YOUTH2000 SURVEY SERIES

Youth19 Rangatahi Smart Survey Initial Findings

Access to Health Services

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YOUTH19 A Youth2000 survey

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Further Youth19 publications are available at www.youth19.ac.nz

Summary

This report highlights findings from the Youth19 Rangatahi Smart Survey (Youth19) about students' access to health care services. It is designed to be read with the *Youth19 Rangatahi Smart Survey, Initial Findings: Introduction and Methods* report (Fleming, Peiris-John et al., 2020), which explains how the survey was conducted, who was included, and how to interpret the results. The *Introduction and Methods* report and other Youth19 outputs are available at www.youth19.ac.nz. The prevalence estimates for 2001, 2007, 2012, and 2019 are national estimates (i.e., the data reported has been calibrated to adjust for differences between the national population of students and those who took part in surveys, as outlined in the *Introduction and Methods* report).

As part of Youth19, secondary school students answered questions about their access to and experience of health care services. We present an overview of findings and changes over time in areas of health care access, first for the total population (all students combined) and then for Māori, Pacific, Asian, and Pākehā and other European groups.

Youth19 data shows that:

- **Many youth have seen a health professional in the previous year** – nearly four in five students have accessed at least one health care service. The family doctor, medical centre, or GP clinic was the most often used health care service. This was **more common among students from higher income neighbourhoods** and for females than for other students.
- Many students did not receive youth appropriate health care; **fewer than half of the students who accessed health care were assured of their confidentiality**, **and fewer than half of the students had the opportunity to talk with a health provider in private**. This was particularly true among Asian students.
- **One in five students were unable to see a health professional when they needed to in the previous year.** This was more common among students from low income neighbourhoods, low decile schools, and small towns, and was more common among rangatahi Māori and Pacific youth than Pākehā and European youth.

These findings highlight lost opportunities for quality health interactions for youth. Access to private and confidential health care for young people is important for good health and wellbeing and helps them to establish good lifelong relationships with future providers. Youth are unlikely to disclose personal concerns (e.g., mental health) when providers do not assure them of confidentiality or when a caregiver is present. Previous Youth2000 results show that students have reduced depressive symptoms, suicidality, and pregnancy in schools where good health care is provided, especially in low income communities (Denny et al., 2013; Denny et al., 2014).

The data presented here show that we have made little progress in improving access to health care and improving access to private, confidential care over the past 18 years. The findings expose the significant health inequities faced by Māori, Pacific and Asian youth, and demonstrate how youth are disadvantaged in our current health care system. Young people require free primary care that meets their developmental and cultural needs in settings that are convenient to them.

More in depth analyses exploring youth health care access and quality are underway, and will be available via www.youth19.ac.nz.

Findings

Health care accessed in the last year

In Youth19, most students (78%) reported that they had accessed at least one health care service in the previous year. Accessing health care was more common among students from wealthier schools and communities. Students from high and middle income areas were more likely to have accessed care in the previous year (81% and 79%) compared with students from low income areas (74%). Similarly, students from high decile schools were more likely to have accessed care (82%) compared to medium (76%) and low decile (75%) schools. Access was higher for those from urban areas (80%) compared to rural areas (76%). Females appeared more likely to have accessed care than males (80% and 77%). The youngest (13 years and under) and the oldest (17 years and older) students were more likely to access health care (81%) than 15-year-olds (76%) and 16-year-olds (75%), as shown in Table 1.

The family doctor, medical centre, or GP clinic was the most used health care service (74%) for all age and ethnicity groups. The use of these services was highest among students in high and middle income areas (78% and 75% compared to 67% from low income areas) and high decile schools (79% compared to 67% for low decile and 72% for medium decile schools). Females were more likely to have accessed this care (76%) compared to males (72%), as were students aged 17 years and older (78%) compared to 15- and 16-year-olds (71%).

The school health clinic was the next most used health care setting. In total 22% of students had accessed a school health service in the last year. This was most common in students from low decile (27%) and high decile (26%) schools, with lower rates of access for students from middle decile schools (15%). Higher use of school health clinics among students from low decile schools may be partly attributable to additional government funding. From 2008, decile 1 and 2 schools received government funding to provide more comprehensive health care services. At the time of the survey, this funding had twice been extended – in 2013, to include decile 3 schools (Denny et al., 2014), and in 2018 to include decile 4 schools. In 2019 this funding was extended to decile 5 schools, but this change had not taken effect at the time of the survey. Students living in urban areas were also more likely to have accessed care through a school health clinic (24% compared to 14% for small towns and 16% for rural areas). Older students (i.e., 25% for 17 years and older compared to 18% for 13 years and younger), and female students (26% compared to 17% for male students) also reported greater use of school clinics.

After-hours or 24-hour accident and medical centres were accessed by 11% of students. They were more commonly used by students from high income areas (15% compared to 10% for medium income and 7% for low income areas). Students in high decile schools (17% compared to 7% for medium decile and 6% for low decile schools) and urban areas (13% compared to 6% for small towns and 8% for rural areas) reported greater use. Again, females reported greater access (13% compared to 9% for male students).

Hospital accident and emergency services were accessed by 13% of students. They were more commonly used by students from high decile schools (16% compared to 11% from low and medium decile schools) and from urban areas (14% compared to 9% from small towns).

Family planning or sexual health clinics were accessed by 2.7% of students. These services were used more by students from high income areas (4.3% compared to 1.5% for medium deprivation areas), high decile schools (4.3% compared to 1.4% for low decile and 1.7% for medium decile schools), and urban areas (3.0% compared to 1.4% for small towns), and by older students (e.g., 5.8% for 17-year-olds and older compared to 0.9% for 14-year-olds and 1.8% for 15-year-olds) and female students (3.9% compared to 1.5% for male students).

It is noteworthy that access to every included health care provider was higher, or at least as high, for students in wealthier schools and communities compared to other students.

Experience of quality, developmentally appropriate health care in the last year

Private and confidential care is an essential component of youth health services (Britto et al., 2010; Ford et al., 2004). Access to private and confidential health care is important for good health and wellbeing and helps establish good lifelong relationships with future health care providers as adults. Youth are unlikely to disclose personal concerns (e.g., mental health) when health providers do not assure them of confidentiality or when a caregiver is present. Previous Youth2000 results show that students have reduced depressive symptoms, suicidality, and pregnancy in schools where good health care is provided, especially in low income communities (Denny et al., 2013; Denny et al., 2014).

Students were asked whether they had talked with a health care provider in private during the previous 12 months and whether a health care provider had assured confidentiality during this period.

Less than half (40%) of the students accessing health care had talked with a health care provider in private in the previous year. Talking in private was more common among students living in low income areas (43%) compared to middle income areas (37%), and among students from low decile schools (46% compared to 37% from high decile schools). Older students (e.g., 58% for students aged 17 years and older compared to 25% for students aged 13 years and younger), and male students (42% compared to 38% for female students) were more likely to have talked with a provider in private, as shown in Table 2.

The proportion of youth who talked with a health professional in private has not changed significantly overall since 2012 but increased among male students between 2007 and 2019 (from 36% to 42%), as shown in Table 3.

Fewer than half (44%) of the students accessing health care in the previous year were assured confidentiality by a health care provider. Assurance of confidentiality was more common for students from low decile schools (57% compared to 42% from medium decile and high decile schools), and for older students (e.g., 55% for students aged 17 years and older compared to 31% for students aged 13 years and younger).

In contrast to the gender difference for talking in private (more prevalent among male students), female students were more likely to be assured confidentiality (46%) than male students (42%). A smaller proportion of students from middle income areas were assured confidentiality (40%) compared to students from high income (45%) and low income (50%) areas. There was no substantial change between 2012 and 2019 for students being assured confidentiality by health professionals.

Foregone health care

Students were asked whether, within the last 12 months, they had been unable to see a doctor, nurse or other health care professional when they wanted or needed to. This is 'forgone health care'. One in five students (20%) reported that they were unable to see a health care worker when they wanted in the previous year.

Forgone health care was more common among students from low income areas (24% compared to 17% for high income areas), low decile schools (28% compared to 21% for medium decile and 17% for high decile schools), and small towns (24% compared to 20% for urban areas).

Students aged 14 years and older were more likely to be unable to see a health care worker (e.g., 20% for 14-year-olds) than students aged 13 years and younger (14%). At the time of the survey, there was funding from the Ministry of Health for free visits to primary care services for enrolled youth under the age of 14.

The proportion of youth who reported forgone health care increased slightly, from 18% in 2012 to 20% in 2019, as shown in Table 3. Secondary school students who forgo health care in New Zealand are at increased risk of physical and mental health problems (Denny et al., 2013).

Access to digital health supports

The Youth19 survey offered students the opportunity to have links for health information and services sent to their phone or email. This was part of the 'Integrating Survey and Intervention Research for Youth Health Gains' research project led by Terry Fleming (Fleming, 2018; Peiris-John et al., 2020). Results from this work will be available via www.youth19.ac.nz.

Table 1: Health care services accessed in the last 12 months

	Accessed at least one health care service		Family doctor, medical centre, or GP clinic		School health clinic		After-hours or 24-hour accident and medical centre		Hospital accident and emergency		Family planning or sexual health clinic	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Total	5,723 (7,380)	78.2 [77.1-79.3]	5,326 (7,359)	73.8 [72.5-75.1]	1,608 (7,359)	21.6 [19.6-23.5]	781 (7,359)	10.9 [9.7-12.2]	939 (7,359)	13.2 [12.2-14.2]	163 (7,359)	2.7 [2.2-3.1]
Sex												
Male	2,554 (3,326)	76.7 [74.9-78.4]	2,369 (3,316)	71.6 [69.6-73.6]	611 (3,316)	17.4 [14.9-20.0]	301 (3,316)	9.0 [6.9-11.1]	446 (3,316)	13.1 [11.6-14.7]	36 (3,316)	1.5 [0.9-2.0]
Female	3,169 (4,054)	79.8 [78.5-81.0]	2,957 (4,043)	76.1 [74.5-77.7]	997 (4,043)	25.6 [22.9-28.4]	480 (4,043)	12.9 [11.2-14.6]	493 (4,043)	13.3 [12.0-14.6]	127 (4,043)	3.9 [3.2-4.5]
Age												
13 and under	1,032 (1,319)	81.1 [78.9-83.2]	946 (1,313)	75.8 [73.1-78.6]	228 (1,313)	17.8 [15.7-19.9]	129 (1,313)	9.2 [7.4-10.9]	174 (1,313)	13.6 [11.8-15.4]	6 (1,313)	0.3 [0.1-0.6]
14	1,276 (1,655)	77.7 [75.2-80.2]	1,184 (1,648)	72.9 [70.4-75.5]	347 (1,648)	20.7 [18.2-23.2]	175 (1,648)	10.1 [8.5-11.7]	206 (1,648)	12.7 [11.5-13.8]	13 (1,648)	0.9 [0.4-1.3]
15	1,231 (1,621)	76.1 [74.6-77.6]	1,144 (1,617)	71.3 [68.6-74.1]	376 (1,617)	22.5 [19.8-25.2]	164 (1,617)	10.8 [9.1-12.5]	201 (1,617)	12.6 [11.4-13.8]	37 (1,617)	1.8 [1.2-2.5]
16	1,091 (1,418)	74.8 [72.7-76.9]	1,032 (1,415)	71.2 [69.2-73.3]	314 (1,415)	20.7 [18.1-23.4]	147 (1,415)	11.8 [9.9-13.8]	191 (1,415)	15.3 [13.6-17.0]	43 (1,415)	3.7 [2.9-4.4]
17 and over	1,093 (1,367)	81.4 [78.6-84.3]	1,020 (1,366)	77.6 [74.6-80.7]	343 (1,366)	24.9 [22.0-27.9]	166 (1,366)	12.3 [9.8-14.8]	167 (1,366)	12.1 [10.1-14.1]	64 (1,366)	5.8 [4.4-7.2]
Neighbourhood Deprivation[1]												
Low	1,680 (2,061)	81.3 [79.7-82.8]	1,607 (2,057)	78.3 [76.6-80.1]	452 (2,057)	23.9 [20.6-27.1]	306 (2,057)	15.3 [13.4-17.2]	295 (2,057)	14.5 [12.9-16.1]	61 (2,057)	4.3 [3.0-5.6]
Medium	2,119 (2,737)	79.1 [77.2-81.0]	1,992 (2,733)	75.1 [72.9-77.4]	582 (2,733)	20.0 [18.0-22.0]	280 (2,733)	9.9 [8.5-11.3]	343 (2,733)	12.6 [11.5-13.7]	46 (2,733)	1.5 [1.0-2.0]
High	1,355 (1,840)	73.7 [72.0-75.4]	1,211 (1,831)	67.4 [64.7-70.0]	418 (1,831)	21.1 [18.6-23.6]	114 (1,831)	6.5 [5.0-8.1]	191 (1,831)	11.2 [9.3-13.0]	31 (1,831)	2.2 [1.3-3.0]
School Decile[2]												
Low	1,034 (1,393)	75.0 [72.4-77.6]	909 (1,385)	67.4 [64.7-70.1]	374 (1,385)	27.3 [22.1-32.5]	83 (1,385)	6.2 [4.9-7.5]	141 (1,385)	10.6 [8.4-12.9]	15 (1,385)	1.4 [0.5-2.2]
Medium	2,374 (3,098)	75.8 [74.1-77.5]	2,219 (3,088)	71.6 [69.4-73.8]	558 (3,088)	15.1 [13.6-16.7]	275 (3,088)	7.2 [5.4-9.0]	375 (3,088)	11.1 [9.0-13.1]	61 (3,088)	1.7 [1.0-2.3]
High	2,278 (2,847)	82.0 [80.3-83.8]	2,167 (2,844)	78.8 [76.9-80.8]	671 (2,844)	26.2 [22.0-30.4]	414 (2,844)	16.7 [14.4-19.1]	413 (2,844)	16.4 [15.4-17.5]	87 (2,844)	4.3 [3.6-5.1]
Urban Rural indicator[3]												
Urban	3,912 (5,035)	79.6 [78.3-81.0]	3,641 (5,024)	74.9 [73.3-76.5]	1,134 (5,024)	24.4 [22.3-26.5]	569 (5,024)	12.5 [11.0-14.0]	637 (5,024)	13.7 [12.7-14.8]	110 (5,024)	3.0 [2.5-3.4]
Small towns	422 (530)	75.4 [72.4-78.4]	396 (529)	72.4 [69.2-75.6]	111 (529)	14.0 [9.4-18.7]	42 (529)	5.5 [3.3-7.7]	62 (529)	9.1 [6.4-11.7]	11 (529)	1.4 [0.4-2.4]
Rural	820 (1,074)	75.5 [72.9-78.1]	773 (1,069)	72.3 [69.4-75.2]	207 (1,069)	15.6 [11.7-19.5]	89 (1,069)	7.7 [5.6-9.7]	130 (1,069)	11.9 [10.2-13.5]	17 (1,069)	2.0 [1.0-3.0]

1 NZ Deprivation Index 2018, Low deprivation (1-3), Medium deprivation (4-7), High deprivation (8-10)

2 School Decile, Low decile (1-3) indicating higher deprivation, Medium decile (4-7), High decile (8-10) indicating lower deprivation.

3 Urban (population of 10,000 or more), Small towns (population between 1,000 and 9,999 people), Rural (population fewer than 1,000)

Table 2: Experience of health care in the last 12 months

	Talked with a health provider in private		Health provider assured confidentiality		Unable to see health care professional when wanted	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Total	2,118 (5,665)	39.7 [38.4-41.0]	2,385 (5,599)	44.2 [42.8-45.6]	1,548 (7,362)	20.2 [19.0-21.5]
Sex						
Male	963 (2,522)	41.7 [39.7-43.7]	982 (2,486)	42.1 [40.1-44.0]	646 (3,311)	19.3 [17.5-21.1]
Female	1,155 (3,143)	37.7 [36.0-39.4]	1,403 (3,113)	46.2 [44.3-48.2]	902 (4,051)	21.1 [19.8-22.5]
Age						
13 and under	271 (1,016)	24.8 [20.8-28.7]	327 (1,005)	30.7 [26.5-34.8]	201 (1,323)	14.2 [12.2-16.3]
14	376 (1,262)	29.5 [27.3-31.6]	479 (1,242)	38.4 [35.6-41.2]	345 (1,644)	19.8 [17.9-21.6]
15	428 (1,218)	38.0 [34.6-41.3]	495 (1,207)	44.7 [41.8-47.6]	379 (1,621)	23.3 [20.8-25.9]
16	464 (1,087)	43.0 [39.6-46.3]	511 (1,074)	48.5 [45.4-51.5]	307 (1,418)	20.7 [19.0-22.5]
17 and over	579 (1,082)	57.5 [54.3-60.7]	573 (1,071)	54.9 [51.9-57.9]	316 (1,356)	21.8 [19.6-24.0]
Neighbourhood Deprivation[1]						
Low	607 (1,669)	39.6 [37.0-42.3]	684 (1,655)	45.4 [43.1-47.7]	348 (2,055)	17.2 [16.3-18.0]
Medium	718 (2,105)	37.1 [34.2-39.9]	811 (2,080)	40.2 [37.8-42.5]	566 (2,736)	20.2 [17.9-22.4]
High	553 (1,331)	43.3 [40.7-46.0]	637 (1,312)	49.5 [46.4-52.5]	467 (1,833)	24.1 [21.9-26.2]
School Decile[2]						
Low	449 (1,010)	45.5 [41.7-49.3]	550 (996)	56.6 [52.7-60.6]	402 (1,392)	28.3 [25.9-30.7]
Medium	861 (2,351)	40.5 [37.3-43.7]	960 (2,310)	41.7 [39.5-43.9]	641 (3,084)	20.5 [17.8-23.1]
High	793 (2,267)	36.7 [34.7-38.7]	862 (2,258)	42.3 [40.5-44.1]	494 (2,844)	16.7 [16.1-17.2]
Urban Rural indicator[3]						
Urban	1,396 (3,878)	38.2 [36.8-39.6]	1,585 (3,837)	44.8 [43.5-46.1]	1,011 (5,019)	19.6 [18.6-20.6]
Small towns	164 (416)	40.6 [36.6-44.7]	203 (406)	46.3 [41.4-51.1]	135 (531)	23.9 [21.4-26.4]
Rural	318 (811)	43.8 [38.1-49.6]	344 (804)	41.0 [37.8-44.2]	235 (1,075)	20.2 [16.0-24.5]

1 NZ Deprivation Index 2018, Low deprivation (1-3), Medium deprivation (4-7), High deprivation (8-10)

2 School Decile, Low decile (1-3) indicating higher deprivation, Medium decile (4-7), High decile (8-10) indicating lower deprivation.

3 Urban (population of 10,000 or more), Small towns (population between 1,000 and 9,999 people), Rural (population fewer than 1,000)

Table 3: Health care access trends

	2001		2007		2012		2019	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Talked with health professional in private in last 12 months								
Total	N/A	N/A	2,607 (7,327)	36.7 [35.3-38.2]	2,448 (6,658)	38.6 [36.9-40.2]	2,009 (5,443)	39.6 [38.3-40.9]
Sex								
Male	N/A	N/A	1,355 (3,871)	35.8 [33.7-37.9]	1,058 (2,929)	37.4 [34.6-40.1]	915 (2,427)	41.7 [39.7-43.7]
Female	N/A	N/A	1,252 (3,456)	37.6 [35.5-39.6]	1,390 (3,729)	39.7 [38.1-41.3]	1,094 (3,016)	37.7 [36.0-39.4]
Health professional assured confidentiality in last 12 months								
Total	N/A	N/A	3,294 (7,257)	46.5 [45.3-47.8]	3,038 (6,620)	46.6 [44.7-48.4]	2,262 (5,380)	44.2 [42.8-45.6]
Sex								
Male	N/A	N/A	1,627 (3,825)	43.3 [41.6-45.0]	1,209 (2,909)	42.5 [39.2-45.8]	936 (2,395)	42.0 [40.1-44.0]
Female	N/A	N/A	1,667 (3,432)	49.7 [47.7-51.6]	1,829 (3,711)	50.4 [48.5-52.3]	1,326 (2,985)	46.2 [44.2-48.1]
Unable to access health care when wanted - at least once in the last 12 months								
Total	N/A	N/A	1,485 (8,818)	16.7 [15.9-17.6]	1,564 (8,402)	17.9 [17.1-18.7]	1,448 (7,061)	20.1 [18.9-21.4]
Sex								
Male	N/A	N/A	681 (4,741)	14.4 [13.2-15.5]	596 (3,815)	15.1 [14.0-16.2]	603 (3,178)	19.2 [17.4-21.0]
Female	N/A	N/A	804 (4,077)	19.1 [17.7-20.5]	968 (4,587)	20.8 [19.6-22.1]	845 (3,883)	21.1 [19.7-22.5]

Notes: When comparing survey years, students from kura kaupapa Māori are not included in 2019 results, as previous survey waves did not include kura kaupapa Māori students. The data reported has been calibrated to adjust for differences between the national population of students and those who took part in surveys. See the *Youth19 Rangatahi Smart Survey, Initial Findings: Introduction and Methods* report for details (available at www.youth19.ac.nz).

N/A = not available. In 2001, these questions were not asked, hence are not included in this table.

Access to health care among rangatahi Māori

Youth19 data shows that almost three quarters (74%) of rangatahi accessed health care in the previous year, with access higher among those living in higher income areas (81%), as shown in Table 4. Most rangatahi Māori sought health care from a family doctor, medical centre or GP clinic (69%), school health clinic (22%) or an after-hours or 24-hour accident and medical centre (19%). There were some differences by deprivation level. A lower proportion of rangatahi Māori from lower income (high deprivation) and middle income areas accessed health care from a family doctor, medical centre or GP clinic (66% and 67%, respectively) than their peers from higher income (low deprivation) areas (80%). Fewer rangatahi Māori from medium decile schools (16%) visited a school health clinic than their peers from low or high decile schools (28% and 29%, respectively).

Of rangatahi Māori who had accessed health care in the previous year, fewer than half (44%) had talked with a health professional in private, and half (50%) had been assured confidentiality by a health professional. There were some differences by deprivation level. A greater proportion of rangatahi Māori from higher deprivation neighbourhoods (low income areas) were assured confidentiality (55%) than their peers from medium income areas (41%).

There has been no notable change since 2012 in the proportion of rangatahi Māori who had talked with a health professional in private or who were assured confidentiality by a health professional, as shown in Table 5.

In Youth19, over a quarter (27%) of rangatahi Māori were unable to access health care when they needed or wanted in the previous year, as shown in Table 5.

Youth19 data shows that in the previous year, when compared to their Pākehā and other European peers, a larger proportion of rangatahi Māori:

- were likely to have talked with a health professional in private, specifically rangatahi females (46% compared to 36% for Pākehā and European females) and to have been assured confidentiality by a health professional (54% for rangatahi females compared to 46% for Pākehā and European females, as shown in Table 10)
- were unable to access health care when they needed to, at least once (27% compared to 17% for Pākehā and European youth).

Table 4: Health care access among rangatahi Māori*

	Accessed at least one health care service in the last 12 months		Talked with health professional in private in last 12 months		Health professional assured confidentiality in last 12 months		Unable to access health care when wanted - at least once in the last 12 months	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Total	1,072 (1,404)	74.2 (72.3-76.2)	440 (1,051)	44.5 [41.3-47.6]	511 (1,031)	50.0 [45.2-54.8]	384 (1,389)	27.1 [24.1-30.2]
Sex								
Male	484 (641)	74.1 (69.9-78.3)	197 (473)	43.1 [39.0-47.2]	204 (461)	46.6 [40.4-52.7]	175 (630)	26.6 [21.4-31.9]
Female	588 (763)	74.4 (69.9-78.9)	243 (578)	46.0 [42.4-49.6]	307 (570)	53.9 [48.6-59.2]	209 (759)	27.6 [25.0-30.3]
Neighbourhood Deprivation[1]								
Low	159 (192)	81.0 (77.1-84.9)	68 (159)	49.0 [42.1-55.8]	77 (156)	54.4 [45.6-63.2]	49 (189)	27.9 [22.4-33.4]
Medium	300 (395)	72.0 (68.5-75.6)	102 (296)	40.2 [35.2-45.2]	110 (288)	41.4 [34.8-48.0]	102 (393)	27.4 [20.4-34.5]
High	425 (569)	72.7 (68.7-76.7)	192 (413)	45.9 [41.1-50.7]	235 (407)	55.5 [50.1-60.9]	163 (559)	26.7 [22.2-31.1]

*Ethnicity is categorised using the NZ census ethnicity prioritisation method

1 NZ Deprivation Index 2018, Low deprivation (1-3), Medium deprivation (4-7), High deprivation (8-10)

Table 5: Health care access trends among rangatahi Māori*

	2001		2007		2012		2019	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Talked with health professional in private in last 12 months								
Total	N/A	N/A	557 (1,358)	42.1 [39.4-44.8]	537 (1,313)	42.0 [39.0-45.0]	338 (841)	44.3 [41.1-47.5]
Sex								
Male	N/A	N/A	256 (682)	38.6 [35.3-41.9]	247 (593)	42.7 [37.5-47.9]	154 (386)	42.8 [38.6-47.1]
Female	N/A	N/A	301 (676)	45.1 [41.0-49.2]	290 (720)	41.4 [38.0-44.8]	184 (455)	46.0 [42.3-49.6]
Health professional assured confidentiality in last 12 months								
Total	N/A	N/A	718 (1,343)	54.7 [51.7-57.7]	682 (1,303)	52.0 [48.5-55.5]	397 (825)	49.9 [45.0-54.8]
Sex								
Male	N/A	N/A	308 (673)	45.8 [42.0-49.6]	286 (590)	48.9 [43.9-53.8]	163 (378)	46.5 [40.2-52.9]
Female	N/A	N/A	410 (670)	62.2 [58.1-66.4]	396 (713)	55.1 [50.7-59.6]	234 (447)	53.6 [48.2-59.1]
Unable to access health care when wanted - at least once in the last 12 months								
Total	N/A	N/A	373 (1,651)	23.1 [20.6-25.5]	367 (1,669)	21.6 [19.6-23.6]	292 (1,106)	26.9 [23.8-30.0]
Sex								
Male	N/A	N/A	154 (850)	18.7 [15.6-21.8]	142 (783)	18.2 [15.6-20.9]	135 (507)	26.5 [21.1-31.8]
Female	N/A	N/A	219 (801)	27.0 [23.8-30.2]	225 (886)	25.2 [22.5-27.9]	157 (599)	27.5 [24.7-30.2]

* Ethnicity is categorised using the NZ census ethnicity prioritisation method

Notes: When comparing survey years, students from kura kaupapa Māori are not included in 2019 results, as previous survey waves did not include kura kaupapa Māori students. The data reported has been calibrated to adjust for differences between the national population of students and those who took part in surveys. See the *Youth19 Rangatahi Smart Survey, Initial Findings: Introduction and Methods* report for details (available at www.youth19.ac.nz).

N/A = not available. In 2001, these questions were not asked, hence are not included in this table.

Access to health care among Pacific youth

Youth19 data shows that almost three quarters (74%) of Pacific youth accessed health care in the previous year, as shown in Table 6. Most Pacific youth sought health care from a family doctor, medical centre or GP clinic (68%), school health clinic (31%) or an after-hours or 24-hour accident and medical centre (17%). There were some differences by deprivation level. A lower proportion of Pacific youth from lower income (high deprivation) areas visited a family doctor, medical centre or GP clinic (65%) than their peers from higher income (low deprivation) areas (76%). A lower proportion of Pacific youth from medium decile schools (17%) visited a school health clinic than their peers from low or high decile schools (34% for both).

Of Pacific students who had accessed health care in the previous year, fewer than half had talked with a health professional in private (43%), and a similar number had been assured confidentiality by a health professional (47%). There were some differences by deprivation level. A greater proportion of Pacific youth from lower income (high deprivation) areas talked with a health professional in private (48%) than from higher income (low deprivation) areas (30%).

There has been no notable change since 2012 in the proportion of Pacific youth who had talked with a health professional in private or who were assured confidentiality by a health professional, as shown in Table 7.

A quarter (25%) of Pacific youth were unable to access health care when they needed or wanted in the previous year. There were some differences by deprivation level. A greater proportion of Pacific youth from low income (high deprivation) (29%) and middle income (medium deprivation) (24%) areas were unable to access health care when needed than from high income (low deprivation) areas (9%). The proportion of Pacific youth who were unable to access health care when they wanted it was unchanged from 2012, as shown in Table 7.

Youth19 data shows Pacific youth were more likely to forgo care (25%) than Pākehā and European youth (17%, as shown in Table 10), especially for males (28% for Pacific males compared to 14% for Pākehā and European males).

Table 6: Health care access among Pacific youth*

	Accessed at least one health care service in last 12 months		Talked with health professional in private in last 12 months		Health professional assured confidentiality in last 12 months		Unable to access health care when wanted - at least once in the last 12 months	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Total	629 (872)	74.0 (70.8-77.2)	258 (619)	43.3 [39.0-47.5]	284 (608)	46.5 [40.6-52.4]	233 (863)	25.1 [22.1-28.2]
Sex								
Male	250 (343)	72.0 (68.5-75.6)	107 (246)	46.5 [38.4-54.6]	97 (240)	43.1 [35.3-50.9]	92 (340)	28.3 [25.8-30.9]
Female	379 (529)	75.7 (71.3-80.0)	151 (373)	40.7 [35.4-46.0]	187 (368)	49.2 [42.1-56.4]	141 (523)	22.4 [17.2-27.7]
Neighbourhood Deprivation[1]								
Low	58 (71)	78.1 (71.8-84.3)	24 (56)	29.9 [20.2-39.7]	23 (55)	45.5 [39.1-51.8]	7 (67)	8.5 [1.8-15.2]
Medium	153 (208)	77.1 (69.5-84.7)	52 (151)	41.1 [35.3-46.9]	66 (149)	43.2 [35.9-50.6]	57 (208)	24.1 [18.7-29.5]
High	346 (499)	71.5 (68.3-74.7)	153 (340)	48.0 [42.3-53.6]	164 (335)	49.2 [42.7-55.8]	151 (500)	29.3 [25.8-32.8]

* Ethnicity is categorised using the NZ census ethnicity prioritisation method

1 NZ Deprivation Index 2018, Low deprivation (1-3), Medium deprivation (4-7), High deprivation (8-10)

Table 7: Health care access trends among Pacific youth*

	2001		2007		2012		2019	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Talked with health professional in private in last 12 months								
Total	N/A	N/A	229 (672)	34.2 [30.9-37.6]	299 (841)	36.8 [33.3-40.3]	256 (614)	43.2 [39.0-47.4]
Sex								
Male	N/A	N/A	132 (361)	35.4 [30.4-40.3]	121 (358)	35.9 [30.7-41.1]	106 (244)	46.3 [38.3-54.4]
Female	N/A	N/A	97 (311)	33.1 [28.6-37.7]	178 (483)	37.8 [33.3-42.2]	150 (370)	40.7 [35.4-46.0]
Health professional assured confidentiality in last 12 months								
Total	N/A	N/A	296 (667)	44.6 [40.2-49.0]	417 (835)	49.7 [46.2-53.2]	280 (602)	46.5 [40.6-52.3]
Sex								
Male	N/A	N/A	143 (356)	38.6 [33.4-43.9]	158 (353)	46.9 [41.2-52.6]	96 (238)	43.1 [35.4-50.8]
Female	N/A	N/A	153 (311)	50.4 [45.7-55.2]	259 (482)	52.6 [47.9-57.2]	184 (364)	49.1 [42.0-56.3]
Unable to access health care when wanted - at least once in the last 12 months								
Total	N/A	N/A	212 (871)	24.2 [21.3-27.1]	283 (1,176)	24.4 [21.8-26.9]	227 (856)	25.1 [22.1-28.1]
Sex								
Male	N/A	N/A	115 (467)	25.1 [22.2-28.0]	105 (505)	21.6 [17.6-25.5]	91 (338)	28.3 [25.7-30.8]
Female	N/A	N/A	97 (404)	23.4 [18.7-28.1]	178 (671)	27.2 [23.5-31.0]	136 (518)	22.4 [17.1-27.6]

* Ethnicity is categorised using the NZ census ethnicity prioritisation method

Notes: When comparing survey years, students from kura kaupapa Māori are not included in 2019 results, as previous survey waves did not include kura kaupapa Māori students. The data reported has been calibrated to adjust for differences between the national population of students and those who took part in surveys. See the *Youth19 Rangatahi Smart Survey, Initial Findings: Introduction and Methods* report for details (available at www.youth19.ac.nz).

N/A = not available. In 2001, these questions were not asked, hence are not included in this table.

Access to health care among Asian youth

Youth19 data shows that three quarters (76%) of Asian youth accessed health care in the previous year, as shown in Table 8. Most Asian youth sought health care from a family doctor, medical centre or GP clinic (69%), school health clinic (21%) or an after-hours or 24-hour accident and medical centre (15%).

Of Asian students who had accessed health care in the previous year, only a third (33%) had talked with a health professional in private, and little over a third (36%) had been assured confidentiality by a health professional. There has been no substantial change since 2012 in the proportion of Asian youth who had talked with a health professional in private or who were assured confidentiality by a health professional, as shown in Table 9.

About a fifth (19%) of Asian youth were unable to access health care when they needed or wanted in the previous year. The proportion of Asian youth who were unable to access health care when they wanted it was unchanged from 2012, as shown in Table 9.

Youth19 data shows that, when compared to their peers, a smaller proportion of Asian youth:

- talked with a health professional in private (33% compared to 40% for Pākehā and European youth), especially among males (34% for Asian males compared to 44% for Pākehā and European males)
- were assured confidentiality by a health professional (36% compared to 44% for Pākehā and European youth).

Table 8: Health care access among Asian youth*

	Accessed at least one health care service in last 12 months		Talked with health professional in private in last 12 months		Health professional assured confidentiality in last 12 months		Unable to access health care when wanted - at least once in the last 12 months	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Total	1303 (1733)	76.0 (73.3-78.7)	406 (1,296)	33.3 [30.4-36.1]	422 (1,281)	36.3 [32.2-40.4]	331 (1,735)	19.4 [17.6-21.2]
Sex								
Male	620 (810)	76.2 (72.7-79.7)	195 (617)	33.7 [30.6-36.7]	196 (607)	35.2 [30.6-39.8]	139 (805)	17.4 [15.0-19.9]
Female	683 (923)	75.8 (71.5-80.1)	211 (679)	32.8 [27.8-37.8]	226 (674)	37.5 [30.5-44.5]	192 (930)	21.5 [18.9-24.2]
Neighbourhood Deprivation[1]								
Low	331 (430)	77.6 (72.7-82.5)	109 (331)	35.1 [30.0-40.2]	100 (327)	36.0 [26.8-45.2]	76 (429)	18.1 [14.2-21.9]
Medium	603 (811)	75.3 (71.6-78.9)	171 (601)	30.1 [26.8-33.4]	190 (597)	34.8 [31.2-38.3]	163 (814)	21.2 [17.5-24.8]
High	272 (358)	75.5 (71.0-80.1)	95 (268)	37.0 [30.6-43.4]	101 (264)	40.8 [34.7-46.8]	64 (358)	17.1 [12.9-21.2]

* Ethnicity is categorised using the NZ census ethnicity prioritisation method

1 NZ Deprivation Index 2018, Low deprivation (1-3), Medium deprivation (4-7), High deprivation (8-10)

Table 9: Health care access trends among Asian youth*

	2001		2007		2012		2019	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Talked with health professional in private in last 12 months								
Total	N/A	N/A	243 (831)	30.2 [25.7-34.7]	234 (790)	31.5 [26.9-36.2]	406 (1,296)	33.2 [30.3-36.1]
Sex								
Male	N/A	N/A	126 (436)	29.7 [24.1-35.4]	126 (382)	34.4 [27.7-41.0]	195 (617)	33.6 [30.6-36.7]
Female	N/A	N/A	117 (395)	30.6 [25.3-35.9]	108 (408)	28.2 [22.7-33.7]	211 (679)	32.8 [27.7-37.8]
Health professional assured confidentiality in last 12 months								
Total	N/A	N/A	247 (822)	30.6 [27.4-33.8]	227 (784)	28.8 [25.4-32.2]	422 (1,281)	36.4 [32.2-40.5]
Sex								
Male	N/A	N/A	127 (432)	29.3 [25.7-33.0]	105 (381)	26.7 [21.7-31.6]	196 (607)	35.3 [30.7-39.9]
Female	N/A	N/A	120 (390)	31.7 [27.2-36.2]	122 (403)	31.4 [27.5-35.2]	226 (674)	37.5 [30.5-44.6]
Unable to access health care when wanted - at least once in the last 12 months								
Total	N/A	N/A	161 (1,100)	15.1 [13.6-16.6]	180 (1,040)	17.2 [15.2-19.1]	331 (1,735)	19.4 [17.6-21.2]
Sex								
Male	N/A	N/A	80 (605)	13.8 [11.4-16.2]	82 (514)	16.3 [13.2-19.4]	139 (805)	17.4 [15.0-19.9]
Female	N/A	N/A	81 (495)	16.4 [13.4-19.5]	98 (526)	18.3 [15.1-21.5]	192 (930)	21.5 [18.9-24.2]

* Ethnicity is categorised using the NZ census ethnicity prioritisation method

Notes: When comparing survey years, students from kura kaupapa Māori are not included in 2019 results, as previous survey waves did not include kura kaupapa Māori students. The data reported has been calibrated to adjust for differences between the national population of students and those who took part in surveys. See the *Youth19 Rangatahi Smart Survey, Initial Findings: Introduction and Methods* report for details (available at www.youth19.ac.nz).

N/A = not available. In 2001, these questions were not asked, hence are not included in this table.

Health care access among Pākehā and European youth

Youth19 data shows that four fifths (80%) of Pākehā and European youth have accessed health care in the previous year, as shown in Table 10. Most sought health care from a family doctor, medical centre or GP clinic (78%), school health clinic (20%) or an after-hours or 24-hour accident and medical centre (22%). There were some differences by gender and deprivation level. A greater proportion of Pākehā and European females accessed school health clinics (24%) compared to males (15%). A lower proportion of Pākehā and European from low income (high deprivation) areas visited a family doctor, medical centre or GP clinic (71%) than their peers from medium and high income (low deprivation) areas (80%). Fewer Pākehā and European youth from lower income (high deprivation) areas visited a school health clinic (15%) than their peers from higher income (low deprivation) areas (24%). This pattern differs from that seen among other ethnic groups in this report.

Of Pākehā and European students who had accessed health care in the previous year, fewer than half had talked with a health professional in private (40%), and a similar number had been assured confidentiality by a health professional (44%). There were some differences by gender and deprivation level. A greater proportion of males talked with health professionals in private (44%) compared to females (36%). A greater proportion of those from low income (high deprivation) areas were assured confidentiality by a health professional (49%) than those from middle income (medium deprivation) areas (41%). There was an increase in the proportion of Pākehā and European males talking with a health professional in private, from 36% in 2012 to 44% in 2019, as shown in Table 11. Conversely, there was a decrease in the proportion of Pākehā and European females talking with a health professional in private, from 42% in 2012 to 36% in 2019. There was also a decrease in the proportion of Pākehā and European females assured confidentiality by a health professional, from 52% in 2012 to 46% in 2019.

About one in six (17%) of Pākehā and European youth were unable to access health care when they needed or wanted in the previous year.

- Pākehā and European females were more likely to report being unable to access health care (19%) than Pākehā and European males (14%).
- The proportion of Pākehā and European youth who reported they were unable to access health care in 2019 (16%) was unchanged from 2012 (15%), as shown in Table 11.

Table 10: Health care access among Pākehā and European youth*

	Accessed at least one health care service in the last 12 months		Talked with health professional in private in last 12 months		Health professional assured confidentiality in last 12 months		Unable to access health care when wanted - at least once in the last 12 months	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Total	2,444 (3,005)	81.1 (79.8-82.4)	926 (2,428)	39.5 [37.6-41.3]	1,069 (2,418)	44.2 [42.4-46.1]	522 (3,009)	16.5 [15.2-17.7]
Sex								
Male	1,070 (1,353)	79.0 (76.5-81.6)	422 (1,059)	43.5 [40.5-46.4]	442 (1,057)	42.6 [39.7-45.4]	200 (1,353)	14.3 [12.9-15.7]
Female	1,374 (1,652)	83.0 (81.1-84.8)	504 (1,369)	36.0 [34.3-37.7]	627 (1,361)	45.7 [43.7-47.6]	322 (1,656)	18.5 [16.7-20.2]
Neighbourhood Deprivation[1]								
Low	1,060 (1,274)	82.1 (80.1-84.0)	382 (1,052)	39.3 [36.6-41.9]	454 (1,047)	45.5 [43.1-48.0]	198 (1,275)	15.8 [14.6-17.1]
Medium	952 (1,174)	82.4 (80.3-84.6)	354 (947)	37.6 [33.7-41.5]	407 (943)	41.1 [37.7-44.5]	207 (1,174)	15.7 [13.6-17.8]
High	246 (321)	76.3 (72.5-80.2)	97 (245)	43.8 [38.0-49.5]	116 (243)	49.3 [44.6-54.0]	72 (323)	20.7 [16.5-25.0]

* Ethnicity is categorised using the NZ census ethnicity prioritisation method

1 NZ Deprivation Index 2018, Low deprivation (1-3), Medium deprivation (4-7), High deprivation (8-10)

Table 11: Health care access trends among Pākehā and European youth*

	2001		2007		2012		2019	
	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]	n (N)	% [95% CI]
Talked with health professional in private in last 12 months								
Total	N/A	N/A	1,434 (4,031)	36.5 [34.6-38.5]	1,238 (3,318)	39.1 [36.6-41.6]	923 (2,425)	39.5 [37.7-41.3]
Sex								
Male	N/A	N/A	766 (2,171)	36.0 [33.3-38.6]	493 (1,424)	36.0 [32.2-39.8]	420 (1,057)	43.5 [40.5-46.4]
Female	N/A	N/A	668 (1,860)	37.1 [34.3-39.9]	745 (1,894)	41.9 [39.6-44.2]	503 (1,368)	36.0 [34.3-37.7]
Health professional assured confidentiality in last 12 months								
Total	N/A	N/A	1,850 (3,991)	46.9 [45.5-48.3]	1,537 (3,305)	47.6 [44.9-50.2]	1,066 (2,415)	44.2 [42.4-46.1]
Sex								
Male	N/A	N/A	961 (2,144)	45.2 [43.2-47.3]	583 (1,414)	42.4 [38.1-46.7]	440 (1,055)	42.6 [39.7-45.4]
Female	N/A	N/A	889 (1,847)	48.5 [46.4-50.7]	954 (1,891)	52.2 [49.6-54.7]	626 (1,360)	45.7 [43.7-47.6]
Unable to access health care when wanted - at least once in the last 12 months								
Total	N/A	N/A	642 (4,674)	13.9 [13.0-14.8]	622 (4,007)	15.3 [14.3-16.4]	521 (3,006)	16.5 [15.2-17.7]
Sex								
Male	N/A	N/A	296 (2,550)	11.9 [10.5-13.4]	223 (1,781)	12.2 [10.8-13.5]	199 (1,351)	14.3 [12.9-15.7]
Female	N/A	N/A	346 (2,124)	16.0 [14.7-17.2]	399 (2,226)	18.3 [16.4-20.3]	322 (1,655)	18.5 [16.7-20.2]

* Ethnicity is categorised using the NZ census ethnicity prioritisation method

Notes: When comparing survey years, students from kura kaupapa Māori are not included in 2019 results, as previous survey waves did not include kura kaupapa Māori students. The data reported has been calibrated to adjust for differences between the national population of students and those who took part in surveys. See the *Youth19 Rangatahi Smart Survey, Initial Findings: Introduction and Methods* report for details (available at www.youth19.ac.nz).

N/A = not available. In 2001, these questions were not asked, hence are not included in this table.

Youth voice

For the first time in a Youth2000 survey, Youth19 included open text questions so that students could express their views about the issues they face. Students could respond in open text boxes, in their own words. Only a quarter to a third of students answered these questions, so it is important to remember that not all students' voices are represented. A summary of this data is available in our *Youth Voices Brief* (Fleming, Ball et al., 2020). Some responses to the question **'What do you think should be changed to support young people in New Zealand?'** related to health services. Examples are included below.

There were multiple comments suggesting the need for more support, especially in areas of mental health and wellbeing.

"I think there should be more help involved and people to be there to listen to you. Even if they're not family and friends. Most teenagers just need someone willing to listen and understand you when things are rough. Something that should be changed in New Zealand is that there should be more help just for people."

Māori female, decile 10, age 15

"More youthlines, have a community for people to talk to."

Māori male, decile 9, age 16

Many comments suggested that services should not rely on young people knowing where to find help or having the skills or confidence to seek it. Students suggested that providers should tell them about available support, make it easy to access, and bring it to them.

"I think high schools should be strongly encouraged to promote mental health. For example, combining careers counselling with a school counsellor check up because even if someone is fine this is beneficial."

Asian female, decile 9, age 17

"Trained professionals wandering around locations e.g schools just talking to students without having an appointment and the professionals themselves go around and speak out as young people might be too shy to go to them to talk about their issues."

Māori male, decile 9, age 15

"They should be told avidly *that there is a place they can go for support and talk about issues.*"

Māori male, decile 5, age 15

"Better mental health facilities and clearer/ easier ways to make appointments with counsellors, etc."

Pākehā male, decile 7, age 17

"Compulsory visits and checkups to the counsellor."

Pacific female, decile 3, age 17

Students identified that they wanted support from people who understood and had insights, provided in non-judgemental, private or youth friendly settings.

"Better support systems that have people that fully understand what young people are going through and can communicate well with them because there are some young people that don't like to talk about their feelings."
Pacific female, decile 3, age 17+

"More counsellors around our age that can understand our feelings better and so we can have a chill conversation rather than a nervy one."
Asian female, decile 9, age 14

"Youth who want to support youth, rather than just adults."
Pākehā male, decile 6, age 15

"Something people can look at like a website or a close family member that is easy to talk to without them worrying or judging."
Pākehā female, decile 8, age 13

What helps to improve health care access?

Overall, access to health care has not improved or has worsened for youth over the past 18 years. Some health professionals working in lower income communities (particularly those working with Māori and Pacific youth) are recognising that youth need to be reassured of confidentiality and be seen alone for at least part of the consultation. However, access to health care for those living in low income areas continues to be a significant barrier and ongoing concern for youth. Health inequity remains stubbornly strong and appears to be worsening for some groups, particularly Māori and Pacific youth.

There are many things we can do in our schools and communities to improve health care access for young people. These include:

- addressing the broader determinants of health and reducing poverty – our findings clearly highlight the impact of poverty on health care access for youth
- free access to accessible, developmentally and culturally appropriate health care in a range of settings
- ensuring young people know about services
- overcoming the effects of 'help negation' (Wilson & Deane, 2012) and ensuring that adults reach out to young people in appropriate ways, rather than assuming young people will necessarily come to them proactively
- training all health care providers in skills for working with young people, including respect for adolescents' privacy and confidentiality in all aspects of encounters and follow-up care.

Access free youth health and youth service information or online training modules through Ara Taiohi (the peak body for youth development in Aotearoa), the Society for Youth Health Professionals Aotearoa New Zealand, the GoodFellow Unit or Werry Workforce Whāraurau.

More to come

We are currently analysing the Youth19 health care access data in more depth. Future publications will include:

- more detail about where and how students access care (e.g., school-based health services and who uses them)
- the prevalence and impact of ethnic discrimination in health care for youth
- the impact of socio-economic factors on youth health care access and wellbeing.

Please see www.youth19.ac.nz for publications as they become available.

For young people: Getting the health care you need

Doctors, nurses, counsellors and other health providers help with lots of different problems and worries. They talk with people about private or embarrassing stuff almost every day. You can see your family doctor or a doctor or nurse at school. You can ring up or book an appointment online – you don't need to say what it's for. You can go with a family member, someone else or alone. You can find out before you go if you will have to pay. Most providers are not allowed to tell anyone else about what you've said without your permission, unless they're really worried about you or someone else right now. You can find more about your rights here: hdc.org.nz/your-rights/the-code-and-your-rights

If you're not sure if you should worry about a health issue, or you don't know where to go, you can call Healthline on 0800 611 116. This is free and you don't need to give your name. You can also check out Youthline – free phone on 0800 376 633, free text on 234, or webchat (www.youthline.co.nz/web-chat-counselling.html). If you're feeling down, worried or stressed, you can call a free counsellor on 1737. There are lots more options at Health Navigator (www.healthnavigator.org.nz) and Family Services Directory (www.familyservices.govt.nz/directory), and we have extra hints for getting started here: info.youth19.ac.nz/talking-to-someone.html

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