

Annual Report

Pūrongo-ā-tau

2023/24



Presented to the House of Representatives
pursuant to section 150 of the Crown Entities
Act 2004 and section 60 of the
Pae Ora (Healthy Futures) Act 2022.

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

First published 2024 by Health
New Zealand | Te Whatu Ora
PO Box 793, Wellington 6140, New Zealand.

ISBN 978-1-991139-08-5 (print)
ISBN 978-1-991139-02-3 (online)

Te Whatu Ora

Health New Zealand

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**Tūria, tūria te mata hau nō Rangi
Tūria, tūria te mata hau nō Papa
Paiheretia te tangata ki te kawa tupua,
ki te kawa tawhito
He kawa ora! He kawa ora!
He kawa ora ki te tangata
He kawa ora ki te whānau
He kawa ora ki te iti, ki te rahi
He kawa tātaki ki au mau ai
Tūturu o whiti, whakamaua kia tīna
Hui e! Tāiki e!**

Elevate and celebrate the gifts of Rangi
Elevate and celebrate the gifts of Papa
People are bound by the spiritual forces of ancestry
Uplift the spirit! Support the spirit!
Raise up the health of people, of family, of all
A spirit that guides me
Hold fast! Uphold the essence
Bring it together! It is complete.

Written by Rāhui Papa

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Section 1

Introduction

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From the Commissioner



At Health New Zealand | Te Whatu Ora our ambition is to provide quality, compassionate, affordable healthcare to all New Zealanders, at the right time and in the right place, and there is considerable work to do to achieve this.

This annual report provides an insight into the work done by Health NZ in 2023/24, as well as the significant challenges facing Health NZ in 2024/25 – specifically waiting time reduction and financial health.

I was appointed as Chair of the Board of Health NZ in June 2024 and in July appointed as Commissioner by the Minister of Health, tasked with restoring the performance of Health NZ by improving access to healthcare services and living within the financial budget.

The Deputy Commissioners and I, working with the Chief Executive have moved swiftly to tackle Health NZ's current distressed financial situation through more robust financial management. We are currently in the early phases of that process as we set effective performance levers and internal controls in place.

Increased waiting times in recent years have led to a steady decline in access to critical health services. We are currently in the process of changing the way we operate, primarily to address the unacceptable waiting times for assessment and treatment. This is not limited to emergency departments and planned care only – it is ultimately about making changes to the flow of patients across the entire health system to promote timely access to all services.

This new way of operating includes a devolved model of decision-making, moving away from the centralised model, empowering regions to make decisions closer to home about how health care is delivered for local communities. Four deputy chief executives have been appointed with responsibility for these devolved services, with the focus on delivering reduced waiting times as well as restoring the organisation to financial health.

I believe that the safest wait is the shortest wait, and every patient, family and community needs and deserves access to the quality care and treatment in a timely way. It will take us time to fulfil these ambitions, but we are moving as quickly as possible to ensure that we do.

In April 2024 the financial performance of Health NZ deteriorated abruptly with a loss for the month of \$197 million revealing a major underlying problem of significant beyond budget expenditure. This beyond budget expenditure continued through to the end of the 2023/24 financial year and into the 2024/25 year, creating a complex set of financial challenges. If this serious recurrent monthly deficit is not reversed it will result in a very large and unacceptable forecast financial deficit for Health NZ approaching \$1.76 billion for the 2024/25 financial year. In this context, returning Health NZ to living within its means requires a comprehensive programme of cost reduction equivalent to the beyond budget expenditure. This is part of the plan for Health NZ, which will run through the remainder of the 2024/25 financial year and into 2025/26.

Health NZ has been working with various expert advisors to quantify and pay our staff amounts owed for holiday pay remediation under the Holidays Act 2003. A single payment of \$240 million was made in August 2023 to currently employed Te Toka Tumai Auckland region staff. A provision of \$1.825 billion for holiday pay remediation is held in the accounts as of 30 June 2024. We acknowledge the work of the remediation team, and that of Audit NZ (who are of the view that elements of the remaining provision may be overstated). We at Health NZ are concerned that adequate provisioning is in place to meet the requirements of the remediation, and we are now focused on making the remaining remediation payments owed to current and former employees as a matter of urgency.

To deliver more health services to our patients, families and communities, and achieve better health outcomes for them, we must use all our funding and resources more efficiently and effectively, particularly considering there have been year-on-year increases in funding to Health NZ with a funding uplift of 6.3 per cent in the current 2024/25 year. We need to ensure the public derives benefit from this increased funding by providing more health services to them.

I would like to highlight and thank our committed, compassionate and highly skilled health workforce. As we address the deteriorating waiting times and overcome our financial difficulties, we will be taking every step we can to strengthen the clinical frontline, support our staff and create a strong clinical culture within Health NZ.

Professor Lester Levy
Commissioner

From the Chief Executive



Our 2023/24 annual report reflects the last year of our two-year transition period. It is a year in which we have faced a significant number of challenges.

Last year we acknowledged it would take time to streamline the 28 former entities into a single organisation. We made some progress, but against a backdrop of financial pressures we were unable to stay within our budget. Health NZ's financial result for the year ended 30 June 2024 is a deficit of \$722 million.

This result has been caused by a range of factors that impacted our financial performance.

Firstly, we recruited more people than we had budget available for. The labour market changed, we attracted more applicants for positions than we expected, and we lacked the internal controls to manage this adequately. The staff were also recruited at a higher salary rate than budgeted due to pay equity and collective employment settlements.

In addition to over recruitment, we also incurred higher costs than budgeted in personnel. These arose from salary changes out of collective settlements above budget (e.g. settlement rates ranging from 4% to 13.8% compared to the budgeted level of 3%), allowances and staff liability uplifts. This resulted in personnel costs greater than budget by \$797m.

Several measures were put in place during quarter four to offset the expenditure trend, however the savings made were insufficient to rebalance expenditure back to budget. These efforts continue into the 2024/25 year as part of Health NZ's reset.

Looking beyond our financial position, we remain committed to delivering a system that protects, promotes and improves everyone's health and this year has shown some 'green shoots'. We have:

- taken a successful health protection approach to manage 12 separate measles responses
- commissioned primary care services to enrol 4.9 million people
- treated and cared for more people in our hospital and specialist services than ever before – over 1.3 million people attended our emergency departments and nearly 2.1 million people received first specialist assessments or follow-ups, a year-on-year increase of over 50,000 and 40,000 respectively. Our hospitals provided for more than 942,000 case-weighted discharges, an increase of over 40,000.
- more training places available at medical school, for pharmacy prescribers and for nurse practitioners.

Our transformation will continue, but the lesson from this year is that it is not an easy journey. We need to work hard to improve health services across New Zealand, while ensuring we stay within the budget we have been set.

The good news is that Budget 2024 provided us with a multi-year funding track so we will be able to plan with certainty and return to budget within two years. The other positive is that we continue to have amazing people as part of our team. Every time I visit a health care facility, or new office around the country, I'm blown away by the dedication and expertise of our people. The work they do supporting some of New Zealand's most vulnerable people cannot be overstated.

Fepulea'i Margie Apa
Chief Executive

Introducing Health New Zealand | Te Whatu Ora

Health New Zealand | Te Whatu Ora is a Crown agent under the Crown Entities Act 2004.

Health NZ leads the day-to-day running of publicly funded health care, with our trusted and skilled workforce providing high-quality health services to New Zealanders.

We deliver many of these services directly (e.g. hospital services) and we partner with providers by purchasing and funding other services (e.g. primary and community care).

The health of our communities is influenced by the conditions in which New Zealanders are born, grow, work, live and age. Our public health service works to minimise the cause and spread of illness, improve our environment and advocate for change to social factors that impact health.

As an organisation, our goals are to:

- keep people well in their communities
- provide people with timely, quality and compassionate care
- ensure our staff are safe and supported to deliver that care
- achieve equity in health for all New Zealanders
- ensure the health system is resilient and supports quality health care delivery
- build towards healthy futures for all New Zealanders.

A board is responsible for our governance and accountable to the Minister of Health. The board was in place for the first two years of the organisation's existence and has now been replaced by a Commissioner for the next financial year, 2024/25.

Our enabling legislation

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

The purpose of the Pae Ora Act is to improve the health of New Zealanders and achieve health equity. It sets Health NZ's five objectives:

- to design, arrange and deliver services to achieve the purpose of the Act in accordance with the health sector principles
- to encourage, support and maintain community participation in health improvement and service planning
- to promote health and prevent, reduce and delay ill health, including by collaborating with other agencies, organisations and individuals to address the determinants of health
- to achieve the best possible health outcomes for all New Zealanders
- to ensure that planning and service delivery respond to the aspirations and needs of the population.

The Pae Ora Act requires Health NZ to act according to the code of expectations for health entities' engagement with consumers and whānau. The code is administered by the Health Quality and Safety Commission (HQSC) and sets expectations for how health entities must work with consumers, whānau and communities in the planning, design, delivery and evaluation of health services.

Our relationship to the Minister of Health

The Minister oversees and manages the Crown's interests in, and relationship with, Health NZ including functions and powers to:

- appoint and remove board members and determine remuneration
- give directions to Health NZ (with some limitations)
- review operations and performance, including through monitoring
- request information
- participate in setting strategic direction and performance expectations.

Our partner agencies and how we work together

Operating and improving the health services we fund and deliver depends on close relationships with our partners and stakeholders including consumer groups, professional bodies, unions, non-governmental organisations, primary health organisations and private companies.

In 2023/24 we worked closely with the following health agencies:

- **Ministry of Health | Manatū Hauora** as the Minister's primary advisor on health policy, regulatory settings and health system performance
- **Te Aka Whai Ora | Māori Health Authority** on significant parts of our work, including the development of health plans and monitoring of our delivery of hauora Māori services¹
- **Pharmac | Te Pātaka Whaioranga** pays Health NZ for pharmaceuticals, which totalled \$2.152 billion in 2023/24. Of this, \$622 million related to our hospital services, with the balance for community dispensed pharmaceuticals
- **Health Quality & Safety Commission | Te Tāhū Hauora** on improvements to our health services and to play back the voice of our consumers from their interactions with us.

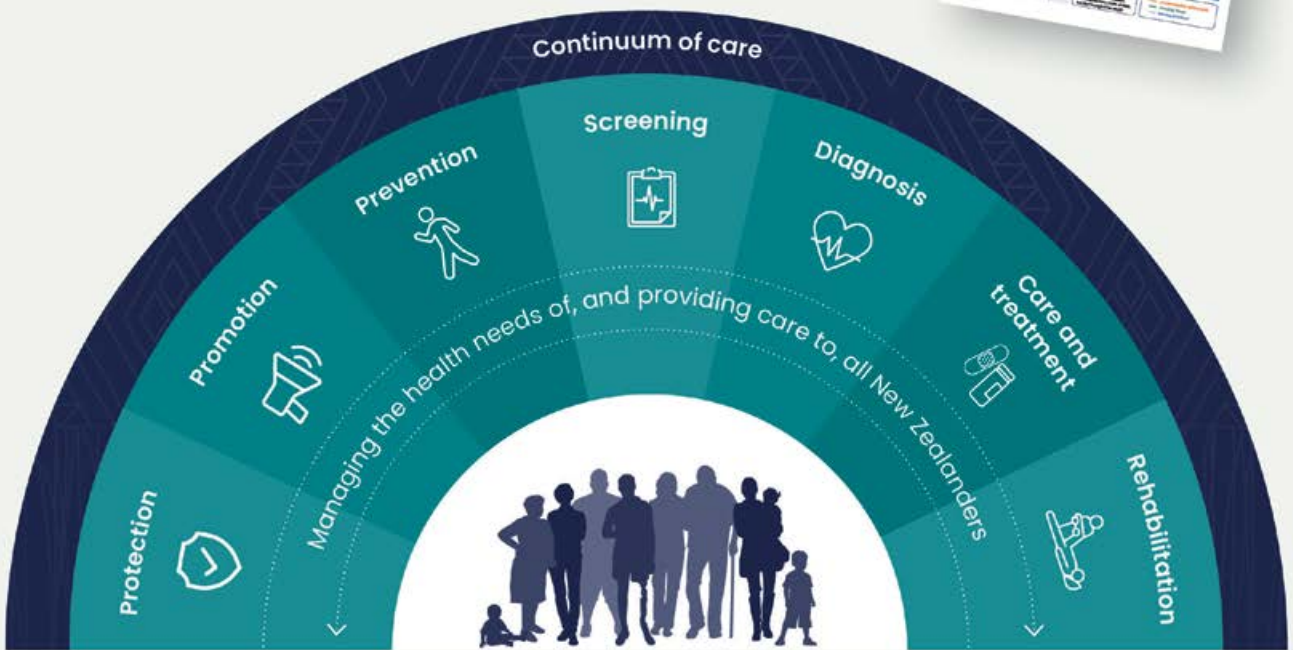
1. Te Aka Whai Ora no longer exists as a separate entity and its operations have moved to Health NZ and the Ministry of Health. Read more on page 50.

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.

Critical entities in the health system

View at [Ministry of Health Annual Report 30 June 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, ophthalmology, 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 (NGOs)
- Community health and social providers
- Hauora Māori services
- Home based support
- General Practices and Primary Health Organisations (PHOs)
- 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

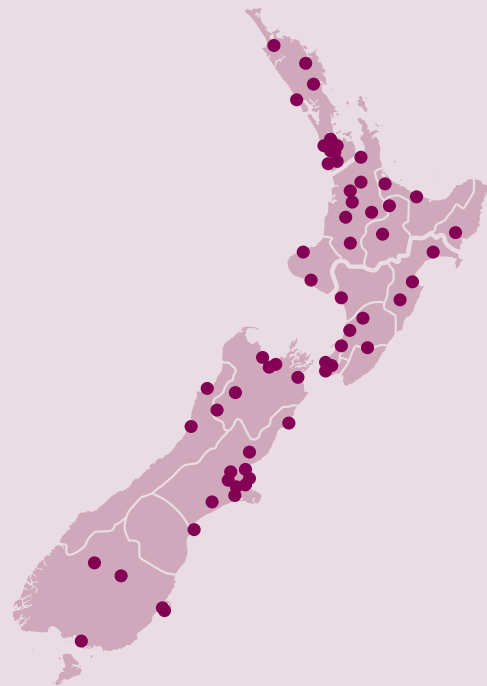
Health NZ owns 86 sites with nearly 11,000 beds or bed spaces. These range from small health care clinics and sub-acute units, through to secondary and tertiary hospitals. Most health clinics offer primary and community health services. They may have inpatient beds for continuing hospital care or low-risk 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.

Health NZ in action Purpose and passion

Starship paediatric cardiologist, Dr Bryan Mitchelson (Ngāti Māhanga/Tainui), was born and raised in Australia, but now living in New Zealand he is re-engaging with his cultural roots to help achieve hauora for mokopuna.

Bryan (pictured opposite) is the clinical lead for paediatric heart failure and transplantation in New Zealand. Although based at Starship Hospital in Auckland, Bryan frequently travels around the motu for outreach clinics to provide care closer to home.

“The best thing about working at Starship is, without a doubt, the people who are focused on providing great care for all mokopuna. I love working here,” said Bryan.

He is passionate about increasing his mātauranga Māori (Māori knowledge) to help build a rapport with patients and whānau. It gives him purpose with his research projects, which are particularly focused on reducing inequity.

Bryan is also carrying out clinical research with a focus on improving Māori health.



“Unfortunately, we see a lot of whānau affected by rheumatic heart disease, which disproportionately affects Māori and sadly has resulted in heart failure and transplant in some young people.”

“On average, Māori survival rates after a heart transplant in childhood are about half as long as the rest of the population.”

Bryan has established a team to create a rheumatic heart disease registry across New Zealand to get a better understanding of this disease. He is also doing research to help identify why heart transplant survival rates for Māori and Pacific are lower than other populations.

“The research is going to take time but is an important step towards understanding the inequities and achieving better health for mokopuna,” Bryan said.

Health NZ in action Creating positive change

The number of people in New Zealand living with dementia is growing significantly and, with an ageing population, will continue to increase.

Currently, many general practitioners don't feel equipped to diagnose dementia and refer to secondary care for assessment, which delays care or the person remains un-diagnosed and unsupported.

A new Cognitive Impairment Assessment process has been created to help GPs confidently diagnose people with dementia and manage their care. This is a big shift in practice and an important step to helping people live with dementia.

The new assessment is part of the Kare programme, which aims to provide a better and more holistic model of care to help keep older adults healthier, so they can stay at home longer. The comprehensive assessment by a nurse assesses cognition, function and social issues that may have not been uncovered in a 15-minute GP visit.

Feedback from GPs and nurses who have received the training and used the Cognitive Impairment Assessment has been very positive.



Dr Diana North (pictured above), a GP and Clinical Lead for Kare, said, “The new assessment enables my nurse to do a holistic assessment looking at function, risk factors and cognitive impairment. This information helps me to guide patients through the early stages of dementia with more confidence, correcting risk factors such as vision and hearing, connecting them with support and starting medication when appropriate.”

With increasing pressure on the health sector and an ageing population, the new assessment means the clinical team can deal with the complex clinical and social issues in older patients.

Te Mauri o Rongo

The New Zealand Health Charter | Te Mauri o Rongo is required by the Pae Ora Act and applies to organisations and workers throughout the health sector.

The charter was developed with input from health workers | kaimahi across the motu and sets out the shared values for everyone working in health care. The values are underpinned by principles and organisational, collective and individual behaviours.



The values are underpinned by principles and organisational, collective and individual behaviours

The four values are:

Wairuatanga

Working with heart, the strong sense of purpose and commitment to service that health workers bring to their mahi.

Rangatiratanga

As organisations we support our people to lead. We will know our people; we will grow those around us and be accountable with them in contributing to healthy futures for all.

Whanaungatanga

We are a team, and together a team of teams. Regardless of our role, we work together for a common purpose. We look out for each other and keep each other safe. "Whiria te tangāta" – we will weave our people together.

Te Korowai Āhuru

A cloak which seeks to provide safety and comfort to the workforce.

Our leadership

Board members

As at 30 June 2024:

- Professor Lester Levy (Chair)
- Naomi Ferguson
- Hon. Amy Adams
- Dr Jeff Lowe
- Ms Tipa Mahuta
- Vanessa Stoddart
- Dr Curtis Walker
- Roger Jarrold

The board had seven committees. Details of these and their membership can be found in Appendix 1.

Note: Roger Jarrold joined the board in the final quarter of 2023/24 and on 1 June 2024 Professor Levy replaced Dame Karen Poutasi as Chair. On 22 July 2024 the Minister appointed Professor Levy as Commissioner for the 2024/25 financial year in place of a board.

The executive leadership team

As at 30 June 2024:

- Fepulea'i Margie Apa | Chief Executive

Delivery and clinical leadership

- Abbe Anderson, National Director, Commissioning
- Dr Dale Bramley, National Director, Service Improvement and Innovation
- Dr Nick Chamberlain, National Director, National Public Health Service
- Fionnagh Dougan, National Director, Hospital and Specialist Services
- Riana Manuel, Chief Executive, Te Aka Wai Ora (until 31 March) / National Director, Hauora Māori Services Group (from 1 April)

- Markerita Poutasi, National Director, Pacific Health
- Dr Richard Sullivan, Chief Clinical Officer

Enabling leadership

- Andrew Slater, Chief People Officer
- Jeremy Holman, Chief Infrastructure and Investment Officer
- Leigh Donoghue, Chief of Data and Digital
- Mahaki Albert, Maiaka Whakaruruhau Tikanga | Chief of Tikanga
- Patrick O'Doherty, Chief Transformation Officer
- Peter Alsop, Chief of Staff
- Ramon Manzano, Chief of Assurance and Risk
- Rosalie Hughes, Chief Financial Officer

Note: As part of the Health NZ reset changes have been made to the executive leadership team. Four regional Deputy Chief Executive roles have been created to empower regions and bring decision-making closer to the communities where care is being provided.

The new Deputy Chief Executives hold budgets and accountability for their regional hospital services and the health services others are funded to provide. This enables them to join up care across community and hospital services.

Details of Health NZ's current leadership arrangements can be found at [Our executive team – Health New Zealand | Te Whatu Ora](#).

Clinical leadership

An important part of providing a joined-up service across the country is strong national clinical leadership and governance. We have appointed a permanent national clinical leadership team, which is critical for providing strong professional leadership for our clinical workforce and will help ensure the delivery of safe, high-quality care.

To further strengthen strategic clinical leadership and engagement in decision-making, we have been establishing national clinical networks throughout 2023/24. The networks comprise of a range of expert health professionals who will develop national clinical standards and models of care. Network co-leads work closely with the national clinical leadership team and with leaders in planning and commissioning to ensure clinical voice is deeply engaged in decision making. The networks will help reduce variation in access to and quality of health care services, and ultimately improve health outcomes for New Zealanders.

National clinical networks

National clinical networks involve experts from different parts of the health system and across professional disciplines working with consumers and whānau, to influence how we prioritise and deliver change. Networks focus on:

- developing national standards and models of care
- identifying ways to address variation in service quality and outcomes

- addressing inequities
- developing innovative, efficient, and evidence-based solutions to inform investments and workforce planning.

The networks work in collaboration with relevant national, regional, and local stakeholders to identify what care and services are required at different levels, who should provide these services, and how they should be delivered. This in turn supports the delivery of consistent service quality and outcomes, including the reduction of access and equity gaps. The Interim New Zealand Health Plan | Te Pae Tata 2022–24 identified the establishment of regional and national networks as a key step in removing unwarranted variations in access to care, waiting times and clinical practice.

During the 2023/24 year, we launched networks for trauma, stroke, cardiac, renal, eye health, radiology, and infection services. To better respond to Māori health aspirations and improve Māori health outcomes, one of the co-leads for each network was appointed by Te Aka Whai Ora. Once appointed, the new co-leads undertook an expression of interest process to establish the wider membership of each network, ensuring interprofessional leadership from across the system.

To date, over 170 clinical staff from across the health system have been recruited as members of the networks.

Networks for cancer, maternity, rural health, diabetes, mental health and addictions, and oral health are expected to launch in the next financial year.

Our workforce

We want our people to feel safe and supported at work.

To help with this, we have focused on the health, safety and wellbeing of our people, invested more in emergency department security, made inroads in addressing longstanding clinical staff shortages (nursing in particular) and worked to improve people's experience at work.

In the past year, there was a rapid change in workforce availability, with more nursing applicants. We hired more nurses and other staff than we have been able to do in recent years.

This meant the cost of our workforce, and in particular our nursing workforce, increased to more than we could afford or had budgeted for. We are now trying to ensure going forward that our ability to recruit new staff is closely aligned to our operating budgets.

Health NZ in action People making a difference

Health NZ's hospital orderlies play an essential role helping medical and nursing staff.

But it's also their special way with patients, charismatic personalities and in-depth knowledge of hospitals that make them both unique and special.

One very special orderly at Taranaki Base Hospital has been playing this pivotal role for almost five decades. Robbie Campbell's huge personality and big heart have kept him happy and dedicated in his orderly role for 48 years.

The 67-year-old secured a permanent role when he was just a teenager.

To say Robbie's seen a lot of changes in health during his career is an understatement. His role was quite different when he started. He assisted with ambulance callouts, groundskeeping, helped district nurses with home care for patients in the community and sometimes drove an ambulance.

These days, Robbie works on the hospital wards and although he's not fazed by most things, he finds it tough seeing injured children and babies.

Robbie pays tribute to the brilliant group of orderlies that make his job great. "I've stayed in the job because of my colleagues. We're one big happy family," he said.



Orderly Robbie Campbell (seated) and his supervisor Ocean Falaniko (standing) at Taranaki Base Hospital

He also loves working with people. His supervisor, Ocean Falaniko said Robbie has a very gentle, calming and soothing way with his patients.

As for retirement, Robbie has no plans for that just yet. He loves what he does and Health NZ loves him. Thank you for your service to health care, Robbie, we are lucky to have you.

Our people

We are the largest Crown entity in New Zealand in terms of the number of our people.

In annual reporting, Health NZ must report on its total workforce. This is a wider group than included in our Health Workforce

Information Programme (HWIP) reporting, which is published quarterly and predates the existence of Health NZ. To date, HWIP has only covered our workforce employed in districts. This annual report covers all Health NZ employees, including those employed by our national office and former shared service agencies.

Definitions

Employee count is a distinct count based on employee number. There is the potential for individuals to be counted more than once if they hold roles with more than one district, or if they hold roles in more than one occupation group.

Contracted FTE – 1 FTE = 2,086 hours per year. This is the number of hours that an employee is contracted to work. It is a simple and convenient calculation that is not subject to significant variation over time (i.e. it does not vary with sick leave, annual leave, accrued leave).

Paid employment status	Employee count	Contracted FTE	% Employee count
Permanent	88,513	76,779.3	85.4%
Fixed term	4,541	4,512.7	4.4%
Others	10,557	1,630.8	10.2%
	103,611	82,923.0	

Employee gender

	Gender	Employee count	Contracted FTE	
Permanent	Female	68,937	58,453.2	
	Male	19,459	18,215.7	
	Gender diverse	14	12.1	
	Unknown	103	98.3	
		88,513	76,779.3	
Fixed term	Female	3,224	3,100.8	
	Male	1,303	1,399.1	
	Gender diverse	S*	S*	
	Unknown	S*	S*	
		4,541	4,512.7	
Others	Female	8,105	1,474	
	Male	1,570	152	
	Gender diverse	S*	S*	
	Unknown	S*	S*	
		10,557	1,631	
Combined	Female	80,266	63,028.5	77.5%
	Male	22,332	19,766.3	21.5%
	Gender diverse	20	13.1	1.0%
	Unknown	993	114.9	
		103,611	82,922.7	100%

*S = Suppressed; When reported results are 5 or below for either employee count or contracted FTE the entire row is suppressed to protect privacy.

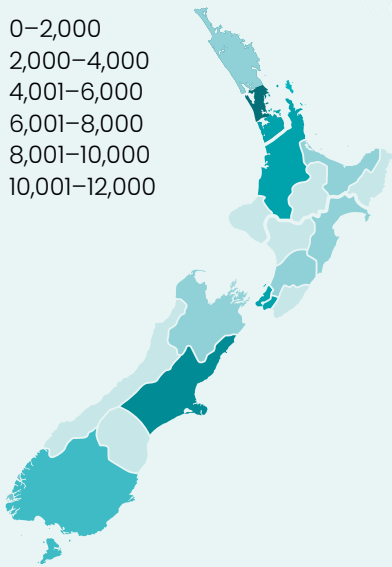
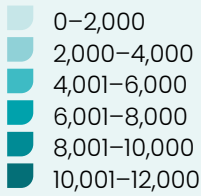
Employee ethnicity

People can and do identify with multiple ethnicities. However the population data presented here is by prioritised ethnicity. This is where an individual is allocated to a single group, as defined by the Ministry of Health's ethnicity protocols (Ministry of Health, 2017). Prioritisation is a reduction process for output and analysis purposes and does not assume this is the ethnic group that a respondent identifies most strongly with.

	Ethnicity	Employee count	Contracted FTE	
Permanent	Asian	25,161	22,800.6	
	European / Other	48,684	41,076.0	
	Māori	6,689	5,770.7	
	Pacific	4,377	4,013.5	
	Unknown	3,602	3,118.5	
		88,513	76,779.3	
Fixed term	Asian	834	906.0	
	European / Other	2,798	2,710.7	
	Māori	486	460.0	
	Pacific	159	156.7	
	Unknown	264	279.3	
		4,541	4,512.7	
Others	Asian	2,306	432.5	
	European / Other	5,402	922.6	
	Māori	848	180.1	
	Pacific	553	32.5	
	Unknown	1,448	63.1	
		10,557	1,630.8	
Combined	Asian	28,301	24,139.1	27.3%
	European / Other	56,884	44,709.3	54.9%
	Māori	8,023	6,410.7	7.7%
	Pacific	5,089	4,202.7	4.9%
	Unknown	5,314	3,460.9	5.2%
		103,611	82,922.7	100%

Workforce snapshot

District clinical workforce by location (FTE)



Te Tai Tokerau Northland	3,315
Waitematā	7,326
Te Toka Tumai Auckland	10,612
Counties Manukau	7,793
Waikato	7,369
Lakes	1,394
Bay of Plenty	3,330
Tairāwhiti	877
Taranaki	1,776
Hawke’s Bay	2,676
MidCentral	2,635
Whanganui	936
Wairarapa	453
Capital, Coast and Hutt Valley	6,174
Nelson Marlborough	2,363
West Coast	700
Canterbury	9,190
South Canterbury	703
Southern	4,673

Employee count

82,923 Contracted FTE
103,611 Employees

Gender

77.5% Female
21.6% Male

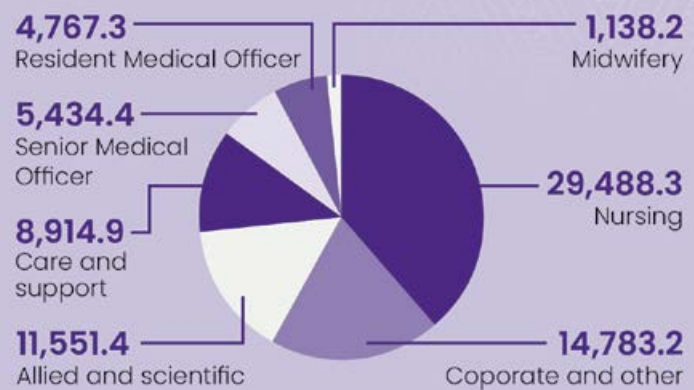
Median salary (total workforce) \$106,739

Health NZ is a 24/7 business, and our staff often receive allowances or additional rates above their usual contracted salaries – for example, to compensate them for working anti-social hours or picking up short-notice work where other staff are sick.

Age and length of service of district clinical workforce by occupation group

Occupation	Mean length of service	Mean age
Nursing	7.6	42.4
Corporate and other	8.1	49.7
Allied and scientific	8.0	43.1
Care and support	6.5	47.0
Senior Medical Officer	10.3	50.0
Resident Medical Officer	1.5	31.4
Midwifery	6.6	46.1

District clinical workforce by occupation



Data for clinical workforce, district FTEs, age and length of service, and employees by occupation groups is sourced from HWIP. Median salary is based on permanent and fixed-term employees on the payroll where FTE is above 0.1.

Workforce partnerships

Unions are a key partner and source of expertise, and another way to get feedback from our staff. We work closely with unions to ensure greater transparency and shared understanding of the direction, opportunities and challenges we face.

We participate in and support union forums including He Ara Tapatahi, alongside NZ Council of Trade Unions and affiliated health unions, and Kāhui Kōkiri, with all health unions, which has focused on people policies and operational issues.

We also have a tripartite health and safety oversight group that ensures our national programmes have prioritised the critical health and safety issues facing our staff.

In addition, local union partners and local leadership teams meet regularly to discuss operational issues, and joint union/Health NZ consultative committees meet at a national and local level.

Pay equity

By late 2023, Health NZ and health unions had resolved all pay equity claims for Health NZ-employed staff, including settlements for nurses, midwives, librarians, interpreters and the allied, scientific and technical workforce. We are working with the unions on implementing these pay equity settlements.

We are also the lead funder for claims in ten funded sectors against:

- providers that employ care and support workers (three claims)
- primary care providers (two claims)
- Plunket (two claims)
- hospice providers
- primary birthing providers
- providers in the care sector for frontline managers and co-ordinators.

We are working with providers and other government agencies to help them settle their claims. In addition, Health NZ has been working with providers to implement the 2022 funded sector social worker pay equity extension.

Diversity and inclusion

Health NZ recognises that a diverse workforce and inclusive practices will help us be fairer, more responsive, provide better support to the communities we serve, and attract and retain our key talent.

We are committed to building a strong and positive culture where our people can be themselves, feel heard and included, and bring their best selves to the work they do – caring for, and supporting our patients and our communities.

Workforce feedback

We ask our staff for feedback on their experiences of working at Health NZ through the pulse survey. We ran our first pulse survey in 2022.

The results highlighted staffing pressures, communications and cultural safety themes.

Actions taken following the 2022 pulse survey

We recruited additional staff to relieve pressure by growing the health workforce and filling vacancies. We funded additional medical school places, expanded a voluntary bonding scheme to include anaesthetic technicians and pharmacists, and established

a nationwide system for managing clinical student placements.

We communicated changes following the health reforms in a clearer way through dedicated virtual webinars and e-newsletters, and we created tools and resources to help our leaders effectively lead through change.

We also prioritised actions to address discrimination and build cultural safety. This included updating our te Tiriti o Waitangi e-learning module and developing an e-learning module on racism, privilege and cultural safety.

We conducted our second pulse survey in April 2024, with 24,000 participants. The results are shown below.

Participation rate

32.5% or 33,416 of our kaimahi participated in the survey



↑ Increase of **5,000** compared to 2022

63% average score across all questions



↑ Increase of **3%** compared to 2022

Highest-rated question

84% – I have the capacity to be compassionate and caring to those around me



↑ Increase of **2%** compared to 2022

Lowest-rated question

40% – My team has the resources we need to perform our roles well



↑ Increase of **7%** compared to 2022

Questions where we saw a decrease

59% – I understand the reasons for changes taking place in our health care system



↓ Decrease of **3%** compared to 2022

51% – The changes our organisation is making will enable us to better meet the needs of our communities



↓ Decrease of **5%** compared to 2022

We asked our people what specific action we could take to improve the experience of working at Health NZ. The five major themes were:

- **employee experience** – training and development, reward and recognition, communication, and fostering a positive and inclusive workplace culture
- **resources** – people, facilities and having the time to do your job well
- **leadership** – leaders do not feel equipped to do their jobs, manage change, make decisions, and communicate openly and transparently
- **operational processes and systems** – enhancing collaboration and being more efficient and cost effective
- **health care services** – putting patients first and providing a level of service and care we can all be proud of.

Health NZ in action Upskilling our people

We held three wānanga to bolster nurse competencies and provide a pathway for select vaccinators to become accreditors, to help address the number of tamariki in MidCentral awaiting immunisations. A majority of the nurses attending the sessions were Māori.

Nurses engaged in hands-on learning and practical sessions, with 65 nurses completing whole-of-life vaccinator training and eight nurses assessed for competency. The wānanga showed the value of a regional approach for developing our nursing workforce and helped foster local relationships to improve collaboration. One nurse commented that it was a “great way to refresh – safe, inclusive”.

It also provided us the opportunity to enhance co-operation and collaboration with other health providers.



Through the fixed and outreach clinics run alongside these wānanga, 232 tamariki were immunised. The wānanga also provided opportunities to raise awareness about immunisations among communities and whānau.

Supporting staff through change and uncertainty

We implemented two programmes to help leaders support our staff through a period of significant change and uncertainty. The 'leading through disruption' seminars gave more than 2,500 people leaders the tools to help manage change more effectively. Our 'leading into transformation' series focused on inspiring leaders, while developing their skills and confidence to lead through uncertainty.

We have also established a leadership development institute, focusing on critical and operational leadership skills. The process to appoint a provider to deliver programmes for the institute is ongoing.

Developing high performing teams

To support leaders in effectively building and managing new and existing teams, we designed e-learning modules on developing high performing teams and leading virtual teams.

The modules help leaders determine where their team's development is at, support their performance and progression, and introduce the nuances of managing remote teams virtually. We have also created additional resources for teams to use the skills in their everyday practices.

Health NZ in action

Recognition of expertise

John Fa'ukafa is of Tongan whakapapa and is a registered nurse at Auckland's Sexual Health Service and Pohutukawa Clinic.

He was inspired to choose a career in nursing after suffering from health issues growing up. "I was always surrounded by nurses and very aware of the importance of health and wellbeing," John said. These experiences, along with his two favourite subjects being health and biology, made the decision to choose a career in nursing an easy one.

John now uses his experience to best support patients regardless of their age, ethnicity, sexuality or gender identity. He always views the service from a patient perspective and finds ways to reduce the barriers to being seen.

A typical day on the job varies but there is always something exciting and different. "The most rewarding part is seeing patients who came into the clinic feeling anxious and intimidated, come out feeling hopeful and informed," John said.



John Fa'ukafa (pictured) was presented with the New Zealand Young Nurse of the Year Award by the New Zealand Nurses Organisation Tōpūtanga Tapuhi Kaitiaki o Aotearoa in September 2023.

Always offering to help every member of the wider multidisciplinary team, John's generosity of spirit improves the working lives of everyone around him.

John was caught off guard by the nomination. "It was a definite surprise that I was being nominated and even more surprising that I won the award," he said.

Health NZ in action Committed to accessibility

Shannon Morris, Senior Advisor in the Health NZ Disability Health Team, was presented with the New Zealand Sign Language (NZSL) Teacher of the Year Award at the 2024 New Zealand Sign Language Awards.

The awards are held annually during NZSL Week to acknowledge and celebrate commitment to, promotion of and maintaining NZSL. The award recognises Shannon's ability to show leadership, passion and professionalism.

Born deaf to hearing parents, Shannon was first introduced to the 'Deaf world' as a baby, when her parents started taking night classes to learn NZSL. They wanted the best for her in both worlds, the Deaf world and the hearing world, and knew that using NZSL and spoken English at home would enable Shannon access to both cultures and languages.

Shannon is a dedicated teacher of NZSL. She is committed to bridging communication gaps and raising awareness within health care services and kaimahi about the needs of Deaf patients, whānau and their families. This involves advocating for the recognition and accommodation of the language and communication strategies. She provides educational guidance on Deaf culture, fostering awareness within Health NZ and beyond.

Shannon regularly engages with the local Deaf community, gathering feedback and advice on ongoing improvements in health care.



Shannon Morris (pictured) with her NZSL Teacher of the Year Award

For Shannon, teaching NZSL is not just a job, it's a passion.

"Sharing the language and culture of the Deaf community brings me absolute joy, and seeing others embrace and enjoy learning NZSL is incredibly rewarding," she said.



Sharing the language
and culture of the Deaf
community brings me
absolute joy

Our regions

Health NZ is split into four regions: Northern, covering the north of the North Island, Te Manawa Taki, covering Waikato and the midland districts, Central | Ikaroa, covering the lower North Island and Te Waipounamu, covering the South Island.

Each region is focused on the priorities of its communities, and working closely with other government services and agencies.

To ensure services meet local needs, regional and local leaders are responsible for service delivery. This includes overseeing hospitals, working with providers such as public health organisations and primary care providers to ensure service continuity, co-ordinating responses to infectious disease, promoting prevention services, maintaining strong relationships with stakeholders and responding to the needs of our priority population groups.

Our regions share best practice and health innovations, and together we aim to have nationally equitable health outcomes. Specific actions may differ in each region, but all have a strong focus on delivering better outcomes and fairer services for everyone.

We also share resources across regions where needed. For example, people have been deployed across the country to support contact tracing and isolation for infectious disease incursions to reduce spread of measles and pertussis (whooping cough).

Working together, we share learnings and best practice to implement initiatives across our regions, such as our measures to respond to peak winter demands or the successful minor conditions consultations in pharmacies.



Working together, we share learnings and best practice to implement initiatives across our regions

Health New Zealand regions

Northern region

The Northern region has the largest and fastest growing population of the four regions, with nearly two million people. It includes our largest city, and a significant rural population. It is the most ethnically diverse region, with many Māori, Pacific Peoples and ethnic communities, including African and Asian communities. There is diversity between the region's four districts, Te Tai Tokerau Northland, Waitematā, Te Toka Tumai Auckland and Counties Manukau. Some areas have the highest life expectancy in New Zealand, while there are concentrated areas with significant health and wellbeing issues.

Te Manawa Taki

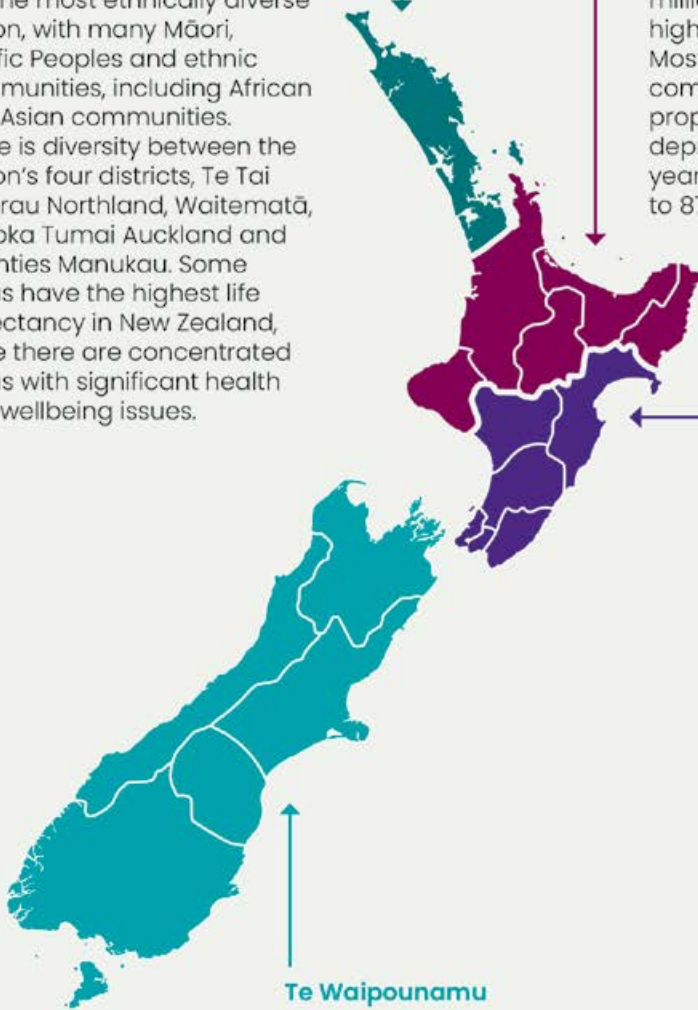
Te Manawa Taki means 'The Heartbeat' and is the name gifted to represent the five districts: Waikato, Bay of Plenty, Taranaki, Tairāwhiti and Lakes. The name in the context of the combined region represents "Always ready to go". It has a population of over one million people – 20% of New Zealand, and the highest proportion of Māori of all the regions. Most Māori and Pacific Peoples live in urban communities and the region has the highest proportion of people living in areas of high deprivation. Life expectancy ranges from 74 years of age in one of the most deprived areas, to 87 years of age in the one of the least.

Central region | Ikaroa

Approximately one million people live in the Central | Ikaroa region. The region covers five districts: Whanganui, Capital, Coast and Hutt Valley, Hawke's Bay, MidCentral and Wairarapa. More than 20 iwi hold mana whenua over the region. Five Iwi Māori Partnership Boards play a vital role in ensuring the voice of iwi, whānau and hapū informs the shape and delivery of health and wellbeing services. There is a lot of innovation occurring throughout this region.

Te Waipounamu

The name Te Waipounamu literally means 'Water and Greenstone', as this is the only place that pounamu is found in New Zealand. Te Waipounamu is geographically the largest and most sparsely populated region, covering the districts of Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern. The regional team works in partnership with Iwi Māori Partnership Boards, Te Tauraki, Te Kāhui Hauora o Te Tau Ihu, and the emerging board for Wharekauri | Rēkohu, and engages widely to understand the needs and aspirations of the people in this region.



Northern region



Population

37.7% of the population lives in the Northern region



Ethnicity

14.4% of these people are Māori
12.7% are Pacific
29.1% are Asian
43.8% are Euro / MELAA* / Other



Social deprivation

24.2% are part of the most deprived quintile
17.3% are part of the least deprived quintile



Rural area population

9.2% of the Northern region population lives in rural areas

Our regions in action

Rheumatic fever prevention sore throat service

In response to rheumatic fever rates in Auckland, we worked with pharmacies to offer free rapid response sore throat management to children and young people at high risk of rheumatic fever. The eight participating pharmacies are located in communities with the highest rheumatic fever rates and have longer opening hours. The pilot programme runs until September 2024 and aims to improve health care access.

Along with assessment and testing, the service facilitates referrals to other services, such as Mana Kids school-based rheumatic fever prevention services and primary care services.

Early results from the pilot are promising, with 40 patients tested in the first few weeks and two cases of Strep A throat infections confirmed. Feedback shows the service improves patient outcomes, with parents relieved they can get fast medical attention, educational support and necessary medications for their children.



Te Manawa Taki



Population

20% of the population lives in the Te Manawa Taki region



Ethnicity

27.7% of these people are Māori
2.6% are Pacific
11.1% are Asian
58.7% are Euro / MELAA* / Other



Social deprivation

28.1% are part of the most deprived quintile
13.1% are part of the least deprived quintile



Rural area population

27.8% of the Te Manawa Taki population lives in rural areas

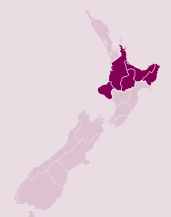
Our regions in action

Transforming primary and community care

We took a regional approach, grounded in te Tiriti o Waitangi and shaped by local voices, to roll out the comprehensive primary and community care teams programme. We worked closely with Te Aka Whai Ora, primary care organisations and hauora Māori partners to review local services, identify service gaps and commission roles to address these gaps.

For example, for Waitara in Taranaki, we commissioned more care co-ordinators, physiotherapists, pharmacists, and kaiāwhina into the area. Now patients in Waitara have faster access to quality care that meets their needs.

Local design groups are now supported by locally agreed change leads, community integration teams, and the hauora Māori services team to address other critical gaps through targeted staffing. This will lead to better access and improved health outcomes for our communities, particularly for Māori, Pacific Peoples, and rural communities.



Source: Stats NZ Prioritised ethnicity population projections 2023/24 (2023 update)

*MELAA = Middle Eastern, Latin American, African

Central region | Ikaroa



Population

18.8% of the population lives in the Central region



Ethnicity

20% of these people are Māori

5.6% are Pacific

11.9% are Asian

62.5% are Euro / MELAA* / Other



Social deprivation

21.9% are part of the most deprived quintile

20.7% are part of the least deprived quintile



Rural area population

17.5% of the Central region population lives in rural areas

Our regions in action

Improving accessibility and increasing childhood immunisation rates

In May 2024, we launched a pilot drop-in immunisation clinic at the Masterton Community Oral Health Clinic with the aim to immunise children. However, whānau members can also receive immunisations as part of a holistic whānau approach to improving community health outcomes.

The clinic addresses a crucial need for after-hours immunisation services in Masterton, and also provides an environment for nurses to train as whole-of-life vaccinators and gain confidence in their practice.

In June 2024, a pilot Whanganui roving team began operating three days a week, to provide catch-up immunisations to unenrolled tamariki under five years of age and their whānau. Immunisation appointments are scheduled alongside other health appointments for tamariki. The environment allows the whole-of-life vaccinator nurses to discuss vaccination decisions with whānau. In some cases, the team has helped whānau choose to receive vaccinations after initially declining vaccination.



Te Waipounamu



Population

23.5% of the population lives in the Te Waipounamu region



Ethnicity

10.8% of these people are Māori

2.8% are Pacific

11.4% are Asian

75% are Euro / MELAA* / Other



Social deprivation

12.5% are part of the most deprived quintile

23.8% are part of the least deprived quintile



Rural area population

28.8% of the Te Waipounamu population lives in rural areas

Our regions in action

Waitaki Health Futures Project | Te Waka Hauora o Waitaki

We launched a partnership with Waitaki local providers and groups in late 2023, in response to hospital and primary care sustainability challenges.

The Waitaki partnership shows that together, health providers can offer sustainable, comprehensive local services that meet local need. It aims to overcome inequities in access and health outcomes some rural communities experience.

First, we focused on the sustainability of Ōamaru Hospital, a vital health care facility. Operational control of the hospital services transferred from Waitaki District Health Services Ltd to Health NZ in July 2024. The joint transition programme resulted in a seamless changeover for community and staff.

The next phase of the project is designing the whole-of-health system model of care for Waitaki, informed by the community and local clinical and consumer representatives. We're aiming to implement the new health care model, in stages, from early 2025.



Source: Stats NZ Prioritised ethnicity population projections 2023/24 (2023 update)

*MELAA = Middle Eastern, Latin American, African

Section 2

Improving the health of New Zealanders

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Focus on health needs.....43



Delivering on our strategic intent

Our Statement of Intent (2022–2024) outlined our intentions for the first two years of Health NZ.

Our board intended to implement a one-system approach to deliver, with our partners, on the Interim New Zealand Health Plan | Te Pae Tata 2022–24, while operating in a fiscally

responsible manner and honouring our responsibilities to te Tiriti o Waitangi. This required significant change in our investment choices and priorities.

Healthy Futures for New Zealanders | Pae Ora

Health System Purposes Pae Ora Act	Mauri ora Healthy individuals Protect, promote and improve the health of all New Zealanders		Whānau ora Healthy families Achieve equity in health outcomes among New Zealand’s population groups, striving to eliminate health disparities in particular for Māori		Wai ora Healthy environments Build towards healthy futures (Pae Ora) for all New Zealanders							
Government priorities and outcomes iGPS	Embedding te Tiriti o Waitangi across the system		Laying the foundations for the success of the system Achieving equity in health outcomes		Keeping people well and independent in their communities		Developing the health workforce of the future		Ensuring a financially stable health system			
Interim NZ Health Plan Te Pae Tata	Embed te Tiriti o Waitangi across the health sector		Place whānau at the heart of the system to improve equity and outcomes		Keep people well in their communities		Develop greater use of digital services to provide more care in homes and communities		Develop an inclusive health workforce		Establish Te Whatu Ora and Te Aka Whai Ora to support a financially sustainable system	
System shifts Year 2 of start-up transition	We will honour te Tiriti o Waitangi		High-quality specialist and emergency care will be equitable and accessible to all when it is needed		Digital services and technology will provide more care in people’s homes and communities		People and whānau will be supported to stay well and connected to their communities		Our health workforce will be valued and well trained, ensuring we have enough skilled people to meet future needs			

While progress has been made in advancing these goals, we have not delivered what was intended – both in terms of our finances and in operational performance. This shortfall has led to a change in governance, noted earlier in this report, with the appointment of a commissioner for the next financial year.

Between them, our accountability documents set out our strategic direction in a way that responds to our legislative mandate under the Pae Ora (Healthy Futures) Act, the Interim Government Policy Statement on Health 2022–2024 (the iGPS), and the Interim New Zealand Health Plan | Te Pae Tata 2022–24. The interrelationships between these are depicted in the table on page 32.

Interim Government Policy Statement on Health

Health NZ set out a commitment to deliver against the six priorities outlined in the iGPS. The progress of the health system in delivering on the iGPS is monitored and reported by the Ministry of Health | Manatū Hauora.

Our Statement of Intent 2022–2024 set out Health NZ's intentions regarding the iGPS. These are summarised in the table below and are more fully outlined in Te Pae Tata. Our progress with the 187 Te Pae Tata priority actions will be reported in a companion document to this report.

Six priorities of the interim Government Policy Statement

Priority 1: Achieve equity in health outcomes

Health NZ intent

Develop te ao Māori and Pacific services to reflect the needs of these communities and ensure that disabled people | tāngata whaikaha, rural communities, rainbow community, refugees, migrant communities have access to services that work for them.

Detail outlined in Te Pae Tata and reported separately.

iGPS measures in this report

- Proportion of people who first start treatment for breast, cervical or bowel cancer services after a screen result. See measures **P2-07, P2-08, P2-09**
- Variation in rates of access for:
 - elective services **P2-40**
 - first specialist assessments **P2-39**
 - colonoscopies **P2-48**
 - youth access to mental health services **P2-69**

Priority 2: Embed Te Tiriti o Waitangi across the health system

Health NZ intent

Work with Te Aka Whai Ora and the Ministry of Health. to realise the aims of the Whakamaui Māori Action Plan 2020-25.

Detail outlined in Te Pae Tata and reported separately.

iGPS measures in this report

- Health entity spending on identified Māori health service providers – see Te Aka Whai Ora Annual Report
- Experiences of health services for Māori **P2-20, P2-21**
- Coverage and utilisation of rongoā Māori services **P2-29**
- Feedback from IMPBs **P2-30**

Priority 3: Keep people well in their communities

Health NZ intent

Work to implement a public health approach in localities to support our communities' mental health and wellbeing outlined in Te Pae Tata.

Detail outlined in Te Pae Tata and reported separately.

iGPS measures in this report

- People reporting unmet need for primary health care **P2-31**
- People waiting for planned specialist care within 4 months **P2-40**
- Immunisation uptake at key ages **P2-03, P2-04, P2-05, P2-140, P2-141**
- Rate of hospital admissions for an illness that might have been prevented or better managed in the community **P2-22, P2-23**
- Access and Choice programme for primary mental health and addiction support services **P2-32, P2-37, P2-69, P2-70**
- Proportion of women enrolled with a primary maternity health provider in the first trimester of pregnancy **P2-33**
- Standardised rate of acute readmissions **P2-42**

Priority 4: Develop the health workforce of the future

Health NZ intent

Actions undertaken to ensure that staff can feel safe in their workplace, prioritising staff wellbeing and having a workplace free of bullying, racism, fatigue and burnout.

These also include actions to develop transformational leadership.

Detail outlined in Te Pae Tata and reported separately.

iGPS measures in this report

- Proportion of Māori and under-represented groups in health workforce, compared with proportion of the total population **P2-62**
- Proportion of Māori and Pacific Peoples in leadership and governance roles **P2-63**

Priority 5: Ensure a financially sustainable health system

Health NZ intent

The health system remains under pressure from both increasing demand (driven by the growing burden of disease, the challenges associated with an ageing population, persistent inequities and consumer expectations) and supply constraints (driven by the rising costs of care, inefficient allocation of resources, wage growth and pay equity claims, and increased costs associated with over-sweating assets).

Actions to manage sustainability include: national integration of the system; removal of duplications inherent in the previous system; taking advantage of scale for digital solutions; prioritisation of investment to areas with the greatest need and improvement in equity and outcome; and optimising the use of existing capacity.

iGPS measures in this report

- Actual expenditure is consistent with overall balance in both budgeted and actual revenue to expenditure ratios – see Te Pae Tata priority action 6
- Proportion of total expenditure directed at mental health and addiction, public health and primary and community care **P2-06, P2-26, P2-66**
- Development of Investment Strategy & National Asset Management Strategy **P2-81**

Priority 6: Lay the foundations for the ongoing success of the health system

Health NZ intent

Consolidation of 26 entities through establishing an operating model to commission and deliver health services and operate core enablers including finance, procurement and intelligence.

In Te Pae Tata we detail implementation of the Health Charter and steps toward an inclusive and smarter system.

iGPS measures in this report

- Experience of primary health care and adult inpatient health services **P2-44**
- Proportion of HNZ districts assessed against CE Q&SM and at Level 3 or 4 **P2-36**
- Proportion of medical appointments completed through digital channels **P2-88**

Five system shifts – the future of health

To demonstrate the progress made in the first two years, we have structured our performance story around five key areas – or five ‘system shifts’ – which the Government identified as the most important changes needed to make the biggest difference for the health of New Zealanders. These formed the strategic intentions for the 2022–24 period.

1

Māori have a greater role in designing health services that better meet the needs of Māori

Over the course of the year, we carried out work that enables us to deliver services to better meet the needs of Māori to improve Māori health outcomes.

We continued to build an operating model that included a working partnership with Te Aka Whai Ora at every level of our organisation; nationally, through our four regions and at a local level with Iwi Māori Partnership Boards to ensure communities have access to the primary and community care they need. The collaborative working style assisted with the integration of hauora Māori services when Te Aka Whai Ora was disestablished.

Alongside the introduction of new human papillomavirus (HPV) self-screening, we also expanded eligibility for free cervical screening. Those who are eligible include women and people with a cervix who are unscreened (have never had a screening test), under-screened (haven’t had a test in the past five years), at higher risk requiring surveillance/follow-up, Māori,

Pacific Peoples, and anyone who is a community services card holder. This enables us to detect cervical cancer earlier, which is particularly important for Māori, who are more likely to have cervical cancer and die from cervical cancer.

We also implemented initiatives to increase accessibility of immunisations (focused on COVID-19, influenza and childhood immunisations) for Māori, with \$2.5 million in funding allocated to organisations nationwide. Initiatives include hapū māmā wānanga, region-wide kōhanga reo events and rangatahi-led long-term trust in immunisation programmes.

We launched a social marketing campaign as part of a wider de-stigmatisation project identified in the Strategy to Prevent and Minimise Gambling Harm 2022/23 to 2024/25. The series aims to start normalising conversations about gambling harm and the associated stigmas for Māori, and provide a new way to engage and talk about gambling harm. We also contracted 15 providers for Kaupapa Māori services to be delivered to prevent and minimise gambling harm.

We added a new feature to My Health Record so individuals with a verified My Health Account can view and update their ethnicity information, which is linked to their National Health Index (NHI) identifier. This is important for Māori, as they tend to be undercounted in the NHI compared to census data. It will improve the quality of information we hold for Māori, enabling us to better design services that meet their needs.

We know there is still work to do in this space, and we look forward to harnessing the work and expertise of our Hauora

Māori Services Group in 2024/25 to design services that better meet the needs of Māori.

Health NZ in action Making health easier

Cervical cancer is one of the most preventable cancers as regular cervical screening can detect early signs before cancer develops.

However, 85 per cent of people diagnosed with cervical cancer in New Zealand have not had regular screening.

With the recent change to the National Cervical Screening Programme (NCSP), screenings can now be done by self-test with a swab at a GP clinic. The test looks for the human papillomavirus (HPV), which causes cell changes that may lead to cervical cancer.

Health NZ has been researching different ways to encourage more people to self-test, with more than 7,000 people taking part in a recently completed trial.

Dr Karen Bartholomew, Director of Health Equity, says the findings and analysis from this research will provide important insight for the NCSP.

"This research has been well received and supports self-testing in primary care, which was implemented in September 2023," said Karen. "The study examined opportunistic offers in primary care, a mail-out, nurse-led results management and a range of approaches in the community such as workplaces, gyms, kōhanga and pharmacies.



Research nurses offering free HPV self-testing at a community event.

"The results are informing future ways to offer self-testing. Working closely with the NCSP it is exciting to see the opportunity for research to directly inform how the programme can grow," Karen said.

Three thousand self-test kits have been mailed out and 4,000 were offered during GP visits. Nearly 500 participants were able to pick up a test from their workplace, pharmacy or at a community event.

Half of the participants were Māori or Pacific Peoples. A third of all participants had never been screened or were more than five years overdue.

2

People will be able to get the health care they need closer to home

In November 2023, Ka Ora Telecare, a rural clinical telehealth service, went live providing rural communities with primary

care (GP consults and nurse triage) after hours. The service has allowed us to provide care to those who otherwise need to travel. We began establishing Comprehensive Primary and Community Teams, with local tailoring and contracting in place by the end of the year.

Funding for this was provided through Budget 22 and will cease at the end of the 2024/25 financial year. We will use learnings to ensure we build on the success of the initiative.

Along with delivering primary care differently to enable services to be provided closer to home, we also acknowledge the importance of boosting capacity. We formally opened the Wānaka Primary Birthing Unit, Rākai Kahukura, expected to provide services for approximately 400 whānau and accommodate around 50 births each year. The unit provides an option for those with low-risk pregnancies to stay locally and removes the need to travel long distances for maternity care. For those who do need to travel to receive care, we increased reimbursement for mileage and accommodation, and easier email claiming options for the National Travel Scheme. The changes will be particularly beneficial to rural communities, and the one in four Māori living in rural communities, who often have to travel to access hospital and specialist services.

3

High quality emergency or specialist care will be available when people need it

We carried out a range of initiatives to increase the availability of emergency and specialist care so that people can access it, when they need it.

Some examples of new services opened include:

- Tōtara Haumarū, the new hospital building on the North Shore Hospital campus. This is part of the significant

capacity we are adding to the hospital and specialist network to serve the growing and diverse population in the Northern region and reduce waiting times.

- A new cardiology clinic, designed for the care of outpatients, at Manukau Health Park as part of the broader redevelopment project. Redevelopment of Manukau Health Park is on schedule for completion in 2025 and, once operational, will enable us to deliver 150,000 extra specialist appointments per year.

We provided additional funding to increase ambulance frontline staff, reducing long-standing staff vacancies across ambulance services. Ambulance providers have increased staff by over 354 FTE from the beginning of the previous financial year. This has helped improve our response rate to emergencies.

National urban response performance to suspected cardiac or respiratory arrest incidents has improved from 47 per cent responded within six minutes (in June 2022) to 58 per cent (in May 2024) and from 92 per cent responded within 12 minutes to 93 per cent. National urban response performance to incidents appearing life threatening or time critical has improved from 36 per cent responded within eight minutes to 44 per cent and from 86 per cent responded within 20 minutes to 92 per cent.

We began implementation of the hospital and specialist services acute care plan, a multi-year programme focusing on patient flow through hospitals and improving consistency of practices across the country.

4

Digital services and technology will provide more care in people's homes and communities

We started a two-year Remote Patient Monitoring pilot, which aims to identify and collect the right health information in a readily consumable, equitable and accessible way for both users and clinicians so better and faster health decisions can be made for those who live in rural areas.

The Remote Patient Monitoring Pilot is recruiting 60 whānau from rural Māori communities and aims to reduce hospital and specialist service use, reduce whānau travel costs and other out-of-pocket expenditure, improve the efficiency

of primary care delivery, and provide positive outcomes to the community. The pilot focuses on heart failure and chronic obstructive pulmonary disease (COPD) care plans and uses a mobile application, Piki Te Ora, to collect data on a participant's physiological parameters (heart and respiratory rate, blood pressure, heart rate variability and oxygen saturation).

We provided improved digital tools to support the HPV Cervical Screening project, which enables women to self-test for their initial cervical screening at home.

We are shifting content to our new consumer-facing website and decommissioning a wide range of older health websites to ensure information is easily accessible and in one place.

Health NZ in action

Recruiting more nurses

When COVID-19 lockdown grounded Victoria Congalton's aircrew career, she used it as an opportunity to map out a new career in nursing.

A few years later, she's now in the thick of it, nursing in the emergency department (ED) at Hawke's Bay Hospital. She is using the people skills learned in her previous career to her advantage in her new profession.

"I love it, I should've trained years ago," she said.

"I was flying for about 10 months when the country went into lockdown and flights were grounded."

It was at that point, during a company-wide restructure, Victoria made a bold decision and decided to enrol in nursing.

"I was in my mid-thirties and wanted some job stability. My mum was a nurse and it always seemed like a very fulfilling career.

"It was daunting at first. But I wanted a job that challenged me, and I wanted to help people."



Victoria Congalton became a nurse to challenge herself and help people

Victoria said she is now unfazed by the busyness of ED and the team was a great support in her first few months on the job.

"I love the critical nature of the work and that you've got the chance to make a difference in what can be one of the worst times of someone's life."

While her focus is now on delivering the best care she can in ED, she is thinking about the future and perhaps taking back to the skies, this time as a flight nurse.

5

Our health workforce will be valued and well trained, ensuring we have enough skilled people to meet future needs

We are committed to building an inclusive leadership and culture by implementing the new **Health Charter | Te Mauri o Rongo**. Developed through extensive consultation with our staff and unions, the Health Charter outlines values, principles, and behaviours that health entities and health workers are expected to demonstrate. We continue to implement the Health Charter across our organisation through flagship initiatives, including informing our position descriptions, policies, and the development and delivery of training programmes.

Ensuring we have enough of the right people in the right places is a key priority for the health sector. In 2023, we implemented the first Health Workforce Plan. The Plan was ambitious and highlighted the importance of:

- **stabilising our workforce** by addressing acute workforce pressures and improving people's experiences at work
- **transforming our practices** by identifying areas we can start to make progress on big shifts, particularly to prototype better ways of doing things, or to scale pilots.

We delivered on these through six action areas:

- Growing pathways for Māori in health
- Growing pathways for Pacific Peoples in health
- Driving locally led innovation in training
- Bolstering priority workforce groups
- Supporting and retaining our valued workforce
- Growing our future leaders

Over 70% of the initiatives from the plan were fully or partially delivered within the agreed timeframes. However, there is still much mahi to do. Several parts of our workforce are still facing acute pressure and as such, transformation and productivity remain key priorities.

Towards the end of the financial year, we drew on our experiences from the delivery of the first Health Workforce Plan and the current state of the system. Using these insights, we developed the Health Workforce Plan 24/27, a multi-year plan aligned to budget commitments.

Since December, almost 20,000 frontline staff have completed situational awareness and de-escalation training to support them with handling violent behaviour. We are on track to meet our target of 33,000 frontline staff being trained by 31 October 2024.

We supported 239 General Practice Education Programme (GPEP) Year 1 trainees in 2024 – an increase of 60 registrars starting compared to 2023 and the biggest intake to date.

We funded 121 places (including 17 Māori and 5 Pacific) on the Nurse Practitioner Training Programme (NPTP), up from the 100 committed to in the Health Workforce Plan and an increase of 51.3% compared to the 2023 academic year.

We re-launched the Midwifery Return to Practice Programme to attract more midwives back into the profession.

The funding available has increased to reflect actual costs incurred for the programme and offers additional support for transport, family care and other costs. The increased funding will also be available to midwives currently on the programme to incentivise completion.

Health NZ in action

Creating pathways for rangatahi

An innovative 10-week programme designed to inspire rangatahi Māori to pursue their own career pathway and become future health leaders has been a great success, with a number of rangatahi securing health placements following the programme.

The programme was a joint partnership between Health NZ and senior taura (students) from Rotorua Girls' High School. It kicked off in April 2024 with activation sessions showcasing different career paths to the 37 participants. Rangatahi led the planning of a 'Mini Health and Career Expo' for their peers. Participants also worked in groups, supported by local health providers, to look at health issues important to them. This strengthened relationships with youth and community services, and provided opportunities for rangatahi to propose creative solutions to health issues.

Since then, four rangatahi have secured oral health placements at Lakes Oral Health and two have short-term placements at a local mental health service. Placements give students insight into different areas of health and potential career pathways, as well as hands-on experience.



Students and exhibitors at the Mini Health and Career Expo

Having a future workforce that better reflects communities is a priority for Health NZ and can help with closing the health equity gap.

Dr Mariana Morrison, Health NZ Senior Locality Manager Commissioning Lakes, said, "We are immensely proud of the leadership and vision of these rangatahi, the tautoko (support) from those who showed up for them, and our Te Whatu Ora community integration team in the Lakes area for helping bring this programme to life."

Working towards fresh health priorities

The 2023/24 year has seen a continuation of recent trends where immunisation rates for children have dropped, people have faced longer delays accessing cancer treatment, emergency department wait times have risen and wait times for a first specialist assessment and elective treatment have increased.

During the year, we worked closely with the Ministry of Health and the other three health entities required to give effect to the Government Policy Statement on Health.

This group proposed three-year priorities and objectives to the Government for the publicly funded health sector to reverse these trends.

The Government confirmed its long-term vision for health and wellbeing is **to achieve longer life expectancy and improved quality of life for all New Zealanders**.

It is focused on **achieving timely access to quality health care**. This includes both mental and physical health.

The Government agreed five health targets and five mental health and addiction targets to be reported from next year and ensure a focus on action.

These are:

- **Faster cancer treatment** – 90% of patients to receive cancer management within 31 days of the decision to treat.
- **Improved immunisation for children** – 95% of children to be fully immunised at 24 months of age.
- **Shorter stays in emergency departments** – 95% of patients to be admitted, discharged, or transferred

from an emergency department within six hours.

- **Shorter wait times for first specialist assessment** – 95% of patients to wait less than four months for a first specialist assessment.
- **Shorter wait times for treatment** – 95% of patients to wait less than four months for elective treatment.

The five mental health and addiction targets are:

- **Faster access to specialist mental health and addiction services** – 80% of people accessing specialist mental health and addiction services are seen within three weeks.
- **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.
- **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.
- **Increased mental health and addiction workforce development** – train 500 mental health and addiction professionals each year.
- **Strengthened focus on prevention and early intervention** – 25% of mental health and addiction investment is allocated towards prevention and early intervention.

Measures in this report selected as new targets are identified in the relevant 'notes to the measure'.

Focus on health needs

New Zealand's health status

During the year, Health NZ published the Health Status Report 2023, the first key set of health needs information that can be viewed at national, regional and district levels.

The report was produced in the shadow of the COVID-19 pandemic, which had impacts on population health outcomes and health care provision around the world. We are one of the few countries to continue to see improvements in life expectancy despite the pandemic: a testament to the outstanding public health response over this time.

Overall, New Zealand's population health status is good and improving. At 16th in the world we enjoy high life expectancy compared to many other countries, and we are living longer (increasing by three years over the past 20 years).

The full report is available at www.tewhatauora.govt.nz/publications/health-status-report

Addressing disparities

All population groups in New Zealand deserve the same access to health care. Despite some improvements over the past decade, there are still persistent disparities in access to health care, quality of services and outcomes for some population groups.

Population groups with the greatest opportunity to improve health are Māori, Pacific Peoples and disabled people | tāngata whaikaha.

Rural communities face unique health challenges that have been exacerbated by systemic issues and the ongoing impacts of the COVID-19 pandemic. There remain substantial difficulties in recruiting and retaining health workforce staff in rural areas. Despite these barriers, there is a growing recognition of the need for a more integrated and collaborative approach to rural health.

To reflect the needs and preferences of the communities we serve, we engage with consumers and whānau on the design, delivery and evaluation of our health system. We use these insights to make decisions about our health care services and programmes.

Health NZ in action
Breaking down barriers

A Health NZ programme that improves access to maternal mental health services for Asian women has seen a 9.25 per cent increase in referrals since the programme launched in 2022.

The Healthy Mother Healthy Future – Asian Perinatal Mental Health and Wellbeing programme was developed in Waitematā after health data showed significant accessibility issues for Asian women.

The programme connects women to existing mental health services and helps tackle barriers with language or culture to ensure they have the same access to services as other ethnic groups do. The number of Asian women accessing maternal mental health services has grown from 13.3 per cent to 22.55 per cent of all referrals.

Over the year, the programme supported 753 pregnant women and postnatal mothers, 411 family members, delivered 1,403 therapeutic or individual support sessions, ran 68 group sessions and workshops for Asian and ethnic communities with 611 attendees, and developed and published resources in 14 languages.



Gill Graham, Team Manager, Perinatal and Infant Mental Health and Grace Ryu, Group Manager, Asian and Ethnic Health Services

Maternal peer support groups were hosted for Chinese, Korean, and Indian / South Asian perinatal women, offering a safe and supportive space for women to share their insights and lived experiences. The women are able to build meaningful connections through their shared journey of motherhood.

Grace Ryu, Group Manager Asian and Ethnic Health Services, said, “We are very pleased this programme is creating a safe place for Asian women needing support during an important time in their lives. We are looking at expanding access to the programme throughout New Zealand.”

Health NZ in action
More testing opportunities

Health NZ has made significant progress in the fight against hepatitis C, a virus that affects thousands of New Zealanders, with many unaware of their potential exposure.

A recent trial in four community laboratories has shown that offering a free hepatitis C blood test alongside existing blood tests can be a highly effective way to reach people and encourage them to take the test.

About 20,000 people in New Zealand live with hepatitis C, many with no idea they have been exposed and are at risk of liver damage and liver cancer.

The virus is spread through blood-to-blood contact and is the country’s leading cause of liver cancer and liver transplant.

The clinical trial, which ran for two weeks in partnership with Awanui Laboratories, saw more than 2,800 people agree to a Hep C test, representing an impressive 79 per cent rate of consent among those approached. This is an exciting step forward in the effort to find, test and treat people living with hepatitis C.



Health NZ Research Assistant Wai (right) worked with Awanui Labs phlebotomists to offer Hep C testing alongside other blood tests

“We’re so encouraged by the response to this testing approach and we’ve captured a lot of key lessons to inform consideration of hepatitis C screening in the future,” said Dr Karen Bartholomew, Director Health Equity, Service Improvement and Innovation.

“This pilot study paves the way for our ongoing work to test for and treat hepatitis C,” said Karen. “Ultimately, we want to eliminate it as a cause of liver cancer and illness.”

Engaging with consumers and whānau

We engage with consumers and whānau through:

- **community engagement** at forums and community workshops, and with expert advisory or focus groups, to discuss and gather feedback on our services
- the **Health NZ whānau, consumer and clinician digital council**, which helps shape how we improve our data and digital technologies
- **surveys and consultations**, which help us to understand consumer opinions and experiences and identify areas for improvement
- our **partnerships with Māori and Pacific communities** (e.g. Iwi Māori Partnership Boards)
- a **co-design approach**, which actively involves consumers, whānau and communities in how our health services are delivered.

Improvements in consumer and whānau engagement

In 2024 we established:

- a **whānau feedback and engagement advisory group** to help develop, approve and implement a plan for the consistent collection and monitoring of consumer and whānau experiences

- a **rainbow expert advisory group** to ensure that rainbow, Takatāpui and MVPFAFF+ voices are included in the design, delivery and performance of the health system
- four **regional consumer councils** to strengthen consumer feedback and help share knowledge and experience consistently at a regional level.

Advice from these groups will be used to improve and support our programme activities, services and policies.

Meeting the code of expectations

We are required by legislation to meet the Health Quality and Safety Commission's (HQSC) code of expectations for health entities' engagement with consumers and whānau. We demonstrate our compliance to the code through:

- the consumer and whānau engagement **quality and safety marker (QSM)** framework, which uses examples to demonstrate how organisations are giving effect to the code
- a **self-assessment** against the QSM framework
- the **certification process** for all hospitals, which involves consumers and staff, and examines how hospitals meet the obligations of the code.

The HQSC administers the code and the QSM and conducts quarterly patient experience surveys. Insights from these activities show us how well we're receiving feedback from consumers and whānau and incorporating it into our health services.

The QSM allows us to report on the implementation of and compliance with the code of expectations. QSM self-assessment submissions are completed by staff in individual districts and by a team at Health NZ national office and reflect a range of consumer experience activity across the motu. In completing the self-assessment, submitters worked with their local consumers to moderate and validate their scores. For the national office submission this function was provided by consumers from the consumer network Aotearoa provided through HSQC.

Survey results for each quarter can be found on the HQSC website at:

[Quality & Safety Markers | Te Tāhū Hauora Health Quality & Safety Commission](#)

The QSM process supports and drives consumer engagement at district, national (and now) regional level across Health NZ. The creation of the Regional Consumer Councils will support and drive the regional submissions, and the new Deputy CEOs will be involved in the process for the September 2024 QSM submission that will provide a baseline for improvement in the range and extent of consumer engagement across Health NZ. This will raise awareness of the Code and ensure that it is considered in their work.

Health NZ in action Taking on feedback

Health NZ has created a national Whānau Feedback and Engagement Advisory Group to help us meet our obligations to work with whānau, consumers and communities. The group met for the first time in June 2024 in Auckland.

The group informs development and implementation of a national consumer feedback and engagement framework to collect and monitor people's experiences with Health NZ. This information is used to improve services.

Laura Ellis, Consumer Engagement and Whānau Voice Group Manager Communities said, "Having a nationally consistent set of expectations and practical resources to guide staff on how to engage with consumers and respond to feedback will enable better health services and outcomes".

The framework will increase staff and consumer capability to support best practice through a standardised approach to using feedback and working with consumers. This approach is underpinned by the code of expectations for consumer and whānau engagement by health entities, required by the Pae Ora (Healthy Futures) Act 2022.



The Whānau Feedback and Engagement Advisory Group meets in Auckland

Three consumers sit on the group, along with local, regional and national representatives from Health NZ, and external stakeholders including Health Quality and Safety Commission | Te Tāhū Hauora members.

The consumer representatives are Ngaire Te Ahu (Waikato), Denise Astill (Auckland) and Charlotte Korte (Auckland), with a fourth to be appointed from the South Island. Collectively they bring a wealth of insights on engaging with the health sector.

Districts use the QSM in several ways: for example, to raise awareness of the code of expectations, to encourage wards, departments and services to work with consumers with lived experience, and to use experience and insights to identify issues and drive improvement.

Certification process

All inpatient / residential services providing more than two overnight beds are required to be audited against NZS 8134:2021 Ngā Parewa Health Certification of Hospitals by a designated Auditing Agency (Ministry of Health approved). These services go through certification every three years and have formal surveillance at 18 months. The audit includes a section on consumer rights.

Certification audits of Health NZ occur through district level reviews, with evidence supplied on how well Health NZ meets the audit criteria. Each district receives a report with findings for each criterion assessed and with risk ratings that determine timeframes for corrective actions. HealthCERT (Ministry of Health) monitors corrective actions taken and high-level summary reports for each district are published on the Ministry of Health website www.health.govt.nz/regulation-legislation/certification-of-health-care-services/certified-providers.

Health NZ monitors certification outcomes, themes findings and tracks risk ratings. Common themes across the motu inform planning and improvement activity.

In the 2023/24 year, there were 10 certification audits undertaken for Health NZ, seven of which were surveillance audits. A summary of are available on [our website](#).

Māori health

Every part of New Zealand's health system is responsible for improving Māori health and equity. Our work reflects this and ensures that our system has a strong focus on te ao Māori.

Although life expectancy rates for Māori have improved steadily over the past 20 years, there is a seven-year life expectancy gap between Māori and non-Māori.

Cardiovascular disease and cancer mortality rates are substantially higher for Māori, and lung cancer mortality rates for Māori women and men are around three times the non-Māori, non-Pacific rates. Poor diabetes control and complication rates are high; the age-standardised mortality rate is around five times higher than for non-Māori, non-Pacific people. Māori have a greater proportion of early onset dementia (before age 65) and they enter aged residential care an average of seven years earlier than non-Māori.

The Interim New Zealand Health Plan | Te Pae Tata 2022-24 prioritised actions that were expected to have a direct impact on Māori health and equity.

Our actions to improve Māori health

Over the past year we have been working with Iwi Māori Partnership Boards to develop interventions that are tailored for Māori and build community capability.

We are continuing to develop and implement evidence-based public health and legislative interventions that reduce harm from alcohol and other drugs.

We have been reviewing the national approach to Māori suicide prevention and constructing suicide prevention approaches consistent with mātauranga Māori.

We are also taking a pro-equity approach to age thresholds for access to cancer screening and removing barriers to primary care to improve early detection.

Another focus has been redesigning primary care to remove barriers to access for Māori and to provide a more comprehensive option for whānau.

Finally, we are designing and expanding te ao Māori mental health service solutions, including primary mental health and wellbeing services (known as Access and Choice).

Health NZ in action

Fostering cultural safety

Health NZ has strengthened mental health support for tāngata whaiora Māori (people seeking health) at Southland Hospital by creating a more culturally safe environment.

Through a newly created Māori social worker role in the hospital's Mental Health Inpatient Unit, there is now more culturally appropriate support for tāngata whaiora and their whānau.

Diana Macaskill, who started in the new role in October 2023, has worked for Health NZ for nearly seven years providing Māori models of practice for both te ao Māori and te ao Pākehā. She said the importance of following tikanga is essential to strengthening mental health support for tāngata whaiora, whānau and kaimahi.

"Having the ability to understand and respect how whānau work, as well as holding timely hui to help explain health processes and terminology to them, has really improved the patient experience.

"It's essential to share this knowledge and help upskill kaimahi so they can provide a culturally safe environment for tāngata whaiora Māori too.



Diana Macaskill, Māori social worker at Southland Hospital's Mental Health Inpatient Unit

"We now have a more culturally safe inpatient unit for everyone, which offers the right support for whānau Māori from the start," said Diana.

The unit prides itself on a wraparound service – wrapping the korowai around the tāngata whaiora when they arrive, walking the journey with them, and taking off the korowai when they leave.

Over the past year we also worked closely with Te Aka Whai Ora on the following priorities:

- growing workforce pathways for Māori and Pacific Peoples
- improving maternity care and care for the early years (preconception to five years old or the first 2,000 days of life)
- rolling out whānau-centred post-diagnostic support and navigation services and respite care trials for people living with dementia
- building consistency in mental health and addiction services and funding
- establishing a pilot expanding age eligibility for abdominal aortic aneurysm and atrial fibrillation screening.

Our report on delivery of the Interim New Zealand Health Plan | Te Pae Tata priority actions will be published later in the 2024/25 financial year on our publications page.

Our vision for Māori health

Improving Māori health outcomes is a central component of the ongoing transformation of our health system.

Our vision is to create a health system focused on healthy futures for all people, whānau and communities. At the core of this is tino rangatiratanga and mana motuhake, enabling self-determination in communities. There are three interconnected elements in achieving our vision:

Mauri ora | healthy individuals

Shifting the mauri (life force) of a person from one that is languishing to one that is flourishing.

Whānau ora | healthy families

Creating strong, healthy, empowered whānau, enabling them to uplift their own health and wellbeing.

Wai ora | healthy environments

Acknowledging the crucial connection and impact of the whenua and living environment to the health and wellbeing of whānau, hapū, iwi and communities.

Our future focus takes a Māori-led approach. We want to see Iwi Māori Partnership Boards in place and engaged around the country at all levels, and more Māori in leadership and decision-making roles in Health NZ.

We also want to establish a te ao Māori intelligence and insights function that incorporates mātauranga Māori, and implements evidence-based policy interventions to address health priorities, including tobacco control, alcohol, obesity and nutrition.

Another focus is to fund Māori providers fairly, valuing their role in primary care and maximising the value of comprehensive models of service delivery. Where there is good performance, we will develop longer-term and more flexible contracts to improve outcomes.

We will commission comprehensive primary and community care services that improve access for Māori populations and ensure accountability for results for Māori.

Finally, we will support health sector interventions to increase the number and type of Māori health workers within the current workforce.

Bringing Te Aka Whai Ora | Māori Health Authority into Health NZ

In early 2024 the Government passed legislation to disestablish Te Aka Whai Ora and made changes to joint decision-making provisions, Iwi Māori Partnership Board functions and the role of the hauora Māori advisory committee.

On 31 March 2024, Te Aka Whai Ora roles and functions were transferred to Health NZ and the Ministry of Health, under the Health Sector (Transfers) Act 1993, to continue advocating for Māori health and working to improve health outcomes for Māori.

During the transition period 1 April to 30 June 2024, the boards continued to work in partnership to deliver the Interim New Zealand Health Plan | Te Pae Tata 2022–2024.

Te Aka Whai Ora was officially disestablished on 30 June 2024 but the kaupapa endures, along with our commitment to bringing change to the health system so we can keep improving health outcomes.

Health of disabled people | tāngata whaikaha

Disabled people make up nearly a quarter of New Zealanders and belong to all age, ethnic and cultural groups, gender identities, sexualities, localities, socioeconomic groups, whānau and communities.

Disabled people have a higher reliance on the health system and much worse experiences and outcomes. Disabled adults are about four times as likely as non-disabled adults to have experienced psychological distress in their lives. Disabled adults also experience inequities in life expectancy, particularly people with learning disabilities, who can expect their lives to be shorter by an estimated 17–24 years compared to the general population, despite using health services more often.

Work undertaken on Health NZ's disability strategy during the year shows that our health system is not equitable for disabled people and that it is not delivering accessible, timely and quality services for all New Zealanders. Our work on Health NZ's disability strategy in 2023/24 highlights that disability inequity also contributes to inequitable outcomes for Māori and Pacific Peoples.

We need strategic collection and application of disability data and insights to address system issues proactively. We can reduce system costs, inefficiencies and resource demand through disability models of care to ensure the health system works better for disabled people.

Health NZ in action**People making a difference**

Treal Niwa (Te Atiawa, Taranaki) had never thought of a career in the health sector, but that all changed when he started working for Health NZ in the orthotics department at Taranaki Base Hospital.

Starting as a cadet orthotist technician through Why Ora, a programme that brings more Māori into the health care workforce, Treal soon moved into a permanent position.

"I don't know anyone else my age in Taranaki doing this job," said Treal.

The job has Treal splitting shoes and raising them for people with leg length discrepancies. Patients bring their shoes in, an orthotist will measure and fit them, then hand over to Treal to split the sole off, apply an adhesive for the measurement they need in the raise, and put the sole back on.

When asked what makes the job enjoyable, he said, "Just helping other people gives me a reason to look forward to coming to work each day. The people make it better too."

**Treal Niwa thrives on helping people**

Senior orthotist technician, Caroline Briggs works alongside Treal and said he is a breath of fresh air.

"I've come to really appreciate his skills, his manner and professionalism, and how he interacts with his patients. To work in orthotics you have to be quite open-minded, willing to learn, change, adapt and think outside the box," Caroline said.

Our actions to improve the health of disabled people**Disability capability framework**

Our disability capability framework is a guided self-assessment, discussion and planning tool for understanding and uplifting the maturity level of our organisational disability capability. It is the first tool of its kind internationally and was co-designed by our disability strategy team and disability community leaders, including tāngata whaikaha Māori, Pacific Peoples and intersectional groups.

In the 2023/24 financial year, we expanded delivery of in-person and online disability capability framework workshops, enabling our people to reframe their understanding of disability, self-assess their current capability and approach to disability equity, and identify areas for improvement in their planning, practice and approach to disability.

We facilitated 43 workshops for delivery, clinical, enabling teams and the office of the chief executive.

The response to these workshops has been positive, with participants expressing surprise at our current maturity level, accompanied by a deeper understanding of why, and how to uplift their own capability. Common feedback indicates teams could identify immediate changes and improvements to implement in their area of work. The top emerging themes for action are disability workforce capacity and capability; disability leadership and culture; and technology, systems, policies and practices.

Based on the workshop outcomes, we have calculated that our organisational disability maturity baseline score is 1.58 out of a possible four, which means our capability state is between 'nil or basic' and 'reactive'. This baseline score informs a prioritised set of actions for us to uplift our disability capability maturity to a score of four ('innovative') over the next three years. These actions relate to both business practices and delivery of services, and apply to our whole organisation.

Disability models of care

Models of care define how health services will be delivered, with guiding principles that they are focused on people and equity, use resources efficiently, and support and set the standard for quality care. They include the whole process of care and may change depending on population, and can be integrated with other parts of the health system.

All projects in the disability strategy work programme fundamentally contribute to or enable disability models of care.

Disability models of care are patient focused, promote equitable and accessible care, provide universal access to assistive products and services (e.g. interpreters and support people), and consider the whole spectrum of health services. A position statement for disability data is in development.

Our policy review guide includes key steps and guidance to ensure that equity for disabled people is an integral part of new and updated policy. It has been reviewed and is being implemented with training for anyone who writes, reviews or owns policies.

In order to implement disability models of care we need data on disabled people's health care; accessible infrastructure, communications and information; a skilled workforce who understand and have the resources and processes to implement a rights-based approach to disability; and the inclusion of disabled people at the start of project planning.

The lack of capacity for direct disability capability guidance and education nationally is a recognised constraint and a risk to consistent national application of disability models of care in clinical and operational settings.

Priority projects underway within the disability models of care work include:

- a consistent safeguarding approach for adults at risk who access health care services, including supported decision-making and informed consent. A report investigating the current state nationwide is almost finished and will be supported by safeguarding e-learning
- work by the disability strategy team and the legal team, with clinical advice, to submit a response to the Law Commission review of the Protection of Personal and Property Rights Act 1998, promoting a rights-based model of disability and the need for supported decision-making in line with the United Nations Convention on the Rights of Persons with Disabilities
- a reasonable accommodations policy for the Health NZ workforce to ensure disabled employees have access to what they need to work safely and effectively. This has been developed and will be progressed in early 2024/25. This policy will be supported by e-learning on hiring guidelines, and e-learning for clinical/frontline staff about providing reasonable accommodations for patients
- working with Te Aho o Te Kahu and the Aotearoa Lung Cancer Screening Programme to understand disability and cancer and inform equitable models of care in service provision and public health campaigns.

Disability data

The patient profile National Health Index project aims to develop digital solutions and data ecosystems to address the historic lack of disability data and provide ways for disabled people to communicate their access requirements. The project was established in October 2023 with the allocation of funds from Budget 2022.

We have been working to understand the service design, technical and business requirements for this project, including a technical proof of concept for the access profile, how this would function within the data and digital work programme, and the position of the project in the broader cross-agency disability data ecosystem.

During May and June 2024, we used an external provider to assess current disability data collection approaches and prepare an initial set of data collection, and access profile questions for testing with the disability community and health care providers.

As the first large scale initiative to collect, analyse and use disability data, and address access requirements for disabled people in New Zealand, the project remains of significant interest to the disability community and across government, particularly Whaikaha, the Ministry of Health and Statistics NZ. We have established a representative cross-agency governance group and a project plan that ensures the disability community is at the forefront of decision-making.

We are now considering the case to build on this work in the 2024/25 financial year as part of our organisation-wide integrated delivery plan.

To achieve health targets and strategic commitments, we need to identify disabled populations to baseline and measure health outcome improvements, apply disability-related insights, and inform more equitable planning and delivery of services. The need for this proposed approach to disability data is supported by the Missing Billion: Lack of Disability Data Impedes Healthcare Equity report and similar findings in New Zealand and is priority five of the health of disabled people strategy.

Pacific Peoples' health

Our vision is a health system that delivers equitable health outcomes for Pacific Peoples and a future where Pacific families live longer, healthier lives.

Improvements in life expectancy have plateaued for Pacific Peoples and there are still gaps in health outcomes. The six-year gap in life expectancy for Pacific Peoples compared to non-Māori, non-Pacific people is largely driven by preventable premature deaths.

For the year to 30 June 2024, potentially preventable acute hospitalisations for Pacific children (0–4 years) were 14,138 per 100,000 compared to 5,719 per 100,000 for non-Pacific, non-Māori children. Pacific adults (45–64 years) were 8,115 per 100,000 compared to 3,083 per 100,000 for non-Pacific, non-Māori adults.

Pacific Peoples also have high rates of chronic conditions (for example, gout, diabetes and cardiovascular disease) and often have more than one chronic condition. They also experience these conditions at younger ages than the general population.

Health NZ in action

Breaking down barriers

A Health NZ diabetic retinal screening (DRS) pilot led by Pacific Health in South Auckland is helping to reduce the risk of people with diabetes developing sight-threatening diabetic eye disease.

The pilot is part of a holistic multi-disciplinary model which supports patients and their āiga (whānau) with a 'by Pacific for Pacific' suite of interconnected practices that are culturally and language appropriate.

"Preventing or delaying the onset of diabetes-related complications, such as eye disease, is paramount to improving quality of life," said Northern Region Director for Pacific Health, Harriet Pauga.

"In South Auckland alone, more than 26,000 people with diabetes have not been screened in the past two years as recommended and 41% of them are Pacific Peoples."

One of the barriers to screening is the wait for a hospital appointment. To reduce the wait and make access easier, participating Pacific GP practices are trialling DRS cameras, meaning patients can have their retinal image taken in a local community clinic. Images showing any abnormality are immediately sent to specialists for review, ensuring timely access to ophthalmology.



Joe Glassie-Rasmussen, Partnership and Networking Lead in the Northern region for Pacific Health looks into the DRS camera with screening vendor Gian Victoria

Through this new model of care, the pilot is improving patient engagement and ensuring equitable access to screening for diabetes-related eye disease.

"It's about trusted faces in trusted places," said Harriet. "Improving access to screening and care for Pacific Peoples living with diabetes through a community model of care is a huge step. We are incredibly positive about what we can achieve as we continue with this pilot before refining it and rolling it out to the wider community."

Ola Manuia | Interim Pacific Health Plan 2022–24

Ola Manuia was developed following an in-depth needs analysis and extensive engagement with communities, leaders and Pacific health providers. It is a companion document to the Interim New Zealand Health Plan | Te Pae Tata 2022–2024.

Its approach is data-led and community informed, and this has allowed us to identify priority outcomes for our community and prioritise what our partners and providers need.

Our immediate priorities under Ola Manuia include:

- developing a national diabetes action plan
- implementing the national oral health equity programme
- working with the Ministry of Social Development to enable cross-agency contract integration for Pacific health providers
- ensuring our workforce reflects the community, through our Pacific workforce development initiative
- working on quality improvement at a system level with the Fatu Fono Ola, Pacific Health Senate.

Our actions to improve Pacific Peoples' health

Outreach programme

During the past financial year, Pacific providers enhanced health care access and service delivery in alignment with Ola Manuia's strategic goals.

Pacific providers worked with public health and Primary Health Organisations to improve community health focusing on immunisation and screenings, and enhanced support for long-term conditions in line with targets established by Health NZ.

Through strategic partnerships, delivering culturally aligned models of care, we have improved Pacific health outcomes and strengthened provider networks. Those networks provide high-impact, accessible health care that is responsive to the needs of Pacific communities.

For example:

- Providers continue to leverage church networks to provide critical health services including immunisations, cancer screenings, smoking cessation, mental health and addictions support, and long-term condition management directly within trusted community spaces.
- Provider pilots for maternity and early years | Kahu Taurima have begun in South Auckland, Wellington and Te Waipounamu (South Island).
- Health campaigns for harder-to-reach groups by extending service hours and holding weekend events through outreach contracts.

- Community providers leading the measles vaccination drive for recognised seasonal employer workers across the country to mitigate against the risk of unvaccinated workers transmitting measles both within New Zealand and upon their return to the Pacific, as seen during the 2019 measles outbreak.
- Increased tailored outreach support for Tagata Sailimalo, a shared vision for and by Pacific families with disabilities. Tofa Mamao, a collective of Tagata Sailimalo, has developed a framework and delivery for integrated services. Vaka Tautua delivered culturally responsive and targeted outreach to 99 per cent of its target audience for mental health needs, follow-up care and significantly enhanced access to disability support.

Pacific provider development fund

The annual Pacific provider development fund supports Pacific health and disability providers to grow their capacity and develop capability to deliver sustainable, high-quality health and disability services to their communities.

Over the past financial year, the fund invested in 25 Pacific providers, two of which are national providers, to design and deliver organisational development projects for their highest need areas. This includes financial management, human resources, service design and evaluation, and leadership and governance.

Several providers were funded to increase the visibility of their data and enhance reporting of the impact of their family models of care, to complement work in the integrated contract programme.

The fund continues to be a major enabler for Pacific providers to help them deliver high-quality, sustainable, 'by Pacific, for Pacific' health services to their communities.

Growing the Pacific health workforce

Health NZ manages **Pacific health scholarships** to support Pacific students studying an approved tertiary health or disability-related qualification. The scholarships increase student retention rates and access to higher education, reduce financial burden and enhance academic performance.

In 2024, we received a large number of scholarship applications – a total of 428 (up from 291 in 2023). Funding of \$2.17 million supported 319 students. Nursing and medicine students received 70 per cent of the total approved scholarships, with midwifery and allied health students receiving 30 per cent.

In addition, we expanded the **Health Science Academies Programme**, which provides Pacific secondary students in the Northern region (years 11–13) who are studying at least two science subjects with targeted academic support, mentoring and exposure to various health-related careers.

In 2023, NZQA results showed that an average of 88 per cent of students on the programme had achieved NCEA, significantly higher than the national average.

In 2024, the programme expanded to include students in years 9–10. An expansion into other regions is planned for FY 2024/25.

Health of rural communities

Nearly a million people live in rural New Zealand – one in five New Zealanders, and one in four Māori.

Primary and community health services are the most frequently accessed health services by New Zealanders. While there are outstanding examples of these services working hard to reach those in need, the system is under significant pressure.

Resource allocation often fails to consider the unique challenges of rural settings, such as geographic isolation, severe weather conditions, and specific rural demands. Workforce shortages and an ageing workforce, particularly in primary care, make it increasingly difficult to meet the health needs of rural communities effectively.

Challenges for rural health care

Historically, the health data of rural communities has not been systematically reported, but existing evidence indicates that people living in rural areas can experience poorer health outcomes, including higher overall mortality rates, increased suicide rates, and lower childhood immunisation rates. Disparities between rural and urban areas are seen in the determinants of health, in health outcomes, and in service utilisation.

Rural communities face unique health challenges that have been exacerbated by systemic issues and the ongoing impacts of the COVID-19 pandemic. People often experience significant barriers to accessing health care, including long travel distances, limited availability of health care providers, and inadequate infrastructure, resulting in worse overall health outcomes.

There are also substantial difficulties in recruiting and retaining health workforce staff in rural areas. However, despite these barriers, there is a growing recognition of the need for a more integrated and collaborative approach to rural health.

Health NZ in action Making health easier

Since February 2023, Wairoa residents have benefitted from locally delivered chemotherapy, rather than needing to travel to Hawke's Bay Hospital in Hastings.

Starting as a temporary measure following Cyclone Gabrielle when Wairoa was cut off from the rest of the country, it has since been made permanent. The service has moved from the outpatients area to a permanent space next to the inpatient ward. As of June 2024, 30 patients had been through the service.

It's the ease of access to treatment for people in Wairoa and surrounding areas that means so much.

Mel Pomana used to have a three hour round trip to Hastings for her treatment.

"It is life changing for me to get chemotherapy at home in Wairoa," said Mel.



Mel Pomana receiving treatment from nurse, Nerys Williams

"It's made the world of difference to me. I would have to go in a van that travels five times a week to Hastings. If you weren't there when the van left, too bad, and no chemotherapy treatment that week. Now, the stress has gone and it is so much easier."

Chemotherapy is one of 61 outpatient services now offered in Wairoa.

Māori, Pacific Peoples and disabled people in rural communities

Māori make up a significant proportion of the rural population and they often face distinct challenges in accessing health services and achieving equitable health outcomes.

Pacific Peoples represent a smaller proportion of rural communities (3 per cent), but this is expected to grow. Rural towns with significant populations of Pacific Peoples, such as Tokoroa, Taupō, Taitoko Levin, Hakatere Ashburton and Ōamaru, face unique health challenges.

For disabled people living rurally, there are issues related to the intersecting experiences of rurality and disability that need to be considered to ensure health care services are accessible, inclusive, and equitable.

For example:

- social determinants of health, e.g. no accessible public transport
- the distance to services – needing to travel even further than non-disabled people due to rural health care services not being accessible or not having the specialist workforce they need
- digital options may not be appropriate or accessible for disabled people in rural locations
- the supports the rural health workforce might need to be disability inclusive in their practice
- limited health data about disabled people, including those who live within rural communities.

New focus through the rural health strategy

In 2023, the Ministry of Health set the direction for improving the health and wellbeing of people in rural communities for the next 10 years through the rural health strategy.

This marks a strategic effort to address challenges and lay a foundation for more integrated and equitable health services. The 2023/24 period has been characterised by both substantial challenges and promising opportunities for advancing rural health, guided by the priorities in the new strategy.

We have established national and regional rural health teams in response to the rural health strategy, creating considerable momentum for positive change. We're also working across the system and gathering data to better understand current issues and develop evidence-informed future solutions.

Better access through technology

Telehealth and digital health solutions have been increasingly used for remote consultations, reducing the need for our rural populations to travel and improving access to care. This has been particularly beneficial for managing chronic conditions and providing mental health support.

We have provided more access to primary care services through initiatives such as the new after-hours clinical telehealth service Ka Ora, which was specifically designed to reduce barriers for rural communities, particularly for priority populations. Ka Ora is staffed by kaiāwhina, nurses, GPs and emergency medicine specialists, and is available to all rural people, whether or not they are enrolled with a primary care practice.

Community organisations, iwi and hapū have played a crucial role in promoting health in rural communities and supporting rural people. These organisations have been instrumental in providing culturally appropriate care and addressing the specific needs of rural populations.

Stabilising rural hospitals

Rural hospitals are integral to delivering care closer to home, offering a wide range of services including primary care, emergency care, inpatient services, radiology, diagnostics, maternity, aged care, Māori health services, allied health, and community services within an integrated care model. However, they are facing increasing strain due to financial pressures and workforce shortages.

There are 26 rural hospitals currently operating in New Zealand and the current approaches to contracting and funding them vary greatly. We are working on a more consistent and sustainable approach to funding and commissioning.

Rural unplanned urgent care redesign project

Rural communities experience inequitable access to unplanned, urgent care, particularly after hours, due to challenges such as distance, road conditions, climate change impacts, and seasonal population fluctuations. A national project has been established to work through these challenges. This initiative, supported by an advisory group of clinicians, operational managers, rural community leaders, lived experience experts, and representatives from Hato Hone St John, ACC, Pharmac, and Fire and Emergency New Zealand, aims to improve access to urgent care in rural areas.

Section 3

Business operations

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Risk management

To ensure that we can focus on improving the health and wellbeing of our people, whānau and communities, we need to manage the risks we face as an organisation. We are committed to embedding best practice to help us better account for risk in organisational decision-making, preparedness and resilience.

To make sure that we effectively manage risk, we follow the approach set out in our enterprise risk management policy and framework. The policy and framework applies to everyone working for and on behalf of Health NZ, and aligns with the International Standards Organization Risk Management standard (31000).

The framework outlines our risk management processes, including regular risk and assurance reporting to the finance, risk and audit committee (previously named the finance and audit committee).

We categorise risks at different levels, focusing on systemic risks arising in more than one business area. These risks are owned by the executive leadership team. Operational risks (those relating to day-to-day activities) are generally managed locally.

In addition to risk levels, we categorise risks under broad headings, based on the source of the risk for our organisation. During the 2023/24 financial year, the risk categories were:

- business continuity
- clinical patient safety
- data and digital systems and services
- equitable health outcomes

- health, safety and wellbeing
- infrastructure and asset management
- legal and regulatory compliance
- organisational sustainability
- organisation – reputation – governance
- people, culture and capability
- programmes and projects.

In the past year, we increased our risk management capacity and capability at a national level, to supplement existing risk resourcing at a local level. This is helping us to develop a consistent approach to risk management across the country.

We also assessed the organisation's current risk management maturity and set targets for our risk maturity levels. The assessment will be used to develop a plan to reach our target maturity levels.

To further lift Health NZ's risk maturity, we will progress work on risk appetite statements, which define the amount of risk an organisation is willing to accept on a broad level. We will be able to refer to these statements when making decisions and determining which risks to prioritise. We will also refresh the enterprise risk management policy and framework next year.

Emergency management

The health system responds to a significant number of emergency events, working closely with other sectors such as local government, civil defence, and social agencies to provide support.

We have a critical role in ensuring readiness and resilience of health care services in the face of emergencies. We have put in place a national approach to emergency management, with resources at local, regional and national levels.

During the last financial year, we supported and managed multiple emergency response events, including

severe weather, power outages, water shortages and wildfires. We also ran and participated in local and national exercises. One was Exercise Rū Whenua, a national all-of-government exercise used to test processes and procedures during a nationally significant emergency. Lessons from these exercises help to strengthen our overall response capability.

Health NZ in action Helping where it counts

Heavy rain in Wairoa on 26 June 2024 saw many of the town's 8,600 residents displaced from their homes into evacuation centres. A state of local emergency was declared following the flood, and 420 of the district's 1,548 homes were disrupted, with 44 per cent assessed as having moderate to major damage.

The flood also disrupted the health system – people couldn't travel to medical and specialist appointments in Wairoa and Hastings, and those with severely affected homes lost access to their medications.

Health NZ gathered information to identify and prioritise health needs, consulted the community, and ensured frontline care and support was readily available.

Wairoa residents got access to free access to GPs, nurses and counselling services, including online doctor consults, pharmacy treatments and medication subsidy support, and the traditional Māori healing practice of rongoā. People were also offered a free after-hours emergency consultation.

Ngaira Harker, Regional Clinical Director Primary and Community Care, Central region I Ikaroa, said funding was allocated to five Māori health providers, including Kahungunu Executive in Wairoa, to facilitate people accessing the telehealth service Practice Plus.

"This gave people a place in the community to ask for help," Ngaira said. "These providers helped people book appointments on the Practice Plus app, including people who were not enrolled with a doctor.

"We know accessing health care is a barrier to some people in our community. Wairoa faces challenges common to rural isolated communities, and long-term planning that incorporates actions for ongoing environmental and other potential health issues is essential. The sooner people see someone, the more positive their health outcomes are, which is why we've worked this into our funding."

The flood event compounded the impacts of Cyclone Gabrielle in February 2023, which damaged 30 per cent of local housing stock, displaced hundreds of families, and caused significant damage to roading and infrastructure. Health NZ is working with the community to ensure their health aspirations are realised and collective solutions continue to develop. This includes not only immediate issues but also longer-term planning in primary care, aged care, mental health and hauora Māori.

Sustainability

Health NZ has many opportunities to become a sustainable and resilient organisation by responding to climate change, protecting the natural environment and enabling better health outcomes. These include supporting whānau and communities to become climate resilient and embedding New Zealand's international commitments under the Paris Agreement.

Carbon Neutral Government Programme

The Carbon Neutral Government Programme (CNGP) has been set up to accelerate the reduction of emissions within the public sector, joining businesses and communities who are already leading the way to a low-emissions economy.

The programme launched in December 2020 and Health NZ supports the whole of government approach to implement the programme.

Our national work programme covers four areas:

- decarbonising the health system
- environment in all practices
- health system resilience and adaptation to climate change
- integrating sustainability into core strategies and culture.

Our emissions reporting aligns to the CNGP guidance and ISO 14064-1:2018 and it has been independently audited by Toitū Envirocare. The audit opinion is available on [our website](#).

Our total annual emissions and sources

Health NZ has a national footprint from Otou North Cape in the North to Motupōhue Bluff in the South. This includes 86 hospital sites throughout New Zealand.

We engage with health providers, health prevention organisations, community groups and government agencies to:

- co-ordinate health interventions
- facilitate community self-management and resilience
- prevent ill-health.

Our largest emissions sources are related to our 24-hour, year-round operation of health facilities as well as travel and office electricity.

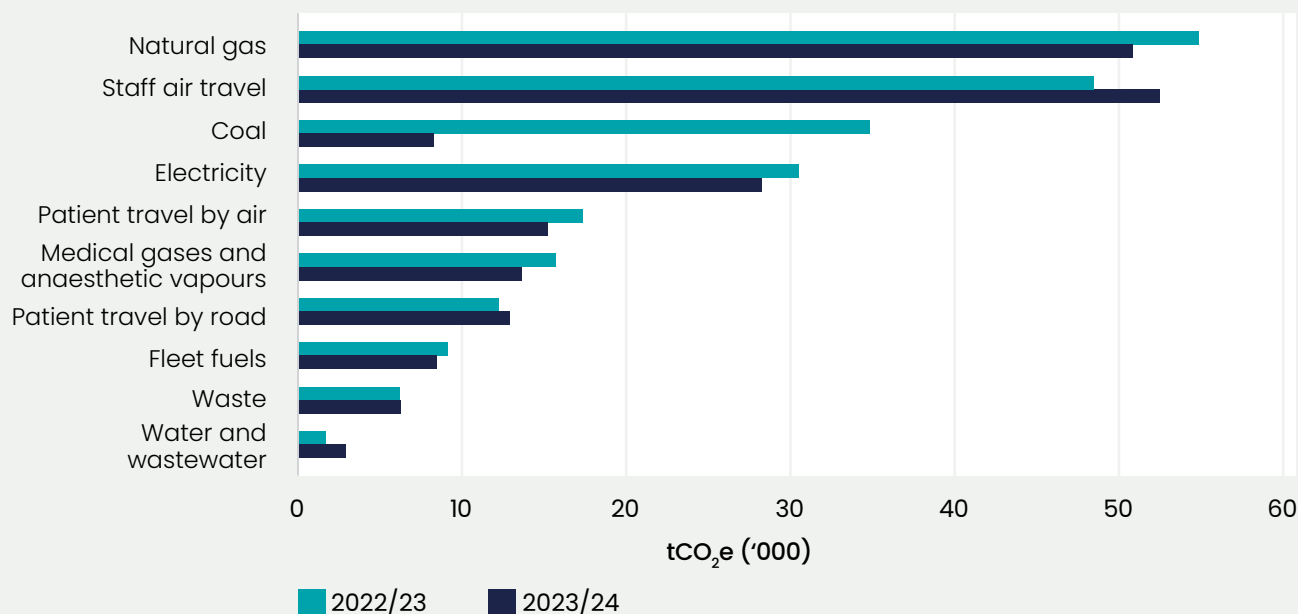
In 2023/24, we emitted a total of 202,562 tonnes of CO₂e across all emissions sources. This is a 15 per cent reduction from our baseline.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-129	CNGP total annual measured emissions for financial year (July to June), reported as total tonnes of carbon dioxide equivalent units (tCO ₂ e)	25% reduction over two years	237,822	202,562 tCO ₂ e	On Track
<p>Health NZ had a target of 25% reduction to category one and 25% reduction to category two emissions between 2022/23 and 2024/25.</p> <p>On track at 14% as at 30 June 2024.</p>					

Ref	Measure
P2-130	Emissions profile broken down by emissions source/scopes (tCO ₂ e)
<p>Detailed breakdown available in Appendix 2: CNGP emissions profile broken down by emissions source / scopes (tCO₂e).</p>	

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-131	CNGP Base year period and total emissions (tCO ₂ e). Change in total emissions each subsequent year compared to the base year (tCO ₂ e)	N/A	237,822	205,275 tCO ₂ e	On Track
<p>A decrease of 32,387 from base year. This is -14% change.</p>					

Comparison of Health NZ top 10 emissions sources 2022/23 (baseline) vs 2023/24



Ref	Measure	2022/23	2023/24
P2-132	Full-time equivalent of staff (FTE) in the reporting period (based on what is reported in Health NZ's annual Report)	78,164	82,923
<p>FTE numbers are based on those reported in the Health NZ Annual Reports.</p> <p>Notes to measure</p> <p>a) Results are based on recorded FTE in the Health Workforce Information Programme. See disclosure on page 18.</p>			

Ref	Measure	2022/23	2023/24
P2-133	Total expenditure in the reporting period (based on what is reported in Health NZ's annual report)	\$26.7 billion	\$27.9 billion
<p>Notes to measure</p> <p>a) 2022/23 results were not published last year but are included in this report for comparative purposes.</p>			

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-134	CNGP 2025 and 2030 gross emissions reduction targets (5) – this must be a combined total across all scopes/sources and can also be broken down by scope/source ^a	25% reduction between 2022/23 and 2024/25	Target set	On track	On track
<p>The Interim New Zealand Health Plan Te Pae Tata 2022–24 stated the following reduction targets:</p> <ul style="list-style-type: none"> • 25 per cent reduction to category one emissions between 2022/23 and 2024/25 • 25 per cent reduction to category two emissions between 2022/23 and 2024/25. <p>Notes to measure</p> <p>a) Our 2024/25 Statement of Performance Expectations states a combined 25% gross reduction target for category one and two emissions between 2022/23 and 2024/25.</p>					

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-135	CNGP Progress towards 2025 and 2030 targets compared to base year (%)	25%	Baseline year	15%	On track
<p>Base year 2023</p> <p>Category 1 – On track</p> <p>Category 2 – Target exceeded</p> <p>Table below outlines results by category.</p>					
Category	FY 2022/23 (base year) tCO ₂ e	FY 2023/24 tCO ₂ e	Decrease (increase) tCO ₂ e	% change	
Category 1 Direct GHG emissions	102,413	83,087	19,327	-19%	
Category 2 Indirect GHG emissions from imported energy	41,705	27,015	14,690	-35%	
Category 3 Indirect GHG emissions from transportation	78,488	80,696	(2,208)	3%	
Category 4 Indirect GHG emissions from products used by organization	15,047	14,476	571	-4%	
Total	237,655	205,272	32,387	-14%	

Ref	Measure
P2-136	<p>CNGP Qualitative commentary on results: Health NZ must explain:</p> <ul style="list-style-type: none"> initiatives for reducing emissions and progress towards these, and the context of emissions inventory and progress, for example, any data gaps, emissions sources excluded and why, challenges or significant changes experienced, and plans for improvement over time
<p>Health NZ has implemented several emissions reduction initiatives that have contributed to significant reductions against our baseline year:</p> <ul style="list-style-type: none"> removal of coal boilers from six sites and partnering with a supplier of steam to switch boilers to biomass replaced 325 combustion engine fleet vehicles with battery electric vehicles resulting in an 8% reduction of 722 tCO₂e energy efficiency projects (such as upgrades to LED lighting) have resulted in electricity emissions reductions of 2,358 or -8% from base year improved management of medical gas and anaesthetic vapour achieving a reduction of emissions of 2,026 tCO₂e or -13%. 	

Demonstrating our sustainability

Transitioning our hospitals to low carbon heat sources

We are decarbonising our energy mix, aiming to be coal-free by June 2025.

By the end of June 2024, we had cut greenhouse gas emissions from coal by 26,700 tCO₂e, or 76 per cent, compared to the previous financial year. This is equivalent to removing about 6,000 cars from the road.

With the support of the State Sector Decarbonisation Fund we removed coal boilers from six sites, which reduced emissions from coal by 12,700 tCO₂e or 63 per cent. The new biomass boilers and ground source heat pumps replaced coal in our Waitaha Canterbury facilities. We achieved further reductions of 13,700 tCO₂e, or 96 per cent, by partnering with a supplier of steam to switch boilers to biomass in Dunedin Hospital.

A national programme is underway to lower carbon sources by transitioning our remaining 12 coal boilers at eight hospital campuses. These projects are fully covered by the fund.

Once completed, the coal boiler conversion initiatives will further reduce coal emissions by about 8,000 tonnes annually and cut annual operational costs by an estimated \$450,000.

Progress from July 2023 to June 2024 includes:

- Taihape replaced two coal boilers with two wood pellet boilers¹
- Invercargill converted existing coal boilers to biomass (wood pellets)
- Taupō added an additional geothermal well and removed coal boilers.²

Health NZ in action Making health easier and more sustainable

In October 2023, we introduced a year-long pilot subsidising public transport for bus users coming to and from Waikato Hospital.

As well as helping staff, patients and visitors travel more sustainably, the 50 per cent subsidy almost eliminated missed appointments due to lack of parking.

Before the subsidy was introduced, reception would get multiple calls a day from frustrated patients who couldn't find a carpark. This meant they would be late or miss their appointment. Since the subsidy was introduced, calls have dropped to less than one a month.

The subsidy also resulted in a 20 per cent increase in passenger usage across all bus services in the first six months of the trial. The collaboration with Waikato Regional Council has also seen the introduction of a park and ride for people coming from north Hamilton.

The objectives of the pilot were to:

- improve travel demand management, and equity of access, to and from Waikato Hospital
- improve physical and equitable access to health and wellbeing services through transport
- show cross sector leadership and partnership with iwi and implement joint actions to deliver improved access to essential health services.

The pilot project ends in October 2024 and has provided excellent evidence and proof of the value of travel planning for our major hospitals.

1. Commissioned July 2023
2. Commissioned March 2024

Health NZ in action Safety first approach protects environment

We issue over 50 million prescriptions per year through the health system. These help our patients manage several ailments and conditions. Over time, medicines can pile up at home or at our workplaces. The Return of Unwanted Medicines campaign encourages the return of unwanted and out-of-date medicines to any pharmacy in the country.

The campaign objective was to help manage pharmaceutical waste better, to reduce pollution in the environment as well as to prevent misuse of medicines. The programme is delivered in partnership with community pharmacies and a specialist waste management provider. By managing the collection and disposal of medicines we are preventing medicines from entering our land and waterways.

Pharmacists properly dispose of medicines to protect both people and our planet – at no cost



to our patients. They accept medicines in any condition, whether they are prescription, home remedies, pet medicines, in blister packs or bottles.

The programme diverts medicines from landfill or inappropriate disposal (such as flushing through the toilet) and operates at community pharmacies nationwide.

Occupational health, safety and wellbeing

Health, safety and wellbeing is at the heart of our work – active participation, strong leadership and accountability are required.

This year, we made significant progress in our focus areas:

- establishing roles and responsibilities
- building and integrating systems, policies and procedures
- prioritising how we manage and respond to critical risks
- forming relationships and partnerships based on values and respect.

The board and executive leadership team guided this crucial work. Regular engagement enabled a strong focus on health, safety and wellbeing at governance and leadership levels. The board conducted its own due diligence to understand critical risks and ensure appropriate responses by leadership.

We focused on developing accurate and consistent national health and safety data, as well as strengthening reporting. By building a collective national view, we highlighted and addressed critical risks across the country. Achievements in the national work programme include:

- disseminating the officers' handbook, which offers guidance to people leaders and staff on how to fulfil their duties as officers of the person conducting a business or undertaking (PCBU)
- finalising the worker participation agreement, an important document that outlines the structure for Health NZ to ensure effective worker engagement. This agreement was a direct result of the work of the tripartite health and safety oversight group.

Workplace safety and security

Managing and minimising fatigue in the workplace

Fatigue at work can have potentially serious consequences for our staff and those in their care. We are equipping people to help manage this workforce issue and implementing practical steps at the local level. In June 2023 we endorsed six priority actions:

- provide accessible and nutritious food options for night workers
- ensure night workers get their existing standard 30-minute meal break
- provide supportive transport options for fatigued night workers
- provide supportive systems for napping, to reduce fatigue
- develop a suite of fatigue education/information
- establish a simple fatigue monitoring system to measure progress and outcomes.

We worked with our unions on national guidelines around the management of fatigue for night workers. These guidelines provide a principles-based approach to addressing fatigue in the workplace, with flexibility for local teams to adopt and implement the principles in ways that work for them.

Emergency departments

Emergency departments (EDs) are a vital part of our health system and everyone should feel safe when they enter these facilities.

Strengthening the capability and security of our EDs is a priority for the Government. As part of its 100-day action plan, the Government allocated a \$5.7 million boost to ED security, resulting in an additional 200 personnel to enhance safety in hospital EDs.

In Budget 2024, multi-year (2024/25–2027/28) funding of \$30.848m was allocated to further increase security in EDs across New Zealand.

Addressing workplace violence and aggression

As part of our programme to help minimise the harm from violence and aggression we offered training and advice on de-escalation. The Prevention First online training covers situational awareness and de-escalation skills, and is available to all patient-facing staff. As of 1 July 2024, almost 20,000 kaimahi have completed the training.

Violence reduction specialist pilot

We conducted a violence reduction specialist pilot to support and train staff who experience medium to high levels of violence at work. The pilot ended on 30 June 2024, and we received very positive feedback from staff about the value of specialist intervention, support and training. Insights from this pilot will inform the expansion of our ED security service.

Privacy

We are supporting our privacy maturity uplift programme.

Five principles underpin our values and behaviours:

- **He Tāngata** (focus on improving people's lives)
- **Manaakitanga** (respect and uphold the mana and dignity of the people, whānau, communities or groups who share their data and information)
- **Mana Whakahere** (empower people by giving choice and enabling their access to and use of their data and information)
- **Kaitiakitanga** (act as a steward in a way that people understand and trust)
- **Mahitahitanga** (work as equals to create and share valuable knowledge)

Weaving the principles throughout our day-to-day business reflects our commitment to nurture a culture of trust, transparency, accountability, and respect as stewards of personal and health information.

Advising the business

Privacy impact assessments and privacy threat assessments are important privacy assessment tools for managing and mitigating privacy risks associated with new technologies or changes in process. By integrating these assessments into projects, teams can proactively identify and mitigate potential privacy risks to data protection.

Using well-developed templates, staff are equipped to evaluate how personal information is collected, used and safeguarded throughout a project's lifecycle and beyond. These assessments ensure that privacy risks are thoroughly assessed and managed, enabling informed decision-making and enhancing overall data protection practices.

Privacy maturity assessment framework

We have submitted a second privacy maturity assessment framework for Health NZ. Due to the disestablishment of the Government chief privacy officer, this assessment has been submitted to the Department of Internal Affairs to finalise into a collective report. Our maturity results indicate that we have a 'foundational maturity level' across the domains, including core expectations, planning, policies and practice, and privacy domains.

A 'foundational' result is defined as an organisation-wide approach to privacy developing: "Good practice occurs in silos, but not at the wider organisational level, and any privacy work programme is driven by individual activities".

This was not an unexpected result and the framework results will give us areas for focus in our privacy programme for 2024/25.

Privacy breaches

Information about privacy breaches helps to identify and address vulnerabilities within a system or process. We are aware that a low number of breaches are reported to us. A national breach reporting system is being developed and is essential to capture all potential and actual breaches. We are legally required to report breaches that may cause harm to the Office of the Privacy Commissioner (OPC), and we do this on a regular basis.

During 2023/24, 57 potential breaches were reported to the OPC. Of these, 45 privacy breaches were reported as 'serious harm' in the year to 1 July 2024. A further 12 were deemed 'notifiable' by the OPC – i.e. the breaches were reported as 'not serious harm' by Health NZ but were changed to 'serious harm' by the OPC.

Using data and digital services to improve health

Supporting better, more equitable health outcomes through data and modern digital services

We made significant progress on modernising and digitally transforming the health system for the benefit of everyone in the 2023/24 financial year. This has been achieved while working to maintain and consolidate IT services from the 28 different entities which came together as Health NZ.

We have implemented new digital technology and supported with data that has helped improve access to care,

enhanced our people's experience of work and supported the health reform goals through greater use of digital services to provide more care in homes and local communities.

As at 30 June 2024, we completed 338 projects and initiatives, valued at \$103.62 million.

Projects ranged from minor enhancements to significant IT programmes, with a focus on maintenance and establishing clinical solutions.

Health NZ in action Creating positive change

Child health equity is making gains across the Northern region thanks to a digital platform and the community delivery co-ordination teams that focus on whānau engagement.

More than 230,000 tamariki are enrolled on the National Child Health Information Platform (NCHIP), which records core information on tamariki to ensure they receive all their health checks and immunisations on time from birth to six years of age.

The platform was introduced across Te Toku Tumai Auckland, Waitematā and Northland districts with a purpose of "no child left behind". Since its launch in February 2020, it has helped doctors, nurses and other child health providers do better health checks and on time. More than 2,500 clinicians in the Northern region have direct access to NCHIP now embedded in their own clinical systems.

Group Manager Natalie Desmond said the platform has many features that support more integrated whole-of-whānau services.

"As soon as pēpi is born, whānau receive information about free health services and the systems they are registered on. About 700 whānau use our QR code to



The community delivery coordination team who work on NCHIP

update their contact details or request assistance in connecting to providers like Well Child Tamariki Ora.

"The platform and our teams help link parents, especially first-time mums, with providers that may be a good fit for their whānau, like tamariki ora Māori and Pacific services, closer to where they live.

"Another whānau centred initiative has been the introduction of a birthday card to 4-year-olds outlining the health checks they are due before starting school.

"Looking ahead, the future of the platform is bright, and plans are underway to introduce additional features that will enhance functionality and user experience as we expand the service," said Natalie.

Delivery highlights

Improving our consumer-facing systems – giving consumers access to health information

Aotearoa Immunisation Register

The Aotearoa Immunisation Register (AIR) replaced previous immunisation and COVID-19 registers. It tracks immunisation records and status for children and adults, and allows more health care providers to access and update them. This means that people can get the right vaccines at the right time and avoid missing or duplicating doses. It therefore helps to reduce errors and data inconsistencies.

The new register also helps us to monitor immunisation services, identify areas for improvements and target resources where they are needed most.

Since its launch on 4 December 2023, over 2.1 million immunisation records have been recorded and more than 4.2 million immunisation status queries have been processed.

Hira

The Hira Programme aims to transform the way people access, use and securely share health data. We completed Tranche 1 on 30 June 2024, which included:

- **Health NZ Digital Services Hub** – The Digital Services Hub provides a developer portal for the wider health sector with API (application programming interfaces) testing capabilities. This enables the development of patient apps which will enable New Zealanders to access and manage their own health

information and share it with people they trust. Since the end of Tranche 1, we have published several services and have 23 organisations onboarded and another 19 in process.

- **My Health Record** – My Health Record is a secure website that gives people access to and a choice in how they view their health information www.my.health.nz. Over time, it will help give millions of New Zealanders the ability to see their health records online, including those who don't have access to a GP patient portal. This was enabled by the interoperability put in place by Hira and is a step toward a New Zealand Summary Care Record. This year 760,000 consumers (unique accounts) have accessed My Health Record.
- **My Health Account** – this is Health NZ's digital health identity service. It helps digital health services such as My Health Record accurately identify you using your 'digital identity'. Digital identity is how you prove who you are online – safely, securely, and easily. This lets you connect to your health information or services online from anywhere in New Zealand. My Health Account is the main verification and identity service for consumer facing applications produced by both Health NZ and third parties. This year there were 1.6 million unique logins across all 24 connected applications to My Health Account.

Further details on the Hira programme of work can be found at www.tewhatauora.govt.nz

Health information and services website

We launched a new public health website at www.info.health.nz. This site provides one place where consumers can find consistent, accessible, reliable, plain language information about health and the services they can access. Since its launch, 1.5 million (1,509,852) users visited the website. The most popular page was 'If you have COVID-19'.

National Disease Management System

Launched in February 2024, the National Disease Management System helps identify people who may have been in contact with measles or COVID-19 and support them not to spread the virus. The system give us the ability to co-ordinate case and contact tracing for communicable diseases at a local, regional and national level. Meningococcal disease and mumps will be added to the system next, with an overall goal to include 65+ notifiable diseases.

Improving our clinical systems, the experience and productivity of clinical staff

New patient information system for South Island replaces eight ageing and disconnected systems

Health NZ's new South Island patient care information system streamlines the patient journey through the health system and make tasks easier for staff, enabling more efficient and connected health care. This system also supports improved analytics, and a view of a single waitlist for the region to support planned care.

New e-prescribing system replaces old paper-based system, benefitting thousands of cancer patients

Raurau Ngaehe is a new oncology and haematology e-prescribing and administration solution that is now used by 600 clinicians in the Northern region. It enables more oncology care to be provided closer to home for patients and helps to address regional inconsistencies in practice. The system also reduces the potential for human error as it automatically calculates and rounds doses, as well as potentially reducing wastage of chemotherapy drugs.

Tap On Tap Off – now live in emergency departments across Waitematā

Over 500 clinical staff no longer need to constantly log on and off during ward rounds and transition between care locations or tasks, saving clinical staff time. This technology also contributes to addressing privacy and security concerns with the reduction in the use of generic logons.

Medtasker – a user-friendly clinical tasking and collaboration tool

This intuitive tool has been rolled out across the Northern region and replaces existing messaging systems and pagers. As a result, clinical staff are being interrupted less often and nurses can see in real time when a task has been accepted and completed.

National Cervical Screening Register

The new population-based National Cervical Screening Register helped us reach 600,000+ more wāhine and people with a cervix. The register went live in September 2023, with all clinics now on one common platform for screening schedules and records. We are working to further improve our digital tools and system integration so that providers can contact unscreened and under-screened people, and so that GPs have direct access to screening history.

New national CRM fosters outreach and support

Launched in December 2023, Whaihua has been extended beyond COVID to support wider Immunisation Outreach Services, Cervical Screening services including Support, and Newborn Enrolment Management.

Improving our core systems – building solid foundations

National data platform

The national data platform, released in June 2024, will be the common hub for our health data. The platform will unify and standardise health data across the country, reducing duplication and fragmentation of data. We will be able to safely access and use health data for statistical analysis, optimising operations and improving service delivery.

Cyber security uplift programme

We have made substantial progress on cyber security over the last year, focusing our investment on reducing

the risk of ransomware incidents and lowering our vulnerability to email phishing campaigns. We have increased protection for our physical devices, implemented a nationwide threat detection system, and developed a multi-layered cyber incident response capability. Our security awareness and education phishing campaigns are well below the industry average “phish-prone” score, meaning we have a more informed and aware workforce.

Hybrid multi-cloud programme

We deployed the Azure sector platform and Azure Web Services sector public cloud platform, which provide the connectivity to support a more modern, resilient and adaptable health IT ecosystem. The cloud platform now hosts components that support the national data platform, Aotearoa Immunisation Register, National Bowel Screening data and Hira Marketplace.

Health sector agreements and payments programme

We are replacing legacy systems that are not fit for the future with a new system that enables a modern and flexible approach to how we procure services from external providers. It will enable changing funding models, different contractual mechanisms and payment arrangements. We have now established a new platform to process dental payments with 800 dental providers onboarded to submit their claims. We also have a new electronic end-to-end process for agreement management.

Improving our corporate systems

We have also made improvements to join up Health NZ systems so our teams can communicate and collaborate more easily. We are removing administrative burden through our digital workspace portfolio:

- **National service desk** – we moved 16 different service desks onto a single national platform, the ServiceNow portal, to streamline and standardise processes and speed up resolution times.
- **National desktop** – updated technology allows staff to access the applications required from a single device. This has now been rolled out to 5,000 staff. Deployment to clinical staff commences in 2025.
- **Deployment of new devices** – we replaced approximately 4,000 aged devices.
- **Identity governance and automation** – we implemented a cloud-based national identity management tool so that access requests will be processed faster with reduced manual work. We now have 93,000 people loaded into this tool.

Managing a complex IT environment

Despite efforts to improve our systems, the inherited patchwork of IT and data systems can still impede rather than enable better patient care, frustrate our employees and impact health system productivity.

Additionally, the long-term underinvestment in data and digital infrastructure and poorly focused investment (reflecting the previous health system structure) has resulted in a large amount of technical debt. When we don't invest in our technology and defer action there is a hidden cost of the undone or left out work – this is technical debt. This is reflected in the table on the next page.

We have aged applications and infrastructure that is end-of-life, out-of-support or not fit for purpose. This means there is a high degree of vulnerability to incidents and outages, including cyber breaches, and a risk of irrecoverable data loss.

The large number of systems, coupled with the technical debt, makes upgrading difficult, including integration with adjacent systems and services, while protecting patient records and ensuring continuity of care.

It has been a significant achievement to transition, improving our systems while also maintaining services within our legacy landscape.

Performance indicators for data and digital assets

Health NZ inherited low asset management maturity and a significant lack of historical investment in data and digital assets across the previous entities. There is no single asset register for data and digital assets and discovery is ongoing. We are in the process of establishing strategic asset management and prioritising investment in service lifecycle management across our portfolio.

Our IT environment

Databases

25% out-of-support
54% on extended support

Servers

43% of virtual servers out-of-support

Critical hardware

50% beyond intended lifecycle
1,000 devices > 10yrs old

Applications

>6,000 applications (consumer, clinical and business)
6,000 databases

Devices

70,000 devices including desktops, laptops and tablets
20,000 mobile phone connections

Infrastructure

Circa 15,000 virtual servers, on 3,000 physical servers – including 600+ in public cloud
5,000 network switches and routers supporting 13,000 Wi-Fi access points from 1,500 hub rooms at 400+ clinical and corporate locations

100+ firewalls
80 hospital computer rooms
130,000 network ports
22,000 storage disks storing 10.6 petabytes* of data

*a petabyte is roughly equivalent to 11,000 movies or 500 billion printed pages

Procurement

Supply chain and health technology management

Procurement supply chain and health technology management services support frontline staff to care for their patients and whānau, regardless of geographical location, helping to reduce inequitable health outcomes and unmet health needs.

Having a national function means we are better placed to reduce unwanted variations that lead to inefficiencies.

A national approach:

- maximises purchasing power (which improves the value delivered)
- centralises management of supply risks such as unavailable stock in normal operational and emergency situations
- increases focus on the stewardship of clinical assets to ensure that we have safe, effective and efficient medical equipment.

A nationally aligned approach to supplier environmental sustainability and broader social outcomes engages suppliers more effectively in achieving Health NZ's organisational goals.

Health technology asset management (clinical equipment)

Health NZ established a centre-led health technology management function towards the end of 2023, bringing together the resources to manage clinical assets at a portfolio level and to establish a unified asset management system. We are busy with our transformation process to establishing an operating model and deeper structure to deliver on this.

This will help reduce variation, inefficiencies, duplication, ineffectiveness and possibly patient, commercial, brand and compliance risks.

Under the new function we have:

- established a national capital asset management information system to create a single asset management tool, with planned completion at the end of FY 2024/25
- established a centre-led strategy and delivery function through national portfolio and programme planning governed by centre-led policies, procedures, and guidelines
- consolidated the capital planning for the clinical asset portfolio to inform capital delivery programmes to drive consistency
- begun delivering the clinical equipment capital prioritisation plan for 2024/25 and beyond in collaboration with the asset portfolios of data and digital and the infrastructure and investment group.

Current state of health technology assets

Our health technology (clinical equipment) assets are summarised in the table below. The relevant

performance measures for the health technology portfolio highlight the need to ensure our clinical assets are in acceptable condition, are well used, and comply with regulatory requirements.

Asset portfolio	Asset purpose	Quantity/capacity (nationally)	Book value (nationally)
Health technology¹ (clinical equipment)	To enable the delivery of high-quality, timely clinical services through the availability of equipment that meets required clinical and safety standards	<p>Major capital items:</p> <p>24x linear accelerators</p> <p>29x Magnetic Resonance Imaging (MRI) systems</p> <p>56x Computerized Tomography (CT) systems²</p> <p>Minor capital items:</p> <p>~261,000 medical equipment (in-hospital and limited community-based items)³</p>	<p>Calculated net book value of assets fleet is \$1.27 billion⁴</p> <p>Calculated replacement value of assets fleet is \$2.030 billion⁵</p>

1. The requirement to report on relevant asset performance indicators for service critical assets is set out in Cabinet Office Circular: CO (23) 9 [Investment Management and Asset Performance in Departments and Other Entities](#).
2. The scanner counts (CT and MRI) are 75% higher than last year. This reflects the work to gain better transparency and control of clinical assets within Health NZ rather than a substantial increase in fleet size. As systems are rolled out across the organisation, such as the national clinical asset information system currently being deployed, the quality of information will continue to improve. Equipment data has been included where the scanners are under the control of Health NZ sites and used to deliver services, regardless of the ownership model.
3. Includes mainly in-hospital devices that are managed by Clinical Engineering and excludes items managed through other service provider support, e.g. leased items, laboratory, and major radiology equipment. Includes clinical items that may not meet the financial definition of an asset. The data was obtained from all our clinical engineering departments in the districts. The data will be confirmed as and when Health NZ migrates the data to a single asset information management system (AMIS), which is aimed to be completed before the end of the 2024/25 financial year.
4. The data was not readily available and may include clinical items that may not meet the financial definition of an asset. The overall net book value was calculated using the overarching 'Clinical Asset' portfolio, which includes other asset classes that are not medical equipment. The data will be further refined when the roll-out of AMIS is completed towards the end of FY2024/25 and the data quality validation has been completed. The migration of the wider Health NZ to a single Financial Procurement Information Management (FPIM) system will also enhance data quality.
5. The overall replacement value was calculated using the overarching clinical asset portfolio, which includes other asset classes that are not medical equipment. The data will be further refined when the roll-out of AMIS is completed towards the end of FY2024/25 and the data quality validation has been completed. The migration of the wider Health NZ to a single Financial Procurement Information Management (FPIM) system will also enhance data quality.

Performance indicators for health technology assets

Safe clinical service delivery requires that all health technology (clinical equipment) assets are fully functional and fit for purpose. Where health technology assets fail against required standards, they are taken out of service. Asset availability is managed

via Service Level Agreements for major assets (some of which are leased) and through built-in redundancy within the asset fleet to enable replacement as required. The following table outlines the health technology (clinical equipment) by considering the asset performance measures, namely condition, availability and utilisation.

Asset group	Measure	2023/24 Average target	2023/24 Average actual
24x Linear Accelerators	Availability/Uptime ⁶	98% ⁷	98.4% ⁸
29x Magnetic Resonance Imaging (MRI) systems	Availability/Uptime	98% ⁷	99% ⁸
56x Computerized Tomography (CT) systems	Availability/Uptime	95.5% ⁷	99% ⁸
~261,000 minor medical equipment items (in-hospital and community based)	Condition-Performance Verification ⁹	93%	81% ¹⁰

6. The Availability/Uptime APM refers to the availability of the asset for clinical use. It considered the available operating hours less the time for any planned or scheduled maintenance activities.
7. The target is based on the Service Level Agreements (SLAs) KPIs established with the service providers and does not consider any utilisation targets set by the individual hospitals.
8. The actual is an average of the SLAs' KPI results, across all machines, as reported by the service providers.
9. Performance verification is testing the performance parameters of the medical equipment and is used to confirm the equipment performs safely and as intended by the manufacturer (a statutory requirement).
10. The actual is based on the average of the available results from 18 districts and only focuses on in-hospital clinical equipment. The target of 93% was not achieved due to the current level of vacancies and funding constraints within Clinical Engineering. These functions were previously managed from within districts. The newly formed Health Technologies Management (HTM) Function has brought the existing known Clinical Engineering Teams under a national structure, which will help realign resources to address capacity gaps where they are evident.

Our physical infrastructure

Getting health infrastructure right is crucial to enabling our clinical workforce to deliver care safely and effectively and for people to receive high-quality care.

Improved health infrastructure is a key enabler of clinical services and improved health outcomes. Clinical services need specialist facilities in their design and their fit-out, which includes clinical and digital equipment. These facilities are among the most challenging to plan, design and build.

An early focus for Health NZ was the development of an integrated operating model for infrastructure, conceived by a working group of external experts with wide stakeholder engagement and input.

The operating model aims to improve efficiency, performance and capability of infrastructure delivery, as well as position infrastructure as a key enabler of health outcomes.

Governance across the portfolio has been improved with the operation of the capital and infrastructure committee and the establishment of new governance and delivery structures for new Dunedin Hospital, Whangārei Hospital and Nelson Hospital redevelopment.

Health NZ in action Collaborating for success

Two new mental health facilities in Ōtautahi Christchurch won the title of Project of the Year – New Build International at the Design in Mental Health Awards in the United Kingdom in June 2024.

The buildings, which opened on the Hillmorton Hospital campus in 2023, were designed by Klein Architects on behalf of Health NZ.

One is a unit for adults with high and complex mental health needs and the other provides inpatient and specialist outpatient mental health services for mothers and babies, children and adolescents, and people with eating disorders.

All the services were previously located at Princess Margaret Hospital.

“The buildings help create an environment that supports *oranga hinengaro* (mental wellbeing) by creating homely spaces that welcome *whānau* and support other aspects of contemporary models of care,” said Rebecca Webster, Clinical Lead Mental Health Facilities, Waitaha | Te Tai o Poutini.

Rob Ojala, Regional Head of Infrastructure for Te Waipounamu, said the work done on the



The homely environment at Whāngai Aroha, where mothers and babies and patients with eating disorders receive support

project will benefit more than just the two buildings at Hillmorton.

“This is the result of a great collaboration between the clinical teams, *tāngata whaiora*, *mana whenua*, designers and the project team. They have delivered an incredible facility, which will inform the design of other mental health builds around the country,” Rob said.

Updating our infrastructure

We are working on ways to understand the total state of our health infrastructure. We inherited a physical infrastructure portfolio with significant historic under-investment, variable quality across the country, many assets close to end of life and a third of them beyond their design life. The infrastructure asset data we have is fragmented and held in multiple asset management systems. Until we implement a national asset management information system and undertake a full baseline condition assessment, it will be challenging to take a nationwide view of the risks and priorities for maintenance and capital investment. The average age of our buildings is 46 years and we regularly uncover new issues and compliance risks.

We have managed cost escalation across the portfolio, lifted the standard of business case investment proposals, and ensured compliance with the requirements of the investment management system. We are also strengthening procurement practices through collaborative approaches to working with suppliers. We have applied greater oversight and leadership to the delivery of mental health infrastructure projects.

Previously the management of health infrastructure was fragmented across 20 district health boards with notable variations in capability. This resulted in uneven performance and outcomes and an inefficient infrastructure.

Our physical infrastructure portfolio includes ageing, earthquake-prone facilities, or facilities that are outdated.

- 36 of our occupied buildings are classified as earthquake prone, and many others may not be able to function immediately following a major earthquake.
- 70 per cent of our mental health facilities do not meet therapeutic and safety requirements.

Twenty-two per cent of the projects we have inherited face delays or cost over-runs, primarily due to the projects being poorly planned and multiple scope changes.

We are aware of deferred maintenance at our sites, however not having the systems and tools to quantify the levels of deferred maintenance means that we are unable to predict the spikes in investment required to maintain an asset's level of service. As an example, a Hawke's Bay pilot to baseline the estate and model the degradation of the building, plant and infrastructure assets using their facilities management software indicates that 57 per cent of their plant assets are beyond their engineered lifespan.

Our immediate priorities include:

- concluding our work on New Zealand's first health infrastructure investment plan, setting out proposed investments over the next 10 years, and the national asset management strategy
- progressing the national roll-out of national project management and construction management systems to enable us to track and monitor our construction projects
- the regional hospital redevelopment programme, with business cases approved for Whangārei and Whakatū Nelson, and planning under way for Tauranga, Papaioea Palmerston North, and Te Matau-a-Māui Hawke's Bay
- the programme to deliver fit-for-purpose mental health infrastructure, with three projects complete and nine with site works under way
- Project Whakatuputupu, new Dunedin Hospital, is being developed in two stages. Stage one, an outpatient building, is on-track for 2026. An options analysis is currently underway for stage two, an inpatient building with a view to deliver the project within the \$1.88b budget. Further details on this project can be found at: [New Dunedin Hospital – Health New Zealand | Te Whatu Ora](#).

Health NZ in action Overcoming hurdles

When it became clear repairs were needed to Wellington Regional Hospital's copper water pipes, clever thinking came to the rescue to avoid losing bed space when work started.

Health NZ created a solution and installed a fully operational 12 bed ward on the flat roof of level three as a back-up while repairs were underway in other wards.

The rooftop ward was built offsite in Upper Hutt and then craned into place. It was fitted out and opened in January 2024.

Described as a 'decant ward', which provides support to the hospital's usual capacity when needed, it is a New Zealand first. Although a temporary solution for now, it blends in on top of the main building and could provide a dozen extra beds on a more permanent basis once the pipe work is finished.

Jamie Duncan, Group Director of Operations Capital and Coast, said the ward has already helped enormously as repair work continues:

"It is a very creative solution to a problem we didn't anticipate and shows how innovative construction can be.



New ward being installed on the roof

"The 400m² ward is equipped with everything you'd find on a usual ward and is connected to the main hospital via an existing hallway.

"Looking at it from outside, or when you are in the ward, you'd think it's always been part of the main hospital," Jamie said.

The rooftop decant ward project was awarded silver at the ACE New Zealand awards and highly commended for collaboration at the New Zealand Building People Awards 2024.

Asset management

Measuring the actual performance of our critical assets against our expected performance measures helps identify and manage both asset and service-related risks.

Knowing our assets and their performance enables us to more effectively plan and implement the steps needed to meet continued growth in demand for our general and specialist health care services.

Some of our assets are of strategic importance to New Zealand as they provide national specialist health services for the country, for example: cancer services; organ donation and transplants; Starship Children's Hospital; plastic surgery; burns units; and spinal units.

Asset portfolio

Current value of the health estate

The public health estate has a land value of \$1.731 billion and more than 1,200 buildings with a net book value of \$9.171 billion and an estimated replacement value of \$38 billion. Health NZ also leases property with rental payments exceeding \$80 million plus GST each year.

Health NZ is an investment intensive agency. A considerable proportion of our asset base is ageing infrastructure, which affects service delivery levels in New Zealand's health system.

Additionally, our low level of asset management maturity is a barrier to us demonstrating compliance with mandatory requirements for asset management, in particular Cabinet Circular CO (23)9: Investment Management and Asset Performance in Departments and Other Entities.

External reports dating back to 2009 have highlighted inconsistent approaches to asset management in health that are not commensurate with the value of the assets and no material improvements in the maturity of health asset management have been noted in subsequent audits.

In 2016, Cabinet issued a policy statement, which was subsequently updated in 2019 and again in 2023, to Cabinet Circular CO (23)9. This circular sets out the obligations of Crown entities regarding the management of investments of both physical and intangible assets.

Asset management maturity

An assessment of asset management maturity, process and practices has shown there is variability across the regions and a significant amount of work is required to implement standardised processes and practices. Several foundational pieces of work are required:

- **Developing an asset management policy and strategy** – the policy will outline the expectations in relation to asset management and the strategy will outline how decisions related to assets will be made and provide a roadmap on how Health NZ will grow its competency in asset management. The policy is in final draft pending review. The first iteration of the National Asset Management Strategy (NAMS) was sent to the Minister and is being reassessed in the light of Health NZ's financial circumstances.
- **Baselining the health estate** – this will confirm what assets are included in the health estate and their condition. We have established a standardised approach to assessing asset condition. Assessments are expected to take approximately three years. This will allow condition performance reporting to be implemented. While this is critical for us to understand our estate and allow us to plan our investments more efficiently, no progress has been made on this outside of a pilot (two sites) that is being finalised.
- **Developing and implementing an asset management information system** – this system will capture the information from the baselining exercise and enable comprehensive analysis and reporting on the health estate, including asset performance reporting. Standardising how we assess and prioritise investment based on nationally set asset levels of service will reduce the inequities in investment that occurred in the past. A business case for the Asset Management Information System (AMIS) has been developed.

Building asset management foundations

We have established workstreams based on risk, ahead of full baseline assessments. These include:

- **Seismic work programme** – to understand our seismic risks and develop an approach to the prioritisation of mitigation work, put in place a seismic policy and strategy, develop technical guidance for new and existing buildings, and put in place procedures and arrangements for post-earthquake response.
- **Climate change risk assessment** – helping us understand priority areas for risk mitigation and adaptation planning. It will also help with communicating key risks and will be useful in broader planning, strategy, and investment prioritisation.

Further information on the first infrastructure and investment report back to the Minister of Health and Cabinet can be found in the [Annual Report to Ministers on Enhancement of Infrastructure Management](#).

Performance indicators for infrastructure assets

Health NZ inherited a significant asset base and capital investment programme. Our total assets had a net book/revalued value of \$9 billion at 30 June 2023 and the capital investment programme is \$9 billion (2023/24), including multi-year projects under implementation.

To enable evidenced-based performance measurement, reporting and forecasting for all our assets requires investment in systems and tools that will capture current performance and be able to ascertain the gap between current performance and expected performance.

Over the next four years Health NZ will be working toward ensuring that we are able to measure and report on our assets' performance across the motu and have systems, tools and processes implemented to do so.

We have a work programme (with milestones) in the National Asset Management Strategy (NAMS) that outlines our road to maturity, and therefore our ability to comply with our obligations under Cabinet Circular CO (23)9. The NAMS has been approved by the board and is due to go to Cabinet in quarter one 2024/25.

Section 4

Statement of Service Performance

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Statement of Service Performance

This is the Statement of Service Performance (SSP) for the Health NZ group^a for the year ended 30 June 2024. It presents a snapshot of the services provided for our population, and how these services are performing across the continuum of care provided.

The SSP is grouped into six output classes, with one sub output class:

1. Public health services
 - a) National COVID-19 response
2. Primary and community services
3. Hospital and specialist services
4. Mental health and addiction services
5. Capital programmes
6. Hauora Māori services.

Measures that help to evaluate Health NZ's performance over time are reported for each output class, recognising the funding received, Government priorities, national decision-making and board priorities.

Our progress towards the strategic priorities and intentions set out in our Statement of Intent (2022-2024) are described in Section 2.

Previous performance measures

On establishment, the performance measures that Health NZ was required to include in its 2022/23 Annual report were articulated in Vote: Health Estimates of Appropriations 2022/23.

These measures were adopted from the interim Government Policy Statement on

Health 2022/23, the Interim New Zealand Health Plan | Te Pae Tata 2022-24 as part of the new entity establishment process, together with selected measures that the (former) District Health Boards or the Ministry of Health previously reported.

In the process of compiling the 2022/23 Annual Report, a number of measures were identified where reporting at an aggregate level was impractical, and these were subsequently removed though the Estimates and Supplementary Estimates processes, setting out the disclosures justifying removal.

For the 2023/24 Annual Report, we are only reporting on measures set out in our accountability documents; namely the Statement of Intent 2022-2024, the 2022-23 and 2023-24 Statements of Performance Expectations, Vote Health: Estimates of Appropriations 2023/24, and Vote Health – Supplementary Estimates 2023/24. The only exceptions to this are six measures we are reporting to allow an informed assessment to be made of Health NZ's operations and performance for the 2023/24 year. These consist of two measures relating to COVID-19 vaccinations, three measures relating to breast, bowel and cervical screening, and a waiting time measure for cancer treatment.

a) See note 11 in Section 5 – Financial Statements

In our view, the performance measures selected for 2023/24 adequately inform users of what we achieved during the year and the progress we are making towards achieving our outcomes.

Changes to performance measures

In reviewing the measures reported last year against the required characteristics and constraints, we made several changes to improve their appropriateness and meaningfulness. Significant changes to performance measures for 2023/24 (i.e. new measures or significantly altered measures) are noted against the relevant measure.

There are nine performance measures that we are unable to report against this year. One is a contingent measure, where the circumstances where it would be required have not eventuated, and the remaining six lack supporting systems or data to enable reporting. These are detailed in Appendix 3.

Performance reporting standard PBE FRS 48

The Statement of Service Performance has been prepared in accordance with the requirements of the Pae Ora (Healthy Futures) Act 2022 and the Crown Entities Act 2004, which include the requirement to comply with New Zealand Generally Accepted Accounting Practice (NZ GAAP). It has been prepared in accordance with tier 1 public benefit entity financial reporting standards, which have been applied consistently throughout the period.

This performance section, together with Appendices 3 and 6, constitutes the service performance information presented in accordance with [Public Benefit Entity Financial Reporting Standard 48 Service Performance Reporting \(PBE FRS 48\)](#).

Statement of compliance

Service performance information for the period of 1 July 2023 to 30 June 2024 has been prepared in accordance with public benefit entity standards.

How we were funded in 2023/24

Health NZ has reporting responsibilities under the Public Finance Act 1989 for the appropriations set out in the table below:

Appropriation	2023/24 Amount of each appropriation \$000s	2023/24 Amount spent against each appropriation \$000s	2022/23 Amount spent against each appropriation \$000s
Delivering Hospital and Specialist Services	14,389,512	14,381,833	12,917,202
Delivering Primary, Community, Public and Population Health Services	8,668,148	8,668,148	8,199,205
Problem Gambling Services	29,557	28,898	20,384
Capital Investment in Health New Zealand	10,916	10,916	23,181
Health Capital Envelope	950,000	521,594	1,591,600
New Dunedin Hospital 2021-2026	156,871	100,080	62,606
Standby Credit to Support Health System Liquidity	200,000	0	0
National Response to Covid-19 Across the Health Sector (non-departmental element only)	210,951	177,448	1,140,340
Implementing the COVID-19 vaccine strategy MCA	105,287	70,287	903,880
Remediation and resolution of Holidays Act 2003 historical claims	572,314	285,836	0

a) Health NZ does not receive all the funds from each appropriation as other agencies also receive funds from these appropriations.

Funding by output class^a

Output Class	In \$ Millions	2023/24 Actual	2023/24 Budget	2022/23 Actual
Public health services	Revenue	486	484	469
	Expenditure	705	484	537
	Net Surplus/(Deficit)	(219)	0	(68)
National COVID-19 response	Revenue	238	295	1,583
	Expenditure	238	295	1,756
	Net Surplus/(Deficit)	0	0	(173)
Primary and community services	Revenue	9,438	9,428	8,086
	Expenditure	9,148	9,428	8,025
	Net Surplus/(Deficit)	290	0	61
Hospital and specialist services	Revenue	14,559	13,800	13,606
	Expenditure	15,303	13,800	14,309
	Net Surplus/(Deficit)	(744)	0	(703)
Mental health and addiction services	Revenue	2,285	2,113	1,946
	Expenditure	2,305	2,113	2,077
	Net Surplus/(Deficit)	(21)	0	(131)
Hauora Māori services ^b	Revenue	174	0	0
	Expenditure	203	0	0
	Net Surplus/(Deficit)	(28)	0	0
Total	Revenue	27,180	26,120	25,690
	Expenditure	27,902	26,120	26,704
	Net Surplus/(Deficit)	(722)	0	(1,013)

a) The cost allocation method for allocating Health NZ costs across output classes is described in the Significant Accounting Policies under Note 1 "cost allocation".

b) This appropriation is reported in the Te Aka Whai Ora Annual Report for the first three quarters of 2023/24.

Financial measures

The performance measures in this section each compare a percentage of Health NZ's total budget with the percentage of total expenditure at year end.

These comparisons will not convey an accurate representation of Health NZ's financial performance, given that we have incurred a net deficit of \$722 million for the year ended 30 June 2024.

Please refer to the table on the previous page for the financial result for each of the output classes reported on below. This will provide context for the reported result.

Ref	Output Class 1: Public health services	Target per SPE / Vote	2022/23 Result	2023/24 Result	Status
P2-06	Percentage spend of Health NZ's total budget on public health	1.85%	2.18%	2.70%	✗

The budget in the Statement of Performance Expectations was 1.85% of total expenditure. Expenditure for NPHS is \$221m greater than budget mainly due to \$203m of unbudgeted COVID-19 national reserve stock (NRS) inherited from the Ministry of Health which was written off (\$103m) and consumed (\$100m) in the year. COVID-19 stock written off was expired stock and stock excess to NRS peak demand requirements.

*If these extraordinary costs are excluded, expenditure is on target (1.73%) and the result for this measure should be achieved.

Ref	Output Class 2: Primary and community services	Target per SPE / Vote	2022/23 Result	2023/24 Result	Status
P2-34	Percentage spend of Health NZ's total budget on Primary and Community Care	36.09%	32.57%	35.02%	✗

The plan in the Statement of Performance Expectations was 36.09% of total expenditure. The actual result was lower than expected due to higher than planned expenditure in other output classes, expenditure transfers to the Hauora Māori output class and in-year one-off accounting benefits.

P2-35	Proportion of total expenditure directed to mental health and addiction meets agreed level	Achieved	New measure	Achieved	✓
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The increased percentage of total budgeted expenditure in mental health (6.30% compared with 6.0%) reflects the commitment to the ringfence while other services face tighter fiscal constraints and received lower uplifts.

Notes to the measure:

- a) This measure was published in the Vote Health – Estimates of Appropriations 2022/23 – Health Sector B.5 Vol5, page 31. A similar measure (P2-74), 'percentage spend of Te Whatu Ora's total budget on mental health' was published in the 2022/24 Statement of Intent, page 33 and is covered by the result shown here.

Ref	Output Class 3: Hospital and specialist services	Target per SPE/Vote	2022/23 Result	2023/24 Result	Status
P2-65	Percentage spend of Health NZ's total budget on hospitals and specialist services	52.83%	58.08%	58.58%	✗
<p>The budget in the Statement of Performance Expectations was 51.61% of total expenditure. The percentage spend is higher than forecast due to over expenditure in Hospital and specialist services. This arose from higher than budgeted personnel costs arising from over recruitment of nursing staff, pay rate changes arising from collective settlements, pay equity adjustments and uplift in staff liabilities, and an increase in personnel outsourcing. Hospital and specialist services has been disproportionately exposed to these increases. Further details can be found in the Notes to the Financial Statements (Note 26).</p>					
P2-66	Proportion of total expenditure directed to mental health and addiction meets agreed level	Achieved	Achieved	Not achieved	✗
<p>While total mental health and addiction spend was higher than budget in 2023/24, the financial pressures in other areas have resulted in a lower proportion as a % for mental health and addiction (SPE 10.7% v Actual 9.7%). Percent increase in mental health was due to higher cost of hospital mental health services due to higher personnel cost.</p>					
Ref	Output Class 4: Mental health and addictions	Target per SPE/Vote	2022/23 Result	2023/24 Result	Status
P2-50	Percentage spend of Health NZ's total budget on mental health	8.1%	8.43%	8.82%	✓
<p>Percent increase in mental health was due to higher cost of hospital mental health services due to higher personnel cost.</p> <p>Despite the increase in cost pressures, the commitment to the ringfence has been maintained.</p>					
P2-75	Mental Health Ringfence expectations are met	Achieved	Achieved	Achieved	✓
<p>Mental health expenditure exceeded ringfence expectations driven by Hospital and specialist services. Percent increase in mental health was due to higher cost of hospital mental health services due to higher personnel cost.</p>					

Ref	Output Class 5: Capital programmes	Target per SPE/Vote	2022/23 Result	2023/24 Result	Status
P2-142	Budgeted to fully spend the \$1.208 billion received from the Capital Appropriation in 2023/24	\$1.208 billion	\$1.3 billion	\$1.6 billion	×
<p>Of the \$1.208 billion Capital Appropriation, only \$956 million was drawn down in 2023/24. The \$1.6 billion of Capital spend was funded from the Health Capital Envelope, Health NZ funding and donations.</p> <p>An integrated approach to Capex planning has been implemented to confirm the organisational priorities for 2024/25 having considered affordability, capacity and co-dependencies.</p>					

Ref	Output Class 6: Hauora Māori	Target per SPE/Vote	2022/23 Result	2023/24 Result	Status
P2-143	No agreed/approved budget for Hauora Māori Services so are only reporting the actuals.	N/A	N/A	\$203 million	—
<p>Hauora Māori Services moved into Health NZ on 1 April 2024 and this output class was not included in the 2023/24 Statement of Performance Expectations. The above results are for three months 01 April – 30 June 2024.</p> <p>Results for the nine months to 31 March 2024 are included in Te Aka Whai Ora Annual Report.</p>					

How we are reporting on our performance

Under our six output classes you will find progress against our performance measures and information about how much our activities cost.

Approach to measurement

Our Budget appropriations have been mapped into the output classes, each with associated performance measures. The output classes provide a framework for both financial and non-financial reporting.

They show how our funding is directed to our activities and how our performance is to be measured. The approach to measurement varies, including:

- periodic sampling of volumes, such as the numbers of children enrolled with an oral health service or general practice
- numbers of activities completed in a financial year, such as the numbers of planned care interventions
- numbers of activities completed in the most recent calendar year (where the source data is collected on this basis) or in the 12 months to the third quarter of the most recent financial year.

Please note, when the percentage sign (%) is used to compare between the 2022/23 and 2023/24 financial years, or between the 2023/24 result and a baseline, this has been done using a percentage point calculation.

For example, if a measure has a target of 95%, was 90% in 2022/23 and is 94% in 2023/24, we would report 1% below target and 4% higher than 2022/23.

The relevant approach to measurement is detailed in the notes for each measure. Where measures formerly referred to Te Whatu Ora, these have been amended to refer to Health NZ.

Reference numbers alongside each measure do not form part of the measure but are included for ease of reference and reconciliation.

Publication of data

All performance data provides a snapshot in time. On any given day, there may be variances depending on when data is uploaded and subsequently extracted. In our disclosures, we explain the lag time to complete data, which means that data for a prior period may become available after the close-off for reporting. To provide the most accurate representation in reporting, we have used the most complete data available, so when comparing the data from the last annual report to this one, you may notice slight variations due to the latter data being more complete. Where updated data is used as a comparison from last year, this is noted in the 'notes to the measure'.

The quality of data has also improved since last year, which enables reporting of patient characteristics not able to be included last year, such as ethnicity and location. Where this information is now available and allows a prior year comparison, this is included. However, there will still be no prior year comparison possible for some measures. The Statement of Performance Expectations 2023/24 is used as the default reference point for baselines and targets.

There are 13 measures where targets have been set for each ethnic group rather than for the overall population. For these measures, baselines are shown and results reported for each ethnic group. There is no overall result shown.

Heatmaps in this report are all designed to represent the individual values within a dataset (the visible data in the table). This is irrespective of the target for the measure – it is simply an aid to draw the readers eye to high or low values.

There are two different displays shown:

- a) where the desired trend arrow on the upper right is upwards, the heatmaps represent the data range from highest to lowest value, with green representing the higher values and yellow the lowest. In the colour gradient, the darker the green, the higher the value and conversely, the lower the value the lighter the yellow.
- b) where the desired trend arrow on the upper right is downwards, the heatmap is reversed so that green is always good, regardless of the desired trend.

Sparklines are used to illustrate trends over time for quantitative measures. These are aggregated over different periods and can show:

- results by month for the 12 months to 30 June 2024
- results by quarter for the 2023/24 year
- rolling 12-month or 24-month periods.

The total column to the right of the sparkline represents the annual result unless otherwise indicated in the notes to the measure.

Data validation is done at both national and (where relevant) local levels, by clinical and data teams, subject matter experts and those involved in the creation of the report. Where the term 'district' is used in this report, it refers to the geographic boundaries covered by former DHBs.

Incorrect workforce numbers

In reporting on Health NZ's workforce, the 2022/23 Annual Report incorrectly used employee numbers generated by the Health Workforce Information Programme (HWIP), which only includes the district workforce. The full Employee Count should have been reported as **98,648** or **78,164** contracted FTEs. This error was disclosed to the Health Select Committee during the 2022/23 Annual Review.

Our performance at a glance

Overall performance by output class.

Health NZ's overall performance for 2023/24 for each output class is shown in the table below. This shows the total number of measures:

- no target set
- baseline set
- achieved
- not achieved.

Financial measures are included in the count of the relevant output class.

Eight Sustainability measures are not included in an output class and are reported separately in Section 3.

Nine measures are reported in Appendix 3 as they are either contingent measures^a that were not required in 2023/24 or measures we are unable to report.

		Total	No target set	Baseline set	Achieved	Not achieved
1	Public health services	17	1	2	6	8
2	Primary and community services	18	2	1	8	7
3	Hospital and specialist services	23	0	0	6	17
4	Mental health and addictions services	11	0	3	3	5
5	Capital programmes	15	3 ^b	0	7	5
6	Hauora Māori services	1		1	0	0
Total measures		85	6	7	30	42
% of Total measures			7%	8%	35%	49%

a) A contingent measure is one that only comes into play if the circumstances it relates to eventuate.

b) A target of 90% was set for P2-90. While part is on track, an options paper for the other part will be put to Cabinet.

National performance by output class

Output class 1: Public health services

Public health aims to prevent disease, prolong life and promote wellbeing, through organised community efforts and plans to:

- protect health against hazards and outbreaks that cause harm and ill-health
- prevent disease through immunisation, screening and early detection
- promote behaviours and environments that support wellbeing and prolong life.

Health NZ established the National Public Health Service (NPHS) on 1 July 2022, as the operational arm of public health in New Zealand by amalgamating the 12 public health units into a single national service. This is made up of 12 Public Health Services, Te Hiringa Hauora (Health Promotion Agency), the national Public Health Advocacy Team, operational teams from the Ministry of Health

(the National Immunisation Programme, National Screening Unit, much of the COVID-19 Directorate and some components of environmental health, border health and intelligence).

Why is this important?

Most illness and disease is caused by factors outside the health system and is preventable. We can reduce the burden of illness on families, the demands on our health care services and the overall cost to the nation by investing in preventative approaches.

We provide health interventions that help to promote good health and prevent or reduce the impact of illnesses and diseases, such as immunisations that protect communities and people from getting sick from a range of illnesses from measles, whooping cough (pertussis) and polio through to influenza.

Progress against our annual output measures











Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-01	Establish a nationally integrated public health service with consistent operating models	No target	On track	On track	—

Baseline: Milestone report

This is a multiyear appropriation, which spans four financial years. The establishment of the National Public Health Service (NPHS) transformed 15 distinct organisations and services into a single Health NZ business unit, including creating new national functions.

In 2023/24, Health New Zealand set out to refine the operating model to reflect final NPHS functions (determined through a review of system accountabilities) and ensure our structure enables ways of working that foster collaboration between national and regional teams. Both these objectives have been achieved and comprehensive documentation of our operating model is available and shared with all staff.

Moving forward, we will continue to work towards high levels of integration and consistency across the system as processes are realigned within Health NZ's business parameters. As examples, we are currently reconfiguring our quality system to better align with a single business unit, rather than continuing to nestle it amongst ex-District Health Board and Ministry of Health processes.

Ref	Measure								
P2-140	Increase the percentage of eligible eight-month-olds enrolled on the Aotearoa Immunisation Register that are fully immunised with age-appropriate immunisations						Desired trend 		
		Target	Baseline	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 5 quarters		
	Overall	95%	84%	83.8%	78.4%	✘	 78.4%		
	Māori			69.4%	64.3%		 64.3%		
	Pacific			82.4%	73.7%		 73.7%		
	Asian			93.9%	89.3%		 89.3%		
	NM/NP/NA*			88.0%	82.9%		 82.9%		
	Northern			84.4%	78.4%		 78.4%		
	Te Manawa Taki			76.2%	71.9%		 71.9%		
	Central Ikaroa			84.6%	79.6%		 79.6%		
	Te Waipounamu			89.7%	85.7%		 85.7%		
	Target: 95% for Maori, 95% Pacific and 95% overall population as per Estimates								
	Baseline: Estimated actual of 84% from the 2023/24 Estimates has been used as the baseline								
	*Non-Māori, Non-Pacific, Non-Asian								

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	62.7%	72.7%	88.8%	82.6%	78.4%
Te Manawa Taki	57.1%	72.1%	89.5%	79.2%	71.9%
Central I Ikaroa	68.3%	77.6%	89.2%	84.9%	79.6%
Te Waipounamu	77.4%	81.7%	91.4%	87.0%	85.7%
All New Zealand	64.3%	73.7%	89.3%	82.9%	78.4%

*Non-Māori, Non-Pacific, Non-Asian

	NIR	AIR
Population	59,571 ^a	62,592 ^b
Completed milestone	49,898	50,423
Result	83.8%	80.6%

- a) Children (8-month-olds) registered at the time of vaccination.
- b) All children (8-month-olds) (registered and unregistered) are now counted in the denominator.

Immunisation coverage is 78.4%, which is 5.4% lower than 2022/23 and 16.6% lower than the 95% target.

Similar to last year, all ethnic groups and regions are below target. Immunisation coverage was lowest for Māori compared to other ethnicities.

Notes to the measure:

- a) Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for Non-Māori, non-Pacific from 89.8% reported.
- b) During the 2023/34 financial year, NPHS transitioned immunisation reporting from the retired National Immunisation Register (NIR) to the Aotearoa Immunisation Register (AIR). The AIR denominator incorporates individuals from the NIR and COVID-19 Immunisation Registers (CIR) and is validated against the National Health Index, which was not previously included in the NIR denominator. As of quarter three, all consumers have been onboarded to AIR. This means a larger denominator, resulting in reported immunisation rates being lower. However, AIR provides a better estimation of immunisation coverage.

Regionally, immunisation coverage remained lowest in the Te Manawa Taki region.

This measure lets us track the uptake of key vaccines against avoidable illnesses that include diphtheria, tetanus, hepatitis B, polio, measles and pertussis (whooping cough). This helps us know the extent to which our infants are protected from preventable infections that can be serious.

This year, there was a continued focus on the newborn enrolment programme, including using enrolment data to create greater visibility of under-vaccinated populations and more targeted approaches to address declining immunisation rates. Health NZ has engaged widely with key stakeholders to highlight an increase in pertussis cases, encourage opportunistic immunisations with Boostrix, and promote free resources. A broader communications approach is currently under development to help increase pertussis vaccination rates with hapū māmā.

Improved immunisation

The benefit of childhood immunisation is well established, protecting children from avoidable health complications and contributing to a reduction in community transmission. Coverage of 95% is

required to achieve population immunity and protects children from vaccine-preventable disease. All the following childhood immunisation coverage results are for the financial year 2023/24.

Ref	Measure					
P2-03	Percentage of children who have all their age appropriate schedule vaccinations by the time they are 24 months of age	Desired trend				
	Target	Baseline	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 5 quarters
Overall	95%		82.4%	77.3%	✗	77.3%
Māori		70%	68.2%	64.9%	✗	64.9%
Pacific		82%	80.6%	73.3%	✗	73.3%
Asian			93.0%	83.7%	✗	83.7%
NM/NP/NA*		90%	86.0%	82.4%	✗	82.4%
Northern			82.1%	76.3%		76.3%
Te Manawa Taki			75.1%	70.1%		70.1%
Central I Ikaroa			83.2%	78.9%		78.9%
Te Waipounamu			89.5%	85.9%		85.9%
2023/24		Māori	Pacific	Asian	NM/NP/NA*	All
Northern		61.8%	72.6%	84.5%	79.9%	76.3%
Te Manawa Taki		57.9%	63.1%	79.5%	77.9%	70.1%
Central I Ikaroa		68.4%	76.1%	83.1%	85.0%	78.9%
Te Waipounamu		80.9%	85.0%	85.3%	87.7%	85.9%
All New Zealand		64.9%	73.3%	83.7%	82.4%	77.3%

Baseline: 2021/22 year in SPE

*Non-Māori, Non-Pacific, Non-Asian

	NIR	AIR
Population	62,090 ^a	65,943 ^b
Completed milestone	50,997	50,128
Result	82.4%	76.02%

- a) Children (24 months of age) registered at the time of vaccination.
- b) All children (24 months of age) (registered and unregistered) are now counted in the denominator.

The overall immunisation rate for children at 24 months of age is 77.3%, a reduction of 5.1% compared to 2022/23 and 17.7% below the 2023/24 target of 95%.

Similar to last year, all ethnic groups and regions are below target. Immunisation coverage is lowest for Māori. Regionally, immunisation coverage remained lowest in the Te Manawa Taki region.

We continued work on eliminating barriers to accessing immunisation, supporting immunisation delivery, raising awareness and engagement, and increasing the vaccinator workforce.

Key initiatives include:

- enabling pharmacies to deliver all scheduled childhood immunisations through the Enabling Community Pharmacies Project
- data sharing agreements with Pacific providers and Hauora Māori partners to help identify and target areas where immunisation rates need to be lifted
- delivering health promotion and social marketing activity to promote on-time immunisations
- improving Aotearoa Immunisation Register reporting to support data-driven vaccination service delivery and ensure more robust information is being released to stakeholders.

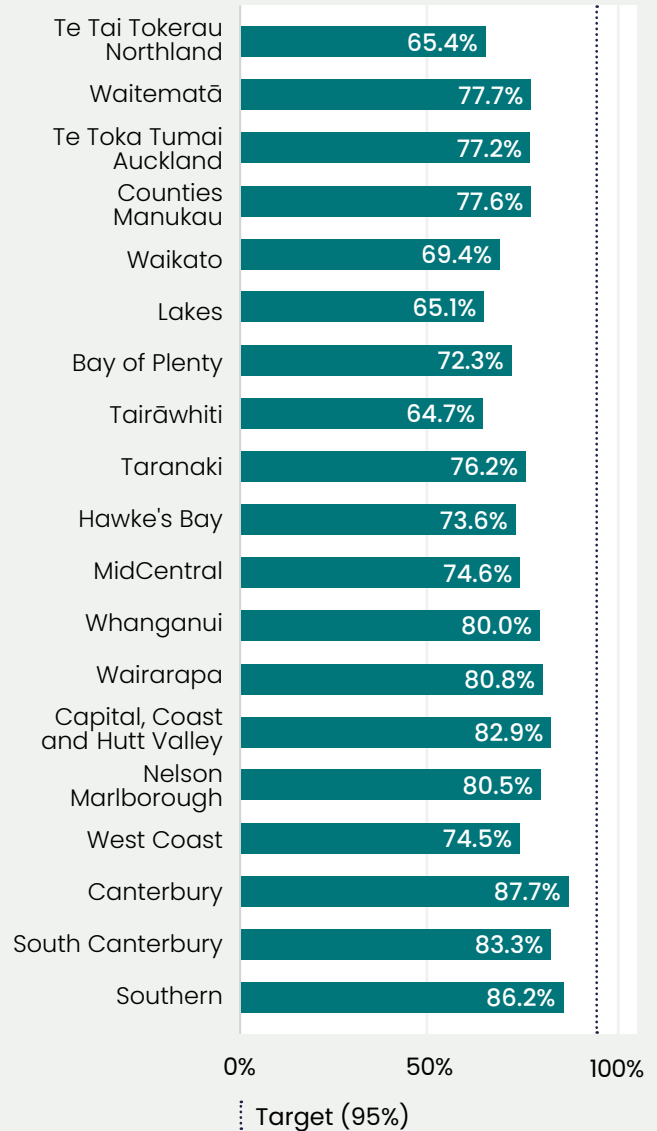
We continue to look for ways to address misinformation and disinformation around immunisations and build trust with the community.

An implementation plan has been developed to help us achieve the Health Target of 95% of tamariki fully immunised at age 24 months by 2030 (the 2024/25 performance milestone is 84% and will increase year on year). Equity will be achieved by taking a whānau-centred approach and ensuring immunisation services are best suited to the needs of priority populations.

Notes to the measure:

- Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for Non-Māori, non-Pacific from 88.1% reported.
- During the 2023/34 financial year, NPHS transitioned immunisation reporting from the retired National Immunisation Register (NIR) to the Aotearoa Immunisation Register (AIR). The AIR denominator incorporates individuals from the NIR and COVID-19 Immunisation Registers (CIR) and is validated against the National Health Index, which was not previously included in the NIR denominator. As of quarter three, all consumers have been onboarded to AIR. This means a larger denominator, resulting in reported immunisation rates being lower. However, AIR provides a better estimation of immunisation coverage.
- Measure wording was changed from 2-year-olds to 24-month-olds in the Supplementary Estimates of Appropriations 2023/24, page 490, and the target was increased to 95% from 90% (note target was 75% in SOI).

District comparison



Change in immunisation reporting

During the 2023/34 financial year, Health NZ transitioned immunisation reporting from the retired National Immunisation Register (NIR) to the Aotearoa Immunisation Register (AIR). The AIR denominator incorporates individuals from the NIR and COVID-19 Immunisation Registers (CIR) and is validated against the National Health Index.

This has identified an increase in active consumers of AIR, resulting in a reduction in reported immunisation rates (as these would generally not be included in the numerator). This is considered an improvement in data collection methodology. The reported prior year figures from NIR and the newly generated AIR figures are compared in the tables above in P2-140 and P2-03.

Ref Measure

P2-141 Increase the percentage of eligible five-year-olds enrolled on the Aotearoa Immunisation Register that are fully immunised with age-appropriate immunisations Desired trend

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 5 quarters
Overall	95%	82%	80.8%	73.5%	✗	73.5%
Māori			70.7%	66.7%	✗	66.7%
Pacific			79.7%	69.8%	✗	69.8%
Asian			86.9%	71.1%	✗	71.1%
NM/NP/NA*			84.3%	79.2%	✗	79.2%
Northern			79.2%	70.7%		70.7%
Te Manawa Taki			73.5%	69.0%		69.0%
Central I Ikaroa			83.5%	75.5%		75.5%
Te Waipounamu			88.9%	82.2%		82.2%

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	63.7%	69.2%	73.0%	73.3%	70.7%
Te Manawa Taki	62.0%	62.3%	64.0%	76.2%	69.0%
Central I Ikaroa	68.6%	71.8%	70.1%	82.1%	75.5%
Te Waipounamu	80.9%	76.6%	71.7%	85.9%	82.2%
All New Zealand	66.7%	69.8%	71.1%	79.2%	73.5%

Baseline: Estimated actual of 82% from the 2023/24 Estimates has been used as the baseline

*Non-Māori, Non-Pacific, Non-Asian

Immunisation coverage is 73.5%, which is 21.5% lower than target and 7.3% lower than 2022/23. All ethnic groups and regions are below target. Immunisation coverage was lowest for Māori compared to other ethnicities.

Regionally, immunisation coverage remained lowest in the Te Manawa Taki region.

Full details on childhood immunisation initiatives are reflected in the two other childhood immunisation measures P2-03 and P2-140.



Notes to the measure:

- a) Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for Non-Māori, non-Pacific from 85.1% reported.
- b) During the 2023/34 financial year, NPHS transitioned immunisation reporting from the retired National Immunisation Register (NIR) to the Aotearoa Immunisation Register (AIR). This validation process has introduced new records that were not previously part of the NIR denominator, leading to an increase. As of quarter three, all consumers have been onboarded to AIR. This means a larger denominator, resulting in reported immunisation rates being lower. However, AIR provides a better estimation of immunisation coverage.

Influenza vaccine

The influenza (flu) vaccine provides people with important protection from getting very sick and ending up in hospital, which in turn helps to reduce the impact on health services over winter. It also provides some protection against people catching flu in the first place. On 1 April 2024, the flu vaccine was made free for people at higher risk of getting very sick, including:

- people aged 6 months and over who have a long-term medical condition like diabetes, asthma, or a heart condition
- tamariki (children) aged 4 years and under who have been hospitalised for respiratory illness, or have a history of significant respiratory illness
- people with mental health conditions and people who are currently accessing secondary or tertiary mental health and addiction services
- pregnant people
- people aged 65 years and over.

Ref	Measure	Desired trend 						
P2-04	Increase the percentage of eligible people aged 65 years and over enrolled on the Aotearoa Immunisation Register who have completed at least one influenza vaccination for the given vaccination year							
		Target	Baseline	2022/23 Result	2023/24 Result	Status		
	Overall	75%		62.0%	61.5%			
	Māori		53%	54.0%	55.1%			
	Pacific		67%	52.0%	54.1%			
	Asian			53.0%	51.5%			
	NM/NP/NA*		64%	65.0%	62.3%			
	Northern			N/A	56.9%			
	Te Manawa Taki			N/A	60.4%			
	Central I Ikaroa			N/A	65.0%			
	Te Waipounamu			N/A	65.9%			
	2023/24			Māori	Pacific	Asian	NM/NP/NA*	All
	Northern			52.9%	53.8%	51.4%	57.5%	56.9%
	Te Manawa Taki			53.4%	52.3%	48.1%	61.5%	60.4%
	Central I Ikaroa			57.1%	56.8%	54.8%	65.9%	65.0%
	Te Waipounamu			61.1%	55.2%	52.1%	66.2%	65.9%
	All New Zealand			55.1%	54.1%	51.5%	62.3%	61.5%
	Baseline: 2021 Calendar year							
	*Non-Māori, Non-Pacific, Non-Asian							

The immunisation rate for people aged 65 years and older who have completed at least one influenza vaccination is 61.5%, which is 13.5% below the target.

Winter is a particularly demanding time for our health system with parts of the system operating at high volumes. Influenza (flu) immunisation, available from 1 April each year before winter starts, is an important part of Health NZ's Systems Pressure Plan supporting our health system to continue operating effectively during this busy season.

Those over 65 years are at a higher risk of increased disease severity and likelihood of complications from flu viruses than other groups.

By measuring the rate of vaccination in this group, we are focused on ensuring people are supported to live well in the community, avoiding unnecessary hospitalisations. We continue to implement strategies to improve uptake of flu vaccinations for those over 65 years of age.

Notes to the measure:

- a) Wording changed from Influenza immunisation rates for aged 65+, in the Supplementary Estimates of Appropriations 2023/24.
- b) During the 2023/34 financial year, NPHS transitioned immunisation reporting from the retired National Immunisation Register (NIR) to the Aotearoa Immunisation Register (AIR). This validation process has introduced new records that were not previously part of the NIR denominator, leading to an increase. As of quarter three, all consumers have been onboarded to AIR. This means a larger denominator, resulting in reported immunisation rates being lower. However, AIR provides a better estimation of immunisation coverage.

Our 2024 social marketing campaign (TV, radio, outdoor, digital, and community press advertising) and outreach call programme via Whakarongorau had excellent reach. In particular, the strategy of early messaging via direct channels assisted with 330,000 people receiving a vaccination within six weeks.

Māori and Pacific community action initiatives concurrently driving flu, COVID-19, and childhood immunisation continued until September 2024. There has been \$1.55 million in Māori community action funding allocated to 20 organisations and \$900,000 in Pacific community action funding allocated to 14 organisations.

It is anticipated that the benefit of these initiatives will not be fully realised until 2024/25, as the flu season and relevant flu vaccination delivery period spans the 2023/24 and 2024/25 financial years. Equitable access continues to be a barrier with a need to focus on ethnicity data, as well as region specific data, to continue a resource targeted approach.

Human Papillomavirus (HPV) programme

HPV is a group of very common viruses that infect about 80% of people in their teenage years. HPV spreads through intimate skin-on-skin contact. Most HPV infections get better on their own, but sometimes they can cause different cancers for all genders later in life – such as cervical and throat cancer.


HPV immunisation began in New Zealand in 2008. On 1 January

2017, HPV immunisation became free for everyone aged 9–26, including non-residents under the age of 18. HPV immunisation aims to protect young people from HPV infection, the risk of developing cervical cancer and a range of other HPV-related diseases later in life.

The HPV vaccine, together with the cervical screening programme, plays an important role in reaching our goal of eliminating deaths from cervical cancer in New Zealand.

Ref Measure

P2-05 Increase the percentage of girls and boys between 9 and 26 who have completed their HPV immunisation course as per Schedule on the Aotearoa Immunisation Register fully immunised

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	70%		56.7%	57.1%	✗
Māori		57%	46.9%	48.4%	
Pacific		61%	50.6%	52.1%	
Asian		65%	61.3%	61.8%	
NM/NP/NA*				60.7%	
Northern			N/A	55.2%	
Te Manawa Taki			N/A	53.4%	
Central I Ikaroa			N/A	60.0%	
Te Waipounamu			N/A	62.2%	

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	45.7%	52.5%	62.2%	56.8%	55.2%
Te Manawa Taki	46.2%	50.4%	57.5%	57.9%	53.4%
Central I Ikaroa	52.3%	50.8%	62.8%	64.5%	60.0%
Te Waipounamu	53.9%	52.9%	63.4%	64.5%	62.2%
All New Zealand	48.4%	52.1%	61.8%	60.7%	57.1%

Baseline: 2021/22

*Non-Māori, Non-Pacific, Non-Asian

The HPV immunisation rate for those between 9 and 26 years old is 57.1%, which is 12.9% below the 70% target. Coverage is lowest ethnically for Māori, while regionally, coverage is lowest in Te Manawa Taki.

HPV vaccinations are primarily (although not exclusively) delivered as part of the School Based Immunisation Programme (SBIP), usually in Year 7 or 8. The SBIP provides free vaccinations in the school setting. In March 2023, Health NZ commissioned an independent review of the SBIP to identify opportunities to improve and support the SBIP and to look for ways to increase immunisation participation, particularly for HPV.

The review recommendations have informed an SBIP Action Plan with the following four components actively being worked on: solutions to increase HPV uptake; consistent delivery models and catch-up vaccinations; increased access points for adolescent vaccinations; and improved processes around consent, data, and reporting.

An audit has been undertaken to identify which schools are not currently providing this service, and we have used this as an opportunity to understand any apprehension or barriers around being part of this programme so that we can work to address these and improve equitable access.

Notes to the measure:











- Results for the Asian ethnicity were not available last year, nor are they available this year.
- The HPV reporting methodology has changed since last year due to the new Aotearoa Immunisation Register (AIR) having a defined population denominator that differs from the old National Immunisation Register, and as such, the 2023/24 result is not comparable to the previous financial year. However, as with previous years, reporting for this measure is based on the relevant birth cohort who have completed their HPV immunisation course. Reporting for this measure in 2023/24 covers children born in 2011 and enrolled on the AIR with a status of 'active'. The 9 to 26 age cohort will be reported in the 2024/25 annual report.
- Measure was changed from percentage of girls and boys in the relevant birth cohort in the Supplementary Estimates of Appropriations 2023/24, page 490, and the target was amended from 75% Māori, Pacific and Total population.

Screening

Breast screening

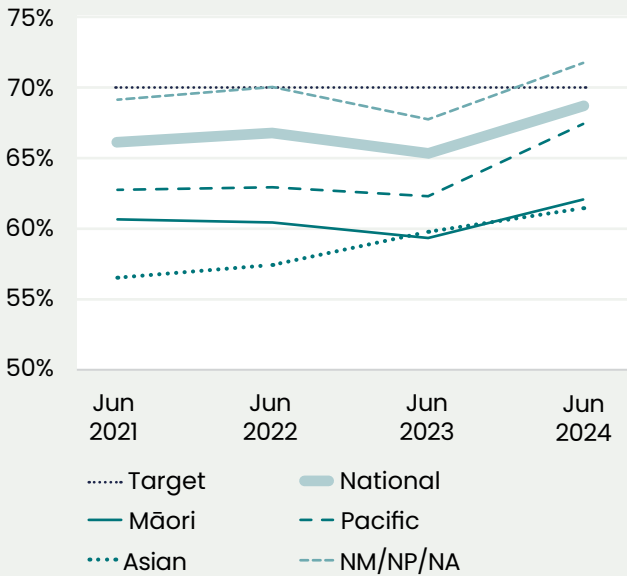
Breast Screen Aotearoa is New Zealand’s free national breast screening programme for women aged 45 to 69 years. Early detection of breast cancer through a mammogram means a better chance breast cancer can be found and treated before it spreads. An independent review of breast cancer screening has led to a range of recommendations

currently being implemented to improve screening access and equity outcomes across New Zealand. At present, Māori and Pacific women have lower survival rates from breast cancer. New initiatives include a Pae Whakatere governance group to oversee the implementation of the recommendations, co-design approaches to improve access to screening, consumer research, and consumer advisory groups.

Ref	Measure					Desired trend 	
P2-07	Percentage of women aged 45–69 who have completed breast screening in the previous two years						
		Target	2022/23 Result	2023/24 Result	Status	Rolling 24-month period for the last 13 months	
Overall		70%	65.2%	68.8%	✗	 68.8%	
Māori			59.3%	62.1%		 62.1%	
Pacific			62.2%	67.5%		 67.5%	
Asian			59.8%	61.5%		 61.5%	
NM/NP/NA*			67.6%	71.8%		 71.8%	
Northern			63.3%	67.1%		 67.1%	
Te Manawa Taki			61.1%	63.6%		 63.6%	
Central Ikaroa			67.6%	70.4%		 70.4%	
Te Waipounamu			69.2%	74.4%		 74.4%	
2023/24			Māori	Pacific	Asian	NM/NP/NA*	All
Northern			64.4%	69.1%	67.5%	67.1%	67.1%
Te Manawa Taki			56.8%	63.8%	43.1%	68.1%	63.6%
Central Ikaroa			61.9%	64.4%	59.1%	74.0%	70.4%
Te Waipounamu			70.2%	61.9%	52.2%	77.2%	74.4%
All New Zealand			62.1%	67.5%	61.5%	71.8%	68.8%

*Non-Māori, Non-Pacific, Non-Asian

Longer-term trend (rolling 24-month period)



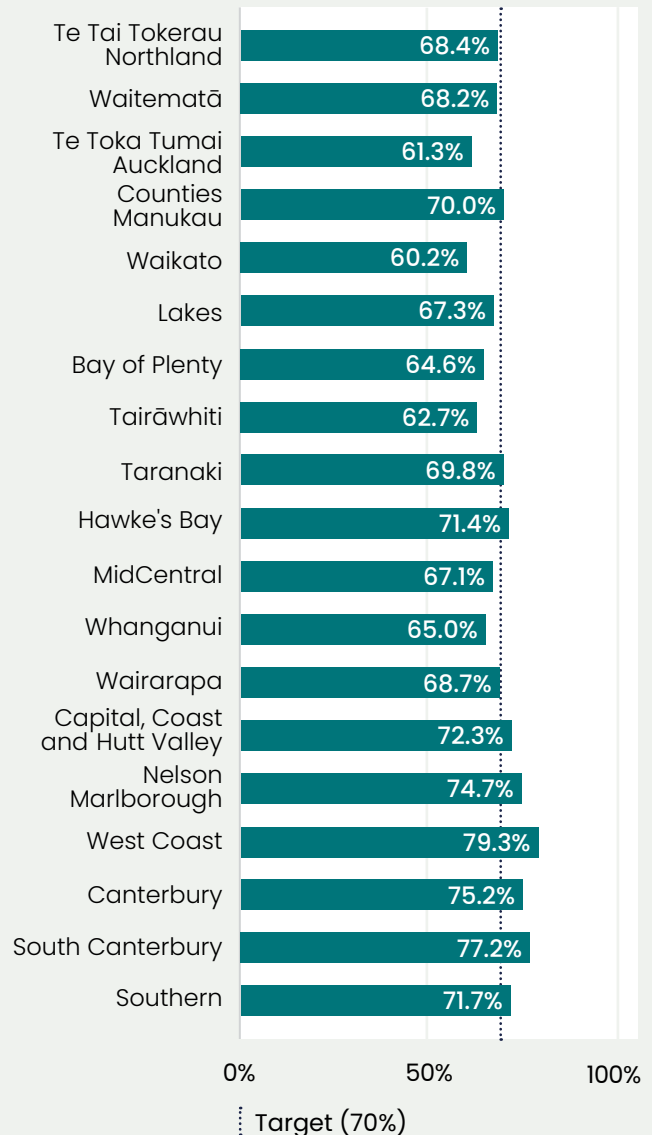
Breast screening coverage is 68.8%, which is an improvement of 3.6% compared to 2022/23, but coverage remains just under the 70% target.

Breast screening coverage was lowest for Asian compared to other ethnicities, with a 10.3% difference compared to the non-Māori, non-Pacific, non-Asian ethnic group. Regionally, the breast screening coverage was lowest in Te Manawa Taki.

The Quality Improvement Review of the national breast screening programme was released in May 2023. The review found evidence of pervasive and systemic factors contributing to low breast screening coverage and made 26 recommendations that focused on improving screening access and equity outcomes across New Zealand.

Key initiatives in response to the recommendations include co-design pilot with wāhine Māori in Kirikiriroa | Hamilton to inform and improve engagement along the breast screening pathway, supporting lead providers to trial new and different ways to offer alternative screening hours and locations, and identifying geographical areas of priority population groups who are unscreened or under-screened to improve targeted support to access screening. The proposed national roll-out of

District comparison



the age extension of free breast screening to 74 years of age is set to start in late 2025.

In April 2024, Breast Screen Aotearoa began publicly reporting Asian screening coverage to ensure that the needs of Asian populations are being met within the breast screening programme. Work is underway to progress initiatives to increase breast screening coverage for Asian women.











Notes to the measure:

- a) This measure was discontinued in Vote Health Estimates of Appropriations 2023/24. Measure added to enable complete assessment of Health NZ's performance during the year. Target is as previously reported.
- b) Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 59.1%, Pacific 61.5%, Non-Māori, non-Pacific 65.6%, Overall 64.5%.
- c) This measure does not count screening for women between 45-69 undertaken by private providers funded by the patient.

Bowel screening

The National Bowel Screening Programme is free for people aged 60 to 74 years. It aims to save lives by finding bowel cancer at an early stage when it can often be successfully treated.

The earlier bowel cancer is diagnosed, the higher the chance of survival. People who are diagnosed with bowel cancer and receive treatment when it is at an early stage have a 90% chance of long-term survival.

Ref	Measure					Desired trend 	
P2-08	Percentage of people who returned a positive Faecal Immunochemical Test (FIT) have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system						
		Target	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 13 months	
	Overall	95%	93.2%	96.7%	✓	 96.7%	
	Māori		93.6%	94.0%		 94.0%	
	Pacific		97.6%	96.8%		 96.8%	
	Asian		96.7%	98.3%		 98.3%	
	NM/NP/NA*		92.5%	96.9%		 96.9%	
	Northern		97.8%	98.5%		 98.5%	
	Te Manawa Taki		92.7%	98.0%		 98.0%	
	Central Ikaroa		96.5%	89.4%		 89.4%	
	Te Waipounamu		85.9%	99.0%		 99.0%	
	2023/24		Māori	Pacific	Asian	NM/NP/NA*	All
	Northern		96.8%	98.1%	98.3%	99.1%	98.5%
	Te Manawa Taki		96.4%	100.0%	100.0%	98.3%	98.0%
	Central Ikaroa		83.8%	87.8%	97.2%	89.9%	89.4%
	Te Waipounamu		98.4%	100.0%	98.5%	99.0%	99.0%
	All New Zealand		94.0%	96.8%	98.3%	96.9%	96.7%

*Non-Māori, Non-Pacific, Non-Asian

Performance in this measure is 96.7%, which is an improvement of 3.5% from 2022/23 and 1.7% above the 95% target.

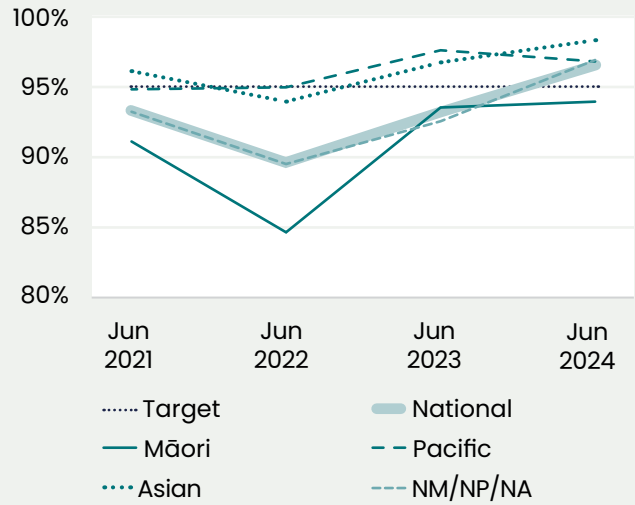
Māori are the only ethnic group to not meet target (94%), but the result is still an improvement from last year. Central is the only region to not meet target.

As the Bowel Screening Programme continues to build momentum around the country and the recommendations of the Planned Care Taskforce come to fruition, we expect results to continue to improve. Ongoing colonoscopy capacity challenges remain and, as such, close monitoring of this metric will continue.

Further initiatives by the National Bowel Screening Programme to improve performance in this measure include:

- national campaigns and resources particularly focused on increasing equity
- the extension of fees-free funding for priority populations
- workforce expansion and training, including an increased number of screen takers
- a switch to a population-based register, which enables the programme to capture the entire eligible population
- new clinical pathways for participants and notifications to increase uptake.

Longer-term trend (rolling 12-month period)



Notes to the measure:

- This measure was discontinued in Vote Health Estimates of Appropriations 2023/24. Measure added to enable complete assessment of Health NZ's performance during the year. Target is as previously reported.
- The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 93.8%, Pacific 97.7%, Asian 96.8% NM/NP/NA 92.7%, Overall 93.4%.


Cervical screening










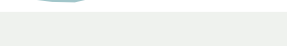
Cervical cancer generally develops slowly, therefore it can be detected and treated early. Treatment can be as simple as removing the affected tissue and has a

high success rate. The first signs show up as 'abnormal' cells, which can take more than 10 years to develop into cancer. This is why regular cervical screening testing is done – it gives us the best chance to find cell changes early.

Ref Measure

P2-09 Cervical (HPV) screening coverage increase to target 80% of eligible women aged 25-69 (five-yearly screening interval)

Desired trend 

	Target	2022/23 Result	2023/24 Result	Status	Rolling 36-month period for the last 13 months
Overall	80%	67.9%	69.3%		 69.3%
Māori		57.1%	60.3%		 60.3%
Pacific		56.2%	64.9%		 64.9%
Asian		57.1%	58.6%		 58.6%
NM/NP/NA*		75.7%	75.9%		 75.9%
Northern		65.3%	67.9%		 67.9%
Te Manawa Taki		67.9%	68.0%		 68.0%
Central I Ikaroa		68.9%	69.0%		 69.0%
Te Waipounamu		71.6%	72.7%		 72.7%

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	57.6%	64.2%	58.7%	79.2%	67.9%
Te Manawa Taki	59.7%	66.3%	51.7%	75.0%	68.0%
Central I Ikaroa	60.3%	65.8%	61.9%	73.1%	69.0%
Te Waipounamu	67.8%	67.5%	61.5%	75.4%	72.7%
All New Zealand	60.3%	64.9%	58.6%	75.9%	69.3%

*Non-Māori, Non-Pacific, Non-Asian

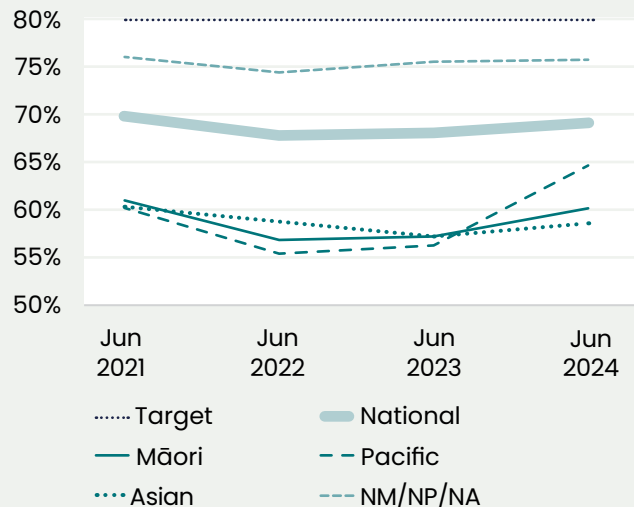
Cervical screening coverage is 69.3%, which is a 1.4% increase since 2022/23. Coverage remains below the 80% target. Coverage for all ethnic groups has improved since the last financial year.

Regionally, cervical screening coverage was lowest in the Northern region and highest in the Te Waipounamu region.

The change from cytology testing to HPV testing as the primary screening test, including the option to self-test, will support a reduction in cervical cancer incidence and mortality rates.

The self-test has greater sensitivity, offers more privacy and comfort during screening, and offers cultural acceptability for Māori and Pacific women and people with a cervix. So far, around 80% of participants have chosen self-testing, and it has been effective and well-received.

Longer-term trend (rolling 36-month period)



Notes to the measure:

- a) This measure was discontinued in Vote Health Estimates of Appropriations 2023/24. Measure added to enable complete assessment of Health NZ's performance during the year. Target is as previously reported.
- b) A new methodology is in place for 2023/24, based on a new HPV screening test with a change in the screening interval from 3 to 5 years.
- c) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 55.1%, Pacific 54.0%, Non-Māori, non-Pacific 74.9%, Overall 68.2%.

Sub output class: National COVID-19 response

We continue to track New Zealanders' uptake of COVID-19 vaccines and report on delivery against the outcomes and output requirements as an organisation. The strategic framework and policy settings have been set by the Ministry of Health / Public Health Agency.

The COVID-19 response policy settings changed in August 2023 with COVID-19 being managed as a usual communicable disease within the health system settings. Since August 2023, there has been a decline in accessing services that corresponds with the change in settings.

For the period 1 July 2023 to 30 June 2024:

- 740,499 doses of the COVID-19 vaccine were administered. Over 80% of COVID-19 vaccines were administered in primary care and pharmacy settings, reflecting the transition of services from a bespoke COVID-19 response to a sustainable and accessible community provider activity.
- 95,789 people who met the antiviral access criteria were clinically assessed and dispensed with antiviral therapeutics within five days of symptoms and positive test results within Care in the Community services. Of those who were dispensed COVID-19 antiviral therapeutics, 84.6% were over the age of 60 years old. Observational real-world evidence suggests that Paxlovid remains effective against COVID-19 variants for vaccinated, high-risk populations. This includes reduced relative risks of hospitalisation ranging from 44% to 54% in Paxlovid treated, high-risk people compared to placebo.
- There were 11,564 COVID-19-related hospital admissions. Of those admitted to hospital, 14% were Māori, 9.2% were Pacific, 9.7% were Asian and 66.4% were European. 68% of COVID-19 related hospital admissions were over the age of 60.

- 338,886 polymerase chain reaction (PCR) tests were taken and processed through our laboratory networks resulting in 31,917 (9.4% positivity rate) COVID-19 positive PCR results for undifferentiated respiratory illness.
- 36,340,900 Rapid Antigen Tests (RATs) were distributed across health care settings and to the public. 230,589,802 items of PPE, including N95/P2 particulate respirators, were distributed to support our health care workforce across the health sector and support outbreak management.
- There was a total of 828 deaths that were attributed to COVID-19. COVID-19 deaths are defined as people who died with the cause of death being attributable to COVID-19 (that is, an underlying or contributory cause).

The removal of the final COVID-19 mandatory measures on 14 August 2023 meant that manaaki support services through Care in the Community and dedicated non-clinical telehealth services were transitioned to Health NZ business as usual (to be delivered through regional public health services) from 1 September 2023.

National COVID-19 response

National COVID-19 response was included as an output class in the Statement of Intent 2022-2024. Although it is shown as an output class in the funding by output class, it is presented here as a sub-output class as part of the Primary and community services output class.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-02	Continue COVID-19 response in line with policy settings, and build towards a new business-as-usual pandemic resilient system	Milestone report	Milestone report	Achieved	✓
<p>Baseline: Milestone reporting 2022/23</p> <p>The National Case Investigation Service (NCIS) for COVID-19 operated from 1 July 2023 to 14 August 2023. The NCIS ceased following the removal of COVID-19 mandatory isolation. Public health capacity for case management and contact tracing is now part of Health NZ business as usual and is delivered through regional public health services.</p> <p>Notes to the measure:</p> <p>a) As per SPE this measure will support ongoing pandemic preparedness planning and development of a resilient, world class health system.</p>					


Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-10	Providers are enabled to deliver COVID-19 vaccinations in line with national guidance operations policies and service standards	Achieved	Achieved	Achieved	✓
<p>During the 2023/24 year, COVID-19 immunisations were administered through 1,100 facilities across New Zealand. This is not where the vaccination took place and a facility will often supply the vaccines to multiple sites. During the 2023/24 year, COVID-19 immunisations were administered through 1,499 sites across New Zealand.</p>					

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-11	Number of approved COVID-19 vaccines administered to individuals in line with the policy setting	Achieved	Achieved	Achieved	✓
<p>During 2023/24 we delivered 740,499 COVID-19 vaccines to individuals across New Zealand in line with the relevant policy setting. Please refer to Ministry of Health website info.health.nz/immunisations/vaccines-aotearoa/covid-19-vaccines.</p> <p>Notes to the measure:</p> <p>a) This measure was included in the Estimates of the Appropriations 2023/24.</p>					

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-12	Number of COVID-19 vaccine doses purchased by Te Pātaka Whaioranga – Pharmac and received by Health NZ in central storage facilities	Achieved	Achieved	Achieved	✓
<p>For the 2023/24 financial year, Health NZ received a total of 3,078,720 COVID-19 vaccine doses in central storage facilities.</p> <p>Notes to the measure:</p> <p>a) Target shows as 'achieved' but measure is number of doses stored.</p>					

Ref Measure

P2-125 Percentage of 5 years of age and older who have completed a covid vaccination primary course since the beginning of the COVID-19 pandemic

Desired trend 

	Target	2022/23 Result	2023/24 Result	Status
Overall	To be established	new measure	79.7%	Baseline set
Māori			68.1%	
Pacific			70.5%	
Asian			77.5%	
NM/NP/NA*			84.5%	
Northern			78.3%	
Te Manawa Taki			77.3%	
Central I Ikaroa			81.3%	
Te Waipounamu			83.0%	

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	67.8%	69.9%	78.1%	83.9%	78.3%
Te Manawa Taki	66.1%	69.9%	74.9%	82.6%	77.3%
Central I Ikaroa	69.5%	72.6%	78.6%	85.9%	81.3%
Te Waipounamu	71.6%	73.3%	76.2%	85.7%	83.0%
All New Zealand	68.1%	70.5%	77.5%	84.5%	79.7%

*Non-Māori, Non-Pacific, Non-Asian

COVID-19 vaccination coverage for those 5 years of age and older is 79.7%. Māori have the lowest coverage for ethnic groups, and the region with the lowest coverage is Te Manawa Taki. The total number of completed courses was 4,114,264.

The COVID-19 response policy settings changed in August 2023 when COVID-19 was transitioned to being managed as a communicable disease within the health system settings. We have noted a decline in accessing services that corresponds with the change in settings.

Notes to the measure:

- This measure was discontinued in Vote Health Estimates of Appropriations 2023/24. Measure added to enable complete assessment of Health NZ's performance during the year.
- A primary course can be one or two vaccinations depending on the type of vaccination administered.
- This measure has been updated to reflect updated age eligibility and clinical recommendations. **Age range has been widened from people aged 12+ to 5+.** We cannot compare 2023/24 results with the prior year due to the change in age group. Contextual information on COVID-19 vaccinations can be found on page 120.

Ref	Measure
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P2-127 Percentage of people 50 years and older who have received an additional dose(s) of the COVID-19 vaccine since the beginning of the COVID-19 pandemic

Desired trend 

	Target	2022/23 Result	2023/24 Result	Status
Overall	To be established	54.3%	83.2%	Baseline set
Māori		46.1%	76.0%	
Pacific		40.2%	76.3%	
Asian		39.2%	78.4%	
NM/NP/NA*		58.2%	85.3%	
Northern			81.3%	
Te Manawa Taki			80.8%	
Central I Ikaroa			85.9%	
Te Waipounamu			85.8%	

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	75.3%	75.4%	77.4%	84.5%	81.3%
Te Manawa Taki	73.7%	75.2%	76.7%	82.7%	80.8%
Central I Ikaroa	78.5%	80.7%	84.5%	87.3%	85.9%
Te Waipounamu	79.2%	78.7%	80.0%	86.6%	85.8%
All New Zealand	76.0%	76.3%	78.4%	85.3%	83.2%

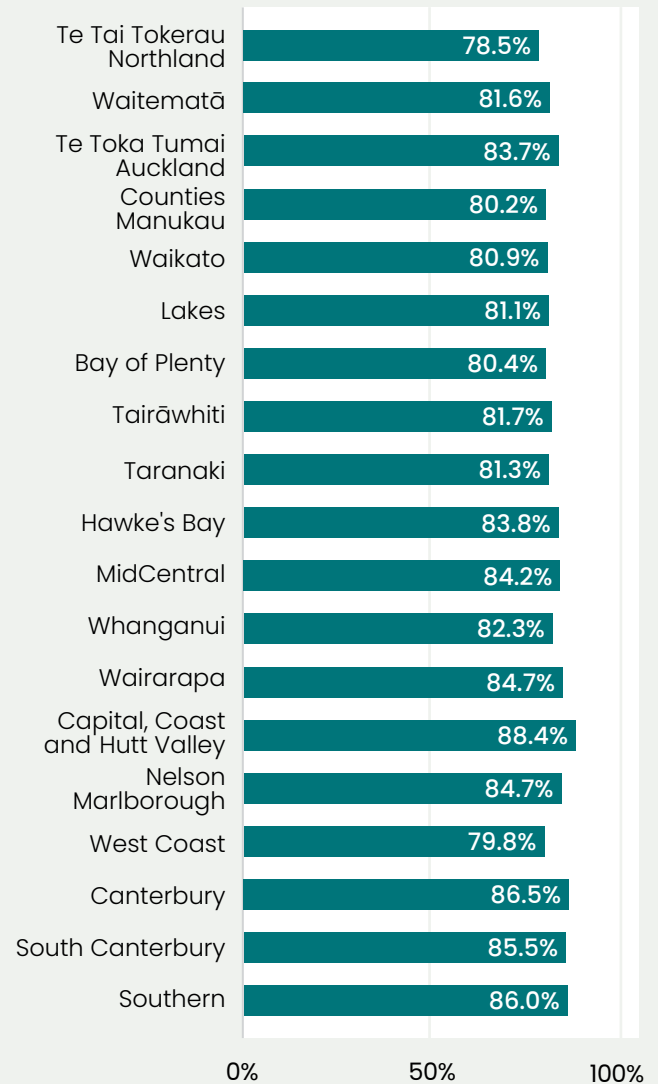
*Non-Māori, Non-Pacific, Non-Asian

COVID-19 vaccination coverage for those aged 50 years and older is 83.2%. Māori have the lowest coverage for ethnic groups, and the region with the lowest coverage is Te Manawa Taki. The total number of doses provided was 1,513,837.

The COVID-19 response policy settings changed in August 2023 when COVID-19 was transitioned to being managed as a communicable disease within the health system settings. We have noted a decline in accessing services that corresponds with the change in settings.

Notes to the measure:

- a) This is a new measure that combines additional vaccination, ie received one or more additional dose(s). This differs from the COVID-19 measure reported in 2023/24 and that only related to people who received a second dose. Contextual information on Covid-19 vaccinations can be found on page 120.
- b) This measure was discontinued in Vote Health Estimates of Appropriations 2023/24. Measure added to enable complete assessment of Health New Zealand's performance during the year.
- c) Additional doses come after a primary course which can be one or two vaccinations depending on the type of vaccination administered.
- d) Because the measure has changed, COVID-19 vaccination coverage for the 2023/24 financial year to the 2022/23 financial year is not comparable. We have also used two differently defined population denominators (Health Service User data in 2022/23 and Aotearoa Immunisation Register data in 2023/24). This means that any narrative around change in coverage percentage from last year would not be useful.

District comparison

Vaccinations delivered over 2023/24

To provide additional context on COVID-19 vaccination coverage for 2023/24, additional information is set out below. This shows the number of people (by all age ranges, including 50+) who have had a COVID-19 vaccination during 2023/24 (i.e. protected by a COVID vaccination this financial year).

In the table below, COVID-19 doses includes both primary course and (potentially) multiple additional dose(s) – as some people get multiple doses within one financial year.

It is important to note that the 2023/24 COVID-19 vaccination measures report cumulative vaccination coverage since the beginning of the pandemic. The rationale is that a large portion of population were fully vaccinated in the initial two years of the pandemic – meaning, if we just look at one year in isolation, we remove a large proportion of the population who have already been vaccinated. This approach is consistent with reporting in our 2022/23 Annual Report.

Age band break-down of the COVID-19 vaccine administered during FY 2023/24

Age	COVID-19 doses 2023/24 ^a	People vaccinated 2023/24 ^b	Population 30 June 2024	Coverage if using people vaccinated in 2023/24
5-11	2,399	2,039	491,627	0.41%
12-17	2,510	2,544	463,657	0.55%
18-34	29,692	28,593	1,358,153	2.11%
35-49	75,527	69,088	1,029,259	6.71%
50-64	168,538	149,552	929,788	16.08%
65+	462,963	376,005	889,704	42.26%
Total	741,629	627,821	5,162,188	12.16%

a) Only includes doses administered in New Zealand.

b) Includes people who received their vaccination overseas.

Source: Health NZ Immunisation Dashboard Summary

Impact of 2023/24 vaccinations on overall vaccination rates and overall levels of community protection

With COVID-19 now being prevalent in the community, vaccination rates are an imperfect proxy for levels of community protection, as our data will not tell us who is 'protected' through recent COVID-19 infection, or those vaccinated overseas (but not registered in the immunisation register). It is therefore important that vaccination data is considered alongside

contextual information – which provides insights into the outcomes sought of a 'protected population' – such as lower numbers of deaths or hospitalisations from COVID-19. This means that if we have a protected population, hospitalisation and death metrics should track down www.tewhātuora.govt.nz/for-health-professionals/data-and-statistics/covid-19-data/covid-19-trends-and-insights.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-89	Maintain an average of 12-week stock in Health NZ's National Protective Equipment (PPE) and Critical Medical Supply Chain	Achieved	Achieved	Achieved	✓
<p>Baseline: 12 weeks' stock on hand</p> <p>Health NZ has continued the management of the National Reserve Supply of personal protective equipment and other consumables for pandemic preparedness and response and holds a minimum of 12 weeks' stock. We have a stock list of the items and quantities required for the NRS. The measure is the holding level vs the minimum quantity required. Stock is monitored frequently and a monthly report provided to the MoH on the status of all products. This ensures Health NZ has continued access to PPE reserves for large or prolonged emergencies that generate unusually high demands on normal health service stocks or supply chains.</p>					








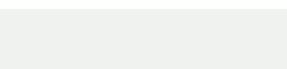
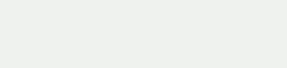
Output class 2: Primary and community services

Primary and community services are vital to detecting and managing health problems early and close to home. They are provided by health professionals in general practice, Māori health providers, Pacific health services, community pharmacies, child and adolescent dental health services, physiotherapy clinics and many others.

Timely access to these services can help people get diagnosed and treated

quicker, and at an earlier stage of an illness or injury, which means they will better maintain their independence and wellbeing or avoid further sickness. Primary and community services are also important for helping people manage chronic conditions like diabetes, respiratory problems, gout or cardiovascular disease so they continue to live as well as possible in their community.

Progress against our annual output measures

Ref	Measure						
P2-33	Increase in percentage of pregnant people who register with a Lead Maternity Carer (LMC) in the first trimester of their pregnancy of all registrations					Desired trend	↑
		2019 Target	2019 Baseline	2021 Result	2022 Result	Status	Yearly for the last 4 years
Overall		See below	73.2%	78.2%	76.4%	✓	 76.4%
Māori		60.1%	64.6%	62.5%			 62.5%
Pacific		45.6%	56.6%	53.4%			 53.4%
Asian		82.2%	83.3%	80.1%			 80.1%
NM/NP/NA*			88.0%	87.6%			 87.6%
Northern			74.3%	72.2%			 72.2%
Te Manawa Taki			79.1%	75.0%			 75.0%
Central I Ikaroa			76.5%	76.0%			 76.0%
Te Waipounamu			86.0%	85.9%			 85.9%
Target: Achieved (increase from baseline)							
*Non-Māori, Non-Pacific, Non-Asian							
Data for this measure is only available a year in arrears. Latest available is the 2022 calendar year. Small increase from baseline for all ethnicities and a small decrease from 2021.							

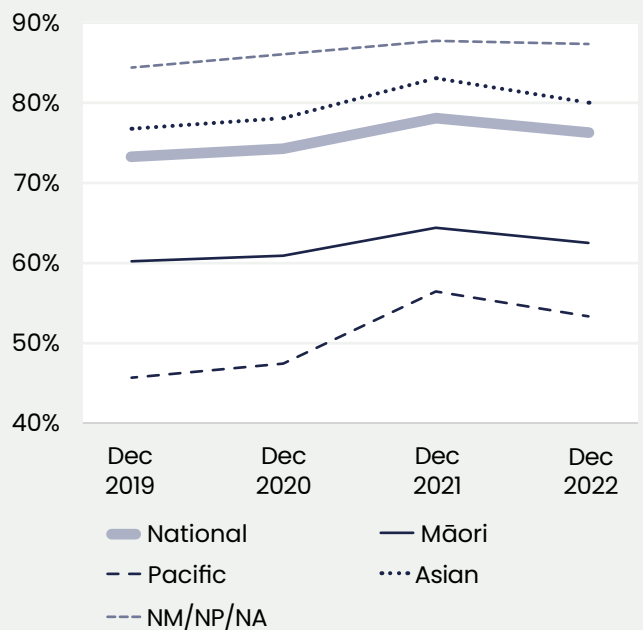
2022	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	58.0%	49.3%	79.3%	86.6%	72.2%
Te Manawa Taki	59.2%	66.5%	80.7%	87.5%	75.0%
Central I Ikaroa	64.6%	56.7%	75.6%	85.6%	76.0%
Te Waipounamu	77.4%	66.4%	85.3%	90.1%	85.9%
All NZ	62.5%	53.4%	80.1%	87.6%	76.4%

*Non-Māori, Non-Pacific, Non-Asian

Notes to the measure:


- a) This new measure was included in the 2023/24 Estimates. Prior year included to allow comparison.
- b) The measure was in the iGPS with a milestone to set a baseline in Year 1 (2023/24). The 2019 result was established as the baseline for this measure and the end of calendar year 2022 is the latest data available. The data for reporting arrives 12 months from the end of each calendar year as the enrolment with an LMC in the first trimester comes from Claims data (the Primary Maternity Services Notice) and LMCs have up to 12 months to claim fees for a pregnant person they have provided care for.











Longer-term trend (rolling 12-month period)



Ref Measure

P2-38 Percentage of children enrolled with a general practice by 3 months of age

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	85%	85%	86.3%	86.6%			88.1%
Māori		67%	76.3%	76.6%			78.3%
Pacific		80%	80.4%	81.2%			84.0%
Asian			93.0%	93.9%			95.1%
NM/NP/NA**		95%	90.8%	91.0%			92.3%
Northern			85.3%	85.5%			87.6%
Te Manawa Taki			84.4%	84.4%			85.4%
Central Ikaroa			85.2%	86.0%			86.7%
Te Waipounamu			91.0%	91.7%			92.9%

2023/24	Māori	Pacific	Asian	NM/NP/NA**	All
Northern	72.5%	80.1%	93.3%	90.6%	85.5%
Te Manawa Taki	75.4%	82.7%	94.2%	90.0%	84.4%
Central Ikaroa	77.8%	82.9%	94.3%	89.9%	86.0%
Te Waipounamu	86.4%	86.3%	95.5%	92.8%	91.7%
All New Zealand	76.6%	81.2%	93.9%	91.0%	86.6%

Target: 85% overall and maintain performance for populations exceeding this target

Baseline: As at 01 April 2022

*Non-Māori, Non-Pacific, Non-Asian

The newborn enrolments rate is 86.6%, which is a 0.3% increase compared to 2022/23 and it is now 1.6% above the target of 85%.

Newborn enrolment rates within all regions are near or above target with Te Waipounamu at 91.7%.

The patterns of enrolments for Māori and Pacific are consistent with historical trends and remain below the total population average.

The newborn enrolment service (NBES) notification system (established in late 2023) has provided more timely notifications to general practice teams

for newborns where parents have a known general practice. A range of initiatives are underway to support newborn enrolment. Agreement has been reached to extend provisional enrolment from 3 months to 12 months, and to remove the requirement to sight a birth certificate before enrolling a baby. This is intended to reduce barriers to enrolment.

Work continues to develop more culturally appropriate support for Māori and Pacific whānau who have difficulty enrolling.

Notes to the measure:

- a) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 69.7%, Pacific 80.2%, Asian 93.0%, Non-Māori, non-Pacific, non-Asian 99.1%, Overall 87.7%.
- b) The sparkline total shows the percentage for the last quarter.

Ref Measure

P2-15 Percentage of children enrolled with an oral health service

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	95%		97.3%	99.4%	✓
Māori		80%	83.4%	87.0%	
Pacific		92%	101.0%	108.5%	
NM/NP*		100%	102.9%	103.7%	
Northern			99.4%	100.9%	
Te Manawa Taki			99.6%	104.8%	
Central I Ikaroa			98.0%	98.6%	
Te Waipounamu			90.3%	91.7%	

2023/24	Māori	Pacific	NM/NP*	All
Northern	89.3%	114.2%	101.7%	100.9%
Te Manawa Taki	89.1%	87.0%	117.9%	104.8%
Central I Ikaroa	82.4%	99.6%	108.0%	98.6%
Te Waipounamu	84.6%	98.8%	93.1%	91.7%
All New Zealand	87.0%	108.5%	103.7%	99.4%

Baseline: Sample as at 01 April 2022

*Non-Māori, Non-Pacific

Preschool enrolment in Community Oral Health Services provides the opportunity for early engagement with tamariki and whānau, and interventions aimed at prevention of oral disease and dental decay.

Total preschool enrolment has increased by 2.1% compared to 2022/23 and is above the 95% target. Preschool enrolment for Māori has increased 3.6% but is below target at 87%. Enrolment rates for Pacific have remained above target at over 100%. Regionally, total preschool enrolment was lowest in Te Waipounamu at 91.7%, with Northern,

Te Manawa Taki and Central I Ikaroa regions all achieving rates above target. Northern and Te Manawa Taki regions have districts that have implemented the National Child Health Information Platform (NCHIP), which is likely to have supported higher enrolment rates in these regions.

The oral health promotion initiative, which provides free toothbrushes and toothpaste alongside oral health education to whānau with tamariki aged 0-4 years, is expected to support increased enrolment and engagement in oral health services.

Notes to the measure:

- a) Data is collected for this measure from school children on a school (calendar) year basis, so the latest data available is for the 2023 calendar year.
- b) Percentages greater than 100% are achieved because the denominator data may not accurately represent actual population data.
- c) This measure was reported in 2022/23 without data available to enable reporting by ethnicity. Ethnicity for 2022/23 is now shown.

Ref Measure

P2- Mean Decayed Missing Filled Teeth (DMFT)
16 at school Year 8 (age 12/13 years)

Desired trend ↓

	Target	Baseline	Average	2022 Result	2023 Result	Status
Overall	See below		See below	0.72	0.74	
Māori	0.98	1.07	1.09	1.16	1.17	×
Pacific	0.81	0.83	0.90	0.81	0.82	×
NM/NP*	N/A (maintain)	0.55	0.56	0.55	0.58	×
Northern				0.50	0.52	
Te Manawa Taki				0.92	0.88	
Central I Ikaroa				0.76	0.85	
Te Waipounamu				0.78	0.83	

Baseline: 2021 Calendar year

Target: 10% reduction from the average for previous 4 years and/or maintain performance for populations with DMFT rates lower than the total population

Average: Average of previous 4 years (2019–2022)

2023/24	Māori	Pacific	NM/NP*	All
Northern	0.85	0.66	0.37	0.52
Te Manawa Taki	1.30	1.13	0.63	0.88
Central I Ikaroa	1.37	1.13	0.65	0.85
Te Waipounamu	1.16	1.21	0.74	0.83
All New Zealand	1.17	0.82	0.58	0.74

*Non-Māori, Non-Pacific

Mean DMFT in 2023 is 0.74, which is a 2.8% increase from 2022.

The target has not been achieved for any ethnicity, with mean DMFT for Māori increasing 0.9% to 1.17, for Pacific increasing 1.2% to 0.82 and for non-Māori, non-Pacific increasing 5.2% to 0.58.

Central I Ikaroa region had the highest percentage increase in mean DMFT for all ethnicities.

Mean DMFT is a measure of the effectiveness and impact of early oral health promotion, and preventative interventions delivered through the Community Oral Health Service. It also provides information on oral health status of young people at the point of transfer between the Community Oral Health Service delivered to children up to School Year 8 and adolescent care under the Combined Dental Agreement, which supports identification and targeting for priority populations.

Notes to the measure:

a) Data is collected for this measure from school children on a school (calendar) year basis, so the latest data available is for the 2023 calendar year. This is reported above, together with 2022 data for the prior year.

Ref Measure

P2-17 Percentage of people enrolled with a general practice (or a kaupapa Māori provider delivering general practice care) Desired trend

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	95%		93.9%	94.4%	✗		94.4%
Māori		83%	83.5%	84.1%			84.1%
Pacific		97%	96.6%	98.8%			98.8%
Asian			84.7%	87.9%			87.9%
NM/NP/NA*		96%	99.5%	99.1%			99.1%
Northern			94.7%	95.6%			95.6%
Te Manawa Taki			92.4%	92.5%			92.5%
Central I Ikaroa			92.8%	93.0%			93.0%
Te Waipounamu			94.8%	95.4%			95.4%
2023/24			Māori	Pacific	Asian	NM/NP/NA*	All
Northern			83.8%	101.2%	90.6%	101.2%	95.6%
Te Manawa Taki			84.1%	96.5%	78.2%	99.1%	92.5%
Central I Ikaroa			83.5%	91.4%	87.2%	97.3%	93.0%
Te Waipounamu			85.9%	94.7%	85.7%	98.4%	95.4%
All New Zealand			84.1%	98.8%	87.9%	99.1%	94.4%

Baseline: As at 01 April 2022

*Non-Māori, Non-Pacific, Non-Asian

Primary care enrolment increased marginally by 0.5% and remains slightly below the target of 95%. The health system continues to achieve high rates of patient enrolment.

Māori enrolment remains significantly below the total population average and the target at 84.1% for 2023/24. There is slight variation between regions.

Primary care capacity continues to be constrained due to workforce and resourcing, resulting in some

practices being unable to enrol new patients. To help address this, we have provided a 5.88% total revenue uplift for primary care, for the 2024/25 financial year.






To improve our understanding of Māori under-enrolment, we are working on a nationally consistent approach to quantify the number of general practice locations with closed books in real-time by the end of quarter one 2024/25.

Notes to the measure:

- a) Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 83.0%, Pacific 95.0%, Non-Māori, non-Pacific 98.0%, Overall 95.0%.
- b) Percentages greater than 100% are achieved because the denominator data may not accurately represent actual population data.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-24	Improve digital access to primary and mental health care to improve access and choice including virtual after-hours and telehealth with a focus on rural communities	Target to be established	Milestone report	Milestone report	✓
<p>Baseline: Milestone report</p> <p>In November 2023, the Rural Clinical Telehealth Service was launched to enhance access to timely health care. This service offers access to general practitioners, nursing, and advice afterhours for individuals residing in or visiting rural areas.</p> <p>As of 30 June 2024, 41% of rural practices had signed up for the service. In 2023/24, collectively the National Telehealth Service and the Rural Clinical Telehealth Service facilitated over 676,920 clinical contacts. Of those, the Rural Clinical Telehealth Service delivered more than 5,460 afterhours consultations with general practitioners and nurse practitioners.</p>					

Ref	Measure	Desired trend
P2-22	Decrease in rate (per 100,000) of hospital admissions for children under five years of age for an illness that might have been prevented or better managed in the community	Desired trend ↓

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Yearly for the last 3 years
Overall	See below		7,849	7,486		 7,486
Māori		6,590	8,304	8,168	✗	 8,168
Pacific		10,258	14,791	14,138	✗	 14,138
Asian			6,946	7,023		 7,023
NM/NP/NA*		4,802	6,420	5,719	✗	 5,719
Northern			N/A	8,196		
Te Manawa Taki			N/A	7,879		
Central I Ikaroa			N/A	7,663		
Te Waipounamu			N/A	5,640		

Target: Improve from baseline (trend to decrease)

Baseline: Q4 2021 to Q3 2022

*Non-Māori, Non-Pacific, Non-Asian

2023/24	Māori	Pacific	NM/NP**	All
Northern	8,199	15,039	6,315	8,196
Te Manawa Taki	8,822	10,099	6,963	7,879
Central I Ikaroa	8,381	14,506	6,390	7,663
Te Waipounamu	6,409	11,224	5,089	5,640
All New Zealand	8,168	14,138	6,134	7,486

**Non-Māori, Non-Pacific

This measure looks at the hospitalisation rate for children (under five) for an illness that might have been prevented or better managed in a community setting. The rates for all ethnicity groups remain above the baselines set for this measure.

The rates for Māori and Pacific remain higher than other ethnicities but have reduced since last year. The Pacific populations rates reduced by 653 admissions per 100,000.

The Northern region has the highest rates for their total population, compared to other regions.

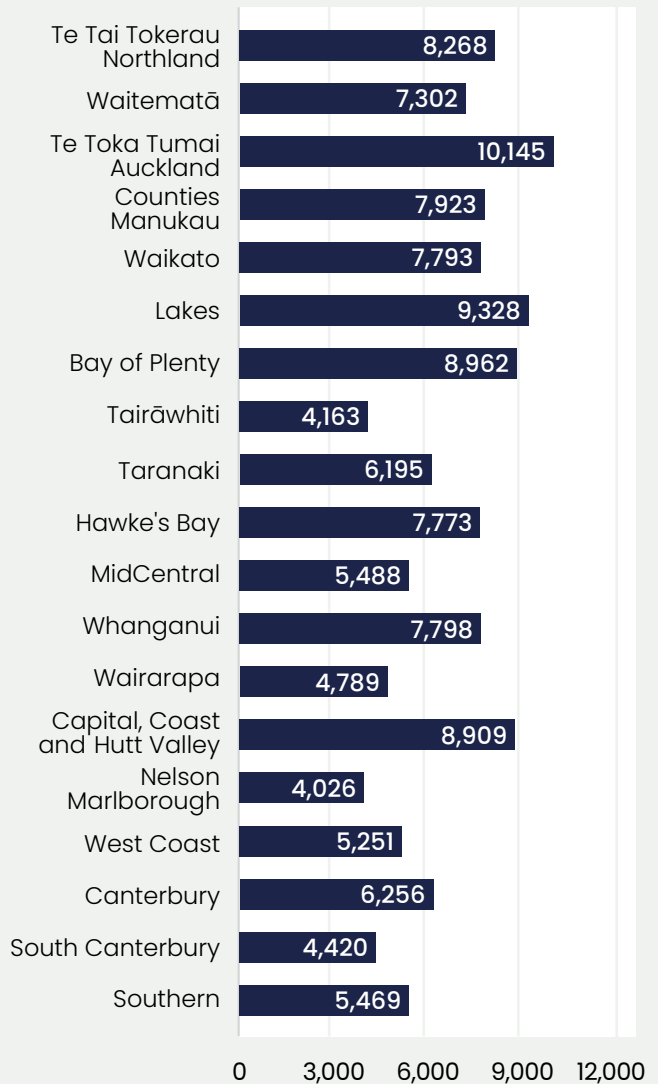
Primary care initiatives through Primary Health Organisations and regional level programmes help reduce the risk of hospitalisations.

Over the year, work has focused on understanding the capacity of general practice, optimising patient flow between primary care and hospitals, and strategically investing in primary care solutions for acute conditions. Local initiatives include improving newborn enrolment rates and childhood immunisation uptake to support children to stay well in the community, improving pathways for children with respiratory conditions, promoting six-week best start checks and following up with children post admission.

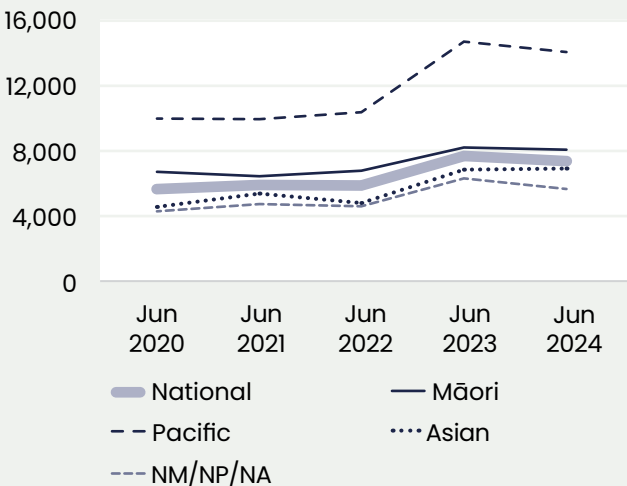
Notes to the measure:

- a) Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 8,192, Pacific 14,639, Non-Māori, non-Pacific 6,616, Overall 7,752.
- b) This data was provided to Health NZ by the Ministry of Health (MoH). It has only recently reported ethnicity level data for all the ethnicities we report on at a national level. Ethnicity level data for regions is only available for Māori, Pacific and Other (i.e. all other ethnicities). Asian ethnicity data is not separated out. MoH have only recently started producing regional breakdowns and separate results for the Asian population. The regional results have not been back dated so previous years' rates are not available.

District comparison









Longer-term trend (yearly trend)



Ref Measure

P2-23 Decrease in rate (per 100,000) of hospital admissions for people aged 45–64 years for an illness that might have been prevented or better managed in the community

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Yearly for the last 3 years
Overall	See below		3,758	3,865		 3,865
Māori		6,739	6,996	7,270	✗	 7,270
Pacific		7,370	7,769	8,115	✗	 8,115
Asian			2,219	2,459	✗	 2,459
NM/NP/NA*		2,869	3,075	3,083		 3,083
Northern			N/A	4,167		
Te Manawa Taki			N/A	4,329		
Central I Ikaroa			N/A	4,272		
Te Waipounamu			N/A	2,710		

Target: Improve from baseline (trend to decrease)

Baseline: Q4 2021 to Q3 2022

*Non-Māori, Non-Pacific, Non-Asian

2023/24	Māori	Pacific	NM/NP**	All
Northern	8,191	8,596	2,939	4,167
Te Manawa Taki	7,564	7,175	3,299	4,329
Central I Ikaroa	7,342	7,922	3,459	4,272
Te Waipounamu	4,414	5,266	2,509	2,710
All New Zealand	7,270	8,115	2,987	3,865

**Non-Māori, Non-Pacific

This measure looks at hospitalisation rates for adults for an illness that might have been prevented or better managed in a community setting. The rates for Māori and Pacific people remain above the baselines set for this measure.

The rate for people aged 45–64 years increased by 107 admissions per 100,000 compared to the same period last year. Māori and Pacific populations have the highest rates, but the largest increase of 346 admissions per 100,000 was for the Pacific population.

There is evidence that general practice is under capacity pressure with higher volumes of activity across all ethnicities. Urgent care providers have also been under pressure from workforce shortages.

Primary care services are focused on providing better support for acute and proactive care in the community. The key area of focus is better management of long-term conditions, which contribute to these admissions.

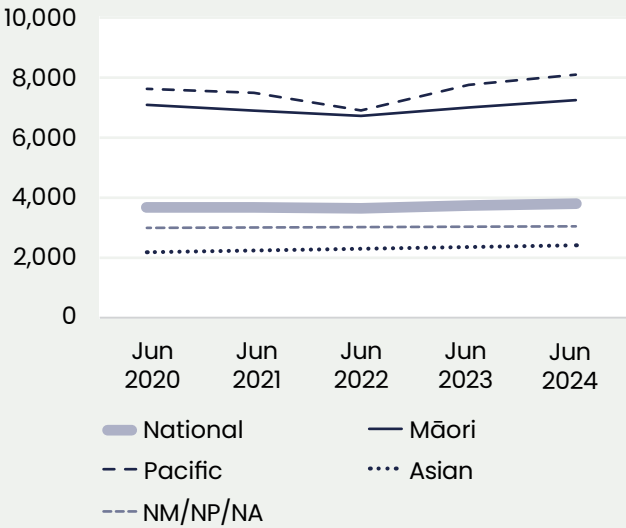
Regional initiatives include:

- the development of a regional clinical dashboard to help with cardiovascular disease management and diabetes
- Health Coaches to focus on healthy eating, physical activity, medication adherence and supporting people to understand their condition
- the development of proactive care plans for those with complex health issues.

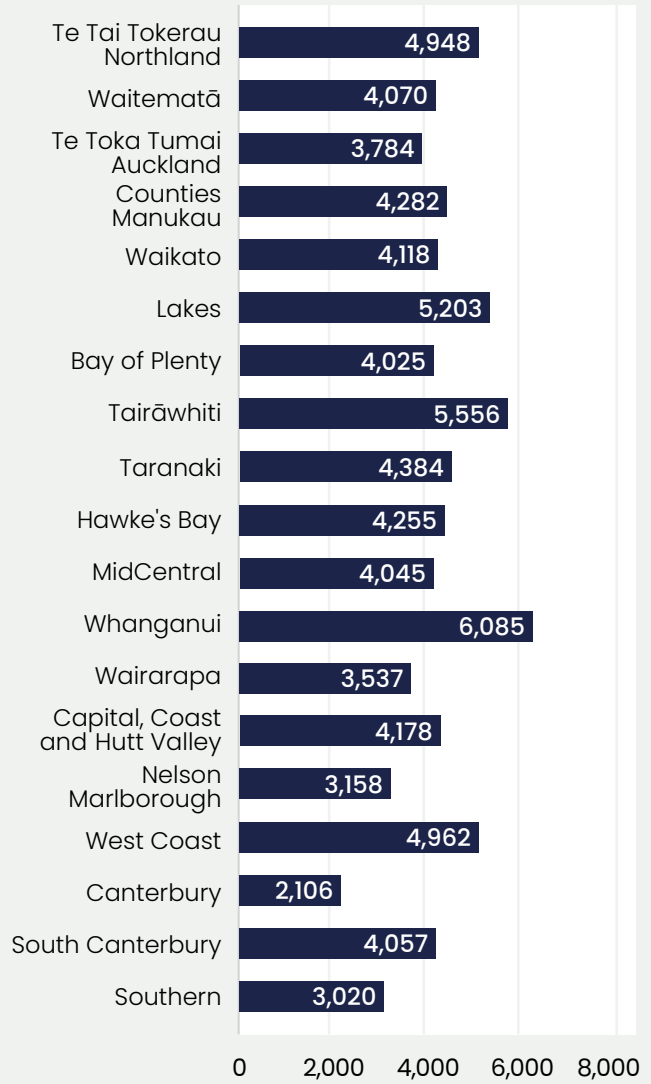
Notes to the measure:

- a) Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 6,981, Pacific 8,127, Non-Māori, non-Pacific 2,944, Overall 3,739.
- b) Age-standardised rates are used to compare health statistics between populations with different age structures e.g. Māori and non-Māori populations.
- c) This data was provided to Health NZ by the Ministry of Health (MoH). It has only recently reported ethnicity level data for all the ethnicities we report on at a national level. Ethnicity level data for regions is only available for Māori, Pacific and Other (i.e all other ethnicities). Asian ethnicity data is not separated out. MoH have only recently started producing regional breakdowns and separate results for the Asian population. The regional results have not been back dated so previous years' rates are not available.



Longer-term trend (yearly trend)



District comparison



Relationships with other service providers

Ref	Measure					Desired trend 
P2-29	Increase in rongoā consultations for rongoā Māori clients provided in terms of both total volumes and spread across the country					
		Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall		Trend to increase	Baseline set	New measure	Achieved	
Māori				29,494	41,025	
Northern				8,154	12,490	
Te Manawa Taki				10,412	14,953	
Central Ikaroa				5,099	7,186	
Te Waipounamu				5,829	6,396	

41,025 rongoā consultations were delivered in 2023/24, an increase of 11,531 from the 29,494 delivered in 2022/23.

This increase was spread across the four Health NZ regions – Northern (4,336), Te Manawa Taki (4,541), Central | Ikaroa (2,087), Te Waipounamu (567).

Client contacts include one or a combination of the following services:

- Mirimiri (massage)
- Karakia (including pastoral support)
- Whitiwhiti kōrero (cultural support).

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-30	Improvement in feedback from the Iwi Māori Partnership Boards on how they are fulfilling their role and whether they are receiving the support they require	Achieved	New measure	Very satisfied – 2 IMPBs Satisfied – 5 IMPBs Partially Satisfied – 2 IMPBs Not Satisfied – 1 IMPB	Baseline set

Baseline: 2023/24 results will become the baseline for this measure

An email questionnaire was sent to all 15 recognised Iwi Māori Partnership Boards (IMPBs) by Te Aka Whai Ora, which was jointly involved in this mahi.

70% of respondents reported that they were either Satisfied or Very Satisfied that they were fulfilling their role in developing health interventions for Māori. 10 out of 15 or 67% of IMPBs responded. The survey did not seek feedback on support received.




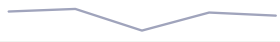
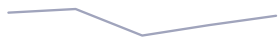
Notes to the measure:

- Te Aka Whai Ora reported on a similar performance measure in its 2023/24 Annual Report, where Iwi Māori Partnership Board feedback was sought via survey. That survey sought feedback on how they are fulfilling their role, but not whether they are receiving the support they require.

Ref Measure

P2-31 Decrease in proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area

Desired trend ↓

Due to cost only	Target	Baseline	2021/22 Result	2022/23 Result	Status	Yearly for the last 5 years
Overall	See below	See below	11.1	12.9	✓	 12.9
Māori			14.9	16.9		 16.9
Pacific			11.0	17.6		 17.6
Asian			10.8	10.4		 10.4
NM/NP/NA*			11.1	12.4		 12.4

Due to wait time

Overall			11.6	21.2	Baseline set
Māori			14.8	23.8	
Pacific			13.8	22.4	
Asian			13.4	19.5	
NM/NP/NA*			10.7	20.9	

Target: Achieved (decrease from baseline)

Baseline (30 June 2019): Unmet need due to cost 13.6%

*Non-Māori, Non-Pacific, Non-Asian

The results reported for 2022/23 are the latest available and report against two dimensions: a) unmet need due to cost and b) unmet need due to wait time.

Results need to be compared with the baseline reported at 30 June 2019, at which time the NZ Health Survey only measured unmet need.

Notes to the measure:

- NZ Health Survey does not publish results for 2023/24 until 19 November, which is too late for inclusion in this report. Latest available is for 2022/23. 2023/24 results will be reported in 2024/25 Annual Report.
- Wait time only available from 2021/22 onwards so no trend data is available.

Results for 2022/23 indicate unmet need due to perceived cost *decreased* from the 2019 baseline year for all ethnicities. Unmet need due to perceived wait time has *increased* from 2021/22 for all ethnicities.

Establishment

Ref	Measure	Target	2022/23 Result	23/24 Results	Status
P2-13	Localities are established	No Target	Milestone report	No target set	—
<p>The timeframe for implementing localities was extended through the enactment of the Pae Ora (Disestablishment of the Māori Health Authority) Amendment Act 2024. This extension allows time for sub-national structures to be reconsidered to reflect the structural changes. The requirement for a locality plan to be developed for each locality takes effect on 1 July 2029.</p>					

Ref	Measure	Target	2022/23 Result	23/24 Results	Status
P2-14	Provider networks are established	No Target	Milestone report	No target set	—
<p>Provider networks were envisaged to be established alongside localities. As legislative change has extended the timeframe for implementation of the localities approach, the related provider network establishment has been deferred.</p> <p>We are working to build on the strengths of existing provider support networks in primary care, mainly PHOs. A project has progressed on the necessary functions of these provider networks in order for them to be fit for purpose in the future.</p>					

Output Class 3: Hospital and specialist services

We want to ensure New Zealanders receive timely access to specialist inpatient and outpatient services to prevent deterioration of their condition and improve their quality of life. We have been working on maximising the capacity of these services and ensuring that everyone can access the same standards of care, no matter where they live.

Providing emergency medical care

Our emergency departments (EDs) treat people who have a serious illness or injury that requires urgent attention. Patients may be referred to an ED by their doctor/GP, the ambulance service or they may refer themselves.











Our EDs have experienced significant pressure over the past year, particularly during periods when respiratory and other illnesses are spreading in our community, such as in winter. Our plan has included initiatives across hospital primary and community services and prevention to ensure that people can access care when they need it.

We also worked on improving the ED experience for Māori and ensuring access to emergency care through the availability of air and road ambulances in urban and rural locations. Additional funding in Budget 2022 was targeted at ambulance services, to ensure ambulance capacity to meet growth in emergency ambulance callouts, make critical upgrades to the helicopter fleet, and improve air ambulance services' infrastructure resilience to weather events.

Shorter stays in emergency departments

ED wait times are an indication of how hospitals are coping and the level of pressure in the hospital system. Delays in patients flowing through the hospital, from admission to discharge, create pressure for bed space and impact the emergency department when they need to admit patients into wards. We need to reduce delays in patients flowing through the hospital system.

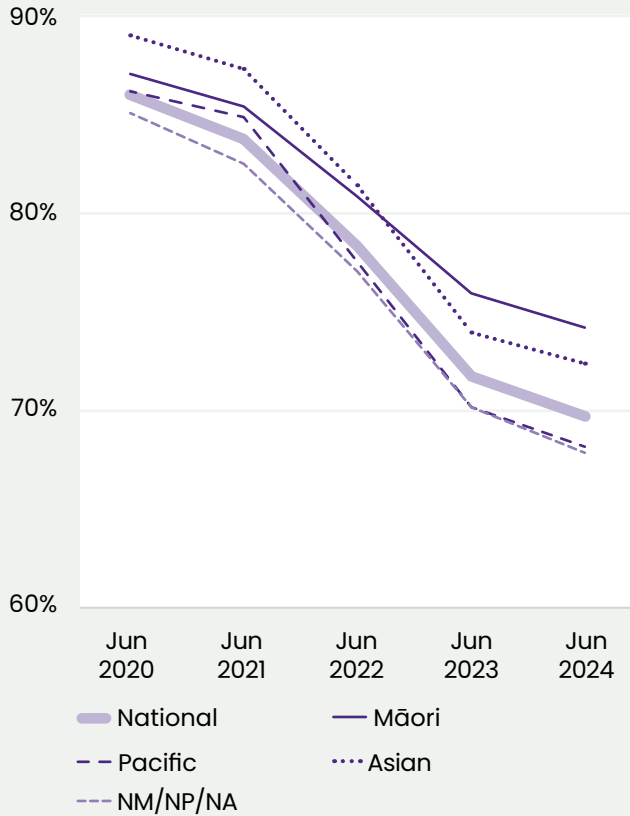
Progress against our annual output measures

Ref	Measure					
P2-45	Percentage of patients will be admitted, discharged, or transferred from an ED within six hours (SSED)		Desired trend 			
	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters
Overall	95%	78.8%	71.7%	69.7%	✗	 71.2%
Māori			75.9%	74.1%		 75.4%
Pacific			70.1%	68.1%		 71.0%
Asian			73.9%	72.3%		 74.8%
NM/NP/NA*			70.1%	67.8%		 68.9%
Northern			71.1%	69.2%		 73.1%
Te Manawa Taki			75.1%	73.3%		 71.9%
Central Ikaroa			62.2%	58.4%		 60.6%
Te Waipounamu			75.9%	74.6%		 75.5%
Baseline: 2021/22 FY						
2023/24	Māori	Pacific	Asian	NM/NP/NA*	All	
Northern	73.5%	67.1%	72.3%	66.7%	69.2%	
Te Manawa Taki	77.8%	76.4%	74.1%	70.3%	73.3%	
Central Ikaroa	64.9%	59.8%	62.7%	55.3%	58.4%	
Te Waipounamu	77.1%	76.6%	77.9%	73.7%	74.6%	
All New Zealand	74.1%	68.1%	72.3%	67.8%	69.7%	
*Non-Māori, Non-Pacific, Non-Asian						
<p>People admitted, discharged or transferred from an ED within 6 hours is 69.7%, similar to performance at the end of 2022/23. Total performance remains below the baseline and below the national target of 95%.</p> <p>Shorter Stays in Emergency Departments (SSED) reflects the performance of the whole health system, not just our emergency departments.</p> <p>New Zealand has a growing and ageing population that requires more hospital support and longer lengths of stay. Some challenges to improving SSED are higher complexity of patients, workforce and infrastructure constraints, and inadequate support available on discharge.</p>			<p>Access to inpatient hospital beds has a significant impact on patient flow through ED and length of stay in ED. We are focused on improving flow through hospitals to relieve access block including improved processes to support discharge for patients with complex care, and district and regional acute flow plans. In the last year Health NZ has implemented an acute care programme of work with a strong focus on length of stay and discharge, hospital escalation protocols, and standardising daily operations for hospital flow.</p> <p>We have also developed a health target implementation plan to improve SSED performance – this starts in quarter one 2024/25 and is a multi-year programme of work.</p>			

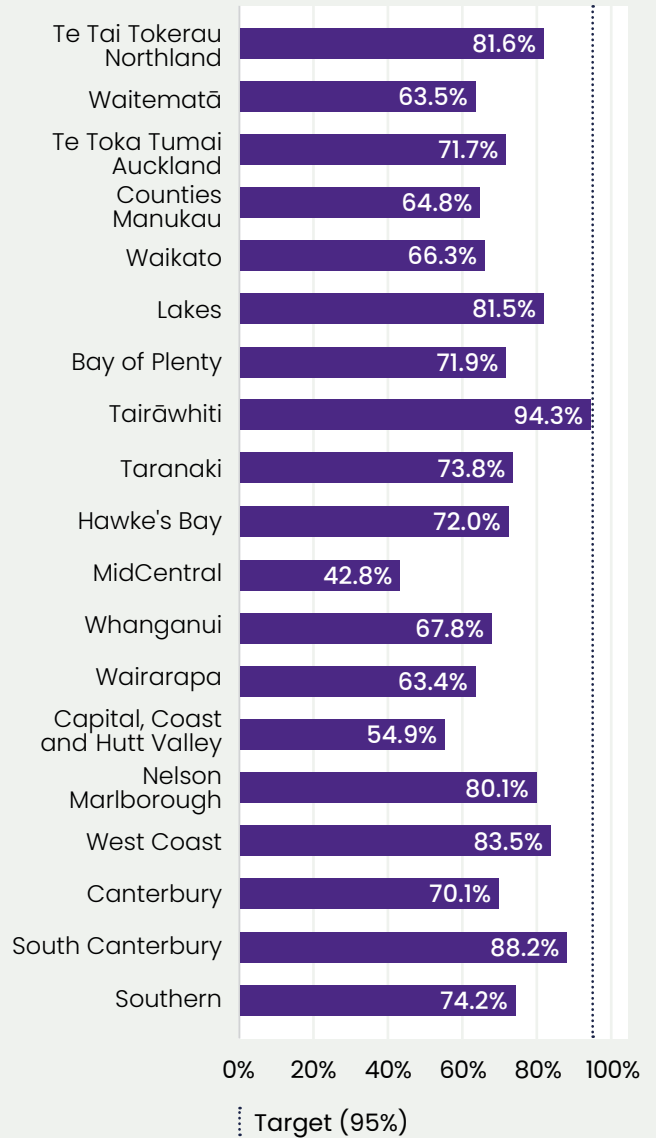
Notes to the measure:

- a) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 75.9%, Pacific 70.2%, Asian 73.9%, Non-Māori, non-Pacific, non-Asian 70.3%, Total 71.8%.
- b) This measure is similar to one of the new health targets, with a slight difference in methodology and target. The replacement measure will commence from the 2024/25 financial year, with a target of 95% to be achieved by 2030.
- c) The sparkline total shows the results for the final quarter.

Longer-term trend









District comparison



Shorter wait times for first specialist assessment

The target is for 95 per cent of patients to wait less than four months for a first specialist assessment.

The sooner a person is seen by a specialist, the sooner they can have certainty about their conditions and what treatment is needed.

Ref	Measure						Desired trend 
P2-39	Proportion of people waiting longer than four months for their first specialist assessment						
	Target	Baseline	2022/23 Result	2023/24 Result	Status	Monthly for the last 24 months	
Overall	0%	26%	30.4%	38.5%	X		38.5%
Northern			32.0%	37.9%			37.9%
Te Manawa Taki			32.8%	44.0%			44.0%
Central I Ikaroa			22.6%	31.8%			31.8%
Te Waipounamu			31.3%	39.0%			39.0%

Target: 0% target means no people waiting longer than four months for first specialist assessments
Baseline: Q4 2021 – Q3 2022

By the end of the financial year, there are 38.5% of people on the waitlist who have been waiting more than four months for their first specialist assessments, which is an increase of 8.1% from 2022/23.






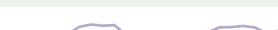



Over the year, we have carried out several initiatives that aim to reduce waitlists and improve waiting times.

- Development and prototyping of new care pathways such as the MSK pathway that uses the skills of the whole team to provide timelier access to the right care. We will be deploying this nationally and will leverage this approach to support better access to other services such as ophthalmology and audiology (supporting patients to access ear, nose and throat first assessment faster).
- Development of the national performance framework and near-real time operational data reporting capability have supported better national and regional performance management.
- Improvement in data quality, waitlist validation and patient communications.
- Development of the expected wait time dashboard, which is on-track for completion and deployment, initially to primary care, from quarter 2 2024/25.
- Development of the National Health Target implementation plans for 2024/25, which define specific areas of focus for local areas and regions, with a degree of national consistency, and carry through the programmes implemented this year.

Ref Measure

P2- Proportion of people given a commitment to treatment
40 and who are not treated within four months

Desired trend ↓

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Monthly for the last 24 months
Overall	0%	41%	36.6%	37.8%	✗	 37.8%
Māori			38.7%	40.1%		 40.1%
Pacific			35.0%	40.8%		 40.8%
Asian			32.6%	36.9%		 36.9%
NM/NP/NA*			36.8%	36.9%		 36.9%
Northern			33.6%	37.1%		 37.1%
Te Manawa Taki			39.1%	35.3%		 35.3%
Central Ikaroa			32.5%	33.9%		 33.9%
Te Waipounamu			42.7%	44.6%		 44.6%

Target: 0% target means no people waiting longer than four months for treatment

Baseline: Q4 2021 – Q3 2022

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	41.1%	41.6%	37.1%	34.6%	37.1%
Te Manawa Taki	38.4%	39.4%	34.9%	33.9%	35.3%
Central Ikaroa	38.1%	33.1%	34.2%	32.7%	33.9%
Te Waipounamu	45.0%	47.9%	41.2%	44.7%	44.6%
All New Zealand	40.1%	40.8%	36.9%	36.9%	37.8%

*Non-Māori, Non-Pacific, Non-Asian

As at the end of 2023/24, 37.8% of patients were waiting longer than 4 months following a commitment to treatment, which is a slight increase of 1.2% from 2022/23.

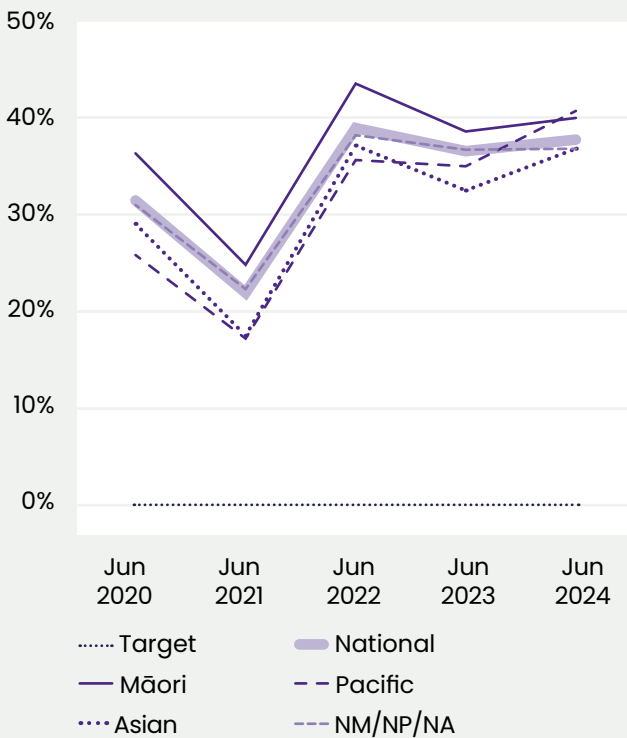
Key activities carried out over the year include:

- Treating our most urgent cases first, while ensuring that the longest waiting patients are booked in order of time waiting. Improvements have been made in key service areas such as orthopaedics.
- Outsourcing elective treatment to make the most of private sector capacity. We will continue to build on these relationships to utilise the capacity of the whole sector in the coming year.
- Delivered around 800 (mainly dental) procedures through partnerships with community providers using mobile surgical services to reach more rural and higher deprivation areas.
- Development of the national performance framework and live operational data reporting capability have supported better national and regional performance management.
- Improving operational management of waitlists, booking order, production planning and establishing better regional coordination and the ability to support patients to travel to receive care outside of their home, which we will continue to expand over the coming year through district-level health target implementation plans.
- Development of the National Health Target implementation plans for 2024/25, which define specific areas of focus for local areas and regions, with a degree of national consistency, and carry through the programmes implemented this year.

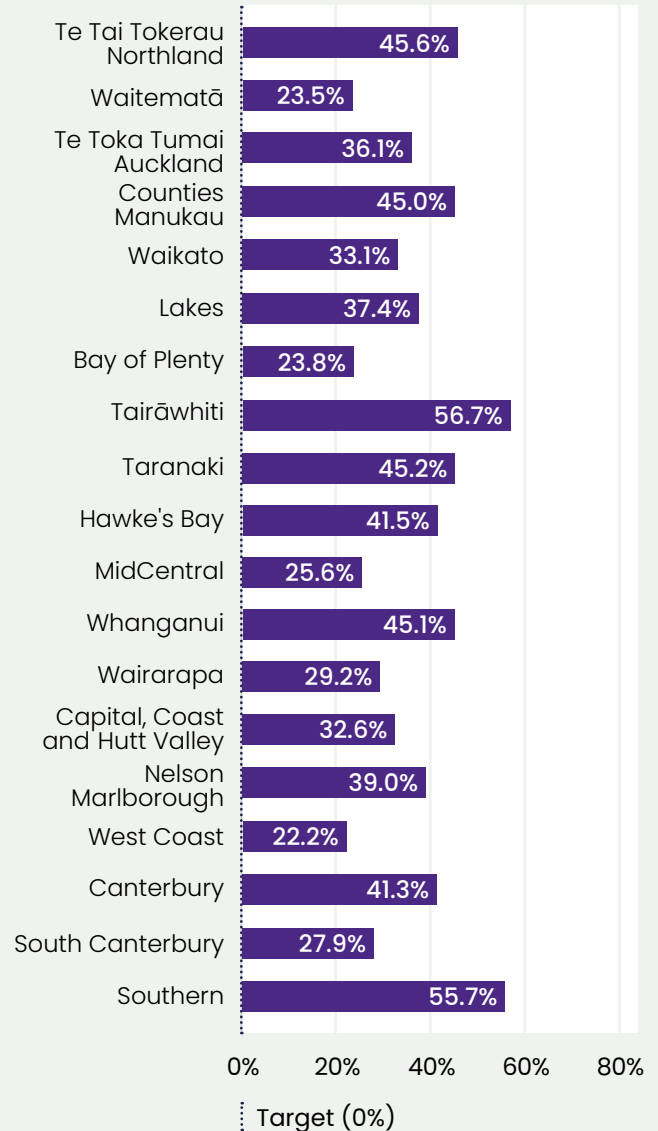
Notes to the measure

- a) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 40.5%, Pacific 35.3%, Asian 33.1%, Non-Māori, non-Pacific, non-Asian 38.5%, Total 38.1%.
- b) This is a multi-year target and operational plans will determine yearly target.
- c) The target is 0% but no milestone has been set for 2023/24. This measure will be replaced by a new health target, which is the inverse of this one. The replacement measure will commence from the 2024/25 financial year, with a target of 95% to be achieved by 2030.
- d) This measure is ESPI5 – Percentage of patients who are waiting over 120 days for treatment.

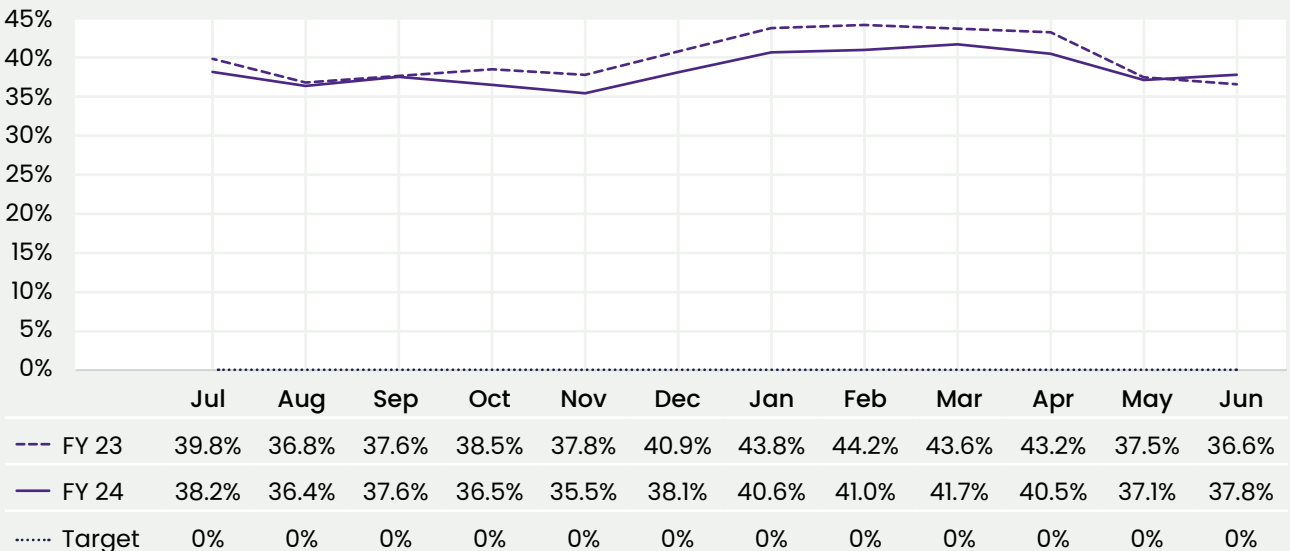
Longer-term trend



District comparison











Proportion of people given a commitment to treatment and who are not treated within four months



Ref Measure

P2-41 Number of acute bed nights spent in hospital

Desired trend ↓

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Yearly for the last 3 years
Overall	See below		2,395,476	2,334,322		 2,334,322
Māori		341,366	390,291	406,531	×	 406,531
Pacific		154,929	186,164	198,767	×	 198,767
NM/NP*		1,577,694	1,819,020	1,729,023	×	 1,729,023
Northern			898,917	910,230		 910,230
Te Manawa Taki			534,611	516,625		 516,625
Central I Ikaroa			431,612	429,034		 429,034
Te Waipounamu			530,336	478,432		 478,432

Target: Improve from baseline (trend to decline)

Baseline: Q4 2021 – Q3 2022

2023/24	Māori	Pacific	NM/NP*	All
Northern	142,430	148,696	619,105	910,230
Te Manawa Taki	138,976	12,755	364,894	516,625
Central I Ikaroa	81,644	24,974	322,416	429,034
Te Waipounamu	43,481	12,343	422,608	478,432
All New Zealand	406,531	198,767	1,729,023	2,334,322

*Non-Māori, Non-Pacific

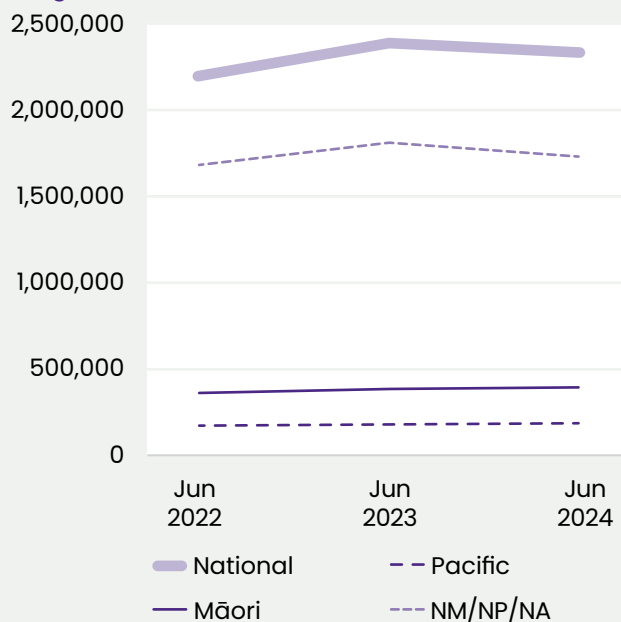
Health NZ focuses on reducing acute bed nights by implementing preventative services, such as immunisation, as well as more community-based services such as primary options for acute care in the community, hospital in the home (in metro Auckland), and early supported discharge (in Waikato). Hospitals have processes in place to review those patients with a length of stay greater than seven days, and work to eliminate barriers to discharge.

Due to population growth and an ageing population, it will remain challenging to decrease this trend.

Notes to the measure

- a) Results for the Asian ethnicity were not available last year, but are reported for comparative purposes here. The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 383,525, Pacific 188,843, Non-Māori, non-Pacific 1,706,842, Overall 2,274,210.
- b) The measure wording (bed nights) set out in the Statement of Intent 2022-2024 is used here.




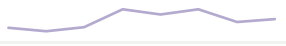





Longer-term trend



Ref Measure

P2-47 Number of mental health bed nights

Desired trend ↓

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	See below		974,911	968,598			240,508
Māori		321,522	353,384	362,284	×		93,427
Pacific		68,202	75,702	73,213	×		17,839
Asian			38,189	40,627	×		9,944
NM/NP/NA*		519,569	507,636	492,474			119,298
Northern			330,117	339,310			85,793
Te Manawa Taki			208,839	210,705			53,262
Central I Ikaroa			200,243	202,078			49,485
Te Waipounamu			217,000	195,357			47,113

Target: Improve from baseline (trend to decline)**Baseline:** 2021/22 FY

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	117,182	48,375	23,166	150,587	339,310
Te Manawa Taki	115,829	4,695	3,519	86,662	210,705
Central I Ikaroa	79,083	15,553	5,556	101,886	202,078
Te Waipounamu	44,674	3,857	7,463	139,363	195,357
Funded for national access	5,516	733	923	13,976	21,148
All New Zealand	362,284	73,213	40,627	492,474	968,598

*Non-Māori, Non-Pacific, Non-Asian

Mental health beds are found in inpatient Health NZ mental health and addictions (MH&A) wards across the country. Hospital beds are for those with severe (and often complex) and acute mental health needs. Non-government organisations' (NGOs') MH&A beds are excluded from this measure and are for those transitioning out of inpatient services or in some areas are available as alternatives to hospital admission. Health NZ forensic beds are for those referred to specialist Forensic Mental Health Services through the New Zealand Courts or because they have acute mental health needs while in prison.

Health NZ has 1,337 MH&A beds, of which 607 are acute adult mental health beds. Adult forensic beds make up a further 370 beds (126 forensic acute, 27 forensic Kaupapa Māori, 169 Forensic Rehab, and 48 Forensic Intellectual Disability). Other major bed types include 48 acute child and adolescent beds

and 169 acute beds for older adults (Mental Health Services of Older Persons).

In the 2023/24 financial year, the number of mental health bed nights decreased from 2022/23. Decreases for Māori and non-Māori, non-Pacific, and non-Asian were most significant and there was a marginal decrease for Pacific. In contrast, mental health bed nights for Asian increased slightly, and more significantly for Māori, who are over-represented in all specialist MH&A service usage measures. This over-representation of Māori is in line with the well-documented need for specialist MH&A services. Overall, in comparison to the 2021/22 baseline, the number of mental health bed nights has increased. It is important to note that despite increases in mental health bed nights in the last two financial years, there is a marginal but discernible downward trend for this measure over the last five years.

The increase in mental health bed nights over the last two years in comparison to 2021/22 will be due to a number of factors; notably, the COVID-19 pandemic and lockdowns had a major impact on access to inpatient MH&A services, thereby impacting the baseline for this measure.

Significant workforce and inpatient capacity challenges are impacting the provision of specialist mental health and addiction services. Acute adult and older adult services are known to operate at maximum capacity and at times at over 100% occupancy. The extent of the MH&A workforce shortages is particularly severe for the Forensic and Forensic Intellectual Disability (ID) services and their inpatient units. Many inpatient MH&A services are supporting a cohort of people who no longer need acute hospital services but cannot be discharged

for a range of reasons including the availability of suitable community options for people with complex needs.

Health NZ is working towards a decrease in mental health bed nights by stabilising and supporting existing specialist services, as well as growing the number and type of community specialist mental health services to intervene earlier in the course of disease/need and earlier in the life course. While the recent decrease and overall downward trend could be an indication that these efforts are taking effect, it may also be an indication of increasing demand for mental health beds over and above existing physical and workforce capacity. Further detailed analysis of the drivers of current mental health bed use and demand, as well as a MH&A prevalence survey, are required to ascertain this accurately.









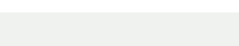
Notes to the measure

- a) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 392,269, Pacific 73,601, Asian 37,657, Non-Māori, non-Pacific 502,586, Overall 1,006,113.
- b) The sparkline total shows the results for the final quarter.

Ref Measure

P2-46 Number of people with an inpatient length of stay of greater than 7 days

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	to be established		60,727	63,242			16,022
Māori		10,836	9,079	9,637	✓		2,438
Pacific		5,342	4,733	5,193	✓		1,267
Asian		51,781	3,930	4,435	✓		1,132
NM/NP/NA*			42,985	43,977			11,185
Northern			24,195	25,310			6,217
Te Manawa Taki			12,909	13,202			3,343
Central I Ikaroa			11,535	12,432			3,190
Te Waipounamu			12,088	12,298			3,272

Baseline: 2021/22 FY

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	3,718	4,035	3,178	14,379	25,310
Te Manawa Taki	3,095	314	366	9,427	13,202
Central I Ikaroa	1,922	612	525	9,373	12,432
Te Waipounamu	902	232	366	10,798	12,298
All New Zealand	9,637	5,193	4,435	43,977	63,242

*Non-Māori, Non-Pacific, Non-Asian

Performance remains below baseline for all ethnicities. The proportion of patients with a long length of stay has remained reasonably static. Although length of stay longer than seven days has remained below baseline, year on year there has been an increase across all ethnicities between 2022/23 and 2023/24.

In the context of an overall increase in admissions, the number of patients with a length of stay >7 days increased relative to 2022/23 for all ethnicities. Despite this, the 2023/24 results remain lower than the 2021/22 baseline.

Long inpatient stays are an indicator of system performance in relation to hospital flow, impacted by complexity, ageing and, in some areas, delays in discharge caused by lack of access to suitable community or residential care facilities. Health NZ is working across the system to put plans in place to keep people well at home and ensure safe and timely discharge following a hospital admission. A complex discharge escalation pathway was implemented. Patients with a length of stay over seven days are reported daily with regular review at a district level to remove barriers to discharge.

Notes to the measure:

a) The sparkline total shows the results for the final quarter.

Ref Measure

P2-42 Standardised rate of acute readmissions within 28 days of discharge

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Rolling 12 months for the last 3 periods
Overall	12%		12.4%	12.4%		12.4%
Māori		12%	13.0%	12.9%	✗	12.9%
Pacific		12%	12.5%	12.4%	✗	12.4%
NM/NP*		12%	12.3%	12.3%	✗	12.3%
Northern			12.5%	12.4%		12.4%
Te Manawa Taki			12.6%	12.5%		12.5%
Central I Ikaroa			12.5%	12.6%		12.6%
Te Waipounamu			12.2%	12.2%		12.2%

Target: This is a multi-year target and operational plans will determine yearly target

Baseline: Q4 2021 Q3 2022

2023/24	Māori	Pacific	NM/NP*	All
Northern	13.2%	12.3%	12.2%	12.4%
Te Manawa Taki	12.7%	13.1%	12.4%	12.5%
Central I Ikaroa	12.6%	12.5%	12.6%	12.6%
Te Waipounamu	13.0%	11.9%	12.1%	12.2%
All NZ	12.9%	12.4%	12.3%	12.4%

*Non-Māori, Non-Pacific

Performance has remained relatively stable over the past 12 months. Acute readmissions within 28 days of discharge are a system performance balancing measure: a measure a health system should track to ensure an improvement in one

area isn't negatively impacting another area. For example, in improving hospital flow by reducing length of stay, we need to ensure the right patients are discharged and there is not an inappropriate increase in readmissions to hospital.

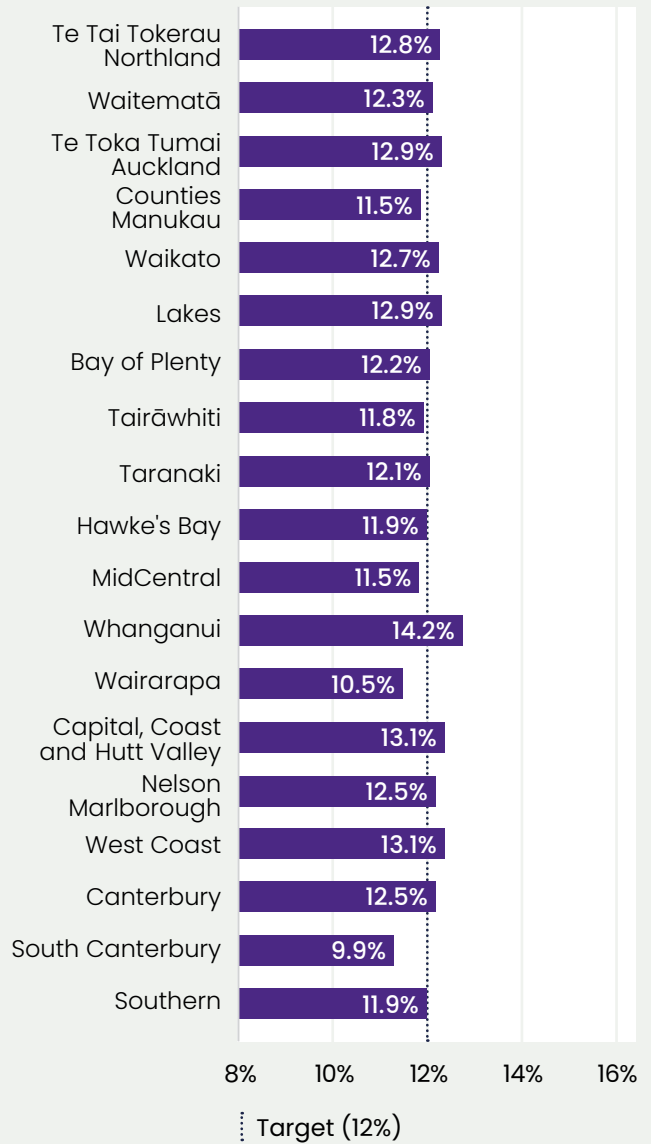
Notes to the measure:

- a) Results for the Asian ethnicity were not available last year, nor this year. The results reported for 2022/23 have been updated since the last Annual Report with a change for most ethnicities – Pacific 12.3%, Non-Māori, non-Pacific 12.4%, Overall, 12.5%.
- b) Acute readmission numbers are standardised by calculating a predicted number of acute readmissions for each district, and then comparing their actual number with the predicted number.
- c) Reporting for the year presents a timing challenge, as it requires admissions in the month beyond 30 June to calculate the rate. Through the normal National Minimum Data Set submission process, we only receive data on admissions once they are discharged and clinically coded, which takes to the end of August or further for some inpatient events. The nature of this calculation has meant that the baseline set in 2022 was for the period Q4 2021 to Q3 2022, and in the Health NZ annual report for 2022/23, the measure was reported for the 12 months to March 2023. This reporting period has been repeated – for the 12 months to 31 March 2024.
- d) Wording of this measure has been changed in Vote Estimates to Decrease in rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area, compared with 2022/23.

Longer-term trend (rolling 12-month period)




District comparison



Ref Measure

P2- 43 Number of planned care interventions delivered against target, including: inpatient surgical discharges; minor procedures delivered in inpatient, outpatient and community settings; and non-surgical interventions

Desired trend 

Inpatients

Baseline 158,693 Status 

	2022/23 Result	2023/24 Result
Māori	25,889	29,116
Pacific	11,385	12,645
Asian	14,822	16,419
Other ethnicity	117,586	125,719
Total	169,682	183,899
Northern	63,261	67,606
Te Manawa Taki	36,263	40,455
Central I Ikaroa	34,532	37,829
Te Waipounamu	35,626	38,009
Total	169,682	183,899

Minor procedures

Baseline 138,572 Status 

	2022/23 Result	2023/24 Result
Māori	9,977	10,859
Pacific	7,126	7,688
Asian	10,342	11,048
Other ethnicity	123,997	125,521
Total	151,442	155,116
Northern	45,178	46,223
Te Manawa Taki	32,039	32,158
Central I Ikaroa	47,050	41,103
Te Waipounamu	27,175	35,632
Total	151,442	155,116

Non-surgical interventions

Baseline 2,429 Status 

	2022/23 Result	2023/24 Result
Māori	363	749
Pacific	280	244
Asian	108	110
Other ethnicity	2,440	2,758
Total	3,191	3,861
Northern	510	203
Te Manawa Taki	252	221
Central I Ikaroa	1,334	685
Te Waipounamu	1,095	2,752
Total	3,191	3,861

Target: Improve from baseline, trend to increase

Baseline: July 2021 – June 2022









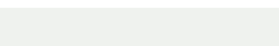
This year we increased our delivery of planned care by 6%, or more than 18,800 interventions. Increased delivery is related to changing models of care, improved theatre productivity, and a focus on improved operational management such as booking and scheduling.

Improved visibility of performance at a district and service-specific level that is regionally and nationally monitored has driven improved delivery this year. Additional investment in planned care has enabled outsourcing for services such as orthopaedics and ophthalmology (e.g. hips and knees, cataracts), which has contributed to this uplift in delivery.

Ref Measure

P2- 58 Decrease in the percentage of missed first specialist assessment appointments for Māori, Pacific, Asian and other people

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters
Overall	Achieved		7.8%	7.4%		 7.2%
Māori	15.54%	15.8%	15.2%	✓	 15.1%	
Pacific	16.93%	18.2%	16.7%	✓	 16.4%	
Asian	5.49%	6.1%	5.8%	✗	 5.3%	
NM/NP/NA*	4.82%	4.9%	4.4%	✓	 4.2%	
Northern		9.2%	8.5%		 8.3%	
Te Manawa Taki		7.8%	7.3%		 7.2%	
Central Ikaroa		6.8%	6.4%		 6.3%	
Te Waipounamu		6.4%	6.5%		 6.2%	

Baseline: 12 months to 30 June 2021/22

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	16.4%	17.1%	5.4%	4.8%	8.5%
Te Manawa Taki	15.1%	14.8%	6.5%	3.9%	7.3%
Central Ikaroa	13.9%	15.7%	5.1%	3.8%	6.4%
Te Waipounamu	13.9%	16.5%	8.5%	5.0%	6.5%
All New Zealand	15.2%	16.7%	5.8%	4.4%	7.4%

*Non-Māori, Non-Pacific, Non-Asian

Overall missed appointments decreased over the last year by 0.4%. Missed appointments are highest for Māori and Pacific Peoples. Districts and regions have been working to reduce missed appointments and there are good examples of cultural support and navigation services that are operational in each region.

Contacting patients using multi-channel communications (text, phone calls, letters and email) is routine practice, however individual contact with patients is a key part of reducing missed appointments, where services contact the patient directly to understand their needs and what support can be provided.

For the Northern region, examples include Kaiārahi Nāhi and Pacific Health navigation teams that

are operational in the Te Toku Tumai Auckland district and which provide a coordinated approach to support patients' attendance at FSAs. This focuses on a streamlined referral process, timely appointment scheduling, patient-centred navigation and cultural and language support. This can also include travel assistance.

In the Te Manawa Taki region, examples include services provided in the Waikato district where the patient is contacted to understand their need for transport to appointments (patient shuttles, national travel assistance schemes), updating addresses, finding out a patient's preferred method of communication (e.g. email, letter), and patient-focused booking to ensure the appointment is booked on a day that helps a patient to attend.

If the patient lives further away, the service works with the booking clerk or nurse in the event that the follow-up can be done via phone consultation, or rescheduled to a later time in the day, avoiding early morning slots. This service also connects patients to a nurse, who will call them if they are unsure about the purpose of the appointment or why they need it, and address any questions or health concerns they may have.

In the Central Ikaroa region, examples include early follow-up, co-ordination and navigation support for ophthalmology, immunology, diabetes, respiratory and ENT clinic for vulnerable patients with high rates of missed appointments and multiple comorbidities in the Capital, Coast and Hutt Valley district; and work in the Hawke's Bay district to develop a pre-operative process to provide education and cultural support to Pacific patients and their families through Talanoa, with

an initial focus on diabetes, cardiac and respiratory services.

In the Te Waipounamu region, examples include the Wellsouth Pou Manaaki team phoning Māori and Pacific patients before their appointments (both first and follow-up) to confirm attendance and offer assistance (such as travel support) as required. When the patient needs to change dates, the service works with booking admin teams to arrange a time that suits the patient. In the West Coast district, Māori and Pacific patients are called prior to appointment and are offered assistance if it is identified there are challenges attending (e.g. financial / physical/ supportive). Patients are linked in with Health Navigators, Poutini Waiora (Local Māori Health Provider), St John Health Shuttle, Kaiāwhina assistance for children, and Public Health Nurses.









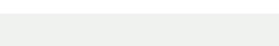
Notes to the measure:

- a) Missed appointments (DNAs) are defined as patients who do not show up for their scheduled medical appointments without providing prior notice.
- b) The wording for this measure was amended in the Supplementary Estimates of Appropriations 2023/24, page 488.
- c) While this is a new measure and not reported in 2022/23, results for that year have been calculated for comparative purposes.
- d) The sparkline total shows the results for the final quarter.

Ref Measure

P2-49 First specialist assessments per 100,000

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	See below	11,010	9,259	9,431	×		2,422
Māori			8,310	8,728			2,255
Pacific			8,564	9,414			2,469
Asian			5,902	6,061			1,581
NM/NP/NA*			10,596	10,703			2,738
Northern			8,920	9,404			2,455
Te Manawa Taki			10,370	9,996			2,607
Central I Ikaroa			10,479	11,172			2,840
Te Waipounamu			7,715	7,528			1,867

Target: Improve from baseline (trend to increase)**Baseline:** Q4 2021 – Q3 2022 as per SOI

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	9,301	9,822	6,468	11,263	9,404
Te Manawa Taki	8,723	8,099	5,277	11,573	9,996
Central I Ikaroa	9,269	10,006	7,298	12,624	11,172
Te Waipounamu	6,592	6,428	3,999	8,242	7,528
All New Zealand	8,728	9,414	6,061	10,703	9,431

*Non-Māori, Non-Pacific, Non-Asian

The total number of first specialist assessments (FSAs) delivered per 100,000 people increased this year by 172. Performance for all ethnicities has improved by 850 for Pacific and 418 for Māori.

Asian (159) and Non-Māori, non-Pacific, non-Asian (107) still showed a slight increase. Overall, the rate per 100,000 people remained below the baseline of 11,010 per 100,000 people.

Notes to the measure:

- The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 9,994, Pacific 10,206, Asian 7,751, Non-Māori, non-Pacific, non-Asian 12,586, Overall 11,193.
- The sparkline total shows the results for the final quarter.

Ref Measure

P2-48 Colonoscopies per 100,000 people

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	See below	1,268	1,250	1,170	×
Māori			760	742	
Pacific			604	644	
Asian			567	570	
NM/NP/NA*			1,670	1,551	
Northern			1,149	1,186	
Te Manawa Taki			1,241	1,189	
Central I Ikaroa			1,271	1,066	
Te Waipounamu			1,398	1,208	

Target: Improve from baseline (trend to increase)**Baseline:** Q4 2021 – Q3 2022 as per SOI

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	857	721	711	1,745	1,186
Te Manawa Taki	703	517	365	1,603	1,189
Central I Ikaroa	650	438	368	1,389	1,066
Te Waipounamu	713	503	330	1,440	1,208
All New Zealand	742	644	570	1,551	1,170

*Non-Māori, Non-Pacific, Non-Asian

This year we have maintained volumes of patients' colonoscopies per 100,000 people. Volumes for Asian and Pacific have slightly improved, however Māori and other ethnicities have decreased.

Health NZ is focused on reducing waitlists through district and regional initiatives, benchmarked against a national performance framework set up by the Ministry of Health. Services monitor the number of patients waiting for MRI, and the number

of patients whose wait times have breached the threshold appropriate to their assessed clinical priorities. This data supports clinical service planning to endeavour to manage potential risk to patients.

A national programme is in development for the faecal immunochemical test for the symptomatic pathway, which is anticipated to reduce the waitlist. This will be implemented in 2025.









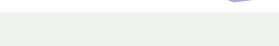
Notes to the measure:

- a) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 739, Pacific 592, Asian 599, Non-Māori, non-Pacific, non-Asian 1,601, Overall 1,219.

Ref Measure

P2- 51 Percentage of patients who receive their first cancer treatment (or other management) within 31 days from date of decision-to treat

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	85%	85%	84.9%	84.2%	✗		83.5%
Māori			85.1%	84.6%			83.1%
Pacific			85.8%	80.3%			79.5%
Asian			85.8%	83.5%			82.4%
NM/NP/NA*			84.8%	84.5%			84.0%
Northern			84.8%	83.5%			83.2%
Te Manawa Taki			83.6%	83.9%			81.5%
Central Ikaroa			85.2%	84.6%			85.7%
Te Waipounamu			86.2%	85.2%			83.8%

Baseline: Estimated actual 85% from 2022/23

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	85.1%	78.5%	82.7%	84.3%	83.5%
Te Manawa Taki	85.5%	75.4%	81.2%	83.7%	83.9%
Central Ikaroa	84.4%	86.8%	87.1%	84.5%	84.6%
Te Waipounamu	81.7%	91.1%	87.5%	85.3%	85.2%
All New Zealand	84.6%	80.3%	83.5%	84.5%	84.2%

*Non-Māori, Non-Pacific, Non-Asian

Performance in this measure has been relatively stable, for all ethnicities other than Pacific over the past 12 months. It has been consistently at or close to 85%. During the 2023/24 year, 84.2% of people received their first treatment within 31 days of a decision to treat. Achievement reached a low point of 78% in January and a high point of 88% during December. This reflects seasonal trends similar to previous years.

There is little variation between groups, which is positive, however treatment times are lower compared to 2022/23 and lowest for Pacific, particularly in the Northern region.

Addressing constraints across the cancer pathway is a focus in all regions with improvement plans in place across districts to improve timeliness to treatment.

Nationally workforce, diagnostics, and access to diagnostic equipment are currently key areas of

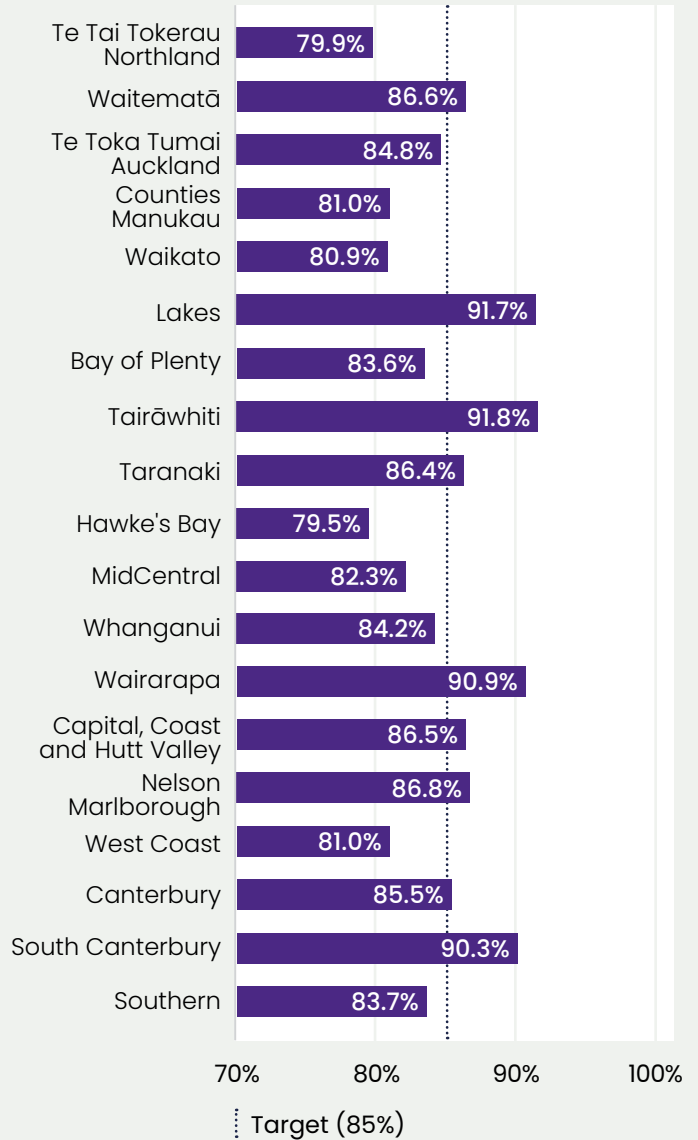
focus for improving our timely cancer service delivery. Initiatives to improve performance include:

- international recruitment for radiation therapists and oncologists
- developing national clinical pathways to facilitate rapid diagnosis of suspected cancer and to eliminate unwarranted variation in the system progressing with the faecal immunochemical test (FIT) for the colonoscopy symptomatic pathway, with implementation commencing in early 2025. The aim of the pathway is to ensure patients are prioritised for treatment appropriately
- developed the internal faster cancer treatment dashboard, which will be enhanced in 2024/25. The dashboard provides visibility of cancer treatment pressures at a local, regional, and national level, acting as a tool for service improvement.

Notes to the measure:

- a) This measure was discontinued in Vote Health Estimates of Appropriations 2023/24. Measure added to enable complete assessment of Health NZ's performance during the year. Target is as previously reported.
- b) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 84.8%, Pacific 86.2%, Asian 85.6%, Non-Māori, non-Pacific, non-Asian 84.7%, Overall 84.9%.
- c) This measure will be replaced by a new health target. The replacement measure will commence from the 2024/25 financial year, with a target of 90%.
- d) The sparkline total shows the results for the final quarter.










District comparison



Ref Measure

P2- 53 Percentage of women, where the diagnosis is cancer who have their initial treatment performed within 31 calendar days of the final decision to treat

Desired trend 

	Target	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	90%	85.5%	85.0%	✘		84.6%
Māori		83.4%	84.6%			83.2%
Pacific		85.7%	79.9%			78.9%
Asian		89.2%	85.1%			83.0%
NM/NP/NA*		85.5%	85.6%			85.7%
Northern		85.8%	84.1%			83.6%
Te Manawa Taki		83.7%	84.2%			81.2%
Central I Ikaroa		85.3%	85.8%			87.3%
Te Waipounamu		87.0%	86.4%			86.4%

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	85.5%	78.2%	85.6%	84.8%	84.1%
Te Manawa Taki	84.7%	68.2%	77.8%	84.8%	84.2%
Central I Ikaroa	84.2%	86.5%	86.5%	86.1%	85.8%
Te Waipounamu	82.6%	94.0%	87.0%	86.6%	86.4%
All New Zealand	84.6%	79.9%	85.1%	85.6%	85.0%

*Non-Māori, Non-Pacific, Non-Asian

Faster cancer treatment (FCT) performance for women has been relatively stable during the year, sitting close to the old target of 85% but below the new target of 90%. The result during 2023/24 was 85.0%. Performance is similar to 2022/23 (85.5%).

During the year 84.6% of Māori women received treatment within 31 days, which is higher than 2022/23 (83.4%). In 2023/24 79.9% of Pacific Peoples received treatment in 31 days compared to 85.7% in 2022/23.

Notes to the measure:

- a) The sparkline total shows the results for the final quarter.
- b) Target was updated from 85% to 90% in the Estimates 2023/24.





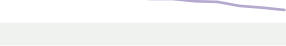




Regional totals show similar or slightly higher results to the general population with Northern achieving 84.1%, Te Manawa Taki 84.2%, Central I Ikaroa 85.8% and Te Waipounamu 86.4%.

There are district plans in place to improve FCT performance where there is underperformance. This includes tumour streams such as breast and gynaecology with actions including pathway improvements to diagnostics and increased access to surgery.

Ref Measure

P2-55 Increase in the percentage of National Bowel Screening programme participants diagnosed with cancer who are referred for pre-operative presentation at a multidisciplinary meeting within 20 working days of diagnosis

Desired trend 

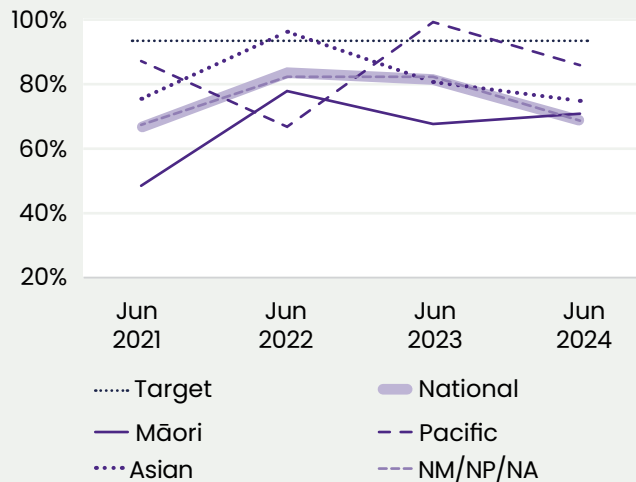
	Target	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 13 months
Overall	95%	83.0%	72.4%	✘	 72.4%
Māori		70.6%	73.2%		 73.2%
Pacific		100.0%	87.5%		 87.5%
Asian		83.0%	77.8%		 77.8%
NM/NP/NA*		84.0%	71.4%		 71.4%
Northern		86.2%	80.4%		 80.4%
Te Manawa Taki		78.1%	54.3%		 54.3%
Central I Ikaroa		82.9%	71.8%		 71.8%
Te Waipounamu		84.9%	79.3%		 79.3%

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	83.3%	100.0%	73.7%	80.8%	80.4%
Te Manawa Taki	68.4%	0.0%	100.0%	50.7%	54.3%
Central I Ikaroa	77.8%	100.0%	50.0%	70.8%	71.8%
Te Waipounamu	71.4%	100.0%	100.0%	78.7%	79.3%
All New Zealand	73.2%	87.5%	77.8%	71.4%	72.4%

*Non-Māori, Non-Pacific, Non-Asian

While there has been a 10.6% reduction in referrals within 20 days from last year, this understates performance as there is no standardised approach across districts. For example, several teams obtain imaging results prior to setting up a meeting. The programme is reviewing this indicator, giving regard to the new multidisciplinary meeting standards published this year. [Cancer Control Agency | Te Aho o Te Kahu – Meeting Standards.](#)

Longer-term trend (rolling 12-month period)



Ref Measure

P2- 56 Decrease the percentage of (elective) cardiac patients who are waiting for treatment beyond 120 days Desired trend

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	25%	25%	21.1%	22.4%	
Māori			13.9%	16.9%	
Pacific			3.7%	23.3%	
Asian			8.3%	20.0%	
NM/NP/NA*			24.8%	24.0%	
Northern			4.5%	8.8%	
Te Manawa Taki			25.0%	27.9%	
Central I Ikaroa			18.5%	29.3%	
Te Waipounamu			39.4%	37.1%	

Baseline: Estimated standard from Supplementary Estimates 2023/24

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	3.6%	10.3%	13.0%	8.8%	8.8%
Te Manawa Taki	27.8%	50.0%	0.0%	27.5%	27.9%
Central I Ikaroa	26.7%	50.0%	50.0%	24.6%	29.3%
Te Waipounamu	25.0%	50.0%	0.1%	37.5%	37.1%
All New Zealand	16.9%	23.3%	20.0%	24.0%	22.4%

*Non-Māori, Non-Pacific, Non-Asian

The percentage waiting beyond 120 days for the 2023/24 financial year is a 1.3% increase. This has fluctuated dependent on a variety of factors, with an increase in the second half of the year.

Over the last six years, nationally cardiac surgery waiting lists have grown beyond a level where they can be managed within a patient’s recommended timeframe. This is a result of increased acute demand displacing elective services, complex presentations overrunning into the next scheduled session, insufficient capacity in Intensive Care Units (ICUs) and wards, a general increase in cardiac

surgery demand, and workforce shortages in theatres, ICUs and wards. Due to many of these pressure points varying each week, districts are unable to continually focus on addressing long-waiting patients.

When possible, a concentrated effort to address patients waiting over 120 days and applying an equity lens across ethnicities continues to be undertaken by the five public hospitals providing cardiac surgery. These are Dunedin Public Hospital, Christchurch Public Hospital, Wellington Regional Hospital, Waikato Hospital and Auckland City Hospital.

Notes to the measure:

- a) Wording change for measure – formerly ‘acute and elective’ but acutes do not wait so have been removed from the measure description.
- b) While this is a new measure and not reported in 2022/23, results for that year have been calculated for comparative purposes.
- c) In the district comparison, Southern region is shown as having 71% of cases beyond 120 days. This was due to delays in data processing and percentage shown at date of printing is 49%.

Ref Measure

P2- Decrease in the rate of diabetes complications
59 for Māori, Pacific, Asian and other people

Desired trend ↓

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	Achieved	2,833	2,833	2,619	✓
Māori			4,030	3,902	
Pacific			5,565	4,248	
NM/NP*			1,953	1,829	

Baseline: Decrease from the 12 months 30 June 2023

*Non-Māori, Non-Pacific

The diabetes complications included in this measure are hospitalisations due to renal failure and amputations. Complications have decreased from last year for all ethnicities. A diabetes clinical network will be established in 2024/25 and will review how this measure is defined and calculated for future years.

Notes to the measure:

- This measure shows the rate of diabetes complications per 100,000 people with diabetes and standardised to WHO population standards.
- This was an iGPS measure and will be reviewed next year once the diabetes clinical network is established. The previous iGPS definition has been used for consistency with previous years.
- While this is a new measure and not reported in 2022/23, results for that year have been calculated for comparative purposes.

Health workforce

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status												
P2-62	Increase in the proportion of Māori and other under-represented groups in the regulated health workforce, compared with the proportion of the total population, in the 12 months prior to 30 June 2022	Achieved	New measure	See below	✓												
<p>Baseline: 30 June 2022, Māori 7.9%, Pacific Peoples 4.0%, proportion of New Zealand population – Māori 17%, Pacific Peoples 9%.</p> <p>There is a year on year increase in the proportion of Māori and Pacific Peoples employed, bringing us closer to the make up of the New Zealand population.</p> <table border="1"> <thead> <tr> <th></th> <th>New Zealand population demographics according to Stats NZ 2023</th> <th>Baseline regulated health workforce demographics as at 2022</th> <th>Regulated health workforce demographics as at 2023*</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>17.0%</td> <td>7.9%</td> <td>8.1%</td> </tr> <tr> <td>Pacific Peoples</td> <td>9.0%</td> <td>4.0%</td> <td>4.1%</td> </tr> </tbody> </table> <p>Notes to the measure:</p> <p>a) While this is a new measure and not reported in 2022/23, results for that year have been calculated for comparative purposes.</p> <p>b) 2023 data has been used for the regulated health workforce demographics as a complete set of workforce demographic data is not currently available for the 2024 year from all Responsible Authorities (registering body). 2024/25 data will be reported in the 2024/25 Annual Report.</p> <p>c) Stats NZ 2023 Census data has been used to provide the proportion of Māori and Pacific Peoples in the total population.</p>							New Zealand population demographics according to Stats NZ 2023	Baseline regulated health workforce demographics as at 2022	Regulated health workforce demographics as at 2023*	Māori	17.0%	7.9%	8.1%	Pacific Peoples	9.0%	4.0%	4.1%
	New Zealand population demographics according to Stats NZ 2023	Baseline regulated health workforce demographics as at 2022	Regulated health workforce demographics as at 2023*														
Māori	17.0%	7.9%	8.1%														
Pacific Peoples	9.0%	4.0%	4.1%														

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status															
P2-63	Increase in proportion of Māori and other under-represented groups in the unregulated health workforce employed by Health NZ – compared with the proportion of the total population, in the 12 months prior to 30 June 2022	Achieved	Māori 17.7% Pacific 11.5%	Māori 16.8% Pacific 11.3%	✗															
<p>Baseline: Māori 17.3%, Pacific Peoples 11.1%, proportion of New Zealand population Māori 17.0%, Pacific Peoples 9.0%</p> <p>While Māori and Pacific Peoples in our Care and Support Occupational Group have decreased as a proportion of our workforce between June 2023 and June 2024, this is being driven by rapid growth in other ethnic groups rather than a decrease in the number of our workforce identifying as Māori and Pacific Peoples.</p> <table border="1"> <thead> <tr> <th></th> <th>New Zealand population demographics according to Stats NZ 2023</th> <th>Unregulated health workforce employed by Health NZ June 2022</th> <th>Unregulated health workforce employed by Health NZ June 2023</th> <th>Unregulated health workforce employed by Health NZ June 2024</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>17.0%</td> <td>17.3%</td> <td>17.7%</td> <td>16.8%</td> </tr> <tr> <td>Pacific Peoples</td> <td>9.0%</td> <td>11.1%</td> <td>11.5%</td> <td>11.3%</td> </tr> </tbody> </table>							New Zealand population demographics according to Stats NZ 2023	Unregulated health workforce employed by Health NZ June 2022	Unregulated health workforce employed by Health NZ June 2023	Unregulated health workforce employed by Health NZ June 2024	Māori	17.0%	17.3%	17.7%	16.8%	Pacific Peoples	9.0%	11.1%	11.5%	11.3%
	New Zealand population demographics according to Stats NZ 2023	Unregulated health workforce employed by Health NZ June 2022	Unregulated health workforce employed by Health NZ June 2023	Unregulated health workforce employed by Health NZ June 2024																
Māori	17.0%	17.3%	17.7%	16.8%																
Pacific Peoples	9.0%	11.1%	11.5%	11.3%																








Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-64	Increase in proportion of Māori and Pacific Peoples in leadership and governance roles in Health NZ, compared with 2022/23	Baseline set	See below	See below	×
<p>As at 30 June 2023 Board members: two of seven identified as Māori. Executive Leadership Team: of 12 members, two identified as Māori and two as Pacific.</p> <p>As at 30 June 2024 Board members: two of eight identified as Māori. Executive Leadership Team: of 15 members, three identified as Māori and two as Pacific.</p> <p>Notes to the measure: a) The results are for Board members and the Executive Leadership Team only. b) There were no changes to ELT between 2022/23 and 2023/24.</p>					

Output Class 4: Mental health and addictions

Mental health and addiction services make a positive difference to people's health and wellbeing by supporting them through mental illness. Some people can get appropriate clinical care through strengthened primary care practices that can provide a comprehensive approach to health and wellbeing.

People with serious mental health illness may need help from specialist inpatient services, followed by support after discharge that enables them to live well in the community. Good quality wraparound mental health services help to reduce future admissions to acute services. They help people with mental health problems maintain relationships, retain jobs and enjoy valued activities.

Progress against our annual output measures

Ref	Measure						
P2-68	People served by specialist MH&A services per 100,000 people (both Health NZ and NGO delivered specialist services)						Desired trend 
	Target	Baseline	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 5 quarters	
Overall	See below		3,467	3,337			3,337
Māori		5,650	5,903	5,762	✗		5,762
Pacific		2,905	2,966	2,839	✗		2,839
Asian			1,183	1,128	✗		1,128
NM/NP/NA*		2,988	3,471	3,366			3,366
Northern			3,254	3,106			3,106
Te Manawa Taki			4,128	3,969			3,969
Central Ikaroa			3,781	3,604			3,604
Te Waipounamu			3,337	3,259			3,259

Target: Improve from baseline (trend to increase)
Baseline: 2021/22.

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	5,942	2,856	1,243	3,484	3,106
Te Manawa Taki	5,950	3,237	973	3,634	3,969
Central Ikaroa	5,797	2,907	1,108	3,443	3,604
Te Waipounamu	6,301	2,799	900	3,198	3,259
All New Zealand	5,762	2,839	1,128	3,366	3,337

*Non-Māori, Non-Pacific, Non-Asian

Health NZ and NGO specialist mental health and addiction (MH&A) services provide assessment, treatment and support for people with moderate to severe mental health and addiction needs. This group requires higher complexity care than those who can receive treatment for these needs in general practice and primary MH&A services.

In the 2023/24 financial year, performance against the measure has decreased slightly but has not changed significantly, and the rate of access per 100,000 has increased from the 2021/22 baseline in line with the target.

Māori had the highest rate of access to specialist MH&A services per 100,000 people, with 1.7 times the rate of access in comparison to Non-Māori, non-Pacific, non-Asian people. The number of people accessing MH&A services per 100,000 decreased from last year at similar rates across all ethnicities, except for Asian where the decrease was the smallest.

In the absence of a recent MH&A prevalence survey, it is not possible to ascertain if the current rates of access to specialist services are at the required level. Further analysis of need is necessary to ascertain the drivers of this measure including an assessment into demand and service delivery models. Largely however it can be expected that access should increase with population growth.

Budget 2022 provided \$100m in funding over 4 years for specialist mental health services to increase the availability and trial new models. The 2023/24 financial year was the second year of the roll-out of this funding. Funding was targeted for areas and services that had the highest need. Services prioritised were Crisis Response Services; Maternal and Infant Mental Health Services; Infant, Child and Adolescent Mental Health Services (ICAMHS); Eating Disorder Services; and Kaupapa Māori Services. In parallel, there continue to be a variety of local initiatives underway in Health NZ districts and NGO services that respond to local needs, including the use of service delivery models that prioritise Kaupapa Māori approaches and support access to services.


There is an international shortage of MH&A clinicians and MH&A services continue to face significant challenges in recruitment and meeting demand due to operating with vacancies. Budget 2022 also rolled out specific funding for workforce development in specialist MH&A services such as trialling the use of Peers Support Specialists within Health NZ multidisciplinary teams and initiatives to upskill, support, and retain (i.e. early career support) Eating Disorder, Maternal Mental Health, and ICAMHS staff. Work over the last year to recruit into vacancies in MH&A services has seen a notable reduction in nursing vacancies. These efforts may have had an impact on recent improvements in this measure in comparison to the 2021/22 baseline.









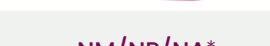
Notes to the measure:

- This measure reports the number of unique persons per 100,000 population under each category. Total count of unique persons per 100,000 population does not equal to the sum of individual categories.
- This measure covers **both** specialist mental health and addiction services.
- There was an error with the results published in the 2022/23 Annual Report; this should have been reported as 3,467 for 2022/23 not 9,095.

Ref Measure

P2- Percentage of child and youth (under 25) accessing
69 mental health services within three weeks of referral

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 8 quarters	
Overall	80%		64.7%	66.7%	×		66.7%
Māori		79%	72.9%	73.3%			73.3%
Pacific		87%	76.4%	77.8%			77.8%
Asian			67.2%	70.5%			70.5%
NM/NP/NA*		68%	59.0%	61.4%			61.4%
Northern			64.6%	66.2%			66.2%
Te Manawa Taki			63.4%	67.9%			67.9%
Central Ikaroa			70.3%	69.2%			69.2%
Te Waipounamu			60.7%	63.9%			63.9%
2023/24			Māori	Pacific	Asian	NM/NP/NA*	All
Northern			71.4%	81.1%	70.8%	58.9%	66.2%
Te Manawa Taki			75.2%	78.6%	70.2%	62.6%	67.9%
Central Ikaroa			75.1%	66.5%	64.6%	66.3%	69.2%
Te Waipounamu			72.7%	67.5%	75.2%	59.7%	63.9%
All New Zealand			73.3%	77.8%	70.5%	61.4%	66.7%

Baseline period: Q4 2021 to Q3 2022

*Non-Māori, Non-Pacific, Non-Asian

This measure includes those under 18 years accessing Specialist Infant, Child and Adolescent Mental Health Services (ICAMHS) due to moderate and severe mental health needs, as well as young people aged between 19-25 years with the same needs who may receive the service in Adult Mental Health Services. The onset of serious mental illness mostly occurs before the age of 25 and, if ineffectively treated, can become a more complex lifelong condition. While this measure represents this wider cohort, it primarily measures and reflects the performance of the ICAMHS sector.

The 2022/23 Health Status Report identified not only increased need in the age group, but also indications of increasing complexity. Demand for MH&A services in this age group has grown significantly following the COVID-19 pandemic but was also high prior. To acknowledge this Health NZ continues to roll out and enhance a wider range of services in schools, universities and Access

and Choice in primary care to intervene early and reduce pressure on specialist services. It is not possible to ascertain the appropriate level of funding for ICAMHS in the absence of recent MH&A prevalence information. Irrespective of this, performance against the measure is extremely challenging, which indicates that the current level of funding and resources in ICAMHS is insufficient.

In the 2023/24 financial year, the percentage of people aged under 25 seen by Specialist Mental Health Services within three weeks of referral was 66.7%. This is a 2% improvement in comparison to the 2022/23 financial year result and the 2021/22 baseline, but short of the 80% target.

Over the last eight quarters since the end of quarter one 2022/23, the trend of the measure showed deterioration against the target from 67.2% in that quarter to as low as 64.1% at the end of quarter two 2023/24. Most recently in quarter four 2023/24, the measure improved by two percentage

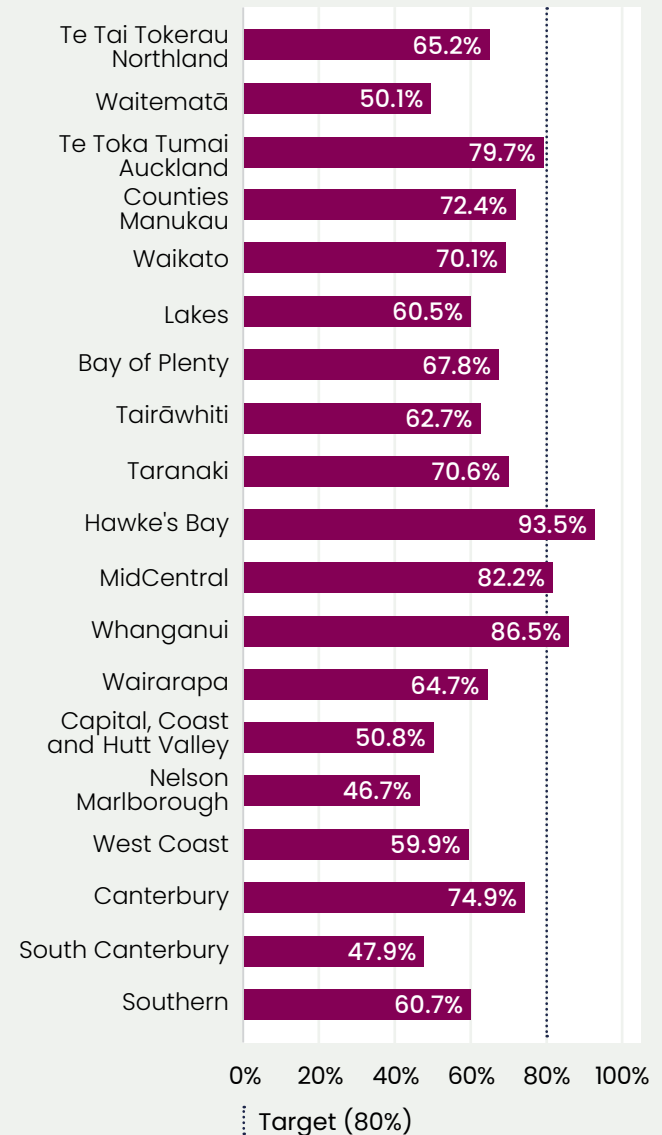
points from quarter three resulting in an overall performance improvement against last year. While a longer-term trend cannot be confirmed this is a noted improvement.

Northern, Te Manawa Taki, and Te Waipounamu all improved performance against last year's results with Te Manawa Taki having a 4.5% improvement, Northern 1.6% and Te Waipounamu 3.2%. The Central I lkaroa region's performance decreased by 1.1% in comparison to last year.

All ethnicities saw improvement in the performance of this measure for their population group. The Non-Māori, non-Pacific, non-Asian cohort is subject to the worst performance against target in 2022/23 and 2023/24 but performance for the group improved by 2.4% this year. Performance for the Pacific cohort is the closest to target at 77.8%.

Infant, Child and Adolescent Mental Health Services (ICAMHS) were prioritised for investment in the Budget 2022 specialist services package, with an investment of \$18.7 million over four years. This investment was mostly focused on increasing the FTE of community-based ICAMHS and trialling new service delivery models. The initial roll-out of the funding over the last two years focused on Northland, MidCentral, and Hawke's Bay – which may in part have supported the performance improvements in the Northern region. At the time of the investment, it was anticipated this would increase ICAMHS access by 1,300 children and young people by the end of 2025/26, however recruitment into these new FTE positions has been an ongoing challenge for ICAMHS. Overall, workforce vacancies in Infant, Child and Adolescent Mental Health Services are the major limiting factor in improving performance in this measure.


District comparison





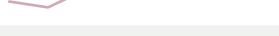


Notes to the measure:

- a) 80% overall and maintain performance for populations exceeding this target.
- b) The results reported for 2022/23 have been updated since the last Annual Report with a change to all ethnicities – Māori 75.5%, Pacific 79.1%, Non- Māori, non-Pacific 63.9%, Overall 68.3%. Note Asian was not reported in 2022/23.

Ref Measure

P2-32 Number of people who have access to Kaupapa Māori, Pacific and Youth Primary Mental Health and Addiction Services through the Access and Choice programme Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	No target	See below	New measure	47,737	Baseline set		11,315
Northern			28,688	23,829			4,964
Te Manawa Taki			4,203	8,065			2,030
Central I Ikaroa			7,471	10,162			2,937
Te Waipounamu			5,197	5,681			1,384

Baseline: Meet annual access level established for 2023/24

Across the Kaupapa Māori, Pacific, and Youth services there has been a 4.8% increase in the number of people who have accessed these services overall.


Kaupapa Māori, Pacific, and Youth services have continued to embed and expand with ongoing recruitment and service development. There are issues with the accuracy and completeness of data across the workstreams. Work is underway to improve the quality and completeness of reporting across the Access and Choice programme.






Notes to the measure:

- a) This is a new measure for 2023/24, however we are able to show previous year's results for comparison.
- b) There are issues of accuracy and completeness of data across the workstreams that prevent a full breakdown of results.
- c) The sparkline total shows the results for the final quarter.

Ref Measure

P2-37 Number of people who have access to primary mental health and addiction services through the Access and Choice programme

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters	
Overall	No target	See below	135,157	159,862	Baseline set		55,114
Northern			49,017	56,959			19,924
Te Manawa Taki			17,054	19,364			6,543
Central I Ikaroa			28,039	31,471			10,251
Te Waipounamu			41,388	52,234			18,408

Baseline: Meet annual access level established for 2023/24

There has been a 15.5% increase in the total number of people who have accessed integrated primary mental health and addiction services (IPMHA) services across the country. There was an increase of at least 11% across all regions.


This coincides with a modest increase in funding levels across the programme in the final year of roll-out, as well as ongoing implementation and promotion of IPMHA services.










Notes to the measure:

- a) This new measure reports the number of unique persons per 100,000 population under each category. Total count of unique persons per 100,000 population does not equal the sum of the individual categories.
- b) There are issues of accuracy and completeness of data across the workstreams – which prevent a full breakdown of results.
- c) The sparkline total shows the results for the final quarter.

Ref Measure

P2-70 Number of people who have accessed services per 100,000 population through the Access and Choice programme

Desired trend 

	Target	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 5 quarters
Overall	No target	3,494	3,934	Baseline set	 3,934
Māori		5,815	6,113		 6,113
Pacific		6,129	6,143		 6,143
Asian		1,628	2,010		 2,010
NM/NP/NA*		3,040	3,626		 3,626
Northern		3,997	4,056		 4,056
Te Manawa Taki		2,059	2,603		 2,603
Central I Ikaroa		3,619	4,192		 4,192
Te Waipounamu		3,834	4,677		 4,677

Target: Expand access (there is no separate access target for these services)

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	8,130	6,458	2,248	3,235	4,056
Te Manawa Taki	3,657	2,135	745	2,481	2,603
Central I Ikaroa	6,812	7,202	1,681	3,570	4,192
Te Waipounamu	6,138	5,258	2,367	4,804	4,677
All New Zealand	6,113	6,143	2,010	3,626	3,934

*Non-Māori, Non-Pacific, Non-Asian

This new measure reports the rate of people accessing primary mental health and addiction services across the Access and Choice programme (Kaupapa Māori, Youth, Pacific and Integrated Primary Mental Health and Addiction services) per 100,000 people. There has been an increase in access to primary mental health and addiction services through the Access and Choice programme across all ethnicities. This reflects the ongoing implementation and promotion of Access and Choice

services and a modest increase in funding levels with the programme in the final year of roll-out.

There are issues with reporting accuracy and data completeness for these services (for example, the number of people seen in groups or whānau settings is not well captured). Work is underway across the Access and Choice programme to improve the quality of reported data, alongside plans to continue to improve access and outcomes.

Notes to the measure:

- a) While this is a new measure and not reported in 2022/23, results for that year have been calculated for comparative purposes.
- b) Change in wording for clarity and consistency with data. Formerly read 'Number of people accessing integrated primary mental health and addiction services per 100,000 people'.

Ref Measure

P2-71 Total number of mental health contacts Desired trend

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters
Overall	See below		4,096,363	4,025,747		1,005,287
Māori		1,242,416	1,321,137	1,311,157	✗	328,930
Pacific		304,963	334,269	331,507	✗	83,648
Asian			231,279	236,700	✗	60,709
NM/NP/NA*		2,538,657	2,209,678	2,146,383		532,000
Northern			1,843,067	1,804,782		452,817
Te Manawa Taki			715,878	700,248		174,751
Central I Ikaroa			767,265	782,187		192,409
Te Waipounamu			757,113	723,424		180,940

Target: Improve from baseline (trend to increase)

Baseline: 2021/22 from SOI

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	569,061	249,589	174,868	811,264	1,804,782
Te Manawa Taki	309,071	16,141	14,797	360,239	700,248
Central I Ikaroa	267,173	44,144	22,960	447,910	782,187
Te Waipounamu	158,611	20,199	23,827	520,787	723,424
Funded for national access	7,241	1,434	248	6,183	15,106
All New Zealand	1,311,157	331,507	236,700	2,146,383	4,025,747

*Non-Māori, Non-Pacific, Non-Asian

People with serious mental health problems may need help from specialist inpatient services, followed by support on discharge that enables them to live well in the community.

In 2023/24 the MH&A system had 4,025,747 contacts – a decrease from the 2022/23 result. Overall this is an increase from the 2021/22 baseline but a decline from the previous year. Contacts include new and existing patients of services.

Non-Māori, Non-Pacific, Non-Asian represent 53% of those contacts, with Māori 33%, Pacific 8%, and Asian 6%. Māori and Pacific had an increase in contacts from baseline, while the number of Non-Māori, Non-Pacific contacts remained largely consistent.


Māori are over-represented in the number of contacts relative to their population size. This is in line with their higher access rates and the well-documented need of Māori for specialist services in comparison to other population groups.










Notes to the measure:

- a) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 1,264,841, Pacific 304,045, Asian 228,038 Non-Māori, non-Pacific, non-Asian 2,173,572, Overall 3,970,496.
- b) Contact is defined as an interaction (face-to-face or non-face-to-face) between tangata whaiora/ consumer and/or family/whānau with a health care organisation that will provide or is providing a service to the tangata whaiora/consumer, or contact between a health care organisation and other agencies.
- c) The sparkline total shows the results for the final quarter.

Ref Measure

P2-72 People served by specialist and NGO mental health services per 100,000 people

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status	Rolling 12-month period for the last 5 quarters
Overall	See below	See note	2,870	2,735	×	 2,735
Māori			4,586	4,421		 4,421
Pacific			2,204	2,065		 2,065
Asian			1,053	998		 998
NM/NP/NA*			2,970	2,858		 2,858
Northern			2,607	2,459		 2,459
Te Manawa Taki			3,465	3,296		 3,296
Central I Ikaroa			3,275	3,076		 3,076
Te Waipounamu			2,750	2,685		 2,685

Target: Improve from baseline (trend to increase)

Baseline: We are using the 2022/23 results as the baseline

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	4,296	2,000	1,090	2,897	2,459
Te Manawa Taki	4,651	2,541	852	3,152	3,296
Central I Ikaroa	4,748	2,302	998	3,009	3,076
Te Waipounamu	4,889	2,252	825	2,667	2,685
All NZ	4,421	2,065	998	2,858	2,735

*Non-Māori, Non-Pacific, Non-Asian

In the 2023/24 financial year, the number of people accessing specialist Health NZ and NGO Mental Health Services per 100,000 has decreased marginally from 2022/23 but has not changed significantly overall.

Notes to the measure:

- This measure reports the number of unique persons per 100,000 population under each category. Total count of unique persons per 100,000 population does not equal to the sum of individual categories.
- This measures **does not** include addiction services.
- In the SOI, the baseline for this measure is the same as P2-68 (from SPE), which includes both Mental Health and Addiction Services.
- The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 4,424, Pacific 2,115, Non-Māori, non-Pacific 2,556. The total reported in prior year annual report (9,095) should have been 2,870 as this is the number per 100,000.

Ref Measure

P2-137 The number of people accessing support from problem gambling services

Desired trend 

	Target	Baseline	2022/23 Result	2023 Result*	Status
Overall	6,750	6,750	4,401	4,817	✗
Māori			1,316	1,524	
Pacific			737	839	
Asian			711	759	
NM/NP/NA*			1,637	1,695	
Northern			N/A	2,338	
Te Manawa Taki			N/A	582	
Central I Ikaroa			N/A	882	
Te Waipounamu			N/A	995	

Baseline: from 2023/24 Estimates, to increase from 6,750

2023*	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	651	625	575	487	2,338
Te Manawa Taki	287	24	24	247	582
Central I Ikaroa	371	155	31	325	882
Te Waipounamu	211	32	129	623	995
Anonymous	4	3	–	13	20
All New Zealand	1,524	839	759	1,695	4,817


*Non-Māori, Non-Pacific, Non-Asian

Notes to the measure:

- Figures for 2023 cover the calendar year, whereas prior figures covered the annual periods (1 July – 30 June). Data for the 2023/24 period is not comparable to prior equivalent periods due to a significant procurement process in 2023 having caused disruption in service delivery from late 2023 calendar year. This disruption reduced the overall volume of activity in late 2024. In addition, post 1 January 2024, some of the new providers were unable to submit data due to not being able to implement the legacy database application used to collect and submit this data.
- Users of this service can be anonymous so may not have a Territorial Local Authority recorded.

Ref Measure

P2-138 The number of brief only interventions delivered

Desired trend 

	Target*	Baseline	2022/23 Result	2023 Result	Status
Overall	6,000	6,000	8,782	8,790	✓
Māori			3,131	3,533	
Pacific			1,767	1,440	
Asian			1,059	1,069	
NM/NP/NA**			2,925	2,748	
Northern			N/A	3,454	
Te Manawa Taki			N/A	1,582	
Central I Ikaroa			N/A	2,103	
Te Waipounamu			N/A	1,261	

2023	Māori	Pacific	Asian	NM/NP/NA**	All
Northern	1,223	809	695	727	3,454
Te Manawa Taki	979	124	40	439	1,582
Central I Ikaroa	874	344	141	744	2,103
Te Waipounamu	289	61	170	741	1,261
Anonymous	168	102	23	97	390
All New Zealand	3,533	1,440	1,069	2,748	8,790

Baseline: Using estimated actuals of 6,000 as the baseline as per Estimates 2023/24

*Target of 6,000 is sessions, not count of people

**Non-Māori, Non-Pacific, Non-Asian.

Brief intervention is a specialised intervention focused on engaging with people at risk of gambling harm and assisting them to recognise any negative effects of their own or another's gambling behaviour. When combined with an appropriately targeted motivational discussion, recognition and awareness-raising can encourage

people experiencing harm from gambling to make changes, even if they never seek formal gambling harm treatment support. 'Brief' interventions are specialised and focused interventions to motivate change, as distinguished from other 'short' interventions that do not take much time.

Notes to the measure:

- See disclosure in P2-137 above regarding the change in providers and non-submission of data.
- Users of this service can be anonymous so may not have a Territorial Local Authority recorded.

Output Class 5: Capital programmes

Capital expenditure is for the construction and refurbishment of health facilities, procurement, upgrade and implementation of information solutions, and the procurement and upgrade of equipment.

When infrastructure is well designed and planned, capital funding is optimally allocated and projects are delivered well, and we then achieve more effective and efficient delivery of health services.

Progress against our annual output measures

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-76	Progress the approved capital infrastructure projects that are underway, taking all practicable measures to ensure that project milestones are met and anticipated benefits realised, within budget	No target	Milestone report	Milestone report	—
<p>Baseline: Milestone report</p> <p>As at 30 June 2024, there were 68 inflight major projects (Health Capital Envelope funded projects and those over \$10M) worth a total of \$6.3 billion currently progressing through the design and construction phases of delivery. We have delivered 42 major projects in the last 12 months. Of our major projects portfolio, 26% are currently rated as Red, and require business case, scope or budget approval. A milestone report has been provided.</p> <p>Through the establishment of our national Infrastructure Investment Group functions, we continue to enhance the quality and practice of investment planning, delivery, management and reporting to address legacy issues with our inflight infrastructure project portfolio.</p> <p>Notes to the measure:</p> <p>a) There is a small wording change – ‘Progress’ is shown here rather than ‘Deliver’ in the SOI to better reflect the long-term nature of these projects.</p>					

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-77	Deliver the approved digital capital projects in line with Business Cases	No target	Milestone report	Milestone report	✓
<p>Baseline: Milestone report</p> <p>We operate a large portfolio of capital projects, many approved prior to Health NZ being formed, that are delivered by multiple teams. A single Programme Management Office system was only formed in April 2024 and controls and reporting are now being standardised. Projects that are outside of approved tolerances are being actively reviewed and corrective action taken.</p> <p>Overall delivery of major capital projects in line with their respective business cases is progressing as planned for the most part. For the 10 most significant projects or programmes currently underway (based on overall implementation value) none have a red status, and the balance are currently indicating an overall RAG status of green or amber.</p> <p>Resource constraints remain a challenge, particularly through the current period of change. While the market appears to be beginning to shift, specialist skills remain scarce and attract a premium. Major reductions in Crown appropriations and baseline funding have already impacted delivery and this will remain for the coming financial year.</p> <p>Notes to the measure:</p> <p>a) We are providing a result of 'achieved' where key project milestones have been achieved. There are no further milestone reports that can be referenced.</p>					

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-78	Develop and implement a national plan to create consistency in data and digital capability across Health NZ	Milestone report	Milestone report	Achieved	✓
<p>Baseline: Milestone report</p> <p>We have developed a national plan to create consistency in capability with a focus on simplifying and standardising the current legacy environment and moving towards fewer, better, national platforms. Priorities include clearing the inherited work programme and refocusing spend on national priorities.</p> <p>The move to Digital Modernisation is no longer possible and we are preparing our future work programme to reflect funding constraints. This means we will continue to operate with more expensive and risky legacy IT arrangements for longer, and the focus shifts to 'keeping the lights on', while we build the broader 10-year Investment Case.</p> <p>Notes to the measure:</p> <p>a) We are providing a result of 'achieved' where key project milestones have been achieved. There are no further milestone reports that can be referenced.</p>					

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-81	Deliver a national asset management plan and capital investment strategy and investment plan by 2023	No target	Milestone report	See footnote b	✓

Baseline: Milestone report

The Infrastructure Investment Plan and the National Asset Management Strategy were approved by Health NZ's board in November 2023 and provided to the Minister of Health in December 2023 for feedback. The Infrastructure Investment Plan is being updated to reflect the health targets and additional modelling scenarios; and the National Asset Management Strategy is being updated to reflect Health NZ's current fiscal position and what can be achieved to lift our asset management maturity. We expect both revised documents to be considered by the Minister of Health and then submitted to Cabinet by the end of 2024. A milestone report has been provided.

Notes to the measure:

- a) This measure is from the Statement of Intent 2022-2024. It is similar to a measure in the Estimates of Appropriations 2023/24 'Develop an Investment Strategy and National Asset Management Strategy by 31 December 2023'.
- b) We are providing a result of 'achieved' where key project milestones have been achieved. There are no further milestone reports that can be referenced.










Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-87	The extent to which actual benefits meet the expected benefits from those capital investments as set out in the relevant business case	80%	Achieved	No results available	—

Capital investments made by Health NZ have a variety of drivers and business cases which articulate the key benefits arising from implementing the investments. A milestone report has been provided. We are currently unable to quantify the percentage of benefits achieved as we have inherited a number of projects with business cases that either have not quantified their benefits, or are unable to be measured as they relate to service delivery. Improving the identification of benefits and how they are reported on project closure is a key priority, and is being incorporated into both the investment stage and the delivery stage of projects moving forward.

Ref Measure

P2-88 Increased proportion of medical appointments completed through digital channels, as compared with 2021/22 baseline measure

Desired trend 

	Target	2021/22 Baseline	2022/23 Result	2023/24 Result	Status	Quarterly for the last 8 quarters
Overall	Achieved	7.0%	6.6%	6.7%	✘	 7.0%
Māori			6.0%	6.3%		 6.5%
Pacific			5.1%	4.9%		 5.2%
Asian			7.1%	6.5%		 6.5%
NM/NP/NA*			6.9%	7.1%		 7.4%
Northern			6.4%	5.7%		 5.7%
Te Manawa Taki			5.2%	5.9%		 6.1%
Central I Ikaroa			6.8%	6.7%		 6.8%
Te Waipounamu			8.4%	9.7%		 10.5%

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	4.8%	4.5%	6.4%	6.2%	5.7%
Te Manawa Taki	6.3%	4.2%	5.4%	5.8%	5.9%
Central I Ikaroa	6.8%	5.0%	5.8%	7.0%	6.7%
Te Waipounamu	10.6%	9.9%	9.1%	9.6%	9.7%
All New Zealand	6.3%	4.9%	6.5%	7.1%	6.7%

*Non-Māori, Non-Pacific, Non-Asian

The number of appointments delivered by digital channels remained relatively static compared with the previous year. Medical appointments through digital channels are lower for Pacific Peoples than other ethnic groups.

Te Waipounamu has the highest proportion of medical appointments through digital channels compared to other regions.

Each district is to include increasing delivery of care through virtual and telehealth modes that

will be monitored through regional and national performance frameworks. The goal is for each district to deliver at least 10% of care through digital channels by quarter four 2024/25.

This is a particular area of opportunity in regions where there is a larger rural population such as Te Waipounamu and Te Manawa Taki. It is an important step in bringing care closer to home, delivered in a way that works better for our communities.

Notes to the measure:

- a) While this is a new measure and not reported in 2022/23, results for that year have been calculated for comparative purposes.
- b) The sparkline total shows the results for the final quarter.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-90	Hospital redevelopment project meets project milestones	90%	46%	Milestone report	—

Infrastructure project delivery schedules are in the Statement of Performance Expectations and reported separately. There are two New Dunedin Projects currently being delivered – the Inpatients Building and the Outpatients Building. The Outpatients Building remains on-track for delivery by the end of 2026. The New Dunedin Hospital Inpatients Building has faced cost pressures and will be providing options for Cabinet to consider in FY 2024/25.

Notes to the measure:

- These major milestones will be confirmed through the Infrastructure Investment Plan. For the Hospital Redevelopment Programme major milestones are expected to come into play from July 2024.
- This measure was published in the Vote Health – Estimates of Appropriations 2022/23.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-91	Remediate all current employees for each Health NZ region, and the New Zealand Blood and Organs Service, within agreed timelines	Completed by 30 June 2024	New measure	Not Achieved	✗

As at 30 June 2024, only current employees in the Auckland metro area have received remediation payments. This is due to the ongoing complexity of configuring payroll systems to calculate and pay entitlements correctly. Delays in remediation are being communicated to staff, and all districts now have rectification and remediation dates associated with them. We expect all payments to current employees to be completed by the end of FY2025.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-92	Establish a national portal to facilitate the identification and remediation of former – Health NZ and New Zealand Blood and Organ Service employees, and commence the remediation payments process for former employees by 31 December 2023	Achieved	New measure	Achieved	✓

A portal for former employees went live on 9 November 2023 and now has over 80,000 registrations.

Delays in payments to former employees are connected to delays in configuration and implementation of payments to existing employees, this is now expected to occur in 2025.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-139	Health New Zealand makes progress towards establishing itself and operating with appropriate infrastructure	Achieved	New measure	Achieved	✓
<p>Health NZ was provided \$10.8M of capital funding for the Hira Programme Tranche 1 to establish the foundations for health information to be joined up across settings nationally. It delivered core interoperability components, and key building blocks for future digital health services were put in place.</p> <p>Key achievements included the delivery of an interoperability platform; launch of My Health Record, the Digital Services Hub, and the National Events Management Service; enhancements to My Health Account; the development of API standards; work on the NZ Patient Summary; and support for the NZ Health Terminology Service. The Hira Tranche 1 is expected to provide substantive service potential to Health NZ to reach the goal of allowing people access, use and appropriate sharing of their health information.</p> <p>Notes to the measure:</p> <p>a) This measure relates to Departmental capital previously under the Ministry of Health.</p> <p>b) The only funding associated with this measure in 2023/24 was the Hira Programme capital funding. All other Capital funding is in the Health Capital Envelope (HCE).</p>					

Procurement, supply chain and health technology management

Procurement, supply chain and health technology management services support frontline staff to care for their patients and whānau, regardless of

geographical location, helping to reduce inequitable health outcomes and unmet health needs.

We have a national function, which means we are better placed to reduce unwanted variations that lead to inefficiencies.

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-82	Deliver the information solution strategy, requirements and road map for procurement and supply chain	Milestone report	Milestone report	On track	✓
<p>We have developed our information strategy and identified key initiatives for its implementation, including technology upgrades and process improvements. Requirements for delivery will be prioritised based on impact and feasibility.</p>					

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-83	Establish the centre-led, nationally, regionally, and locally delivered procurement and supply chain function building on the existing operations	Milestone report	Milestone report	Milestone report	✗
<p>We established and implemented the structure for a national procurement and supply chain function. Health technology management was added to the existing procurement and supply chain functions to form procurement, supply chain and health technology management. The structure change is not complete and further consultation is required to finalise this.</p>					

Asset management

Measuring the actual performance of our critical assets against our expected performance measures helps identify and manage both asset and service-related risks. Knowing our assets and their performance enables us to more effectively plan and implement the steps needed to meet continued growth in demand for our general and specialist health care services.

Some of our assets are of strategic importance to New Zealand as they provide national specialist health services for the country, for example: cancer services, organ donation and transplants, Starship Children's Hospital, plastic surgery, burns units and spinal units.

Asset performance

Asset levels of service, measures and targets for condition, fitness for purpose and use are required to enable asset performance reporting.

This is a large and complex task and we have yet to complete the national baseline assessments of condition that will enable complete asset performance reporting as at 30 June 2025.

As we mature our asset management processes and systems, more asset performance indicators will be added to include fitness for purpose and use. It is important that the evidence supporting performance indicators is robust and auditable, to promote transparency of how the health estate is performing.

Asset performance measures

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-85	Health NZ is seen as a high-quality asset manager for the health estate as measured by the Asset Management Maturity index for the health portfolio	40-60%	32%	38-40%	✗
<p>Some workstreams required to lift the asset management maturity have commenced with the Asset Management Information System (AMIS) business case being developed, with expected implementation in FY2024/2025.</p> <p>A National Asset Policy is being finalised for Commissioner approval.</p> <p>Notes to the measure:</p> <p>a) The AMIS business case has since been approved.</p>					
Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-86	Health NZ provides an annual update to the ministers of Health and Finance on the improvement programme's enhancement of the asset and investment management framework	Achieved	Achieved	Achieved	✓
<p>The first annual report on the improvement programme's enhancement of the asset and investment management framework was provided to Joint Ministers in July 2023.</p>					

Output Class 6: Hauora Māori

Hauora Māori services are a mix of services, including kaupapa Māori, that have been developed to improve Māori health outcomes and reduce health inequities.

All Hauora Māori non-financial performance measures are reported in Te Aka Whai Ora annual report for 2023/24. <https://www.tewhatauora.govt.nz/publications/te-aka-whai-ora-maori-health-authority-te-purongo-a-tau-annual-report-2023-2024>

Entity wide performance measures

Engaging with consumers and whānau

The following measures relate to consumer surveys undertaken by the Health Quality and Safety Commission. These relate to the primary and community and hospital and specialist

services output classes but are placed here to enable readers to gain an appreciation of our performance in meeting the expectations of consumers and whānau. Further details on engaging with consumers and whānau, and meeting the code of expectations can be found in Section 2 – Page 45.

Ref Measure

P2-21 Increase in percentage of Māori, Pacific, Asian and other people who say they receive care from a GP or nurse when they need it

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	Achieved		76.4%	76.7%	
Māori	73%	73%	71.0%	71.8%	×
Pacific	77%	77%	73.2%	74.9%	×
Asian	80%	80%	76.8%	78.9%	×
NM/NP/NA*			77.5%	77.3%	
Northern			76.2%	77.2%	
Te Manawa Taki			74.8%	74.8%	
Central I Ikaroa			74.3%	74.2%	
Te Waipounamu			79.5%	79.2%	

Target: Improve from baseline (trend to increase)

Baseline: Q4 2021 – Q3 2022

*Non-Māori, Non-Pacific, Non-Asian

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	71.7%	74.9%	80.0%	77.7%	77.2%
Te Manawa Taki	72.9%	74.8%	75.2%	75.3%	74.8%
Central I Ikaroa	69.6%	73.1%	72.9%	75.3%	74.2%
Te Waipounamu	73.0%	77.9%	80.9%	79.7%	79.2%
All New Zealand	71.8%	74.9%	78.9%	77.3%	76.7%

*Non-Māori, Non-Pacific, Non-Asian

Māori and Pacific Peoples have slightly lower perceptions of access compared to Non-Māori, non-Pacific, non-Asian, but the trend is similar for these groups to the total population over time and the result remains below baseline. This fits with other

measures showing constrained access to general practice across New Zealand. Work is underway to address the issues through the Primary Care Development Programme.

Notes to the measure:

- There has been a change of methodology for the calculation of this measure based on all the surveys conducted in the 2023/24 financial year. For 2022/23 this was based on the result of the May 2023 survey. Amended results for 2022/23 are shown above.
- The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 72.4%, Pacific 73.8%, Asian 76.1%, Non-Māori, non-Pacific, non-Asian 78.5%, Overall 77.3%.
- Further details on the survey methodology can be found at: www.hqsc.govt.nz/our-data/patient-reported-measures.

Ref Measure

P2- Increase in percentage of Māori, Pacific, Asian, and other people who say
20 they feel involved in their own care and treatment with their GP or nurse

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	See below		86.1%	89.8%	
Māori		84%	85.3%	88.3%	✓
Pacific		84%	85.1%	88.7%	✓
Asian			84.4%	89.4%	
NM/NP/NA*		86%	86.6%	90.2%	✓
Northern			86.6%	89.9%	
Te Manawa Taki			86.0%	89.7%	
Central I Ikaroa			84.9%	89.2%	
Te Waipounamu			86.5%	90.1%	

Target: Target changed to at least 86% in Supplementary Estimates 2023/24

Baseline: Q4 2021 – Q3 2022

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	88.1%	88.5%	89.7%	90.7%	89.9%
Te Manawa Taki	89.3%	89.6%	89.4%	89.9%	89.7%
Central I Ikaroa	86.9%	88.6%	89.7%	89.7%	89.2%
Te Waipounamu	88.5%	90.1%	87.9%	90.3%	90.1%
All New Zealand	88.3%	88.7%	89.4%	90.2%	89.8%

*Non-Māori, Non-Pacific, Non-Asian

The results point to high perceptions of involvement by people in their care, continuous improvement over time and some slight variation between some ethnicities and age groups.

Data shows a high rate of involvement by people in their own care with 89.8% of people answering yes. The trend is also positive with a continuous improvement across the period from August 2020 to February 2023.

Notes to the measure:

- The survey question asks whether respondents report they were involved as much as they wanted to be in **decisions about** their care and treatment. Slight editorial changes were made in wording in forecast accountability documents that differ from survey wording, but the prior year result is still directly comparable to 2023/24.
- The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 85.8%, Pacific 85.2%, Asian 89.9%, Non-Māori, non-Pacific, non-Asian 87.2%, Overall 86.7%.
- The Statement of Intent 2022-2024 added Disabled people (with baseline of 84%) as an additional population group. HSQC is currently unable to provide weighted data for this group to allow comparison.
- Wording for this measure was changed from Percentage of people who say they felt involved in their own care and treatment with their GP or nurse in the Supplementary Estimates 2023/24.

Māori and Pacific Peoples have slightly lower perceptions of involvement compared to Non-Māori, non-Pacific, non-Asian, but the trend remained positive over time for Māori and Pacific Peoples in line with the total population result.

Over the life course as people age, they are more likely to say yes in terms of involvement in their own care.

Survey size, response rate, and confidence interval

Approximately 205,000 – 225,000 patients are invited to participate in the Adult primary care survey each survey wave. Below is table detailing the response rate and the number of responses for the last four survey waves.

The 'Response included' column shows the total number of respondents for the QPC_access question. The 'Response rate' column shows the percentage of total invited respondents (210,000) who answered the QPC_access question. Unweighted results were used here because whole numbers make more sense.

	Response included (for survey)	Response rate	Confidence interval (for relevant question)
Q1 2023/24 August 2023	35,440	16.87%	+/- 0.7 percentage points
Q2 2023/24 November 2023	24,662	11.74%	+/- 0.8 percentage points
Q3 2023/24 February 2024	31,692	15.09%	+/- 0.3 percentage points
Q4 2023/24 May 2024	31,690	15.09%	+/- 0.3 percentage points

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-36	Increase the proportion of primary, community, public and population health, and hospital and specialist services within Health NZ that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4	Achieved	New measure	Not Achieved	✗

Baseline: March 2023 – 16 districts reported

As noted below, we cannot provide level of granularity below district level. In September 2023, 16 of 19 districts (84.2%) reported against the Consumer Engagement Quality and Safety Marker (CE QSM).

In March 2024, 13 of 19 districts (68.4%) plus National office reported. Of the 13 districts that did submit in March 2024, those assessing themselves as at level 3 (Involvement) or 4 (Partnership and Shared Leadership) in one or more of the domains were as follows.

- Responsiveness: 5 (down from 10) reported as being at Level 3 and none at Level 4.
- Engagement: 4 (down from 8) reported as being at Level 3 and none at Level 4.
- Experience: 5 (down from 13) reported as being at Level 3 and one at Level 4.

From 2024/25 Health NZ will move to regional and national reporting against the CE QSM. We will leverage opportunities in the new regional structures to improve the understanding of, and compliance with the code of expectations. This will include lifting capability and contributing to continuous improvement, which will be reflected in the CE QSM reporting.

Notes to the measure:

- Survey design currently doesn't align with measure as it only captures a single return from each district – for all services provided from that district. The result cannot be broken down by primary, community, public and population health.
- Another measure (P2-67) relates specifically to reporting against the CE QSM for Hospital and Specialist Services. As it is not possible to report separately for these services at this time, that measure has been removed as it essentially duplicates this one.

Ref Measure

P2-44 Percentage of people in adult inpatient care who responded, who report they were involved as much as they wanted to be in making decisions about their treatment

Desired trend 

	Target	Baseline	2022/23 Result	2023/24 Result	Status
Overall	See below		81.8%	81.5%	
Māori		77.0%	80.4%	80.2%	×
Pacific		77.0%	85.9%	83.8%	×
NM/NP*		78.0%	81.8%	81.7%	×
Asian			88.7%	87.6%	
NM/NP/NA**			81.1%	81.0%	
Northern			81.9%	80.7%	
Te Manawa Taki			79.7%	80.8%	
Central I Ikaroa			82.5%	82.7%	
Te Waipounamu			84.0%	82.4%	

Target: Improve from baseline (trend to increase)

Baseline: 2021/22 FY

2023/24	Māori	Pacific	Asian	NM/NP/NA*	All
Northern	80.7%	82.1%	85.1%	79.2%	80.7%
Te Manawa Taki	80.2%	82.5%	91.6%	80.4%	80.8%
Central I Ikaroa	79.5%	88.4%	89.9%	82.7%	82.7%
Te Waipounamu	80.7%	94.5%	93.8%	81.9%	82.4%
All New Zealand	80.2%	83.8%	87.6%	81.0%	81.5%

*Non-Māori, Non-Pacific

**Non-Māori, Non-Pacific, Non-Asian.

While we have improved from baseline, year on year the trend has not increased for this measure.

This measure indicates how adult inpatients want to be involved in decisions about their care and treatment as a proportion of all patients who responded to the Health Quality and Safety Commission (HQSC) quarterly survey of hospital inpatients. There are subtle fluctuations with variations in responses across the four quarters for this year. National performance is steady showing that our hospital staff continue to actively involve most patients and whānau in decisions about their care and treatment.

When comparing the current reporting period with the previous annual reporting period, a similar pattern emerges. Asian patients and whānau report the highest involvement, while Māori report lower involvement.

While there was a very slight downward trend across all populations for this measure compared with the previous annual reporting period, performance remains higher than the original baseline for all populations measured.

A range of improvement initiatives identified by Iwi Māori Partnership Boards aims to improve the experience for hospitalised Māori patients and whānau but it is too early to see the impact of these initiatives reflected in this annual data.

We have been testing a Talanoa based patient experience tool in some regions to supplement insights from the HQSC quarterly inpatient surveys with more detailed narrative around the experience of Pacific patients and whānau to drive improvements. A staggered national roll-out of this feedback approach is underway.

In quarter four, we established an Advisory Group to support the development of a National Whānau Feedback and Insights Framework with the HQSC and consumer representatives. This aims to improve staff capability around using whānau

voice to inform improvements for all patients, but with a key focus on priority populations including Māori and Pacific Peoples. Over time this should see less variation between different populations, around involvement in health care decision-making.

Notes to the measure:

- a) The results reported for 2022/23 have been updated since the last Annual Report with a change for all ethnicities – Māori 82.8%, Pacific 84.8%, Asian 90.9%, Non-Māori, non-Pacific, non-Asian 82.0%, Overall 82.9%.
- b) The Statement of Performance Expectations 2023–2024 added Disabled people (with baseline of 71%) as an additional population group. HSQC is currently unable to provide weighted data for this group to allow comparison.

Disclosures

Disclosure of judgements

Under reporting standard PBE FRS 48, Health NZ is required to disclose the judgements that had the most significant effect on the selection, measurement, aggregation and presentation of our performance information.

Judgements on the selection of performance information

We are tracking our performance using non-financial measures from our Statement of Intent 2022–24, the 2023/24 Statement of Performance Expectations, Vote Health and the Estimates of Appropriations 2023/24 from Budget 2023.

We are focused on creating a performance picture from our founding date, 1 July 2022. If information on measures from previous years can give better context for this year's performance, this has been included.

To further achievement of equity in health outcomes, performance results in this report provide ethnic breakdowns for Māori, Pacific Peoples and the population that is Non-Māori, non-Pacific, aligned with the Statement of Performance Expectations 2023/24. We also signalled our intention to improve the disaggregation of health data to include Asian ethnicities in our first annual report.

We have also aggregated our data to reflect our new structure to provide a regional and national view of our performance. District-level information for 2023/24 is shown for selected 'material' measures.

Some performance measures are descriptive or qualitative, while many are numerical or quantitative in nature. To ensure accessibility and understandability of the data, we present our performance results in text form and in a visual way, often using bar, or line graphs and 'heat maps'. For clarity, we also disclose where there may be gaps or anomalies in the data, in the wording or in other aspects of the recorded measures. If there is no target to report against, we provide a progress update.

Together with a status result, our narratives, disclosures and graphs for each measure provide a complete picture of our performance.

Changes to performance measures

The measures in our first annual report were selected from measures inherited from the Ministry of Health, together with measures from the interim Government Policy Statement on Health 2022/23 and the Interim New Zealand Health Plan Te Pae Tata 2022–24. In setting out our accountability documents for 2023/24, we took the opportunity to review these measures to better portray our current context.

In reviewing these measures against the required characteristics and constraints, we made several changes to improve their appropriateness and meaningfulness. New performance measures, or those with significant changes for 2023/24, are detailed in the relevant notes to the measure.

Discontinued measures after 2022/23 and not included in the 2023/24 report are set out in Appendix 6. In our view, the performance measures selected for 2023/24 adequately inform users of what we achieved during the year and the progress we are making towards achieving our outcomes.

Data collection disclosure

During the year, Health NZ continued to migrate from a data collection system that was managed by the 20 DHBs, with data integrated and reported by the Ministry of Health, to a single, unified system. Data continues to be collected at each treatment site as part of each inpatient, outpatient or community visit.

The Ministry of Health mainly collected data for statistical purposes (monitoring and policy development). We now use it to inform operational decision-making, with more stringent data standards, which can delay data publication.

Hospitals are required to classify diagnoses, injuries, external causes of injuries and procedures on public hospital discharge events, and to report these events to the national minimum dataset in the national collections within 21 days of the end of the month of discharge. Total annual discharges reported to the national minimum dataset are approximately 1.2 million.

Clinical coding is undertaken in our hospitals to support planning of services (capacity), understanding variation (warranted and unwarranted), and support research and policy development. Regions are required to report clinically coded data in a specified format to the national minimum dataset.

Clinical coding is a time intensive process requiring input by trained coders. Staff absences due to vacancies, leave or illness can reduce the availability of coding resources and delay throughput of coded data. This is being addressed through recruitment and training of new coders and investment in new technology to support the coding process.

Our national collections team maintains data integrity and supports high quality reporting. It plays a central role in leadership and direction for national clinical coding – ensuring quality information is available for case mix, research, health service planning, evaluation and funding.

National collections ensure New Zealand is represented in benchmarking and information sharing with international health care organisations and works with the classification providers in the development of clinical classification systems.

The need for data collection uplift and modernisation at source has been identified. Work is underway to identify requirements and to consult and shape up what needs to change. Health NZ will consider the indicative investment costs for proposed solutions.

Surveys disclosure

Some of our performance measures relate to data collected via surveys conducted by the Health Quality and Safety Commission. This is disclosed in the notes to the relevant measures.

The HQSC runs three adult patient experience surveys on primary care, hospital inpatients and hospital outpatients. The surveys cover different aspects of patient experience, including communication, partnership, physical and emotional needs, cultural safety and access to care. It is one of the largest survey programmes in the country.

The surveys invite feedback from people aged 15 and over, and participation is voluntary and anonymous. Feedback is used to help improve the quality of care, patient safety and access to health services, and to benchmark patient experiences across the country.

These surveys are quarterly 'snapshots', with quarter one in August, quarter two in November, quarter three in February and quarter four in May. The quarters commencing August 2023 through to May 2024 are reported in this report.

Attitudes and behaviours are subject to external influences (such as economic conditions and social events) and therefore the results of the relevant performance measures can be affected by factors outside of our control.

Hauora Māori

Prior to being disestablished, Te Aka Whai Ora produced an annual report on its activities and performance for the period up to 31 March 2024. This includes reporting on all non-financial performance measures for the full year through to 30 June 2024.

Reporting on hauora Māori services transferred to Health NZ from 31 March 2024, and financial performance for the period 1 April to 30 June 2024 is covered in this report as part of the Hauora Māori output class. All non-financial measures for 2023/24 have been reported by Te Aka Whai Ora in that entity's annual report.

Interim New Zealand Health Plan | Te Pae Tata 2022-24

The plan outlined the first steps that Health NZ and Te Aka Whai Ora planned to take to better serve all New Zealand's people and communities. Progress on delivering the actions across the six priority outcome areas and to provide accountability for delivering on the expectations of our communities will be published in a supplementary Te Pae Tata Annual Report.

Sustainability disclosure

The carbon emissions quantification provided in these measures is taken from Health NZ's Emissions Inventory Report for 2023–2024. The Emissions Inventory Report contains a complete and accurate quantification of the amount of GHG emissions and removals that can be directly attributed to the organisation's operations within the declared boundary and scope for the specified reporting period. This report has been prepared in accordance with ISO 14064-1:2018 Specification with Guidance at the Organization Level for Quantification and Reporting of Greenhouse Gas Emissions and Removals and the Greenhouse Gas Protocol: A Corporate Accounting and Reporting Standard (2004)^a. Where relevant, the inventory reporting aligns with industry or sector emissions measurement and reporting practices.

Noting the above, we acknowledge that there is inherent uncertainty because the scientific knowledge and methodologies to determine the emissions factors and processes to calculate and estimate quantities of GHG sources are still evolving, as are GHG reporting and assurance standards.

Greenhouse gas emissions

Health NZ is in the process of finalising its first organisation-wide detailed Emissions Reduction Plan (ERP) in line with the Carbon Neutral Government Programme direction. This is due to be submitted to the Ministry for the Environment at end of 2024 and published in 2025. Future plans are likely to set emissions reduction targets beyond 2024/25.

Budget significant initiatives disclosure

From 2023, departments and Crown entities like Health NZ are required to report on significant Budget initiatives. This supports the focus on increased transparency for annual reporting and helps the public understand the outcome of those significant investments.

Since our establishment on 1 July 2022, additional appropriations through Budget 2023 have resulted in a total revenue increase from \$22.2 billion^b in 2022/23 to \$23.5 billion^c in 2023/24. The additional output expenses are within our existing reportable class of outputs and associated performance measures presented.

A summary of significant Budget initiatives can be found in Appendix 4.

- a) Throughout this document 'GHG Protocol' refers to the GHG Protocol Corporate Accounting and Reporting Standard and 'ISO 14064-1:2018' means the international standard Specification with Guidance at the Organizational Level for Quantification and Reporting of Greenhouse Gas Emissions and Removals.
- b) As reported in the 2022/23 annual report.
- c) As reported in the 2023/34 annual report.

Section 5

Financial Statements



Statement of Responsibility

We are responsible for the preparation of the Health New Zealand | Te Whatu Ora (Health NZ) group financial statements and statement of performance and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Health NZ group under section 19A of the Public Finance Act 1989, whether or not that information is included in the annual report.

From the date of the appointment of the Commissioner to replace the Board of Health NZ, we are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting. Before that date, the Board of Health NZ had that responsibility.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Health NZ group as at 30 June 2024.

On behalf of the Commissioner and Deputy Commissioners

Signed by:



Professor Dr Lester Levy
Commissioner
Health NZ | Te Whatu Ora
Dated: 14 November 2024



Roger Jarrold
Deputy Commissioner
Health NZ | Te Whatu Ora
Dated: 14 November 2024

Statement of comprehensive revenue and expense for the year ended 30 June 2024

	Notes	Group		
		Actual 2024 \$m	Budget 2024 \$m	Actual 2023 \$m
Revenue				
Crown funding (from the MoH)	2	23,483	23,193	22,180
Other funding from the Crown/Crown Entities	2	2,988	2,422	2,963
Interest revenue		159	159	90
Other revenue	2	550	346	457
Total revenue		27,180	26,120	25,690
Expenditure				
Personnel costs	3	11,742	10,945	11,327
Outsourced personnel		538	281	490
Outsourced services		846	968	889
Clinical supplies		2,486	1,949	2,533
Depreciation and amortisation costs	12, 13	846	809	737
External service providers		9,189	9,045	8,546
Capital charge	4	470	447	424
Interest expense		7	8	7
Infrastructure, non-clinical supplies and other	5	1,778	1,668	1,750
Total expenditure		27,902	26,120	26,703
Surplus/(Deficit)	25	(722)	-	(1,013)
Other comprehensive revenue and expense				
Gain/(Loss) on property revaluations	12	-	-	1,091
Total other comprehensive revenue and expense		-	-	1,091
Total comprehensive revenue and expense		(722)	-	78

The budget figures included in these financial statements are from the Statement of Performance Expectations (dated 23 June 2023) although reclassification of certain revenue and expense line items has been required to align to Health NZ standard reporting format. Comparison of the actual financial result has been performed against the reclassified budget.

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2024

	Notes	Group		
		Actual 2024 \$m	Budget 2024 \$m	Actual 2023 \$m
Balance at 1 July	24	9,313	9,276	8,567
Capital contributions from the Crown	19	957	1,208	686
Capital contributions returned to the Crown	19	(12)	-	(12)
Net assets transferred on amalgamation of Māori Health Authority	27	77	-	-
Adjustments for capital contributions accrued		-	-	(7)
Movements in trust and special funds		3	-	1
Movements in minority interests		(4)	-	-
		10,334	10,484	9,235
Comprehensive Income				
Surplus/(Deficit) for the year		(722)	-	(1,013)
Other comprehensive revenue and expense				
Gain/(Loss) on property revaluations	12	-	-	1,091
Total comprehensive revenue and expense for the year		(722)	-	78
Balance at 30 June	19	9,612	10,484	9,313

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2024

	Notes	Group		
		Actual 2024 \$m	Budget 2024 \$m	Actual 2023 \$m
Assets				
Current assets				
Cash and cash equivalents	6	840	1,869	2,019
Receivables	7	409	917	566
Prepayments		105	190	94
Investments	8	393	-	53
Inventories	9	184	590	382
Assets held for sale	10	5	-	13
Total current assets		1,936	3,566	3,127
Non-current assets				
Prepayments		6	19	6
Investments	8	121	118	113
Investments in associates and joint ventures	11	3	644	7
Property, plant and equipment	12	13,782	13,794	13,109
Intangible assets	13	539	262	429
Total non-current assets		14,451	14,837	13,664
Total assets		16,387	18,403	16,791
Liabilities				
Current liabilities				
Payables and deferred revenue	14	2,027	3,202	1,857
Borrowings	15	11	-	28
Employee entitlements	16	4,250	4,314	5,072
Provisions	18	85	-	134
Total current liabilities		6,373	7,516	7,091
Non-current liabilities				
Borrowings	15	97	81	82
Employee entitlements	16	300	289	296
Restricted funds	17	2	30	1
Provisions	18	3	3	8
Total non-current liabilities		402	403	387
Total liabilities		6,775	7,919	7,478
Net assets		9,612	10,484	9,313
Equity				
Crown equity	19	4,102	4,401	3,080
Accumulated surpluses/(deficits)		(1,735)	-	(1,013)
Revaluation Reserves		7,175	6,079	7,175
Trust and special funds		67	-	64
Minority interests		3	4	7
Total equity		9,612	10,484	9,313

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2024

	Notes	Group		
		Actual 2024 \$m	Budget 2024 \$m	Actual 2023 \$m
Cash flows from operating activities				
Funding from the Crown/Crown Entities		26,493	25,615	25,574
Interest received		161	150	112
Other revenue		643	355	426
Payments to employees		(12,521)	(11,153)	(10,122)
Payments to suppliers		(14,685)	(14,180)	(13,577)
Capital charge		(470)	(455)	(424)
Interest paid		(6)	-	(7)
GST (net)		85	19	(67)
Net cash flows from operating activities		(300)	351	1,915
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		18	-	2
Receipts from sale or maturity of investments		1,886	-	568
Investment in restricted and trust funds		(3)	-	-
Funds placed on short term deposit >3months		(2,222)	-	(601)
Purchase of Property, Plant and Equipment		(1,445)	(2,117)	(1,115)
Purchase of Intangible assets		(185)	-	(110)
Net cash flows from investing activities		(1,951)	(2,117)	(1,256)
Cash flows from financing activities				
Capital contributions from the Crown	19	957	1,208	686
Capital contributions returned to the Crown	19	(12)	-	(12)
Private sector debt repaid		(10)	-	-
Net cash flows from financing activities		935	1,208	674
Net (decrease)/increase in cash and cash equivalents				
Cash and cash equivalents at the start of the year		2,019	2,427	686
Cash transferred in on amalgamation of the Māori Health Authority	27	137	-	-
Cash and cash equivalents at the end of the year	6	840	1,869	2,019

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2024 (continued)

Reconciliation of reported operating surplus/(deficit) with net cash inflow/(outflow) from operating activities

	Notes	Group	
		Actual 2024 \$m	Actual 2023 \$m
Reported Net Surplus/(Deficit) for the Year		(722)	(1,013)
Add Non-Cash Items:			
Depreciation and amortisation expense	12, 13	846	737
Total non-cash items		846	737
Add Items Classified as Investing Activities:			
(Gain)/loss on disposal of property, plant and equipment		(5)	(1)
(Gain)/loss on Investments in Associates		4	-
Total items classified as investing or financing activities		(1)	(1)
Add Movements in Statement of Financial Position Items:			
Decrease in Receivables		157	1,012
Decrease/(increase) in Prepayments		(11)	87
Decrease in Inventories		198	187
Increase/(decrease) in Payables and Deferred Revenue		105	(288)
Increase/(decrease) in Provisions		(62)	124
Increase/(decrease) in Employee Entitlements		(810)	1,070
Net movements in working capital items		(423)	2,192
Net Cash Inflow/(Outflow) from Operating Activities		(300)	1,915

The accompanying notes form part of these financial statements.

Notes to the financial statements

1 Statement of accounting policies for the year ended 30 June 2024

REPORTING ENTITY

Health New Zealand (Health NZ) is a Crown entity as defined by the Crown Entities Act 2004 (CEA) and is domiciled and operates in New Zealand. The relevant legislation governing Health NZ's operations is the CEA and the Pae Ora (Healthy Futures) Act 2022 (the Act). Health NZ's ultimate parent is the New Zealand Crown.

The consolidated financial statements of Health NZ for the year ended 30 June 2024 comprise Health NZ (the parent entity) and its subsidiaries (**Note 11**), together referred to as the "group". Its interests in associates and joint ventures (**Note 11**) are equity-accounted for in the group financial statements. Health NZ's subsidiaries, associates and joint ventures are incorporated and domiciled in New Zealand.

Health NZ's primary objective is to deliver health, disability, and mental health services to the communities across New Zealand. Health NZ does not operate to make a financial return.

Health NZ is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP) in New Zealand. The financial statements for the Health NZ group are for the year ended 30 June 2024 and were approved for issue by the Commissioner on 14 November 2024.

BASIS OF PREPARATION

Health Sector Reforms

Health NZ was formed on 1 July 2022 from the amalgamation of 20 District Health Boards (DHBs), the Health Promotion Agency, six shared service agencies and some functions of the Ministry of Health, referred to as the "Combining Entities".

On 5 March 2024 the Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024 was passed by the Government. Effective from 1 April 2024, certain functions, assets, liabilities and staff of the Māori Health Authority (MHA) were transferred to Health NZ, with a small number transferred to the Ministry of Health – Manatū Hauora.

Measurement of the Assets and Liabilities on amalgamation

The assets and liabilities of the Combining Entities and MHA were measured at their carrying amount as of the amalgamation date in accordance with the requirements in PBE standards, with adjustments made where required to conform to Health NZ's accounting policies and to eliminate balances between the Combining Entities – refer to **Notes 24 and 27**.

Going Concern:

The financial statements have been prepared on a going concern basis. The Commissioner and Deputy Commissioners, after making enquiries, have a reasonable expectation that Health NZ will have adequate cash resources to continue operations for the foreseeable future. The Commissioner and Deputy Commissioners have reached this conclusion having regard to circumstances which they consider likely to affect Health NZ during the period of one year from the date of signing the 2023/24 financial statements, and to circumstances which they know will occur after that date which could affect the validity of the going concern assumption. The key considerations are set out below:

- The budget for 2024/25 has been reset at a deficit of \$1.1b. This will be updated into the final Statement of Performance Expectations for 2024/25.

1 Statement of accounting policies for the year ended 30 June 2024 (continued)

- The plan for 2025/26 is a deficit of \$200m. The plan for 2026/27 is to bring the overall financial performance of Health NZ within the revised funding levels. The following turnaround activities are being implemented to return Health NZ to a financially sustainable path:
 - A programme with a governance structure has been developed for the three-year savings programme. Savings are planned to be realised from staff redundancies mainly in non-clinical management and admin areas, which will assist in reducing the overhead costs of Health NZ. Savings are also planned from rationalisation of procurement contracts and purchase of services as well as better utilisation of resources, efficiencies and innovation in business processes and systems.
 - A robust process has been completed to inform the 2024/25 capital expenditure budget which was approved by the Commissioner in October 2024. This involved review of the full capital programme carried forward from prior years and new requests for the current year, considering critical risks, capacity (internal and industry wide to implement) and affordability of both capital funding and flow on operational cost impacts. The plan has been nationally prioritized across all portfolios and is to be strictly implemented within the approved funding envelope.
 - Health NZ has reset its operating model to empower regional decision-making and clinical leadership, reduce inefficiencies and remove duplication. This will strengthen financial accountability by devolving the majority of Health NZ's revenue and expenditure to the four regions. This will support more effective prioritisation and responsiveness to regional, district and local needs – within our available funding.
- Health NZ plans to drawdown \$1.1b of Crown equity for Crown funded projects in 2024/25.
- Health NZ is required to settle the Holidays Act remediation liabilities as disclosed in note 16. Until the remediation projects are completed for all components of Health NZ, there remains uncertainty as to the actual amount Health NZ will be required to pay to current and former employees. Crown equity funding amounting to \$1.663b has been appropriated for this in FY 2024/25.
- Health NZ received \$419m Crown equity in September 2024 to reimburse the pay equity settlement costs incurred in 2023/24 related to Allied Health and Midwifery Pay Equity.
- The Crown (Minister of Health and Minister of Finance) has provided a Letter of Comfort to Health NZ acknowledging that Crown equity support may be required, and the Crown will provide such support where necessary, to maintain the viability of Health NZ.

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the CEA which includes the requirement to comply with New Zealand GAAP.

The financial statements have been prepared in accordance with and comply with the PBE Reporting Standards for Tier 1 public benefit entities.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars (NZ dollars) and all values, other than the board and co-opted committee members disclosures in Note 3, are rounded to the nearest million dollars (\$m). The board and co-opted committee members disclosures are rounded to the nearest thousand (\$000).

1 Statement of accounting policies for the year ended 30 June 2024 (continued)

Changes in accounting policies

There have been no changes in the group's accounting policies since the date of the last audited financial statements.

New standards, amendments and interpretations applied

2022 Omnibus Amendments to PBE Standards

The 2022 Omnibus Amendments issued by the External Reporting (XRB) include several general updates and amendments to several Tier 1 Public Benefit Entity (PBE) accounting standards, effective for reporting periods starting 1 January 2023.

They make changes to the following standards that are relevant to Health NZ:

- PBE IPSAS 30 *Financial Instruments: Disclosures*
- PBE IPSAS 13 *Leases*
- PBE IPSAS 21 *Impairment of Non-Cash-Generating Assets and PBE IPSAS 26 Impairment of Cash-Generating Assets*
- PBE IPSAS 22 *Disclosure of Financial Information about the General Government Sector*
- PBE IPSAS 41 *Financial Instruments*
- PBE IPSAS 19 *Provisions, Contingent Liabilities and Contingent Assets*
- PBE IPSAS 19 *Provisions, Contingent Liabilities and Contingent Assets: Application Guidance Changes in Existing Decommissioning, Restoration and Similar Liabilities*
- PBE IPSAS 17 *Property, Plant and Equipment*
- PBE IPSAS 5 *Borrowing Costs*

Health NZ has adopted the revised PBE standards for the year ended 30 June 2024, and the adoption did not result in any significant impact on Health NZ's financial statements.

Standards, amendments, and interpretations issued but not yet effective and not early adopted

2022 Omnibus Amendments to PBE Standards

2022 Omnibus Amendments to PBE Standards makes changes to the following standards that are relevant to Health NZ and are effective for the year ending 30 June 2025:

Disclosure of Fees for Audit Firms' Services (Amendments to PBE IPSAS 1) amends the disclosures for fees relating to services provided by the audit or review provider, including a requirement to disaggregate the fees into specific categories. The amendment will be effective for the year ending 30 June 2025. Early adoption is permitted.

Health NZ has not yet assessed the impact of the new standards or amendments.

1 Statement of accounting policies for the year ended 30 June 2024 (continued)

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

Basis of consolidation

Health NZ consolidates in the group financial statements all entities where Health NZ has the capacity to control financing and operating policies to obtain benefits from the activities of subsidiaries. This power exists where Health NZ controls the majority voting power on the governing body or where financing and operating policies have been irreversibly predetermined by Health NZ.

The group financial statements are prepared by adding like items of assets, liabilities, equity, revenue, expenses, and cash flows of entities in the group on a line-by-line basis. All intra-group balances, transactions, revenue and expenses are eliminated on consolidation.

The group financial statements are prepared using uniform accounting policies for like transactions and other events in similar circumstances. The consolidation of an entity begins from the date Health NZ obtains control of the entity and ceases when Health NZ loses control of the entity.

Foreign currency transactions

Foreign currency transactions are translated into NZ dollars (the functional currency) using the spot exchange rate prevailing at the date of the transaction. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in surplus or deficit.

Patient trust money

Health NZ administers funds on behalf of certain patients, which are held in bank accounts that are separate from Health NZ's normal banking facilities. Interest earned on the funds is allocated to individual patients. Patient fund transactions and balances are not recognised in Health NZ's financial statements.

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue (IR) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IR, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Health NZ is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

1 Statement of accounting policies for the year ended 30 June 2024 (continued)

Budget figures

The 2023/24 budget figures are derived from the Statement of Performance Expectations dated 23 June 2023. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Commissioner and Deputy Commissioners in preparing these financial statements.

Cost allocation

The cost of outputs (as set out on page 94 of the annual report) has been determined using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output. Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged based on asset utilisation. Personnel costs are charged based on actual time incurred. Property and other premises costs, such as maintenance, are charged based on floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

- Classification of Leases – refer to note 15.
- Determining whether Health NZ is a principal or an agent of Pharmac (Pharmaceutical Management Agency) in relation to community pharmaceutical funding and expenditure transactions – as there is no written agreement between Health NZ and Pharmac, judgement has been exercised in assessing which party has exposure to the significant risks and rewards associated with the supply of community pharmaceuticals

Management has reached the view that Health NZ is acting as a principal, and has therefore recognised the funding from Pharmac as revenue and the payment of claims from community pharmacies for their dispensation of funded pharmaceuticals as expenditure based on the following indicators:

- Health NZ is primarily responsible for the supply of pharmaceuticals to community pharmacy service users as set out in the Pae Ora (Healthy Futures) Act 2022, and contracts with community pharmacies across New Zealand to dispense pharmaceuticals.
- The funding that Health NZ receives from Pharmac is reimbursement for Health NZ's expenditure on community pharmaceuticals.

1 Statement of accounting policies for the year ended 30 June 2024 (continued)

Critical accounting estimates and assumptions

The Commissioner and Deputy Commissioners have made estimates and assumptions concerning the future. These estimates and assumptions might differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are in respect of:

- Estimating the fair value of land and buildings – refer to **Note 12**
- Measuring the liabilities for Holidays Act 2003 remediation, long service leave, retirement gratuities, sabbatical leave, and continuing medical education leave – refer to **Note 16**
- Estimated useful life of property, plant and equipment – refer to **Note 12**
- Estimated useful life of intangible assets – refer to **Note 13**
- Provision for expected credit losses – refer to **Note 7**
- Provision for Covid-19 inventory obsolescence – refer to **Note 9**

2 Revenue

Accounting Policy

Crown funding

Health NZ receives annual funding from MoH, which is based on appropriations made from the Treasury as part of Vote Health, to support the health sector.

Crown funding is restricted in its use for the purpose of meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of MoH. Funding is recognised as revenue when it becomes receivable unless there is an obligation in substance to return the funds if conditions are not met. If there is an obligation, the funding is initially recorded as deferred revenue and recognised as revenue when conditions of the funding are satisfied. The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Other funding from Crown/Crown entities

Health NZ receives funding from the Ministry for Disabled People for specific services to support disabled people and from Pharmac to reimburse Health NZ for hospital and community pharmaceutical expenditure.

The Crown funding accounting policy also applies for funding from the Ministry for Disabled People.

Pharmac funding is recognised as revenue when Health NZ is entitled to be reimbursed for the pharmaceutical expenditure, which is when the pharmaceuticals have been dispensed.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided, and any contract conditions have been fulfilled.

Sale of goods

Revenue from goods sold is recognised when Health NZ has transferred to the buyer the significant risks and rewards of ownership of the goods and Health NZ does not retain either, continuing managerial involvement to the degree usually associated with ownership, nor effective control over the goods sold.

Other services rendered

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the receivable associated with the transaction will flow in and that it can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by the service provider.

All services are provided on commercial terms and considered to be exchange transactions.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Rental revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term. Lease incentives granted are recognised as an integral part of the total rental revenue over the lease term.

2 Revenue (continued)

Accounting Policy (Continued)

Donations and bequests

Donated and bequeathed financial assets are recognised as revenue unless there are substantive use or return conditions. A liability is recorded if there are substantive use or return conditions, and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Donated services

Certain operations are reliant on services provided by volunteers. Volunteers' services received are not recognised as revenue or expenditure by Health NZ as their value cannot be readily determined.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the entity obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Grants revenue

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Research revenue

For an exchange research contract, revenue is recognised on a percentage completion basis when the conditions of the contracts have been met. The percentage of completion is measured by reference to the actual research expenditure incurred as a proportion to total expenditure expected to be incurred. A liability reflects funds that are subject to conditions that, if unfulfilled, are repayable until the condition is fulfilled.

For a non-exchange research contract, the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as contract monitoring mechanisms of the funder and the past practice of the funder.

Dividend revenue

Revenue is recognised when the right to receive payment has been established.

2 Revenue (continued)

Patient care revenue

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Crown funding – health services	23,245	20,714
Crown funding – Covid-19 response	238	1,466
Total Crown funding	23,483	22,180
ACC Contract revenue	428	371
Other funding from the Crown/Crown Entities	2,560	2,592
Total other funding from the Crown/Crown Entities	2,988	2,963
Total patient care revenue	26,471	25,143

Other revenue

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Gain on sale of property, plant and equipment	5	1
Donations and bequests received	25	27
Rental and accommodation revenue	30	23
Direct charges revenue	40	35
Drug trial revenue	14	8
Research grants	35	33
Other revenue (insurance claims, retail sales, carpark, laundry, pathology, equipment rental, training and consultancy fees)	401	330
Total other revenue	550	457

Non-cancellable leases as a lessor

The future aggregate minimum lease payments to be received under non-cancellable operating leases are as follows:

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Not later than one year	11	22
Later than one year and not later than five years	21	35
Later than five years	8	11
Total future minimum lease payments to be received as a lessor	40	68

3 Personnel costs

Accounting Policy

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

Superannuation schemes

Defined contribution schemes

Employer contributions to KiwiSaver, the Government Superannuation Fund and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in surplus or deficit as incurred.

Defined benefit schemes

Health NZ makes employer contributions to the Defined Benefit Plan Contributors Scheme, which is managed by the Board of Trustees of the National Provident Fund (NPF), and to the ASB Group Master Trust Scheme (collectively the schemes). The schemes are multi-employer defined benefit schemes.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the schemes the extent to which surplus or deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The schemes are therefore accounted for as defined contribution schemes.

The funding arrangements for the Defined Benefit Plan Contributors Scheme are governed by section 44 of the National Provident Fund Restructuring Act 1990 and by a Trust Deed. This Act requires that any increase or decrease to the employer contribution rate should result in contributions being at a level which, on reasonable assumptions, is likely to achieve neither a surplus nor deficit in the trust fund of the scheme at the time that the last contributor to that scheme ceases to so contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and the interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

Breakdown of personnel costs and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Salaries and wages	12,004	9,928
Defined contribution plan employer contributions	363	273
Movement in employee entitlements liability	(649)	860
Movement in Holidays Act remediation liability	80	210
Release of restructuring provision	(56)	56
Total personnel costs	11,742	11,327

3 Personnel costs (continued)

Board and co-opted Committee member remuneration

	Group	
	Actual 2024 \$000	Actual 2023 \$000
Board member remuneration – in thousands		
Dame Dr Karen Poutasi (Chair, 1 July 2023 – 31 May 2024)	201	94
Professor Lester Levy (Chair, from 1 June 2024)	33	-
Naomi Ferguson (Interim Chair, 1 March 2023–30 June 2023; resigned 9 July 2024)	88	145
Hon Amy Adams (resigned 8 July 2024)	70	70
Dr Jeff Lowe (resigned 9 July 2024)	68	59
Ms Tipa Mahuta (Waikato, Maniapoto, Ngāpuhi) (from 1 July 2023 – 30 June 2024)	35	21
Ms Vanessa Stoddart (resigned 8 July 2024)	85	84
Dr Curtis Walker (Te Whakatōhea rāua ko Ngāti Porou) (resigned 9 July 2024)	25	44
Roger Jarrold (from 29 March 2024)	84	-
Mr Rob Campbell (Chair, until 28 February 2023)	-	175
Total board member remuneration	689	692
Co-opted committee members – in thousands	\$000	\$000
Jonathan Oram (to July 2023)	1	6
Lale Ieremia	12	8
Marc Rivers (resigned 15 July 2024)	33	37
Marcus Porter (term ended 31 May 2023)	-	6
Mei Fern Johnston	5	8
Michal Noonan (to 30 June 2024, committee discontinued)	13	8
Professor Marie Bismark (to 30 June 2024, committee discontinued)	12	10
Scott Pritchard	9	12
Tevita Funaki (to 30 June 2024, committee discontinued)	7	5
Vena Crawley (to 30 June 2024, committee discontinued)	19	8
Total co-opted committee members	111	108

Health NZ has provided a deed of indemnity to Directors and Board Members for certain activities undertaken in the performance of Health NZ's functions. Health NZ has renewed Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

On 22 July 2024 the Minister of Health Dr Shane Reti announced the appointment of Professor Lester Levy, the recently appointed Chair of Health NZ, as Commissioner for a 12-month term. The Commissioner replaces the previous Health NZ Board.

No Board members received compensation or other benefits in relation to cessation (2022/23: nil).

All Board Committees, except the Finance and Audit Committee, were discontinued effective 1 July 2024.

4 Capital charge

Accounting Policy

The capital charge is recognised as an expense in the financial year to which the charge relates.

Further Information

Health NZ pays a capital charge every six months to the Crown. The charge is based on the previous six-month actual closing equity balance as at 31 December and 30 June. The capital charge rate for the year ended 30 June 2024 was 5.00% (2022/23: 5.00%).

5 Infrastructure, non-clinical supplies and other expenses

Accounting Policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to Health NZ.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in surplus or deficit as a reduction of operating lease expense over the lease term.

Breakdown of infrastructure, non-clinical supplies and other expenses

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Audit New Zealand fees for audit of financial statements	5	6
Rental expenses including operating leases	91	87
Software – annual license fees	233	205
Information and communication technology expenses	116	122
Impairment loss on receivables (Note 7)	22	15
Board member fees	1	1
Loss on disposal of property, plant and equipment	4	3
Loss on disposal of intangible assets	8	1
Impairment of work in progress	11	21
Food, cleaning and laundry services	298	272
Utilities	110	111
Maintenance	118	120
Other facilities expenses	105	124
Compliance and corporate	199	171
Transport and travel	77	66
Other expenses (retail COGS, minor equipment, repairs, office costs, staff training and support)	380	425
Total infrastructure, non-clinical supplies and other expenses	1,778	1,750

Some 2023 comparatives have been restated for consistency with 2024 classifications

5 Infrastructure, non-clinical supplies and other expenses (continued)

In addition to the Audit New Zealand audit fees above, there were fees paid to Audit New Zealand for 1) \$0.93m (2022/23: nil) for the audits of the New Zealand Health Plan for 1 July 2024 to 30 June 2027 and the annual performance reports against the interim New Zealand Health Plan for 2022/23 and 2023/24 combined, and 2) \$0.01m (2022/23: \$0.12m) for assurance services over the project management and procurement for some construction projects. Total fees to firms other than Audit New Zealand for the audit of the financial statements of subsidiaries of Health New Zealand were \$0.45m (2022/23: \$0.26m).

Non-cancellable operating lease commitments as lessee

Health NZ leases buildings, vehicles and office equipment under operating leases.

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Not later than one year	87	72
Later than one year and not later than five years	194	175
Later than five years	62	81
Total non-cancellable operating lease commitments as lessee	343	328

6 Cash and cash equivalents

Accounting Policy

Cash and cash equivalents include cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts that are considered to form an integral part of cash management are included as a component of cash and cash equivalents. All other bank overdrafts are presented within borrowings in current liabilities in the statement of financial position.

Loss allowance

While cash and cash equivalents are subject to the expected credit loss requirements of PBE IPSAS 41, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Breakdown of cash and cash equivalents and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Current assets		
<i>Bank balance and cash on hand*</i>	284	66
<i>Health NZ BNZ Cash Offset Balance</i>	556	1,953
Total cash and cash equivalents in the statement of cash flows	840	2,019

* includes \$236m (2022/23: \$4m) of term deposits with original maturities of less than 3 months

6 Cash and cash equivalents (continued)

Treasury Services Agreement

Health NZ is party to a Treasury Services Agreement with two of its wholly owned subsidiaries (Enable New Zealand Limited and Allied Laundry Services Limited). Under this Agreement, Health NZ invests surplus funds to maximise interest revenue and manage the combined cash flows efficiently. Each participating entity under this Agreement must ensure that the debit balance owing by it and its subsidiaries at any given time will not exceed an amount equal to one month's operating budget of the relevant entity, inclusive of GST.

Health NZ also has a Cash Offset Arrangement with Bank of New Zealand across its bank accounts and the accounts of two of its wholly owned subsidiaries (Enable New Zealand Limited and Allied Laundry Services Limited). Under this arrangement, individual accounts can be in debit but there must always be a positive net balance overall. In addition, the Maximum Gross Debit Balance must not exceed \$3.0b.

Health NZ has a \$200m Standby Credit Facility with the Crown available for drawdowns of up to 10 days to manage fluctuations in working capital and treasury management liquidity.

7 Receivables

Accounting Policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. Health NZ applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed on a debtor category basis as each category possesses different credit risk characteristics. They have been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include, the debtor being in liquidation or a failure to make contractual payments for a period of greater than 90 days past due. Receivable balances have to be written off before they can be referred to external debt collectors.

The expected credit loss rates for receivables are based on the payment profile of revenue on credit at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward-looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macro-economic factors is not considered significant.

Breakdown of receivables and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Receivables	170	187
Other accrued income*	265	403
Less: Allowance for expected credit loss	(26)	(24)
Total receivables	409	566

* Includes \$218m accrual for Pharmac funding (2022/23: \$297m).

7 Receivables (continued)

The ageing profile of trade receivables at year end is detailed below:

Receivable days past due	Group			
	Gross 2024 \$m	Expected credit loss allowance 2024 \$m	Gross 2023 \$m	Expected credit loss allowance 2023 \$m
Not past due	339	(1)	495	-
Past due 0-30 days	32	(3)	14	(4)
Past due 31-90 days	14	(3)	26	(5)
Past due 91-360 days	27	(11)	34	(7)
Past due more than 1 year	23	(8)	21	(8)
Total	435	(26)	590	(24)

Allowance for expected credit loss is calculated based on a review of significant debtor balances and an assessment of impairment using an "expected credit loss" model. The impairment assessment is based on an analysis of the likelihood of paying based on current circumstances and past collection history and write-offs. The expected credit loss rate is variable depending on the debtor category.

Movements in the allowance for expected credit loss are as follows.

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Balance 1 July	(24)	(18)
Additional allowances (made)/released	(22)	(15)
Written off during year	20	9
Balance at 30 June	(26)	(24)

8 Investments

Accounting Policy

Bank term deposits

Bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial. Fair value has been calculated based on discounted cash flows, using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments.

Trust/special fund assets

The assets are funds held by Health NZ and comprise donated/endedowed and research funds. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenues and expenditures in respect of these funds are recognised in the surplus or deficit and are transferred from/to trust funds in equity.

8 Investments (continued)

Accounting Policy (continued)

Residential care loans

Interest free loans are provided to eligible rest home patients. The loans are secured over the property of the borrower and repayable at the earlier of sale of the secured property or death of the borrower. The loans are recorded at valuation based on an actuarial valuation carried out by Deloitte Ltd using the property prices as at 31 May 2024 based on the return in the Reserve Bank of New Zealand (RBNZ) House Price Index. The discount rate applied is based on the risk-free spot rates prescribed by the Treasury for use for valuations as at 31 May 2024.

Equity investments

Health NZ designates short-term investments at fair value through other comprehensive revenue or expense, which is initially measured at fair value plus transaction costs. After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expense. When sold, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is transferred within equity to accumulated surplus/deficit.

Investment Portfolios with fund managers and some equity investments are measured at fair value through surplus or deficit, having been designated as such on initial recognition. The fair value of portfolio investments and some equity investments has been calculated based on quoted market prices at the balance sheet date without deduction for transaction costs.

Breakdown of investments and further information

Investments are comprised of term investments and on-call deposits with All of Government Banking services providers and the banks that have Standard & Poor's Rating of "A+" or better.

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Current assets		
Short term deposits > 3 months < 12 months	389	43
Investment portfolios with fund managers – trusts and special funds	4	10
Total current portion	393	53
Non-Current assets		
Term deposits	28	27
Investment portfolios with fund managers – trusts and special funds	35	31
Residential Care Loans	55	52
Other investments – trusts and special funds	3	3
Total non-current portion	121	113
Total Investments	514	166

The carrying value of investments approximates their fair value.

9 Inventories

Accounting Policy

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the weighted average cost method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the year of the write-down.

The inventories mainly comprise of pharmaceuticals, surgical, medical supplies and COVID-19 stocks. No inventories are pledged as security for liabilities. However, some inventories are subject to retention of title clauses.

Breakdown of inventories and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Current assets		
Pharmaceuticals	41	30
Surgical and medical supplies	140	339
Other supplies	3	13
Total Inventories	184	382

Inventories recognised as an expense during the year were \$1,720m (2022/23: \$1,850m), which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

This includes a \$103m (2022/23: \$284m) write-down of Covid-19 inventories that have expired or will become obsolete. This has been calculated based on product expiry dates (\$39m expired stock on hand) and the expected future usage given the current national pandemic response settings (\$64m excess stock on hand). There have been no reversals of previous write-downs.

10 Assets held for sale

Accounting Policy

Non-current assets held for sale

A non-current asset is classified as held for sale if the carrying amount will be recovered principally through sale rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale, while classified as held for sale, are recognised in surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

10 Assets held for sale (continued)

Accounting Policy (continued)

Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Breakdown of assets held for sale

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Land	4	12
Buildings	1	1
Total assets held for sale	5	13

11 Investments in subsidiaries, associates, and joint ventures

Accounting Policy

Subsidiaries

Health NZ consolidates in the group financial statements those entities it controls. Control exists where Health NZ is exposed, or has rights, to variable benefits (either financial or non-financial) and has the ability to affect the nature and amount of those benefits from its power over the entity. Power can exist over an entity if, by virtue of its purpose and design, the relevant activities and the way in which the relevant activities of the entity can be directed has been predetermined by Health NZ.

Associates

An associate is an entity over which the group has significant influence and that is neither a subsidiary nor an interest in a joint venture. The group's associate investment is accounted for using the equity method of accounting. The investment in an associate is initially recognised at cost and the carrying amount in the financial statements is increased or decreased to recognise the group's share of the surplus or deficit of the associate after the date of acquisition. Distributions received from an associate reduce the carrying amount of the investment in the group financial statements.

If the share of deficits of an associate equal or exceed the group's interest in the associate, the group discontinues recognising its share of further deficits. After the group's interest is reduced to zero, additional deficits are provided for, and a liability is recognised, only to the extent that the group has incurred legal or constructive obligations or made payments on behalf of the associate. If the associate subsequently reports surpluses, the group will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

Where the group transacts with an associate, gains and losses are eliminated to the extent of the interest in the associate.

Joint Arrangements

Investments in joint arrangements are classified as either joint ventures or joint operations. The classification depends on the contractual rights and obligations of each investor.

11 Investments in subsidiaries, associates, and joint ventures (continued)

Accounting Policy (continued)

Joint Ventures

A joint venture is a binding arrangement whereby two or more parties are committed to undertake an activity that is subject to joint control. Joint control is the agreed sharing of control over an activity. The consolidated financial statements include Health NZ's joint interest in jointly controlled entities, using the equity method, from the date that joint control commences until the date that joint control ceases.

Joint Operations

A joint operation is a joint arrangement whereby the parties that have joint control of the arrangement recognise their direct right to the assets, liabilities, revenues and expenses of joint operations and their share of any jointly held or incurred assets, liabilities, revenues and expenses. These have been incorporated in the financial statements under the appropriate headings.

Breakdown of subsidiaries, associates and joint arrangements

General Information	Group	
	Interest held 2024 %	Interest held 2023 %
Name of subsidiaries		
Kaipara Total Health Care Joint Venture	54%	54%
Three Harbours Health Foundation	100%	100%
Auckland Hospitals Research and Endowment Fund	100%	100%
Auckland Hospital Foundation	100%	100%
Waikato Health Trust	100%	100%
Spectrum Health Limited	100%	100%
Lakes District Hospitals Charitable Trust	100%	100%
Tairāwhiti Laundry Services Limited	100%	100%
Enable New Zealand	100%	100%
Canterbury Linen Services Limited	100%	100%
Brackenridge Services Limited	100%	100%
New Zealand Health Innovation Hub Management Limited	100%	100%
Allied Laundry Services Limited	100%	100%
South Canterbury Eye Clinic Limited	100%	100%
Name of associates		
TLab Limited	50%	50%
Gisborne Laundry Services	50%	50%
Streamliners NZ Limited	20%	20%
Name of joint venture		
HealthOne (2021) Limited Partnership	50%	50%

TLab Limited

TLab Limited is an unlisted limited liability company providing laboratory services.

II Investments in subsidiaries, associates, and joint ventures (continued)

Gisborne Laundry Services

Gisborne Laundry Service is an unlisted partnership with Tairāwhiti Laundry Services Ltd providing laundry services in Gisborne and Hawke's Bay.

Streamliners NZ Limited

Streamliners is owned by The Joined Up Systems Trust (JUST) and Health NZ (through New Zealand Health Innovation Hub Management Ltd).

Streamliners provides a common platform called HealthPathways which is an online manual used by clinicians to help make assessment, management, and specialist request decisions for over 550 conditions.

HealthOne (2021) Limited Partnership

Health NZ has a 50% interest in HealthOne (2021) Limited Partnership through its wholly owned subsidiary NZ Health Innovation Hub Management Ltd (NZHIH) with Pegasus Health (Charitable) Limited. HealthOne (2021) Limited Partnership is an unlisted limited partnership.

Breakdown of investments and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
HealthOne (2021) Limited Partnership	0.6	1.2
Streamliners NZ Ltd	2.5	5.3
Gisborne Laundry Services	-	0.2
TLab Limited	0.3	0.3
Total investments in associates and joint ventures	3.4	7.0

Joint operations

Awhina Waitakere Health Campus is a jointly controlled operation between New Zealand Institute of Skills and Technology – Te Pūkenga and Health NZ per the terms of the joint venture agreement dated March 2011. Each party has provided certain capital inputs and shares the operating costs of the Simulation Centre and conference facilities.

In 2018/19, Health NZ Canterbury district entered a joint property lease with Ara Institute of Canterbury – Te Pūkenga for the new Health Research Educational Facility known as the Manawa building. The arrangement is by way of jointly controlled operations.

Health NZ Auckland district entered into a long-term agreement (joint operation) with Slade Health to provide a sterile compounding facility and services for delivery of chemotherapy, antibiotics, analgesics and nutritional infusions. Previously, Health NZ Auckland district compounded chemotherapy and other sterile products in-house. The outsourcing of this service to Slade means that patient specific infusions can be compounded quicker with less wastage and reduced potential for medication errors – while also keeping up with the demand for these services which is expected to double by 2040. The price for the medicines produced by Slade is governed by the Pharmac pricing schedule.

12 Property, plant and equipment

Accounting Policy

Property, plant, and equipment consist of the following asset classes: land, buildings (including fit out, leasehold improvements and underground infrastructure), clinical equipment, other equipment, IT/ ITC equipment, motor vehicles and work in progress.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Work in progress (WIP) is recognised at cost less impairment and is not depreciated.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years.

The carrying values of land and buildings are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in surplus or deficit will be recognised first in surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Health NZ and the cost of the item can be measured reliably.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to Health NZ and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in surplus or deficit as they are incurred.

Disposals

Gains or losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. The net gain or loss on disposals is reported in the surplus or deficit. When revalued assets are sold, the amounts included in the property revaluation reserves in respect of those assets are transferred to accumulated surpluses or deficits in equity.

12 Property, plant and equipment (continued)

Accounting Policy (continued)

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment, other than land, at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant, and equipment have been estimated as follows:

Buildings	5 to 80 years
Leasehold improvements	over the lease term ranging from 2 to 30 years
Clinical equipment	5 to 25 years
Other equipment	5 to 25 years
IT/ITC equipment	3 to 8 years
Motor vehicles	5 to 15 years

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year-end.

Impairment of property, plant, and equipment

Property, plant and equipment that has a finite useful life is reviewed for impairment at each reporting date. Property, plant, and equipment is reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to its recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expense and decreases the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in surplus or deficit.

The reversal of an impairment loss on a revalued asset is recognised in other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in surplus or deficit, a reversal of an impairment loss is also recognised in surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in surplus or deficit.

12 Property, plant and equipment (continued)

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

The most recent valuations were performed as at 30 June 2023. Each of the 20 Health NZ districts engaged their independent valuers to perform valuations of the land and building assets.

Independent valuer	District(s)	Valuation approach	Carrying value of land (\$m)	Carrying value of buildings (\$m)
TelferYoung from CBRE	Auckland	Desktop/indexed movement	378	1,004
	Canterbury	Desktop/indexed movement	167	1,429
	Taranaki ¹	Full valuation	17	204
	Waitemata	Desktop/indexed movement	328	622
	Whanganui	Desktop/indexed movement	6	104
RS Valuation Limited	Bay of Plenty	Full valuation	54	419
	Counties Manukau	Full valuation	274	1,189
	Lakes	Full valuation	30	264
	Mid Central	Full valuation	25	313
	Northland	Full valuation	26	395
	Waikato	Full valuation	101	1,090
Colliers	Capital and Coast ¹	Full valuation	57	645
	South Canterbury	Desktop/indexed movement	7	57
CBRE Limited	Hutt Valley	Desktop/indexed movement	32	250
	Wairarapa	Desktop/indexed movement	5	54
Beca	Southern ²	Desktop/indexed movement	138	361
	Nelson Marlborough ¹	Desktop/indexed movement	40	186
Added Valuation Limited	Hawkes Bay	Full valuation	20	187
JLL	Tairāwhiti	Full valuation	6	80
Coast Valuations Limited	West Coast	Desktop/indexed movement	9	183
Total			1,720	9,036

¹ Previous full valuation undertaken at 30 June 2021, all others at 30 June 2022.

² Full valuation undertaken for New Dunedin Hospital site.

Full valuations had been undertaken by 17 of the former DHBs at of 30 June 2022, and by the three remaining DHBs at 30 June 2021.

For 2023 the Group used the information obtained from the valuations, which included full valuations, desktop valuations and indexed movements, to record a valuation increase of \$1.149 billion as at 30 June 2023. The desktop valuations and indexed movements are less robust than full valuations as they do not involve the depth of analysis undertaken for a full valuation.

12 Property, plant and equipment (continued)

Critical accounting estimates and assumptions (continued)

Fair Value Assessment 2024

Management undertook a fair value assessment with the assistance of Independent Valuer CBRE to determine if the fair value of land and buildings could be materially different to carrying value at 30 June 2024. Reference was made to relevant market-based evidence when assessing the fair value of land and movements in construction cost indices (as provided by Rider Levett Bucknall) when assessing the fair value of buildings. The conclusion was reached that there was no material difference between the fair value of land and buildings and their carrying value at 30 June 2024.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. The comparable land value rates (\$/m²) that have been applied across Health NZ land vary from site to site across New Zealand.

Titles to land transferred from the Crown to Health NZ are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988).

Some of the land is subject to Right of First Refusal (RFR) in favour of certain iwi under the Ngai Tahu Claims Settlement Act 1998 and the Tamaki Collective Deed of Settlement.

Land held in the Auckland Region is subject to Section 148 of Nga Mana Whenua o Tamaki Makaurau Collective Redress Act 2014 ("The Act") which means that the land is RFR land as defined in section 118 and is subject to Subpart 1 of Part 4 of The Act, which restricts disposal, including leasing of the land.

Disposal of certain properties may be subject to the provision of section 40 Public Works Act 1981.

Health NZ does not have full title to Crown land it occupies but transfer is arranged if/when land is sold.

Restrictions on Health NZ's ability to sell land would normally not impair the value of the land because Health NZ has operational use of the land for the foreseeable future and will substantially receive the full benefit of outright ownership. However, adjustments have been made to some "unencumbered" land values for where there is a designation against the land, or the use of the land is restricted. These adjustments vary across sites depending on the designation/restriction and reflect the negative effect on the land value where Health NZ is unable to use the land more intensely or at highest and best use.

Buildings

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using several significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts awarded for similar assets, Quantity Surveyor (QS) cost estimates or by applying relevant indices (e.g., Property Institute of New Zealand) to previous replacement costs.

12 Property, plant and equipment (continued)

Critical accounting estimates and assumptions (continued)

- For earthquake-prone buildings that are expected to be strengthened, the estimated earthquake-strengthening costs have been deducted off the depreciated replacement cost in estimating fair value. Where no decision has been made to strengthen earthquake-prone buildings, the remaining useful life has been reduced if Health NZ is required to remediate the buildings within a specific timeframe.
- The estimated cost of asbestos/other remediation works has been deducted off the building depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated after considering factors such as the condition of the asset, future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires several factors to be considered such as the physical condition of the asset, expected period of use of the asset by Health NZ, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the Statement of Financial Position. Health NZ minimises the risk of this estimation uncertainty by:

- regular/cyclical physical inspection of critical buildings and associated plant
- asset replacement programmes
- review of market prices for similar assets; and
- analysis of prior asset sales.

Health NZ has not made significant changes to past assumptions concerning useful lives/residual values.

12 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

	Group							Total \$m
	Land \$m	Buildings \$m	Clinical Equip. \$m	Other Equip. \$m	IT/ITC \$m	Motor Vehicles \$m	Work in Progress \$m	
Cost								
Balance at 30 June 2023	1,720	9,097	1,838	274	397	101	1,402	14,829
Transfers from WIP	11	655	246	26	49	11	(998)	-
Additions to WIP	-	-	-	-	-	-	1,465	1,465
Impairment Losses	-	-	-	-	-	-	-	-
Disposals/transfers between classes	-	(1)	(56)	(7)	(4)	(3)	(13)	(84)
Transfers to Intangibles	-	-	-	-	(7)	-	(6)	(13)
Revaluation	-	-	-	-	-	-	-	-
Balance at 30 June 2024	1,731	9,751	2,028	293	435	109	1,850	16,197
Depreciation and impairment losses								
Balance at 30 June 2023	-	54	1,168	132	288	79	-	1,721
Depreciation	-	528	154	22	50	7	-	761
Impairment Losses	-	1	-	-	-	-	11	12
Disposals/transfers between classes	-	(3)	(51)	(9)	(13)	(3)	-	(79)
Transfers to Intangibles	-	-	-	-	-	-	-	-
Reversal of accum depre on revaluation	-	-	-	-	-	-	-	-
Balance at 30 June 2024	-	580	1,271	145	325	83	11	2,415
Carrying Amount								
At 30 June 2023	1,720	9,044	669	142	109	22	1,402	13,109
At 30 June 2024	1,731	9,171	757	148	110	26	1,839	13,782

12 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

	Group							Total \$m
	Land \$m	Buildings \$m	Clinical Equip. \$m	Other Equip. \$m	IT/ITC \$m	Motor Vehicles \$m	Work in Progress \$m	
Cost								
Balance at 1 July 2022	1,728	7,786	1,775	229	427	93	1,263	13,301
Transfers from WIP	2	540	222	50	51	10	(875)	-
Additions	49	88	-	-	-	-	1,041	1,178
Impairment Losses	-	-	-	-	-	-	(20)	(20)
Disposals/transfers between classes	-	-	(159)	(5)	(25)	(2)	(6)	(197)
Transfers to Intangibles	-	-	-	-	(56)	-	(1)	(57)
Revaluation	(59)	683	-	-	-	-	-	624
Balance at 30 June 2023	1,720	9,097	1,838	274	397	101	1,402	14,829
Depreciation and impairment losses								
Balance at 1 July 2022	-	97	1,140	135	322	75	-	1,769
Depreciation	-	436	139	22	46	6	-	649
Impairment Losses	-	-	(1)	-	-	-	-	(1)
Disposals/transfers between classes	-	(13)	(110)	(25)	(31)	(2)	-	(181)
Transfers to Intangibles	-	-	-	-	(49)	-	-	(49)
Reversal of accum depre on revaluation	-	(466)	-	-	-	-	-	(466)
Balance at 30 June 2023	-	54	1,168	132	288	79	-	1,721
Carrying Amount								
At 1 July 2022	1,728	7,689	635	94	105	18	1,263	11,532
At 30 June 2023	1,720	9,044	669	142	109	22	1,402	13,109

Work in progress

Property, plant and equipment under construction by class of asset are detailed below:

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Buildings	1,651	1,219
Clinical equipment	132	91
Information technology	37	68
Motor Vehicles	4	2
Other equipment	15	22
Total work in progress	1,839	1,402

12 Property, plant and equipment (continued)

Leased assets

Health NZ enters into finance leases for the lease of equipment. The net carrying amount of the leased items within each class of property, plant and equipment is included above. Refer finance leasing arrangements in **Note 15**.

Capital commitments

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Property	1,071	1,361
Intangible assets and other equipment	153	75
Total capital commitments	1,224	1,436

13 Intangible assets

Accounting Policy

Computer software development and acquisition

Computer software, which is not an integral part of a related hardware item, is recognised as an intangible asset. The costs incurred internally in developing computer software are also recognised as intangible assets where the group has a legal right to use the software and the ability to obtain future economic benefits from that software.

Acquired software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Cloud based software/infrastructure-as-a-service arrangements are recognised as an intangible asset where the group has the right to use and the ability to control and obtain future economic benefits.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired and internally developed computer software 2 – 20 years

Impairment of intangible assets

Intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

13 Intangible assets (continued)

Breakdown of intangible assets and further information

Movements for each class of intangibles are as follows:

2024	Group		
	Computer Software \$m	Work in Progress \$m	Total \$m
Cost			
Balance at 30 June 2023	1,032	145	1,177
Additions from WIP	94	(94)	-
Additions	-	189	189
Transfers from Property, plant and equipment	(1)	14	13
Disposals	(7)	(6)	(13)
Balance at 30 June 2024	1,118	248	1,366
Accumulated depreciation and impairment losses			
Balance at 30 June 2023	748	-	748
Amortisation	85	-	85
Disposals	(5)	-	(5)
Balance at 30 June 2024	828	-	828
Carrying amount 30 June 2023	284	145	429
Carrying amount 30 June 2024	291	248	539
2023	Group		
	Computer Software \$m	Work in Progress \$m	Total \$m
Cost			
Balance at 1 July 2022	904	142	1,046
Additions from WIP	102	(102)	-
Additions	5	105	110
Transfers from Property, plant and equipment	56	1	57
Disposals	(35)	(1)	(38)
Balance at 30 June 2023	1,032	145	1,177
Accumulated depreciation and impairment losses			
Balance at 1 July 2022	639	-	639
Amortisation	88	-	88
Impairment losses	1	-	1
Transfers from property, plant and equipment	49	-	49
Disposals	(29)	-	(29)
Balance at 30 June 2023	748	-	748
Carrying amount 1 July 2022	265	142	409
Carrying amount 30 June 2023	284	145	429

14 Payables and deferred revenue

Accounting Policy

Short-term payables are measured at the amount payable. Deferred revenue represents revenues received in advance (**Note 2 Revenue**).

Breakdown of payables and deferred revenue

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Payables under exchange transactions		
Creditors	1,618	1,566
Deferred revenue	45	74
Total payables under exchange transactions	1,663	1,640
Payables under non exchange transactions		
GST, WHT, PAYE & FBT payable	364	217
Total payables under non exchange transactions	364	217
Total payables and deferred revenue	2,027	1,857

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

15 Borrowings

Accounting Policy

Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. After initial recognition, interest bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis. Borrowings are classified as current liabilities unless Health NZ has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Overdraft facility

Bank overdrafts that are considered to form an integral part of cash management are included as a component of cash and cash equivalents. All other bank overdrafts are presented within borrowings in current liabilities in the statement of financial position and are recorded at the amount payable plus accrued interest.

Finance leases

A finance lease is a lease that transfers to Health NZ substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

15 Borrowings (continued)

Accounting Policy (continued)

The finance charge is charged to surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether Health NZ will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Critical judgements in applying accounting policies

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Health NZ. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment and intangible assets, whereas for an operating lease no such asset is recognised. Health NZ has exercised its judgement on the appropriate classification of leases.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to Health NZ.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in surplus or deficit as a reduction of operating lease expense over the lease term.

Breakdown of borrowings and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Current		
Finance Leases	10	28
Other	1	-
Total current portion	11	28
Non-current		
Finance Leases	95	80
Other	2	2
Total non-current portion	97	82
Total borrowings	108	110

15 Borrowings (continued)

The net carrying amount of the leased items within each class of property, plant, and equipment is included in **Note 12**. There are no restrictions placed on the group by any of the finance leasing arrangements. Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

Analysis of finance lease liabilities

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Minimum lease payments payable:		
No later than one year	16	16
Later than one year and not later than five years	47	48
Later than five years	112	116
Total minimum lease payments	175	180
Future finance charges	(70)	(72)
Present value of minimum lease payments	105	108
Present value of minimum lease payments payable:		
No later than one year	14	15
Later than one year and not later than five years	39	41
Later than five years	52	52
Total present value of minimum lease payments	105	108

Corrections have been made to some of the 2023 amounts

The carrying value of finance lease liabilities approximates their fair value.

16 Employee entitlements

Accounting Policy

Short-term employee entitlements

Employee entitlements that are expected to be settled wholly before 12 months after the end of the reporting period in which the employees render the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, and sick leave.

Long-term employee entitlements

Employee entitlements that are not expected to be settled wholly before 12 months after the end of the reporting period in which the employees render the related service, such as sabbatical leave, continuing medical education leave, long service leave, and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

16 Employee entitlements (continued)

Accounting Policy (continued)

- likely future entitlements accruing to employees, based on years of service, years to entitlement, the likelihood that employees will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, continuing medical education leave, annual leave, long service leave that is available for use, and sabbatical leave that is available for use are classified as a current liability. Long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

Critical accounting estimates and assumptions

Long service leave and retirement gratuities

The present value of sabbatical leave, long service leave, and retirement gratuities obligations depends on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating these liabilities are the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary.

The discount rates used are those advised by the New Zealand Treasury published risk-free discount rates as at 30 June 2024 and range between 4.57% and 5.28% (2022/23: 4.30% and 5.43%). The salary inflation factor is 3.0% (2022/23: 4.5%) which is Health NZ's best estimate forecast of salary increments.

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the long service leave and retirement gratuities obligations would be an estimated \$29.9m higher/\$21.5m lower (2022/23: \$21.6m higher/\$31.1m lower). If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the long service leave and retirement gratuities obligations would be an estimated \$30.1m higher/\$22.1m lower (2022/23: \$21.1m higher/\$31.4m lower).

Holidays Act 2003 remediation

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 (the Holidays Act).

Work commenced in 2016 on behalf of the former DHBs (now Health NZ) and the New Zealand Blood Service, with the Council of Trade Unions, health sector unions, and the Ministry of Business, Innovation and Employment Labour Inspectorate, to come up with an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance.

Prior to the establishment of Health NZ, DHBs agreed to a Memorandum of Understanding (MOU) and Baseline Document, which contains a method for determination of individual employee earnings, for calculation of minimum entitlements to remediate any historical non-compliance.

16 Employee entitlements (continued)

Critical accounting estimates and assumptions (continued)

The health sector has a workforce that includes differential occupational groups with complex entitlements, non-standard hours, allowances/overtime. The remediation project, including the process of reviewing payroll processes and assessing non-compliance with the Holidays Act and determining any additional payment, is a significant undertaking and the work required is time consuming and complicated.

Judgements and assumptions have been made to make an estimate of the liability.

The opening balance transferred to Health NZ from combining entities on 1 July 2022 had been estimated either by using remediation scripts (where 100% of the population is recalculated) or using a sample and extrapolation approach across the population. The sample and extrapolation method generated an estimate by using both terminated and current employees. Employees were taken from each district that were employed between 1 May 2010 and 30 June 2022 (being the agreed remediation period).

For both 2022/23 and 2023/24, no further sampling and extrapolation has been completed given the progress made on remediation projects, with payments having commenced in July 2023 to current employees in some districts. Also, further sampling and extrapolation would be unlikely to provide a significantly different financial liability estimate.

An estimate has been made of the amount required for each additional year of non-compliance since 1 July 2022 and this has been added to the provision in the 2022/23 and 2023/24 financial years (until the payroll system is rectified and remediation payments to current employees are made). Ernst & Young (EY) modelling was used to estimate the uplift required in the provision for each year for those districts where a sample and extrapolation method was used to estimate the liability.

A level of non-compliance based on a percentage of gross pay on average has been assumed as the level of ongoing non-compliance in both 2022/23 and 2023/24 on a district-by-district basis. The percentage ranges from 2.34% to 4.02%. This assumes that no corrective actions have been taken to reduce non-compliance with the Holidays Act and that the level of non-compliance is therefore consistent across years on a district-by-district basis.

For districts that used remediation scripts, the liability uplift was determined from updated remediation scripts or the weighted average estimated level of ongoing non-compliance for districts from EY's modelling of 3.09%.

Payments to settle this provision commenced in July 2023, with \$240m paid to employees in the year ended 30 June 2024. Payments made during the 2023/24 year have been deducted from the provision.

An amount of \$107m was also deducted from the provision when payments were made to employees. This was because the provision included an amount to "revalue" the annual leave balances of these employees to reflect the leave rates agreed to be used for calculating annual leave entitlements as part of the remediation project. When these employees received remediation payments, this "revaluation" was transferred to the annual leave balance.

16 Employee entitlements (continued)

Critical accounting estimates and assumptions (continued)

During 2023/24 EY completed further modelling for the three metro Auckland districts. These models use better quality data and take account of decisions made by Health NZ about remediation entitlements and the circumstances of individual employees to calculate the estimated amounts to pay.

As a result of this updated modelling, \$153m of the provision was released. The effect of the decisions made, or the circumstances of individual employees, on the provision recorded for the remaining 17 districts has not been determined. Further adjustments may be required to the provision as the remediation project progresses and further payments are made.

The liability recognised is Health NZ's best estimate at both 30 June 2023 and 30 June 2024. Until the remediation projects are completed for all districts, significant uncertainties remain about the actual amount Health NZ will be required to pay to all other current and former employees. The actual payments made may differ significantly from the financial liability estimate recorded.

Breakdown of employee entitlements

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Current*		
Accrued salaries and wages	296	311
Annual leave	1,593	1,260
Holidays Act 2003 remediation	1,825	2,101
Continuing education leave and expenses	312	313
Sick leave	33	33
Long service leave	62	47
Retirement gratuities	60	47
Other employee entitlements**	69	960
Total current portion	4,250	5,072
Non-current		
Long service leave	76	77
Retirement gratuities	168	177
Other entitlements	56	42
Total non-current portion	300	296
Total employee entitlements	4,550	5,368

** 2023 includes provisions for the 2022/23 cost impact of pay equity settlements agreed after 30 June 2023 (\$644m for nurses, \$48m for midwives and \$167m for allied health). The provision is based on modelled cost estimates completed during the bargaining process.

* Some 2022/23 prior year comparatives have been restated for consistency with 2023/24 classification.

16 Employee entitlements (continued)

Movements in Holidays Act 2023 Remediation Provision

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Opening Balance	2,101	1,832
Additional provision made	233	269
Paid to employees	(240)	-
Kiwisaver and ACC paid	(9)	-
Leave revaluation transferred to staff liabilities	(107)	-
Unused amount reversed	(153)	-
Closing Balance	1,825	2,101

17 Restricted funds

Breakdown of restricted funds

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Non-current liabilities		
Balance 1 July	1	1
Balance 30 June	2	1
Total restricted funds	2	1

This interest earning fund was from sale proceeds on an endowment property, to be used in conjunction with Health NZ Auckland Treaty partner, Ngāti Whātua.

18 Provisions

Accounting Policy

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event
- it is probable that an outflow of future economic benefits will be required to settle the obligation; and
- a reliable estimate can be made of the amount of the obligation

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in "finance costs".

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected or has already started being implemented.

18 Provisions (continued)**Accounting Policy (continued)***Onerous contracts*

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

ACC Accredited Employers Programme

Health NZ belongs to the ACC Accredited Employers Programme (the Programme) whereby Health NZ accepts the management and financial responsibility for employee work-related illnesses and accidents.

Under the Programme, Health NZ is liable for all claim costs for a period of two years after the end of the cover period in which the injury occurred. At the end of the two-year period Health NZ pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the Programme is measured using actuarial techniques at the present value of expected future payments to be made for employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels, and experience of employee claims and injuries. Expected future payments are discounted using market yields at balance date on government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Holidays Act Remediation Project

The provision is for the costs expected to complete the remediation project works.

Breakdown of provisions and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Current		
ACC Accredited Employers Programme	19	12
Holidays Act Remediation Project	66	66
Restructuring	-	56
Total current	85	134
Non-current		
ACC Accredited Employers Programme	1	4
Other	2	4
Total non-current	3	8
Total provisions	88	142

18 Provisions (continued)

Movement for each class of provision is as follows:

	Group	
	Actual 2024 \$m	Actual 2023 \$m
ACC Accredited Employers Programme		
Opening balance	17	16
Additional provisions made	13	5
Amounts used	(6)	(4)
Amount unused and reversed during the year	(4)	-
Closing balance	20	17
Holidays Act Remediation Project		
Opening balance	66	76
Additional provisions made	48	9
Amounts used	(48)	(19)
Closing balance	66	66
Restructuring Provision		
Opening balance	56	-
Additional provisions made	-	56
Amount unused and reversed during the year	(56)	-
Closing balance	-	56
Other		
Opening balance	4	2
Additional provisions made	-	2
Amounts used	(2)	-
Closing balance	2	4

19 Equity

Accounting Policy

Health NZ's capital is its equity, which consists of Crown equity, accumulated surplus or deficit, revaluation reserves, and trust funds. Equity is represented by net assets.

Health NZ is subject to the financial management and accountability provisions of the CEA, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

Health NZ manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purposes while remaining a going concern.

Equity is measured as the difference between total assets and total liabilities.

19 Equity (continued)**Accounting Policy (continued)**

Equity is disaggregated and classified into the following components:

- Crown Equity
- Accumulated surpluses or deficits
- Revaluation reserves
- Trust and special funds

Contributions from/(repayment to) the Crown

This relates to funding from the Crown for Crown approved capital projects and for Holidays Act remediation.

Revaluation reserves

These reserves relate to the revaluation of property, plant and equipment to fair value.

Trust and special funds

The receipt of donations, bequests, and investment revenue earned on trust funds, is recognised as revenue and then transferred to the trust funds' reserve from accumulated surplus or deficit. Application of trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to accumulated surplus or deficit from the trust funds' reserve.

This reserve records the unspent amount of unrestricted donations and bequests provided to Health NZ.

Breakdown of equity and further information

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Crown Equity		
Opening balance 1 July	3,080	2,413
Capital contributions from the Crown – capital projects	682	686
Capital contributions from the Crown – Holidays Act remediation	275	-
Adjustment for Capital Contributions accrued	-	(7)
Capital contribution returned to the Crown	(12)	(12)
Maori Health Authority – equity on amalgamation (refer to note 27)	77	-
Balance at 30 June	4,102	3,080
Accumulated surpluses/(deficits)		
Opening balance 1 July	(1,013)	-
Surplus/(deficit)	(722)	(1,013)
Balance at 30 June	(1,735)	(1,013)
Revaluation reserves		
Opening balance 1 July	7,175	6,084
Revaluations (refer to note 12)	-	1,091
Balance at 30 June	7,175	7,175

19 Equity (continued)

Breakdown of equity and further information (continued)

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Trust and special funds		
Opening balance 1 July	64	63
Movements in trust and special funds	3	1
Balance at 30 June	67	64
Minority interests		
Opening balance 1 July	7	7
Movements in minority interests	(4)	-
Balance at 30 June	3	7
Total Equity	9,612	9,313
Revaluation reserves consist of		
Land	1,640	1,640
Buildings	5,535	5,535
Total revaluation reserves	7,175	7,175

20 Contingencies

Contingent Liabilities

Unquantifiable contingent liabilities as at 30 June 2024

- Health NZ is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, Health NZ could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, Health NZ could be responsible for an increased share of the deficit. Based on historic trends there is no deficit to fund.
- Stafford litigation: Crown Law is acting for the Attorney-General on behalf of the Crown in Stafford v Attorney-General, in which it is claimed that the Crown breached trust, fiduciary and other equitable obligations relating to land transactions in the top of the South Island in the 1840s. The plaintiff seeks the return of land they say the Crown holds on trust for the successors of the original owners and compensation, or other relief. This extends to land currently owned by a number of Crown entities, including Health NZ, and an SOE. In February 2017, the Supreme Court held that the Crown owed a fiduciary duty in relation to the land transactions concerned, but remitted matters of breach, defences and remedy to the High Court for a further hearing or hearings. The matter is large and complex and could take many years to resolve.

21 Related party transactions

Related parties include:

- The Crown, as the ultimate controlling entity of Health NZ.
- Other entities subject to common control, such as government departments, Crown entities, and state-owned enterprises.
- Associates (refer to **Note 11**).
- Key management personnel and their close family members. Key management personnel are Board Members, the Leadership Team, and their close family members are their spouses, children and dependants.
- Entities in which Board members, members of the Leadership Team or their close family members hold a substantial ownership interest or over which these individuals are able to exercise significant influence.

There are no other related parties as no other parties are controlled by Health NZ, other than those that are consolidated into the group's financial statements.

Related party disclosures have not been made for transactions with related parties, including associates that are:

- within a normal supplier or client/recipient relationship; and
- on terms and conditions no more or less favourable than those that it is reasonable to expect that the group would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies.

Key management personnel compensation

	Group	
	Actual 2024	Actual 2023
Board Members		
Remuneration	\$0.69m	\$0.69m
Full-time equivalent members*	1.50	1.48
Leadership Team		
Remuneration	\$8.29m	\$10.66m
Full-time equivalent members	13.98	19.70
Total key management personnel remuneration	\$8.98m	\$11.35m
Total full time equivalent personnel*	15.48	21.18

*corrections have been made to the 2023 FTE numbers

The Leadership Team comprises the Chief Executive Officer and Executive Team Members. Appointments to the Executive Leadership Team occurred at various times throughout 2022/23 with one remaining interim role permanently filled in 2023/24. The full-time equivalent for Board members has been determined on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings. An analysis of Board member remuneration is provided in **Note 3**.

22 Financial Instruments

The carrying amounts of financial assets and liabilities in each financial instrument category are as follows:

	Group	
	Actual 2024 \$m	Actual 2023 \$m
<i>Financial assets measured at amortised cost</i>		
Cash and cash equivalents	840	2,019
Receivables	409	566
Term deposits	417	70
Total financial assets measured at amortised cost	1,666	2,655
<i>Financial assets measured at fair value through surplus or deficit</i>		
Investment portfolios with fund managers	39	41
Residential care loans and other	58	55
Total financial assets measured at fair value through surplus or deficit	97	96
<i>Financial liabilities measured at amortised cost</i>		
Payables (excluding revenue in advance and taxes payable)	1,618	1,566
Borrowings and finance leases	108	110
Restricted funds	2	1
Total financial liabilities measured at amortised cost	1,728	1,677

Fair value hierarchy disclosures

For those instruments recognised at fair value in the Statement of Financial Position, fair values are determined according to the following hierarchy:

- Quoted market price (level 1) – Financial instruments with quoted prices for identical instruments in active markets.
- Valuation technique using observable inputs (level 2) – Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable.
- Valuation techniques with significant non-observable inputs (level 3) – Financial instruments assets valued using models where one or more significant inputs are not observable.

22 Financial Instruments (continued)

Fair value hierarchy disclosures (continued)

The following table analyses the basis of the valuation of classes of financial instruments measured at fair value in the Statement of Financial Position:

	Valuation technique			Significant non-observable inputs \$m
	Total \$m	Quoted market price \$m	Observable inputs \$m	
Group 30 June 2023				
Financial Assets				
Investment portfolios with fund managers	41	-	41	-
Residential care loans and other	55	-	55	-
Group 30 June 2024				
Financial Assets				
Investment portfolios with fund managers	39	-	39	-
Residential care loans and other	58	-	58	-

Financial Instrument risks

Health NZ's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. Health NZ has a series of policies to manage the risks associated with financial instruments which seek to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. Health NZ has no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. Health NZ's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as bank deposits are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Health NZ's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Sensitivity analysis

At 30 June 2023 and 30 June 2024, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, there would have been an insignificant impact on the deficit for the year.

22 Financial Instruments (continued)

Market risk (continued)

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end Health NZ had no direct exposure to foreign currency risk.

Sensitivity analysis

At 30 June 2023 and 30 June 2024, if the New Zealand dollar had weakened/strengthened against any foreign currency, there would have been an insignificant impact on the deficit for the year. Health NZ has no outstanding foreign denominated payables at balance date.

Credit risk

Credit risk is the risk that a third party will default on its obligation to Health NZ, causing it to incur a loss. Due to the timing of Health NZ's cash inflows and outflows, surplus cash of the group is invested with registered banks. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks, debtors and other receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

Health NZ only places term investments and on-call deposits with All of Government banking services providers and banks who have Standard & Poor's Rating of "A+" or better subject to the permitted exposure limits. There were no defaults of interest or principal payments.

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor and is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates.

	Group	
	Actual 2024 \$m	Actual 2023 \$m
Counterparties with credit ratings		
Cash, cash equivalent and bank term deposits		
All of Government banking service providers	1,257	2,089
Total counterparties with credit ratings	1,257	2,089
Counterparties without credit ratings		
Investment portfolios with fund managers – no defaults in the past	39	41
Residential care loans and other – no defaults in the past	58	55
Receivables		
Existing counterparty with no defaults in the past	409	566
Existing counterparty with defaults in the past	-	-
Total counterparties without credit ratings	506	662

22 Financial Instruments (continued)

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the group will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

Health NZ mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities, excluding derivatives

The table below analyses financial liabilities (excluding derivatives) into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest cash outflows. Trade and other payables exclude revenue in advance and taxes payable.

2024	Group					
	Carrying amount \$m	Contractual cash flow \$m	Less than 1 year \$m	1-2 years \$m	2-5 years \$m	More than 5 years \$m
Trade and other payables	1,618	1,618	1,618	-	-	-
Borrowing & finance leases	108	174	16	17	30	112
Total	1,726	1,792	1,634	17	30	112

2024	Group					
	Carrying amount \$m	Contractual cash flow \$m	Less than 1 year \$m	1-2 years \$m	2-5 years \$m	More than 5 years \$m
Trade and other payables	1,566	1,566	1,566	-	-	-
Borrowing & finance leases *	110	180	16	12	36	116
Total	1,676	1,746	1,582	12	36	116

*corrections have been made to the carrying amounts and contractual cashflow phasing

23 Events after balance date

On 22 July 2024, the Minister of Health removed the Board of Health NZ and replaced it with a Commissioner (Professor Lester Levy) appointed effective 24 July 2024, under section 62 of the Pae Ora (Healthy Futures) Act 2022.

The Commissioner has subsequently appointed three Deputy Commissioners – Roger Jarrold, Ken Whelan and Kylie Clegg.

24 Establishment of Health NZ

When Health NZ was formed on 1 July 2022 (from the amalgamation of 20 District Health Boards, the Health Promotion Agency, six shared service agencies and some functions of the Ministry of Health, referred to as the Combining Entities), the following adjustments were made to the carrying amounts of assets and liabilities recorded by each combining entity.

	Sum of Combining Entities (CE's)* \$m	Group Elimination of transactions between CE's \$m	Financial Position as at 1 July 2022 \$m
Total Assets	16,027	(888)	15,139
Total Liabilities	7,236	(664)	6,572
Net Assets	8,791	(224)	8,567

Net assets/equity analysis on amalgamation

	Sum of Combining Entities (CE's)* \$m	Group Elimination of transactions between CE's \$m	Financial Position as at 1 July 2022 \$m
Crown Equity	2,637	(224)	2,413
Revaluation Reserves	6,084	-	6,084
Special/trust funds	63	-	63
Minority interests	7	-	7
Net Assets	8,791	(224)	8,567

*Sum of the Combining Entities does not constitute Health NZ's consolidated position as at 1 July 2022.

There were no adjustments necessary to conform to Health NZ's accounting policies.

Financial statements of the combining entities for periods prior to amalgamation are available on Health NZ's website.

25 Significant items affecting the financial result

Health NZ recorded a deficit of \$722m (2022/23: deficit \$1.013b) for the financial year 2023/24 against a breakeven Statement of Performance Expectations (SPE) budget.

Background

The 2022/23 deficit included an \$859m expense accrual for pay equity for nursing, allied health and midwifery staff for the 2022/23 cost impact of settlements agreed post balance date. The corresponding funding was not able to be accrued in 2022/23 as it was subject to Cabinet approval and to be received in 2023/24. The SPE 2023/24, showing a break-even position, was prepared and approved in June 2023. This was prior to the ratification of the pay equity settlements and therefore the revenue accrual for 2023/24 occurred after the SPE was finalised.

Due to the pay equity revenue recognition flowing into 2023/24, there was an expectation for Health NZ to deliver a surplus of \$859m in 2023/24. This was revised down to \$583m after adjusting for Covid inventory expected to be written down of \$255m and an additional capital charge of \$21m. In June 2024, the expected surplus was further reduced to \$54m due to \$529m of funding not received in 2023/24 to offset pay equity costs for allied health staff (\$390m), midwifery (\$29m) and nursing lumpsum payments (\$110m).

The result achieved of \$722m was therefore unfavourable to the SPE budget by \$722m and to the expected surplus of \$54m by \$776m.

Significant Items

Significant items affecting the financial result include one-off and unbudgeted or above budget cost pressures, with some offsets in funding and other expenditure movements. These include:

- \$797m adverse personnel costs:** There are several factors operating together impacting the overall adverse variance in personnel costs which include FTE volume driven changes, salary price driven changes, staff liability movements, budget anomalies/savings and accruals movements.

Key drivers for the adverse variance include unbudgeted or unfunded cost impacts due to MECAs settled above budgeted levels (settlements ranged from 4% to 13.8% compared to the budgeted cost of settlement of 3%), increase in salaries from pay equity settlements and step changes, over recruitment in personnel (mainly in nursing and support staff), uplift in staff liabilities following year end valuation and Health NZ moving to ACC AEP as a single entity and unrealised budgeted savings.
- \$203m national reserve stock (NRS) for Covid19 expensed during the year:** Of the balance of stock transferred to Health NZ from the Ministry of Health, \$203m was stock on hand carried forward from 2022/23 and not budgeted for in the 2023/24 SPE. This has impacted the 2023/24 financial result, with \$100m of this consumed during the year and \$103m written-off at year end being expired stock and excess to NRS peak demand requirements.
- \$257m overspend in outsourced staff costs:** Of this, \$41m related to outsourced staff for delivering additional planned care services (with the cost fully offset by unbudgeted additional planned care funding). The balance of \$216m was mainly backfill for staff vacancies/leave and was offset by vacancy savings of \$87m realised in personnel costs
- \$48m unbudgeted expenses for the Holidays Act Remediation project costs.** Remediation processes are continuing to ensure all current and former employees are paid their dues and that payroll systems are rectified to calculate pay correctly.

25 Significant items affecting the financial result (continued)

- The above adverse impacts on the financial result were offset by \$204m net favourable movements in other revenue (across various income streams). There were also other offsetting movements across other expenditure lines.

26 Explanation of major variances against budget

The budget figures included in the financial statements are from the SPE 2023/24 and the comparison of the actual financial statements has been performed against this budget, noting that some line items in the SPE have been reclassified to align to Health NZ standard reporting format.

The major variances in the Statement of Comprehensive Revenue and Expenses

Crown Funding revenue is favourable to budget by \$290m, mainly:

- \$175m unbudgeted Hauora Māori funding (with offsetting costs) for the last quarter of 2023/24 following the disestablishment of the Māori Health Authority and transfer of services into Health NZ on 1 April 2024
- \$110m unbudgeted planned care funding with offsetting expenditure.

Other Funding from the Crown/Crown Entities revenue is favourable to budget by \$566m, mainly:

- ACC contract revenue is \$52m above budget mainly demand driven and due to improved billing.
- Other funding from the Crown/Crown Entities, \$433m above budget due to additional Pharmac funding (\$204m) from higher demand for funded medicines and increases in subsidy rates as per the Pharmaceutical Schedule. Also contributing to the variance is \$135m unbudgeted funding for disability services for a Health NZ subsidiary (Enable) with offsetting unbudgeted expenditure in infrastructure and non-clinical supplies.
- Other revenue is \$204m above budget, mainly due to demand driven revenue from non-resident patients and settlement of legal proceedings.

Personnel costs are \$797m over budget

The \$797m unfavourable variance to budget is driven by:

- \$489m unbudgeted costs attributed to volume drivers. Average FTEs were 954 higher than budget for the year. The over-recruitment in nursing (1,445 FTEs above budget) and allied health (85 FTE above budget) was offset by lower than budget FTEs in medical, support and management and admin staff (combined 576 FTEs below budget). Nursing FTE variance over budget includes over recruitment of nursing graduate intake, CCDM safe staffing contractual obligations meaning more nursing staff are required to fill rosters. Compounding the volume driven variance is also a price factor in that the salary rates for the overrecruited FTEs were also higher than rates assumed in the SPE budget following pay equity settlements.
- \$487m unbudgeted costs are attributed to price drivers (i.e. pay rate changes). These include impact of MECAs settled above budgeted levels for instance, MECAs settled for PSA Allied Health, NZNO, RDA/SToNZ, ASMS had a cost of settlement ranging from 4% to 13.8% which was higher than the budgeted level of 3% and not funded. Settled MECAs also include step progressions which move staff into higher salary bands than levels budgeted. Other contributing factors include unbudgeted RMOs incentive allowances for unsociable hours; uplift in liabilities for staff including leave liabilities; actuarially valued liabilities (e.g. long service leave and retiring gratuities) and unrealised budgeted savings.
- These were offset by vacancy savings mainly in medical, allied and management and admin costs circa \$87m for the year.

26 Explanation of major variances against budget (continued)

The major variances in the Statement of Comprehensive Revenue and Expenses (continued)

Outsourced personnel costs are \$257m over budget

The unfavourable variance to budget reflects backfill with outsourced staff to cover rosters, vacancies and staff leave. Personnel costs are budgeted based on full employment establishment and gaps in established positions are covered by outsourced staff. Also contributing to the variance are unbudgeted outsourced staff for time bound projects and initiatives including capital, some with offsetting funding.

Clinical supplies are \$537m over budget, mainly:

- Unbudgeted Covid-19 stock movement \$203m, made up of community provider and hospitals consumption \$100m and year end write-off of expired and excess stock inherited from the Ministry of Health \$103m (2022/23: \$284m).
- Hospital pharmaceuticals \$250m, with \$175m of this offset by funding from Pharmac for demand driven funded pharmaceutical drugs and \$75m related to price above budgeted inflation level for clinical supplies.
- \$64m savings in clinical supplies planned from procurement activity were not achieved, contributing to the variance.

Infrastructure, non-clinical supplies and other expenses are \$110m over budget

Underlying unfavourable variances included expenditure incurred by Enable not included in the budget (\$135m), with offsetting unbudgeted funding noted above, unbudgeted rent utilities and storage costs (\$75m) and an uplift in project cost provisions for the Holidays Act Remediation project costs (\$48m).

These were offset by other expenditure reductions within this cost category.

The major variances in the Statement of Financial Position

A number of the variances are directly related to the SPE not correctly reflecting the position post amalgamation, in that certain balances have not been eliminated. As the SPE was for the two periods ended 30 June 2023 and 2024 the same variance occurs in both years.

Some restricted funds were incorrectly classified as non-current liabilities in the SPE. These funds have been reclassified to equity in the budget and actuals in the annual report.

Cash and Cash Equivalents are under budget. The budget for Health NZ was the best estimate created prior to amalgamation of the District Health Boards, their Shared Service Agencies (subsidiaries) and prior to the transfer of services and functions from Ministry of Health/Manatū Hauora. The actual cash and cash equivalent reflects the true consolidated position post amalgamation.

Receivables are under budget mainly because the budget was set at a higher level based on the consolidated view of prior DHBs and their Shared Service Agencies. The actuals reflect the consolidated position after a national review of balance sheets of all Health NZ components to ensure consistent accounting treatment.

Inventories are under budget reflecting Covid-19 inventories expected to be carried forward to 2023/24 however \$284m of expired inventory was written off in 2022/23. A further write off of \$103m was accounted for in 2023/24, which was also not budgeted for.

Intangibles are over budget as the SPE did not fully capture the extent of the larger data and digital projects under development.

Investment in Associates and JV's – the SPE budget did not eliminate the investment in the shared service agencies when combining the amalgamated position.

26 Explanation of major variances against budget (continued)

The major variances in the Statement of Financial Position (continued)

Payables and Deferred Revenue are under budget. This is due to eliminating last year's inter entity balance sheet accounts as part of amalgamation adjustments, capital charge was paid before year end and there were reduced Covid commitments at year end when compared to the budget.

Revaluation Reserves above budget reflects the impact of land and building revaluations completed on 30 June 2023 that were not budgeted for.

The major variances in the Statement of Cash Flows

Funding from the Crown/Crown Entities is favourable to budget. Refer to the explanation for the revenue variances for the reasons for this.

Payments to Employees are above budget which reflects the cost of the additional unbudgeted nurses recruited, MECA's settled at amounts above budget, timing of pay equity settlements and payments for remediation for non-compliance with the Holidays Act. The SPE budget was set prior to the ratification of the various collective agreements.

Payments to Suppliers are above budget reflecting an expenditure uplift in line with the funding uplift. Other underlying variances include increased pharmaceutical costs (for which additional funding was received) and increased outsourced costs.

Capital charge payments were over budget which is mainly due to the increase in Crown equity from asset revaluations in 2022/23 and drawdowns against the Health Capital Envelope for Health NZ funded projects. Capital charge was incorrectly budgeted under cashflows from financing activities in the SPE. The budget and actuals have been reclassified to cashflows from operating activities.

Property, Plant and Equipment costs are below budget due to the SPE budget being completed prior to the phased capital plan for 2023/24 being approved.

27 Amalgamation of Te Aka Whai Ora | Māori Health Authority

Adjustments made to the carrying amounts of assets and liabilities and net assets on amalgamation of MHA into Health NZ

The Government passed legislation on 5 March 2024 to disestablish the Māori Health Authority (MHA) on 30 June 2024.

On 1 April 2024, the majority of the roles and functions of the MHA were amalgamated with Health NZ.

The combination has been accounted for as an amalgamation because the MHA and Health NZ were under common control and no consideration was paid for the acquisition.

The amalgamation has been accounted for using the pooling of interests method, which results in the assets and liabilities of MHA measured at their carrying amounts being combined with Health NZ assets and liabilities at the amalgamation date

As a result of the amalgamation the following assets and liabilities of the MHA were transferred to Health NZ under the Health Sector (Transfers) Act 1993:

	1 April 2024 \$m
Current Assets	
Cash and cash equivalents	137
Receivables	27
Prepayments	8
Total Current Assets	172
Total Assets	172
Current Liabilities	
Trade payables and deferred revenue	91
Employee entitlements	4
Total Current Liabilities	95
Total Liabilities	95
Net Assets	77

No adjustments were necessary to the carrying amounts of assets and liabilities and net assets as reported by the MHA at amalgamation date to conform the MHA accounting policies to Health NZ policies. \$22m of MHA receivables from Health NZ (payable by Health NZ to MHA) were eliminated on amalgamation.

Health NZ has elected not to present financial statements for the MHA for the period 1 July 2023 to 1 April 2024. Financial statements of the MHA for periods prior to amalgamation are available on the Health NZ website. MHA continued to exist as a legal entity until 30 June 2024. MHA has presented a final report for the period ending that date which is also available on Health NZ's website.

Revenue of \$549m, expenses of \$565m and a deficit of \$16m were reported by the MHA for the nine-month period from 1 July 2023 to 31 March 2024.

28 Statement of Performance Expectations 2024/25

Section 149C of the Crown Entities Act 2004 s149C requires each Crown Entity to prepare a Statement of Performance Expectations (SPE) before the start of each financial year. The 2024/25 SPE was not completed by 1 July 2024. The SPE is being revised to reflect the budget reset forecasts that indicate a larger deficit than previously planned for 2024/25.

29 Breach of Statutory Reporting Timeframes

The 2023/24 Annual Report of the Health New Zealand group was not completed by 31 October 2024, as required by section 156 of the Crown Entities Act 2004.

Additional Disclosures – Employee Remuneration

The number of Health NZ employees receiving remuneration over \$100,000 on an annualised basis.

Remuneration range	Actual 2024	Remuneration range	Actual 2024
\$100,000 – \$109,999	7,359	\$600,000 – \$609,999	16
\$110,000 – \$119,999	6,688	\$610,000 – \$619,999	18
\$120,000 – \$129,999	6,507	\$620,000 – \$629,999	18
\$130,000 – \$139,999	5,963	\$630,000 – \$639,999	8
\$140,000 – \$149,999	4,762	\$640,000 – \$649,999	9
\$150,000 – \$159,999	3,814	\$650,000 – \$659,999	6
\$160,000 – \$169,999	3,025	\$660,000 – \$669,999	9
\$170,000 – \$179,999	2,190	\$670,000 – \$679,999	6
\$180,000 – \$189,999	1,469	\$680,000 – \$689,999	4
\$190,000 – \$199,999	1,090	\$690,000 – \$699,999	8
\$200,000 – \$209,999	770	\$700,000 – \$709,999	6
\$210,000 – \$219,999	639	\$710,000 – \$719,999	3
\$220,000 – \$229,999	524	\$720,000 – \$729,999	6
\$230,000 – \$239,999	429	\$730,000 – \$739,999	4
\$240,000 – \$249,999	351	\$740,000 – \$749,999	7
\$250,000 – \$259,999	341	\$750,000 – \$759,999	5
\$260,000 – \$269,999	311	\$770,000 – \$779,999	4
\$270,000 – \$279,999	263	\$790,000 – \$799,999	1
\$280,000 – \$289,999	268	\$800,000 – \$809,999	2
\$290,000 – \$299,999	247	\$810,000 – \$819,999	1
\$300,000 – \$309,999	257	\$820,000 – \$829,999	1
\$310,000 – \$319,999	238	\$830,000 – \$839,999	1
\$320,000 – \$329,999	228	\$840,000 – \$849,999	1
\$330,000 – \$339,999	202	\$850,000 – \$859,999	1
\$340,000 – \$349,999	206	\$880,000 – \$889,999	2
\$350,000 – \$359,999	169	\$890,000 – \$899,999	1
\$360,000 – \$369,999	148	\$900,000 – \$910,000	2
\$370,000 – \$379,999	178	\$910,000 – \$919,999	3
\$380,000 – \$389,999	143	\$920,000 – \$929,999	1
\$390,000 – \$399,999	134	\$930,000 – \$939,999	1
\$400,000 – \$409,999	140	\$940,000 – \$949,999	3
\$410,000 – \$419,999	127	\$950,000 – \$959,999	1
\$420,000 – \$429,999	105	\$970,000 – \$979,000	1
\$430,000 – \$439,999	107	\$980,000 – \$989,999	1
\$440,000 – \$449,999	92	\$1,010,000 – \$1,019,999	1
\$450,000 – \$459,999	86	\$1,060,000 – \$1,069,999	1
\$460,000 – \$469,999	71	\$1,070,000 – \$1,079,999	1
\$470,000 – \$479,999	69	\$1,080,000 – \$1,089,999	1
\$480,000 – \$489,999	55	\$1,100,000 – \$1,109,999	1
\$490,000 – \$499,999	51	\$1,110,000 – \$1,119,999	1
\$500,000 – \$509,999	44	\$1,120,000 – \$1,299,999	1
\$510,000 – \$519,999	40	\$1,170,000 – \$1,179,999	1
\$520,000 – \$529,999	22	\$1,230,000 – \$1,239,999	1
\$530,000 – \$539,999	30	\$1,260,000 – \$1,269,999	1
\$540,000 – \$549,999	30	\$1,350,000 – \$1,359,999	1
\$550,000 – \$559,999	17	\$1,370,000 – \$1,379,999	1
\$560,000 – \$569,999	16	\$1,390,000 – \$1,399,999	1
\$570,000 – \$579,999	15	\$1,470,000 – \$1,479,999	2
\$580,000 – \$589,999	13	\$1,530,000 – \$1,539,999	1
\$590,000 – \$599,999	11	\$1,580,000 – \$1,589,999	1
		Total	50,232

730 employees received compensation and other benefits in relation to cessation totaling \$22,899,478. Annualised remuneration increased in 2023/24 due to Holidays Act remediation, pay equity settlements and MECA step changes.



INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF THE GROUP FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION OF HEALTH NEW ZEALAND | TE WHATU ORA FOR THE YEAR ENDED 30 JUNE 2024

I have audited the financial statements and performance information, including the performance information for each appropriation, of Health New Zealand | Te Whatu Ora (the Group) for the year ended 30 June 2024, using my staff and resources.

The financial statements of the Group on pages 193 to 249 comprise the statement of financial position as at 30 June 2024, the statement of comprehensive revenue and expense, statement of changes in equity, and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information.

The performance information, which reports against the Group's statement of performance expectations and appropriations for the year ended 30 June 2024, is contained on pages 91 to 189, 261 to 264 and 274 to 278.

Opinion

In my opinion:

- the financial statements of the Group:
 - present fairly, in all material respects:
 - its financial position as at 30 June 2024; and
 - its financial performance and cash flows for the year then ended; and
 - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.
- the performance information of the Group for the year ended 30 June 2024:
 - presents fairly, in all material respects, for each class of reportable outputs:
 - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
 - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
 - presents fairly, in all material respects, for the appropriations:
 - what has been achieved with the appropriations; and
 - the actual expenses or capital expenditure incurred as compared with the expenses or capital expenditure appropriated or forecast to be incurred; and
 - complies with generally accepted accounting practice in New Zealand.

My audit was completed on 14 November 2024. This is the date at which my opinion is expressed.

The basis for my opinion is explained below. I outline the key audit matters addressed in my audit, and I draw attention to the financial statements being prepared on a going concern basis. In addition, I outline the responsibilities of the Commissioner and Deputy Commissioners for the financial statements and the performance information, and my responsibilities. I also comment on other information and explain my independence.

Basis for my opinion

I carried out my audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. My responsibilities under those standards are further described in the *Responsibilities of the auditor* section of this report.

I have fulfilled my responsibilities in accordance with the Auditor-General's Auditing Standards.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Key audit matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial statements and the performance information of the Group for the current year. In making this determination, I considered those matters that are complex, have a high degree of uncertainty, or are important to the public because of their size or nature.

The key audit matters were addressed in the context of my audit of the financial statements and the performance information of the Group as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

The key audit matters are described below.

Entitlements under the Holidays Act 2003	How we addressed this matter
<p>As outlined in note 16, the employee entitlements liability includes a \$1.83 billion 'Holidays Act 2003 remediation' provision. This provision is for amounts owing to employees who have been paid less than their legal leave entitlements under the Holidays Act 2003 (Holidays Act).</p> <p>Progress on paying out affected employees has been slow, with payments made during the 2023/24 financial year only to current employees in the Auckland region.</p> <p>The Group has not yet finished determining the final amounts it owes to all other current and former employees and there is significant uncertainty about the actual payments required to be made until this is done.</p> <p>The Group operates many payroll systems. Other than the Auckland region, the systems do not comply with the Holidays Act. Each system will remain non-compliant until final amounts to current employees paid through the system are determined and remediated.</p> <p>A sufficiently reliable estimate of the Group's liability has been made. This includes bringing forward the opening provision, reducing it based on updated modelling, adding an estimate of the amount required for the additional year of non-compliance and deducting payments made during the 2023/24 financial year.</p> <p>The Group's external experts completed further modelling for the three metro Auckland districts following payments to current employees in those districts. These models use better quality data and take account of decisions made by the Group about remediation entitlements and the circumstances of individual employees to calculate the estimated amounts to pay.</p> <p>I considered this to be a key matter due to the significant amount of public money involved, the judgements and assumptions involved in estimating the liability and the impact on many thousands of current and former health sector employees.</p>	<p>We obtained an update on the progress made during the year in calculating the amounts owed, and paid, to affected employees.</p> <p>We made enquiries of management to obtain an understanding of the method, data and assumptions used to estimate the amount required for the additional year of non-compliance and assessed the method for compliance with the requirements of PBE IPSAS 39, <i>Employee Benefits</i>.</p> <p>We considered the appropriateness and reasonableness of key judgements made and assumptions applied and tested the source data used and calculations of the additional amount of the provision for this year.</p> <p>We reviewed the appropriateness of the remodelling work completed by the Group's external expert for the three metro Auckland districts.</p> <p>We evaluated whether the provision recorded for the three metro Auckland districts has been estimated using assumptions that reflect the best available information.</p> <p>We evaluated the relevance of the model outcomes for the three metro Auckland districts to the remaining 17 districts. We encountered challenges in obtaining adequate evidence about its relevance and likely consequence, because the Group did not determine the effect of the decisions made or the circumstances of individual employees on the provision recorded for the remaining 17 districts.</p> <p>Based on additional procedures performed, we considered whether the total amount of the provision could be materially overstated.</p> <p>We assessed whether the Group has adequately addressed estimation uncertainty, including making appropriate disclosures.</p> <p>I am satisfied that the provision of \$1.83 billion for employees who have been paid less than their legal leave entitlements under the Holidays Act 2003 is reasonable but significant uncertainty remains.</p>

Fair value of buildings	How we addressed this matter
<p>As outlined in note 12, the Group owns a large portfolio of building assets with a carrying value of \$9.17 billion at 30 June 2024.</p>	<p>We made enquiries of management about how it has determined that the carrying value of buildings is not materially different to fair value.</p>
<p>These assets were last revalued at 30 June 2023.</p>	<p>We reviewed the assessment completed by management and evaluated whether it is sufficiently robust to comply with the requirements of PBE IPSAS 17, <i>Property, Plant and Equipment</i>.</p>
<p>Due to the specialised nature of most of the Group's buildings, they are valued using a depreciated replacement cost methodology. A small number of non-specialised buildings are valued using a market-based approach.</p>	<p>We evaluated the application of the method, reliability of data and appropriateness of assumptions used and tested management's estimate of the fair value of buildings, including calculations, and considered the sensitivity of the estimate of fair value to changes in assumptions.</p>
<p>When the carrying amount of revalued assets differs materially from their fair value, accounting standards require a revaluation to be performed for the entire asset class.</p>	<p>We evaluated the appropriateness of the cost escalation between years by comparing this to relevant price indices.</p>
<p>Management made an assessment with the assistance of independent valuers and other experts to determine if fair value could be materially different to carrying value at 30 June 2024.</p>	<p>We assessed the expertise of the independent valuers and other experts for the work and their objectivity.</p>
<p>I considered the fair value of buildings to be a key matter because of the financial significance of the asset balance and the judgements and assumptions involved in determining fair value.</p>	<p>We determined if assets have been appropriately assessed by management for impairment as part of this exercise.</p> <p>I am satisfied that the value of building assets held at fair value in the Group's financial statements is reasonable.</p>

Emphasis of matter – Going concern is dependent on a letter of support

Without modifying my opinion, I draw your attention to Note 1 on pages 198 and 199, which outlines that the financial statements have been prepared on a going concern basis. There is uncertainty whether the Group will be able to meet its obligations because a net loss of \$722 million was incurred for the current year (see page 193), and an operating loss of \$1.10 billion is forecast for the financial year ending 30 June 2025. The Group's current liabilities also exceed its current assets by \$4.44 billion (see page 195).

The Group therefore obtained a letter of support from the Ministers of Health and Finance to confirm the Government's commitment to maintain the Group's financial viability. The letter acknowledges that equity support may be required and that the Crown will provide such support where necessary.

Responsibilities of the Commissioner and Deputy Commissioners for the financial statements and the performance information

The preparation of the financial statements and performance information of the Group is the responsibility of the Commissioner and Deputy Commissioners.

The Commissioner was appointed to replace the Board of Health New Zealand in accordance with the Pae Ora (Healthy Futures) Act 2022. The Commissioner's term started on 24 July 2024. The Commissioner has subsequently appointed three Deputy Commissioners.

The Commissioner and Deputy Commissioners are responsible on behalf of the Group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

Up until the appointment of the Commissioner, the Board of Health New Zealand was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error. Since their appointment, the Commissioner and Deputy Commissioners took over these responsibilities to enable the completion of the financial statements and performance information.

In preparing the financial statements and the performance information, the Commissioner and Deputy Commissioners are responsible, on behalf of the Group, for assessing the Group's ability to continue as a going concern. The Commissioner and Deputy Commissioners are also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Group, or there is no realistic alternative but to do so.

The responsibilities of the Commissioner and Deputy Commissioners arise from the Pae Ora (Healthy Futures) Act 2022, the Crown Entities Act 2004 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

My objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, my procedures were limited to checking that the information agreed to the Group's statement of performance expectations and relevant Estimates and Supplementary Estimates of Appropriations 2023/24.

I did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- I identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, because fraud can involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- I obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.
- I evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioner and Deputy Commissioners.
- I evaluate the appropriateness of the performance information which reports against the Group's statement of performance expectations and appropriations.
- I conclude on the appropriateness of the use of the going concern basis of accounting by the Commissioner and Deputy Commissioners and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Group's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- I evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- I obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. I am responsible for the direction, supervision and performance of the Group audit. I remain solely responsible for my audit opinion.

I communicate with the Commissioner and Deputy Commissioners regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

From the matters communicated with the Commissioner and Deputy Commissioners, I determine those matters that were of most significance in my audit of the financial statements and the performance information for the current year and are therefore the key audit matters described in this report.

My responsibilities arise from the Public Audit Act 2001.

Other information

The Commissioner and Deputy Commissioners are responsible for the other information. The other information comprises the information included on pages 1 to 89, 190, 192, 250, 259 to 260 and 265 to 273 but does not include the financial statements and the performance information, and my auditor's report thereon.

My opinion on the financial statements and the performance information does not cover the other information and I do not express any form of audit opinion or assurance conclusion thereon.

In connection with my audit of the financial statements and the performance information, my responsibility is to read the other information. In doing so, I consider whether the other information is materially inconsistent with the financial statements and the performance information or my knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on my work, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Independence

While carrying out this audit, my staff and I complied with the Auditor-General's independence requirements, which incorporate the independence 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.

My staff and I use publicly funded health services on the same basis as others. This has not impaired my staff's independence, or me in exercising my functions and powers under the Public Audit Act 2001 as the auditor of public entities.

In addition to the audit, my staff and appointed auditors and their staff have carried out the assurance engagements outlined in note 5 of the financial statements. These are compatible with those independence requirements. This has not impaired my independence as auditor of the Group. Other than these engagements, and in exercising my functions and powers under the Public Audit Act 2001 as the auditor of public entities, I have no relationship with or interests in Health New Zealand or any of its subsidiaries or controlled entities.



John Ryan
Controller and Auditor-General | Tumuaki o te Mana Arotake
Wellington, New Zealand

Section 6

Appendices

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Other appendices available on [our website](#)

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- Summary of Ngā Parewa Audit results for 2023/24



Appendix 1: Board committee membership

1. Capital and Infrastructure Committee

Chair: Naomi Ferguson

ELT lead: Jeremy Holman

Te Aka Whai Ora attendee:

Fiona Pimm

Members: Dame Dr Karen Poutasi, Hon. Amy Adams

Independent Members: Lale Ileremia, Mei Fern Johnston, Scott Pritchard

2. Clinical Quality Assurance Committee

Chair: Dr Curtis Walker

ELT lead: Dr Dale Bramley

Te Aka Whai Ora attendee:

Dr Sue Crengle

Members: Dr Jeff Lowe, Dame Dr Karen Poutasi

Independent Members: Dr Marie Bismark

3. Data, Digital and Innovation Committee

Chair: Hon. Amy Adams

ELT lead: Leigh Donoghue

Te Aka Whai Ora attendee:

Dr Mataroria Lyndon

Members: Naomi Ferguson, Dr Jeff Lowe

Independent Members: Marcus Porter

4. Finance and Audit Committee

Chair: Marc Rivers (Independent Member) (until April 2024)

Chair: Roger Jarrod (from May 2024)

ELT lead: Rosalie Hughes

Te Aka Whai Ora attendee:

Steven McJorow

Members: Hon. Amy Adams, Naomi Ferguson, Vanessa Stoddart, Roger Jarrod (from March 2024)

Independent Members: Jonathan Oram

5. Health, Safety and Wellbeing Committee

Chair: Vanessa Stoddart

ELT lead: Andrew Slater

Te Aka Whai Ora attendee:

Tipa Mahuta

Members: Dame Dr Karen Poutasi, Dr Curtis Walker, Naomi Ferguson

6. People, Culture, Development and Change Committee

Chair: Vanessa Stoddart

ELT lead: Andrew Slater

Te Aka Whai Ora attendee:

Tipa Mahuta

Members: Dr Curtis Walker, Naomi Ferguson, Dame Dr Karen Poutasi

Independent Members: Vena Crawley

7. Health Services Committee

Chair: Dame Dr Karen Poutasi

ELT lead: Dr Nick Chamberlain,

Abbe Anderson, Fionnagh Dougan

Te Aka Whai Ora attendee:

Te Awerangi Tamihere, Dr Sue Crengle

Members: Dr Jeff Lowe

Independent Members: Tevita Funaki, Michal Noonan

Appendix 2: CNGP emissions profile broken down by emissions source / scopes (tCO₂e)

CNGP Activity Groups	tCO ₂ e	CNGP Activity Groups	tCO ₂ e
Scope 1 – Agriculture (all emissions)	-	Scope 3 (mandatory) – Freight	-
Scope 1 – Biofuel (fossil fuel emissions and N ₂ O and CH ₄ component for the biofuel portion)	-	Scope 3 (mandatory) – Staff working from home	-
Scope 1 – Biomass (fossil fuel emissions and N ₂ O and CH ₄ component for the biofuel portion)	10	Scope 3 (mandatory) – Transmission and distributions losses (electricity)	1,810
Scope 1 – Forestry – harvest/deforestation	-	Scope 3 (mandatory) – Transmission and distributions losses (natural gas)	1,821
Scope 1 – Refrigerants, medical and other gases	15,682	Scope 3 (mandatory) – Waste (to landfill)	6,368
Scope 1 – Other	-	Scope 3 (mandatory) – Wastewater	2,712
Scope 1 – Stationary combustion – coal	7,718	Scope 3 (mandatory) – Water	210
Scope 1 – Stationary combustion – natural gas and LPG	49,684	Scope 3 (other material) – Emissions from purchased goods and services	15,347
Scope 1 – Stationary combustion – other (e.g. diesel)	1,497	Scope 3 (other material) – Emissions from purchased capital goods	-
Scope 1 – Transport fuels – aviation	-	Scope 3 (other material) – Other (e.g. staff commuting, investments, leased assets)	8,655
Scope 1 – Transport fuels – other (e.g. shipping fuel)	-	Scope 1 Biogenic emissions – Biofuel CO ₂ component (considered carbon neutral)	-
Scope 1 – Transport fuels – vehicle fleet	8,493	Scope 1 Biogenic emissions – Biomass CO ₂ component (considered carbon neutral)	27,942
Scope 2 – Electricity	26,425	Removals – Forest growth removals	-
Scope 2 – Other (e.g. purchased steam)	586		
Scope 3 (mandatory) – Air travel domestic	30,329		
Scope 3 (mandatory) – Air travel international	25,350		
Scope 3 (mandatory) – Business travel other (eg. taxi, hotel, rental cars)	2,570		

Appendix 3: Performance measures unable to be reported in 2023/24

This appendix sets out nine performance measures that we are unable to report this year.

Two of these are contingent measures, where the circumstances required to use them have not eventuated. The remaining seven are measures where the systems necessary to enable reporting have not been established, or data was not available to enable reporting.

These measures will be reviewed following the publication of this report and decisions made on whether these should continue in future years.

Output class 1: Public health services

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-128	Maintain Public Health contact tracing and case management capacity through scalable telehealth services and digital pathways in line with response/pandemic requirements	Up to 1,000 cases per day	Achieved	Has not been required	—
<p>The National Case Investigation Service (NCIS) for COVID-19 operated from 1 July 2023 to 14 August 2023. The NCIS ceased following the removal of COVID-19 mandatory isolation. Public health capacity for case management and contact tracing is now part of Health NZ business as usual and is delivered through regional public health services.</p> <p>Notes to the measure:</p> <p>a) Results for prior year – average of 2,877.</p> <p>b) NPHS maintains capacity for case management and contact tracing as part of its capability to respond to any communicable disease that requires this level of management. With the removal of mandatory isolation, COVID-19 funding for this function has been returned and that capacity has not been maintained.</p>					

Output class 2: Primary and community services

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status												
P2-18	Percentage of smokers enrolled with a stop smoking service, who set a target quit date and will be CO validated at 4 weeks	50%	New measure	Unable to report	—												
<p>Baseline: Māori 49%, Pacific 18%, non-Māori, non-Pacific 33%</p> <p>The status against target is 'unable to report' for 2023/24. More work is required to ensure our provider network accurately and consistently report their activities so the result for this measure can be accurately calculated.</p> <p>Notes to the measure:</p> <p>a) Spelling error in measure as originally published in Statement of Performance Expectation 2023/24 referred to 'CO₂ validated' where it should be 'CO validated'.</p>																	
P2-26	Increase in actual expenditure by kaupapa Māori hospital and specialist health service providers compared with the average of last five financial years	Achieved	47.0% increase	Unable to report	—												
<table border="1"> <thead> <tr> <th></th> <th>2022/23 \$000</th> <th>2023/24 \$000</th> </tr> </thead> <tbody> <tr> <td>Te Aka Whai Ora</td> <td>478,060</td> <td>516,537</td> </tr> <tr> <td>Hauora Māori Directorate (Health NZ)</td> <td>-</td> <td>187,438</td> </tr> <tr> <td></td> <td>\$478,060</td> <td>\$703,975</td> </tr> </tbody> </table> <p>Notes to the measure:</p> <p>a) Much of the Māori health spend was moved to Te Aka Whai Ora on 1 July 2022 and came under that entity for the 21 months from 1 July 2022 to 31 March 2024. During 2022/23 the transferred funding continued to be in the Primary and community appropriation, with new funding provided through a new Hauora Māori appropriation. In 2023/24, these funding streams were merged into the Hauora Māori appropriation. The expenditure shown here is the commissioning spend for Te Aka Whai Ora and Hauora Māori.</p> <p>b) There were transfers from Health NZ to Te Aka Whai Ora which increased the Hauora Māori appropriation for specific projects (e.g. immunisations).</p> <p>c) Comparison is only available against 2022/23. We will move towards a 5-year comparison as that history is built up.</p>							2022/23 \$000	2023/24 \$000	Te Aka Whai Ora	478,060	516,537	Hauora Māori Directorate (Health NZ)	-	187,438		\$478,060	\$703,975
	2022/23 \$000	2023/24 \$000															
Te Aka Whai Ora	478,060	516,537															
Hauora Māori Directorate (Health NZ)	-	187,438															
	\$478,060	\$703,975															
P2-147	Expenditure is consistent with budget for this Appropriation against key line items and overall	Achieved	New measure	Unable to report	—												
<p>This measure relates to Delivering Primary, Community, Public and Population Health Services appropriation.</p> <p>We are unable to report against these performance measures as our cost allocation systems is designed to report against our output classes. Our output class reporting on page 94 provides details of budgeted and actual expenditure on an output class basis.</p>																	

Output Class 3: Hospital and specialist services

Ref	Measure	Target per SPE/Vote	2022/23 Result	2023/24 Result	Status
P2-60	Increase in actual expenditure by kaupapa Māori hospital and specialist health service providers compared with the average of last five financial years	Achieved	New measure	Unable to report	—
<p>All the transferred funding into Te Aka Whai Ora from Ministry of Health/District Health Boards was tagged as Primary and Community and related to commissioned health services and some staff. There are no external Māori hospital and specialist health service providers funded from this output class – so there is no related expenditure.</p>					
P2-54	Percentage of women, who have evidence of clinical suspicion of invasive carcinoma, or a laboratory report indicating 'features suspicious for invasion', or 'changes consistent with squamous cell carcinoma', or similar, who receive a date for a colposcopy appointment or a gynaecological assessment that is within 10 working days of receipt of the referral	Greater than or equal to 95%	New measure	Unable to report	—
<p>Notes to the measure:</p> <p>a) The status against target remains 'unable to report' for 2023/24, as this has not been able to be measured since it was introduced. The measure will be discontinued from 2024/25.</p>					
P2-67	The proportion of hospital and specialist services within Health NZ that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4	Achieved	N/A	Unable to report	—
<p>This measure relates specifically to reporting against the CE QSM for hospital and specialist services. As it is not possible to report separately for these services at this time, this measure has been combined with P2-36.</p>					
P2-148	Expenditure is consistent with budget for this Appropriation against key line items and overall	Achieved	New measure	Unable to report	—
<p>This measure relates to Delivering Hospital and Specialist services appropriation.</p> <p>We are unable to report against these performance measures as our cost allocation systems is designed to report against our output classes. Our output class reporting on page 94 provides details of budgeted and actual expenditure on an output class basis.</p>					

Output Class 5: Capital programmes

Ref	Measure	Target	2022/23 Result	2023/24 Result	Status
P2-93	Percentage of drawdowns repaid in 10 business days or less	100%	N/A	Has not been required	—

Health NZ has a \$200m Standby Credit Facility with the Crown, set up in May 2023.

This has not been accessed to date as Health NZ has had sufficient cash to meet its obligations

Appendix 4: Significant budget initiatives

Budget 23 Initiatives: updates

North Island Weather Events: Primary, Community and Residential Care Recovery

This initiative provides funding to support provision of primary, community and residential care services to the population affected by the North Island weather events.

Total funding
(across life of
initiative)

\$6.111m

Overall
spend to
30 June 2024

\$4.636m

During the year, we provided workforce relief through provision of locum general practitioners, pharmacy and nursing staff to communities affected by the North Island weather events. The ability of pharmacies to mitigate some of the pressure on general practice has been welcomed.

We have also increased national telehealth capacity, including through providing equipment for practices to do this.

North Island Weather Events: Hospital and Specialist Services

This initiative provides funding for air and road transport enabling planned care, outreach, and other hospital services for isolated communities. It also funds alternative provision of acute health care, and urgent repairs to hospital facilities because of the impact of the North Island weather events.

Total funding
(across life of
initiative)

\$8.850m

Overall
spend to
30 June 2024

\$3.215m

Air ambulance team resilience funding updates

Northern Rescue Helicopters Ltd (NRHL)

- Two 1900-litre Jet A1 fuel trailers were purchased. One is on site at Kaitaia Hospital. The second trailer will be stored by a local contractor until the new garage is constructed.
- Road ambulance support has been a stalling point for the helipad upgrades, as the temporary landing zones will require a road ambulance transfer to get the patient from helicopter to hospital. To resolve this issue, NRHL has opted to provide the road service themselves, using their backup vehicle to transfer patients from Whangārei hospital to the Kensington helicopter base.
- NRHL have developed contingency plans in the event the primary vehicle is out for maintenance.

Central Air Ambulance Rescue Limited

- Enhancements at Gisborne base are awaiting Council approval.
- Improvements to Te Araroa helipad and surrounds have commenced.
- Fuel supplies in place at Ruatoria Airport. Ruatoria Helipad will require NZCAA Part 157 notification, which is being prepared.
- Improved timely access for remote communities and disaster resilience for the East Cape.

Geofencing

- Additional support from air ambulance helicopters was put in place in Tairāwhiti to facilitate access to health care for communities affected by roading infrastructure damage during severe weather events.

This initiative has helped improve air and road transport which enables planned care, outreach and other hospital services for those living in isolated communities in the Northern and Central Ikaroa region.

North Island Weather Events: Mental Health and Wellbeing Response

This initiative provides funding for locally led, community-based mental wellbeing initiatives to meet the psychosocial care need for populations in areas affected by the North Island weather events, including Māori, Pacific Peoples and youth. This includes funding of \$3.747 million for the expansion of the Mana Ake – Stronger for Tomorrow programme into Hawke's Bay and Tairāwhiti.

Total funding
(across life of
initiative)
\$10.000m

Overall
spend to
30 June 2024
\$9.713m

Majority of the funding has been allocated to communities and implemented. This has seen over 25,000 people able to access additional support including counselling and wellbeing initiatives.

Contracts are in place with Mana Ake providers for school-based wellbeing support in Tairāwhiti and service delivery has commenced. Service delivery is expected to commence in Hawke's Bay in Term 3 2023/24.

Support Workers (Pay Equity) Settlements Act 2017

This initiative provides funding for support worker wages increases from 1 July 2021 specified in the Support Workers (Pay Equity) Settlements Act 2017.

Total funding
(across life of
initiative)
\$193.145m

Overall
spend to
30 June 2024
\$77.258m

All funding for Pay Equity Labour Cost Index settlement increase for support workers has been paid out to providers through an increased price and is now built into baseline.

Emergency Road Ambulance Services – Additional Support Funding

This initiative provides additional funding to support essential emergency road ambulance services for New Zealand's urban and rural communities.

Total funding
(across life of
initiative)
\$166.06m

Overall
spend to
30 June 2024
\$76.508m

- Ambulance providers have increased frontline staff by over 345 FTE from the beginning of the previous financial year.
- National urban response performance to suspected cardiac or respiratory arrest incidents has improved from 47% responded within 6 minutes (in June 2022) to 58% (in May 2024) and from 92% responded within 12 minutes to 93%.
- National urban response performance to incidents appearing life threatening or time critical has improved from 36% responded within 8 minutes (in June 2022) to 44% (in May 2024) and from 86% responded within 20 minutes to 92%.

Comprehensive Primary Care Teams

This initiative provides funding for the establishment of tightly integrated primary care teams within locality provider networks

Total funding
(across life of
initiative)

\$102.00m

Overall
spend to
30 June 2024

\$65.30m

Regions are implementing the Comprehensive Primary Care Teams (CPCT), with support from the national team.

Confirmed roles recruited and in place nationally equalled 215.2 FTE at the end of June. In addition, Haoura Māori partners have employed the equivalent of 129 Kaiāwhina (including full and part-time roles) and Pacific providers have been contracted to employ the equivalent of 55.5 FTE Pacific Kaiāwhina. This brings the total roles funded to 399.7 FTE.

A national reporting framework has been established for the regions to report contractual outcome measures quarterly or six monthly. The outcome measures reported will differ depending on the focus of the CPCT and the roles recruited.

As the funding is time-limited to the end of FY2024/25, many roles have been recruited as fixed term positions. The regional commissioning teams will continue to work with their local PHOs and practices to explore options for ongoing funding of CPCT roles.

Specialist Mental Health and Addiction Services – Increasing Availability of Focused Supports

This initiative provides funding to increase the availability and trial new models of specialist mental health and addiction services to support people with specific needs in targeted areas across the country

Total funding
(across life of
initiative)
\$100.00m

Overall
spend to
30 June 2024
\$16.97m

Eating Disorders: This funding increases annually over a four-year period through to June 2026 and is intended to expand the four existing Regional Eating Disorders Services. At full scale in June 2026 this initiative will fund 12.5 additional FTE across the four services. While workforce shortages have resulted in some delays, there is ongoing recruitment and good progress is being made.

Maternal and Infant Mental Health Services: This funding increases annually over a four-year period through to June 2026 and is intended to fund additional FTE for community-based specialist maternal mental health services, including home based supports for whānau with higher needs. At full scale from the end of 2025/26, this initiative will fund approximately an additional 21 FTE per annum and approximately 97 packages of care. Packages of Care are flexibly tailored whānau-centred support packages, including home based respite, practical support and other respite options as appropriate.

Community Based Crisis Services: This funding is aimed at expanding community-based crisis services including a mix of intensive community supports, Police co-response services, expanding community-based crisis teams, homes-based respite and peer-led services. Funding has been targeted at those areas with the lowest level of investment compared to other parts of the country.

Infant Child and Adolescent Mental Health Services: This funding is aimed at expanding specialist mental health and addiction services for infants, children and young people (ICAMHS). Funding has been utilised to expand services in areas with low levels of investment compared with other parts of the country (Northland, Hawke’s Bay and MidCentral), with the majority of these new roles in place. Funding was also made available to provide increased mental health and addiction support in Oranga Tamariki residences in Hutt Valley and Invercargill, and to fund Oranga Tamariki Social Workers in the three child and youth mental health inpatient units across the country (Auckland, Wellington and Christchurch) in order to enhance pathways and co-ordination of care for young people who access both mental health and addiction and Oranga Tamariki services.

Drug Checking Services: Four licensed drug checking providers are continuing to deliver drug checking services. Drug checking providers tested more than 3,500 samples on the frontline between 1 Dec 2023 and 15 Jan 2024. This compares to approximately 2,400 samples tested across the same period the previous summer.

North Island Weather Events: Transport and Power

This initiative provides funding for leasing suitable additional vehicles to provide for patient access where road infrastructure is compromised, and generators and diesel for the continued operation of health services while repairs are undertaken, following the North Island weather events.

Total funding
(across life of
initiative)
\$1.736m

Overall
spend to
30 June 2024
\$3.680m

- 32 generators procured to ensure business continuity during ongoing power outages.
- Appropriate vehicles to enable outreach activities were procured for access to communities where road access is limited
- Leased two large scale generators (one in Tairāwhiti, one in Wairoa) to provide back-up power to hospitals.

Population Health and Disease Management Digital Capability

This initiative provides ongoing funding to retain selected capability and infrastructure developed in response to the COVID-19 pandemic and to provide a basis for future population health and disease management digital capability.

Total funding
(across life of
initiative)
\$125.32m

Overall
spend to
30 June 2024
\$66.186m

The Notifiable Disease Management System (NDMS) went live at the end of February. This will enable management of communicable diseases at a local, regional and national level, allowing a national, co-ordinated response to case and contact tracing. Measles and COVID-19 are now supported by this system allowing nationally consistent management of outbreaks. Meningococcal, pertussis (whooping cough), mumps, and enteric diseases will be moved onto the system in August, September, October and December 2024 respectively.

My Health Record, a new consumer self-service platform, was released in March 2024 and includes the ability for health care consumers to view their NHI details and update preferred name, address, ethnicity and gender, view some NHI details for linked children, view entitlements (High Use Health Card and Community Services Card) and view linked children's COVID-19 test results. This was a re-use of the My Covid Record solution.

The Aotearoa Immunisation Register (AIR), which was launched in December 2024, tracks immunisation records and status for children and adults. AIR used the learnings from the interim COVID-19 Immunisation Register (CIR).

Covid-19 platforms and infrastructure that are no longer required have been decommissioned.

The reduction in funding has resulted in a significant change to scope for a number of services. We will continue to operate with more expensive and risky legacy IT arrangements for longer and the focus shifts to 'keeping the lights on', while we build the broader 10-year Investment Case.

Appendix 5: Glossary of terms, acronyms and definitions

Acronyms and definitions

Term	Definition
ACC	Accident Compensation Corporation
AIR	Aotearoa Immunisation Register
API	Application Programming Interface
ARC	Aged Residential Care
ASH	Ambulatory sensitive (avoidable) hospital admissions
Case-weights	A case-weight reflects the resources needed to diagnose and treat a case in a respective case group compared to the average cost of diagnosing and treating across all cases. The case mix is the sum of the relative casegroup weights of all cases treated in a health facility during a given period. In general, the case mix of lower-level facilities is lower than that of higher-level facilities, such as tertiary hospitals, that provide a higher share of complex services.
CEQSM	Consumer engagement Quality Safety Marker
CIR	COVID-19 Immunisation Register
COPD	Chronic obstructive pulmonary disease
CPAC	Clinical Prioritisation Assessment Criteria
CNPG	Carbon Neutral Government Programme
CT	Computerized Tomography
DHB	District Health Board (no longer in operation)

Term	Definition
DMFT	Decayed Missing Filled Teeth
DRS	Diabetic retinal screening
ED	Emergency Department
ENT	Ear, nose and throat
ESPI	Elective services patient flow indicators
FENZ	Fire and Emergency New Zealand
FIT	Faecal immunochemical test
FSA	First specialist assessment
FTE	Full Time Equivalent
FY	Financial year
GP	General Practice
GPEP	General Practice Education Programme
HCE	Health Capital Envelope
HCSS	Home and community support services
HIRA	National digital exchange platform for health information
HNZ	Health New Zealand
HPV	Human papilloma viruses
HSS	Hospital and specialist services
HSU	Health Service Users
ICT	Information and Communication Technology
iGPS	Interim Government Policy Statement on Health

Term	Definition
IMPB	Iwi Māori Partnership Board
IPMHA	Integrated primary mental health and addiction services
LMC	Lead Maternity Carer
MECA	Multi-Employer Collective Agreement
MH&A	Mental health and addictions
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
N/A	Not available
NAMS	National Asset Management Strategy
NBES	Newborn enrolment service
NBSP	National Bowel Screening Programme
NCEA	National Certificate of Education Achievement
NCIS	National Case Investigation Service
NCSP	National Cervical Screening Programme
NGO	Non-government organisation
NHI	National Health Index
NIR	National Immunisation Register (replaced with AIR)
NMDS	National Minimum Dataset
NPHS	National Public Health Service

Term	Definition
NPTP	Nurse Practitioner Training Programme
NZQA	New Zealand Qualifications Authority
On extended support	The vendor has agreed to provide support for 'Out-of-support' products, usually for additional cost at a premium price and limited to security updates.
OPC	Office of the Privacy Commissioner
Out-of-support	The product is end-of-life and is no longer supported by the vendor for functional, performance, scalability or security updates. These services may be able to be bought for additional costs usually at a premium price.
Out-of-extended support	There is no longer an option to pay for extended support.
PCR	Polymerase chain reaction tests
PPE	Personal Protective Equipment
RAT	Rapid Antigen Tests
RMO	Resident Medical Officer
SBIP	School based immunisation programme
SMO	Senior Medical Officer
SSED	Shorter stays in emergency departments
SSP	Statement of Service Performance
YTD	Year to date

Translations

Term	Definition
Āiga	Whānau / family
Hapū	Pregnant
Hapū māmā	Pregnant mother
Hauora	Health
Iwi	Extended kinship group, tribe, nation, people, nationality, race
Ka Ora Telecare	Rural clinical telehealth service
Kaiāwhina	Helper, assistant, contributor, counsel, advocate
Kaimahi	Worker, employee, clerk, staff
Kaupapa Māori	The knowledge, attitudes and values that are inherently Māori as held and followed by hapū and iwi. This is synonymously linked to mātauranga Māori and underpinned by te Tiriti o Waitangi, self-determination, cultural validity, culturally preferred teaching, socioeconomic mediation of Māori disadvantage, whānau connections, collective aspirations, and respectful relationships underpinned by equality and reciprocity.
Korowai	Traditional feathered cloak
Mahi	To work, do, perform, make, accomplish, practice, raise (money)
Mana motuhake	Self-determination, autonomy

Term	Definition
Manaaki	To support, take care of, give hospitality to, protect, look out for – show respect, generosity and care for others.
Manatū Hauora	Ministry of Health
Marae	Courtyard – the open area in front of the wharenuī, where formal greetings and discussions take place. Often also used to include the complex of buildings around the marae.
Mātauranga Māori	Māori knowledge systems that reflect indigenous ways of thinking, relating, and discovering. It links indigenous peoples with their environments, is often inspired by environmental encounters and is conveyed within the distinctiveness of indigenous languages and cultural practices
Mauri ora	Healthy individuals
Mokopuna	Descendant and can be defined as 'a reflection of one's ancestors'
Motu	Island, country
Ola Manuia	Interim Pacific Health Plan 2022-24
Pae Ora Act	Healthy Futures Act 2022
Pēpi	Baby
Rangatahi	Youth
Rongoā	To treat, apply medicines

Term	Definition
Tamariki	Children
Tāngata	To be a person, man, human being, individual
Tāngata whaikaha	People with disabilities
Tangata whaiora	A person seeking health
Te Aho o Te Kahu	Cancer Control Agency
Te Aka Whai Ora	Māori Health Authority
Te Hiringa Hauora	Health Promotion Agency
Te Ikaroa	The Central region covers five districts: Whanganui, Capital, Coast and Hutt Valley, Hawke's Bay, MidCentral and Wairarapa
Te Manawa Taki	'The heartbeat' represents the five districts: Waikato, Bay of Plenty, Taranaki, Tairāwhiti and Lakes
Te Pae Tata	Interim New Zealand Health Plan
Te Pātaka Whaioranga	Pharmac

Term	Definition
Te Tāhū Hauora	Health Quality and Safety Commission
Te Waipounamu	Water and Greenstone' covering the districts of Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern
Te Whatu Ora	Health New Zealand
Tino rangatiratanga	Self-determination
Wai ora	Healthy environments
Wānanga	A method of sharing and acquiring knowledge
Whaihua	Useful, informative, worthwhile
Whaikaha	Ministry of Disabled People
Whakarongorau	Outreach call programme
Whānau	Family
Whānau ora	Healthy families

Appendix 6: Performance measures that were included in the 2022/23 annual report and removed in the 2023/24 annual report

Output class

- 1 Public health Services
- 2 Primary and Community Services
- 3 Hospital and specialist services
- 4 Mental health and addiction services
- 5 Capital Programmes

The following measures were discontinued through the Vote Health: Estimates 2023/24.

ID#	Output class	Measure
PY1	5	Joint agencies involved in any transfer of net assets agree to the changes
PY2	1	Minimum of 90% of New Zealanders can access COVID-19 testing within a 20 minute drive to a testing point. This includes priority population groups and people at higher risk of serious illness from COVID-19
PY3	1	Monitoring border worker testing compliance through the Border Worker Testing Register (PCR testing)
PY4	1	Percentage of obese children referred to a specialist service
PY5	1	Percentage of smokers offered to help quit in past 15 months
PY6	2	Percentage of children enrolled with general practice or a kaupapa Māori provider by age 6 weeks
PY7	2	Percentage of infants fully breastfed at three months of age as recorded on the WCTO NHI dataset
PY8	2	Percentage of pre-school and primary school children enrolled with Te Whatu Ora-Health New Zealand/Te Aka Whai Ora-Māori Health Authority funded oral health services that are overdue for their scheduled examinations
PY9	2	Percentage of the Māori population enrolled with a PHO
PY10	2	The approved New Zealand Health Plan sets out mechanisms to be developed to elevate the voices of people with lived experience in the design of primary and community care services

ID#	Output class	Measure
PY11	2	Actual investment decisions ensure balanced investment across appropriations and time horizons [short (up to 2 years), medium (3-5 years) and longer-term (5+ years)] to shift investment into primary and community care services
PY12	2	Service coverage expectations (appended to the interim Government Policy Statement) are fully met for Primary, Community, Public and Population Health Services
PY13	2	All approved NZHP milestones agreed with the Minister for Primary, Community, Public and Population health services are delivered or adjusted milestones are agreed
PY14	2	The New Zealand Health Plan sets out a path in agreed service areas to improve the consistency of primary and community care service provision to align with population need over time
PY15	2	Improvement plans are in place for agreed Health System Indicators relevant to annual Ministerial priorities for primary and community care by the date agreed by the Minister of Health
PY16	2	Percentage of PHOs that have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period
PY17	2	Percentage of PHOs with Stage 3 EDAT results that show a level of match in ethnicity data of greater than 90 percent
PY18	2	Percentage of people enrolled with a PHO aged 15-74 with diabetes on the health virtual diabetes register with a most recent HbA1c during the past 12 months of equal to or less than 100mmol/mol; and greater than 100mmol/mol)
PY19	2	Percentage of people enrolled with a PHO aged 15-74 with diabetes on the health virtual diabetes register with a most recent HbA1c during the past 12 months of equal to or less than 64mmol/mol
PY20	2	Percentage of people enrolled with a PHO aged 15-74 with diabetes on the health virtual diabetes register with a most recent HbA1c during the past 12 months of equal to or less than 80mmol/mol
PY21	3	Percentage of Planned Care Inpatient treatment case mix including elective and arranged discharges from a surgical specialty, or from a medical specialty where a surgical procedure has been provided are no less than the discharges planned to be delivered nationally by DHBs in 2021-22
PY22	3	Percentage of Planned Care minor Interventions comprised of elective or arranged non-case mix surgical procedures, which are completed in an inpatient setting and coded to NMDS and Outpatient or Community based minor procedures, which are completed in an outpatient or community setting and coded to NNPAC, that are delivered are no less than the interventions planned by DHBs in 2021-22
PY23	3	ESPI 1 – Percentage of services that report that more than 90% of referrals within the service are processed in 15 calendar days or less

ID#	Output class	Measure
PY24	3	ESPI 3 – Percentage of patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
PY25	3	Percentage of Acute Coronary Syndrome patients undergoing coronary angiogram meeting ANZACS-QI indicator door to cath timelines of within 3 days
PY26	3	Percentage of Acute Coronary Syndrome patients who undergo coronary angiogram and have a pre-discharge echocardiogram or LVgram
PY27	3	Percentage of Acute Coronary Syndrome patients who undergo coronary angiogram and are prescribed a secondary prevention medication at discharge (in the absence of a documented contraindication/intolerance)
PY28	3	Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days of discharge
PY29	3	Percentage of patients who have pacemaker or implantable cardiac defibrillator implantation /replacement and have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure
PY30	3	Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 3 months of discharge
PY31	3	Percentage of patients with accepted referrals for elective coronary angiography who receive their procedure within 3 months (90 days)
PY32	3	Percentage of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
PY33	3	Percentage of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval
PY34	3	Percentage of patients admitted with acute stroke who are transferred to in-patient rehabilitation services within 7 days of acute admission
PY35	3	Percentage of stroke patients referred for community rehabilitation who are seen face to face by a member of the community rehabilitation team (i.e., RN/PT/OT/SLT/SW/Dr/ Psychologist) within 7 calendar days of hospital discharge
PY36	3	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less, 100% within 30 days or less
PY37	3	70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less
PY38	3	70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less

ID#	Output class	Measure
PY39	3	Percentage of ophthalmology patients who wait no more than or equal to 50% longer than the intended time for their appointment
PY40	3	The percentage of patients who were acutely re-admitted post discharge improves from average DHB base level from 2019-20 to 2021-22
PY41	3	Actual investment decisions ensure balanced investment across appropriations and time horizons [short (Up to 2 years), medium (3-5 years) and longer-term (5+ years)] to maintain hospital and specialist services
PY42	3	The approved New Zealand Health Plan provides evidence of mechanisms to elevate the voices of people with lived experience in the design of hospital and specialist services
PY43	3	All approved NZHP milestones agreed with the Minister for hospital and specialist services are delivered or adjusted milestones are agreed
PY44	3	Service coverage expectations (appended to the interim Government Policy Statement) are fully met for hospital and specialist services
PY45	3	Improvement plans are in place for the agreed Health System Indicators relevant to annual Ministerial priorities for hospital and specialist services
PY46	3	The New Zealand Health Plan sets out a path in agreed service areas to improve the consistency of hospital and specialist service provision to align with population need over time
PY47	3	Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks
PY48	4	Māori access as a percentage of all people accessing primary mental health and addiction: Access and Choice services

The following measures were discontinued through the Vote Health: Supplementary Estimates 2023/24.

ID#	Output class	Measure
PY49	3	Percentage of patients (both acute and elective) who are waiting for their cardiac surgery and are within the urgency timeframe based on their clinical urgency
PY50	3	Percentage of patients with accepted referrals for CT scans who receive their scan, and the scan results are reported, within 6 weeks (42 days)
PY51	3	Percentage of patients with accepted referrals for MRI scans who receive their scan, and the scan results are reported, within 6 weeks (42 days)

These measures were neither Estimate or SPE measures. They were previously added as additional information to enable complete assessment of Health New Zealand's performance during the 2022/23 year. These were not carried forward in accordance with other changes to COVID-19 related measures.

ID#	Output class	Measure
PY52	1	Percentage spend of Te Whatu Ora's total budget on COVID-19
PY53	1	% of eligible 18+ who have received a first booster since the beginning of the COVID-19 pandemic to 30 June 2023

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