

# Te Pae Tata report

How we performed through our first two-years

**December 2025**



Presented to the House of Representatives pursuant to section 52 of the Pae Ora (Health Futures) Act 2022.

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**Health New Zealand**  
**Te Whatu Ora**

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# Foreword

I am pleased to present this report on the Interim New Zealand Health Plan | Te Pae Tata, which covers the period from 1 July 2022 to 30 June 2024.

The establishment of Health New Zealand | Te Whatu Ora (Health NZ) and Te Aka Whai Ora | Māori Health Authority (Te Aka Whai Ora) brought a significant shift from 20 district health boards and eight shared-service agencies to an amalgamated national health service, tasked with ensuring more cohesive and equitable access to health care and health outcomes for all New Zealanders.

The amalgamation resulted in a fragmented system with deep silos, exacerbated by a range of significant financial issues as revealed in an **independent review of Health NZ's financial management**. This review highlighted substantive underlying financial issues, systemic failings and underscored a strong need to immediately improve financial discipline, control and performance. Importantly, the report highlighted that despite significant problems to be overcome, there was potential for positive change.

These financial challenges associated with the long-run, multi-year decline in system level performance led to my appointment as Commissioner in July 2024 and the initiation of rapid action to address these problems. The 2024/25 year has been pivotal in the short journey of Health NZ and through rapid decision-making and action since July 2024 the year ended with a significant part of the performance turmoil of 2023/24 behind us.

The long-run, multiyear decline in health system level performance includes waiting times for emergency department treatment, elective surgery, first specialist appointments, cancer treatment and diagnostics as well as immunisation rates and productivity. A good start has been made on reducing waiting times, improving emergency department throughput and providing more access to critical services such as cancer treatment and childhood immunisations.

We are now in the process of consolidating and advancing the early gains we have made. For these to become sustainable requires us to embed a devolved and clinically led model of care. The development of a strong culture of innovation and ownership is also critical. Supporting regional and local decision-making and strengthening clinical leadership will put patients at the forefront of operational choices and maximise the resources at our disposal to deliver sustainable and equitable healthcare to everyone.

I want again to thank our committed, compassionate, and highly skilled health workforce – the work you do on behalf of our patients and communities is a testament to your skills, care and dedication.

Professor Lester Levy  
**Board Chair, Health New Zealand | Te Whatu Ora**

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# Executive summary

In June 2022, Health NZ and Te Aka Whai Ora were established to draw 28 entities together and address differing levels of services around the country.

New Zealand was emerging from the COVID-19 pandemic, and the new entities faced workforce shortages, increased demand from population growth and aging, and a post-pandemic backlog of people waiting for services. A new health plan, Te Pae Tata, focused on actions to set up the new entities, and the population health initiatives to improve health outcomes for all New Zealanders regardless of where they live.

Health NZ and Te Aka Whai Ora delivered and embedded into business-as-usual 152 (83%) of the 184 actions in Te Pae Tata. In 2022, three taskforces expedited some of the work, including for the health workforce, planned hospital care and immunisation. Although for immunisation, a sustained effort was required with rates lifting in early 2025. The restructure to bring 20 district health boards (DHBs) and eight 8 shared service agencies together was begun soon after establishment and completed by June 2024.

From early 2023, the first signs of the challenges to establish operating procedures appeared. Data mistakes in public performance reports revealed the challenge to extract consistent data from 20 districts. This is a significant challenge related to 20-years of separate entities and thousands of information system applications.

Health NZ made significant progress to address data issues and with roadmaps for digital investment to achieve national consistency. In July 2024, it launched a new national data platform, and by early 2025, there were national dashboards to track daily and weekly activity in emergency departments and theatres.

Achieving a consistent national operating structure proved too difficult in the two-year period covered by Te Pae Tata. Strong financial controls and a culture of financial management was lost despite improvements to capability with delivery of a new finance, procurement and supply-chain system across all districts. Another large project, still underway, is to replace Health NZ's legacy payments systems. Work to improve workforce data from 29 payroll systems continues.

At 30 June 2024, Health NZ reported a \$722 million operating deficit and faced a forecast deficit of \$1.4 billion for the 2024/25 year. This could be likened to the pattern of deficits that characterised 20-years of district health boards. The 2020 Health and Disability System Review had recommended stronger planning and financial control, which was not achieved in the first two years. In July 2024, the Minister of Health appointed a commissioner to return the organisation to budget settings.




Around two-thirds of Te Pae Tata focused on population health actions to improve health outcomes in priority areas. Most were delivered and embedded as business-as-usual to improve primary and community care, hospitals, and emergency services; services for

cancer, long-term conditions, maternity and children, mental health; and four new regional consumer councils.

The 2020 health reforms anticipated efficiencies from removal of duplications across DHBs and standardising operations. While 2,000 management and administration roles were removed, the anticipated efficiencies were not realised. An unintended impact of the restructure was to distract management from financial operating controls and the management of front-line services where most costs occur.

Table 1 below shows performance as at 30 June 2024 against the four sections of Te Pae Tata, discussed in more detail through the rest of this report.

**Table 1: Overall performance against actions in Te Pae Tata**

Sections			
People and whānau at the heart of healthcare – 19 actions	17 (89%)	2 (11%)	-
Priorities for improving health outcomes and equity – 40 actions	31 (77.5%)	6 (15%)	3 (7.5%)
A unified, smarter, sustainable and equity-led health system – 64 actions	50 (78%)	9 (14%)	5 (8%)
Priority populations – 61 actions	54 (89%)	5 (8%)	2 (3%)
<b>Total</b>	<b>152</b> <b>(83%)</b>	<b>22</b> <b>(12%)</b>	<b>10</b> <b>(5%)</b>

Te Pae Tata was a two-year plan covering the establishment period for Health NZ, which is why we summarise our results at the end of the two-year period. Because the Pae Ora (Health Futures) Act 2022 requires us to report annually, throughout this document we also report our progress at the end of the first year. Progress on actions varied depending on how quickly teams were established through the Unify to Simplify programme of structural change.

Section 5 of this report sets out results against the performance measures that were adopted in Te Pae Tata from the interim Government Policy Statement on Health. The measures were developed in advance of Te Pae Tata and do not necessarily reflect areas of Health NZ's service delivery that would be impacted by the actions in Te Pae Tata, however in Section 5 we have grouped them as best we can to match to the relevant sections of the plan.

# >>> Introduction



# Introduction

On 1 July 2022, Te Aka Whai Ora and Health NZ became legal entities under the Pae Ora (Healthy Futures) Act 2022. This followed the March 2020 review of the health system, and two years of the COVID-19 pandemic. The government formally ended the pandemic response in September 2022.

The Health and Disability System Review (Simpson review) recommended changes to redesign the health system to enable integrated long-term plans, strengthen financial management and improve the equity of health outcomes for all New Zealanders. The system of 20 district health boards (DHBs) and eight shared service organisations was associated with unwarranted variations in health outcomes around the country. It also lacked capacity for integrated planning, overall financial management and service delivery coordination, which was evident during the COVID-19 response.

The Pae Ora (Healthy Futures) Act 2022 required Health NZ and Te Aka Whai Ora to produce the Interim New Zealand Health Plan (Te Pae Tata) to be approved by the Minister of Health. While this plan was informed by the Simpson Report, there was little evidence of the additional planning required when the Minister of Health announced that the 20 DHBs, eight shared services agencies and some functions from the Ministry of Health would be merged into Health NZ.

In September 2022, Te Aka Whai Ora and Health NZ jointly developed an implementation plan for Te Pae Tata. This plan allocated Te Pae Tata actions to interim executive leaders. As permanent leaders were recruited, they led the merger required with districts for their respective functions. Once in place, teams from both organisations began to deliver the Te Pae Tata actions.

By April 2023, lack of attention to the requirements of a large-scale merger emerged. There were mistakes in performance reports due to challenges with consistency in data extracted from 20 districts' systems. While Health NZ was successful in delivery of integrated financial reporting within its first year, this was highly manual and prone to mistakes, and it proved much more difficult to exercise financial control over the 28 entities that had been merged. Despite these challenges, Te Aka Whai Ora and Health NZ largely succeeded in delivery of the Te Pae Tata actions.

By early 2024, given the emergence of financial and service delivery performance issues, there were new government directives. This saw Te Aka Whai Ora disestablished and a strengthened regional focus for Health NZ.

This report tracks Health NZ and Te Aka Whai Ora's performance through their first two-years. This section begins with an overview of the health system reforms, the development and implementation of Te Pae Tata, and government changes in direction.

## Health system reforms 2018–2024

Published in March 2020, the Simpson review recommended a population health approach<sup>1</sup> to drive improvements in the health sector. Four recommendations for cultural change shaped Te Pae Tata, including:

1. Improve health outcomes, ensure consumers and whānau are at the heart of healthcare, and there are changes to improve access to community and primary health services.
2. Establish active and focused leadership throughout the sector, and a health charter setting the shared values and workplace behaviours expected.
3. Create te Tiriti o Waitangi based partnerships and a system that works better for Māori, improving their health outcomes.
4. Develop stronger plans and financial management with investment priorities, reduced duplication, improved digital technology, and workforce regulatory bodies working better together.

The Simpson review's structural recommendations were partially adopted:

- The Ministry of Health remained as chief steward of the health system.
- Te Aka Whai Ora | Māori Health Authority was established to improve health outcomes for Māori by working with Health NZ and monitoring its performance.
- Health NZ was established to lead service delivery.
- In a variation from the recommendations, Health NZ was formed through a merger of all DHBs, shared services agencies and some functions from the Ministry of Health, rather than as a separate oversight entity.

In addition to creating two new entities, the Pae Ora (Healthy Futures) Act 2022 required the development of the Interim Government Policy statement and Interim New Zealand Health Plan (Te Pae Tata). Te Aka Whai Ora was to establish the Iwi Māori Partnership Boards for engagement with Iwi-Māori, and Health NZ to establish Localities for community-led planning.

## Te Pae Tata development

Development of the Interim New Zealand Health Plan (Te Pae Tata) was initiated in early 2022, as the Health and Disability Review Transition Unit (the Transition Unit) prepared to establish the two new entities. Both the Interim Government Policy Statement on Health (GPS) and Te Pae Tata embraced the Simpson review's recommendations. The Boards of

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<sup>1</sup> Population health assesses the health needs of communities and aims to allocate resources to keep people well and to appropriately treat health in the community, reducing the need for hospital treatments.

Health NZ and Te Aka Whai Ora jointly oversaw the development of the plan; and the Minister of Health and several government agencies, including the Treasury and the Ministry of Health, reviewed drafts.

‘Te Pae Tata’ refers to embracing knowledge from the past and present, and charting a course towards the immediate future. It was intended to get the two new entities ‘up and running’ through the first two-years while a full process was undertaken to design the first fully costed New Zealand Health Plan 2024-2027.

Te Pae Tata was to be fully funded, so without substantial work on the system’s financial sustainability, the plan focused on nationwide adoption of priority population health interventions that were in place in some districts, and on funded priorities for digital and infrastructure projects.

Once established, Te Aka Whai Ora and Health NZ developed their Statements of Intent and Statements of Performance Expectations. These accountability documents are required under the Crown Entities Act 2004. The Statements of Performance Expectations include financial and health outcomes measures that are reported on in Annual Reports. Actions delivered under Te Pae Tata are expected to impact health outcomes in following years.

The **New Zealand Health Plan 2024-2027** is named ‘Te Pae Waenga’ in recognition of the next stage in the journey. It reflects the pathway taken by Tāwhaki, sent on a quest for higher learning where he ascended the heavens and received the three baskets of knowledge. Like the journey of Tāwhaki, Te Pae Waenga supports the ascent, giving the opportunity to reflect, learn and consolidate work. That plan should be read alongside the corresponding Statement of Performance Expectations.

Te reo Māori names for these plans reflect the scale of changes ushered in by the reforms, which were anticipated to require a sustained effort to embed changes over several years.

## Challenges and changes

Some challenges of the reforms emerged from 2023. Errors in Health NZ’s performance reporting were related to both structural change that resulted in a loss of expertise and the larger task of driving data collection and reporting consistency across districts that had operated independently for more than 20-years.

In May 2023, an assessment of Te Aka Whai Ora’s progress acknowledged the ‘start up’ effort required, the difficulties of a tight labour market, and the intensity of demands from Ministers and the public. A projected underspend of \$66 million was due to difficulties with in-depth planning and delays to service commissioning.

The November 2023 report of the Ministerial Advisory Committee for Health Reform Implementation warned of the potential for operational challenges to overwhelm transformation planning. It acknowledged the value of having ‘one system’ to manage winter pressures, patient lists for radiation oncology and cardiac surgery, and the response to Cyclone Gabrielle. However, it identified risks around corporate systems such as payroll,

implementation plans for workforce development, the sustainability of primary care, the scope and roles of Localities and National Public Health Service, and the need to improve data and analytics.

For the 2022/2023 financial year, Health NZ recorded an operating deficit of \$1.389 billion. This largely related to one-off financial events. Health NZ had been successful in delivering integrated financial reporting from the underlying 20 district systems. However, a 2022/2023 Auditor General's report found that Health NZ needed to improve its management and financial controls. For the 2023/24 financial year, Health NZ reported a deficit of \$722 million. An estimated \$1.4 billion deficit was forecast for the 2024/2025 financial year.

In early 2024, following a change in government, the Pae Ora (Healthy Futures) Act was amended to disestablish Te Aka Whai Ora, moving its delivery functions into Health NZ and its monitoring functions into the Ministry of Health. The amendments to the Act paused establishment of Localities until 1 July 2028 and Locality plans until 1 July 2030. These changes impacted the delivery of some Te Pae Tata actions.

In March 2024 the government reintroduced health targets to drive improvements in health service delivery. These targets focused on faster cancer treatment, improved immunisation for children, shorter stays in emergency departments, shorter wait times for first specialist appointments and shorter wait times for planned care treatments in hospital.

In July 2024, the government replaced the Health NZ Board with a Commissioner, and subsequently he appointed three deputy Commissioners to tackle the estimated \$130 million per month overspend.

## Implementation of Te Pae Tata

In September 2022, Te Aka Whai Ora and Health NZ agreed on a plan that allocated responsibility for Te Pae Tata implementation. The two chief executives had begun planning while in the Transition Unit and Te Pae Tata actions were allocated to interim leadership teams in both entities, while they recruited permanent appointees.

In 2022/23, progress to implement many Te Pae Tata actions was slow as the new entities established teams for delivery. In November 2022, Health NZ began 'Unify to Simplify', a series of nationwide consultations to incorporate 89,000 staff into a new national structure. While actions were largely assigned by early 2023, new people continued to join teams through to March 2024.

As shown in the body of this report, some work progressed slowly in 2year one. Once teams were assigned their tasks, they began detailed planning, often revising the initial milestones, completing stocktakes to understand the practice variations among districts, and determining the best way forward.

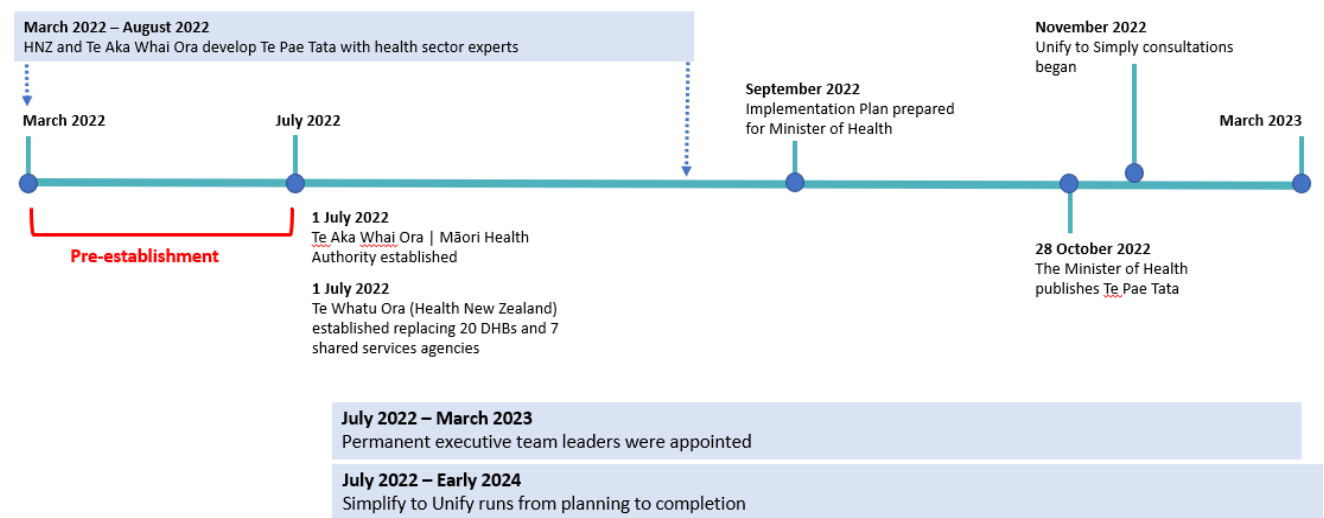
Health NZ established monthly and quarterly progress monitoring, and a 'change control' process to approve any requested changes to Te Pae Tata actions. The original 192 actions were consolidated to 183 and one new action added to make 184:

- Eight actions were merged with other actions, as teams found overlaps.
- Fourteen actions had wording changes to adjust the action to the organisation’s environment once established.
- One new action was added to develop an operating structure for all functions.

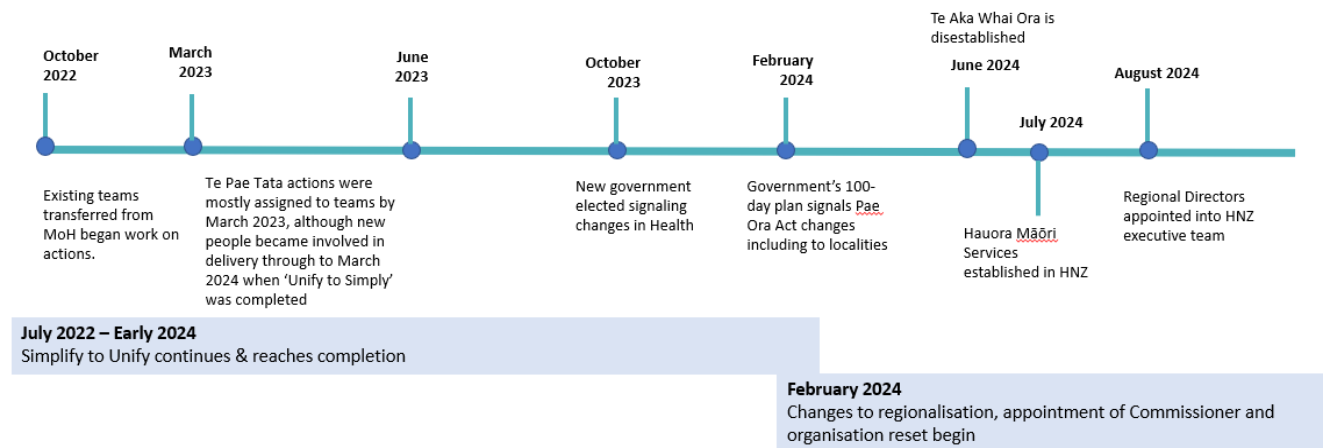
See Appendix 1 for a summary of these changes.

Figures 1 and 2 below show the 2022-2024 timeline for delivery of Te Pae Tata. Development of the plan preceded the establishment of the entities, and ongoing changes slowed delivery of the plan.

**Figure 1: Te Pae Tata development and Unify to Simplify**



**Figure 2: Delivery of Te Pae Tata actions**



## The actions and sections in Te Pae Tata

The Te Pae Tata actions were developed in the Transition Unit ahead of the establishment of Te Aka Whai Ora and Health NZ. The purpose of these actions was to ensure that

critically important components of a national health service organisation were established, embedded in the organisation and focused on ensuring consistency of capability and service delivery nationwide.

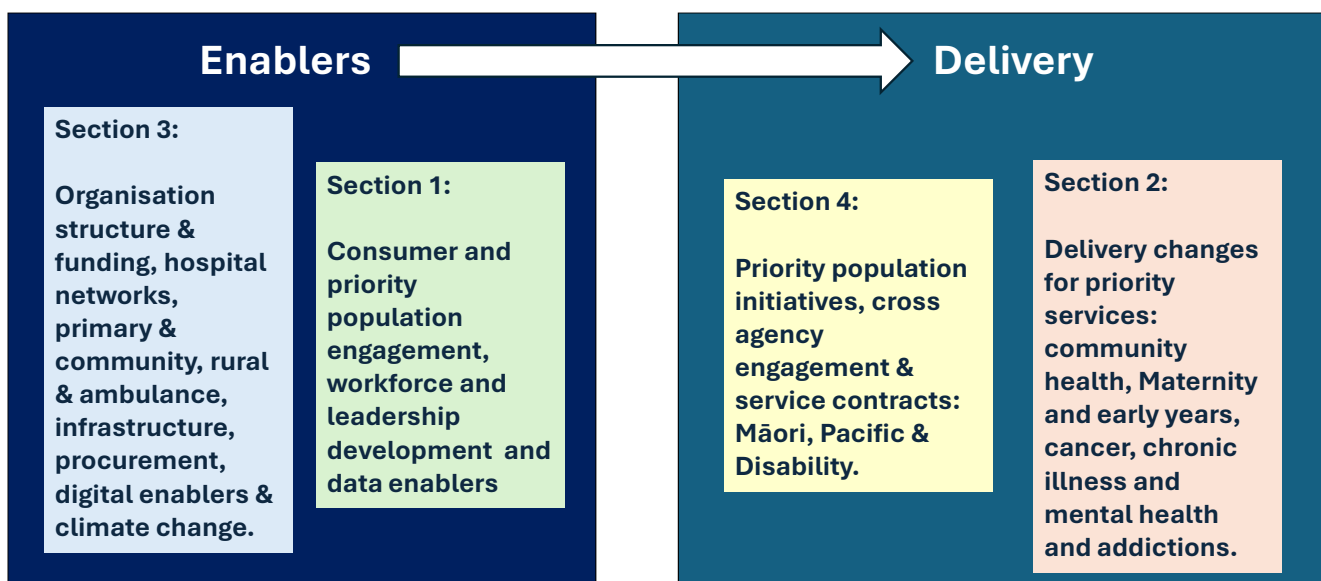
Many actions are broad in scope, reflecting the lack of context about the organisation design, teams and resources that would be in place to deliver the actions. Throughout this report, most actions entail ongoing work, such as workforce development in Section 1, improving cancer screening and treatments in Section 2, strengthening primary and community care in Section 3, and strengthening services for priority populations in Section 4.

Actions also work across the Te Pae Tata sections e.g. consumer engagement in Section 1 contributes to design of clinical pathways that are developed in Section 2 and supported through clinical networks in Section 3, used to inform the design of service contracts in Sections 2 and 4, and can also be supported by new digital services in Section 3.

As shown in Figure 3 below, Sections 3 and 1 are focused on enabling functions. Section 3 includes establishing the organisation, networked ways of working, funding arrangements, infrastructure and digital capability, while Section 1 includes building our capacity to engage with consumers and priority populations, develop our workforce and leadership, and our data capabilities.

Teams working on the enabling actions worked closely with teams working on delivery actions. Section 4 included delivery of service initiatives for Māori, Pacific and Disabled people. Teams working on services for these priority populations also collaborated with the teams designing and delivering services for priority health conditions in Section 2. Priority health conditions include healthy communities, maternity and early years, cancer, chronic health conditions and mental health and addictions.

**Figure 3: How Te Pae Tata Sections work together**






## How we assess our performance

This report follows the layout of Te Pae Tata. Sections 1 to 4 report our performance on 184 actions for 2022/23 and 2023/24. Section 5 reports on the measures required by the Interim GPS and adopted in Te Pae Tata.

Performance narratives come from quarterly reports from the business units, and follow up inquiries to clarify details. Narratives for 2022/23 are generally lighter, which reflects delays from the Unify to Simplify restructure. Narratives and progress ratings have been quality assured with business unit leaders.

Table 6 below shows the three performance ratings used. In each case, ongoing work has been embedded into business as usual.

**Table 2: How we scored outcomes**

Description	Icon
The work was delivered, and ongoing work is business as usual.	
While not fully delivered, progress was made to embed work and continue as business as usual.	
Work was rescoped and delayed due to government policy changes.	

»»» People and whānau at  
the heart of healthcare



# 1. People and whānau at the heart of healthcare

The health reforms disestablished elected boards, and Health NZ was tasked to ensure that people and whānau are at the heart of healthcare. We must consult consumers in our service designs and plans, value and support our health workforce, establish inclusive leadership and a safety culture, and improve our use of data and intelligence to support decisions. These are enabling actions for design and delivery of services.

Teams working on these actions engaged closely with staff who worked on the funding, design and delivery of services for priority conditions in Section 2 and for priority populations in Section 4. Examples include health workforce planning in Section 1,

## **We delivered and embedded 17 of the 19 actions, including:**

- Engaged with Health Quality Safety Commission to improve consumer surveys, established regional consumer boards and engaged whānau voice in service design.
- Created guidance frameworks, tools and reached into communities to improve understanding about the service needs for Māori, Pacific Peoples, disabled people and rainbow communities.
- Developed the Health Workforce Plan 2023-24 and forecasting models, settled pay equity claims for 74,000 people, addressed barriers to entry for the health workforce and professional registration, established our workforce Charter and began the Health Workforce Plan 2024-2027.
- Developed a new national rapid data platform and loaded initial datasets that support nationwide reporting on a daily and weekly basis.




## **Two actions were progressed but not delivered including:**

- Development of an inclusive leadership culture and management training programmes. (These are likely to progress in a more stable environment).

Table 3 on the following page summarises performance at the end of the 2-year period of Te Pae Tata.

Included in the detailed narratives in this section is a score for the first year, which indicates how rapidly teams were established to deliver the actions.

**Table 3: Performance for people and whānau at the heart of healthcare**

<b>People and whānau at the heart of healthcare</b>			
Valuing the voices of consumers and whānau – 7 actions	7 (100%)	-	-
Strengthening the health workforce – 6 actions	6 (100%)	-	-
Developing an inclusive leadership and culture – 4 actions	2 (50%)	2 (50%)	-
Strengthening the use of health insights and intelligence – 2 actions	2 (100%)	-	-
<b>Sub-total</b>	<b>17 (89%)</b>	<b>2 (11%)</b>	-

## 1.1 Valuing the voices of consumer and whānau

Removing barriers to people accessing care was central to the reforms. To understand the barriers, we must engage with people and identify opportunities for improvement. Experience through the COVID-19 pandemic showed how NGOs and alternative models of service delivery can reach communities that do not regularly engage with traditional health services. Consumers who experience poorer health outcomes, include Māori, Pacific Peoples and rural communities, disabled people, and the Rainbow Communities.

**1.1.1 Consumers:** Implement mechanisms that ensure Health NZ and Te Aka Whai Ora value the voices of consumers and whānau in all service design and improvement.


### 1.1.1a Establish a national consumer leadership network.

**22/23** The Health Quality and Safety Commission (HQSC) operate a national consumer leadership network. Health NZ decided with HQSC that this network could be used for national consultation where appropriate. To reflect the diversity of New Zealanders, we also planned to establish a National Whānau Feedback and Engagement Advisory Group and regional consumer councils.

**23/24** The advisory group was established with representatives from Māori, Pacific, Asian and rural communities, and disabled people and Rainbow communities. By June 2024, regional consumer councils were established, along with a framework and policies to guide their operations, and processes to support their referral of work to the advisory group. Beyond the two-year period, work has continued to establish regular communication between the advisory group, Hauora Māori Services and Health NZ's national quality and safety leads.

### 1.1.1b Measure and publish consumer and whānau experience.


**22/23** Health NZ became the funder for the patient experience surveys, that the HQSC oversees and publishes quarterly. The first step was to establish a relationship and renew contracts for surveys in primary care, hospital inpatients and outpatients. Once the team was fully established, collaborative work began to examine how these surveys can be improved to incorporate consumer and whānau voices and to assess the equity of health outcomes.


- 
-  **23/24** We worked with HQSC to improve survey questions and interpretation of results so they are more useful for districts to improve services. We established a community of practice between HQSC, Health NZ and IPSOS which conducts the surveys. Beyond June 23/24, HQSC developed reports to make survey findings easier to use for districts. As part of this we engaged with district patient experience coordinators, quality managers, and patient complaints managers.

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### 1.1.1c Implement people and whānau centred design.

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-  **22/23** Multiple teams in Health NZ and Te Aka Whai Ora, adopted people and whānau centred design, particularly for design of contracts with service providers. There are more detailed accounts of this work in actions to improve community services for Māori and Pacific Peoples, and care pathways for priority health conditions.


-  **23/24** We funded a reimplementation of Kōrero Mai in districts, a HQSC programme to support families and whānau to escalate their concerns to clinicians if they see a family members health declining.

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**1.1.2 Whānau voice:** Build a national Pacific community and lived experience engagement framework to include and embed diverse Pacific voices into the design, delivery and performance of health services.


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-  **22/23** We engaged with diverse voices within Pacific communities to understand their health needs. This informed a framework to guide Health NZ about Pacific People's expectations for service design.


-  **23/24** The Pacific Patient Experience Framework was used to continue engagement, amplify the Pacific voice, and foster Pacific Peoples' trust and confidence in health services.
-


**1.1.3 Disabled people:** Build a platform with the Whaikaha / Ministry of Disabled People to include disabled peoples' voices in the design, delivery and performance of the health system.

 **22/23** Disabled people are a highly diverse group. We engaged with Whaikaha to determine a way forward. It was agreed to adopt Whaikaha's 'Enabling Good Lives Principles' to educate Health NZ staff about how to design services for disabled people.


 **23/24** As Health NZ was established, efforts concentrated on setting up a national disability health team and a nationwide network. We raised awareness of what an accessible and inclusive health service looks like. This laid the foundation for a more cohesive system that can better respond to disabled people.


**1.1.4 Ethnic communities:** Build a platform with the Ministry for Ethnic Affairs to include diverse ethnic voices in the design, delivery and performance of the health system.

 **22/23** We researched the healthcare experiences of disabled people from different ethnic groups and began collaboration with the Ministry for Ethnic Communities.

 **23/24** We meet regularly with leaders from the Ministry for Ethnic Communities for joint monitoring of improvements, including those introduced by the Ministry for Ethnic Communities.

**1.1.5 Rainbow community:** Build a platform with the Rainbow community to include their voices in the design, delivery and performance of the health system.


 **22/23** We networked with Rainbow Communities to inform an options paper for ongoing engagement and incorporation of diverse Rainbow perspectives into health service design.


 **23/24** An purchased an electronic tool for engagement 'The Thought Engagement Platform.' We launched the platform with a group of Rainbow leaders to capture their communities' experiences into our service design. We also continued face-to-face communication for people who don't engage online.

## 1.2 Strengthening workforce whānau


Health service delivery depends on many people performing a wide range of clinical, support and management roles. Health NZ needs workforce modelling, training and recruitment plans to have the right mix and numbers of staff to meet service demand. To grow workforce numbers, funding is required. We also need to encourage more Māori and Pacific Peoples to enter the health workforce. Our new legislation required development of the New Zealand Health Charter / Te Mauri o Rongo to communicate shared values and expected behaviours for everyone in the healthcare workplace.


**1.2.1** Implement a programme to grow the numbers and diversity of the health workforce, including Māori, Pacific Peoples and disabled people to address critical workforce gaps identified by the Workforce Taskforce.

 **22/23** In 2022, a health taskforce set the stage for our work. We developed the Health Workforce Plan 2023-2024, which Cabinet endorsed.


 **23/24** We delivered most initiatives, including for international recruitment, national nursing student and nursing recruitment campaigns, and increased funding for nurse practitioners. The Health Workforce Plan 2024-2027 was in development.


**1.2.2** Establish supply-demand models for key workforces, informed by intelligence, and work with education providers and professional bodies to ensure education and training programmes respond to this intelligence to grow the right numbers of health workers in the right places with the right skills.

 **22/23** We developed supply-demand forecasting models using population demand data from Statistics NZ and workforce supply data from annual practicing certificates, education providers, and extracts from Health NZ's 29 payroll data systems.


 **23/24** Comprehensive workforce forecasting is ongoing and has informed the new Health Workforce Plan 2024-2027.


**1.2.3** Work in partnership with Responsible Authorities to standardise professional and regulatory requirements across Health NZ, Te Aka Whai Ora and ACC to enable registered and unregistered staff to train and experience pathways to advanced roles and improved interdisciplinary working for urban and rural health services.

 **22/23** Responsible authorities govern the health professions independently from Health NZ. We engaged with responsible authorities to encourage them to streamline their registration processes for internationally qualified health professionals.

 **23/24** Work is ongoing to develop and evolve pathways for registration, and a Ministry of Health regulatory review is required to support progress. Despite this, we have made some progress with training pathways for our unregistered workforce to enter regulated professions. Health NZ provided workforce intelligence and operational advice to responsible authorities on competency standards and scopes-of-practice, including creation of a transitional master's programme for midwifery and reduction of clinical training hours for several professions.

**1.2.4** Support the government's planning for future investments in pay equity and pay parity to ensure a fair health workforce environment.


 **22/23** We worked with unions and The Treasury to deliver tranche 1 funding for pay equity. We confirmed mechanisms to sustain pay equity and parity in negotiations, working with the Public Service Commission, the Ministry of Health, Te Aka Whai Ora and ministers.


 **23/24** All pay equity claims for 74,000 people were resolved. Tranche 2 pay disparity funding was allocated to eligible sector employers.

**1.2.5** Support educational interventions to increase Māori and Pacific access to health profession training, to build a workforce pipeline to grow te ao Māori and Pacific services.


This action was consolidated with action 1.2.1.


**1.2.6** Establish, implement and monitor a coherent approach for te Tiriti o Waitangi, equity and cultural safety education and training for our workforce.

 **22/23** We engaged with Te Aka Whai Ora and the Pacific team to identify gaps and align priorities for the workforce, including to address barriers to entry, growing Māori and Pacific leadership, and improving cultural safety.

 **23/24** We aligned initiatives with the Health Workforce Plan 20/24 and integrated the New Zealand Health Charter / Te Mauri o Rongo with other well-being investments. An eLearning course was in development.

**1.2.7** Informed by the Health Charter / Te Mauri o Rongo, implement and monitor actions to improve the workplace experience of the healthcare workforce.


 **22/23** While we began work on the Health Charter, we initiated the first pulse survey to gather employee feedback on how to improve our workplace. More than 27,700 staff responded with ideas to improve staff support and empowerment, complementing work on the Health Charter. We began actions to value the contributions of health workers and support their wellbeing nationally and locally and shared our progress on the Health NZ intranet.


 **23/24** The second pulse survey was conducted in April 2024 to further monitor progress and refine actions to enhance the workplace experience in line with Health Charter values. The 2024 pulse survey showed a three percent improvement in overall scores reflecting progress, and the work continues as business-as-usual.

## 1.3 Developing an inclusive leadership and culture


The Simpson review identified lack of a collective culture in health, and the need for more active leadership at every level. This includes upskilling managers and developing a culture of collective responsibility in our workforce. Leadership diversity is important to reflect the communities we serve and to ensure services are accessible and appropriate for all New Zealanders.


### 1.3.1 Increase the number of Māori, Pacific Peoples and disabled people in leadership and decision-making roles across the system.

 **22/23** We reviewed and strengthened recruitment processes to ensure there are no barriers for applicants. Next, we looked at how this could be monitored.


 **23/24** Monitoring is still in development. It is part of a larger task to improve the quality of our workforce data from 28 payroll systems. Efforts continued to ensure equitable recruitment practices remained in place.


### 1.3.2 Establish leadership programmes to develop our existing and future leaders in health.

 **22/23** The initial strategy was to establish a health leadership institution as part of an education provider or university. Planning was completed and a request for proposal released.


 **23/24** Following investigation, we revised the plan to establish leadership programmes rather than an institute. A request for proposal was in progress, and we secured funding for 24/25 delivery.


### 1.3.3 Establish Pacific-led regional leadership structures for Pacific Health in each region.

 **22/23** National leadership was established, and an engagement framework developed to enhance communication between Pacific leaders and Pacific communities. This is used to guide local services on how to improve health outcomes for Pacific Peoples.

 **23/24** We established Pacific leadership structures in each region, to strengthen relationships with regions and Pacific providers, and contribute to regional health and well-being plans. We supported the starting well, living well, ageing well, mentally well and disability commissioning teams. We collaborated with the Public Service Commission Vaka group to resolve issues with the Recognised Seasonal Employer scheme, and with the Ministry for Pacific Peoples to deliver 600 healthy homes. Most work was completed by June 2024, with final delivery in December 2024.

### 1.3.4 Establish a national dedicated disabled people strategic leadership team.


 **22/23** We established a national disability health team to lead service improvement and improve workforce opportunities for disabled people.


 **23/24** We leveraged our networks and engagement and built a work programme to improve services for disabled people and improve their workplace experiences.

## 1.4 Strengthening the use of health insights and intelligence


High quality data is essential for generating the insights we need for service plans, performance reporting, financial management, clinical quality management and workforce plans. To strengthen the evidence base that informs both clinical and management decisions – and ultimately leads to better health outcomes – we must enhance data consistency, timeliness and sharing across systems at district, regional and national levels.


**1.4.1** Establish intelligence and insight leadership that ensures te ao Māori, mātauranga Māori, Pacific Peoples and disabled people's world views are reflected in the use of health intelligence.

 **22/23** Intelligence functions were established in Te Aka Whai Ora, the Pacific health team, and Health NZ overall. We collaborated to incorporate te ao Māori, Pacific Peoples' and disabled people's perspectives into health intelligence and decision-making.

 **23/24** The intelligence teams continued efforts to capture the data needed for culturally diverse stories and to highlight health inequities constructively, recording people's outcomes without assigning blame.

**1.4.2** Implement a nationally consistent system of data capture, analytics and intelligence so health intelligence and insights inform equity of access and health outcomes for health services across Aotearoa New Zealand. This includes the Patient Profile and National Health Index to identify disabled people's experience of health, and Geographic Classification for Health.

 **22/23** We completed planning for a national data platform to store standardised national data to support operational decisions through faster capture and retrieval than the traditional collated data collections we use for published reports. As this project progressed, we received increased requests from stakeholders to add datasets. To manage demand, we created a framework, linked with the Māori data Sovereignty Framework, to prioritise datasets.

 **23/24** The national data platform went live on 1 July 2024 with its first datasets, and work has continued as more datasets are added. The national data platform provides high-quality health data within Health NZ and to iwi Māori organisations. Work on the geographic classification was underway. We paused work on the profile for disabled people, while we wait for funding to be determined.

»»» Priorities for improving health outcomes and equity



## 2. Priorities for improving health outcomes and equity

At the heart of Te Pae Tata is a commitment to improving health outcomes and the equity of those outcomes for all New Zealanders. This begins with a population health approach to identify people's health needs, followed by resource allocation and service designs to lift performance. To improve health outcomes overall, we must focus on those who experience the greatest inequities – particularly Māori, Pacific Peoples, disabled people and rural communities. The teams working on these actions to deliver priority services were supported by teams working on people and whānau voice in Section 1, and the teams working on establishing organisation networks, new funding models and digital capability in Section 3.

### **For our first two-years, Te Pae Tata set out five areas for action:**

- Implement public health interventions and engage with other agencies to promote community wellbeing and reduce community harm.
- Redesign the national model of care for maternity and early years.
- Improve Māori and Pacific Peoples' participation in cancer screening and their access to diagnoses and treatments.
- Design and implement nationally consistent clinical pathways for chronic or long-term health conditions, such as respiratory, cardiac and diabetes.
- Implement a nationally consistent approach to mental health and addiction services and expand te ao Māori mental health service solutions.

### **We delivered and embedded 31 out of the 40 actions, including:**

- Better health in our communities: promotion of public health policies, mental health support programmes, and Smokefree by 2025. We also worked on interagency housing initiatives, reduction of anti-microbial resistance and a strengthened, consistent approach to family violence prevention.
- Maternity and early years: a universal model of maternity care and pilots for te o Māori and Pacific options, support for disabled parents, care pathways for maternal mental health, two pilots for integrated maternity and early years services for Māori, and work with Oranga Tamariki on the Gateway programme for children in care.
- Cancer: investment to improve screening programmes, development of new care pathways for bowel cancer and abnormal uterine bleeding, replacement of nine LINAC radiotherapy machines, and new policies for accommodation and travel for treatment.
- Chronic or long-term illness: diabetes and childhood asthma care pathways, guidance to improve self-management for Māori and Pacific Peoples', and credentialling of support workers for diabetes care in South Auckland.

- Mental distress, illness and addictions: a nationally consistent approach to specialist mental health services, implementation of Access and Choice services in 576 general practices, refurbishments and rebuilds of mental health units, cross-agency work on safe and affordable housing and treatments for methamphetamine users, work with the alcohol and drug treatment courts in Auckland and Hamilton, new models of care for Māori youth, and continuation of the Piki programme for young people.

**Six actions were progressed but not delivered, including:**




- Full implementation of the HIV plan and the Hepatitis C pathway, community-based oral treatment and oral surgery for children, and purchase and implementation of equipment for infants’ retinal screening.

**Two actions were paused due to changes in government priorities, including:**

- Place-based initiatives to promote better health in communities that were linked to the Localities approach, and a multi-agency response for mental health crisis.

Table 4 below summarises our performance at the end of the 2-year period of Te Pae Tata. Included in the detailed narratives in this section is a score for the first year, which indicates how rapidly teams were established to deliver the actions.



**Table 4: Performance for priorities for improving health outcomes & equity**

Priorities for improving health outcomes and equity			
Better health in our communities / Pae ora – 10 actions	7 (70%)	2 (20%)	1 (10%)
Maternity and early years / Kahu taurima – 10 actions	6 (60%)	3 (30%)	1 (10%)-
People with cancer / Mate pukupuku – 6 actions	6 (100%)	-	-
People living with chronic illness / Māuiuitanga taumaha – 3 actions	3 (100%)	-	-
People living with mental distress, illness and addictions / Oranga hinengaro – 11 actions	9 (82%)	1 (9%)	1 (9%)
<b>Sub-total</b>	<b>31 (77.5%)</b>	<b>6 (15%)</b>	<b>3 (7.5%)</b>


## 2.1 Better health in our communities / Pae ora


Better health in our communities starts with strengthening the community and whānau environments that support and sustain better health outcomes. As part of this, Health NZ must engage with other agencies and local government who contribute to community wellbeing. Public health interventions aim to reduce harmful substances, protect and prevent disease, and to improve community health knowledge. Interventions should be evidence-based, community-led, coordinated and coherent, and reflect the community's strengths and aspirations. The Pae Ora (Healthy Futures) Act set out a new approach for community plans, known as Localities. Localities were paused by government in June 2024, and in many cases work was redirected into regions. In cases where the localities planning work involved initiatives that are directly under HNZ's control, it was possible to move this planning into regions.

**2.1.1 Better health in our communities, public health policies:** Implement healthy public policies locally and regionally, to reduce harm from alcohol and other drugs, tobacco, unhealthy foods and obesogenic environments for all communities, with a focus on those with high proportions/numbers of Māori, Pacific Peoples and other groups with inequitable outcomes.


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**22/23** A national structure was developed to draw together the functions of the Public Health Promotion Agency and the 12 public health units that had been housed with some DHBs. Work to reduce harmful substances and promote healthy environments and behaviours continued through this transition period.
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**23/24** A nationally consistent approach to implement public health policies was established. We collaborated with local government agencies to influence policies on alcohol licensing, food environments and smoking. Healthy public policies were implemented, such as the National Food and Drink Policy. We completed setting the alcohol levy for 2024/25. With this funding in place, we designed initiatives for alcohol harm reduction.


**2.1.2 Better health in our communities, mental health:** Working with the Mental Health and Wellbeing Commission (MHWC), Locality plans will support improved mental health and wellbeing, and reduced harm from alcohol and other drugs in local communities.

 **22/23** We collaborated with the Mental Health and Wellbeing Commission to incorporate mental health and wellbeing approaches into Locality plans with development guidance for districts and provider networks on how to do this.

 **23/24** Following new government priorities, Locality planning evolved to a regional approach. Work progressed and activities continued such as Mana Ake<sup>2</sup>, Youth One Stop Shop<sup>3</sup>, SPARX<sup>4</sup>, and Ka Ora Ka Ako<sup>5</sup>. We integrated community feedback to inform the redesign of mental health services for young people.

**2.1.3 Better health in our communities, housing:** Engage with the Ministry of Housing and Urban Development (HUD), Kainga Ora and MSD on options to ensure that people with enduring mental illness and addiction problems can access sustainable housing.

 **22/23** We contributed to a review of emergency housing processes, and in December 2022, the Rotorua Housing Accord<sup>6</sup> was signed. A memorandum of understanding outlining our process and objectives for collaboration, was progressed between Health NZ and Kāinga Ora. An options paper was in development to inform cross-agency implementation.

 **23/24** We continued to participate in the emergency housing review process and contribute to service development. The memorandum of understanding with Kāinga Ora was finalised. A service review for the Rotorua Housing Accord informed improvements to the temporary housing system and guided longer-term initiatives.

<sup>2</sup> Mana Ake provides support to children in Canterbury, in years 1-8 at school, promoting wellbeing and positive mental health.


<sup>3</sup> Youth One Stop Shops provide a range of free accessible, youth-centred, holistic, primary health, mental health and social services to rangatahi aged from 10–24 years.


<sup>4</sup> SPARX is an internet-based e-therapy programme for young people experiencing mild to moderate depression or anxiety.

<sup>5</sup> Ka Ora Ka Ako is the healthy school lunches programme in Aotearoa New Zealand.

<sup>6</sup> Signed in 2022, the Rotorua Housing Accord is a commitment between Government, Rotorua Lakes Council and Te Arawa Iwi to work together to build a better housing and urban future for Rotorua.

**2.1.4 Better health in our communities, healthy choices:** Commission approaches to support greater health and wellbeing making the healthy choices the easy choice for people at risk of chronic conditions and for families raising small children.


 **22/23** When communities live in healthy environments, they make healthier choices and experience better health outcomes. Healthy environments include secure dry housing, education, safe neighbourhoods, access to transport and to local health services. This long-term strategy to improve health outcomes began with 12 prototype Localities, established for communities to plan local improvements and realise better health outcomes.


 **23/24** While the Locality approach was paused on 27 February 2024 at the direction of the Minister of Health, the team completed work to transfer the established Localities to their respective regions by the end of June.

**2.1.5 Better health in our communities, suicide prevention:** Reduce the impact of suicide on communities, including approaches consistent with mātauranga Māori, by accelerating implementation of Every Life Matters / He Tapu te Oranga o ia Tangata, Suicide Prevention Action Plan 2019-2024.



This action was consolidated with action 4.1.1c (see page 72).

**2.1.6 Budget 21/22 and government priorities, HIV:** Implement the HIV Action Plan.



 **22/23** The HIV Action Plan was on track for implementation with a contract secured with a new kaupapa Māori peer-led organisation. For those at risk of HIV, we scaled up peer and community-led programmes and resources to focus on connecting and empowering people who live with HIV. Preparations were underway for a HIV Forum with stakeholders from across the sector.

 **23/24** Significant progress was made with peer and community-led programmes scaled up. For migrant communities from high-prevalence countries, we focused on promotion of knowledge and improved access to combined prevention strategies. For those at risk of HIV, we expanded innovative HIV testing and workforce training. We also developed an HIV monitoring plan.



### 2.1.7 Budget 21/22 and government priorities, Smokefree: Implement the Smokefree 2025 Plan with the Public Health Agency.

-  **22/23** We implemented the Smokefree 2025 Plan (the SF Plan), with it mostly completed, in place, or on track. Health promotion work for World Smokefree May was delivered and a new campaign launched, 'Breakfree to smokefree'. Five providers were commissioned to deliver innovative stop smoking services, and delivery was started.
-  **23/24** To align with new government directives, we revised the SF Plan, continued implementation, and published 'Getting to Smokefree 2025'. Campaigns for Protect Your Breath (vaping) and Breakfree to Smokefree were expanded and delivered across multiple media channels. We relaunched social marketing to young people, to reduce vaping harm. A monitoring and reporting framework with regional and national views was established to strengthen smokefree compliance.


### 2.1.8 Budget 21/ 22 and government priorities, healthy homes: Implement the Budget 21 expansion of the Healthy Homes initiative.


-  **22/23** The Healthy Homes initiative aims to increase the number of children and families living in warm, dry and healthy homes to enhance their health and wellbeing, and to reduce the number of housing-related hospitalisations. This initiative was successfully implemented.
-  **23/24** The initiative and related activities were completed on time.

### 2.1.9 Budget 21/22 and government priorities, AMR: Develop a national plan to reduce the threat of antimicrobial resistance (AMR).


-  **22/23** The previous action plan was across multiple agencies, with scope beyond human health. Health NZ worked with the Ministries of Health and Primary Industries to explore adoption of the World Health Organization's antimicrobial resistance (AMR) recommendations into the New Zealand context.
-  **23/24** Key achievements include the development and provision of a multi-drug-resistant organism screening tool for hospitals, and the ongoing development of the national antimicrobial guidelines. Conversations continue with the two Ministries regarding AMR priorities.


### 2.1.10 Budget 21/22 and government priorities, Hepatitis C: Implement the National Hepatitis C Action Plan for Aotearoa New Zealand.

 **22/23** The national hepatitis C health pathway for primary care was completed and provided to regions, so they can adapt it to their local services. The national hepatitis C group was refreshed to align with new priorities to develop a sexually transmitted and blood borne infection strategy. We progressed expansion of hepatitis C prescribing to nurses and pharmacists.

 **23/24** We launched the national hepatitis C health pathway and promoted it in primary care. Regional hepatitis C treatment continued in nurse-led clinics and we developed training for nurse and pharmacist prescribers. We relaunched a national campaign to raise awareness and increase testing and treatment for World Hepatitis Day.

### 2.1.11 Budget 21/22 and government priorities: Ensure national consistency in early support for people and whānau experiencing family harm and violence by connecting them to community providers.



 **22/23** Work began with cross-agency and community collaboration to determine best practices for whānau experiencing family harm and violence, and to identify service gaps.

 **23/24** We identified areas for improvement, including health workforce capability and cultural competency, strengthening Health NZ's role in regional responses, and aligning investments with government priorities. Significant progress was made, including a comprehensive review of the Violence Intervention Programme for health services, re-development of the Gateway Assessment Programme for children, and work to integrate and strengthen non-fatal strangulation and sexual abuse assessment and treatment services.



## 2.2 Maternity work and early years / Kahu Taurima

A range of maternity and early years services are essential to ensure mothers and babies have the foundation for future health and well-being. Te Pae Tata actions included work with whānau, communities and service providers to design and commission new service models that integrate the traditionally separate services provided to mothers and babies through pregnancy and the first 2,000 days of life. Services need to fit community and whānau needs and optimise early child development. Several years of sustained effort is needed to take various initiatives through planning, funding, design, commissioning and delivery. Some require investment in enabling technologies and teams, such as retinal scanning and mobile dental units.



**2.2.1 Maternity work and early years, universal model of care:** Redesign the universal model of care, working with lead maternity carers and Well Child Tamariki Ora providers to implement a more flexible and responsive model.

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**22/23** The universal model of care refers to the services that all whānau are entitled to receive for pregnancy and early childhood. We collated whānau voice, technical and clinical information to develop the work programme. Our Hauora Māori and Pacific providers began testing proposals for integrated maternity and early years care in priority populations across the country.
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**23/24** We updated an assessment tool to monitor child growth and development and commissioned six partners to test these changes in 2024 and 2025. Working with midwifery leaders, we surveyed the workforce on new options for community midwifery and to inform service design. We continued to support Hauora Māori partners and Pacific providers to deliver maternity and early years care in their communities.



**2.2.2 Maternity work and early years, te ao Māori and Pacific aiga:** Design and commission te ao Māori, whānau-centred and Pacific family-centred integrated maternity and early years services.

-  **22/23** Funding was secured, and the commissioning process began for maternity and early years services for Māori whānau and Pacific aiga.
-  **23/24** Five Pacific providers were contracted, two in Northern, two in Te Ikaroa Hastings and one in Southern / Te Waipounamu. Pilots have commenced in these three regions, along with reporting tools to monitor progress. Forty-six Hauora Māori providers were contracted to deliver integrated models of care for the first 2000 days of life.


**2.2.3 Maternity work and early years, oral health:** Redesign community-based oral health services for children so they are responsive to Māori whānau and Pacific aiga to reduce the inequity of access and outcomes.


-  **22/23** The Health NZ Board endorsed the establishment of a national oral health equity programme. We collated baseline data as part of developing a programme for the redesign of community-based oral health services.
-  **23/24** The first stage of redesign was a landscape survey of the oral healthcare in each region. We then began the first tranche of investment in a multi-year programme to create mobile services. This involves purchase of suitable vehicles and commissioning their fitout with specialist dental equipment. This first tranche focused on Māori and Pacific-led models of care and five of the new services are with Hauora Māori providers.

**2.2.4 Maternity work and early years, oral surgery:** Ensure national consistency and increased access to urgent oral surgery for children.


-  **22/23** We mobilised a plan to improve children's oral surgery, with monitoring of progress, equity of delivery and financial performance. The initiative resulted in the delivery of additional surgeries, achieving 64.52% of the annual target.
-  **23/24** Mobile dental surgery was provided to children in rural and higher deprivation areas. The new oral health funding model was still in development. While districts provide urgent oral surgery as part of their regular work, further work is needed to achieve national consistency.


**2.2.5 Maternity work and early years, disabled parents:** Provide education and resources to providers for the care of disabled parents and parents welcoming babies with impairments, aligned with the principles of Enabling Good Lives.

 **22/23** We worked in partnership with Te Aka Whai Ora to establish a disabled people's workstream within the maternity and early years work programme. This produced insights into challenges experienced by whānau living with disabilities.


 **23/24** We supported the national commissioning team via a series of online workshops, to gain a better understanding of Enabling Good Lives<sup>9</sup> to deliver services and incorporate a disability lens across all maternity and early years work programmes.


**2.2.6 Budget 22 and government priorities, maternal mental health:** Establish maternal mental health and wellbeing care pathways, including for bereavement and access to specialist mental health services.

 **22/23** Maternity and early years teams supported the development of care pathways, investment in mental health services, and commissioned providers to support bereavement care.



 **23/24** We supported equity initiatives including the national rollout of manaaki mats, development of te ao Māori maternal mental health and wellbeing assessment tool and contracted a provider to develop a national bereavement care pathway.

**2.2.7 Budget 22 and government priorities, neonatal retinal screening:** Improve access and consistency of access to neonatal retinal screening for premature babies.



 **22/23** We commenced a procurement process for retinal cameras for screening babies. While regional service plans were developed, the procurement of retinal camera systems proved challenging. Purchase of a fleet of cameras with software and network services at country level was new for all parties, and we had to secure around \$6.3 million over two-years for purchase and installation.

 **23/24** Challenges saw funding approval for 21 harmony ophthalmic viewing systems finally secured in February 2025, The cameras are now being rolled out through 2025-2026. Regions continue to prepare by developing local clinical pathways ahead of their installations.



### 2.2.8 Budget 22 and government priorities, well child integrated care: Extend the Well Child Tamariki Ora Enhanced Support Pilots as part of integrated care models.

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**22/23** To pilot integrated models of care, two regions offering enhanced Well Child Tamariki Ora support services to whānau extended these services to fully support maternity and early years.
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**23/24** Following these pilots, we moved these integrated and extended services, for Well Child Tamariki Ora, into business-as-usual Hauora Māori provider operations.

### 2.2.9 Budget 22 and government priorities, place-based initiatives: Support the health sector to participate in place-based, integrated health and social sector services through Localities development.

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**22/23** The rollout of local or place-based models for integrated health and social services progressed across the country. The programme was extended to include 33 services.
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**23/24** While the Localities approach was paused on 27 February 2024 at the direction of the Minister of Health, efforts to foster community strategies and collaboration continues, including monthly monitoring.



### 2.2.10 Budget 22 and government priorities, Oranga Tamariki: Implement Oranga Tamariki Action Plan with an initial focus on a review of the Gateway programme.

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**22/23** We established a cross-agency work programme for health needs assessments for children and young people in care and youth justice. As part of this, a review of the Gateway Assessment programme commenced. The aim of these assessments are to identify the health, disability and education needs for each of these children and young people, and to ensure a coordinated cross-sector plan is in place to address their needs.
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**23/24** The Gateway Assessment programme review was completed with recommendations for improvement. We consulted stakeholders to validate the findings and recommendations, and to identify implementation considerations. Work started on opportunities to identify children or young people in Oranga Tamariki care, and to ensure they receive the necessary supports.


## 2.3 People with cancer / Mate pukupuku


The rate of cancers diagnosed has remained stable over recent years, and the death rate has slowly declined. However, Māori experience 1.2 times the rate of cancer diagnosis and are nearly twice as likely to die compared with non-Māori. Pacific people also have higher death rates, while Asians have lower death rates than other ethnicities. Around 30-50 percent of all cancers are preventable, and once diagnosed, timely best practice treatments can improve life expectancy. Te Pae Tata tasked Health NZ to partner with the Cancer Control Agency / Te Aho o Te Kahu to develop and implement better cancer care for all New Zealanders. This includes multi-year work to design and fund initiatives to improve screening rates, introduce new screening technologies, design treatment pathways, and to invest in new equipment, technology upgrades and medicines.

**2.3.1 People with cancer, Māori and Pacific screening actions:** Improve Māori and Pacific participation in breast, cervical and bowel screening through targeted approaches with Māori and Pacific community providers.


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**22/23** We implemented breast screening initiatives to help improve Māori and Pacific participation rates, including direct-to-consumer campaigns, prioritisation of appointments for wāhine Māori, and increased availability of Saturday and late-night screening. There was a consistent increase in cervical screening coverage across all ethnicities, with targeted efforts such as the free cervical screening to address engagement and cost barriers. During the 2022/23 financial year, the National Bowel Screening Programme reached the milestone of detecting over 2,000 cancers, with at least two thirds of these being caught early at stages 1 and 2.
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**23/24** We developed an investment case and secured approval for 'Achieving Equity in Breast Screening Coverage in Aotearoa New Zealand'. This funded implementation of recommendations from the 'BreastScreen Aotearoa Quality Review'. Of the 27 initiatives identified, three were implemented and 16 underway. Implementation included 'fees free' cervical screening for eligible groups, transition to human papillomavirus (HPV) self-testing, expansion of the non-clinical workforce for HPV screening, and a pilot for increased outreach services using the population identification register. We rolled out a bowel screening promotion campaign, and improved functionality in the bowel screening register. Invitations to consumers and delivery of screening kits at in-person events was live in twelve districts.


**2.3.2 People with cancer, new pathways:** Develop new, joined-up pathways to facilitate rapid diagnosis of suspected cancer, beginning in primary care to support equitable access to cancer diagnostic and treatment options.

 **22/23** The Cancer Control Agency and Health NZ reviewed alignment of existing cancer pathways to directions in Te Pae Tata, to inform the Cancer National Clinical Network work programmes.


 **23/24** Initiatives included the development of a lung cancer pathway, national guidance for obtaining clinical consensus, a colorectal symptoms' pathway, and a pathway for abnormal uterine bleeding.


**2.3.3 People with cancer, radiotherapy:** Establish the agreed radiotherapy satellite sites for linear accelerator services (LINAC rollout) to improve people's access to cancer treatment in their communities and ensure equity of access to radiotherapy.

 **22/23** A plan was developed to enhance local access to cancer treatments through upgrade of existing and installation of new LINAC facilities.



 **23/24** The installation of replacement machines progressed with nine out of 24 existing LINAC machines being replaced. Three new LINAC facilities were planned for construction in Taranaki, Northern and Te Matau-a-Māui Hawke's Bay by 2026.

**2.3.4 People with cancer, travel and accommodation:** Review the travel and accommodation policy to ensure it addresses the needs of rural and complex care patients.



 **22/23** Early work to review and redesign policies was delayed while we established teams and funding.

 **23/24** We implemented changes to the national travel assistance scheme, including increased mileage and accommodation rates, and an additional option for eligible people to email their claims. The Cancer Control Agency completed phase 1 analysis to assess people's utilisation of the new policies, to inform changes to eligibility criteria.

**2.3.5 Budget 22 and government priorities, equity focused screening actions:** Deliver new equity-focused screening initiatives while sustaining those already developed, including age extension for bowel cancer, HPV self-testing and consideration of lung cancer screening.

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**22/23** We allocated investment from a \$55.6 million multi-year upgrade of the BreastScreen Aotearoa ICT system to use our population register to enable people to opt-out of screening. Funding to continue free cervical screening for eligible groups was confirmed and we commenced transition plans to the less invasive HPV primary screening and self-test. A business case for age extension for bowel cancer screening was considered alongside a pilot evaluation for Māori and Pacific peoples aged 50-59. We also introduced a redesigned bowel screening kit.
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**23/24** We launched HPV primary screening and filled critical breast screening roles. For priority groups, the change to HPV screening and extension of fees-free funding improved participation and equity of access, by addressing barriers such as time, cost and test acceptability. The national bowel screening programme age extension was being evaluated in three districts. Planning for the Aotearoa lung screening programme was underway.



**2.3.6 Budget 22 and government priorities, new cancer drugs:** Work with Pharmac to support the equitable implementation of new cancer drugs approved for use in Aotearoa New Zealand.

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**22/23** We engaged with Pharmac and other stakeholders on the new medicine proposals, and hospitals prepared clinical processes and capacity so the new measures could be used in treatments.
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**23/24** Two new lung immunotherapy drugs were made available nationwide with monitoring by Health NZ. Funding was confirmed for implementation of new cancer medicines for the 2024/25 period.


## 2.4 People living with chronic illness / Māuiuitanga taumaha


One in four New Zealanders lives with multiple chronic or long-term health conditions. The greatest burden is experienced by Māori and Pacific Peoples who develop these conditions 10-20 years earlier than other groups. Te Pae Tata identified conditions where health services need to work alongside whānau to improve outcomes. These conditions include diabetes, cardiovascular disease, respiratory disease, stroke and gout.

**2.4.1 People living with chronic illness, clinical pathways actions:** Implement accessible and nationally consistent clinical pathways for diabetes, cardiovascular diseases, respiratory conditions, stroke and gout, supporting specialist teams to integrate with primary and community care providers to create seamless pathways for whānau.


-  **22/23** A review of existing diabetes clinical pathways was completed and the Diabetes Action Plan was under development. Planning began to achieve nationwide consistency in other clinical pathways.
-  **23/24** National clinical networks were established to assist with pathway development and implementation, for cancer, cardiac, diabetes and stroke pathways. Maintenance work was completed on a suite of diabetes pathways designed for general practice teams, and we identified further work necessary to address local service gaps, and unwarranted variations across the country. This work will continue with a three-year review cycle. The asthma in children pathway was targeted for release in 2024. These pathways are locally agreed and designed to support general practice teams to make the right decisions with patients, at the point of care.


**2.4.2 People living with chronic illness, self-management:** Identify and support Māori and Pacific NGOs to work with whānau to support self-management of their chronic conditions.

 **22/23** We assessed performance for providers who support peoples' self-management of their chronic conditions. These evaluations showed improvements to peoples' health markers, which resulted in 12-month extensions to provider contracts. We began trialling a heart health plan with two Primary Health Organisations and planned to refine the tool and partner with community-based Māori and Pacific providers in 2023 and 2024.

 **23/24** To further support self-management, we developed comprehensive guidance and resources for better lifestyle choices and self-management of chronic conditions. This included engagement with several Māori and Pacific providers and was completed by June 2024.

**2.4.3 Budget 22 and government priorities, Pacific diabetes:** Develop a Pacific aiga-focused integrated care model for diabetes and implement a dedicated prevention and management programme in South Auckland for Pacific communities.

 **22/23** We implemented an integrated diabetes prevention and management programme for Pacific communities in South Auckland, including culturally appropriate support and resources. Assessment of programme outcomes was underway, along with work to scale it up to operate across Localities and in regions.


 **23/24** We finalised a micro-credentialing course for basic diabetes care and management, and established referral pathways for weight management groups. Collaborative efforts included a symposium to identify shared priorities and values. The Diabetes Retinal Screening Artificial Intelligence pilot was expected to improve Pacific patients' access to essential services.


## 2.5 People living with mental distress, illness and addictions / Oranga hinengaro

Over 50 percent of New Zealanders will experience mental distress and addiction issues at some point in their lives. Māori experience poorer outcomes than the overall population. Investment in mental health and addiction services benefits people's health and wellbeing, and our national economy. Health NZ was tasked to implement nationally consistent services across the care continuum, improve te ao Māori and Pacific services and deliver new buildings for mental health care.

### 2.5.1 People living with mental distress, illness and addictions, specialist services:


Implement a nationally consistent approach which will see specialist mental health and addiction services providing advice and support to primary care services to support people with mental health and addiction issues.


 **22/23** We surveyed all districts on their models-of-care, across specialist and primary care services. This data was being analysed and a report in development.

 **23/24** The stocktake of current approaches was completed, and a report of findings produced. We were considering the next steps to improve consistency, including engagement with the regions to implement the access and choice programme.

### 2.5.2 People living with mental distress, illness and addictions, Māori and Pacific:



Design and expand te ao Māori and Pacific mental health service solutions, including primary mental health and wellbeing, access and choice services.

 **22/23** The Access and Choice programme offers mental health services within a primary care environment. Te Aka Whai Ora led expansion of these services for Māori with te ao Māori mental health contracted to five Hauora Māori partners. The phased implementation was on track.

 **23/24** The phased roll-out of services continued, and renewed agreements were put in place for 2024/25. Access and Choice services improved access using new and flexible models-of-care, including Kaupapa Māori and Pacific-led services.

### 2.5.3 People living with mental distress, illness and addictions, infrastructure:

Deliver the mental health and addictions projects within the Mental Health Infrastructure programme, taking all practicable measures to accelerate project delivery and ensure that anticipated benefits are realised.


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**22/23** The Mental Health Infrastructure Programme is a multi-year refurbishment or rebuild of 16 mental health units begun under the Ministry of Health. Phase one of a new unit at Counties Manukau had opened in 2018 and phase 2 in 2020. In 2022, we completed work on and opened the new unit at Capital and Coast in Wellington. By June 2023, we had one project in the concept stage, eight being designed and five being built. Progress was reported monthly to government, including risk ratings related to schedules and budgets. At this stage, we reported risks for the Whakatane and Waikato hospital projects.
- 
**23/24** In June 2024, three projects were in design phase and ten were being built. One project at Whakatane Hospital was on hold while alternatives were explored. Risks were reported for Hillmorton Hospital and Hutt Hospital tranche two. We also completed the relocation project for Princess Margaret in Christchurch in 2024.


### 2.5.4 People living with mental distress, illness and addictions, crisis response:

Develop solutions with communities, including with NZ Police, to support people who are in mental distress or experiencing an acute mental health and addiction episode to access timely care and support.


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**22/23** We collaborated with the New Zealand Police to complete a stocktake across all districts on their arrangements for managing crisis response situations. This data was being analysed, and a report was expected by early September 2023.
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**23/24** Following a change in government, the joint agency work was rescoped. A joint cabinet paper to inform the next steps was due in November 2024. Other work continued, including trialling peer-support in emergency departments and improved Whakarongorau responses to mental health emergencies. Work continues with New Zealand Police, Ministry of Social Development and Ministry of Health on the transition to a multi-agency response model.


**2.5.5 People living with mental distress, illness, housing:** Work with Housing and Urban Development (HUD), the Ministry of Social Development, Kainga Ora and housing providers to improve access to quality, safe and affordable housing with support services, to transition people from inpatient mental health units into the community.

 **22/23** Work focused on the delivery of the Rapua Te Āhuru Mowai<sup>11</sup> services located in Hamilton and Auckland. Engagement with Housing and Urban Development explored funding opportunities to sustain service delivery. Both pilot sites were operational. The service evaluation was underway, and a paper developed to request funding to continue the pilots for a further two years.


 **23/24** We continued work on the Rapua Te Āhuru Mowai services. Funding was secured through the Homelessness Action Plan contingency fund. Interim evaluations for both the Hamilton and Auckland pilots were underway. Preparations for a two-year extension of these pilot services were initiated.


**2.5.6 People living with mental distress, illness and addictions, methamphetamine:** Continue the Te Ara Oranga partnership between NZ Police, mental health and addiction services, community groups and Iwi service-providers to give methamphetamine-users the opportunity to get therapeutic help and employment support.

 **22/23** The Te Ara Oranga partnership continued in Northland, with efforts underway to expand in the Eastern Bay of Plenty. The Te Ahi 12 programme<sup>13</sup> in Murupara was scaling up, and a service delivery contract for Pou Oranga Whai Ora was signed. Ongoing partnerships were established with Bay of Plenty district, Te Aka Whai Ora and Eastern Bay of Plenty Alliance representatives.


 **23/24** The Te Ara Oranga partnership continued its efforts to support methamphetamine users in Northland and expanded into the Eastern Bay of Plenty. Te Ahi Mauri in Murupara scaled up operations, and Pou Oranga Whai Ora launched a community and a residential service.


**2.5.7 Budget 22 and government priorities, alcohol and drug courts:** Continue the alcohol and other drug treatment courts in Tamaki Makaurau Auckland, Waitākere and Waikato.

 **22/23** Work was underway for the launch of the transitional accommodation facility in Rotokauri. The Waikato clinical governance group developed a work plan aimed at increasing referral numbers and improving communication with the courts.


 **23/24** The alcohol and other drug treatment courts in Auckland, Waitākere and Waikato continued to operate effectively. The treatment courts provided vital support that contributed to reduced reoffending and improved well-being for Māori participants.


**2.5.8 Budget 22 and government priorities:** Continue the rollout of integrated mental health and addiction (IPMHA) services in primary care and for young people.

 **22/23** The work progressed well including the launch of the Access and Choice service directory to help people navigate services.


 **23/24** Integrated primary mental health and addiction services were available in 576 general practices across New Zealand, serving an enrolled population of 3.4 million, with a target of 3.5 million by the end of the financial year 2025/26.


**2.5.9 Budget 22 and government priorities:** Expand the availability and trial new models of specialist mental health and addiction services for Budget 22, to support child and adolescent mental health and addiction, eating disorders and taurite specialist Māori services.

 **22/23** Active collaboration with the workforce team and district sites was underway to address recruitment challenges to progress this action.


 **23/24** Significant progress was made including the recruitment of additional staff. Workforce development, with planning underway to deliver the relevant training and support.


**2.5.10 Budget 22 and government priorities:** Continue and expand Mana Ake, a school-based mental health and wellbeing initiative, for primary and intermediate aged children.

 **22/23** Service delivery was ongoing in Waitaha Canterbury, Kaikōura, West Coast and Lakes/Bay of Plenty. Northern / Te Tai Tokerau had successful recruitment, while Counties Manukau faced recruitment challenges. Larger-scale service delivery was planned to begin once NGO providers were contracted.

 **23/24** The Mana Ake programme was initially on track, but progress slowed due to challenges with scaling services in larger areas. The programme depends on child and youth mental health and addictions specialists to develop the workforce. Service delivery continued successfully in Waitaha Canterbury, Kaikōura, West Coast, Lakes/Bay of Plenty and Northern / Te Tai Tokerau, and recruitment continued for roles in Counties Manukau. An evaluation of the Mana Ake programme was scheduled for July 2024.

**2.5.11 Budget 22 and government priorities:** Ensure the continuity of Piki, an integrated mental health support initiative for young people.

 **22/23** Piki continued to provide essential mental health support for young people.

 **23/24** Piki continued its service delivery. Funding was secured and we signed a contract for ongoing service delivery with Tū Ora Compass Health through to 30 June 2026.

»»» A unified, smarter, sustainable  
and equity-led system



### 3. A unified, smarter, sustainable and equity-led health system

Te Pae Tata set out actions to establish Health NZ. This included setting up a new national structure with four regions and nationally consistent corporate functions. A network approach was important for organising services and operating policies nationwide, including networked hospitals to optimise planning and capacity utilisation, clinical networks for clinical consensus on service access and treatments, and strategic networks for managing community and primary contracts. The 12 public health units were to be integrated nationally, primary care to be strengthened, and rural locations to have better transport and telehealth services. System enablers such as digital and infrastructure were to be strengthened. Localities were a new mechanism to enable community-level planning. Management of the COVID-19 outbreak was to transition to business-as-usual. Te Pae Tata was supposed to be a fully costed plan. So, in the absence of full costing, its actions were mostly population health programmes that existed in some districts and needed to be consistently implemented nationwide, along with the development of investment plans and delivery of already funded projects.

#### **We delivered and embedded 50 of the 64 actions, including:**

- Transition to transformation: strategic networks for primary and community services based on life stages, clinical networks to bring together experts on priority health conditions; national leadership for design of care pathways and partnering with ACC and HQSC.
- An enhanced National Public Health System (NPHS): integration of the 12 public health units, a standardised operating structure, strengthened surveillance capability and design of national digital systems.
- Stronger primary and community care: creation of national and regional teams to commission primary and community services, work to improve primary and community palliative care, changes to the community pharmacy contract, implementation of comprehensive primary care teams to expand community services, review of aged care funding, implementation of payments to family carers, expansion of school-based services, contracts for dementia care, and guidance for the health workforce on transgender and intersex services.
- Rural healthcare: review and redesign work on rural urgent and afterhours care, contracted telehealth services for consumers and specialist liaison, and identified priorities for regional plans.
- Networked hospital and specialist care: review of theatre capacity and access criteria, created national theatre dashboards to match capacity and demand for planned care, managed surge demand through winter, developed the first national hospital production plans and long-term agreements with private hospitals, established regional datasets to track equitable access to services and to track outpatient bookings, contracted for

improved emergency air and road transport, and improved coordination of organ donation.

**To strengthen our system enablers:**

- Digital began the rollout of a single desktop and file management system nationwide, completed foundations for 'My Health Record, commissioned a digital system for NPHS, worked on interoperability for clinical data, commissioned telehealth services for after-hours and rural services, replaced all district financial systems and onboarded tranches of providers to our new payments system.
- Infrastructure continued delivery of new builds and refurbishments, asset management strategy and investment plans, standards for facility design and accessibility for disabled people, and developed construction sector partnerships.
- Procurement progressed clinical engagement to strengthen procurement processes, and the climate change team reduced our emissions and waste.

**Nine actions were progressed but not delivered, including:**

- Established a new national structure by June 2024, which was changed to a stronger regional approach following the 2024 appointment of Commissioners.
- Two actions to lift immunisation rates were slow to deliver results. However, with sustained effort, immunisation rates have begun to increase in early 2025.
- Two hundred hauora Māori and Pacific providers were transitioned to new contracts but we did not meet the target to grow the numbers of these providers.
- We developed regional plans, which are being redeveloped following the 2024 appointment of commissioners.
- There are several years of work to achieve nationwide consistency in digital systems. We progressed funded projects and developed road maps for future work.
- There are several years of work to standardise operating structures for the procurement functions of 20 districts. We began with consolidation of the procurement functions and commenced work on national policies and detailed operating structures.
- Three of our seven actions for climate change proved challenging, including two for nationwide resilience and response plans, and one for building climate change policies into procurement contracts.




**Five actions were not delivered, including:**

- Capture of efficiencies through consolidation, which reduced staff numbers in management and administration but detracted attention from financial and operational management of frontline service delivery.
- Implementation of a nationwide operating structure, which was evident in weak levers to control financial performance.

- Establishment of Localities, which paused following a change in government. Twelve prototypes were established and have become part of their respective regions.

Table 5 below summarises our performance at the end of the 2-year period of Te Pae Tata. Included in the detailed narratives in this section is a score for the first year, which indicates how rapidly teams were established to deliver the actions.


**Table 5: Performance for a unified, smarter, sustainable and equity-led health system**

<b>A unified, smarter, sustainable and equity-led health system</b>			
Transition to transformation – 13 actions	6 (46%)	3 (23%)	4 (31%)
An enhanced National Public Health service – 3 actions	3 (100%)	-	-
Stronger primary and community care – 14 actions	12 (86%)	1 (7%)	1 (7%)
Rural healthcare – 4 actions	4 (100%)	-	-
Networked hospital and specialist service delivery – 9 actions	9 (100%)	-	-
Outbreak response and managing COVID-19 – 0 actions	-	-	-
Strengthening our system enablers – 21 actions	16 (76%)	5 (24%)	-
<b>Sub-total</b>	<b>50 (78%)</b>	<b>9 (14%)</b>	<b>5 (8%)</b>

## 3.1 Transition to transformation


A new national structure joined a new national office to four regions and their districts, with standardised operating procedures. This transition, known as 'Unify to Simplify' was expected to generate efficiencies through reduction of duplications in management and administrative staff across the districts. Strategic networks were to be set up nationwide to improve information sharing, including clinical networks for priority conditions, and commissioning and provider networks for community and primary services. Each of the four regions was to produce an operational plan, along with Localities plans that were a longer-term initiative at community level. Other strategic actions focused on interagency collaboration with the Health Quality Safety Commission (HQSC) to improve service quality and work with the ACC to improve road and air ambulance services.


**3.1.1a Establishing Health NZ, organisation structure:** Implement a national, regional and local organisation structure that unifies and simplifies the system using a consistent standardised operating model for corporate functions, including people and culture, finance, commissioning, hospital and specialist, data and digital and infrastructure.

 **22/23** In April 2022 the incoming chief executive published proposals to create a national and regional organisation structure. Within four months, we began the first of three phases of staff consultations to refine the proposals. The new structure included a national office and four regions Northern, Te Manawa Taki, Central and Te Waipounamu. Each region had a regional integration team to plan the delivery of their services, aligned to national priorities. In June 2023, the final phase of consultation had begun, for staff to express interest in the new roles, and to receive support through the transition.


 **23/24** All corporate functions, including people and culture, finance, commissioning, hospital and specialist, data and digital and infrastructure implemented their new structures. Design and implementation of nationwide standardised operating controls proved more difficult in this timeframe. In July 2024, following the appointment of a commissioner, a further organisational reset began with staff consultations on these changes from late 2024.


**3.1.1b Establishing Health NZ, efficiencies:** Capture the efficiencies of consolidation to redirect resources to the delivery of healthcare: reduce the overall proportion of expenditure related to management costs and redeploy those savings to front-line staff and services.

 **22/23** There was considerable focus on reduction of duplication through the Unify to Simplify restructure, focused on management and administrative roles. At the same time there was international recruitment for clinical and nursing staff to address post-COVID-19 shortages, with around 4,000 nurses recruited. Systems to support the administrative restructure and the wider oversight of frontline operations were inadequate to the task of capturing efficiencies.


 **23/24** By June 2024, it appeared that overall staff numbers had increased by 2,000. In September 2023, concerns first emerged about recruitment of nursing resources above budget and the consistency of district systems used to determine this. This echoed earlier issues with timely and accurate reporting of non-financial data from 20 districts. In March 2024, a project began to create a common dataset for the 28 payroll systems to align with the new finance system for timely accurate reporting. There were also ineffective controls over the hours paid to deliver work. This relates to the need for continuous local management control over recruitment, staff rosters and overtime that is crucial to controlling front-line staff costs.


**3.1.1c Establishing Health NZ, operating structure:** Implement a consistent standardised operating structure for corporate functions, including people and culture, finance, commissioning, hospital and specialist, data and digital and infrastructure.

 **22/23** Work proceeded in finance, human resources, digital, clinical networks and a new policy harmonisation team. Parts of the operating structure were stood up, such as workforce, procurement, and hospital network processes. However, there was insufficient attention to planning, budgeting and financial controls.


 **23/24** From early 2023, operating challenges emerged beginning with data timeliness and accuracy, and by November 2023 there were also concerns about an underlying deficit, despite more optimistic budget predictions. While the finance function produced integrated reports from the 20 district finance systems, operating structures for financial control were not sufficient to avoid a deficit of \$722m in 2023/24.


**3.1.2a Localities, learning collaborative:** Establish a Localities Learning Collaborative to facilitate learning, including understanding the whānau and community experience.

 **22/23** A national Localities team was established and developed a collaboration hub, programme and tools to support Localities development. The concept of Localities is to establish collaboration at community-level to identify and reduce the socio-economic barriers to improving health outcomes. A locality could include representatives from Iwi-Māori, local health providers, schools, sports clubs, churches, local government and local branches of central government agencies.

 **23/24** The work continued until February 2024, when a new government decided the Localities programme would be paused. Up to 30 June 2024, the Localities team worked to hand over the learnings and tools to the regions.


**3.1.2b Budget 22 and government priorities, localities models:** Implement the localities model across Aotearoa New Zealand with locality partnership groups and provider networks to ensure all New Zealanders are part of a locality, with published plans agreed with Iwi Māori Partnership Boards (IMPBs).


 **22/23** Twelve communities were identified to develop locality plans as prototypes for this new approach to community-based health planning. Engagement with IMPBs, local authorities and communities was underway to establish Localities across New Zealand.

 **23/24** The first three Localities published their plans, and nine others had plans at different stages of development. On 27 February 2024, there was a Ministerial directive to pause the Localities work programme. Subsequently the established Localities became part their respective health region.


**3.1.3a Strategic networks, cross-sector teams:** Establish cross sector teams to design improved health outcomes and address equity of access in priority areas:


- Better health in our communities / Pae ora
- Maternity and early years / Kahu taurima
- People living with chronic health conditions / Māuiuitanga taumaha
- People living with mental distress, illness and addictions / Oranga hinengaro

 **22/23** The new commissioning function was formed using cross sector teams for overall leadership and strategic networks to enable information sharing and innovation nationwide. Cross-sector was a reference to taking a holistic rather than siloed approach across community and primary care. As part of the Unify to Simply process, a proposal to establish cross-sector teams and to enable strategic networks was presented to the Executive Leadership Team and the health services committee.

 **23/24** We established national and regional teams organised around people's life course, including starting well, living well, mentally well and ageing well. These cross functional teams support service planning, service design, funding models, contracting and implementation of services for primary and community care. These teams work on strategic alignment in services across regions, as well as commissioning and supporting implementation of programmes of work.


**3.1.3b Strategic networks, clinical networks:** Implement national specialist networks to support specialist, planned and urgent care access and outcomes across Aotearoa New Zealand.


 **22/23** National specialist networks, also called clinical networks, bring together clinical experts to develop advice, processes and policies around services and treatments. We secured funding for the first four networks and invited expressions of interest from clinicians for co-lead roles for stroke, cardiac, trauma and renal networks. Our new governance group approved this first tranche of national clinical networks. We signed a statement of intent with ACC to establish the national trauma network.

 **23/24** We implemented eight national clinical networks for stroke, cardiac, trauma, renal, eye health, radiology, infection services and maternity. We recruited co-leads for additional networks in rural health, oral health, mental health and addiction, and diabetes. A national office, now under the chief medical officer, supports the national co-leads and programme delivery.


**3.1.4 Joined-up and integrated pathways:** Develop whole-of-system pathways including for prevention, self-care, community and primary care and in hospital settings to achieve nationally consistent, evidence-based care in the best settings for people and whānau for priority health needs, including:


- Develop health pathways that support equity, incorporating mātauranga Māori, te ao Māori approaches, and integrating whānau perspectives to reduce the burden on whānau to navigate health services, particularly for complex care.
- Standardise pathways across Aotearoa New Zealand to remove differences in eligibility criteria and access to health pathways, including diagnostics.

 **22/23** A 'clinical pathway' describes how people's access to health services is facilitated by different types of health practitioners, use of assessment tools, clinical criteria for treatment and referrals. Priorities for clinical pathways development reflect service priorities, and regular schedules of review. We completed the national hepatitis C pathway, ready for adoption by regions and districts. Most regions adopted and tailored the pelvic mesh pathway, and the lung cancer pathway completed its clinical review. While the HPV screening pathway progressed slowly, we contracted Streamliners to provide the national platform to support clinicians.


 **23/24** Pathway development and localised adoption continued. Our national cognitive impairment pathway included culturally appropriate assessment tools for Māori. A national webinar was developed to support clinicians with the Meihana model in clinical assessment.


**3.1.5a Quality and safety, HQSC:** Partner with HQSC and clinical leaders across the system to ensure that quality and safety is reflected in performance monitoring, in the delivery of Te Pae Tata and in the delivery of all services.

 **22/23** We collaborated with the HQSC to support the national clinical governance forum and the clinical quality assurance committee, and to produce quarterly reports.


 **23/24** A comprehensive national quality and safety measures framework was developed. Measures were reported to the national clinical governance forum and the clinical quality assurance committee.


**3.1.5b Quality and safety, ACC:** Partner with ACC to improve road and air ambulance services, increase medication safety and support the work on injury prevention, including falls.

 **22/23** We engaged with emergency road ambulance and communication service providers to reduce fall injuries. We collaborated with key partners and stakeholders, including peak bodies, primary care organisations, occupational therapy groups, ACC injury prevention, and Whakarongorau. As a result, several referral pathways were established for ambulance officers to utilise for fall patients.


 **23/24** A new agreement formalised the relationship between Health NZ and ACC, for co-funding and co-governance of the ambulance team based at Health NZ. The ambulance team is responsible for overall management, contracting and performance monitoring of ambulance services under the direction of the ambulance governance group. HNZ also works with ACC, the HQSC and Medsafe on medication safety and injury prevention.


**3.1.6a Strategic commissioning, policy:** Implement a commissioning policy that embeds excellent commissioning practice across Health NZ and Te Aka Whai Ora.

 **22/23** A commissioning operating model and procurement policies, for contracting with health service providers like PHOs and NGOs, were introduced to support best practice commissioning. We developed and socialised an implementation plan for co-commissioning with Te Aka Whai Ora, so it could be refined and adopted by both entities.


 **23/24** The refined plan was presented to internal teams as we worked through Unify to Simplify and established our new structure. We began the next step to finalise commissioning policies and implement these across the regions.


**3.1.6b Strategic commissioning, Māori and Pacific providers:** Develop sustainable and integrated funding arrangements for existing and new Iwi and Māori organisations and Pacific providers reaching 25 percent of eligible providers in the first and 50 percent in second year.

 **22/23** Te Aka Whai Ora led the work with iwi Māori providers. Our first task was to work with iwi, Māori organisations and Pacific providers to ensure service continuity through the changes. We decided that it was not feasible to achieve the increase to 25 per cent of eligible providers being Maori and Pacific in our first year. Contracting continued with a plan to reach 50 per cent by year two.

 **23/24** Following the change of government, there was an additional directive to change to contracts that bundle several services and for providers to report on improvements to people's health outcomes. We supported nearly 200 hauora Māori and Pacific partners to transition to these new contracts for the 2024/25 year. These new agreements are designed to enable the tracking of whānau outcomes in addition to collecting mandatory service data.

### 3.1.6c Develop Regional Health Services Plans.



 **22/23** Planning guidance was issued to regions, and priorities and contents for plans agreed. The health needs assessment was released to regions for feedback, and to support their local planning efforts. All regions were actively engaged in development of their plans.

 **23/24** Regional plans were completed and ready for approval in June 2024. In July, following the replacement of the Health NZ Board with a commissioner, four deputy chief executives were appointed to lead the regions. Following this change to a more decentralised operating model, the existing regional plans were discontinued. Regions began to redevelop these plans.


## 3.2 An enhanced national public health system


Public health services promote community health and wellbeing and protect people against disease and environmental hazards. Through the COVID-19 pandemic it was clear that a more unified service was needed, and the health reforms included the amalgamation of the 12 public health units into a national service. This National Public Health Service (NPHS) was tasked to work in partnership with the Ministry of Health, Te Aka Whai Ora and other Health NZ delivery functions to improve equitable health outcomes for New Zealanders. Its core functions are health promotion, health protection, preventive interventions, health assessment and surveillance, and public health capacity development.

**3.2.1 Public health actions:** Establish the NPHS function, embedding te Tiriti and leading implementation of a population health approach across service commissioning and localities, including working with Iwi Māori Partnership Boards.


-  **22/23** We established the organisation and operating structures to bring the NPHS units together. This included embedding te Tiriti o Waitangi and equity principles. NPHS engaged with Health NZ business units and partner agencies to align delivery of Te Pae Tata actions. We also identified te Tiriti training options for NPHS staff.
-  **23/24** NPHS transitioned into its new structure within Health NZ. Partnerships were progressed with communities and Iwi Māori Partnership Boards (IMPBs). NPHS presented its structure and operating model to the IMPBs national conference, to enhance mutual engagement and co-operation. We made significant progress to embed te Tiriti and adopt a population health approach, though challenges remain due to budget constraints.


**3.2.2 Public health actions:** Maintain and strengthen robust national surveillance mechanisms for detecting and responding to future communicable disease outbreaks and threats.

 **22/23** Work began to incorporate and resource surveillance activities within the NPBS operating model. We reviewed the accountabilities framework to clarify roles and responsibilities between NPBS operational surveillance and the Ministry of Health's strategic surveillance.

 **23/24** We established national operational surveillance processes and products. NPBS actively supported multiple notifiable disease incursions and responded to environmental and weather events. We implemented standardised emergency response procedures and situational reports that were stress-tested during active responses. These experiences helped to streamline national surveillance mechanisms, allowing analysts to work more effectively across regions.

**3.2.3 Budget 22 and government priorities:** Develop and agree the investment in data and digital infrastructure to support the establishment of the NPBS.



 **22/23** NPBS and digital services established a joint governance board. The board oversaw completion of a survey of the digital systems in use across public health units. This was to inform decisions to develop consistency, address gaps in systems and determine investment requirements.

 **23/24** Upgrade work continued to replace the communications technology for the BreastScreen Aotearoa system. In December 2023, we began data transfer from the old registers to the Aotearoa Immunisation Register, marking the transition to a nationwide system for vaccination records. By February 2024, we had developed a new system to manage notifiable diseases with measles and COVID-19 management live, and ongoing work to add more notifiable diseases. We initiated engagement with NPBS users to establish requirements for development of the Aotearoa Public Health Operations System.



## 3.3 Stronger primary and community care

Primary and community care is complex and wide-ranging. Along with the general practices that are grouped as primary health organisations, it includes midwifery and early childhood services, pharmacies, aged care services and rest homes, Whānau Ora, mental health, district nursing and allied health services. Te Pae Tata introduced new structures: Localities and Iwi Māori Partnership Boards. It tasked us to establish these new structures and work together with health providers to create networks, share information and address service barriers to unmet need, treat people closer to home and reduce the demand for specialist health services. We were to strengthen our management of unscheduled or urgent care to ensure people receive care in the right place, at the right time, with the right person, and to better support older peoples' care away from hospitals. Following the changes in government direction, the Localities approach was paused, although the direction to establish comprehensive primary and community care teams remained. These teams include a wider range of health professionals and assistants who work together, expanding the traditional functions of general practices.



**3.3.1 Stronger primary and community care, immunisation:** Implement an immunisation and screening catch-up programme including those delivered by Māori and Pacific providers.

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**22/23** We began with regional engagement and plans to identify opportunities to equitable access to immunisation. We launched four media campaigns to inform Māori and Pacific communities about the benefits of vaccinations for tamariki and bowel screening for adults aged 60 to 74. Additional campaigns focused on flu immunisation. Workshops were held with services providers which secured service level agreements. We created a prioritisation matrix to support the efforts of outreach services to reach Māori and Pacific tamariki.
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**23/24** We targeted regions with low immunisation rates using short-term catchup funding for several hauora Māori and Pacific service providers. Other initiatives to lift childhood immunisation rates, included pharmacy vaccinations, incentives for general practices to immunise babies at six-weeks, extending the vaccinator workforce, and encouraging all providers to use the Aotearoa Immunisation Register. Health promotion campaigns were used to build public trust and confidence, and we encouraged opportunistic vaccinations in various settings. We made significant progress in cancer screening, including using the consumer population identification and registration system for breast screening, ongoing funding uplift for cervical screening, transition to HPV screening, and targeted messaging for bowel screening.


**3.3.2 Stronger primary and community care, palliative care:** Develop a nationally consistent model for paediatric and adult palliative and end-of-life care that is integrated across primary and community health and strengthens the equitable provision of palliative care across Aotearoa New Zealand.


-  **22/23** A draft programme for palliative care was approved, and we issued expressions of interest for partners to further develop and implement the programme.
-  **23/24** The paediatric model of care working group was on track to finalise a proposed national paediatric palliative care service. An equity working group developed a framework to be applied across all the workstreams. We formed the adult models of care working group who are on track to provide advice on the model of care requirements.

**3.3.3 Stronger primary and community care, community pharmacy:** Negotiate a community pharmacy services agreement to enable improved integration of clinical services, improvements to access and outcomes, and to drive equity gains.


-  **22/23** We reviewed the national integrated community pharmacy services agreement with the aim to advance the role of pharmacies to deliver comprehensive services and more integrated services.
-  **23/24** All pharmacies accepted the variation to the agreement. The agreement enabled the pharmacy development workstream under our primary care development programme.


**3.3.4 Stronger primary and community care, admission avoidance:** Prototype admission avoidance, including early discharge and home-based care, including remote monitoring pilots; and refocus community nursing, allied health and the Needs Assessment and Service Coordination services to be part of comprehensive primary and community care teams.

 **22/23** The comprehensive primary and community care teams framework was created. This combines primary and community care within local areas, with new funding, accountability structures and roles to improve access to care and management of unscheduled care. Funding focused on workforce development and change management to support four new roles: kaiāwhina or support, practice pharmacist, physiotherapist and care coordinator, and extended care paramedics in some settings.



 **23/24** We continued to manage necessary change to refocus services. Work was ongoing to secure resources beyond 2025.

**3.3.5 Stronger primary and community care, aged care:** Review the aged care, home and community support services models to improve the sustainability of services and ensure equity of access and outcomes.



 **22/23** A project initiation document to review aged care was developed, and resources secured to implement the review. Timelines were adjusted to reflect resources available.

 **23/24** The review progressed well with the phase 1 report waiting for Ministerial approval. Phase 2 was designed around national workshops with completion due in May 2024. The executive advisory group assisted regional teams as needed, with fortnightly monitoring.

**3.3.6 Budget 22 and government priorities, localities:** Establish comprehensive primary and community care teams within locality provider networks. These will combine traditional primary care services with physiotherapists, pharmacists, care coordinators, advanced paramedics (rural focus), registered social workers and kaiāwhina.

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**22/23** We began regional change implementation of the first phase of comprehensive primary care teams. This focused on establishing the kaiāwhina or support roles, and comprehensive primary care teams in priority areas. We began planning for phase two, the regional implementation the new roles.
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**23/24** We completed regional plans for comprehensive primary care team roles, with contracts and recruitment underway. We focused on partnerships with Māori and Pacific organisations, particularly for kaiāwhina roles. Local monitoring and reporting frameworks were being established. The Localities aspect of this work was paused.

**3.3.7 Budget 22 and government priorities, general practice:** Implement a revised general practice funding model that is responsive to health needs and equitable outcomes for Māori and Pacific Peoples.

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**22/23** We implemented an equity adjustment for general practice capitation, related to Māori and Pacific populations. Work was underway to design broader changes to the primary and community funding model.
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**23/24** We continued analytic and design work to link primary and community funding adjustments to population need, along with other broader changes to the funding model.

**3.3.8 Budget 22 and government priorities, Pacific:** Commission comprehensive primary care models in high Pacific populations that address the needs of the community.


- 22/23** Commissioning in high Pacific populations progressed as planned. Work continued to update the primary and community care funding model. Implementation began in phases across the country.
- 23/24** Work was completed including local tailoring to community needs. All contracting, including for full-time equivalent positions, change management and workforce development was in place. Recruitment into new roles was well underway, with up to 200 positions being filled, including kaiāwhina roles within prioritised Pacific provider partners. Local monitoring and reporting frameworks were being established.

**3.3.9 Budget 22 and government priorities:** Implement the payment to family members for Support Services for those who choose this option.


- 22/23** We implemented the payment to family carers. As uptake was low, we decided to monitor participation rates and assess potential barriers. We continued efforts to increase family awareness and facilitate access to this option for family carers.
- 23/24** Progress was made with funding used to purchase glucose monitoring devices. There was a significant increase in the uptake of paid family carers.


**3.3.10 Budget 22 and government priorities, Māori:** Commission comprehensive primary and community care models in high Māori populations that address the needs of the community.

- 22/23** Implementation of comprehensive primary and community care models were underway to prioritise the needs of Māori communities in partnership with Te Aka Whai Ora. Change implementation proceeded in phases across the country, ensuring that services were tailored to meet local community needs.


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**23/24** Contracting for new roles, change management and workforce development was in place, with recruitment underway. Up to 200 roles, including kaiāwhina in targeted Māori providers, were recruited. Local monitoring and reporting frameworks were being established.


**3.3.11 Budget 22 and government priorities, schools:** Expand School Based Health Services into activity centres and increase service delivery levels in kura kaupapa for high need students.

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**22/23** We completed an environmental scan to understand the level of health services delivered in kura kaupapa settings. We contracted with a provider to deliver a Te Ūkaipō wānanga programme, to upskill staff in school-based health services and ensure care aligns with the vision and values framework for these services. We implemented funding and began to expand school-based health services into education activity centres.

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**23/24** Roll-out of the remaining funding included Puna Ako, an initiative to increase school-based health services in kura kaupapa. We transferred funding to hauora Māori Services to roll-out the services working closely with kura and the peak bodies.



**3.3.12 Budget 22 and government priorities, dementia:** Implement the Dementia Mate Wareware Action Plan<sup>7</sup>.

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**22/23** We contracted seven providers over four years, with contracts signed and ready for execution. The request for proposal process concluded and debriefing sessions were held with all applicants.



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**23/24** The Ministry of Health secured funding for a comprehensive evaluation of our action plan, using an independent evaluator. Five of the seven post-diagnostic support and respite care contracts included partnerships with Hauora Māori providers.

<sup>7</sup> The Dementia Mate Wareware initiative was funded for four years in budget 2022 to introduce support services for people and whānau following a dementia diagnosis.

### 3.3.13 Budget 22 and government priorities, transgender: Improve access to primary healthcare services for Transgender Peoples.

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**22/23** We established an expert advisory group and work programme. We contracted providers, including for two community models of care, training and development, and development of service guidelines.
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**23/24** Four new providers were contracted to deliver community models of care in Auckland, Hawke's Bay and Porirua, Whanganui and Christchurch. Data collection was underway to inform the evaluation of the initiative. Workforce development and training for gender affirming primary care continued, along with updated guidelines for gender affirming healthcare for publication in early 2025.



### 3.3.14 Budget 22 and government priorities, intersex: Implement services to support health practitioners to provide best practice healthcare to intersex children and young people and to empower intersex children and young people and their whānau to make informed decisions about medical interventions.

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**22/23** We established a steering group to oversee the project plan and procurement phases. A procurement process was agreed to secure providers for best practice guidelines, workforce development and training, peer and psychosocial support, and information resources for children, young people and whānau.
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**23/24** We included people with lived experience in the procurement of providers to deliver the components of the initiative. Three providers were contracted to deliver: best practice guidelines, workforce development, training services, and resources for children, young people, and whānau; co-design of the peer and psychosocial support service; and an independent evaluation.



## 3.4 Rural healthcare

More than 700,000 people live in rural New Zealand, where children, older people and Māori form a larger proportion of the population. Health NZ was tasked to work with the Ministry of Primary Industries to ensure service commissioning and design recognises the strengths, aspirations and barriers in rural communities. Strategies include to expand digital and telehealth services for our workforce and those receiving care, increasing appropriate access to high-quality care and the continuity of care. Face-to-face services will support people and situations where digital technologies are not appropriate.


**3.4.1 Rural healthcare actions:** Design a rural unplanned, urgent care system that is responsive to rural communities' needs and results in equity of both access and outcomes.


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**22/23** Rural services were reviewed as part of a broader urgent care programme, and project documentation was finalised.
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**23/24** An expert advisory group was established to review and redesign the primary response in medical emergencies, a service for coordination and management of rural emergencies that is jointly funded by Health NZ and ACC, and delivered by Hato Hone St John. A draft current state analysis was completed and provided to the advisory group for review.

**3.4.2 Rural healthcare actions:** Determine how to scale digital telehealth services to provide rural communities with reliable and sustainable afterhours access. Introduce and expand specialist advice models for virtual consultations with both whānau, and primary and community services providers.


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**22/23** A request for proposal for rural telehealth services was launched, with all deadlines met. This service is to be accessible to all patients, regardless of enrolment with primary care, who live in or visit rural areas, as well as those enrolled in rural practices. It will be an after-hours service from 5pm to 8am on weekdays and 24 hours on weekends and public holidays.
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**23/24** We completed and implemented contracting for the service for people in rural communities in November 2023.


**3.4.3 Rural healthcare actions:** Commission a national telehealth medical and specialist liaison service, with a specific focus to support rural areas and drive equity of access across key populations.

 **22/23** Commissioning of a national telehealth medical and specialist liaison service was underway, and rollout of this service progressing smoothly.

 **23/24** Contracting for the service was completed, and it was implemented in November 2023. The service is free for health navigation advice, health information, or advice from kaiāwhina or a nurse. Medical consultations are free for children under 14-years, with reduced rates for Community Services Card holders and those over 65-years. Patients can access the service through general practices with after-hours call diversion, by calling a free 0800 number, or by scheduling an appointment via an online portal.

**3.4.4 Rural healthcare actions:** Ensure locality planning in rural areas improves access to healthcare in the most appropriate and sustainable way.

 **22/23** We consulted on locality boundaries for rural communities, and a report on leadership capability, rural localities, and diversity was submitted to the Health NZ board.

 **23/24** We drew on regional rural priorities and work completed for localities to develop the national rural health work programme.

## 3.5 Networked hospital and specialist service delivery

Demand for hospital care and specialist appointments has grown as our population has grown and includes more older people. There are more people with long-term health conditions and there are a growing number of treatments that can improve people's longevity and quality of life. People's access to hospital care varies depending on where they live and the type of specialist care they need. At a national and regional level, HNZ is tasked to use network arrangements and plans to optimise the use of hospital resources and improve the transport and accommodation options for people who need to travel to receive specialist care.

**3.5.1 Networked hospital and specialist services, planned care:** Implement the plan for Reset and Restore of Planned Care, with demand balanced across sites to maximise delivery to all our communities, utilising all the resources available.

**22/23** This work benefited from a taskforce in early 2022. We worked with regions to plan service delivery for the upcoming year. A survey of national physical theatre capacity was completed, and a dashboard was designed for inclusion in national health service reporting. Plans were also underway to standardise access thresholds for cataract surgery.


**23/24** We implemented with 61 of the 101 taskforce recommendations. A further 37 recommendations were in progress, and three were moved to 2024-2025 work plans. Additional capacity for planned care was commissioned. A live dashboard of national theatre performance was launched.


**3.5.2 Networked hospital and specialist services, winter pressures:** Develop and implement surge planning that utilises regional and community care capacity to maintain safe patient and staff environments.

**22/23** We completed the winter review for 2023. We increased coordination across districts and regions to establish shared knowledge and better manage acute demand. Regional and national escalation pathways were put in place.


**23/24** Surge planning was implemented. A national escalation matrix for hospitals and districts was established, with data and digital support for integrated operation centres. We created lead roles to work across the regions, assess the maturity of our operation centres, and inform a roadmap for digital solutions.


**3.5.3 Networked hospital and specialist services, production plans:** Develop regional and national production plans by 1 July 2023, to drive delivery of equitable, and greater levels of planned care for the next three years.

 **22/23** Production plans were being finalised with regional partners with an expectation that care volumes would exceed those of 2019, which was the best year in the past five years. Regular monitoring and reporting mechanisms were established to ensure ongoing oversight.


 **23/24** Regional and national production plans were successfully completed, with the plans for 2024-2025 in the final stages of implementation. Plans were closely aligned with health target expectations.


**3.5.4 Networked hospital and specialist service, equity measures:** Implement regional equity accountability measures, to set clear expectations that specialist and hospital services are responsible for achieving equitable outcomes.

 **22/23** The waitlist was reduced by 131,971 patients, and we treated all patients who had waited longer than three years. In June 2023, we paused development of the wait list adjustor for ethnicity, rurality and social deprivation.


 **23/24** An equity advisory group was established to advise on development of an organisational equity framework. The objective was to align comprehensive equity measures to the Interim Government Policy Statement. We disaggregated regional performance metrics to report outcomes by ethnicity, and further work is needed to report outcomes for populations at district level.


**3.5.5 Networked hospital and specialist services, booking systems:** Develop regional booking and scheduling tools, including patient-led bookings to equitably improve the experience of patients and whānau.

 **22/23** We worked on the feasibility of creating a patient booking portal, and on broader strategies for to improve regional booking processes.

 **23/24** A reporting system for bookings at regional and specialty levels was developed, along with national guidance on booking suspensions, consistency in booking priorities and mapping these priorities to our national data sets. A project for access, booking, and waitlist management produced a planned care patient pathway, which is currently under national consultation.

**3.5.6 Networked hospital and specialist service, private hospital contracts:** Build a sustainable commissioning relationship with the private hospital sector establishing longer term agreements.

 **22/23** Requests for proposal were issued to the private sector for regional panel agreements. Local agreements were extended on existing terms and conditions, including price, to ensure continuity of service.

 **23/24** Key milestones included the finalisation of the 2024-25 production plans and the completion of a strategic market assessment which created a foundation for developing long-term agreements. Implementation planning was underway.

**3.5.7 Budget 22 and government priorities, emergency air transport:** Ensure emergency air transport is consistently available to all New Zealanders with the required level of infrastructure and resource availability.

**22/23** We collaborated with ACC to explore various options, including a step-in approach, which would allow one party to take over the obligations of the other if needed. Step-in was replaced by financing arrangements with ACC. Work was underway to identify newer helicopters while finalising negotiations and procurement plans for fixed-wing contract renewals.

**23/24** An indicative business case was developed, and Health NZ and ACC secured funding to replace eight helicopters in the 2024-25 fiscal year.

**3.5.8 Budget 22 and government priorities, emergency road transport:** Ensure essential emergency road ambulance services are consistently available for all New Zealanders in urban and rural communities.

**22/23** Extra funding was allocated to improve ambulance workforce numbers. Approximately 98 full-time equivalent staff were recruited and all management positions filled. We continued performance monitoring.

**23/24** Hato Hone St John reported its lowest frontline vacancy rate in years. Since 2022, more than 300 additional front line and communication centre staff have been recruited through contracts with Hato Hone St John and Wellington Free Ambulance.

**3.5.9 Budget 22 and government priorities, NZ Blood Service:** Support the New Zealand Blood Service to meet the demand for organ donation and transplantation support.

**22/23** Development of an enhanced model for organ donation and transplantation was not completed.

**23/24** We made significant progress, securing \$4.5 million to lift capacity and improve coordination for stem cell transplants in Auckland and Christchurch. This will mean 26 additional transplants in 2024/25 and a further uplift in 2025/26.

## 3.6 Outbreak response and managing COVID-19

In February 2020, New Zealand closed its international borders to prevent the spread of COVID-19, followed a month later by nationwide lockdowns. We experienced more than 2.2 million cases and 3,000 deaths; yet our health system contributed to better outcomes than most countries, assisted by our relative isolation and our prompt response once the first cases were detected. Health NZ took over the management of the pandemic response, from the Ministry of Health, on 1 July 2022.

During the pandemic, health system capacity was directed to prevent, treat and respond to COVID-19. Alongside greater reliance on people's self-management, the health sector introduced new provider contracts for immunisation, telehealth services, primary and community access to testing, and community access to antivirals where appropriate. Hospitals intensified infection control measures, retrofitted selected wards so COVID-19 patients could be treated separately, and purchased more patient ventilators and protective equipment for staff. Unfortunately, this focus on COVID-19 reduced access for other health conditions and increased wait times for general practice and hospital specialist appointments, and for planned surgeries.

A 2024 review found that difficulties coordinating the health sector response, related to the many years of decentralisation, previously identified in the 2020 Simpson review. We gained insights about strengthened emergency preparedness, data sharing and the value of NGOs to reach and vaccinate populations that find it difficult to engage with regular health services.

Many lessons from the COVID-19 response are now integrated into Health NZ and included among actions in this report. These include consolidation of 12 public health units to form the National Public Health Service, with a nationwide operating structure, advancements in digital tools, hospital infrastructure improvements around gas reticulation and ventilation, a closer relationship with the Institute of Environmental Science and Research, expansion of the vaccination workforce, commissioning community service providers, consistency in clinical guidance for communicable disease, and strengthening our national surveillance mechanisms for detection of future outbreaks.


## 3.7 Strengthening our system enablers


Health NZ has a large highly skilled workforce. Many types of system enablers are important to ensure we have the right mix of clinicians and to support and improve the productivity of service delivery. Digital support is essential for efficient management of resources, workflow and protection of patients' health records. Health NZ has more than 1200 buildings, most containing complex systems and equipment important to a safe care environment. Clinicians and patients need the right equipment, supplies and medicines to be available at the right place and right time to support treatments. Hospitals must also contribute to reducing emissions from systems like boilers and reduce the waste associated with supplies.

**3.7.1a Digital healthcare, consistency in systems:** Create and implement actions to deliver national consistency in data and digital capability and solutions across Health NZ, including streamlining duplicate legacy systems inherited from district health boards and Shared Service Agencies, to improve intra-operability and reduce operating costs.


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**22/23** The data and digital strategy and roadmap were approved to simplify and streamline national applications. As part of Unify to Simplify, we consulted with staff nationwide on a new operating structure to reduce duplication. We made significant progress with two major digital projects. We added seven more districts to our new finance and procurement system, bringing the total entities migrated to 19. We onboarded 800 dental providers to our new health sector agreements and payments system. Health NZ processes 120 million claims and \$13 billion in payments annually.
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**23/24** We established our organisation and operating structure, with integration of IT operations from 28 entities to regional and national teams. We cleared our inherited work programme and focused national clinical and business priorities, standardisation and consolidation of existing systems, and remediation of operational risk. We established an investment prioritisation framework to maintain progress. By June 2024, the finance and procurement system was operating in a further eight districts and two entities. Our health sector agreements and payments system had moved \$375 million of hospital medicine claims to the new platform and launched the new system for agreements. In early 2025, all districts are on the new finance system, with only four legacy systems to archive, and we are planning to onboard \$2.1 billion in community pharmacy claims for payment.


**3.7.1b Digital healthcare, Hira:** Implement Hira, a user friendly, integrated national electronic health record, to the agreed level, ensuring the expected benefits of the investment are achieved, and taking all practicable measures to ensure that project milestones are met.

 **22/23** Progress was made with technology to support interoperability, so Hira can share information from different IT systems with consumers. We reviewed and rescoped the Hira delivery plan for 2023/24.


 **23/24** Work on the first stage of Hira was completed, and the programme paused. Hira made significant progress with the delivery of key components, including an interoperability platform, our national digital event management service, and the My Health Record website.


**3.7.1c Digital healthcare, NPBS systems:** Scale and adapt population health digital services developed to support the COVID-19 response to serve other key population health priorities.

 **22/23** Work progressed well, with permanent resourcing established. Key programmes for NPBS were approaching their important go-live dates.


 **23/24** We adapted and scaled population health digital services for nationwide use. The new notifiable disease management system was implemented which means that communicable diseases can be more easily managed. The Aotearoa Immunisation Register was launched, offering a digital platform for tracking immunisation coverage. My Health Record was released, allowing consumers to manage their personal health details.


**3.7.1d Digital healthcare, interoperability:** Improve the interoperability of data and digital systems across the hospital network, and between primary, community and secondary care settings.

 **22/23** Health NZ integration teams collaborated with the Hira team to enhance interoperability standards. Efforts focused on alignment of applications nationwide, establishing a common backlog, and standardising tools within data and digital. Experts were engaged to address the skills gap, and progress was underway to connect applications and develop the necessary standards.


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**23/24** We improved interoperability of disease management by implementing a new system, with foundational platforms and application interfaces, so public health systems will have reliable mechanisms to operate at national scale in an outbreak.


**3.7.1e Digital healthcare, primary care:** Improve digital access to primary care as an option to improve access and choice, including virtual after-hours and telehealth, with a focus on rural communities.

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**22/23** The rollout of phase two of the digital enablement programme progressed, successfully expanding the COVID-19 consumer campaign to cover additional health conditions. The project remains on track to improve people's access to primary care.


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**23/24** Contracting for virtual after-hours and telehealth services was completed, and the programme launched in November 2023.


**3.7.2a Health infrastructure, capital projects:** Deliver the approved capital projects that are underway, taking all practicable measures to ensure that project milestones are met, and anticipated benefits realised.

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**22/23** In June 2023, we had 79 inflight projects and 31 completed, including the mental health infrastructure programme. Of the 79 projects, five were in the concept phase, 31 in design, and 43 being delivered. Risks were reported to ministers for 10 projects, 27 projects were managing their risks and 45 projects were progressing with no significant risks or issues.


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**23/24** In June 2024, we had delivered 14 more projects and had 68 inflight, including for mental health. Of the inflight projects, three were new and in the concept phase, 19 were in design and 46 were being delivered. We reported significant risks for 18 projects due to their budget or schedule. Of the remainder, 16 were managing their risks, and 34 were progressing with no significant risks or issues.


### 3.7.2b Health infrastructure, asset management: Deliver a National Asset Management Strategy by December 2023.

 **22/23** We developed an asset management strategy to prioritise the refurbishment and replacement of health infrastructure. This used evidence and insights on asset condition and service needs to improve management of our asset portfolios.


 **23/24** The national asset management strategy was approved by the board in November 2023, and submitted to the Minister of Health for approval in December 2023.


### 3.7.2c Health infrastructure, investment plan: Deliver an Infrastructure Investment Plan by December 2023.

 **22/23** Development of a 10-year strategic roadmap for health infrastructure investment commenced. We progressed the tasks to integrate this roadmap into our service plans. Oversight was established, regional engagement was ongoing, and information collection for investment submissions and clinical service demand was underway.


 **23/24** The infrastructure investment plan and investment scenarios were approved in by the Health NZ board in November 2023, and submitted to the Minister of Health in December 2023.


### 3.7.2d Health infrastructure, digital strategy: Develop the information strategy, requirements and road map for asset management and investment analysis.

 **22/23** Work toward an information solution for asset management and investment analysis was on track. We captured the current state of asset information systems nationwide and developed high-level requirements. Plans and resource strategies and roadmap development was underway.


 **23/24** The information strategy and roadmap for asset management and investment analysis were progressed. Following an executive review, we refined the business case. Implementation plans for the asset management system for buildings, plants and infrastructure was underway, with proof-of-concept nearing completion.


**3.7.2e Health infrastructure, facility standards:** Develop design standards for Aotearoa health facilities, contributing to and building on the Australasian Health Facility guidelines.

 **22/23** Work was on track, with a steering group oversight. The design standards were drafted, approved and published. Additional technical guidance for engineering services, fire and seismic design was in development to support these standards.


 **23/24** A process was established to regularly review and develop design guidance. Health NZ collaborates with the Australasian Health Facility Guidelines organisation, as well as adapting and creating guidelines for New Zealand conditions.


**3.7.2f Health infrastructure, partnerships:** Develop partnerships with other government sectors to align with and leverage off large capital delivery programme in other sectors.

 **22/23** Our infrastructure investment group actively developed relationships through the construction sector accord.


 **23/24** Through our partnerships with the government sector, we gained insights from capital infrastructure delivery in other agencies. We benefited from engagement with Rau Paenga, the agency for Crown infrastructure delivery. As we developed the Health NZ capital policy and capitalisation methodology, we consulted with New Zealand government agencies and Health Infrastructure New South Wales.


**3.7.2g Health infrastructure, accessibility standards:** Establish accessibility standards with the disabled community for all new builds, new contracts and new services including transport and mobility options, and develop a plan to make existing infrastructure, services and environments compliant with new standards.

 **22/23** Work began to ensure compliance with accessibility standards, for the disabled community, to be included in new builds, contracts and services.


 **23/24** The programme for implementing these standards was developed, while waiting for funding approval.


**3.7.3a Procurement and supply chain, national function:** Build the national procurement and supply chain function that implements supply chain strategy, policies, and guidance.

 **22/23** We developed, consulted on, and implemented the first stage of the national procurement and supply chain operating structure. This defined responsibilities and deliverables for senior leaders, initiated transition from district to national structures, including the formation of broader national teams. By November 2022, the national procurement and supply chain strategy for 2022- 2024 was developed and approved, and implementation had begun.



 **23/24** We reviewed and implemented a national procurement and supply chain structure, consolidating the functions of the twenty districts and our shared service agencies. We commenced revision of our strategy and creation of essential national policies, including the procurement policy.

**3.7.3b Procurement and supply chain, clinical engagement:** Establish the clinical engagement, sustainability, and equity requirements for the Procurement and Supply Chain function.



 **22/23** We established a national clinical lead to bring clinical expertise into procurement and supply chain operations. Clinical product management functions were established in the districts to engage with clinicians to ensure products are fit for purpose, and capture their issues and concerns. We began consultation, including engagement with other government agencies, to bring sustainability and equity requirements into Health NZ procurement processes. Work was begun on how to move our fleet management to electric vehicles, to reduce CO2 omissions.

 **23/24** We appointed a national equity lead, to support the development of a nationally consistent approach to meet equity requirements in procurement and supply chain functions. We enhanced relationships with sustainability business partners, with established a sustainability policy for warehouses' staff travel. Our sustainability and equity guidance was ready for consultation, which we completed in 2024/25.



**3.7.4a Climate change, response planning:** Implement a climate sustainability and response plan across the health sector.

-  **22/23** Work on climate risk began and was delayed due to organisation restructure. Progress resumed in the 2023/24 financial year.
-  **23/24** In May 2024, we published climate change scenarios that investigate the plausible impacts on human health, and the health sector's ability to deliver services. This work will inform development of Health NZ's climate response plan, due for completion by December 2026.

**3.7.4b Climate change, carbon neutral:** Implement emissions targets and performance indicators for national, regional and local levels, and build a national database to track the operational and embedded carbon emission impacts of the health sector.

-  **22/23** We established a reporting framework and tools to comply with government carbon neutral targets. An inventory of our greenhouse gas emissions was completed. We planned emissions reduction using the 2022/23 as our baseline.
-  **23/24** Annual and quarterly emissions reports are published on the Health NZ website. This shows a reduction of around 14 percent since 2022/23. Additional data collection was being explored.

**3.7.4c Climate change, resilience and sustainability:** With Iwi Māori and other stakeholders, co-design a framework for Health NZ's approach to climate change, service resilience and environmental sustainability.

-  **22/23** Implementation was delayed as the operating structure consultation progressed. However, early engagements began, establishing a foundation for future progress.
-  **23/24** Despite the delays with the framework, we continued to refine and embed a multi-year work plan. We implemented measures to capture sustainability benefits and integrate sustainability into decision making and business case processes.

**3.7.4d Climate change, category-1 emissions:** Identify actions to achieve a 25 percent reduction of category-1 emissions by 2025, including a fleet optimisation plan, transitioning boilers to low emission technologies, a nitrous oxide scavenging and destruction pilot and supporting desflurane phase out.

**22/23** Category-1 emissions are the greenhouse gases released directly from sources we own or control, such as vehicles, buildings and industrial processes. Health NZ adopted the objective to achieve a 25 per cent reduction in category-1 emissions by 2025. Work included transition of fleet vehicles to battery electric vehicles, and investigation of our medical gases. Use of desflurane gas for anaesthesia has reduced year on year.


**23/24** We continued to transition our fleet to battery electric vehicles and invest in energy saving projects using funding from the Energy Efficiency and Conservation Agency. Our category 1 and 2 emissions reduced by 24% through 2022/23 and 2023/24.


**3.7.4e Climate change, category-2 emissions:** Identify actions to achieve 25 percent reduction of category-2 emissions by 2025, including Health NZ designing an energy efficiency programme by 2023 and an LED lighting conversion programme.

**22/23** Category 2 emissions are the greenhouse gases emitted from the electricity, steam, heating and cooling that an organisation purchases and uses. We reduced reliance on coal for heat and steam production from third party owned boilers. An energy transition programme was launched and was on track, including conversion to LED.


**23/24** We continued to transition priority projects, including LED lighting conversions and several electrical energy efficiency projects such as chiller unit replacements. Collaborations with energy providers led to the removal or conversion of several large coal boilers to biomass. Our category 1 and 2 emissions reduced by 24 per cent through 2022/23 and 2023/24.


**3.7.4f Climate change, waste management:** Develop nationally consistent best practice for waste management and business travel policies to reduce flight-related emissions.

 **22/23** We commenced early scoping conversations. The business travel policy was prepared for consultation, with further work planned for 2023/24.

 **23/24** We progressed integration of sustainability considerations into national harmonisation of district travel policies. Measures to contain business travel costs were established and expected to reduce costs and emissions in 2024/2025. A waste working group reviewed our current state and designed strategies for improvement.

**3.7.4g Climate change, procurement:** For all Health NZ procurement contracts, develop, include and enforce policies for social and environmental outcomes and sustainability principles.

 **22/23** We reviewed existing district policies and commenced design of a national policy.

 **23/24** We developed national procurement policy guidance to deliver value and achieve social, sustainability and environmental outcomes. This was consulted nationally and applies to all Health NZ staff.

# >>> Priority populations



## 4. Priority populations

To improve health outcomes for all New Zealanders, we also need to focus on people who experience poorer outcomes particularly Māori, Pacific Peoples and disabled people. Teams focused on these priority population actions worked across Health NZ, working with the teams focused on improving services for priority conditions in Section 2, and supported by the team working on people and whānau voice in Section 1, and those engaged in establishing Health NZ and new ways of working in Section 3.

Te Aka Whai Ora was established to improve health outcomes for Māori, through leading work, partnering with Health NZ, and monitoring changes in health outcomes for Māori. Its Te Pae Tata actions included recognition of te Tiriti o Waitangi and development of culturally appropriate, whānau-centred services with Māori leadership.

For the other two priority groups, Pacific Peoples and disabled people, Health NZ established functions to lead the work to improve their health outcomes. For Pacific health, Te Pae Tata actions were to address areas of longstanding health inequities and to reduce the gap in life expectancy. For the health of disabled people, the actions included development of a more accessible, inclusive and equitable health system, with services tailored for disabled individuals and whānau.

### Māori

In two-years of operations, Te Aka Whai Ora and Health NZ delivered and embedded 24 of its 27 actions to improve Māori health. We achieved this through collaboration and the work continues coordinated by Health NZ's Hauora Māori Services function.

#### **Achievements include:**

- A major accomplishment was the establishment of 15 Iwi-Māori Partnership Boards, recognised under the Pae Ora (Health Futures) Act 2022.
- Work to improve Māori health outcomes: to reduce harm from alcohol and drugs, suicide prevention, improved participation in cancer screening, new lung cancer pathways and cancer drugs, improved funding models for primary care, and public health policies around tobacco, obesity and healthy food.
- New funding models and services commissioned to: improve maternity, early years and immunisation services with 46 hauora Māori contracts, te ao Māori approaches for 33 mental health services across the country, trials of taurite specialist mental health and addiction services, introduction of kaiāwhina or support roles as well as training to strengthen general practices, and exceeding government targets for contracting with Māori-owned businesses.
- Work completed to improve data and monitoring for Māori health outcomes included protocols to capture ethnicity, data sovereignty, and Māori equity performance measures.

**Two actions were progressed although not delivered, including:**

- Developing the capability of Iwi-Māori Partnership Boards, ensuring access to cancer treatment is timely, and an assessment of the cultural safety of healthcare delivery organisations. Each of these tasks will require a long-term effort.

One task not delivered due to government changes in direction was the interagency initiative to respond to mental health crisis.

**Pacific health****The Pacific health function within Health NZ delivered and embedded 22 of 25 actions, including:**

- Established networks and engagement tools to: capture Pacific Peoples voices to inform service design, share information among Pacific clinicians and service organisations, and identifying ways to design care pathways to reduce barriers.
- Investment in new, extended and integrated contracts so providers offer a range of services tailored to the needs of Pacific aiga, including a South Auckland pilot to improve diabetes management and outcomes.
- Collaborative work within Health NZ to improve care for conditions where Pacific Peoples experience poorer outcomes: management of diabetes complications, planned surgeries, maternity and early years, maternal mental health and cancer, along with care for children, older people and Pacific Rainbow communities.
- Collaboration within Health NZ and with Te Aka Whai Ora to address workforce issues, including modelling, planning, and people's access to training and entry to practice.

**Two actions were progressed but not delivered, including:**

- Research to expand primary care for Pacific People in Hawkes Bay and the South Island was not currently feasible, although there was expansion of some services around South Island.
- Collaborative work to improve immunisation has taken time to show results, although improvements are evident in early 2025. Improving children's oral health and oral surgery are long-term initiatives that depend on funding.

One action was subject to government changes in direction. When Localities were discontinued, the Pacific function redirected efforts for Pacific community planning to the four regions.

## Disabled people

Health NZ established a disability health team to improve health outcomes for disabled people.

### The team delivered and embedded 8 of 9 actions, including:

- Engaged feedback from disabled people on services, made our publications and recruitment accessible for disabled people, advised on the needs of disabled people in service design, planning and commissioning, and contributed to the workforce plans.




### One action was progressed but not delivered:

This was to identify people with disabilities in our National Health Index in collaboration with Health NZ digital services. This is complex given the range of disabilities and will require funding to progress further.

Table 6 below summarises our performance in relation to priority populations at the end of the 2-year period of Te Pae Tata.

Included in the detailed narratives in this section is a score for the first year, which indicates how rapidly teams were established to deliver the actions.


**Table 6: Performance for priority populations**


Priority populations			
Māori health improvement – 27 actions	24 (89%)	2 (4%)	1 (4%)
Pacific health – 25 actions	22 (84%)	2 (8%)	1 (4%)
Health of tāngata whaikaha / disabled people – 9 actions	8 (89%)	1 (11%)	-
<b>Sub-total</b>	<b>54</b> <b>(89%)</b>	<b>5</b> <b>(8%)</b>	<b>2</b> <b>(3%)</b>

## 4.1 Māori health improvement


During the COVID-19 pandemic, when Māori communities had opportunities to develop their own solutions, they worked collaboratively with health providers and within their communities to achieve better health outcomes. Te Aka Whai Ora was tasked to create a te Tiriti-dynamic and lead the change to a culturally appropriate health system. To improve the equity of health outcomes, Te Aka Whai Ora and Health NZ together focused on opportunities for improvement, including in the health workforce, public health, cancer, chronic health conditions, maternity and early years, and mental health and addictions.


**4.1.1a Māori health improvement, partner with Iwi:** Partner with Iwi Māori Partnership Boards (IMPB) to develop interventions that are tailored for Māori, build community capability and ultimately work for Māori.

 **22/23** Te Aka Whai Ora engaged with Iwi to agree the numbers and boundaries of IMPBs. In January 2023, the first 11 IMPBs were recognised, followed by a further four in July. Te Aka Whai Ora provided administrative, analytical and funding support to assist IMPBs. In accordance with the Pae Ora (Healthy Futures) Act, IMPBs are to identify and inform local solutions to improve Māori health and to monitor Māori health outcomes.


 **23/24** Te Aka Whai Ora collaborated with the Ministry of Health to tailor capability support, so each IMPB could identify and address the health needs of regions, develop administrative capacity and establish operating models.


**4.1.1b Māori health improvement, Public Health Agency:** Work with the Public Health Agency (PHA) to develop and implement evidence based public health and legislative interventions that reduce harm from alcohol and other drugs.

 **22/23** Te Aka Whai Ora collaborated with the PHA to complete an environmental scan of current interventions and gaps in harm reduction for alcohol and other drugs.


 **23/24** Findings from the environmental scan informed recommendations on effective alcohol and drug interventions for Māori. Working together with the PHA, we completed projects such as review of the alcohol levy, the briefing on fetal alcohol spectrum disorder for the minister, and a service level agreement for allocation of the alcohol levy for 2023/24.


**4.1.1c Māori health improvement, suicide prevention:** Review the national approach to Māori suicide prevention and construct approaches consistent with mātauranga Māori to reduce the rate of suicide and suicidal behaviour.

 **22/23** Te Aka Whai Ora completed a review of the expiring contracts and uncommitted budget, for the Māori suicide prevention programme.


 **23/24** We completed the annual performance report for publication, and an implementation plan to improve service design and delivery, tailored to Māori communities.


**4.1.2a Māori health improvement, cancer screening:** Take a pro-equity approach to age thresholds for access to screening and removing barriers to primary care to improve early detection.

 **22/23** Māori experience bowel cancer at earlier ages than non-Māori, so earlier screening is expected to catch cancers earlier when they can be more effectively treated. Following a pilot in Auckland, the Waikato district extended the free bowel screening for Māori and Pacific peoples to include aged 50-59 years as well as the standard 60-74 years. Evaluation of this initiative helped to inform the development of a business case for extending bowel cancer screening eligibility.


 **23/24** Māori and Pacific women are more likely to develop and die from breast cancer than other ethnicities. To address this disparity, we completed a literature review on the efficacy of breast screening for Pacific and Māori women aged 40-45 years. We also completed an equity and impact assessment for age extension from 70 to 74-years. For bowel cancer, Tarāwhiti and MidCentral districts began two-year age extension pilots for Māori and Pacific Peoples, and we concentrated on improving Māori and Pacific participation in screening through targeted approaches with community providers. In May 2024, we focused on primary care practices to encourage Māori and Pacific Peoples to take part in bowel screening, with promising results. In 2025, a change in government direction is to offer bowel screening to all people from 58 years. People who have taken part in pilots will continue to receive invitations for screening from age 50 years.


**4.1.2b Māori health improvement, cancer treatment:** Ensure access to timely best-practice treatment once cancer is diagnosed, with auditing to ensure deviations are justified.

 **22/23** We consulted with regions to understand their priorities for treatment access and develop improvement strategies and developed rapid data to track all patients' journeys from referral to treatment.


 **23/24** Health NZ launched a dashboard to monitor access to cancer treatments across districts and regions. Other complementary work was the development of national clinical and regional networks to support cancer service delivery.


**4.1.2c Māori health improvement, lung cancer and new medicines:** Continue to explore a programme for lung cancer early detection and improve the funding of pharmacological treatments.

 **22/23** The incidence and death rate for lung cancer is higher for Māori than non-Māori. To introduce early detection of lung cancer for all people, methods need to be developed and funding sourced. Work was completed to identify barriers and develop proposals.

 **23/24** We collaborated with Pharmac and the Ministry of Health's Cancer Control Agency on cancer research. The National Screening Advisory Committee reviewed evidence for prostate cancer, hepatitis C screening and the use of artificial intelligence and cancer biomarker tests. Further work will develop tools and frameworks to enhance information around health system pressures and waitlists for cancer care.

**4.1.3a Māori health improvement, chronic illness:** Redesign primary care to remove barriers to access for Māori and to provide a more comprehensive option for whānau.


 **22/23** Health NZ and Te Aka Whai Ora worked with providers on a life stage model for primary care. This included collaboration with the Ministry of Health to ensure the new model would meet the needs of Māori communities and their access to services. Next, we developed a service commissioning approach.


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-  **23/24** We produced a discussion document on implementation of provider commissioning and changes to the weighting of the population-based funding. This was aligned with broader delivery and policy programmes following discussion with the Ministry of Health.

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**4.1.4a Māori health improvement, maternity and early years:** Provide wrap-around support for wāhine hapū antenatal and birthing care, including identifying ways to provide longer-term intervention and prevention services.

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-  **22/23** Te Aka Whai Ora and Health NZ collaborated to incorporate whānau voices, develop outcome and evaluation frameworks, and a new model to support child development. We focused on a simplified universal model of care for pregnancy and the first 2,000 days of infants' lives. We began revision of joint delivery plans for 2023-2024.


-  **23/24** Nationwide, Te Aka Whai Ora invested funds to implement te ao Māori services for maternity and early years. Our service providers contributed to a new whānau-centred tool to assess maternal mental health. Funding was directed to remove service barriers in primary, community and specialist services. Intensive work was completed on telehealth pathways, strengthened Māori midwifery and early childhood workforces, and development of an education programme.

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**4.1.4b Māori health improvement, immunisation and child health:** Design immunisation and Well Child Tamariki Ora services that work for Māori and build off a strongly integrated maternity service.


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-  **22/23** Following service and commissioning design work, contract offers were sent to 46 hauora Māori partners. Collaboration between Te Aka Whai Ora and Health NZ focused on creating a simplified universal service for integrated care during the first 2,000 days.


-  **23/24** Hauora Māori partners were supported to establish services for whānau in urban and rural communities, with additional support where needed. The initiative included comprehensive antenatal education, midwifery services, and navigator support grounded in mātauranga Māori to increase health literacy and empower whānau to manage their own care.
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**4.1.4c Māori health improvement, whānau services:** Develop whānau-orientated interventions that provide intensive support for maternity and the early years.

 **22/23** Te Aka Whai Ora sent contract offers to 46 hauora Māori partners. some of whom required additional support to progress service implementation. Collaboration between Te Aka Whai Ora and Health NZ focused on creating a simplified universal service that included antenatal education, midwifery services and navigator support for connecting whānau with general practice, lead maternity carers and other agencies.


 **23/24** Work continued to strengthen service delivery for urban and rural communities. We refreshed 23/24 joint delivery plans to incorporated learnings and implementation timelines. The mātauranga Māori-based approach continued implementation across services to enhance health literacy and empower whānau in their healthcare journeys.


**4.1.5a Māori health improvement, primary care mental health and addictions:** Design and expand te ao Māori mental health service solutions including primary mental health and wellbeing services, known as Access and Choice.

 **22/23** Te Aka Whai Ora led this work. It tailored services for Māori and devised commissioning solutions to test and refine these new service models.


 **23/24** Te Aka Whai Ora and Health NZ implemented these service models across the country. The programme was extended to include 33 services, providing nationwide coverage.


**4.1.5b Māori health improvement, crisis services for mental health and addictions:** Ensure the effective links/pathways between mental health crisis services, NZ Police and other social services in rural and urban areas to address the needs of people who present as acutely distressed.

 **22/23** Health NZ collaborated with Te Aka Whai Ora and NZ Police, to produce an interagency review and stocktake to identify existing consumer pathways, best practice and opportunities for improvement.


 **23/24** Working with our stakeholders, we designed implementation. Changes were made following new government directives.

**4.1.5c Māori health improvement, Māori specialist models for mental health and addictions:** Increase the availability of, and trial, new models of taurite specialist Māori mental health and addiction services.

 **22/23** Health NZ collaborated with Te Aka Whai Ora to review existing taurite specialist mental health and addiction services. We engaged with partners and stakeholders to determine how to increase service availability and trial new services.

 **23/24** We delivered a phased expansion of services and trials of new services, along with monitoring and evaluation. This included gambling harm reduction. The work is ongoing.

**4.1.6a Māori health enablers, IMPBs:** IMPBs are in place and engaged locally, regionally, and nationally.


 **22/23** Te aka Whai Ora took legal advice and received ministerial approval for the plan to establish IMPBs. The IMPBs were established, and funding allocated to support the design and refinement of their operating model.


 **23/24** A national IMPB hui contributed to aligning Māori health priorities.

**4.1.6b Māori health enablers, leadership:** More Māori are in leadership and decision-making roles in Health NZ and Te Aka Whai Ora.


This action was consolidated with action 1.3.1.


**4.1.7a Māori health enablers, intelligence and insights:** Establish a te ao Māori intelligence and insights function, that includes use of mātauranga Māori.

 **22/23** We established a te ao Māori intelligence and insights function. Health NZ and Te Aka Whai Ora collaborated to investigate and agree priorities for mātauranga Māori insights.


 **23/24** Together, we developed measurement approaches, and designed testing and evaluation.


**4.1.8a Māori health enablers, public health:** Implement evidence-based policy interventions to address health priorities for Māori, including tobacco control, alcohol, obesity and diet.

 **22/23** Health NZ collaborated with Te Aka Whai Ora and the Ministry of Health to review the funding streams for public health interventions directed to Māori. We developed a healthy food and drink policy, and a healthy food environments paper. We reviewed the first year's results from the Brown Buttabean Motivation programme to reduce obesity in Māori and Pacific communities. Following an independent review of the alcohol levy, we assessed current and future approaches to reduce harm. This levy funds interventions to reduce harm from alcohol.


 **23/24** Collaboration continued, with regional engagement with councils, schools and Iwi on implementation of smokefree and vape free policies. We engaged with NZ Police, local government, sports clubs and NGOs to strengthen local alcohol policies, such as education around host responsibility. We engaged with hospitals, retailers, schools, local government and other settings to implement healthy food and drink policies. We also engaged with local government on policies that support active transport and increased community access to recreation facilities. Funding for the alcohol levy was confirmed, and planning initiated for alcohol levy settings for 2024/25.


**4.1.9a Māori health enablers, primary and community funding:** Fairly fund hauora Māori providers, valuing their role in primary care and maximising the value of comprehensive models of service delivery. Where there is good performance, we will develop longer-term and more flexible contracts to improve outcomes.

 **22/23** Health NZ collaborated with Te Aka Whai Ora to review Māori community needs, providers funding levels and performance. This informed an implementation plan to strengthen services.


 **23/24** We designed an equity payment to address shortfalls in the population funding model in accordance with WAI 2575 findings.


**4.1.9b Māori health commissioning, comprehensive primary and community teams:** Commission comprehensive primary and community care services for Māori populations that improve access.

 **22/23** Health NZ collaborated with Te Aka Whai Ora to assess the primary and community health needs of Māori communities.

 **23/24** Initiatives to address unmet need include te ao Māori services for maternity and early years, and access to services in comprehensive primary care teams. We introduced Kaiāwhina roles to support general practice.

**4.1.9c Māori health commissioning, contracts for primary and community:** Commission comprehensive primary and community care services for Māori populations that improve access.

 **22/23** Health NZ collaborated with Te Aka Whai Ora to establish comprehensive primary and community care teams, including local tailoring to enhance access for Māori communities.

 **23/24** Implementation was completed with contracts established for 83 hauora Māori partners to deliver up to 129 kaiāwhina roles. Work on local monitoring and reporting frameworks was underway.

**4.1.10a Health workforce, a culturally safe workforce:** Support educational interventions to increase Māori access to health professionals training within the tertiary sector.

This action was consolidated with action 1.2.1.

**4.1.10b Health workforce, increase Māori health workers:** Support health sector interventions to increase the number and type of Māori health workers within the current workforce.


This action was consolidated with action 1.2.1.

**4.1.10c Health workforce, Te Tiriti and equity education:** Set mandatory education for te Tiriti o Waitangi, equity, racism and bias for the whole health workforce to ensure they can deliver culturally safe and culturally competent healthcare.


This action was consolidated with action 1.2.6.


**4.1.10d Health workforce, assess cultural safety of organisations:** Assess and improve the cultural safety of healthcare organisations.

 **22/23** Te Aka Whai Ora prepared a paper on cultural safety for leadership.


 **23/24** We decided to integrate this work with a strategy to enhance te Tiriti responsiveness, cultural safety and equity of resources. We developed an initial strategy and plan, and a stocktake of cultural safety standards was underway to inform our 2024/25 planning.


**4.1.10e Health workforce, non-Māori mentors for cultural safety:** Build a network of non-Māori practitioners who are mentors and leaders on cultural safety work, who can build te Tiriti awareness and help non-Māori understand their responsibilities to Māori.

 **22/23** While we identified suitable candidates to support this action, they did not have the capacity to become mentors at this time.


 **23/24** This action was rescoped to be addressed in the Health Workforce Plan 23/24. Progress was underway to develop cultural safety capabilities across Health NZ and integrate these with Te Mauri o Rongo.


**4.1.11a Māori health accountability, monitor performance: Ensure universal responsibility for monitoring performance by ethnicity and acting on the results.**

 **22/23** To ensure Pae Ora priorities incorporate ethnicity, health NZ reviewed existing non-financial monitoring and reporting of performance measures.


 **23/24** This is business as usual, with national and subsequently regional metrics disaggregated by ethnicity.


**4.1.11b Māori health accountability, equity performance:** Set Māori equity key performance indicators within health service delivery and seek action plans for remediation where performance is below the indicator, where there is no existing plan.

 **22/23** An assessment of current system-level indicators was completed. A paper on the equity performance framework was endorsed by Health NZ's Executive Leadership Team.


 **23/24** Development of the equity performance framework commenced. Existing datasets and prioritisation methods were used to test and refine the performance measures.


**4.1.11c Māori health accountability, data sovereignty:** Embed Māori sovereignty frameworks and practice for governance of data and information, privacy and security. Ensure appropriate data and protection standards are in place.

 **22/23** Te Aka Whai Ora collaborated with Health NZ and initial progress was slow.


 **23/24** A framework was developed and tested, including standards to support Māori data sovereignty. While these standards were not adopted in 2023/24, plans for implementation began.


**4.1.11d Māori health accountability, ethnicity data protocol:** Ensure ethnicity data is collected according to a common ethnicity data protocol and there is a universal responsibility for all parts of the system to monitor performance on equity, with public transparency of performance.

 **22/23** Health NZ assessed protocols for how ethnicity data is captured, and created toolkits to audit and enhance compliance. This ensures the way ethnicity data is collected is consistent across the health care system and can support performance monitoring.


 **23/24** Healthcare agencies have the tools to properly collect ethnicity data and to consistently report by Māori ethnicity.


**4.1.11e Māori health accountability, equity initiatives:** Empower the system to identify and implement solutions to address inequities and monitor the impact of actions.

 **22/23** Health NZ established accountabilities for equity at national level in Health NZ.

 **23/24** A Health NZ equity framework was developed. Actions included routine disaggregation of health data reported to Health NZ's operational performance committee, support for the Health Status Report, and a range of projects directed to address life expectancy gaps.

**4.1.11f Māori health accountability, MBIE contract targets:** Ensure we meet the Ministry of Business, Innovation and Employment's (MBIE) target that at least five percent of contracts are awarded to Māori.


 **22/23** Health NZ developed a procurement policy to raise awareness, promote pro-equity commissioning, and identify innovative ways to engage with Māori businesses.


 **23/24** We exceeded MBIE's target for the percentage of contracts awarded to Māori providers, with a result of 8.4 per cent. The broader outcomes framework and progressive procurement policy development were nearing completion.

## 4.2 Pacific health


The Health NZ Pacific Health Group led efforts to work with Pacific communities, to understand communities' needs and invest to accelerate Pacific health gains. This included South Auckland pilots to improve diabetes care, design of new models of care for maternity and early years, reverse declines in cancer screening, expand Pacific providers in areas of Pacific population growth, and introduce kaiāwhina roles for more integrated care. 'Integrated care' refers to closer communication among different care services and some services delivered together.


**4.2.1a Pacific health enablers, embed Pacific voices:** Embed diverse Pacific voices in decision making across the health system.

 **22/23** An interim Pacific leadership function was established and contributed to Localities work to ensure that Pacific voices were incorporated into the plans and service designs. In January 2023, we established the Pacific Health Senate, Fatu Fono Ola, to provide strategic advice to Health NZ, and to support the delivery of equitable health outcomes for Pacific Peoples.


 **23/24** Health NZ formally established its Pacific Health Group to deliver Ola Manuia, the Interim Pacific Health Plan. We recruited Pacific directors and partnership teams in each region.


**4.2.1b Pacific health enablers, engagement framework:** Build on the Pacific community engagement framework in partnership with Pacific communities and relevant stakeholders to embed Pacific aiga and community voice into the reformed system.

 **22/23** We established monthly fono in the regions and quarterly national fono with Pacific health providers and the Pacific Health Group.


 **23/24** Our regional teams and provider networks delivered community health events, with opportunities for people to gather and receive health services, including in rural settings. Pacific Health teams worked with Hospital and Specialist Services to improve the patient experience survey for Pacific people.


**4.2.1c Pacific health enablers, Pacific networks:** Strengthen and build on existing Pacific networks and develop new networks where there are current gaps including churches and other community groups, to develop, support and implement the engagement framework.

 **22/23** Regional directors supported Pacific providers to enhance their services in community. Commissioning delivered 220 contracts across multiple services and began consolidation of district budgets.


 **23/24** We increased the visibility of Pacific networks, with emphasis on Pacific health priorities for access and service delivery. Thirty-three Pacific providers were delivering outreach contracts across the Northern, Te Manawa Taki, Te Ikaroa and Te Waipounamu regions. Outreach contracts support the delivery of immunisations, long-term condition management, screening programmes and community emergency response.


**4.2.1d Pacific health enablers, Localities:** Support Pacific communities and providers to be active partners in the establishment of localities.

 **22/23** We partnered with Health NZ's Localities team to include Pacific needs and perspectives in the development of Locality plans.


 **23/24** While Localities were discontinued from early 2024, the Pacific team continued to complete work through the regional integration teams.


**4.2.1e Pacific health enablers, data and intelligence:** Establish a robust national Pacific Health data and intelligence function.

 **22/23** We established the Pacific health data and intelligence function to ensure Pacific ethnicity and service level data was incorporated into regional and national data collections.


 **23/24** The Pacific health data and intelligence function delivered a national patient experience survey and a national Pacific provider survey. The team implemented a weekly immunisation report reflecting Pacific provider inputs into national coverage.


**4.2.1f Pacific health enablers, clinical network:** Establish a highly connected national Pacific Clinical Network to help support and mobilise the clinical workforce and create a forum where insights from front-line staff are systematically captured and used to inform quality improvement and service development.

 **22/23** We developed the Pacific Clinical Senate, Fatu Fono Ola, to secure clinical insights and inform our work.


 **23/24** The Pacific clinical network advises on national vulnerable services, quality measures, targeted interventions to reduce the Pacific life expectancy gap, and endorses the Pacific National Workforce Plan.


**4.2.1g Pacific health enablers, care pathways:** Commission research to support development of evidence-based care pathways and responsive models in priority clinical areas, including maternity and early years care, long-term conditions and mental health services.

 **22/23** We selected providers to develop evidence-based pathways for maternity and early years, mental health and diabetes.


 **23/24** As part of implementing new pathways, we planned training for the kaiāwhina workers in primary care. In South Auckland, we commenced a pilot to improve the diabetes retinal screening pathway using artificial intelligence to read scans. This innovation begins to make retinal screening available in primary care settings, which can reduce the complication of blindness among New Zealand's working population.


**4.2.2a Pacific health commissioning, provider development:** Resource regional Pacific Community Hubs so that Pacific providers can work together in an integrated way at local and regional levels.

 **22/23** Working with providers, we planned for six Pacific provider hubs across the country. We completed feasibility studies to resource the hubs in the four regions.


 **23/24** We established Pacific provider hubs across the four regions. These hubs support providers to work together, collaborate with other health services and improve access to services for Pacific communities. A feasibility study for the Hawkes Bay region is planned for completion in 2024/25.


**4.2.2b Pacific health commissioning, partnerships:** Co-create partnerships with new Pacific providers in growth localities that do not currently have a Pacific health provider.

 **22/23** The Pacific team completed a needs assessment, reviewed funds available from the Pacific provider development fund, and developed a plan to strengthen new Pacific providers.


 **23/24** We worked with new Pacific providers to establish partnerships, and with regions to identify Pacific people's needs that were not covered by Pacific providers. In Te Waipounamu, we expanded providers from five to 11 and extended services for mental health, addictions and alcohol.


**4.2.2c Pacific health commissioning, expand Pacific providers:** Conduct feasibility studies for Te Matau-a-Māui Hawke's Bay and South Island / Te Waipounamu providers to expand into primary care.

 **22/23** We completed feasibility studies in the Hawkes Bay and the South Island where there was high growth in Pacific populations and planned to strengthen Pacific providers and services.


 **23/24** The Te Waipounamu study found that it was not currently feasible to expand providers into primary care. Instead, we opened hubs with outreach services extended into Balclutha, Fiordland, Queenstown and Timaru. We paused the Hawke's Bay study.


**4.2.2d Pacific health commissioning, infrastructure investment:** Support the continuation of innovative models of care developed through the COVID-19 response: strengthen Pacific providers by investing in the infrastructure required to sustain innovative models of care and assess how innovative models of care can be scaled up across the regions.

 **22/23** We invested in Pacific provider assets such as vaccine fridges and mobile cold chain equipment and vehicles, and staff training to increase immunisation services in the regions. We reviewed the performance data on innovative models of care developed during the COVID-19 response.


 **23/24** We invested in 34 new outreach contracts for Pacific providers, improving their mobility, people's access to services, and improved Pacific immunisation rates.


**4.2.2e Pacific health commissioning, new models of care:** Fund Pacific providers who implement models of Pacific family-centred care that integrate maternity, early years care, primary care, hospital and social service providers.

 **22/23** We focused on integrating care for maternity, early years, primary care and social services for Pacific families. Following a pilot, we implemented integrated contracts.


 **23/24** We piloted Kahu Taurima Pacific family centred models of care for maternity and early years. Our first national fono for maternity and early year providers produced insights around comprehensive services for mothers, babies and their families. We funded and implemented new kaiāwhina roles across community settings.


**4.2.2f Pacific health commissioning, outcome-based contracts:** Enter into high-trust, flexible and outcomes-based contracts with Pacific providers based on a shared understanding of their needs and innovative approaches.

 **22/23** Outcomes-based contracts focus on ensuring people receive the mix of services they need and their health condition improves. We co-designed outcomes-based contracts with six Pacific providers.


 **23/24** We implemented a new outcomes framework including guidelines for funding models and reporting requirements. Four pilots for outcomes-based contracts were in place and set to go live from 1 July 2024. This was supported by an overall master contract to managed interdependencies across services.


**4.2.3a Pacific health commissioning, diabetes pilot:** Develop a Pacific whānau-focused diabetes integrated care model: Invest in a South Auckland-based pilot over a four-year period that brings together Pacific communities and providers to deliver health promotion, community-based primary and secondary care focused on prevention, early intervention and optimal treatment of diabetes.

 **22/23** For our South Auckland based pilot, we co-designed a Pacific whānau-focused diabetes care model with providers. The care model included health promotion and prevention strategies for diabetes management, evidence-based guidance on medicines for Pacific Peoples' with diabetes and the use of retinal screening in general practice to identify people at risk of blindness.


 **23/24** The pilot enhanced access to comprehensive, family-centred care for Pacific communities. We funded seven general practices to deliver this care model and planned training for kaiāwhina workers in diabetes care. We funded eight community providers for services to support people's overall health and wellbeing, weight management and to better manage their diabetes. We began a pilot, to assess the use of artificial intelligence to read scans in the New Zealand setting. The pilots have been extended across Auckland locations for 2024/25 with five retinal cameras purchased.


**4.2.3b Pacific population priorities, diabetes complications:** Evaluate current models offering primary through to specialist care including screening, prevention, early treatment and management of eye, foot and kidney complications, and assess how these can be scaled up at different localities and regional levels.

 **22/23** We investigated best practice models for care of eye, foot, and kidney complications in diabetes. In partnership with Te Aka Whai Ora, we drafted the National Diabetes Action Plan.


 **23/24** Following a discussion with the Minister of Health, we refined the National Diabetes Action Plan and began a baseline review of Health NZ's expenditure on diabetes services. Recruitment was underway for two co-leads for the national diabetes clinical network. We developed a training programme 'Stay well to stay strong' to support kaiāwhina in Pacific providers.


**4.2.3c Pacific population priorities, communities:** Support Pacific providers to identify and address the health needs of priority communities, including youth, the rainbow community, older people, Tagata sa'ilimalo/the collective of families, carers and people with disabilities, and those with lived experience of mental illness and addiction.

 **22/23** We integrated Pacific community priorities into the Localities plans to reflect the voices and needs of diverse groups, including youth, Rainbow communities, older individuals, and those with lived experiences of mental illness and addiction.


 **23/24** Pacific providers identified priority groups with specific needs. In Te Waipounamu, we worked closely with Pacific providers on community outreach programmes. Regular meetings were critical for sustained relationships and to facilitate service delivery. We funded a new service in Hawke's Bay for the rainbow community.


**4.2.3d Pacific population priorities, planned care:** Ensure Pacific Peoples and aiga are prioritised in the restart of planned care following the pandemic.

 **22/23** We began with analysis of Pacific Peoples and aiga waiting for planned care in our regions and districts, following the COVID-19 pandemic.


 **23/24** We worked closely with hospital and specialist services to influence their strategy and plans for priority populations. We developed performance reports for Pacific planned care that now highlight progress on achieving health targets.


**4.2.3e Pacific population priorities, maternity and early years:** Develop and implement Pacific integrated models of care for maternity and early years.

 **22/23** We launched four pilots for Pacific integrated models of care in Auckland, Wellington and Christchurch complementing the work on maternity and early years contracts and workplans led by Te Aka Whai Ora.

 **23/24** We supported five Pacific providers to deliver Kahu Taurima integrated models of care to enhance Pacific Peoples' access to integrated maternity and early years care. Thirty-four Hauora Māori and five Pacific partners now deliver whānau-centred, integrated, locally tailored, Kahu Taurima care.


**4.2.3f Pacific population priorities, children:** Work with health providers and sector leaders to address the health gaps and needs of Pacific children following the pandemic, with a focus on strengthening immunisation services and oral health with improved coverage.


 **22/23** We strengthened immunisation services and improved oral health coverage within Pacific communities. We identified Pacific health providers to improve immunisation and oral health services for children.

 **23/24** We contracted Pacific health providers to improve coverage of immunisations as part of maternity and early years. We continued discussions nationwide on improving access and increasing services for children's oral health.

**4.2.3g Pacific population priorities, cancer screening:** Support ongoing work across the sector to reduce current cancer health inequities of Pacific Peoples and families:

- Urgently address the decline in Pacific people's breast, bowel and cervical cancer screening rates and ensure Pacific people with a diagnosis get the care needed.
- Work with relevant Northern / Te Tai Tokerau health providers and health leaders to provide sufficient resource and ongoing support for a consistent approach to the early diagnosis and treatment of endometrial cancer.
- Work with Cancer Control Agency / Te Aho o Te Kahu to develop closer to home care principles for cancer patients and their aiga.
- Work with Northern / Te Tai Tokerau region health providers, health leaders and researchers to develop maternal mental health models of care for Pacific women; to be implemented as part of Maternity and early years.


 **22/23** To understand Pacific people's needs, we used regional and district data and engaged with the providers delivering screening services. This informed a plan to improve screening rates for everyone who is eligible. Using insights from COVID-19 contracts, we implemented outreach contracts with Pacific providers to support cancer, breast, and bowel screening programmes.


 **23/24** Outreach contracts continued. We funded a campaign to improve health literacy among Pacific peoples, including education on endometrial cancer and how to access screening services. This aims to detect cancer earlier, when it can be more effectively treated. We contributed to work on training for pipelle biopsies in primary care.

**4.2.3h Pacific population priorities, maternal models of care:** Work with Northern / Te Tai Tokerau health providers, health leaders and researchers to develop maternal mental health models of care for Pacific women; to be implemented as part of maternity and early years


This action was consolidated with action 4.2.3(g)


**4.2.4a Pacific health workforce, strategy:** Develop a comprehensive Pacific Health Workforce Development Strategy to attract, train, strengthen, upskill and retain a growing Pacific workforce.

 **22/23** We developed a comprehensive Pacific health workforce development strategy to attract, train, upskill and retain a growing Pacific workforce.


 **23/24** We completed, published and implemented the Pacific workforce strategy in May 2024.


**4.2.4b Pacific health workforce, reduce barriers to training:** Work with the education sector to identify secondary and tertiary education barriers to Pacific health education and training, and the solutions to help.

 **22/23** We collected data on the challenges faced by Pacific students and engaged with educational institutions. This informed a plan to address the barriers to education.



 **23/24** We engaged with 750 students across 13 Auckland high schools through the Pacific Health Science academies and introduced a junior programme for Year 9 and 10 students. We invested to increase the scholarships available.

**4.2.4c Pacific health workforce, service provider resources:** Invest in initiatives and activities supporting Pacific health providers' workforce capability and capacity development.



 **22/23** We identified opportunities, secured funding, and developed a plan to increase workforce resources and provide staff training for Pacific providers.

 **23/24** Initiatives included the Aniva Leaders Programme to increase the number of nurses and midwives. We funded 18 providers for 55.5 full-time equivalent kaiāwhina workers to enhance integrated care.

**4.2.4d Pacific health workforce, Pacific nurse specialists:** Establish a programme to support the training and employment of Pacific nurse specialists in priority clinical areas of maternity and early years care and diabetes.

-  **22/23** We assessed the needs of Pacific nurses and planned a pathway to nurse practitioner training.
-  **23/24** We established the programme and implemented a nurse practitioner pathway with resources to support career progression for Pacific nurses. We supported five trainees compared to no trainees in the previous two years.

**4.2.4e Pacific health workforce, general practice education:** Investigate options to increase General Practice Education Programme (GPEP) 1 and 2 teaching practices within Pacific providers.

-  **22/23** We developed a plan to build the capacity of Pacific health providers to deliver training for general practitioners.
-  **23/24** We increased the number of General Practice Education Programme trainees, including resources to support Pacific training providers. We also developed a community based clinical attachment process to enhance understanding among Pacific providers regarding the process.


## 4.3 Health of disabled people / tāngata whaikaha


Creating a health system that is fully accessible, inclusive and equitable for disabled people is essential to achieve fair and effective care for everyone. Between 17 and 24 per cent of New Zealanders identify as disabled and are frequent users of health services, and many people experience disability as part of illness. Health NZ and Te Aka Whai Ora were to work with Whaikaha | Ministry of Disabled People to adopt a rights-based approach, engage with disabled people in service design, and to improve the delivery of care for disabled people.

**4.3.1a Disabled people's health, accessible buildings:** Establish accessibility standards for all new builds, new contracts and new services including transport and mobility options, and develop a plan for existing infrastructure, services and environments to be compliant with new standards.


This action was consolidated with action 3.7.2e.


**4.3.1b Disabled people's health, accessible publications:** Establish baseline accessibility and usability requirements for the production and publication of all public facing health information, including accessible language, accessible channels to find and use information, and alternative formats for health information.

 **22/23** We established accessibility and usability requirements for all Health NZ public communications. An independent review confirmed the effectiveness of these standards.


 **23/24** This was completed in year one.


**4.3.2a Disabled people's health, workforce training:** Train the healthcare workforce on supported decision-making and informed consent processes and implement inclusive practices in models of care, for example, NZ Sign Language interpreters, hoists and sensory reduction, using e-technology.

 **22/23** Regions had differing levels of capability so we needed to better understand the gaps. A new disability strategy was created to allow us to progressively implement improvements for services to disabled people.


 **23/24** A national disability education suite was introduced and a disability resource hub with e-learning modules went live. Workshops on reframing disability were conducted across Health NZ. Non-clinical policies were reviewed to ensure disability inclusiveness. Further work on this action was underway, including development of the te ao Rereke hybrid learning package addressing disability and unconscious bias.


**4.3.2b Disabled people's health, workforce plan:** Develop a plan to ensure health careers are accessible, equitable and inclusive for disabled people.

 **22/23** This work began with collaboration between Health NZ's disability and workforce functions and Te Aka Whai Ora.


 **23/24** We worked to ensure the workforce plan includes careers for people with disabilities. A reasonable accommodations policy was drafted, critical for creating a welcoming environment for disabled staff. An e-Learning module was developed to build confidence among hiring managers when recruiting disabled individuals.

**4.3.3a Disabled people's health, social determinants of health:** Mandate pro-equity strategic development, service planning and commissioning embedded with social determinants of health and wellbeing outcomes for disabled people.

 **22/23** We built on earlier work to complete the disability capability framework. Workshops based on the framework began in the Wellington and Hutt Valley districts. There was active participation from areas such as maternity and early years, and immunisation services.


 **23/24** National rollout of the disability capability framework continued. We were able to work with staff to identify ways to improve the organisational capability to develop inclusive and accessible health services for disabled people.


**4.3.3b Disabled people's health, leadership:** Establish a disabled people's strategic leadership team to oversee implementation of Te Pae Tata and maintain strong, transparent, continuous community involvement.

 **22/23** This action was started as part of the Unify to Simplify change process.


 **23/24** A national disability health team was established.


**4.3.4a Disabled people's health, service design:** Increase the disability leadership capacity in the design and development of health services.

 **22/23** Work started to design a guide for planners to enhance the inclusion of the disabled voice.


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**23/24** A network was established across the disability function and other Health NZ disability roles. A three-year work plan was created to improve Health NZ's performance against the disability capability framework. This includes engagement with the disability community.


**4.3.4b Disabled people's health, feedback:** Implement appropriate and accessible feedback processes for locality, service design and commissioning processes.

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**22/23** Tools developed in the Wellington and Hutt Valley districts were adopted and rolled out for national use to engage with disabled people. Efforts to connect with Localities were underway.


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**23/24** Questions were designed for inclusion in consumer engagement processes to allow us to track trends related to issues and to inform future service design. An investigation was commissioned to identify how Health NZ can engage with the disabled people in the future.


**4.3.4c Disabled people's health, Māori and Pacific:** Support disabled people in culturally appropriate ways in Māori, Pacific and other community-specific health services ensuring they are led by disabled people from those communities.

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**22/23** Work began to establish relationships and appropriate networks nationwide.

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**23/24** Disability roles were established in Te Aka Whai Ora and Pacific Health. Valuable partnerships enhanced development of disability data collection and workforce planning. The proof of concept for the Patient Profile and National Health Index project was developed.

**4.3.4d Disabled people's health, National Patient Index:** Implement the Patient Profile and National Health Index to provide a foundational data ecosystem to understand inequities facing disabled people.

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**22/23** We advised the digital project team to adapt their approach so feasibility studies with disabled individuals could be included. Perspectives of disabled people in feasibility testing is crucial, otherwise the data ecosystem may not address the needs and challenges faced by disabled people.

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**23/24** The discovery phase of the project was completed, however the project stopped due to lack of funding. This project was completed in a way that, if funding became available, the project could continue without rework.

# >>> Performance measures



## 5. Performance measures

Te Pae Tata includes performance measures to align with Government expectations. These come from interim Government Policy Statement on Health 2022-23 and Whakamaua Māori Health Action Plan 2020-2025 developed by the Ministry of Health and the Health System Indicators reported by the Health Quality Safety Commission.

The Ministry of Health devised and has reported on these measures as part of its monitoring role – please see the website locations below. For some measures, Health NZ reports results in quarterly and annual reports. This includes measures for Māori previously reported by Te Aka Whai Ora.

In this section, we report these against Te Pae Tata sections. To avoid duplication, we report measures once even where they relate to more than one section. Unless otherwise stated, results are for financial years 2022/23 and 2023/24.

Tables 1-5 below show the results mapped to Te Pae Tata sections, including the Performance measure description, source of result, target or baseline measure, and the 2022/23 and 2023/24 performance.

### 5.1 Website locations for sources of measures:

- [Interim Government Policy Statement Measures Snapshot Report 2022/23](#)
- [Interim Government Policy Statement Measures Snapshot Report 2023/24](#)
- [Whakamaua Quantitative Dashboard](#)
- [Health Quality and Safety Commission, Survey Results](#)

Table 7: Measures for people and whānau at the heart of health

Performance measure description	Source	Target and/or baseline	22/23 result	23/24 result
Experience of primary health services as measured by the primary health care patient experience survey	HSI	No baseline or target identified.	Q4: 92.1% involved in decisions about their care and treatment.	Q4: 92.3% involved in decisions about their care and treatment.
Experience of health services for Māori as measured by the primary health care patient experience survey.	HSI	No baseline or target identified.	Q4: 89.6% involved in decisions about their care and treatment.	Q4: 90.2% involved in decisions about their care and treatment.
Experience of health services as measured by the adult inpatient patient experience survey.	HSI	No baseline or target identified.	Q4: 81.2% involved in decisions about their care and treatment:	Q4: 81.4% involved in decisions about their care and treatment:
Experience of health services for Māori as measured by the adult inpatient patient experience survey.	HSI	No baseline or target identified.	This was a new measure so no results at this time.	Very satisfied: 2 IMPBs Partially satisfied: 2 IMPBs Not satisfied: 1 IMPB
Feedback from the Iwi Māori Partnership Boards on how they are fulfilling their role and whether they are receiving the support they require.	Health NZ Annual Report 23/24	No baseline or target identified. 2023/2024 results will become the baseline.	This was a new measure so no results at this time.	Very satisfied: 2 IMPBs Satisfied: 5 IMPBs Partially satisfied: 2 IMPBs Not satisfied: 1 IMPB
Engagement survey of staff on culture and shift towards one team ethos.	Health NZ Annual Reports 22/23 and 23/24	No baseline or target identified.	Survey delivered. 27,764 staff participated.	Second survey delivered. 33,416 staff participated.
Number and proportion of graduates of health training programmes from demographic groups under-represented in the health workforce, compared to the demographics of the population.	MoH report 23/24	No baseline or target identified. 2022 result will become the baseline.	CY 2022: 14.9% of Māori completed tertiary qualifications in health.	Not available.
Proportion of Māori and other under-represented groups in the regulated and unregulated health workforce, compared to the demographics of the total population.	MoH report 23/24	Regulated Māori workforce baseline: Midwives: 11.0%; Nurses: 7.8%; Doctors: 4.5%	CY 2022 Midwives: 11.9% Nurses: 7.8% Doctors: 4.7%	CY 2023 Midwives: 12.5% Nurses: 7.6% Doctors: 5.0%
		Unregulated Māori workforce baseline: 11.5%	CY 2022: 11.3%	CY 2023: 11.7%

Performance measure description	Source	Target and/or baseline	22/23 result	23/24 result
Proportion of Māori and Pacific people in leadership and governance roles across the Ministry of Health and health sector Crown entities. Note: This measure also maps to Section 4.	MoH reports 22/23 and 23/24	Baseline: 23.5%	Q4: 22.6%	Q4: 24%
Number of kaupapa Māori research proposals receiving ethics approval that focus on Māori health and disability. Note: This measure also maps to Section 4.	Whakamaui	No baseline or target identified. In 2016, the number was 52.	CY 2022: 73 kaupapa Māori research proposals were approved.	CY 2023: 77 kaupapa Māori research proposals were approved.

**Table 8: Measures for priorities for improving health outcomes & equity**

Performance measure	Source	Target and/or baseline	22/23 result	23/24 result
Enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area.	MoH report 23/24	73.2%	CY 2022: 62.5%. Most up to date result.	No results available.
Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by the end of June 2024.	Health NZ Annual Report 23/24	No baseline or target identified.	135,157 people.	159,862 people.
Uptake of immunisations for key age groups, reported by ethnicity and geographic area. Note: This measure also maps to Section 3.	Health NZ Annual Report 23/24	8mo target: 95% 2-yo target: 95% 5-yo target: 95% HPV target: 70% Flu for 65+ target: 75%	8mo: 83.8% 2-yo: 82.4% 5-yo: 80.8% HPV: 56.7% Flu for 65+: 62%	8mo: 78.4% 2-yo: 77.3% 5-yo: 73.5% HPV: 57.1% Flu for 65+: 61.5%
Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups. Note: This measure also maps to Section 3.	Health NZ Annual Report 23/24	No baseline or target identified.	ASH 0-4yrs: 7849 ASH 45-64yrs: 3758	ASH 0-4yrs: 7486 ASH 45-64yrs: 3865
Proportion of people reporting unmet need for primary healthcare, reported by ethnicity and geographic area. Note: This measure also maps to Sections 3 & 4.	MoH reports 22/23 and 23/24.	Total population baseline: 13.6% Baseline for Māori: 21.3%	Total population: 12.9% Māori: 16.9%	Total population: 15.5% Māori: 19.6%

Performance measure	Source	Target and/or baseline	22/23 result	23/24 result
Proportion of people waiting for planned specialist care who receive it within four months, reported by ethnicity and geographic area. Note: This measure also maps to Section 3.	Health NZ Annual Report 23/24	0% target means no people waiting longer than four months for treatment	FSA: 30.4% Treatment: 36.6%	FSA: 38.5% Treatment: 37.8%
Standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area. Note: This measure also maps to Sections 3 & 4.	Health NZ Annual Report 23/24	Target for total population: 12% Baseline for Māori: 12%	Total population: 12.4% Māori: 13%	Total population: 12.4% Māori: 12.9%
Reducing bowel cancer incidence.	MoH 23/24 report	Measure still in development.	Not available.	Not available.
Participation in bowel screening programme				
Proportion of people who start first treatment for breast, cervical and bowel cancer after a screening result shows presence of cancer, reported by ethnicity and geographic area	MoH 22/23 and 23/24 reports	Within 31 days target: 85% Within 62 days target: 90%	Q4: 84.1% Q4: 75.1%	Q4: 83.5 Q4: 70.2
Variation of clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area. Note: This measure also maps to Section 3.	MoH 22/23 and 23/24 reports	Target: 100%	Q4: 99.2%	Q4: 98%
Rate of diabetes complications, reported by ethnicity and geographic area. Note: This measure also maps to Section 4.	Health NZ Annual Report 23/24	Baseline for total population: 2,833 Baseline for Māori: 4,030	Total population: 2,833 Result for Māori: 4,030	Total population: 2,619 Result for Māori: 3,902
Percentage of stroke patients referred for community rehabilitation who are seen face to face by a member of the community rehabilitation team within seven calendar days of hospital discharge.	Health NZ Annual Report 22/23 and 23/24	No baseline or target identified.	Unable to report. Data collection stopped June 2022, when DHBs were disestablished.	Measures were discontinued through Vote Health: Estimates 2023/24.
Percentage of spend of HNZ total budget on mental health.	Health NZ Annual Report 23/24	22/23 SPE target: 7.90% 23/24 SPE target: 8.1%	8.43%	8.82%

**Table 9: Measures for a unified, smarter, sustainable and equity-led health system**

Performance measure	Source	Target and/or baseline	22/23 result	23/24 result
Proportion of entities or services that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4.	Health NZ Annual Report 23/24	Baseline: March 2023 – 16/19 districts (84.2%) reported against the marker.	New measure	Not achieved
Health entity spending on Māori health service providers. Note: This measure also maps to Section 4.	MoH report 23/24	Baseline: \$613.7 million	\$817.4 million	22/23 is the most updated reported result.
Geographical coverage and utilisation of Rongoā Māori services. Note: This measure also maps to Section 4.	MoH 22/23 and 23/24 reports	2019/20: 14,211 2020/21: 12,802	2021/22: 23,224	2022/23: 26,292
Percentage of spend of Health NZ total budget on public health.	Health NZ AR 23/24	22/23 SPE target – 1.90% 23/24 SPE target - 1.85%	2.18%	2.70%
Percentage spend of Health NZ total budget on primary and community care.	Health NZ Annual Report 23/24	22/23 SPE target – 32.82% 23/24 SPE target – 36.09%	32.57%	35.02%
General practitioner numbers as full-time equivalents per 100,000 population – developmental measure, mandatory contributory measure.	The NZ Medical Workforce in 2023 (p4)	No baseline or target identified.	2022 CY: 366.7 doctors per 100,000	2023 CY: 372.2 doctors per 100,000
Missed appointments for specialist care, reported by ethnicity and geographic area.	Health NZ Annual Report 23/24	No baseline or target identified.	7.8%	7.4%
Variation in the rates of access to key identified services by ethnicity, geographic area and other characteristics. Initial areas include surgery, first specialist assessments, gender affirming care, colonoscopies, access to specialist mental health, including for rangatahi, and screening.  Note: The access to specialist mental health for rangatahi measure also maps to Sections 2 and 4.	MoH 22/23 and 23/24 reports	Elective surgery baseline 23/24: 244	Q4: 256 standardised rate per 100,00 people	Q4: 254 standardised rate per 100,00 people
		FSA baseline 23/24: 1079	Q4: 1097 standardised rate per 100,00 people	Q4: 1,149 standardised rate per 100,00 people
		Gender affirming care: Developmental measure (not currently reported)		
		Colonoscopies baseline 23/24: 132	Q4: 141 standardised rate per 100,00 people	Q4: 139 standardised rate per 100,00 people

Performance measure	Source	Target and/or baseline	22/23 result	23/24 result
		Youth <25 years access specialist MH within 3 weeks baseline: 72.4%	Total Q4: 68.3% Q4 result for Māori: 75.5%	Q4: 66.7% Q4 result for Māori: 73.3%
		Screening: Developmental measure (not currently reported)		
Percent spend of HNZ total budget on specialist and hospital services.	Health NZ Annual Reports 22/23 and 23/24	22/23 SPE target 51.61% 23/24 SPE target: 52.83%	58.08%	58.58%
Did not attend and did not wait percentages for Māori at outpatient services, including a comparison between percentages for Māori and non-Māori, non-Pacific. Note: This measure also maps to Sections 2 and 4.	Health NZ Annual Reports 23/24	Baseline for Māori: 15.54% Baseline for non-Māori, non-Pacific and non-Asian: 4.82%	Māori: 15.8% non-Māori, non-Pacific and non-Asian: 4.9%	Māori: 15.2% non-Māori, non-Pacific and non-Asian: 4.4%
Equitable reduction in standardised rates of intervention.				
Proportion of medical appointments completed through digital channels, initially for outpatients and expanding to include GP appointments when data is available.	Health NZ Annual Reports 23/24	Baseline: 7.0%	6.6%	6.7%
Develop an Investment Strategy and National Asset Management Strategy by December 2023.	Health NZ Annual Reports 23/24	The narrative results for this measure have been reported on in this report as one of the Te Pae Tata actions. This can be found under section three across actions 3.7.2b and 3.7.2c.		

**Table 10: Measures for priority populations**

Performance measure	Source	Target and/or baseline	22/23 result	23/24 result
Measures of the health of Māori-Crown partnerships being developed by Office for Māori Crown Relations – Te Arawhiti, as evidenced in the health and disability system.	Te Arawhiti	Measures in development by Te Arawhiti	Measures in development by Te Arawhiti	Measures in development by Te Arawhiti
Percentage spend of Health NZ total budget on Hauora Māori Services.	Health NZ Annual Report 23/24	No baseline or target identified. Hauora Māori Services was established 1 April 2024.	Not available.	\$203 million is the actual spend for 1 April – 30 June 2024.

**Table 11: Other relevant measures for Te Pae Tata**

Performance measure	Source	Target and/or baseline	22/23 result	23/24 result
Health entities are clear about their own and other entities' roles and responsibilities and are delivering to these.	MoH report 23/24	No target or baseline identified.	All entities had signed Statements of Intent and Statements of Expectations for 22/23	All entities had signed Statements of Intent and Statements of Expectations for 23/24
Develop and monitor an agreed measure of quality-adjusted, system-level productivity.	MoH report 23/24	Developmental measure (not currently reported).	Developmental measure (not currently reported)	Developmental measure (not currently reported)

# Appendix 1: Changes to Te Pae Tata actions

This appendix sets out 22 changes to reword or consolidate Te Pae Tata actions, and the creation of one new action. Te Pae Tata actions were drafted in 2022 ahead of the establishment of Te Aka Whai Ora and Health NZ. As teams were appointed and assessed the environment, requests to change actions were submitted to Executive Leadership Teams of both agencies for approval.

## There are two reasons for changes to Te Pae Tata actions:

Fourteen reworded actions, reflect the need to update or clarify the actions once teams had been established.

Eight consolidated actions, reflect the need for several teams to collaborate. Once teams were established, it was evident that some work should be led in one area, such as workforce plans that were led by Health NZ with support from Te Aka Whai Ora and the Pacific and disability health teams.

One new action was added to actions under 'transition to transformation'. This was to implement a consistent standardised operating structure for corporate functions.

**Table 12: Changes to Te Pae Tata actions**

Te Pae Tata action	Change
<b>1.2.2: Implement a workforce pipeline that is informed by intelligence (including a Common Person Number), works with education providers and professional bodies to ensure education and training programmes are in place to grow a quality and diverse healthcare workforce that supports all healthcare providers.</b>	Reworded to: Establish supply-demand models for key workforces, informed by intelligence, and work with education providers and professional bodies to ensure education and training programmes respond to this intelligence to grow the right numbers of health workers in the right places with the right skills.
<b>1.2.5: Support educational interventions to increase Māori and Pacific access to health professional training, building the workforce pipeline to grow te ao Māori and Pacific services.</b>	Consolidated into action 1.2.1. Implement a programme to grow the numbers and diversity of the health workforce, including Māori, Pacific Peoples and disabled people to address critical workforce gaps identified by the Workforce Taskforce.
<b>1.2.6: Implement and monitor a Te Whatu Ora programme providing nationally consistent cultural safety training to and Te Aka Whai Ora workforces.</b>	Reworded to: Establish, implement and monitor a coherent approach for te Tiriti o Waitangi, equity and cultural safety education and training for our workforce.

Te Pae Tata action	Change
<b>1.3.2: Establish the Pae Ora Leadership Institute to develop our existing and future leaders in health.</b>	Reworded to: Establish leadership programmes to develop our existing and future leaders in health.
<b>2.1.5: Reduce the impact of suicide on communities, including approaches consistent with mātauranga Māori, by accelerating the implementation of Every Life Matters / He Tapu te Oranga o ia Tangata, Suicide Prevention Action Plan 2019-2024.</b>	Consolidated into action 4.1.1c. Review the national approach to Māori suicide prevention and construct approaches consistent with mātauranga Māori to reduce the rate of suicide and suicidal behaviour.
<b>2.2.9: Support Place based initiatives, including South Auckland and Manaaki Tairāwhiti. Extend the capacity of the health sector, including providers, to participate in place-based, integrated health and social sector services approaches – Budget 22.</b>	Reworded to: Support the health sector to participate in place-based, integrated health and social sector services through Localities development.
<b>2.2.10: Implement the health sector agreements in the Oranga Tamariki Action Plan to improve outcomes for children in their care.</b>	Reworded to: Implement Oranga Tamariki Action Plan with an initial focus on a review of the Gateway programme.
<b>2.3.4: Implement national pathways to access transport and accommodation to support the equitable completion of cancer treatment.</b>	Reworded to: Review the travel and accommodation policy to ensure it addresses the needs of rural and complex care patients.
<b>2.5.1: Implement a nationally consistent approach to the integration of specialist community mental health and addiction teams with NGOs, primary and community care</b>	Reworded to: Implement a nationally consistent approach which will see specialist mental health and addiction services providing advice and support to primary care services to support people with mental health and addiction issues.
<b>2.5.3: Urgently progress the mental health inpatient units approved builds and ensure the construction programme meets the agreed milestones.</b>	Reworded to: Deliver the mental health and addictions projects within the Mental Health Infrastructure programme, taking all practicable measures to accelerate project delivery and ensure that anticipated benefits are realised.
	This is a new action. 3.1.1c: Implement a consistent standardised operating structure for corporate functions, including people and culture, finance, commissioning, hospital and specialist, data and digital and infrastructure.
<b>3.1.3a: Establish national strategic networks in the priority areas of:</b> <ul style="list-style-type: none"> <li>• Pae ora / Better health in our communities</li> <li>• Kahu Taurima / Maternity and early years</li> </ul>	Reworded to: Establish cross sector teams to design improved health outcomes and address equity of access in priority areas: <ul style="list-style-type: none"> <li>• Better health in our communities / Pae ora</li> </ul>

Te Pae Tata action	Change
<ul style="list-style-type: none"> <li>• Māuiuitanga taumaha / People living with chronic health conditions</li> <li>• Oranga hinengaro   People living with mental distress, illness and addictions</li> </ul>	<ul style="list-style-type: none"> <li>• Maternity and early years / Kahu taurima</li> <li>• People living with chronic health conditions / Māuiuitanga taumaha</li> <li>• People living with mental distress, illness and addictions / Oranga hinengaro</li> </ul>
<p><b>3.1.6c: Implement a programme of pro-equity service planning to inform infrastructure, workforce, digital and transport. This will include regional service planning and individual national specialist service plans in agreed priority areas.</b></p>	<p>Reworded to: Develop Regional Health Services Plans.</p>
<p><b>3.4.1: Review the Primary Response in Medical Emergencies model with ACC and develop integrated and responsive rural ambulance programmes to improve access to primary and community care services.</b></p>	<p>Reworded to: Design a rural unplanned, urgent care system that is responsive to rural communities' needs and results in equity of both access and outcomes.</p>
<p><b>3.7.2b: Deliver a National Asset Management Strategy and Capital Investment Plan by December 2023 including the information solution strategy, requirements and road map for asset management and investment analysis.</b></p>	<p>This was reworded to split out into three separate actions:</p> <p>3.7.2b: Deliver a National Asset Management Strategy by December 2023.</p> <p>3.7.2c: Deliver an Infrastructure Investment Plan by December 2023.</p> <p>3.7.2d: Develop the information strategy, requirements and road map for asset management and investment analysis.</p>
<p><b>4.1.5b: Develop local urban and rural community networks, including NZ Police, to support people who are in mental distress or experiencing an acute mental health and addiction episode</b></p>	<p>Reworded to: Ensure the effective links/pathways between mental health crisis services, NZ Police and other social services in rural and urban areas to address the needs of people who present as acutely distressed.</p>
<p><b>4.1.6b: More Māori are in leadership and decision-making roles in Health NZ and Te Aka Whai Ora.</b></p>	<p>Consolidated into action 1.3.1. Increase the number of Māori, Pacific Peoples and disabled people in leadership and decision-making roles across the system.</p>
<p><b>4.1.10a: Support educational interventions to increase Māori access to health professionals training within the tertiary sector.</b></p>	<p>Consolidated into action 1.2.1. Implement a programme to grow the numbers and diversity of the health workforce, including Māori, Pacific Peoples and disabled people to address critical workforce gaps identified by the Workforce Taskforce.</p>

Te Pae Tata action	Change
<p><b>4.1.10b: Support health sector interventions to increase the number and type of Māori health workers within the current workforce.</b></p>	<p>Consolidated into action 1.2.1. Implement a programme to grow the numbers and diversity of the health workforce, including Māori, Pacific Peoples and disabled people to address critical workforce gaps identified by the Workforce Taskforce.</p>
<p><b>4.1.10c: Set mandatory education for te Tiriti o Waitangi, equity, racism and bias for the whole health workforce to ensure they can deliver culturally safe and culturally competent healthcare.</b></p>	<p>Consolidated into action 1.2.6. Establish, implement and monitor a coherent approach for te Tiriti o Waitangi, equity and cultural safety education and training for our workforce.</p>
<p><b>4.2.3g: Support ongoing work across the sector to reduce current cancer health inequities of Pacific Peoples and families:</b></p> <ul style="list-style-type: none"> <li>• <b>Urgently address the decline in Pacific people’s breast, bowel and cervical cancer screening rates and ensure Pacific people with a diagnosis get the care needed.</b></li> <li>• <b>Work with relevant Northern / Te Tai Tokerau health providers and health leaders to provide sufficient resource and ongoing support for a consistent approach to the early diagnosis and treatment of endometrial cancer.</b></li> <li>• <b>Work with Te Aho o Te Kahu to develop closer to home care principles for cancer patients and their aiga.</b></li> </ul>	<p>Reworded to: Support ongoing work across the sector to reduce current cancer health inequities of Pacific people and families</p> <ul style="list-style-type: none"> <li>• Urgently address the decline in Pacific people’s breast, bowel and cervical cancer screening rates and ensure Pacific people with a diagnosis get the care needed.</li> <li>• Work with relevant Northern / Te Tai Tokerau health providers and health leaders to provide sufficient resource and ongoing support for a consistent approach to the early diagnosis and treatment of endometrial cancer.</li> <li>• Work with Te Aho o Te Kahu to develop closer to home care principles for cancer patients and their aiga.</li> <li>• Work with Northern / Te Tai Tokerau health providers, health leaders and researchers to develop maternal mental health models of care for Pacific women; to be implemented as part of Kahu Taurima.</li> </ul>
<p><b>4.2.3h: Work with Northern / Te Tai Tokerau health providers, health leaders and researchers to develop maternal mental health models of care for Pacific women; to be implemented as part of maternity and early years.</b></p>	<p>Consolidated into 4.2.3(g). Support ongoing work across the sector to reduce current cancer health inequities of Pacific Peoples and families:</p> <ul style="list-style-type: none"> <li>• Urgently address the decline in Pacific people’s breast, bowel and cervical cancer screening rates and ensure Pacific people with a diagnosis get the care needed.</li> <li>• Work with relevant Northern / Te Tai Tokerau health providers and health leaders to provide sufficient resource and ongoing support for a consistent approach to the early diagnosis and treatment of endometrial cancer.</li> </ul>

Te Pae Tata action	Change
	<ul style="list-style-type: none"> <li>• Work with Cancer Control Agency / Te Aho o Te Kahu to develop closer to home care principles for cancer patients and their aiga.</li> <li>• Work with Northern / Te Tai Tokerau region health providers, health leaders and researchers to develop maternal mental health models of care for Pacific women; to be implemented as part of Maternity and early years.</li> </ul>
<p><b>4.3.1a: Establish accessibility standards for all new builds, new contracts and new services including transport and mobility options, and develop a plan for existing infrastructure, services and environments to be compliant with new standards.</b></p>	<p>Consolidated into action 3.7.2(e). Develop design standards for Aotearoa health facilities, contributing to and building on the Australasian Health Facility guidelines.</p>

# Appendix 2: Independent Auditor's Report

AUDIT NEW ZEALAND  
Mana Arotake Aotearoa

## Independent Audit Report

### To the readers of the performance report against the interim New Zealand Health Plan | Te Pae Tata for the two years ended 30 June 2023 and 30 June 2024

#### Introduction

Health New Zealand | Te Whatu Ora (Health New Zealand) is required by the Pae Ora (Healthy Futures) Act 2022 (the Act) to prepare an annual performance report against the New Zealand Health Plan (the Health Plan).

An interim Health Plan | Te Pae Tata (Te Pae Tata) was in place from 1 July 2022 and applied until the first New Zealand Health Plan took effect on 1 July 2024. Until the disestablishment of Te Aka Whai Ora | Māori Health Authority (Te Aka Whai Ora) on 30 June 2024, Health New Zealand and Te Aka Whai Ora shared responsibility for Te Pae Tata and reporting against Te Pae Tata. The Act required that Te Pae Tata be treated as if it were the New Zealand Health Plan.

Health New Zealand has combined the reporting against Te Pae Tata for the years ended 30 June 2023 and 30 June 2024 into a report of performance against Te Pae Tata covering the period 1 July 2022 to 30 June 2024 (the performance report).

The Act requires the Health Plan, among other things, to identify desired improvements in health outcomes and their priorities and specify, where appropriate, measurable outcomes for the identified priorities. The Act requires a performance report against the Health Plan to include an assessment of the performance of Health New Zealand against outcomes specified in the Health Plan (that is, against the measurable outcomes specified in the Health Plan, if any). The assessment must include an evaluation of any new interventions or services for Māori health that Health New Zealand has provided or funded.

Te Pae Tata identified priorities for improving health outcomes but did not specify any measurable outcomes. Therefore, the performance report does not include an assessment of performance against specified outcomes. The performance report does however contain an assessment of performance under the six priority actions, including detailed actions and performance measures, that were specified in Te Pae Tata.

The Auditor-General is required by the Act to audit the performance report. The Auditor-General has appointed me, Stephen Lucy, using the staff and resources of Audit New Zealand, to carry out, on his behalf, the audit of the performance report for the two years ended 30 June 2024.

## Disclaimer of Opinion

Because of the significance of the matters discussed below in the *Basis for Disclaimer of Opinion* section of our report, we are not able to form an opinion on whether the performance report provides, in all material respects, an appropriate assessment of the performance for the two years ended 30 June 2024 of Health New Zealand and Te Aka Whai Ora against the actions and performance measures specified in Te Pae Tata.

Our audit was completed on 12 December 2025.

## Basis for Disclaimer of Opinion

The performance report contains reporting against the actions specified in Te Pae Tata. We identified the following main issues with the reporting:

- *Unclear actions and link to performance reporting.* Many of the actions specified in Te Pae Tata (and repeated in the performance report) were not clearly defined and lacked targets or milestones against which they could be measured. This lack of specificity meant that that the reporting in the performance report could not be linked to those actions.
- *Unable to assess the scoring of the outcomes:* In cases where it is unclear what the action was, and/or how the reporting linked to the action, we could not assess whether the categorisation of performance against the actions as red, orange, or green was appropriate.

The performance report also contains reporting against the performance measures specified within appendix three of Te Pae Tata. Although the measures support the priority actions, Te Pae Tata did not clearly link the measures to the actions contained within Te Pae Tata. The performance report has not remedied this lack of linkage. Many of the performance measures in Te Pae Tata lacked targets against which performance could be measured. Therefore, the performance report is not clear whether performance was achieved or not (as there was no expected level to report against).

As a result of these matters, we are unable to form an opinion as to whether the performance report provides, in all material aspects, an appropriate assessment of the performance of Health New Zealand against the actions and performance measures specified in Te Pae Tata.

We carried out the audit in accordance with the International Standard on Assurance Engagements (New Zealand) 3000 (Revised) *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information* (ISAE (NZ) 3000), issued by the New Zealand Auditing and Assurance Standards Board and elements of the Auditor-General's Auditing Standards, as appropriate.

## The responsibilities of the Board for the preparation of the performance report

The responsibility of Health New Zealand is to prepare an annual performance report.

The performance report must:

- provide an assessment of the performance of Health New Zealand against outcomes specified in Te Pae Tata; and

- include in the assessment an evaluation:
  - of any new interventions or services for Māori health that Health New Zealand has provided or funded; and
  - that is conducted in accordance with culturally relevant evaluation methods.

The responsibilities of Health New Zealand, and the required content of the performance report, are set out in section 52 of the Act.

### **Responsibilities of the auditor for the audit of the performance report**

We are required to audit the performance report, which is a responsibility set out in section 52(c) of the Act. To meet this responsibility, we planned and performed procedures to obtain reasonable assurance about the matters included in our opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAE (NZ) 3000, and elements of the Auditor-General's Auditing Standards will always detect a material misstatement.

The procedures selected, depend on our professional judgement, which includes considering the risks of material misstatement in the annual performance report. The planned procedures included:

- assessing the systems, processes and controls applied to prepare the annual performance report;
- evaluating the appropriateness of the approach to determining the performance measures and case studies selected to illustrate progress, including any interventions or services for Māori health;
- assessing whether the measurement bases or evaluation methods provide for relevant, reliable, and neutral assessment;
- assessing whether the performance information is prepared in accordance with the measurement bases or evaluation methods as selected by Health New Zealand;
- considering, where relevant, the evidence obtained from the annual audits of Health New Zealand; and
- considering the content and overall presentation, coherence, and clarity of the annual performance report.

However because of the significance of the matters described in the *Basis for Disclaimer of Opinion* section of our report, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an opinion on the performance report.

## Independence and quality management

We are independent of Health New Zealand in accordance with the independence requirements of the Auditor-General's Auditing Standards.

In carrying out this audit, we have complied with the Auditor-General's:

- Independence and other ethical requirements, which incorporate the requirements of Professional and Ethical Standard 1 *International Code of Ethics for Assurance Practitioners (including International Independence Standards) (New Zealand)* (PES 1) issued by the New Zealand Auditing and Assurance Standards Board. PES 1 is founded on the fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.
- Quality management requirements, which incorporate Professional and Ethical Standard 3 *Quality Management for Firms that Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements* (PES 3) issued by the New Zealand Auditing and Assurance Standards Board. PES 3 requires us to design, implement and operate a system of quality management including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In addition to this audit, we have carried out other audit and assurance engagements relating to Health New Zealand, which are compatible with these Standards. These other engagements have not impaired our independence. In addition, we use publicly funded health services on the same basis as others. Other than these matters, we have no relationship with or interests in Health New Zealand.



S B Lucy  
Audit New Zealand  
On behalf of the Auditor-General  
Wellington, New Zealand

## Appendix 3: Glossary of terms, acronyms and translations

Term	Definition
ACC	Accident Compensation Corporation
aiga	Family
DHB	District Health Boards (no longer in operation)
Fatu Fono Ola	National Pacific Health Senate
GP	General Practice
hauora	Health
Hira	National digital exchange platform for health information
HIV	Human immunodeficiency virus
HPV	Human papilloma viruses
IMPB	Iwi Māori Partnership Board
Iwi	Extended kinship group, tribe, national, people, nationality, race
kahu taurima	Maternity and early years
Kaupapa Māori	The knowledge, attitudes and values that are inherently Māori as held and followed by hapū and Iwi. This is synonymously linked to mātauranga Māori and underpinned by te Tiriti o Waitangi, self-determination, cultural validity, culturally preferred teaching, socioeconomic mediation of Māori disadvantage, whānau connections, collective aspirations, and respectful relationships underpinned by equality and reciprocity
kaiāwhina	Helper, assistant, contributor, counsel, advocate, supporter
kura kaupapa	Māori language immersion schools in New Zealand
mate pukupuku	People with cancer
māuiuitanga taumaha	People living with chronic illness
mātauranga Māori	Māori knowledge systems that reflect indigenous ways of thinking, relating and discovering. This links indigenous peoples with their environments, is often inspired by environmental

Term	Definition
	encounters and is conveyed within the distinctiveness of indigenous languages and cultural practices.
NGO	Non-governmental organisation
NPHS	National Public Health Service
oranga hinengaro	People living with mental distress, illness and addictions
pae ora	Better health in our communities
tagata sa'ilimalo	Pacific term for the collective concept inclusive of families, carers and people with disabilities
tamariki	Children
tangata	To be a person, man, human being, individual
tangata whaikaha	Disabled people
taurite services	These are services that braid clinical and cultural care. They can be delivered by a Māori provider or a non-Māori provider. If delivered by a non-Māori provider, high-quality taurite services are delivered in partnerships with Māori.
Te Aho o Te Kahu	Cancer Control Agency
Te Aka Whai Ora	Māori Health Authority
te ao Māori	Māori world view
te ao Rereke	Hybrid learning package
Te Pae Tata	Interim New Zealand Health Plan 2022-2024
Te Pae Waenga	NZ Health Plan, currently in development
Te Whatu Ora	Health New Zealand
LINAC machine	A medical linear accelerator directs beams of radiation into tumours to treat people with cancer
wāhine	Women
Whaikaha	Ministry of Disabled People
whānau	Family

## Appendix 4: Related reports

Health and Disability system Review: Final Report 2020

<https://www.health.govt.nz/publications/health-and-disability-system-review-final-report>

Health and Disability System Reform – Implementation and Transitional Arrangements 2021

<https://www.dPMC.govt.nz/sites/default/files/2021-12/cabinet-material-health-disability-reform-nov21-updated.pdf>

Pae Ora (Healthy Futures) Act 2022

<https://www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx>

Interim Government Policy Statement on Health 2022/24

<https://www.health.govt.nz/publications/interim-government-policy-statement-on-health-2022-2024>

Te Pae Tata Interim New Zealand Health Plan 2022

<https://www.tewhātuora.govt.nz/publications/te-pae-tata-interim-new-zealand-health-plan-2022>

Review of the process underlying publication of clinical data on the website of Te Whatu Ora April 2023

<https://www.tewhātuora.govt.nz/assets/About-us/News-and-updates/Clinical-Data-Review-Report.pdf>

Ministerial Advisory Committee for Health Reform Implementation November 2023

<https://www.health.govt.nz/about-us/new-zealands-health-system/health-system-roles-and-organisations/health-committees-and-boards/other-health-committees/ministerial-advisory-committee-on-health-reform-implementation>

Te Aka Whai Ora / Māori Health Authority Annual Report 2022/23

<https://www.tewhātuora.govt.nz/publications/download202223-te-aka-whai-ora-maori-health-authority-annual-report>

Te Whatu Ora / Health New Zealand Annual Report 2022/23

<https://www.tewhātuora.govt.nz/publications/download202223-te-aka-whai-ora-maori-health-authority-annual-report>

Te Aka Whai Ora / Māori Health Authority Annual Report 2023/24

<https://www.tewhātuora.govt.nz/publications/download202223-te-aka-whai-ora-maori-health-authority-annual-report>

Te Whatu Ora / Health New Zealand Annual Report 2023/24

<https://www.tewhātuora.govt.nz/publications/health-new-zealand-te-whatu-ora-annual-report-purongo-a-tau-2023-2024>

Health NZ Financial Management Review December 2024

<https://www.tewhātuora.govt.nz/assets/Uploads/HNZ-Financial-Review-Report.pdf>

