

Annual Update of Key Results 2013/14

New Zealand Health Survey



New Zealand Health Survey

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MANATŪ HAUORA



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Foreword

I am pleased to present the latest findings from the New Zealand Health Survey. This report provides information on the health of both adults and children from June 2013 to July 2014, together with historic trend data.

The New Zealand Health Survey became a continuous survey in 2011, enabling the publication of annual updates on the health of New Zealanders. This report provides an update to the *New Zealand Health Survey: Annual update of key findings 2012/13*.

Having up-to-date information on the key health issues facing New Zealanders enables us to effectively monitor trends and identify changing patterns of disease. These findings will help us ensure health services in New Zealand are able to meet the current needs of our population and are better prepared to meet the challenges of the future.

A number of indicators collected by the New Zealand Health Survey have been designated as key official statistics. These statistics, known as Tier 1 statistics, include smoking (current), obesity, self-rated health and mental health status (psychological distress). This report has been produced, analysed and released according to the high statistical standards expected of producers of Tier 1 statistics.

The continuous nature of the survey enables us to combine multiple years of data, allowing more detailed analysis at smaller population levels. We will be publishing district health board (DHB) survey results for all 20 DHBs in New Zealand in a separate report in 2015. This information will help us identify differing patterns of health across New Zealand and will help support local health service planning.

I would like to thank the many people who have been involved in the survey. I would also like to extend a special thank you to the many thousands of New Zealanders who gave their time to take part. The information they have provided is critical in developing and monitoring health policy and services in New Zealand.

I hope you find this report of interest.

Chai Chuah
Acting Director-General of Health
Ministry of Health

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Thank you also to the many thousands of New Zealanders who gave their time to participate in the New Zealand Health Survey. This report would not have been possible without your generosity.

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Executive summary

The following is a summary of the key findings of the 2013/14 New Zealand Health Survey (NZHS), including notable trends and differences between population groups.

- **Most New Zealanders report being in good health:** nine out of ten adults (91%) rate their health as good, very good or excellent. The self-reported good health of older adults (those aged 75 and over) has steadily improved, from 80% in 2006/07 to 87% in 2013/14. Nearly all parents (98%) consider their children to be in good health.
- **Māori smoking rates remain high:** Māori have the highest current smoking rate (41% smoke at least monthly), and there has been no significant change since 2006/07 (when 42% smoked). The overall current smoking rate in adults declined from 20% in 2006/07 to 17% in 2013/14. The current smoking rate in youth (those aged 15–17 years) has halved since 2006/07, falling from 16% to 8%. Smoking rates are strongly positively related to socioeconomic deprivation: adults living in the most deprived areas were 3.5 times as likely to be current smokers as adults in the least deprived areas, after adjusting for age, sex and ethnic differences.
- **Hazardous drinking rates are highest in young people:** one in six adults (16%) has a hazardous drinking pattern, down from 18% in 2006/07. Hazardous drinking rates peak in the 18–24-year age group. One-third of 18–24-year olds (33%) are hazardous drinkers: an improvement on 2006/07 (when the equivalent figure was 43%). Men are twice as likely to have hazardous drinking patterns as women (the rates are 22% and 11% respectively).
- **Adult and child obesity rates are similar to last year:** three out of ten adults (30%) are obese. One in ten children is obese. There has been no significant change in the adult and child obesity rates since 2011/12, but more data is required to confirm whether this represents a slowing in the growth of obesity rates. Pacific adults are 2.5 times as likely to be obese as non-Pacific adults, and Pacific children are 3.2 times as likely to be obese as non-Pacific children. Obesity rates are strongly positively related to socioeconomic deprivation; the obesity rate for children living in the most deprived areas is 2.7 times the rate in the least deprived areas, after adjusting for age, sex and ethnic differences.
- **Women are less likely to meet the recommendations for fruit intake than in previous years:** 64% of adults meet the recommended vegetable intake of at least three servings per day, and 57% of adults meet the recommended fruit intake of at least two servings per day. Women are more likely than men to meet recommendations for vegetable and fruit intake. However, the percentage of women eating the recommended daily intake of fruit is lower now than it was in 2006/07 (62%, compared with 69%).
- **Long-term health conditions are common in older adults:** the prevalence of most long-term conditions increases with age. For adults aged 75 years and over, common long-term conditions include medicated high blood pressure (52%), arthritis (49%), chronic pain (32%) and medicated high cholesterol (31%).
- **Rates of diagnosed mental health conditions are rising:** 18% of adults have been diagnosed with a mood disorder (depression or bipolar disorder) and/or anxiety disorder at some time in their life, up from 16% in 2012/13 and 13% in 2006/07. As in 2012/13, 4% of children have been diagnosed with emotional and behavioural problems, up from 2% in 2006/07. Women are 40% more likely than men to have ever been diagnosed with a mood or

anxiety disorder. In contrast, boys are 2.5 times more likely to have been diagnosed with emotional or behavioural problems than girls.

- **Pacific and Māori experience higher rates of psychological distress than other adults:** overall, 6% of adults had experienced high or very high levels of psychological distress in the last four weeks, indicating a high probability of an anxiety or depressive disorder. Māori are 1.6 times as likely and Pacific people are 2.1 times as likely to have experienced high levels of psychological distress as non-Māori and non-Pacific people respectively.
- **Over three million New Zealanders visited a general practitioner (GP) in the last year:** most adults (78%) and children (75%) have visited a GP in the last 12 months. These rates are lower than they were in 2006/07 (when the rates were 81% of adults and 79% of children).
- **Confidence and trust in GPs is high:** most adults (80%) have confidence and trust in the GP they last visited; this figure is lower than it was in 2011/12 (84%). There is a similar drop (to 78%) for parents' confidence and trust in the GP their child last visited (the equivalent figure was 83% in 2011/12). There are little or no differences in people's confidence and trust in GPs by sex, ethnic group or level of neighbourhood deprivation.
- **Unmet need for primary health care is more common in deprived areas:** 28% of adults and 22% of children had one or more types of unmet need for primary health care in the past 12 months. Unmet need takes various forms, including a person being unable to get an appointment at their usual medical centre within 24 hours and a person not going to a GP and/or after-hours medical centre when they had a medical problem due to cost or lack of transport. Neighbourhood deprivation is strongly linked to unmet need for primary health care. About one in three adults living in the most deprived areas (35%) had an unmet need for primary health care, compared with one in five (20%) of those living in the least deprived areas.
- **Adults and children living in the most deprived areas are more likely to miss out on prescriptions due to cost:** 6% of adults and 4% of children did not collect one or more prescription items due to cost in the last 12 months; these figures are similar to last year's NZHS. There is a strong positive association between living in a highly deprived neighbourhood and not being able to pay for a prescription. Adults living in the most deprived areas are 3.3 times as likely to have been unable to collect a prescription due to cost than adults living in the least deprived areas, after adjusting for age, sex and ethnic differences. Similarly, parents of children living in the most deprived areas are 4.5 times as likely to have not filled a prescription for their child due to cost as those in the least deprived areas, after adjusting for age, sex and ethnic differences.
- **One in two adults visited a dental health care worker in the last year:** only half of adults (50%) with natural teeth visited a dental health care worker in the past year. Adults living in the most deprived areas are 40% less likely to have visited a dental health care worker than those in the least deprived areas, after adjusting for age, sex and ethnicity. In contrast, most children (84%) visited a dental health care worker in the last year, with little variation by neighbourhood deprivation. Rates for this measure have increased steadily since 2006/07 (when the rate was 76%).
- **Māori have poorer health and more unmet need for health care:** Māori adults have higher rates for most health conditions: most notably for diabetes, high blood pressure and asthma. Māori adults are 10% less likely than non-Māori adults to rate their health as good, very good or excellent, after adjusting for age and sex differences. Part of the reason for difference in health status may be barriers to accessing health care. Māori adults and children

are more likely than non-Māori to report one or more types of unmet need for health care, including being unable to get an appointment at a medical centre within 24 hours; not visiting a GP or after-hours service when they have a medical problem due to cost or a lack of transport.

- **Obesity and diabetes are major challenges for Pacific adults:** Pacific adults have high rates of obesity (67%) and diagnosed diabetes (9%) compared with non-Pacific adults. After adjusting for age and sex differences, the rates of Pacific adult obesity and diabetes are 2.5 times and 2.8 times the non-Pacific rates, respectively. Pacific children also have high levels of obesity (25%), which is likely to increase their risk of developing diabetes as adults.
- **Asian health is generally good, but diabetes is a concern:** overall, Asian adults are in good health. In particular, Asian adults have comparatively low rates of smoking, hazardous drinking, asthma, arthritis, chronic pain and diagnosed mood or anxiety disorders. However, Asian adults are about 1.8 times as likely to have been diagnosed with diabetes as non-Asians, after adjusting for age and sex differences. Asian adults generally report lower use of primary health services than other adults, possibly due to their better health status. They are also less likely to report unmet need for health care. Note that the Asian ethnic group is very diverse, and therefore caution should be employed in interpreting the data. For example, the health profile of Indians is different to that of Chinese. Furthermore, profiles differ within these Asian groups; for example, depending on whether people were born in New Zealand or in overseas countries.
- **People living in more deprived areas have poorer health and report greater unmet need for health care:** adults living in the most socioeconomically deprived areas have significantly higher levels of all health risks, including smoking, hazardous drinking, inadequate fruit and vegetable intake, low physical activity and obesity. They also have higher rates of psychological distress, diabetes, asthma and chronic pain.

Children living in socioeconomically deprived areas also have higher levels of most health risks. For example, they are more likely to watch two or more hours of television each day, and are more likely to be obese.

Although adults and children living in the most deprived areas report similar use of GPs over the last year to those living in the least deprived areas, they have much higher levels of unmet need for health care with cost being the main barrier. Adults and children living in the most deprived areas are more than three times as likely as those living in the least deprived areas to have not filled a prescription due to cost in the past year. These types of unmet need for health care are of particular concern where they affect people who are already in poor health. Higher rates of unmet need are likely to reflect greater need for health care due to worse health status in deprived areas.

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Introduction

Overview

The NZHS conducts face-to-face interviews with more than 13,000 adults and the parents/ caregivers of over 4000 children annually. The survey collects a wealth of information on the health and wellbeing of New Zealanders. Every year it includes a core set of questions, which help us identify key issues and monitor trends.

Here we present the annual update of key results from the 2013/14 NZHS. The report includes data for key survey indicators, which provide a snapshot of health behaviours, health status and access to health care for both adults and children. These key indicators help highlight at-risk groups and focus attention on important issues, as well as identifying areas for further research.

Data from the 2013/14 NZHS is made available in a range of formats to suit the needs of different users, including:

- an annual update of key findings (this report)
- adult and child online tables – detailed national results broken down by age, sex, ethnic group and deprivation (previous survey results are also provided for comparison)
- district health board (DHB) online tables of adult and child results for each of the 20 DHBs in New Zealand (pooled with data from previous surveys): this will be published in 2015
- an interactive mapping tool presenting key adult and child data for DHBs: this will be published in 2015.

The 2013/14 NZHS publications are intended to answer three questions for each indicator.

1 What is the rate in the total population?

- The report presents 2013/14 rates (and estimated numbers) for adults and children.

2 What is changing?

- Where available, we have presented 2006/07 and 2012/13 rates for the key survey indicators alongside current rates, allowing comparisons to be made over time. We have highlighted significant changes in the data boxes and in the text.
- Online tables provide more detailed trend data, including analyses by sex, age and ethnicity, alongside 2011/12 data.

3 Are the results the same for everyone? In particular, do indicators vary by sex, age, ethnicity or neighbourhood deprivation?

- We provide key survey indicators for Māori and Pacific people at the end of the adult and child sections of this report.
- We provide rate ratios comparing male to female, Māori to non-Māori, Pacific to non-Pacific and high-deprivation to low-deprivation areas for each key survey indicator. We have adjusted these rate ratios for differences in the age, sex and ethnic structure of the population groups being compared.

- We have summarised the age distribution of each indicator in a bar chart. The online tables provide detailed results by age group.
- Results by DHB will be made available in early 2015. Where there are sufficient survey respondents, this data will be presented by age and sex.

Methodology

Sample selection

The 2013/14 results provided in this report refer to the sample selected from 1 July 2013 to 30 June 2014. The survey results refer to the usually resident population of all ages living in permanent dwellings, aged-care facilities and student accommodation. Not included in the survey were: people living in institutions (such as for long-term hospital care, hospital- and dementia-level care in aged-care facilities, and in prisons), the homeless, short-term visitors and tourists. Trained surveyors from CBG Health Research Ltd randomly selected participants and carried out the survey interviews.

Sample size

Of those invited to participate in the survey, 80% of adults (13,309 adults) and 85% of parents/caregivers (representing 4699 children) agreed to be interviewed. The following table provides a summary of the number of survey respondents by ethnic group. Please note that the data in the table is based on total response ethnicity, and so when summed the total is greater than the total number of respondents. Appendix 1 provides further information on total response ethnicity.

Table 1: Sample sizes for children and adults, by ethnic group, NZHS 2013/14

Ethnic group (total response)	Adults	Children
European/Other	9897	3101
Māori	2837	1779
Pacific	802	677
Asian	1089	522

Interview process

Data collection involved a face to face interview, followed by measurement of height (in those aged two years and over), weight (in those aged two years and over), waist circumference (in those aged five years and over) and, in adults, blood pressure.

Annual indicators from the survey

Table 2 lists the annual indicators from the survey for adults and children. The annual indicators either pertain to single survey questions or are derived indicators based on a number of questions. This table provides brief definitions for each indicator presented in this report. The *Indicator Interpretation Guide 2013/14: New Zealand Health Survey* provides more detailed definitions, and reproduces the survey questions.

In addition to those included in this report, online tables include a number of supplementary indicators.

Table 2: Annual indicators from the survey

Topic	Adult indicator	Child indicator
Health status, health behaviours and risk factors	Good self-rated health <i>Self-rated health: full response breakdown</i> Current smoking Daily smoking <i>Ex-smokers</i> Hazardous drinking (total population) <i>Hazardous drinking (past-year drinkers)</i> <i>Current drinkers</i> Vegetable intake Fruit intake Physically active <i>Little or no physical activity</i> <i>Mean body mass index (BMI)</i> <i>Mean height, weight and waist</i> Obesity <i>Obese Class 1</i> <i>Obese Class 2</i> <i>Obese Class 3</i> <i>Overweight</i> <i>Healthy weight</i> <i>Underweight</i>	Good parent-rated health <i>Parent-rated health: full response breakdown</i> Given solid food before four months (four months to four years) <i>Fast food intake (2–14 years)</i> <i>Fizzy drink intake (2–14 years)</i> Eating breakfast at home every day (2–14 years) <i>Vegetable intake (2–14 years)</i> <i>Fruit intake (2–14 years)</i> Television watching (2–14 years) <i>Active travel (5–14 years)</i> <i>Mean BMI (2–14 years)</i> <i>Mean height and weight (2–14 years)</i> <i>Mean waist (5–14 years)</i> Obesity (2–14 years) <i>Obese Class 1 (2–14 years)</i> <i>Obese Class 2 or 3 (2–14 years)</i> <i>Overweight (2–14 years)</i> <i>Healthy weight (2–14 years)</i> <i>Thinness (2–14 years)</i>
Health conditions	High blood pressure (medicated) High cholesterol (medicated) Ischaemic heart disease (diagnosed) Stroke (diagnosed) Diabetes (diagnosed) Asthma (medicated) Arthritis (diagnosed) Chronic pain Mood or anxiety disorder (diagnosed) Psychological distress	Asthma (medicated) (2–14 years) <i>Eczema (medicated)</i> <i>Diabetes (diagnosed)</i> <i>Rheumatic heart disease (diagnosed)</i> Emotional and behavioural problems (diagnosed) (2–14 years) <i>Autism spectrum disorder (diagnosed) (2–14 years)</i>
Primary health care use	Visited a GP Visited a practice nurse Visited an after-hours medical centre	Visited a GP Visited a practice nurse Visited an after-hours medical centre
Barriers to accessing primary health care	Unmet need for primary health care Unable to get an appointment at usual medical centre within 24 hours Unmet need for GP services due to cost <i>Unmet need for GP services due to lack of transport</i> Unmet need for after-hours services due to cost <i>Unmet need for after-hours services due to lack of transport</i> Unfilled prescription due to cost Definitely had confidence and trust in GP	Unmet need for primary health care Unable to get an appointment at usual medical centre within 24 hours Unmet need for GP services due to cost <i>Unmet need for GP services due to lack of transport</i> Unmet need for after-hours services due to cost <i>Unmet need for after-hours services due to lack of transport</i> <i>Unmet need for GP services due to lack of childcare</i> Unfilled prescription due to cost Definitely had confidence and trust in GP
Oral health status and service use	Dental health care worker visit Teeth removed due to decay Usually only visits dental health care worker for dental problems (or never visits)	Dental health care worker visit (1–14 years) Teeth removed due to decay (1–14 years)

Note: Indicators in italics are included in online tables only.

Definitions and statistical methods

Appendix 1 provides information on the statistical methods used in this report.

Additional information

The following publications provide additional information about the NZHS:

- *Methodology Report 2013/14: New Zealand Health Survey*
- *Indicator Interpretation Guide 2013/14: New Zealand Health Survey*
- *Content Guide 2013/14: New Zealand Health Survey.*

How are the results reported?

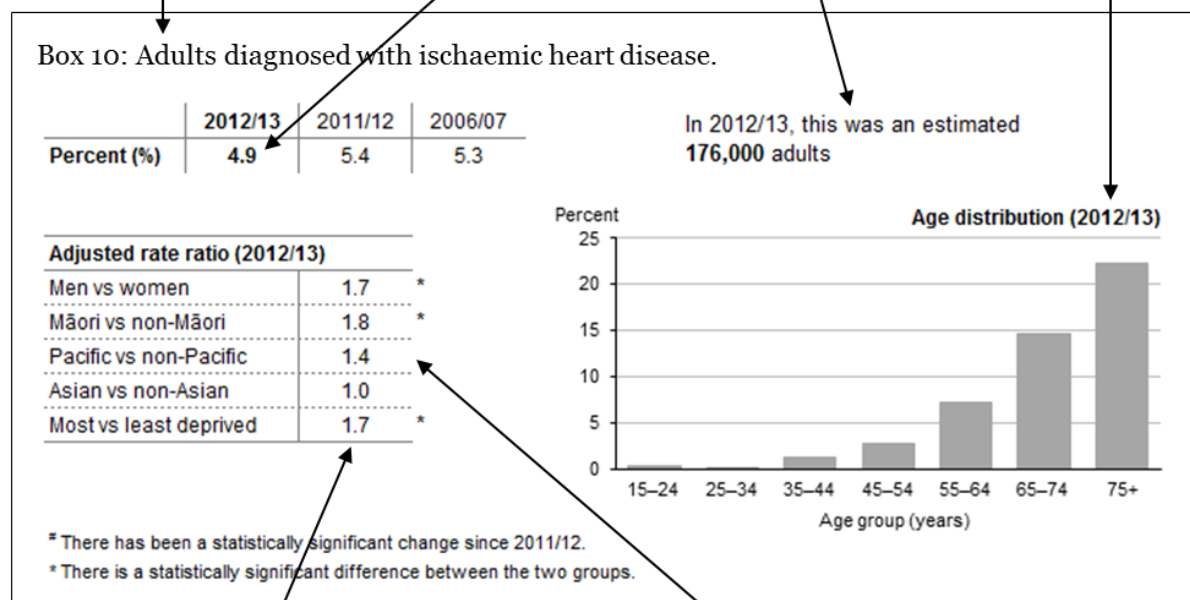
Results for each of the survey indicators are summarised in the format shown below.

A brief definition of the indicator is given in the box title (more detailed definitions can be found in the survey indicator interpretation guide).

Results are presented as the percentage of survey respondents.

An estimate is provided of the total number of New Zealanders who fell within this category in 2012/13.

This graph shows how the results differ with age.



Rate ratios are used to compare the results for different population groups. They tell us whether the results are more or less likely in the group of interest, as follows:

- a rate ratio above 1 = more likely
- a rate ratio of 1 = equally as likely
- a rate ratio less than 1 = less likely.

For example, the above data show that Māori are 1.8 times as likely than non-Māori to have ischaemic heart disease.

The rate ratios presented in this report have been adjusted for other demographic factors that may be influencing the comparison, such as age, sex and ethnic group.

- The sex comparison is adjusted for age.
- Ethnic comparisons are adjusted for age and sex.
- Deprivation comparisons are adjusted for age, sex and ethnic group.

We have adjusted the significance (*p*-values) of differences between years for differences in the age structures of the underlying populations over time. Statistical significance is measured at the 5% significance level (that is, a *p*-value less than 0.05).

The health of New Zealand adults

This section includes information on:

- health status, health behaviours and risk factors
- health conditions
- access to health care
- oral health
- key survey results for Māori adults
- key survey results for Pacific adults.

Table 3: Key survey results for adults (15 years and over)

Indicator	Percent 2013/14	Percent 2012/13	Percent 2006/07	Change since 2012/13	Change since 2006/07
Health status, health behaviours and risk factors					
Excellent, very good or good self-rated health	91.4	89.6	89.6	▲	▲
Current smoking	17.2	17.6	20.1	=	▼
Daily smoking	15.5	15.5	18.3	=	▼
Hazardous drinking	16.1	15.4	18.0	=	▼
Vegetable intake (3+ servings per day)	63.6	66.3	63.9	▼	=
Fruit intake (2+ servings per day)	56.8	58.2	59.9	=	▼
Physically active	51.4	51.6	52.0	=	=
Obesity ¹	29.9	30.6	26.5	=	▲
Health conditions					
High blood pressure (medicated)	15.9	15.9	13.8	=	▲
High cholesterol (medicated)	11.0	11.0	8.4	=	▲
Ischaemic heart disease (diagnosed)	4.6	4.9	5.3	=	▼
Stroke (diagnosed)	1.8	2.0	1.9	=	=
Diabetes (diagnosed)	5.5	5.8	5.1	=	=
Asthma (medicated)	11.0	11.0	11.8	=	=
Arthritis (diagnosed)	16.2	15.1	14.9	=	▲
Chronic pain	19.0	17.8	17.0	=	▲
Mood or anxiety disorder (diagnosed)	18.4	16.3	12.7	▲	▲
Psychological (mental) distress	6.2	6.1	6.6	=	=
Access to health care					
Visited a GP in the last 12 months	78.4	78.8	81.3	=	▼
Visited a practice nurse without seeing a GP at the same visit in the last 12 months	30.6	30.1	28.7	=	▲
Visited an after-hours medical centre in the last 12 months	10.9	12.0	.	=	.
Experienced one or more types of unmet need for primary health care in the last 12 months:	27.7	27.1	.	=	.
• Unable to get an appointment at usual medical centre within 24 hours	16.4	15.6	17.6	=	=
• Unmet need for GP due to cost	14.0	14.5	.	=	.
• Unmet need for after-hours services due to cost	6.9	7.1	.	=	.
Unfilled prescription due to cost	6.0	6.1	.	=	.
Definitely had confidence and trust in GP	80.5	81.4	.	=	.
Oral health					
Visited a dental health care worker in the last 12 months ²	49.7	47.5	51.5	▲	=
Had any teeth removed due to decay, an abscess, infection or gum disease in the last 12 months	6.9	6.8	.	=	.
Usually only visits a dental health care worker for dental problems (or never visits) ²	52.8	55.1	49.1	▼	▲

Key: ▲ Statistically significant increase³ = No statistically significant change
 ▼ Statistically significant decrease³ . Data not available

1 Revised from the *New Zealand Health Survey: Annual update of key findings 2012/13*.

2 Among adults with natural teeth.

3 The significance (*p*-values) of differences between years is based on age-standardised rates.

Health status, health behaviours and risk factors

Over 90% of adults report that they are in good health

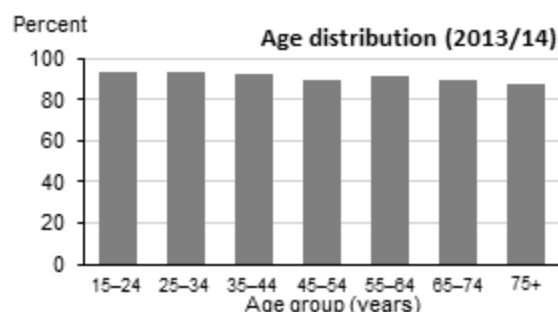
Box 1: Adults who rated their health as at least good (including excellent, very good or good)

	2013/14	2012/13	2006/07
Percent	91.4 [#]	89.6	89.6

In 2013/14 this was an estimated 3,268,000 adults

Adjusted rate ratio (2013/14)

Men vs women	1.0
Māori vs non-Māori	0.9 *
Pacific vs non-Pacific	0.9 *
Asian vs non-Asian	1.0 *
Most vs least deprived	0.9 *



There has been a statistically significant change since 2012/13.

|| There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

Self-rated health is a widely used indicator of health. The survey asked an internationally used question: 'In general, would you say your health is ... excellent, very good, good, fair, or poor?'. In this report, 'being in good health' means having good, very good or excellent health.

Nine out of ten adults (91%) were in good health; this figure is slightly greater than it was in 2012/13 (when the rate was 90%).

The percentage of adults in good health has increased for most age groups since 2006/07; most markedly among older people. A larger percentage of people aged 75 and over were in good health compared with 2006/07 (87% compared with 80%).[‡] Similarly, 89% of 65–74-year-olds were in good health in 2013/14, compared with 85% in 2006/07.

Māori and Pacific adults were slightly less likely (0.9 times) to be in good health compared with non-Māori and non-Pacific adults, after adjusting for age and sex differences.

Similarly, those living in the most deprived areas were slightly less likely (0.9 times) to be in good health compared with those living in the least deprived areas, after adjusting for age, sex and ethnic differences.

[‡] Results are available in the online tables accompanying this report.

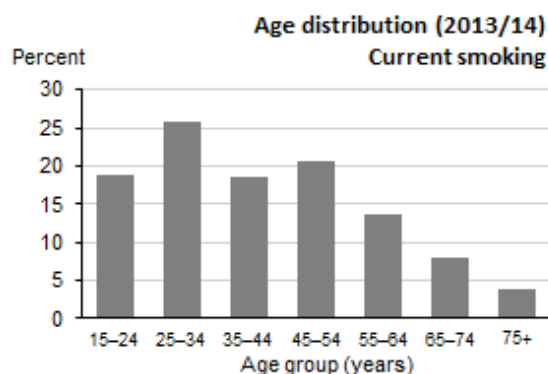
Māori smoking rates remain high

Box 2: Adults who are either current smokers (smoke at least monthly) or daily smokers

	2013/14	2012/13	2006/07
Current smoking %	17.2 [‡]	17.6	20.1
Daily smoking %	15.5 [‡]	15.5	18.3

In 2013/14 this was an estimated
615,000 current smokers

Adjusted rate ratio (2013/14)	
Current smoking	
Men vs women	1.2 *
Māori vs non-Māori	2.7 *
Pacific vs non-Pacific	1.3 *
Asian vs non-Asian	0.4 *
Most vs least deprived	3.5 *



‡ There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

Smoking was the leading modifiable risk to health in 2006, accounting for 9% of all illness, disability and premature mortality (Ministry of Health 2013a). 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 2013/14, 17% of adults were current smokers (smoke at least monthly), including 15% who smoked daily. One in four adults was an ex-smoker, around 897,000 adults.[‡]

Both current and daily smoking levels have decreased since 2006/07, when 20% of the population were current smokers, including 18% who were daily smokers.

Substantial reductions in youth current smokers (those aged 15–17 years) were observed in the 2011/12 NZHS (when the rate was 8%) compared to 2006/07 (when the rate was 16%).[‡] In 2013/14, low rates of smoking among 15–17 year olds continued (the rate, again, was 8%), in line with trends observed in the largest survey of youth smoking in New Zealand, the ASH Year 10 Snapshot Survey.

Current smoking rates peaked among adults aged 18–24 (of whom 24% smoke) and 25–34 (26%). The percentage of adults who were current smokers declined from age 55 years to 3.9% for adults aged 75 and over.

Māori adults were more likely to be current smokers than non-Māori, similar to 2006/07 (the latest and previous rates are 41% and 42% respectively).[†] Similarly, there was no significant difference in the percentage of Pacific adults who were current smokers (25%) compared with 2006/07 (27%). Asian adults had the lowest current smoking rate of any ethnic group, at 8%.[‡]

Adults living in the most deprived areas were 3.5 times as likely to be current smokers as adults in the least deprived areas, after adjusting for age, sex and ethnic differences.

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific adults are provided at the end of the adult section.

One-third of 18- to 24-year-olds drink alcohol to a level that is hazardous to their health

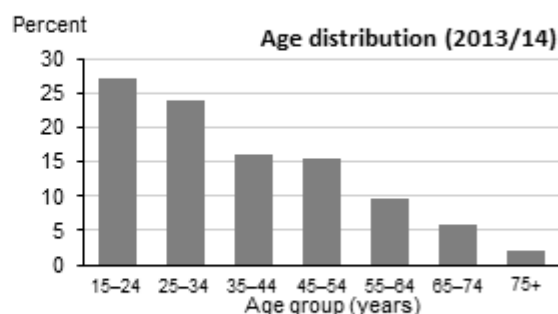
Box 3: Adults who are hazardous drinkers (score 8 or more on the Alcohol Use Disorders Identification Test)

	2013/14	2012/13	2006/07
Percent	16.1 [‡]	15.4	18.0

In 2013/14 this was an estimated 575,000 adults

Adjusted rate ratio (2013/14)

Men vs women	2.0	*
Māori vs non-Māori	1.9	*
Pacific vs non-Pacific	1.0	
Asian vs non-Asian	0.2	*
Most vs least deprived	1.4	*



‡ There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

Alcohol accounted for about 4% of total health loss in 2006 (Ministry of Health 2013a). Just over half (54%) of this impact was due to diseases (especially mental illness, such as alcohol use disorder); the remainder was due to injury. Hazardous drinking is defined as behaviour that results in a score of 8 points or more on the Alcohol Use Disorders Identification Test (AUDIT). ‘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.

Most adults (80%) consumed alcohol in the past 12 months.[‡] The percentage of adults who were hazardous drinkers (16%) was lower than it was in 2006/07 (18%). One in five adults (20%) who drank alcohol in the last year was a hazardous drinker.

Hazardous drinking patterns were more common among men (22%) than women (11%). The rate of hazardous drinking has declined for men: it was 26% in 2006/07.[‡] In comparison, although women were less likely to have a hazardous drinking pattern, there has been no change in their hazardous drinking rates since 2006/07.

Hazardous drinking rates peaked in the 18–24-year age group at 33%, dropping to 16% for those aged 35–54 years.[‡] The hazardous drinking rate for the 18–24-year age group was down from 43% in 2006/07. The rate of hazardous drinking in youth (aged 15–17 years) was 14%, down from 19% in 2006/07 (this decrease was not statistically significant). Despite improvements in hazardous drinking rates among younger people since 2006/07, there has been no significant improvement for adults aged over 24 years. In contrast, hazardous drinking rates have steadily increased for adults aged 45–54 years, from 12% in 2006/07 to 16% in 2013/14.[‡]

Nearly one-third of all Māori adults (30%) were hazardous drinkers.[†] After adjusting for age and sex differences, Māori adults were nearly twice as likely to drink at hazardous levels as non-Māori. By contrast, Asian adults were 80% less likely to be hazardous drinkers than non-Asian adults, after adjusting for age and sex differences.

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific adults are provided at the end of the adult section.

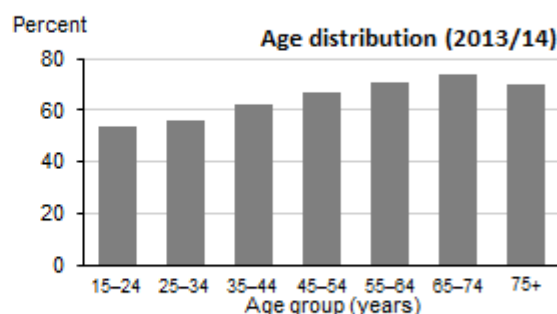
Young people are less likely to meet recommendations for vegetable intake

Box 4: Adults who eat at least three servings of vegetables per day, as recommended by the Ministry of Health

	2013/14	2012/13	2006/07
Percent	63.6 [#]	66.3	63.9

In 2013/14 this was an estimated
2,274,000 adults

Adjusted rate ratio (2013/14)		
Men vs women	0.9	*
Māori vs non-Māori	1.0	
Pacific vs non-Pacific	0.7	*
Asian vs non-Asian	0.8	*
Most vs least deprived	0.8	*



[#] There has been a statistically significant change since 2012/13.

* There is a statistically significant difference between the two groups.

Eating plenty of vegetables and fruit can help protect against major diseases like heart disease, stroke, high blood pressure and some cancers. Ministry of Health nutrition guidelines recommend eating at least three servings of vegetables and at least two servings of fruit per day for good health.

Approximately two-thirds of adults (64%) ate at least three servings of vegetables per day.

Women were more likely to eat at least three servings of vegetables per day than men (the rates were 67% and 60% respectively).[‡]

The percentage of adults that ate at least three servings of vegetables increased with age. Only 54% of 15- to 24-year-olds ate at least three servings of vegetables per day, compared with 74% of 65–74-year-olds.

Pacific and Asian adults were less likely to eat at least three servings of vegetables per day than non-Pacific and non-Asian adults. Less than half of Pacific and Asian adults ate at least three servings of vegetables per day (the rates were 45% and 49% respectively).[‡]

Adults living in the most deprived areas were less likely to eat at least three servings of vegetables per day compared with adults living in the least deprived areas (the rates were 54% and 68% respectively).[‡] Adults in the most deprived areas were 20% less likely to eat at least three servings of vegetables per day as adults living in the least deprived areas, after adjusting for age, sex and ethnic differences.

[‡] Results are available in the online tables accompanying this report.

Women are less likely to meet recommendations for fruit intake than in previous years

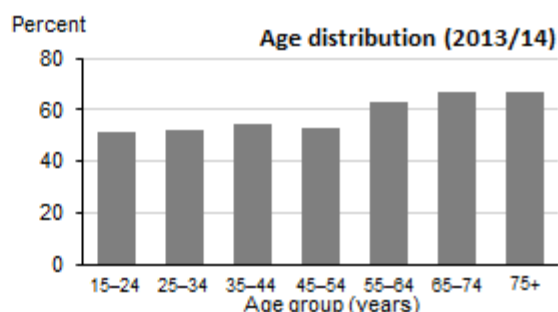
Box 5: Adults who eat at least two servings of fruit per day, as recommended by the Ministry of Health

	2013/14	2012/13	2006/07
Percent	56.8 [‡]	58.2	59.9

In 2013/14 this was an estimated 2,030,000 adults

Adjusted rate ratio (2013/14)

Men vs women	0.8	*
Māori vs non-Māori	0.8	*
Pacific vs non-Pacific	0.9	*
Asian vs non-Asian	1.0	
Most vs least deprived	0.8	*



‡ There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

As outlined previously, eating plenty of vegetables and fruit can help protect against major diseases like heart disease, stroke, high blood pressure and some cancers. Ministry of Health nutrition guidelines recommend eating at least three servings of vegetables and at least two servings of fruit per day for good health.

Fifty-seven percent of adults ate at least two servings of fruit per day; women were more likely to do so than men (the rates were 62% and 52% respectively).[‡]

The percentage of adults who ate at least two servings of fruit per day has decreased since 2006/07, from 60% to 57%. The decline is due to a decrease in the percentage of women who ate at least two servings of fruit per day, from 69% in 2006/07 to 64% in 2012/13 and 62% in 2013/14.[‡] There was no change for men over the same period.

Only 51% of 15–24-year-olds ate at least two servings of fruit per day. The percentage of adults who ate at least two servings of fruit per day increased with age: 63% of 55–64-year-olds ate at least two servings of fruit per day.

Less than half of Māori and Pacific people ate at least two servings of fruit per day (the rates are 47% and 49% respectively).[†] The percentage of Māori adults who ate at least two servings of fruit per day, declined from 55% in 2006/07 to 47% in 2013/14. Similarly, there has been a decline in the percentage of Pacific adults eating at least two servings of fruit per day, from 59% in 2006/07 to 49% in 2013/14.

Adults living in the most deprived areas were less likely to eat at least two servings of fruit per day compared with adults living in the least deprived areas (the rates are 48% and 64% respectively).[‡] After adjusting for age, sex and ethnic differences, adults living in the most deprived areas were 20% less likely to eat at least two servings of fruit per day.

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific adults are provided at the end of the adult section.

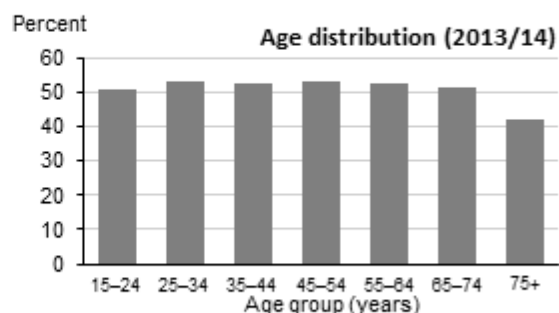
One in two adults are physically active

Box 6: Adults who were physically active for at least 30 minutes on five or more days in the last week

	2013/14	2012/13	2006/07
Percent	51.4	51.6	52.0

In 2013/14 this was an estimated
1,839,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	1.1 *
Māori vs non-Māori	1.0
Pacific vs non-Pacific	0.9 *
Asian vs non-Asian	0.8 *
Most vs least deprived	0.8 *



* There is a statistically significant difference between the two groups.

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 and preventing and reducing obesity. Physical activity is defined as any musculoskeletal movement that requires energy expenditure above resting level. It includes deliberate exercise (eg, running and sports) that are planned, structured and repetitively performed; activities of daily living (eg, housework); work-related activity; and active transport. Low physical activity accounted for about 4% of all illness, disability and premature mortality in 2006 (Ministry of Health 2013a).

The Ministry of Health recommends that adults do at least 30 minutes of moderate-intensity physical activity (eg, brisk walking) at least five days per week. In this report, being physically active is defined as meeting this recommendation. Note: for children and young people, the Ministry of Health recommends at least 60 minutes of physical activity every day.

About half of all adults (51%) were physically active. There was little variation by age group; at least one in two adults was physically active until age 75 years. Less than half (42%) of those aged 75 years and older were physically active.

Overall, the percentage of adults who were physically active has remained relatively constant since 2006/07, for both men and women. However, trends varied by age group. Since 2006/07, physical activity levels have declined for younger adults (those aged 15–24 years), from 56% to 51%[‡]. In the same period, the percentage of physically active adults aged 75 years and older increased from 34% to 42%.

Asian and Pacific adults were less likely to be physically active than non-Asian adults and non-Pacific adults (20% and 10% less respectively), after adjusting for age and sex differences.

People living in the most deprived areas were 20% less likely to have been physically active than those in the least deprived areas, after adjusting for age, sex and ethnic differences.[‡]

Fourteen percent of adults had done little or no physical activity (less than 30 minutes in total) in the seven days prior to being surveyed: a higher percentage than in 2006/07 (10%).[‡]

[‡] Results are available in the online tables accompanying this report.

Three in ten adults are obese

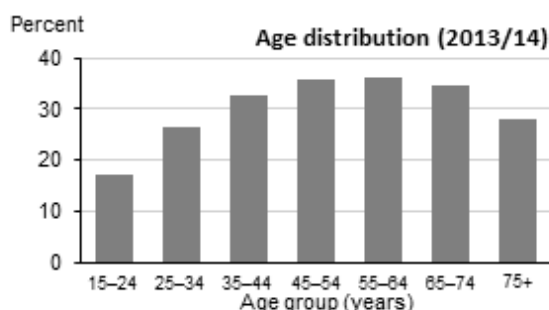
Box 7: Adults who are obese, with a measured BMI of 30 or more (or equivalent for <18 years)

	2013/14	2012/13 [♢]	2006/07
Percent	29.9	30.6	26.5

In 2013/14 this was an estimated
1,069,000 adults

Adjusted rate ratio (2013/14)

Men vs women	1.0
Māori vs non-Māori	1.8 *
Pacific vs non-Pacific	2.5 *
Asian vs non-Asian	0.5 *
Most vs least deprived	1.8 *



^{||} There has been a statistically significant change since 2006/07.

[♢] Revised from the statistic first published in *New Zealand Health Survey: Annual update of key findings 2012/13*, due to correcting the truncation of height measurements to the next lowest centimetre during data transfer.

* There is a statistically significant difference between the two groups.

Excess weight is a leading contributor to a number of health conditions, including type 2 diabetes, cardiovascular diseases, some types of cancer (eg, kidney and uterus), osteoarthritis, gout, sleep apnoea, some reproductive disorders and gallstones. High BMI accounted for 8% of all illness, disability and premature mortality in 2006, making it the second leading cause of health loss after smoking. Obesity is defined as a BMI of 30 or more (or equivalent for those younger than 18 years). Survey interviewers measured respondents' height and weight, from which BMI is calculated.

Three in ten adults (30%, equating to 1,069,000 adults) were obese in 2013/14; this figure was similar in 2012/13.

The obesity rate peaked in middle-aged adults (those aged 45–64 years) at 36%, dropping to 28% for those aged 75 years and over.

Obesity rates were highest in Pacific adults (67%).[†] Rates of obesity were also high among Māori adults, among whom almost half (46%) were obese. In contrast, only one in seven Asian adults was obese (14%).[‡]

Obesity was positively associated with neighbourhood deprivation. Forty-four percent of adults living in the most deprived areas were obese, compared with 21% in the least deprived areas. [‡]

[†] Results for Māori and Pacific adults are provided at the end of the adult section.

[‡] Results are available in the online tables accompanying this report.

Health conditions

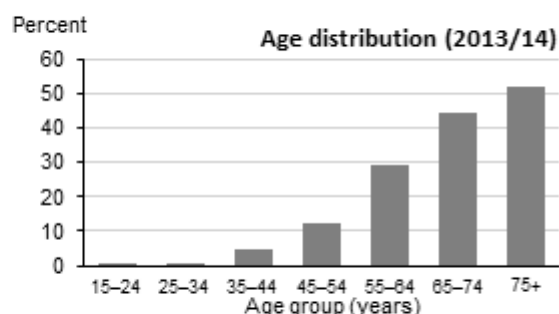
One in six adults has high blood pressure and is taking medication to treat it

Box 8: Adults diagnosed with high blood pressure and currently taking medication for this condition (excludes pregnant women)

	2013/14	2012/13	2006/07
Percent	15.9	15.9	13.8

In 2013/14 this was an estimated
567,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	1.0
Māori vs non-Māori	1.4 *
Pacific vs non-Pacific	1.4 *
Asian vs non-Asian	1.1
Most vs least deprived	1.4 *



^{||} There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

High blood pressure (also called hypertension) can damage the heart and kidneys. It can also lead to ischaemic heart disease, stroke and kidney (renal) failure. High blood pressure accounted for 6% of illness, disability and premature mortality in 2006 (Ministry of Health 2013a).

One in six adults (16%) had high blood pressure (medicated), up from 14% in 2006/07.*

High blood pressure (medicated) rates increased steeply with age; over half of adults aged 75 years and over (52%) were affected.‡

Both Māori and Pacific adults were 1.4 times as likely as non-Māori and non-Pacific adults to have high blood pressure (medicated), after adjusting for age and sex differences.

Adults living in the most deprived areas were 1.4 times as likely as other adults to have high blood pressure (medicated) than those in the least deprived areas, after adjusting for age, sex and ethnic differences.

Note: the NZHS has historically collected self-reported information on high blood pressure as is presented above. From 2012/13 the survey included measured blood pressure. In 2015 the Ministry of Health plans to produce a separate report examining measured blood pressure results from the 2012/13 and 2013/14 surveys.

* This may partly reflect the introduction of the health target 'Better diabetes and cardiovascular services' in 2009. From 1 January 2012, the target was called 'More heart and diabetes checks'.

‡ Results are available in the online tables accompanying this report.

One in three older adults has high cholesterol and is taking medication to treat it

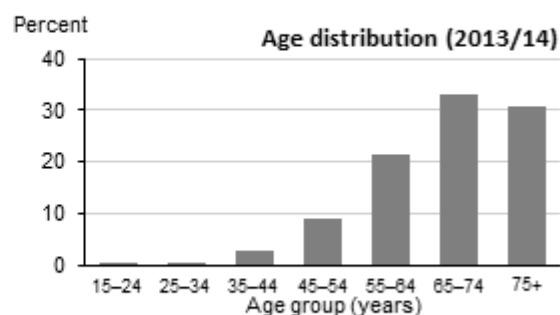
Box 9: Adults diagnosed with high cholesterol and currently taking medication for this condition

	2013/14	2012/13	2006/07
Percent	11.0 [¶]	11.0	8.4

In 2013/14 this was an estimated 392,000 adults

Adjusted rate ratio (2013/14)

Men vs women	1.4
Māori vs non-Māori	1.2
Pacific vs non-Pacific	1.3
Asian vs non-Asian	1.1
Most vs least deprived	1.2



¶ There has been a statistically significant change since 2006/07.

High blood cholesterol increases a person's risk of developing ischaemic heart disease and ischaemic stroke. High blood cholesterol accounted for 3% of illness, disability and premature mortality in 2006 (Ministry of Health 2013a).

About 392,000 adults (11%) had been diagnosed with high cholesterol (medicated), up from 8% in 2006/07.*

The rate of high cholesterol (medicated) increased steeply with age, and peaked at one in three adults aged 65–74 years (33%).

High cholesterol (medicated) rates have increased for European/Other adults and Māori adults since 2006/07 (increasing from 9% to 12% and 5% to 9%, respectively).‡

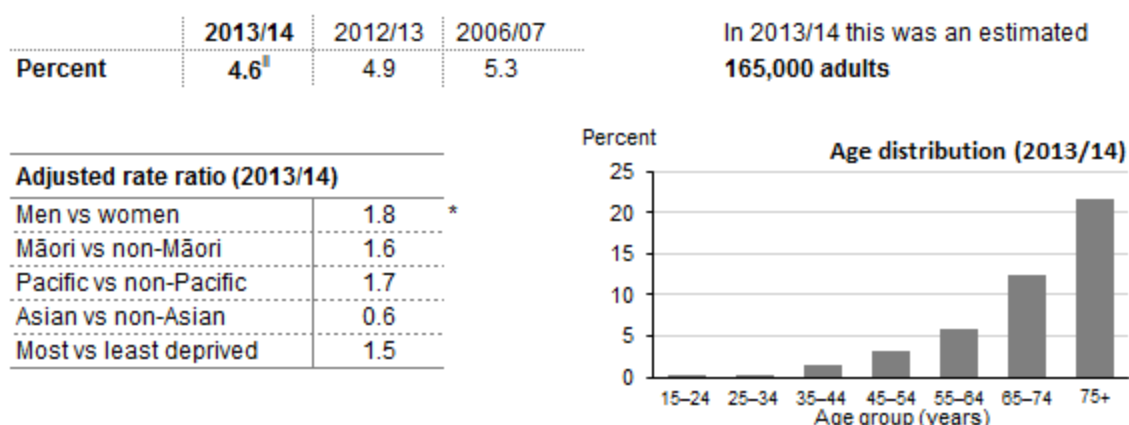
In 2014/15, for the first time, the NZHS measured blood cholesterol levels in a sub-sample of adults. The Ministry of Health plans to produce a separate report examining measured cholesterol results in 2016.

* This may partly reflect the introduction of the health target 'Better diabetes and cardiovascular services' in 2009. From 1 January 2012, the target was called 'More heart and diabetes checks'.

‡ Results are available in the online tables accompanying this report.

Ischaemic heart disease rates are falling for older adults

Box 10: Adults diagnosed with ischaemic heart disease



‡ There has been a statistically significant change since 2006/07.

Ischaemic heart disease (also known as coronary heart disease) mortality rates fell by about 70% between 1980 and 2010 (Ministry of Health 2013b). Coronary heart disease was the leading cause of health loss in 2006, accounting for 9% of illness, disability and premature mortality (Ministry of Health 2013a).

In this report, a person is defined as having ischaemic heart disease if they have been admitted to hospital with a heart attack at some time in their life, or if they have been diagnosed with angina (typically temporary chest pain while doing exercise) by a doctor.

In 2013/14, nearly one in 20 adults (4.6%) reported that they had been diagnosed with ischaemic heart disease, down from 5.3% in 2006/07.

Six percent of men had ischaemic heart disease, compared with 3% of women. ‡ Men were 1.8 times more likely than women to have ischaemic heart disease, after adjusting for age differences.

Older people were much more likely to have ischaemic heart disease: 22% of those aged 75 years and over were affected.

The percentage of adults with ischaemic heart disease has fallen for those aged 65–74 years, from 18% in 2006/07 to 12% in 2013/14.‡

‡ Results are available in the online tables accompanying this report.

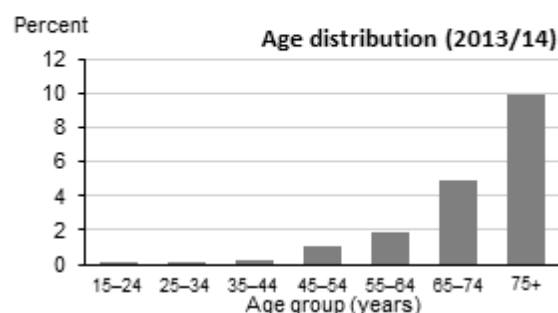
One in ten adults aged 75 years and over has had a stroke

Box 11: Adults diagnosed as having had a stroke, excluding transient ischaemic attacks

	2013/14	2012/13	2006/07
Percent	1.8	2.0	1.9

In 2013/14 this was an estimated
64,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	1.2
Māori vs non-Māori	1.8
Pacific vs non-Pacific	0.7
Asian vs non-Asian	1.1
Most vs least deprived	3.0



After a stroke, many people recover well; however, some may be permanently disabled or die. Stroke accounted for 4% of illness, disability and premature mortality in 2006 (Ministry of Health 2013a).

In this report, a person is defined as having had a stroke if a doctor has told them at some time in their life that they have had a stroke (this excludes transient ischaemic attacks, which are sometimes referred to as mini-strokes).

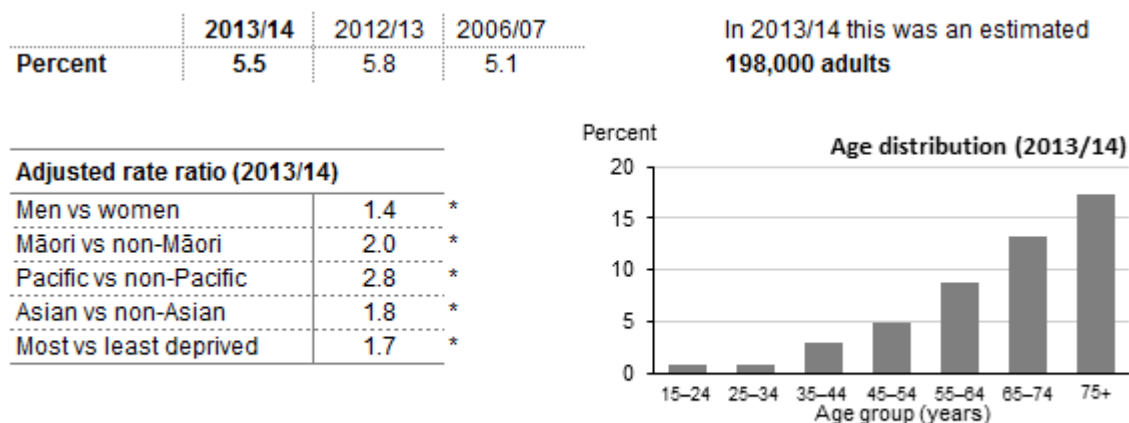
About 64,000 adults (1.8%) report having had a stroke during their lifetime. Older people were more likely to have had a stroke than those in younger age groups. One in ten adults aged 75 years and over (10%) reported having had a stroke. Nevertheless, over half of adults who have had a stroke (37,000 adults) were less than 75 years.‡

While not statistically significant, adults living in the most deprived areas were three times as likely to have had a stroke as those living in the least deprived areas.

‡ Results are available in the online tables accompanying this report.

Pacific, Māori and Asian adults are more likely to have diabetes

Box 12: Adults diagnosed with diabetes, excluding diabetes in pregnancy



* There is a statistically significant difference between the two groups.

Diabetes can cause kidney disease, vision loss and nerve damage, and may eventually require amputation of a foot or lower leg. It can lead to other health conditions, such as heart disease and stroke. Diabetes accounted for 3% of all illness, disability and premature mortality in 2006 (Ministry of Health 2013a).

In this report the term ‘diagnosed with diabetes’ refers to people who reported that a doctor has told them at some time in their life that they have diabetes. Around 198,000 adults (6%) have diabetes. Men were more likely to have diabetes than women (the rates were 6.3% and 4.8% respectively).[‡]

The rate of diabetes increased with age. More than one in ten adults aged 65 years and over had been diagnosed with diabetes.

Diabetes rates were high among Pacific, Māori and Asian adults (the rates were 9%, 7% and 6% respectively).[‡]

The rate of diabetes was 7.9% for adults living in the most deprived areas; this figure was much higher than for adults living in the least deprived areas (4.9%).[‡]

According to the Ministry of Health’s Virtual Diabetes Registry (VDR), 241,381 adults (aged 15 years and over) had diabetes as at December 2013. The VDR shows that Indian, Pacific and Māori adults have higher rates of diagnosed diabetes than other ethnic groups.

The NZHS diabetes estimate is lower than the number of entries in the VDR, possibly because people may be unaware of their diagnosis or deny it. Note that both the VDR and the NZHS results underestimate the true prevalence of diabetes, because they do not include undiagnosed diabetes.

[‡] Results are available in the online tables accompanying this report.

One in nine adults has asthma and is taking medication to treat it

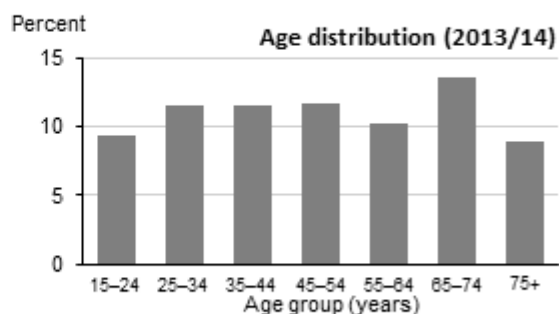
Box 13: Adults diagnosed with asthma and currently taking medication for this condition

	2013/14	2012/13	2006/07
Percent	11.0	11.0	11.3

In 2013/14 this was an estimated
393,000 adults

Adjusted rate ratio (2013/14)

Men vs women	0.6	*
Māori vs non-Māori	1.4	*
Pacific vs non-Pacific	1.0	
Asian vs non-Asian	0.5	*
Most vs least deprived	1.5	*



* There is a statistically significant difference between the two groups.

In this report, the term ‘diagnosed with asthma’ refers to people who reported that a doctor has told them that they have asthma and that they were currently taking medication to treat it. Medication can be taken daily to prevent symptoms, or only when needed to relieve symptoms.

The asthma (medicated) rate has remained stable since 2006/07, at 11% of adults.

Women were more likely to have asthma (medicated) than men (the rates were 13% and 8% respectively).[‡] After adjusting for age, women were 40% more likely to have asthma than men. This sex-related disparity was reversed for children: girls were less likely to have asthma (medicated) than boys (see page 46).

Asthma rates vary by ethnic group. Fourteen percent of Māori have asthma (medicated), compared with 5% of Asians.[‡] After adjusting for age and sex differences, Māori were 40% more likely to have asthma (medicated) than non-Māori, and Asians were half as likely to have asthma (medicated) as non-Asians.

Adults living in the most deprived areas were more likely to have asthma (medicated) than adults in the least deprived areas (the rates were 13% and 10% respectively).[‡] After adjusting for age, sex and ethnic differences, adults in the most deprived areas were 1.5 times as likely to have asthma (medicated) as those in the least deprived areas.

[‡] Results are available in the online tables accompanying this report.

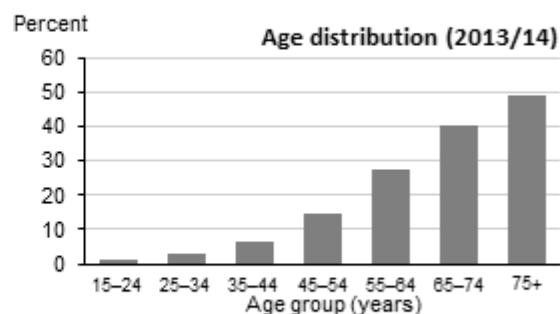
Half of adults aged 75 years and over have arthritis

Box 14: Adults diagnosed with arthritis, including osteoarthritis, rheumatoid arthritis, gout, lupus and psoriatic arthritis

	2013/14	2012/13	2006/07
Percent	16.2 [‡]	15.1	14.9

In 2013/14 this was an estimated
578,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	0.9 *
Māori vs non-Māori	1.3 *
Pacific vs non-Pacific	1.3 *
Asian vs non-Asian	0.5 *
Most vs least deprived	1.2



‡ There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

There are many different types of arthritis, which can affect people of any age. Chronic (long-term) arthritis can result in long-lasting pain and deformity, and is a major cause of disability in older people. Together osteoarthritis and rheumatoid arthritis accounted for 3% of all illness, disability and premature mortality in 2006 (Ministry of Health 2013a).

In this report, the term ‘diagnosed with arthritis’ refers to people who reported that a doctor has told them at some time in their life that they have any type of arthritis, including osteoarthritis, rheumatoid arthritis, gout, lupus and psoriatic arthritis.

About 578,000 people, or one in six adults (16%), have been diagnosed with arthritis. Women were 10% more likely to have arthritis than men, after adjusting for age differences.

The rate of arthritis increased steeply with age, with about half of adults aged 75 years and over (49%) affected.

Arthritis rates vary by ethnicity. Although the observed rate was highest for the European/Other group (18%), when age and sex were adjusted for, both Māori and Pacific adults were 1.3 times more likely to have arthritis than non-Māori or non-Pacific adults.[‡]

Only 5% of Asian adults have been diagnosed with arthritis.[‡] Asian adults were half as likely to have arthritis as non-Asian adults, after adjustment for age and sex.

[‡] Results are available in the online tables accompanying this report.

One in five adults experience chronic pain

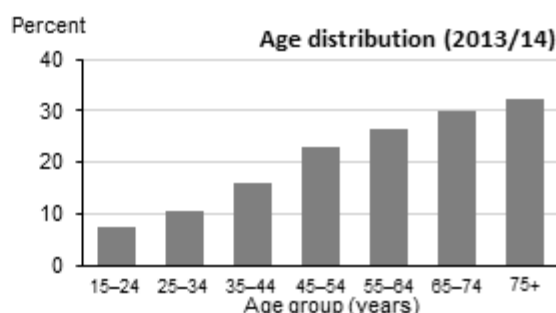
Box 15: Adults with chronic pain

	2013/14	2012/13	2006/07
Percent	19.0 [‡]	17.8	17.0

In 2013/14 this was an estimated 679,000 adults

Adjusted rate ratio (2013/14)

Men vs women	1.0
Māori vs non-Māori	1.2 *
Pacific vs non-Pacific	0.9
Asian vs non-Asian	0.7 *
Most vs least deprived	1.5 *



‡ There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

Chronic pain can be debilitating, and affect a person's ability to carry out their usual activities.

In this report, 'chronic pain' is self-reported, and is defined as pain that is present almost every day and has lasted, or is expected to last, more than six months.

About one in five adults (19%) had experienced chronic pain.

The percentage of adults who experienced chronic pain (19%) has increased since 2006/07 (17%).

Rates of chronic pain increase with age; almost one-third of adults aged 75 years and over (32%) were affected.

Prevalence of chronic pain varies by ethnicity. One in nine Asian adults (11%) experienced chronic pain; ‡ Asian adults were 30% less likely to experience chronic pain than non-Asians, after adjusting for age and sex differences. In contrast, Māori adults were 20% more likely to experience chronic pain than non-Māori, after adjusting for age and sex differences.

The rate of chronic pain was positively associated with neighbourhood deprivation. About one in five adults (21%) living in the most deprived areas experienced chronic pain, compared with one in six (16%) of those living in the least deprived areas.‡ Those living in the most deprived areas were 50% more likely to experience chronic pain than those in the least deprived areas after adjusting for age and sex.

‡ Results are available in the online tables accompanying this report.

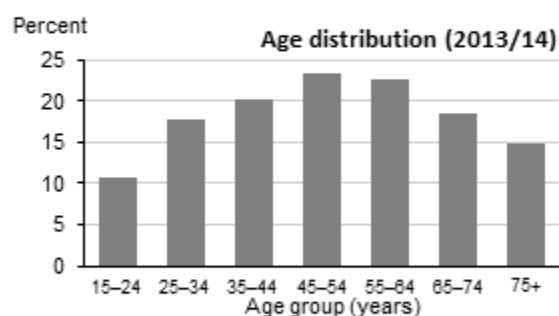
The rate of diagnosed mood and anxiety disorders is rising

Box 16: Adults diagnosed with a mood disorder (depression or bipolar disorder) and/or anxiety disorder

	2013/14	2012/13	2006/07
Percent	18.4 [#]	16.3	12.7

In 2013/14 this was an estimated 659,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	0.6 *
Māori vs non-Māori	1.0
Pacific vs non-Pacific	0.5 *
Asian vs non-Asian	0.4 *
Most vs least deprived	1.4 *



There has been a statistically significant change since 2012/13.

|| There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

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 and depressive disorders accounted for 5% of all illness, disability and premature mortality in 2006 (Ministry of Health 2013a).

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

Eighteen percent of adults have been diagnosed with a mood disorder and/or anxiety disorder at some time in their life; this figure has increased since 2006/07 (when it was 13%).

Women were more likely to have been diagnosed with a mood and/or anxiety disorder than men (the rates were 23% and 13% respectively). ‡ After adjusting for age differences, women were nearly twice as likely as men to have ever been diagnosed with a mood and/or anxiety disorder.

The prevalence of diagnosed mood and/or anxiety disorders was lowest for the youngest and oldest age groups (those aged 15–24 years and 75 years and over respectively). The relatively low prevalence in older adults may reflect changes in practice 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.

The prevalence of diagnosed mood and/or anxiety disorders was lower among Pacific and Asian adults (the rates were 9% and 7% respectively).‡ Pacific and Asian adults were about half as likely as non-Pacific and non-Asians to have ever been diagnosed with a mood and/or anxiety disorder. In contrast, Pacific adults were 2.1 times as likely as non-Pacific adults to have a high probability of having an anxiety or depressive disorder (see page 24).

‡ Results are available in the online tables accompanying this report.

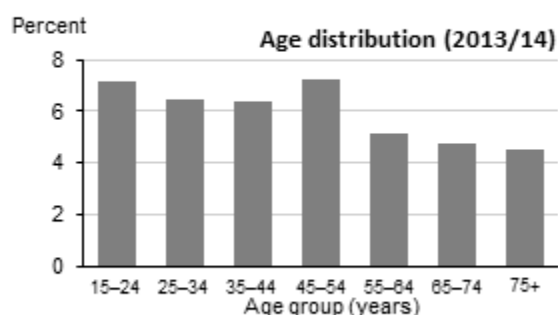
One in eight Pacific adults has a high probability of having an anxiety or depressive disorder

Box 17: Adults experiencing psychological distress in the last four weeks; that is, scoring 12 or over on the Kessler Psychological Distress Scale

	2013/14	2012/13	2006/07
Percent	6.2	6.1	6.6

In 2013/14 this was an estimated
221,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	0.7 *
Māori vs non-Māori	1.6 *
Pacific vs non-Pacific	2.1 *
Asian vs non-Asian	0.7 *
Most vs least deprived	1.7 *



* There is a statistically significant difference between the two groups.

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 (ie, a score of 12 or more) in the last four weeks.

Six percent of adults experienced psychological distress in the last four weeks. Men were less likely to have experienced psychological distress than women (the rates were 5% and 7% respectively).[‡] Women were 30% more likely to have experienced psychological distress than men, after adjusting for age differences.

Pacific and Māori adults were more likely to have experienced psychological distress (the rates were 13% and 9% respectively).[†] After adjusting for age and sex differences, Pacific adults were 2.1 times as likely to have experienced psychological distress as non-Pacific adults, and Māori adults were 1.6 times as likely to have experienced psychological distress as non-Māori adults.

The prevalence of psychological distress was higher in the most deprived neighbourhoods. Those living in the most deprived areas were 1.7 times as likely to have experienced psychological distress as those in 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.

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific adults are provided at the end of the adult section.

Access to health care

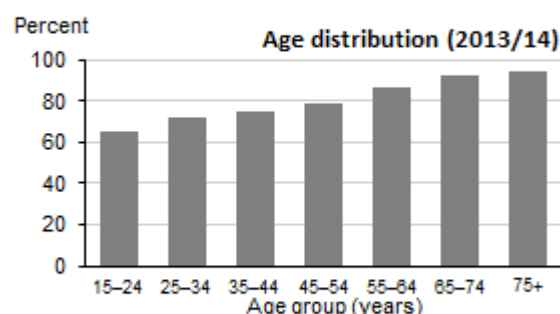
Most adults have visited a GP in the last 12 months

Box 18: Adults who have visited a GP in the last 12 months

	2013/14	2012/13	2006/07
Percent	78.4 [‡]	78.8	81.3

In 2013/14 this was an estimated
2,804,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	0.9 *
Māori vs non-Māori	1.0 *
Pacific vs non-Pacific	1.0
Asian vs non-Asian	0.9 *
Most vs least deprived	1.0



‡ There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

Most New Zealanders (95%) are enrolled with a primary health organisation (PHO) that is funded by their local DHB to provide general practice and other primary care services. Additional funding is provided to meet the health needs of high-risk patients and to lower the cost of accessing services. PHO enrolment information shows that 84% of enrolled adults (those aged 15 years and over) had a consultation with a health practitioner (eg, a GP or practice nurse) in the last 12 months (or since May 2013), equating to 80% of the total population.

The percentage of adults who have visited a GP in the last 12 months (78%) was lower than it was in 2006/07 (when it was 81%). This decline was primarily due to a fall in the percentage of men visiting their GP: from 78% in 2006/07 to 73% in 2013/14.[‡]

Young men were the least likely to have visited a GP. Only 56% of men aged 15–24 years and 63% of men aged 25–34 years visited a GP in 2013/14.[‡]

Older people were more likely to have visited a GP in the last 12 months than younger people: more than 90% of adults aged 65 years and over have visited a GP in the last 12 months.

There was no difference in the likelihood of a person having visited a GP in the last 12 months by neighbourhood deprivation, after adjusting for age, sex and ethnic differences.

‡ Results are available in the online tables accompanying this report.

Half of all adults aged over 65 years have visited a practice nurse in the last 12 months

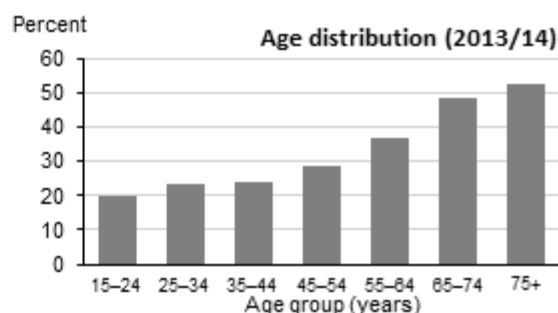
Box 19: Adults who have visited a practice nurse in the last 12 months without seeing a GP at the same visit

	2013/14	2012/13	2006/07
Percent	30.6 [‡]	30.1	28.7

In 2013/14 this was an estimated
1,093,000 adults

Adjusted rate ratio (2013/14)

Men vs women	0.7	*
Māori vs non-Māori	1.1	
Pacific vs non-Pacific	0.8	*
Asian vs non-Asian	0.6	*
Most vs least deprived	1.0	



[‡] There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

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 families.

The percentage of adults who visited a practice nurse in the last 12 months without seeing a GP remained stable between 2011/12 (when it was 30%) and 2013/14 (when it was 31%), although higher than in 2006/07 (when it was 29%).[‡]

Women were more likely to have visited a practice nurse in the last 12 months than men (the rates were 37% and 24% respectively).[‡] After adjusting for age, women were 30% more likely than men to have visited a practice nurse without seeing a GP at the same visit. This sex disparity was most pronounced for adults under 45 years (reflecting the health care needs of women of childbearing age).

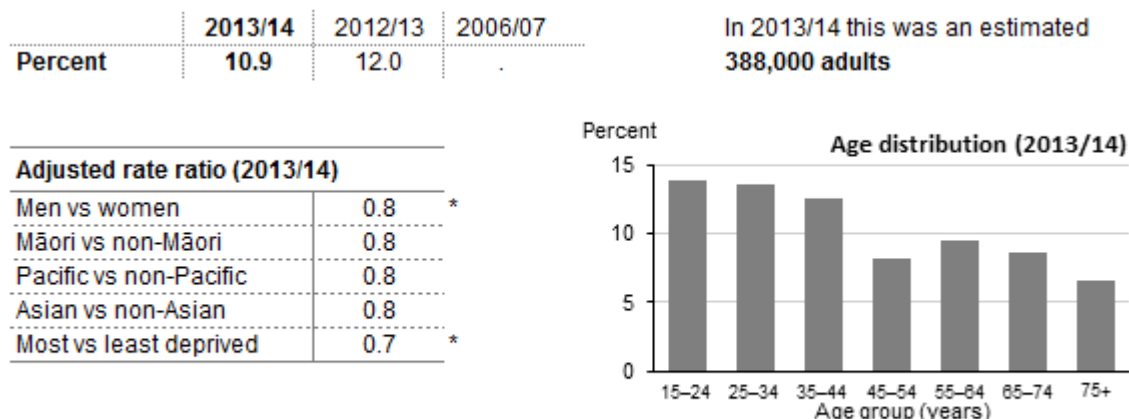
Visits to a practice nurse for all adults increased with age. Over half (52%) of those aged 75 years and over have seen a practice nurse without seeing a GP at the same visit in the last 12 months.

Asian adults (16%) and Pacific adults (21%) were less likely than Māori (29%) or those in the European/Other (34%) ethnic group to have visited a practice nurse in the last 12 months without seeing a GP at the same visit.[‡] After adjusting for age and sex, Asian adults were 40% less likely than non-Asian adults, and Pacific adults were 20% less likely than non-Pacific adults, to have visited a practice nurse without seeing a GP at the same visit.

[‡] Results are available in the online tables accompanying this report.

Younger adults are more likely to have visited an after-hours medical centre in the last 12 months

Box 20: Adults who have visited an after-hours medical centre in the last 12 months



* There is a statistically significant difference between the two groups.

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 nine adults (11%) had visited an after-hours medical centre in the last 12 months. Men were less likely than women to have visited an after-hours medical centre (the rates were 9% and 12% respectively).‡

The percentage of adults who had visited an after-hours medical centre in the last 12 months decreased with age. One in seven 15–24-year-olds (14%) had visited an after-hours medical centre in the last 12 months, compared with less than 10% of those aged 45 years and over.

Adults from the most deprived areas were 30% less likely to have visited an after-hours medical centre than those in least deprived areas, after adjusting for age, sex and ethnic differences.

‡ Results are available in the online tables accompanying this report.

Rates of unmet need for primary health care are highest for 25- to 54-year-olds

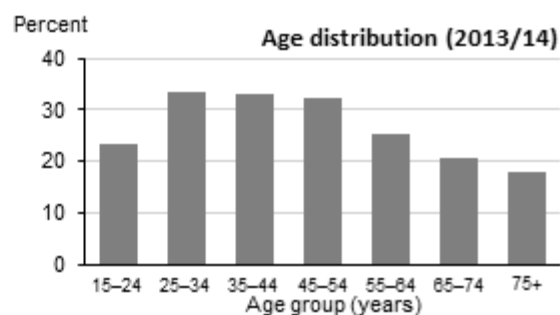
Box 21: Adults who have experienced one of more types of unmet need for primary health care in the last 12 months

	2013/14	2012/13	2006/07
Percent	27.7	27.1	.

In 2013/14 this was an estimated 990,000 adults

Adjusted rate ratio (2013/14)

Men vs women	0.7	*
Māori vs non-Māori	1.4	*
Pacific vs non-Pacific	1.2	*
Asian vs non-Asian	0.7	*
Most vs least deprived	1.7	*



* There is a statistically significant difference between the two groups.

The survey asked adults whether they had been unable to access primary health care when they needed it at any point in the last 12 months.

This indicator investigates whether people had experienced any of the following five barriers in accessing primary health care in the last 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 (ie, they have not experienced any of the five barriers listed above). However, 28% of adults had an unmet need for primary health care in the last 12 months. The most common reasons for this unmet need were: being unable to get an appointment within 24 hours (16%), the cost of GP services (14%) and the cost of after-hours services (7%).[‡]

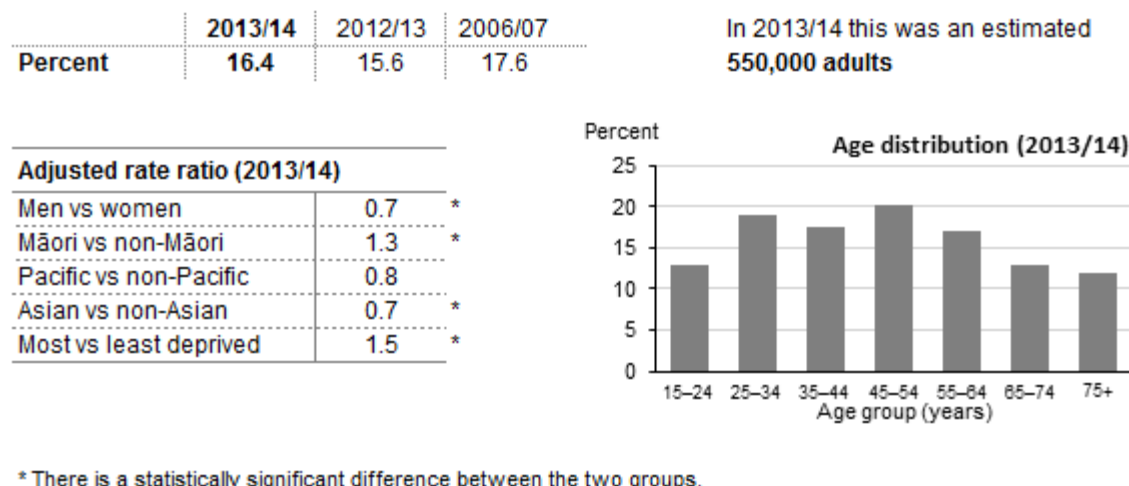
Rates of unmet need for primary health care varied by sex, age, ethnic group and area deprivation, as follows.[‡]

- Women had higher rates of unmet need than men (the rates were 33% 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.
- Māori and Pacific people had relatively high rates of unmet need (the rates were 37% and 33% respectively), whereas Asian adults had relatively low rates (22%).
- Adults living in the most deprived areas were more likely to have had an unmet need for primary health care than adults living in the least deprived areas (the rates were 35% and 20% respectively). After adjusting for age, sex and ethnic differences, adults in the most deprived areas were 1.7 times as likely to have had an unmet need for primary care, as those living in the least deprived areas.

[‡] Results are available in the online tables accompanying this report.

One in six adults reported being unable to get an appointment at their usual medical centre within 24 hours

Box 22: Adults who were unable to get an appointment at their usual medical centre within 24 hours at any point in the last 12 months



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 last 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.

One in six adults (16%) was unable to get an appointment at their usual medical centre within 24 hours at some point in the last 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 19% and 14% respectively).‡

Māori were more likely to have been unable to get an appointment at their usual medical centre within 24 hours than non-Māori (the rate was 20%).‡ In contrast, Asian adults were less likely than non-Asian adults to have been unable to get an appointment at their usual medical centre within 24 hours (the rate was 13%).

Adults living in the most deprived areas were more likely to have been unable to get an appointment at their usual medical centre within 24 hours than those in the least deprived areas, after adjusting for age, sex and ethnic differences (the rates were 20% and 12% respectively).‡

‡ Results are available in the online tables accompanying this report.

Cost prevents one in five adults living in the most deprived neighbourhoods from visiting a GP

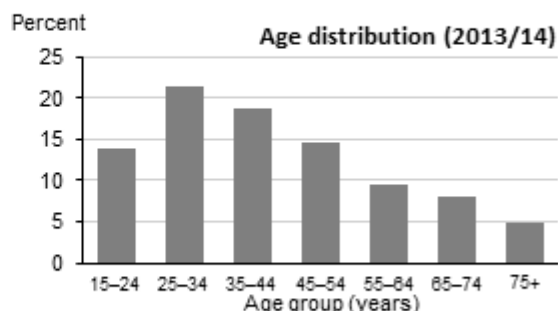
Box 23: Adults who did not visit a GP due to cost at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	14.0	14.5	.

In 2013/14 this was an estimated 502,000 adults

Adjusted rate ratio (2013/14)

Men vs women	0.6	*
Māori vs non-Māori	1.5	*
Pacific vs non-Pacific	1.4	*
Asian vs non-Asian	0.7	*
Most vs least deprived	2.1	*



* There is a statistically significant difference between the two groups.

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.

This indicator focuses on whether there had been an occasion in the last 12 months on which adults who had a medical problem did not visit a GP because of cost.

One in 7 adults (14%), reported having a medical problem but was unable to visit a GP due to cost at some time in the last 12 months.

Rates of being unable to visit a GP due to cost varied by sex, age, ethnic group and area deprivation, as follows.‡

- Women were more likely not to have visited a GP due to cost than men (the rates were 17% and 11% respectively).
- Unmet need for GP visits due to cost peaked among those aged 25–34 years. Cost was much less likely to be a barrier for adults aged 55 years and over: fewer than 10% have experienced unmet need for this reason.
- Māori and Pacific adults had relatively high rates of unmet need for GP services due to cost (the rate for both groups was 21%). In contrast, cost of GP visits was much less likely to be a barrier for Asian adults (for whom the rate is 11%).
- About one in five adults (19%) living in the most deprived areas did not visit a GP at some time in the last 12 months due to cost. Adults living in the most deprived areas were 2.1 times as likely to have not visited a GP due to cost at some time in the last 12 months as those living in the least deprived areas.

Another reason for not visiting a GP identified in this report is a lack of transport. This prevented 2.9% of adults from visiting a GP when they needed to in the last 12 months.‡ Lack of transport to visit a GP was strongly related to deprivation; the rate was much higher for adults living in the most deprived areas (6.0%) than for those in the least deprived areas (1.3%).

‡ Results are available in the online tables accompanying this report.

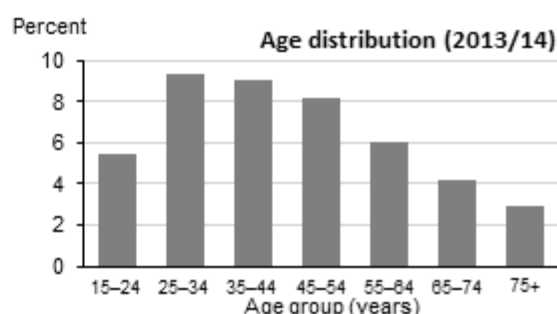
Women are twice as likely as men not to have visited an after-hours medical centre due to cost

Box 24: Adults who did not visit an after-hours medical centre due to cost at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	6.9	7.1	.

In 2013/14 this was an estimated 247,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	0.5 *
Māori vs non-Māori	1.9 *
Pacific vs non-Pacific	1.6 *
Asian vs non-Asian	0.7 *
Most vs least deprived	1.9 *



* There is a statistically significant difference between the two groups.

As outlined earlier, after-hours medical centres provide primary health care outside usual business hours (nights, weekends and public holidays). DHBs 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 for services during usual business hours particularly for people who are not enrolled with a primary health organisation.

This indicator focuses on whether there had been a time in the past 12 months when people had a medical problem after-hours, but did not visit an after-hours medical centre due to cost.

Seven percent of adults did not visit an after-hours medical centre due to cost at some time in the last 12 months. This rate has remained stable since 2011/12 (when it was also 7%).[‡]

Rates of being unable to visit an after-hours medical centre due to cost varied by sex, age, ethnic group and area deprivation, as follows.[‡]

- More women than men did not visit an after-hours centre due to cost (the rates are 8.9% and 4.7% respectively).
- Younger adults (those aged 25–44 years) were more likely not to have visited an after-hours centre due to cost: less than 5% of older adults (those aged 65 years and over) experienced this barrier at some point in the past 12 months.
- Māori and Pacific adults had relatively high rates of unmet need for after-hours medical centres (the rates were 12% and 11% respectively). In contrast, only 5% of Asians did not visit an after-hours medical centre due to cost at some point in the past 12 months.
- Adults living in the most deprived areas were 1.9 times as likely not to have visited an after-hours medical centre due to cost as those living in the least deprived areas (the rate was 11%), after adjusting for age, sex and ethnic differences.

Another reason for not being able to visit an after-hours service identified in this report, is a lack of transport. This prevented 1.2% of adults from going to an after-hours medical centre when they needed to at some time in the last 12 months.[‡]

[‡] Results are available in the online tables accompanying this report.

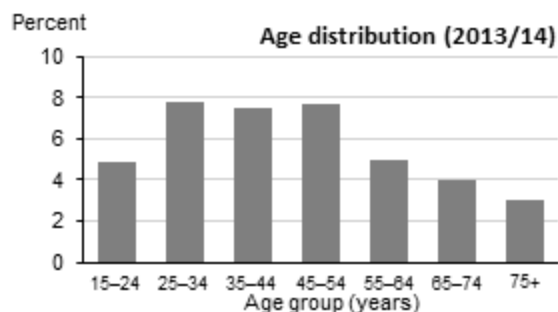
One in eight adults living in the most deprived areas did not collect a prescription due to cost at some time in the last 12 months

Box 25: Adults who did not collect a prescription item due to cost at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	6.0	6.1	.

In 2013/14 this was an estimated
216,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	0.6 *
Māori vs non-Māori	2.4 *
Pacific vs non-Pacific	2.8 *
Asian vs non-Asian	0.5 *
Most vs least deprived	3.3 *



* There is a statistically significant difference between the two groups.

In New Zealand, most prescription medicines are subsidised under a co-payment system, so people pay a relatively small amount for each medication. The co-payment applies to the first 20 prescriptions per family per year. The co-payment for subsidised prescription items increased from \$3 to \$5 on 1 January 2013. The survey asked adults to consider their experience over the last 12 months (July 2012–June 2013); this means that the 2013/14 survey results refer to both before and after subsidised prescriptions costs increased.

There was a small drop in the percentage of adults prevented from collecting a prescription due to cost between 2013/14 and 2011/12, from 7% to 6%.‡

Rates of being unable to collect a prescription item due to cost in the last 12 months varied by sex, age, ethnic group and area deprivation, as follows.‡

- More women than men did not collect a prescription due to cost at some point in the past 12 months (the rates were 7.5% and 4.5% respectively).
- Adults aged 25–54 years were more likely than other age groups not to have collected a prescription due to cost (around 8%).
- Māori adults were 2.4 times as likely and Pacific adults 2.8 times as likely not to have collected a prescription due to cost than non-Māori and non-Pacific adults (the rates were 13% and 16% respectively). Māori rates have improved since 2011/12, when 18% reported having not collected a prescription due to cost at some point in the past 12 months.
- In contrast, only 3.5% of Asian adults were unable to fill a prescription due to cost at some point in the past 12 months.
- Twelve percent of adults living in the most deprived areas were unable to fill a prescription due to cost. Adults living in the most deprived areas were 3.3 times as likely to have been unable to collect a prescription due to cost than adults living in the least deprived areas, after adjusting for age, sex and ethnic differences.

‡ Results are available in the online tables accompanying this report.

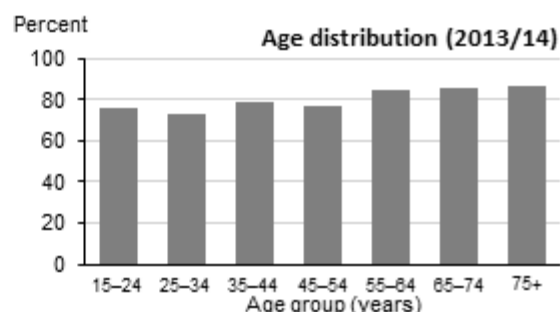
Four out of five adults definitely have confidence and trust in their GP

Box 26: Adults who definitely have confidence and trust in the GP they last visited (of those who had visited a GP in the last three months)

	2013/14	2012/13	2006/07
Percent	80.5	81.4	.

In 2013/14 this was an estimated
1,400,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	1.0
Māori vs non-Māori	1.0 *
Pacific vs non-Pacific	1.0
Asian vs non-Asian	1.0
Most vs least deprived	0.9 *



* There is a statistically significant difference between the two groups.

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

The survey asked adults who had visited a GP in the last three months: 'Did you have confidence and trust in the GP you saw? Yes, definitely / Yes, to some extent / No, not at all'.

Four out of five adults (80%) who had visited a GP in the previous three months definitely had confidence and trust in their GP. However, confidence and trust in GPs has fallen since 2011/12 (when the rate was 84%).[‡]

Older adults (those aged 55 years and over) were more likely to definitely have confidence and trust in the GP they last visited than those under 55 years.

There were little or no differences in adults' confidence and trust in GPs by sex, ethnic group or level of neighbourhood deprivation.

[‡] Results are available in the online tables accompanying this report.

Oral health

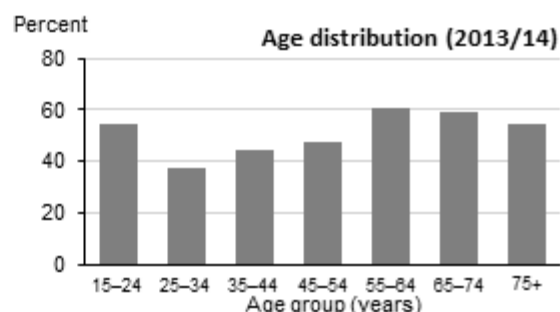
One in two adults visited a dental health care worker in the last 12 months

Box 27: Adults (with natural teeth) who have visited a dental health care worker in the last 12 months

	2013/14	2012/13	2006/07
Percent	49.7 [#]	47.5	51.5

In 2013/14 this was an estimated
1,666,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	0.9 *
Māori vs non-Māori	0.8 *
Pacific vs non-Pacific	0.7 *
Asian vs non-Asian	0.8 *
Most vs least deprived	0.6 *



[#] There has been a statistically significant change since 2012/13.

* There is a statistically significant difference between the two groups.

Most adults are required to pay for the full cost of their dental health services. However, a limited range of public funding for oral health services is available. This includes funding for dental treatment required due to an accident or injury, dental treatment for people with medical conditions and/or disabilities that prevent them from normally accessing community-based dental care and emergency dental treatment for eligible low-income adults. Young adults aged 15–17 years are entitled to free basic health services provided through contracted dental services in the community (see page 57). The Ministry of Health and the New Zealand Dental Association recommend regular dental checks to keep teeth and gums healthy.

Half of all adults (50%) with natural teeth had visited a dental health care worker§ in the last 12 months. Visits to a dental health care worker in the last 12 months by adults with natural teeth varied by sex, age, ethnic group and area deprivation, as follows.‡

- Men were less likely than women to have visited a dental health worker in the last 12 months (the rates are 47% and 53% respectively).
- Adults aged 25–34 years were the least likely of all age groups to have visited a dental health care worker in the last 12 months.
- Pacific, Māori and Asian adults were less likely to have visited a dental health care worker than non-Pacific, non-Māori and non-Asian adults respectively (the rates were 32%, 40% and 37% respectively). In contrast, over half (55%) of European/Other adults had visited a dental health care worker in the last 12 months.
- Just over one-third (36%) of adults living in the most deprived areas had visited a dental health care worker in the last 12 months, compared with nearly two-thirds (62%) of adults in the least deprived areas.

§ The term ‘dental health care worker’ refers to dentists and other dental health care workers, such as dental therapists, dental hygienists, as well as dental health specialists, such as orthodontists.

‡ Results are available in the online tables accompanying this report.

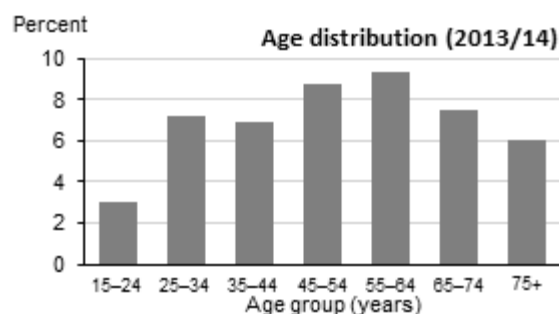
A quarter of a million adults have had a tooth extracted in the last 12 months due to poor oral health

Box 28: Adults who had any teeth removed in the last 12 months due to decay, an abscess, infection or gum disease

	2013/14	2012/13	2006/07
Percent	6.9	6.8	.

In 2013/14 this was an estimated
248,000 adults

Adjusted rate ratio (2013/14)	
Men vs women	1.2
Māori vs non-Māori	1.5 *
Pacific vs non-Pacific	1.5 *
Asian vs non-Asian	0.9
Most vs least deprived	2.1 *



* There is a statistically significant difference between the two groups.

Removal of a tooth as a consequence of tooth decay or an abscess, infection or gum disease is often the result of not seeking preventive or treatment services early. Tooth loss affects quality of life, and is related to general poor health.

The survey asked if people had had a tooth removed in the last 12 months because of tooth decay, an abscess, infection or gum disease. Note that this excludes teeth lost for other reasons, such as injury, a crowded mouth or orthodontics.

Seven percent of adults have had one or more teeth removed in the last 12 months for the reasons given above.

Only 3% of adults aged 15–24 years have had any teeth removed for these reasons in the last 12 months; this figure is much smaller than for older age groups.

Māori and Pacific adults were more likely to have had teeth removed for these reasons in the last 12 months than non-Māori and non-Pacific adults (the rate is 9% for both groups).[†]

One in ten adults (10%) living in the most deprived areas have had teeth removed for these reasons in the last 12 months, compared to one in fifteen adults (6%) in the least deprived areas.[‡] Adults living in the most deprived areas were 2.1 times as likely to have had a tooth removed in the last 12 months as those living in the least deprived areas, after adjusting for age, sex and ethnic differences.

[†] Results for Māori and Pacific adults are provided at the end of the adult section.

[‡] Results are available in the online tables accompanying this report.

The majority of adults living in deprived areas only visit dental health care workers for dental problems, or never visit

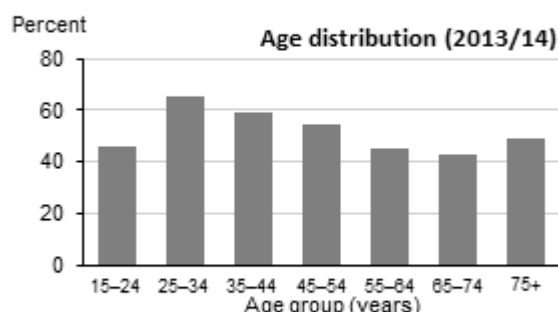
Box 29: Adults (with natural teeth) who never visit a dental health care worker, or only visit when they have dental problems

	2013/14	2012/13	2006/07
Percent	52.8 [#]	55.1	49.1

In 2013/14 this was an estimated
1,771,000 adults

Adjusted rate ratio (2013/14)

Men vs women	1.1	*
Māori vs non-Māori	1.4	*
Pacific vs non-Pacific	1.5	*
Asian vs non-Asian	1.2	*
Most vs least deprived	2.1	*



There has been a statistically significant change since 2012/13.

|| There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

Through regular dental check-ups, dental health care workers§ can detect early signs of oral disease and provide timely treatment and/or preventive measures.

Over half of adults with natural teeth (53%) reported never having visited a dental health care worker, or only visiting for toothache or other dental problems.

People under 18 years in New Zealand have access to free basic dental services. The survey found that young adults aged 15–17 years were least likely to report only visiting dental health care workers for dental problems, or never (the rate was 13%).‡ In contrast, 60% of those aged 18–24 years reported having visited dental health care workers only for dental problems.

The percentage of adults visiting dental health workers only for dental problems was higher for:

- men compared with women (the rates were 56% and 50% respectively)
- Māori, Pacific and Asian adults compared with non-Māori, non-Pacific and non-Asian adults (the rates were 73%, 77% and 64% respectively)
- adults living in high-deprivation areas compared with low-deprivation areas (the rates were 76% and 33% respectively).‡ After adjusting for age, sex and ethnic differences, adults living in the most deprived areas were 2.1 times as likely to never have visited a dental health care worker, or only to have visited for dental problems, as adults in the least deprived areas.

§ The term 'dental health care worker' refers to dentists and other dental health care workers, such as dental therapists, dental hygienists, as well as dental health specialists, such as orthodontists.

‡ Results are available in the online tables accompanying this report.

Table 4: Key survey results for Māori adults

Indicator	Percent 2013/14	Percent 2012/13	Percent 2006/07	Change since 2012/13	Change since 2006/07
Health status, health behaviours and risk factors					
Excellent, very good or good self-rated health	87.1	84.2	86.5	▲	=
Current smoking	40.6	39.2	42.1	=	=
Daily smoking	37.1	36.1	39.2	=	=
Hazardous drinking	30.5	30.9	33.5	=	=
Vegetable intake (3+ servings per day)	61.2	60.9	59.9	=	=
Fruit intake (2+ servings per day)	47.3	49.3	55.2	=	▼
Physically active	50.1	47.0	56.3	=	▼
Obesity ¹	45.5	47.4	41.6	=	▲
Health conditions					
High blood pressure (medicated)	13.9	13.5	10.3	=	▲
High cholesterol (medicated)	8.8	9.1	5.5	=	▲
Ischaemic heart disease (diagnosed)	4.0	4.8	4.7	=	=
Stroke (diagnosed)	1.6	1.6	1.8	=	=
Diabetes (diagnosed)	7.0	7.3	5.8	=	=
Asthma (medicated)	14.4	15.8	15.4	=	=
Arthritis (diagnosed)	13.5	12.5	11.1	=	▲
Chronic pain	18.7	19.6	17.2	=	=
Mood or anxiety disorder (diagnosed)	17.3	15.7	11.9	=	▲
Psychological (mental) distress	9.3	9.6	10.9	=	=
Access to health care					
Visited a GP in the last 12 months	72.1	74.2	78.8	=	▼
Visited a practice nurse without seeing a GP at the same visit in the last 12 months	29.4	29.3	27.7	=	=
Visited an after-hours medical centre in the last 12 months	10.1	10.3	.	=	.
Experienced one or more types of unmet need for primary health care in the last 12 months:	37.1	38.9	.	=	.
• Unable to get an appointment at usual medical centre within 24 hours	20.4	21.0	22.4	=	=
• Unmet need for GP due to cost	21.5	25.1	.	▼	.
• Unmet need for after-hours services due to cost	12.5	14.6	.	=	.
Unfilled prescription due to cost in the last 12 months	12.6	14.6	.	=	.
Definitely had confidence and trust in GP	76.0	76.1	.	=	.
Oral health					
Visited a dental health care worker in the last 12 months ²	40.4	33.7	38.6	▲	=
Had any teeth removed due to decay, an abscess, infection or gum disease in the last 12 months	9.1	8.4	.	=	.
Usually only visits a dental health care worker for dental problems (or never visits) ²	72.7	76.2	69.7	▼	=
Key:	▲ Statistically significant increase ³ ▼ Statistically significant decrease ³				
	= No statistically significant change . Data not available				

1 Revised from the *New Zealand Health Survey: Annual update of key findings 2012/13*.

2 Among adults with natural teeth.

3 The significance (*p*-values) of differences between years is based on age-standardised rates.

Table 5: Key survey results for Pacific adults

Indicator	Percent 2013/14	Percent 2012/13	Percent 2006/07	Change since 2012/13	Change since 2006/07
Health status, health behaviours and risk factors					
Excellent, very good or good self-rated health	88.0	87.6	85.5	=	=
Current smoking	25.1	24.7	27.1	=	=
Daily smoking	23.3	22.1	24.8	=	=
Hazardous drinking	19.2	17.8	23.4	=	=
Vegetable intake (3+ servings per day)	44.7	46.8	44.9	=	=
Fruit intake (2+ servings per day)	48.9	54.3	58.8	=	▼
Physically active	44.9	46.7	48.9	=	=
Obesity ¹	66.7	67.1	63.4	=	=
Health conditions					
High blood pressure (medicated)	13.0	12.5	10.6	=	=
High cholesterol (medicated)	8.6	8.7	6.7	=	=
Ischaemic heart disease (diagnosed)	4.1	3.6	2.9	=	=
Stroke (diagnosed)	0.7	1.4	2.1	=	=
Diabetes (diagnosed)	9.5	12.5	9.8	=	=
Asthma (medicated)	11.3	8.3	9.0	=	=
Arthritis (diagnosed)	13.5	6.9	7.9	▲	▲
Chronic pain	13.8	11.5	12.0	=	=
Mood or anxiety disorder (diagnosed)	9.4	4.3	6.2	▲	▲
Psychological (mental) distress	12.6	8.9	13.2	▲	=
Access to health care					
Visited a GP in the last 12 months	74.6	74.7	78.1	=	=
Visited a practice nurse without seeing a GP at the same visit in the last 12 months	20.9	20.8	17.9	=	=
Visited an after-hours medical centre in the last 12 months	9.5	12.0	.	=	.
Experienced one or more types of unmet need for primary health care in the last 12 months:	33.1	31.0	.	=	.
• Unable to get an appointment at usual medical centre within 24 hours	14.1	10.9	20.7	=	▼
• Unmet need for GP due to cost	21.1	21.0	.	=	.
• Unmet need for after-hours services due to cost	11.2	10.3	.	=	.
Unfilled prescription due to cost in the last 12 months	15.7	15.4	.	=	.
Definitely had confidence and trust in GP	80.4	77.9	.	=	.
Oral health					
Visited a dental health care worker in the last 12 months ²	32.3	29.8	34.8	=	=
Had any teeth removed due to decay, an abscess, infection or gum disease in the last 12 months	9.1	11.0	.	=	.
Usually only visits a dental health care worker for dental problems (or never visits) ²	77.0	78.2	76.8	=	=

Key: ▲ Statistically significant increase³ = No statistically significant change
▼ Statistically significant decrease³ . Data not available

1 Revised from the *New Zealand Health Survey: Annual update of key findings 2012/13*.

2 Among adults with natural teeth.

3 The significance (*p*-values) of differences between years is based on age-standardised rates.

The health of New Zealand children

This section includes information on:

- health status, health behaviours and risk factors
- health conditions
- access to health care
- oral health
- key survey results for Māori children
- key survey results for Pacific children.

Table 6: Key survey results for children (aged 0–14 years)

Indicator	Percent 2013/14	Percent 2012/13	Percent 2006/07	Change since 2012/13	Change since 2006/07
Health status, health behaviours and risk factors					
Excellent, very good or good parent-rated health	98.5	98.1	97.6	=	▲
Given solid food before four months (four months–four years)	8.8	10.2	15.8	=	▼
Ate breakfast at home every day (2–14 years)	86.1	86.6	87.7	=	=
Usually watched 2+ hours of television each day (2–14 years)	49.8	51.8	.	=	.
Obesity (2–14 years) ¹	10.1	10.5	8.4	=	▲
Health conditions					
Asthma (medicated) (2–14 years)	15.3	14.5	14.9	=	=
Diagnosed emotional or behavioural problems (2–14 years)	3.9	4.3	1.8	=	▲
Access to health care					
Visited a GP in the past 12 months	74.9	74.5	79.2	=	▼
Visited a practice nurse (without seeing a GP at the same visit) in the past 12 months	23.2	25.1	22.8	=	=
Visited an after-hours medical centre in the past 12 months	20.7	21.4	.	=	.
Experienced any unmet need for primary health care in the past 12 months:	21.5	20.7	.	=	.
• Unable to get appointment at usual medical centre within 24 hours	15.1	12.8	.	▲	.
• Unmet need for GP services due to cost	5.2	6.3	.	=	.
• Unmet need for after-hours services due to cost	3.6	4.5	.	=	.
Unfilled prescription due to cost in the past 12 months	4.1	4.4	.	=	.
Definitely had confidence and trust in GP	78.4	82.3	.	▼	.
Oral health					
Visited a dental health care worker in the past 12 months (1–14 years)	83.8	81.3	75.7	▲	▲
Had any teeth removed due to decay, abscess, infection or gum disease in the past 12 months (1–14 years)	4.1	3.6	.	=	.

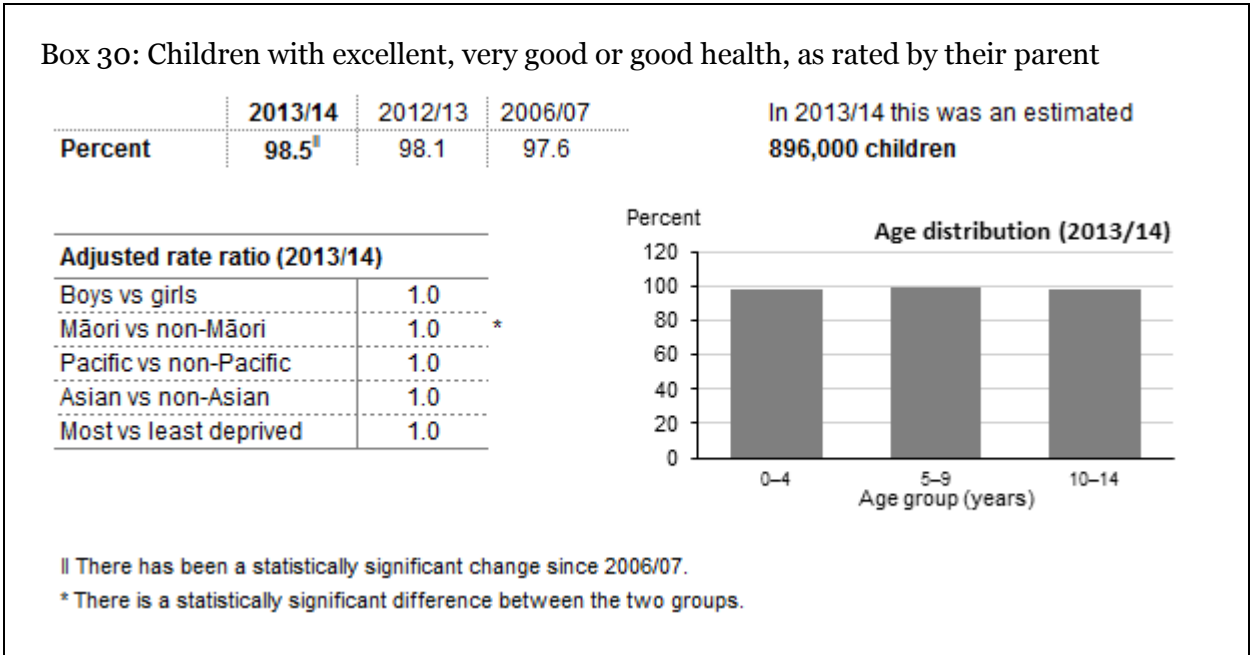
Key: ▲ Statistically significant increase² = No statistically significant change
▼ Statistically significant decrease² . Data not available

1 Revised from the *New Zealand Health Survey: Annual update of key findings 2012/13*.

2 The significance (*p*-values) of differences between years is based on age-standardised rates.

Health status, health behaviours and risk factors

Almost all parents consider their children to be in good health



Surveyors asked the parents of all children participating in the survey whether they considered their child’s health to be ‘excellent, very good, good, fair or poor’. In this report, ‘good health’ means good, very good or excellent health, as reported by a parent.

The majority of parents (98%) rated their child’s health as good, very good or excellent.

Parent-rated health status was similar for all age groups, and did not differ by ethnic group or deprivation.

The percentage of babies given solid food before four months of age is falling

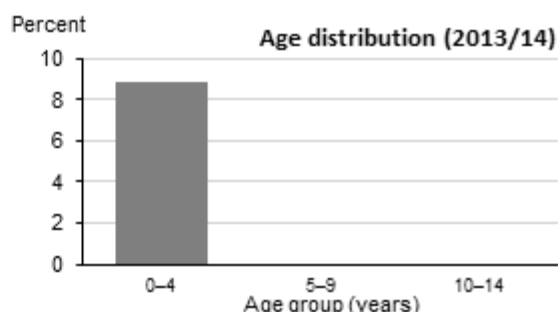
Box 31: Children aged four months to four years who were given solid food before four months of age

	2013/14	2012/13	2006/07
Percent	8.8 [†]	10.2	15.8

In 2013/14 this was an estimated 27,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	0.8
Māori vs non-Māori	2.0 *
Pacific vs non-Pacific	1.2
Asian vs non-Asian	0.6
Most vs least deprived	2.3



† There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

The Ministry of Health nutrition guidelines for infants and toddlers changed in 2008 to recommend exclusive breastfeeding until around the age of six months, when the Ministry recommends introducing solid food. Before 2008 the Ministry of Health recommended exclusive breastfeeding until around four to six months of age, and the introduction of solid food at around the same age. Introducing solid food before four months of age may be associated with an increased risk of a number of health conditions, such as eczema, asthma, food allergies, respiratory disease and gut infections. Introducing solid food later than six months of age may be associated with an increased risk of iron deficiency, malnutrition and delays in oral motor development.

The survey asked parents of children aged four months to four years at what age their child was first given solid food.

One in eleven children (9%) was given solid foods before four months of age, down from 16% in 2006/07.

One in seven Māori children (14%) was given solid food before four months of age, an improvement on 2006/07 (when the rate was 22%).[†] After adjusting for age and sex differences, Māori children were twice as likely to have been given solid food before four months of age as non-Māori children.

[†] Results for Māori and Pacific children are provided at the end of the child section.

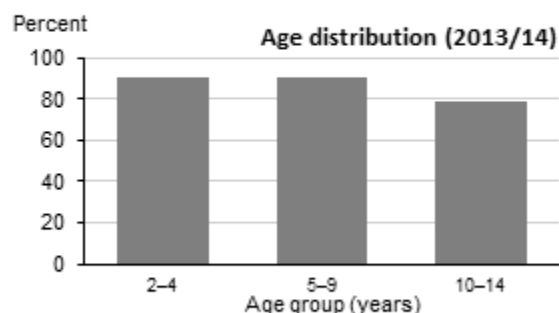
Nine out of ten children eat breakfast at home every day

Box 32: Children aged 2–14 years who ate breakfast at home every day in the past week

	2013/14	2012/13	2006/07
Percent	86.1	86.6	87.7

In 2013/14 this was an estimated
670,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	1.0 *
Māori vs non-Māori	0.9 *
Pacific vs non-Pacific	0.8 *
Asian vs non-Asian	1.1 *
Most vs least deprived	0.9 *



* There is a statistically significant difference between the two groups.

Eating breakfast at home every day is an indicator of a nutritious diet and healthy eating behaviours.

The majority of children surveyed (86%) had eaten breakfast at home every day in the last week.

Children aged 10–14 years were less likely to have eaten breakfast at home every day than those under 10 years (the rates were 79% for 10–14 year olds, 90% for 5–9 year olds and 91% for 2–4 year olds).

There has been a decrease in the percentage of two–four-year old children who ate breakfast at home every day (91%) since 2006/07 (when the rate was 95%).[‡]

After adjusting for age and sex differences, Māori children were 10% less likely and Pacific children 20% less likely to eat breakfast at home each day than non-Māori and non-Pacific children respectively.

Children living in the most deprived areas were 10% less likely to eat breakfast at home every day than children living in the least deprived areas, after adjusting for age, sex and ethnic differences.

[‡] Results are available in the online tables accompanying this report.

Half of all children watch two or more hours of television each day

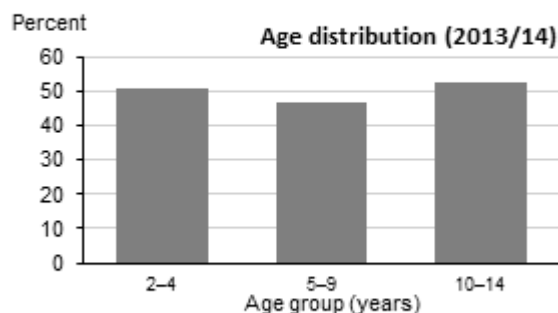
Box 33: Children aged 2–14 years who watch two or more hours of television each day

	2013/14	2012/13	2006/07
Percent	49.8	51.8	.

In 2013/14 this was an estimated
387,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	1.0	
Māori vs non-Māori	1.4	*
Pacific vs non-Pacific	1.4	*
Asian vs non-Asian	0.8	*
Most vs least deprived	1.5	*



* There is a statistically significant difference between the two groups.

Watching television is a sedentary behaviour. It takes up time that could be spent being physically active. New Zealand's physical activity guidelines recommend that young people (those aged 5–18 years) spend no more than two hours in front of television, computers and games consoles per day (out of school time).

This indicator focuses on the percentage of children aged 2–14 years who watch two or more hours of television per day (averaged over a week). The survey did not ask about other screen time – for example, use of computer games or social media sites – so these results are likely to underestimate total screen time.

One in two children (50%) usually watched two or more hours of television each day, down from 53% in 2011/12.[‡] However, a greater percentage of Pacific children (67%) watched two or more hours of television a day, compared with 2011/12 and 2012/13 (the rate was 59% in both of those years).

Māori and Pacific children were 40% more likely to watch two or more hours of television each day compared with non-Māori and non-Pacific children respectively, after adjusting for age and sex differences.

Children living in the most deprived areas were more likely to watch two or more hours of television each day than children living in the least deprived areas (the rates were 64% and 36% respectively).[‡] After adjusting for age, sex and ethnic differences, children in the most deprived areas were 1.5 times as likely to watch two or more hours of television than children in the least deprived areas.

[‡] Results are available in the online tables accompanying this report.

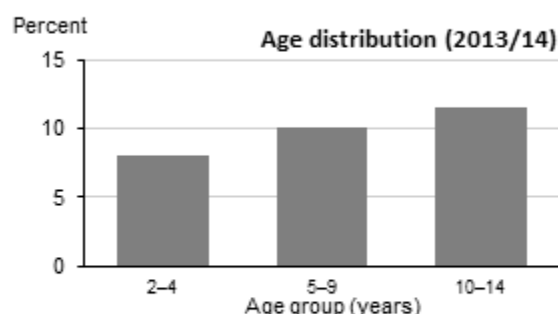
Child obesity rates are higher in deprived areas

Box 34: Children aged 2–14 years who are obese, with a BMI equivalent to an adult BMI of 30 (or greater)

	2013/14	2012/13 [◇]	2006/07
Percent	10.1 [‡]	10.5	8.4

In 2013/14 this was an estimated 79,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	0.9
Māori vs non-Māori	1.9 *
Pacific vs non-Pacific	3.2 *
Asian vs non-Asian	0.6 *
Most vs least deprived	2.7 *



‡ There has been a statistically significant change since 2006/07.

◇ Revised from the statistic first published in New Zealand Health Survey: Annual update of key findings 2012/13, due to correcting the truncation of height measurements to the next lowest centimetre during data transfer.

* There is a statistically significant difference between the two groups.

A healthy body size is important for good health and wellbeing. Overweight and obese children are more likely to be obese as adults. In addition, they are more likely to have abnormal cholesterol and blood pressure levels at a younger age than children who are within a normal weight range. Being overweight or obese in childhood is also associated with social and mental health problems, including low self-esteem.

This report uses the revised International Obesity Task Force (IOTF) BMI reference values to classify overweight and obesity in children and adolescents aged 2–14 years (Cole and Lobstein 2012). The IOTF cut-off points are sex- and age-specific, and are designed to coincide with the World Health Organization's adult BMI cut-off points at age 18 years.

Around 79,000 children, or one in ten children aged 2–14 years (10%), were obese. There has been no significant change in the child obesity rate since 2011/12 (when it was 11%).[‡]

Fifteen percent of Māori children were obese.[†] After adjusting for age and sex differences, Māori children were nearly twice as likely to be obese as non-Māori children.

One in four Pacific children (25%) was obese.[†] After adjusting for age and sex differences, Pacific children were 3.2 times as likely to be obese as non-Pacific children. Obesity rates were lowest in Asian children (for whom the rate is 7%).[‡]

The childhood obesity rate was much higher in children living in the most deprived areas than it was for children living in the least deprived areas (the rates were 18.3% and 4.5% respectively).[‡] After adjusting for age, sex and ethnic differences, children living in the most deprived areas were 2.7 times as likely to be obese as children living in the least deprived areas.

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific children are provided at the end of the child section.

Health conditions

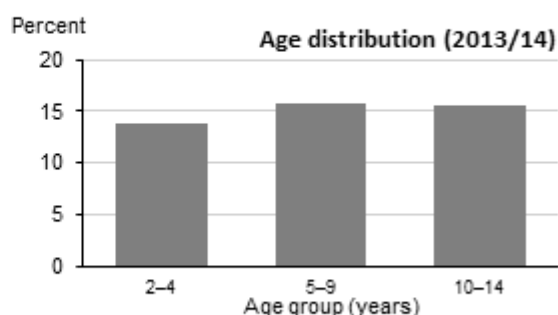
Māori children are more likely to be taking medication for asthma

Box 35: Children aged 2–14 years diagnosed with asthma and currently taking medication for this condition

	2013/14	2012/13	2006/07
Percent	15.3	14.5	14.9

In 2013/14 this was an estimated
119,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	1.3 *
Māori vs non-Māori	1.5 *
Pacific vs non-Pacific	1.1
Asian vs non-Asian	1.0
Most vs least deprived	0.8



* There is a statistically significant difference between the two groups.

This indicator focuses on children aged 2–14 years who have been told by a doctor that they have asthma and who currently take medication to treat it. Medication can be taken daily to prevent symptoms or only when needed to relieve symptoms.

Around 119,000 children aged 2–14 years (15%) had been diagnosed with asthma (medicated); this rate is similar to previous years.

Boys were more likely to have asthma (medicated) than girls (the rates were 17% and 13% respectively).[‡] This was particularly pronounced for children aged 2–4 years, among whom 18% of boys have asthma (medicated) compared with 10% of girls. Boys were 1.3 times as likely to have asthma (medicated) as girls, after adjusting for age differences. This sex-related disparity was reversed for adults: more women have asthma (medicated) than men (see page 20).

About one in five Māori children (21%) has asthma (medicated).[†] After adjusting for age and sex differences, Māori children were 1.5 times as likely to have asthma (medicated) as non-Māori children.

Asthma (medicated) was more common in children (for whom the rate was 15%) than in adults (for whom the rate was 11%). For more information, see page 20.

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific children are provided at the end of the child section.

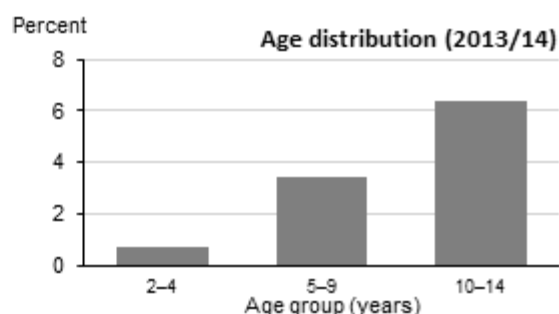
Boys are more likely to have been diagnosed with emotional or behavioural problems than girls

Box 36: Children aged 2–14 years diagnosed with emotional and/or behavioural problems, specifically: depression, an anxiety disorder, attention deficit disorder and/or attention deficit and hyperactivity disorder

	2013/14	2012/13	2006/07
Percent	3.9	4.3	1.8

In 2013/14 this was an estimated
31,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	2.5 *
Māori vs non-Māori	1.3
Pacific vs non-Pacific	0.4 *
Asian vs non-Asian	0.6
Most vs least deprived	1.4



^{||} There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

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 these conditions.

Around 31,000 children (3.9%) aged 2–14 years, had been diagnosed with emotional and/or behavioural problems at some time in their life. The percentage of children with diagnosed emotional and/or behavioural problems has increased since 2006/07 (when the rate was 1.8%).

Boys were 2.5 times as likely to have ever been diagnosed with emotional and/or behavioural problems as girls, after adjusting for age differences.[‡]

Pacific children (1.4%) were less likely to have ever been diagnosed with emotional and/or behavioural problems than non-Pacific children, after adjusting for age and sex differences.[†]

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific children are provided at the end of the child section.

Access to health care

Three out of four children have visited a GP in the last 12 months

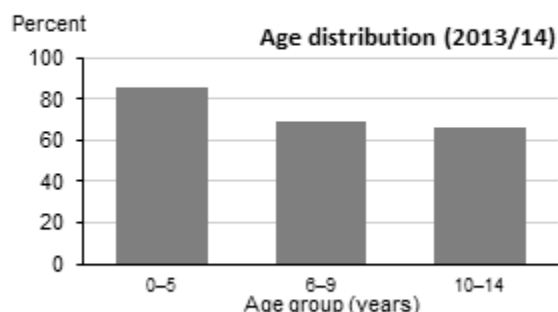
Box 37: Children who have visited a GP in the last 12 months

	2013/14	2012/13	2006/07
Percent	74.9 ^{II}	74.5	79.2

In 2013/14 this was an estimated
682,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	1.0
Māori vs non-Māori	1.0
Pacific vs non-Pacific	1.0
Asian vs non-Asian	1.0
Most vs least deprived	1.0



II There has been a statistically significant change since 2006/07.

As at July 2014, 99.7% (890,000) of children aged under 15 years were enrolled with a primary health organisation (PHO) funded by their local DHB to provide general practice and other primary care services. The Ministry of Health provides additional funding to encourage free GP consultations for children under six years of age (Zero Fees for Under 6s initiative). PHO enrolment information shows that 80% of enrolled children had a consultation with a health practitioner (eg, a GP or practice nurse) in the last 12 months.

This indicator reports on the percentage of children aged 0–14 years who had visited a GP at their usual medical centre, or somewhere else, in the last 12 months. For age group analyses, children aged 0–5 years have been grouped together, to reflect the higher level of subsidies in place for this age group.

Three out of four children (75%) had visited a GP in the last 12 months.

Children younger than six years were more likely to have visited a GP in the last 12 months than older children (the rate was 86%).

There were no differences in the percentage of children who visited a GP by sex, ethnic group or neighbourhood deprivation level.

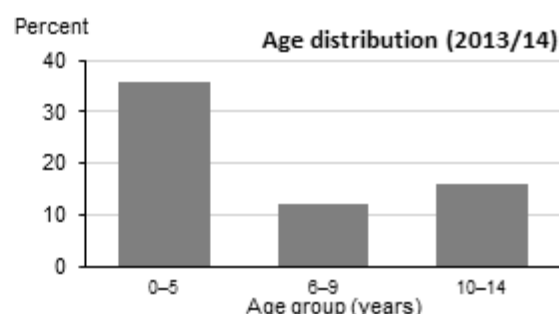
Children under six years are most likely to have visited a practice nurse in the last 12 months

Box 38: Children who have visited a practice nurse in the last 12 months without seeing a GP at the same visit

	2013/14	2012/13	2006/07
Percent	23.2	25.1	22.8

In 2013/14 this was an estimated
211,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	0.9
Māori vs non-Māori	1.0
Pacific vs non-Pacific	0.8
Asian vs non-Asian	0.8 *
Most vs least deprived	0.9



* There is a statistically significant difference between the two groups.

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 families. As outlined earlier, the Ministry of Health provides additional funding to encourage free practice nurse consultations for children under six years of age (Zero Fees for Under 6s initiative).

One in four children (23%) had visited a practice nurse during the last 12 months without seeing a GP at the same visit.

Children younger than six years were much more likely than older children to have visited a practice nurse without seeing a GP at the same visit in the last 12 months (the rate was 36%).

Asian children were less likely to have visited a practice nurse in the last 12 months without seeing a GP at the same visit (the rate was 19%) than non-Asian children.† There were no other significant differences by sex, age or ethnic group.

† Results are available in the online tables accompanying this report.

One in five children have visited an after-hours medical centre in the last 12 months

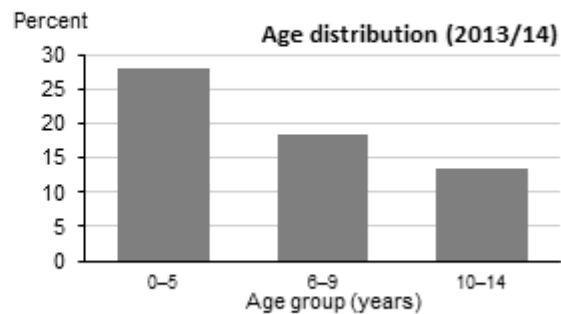
Box 39: Children who have visited an after-hours medical centre in the last 12 months

	2013/14	2012/13	2006/07
Percent	20.7	21.4	.

In 2013/14 this was an estimated
189,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	1.0
Māori vs non-Māori	0.8 *
Pacific vs non-Pacific	1.1
Asian vs non-Asian	1.0
Most vs least deprived	0.9



* There is a statistically significant difference between the two groups.

After-hours medical centres provide primary health care outside usual business hours. The cost of care in after-hours medical centres is higher than for services during usual business hours, particularly for people who are not enrolled with a primary health organisation. On 1 July 2012, the Ministry of Health introduced funding to encourage free access to after-hours services for children under six.

About one in five children (21%) visited an after-hours medical centre in the last 12 months.

Children aged under six were more likely than older children to have visited an after-hours medical centre in the last 12 months (the rate was 28%). There was no significant change in the percentage of children under six who visited after-hours medical centres since 2011/12 (when the rate was 29%).[‡]

Māori children were less likely to have visited an after-hours medical centre in the last 12 months (the rate was 17%) than non-Māori children.[†]

[‡] Results are available in the online tables accompanying this report.

[†] Results for Māori and Pacific children are provided at the end of the child section.

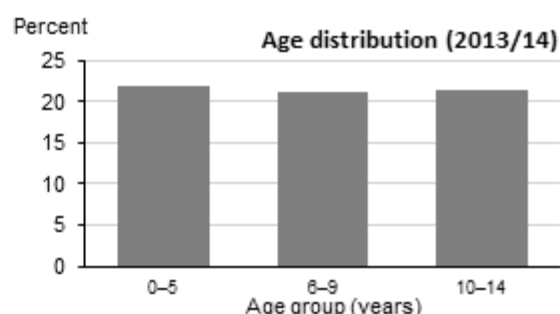
One in five children had an unmet need for primary health care in the last 12 months

Box 40: Children who have experienced one or more types of unmet need for primary health care at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	21.5	20.7	.

In 2013/14 this was an estimated
196,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	0.8
Māori vs non-Māori	1.4 *
Pacific vs non-Pacific	1.4 *
Asian vs non-Asian	0.8 *
Most vs least deprived	1.5 *



* There is a statistically significant difference between the two groups.

Even with almost New Zealand wide free access to primary health care services, some children experience unmet need for primary health care. To reduce the effect of cost for accessing primary health care services, the Zero Fees for Under 6s initiative supports practices to provide free primary health care to children under 6 during the day time and outside usual business hours.

This indicator investigates whether children had experienced any of the following six barriers to accessing primary health care services in the last 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, lack of childcare for other children and inability to get an appointment at their usual medical centre within 24 hours.

Twenty-two percent of children experienced one or more types of unmet need for primary care at some point in the last 12 months. This unmet need was due to:

- inability to get an appointment within 24 hours (15.1%)
- the cost of GP services (5.2%)
- the cost of after-hours services (3.6%)
- lack of transport to a GP (2.3%)
- lack of childcare (2.0%)
- lack of transport to an after-hours service (0.8%).‡

Rates of unmet need for primary health care vary by ethnicity. Māori and Pacific children were both 1.4 times as likely not to have accessed primary health when they needed it as non-Māori and non-Pacific children respectively. Asian children were 20% less likely to have an unmet need for primary health care than non-Asian children.

Children living in the most deprived areas had higher rates of unmet need for primary health care than those in the least deprived areas (the rates were 26% and 13% respectively).‡ Children living in the most deprived areas were 1.5 times as likely to have an unmet need for primary care as those in the least deprived areas, after adjusting for age, sex and ethnic differences.

‡ Results are available in the online tables accompanying this report.

One in seven children was unable to get an appointment at their usual medical centre within 24 hours at some time in the last 12 months

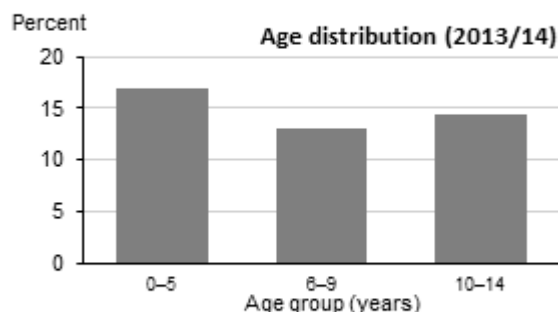
Box 41: Children who were unable to get an appointment at their usual medical centre within 24 hours at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	15.1 [#]	12.8	.

In 2013/14 this was an estimated 134,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	0.9
Māori vs non-Māori	1.4 *
Pacific vs non-Pacific	1.1
Asian vs non-Asian	0.8
Most vs least deprived	1.5 *



[#] There has been a statistically significant change since 2012/13.

* There is a statistically significant difference between the two groups.

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

The survey asked parents whether there had been a time in the last 12 months when they wanted their child 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. The parents of about one in seven children (15%) said 'yes'.

Parents of Māori children (19%) were more likely to have been unable to get an appointment for their child at their usual medical centre within 24 hours than parents of non-Māori children.[†] After adjusting for age and sex differences, parents of Māori children were 1.4 times more likely to have experienced this barrier than parents of non-Māori children.

Parents of children in more deprived areas were 50% more likely than parents of children in the least deprived areas to have been unable to get an appointment for their child at their usual medical centre within 24 hours, after adjusting for age, sex and ethnic differences.

[†] Results for Māori and Pacific children are provided at the end of the child section.

One in twenty children was unable to visit a GP due to cost at some time in the last 12 months

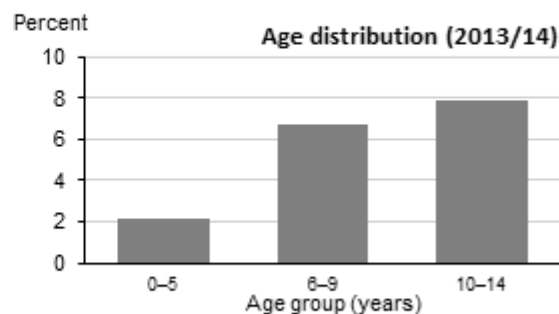
Box 42: Children who did not visit a GP due to cost at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	5.2	6.3	.

In 2013/14 this was an estimated 47,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	1.0
Māori vs non-Māori	1.4 *
Pacific vs non-Pacific	2.0 *
Asian vs non-Asian	0.7
Most vs least deprived	1.9



* There is a statistically significant difference between the two groups.

This indicator focuses on whether there had been an occasion in the last 12 months on which children had a medical problem, but their parents did not take them to visit a GP because of cost.

Around 47,000 children (5%) were unable to visit a GP due to cost at some point in the last 12 months.

Very few children younger than six years (2.2%) had an unmet need for GP services due to cost; this reflects higher subsidies for children in this age group.

Māori children were 1.4 times more likely than non-Māori children to have been unable to visit a GP due to cost, after adjusting for age and sex differences.

Nine percent of Pacific children did not visit a GP due to cost at some time in the last 12 months.[†] Pacific children were twice as likely as non-Pacific children to have been unable to visit a GP due to cost, after adjusting for age and sex differences.

[†] Results for Māori and Pacific children are provided at the end of the child section.

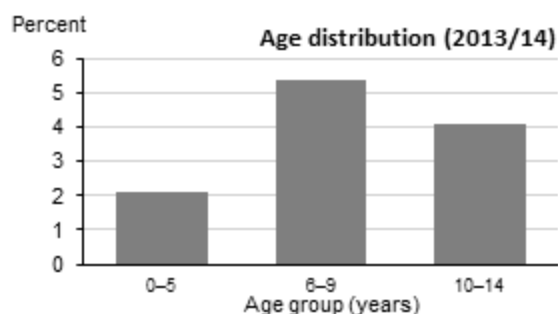
Few children had an unmet need for after-hours services due to cost at some time in the last 12 months

Box 43: Children who did not visit an after-hours medical centre due to cost at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	3.6	4.5	.

In 2013/14 this was an estimated 33,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	1.1
Māori vs non-Māori	1.5
Pacific vs non-Pacific	2.3 *
Asian vs non-Asian	0.6
Most vs least deprived	1.0



* There is a statistically significant difference between the two groups.

The Zero Fees for Children Under 6s scheme includes free after-hours access to GP services and has almost 98% coverage of children in this age group (approximately 354,000 children).

This indicator focuses on whether there had been an occasion in the last 12 months on which a child had a medical problem outside regular office hours, but their parents did not take them to visit an after-hours medical centre because of cost.

Around 33,000 children (3.6%) did not visit an after-hours medical centre due to cost at some time in the last 12 months. Unmet need for after-hours services was much less common in children compared with adults (for whom the rate was 7%, see page 31 for more information).

There was variation by ethnic group in the percentage of children who experienced an unmet need for after-hours care due to cost. Seven percent of Pacific children did not use after-hours medical centres due to cost at some time in the last 12 months.[†] Pacific children were 2.3 times more likely to have had an unmet need for after-hours services due to cost as non-Pacific children, after adjusting for age and sex.

In contrast, only 2.1% of Asian children did not visit an after-hours medical centre due to cost at some time in the last 12 months.[‡]

There were no differences in use of after-hours care due to cost by neighbourhood deprivation.

[†] Results for Māori and Pacific children are provided at the end of the child section.

[‡] Results are available in the online tables accompanying this report.

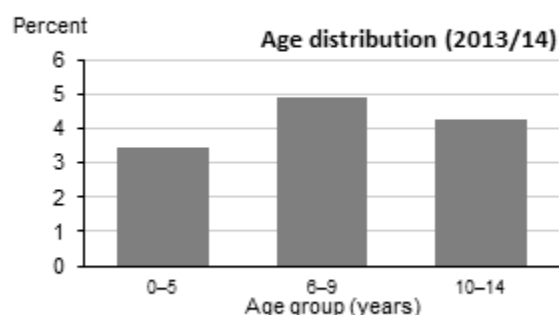
One in eleven children living in the most deprived areas missed out on a prescription due to cost at some time in the last 12 months

Box 44: Children who had a prescription item that was not collected due to cost at any point in the last 12 months

	2013/14	2012/13	2006/07
Percent	4.1	4.4	.

In 2013/14 this was an estimated 37,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	1.0
Māori vs non-Māori	2.3 *
Pacific vs non-Pacific	4.3 *
Asian vs non-Asian	0.3 *
Most vs least deprived	4.5 *



* There is a statistically significant difference between the two groups.

Most prescription medicines are subsidised in New Zealand so people pay a relatively small amount for each medication. The co-payment applies to the first 20 prescriptions per family per year. The co-payment for subsidised prescription items increased from \$3 to \$5 on 1 January 2013 for those aged 6+ years. Prescriptions for children under six are free.

The survey asked parents whether there had been a time in the last 12 months (July 2012–June 2013) when they had been given a prescription for their child but did not collect one or more items because of cost. The 2013/14 survey results refer to time periods both before and after subsidised prescriptions costs increased.

There has been a decline in the percentage of children for whom a prescription item was not collected due to cost, from 6.8% in 2011/12 to 4.1% in 2013/14.‡

Parents of Pacific and Māori children were more likely than parents of non-Pacific and non-Māori children, not to have collected a prescription for their child due to cost in the last 12 months (the rates were 12% and 7% respectively).‡ In contrast, only 1.3% of Asian children had an uncollected prescription due to cost. Pacific children were more than four times as likely to have experienced this barrier as non-Pacific children. Māori children were 2.3 times as likely to have experienced it as non-Māori children, after adjusting for age and sex differences.

Neighbourhood deprivation was strongly linked to prescriptions not being collected due to cost. After adjusting for age, sex and ethnic differences, parents of children living in the most deprived areas were 4.5 times as likely to have not collected a prescription due to cost at some time in the last 12 months as those in the least deprived areas.

‡ Results are available in the online tables accompanying this report.

Parents' confidence and trust in their child's GP is falling

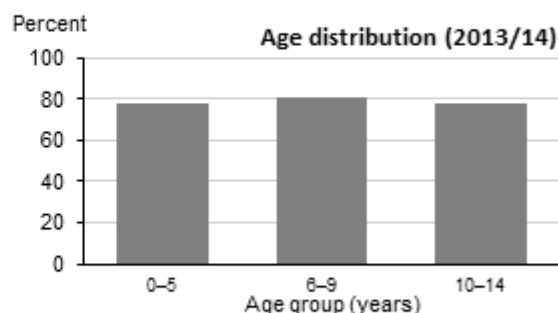
Box 45: Parents who definitely have confidence and trust in the GP their child last visited (of those who had visited a GP in the last three months)

	2013/14	2012/13	2006/07
Percent	78.4 [#]	82.3	.

In 2013/14 this was an estimated
292,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	1.0
Māori vs non-Māori	0.9 *
Pacific vs non-Pacific	0.9 *
Asian vs non-Asian	1.0
Most vs least deprived	0.9



[#] There has been a statistically significant change since 2012/13.

* There is a statistically significant difference between the two groups.

As outlined previously, 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 a clear explanation of conditions and treatment are important elements of patient experience.

The survey asked parents of children who had visited a GP in the last three months: 'Did you have confidence and trust in the GP [Name] saw? Yes, definitely / Yes, to some extent / No, not at all'.

Parents' confidence and trust in the GP that their child last visited has dropped to 78%; this represents a decline since 2011/12 (when the rate was 83%).[‡]

This decline in confidence and trust in GPs was particularly marked for parents of Pacific children from 79% in 2012/13 to 69% in 2013/14.[‡]

Parents of Māori and Pacific children were 10% less likely to have confidence and trust in their GPs compared to parents of non-Māori and non-Pacific children respectively, after adjusting for age and sex differences.

There were little or no differences in parents' confidence and trust in GPs by sex or level of neighbourhood deprivation.

[‡] Results are available in the online tables accompanying this report.

Oral health

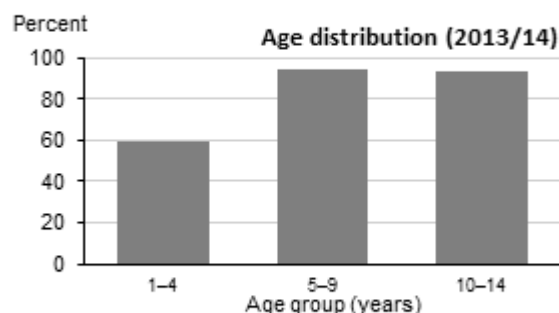
More children are visiting dental health care workers

Box 46: Children (aged 1–14 years) who have visited a dental health care worker in the last 12 months

	2013/14	2012/13	2006/07
Percent	83.8 [#]	81.3	75.7

In 2013/14 this was an estimated
711,000 children

Adjusted rate ratio (2013/14)	
Boys vs girls	1.0
Māori vs non-Māori	1.0
Pacific vs non-Pacific	1.0 *
Asian vs non-Asian	1.0 *
Most vs least deprived	1.0



[#] There has been a statistically significant change since 2012/13.

^{||} There has been a statistically significant change since 2006/07.

* There is a statistically significant difference between the two groups.

If children have regular dental visits, a dental health care worker§ is more likely to detect oral health problems early. Dental health workers can also apply timely preventive measures and treatments (such as tooth fillings) to maintain and improve oral health.

New Zealand publicly funds basic oral health services for children from birth up until their 18th birthday. The majority of dental services for children up to school year 8 (age 12–13 years) is provided by dental therapists within the Community Oral Health Service provided by DHBs (formerly the School Dental Service).

The percentage of children who visited a dental health care worker in the last 12 months was 84% in 2013/14, up from 76% in 2006/07.

Since 2006/07, rates of visiting dental health care workers have improved for all the population groups discussed in this report (girls and boys, the three age groups and the four ethnic groups).‡

Children aged 1–4 years were much less likely to have visited a dental health care worker in the last 12 months (the rate was 59%) than children of school age.

There were little or no differences in rates of visiting a dental health care worker by sex, ethnic group or level of neighbourhood deprivation.

§ The term ‘dental health care worker’ refers to dentists and other dental health care workers, such as dental therapists, dental hygienists, as well as dental health specialists, such as orthodontists.

‡ Refer to online tables accompanying this report for more detailed results.

Around 35,000 children had teeth extracted due to decay in the last 12 months

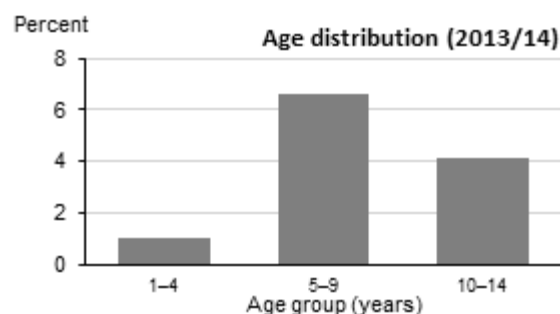
Box 47: Children (aged 1–14 years) who had any teeth removed due to decay, an abscess, infection or gum disease in the last 12 months

	2013/14	2012/13	2006/07
Percent	4.1	3.6	.

In 2013/14 this was an estimated 35,000 children

Adjusted rate ratio (2013/14)

Boys vs girls	1.0
Māori vs non-Māori	1.6 *
Pacific vs non-Pacific	1.5
Asian vs non-Asian	0.9
Most vs least deprived	2.0



* There is a statistically significant difference between the two groups.

Tooth decay is the most common disease of childhood, and one of the three leading causes of potentially avoidable hospitalisations among children in New Zealand. When a child presents with irreversible tooth decay, the aim is to provide care and treatment to enable the child to be free of pain, infection and disease. Sometimes this is best achieved by filling or extracting the tooth.

The survey asked parents of children aged 1–14 years if their children had had one or more teeth (primary or permanent) removed due to decay, abscess or infection in the last 12 months. Note that this excludes teeth lost for other reasons, such as injury, a crowded mouth or orthodontics.

Parents of around 35,000 children (4.1%) reported that their child had one or more teeth removed due to decay, abscess or infection in the last 12 months.

Tooth removal due to decay, abscess or infection in the last 12 months was lowest among those aged 1–4 years (for whom the rate was 1%), and most common among 5–9 year olds (for whom the rate was 6.6%).

One in 20 Māori children (5%) had teeth removed due to decay in the last 12 months.[†] After adjusting for age and sex differences, Māori children were 1.6 times as likely as non-Māori to have had a tooth extracted in the last 12 months.

[†] Results for Māori and Pacific children are provided at the end of the child section.

Table 7: Key survey results for Māori children

Indicator	Percent 2013/14	Percent 2012/13	Percent 2006/07	Change since 2012/13	Change since 2006/07
Health status, health behaviours and risk factors					
Excellent, very good or good parent-rated health	97.2	96.4	97.5	=	=
Given solid food before four months (four months–four years)	13.7	15.9	21.7	=	▼
Ate breakfast at home every day (2–14 years)	82.8	81.2	83.7	=	=
Usually watched 2+ hours of television each day (2–14 years)	62.9	61.2	.	=	.
Obesity (2–14 years) ¹	15.5	17.7	11.8	=	▲
Health conditions					
Asthma (medicated) (2–14 years)	20.7	22.4	20.3	=	=
Diagnosed emotional or behavioural problems (2–14 years)	4.6	6.1	1.9	=	▲
Access to health care					
Visited a GP in the past 12 months	74.6	74.1	80.1	=	▼
Visited a practice nurse (without seeing a GP at the same visit) in the past 12 months	24.2	24.9	24.6	=	=
Visited an after-hours medical centre in the past 12 months	17.4	19.9	.	=	.
Experienced any unmet need for primary health care in the past 12 months:	27.4	27.6	.	=	.
• Unable to get appointment at usual medical centre within 24 hours	18.9	15.8	.	=	.
• Unmet need for GP services due to cost	6.5	8.9	.	▼	.
• Unmet need for after-hours services due to cost	4.7	6.7	.	=	.
Unfilled prescription due to cost	7.0	9.3	.	=	.
Definitely had confidence and trust in GP	73.6	74.1	.	=	.
Oral health					
Visited a dental health care worker in the past 12 months (1–14 years)	80.8	78.2	74.1	=	▲
Had any teeth removed due to decay, abscess, infection or gum disease in the past 12 months (1–14 years)	5.5	5.1	.	=	.

Key: ▲ Statistically significant increase² = No statistically significant change
▼ Statistically significant decrease² . Data not available

1 Revised from the *New Zealand Health Survey: Annual update of key findings 2012/13*.

2 The significance (*p*-values) of differences between years is based on age-standardised rates.

Table 8: Key survey results for Pacific children

Indicator	Percent 2013/14	Percent 2012/13	Percent 2006/07	Change since 2012/13	Change since 2006/07
Health status, health behaviours and risk factors					
Excellent, very good or good parent-rated health	97.8	98.5	97.9	=	=
Given solid food before four months (four months–four years)	10.3	9.3	20.7	=	▼
Ate breakfast at home every day (2–14 years)	75.2	80.3	79.4	=	=
Usually watched 2+ hours of television each day (2–14 years)	67.5	59.2	.	▲	.
Obesity (2–14 years) ¹	24.8	26.3	23.1	=	=
Health conditions					
Asthma (medicated) (2–14 years)	16.8	16.5	14.8	=	=
Diagnosed emotional or behavioural problems (2–14 years)	1.4	0.9	0.4	=	=
Access to health care					
Visited a GP in the past 12 months	76.7	75.8	83.4	=	▼
Visited a practice nurse (without seeing a GP at the same visit) in the past 12 months	20.5	19.4	18.9	=	=
Visited an after-hours medical centre in the past 12 months	22.8	21.4	.	=	.
Experienced any unmet need for primary health care in the past 12 months:	28.8	23.7	.	=	.
• Unable to get appointment at usual medical centre within 24 hours	15.6	11.0	.	=	.
• Unmet need for GP services due to cost	8.8	7.7	.	=	.
• Unmet need for after-hours services due to cost	7.1	7.9	.	=	.
Unfilled prescription due to cost	12.2	10.2	.	=	.
Definitely had confidence and trust in GP	68.7	79.3	.	▼	.
Oral health					
Visited a dental health care worker in the past 12 months (1–14 years)	78.9	73.2	69.2	=	▲
Had any teeth removed due to decay, abscess, infection or gum disease in the past 12 months (1–14 years)	5.6	5.5	.	=	.

Key: ▲ Statistically significant increase² = No statistically significant change
▼ Statistically significant decrease² . Data not available

1 Revised from the *New Zealand Health Survey: Annual update of key findings 2012/13*.

2 The significance (*p*-values) of differences between years is based on age-standardised rates.

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Appendix 1: Definitions and statistical methods

This section gives some key information to aid interpretation of the survey results. For more details about the survey methodology, see the *Methodology Report 2013/14: New Zealand Health Survey* and *Indicator Interpretation Guide 2013/14: New Zealand Health Survey*.

Results are representative of the total adult or child population

All results presented in this report are weighted so that they are representative of the total population of either adults (15 years and above) or children (0–14 years).

Percentages refer to unadjusted values

Any percentages given in the text refer to the *unadjusted prevalence*; that is, the percentage of people affected in the population group of interest.

Total response ethnicity

This report uses total response ethnicity to define ethnic groups. Total response ethnicity classifies a person in all the ethnic groups they identify with. This means that people can appear in more than one ethnic group.

Statistical significance

Statistical significance is measured at the 5% significance level (that is, a *p*-value less than 0.05). If needed, a statistical test (a *t*-test) is carried out to confirm that the finding was statistically significant. Due to the large number of results included in this report, some results identified as significant could be chance findings.

Time trends

The prevalence estimates used in this report reflect the actual (unadjusted) percentage of the population affected in each time period. However, the significance (*p*-values) of differences between years has been adjusted for differences in the age structures of the underlying populations over time.

Survey results show associations, not cause-and-effect relationships

This survey presents a snapshot of the health of New Zealand adults and children at one point in time. The survey can be used to look at associations between different factors, such as health status and neighbourhood deprivation. However, we cannot conclude that the survey results show cause-and-effect relationships between these factors, in part because we do not know which factor occurred first.

For example, if the survey finds that a particular condition is more common in people living in deprived areas, an association has been identified. This association does not necessarily mean the condition is caused by living in deprived areas.

Reliability of survey results

The survey results are likely to underestimate or overestimate some indicators due to the nature of self-reported information.

For example, many of the survey results assume that respondents can accurately recall previous events (such as a diagnosis by a doctor). Also, many indicators in this report are about *diagnosed* conditions, and not everyone with a particular condition will have had it diagnosed by a doctor. People may also over-report good behaviours or under-report risk behaviours based on what they consider to be socially desirable. The amount of error will vary by indicator, depending on a number of factors (including the age of the respondent).

Indicators about body size (such as obesity) are based on height and weight measurements taken by the interviewers, rather than self-reported information. These results are more reliable than self-reported information would have been.