

“The welfare system is a necessity for us”: providers’ perspectives on the barriers to accessing welfare support for people living with work-limiting conditions and disability in Aotearoa New Zealand

Lynley Uerata, Amy Jones, Polly Atatoa Carr, Jade Tamatea, Nina Scott, Ross Lawrenson

ABSTRACT

AIMS: Income is a key determinant of health and health equity. This paper outlines the current welfare supports for people with long-term conditions and reviews the issues associated with accessing those supports, particularly during health system engagement.

METHODS: Weaving a Kaupapa Māori methodology, the He Pikinga Waiora framework and a qualitative approach, our team spoke to 130 healthcare providers across the Waikato Region in face-to-face and virtual engagements about system-level issues associated with accessing welfare support. Notes taken during these engagements were analysed using inductive thematic analysis, systems thinking and a Kaupapa Māori lens.

RESULTS: Because of the way health and welfare systems operate and limited access to advocacy, computerised resources and information about welfare and other supports, key informants observed that patients experienced many difficulties accessing the right type and level of welfare support, with likely consequent impact on health outcomes. These realities were exacerbated because providers were not enabled to help patients navigate the welfare system.

CONCLUSION: The health and welfare systems are not designed to enable access to welfare support. Providers could have a more meaningful role ensuring equitable access to welfare and other supports but are underfunded, understaffed and unsupported. A more integrated approach and cross-sectoral action are needed.

Health and welfare are interconnected, and income is a critical determinant of health outcomes and the equitable distribution of health outcomes.¹ Health conditions have significant and diverse effects on labour market participation.^{2,3} The functional and cognitive limitations imposed by a health condition and the pain experienced combine to reduce the number of hours and type of work people with work-limiting conditions and disabilities can do.³ They tend to move in and out of the labour market, have a reduced capacity to earn and are more likely to be unemployed.²⁻⁷

Low access to economic resources, including income, exacerbates poor health outcomes in many ways.¹⁻¹¹ As economic resources are absorbed through higher health costs,^{3,10,11} low access to economic resources constrains self-care and access to health-enabling resources, such as health insurance and stable housing,^{10,11} and increases

stress and anxiety.^{11,12} While these factors elevate the need to access the health system, low economic resources make it difficult to get to and access the health system, including medication and forms of healthcare.¹⁰ The role of appropriate income support becomes increasingly important to achieve health and health equity gain.

Income support systems function as a social safety net designed to support people experiencing economic hardship caused by unemployment, disability, illness or old age.^{1,6,13} Income support systems typically assist with costs associated with housing, children and childcare, and health conditions or disabilities, and are purported to provide a basic standard of living.^{1,6} While the right to access social security is outlined in Article 22 of the Universal Declaration of Human Rights and Article 9 of the International Covenant on Economic, Social and Cultural Rights,¹⁴ national and international research shows income support

rates are often significantly less than the total eligible population because of complex and time-consuming government processes.^{1,6}

In Aotearoa New Zealand, Article 2 (tino rangatiratanga) of Te Tiriti o Waitangi (Te Tiriti) sets out the government's obligation to ensure Māori have the same rights and privileges, including health and wellbeing, as other New Zealanders.^{1,6,15} As citizens and partners to the Crown under Te Tiriti, Māori should be able to access welfare and other support.^{1,6,10,15} Māori experiences of colonisation and harmful colonial systems mean the need for support for Māori is disproportionately higher.^{6,10,15} However, research shows Māori tend to have lower access to these supports because of the complex, changing and time-consuming nature of government policies and processes, and systemic racism.^{1,3,6,10,15} Even if Māori and others needing welfare support received what they are entitled to, the level of welfare support is “woefully inadequate”.¹⁵ These realities represent a systems failure.

Current welfare supports

In Aotearoa New Zealand two government agencies—Ministry of Social Development (MSD) and Accident Compensation Corporation (ACC)—provide financial and other support to people with work-limiting health conditions sustained through disability, illness or injury.¹ ACC does not cover long-term conditions that are not work- or injury-related, however, and is not included in this substudy. While the type and level of support provided depends on how an impairment occurred and incapacity manifests,^{1,7} the level of weekly payment depends on the age, relationship status and number of dependent children.¹⁶ Administered through Work and Income New Zealand (WINZ), MSD provides two main benefits for people with work-limiting health conditions or disability, including Jobseeker Support—Health Condition or Disability (JS-HCD) for short-term incapacity and the Supported Living Payment (SLP) for permanent and severe incapacity.¹⁶ These main benefits can be accessed by citizens, permanent residents or residence-class visa holders who have lived in Aotearoa New Zealand for more than 2 years.¹⁶ MSD uses an individualised application process and provides flat-rate, means-tested support.^{1,17} All recipients are subject to case management and medical reassessment.^{1,16}

SLP

The SLP is a weekly payment for people with

work-limiting health conditions, injury or disability or a full-time, home-based carer.¹⁶ Eligible individuals are 16 years or older, and totally blind or have a health condition, injury or disability that severely restricts their ability to work more than 15 hours weekly. It is expected that their incapacity will last longer than 2 years, or life expectancy is less than 2 years.¹⁶ Where the spouse being cared for would otherwise need hospital- or residential-level care, a carer can apply who is 16 years or older and without dependent children, or 20 years or older with dependent children.¹⁶

JS-HCD

The JS-HCD benefit is a subset of the Jobseeker Support benefit and only available to a person living with a work-limiting health condition or disability.¹⁶ Eligible individuals are 18 years or older without dependent children, or 20 years or older with dependent children, and unable or limited in their capacity to work full-time, or are in employment but can only work between 15 and 29 hours weekly. From 1 July 2025, recipients will be provided 26 weeks (previously 52 weeks) of support before they need to re-apply.¹⁸ Both SLP and JS-HCD applicants must complete a Work Capacity Medical Certificate penned by a registered doctor, dentist, midwife or nurse. Both SLP and JS-HCD recipients are automatically provided the Winter Energy Payment and can apply for the Accommodation Supplement and Disability Allowance for ongoing housing and health costs.¹⁶

This substudy is part of a larger project to co-design a hauora (wellbeing) needs assessment that integrates the socio-economic determinants and clinical support for Indigenous Māori living with chronic disease. When participants in the larger project described access to welfare support as a critical and continuing issue for Māori patients for many reasons,¹⁰ our team decided to explore what was going on, particularly the higher-level drivers and government responsibilities, and drive change. Alongside other published and forthcoming papers,¹⁰ this substudy explores, from providers' perspectives, barriers to accessing income and other support for eligible patients and monitors the Crown against its Te Tiriti obligations to Māori.

Methods

This substudy is part of a response to a whānau- and community-defined problem that is grounded in a Kaupapa Māori methodology,^{19,20} guided by

the He Pikinga Waiora framework,^{21,22} and used a qualitative approach. Key informants were recruited for in-person and virtual engagements between 2021 and 2023 via community and clinical networks, hospital teams and digital or physical pānui (poster), with snowball sampling leading to further referrals. Key informants' perspectives were gained using semi-structured, qualitative engagements, which enabled an in-depth, flexible exploration of experiential understanding across health contexts, focussing on Māori patients' experiences.²⁰ Because research practices can be a barrier to participation, we took an informal approach to the engagements, which did not include written consent and audio-recording.

Individual and group engagements were undertaken with 130 Māori and non-Māori providers working across many health contexts and roles (Table 1). Beginning with tikanga (practices), such as karakia (prayer) and whakawhanaungatanga (making connections),^{19,20} engagements explored providers' observations of the health determinants and systemic issues impacting patients' lives and service provision. Examples of questions asked were: What health determinants are operating in patients' everyday lives? What systemic issues enable and constrain your service? With informants' verbal consent, the information was written in notes by LU during the engagement, then discussed with the research team.

Systems thinking and inductive thematic analysis of the notes were undertaken by LU, then developed into themes with the research team and a social worker.^{20,23} Inductive thematic analysis enabled

themes to emerge from the empirical material rather than be categorised into predetermined boxes.^{20,23} Themes were then contextualised within the layers of the health and government systems, and issues of power, privilege and racism were highlighted using systems thinking.^{21,22,24} Victim-blaming and cultural deficit theories were rejected in the writing up of the results, and a mana-enhancing, rights-based account provided about how a group of Māori people are negatively impacted by colonial systems. The team—comprising Māori and non-Māori researchers and healthcare providers—shared results in many contexts, such as conferences, policy discussions and decision-maker engagement, while using whānau and provider feedback to drive systems-level change and implementation. Social workers are often mentioned specifically in the results because they play a key role in supporting patients needing welfare support.

A key tension in this substudy was the use of Māori and non-Māori providers' perspectives who see and support Māori in many contexts. We have used these perspectives because they encounter systems from within and provide valuable insights about how system-level issues shape whānau experiences. These perspectives may be different from whānau lived experience, however, and they could be read alongside Uerata et al., which explored whānau lived experience of health determinants, including the welfare system.¹⁰ Ethical approval was granted by the Health and Disability Ethics Committee (Ref: 21/NTB/148) and Waikato DHB Māori Research Review Committee.

Table 1: Types of organisations and roles held by participants.

Type of organisation	Number of key informants	Type of role	Number of key informants
Hospital	77	Allied health	56 (including 9 social workers)
Community	17	Clinical	44
Māori primary care/ primary care	16/4	Management and leadership	14
University	8	Mental health	8
Māori and/or Pacific support services	5	Research	6
Government	3	Culture	2
Total	130		130

Results

Three themes particular to the hospital context were developed: the application process, pushed around and missing out, and WINZ policies and processes. Key informants reported that patients presented to the hospital with significant social needs, especially housing and income support. Patients described many difficulties when engaging WINZ, especially Māori patients, and asked for social workers to support them. Social workers reported that they helped patients to access welfare support every day because of high unmet need and because many patients were receiving the wrong type and level of support. Providers noted that many patients were unemployed and worried about paying for basic living and health costs on a low income. Poor access to food and heating were common, and those affected were often unwell.

The application process

Key informants reported that many eligible patients experienced limited access to information about how to access services and support. Social workers observed that patients spent significant time waiting for WINZ to answer the phone and became frustrated when redirected to complete an online application form, because the WINZ website stated they could apply by phone. Key informants noticed that the individualised application process was especially difficult for the newly diagnosed who were coming to terms with long-term disease and the specificities of a complex welfare system they might not have previously accessed. Additional challenges in the application process were noted for those who found it difficult to navigate online platforms and processes, those without internet access and appropriate technology and those with learning support needs. These experiences show how information barriers intersect with individual barriers to constrain access to welfare support. Informants identified many groups of people with the greatest need who seemed to experience the greatest difficulty accessing support intended for those with the least.

Social workers observed that government representatives questioned the existence of patients' conditions and the medication taken, including those with advanced renal disease. Answering questions about their condition after providing the necessary documentation was "disempowering" and demeaning for patients. While the welfare system required a lot of information from appli-

cants, a lack of communication from the welfare system left many patients waiting and wondering whether they would receive support.

Pushed around and missing out

Key informants mentioned that many patients assumed ACC would help them and were surprised when referred on to WINZ without any support. When patients also found it difficult to get help from WINZ, key informants observed that many patients gave up trying to access support. When advocating for patients, social workers noticed that many existing welfare recipients were not on the right type and level of welfare support and accessing additional support was difficult, such as the Disability Allowance, housing or support for food. Gaining social housing was described by one social worker as "impossible". Key informants across many health contexts explained that WINZ's reimbursement mechanism requires pre-payment and reimbursement takes significant time to be processed. Consequently, many patients were choosing to forego accessing healthcare rather than use this financial support.

WINZ is presented by key informants as unwilling to see and support people's situations appropriately and holistically, and as pushing people to the next government agency without support or direction.¹⁰ This approach is more significant for people with complex needs because they cannot access other government services, such as the Winter Energy Payment and housing, without first accessing MSD support. Because Māori experience a higher burden of chronic disease and are more likely to experience circumstances that require benefit use, they are more likely to be adversely affected by being without welfare support and experience further delays to accessing the health system.^{1,10,11}

WINZ processes and policies

Because of the way the welfare system operates, patients approached social workers to help them navigate WINZ and other government agencies. When trying to advocate for patients, social workers found it difficult to get through to WINZ and it was impractical to wait by patients' beds for long periods of time. When the phone was answered, WINZ representatives were not forthcoming with information and were sometimes unwilling to communicate with them. While there was a Kāinga Ora Homes and Communities (government housing agency) representative to answer queries about housing, there was lacking an MSD representative to address

queries about welfare support. For these reasons, alongside a shortage of social work staff, some social workers were directed by departmental leadership not to support patients to access welfare support. How widely this is practised is unknown. For the reasons described above, social workers said they were forced to be “creative” and “persistent” in their advocacy for patients. They routinely helped to correctly complete application forms and provided questions for patients and whānau to ask WINZ, and sometimes bypassed unhelpful local agency offices to communicate directly with MSD leadership.

Key informants identified many ways the health and welfare systems are not set up to enable access to support, describing that system-level issues across the health and welfare systems interacted to constrain access. The difficulties faced by hospital-based social workers mean the scope for intervention for the benefit of patients can be ineffective and restrictive, and their role to support access for patients is severely undermined. Consequently, the difficulties faced by patients and their whānau will continue.

Discussion

This substudy highlights issues associated with accessing welfare support for Māori patients with long-term conditions from providers’ perspectives. Providers’ experiences present the welfare system as demeaning, difficult, time-consuming, unresponsive and unwilling to see and support real people appropriately, meaningfully and holistically.^{10,15} Crucial supports that enable access to welfare support are not being provided, including advocacy within the hospital context. Consequently, many eligible Māori patients are not accessing and being denied their full right to welfare support.^{1,6,10,15} The various barriers and blocks described above show the health and welfare systems are not designed to enable access, consider equity, nor appropriately counteract the effects of colonisation and systemic racism.^{10,15} These are breaches of the right for Māori to access income and other support.^{1,6,15}

Access to economic security is essential to health and wellbeing, especially for people with long-term conditions.^{1,6,10,15} Access to such support is crucial for Māori and Pacific patients as they tend to be diagnosed younger than non-Māori, non-Pacific people, and their experience of long-term conditions is exacerbated by inequitable

access to healthcare and poorer care.^{10,25} The National Party-led coalition government’s (2023–) commitment to reduce welfare receipt, increase the obligations of recipients and apply sanctions more strictly will make life more difficult for people with long-term conditions and result in further economic hardship.^{26,27}

The current approach to welfare provision positions providers as gatekeepers to income and other support, and they therefore have a role in ensuring equitable access. However, this is currently underfunded, understaffed and providers need support from MSD and WINZ to ensure they understand the available welfare supports. The current approach also puts significant onus on advocates and individuals in difficult situations to navigate a “*landscape of diverse, uncoordinated and disordered service provision*” to access the support patients are eligible for.²⁸ If constrained, stretched, underfunded non-government and community organisations (whose contracts have been cut) continue to be expected to overcome these government failures,²⁹ the government will not fix the failures it creates and recreates. We urge government agencies to take responsibility for the failures and make change.

Given the importance of income to wellbeing, we agree with the findings of the 2018 Welfare Expert Advisory Group that an integrated approach to accessing welfare support and cross-sectoral action are needed.¹ The recent report *Determining our Future* by the Public Health Advisory Committee notes that income support policies are one of the most effective interventions at improving health outcomes and health equity.³⁰ Therefore, it is essential that reform across the health and welfare sectors is actioned to reduce siloes and foster preventative care. An integrated approach that enables easy access to the right type and level of welfare support for those in contact with health services is recommended. The integrated approach should be co-designed (including with whānau, government and non-government services), with appropriate data sharing and troubleshooting. Opportunities are needed for those with health concerns to be supported by a dedicated MSD team to respond to queries and progress applications for welfare supports. Health workers need to understand their roles and opportunities to enable the available welfare supports. This approach can be fostered by workforce development within the existing sector services and the provision of further social worker and navigator

supports in health contexts to initiate applications for patients. Secondments of MSD staff into the health sector, embedding health sector knowledge into the benefit review system, and cross-sectoral governance support can also reduce gatekeeping and enable integrated practice. Ensuring access to income and other supports through an integrated approach is also relevant to the Crown meeting its obligations under Te Tiriti.

The results of this substudy should be considered in light of some limitations. Only the perspectives of providers in the Waikato Region are presented and may be different from whānau lived experiences and other regions. Audio-recording the engagements would have been beneficial, adding quotes to the results.

Conclusion

The welfare system continues to be complex and multiple barriers impede access, including the gatekeeper role of doctors, nurses and social workers. The workforce constraints described by providers, coupled with the changing and complex welfare system, likely exacerbate the inadequate and inequitable delivery of income support to those with the greatest need; thus, perpetuating critical health inequity. Providers could have a more meaningful role in ensuring equitable access to welfare and other supports, but funding and support are needed. An integrated approach and cross-sectoral action are essential.

COMPETING INTERESTS

The Health Research Council of New Zealand provided the funding for the parent project and the present paper. There are no known conflicts of interest. We accept full responsibility for the conduct of the study, for our access to the data and for our decision to publish.

ACKNOWLEDGEMENTS

Our research team thanks the Health Research Council [20/1178] for funding this work and the key informants for sharing their stories and perspectives with our team.

AUTHOR INFORMATION

Dr Lynley Uerata: Researcher and Evaluator, Māori Health, Health New Zealand – Te Whatu Ora Waikato, Hamilton, New Zealand.

Dr Amy Jones: Programme Manager, Māori Health, Health New Zealand – Te Whatu Ora Waikato, Hamilton, New Zealand.

Associate Professor Polly Atatoa Carr: Associate Professor of Population Health, Te Ngira: Institute for Population Research, University of Waikato, Hamilton, New Zealand; Public Health Physician, Paediatrics, Health New Zealand – Te Whatu Ora Waikato, Hamilton, New Zealand.

Dr Jade Tamatea: Endocrinologist, Health New Zealand – Te Whatu Ora Waikato, Hamilton, New Zealand; Senior Lecturer Māori Health, Te Kupenga Hauora Māori, The University of Auckland, Hamilton, New Zealand.

Dr Nina Scott: Interim Chief Medical Officer, Hauora Māori Services, Health New Zealand – Te Whatu Ora Waikato, Hamilton, New Zealand.

Professor Ross Lawrenson: Professor of Population Health, University of Waikato, Hamilton, New Zealand.

CORRESPONDING AUTHOR

Dr Lynley Uerata: Researcher and Evaluator, Māori Health, Health New Zealand – Te Whatu Ora Waikato, Hamilton, New Zealand. Hockin Level 1, Waikato Hospital, Pembroke St, Hamilton, Private Bag 3200, Hamilton 3240, New Zealand.
E: lynley.uerata@tewhatauora.govt.nz

URL

<https://nzmj.org.nz/journal/vol-139-no-1629/the-welfare-system-is-a-necessity-for-us-providers-perspectives-on-the-barriers-to-accessing-welfare-support-for-people-living-w>

REFERENCES

1. Welfare Expert Advisory Group. Current state: the welfare system and people with health conditions or disabilities [Internet]. Ministry of Social Development – Te Manatū Whakahiato Ora; 2019 [cited 2024 Apr 30]. Available from: <http://www.weag.govt.nz>.
2. Madden D. Labour market discrimination on the basis of health: an application to UK data. *Appl Econ*. 2004;36(5):421-42.
3. Uerata LM. Unpredictable, incurable, unemployable? a collection of constructed narratives exploring the experiences of people with chronic conditions in relation to finding and keeping work [MA thesis]. Hamilton: Waikato University; 2011.
4. Francis H. How do people with multiple long-term conditions experience the self management approach to health care [dissertation]. Palmerston North: Massey University; 2017.
5. Ávila CC, Ayuso-Mateos JL, Muñoz-Murillo A, et al. Identifying the employment needs of people with chronic health conditions in Europe. *J Occup Med*. 2018;60(11):e618-24.
6. Welfare Expert Advisory Group. The take-up of income support: analysis and options [Internet]. Ministry of Social Development – Te Manatū Whakahiato Ora; 2018 [cited 2025 Jan 29]. Available from: <https://www.weag.govt.nz>.
7. Stephens R. Horizontal equity for disabled people: incapacity from accident or illness. *Vic Univ Wellingt Law Rev*. 2004;35(4):783-800.
8. Paez KA, Zhao L, Hwang W. Rising out-of-pocket spending for chronic conditions: a ten-year trend. *Health Aff*. 2009;28(1):15-25.
9. Lehnert T, Heider D, Leicht H, et al. Review: health care utilization and costs of elderly persons with multiple chronic conditions. *Med Care Res Rev*. 2011;68(4):387-420.
10. Uerata LM, Scott N, Tamatea J, et al. Understanding the determinants of health for Māori living with chronic disease in Aotearoa New Zealand. *J Prim Health Care*. Forthcoming 2025. doi:10.1071/HC25064.
11. Lisipeki S, Masters-Awatere B, Hodgetts D, Liew TV. Reciprocal relations between cardiovascular disease, employment, financial insecurity, and post cardiac event recovery among Māori men: a case series. *J Med Case Rep*. 2023;17(468):1-8.
12. Jeon YH, Essue B, Jan S, et al. Economic hardship associated with managing chronic illness: a qualitative inquiry. *BMC Health Serv Res*. 2009;9:182.
13. Currie J. The take up of social benefits. Working Paper 10488. In: Auerbach A, Card D, Quigley J, editors. *Poverty, the distribution of income, and public policy*. New York: Russell Sage; 2006:80-148.

14. Human Rights Commission. Right to social security [Internet]. Wellington, New Zealand: Human Rights Commission; [cited 2025 Apr 30]. Available from: <https://tikatangata.org.nz/human-rights-in-aotearoa/right-to-social-security>.
15. O'Brien M, St John S. Ensuring benefit recipient income levels support family wellbeing [Internet]. Auckland: Child Poverty Action Group; 2023 [cited 2025 Apr 30]. Available from: <https://www.cpag.org.nz>.
16. Work and Income New Zealand. A-Z benefits and payments [Internet]. Wellington: Ministry of Social Development – Te Manatū Whakahiato Ora; [cited 2025 Jan 30]. Available from: <https://www.workandincome.govt.nz/products/a-z-benefits>.
17. Wilson M, McLeod K. Understanding the growth in Invalid's benefit receipt in New Zealand. *Soc Policy J N Zeal*. 2006;29:127-45.
18. Work and Income New Zealand. Jobseeker Support reapplication changes [Internet]. Wellington: Ministry of Social Development – Te Manatū Whakahiato Ora; 2025 [cited 2025 Jul 1]. Available from: <https://www.workandincome.govt.nz>.
19. Haitana T, Pitama S, Cormack D, et al. The transformative potential of Kaupapa Māori research and indigenous methodologies: positioning Māori patient experiences of mental health services. *Int J Qual Methods*. 2020;19.
20. Pihama L. Kaupapa Māori theory: transforming theory in Aotearoa. *He Pukenga Kōrero: A Journal of Māori Studies*. 2010;9(2):5-14.
21. Oetzel J, Scott N, Hudson M, et al. He Pikinga Waiora implementation framework: a tool for chronic disease intervention effectiveness in Māori and other indigenous communities. *Int J Integr Care*. 2018;18(s1):1-8.
22. Rarere M, Oetzel J, Masters-Awatere B, et al. Critical reflection for researcher–community partnership effectiveness: the He Pikinga Waiora process evaluation tool guiding the implementation of chronic condition interventions in Indigenous communities. *Aust J Prim Health*. 2019;25(5):478–85.
23. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101.
24. Curtis E. Indigenous positioning in health research: the importance of Kaupapa Māori theory-informed practice. *Alternative*. 2016;12(4):396-410.
25. Palmer SC, Gray H, Huria T, et al. Reported Māori consumer experiences of health systems and programs in qualitative research: a systematic review with meta-synthesis. *Int J Equity Health*. 2019;18(1):1-26.
26. Radio New Zealand. Watch: Government further increases sanctions for beneficiaries [Internet]. Radio New Zealand; 2024 Aug 12 [cited 2025 Jan 25]. Available from: <https://www.rnz.co.nz/news/political/524919/watch-government-further-increases-sanctions-for-beneficiaries>.
27. Palmer R, Hanly L. Government benefit sanctions 'waging a war on the poor' – Greens [Internet]. Radio New Zealand; 2024 Aug 13 [cited 2025 Jan 25]. Available from: <https://www.rnz.co.nz/news/political/524959/government-benefit-sanctions-waging-a-war-on-the-poor-greens>.
28. Hodgetts D, Chamberlain K, Groot S, Tankel Y. Urban poverty, structural violence and welfare provision for 100 Families in Auckland. *Urban Stud*. 2013;51(10):2036-51.
29. Social Service Providers | Te Pai Ora o Aotearoa. Social Service Providers throughout Aotearoa New Zealand continue to lose funding [Internet]. Social Service Providers | Te Pai Ora o Aotearoa; 2024 [cited 2025 Oct 8]. Available from: <https://www.sspa.org.nz>.
30. Public Health Advisory Committee. Determining our future. Social, cultural, economic and commercial determinants of wellbeing in Aotearoa New Zealand: actions to improve our health and wellbeing [Internet]. Wellington, New Zealand: Ministry of Health – Manatū Hauora; 2025 [cited 2025 Oct 8]. Available from: <https://www.health.govt.nz>.