Homecare **Medical**
partners in connected care

Wellbeing Strategy for Priority Populations
Benjamin Strickland Manager, Māori and Pacific Strategies
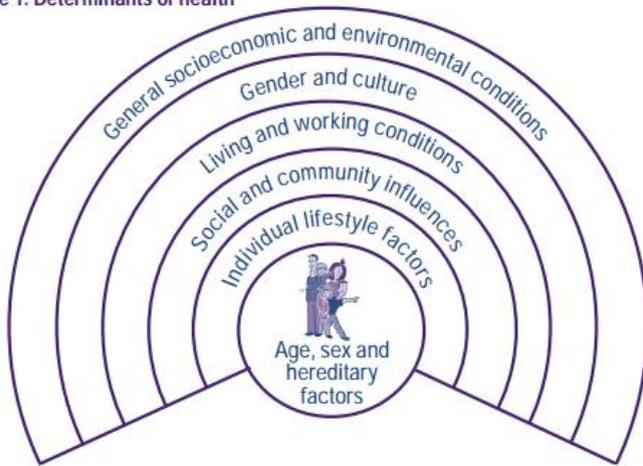## 22 April 2016

Contents

A. Problem Definition

Health inequalities and inequities: a major health problem in New Zealand

Figure 1: Determinants of health

Disparities in health outcomes run across New Zealand society. For Māori, these have been evident since colonisation. Like Māori, Pacific peoples and Asian populations also have high rates of health issues like smoking, hazardous drinking and psychological distress. These priority populations are highly likely to reside in the most deprived areas. The health issues they face can be compounded by difficulty accessing healthcare because of cost.

Individual people's health is affected by a combination of socioeconomic, environmental and cultural factors (see Figure 1 below), and poor health outcomes impact differently on people's quality of life, as well as placing a large burden on the health system.[1] Appendix Two provides a more detailed problem definition, including information on priority populations and the health issues they experience.

Reducing health inequalities and inequities[2] is a key priority of the Ministry of Health, and is important for all health service providers in New Zealand. Homecare Medical is committed to this ultimate goal through:

- delivering consumer-centered outcomes, supporting a holistic view of the consumer's life
- providing services in a non-judgmental, culturally appropriate manner
- addressing the needs of a wide range of communities, including vulnerable Whānau, new migrants, and other communities that experience multiple social and economic disadvantages.[3]

Term[4]	Definition
Health Inequality	Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes.
Health Inequity	Health inequities are *avoidable* inequalities in health between groups of people within countries and between countries. These inequities arise from inequalities within and between societies. Social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs.

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[1] Ministry of Health, Equity of Health Care for Māori - A Framework, Wellington, 2014

[2] Ministry of Health, Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document, 2015, p11; Ministry of Health, Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014–2018, Wellington, 2014.

[3] Ministry of Health Agreement of Services – Section 4 (Objectives of the Services), 2015, p10

[4] World Health Organization, Closing the gap in a generation: Health equity through action on the social determinants of health, Switzerland, 2008

Te Tiriti o Waitangi – acknowledge and integrate

Acknowledge

To reiterate, te Tiriti o Waitangi caused controversy through the years, mainly because of translation problems. Successive governments believed the Treaty enabled complete sovereignty over Māori, their lands and resources. But Māori believed that they were merely giving permission for the British to use their land.

Disputes over ownership followed a series of violent conflicts during the 19th century. These became known as the New Zealand Land Wars, where Māori suffered considerable losses. Land confiscation and questionable land sales by the British Crown carried on through to the 20th century, until the vast majority of land in New Zealand was owned by settlers and the Crown.

Integrate

The status of the Treaty has evolved over time and is considered New Zealand's founding document. It effectively created the constitutional space for the establishment of the nation.

Initiatives to address Māori health and disability needs in Homecare Medical will be based on the three key principles articulated as the Treaty of Waitangi principles:

- Partnership – Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- Participation – Involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services.
- Protection – Working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

These principles will set the framework to inform health and disability needs for all New Zealanders.

B. The Strategy

Priority Populations Wellbeing Strategy

Homecare Medical's Values

| Passion for Better | Motivated by Quality | Pokohiwi ki Pokohiwi | Do the Right Thing |

Vision

Improved health outcomes for Priority Populations
(Māori, Pacific peoples and Asian)

Principles

The Strategy acknowledges Te Tiriti o Waitangi
The Homecare Medical Cultural Diversity Steering Group will act as an advisory group for all deliverables that impact on Māori, Pacific peoples and Asian

Outcomes

Better Consumer Experience

More Capable Workforce and Service	Better Collaboration	Better Reach and Access
Deliver culturally appropriate services	Obtain shared understanding about improving health inequities	Enhance all channels to reach effectively
Increase cultural capability through recruitment		Build trusted brands and reputation
Improve staff engagement and retention	Build trust through respectful relationships	Resource to inform consumers and stakeholders
Access right L&D programmes		
Embed service measures, evaluation and feedback loop	Connect with the right people	Integrate quality market research and evaluation

1. Improved Health Outcomes for Priority Populations (Ultimate Outcome)

Government, including health and social sector agencies, and Homecare Medical are committed to improving health outcomes for priority populations. Improving access to health services for Māori, indigenous peoples and minority ethnic groups is a national priority.[5]

Homecare Medical defines improved health outcomes for priority populations as positive *cultural* experiences and solutions (treatment, service, advice) by consumers. These address the health needs that they (priority populations) are empowered to work on as individuals and in a collective environment as whānau (Better consumer experience). Homecare Medical provides the platform through its services for this consumer - provider partnership to occur.

Homecare Medical will strive to work well for all New Zealanders, with the aim that priority populations' experience health equity through access to high quality health and disability services, responsive to their needs and aspirations.[6]

2. Better Consumer Experience (Long-term outcome)

The purpose is to achieve positive consumer experiences and solutions through Homecare Medical.

Intermediate outcomes

- Better capable workforce and service – Homecare Medical will continually improve and foster its recruitment, retention strategies, delivery and diversity in order to provide the right effective service for priority populations.
- Better collaboration – key leaders, stakeholders and intermediaries* and communities will trust and collaborate with Homecare Medical to deliver holistic models of care
- Better reach and access – Homecare Medical will reach priority population consumers effectively by improving access of its health services

Term	Definition
Stakeholders	Groups that have an interest with Homecare Medical but not direct involvement i.e. Politicians, Health Professional organisations
Intermediaries	Groups that have a direct involvement with Homecare Medical and influence consumer behaviour i.e. referring organisations, health promoters, pharmacists.

Before developing solutions, Homecare Medical needs to understand the realities of our priority populations. For example, Pacific peoples can experience financial, cultural, logistical, physical or linguistic barriers to health and disability services. These barriers are key reasons why Pacific peoples benefit less from health services than other groups.[7]

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[5] Ministry of Health, Equity of Health Care for Māori - A Framework, Wellington, 2014

[6] Ministry of Health, Equity of Health Care for Māori - A Framework, Wellington, 2014; Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P9-10.

[7] Ministry of Health, Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014–2018, Wellington, 2014

Priority populations may also value collectives or groups. For instance, the financial priorities of many Pacific individuals' center on maintaining relationships, donating to church, and making contributions to family, both in New Zealand and in Pacific Island countries of origin.[8] There are examples of strategies that focus on empowering whānau to support individuals, so positive health outcomes are shared across generations.[9]

Acquiring knowledge and understanding of the symptoms that drive and motivate priority populations will assist in making decisions around prioritisation i.e. investing into pregnant youth needs could be priority over Māori men with mental health conditions.

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[8] Ministry of Health, Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014–2018, Wellington, 2014

[9] 9 Ministry of Health, Taking Action on Foetal Alcohol Spectrum Disorder (FASD): A discussion document, Wellington, 2015, P13-15

3. Better Capable Workforce and Service

To work more effectively with priority populations, we need to improve recruitment of culturally capable staff,[10] maintain their skills through training, retention and development of the right services for priority populations i.e. access to a Samoan-speaking counsellor. Culturally capable staff will be of two types; Māori, Pacific and Asian staff or staff that can engage appropriately and effectively with our priority populations. Increasing a diverse health workforce is fundamental to improving the quality and effectiveness of care.

There is no 'single action', but many directions and initiatives to explore to build a culturally capable workforce and create an organisational culture, responsive to Māori, Pacific and Asian staff. Improvement in workforce disparities takes time, a realistic funding commitment (i.e. for training, recruitment and business cases for cultural roles) and leadership, particularly from the Board and ELT.[11]

The organisation may wish to consider supporting treatment methods and practices that have cultural significance, but outside the scope of the mainstream medical model i.e. Māori healing practices, Chinese homeopathy). Building awareness around the risks and benefits of alternative treatment (which may be normal treatment within priority populations) is worth exploring for the purposes of supporting consumer choice.

To achieve a better capable workforce and service, Homecare Medical will need to focus on the following areas such as

a. Delivering culturally appropriate services
b. Increasing cultural capability through recruitment
c. Improving staff engagement and retention
d. Accessing the right (relevant) learning and development (L & D) programmes
e. Embedding service evaluation and feedback loops

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[10] Ministry of Health, Te Puāwaitanga Māori Mental Health National Strategic Framework, Wellington, 2002; Ministry of Health, Statement of Intent 2014 to 2018 – Ministry of Health, Wellington, 2014, P32

[11] April Taggart, Beyond Diversity: Becoming a culturally competent organization, 2007 (online issue)

[12] Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P5

a) Deliver culturally appropriate services

Homecare Medical is committed to connecting our priority populations to the 'right' services. These services are culturally accessible and responsive, so they:[12]

- remind us that addressing the determinants of health is essential to understanding the holistic need of consumer(s)[13]
- maintain a focus on improved health outcomes for Māori, Pacific peoples and Asian.

Within Māori, Pacific and Asian populations, there are many groups with different needs and aspirations affecting their healthcare requirements. This means the way Homecare Medical delivers its services need to span a wide continuum from prevention to treatment, ensuring services are appropriate for all demographic groups (i.e. pregnant, rural, urban, New Zealand born vs. immigrants etc).[14]

The knowledge to develop the 'right' service for priority populations lies within communities. This includes incorporating or aligning with cultural models of health and wellbeing that support our priority populations (i.e. Te Whare Tapawha, Fono Fale), promoting the use of rongoā (traditional Māori healing), Kaumatua support, massage treatments (fofo), counselling techniques and herbal preparations (Vai laau Fa'aSamoa).[15]

Delivering a culturally appropriate service is a collective responsibility, meaning all Homecare Medical staff need to share this responsibility. It is critical that Māori, Pacific and Asian staff that are able to foster bringing staff to a comfortable and competent level, are supported too. Performance measures need to be in place to provide a benchmark for staff competencies and enhance staff accountability to deliver quality services for priority populations.[16]

b) Increase cultural capability through recruitment

Investing in a diverse workforce (seeking people of the same ethnic group, or with the capability to engage effectively with Māori, Pacific Peoples and Asian) will improve quality of care, expand access to services, increase cultural safety and minimise miscommunication, leading to improved outcomes for priority populations.[17] A diverse workforce will contribute to long-term service sustainability for Homecare Medical.[18]

A strong recruitment strategy should set in place:

- joint career initiatives with industry and tertiary education providers within the health sector – this is an opportunity to promote health careers locally to secondary schools, rangatahi, whānau and communities i.e. Kia Ora Hauora (KoH) joint regional work programme between Waitemata District Health Board (WDHB) and Auckland District Health Board (ADHB)
- an external governance group (Māori, Pacific or Asian) who have the ability to provide direction in the allocation of resources to build cultural capability and overcome organisational barriers within Homecare Medical[19]
- channeling graduates to visit and learn about Homecare Medical as a potential career
- employment opportunities for priority populations
- special measures in its recruitment process to avoid discriminating against priority populations (i.e. Māori, who like many other applicants may not have high levels of training or vast work experience, but their life experience may have provided them with valuable attributes and qualities).[20]

c) _____

[13] Ministry of Health, Te Puāwaitanga Māori Mental Health National Strategic Framework, Wellington, 2002
[14] Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P4

c) Improve staff engagement and retention

Staff provide the best service when they work to the best to their ability, thrive on quality, celebrate success, learn from each other (peer support), and embrace a supportive whānau environment. Clarity and transparency is critical to ensure all staff know what is happening in the organisation, are on board the same journey, and can discuss with each other to shape the journey where relevant.

Incorporating a Māori, Pacific and Asian component to improve staff engagement means that all staff will continue to work together within a supportive 'whānau' environment through being responsive to the values, concepts and day-to-day realities of these populations.

Homecare Medical will adapt a retention strategy for priority population capability. Reasons why culturally capable staff may leave the workplace can include burnout and a feeling of isolation from being the only cultural expert in a predominately mainstream service.[21]

Factors that can help retain these staff are:

a. Adapting and normalising cultural rituals and activities in the workplace to promote a whanau (close knit) atmosphere[22]
b. Support for cultural experts through access to other cultural experts, facilities or programmes
c. Promoting and participating in social work activities that acknowledge and resonate to the cultures of our priority populations.

d) Access right learning and development programmes

The first step towards achieving this outcome is to conduct a gap analysis on training needs we need to meet to deliver culturally capable services to a high standard. Secondly, we need to identify existing quality programmes, or develop new programmes to meet training needs. Lastly, we need to make these programmes accessible and measureable for effectiveness, followed by exploring professional development opportunities as a career pathway milestone.

Other aspects to consider during engagement with consumers is the ability to build instant rapport with the consumers and resonate. We have the opportunity to build a knowledge bank of staff lessons from cultural training and experiences, to share with and support other staff encountering similar situations with customers.

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[15] Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P9-10; Ministry of Health, Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014–2018, Wellington, 2014

[16] Ministry of Health, Te Puāwaitanga Māori Mental Health National Strategic Framework, Wellington, 2002

[17] Spiller C, Spiller R, Henare M. Making a difference. Why and how to employ and work effectively with Maori. Auckland: EEO Trust, 2006; Health Funding Authority. Improving Access to Primary Care for Māori, and Pacific peoples: A literature review commissioned by the Health Funding Authority. Wellington: Health Funding Authority, 2000.

[18] Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care: Institute of Medicine, 2002.

[19] Burrell M, Blight M, Moore D, et al. The economic and social benefits of increasing the professional Maori health workforce. In: Ltd L, ed. Wellington, 2005.

[20] Website - http://www.eeotrust.org.nz/toolkits/maori.cfm?section=howtotapthepotentialofmaori#faq811

[21] Hilda Hempo, Retention Strategies for Psychologists in Child and Adolescent Mental Health Services: A Maori Perspective, Auckland, 2004.

[22] Jenny Sheriff, Investigating Factors Influencing the Retention of Maori Students within Secondary Education in Aotearoa, Auckland, 2010

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e) Embed service measures, evaluation and feedback loops

The function of evaluation and quality improvement is threefold. Homecare Medical needs to:

- seek and adopt evidence-based practices or models to improve service effectiveness and sustainability[23]
- evaluate projects, practices and services that impact on priority populations through a cultural lens to inform service effectiveness and sustainability
- adopt a continuous quality improvement process that seeks to improve appropriate care for priority populations (i.e. explore adapting the clinical audit tool to consider use of Tongan language and concepts to review consumer engagement).

In order for evaluators to make decisions that are based on the specific context of the population, the evaluators need to take steps to understand the specific culture of that population.[24] Those steps can include:

1. Learning about the priorities and preferences of the culture and considering how those priorities are or are not reflected in the priorities of the project being evaluated
2. Assessing whether there are specific ways in which a traditional evaluation approach would be a poor match for the community under consideration
3. Learning about the community (from community leaders, members of the community, other culturally competent evaluators with experience in the community, etc.) and assessing how the specific qualities of this population impact how the evaluation should be conducted
4. Considering life experiences that the evaluators do not share in common with the population, and thinking about how to better understand and appreciate both sets of experiences for that lack of commonality.

These measures will provide managers with rapid and detailed information on the progress in service improvements of Homecare Medical, that impact on our priority populations. With this information, Homecare Medical can take action to correct problems and make improvements as quickly as possible.

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[23] Ministry of Health, Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document, 2015, p11

[24] Public Policy Associates Incorporated, Considerations for Conducting Evaluation Using a Culturally Responsive and Racial Equity, April 2015

4. Better Collaboration

By collaborating more effectively, we will build trust, confidence and strong networks with key leaders and organisations that have a stake (now or in the future) with Homecare Medical. Collaborating within teams internally and across the health and social sectors is essential to implementing holistic models of care and wellbeing.[25]

The concept of reciprocity is the heart of this outcome, and raises the underlying question: what's in it for our intermediaries and stakeholders when they collaborate with Homecare Medical? What's in it for us?

Some of the reasons for collaborating include:

- Sharing the workload – Homecare Medical has the capability and capacity to contact large numbers of consumers and reach them during high demand periods i.e. after work, early evenings.
- Leveraging off each other to provide a seamless programme – Homecare Medical and face-to-face services can use their different strengths in smarter ways to provide a seamless service. For example, primary care providers may be better at responding to the language needs of our Pacific consumers.[26]
- Business opportunity – Homecare Medical could sell its triage capability and platform to stakeholders to enhance accessibility for priority populations.

In addition, having a shared understanding and working towards a shared goal ensure all parties collaborate with purpose.[27] Parties are encouraged to avoid gatekeeping behaviour and share relevant knowledge, adopting positive behaviours so they can meet their joint outcomes.

To achieve better collaboration, Homecare Medical is committed to focusing on these key areas:

a) Develop a shared understanding about improving health inequities and inequalities

Through training, communication, conversation, hui, whakatau, powhiri, and fono (just some examples), Homecare Medical and its intermediaries can better understand why priority populations face the health issues they experience. Next, we can use our understanding to learn how we can work smarter, collaborating on interventions that improve the wellbeing or priority populations. Working with intermediaries right across the health sector, from providers to DHBs to the Ministry of Health, will allow for better service integration, planning and support for priority populations and their whānau.[28]

This outcome promotes the opportunity of identifying potential business relationships with organisations. For example, within the meat industry, there is a huge number of smokers which is reducing productivity as a result of increased smoking breaks. The opportunity is collaborating with the Ministry for Primary Industries to integrate a channel to support Meat industry employees to quit smoking.

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[25] Ministry of Health, Te Puāwaitanga Māori Mental Health National Strategic Framework, Wellington, 2002
[26] Ministry of Health, Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014–2018, Wellington, 2014
[27] Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P3

b) Build trust through respectful relationships

Effective engagement between Homecare Medical, intermediaries and stakeholders is about achieving trust and confidence. Trust is key to maintaining the relationships we need to keep improving Homecare Medical's service delivery to consumers and innovative edge for enhancing accessibility into the Health Sector i.e. connecting into whānau through digital means. It's about respecting, being aware and sensitive to the differences of intermediaries and stakeholders, and ensuring rapport is built appropriately. Homecare Medical can ensure this through understanding the reality of the stakeholder's goals and working environments.

In turn, intermediaries and stakeholders also have a stake with Homecare Medical for (but not limited to) information for planning and research, collaborative opportunities and consultation to strengthen communities.[29] Collaborative opportunities could include streamlining Homecare Medical's Quitline services and Māori cessation services so that consumers receive full attention and support from two services.

c) Connect with the right people

The purpose of connecting with the right people is to identify which Homecare Medical staff member has the right skillset to initially reach out intermediaries that work with priority populations. If a change of ownership occurs during the relationship, guidelines need to be clearly defined to ensure the relationship is sustained i.e. develop a handover process.

Homework and research is required to understand and learn about the stakeholder (acknowledging their differences and passions), such as learning about who they are, reasons for engagement and what's in it for them. For example, participation in planning with Māori providers is key to achieving buy in and understanding of what is appropriate for that community.[30]

[28] Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P9-10; Ministry of Health, Taking Action on Foetal Alcohol Spectrum Disorder (FASD): A discussion document, Wellington, 2015, P13-15

[29] Ministry of Health, Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document, 2015, p11

[30] Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P9-10.

5. Better Reach and Access

The purpose is about stimulating demand for Homecare Medical's service among priority populations, so they are informed of and expect to access high quality services they can trust.

Homecare Medical has the opportunity to become the consumer's first point of contact for accessing its services. We can help promote access to other services such as face-to-face services within the health sector, and expand out to put people in touch with social sector services in the future.[31]

Through this approach, consumers can be empowered to acknowledge the risks and impacts of their addictions and health conditions, and the benefits of improving their health and wellbeing. There is no limit on using Homecare Medical services, meaning consumers can access as much support as they wish.

To achieve better reach and access, Homecare Medical will commit to focusing on these key areas:

a) Build trusted brands and reputation

We need to thoroughly understand our consumers, intermediaries and stakeholders (i.e. know regional differences, how to connect appropriately) to shape the services we offer to inform a trusted brand. For example, addiction service lines under Homecare Medical could adapt dedicated Māori or Pacific web pages as a way of attracting Māori and Pacific consumers and intermediaries.

It is also important that we make sure the Homecare Medical brand is promoted, recognised and socialised with all audiences.

b) Integrate quality market research and evaluation

All research projects need to adopt a culturally appropriate model to accommodate the values and realities of Māori, Pacific peoples and Asian peoples. For example, setting up interviews in the communities with respondents can result in benefits such as quality conversations, trust built and increased reputation for Homecare Medical.

We will also consider learning from indigenous health models from overseas.[32] Homecare Medical will commit to providing knowledge into a rich database that its research function can use, enhancing the impact of our services to priority populations and generating significant returns. We will consult regularly with key intermediaries (Māori Governance group, other Governance groups of relevance, Health Promotion Agency) through the development of any research and evaluation.

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[31] Ministry of Health, Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014–2018, Wellington, 2014

[32] Ministry of Health, Taking Action on Fetal Alcohol Spectrum Disorder (FASD): A discussion document, Wellington, 2015, P13-15

c) Resources to inform consumers, intermediaries and stakeholders

Enhanced engagement with key groups – including priority populations – requires resources outside of sponsorship funding. The purpose of these resources is:

For consumers –

- To inform the services on offer, the benefits of these services, and how they can meet the needs of different groups within a priority population, i.e. those who have mental health needs, are pregnant, live in rural or urban area, are New Zealand born, youth
- To encourage customers to see why these services are relevant and appropriate for Māori, Pacific peoples and Asian peoples.

For stakeholders –

- To inform about the services on offer, so stakeholders can promote to customers
- To highlight opportunities to collaborative to get shared outcomes for customers
- To inform about relevant business activities that enhance care for priority populations.

d) Enhance all channels to reach priority populations effectively

Reach and access is not only about brand, market research and resources, but about the services themselves. The purpose is to provide a telehealth service that effectively reaches and meets the needs of priority populations, providing a platform for continuous improvement and care innovation. The telehealth service will:

- promote easier access to care
- take a more holistic approach of care to meet more than one need at one time
- harness new technologies to support consumer-led 'digitally enabled' healthcare
- is a built-in platform for bringing together different health and disability services (i.e. directory to all Māori, Pacific and Asian Health Services, triage to General Practice, etc.).

Services should be organised around the needs of priority populations and their family/Whānau rather than the needs of providers. Homecare Medical's commitment to achieve this means removing infrastructural, financial, cultural, geographical, physical and other barriers between its different services that act as obstacles to seamless delivery of care.[33]

All communication/ promotional channels (television, online, radio, community visibility including events participation, media) require a creative arm to seek better ways to reach, stimulate and inform demand. Working at community events takes into account the promoting function, and in some cases a treatment function as well i.e. having Mental Health and Addiction advisors or nurses at events to provide addiction support or health support.

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[33] Ministry of Health, The Guide to He Korowai Oranga: Māori Health Strategy, Wellington, 2014, P9-10.

C. Appendix One

A Detailed Problem Definition

Smoking

The smoking rate is decreasing for adults aged under 45 years[34]

Smoking was one of the two leading modifiable risks to health in 2013 (the other being high body mass index), accounting for about 9% of all illness, disability and premature mortality (IHME 2015). Smoking harms nearly every organ and system in the body. It is the main cause of lung cancer and chronic obstructive pulmonary disease. It is also a major cause of heart disease, stroke and other cancers.

In 2014/15, 17% of adults were current smokers (smoke at least monthly), including 15% who smoked daily. Both current and daily cigarette smoking rates declined from 2011/12, when 18% of the population were current smokers, including 16% who were daily smokers.

Men were more likely to be current smokers than women (the rates were 18% and 15% respectively). However, **Māori** women (42%) were more likely to be current smokers than **Māori** men (34%).

The most substantial reduction in current smoking since 2006/07 was for youth (those aged 15–17 years), 6% of whom smoked in 2014/15, compared with 16% in 2006/07. Adults aged 18–34 years had the highest rates of current smoking (24% for those aged 18–24 years and 23% for those aged 25–34 years). Current smoking rates for those aged 18–45 years declined from 2011/12. However, smoking rates in older adults have not changed since 2006/07. About one in five adults aged 45–54 years (19%) were current smokers – not significantly different to 2011/12 (17%). Furthermore, the current smoking rate for those aged 55–64 years remained the same: 15% in both 2011/12 and 2014/15.

The current smoking rate for **Asian** adults almost halved since 2006/07, from 11% to 6%, while the European/Other rate declined from 19% to 15%. In contrast, **Māori** (38%) and **Pacific** (25%) adults' current smoking rates have not declined significantly since 2006/07.

The average number of cigarettes smoked per day declined from 11.5 in 2006/07 to 10.6 in 2014/15. However, this decline was only significant for the total population, **Māori** and **Asian** daily smokers.

Adults living in the most socioeconomically deprived areas were 3.1 times as likely to be current smokers compared with adults living in the least deprived areas, after adjusting for age, sex and ethnic differences.

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[34] Ministry of Health, Annual Update of Key Results 2014/15 – New Zealand Health Survey, Wellington, 2015, p.12

Depression

Women experience higher rates of psychological distress than men[35]

The NZHS measures psychological (mental) distress using the Kessler Psychological Distress Scale (K10) (Kessler et al 2003). This measures a person's experience of symptoms such as anxiety, confused emotions, depression or rage in the past four weeks. People who have a score of 12 or more have a high probability of having an anxiety or depressive disorder.

In this report, 'psychological distress' means high or very high levels of psychological distress according to the K10 scale (i.e. a score of 12 or more) in the past four weeks.

Six percent of adults experienced psychological distress in the past four weeks.

Prevalence of psychological distress varied by sex, age, ethnic group and neighbourhood deprivation, as follows:

- Women were more likely to have experienced psychological distress than men (the rates were 8% and 5% respectively).
- Psychological distress rates decreased with age. Less than 5% of adults aged 65 years and over experienced psychological distress in the past four weeks.
- One in ten **Pacific** and **Māori** adults experienced psychological distress in the past four weeks. After adjusting for age and sex differences, **Pacific** and **Māori** adults were 1.6 times as likely to have experienced psychological distress as non-Pacific and non-Māori adults respectively.
- The prevalence of psychological distress was higher in the most socioeconomically deprived neighbourhoods (10%), than in the least deprived neighbourhoods (3%). Those living in the most deprived areas were three times as likely to have experienced psychological distress as those in the least deprived areas, after adjusting for age, sex and ethnic differences.

Differences in the prevalence of psychological distress and diagnosed mood and anxiety disorders could indicate differences in people's understanding of their own symptoms, health service provision and use of health services by different groups.

Child physical punishment rates are declining[36]

Physical punishment is a predictor of a wide range of negative developmental outcomes, including increased child aggression, antisocial behaviour, poorer cognitive development, poorer quality of parent–child relationships and mental health problems (such as depression) (Smith 2006). It is important to support parents to use more positive methods of parenting. In 2007 the law was changed in New Zealand, making it illegal to physically punish children. The surveyors asked parents/caregivers if they had physically punished (such as smacked) their child in the past four weeks for misbehaviour.

The percentage of children who had received physical punishment in the past four weeks fell from 10% in 2006/07 to 6% in 2014/15.

The percentage of children receiving physical punishment in the past four weeks varied by age, ethnic group and neighbourhood deprivation, as follows:

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[35] Ministry of Health, Annual Update of Key Results 2014/15 – New Zealand Health Survey, Wellington, 2015, p.28
[36] Ministry of Health, Annual Update of Key Results 2014/15 – New Zealand Health Survey, Wellington, 2015, p.50

- Young children were more likely to have been physically punished than older children. Seven percent of children aged 0–9 years were physically punished compared with 3.7% of children aged 10–14 years.
- One in ten Pacific children (10%) and 9% of Māori children had been physically punished in in the past four weeks. Māori and Pacific children were 1.8 times as likely to have been physically punished as non-Māori and non-Pacific children respectively, after adjusting for age and sex differences. In contrast, only 2.4% of Asian children had been physically punished.
- Children living in the most socioeconomically deprived areas were more likely to have been physically punished (9.7%) than those in the least deprived areas (2.9%).

According to the Youth 2012 survey, 14% of school children (Year 9–15 students, majority aged 13–17 years) reported that they were hit or physically harmed in the past 12 months in their home by an adult (Clark et al 2013). Older children were less likely to be physically harmed by an adult than younger children. The Youth 2012 survey found no significant change since 2001 in the percentage of children who witnessed an adult physically hurting a child in their own home in the past 12 months (16% in 2001 and 14% in 2012). The child-reported rates of violence in the Youth 2012 survey were higher than those reported by parents in the NZHS despite the younger age group in NZHS. (Note: The surveys used different violence definitions.)

Boys are more likely to have been diagnosed with emotional or behavioural problems than girls[37]

In this report, 'emotional and/or behavioural problems' refers to depression, an anxiety disorder, attention deficit disorder (ADD) and/or attention deficit and hyperactivity disorder (ADHD). Surveyors recorded children as having been diagnosed with emotional and/or behavioural problems if their parents indicated that they had been told by a doctor at some time in their child's life that the child had one of the above conditions.

Around 32,000 children (4%) aged 2–14 years had been diagnosed with emotional and/or behavioural problems at some time in their life, up from 1.8% in 2006/07.

The percentage of children with emotional and/or behavioural problems varied by sex, age, ethnic group and neighbourhood deprivation, as follows:

- Boys were 1.6 times as likely to have ever been diagnosed with emotional and/or behavioural problems as girls, after adjusting for age differences.
- The percentage of children with emotional and/or behavioural problems increased with age, from 0.5% of those aged 2–4 years to 6.6% of those aged 10–14 years.
- After adjusting for age and sex differences, Asian children were half as likely to have been diagnosed with emotional and/or behavioural problems as non-Asian children.
- Children living in the most socioeconomically deprived areas were more likely to have been diagnosed with emotional and/or behavioural problems than those in the least deprived areas, after adjusting for age, sex and ethnic differences. The same pattern was found for adults with mood and/or anxiety disorders (see page 27).

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[37] Ministry of Health, Annual Update of Key Results 2014/15 – New Zealand Health Survey, Wellington, 2015, p.52

The most common types of emotional and behavioural problems were anxiety disorder (2.6%), followed by ADD/ADHD (1.9%) and depression (1.1%). Boys were more likely to have ADD/ADHD than girls (the rates were 2.9% and 0.8% respectively).

The NZHS online data tables include statistics on autism spectrum disorder (ASD, including Asperger's syndrome), which is a pervasive developmental disorder typified by emotional and behavioural problems. About one in a hundred children (1.2%) had ASD.

Suicide within Population Groups[38]

Issues for Māori

Suicide is a complex issue and, as such, requires a multi-faceted and diverse range of responses. Such responses must also take account of the heterogeneity of Māori. For Māori, a strong cultural base is a central source of identity (Durie 1998; Hirini and Collings 2005). Having a positive attitude about identity is important for Māori towards achieving cultural and spiritual wellbeing. Culture influences expressions of health. It also influences how health workers and whānau understand and respond (Lawson-Te Aho 1998). To address the loss suffered by Māori, it is important to acknowledge the past, confront the present and strengthen the future to protect the continuation of whakapapa, Hapū and iwi structures.

According to ancient Māori beliefs, the union between Tāne and Hineahuone symbolises the unique beginning of physical human life and the ultimate origins of whānau, Hapū and iwi. For Māori, it is important that this knowledge lives on through their stories and whakapapa. Whakapapa provides the links between whānau, Hapū and iwi. The added dimension beyond the loss of a precious life is the loss of that whānau member's unique contribution and continuation of whakapapa. Whānau, Hapū and iwi are dependent upon each member for their continued existence. Support of both structures and expressions of culture through concepts of tātou tātou (togetherness), manaakitanga (care and hospitality), wairuatanga (spirituality), whanaungatanga (relationships), kawa (process) and tikanga (principles) are significantly threatened with the high rates of suicide experienced across some age groups of Māori.

Whakamomori (Māori suicide)

Whakamomori is a term often used in relation to Māori suicide. It is not universal to all iwi. Northern Iwi for example use the term "tārona" (strangulation) (Coupe 2005). Nevertheless, Whakamomori is the most widely acknowledged term for Māori suicide. Whakamomori has been defined by Williams (1971) as "commit(ting) suicide or any other act of desperation". It has also been interpreted as a "deep seated underlying sadness", "in built tribal suffering", "grieving without a death" and a "psychological, spiritual and cultural or collective state of being that may or may not result in death" (Lawson-Te Aho 1998). Consequently, it is important to acknowledge the use of the term Whakamomori and the differences in interpretation and meaning within a given context.

Suicidal behaviour in Māori, as well as non-Māori, is closely linked to mental health status. However, when set against the historical context, many other factors have been suggested as intensifying the risk factors for Māori. Suicidal behaviour among Māori today are extremely complex; however, ethnic and cultural differences and their effects on behaviour are important considerations in reducing Māori suicide (Lawson-Te Aho 1998).

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[38] Ministry of Health, New Zealand Suicide Prevention Strategy 2006 – 2016, Wellington, 2006, p20-22

Issues for Pacific peoples

Pacific peoples living in New Zealand represent 22 different cultures and speak an even greater number of languages (Ministry of Pacific Island Affairs 1999). The Pacific population is predominantly a young population with a high percentage of children under the age of 15 years.

Pacific peoples comprise 6.5 percent of New Zealand's population (Statistics New Zealand 2006) and this is projected to increase to 13 percent by 2031 (Gray 2001). The socio-cultural fabric of the Pacific populace is culturally diverse. Differences exist between and amongst ethnic nation groups, including island-born, New Zealand-born and New Zealand-raised, regarding languages, values, cultural norms, customs and newly acquired lifestyles. Contrary to common belief, **Pacific peoples** do not necessarily share a common migration and acculturation history because of their different constitutional relationships with New Zealand (Ministry of Pacific Island Affairs 1999).

While there are many differences within the Pacific populace, there are some areas of commonality. **Pacific peoples** tend to be geographically clustered within low socioeconomic areas, often living in overcrowded conditions and having low family or household incomes. The increased number of **Pacific peoples** accessing mental health services is an indication that unemployment, low income, poor housing, extended family breakdowns, cultural fragmentation and increased social problems are having an increasing impact on their mental health and, therefore, suicidal tendencies of **Pacific peoples** (Tiatia and Coggan 2001; Tiatia 2003).

Pacific peoples often have a strong sense of belonging to their Whānau, their church and the **Pacific** community. An individual's identity and wellbeing are traditionally dependent on family heritage, family connections, roles and responsibilities. Although the closeness of mutual family obligations is weakening because of socioeconomic factors and acculturation to New Zealand society, the extended family structure is still at the centre of **Pacific** cultures, behaviours and beliefs (Finau 1982; Ministry of Health 1997). The social organisations of family and church provide significant and meaningful relationships, which protect members against suicide (Finau 1994; Skegg 1997). Mainstream approaches to suicide prevention for **Pacific peoples** are unlikely to be effective on their own, and community development in isolation does not necessarily deal with reducing mental health problems or suicidal behaviours (Disley 1997). Consequently, suicide prevention policies, programmes and services aimed at **Pacific peoples** require consideration of their cultural contexts and their beliefs about issues such as mental health, which may differ from mainstream culture (Beautrais et al 2005).

Issues for Asian populations

The **Asian** population is the fastest growing ethnic community in New Zealand and makes up almost seven percent of the population (Statistics New Zealand 2006). Like **Pacific peoples**, **Asian** groups are culturally diverse and have varying degrees of acculturation to New Zealand society (New Zealand Guidelines Group and Ministry of Health 2003). Consequently, suicide prevention policies, programmes and services need to account for this diversity.

Over 40 percent of the total **Asian** population in New Zealand identify as Chinese, making this the single largest **Asian** group (Statistics New Zealand 2006). There is a strong stigma attached to suicide for many Chinese, with it often seen as shameful to both the individual and the collective esteem of the family. They often regard mental health problems, including depression and suicidal behaviours, to be caused by social factors, such as failure to fulfil family and societal expectations.

In addition, they may be more reluctant to seek professional help for mental health problems unless they experience substantive physical symptoms at the same time (New Zealand Guidelines Group and Ministry of Health 2003).

Mental Health

Asian and Pacific adults have low rates of diagnosed mood and/or anxiety disorders[39]

Good mental health is an essential part of overall good health and wellbeing. Mental health conditions can affect people's ability to perform everyday tasks, have healthy relationships and cope with anger or stress. Anxiety, depressive and bipolar disorders accounted for about 7% of all illness, disability and premature mortality in 2013 (IHME 2015).

In this report, 'diagnosed with mood disorder and/or anxiety disorder' refers to people who reported that at some time in their life a doctor had told them they had depression, bipolar disorder and/or anxiety disorder (including generalised anxiety disorder, phobias, post-traumatic stress disorder and obsessive-compulsive disorder).

In 2014/15 an estimated 636,000 adults (17%) had been diagnosed with a mood disorder and/or anxiety disorder at some time in their life.

Prevalence of diagnosed mood and/or anxiety disorders varied by sex, age, ethnic group and neighbourhood deprivation, as follows.

- More women (22%) had been diagnosed with mood and/or anxiety disorders than men (12%).
- The prevalence of diagnosed mood and/or anxiety disorders was lowest for the youngest (15–24 years) and oldest (75 years and over) age groups. Reasons for the relatively low prevalence in older adults may be: practice has changed with regard to diagnoses of mental health conditions; adults born in the first half of the 20th century may be less likely to have mental health conditions than those born more recently; or older people may under-report mental health conditions to a greater extent.
- Asian (5%) and Pacific (8%) adults had the lowest rates of diagnosed mood and/or anxiety disorders. Despite these low rates, Pacific adults were more likely than non-Pacific adults to have experienced high levels of psychological distress in the past four weeks, which is indicative of anxiety or depressive disorders (see page 28).
- Adults in the most socioeconomically deprived areas were more likely to have been diagnosed with mood and/or anxiety disorders (19%) than those in the least deprived areas (17%).

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[39] Ministry of Health, Annual Update of Key Results 2014/15 – New Zealand Health Survey, Wellington, 2015, p.27

Access to health care

Eight in ten adults have visited a GP in the past 12 months[40]

Most New Zealand adults (94% or 3.4 million) are enrolled with a primary health organisation that is funded by their local district health board (DHB) to provide general practice and other primary care services. Additional funding is provided to meet the health needs of high-needs patients and to lower the cost of accessing services.

Four out of five adults (80%) had visited a GP in the past 12 months. Women were more likely to have visited a GP in the past 12 months (84%) than men (76%). This difference was only evident in those aged 15–44 years, when women may have visited a GP for reproductive health reasons.

Young men were the least likely to have visited a GP in the past 12 months. Only 64% of men aged 15–24 years and 63% of men aged 25–34 years had visited a GP in the past 12 months.

Older people were more likely to have visited a GP in the past 12 months than younger people: more than 90% of adults aged 65 years and over had visited a GP in the past 12 months, compared with less than 80% of those younger than 45 years.

Eighty-two percent of those in the least socioeconomically deprived neighbourhoods had visited a GP in the past 12 months, compared with 79% in the most deprived neighbourhoods. Any such difference between these groups was removed after adjusting for age, sex and ethnic differences. However, it should be noted that reported unmet need for primary health care was higher in the more deprived neighbourhoods than the least deprived neighbourhoods (see page 32), reflecting the higher rates of illness in the most deprived neighbourhoods.

On average, adults had visited a GP 3.1 times in the past 12 months (this average includes adults who had not visited a GP in the past 12 months). However, the number of GP visits was higher for older adults: 4.1 for those aged 65–74 years and 5.2 for those aged 75 years and over.

Three in ten adults have visited a practice nurse in the past 12 months[41]

Practice nurses work within a general practice setting, providing a comprehensive range of primary health care services. They are a key part of the general practice team. Practice nurses focus on health promotion, disease prevention, wellness, first-point-of-contact care and disease management across the lifespan. They run screening and preventative programmes, such as immunisations, and have an important role in care coordination for patients and their Whānau. In this report, the term 'visited a practice nurse in the past 12 months' only includes visiting a practice nurse without seeing a GP at the same visit.

Thirty percent of adults reported visiting a practice nurse in the past 12 months.

Rates of visiting a practice nurse in the past 12 months varied by sex, age and ethnic group, as follows.

- Women were more likely to have visited a practice nurse in the past 12 months than men (the rates were 34% and 25% respectively). This sex difference was most pronounced for adults under 45 years (probably reflecting the health care needs of women of childbearing age).

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[40] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P29
[41] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P30

- Visits to a practice nurse for all adults increased with age. Over 40% of those aged 65 years and over had seen a practice nurse in the past 12 months. Less than a quarter of those aged under 45 years had visited a practice nurse in the past 12 months.
- **Asian** (14%) and **Pacific** (20%) adults had the lowest rates of having visited a practice nurse in the last 12 months. After adjusting for age and sex differences, **Asian** adults were half as likely as non-Asian adults, and **Pacific** adults were 0.7 times as likely as non-Pacific adults, to have visited a practice nurse.

Adults living in the most socioeconomically deprived areas were about as likely to have visited a practice nurse in the past 12 months (30%) as those living in the least deprived areas (29%).

On average, adults visited a practice nurse (without seeing a GP at the same visit) less than once in the past 12 months (0.7 visits). However, older adults (65 years and over) had at least one practice nurse visit, on average, in the past 12 months.

The percentage of adults visiting an after-hours Medical centre has declined since 2011/12[42]

After-hours Medical centres provide primary health care outside usual business hours. District health boards are required to ensure that at least 95% of the enrolled population have access to after-hours care. The cost of care in after-hours Medical centres is higher than it is for services during usual business hours, particularly for people who are not enrolled with a primary health organisation.

One in ten adults (10%) had visited an after-hours Medical centre in the past 12 months, down from 13% in 2011/12.

The percentage of adults who had visited an after-hours Medical centre in the past 12 months declined with age. Thirteen percent of those aged 15–24 years had visited an after-hours Medical centre in the past 12 months, compared with less than 10% of those aged 55 years and over.

One in twelve **Asian** adults (8%) had visited an after-hours Medical centre in the past 12 months. **Asian** adults were less likely to have visited an after-hours Medical centre than non-Asian adults, after adjusting for age and sex differences.

Rates of unmet need for primary health care are lowest for over 65-year-olds[43]

This indicator investigates whether people had experienced any of the following five barriers to accessing primary health care in the past 12 months: unmet need for a GP due to cost; unmet need for after-hours services due to cost; unmet need for a GP due to lack of transport; unmet need for after-hours services due to lack of transport; and inability to get an appointment at their usual Medical centre within 24 hours.

Most adults were able to access primary health care when they needed to (i.e. they had not experienced any of the five barriers listed above). However, 27% of adults reported one or more types of unmet need for primary health care in the past 12 months. The most common reasons for this unmet need were: being unable to get an appointment within 24 hours (17%), the cost of GP services (14%) and the cost of after-hours services (6%). These three most common reasons for unmet need are covered in more detail on the following three pages.

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[42] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P31
[43] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P32

Rates of unmet need for primary health care in the past 12 months varied by sex, age, ethnic group and neighbourhood deprivation, as follows.

- Women had higher rates of unmet need than men (the rates were 32% and 22% respectively).
- About one in five adults aged 65 years and over had experienced an unmet need for primary health care, compared with about one in three adults aged 25–54 years.
- One in three **Māori** adults (33%) had an unmet need for primary health care, which was an improvement on 2011/12 (39%). The **Māori** rate was 1.3 times as high as the rate for non-Māori adults, after adjusting for age and sex differences. The rate was lowest in **Asian** adults: about one in five **Asian** adults (21%) had an unmet need for primary health care.
- Adults living in the most socioeconomically deprived areas had higher rates of unmet need in the past 12 months (33%) than those living in the least deprived areas (23%).

About one in five adults aged 25–64 years could not get an appointment at their usual Medical centre within 24 hours[44]

Timely access to care when it is needed is an important dimension of quality of care.

This indicator is defined as whether there had been an occasion in the past 12 months when adults had wanted to see a GP, nurse or other health care worker at their usual Medical centre within the next 24 hours, but this had not been possible.

Seventeen percent of adults had been unable to get an appointment at their usual Medical centre within 24 hours at some point in the past 12 months. This rate has remained relatively stable since 2006/07, when it was 18%.

Women were more likely to have been unable to get an appointment than men (the rates were 20% and 13% respectively).

Rates of being unable to get an appointment peaked in those aged 25–64 years (prime working age), where about one in five had been unable to get an appointment within 24 hours. Among adults aged 55–64 years, the percentage who had been unable to get an appointment within 24 hours rose from 14% in 2006/07 to 18%.

Asian adults had the lowest rate (13%) of being unable to get an appointment at their usual Medical centre within 24 hours.

Adults living in the most and the least socioeconomically deprived areas showed little or no difference from each other in terms of whether they had been unable to get an appointment at their usual Medical centre in the past 12 months, after adjusting for age, sex and ethnic differences.

Cost is more likely to be a barrier to visiting a GP for younger adults[45]

All New Zealanders are eligible for reduced health care costs when they go to their usual Medical centre. However, cost may still be a barrier to accessing primary health care.

In this report, the term 'did not visit a GP due to cost' means that there had been an occasion in the past 12 months when adults who had a Medical problem did not visit a GP because of cost.

Fourteen percent of adults reported not visiting a GP due to cost.

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[44] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P33
[45] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P34

Rates of not visiting a GP due to cost varied by sex, age, ethnic group and neighbourhood deprivation, as follows:

- Women were almost twice as likely as men to not visit a GP due to cost, after adjusting for age differences (the rates were 17% and 10% respectively).
- Unmet need for GP visits due to cost peaked among those aged 25–44 years, at about one in five adults. Cost was much less likely to be a barrier for adults aged 65 years and over: less than 10% had experienced unmet need for this reason.
- One in five **Pacific** and **Māori** adults (20%) had not visited a GP due to cost. **Pacific** and **Māori** adults were 1.4 times as likely as non-Pacific and non-Māori adults respectively to not visit a GP due to cost, after adjusting for age and sex differences. **Asian** adults had the lowest rate of not visiting a GP due to cost: one in nine (11%).
- Eighteen percent of adults living in the most socioeconomically deprived areas had not visited a GP due to cost. These adults were 2.5 times as likely as those living in the least deprived areas to not visit a GP due to cost, after adjusting for age, sex and ethnic differences.

Another reason for not visiting a GP is a lack of transport, which was a barrier for 3.2% of adults in the past 12 months. Lack of transport was patterned by deprivation; the rate was much higher for adults living in the most deprived areas (7.0%) than for those in the least deprived areas (1.4%).

Older adults are more likely than younger adults to report confidence and trust in their GP[46]

Patient experiences of Medical care are reflected in the confidence and trust they have in their GP. Being treated with dignity and respect, having privacy protected and being given clear explanations of conditions and treatment are important elements of the patient experience.

The surveyors asked adults who had visited a GP in the past three months, 'Did you have confidence and trust in the GP you saw? Yes, definitely / Yes, to some extent / No, not at all'. In this report, having 'confidence and trust' means definitely having confidence and trust in the GP visited.

Eight out of ten adults (80%) who had visited a GP in the previous three months had confidence and trust in their GP. However, confidence and trust in GPs fell slightly from 2011/12, when the rate was 84%.

Adults aged 65 years and over (85%) were more likely to have confidence and trust in the GP they last visited than those aged 25–44 years (76%).

There was little or no difference in adults' confidence and trust in GPs by sex, ethnicity or by level of neighbourhood deprivation. **Māori** adults (74%) had slightly lower confidence and trust in GPs than non-Māori adults.

The following were other patient GP experience questions included in the NZHS:

- 'Thinking about your last visit to a GP, how good was the doctor at explaining your health conditions and treatments in a way that you could understand?'
- How good was the doctor at involving you in decisions about your care, such as discussing different treatment options?'

'Most adults reported that their GP was very good or good at explaining their health conditions and treatments (92%), and at involving them in decisions about their care (90%).

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[46] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P37

Alcohol and Drug

Alcohol harm[47]

Alcohol harm is driven by the total volume consumed and by patterns of drinking (WHO 2014). Alcohol accounted for about 4% of total health loss in 2013 (IHME 2015). Half of health loss was due to disease (especially mental illness, such as alcohol use disorder); the remainder was due to injury. The percentage of adults who had a drink containing alcohol in the past year, 'past-year drinkers', provides context to the potential for alcohol-related harm.

Four out of five adults (80%) were past-year drinkers, no different to the previous three years. Men were more likely to be past-year drinkers than women (the rates were 84% and 75% respectively).

Over half of youth aged 15–17 years (57%) were past-year drinkers. About four out of five adults aged 18–74 years drank in the past year, while the rate declined for those aged 75 years. The decline was sharper in older women than men: the rate of 73% of women aged 65–74 years fell to 59% for those aged 75 years and over; for men in the same age groups, the rate fell from 82% to 79%.

Only 56% of **Asian** and **Pacific** adults were past-year drinkers. **Asian** and **Pacific** adults were much less likely to be past-year drinkers than non-Asian and non-Pacific adults respectively, after adjusting for age and sex differences.

Adults in the most socioeconomically deprived areas were less likely to be past-year drinkers (71%) than people in the least deprived areas (85%). This disparity in alcohol use was reversed for drinking patterns hazardous to health: those living in the most deprived areas were more likely to be hazardous drinkers than those living in the least deprived areas.

According to Statistics New Zealand (2015), the average amount of standard alcohol drinks available for consumption by adults aged 15+ years in 2014 has not changed since 2013: 2.0 standard drinks per day. This does not include alcohol produced by households (e.g., homebrew).

Hazardous drinking[48]

'Hazardous drinking' refers to an established drinking pattern that carries a risk of harming the drinker's physical or mental health, or having harmful social effects on the drinker or others. Hazardous drinking is defined as a score of 8 points or more on the Alcohol Use Disorders Identification Test (AUDIT).

About one in six (18%) adults (including non-drinkers) had a hazardous drinking pattern. However, among past-year drinkers, about one in five (22%) had a hazardous drinking pattern.

Following a decline in 2011/12 (to 15%), the hazardous drinking rate returned to the 2006/07 rate (18%). The greatest increase in hazardous drinking was for those aged 45–54 years (18%, up from 12% in 2006/07). Hazardous drinking rates for those aged 18–24 years (34%) remained lower than in 2006/07 (43%).

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[47] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P13
[48] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015, P13

Rates of hazardous drinking varied by sex, age, ethnic group and area deprivation, as follows:

- Twenty-five percent of men were hazardous drinkers compared with 11% of women.
- Hazardous drinking rates peaked among young adults (43% of men and 24% of women aged 18–24 years), and decreased thereafter. By the age of 75 years and over, hazardous drinking rates decreased to 5.4% of men and 0.8% of women. Young adults (aged 18–24 years) also had the highest rate of drinking six or more drinks on one occasion (also known as binge drinking) at least weekly (19%).
- About one in three **Māori** adults (32%) had a hazardous drinking pattern, as did 23% of **Pacific** adults. Despite relatively low rates of **Pacific** adults drinking alcohol in the past year (see page 13), **Pacific** adults were more likely to have a hazardous drinking pattern than non-Pacific adults, after adjusting for age and sex differences. Over half of male **Pacific** drinkers (52%) were hazardous drinkers. **Asian** adults (5%) were much less likely to be hazardous drinkers than non-Asian, after adjusting for age and sex differences.
- Adults in the most socioeconomically deprived areas were more likely to be hazardous drinkers (23%) than those in the least deprived areas (14%).

Prevalence of Fetal Alcohol Spectrum Disorder (FASD)[49]

There is no New Zealand data on the prevalence of FASD, but studies from the USA suggest that 1% of the population (May and Gossage 2001) is a solid, conservative estimate for New Zealand.[50] This implies that about 46,000 people in New Zealand may have an FASD, with around 570 more born each year. Around 10% of these may have FAS.[51]

International research suggests that out of this 46,000:

- 38,180 have speech and language disorders
- 32,200 will develop a mental illness
- 21,160 have congenital heart defects
- 18,400 are diagnosed with attention deficit hyperactivity disorder
- 12,880 experience sensorineural hearing loss
- 8740 have an intellectual disability (Thanh and Jonsson 2009).

As New Zealand has higher rates of drinking during pregnancy than the USA,[52] we would reasonably expect the figure of 1% to underestimate the prevalence of FASD and related issues in New Zealand.

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[49] Ministry of Health, Taking Action on Foetal Alcohol Spectrum Disorder (FASD): A discussion document, Wellington, 2015, P6

[50] International research has produced a range of estimates of FASD prevalence. Some studies have estimated that prevalence rates in the USA and Western Europe could be between 2% and 5% of the general population (see May et al 2009), although others have produced much lower estimates (see Ospina and Dennett 2013 for a summary). Although the wide range of estimates makes it difficult to know with certainty what the prevalence is likely to be, a widely used figure is 1%. We have therefore also assumed a figure of 1% in line with overseas practice.

[51] Again a range of estimates have been produced for FAS prevalence and the ratios of FAS to other FASDs. We've based our estimate of 10% on the findings of Astley (2010) which align well with what we are hearing from local clinicians. However, we note that based on estimates from the Office of the US Surgeon General, 25% of those born with an FASD may have FAS (US Department of Health and Human Services 2005, cited in SAMHSA 2014a: 1–4).

[52] About 10% of American women report drinking during pregnancy, with around 3% drinking at high risk levels. See Tan et al 2015.

Gambling

The nature of gambling harm[53]

Harm from gambling can include, among other things, relationship breakdown, depression, suicide, reduced work productivity, job loss, bankruptcy, and various types of gambling-related crime (including family violence and crime committed to finance gambling). There are 'ripple effects'; that is, harms can and often do extend beyond gamblers to encompass family members, whānau, friends, employers, colleagues and whole communities.

Ethnicity and gambling harm[54]

There continues to be compelling evidence that **Māori** and **Pacific peoples** are more likely to suffer gambling harm (whether as a result of their own or someone else's gambling), and more likely to be at risk of future harm, than people in other ethnic groups. Some specific **Asian** populations and subgroups also seem to be more likely to suffer gambling harm.

For example, analysis in the 2006/07 and 2011/12 iterations of the NZHS and multivariate analysis in the 2012. NGS concluded that even after taking into account key demographic and socioeconomic variables, **Māori** and **Pacific peoples** were significantly more likely to experience gambling harm (Rossen 2014; Abbott et al 2014b). In addition, estimates from the 2012 NGS suggested that close to 50 percent of problem gamblers and close to 40 percent of moderate risk gamblers are **Māori** or **Pacific**.

The 2012 NGS concluded that 'ethnic and other disparities in the burden of harm have persisted since the time the first gambling survey was conducted in 1991' (Abbott et al 2014b, p 18).

The '**Pacific**' and '**Asian**' categories each encompass a variety of different population groups. Within each of these categories, some population groups have low rates of participation in gambling. For example, it is likely that these rates are lower among the Indian population in New Zealand than among the East Asian and Southeast Asian populations. As a result, high level analysis tends to mask inequities among or within populations.

Even at a high level, however, some inequities among populations are readily apparent. For example, the 2012 NGS found that, overall, **Asian** and **Pacific** adults are less likely to participate in gambling than European/Other and **Māori** adults (the figures were 61 percent, 75 percent, 82 percent and 85 percent respectively). Taken together with prevalence rates for at-risk gambling, this means that **Pacific**, **Māori** and **Asian** adults who do gamble are at much higher risk than the European/Other gambler group. The NGS estimated that almost a fifth (17 percent) of **Pacific** gamblers are in the combined moderate risk and problem gambler group. The figures for **Māori** and **Asian** gamblers were 16 percent and 14 percent respectively. The equivalent figure for European/Other gamblers was eight percent (Abbott et al 2014b, p 48).

The 2012 NGS also suggested that the prevalence of at-risk gambling varies significantly by gender both among and within some of these overall population categories. After adjusting for age, the NGS found that **Asian** and European/Other females were less likely to be moderate-risk or problem gamblers than **Māori** or **Pacific** females. By contrast, it found that **Asian** males (like **Māori** and **Pacific** males) were more likely to be in the combined group than European/Other males, and more likely to be in the combined group than **Asian** females.

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[53] Ministry of Health, *Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document*, 2015, p4

[54] Ministry of Health, *Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document*, 2015, p5-6.

It also found that **Pacific** males were more likely to be in the combined group than **Pacific** females and more likely to be in the combined group than both males and females in each of the other three population categories (Abbott et al 2014b, pp 46 and 47).

Other research commissioned by the Ministry suggests that specific **Asian** subgroups (for example, recent migrants and international students) might be particularly vulnerable to gambling harm (Sobrun-Maharaj et al 2012). New Zealand's **Asian** population is growing, particularly in Auckland. As a result, it is important to address the vulnerability of specific segments of the **Asian** population to gambling harm.

Māori and **Pacific** populations are generally younger, and their proportion of the total population is also predicted to grow in future. As a result, it is important that the issue of **Māori** and **Pacific** vulnerability to gambling harm be given priority. In this context, recent research examining the impact of gambling on **Pacific** Whānau and communities (Bellringer et al 2013) and the gambling reports from the **Pacific** Island Whānau longitudinal study (to date, Bellringer et al 2008 and 2012) are likely to become increasingly important and useful.

Geography and harm from gambling[55]

As noted in some of the results reported above, people living in more deprived areas are disproportionately affected by, or at risk of, gambling harm. This is consistent with the geographical analysis discussed most recently in Allen and Clarke 2015. These analyses showed that people living in more deprived areas were at greater risk of developing problems with gambling, that most NCGM expenditure occurred in higher deprivation areas and that **Māori** and **Pacific peoples** were over-represented in these areas, suggesting that they were more likely to be affected. The studies also found that, although there were fewer NCGMs than there had been historically, they were still concentrated in more deprived areas.

Co-morbidities[56]

There is compelling evidence from New Zealand and international research that at-risk gambling is associated with higher levels of smoking, hazardous alcohol consumption, other drug use and depression, and with poorer self-rated health. For example, the 2011/12 NZHS reported that low-risk gamblers were twice as likely and adults in the combined moderate risk and problem gambler group were almost six times as likely to have an anxiety or depressive disorder. Further, adults in the combined group were almost three times more likely to have been diagnosed with a common mental disorder than those with no gambling problems, and were three times more likely to have been diagnosed with depression specifically.

It is worth noting that at-risk gambling also tends to be associated with higher usage of health and allied services. For example, the 2011/12 NZHS found that adults in the combined moderate risk and problem gambler group were twice as likely as those with no gambling problems to have consulted a General Practitioner in the year before being surveyed.

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[55] Ministry of Health, Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document, 2015, p8
[56] Ministry of Health, Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document, 2015, p8

Health Conditions

Men are more likely to be physically active than women[57]

Physical activity helps protect against heart disease, stroke, type 2 diabetes, certain cancers, osteoporosis and depression. It is also important for maintaining a healthy weight. Physical activity is defined as any musculoskeletal movement that requires energy expenditure above resting level. It includes deliberate exercise (i.e. running and sports) that is planned, structured and repetitively performed; activities of daily living (i.e. housework); work-related activity; and active transport. Low physical activity (which includes low and no activity) accounted for about 3% of all illness, disability and premature mortality in 2013 (IHME 2015).

The Ministry of Health recommends that adults do at least 30 minutes of moderate-intensity physical activity (i.e. brisk walking or equivalent vigorous activity, see *Indicator Interpretation Guide 2014/15: New Zealand Health Survey*) at least five days per week. In this report, being physically active is defined as meeting this recommendation. Note: For children and young people (5–18 years of age), the Ministry of Health recommends at least 60 minutes of physical activity every day. While those aged 15–18 years fall under the children and young people's guidelines, for NZHS purposes they are analysed here using the adult guidelines. The NZHS categorises physical activity into three groups: those who are physically active; those who are somewhat active but do not meet the physical activity guidelines; and those who do little or no physical activity (defined as less than 30 minutes per week). This report presents data on the first and third categories.

About one in two adults (51%) were physically active. Men (55%) were more likely to be physically active than women (47%).

There was little variation in physical activity by age group, apart from for those aged 75 years and over, of whom only 35% were physically active. This exception is consistent with the high proportion of adults in the same age group who did little or no physical activity (see page 18).

Less than half of **Asian** adults (45%) were physically active. **Asian** adults were 25% less likely to be physically active than non-Asian adults, after adjusting for age and sex differences.

The percentage of adults who are physically inactive is increasing[58]

Physical inactivity is different to sedentary behaviour, which is classed as doing activities that use very little or no energy (i.e. sitting down, lying down, watching television or using a computer). Adults who engaged in little or no physical activity – that is, less than 3o minutes physical activity in the past week – are described as physically inactive in this report.

One in seven adults (14%) was physically inactive, which was a higher proportion than in 2006/07 when one in ten adults was physically inactive (10%).

Women were more likely to be physically inactive than men: one in six women (16%) and about one in eight men (12%) were physically inactive.

Levels of physical inactivity increased from 55 years onwards. At the peak of this trend, about one in three adults (34%) aged 75 years and over was physically inactive.

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[57]Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015
[58] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015

Māori, **Pacific** and **Asian** adults were 30% more likely to be physically inactive than non-Māori, non-**Pacific** and non-Asian adults respectively, after adjusting for age and sex differences. The proportion of physically inactive **Māori** adults almost doubled from 9% in 2006/07 to 17% in 2014/15.

Adults living in the most socioeconomically deprived areas were twice as likely to be physically inactive as adults living in the least deprived areas, after adjusting for age, sex and ethnic differences.

Three in ten adults are obese[59]

Excess weight is a leading contributor to a number of health conditions, including type 2 diabetes, cardiovascular diseases, some types of cancer (i.e. kidney and uterus), osteoarthritis, gout, sleep apnoea, some reproductive disorders and gallstones. High BMI (overweight or obese) accounted for about 9% of all illness, disability and premature mortality in 2013, making it the leading modifiable risk to health, equal with smoking (IHME 2015). Obesity is defined as a BMI of 30 or more (or equivalent for those younger than 18 years). Surveyors measured respondents' height and weight, from which BMI is calculated, gaining these measurements for 96% of adults (excluding pregnant women).

Three in ten adults (31%) were obese, which was an increase since 2011/12 (29%), but no different to 2012/13 (31%). However, mean BMI and mean waist measurements continued to increase in nearly all population groups since 2011/12. Furthermore, the percentage of people who were morbidly obese (that is, in obese class 3, with a BMI of 40 or more) increased from 3.4% in 2006/07, to 3.8% in 2011/12, to 5.3% in 2014/15. The inequality between adults living in the most deprived and the least deprived neighbourhoods was bigger for morbid obesity rates (adjusted rate ratio of 3.1) than for obesity rates (adjusted rate ratio of 1.7).

Rates of obesity varied by sex, age, ethnic group and neighbourhood deprivation, as follows:

- Thirty-two percent of women were obese compared with 29% of men.
- The obesity rate increased with age, but was lowest at either end of the age spectrum: one in five aged 15–24 years (20%) and one in four aged 75 years and over (25%) were obese.
- Of the 1.1 million obese adults in New Zealand, 73% (816,000) were of European/Other ethnicity. Obesity rates were highest in Pacific adults (66%) and Māori adults (47%) and lowest in Asian adults (12%). After adjusting for age and sex differences, Pacific and Māori adults were more likely to be obese than non-Pacific and non-Māori adults respectively, and Asian adults less likely to be obese than non-Asian adults.
- Forty-two percent of those living in the most deprived areas were obese, compared with 22% in the least deprived areas.

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[59] Ministry of Health, Annual Update of Key Results 2014/15: New Zealand Health Survey, Wellington, 2015