Briefing to the Incoming Minister

November ——— 2023

Te Kāwanatanga o Aotearoa
New Zealand Government

Te Whatu Ora
Health New Zealand

Contents

Welcome from the Chair

Tēnā koe and congratulations on your appointment as Minister of Health. We look forward to supporting you to implement the Government's priorities to improve the health and wellbeing of all New Zealanders.

We are now over 16 months old, having been established on 1 July 2022. We have made early progress realising the benefits of merging 28 entities, and some functions of the Ministry of Health, while maintaining continuity of services locally. There is much more work to do as we seek to build a modern, sustainable health system that delivers quality health care for all New Zealanders.

This briefing provides you with an initial overview of our work, and how we will support you to deliver on the Government's priorities. It provides information about our role, how we work to support you and the wider health system, and the opportunities and challenges we face in improving health outcomes. We look forward to providing you with further advice on topics aligned with your goals and priorities.

On behalf of the Board, we look forward to working with you and meeting at your earliest convenience.

Ngā mihi

Dame Dr Karen Poutasi
Chair

What we do

Te Whatu Ora | Health New Zealand (Te Whatu Ora) was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act). It replaced the 20 district health boards (DHBs), eight shared service agencies, and absorbed some functions from the Ministry of Health | Manatū Hauora (the Ministry).

We lead the day-to-day running of the public health system, with our trusted and skilled workforce providing high-quality health services to New Zealanders. We deliver many of these services directly (e.g., hospital services), and we partner with providers by purchasing and funding other services (e.g., primary and community care). Operating and improving the health system depends on close relationships with all our stakeholders, including consumer groups, professional bodies, unions, non-government organisations, Primary Health Organisations (PHOs), and private companies.

The purpose of the Pae Ora Act is to improve the health of all New Zealanders and achieve health equity. It sets us three objectives:

- Design, arrange, and deliver services to achieve the purpose of the Pae Ora Act in accordance with the health sector principles.
- Encourage, support, and maintain community participation in health improvement and service planning.
- Promote health and prevent, reduce, and delay ill-health, including by collaborating with other agencies, organisations, and individuals to address the determinants of health.

The health agencies we work the most closely with on a day-to-day basis are:

- the Ministry, which is your advisor on stewardship of the whole health system, including providing you with advice on policy and regulatory settings and system performance.
- Te Aka Whai Ora | Māori Health Authority (Te Aka Whai Ora), who we have collaborated with effectively across significant parts of our work. The Pae Ora Act requires us to jointly develop the New Zealand Health Plan. We must also engage with Te Aka Whai Ora as we develop locality plans, and these must be agreed by Te Aka Whai Ora, relevant Iwi-Māori Partnership Board and ourselves. Te Aka Whai Ora also monitors our delivery of hauora Māori services.

Our context

Public spending on health is a social investment with economic benefits

The creation of Te Whatu Ora enables us to maximise the scale and efficiency of our expenditure to contribute to the overall health and wellbeing of New Zealanders. By ensuring access to health care services to keep people well, improving public health, detecting disease early, and managing care proactively, we can lower future demand (and lower the total cost over time). This leads to healthier people who can better contribute to their community and are productive in the workforce.

In our first 16 months, we have begun optimising our expenditure to achieve early benefits of these economies of scale, seeing cost savings in some areas, being more effective at responding to demand, and introducing new services. However, there is much to do to accelerate and scale such changes to fully realise the potential of the new system and address the major challenges we face in service supply and capacity.

Some health outcomes are improving but the system is under pressure

Our Health Status Report 2023, which we will publish soon, shows New Zealanders are living longer lives, with life expectancy high compared to other countries – we rank sixteenth in the world. Overall life expectancy is 82 years, a three-year increase over the past two decades.

These improvements, however, are not universal across the population. Life expectancy is lower for high-need groups, including Māori, Pacific, and disabled people, and people living in low socioeconomic areas. These groups are more likely to experience long-term conditions that impact life expectancy, such as respiratory conditions, and early onset of long-term conditions such as diabetes, cancers, and heart disease.

Although 88% of adults report their health as excellent, very good or good, consumers experience pressures on our system through long waits for GP appointments, full emergency departments (EDs) and longer stays in hospital than needed. This pressure stems from a lack of supply – we do not have enough health professionals, many community providers are at capacity, hospitals are often full, and preventative services (e.g., immunisation) are not easily accessible for everyone. We are not alone in facing these challenges; Australia, Canada and the United Kingdom face similar and significant system pressures.

On top of this, demand is high. In the 12 months to June 2023, there were 105,000 more people living in New Zealand. Health service demand is expected to further increase as a result of a growing and ageing population. For example, the number of people aged 75 and over in New Zealand is projected to increase by 3.8% per year in the next 10 years. The health system was not configured to support the growth in overall demand.

We now better understand challenges built up over many years

We inherited the systems, infrastructure, and ways of working of 28 organisations, along with functions from the Ministry, each with their own challenges. These include:

- High demand and complex cases constrain flow throughout the whole system, with hospitals and primary and community providers operating at capacity; 1,574 people were in hospital for longer than seven days for the week ending 12 November 2023.

- Workforce shortages that lead to burnout on the front line, with 4,800 nurses and 1,700 doctors needed immediately across the whole system. We alone have over 6,000 FTE vacant clinical roles as of June 2023.
- Ongoing work nationally to expose unwarranted variation in local services (and underlying differences in resources available locally) that leads to 'post code lottery' experiences, particularly in access to specialist and primary care services.
- Ageing physical infrastructure (1,273 buildings on 86 campuses) that is not always fit for purpose, nor able to support modern healthcare practice, and comes with high remediation costs to comply with seismic and health and safety standards.
- A fragmented data and digital environment with over 4,000 clinical and business system applications, many of which have reached, or are beyond, end of life with high technical debt. For example, inherited payroll systems are in a fragile state, with significant risk to meeting regular staff payments; this will take considerable time and resource to stabilise.
- A regulatory environment that can be a barrier to innovation in areas such as workforce diversity and research and development (e.g., clinical trials capacity).

Overcoming these challenges will take time and effort, and require collaboration with the wide range of organisations that are essential to delivering and improving health services. The opportunities for harmonising the way we work in back-office functions are significant. These opportunities have the potential to release resources to support more frontline delivery of care over time. Some of these opportunities, however, will require investment that may not all be met from reprioritisation within existing baseline funding.

Progress shifting the system

Shifting care closer to home and leveraging primary and community care

- During winter 2023, **more than 730** community pharmacies were authorised and funded to dispense medications and provide consultations for minor ailments, with **over 137,000** consultations by the end of September 2023.
- Community pharmacies are now authorised and funded to administer an additional **four** National Immunisation Schedule vaccines, expanding access for flu and childhood immunisations for everyone over two years old.
- **108** new Access and Choice primary mental health and addiction services have opened across the country since July 2022. These services supported **181,073** people between July 2022 and June 2023.

Shortening wait lists for planned care

- **Northern and Te Manawa Taki** regions are on track to meet the target of no people waiting more than 365 days for treatment (excluding orthopaedics) by 31 December 2023. **Central and Te Waipounamu** are forecast to meet the target by 31 March 2024.
- **45** new critical care beds have been brought online nationally, with over **180** new staff to support the new beds to enable more capacity for complex surgery.

Growing our workforce

- **9,742** health sector workers have been approved for Accredited Employer Work Visas since July 2022, with **3,944** of these workers approved to work at Te Whatu Ora.
- **1,850** internationally qualified nurses have been assisted to become registered to work for Te Whatu Ora and in the funded sector.
- A record **303** New Entry to Specialist Practice nurses and **87** allied health workers have started their mental health and addiction careers.
- We have more than **trebled** the number of funded clinical psychology interns and established **four** training hubs. **Two** of these have established kaupapa Māori clinical psychology training.
- Ambulance providers have increased the frontline workforce by **176** FTE, from **1,722** to **1,898**.

Leveraging the value of a national health system

- There was no interruption to services during the transfer of approximately **90,000** staff from **28** organisations and some functions from the Ministry to Te Whatu Ora.
- Consolidating multiple insurance policies, IT systems and other costs, saved approximately **$75 million** in our first year.
- Continued improvements, such as consolidating mobile phone contracts, with significant potential cost savings.
- We have resolved all pay equity claims with our employed workforce where sex-based undervaluation has been established, resolving claims for around **74,000** people.

Roles and responsibilities

We are a Crown agent under the Crown Entities Act 2004. Our Board is responsible for the governance of the entity and accountable to you for performing its duties.

Responsibilities of the Minister of Health

You oversee and manage the Crown's interests in, and relationship with, Te Whatu Ora, including functions and powers to:

- Appoint and remove Board members and determine remuneration.
- Give directions to Te Whatu Ora (with some limitations).
- Review operations and performance, including through monitoring.
- Request information.
- Participate in setting strategic direction and performance expectations.

We will support you to discharge these responsibilities and to deliver the Government's priorities. This will include regularly communicating with you and your office and providing information and advice relating to ministerial correspondence, Official Information Act 1982 requests (OIAs), and parliamentary questions.

Your key strategic and accountability mechanisms

As a matter of priority, the Ministry will work with you to develop your **Letter of Expectations** to us as a Crown agent. They will also work with you to develop the **Government Policy Statement on Health (GPS)** that will set system priorities for 2024-27.

Working with Te Aka Whai Ora, we are developing the next **New Zealand Health Plan**, which will set out how we give effect to the GPS for 2024-27. The Pae Ora Act requires this plan to be developed jointly and submitted for your approval.

We will shortly publish our first **Annual Report**, reporting on our progress, including important changes, in our first year. We will brief you on specific details closer to release and tabling in the House of Representatives.

We will also develop a **Statement of Intent**, with your involvement, that outlines our direction and priorities. Alongside, we will work with you to develop our **Statement of Performance Expectations**, which sets our performance metrics. Both will apply from 1 July 2024.

These mechanisms are your key levers to set the direction and priorities for us, alongside our regular interactions with you through our Board, Chief Executive and executive leaders.

Responsibilities of the Board

Our Board must have between five and eight members; there are currently seven, introduced in Appendix 1. The Board is chaired by Dame Dr Karen Poutasi. The chair of Te Aka Whai Ora, Tipa Mahuta, is by virtue of holding that office also a member of our Board.

Decisions relating to our operations must be made by, or under the authority of, the Board. The Board delegates responsibility to the Chief Executive, Fepulea'i Margie Apa, for day-to-day management and leadership. The Chief Executive is accountable to the Board.

Responsibilities of the Executive Leadership Team

The Executive Leadership Team (ELT) works to discharge the Chief Executive's delegations in three broad ways:

- Delivery executives are responsible for service delivery and consumer experience including commissioning (planning and funding), hospital and specialist services, the National Public Health Service, Pacific health, Māori health (including working closely with Te Aka Whai Ora), and service improvement and innovation.
- Clinical executives, led by the Chief Clinical Officer, are responsible for professional leadership and ensure effective clinical governance. They are a team of national professional leaders in medical, nursing, allied health, technicians and midwifery.
- Enabling executives provide corporate and back-office support to frontline delivery, including finance, people and culture, data and digital, and infrastructure and investment.

An overview of the ELT's responsibilities is included in Appendix 2.

Balancing national, regional and local responsibilities

Back-office functions are centralised nationally

We have made progress leveraging economies of scale and centralising back-office functions. This has enabled us to generate initial savings, including:

- Reducing consultancy costs from nationally renegotiating contracts for corporate services.
- Developing and implementing the Health Workforce Plan to quantify gaps and engage with education partners with a unified voice, laying a stronger platform for implementing solutions.
- Engaging more effectively with the construction sector on infrastructure projects to support regional hospital development projects.
- Consolidating financial information to understand costs and better inform investments.

For example, we have leveraged our national size and scale to:

- Save $53 million (annualised $173 million in 2023-24) in corporate costs such as insurance and procurement.
- Reduce our management and administration headcount generating $23.7 million in savings (annualised $70.5 million).
- Reduce the number of contractors from over 1200 to 621 (as of 30 June 2023).

Centralising functions nationally has also enabled us to better respond to risks such as:

- Regional and local projects impacting clinical delivery, such as the problematic implementation of Radiology Information Systems in the Central region (specifically Hawke's Bay).

- Payroll teams are supplementing uneven resourcing in local teams as we rollout Holidays Act 2003 remediation payments and implement Multi-Employer Collective Agreement (MECA) and pay equity settlements.
- Ongoing work to harmonise payment rates for additional duties across the country.
- Coordinating actions to improve health and safety risks for our frontline teams, such as violence and aggression, and short staffing.

There is more to be done to realise benefits. We continue to merge functions and teams and are in the final stages of our first restructure to further reduce duplication. This has reduced management and administrative positions by approximately 1,300 between 1 July 2022 to 1 July 2023. We expect further reduction in such positions ahead.

Some further efficiencies in back-office functions will require investment (e.g., unified payroll) and some clinical service investments will be scoped as part of future models of care and service redesign (e.g., expanded virtual health, automated booking and scheduling).

Regional and local leaders are responsible for service delivery

To ensure services meet local needs, regional and local leaders are responsible for service delivery:

- Regional Directors of Hospital and Specialist Services oversee local networks of hospitals. These are significant leadership roles, with key decision rights and similar financial delegations to previous DHB Chief Executives.
- Regional Wayfinders (commissioners) work with regional and local provider networks, including PHOs and primary care. They ensure service continuity against current contracts, while also working on changes we can make to contracts to improve future outcomes.
- Regional Directors of Public Health Services coordinate responses to infectious disease incursions (e.g., measles, COVID-19), promote prevention services (e.g., immunisation, screening) and protect health (e.g., tobacco and vaping controls).
- Regional Directors across the organisation also ensure responsiveness to Māori (closely alongside the work of Te Aka Whai Ora), Pacific and other priority populations is factored into service delivery.

Regional leaders are also responsible for maintaining key regional relationships, including fostering strong, whole-of-government connections with Regional Public Service Commissioners and relevant social sector leads.

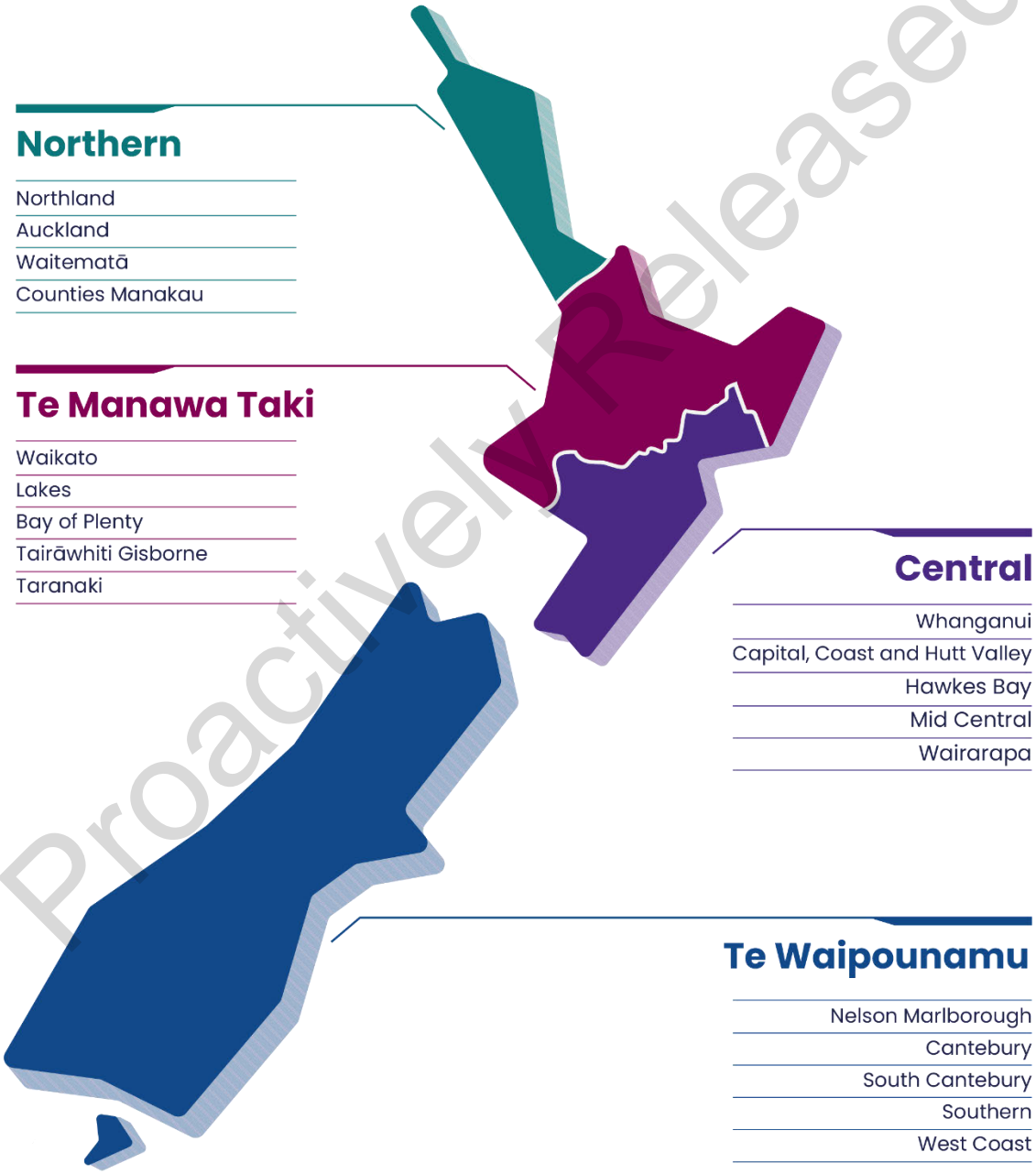
Delivery will be increasingly supported by clinical networks to establish national standards, clinical priorities, and advise on unwarranted variation in service access and outcomes across the country. Trauma, stroke, cardiac and renal networks are already established, and seven more are under way. These networks are jointly led with Te Aka Whai Ora.

So far, these arrangements have been deployed across regions to support local delivery and better manage delivery risks. For example:

- The cancer network is supporting Southern Radiation Oncology and is supporting the formation of Regional Cancer Services.
- The cardiac network is moving patients across hospital networks to support constrained capacity in Waikato.

- The Northern region is implementing a consistent threshold for access to cataract treatment, that will be rolled out nationally.
- Public health resources have been deployed across the country to support contact tracing and isolation for infectious disease incursions to reduce spread of measles and pertussis.

These arrangements have also enabled us to implement national programmes at regional and local levels (e.g., winter measures) and support expanded services to local populations (e.g., minor conditions consultations in pharmacies).



Realising the Government's policy commitments

Below is an early assessment of some of the Government's key commitments. We look forward to discussing all commitments, including the priority in which you would like them advanced. There are also policies outside the health portfolio that will help advance our work and improve outcomes for New Zealanders.

- **Using health targets to drive performance** – there is 'muscle memory' in the system to quickly establish and implement health targets. We collect the data, have a strong focus on data validation, and have reporting mechanisms in place. We also understand the need for balancing metrics to monitor flow-on and wider performance (such as considering ED performance within the broader context of primary care utilisation and hospital bed blocking).
- **Improving security in our emergency departments** – we have been reviewing security in the context of health and safety risks. Violence in the workplace is one of our most significant risks as a Person Conducting a Business or Undertaking (PCBU). We are working closely with unions, and recently launched a national programme to improve safety and wellbeing of staff, patients and communities. We are well placed to introduce new measures; we have assessment and costing work underway.
- **Disestablishing Te Aka Whai Ora** – we will have a strong focus through the transition on maintaining positive momentum towards removing the persisting negative differential in health outcomes for Māori. This includes supporting colleagues in Te Aka Whai Ora and nurturing the talent of its workforce and provider network. We will also strengthen the part Iwi Māori Partnership Boards can play in our regional and local work.
- Expanding eligibility for **free breast cancer screening to 74 years old** – we will implement this change; investments in prevention and screening like this are the sort of shift in focus and funding we are keen to make. We will brief you on how we will manage flow-on impacts.
- We have a direct interest in the opportunities the **Waikato medical school** could provide and will support the requisite work on the full cost-benefit analysis. We will seek a strategic partnership with Waikato University to support clinical training; help plan flow-through to employment (both public and funded sector, including primary care); and integrate with our infrastructure planning. More broadly, we support training more health professionals to both help improve health outcomes and reduce workforce pressure. The Government's commitment to better recognise overseas credentials will also support our progress with international recruitment.
- **Mental health** – we look forward to supporting the Minister for Mental Health and welcome additional focus on this important health area. Our merging of commissioning and provision of mental health and addiction services has been positive. Close alignment of such services with the broader health system is also critical, as they often rely on the same infrastructure, workforces and providers.

Improving health outcomes for populations with high needs

While New Zealanders have experienced steady improvements in health outcomes, these improvements are not universal or evenly shared across the population. Data confirms the ongoing challenges faced by Māori, Pacific, disabled people, people living in low socioeconomic areas and rural communities, in both service access and health outcomes. This needs ongoing targeted attention in how we design, prioritise and deliver services.

Below we elaborate on our work for Māori, Pacific people, and people with disabilities – the three priority populations in the Interim New Zealand Health Plan that experience poorer health outcomes. We also work to support access to health care for rural communities, and to target access for people living in low socio-economic areas.

Māori

While life expectancy rates for Māori have steadily improved over the past 20 years, there remains a significant gap compared to the national average. For Māori:

- Cardiovascular disease (CVD) and cancer mortality rates are substantially higher. For example, lung cancer mortality rates for Māori women and men are around triple the non- Māori non-Pacific rates.
- Diabetes control and rates of complications are high, the age-standardised mortality rate is around five times higher than for non-Māori non-Pacific people.
- There is a greater proportion of young onset (before age 65) dementia and Māori enter aged residential care on average seven years earlier than non-Māori.

Current priorities, on which we have worked closely with Te Aka Whai Ora, include:

- Growing workforce pathways for Māori and Pacific people.
- Improving maternity care and early years (pre-conception to five years old, or the first 2,000 days of life).
- Rolling out whānau-centred post-diagnostic support and navigation services and respite care trials for people living with dementia.
- Building consistency in mental health and addiction services and funding.
- Establishing a pilot expanding age eligibility for Abdominal Aortic Aneurysm and Atrial Fibrillation screening.

Pacific people

Improvements in life expectancy have plateaued for Pacific people and gaps in health outcomes persist. In particular:

- The six-year gap in life expectancy for Pacific people compared to European/Other people is largely driven by preventable premature deaths.
- Pacific people have high rates of chronic conditions (e.g., gout, diabetes, CVD), often have more than one chronic condition, and experience these conditions at younger ages than the general population.
- For the 12 months to 30 June 2023, Ambulatory Sensitive Hospitalisation events for Pacific children (0-4 years) were 14,639 per 100,000 compared to 6,616 per 100,000 for non-Pacific non-Māori children.

We are responsible for delivering Ola Manuia: Interim Pacific Health Plan July 2022 – June 2024. Our immediate priorities include:

- Developing a National Diabetes Action Plan focused on obesogenic environments, weight management services, services in primary care, podiatry and retinopathy in the community.
- The National Oral Health Equity Programme, which will redesign community-based oral health services for under 18s to improve accessibility to oral health services, improve overall outcomes and reduce inequities. We are also working to manage waitlists for planned surgical dental care, invest in additional mobile dental clinics, deliver oral health promotion initiatives, and support workforce challenges.
- Working with the Ministry of Social Development to enable cross-agency contract integration for Pacific health providers.
- Ensuring our workforce reflects the community, through our Pacific Workforce Development initiative. We are also recruiting Pacific kaiāwhina to join integrated primary care teams.

Disabled people

Disabled people make up nearly a quarter of New Zealanders. Overall disabled people have a higher reliance on the health system, and much worse experiences and outcomes.

- Disabled adults are about four times as likely as non-disabled adults to have experienced psychological distress in their lives.
- Disabled adults experience inequities in life expectancy, particularly people with learning disabilities, who can expect their lives to be shorter by an estimated 17-24 years compared to the general population, despite using health services more.

The Interim New Zealand Health Plan sets out the principles and action that underpin our work to better meet the needs of disabled people. Our current priorities are to:

- Improve how we collect, access, and use disability data and access information, linking this work with national data projects.
- Complete a nationwide disability stocktake to identify disability-related resources and initiatives, and where these can be expanded, consolidated or updated.
- Apply a disability capability framework to assess and identify improvements in our capability to deliver services.
- Expand the disability resource hub to support staff and providers with resources, research, education, models of care and guidance.
- Improve how we provide consistent and timely public health information in plain language and alternative formats (building on lessons from the COVID-19 and Cyclone Gabrielle responses).

Reflecting priorities in the New Zealand Health Plan

The Pae Ora Act requires Te Whatu Ora and Te Aka Whai Ora to jointly develop a New Zealand Health Plan for delivering publicly funded services by both organisations. The plan must give effect to the Government's priorities as set out in the Government Policy Statement on Health.

The Interim New Zealand Health Plan for 2022–2024 sets out actions to improve health outcomes for all New Zealanders, including targeted actions for high need populations – Māori, Pacific people, and disabled people. We must deliver a report each year (separate to our Annual Report) on how we have performed against the New Zealand Health Plan; we will update you in early 2024 on the first report.

We are currently developing the next iteration of the New Zealand Health Plan for 2024 – 2027 (for application from 1 July 2024). This work is closely linked to work with the Treasury and Ministry to pursue three-year funding through Budget 24 (discussed below).

Working toward a three-year funding path

Our total revenue for 2023/24 is $26.308 billion, with $23.25 billion of this as appropriations from Vote Health funding. We receive most of our operational funding from two appropriations, totalling $22.916 billion.

- Delivering Primary, Community, Public and Population Health Services ($8.713 billion in 2023/24), which includes funding for public health services and services we purchase such as primary care.
- Delivering Hospital and Specialist Services ($14.203 billion in 2023/24), which funds our hospital operating costs.

The remaining $334 million of appropriation funding comes from COVID-19 funding and Problem Gambling Services. Outside of appropriations, our remaining revenue is third-party revenue from Pharmac, ACC and others.

Capital funding is provided through appropriations for major works and depreciation expensed for maintenance. This includes the Health Capital Envelope appropriation (estimated $1.208 billion for 2023/24), primarily for investments in infrastructure (e.g., New Dunedin Hospital).

Transitional funding for the first two years

As part of Budget 22, we received:

- A cumulative funding uplift in 2022/23 to provide sufficient funding so that we would start on "Day 1" with no hospital operating deficits, be able to meet expected costs, and not be forecasting a deficit position.
- A cost-pressure tagged contingency of $1.297 million each year for four years, to address cost pressures.

Our business-as-usual operational result was a $5 million surplus for the 2022/23 year. However, our reported result was a net deficit of $1.013 billion. This is due to the accounting treatment of the nursing pay equity settlement, the Allied pay equity settlement, and COVID-19 inventory transferred from the Ministry.

Budget 23 was the second year of transitional funding. Expenditure decisions included funding to support the health system during winter, reduce waitlists, wage and price increases for the workforce, and investments to improve equity for Māori and Pacific people, including for immunisation and screening, and innovations to increase life expectancy.

Budget 24

s 9(2)(f)(iv)

Items that require early engagement with you

The table below lists key matters we need to engage you on soon, subject to changes and additions based on our early discussions with you.

Focus	Description	Timeframe
Annual Report	Overview of our first Annual Report, which must be published no later than 5 December	Imminent
Budget 24	s 9(2)(f)(iv)	December
New Zealand Health Plan 24/27		December
Budget 21 and 22	Seeking your agreement to drawdown of contingency funding	By February / March 2024
Bowel Screening Programme	s 9(2)(f)(iv)	November / December
Care & Support Worker Pay Equity Claim		December
Health Workforce Plan 2023/24 quarterly report	Your endorsement will be sought on the first quarterly report back to Cabinet (noting) on implementing the Workforce Plan 2023/24	November
Infrastructure Investment Plan and National Asset Management Strategy	s 9(2)(f)(iv)	December

Current priorities

Workforce

Approximately 250,000 people work in health in New Zealand, and 90,000 (estimated 84,000 FTEs) work directly for Te Whatu Ora. We have a talented and deeply committed workforce, though shortages mean we do not always have the right people and skills in place to meet communities' needs. Our workforce represents a large portion of our system's cost (~$11 billion per year) and is also our greatest asset in delivering care.

Eight major unions represent our workforce and we engage regularly through collective bargaining, pay equity matters, and day-to-day staff management. Pay increases in recent years have made health a more attractive sector to work in, but they have not resolved underlying workforce pressures.

In August 2023, the New Zealand Health Charter | Te Mauri o Rongo was tabled in Parliament. The Charter sets out the values and behaviours that health entities and workers throughout the health sector are expected to demonstrate. This is now being implemented, including with work alongside unions.

Immediate priorities

Our immediate priorities include:

- Addressing immediate health and safety priorities to mitigate risks to frontline staff – We have launched a national programme to improve health and safety and are engaging with unions on issues including violence and aggression in the workplace. This is under close oversight by the Board Health, Safety and Wellbeing Committee. Your priority for improved ED security can be actioned through this work.
- Resolving pay equity claims with the funded sector care and support workers claim, upcoming bargaining with junior doctors and support workforces (in late 2023 and early 2024).
- Holidays Act 2003 remediation payments progressively being made across the country.
- Implementing and expanding the Health Workforce Plan 2023/24 to support your workforce priorities, including training more doctors, nurses, midwives and other health professionals.
- Sustaining our people systems like payroll and rostering to mitigate risk, realise medium-term savings, and give us better data on our people.

Primary and community health services

Primary and community health care services are the most accessed services in the system, yet these services do not work well for everyone and are under immediate pressure. For example:

- People cannot get GP appointments due to long waiting times – in 2021/22, 478,000 adults (11.5%) and 73,000 children (7.6%) could not get an appointment at least once during that year.
- By 2030, if current trends continue, we will need around 16,000 more aged residential care beds to support our ageing population.

These challenges stem from a primary and community care workforce that has not been funded to keep pace with demand, care models that do not meet the needs of an ageing population, and patients with increasingly complex needs.

Immediate priorities

Our immediate priorities focus on stabilising capacity to reduce pressure on hospital and acute care services and keep people well in their communities. Specifically:

- Responding to funding reviews of the sustainability of core general practice services and whether first contact and core services need wholesale adjustment, or whether targeting to higher cost enrolees is preferrable (e.g., equity and complexity adjustments).
- Stabilising and reviewing access to urgent and after-hours care.
- Supporting the primary and community care workforce through collaborative recruitment pipelines, increasing subsidies to training, adding roles to primary care teams (e.g., allied health and clinical pharmacy, as well as newer roles such as physician associates), and increasing clinical support to after-hours services.
- Stabilising care for older people and 'unblocking' the system to support timely discharge from hospital for those who are medically cleared but have limited options for early discharge into community settings.
- Expanding pharmacy services to provide a wider range of services in communities (e.g., immunisation for under 2-year-olds).
- Expanding acute and planned care services in the community (e.g., radiology) to reduce pressure on hospitals.
- Improving maternity and early years care and stabilising maternity delivery given workforce shortages.
- Supporting rural health services to ensure access to primary, urgent and specialist health care services for rural communities (e.g., rural telehealth services).

Public and population health

Public health initiatives work to prevent disease and prolong life for everyone and can reduce pressure on the health system by keeping people out of hospitals. These initiatives can help achieve better health outcomes relative to similar levels of investment in treatment. We need to focus on public health interventions, because:

- As at 30 June 2023, only 68.2% of tamariki Māori and 80.6% Pacific children are fully immunised at 24 months, compared to 88.1% of non-Māori, non-Pacific children.
- Obesity and dietary risks are responsible for an estimated $2 billion in health costs each year, and significant broader socio-economic costs.

Immediate priorities

Our current priorities include:

- Improving childhood immunisation, prioritising on-time and catch-up immunisations, particularly for Māori and Pacific children who have lowest uptake. We know this work will benefit from the focus provided by a health target.

- Expanding and improving adult cervical, breast and bowel cancer screening programmes, further noting the Government's commitment to expand eligibility for breast cancer screening to age 74.
- Sustaining and strengthening protection against outbreaks such as this year's measles, pertussis and cryptosporidium outbreaks.
- Addressing the wider determinants of health such as alcohol, tobacco and unhealthy food.

Hospital and specialist services

Hospitals are under pressure, with busy emergency departments (ED), waits for specialist and planned care, and shortages in community services meaning people are staying in hospital for longer. COVID-19 pandemic service disruption continues to be felt. For example:

- In 2022/23, the number of people waiting longer than four and 12 months for treatment was 38% and 7% respectively, compared to 10% and 1% respectively in 2018/19, prior to the COVID-19 pandemic.
- For the six weeks ending 22 October 2023, an average of 1,633 patients each week were in hospital for longer than seven days compared to an average of 1,464 patients each week for the six weeks ending 23 October 2022.
- In 2022/23, 72% of people were admitted, discharged, or transferred from ED within six hours, down from 92% of people in 2013/14.

Workforce is central to these challenges, with critical shortages of anaesthetic technicians, midwives, radiologists, radiation oncologists, pathologists, and orthopaedic surgeons. Hospitals also face cost pressures that threaten financial sustainability including wage pressures, pay equity settlements, and purchasing cost increases and inflation.

Immediate priorities

Alongside workforce priorities, our immediate focus is on:

- Reducing wait times for planned care focusing on people who have been waiting longer than 12 months for care, and incorporating planned care health targets into this work in a way that drives performance and addresses relevant context.
- Building national consistency of access through national standards and models of care, such as developing a nationally consistent threshold for cataract surgery, and establishing clinical networks.
- Supporting people to get care closer to home and reducing pressure on EDs by strengthening primary and community services and improving how patients move through, and are discharged from, hospital (including ongoing work with aged residential care providers). For planned care, we can incorporate an ED health target into this work, focusing on robust data definitions, collection and reporting.
- Explore how we best implement the Government's commitments for post-birth hospital stays and maternity care.

Mental health and addiction

Over half of New Zealanders will experience mental distress and addiction challenges at some point in their lives, with rates of mental distress increasing, particularly for children and young people. For example:

- Almost one in four (23.6%) young people aged 15-24 years experienced high or very high levels of psychological distress in 2021/22, up from 5.1% in 2011/12.
- Suicide trend data shows that between 1996 and 2016 suicide rates were significantly higher for Māori than for other ethnic groups.

While access to services has increased over time, investment and supply have not kept pace with demand. Our physical infrastructure is also no longer fit for purpose, and we have critical workforce shortages across all mental health and addiction (MHA) services.

The combined agency Briefing to the Incoming Minister of Mental Health will provide you with more detailed information on this important area.

Immediate priorities

Our immediate priorities include:

- Implementing the Oranga Hinengaro: Mental Health and Addiction System and Services Framework, which sets out a contemporary MHA system, starting with a stocktake of national mental health service investment.
- Growing and strengthening the MHA workforce, including work with the Royal Australian & New Zealand College of Psychiatrists to increase the number of psychiatric registrars and working with universities and providers to increase the number of clinical psychology places.
- Completing the final year of Access and Choice programme roll out that delivers primary MHA services in general practice, youth specific, kaupapa Māori and Pacific settings.
- Stabilising specialist, forensic and acute MHA services by revising models of care and creating a continuum of well-integrated services to meet demand.

Cancer

Cancer is the leading cause of health loss in New Zealand. We work with the Cancer Control Agency and Hei Āhuru Mōwai | Māori Cancer Leadership Aotearoa to develop and implement better cancer care for New Zealanders.

- Each year, around 26,000 people are diagnosed with cancer and 9,500 people die from the disease.
- Māori and Pacific people are more likely to develop, and die from, cancer than other New Zealanders, with Māori nearly twice as likely to die than non-Māori.

While cancer survival is improving in New Zealand, our rate of improvement is slower than comparable countries. Our work focuses on delivering equitable care, and addressing unwarranted variations, so that everyone can access high-quality cancer care. This includes cancer prevention (30- 50% of cancers are preventable), improved diagnostic pathways, and access to timely treatment once cancer is diagnosed.

Immediate priorities

Our current priorities are:

- Developing new pathways to facilitate rapid diagnosis of suspected cancer and engagement to support patients to enter cancer pathways and complete cancer treatment programmes (including implementing tumour pathways with the Cancer Control Agency).
- Implementing the updated Cancer Control Agency PET-CT indications to ensure that there is equity in the range of PET-CT imaging available between regions.
- Establishing the agreed radiotherapy satellite sites for linear accelerator services (LINAC), bringing the total number of LINACs in the public system to 26.
- s 9(2)(f)(iv) National Travel Assistance
- Implementing a National Radiation Oncology Clinical Network to provide a joined-up approach to national leadership and planning for the full range of cancer services.
- Scoping the feasibility of a lung cancer screening pathway testing with Māori as first prototype group.
- Working with our colleagues in the Ministry, Pharmac and the Cancer Control Agency to fund and implement additional cancer treatments.

Infrastructure – facilities, data, and digital

As a national organisation, we are now positioned to understand the total state of our health infrastructure. We inherited a physical and digital infrastructure portfolio with significant historic under-investment, variable quality across the country, and many assets at or close to end-of-life – and we are still uncovering new issues.

The physical infrastructure portfolio includes ageing earthquake-prone facilities, or facilities that are outdated and prevent us from implementing new models of care. For example:

- 36 occupied buildings are classified as earthquake prone, and many others may not be able to function following a major earthquake.
- 70% of mental health facilities do not meet therapeutic and safety requirements.
- 22% of projects face delays or cost overruns.

Our digital portfolio is complex, comprising the data and digital environments of 28 entities, with varying degrees of maturity and quality, and significant technical debt. Specifically:

- Capability and investment have varied across the country, with a patchwork of about 4,000 systems that are not integrated, and are often out of date with no effective back-up.
- Significant resources are required to maintain legacy systems, particularly those reaching end-of-life, contributing to more serious and more frequent service outages.
- Significant data gaps and limitations (e.g., different data structures) make integration labour intensive, compounded by legacy work practices that risk unsafe data sharing and breaches.

Together, these challenges impact our ability to target investment, and deliver consistent, high-quality care. Solutions will take many years and require us to re-think how we deliver on infrastructure investment. Notwithstanding this challenge, there are significant opportunities ahead from infrastructure investment, including improved asset management.

Immediate priorities

Our immediate priorities include:

- Concluding our work on New Zealand's first Infrastructure Investment Plan, setting out proposed investments over the next ten years, and the National Asset Management Strategy, providing a standard approach for managing facilities and infrastructure across the whole portfolio. Cabinet directed us to develop and present a Capital Investment Plan and National Asset Management Strategy by December 2023. We will provide advice on these shortly.
- Regional Hospital Redevelopment Programme, with business cases approved for Whangārei and Nelson, and planning under way for Tauranga, Palmerston North, and Hawke's Bay.
- Mental Health Infrastructure Programme (MHIP) to deliver fit-for-purpose mental health infrastructure, with three projects complete and nine with site works under way.
- Project Whakatuputu | New Dunedin Hospital – Stage 1, an outpatient building, is on track for mid-2026 and Stage 2, an inpatient building, is due in 2029. We will brief you further on this important project, New Zealand's largest ever hospital build, s 9(2)(f)(iv) .
- Standardising and automating national data collection and building national consistency to mitigate the risk of privacy breaches and improve reporting and innovation.
- Simplifying the clinical application landscape by limiting the proliferation of ICT systems and moving to fewer, more robust platforms.
- Migrating local ICT systems to accredited Cloud providers to increase service resilience and availability in a more cost-effective and secure way.
- Accelerating new ICT capabilities for new models of care and broadening investment beyond the traditional focus on hospital care to focus on shifting care closer to home.

Appendix 1 – Our Board

Dame Dr Karen Poutasi
Chair, Te Whatu Ora

Dame Dr Karen Poutasi is medically-qualified with a specialisation in public health and has significant governance and leadership experience in the health and education sectors. Her executive positions have included Director- General of Health and Chief Executive of the New Zealand Qualifications Authority. Her governance roles have included Network for Learning, Commissioner for Waikato District Health Board, and she is also Chair of Taumata Arowai and Kāpuhipuhi Wellington Uni Professional.

Naomi Ferguson
Chair, Te Whatu Ora Capital and Infrastructure Committee

Naomi is a highly accomplished leader with significant experience in both governance and executive roles. Most recently she served as Commissioner and Chief Executive of Inland Revenue successfully delivering the Business Transformation Programme. Naomi is a strong champion of diversity and inclusion and led this work across the Public Sector as co-chair of Papa Pounamu. Naomi is also currently Chair of Education Payroll Ltd.

Hon Amy Adams
Chair, Te Whatu Ora Environmental Sustainability Committee
Chair, Te Whatu Ora Data, Digital and Innovation Committee

Amy is a lawyer by profession having been a partner in her firm specialising in commercial and property law before entering Parliament in 2008 where she served for 12 years. Amy's ministerial portfolios included being Minister for Justice and Courts, Social Investment, Communications and Information Technology, Environment, Internal Affairs and Associate Finance minister. She also serves as Chancellor of the University of Canterbury.

Dr Jeff Lowe
Chair, Te Whatu Ora Health Services Committee

Dr Jeff Lowe trained in Otago and graduated in 1984, before working at Karori Medical Centre as a registrar and locum and then becoming a partner. He is a trainer in general practice and has a role teaching general practice to doctors training in this speciality. Dr Lowe is currently chair of General Practice New Zealand. He is a board member of Cosine Primary Care Network, the Federation of Primary Health Aotearoa; and Collaborative Aotearoa. He also worked on Te Whatu Ora – Health New Zealand's Planned Care Taskforce and COVID-19 Health System Preparedness group.

Ms Tipa Mahuta (Waikato, Manipoto, Ngāpuhi)
Chair, Te Aka Whai Ora

Ms Mahuta is currently the Chair of the Taumata Arowai Māori Advisory Group, a councillor with the Waikato Regional Council, co-chair of the Waikato River Authority and Board member with the Te Kotahi Research Centre.

"My marae established the first marae-based health clinic in the 1980s as a model of care for our whānau and to increase access to hauora services. Waikato has had to employ our own responses since Raupatu where landlessness, poverty and epidemics have caused us to create our own strategies for survival like other whānau and communities around the motu." Ms Tipa Mahuta

Ms Vanessa Stoddart
Chair, Te Whatu Ora Health, Safety and Wellbeing Committee
Chair, Te Whatu Ora People, Culture, Development and Change Committee

Vanessa is a graduate of the Australian Institute of Directors, a chartered fellow of the New Zealand Institute of Directors, Honorary Fellow of HRINZ and Companion of Engineering NZ. Previous government appointments include having been a member of the Better Public Services Advisory Group, DOC Audit and Risk Committee, Defence Employer Support Council, Chair of MBIE's Audit and Risk Committee and Tertiary Education Commission. Vanessa is currently a member of the Financial Markets Authority and holds other board appointments for a range of companies, not for profits and charitable organisations. Prior to her governance career Vanessa held legal, change management and senior executive transformation roles for Air New Zealand and Carter Holt Harvey. Vanessa is passionate about diversity and inclusion having previously chaired Global Women.

Dr Curtis Walker (Te Whakatōhea rāua ko Ngāti Porou)
Chair, Te Whatu Ora Clinical Quality Assurance Committee

Dr Curtis Walker is the current chair of the Medical Council, and has extensive experience in governance, clinical leadership and public policy and works in Palmerston North Hospital as a Kidney Specialist.

"We cannot underestimate the importance of the opportunity to reform our public health system into a more cohesive and effective whole, where health outcomes are equitable for all. It is a privilege to serve Aotearoa New Zealand on the Board and a privilege to continue to serve patients as a practising doctor." Dr Curtis Walker

Appendix 2 – Our Leadership

Regional Leadership

Northern

Dr Hayden McRobbie
Regional Director,
National Public Health Service

Mark Shepherd
Regional Director,
Hospital and Specialist Services

Danny Wu
Regional Wayfinder,
Commissioning

Te Manawa Taki

Dr Natasha White
Regional Director,
National Public Health Service

Chris Lowry
Regional Director,
Hospital and Specialist Services

Nicola Ehau
Regional Wayfinder,
Commissioning

Central

Paula Snowden
Regional Director,
National Public Health Service

Russell Simpson
Regional Director,
Hospital and Specialist Services

Tricia Keelan
Regional Wayfinder,
Commissioning

Te Waipounamu

Vince Barry
Regional Director,
National Public Health Service

Dan Pallister-Coward
Regional Director,
Hospital and Specialist Services

Chiquita Hansen
Regional Wayfinder,
Commissioning