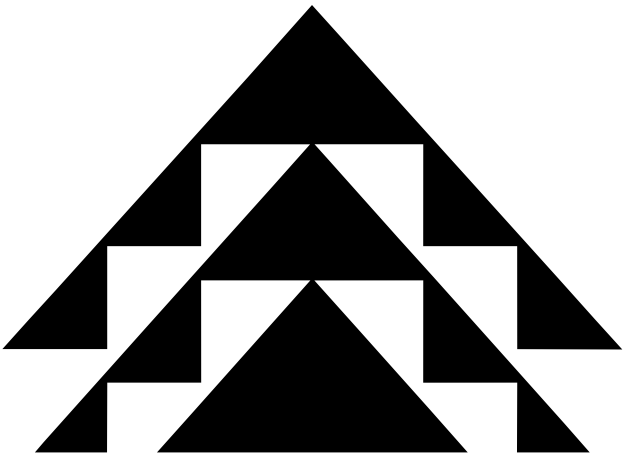
Analysis report

Identifying the top five regional Māori health priorities for Te Ikaroa Iwi Māori Partnership

Report prepared for Te Ikaroa IMPBs by Baker Consulting Ltd

24 April 2026



ĀTI AWA TOA HAUORA PARTNERSHIP BOARD

TE KARU O TE IKA POARI HAUORA

TIHEI TAKITIMU IWI MĀORI PARTNERSHIP BOARD

Te Pae Oranga

TE MĀTUKU

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Executive summary

The aim of this report is to identify the top five priorities for Te Ikaroa region's Iwi Māori Partnership Boards (IMPBs). It draws on existing reports from each of the five Te Ikaroa IMPBs, published literature, and publicly available government policy and data reports.

Prioritisation framework
Prioritisation is difficult in the health sector as almost everything seems essential to our wellbeing. Nevertheless, it is crucial for IMPBs to focus on a smaller number of important areas in order to have the most impact.

There are lots of different ways to prioritise, but there are few – if any – existing tools that prioritise based on equity. Furthermore, the type of prioritisation tool or approach you use depends on your roles and functions. Therefore, for this report, we need a prioritisation framework that supports IMPB strategic and advisory roles, gives focus to monitoring and is meaningful to whānau and communities at regional and local levels.

This report presents a framework, drawing on cost-effectiveness, equity tools, and Te Tiriti o Waitangi principles, with three questions:

1. What health issues are most important regionally? This stage is based on community health plan (CHP) and IMPB health profile data.
2. What interventions support equitable outcomes? This stage is based on an environmental scan of policy and research.
3. What actions can IMPBs undertake within the priority areas? This stage is an extra check that the priorities align to IMPB roles regionally and support Māori leadership, knowledge, and aspirations.

What health issues are most important regionally?
This report considers all priorities identified across the five Te Ikaroa IMPB CHPs. Each IMPB approached the task of developing a CHP differently (which makes sense given that each IMPB should be preparing plans that resonate with their own communities), and this meant that our analysis had to be nuanced and understand the context of each CHP.

In the CHP analysis, a total of 121 priorities were identified. A subset of 31 priorities was then selected (these were priorities shared by three or more IMPBs).

The report then considers the five Te Ikaroa IMPB data profiles (released in 2023 and 2024). We sought to identify the health indicators that represented the greatest health burden for Māori and, using an equity lens, looked at areas where risk ratios suggested Māori are more likely to experience barriers to health services or specific health issues or outcomes.

Combining the CHP and data analysis, we identify five areas to look at in more depth:

- Mental health and wellbeing, particularly looking at community mental health services and improving access to appropriate medicines
- Oral health, and improving access to services for whānau – but especially tamariki
- Improving access to cancer screening so that Māori whānau can experience the full benefits of this public health intervention
- Improving access to high quality primary health care and community-based support (around diabetes, asthma, and cardiovascular disease (CVD)) and extending primary and community health care service offerings, so that all Māori whānau, including kaumātua, tāngata whaikaha and whānau who live in rural areas can access services they most need
- Improving access to hospital and specialist services.

What interventions support equitable outcomes?
For each of the five areas outlined above, we conducted a rapid environmental scan – aiming to gather more information and background on the area, to understand current government approaches and to identify different intervention points supported by published evidence. The environmental scans are summarised in the body of the report, with more detail provided in Appendix 1.

A set of questions were used in this stage of the framework to explore the impact of each intervention on equity and to identify any mitigations that need to be put in place to avoid any negative, unintended, consequences.

What actions can IMPBs undertake within the priority areas?
The final stage of the prioritisation framework considers the extent to which actions proposed also align to the regional role of Te Ikaroa IMPBs. Specifically, the report considers how the proposed focus areas within each priority support Māori leadership, draws on Māori knowledge and expertise, and supports Māori aspirations in line with Te Tiriti o Waitangi.

Proposed priority areas
Having applied the three stages of the prioritisation framework, the report concludes by outlining five priority areas – each with a set of focus areas for action by Te Ikaroa IMPBs regionally. These priority areas are set out on the following page, in Table 1.

As with most prioritisation processes, the conclusions are based on the best information we could access at a single point in time. As government priorities and other circumstances change, it may be that the priorities need to be reviewed periodically. The description of the prioritisation framework developed for this report should provide guidance in this future process.

Table 1: Proposed IMPB priorities and focus areas

Priority	Focus area for action
Mental health and wellbeing	• Advising on and supporting greater Māori involvement in the consultation and development of the Mental Health and Wellbeing Strategy • Monitoring rates of compulsory care under the Mental Health Act and seclusion at a regional level for Māori (compared to non-Māori) to get insights into the effect of health legislation on Māori • Advising on ongoing investment in Māori mental health providers across the region, and monitoring both total investment levels for Māori mental health providers and sustainable contracting arrangements regionally • Monitoring mental health indicators for Māori compared to non-Māori within the region and to advocate for better data to allow for monitoring of mental health indicators for tāngata whaikaha Māori • Monitoring primary health care mental health interventions, and equitable access to selective serotonin reuptake inhibitors (SSRIs) and other uptake inhibitors.
Oral health	• Taking an advisory role in the oral health system review currently underway and supporting strong Māori involvement in all remaining stages of the review • Advising on regional gaps in oral health services, especially when it comes to Māori oral health providers (with an emphasis on the need for mobile oral health services) • Advising on and supporting targeted community events for oral health when they are run in ways that support community connection to Māori oral health providers • Monitoring ongoing investment in Māori oral health across the region (both to look at total investment levels and at sustainable contracting arrangements regionally) • Monitoring oral health indicators for Māori compared to non-Māori within the region and advocating for better data for tāngata whaikaha Māori and other invisibilised groups.
Cancer screening	• Tracking the lung cancer screening research programme over time and supporing for the roll out of an equitable screening programme across Te Ikaroa • Advising on the equitable implementation of the bowel cancer screening programme and monitoring bowel cancer outcomes for Māori aged 45 and older (compared with non-Māori) within Te Ikaroa • Monitoring and tracking implementation of the 2024 Breast Screening Action Plan, with a focus on implementation within Te Ikaroa • Advising on regional gaps in wāhine Māori-focused cancer screening programmes across the region and monitoring investment in kaupapa Māori programmes that support cancer screening • Supporting the development of appropriate communication to Māori communities on screening, through Māori health providers • Monitoring Māori participation rates (compared to non-Māori) in cancer screening across the region.
Primary health care	• Advising on the need for Māori voice, leadership, and input into ongoing primary health care reform – to address gaps identified in previous primary health care policy design and implementation • Close monitoring of performance against the primary health care target and implementation of other reforms (from 1 July 2026), by ethnicity • Advising on the need for increased support for Māori health providers in primary health care across the region, and monitoring primary health care investment in the region overall • Advising on gaps in culturally safe and/or Māori-led primary health care programmes to support diabetes, respiratory, and CVD outcomes for Māori • Monitoring all relevant health services in the region to ensure equitable Māori access to culturally safe primary health care.
Access to hospital / specialist services	• Strong monitoring of elective surgery outcomes (including those outsourced) at a regional level, by ethnicity • Supporting increased Māori involvement in the delivery of secondary care services • Monitoring Māori workforce levels in both public and private hospitals in the region • Advising on gaps in community-based outreach throughout the region and supporting ongoing partnership with Māori providers, particularly in rural areas.

Introduction

The purpose of this report is to identify the top five Te Ikaroa health priorities for the region's Iwi Māori Partnership Boards (IMPBs), based on a prioritisation framework that is evidence-based and incorporates an equity and Te Tiriti o Waitangi (Te Tiriti) assessment.

The Pae Ora (Healthy Futures) Act 2022 (the Act) first made provision for IMPBs. Over time the role has changed and may continue to do so in line with changes to the wider health system. However, broadly the role of IMPBs is to represent local Māori perspectives on the health needs of Māori and how well the health sector is meeting those needs.

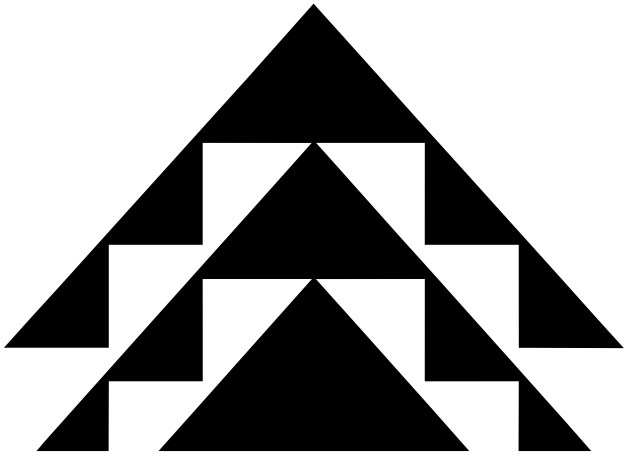
While the Act sets out roles for IMPBs at a local, district or rohe level, there are benefits, at times, for IMPBs to come together in regional groupings, especially in engaging with Health New Zealand / Te Whatu Ora (HNZ)and the Ministry of Health. Within Te Ikaroa region (which covers the lower North Island, south of Hawke's Bay and Whanganui rohe) there are five IMPBs:

- Tihei Takitimu
- Te Pae Oranga o Ruahine o Tararua
- Te Mātuku
- Te Karu o Te Ika Poari Hauora
- Ātiawa Toa Hauora Partnership Board

Te Ikaroa IMPBs have a Te Tiriti o Waitangi based relationship with HNZ at a regional level through the Te Ikaroa Local Leadership Group.

This report starts by outlining a prioritisation framework for the region, which draws on a range of existing equity tools and Te Tiriti o Waitangi guidance. The report then applies this framework and analyses each of the local community health plans developed by the five IMPBs and the available health profile data for the region.

To support the analysis, a set of five environmental scans were conducted to explore what interventions would have the greatest impact for the region and where Te Ikaroa IMPBs could focus their efforts.



Developing a priorities framework

Identifying the right health priority is a critical challenge for the health sector. Prioritising is inherently about trade-offs (if one thing is a priority then something else is not), and the factors accounted for in this trade-off might be contradictory (being affordable is not necessarily the same as being mana-enhancing or equitable and which is more important?).

The way you prioritise (and what you prioritise) also depends on your purpose. The way new budget initiatives are prioritised by the government in an annual budget process are different from how communities and whānau decide what is most important to them. The former is interested in value for money and cost effectiveness, while the latter is often based on lived realities, aspirations, cultural values and needs.

This section briefly outlines different approaches to prioritisation and the factors we took into consideration when developing a framework that is flexible enough to work in the roles and functions of Te Ikaroa IMPBs at a regional level.

Cost-effectiveness

Many prioritisation frameworks begin and end with whether something is cost-effective and affordable. This approach could be characterised as seeking the greatest possible health gain (however that is measured) within a (constrained) budget. Calculations are then used to rank programmes or initiatives according to their cost-effectiveness ratio.[1]

Conventional health economics approaches often base these calculations on measures like quality adjusted life years (QALYs) or disability adjusted life years (DALYs), both of which have limitations (including criticisms that the calculations presuppose that the lives of disabled people have less value than those of people without disabilities).[2]

For the past decade or so, successive governments have also been interested in more holistic "social investment" or "return on investment" approaches that involve identifying the full costs of a policy or programme in monetary terms (regardless of whether those costs are met by households, government, or the private sector) and comparing those to the monetary value of direct and indirect benefits of the policy or programme (such as better health and wellbeing, education, employment, and reduction in accidents). This then provides a ratio which can be used to compare or understand the true benefits of policies or programmes.[3] These approaches have been criticised for the way value is assigned and the way it relies on the types of data the Crown holds. As one commentator has highlighted "[a]nalysts cannot create data out of nothing, so they tend to go where the data already exists."[4]

[1] Hauk et. al., 2004.
[2] Arnesen et. al., 1999.
[3] Baker, 2024.
[4] Moses, 2020. p40.

With these limitations in mind, elements of cost-effectiveness may still be useful here. Specifically, the underpinning values of affordability and ability to achieve returns (of some kind) are important background factors for Te Ikaroa when "[i]dentifying and applying prioritisation tools and equity frameworks to embed Māori health outcomes and Te Tiriti principles in all commissioning decisions".[5]

Equity tools

The Ministry of Health definition of equity is that "[i]n Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."[6]

There are different ways to conceptualise the drivers of unfair differences in health outcomes between population groups, but causes can usually be linked to a combination of differential exposure to the determinants of health and things that keep us well or make us unwell, differential access to services, and differential health system responsiveness (including institutional racism and discriminatory behaviour of clinicians and other health professionals).

Equity (which has gone by various names, including 'closing the gaps', 'reducing disparities', and 'reducing variation') has been an explicit priority of the health sector in New Zealand for decades, however progress has been slow. An enduring criticism of the health sector is that it is good at describing inequities but less good at taking action that would make fundamental improvement.[7]

Both internationally and in Aotearoa New Zealand, there are many equity tools we could draw on, but few explicitly consider prioritisation in a way that is helpful for IMPBs. For example, a Canadian review of equity tools from 2016 identified nine types of equity tools available, but none of the tools it considered looked specifically at what actions to prioritise in a governance, monitoring, or co-commissioning capacity.[8]

To inform the prioritisation framework for this report, we focused on three equity tools developed in New Zealand. These tools are arguably dated (the oldest being nearly 25 years old), but they still provide some useful guidance for IMPB work at a regional level.

[5] Draft Te Ikaroa Local Leadership Group Terms of Reference (as at March 2026).
[6] Ministry of Health, 2019.
[7] Waitangi Tribunal, 2019; Rahiri, et. al., 2024.; Baker, 2024 Hobbs, et. al. 2019.
[8] Pauly, et.al, 2016.

- *Equity of Health Care for Māori: A Framework (2014).*[9] This was designed to guide health practitioners, organisations, and the system to achieve equitable health care for Māori. It is not a prioritisation tool as such, but it emphasises the importance of showing leadership (championing the provision of high-quality health care that delivers equitable outcomes), knowledge (building up the knowledge base around equity and effective monitoring), and commitment (providing health services that meet the needs and aspirations of Māori).

- *The Whānau Ora Health Impact Assessment (2007).*[10] This tool is meant to be used when deciding between two or more options. The aim is to identify equity issues presented by the various options and find solutions that improve outcomes equitably, that are evidence based, and consultative. The tool's questions, especially around the way root causes are identified and unintended consequences articulated and mitigated (in partnership with communities) are all relevant to the work of IMPBs and this report.

- *The Health Equity Assessment Tool (2002).*[11] This tool is a set of questions to help identify the root causes of inequities and to identify the best intervention points. The tool's questions around understanding the issues (especially asking who is most advantaged and how) and understanding whether an intervention is focused on the right level (that is are they structural issues, issues around health behaviours, issues of health service delivery, or issues about the impact of health services?) directly informed the framework for this report.

Te Tiriti o Waitangi

Te Tiriti o Waitangi (Te Tiriti) is a founding, constitutional, document for Aotearoa New Zealand and as such is not merely a 'prioritisation' framework. However, its proper implementation is an expectation on the Crown, and so it is an important to factor into what the health sector could and should do to advance Māori health.

Since 2019, the health sector has focused on the five principles articulated by the Waitangi Tribunal in its *Hauora* report.[12]

- Tino Rangatiratanga, which is articulated in the Hauora report as providing "for Māori self-determination and mana motuhake in ... design, delivery, and monitoring"

- Equity, which involves a commitment to achieving equitable outcomes and extends to ensuring there is high quality data collected and routinely used in monitoring"[13]

[9] Available online: https://www.health.govt.nz/publications/equity-of-health-care-for-maori-a-framework (accessed 17 April 2026).
[10] Available online: https://www.health.govt.nz/publications/whanau-ora-health-impact-assessment-2007 (accessed 17 April 2026).
[11] A guide to using the tool (from 2008) is available online: https://www.health.govt.nz/publications/the-health-equity-assessment-tool-a-users-guide (accessed 17 April 2026).
[12] Waitangi Tribunal, 2019.
[13] Ibid, p180.

- Active protection, which requires the Crown to "act, to the fullest extent practicable, to achieve equitable health outcomes for Māori". Earlier Tribunal reports have also emphasised that this principle requires government agencies to adapt their approaches to the different needs and priorities of Māori populations.[14]

- Options, which requires the Crown to properly resource kaupapa Māori services. The Crown also has to make sure mainstream services are culturally appropriate and recognise that, for Māori, health and wellbeing is holistic.

- Partnership, which requires the Crown to work in partnership with Māori in the governance, design, delivery, and monitoring of its services.

The three-stage framework we developed for this report considers all of these principles. Stage 1 considers what Māori communities, through IMPBs, have identified as the most important priorities, Stage 2 looks explicitly at the principles of equity, active protection, and options, and Stage 3 focuses on Māori participation in decision making and service design.

We note that this set of Te Tiriti principles is helpful (and increasingly understood in the health sector) but that there are grounds for caution. Firstly, there are not only five principles of Te Tiriti. The Courts and government agencies have a longer list of principles they apply, of which the above five are just a subset.[15] In other words, they are a starting point only. Secondly, principles of Te Tiriti can help guide IMPB input into the kawanatanga sphere but will not (and cannot) address the wider constitutional issues of the relationship between Crown and Māori.

[14] Waitangi Tribunal, 2001.
[15] Te Puni Kōkiri, 2001.

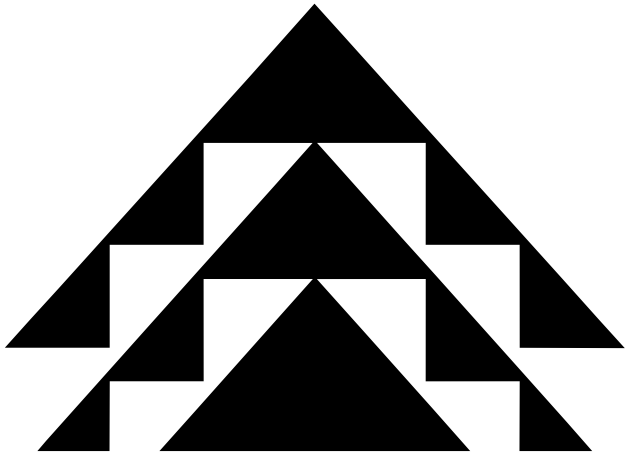
The prioritisation framework

The framework we developed for this report has three components:

Stage 1: What health issues are most important? This stage involves analysis of the community health plans (CHPs) from each IMPB and the five IMPB Māori health profiles.

Stage 2: What interventions support equitable outcomes? This stage considers the most equity-focused intervention points within the top five issues identified in stage 1 that are also within the scope of IMPBs. This section is based on environmental scans of current government activity, expert opinion, and published evidence.

Stage 3: What actions can IMPBs undertake within the priority areas? This stage considers the IMPB priorities (identified through the first two stages) to ensure they relate to IMPB roles supporting Māori leadership, knowledge, and aspirations (in other words the principles of partnership and guarantee of tino rangatiratanga).



Stage 1: What health issues are most important?

Community Health Plan Analysis

Community health plans (CHPs) set out how IMPBs will deliver their legislative functions (over three to five years) and usually include a local health needs assessment. This section of our report summarises an analysis of the region's five IMPB CHPs, with the aim of identifying a Community health plans (CHPs) set out how IMPBs will deliver their legislative functions (over three to five years) and usually include a local health needs assessment. This section of our report summarises an analysis of the region's five IMPB CHPs, with the aim of identifying a small number of shared priorities across Te Ikaroa.

The five CHPs for Te Ikaroa are:

- Tihei Takitimu Programme Plan, September 2024
- Te Pae Oranga Te Pae Anamata, December 2024
- Te Mātuku Community Health Plan, December 2024
- Te Karu o Te Ika Poari Hauora Community Health Plan, March 2025
- Ātiawa Toa Hauora Partnership Board Community Health Plan 2024-2028, 2024.

Each IMPB has approached the development of a CHP in a way that resonates best with their local communities. This is appropriate, given the purpose of a CHP and the role and functions of IMPBs. However, it means that analysing and comparing across Te Ikaroa CHPs requires judgment and careful thought.

Using a 'frequency test' (that is counting the number of times a priority appears) to identify the most common IMPB priorities across the region will not necessarily reflect the importance of an issue. No two IMPBs have taken the same approach for describing a priority and often the way a priority is articulated in one CHP is materially different to how it is described in another, even though the priority might have the same name. For example, if one IMPB talks about lung cancer as a priority they may mean also that they want to address smoking as a major risk factor even if they do not identify reducing smoking as a priority while other CHPs may identify these as two distinct priorities. Our review of the CHPs also noted that each IMPB has a different number of headline priorities, each IMPB has presented government and system level priorities in their own ways, and some IMPBs have included detailed descriptions of their whānau voice in their CHP where others have presented their whānau voice analysis in separate documents. These factors also mean that a simple count of the number of times something is referenced in a CHP is likely to be misleading.

To incorporate more nuance into a 'frequency test', we carefully considered each CHP by identifying:

- Core priorities (these are things that IMPBs explicitly call priorities or that are given the importance of a top priority)
- Secondary priorities (things that came up repeatedly or are used as indicators of success), and
- Implied priorities (things that are not explicitly called priorities or measured as indicators but are nevertheless highlighted as important to the IMPB and its Māori communities).

This process identified an initial list of 121 priorities. Within this long list, there were 31 priorities (core priorities, secondary priorities or implied priorities) that were shared by three or more CHPs. The analysis of these 31 priorities is presented in Table 2.

Table 2: Te Ikaroa IMPB Community Health Plan – Common Priorities

Priority Area	Tihei Takitimu	Te Pae Oranga	Te Mātuku	Te Karu o Te Ika	Ātiawa Toa
Mental health and wellbeing (general)	+	+	+	+	+
Kaupapa Māori mental health programmes	+	+	+	^	
Improve access to comprehensive mental health services	+	+	+	^	
Whānau-centred mental health support and programmes	^	+	+	^	^
Rangatahi and pakeke mental health and wellbeing	+	+	+	+	+
Mokopuna Ora (general)	+	+	+	^	+
Immunisation	+	+	+	+	+
Support for māmā, pēpi, and whānau	+	+	+	+	+
Improve access to kaupapa Māori services to support tamariki and whānau	+	+	^	+	^
Healthcare sustainability	^	+	+	^	^
Workforce development especially for Māori	+	+	+	+	+
Reimagining healthcare investment	^	^	+	^	+
Kaumatua ora	+		+	+	+
Rongoā	+	+	+	+	+
Public health and preventative health		+	+	+	
Mobile health services[16]	+	+	+	+	+
Rural health outreach	+	+	+	+	

[16] Includes mobile oral health services.

Priority Area	Tihei Takitimu	Te Pae Oranga	Te Mātuku	Te Karu o Te Ika	Ātiawa Toa
Communication and cultural safety	^	[+]	[+]	^	[+]
Iwi-led programmes and campaigns	^	[+]	[+]	+	[+]
Changing and improving the primary health care model	+	^	^	+	^
Addressing affordability	+	[+]		^	[+]
Primary health care enrolment	^	[+]	[+]	^	+
Better management of chronic conditions in the community	^	[+]		[+]	+
Oral health	[+]	+	^	[+]	+
Improving oral health service availability and uptake	[+]	[+]		^	[+]
Hospital wait times	^	[+]		[+]	[+]
Housing	^	^		[+]	+
Unified view across health and social services	^	[+]		^	
Cancer treatment and screening	[+]	[+]	^	[+]	[+]
Smoking and vaping	+	[+]		[+]	
Disability voice / improved services	+	[+]		[+]	

Table notes:

+ Indicates an area explicitly identified as a top priority in the CHP

[+] Indicates an area is a secondary priority (e.g., selected as an indicator of success)

^ Indicates an area that is implied to be a priority (e.g., where it is assumed as a priority because it is a necessary first step to another priority).

CHP Observations

As shown in Table 2, just over half (17) of the 31 health were common to all five IMPBs. However, being the most frequently cited priority does not necessarily make something a regional priority.

- The nature of the priorities identified in Table 1 varies greatly. Some of the priorities are clinical health areas (such as cancer or chronic conditions), some are about the model of care (such as the primary health care system, or use of kaupapa Māori services to reach Māori communities) and some are about improving performance of existing services (such as hospital wait times). So it can be hard to compare apples with apples.

- There is overlap amongst the list of 31 priorities meaning that identifying a shorter list of top priorities might be artificial. For example, the disability voice priority area, which also includes improved services for tāngata whaikaha Māori (Māori with lived experience of disability), is connected with all of the other priority areas (that is mental health services have to work for tāngata whaikaha Māori, mokopuna ora services have to work for tāngata whaikaha Māori and so on). For these areas it is important that they remain visible in the discussions around regional priorities even if they are not identified as standalone priorities.

With these caveats, the broad areas of common interest across the CHPs are:

- Mental health and wellbeing
- Mokopuna ora / child health and wellbeing
- Sustainable health services (including kaupapa Māori / Iwi-led services and approaches)
- Mobile health services
- Improving primary health care
- Oral health
- Improving cancer treatment and screening.

There are also some areas that appear to warrant further investigation, specifically rongoā, kaumātua ora, rural health, hospital wait times and disability voice and these will continue to be part of analysis in the environmental scans (in Stage 2).

Te Ikaroa IMPB Health Profile analysis

Understanding what government data says about Māori health in Te Ikaroa region helps to identify what health areas are most important. Data, of course, has its limitations. The data government collects can be of variable quality, especially when it comes to ethnicity data, and because the way data is collected and analysed can change it is not always possible to be able to compare trends over time. Furthermore, the data the government collects is often a reflection of its own priorities and what is possible to collect (eg clinical indicators) and are not necessarily a reflection of what is most meaningful to communities.

While there were several ways we could look at health data for the region, for consistency (that is ensuring the same data is available for the same time periods across all IMPBs in the region), robustness (data and analysis that had been through peer review and quality assurance processes) and time (able to be completed within the time frames of this report), we focused on the Māori health profiles completed for all five IMPBs in 2023 and 2024.

A structured analysis was undertaken of all the region's IMPB health profile reports to identify the health areas across the Te Ikaroa IMPB collectives of most concern - that is the health indicators that represented the greatest health burden for Māori (such as the leading causes of death and hospitalisations presented at the DHB/regional level). An equity lens was then focused on disparities or differences between Māori and non-Māori from the data, using rate ratios (RR) to quantify the extent to which Māori are more likely to experience specific health outcomes.

For each report, *all statistically significant* RRs were scanned. For health conditions we focused initially on those indicators with an RR of approximately 2.0 or higher (meaning that Māori were twice as likely as non-Māori to be affected by the health issue) to identify areas of substantial inequity. It is also important to note that in some areas (like medication dispensing) a RR of below 1 for Māori compared with non-Māori indicates lower rates of access or use, which in some contexts suggests Māori are missing out on services relative to need. Where relevant, inequities were examined across gender and age groups when rate ratios were particularly pronounced and statistically significant. Together, these lenses enabled the identification of health area or concerns that are not only highly prevalent but also represent greatest health burden and inequity for Māori (and their whānau) across the Te Ikaroa region.

Many of the areas identified in data analysis overlapped with many of the common priorities identified in the CHP analysis. Table 3 summarises our analysis of those issues in the health profiles that both linked in in some ways with the CHP analysis while demonstrating areas

of high unmet health need.

Table 3: Te Ikaroa IMPB health profile analysis summary of notable areas

Broad topic area	Indicator area	Tihei Takitimu	Te Pae Oranga	Te Mātuku	Te Karu o Te Ika	Ātiawa Toa
Kahu Taurima	Child oral health; % with Caries at age 5 years, 2022.	**RR: 1.95** Māori: 53.9% (n=370) Non-Māori: 30.3% (n=230)	**RR: 1.57** Māori: 61.9% (n=130) Non-Māori: 39.5% (n=412)	**RR: 2.12** Māori: 62.7% (n=210) Non-Māori: 29.6% (n=149)	**RR: 1.90** Māori: 40.5% (n=49) Non-Māori: 21.3% (n=64)	**RR:1.73** Māori: 52.9% (n=388) Non-Māori: 30.6% (n=1,025)
Long-term conditions	Diabetes prevalence, 25 years and over, 2022.	**RR: 2.14** Māori: 9.1% (n=3,267) Non-Māori: 4.3% (n=7,294)	**RR: 1.59** Māori: 7.6% (n= 2,049) Non-Māori: 4.8% (n=8,702)	**RR: 1.80** Māori: 9.0% (n=1,301) Non-Māori: 4.8% (n=3,218)	**RR: 2.22** Māori: 8.0% (n=529) Non-Māori: 3.6% (n= 2,168	**RR: 1.60** Māori: 7.6% (n=3,420) Non-Māori: 4.8% (n=21,505)
	Respiratory; Asthma hospitalisations 0-14 years, July 2022 – June 2023.	**RR: 1.92** Māori rate: 495 (nᵅ=76) Non-Māori rate: 257 (nᵅ =49)	**RR: 2.78** Māori rate: 424 (nᵅ =53) Non-Māori rate: 153 (nᵅ =34)	**RR: 2.53** Māori rate: 493 (nᵅ =30) Non-Māori rate: 195 (nᵅ =14)	RR: 2.17 Māori rate: 224 (nᵅ =7) Non-Māori rate: 103 (nᵅ =6)	**RR: 1.39** Māori rate: 285 (nᵅ =54) Non-Māori rate: 205 (nᵅ =124)
	Respiratory; Asthma hospitalisations 35-64 years, July 2022 – June 2023.	**RR: 3.91** Māori rate: 210 (nᵅ =32) Non-Māori rate: 54 (na =31)	RR: 1.57 Māori rate: 133 (n=17) Non-Māori rate: 85 (na =47)	**RR: 3.59** Māori rate: 422 (nᵅ =26) Non-Māori rate: 118 (na =22)	**RR: 3.05** Māori rate: 191 (nᵅ =5) Non-Māori rate: 63 (na =9)	**RR: 3.17** Māori rate 233 (nᵅ =49) Non-Māori rate:73 (na =119)
	Respiratory; COPD hospitalisations 45 years and over, 2022-2023.	**RR: 4.92** Māori rate: 1,456 (nᵅ= 249) Non-Māori rate: 296 (nᵅ = 357)	**RR: 3.06** Māori rate: 823 (nᵅ =105) Non-Māori rate: 267 (nᵅ =357)	**RR: 3.52** Māori rate: 1,619 (nᵅ =122) Non-Māori rate: 450 (nᵅ =220)	**RR: 3.84** Māori rate: 811 (nᵅ =27) Non-Māori rate: 211 (nᵅ =97)	**RR: 5.19** Māori rate: 876 (nᵅ =173) Non-Māori rate:169 (nᵅ =485)

Broad topic area	Indicator area	Tihei Takitimu	Te Pae Oranga	Te Mātuku	Te Karu o Te Ika	Ātiawa Toa
Cancer	Lung cancer registrations	**RR: 2.69** Māori rate: 39 (n^a =35) Non-Māori rate: 13 (n^a =76)	**RR: 2.18** Māori rate: 31 (n^a = 18) Non-Māori rate: 14 (n^a =92)	**RR: 2.55** Māori rate: 32 (n^a =12) Non-Māori rate: 12 (n^a =36)	**RR: 3.84** Māori rate: 41 (n^a =6) Non-Māori rate: 11 (n^a =22)	**RR: 3.17** Māori rate: 30 (n^a =30) Non-Māori rate: 9 (n^a =140)
	Breast cancer screening coverage, % screened aged 45-69 years, December 2023.	Māori coverage: 54.5%, (n^s = 3,500) Non-Māori coverage: 73.9% (n^s= 23,015)	Māori coverage: 59.4% (n^s =2690) Non-Māori coverage: 68.1% (n^s =16,997)	Māori coverage: 55.1% (n^s =1,120) Non-Māori coverage: 64.7% (n^s =6,743)	Māori coverage: 56.2% (n^s =638) Non-Māori coverage: 58.7% (n^s =4,659)	Māori coverage: 65.3% (n^s =5,214) Non-Māori coverage: 71.0% (n^s =45,371)
	Cervical cancer screening coverage, aged 25-69 years, December 2023.	Māori coverage: 53% (n^s =6,639) Non-Māori coverage: 72% (n^s =24,102)	Māori coverage: 56.3% (n^s =5324) Non-Māori coverage: 68.3% (n^s =26,971)	Māori coverage: 51.9% (n^s =2,540) Non-Māori coverage: 64.7% (n^s =8,283)	Māori coverage: 64.9% (n^s =1,395) Non-Māori coverage: 66.9% (n^s =7,529)	Māori coverage: 60.8% (n^s =10,636) Non-Māori coverage: 72.9% (n^s =84,828)
	Bowel cancer screening participation, aged 60-74 years, 2023.	Māori coverage: 48% (n^s =2,248) Non-Māori coverage: 64% (ns =16,114)	Māori coverage: 53.7% (n^s =1,130) Non-Māori coverage: 62.4% (ns =17.049)	Māori coverage: 55.1% (n^s =1,120) Non-Māori coverage: 64.7% (ns =10,422)	Māori coverage: 67% (n^s =550) Non-Māori coverage: 66.7% (ns =5,851)	Māori coverage: 52.9% (n^s =2,942) Non-Māori coverage: 61.1% (ns =26,878)
Mental health	Medicines: People regularly dispensed an SSRI or other reuptake inhibitor, aged 15 years and older (2022).[17]	**RR: 0.51** Māori rate: 4,017 Non-Māori rate: 7,877	**RR: 0.79** Māori rate: 4,926 Non-Māori rate: 11,678	**RR: 0.43** Māori rate: 3,507 Non-Māori rate: 8,085	**RR: 0.79** Māori rate: 4,928 Non-Māori rate: 11,678	**RR: 0.66** Māori rate: 5,753 Non-Māori rate: 8,085

[17] SSRIs or other reuptake inhibitors are the first-line treatment for anxiety and/or depression. (Health Quality and Safety Commission, 2021).

Broad topic area	Indicator area	Tihei Takitimu	Te Pae Oranga	Te Mātuku	Te Karu o Te Ika	Ātiawa Toa
System indicators	Missed first medical specialist appointments, 2023.	**RR: 3.36** Māori: 11.1% (n=258) Non-Māori: 3.3% (n=208)	**RR: 2.97** Māori: 10.9% (n=258) Non-Māori: 4.1% (n=412)	**RR: 3.33** Māori: 10.0% (n=112) Non-Māori: 3.0% (n=96)	**RR: 2.83** Māori: 13.0% (n=66) Non-Māori: 4.6% (n=100)	**RR: 2.73** Māori: 13.4% (n=553) Non-Māori: 4.9% (n=1,175)
	Missed first surgical specialist appointment.	**RR: 2.87** Māori: 12.9% (n=392) Non-Māori: 4.5% (n=463)	**RR: 2.66** Māori: 13.1% (n=392) Non-Māori: 4.2% (n=652)	**RR: 2.97** Māori: 10.1% (n=164) Non-Māori: 3.4% (n=188)	**RR: 2.49** Māori: 14.2% (n=118) Non-Māori: 5.7% (n=270)	**RR: 2.80** Māori: 15.4% (n=610) Non-Māori: 5.5% (n=1,339)
Leading causes of death	Highest age-standardised rate per 100,000.	**Ischaemic heart disease** **RR: 2.42** Māori rate: 46 (n_a =36) Non-Māori rate: 19 (n_a =36)	**Ischaemic heart disease** **RR: 1.69** Māori rate: 35 (n_a =20) Non-Māori rate: 21 (n_a =214)	**Ischaemic heart disease** **RR: 1.84** Māori rate: 43 (n_a = 36) Non-Māori rate: 23 (n_a = 94)	**Ischaemic heart disease** **RR: 2.15** Māori rate: 45 (n_a =7) Non-Māori rate: 21 (n_a =71)	**Ischaemic heart disease** **RR: 2.05** Māori rate: 35 (n_a =30) Non-Māori rate: 17 (n_a =368)

Table notes:
RR means rate ratio.
Bold text indicates statistical significance. Note that confidence intervals are available in each of the IMPB health profiles.
n = the total number of the population.
n_a = the average number of the population affected.
n_s = number screened.
Rates in this table are the age-standardised rate per 100,000. Rates have been rounded to the nearest whole number.
The number of the population affected or average number of the population affected was not always provided for the mental health indicator so has not been included here.

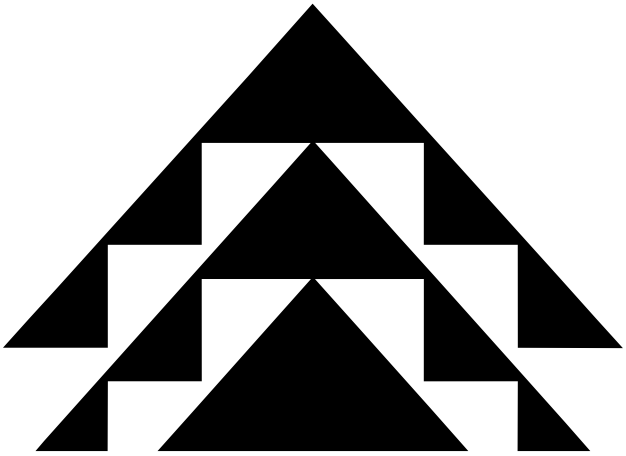
Many of the issues identified in Table 3 – such as asthma, diabetes, oral health, access to medication, and even access to hospital-based specialists – link to the way services are provided in the community / through primary health care and therefore fit within the monitoring and advisory roles of IMPBs.

Moving to the next stage of prioritisation

Throughout this stage, the aim has been to identify the areas where unmet needs are most evident for Māori in the rohe. In combining the CHP and data analysis we have identified five areas for further investigation:

- Mental health and wellbeing, particularly looking at community mental health services and improving access to appropriate medicines
- Oral health, and improving access to services for whānau – but especially tamariki
- Improving access to cancer screening so that Māori whānau can experience the full benefits of screening
- Improving access to high quality primary health care and community-based support (around diabetes, CVD, and asthma) and extending primary and community health care service offerings, so that all Māori whānau, including kaumatua, tāngata whaikaha and whānau who live in rural areas can access services they most need
- Improving access to specialist services.

In Stage 2, we consider these areas in more depth to identify whether there are specific aspects of the priority areas that IMPBs could focus on at a regional level to address inequities.



Stage 2: What interventions support equitable outcomes?

Rapid environmental scans

Once an area of demonstrated unmet need is confirmed, the next stage of our framework is to identify what is going to have the biggest impacts in terms of equity and sustainable improvement in health outcomes (within the scope of IMPB roles and functions regionally).

To undertake this analysis, we completed rapid reviews on the five areas identified in Stage 1. These rapid reviews involved gathering more background on the area and current government approaches, identifying different intervention points that are supported by evidence and within the scope or areas of interests of IMPBs at a regional level, and exploring the impact any intervention or prioritisation of the area might have on equity, including any unintended consequences and what mitigations can be put in place.

Mental health and wellbeing

Despite making up around 17% of the population of New Zealand, Māori represent just over 30% of all mental health service users.[18] National survey data shows ongoing and high levels of mental health need across the country. The most recent NZ Health Survey indicates an increase in psychological distress, and unmet need for mental health and addiction care. In general, findings show significant inequities for disabled adults and Māori and Pacific adults.[19]

Data on the NZ Health Survey explorer website is not broken down by ethnicity within Te Ikaroa district, but there is some evidence that Te Ikaroa as a whole has higher rates of some mental health issues compared to the national total population, and evidence of inequities at a national level when comparing the Māori and total populations. These inequities include:[20]

- 17.5% of adults in Te Ikaroa and 22.5% of Māori adults nationally have experienced high or very high levels of psychological distress in the past four weeks in 2024/25 compared to 14% of the total population.
- 12.9% of adults in Te Ikaroa and 16.1% of Māori adults nationally have had unmet need for professional help with mental health or addiction services in the past 12-months in 2024/25 compared to 10.5% of the total population.

The Ministry of Health also notes that "Māori have experienced longstanding inequitable outcomes which can be further compounded as Māori are also overrepresented within other groups that experience poorer outcomes" [21] and that other groups with "distinct needs and poorer outcomes" include children and young people, disabled people, pregnant women and new mothers, rainbow communities, veterans, people who are in prisons or who have been released from prisons, people who are at risk of or are experiencing homelessness, rural communities, survivors of abuse in state care, older people, people on low incomes, those who have other specific conditions and/or who identify across more than one of the groups.[22]

[18] Office of the Director of Mental Health and Addiction Services, 2026.
[19] Te Hiringa Mahara (2025). https://www.mhwc.govt.nz/news-and-resources/key-mental-health-and-addiction-findings-nz-health-survey/
[20] NZ Health Survey Data Explorer, November 2025.
[21] Ministry of Health, 2026. https://www.health.govt.nz/system/files/2026-04/Draft-Mental-Health-and-Wellbeing-Strategy-2026-2036.pdf
[22] Ibid.

The Director of Mental Health and Addiction Services reported in March 2026 that:[23]

- Māori are more likely to be assessed or treated under the Mental Health (Compulsory Care and Treatment) Act 1992[24] than other ethnicities,
- Māori are 2.3 times more likely than non-Māori, non-Pacific peoples to be subject to a community compulsory treatment order
- Māori are 2.1 times more likely to be subject to an inpatient compulsory treatment order
- Māori were more likely than non-Māori to be secluded, with more seclusion events, on average, and had longer periods of seclusion.[25]

Intervention points

The government has several ways it could intervene to improve mental health and address inequitable mental health outcomes for Māori. These range from mental health promotion and prevention activities through to clinical interventions and even changes to the Mental Health Act.

The Ministry of Health is currently consulting on its Mental Health and Wellbeing Strategy.[26] The intention of the strategy is to set out a pathway for improving mental health and wellbeing outcomes over the next ten years and improving mental health and addiction support, preventing suicide, and reducing harms from substance use and gambling.

The consultation draft of the Mental Health and Wellbeing Strategy (the consultation draft), while acknowledging the high levels of unmet mental health need amongst Māori populations, does not explicitly identify priorities or actions that are squarely focused on improving Māori mental health outcomes.

The consultation draft instead identifies 'strategic actions' under the four proposed priority areas (strengthened focus on prevention and early intervention, increased access to mental health and addiction supports and services, growing the mental health and addiction workforce, improving the effectiveness of mental health and addiction support areas). The strategic actions include growing local supports that help pregnant people and parents of young children maintain good mental wellbeing, expanding community-based supports and improve access to a full range of mental health and addiction services, building a larger, more diverse skilled workforce that can provide welcoming, culturally safe, person-centred care, and building more lived-experience and peer leadership into the system.

The monitoring of these actions at a regional level might provide opportunities for IMPB leadership, but none directly relate to lifting primary mental health care performance[27] and the area we identified in stage one as an unmet need: dispensing of SSRIs or other uptake inhibitors.

[23] Ibid.

[24] The Mental Health Act provides a legal framework for those who require compulsory psychiatric assessment and treatment for people experiencing a mental illness.

[25] Seclusion occurs where a service user is 'placed alone in a room or area, at any time and for any duration, from which they cannot freely exit. In New Zealand, seclusion can only lawfully occur under the Mental Health Act or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

[26] Until Monday 18 May 2026 (at 5PM)

[27] The five mental health and addictions targets include a primary health care indicator that relates to timely access to a specific mental health programme (Access and Choice) not overall access to primary health care nor quality of primary health care or prescribing.

SSRIs or other uptake inhibitors are considered the first-line treatment for anxiety and/or depression, and there are ethnic inequities nationally between the European/other ethnicity which receives SSRIs at 2-3 times the rate of all other ethnicity groups,[28] thus raising serious questions about access to high quality primary mental health care for Māori communities.

Our environmental scan looked at what could be done at a broad societal level, at an individual level, and within the health system to improve mental health for Māori whānau and communities within Te Ikaroa. For interventions identified in our environmental scan we then considered impacts on equity and how any unintended consequences (that would negatively impact Māori health outcomes and equity) might be mitigated. Table 4, below, summarises the most compelling interventions identified in our environmental scan. A more detailed explanation, including a referenced summary of our rapid environmental review is attached at Appendix 1.

Table 4: Mental health - summary results of environmental scan

Intervention	Impact on equity in long term	Fit within IMPB regional scope	Unintended consequences	Possible Mitigations
Improve mental health and wellbeing education in school based-settings	Moderate	Low	While studies show positive outcomes, there is a gap in terms of the education being commensurate with Te Tiriti and an educative approach to mental health	Requires support from education curriculum overall and targeted support to Māori communities
Strengthened Mental health and Wellbeing strategy that includes addressing the structural determinants of mental health and wellbeing, addressing the harmful effects of health legislation, and improving primary mental health care in the community	Moderate	Moderate to high- given it is already under review nationally	The current lack of explicit reference to Māori in the proposed actions and monitoring indicates a risk that while outcomes may improve overall, current inequities will continue to be replicated or even increase.	Requires strong Māori leadership in the strategy's final stages. Requires strong monitoring of Māori mental health outcomes and investment over time so that as risks become apparent changes or improvements are made swiftly.
Improve primary health care quality and effectiveness	Discussed further under the primary health care priority (below)			
Increase access to kaupapa Māori mental health initiatives	Moderate to High	High	The scale of the problem is likely to be overwhelming / difficult for existing providers to meet within their existing funding and staffing levels.	Requires ongoing support from funders through long-term contracts to give providers certainty; May require focusing on one area first, such as maternal mental health.

[28] Health Quality and Safety Commission, 2021. https://www.hqsc.govt.nz/our-data/atlas-of-healthcare-variation/mental-health-in-primary-care/

From this analysis, the areas within mental health that Te Ikaroa IMPBs could focus on most effectively within its role and to improve Māori health outcomes equitably are:

- Advising on and supporting greater Māori involvement in the Mental Health and Wellbeing Strategy consultation (closing 18 May 2026)
- Monitoring rates of compulsory care under the Mental Health Act and seclusion at a regional level for Māori to get insights into the effects of health legislation on Māori
- Advising on ongoing investment in Māori mental health providers across the region and monitoring both total investment levels for Māori providers and sustainable contracting arrangements regionally
- Monitoring mental health indicators for Māori compared to non-Māori within the region, and to advocate for better data to allow for monitoring of mental health indicators for tāngata whaikaha Māori, and other groups not appropriately captured in monitoring data
- Monitoring primary health care mental health interventions, specifically equitable access to SSRIs and other uptake inhibitors.

Oral health

Decades of research and policy have documented the clear and persisting inequity in oral health status for Māori, with higher prevalence and severity of dental caries for tamariki and rangatahi Māori. It is also important that intersectionality is considered, as it is noted that poor dental health is also associated with disability and neighbourhood deprivation.[29]

Based on Community Oral Health Service data,[30] while 58.8% of all tamariki aged 5 years in within Te Ikaroa are caries free, less than half of tamariki Māori (44.2%) in the region are caries free.

The latest, Tatau Kahukura: Māori Health Chartbook[31] outlines the following for oral health inequities for tamariki Māori nationally:

- At school entry (five years of age), Māori children had a higher mean number of decayed, missing or filled teeth than non-Māori children in 2022 and were less likely to be caries-free
- There was some reduction in the disparity by school year 8, although Māori children still had a higher mean number of decayed, missing and filled teeth than non-Māori and were less likely to be caries-free
- Māori children aged 1–14 years were more than twice as likely as non-Māori children in the same age group to have had any teeth extracted due to decay, abscess or infection in the past 12 months
- For adults, NZ Health Survey data[32] shows that cost is a substantial barrier to accessing oral health services with 43% of all people in Te Ikaroa aged 15 years and over have experienced unmet need for dental health care due to cost in the past 12 months between July 2024 and June 2025.

[29] Tustin et al., 2024.
[30] https://www.healthnz.govt.nz/about-us/health-data/data-sets-and-collections/oral-health-data-and-statistics#oral-health-status-at-age-5-and-school-year-8-data-22194
[31] Ministry of Health, 2024.
[32] NZ Health Survey Data Explorer, November 2025.

Intervention points

The government has a range of intervention points available to it to improve oral health. Table 5, below, summarises these possible oral health interventions that relate to the roles and functions of Te Ikaroa IMPBs, impacts on equity and how any unintended consequences (that would negatively impact Māori health outcomes and equity) might be mitigated. A more detailed explanation, including a summary of our rapid environmental review is attached at Appendix 1.

Table 5: Oral health interventions - summary results of environmental scan

Intervention	Impact on equity in long term	Fit within IMPB regional scope	Unintended consequences	Possible Mitigations
Water fluoridation	High	Low	High risk that it will most benefit communities already on town water supplies	Targeted support to Māori communities
Toothpaste and toothbrushing campaigns	Low	Low	Those who already benefit from health promotion messages will benefit most	Targeted support to Māori communities, Māori providers
Health system – reorganise	High	Moderate to high, given it is already under review nationally	A focus on affordability could maintain the status quo	Increase Māori voice in process; support Māori providers to expand oral health services
Health system – extend free or low-cost oral health services	High	Moderate	Could increase inequities between those in communities with existing oral health services and those without (eg rural areas)	Support Māori providers to expand oral health services, including mobile services
Health services – targeted community events	Moderate	High	One off nature means that it does not address issues in ongoing sustainable way; maintains long term inequities	Run one off events alongside increased support to Māori oral health providers.
Health services – support Māori providers to extend services to include oral health	Moderate to high	High	Could create burden for Māori providers if not properly resourced (including difficulties recruiting and retaining workforce)	Requires ongoing support from funders through long-term contracts to give providers certainty

From this analysis, the areas within oral health that Te Ikaroa IMPBs could focus on most effectively are:

- Taking an advisory role with the oral health system review currently under way[33] and supporting strong and diverse Māori involvement for all remaining stages of the review, including in decision-making
- Advising on regional gaps in oral health services, especially when it comes to Māori oral health providers, with an emphasis on the need for mobile oral health services
- Advising on and supporting targeted community events for oral health when they are run in ways that supports ongoing community connection to Māori oral health providers and address barriers relating to cost
- Monitoring ongoing investment in Māori oral health across the region (both looking at total investment levels and at sustainable contracting arrangements regionally)
- Monitoring oral health indicators for Māori compared to non-Māori within the region, and to advocate for better quality data to allow for monitoring of oral health indicators for tāngata whaikaha Māori, and other groups not appropriately captured in monitoring data.

Cancer screening

Throughout our review, cancer treatment and screening has been identified as an important health issue. For the environmental scan, we focused on cancer screening as an intervention to improve Māori health outcomes and achieve equity – if properly implemented. We note, however, that ultimately a comprehensive approach to cancer is required – one that addresses harms caused by alcohol and tobacco as well as increasing access to high quality, equitable, screening programmes.

Te Aho o Te Kahu, the Cancer Control Agency, states that ensuring screening programmes are accessible for all remains a challenge, with significant inequities for Māori across the screening programmes.[34] It also reports on international literature showing that disabled people are screened at a lower rate, and even more so for Indigenous disabled people. This is likely to be the case in Aotearoa too, but data limitations (including a distinct lack of disability data) means we cannot measure this in national statistics. New Zealand based research has, however, described access to and engagement with cervical and breast screening services for Deaf women or women live with a physical or sensory disability and found that women with multiple disabilities may be disadvantaged in the seeking and delivery of screening and that policies need to take into consideration multiple needs when designing services.[35]

There are three national cancer screening programmes in Aotearoa, which focus on bowel, breast, and cervical cancer respectively. These are managed by the National Screening Unit within HNZ. Two advisory groups, the National Screening Advisory Committee and the Māori Monitoring and Equity Group, advise HNZ on changes to existing screening programmes and any potential new programmes for consideration. [36]

[33] For more information visit: https://www.healthnz.govt.nz/about-us/what-we-do/programmes-and-initiatives/oral-health-services-review (accessed 21 April 2026).
[34] Te Ao o Te Kahu, 2025.
[35] Pearson, J. et. al., 2022.
[36] Te Ao o Te Kahu, 2025.

Tatau Kahukura: Māori Health Chartbook 2024 reports that for both breast screening and cervical screening programmes coverage was lower for Māori than non-Māori in 2020:[37]

- BreastScreen Aotearoa coverage for 24 months to 31 March 2020, females 50-69 years – Māori 66.8% as compared to 71.4% for non-Māori
- National Cervical Screening programme three-year coverage to 31 March 2020, females aged 25-69 years – Māori 55.7% as compared to 59.3% for non-Māori.

Bowel cancer screening in Aotearoa has been contentious because, despite bowel cancer affecting Māori at younger ages than non-Māori (and the substantial body of research evidence highlighting the need for earlier intervention for Māori health equity),[38] there is a one-size-fits-all screening age range (currently 58-74 years). Data released in 2023[39] shows Māori were less likely than most other ethnic groups within the eligible age range to have been screened (49.6% of Māori were screened in 2022 compared with 62.6% of others – made up of non-Māori, non-Pacific, and non-Asian groups).

Lung cancer is the cause of the highest cancer mortality and hospitalisations for Māori nationally and the leading cause of cancer death for both Māori females and Māori males was lung cancer.[40] Lung cancer screening has been proven effective overseas, and offers potential benefits for Māori – if properly implemented.[41] A lung cancer screening research programme is underway to ensure that the eventual national programme is culturally safe, acceptable, and clinically safe and able to be implemented in a way that does not replicate the inequities of other national screening programmes.

Intervention points

The latest report from Te Aho o Te Kahu[42] shows that while screening rates are improving across all screening programmes, inequities remain for Māori.

Improving existing screening programmes to address both health needs and barriers to screening requires work at a national level. For example, for bowel cancer screening, reducing the screening eligibility age for Māori is essential to ensure equitable outcomes. For lung cancer screening, the government would need to commit to the equitable roll out of a national programme, in line with the lung cancer screening research programme. However, these intervention points are out of the direct scope of IMPBs regionally.

This section, therefore, focuses on effective local (and regional) solutions including partnerships with community-based providers in order to remove barriers to screening.

Table 6, below, summarises the different screening interventions available, the likely impacts on equity, the extent to which it fits within the IMPB regional scope, and an assessment of unintended consequences that need to be mitigated. A more detailed explanation, including a summary of our rapid environmental review is attached at Appendix 1.

[37] Although this is older data than individual IMPBs and Te Whatu Ora will have access to, it is the most up to date publicly available and statistically robust information we could access. Crude rates and prioritised ethnicity have been used, see Tatau Kahukura 2024 for more details on methods used.
[38] See for example: Longmore 2025; Scott et al. 2025; McLeod et al. 2017, McLeod et al. 2021.
[39] Health New Zealand / Te Whatu Ora, 2023
[40] Ministry of Health, 2024.
[41] McLeod et al., 2020.
[42] Te Aho o Te Oahu, 2025.

Table 6: Cancer screening - summary results of environmental scan

Intervention	Impact on equity in long term	Fit within IMPB regional scope	Unintended consequences	Possible Mitigations
Breast screening – track implementation of the 2024 Breast Screening Action Plan regionally to rapidly increase Māori and Pacific participation to 70%	High	High - when focused on monitoring	The plan itself is comprehensive and focusing on all actions as they are written could be distracting	Focus on screening participation rates, monitoring and performance frameworks, and workforce and training actions to be undertaken in partnership with Māori providers
Increase support to (and number of) wāhine Māori focused programmes across the region, to increase participation in breast and cervical cancer screening	High	High	The lack of proper support from funders is a challenge to Māori providers already operating these supports, and putting additional expectations on them without appropriate contracts / funding could increase inequitable expectations on Māori compared with mainstream providers	Requires ongoing support from funders through long-term contracts to give providers certainty
Targeted information to Māori within the eligible age-range on bowel cancer screening in the region	Moderate	High	Possibly reach those who already benefit from health promotion messages (eg may not reach tāngata whaikaha Māori or other invisibilised populations)	Supported with targeted support to Māori communities through Māori providers and use of champions for bowel cancer screening
Active follow up support for bowel cancer screening recruitment	Low	Moderate	Known to increase participation but not reduce inequities - perhaps because it reaches those who are already easiest to reach	Supported with targeted support to Māori communities through Māori providers and use of champions for bowel cancer screening

From this analysis, the areas within cancer screening that Te Ikaroa IMPBs could focus on most effectively are:

- Tracking progress with the lung cancer screening research programme and supporting the roll out of an equitable lung cancer screening programme across Te Ikaroa
- Supporting equitable implementation of the bowel cancer screening programme and monitoring bowel cancer outcomes for Māori aged 45 and older within Te Ikaroa compared with non-Māori
- Monitoring and tracking implementation of the 2024 Breast Screening Action Plan, with a focus on implementation within Te Ikaroa
- Advising on regional gaps in wāhine Māori focused cancer screening programmes across the region and monitoring investment in kaupapa Māori programmes that support cancer screening
- Supporting the development of appropriate communication to Māori communities on screening, through Māori health providers
- Monitoring Māori participation rates in cancer screening within the region compared to non-Māori.

Primary health care

According to NZ Health Survey data for 2024/25, unmet need for primary health care continues to be an issue for Māori nationally and for the total population of Te Ikaroa region (as we have noted in other sections, the publicly available data from the NZ Health Survey for Te Ikaroa is not broken down by ethnicity).[43]

- 15.9 % of people in Te Ikaroa and 18.7% of Māori nationally did not visit a GP in the previous year when they needed to because of cost. This is compared to the national total population rate of 14.9%.
- 26.7% of people in Te Ikaroa and 26.2% of Māori nationally did not visit a GP in the previous year when they needed to because of wait times. This is compared to the national total population rate of 25.5%.
- 3.8% of people in Te Ikaroa and 4.6% of Māori nationally did not visit a GP in the previous year when they needed to because of transport issues. This is compared to the national population rate of 3.1%.

There are longstanding criticisms of New Zealand's primary health care system, especially when it comes to Māori health and health equity. Primary health care leaders "overwhelmingly judge" that progress had not been made in eliminating inequity between Māori and non-Māori. [44] The Waitangi Tribunal's Hauora report (which covers the primary health care claims within Wai 2575 the health services and outcomes kaupapa inquiry), also summarises a range of criticisms of primary health care in New Zealand, including that Māori were not adequately involved in the design of the primary health care system from the outset, that the policy intentions were not matched with tangible actions, that the funding formulae at times supported inequitable outcomes (was anti-equity), that Māori health providers and Māori-led PHOs were not adequately supported to participate in primary health care, and that there was insufficient monitoring of primary health care by DHBs and by the Ministry of Health.[45]

[43] NZ Health Survey Data Explorer, November 2025.
[44] Tenbensel, T., et. al., 2026.
[45] Waitangi Tribunal, 2019.

Within the last year the government has announced its intentions to strengthen the primary health care system – through new targets, a new funding formula, and other initiatives (like building a stronger/fit for purpose workforce). There remains concerns that these primary health care reforms will not address inequities or improve Māori health outcomes.[46]

Intervention points

To identify possible intervention points for primary health care, our environmental scan looked both at the primary health care reforms and initiatives or approaches that work in primary health care to address diabetes, respiratory and CVD inequities.

Table 7 summarises the different interventions available, the likely impacts on equity, the extent to which it fits within the IMPB regional scope, and an assessment of unintended consequences that need to be mitigated. A more detailed explanation, including a summary of our rapid environmental review is attached at Appendix 1.

Table 7: Primary health care - summary results of environmental scan

Intervention	Impact on equity in long term	Fit within IMPB regional scope	Unintended consequences	Possible Mitigations
Primary health care reform	High	Moderate given national level – in advisory and monitoring capacity	NZ has a history of not implementing primary health care reform in a way that supports equitable health outcomes for Māori – tends to benefit non-Māori providers and non-Māori population more. Funding formulae that do not explicitly include ethnicity components may lead to anti-equity consequences	Requires strong Māori leadership – and an increase Māori involvement in decision-making and design nationally and regionally. Ensure adequate monitoring of impacts of funding and system changes at a regional level by ethnicity and disability where possible
Increase support for Māori health providers in primary care settings across the region	High	High	While there is a growing evidence base of the effectiveness of Māori-led services for Māori health outcomes (eg in diabetes and respiratory condition management) there is also evidence that Māori providers have historically been underfunded to deliver primary health care in line with the Primary Health Care Strategy.	Requires ongoing support from funders

[46] See for example NZ Doctor article (13 April 2026). Available online https://www.nzdoctor.co.nz/article/news/hauraki-pho-remains-angry-over-ethnicity-still-posts-profit (paywall)

Intervention	Impact on equity in long term	Fit within IMPB regional scope	Unintended consequences	Possible Mitigations
Increase Māori-led primary-care based programmes to support improved diabetes and respiratory condition identification and management, and to increase Māori access to CVD risk assessment	High	High	Obligations to address Māori health inequities could be seen as a problem for Māori providers to solve rather than recognising the roles all primary health care services in the region have to play. As with other areas, success depends on appropriate funding to Māori health providers	Requires ongoing support from funders through long-term contracts that give providers certainty. Monitoring of all relevant health services in region to ensure Māori access to culturally safe diabetes, respiratory condition programmes and CVD risk assessment (regardless of whether these are delivered by Māori providers.

From this analysis, the areas within primary health that Te Ikaroa IMPBs could focus on most effectively are:

- Advising on the need for Māori voice, leadership, and input into ongoing primary health care reform – in order to address the gaps identified in previous primary health care policy design and implementation
- Close monitoring of performance against the primary health care target and implementation of other reforms (from 1 July 2026), by ethnicity
- Advising on the need for increased support for Māori health providers in primary health care across the region, and monitoring primary health care investment in the region overall
- Advising on gaps in culturally safe and/or Māori-led primary health care programmes to support diabetes, respiratory, and CVD outcomes for Māori
- Monitoring all relevant health services in the region to ensure equitable Māori access to culturally safe primary health care.

Access to hospitals and specialist services

The New Zealand health system separates health care broadly into two main areas:

- Primary health care (discussed above, and which can include a comprehensive range of services like general practice and mental health, and is mostly provided in the community, by private, non-governmental organisations (NGOs), or Māori-owned health services) and
- Secondary and tertiary level care, much (but not all) of which is provided in hospitals and fully funded by government for New Zealand citizens.

It is in this second hospital setting that most people access specialist services on referral from primary health care. Despite hospital and specialist services being an expensive part of the health system there is a tendency for discourse around Māori health to focus on care delivered in the community – without sufficient focus on hospital performance.

Nevertheless, hospital-level health care is an important site of inequity, as is seen in relation to specialist appointments (outlined in Stage 1 of this report). There is also evidence that Māori have higher rates of 30- and 90-day post-operative mortality across most broad procedure categories, with inequities between Māori and European populations strongest for elective/ waiting list procedures.[47] The Auditor-General, when looking into planned care in New Zealand, also noted that people waiting longer for planned care are disproportionately rural, those experiencing social deprivation, Māori, Pacific, or disabled people.[48] A Hawke's Bay study has also indicated that over an 8-year period rural and Māori patients in the rohe experienced longer wait times for publicly funded elective procedures than others.[49]

Intervention points

There were few interventions identified in our environmental scan, but there was some evidence that outreach clinics lead to a reduction in first specialist appointment (sometimes called FSA) waiting times for rural and regional patients and that the possibility that further investigation could support the evolution of outreach clinics so that they meaningfully address inequities for Māori.[50]

More notably, our environmental scan also noted concerns that outsourcing for elective surgery (through Electives Boost, the government's most public investment in addressing hospital wait times) may actually increase inequities.[51] Further, there are concerns that moves towards outsourcing exclude Māori decision-making and advice, can exclude Māori from being involved in service delivery, and can be difficult (if not impossible) to monitor with an equity lens.[52]

Table 8 summarises the main interventions available. Unlike the previous priorities this includes an action that could have negative impacts on equity (outsourcing to private surgery providers), which makes identifying possible mitigations even more important for Te Ikaroa. A more detailed explanation, including a summary of our rapid environmental review is attached at Appendix 1.

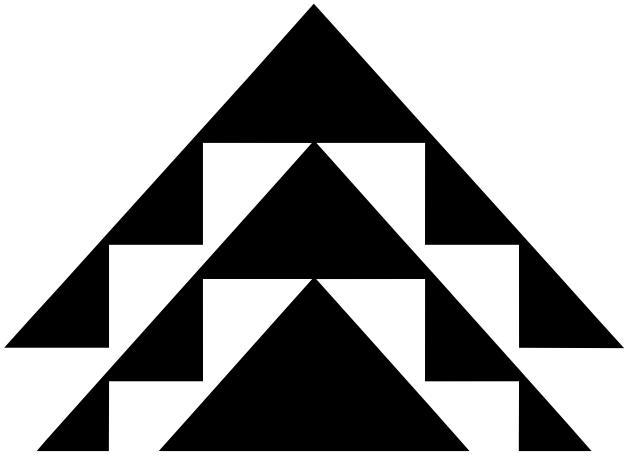
[47] Gurney, J., et. al., 2021.
[48] Office of the Controller and Auditor General, 2025.
[49] Cowan, S., et. al., 2025.
[50] Cowan, S., et. al., 2025.
[51] Office of the Controller and Auditor General, 2025.
[52] Baker, G., 2025.

Table 8: Access to hospital / specialist services - summary results of environmental scan

Intervention	Impact on equity in long term	Fit within IMPB regional scope	Unintended consequences	Possible Mitigations
Increasing access to elective surgery through outsourcing	Possibly negative	Moderate to high given risks	Evidence suggests outsourcing works for lower complexity surgeries and can disproportionate benefit well off, non-Māori populations; risk that an over-reliance on outsourcing could increase, rather than remove inequities	Strong monitoring of elective surgery outcomes at a regional level by ethnicity; long term increase in local hospital capacity and Māori providers
Increase Māori involvement in delivery of secondary care services	High	High	This is an area of development that would require significant investment, making it unlikely that many Māori providers – if any – are able to participate in these services without additional investment.	Requires ongoing support from funders through long-term contracts to give Māori providers certainty; monitoring Māori workforce in both public and private settings.
Increase community-based outreach clinics, particularly in rural areas	Unclear but high potential	Moderate	Current evidence suggests this is effective for rural communities, but more investigation is needed to understand impacts for Māori.	Requires strong monitoring and support for Māori provider involvement/partnership.

From this analysis, the areas within hospital / specialist services that Te Ikaroa IMPBs could focus on most effectively relate to elective services and planned care. They include:

- Strong monitoring of elective surgery outcomes (including those outsourced) at a regional level by ethnicity
- Supporting increased Māori involvement in delivery of secondary care services
- Monitoring Māori workforce in both public and private hospitals in the region
- Advising on gaps in community-based outreach throughout the region and supporting ongoing partnership with Māori providers in the provision of outreach clinics, particularly in rural areas.



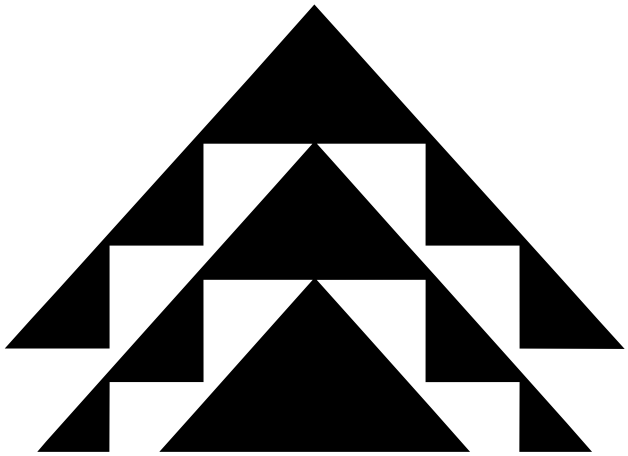
Stage 3: What actions can IMPBs undertake within the priority areas?

The final stage of our prioritisation framework is to ensure possible IMPB priorities (identified through the first two stages) support Māori leadership, knowledge, and aspirations (in other words the principles of partnership and guarantee of tino rangatiratanga). This assessment is based on the aspirations expressed in the IMPB CHPs and the information gathered in the environmental scans. Table 9 sets out our analysis.

Table 9: Possible Te Ikaroa IMPB regional actions

Priority area	Proposed Te Ikaroa IMPBs regional focus	Supports Māori leadership	Draws on Māori knowledge and expertise	Supports Māori aspirations
Mental health and wellbeing	Advising on, and supporting greater Māori involvement in the Mental Health and Wellbeing strategy consultation and development	Yes	Yes	Yes
	Monitoring rates of compulsory care under the Mental Health Act and seclusion at a regional level for Māori (compared to non-Māori) to get insights into the effects of health legislation on Māori	Yes	Yes	Yes
	Advising on ongoing investment in Māori mental health providers across the region and monitoring both total investment levels for Māori mental health providers and sustainable contracting arrangements regionally	Yes	Yes	Yes
	Monitoring mental health indicators for Māori compared to non-Māori within the region, and to advocate for better data to allow for monitoring of mental health indicators for tāngata whaikaha Māori	Yes	Yes	Yes
	Monitoring primary health care mental health interventions, specifically equitable access to	Indirectly	Yes	Indirectly
Oral health	Taking an advisory role on the oral health system review currently under way and supporting strong Māori involvement for all remaining stages of the review, including in decision-making	Yes	Yes	Yes
	Advising on regional gaps in oral health services, especially when it comes to Māori oral health providers, with an emphasis on the need for mobile oral health services	Yes	Yes	Yes
	Advising on and supporting targeted community events for oral health when they are run in ways that support community connection to Māori oral health providers	Yes	Yes	Yes
	Monitoring ongoing investment in Māori oral health across the region (both looking at total investment levels and at sustainable contracting arrangements regionally)	Yes	Yes	Yes
	Monitoring oral health indicators for Māori compared to non-Māori within the region, and to advocate for better data to allow for monitoring of oral health indicators for tāngata whaikaha Māori, and other invisibilised groups.	Yes	Yes	Yes

Priority area	Proposed Te Ikaroa IMPBs regional focus	Supports Māori leadership	Draws on Māori knowledge and expertise	Supports Māori aspirations
Cancer screening	Tracking the lung cancer screening research programme over time and supporting the roll out of an equitable screening programme across Te Ikaroa	Yes	Yes	Yes
	Advising on the equitable implementation of the bowel cancer screening programme and monitoring bowel cancer outcomes for Māori aged 45 and older within Te Ikaroa compared with non-Māori	Yes	Yes	Yes
	Monitoring and tracking implementation of the 2024 Breast Screening Action Plan, with a focus on implementation within Te Ikaroa	Yes	Yes	Yes
	Advising on regional gaps in wāhine Māori focused cancer screening programmes across the region and monitoring investment in kaupapa Māori programmes that support cancer screening	Yes	Yes	Yes
	Supporting the development of appropriate communication to Māori communities on screening, through Māori health providers	Yes	Yes	Yes
	Monitoring Māori participation rates in cancer screening across the region compared to non-Māori.	Yes	Yes	Yes
Primary health care	Advising on the need for Māori voice, leadership, and input in ongoing primary health care reform to address gaps identified in previous policy design and implementation	Yes	Yes	Yes
	Close monitoring of performance against the primary health care target and implementation of reforms (by ethnicity)	Yes	Yes	Yes
	Advising on the need for increased support for Māori health providers in primary health care across the region, and monitoring primary health care investment in the region	Yes	Yes	Yes
	Advising on gaps in culturally safe and/or Māori-led primary health care programmes to support diabetes, respiratory and CVD outcomes for Māori	Yes	Yes	Yes
	Monitoring all relevant health services in the region to ensure equitable Māori access to culturally safe primary health care.	Yes	Yes	Yes
Improving access to specialist services	Strong monitoring of elective surgery outcomes (including those outsourced) at a regional level, by ethnicity	Indirectly	Yes	Yes
	Supporting increased Māori involvement in the delivery of secondary care services	Yes	Yes	Yes
	Monitoring Māori workforce levels in both public and private hospitals in the region	Yes	Yes	Yes
	Advising on gaps in community-based outreach throughout the region and supporting ongoing partnership with Māori providers, particularly in rural areas.	Yes	Yes	Yes



Conclusions – proposed Te Ikaroa IMPB priorities

The purpose of this report was to identify the top five Te Ikaroa priorities for the region's five IMPBs, based on a prioritisation framework that was evidence-based and incorporated an equity and Te Tiriti o Waitangi assessment.

In this report we have outlined a prioritisation framework that asks three main questions:

1. What health issues are most important?
2. What interventions support equitable outcomes?
3. What actions can IMPBs undertake within the priority areas?

Having applied this prioritisation framework we propose the following five priority areas (set out in Table 10), each with a set of focus areas or indicators that the IMPBs could use regionally to drive improved Māori health outcomes within the scope of the Te Ikaroa IMPBs terms of reference.

Table 10: Top five priorities for Te Ikaroa IMPBs

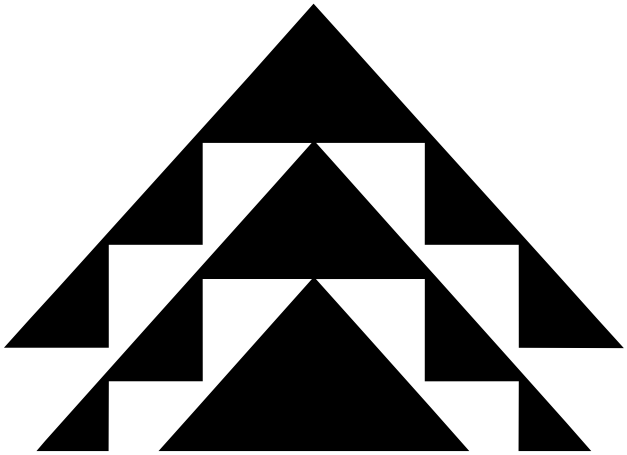
Priority	Focus area for action
Mental health and wellbeing	• Advising on and supporting greater Māori involvement in the consultation and development of the Mental Health and Wellbeing Strategy • Monitoring rates of compulsory care under the Mental Health Act and seclusion at a regional level for Māori (compared to non-Māori) to get insights into the effect of health legislation on Māori • Advising on ongoing investment in Māori mental health providers across the region, and monitoring both total investment levels for Māori mental health providers and sustainable contracting arrangements regionally • Monitoring mental health indicators for Māori compared to non-Māori within the region and to advocate for better data to allow for monitoring of mental health indicators for tāngata whaikaha Māori • Monitoring primary health care mental health interventions, and equitable access to SSRIs and other uptake inhibitors.
Oral health	• Taking an advisory role in the oral health system review currently underway and supporting strong Māori involvement in all remaining stages of the review • Advising on regional gaps in oral health services, especially when it comes to Māori oral health providers (with an emphasis on the need for mobile oral health services) • Advising on and supporting targeted community events for oral health when they are run in ways that support community connection to Māori oral health providers • Monitoring ongoing investment in Māori oral health across the region (both to look at total investment levels and at sustainable contracting arrangements regionally) • Monitoring oral health indicators for Māori compared to non-Māori within the region and advocating for better data for tāngata whaikaha Māori and other groups.

Priority	Focus area for action
Cancer screening	• Tracking the lung cancer screening research programme over time and supporting the roll out of an equitable screening programme across Te Ikaroa • Advising on the equitable implementation of the bowel cancer screening programme and monitoring bowel cancer outcomes for Māori aged 45 and older (compared with non-Māori) within Te Ikaroa • Monitoring and tracking implementation of the 2024 Breast Screening Action Plan, with a focus on implementation within Te Ikaroa • Advising on regional gaps in wāhine Māori-focused cancer screening programmes across the region and monitoring investment in kaupapa Māori programmes that support cancer screening • Supporting the development of appropriate communication to Māori communities on screening, through Māori health providers • Monitoring Māori participation rates (compared to non-Māori) in cancer screening across the region.
Primary health care	• Advising on the need for Māori voice, leadership, and input into ongoing primary health care reform – in order to address the gaps identified in previous primary health care policy design and implementation • Close monitoring of performance against the primary health care target and implementation of other reforms (from 1 July 2026), by ethnicity • Advising on the need for increased support for Māori health providers in primary health care across the region, and monitoring primary health care investment in the region overall • Advising on gaps in culturally safe and/or Māori-led primary health care programmes to support diabetes, respiratory, and CVD outcomes for Māori • Monitoring all relevant health services in the region to ensure equitable Māori access to culturally safe primary health care.
Access to hospital / specialist services	• Strong monitoring of elective surgery outcomes (including those outsourced) at a regional level, by ethnicity • Supporting increased Māori involvement in the delivery of secondary care services • Monitoring Māori workforce levels in both public and private hospitals in the region • Advising on gaps in community-based outreach throughout the region and supporting ongoing partnership with Māori providers, particularly in rural areas.

Next steps

The next step for Te Ikaroa IMPBs is to incorporate the findings of this review in their ongoing work with HNZ. We hope that the rapid environmental scans (in Appendix 1) provide some evidence and further guidance in this ongoing work.

As with most prioritisation process, the conclusions are based on the best information at a single point in time. As government priorities and other circumstances change over time it may be that the priorities need to be reviewed. The description of the prioritisation framework developed for this report should also provide guidance in this future process.



Appendices

Appendix 1: Rapid environmental scan details

Mental health and wellbeing

At a societal level:

Our environmental scan highlighted the importance of the link between experiences of racism and its negative impacts on mental wellbeing in Aotearoa.[53] Research also indicates that addressing inequitable mental health harm requires improvements to the social ecosystems that disproportionately harm Māori youth, including colonial systems that consistently impact Indigenous youth mental health, particularly housing precarity, poverty, violence, bullying, and racism.[54]

At an individual or whānau level:

There is some discussion in literature of the benefit of education programmes around mental health in schools. Weber et. al. (2024) note that "while studies have shown that positive psychology interventions can positively impact students' well-being, mental health, behaviour, and achievement, the focus remains on individual mental health and behavioural outcomes, rather than on learning" in a way that is "incommensurate with both Te Tiriti o Waitangi and an educative approach to mental health". The authors argue that "when guided by Te Tiriti o Waitangi, mental health education policy can give clear direction for schools and boards, be inclusive of diverse worldviews and experiences, and be community-led".[55]

At a health system level:

A comprehensive approach to removing health system barriers for Māori bipolar disease has been outlined by Haitana et. al. (2023). This includes addressing the harmful effects of health legislation (specifically fixing harmful legislation/seclusion/restraint/security practices in services to protect Māori patients/whānau).

At a health service level:

The analysis by Haitana et. al. (2023, mentioned above) includes recommendations to eliminate barriers of access to primary health care and barriers to prescription medication (including cost barriers), delivering primary health care in community settings that work for Māori whānau, addressing workforce gaps, and eliminating variation in mental health care quality for Māori.[56]

[53] Meredith, et. al., 2025 (a).
[54] Clark, et. al., 2025. https://doi.org/10.1186/s12889-025-24845-z
[55] Webber, et. al. 2024.
[56] Haitana, et. al. 2023.

There is evidence that effective mental health services for Māori, especially parents, involves engaging with providers that support kotahitanga (by expressing values such as whanaungatanga, tikanga, and mana)[57] – emphasising the need for clinical and cultural excellence.[58] This is aligned with broader calls for prioritisation of mātauranga Māori mental health interventions within the health sector and by-Māori, for-Māori approaches.[59] Government consultation has also confirmed that when it comes to mental health, Māori are seeking strengthened services by and for Māori, and collaboration to foster and embed Kaupapa Māori approaches and cultural values within service delivery.[60]

Despite Māori adults being about 1.5 times as likely as non-Māori to report higher probability of anxiety or depression, there are lower dispensing rates of SSRIs for Māori, which could indicate concerns about talking to / sharing mental health concerns with their GP or nurse prescriber, underdiagnosis of mental health conditions in primary health care, or under-prescribing.[61]

Access to quality primary health care can also be affected by practitioner perceptions of people with mental health conditions. Despite Māori adults being about 1.5 times more likely than non-Māori to report higher probability of anxiety or depression, there are lower dispensing rates of SSRIs for Māori, which could indicate an issue with service quality or that Māori patients are uncomfortable seeking mental health support from their primary health care providers. There is also evidence of diagnostic overshadowing (where physical symptoms are overlooked or mis-attributed to mental health issues by clinicians, leading to misdiagnosis or inappropriate treatment) that disproportionately impacts Māori,[62] further emphasising the need for overall primary health care improvement.

Oral health

At a societal level:

Water fluoridation is widely seen as an effective way to address dental caries in communities. For example, Te Rōpu Niho Ora, a national body supporting Māori providers state their support of fluoridation as an essential tool to reduce oral health inequities. There is also evidence that fluoridation of water supplies is inequitable across the country, with one estimate that 61,000 additional Māori would need access to community water fluoridation to get the same access as non-Māori.[63] This has a high potential to improve population oral health, but the way in which fluoridation decisions are made and implemented is supported could drive widening inequities if Māori communities are not provided targeted support.

[57] Meredith et. al., 2025 (a).
[58] Meredith, et. al., 2025(b).
[59] Rolleston, et. al., 2020.
[60] Ministry of Health, 2026.
[61] Sheridan, N., et. al. 2024.
[62] Cunningham, et. al., 2023.
[63] Chambers, et. al., 2025.

At an individual or whānau level:

Despite fluoridation being widely agreed as an effective intervention, it is not always straightforward. At an individual or whānau level access to subsidised fluoride (toothpaste and other products) could be supported to prevent dental caries along with maintaining good oral hygiene (brushing teeth every day with a fluoridated toothpaste) and minimising the intake of sugary foods and drinks.[64] The evidence examining school-based campaigns to improve oral hygiene and toothbrushing was considered in a 2019 review as part of the National Science Challenge. The review noted there was moderate evidence that education and behavioural interventions based in primary schools can reduce children's plaque levels.[65] There is always a risk of health promotion and health education campaigns that they work best the most advantaged populations, which may be mitigated through targeted support to Māori communities or having programmes developed or delivered by Māori oral health providers or educators.

At a health system level:

Improving the design and operation of the oral health system is supported by a range of groups. The NZ Dental Association supports "Māori determining the design, delivery, and monitoring of their health services to support achieving equitable health outcomes". There are also calls from advocacy groups (such as the Dental For All Coalition) for free dental care to be extended to those aged over 18 years.

HNZ have also acknowledged that access to community-based oral health services has reduced over time, with fewer children receiving services and high numbers of children who have not been seen by oral health services within the expected timeframes. In response, HNZ has scoped a review[66] (due for completion at the end of the year) to identify and define the appropriate oral health model(s) of care, including prevention and promotion, to:

- Improve access and outcomes for children and young people, with a particular focus on Māori, Pacific and disabled people and other populations with the greatest level of need
- Develop a commissioning framework for the oral health system that supports delivery of the model(s) of care - including a workforce model, funding model, contract mechanisms and performance and accountability measures, and
- Provide clear and realistic recommendations within the current funding and policy settings that will support improved oral health outcomes and equitable access to services for all children and young people aged 0-17 years.

HNZ has also acknowledged that there are low numbers of Māori and Pacific health providers offering oral health services and highlighted mobile dental clinic investment as part of the new models being explored.[67]

[64] Robson, et. al., 2007.
[65] Maesson, et. al., 2019.
[66] Health New Zealand, 2025.
[67] Health New Zealand, 2024 (Correspondence).

At a health service level:

While achieving equitable oral health outcomes is often positioned as a whole-of-system issue, there is some evidence of the potential of opportunistic touchpoints such as hospital appointments and admissions as an opportunity to improve oral health particularly for Māori (and Pacific) children.[68]

There is also some support for one-off targeted community oral health events, often aimed at adults but available for the whole whānau, such as Tō Waha Wairoa[69] and the free dental events, such as that held in Porirua as part of Te Wāhi Tiaki Tatou which saw 328 people receive 1,019 procedures, including 180 extractions and 122 fillings.[70]

While these initiatives can provide essential, one-off oral health support for whānau Māori in the region, they work best alongside longer-term strategies, including improving access to hauora Māori providers, which is seen as a critical intervention point for equity.[71]

HNZ has indicated there are a "small number" of Māori oral health providers currently.[72] Therefore, to provide this long-term support, there needs to be more Māori oral health providers. This requires significant investment. In the 2000s the Ministry of Health supported five Māori oral health providers across the country to fit out oral health facilities, most of which were mobile units. This project was found to have positively increased provider capacity and capability, but the evaluation reiterated that the funding for equipment needed to be matched by funder (at that point DHB) behaviour that supported the providers through ongoing service funding.[73]

In preparing this report, we asked HNZ for data on mobile units in the rohe delivering oral health services. The HNZ information (which came with their own caveats about accuracy) showed that there were three mobile units run by Māori providers and offering oral health services (Bestcare Whakapai Hauora, Te Taiwhenua o Heretaunga, and Ora Toa), but there was not reliable information on the number of dental chairs within these services.

Cancer screening

Cancer has been identified as an issue for the region based on CHPs and government data, with a strong focus on ensuring that Māori benefit equitably from cancer screening programmes. Screening involves testing where there are no symptoms apparent. It requires a high-quality screening pathway that includes referral to diagnosis and early treatment. Bowel and cervical screening can also prevent cancer by identifying and treating abnormal cell changes before they become cancer.[74]

[68] Thompson, et. al., 2025.
[69] https://www.maorioralhealth.org.nz/ourmahi
[70] Kearns, et. al., 2025.
[71] Aroturuki Tamariki Independent Children's Monitor, 2024.
[72] Health New Zealand, 2025.
[73] Wehipeihana, et. al., 2011.
[74] Cancer Society of NZ, https://www.cancer.org.nz/cancer/find-cancer-earlier/screening-and-early-detection/ (accessed 17 April 2026)

As the focus of this environmental scan is health services, unlike the previous two priorities, we have focused on how to make the health services themselves more accessible, more effective, and higher quality.

Addressing barriers to access

Slater et al. (2016) states that community focused Māori health providers are uniquely positioned to provide cancer care and screening services to their communities. Their research found that main reasons given for delays in accessing cancer screening were financial barriers and limited information. Other reasons included; lack of cultural safety by the screening provider, provider issues (e.g., not having a regular GP) and absence of Māori health workers, aspects that Māori health providers are able to meet.

Breast screening

A quality improvement review of the national breast screening programme, Breastscreen Aotearoa, was published in May 2023. This was in response to failings in screening at Hutt Valley DHB and was an opportunity to provide recommendations for improving the screening programme.

The review identified areas for improvement in the breast screening programme with a specific focus on wāhine Māori and Pacific women. Following this review, HNZ addressed the recommendations of the review and funded 27 initiatives which were detailed in an Action plan released in June 2024 (Health NZ, 2024). The Action Plan identified a number of actions that relate to Māori health equity, for example; developing a Māori community of practice, co-designing with Māori, Māori data sovereignty, ethnicity data quality, monitoring and reporting framework, cultural safety and anti-racism training, kaupapa Māori accreditation programme and to 'rapidly increase Māori and Pacific participation to 70%'.

Some tangible steps are identified in the action plan that were worked on in 2024/25 such as:

- Training (via Kaimahi Training and Development funding) to build capacity and capability of workforce (including cultural safety, addressing racism and systemic biases)
- Telehealth follow-up calls for no response to screening invites
- Funding to BSA providers to; offer screening after hours and in different locations, and trialling new ways of engaging wāhine Māori.
- Funding to screening support services for initiatives to encourage screening (e.g., promotion, infrastructure).

There are examples of Māori-focused programmes that have had positive impacts for Māori women, including within Te Ikaroa.

- The Mana Wāhine (Empowered Women) programme[75] is a Māori health provider collective network[76] that works together with wome n and their whānau "to ensure spiritual and cultural needs are acknowledged and that women are prepared, informed, and supported to access screening". Key challenges highlighted for the programme are the lack of security in contracting, funding, staff retention and impacts of ongoing health restructuring. Despite the challenges, it is clear for the programme that partnerships are key - and "the future direction for Mana Wāhine is co-designing the service with whānau at the centre".

- Mauri Tū Mauri Ora (M2MO) is a health promotion and support to cancer screening programme for whānau in West Auckland. For breast screening, kaimahi liaise with BreastScreen Aotearoa staff to identify overdue whānau and make block bookings for groups of wāhine at the BreastScreen clinic, with wrap around support included to navigate the process. An evaluation of the whole service showed that the wrap around nature of the service, addressing access difficulties and provision of culturally safe care reduced barriers.[77] The report makes recommendations for increased stable funding, additional transport and staff resources, educational resources, data gathering and data sharing

Aye et al. (2025) undertook a data linkage project in Northern Aotearoa to improve participation in the screening programme. The project also provided evidence for the value of a population register (which, as Aye reports is now funded and underway). The research found that "Māori women who had not been enrolled in the programme were willing to participate when they were invited to screening programme systematically".[78]

Cervical screening

From July 2023, the primary test for cervical screening changed to a human papillomavirus(HPV) test a departure from the previous cytology-based 'smear' programme. Primary HPV testing is more sensitive than cytology testing and this new test means people can be tested every 5 years instead of every 3 years. This change also allows for 'self-testing'. Self-testing has been shown to help more people access testing and improve equity in coverage.

In September 2023, the Government committed funding for the programme, a decision supported by Hei Āhuru Mōwai who commended the move to fund the HPV self-testing for wāhine Māori, Pasifika, community service card holders, and those who've never been screened or haven't been tested in the past five years - stating that it will save lives by "removing barriers for wāhine Māori and tangata Māori who have a cervix by increasing access to cervical screening".

[75] Albert, et. al., 2024.
[76] Mana Wāhine (Empowered Women) is a collective of five Indigenous health providers working across health districts in the greater Wellington region funded to provide support to Māori, Pacific, Asian, under-screened, and never-screened peoples to participate in cancer screening programs.
[77] Te Whānau o Waipareira, 2024.
[78] Aye, et. al., 2025.

The Government has reconfirmed funding through to June 2026 to provide free cervical screening for high-priority groups, including Māori and Pacific peoples, people with a Community Services Card and people who are very overdue to be screened. Correspondence in March 2025 acknowledged the disparities that have persisted in the National Cervical Screening Programme and emphasised that further initiatives (as well as the self-test) were required to tackle these inequities – including 'having self-testing available through a wider range of providers and continuing with providing free screening for priority groups'.

A growing body of research has demonstrated the high acceptability of the HPV self-test option.[79] For example, one study involving a cross-sectional survey[80] found high acceptability from Māori participants for the self-test option. Study participants recommended that the HPV programme could be improved by;

- Increased awareness/promotion of the HPV self-test (e.g., media, posters in marae, clinics)
- Location choices offered and supported by staff such as kaiawhina, facilitation for at home testing or other preferred settings.
- Clear information about the test was highlighted as very important.
- Pro-equity systems and culturally appropriate service provision.

Research by Adcock et al. (2021) also cautioned that following the screening test and when results are delivered and communicated, 'primary care and colposcopy services need to take special care with never-/under-screened Māori women to provide sensitive, responsive care, and mitigate trauma'.

There is a lack of research on the experiences of sexual minority women (SMW; lesbian, wāhine takatāpui, bisexual women etc). Research[81] talks to lower participation rates, including for Māori. Findings indicated the need for provision of affirmative services, clarity of information, and specifically targeted promotion were key factors that might facilitate the engagement of SMW in cervical screening.

Slater et al. (2025) explored how younger cohorts (18–30-year-olds) respond to joining and participating in the screening programme. The study found the ease of the HPV self-test encouraged participation, with cost (and transparency / information about the cost) reported as the biggest barrier. Other barriers included the logistics of living rurally (compounded by weather events, pandemics), difficulty getting appointments and the need for flexible options (like walk-ins, after hours, multiple locations, mobile services, sending tests by post). Inviting rangatahi leadership into shaping the narrative was seen as a way to switch "the narrative of cervical screening from burden to action".

[79] Adcock, et. al., 2021; Lawton, et. al,, 2023; Whaiti, et. al., 2025.
[80] Whaiti, et. al., 2025.
[81] Ellis, 2024.

In terms of specific/evaluated approaches to cervical screening in New Zealand:

- An evaluation for the 'Smear your mea campaign'[82] found:
    - Barriers to screening included such aspects as; mistrust arising from negative and culturally unsafe engagement with health system, lack of culturally, practical structural barriers (e.g., cost, availability, timing, transport) as well as fear and feeling whakamā.
    - What works included; Kaupapa Māori approaches, Māori led approaches, trusted relationships, community connection, safe welcoming environments, bringing services out via mobile units, events (opportunistic), and promotion via varied formats.

- As mentioned earlier, Mauri Tū Mauri Ora (M2MO) is a health promotion and support for cancer screening programme for whānau in West Auckland and has good results especially with people who have never screened before. A mixed methods approach informed the evaluation, which also included surveys of attendees to cervical cancer screening clinics. The service provides support to facilitate the screening process as well as support with aspects like transport to the clinic. The need for accurate data was also highlighted. Overall, the evaluation found that mana enhancing engagement, kotahitanga, accessibility and convenience of services and creation of holistic safe spaces, are some of the successes of the programme.

Bowel screening

We know that Māori are more likely to be diagnosed with bowel cancer at younger ages and at a more advanced stages - with a substantial body of research highlighting the need for earlier intervention and exploring implications of the screening programme for Māori health equity.[83]

Between 2022 and 2025, free bowel screening was offered to Māori and Pacific Peoples aged 50 to 74 who lived in the MidCentral, Tairāwhiti, or Waikato areas, as part of a two-year learning pilot. However, in early 2025, HNZ announced the targeted pilot for 50-59 year-olds was ending, to be replaced by a universal screening starting age of 58 across the country (from Oct 2025). Participants already in the pilot were expected to be "grandparented" in to continue their screening. This is despite concerns that the backtrack of lower age for Māori screening reduces early detection for high-risk, younger Māori, who often develop cancer earlier.

When the pilot was ended, many Māori health experts called out the detrimental and real-life impacts of this decision. As Dr Rawiri McKree Jansen stated "the government could have chosen to keep the bowel screening entry age at 50 for Māori and Pacific while lowering it to 58 for the rest of the population. In choosing to make the age universal, the government is knowingly increasing inequities in access to bowel cancer screening, in cancer deaths and in life expectancy".[84] More recently, Lady Tureiti Moxon, continued the

[82] Powell, et.al., 2021.
[83] For example: Longmore, 2025; Scott, et. al., 2025; Mcleod, et. al., 2017; McLeod, et. al., 2021.
[84] Fuatai, T. 2025.

call urging "the Government to urgently reinstate bowel screening from age 50 for Māori and implement immediate interim measures for those currently excluded."[85]

Independent of the issue of age range, authors have stated[86] that achieving equitable participation for Māori and Pacific Peoples remains the programme's biggest challenge but that "once an individual is participating in the programme any equity gaps diminish significantly" and that addressing participation gaps requires "equity-focused monitoring, dedicated funding, and the willingness to constantly test, review, and adjust new approaches".

The National Bowel Screening Programme Qualitative Research: Insights Report presents findings from kaupapa Māori–informed qualitative research and focuses on perceptions, experiences, barriers, and motivations in relation to bowel screening.[87] This report found that participants understood that cancer was serious (including bowel cancer) but had limited knowledge about the screening 'until the pack came in the mail' – with many not realising it was an 'in-home' test. Whilst instructions were clear and many appreciated the privacy of home, participants indicated there would be value in having help and/or support as well as more education and awareness. This report also highlights that a"[f]or Māori, by Māori whānau, marae, hapū, iwi and community approach was identified as what would be the most effective" and that the programme needed "champions who are knowledgeable, reputable, trusted, and credible to champion the campaign such as Māori health providers, iwi and whānau leaders".

Research from earlier in the screening roll-out explored whether a telephone follow up service would be effective for increased screening participation.[88] Key findings of this research were that follow up by phone, while more expensive than postal reminders, had the advantage of assisting with logistical issues for respondents.

More recently, researchers found that active follow up did increase participation for Māori and Pacific, reducing but not eliminating health inequities.[89] McMenamin et al. (2026) also found that there was still a place for system support and follow up "via text, phone calls or outreach kaimahi" to improve the return rate of kits. Other suggestions were:

- Reminders (eg, opportunistic reminders, via the tuku tool – a portal for practitioners that shows variable use indicating more scope for us)
- QR codes to access multiple language instructions
- Expand number of participating practices
- Staff (especially kaiawhina roles) to demonstrate use of the screening kit and engage in follow-up.

[85] NZ Doctor, 2026.
[86] Parry, et. al., 2025.
[87] Puhimoana Ariki Collective, 2022
[88] Sandiford, et. al., 2019.
[89] Sandiford, et. al., 2026.

Māori research underway[90] points to potential enablers that could improve bowel screening for Māori, including:

- Māori health providers delivering information, education and screening packages
- Kaiāwhina for delivery and pick-up of bowel screening packages
- Design of local bowel screening program by Māori.

Primary health care

Our environmental scan looked at primary and community health care, both because of recognised aspirations to improve primary health care in the CHP analysis and because primary health care is the entry point for care in areas like CVD, diabetes, mental health, asthma, and respiratory conditions (all of which were identified through the IMPB profiles as equity issues across the region).

The focus on one element of the health system (primary and community health care) means that, unlike the first two health areas, we have not considered societal or individual/whānau level interventions but how the health system and health services can be more effective to address inequities for Māori populations within Te Ikaroa region. We note of course that diabetes, asthma and respiratory conditions and CVD conditions all have causes outside of the health sector and within the wider determinants of health.

It is outside the scope of this review to describe the primary health care system in detail, except to note that primary and community health care is the entry point to the health system for most people. Through primary health organisations, New Zealanders access primary health professionals (such as general practitioners and nurse practitioners) and get support to stay and be well. Primary and community health care are also the main access gateway to more specialised health care (for example in hospitals).

At a health system level:

There are longstanding criticisms of New Zealand's primary health care system, especially when it comes to Māori health and health equity. Many of these criticisms are outlined in the Waitangi Tribunal's Hauora report (which covers the primary health care claims within Wai 2575 the health services and outcomes kaupapa inquiry), including that Māori were not adequately involved in the design of the primary health care system from the outset, that the policy intentions were not matched with tangible actions, that the funding formulae at times supported inequitable outcomes (was anti-equity), that Māori health providers and Māori-led PHOs were not adequately supported to participate in primary health care, and that there was insufficient monitoring of primary health care by DHBs and by the Ministry of Health.[91] Claimants in the most recent stage of the Wai 2575 inquiry (looking at disability) have also highlighted the lack of provision within primary health

[90] See: https://bowelcancernz.org.nz/new/new-research-underway/#:~:text=Once%20the%20final%20two%20interviews,requires%20further%20analysis%20and%20finalisation.
[91] Waitangi Tribunal, 2019.

care policy, implementation, and practice for tāngata whaikaha leadership, health needs, and aspirations for wellbeing.[92]

Recently-published research on primary health care indicates that primary health care leaders (from practice to policy level) "overwhelmingly judge" that progress had not been made in eliminating inequity between Māori and non-Māori.[93] There are several possible reasons for this, including a mix of a lack of political will at a national level, a failure of policy implementation and the fact that resource and power in primary health care did not fundamentally change hands at the introduction of the Primary Health Care Strategy in 2001.[94] There is also research to suggest that primary health care in New Zealand is particularly underserving Māori who have been released from prison and that the funding rules (based on enrolment) prevent high quality continuous primary health care for this population.[95]

A report, commissioned by Waitangi Tribunal claimants in 2021, showed that there was significant and direct underfunding of Māori primary health care of up to $500million nationally since the primary health care funding formula began.[96] There is also evidence that within the current primary and community health care system Māori providers are delivering high quality care to Māori whānau in a way that supports Māori leadership and mana motuhake. Looking at clinical data, one published paper found that there was not a significant difference in health outcomes for Māori patients enrolled at Māori practices compared to other models of care (like traditional or corporate practices), but that this has to be understood alongside Māori practices serving a population with higher primary health care needs.[97] The conclusion of this paper was that Government funding "should support under resourced Māori practices and ensure accountability for the health outcomes of Māori patients in all models of general practice".[98]

Widespread fixes to the primary health care system have been expected now for several years. In 2025, the Minister of Health – Hon Simeon Brown, announced changes to the primary health care system including:

- Updating the funding formula for PHOs
- Setting a new health target for faster GP access.[99]

The current funding formula uses just two factors, sex and age, but these are not the only factors that impact people's health needs. To address this, the updated approach (to take effect from 1 July 2026) includes a range of factors including age, gender, 'multi-morbidity' (when someone has two or more chronic conditions), rurality and socio-economic deprivation. Critically, despite the evidence, ethnicity has not been included in this

[92] The disability claims have all been heard by the Waitangi Tribunal, who are currently considering evidence and preparing a report. For examples of claimant arguments see the evidence of Associate Professor Dr Tristram Ingham (Wai 2575, #H19).
[93] Tenbensel, T., et. al., 2026.
[94] Reidy, J., et. al., 2025.
[95] King, P. T., et. al., 2025.
[96] Love, T., 2021.
[97] Sheridan, N., 2024.
[98] Ibid.
[99] See: https://www.beehive.govt.nz/release/strengthening-primary-care-better-meet-patient-needs (accessed 17 April 2026).

updated approach, a move that has raised concerns amongst Māori primary health care experts.[100] Building on the lessons of Wai 2575's Hauora report, it is important that the impacts of the funding changes are monitored by ethnicity within regions to be able to identify the equity impacts for Māori patients, whānau, and communities in real time so that advice can be given to decision-makers quickly if changes need to be made. It is also important that the impact of funding changes for Māori primary health care providers is closely monitored.

At a health service level:

In addition to supporting Māori-owned and Māori-governed / kaupapa Māori health providers to offer a full range of comprehensive services, there is evidence of effective local / provider-based initiatives that support better primary health care outcomes for Māori around diabetes, asthma and respiratory conditions, and CVD.

Diabetes

There were several Māori-led, primary health care-based diabetes prevention and management programmes for Māori adults identified in our environmental scan. This included interventions that involved additional, wrap-around, support in a clinical setting,[101] and community co-designed lifestyle programmes.[102]

A scoping review of interventions with measurable clinical outcomes found that clinical and peer support alongside active involvement of whānau worked well for Māori. The review concluded that culturally appropriate approaches to improving engagement and acceptability for Māori, while addressing lifestyle and medication adherence were essential.[103] The need for holistic, culturally responsive, type-2 diabetes care is also recognised by other authors,[104] as is the need to have Māori health providers play a role in diabetes programmes (as influential partners,[105] or as intervention leads).[106] The importance of ensuring performance measures capture and accommodate cultural appropriateness has also been emphasised.[107]

Asthma and respiratory conditions

Given the level of Māori health need (for children and adults), there are few studies we found in our environmental scan able to provide evidence-based interventions in primary health care.

A recent analysis of asthma interventions in New Zealand emphasised the lack of attention on respiratory health for Māori and Pacific children.[108] That article did, however, helpfully

[100] See for example NZ Doctor article (13 April 2026). Available online https://www.nzdoctor.co.nz/article/news/hauraki-pho-remains-angry-over-ethnicity-still-posts-profit (paywall)
[101] Tane, T., et. al., 2021.
[102] Masters-Awatere, B., et. al, 2021.
[103] Mustafa, S., et. al., 2024.
[104] See for example Crosswell, R., et. al., 2025.
[105] Beaton, A., et. al., 2019.
[106] Tane, T., et. al., 2021.
[107] Beaton, A., et. al., 2019.
[108] Matenga-Ikihele, A., 2024.

identify that there was research evidence supporting the importance of improving housing quality and heating as an effective respiratory health intervention. It also indicated some promising research on improving use of medications, school-based clinics (specifically around throat swabbing/sore throats and rheumatic fever), and the links between conditions like influenza and asthma, especially for tamariki. The article's analysis highlighted the impacts of 'inhospitable' services on parent decisions to seek health professional support and the importance of bringing culturally responsive care to the fore for Māori and Pacific children.

For tamariki, there is concern that despite most recommended medicines being fully subsidised by Pharmac, there is still 'sub-optimal' use, meaning tamariki Māori are not receiving the full benefits of this medication. There is some evidence that combining asthma education with a nurse-led, evidence-based asthma assessment and education intervention led to sustained improvements in asthma control in pre-school populations.[109]

For adults there is research evidence that supports cultural safety in respiratory health interventions. One study looked at factors affecting uptake of pulmonary rehabilitation by Māori adults with COPD[110] and found that Māori placed a high value on whakawhanaungatanga and that when appropriate communication and relationship building was absent, they felt reluctant to attend pulmonary rehabilitation. A key finding of the study was that Indigenous-led and culturally responsive health care interventions for COPD may provide a solution to disparities in the area.[111] National respiratory targets alongside fully funded quality health services with monitoring of all asthma services has also been recommended.[112]

CVD risk assessment

As with diabetes and asthma, there are a wide range of intervention points that could support more equitable health outcomes for Māori. The focus of our environmental scan, however, was on evidence-based cardiovascular disease risk assessment (CVDRA). Māori have lower odds of having a CVDRA in primary care, and there is an identified and critical need for strategies that eliminate inequities for Māori and other underserved populations.[113]

Opportunities for managing gaps in CVDRA include providing adequate CVD literacy, involving whānau in care, improving patient-provider relationships, increasing access to high quality care, and enhancing cultural safety.[114] Overall, there is support for moving away from one-size-fits-all approaches to CVDRA.[115] Authors of the articles we identified tend to support the need for political commitment to ensure interventions that are

[109] Walker, N., et. al., 2022.
[110] Chronic Obstructive Pulmonary Disease.
[111] Levack, W. M. M., 2016.
[112] Jones, B., 2017.
[113] Selak, V., et. al., 2025.
[114] Wheeler, A., et. al., 2025.
[115] Selak, V., et. al., 2020.

designed for Māori and other populations with higher needs for CVDRA are properly implemented and evaluated.[116]

Improving access to hospital and specialist services

The New Zealand health system separates health care broadly into two main areas:

- Primary health care (discussed above, and which can include a comprehensive range of services like general practice and mental health, and is mostly provided in the community, by private, non-governmental organisations (NGOs), or Māori-owned health services) and
- Secondary and tertiary level care, much (but not all) of which is provided in hospitals and fully funded by government for New Zealand citizens.

Most people access hospital or specialist services on referral from primary health care. Despite being an expensive part of the health system there was not a lot of material identified in our environmental scan about interventions that could improve Māori access to specialist services.

There are some studies that look at access to hospital services for Māori. One literature review identified five common barriers to hospital care experienced by whānau Māori: poor communication from health professionals, hostile health care environments, primary health care barriers (and difficulties with the transition between primary and secondary care), racism (including institutional racism) and practical barriers (such as financial/cost barriers, transport barriers, and a lack of childcare).[117] Conversely the literature review found that whanaungatanga, whānau involvement, manaakitanga, ethnic concordance (that is, that Māori consistently report positive experiences with Māori providers) and practical facilitators (such as transport to appointments and prescription deliveries) help support access to hospital care for Māori.

A qualitative systematic review of Māori experiences of hospital care indicated similar barriers to care for Māori, noting the need for cultural safety to be included into routine practice in hospitals. The review also identified the need for leadership and workforce representation (the review noting that the hospital workforce tended to reflect societal divisions based on ethnicity and socio-economic status) and the role played by structural barriers such as bureaucratic intake processes, poor referrals, and lack of information for Māori patients / communities about the supports they're entitled to.[118]

When talking about hospital performance, the focus – at least in media and government statements – is often on planned care / elective surgery. There is evidence that Māori have higher rates of 30- and 90-day post-operative mortality across most broad procedure categories, with inequities between Māori and European populations strongest for

[116] Ibid.
[117] Espiner, E., et. al., 2023.
[118] Thomas, C., et. al., 2022.

elective/waiting list procedures.[119] The Auditor-General, when looking into planned care in New Zealand, also noted that people waiting longer for planned care are disproportionately rural, those experiencing social deprivation, Māori, Pacific, or disabled people.[120] A Hawke's Bay study has also indicated that over an 8-year period rural and Māori patients in the rohe experienced longer wait times for publicly funded elective procedures than others.[121]

A common government response to inadequate hospital capacity elective surgery procedures is to outsource services to private hospitals. This is certainly the basis of the current Electives Boost programme[122] announced in 2025.

There are equity concerns with a reliance on outsourcing. The Office of the Auditor-General noted there is a risk that some actions designed to provide more timely treatment, like outsourcing, could result in less equitable access.[123] This is for a range of reasons, including international evidence that the types of procedures suitable to be delivered in private hospitals tend to be less complex, which in turn tends to support wealthier, younger, and white populations disproportionately.[124] The Office of the Auditor-General has recommended that HNZ ensures that it has clear actions in place to improve equity of access to treatment and that efforts to improve timeliness do not increase inequities.

Although there were few interventions identified in our environmental scan, there was some evidence that outreach clinics lead to a reduction in FSA waiting times for rural and regional patients and that the possibility that further investigation could support the evolution of outreach clinics so that they meaningfully address inequities for Māori.[125] There is also a suggestion – from a study into access to rural hospitals in New Zealand – that equity needs to underpin investment and resource allocation in rural health and that quality measures need to be interpreted in the context of rural-specific measures.[126] In other words the monitoring of rural health needs to be fit for purpose to the locality.

Our environmental scan also noted concerns that outsourcing for elective surgery can exclude Māori decision-making and advice, can exclude Māori from being involved in service delivery, and can be difficult (if not impossible) to monitor with an equity lens.[127] The Auditor-General also raises concerns about monitoring (with concerns about the usefulness of what is available) and critical data gaps for some populations (such as disabled people).[128]

We note that for outsourcing to be a long-term solution and aligned with government Te Tiriti commitments there needs to be true partnership in the delivery of outsourced health

[119] Gurney, J., et. al., 2021.
[120] Office of the Controller and Auditor General, 2025.
[121] Cowan, S., et. al., 2025.
[122] See: https://www.beehive.govt.nz/release/elective-boost-get-more-kiwis-out-pain (accessed 17 April 2026).
[123] Office of the Controller and Auditor General, 2025.
[124] For a brief discussion on international evidence for outsourcing see Baker, G., 2025.
[125] Cowan, S., et. al., 2025.
[126] Atmore, C., et. al., 2023.
[127] Baker, G., 2025.
[128] Office of the Controller and Auditor General, 2025.

care and support for Māori health providers to expand into the delivery of private health services and provide a wider range of services (perhaps including diagnostic services) in the community[129], such as Te Kōhao Health's Taakiri Tuu Wellness and Diagnostic Centre

As a minimum, there needs to be greater access to transparent data at a regional level to ensure proper performance monitoring of Electives Boost and to support greater collaboration at a regional level.

[129] Baker, G., 2025.

Appendix 2: References

Adcock, A., Stevenson, K., Cram, F., MacDonald, E. J., Geller, S., Hermens, J., & Lawton, B. (2021). He Tapu Te Whare Tangata (sacred house of humanity): *Under-screened Māori women talk about HPV self-testing cervical screening clinical pathways. International Journal of Gynecology & Obstetrics*, 155(2), 275-281.

Albert, T., Doherty, J., Olsen, T. (2024). Mana Wāhine: Empowered Women: A Cultural Response to Encouraging Cancer Screening. In: Garvey, G. (eds) *Indigenous and Tribal Peoples and Cancer.* Springer, Cham.

Arnesen, T., & Nord, E. (1999). The value of DALY life: problems with ethics and validity of disability adjusted life years. *BMJ*, 319(7222), 1423-1425.

Aroturuki Tamariki Independent Children's Monitor. 2024. Access to *Primary Health Services and Dental Care*. Wellington, New Zealand. ISBN 978-0-473-69996-3.

Atmore, C., Dovey, S., Gauld, R., & Stokes, T., 2023. What is important for high quality rural health care?: A qualitative study of rural community and provider views in Aotearoa New Zealand. Rural and remote health, 23(1), 1-8.

Aye, P. S., Bartholomew, K., Walsh, M., Pritchard, K., Pierce, M., Richards, J., ... & Jansen, R. M., 2025. The potential of a population register for addressing health inequities: an observational study using data linkage to improve breast cancer screening enrolment and participation in Indigenous Māori women in Aotearoa New Zealand. BMC Health Services Research, 25(1), 64.

Baker, G., 2024a. *Social investment: definitions and key issues – short report. Prepared for Te Kāhui Raraunga.* Baker Consulting Ltd. Wellington.

Baker, G., 2024b. "Māori health inequalities reveal uncomfortable truths", NZ Doctor, 6 June 2024.

Baker, G., 2025. Māori health, Te Tiriti o Waitangi, and the impacts of outsourcing. ASMS. Wellington.

Beaton, A., Manuel, C., Tapsell, J., Foote, J., Oetzel, J. G., & Hudson, M., 2019. He Pikinga Waiora: supporting Māori health organisations to respond to pre-diabetes. *International Journal for Equity in Health*, 18(1), 3.

Bowden, N., Gibb, S., Thabrew, H., Audas, R., Camp, J., Taylor, B., & Hetrick, S. (2019). IDI trends in antidepressant dispensing to New Zealand children and young people between 2007/08 and 2015/16. *The New Zealand Medical Journal* (Online), 132(1505), 48-61.

Chambers, T., Broadbent, J., Puente-Sierra, M., Carrington, S., & Hobbs, M. (2025). The health equity implications of the Health (Fluoridation of Drinking Water) Amendment Act 2021 for access to (and performance of) community water fluoridation in New Zealand. *New Zealand Dental Journal*, 121(2), 61-69.

Clark, T. C., Yao, E. S., Harrison, N., Drayton, B., Hamley, L., Fleming, T., & Crengle, S. (2025). Indigenous youth mental health: an ecological approach to understanding risk and protective factors for Māori youth in Aotearoa New Zealand. *BMC public health*, 25(1), 1-14.

Cowan, S., Waaka, H., Wells, C., Campbell-Seymour, M., Tahuri, T., Puckett, J., ... & Rahiri, J. L., 2025. Investigating Postcode Lottery: Do Regional Outreach Clinics Improve Waiting Times to Elective General Surgical Care for Rural and Māori Populations?. *Australian Journal of Rural Health*, 33(6), e70127.

Crosswell, R., Nikora, H., Paul, R., Buntting, C., Roa, T., Keenan, R., ... & Tiatia Fa'atoese Latu, A., 2025. Ascending the Poutama: culturally responsive diabetes care for Māori communities. *The Journal of Primary Health Care*, 17(4), 338-346.

Cunningham, R., Imlach, F., Lockett, H., Lacey, C., Haitana, T., Every-Palmer, S., ... & Peterson, D. (2023). Do patients with mental health and substance use conditions experience discrimination and diagnostic overshadowing in primary care in Aotearoa New Zealand? Results from a national online survey. *The Journal of Primary Health Care*, 15(2), 112-121.

Ellis, S. J. (2024). Improving cervical screening rates among sexual minorities: Insights from Aotearoa New Zealand. *Health Promotion Journal of Australia*, 36(1), e904.

Espiner, E., Paine, S. J., Weston, M., & Curtis, E., 2021. Barriers and facilitators for Maori in accessing hospital services in Aotearoa New Zealand. *NZ Med J*, 134(1546), 47-58.

Fuatai, T. 2025. Bowel screening change 'totally unethical'. E-Tangata. Available online: https://e-tangata.co.nz/comment-and-analysis/bowel-screening-change-totally-unethical/ (last accessed 17 April 2026).

Gurney, J., McLeod, M., Stanley, J., Sarfati, D., Campbell, D., Davies, C., ... & Koea, J. ,2021. Disparities in post-operative mortality between Māori and non-Indigenous ethnic groups in New Zealand. Iti noa ana he pito mata/from the withered tree a flower blooms: healthy equitable climate policy in Aotearoa New Zealand, 134(1542).

Haitana, T., Pitama, S., Cormack, D., Rangimarie Clark, M. T., & Lacey, C. (2023). 'It absolutely needs to move out of that structure': Māori with bipolar disorder identify structural barriers and propose solutions to reform the New Zealand mental health system. *Ethnicity & Health*, 28(2), 234-256.

Hauck, K., Smith, P. C., & Goddard, M. (2004). *Economics of Priority Setting for Health Care: A Literature Review.* World Bank, Washington, DC.

Health New Zealand | Te Whatu Ora. 2023. National Bowel Screening Programme Monitoring Report. Wellington: Health New Zealand | Te Whatu Ora.

Health New Zealand - Te Whatu Ora. 2025. Final Scoping Document- Review of Oral Health Services Delivered in Community Settings for 0-17 year olds. Health New Zealand - Te Whatu Ora.

Health Quality and Safety Commission. (2021). *Atlas of Healthcare Variation: Mental health in primary care.* HQSC. Available online: https://www.hqsc.govt.nz/our-data/atlas-of-healthcare-variation/mental-health-in-primary-care/ (last accessed: 17 April 2026).

Hobbs, M., Ahuriri-Driscoll, A., Marek, L., Campbell, M., Tomintz, M., & Kingham, S. (2019). Reducing health inequity for Māori people in New Zealand. *The Lancet*, 394(10209), 1613-1614.

Jones, B. D. (2017). Achieving Equitable Asthma Services for Māori (Masters dissertation, University of Otago).

King, P. T., Petrović-van der Deen, F. S., Davies, C., Robson, B., Crengle, S., Baker, G., ... & Cunningham, R., 2025. Health in justice or health injustice? Indigenous Māori experiences of primary care following release from New Zealand prisons: a national record study. *Social Science & Medicine*, 118543.

Lawton, B., MacDonald, E. J., Storey, F., Stanton, J. A., Adcock, A., Gibson, M., ... & Saville, M. (2023). A model for empowering rural solutions for cervical Cancer prevention (he Tapu Te Whare Tangata): protocol for a cluster randomized crossover trial. *JMIR Research Protocols*, 12(1), e51643

Levack, W. M., Jones, B., Grainger, R., Boland, P., Brown, M., & Ingham, T. R., 2016. Whakawhanaungatanga: the importance of culturally meaningful connections to improve uptake of pulmonary rehabilitation by Māori with COPD–a qualitative study. International journal of chronic obstructive pulmonary disease, 489-501.

Longmore, M. (2025). Bowel cancer screening changes' dangerous for Maori', say Maori health leaders. *Kai Tiaki: Nursing New Zealand*, 26-28.

Love, T., Moore, D., Milkop, A., Woon, L., Young, M., Comendant,C., Young, M. *Methodology for Estimating the Underfunding of Māori Primary Health Care Methodology and proof of concept with key results – report for Wai 2575 claimants.* Sapere, Wellington.

Maessen SE, Derraik JGB, Broadbent JM. Oral health promotion and early preventive interventions in a community setting. In: Cutfield WS, Derraik JGB, Waetford C, Gillon GT, Taylor BJ [editors]. *Brief Evidence Reviews for the Well Child Tamariki Ora Programme.* A Better Start National Science Challenge. Auckland, New Zealand; 2019; p. 217-254.

Masters-Awatere, B., Cassim, S., Tamatea, J., Scott, N., Simpson, C., & Paekau, C., 2021. He Pikinga Waiora Kimi Ora lifestyle programme: case study of a successful community-based Indigenous diabetes intervention. *NZMJ Vol 134 No 1545*

Matenga-Ikihele, A., Fa'alili-Fidow, J., Tiakia, D., Gentles, D., Natua, J., Malungahu, G., ... & Goodyear-Smith, F., 2025. Respiratory research with Māori and Pacific children living in Aotearoa, New Zealand: a systematic review and narrative synthesis. *Journal of Primary Health Care*, 17(1).

McLeod, M., Kvizhinadze, G., Boyd, M., Barendregt, J., Sarfati, D., Wilson, N., & Blakely, T., 2017. Colorectal cancer screening: how health gains and cost-effectiveness vary by ethnic group, the impact on health inequalities, and the optimal age range to screen. *Cancer epidemiology, biomarkers & prevention*, 26(9), 1391-1400.

McLeod, M., Sandiford, P., Kvizhinadze, G., Bartholomew, K., & Crengle, S. (2020). Impact of low-dose CT screening for lung cancer on ethnic health inequities in New Zealand: a cost-effectiveness analysis. *BMJ open*, 10(9), e037145.

McLeod, M., Harris, R., Paine, S. J., Crengle, S., Cormack, D., Scott, N., & Robson, B. (2021). Bowel cancer screening age range extension for Māori: what is all the fuss about?. *The New Zealand Medical Journal (Online)*, 134(1535), 71-77.

McMenamin, J., Parry, S., Rendle, B., & Whiteside, C. 2026. Improving National Bowel Screening participation through primary care engagement: a quality improvement report. *The Journal of Primary Health Care.*

Meredith, C., Haitana, T., McKerchar, C., & Pitama, S. (2025(a)). Kotahitanga—connection, unity, and belonging: perspectives of Māori mothers on a kaupapa Māori group intervention for perinatal mental health. *AlterNative*, 21(2), 204-215.

Meredith, C., Haitana, T., McKerchar, C., & Pitama, S. (2025(b)). "They were my anchors" Māori with perinatal mental illness identify culturally safe and clinically excellent health care. *International Journal for Equity in Health*, 24(1), 226.

Ministry of Health. (2019). Defining Equity. Available online: https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/equity (last accessed: 17 April 2026).

Ministry of Health. (2024). Tatau Kahukura – Māori Health Chartbook 2024. Ministry of Health.

Ministry of Health. (2026). Draft Mental Health and Wellbeing Strategy: 2026-2036. Ministry of Health, Wellington.

Moses, Caleb. (2020). "The integrated data infrastructure – Te hanganga o ngā raraunga kōmitimiti me te whakaaetanga ā-iwi". In Chen, Andrew (ed) *Shouting Zeros and Ones: Digital Technology, Ethics and Policy in New Zealand.* Bridget Williams Books Ltd. Wellington.

Mustafa, S., Norman, K., Kenealy, T., Paul, R., Murphy, R., Lawrenson, R., & Chepulis, L., 2024. Management of type 2 diabetes in New Zealand: a scoping review of interventions with measurable clinical outcomes. *Public Health*, 234, 1-15.

Office of the Controller and Auditor General, 2025. Providing equitable access to planned care treatment. OAG. Wellington.

Office of the Director of Mental Health and Addiction Services, 2026. *Regulatory Report: 1 July 2023 to 30 June 2024.* Ministry of Health, Wellington.

Parry, S., Bissett, I., McMenamin, J., Bloomfield, A., Porteous, M., Childs, J., & Woodley, D. (2025). From small steps to big impact: what we learnt from the National Bowel Screening Programme. *Journal of the Royal Society of New Zealand*, 55(5), 1304-1321.

Pauly, B., MacDonald, M., Hancock, T., O'Briain, W., Martin, W., Allan, D., Riishede, J., Dang, P., Shahram, S., Strosher, H., & Bersenev, S. on behalf of the ELPH Research Team (2016). *Health Equity Tools.* Victoria, BC: University of Victoria. [Available from www.uvic.ca/elph]

Pearson, J., Payne, D., Yoshida, K., & Garrett, N. (2022). Access to and engagement with cervical and breast screening services for women with disabilities in Aotearoa New Zealand. *Disability and Rehabilitation*, 44(10), 1984-1995.

Powell, E., Kohere, C., Hockings, N., Dinsdale-Kingi, T., & Charlton, A. R. (2021). *Evaluation report for Smear Your Mea.* The University of Waikato.

Rahiri, J. L., Tuhoe, J., Anderson, A., & Harwood, M. (2024). A view from Aotearoa regarding indigenous health equity—looking back to move forward. *Journal of Public Health and Emergency*, 8, 34.

Reidy, J., Bevin, N., Matheson, D., Rae, N., Keenan, R., Crampton, P., & Harris, M., 2025. Equity, power and resources in primary health care reform: insights from Aotearoa New Zealand. *International Journal for Equity in Health*, 24(1), 124.

Robson B, Harris R. (eds). 2007. *Hauora: Māori Standards of Health IV. A study of the years 2000-2005.* Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

Rolleston, A. K., Cassim, S., Kidd, J., Lawrenson, R., Keenan, R., & Hokowhitu, B. (2020). Seeing the unseen: evidence of kaupapa Māori health interventions. AlterNative: *An International Journal of Indigenous Peoples*, 16(2), 129-136.

Sandiford P, Buckley A, Holdsworth D, Tozer G, Scott N. (2019). Reducing ethnic inequalities in bowel screening participation in New Zealand: A randomised controlled trial of telephone follow-up for non-respondents. *Journal of Medical Screening.* 26(3):139-146. doi:10.1177/0969141318815719

Scott, N., Kidd, J., Arnet, H., Dargaville, C., Goza, M., Crengle, S., ... & Jansen, R. M. (2025). Tūtakarerewa-Indigenous advocacy and structural racism in bowel cancer screening in Aotearoa New Zealand. *New Zealand Medical Journal*, 138(1627), 79-89.

Selak, V., Poppe, K., Grey, C., Mehta, S., Wynter-Smith, J., Jackson, R., ... & Harwood, M., 2020. Ethnic differences in cardiovascular risk pro les among 475,241 adults in primary care in Aotearoa, New Zealand. *NZ Med J*, 1521, 14-27.

Selak, V., Paynter, J., Hanchard, S., Brewer, K. M., Taueetia-Su'a, T., Mehta, S., ... & Grey, C., 2025. CVD risk assessment by ethnicity in Aotearoa New Zealand: a national observational study. *BMC Global and Public Health*, 3(1), 94.

Sheridan, N., Jansen, R. M., Harwood, M., Love, T., & Kenealy, T., 2024. Hauora Māori–Māori health: a right to equal outcomes in primary care. *International Journal for Equity in Health*, 23(1), 42.

Slater, T., Matheson, A., Davies, C., Goodyer, C., Holdaway, M., & Ellison-Loschmann, L. 2016. The role and potential of community-based cancer care for Māori in Aotearoa/New Zealand. *NZ Med J*, 129(1430), 29-38.

Tane, Taria, et al., 2021. "Māori and Pacific peoples' experiences of a Māori-led diabetes programme." NZ Med J 134.1543: 79-89.

Te Aho o Te Kahu | Cancer Control Agency. (2023). *He Urupare: Responding to the experiences of whānau Māori affected by cancer.* Wellington: Te Aho o Te Kahu | Cancer Control Agency.

Te Aho o Te Kahu | Cancer Control Agency. 2025. *The State of Cancer in New Zealand 2025 | He Pūrongo Mate Pukupuku o Aotearoa 2025.* Wellington: Te Aho o Te Kahu | Cancer Control Agency.

Te Hiringa Mahara. (2025). Key Mental Health and Addictions Fundings: NZ Health Survey August 2025. Available online https://www.mhwc.govt.nz/news-and-resources/key-mental-health-and-addiction-findings-nz-health-survey/ (last accessed 17 April 2026).

Te Puni Kōkiri. (2001). *He Tirohanga ō Kawa ki te Tiriti o Waitangi.* Te Puni Kōkiri, Wellington.

Te Whānau o Waipareira .(2024). Mauri Tū Mauri Ora Programme evaluation July 2023-March 2024. Te Whānau o Waipareira, Auckland.

Tenbensel, T., Middleton. L., Silwal, P., Cumming, J. (2026), "Using the policy capacity framework to evaluate New Zealand's primary health care policy implementation". *Public Administration and Policy*, Vol. ahead-of-print

Thomas, C., Weller, J., Rahiri, J. L., Harwood, M., & Pitama, S., 2022. Māori experiences of hospital care: A qualitative systematic review. *AlterNative: An International Journal of Indigenous Peoples*, 18(3), 455-464.

Thompson, J. M., Wilson, J., Byrnes, C. A., Trengrove, H., Koopu, P., Grey, C., & Leversha, A. (2025). Oral Health Inequities: Using Every Opportunity for Opportunistic Oral Healthcare. *Journal of Paediatrics and Child Health*, 61(10), 1612-1620.

Tustin K, Adams J, McAnally H, Duncanson M, Wicken A, Taylor B, & Turnbull F. (2024). *Oral health of children and young people in Aotearoa 2023.* Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago.

Waitangi Tribunal. (2001). *The Napier Hospital and Health Services Report (Wai 692).* Legislation Direct, Wellington.

Waitangi Tribunal. (2019). *Hauora (Wai 2575).* Legislation Direct, Wellington.

Walker, N., von Blaramberg, T., Mackay, J., McNaughton, W., Strickland, J., Van Mil, J., ... & Metcalfe, S. S., 2022. Effectiveness of a preschool asthma education programme, compared to usual care, on the frequency of acute asthma events: a community-based cluster randomised trial. *NZ Med J*, 135(1554), 80-9

Webber, M., Fitzpatrick, K., Hoskins, T. K., Veukiso-Ulugia, A., Fenaughty, J., Powell, D., & Madden-Smith, A. (2024). Kua takoto te mānuka, mā wai e hiki ake? Advancing a Te Tiriti o Waitangi-led approach to mental health education in schools. *Kōtuitui: New Zealand Journal of Social Sciences Online*, 19(4), 355-375.

Wehipeihana, N., Oakden, J., Spee, K., Cram, F., Pipi, K., & Porima, L. (2011). Evaluation of the Māori Oral Health Providers Project – Report to the Ministry of Health. Research Evaluation Consultancy Limited. NZ.

Whaiti, S. T., Rose, S. B., Innes, C., Bell, R., Tino, A., McBain, L., & Sykes, P. (2025). "Mana Motuhake-I am in Charge and Have Control Over my Body": a Cross-Sectional Survey Describing Māori Participants' Experience with HPV Primary Screening in Aotearoa New Zealand. *Journal of Racial and Ethnic Health Disparities*, 1-15.

Wheeler, A., Rahiri, J. L., Ellison-Lupena, R., Hanchard, S., Brewer, K. M., Paynter, J., ... & Harwood, M., 2025. Assessing the gaps in cardiovascular disease risk assessment and management in primary care for Māori and Pacific peoples in Aotearoa New Zealand—a systematic review. *The Lancet Regional Health–Western Pacific*, 56.