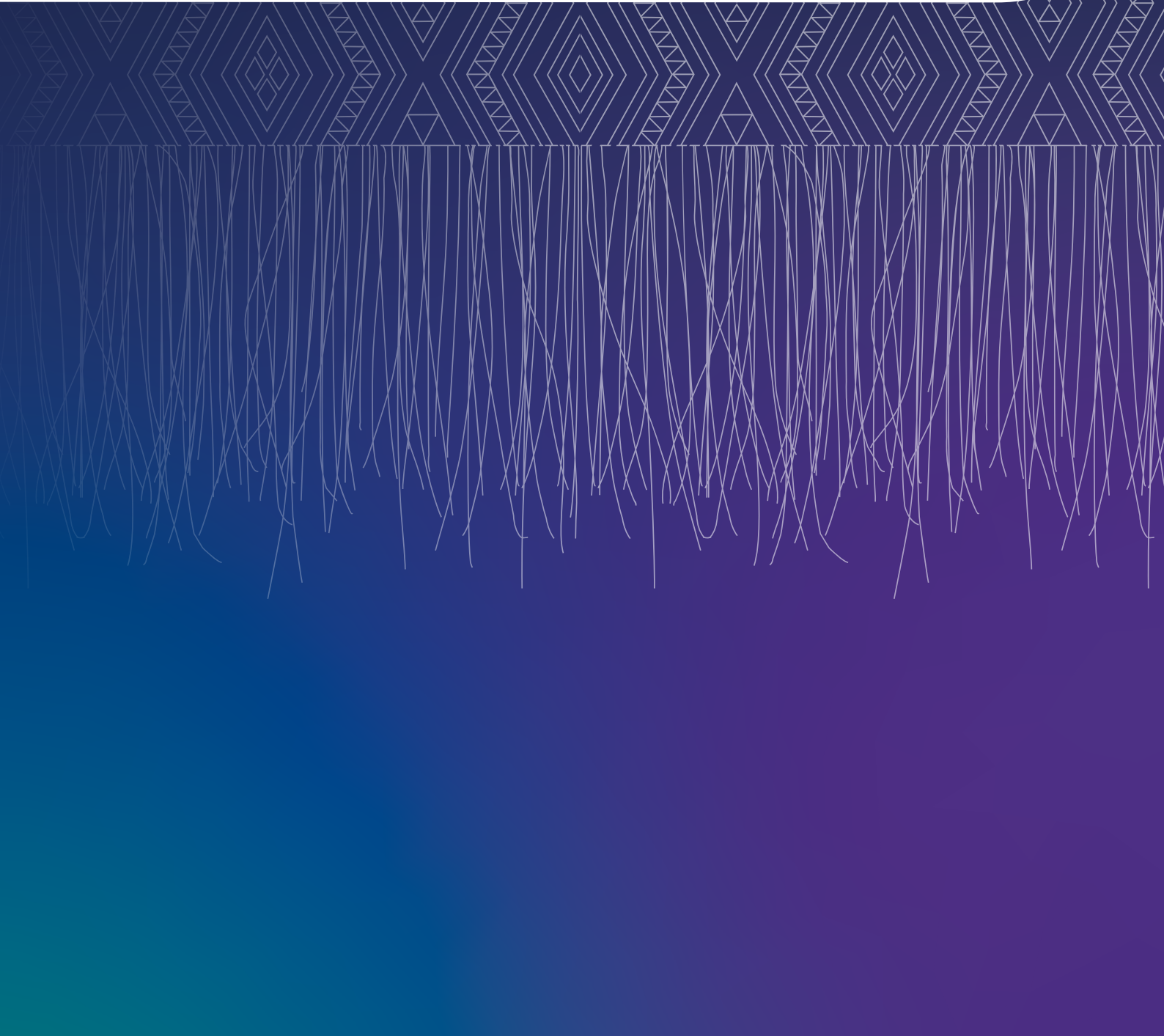


Health New Zealand | Te Whatu Ora

Statement of Performance

Expectations

2024/25



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Statement of responsibility

This document is the Statement of Performance Expectations (SPE) for Health New Zealand I Te Whatu Ora (Health NZ) as required under the Crown Entities Act 2004.

Health NZ's Commissioner acknowledges responsibility for the preparation of this SPE, which reflects the forecast performance and the forecast financial position of Health NZ for the financial year ending 30 June 2025.

This SPE includes prospective financial statements and performance expectations prepared in accordance with generally accepted accounting principles.

I certify that the information contained in this SPE 2024 is consistent with the appropriations contained in the Vote Health Estimates of Appropriations 2024/25. These were laid before the House of Representatives under section 9 of the Public Finance Act 1989.



A handwritten signature in black ink, which appears to read 'Lester Levy'. The signature is stylized and fluid.

Professor Lester Levy, CNZM
Commissioner, Health New Zealand
14 November 2024

Introduction

I am pleased to present this 2024 Statement of Performance Expectations for Health NZ.

At Health NZ our aspiration is to provide quality, compassionate, affordable health care to New Zealanders, at the right time and in the right place.

In June 2024 I was appointed as Chair of the Board of Health NZ and in July I was appointed Commissioner by the Minister of Health and tasked with restoring the performance of Health NZ. This involves the implementation of a turnaround plan which includes returning Health NZ to live within its budget. Health NZ received significantly more funding from the Government in Budget 2024-25 and that funding and all our resources need to be used efficiently and effectively to deliver more health services to our patients, families and communities, and achieve better health outcomes for them.

The Chief Executive, Deputy Commissioners and I have moved swiftly to tackle Health NZ's current distressed financial situation and ensure that there is robust financial management and accountability across the organisation. We are currently in the early phases of that process as we set appropriately effective internal controls in place.

We are in a 'hard reset' changing the way we operate, primarily to address unacceptable waiting times for assessment and treatment. This is not limited to emergency departments and planned care – it is about making changes to the flow of patients across the entire health system to promote timely access to quality services.

The reset includes a devolved model of decision-making empowering regions to make decisions closer to home about how health care is delivered for local communities. Four new establishment Deputy Chief Executive roles are responsible for these devolved services with the focus on delivering on the Government's national health targets and mental health and addiction targets as well as restoring the organisation to financial health.

Reporting on the national health targets and mental health and addiction targets will begin in Quarter 1 2024/2025. I believe that the safest wait is the shortest wait and every patient, family and community needs and deserves access to the best possible care and treatment in a timely and accessible way. It will take time to fulfil these aspirations, but it is our ambition to do so.

I would like to highlight our committed, compassionate and highly skilled health workforce. As we overcome our financial difficulties, we will be taking every step we can to strengthen the clinical frontline and support all our staff. It is also our ambition to create a rewarding working environment for all.



A handwritten signature in black ink, appearing to read 'Lester Levy'. The signature is fluid and cursive, with a large loop at the end.

Professor Lester Levy, CNZM
Commissioner, Health New Zealand
14 November 2024

Te Tiriti o Waitangi

Health NZ acknowledges the enduring inequity in health outcomes experienced by some population groups in New Zealand, including Māori. The establishing legislation of Health NZ, the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act) acknowledges those populations with specific strategies including Pae Tū the Hauora Māori Strategy, intended to improve the health sector for Māori and improving Māori outcomes. We will work closely with Iwi-Māori Partnership Boards in holding ourselves accountable for equitable outcomes.

Te Mauri o Rongo

Te Mauri o Rongo is a statement of values, principles, and behaviours that workers at Health NZ and all other health entities are expected to demonstrate at a collective, organisational, and an individual level. The principles described in Te Mauri o Rongo are:

- **Wairuatanga**
working with heart
- **Rangatiratanga**
supporting our people to lead at all levels
- **Whanaungatanga**
we are a team of teams working together for common purpose
- **Te Korowai Āhuru**
cloak our people with regard for their safety and comfort.

Te Mauri o Rongo sits alongside the Health Quality and Safety Commission's 'Code of expectations for health entities' engagement with consumers and whānau', and the Health and Disability Commissioner's 'Code of Health and Disability Services Consumers' Rights' (Code of Rights) as key expectations of Health NZ.

Iwi Māori Partnership Boards

Iwi Māori Partnership Boards are central to the health reforms, to give voice to Māori within a specific rohe, geographical area. Iwi Māori Partnership Boards comprise iwi, mātāwaka (people who whakapapa to other areas), and tāngata with relevant expertise from that rohe.

Health NZ works with Iwi Māori Partnership Boards, providing the support they need to prioritise hauora Māori improvements and related kaupapa Māori investment.

Iwi Māori Partnership Boards will ensure whānau and hapori Māori have a voice in identifying local health needs and solutions. They will support the exercise of tino rangatiratanga and mana motuhake over their health and wellbeing.

The aim is to see Māori communities and future generations active as key decision makers in securing health and wellbeing.

We work with others

Operating and improving the delivery of publicly funded health care services depends on close relationships with others. These include working with consumer groups, government agencies, professional bodies, unions, non-government organisations, Primary Health Organisations (PHOs), general practice teams, pharmacies, and communities themselves who are also active contributors to and co-designers of better health services and outcomes. This means responsibility for delivery on some of our major objectives and measures may be shared across a range of stakeholders.

Through careful investment and working closely with our key stakeholders and delivery partners, we are building a more sustainable organisation. Details of our activities to support organisational and environmental sustainability and build workforce capability are contained in our Statement of Intent and the New Zealand Health Plan (NZ Health Plan).

Our strategic framework

Our strategic framework shows the connections between our strategic priorities and the long-term objectives of the GPS – to achieve longer life expectancy and improved quality of life for all New Zealanders.

Our Strategic Priorities give effect to the GPS. They are:

1 Deliver the NZ Health Plan, including:

- Achieving Timely Access to Quality Health care through delivery of five national health targets, five targets for mental health and addiction, action to address five risk factors of poor health, and improvement in prevention and management of five key long-term conditions that contribute to ill health, reduced quality of life, and reduced life expectancy.
- Strengthening enablers of delivery with a continued focus on workforce development and infrastructure – both technological (digital) and physical.
- Improving equity of outcomes for our key population groups.

2 Empower and enable leadership at all levels:

- Establishing regional autonomy informed by clinical leadership and community voice.
- Strengthening clinical leadership through National Clinical Networks to address unwarranted variation in care and outcomes.
- Enabling technology that supports the delivery of care.
- Careful management of our asset and infrastructure investment.
- Supporting our workforces to ensure they have the right capability and capacity to meet the needs of all New Zealanders.

Note as the SPE and the SOI are being finalised during a time of change for Health NZ there could be instances where the information included becomes out of date or incorrect. Should this occur the Crown Entities Act (S148 and S149k) provides for the entity to produce a revised version.

Our performance

This SPE records how we will measure our financial and non-financial performance during 2024/25. Reporting against the 'Our Performance' and 'Our Prospective Financial Statements' sections form part of the auditable sections of the Annual Report 2024/25.

Performance framework

Health NZ has developed a new, strategically aligned Entity Performance Framework, with a set of high-level measures that enable us to tell our organisational performance story and provide clear line of sight on how we are going to achieve both intermediate and long-term equitable health outcomes. Our performance framework will undergo endorsement by the Ministry of Health and Health Quality and Safety Commission, and this endorsement process is underway alongside the development of our Statements of Intent and Performance Expectations. This process is likely to occur after the finalisation of the SPE.

Our performance framework reflects the key national priorities and health targets detailed in the GPS and the Minister of Health's planning priorities that has informed the Health NZ Plan.

Good design and effective delivery of services (inputs and outputs) enable Health NZ to provide timely access to quality care (impacts), leading to equitable health improvement – improved quality of life and longer life expectancy – in the lives of New Zealanders over time (outcomes).



HEALTH NEW ZEALAND | TE WHATU ORA ENTITY PERFORMANCE FRAMEWORK

Service Design and Provision

Inputs and Processes

Resources available, decisions made, and actions taken

Strategic Direction

Budget

- Workforce
- Capital Expenditure and Assets (Buildings, Digital and Equipment)
- Leadership and Governance
- Operational and Financial Planning
- Business Systems and Processes
- Commissioning of Funded Services
- Consumer and Whānau Voice
- Iwi Māori Partnership Boards

Outputs

Delivery of health services

- Public health services
- Primary and community care services
- Hospital and specialist services
- Mental health and addiction services
- Hauora Māori services

Equitable and sustainable health services

Health Journeys

Impacts

Utilisation and quality of interactions with health services

Outcomes

Longer life expectancy and better health outcomes

More timely access to services

More equitable access to services

Better quality services delivered:

Appropriate
Safe
Valuable care
Patient and whānau experience

Longer life expectancy
Improved quality of life

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

Equitable improvements in health and wellbeing

SPE measures

This section describes each of our five output classes and how we will assess performance by measuring our impacts. It also provides a breakdown of our expected revenue and proposed expenditure for each of the output classes.

During 2024/25, we will commence the development of subcategorisation of our output classes, with the introduction of new sub-output classes planned to begin from 2025/26. These will be specified in our next SPE.

Improving performance against SPE measures will contribute to us moving toward the intermediate outcome goals outlined in our Statement of Intent 2024–2028. This will ultimately result in better health for New Zealanders, measured by our two long term outcomes:

- an increase in life expectancy;
- improved quality of life.

The impact measures in our performance framework are complementary to the Government's five health targets and five mental health and addictions targets set out in the GPS. All impact measures and government targets are included in this SPE. The health targets largely reflect the timeliness aspect of the Government's vision. The other impact indicators were selected to demonstrate the quality and access aspects. Together they are part of Health NZ's wider performance story.

The measures in our SPE aim to represent the core services we provide or fund, and those that are the most meaningful to the public. The measures allow us to monitor performance across the three dimensions of our goal of providing timely access to quality health care:

Access: does every person, regardless of where they live in New Zealand, have equitable access to the health care services they need?

Timeliness: can people access the health care and services they need, when they need it, in a prompt and efficient way?

Quality: are the health care and services delivered in New Zealand safe, easy to navigate, understandable and welcoming to users? Is there continuous improvement?

Our SPE measures are sourced largely from the GPS (including the health targets) and the Vote Health Estimates of Appropriations 2024/25. This linkage (see key below) is detailed in each of the output class tables that follow. The GPS targets are ambitious and longer term, whereas this SPE details the incremental milestones for 2024/25. The wording of some measures and targets were updated for clarity from their wording in the Vote Health Estimates of Appropriations 2024/25 supporting information.

Link	Government document
GPS	Government Policy Statement on Health 2024-2027
HT	Government health target (in GPS)
MHA	Government mental health and addiction target (in GPS)
VH	Vote Health Estimates of Appropriation 2024/25




Our measures were selected in accordance with the Public Benefit Entity Financial Reporting Standard 48 Service Performance Reporting (PBE FRS 48).

Our work is funded through annual and multi-year appropriations under Vote Health. The largest revenue contribution (\$24.8 billion) is revenue from the Crown, with a further amount (\$3.5 billion) funded through third parties.

Targets and comparative historic data for each measure are included in the following sections. Where the target set is as an improvement from baseline, the baseline data period is 2022/23 (unless stated otherwise). The 2023/24 Estimated Actual is a forecast of the expected 2023/24 year-end performance, based on data available at the time this SPE was prepared. Additionally, Health Targets, like many of the measures, will also be monitored quarterly where the baseline will Quarter 4 2023/24.

Criteria for performance reporting

We will use the following criteria to rate performance against each measure (except the Mental health and addiction ringfence expectations where Achieved & Not achieved will apply only). This will be reported in our Annual Report at the end of the financial year.

Criteria *relative to target	Rating
On target or better	Achieved 
95–99.9% 0.1–5%* away from target	Partially achieved 
<95% >5%* away from target	Not achieved 



Output Class One: Public health services

Public health services improve community health by population level actions to prevent or reduce illness and disease and promote quality of life.

This output class aims to reduce the burden of illness on people and the demand on our health care services by investing in prevention and health promotion. It is intended to secure public health services in line with existing service coverage expectations and operating policy requirements, and actions as set out in the New Zealand Health Plan.

This output class funds protection and enforcement functions and the maintenance of public health infrastructure to respond to outbreaks of communicable diseases as well as the activity managed by Health NZ's National Public Health Service.

This includes:

- immunisation programmes (e.g. measles, whooping cough, polio, influenza and COVID-19).
- screening programmes (e.g. for cervical, breast and bowel cancers).
- enforcement of health related regulations and legislation.
- programmes to address modifiable risk factors for ill-health (harmful alcohol consumption, smoking, poor nutrition, lack of physical activity).
- processes and systems to respond to outbreaks of communicable diseases.
- activity relating to protection against environmental hazards for health.

This work is funded through the Vote Health Delivering Primary, Community, Public and Population Health Services appropriation.

Expected revenue and proposed expenditure	2023/24 Estimated Actual \$ million	2024/25 Budget \$ million*
Operating revenue		
Revenue – Crown	486	533
Other revenue	0	0
Total operating revenue	486	533
Total operating expense	705**	533
Surplus/(deficit)	(219)	0

*Note includes \$56M funding and expenditure for COVID-19.

**Note includes COVID-19 stock consumed or written-off of \$203M.

Performance measure	Link	2022/23 baseline	2023/24 actual	2023/24 target	2024/25 target (overall target)
Percentage of children fully immunised at 24 months of age	HT VH	New measure ¹	New measure	New measure	84% (95%)
Percentage of children fully immunised at 8 months of age	VH	Māori 69.4% Pacific 82.4% Euro/Other 89.8% Total 83.8%	Māori 66.8% Pacific 80.7% Total 82.7%	95%	95%
Percentage of children fully immunised at 5 years of age	VH	Māori 70.7% Pacific 79.7% Euro/Other 85.1% Total 80.8%	Māori 60.7% Pacific 79% Total 80.5%	95%	95%
Percentage of males and females aged 9–26 years fully immunised for HPV	VH	Māori 32% Pacific 33% Asian 33% Euro/Other 36% Total 35% (Q1 2023/24)	Māori 30.4% Pacific 35.3% Total 38.3%	75%	75%
Percentage of people aged at least 65 years who have completed at least one influenza vaccination	VH	Māori 54% Pacific 52% Asian 53% Euro/Other 65% Total 62%	Māori 57% Pacific 57% Total 64.3%	75%	75%
Percentage of women aged 45–69 years who have a breast cancer screen in the last 2 years	GPS	Māori 59.4% Pacific 62.3% Asian 59.6% Euro/Other 67.8% Total 65.3%	Māori 62.3% Pacific 67.6% Asian 61.7% Euro/Other 72.2% Total 69.1%	70%	70%
Bowel screening rates of adults aged 60–74 years (two-yearly screening interval)		Māori 49.3% Pacific 38.7% Asian 46.9% Euro/Other 62.0% Total 58.0%	Māori 49.4% Pacific 38.2% Asian 43.3% Euro/Other 61.6% Total 57.0% (Mar 24)	60%	60%
Cervical (HPV) screening rates of eligible women aged 25–69 years (five-yearly screening interval)	GPS	Māori 57.2% Pacific 56.2% Asian 57.1% Euro/Other 75.7% Total 67.9%	Māori 60.4% Pacific 64.9% Asian 58.6% Euro/Other 75.9% Total 69.3%	80%	80%
Mental health and addiction expenditure ringfence expectations are met	VH	Achieved	Achieved	Achieved	Achieved

1. The denominator of this measure has changed to the Aotearoa Immunisation Register (AIR) which is derived from the National Health Identifier (NHI) database and therefore is treated as a new measure.



Output Class Two: Primary and community care services

The primary and community care network of providers delivers services across the spectrum of prevention, early detection, treatment of illness, and rehabilitation, to quickly treat and manage illness as close to home as possible. This helps people and whānau maintain independence and avoid further sickness.

This output class enables the commissioning of primary and community care services in line with service coverage expectations and

operating policy requirements, and actions as set out in the New Zealand Health Plan. This includes supporting people in the community with long-term conditions, such as diabetes, cardiovascular disease and mental health and addiction conditions.

This output class funds the delivery of care by over 3,000 providers.

It is funded through the Vote Health Delivering Primary, Community, Public and Population Health Services appropriation. It also includes revenue and expenditure related to Vote Health Problem Gambling Services appropriation of \$20M in 2023/24 and \$17M in 2024/25.

Expected revenue and proposed expenditure	2023/24 Estimated Actual \$ million	2024/25 Budget \$ million
Operating revenue		
Revenue – Crown	7,455	7,770
Other revenue	1,983	1,617
Total operating revenue	9,438	9,387
Total operating expense	9,148	9,637
Surplus/(deficit)	290	(250)

Performance measure	Link	2022/23 baseline	2023/24 actual	2023/24 target	2024/25 target (overall target)
Percentage of people who received health care from a GP or nurse when they wanted it in the last 12 months ²	VH	Māori 71.0% Pacific 73.2% Asian 76.8% Euro/Other 77.5% Total 76.4% (12 months to 05/2023)	Māori 71.8% Pacific 74.9% Asian 78.9% Euro/Other 77.3% Total 76.7% (12 months to 05/2024)	Increase from baseline	Increase from baseline
Percentage of people enrolled with a general practice or kaupapa Māori provider delivering general practice care		Māori 83% Pacific 95% Euro/Other 98% Total 95%	Total 97%	95%	95%
Percentage of smokers enrolled with a stop smoking service, who set a target quit date and will be CO validated at 4 weeks		New measure	Unable to report until 11/2024	50%	50%
Percentage of patients who reported being involved by the health care professional in decisions about treatment and care during their most recent appointment	GPS VH	Māori 85.3% Pacific 85.1% Asian 84.4% Euro/Other 86.6% Total 86.1% (12 months to 05/2023)	Māori 88.3% Pacific 88.7% Asian 89.4% Euro/Other 90.2% Total 89.8% (12 months to 05/2024)	Increase from baseline	Increase from baseline
Percentage of people reporting that the health care professional treated them with respect and kindness		Māori 94.6% Pacific 94.6% Asian 95.2% Euro/Other 95.6% Total 95.4% (12 months to 05/2023)	Māori 94.9% Pacific 96.0% Asian 96.0% Euro/Other 96.2% Total 96.0% (12 months to 05/2024)	New SPE measure	Maintain baseline
Ratio of mean decayed, missing, filled teeth (DMFT) at school Year 8	GPS	Māori 1.15 Pacific 0.81 Euro/Other 0.55 Total 0.72 (CY 2022)	Can not be reported until 30 June 2024	10% reduction from baseline and/or maintain baseline if lower than total	10% reduction from baseline for Māori, Pacific

2. The data is from respondents who answer 'no' to the survey question: "In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you could not get it?"

Performance measure	Link	2022/23 baseline	2023/24 actual	2023/24 target	2024/25 target (overall target)
Percentage of children enrolled with a general practice or kaupapa Māori provider delivering general practice care by age 3 months		Māori 69.7% Pacific 80.2% Asian 93.0% Euro/Other 99.1% Total 87.7%	Total 87%	85%	85%
Percentage of pregnant women registered with a lead maternity carer in the first trimester of pregnancy	GPS VH	Māori 93.1% Pacific 90.0% Asian 95.2% Euro/Other 97.3% Total 94.9%	Achieved	Achieved	Increase from baseline
Rate of ambulatory sensitive hospitalisations per 100,000 population for children aged 0-4 years	GPS VH	Māori 8,192 Pacific 14,639 Euro/Other 6,616 Total 7,752	Not achieved	Decrease from baseline	Decrease from baseline
Rate of ambulatory sensitive hospitalisations per 100,000 population for people aged 45-64 years	GPS VH	Māori 6,981 Pacific 8,127 Euro/Other 1,994 Total 3,739	Not achieved	Decrease from baseline	Decrease from baseline
Mental health and addiction expenditure ringfence expectations are met	VH	Achieved	Achieved	Achieved	Achieved



Output Class Three: Hospital and specialist services

The focus for hospital and specialist services is to ensure all people in New Zealand receive timely access to specialist outpatient and hospital services to prevent deterioration of their condition and improve their quality of life.

This output class is intended to secure hospital and specialist services for the eligible New Zealand population in line with service coverage expectations and operating policy requirements, and the actions set out in the New Zealand Health Plan.

Specialist services are typically situated in intensive health service environments like surgical centres and hospitals but may also be provided in community settings or virtually through telehealth. Specialist clinicians provide diagnosis, planned and emergency treatment, and rehabilitation to reduce mortality, restore functional independence, and improve health-related quality of life.

This output class funds acute presentations and inpatient admissions, diagnostics (imaging and pathology), planned care assessments and treatments, including surgery.

It is funded through the Vote Health Delivering Hospital and Specialist Services appropriation.

Expected revenue and proposed expenditure	2023/24 Estimated Actual \$ million	2024/25 Budget \$ million
Operating revenue		
Revenue – Crown	12,856	13,248
Other revenue	1,703	1,868
Total operating revenue	14,559	15,116
Total operating expense	15,303	15,966
Surplus/(deficit)	(744)	(850)

Performance measure	Link	2022/23 baseline	2023/24 actual	2023/24 target	2024/25 target (overall target)
Percentage of patients receiving cancer management within 31 days of the decision to treat	HT VH	Māori 84.8% Pacific 86.2% Asian 85.6% Euro/Other 84.7% Total 84.9%	New measure	New SPE measure	86% (90%)
Percentage of patients admitted, discharged or transferred from an ED within 6 hours	HT VH	Māori 75.9% Pacific 70.2% Asian 73.9% Euro/Other 70.3% Total 71.8%	New measure	New SPE measure	74% (95%)
Percentage of patients waiting less than 4 months for a first specialist appointment	HT VH	Total 69.6% (06/2023)	New measure	New SPE measure	62% (95%)
Percentage of patients waiting less than 4 months for elective treatment	HT VH	Māori 59.5% Pacific 64.7% Asian 66.9% Euro/Other 61.5% Total 61.9% (06/2023)	New measure	New SPE measure	63% (95%)
Percentage of cardiac patients waiting >120 days for treatment	VH	New measure	New measure	New SPE measure	25%
Rate of acute readmissions within 28 days of discharge	VH	Māori 13.0% Pacific 12.3% Euro/Other 12.4% Total 12.5%	Data not available	12%	12%
Rate of acute bed nights spent in hospital per 1,000 population		Māori 415 Pacific 484 Euro/Other 428 Total 429	Māori 605 Pacific 749 Other 361 Total 421 (12/2023)	Decrease or maintain standardised rate	Decrease from baseline
Percentage of people with an inpatient length of stay of greater than 7 days		Māori 7.4% Pacific 8.5% Asian 6.8% Euro/Other 11.3% Total 9.8%	8.9% (06/2023)	To be established	Decrease from baseline

Performance measure	Link	2022/23 baseline	2023/24 actual	2023/24 target	2024/25 target (overall target)
Percentage of missed first specialist assessment appointments	GPS VH	Māori 18.5% Pacific 21.4% Asian 6.1% Euro/Other 5.1% Total 8.6%	Not achieved	Achieved	Decrease from baseline
Number of planned care interventions delivered, including: – inpatient surgical discharges – minor procedures – non-surgical interventions		318,789	Not achieved	Deliver in line with planned volumes	Deliver in line with planned volumes
Percentage of inpatients who reported they were involved as much as they wanted to be in making decisions about their treatment and care	GPS	Māori 80.4% Pacific 85.9% Asian 88.7% Euro/Other 81.1% Total 81.8% (12 months to 05/2023)	Māori 80.2% Pacific 83.8% Asian 87.6% Euro/Other 81.0% Total 81.5% (12 months to 05/2024)	Increase from baseline	Increase from baseline
Percentage of inpatients who reported that their doctors treated them with respect and kindness		Māori 89.3% Pacific 93.3% Asian 95.2% Euro/Other 92.0% Total 91.8% (12 months to 05/2023)	Māori 90.4% Pacific 93.8% Asian 94.7% Euro/Other 92.0% Total 92.0% (12 months to 05/2024)	New SPE measure	Maintain baseline
Mental health and addiction expenditure ringfence expectations are met	VH	Achieved	Achieved	Achieved	Achieved



Output Class Four: Mental health and addiction

Mental health and addiction services provide support to people experiencing issues which cause distress or wellbeing impacts. They enable people to get through a challenging time without serious or lasting disruption to their lives.

This output class is intended to achieve improved and appropriate access to services to support improved mental health and addiction outcomes. This includes community-based early intervention options, and ensures services and support make a positive difference to how people experience services and their recovery.

This output class also ensures people with serious mental health and addiction conditions can gain help from specialist inpatient services, followed by support on discharge that enables them to live well in the community. Good quality wraparound services help to reduce future admissions to acute services, and help people maintain relationships, retain jobs, and enjoy valued activities. The output class also funds mental health and addiction actions as set out in the New Zealand Health Plan.

This work is funded through the Vote Health Delivering Hospital and Specialist Services, Vote Health Delivering Primary, Community, Public and Population Health Services, and Vote Health hauora Māori services appropriations. From 2024/25, there is an increase of \$180M for this output class for hauora Māori mental health services.

Expected revenue and proposed expenditure	2023/24 Estimated Actual \$ million	2024/25 Budget \$ million
Operating revenue		
Revenue – Crown	2,285	2,683
Other revenue	0	0
Total operating revenue	2,285	2,683
Total operating expense	2,305	2,683
Surplus/(deficit)	(21)	0

Note: The 2023/24 Statement of Performance Expectations did not include Vote Health Delivering hauora Māori services appropriation funding as at that time this was the responsibility of Te Aka Whai Ora / Māori Health Authority.

Performance measure	Link	2022/23 baseline	2023/24 actual	2023/24 target	2024/25 target (overall target)
Percentage of people accessing specialist mental health and addiction services seen within three weeks	MHA VH	New measure	New measure	New SPE measure	80% (80%)
Number of mental health and addiction professionals trained each year	MHA VH	New measure	New measure	New SPE measure	Establish baseline (500)
Percentage of people accessing primary mental health and addiction services through the Access and Choice programme seen within one week	MHA VH	New measure	New measure	New SPE measure	Establish baseline (80%)
Percentage of mental health and addiction-related presentations admitted, discharged, or transferred from an ED within six hours	MHA	New measure	New measure	New SPE measure	74% (95%)
Percentage of mental health and addiction investment allocated towards prevention and early intervention	MHA	New measure	New measure	New SPE measure	Establish baseline (25%)
Number of people who accessed primary mental health and addiction services through the Integrated Primary Mental Health and Addiction Services		21,664 (06/2023)	Achieved	Achieved	Establish annual access level
Number of people who accessed Kaupapa Māori, Pacific and Youth Integrated Primary Mental Health and Addiction Services through the Access and Choice programme	VH	Kaupapa Māori 6,445 Youth 2,784 Pacific 1,006 (12/2023)	Kaupapa Māori 11,040 Youth 2,500 Pacific 1,394 (06/2024)	Achieved	Establish annual access level
Percentage of rangatahi seen within the three weeks from a mental health and addiction referral	VH	Māori 75.5% Pacific 79.1% Euro/Other 63.9% Total 68.3%	Achieved	80%	≥80%
Mental health and addiction expenditure ringfence expectations are met	VH	Achieved	Achieved	Achieved	Achieved



Output Class Five: Hauora Māori services

This output class funds a range of services that are kaupapa Māori-based and were developed to improve Māori health outcomes and reduce health inequities.

It provides for the development, implementation and delivery of hauora Māori services, including the development of hauora Māori partners, of partnerships with iwi, commissioning for integrated outcomes and implementation of hauora Māori actions as set out in the New Zealand Health Plan.

The purpose of this output class is to ensure the needs and aspirations of Māori are reflected in the priorities and plans of the health system, and in the way that services are designed

and delivered. This involves the use of Māori wellbeing models and the application of mātauranga Māori in the health system.

While this output class focuses on Māori, it does not fund all care that Māori receive. The impact on outcomes for Māori needs to be seen in the context of contributions from other output classes that also fund access for Māori.

This work is funded through Vote Health Delivering hauora Māori services appropriation. It also includes revenue and expenditure related to the Vote Health Problem Gambling Services appropriation of \$1.5M 2023/24 and \$6M 2024/25.

Expected revenue and proposed expenditure	2023/24 Estimated Actual \$ million*	2024/25 Budget \$ million
Operating revenue		
Revenue – Crown	174	576
Other revenue	0	2
Total operating revenue	174	578
Total operating expense	203	578
Surplus/(deficit)	(28)	0

*Note 2023/24 Actuals only include April to June, as prior to April 2024 the Delivering hauora Māori services appropriation and Output Class was the responsibility of Te Aka Whai Ora / Māori Health Authority.

Performance measure	Link	2022/23 baseline	2023/24 actual	2023/24 target	2024/25 target (overall target)
Percentage of Iwi Māori Partnership Boards that participate in setting strategic priorities for commissioning in Health New Zealand Te Whatu Ora		New measure	New measure	New SPE measure	80%
Percentage of Māori scholarship grants offered under the Hauora Māori appropriation that are taken up		New measure	New measure	New SPE measure	100%
Percentage of people reporting that their family/whānau or someone close to them were involved in discussions about the care received		Māori 76.8% Pacific 84.0% Asian 86.5% Euro/Other 76.4% Total 77.6% (12 months to 05/2023)	Māori 77.9% Pacific 85.2% Asian 85.3% Euro/Other 77.4% Total 78.6% (12 months to 05/2024)	New SPE measure	Increase from baseline
Percentage of people reporting that they had trust and confidence in their treatment provider		Māori 84.5% Pacific 86.2% Asian 85.8% Euro/Other 86.1% Total 85.9% (12 months to 05/2023)	Māori 85.8% Pacific 88.2% Asian 88.4% Euro/Other 88.2% Total 87.9% (12 months to 05/2024)	New SPE measure	Increase from baseline
Percentage of Hauora Māori partners that have moved to integrated or outcomes contracts by 30 June 2025		0% (2023/24)	New measure	New SPE measure	Increase from baseline
Percentage of Hauora Māori partners that are meeting their contracted outcome targets as defined in the new outcomes-based contracts		New measure	New measure	New SPE measure	50%
Mental health and addiction expenditure ringfence expectations are met	VH	Achieved	Achieved	Achieved	Achieved

Our prospective financial statements

The purpose of the prospective financial statements is to provide a base against which our future actual financial performance can be assessed and to enable Parliament, and the New Zealand public, to be informed of those expectations.

The prospective financial statements are prepared to support internal management and resource allocation, to support governance by our Commissioner and Ministers and to support public accountability through external publication.

The prospective financial statements have been prepared in accordance with New Zealand generally accepted accounting practice (New Zealand GAAP) for Public Benefit Entities, PBE FRS 42 Prospective Financial Statements.

Our purpose is to assure Parliament of the planned financial performance of Health NZ. The use of the information for any other purpose may not be appropriate.

By nature, prospective financial statements make assumptions about future events, which may or may not transpire. Not all events will be known at the time of preparation, as such, users of this information need to be mindful of the degree of uncertainty attaching to this prospective financial information and the potential impacts the uncertainty may have on future results.

We have disclosed the basis on which the significant assumptions underpinning the prospective financial statements have been prepared (including the principal sources of information from which they have been derived), risks surrounding assumptions and the potential impact of a change in an assumption on the prospective financial statements. Refer to the Preparation of financial forecasts – underlying assumptions and Notes to the prospective financial statement sections.

The audited future actual financial results for the periods covered may vary from the prospective information presented, and the variations may be material.

In our view, the prospective financial statements of Health NZ comply with all the requirements of PBE FRS 42.

Reporting entity

Health NZ is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing Health NZ's operations is the Crown Entities Act and the Pae Ora (Healthy Futures) Act 2022 (the Act). Health NZ's ultimate parent is the New Zealand Crown.

Health NZ is an amalgamation of the 20 District Health Boards, Health Promotion Agency (Te Hiringa Hauora), the Māori Health Authority (Te Aka Whai Ora) and their subsidiaries. Health NZ also received many functions that were transferred from the Ministry of Health.

Health NZ's primary objective is to deliver and fund health, disability, and mental health services to the communities across New Zealand. Health NZ does not operate to make a financial return.

The prospective financial statements present a consolidated view of all the entities that have been amalgamated into Health NZ as part of the reform outlined in the Pae Ora (Health Futures) Act 2022 and the Pae Ora (Disestablishment of the Māori Health Authority) Amendment Bill 2024.

Statement of compliance and basis of preparation

The prospective financial statements have been prepared in accordance with the requirements of the Crown Entities Act which includes the requirement to comply with GAAP.

The prospective financial statements have been prepared in accordance with and comply with the PBE FRS 42 Prospective Financial Statements XRB Public Sector Standards.

Health NZ is a Crown agent within the meaning of section 10(1)(a) of the Crown Entities Act 2004. Requirements include the need for Health NZ to have a Board of Directors. Currently, Health NZ has a Crown appointed Commissioner – Professor Lester Levy, who replaced the Board in July 2024. Three Deputy Commissioners have been appointed by the Commissioner: Mr Roger Jarrold, Mr Ken Whelan and Ms Kylie Clegg.

Preparation of financial forecasts – underlying assumptions

The following assumptions have been used in preparing these prospective financial statements:

Revenue

	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m	Increase or (Decrease) %
Revenue	27,180	28,297	4.1%
Appropriations – Crown funding ex MOH	23,483	24,754	5.4%
Other funding ex Crown/Crown entities	2,750	3,016	9.6%
Covid-19 funding	238	56	(76.5%)
Third party and other revenue	550	393	(28.4%)
Interest received	159	78	(50.9%)

Appropriations – Crown funding from Ministry of Health: As advised by the Government in the Vote Health Estimates of Appropriation 2024/25, most of the increase between 2023/24 and 2024/25 related to funding uplifts for core cost pressures for Delivering Hospital and Specialist Services, Delivering Primary, Community, Public and Population Health Services, and Delivering hauora Māori services appropriations. Additional movements relate to funding increases for Government initiatives through Budget 2024.

Note the appropriation revenue (and expenditure) baseline for 2024/25 cannot be compared directly to total funding in 2023/24. A large number of time-limited and one-off funds were provided in the 2023/24 year that are no longer required. These funded initiatives were time-limited or one-off such as the backdated impact of pay equity commitments or they represented funding transferred forward from the 2022/23 year to finish projects that had flowed into the 2023/24 year (e.g. \$110 million for Planned Care catch up, and funding for the COVID-19 response).

We note the commentary in the Quarter 4 Performance Report: Preliminary appropriation and output class reporting provided in this section is based on the funding and expenditure allocation assumptions used during the first two transitional years of Health reform. These assumptions mean nearly all of Health New Zealand's enabling services are reported against the Hospital and Specialist Services appropriation and output class. In practice they also enable primary and community, public health and Hauora Māori services.

Refinement of funding and expenditure allocation at appropriation and output class levels is underway for 2024/25 reporting, as per the requirements of the Government Policy Statement 2024-27. Refinement includes better allocating service delivery and enabling service funding and expenditure between appropriations and output classes.

In that context:

- **Public Health:** In the 2023/24 SPE, the Public Health Output Class was budgeted at break-even, with \$484M of revenue and expenses forecast. The actual position was a deficit of \$219M, which was primarily due to the expensing of COVID-19 stock consumed or written-off (~\$202M).
- **Primary and Community:** In the 2023/24 SPE, the Primary and Community Output Class was budgeted at break-even, with \$9,428M of revenue and expenses forecast, including \$1,560M of third-party revenue (primarily the PHARMAC Community Pharmaceuticals). The actual position was a surplus of \$290M. The surplus position resulted from expenses decreasing (\$280M) while revenue increased (compared to budget) including third-party revenue (\$10M).
- **Mental Health and Addictions:** In the 2023/24 SPE, the Mental Health & Addictions Output Class was budgeted at break-even, with \$2,113M of revenue and expenses forecast. The actual position was a deficit of \$21M. While revenue was \$172M more than budget, expenditure was \$192M more than budget. Revenue and expenditure were greater than budget in both the Hospital and Specialist Services and Primary, Community, Public and Population Health appropriations.
- **Hospital and Specialist Services:** In the 2023/24 SPE, the Hospital and Specialist Services Output Class was budgeted at break-even, with \$13,800M of revenue and expenses forecast. The actual position was a deficit of \$744M. While revenue was \$759 more than budgeted, expenditure was \$1,503 more than budget. The key driver of greater than budget expenditure were above budget personnel costs, including pay equity for Allied Health and midwifery costs not funded in 2023/24 – funding being received in 2024/25 as Crown equity.
- Note **Hauora Māori Services** was not an output class in the 2023/24 Health NZ SPE.

The table below shows the reconciliation mapping of output classes changes by appropriation.

Budgeted SPE v. Unaudited Actual 2023/24 Revenue & Expenditure by Output Class	Hospital and Specialist Appropriation \$m	Primary and Community Appropriation \$m	Hauora Māori Appropriation \$m	National Pandemic Response \$m	Third Party Revenue \$m	Total \$m	%
Revenue							
Hospital and specialist services	411				348	759	3%
Mental health and addictions	62	110				172	0%
Primary and community services		(412)			422	10	0%
Public health services		2				2	0%
Hauora Māori Services			0				
Covid-19				(57)		(57)	0%
Total Revenue	473	(299)		(57)	770	886	
Total Expenditure	1,312	(445)	28	(57)	770	1,608	
Net Surplus / (Deficit)	(839)	146	(28)	0	0	(722)	0%

The table below shows the output classes mapped to appropriations for 2024/25.

2024/25 Revenue & Expenditure by Output Class	Hospital and Specialist Appropriation \$m	Primary and Community Appropriation \$m	Hauora Māori Appropriation \$m	Third Party Revenue \$m	Total \$m	%
Revenue						
Hospital and specialist services	13,248			1,868	15,116	53%
Mental health and addictions	1,713	790	180		2,683	9%
Primary and community services		7,770		1,617	9,387	33%
Public health services		533			533	2%
Hauora Māori Services			576	2	578	2%
Total Revenue	14,961	9,093	756	3,487	28,297	
Total Expenditure	15,811	9,343	756	3,487	29,397	
Net Surplus / (Deficit)	(850)	(250)	0	0	(1,100)	

Other funding ex Crown/Crown entities:

As agreed with funding entities (e.g., PHARMAC, Whaikaha, ACC) based on expected activity and associated funding arrangements. Approximately two-thirds of funding within this category relates to the Combined Pharmaceutical Budget administered by PHARMAC.

Covid-19 funding: As advised by the Government in the Vote Health Estimates of Appropriation 2024/25.

Third party and other revenue: Estimated, based on historic trends and going market conditions, adjusted for time-limited revenue.

Interest received: As forecast based on anticipated investments and expected rates of return.

Operating costs

	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m	Increase or (Decrease) %
Expenditure – Operating Costs	27,902	29,397	5.36%
Personnel costs	11,742	12,466	6.2%
Outsourced personnel	538	270	(49.8%)
Outsourced services	846	752	(11.1%)
Clinical supplies	2,486	2,483	(0.1%)
Depreciation and amortisation	846	888	5.0%
External service providers	9,189	10,235	11.4%
Capital charge	470	529	12.6%
Interest expense	7	7	0.0%
Infrastructure, non-clinical supplies & other	1,778	1,767	(0.6%)

The forecast operating costs for Budget 2024/25 have been prepared based on known and planned expenditure to deliver the planned level of service provision and the budget priorities as outlined by the Government for Vote Health appropriations, and the expectations of other funders (e.g. PHARMAC, Whaikaha, and ACC), subject to the savings required to live within expected revenue as outlined further below.

Inflation is one driver of cost pressures.

While there are variations, general economy-wide measures of inflation, and inflation within the health sector, tend to track in parallel with each other over the medium to long-term.

Funded sector prices: Provider expectations of price uplifts could also increase due to sustained cost pressures, particularly from inflation and wage pressures.

Lower inflationary pressure would provide for greater ability to manage risks over the forecast period, which might also allow for targeted performance improvement actions to continuously lift baseline performance should there be sufficient funding to allow for this.

We will manage these operating performance risks through further developing costing models (for Hospital and Specialist Services) and pricing uplift models (for the funded sector) to inform estimates of potential impacts of prioritisation and de-prioritisation decisions. For example, in Hospital and Specialist Services we are introducing revenue allocation for services provided, over the course of 2024/25, which will support efficiency, benchmarking, greater funding and management controls. Similarly, we are working with the Ministry of Health | Manatū Hauora to develop new service and funding models for key funded sector services (e.g. primary care, health of older people) which will support improved policy levers and value for money.

Operating model changes: We are re-setting Health NZ's operating model to empower regional decision-making and clinical leadership, reduce inefficiencies and remove duplication. We have established four new Deputy Chief Executive (DCE) roles – one for each region (Northern, Te Manawa Taki, Central and Te Waipounamu). They are responsible for services provided and funded by Health NZ in their region and support Health NZ to deliver to the Health Targets. We are strengthening 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.

We are in the process of strengthening system planning, performance and improvement through consolidation of roles, responsibilities and expertise into a single national function, and streamlining key enabling functions such as Finance, People & Communications, Data & Digital and Infrastructure & Investment.

Operating costs – Savings: The forecast impact on the 2024/25 result are savings in the order of \$0.66bn in this year including voluntary staff redundancies, followed by further savings in the year after. These savings will not impact frontline clinical care, with a commitment to maintain, and grow in appropriate areas, clinical headcount.

Holidays Act remediation costs:

The financial projections assume that the Holidays Act remediation and rectification programme will be completed across all Health NZ components during the year. Until the remediation projects are completed for all components, there remain uncertainties as to the actual amount Health NZ will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. We are working closely with the Ministry of Health to understand the impact of leave entitlement costs and provisions related to Holidays Act remediation.

Refer to Critical accounting estimates and assumptions section for further details regarding Holidays Act remediation costs.

Pay equity costs: Personnel costs include the estimated costs of pay equity settlements in 2024/25 for Nursing, Midwifery and Allied Health, ongoing and one-off as relevant.

Also note that Health NZ has received reimbursement for the already incurred costs in 2023/24 related to Allied and Midwifery Pay Equity settlements of \$419m in September 2024 as a Crown Equity Injection

Māori Health Authority | Te Aka Whai Ora

On 5 March 2024 the Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024 was passed by Government. Effective from 1 April 2024, the functions, assets, liabilities and staff of the Māori Health Authority largely transferred to Health NZ, with a small number transferring to the Ministry of Health | Manatū Hauora.

The opening balance sheet and financial results of the Māori Health Authority are reported in Health NZ effective from 1 April 2024.

Prospective financial statements

The following tables provide information on the forecast financial performance, position, and cash flows of Health NZ.

Forecast Statement of Comprehensive Revenue and Expenses

	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m
Revenue		
Appropriations – Crown funding ex MOH	23,483	24,754
Other funding ex Crown/Crown entities	2,750	3,016
Covid-19 funding	238	56
Third party and other revenue	550	393
Interest received	159	78
Total revenue	27,180	28,297
Expenditure – Operating Costs		
Personnel costs	11,742	12,466
Outsourced personnel	538	270
Outsourced services	846	752
Clinical supplies	2,486	2,483
Depreciation and amortisation	846	888
External service providers	9,189	10,235
Capital charge	470	529
Interest expense	7	7
Infrastructure, non-clinical supplies and other	1,778	1,767
Total expenditure	27,902	29,397
Surplus/(Deficit)	(722)	(1,100)
Other comprehensive revenue and expenses		
Gain/(loss) on property revaluations	0	0
Total other comprehensive revenue and expenses	0	0
Total comprehensive revenue and expenses	(722)	(1,100)

Forecast Statement of Changes in Equity

	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m
Balance at 1 July	9,313	9,614
MHA Balance transferred 1 April 2024	77	0
Capital contributions from the Crown	957	3,234
Capital contributions returned to the Crown	(12)	(12)
Movements in trust, special funds & other reserves	1	0
	10,336	12,836
Comprehensive income		
Surplus/(deficit) for the year	(722)	(1,100)
Other comprehensive revenue and expense	(722)	(1,100)
Gain/(loss) on property revaluations	0	0
Total comprehensive revenue and expense for the year	(722)	(1,100)
Balance at 30 June	9,614	11,736

Forecast Statement of Financial Position

	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m
Assets		
Current assets		
Cash and cash equivalents	840	31
Receivables	409	426
Prepayments	106	106
Investments	393	33
Inventories	184	165
Assets held for resale	5	(0)
Total current assets	1,937	761
Non-current assets		
Prepayments	6	6
Investments	121	121
Investments in associates and joint venture	3	3
Property, plant and equipment	13,782	15,169
Intangible assets	539	354
Total non-current assets	14,451	15,654
Total assets	16,388	16,415
Liabilities		
Current liabilities		
Payables and deferred revenue	2,019	1,809
Borrowings	11	11
Employee Entitlements	4,258	2,194
Provisions	85	212
Total current liabilities	6,372	4,226
Non-current liabilities		
Borrowings	97	147
Employee entitlements	300	300
Restricted funds	2	2
Provisions	3	3
Total non-current liabilities	402	452
Total liabilities	6,774	4,678
Net assets	9,614	11,736

Forecast Statement of Financial Position – Continued

	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m
Equity		
Crown equity	4,101	7,324
Accumulated Surpluses/(deficits)	(1,735)	(2,835)
Revaluation reserves	7,173	7,173
Trust and special funds	72	72
Minority interests and other reserves	3	2
Total Equity	9,614	11,736

Forecast Statement of Cash Flows

	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m
Cash flows from operating activities		
Funding from the Crown/Crown entities	26,493	27,826
Interest received	161	78
Other revenue	643	393
Payments to employees	(12,521)	(14,616)
Payments to suppliers	(14,685)	(15,488)
Capital charge	(470)	(529)
Interest paid	(6)	(7)
GST (net)	85	0
Net cash flows from operating activities	(300)	(2,343)
Cash flows from investing activities		
Receipts from sale of property, plant and equipment	18	5
Receipts from sale or maturity of investments	1,880	1,108
Funds placed on short term deposit >3 months	(2,226)	(750)
Purchase of property, plant and equipment	(1,445)	(2,028)
Purchase of intangible assets	(185)	(63)
Net cash flows from investing activities	(1,958)	(1,728)
Cash flows from financing activities		
Capital project contributions from the Crown	682	1,572
Holidays Act remediation Crown equity	275	1,663
External borrowings	0	50
Capital contributions returned to the Crown	(12)	(12)
External borrowings repaid	(3)	(11)
Net cash flows from financing activities	942	3,262
Net increase/(decrease) in cash and cash equivalents	(1,316)	(809)
Cash and cash equivalents at the start of the year	2,019	840
MHA cash transferred 1 April 2024	137	0
Cash and cash equivalents at the end of the year	840	31

Notes to the prospective financial statements

1. Prospective financial statements and assumptions

These prospective financial statements have been prepared in accordance with the Crown Entities Act 2004. They provide information about the future operating intentions and financial position of Health NZ, against which it must report and be formally audited at the end of the financial year.

The information in these financial statements may not be appropriate for purposes other than those described above. Health NZ has complied with financial reporting standard PBE FRS 42 Prospective financial statements in the preparation of these prospective financial statements.

These prospective financial statements are based on significant financial assumptions about future events that Health NZ reasonably expects to occur. Any subsequent changes to these assumptions will not be reflected in these financial statements.

Actual results for the forecast period are likely to vary from the information presented, and variations may be material.

Statement of significant underlying assumptions

Health NZ has made assumptions in preparing the prospective financial statements. The most significant of these are outlined below.

2. Statement of accounting policies

Reporting Entity

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.

Health NZ is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP). The prospective financial statements for the Health NZ are for the year ended 2024/25. They were approved for issue by the Commissioner on 14 November 2024.

Basis of Preparation

Accounting Policies

The prospective financial statements have been prepared with the accounting policies expected to be used for future period reporting of general-purpose financial statements in accordance with GAAP.

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 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.

Going Concern

The prospective financial statements have been prepared on a going concern basis. The Commissioner of Health NZ, after making enquiries, has a reasonable expectation that Health NZ has adequate resources to continue operations for the foreseeable future subject to the matters set out below. The Commissioner has 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 prospective 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:

- Forecast financial performance and cashflows prepared using funding expectations indicate that Health NZ will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet forecast operating and investing cash flow requirements for 2024/25 year subject to:

- Sufficient funding is appropriated by the Crown to enable Health NZ to settle the holiday pay liability and payments
- Sufficient funding is made available for approved capital plans to implement the projects either through the Health Capital Envelope or other funding streams agreed with the Crown
- The Crown provides equity support where necessary to maintain Health NZ's viability as per the Letter of Comfort provided by Joint Ministers dated 31 October 2024
- Health NZ's turnaround plan for 2024/25 generates sufficient cost savings to stabilise the organisation's cash position from January 2025.

3. Statement of significant accounting policies

The following is a summary of the significant accounting policies that affect the prospective financial statements. A comprehensive list of policies is contained within the Health NZ 2022/23 Annual Report – there have been no changes to the accounting policies.

Basis of Consolidation

Health NZ consolidates in the group prospective financial statements all entities where Health NZ has the capacity to control financing and operating policies so as 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 prospective financial statements are prepared by adding together 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 prospective 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.

Estimated Actuals 2023/24

The estimated actual financial statements for 2023/24 are the unaudited actual results to 30 June 2024.

Crown funding

Health NZ receives annual funding from the Ministry of Health (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 to the 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 is recognised as revenue when eligible services are provided, and any contract conditions have been fulfilled.

Cost allocation

The cost of outputs 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 on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of 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.

Personnel costs

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 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.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Classification of Leases

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 exercises its judgement on the appropriate classification of leases.

Principal or agent of the Pharmaceutical Management Agency (Pharmac)

Determining whether Health NZ is a principal or an agent of Pharmac 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 reached the view that Health NZ is acting as a principal, and therefore recognises the funding from Pharmac as revenue and the payment of claims from community pharmacies for their dispensation of funded pharmaceuticals as expenditure.

Critical accounting estimates and assumptions

Health NZ has 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

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.

The disposal of certain properties may also be subject to the provision of section 40 of the Public Works Act 1981.

As Health NZ does not have full title to Crown land it occupies but transfer is arranged if and when land is sold.

Restrictions on Health NZ's ability to sell land would normally not impair the value of the land because Te Whatu Ora 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 from site to site, depending on the designation/restriction, and are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely or at its 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 a number of 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.
- 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 have 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.

Estimated useful life 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 a number of 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 second-hand market prices for similar assets; and
- analysis of prior asset sales.

Health NZ has not made significant changes to past assumptions concerning useful lives and residual values.

Measuring the liabilities for Holidays Act 2003 remediation

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 has been ongoing since 2016 on behalf of 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, for an agreed approach to identify, rectify and remediate any Holidays Act non-compliance. Prior to the establishment of Health NZ, the then-DHBs agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for the calculation of the liability for any historical non-compliance.

The health sector has a workforce that includes differential occupational groups with complex entitlements, non-standard hours, allowances/overtime. The process of assessing non-compliance with the Holidays Act and determining any additional payment is complex.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance progressed during the current financial year. As a result, Health NZ recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine the liability based on its own review of payroll processes which identified instances of non-compliance with the Holidays Act and the requirements of the MOU. The liability as of 30 June 2024 is based on the opening balance transferred to Health NZ from Combining Entities that had previously been developed on the following basis:

- The old DHBs either used remediation scripts (where 100% of the population is recalculated) or used a sample and extrapolated variances across the population. The remediation script and sample 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). Estimations for the programme costs to complete the remediation work were also included into the liability estimates for each district.

No further sampling and extrapolation has been completed given the progress made on remediation projects, with a number of these paid or nearing the point of making payments to current employees (current tenure). Also, further sampling and extrapolation would be unlikely to provide a significantly different financial liability estimate.

Sampling estimates that were prepared by Ernst and Young for Health NZ components make up 85% of the total liability. The Ernst and Young modelling has therefore been used to project forward the liability balance:

- The key assumption used to establish this forward projection is that the level of non-compliance is consistent across years on a district-by-district basis. A level of non-compliance of 3.09% of gross pays on average has been assumed as the level of ongoing non-compliance. This assumes that no corrective actions are taken to reduce non-compliance with the Holidays Act and that there is no ongoing non-compliance issue relating to leave transfers.
- For Districts that used remediation scripts, the liability uplift was from a combination of district level reassessments of remediation scripts and forward projections to estimate their balances. A review was also completed on the components that were included in those estimations to ensure consistency with the components included in the Ernst and Young model.

Until the remediation projects are completed for all components, there remain substantial uncertainties as to the actual amount Health NZ will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

Payments to settle this provision commenced in July 2023 and are on-going.

Measuring the liabilities long service leave, retirement gratuities, sabbatical leave, and continuing medical education leave

Long service leave and retirement gratuities

The present value of sabbatical leave, long service leave, and retirement gratuities obligations depend 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 the end of each financial year end the salary inflation factor is Health NZ's best estimate of forecast 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 not be materially higher or 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 not be materially higher or lower.

Provision for Covid-19 inventory obsolescence

Covid-19 inventories may become obsolete. Covid-19 inventory obsolescence is calculated based on product expiry dates and the expected future usage given the current national pandemic response settings.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates. The capital charge rate for the year ended 30 June 2024 was 5.00% and the prospective financial statements for 2024/25 are prepared using 5%.

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 revenue and expenditure in respect of these funds are recognised in the surplus or deficit and is transferred from/to trust funds in equity.

Loan receivables

The long-term loan receivables are initially measured at fair value plus transaction costs. The loans receivable has been measured at fair value through surplus or deficit.

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 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.

Equity investments

Portfolio investments 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 is calculated based on quoted market prices at the balance date without deduction for transaction costs.

Equity

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 Crown Entities Act, which impose restrictions in relation to borrowings, acquisition of securities, issue of 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. Equity is disaggregated and classified into the following components:

- Crown Equity
- Accumulated surplus or deficit
- Revaluation reserves
- Trust and special funds
- Minority interests and other reserves.

Contributions from/(repayment to) the Crown

This relates to funding from the Crown for Crown approved capital projects, funding of Holidays Act Remediation and project costs and funding for pay equity for Allied Health and Midwifery.

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.

Forecast Statement of Service Performance

Output Class	Group 2023/24 Est. Actual \$m	Group 2024/25 Budget \$m
Hospital and specialist services		
Revenue	14,559	15,116
Expenditure	15,303	15,966
Net Surplus / Deficit	(744)	(850)
Mental health and addiction		
Revenue	2,285	2,683
Expenditure	2,305	2,683
Net Surplus / Deficit	(21)	0
Primary and community services		
Revenue	9,438	9,387
Expenditure	9,148	9,637
Net Surplus / Deficit	290	(250)
Public health services		
Revenue	486	533
Expenditure	705*	533
Net Surplus / Deficit	(219)	0
Hauora Māori services**		
Revenue	174	578
Expenditure	203	578
Net Surplus / Deficit	(28)	0
COVID-19 – National Response***		
Revenue	238	0
Expenditure	238	0
Net Surplus / Deficit	0	0
Total revenue	27,180	28,297
Total operating expenditure	27,902	29,397
Net Surplus / Deficit	(722)	(1,100)

*Note includes COVID-19 stock consumed or written-off of \$201M.

**Note 2023/24 Actuals only include April to June, as prior to April 2024 the Delivering hauora Māori services appropriation and Output Class was the responsibility of Te Aka Whai Ora / Māori Health Authority.

***Note the COVID-19 – National Response Output Class ceased at the end of the 2023/24 financial year.

Glossary

The following terms and acronyms have been used within this Statement of Performance Expectations 2024/25.

Term / Acronym	Description
CEA	Crown Entities Act 2004
DHB	District Health Board
GPs	General Practitioners
GST	Goods and services tax
Health NZ	Health New Zealand Te Whatu Ora
HPA	Health Promotion Agency Te Hiringa Hauora
HQSC	Health Quality and Safety Commission Te Tāhū Hauora
IR	Inland Revenue Department
MoH	Ministry of Health Manatū Hauora
NZ GAAP	New Zealand generally accepted accounting practice
NZHP	New Zealand Health Plan
PBE	Public Benefit Entity
SPE	Statement of Performance Expectations
SSA	Shared Services Agencies

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