Health New Zealand
Te Whatu Ora

New Zealand Health Plan
Te Pae Waenga

Timely access to quality health care

1 July 2024 – 30 June 2027

Our journey to Pae Ora began in 2022 with a vision inspired by the Tongikura of Kīngi Tāwhiao, "E kore tēnei whakaoranga e huri ki tua o aku mokopuna – Our mokopuna shall inherit a better place than I inherited".

We acknowledge this past, including the decades of prior mahi that prepared us for our current journey. We honour those holding the vision of an improved health system and those who strived to advance the health of Māori.

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Commissioner's Foreword

Tēnā koutou katoa

I am pleased to present the New Zealand Health Plan | Te Pae Waenga which outlines actions to deliver better health outcomes for all New Zealanders. I am personally deeply committed to doing everything I can to ensure we deliver more healthcare for New Zealanders.

In supporting the Pae Ora (Health Futures) Act 2022, our role at Health New Zealand | Te Whatu Ora is to deliver quality, compassionate and affordable healthcare to New Zealanders. This plan sets out how we will achieve these objectives.

In July 2024 I was appointed Commissioner by the Minister of Health, who tasked me with restoring the performance of Health NZ and returning the organisation to living within its means and providing timely access to quality health care.

Health NZ received funding increases in both Budget 2023/24 and 2024/25 - we are focused on using all of our funding effectively to strengthen the clinical frontline, deliver more health services and achieve better health outcomes.

Our Health Delivery Plan operates alongside this plan. It articulates how we are implementing a reset to fundamentally change how we operate, with a primary focus on reducing wait times for assessments and treatments so that New Zealanders can get the health care they need.

This is not limited to emergency departments and planned care – it is about making changes to the flow of patients across the entire health system. The safest wait is the shortest wait. Every patient, family and community should have access to the best possible care and treatment in a timely and accessible way and we will be working hard to achieve that.

Our committed and skilled health workforce will be supported and empowered to deliver high-quality and compassionate health care to communities. We have more work to do to create a clinical culture that delivers more and better healthcare and ensures work is rewarding for all.

We have empowered regions to make decisions closer to home about how health care is delivered for local communities. Four regional leadership roles are responsible for these devolved services with a focus on delivering the health targets as well as the mental health and addiction targets. They are also charged with restoring Health NZ's financial performance by getting the organisation back to budget.

We are committed to making tangible, year-on-year progress and delivering for New Zealanders.

Professor Lester Levy
Commissioner

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Introduction

The New Zealand Health Plan | Te Pae Waenga (the plan) is the three-year plan legislated under the Pae Ora (Healthy Futures) Act 2022 for Health New Zealand | Te Whatu Ora (Health NZ). This plan outlines the actions Health NZ will deliver to ensure a fair system and improve health outcomes for all New Zealanders, including populations with greater needs. The purpose of the Pae Ora Act and our health system is to:

- Protect, promote, and improve the health of all New Zealanders,
- Achieve equity in health outcomes among New Zealand's population groups, including eliminating disparities; especially for Māori, and to
- Build towards pae ora (healthy futures) for all New Zealanders.

The plan gives effect to the government health priorities set out in the Government Policy Statement on Health 2024-2027 (GPS) within the funding allocated for publicly-funded health services. After addressing the more than 64 GPS expectations, we have limited ability to make meaningful additional investments. The GPS has effectively acted as our prioritisation / trade-off framework for the actions included in this plan.

Central to the GPS is achieving timely access to quality health care with five priority areas: Access, Timeliness, Quality, Workforce and Infrastructure. Five health and five mental health targets have been introduced in the GPS to focus the health system on outcomes. Implementation plans for both sets of targets form part of this plan. See section 1.

The GPS identifies five modifiable risk factors that contribute to poor health or illness: tobacco, alcohol, poor nutrition, physical inactivity, and adverse social and environmental factors. Five long-term conditions, also outlined in the GPS, are responsible for around 80 per cent of all deaths in New Zealand and a considerable amount of health loss (ill health and early death). They are cancer, diabetes, cardiovascular disease, respiratory disease, and mental health and addictions issues.

We will work with organisations across government to reduce exposure to modifiable risk factors which can impact the development of long-term conditions.

From Te Pae Tata to Te Pae Waenga

The Te Pae Tata Interim New Zealand Health Plan 2022 created the foundations to start our journey towards pae ora to improve the health and wellbeing of communities.

This plan is named Te Pae Waenga in recognition of the next stage in this 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 our ascent, giving us the opportunity to reflect, learn and consolidate our work.

Te Pae Waenga builds on the achievements started through Te Pae Tata with each step taking us closer to Te Pae Tawhiti, our destination.

Strategic context

The context for this plan is shown in our strategic framework (Table A, page 10). It shows the connections between the Act, our statutory objectives, the Government's vision, the New Zealand Health Plan | Te Pae Waenga, the strategic priorities in our Statement of Intent 2024 - 2028 (SOI), and the core services we deliver or fund other providers to deliver.

Our approach to planning

Health NZ was established in July 2022 and as a newly established entity it has much to do in developing nationally consistent policies, systems and practices – as such it is still early in its maturation journey. An integrated nationwide operational and financial planning approach is not yet fully developed. We anticipate it will take at least two three-year planning cycles to fully develop and implement systems and processes. This will enable us to fully understand and cost all aspects of the services we fund and deliver and the programmes we must undertake to improve these. We are undertaking regular capability assessments to understand how we are progressing toward building a mature, collaborative and well-planned entity.

The Pae Ora Act requires us to identify our desired improvements in health outcomes (improvements) and to prioritise these. The Health Status Report describes the current state of health of New Zealanders and assisted us in determining our desired improvements for equitable health outcomes. This plan is focused on actions to deliver these improvements, but it does not describe everything that we will do over the three-year period.

The improvements in health outcomes we are seeking are:

Long-term:
- Increased life expectancy
- Improved quality of life

Intermediate:
- Reduction of modifiable risk behaviours
- Reduction in the incidence of communicable diseases
- Reduction in severity, prevalence and reoccurrence of non-communicable diseases.

Our Entity Performance Framework (the Framework) on page 60 and 61, provides a clear line of sight on how we will know we have made measurable improvements in health outcomes.

Priorities for how we should go about achieving improvements in health outcomes are derived from the Government's priority areas for action outlined in the GPS (section 1.1):

- Access (A)
- Timeliness (T)
- Quality (Q)

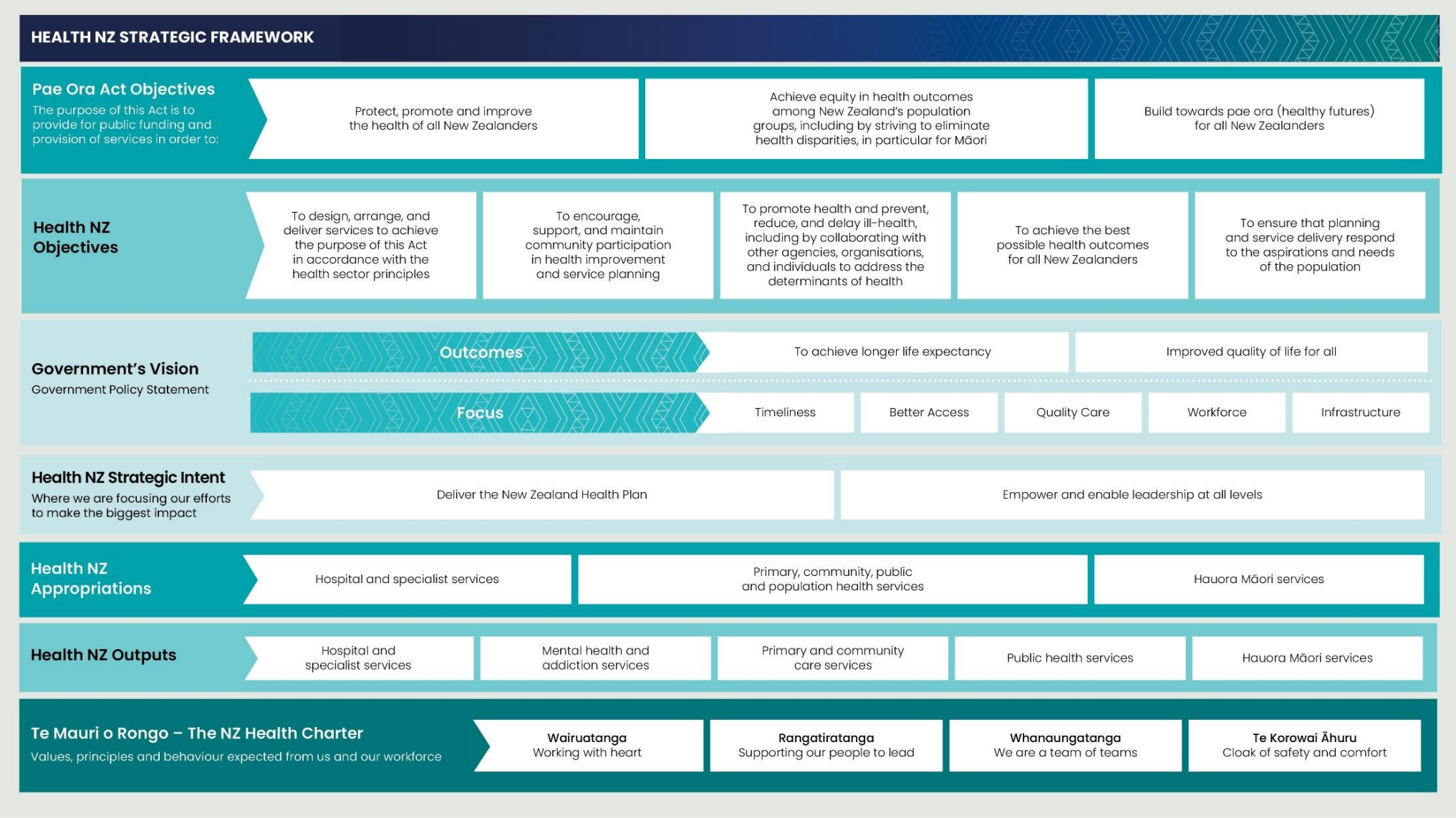
Throughout this plan (**A**), (**T**), or (**Q**) denotes actions that should contribute incrementally to these Government priorities. Action tables have columns showing which year(s) that activity will occur in.

Significant or measurable changes in our priorities for improvements may not become evident within a three-year cycle. However, we can track progress against the plan, including our actions, by monitoring the framework's measures. For more information see section 7. More information on how this plan was developed is in Appendix 1.

The Health Delivery Plan (March 2025 to June 2026) is specifically designed to change and re-set our core operations. It sits alongside the NZ Health Plan and covers how we achieve the health targets, improve access to services, support local delivery, partner with clinicians, get us back to budget and prepare for the future. See section 6 for more information.

This plan should be read in conjunction with the annual SPE for the respective year, and the SOI. Implementation of this plan is identified as a strategic priority in our SOI.

Table A: Our Strategic Framework for 2024-2027



Government health priorities for Māori

The Pae Ora Act gives Health NZ its power to operate, with a strong focus on achieving equity in health outcomes. It requires us:

- To be guided by the health sector principles which, among other things, are aimed at improving the health sector for Māori and improving hauora Māori health outcomes;
- To maintain systems and processes to ensure we have the capacity and capability to understand Te Tiriti o Waitangi, mātauranga Māori and Māori perspectives of services.

Health NZ acknowledges the enduring inequity in health outcomes experienced by some population groups in New Zealand, including Māori. The Pae Ora Act acknowledges those populations with specific strategies, including Pae Tū the Hauora Māori Strategy and Whakamaua: Māori Health Action Plan 2020-2025, intended to improve the health sector for Māori and improving Māori outcomes.

The Government's priorities in the GPS have a strong focus on improving health outcomes for Māori, with Iwi Māori Partnership Boards (IMPBs) playing an important role (see below). We will work closely with IMPBs in holding ourselves accountable for equitable outcomes. Inequitable health outcomes arise when our systems, practices and procedures present barriers for people or result in some groups being treated unfairly.

The Hauora Māori Advisory Committee also monitors the health system with assessments and advice provided to the Minister.

Iwi Māori Partnership Boards

IMPBs are provided for under the Pae Ora Act and enabled by Health NZ as one of the ways we give effect to Te Tiriti o Waitangi.

15 boards are currently recognised in accordance with processes set out in the Pae Ora Act. Two further organisations are in the process of becoming recognised. See the list and map of locations here.

As outlined in the Act, IMPBs must engage with communities, assess the state of hauora Māori, monitor health sector performance, and work with Health New Zealand | Te Whatu Ora to develop priorities for improving hauora Māori.

From January 2025, IMPBs became part of business planning, service design and service monitoring within Health NZ. From July 2025, they will be supported to influence the planning, design and monitoring of health services in line with their Community Health Plan priorities.

The IMPB functions represent critical steps in an end-to-end commissioning cycle. IMPBs are not hauora Māori providers nor do they deliver health services.

The Pae Ora Act also requires Health NZ to develop meaningful relationships with Māori to ensure their needs and aspirations inform the performance of its functions and the development of the health system. To do this, Health NZ:

- Provides administrative, analytical, financial support where needed; and
- Provides sufficient and timely information; and
- Engages with IMPBs when determining priorities for kaupapa Māori investment.

In addition to IMPBs, Iwi across the motu can work directly with Health NZ. In some cases, these engagements are supported by iwi accords and relationship agreements. We have further mechanisms in place for local Māori perspectives, including Māori representation on:

- Whānau, Consumer and Clinical Digital Council.
- Regional whānau consumer networks.
- Whānau community groups for rangatahi, kaumatua, wāhine, lived experience, Rainbow and whaikaha.
- Māori partner network.
- Health Quality and Safety Commission consumer group.

Our regions

Our four regions (see below) are the connection between national and regional planning and local delivery of care.

Leadership roles in each region are responsible for ensuring the delivery of quality services to the communities they serve. This includes a focus on achieving the Government's national health targets and mental health and addiction targets.

Our regions are progressively being devolved responsibility over resource allocation, tailoring services to meet local needs while still aligning with the national strategic direction. Regions are taking on greater accountability for outcomes, with clearer support from governance frameworks.

They will also see enhanced collaboration with local teams, fostering innovation and responsiveness to community demands. Regions will have a stronger voice in shaping national policies, ensuring that local realities are reflected in broader strategic decisions.

Our aim is for regional decision-making to be informed by strong clinical leadership and community and whanau voices, to reflect local needs. This includes the regions working closely with IMPBs and a range of other government services and agencies.

IMPBs have developed Community Health Plans, which outline how they will fulfil their legislative functions in their communities over the next three to five years. This includes a prioritised local needs assessment, identifying Māori community health priorities, influencing the commissioning of services and fulfilling accountability arrangements.

Many actions throughout this plan are developed or delivered regionally including:

- Cancer medicine access: developing a model supporting regional delivery.
- Communicable disease regional outbreak models and processes.
- Data services products developed regionally to support integrated care.
- Infrastructure and Investment Group operating model.
- Regional planning informed by assessment of our health system resilience to climate events.
- Actions for populations with greater needs, including Māori, Pacific People and disabled people.
- Regional input to the Kahu Taurima revised framework for maternity and early years.

Figure 1: The four Health NZ regions

Northern comprises Northland, Te Toka Tumai, Auckland, Waitematā and Counties Manukau. This covers our largest city and has a substantial rural population.

Te Manawa Taki means ‘the heartbeat,’ a name gifted and agreed to represent Bay of Plenty, Hauora Tairāwhiti, Lakes, Taranaki and Waikato. Te Manawa Taki in this context means ‘always ready to go’.

Central | Te Ikaroa covers Whanganui, Capital Coast, Hutt Valley and Wellington, Hawke’s Bay, Mid-Central and Wairarapa.

Te Waipounamu means ‘water and greenstone’ and is the only place pounamu is found in New Zealand. This region covers Te Waipounamu | South Island, Rakiura | Stewart Island and Rēkohu | Chatham Islands.

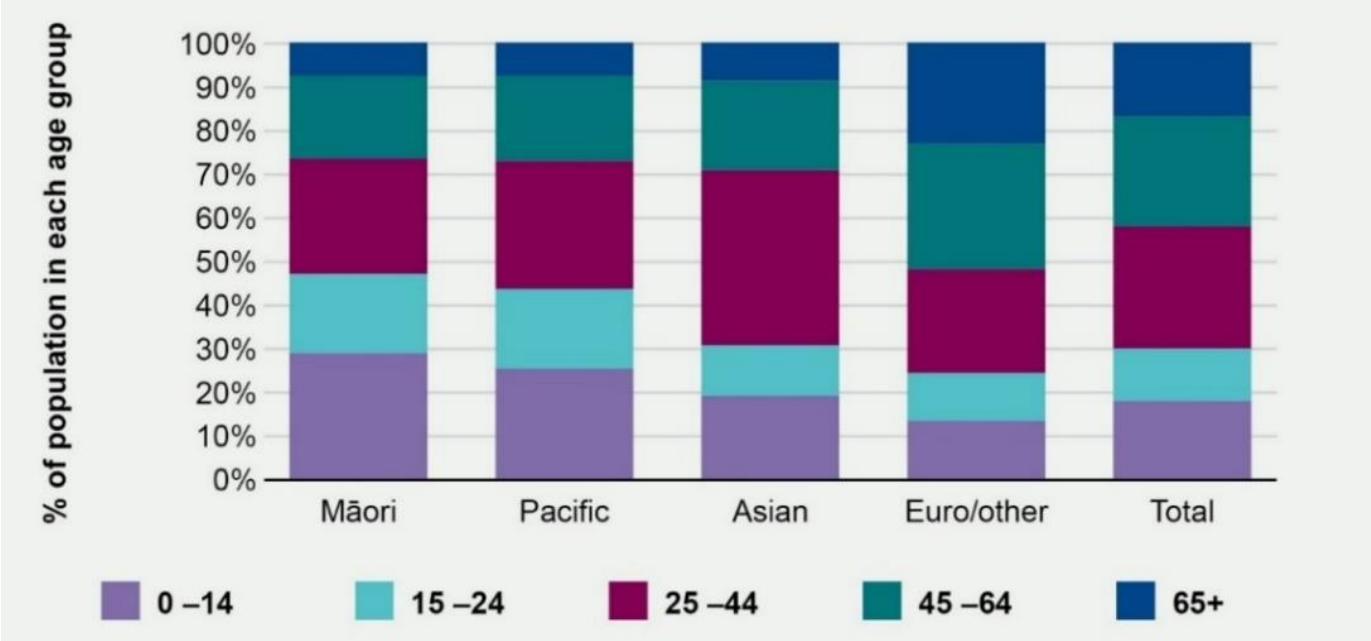
Health status of New Zealanders

The Health Status Report informs our priorities for improvements described in this plan, with key indicators for current health and wellbeing of New Zealanders summarised in this section. The report brings together data about the population and the wider contributors to health and wellbeing (determinants). It outlines preventable risk and protective factors for health conditions, the status of people's health, and use of health services.

Factors such as income, housing, education, racism, ableism, and timely access to quality health care are powerful determinants of health and wellbeing. Important protective factors include connection to community, cultural identity, social capital and social cohesion.

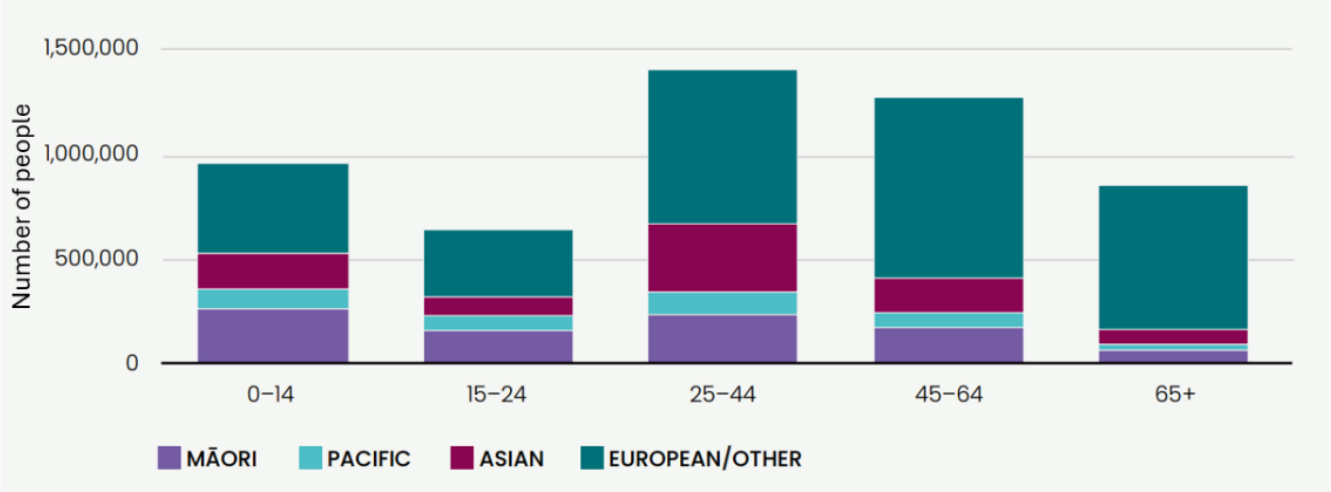
Our population – who we are and what impacts our health

Figure 2: Age structure in each age group by ethnicity, national, 2022/23 [1]



[1], [2] Statistics NZ population projections based on 2018 Census, 2022 update

Figure 3: Population size in each age group by ethnicity, national, 2022/23 [2]



Ethnic diversity

New Zealand's population is becoming more ethnically diverse:

- Māori 17 per cent and growing;
- Pacific 7 per cent and growing;
- Asian 16 per cent and growing;
- European / Other people 59 per cent and declining.

Disability

- Almost one in four people report having a disability.
- Tāngata whaikaha | disabled people experience barriers to accessing health services and poorer health outcomes.
- In the 2019/20 NZ Health Survey, disabled adults were less likely to rate their health as excellent, very good or good.

Key demographics

- New Zealand's population in 2022/23 was 5.1 million. Our population continues to get older – 17 per cent of the population (around 850,000 people) are aged 65 years and over, and that is expected to increase to around 1.3 million (22 per cent) by 2042/43.

- Māori and Pacific Peoples have a younger age profile than European/other people. Increasing investment early in the life course (first 2000 days / Kahu Taurima) is a key strategy toward improving equitable health outcomes.
- Almost one in five New Zealanders, just under one million people, live in rural areas. A higher proportion of Māori live in rural areas (23 per cent) than urban areas (16 per cent). Rural communities also have a larger proportion of people aged 65 years and over.

Key modifiable risk factors contributing to avoidable health loss and inequities in health outcomes include:

- tobacco
- alcohol
- poor nutrition
- physical inactivity
- adverse social and environmental factors.

Other important factors are healthy weight and social connection. Key aspects to improving the population's health and achieving equity in health outcomes are addressing risk factors, reducing exposure to unhealthy environments, and increasing people's connection to their culture and community.

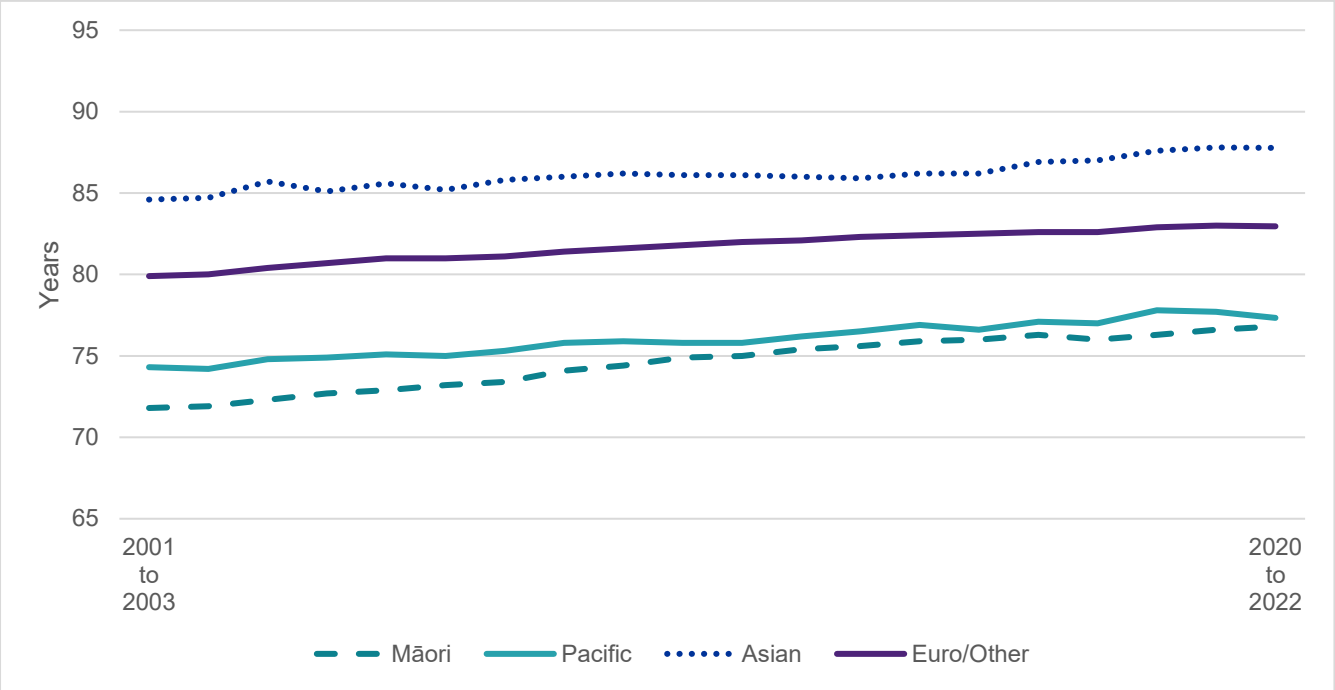
Main health condition (disease) contributors to health loss and inequities in health outcomes include:

- cancer
- cardiovascular diseases
- diabetes
- chronic respiratory diseases
- mental distress and illness, and substance use.

Other important causes of health loss include bone and muscle conditions (and associated chronic pain and impairment), injuries (particularly for our children and young people) and nervous system conditions such as dementia.

The main contributors to health loss are different at different stages of life. For children and young people, the biggest contributors to health loss include Sudden Unexpected Death in Infancy (SUDI), neurodevelopmental disorders, congenital disorders, skin and respiratory infections and disease, injuries, anxiety disorders, self-harm, and suicide.

Figure 4: Trend in life expectancy at birth by ethnicity, 2001-03 to 2020-22 [3]



Our health status compares well internationally, and we continue to make gains in life expectancy, but there are still unacceptable gaps between population groups. The largest gap in equitable health outcomes for life expectancy continues to be for Māori (seven years) and Pacific Peoples (six years). Eighty-one per cent of Māori and 83 per cent of Pacific Peoples rate their health as excellent, very good or good compared with 88 per cent of adults overall.

Populations most disadvantaged by health outcome inequities

The Health Status Report identifies groups with specific needs who experience greater and unfair exposure to preventable risk factors and have poorer health outcomes.

Most health loss and inequities are caused by differences in the level of exposure to the determinants of health and modifiable risk factors. Populations with greater needs who experience significant health inequities include Māori, Pacific Peoples and disabled people.

Rural communities, women, Rainbow community members, refugee communities, and ethnic communities also have specific needs that impact their health. People belonging to more than one group may experience even greater health loss and health inequity.

Section 4 focuses on actions to improve health outcomes for populations with greater needs.

[3] Calculation from Statistics NZ life tables, three-year rolling averages

Mobile breast screening unit in Pātea.

Section 1: Government priorities for health in New Zealand

1.1 Timely access to quality health care

The Government has determined priority areas for action through the GPS, including targets for both physical and mental health.

These areas for action to meet access, timeliness and quality, are supported by workforce and infrastructure enablers (see Section 3).

Access	Ensure that every person, regardless of where they live in New Zealand, has equitable access to the health care and services they need.
Timeliness	Ensure that people can access the health care and services they need, when they need it in a prompt and efficient way.
Quality	Ensure that health care and services delivered in New Zealand are safe, easy to navigate, understandable and welcoming to users, and are continuously improving.
Workforce	Develop a skilled and culturally capable workforce who are accessible, responsive, and supported to deliver safe and effective health care.
Infrastructure	Ensure that the health system is resilient and has the digital and physical infrastructure it needs to meet people's needs now and into the future.

1.2 Five health targets

The Government has established five health targets to improve health system performance. Meeting these targets requires the combined effort of primary and community services, and hospital and specialist services. This includes services such as radiology and laboratory, which help with diagnosis and treatment.

Table B: Five physical health targets and their annual performance milestones

Health target	Performance milestones 2024/25	2025/26	2026/27
Faster cancer treatment			
90% of patients to receive cancer management within 31 days of the decision to treat.	86%	87%	88%
Improved immunisation			
95% of children fully immunised at 24 months of age.	84%	87%	90%
Shorter stays in emergency departments			
95% of patients to be admitted, discharged or transferred from an emergency department within six hours.	74%	77%	80%
Shorter wait times for first specialist assessment			
95% of patients wait less than four months for a first specialist assessment.	62%	65%	70%
Shorter wait times for elective treatment			
95% of patients wait less than four months for elective treatment.	63%	67%	71%

Our Health Target Implementation Plan forms part of this plan. It will contribute towards our priority improvements of timeliness, access and quality. We will ensure that activity to achieve targets considers the impact for populations with greater needs. Inequities can worsen without a dedicated focus on having the right interventions at the right time and in the right place.

1.3 Five mental health and addiction targets

The Government has set five specific targets related to mental health, addiction and suicide prevention, and appointed the first dedicated ministerial portfolio for Mental Health. Over the next three years we will:

- Increase access to mental health and addiction support;
- Grow the mental health and addiction workforce;
- Strengthen the focus on prevention and early intervention;
- Improve the effectiveness of mental health and addiction support.

Table C: Five mental health targets and their annual performance milestones

Target	Performance milestones 2024/25	2025/26	2026/27
Faster access to specialist mental health and addiction services			
80% of people accessing specialist mental health and addiction services are seen within three weeks.	80% (under 25s - 72%)	80% (under 25s - 75%)	80% (under 25s - 78%)
Faster access to primary mental health and addiction services			
80% of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week.	Establish data collection and set baselines	80% (or an increase from baseline)	80% (or an increase from baseline)
Shorter mental health and addiction-related stays in emergency departments			
95% of mental health and addiction-related emergency department presentations are admitted, discharged or transferred from an emergency department within six hours.	74%	77%	80%
Increased mental health and addiction workforce development			
Train 500 mental health and addiction professionals each year.	Confirm baseline	500	500
Strengthened focus on prevention and early intervention			
25% of mental health and addiction investment is allocated towards prevention and early intervention.	Confirm baseline	TBC	TBC

Our Achieving the mental health and addition targets – High-level implementation plans form part of this plan.

Where possible, our performance reporting against the ten health and mental health targets will be broken down by ethnicity, district and region. Over time we will aim to expand this breakdown to include gender, health condition and urban / rurality. This will help us to identify any unwarranted variation in service use and health outcomes.

1.4 A stronger focus on prevention

Keeping people well in their communities is better for them and the health system. We can reduce the chance of people becoming unwell and needing hospital treatment. We do this by prioritising prevention and promoting wellbeing across the life course, with a focus on the early years.

Many prevention decisions and activities occur in central and local government, communities and across various sectors.

This plan describes Health NZ's involvement across the range of prevention activities:

- **Preventing disease risk factors:** addressing the environmental, social, economic and commercial factors that influence health, collectively called the determinants of health. This includes education, employment, income, housing and climate.
- **Preventing onset of disease (non-communicable and communicable) or injury:** immunisation, preventative oral health services and reducing exposure to risk factors such as tobacco, alcohol and other harmful substances.
- **Early detection to improve the chances for positive health outcomes:** screening of people without symptoms, improvements in timeliness and access for people with specific symptoms, and actions to manage risks such as cardiovascular disease risk.
- **Rehabilitating and restoring function after disease or injury:** managing existing conditions and screening to prevent complications or further damage (for example, retinal eye screening for people with diabetes).

1.5 Focus on five modifiable risk factors

Five key modifiable risk factors contribute to poorer health or illness: tobacco, alcohol, poor nutrition, physical inactivity, and adverse social and environmental factors. Addressing the determinants of health is key to influencing these modifiable risk factors and achieving health equity.

Our focus in this part of the plan is helping people to quit smoking and reducing harm from alcohol, contributing to our improvements. We support Smokefree 2025 by implementing this programme's action plan. This includes actions in health promotion, support for stopping use and complying with legislation.

We aim to reduce the availability and social acceptance of alcohol and address fetal alcohol spectrum disorder (FASD) with several initiatives, including those funded by the alcohol levy. The levy enables recovery of some of the costs of addressing the harm caused by alcohol, including programmes to prevent harm and address FASD.

We continue to address the modifiable risk factors of poor nutrition, physical inactivity, and adverse social and environmental factors. A wide range of programmes are focused on improving the environments where people live, learn, work and play, and on supporting people to live healthier lives. (See also the Mental health, addiction and wellbeing section 1.6.1)

We work across sectors to implement health promotion and community-based approaches and to provide public health advice through a 'Health in All Policies' approach.

Table D: Addressing modifiable risk factors **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	2024/25 – 2026/27 Year 1	Year 2	Year 3
1.5.1 Reduce harm from tobacco, vaping and alcohol through implementation of the refreshed Smokefree 2025 Plan and strengthening compliance and regulatory approaches. (A)	✓	✓	✓
1.5.2 Support the development and implementation of a refreshed Fetal Alcohol Spectrum Action (FASD) plan. (T, Q)	✓	✓	✓

1.6 Focus on five long-term conditions

One in four New Zealanders live with multiple long-term conditions. Five key conditions are responsible for around 80 per cent of all deaths from long-term conditions and a considerable amount of health loss (ill health and early death). They are cancer, diabetes, cardiovascular disease, respiratory disease, and mental health and addictions issues. These five conditions are also called non-communicable diseases.

They share many common causes, risk factors, and prevention and management opportunities. Whānau-centred models of care that bring care together for people with multiple health conditions are important.

Our close partnership with the Cancer Control Agency | Te Aho O Te Kahu will help to reduce differences in cancer screening, treatment and survival rates. The Health Target Implementation Plan outlines further actions on faster cancer treatment.

We are developing a national diabetes action plan, with a medium- to long-term view on key focus areas. Our aim is to improve early access, treatment and self-management, especially for Māori and Pacific Peoples.

Many cardiovascular conditions are preventable through addressing modifiable risk factors, especially living smokefree, access to nutritious food, and regular physical activity. Access to health services for early detection and treatment is important, including diagnosis and management of hypertension (high blood pressure).

Respiratory diseases affect the lungs and airways, making breathing difficult. Children are more greatly affected. Respiratory diseases account for one-third of all acute hospital admissions for children. Three-quarters of these are children under five years of age.

Our improvements are achieved by helping slow disease progression through early detection and management of disease. Over time, investing early in life, addressing determinants, and addressing modifiable risk factors will reduce the number of people experiencing long-term conditions. Section 2 outlines further actions.

Table E: Actions to improve long-term conditions **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27**		
	Year 1	**Year 2**	**Year 3**
1.6.1 Ensure timely access to community-led solutions for prevention, early risk detection, diagnosis and self-management solutions for long-term conditions that disproportionately affect Māori. (T, Q)	✓	✓	
1.6.2 Promote and support increased participation (including relevant age extensions) in bowel, breast and cervical screening, with a focus on access for populations with the greatest need. (A, T, Q)	✓	✓	✓
1.6.3 Establish access to new cancer medicines. (A)	✓	✓	
1.6.4 Support timely access for whānau Māori to cancer prevention, early detection, and navigational services (treatment, palliative care and survivorship). (T, Q)	✓	✓	
1.6.5 Improve access and quality of care for people experiencing diabetes. (A, Q)	✓	✓	✓
1.6.6 Standardise and support adoption of Cardiovascular Disease Risk Assessments (CVDRA) within Primary and Community Care (Q)	✓	✓	
1.6.7 Pilot and further develop Heart Health Plan (HHP). (T, Q)	✓	✓	

1.6.1 Mental health, addiction and wellbeing

Mental health and addictions and suicide prevention are key Government priorities with five mental health targets (section 1.3) and a new ministerial portfolio for Mental Health. A mental health funding 'ringfence' ensures specific funding is allocated.

The meaning of mental wellbeing differs across people and across time, but everyone can enjoy good mental wellbeing, regardless of the presence or absence of a mental health condition or addiction.

Mental wellbeing is strengthened by a range of protective factors and made worse by poor social, cultural, environmental, and economic factors (determinants of health). People with different backgrounds and circumstances will experience determinants of mental wellbeing at differing levels and at different times of their lives.

The need for mental health services is increasing, particularly for young people. Half of those who develop mental health conditions have problems by the age of 15 years and three out of four people with substance use disorder are under 24 years of age.

Suicide particularly affects men, young Māori men, the Rainbow community, those in rural communities and people who use mental health services. Māori are more likely to die by suicide and more likely to experience addiction than other ethnic groups.

Our aim is to improve supports and services including with innovative initiatives, and to contribute to meeting the national mental health targets. See section 3 for information on the Mental Health and Addiction Workforce Plan 2024-2027.

Table F: Actions to improve mental health, addictions and suicide prevention **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27** **Year 1**	**Year 2**	**Year 3**
1.6.8 Develop national clinical service and campus planning for specialist mental health and addiction services. (A)	✓	✓	
1.6.9 Progress development and implementation of the multi-agency plan for response to 111 calls from people with mental distress. (T)	✓	✓	✓
1.6.10 Implement the Police Programme of Change Plan. (T)	✓	✓	
1.6.13 Progress locally designed and tailored whānau-centred and community-based mental health services and addictions initiatives for Māori. (A, Q)	✓	✓	
1.6.14 Implement the Mental Health and Addiction Community Sector Innovation Fund (A)	✓	✓	

1.7 Managing communicable diseases

We manage communicable diseases as part of core public health activity. We do this by reducing risk (e.g. with vaccinations), readiness activities, responding to threats and outbreaks, and recovery activities.

Preparing for and responding to outbreaks, epidemics and pandemics involves individuals, communities and a whole of health system approach which includes public health, primary and community health services, hauora Māori and Pacific providers, and hospitals. We learnt this in both the Covid-19 pandemic and severe weather events, when a holistic response was achieved to help meet people's social and economic needs.

Measles remains a high-risk threat due to cases of the disease globally, open borders, and declining immunisation rates in New Zealand. Responding to infectious diseases such as measles requires community engagement and partnerships, particularly with populations that currently have poorer outcomes.

Sexually transmitted infection rates are increasing, and some groups in the community are at greater risk and affected inequitably. The Sexually Transmitted and Blood Borne Infection Strategy aims to improve collaboration and support collective action and a unified direction. The Needle Exchange Programme is being enhanced to ensure it is fit-for-purpose, sustainable and responsive.

Addressing wider risk factors of infectious disease requires working in collaboration with multiple organisations. We will contribute to achieving our improvements by strengthening our responses and preparedness to communicable disease outbreaks including measles and sexually transmitted blood borne infections.

Table G: Actions to improve prevention of and response to communicable diseases **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27** **Year 1**	**Year 2**	**Year 3**
1.7.1 Develop and enhance national and regional communicable disease outbreak models and processes, incorporating targeted interventions for populations with greatest need. (T)	✓	✓	✓
1.7.2 Implement the Sexually Transmitted Blood Borne Infections Programme to support action plans for Human Immunodeficiency Virus (HIV), Hepatitis C, the Syphilis Action Plan and Needle Exchange Programme. (A)	✓	✓	

Surgical staff preparing for cataract surgery at Kaitaia Hospital.

Section 2: Clinical leadership, continuous quality improvement and innovation

We need strong clinical leadership and effective partnerships with organisations across the health system. Strengthening clinical leadership will ensure there is a clinical lens across decision-making. We also need people with lived experience of health conditions, including disabled people, to assist with continuously improving the quality of our services.

The Chief Clinical Officer will provide professional and strategic clinical leadership and governance to ensure we have high-quality and safe regional and local health care services.

National Clinical Networks will develop innovative, efficient, and evidence-based solutions, including considering new models of care. This will help us to have strong clinical engagement and robust clinical frameworks to inform all planning and decision making.

Our approach will help make services safe, understandable, easy to navigate, and welcoming to users. We aim for treatments and practices to be based on sound evidence, robust data, research and evaluation.

The National Whānau Feedback and Engagement Advisory Group provides information on service improvement to national leadership through feedback and engagement. A framework and equity-led approach aims to improve services and standardise practice by making sure people's experiences are heard.

Hauora Māori actions throughout this plan ensure that Māori receive services that are safe, easy to navigate, understandable and welcoming, and are continuously improving.

We will contribute to our improvements by developing stronger mechanisms for understanding quality of care, learning from health care harm, and actively identifying areas for development. This includes listening and responding to feedback.

Table H: Actions to improve overall quality of health care **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27** **Year 1**	**Year 2**	**Year 3**
2.1.1 Improve Quality of Health Care – Progress key life expectancy gap initiatives for Māori and Pacific peoples, including nationalisation of lung and Abdominal Aortic Aneurysm (AAA) screening programmes. (Q)	✓	✓	✓
2.1.2 Design and implement a national clinical quality and safety measures framework and digital reporting system. (Q)	✓	✓	
2.1.3 Extending the development of patient-centred measures: PREMs (Patient-Reported Experience Measures) and PROMs (Patient-Reported Outcome Measures) to enhance effectiveness of health care received. (Q)	✓	✓	✓
2.1.4 Establish a consistent balanced scorecard approach across Health NZ. (Q)	✓		
2.1.5 Collaborate with Health Quality & Safety Commission (HQSC) | Te Tāhū Hauora and other health entities to develop a system's safety strategy to set expectations for NZ and benchmark internationally. (Q)	✓	✓	✓
2.1.6 Embed a national framework for feedback and consumer engagement to ensure communities, consumers and whānau across the motu are engaged in service design, delivery and evaluation. (Q)	✓	✓	✓
2.1.7 Establish and enhance National Clinical Networks and implement national pathways for the management of long-term conditions: cancer, diabetes, cardiovascular disease, respiratory disease, and Mental Health and Addictions. (Q)	✓	✓	✓

Nurses in Medical Assessment and Planning Unit (MAPU) at Wellington Regional Hospital.

Section 3: Strengthening enablers

Enablers are the key parts of the health system that make it possible to provide care and treatment. They include our workforce, buildings including hospitals, and the technology and digital platforms our staff use to provide timely and quality health care. These enablers are priority areas for action in the GPS.

3.1 Workforce

Our workforce is dedicated, skilled and essential to delivering this plan. Our people are the key drivers of timeliness, access, service quality, performance and change. The pandemic legacy and other demand and supply pressures have had an impact on our workforce. We are working to address these pressures sustainably.

We want to strengthen and foster our safety and wellbeing culture so that our people and consumers are safe in health care environments. Te Mauri o Rongo | the Health Charter guides our workforce in setting values, principles and behaviours that workers in Health NZ and all other health entities are expected to demonstrate.

Our evolving workforce needs are driven by population growth and demographic changes. As an employer we have a responsibility to ensure the future sustainability of specialist workforces in all clinical disciplines. As global competition for health workers continues to be challenging, we need to grow and retain our workforce.

To continuously improve, we aim to project workforce needs, assess the impact of changes in models of care, and consider the impact of technologies.

Achieving workforce sustainability requires planned growth in specific areas to make better use of our available workforce. This includes helping our health workers to make best use of their capabilities by working at the top of their scope in an interdisciplinary way.

Māori and Pacific Peoples are under-represented in our health workforce. In March 2024, Māori comprised 8.4 per cent of our employed workforce and Pacific Peoples 4.9 percent, compared to a total population of 17 per cent Māori and 9 per cent Pacific Peoples.

Ethnic, cultural and other types of diversity in our workforce help to ensure that the workforce mirrors the diversity of our population. Initiatives to strengthen Māori health and Māori mental health workforces are outlined in the New Zealand Health Workforce Plan (Health Workforce Plan) including growing mātauranga Māori specialists.

Our Health Workforce Plan (2024) outlines how we intend to develop the workforce to strengthen the clinical frontline, deliver on the Government's priorities and be sustainable. This includes strengthening leadership across all areas and increasing timely access to care for communities.

Our Mental Health and Addiction Workforce Plan 2024-2027 operates alongside the wider workforce plan. It outlines how we will address mental health workforce shortages.

Table I: Actions to improve our health workforce **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27** **Year 1**	**Year 2**	**Year 3**
3.1.1 Implement the Health Workforce Plan and monitor the delivery of agreed workforce initiatives. (A, T, Q)	✓	✓	✓
3.1.2 Implement the Mental Health and Addiction Workforce Plan. (A, T, Q)	✓	✓	✓
3.1.3 Complete the stabilisation of rostering and payroll systems.		✓	✓

3.2 Infrastructure - data and digital

Clinical and non-clinical services that are well supported by data and digital services are essential to improve health services. Our aim is to modernise and improve our health data and digital platforms, processes and standards.

Our challenges include fragmented and ageing technology assets and a lack of modern digital platforms and tools, poor integration of systems and poor access to data. This is particularly so for our priority populations, including Māori, Pacific Peoples, and disabled people.

We have some solid foundations to build on, including national health identifiers and modern digital platforms for public health and data services.

We aim to have a sustainable, resilient and productive organisation by delivering operational efficiency and fit-for-purpose digital services. We intend to simplify and modernise our digital health services and improve the data available for analysis and insights. This will improve clinical user experience and optimise digitally-enabled health care with improved analysis to help make evidence-based decisions.

We are starting to incorporate technologies including artificial intelligence and will focus on delivering value across all settings for whānau, communities and clinicians.

Table J: Actions to improve our data and digital infrastructure **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27**		
	Year 1	**Year 2**	**Year 3**
3.2.1 Agree a long-term investment plan for digital modernisation of the New Zealand health system. (A, T, Q)	✓		
3.2.2 Extend options for people to digitally access and manage their own health information, including related to advice, entitlements and service eligibility. (A, Q)	✓	✓	✓
3.2.3 Expand the availability of specialist care at home supported by digital tools, so fewer people need to be admitted to hospital. (A,Q)	✓		
3.2.4 Building data services that enable access to data for planning, reporting, monitoring and insights to support integrated care. (Q)	✓	✓	
3.2.5 Modernise the systems used across public radiology services to address digital platform instability and progress towards national radiology reporting and data access. (A, Q)	✓	✓	✓

Aerial view of Christchurch Hospital, Christchurch Women's Hospital, University of Otago Christchurch campus and Manawa education campus.

3.3 Infrastructure - buildings

We are responsible for more than 1,200 buildings on 86 campuses, ranging from large hospitals to smaller health care facilities. Safe and fit-for-purpose buildings and equipment are crucial for our workforce to deliver timely, quality care safely and effectively.

Health services need specialised facilities, including clinical and digital equipment. These facilities are complex to plan, design and build, and involve substantial consultation with clinicians and community representatives. The first steps of our national approach are:

- National Asset Management Strategy to provide a consistent approach to managing our national health infrastructure assets.
- Infrastructure investment planning to enable us to meet the growing demand of the population's health needs, to address the gap between capacity and demand, and to align our facilities, geographic distribution and health needs.

The Nationwide Clinical Service and Campus Plan (in development) will help to improve alignment of clinical service delivery. Our aim is to continue to improve our infrastructure to support delivery of timely, accessible and high-quality care. See the Infrastructure Planning Framework for further information.

Table K: Actions to improve our physical infrastructure **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27**		
	Year 1	**Year 2**	**Year 3**
3.3.1 Implement the Health Infrastructure Plan and National Asset Management Strategy. (A, T, Q)	✓	✓	✓
3.3.2 Grow a strong health and safety culture underpinned by consistently applied safe systems of working, clear site practices, improved incident and near miss reporting, and robust investigation processes. (Q)	✓	✓	
3.3.3 Implement the Infrastructure and Investment Group operating model to support investment planning and monitoring, asset management and project delivery. (A, T, Q)	✓	✓	
3.3.4 Deliver the Mental Health Infrastructure Programme. (A, T, Q)	✓	✓	✓

Solar panels at Taranaki Renal Unit | Te Huhi Raupō.

3.4 Sustainability and climate change

Climate change impacts community health and wellbeing. Severe climate events are becoming more frequent, placing increasing stress on our health systems and the health of the community.

These events will have a greater impact on Māori, Pacific People, disabled people and rural communities for reasons including a greater proportion of those population groups living in geographical locations impacted by extreme weather and sea level rise, access ability and loss of connection to place. Preparation and planning by working closely with communities and other organisations, will help ensure greater system resilience and response.

Prevention and health promotion initiatives aim to help people live healthier lives, meaning we may need to provide less frequent or less intensive support for health conditions. This gives us the opportunity to reduce our emissions and environmental impact by reducing or avoiding travel, using less energy, materials and consumables, therefore generating less waste.

Our improvements are achieved through contributory factors including reducing the impact of climate change and air pollution on health and enhancing healthy environments and lifestyles. We are designing resilient models of care with efficient facilities, processes and assets that will help to reduce our environmental impact, reliance on single-use devices, waste and emissions.

Table L: Actions to improve the sustainability of our health services **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27** **Year 1**	**Year 2**	**Year 3**
3.4.1 Embed sustainability across decision making, investment planning, procurement and the development of models of care supported by a Sustainability Framework (Q).	✓	✓	✓
3.4.2 Develop an emissions reduction plan by end of 2024 to achieve a 25 per cent reduction of category 1 and 2 emissions by end of 2024/25. (Q)	✓	✓	✓
3.4.3 Progress assessment of system resilience to climate events to inform national, regional, and local climate response plans. (Q)	✓	✓	✓

Consultation with nurse at a Hauora Māori service provider.

Section 4: Improving health for populations with greater needs

4.1 Māori

To address the higher health needs of Māori, we are focusing our activity on cancer, long-term conditions (cardiovascular disease, diabetes, stroke, chronic respiratory disease), the first 2,000 days of life for pēpi, and mental health and addictions.

To understand more about areas of high need, we continue to build Māori health knowledge including through Iwi Māori Partnership Boards, whānau voice, and by drawing on existing reports, strategies and research.

Actions throughout this plan draw on hauora Māori service models and the skillsets of Māori health providers and the Māori workforce. Some actions relate to services focused on the five long-term conditions and modifiable risk factors. Some focus on improving Māori health and wellbeing at different life stages, while other actions are holistic in addressing multiple focus areas including strengthening mātauranga Māori practice.

These actions aim to improve both the quality of, and timely access to public health, primary and community care, and hospital-based services for Māori. Hauora Māori actions ensure that Māori

receive services that are safe, easy to navigate, understandable and welcoming, and are continuously improving.

The following actions focus on specific kaupapa Māori services delivered by Māori health providers. These actions reflect a holistic population health approach with the aim of improving outcomes for Māori across generations.

Actions to address workforce are included in the Health Workforce Plan in section 2.

Table M: Integrated actions to improve health care for Māori **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27** **Year 1**	**Year 2**	**Year 3**
4.1.1 Implement services and solutions that expand the practice of mātauranga Māori and meet the needs of communities by working with Iwi Māori Partnership Boards. (A, Q)	✓	✓	✓
4.1.2 Commission integrated and outcome-based population health approaches at the local level. (Q)	✓	✓	✓
4.1.3 Collaborate with the Hauora Māori Advisory Committee for outcomes monitoring. (Q)	✓	✓	✓

4.2 Pacific Peoples

Our aim is to provide improvements to health services that deliver healthy futures for all Pacific Peoples, their families, whānau, aiga, ngutuare tāngata, kāinga, famili, kāiga, magafaoa, vuvale and communities.

Our Pacific health providers are key partners to achieve this. Our providers work closely with communities to design services that reflect Pacific families and their lives and deliver primary health care alongside broader social services. This integrated approach means we have greater flexibility for Pacific providers to deliver holistic models of care.

There are many excellent models of care across the country that we can build on. Improving health pathways is a critical part of achieving better access and quality of care.

Our intended outcomes are to improve timely access to primary and community care, and hospital-based services for Pacific Peoples, that helps reduce avoidable ill-health and death.

Actions to address workforce are included in the Health Workforce Plan in section 2.

Table N: Actions to improve health care for Pacific People **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27** **Year 1**	**Year 2**	**Year 3**
4.2.1 Strengthen existing Pacific networks, and develop new networks where there are gaps, which include churches and other community groups to develop, support and broaden capacity. (A, Q)	✓	✓	
4.2.2 Improve performance monitoring for Pacific providers so that evidence-based improved outcomes for Pacific families demonstrate value for money. (Q)	✓	✓	
4.2.3 Establish pathways with Pacific Providers and non-government organisations to focus on Pacific peoples presenting to emergency departments. (A, T)	✓	✓	
4.2.4 Develop and implement a coordinated approach to increase access to first specialist appointments and elective treatment for Pacific Peoples. (A, T)	✓	✓	

NZ Sign Language interpretation during an online study day ‘Applying disability equity’.

4.3 Disabled people | tāngata whaikaha

A quarter of New Zealanders live with a disability. They experience poorer health outcomes than non-disabled people. They belong to all ages, ethnic and cultural groups, gender identities, sexualities, socio-economic groups and communities.

Poorer health outcomes are worse for tāngata whaikaha Māori, Pacific disabled people or disabled people who may be part of another group with greater needs.

Changing how our health system approaches and understands disability means we need to challenge basic assumptions, including discrimination in favour of able-bodied people and outdated ways our system works.

Disabled people are under-represented in health policy areas and in data and accountability. Disability leadership and representation is crucial to the collection and analysis of data and for directing action to improve health services.

Foundations have been established with principles for inclusive, accessible, and fair health services. New programmes and actions in this plan are both aspirational and immediate, building on these foundations and aligning with the Health of Disabled People Strategy, currently being refreshed.

Our aim is to build better health services that work with and for disabled people.

Table O: Actions to improve health care for disabled people **Priority improvements key:** (A) Access (T) Timeliness (Q) Quality	2024/25 – 2026/27 Year 1	Year 2	Year 3
4.3.1 Implement the Patient Profile and National Health Index programme and build data intelligence capabilities to be more responsive to disabled people. (Q)	✓	✓	✓
4.3.2 Design and implement the disability model of care with a focus on infrastructure, workforce capability and capacity, policies, processes, practices and information accessibility (A, Q)	✓	✓	✓
4.3.3 Implement actions that project the disability consumer and whānau voices into key areas of work, including service design and planning. (Q)	✓	✓	✓

4.4 Rural communities

Almost one in five New Zealanders live in rural communities. There is a greater percentage of older people and Māori in rural areas than urban areas. Rural communities face additional geographic, distance and cost barriers to access services.

Rural communities have reduced access to screening programs (e.g. for cancer, diabetes, cardiovascular disease) compared to their urban counterparts.

The Rural Health Strategy sets the direction for improving the health and wellbeing of rural communities over the next 10 years. We need to develop our rural health workforce and support them to meet the broader health needs within rural communities.

Iwi Māori Partnership Boards strengthen the overall health system to ensure Māori voices are heard in decision-making that affects Māori health. They foster culturally relevant health services, which may include rural approaches to health care.

Future planning includes enabling access to services that are closer to home, and expanding the use of digital, telehealth and prevention services. This will improve connectivity and continuity of care. We also intend to support families who need to access care outside their usual community.

Actions are included throughout this plan.

4.5 Groups with specific needs

Rainbow, Takatāpui, MVPFAFF+ (Pacific Peoples' diverse identities) communities, Asian and Middle East Latin America and Africa (MELAA) populations, migrants, former refugees, asylum seekers, women and people living with rare disorders need to be considered.

Challenges include stigma, discrimination, lack of confidentiality, safety and more. For some it is resettlement stress, financial and transport stressors, language barriers, lack of knowledge of the health system, lack of trust and understanding of models of care that are still predominantly

Western. For others it can be cultural differences in assessment and treatment, and lack of cultural competence among health professionals.

People living with rare conditions have unique needs. The New Zealand Rare Disorders Strategy sets a new direction on how the health system can provide better support.

Climate change and worsening conditions in the environment typically affect populations or groups with greater needs most severely. We must consider this when planning our actions for these communities.

Actions appear throughout this plan including in the Mental health, addiction and wellbeing section.

Staff at a local community pharmacy based at Palmerston North Hospital.

Section 5: Improving timely access to primary and community care

Effective primary and community health care services play an important role in releasing pressures in other parts of the health system.

Alongside family and whānau care, most support is provided by community-based health care services such as general practice, pharmacies, kaupapa Māori services, aged residential care and other home and community services. People in rural communities can have greater needs, where pressures on primary care are often higher in rural communities.

GP services are a first point of access, deliver most diagnosis and treatment and are responsible for continuity of care. However, about a third of GPs have closed books[4], and many people have an unmet need because waiting times for a GP are too long. Disabled adults, women and Māori are more likely to not have visited a GP due to cost in the last 12 months, than non-disabled adults, men and non-Māori.

We are supporting other ways of working, including moving some tasks usually done by GPs to others such as nurse practitioners, paramedics, physiotherapists, practice assistants and pharmacists. We are resolving pay equity claims and improving nursing recruitment and retention by ensuring there is consistency in nurses' pay. We aim to optimise use of telehealth services to improve access and reduce the burden of afterhours care on practitioners.

[4] HealthPoint.co.nz data, September 2024

Primary Health Organisations (PHOs) have an important role to play in supporting GPs and joining up care across providers for people with complex needs. Health NZ makes a significant investment to primary care through PHOs. They deliver a range of additional local services and are responsible for improving health outcomes for their enrolled population.

PHOs can make a significant contribution to helping us achieve the Government's priorities, including the health targets. We are working with PHOs and other providers to establish how their roles can be clarified and strengthened. We want to strengthen accountability by publishing PHO and provider performance.

We are working with PHOs and other primary care providers to establish how their roles can be clarified and strengthened, with the aim of improving people's access and timeliness of care.

Table P: Actions to improve access and timeliness of primary and community health care services **Priority improvements key: (**A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27**		
	Year 1	**Year 2**	**Year 3**
5.1.1 Enhanced capitation and accountability through a primary care development programme. (A)	✓	✓	✓
5.1.2 Improve access to enhanced community pharmacy services. (A)	✓	✓	✓
5.1.3 Expand access to telehealth services. (A, T)	✓	✓	✓
5.1.4 Improve awareness and targeting of the National Travel Assistance Scheme to support consumer and whānau access to specialist health services (A)	✓	✓	

Specialist care hospital dentist with the mobile surgical unit, Rangiora, North Canterbury.

5.1 Improving community health care throughout life

Using a ‘life course’ approach helps us better understand individuals and the health care they need throughout their lives, from pre-conception, infancy, through early childhood to adolescence, youth, adulthood and into older age.

Ensuring children have the best start in life is essential for setting the foundation for lifelong learning, health and wellbeing. Improved child health is linked to improved adult health, better educational outcomes, and more economic participation throughout life.

Community health care services are important to expanding the choice of whānau-centred maternity and early years services, including options based on te ao Māori models.

We are contributing to our improvements by lifting immunisation rates, reducing rheumatic fever and the impact of rheumatic heart disease and transforming services with programmes for the first 2,000 days of life.

Adulthood is the time where we can take early action to detect or prevent health problems, manage chronic diseases, and reinforce healthy habits. Our aim is to prevent and diagnose conditions early, reduce the risk of complications, and provide people with the support and resources to manage their health. This includes reducing the need to go to an emergency department.

In the next 15 years, the number of people aged 65 years and over is expected to increase by 44 per cent and those over 85 years will double. We aim to support older people to live well, age well and have a respectful end of life in age-friendly communities.

Support services to live well in the community are not limited to people older than 65 years. Many younger disabled people and those with chronic health conditions require care and support to

manage their health needs, retain physical mobility and mental sharpness, and to stay socially connected.

Caring for people at the end of their lives is part of helping people to live well. We aim for people to have access to end-of-life and palliative care services that cater to physical, cultural and spiritual needs, no matter where they live.

Actions to improve children's immunisation, shorter stays in emergency departments, faster cancer treatment and improved waiting times are in the Health Target Implementation Plan.

Table Q: Actions to improve health care throughout life **Priority improvements key**: (A) Access (T) Timeliness (Q) Quality	**2024/25 – 2026/27**		
	Year 1	**Year 2**	**Year 3**
5.1.5 Develop and implement a new Kahu Taurima commissioning framework for maternity and early years. (A, Q)	✓	✓	
5.1.6 Develop and implement redesigned oral health services to improve outcomes for Māori and Pacific and children with disabilities. (A)	✓	✓	✓
5.1.7 Implement the Rheumatic Fever (RF) Roadmap, 2023-2028. (T, Q)	✓	✓	✓
5.1.8 Improve access to and implementation of prevention services to older people. (A, T)	✓	✓	✓
5.1.9 Improve the effectiveness of community care to support older people to maintain independence, self-care, and connection with family | whānau and communities (Q)	✓	✓	✓
5.1.10 Redesign arrangements for commissioning of aged care services, including to improve service sustainability. (A)	✓	✓	✓
5.1.11 Managing the growing prevalence of dementia by implementing and evaluating the Dementia Mate Wareware Action Plan. (A, T)	✓	✓	✓
5.1.12 Develop a consistent model of palliative care across New Zealand. (A, Q)	✓	✓	✓

Section 6: Costing this plan

The Pae Ora Act requires Health NZ to produce a three-year costed plan for the delivery of publicly funded services. We have considered the financial constraints we will face over the next three years, how we intend to fund core health services and any improvement actions, and how we expect to respond to risks and challenges.

As an organisation, Health NZ is still maturing, having been established on 1 July 2022 following the rapid amalgamation of the previous District Health Boards. Within the first two years of operations, Health NZ had not focused sufficiently on building an operating model that ensured alignment between financial reporting and management accountabilities. This meant one of the key objectives of the health reform – to achieve integrated planning, financial management and service coordination – has not yet been achieved. We have spent the last 12 months undertaking regular assessments to understand how we are progressing in developing systems and processes that reflect a mature, collaborative and well-planned organisation. This includes growing and developing our ability to budget and forecast across all the core organisational, process, people, policy, control, data and technology settings.

When Health NZ was established, it was anticipated that it would take at least two three-year planning cycles to fully develop and implement new systems and processes. This is to ensure that our core business is (and thus the New Zealand Health Plan) fully costed and budgets allocated and monitored at a national, regional and local level.

The New Zealand Health Plan 2024-27 is a plan that is indicative of our current level of maturity. It is not costed to the level of traceability and integration between the financials, activities, and desired improvements expected from a fully mature New Zealand Health Plan.

6.1 Understanding our cost base

During 2022/23 we undertook a suite of mapping activities to understand our cost base in detail, noting that the former District Health Boards had a range of funding, commissioning, and cost allocation approaches which were inconsistent.

We built on this work through 2023/24 leading into Budget 2024 (see 6.3 Our funding parameters), in which we took a deep-dive approach to further understand our cost base. This included assessing enterprise-level, appropriation-level, service-level, and individual cost-driver levels – and included three detailed independent baseline reviews of major spending areas: Hospital and Specialist Services, Workforce, and Child / Youth services.

We now have in place:

- Financial Procurement Information Management Oracle – a singular nationwide service purchasing and payment platform which will support consistent expenditure tracking.

- Health Sector Agreements and Payments Programme – a singular nationwide agreements and payments system, allowing easier tracking of contracts and expenditure on commissioned services (the funded sector).

6.2 Our approach to setting budgets and costing activity

This plan is effectively a summary of all the services that Health NZ funds or delivers as well as a list of actions / initiatives (projects or programmes of work) that will be delivered over the period 2024-2027, which aim to improve timely access to quality services (and therefore improved health outcomes).

Developing and setting high-level budgets for 2024/25 – 2026/27

We are in the process of maturing our budget and service planning processes. This work includes progressing the development of more enhanced driver-based budgeting and forecasting methodologies, incorporating both financial and non-financial inputs. This will include activity-based costing, moving to a set of activity-based targets that inform budget allocations.

In effect, this means shaping our budgets based on activity targets (how much care we are wanting to deliver), rather than planning our activity based on our budgets (how much we are wanting to spend). This change of approach will place service delivery for our patients front-and-centre, allow more accurate service planning for the year ahead, and help us to identify where cost and/or productivity improvements need to be made to meet our activity targets within budget.

The 2025/26 budget will incorporate an initial level of activity-based costing, which will mature over the coming years. We are also focussed on ensuring that costs of back-office functions (enabling services) are appropriately allocated to relevant budgets and output classes – currently they are all attributed to our hospital and specialist services output class.

Health NZs 2024/25 budget was developed from October 2023 to November 2024. This included national, regional and local service planning for Health NZ delivered services and those commissioned from the funded sector and third-party providers, in the context of upcoming government priorities such as health targets. This forms the basis of the forecast activity levels set out in Table T.

Given the financial challenges facing Health NZ, a key focus to living within our budget for 2024/25, has been on identifying savings to address the structural deficit of $1.76bn revealed through 2023/24. Savings of ~$660m, factored into the 2024/25 budget, were developed through engagement with each organisational business unit, focusing on what is practical and feasible while ensuring the organisation can deliver on government priorities. In doing so, priority has been given to protecting and enhancing front-line health services and optimising back-office functions.

The indicative financial statements shown in Table R (Forecast income and expenditure by output class annually), are based on:

- Forecast appropriation revenue by year, as advised by the Ministry of Health.
- Indicative third-party revenue growth of ~2% per year.
- A financial pathway back to breakeven by 2026/27: $1.1bn deficit in 2024/25, $200m deficit in 2025/26, and break even in 2026/27.
- Savings as budgeted in 2024/25, and in 2025/26 and 2026/27 allocated to the Primary and community services and Hospital and specialist services output classes, being the largest areas of Health NZ spend, including on back-office functions.
- Protecting the Mental Health ringfence (Mental Health & Addictions output class) while allowing for some growth over the 3-year period.

Approach for services we fund (Commissioning)

Historically, and since Health NZ was formed, we have determined a budget for services that we fund for the following year that allows for an uplift for the funded sector that recognises price and volume pressures but enables us to remain within the available budget.

As part of planning for Budget 24, for the price component, a model was developed that weighted economic index forecasts by sector, based on the underlying cost structures of providers. Many services are also contracted on a fee for service volume-based payment. For these volume pressures, each sector was modelled utilising historic growth patterns and future projections of specific population groups where appropriate.

The organisational focus on living within budgets resulted in an available funding envelope below what was modelled. This required a pragmatic approach to maintain sustainability and ensure the funding allocations for core frontline services such as primary care, aged residential care and home-based support remained relative to previous funding allocations. The allocations were budgeted at a fixed amount, along with a fixed increase for mental health and addiction services to maintain parity with the Mental Health ringfence expectation set by the Minister. The remaining amount in the available envelope was then apportioned to other services equally.

For 2024/25 the budget was set, based firstly on the known and normalised, contracted and claimed spend from 2023/24. Then the volume pressure and agreed price uplift for 2024/25, based on the modelling described above, was overlayed.

For 2025/26 a refinement of the budget modelling is already underway which breaks services down into further subgroups, examines their underlying cost structures, and forecasts expected price increases and productivity improvement opportunities.

Services with fixed or contractually required uplifts are also being identified and included. Volume or demand increase modelling is also being improved to better understand the future unavoidable growth, given existing policy settings and service configuration. Further processes are also being developed to link monthly activity forecasts to financial forecasts – this will enable us to understand the underlying drivers of any variances and signal risks earlier.

This approach will be continually developed and improved, including incorporating feedback loops from forecasts vs actuals, over the remainder of 2024/25 and into years two to three and beyond.

Approach for Hospital and Specialist Services

Historic budget setting for these services tended towards a 'starting budget plus %' approach.

When commencing the build of the 2024/25 operational budget we had recognised material overspending against the 2023/24 budget, with several material drivers across both cost pressures such as pricing changes for goods and other resources (cost of employment) and changes in activity delivery due to population growth, the increasing impacts of non-communicable diseases and changes in demographics (i.e. ageing).

Rather than reapply the historic budgeting approach, we took the approach of first recognising the underlying run-rate of expenditure, with the premise that this would uplift budgets at least to the level of expense incurred in delivering 2023/24 activities. Specific new programmes or cost pressures were added above the 2023/24 run-rate where supported, such as expanding access to stem cell transplant services, or new facilities coming online such as Hawkes Bay theatres.

This approach resulted in an initial costed budget above the available funding. Health NZ is in the early stages of working through options to initiate activity-based funding to our four regions and the districts within them (see more below). In the interim, existing activity-based costing and activity plans were used in comparing overall shares of cost / resource allocations across regions, and in determining a 'fair' share of a back to budget savings target. This is expected to be expanded in 2025/26, including ensuring that activity funded via third parties (i.e. ACC) is reflected in calculations.

The indicative financial statement presented as Table R sets out 2025/26 and 2026/27 budget position based on an agreed pathway back to budget. The 2025/26 operational budget is currently under development and is intended to align with the bottom-line position agreed. The budgeting approach for 2025/26 has engaged early to align timelines for financial budgeting with activity planning, so that incremental cost implications for achieving the required 2025/26 activity levels can be explicitly built into operational budgets.

To further support understanding of links between hospital delivered activity and expenditure, Health NZ will continue to improve its activity-based costing capability. Accurate activity-based

costing of services is complex and relies on appropriate financial and activity data systems being in place to produce the correct outputs in a standardised and consistent way.

Activity-based costing at the event and speciality level was not something that was consistently undertaken by all districts prior to the establishment of Health NZ. However, we have been implementing a costing roadmap which has led to clinical costing systems now being active in all 20 districts. As a result, we now have the technical capability to produce activity-based costings. Our focus over the next two years will emphasise standardisation and quality improvement of data (particularly where activity-based costing systems have recently been implemented), and implementation of a new National Activity-based Cost Collection (NACC) to replace a legacy collection that is no longer fit for purpose.

Approach to expand output classes and better link activity to financials

Revised output classes are required to enable us to tell a better performance story aligned to Health NZs strategic intent and to provide increased transparency in reporting to meet the Public Benefit Entity Financial Reporting Standard 48 (PBE FRS 48).

We have agreed with officials from the Ministry of Health and the Treasury to maintain the existing output class structure while building sub-output classes that provide insight into significant areas of delivery phased over the next five years.

Sub-output classes would be meaningful chunks of service activity and spending which are expected to have reportable outputs, which fall within an appropriation and output class, and in a mutually exclusive, collectively exhaustive way.

A small set of new sub-output classes were expected to be developed for the 2025/26 financial year. However, due to where we are in our organisational maturity and the processes currently underway described above, we will undertake this work during 2025/26 for inclusion in our 2026/27 Statement of Performance Expectations.

This is particularly necessary for current output classes that have significant budget allocations (i.e. Primary and Community Care and Hospital and Specialist Services). It will require improvements to financial and non-financial reporting and within that, improved capture and / or categorisation of financial and activity data.

6.3 Our funding parameters and the fiscal environment

Appropriations are financial groupings that provide a minister with the authority from Parliament to spend public money or incur expenses or liabilities on behalf of the Crown.

Health NZ has been provided with a multi-year cost pressure package covering Budgets 2024, 2025, and 2026. This gives us certainty of revenue, which will enable multi-year planning and

better financial discipline. However, it also means we must be deliberate and disciplined with our spending.

We are focused on getting better value and making well-considered trade-offs. This plan prioritises community-focused health approaches of prevention, treatment, management in the community and care closer to home.

Health NZ received $24,810 million of funding through appropriations in 2024/25 and further funding from other sources of $3,487 million. More than $14,000 million is from the Delivering Hospital and Specialist Services appropriation, $9,100 million from the Delivering Primary, Community, Public and Population Health Services appropriation and $756 million from Delivering Hauora Māori Services appropriation. The remainder is received from a group of COVID-19, Crown sources and third parties.

Our cost pressures

Our services have the same cost pressures other health providers face across the world. Two years on from the establishment of Health NZ, we continue to transition and integrate the systems and processes brought together following the health reforms.

Inflation

Costs to build infrastructure and deliver services have continued to grow due to a constrained supply chain and heightened global competition in health care procurement and purchasing. As a single organisation we have greater negotiating and purchasing power, and we are in the process of integrating our purchasing and contracting systems.

Population growth

Our population has grown significantly in recent years, with a record net migration gain of 110,200 people in the year to August 2023. Longer-term, we face the challenge of servicing the health needs of an ageing population and the impact of non-communicable diseases. We are also seeing continued growth in complexity of cases presenting to hospitals.

Workforce

Our workforce is our most valuable and most expensive input. In a competitive international environment, the costs of recruiting and retaining our workforce continue to grow. We face continued pressure in all sectors, across all regions and most professions. The Health Workforce Plan 2024 provides a pathway of improvement to make our workforce more sustainable.

6.4 How our services are funded

Output classes are the way we group a common set of goods or services funded in a financial year. They provide useful insight into the scale of spending across different settings.

We track spending within output classes by major service group and activity, where appropriate, and are working towards developing sub-output classes to better tell our integrated financial and non-financial performance story.

Table R: Forecast income and expenditure by output class annually ($ million)

Income	2024/25	2025/26	2026/27
Appropriation funding	24,810	25,787	27,116
Other funding	3,487	3,558	3,629
Total	**28,297**	**29,345**	**30,745**

Expenditure	2024/25	2025/26	2026/27
Public Health Services	533	556	579
Mental Health and Addictions	2,683	2,743	2,915
Primary and Community Services	9,637	9,801	10,199
Hospital and Specialist Services	15,966	15,841	16,424
Hauora Māori Services	578	603	628
Total	**29,397**	**29,545**	**30,745**

Table R Income and expenditure by output class annually, will be updated each year in the SPE.

Funding the improvement actions in this plan

Some of the actions in this plan are funded directly as an initiative from Budget 24, or by a previous Budget decision. Others are funded by the redesign and re-contracting of existing services. Some require no additional funding as they are funded by the consolidation of existing resources.

Budget 2024 investments to deliver core Government priorities are as follows:

Table S: Budget 2024 Investment	**2024/25 ($m)**	**2025/26 ($m)**	**2026/27 ($m)**
Mental Health and Addiction Community Sector Innovation Fund	5.000	4.720	*
Gumboot Friday - Delivering Free Youth Mental Health Counselling Services	6.000	6.000	6.000
Training 25 More Doctors	0.300	0.300	0.300
Improving hospital emergency department health workforce security	6.170	8.226	8.226
Extending free breast screening for those aged up to 74 years	6.000	6.000	6.000
COVID-19 and Pandemic Preparedness	56.435	50.558	43.460

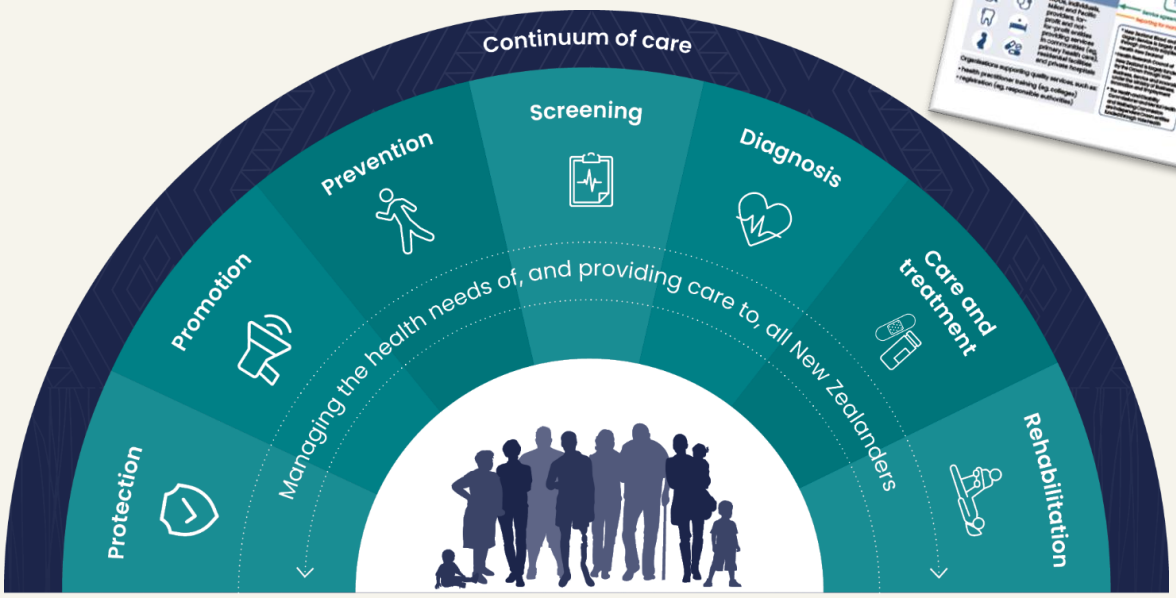
* The Government allocated $10 million over two years. Further decisions on funding will be made toward the end of the two-year period based on the success of the fund and return on social investment.

6.5 Services Health NZ funds or delivers

Health NZ funds and delivers health care services that span the continuum of care. Operating and improving the delivery of publicly funded health care services depends on close relationships with others.

Core entities in the health system

Ministry of Health Annual Report 2024



Examples of services

Protection Environmental and border controls, outbreak control and contact tracing

Promotion Health promotion and education to address harmful alcohol consumption, smoking, poor nutrition, lack of physical activity

Prevention Immunisation programmes and sexual health

Screening Cancer screening (breast, bowel, cervical), child health checks and antenatal screening

Diagnosis Blood and tissue testing, radiology and other imaging

Care and treatment Trauma care, oral health, reproductive health, mental health and addiction services, general medicine and general surgery, paediatrics, maternity, orthopaedics, opthalmology, urology, end of life and hospice care

Rehabilitation Physiotherapy, audiology, occupational health, home based support, aged residential care

Funded providers

Health NZ has partnerships with a range of providers:

- Aged residential care
- Allied health providers
- Ambulance non-government organisations
- Community health and social providers
- Hauora Māori services
- Home based support
- General Practices and Primary Health Organisations
- Laboratories and Radiology facilities
- Mobile services (i.e. screening and immunisations)
- National health NGOs
- Pacific health services
- Pharmacies
- Primary maternity services
- Private hospitals
- Urgent care clinics

Public hospitals

Health NZ owns 86 sites with nearly 11,000 beds or bed spaces. These range from small health care clinics and sub-acute units, through to secondary and tertiary hospitals. Most health clinics offer primary and community health services. They may have inpatient beds for continuing hospital care or low-risk births and transfer emergency or complex patients to a secondary or tertiary hospital. We often partner with community organisations to deliver care in these clinics. Sub-acute units provide day surgery, lower-level diagnostics, day stay care, some inpatient surgery and some clinical support services.

Secondary hospitals cater for most of the local population's health needs, offering 24-hour acute services and intensive care, planned surgery and care across a range of subspecialties. Our tertiary hospitals provide the greatest range of subspecialties and are staffed with 'on-site' rather than 'on-call' specialists. Across our sites over 60 service subspecialties are offered.

Primary care facilities are spread throughout New Zealand. These consist of GP practices, pharmacies and accident and emergency centres.

Locations in New Zealand

Regions	Total number of beds*
Northern	4,209
Te Manawa Taki	2,708
Central | Ikaroa	1,749
Te Waipounamu	2,079

*This reflects total beds/bed space Health NZ is certified to provide. It represents all types of hospital beds (ICU, neonatal, adult medical, etc). The number is the total physical spaces, not resourced/non resourced beds.

The national minimum range of services funded for eligible people by Health NZ, and other specified health entities and agencies, is outlined in the Service Coverage Expectations available from Ministry of Health.

The tables below detail the key services provided across each output class and activity expected to be delivered over the life of this plan.

Table T: Service volumes by output class

Output Class 1: Public Health Services		2024/25	2025/26	2026/27
Funding prevention and health promotion services to reduce the burden of illness and disease and promote quality of life.				
Immunisations*	24 months	490,212	513,810	537,903
	Influenza Over 65	538,645	545,109	551,650
Screening #	Breast Screening	276,402	282,605	294,453
	Bowel Screening	239,697	243,436	247,145
	Cervical Screening +	329,475	331,855	202,606

* Based on population growth estimates. Significant variance in population growth across different age cohorts may occur. Coverage volumes are indicative only.

Screening volumes indicative only. Possible bowel screening age extension not accounted for.

+ Cervical screening interval increased from three-yearly to five-yearly in 2023.

Output Class 2: Primary and Community Care Services		2024/25	2025/26	2026/27
Funding a wide range of routine, urgent and proactive services to avoid further illness and support peoples in managing their long-term conditions.				
Ambulance	111 Calls	719,300	736,400	753,500
	Road ambulance attendances	625,700	640,500	655,200
	Transport to emergency departments	353,500	361,600	369,600
	Rotary wing transport	11,800	12,300	12,800
Primary care	General Practice Enrolments	5,076,300	5,129,700	5,182,600
	General Practice Encounters	21,593,000	21,819,800	22,044,600
	Well Child Assessments	48,500	48,500	48,500

	Year 10 Home, Education, Activities / Employment, Drugs, Suicidality and Sex (HEADSS) Assessments	19,200	19,200	19,200
Residential aged care	Aged Residential Care Bed Days	9,910,000	10,075,000	10,255,000
Home and community support	Home Care Support Hours	9,335,000	9,690,000	10,095,000
	Community InterRAI Assessments	50,900	52,700	54,500
Dental	Adolescent Oral Health Providers	760	760	760
	Young People Seen	196,800	196,000	195,300
	Preschool Dental Enrolments	299,800	299,800	299,800
Community radiology	Community Radiology Facilities	188	188	188
	Maternity Ultrasound Scans	267,900	268,400	268,900
Maternity	Supported births	57,000	57,100	57,200
	First Trimester Registrations	75,600	75,800	76,000
	Lead Maternity Carers	1,163	1,134	1,111
Community pharmacy	Prescriptions – Written and Dispensed	60,240,000	62,130,000	66,160,000
	Pharmacy Items Dispensed	97,750,000	101,780,000	106,650,000
	Community Pharmacy Long-Term Conditions (LTC) Service	167,900	177,900	188,600

Output Class 3: Hospital and Specialist Services		**2024/25**	**2025/26**	**2026/27**
Funding intensive care and specialist services to prevent deterioration and improve quality of life.				
Emergency Services	Non-Admitted Attendances	679,339	702,465	729,320
	Admitted Attendances	698,004	742,293	790,248
Specialist Surgical Services	Acute Case Weighted Discharges	247,576	259,258	272,127
	Planned Case Weighted Discharges	235,100	237,168	239,550
	First Specialist Appointments	449,108	465,870	485,253
	Follow Up Appointments	876,385	904,539	937,262
	Planned Care Minor Procedures	165,076	172,670	181,293
	Acute Case Weighted Discharges	302,140	318,014	335,311
	Elective Case Weighted Discharges	19,821	20,049	20,385

Specialist Medical Services	First Specialist Appointments	222,349	228,021	235,028
	Follow Up Appointments	426,731	429,529	434,684
	Health of Older People Inpatient	278,908	288,469	299,734
	Health of Older People Outpatient	177,242	181,130	185,879
	Renal Dialysis Ambulatory Care	312,636	325,764	340,071
Maternity and Specialist Neonatal Services	Inpatient Neonatal Case Weighted Discharges	32,396	32,494	32,797
	Inpatient Maternity Case Weighted Discharges	65,110	65,755	66,750
	First Specialist Appointments	40,821	40,990	41,304
	Follow Up Appointments	37,630	37,376	37,297
	Consults	115,361	120,297	126,109
	Clinics	21,708	22,289	23,000
Paediatric and Child Specialty Services	Acute Case Weighted Discharges	45,483	48,388	51,604
	Elective Case Weighted Discharges	4,395	4,226	4,086
	First Specialist Appointments	35,853	36,846	37,996
	Follow Up Appointments	97,340	96,984	97,020
Specialty Cancer Services	Inpatient Cancer Case Weighted Discharge	9,854	10,132	10,440
	First Specialist Appointments	22,549	22,647	22,774
	Follow Up Appointments	140,255	140,372	140,740
	Intravenous Chemotherapy	107,398	109,057	111,117
	Radiation Oncology Sessions	150,019	147,428	145,111
Community Teams and Rural Hospitals	Allied Health Interventions	696,444	713,473	735,187
	Nurse Led Clinics	406,906	432,344	460,214
	Community Nursing	1,213,789	1,268,214	1,329,561
	Community Radiology	825,866	856,608	892,293

Output Class 4: Mental Health and Addiction Services		2024/25	2025/26	2026/27
Funding support and treatment options across the continuum of mental health to support recovery and maximise outcomes.				
Primary and community mental health and addiction services	Access and Choice – people seen	325,000	325,000	325,000
Specialist Mental Health & Addiction Services (bed nights)	Mental health intensive care inpatient or equivalent occupied bed nights	57,997	57,997	57,997
	Mental health acute inpatient or equivalent occupied bed nights	184,250	184,250	184,250
	Mental health sub-acute inpatient or equivalent occupied bed nights	13,214	13,214	13,214
	Maximum secure inpatient occupied bed nights	11,770	11,770	11,770
	Medium secure inpatient occupied bed nights	62,385	62,385	62,385
	Minimum secure inpatient occupied bed nights	16,355	16,355	16,355
	Substance abuse Withdrawal management/detoxification occupied bed nights (medical)	6,954	6,954	6,954
	Psychiatric disability rehabilitation occupied bed nights	44,835	44,835	44,835
Specialist Mental Health & Addiction Services (contacts)	Mental health crisis attendances	124,055	126,525	129,200
	Group programme session attendances	74,657	78,692	83,035
	Care/liaison co-ordination contacts	363,551	368,177	373,231
	Court liaison attendances	8,442	8,442	8,442
	Methadone treatment specialist service attendances	33,669	34,428	35,256
	Contact with family/whānau, consumer not present	156,450	157,489	158,591

	Integrated Māori and clinical interventions	16,157	16,607	17,090
	Peer Support	10,108	10,412	10,746
	Triage and/or screening	63,398	66,282	69,405
	Individual treatment attendance	1,394,389	1,405,604	1,417,630

Note: The methodology for quantifying Mental Health & Addictions activity using PRIMHD data* is developmental in 2024/25 and should be treated as indicative. Bed nights are stabilised across years as there is no confirmed increase in resourced bed capacity. The small annual increases for contacts are based on anticipated growth in the mental health workforce (fewer vacancies). Court Liaison contacts are held steady across the years as data improvement is undertaken.

* PRIMHD data is Health NZ's national mental health and addiction information collection of activity and outcomes data.

Output Class 5: Hauora Māori Services **		**2024/25**	**2025/26**	**2026/27**
Funding Kaupapa Māori-based services to improve Māori health outcomes and reduce health inequities.				
Supporting Iwi Māori Partnership Boards	IMPBs are a mechanism to support mana motuhake for Māori (number of IMPBs)	17	17	17
Strengthening the workforce	Māori Health Workforce (scholarships taken up)	700 +	700 +	700 +
Commissioning for impact	Commissioning of te ao Māori services (number of contracted partners)	169	169	169
	Contracting for hauora outcomes (number of whānau supported)	-	TBC	TBC

** Note: Health NZ commissions te ao Māori services that improve whānau wellbeing. This is an integrated, outcomes-based approach with contracts focused on delivering results and impact for whānau rather than setting fixed levels of volumes of activity.

6.6 Health Delivery Plan

The Health Delivery Plan articulates how we are continuing to reset how we operate. It has a primary focus on reducing wait times for assessments and treatments so that New Zealanders can get the health care they need.

It summarises what we are delivering from March 2025 to June 2026. Without intervention, we would continue to overspend by around $130 million per month

We have empowered our four regions to make decisions closer to home about how health care is delivered for local communities, particularly for the families and communities experiencing the highest health needs. This includes:

- increasing focus on delivery of health targets
- reducing wait times though greater partnering with the private sector
- enabling faster access to primary care services.
- getting back to budget and improving value for money.

To achieve these, we need to make better use of the overall capacity of the health system in New Zealand and build partnerships with health providers and private hospitals.

We want to reset the relationship with clinicians who must be in the centre of what we do. There will be extensive new arrangements set in place to make this a reality.

The plan has been designed to evolve and adapt, taking into account progress on existing initiatives, findings from reviews and insights on the effectiveness of current health service delivery.

Six workstream plans detail how the priorities, objectives and milestones are being delivered:

- Improve New Zealanders' access to services and reduce waitlists
- Quality and safety of healthcare at the centre of what we do
- Shift resources to the front line and reduce bureaucracy
- Get back to budget and improve value for money
- Strengthen leadership and culture
- Develop new ways to deliver health care sustainably

Considerable progress has been made including significant and disruptive changes in the organisation. For our new structure to work effectively for patients and our people it requires an alignment of planning, performance management, decision-making and delivery at all levels. This is being refined and progressively implemented. It is expected to be fully embedded by mid-2026.

Section 7: Monitoring and Reporting

7.1 Monitoring financial and non-financial performance

We have developed an Entity Performance Framework (the framework) aligned to our organisational strategy. The framework, along with a suite of performance measures, provides a clear line of sight across a range of high-level measures that inform progress toward achieving both intermediate and long-term health outcomes.

The framework reflects the key priorities detailed in the GPS. The framework, including results for measures and health targets, is designed to inform better management decisions at national, regional and local levels, and actions to effect change to address any challenges.

Our performance measures are grouped under four categories as illustrated on the next page:

a. **Input measures** are indicators of the nature and scale of investment, the capacity and capability of our workforce, and the business systems and process used to support the operation of Health NZ to make decisions around service delivery and design.

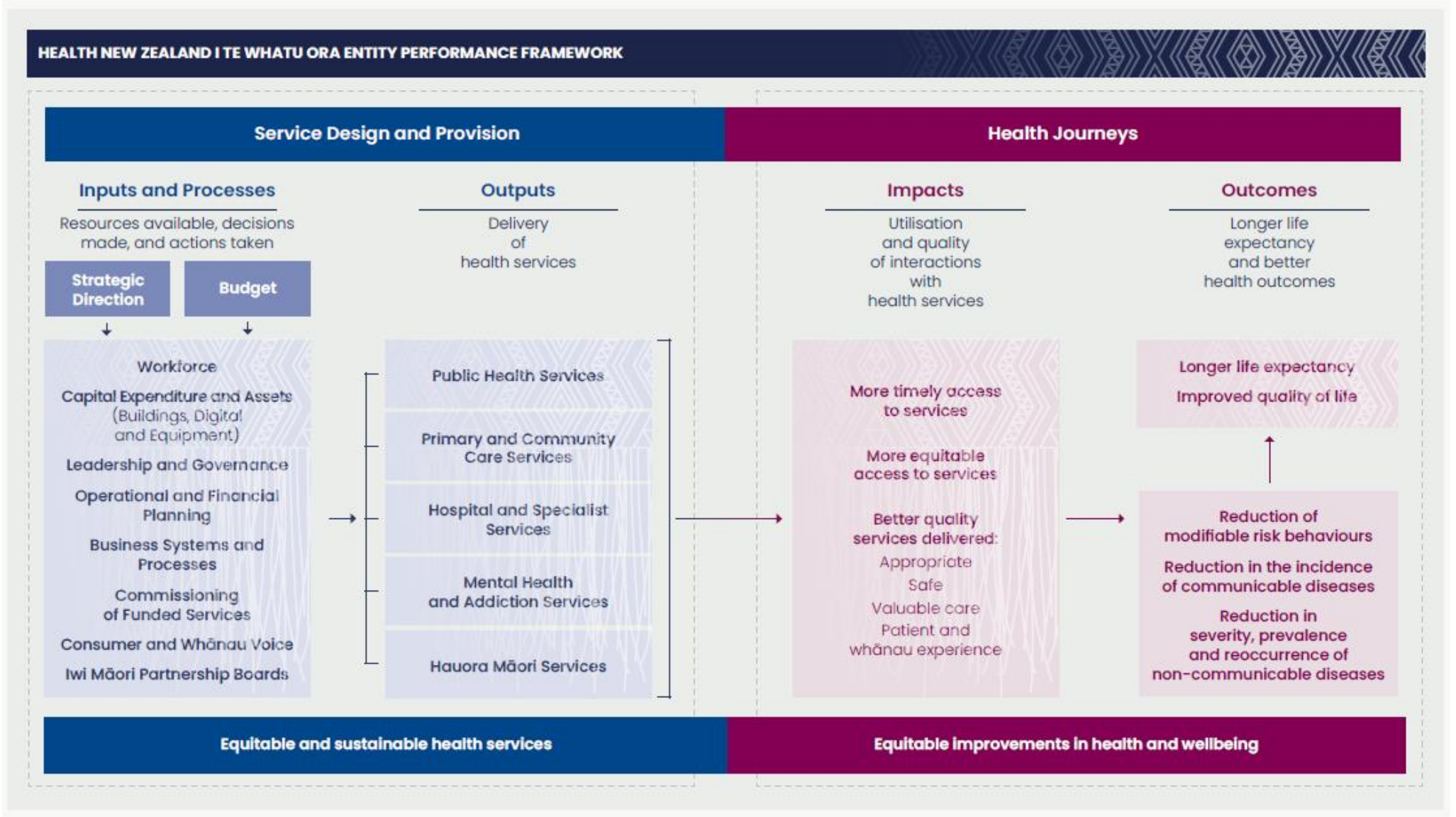
b. **Output measures** are indicators of the capacity and capability of our workforce, health services available and improvements in the clinical digital and physical infrastructure.

c. **Impact measures** are indicators of the utilisation and timeliness of services as well as the quality of care provided. These measures provide an early indication that the service design decisions were appropriate to meet the health needs of New Zealanders.

d. **Outcome measures** are indicators of the prevalence and severity of disease as well as modifiable behavioural changes. These measures provide evidence that improvements in the timely access to quality care are having a positive impact on people's health.

As we continue to unify and embed our business systems and processes (inputs) we will modernise both capacity and capability across the health system (outputs). This will enable us to meet the government priority of providing timely access to quality care (impacts), leading to a decrease in the prevalence and severity of illness over time (outcomes). This is the performance story the framework will enable us to tell.

We will be doing regular capability assessments to understand how we are progressing in developing systems and processes that reflect a mature, collaborative, and well-planned organisation. These will help to assess our ability to budget and forecast across the core organisational, process, policy, data and technology settings. More information on the framework is available in our SOI and our SPE.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Service Design and Provision
Health Journeys
Inputs and Processes
Resources available, decisions made, and actions taken
Strategic Direction
Budget
Workforce
Capital Expenditure and Assets (Buildings, Digital and Equipment)
Leadership and Governance
Operational and Financial Planning
Business Systems and Processes
Commissioning of Funded Services
Consumer and Whānau Voice
Iwi Māori Partnership Boards
Outputs
Delivery of health services
Public Health Services
Primary and Community Care Services
Hospital and Specialist Services
Mental Health and Addiction Services
Hauora Māori Services
Impacts
Utilisation and quality of interactions with health services
More timely access to services
More equitable access to services
Better quality services delivered:
Appropriate
Safe
Valuable care
Patient and whānau experience
Outcomes
Longer life expectancy and better health outcomes
Longer life expectancy
Improved quality of life
Reduction of modifiable risk behaviours
Reduction in the incidence of communicable diseases
Reduction in severity, prevalence and reoccurrence of non-communicable diseases
Equitable and sustainable health services
Equitable improvements in health and wellbeing

7.2 Reporting on the Government Policy Statement on Health

The Government Policy Statement on Health 2024-2027 (GPS) sets out how progress on the Government priorities will be measured.

We will report on the five physical health targets and the five mental health and addiction targets as well as the measures below, which come from the GPS, SOI, SPE and/or Vote Health Estimates of Appropriation 2024/25 (VH).

7.3 Measures

Table U: Measures by sections in this plan and GPS

Addressing modifiable factors for non-communicable diseases	
Measures	- Percentage of adults aged 15+ who smoke daily. (SOI, GPS) - Percentage of people eating the recommended daily intake of vegetables and fruit. (SOI, GPS) - Percentage of adults meeting physical activity guidelines. (SOI, GPS) - Percentage of adults who report hazardous drinking patterns. (SOI, GPS)
Why these measures are important	Measuring the trends of modifiable risk factors helps us to understand what the biggest risk areas are and helps us decide what else needs to be done to reduce inequities and improve people's health.
Long-term Conditions	
Measures	- Percentage of eligible women aged 45-69 years who have a breast cancer screen in the last two years. (SPE, SOI) - Cervical screening rates of eligible women aged 25–69 years (five-yearly screening interval) (SPE, SOI, GPS) - Bowel screening rates of adults aged 60–74 years (two-yearly screening interval) * (SPE, GPS) - Percentage of patients to receive cancer management within 31 days of the decision to treat. (VH, SPE, SOI, GPS) - Rates of registrations on Virtual Diabetes Register (VDR). (GPS) - Rate of lower limb amputation hospitalisations, age-standardised per 100,000 ethnic specific population with diabetes. (SOI, GPS) - Renal failure hospitalisations, age-standardised per 100,000 ethnic specific population with diabetes. (SOI, GPS) - People with diabetes regularly receiving any hypoglycaemic medication in the relevant year. (GPS) - Percentage of cardiac patients who wait less than 4 months for elective treatment. (VH, SPE) - Ambulatory sensitive hospitalisations for respiratory conditions per 100,000 in those aged 0-4 years. (SOI) - Ambulatory sensitive hospitalisations for respiratory conditions per 100,000 in those aged 45-64 years. (SOI)

Why these measures are important	These measures help identify inequalities in health outcomes, monitor the progress and impact of the actions, and improve timely access to quality care to support people with long-term conditions.

* There is a time lag for bowel screening participation, as once FIT kits are sent out, participants have six months to complete and return the kit and therefore reporting on this indicator requires the six months to elapse.

Mental health and addictions	
Measures	See section 1.3 mental health and addiction targets (VH, SPE, SOI, GPS) - Proportion of population aged 15+ years with high or very high psychological distress. (SOI, GPS) - Reduction in participants reporting feeling lonely most or all the time in the last four weeks. (GPS) - Reduction in the percentage of people who experience unmet need for mental health support in the past 12 months. (GPS) - The numbers and rates of people accessing primary and specialist mental health and addiction services. (GPS)
Why these measures are important	These measures enable us to monitor the progress of actions, including reducing psychological distress, loneliness, and unmet need for mental health support, and increasing access to primary and specialist mental health and addiction services. They support the mental health and addiction targets.

Health workforce	
Measures	- Health NZ workforce turnover rate. (GPS) - Increase representation of Māori and Pacific in the health workforce. (GPS)
Why these measures are important	Measuring diversity in our workforce helps to ensure that the workforce mirrors our population. Turnover is one way of monitoring the workforce to ensure we retain key skills and experience in New Zealand.

Data and digital	
Measures	- First Specialist Assessment and follow up outpatient appointments delivered via telehealth. (GPS) - Increased Access to My Health Record. (GPS)
Why these measures are important	Timely access to health care consultation through digital means, and the ability to access information about your own health are important in our system. It enables access to services throughout the country and facilitates access to health results in a secure system.

Physical infrastructure	
Measures	- The amount spent on infrastructure asset maintenance as a percentage of the book value of the estate, benchmarked against industry best practice. (GPS) - Percent of major projects (>$10 million) completed within scope, timeframes and budget. (GPS) - Delivery of a service-led 10-year infrastructure plan that incorporates associated performance expectations. (GPS)
Why these measures are important	A well-developed infrastructure supports the efficient functioning of health services, enabling the delivery of care to diverse and geographically-dispersed populations. It also facilitates the implementation of new health initiatives and the integration of services across different regions.

Hauora Māori	
Measures	- Percentage of Iwi Māori Partnership Boards that participate in setting strategic priorities for commissioning in Health New Zealand | Te Whatu Ora (SPE)
Why these measures are important	IMPBs are the mechanism to identify local health need and establish the priorities for future improvement and investment. Iwi expertise will ensure that investments are targeted, are designed for impact and demonstrate the expected outcomes.

Improving timely access to primary and community care	
Measures	- Percentage of people enrolled with a general practice (or a kaupapa Māori provider delivering general practice care). (SPE, SOI) - Percentage of people who experience unmet need to see a GP in the past 12 months due to cost. (GPS) - The percentage of people who experience unmet need to see a GP in the past 12 months due to time taken to get an appointment. (GPS) - Percentage of people who report they understood the information about their care (GPS)
Why these measures are important	By measuring the enrolment, access and satisfaction of people with primary and community care services, we can ensure they are receiving the best possible care across different settings and regions.

Improving community health care throughout life	
Measures	- Percentage of pregnant women registered with a lead maternity carer in the first trimester of pregnancy. (SPE) - Percentage of pregnant women registered with a primary maternity carer in the first trimester of pregnancy. (VH, GPS) - Percentage of children fully immunised at 24 months of age. (VH, SPE, SOI, GPS) - Ratio of mean decayed, missing, filled teeth at age 5 (GPS) - Ratio of mean decayed, missing, filled teeth at school Year 8 (SPE, GPS) - Improve the proportion of InterRAI assessments completed in community settings. - Percentage of people aged at least 65 years who have completed at least one influenza vaccination (VH, SPE) - Reduction in the number of inpatient discharges where a fall occurred while in hospital. (GPS) - Reduction in the number and proportion of inpatient events with a pressure injury diagnosis. (GPS) - Improve proportion of people aged over 65 years dispensed five or more unique long-term medicines. (GPS)
Why these measures are important	Multiple interconnected services are required to meet the people's different health needs. This includes immunisation, oral health, maternity services. Completing more InteRAI assessment will inform us to provide more integrated, person-centred and sustainable care for the ageing population.

Financial Sustainability	
Reporting requirements	- Detailed monthly reporting on financial, recruitment and activity forecasts, including Hospital and Specialist Services activity reporting showing actual vs. budgeted production volumes. (GPS) - Detailed quantified quarterly reporting to monitors on financial risks, including additional reporting if risks arise. (GPS) - Visibility for monitors of a consistent approach to investment and disinvestment decision-making. (GPS) - Performance against measures in the productivity plan to reduce unwarranted variation in costs. (GPS) - Quarterly reporting against Costing Initiative Plans and milestones provided to monitors. (GPS) - Plan for improving visibility of spend on, and better targeting of funding towards, preventative measures and early interventions. (GPS)
Why these are important	Financial sustainability is essential to ensure that resources are allocated efficiently and that timely access to quality care can be experienced by everyone. Measuring and reporting performance against financial sustainability indicators helps identify areas needing improvement, enabling informed decision-making and fostering accountability.
Government Policy Statement	
Measures	- Access to first specialist assessments (total, and standardised rates). - Elective Surgical discharges (total, and standardised rates). - Responsiveness, engagement and experience as captured in the Code of expectations for health entities' engagement with consumers and whānau. (GPS)
Why these measures are important	Monitoring access to first specialist assessments and elective surgical discharges ensures the health care system is efficient and equitable. Timely access to care impacts patient outcomes and satisfaction. These metrics support our health targets.

Glossary

Term / acronym	Description
AAA	Abdominal aortic aneurysm
Ableism	Discrimination in favour of able-bodied people, prejudice against disabled people
CVDRA	Cardiovascular Disease Risk Assessment
ED	(Hospital) Emergency Department
ERP	Emissions Reduction Plan
Equity / equitable	In New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.[5]
FASD	Fetal Alcohol Spectrum Disorder
GP	General Practitioner
GPS	Government Policy Statement on Health 2024-2027
Health NZ	Health New Zealand | Te Whatu Ora
HCSS	Home and Community Support Services
HHP	Heart Health Plan
HIV	Human immunodeficiency virus
Holistic	Treatment of the whole person, considering mental and social factors, rather than just the symptoms of an illness
HPV	Human Papillomavirus
HQSC	Health Quality and Safety Commission
ICP	Integrated Contracts Programme
IMPB	Iwi Māori Partnership Boards
Improvements	Desired improvements in health outcomes as defined in the Pae Ora Act
InterRAI	The primary assessment instrument for older people receiving support to live at home or in aged residential care in New Zealand.
MELAA	Middle East, Latin America and Africa

[5] https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/equity

MVPFAFF+	An acronym to describe Māhū (Tahiti and Hawaii), Vaka sa lewa lewa (Fiji), Palopa (Papua New Guinea), Fa'afafine (American Samoa, Samoa and Tokelau), Akava'ine (Cook Islands), Fakaleiti or Leiti (Tonga), Fakafifine (Niue). These are some terms used by Pacific Peoples to describe cultural and gender identities. These concepts are more, or just as much, about familial, genealogical, social and cultural selfhood. This is not an exhaustive list of Pacific People's terms. These cultural and gender identities do not often have an equivalent in English language/terminology.
PHA	Public Health Agency
PHO	Primary Health Organisation
Practical completion	Practical completion refers to the stage in a construction project when the building and fit-out are complete, except for minor omissions and defects that do not prevent the property from being used for its intended purpose. It is a key milestone marking the point at which the infrastructure component is considered complete. Operational go-live is when the facility is being used.
PREMs	Patient-Reported Experience Measures
PROMs	Patient-Reported Outcome Measures
Rainbow	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual and other diverse gender or sexual identities
RF	Rheumatic fever
SOI	Health NZ's Statement of Intent 2024-2028 (published on our website)
Social capital	The network of relationships among people who live and work in a society, to enable that society to function effectively
Social cohesion	The willingness of diverse individuals and groups to trust and cooperate with each other, supported by shared inter-cultural norms and values
SPE	Health NZ's annual Statement of Performance Expectations (published on our website)
STI	Sexually transmitted infections
THEIA™	An Artificial intelligence enabled clinical tool used for retinal screening
Unwarranted variation	Differences in health care that cannot be explained by illness, medical need or evidence-based treatment
VH	Vote Health Estimates of Appropriation 2024/25

Te reo Māori

These words or terms are a guide and are not necessarily precise for all iwi, hapū, whānau. There may be regional dialects, variations and interpretations.

Term	Description
hapori	community
hapū	kinship group, clan, tribe, sub-tribe
hauora	health and wellbeing
iwi	extended kinship group, tribe, nation
kahu taurima	The name ‘kahu taurima’ has many connections to maternity and early years. ‘Kahu’ speaks to the korowai (cloak) of services and support that wraps around whānau as well as an alignment with He Korowai Oranga: Māori Health Strategy. ‘Taurima’ means caring, nurturing, and fostering our most cherished pēpi, tamariki and whānau.
kaiāwhina	helper, assistant, contributor, counsel, advocate
kaupapa	topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative
mana motuhake	separate identity, autonomy, independence
mātauranga	knowledge, wisdom
mate wareware	dementia
motu	country
pēpi	baby, infant
rangatahi	youth, younger generation
takatāpui	Takatāpui historically means 'intimate companion of the same sex'. The term was reclaimed in the 1980s and used by individuals who were gay, lesbian, bisexual, transgender, intersex or part of the rainbow community. The use of 'takatāpui' as an identity is a response to western ideas of sex, sexuality and gender, and emphasises one’s identity as Māori as inextricably linked to their gender identity, sexuality or variation of sex characteristics.
tamariki	children
tāngata whaikaha	people with disabilities

te ao Māori	Māori world view
tino rangatiratanga	self-determination / autonomy
whānau	extended family, family group

Pacific

These words or terms are a guide and are not necessarily precise for all Pacific People's. There may be regional dialects, variations and interpretations.

Term	Description
aiga	family (Samoa)
famili	immediate family (Tonga - couple and children)
kāiga	family (Tuvalu - includes extended family)
kainga	extended family (Tonga - the wider family setting)
magafaoa	family (Niue). The centre of Niuean life is magafaoa.
ngutuare tāngata	family (Cook Islands)
vuvale	family (Fijian). It encompasses family members and extends to 'my home is your home'

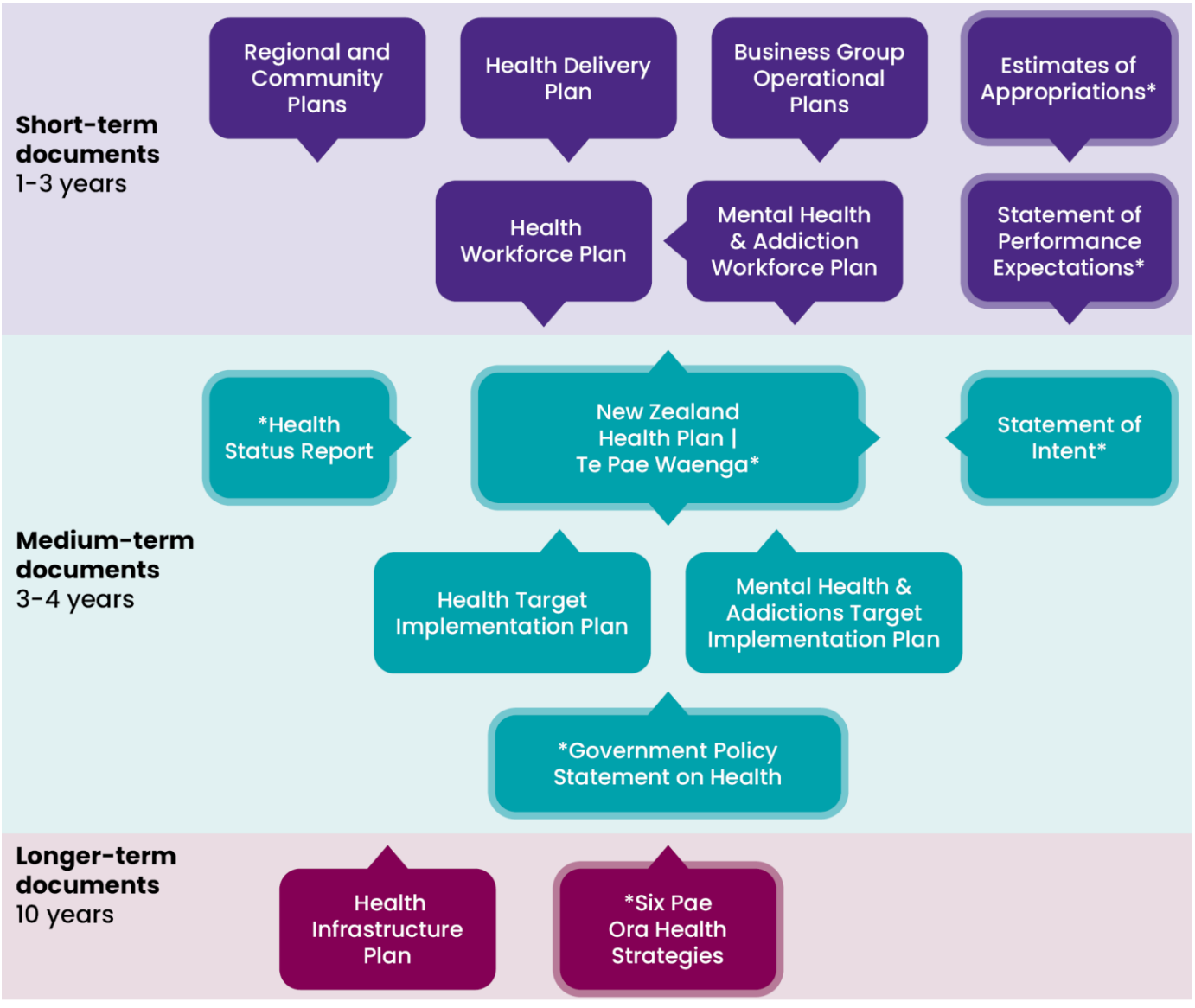
Links to supporting documentation

- Government Policy Statement on Health (GPS)
- Health Strategies
- Service Coverage Expectations
- Statement of Intent
- Statement of Performance Expectations
- Health Status Report
- New Zealand Health Workforce Plan 2024
- Mental Health and Addiction Workforce Plan 2024 - 2027
- Health Targets Implementation Plan
- Achieving the mental health and addiction targets - High level implementation plans New Zealand Cancer Action Plan 2019-2029
- Whakamaua: Māori Health Action Plan 2020-2025

Appendix 1 - How this plan was developed

Our planning landscape

The relationships between this plan and other strategy and accountability documents are illustrated below, including those required under the Pae Ora Act and the Crown Entities Act 2004.



Health NZ and this plan are guided by the long-term direction for the health system set out in the six Pae Ora Health Strategies - The New Zealand Health Strategy; Pae Tū: Hauora Māori Strategy; Te Mana Ola: The Pacific Health Strategy; the Health of Disabled People Strategy; the Rural Health Strategy; and the Women's Health Strategy.

The plan is supported by more specific plans referenced throughout this plan, including the Cancer Action Plan, Health Workforce Plan, Mental Health and Addiction Workforce Plan and the Health Infrastructure Plan.
This plan recognises the need for more detailed planning at national, regional and local levels, and for specific areas. Having been established just since July 2022, our planning systems and processes are still maturing. In future, we expect Iwi Māori Partnership Boards' role in determining health needs and priorities for Māori will be key to influencing future planning.

Inputs

This plan was jointly developed with Te Aka Whai Ora | Māori Health Authority (until its disestablishment on 30 June 2024). Development of the GPS by the Ministry of Health and Budget 2024 decision-making processes occurred concurrently to developing this plan. Both have informed each other. Inputs include:

- An assessment of our population health needs in the Health Status Report;
- The Government's priorities, including five health targets and five mental health and addiction targets;
- Health NZ's Entity Performance Framework
- Workshops to prioritise actions within the plan. Content from the workshops were also used to develop the GPS
- Submissions from other health entities
- The Government Policy Statement on Health;
- Our analysis of the constraints in how we deliver and fund services following the merger of entities to establish Health NZ. This includes our current and forecast budgets, our capacity, including workforce to meet demand for services, and how we maintain and plan buildings;
- Contributions from Iwi Māori Partnership Boards and whānau voice feedback;
- The contributions of other health entities which also impact the social determinants of health.

Engagement

This plan has been developed with subject matter experts across Health NZ and our providers.

Te Aka Whai Ora (prior to disestablishment) worked with the Ministry of Health to engage with Māori providers, whānau and hapori on the development of Pae Tū: Hauora Māori Strategy. That engagement has informed this plan. We engaged with Iwi Māori Partnership Boards at various stages of development.

We engaged with the Ministry of Health and other health agencies as required by section 53 of the Pae Ora Act, as listed below.

Entity	Roles and responsibilities	Contribution to health outcomes
Ministry of Health	Chief steward for the health of the population and the health system, and lead advisor to Government on health. The Ministry a) sets direction, policy, the regulatory framework and, b) investment for health, and monitors outcomes, system and organisational performance.	Development of the Government Policy Statement on Health which this plan must give effect to.
Public Health Agency	The Public Health Agency leads and strengthens population and public health, with a greater emphasis on equitable health outcomes and the wider determinants of health such as income, education and housing.	Leading on all public and population health strategy, policy, regulatory, intelligence, surveillance and monitoring functions.
Cancer Control Agency	Provides central leadership and oversight of cancer control. The Cancer Control Agency is responsible for the Cancer Control Plan.	Reducing the impact that cancer has as a long-term condition and improve timeliness access and quality of cancer prevention, screening, diagnosis and treatment.
Pharmaceutical Management Agency (Pharmac)	Pharmaceutical Management Agency (Pharmac) has a growing role in deciding which medicines, vaccines, medical devices and related products should be funded and made available to New Zealanders from within a capped budget set by the Government.	Providing pharmaceuticals through public hospitals, community and hospital pharmacies.
Health Quality and Safety Commission	Leads and coordinates work across the health sector to monitor and improve the quality and safety of health services.	Improving the quality of the hospital specialist services, public health services and primary and community care services.
New Zealand Blood and Organ Service	Sole provider of blood, blood products and associated services, including co-ordination of deceased organ donation, tissue donation (eye tissue, heart valves and skin) hip bone donation and operating the National Heart Valve Bank and the New Zealand Bone Marrow Donor Registry.	Developing a strategy for blood management in New Zealand.

Health Research Council	Government's principal funder of health research.	Supporting the Ministry of Health, health sector and community-led research efforts to address issues across the health sector by pooling resources in joint funding calls.
Mental Health and Wellbeing Commission	Provides independent, system-level oversight of mental health and wellbeing in New Zealand.	Progressing the government targets for mental health, better target system settings and existing investment, and to align and consolidate measurement of wellbeing.
Health and Disability Commissioner	Supports health and disability service providers to uphold the rights of consumers of those services.	Supporting and upholding the consumer voice and raising and addressing issues related to inequitable health outcomes or access to health services.
Te Whaikaha – Ministry of Disabled People	Works in partnerships with the disability community, Māori and Government for a better, more independent future for disabled people and whānau in New Zealand.	Ensuring that Health New Zealand services and policies promote equitable health outcomes and access to health services for disabled people | tāngata whaikaha.

Other agencies and entities that we have engaged with include:

Accident Compensation Commission

Alzheimer's New Zealand

Home and Community Health

Ministry of Ethnic Affairs

Ministry of Housing and Urban Development

Ministry of Justice – Harm Reduction and Public Safety

Ministry for Primary Industries

Ministry of Social Development

Ministry for Women

New Zealand Police

Oranga Tamariki

Tertiary Education Commission

Appendix 2 – Letter of Representation and Auditor-General's audit report

Health New Zealand
Te Whatu Ora

23 May 2025

John Ryan
Controller and Auditor-General
PO Box 3928
Wellington 6140

Tēnā koe John,

Letter of representation for the audit of the New Zealand Health Plan

This representation letter is given in connection with your audit of the New Zealand Health Plan (the Plan) for the three-year period 1 July 2024 to 30 June 2027.

This representation letter is provided to you in connection with your responsibility under the Pae Ora (Healthy Futures) Act 2022 (the Act) to audit the Plan.

We understand that your audit was carried out in accordance with International Standard on Assurance Engagements (New Zealand) 3000 (Revised) *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information*. In meeting the requirements of this standard, we understand you considered elements of the Auditor-General's Auditing Standards and International Standard on Assurance Engagements 3400 *The Examination of Prospective Financial Information* that were consistent with those requirements.

We also understand that your audit was (to the extent that you deemed appropriate) for the purposes of expressing an opinion about whether the Plan:

- gives reasonable effect to the Government Policy Statement on Health 2024-2027 (the GPS);
- provides a reasonable basis for:
    - delivering publicly funded health services by Health New Zealand – Te Whatu Ora (Health New Zealand); and
    - achieving the desired improvements in health outcomes, including improvements to address health disparities.
- has been costed by Health New Zealand, based on reasonable assumptions for delivering the publicly funded health services and the priorities for the desired improvements; and
- sets out reasonable performance measures for the key services and activities to be delivered and reasonable outcome measures intended to be achieved for the prioritised desired improvements in health outcomes.

We understand the audit would not necessarily disclose any or all irregularities should any exist.

We acknowledge that actual results are likely to be different from the forecast information because anticipated events frequently do not occur as expected and the variation may be material, and that you express no opinion about whether the forecasts will be achieved. We also acknowledge that you do not express an opinion on the merits of any policy content of the Plan.

We note that until 30 June 2024 the preparation of the Plan was a joint responsibility of Health New Zealand and Te Aka Whai Ora | Māori Health Authority (Te Aka Whai Ora).

We confirm, to the best of our knowledge and belief, the following representations:

New Zealand Health Plan is a substantially developed Plan that will continue to evolve

1. The Act states that the purpose of the Plan is to provide a 3-year costed plan for the delivery of publicly funded services by Health New Zealand.

2. There is no definition in the Act of the term "costed Plan". The term is not used in any other New Zealand legislation.

3. As an organisation, Health New Zealand is still maturing, having been established less than three years ago. The Minister of Health has expressly recognised that the systems and processes that Health New Zealand inherited from some of the previous District Health Boards were not adequate for the purpose of overseeing the financial and non-financial performance of Health New Zealand.[1]

4. Within the first two years of operations, Health NZ had not focussed sufficiently on building an operating model that ensured alignment between financial reporting and management accountabilities. This meant one of the key objectives of the health reforms – to achieve integrated planning, financial management and service coordination – has not yet been achieved. This was recognised in the recently published "Health NZ Financial Management Review" undertaken by Deloitte, which expressly acknowledges the material challenges which resulted from the shift from a decentralised to a national operating model. We are still developing systems and processes that in due course will reflect a mature, collaborative, and well-planned organisation.

5. In that context there is material uncertainty as to what the term "costed Plan" was realistically intended to mean at this stage of Health New Zealand's maturity journey.

6. As noted in the Plan, when Health New Zealand was established, it was anticipated that it will take at least two full three-year planning cycles to develop and implement new systems and processes that will enable the services that we provide to be costed.

7. Despite that expectation, significant work has already been undertaken in relation to activity and production planning and setting budgets, and some work has been undertaken towards developing nationally consistent approaches to costing. The linkages between planning, budgets and costing will (going forward) be developed to a degree of granularity and traceability that will in due course provide stronger support for your audit processes.

8. Our responsibility therefore is to develop and submit to the Minister a Plan that reports on the activities that we are undertaking, presents the outputs of our work to date, and describes the further progress we intend to make in the development of a plan in which all the services we provide are costed. We take that responsibility seriously.

[1] https://www.beehive.govt.nz/release/commissioner-replaces-health-nz-board

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Assessment of population health needs

9. The Plan contains a summary of the published Health Status Report on pages 14 to 17, together with a link to the full Health Status Report on our website. It is our view that the Health Status Report meets the requirements of the Act that the Plan must contain an assessment of population health needs. We are of this view because the Health Status Report does assess population health needs and identifies opportunities for outcome improvement (including equity).

Prioritised improvements

10. The Health Status Report assisted us to determining our desired improvements for equitable health outcomes which are described on pages 7 to 8 of the Plan. Our Entity Performance Framework set out on page 60 to 61 provides a clear line of sight on how we will know we have made measurable improvements in health outcomes.

11. Priorities for how we should go about achieving the improvements are derived from the GPS – namely actions focussed on improving access, timeliness or quality of healthcare services. These actions are outlined on pages 18 to 43. Together, these actions are intended to lead to desired improvements in health outcomes.

12. The actions are our best estimate of what is able to be achieved within the three years commencing 1 July 2024 to give effect to the objectives and expectations in the GPS.

Health sector principles

13. We confirm that, in developing the Plan, we have been guided by the health sector principles as far as reasonably practicable, having regard to all the circumstances, including any resource constraints (as required by Section 7(2) of the Act).

Underlying information and assumptions

14. We have provided you with all the supporting information that has underpinned the Plan. The Plan has been prepared using the best information currently available to us, noting the limitations described on pages 7 to 8 of the Plan around our maturity in integrated nationwide operational and financial planning and pages 44 to 48 on fully understanding our cost base, and our plans to move to activity-based planning.

15. Accordingly, the underlying forecast information included in the Plan is our best estimate, at this point in time, of the events that are anticipated to occur over the three-year period commencing 1 July 2024.

16. All significant forecasting assumptions have been included in the preparation of the forecast information and have been provided to you for testing the underlying forecast information. Where significant forecasting assumptions have a high level of uncertainty, we described that uncertainty to you with their potential effects on the forecast information.

Performance framework

17. The performance measures specified or referred to on pages 60 to 65 of the Plan reflect how we will measure the outcomes and impacts of the actions intended to be achieved by Health New Zealand in giving effect to the GPS.

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General

18. We accept that we are responsible for the development of a Plan.

19. For the reasons noted above, we consider that we have discharged, and are continuing to discharge, that responsibility to the best of our ability given the acknowledged deficiencies of the systems and processes that Health New Zealand inherited at its establishment. We further consider that significant progress has been made in addressing these deficiencies, particularly on the areas of activity and production planning and budget setting, and we have a roadmap to guide our work to improve our costing.

20. We have complied with our responsibility to engage with the Ministry, other health entities, relevant Māori organisations, and individuals and organisations that Health New Zealand deemed necessary to prepare the Plan (as set out in sections 20(1)(b)(i) and 53(1) of the Act).

21. We confirm that (having made such enquiries as we considered necessary for the purpose of appropriately informing ourselves) we have provided you with:

    - all information that is relevant to preparing and presenting the Plan; and
    - unrestricted access to persons within Health New Zealand from whom you determined it necessary to obtain audit evidence.

22. We confirm that all minutes of meetings of the Commissioner and Deputy Commissioners and their sub-committees (as well as those of the previous Boards and sub-committees of Health New Zealand and Te Aka Whai Ora) held to date in connection with the Plan have been made available to you for inspection, including summaries of recent meetings for which minutes have not yet been prepared or approved.

23. We have provided you with the Health Status Report and health target high-level implementation plans that are part of the Plan and website links to other relevant published plans which form part of Health New Zealand's overall planning landscape, and confirm there are no other documents that will accompany the Plan. The Health Status Report is consistent with the other parts of the Plan, and we have taken all reasonable steps to ensure that the Plan does not contain any material misstatements.

24. The Commissioner and Deputy Commissioners accept responsibility (in the period since 1 July 2024) for establishing and maintaining systems and processes that provide a reasonably reliable basis for development of the Plan, and for deriving its underlying information. We have made substantial progress towards implementing and strengthening our processes to further support this objective.

25. The Commissioner and Deputy Commissioners accept responsibility for the electronic presentation of the audited Plan and audit report, and that the information presented on the website will be the same as the final signed version.

26. We have assessed the security controls over audited forecast information and the related audit report and are satisfied that procedures in place are adequate to ensure the integrity of the information provided.

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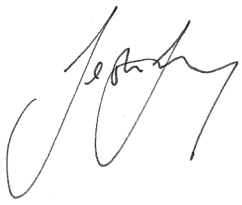
Sign-off on these representations

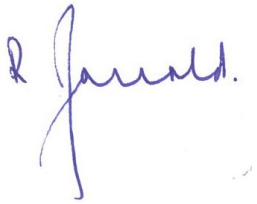
These representations are made at your request, and to supplement information obtained by you from the records of Health New Zealand and to confirm information given to you orally.

For and on behalf of the Commissioner and Deputy Commissioners:

Nāku noa, nā



Professor Lester Levy
Commissioner



Roger Jarrold
Deputy Commissioner

TeWhatuOra.govt.nz
PO Box 793, Wellington, Postcode 6140

INDEPENDENT AUDIT REPORT

TO THE READERS OF

THE NEW ZEALAND HEALTH PLAN | TE PAE WAENGA
FOR THE 3-YEAR PERIOD 1 JULY 2024 TO 30 JUNE 2027

Health New Zealand | Te Whatu Ora (Health New Zealand) is required by the Pae Ora (Healthy Futures) Act 2022 (the Act) to develop a New Zealand Health Plan | Te Pae Waenga. Until the disestablishment of Te Aka Whai Ora | Māori Health Authority (Te Aka Whai Ora) on 30 June 2024, this was a joint responsibility of Heath New Zealand and Te Aka Whai Ora.

This New Zealand Health Plan | Te Pae Waenga (the Plan) covers the 3-year period from 1 July 2024 to 30 June 2027 and comprises the following documents:

- the New Zealand Health Plan document;
- the Health Status Report 2023;
- Achieving the Health Targets - High Level Implementation Plans July 2024 – June 2027; and
- Achieving the Mental Health and Addiction Targets - High Level Implementation Plans July 2024 – June 2027.

I am required by the Act to carry out an audit of the Plan.

Disclaimer of Opinion

Because of the significance of the matters discussed below in the *Basis for Disclaimer of Opinion* section of my report, I am not able to form an opinion on whether the Plan provides a reasonable basis for delivering publicly funded health services to achieve desired improvements in health outcomes, or gives reasonable effect to the Government Policy Statement on Health.

Basis for Disclaimer of Opinion

The Act states that the purpose of the Plan is to provide a 3-year costed plan for the delivery of publicly funded services by Health New Zealand. The Plan should enable a subsequent assessment of the performance of Health New Zealand in the annual performance report against the Plan as required by the Act.

The Plan is required by the Act to identify desired improvements in health outcomes and priorities for the improvements. The Plan sets out five high-level desired improvements in health outcomes on page 7 as well as 10 health targets on pages 19 and 20. The Plan also includes actions intended to achieve improvements in aspects of the health system. I expected the Plan to provide a clear explanation of how the actions have been selected and prioritised, and how the actions will contribute to the achievement of the desired improvements and targets. The Plan does not do this.

I consider that a costed plan should clearly set out the publicly funded health services and activities to be delivered and their forecast cost. I expected the Plan to be based on clear and reasonable assumptions about health needs and the expected quantity of service demand, the resources needed to provide those services, and the forecast cost of those resources. The Plan does not do this.

The Plan is required by the Act to describe how service and investment changes, and how providing and commissioning services, will achieve the desired improvements in health outcomes. These service and investment changes should be based on clear and reasonable assumptions (including required resources and trade-offs with other services), and costings that can be traced through to the overall costing of the Plan.

The Plan developed by Health New Zealand does not meet my expectations for a costed Plan as set out above.

Health New Zealand has provided information on its approach to costing in Section 6 of the Plan. This section includes the statement:

"*The New Zealand Health Plan 2024-27 is a plan that is indicative of our current level of maturity. It is not costed to the level of traceability and integration between the financials, activities, and desired improvements expected from a fully mature New Zealand Health Plan*."

This statement is consistent with our findings. Section 6 of the Plan also sets out work underway and planned by Health New Zealand to improve costing going forward.

The responsibilities of the Commissioners for the development of the Plan

The responsibility of Health New Zealand is to develop a 3-year plan for delivering publicly funded health services, that:

- gives effect to the Government Policy Statement 2024-2027 (the Government Policy Statement); and
- provides costings.

In developing the Plan, Health New Zealand must:

- be guided by the health sector principles set out in section 7 of the Act;
- engage with the Ministry of Health, other health entities, and other organisations and individuals Health New Zealand considers appropriate; and
- take into account:
    - the functions and services of health entities and government agencies that contribute to improving health outcomes;
    - the roles of the Cancer Control Agency, the Health and Disability Commissioner, the Health Research Council, the Mental Health and Wellbeing Commission, and the Ministry of Health (including the Public Health Agency); and

- the functions and services of non-government agencies.

The Plan must:

- set out how the purpose of the Act will be achieved;
- contain an assessment of population health needs;
- identify desired improvements in health outcomes and priorities for the desired improvements;
- specify measurable outcomes for the priorities, including outcomes that are culturally specific;
- describe how publicly funded health services will be delivered to achieve the desired improvements, and which health entities and agencies will be responsible for delivering these services and contributing to the desired improvements;
- set out key performance measures for the planned services and activities to be delivered; and
- set out how Māori will be engaged with and empowered to improve their health, and how Māori interests and aspirations will be protected.

The responsibilities of Health New Zealand and the required content of the Plan are set out in sections 50, 51, and 53 of the Act.

My responsibility for the audit of the Plan

I am required to audit the Plan. This is a responsibility set out in section 53(2) of the Act. To meet this responsibility, my staff and I planned and performed procedures to obtain reasonable assurance about the matters to be included in my opinion.

The audit was planned 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), which is issued by the New Zealand Auditing and Assurance Standards Board, and elements of the Auditor-General's Auditing Standards, as appropriate.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out 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 my professional judgement, which includes considering the risks of material misstatement in the Plan. The planned procedures included:

- assessing the systems, processes, and controls applied to prepare the Plan;

- assessing how the Plan gives effect to the Government Policy Statement and how the Plan has taken into account:
    - the health sector principles;
    - the results of engagement with those parties required by the Act; and
    - the functions, services, and roles of health-related government agencies and non-government agencies.
- assessing how the population health needs assessment was carried out, and how the desired improvements in health outcomes and the priorities for those desired improvements have been identified, including improvements to address health disparities, particularly for Māori;
- assessing the process for identifying service and investment changes proposed to deliver the desired improvements in health outcomes, and the expert evidence to support those changes contributing to or achieving the desired improvements;
- assessing how the resources required to deliver the Plan (including human and physical resources), and the proposed changes in service and investment, have been determined and how these compare with planned resources available over the term of the Plan;
- testing controls over the preparation of the costings for the 3-year period of the Plan and testing that the costings are based on reasonable assumptions for delivering the publicly funded health services set out in the Plan;
- assessing how measurable outcomes of the priorities for health improvement and performance measures have been determined, and assessing whether those measures are appropriate; and
- considering the content and overall presentation, coherence, and clarity of the Plan.

However, because of the significance of the matters described in the *Basis for Disclaimer of Opinion* section of my report, I was not able to obtain sufficient appropriate audit evidence to provide a basis for an opinion on the Plan.

This audit is not intended to provide assurance that the planned health services, health outcomes, costings, or performance measures will be achieved, because events do not always occur as expected and variations may be material. Nor does it guarantee complete accuracy of the information in the Plan.

This audit is also not intended to express an opinion on the merits of the policy content described in the Plan, the Government Policy Statement, or the health strategies.

Independence and quality management

As an Officer of Parliament, I am constitutionally and operationally independent of the Government.

In carrying out this audit, my staff and I 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.

We have also complied with the Auditor-General's 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 about compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

As well as this audit, my staff and I carried out other audit and assurance engagements in respect of Health New Zealand that are compatible with these Standards. These other engagements have not impaired my independence. My staff and I use publicly funded health services on the same basis as others. Other than these matters, and in exercising my functions and powers under the Public Audit Act 2001, I have no relationship with or interests in Health New Zealand.

John Ryan
Controller and Auditor-General
Wellington, New Zealand
23 May 2025

Health New Zealand
Te Whatu Ora