A Window on Disability

New Zealand Government
Te Kāwanatanga o Aotearoa

Health Quality & Safety Commission
Te Tāhū Hauora

Cover artwork by Sasha Wells, Dunedin, 1986.

Sasha Wells is a Studio2 artist. Sasha likes to draw dogs and cats, using different colours to layer paint, pens, and coloured pencils. Sasha enjoys coming to Studio2 because it's fun – 'This is a picture of sleeping dogs.'

Studio2 is a creative studio space in Ōtepoti Dunedin, where disabled artists are supported to create artwork, experiment with a range of materials, and develop their own artistic styles and profiles.

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Chapter 6

Conclusion and recommendations

As this Window report has demonstrated, the nature of our data on disabled people depends critically on the questions that are asked, when they are asked, who they are asked of and how they are asked. Greater rigour is urgently needed in the way disabled people's health and safety are documented within New Zealand's public health system. While the complexity of capturing disability data, and the gaps in the evidence base are clear, the data that does exist tells a consistent and deeply concerning story.

Disabled people in New Zealand are among the most frequent users of the health system. Drawing on the government's own data, this Window report affirms what many disabled people already know through lived experience: disabled people experience poorer health and safety outcomes than their non-disabled peers, with disparities further compounded for Māori and Pacific disabled people.

In preparing this Window report, disability health experts emphasised that health outcomes are significantly shaped by age and life stage. Many disabled people reported declines in both health service experiences and outcomes as they age. In response, this Window report adopted a life-course approach, beginning with disabled people's experiences of maternity and perinatal services.

Disabled people who become pregnant are less likely to enrol with a lead maternity carer (LMC) during their first trimester, have a higher prevalence of pre-term births, and generally report lower satisfaction and poorer overall experiences with maternity care services.

Health outcomes for disabled children are broadly comparable with those of non-disabled children, suggesting that early intervention and public health initiatives are, for the most part, inclusive and accessible. However, as disabled children age, disparities begin to emerge. Across areas such as immunisations, oral health, asthma, ASH conditions, and unmet need, the gap between disabled children and their peers widens over time. These inequities become particularly pronounced as young people transition out of paediatric services and into adult health care, a transition that disability health experts consistently identify as a critical point of failure within the system.

Disabled adults experience higher rates of chronic conditions, mental health distress and major cancers, while also encountering significant systemic barriers, including prolonged wait times for surgery and higher rates of post-operative complications. These inequities are most acute for Māori and Pacific disabled people and are compounded by a critical unmet need for primary, mental and oral health care. Consequently, some disabled adults are prematurely funnelled into aged residential care, while others experience avoidable health declines due to delayed or inadequate support.

Finally, significant data gaps persist regarding the health experiences of older disabled people, particularly in how they differ from those who acquire age-related impairments later in life. Despite these gaps, some disparities are evident in home and community support outcomes between disabled and non-disabled older populations. Most critical, however, is the evidence that disabled people face significantly lower life expectancy than their non-disabled peers.

While recent decades have seen some improvements in health outcomes and service experiences, significant gaps remain. These include in what the UNCRPD Committee identified as 'serious shortcomings' in disability-related data. The Committee recommended that the New Zealand Government work alongside Stats NZ to establish a national disability data framework that ensures the collection and public reporting of disaggregated data.[100] The health system and its workforce need to design and deliver services that are genuinely disability- and age-responsive, attentive to how different factors interact to compound need and disadvantage. Doing so will advance pae ora (healthy futures), in which all disabled people are able to 'live long, fulfilling and more independent lives in good health'.[101]

Recommendations

1. We need to know

The central problem identified in this Window report is the absence of disaggregated data related to disability. Disability must be accurately reflected in national health data.

Programmes such as the Patient Profile and National Health Index (PPNHI) show a way forward. Both Health NZ and the Ministry of Health are engaged in work around approaches to effective and accurate reflection of disability in national health data.

This work must be genuinely led by disabled people, tāngata whaikaha and their whānau and fully engaged with by every health service and agency in the country as a matter of priority.

A good first step would be to:

- commit to, and fully resource, the mandatory inclusion of standardised disability identification questions across all existing and future health data collection processes.

2. We need to train

Disability knowledge must be embedded into all stages of the education, training and professional development of our health care workforce. We must agree on a disability curriculum with the disability community and make it compulsory.

This responsibility falls to the governing bodies of the medical schools, the medical and nursing councils, the Ministry of Health and Health New Zealand | Te Whatu Ora.

A good first step would be to:

- mandate a high-level working group to embed disability-inclusive competencies across all health workforce curricula. This group needs to comprise disabled people, tāngata whaikaha and their whānau, and disability health experts, alongside senior decision-makers from professional training and development bodies.

3. We need to employ

Every health agency and service can benefit their users through the employment of disabled people and tāngata whaikaha who understand the disability experience. Actions to recruit, retain, make reasonable accommodations for and support the progression of disabled people within the health workforce are needed to achieve this.

A good first step would be to:

- conduct a comprehensive review of existing hiring frameworks to identify and extend, and if necessary develop robust inclusivity and accessibility policies. This includes recruitment, ensuring that both digital platforms and physical interview processes are accessible by design, and support is provided for disabled people's long-term success and career progression within the role.

4. We need to involve

We must embed self-determination and supported decision-making as core principles in the New Zealand health system. Disabled people, tāngata whaikaha and their whānau must be involved, and know they are involved, in decisions about their treatment and care. They must be provided the means to enable this: accessible tools and information, communication supports, and time to enable meaningful participation.

A good first step would be to:

- implement nationwide supported decision-making frameworks and training, developed in partnership with disabled people, and tailored specifically for frontline health services to ensure clinical practice aligns with the human rights of disabled people and tāngata whaikaha. ■

Appendix 1: A brief history of disability data in New Zealand

Guest essay by Sam Murray and Phoebe Eden-Mann

Emerging from the vacuum (before 1996)

Historically, the New Zealand government has had little interest in collecting statistics on disabled people. Between 1916 and 1996 no disability-related questions were included in the Census.

By the mid-1980s, the disability movement had grown in strength and the large residential institutions were slowly being phased out. As a result, the government began taking disability statistics more seriously. Between 1986 and 1993, the government commissioned a number of surveys from the research agency BERL and from Stats NZ. These surveys gave wildly inconsistent results: reported disability prevalence varied from 14% to 40%.

With other methods proving unreliable, people in the disability community began to pressure the government to include disability questions in the Census. Stats NZ was reluctant to do this, citing Canadian experience that the inclusion of disability questions produced unreliable results without a follow-up survey. Unfortunately Stats NZ lacked the funding to perform the necessary follow-up surveys. However, it approached IHC[102] and CCS Disability Action[103] to help fund the first follow-up survey, which went ahead in 1996.

The Disability Survey era (1996 to 2013)

The new post-Census follow-up surveys were collectively referred to as the Disability Survey, and reached two different groups: a larger private household survey, and a smaller survey of people living in residential facilities. Both surveys were used to estimate the prevalence of disability in New Zealand.

Disability surveys were run after the Census in 1996, 2001, 2006 and 2013, and although flawed in some aspects, these surveys quickly became the pre-eminent source of disability data in New Zealand. Information we now take for granted – such as one in four New Zealanders being a person with a disability – came from these disability surveys. That data point is from 2013, the last year the Census follow-up surveys were run.

Survey cancelled (2013 to 2015)

In 2012, the 2018 Disability Survey was cancelled, without any notification or consultation with the disability community. The cancellation was not announced publicly until 2015, surprising both the disability community and those who relied on this data. Instead of running after every Census, the survey would now only run after every second Census: once every 10 years.

That same year, the Disability Data and Evidence Working Group was formed with a goal of improving data collection and statistics about disabled people. Some members of the working group only found out about the cancellation of the Disability Survey as part of the background reading for the Group's work.

The cancellation was a sobering reminder that despite all the progress, there remains a need for constant pressure and vigilance. The Office for Disability Issues at the time and Stats NZ have acknowledged that they should have consulted with the disability community and have promised to do this in the future.

Where are we at now? The Washington Group era (2015 to present)

The change to a 10-year cycle meant the next Disability Survey would not run until 2023, creating a major gap in disability data and impacting the ability of disabled people, agencies and advocates to access funding and make good decisions.

To help close this gap, Stats NZ added a short international disability question set into its regular household surveys. This question set is called the Washington Group Short Set on Functioning (WG-SS).[104] The Washington Group is a United Nations Statistical Commission group made up of officials from a wide range of statistical agencies around the world.[105]

The WG-SS was added to a range of New Zealand government surveys, including:

- the General Social Survey (from 2016)
- the Household Labour Force Survey (June of every year from 2017 onwards)
- Te Kupenga (2018)
- the 2018 Census
- the New Zealand Crime and Victims Survey (2018/19)
- the New Zealand Health Survey (2019/20).

In addition to the above, the 2020 Household Economic Survey included a longer Washington Group question set, the WG-SS Enhanced,[106] and a module for children under the age of 5, the Washington Group/UNICEF Child Functioning Module.[107]

The use of Washington Group question sets has greatly increased the availability and range of disability data, especially regularly collected data. Unfortunately, the WG-SS collects data from a much smaller and less representative group of disabled people than the post-Census disability surveys. Relative to other disabled people, the following groups tend to be under-represented in this data:

- disabled people aged under 65 years
- people with learning disabilities
- neurodiverse people
- people with lived experience of mental health conditions.

The smaller number of people identified with the Short Set also makes it difficult to break the data apart to look at groups, such as ethnic groups and young people with disabilities. The over-representation of disabled people over 65 in the data also causes issues. There are several reasons for this.

- Many disabled people over 65 acquired their impairment after reaching the age of 65, because the disability rate rapidly increases among people over the age of 65.
- Disabled people who acquire their impairment later in life are likely to have more wealth, be retired and not seeking employment.
- Our superannuation is higher than working-age benefits and many older people in general own their house.

As a result, disabled people over 65 tend to be better off financially than younger disabled people. For example, in the General Social Survey 2018, disabled people under 65 were almost 2.5 times more likely to report not having enough income than non-disabled people under 65. By comparison, disabled people over 65 were only 1.5 times more likely to report not having enough income.

In common with non-disabled people, the experiences of disabled people under the age of 65 tend to get especially hidden in the WG-SS data for two further reasons: Disabled people over 65 are overrepresented in the Short Set disability data, and the low percentage of disabled people identified by the WG-SS data (especially younger disabled people) makes it difficult to accurately break down the data any further by age. ■

Appendix 2: Models, contexts and strategies for disability

The different models of disability

Models of disability describe the way society views and understands disability. Several models of disability have been widely used, including the following.

- The **charity model** views disabled people as victims of circumstance, and considers that non-disabled people should pity them and help them with generosity.[108]
- The **medical model** views disability as a disease or medical problem in need of fixing. Additionally, disabled people are viewed as abnormal, echoing ableist assumptions that being able-bodied is the ideal and should be aspired to.[109]
- The **social model** is more accepted by the disability community and views disability as a social construct made up of barriers in society that people with impairments experience.[110] From this understanding, people with impairments are disabled by the barriers in society. Based on the social model of disability, oppressive and exclusive structures and barriers can be challenged and eliminated through social change.
- The **human rights model** is complementary to and builds on the social model. It is a tool for disability policy and guides policy responses to adopt an approach aligned with human rights and obligations when addressing disability issues.[111]

Māori and Pacific models of disability

Tāngata whaikaha and whānau hauā models of disability

Within te ao Māori, understandings of disability are often described through two key frameworks: the whānau hauā model and the tāngata whaikaha model.

The whānau hauā approach highlights how the legacy of colonisation, along with ongoing discriminatory systems, continues to shape the experiences of Māori disabled people. In this model, whānau includes both whakapapa and kaupapa whānau, while hauā draws on hau (the uplifting wind), symbolising the collective support extended to disabled members. It places responsibility for wellbeing not on individuals, but on the wider collective, recognising that inequities produced by ableism and colonisation limit people's ability to have their needs met.[112]

The second model, tāngata whaikaha, centres the capabilities, resilience and mana of Māori disabled people. This term has gained significant traction across Aotearoa New Zealand and is reflected, for example, in the name of Whaikaha – Ministry of Disabled People. The late Matua Maaka Tibble (Ngāti Porou) was closely associated with the introduction of whaikaha, which he offered as an alternative to the deficit-based language of 'disability'. As described in *Te Reo Hāpai*, whaikaha conveys a sense of strength, ability and being 'otherly abled' – a concept developed from within the Māori disabled community itself.[113]

Importantly, not all members of the disability community:

> identify with disability-focused language … Most Māori disabled people identify as Māori first. The importance of their cultural identity, which encompasses language, whānau, cultural principles, practices and linkages to the land through genealogy, is paramount to how they live their day to day lives in both Te Ao Māori and Te Ao Pakeha.[114]

Māori disabled people are likely to be undercounted in the government's administrative data.[115]

Te Whare Tapa Whā model of Health

Developed by Sir Mason Durie in 1984, Te Whare Tapa Whā conceptualises hauora (wellbeing) as a four-walled meeting house (wharenui) built upon the foundation of the land (whenua). The model posits that health is a holistic balance of four walls: taha tinana (physical), taha whānau (social), taha hinengaro (mental/emotional), and taha wairua (spiritual). If any single wall is neglected or weakened, the stability of the entire structure is compromised. Therefore, achieving true wellness requires the active nurturing and integration of all four pillars to maintain overall strength and stability.[116]

Pacific model of disability

The Tagata Sa'ilimalo model, created by Pacific disabled communities in New Zealand, offers a valuable lens for understanding the health service experiences of some Pacific disabled people. In this framework, 'tagata' refers to people, while 'sa'ilimalo' speaks to striving for achievement. According to the Tagata Sa'ilimalo Strategic Framework:

> Tagata Sa'ilimalo is an aspirational vision of the pursuit of success underpinned by sheer determination and sustained by the collective vitality of Pacific peoples. It is a vision that reflects the hopes of the disability community to imagine better for their future. The Tagata Sa'ilimalo vision is inclusive of all Pacific peoples in Aotearoa and all disability types.[117]

While not all Pacific disabled people embrace this model, it has gained momentum among some communities due to its emphasis on collective strength, resilience and a community-driven understanding of success.

Fonofale Model of Health

Various Pacific frameworks have been established to ensure that health and wellbeing initiatives are culturally grounded and community-specific. A primary example is the Fonofale model, created by Fuimaono Karl Pulotu-Endemann following extensive consultation with Pacific communities in Aotearoa regarding the core determinants of health. This holistic framework integrates the shared values of Samoan, Cook Island, Tongan, Niuean, Tokelauan and Fijian peoples through the metaphor of a Samoan *fale* (house). Within this structure, the foundation signifies the family and *gafa* (genealogy), while the roof embodies cultural values. Supporting the roof are four *pou* (posts), which represent spiritual, mental, and physical wellbeing, alongside a fourth category for diverse factors like gender, age, and socioeconomic status. The entire *fale* is situated within a broader environment shaped by time, context, and the physical surroundings. The fonofale model is one that has been drawn on in disability and health settings.[118]

United Nations Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is an international human rights convention that protects and promotes the rights of disabled people and ensures their full and equal enjoyment.[119] The UNCRPD states the actions that governments must take to ensure disabled people enjoy the same rights as non-disabled people.[120] The New Zealand Government signed and ratified the UNCRPD in 2008 and ratified the Optional Protocol in 2016.[121]

Article 25 of the UNCRPD concerns health and states that signatories of the convention recognise that disabled people have the right to the highest attainable standard of health. Further, the UNCRPD calls on State Parties to 'take all appropriate measures' to ensure disabled people have access to health services.[122] Article 31 of the UNCRPD relates to statistics and data collection and calls on State Parties to 'collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention'.[123]

Health of Disabled People Strategy

The Ministry of Health developed the Health of Disabled People Strategy (HoDP Strategy) as required by the Pae Ora (Healthy Futures) Act 2022, alongside five other health strategies – Pae Tū: Hauora Māori Strategy, Te Mana Ola: The Pacific Health Strategy, Rural Health Strategy, Women's Health Strategy and the New Zealand Health Strategy.

The purpose of the HoDP Strategy is to set 'the direction and long-term priorities for achieving equity in disabled people's health and wellbeing outcomes over the next 10 years'.[124] The priorities outlined in the HoDP Strategy were developed through engagement with disabled people and their whānau, and through assessment of health sector performance and disabled people's health outcomes. The following are the five key health system priorities.

- Priority 1: Embed self-determination of disabled people and their whānau as the foundation of a person- and whānau-centred health system.
- Priority 2: Ensure the health system is designed by and accessible for disabled people and their whānau and provides models of care that suit their needs.
- Priority 3: Ensure the health system is part of a coherent cross-government system that addresses broader drivers of poor health and wellbeing.
- Priority 4: Build health workforce capacity and capability to meet the needs of disabled people and their whānau.
- Priority 5: Increase the visibility of disabled people in health data, research and evidence as part of an active learning system.[125]

These priorities have been identified as necessary for achieving pae ora (healthy futures) for disabled people and their whānau.

New Zealand Disability Strategy 2026–2030

The New Zealand Disability Strategy 2026–2030 (NZDS) gives guidance to the New Zealand Government on issues important to disabled people, tāngata whaikaha Māori, and whānau. Development of the current NZDS was led by Whaikaha – Ministry of Disabled People, with input from disability groups and working groups (disabled people, sector experts and government officials). The NZDS is underpinned by the Enabling Good Lives principles, the UNCRPD and Te Tiriti o Waitangi.

The vision for the NZDS describes what disabled people want for the future of New Zealand: 'New Zealand is an equitable and accessible place for all disabled people and their whānau – where disabled people thrive, contribute, and choose the lives they want to lead'.[126]

The principles for the strategy are: accessibility; self-determination; upholding equity, culture and identity; participation and inclusion; and respect and dignity.

The NZDS comprises five priority outcome areas that were agreed by Cabinet and further developed by working groups. These areas are education, employment, health, housing and justice, and each has a separate goal and required actions.

Progress on the vision and principles will be measured using the following indicators:

- percentage of disabled adults (aged 15 years and over) who rated their overall life satisfaction highly (7 or higher on a 0–10 scale)
- percentage of disabled adults (aged 15 years and over) who rated the level of control they feel they have over their lives highly (7 or higher on a 0–10 scale)
- percentage of adults (aged 15 years and over) who felt comfortable or very comfortable about a new neighbour who had a disability or long-term health condition
- percentage of children in disabled households living in material hardship.[127]

Further, there are primary indicators and measures for each priority outcome area, and an indicator framework developed by Whaikaha that will measure the strategy's success.

The goal for the priority outcome area of health is 'disabled people will achieve the highest possible standard of health and wellbeing. They will decide what this means for themselves and their whānau'.[128] Among the five actions associated with this goal, actions four and five relate specifically to data: 'identify disabled people in national health data' and 'put a system in place so disabled people can record their accessibility needs against their National Health Index (NHI)'.[129] The four indicators that will be used to measure the success of the goal are:

- percentage of disabled people with good, very good or excellent self-rated health
- percentage of disabled adults (aged 15 years and over) who reported that the health care professional at their most recent appointment involved them as much as they wanted in making decisions about their treatment and care
- percentage of disabled adults (aged 15 years and over) who had unmet need for a GP
- percentage of adults (aged 15 years and over) with a disability, impairment or long-term health condition who felt their accessibility needs were met.[130]

The data sources used to measure the baseline of these indicators include the New Zealand Health Survey 2023/24 and the Health Quality & Safety Commission Te Tāhū Hauora adult primary care patient experience survey 2024.

New Zealand Health Plan | Te Pae Waenga

The New Zealand Health Plan | Te Pae Waenga is the three-year plan legislated under the Pae Ora (Healthy Futures) Act 2022 for Health New Zealand | Te Whatu Ora. [131]

Under Section 4: Improving health for populations with greater needs, section 4.3: Disabled people | tāngata whaikaha states:

> Changing how our health system approaches and understands disability means we need to challenge basic assumptions, including discrimination in favour of able-bodied people and outdated ways our system works.

> Disabled people are under-represented in health policy areas and in data and accountability. Disability leadership and representation is crucial to the collection and analysis of data and for directing action to improve health services …
>
> Our aim is to build better health services that work with and for disabled people.

Three actions to improve health care for disabled people are listed:

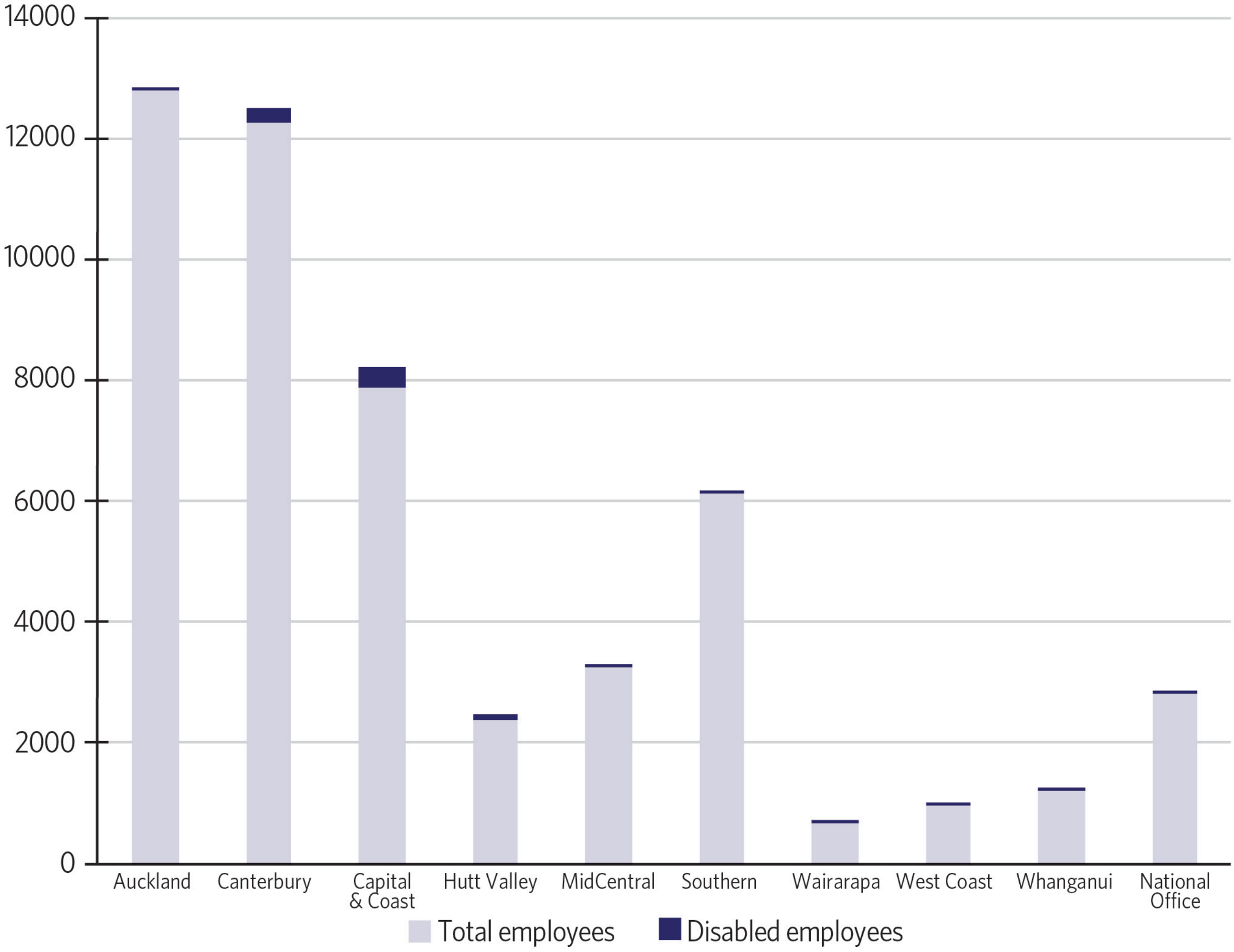
> 4.3.1 Implement the Patient Profile and National Health Index programme and build data intelligence capabilities to be more responsive to disabled people.
>
> 4.3.2 Design and implement the disability model of care with a focus on infrastructure, workforce capability and capacity, policies, processes, practices and information accessibility.
>
> 4.3.3 Implement actions that project the disability consumer and whānau voices into key areas of work, including service design and planning. ■

Appendix 3: Workforce representation

District employee data for Health New Zealand | Te Whatu Ora was made available to us by the Health Workforce Information Programme. Many districts did not capture disability status. Those that did had a total of 55,344 employees at 31 July 2025, of whom 797 identified as having a disability. This is just 1.4%.[132]

As Figure 76 shows, the proportion of disabled employees (in dark blue) in these districts that did capture disability status is vanishingly small – it can literally barely be seen.

Figure 76: Total employees and employees identifying as disabled by Health New Zealand districts that report, 31 July 2025



Source: Health Workforce Information Programme

In comparison, 11.8% of the all employed people aged 15 years and over were disabled. Of those who are employed, disabled people are over-represented in the health care and social assistance industry. However, due to the much lower employment rates for disabled people they are under-represented when compared with the total population aged 15 and over (disability rate 18%). ■

Appendix 4: Glossary

Accessibility: The provision of flexibility to accommodate a user's needs and preferences; when used with reference to disabled people, any place, space, item or service, whether physical or virtual, that is easily approached, reached, entered, exited, interacted with, understood or otherwise used by people with varying disabilities, is determined to be accessible.[133]

Birthing parent: A gender-inclusive term that refers to the individual who physically gives birth to a child.

Disability: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".[134]

Disability versus impairments: Reflecting the social and rights models of disability, disabled people and disability are terms that have been used throughout this report when referring to individuals and communities that are disabled by socially constructed barriers. Impairment/s is used when referring to one or more impairments that a disabled person lives with.

Intersectionality: A concept and theoretical framework that facilitates the recognition of the complex ways in which social identities overlap and can create compounding experiences of discrimination and concurrent forms of oppression.[135]

Inverse Care Law: The availability of good medical care tends to vary inversely with the need for it in the population served.[136]

Learning disability: An alternative term to describe intellectual disability. It is the term preferred by self-advocates with learning disabilities in Aotearoa New Zealand.[137]

Mental access: An individual's ability to access services with a sense of mental wellbeing and safety.[138]

Neurodivergence: An umbrella term that "encompasses people whose brain functions differ from the neuro-normative majority. ADHD, Dyslexia, and Autism are all examples of neurodivergent, A person can have an innate (from birth) neurodivergence or acquired (such as in the case of traumatic brain injury.)".[139]

Older adult: Disabled person over 65 years.

Person-centred: An approach which focuses "on the needs of the individual; ensuring that people's preferences, needs, and values guide clinical decisions or disability support; and providing care that is respectful of and responsive to them".[140]

Substituted decision-making: The conditions of substituted decision making are '(a) legal capacity is removed from a person, even if this in respect of a single decision; (b) a substitute decision maker can be appointed by someone other than the person concerned, and this can be done against his or her will; or (c) any decision made by a substitute decision maker is based on what is believed to be in the objective 'best interests' of the person concerned, as opposed to being based on the person's own will and preferences".[141]

Supported decision-making (SDM): An emerging paradigm in which people use friends, family members, and professionals to help them understand and address the situations and choices they encounter in everyday life prioritising people's 'will and preference' rather than what is thought to be in their 'best interests'.[142]

Tāngata Turi Māori: Māori D/deaf people.

Tāngata whaikaha: Disabled people.

Tāngata whaikaha Māori: Māori disabled people.

Twin-track: Where a disabled person has access to, and choice between, both mainstream health services, as well as culturally aligned, disability-specific services, as well as choice to use either type of service.[143]

Whānau hauā: A Māori perspective on disability that is holistic, relational, collective, and culturally grounded. It reflects Indigenous worldviews where disability is not only an individual issue but involves the family (whānau) and their shared responsibilities. The term whānau hauā metaphorically signifies "the wind that propels whānau with member(s) who have a disability," indicating movement, energy and collective force.[144]

Younger adult: Disabled adults under the age of 65. ■

Endnotes

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Comparison between disabled and non-disabled populations is enabled by creating a 'derived variable', combining those identified as being disabled through either question. To confirm the suitability of this approach, we consulted with subject-matter experts, including Stats NZ, the Human Rights Commissioner and Whaikaha – Ministry of Disabled People.

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sample of the population as a whole. This means disabled people who are not enrolled with or who do not access primary care are not included in these results, so it is not accurate to generalise the results to the population level. A better way to use the results is to make comparisons between groups, such as disabled versus non-disabled respondents, and respondents of different age groups and ethnic groups. Because the sample size is large, the results show any statistically significant differences between sub-groups.

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Where the IDI has been used as the data source, this is noted under each table and graph. Access to the anonymised data used in this study was provided by Stats NZ under the security and confidentiality provisions of the Data and Statistics Act 2022 and the Privacy Act 2020. The Data and Statistics Act 2022 allows public sector agencies to request data on behalf of the Government Statistician for inclusion in the IDI and to use it for approved statistical and research purposes. Only individuals authorised under the Data and Statistics Act 2022 are permitted to access data about a particular person, household, business or organisation. All results in this report have been confidentialised to protect these groups from identification and to ensure their information remains secure.

Careful consideration has been given to privacy, security and confidentiality issues associated with using administrative and survey data in the IDI. Further detail can be found in the privacy impact assessment for the IDI.

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- 75% had a known disability status
- 29% had two or more functional disabilities

Provider results are reported only for providers with at least 30 respondents for each of the seven questions.

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