

What whānau tell us



You wait months for an appointment. Then the day comes and they cancel it. No explanation. You're back to the start.

WHĀNAU VOICE · SPECIALIST PATHWAY



You can't get in to a GP when you need one, so you wait in ED. Then you leave, because it's not worth the wait, or you get sicker there.

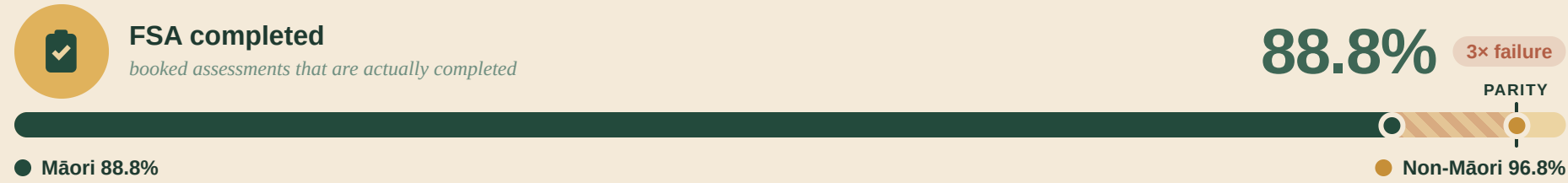
WHĀNAU VOICE · PRIMARY CARE TO ED

Health New Zealand has designed an outpatient and specialist system that does not enable Māori to complete first specialist assessments, delays elective treatment, and absorbs preventable crisis presentations. These are not access gaps. They are system design failures that produce predictable, measurable harm at every stage of the pathway, from referral through to surgery.

By the time whānau Māori reach hospital and specialist services, the primary care front door has already failed them. What follows is a second failure: outpatient pathways that do not support completion, elective pathways that delay treatment, and emergency departments absorbing the harm that should never have reached them.

Māori are excluded at the specialist referral gateway OUR ROHE

First specialist assessment is the door to all planned hospital care, Māori fall behind at it, and never complete it at three times the rate



PLATFORM SIGNAL · ONE MISSED STEP, FIVE COMPOUNDING HARMS



A missed first specialist assessment is not the end of the referral. It is the start of a longer, harder pathway, one that runs through ED, through late diagnosis, and through surgery that didn't need to be this complex.

64%

of Māori assessments that **fall through** are surgical, where delay does the most harm.

OUR ROHE

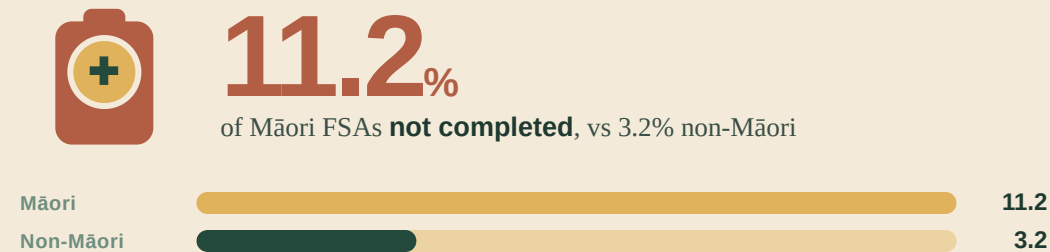
3.5x

the rate ratio for missed assessments has **barely moved in six years** (3.56x in 2018), even as both Māori and non-Māori rates improved. Equity has not.

OUR ROHE

Referred, then lost before assessment OUR ROHE

FSA non-completion, Māori vs non-Māori



More than **three times** the non-Māori rate. In 2024 this was **679 Māori appointments** lost, not to chance but to referral, timing, recall and follow-up systems not built for whānau.

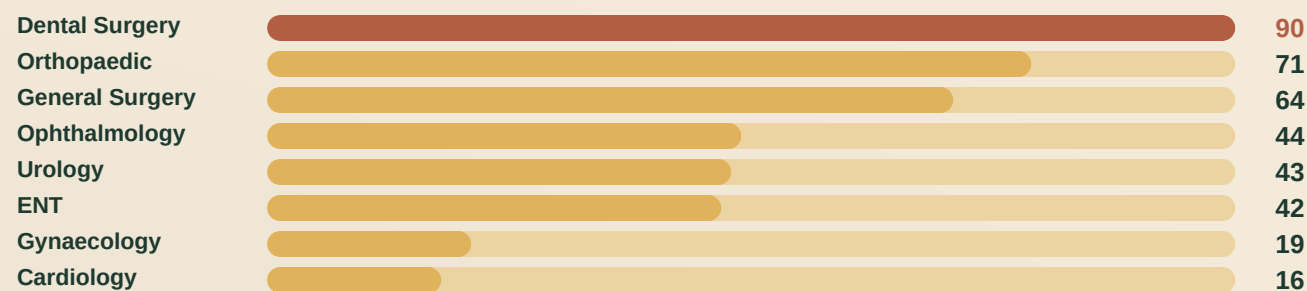
WHERE THE WAITLIST CONCENTRATES

FSA waitlist: where Māori wait for assessment OUR ROHE

- General Surgery**
The largest single concentration of Māori waiting for assessment.
- ENT**
The other major Māori waitlist, alongside General Surgery.
- Ophthalmology** *emerging*
A rising priority given higher diabetes prevalence among Māori.

Māori elective waitlist by specialty OUR ROHE

Dental Surgery holds more than twice the next-largest specialty



Dental Surgery is more than twice the next-largest specialty. It is the clearest immediate priority.

ELECTIVE PERFORMANCE



THE BARRIERS COMPOUND AT EVERY STEP OUR ROHE



Seen quickly, but *too late in the pathway*

Four government targets, and where they hide inequity IMPB Q2 2025/26

Māori local performance against the target, the non-Māori marker, and the national Māori figure

TARGET	GOAL	MĀORI LOCAL VS NON-MĀORI VS TARGET	MĀORI	GAP	NAT'L
Shorter FSA waits <i>seen within 4 months</i>		<i>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.</i>			
Shorter elective waits <i>treated within 4 months</i>	95%		79%	Δ +14	64%
Shorter stays in ED <i>within 6 hours</i>	95%		64%	Δ +6	77%
Faster cancer treatment <i>within 62 days</i>	90%		97%	Δ +10	90%

Where Māori appear **ahead of non-Māori** (Δ), the lead is not an equity win. It is the cost of arriving **later and sicker**, faster throughput once finally in the system, not earlier or fairer access to it. Not one of these four targets is met for Māori on equitable terms, and where the number looks strong, it reflects late, higher-acuity presentation rather than earlier or fairer access.

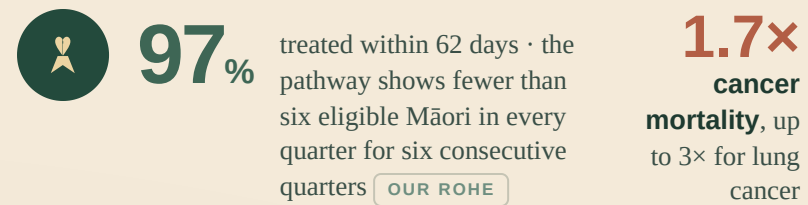
THE MASKING EFFECT · READ THE TABLE AGAIN

Three of the four targets flatter the system

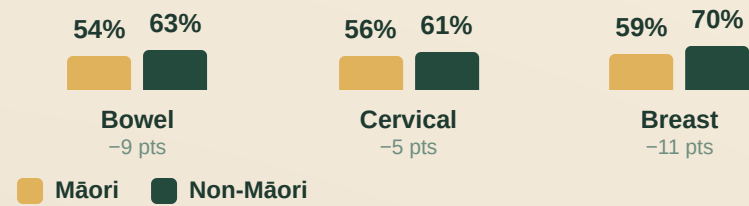
Three of the four targets show Māori outperforming non-Māori. Health New Zealand reports this as system performance. It is not. Each number measures the bottom of a pathway whose top has already failed whānau. Faster movement once finally inside the system is not evidence of equity. It is evidence that the system absorbed a crisis it caused. The panels below show what each fast number is hiding.

MASKING · CANCER & PREVENTION

A fast number sits on a failed pathway

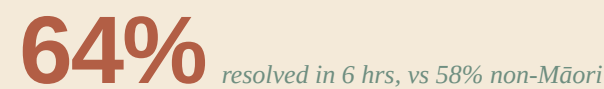


SCREENING REACHES FEWER MĀORI AT EVERY SCREEN OUR ROHE

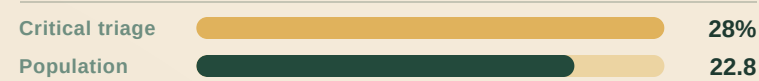
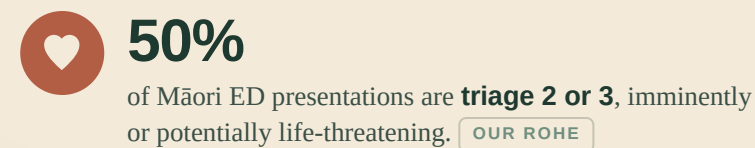


MASKING · EMERGENCY

Faster, because sicker



Māori clear ED faster, not because the system serves them better, but because they arrive at higher acuity. OUR ROHE



Māori are **28% of the most critical presentations** on 22.8% of the population. **17.5% more likely to leave** before treatment, including 6% of the most critical. OUR ROHE

MASKING · ELECTIVE

The target excludes the people it should be measuring



The elective number rose to 79%, an apparent +14 over non-Māori. But the target counts **only whānau already on the waitlist**. Those never enrolled, never seen, never referred are never measured. OUR ROHE

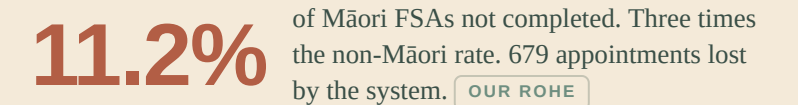
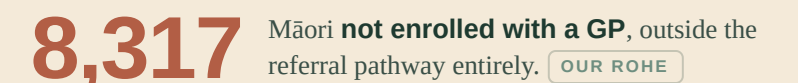


An **11-point enrolment gap** and a **0.68 utilisation ratio** truncate the pathway before the target begins to count. OUR ROHE

MASKING · FIRST SPECIALIST APPOINTMENTS

A completion rate that excludes everyone who never got it

The FSA target measures wait time for whānau already on the waitlist. It does not measure who never reached it. Health NZ does not publish the FSA result by ethnicity for our rohe, so even that restricted measure cannot be checked locally. What can be checked is what sits upstream of it: 8,317 unenrolled Māori were never referred at all. The real gap is not on the target's scoreboard. It is invisible by design.



WHY THIS HAPPENS · THE ONE UPSTREAM CAUSE

Primary care access failure drives hospital demand

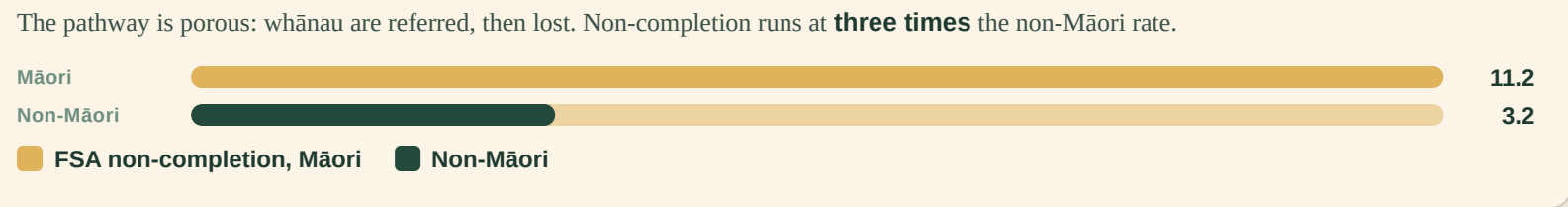
The outpatient and surgical systems cannot compensate for a failed front door. Māori are enrolled at **81% against 94%** and access GP care at only **68%** of need. Every HSS target is measured on whānau **already inside the system**, so the gap filters every result downstream, from who reaches assessment to who reaches surgery.

- 81% vs 94% enrolment
- 0.68 GP utilisation
- 33% growth in dental hardship grants, 4 years

“Go to the local community hospital and they'll just tell you to go to Palmerston North. That's an hour's drive, if you've got a vehicle.”

WHAT MUST IMMEDIATELY CHANGE · TWO ACCOUNTABILITY CONDITIONS, EACH OWNED BY HEALTH NEW ZEALAND

01 CONDITION ONE Enable Māori to complete first specialist assessments



WHAT MUST CHANGE

- Review referral triage rules to identify and remove criteria that systematically disadvantage Māori, including late-presentation bias and cultural unsafety at the entry point.
- Adjust appointment scheduling to enable Māori attendance: timing, communication method, and appointment design reviewed against DNA pattern data by ethnicity.
- Implement active recall and follow-up for every Māori referral, with no whānau classified as DNA without a system-initiated re-contact attempt.
- Produce an ethnicity-disaggregated FSA and DNA baseline by district and specialty, followed by quarterly reporting with escalation built into system operations.

The standard: Māori FSA non-completion rate reduces from 11.2% toward the non-Māori rate of 3.2% across four consecutive reporting quarters. Tracked by ethnicity at district and specialty level. Published by Te Pae Oranga six-monthly.

Accountable: Health New Zealand · Hospital & Specialist Services · Hauora Māori Service Directorate

DATA SOURCES

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.

NZ Health Survey, Ministry of Health, 2022/23–2024/25
Whiria Dashboard, Te Pae Oranga, Q2 2025/26
Whakamaua Quantitative Dashboard, Ministry of Health, 2018–2024
MSD Dental Hardship Grants, Official Information Act response, 2026

Health New Zealand, Primary Care and Immunisation data, current reporting period
Health New Zealand, ED triage acuity data, August 2025
Health New Zealand, dental arrears data, November 2025

WHAT WORKS · CAOHS, COMMUNITY ORAL HEALTH

Tamariki dental arrears, turned around

39% → **below the statistical control limit**

Arrears peaked at **39% in Nov 2023** with 400 tamariki waiting for general anaesthetic. A redesigned, equity-led model has driven arrears below the control limit, the model of care, not chance, is responsible. [OUR ROHE](#)

- Direct iwi engagement, cultural safety**
A te reo Māori-speaking dental assistant and, with Muaūpoko and Te Puna o Oranga o Ōtaki, mobile clinics on kura grounds for the first time.
- Equity-focused service schedule**
Decile 4-and-below schools now visited by mobile unit every 12 months, resource redirected to the 0–12 service.
- Expanded mobile coverage**
Three new mobile runs, Botanical Belt, Foxton–Shannon and Feilding, replacing hub travel for those whānau.

02 CONDITION TWO Reduce the dental surgery waitlist, and what fills it

Dental Surgery holds **more than twice** any other specialty, the end point of withheld prevention. Most whānau reach it only in crisis.



+33% dental hardship grants in four years, 4,788 → 6,729, Māori 32% of applicants

“He was told to be prepared because he was going in for surgery. Then come the next appointment, he was told no, sorry, you're not going off to surgery, there's nothing we can do.”

WHĀNAU VOICE · ELECTIVE PATHWAY

WHAT MUST CHANGE

- Reduce the Māori dental surgery elective waitlist (90 whānau waiting, the largest specialty concentration in the rohe) with a plan naming capacity, prioritisation settings, and navigation support.
- Correct clinical prioritisation so Māori who present late due to cost barriers are not deprioritised for a delay the system caused.
- Address the upstream access failures feeding the waitlist: cost barriers to primary dental care, COHS recall failures for tamariki Māori, and the absence of kaupapa Māori oral health pathways at scale.
- Strengthen referral links between COHS, primary care, and Māori oral health providers. The Te Ikaroa Māori Oral Health Current State Report (Keenan, 2025) documents the full range of actions available.

The standard: Māori proportion of the dental surgery elective waitlist reduces toward population share. Upstream oral health access barriers documented and remediation commenced. Tracked quarterly, published by Te Pae Oranga six-monthly.

Accountable: Health New Zealand · Hospital & Specialist Services · Hauora Māori Service Directorate