Access & Equity in *Primary & Community Care*

01 ACCESS GAP

What whānau tell us

Take away the cost. That is the biggest barrier for our whānau.

Across the rohe, whānau are telling us the same thing. The cost of care is impossible. The wait is too long. The system does not feel safe, and it does not feel like it was built for them. Whānau are not disengaging from health care. They are being pushed out of it.

We hear this in every engagement. Whānau are making impossible choices, between a GP visit and food on the table, between their child's health and $60 they do not have. When they finally reach the system, they often find it does not know them, does not reflect them, and does not follow through.

Te Pae Oranga holds these accounts. They are the reason this report exists.

The data confirms what whānau describe. The system is not reaching them, and the commissioning decisions that would change this have not been made.

Two structural gaps open before the front door `OUR ROHE`

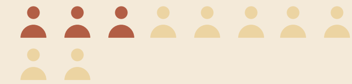
Māori measured against the benchmark, enrolment and utilisation are the entry points to all care

PLATFORM SIGNAL · THE STRUCTURAL ENTRY POINT

5 government targets ride on two upstream signals

Every national target is measured on people **already enrolled**. Fix the front door and five targets move at once, leave it, and an 11-point enrolment gap quietly filters every result downstream.

8,317

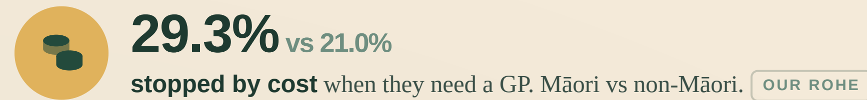


Māori not enrolled with a GP. `OUR ROHE`

NEARLY

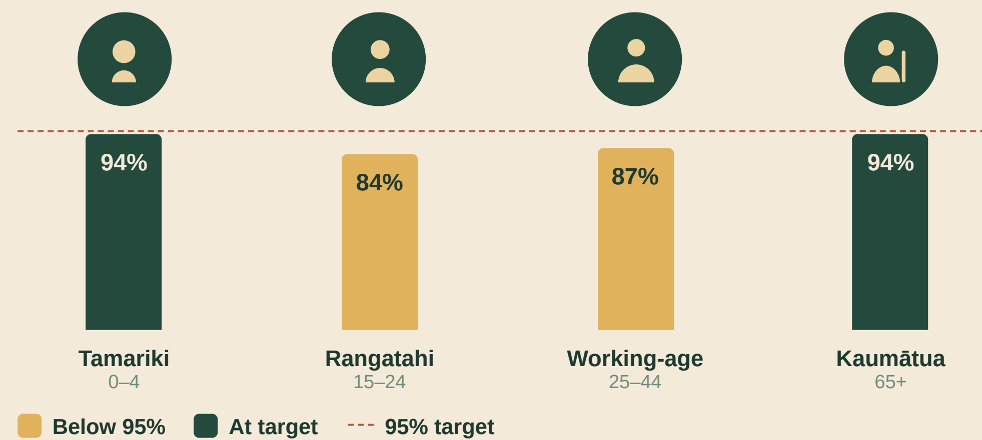
1 in 5

eligible Māori has **no enrolled GP at all**, most where cost and distance make care hard to reach. The front door never opens.



Enrolment by age `OUR ROHE`

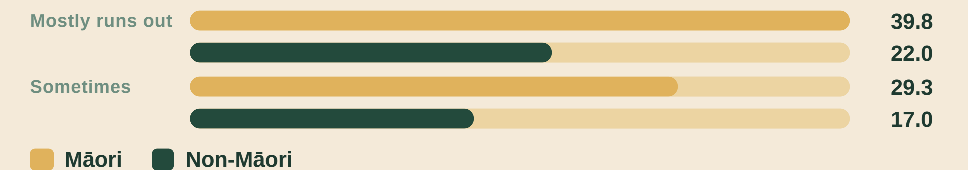
Rangatahi and working-age adults miss the 95% target most



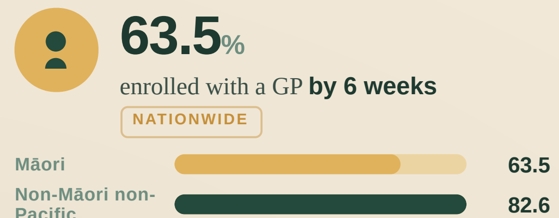
THE UPSTREAM DRIVER

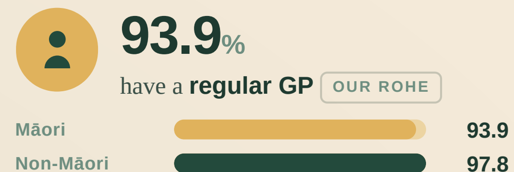
Food insecurity sits behind every gap

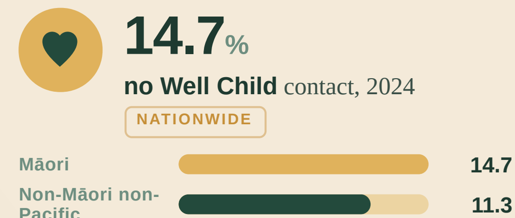
of tamariki Māori live in households where **food mostly runs out**, against 22.0% non-Māori. It is the driver upstream of the access, immunisation and oral-health gaps alike. `OUR ROHE`

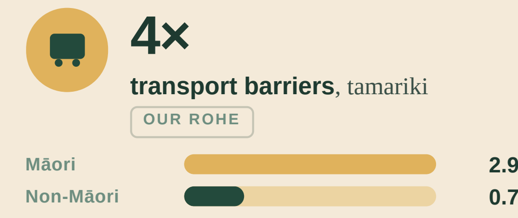


THE GAP STARTS AT BIRTH, AND COMPOUNDS WITH EVERY YEAR









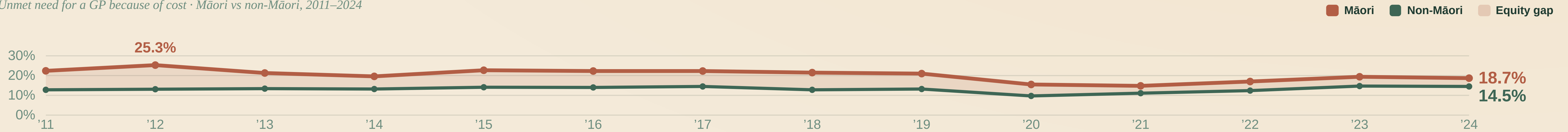
It just took forever to get treatment going, the referral times, the wait times. It just took forever.

Te Pae Oranga

The barriers, and *what the targets hide*

Locked out by cost for fourteen years NATIONWIDE

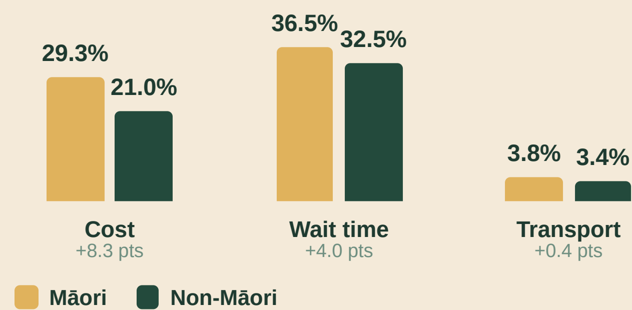
Unmet need for a GP because of cost · Māori vs non-Māori, 2011–2024



The gap has **nearly halved since 2012** (1.93× → 1.29×) but has never closed: no year in the record shows parity. Māori start higher and stay higher, and both rates are rising again post-2021 as affordability worsens for everyone.

Three barriers to a GP visit OUR ROHE

Adults reporting each barrier



Tamariki GP access worsened NATIONWIDE

Share of tamariki (0–14) who saw a GP or nurse

11.0% ↓ **6.8%**

8.8% ↑ **9.8%**

The gap did not widen. **It reversed.** Tamariki Māori once saw a GP more often than non-Māori. Now they see one least, at 6.8%, down from 11.0% in two years, while non-Māori recovered to 9.8%.

The local cause OUR ROHE

Behind the national collapse

4.8% vs 2.2%

cost barrier for tamariki Māori, more than twice as likely to go without a GP because of cost.

The national collapse is the output. **Cost is the cause** the time-series cannot show.

The weight of the wait OUR ROHE

36.5%

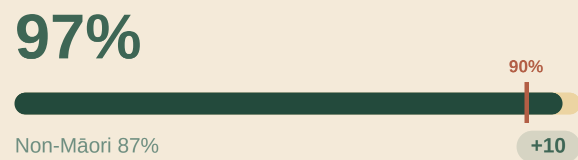
of Māori adults report **wait time** as a barrier to a GP visit.

That wait is not measured by any government target. The five targets below start their clocks only after whānau get through a door that for too many never opens.

FIVE GOVERNMENT TARGETS, MEASURED ONLY ON PEOPLE ALREADY INSIDE THE SYSTEM

Faster Cancer Treatment

97%



Not an equity win, see below.

Improved Immunisation

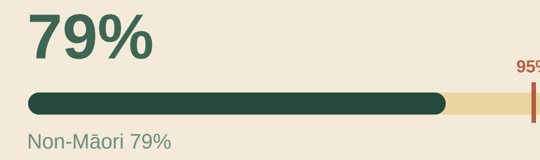
72%

Shorter Stays in ED

64%

Shorter Elective Waits

79%



Shorter FSA Waits

Health NZ does not publicly report First Specialist Assessment wait times by ethnicity. This is not a data gap. It is a reporting decision that removes Māori from the target record entirely.

MASKING CASE · CANCER

Targets are masking inequity

97%

of Māori treated **within the 31-day target**

On paper this looks like the system performing for Māori. It is not. Because screening reaches fewer Māori (see right), they arrive at cancer care **later and sicker**, then are treated quickly. Speed once you finally present is not system performance, it is the cost of a failed front door.

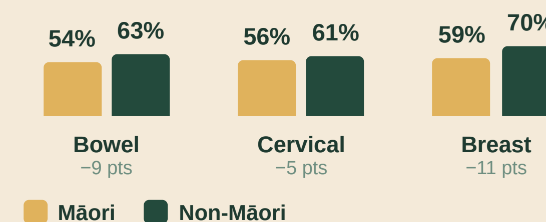
CRITICAL FRAMING · CANCER

A fast number is not an equity win

Māori who reach a treatment decision are seen quickly (97%). But **44–46% of eligible Māori** complete none of the three screening programmes. The 62-day referral-to-treatment pathway is suppressed in all 6 consecutive quarters (**fewer than 6 cases**), confirming it does not reach Māori at volume. The denominator is already filtered by upstream failure: speed is **late presentation at higher acuity**, not equity.

The screening gap OUR ROHE

Māori trail at every screen



WHAT COST BARRIERS PRODUCE

15.6% vs 6.4%
Prescription cost barrier · adults OUR ROHE
Cost does not stop at the clinic door. More than 1 in 7 Māori adults cannot afford to collect a prescription, against 1 in 16 non-Māori. The treatment gap extends past the appointment.

19.0% vs 14.8%
ED use · adults OUR ROHE
When the front door is closed, whānau reach the health system through emergency. A 4-point gap in ED visits that five government targets do not measure.

1.7×
Cancer mortality NATIONWIDE
Māori die from cancer at 1.7 times the rate of non-Māori. The screening gap on this page is the upstream cause.

Te Pae Oranga

Where the system *gets it right*, and must scale it

THE STANDARD WE EXPECT

Enforced, not aspirational

≥95% Māori enrolled with a GP

90% seen within one week

Written into **commissioning, contracts and reporting** as requirements, not aspirations. Where the system meets them, the access gap closes.

> *Our health services are relying on us as whānau to be there... but I don't feel that there's that connection well enough.*

THE CHANGE WE EXPECT

This harm is preventable. Six decisions that would prevent it.

- **Enforced Māori enrolment target** — In every PHO commissioning contract. None exists today.
- **Ethnicity-disaggregated reporting** — For all five targets at district level, no blended totals.
- **Zero-cost access for enrolled Māori** — Cost is the single largest barrier; remove the co-payment.
- **Prioritise kaupapa Māori models in commissioning decisions** — Scale up iwi and Māori provider resourcing.
- **Mobile outreach & transport** — Standard resourcing for enhanced access.
- **ED acuity as an access signal** — Read Māori ED data upstream, not just as throughput.

GAIN · IMMUNISATION OUR ROHE

64% → **72%** **Immunisation is rising**

Māori-led outreach lifted tamariki coverage **8 points in 12 months**. Proactive, whānau-centred delivery moves the dial.

GAIN · TELEHEALTH OUR ROHE

1,553 **Whānau-led access works**

Virtual GP visits in six months without sending whānau to ED. 41% were for Māori, 1.5× their population share; most from the lowest-income households.

The access gap is not inevitable. Across the rohe, whānau-led and iwi-led services are already closing it. The system's job is to fund and scale what works, and be held to account when it does not.

WHAT GOOD PRACTICE LOOKS LIKE · THE PRINCIPLES THE EXAMPLES BELOW SHARE

1. **Whānau voice response** — Services shaped directly by what whānau tell us about their lived experience.
2. **Proactive enrolment** — Actively enrol whānau rather than waiting, closing the gap at the front door.
3. **Same-week appointments** — Seen within one week, not pushed to ED or left waiting.
4. **Flexible hours** — Hours built around working-age and rangatahi lives, the groups missing out most.
5. **Alternative care pathways** — Transport, outreach and telehealth that remove rural barriers to care.
6. **Iwi and hauora Māori-led** — Delivered with iwi and hauora Māori providers: culturally safe and trusted.

PROOF THE STANDARD IS ACHIEVABLE · EACH IS A LEVER ALREADY WORKING IN THE ROHE

01 0800 4 TĀKUTA

Horowhenua · Telehealth

SAME-WEEK · FLEXIBLE HOURS · IWI & HAUORA

WHAT THEY DID

Free, same-day telehealth GP appointments with kaiāwhina support, removing cost, enrolment and after-hours barriers.

RESULT

1,553 visits in six months · 73% from the lowest-income households · unenrolled whānau seen same day.

> *"I struggle to get appointments because I'm unenrolled, but I got seen the same day."*

02 Oranga Ōtaki & Te Kahu Hauora

Ōtaki & Tararua · Iwi-led GP

PROACTIVE ENROLMENT · WHĀNAU VOICE · IWI & HAUORA

WHAT THEY DID

Kaupapa Māori and iwi-led GP services across the rohe, culturally grounded, whānau-led care, open to all.

WHY IT MATTERS

Trusted by whānau who feel disconnected from mainstream services.

> *"A new Māori hauora moved into Ōtaki, so I switched over. Very kaupapa Māori, and absolutely stunning."*

03 Immunising our Tamariki

Manawatū · Immunisation

PROACTIVE ENROLMENT · WHĀNAU VOICE · IWI & HAUORA

WHAT THEY DID

Hauora Māori providers finding and supporting whānau directly, Te Wakahuia Manawatū, Ngāti Kahungunu ki Tāmaki nui-a-Rua, He Puna Hauora, Muaūpoko Tribal Authority, Te Puna Oranga o Ōtaki, Ngā Kaitiaki o Ngāti Kauwhata and Māori Womens' Welfare League.

RESULT

Lifted tamariki Māori immunisation **64% → 72%** in 12 months.

> *"Heaps of whānau had heaps of questions, and between us we answered all their worries."*

04 Cancer Coordination · Whakapai Hauora

Palmerston North · Iwi-led

WHĀNAU VOICE · ALT. PATHWAYS · IWI & HAUORA

WHAT THEY DID

Māori Cancer Coordinators give whānau wrap-around support and fill gaps in screening outreach.

WHAT WOULD HELP

Catches cancer earlier, yet is **not properly funded**. Fund the screening, navigation and outreach it covers, and scale the service into Manawatū.

> *"Our [funded] mahi typically begins post-diagnosis, with crucial wrap-around services for whānau facing cancer."*

Whānau voice is the tuakana dataset. It is the evidence the data below must answer to. *Source: Whānau voice, Te Pae Oranga engagement, 2025/26.*

DATA SOURCES: NZ Health Survey, 2022/23–2024/25, IMPB-filtered, Ministry of Health · Health NZ Government Targets, 2025/26 Q2, IMPB-filtered · IMPB Dashboard, 2025/26 Q2 · Hauora Māori Advisory Committee, Priority 2 Key Insights, February 2026 · Service Provider Report, 2026