be found at this website: [Government Targets | Department of the Prime Minister and Cabinet \(DPMC\)](#)

Ministry of Health | Manatū Hauora

71 The Ministry of Health has a central role in determining how healthcare is delivered in New Zealand. Its current work includes the following:

*Health of Disabled People Work Programme 2024 – 2027:*⁴⁴

72 The Ministry is progressing work under the Provisional Health of Disabled People Strategy to improve access to the health system and health services for the disabled population. This work:

- focuses on foundational actions to enable the health system to respond in an appropriate and timely manner to disabled peoples' health needs
- aligns with a wide range of actions underway for disabled people, including across the Ministry of Health and Health New Zealand.

73 The work programme is guided by what disabled communities have said is most important to them and what will have the most impact and value on their health, as outlined in the Health of Disabled People Strategy and the other Pae Ora strategies. This work is set out in detail at Appendix B and includes actions that:

- focus on those with highest health need, including tāngata whaikaha Māori, Pacific disabled people and

intellectually disabled groups, considering models of care that are appropriate and responsive to their needs

- improve disabled people's access to primary and community health care
- prepare a disability-competent and more confident health workforce in caring for and supporting the choices and decisions that disabled people make about their health
- generate quality health data and insights on disabled population health
- monitor health system performance and outcomes for the disabled population.

Fetal Alcohol Spectrum Disorder (FASD) action plan:^{viii}

74 The Ministry of Health (through its Public Health Agency) and Health New Zealand are co-leading the development of an FASD plan to ensure a system-wide response and priorities to prevent FASD and support people with FASD. A draft is currently in consultation and the final is expected to be released in 2025.

Health NZ | Te Whatu Ora

^{viii} The previous plan is available at: [Taking Action on Fetal Alcohol Spectrum Disorder: 2016–2019: An action plan.](#)

75 Health NZ | Te Whatu Ora is responsible for the funding, commissioning, and delivery of primary, secondary, and tertiary healthcare in New Zealand. This includes ensuring all services are inclusive of, and accessible to, disabled people, as well as the delivery of services that are specific to disabled people.

*Te Pae Tata | Interim New Zealand Health Plan 2022*⁴⁵

76 *Te Pae Tata* is the key document that determines allocation of resources, policy settings and service levels across the New Zealand health system. The plan sets out the actions necessary to prevent illness and support good health and wellbeing for all New Zealanders, no matter who you are or where you live.

77 Disabled people are prioritised as an equity group in the plan, alongside Māori and Pacific populations. Priorities provide a strong focus for all work across Health NZ:

- make all health services accessible, inclusive, and equitable for disabled people
- create “twin-track” pathways and services for disabled people and communities who need them to commit to continued, radical and measurable change.

78 For the purposes of this work, Health NZ has advised that the next Health NZ Plan Te Pae Waenga includes three actions aimed at creating an inclusive, accessible and equitable health service for disabled people. These are to:

- implement the Patient Profile and National Health Index (PPNHI) programme and build data intelligence capabilities to better understand how to be more responsive to disabled people in health settings
- design and implement the disability model of care with a focus on infrastructure, workforce capability and capacity, policies, processes, practices and information accessibility
- implement actions that project the disability consumer and whānau voices into key areas of work, including service design and planning.

Te Aho o Te Kahu | Cancer Control Agency

Disabled People and Cancer: A Literature Review and Data Project

79 This research will shortly be released and will seek to fill a gap in the research around the incidence of cancer and cancer outcomes for disabled New Zealanders. It includes two separate pieces of research. A literature

review that aims to provide insight into disabled people with cancer, synthesising local and international evidence found to better understand the factors that impact disabled people when navigating the cancer care system will be published shortly. This will be followed by a data project exploring the correlation between cancer and disability in the New Zealand health system using a retrospective cohort study of disabled people with cancer compared to the general population.

Te Tāhū Hauora Health Quality and Safety Commission

Window on Disability report

80 Every year the Health Quality & Safety Commission publishes a document called a "windows" document on the quality of New Zealand's health care. There is a specific focus each year, and this year's report will be focused on the health and health experiences of disabled people.

Health and Disability Commission – Te Toihau Hauora, Hauātanga (HDC)

Review of the Act and Code 2024⁴⁶

81 The HDC reviews the Health and Disability Commissioner Act 1994 (the Act) and the Code of Health and Disability Services Consumers' Rights (the Code) at regular

intervals. The reviews provide an opportunity to make sure the Act and Code remain effective in protecting and promoting the rights of everyone using health and disability services. The Minister of Health tabled HDC's latest recommendations report in Parliament in March of this year. Disabled people contributed 28 percent of written feedback and disability was the largest singular engagement group.

Wai 2575 Health Services and Outcomes Inquiry

82 The Waitangi Tribunal's inquiry into health services and outcomes was initiated in 2016, and in 2017 the Tribunal confirmed the inquiry would proceed on a phased and thematic basis. Stage one inquired into the legislative and policy framework of the primary healthcare system. The Tribunal's report for stage one (the Hauora Report)^{ix} was released on 1 July 2019.

83 Closing submissions for phase two (the disability phase)^x were presented to the Waitangi Tribunal in December 2024, concluding the hearings phase of the

^{ix}

https://forms.justice.govt.nz/search/Documents/WT/WT_DOC_195476216/Hauora%202023%20W.pdf

^x Phase two, commencing in 2024, will hear claims concerning grievances relating to mental health (including suicide and self-harm), and alcohol and substance abuse (including tobacco). Stage three will hear remaining national significant issues and eligible historical issues.

inquiry. The Waitangi Tribunal's next report is expected to make recommendations on Crown actions to address key grievances (e.g., improve Māori disabled access to rural health services, systemic issues, poor data, workforce issues, amongst other issues).

Critical analysis

- 84 The inequity, and drivers of inequity, preventing disabled people from reaching the highest attainable level of health and wellbeing are significant, deep and systemic.
- 85 Disabled people die early, experience higher rates of coexisting conditions, need more emergency care, spend more time in hospital and have far greater unmet needs than their non-disabled peers. These issues are compounded by intersectionality.
- 86 Concerted efforts will be required to improve health outcomes, deliver inclusive, accessible healthcare that is consistently of a high quality, and shift health outcomes towards equity for all disabled people. There is also a need to build trust among the disabled people in the health system.

87 Over the past decade several significant reports (both technical and community-based)^{xi} have been published on the issue. There have also been significant global initiatives driving the agenda forward^{xii}.

88 It is clear that there is already much agreement about what needs to be done to improve health outcomes for disabled people. The range of documents published on this topic broadly agree on what actions should be taken. Repeated themes include:

- accessibility of services
- self-determination
- data collection
- attitudes
- inclusion and consultation of disabled people
- training for health professionals working with disabled people

^{xi} Examples include: Health and Disability System Review (The Simpson Report), Abuse in Care Royal Commission of Inquiry, Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry (Wai 2575), From Data to Dignity: Health and Wellbeing Indicators for New Zealanders with Intellectual Disability, Enabling Good Lives Report. Details for all of these reports can be found in the Reference section.

^{xii} International examples include UNCRPD processes, Sustainable Development Goals, The Missing Billion initiative.

- employment opportunities for disabled people.

89 Many of these elements are covered in the current *New Zealand Disability Strategy (2016-2026)*, reflected in the *Enabling Good Lives* approach, and addressed in the Provisional Health of Disabled People Strategy.

90 The following suggestions provide some areas that could be considered by the working group as part of the NZDS refresh.

Governance, leadership, oversight

91 The working group may wish to review and consider the governance arrangements that oversee delivery of health services to disabled people and whether any changes to current arrangements for leadership and oversight could improve outcomes for disabled people and their families.

Building workforce capabilities and competence

92 Developing a health workforce that is knowledgeable about disability and has the skills and mindset to provide quality care could be one area to include in the NZDS. One way to achieve this would be to improve staff competency by increasing education and training with regards to working with disabled people. Another option would be to ensure that employment in the health service is open and accessible to disabled people to boost the numbers of people with lived experience of

disability working in the health system. This would support priority five of *The Health Workforce Plan 2024* to improve the diversity of the workforce, including disabled workers, so that the health workforce better represents the community it serves.

Prioritise autonomy and awareness

93 Ensure that supported decision making is available so disabled people are supported to make decisions about their health and are aware of their rights, understand their options, make informed choices, and can access services at the same rates as non-disabled people.

All health services, including health facility infrastructure and information, are accessible and inclusive

94 Accessibility must be understood in its broadest sense to include information, communication and environmental factors but also extends to financial, technological, and cultural access.

95 It requires translation or interpreters and support staff to be readily available and a commitment to reasonable accommodation adjustments required to ensure that disabled people receive an equitable standard of service provision.

96 Acquiring health literacy to the highest extent possible for an individual and whānau to make the best health decisions for their situation begins with accessible education and resources.

97 Commissioning of work to encourage health promoting behaviours should be better targeted, accessible, inclusive and relevant to disabled people. Especially where the activity being encouraged is known to be challenging for disabled groups.

Make disability a core part of data collection and utilise it to improve health outcomes for disabled people

98 The collection of health data includes information about disabilities and is able to be disaggregated by population group. Resulting information can be shared across all levels and parts of the health service to improve decision-making and policies in relation to the health of disabled people.

Ensure that disabled people are included in decision-making

99 Representatives of the disabled community (including disabled people from within the health workforce) should be included as part of governance and monitoring work for mainstream health services as well as work targeting disabled populations.

UNCRPD Concluding Observations of the Committee

100 There are 17 concluding observations that Cabinet⁴⁷ has agreed will be considered as part of the NZDS refresh. There are four that are relevant to the health sector.^{xiii} These are set out in full at Appendix C.

International good practice examples supporting improved health outcomes and more inclusive health systems

101 There are many international strategies or documents dedicated to the aim of increasing positive health outcomes of disabled people in their jurisdiction and make real the UNCRPD Article 25 (Health) which states 'persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.'

102 Themes of timely access to the health and mental health system are repeated across these documents and include access to information, technology and trained health professionals. Sound cultural competency of the

^{xiii} UNCRPD Concluding Observations in brief: CO28(b) Repeal certain provisions in the Intellectual Disability (Compulsory Care and Rehabilitation) Act of 2003, CO36(a) Immediately place a moratorium on sterilization, contraception and abortion procedures performed without personal consent, CO 36(f) develop reporting on sterilization, contraception and abortion procedures on intersex children and on growth attenuation treatment. CO42: funding for assistive technology.

local or national health system for disabled indigenous peoples and specific choice for culturally appropriate programmes similar to kaupapa Māori services are also embedded.

103 Other themes include regular interventions to help disabled people identify health conditions early and also to engage with disabled communities to understand health literacy and socioeconomic gaps.

Australia's Disability Strategy 2021 – 2031: Building a more inclusive Australia

104 . Australia's Disability Strategy was refreshed in 2024⁴⁸ following a review, and is Australia's national disability policy framework, it includes a roadmap and an action plan. The strategy has similar health and wellbeing outcome themes as New Zealand's Provisional Health of Disabled People Strategy The strategy's health outcome reflects UNCRPD Article 25 across the life of a disabled person and the policy priorities are to improve:

- experiences of disabled people when they need to access health services,

- access to health care to prevent conditions and intervene early
- experience of mental health care and supporting the mental health of disabled people
- emergency services responses for disabled people.

Australia – Down Syndrome Health Ambassadors

105 Down Syndrome Health Ambassadors are a group of individuals with Down syndrome, who work to inform health care workers about how best to include people with Down syndrome in their own health conversations.

United Kingdom: Accessible Information Standard (AIS)

106 The UK's AIS mandates that all health and social care providers ensure accessible communication for disabled individuals, including sign language interpreters and easy-read materials.

Ireland: National Clinical Programme for People with Disability⁴⁹

107 The National Clinical Programme for People with Disability is housed within the Ministry of Health, seeks to support the provision of effective and efficient health and social care for people with disabilities.

108 Created in March 2020 and composed of three members and a number of associated disability

specialists, the programme aims to design clinical services that are evidence-informed, context-appropriate, and based in the social and rights model of disability.

109 The programme has a clear governance structure, including advice provided by the Disability Advisory Group, consisting of 20 members drawn from each of the nine disciplines which each have a uni-disciplinary sub-committee, a range of disability stakeholders (e.g., service users, carers' associations, service providers) and representatives of the National Disability Operations and Strategy and Planning programmes. Disabled people are at the centre of the programme and it has strong backing from health and social care leadership.

110 Transferable lessons to date include that:

- the relevance of the UNCRPD to clinical contexts has to be claimed and demonstrated
- the principle of participation has to be embedded for service providers as well as service users
- conventional practices need to be challenged by credible people with credible alternatives
- senior allies open to change must be identified and engaged⁵⁰.

International: The Missing Billion Initiative

111 The Missing Billion Initiative^{xiv} is a 'think-and-do' tank working at an international level to advance disability-inclusive health by delivering a case for action to funders and implementors and supporting them in the adoption of high impact interventions.

112 They promote a number of policy tools that are useful ways of conceptualising an inclusive approach to healthcare including 'Missing Billion Inclusive Health Systems Framework' and 'Inclusive care pathways for disabled people' as well as producing research in new areas of interest such as artificial intelligence.⁵¹

End

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^{xiv} [Missing Billion Initiative](#)

Appendix A: Health Indicators for people aged 15 and over, July 2023 – June 2024

Cardiovascular health conditions (lifetime diagnosis prevalence)

Ischaemic heart disease:

- non-disabled people 3.8%
- disabled people: 12.5%

Heart failure:

- non-disabled people: 1.9%
- disabled people: 8.7%

Stroke:

- non-disabled people: 1.3%
- disabled people: 8.3%

High blood pressure (and was taking medication):

- non-disabled people: 16.2%
- disabled people: 34.6%

Other health conditions and body size

Asthma (ever been diagnosed and was taking medication)

- non-disabled people: 11.6%

- disabled people: 21.4%

Diabetes (ever been diagnosed)

- non-disabled people: 5.7%
- disabled people: 14.4%

Chronic pain lasting six or more months

- non-disabled people: 16.9%
- disabled people: 50.2%

Arthritis (ever been diagnosed):

- non-disabled people: 15.3%
- disabled people: 42.4%

Obesity (BMI of 30+ or equivalent for ages 15-17)

- non-disabled people: 32.9%
- disabled people: 44.3%

Healthcare usage (in the past 12 months)

Visited Emergency Department

- non-disabled people: 16%
- disabled people: 37.6%

GP visit

- non-disabled people: 74.1%
- disabled people: 91.7%

Consulted a nurse or GP about mental health

- non-disabled people: 11.3%
- disabled people: 24.4%

Consulted a psychologist, counsellor, or psychotherapist about mental health

- non-disabled people: 8.7%
- disabled people: 16.9%

Barriers to health services⁵²

Unmet need for a GP due to cost

- non-disabled people: 14.9%
- disabled people: 22.3%

Unmet need for GP due to wait time

- non-disabled people: 25.0%
- disabled people: 32.0%

Unmet need for a GP due to lack of transport

- non-disabled people: 2.9%
- disabled people: 8.4%

Unmet need for mental health or addiction services

- non-disabled people: 9.6%
- disabled people: 22.2%

Unmet need for a GP due to dislike or fearing the GP

- non-disabled people: 2.4%

- disabled people: 6.2%

Unfulfilled prescription due to cost

- non-disabled people: 3.8%
- disabled people: 11.2%

Appendix B: Ministry of Health Disabled People Work Programme 2024-2027

DOMAINS	PROPOSED ACTIONS	WORK PROGRAMME SCOPING/ STATUS (June 2024)	DURATION	LEAD Support	KEY EXTERNAL LINKAGES
POPULATION HEALTH NEED Disabled people with highest health need	1. Tāngata whaikaha Māori / Māori disabled people Health improvement	Develop strategic actions for Māori disabled health in the refresh of Pae Tū: Hauora Māori Strategy: - Model of healthcare for Māori disabled people. - Health intelligence on the Māori disabled population. - Monitoring of cultural quality in health services. - Development of community plans and local needs assessment. Action supported by Māori Health (subject to decisions on Māori Health direction)	Ongoing Plan 2024 Start 2025 Review 2026	Māori Health Disability Policy	Iwi Māori Partnership Boards Hauora Māori Advisory Board Waitangi Tribunal (WAI 2575) Whaikaha (Māori Disability Action Plan).
	2. Tagata sa'ilimalo/ Pacific disabled people Health improvement	Develop actions for Pacific disabled health in the Te Mana Ola: The Pacific Health Strategy - Model of healthcare for Pacific disabled people. - Health intelligence on the Pacific disabled population. - Monitoring of cultural quality in health services. Action to be scoped with Pacific Health (subject to Pacific Health finalising annual work plan)	Ongoing Plan 2024 Start 2025 Review 2026	Pacific Health Disability Policy	Health NZ, Whaikaha (Pacific Disability Action Plan).
	3. Intellectually disabled people Annual Health Checks	- Scope a social investment/ budget bid on a prototype for Annual Health Checks in primary care. - Develop health actions for intellectually disabled people. Action to be scoped by Disability Policy	Two-years Plan 2024/25 Start 2025 End 2027	Disability Policy Primary Care Clinical Office Māori Health Pacific Health	Health NZ, Whaikaha, Royal New Zealand College of General Practitioners.
ACCESS & PREVENTION Improving access to healthcare, promoting health & preventing further health problems	4. Supported Decision Making Resources for health practitioners on supported decision making	- Scope resources for health practitioners to assist consumers needing support to make decisions on their health services. - Develop and promote supportive resources for the health sector, including mental health and aged care. Action agreed as high priority within the Ministry and with Health New Zealand and Whaikaha	One-year Plan 2024 Start 2025 End 2025 Review	Disability Policy Clinical Office Mental Health Māori Health Pacific Health Public Health	Health NZ, Ministries of Children, Disabled People, Education & Social Development, ACC, Health and Disability Commissioner.
	5. Primary Care Primary Care-level monitoring and surveillance of disabled people's health	- Review the approach to monitoring of primary care for the early detection and prevention of disabled people's health problems over the lifespan. - Develop a monitoring model for primary care on early detection and prevention of health conditions in disabled people. Action to be scoped and agreed with Primary Care	Two-years Plan 2024 Start 2025 End 2027	Primary Care Disability Policy	Health NZ, Ministries of Children, Disabled People, Education & Social Development.
WORKFORCE Improving disability capability of health workers	6. Mental Health Promotion of mental health wellbeing for disabled people	Develop a mental health wellbeing approach, covering risk and protection factors, for disabled people. Action supported by Mental Health (subject to decisions on Mental Health strategic direction)	18-months Start 2025 End 2026	Mental Health Disability Policy	Health NZ, Whaikaha.
	7. Health Workforce Strengthening health workforce, training, knowledge and competency in disability	- Review of Health Practitioners Competency & Assurance Act 2003 - identify safety risks to disabled people in health services resulting from lack of practitioner competence. - Regulatory policy development on health practitioner competency standards and training requirements in disability. - Health workforce performance monitoring. - Opportunities for disabled people in health workforce Action supported by Health Workforce (subject to agreement)	Ongoing Plan 2024 Start 2024 Review annually	Regulation Policy Regulation & Monitoring Disability Policy	Health NZ, Whaikaha, Health Quality & Safety Commission
	8. Health intelligence Disaggregation of disability data in national health surveys and data collections	- Lead project to generate good data and insights on disabled population health. Support Ministry of Health's data stewardship function in relation to national disability data. - Support Health NZ's current work to identify disabled people by a new National Health Index identifier in national health datasets. - Identify investment opportunities in disability data infrastructure development. - Develop a snapshot on disabled population health (Disability Chartbook) Action supported within Ministry and by external stakeholders (to be scoped by Disability Policy)	Three-years Plan 2024 Start 2025/26 END 2027	Disability Policy Strategy & Policy Clinical Office Research Regulation Public Health Mental Health Māori Health Pacific Health	Health NZ, ACC, Stats NZ, Ministries of Children, Disabled People, Education & Social Development.
HEALTH SYSTEM Health of disabled population policy and outcomes monitoring framework	9. Monitoring of Disabled Population Health Outcomes Monitoring health system performance and outcomes for disabled population	- Lead a policy project on the health system-level monitoring arrangements for the disabled population. - Develop an approach to monitoring Disabled Population Health Outcomes, aligning with the Ministry's Outcomes Framework. Action agreed (start-up subject to successful application of Evaluation and Research funding)	18-months Plan 2024 Start 2024/25 End 2026	Disability Policy Strategy & Policy Research Regulation Public Health Mental Health Pacific Health Māori Health	Health NZ, Health Quality & Safety Commission, ACC, Ministries of Children, Disabled People, Education & Social Development.
	10. Disabled Population Health Policy Framework Health Model of Disability	- Lead a policy project to develop an evidence-based policy approach to the health of disabled people, drawing on best practice. - Publish and disseminate a "Health Model of Disability" policy resource.	18-months Plan 2024 Start 2024 End 2025/26	Disability Policy Strategy & Policy Clinical Office Research Public Health	Health NZ, ACC, Ministries of Children, Disabled People, Education
		Action supported within Ministry and by external stakeholders (to be scoped by Disability Policy)		Mental Health Pacific Health Māori Health	& Social Development.

Appendix C: UNCRPD Concluding Observations relevant to Health outcome area of NZDS

Concluding Observation 28 (b):

Repeal provisions within the Intellectual Disability (Compulsory Care and Rehabilitation) Act of 2003 that allow for persons with disabilities to be detained for periods of time exceeding the maximum length of the sentence they would be liable to in the criminal justice system.

Liberty and security of person (art. 14)

Proposed Action

Lead agency: Ministry of Health

Compulsory care under the IDCCR Act is not correctional detention, nor intended as a punishment for the crime that the person has been charged or convicted with. Instead, it provides individuals with support to learn skills and positive behaviours and length of care is determined by whether the person is assessed as being able to live independently and safely. In 2023, the MDP launched the High and Complex Framework, which works alongside the IDCCR Act to provide diversionary pathways away from prison for people with intellectual disabilities.

Concluding Observation 36 (a):

Immediately place a moratorium on sterilization, contraception and abortion procedures performed without personal consent, and take urgent action to adopt uniform legislation prohibiting such procedures on women and girls with disabilities.

Protecting the integrity of the person (art. 17)

Proposed Action

Lead agency: Ministry of Health

The Ministry of Health proposes to address the key concerns raised in this recommendation through its new Health of Disabled People work programme 2024-27 and with Health New Zealand. The new work programme has actions that aim to improve safeguards and assure safety of disabled people when they need to access the health system and health care.

Concluding Observation 36 (d):

Adopt legislative provisions to prohibit growth attenuation treatment (Ashley Treatment), including a prohibition on procedures sought outside New Zealand.

Protecting the integrity of the person (art. 17)

Proposed Action

Lead agency: Ministry of Health

The Ministry of Health proposes to address the key concerns raised in this recommendation through its new Health of Disabled People work programme 2024-27 and with Health New Zealand. The new work programme has actions that aim to improve safeguards and assure safety of disabled people when they need to access the health system and health care.

Concluding Observation 36 (f):

Develop measures to ensure reporting and data collection on sterilization, contraception and abortion procedures performed without personal consent, on non-urgent medical interventions performed on intersex children and on growth attenuation treatment.

Protecting the integrity of the person (art. 17)

Proposed Action

Lead agency: Ministry of Health

The Ministry of Health proposes to address the key concerns raised in this recommendation through its new Health of Disabled People work programme 2024-27 and with Health New Zealand. The new work programme has actions that aim to improve safeguards and assure safety

of disabled people when they need to access the health system and health care.

Concluding Observation 42:

The Committee recommends that the State party take measures to ensure the affordability of necessary assistive devices, modification services and mobility aids, including assistive technology for persons with disabilities.

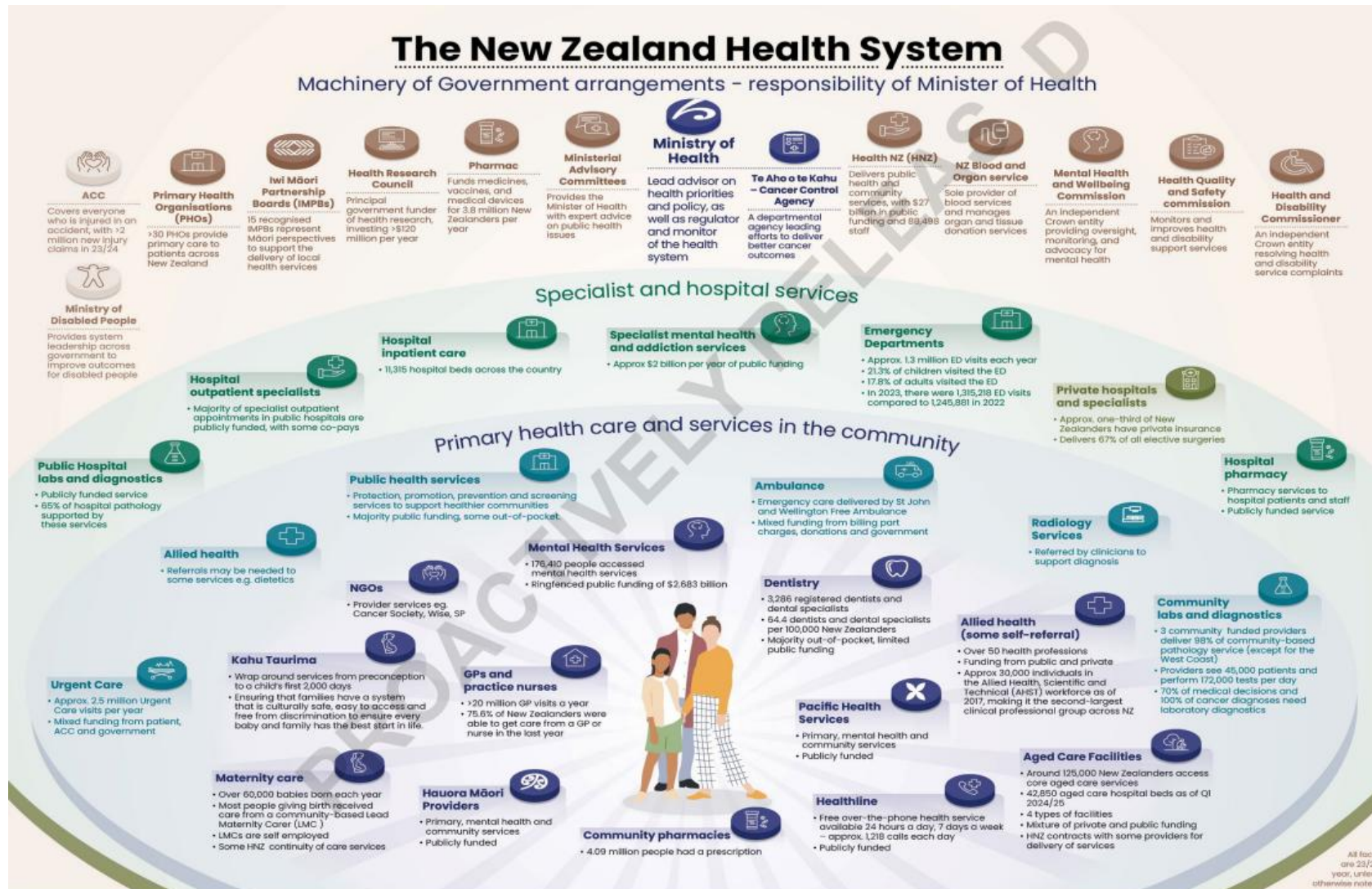
Personal mobility (art. 20)

Proposed Action

Lead agencies: Ministry of Social Development and Ministry of Health

Future actions will be considered through the development of the refreshed NZDS.

Appendix D: Overview of the New Zealand Health System as at 25 January 2025



Appendix D: Accessible Description of the Overview of the New Zealand Health System as at 25 January 2025

Description of image

Image is a diagram of the different organisations that together make up the NZ Health System.

An illustration of three people sits in the centre bottom of the whole image.

There are three concentric ovals radiating out from the people.

The central circle (closest to the people) is the biggest and is titled: the Primary Health care and services in the Community. This section includes 18 different organisations.

These are:

- Community pharmacies
 - 4.09 million people had a prescription
- Healthline
 - Free over the phone health service available 24 hours a day, 7 days a week – approx. 1218 calls each day
 - Publicly funded
- Hauora Māori providers

- Primary, mental health and community services
 - Publicly funded
- Pacific Health Services
 - Primary, mental health and community services
 - Publicly funded
- GPs and practice nurses
 - More than 20 million GP visits per year
 - 75.6% of New Zealanders were able to get care from a GP or nurse in the last year
- Dentistry
 - 3286 registered dentists and dental specialists
 - 64.4 dentists and dental specialists per 100 000 New Zealanders
 - Majority out of pocket, limited public funding
- Allied Health (some self referral)
 - Over 50 health professions
 - Funding from public and private
 - Approx 30000 individuals in Allied Health Scientific and Technical (AHST) workforce as of 2017, making it the second largest clinical professional group across New Zealand
- Aged care facilities
 - Around 125000 New Zealanders access aged care services

- 42,850 aged care hospital beds as of Quarter 1 2024/25
- Four types of facilities
- Mixture of private and public funding
- HNZ contracts with some providers for delivery of services
- Mental health services
 - 176,410 people accessed mental health services
 - Ringfenced public funding of \$2.683 billion
- NGOs
 - Provider services e.g. Cancer Society, Wise, SP
- Kahu Taurima
 - Wrap around services from preconception to child's first 2000 days
 - Ensuring that families have a system that is culturally safe, easy to access and free from discrimination to ensure every baby and family has the best start in life
- Maternity care
 - Over 60,000 babies born each year
 - Most people giving birth received care from a community-based Lead Maternity Carer (LMC)
 - LMCs are self employed
 - Some HNZ continuity of care services

Also in the primary healthcare and services in the community bubble, but around edges and different colour.

- Urgent care
 - Approx 2.5million Urgent Care visits per year
 - Mixed funding from patient, ACC and government
- Allied Health
 - Referrals may be needed to some services e.g. dietetics
- Public health services
 - Protection, promotion, prevention and screening services to support healthier communities.
 - Majority public funding, some out of pocket
- Ambulance
 - Emergency care delivered by St John and Wellington Free Ambulance
 - Mixed funding from billing part charges, donations and government
- Radiology services
 - Referred by clinicians to support diagnosis
- Community labs and diagnostics
 - Three community-funded providers deliver 98% of community-based pathology service (except for the West Coast)
 - Providers see 45,000 patients and perform 172,000 tests per day

- 70% of medical decisions and 100% of cancer diagnoses need lab diagnostics

The middle circle is titled 'Specialist and Hospital Services': this features 7 different organisations.

These are:

- Public hospital labs and diagnostics
 - Publicly-funded service
 - 65% of hospital pathology supported by these services
- Hospital outpatient specialists
 - Majority of specialist outpatient appointments in public hospitals are publicly funded, with some co-pays.
- Hospital inpatient care
 - 11,315 hospital beds across the country
- Specialist mental health and addiction services
 - Approx 2 billion dollars per year of public funding
- Emergency Departments
 - Approx 1.3 million ED visits each year
 - 21.3% of children visited the ED
 - 17.8% of adults visited the ED
 - In 2023, there were 1315218 ED visits compared to 1245881 in 2022

- Hospital pharmacy
 - Pharmacy services to hospital patients and staff
 - Publicly funded service
- (In a different shade) Private hospitals and specialists
 - Approx one third of New Zealanders have private insurance
 - Delivers 67% of all elective surgeries

The outer circle is titled 'Machinery of Government arrangements - responsibility of Minister of Health' this includes 14 different organisations.

First bubble colour

- ACC
 - Covers everyone who is injured in an accident with more than 2 million new injury claims in 2023/24
- Ministry of Disabled people
 - Provides system leadership across government to improve outcomes for disabled people

Second bubble colour

- Ministry of Health
 - Lead advisor on health priorities and policy, as well as regulator and monitor of the health system
- Te Aho o Te Kahu – Cancer Control Agency

- A departmental agency leading efforts to deliver better cancer outcomes

Third bubble colour

- Primary Health Organisations (PHOs)
 - More than 30 PHOs provide primary care to patients across New Zealand
- Iwi Māori Partnership Boards (IMPBs)
 - 15 recognised IMPBs represent Māori perspectives to support the delivery of local health services.
- Health Research Council
 - Principle government funder of health research, investing more than 120 million dollars per year.
- Pharmac
 - Funds medicines, vaccines and medical devices for 3.8 million New Zealanders per year
- Ministerial Advisory Committee
 - Provides the Minister of Health with expert advice on public health issues
- Health NZ (HNZ)
 - Delivers public health and community services, with 27 billion dollars in public funding and 88498 staff.
- The NZ Blood and Organ Service

- Sole provider of blood services and manages organ and tissue donation services.
- Mental Health and Wellbeing Commission
 - An independent crown entity providing oversight, monitoring and advocacy for mental health.
- Health Quality and Safety Commission
 - Monitors and improves health and disability support services
- Health and Disability Commissioner
 - An independent crown entity resolving health and disability service complaints.

At the bottom of the diagram there is text reading, 'All facts are 23/24 year unless otherwise noted.'

Endnotes

¹ The two key treaties specific to this paper are the Convention on the Rights of Persons with Disabilities (UNCRPD): Article 25 (2006) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

² <https://tikatangata.org.nz/human-rights-in-aotearoa/right-to-health>

³ Minister of Health. (2023). (p11-13). *Provisional Health of Disabled People Strategy*. [Provisional Health of Disabled People Strategy | Ministry of Health NZ](#) , accessed 5 March 2025.

⁴ Minister of Health. 2024. (p13). Government Policy Statement on Health 2024 – 2027. Government Policy Statement on Health 2024–2027 | Ministry of Health NZ , accessed 5 March 2025.

⁵ In addition to the Health and Disability paper, Whaikaha is preparing working papers for education, housing, justice, and employment.

⁶ Ministry of Health. 2024. (p10) *Health and Independence Report 2023 - Te Pūrongo mō te Hauora me te Tū Motuhake 2023*. Wellington: Ministry of Health, [Health and Independence Report 2023](#) , accessed 1 April 2025

⁷ Ingham TR, Jones B, Perry M, King PT, Baker G, Hickey H, Pouwhare R, Nikora LW. The Multidimensional Impacts of Inequities for Tāngata Whaikaha Māori (Indigenous Māori with Lived Experience of Disability) in Aotearoa, New Zealand. *International Journal of Environmental Research and Public Health*. 2022; 19(20):13558. <https://doi.org/10.3390/ijerph192013558>

⁸ King, Paula. (2019). *Māori With Lived Experience of Disability, Part I*, Waitangi Tribunal, p359 [Microsoft Word - Final Waitangi Tribunal Report Disability Part I 27_06_2019.docx](#)

⁹ Stats NZ (2023). Pacific housing: People, place, and wellbeing in Aotearoa New Zealand. [Pacific housing: People, place, and wellbeing in Aotearoa New Zealand | Stats NZ](#) , accessed 19 March 2025

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- ¹⁰ Ministry for Pacific Peoples. (2020). *Pacific Aotearoa Status Report, A Snapshot*. [Pacific-Peoples-in-Aotearoa-Report.pdf](#) accessed 14 March 2025.
- ¹¹ Minister of Health. 2023. *Te Mana Ola: The Pacific Health Strategy*. Wellington: Ministry of Health. [Te Mana Ola: The Pacific Health Strategy](#) accessed 03 April 2025.
- ¹² Ministry of Health. (2024). *Annual Data Explorer 2023/24: New Zealand Health Survey* [minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/ w 4b938bb8/#!/explore-indicators](#) ,accessed 03 April 2025.
- ¹³ Ministry of Health. 2011. *Health Indicators for New Zealanders with Intellectual Disability*. Wellington: Ministry of Health.
- ¹⁴ [Health Indicators for New Zealanders with Intellectual Disability | Ministry of Health NZ](#) , accessed 19 March 2025.
- ¹⁵ Ministry of Health. 2011. *Health Indicators for New Zealanders with Intellectual Disability*. Wellington: Ministry of Health.
- ¹⁶ IHC. (2023). *From Data to Dignity: Health and Wellbeing Indicators for New Zealanders with Intellectual Disability*. [From Data to Dignity: Health and Wellbeing Indicators for New Zealanders with Intellectual Disability \(full report\)](#)
- ¹⁷ WHO Discussion Paper. (2012). *Risks to mental health: an overview of vulnerabilities and risk factors background paper by who secretariat for the development of a comprehensive mental health action plan*, [WHO Discussion Paper Risks to Mental Health](#) , accessed 19 March 2025
- ¹⁸ WHO Discussion Paper. (2012). P10.
- ¹⁹ Australian Institute of Health and Welfare (2024) [Health of people with disability](#), AIHW, Australian Government, accessed 28 February 2025
- ²⁰ McKee, R., and Vale, M. (2014) *The vitality of New Zealand Sign Language project: Report on a survey of the Deaf / NZSL community*. Victoria University of Wellington, [Microsoft Word - NZSL Vitality Deaf Community Survey Report Sept 2014 .docx](#) , accessed 20 March 2025
- ²¹ Statistics NZ, (2025). [Child poverty statistics: Year ended June 2024 | Stats NZ](#)

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- ²² Ministry of Health. (2024). *Annual Data Explorer 2023/24: New Zealand Health Survey [Data File]*. URL: <https://minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/>
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