AWHC

NEWSLETTER

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a voice for women's health

Auckland Women's Health Council

PO Box 32-445
Devonport
Auckland 0744

EMAIL:
awhc@womenshealthcouncil.org.nz

WEBSITE:
www.womenshealthcouncil.org.nz

EDITOR:
Sue Claridge

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Don't forget to let us know what health topics you are most interested in.

For back issues of our Newsletter, check out our website.

Vote Health!

By Sue Claridge

In this edition of the *Newsletter* we urge you to Vote Health! To vote with the state and future of our health system in mind.

We know that there are many issues that are at the forefront of people's concerns a week out from the election. We know that for the majority of New Zealanders, the cost-of-living crisis is likely to be the priority.

However, we feel that the crisis in our health system must be high on many people's agendas. To those living in good health, with scant need for care in our health system, you are indeed lucky and privileged. But it cannot have escaped your atten-tion that our health system is broken. As we reported in the August-September *Newsletter*, Malcolm Mulholland, Founder of Patient Voice Aotearoa, described our health system as being "in intensive care and starting to flatline."

Since then, Malcolm, together with Dr David Galler, have traversed the country, visiting 27 towns and cities from Bluff to Kaitaia, on a Kaitiaki Hauora Roady to talk to health consumers and health professionals about their experiences in our health system. David Galler's account of what they learned over those two weeks on the road is the first of our two feature articles (see page 5) that we hope will give you important information, as you consider your vote in the final days before the election.

We hope that you will gain an understanding of what it is like for New Zealanders around the motu as they seek health care, or as they work in public health trying to do their best for the health of New Zealanders.

In our second article (page 10), we have looked at the health policies of all the parties currently in Parliament plus the Opportunity Party (as they are currently polling just high enough to get into Parliament). No matter who forms the Government, it is clear that it will be another coalition after the 7th of November, and the health policies of the minor parties could be up for negotiation in post-election discussions. We've looked at the main planks of the health policies, what makes each party policy different and what they have offered for women's health.

Kaitiaki Hauora, of which we are members, sets out three very basic asks for our health system. That the next Government:

- Funds public health properly — so everyone gets care when they need it.
- Honours Te Tiriti — ensuring Māori lead on equity in the health system.
- Keeps healthcare public — so care stays for people, not profit.

We are also members of the Health Coalition Aotearoa. Their concerns are with the commercial determinants of health: tobacco and vaping, alcohol, and unhealthy diet. They are advocating for increased investment in public health, Te Tiriti-led initiatives to re-balance inequitable health out-comes, and protection of evidence-based prevention from commercial influence, such as lobbying by wealthy multinational interests. They are focussed on creating healthy environments, and protecting against preventable disease and death with evi-dence-based policy and initiatives.

The social determinants of health are also vitally important — housing, education, income and poverty, employment and welfare support, violence including family violence, ethnicity and racism, drug use and addiction, gambling. We don't have room to consider the party policies on these issues, but if the state of health in Aotearoa New Zealand is a driving factor in how you vote, these are issues that need to be considered as well.

In this edition, we also have a review of the Patient Safety Day activities and Patient Safety Forum, held on the 17th of September (page 21). This is not specifically a "Vote Health" article, but it does reflect some of the most important issues that are faced by those working in and seeking care in our health system — patient harm and patient safety.

The reality is that "if it is not safe, it is not care"*. Our nurses have been campaigning for years now,

Continued on page 4

not just for fair pay, but for safer, better working conditions and for adequate staffing of shifts… because they cannot keep their patients safe in our hospitals.

The state of our health system is so bad that patients are literally not safe. They are not safe in a multitude of different ways, including:

- insufficient GPs, midwives, nurses, physicians and specialists;
- delays in treatment;
- missed and incorrect diagnoses;
- patients waiting weeks to see a GP, perhaps longer to see their own GP and needing continuity of care;
- EDs that are so over capacity that patients wait in ambulances on ramps, lie on beds angle parked in corridors, and wait more than 12 hours to be seen even when suffering life threatening conditions;
- waiting lists so long that many chronically ill and disabled patients are on waiting lists to get onto waiting lists;
- hospital facilities that are old and under-maintained.

Patient safety ***IS*** a political issue, because it is going to take political will to act and make patient safety a priority in Aotearoa New Zealand.

In our view, no single political party has a health policy that comes close to fixing the health system. No matter who forms the next Government we, the health consumers and the health workers, are going to have to hold that Government to account. We are going to have to keep applying pressure until we can see a commitment — and an action plan — from those with the power to effect change, to turn our health system into the world class, best-practice health system that we deserve!

We hope that this edition of the *Newsletter* will give you food for thought in the final days ahead of the election. We hope that New Zealanders will turn out in their droves on the 7th of November and vote for health!

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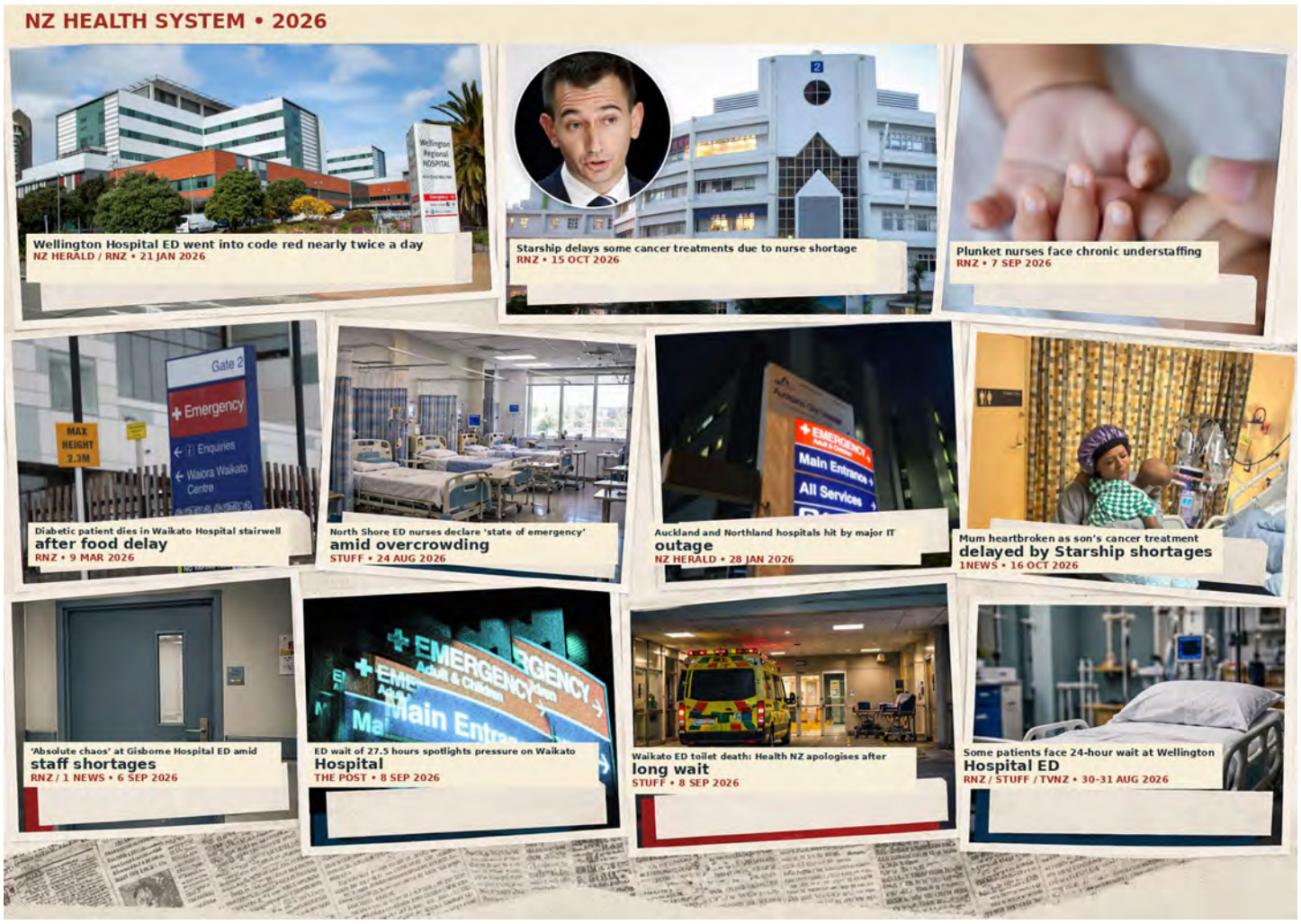
* Dr Tedros Adhanom Ghebreyesus Director-General of the World Health Organization at the 5th Global Ministerial Summit on Patient Safety, 2023.



What Health Consumers and Health Workers Experience and What They Need

Messages From Local Communities and From Health Workers From Bluff to Kaitaia

By Dr David Galler

Background

There have been myriad reports of healthcare failures hitting the media — on an almost daily basis — this year, so Malcolm Mulholland and I thought we would go out to hear directly from users and providers of healthcare from across the country.

Twenty seven locations in two weeks from Bluff to Kaitaia; midday and evening meetings in different towns. Mostly small. Our advertising wasn't great so numbers varied from our lowest of three to our highest of 100, but more frequently 20-ish people came along. In each location we had one or two local speakers.

The format was one of introductory remarks from Malcolm, myself and the local speaker, then the discussion was thrown open to those attending.

Because of the smaller numbers, the nature of those that came, that we were strangers to each other in a safe space, the discussions were high quality, personal, deep and full of insight and meaning. Strangely, I was reminded of the conversations I used to have at work with our patients and their families, when at the end of our meetings it felt like we had become confidantes and that we now had a real and enduring bond between us.

Summary

We were humbled by the welcome we received from people happy and grateful that we had bothered to come to listen to them. However, the overall picture is more grim than we could ever have imagined.

Most people know that the health system has been under stress for a long time, but the deterioration

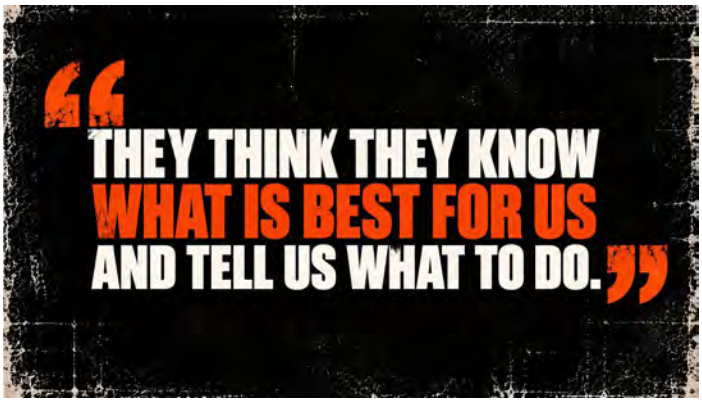
Dr David Galler and Dr Malcolm Mulholland

across all fronts and in all regions has been dramatic during the term of this Government. Our view is one of utter neglect and an emerging chaos, alongside a strong sense from people that the system they knew to be stressed has become corrupted for political and ideological purposes.

Health services everywhere are imploding and in disarray; we concluded that there is no 'system'. Our agencies and services are in Brownian motion* working independently of each other. They serve the

Minister not the people and their decision making, edicts and actions do not support good care.

Users and providers of healthcare have lost trust in the 'system' and feel abandoned. Health workers know they are good at looking after people, but they don't have influence over the circumstances in which that care takes place. Those decisions, which are made by people who are removed from the reality of everyday work and their decisions, more often than not, increase the likelihood of failure. One could make the case that the Minster of Health and HealthNZ (HNZ) are doing actual harm to patients and families.



Despite a pervasive sense of apathy and hopelessness for some, more and more people are angry and want this to change. They want a plan, they want long term planning, they want a system that works for them, and they want a political consensus for that. If that's not possible, they want health to be removed from their influence.

There are bright spots, but no one seems interested in finding these and and learning from them.

Communities are asking for support; they want HNZ to walk alongside them to better understand their need, and provide support for them to be able to get the services they need. People and providers want a clear plan at a local and regional level about how the system is supposed to work for for people.

People are shocked by the magnitude of the underfunding of our health system compared to the average of 16 similar countries in the OECD.

Importantly, we did not hear any views disavowing the need to honour Te Tiriti o Waitangi, in fact, the opposite. Kaupapa Māori services provided to Māori and pākehā stood out as exemplars — they affirm that cultural safety is patient safety.

Key themes

Gratitude

People were so happy that we have bothered to come to their towns to listen to their concerns, It seems that HNZ doesn't do this — instead "they think they know what is best for us and tell us what to do" ... "perhaps if they showed an interest we would have better health services and people would have better health".

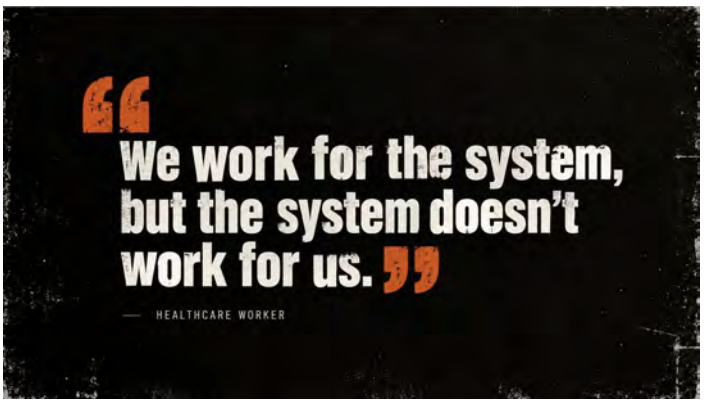
Isolation and abandonment

There is no system, we use that word only out of

* Literally, Brownian motion is the random, jittery movement of microscopic particles suspended in a fluid or gas; however, in this context the term is used figuratively to represent the chaos and lack of cohesion, pattern and logic to what is observed in the health system.

convenience. Users of the 'system' ask "when was the last time someone came to listen to us". Individuals, whānau and communities feel abandoned and unable to get what they need, often at times when they need help most.

The workforce and organisations in small towns and larger centres feel the same. Organisations and practices do their best in isolation from each other and an overall plan.



A common remark by local community providers was "Who knows who does what and has what contract here". They don't understand how the 'system' is supposed to work and are unsure of their place alongside others. There is no obvious plan or map to guide users and providers of care to manage patients across the 'system', at local, regional and the national level. Instead the provision of services appears random in time, confused and chaotic.

It is clear there is no-one coordinating the resources that are available in localities and regions, let alone identifying and dealing with the gaps.

An atmosphere of intimidation towards healthcare staff

This is real and was remarked upon by many. When one member of the public heard this from a health worker, he said this was like what would be expected in Russia. It is clear that staff mistrust the Minister, this Government and HNZ. Most of the healthcare workers who spoke to us are profoundly angry.

A lack of public health

This is a huge issue in many small towns – most notably, poor quality housing, endemic poverty, low wages, and a lack of jobs especially for youth. These are communities ravaged by alcohol, unhealthy food, pokie machines and meth; these are everywhere.

There is an increasing understanding that our healthcare 'system' needs to sit in a broader context where the health and wellbeing of people is promoted and maintained, instead of where we are now, where the health of people is being actively undermined.

No obvious workforce plan and no sense of confidence in the future

Most people know there are severe shortages of staff across all areas. We have a strong reliance on overseas doctors, many of whom move on.

Morale is poor, clinical staff are burning out and leaving to go to private practice, to Australia or leaving medicine altogether. They believe the Government sees them as a cost and a liability, not the asset that they are. The health workforce has little say in the design and delivery of services. One clinician said "we work for the system, but the system doesn't work for us."

The NZ Health Charter* was seen as a means of addressing some of those issues, but that has now been lost.

The public and clinical staff see a reluctance by HNZ to fill obvious gaps, piling more and more work onto those who are left. They see a series of temporary sticking plaster solutions, like the use of expensive locums instead of the Government and HNZ addressing more fundamental issues. These are becoming more and more obvious especially in rural New Zealand.

One healthcare worker "wondered what HNZ does."

Little support for the workforce or understanding of the reality of everyday work

The Government axed the Health Charter, and in doing so, lost a means to understand what is necessary to improve outcomes. As important as the Minister and bureaucracy might be in making a system functional, they don't provide care, so "they need to find out what is needed to support good care in different locations."

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* The New Zealand Health Charter was a requirement under the Pae Ora (Healthy Futures) Act 2022. It was repealed by the National-led Coalition Government on July 10, 2026, under section 29 of the Healthy Futures (Pae Ora) Amendment Act 2026. The Health Charter can still be found online here.

Primary care chaos

Primary care is the foundation of our healthcare system, yet it is in a state of chaos. It's the wild west:

- areas with no primary care at all, people with no access to primary care or very long waits, increasing numbers of people without a GP practice;
- many GPs near retirement;
- more and more corporate buyouts with private equity interests moving in;
- huge fees at after hours urgent care centres;
- people needing to chase up their own results and many results lost.

There is no overall plan and no coordination of services locally. What happens is the result of the market and the market is failing people up and down the country.

Access to diagnostics and to advice from hospital specialists, and access for patients to be seen by hospital specialists is a massive issue and getting worse. As a result people and practitioners have lost trust in the 'system'.

The important issues for primary care providers include:

- The percentage of health spending going to primary care is woefully inadequate and way behind OECD averages. Currently around 5%; that should at the very least double.
- The burden of administration is huge, making the job and pay unattractive.
- Specialist GPs should be paid like hospital specialists.
- Recruitment and retention of staff in rural areas: there is no one approach to fit all contexts — many favour a role for the state in offering employment in hard to recruit to areas.
- People want their community care providers to work together in a more coordinated way and link into hospital services and advice from other specialists to improve their care in the community.
- When specialist GPs refer their patients into the hospital they expect them to be seen, not sent back!

Mental health and addiction

This is more of the same. There is no plan obvious to providers or users; a total absence of services in many areas, in others all services are overwhelmed. People in acute distress are unable to access help. There is high youth suicide rates in many towns, and examples of good local initiatives not being supported, including John Kirwan's school programme helping children understand their emotions. Young people who have attempted suicide and those who have helped them cannot get help — there were some truly gruesome examples. And there are no residential facilities for those that need them.

Utter disarray!

Dental

Everywhere we went we heard stories from dentists about the appalling state of children's teeth, and the high and rising numbers of theatre lists devoted entirely to removing kids' teeth — hours and hours of theatre time. These issues are preventable with the right support, care and messaging.

Hospitals

Hospitals are working in relative isolation from each other. This is the easiest part of the puzzle to "fix" through networking across the hospital system into local communities to support good care.

However, as it stands they are run off their feet so the opportunity to network resources to cover need becomes increasingly hard if not impossible. Again, there is no plan, no 'system'; all are utterly overwhelmed and staff are at their wits end.

There are shortages across all the specialties. This is a vicious cycle; the lack of staff leads to staff burnout and resignations, which puts more pressure on existing staff. This plays out in long waiting times for specialist care. GPs' referrals are being declined and many have stopped referring, creating waiting lists for the waiting lists. The targets don't measure the need and are seen as political nonsense.

Privatisation is seen as socially divisive, eroding the ability of people to get care in public. The people and health workers support the expansion of public provision of care.

The public private interface

All the people who spoke with us believe that healthcare should be public, and the current move to privatisation is dangerous and is undermining the future of public healthcare, driving inequity and poor outcomes.

The current approach is failing Māori

The approach by the current Government will do further damage, yet some of the best examples of care are kaupapa Māori services.

"The Government's one size fits all approach shows how ignorant they are of what matters to many people."

The constitutional, evidential, ethical and moral case for kaupapa Māori services and cultural safety seemed uncontroversial even in rural parts of Southland!

No interest from Health NZ

What exactly does this organisation do?

They are absent in all places and seem disinterested in finding out what is working well, and supporting and spreading those initiatives elsewhere.

Of the community services we saw, these three stood out:

- Ngā Kite Matauranga Pounamu in Invercargill and Bluff
- Aupōuri Ngāti Kahu Te Rarawa Trust in Kaitaia
- NorthAble Matapuna Hauora in Northland

If there is a 'system' it is oriented up not out

The 'system' appears to be there to support a Minister and his political ambitions, with no obvious interest in understanding the reality of everyday work or what is necessary to support good care where it happens. The staff feel that "we are working for the system not the system working for us and the people."

Health is about more than healthcare

In smaller towns across Aotearoa, communities described how poverty, poor-quality housing, low wages and limited employment opportunities, particularly for young people, are affecting people's health and wellbeing. They also raised concerns about the impacts of alcohol, methamphetamine, unhealthy food and the widespread availability of pokie machines.

These are not problems the healthcare system can solve on its own. What Kaitiaki Hauora heard reinforced the need for a much stronger public health approach that addresses the conditions in which people live, rather than focusing almost entirely on treating illness once it occurs. Improving health means investing in prevention, healthier communities and the social and economic conditions that allow people to thrive.

What people want

Despite the frustration, anger and loss of trust expressed throughout the Roady, people have not given up on public healthcare. They want a properly funded, coordinated system that responds to the needs of their communities, with Health New Zealand working alongside local providers, patients and whānau rather than making decisions in isolation.

Communities want clear local and regional plans, stronger connections between primary care, hospitals and specialist services, and meaningful involvement from healthcare workers in decisions about how care is designed and delivered. Above all, they want long-term planning and political consensus that puts the needs of patients and communities ahead of short-term decisions.

People aren't asking for the impossible. They're asking for a public health system that works.

The system must work for people, not the other way around

One of the clearest conclusions from the Roady is that our health system appears increasingly focused upwards, towards ministers and bureaucracy, rather than outwards towards the people it exists to serve. Decisions are being made without sufficient understanding of what happens on the frontline or what patients, whānau and health workers need to deliver and receive good care.

Throughout the journey, healthcare workers described feeling as though they work for the system, rather than the system working for them and the people they care for. Their experience, knowledge and understanding of local needs should be central to decisions about how healthcare is organised and delivered.

Ministers and health administrators have essential roles, but they are not the people providing care. Their responsibility is to listen to those who do, understand what is needed in different communities and ensure the resources, coordination and support are in place to make good care possible.

Promises, Promises!

Health at the ballot box: where the parties stand

By Sue Claridge

Every party agrees that Aotearoa New Zealand's health system is under strain: long GP waits, workforce shortages, crowded emergency departments and a medicines budget that lags Australia's. The incumbents would argue that things aren't as bad as has been reported and that they've done more for health than the last Government. This is just politicking, and we are all familiar with how much of a political football health has become.

You only need to hear what the health professionals — the doctors and nurses — at the coal face are saying, and listen to the lived experience of New Zealanders over the last three years, to know that the politicians are either wilfully ignorant of the reality, or completely out of touch with reality. While the focus of many New Zealanders is on the current Government, the truth is that successive governments have led us to the crisis our health system is in, notwithstanding the impact of the pandemic and global health workforce shortages.

Our health system is broken and on its knees. Our health workforce is overwhelmed, over worked, burnt out and suffering the impact of the loss of many skilled professionals over recent years.

The seven main political parties (the six currently in Parliament and the Opportunity Party*) disagree on the cure. Some want to remove the cost of care, some to boost the supply of clinicians, and others to change who decides and delivers. This guide summarises each party's published policy (at the time of publication) ahead of voting day on Saturday the 7th of November, with extra attention on prevention and women's health, and also flags policy that is distinctive.

So that you can easily identify the policies that impact women's health specifically, we've shaded them purple.

National

National offers continuity, plus more medicines and earlier screening. Its headline new commitment is a further $604 million for Pharmac, paid for largely by cutting foreign aid outside the Pacific by 10%, which it says saves about $431 million. It also plans to unlock CAR-T cell therapy by supporting our medical sector to develop and produce this potentially life-changing cancer treatment in New Zealand. National will set a national target that within ten years, 5% of cancer patients will have part of their care delivered through a clinical trial, where a trial is right for them, and they want to take part.

Prevention is mainly focused on screening: free bowel screening from age 50 by 2029 (the age is falling to 56 from September), backed by extra colonoscopies although they don't say how they are going to deliver increased capacity; breast screening extended to the age of 74 by 2029; and pilots for lung and prostate cancer. A Healthy Kiwis Programme would double the number of people on "active prescriptions" — where a GP or nurse prescribes exercise and healthier eating — by 2030.

* We have included the Opportunity Party as they have been consistently polling high enough to make it into Government in a potential coalition agreement.

For women, National promises free cervical screening for ages 25 to 69 from March 2027, completion of the breast screening extension, and three-day postnatal stays, which were funded in Budget 2026.

What's different:

New lung and prostate pilots, CAR-T cell therapy, a national clinical-trials target, and foreign aid as the funding source.

See National's policies in more detail here and here.

Labour

Labour's focus is affordability. A new Medicard would give every New Zealander three free GP visits a year, and the $5 prescription charge would go from 1 July 2027. Supply-side measures include a Family Doctor Loan Scheme to help GPs buy into practices and stay in their communities, an Independent Pricing Authority to set GP funding, and an emergency department recovery plan. Labour would also guarantee that the approximately 2,400 nursing graduates a year would be offered work, with roles on graduation from 2027, and to end National's hiring freeze. The Medicard package costs $393 million in 2027/28, rising to about $553 million, and is funded by a 28 percent tax on profit from selling investment property, ring-fenced for health. They also plan to initiate an independent report on deaths linked to long ED waits, a nationwide stocktake of closed and unopened beds, as well as restarting winter planning, and requiring stronger reporting.

Labour also plans to deliver a Rainbow Pae Ora health strategy, which would ensure LGBTQI+ needs are embedded in the health system. It would include identifying barriers to access, and culturally competent care that respects their identities and needs.

On prevention, Labour plans to restore the Smokefree Generation policy and reverse the coalition Government's heated tobacco policy, which saw the current Government cut the excise duty on heated tobacco products by 50% in July 2024; make cervical screening free for all eligible New Zealanders; and restore the healthy school lunches programme.

Labour has the most women-specific policies. Cervical screening becomes free for all eligible 25 to 69-year-olds from 1 October 2027, at $21.6 million in the first full year. Referred maternity ultrasound scans, which cost up to $90 each and are free in only a few regions, become free everywhere from July 2028, with 24 paid trainee sonographers to expand capacity. The entitlement would be loaded on to the Medicard upon referral from a GP, midwife or specialist. Labour would also restore pay equity and give care and support workers — a workforce that is largely female — a $4 hourly pay rise.

What's different:

Free GP visits, prescriptions and maternity scans in one package, and the Rainbow Pae Ora health strategy. It is the only party promising free maternity scans.

See Labour's policies in more detail here.

Greens

The Greens aim for publicly delivered, increasingly free care: they would work towards fully free primary and dental care, ambulance and emergency services, aged care, palliative care, and mental health services, and fund mobile clinics and dental vans for rural areas, lift Pharmac funding and set pay parity for primary care nurses.

Prevention is central. The manifesto prioritises early screening and treatment of cancers, diabetes, and kidney, heart and lung disease, and treats housing, income, food and transport as health policy. They have adopted the Te Whare Tapa Whā framework that explores conceptual and practical ways to address health and health equity through the values of whānau, hinengaro, tinana, and wairua.

For women, the Greens would fund one-stop shops offering wrap-around support for whānau through pregnancy and after birth, plus dedicated postnatal mental health support. They would also speed up endometriosis diagnosis through formal clinical guidelines for endometriosis and other pelvicpain, and specialised clinics around the country. In mental health they would phase out seclusionand expand youth services such as Piki and Mana Ake.

What's different:

The only party reviewed to commit to endometriosis care, and they have the broadest social-determinants approach.

See the Greens policies in more detail here and here.

ACT

ACT wants more clinicians and a wider scope of practice, and supports greater use of private providers to reduce public waiting lists. It would add $100 million a year to general practice ($400 million over four years) to retain GPs and reward extra appointments, and streamline registration for overseas-trained doctors. Pharmacies could treat more conditions, from ear and chest infections to gout, monitor stable hypertension, type 2 diabetes and high cholesterol, and run skin-lesion check pilots. ACT would raise the medicines share of the health budget one percentage point a year until it matches Australia's in 2033 (4.9% now, against 12.2%), funded from health budget growth rather than new taxes. It also proposes a National Cancer Centre with campuses in Auckland and Christchurch, and would end ethnicity-based prioritisation.

ACT also proposes to strengthen end of life choices by replacing the six-month prognosis requirement so that terminally ill persons with irreversible decline and experiencing unbearable suffering can access the service.

ACT's prevention is early detection rather than population-level action.

Women's health appears only through pharmacy access: treatment for vaginal thrush and period pain, and STI self-swab testing.

What's different:

A pharmacy-first model, cancer centres, and a fixed seven-year path for medicines funding, and strengthening the End of Life Choices Act.

See ACT policies in more detail here.

NZ First

NZ First's "Make NZ Healthy" plan is the most explicitly prevention-led. It targets metabolic health as a driver of chronic illness, would teach nutrition from primary school to medical school, review dietary guidelines and vitamin D levels, place health coaches in general practice, fund research on nutrition and mental illness, run hospital trials of intravenous vitamin C, and remove Medsafe and Pharmac barriers to "recognised safe nutrients".

A specific part of their policy is to "Ensure that informed consent is a core part of quality healthcare."

There is little to disagree with here, although RNZ reported the policy appears nearly identical to content on the Make New Zealand Healthy Charitable Trust's website. Winston Peters said that NZ First had been working with Make New Zea-land Healthy for years, and the Trust states on their home page that one of their objectives for 2026 is to "shape the national election agenda discussions by elevating health as a defining issue."

This writer does not care whether they have copied from Make New Zealand Healthy to create their policy, or worked with them, or just paid attention to what Make New Zealand Healthy has to say. Whoever forms our next Government, they could do a lot worse than to adopt these policies, starting with putting prevention back at the heart of healthcare.

On their health policy webpage, NZ First says "We need a serious direction change of what our health system does and how it is funded. This is just the first campaign announcement in the larger plan to Make NZ Healthy". However, at the time of writing there was no further policy detail available. Despite that, it has been reported elsewhere that NZ First plans to replace Pharmac with a new agency backed by an extra $1.3 billion, a $925 million GP-controlled Waitlist Reduction Fund, and about 2,000 more doctors recruited internationally.

No women's health specific policy was found.

What's different:

Focusing their policy on prevention, replacing Pharmac with a new agency, giving GPs a purchasing budget, and specifically mentions informed consent rights.

See NZ First policies in more detail here.

Opportunity

Opportunity's answer to the public health crisis is stability, and that addresses the political football that health has become in this country, and is aligned with the views of numerous of health professionals and advocates, such as Sir Ashley Bloomfield, and Drs Art Nahill and Glenn Colquhoun (see review of their book *Rethinking Health* in the AWHC August-September *Newsletter*). Opportunity propose a cross-party, legislated 10-year health plan, lifting health spending from 7.4% to 9% of GDP and first-level care from 5.7% to 10% of HealthNZ spending.

Its prevention agenda targets tobacco, alcohol and unhealthy food, which it says cause about a quarter of healthy years lost. It would: legislate nutrition standards for schools, early childhood centres,

prisons and aged care; commission a National Nutrition Survey (the last children's survey was in 2002); set a path to a smokefree New Zealand including de-nicotinisation; and restore the pre-2024 school lunch programme. A public lobbyist register and cooling-off periods would shield health policy from industry influence. These policies are particularly aligned with Health Coalition Aotearoa, of which AWHC is a member.

They also support more primary care funding to enable earlier detection of non-communicable diseases such as diabetes, cardiovascular disease and chronic kidney disease.

Midwives are named within the primary care it wants to grow, but there is no women's health item in their policy.

What's different:

The decade-long multi-party plan, focus on industry lobbying, and placing decisions on where to spend available funding with health experts not politicians.

See Opportunity policies in more detail here.

Te Pāti Māori

Te Pāti Māori leads with governance: rebuild and strengthen a Māori-led health authority, shift towards prevention and whānau wellbeing, and make services culturally safe and accountable to Māori. They propose to transform the health system by transferring 25% of total health and ACC funding to Māori-led systems, establish a Māori Accident Compensation Authority, and to appoint a Te Tiriti Hauora Commissioner.

Te Pāti Māori also focus on increasing access to health care for all New Zealanders by investing in free primary health care, dental care and medication delivery. They have a strong prevention focus as well, starting with lowering the bowel screening age to 45 for all, and to 35 for Māori, and fully funding screening and prevention programmes for cervical cancer, lung cancer, and skin cancer. Their prevention policy also addresses the commercial determinants of health — tobacco, unhealthy food and alcohol.

Other policy of note is investing in Māori mental health, expanding Māori workforce and training, establishing a Māori Data Authority and conducting biannual Te Tiriti o Waitangi audits. They also have a specific Takatāpui policy guaranteeing gender-affirming, Kaupapa Māori healthcare within the public system, including mental health and suicide prevention services.

While much of Te Pāti Māori health policy is specifically about improving Māori health and health equity, much of their policy would serve all New Zealanders, including workforce investment, investment in mental health and addiction services, and increasing funding to Pharmac.

Other than a fully funded cervical screening and prevention plan for cervical cancer there is no other focus on women's health.

What's different:

Māori-led commissioning and delivery, and a strong focus on equity for Māori through upholding obligations under Te Tiriti, as well as protecting rongoā Māori.

See Te Pāti Māori policies in more detail here and for Takatāpui here.

Women's health: consensus and gaps

It is disappointing to see that there is not a lot of women's health in the policies of the major parties. Women/wāhine are just over 50% of the population and women's health is a seriously neglected issue, 2000+ years in the making (see 'Women's Health: invisible, ignored, misdiagnosed' in the March 2020 AWHC *Newsletter* among many other articles). We are disproportionately harmed by medical injury and patient harm, especially where implantable medical devices are concerned. We disproportionately suffer from autoimmune diseases and conditions like migraine, and menopause is barely emerging from centuries of attitude that this life stage — which affects all women who live beyond their fertile years — is "secret women's business" and should never be spoken of.

Despite affecting one in ten women, endometriosis imposes years of suffering before it is diagnosed, yet it was mentioned in only one party's policy. Ovarian cancer takes the lives of more women than all other gynaecological cancers combined, with 30% of those diagnosed dying in the first year, while 42% of women diagnosed are so sick that they are diagnosed in emergency care. Bizarrely some doctors (and many women/wāhine) seem to think that cervical screening picks up ovarian cancer — it does not! However, ovarian cancer didn't rate a mention in any health policy.

The national women's health strategy that was launched in mid-2023 seems to have disappeared without a trace. Yes, the same women's health strategy AWHC strongly advocated for in 2021 in

our submission on the Pae Ora (Health Futures) Bill, and for which we were considered a key stakeholder in its development, making submissions and having meetings with Ministry of Health staff who were writing it. If it still exists in the dim, dark archives of health system reform, there has certainly been little or no delivery on what it promised, and I would be surprised if any of the current Government have laid eyes on it.

On the plus side, free cervical screening for 25 to 69-year-olds has been promised by both National (from March 2027) and Labour (from October 2027). Beyond that the parties diverge: Labour on maternity scans, National on breast screening and postnatal stays, the Greens on endometriosis and postnatal mental health, ACT on pharmacy access. None of the party material reviewed mentions menopause, and Endometriosis New Zealand is still asking parties for a national action plan.

Journalist Niki Bezzant noticed the same general absence of women/wāhine specific health policy, with what was there very focussed on the traditional view of women's health, that it's all about babies and breasts, or what she termed "bikini medicine". So, Niki sent the same eight questions to each of the political parties that have been reviewed in this article, to see if she could get more information on their approach to women's health. Six parties responded; NZ First didn't.

Niki Bezzant has done a fabulous piece of work and come up with a women's health score card. You can find her article and the visual scorecard online.

Niki considered 19 aspects of women's health and rated them by party based on their published policy statements ***and*** answers to her eight questions. We've reproduced her visual scorecard here (page ??), and recommend that you read Niki's article in its entirety, including the questions she asked of the political parties.

The scorecard is very interesting and how you view it will likely depend on the specific women's health issues that are most important to you, and no doubt in the context of your overall political beliefs. On the face of it the Greens and Te Pāti Māori do very well, National come in third, and Labour a disappointingly mediocre fourth. ACT, NZ First and Opportunity all appear not to have noticed the significant unmet need in women's health; we give them all a big fat F on women's health!

It is hugely disappointing that not a single party has a specific policy or commitment explicitly addressing menopause, a life stage that brings significant health impacts and affects at least one million women/wāhine in New Zealand (based on the female population over 50 years of age, and ignoring premature menopause and peri-menopause that can start in the late 30s and 40s in some women). Menopause doesn't just impact women/wāhine; it affects their whānau and their employers, and as a result it impacts on communities through loss of productivity and contribution to social and community activities and initiatives. Unaddressed health impacts of menopause, such as osteoporosis and cardiovascular disease, also costs our health system.

The Delivery Test

Election policy and election promises are not outcomes. Free GP visits need enough GPs for our population. Lower screening ages need colonoscopy and pathology capacity, and prevention gets less attention than treatment. Yes, it is vital that we treat the sick with world class, best-practice healthcare, but we must address the declining health of our citizens with greater focus on, and greater investment in prevention.

Voters might ask less who promises the most than what each plan would take to deliver. Ask yourself who will genuinely have the best shot at breathing life and efficacy back into our public health system as fast as possible, making it a safe place to both work and seek health care. Who will genuinely have the best shot set the health system on the road to being a world class health system offering world's best-practice health care?

Additional Sources

- Frizelle F, 2026: Election 2026 and health: promises, priorities and delivery, *NZ Med J* 2026;139(1643)
- RNZ, 2026: Health policy guide, *Radio New Zealand*, accessed 21 October 2026.
- O'Dwyer E, 2026: Labour promises to reinstate Smokefree Generation policy, *Radio New Zealand* 25 August 2026.
- Labour Party, 2026: Labour to deliver stronger healthcare and protections for rainbow communities, Press release, 22 September 2026.
- APEX, 2026: APEX's Election 2026 Guide to Party Policies, 9 October 2026.
- Policy.nz, 2026: Policies > health, NZ Election 2026.

A women's health scorecard

Source: Niki Bezzant's *A women's health scorecard*.

🟢 **Women-specific**: a policy or commitment explicitly addressing this

🟡 **Broader health policy**: a general health policy that is relevant to women but isn't specifically designed around women's health OR a general response indicating willingness to explore this

⚪ **No specific commitment found**

Note: NZ First did not respond to Niki Bezzant's questions

Women's health issue	National	Labour	Greens	ACT	NZ First	Te Pāti Māori	TOP
Women's health strategy	🟢	🟢	🟢	🟡	⚪	🟢	🟡
Menstrual health	⚪	⚪	🟢	⚪	⚪	🟡	⚪
Contraception	🟢	🟡	🟢	⚪	⚪	🟢	🟡
Abortion	🟢	🟢	🟡	⚪	⚪	🟢	🟡
Fertility	⚪	⚪	🟡	⚪	⚪	🟢	🟡
Endometriosis / gynae health	🟢	🟡	🟢	⚪	⚪	🟢	⚪
Pregnancy & birth	🟢	🟢	🟢	🟡	🟡	🟢	🟡
Postnatal care	🟢	🟢	🟢	⚪	🟡	🟡	⚪
Breast cancer/screening	🟢	🟡	🟡	🟡	⚪	🟢	⚪
Cervical cancer/screening	🟢	🟢	🟡	🟡	⚪	🟢	⚪
Women's mental health	🟢	🟡	🟢	🟡	🟡	🟢	🟡
Menopause policy	🟡	🟡	🟡	⚪	⚪	🟡	⚪
HRT / menopause treatment	🟢	🟢	🟢	🟡	⚪	🟢	⚪
Women's health at work	⚪	🟡	🟢	⚪	⚪	🟢	⚪
Heart health	🟡	🟡	🟢	🟡	🟡	🟢	🟡
Bone health/osteoporosis	🟢	🟡	🟢	⚪	⚪	🟢	⚪
Brain health/dementia	⚪	🟡	🟢	⚪	⚪	🟢	⚪
Older women/healthy ageing	🟡	🟡	🟢	🟡	🟡	🟢	🟡
Māori women's health equity	🟡	🟢	🟢	🟡	⚪	🟢	🟡

He wāhine, he whenua, ka ngaro te tangata

The Parliamentary Review Committee Report on the National Cervical Screening Programme

By Sue Claridge

He wāhine, he whenua, ka ngaro te tangata

Without women, without the land, humanity ceases[1]

This whakataukī* is printed twice on the first page of the Parliamentary Review Committee Report into the National Cervical Screening Programme (NCSP).

In the context of the last three years, where in many parts of our public service, legislation and policy, te reo, te ao Māori, matauranga Māori, and honouring and giving effect to the principles Te Tiriti o Waitangi, have been erased, this whakataukī not only held wisdom and acknowledgement, but hope, and quiet defiance of and resilience to, the insistence that equality not equity is what matters in health.

* A traditional Māori proverb.

Before I discuss the Parliamentary Review Committee Report and its conclusions, it is well worth considering this passage from the opening mihi in its entirety:

> *"He wāhine, he whenua, ka ngaro te tangata.*
>
> *Without women, without the land, humanity ceases. Wāhine Māori are not a demographic. They are not a statistic. They are not a priority group to be managed within a programme. They are the condition on which all of us exist.*
>
> *And yet, between 2018 and 2022, wāhine Māori died from cervical cancer at more than twice the rate of other New Zealanders. Not because cervical cancer cannot be prevented. It can. Not because we lacked the tools. We had them. But because a system — designed without wāhine Māori at its centre — consistently, predictably and structurally left them behind."*[1]

The Committee go on to acknowledge that, while the shift to human papillomavirus (HPV) self-testing was a turning point, "a new test is not a new system. Barriers remain. Te Tiriti o Waitangi obligations remain unmet. And wāhine Māori are still waiting for a programme that places them — not

as an afterthought, not as a target group — but at the heart of every decision made."[1]

The Health Act 1956 demands that a review of the NCSP must occur every three years. In the 2025 review, the review Committee were expected to focus on population groups who have been under-screened/unscreened and over-represented in cervical cancer incidence and mortality rates, including wāhine Māori and Pasifika.

The release of this report on the 21st of September came hot on the heels of the damning report on the NCSP Register on the 3rd of August, which re-vealed myriad flaws and raised the spectre of serious harm to an unknown number of women eligible for cervical screening.[2]

Fifth Review, Familiar Warnings

It pains me to write this for the second time in as many *Newsletters*, but 38 years after the Cartwright Inquiry women/wāhine* are still waiting for a cervical screening programme that is safe, equitable and accountable. The report of the 2025 Parliamentary Review Committee (PRC), the fifth statutory review of the National Cervical Screening Programme, is now public. In August we reported on the failures of the NCSP Register, and said that report and the PRC's report needed to be considered together with the capacity of colposcopy clinics, to decide if a thorough independent audit of the NCSP is justified.[2]

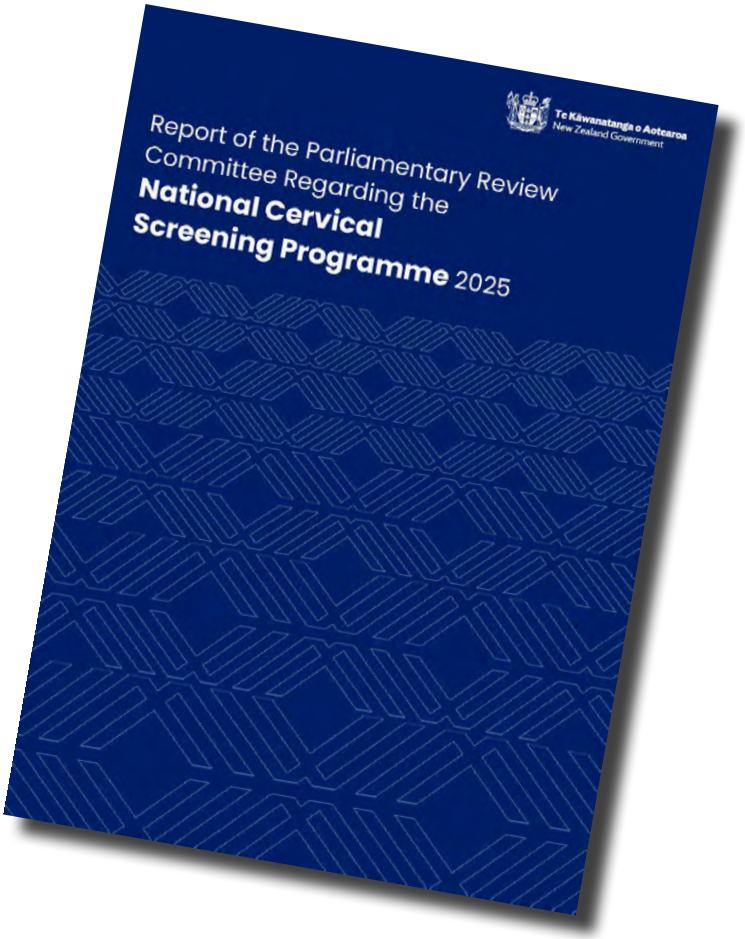
The PRC did not see the separate Register review until its own report was drafted, so could not consider the Register review in their deliberations or recommendations.

The PRC has identified problems with the NCSP and called for right remedies. The question, as always, is whether anyone with the power to act will do so.

The Review

The three-member Committee (Sarina Ponga, Dr Tania Slater and Julie Avery) was appointed in July 2025 by Health Minister Simeon Brown.

It conducted 44 interviews and drew on 405 consumer survey responses, 69 provider and practitioner responses, and input from Iwi-Māori Partnership Boards (IMPBs). It is the first PRC report to include consumer voices, and the report is richer for it; consumer comment and feedback, as well as comments from other interviewees and



service providers, are found throughout the report. Consumer participation in decision-making is one of AWHC's founding philosophies and it is good to see it written into the Parliamentary review process at last. Among consumers interviewed were those living with disabilities, and people with mental health and behavioural issues, and experiences of trauma.

Four principles, plainly stated

The PRC's review was shaped by four foundational principles:

- Te Tiriti o Waitangi is a binding obligation, not a policy aspiration; the NCSP must be measured against it, and failures treated as Treaty breaches.
- The NCSP exists to eliminate cervical cancer inequities; technical robustness serves that purpose but cannot be the primary measure of success.
- Māori data sovereignty requires that Māori screening data be treated as taonga, governed with and by wāhine Māori through the National Kaitiaki Group.
- Equity must be binding, resourced, monitored and enforceable, with Māori and Pasifika outcomes reported first and co-governance embedded across all parts of the NCSP.

These are not abstractions. Between 2018 and 2022, wāhine Māori died from cervical cancer at more

* In this article, women/wāhine includes trans men and non-binary people with a cervix, as in the Committee's report.

than twice the rate of other New Zealanders, from a disease we know how to prevent. The Cartwright Inquiry exposed a system that treated wāhine Māori as passive recipients of care rather than partners. The Committee is telling us, four decades on, that the lesson has not been learned. The second principle is especially pointed: a programme can go live on schedule, be technically impressive (at least in theory, *vis a viz* the August NCSP Register review report), and still fail the women it exists for.

The Review Committee's Findings

There is good news; HPV self-testing is widely accepted and is lifting participation in cervical screening, including among wāhine Māori. Participation of eligible women/wāhine has risen from 67.4% in 2022 to 75.3% in 2025, though it is still short of the 80% target, and Asian women remain the least screened at 62.6%. However, a new test is not a new system.

The key findings are:

- **The main equity risk has moved from screening to follow-up, with a**ccess to cytology and colposcopy not consistently timely or equitable.
- **Governance is not yet Te Tiriti based.** The review found no clear governance in place for the NCSP. The equity advisory rōpū that guided the 2023 transition was paused in August 2025, and IMPBs described a partnership that feels consultative rather than co-governed.
- **Māori data governance needs strengthening**, with clear processes, resourcing and auditing.
- **Cost barriers persist.** Some priority-group women/wāhine were charged for HPV tests, with fees up to over $100.*
- **Workforce and capacity are stretched**, with burnout reported across the pathway.
- **Monitoring and public reporting are insufficient.** The Committee itself had to use older public data because recent programme data were unavailable.
- **The Register urgently needs to be made fit for purpose.**

Aotearoa New Zealand also lacks a cervical cancer elimination strategy and action plan. HPV vaccination coverage for 14-year-old Māori sits at 49%, compared with 63% for European/Other.

The Seventeen Recommendations

On **governance and direction** (recommendations 1–4), the Committee calls for Te Tiriti based co-governance that gives Māori a sustained voice and real decision-making authority; a documented role for IMPBs; the NCSP and the National Kaitiaki Group (NKG) jointly strengthening Māori data governance, including affirming screening data as taonga and resourcing the NKG's statutory role; restored equity, clinical and technical advisory functions; and a Māori-led, funded Elimination Strategy and Action Plan, with continued equity focus for wāhine Māori and Pasifika and under-screened/unscreened people.

On **access and workforce** (recommendations 5–12), it called for free screening for everyone with a cervix*; sustained media, communication and information about cervical cancer and elimination

* The National-led coalition Government announced on the 1st of September 2026, that cervical screening will be free for all eligible women from the 1st of March 2027.

of the disease; increased support and resourcing for primary care and community screeners, including paying midwives as screeners and funding training; investigating point-of-care HPV self-tests; resourcing community and mobile services such as marae-based clinics and Smear Your Mea; respond effectively to groups traditionally underserved by the NCSP, including women in prison; and cultural safety training at every level.

On **system settings** (recommendations 13–17), it calls for a national assessment of colposcopy and laboratory services demand and capacity; timely and transparent public reporting across the whole pathway, not just screening uptake; ensuring a review of the NCSP Register is available for future PRC reviews or include a review of the register as part of the Parliamentary review; extension of the review cycle to five years with funding to action it; and filling NCSP national team vacancies addressing capacity and resourcing requirements.

The Register

Recommendation 15(a) deserves specific note. Until the Register is "fully functioning and reliable", the Committee wants screeners to keep their own recall systems. Health NZ and the current and future Ministers of Health should think about what that says. The statutory reviewer of the NCSP is advising practices not to rely on the very safety net Judge Cartwright urged our health agencies to build.

This is consistent with what the Register review found:[2, 3] around 968,000 women/wāhine, 62% of those eligible, were not sent notifications as of June 2025; women wrongly excluded as "inactive"; no look-back functionality; backlogs of unresolved laboratory mismatches. It also fits with the PRC's central finding that follow-up is now a far greater problem than participation in primary screening. "Rose", the 30-year-old Māori woman who waited six and a half months for colposcopy after a positive HPV 16/18 result and was then diagnosed with stage 3 cancer,[4] is that finding personified.

Data sovereignty has a hard edge here too. One in five Māori are not identified as Māori on the National Health Index. It is difficult to be kaitiaki of data the system has not counted properly. Because the Committee could not weigh the Register review report in their own review of the entire NCSP, our call stands for an independent audit of the NCSP, including a continuous prospective audit of all cervical cancer diagnoses.

Free at Last?

Recommendation 5 reaffirms what the 2015, 2018 and 2022 reviews also said, and what was originally promised when the NCSP was being established 36 years ago. The Government has now announced that screening will be free from March 2027. We welcome that, but ask the same questions as before: why did it take 36 years, and what is driving the timing? The Committee findings offer a practical lesson for the implementation of truly free cervical screening. Inconsistent charging persists even under existing zero-fee funding for priority women/wāhine. "Free" ***must mean free***, everywhere, and be clearly communicated; there can be no room for confusion.

What is Missing?

The Parliamentary Review Committee noted that both the Cartwright and Gisborne cervical cancer inquiries highlighted a "lack of accountability by the health system towards wāhine Māori and all women and people with a cervix" and exposed a lack of consequences when breaches occur. The PRC continues to call for explicit remedial action, timeframes and consequences. Yet the recommendations, as listed, carry no costings or deadlines, and a PRC can only recommend. Recommendations 1 and 4 appeared in earlier reviews.

Reaffirming is not the same as acting.

In the 2022 report, the PRC said that "Racism is embedded across the screening pathway and is a modifiable determinant of health inequities. We recommend the NSU co-design an anti-racism plan for the sector to coordinate, consolidate and strengthen existing efforts." In the current report[1] the PRC noted that "Work has not yet been progressed for this recommendation."

This is enormously disappointing!

We also have concerns about Recommendation 16. A five-year cycle is acceptable only if the pathway-wide public reporting in Recommendation 14 — to provide timely and transparent public reporting across all parts of the pathway — actually happens, and soon. It is notable and concerning that the Register failures stayed hidden from the public for more than a year.[2]

What We Want

The PRC report should not sit in a drawer while the election campaign rolls on. We are calling for:

- a public Government response with timeframes, costings and accountable agencies for every recommendation;
- an independently peer-reviewed monitoring report on HPV primary screening, ASAP;
- direct contact with every woman affected by a missed or delayed notification;
- ring-fenced clinical leadership and resourcing for the NCSP, protected from further restructuring;
- Te Tiriti based co-governance and a properly resourced National Kaitiaki Group;
- an independent audit of the programme.

Cervical cancer is preventable. The Parliamentary Review Committee commenced the report's Foreword with the whakataukī *he tapu te whare tangata*, the sacredness of the womb as the house of humanity, where all human life grows. We have the tools, the evidence, and now five reviews' worth of expert advice. What has been missing, again and again, **is the political will and sustained resourcing to act**.

We will keep asking for it, again and again, as we have since 1988, until there is the political will and accompanying action.

References

1. Parliamentary Review Committee, 2026: *Report of the Parliamentary Review Committee Regarding the National Cervical Screening Programme 2025*. Wellington: Ministry of Health.
2. Claridge S, 2026: Damning Report on NCSP Register Raises Significant Concerns, Auckland Women's Health Council August-September 2026 *Newsletter*; 11 September 2026.
3. HNZ, 2026: *Review of the National Cervical Screening Programme's Population Based Register*. Wellington: Health New Zealand | Te Whatu Ora. August 2026.
4. Jones N, 2026: Devastating cancer bottleneck experts say shouldn't have happened - and the human cost, *Stuff*, 24 August 24 2026.

Help Us Continue Our Work

We need your help to continue our important work for the women/wāhine of Aotearoa New Zealand.

Auckland Women's Health Council relies on community funding grants and donations to keep our organisation functioning and to pay for operating expenses.

Subscription to our *Newsletter* and membership of the Council are free. People can subscribe to the *Newsletter* without becoming a member and receive the *Newsletter* directly into their email inbox. We continue to make it freely available on our website from the date of publication. We strongly believe in the importance and value of the information that we provide, the analysis and gendered perspectives on health, and we want all women/wāhine to have access to this without the burden of cost.

We have made donating to the Auckland Women's Health Council easier for those able to support us financially. We don't ask for a specific amount, but because we are a registered charity, any donations of $5 or over are eligible for a New Zealand charitable giving tax credit.

There are two ways that you can donate directly to the AWHC: through internet bank transfer or via Givealittle using your credit card. Information on making a donation through either of these methods is provided on our website. Thank you in advance to all those who can support us through a donation.

Auckland Women's Health Council

Shining a Light on Patient Safety Because it Matters

Written by the Health Consumer Advocacy Alliance, and Anne Daniels, registered nurse, President and co-Chair of New Zealand Nurses Organisation, contributing in her personal capacity.

Patient safety is arguably the top priority for many New Zealanders, as the nation heads into the election. Growing concern regarding the ability of the New Zealand health system to keep patients safe underpin mounting public and professional calls for change, echoed nationally and internationally.

World Patient Safety Day is held by the World Health Organization (WHO) on the 17th of September each year. It is a major global event observed by many countries around the world, and aims to raise awareness of patient safety, foster global solidarity, and inspire evidenced-based action to reduce preventable harm in healthcare. Each year has a different theme; this year's was Safer Care for Non-Communicable Diseases.[1]

Aotearoa New Zealand has joined this global movement, and the Health Consumer Advocacy Alliance (HCAA) is incredibly proud to have led the first nationwide coordinated campaign, *Light It Orange for Patient Safety & Health System Safety*. HCAA wanted to put patient safety firmly in the spotlight, says Charlotte Korte.

"The goal was to make patient safety visible, bring people together, and ensure New Zealand had a voice and a presence on the international stage on World Patient Safety Day."

Light It Orange for Patient Safety & Health System Safety

Health workers, patients, whānau and communities came together in a shared moment of connection, recognition and action. Twenty-three landmarks across the motu were illuminated in orange, while people and organisations took part in activities to raise awareness. Some wore orange, while others

Staff at the Titirangi Medical Centre go orange for Patient Safety Day

made patient safety visible in their workplaces. Others shared their lived experience and highlighted what patient safety means in their own contexts, communities and health settings, including wider system perspectives.

Every conversation, story, event and orange light helped make patient safety more visible across Aotearoa. The driving force behind this campaign were health consumers/patients, whānau, communities, and health professionals.

HCAA was encouraged to see the Health and Disability Commission | Te Toihau Hauora, Hauātanga, Ministry of Health | Manatū Hauora and Health Quality & Safety Commission | Te Tāhū Hauora take part. We believe it is important for Aotearoa to support this day with the international community, on the same day. It was great to see these health entities mark the occasion. Hopefully, more of our health entities will come on board next year.

International Recognition

Aotearoa's first nationwide World Patient Safety Day campaign attracted attention from WHO, England's Health Services Safety Investigations Body (HSSIB) and Scotland's Patient Safety Commissioner, Karen Titchener. On the WHO Global Patient Safety Platform, WHO welcomed patient and whānau leadership and expressed interest in learning from Aotearoa's experience and following the impact of the National Patient Safety Forum and Light It Orange activities.

England's Health Services Safety Investigations Body (HSSIB) congratulated New Zealand, saying:

"We were pleased to see Aotearoa New Zealand mark the occasion in such a visible and meaningful way. For the first time, New Zealand took part in a nationwide, coordinated World Patient Safety Day campaign. From community activities to landmarks illuminated in orange, the campaign demonstrates a shared commitment to reducing avoidable harm and making healthcare safer for everyone.

International recognition and collaboration create opportunities to learn from one another, strengthen patient safety culture and ultimately reduce harm for patients and families everywhere.

We congratulate everyone involved in New Zealand's inaugural Light It Orange campaign. Seeing countries across the world unite behind patient safety sends a powerful message: we are stronger when we learn, listen and act together."[2]

Patient Safety Forum

As part of the activities on the day, a Patient Safety Forum was held in Auckland (livestreamed nationwide), hosted by Health Consumer Advocacy

Lighting it Orange at Nelson Catherdral

Alliance, Patient Voice Aotearoa and Kaitiaki Hauora, and supported by New Zealand Nurses Organisation | Tōpūtanga Tapuhi Kaitiaki o Aotearoa.

Patients, whānau and health professionals shared their lived experiences and the changes they believe are needed to reduce preventable harm and build a safer health system. Health spokespeople from six political parties attended to listen and respond: Dr Carlos Cheung (National), Phil Twyford (Labour), Antonia Modkova (ACT), Ricardo Menéndez March (Green Party), Alfred Ngaro (New Zealand First) and Cody Marsh (Opportunity Party).

There was also widespread coverage by several media outlets after the event.

Listening to people sharing stories of the significant, irreversible, avoidable harm was extremely confronting. The trauma and damage caused to these families, and the many others' spoken about on the night, can never be undone. The impact of this on health professionals was expressed very clearly, and the reality of our health system was revealed for all to hear. However, solutions were also presented.

Anne Daniels, NZNO Co-President, stood with Charlotte Korte (HCAA) and spoke about Sebby Chua, a four-year-old who had died from sepsis in 2022.* The concerns of his mother, also a nurse, went unheard.

Ms Daniels spoke about the excellent work undertaken by Te Toka Tumai and Dr Liz Manley (HCAA) to embed Kōrero Mai, a patient deterioration escalation tool at Auckland Hospital. She used this as an example of what could be achieved across all hospitals. A request was made to all political parties present to commit to mandating it; to make Kōrero Mai a national requirement, and to provide proper resourcing and funding to implement a comprehensive nationwide roll out.

Sadly, this was not a new request. Two years earlier, HCAA had called for Kōrero Mai to be properly resourced, rolled out nationally and made highly visible in all hospitals during its presentation to the Health Select Committee on its independent Patient Safety Commissioner petition.

Anne Daniels also supported HCAA's request in her supplementary submission to the Committee. Following a year's research into Kōrero Mai across all DHBs, Ms Daniels found that few nurses knew about the strategy or had even seen the poster. A patient safety strategy cannot improve safety if health professionals don't know it exists. As Ms Daniels

* After four years, the HDC has recently released the report into its investigation into Sebby's death and found a breach of his rights arising from delays in recognising and treating sepsis.

Anne Daniels (right) with Charlotte Korte, sharing Sebby Chua's story at the patient Safety Forum on the 17th of September.

Korero Mai and Martha's Rule

Kōrero Mai (Talk to Me), developed by Te Tāhū Hauora | Health Quality & Safety Commission, empowers patients and whānau to speak up when they are concerned about a patient's condition. It provides a clear, three-step process for raising concerns if they feel they are not being heard, or if a patient's deterioration is not being recognised or responded to appropriately. Step three allows a further clinical review to be requested by a separate team, providing an additional pathway for escalating unresolved concerns, including when a patient's condition clearly warrants further assessment but does not meet the usual clinical escalation criteria. Kōrero Mai is not available in all hospitals across Aotearoa, and the contact arrangements also vary between locations.

Martha's Rule was named for Martha Mills, a 13-year-old girl who died from sepsis in 2021 at King's College Hospital, London. It is a patient safety initiative in England that that enables patients, families, carers and staff to request an urgent independent review if a patient's condition is deteriorating and their concerns are not being addressed. A dedicated, 24-hour contact number provides access to an independent critical care outreach team. All public hospitals in England are required to implement Martha's Rule's by 31 March 2027.

Both initiatives reinforce a culture where speaking up is encouraged, concerns are taken seriously, and patients, whānau and staff feel supported to raise concerns before a situation escalates. Learning from the implementation of Martha's Rule could help inform the consistent implementation of Kōrero Mai.

stated, "a big opportunity for change in improving patient safety has been missed."

HCAA agrees. Martha's Rule (see page , a similar patient safety escalation tool, is a national requirement across England's acute health settings.[3] Following a review that exposed serious and sustained failures, it has now been extended to all maternity settings as well. Evidence shows it benefits both staff and patients and most importantly reduces adverse events. The benefits are proven. New Zealand needs to act and make Kōrero Mai a requirement in all hospitals.

Subsequent follow up by HCAA with all political parties after the Patient Safety Forum resulted in new commitments made on Kōrero Mai, and detailed responses to other questions submitted (See page ??).

Safer Care for Non-Communicable Diseases

The World Patient Safety Day theme this year, was "Safer Care for Non-Communicable Diseases". These include a huge variety of conditions such as cancer, diabetes, heart disease and chronic respiratory disease[4], all of which are preventable through improving social determinants of health and reducing health inequities. The campaign honours the World Health Organization's focus on safe patient care by shining a light on the need for appropriate funding and resourcing for our health workforce so they can provide safer healthcare for every patient, whānau and community.

Good health is an unassailable human right

Good health is an unassailable human right, and yet in Aotearoa New Zealand, it has been in a form of managed decline since 2011/12, according to the Ministry of Health's own annual survey[5] and as highlighted in an Association of Salaried Medical Specialists report.[6] Underinvestment in health by successive governments, alongside under investment in housing, welfare and education, may have improved the government's books, but the cost is being borne by the people of Aotearoa. This shows up in the statistics around unmet need for health care, with people finding it increasingly difficult to access mental health care and see a general practitioner. This unmet need doesn't simply disappear. Instead, it shows up in other parts of the health system — such as the emergency department — and results in the deterioration of people's health.

Preventable patient harm comes at a cost. To the individual and society, from 2011/12 to 2024, there was an additional social cost of between $2.6 and $8.6 billion a year.[6]

Martha's Rule

Evidence Suggests It is Saving Lives

To assess the effectiveness and impact that Martha's Rule is having, and to better understand the learning that is taking place, the NHS regularly collects data from sites where Martha's Rule is in place. NHS England states: "Early evidence suggests Martha's Rule is saving lives and helping thousands of patients benefit from changes to their care."[7]

Martha's Rule is helping patients receive more timely responses and further clinical intervention when needed. Between June 2025 and July 2026, 82% of Martha's Rule calls [see orange box on page 23] relating to acute deterioration would not have triggered escalation based on the early warning score alone. The early warning score system assesses patients using vital signs, including breathing rate, oxygen levels, blood pressure, heart rate and temperature, as well as their level of consciousness, to identify signs of deterioration. This highlights how Martha's Rule can help identify deteriorating patients who may not meet the usual threshold for escalation.

The data[3] highlights the importance of listening to patient and family/carer concerns and how Martha's Rule can work alongside existing physiological scoring systems to increase the reliability of identifying and responding to acute deterioration."

Targeted, sustainable investment in the public health system, particularly primary and public health care, is essential to improve timely access and affordability through an integrated, multidisciplinary, holistic shift in focus from cure to prevention, to realise the aspirations of the original Pae Ora (Healthy Futures) Act 2022.

Planning Long Term: A Health System That Listens, Learns and Plans for Patient Safety

New Zealand's Health and Disability System Safety Strategy sets the direction for a whole-system approach to improving safety through people centred care, learning, cultural safety, risk reduction, equity and system-wide change.[8] This is a step in the right direction, but we need long-

term cross-party healthcare planning, implementation and monitoring, not another strategy!

The current approach, which prioritises short-term budget savings over long-term positive patient outcomes and the continuous improvement of our nation's health and wellbeing, will cost much more in the long term. It is also causing unnecessary suffering for those needing care and the health professionals who provide it.[9]

Patient safety requires connected care, shared learning, and meaningful involvement of patients/ consumers, whānau, communities, and health professionals in shaping improvements.

World Patient Safety Day is an opportunity for people to come together, collaborate, have honest conversations and make patient safety a priority. This was New Zealand's first nationwide grass-roots campaign, and HCAA are incredibly proud of what was achieved. "We look forward to building on this momentum and making World Patient Safety Day an annual part of New Zealand's patient safety calendar.

We want to thank all those who took part."

References

1. WHO, 2026: World Patient Safety Day 2026: Safe care for noncommunicable diseases. World Health Organization.
2. Comment from HSSIB on LinkedIn.
3. NHS, 2026: Martha's Rule programme: April 2026. Statistics » Martha's Rule Programme April 2026. NHS England.
4. WHO, 2025: Noncommunicable diseases, WHO website Fact Sheet, World Health Organization, 25 September 2025.
5. MoH, 2024: Annual update of key results 2023/24: New Zealand Health Survey. Ministry of Health NZ, 19 November 2024.
6. Black A, 2025: *Managed decline: The health of New Zealand 2011 to 2024*, Association of Salaried Medical Specialists; October 2025.
7. NHS, no date: Martha's Rule. Patient Safety » Martha's Rule, NHS England.
8. HQSC, 2026: *The New Zealand Health and Disability System Safety Strategy 2026 to 2036*, Health Quality & Safety Commission | Te Tāhū Hauora; June 2026.
9. Wells CI, *et al.*, 2026. Association of surgical ward nurse staffing with postoperative mortality and failure to rescue. *ANZ Journal of Surgery.* (2026): 1–10.

Political Party Responses to HCAA's Questions Following Patient Safety Forum, 17 September 2026

The first email to all political parties, thanking them for attending the forum and requesting responses to our questions, was sent on 19 September. Since then, several reminder emails have been sent, and a phone call was made to each party. HCAA fully understands that life is busy for MPs and their staff during an election. We endeavoured to allow plenty of time for these questions to be answered before the dissolution of Parliament on 1 October.

National, New Zealand First and ACT acknowledged receipt of our initial email but did not respond to our questions. At the time of publication, we had yet to receive their responses. We hope to hear from them soon.

What does cross party collaboration look like for you, and is it important to you personally?

Labour Labour believes that cross party collaboration along with long term planning and funding is critical to keep our health system functioning well now and into the future.

Health shouldn't be a political football, and it's up to successive governments to ensure funding is there to continue good, evidence-based work that helps people stay well and reduce pressure on our hospitals.

Long term thinking is also why Labour introduced multi-year funding rather than year to year Budget allocations, and I'm glad to see the current government has seen the benefit in that.

OPPORTUNITY It is the centre of our health policy: a ten-year Health Plan agreed across Parliament, with progress reported every year to Parliament rather than the Minister, so a change of government doesn't undo it. Patient safety is an easy place to start, and support for Kōrero Mai already crosses party lines. As a healthcare professional and personally, I want to see our health system improved so that my patients have better outcomes, and when our system fails someone, it is actually addressed. The flipflop each election means we aren't moving forward and our system maintains the current path of slow decline.

Green Politicians have a responsibility to put people's wellbeing ahead of partisan advantage — patient safety should never become a political football. Cross-party collaboration means being willing to listen to patients, whānau, clinicians and advocates, find areas where there is genuine agreement, and work together to make lasting improvements.

What actions are you going to take to show that you are seriously doing something about reducing avoidable harm?

OPPORTUNITY Meet health cost pressures in full every year, plan the workforce ten years out, lift primary and community care from 5.7 to 10 per cent of Health New Zealand's spending so illness is found earlier, and connect patient records across services. We will keep backing Kōrero Mai publicly.

Green For the Greens, reducing avoidable harm means addressing both immediate patient safety issues and the pressures across our health system that contribute to unsafe care. We need a properly resourced public health system with safe staff to patient ratios, and strong mechanisms for patients and whānau to raise concerns. We will continue listening to patients, advocates and health workers and pushing for solutions that put people's safety and dignity at the centre of healthcare.

Labour We acknowledge that behind every instance of patient harm is a person, their family, whānau and friends and potentially lifelong harm and distress. We expect Health New Zealand and the wider health system to be constantly working towards greater improvement in patient safety and a reduction in patient harm.

Will you ensure that Kōrero Mai is embedded and highly visible across all hospitals and mandated, so that it is not only working effectively but that its effectiveness can be measured?

Green We are supportive of a nationally consistent approach so that access to an escalation pathway does not depend on which hospital somebody happens to be in. Any national requirement needs to be backed by proper resourcing, workforce engagement and implementation, rather than simply imposing another obligation on already stretched services.

The Greens strongly support the principle behind Kōrero Mai: patients and whānau need a clear and accessible way to escalate concerns when they believe someone's condition is deteriorating and they are not being heard. We support Kōrero Mai being properly resourced, highly visible and consistently available across our public hospitals. We will take the proposal for a comprehensive national rollout into our health policy work and are supportive of ensuring patients and whānau can access this kind of escalation pathway wherever they receive hospital care.

Labour Labour supports further roll-out of Kōrero Mai with periodic evaluation. We see family and whānau-led escalation processes in health care settings as an important and effective complement to clinical escalation pathways. We are looking closely at what other countries are doing, like with the expansion of Martha's Rule in UK emergency departments. These processes can save lives and prevent patient harm.

OPPORTUNITY Yes. We would make patient and whānau escalation a national requirement of every public hospital, with Health New Zealand delivering it and the [Health Quality and Safety] Commission measuring and publishing how often people escalate, how quickly they are reviewed, and what changed as a result. Visibility should be measured, not assumed.

We support a full national rollout of Kōrero Mai, and you can hold us to that publicly. We won't be adding it to our health policy document itself. Healthy People is deliberately high level: it sets the long-term plan, the funding and the rules, and leaves decisions about which services and programmes get what to the health professionals who run the system. That's a principle we hold across the board, not a judgement about Kōrero Mai. We also agree with you that no single tool will do it alone. Escalation works when there are enough staff to respond, records follow patients, and funding is stable, which is what Healthy People is built on.

Health New Zealand would deliver it and the Health Quality & Safety Commission measuring and would publish the results. What made Martha's Rule work in England was a national commitment, funding and independent evaluation. That is the model we would back.

We are supportive of this outcome. There is little value in having a patient-safety mechanism if patients and whānau do not know it exists or staff are not supported to make it work. Kōrero Mai should be visible, accessible and properly embedded in hospital practice. Its implementation should also be monitored so we can understand whether patients are using it, whether concerns are being responded to appropriately, and what improvements are needed.

Who should be responsible for making sure the health system learns from that harm?

Labour The Health Quality and Safety Commission. In government, we would be open to considering advice on the merits on an independent Patient Safety Commissioner or ways to strengthen the HQSC's work on improving patients' health care experience.

We also support the work undertaken by the Nationwide Health and Disability Advocacy Service and would take advice in government on ways that these processes can be improved to better support patients.

We welcomed Health New Zealand restarting reporting on serious adverse events this year. Transparency is an important step to taking accountability and making improvements.

In government, we want to see the Health and Disability Commissioner clear its backlog of complaints. We would be open to considering advice on introducing a right to appeal HDC decisions.

OPPORTUNITY Health New Zealand owns it, the Commission sets the standard and checks it happens, and the Health and Disability Commissioner resolves complaints fairly and on time.

Health New Zealand should own learning from harm, as the organisation that delivers care. The Health Quality & Safety Commission should set the standard and check that learning actually happens. The Health and Disability Commissioner should resolve complaints fairly and on time. The fix for unclear boundaries is not another restructure or agency. It is to write down who is responsible for what and report against it. Under our ten-year Health Plan, progress is reported annually to Parliament. We would include patient safety: adverse events reviewed, recommendations implemented, and whether the same harm recurred.

Green Ultimately, accountability has to sit clearly within our public health system rather than being passed between agencies. Health NZ must have responsibility for ensuring services learn from harm, but this also requires strong independent oversight and a system in which patients and whānau can raise concerns and see meaningful action follow.

Is Your Mood Really Bad Before Your Period?

Perhaps it's Premenstrual Dysphoric Disorder

Almost all women will have heard of, and many will have experienced, PMS, or premenstrual syndrome. But for some women, what they experience in the one to two weeks before their period is significantly worse.

PMDD Aotearoa* says that "Premenstrual Dysphoric Disorder (PMDD) is a severe, hormone-related condition that affects mood, body, and daily life. While many people experience PMS, PMDD is much more intense. Symptoms can feel overwhelming, often disrupting work, relationships, and overall wellbeing."

PMDD is officially recognised as a medical and psychiatric condition.

A new Healthify** page on Premenstrual Dysphoric Disorder provides important and easy-to-understand information about PMDD:

- PMDD is a mood disorder that affects about 3% of people who have menstrual periods. It's not the same as PMS.
- Mood symptoms include feeling irritated, low or tearful, anxious, lacking energy and interest in life, and having sleep and appetite changes. You might feel out of control.
- You may have physical symptoms such as sore breasts, bloating and joint or muscle pains.
- Symptoms appear in the two weeks before your

If you think you may have PMDD

1. Track your cycle and symptoms – write them down, complete the recommended symptom tracker, or use an app.
2. Talk to a healthcare provider and take your records with you.
3. Reach out for support – connect with others who understand (see PMDD Aotearoa's Resources page).
4. Stay safe – if you experience suicidal thoughts, please reach out immediately to a crisis helpline.

NZ Crisis Helplines:

Lifeline: 0800 543 354

Suicide Crisis Helpline: 0508 828 865

* PMDD Aotearoa is a non-profit that advocates alongside health professionals, workplaces, and policymakers to improve recognition of PMDD and access to care. They host events and initiatives that build visibility and community strength, and direct funding toward vital research to deepen understanding of PMDD, improve treatment options, and influence lasting systemic change.

** Healthify | He Puna Waiora is Aotearoa New Zealand's largest free, consumer-focused health information website (formerly known as Health Navigator).

period and must resolve within several days of each menstrual period starting for it to be PMDD and not some other mood disorder.

- PMDD symptoms happen almost every menstrual period and make social life, work, or school noticeably more difficult than usual.

Anyone can develop PMDD, but women/wāhine may be at increased risk if they:

- have a family history of depression, PMS, PMDD, perinatal depression or a mood disorder;
- have experienced early life trauma;
- smoke cigarettes;
- have ADHD.

PMS and PMDD can get worse around the time of menopause as hormone levels change.

New Zealand Research into PMDD

Dr Hannah Douglass, Professor Suresh Muthukumaraswamy, Dr Rachael Sumner, and PhD Candidate Yuyun Ni, are part of the Auckland Neuropsychopharmacology Research Group at the University of Auckland and are currently conducting one of the first studies investigating PMDD in Aotearoa New Zealand.

The study is the largest internationally to use electroencephalography (EEG) non-invasive neuroimaging to identify biomarkers for PMDD. As part of this study, they are also conducting a nationwide survey and developing a symptom tracking app.

They designed the project to inform larger-scale clinical trials of novel therapeutic interventions for PMDD, with the additional aim of raising public and clinical awareness of the condition. The study has been co-designed by lived experience experts.

The research team are looking for women/wāhine in Tāmaki Makaurau Auckland who have PMDD to take part in their study. To participate, women/wāhine must:

- experience severe mood symptoms before their period;
- be aged between 18 and 45;
- have a regular menstrual cycle;
- not be using any hormonal contraception.

For more information see page 30.

If you are eligible to participate you'll receive a comprehensive patient information sheet setting out the purpose of the study, what the study involves, your rights as a participant, including that your participation is voluntary and you have the right to withdraw at any time.

The patient information sheet includes cultural considerations for wāhine Māori. If you are invited to participate and agree to be part of the study, you will be asked to sign a consent form. Women/wāhine who participate will receive koha for their time.

The study is part of an international collaboration with leading PMDD researchers at Uppsala University in Sweden. The Aotearoa New Zealand research team also works closely with the lived-experience charitable foundation PMDD Aotearoa, for which Dr Sumner and Professor Muthukumaraswamy are board members. The research team also published the Healthify page about PMDD.

AUCKLAND NEUROPSYCHOPHARMACOLOGY RESEARCH GROUP

Waipapa Taumata Rau University of Auckland

Does your mood get really bad before your period?

Join a research study tracking brain changes across the menstrual cycle

To participate, you must:

- Experience severe mood symptoms before your period
- Be aged between 18 - 45
- Have a regular menstrual cycle
- Not be using any hormonal contraception

Prescreening Questionnaire:

What's involved:

- **First 2 months:** A 5 minute online daily survey about your period and mood
- **Second 2 months:** 2 study visits (3-4 hrs):
  - Brain imaging, blood samples, an interview, and psychological questionnaires
- **Optional:** 6-monthly follow-up calls
- **Where:** Clinical Research Centre, Grafton
- **Koha:** $170 in vouchers + up to $60 in winnings from a behavioural task

peeg@auckland.ac.nz

The Auckland Neuropsychopharmacology Research Group will be conducting the first neuroimaging studies in Aotearoa New Zealand on severe premenstrual syndrome to improve the understanding, diagnosis and treatment of this under-researched condition.

The study has been approved by a HDEC ethics commitee (2026 EXP 25371).