

Annual Report

Pūrongo-ā-tau

2024-25



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 2024/25

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Health New Zealand
Te Whatu Ora

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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

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 Health NZ group under section 19A of the Public Finance Act 1989, whether or not that information is included in the annual report.

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.

In our opinion, these financial statements and statement of performance fairly reflect the financial statements and operations of the Health NZ group for the year ended 30 June 2025.

On behalf of the Board of Health New Zealand.

Signed by:



Professor Dr Lester Levy
Board Chair
Health NZ | Te Whatu Ora
Dated: 31 October 2025

Signed by:



Roger Jarrold
Board Member
Health NZ | Te Whatu Ora
Dated: 31 October 2025

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Foreword

From the Board Chair

The past year has been a pivotal one in the short journey of Health NZ. The performance turmoil of 2023/24, marked by significant underlying financial issues, highlighted systemic failings and underscored a strong need to immediately improve financial discipline, control and performance.



This led to my appointment as Commissioner in July 2024 and the initiation of rapid action to address not only the pressing financial issues but also the long-run, multiyear decline in service performance, particularly emergency department, first specialist appointment, elective surgery and cancer treatment waiting times. Furthermore, immunisation rates and productivity had been in decline for a similar period. This deterioration in performance commenced before COVID-19, continued through the pandemic and deteriorated even further during the implementation of the health reforms, despite the ever-present dedication and care of our staff.

This annual report reflects the progress made, the challenges overcome, and the lessons learned since July 2024 as we work towards building high-performing health services that are nationally coordinated, locally responsive and always focused on patients. Over this past year working with the three Deputy Commissioners and the interim, then permanent Chief Executive, significant improvements in both financial and service performance have been achieved. We have a **delivery plan** in place, which provides the roadmap to further reduce waiting times, improve emergency department performance and provide enhanced access to critical services such as cancer treatment and childhood immunisations.

These rapidly achieved improvements are a testament to our workforce and the potential of Health NZ, but the work is just starting. To consolidate and advance these gains will require us to embed a devolved and clinically led model of care and ingrain a culture of compassion, innovation and ownership. Supporting regional and local decision-making and strengthening clinical leadership in the ways we intend will put patients at the forefront of operational choices. This will also maximise the levers and resources at the disposal of our managers and clinicians to create a sustainable and fair health system for everyone.

Professor Lester Levy

Chairman of the Board

Health New Zealand | Te Whatu Ora

From the Chief Executive

There was a significant shift in Health NZ's focus in 2024/25 to prioritise improving access to services as well as lifting health outcomes for our patients, whānau and communities.

Access to care steadily improved and wait times for treatment began to fall because of our drive to lift health outcomes for New Zealanders.

I want to acknowledge the dedication and professionalism of our people. Across the motu, our teams have shown resilience, innovation and a deep commitment to improving health outcomes.

In our hospitals, more people had the contact they needed with clinical teams to make decisions about the best treatment option for them. 693,422 first specialist appointments (FSAs) took place this year, up from 685,044 last year.

Since peaking in January, our FSA waiting list reduced by more than 10,800 people to the end of June.

More people received elective care than ever. 198,897 people had an elective procedure in 24/25, up from 190,162 in 23/24. After reaching record peaks in January 2025, elective waiting lists are now declining.

The number of emergency department attendances we managed rose from 1,289,326 in 23/24 to 1,341,270 in 24/25.

At the same time, we continued to deliver for our communities:

- Increasing childhood immunisation rates remains a key priority to prevent avoidable infections. We made significant improvements in coverage rates for children 24 months of age, but we know we still have a long way to go in this area and are working closely with our community-based providers to overcome barriers to vaccination.
- We expanded access to primary and community care, with over 4.9 million people enrolled with primary healthcare organisations.
- We saw significant improvements in some of our screening programmes, for example cervical screening coverage rose from 69.2% to 74.1%.

While there is still much more to do, 2024/25 will be remembered as the year when Health NZ began to deliver on its promise.

It was a year in which we moved from transition to traction—delivering more care, stabilising our finances and laying the groundwork for the services we fund or deliver to be more sustainable and equitable.

These efforts are already delivering results. Our financial result for the year ended 30 June 2025 is a deficit of \$947m, which is \$153m better than the budgeted deficit of \$1.1bn. We've strengthened our financial capability, and we intend to be back living within our means by 2026/27.

While we can be proud of our achievements, the year has not been without challenges. Examples include:



- Internal change processes took longer than expected and affected thousands of staff. Delays also impacted some of our strategic programmes of work.
- The industrial climate was challenging for all employers in 2024/25. For Health NZ, this resulted in 2 days of national strike action and 12 days of district specific strike action in our hospitals and specialist services.

Looking ahead, our focus remains on improving access and outcomes for all New Zealanders, and financial sustainability. I am committed to leading with compassion and ensuring our staff are enabled to bring a similar approach to their work, whatever their role in Health NZ.

Dr Dale Bramley

Chief Executive

Health New Zealand | Te Whatu Ora

Introducing Health NZ

Introducing Health NZ | Te Whatu Ora

Health NZ is a Crown agent under the Crown Entities Act 2004. Health NZ was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act), replacing the 20 district health boards (DHBs) and eight shared service agencies, as well as absorbing some functions from the Ministry of Health.

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

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

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

- design, arrange, and deliver services
- encourage, support, and maintain community participation
- promote health and prevent, reduce, and delay ill-health
- achieve the best possible health outcomes for all New Zealanders
- ensure that planning and service delivery respond to the aspirations and needs of the population.

A board is responsible for our governance and accountable to the Minister of Health and operated for the first two years of Health NZ's existence until 22 July 2024, when a Commissioner was appointed.

The Healthy Futures (Pae Ora) Amendment Bill was introduced to Parliament on 23 July 2025 and may result in future changes to the Act.

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.

There is also a Minister of Mental Health, whose responsibilities include the oversight of strategic and policy matters within the health system relating to mental health and addiction services and supports.

Our partner agencies

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 many third-party providers.

In 2024/25 we worked closely with the following health agencies:

- **Ministry of Health | Manatū Hauora** and its departmental agencies (Public Health Agency and Cancer Control Agency) as the Minister's primary advisor on health policy, regulatory settings and health system performance
- **Pharmac | Te Pātaka Whaioranga** reimburses Health NZ for its expenditure on pharmaceuticals used in hospital and specialist 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.

Our Leadership

Governance

On 24 July 2024, the Minister appointed Professor Levy as Commissioner for a 12-month period in place of a board. The Commissioner appointed three Deputy Commissioners to assist in managing the organisation's financial recovery, identifying efficiencies, and overseeing the delivery of a sustainable health system.

Commissioner - Professor Lester Levy CNZM

Deputy Commissioners – Roger Jarrold, Ken Whelan and Kylie Clegg

In mid-2025, Health Minister Simeon Brown re-established a Board for Health NZ, replacing the Commissioner-led governance model from 22 July. The Minister also established a Ministerial Health Infrastructure Committee to oversee major hospital and facility investments, ensuring projects are delivered efficiently, on budget, and aligned with national priorities.

Details of the new Board are available on our [website](#) and will be included in our 2025/26 Annual Report.

Executive Leadership Team (as at 30 June 2025)

Dr Dale Bramley, Interim Chief Executive

Delivery and clinical leadership

Dr Nick Chamberlain, National Director National Public Health Service

Catherine Cronin, Regional Deputy Chief Executive Midland | Te Manawa Taki

Selah Hart, Interim National Director Hauora Māori Services

Martin Keogh, Regional Deputy Chief Executive Southern | Te Waipounamu

Jason Power, Interim National Director, Planning, Funding & Outcomes

Robyn Shearer, Interim Regional Deputy Chief Executive Central | Te Ikaroa

Mark Shepherd, Regional Deputy Chief Executive Northern

Dr Richard Sullivan, Chief Clinical Officer

Enabling leadership

Mahaki Albert, Maiaka Whakaruruhau Tikanga (Chief of Tikanga)

Richard Aldous, Group Financial Controller

Andrew Cordner, Chief Legal Counsel

Catherine Delore, Chief Communications and Government Services Officer

Darren Douglass, Acting Chief Information Technology Officer

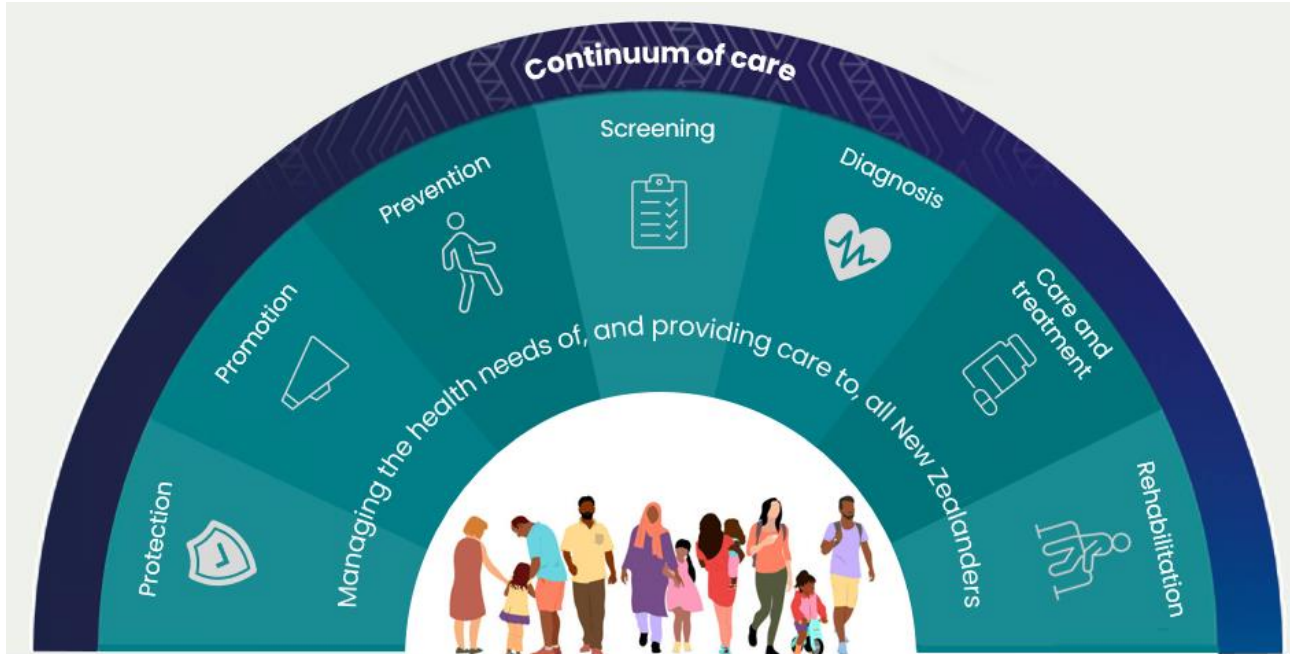
Jeremy Holman, Chief Infrastructure and Investment Officer

Fiona McCarthy, Interim Chief Human Resources Officer

Bevan McKenzie, Chief Financial Officer

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 healthcare depends on close relationships with others.



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

Nationally, regionally and locally, Health NZ partners 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

Our Regions

Health NZ organises itself into four regions: Northern covering the north of the North Island, Midland | Te Manawa Taki covering Waikato and the midland districts, Central | Te Ikaroa covering the lower North Island and Southern | Te Waipounamu covering the South Island, Rakiura | Stewart Island and Rēkohu | Chatham Islands.

Each region is divided into districts and focuses 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 access to health services and equitable 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. 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.

Northern

Northern covers four districts: Northland, Auckland, Waitematā, Counties Manukau.



Population

37.7% of the New Zealand population lives in region



Ethnicity

14.4% Māori | 12.7% Pacific | 29.1% Asian | 43.8% Euro / MELAA* / Other



Social deprivation

24.2% live in most deprived quintile | 17.3% live in least deprived quintile



Rural area population

9.2% of people in the Northern region live in rural areas

Source: Stats NZ Prioritised ethnicity population projections for 2025 (2024 update)



*MELAA = Middle Eastern, Latin American, African

Midland | Te Manawa Taki

Te Manawa Taki means ‘the heartbeat,’ a name gifted to this region covering five districts: Bay of Plenty, Tairāwhiti, Lakes, Taranaki and Waikato.



Population

20% of the New Zealand population lives in region



Ethnicity

27% Māori | 3% Pacific | 12% Asian | 58% Euro / MELAA* / Other



Social deprivation

28.1% live in most deprived quintile | 13.1% live in least deprived quintile



Rural area population

29% of people in the Midland | Te Manawa Taki region live in rural areas

Central | Te Ikaroa

Central | Te Ikaroa covers five districts: Whanganui, MidCentral, Capital & Coast and Hutt Valley (these two areas are one district, but in this report the results are reported separately), Hawke's Bay, and Wairarapa.



Population

18% of the New Zealand population lives in the Central | Te Ikaroa region



Ethnicity

20% Māori | 6% Pacific | 14% Asian | 60% Euro / MELAA* / Other



Social deprivation

19% live in most deprived quintile | 23% live in least deprived quintile



Rural area population

18% of people in the Central | Te Ikaroa region live in rural areas

Southern | Te Waipounamu

Te Waipounamu means ‘water and greenstone’ and is the only place pounamu is found in New Zealand. This region covers five districts: Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern.



Population

24% of the population lives in the Southern | Te Waipounamu region



Ethnicity

11% Māori | 3% Pacific | 13% Asian | 73% Euro / MELAA* / Other



Social deprivation

12% live in most deprived quintile | 25% live in least deprived quintile



Rural area population

28% of people in the Southern | Te Waipounamu region live in rural areas

Source: Stats NZ Prioritised ethnicity population projections for 2025 (2024 update)

*MELAA = Middle Eastern, Latin American, African

Workforce Snapshot

Location	Employee Count [^]	Contracted FTE [#]
Auckland	11,534	10,372
Canterbury	10,810	9,045
Capital, Coast & Hutt Valley	9,111	7,937
Counties Manukau	8,649	7,634
Waitematā	8,554	7,416
Waikato	8,281	7,211
Southern	5,705	4,794
Bay of Plenty	3,848	3,178
Northland	3,779	3,143
National Office ^{**}	3,752	3,655
Hawke's Bay	3,215	2,670
MidCentral	3,013	2,551
Nelson Marlborough	2,810	2,242
Taranaki	2,104	1,741
Lakes	1,657	1,386
Whanganui	1,080	909
Tairāwhiti	1,026	862
South Canterbury	845	690
West Coast	803	660
Wairarapa	582	445
Total	91,158	78,540

rounded for snapshot purposes

[^] excludes 9,471 employees on parental leave, leave without pay and casual contracts

* National Office length of service data is excluded due to low data quality.

** Health NZ's National Office is located in Wellington; however National Office staff are located across the motu.

~ includes employees on parental leave, leave without pay and casual contracts

Staff Numbers~

100,629

Employees

80,231

Contracted FTE

Gender

78.1%

Female

21.8%

Male

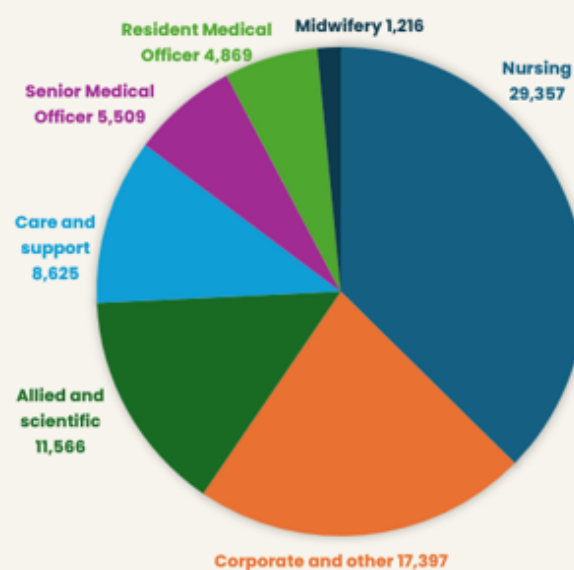
0.1%

Gender diverse

Age and length of service of workforce by occupation group

Occupation Group [^]	Mean length of service [*]	Mean age
Nursing	8.0	42.8
Corporate and other	7.7	49.5
Allied and scientific	8.2	43.4
Care and support	7.1	47.8
Senior Medical Officer	10.4	50.2
Resident Medical Officer	1.6	31.3
Midwifery	6.6	46.0

Contracted FTE



Progress on Strategic Intentions

Delivering on our Strategic Intent

The Government Policy Statement on Health (GPS) lays out the Government's long-term vision for health and wellbeing - to achieve longer life expectancy and improved quality of life for all New Zealanders. The Government is focused on achieving timely access to quality health care enabled by a stable workforce and infrastructure. The GPS identifies 23 objectives and 77 expectations (75 apply to Health NZ), including five health targets and five mental health and addiction targets to ensure a focus on timely access to care.

Statement of Intent 2024-28

Our **Statement of Intent** (SOI) was published at the beginning of 2024/25 and sets out our intended direction and goals over the medium-term four-year period, 2024-2028. It outlines our key priorities, how we will assess our own performance against those priorities, and how we plan to develop our organisation to enable us to achieve them. The document is one of the ways in which we can stay open and accountable to the public.

This is the first of four years of this SOI, developed at a time when Health NZ was barely two years into having been established. A refreshed approach was taken from the previous SOI 2022-24, at a time when significant challenges were being faced by Health NZ including extensive internal restructuring.

Our strategic framework, available in our SOI 2024-2028, shows the connections between our longer-term objectives of the GPS and our Strategic Objectives which are to:

1. Deliver the New Zealand Health Plan; and
2. Empower and enable leadership at all levels.

The SOI should be read together with the **Statement of Performance Expectations 2024-25** (SPE). This provides an annual outline of what we deliver and invest in over the financial year to achieve the objectives in the SOI, and how our performance will be monitored. Reporting against the measures set out in the SOI and the SPE can be found in the Statement of Performance section of this report from page 34 onwards.

Deliver the New Zealand Health Plan

The New Zealand Health Plan | Te Pae Waenga 2024-2027 (the NZHP) gives effect to the GPS by laying out the actions we will deliver within our available resources over three years, including:

- Achieving Timely Access to Quality Healthcare 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 and reduced quality of life.
- Strengthening enablers of delivery, including a continued focus on workforce development and infrastructure – both technological (digital) and physical.
- Improving equity of outcomes and meeting the needs for all New Zealanders.

Development of the NZHP commenced in 2023 with extensive consultation into early 2024. This was the first 'real' NZHP produced by a newly formed organisation, following Te Pae Tata | the Interim New Zealand Health Plan 2022 which was developed by a transition team as Health NZ was being formed. The GPS was finalised much later than expected in June 2024 and a Commissioner was appointed in July 2024, both impacting the NZHP finalisation timeline.

After the NZHP was endorsed by Commissioners it was provided to the Auditor-General late December 2024 for audit assurance in accordance with the Pae Ora Act. His report was received 23 May 2025 and, following consultation with the Ministry of Health, the final plan was submitted to the Minister of Health for approval on 16 July 2025. The Minister approved the plan on 31 July, and it was presented to Parliament in accordance with the Act and published on Health NZ's website on 1 August 2025.

Despite the delays in finalising the plan, Health NZ still progressed and monitored delivery against the commitments it had set out in the draft NZHP. Significant highlights during 2024/25 included:

- By 30 June 2025 the Faster cancer treatment <31 days milestone was achieved. See Government priorities - Ten Targets on page 25 of this report and Output Class 3: Hospital and specialist services on page 105.
- Screening coverage for bowel, cervical and breast cancers improved. See Output Class 1: Public health services on page .
- The emergency department (ED) health target improved, and by 30 June 2025 we were just 0.1 per cent away from achieving the target milestone for shorter stays in ED <6 hours. See Government priorities - Ten Targets on page 25.
- Childhood immunisation rates improved, although we did not reach the target milestone by 30 June 2025. Health NZ implemented initiatives across five action areas
- including strengthening the partnership with Primary Health Organisations to assist meeting this target. See Government priorities - Ten Targets on page 25 and Output Class 1: Public health services on page .
- By 30 June 2025 two mental health and addiction targets were achieved (faster primary access <1 wk and faster specialist access <3 wks). See Government priorities - Ten Targets on page 25. Access to mental health services for youth under age 25 also improved, see Output Class 4: Mental health and addiction services on page 143.
- High performance across all measures for Hauora Māori Services. See Output Class 5: Hauora Māori services on page 167.
- Ambulatory sensitive hospitalisation (ASH) rates for children 0-4 years reduced nationally, with fewer children admitted to hospital with preventable illness. However, some regions report an increase with Pacific children continuing to have the highest ASH rates. Government announcements related to strengthening primary care will assist improving access to primary health care services. See Output Class 2: Primary and community care services on page 73.

Challenges included:

- Whilst the annual milestone was achieved by 30 June 2025 in the first specialist appointment (FSA) target, performance year-on-year declined. In response, Health NZ initiated a nationally integrated planned care programme for FSAs. See Output Class 3: Hospital and specialist services on page 105.
- Whilst the annual milestone was achieved by 30 June 2025 in the elective treatment target, performance year-on-year declined. In response, Health NZ launched the Electives Boost with the goal of providing additional outsourced procedures aimed at long-waiting patients as a priority. See Output Class 3: Hospital and specialist services on page 105.

Further NZHP related achievements during 2024/25 included:

- Health Workforce Plan published in December 2024
- Mental Health and Addiction Workforce Plan published in September 2024
- National Asset Management Strategy (Infrastructure) finalised in December 2024
- Health Infrastructure Plan published in April 2025
- National Clinical Networks were established (see more on page 183)
- a Nationally Coordinated Response Plan for Outbreaks of Communicable Disease was updated
- Emergency Department Mental Health Peer Support trials commenced in several hospitals
- Getting to Smokefree 2025 Plan was completed in November 2024
- Four new Hauora Māori and Pacific mobile oral health services were implemented

Reporting against delivery of the NZHP occurs separately and, along with several of the published plans mentioned above, is available on Health NZ's website at <https://www.tewhatauora.govt.nz/corporate-information/planning-and-performance>.

Empower and Enable Leadership at all levels

Health NZ is committed to empowering regions, bringing decision-making closer to communities and enabling leadership at all levels. The following priority actions contribute towards this:

- Health Delivery Plan workstream 5: Strengthen leadership and culture (see page 26); and
- NZHP Section 2: Clinical leadership, continuous quality improvement and innovation (see above)

Highlights of achievements over the year towards this strategic priority include:

- **National Clinical Networks** and the **New Zealand Clinical Senate** were established (see Clinical leadership on page 183)
- Organisational structure change processes designed to enhance Health NZ's performance, improve delivery of core functions and support local and clinical leadership, were finalised across most business units. A chief public health clinical

officer leadership role was established in the National Public Health Service to better support public health clinical leadership at all levels.

- Governance arrangements were established in regions to ensure oversight of financial, clinical and operational management across each region and in their districts.
- We recruited for 23 vacant district clinical chief roles in medical, nursing and allied health (scientific and technical), to strengthen clinical leadership locally. Chief midwifery roles were established in districts that did not previously have a chief midwife.
- The Northern region re-established the joint alliance leadership team of Primary Health Organisation (PHO) chief executives and clinical directors, to provide a regional oversight of primary care, and a platform to discuss challenges and improvements.
- Te Kāhui o Te Whiri Kaha | Māori Clinical Forum supported the National Clinical Networks to develop frameworks for equitable advice and decision-making. The forum is a group of Māori clinicians from diverse communities and professions, who meet to address health issues that most affect Māori. The forum also supported development of the perinatal bereavement care pathway and primary care system level measures.
- A director of digital innovation and AI was appointed, to lead Health NZ's commitment to leveraging AI in improving health outcomes. Health NZ supports the safe, effective, and equitable use of AI to support frontline staff to improve patient experience.
- Clinical input continues to be embedded into digital initiatives via national and regional digital governance forums, and development of the Digital Investment Plan and roadmaps. Quarterly planning and prioritisation with clinical leaders are now in place to ensure investment is directed to high priority areas.
- The Resident Doctors Support Service was established. It partners with key stakeholders, including unions, the Medical Council of New Zealand and medical colleges, to help develop a well-trained and supported medical workforce.

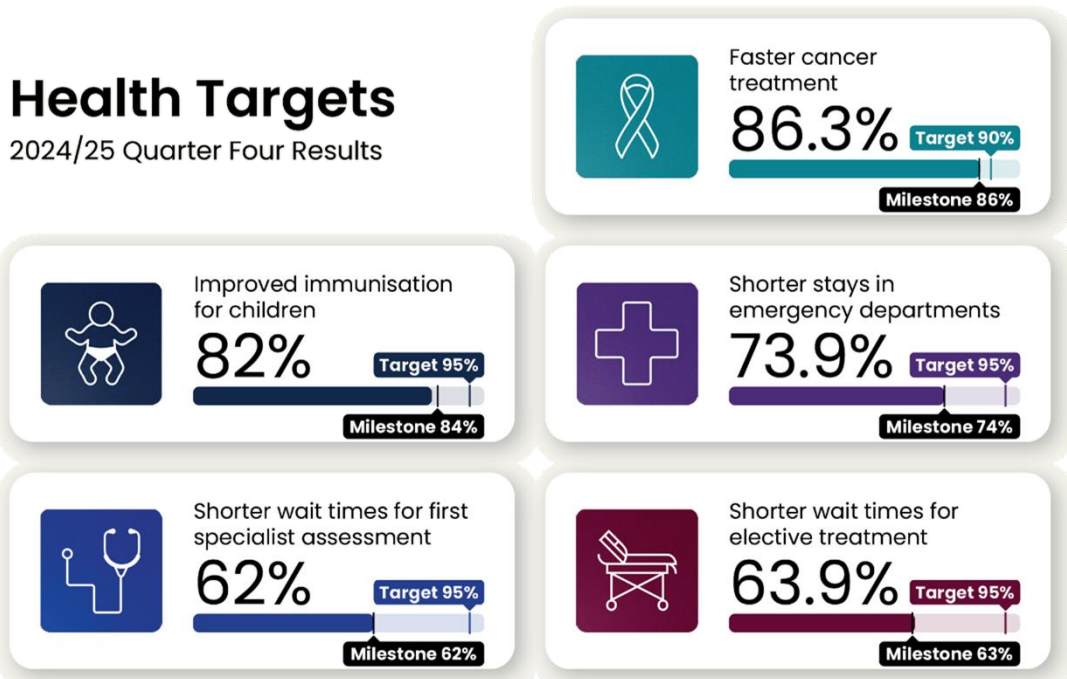
Assessment of Operations and Performance

Government priorities – Ten Targets

The Government introduced 10 health targets from 1 July 2024, activated via the GPS which set annual milestones for their achievement. The results below show our performance as at 30 June 2025, reflecting the sharp focus throughout 2024/25 towards achieving the GPS milestones by the end of the financial year. The Statement of Performance section of this report shows more detail on our annual performance against the targets and thus reflects the full year result.

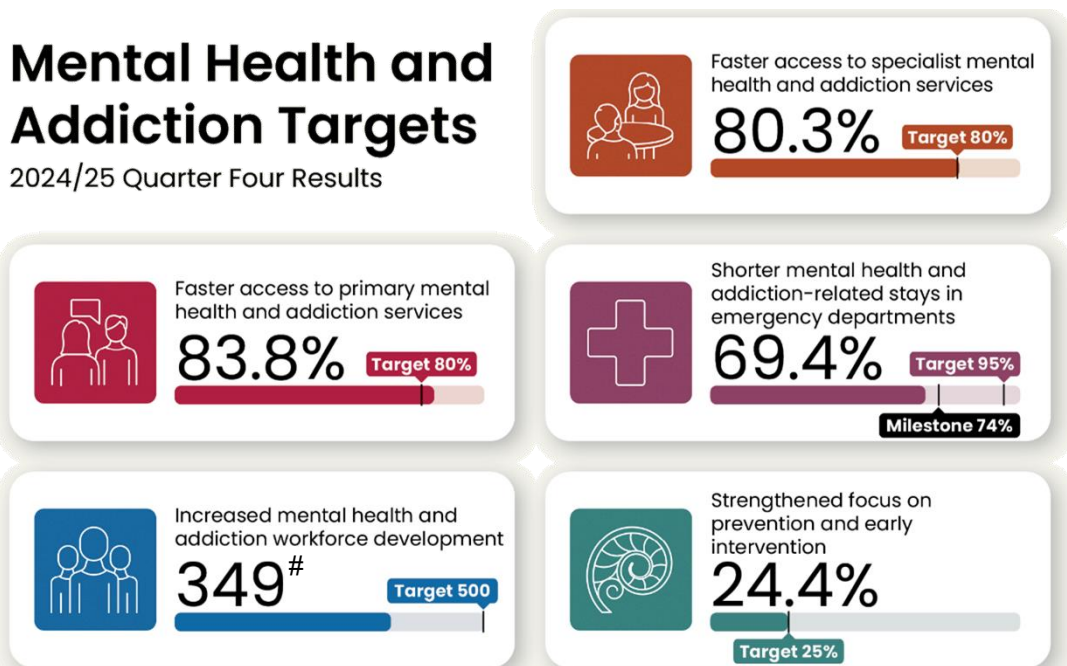
Health Targets

2024/25 Quarter Four Results



Mental Health and Addiction Targets

2024/25 Quarter Four Results



= Represents a partial result (only semester one) for the 2025 academic/calendar year. The 2024 academic/calendar year result was 457.

Health Delivery Plan

The **Health NZ Delivery Plan** (HDP) is Health NZ's operational plan through to June 2026, which emerged as an iteration of the Commissioner's turnaround plan. The first version of the HDP was released on 7 March 2025, alongside the Minister of Health's Letter of Expectations (LoE). It incorporated elements of the turnaround plan and the Minister's priorities into six workstreams with milestones through to mid-2026, when the turnaround phase for Health NZ will be completed. The focus of the first iteration of the HDP was on improving financial sustainability, delivering more health services locally and achieving the Minister's priorities as set out in his LoE.

Over the first quarter of the HDP, to the end of June 2025, governance of the HDP was undertaken by a Delivery Committee which included the Commissioner, deputy Commissioners, the Chief Executive and independent members appointed by the Commissioner. This Committee provided oversight of the delivery of the plan, approved the detailed delivery plans, made decisions and provided direction to ensure delivery. Senior leaders of Health NZ were appointed to lead delivery of each project within the six workstreams.

Work was undertaken from March to June to align plans across Health NZ, with a new updated HDP released in July 2025 alongside the 2025/26 Statement of Performance Expectations. HDP workstream progress to June 2025 included:

Workstream 1: Improve access to services and reduce waitlists

This workstream focused on improving healthcare delivery by reducing waitlists, increasing access to primary care, and meeting government targets. Initiatives funded from Health NZ baselines and Budget 2025 were implemented:

- \$66 million Budget 25 Elective Boost delivered the target 10,579 elective surgical cases by the end of June 2025.
- \$95 million was internally funded for enhanced capitation in 2025/26 (\$285 million over three years), alongside implementation of Budget 2025 investments to improve primary care access including the launch of Urgent Care and 24/7 digital services and increase GP and nurse practitioner training.

Updates on Government priorities - Ten Targets are reported on page 25 and in the Statement of Performance section of this report which starts on page 34.

Workstream 2: Quality and safety of healthcare at the centre of what we do

This workstream aimed to embed clinical leadership and robust safety systems throughout Health NZ. The goal is to achieve demonstrable improvements in clinical quality and safety outcomes.

- A new Clinical Senate was established to provide strategic advice to the Health NZ Board. It is a multidisciplinary group of professions and specialties from across New Zealand.

- National and regional clinical networks, teams and partnerships continued to form, evolve and engage to work towards co-designed services and shared accountability for outcomes at national, regional and district levels.
- A National Clinical Quality and Safety System was implemented, in response to a benchmark review undertaken in 2024. Four regional governance groups were established with standard terms of reference and aligned reporting.
- Health New Zealand actively participated in HQSC-led Quality Forums by collaborating with regional and national clinical networks to co-design services and share accountability for quality and safety outcomes.

Workstream 3: Shift resources to the front line and reduce bureaucracy

This workstream supported decentralisation by moving decision-making closer to patients and communities. Achievements included:

- Major back-office organisation changes were completed, with the national office of Health NZ now located in Wellington.
- Processes to appoint a permanent Executive Regional Director in each of the four regions were completed. These roles will lead the next stage of devolution supporting front-line health services delivery at the district level by June 2026.
- Work to align national service and enabling plans (people, digital and infrastructure) was progressed in stages, with plans established to devolve and embed enabling functions in regions, districts and nationally in 2026.

Workstream 4: Get back to budget and improve value for money

This workstream addresses financial sustainability by achieving the budgeted deficit for 2024/25 of \$1.1 billion and then reducing it over the course of 2025/26 to \$200 million. The focus is on financial discipline and efficiency, predictable delivery of capital programmes, and ensuring value for money in infrastructure investments.

During 2024/25, Health NZ undertook a significant transformation in its financial governance and management practices, following the findings of an **independent review** conducted by Deloitte and published in March 2025. Commissioned jointly by Health NZ, the Ministry of Health and Treasury, the review examined the drivers behind the rapid deterioration in financial performance and cash position during 2023/24. The review identified a loss of effective financial control as the central cause of the financial decline.

In response to the review, Health NZ took decisive steps to restore financial stability and rebuild trust in its financial stewardship, which in March to June 2025 included:

- Implementation of all prioritised Deloitte recommendations: Health NZ is executing a comprehensive reform programme to strengthen financial controls, governance, and reporting. Districts began reporting financials through a single platform; better month-end and forecasting processes were put in place, with efficiency programmes integrated and reviewed monthly.
- Return to fiscal discipline: The organisation has reduced its forecasted structural deficit from \$1.76 billion in 23/24 to achieve its budgeted \$1.1 billion deficit in 2024/25.

Reporting at a regional level was put in place and, for the first time, Health NZ was able to devolve a national budget and production plans to regional and local levels.

- Enhanced financial planning and monitoring: New systems and processes have been introduced to improve monthly budget phasing, align expenditure with activity, and ensure early detection of financial risks. Budget 2025/26 was approved and issued, meeting fiscal requirements.
- Capability rebuilding: Steps were put in place to stabilise teams, rebuild financial capability, and embed a new operating model with clear decision-rights and accountabilities. Deputy Chief Financial Officers were established in each region.
- A 10-year infrastructure investment plan was agreed and released. The plan identified the more than \$20 billion investment required to meet future health needs and introduced a more efficient way of delivering large hospital projects.
- A 10-year digital investment roadmap was progressed to support regional and local service needs.

These changes are not only restoring financial control but also enabling Health NZ to deliver on its broader strategic objectives - improving health outcomes while ensuring long-term fiscal sustainability.

Workstream 5: Strengthen leadership and culture

This workstream aims to build a supportive and effective organisational culture. Several actions were progressed during the March – June period with a plan for the delivery of recommendations from an independent health, safety and wellbeing review released with actions for leaders to implement. Processes to support a re-established Health NZ Board were put in place and recruitment and decision-making to appoint a permanent Chief Executive finalised.

The most significant achievement under this workstream was the adoption of a new Governance Code (Version 1.0) —a foundational framework that defines how governance, accountability, and decision-making operate across the entity. This milestone reflects our commitment to delivering and funding services that are equitable, transparent, and responsive to the needs of all New Zealanders.

The Code sets out the principles and structures that underpin effective governance across Health NZ. It is grounded in the Pae Ora (Healthy Futures) Act 2022 and aligns with the Crown Entities Act 2024, the Government Policy Statement on Health, and other statutory and policy instruments. At its core, the Code:

- Devolves decision-making to the closest practical point of care — empowering regional, district, and frontline leaders to act with clarity and accountability.
- Integrates clinical, operational, and enterprise governance to ensure decisions are informed by evidence, aligned with strategy, and responsive to community needs.
- Centres equity and Te Tiriti o Waitangi by embedding mechanisms for Māori partnership and ensuring services are proportionate to population health needs.
- Promotes a culture of trust, accountability, and continuous improvement, with clearly defined roles for Accountable Officers and governance committees.

In 2024/25 meaningful progress was made in embedding the Governance Code across the organisation:

- Finalisation and publication of Version 1.0: The Code was refined through extensive consultation and formally adopted in mid-2025, replacing earlier drafts.
- Operationalisation of devolved decision-making: Approximately 85% of roles are now positioned locally, with regional coordination and national oversight focused on strategy, policy, and standards.
- Strengthening of clinical governance: Clinical governance was embedded as a central pillar of decision-making, with clinical leaders working in partnership with operational and enterprise leaders to optimise care delivery.
- Establishment of governance committees: Committees now operate across three lenses - fiduciary, strategic, and generative - supporting Accountable Officers in making timely, informed decisions.
- Monitoring and assurance mechanisms: The Code outlines clear roles for the Health NZ Board, Ministry of Health, central agencies, and the Office of the Auditor-General in overseeing governance performance.

The Governance Code continues to evolve as a living document, with ongoing review and refinement to reflect the dynamic nature of the broader health system and the needs of our communities.

Workstream 6: Develop new ways to deliver healthcare sustainably

This workstream focuses on long-term transformation of healthcare delivery. It involves analysing future health service demand, reviewing global innovations, developing new models of care, and creating a strategic roadmap. During 2024/25 an inventory of all “future of health” strategy and planning work across Health NZ was completed.

Significant investments from Budget 2024

To ensure that Health NZ is prioritising the areas it wants, the government allocates funding for initiatives that have significant budget implications (budget initiatives). Budget initiatives are often multi-year to support longer-term planning, especially if the initiatives are large and complex.

We progressed work to deliver on 32 budget initiatives during the year, six of which began in 2024/25 (shown in the tables below – there the ‘total funding’ is across the life of the initiative). These budget initiatives had a clear focus on improving health outcomes through improving timely access to quality health care.

Breast Screening Extension of Eligibility to Include 70 to 74-year-olds as part of the Free National Programme			
Multi-year funding: \$30m			
This initiative provides funding to extend the BreastScreen Aotearoa programme to include free mammograms for women up to 74 years of age. The current screening age for the programme is women aged 45-69. This expansion will be implemented through a phased roll-out	2024/25 Budget	2024/25 Spend	Variance
	\$1.248m	\$0.35m	\$0.898m

An age extension pilot was launched in the Nelson Marlborough district within the Te Waipounamu region in October 2024. This meant that women born on or after 1 October 1954 and who live in Nelson Marlborough became eligible for breast screening. As part of this age extension pilot, an additional 370 women have received a breast screen.

Extending free screening to women turning age 70 and those aged 74 supports better health outcomes for older women, including reduced breast cancer mortality and improved quality of life through early detection.

Health NZ is now preparing to provide the same age extension service to the rest of the country. New equipment has been ordered, including mobile units, mammograph and ultrasound machines. Providers have begun to recruit additional workforce to fill the resource gap. Te Puna, the newly-developed breast screening system will enable women to easily enrol and book a free breast screening appointment.

Primary Care Tactical Action Plan funding (PCTAP)			
Multi-year funding: \$17.912m			
The PCTAP includes projects to increase the workforce in primary care (doctors and nurses), extend the prescribing length to 12-months, establish 24/7 digital care, and enable consistent delivery of urgent and after-hours care and performance-based capitation.	2024/25 Budget	2024/25 Spend	Variance
	\$3.272m	\$2.685m	\$0.587m

The PCTAP aims to grow and retain the primary care workforce with improved career pathways and incentivise general practitioner providers. It will enable faster access to care and increase access to sustainable after-hours and urgent care services. This year we a) fully implemented governance oversight across all projects; b) commenced growing our domestic general practitioner and nursing workforce by creating clearer pathways; c) undertook a very successful test period for the 24/7 Digital Service (which subsequently went live from 1 July 2025); d) confirmed implementation of performance-based capitation to commence in 2025/26; and e) Identified and planned for new and expanded urgent and after-hours services.

Emergency Department Security Improvement Programme

Multi-year funding: \$39.074m

This initiative provides funding for an uplift in 24/7 security guards across the highest-risk emergency departments (ED), an increase in training and support roles to improve security capability across the country, and an uplift in flexible surge capacity where needed. It intends to support safer care and safety for Health New Zealand staff and people visiting its hospitals and facilities.

2024/25 Budget	2024/25 Spend	Variance
\$6.170m	\$3.397m	\$2.773m

ED Security Guards (budget \$3.96m): A total of 44 full-time equivalent (FTE) security guards were deployed across eight priority EDs: Waitakere, North Shore, Auckland City, Middlemore, Waikato, Wellington, Christchurch, and Dunedin Hospitals. These EDs now have a permanent 24/7 security presence.

ED Surge Guards (budget \$815k): Surge guard funding is available to all hospitals with EDs. 37 surge guards were deployed across 21 hospitals this year. These placements were essential in managing increased demand during summer, ensuring safety for both frontline staff, patients, and whānau during peak periods.

Violence Reduction Training (budget \$1.395m): This training is for security guards, clinicians, doctors, and other front-facing staff working in EDs. It aims to provide them with the knowledge and skills they need, based on their roles and the risks they face, to keep themselves and others safe from abuse, threats, and violence. Feedback on the quality and delivery of the training has been consistently positive, with participants requesting more sessions. The training took place at eight priority EDs and 1,638 staff (security: 347; clinical: 1,291) were trained.

Prevention First eLearning module: By June 2025, more than 45,000 Health NZ staff had engaged with the *Prevention First* eLearning module, and over 33,000 completions had been recorded. Efforts are underway to meet the target of 66,000 completions by October, further supporting a national approach to violence prevention and staff safety.

Mental Health and Addiction Community Sector Innovation Fund			
Multi-year funding: \$9.72m			
This initiative provides \$9.720 million total operating funding for a national Mental Health and Addiction Community Sector Innovation Fund by reprioritising existing baseline funding.	2024/25 Budget	2024/25 Spend	Variance
	\$2.353	\$2.353	\$0.0m
This will enable community organisations to submit proposals for innovative new time-limited approaches to address the mental health and wellbeing needs of New Zealanders.			

This year we contracted with Youthline, Sir John Kirwan Foundation, MATES in Construction, Mental Health Foundation, Wellington City Mission, Rotorua Community Youth Centre Trust and Women’s Refuge, Just a Thought (Social Innovation Ltd) and Tend Health. They are providing innovative services that will increase access to services for those who require them.

We are currently evaluating new innovative mental health proposals from providers for the next round of funding. Successful providers are expected to be in place from October 2025.

Data and Digital Infrastructure and Capability for Payroll System Remediation and Stabilisation			
Multi-year funding: \$12m			
This initiative will transition eight districts under one payroll platform. The districts are Northland, Whanganui, MidCentral, Tairāwhiti, Canterbury and West Coast, Lakes and Bay of Plenty.	2024/25 Budget	2024/25 Spend	Variance
	\$8m	\$0.0m	\$8m
The two additional hospitals included are Taranaki and Hutt Valley.			

The discovery phase has been completed in seven districts, with work currently underway in the eighth. Completing the discovery phase enables a clearer understanding of current processes, gaps, and resource needs, which is critical for informed decision-making

A workshop has been conducted to explore the complex interdependencies between transitioning eight payrolls. This will minimise the risk of delays or errors in payroll delivery.

COVID-19 and Pandemic Preparedness – Maintaining Essential Health Services and Critical Surveillance Infrastructure

Multi-year funding: \$237.371m

This initiative provides funding for operational delivery costs to support timely access to COVID-19 vaccines and therapeutics. It also retains critical public health surveillance infrastructure, supporting system preparedness to identify and respond to future disease outbreaks.	2024/25 Budget	2024/25 Spend	Variance
	\$56.435	\$53.423m	\$3.012

This initiative has continued to fund the administration of COVID-19 vaccinations to eligible people; everyone aged 5 and over and tamariki from age 6 months who are at greater risk of severe illness.

Pharmac is considering a proposal to continue with the current vaccine and eligibility criteria, which Health NZ has provided formal feedback on.

580,843 COVID-19 vaccinations were administered over the year. There was a significant increase in vaccination during quarter four with the release of the annual influenza campaign.

Health NZ is working on ensuring that COVID-19 vaccinations are available in multiple settings, including general practice, pharmacy, Māori and Pacific providers, and outreach services. In quarter one, 81% of the COVID-19 vaccinations were done in pharmacies.

The administration of COVID-19 vaccinations was incorporated into the Integrated Community Pharmacy Agreements on 1 July 2025 to encourage and support pharmacies to continue to provide this service to their communities.

In 2025/26 some of these budget initiatives will be embedded in Health NZ everyday operations to become 'business-as-usual'.

Statement of Performance



Statement of Service Performance

Entity Performance Framework

Health NZ has a strategically-aligned, entity-wide performance framework, with an accompanying set of high-level measures, that enables 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.

As we continue to unify and embed our business systems and processes (inputs) over the medium term, we will modernise both capacity and capability across the health services we fund and deliver (outputs) in a financially sustainable way. Combined, these improvements will enable Health NZ to meet the Government priority of providing timely access to quality care (impacts) as set out in the GPS and embodied in the 10 health targets, leading to a decrease in the prevalence and severity of illness in New Zealand over time (outcomes).

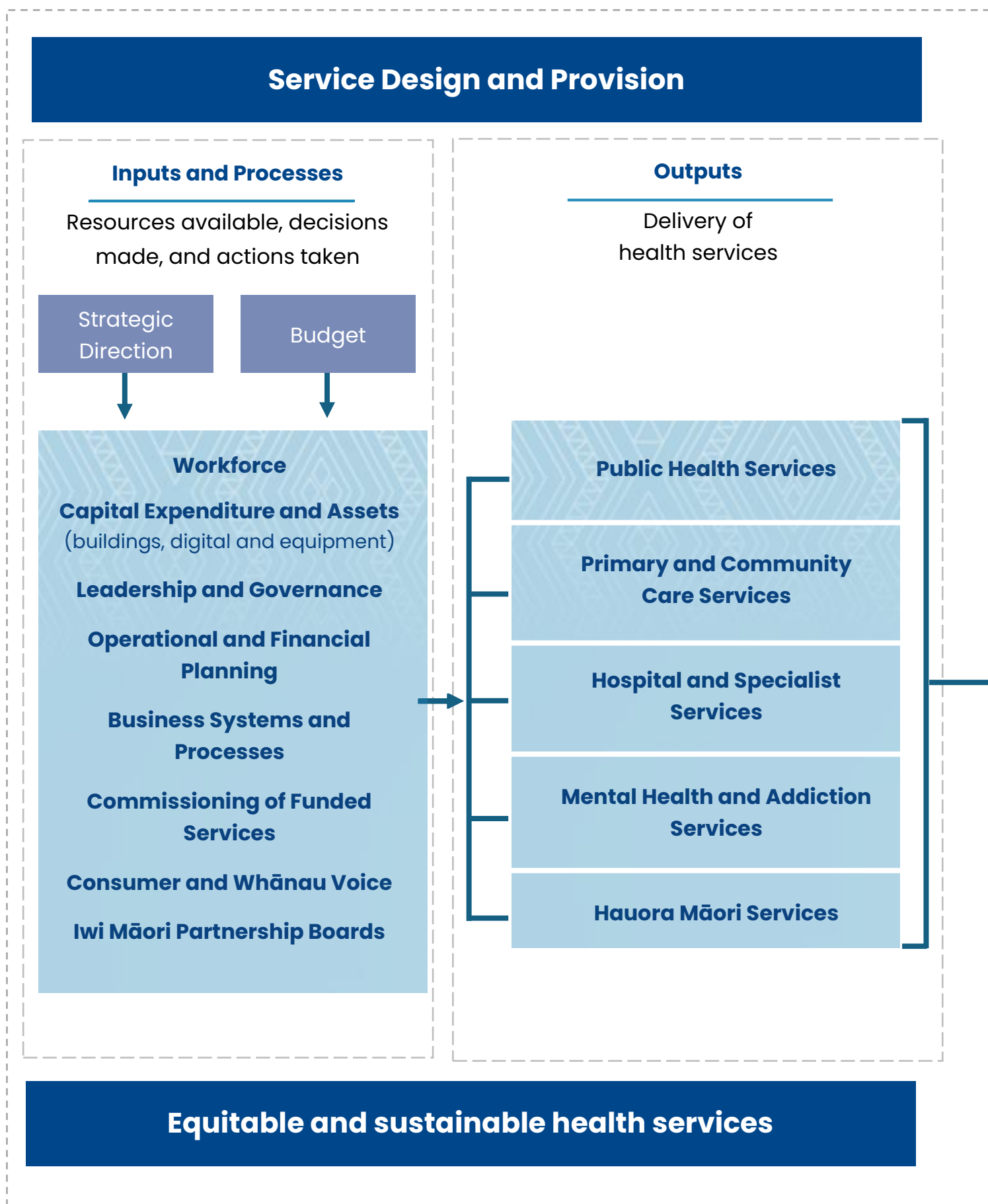
The framework is in two halves reflecting the two different aspects of our performance story. The objective for service design and provision (left hand side) is to deliver equitable and sustainable health services, while the objective across people's health journeys (right hand side) is to make equitable improvements to health and wellbeing. When we see improvements in timely access to quality care, we will know that our service design decisions are providing for value-based care.

Our entity performance measures reported in this section (page 45 onwards) are grouped within the four categories detailed in the framework. The categories are:

- **Inputs** These are indicators of the nature and scale of investment, the capacity and capability of our workforce, and the business systems and processes used to support the operation of Health NZ to make decisions around service delivery and design.
- **Outputs** These are indicators of the capacity and capability of our workforce, health services available and improvements in the clinical digital and physical infrastructure. These are the health services that New Zealanders interact with.
- **Impacts** These are indicators of the utilisation and timeliness of services as well as the quality of care provided. These measures provide an early indication that the service design decisions were appropriate to meet the health needs of New Zealanders.
- **Outcomes** These are indicators of the prevalence and severity of disease as well as modifiable behavioural changes. These measures provide evidence that improvements in the timely access to quality care are having a positive impact on the health of New Zealanders.

While the current approach to our performance story utilises existing and well-tested measures, the development of a suite of measures to better enable us to tell our performance story is a focus over the coming years as we unify and embed our systems and our processes as a single national entity implementing the Government's Priorities.

Health New Zealand | Te Whatu Ora Entity Performance Framework



Health Journeys

Impacts

Utilisation and quality of interactions with health services

More timely access to services

More equitable access to services

Better quality services delivered:

Appropriate

Safe

Valuable care

Patient and whānau experience

Outcomes

Longer life expectancy and better health outcomes

Longer life expectancy

Improved quality of life

Reduction of modifiable risk behaviours

Reduction in the incidence of communicable diseases

Reduction in severity, prevalence and reoccurrence of non-communicable diseases

Equitable improvements in health and wellbeing

How we report on our performance

This is the Statement of Service Performance (SSP) for Health NZ for the year ended 30 June 2025. 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 five output classes, as articulated in our entity performance framework (see page 35):

1. Public health services
2. Primary and community services
3. Hospital and specialist services
4. Mental health and addiction services
5. Hauora Māori services

Under each of our output classes you will find progress against relevant performance measures and information about how much our activities (outputs) cost. 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 SOI are described in the Progress on Strategic Intentions section.

Previous performance measures

For the 2024/25 Annual Report, we are only reporting on measures set out in our accountability documents; namely the Statement of Intent 2024-2028, the 2024-25 Statement of Performance Expectations, Vote Health: Estimates of Appropriations 2024/25, and Vote Health – Supplementary Estimates 2024/25.

In our view, the performance measures selected for 2024/25 adequately inform users of what we achieved during the year and the progress we are making towards achieving our outcomes. There are three performance measures that we are unable to report against this year. These are detailed in Appendix 3.

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 2024/25 (i.e. new measures or significantly altered measures) are noted against the relevant measure in the notes to the measure.

Performance reporting standard PBE FRS 48

The SSP has been prepared in accordance with the requirements of the Pae Ora 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 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 2024 to 30 June 2025 has been prepared in accordance with public benefit entity standards.

Approach to measurement

Our Budget appropriations have been mapped into the output classes, each with associated performance measures. The detail of this mapping can be found in the End-of-year performance information on appropriations section of this report, see page 41. 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 measurement basis is disclosed in the notes to each measure where relevant. 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.

For more information on the measurement basis, please refer to this document published on our website “Accountability Performance Measures Specifications – September 2025” for more information.

Visualisation of the results

The Statement of Performance Expectations 2024/25 is used as the default reference point for baselines and targets. In accordance with the Statement of Performance Expectations 2024/25, the following criteria are used to rate performance against each measure. Where a baseline has not been specified, the national baseline has been used for comparison.

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

* Relative to target

The ratings are located to the right of the reported 2024/25 result in the visualisations. Sparklines are used to illustrate trends over time for quantitative measures. These are aggregated over different periods and, depending on data availability, show:

- results by month for the 12 months to 30 June 2025,
- results by quarter for the 2024/25 year; or
- rolling 12-month or 24-month periods.

The total column to the left of the sparkline represents the starting position of the sparkline, with the 2024/25 result located to the right of the sparkline, unless otherwise indicated in the notes to the measure.

Please note, when the percentage sign (%) is used to compare between the 2023/24 and 2024/25 financial years, or between the 2024/25 result and a baseline, this has been done using a percentage point calculation.

For example, if a measure has a target of 95%, and the result was 90% in 2023/24 and is 94% in 2024/25, we would report our result as 1% below target (partially achieved) and 4% higher than 2023/24.

The relevant approach to measurement is detailed in the Approach to measurement section above. 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. A target

symbol  identifies the measures that are part of the **Government's ten health targets**.

A Parliament symbol  identifies targets that form part of the **nine All-of-Government targets**.

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 our annual reporting, we have applied a 2% materiality when comparing the 2023/24 results published in last year's report to the same period recalculated as part of this year's annual report process. This means that performance measure results for 2023/24, calculated in 2025 using the most up-to-date data available, that have a variation which exceeds 2% at a national, regional or ethnicity level are reporting in this report using the most recent data and this is disclosed in the measure notes. Where measures are reported for the first time or there is a change to the calculation method this year, data has been regenerated from current datasets

The target and baseline in the Statement of Performance Expectation 2024/25 has been used as primary basis for reporting. Where this differs or there has been a material change in the calculation basis, this is noted in the notes to the measure.

The quality of data has also improved since last year, which enables further disaggregation for many measures by region, ethnicity, district and rurality. Work is still underway to develop the ability to report by disability status.

Data validation is done at national, regional and (where relevant) district level, 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.

Rurality is based off Geographical Classification for Health 2018, classifying all areas of New Zealand as rural or urban according to their proximity to larger urban areas with respect to health. All records identified as urban 1 or 2 have been assigned urban, all records identified as rural 1, 2 or 3 have been assigned rural, and where records are unknown this has been quantified in the notes to the measure where relevant.

End-of-year performance information on appropriations

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

Appropriation	2024/25 Amount of each appropriation \$000s	2024/25 Amount spent against each appropriation \$000s	2023/24 Amount spent against each appropriation \$000s
Delivering Hospital and Specialist Services	14,850,019	14,520,631	14,381,833
Delivering Primary, Community, Public and Population Health Services	9,112,732	9,048,562	8,668,148
Delivering Hauora Māori Services ¹	766,166	718,966	
Problem Gambling Services	20,023	19,823	28,898
Capital Investment in Health New Zealand ²	0	0	10,916
Health Capital Envelope	1,312,738	1,149,327	521,594
New Dunedin Hospital 2021-2026	190,000	206,200	100,080
Standby Credit to Support Health System Liquidity	200,000	0	0
National Response to Covid-19 Across the Health Sector (non-departmental element only) ²	0	0	177,448
Implementing the COVID-19 vaccine strategy MCA ²	0	0	70,287
Remediation and resolution of the Holidays Act 2003 historical claims	1,623,044	256,717	285,836

1. 2024/25 is the first year that Health NZ has been required to report against this appropriation.

2. This appropriation was discontinued at the end of the 2023/24 year.

Notes:

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

b) The Statement of Performance section of this report sets out what has been achieved by Health NZ with the funding it has received from each appropriation.

Revenue and Expenditure by Output Class

Output Class	In \$ Millions	2024/25 Actual	2024/25 Budget	2023/24 Actual
Public health services	Revenue	541	533	486
	Expenditure	510	533	705
	Net Surplus/(Deficit)	31	0	(219)
Primary and community services	Revenue	9,789	9,387	9,438
	Expenditure	9,491	9,637	9,148
	Net Surplus/(Deficit)	297	(250)	290
Hospital and specialist services (HSS)	Revenue	14,480	15,116	14,559
	Expenditure	15,823	15,966	15,303
	Net Surplus/(Deficit)	(1,344)	(850)	(744)
Mental health and addiction services (MH&A)	Revenue	2,719	2,683	2,285
	Expenditure	2,756	2,683	2,305
	Net Surplus/(Deficit)	(37)	0	(21)
Hauora Māori services	Revenue	549	578	174
	Expenditure	444	578	203
	Net Surplus/(Deficit)	105	0	(28)
National COVID-19 response*	Revenue	0	0	238
	Expenditure	0	0	238
	Net Surplus/(Deficit)	0	0	0
*This is no longer an output class and is included here for comparative purposes				
Total	Revenue	28,077	28,297	27,180
	Expenditure	29,024	29,397	27,902
	Net Surplus/(Deficit)	(947)	(1,100)	(722)

Expenditure has been determined using the following cost allocation system:

Direct costs are costs that can be directly attributed to a specific output class (OC). **Indirect costs** are costs incurred in enabling, national or corporate functions that provide services across various OCs. Health NZ's financial system captures costs at a Responsibility Centre (RC) level. RCs are mapped to a specific OC (where the costs are directly attributed to that OC) or to a "shared function". Costs of shared functions are charged to OCs based on cost drivers and related activity/usage information. For example, depreciation is charged on the basis of asset utilisation by each OC; indirect personnel costs are charged to OCs based on actual time spent on supporting or delivering services for specific OCs; and other indirect costs are allocated to OCs based on the proportion of total costs for each OC.

Our performance at a glance

Health NZ's overall performance for 2024/25, for each output class, is shown in the table below. This shows the total number of measures:

- no target set
- baseline set
- achieved (on target or better)
- partially achieved (0.1% - 5% away from the target)
- not achieved (> 5% away from the target)

		Total	Achieved	Partially achieved	Not achieved	Not Reported/No Target
OC1^a	Public health services	16	1	9	6	0
OC2^a	Primary and community services	14	6	4	2	2 ^b
OC3^a	Hospital and specialist services	20	6	11	2	1 ^c
OC4^a	Mental health and addiction services	12	8	1	3	0
OC5^a	Hauora Māori services	8	7	0	0	1 ^c
Page 195	Infrastructure	3	2	0	1	0
Page 204	Sustainability	8	0	1	1	6 ^d
Page 216	Holidays Act Remediation	2	0	0	2	0
	Total measures	83	30	26	17	10
	% of Total measures	100%	36%	31%	20%	12%

Notes

- OC = Output Class
- Data integrity issues, please see appendix 2 for more information.
- Data not available, please see appendix 2 for more information.
- Some Carbon Neutral Government Programme measures do not have targets set.

The following two pages provide a visualisation of our performance framework with the performance measures reported in this section mapped to it by output class.

Service Design and Provision		
 Inputs and Processes Resources available, decisions made, and actions taken		 Outputs Delivery of health services
Output Class 1 – Public Health Services		
Budgeted Revenue & Expenditure 24/25 \$533m		
Output Class 2 – Primary and Community Services		
Budgeted Revenue 24/25 \$9,387m Budgeted Expenditure \$9,637m		
Output Class 3 – Hospital and Specialist Services		
Budgeted Revenue 24/25 \$15,116m Budgeted Expenditure \$15,966m	P2-36 Consumer Engagement Quality and Safety P2-85 High-quality asset manager P2-90 Hospital redevelopment project meets milestones P2-93 Drawdowns repaid	P2-129 Total annual emissions P2-130 Emissions profile P2-131 Change in total emissions P2-132 Staffing – FTE P2-133 Total expenditure HNZ P2-135 Progress towards 2024 and 2030 targets P2-136 Emissions initiative P2-238 Holiday's Act Remediation commenced P2-91 Holiday's Act Remediation – current employees P2-87 Capital investment benefits met P2-88 Medical appts via telehealth (digital) P2-43 Number of planned care interventions delivered
Output Class 4 – Mental Health and Addiction Services		
Budgeted Revenue & Expenditure 24/25 \$2,683m	P2-154 MHA ringfence expectations P2-198 New MHA professionals trained  P2-200 MHA prevention and intervention 	P2-137 Problem Gambling – number seen P2-138 Problem Gambling – brief interventions P2-32 Kaupapa Māori, Pacific and Youth P2-37 MHA access, Integrated Primary P2-199 MHA access, Access and Choice
Output Class 5 – Hauora Māori Services		
Budgeted Revenue & Expenditure 24/25 \$578m	P2-26 Kaupapa Māori expenditure P2-205 Hauora Māori contracted outcomes P2-208 IMPB strategic involvement P2-237 IMPB – Section 30 P2-239 Hauora Māori contracts	P2-110 Māori Scholarship Grants
Equitable and sustainable health services		

Health Journeys



Impacts

Utilisation and quality of interactions with health services



Outcomes

Longer life expectancy and better health outcomes

Output Class 1 – Public Health Services

P2-140	Improved immunisation for children 8 months	P2-159	Life expectancy at birth
P2-03	Improved immunisation for children 24 months	P2-160	Good or better rated health
P2-141	Improved immunisation for children 5 years	P2-161	Daily smokers
P2-05	HPV Immunisation 9-26 years	P2-162	Physical activity guidelines met
P2-04	Flu vaccinations >65 years	P2-163	Daily intake of vegetables and fruit
P2-07	Breast screening coverage	P2-165	Family wellbeing – High or Very High
P2-09	Cervical screening coverage	P2-166	Hazardous drinking patterns
P2-158	Bowel screening participation	P2-167	Psychological distress > High

Output Class 2 – Primary and Community Services

P2-17	GP enrolment		
P2-38	Newborn GP enrolment		
P2-16	DMFT – Year 8	P2-22	ASH Rate Child 0-4yrs per 100,000
P2-176	Primary care available when needed	P2-23	ASH Rate Adults 45-64yrs per 100,000
P2-178	Involvement in decisions (primary care)	P2-184	ASH Rate CVD 45-64yrs
P2-179	Treated with respect (primary care)		
P2-18	Stop smoking service – CO validated		
P2-33a	Primary maternity carer registrations		

Output Class 3 – Hospital and Specialist Services

P2-55	Bowel screening MDM within 20 days		
P2-17	Lower limb amputation hospitalisations		
P2-196	Renal failure hospitalisations		
P2-39	Shorter wait times for FSA		
P2-40	Shorter wait times for elective treatment		
P2-41	Acute bed nights		
P2-44	Involved in care decisions (hospital)	P2-188	Bowel cancer mortality
P2-45	Shorter stays in ED <6 hours	P2-189	Breast cancer mortality
P2-46	Inpatient >7 days		
P2-51	Faster cancer treatment <31 days		
P2-56	Cardiac wait times <4 months		
P2-58	Missed FSA appointments		
P2-190	Treated with respect (hospital)		
P2-42	Readmissions within 28 days		

Output Class 4 – Mental Health and Addiction Services

P2-201	Shorter MHA stays in ED <6 hours		
P2-202	MHA Access and Choice <1 week		
P2-203	MHA Faster specialist access <3 weeks		
P2-69	MHA Youth seen <3 weeks		

Output Class 5 – Hauora Māori Services

P2-207	Family involved in care decisions (hospital)		
P2-210	Trust and confidence (primary care)		

Equitable improvements in health and wellbeing

Output Class 1: 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.

Health NZ organises its public health service delivery via a division called the National Public Health Service (NPHS).

Public health achieves its outcomes, 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.

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 the NPHS.

The NPHS is a core clinical delivery service comprising approximately 2,000 staff, delivering local, regional and national services. On 10 February 2025, because of internal Health NZ restructuring activity, 732 public health nurses and associated allied health staff (571 FTE) were transferred into NPHS.

Why is this important?

Most illness and disease are caused by factors outside the health system and are preventable.

By investing in preventative approaches, we can reduce the burden of illness on families, ease the demands on primary care and hospital services, and lower the overall cost to the nation.

Public health action protects communities from both communicable and non-communicable diseases and addresses avoidable differences in health outcomes between population groups.

We provide health interventions that promote good health and help prevent or reduce the impact of illnesses and diseases, interventions such as cancer screening, and immunisations that protect communities.

Summary of Performance

Health NZ's overall performance for 2024/25, for this output class was:

	Total	Achieved	Partially achieved	Not achieved	Not Reported/No Target
Number of measures	16	1	9	6	0
% of Total measures	100%	6%	56%	38%	0%

This year we focused on improving childhood immunisation rates, especially for 24-month-olds. Community initiatives with Hauora Māori partners, Awhina Plunket, pharmacies and PHOs supported improvements in the 8-month and 24-month immunisation rates when compared to last year. The immunisation rates for 5-year-olds decreased largely due to the focus on improving the 24-month immunisation rates. We are looking to expand the initiatives from Awhina Plunket and Pharmacies to try to improve the 5-year immunisation rate next year.

Targeted initiatives, such as returning bowel screening kits to community labs, have improved screening rates for breast, cervical and bowel cancer when compared to last year. We were only 1.1 percentage points away from meeting the breast screening target and 2.2 percentage points way from meeting the bowel screening target, both being partially achieved.

The outcome measures for public health are shifting slowly over time and are influenced by lifestyle, environment, access to care, housing, socioeconomic deprivation and other wider determinants of health. Although the smoking rate has increased by a relatively insignificant 0.1 percentage points, there has been a significant decrease in smoking rates for Māori.

Results for output class measures

The following sections present all the measures classified, in accordance with our performance framework by whether they are an input, output, impact or outcome measure.

Inputs: Summary of Financials

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

Expected revenue and proposed expenditure	2024/25 Actual \$ million	2024/25 Budget \$ million	2024/25 Variance \$ million	2023/24 Estimated Actual \$ million
Revenue – Crown	541	533	8	486
Other revenue	0	0	0	0
Total operating revenue	541	533	8	486
Total operating expense	510	533	23	705
Surplus/(deficit)	31	0	31	(219)

Impact measures

Ref	Measure					Desired Trend 
P2-140	Percentage of children fully immunised at eight months of age					
	Target	2023/24 Result	2024/25 Result		Rolling 12-month period for the last 5 quarters	
Overall	95%	78.4%	79.8% 		78.3% 	79.8%
Māori		64.3%	64.3% 		64.4% 	64.3%
Pacific		73.7%	76.3% 		73.8% 	76.3%
Asian		89.3%	93.3% 		88.7% 	93.3%
NM/NP/NA*		82.9%	83.6% 		83.0% 	83.6%
Northern		78.4%	79.8% 		78.3% 	79.8%
Te Manawa Taki		71.9%	71.9% 		72.0% 	71.9%
Central Te Ikaroa		79.6%	82.4% 		79.7% 	82.4%
Te Waipounamu		85.7%	86.6% 		85.7% 	86.6%

*Non-Māori, Non-Pacific, Non-Asian

This measure is also in the Vote Health: Estimates 2024/25/Supplementary Estimates 2024/25 with the same target

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	60.3%	74.2%	92.5%	83.3%	81.1%	63.7%
Te Manawa Taki	57.3%	77.4%	94.0%	78.2%	73.2%	68.1%
Central Te Ikaroa	71.6%	83.6%	94.0%	86.4%	83.7%	75.9%
Te Waipounamu	77.1%	87.6%	94.7%	87.0%	87.9%	83.3%
All New Zealand	64.3%	76.3%	93.3%	83.6%	81.3%	73.6%

**Rurality status is unknown for 147 (0.25%) out of the 58,872 total eligible children at eight months of age

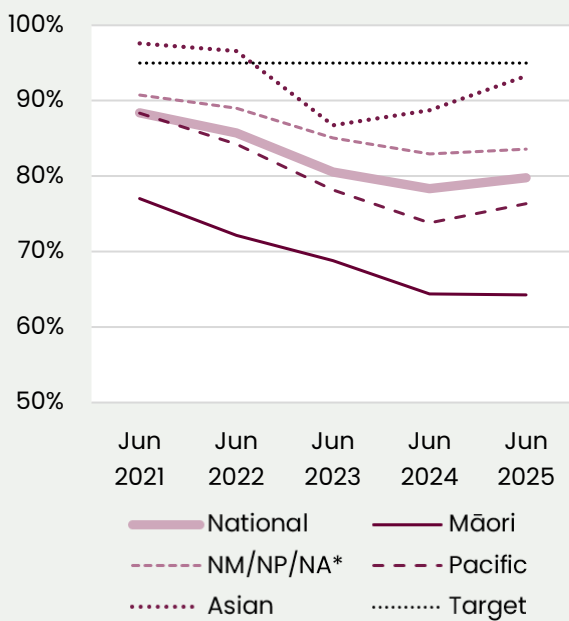
 Target Achieved
  Partially Achieved (0.1-5% away from target)
  Not Achieved (>5% away from target)

Over 24/25, we have continued our focus on newborn enrolment, including the use of enrolment data to identify district and regional variations in enrolment rates. Improving newborn enrolment rates is strongly linked to increased immunisation coverage.

Health NZ has actively engaged with key stakeholders to:

- Highlight the increase in pertussis cases;
- Encourage opportunistic immunisations with Boostrix;
- Promote free resources to support vaccination efforts.

Longer-term trend (rolling 12-month period)



Efforts are underway to address challenges such as inconsistent outreach immunisation service models, rising vaccine hesitancy, access barriers, and regional and ethnic disparities.

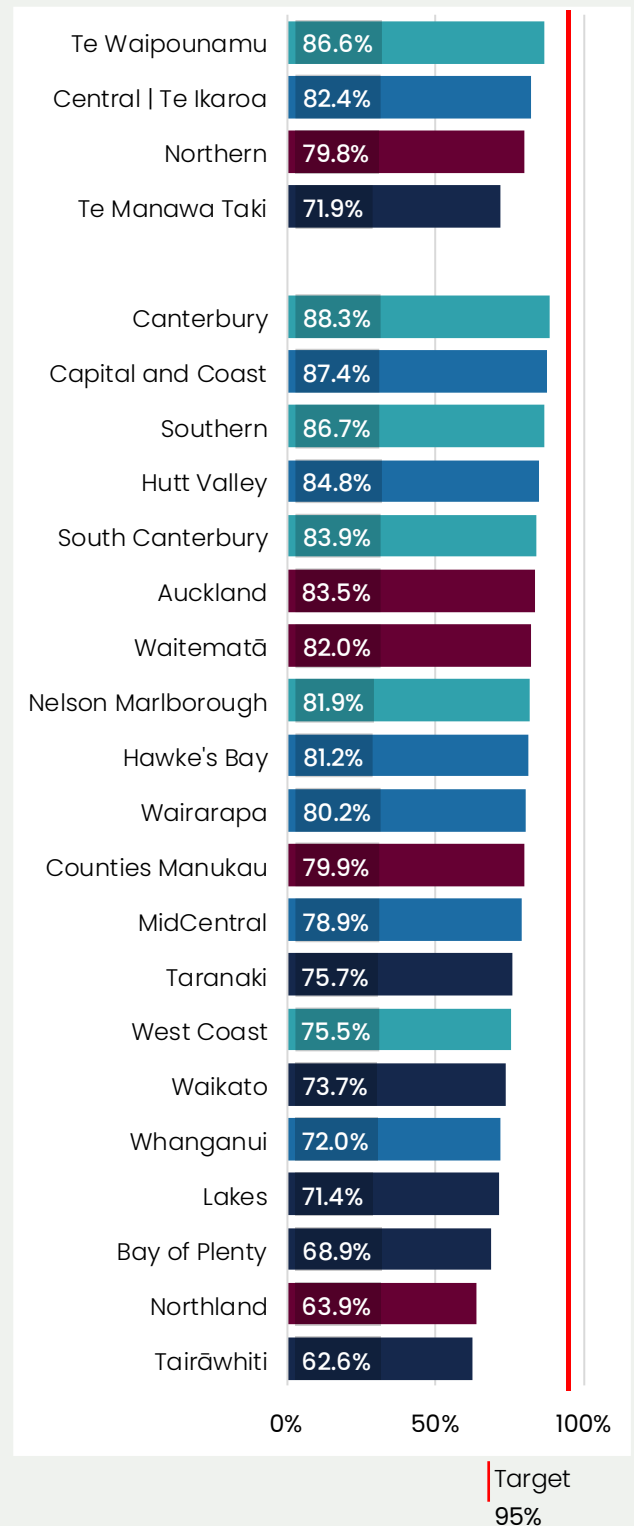
A broader communications strategy is currently being developed to increase pertussis vaccination rates among pregnant women, helping protect both mother and baby.

Funding of \$4.6 million was provided to Primary Health Organisations (PHOs) for the Pre-call / Recall Initiative, which supports general practices by providing additional funding for every baby that receives their six-week immunisations.

Notes to the measure:

- a) The rolling 12-month trend is provided for the 5 quarters since the Aotearoa Immunisation Register (AIR) was fully implemented as the system used for record keeping. In the 2024/25 annual report this trend will align to our standard 8 quarter approach.

Results by Region and Districts



Ref	Measure							
P2-03	Percentage of children fully immunised at 24 months of age					Desired Trend 		
								
	2024/25	2030	2023/24	2024/25	Quarterly for the last 5 quarters			
	Milestone	Target	Result	Result				
Overall	84%	95%	77.3%	78.1%		76.5%		82.0%
Māori			64.9%	64.6%		63.3%		68.4%
Pacific			73.3%	73.6%		71.2%		81.3%
Asian			83.7%	87.2%		84.1%		94.5%
NM/NP/NA*			82.4%	83.2%		81.7%		85.0%
Northern			76.3%	77.2%		75.8%		82.2%
Te Manawa Taki			70.1%	70.9%		67.6%		75.1%
Central Te Ikaroa			78.9%	80.6%		78.6%		83.9%
Te Waipounamu			85.9%	85.6%		85.6%		87.4%

*Non-Māori, Non-Pacific, Non-Asian

This measure is also in the Vote Health: Estimates/Supplementary Estimates 2024/25 with the same target

Prioritised Ethnicity					Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	60.7%	71.4%	86.7%	82.1%	78.5%	63.4%
Te Manawa Taki	58.4%	75.2%	84.2%	77.6%	71.9%	68.3%
Central Te Ikaroa	69.8%	77.6%	88.4%	86.4%	82.2%	73.7%
Te Waipounamu	77.8%	83.7%	90.9%	86.7%	86.9%	81.9%
All New Zealand	64.6%	73.6%	87.2%	83.2%	79.4%	72.7%

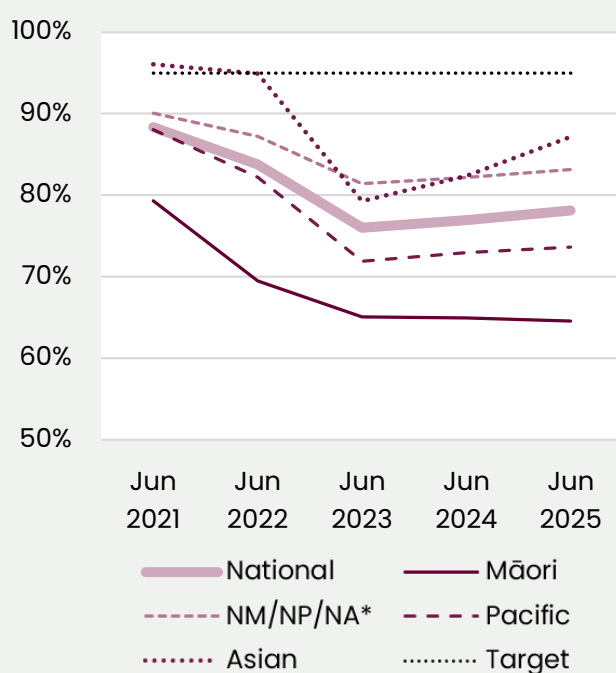
**Rurality status is unknown for 65 (0.11%) out of the 59,280 total eligible children at 24 months of age

● Target Achieved
 ● Partially Achieved
 ● Not Achieved
 (0.1-5% away from target) (>5% away from target)

In 2024/25, Health NZ advanced several targeted initiatives to improve childhood immunisation rates. A two-year pilot programme led by Whānau Āwhina Plunket, with a \$1 million investment, focused on reaching tamariki not enrolled with or accessing immunisation services through primary care. The pilot also targets high-priority population groups to improve immunisation coverage.

Since its launch in December 2024, the pilot has delivered 869 doses to 279 tamariki across 10 locations, with plans to expand to up to 27 locations by the end of 2025. Through the Enabling Pharmacies Project, pharmacies have delivered 800 childhood vaccine doses since the programme began in April 2024. Within this project, there was a 61% increase in doses administered in Q4 of 2024/25 compared to Q3..

Longer-term trend (rolling 12-month period)



Health NZ has made significant investments to improve childhood immunisation rates, particularly for tamariki under 24 months.

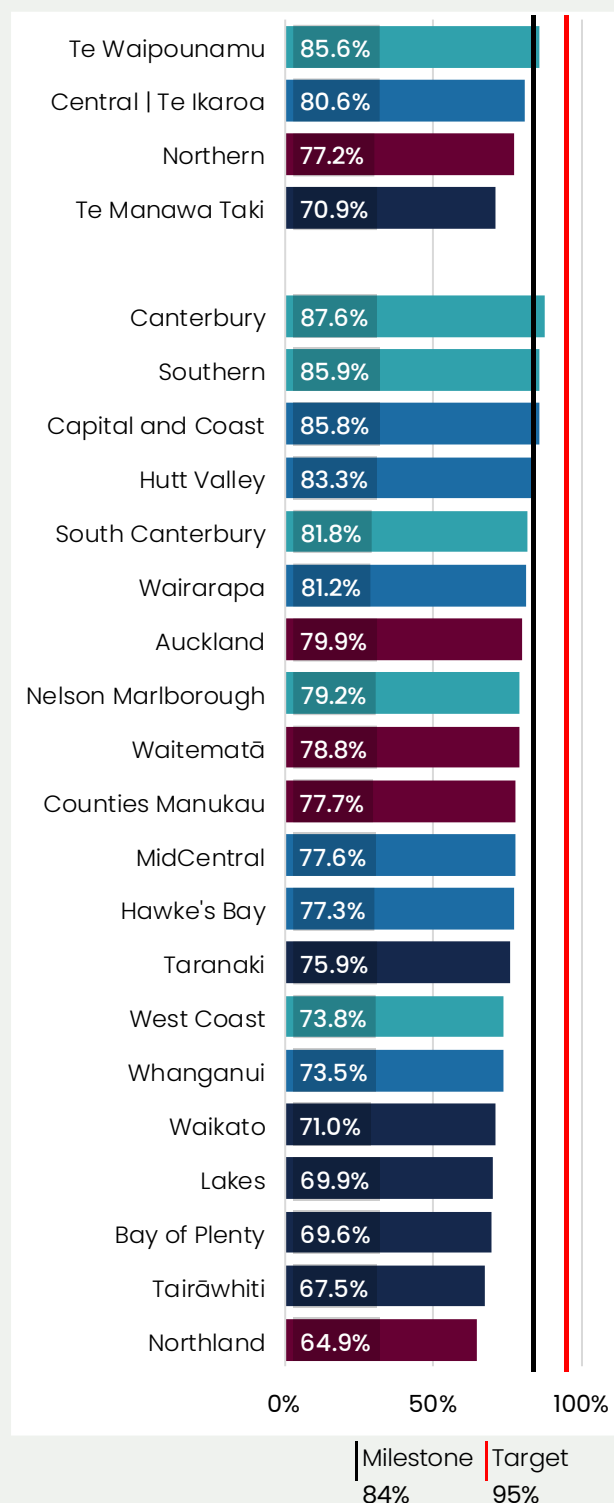
Through the \$25 million Immunising our Tamariki programme, hauora Māori partners were supported to reach children unlikely to be immunised through primary care or traditional immunisation services.

This contributed to a 5.1 percentage point increase in immunisation coverage for tamariki Māori, rising from 63.3% in June 2024 to 68.4% in June 2025.

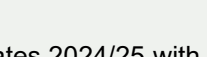
Notes to the measure:

- This result is a 12-month rolling average of performance to 30 June 2025 and therefore differs from the Quarter 4 result on page 25.
- Measurement of the result and red/amber/green rating is against the 2024/25 milestone.
- The rolling 12-month trend is provided for the 5 quarters since the Aotearoa Immunisation Register (AIR) was fully implemented as the system used for record keeping. In the 2024/25 annual report this trend will align to our standard 8 quarter approach.
- This measure captures all those who receive full course of recommended immunisation (numerator) as a proportion of all those who turned 24 months in the period (denominator). To be counted the child has to have been included the Aotearoa Immunisation Register.

Results by Region and Districts



- There is a decrease in denominator between 2023/24 and 2024/25, this is due to:
 - Decline in birth rates
 - System improvements have made more timely updates to the register possible, enabled more accurate identification of individuals who are no longer resident in the country, e.g through migration. As a result, these individuals are being removed from the register, leading to a reduction in the denominator.

Ref	Measure					
P2-141	Percentage of children fully immunised at five years of age					
		Desired Trend 				
	Target	2023/24 Result	2024/25 Result	Rolling 12-month period for the last 5 quarters		
Overall	95%	73.5%	70.9% 	73.1%		70.9%
Māori		66.7%	63.8% 	66.8%		63.8%
Pacific		69.8%	65.5% 	69.3%		65.5%
Asian		71.1%	68.6% 	69.6%		68.6%
NM/NP/NA*		79.2%	77.6% 	79.1%		77.6%
Northern		70.7%	66.6% 	70.1%		66.6%
Te Manawa Taki		69.0%	66.4% 	68.8%		66.4%
Central Te Ikaroa		75.5%	74.0% 	75.4%		74.0%
Te Waipounamu		82.2%	82.4% 	81.8%		82.4%

*Non-Māori, Non-Pacific, Non-Asian

This measure is also in the Vote Health: Estimates 2024/25/Supplementary Estimates 2024/25 with the same target

2024/25	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	58.6%	63.7%	68.9%	70.6%	67.3%	59.3%
Te Manawa Taki	58.5%	64.3%	62.2%	74.5%	67.4%	63.9%
Central Te Ikaroa	68.2%	69.2%	67.5%	81.0%	74.8%	70.3%
Te Waipounamu	79.4%	76.7%	74.9%	85.9%	84.1%	77.9%
All New Zealand	63.8%	65.5%	68.6%	77.6%	71.7%	68.7%

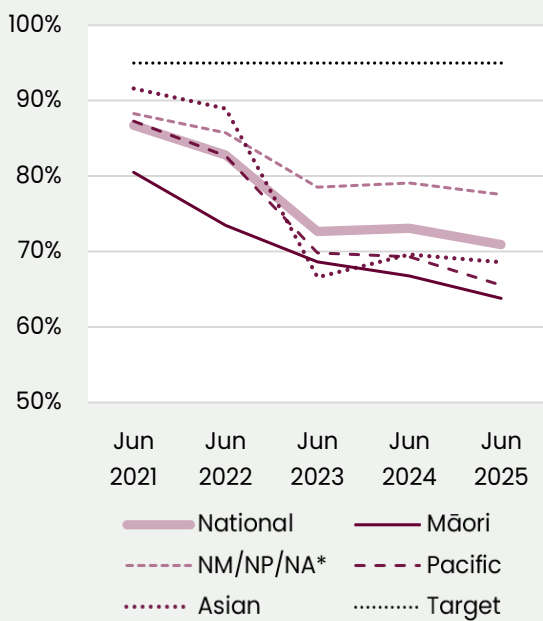
**Rurality status is unknown for 228 (0.34%) out of the 66,260 total eligible children at five years of age

 Target Achieved
  Partially Achieved (0.1–5% away from target)
  Not Achieved (>5% away from target)

For 2024/25, immunisation coverage was 70.9%, a decrease of 2.6 percentage points from the 2023/24 result of 73.5%. This is 24.1 percentage points below the target of 95%.

As with last year, all ethnic groups remain below the 95% target. Coverage was lowest for Māori children at 63.8%.

Longer-term trend (rolling 12-month period)



Coverage for 5-year-olds saw a slight decline this year, primarily due to the concentrated national effort to meet the 24-month health target.

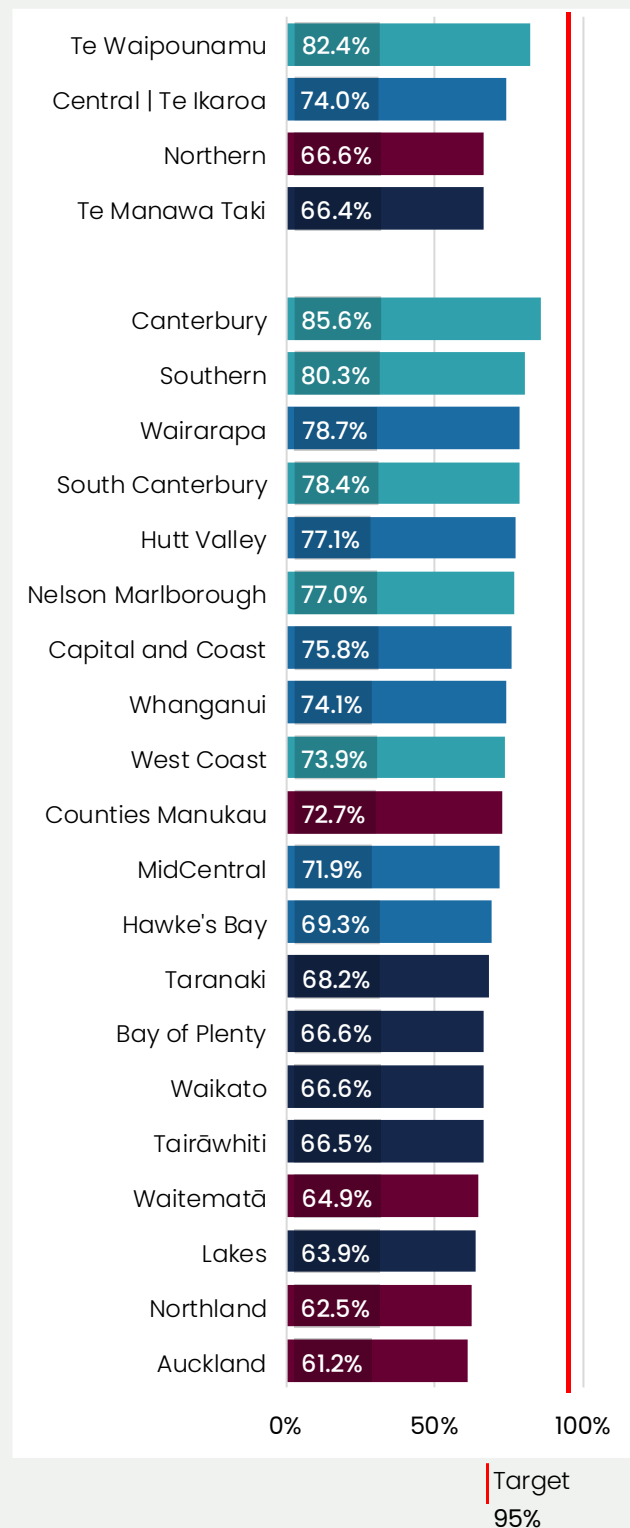
However, insights gained from this work - alongside new initiatives such as expanding pharmacists' scope of practice and onboarding Plunket as a provider - are expected to contribute to improved coverage for 5-year-olds in the coming year.

Efforts are underway to address challenges such as inconsistent outreach immunisation service models, rising vaccine hesitancy, access barriers, and regional and ethnic disparities.

Notes to the measure:

- a) The rolling 12-month trend is provided for the 5 quarters since the Aotearoa Immunisation Register (AIR) was fully implemented as the system used for record keeping. In the 2024/25 annual report this trend will align to our standard 8 quarter approach.

Results by Region and Districts



Ref	Measure	Desired Trend 		
P2-05	Percentage of males and females aged 9-26 years fully immunised for HPV			
		2023/24	2024/25	
	Target	Result	Result	
	Overall	75%	36.2%	38.5% 
	Māori	34.5%	36.3%	
	Pacific	33.0%	34.8%	
	Asian	33.2%	35.5%	
	NM/NP/NA*	38.7%	41.4%	
	Northern	33.9%	36.2%	
	Te Manawa Taki	32.9%	34.7%	
	Central Te Ikaroa	39.7%	42.2%	
	Te Waipounamu	40.7%	43.1%	

*Non-Māori, Non-Pacific, Non-Asian

This measure is recorded in the Vote Health: Supplementary Estimates for 2024/25 as: “Increase the percentage of girls and boys between 9 and 26 who have completed their HPV immunisation course as per Schedule and recorded on the Aotearoa Immunisation Register fully immunised”. The target and result are the same.

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	34.1%	35.3%	35.9%	38.0%	36.9%	28.1%
Te Manawa Taki	34.2%	30.5%	28.0%	36.8%	35.0%	34.1%
Central Te Ikaroa	40.3%	35.8%	37.3%	45.3%	42.7%	39.5%
Te Waipounamu	39.8%	33.3%	38.2%	45.4%	44.7%	38.0%
All New Zealand	36.3%	34.8%	35.5%	41.4%	39.2%	35.2%

**Rurality status is unknown for 3,608 (0.27%) out of the 1,358,024 total eligible girls and boys between 9 and 26

 Target Achieved
  Partially Achieved
  Not Achieved

(0.1-5% away from target)
 ( >5% away from target)

The HPV vaccine protects against human papillomavirus (HPV) — a group of very common viruses that infect 4 out of 5 people during their lifetime. These viruses can lead to a range of HPV-related cancers, the most common being cervical cancer, and head and neck cancers, with significant associated detection and treatment costs to the health system.

While there has been an increase in coverage compared with last year, we are still significantly below our target of 70%. Throughout 2024/25, the focus was on strengthening the School Based Immunisation Programme (SBIP), which remains the primary delivery model for HPV vaccination, including the establishment of national and regional working groups to support the implementation of strengthening initiatives.

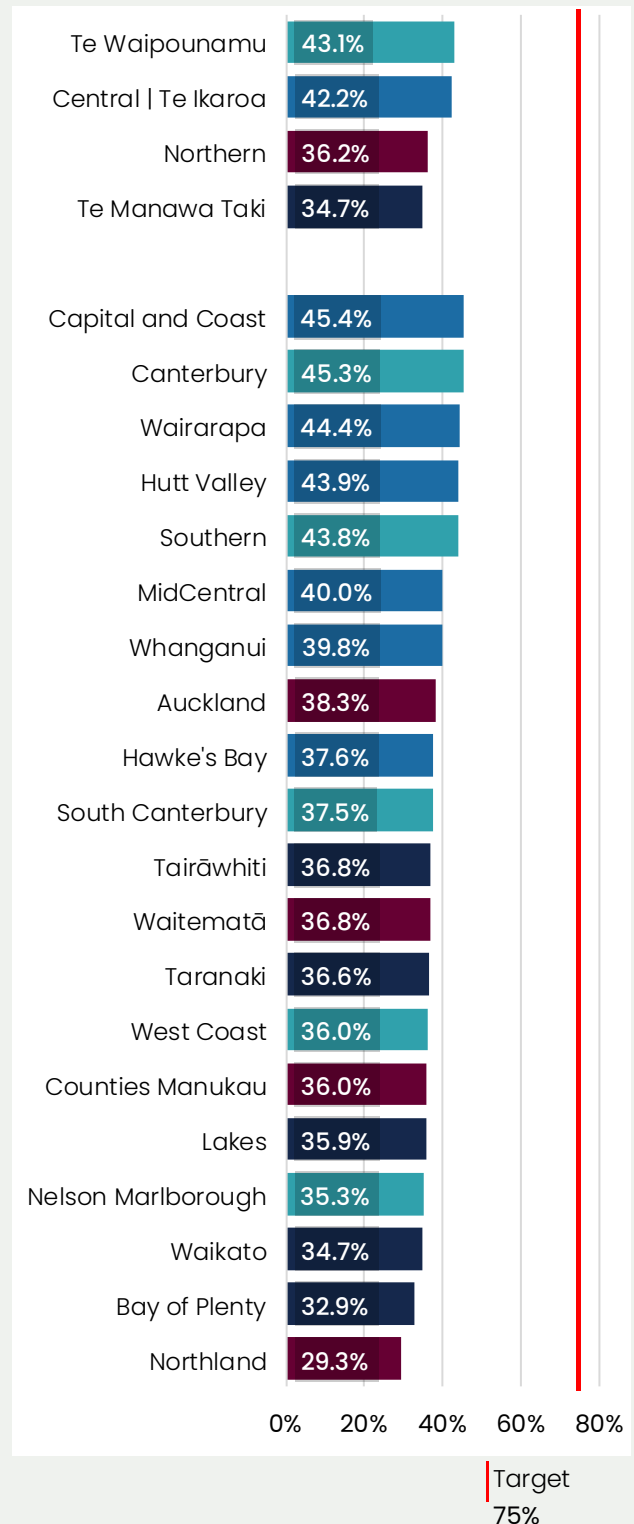
Initiatives to improve performance against the target in 2024/25 included:

- National implementation of the SBIP co-delivery model, supported by updated operating guidelines and parental consent forms.
- Digital system enhancements, including an e-consenting solution, national NHI matching, and updates to the Aotearoa Immunisation Register to better support SBIP delivery.
- Strengthened utilisation of community providers for HPV vaccination to ensure HPV vaccination is accessible to young people eligible and overdue for HPV dose one.
- A targeted communications strategy will be developed to raise awareness among adolescents about the importance of HPV vaccination in cancer prevention.
- Continued improvements to HPV immunisation data reporting will also support monitoring and decision-making.

Notes to the measure:

- a) Longer-term and quarterly trends are not feasible within the annual reporting timeline this year for the following reasons:
- New methodology used this year – All 9 and 26 years are included in this year's calculation rather than individual cohort years (previous method) which change annually.
 - No standard approach for defining historical populations using Aotearoa Immunisation Register (AIR) data. i.e., this would require retrospective snapshots to be taken (coverage as at those dates, extracted at a certain later date). The Immunisations Intel team have an item on their work programme to establish a standard approach so that this may be feasible and robust for future annual reports.

Results by Region and Districts



Ref	Measure						
P2-04	Percentage of people aged at least 65 years who have completed at least one influenza vaccination					Desired Trend 	
			2023/24	2024/25			
		Target	Result	Result			
Overall		75%	59.3%	58.5%			
Māori			52.0%	49.3%			
Pacific			50.3%	48.2%			
Asian			48.0%	48.9%			
NM/NP/NA*			61.7%	61.0%			
Northern			54.6%	54.0%			
Te Manawa Taki			58.3%	56.3%			
Central Te Ikaroa			62.7%	61.9%			
Te Waipounamu			63.9%	63.7%			
*Non-Māori, Non-Pacific, Non-Asian							
		Prioritised Ethnicity			Rurality**		
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural	
Northern	47.7%	47.9%	48.9%	57.1%	55.0%	47.7%	
Te Manawa Taki	47.3%	47.3%	43.8%	58.2%	57.9%	52.8%	
Central Te Ikaroa	50.7%	51.1%	52.6%	64.0%	62.6%	59.4%	
Te Waipounamu	56.1%	48.2%	48.9%	64.7%	65.6%	59.2%	
All New Zealand	49.3%	48.2%	48.9%	61.0%	59.5%	55.2%	
**Rurality status is unknown for 1,169 (0.13%) out of the 931,528 total eligible people aged at least 65 years							
 Target Achieved  Partially Achieved (0.1–5% away from target)  Not Achieved (>5% away from target)							
Winter is a particularly demanding time for our health system as New Zealand experiences increased rates of respiratory illness. People aged over 65 are at greater risk of severe disease and hospitalisation due to influenza and are eligible for funded vaccination. For the 2025 flu season, Health NZ continued to implement strategies to maximise flu vaccination uptake among eligible populations and address equity gaps. A three-phased promotional campaign was rolled out to encourage and support vaccination, including direct marketing to individuals aged 65 and over.							

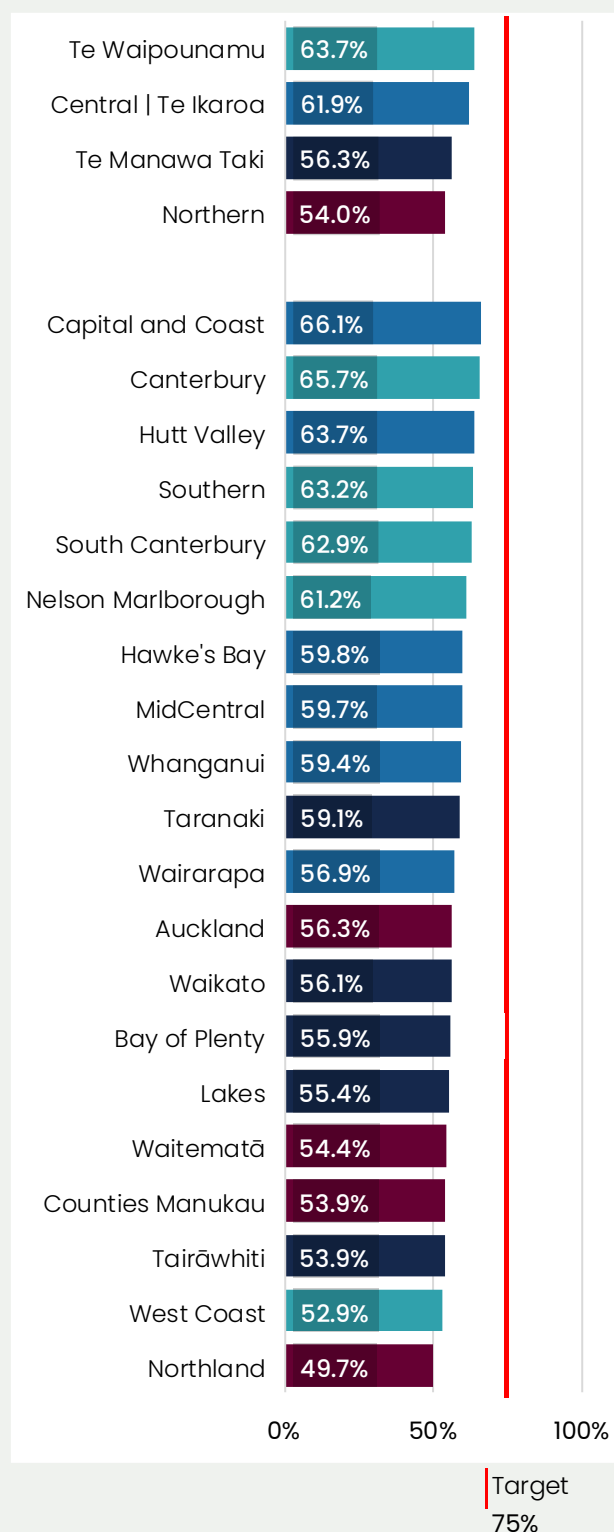
Digital platforms were used to facilitate bookings, connecting consumers with their local immunisation providers such as general practices, pharmacies, kaupapa Māori services, and Pacific health providers.

The Immunising our Tamariki programme also supports hauora Māori partners to offer flu vaccination alongside childhood immunisations, using a whānau-centred approach.

Notes to the measure:

- a) Longer-term and quarterly trend are not feasible within the annual reporting timeline this year for the following reasons:
- New methodology used this year - Due to the nature of the flu vaccination programme being seasonal, coverage rates have been provided for the date range 1 March 2024/2025 to 30 June 2024/2025.
 - No standard approach for defining historical populations using Aotearoa Immunisation Register (AIR) data. i.e., this would require retrospective snapshots to be taken (coverage as at those dates, extracted at a certain later date). The Immunisations Intel team have an item on their work programme to establish a standard approach so that this may be feasible and robust for future annual reports.

Results by Region and Districts



Ref	Measure				Desired trend 
P2-07	Percentage of women aged 45-69 years who have a breast cancer screen in the last two years				
		Target	2023/24 Result	2024/25 Result	Rolling 24-month period for the last 13 months
Overall	70%	68.6%	68.9%		68.6%  68.9%
Māori		62.6%	63.3%		62.6%  63.3%
Pacific		66.2%	67.9%		66.2%  67.9%
Asian		60.7%	58.5%		60.7%  58.5%
NM/NP/NA*		71.6%	72.8%		71.6%  72.8%
Northern		66.3%	66.7%		66.3%  66.7%
Te Manawa Taki		64.4%	65.1%		64.4%  65.1%
Central Te Ikaroa		70.4%	70.3%		70.4%  70.3%
Te Waipounamu		73.7%	74.4%		73.7%  74.4%

*Non-Māori, Non-Pacific, Non-Asian

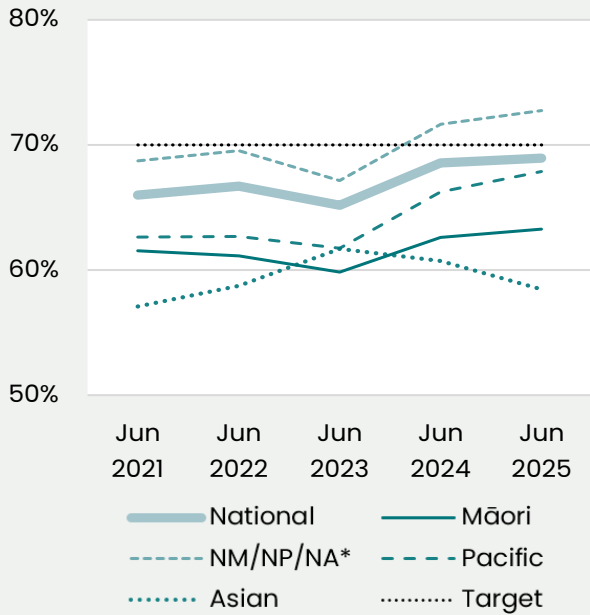
	Prioritised Ethnicity			
2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	65.8%	70.0%	61.2%	69.3%
Te Manawa Taki	58.1%	61.0%	49.7%	69.2%
Central Te Ikaroa	63.7%	64.3%	55.3%	74.4%
Te Waipounamu	68.8%	62.0%	54.7%	77.3%
All New Zealand	63.3%	67.9%	58.5%	72.8%

 Target Achieved
  Partially Achieved
  Not Achieved
 (0.1-5% away from target) (>5% away from target)

Breast screening coverage improved during the year for Māori, Pacific, and NM/NP/NA, while coverage for Asian women decreased by 2.2 percentage points to 58.5%. Most ethnic groups remain below the target: Māori (63.3%), Pacific (67.9%), and Asian (58.5%), with only the NM/NP/NA exceeding the target at 72.8%. Coverage was lowest among Asian women, with a 14.3 percentage point gap compared to NM/NP/NA. Regionally, Central | Te Ikaroa (70.3%) and Southern | Te Waipounamu (74.4%) exceeded the target, while Northern (66.7%) and Midland | Te Manawa Taki (65.1%) remained below.

Over the past year, BreastScreen Aotearoa (BSA) has made key advancements to improve access, equity, and programme performance. In June 2025, the new National Breast Screening System, Te Puna, was successfully launched, enabling active identification and invitation of eligible women to enrol and book appointments via a self-service portal. The shift to an active requirement to opt-out of enrolment (rather than an opt-in approach) is expected to increase coverage over time.

Longer-term trend (rolling 24-month period)



Updated Stats NZ projections increased the estimated Asian population, which contributed to lowering calculated coverage rates for Asian women—who continue to have the lowest screening rates. In response, BSA is working with Health NZ's Asian and Ethnic Health Services (AEHS) to support screening uptake among Asian women in Auckland and Waitematā. The AEHS is trained in Te Puna and aims to expand support nationwide via the Asian Health Line. The impact on screening coverage is not yet visible.

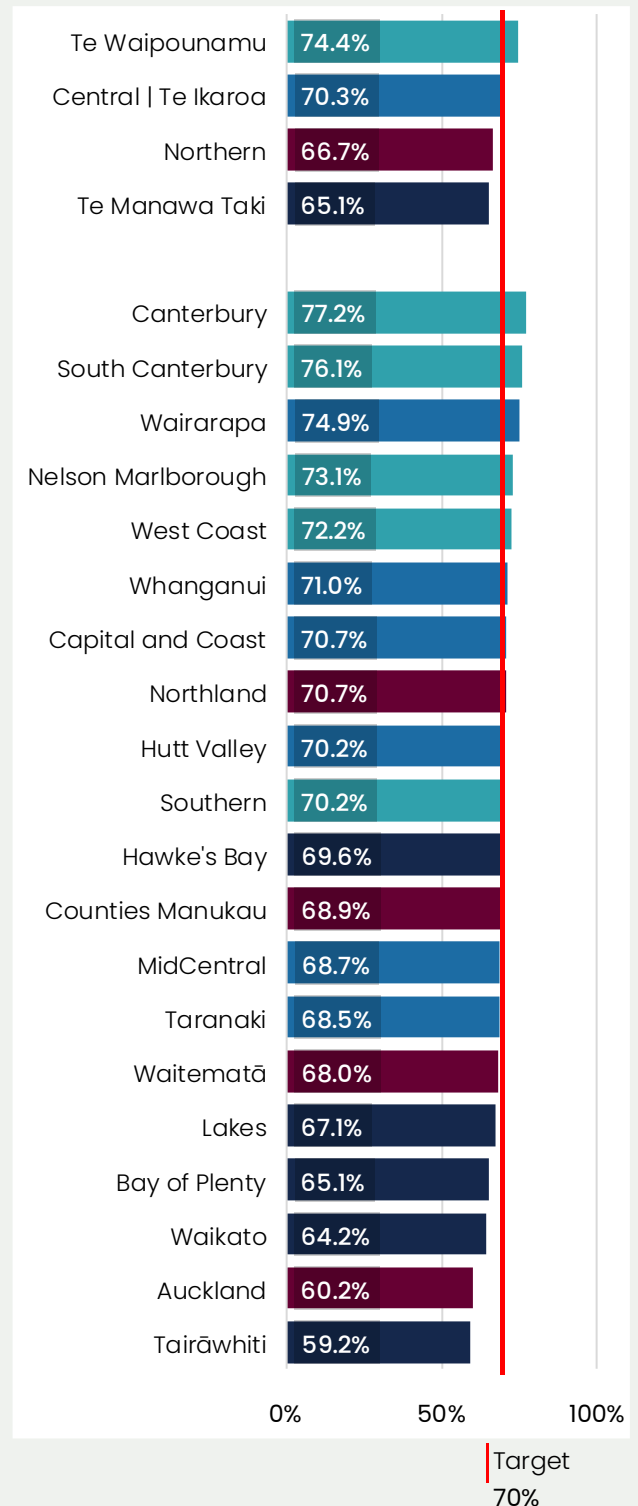
Regionally, screening rates remain lowest in Midland | Te Manawa Taki and metro-Auckland. BSA is collaborating with providers and community partners, supported by targeted funding, to improve access and participation in these areas.

By 30 June 2025, over 5,500 wāhine were screened as a result of implementing recommendations from the 2023 Quality Improvement Review, including more than 3,400 women from high-needs populations - estimated to include 1,800 Māori and 1,000 Pacific women. To further strengthen engagement, two national campaigns were launched to further increase screening rates among priority groups

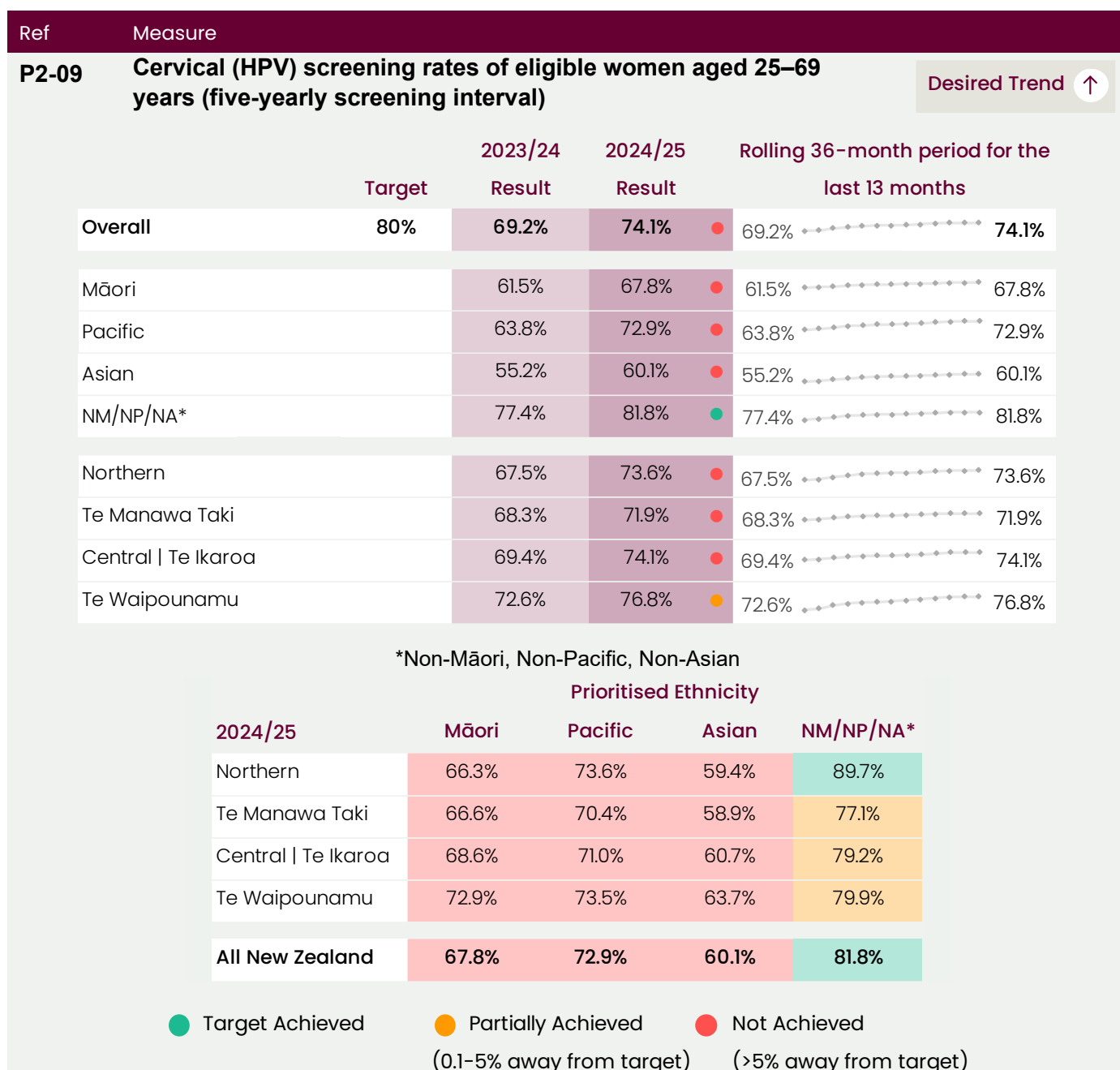
Notes to the measure:

- This measures the proportion of women eligible for screening who have received a publicly funded screen in the previous two-year period.
- Result for 2023/24 have changed from previously reported values due to improvements in completeness and accuracy of data.

Results by Region and Districts



- The number of women eligible is derived from Statistics NZ Census populations projections at the midpoint of the two-year screening period. A monthly smoothing method is applied to population projections.
- Rurality cannot be reported. Population projections with rurality breakdown are not available for the required periods.
- Screened women are included based on their age at the time of screening, meaning those who turned 70 or 71 during the period are included.



For 2024/25, national cervical screening coverage is 74.1%, reflecting a 4.9 percentage point increase since 2023/24, although it remains below the target of 80%. Coverage has improved across all ethnic groups, with increases ranging from approximately four to nine percentage points, and the NM/NP/NA ethnic group now exceeding the 80% target.

A major achievement has been the continued embedding of HPV testing as the primary screening method for cervical cancer. This includes the option of self-testing, which offers participants greater choice, privacy, and comfort. Now nearly two years into its initial five-year implementation cycle, the shift to HPV testing is showing early signs of impact, with increased coverage likely influenced by the popularity of self-testing.

Supporting activities including targeted media campaigns launched with the introduction of HPV primary screening and workforce expansion to support delivery, have contributed to improved access and engagement. Health NZ continues to fund zero-fees screening for priority groups, to improve access for those disproportionately affected by cervical cancer.

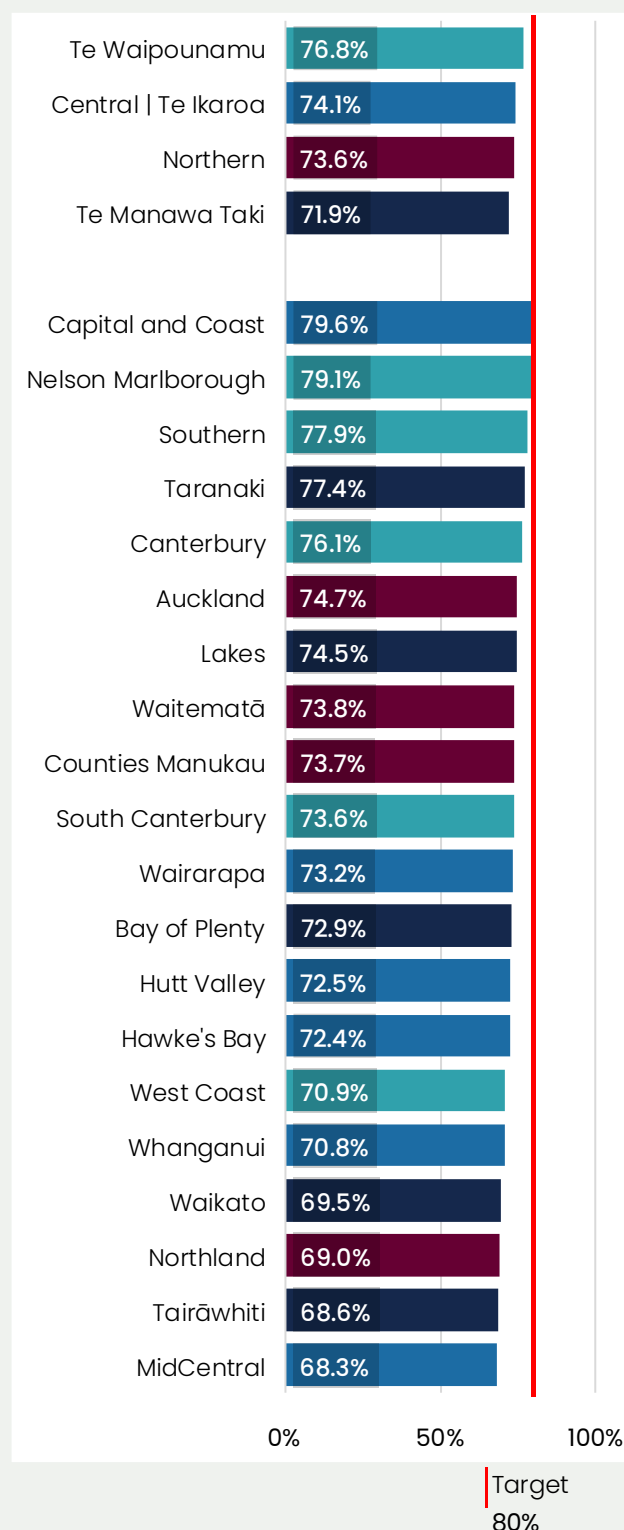
The transition to HPV primary screening and the introduction of self-testing enabled the NCSP to develop training and credentialing for unregistered staff to facilitate HPV self-testing. Delivered in partnership with Screening Support Services, the initiative has credentialed nine staff, who are now actively working in communities and proving highly effective in engaging participants facing barriers to screening.

Notes to the measure:

- a) Rurality cannot be reported - cervical screening coverage denominator is the projected population for the endpoint of the monitoring period (e.g. for coverage as of June 2025, the denominator is the projected population for 30 June 2025). A monthly smoothing method is applied to population projections. Population projections with rurality breakdown are not available for the required periods.
- b) A change to the cervical screening interval occurred on 12 September 2023 as HPV primary screening replaced previous cytology-based programme. The cervical screening coverage rate indicator should technically be referred to 'up to date' rather than 'five-year screening interval'. The coverage calculation considers the timing of a participant's most recent test relative to the implementation of HPV primary screening, to reflect the transition period. For example,
 - A participant whose most recent test was prior to 12 September 2023 would be considered up to date for three years following that test (i.e., until 12 September 2026),
 - A participant whose most recent test was after 12 September 2023 would be considered up to date for five years following that test

Therefore, it will not be until 12 September 2026 in which all participants will be aligned with the five-year screening interval, and until then the three-year (36 month) reporting period remains valid.

Results by Region and Districts



Ref	Measure	Desired Trend
P2-158	Bowel screening rates of adults aged 60–74 years (two-yearly screening interval)	↑

	2023/24	2024/25	Rolling 24-month for the last 13 months
Target	Result	Result	
Overall	60%	57.1%	57.8%
Māori	49.4%	51.3%	
Pacific	38.3%	39.1%	
Asian	43.7%	44.2%	
NM/NP/NA*	61.6%	62.4%	
Northern	50.4%	51.3%	
Te Manawa Taki	56.4%	56.8%	
Central Te Ikaroa	60.6%	61.4%	
Te Waipounamu	64.7%	65.3%	

*Non-Māori, Non-Pacific, Non-Asian

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	49.4%	37.8%	43.7%	57.3%	50.4%	57.4%
Te Manawa Taki	46.1%	41.6%	38.4%	60.7%	56.6%	57.1%
Central Te Ikaroa	54.7%	41.6%	48.9%	64.6%	61.0%	63.1%
Te Waipounamu	63.4%	46.1%	46.9%	66.8%	65.3%	65.4%
All New Zealand	51.3%	39.1%	44.2%	62.4%	56.8%	61.0%

**Rurality status is unknown for 1,271 (0.15%) out of the 825,334 total eligible adults aged 60-74 years

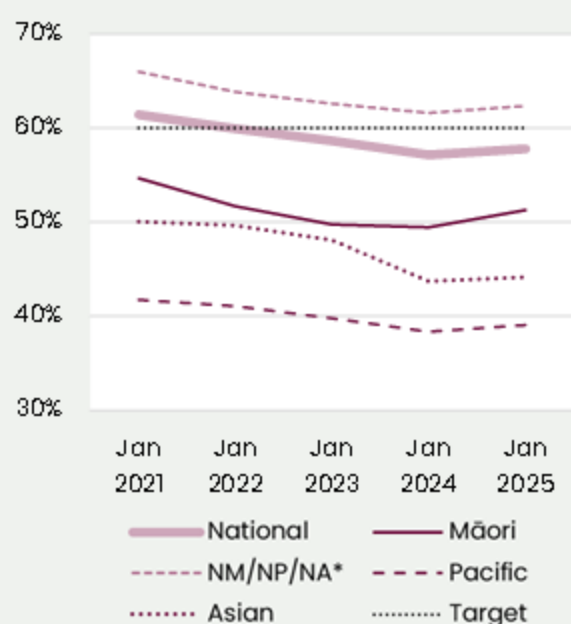
● Target Achieved
 ● Partially Achieved (0.1–5% away from target)
 ● Not Achieved (>5% away from target)

As of January 2025, the national bowel screening participation rate reached 57.8%, marking a 0.7 percentage point increase compared to January 2024. Participation rose across all ethnicities and regions.

Despite some improvements, most ethnic groups remain below the 60% target: Māori at 51.3%, Pacific at 39.1%, and Asian at 44.2%. Only the NM/NP/NA group exceeded the target at 62.4%. Pacific peoples had the lowest participation rate, with a 23.3 percentage point gap compared to the NM/NP/NA group.

This year the National Bowel Screening Programme (NBSP) implemented several initiatives to improve participation and equity, especially for Māori and Pacific communities. A major change enables participants in selected districts to return completed kits to community labs or health facilities, addressing cultural discomfort with mailing kits. This is expected to boost participation by 1–3%.

Longer-term trend (rolling 24-month period)



Barcoded kit trials in Waikato and Whanganui aim to support direct distribution to Māori, as requested by the sector and the NBSP National Māori Network. The current manual process is being evaluated for automation to enable wider implementation.

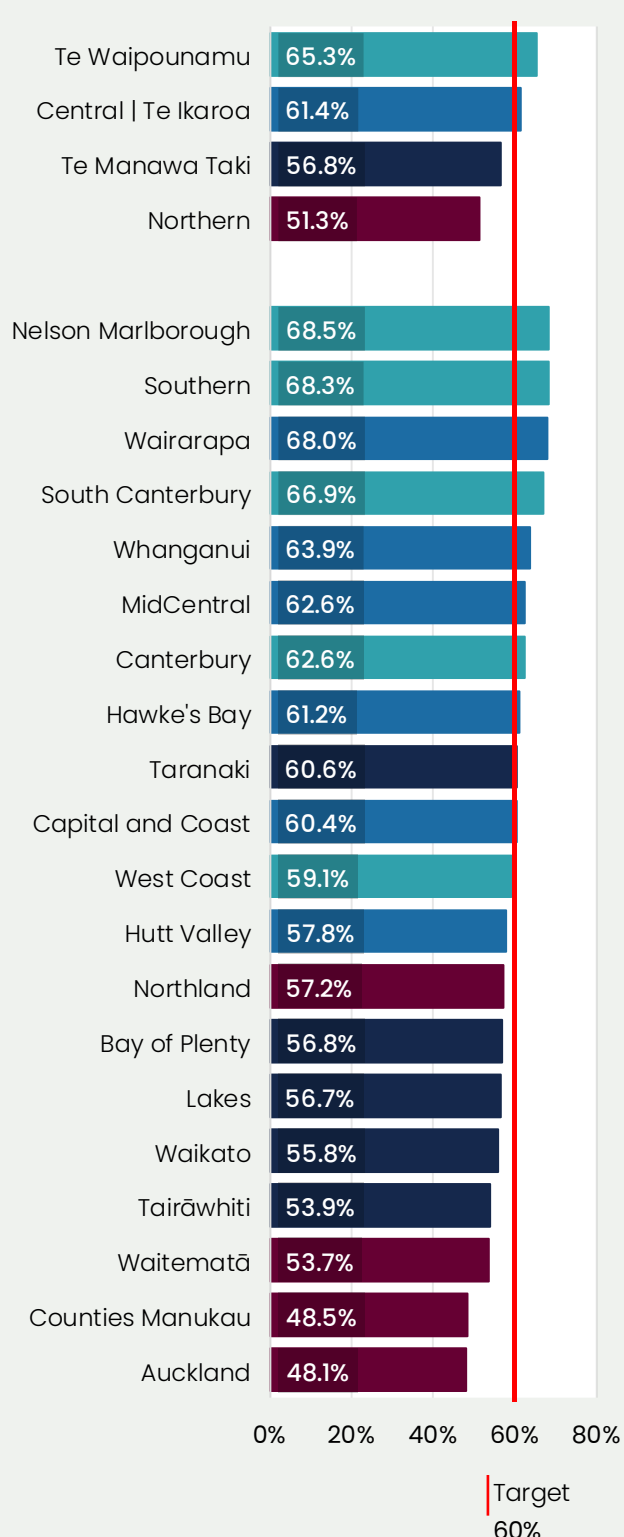
In May 2025, a primary care campaign encouraged over 400 general practices to initiate opportunistic screening conversations with high-need patients.

As part of the support for extending the eligible age range to 58, additional funding has been allocated to develop and implement community-based initiatives aimed at encouraging participation among priority populations.

Notes to the measure:

- a) Bowel screening participation is only available with a 6-month lag to allow for the returning of kits, so the latest available data is January 2025. Results for the 12 months to January 2025 have been reported as 2024/25 Result, and 12 months to January 2024 as 2023/24 Result.

Results by Region and Districts

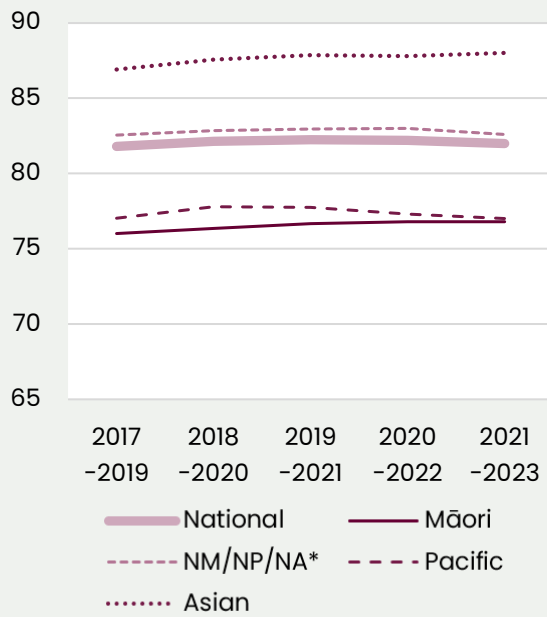


Outcome measures

Public health outcomes are vital indicators of how well the health system supports population wellbeing. Measuring them helps track progress, identify gaps, and guide improvements. However, these outcomes are shaped by a wide range of social, environmental, and economic factors. While Health NZ plays a central role in service delivery, improving public health requires coordinated efforts across sectors and communities. Data on health trends and long-term outcomes is available through the [New Zealand Health Survey](#), published by the Ministry of Health updated annually in November, and Health NZ's [Health Status Report](#) which was published in February 2024.

Ref	Measure										
P2-159	Life expectancy at birth by ethnicity, three-year aggregated estimate								Desired Trend 		
						3-year aggregated estimate					
		Baseline	Target	2020-2022	2021-2023	from 2017-19 to 2021-2023					
Overall	82.2	see below	82.2	82.0		81.8				82.0	
Māori			76.8	76.8		76.0				76.8	
Pacific			77.3	77.0		77.0				77.0	
Asian			87.8	88.0		86.9				88.0	
NM/NP/NA*			83.0	82.6		82.5				82.6	
Northern			82.9	82.6		82.5				82.6	
Te Manawa Taki			81.4	81.1		80.9				81.1	
Central Te Ikaroa			81.8	81.6		81.3				81.6	
Te Waipounamu			82.4	82.2		82.1				82.2	
*Non-Māori, Non-Pacific, Non-Asian											
Target: Improve from baseline, trend to increase											
Baseline: 2022											
Prioritised Ethnicity											
2021-2023		Māori	Pacific	Asian	NM/NP/NA*						
Northern		76.8	76.5	87.4	83.5						
Te Manawa Taki		75.4	77.0	89.7	82.4						
Central Te Ikaroa		76.9	77.4	88.0	82.4						
Te Waipounamu		80.6	82.6	90.3	82.1						
All New Zealand		76.8	77.0	88.0	82.6						
 Target Achieved  Partially Achieved (0.1-5% away from target)  Not Achieved (>5% away from target)											

Longer-term trend (3-year aggregated estimate)



Life expectancy at birth was lowest for Māori (76.8 years), followed by Pacific peoples (77.0 years), Non-Māori, Non-Pacific, Non-Asian (82.6) and Asian peoples (88.0).

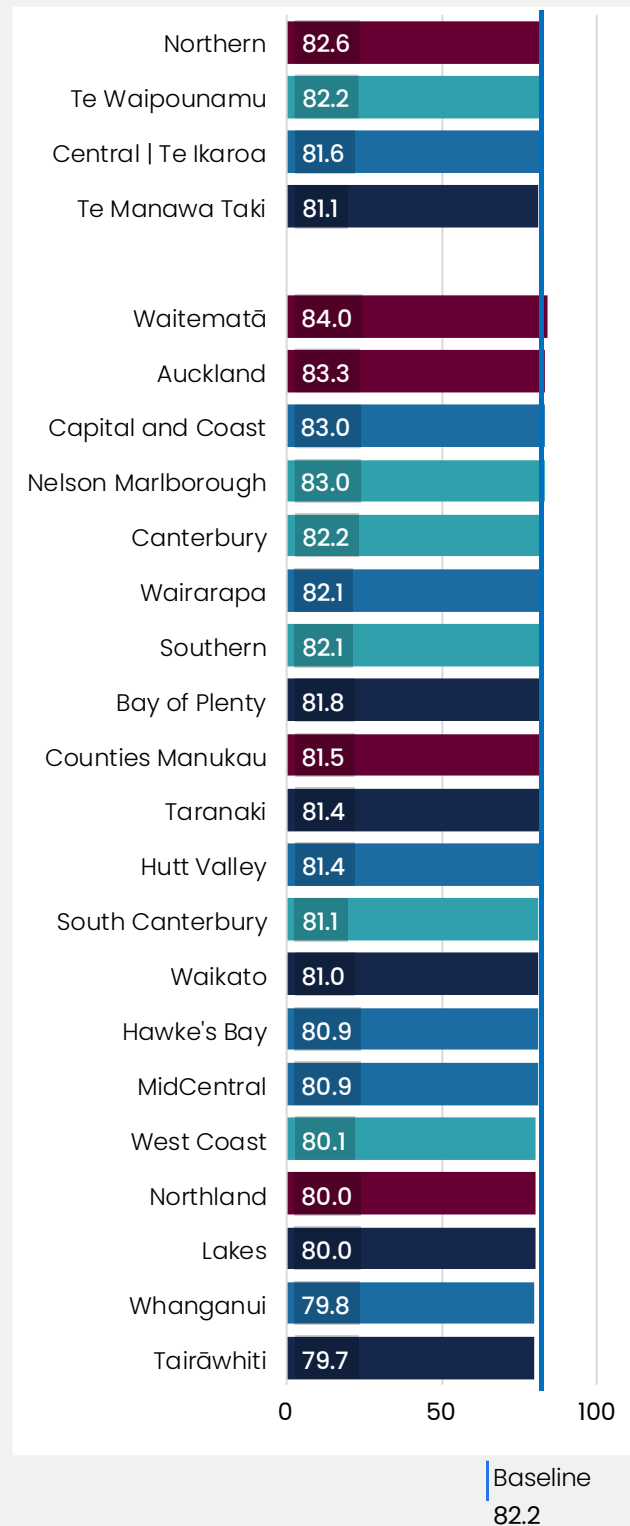
That gap of roughly almost 6 years between Māori and Non-Māori, Non-Pacific, Non-Asian populations has persisted over time, despite overall increases in life expectancy, and reflects enduring inequities driven by social, economic and structural determinants of health.

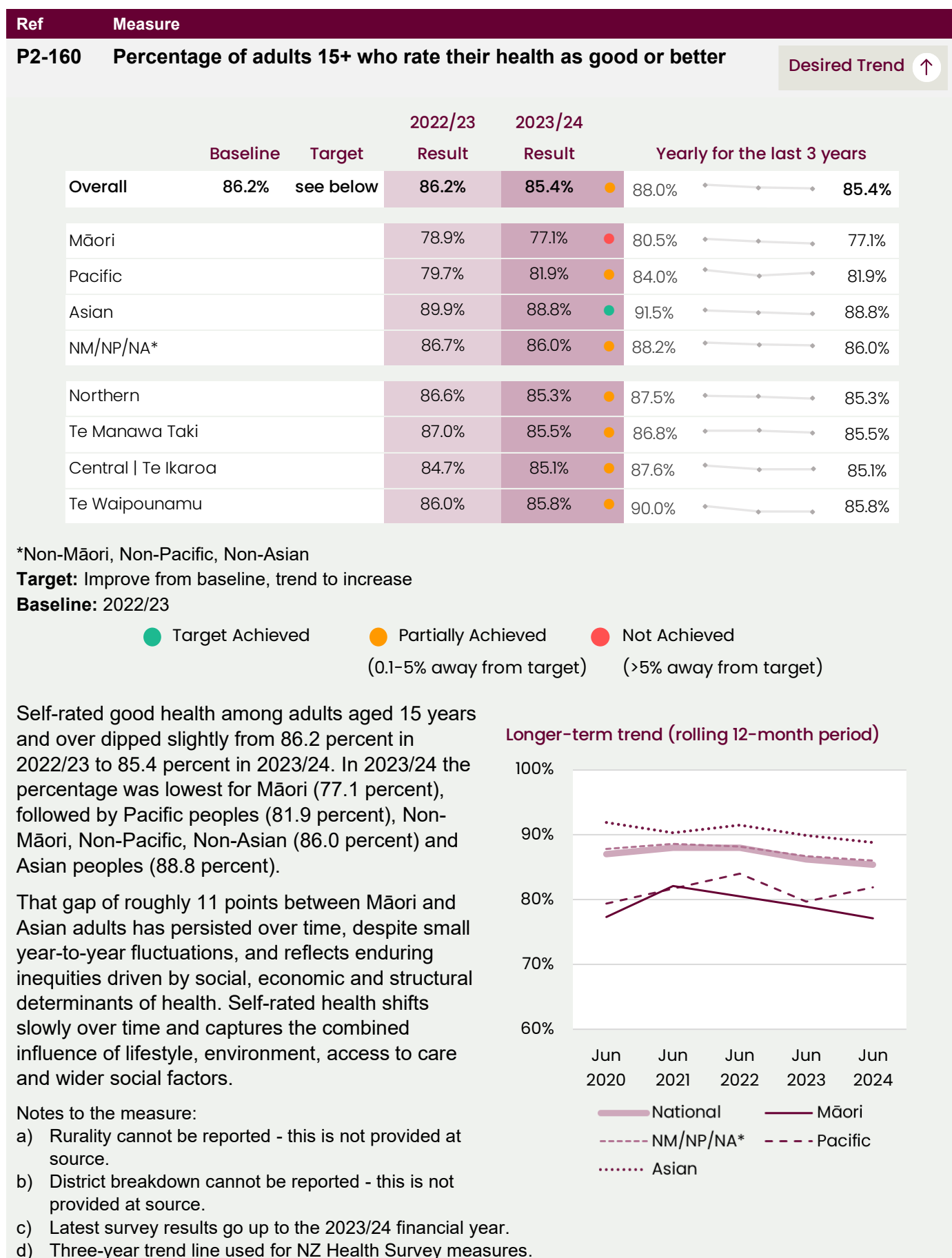
Life expectancy shifts gradually over time and reflects the combined influence of health, lifestyle, environment, and wider social factors.

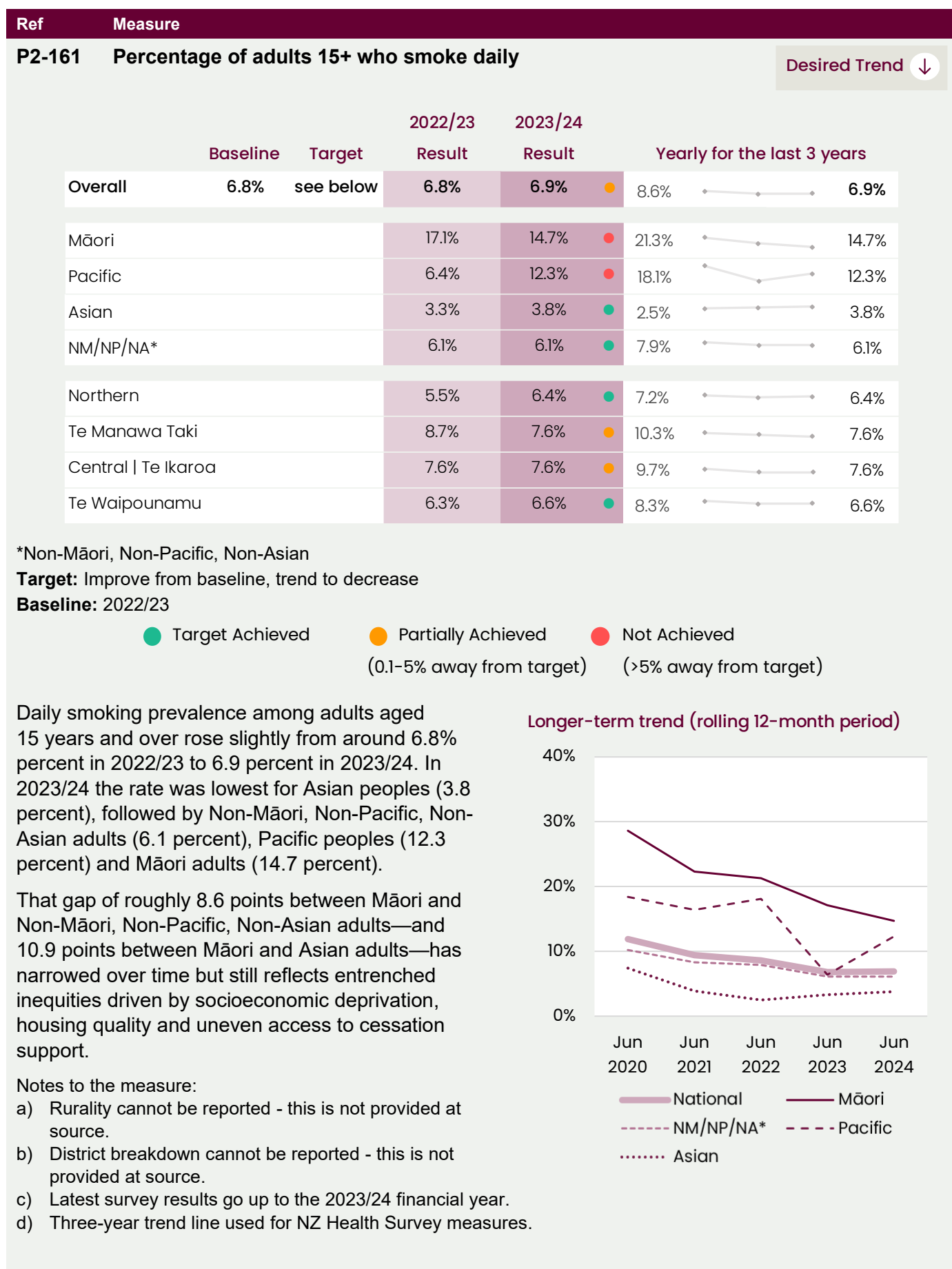
Notes to the measure:

- Rurality cannot be reported – life expectancy by rurality is not calculated as part of routine updates.
- Latest Health Status Report results go up to the 2021-2023 cohort.

Results by Region and Districts







Ref	Measure	Desired Trend
P2-162	Percentage of adults meeting physical activity guidelines	↑

	Baseline	Target	2022/23 Result	2023/24 Result		Yearly for the last 3 years	
Overall	46.5%	see below	46.5%	46.6%	●	51.3%	46.6%
Māori			46.8%	48.5%	●	50.7%	48.5%
Pacific			39.6%	38.8%	●	44.1%	38.8%
Asian			39.5%	37.9%	●	43.7%	37.9%
NM/NP/NA*			48.3%	49.7%	●	53.2%	49.7%
Northern			42.0%	38.4%	●	49.1%	38.4%
Te Manawa Taki			49.5%	50.1%	●	47.5%	50.1%
Central Te Ikaroa			46.6%	52.0%	●	52.0%	52.0%
Te Waipounamu			50.4%	51.4%	●	56.4%	51.4%

*Non-Māori, Non-Pacific, Non-Asian

Target: Improve from baseline, trend to increase

Baseline: 2022/23

● Target Achieved
 ● Partially Achieved
 ● Not Achieved
 (0.1-5% away from target) (>5% away from target)

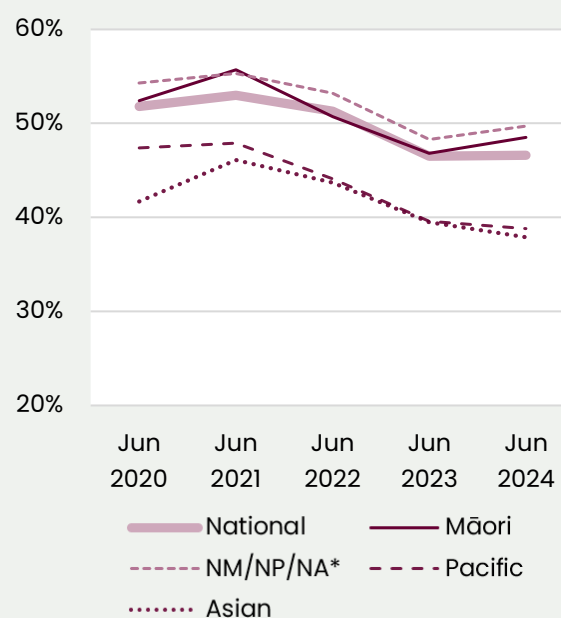
The proportion of adults aged 15 years and over meeting the Ministry of Health's physical activity guidelines was 46.6 percent in 2023/24. In that year, rates were lowest for Asian adults (37.9 percent), followed by Pacific adults (38.8 percent), Māori adults (48.5 percent) and Non-Māori, Non-Pacific, Non-Asian adults (49.7 percent).

That gap of roughly 11.8 percentage points between the most and least active groups has persisted over time, reflecting entrenched inequities driven by socioeconomic conditions, neighbourhood design and cultural barriers. Physical activity levels shift gradually, mirroring the combined influence of the built environment, social norms, access to recreation facilities and wider determinants of health.

Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- District breakdown cannot be reported - this is not provided at source.
- Latest survey results go up to the 2023/24 financial year.
- Three-year trend line used for NZ Health Survey measures.

Longer-term trend (rolling 12-month period)



Ref	Measure						
P2-163	Percentage of children aged 2-14 years eating the recommended amount of vegetables and fruit a day				Desired Trend ↑		
	Baseline	Target	2022/23 Result	2023/24 Result	Yearly for the last 3 years		
Overall	8.1%	see below	8.1%	7.8% ●	7.9%		7.8%
Māori			8.0%	7.4% ●	10.8%		7.4%
Pacific			5.0%	6.3% ●	5.9%		6.3%
Asian			8.8%	5.0% ●	2.3%		5.0%
NM/NP/NA*			7.8%	9.2% ●	8.8%		9.2%
Northern			7.6%	5.9% ●	7.0%		5.9%
Te Manawa Taki			6.1%	7.6% ●	8.4%		7.6%
Central Te Ikaroa			9.3%	7.1% ●	6.3%		7.1%
Te Waipounamu			9.8%	12.3% ●	10.1%		12.3%

*Non-Māori, Non-Pacific, Non-Asian

Target: Improve from baseline

Baseline: 2022/23

● Target Achieved ● Partially Achieved ● Not Achieved
(0.1-5% away from target) (>5% away from target)

The proportion of New Zealand children aged 2–14 who ate the recommended daily servings of both fruit and vegetables was just 7.8 percent in 2023/24, down from 8.1 percent in 2022/23. That rate is lowest in Asian households (5%) and remains far below that of Non-Māori, Non-Pacific, Non-Asian children (9.2%). While the decline in Asian households from 8.8% in 2022/23 to 5.0% in this year is an improvement on 2021/22 result of 2.3%, it is unclear why this has fluctuated over the three periods.

Daily fruit and vegetable intake is influenced by household resources, local food environments, cultural factors and wider determinants of health and may be skewed by survey sample sizes for some cohorts.

Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- District breakdown cannot be reported - this is not provided at source.
- Longer-term trend cannot be reported - data for 2019/20 and 2020/21 is not provided at source.
- Latest survey results go up to the 2023/24 financial year.
- Three-year trend line used for NZ Health Survey measures.

Ref	Measure						
P2-165	Percentage of adults aged 15+ years who rate their family wellbeing as high or very high						Desired Trend ↑
	Baseline	Target	2022/23 Result	2023/24 Result		Yearly for the last 3 years	
Overall	83.7%	see below	83.7%	82.0%	●	82.9%	82.0%
Māori			78.0%	75.1%	●	79.1%	75.1%
Pacific			82.7%	78.8%	●	85.8%	78.8%
Asian			89.0%	87.5%	●	86.6%	87.5%
NM/NP/NA*			82.8%	81.6%	●	82.2%	81.6%
Northern			85.8%	81.7%	●	84.4%	81.7%
Te Manawa Taki			82.3%	80.8%	●	82.0%	80.8%
Central Te Ikaroa			82.3%	83.6%	●	83.1%	83.6%
Te Waipounamu			82.7%	82.3%	●	81.5%	82.3%

*Non-Māori, Non-Pacific, Non-Asian
Target: Improve from baseline, trend to increase
Baseline: 2022/23

● Target Achieved ● Partially Achieved ● Not Achieved
 (0.1-5% away from target) (>5% away from target)

Overall performance slipped from 83.7% in 2022/23 to 82.0 % in 2023/24—below the 83.7% baseline. In 2023/24, Māori recorded the lowest result at 75.1%, Pacific peoples 78.8 %, Asian 87.5% and Non-Māori, Non-Pacific, Non-Asian adults 81.6 %. That gap of roughly 12.4 points between Asian and Māori—and 5.9 points between Asian and the NM/NP/NA group—has persisted over the past three years, reflecting enduring inequities in access, trust and culturally responsive services.

Regionally, the Northern district saw the steepest fall (85.8 to 81.7 %), whereas Central |Te Ikaroa improved slightly (83.6 to 82.3 %). These downward trends—especially among Māori, whose three-year average has declined from 79.1 to 75.1 underscore the need for tailored, place-based action to address the social and structural drivers behind these persistent differences.

Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- District breakdown cannot be reported - this is not provided at source.
- Longer-term trend cannot be reported - data for 2019/20 and 2020/21 is not provided at source.
- Latest survey results go up to the 2023/24 financial year.
- Three-year trend line used for NZ Health Survey measures.

Ref	Measure						
P2-166	Percentage of adults aged 15+ years reporting hazardous drinking patterns						Desired Trend ↓
	Baseline	Target	2022/23 Result	2023/24 Result		Yearly for the last 3 years	
Overall	16.0%	see below	16.0%	16.6%	●	18.7%	16.6%
Māori			25.1%	29.6%	●	33.4%	29.6%
Pacific			21.5%	16.2%	●	21.5%	16.2%
Asian			4.9%	5.7%	●	6.2%	5.7%
NM/NP/NA*			16.9%	17.9%	●	20.0%	17.9%
Northern			12.6%	13.5%	●	15.1%	13.5%
Te Manawa Taki			17.0%	18.6%	●	16.8%	18.6%
Central Te Ikaroa			19.1%	18.8%	●	22.6%	18.8%
Te Waipounamu			17.3%	17.4%	●	21.5%	17.4%

*Non-Māori, Non-Pacific, Non-Asian

Target: Improve from baseline, trend to decrease

Baseline: 2022/23

● Target Achieved ● Partially Achieved ● Not Achieved
(0.1–5% away from target) (>5% away from target)

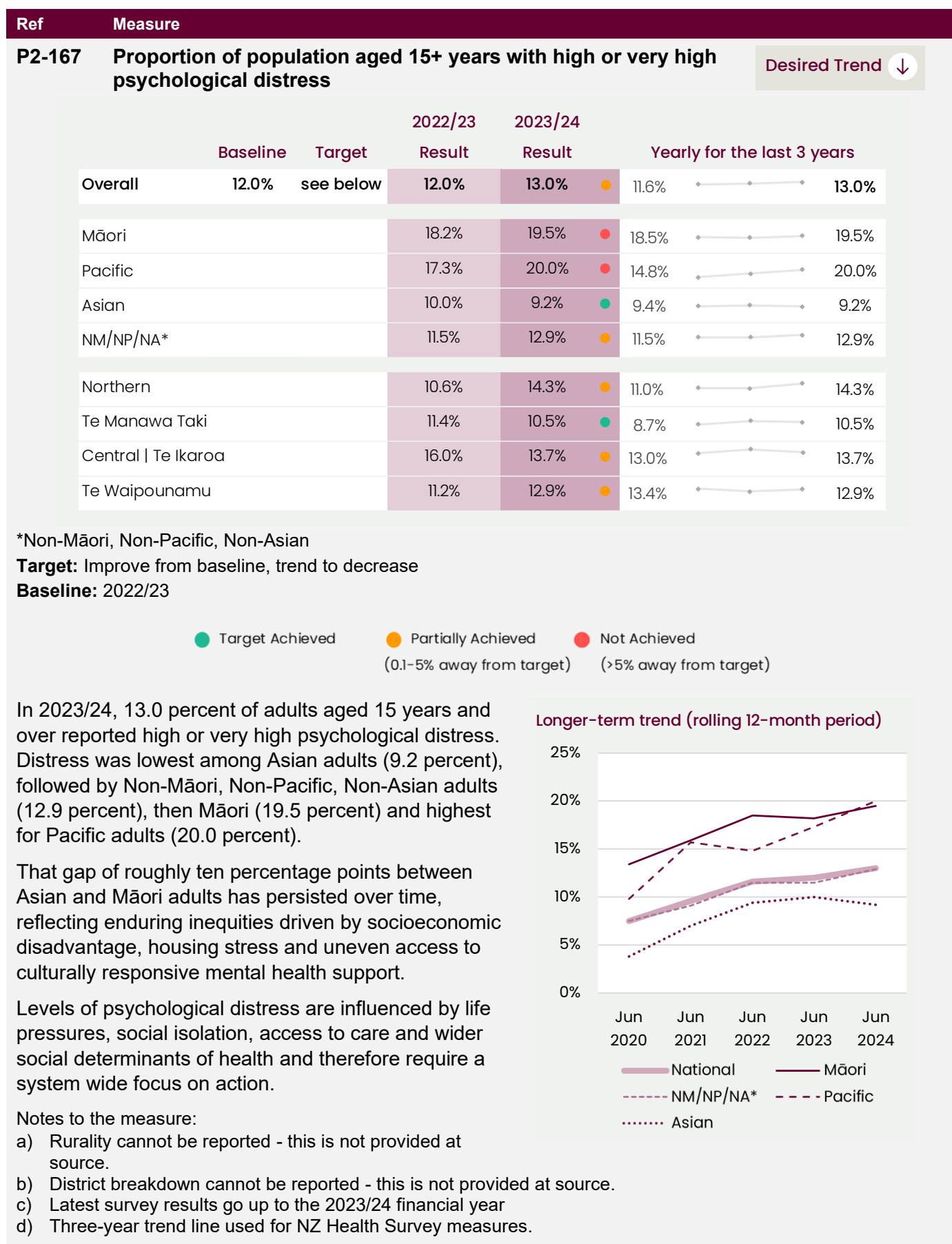
The proportion of adults aged 15 years and over reporting hazardous drinking was 16.6 percent in 2023/24, up slightly from 16.0 percent in 2022/23. In 2023/24 the rate was lowest for Asian adults (5.7 percent), followed by Pacific peoples (16.2 percent), Non-Māori, Non-Pacific, Non-Asian adults (17.9 percent) and highest for Māori adults (29.6 percent).

That gap of nearly 24 percentage points between Māori and Asian adults has remained wide over the past decade, reflecting persistent inequities driven by socioeconomic factors, availability of alcohol and uneven access to effective prevention and support services.

Hazardous drinking trends are not immediately impacted by direct action of Health NZ, mirroring the combined influence of cultural norms, availability of alcohol, targeted public health measures and broader social determinants of health.

Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- District breakdown cannot be reported - this is not provided at source.
- Latest survey results go up to the 2023/24 financial year.
- Three-year trend line used for NZ Health Survey measures.



Output Class 2: Primary and community care services

Over 3,000 providers are funded via this output class and deliver a wide range of routine, urgent, and proactive care services, in a community setting, spanning prevention, early detection, treatment, long-term condition management, and rehabilitation. This includes general practice, Māori health providers, Pacific health services, aged care providers, community pharmacies, child and adolescent dental health services, physiotherapy clinics and others.

These 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.

Why is this important?

This output class is intended to provide services that are designed to help people stay well and manage health conditions effectively with specialist input as clinically needed to maintain their independence and avoid further illness. 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 such as diabetes, respiratory problems, gout or cardiovascular disease, so they continue to live as well as possible in their community.

Summary of Performance

Health NZ's overall performance for 2024/25, for this output class was:

	Total	Achieved	Partially achieved	Not achieved	Not Reported/No Target
Number of measures	14	6	4	2	2
% Total measures	100%	43%	29%	14%	14%

This summary does not however tell the story of improvement since 2023/24. Further, because we must report on our annual result (which for many measures reflects an average of our full year performance), the overall results do not fully tell the story of progress that occurred during the year. For that story we invite you to read the narrative for each measure and review the spark lines and long-term trend lines which visualise the movement in performance over time.

There has been an overall increase in the percentage of patients reporting that they received care from a GP or nurse when they needed it, across all ethnic groups. The percentage of people who reported being involved in decisions about treatment and care is also high and has remained high in the last year. The trend is positive with a continuous improvement over the last 5 years.

The percentage of people overall reporting that the health care professional they saw in primary care treated them with respect and kindness is high, and consistently high over several years. This result shows partial or full achievement of the target across ethnic groups and regions which is a result of the efforts of continuous improvement and the dedication of our primary care staff.

The rate of Ambulatory Sensitive Hospital (ASH) admissions for children aged 0-4 years for an illness that might have been prevented or better managed in the community, has improved across the 3-year timeframe (2023-25), despite an increase over the last 12 months. The overall ASH target for children aged 0-4 years is met.

ASH rates for cardiovascular conditions for adults aged 45-64 years are incrementally improving. There have been improvements for all ethnic groups, except for Māori.

Newborn enrolment rates have been declining over the past year, across all regions and ethnicities. Systems are not consistent across the country and create barriers for some whānau. Work is underway to reduce administrative steps and to connect systems, to make it easier for whānau to enrol their newborns.

For decayed, missing, filled teeth (DMFT) at school year 8, the target has not been achieved for any ethnicity. This measure supports identification and targeting for priority populations.

Results for output class measures

The following sections present all the measures classified, in accordance with our performance framework, by whether they are an input, output impact or outcome measure.

Inputs: Summary of Financials

This output class 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 appropriation of \$17M in 2024/25.

Expected revenue and proposed expenditure	2024/25	2024/25	2024/25	2023/24
	Actual \$ million	Budget \$ million	Variance \$ million	Estimated Actual \$ million
Revenue – Crown	7,726	7,770	(44)	7,455
Other revenue	2,063	1,617	446	1,983
Total operating revenue	9,789	9,387	402	9,438
Total operating expense	9,491	9,637	146	9,148
Surplus/(deficit)	297	(250)	547	290

Impact measures

Ref	Measure						
P2-17	Percentage of people enrolled with a general practice (or a kaupapa Māori provider delivering general practice care)		Desired Trend 				
			2023/24	2024/25	Quarterly for the last 8		
	Baseline	Target	Result	Result	quarters		
Overall	95%	95%	94.4%	94.2%		94.1%	94.2%
Māori	83%		84.1%	84.4%		83.7%	84.4%
Pacific	95%		98.8%	99.4%		97.1%	99.4%
Asian	98%		87.9%	89.4%		85.8%	89.4%
NM/NP/NA*	98%		99.1%	98.3%		99.4%	98.3%
Northern			95.6%	95.5%		95.0%	95.5%
Te Manawa Taki			92.5%	92.1%		92.4%	92.1%
Central Te Ikaroa			93.0%	92.3%		92.9%	92.3%
Te Waipounamu			95.4%	95.4%		95.0%	95.4%

*Non-Māori, non-Pacific, non-Asian

Baseline: 2022/23 FY

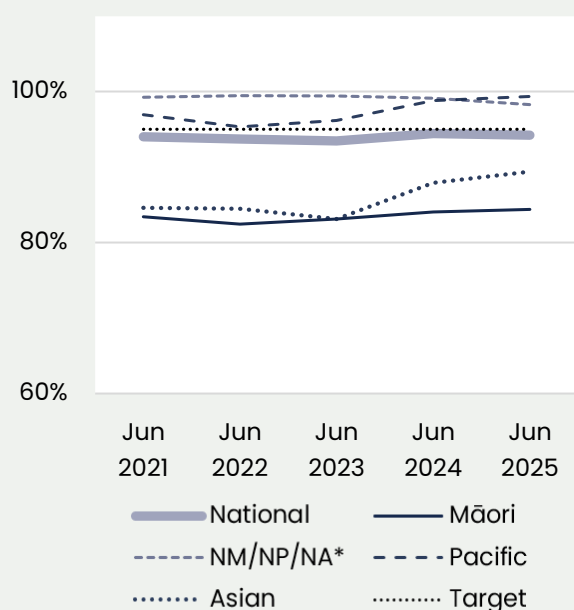
2024/25	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	84.0%	101.7%	91.5%	100.6%	95.2%	91.7%
Te Manawa Taki	84.5%	98.7%	81.3%	97.8%	93.0%	88.4%
Central Te Ikaroa	83.3%	91.6%	88.6%	96.1%	92.0%	95.2%
Te Waipounamu	86.7%	95.6%	88.4%	97.9%	94.6%	93.5%
All New Zealand	84.4%	99.4%	89.4%	98.3%	94.1%	91.9%

**Rurality status is unknown for 60,289 (1.18%) out of the 5,097,065 total eligible people enrolled with a general practice (or a kaupapa Māori provider delivering general practice care)

 Target Achieved
  Partially Achieved (0.1-5% away from target)
  Not Achieved (>5% away from target)

There is high level of enrolment across time. Most recently, this sees a result of over 94% of the estimated population of New Zealanders being enrolled. The biggest contributors to this are Northern Region and Southern | Te Waipounamu at over 95%, while Midland | Te Manawa Taki and Central | Te Ikaroa are at just over 92%. We have also achieved our target across all ethnicities with the exception of Asian and Maori people.

Longer-term trend (snapshot date)



Around 30% of general practices have “closed books” and are not accepting enrolments due to capacity issues.

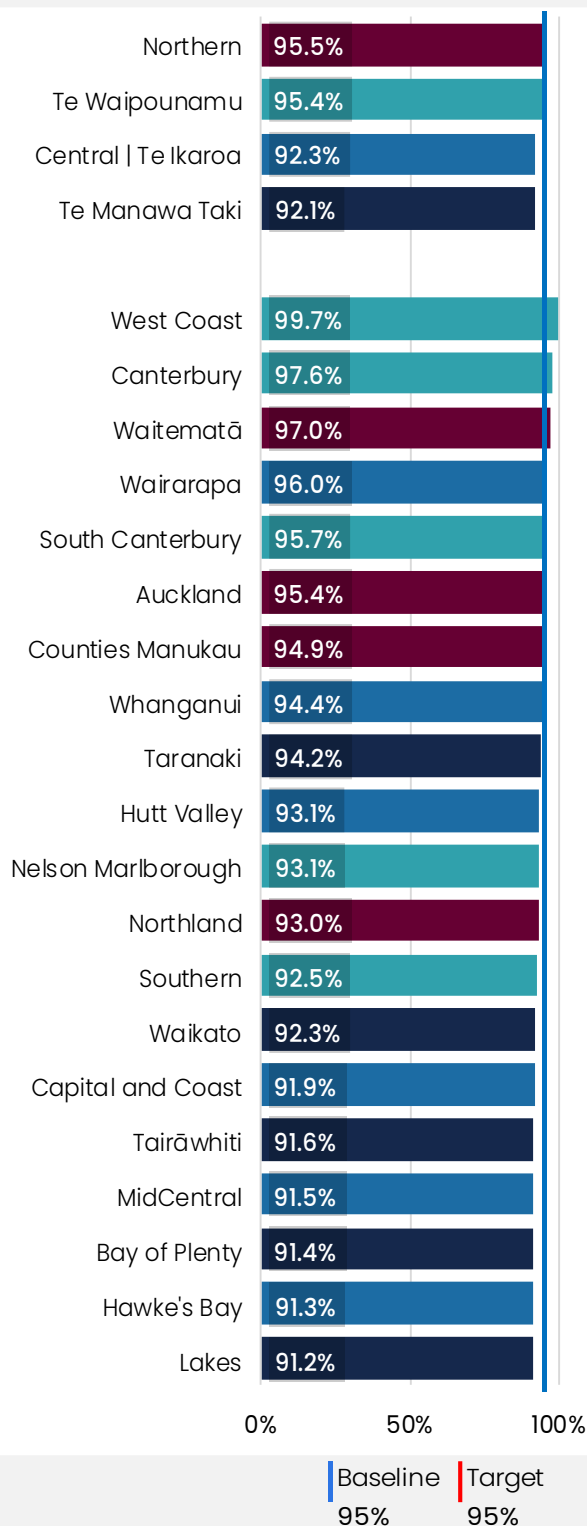
This is most evident in Central | Te Ikaroa where we see 49% of general practices have closed books, followed by Midland | Te Manawa Taki (29%), Southern | Te Waipounamu (28%) and Northern (18%).

Increases in capitation funding which are being implemented should support enrolment.

Notes to the measure:

- a) Percentages greater than 100% are achieved because the denominator data may not accurately represent actual population data.

Results by Region and Districts



Ref	Measure					Desired Trend 
P2-38	Percentage of children enrolled with a general practice (or a kaupapa Māori provider delivering general practice care) by age 3-months					
			2023/24	2024/25		
		Target	Result	Result	Quarterly for the last 8 quarters	
Overall		85%	86.6%	84.9%		85.7%  82.9%
Māori			76.6%	75.8%		75.9%  74.2%
Pacific			81.2%	79.8%		79.6%  77.0%
Asian			93.9%	91.7%		93.5%  89.7%
NM/NP/NA*			91.0%	89.0%		90.4%  87.0%
Northern			85.5%	84.8%		84.5%  82.8%
Te Manawa Taki			84.4%	82.9%		83.5%  81.5%
Central Te Ikaroa			86.0%	82.4%		85.3%  80.8%
Te Waipounamu			91.7%	89.2%		90.7%  86.1%

*Non-Māori, non-Pacific, non-Asian

Target: Increase from baseline

2024/25	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	73.4%	79.3%	91.7%	89.5%	85.6%	75.0%
Te Manawa Taki	75.7%	79.4%	91.5%	87.9%	83.3%	81.6%
Central Te Ikaroa	74.7%	78.7%	90.6%	86.7%	84.1%	74.4%
Te Waipounamu	82.9%	85.7%	92.4%	90.8%	89.4%	88.8%
All New Zealand	75.8%	79.8%	91.7%	89.0%	85.6%	81.5%

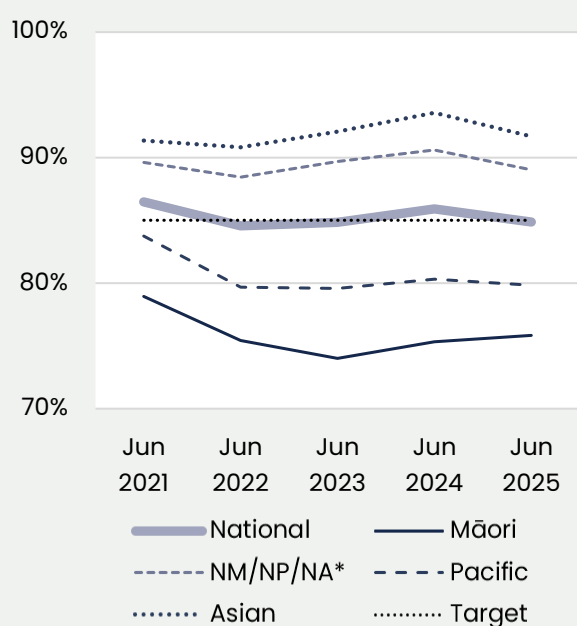
**Rurality status is unknown for 24 (0.04%) out of the 57,201 total eligible children at age 3-months

 Target Achieved
  Partially Achieved (0.1-5% away from target)
  Not Achieved (>5% away from target)

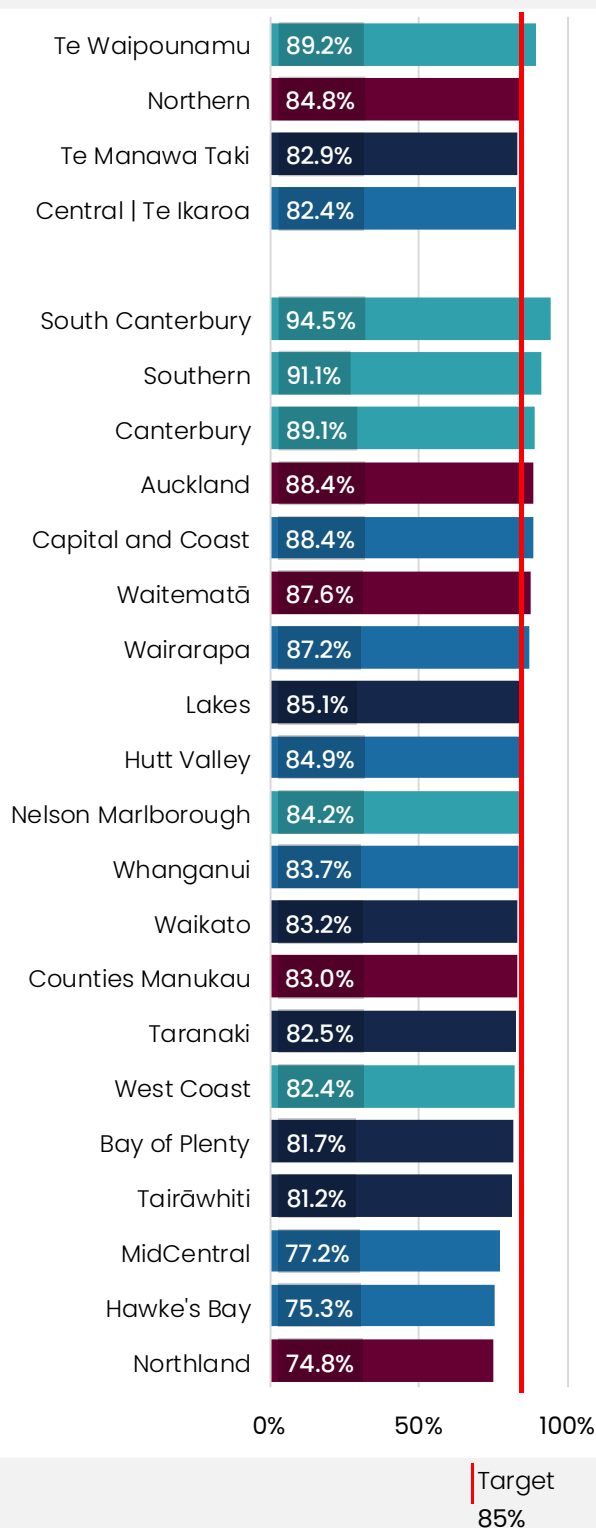
Newborn enrolment rates have been declining over the past year, across all regions and ethnicities.

Newborn enrolment systems are not consistent across the country and create barriers for some whānau, with significant variation of rates being seen at a district and regional level.

Longer-term trend (rolling 12-month period)



Results by Region and Districts



Southern | Te Waipounamu is the only region to have achieved the target, with the remaining three regions within 2% of each other.

Work is underway to reduce the steps involved for whānau in enrolling a newborn. This will lead to early identification of families who may need more support to enrol.

Ref	Measure				
P2-16	Mean decayed, missing, filled teeth (DMFT) at school year 8				
					Desired Trend ↓
			2023	2024	
	Target	Baseline	Average	Result	Result
Overall	see below		see below	0.74	0.75
Māori	1.00	1.16	1.12	1.14	1.19 ●
Pacific	0.76	0.81	0.85	0.82	0.84 ●
NM/NP*	N/A (maintain)	0.55	0.57	0.58	0.60 ●
Northern				0.52	0.54
Te Manawa Taki				0.88	1.02
Central Te Ikaroa				0.83	0.83
Te Waipounamu				0.83	0.79

*Non-Māori, non-Pacific

Target: 10% reduction from baseline for Māori, Pacific.

Baseline: 2022 calendar year

Average: Average of previous four years (2020-2023)

2024/25	Prioritised Ethnicity		
	Māori	Pacific	NM/NP*
Northern	0.85	0.69	0.40
Te Manawa Taki	1.45	1.31	0.78
Central Te Ikaroa	1.27	1.16	0.64
Te Waipounamu	1.26	1.11	0.68
All New Zealand	1.19	0.84	0.60

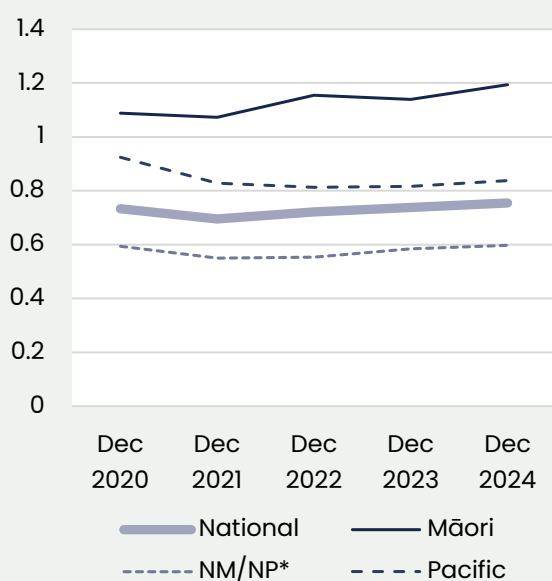
● Target Achieved ● Partially Achieved ● Not Achieved
(0.1-5% away from target) (>5% away from target)

Mean DMFT in 2024 is 0.75, which is a 1.4% increase from 2023.

The target has not been achieved for any ethnicity, with mean DMFT for Māori increasing 4.4% to 1.19, for Pacific increasing 2.4% to 0.84 and for non-Māori, non-Pacific increasing 3.4% to 0.60.

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.

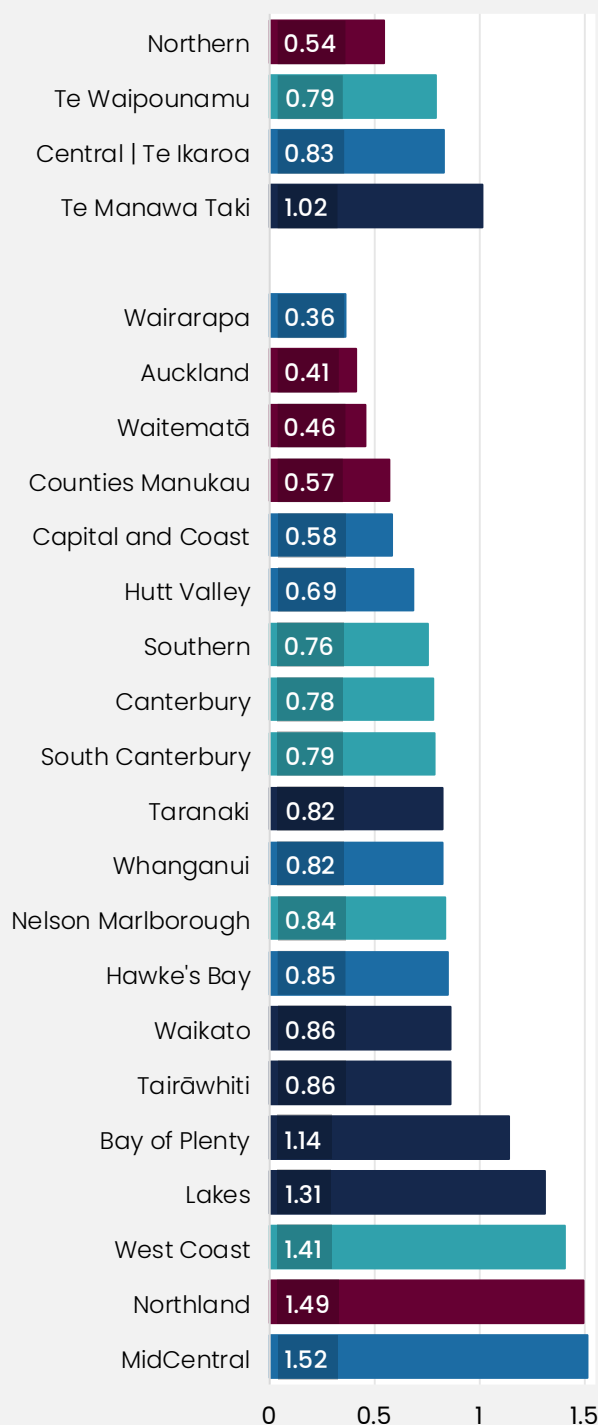
Longer-term trend (rolling 12-month period)

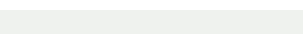


Notes to the measure:

- Rurality cannot be reported - we have aggregate data at a district level not at NHI level, so we are unable to breakdown further than district or ethnicity.
- Data is collected for this measure from school children on a school (calendar) year basis, so the latest data available is for the 2024 calendar year. This is reported above, together with 2023 data for the prior year.
- No status by region in heatmap - DMFT varies significantly by region due to water fluoridation status and therefore cannot be assessed against the national targets.

Results by Region and Districts



Ref	Measure						Desired Trend 
P2-176	Percentage of people who received health care from a GP or nurse when they wanted it in the last 12 months.		2023/24	2024/25	Quarterly for the last 8		
	Baseline	Target	Result	Result	quarters		
Overall	76.4%	Achieved	76.7%	77.7%		74.9% 	79.5%
Māori	71.0%		71.8%	72.9%		69.7% 	73.8%
Pacific	73.2%		74.9%	76.0%		70.4% 	77.1%
Asian	76.8%		78.9%	80.1%		77.1% 	81.7%
NM/NP/NA*	77.5%		77.3%	78.4%		75.9% 	80.5%
Northern			77.2%	77.9%		75.1% 	79.4%
Te Manawa Taki			74.8%	75.8%		73.7% 	77.1%
Central Te Ikaroa			74.2%	75.6%		71.6% 	78.4%
Te Waipounamu			79.2%	80.4%		78.0... 	82.4%

*Non-Māori, non-Pacific, non-Asian

Target: Increase from baseline

Baseline: 2022/23 FY

This measure is also in the Vote Health: Supplementary Estimates 2024/25 as “Increase in percentage of people who say they receive care from a GP or nurse when they need it” with a target of Achieved. Result is the same

Prioritised Ethnicity

2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	72.0%	76.7%	81.0%	78.2%
Te Manawa Taki	73.7%	71.6%	76.8%	76.5%
Central Te Ikaroa	73.1%	73.3%	75.3%	76.3%
Te Waipounamu	72.7%	78.1%	82.1%	81.1%
All New Zealand	72.9%	76.0%	80.1%	78.4%

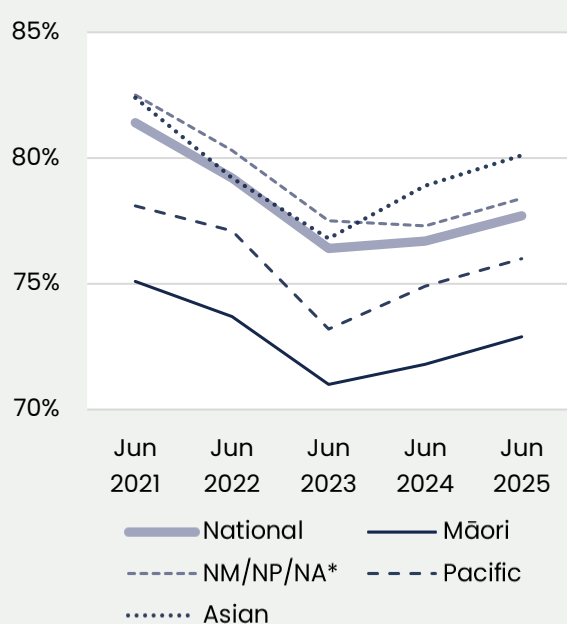
 Target Achieved
  Partially Achieved (0.1-5% away from target)
  Not Achieved (>5% away from target)

There has been an overall increase in the percentage of patients reporting that they received care from a GP or nurse when they needed it, across all ethnic groups.

Māori and Pacific Peoples report lower access compared to the Non-Māori, non-Pacific, non-Asian group.

Work continues to address barriers to primary care access for all populations.

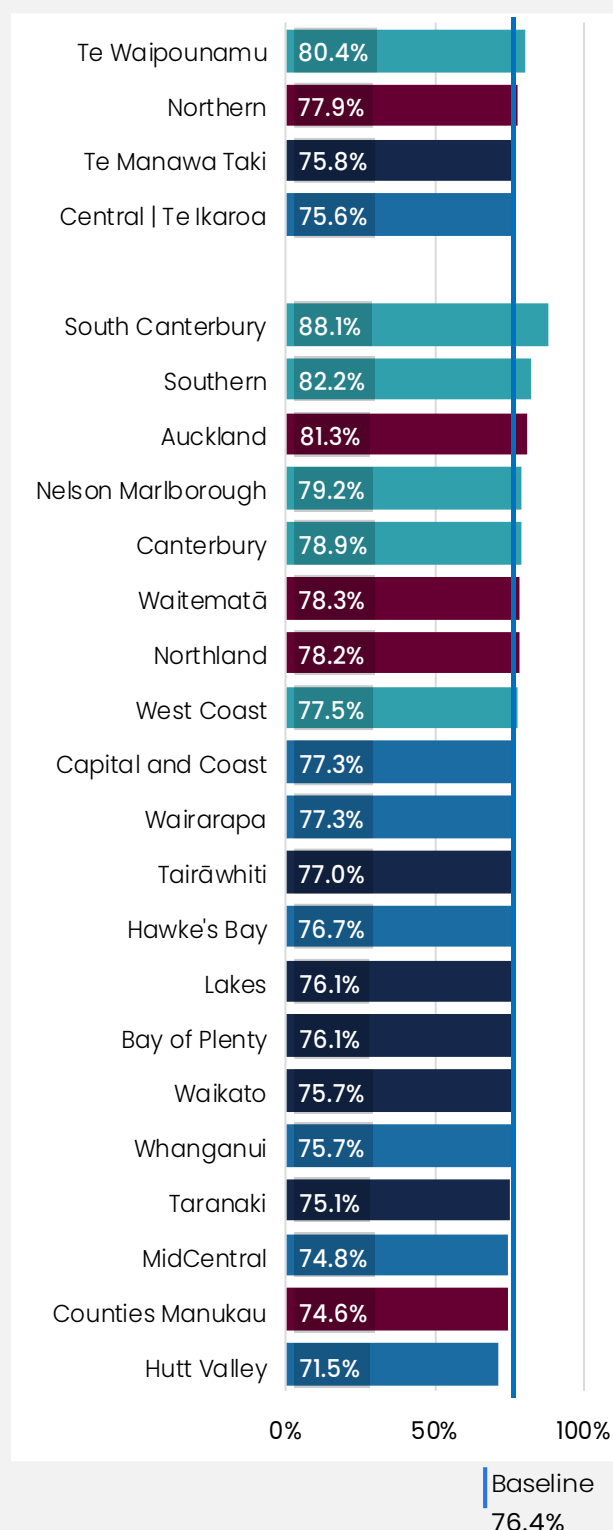
Longer-term trend (rolling 12-month period)



Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- Sparklines represent eight quarters to May 2025.
- Further details on the survey methodology can be found at: www.hqsc.govt.nz/our-data/patient-reported-measures.
- Regional comparisons: the national 2023/24 FY baseline has been used as the baseline for regional target comparisons
- Please see page 180 for the relevant survey disclosure.

Results by Region and Districts



Ref	Measure	Desired Trend
P2-178	Increase in percentage of people who say they feel involved in their own care and treatment with their GP or nurse	↑

	Baseline	Target	2023/24 Result	2024/25 Result		Quarterly for the last 8 quarters	
Overall	86.1%	see below	89.8%	89.8%	●	89.3%	90.1%
Māori	85.3%		88.3%	88.4%	●	86.3%	88.9%
Pacific	85.1%		88.7%	89.9%	●	86.2%	90.2%
Asian	84.4%		89.4%	89.5%	●	88.6...	90.3%
NM/NP/NA*	86.6%		90.2%	90.2%	●	90.2%	90.4%
Northern			89.9%	89.9%	●	89.4...	90.6%
Te Manawa Taki			89.7%	89.9%	●	89.0%	89.6%
Central Te Ikaroa			89.2%	89.1%	●	88.2...	89.8%
Te Waipounamu			90.1%	90.2%	●	90.2...	90.2%

*Non-Māori, non-Pacific, non-Asian

Target: Increase from baseline

Baseline: 2022/23 FY

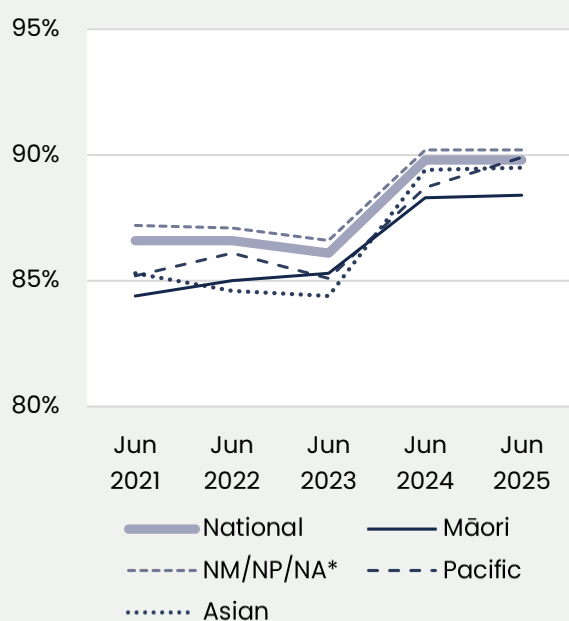
	Prioritised Ethnicity			
2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	88.0%	89.6%	89.1%	90.7%
Te Manawa Taki	89.3%	90.7%	90.2%	90.0%
Central Te Ikaroa	87.8%	90.8%	89.4%	89.2%
Te Waipounamu	87.8%	90.5%	91.4%	90.4%
All New Zealand	88.4%	89.9%	89.5%	90.2%

● Target Achieved
 ● Partially Achieved (0.1-5% away from target)
 ● Not Achieved (>5% away from target)

The percentage of people who reported being involved in decisions about treatment and care is high and has remained high in the last year.

Data shows a high rate of involvement by people in their own care with 89.8% of people answering yes against a baseline of 86.1% meaning our target has been met. The trend is also positive with a continuous improvement over the last 5 years from June 2021 to June 2025.

Longer-term trend (rolling 12-month period)

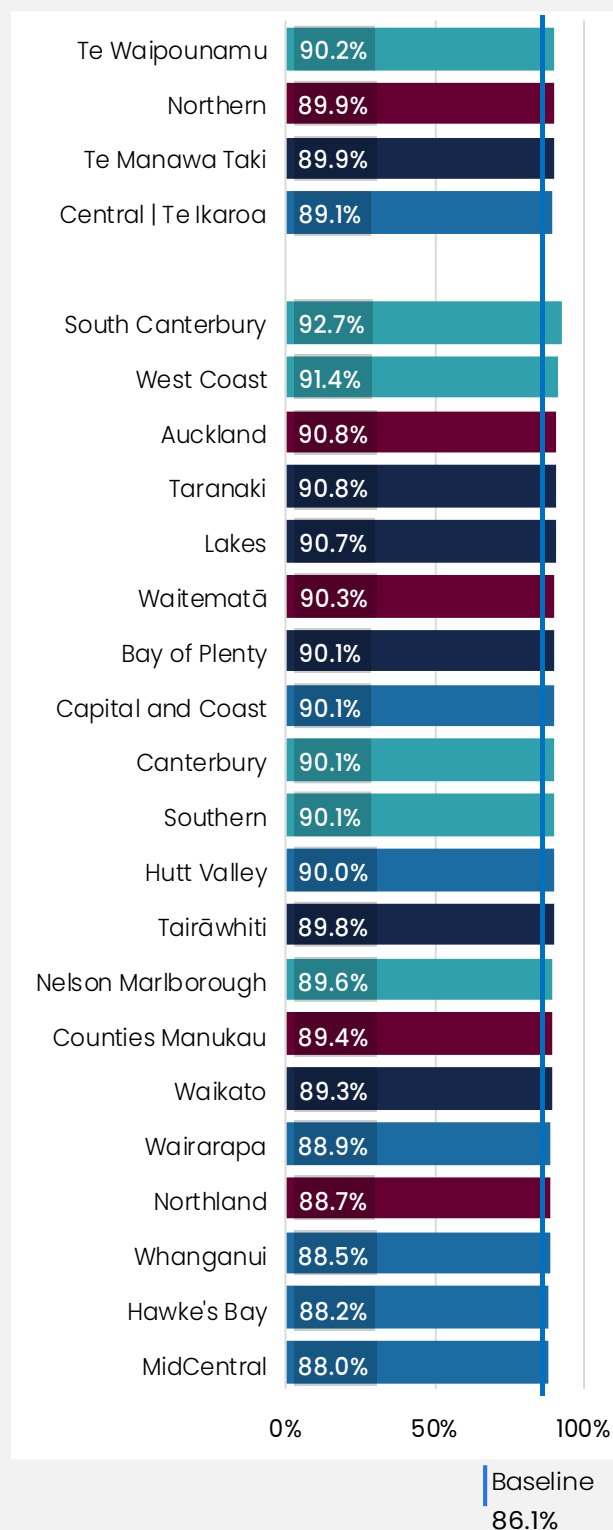


Māori and Pacific Peoples have slightly lower perceptions of involvement compared to Non-Māori, non-Pacific, non-Asian, but the trend remains positive over time for Māori and Pacific Peoples in line with the total population result.

Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- Measure definition as per Statement of Performance Expectations (SPE) 2024-25: "Percentage of patients who reported being involved by the health care professional in decisions about treatment and care during their most recent appointment"
- Sparklines represent eight quarters to May 2025.
- Further details on the survey methodology can be found at: www.hqsc.govt.nz/our-data/patient-reported-measures.

Results by Region and Districts



Ref	Measure					Desired Trend 
P2-179	Percentage of people reporting that the health care professional treated them with respect and kindness					
			2023/24	2024/25		
	Baseline	Target	Result	Result	Quarterly for the last 8 quarters	
Overall	95.4%	see below	96.0%	95.9%		96.1%
Māori	94.6%		94.9%	95.0%		95.5%
Pacific	94.6%		96.0%	96.6%		96.7%
Asian	95.2%		96.0%	95.7%		96.2%
NM/NP/NA*	95.6%		96.2%	96.0%		96.2%
Northern			96.2%	95.9%		96.4%
Te Manawa Taki			95.9%	96.2%		96.2%
Central Te Ikaroa			95.6%	95.6%		95.9%
Te Waipounamu			96.1%	95.8%		95.7%

*Non-Māori, non-Pacific, non-Asian

Target: Maintain baseline

Baseline: 2022/23 FY

2024/25	Prioritised Ethnicity			
	Māori	Pacific	Asian	NM/NP/NA*
Northern	94.8%	96.6%	95.2%	96.3%
Te Manawa Taki	95.5%	96.7%	96.7%	96.3%
Central Te Ikaroa	94.7%	97.0%	96.0%	95.6%
Te Waipounamu	94.8%	96.3%	97.1%	95.8%
All New Zealand	95.0%	96.6%	95.7%	96.0%

 Target Achieved

 Partially Achieved

 Not Achieved

(0.1-5% away from target)

(>5% away from target)

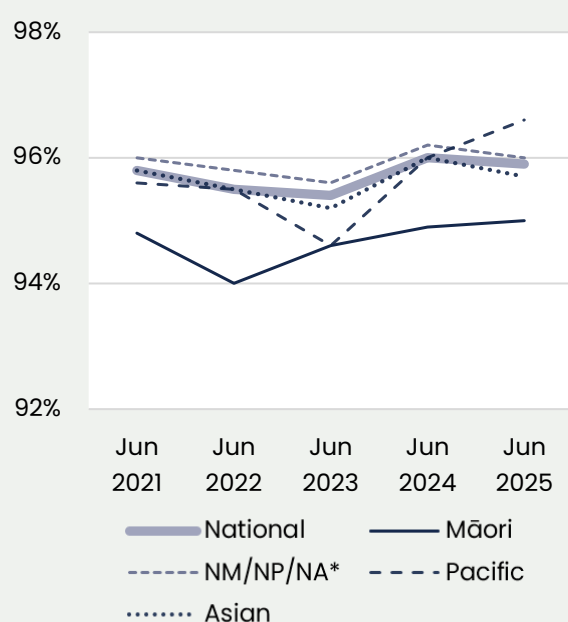
Overall, the percentage of people reporting that the health care professional they saw in primary care treated them with respect and kindness is high, and consistently high over several years.

These results show partial or full achievement of the target across ethnic groups and regions which is a result of the efforts of continuous improvement initiatives over time and the dedication of our primary care staff.

Data shows all results falling within a 1% range (95-96%). The trend is also positive with a continuous improvement over the last 5 years from June 2021 to June 2025.

Māori and Asian Peoples have slightly lower perceptions of involvement compared to Non-Māori, non-Pacific, non-Asian, with Pacific peoples showing the highest rate at 96.6%, up 0.6% since last year.

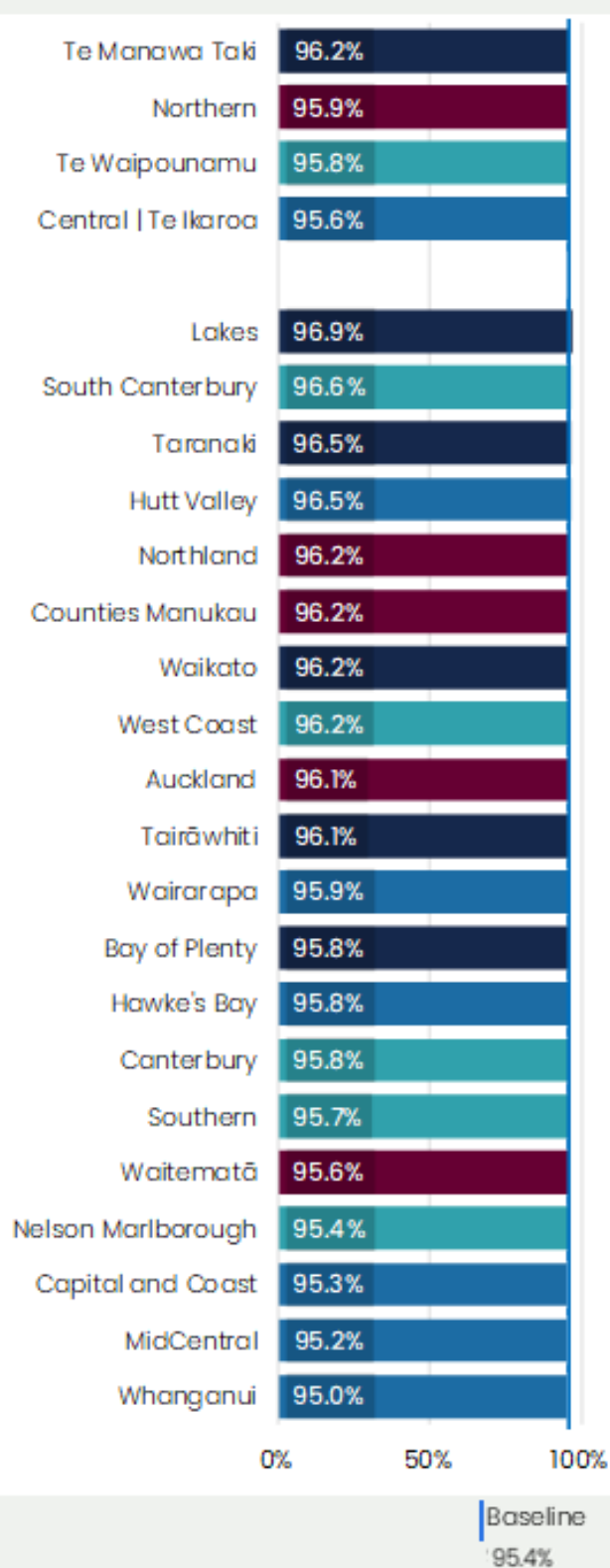
Longer-term trend (rolling 12-month period)



Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- Sparklines represent eight quarters to May 2025.
- Further details on the survey methodology can be found at: www.hqsc.govt.nz/our-data/patient-reported-measures.

Results by Region and Districts



Ref	Measure						Desired Trend	↑
P2-33b	Percentage of pregnant women registered with a lead maternity carer in the first trimester of pregnancy							
	Baseline	Target	2022 Result	2023 Result		Yearly for the last 5 years		
Overall	78.2%	see below	76.3%	73.0%	●	73.3%		73.0%
Māori	64.6%		61.4%	58.9%	●	59.2%		58.9%
Pacific	56.6%		52.8%	49.4%	●	44.8%		49.4%
Asian	83.3%		80.0%	74.7%	●	76.7%		74.7%
NM/NP/NA*	88.0%		87.4%	85.9%	●	84.4%		85.9%
Northern			71.9%	68.9%	●	66.6%		68.9%
Te Manawa Taki			74.9%	68.5%	●	75.7%		68.5%
Central Te Ikaroa			75.9%	74.9%	●	74.4%		74.9%
Te Waipounamu			85.8%	83.6%	●	81.4%		83.6%

*Non-Māori, non-Pacific, non-Asian

Target: Achieved (increase from baseline)

Baseline: 2021

2023	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	54.7%	45.1%	74.9%	86.1%	68.4%	75.0%
Te Manawa Taki	54.8%	55.1%	67.5%	82.7%	70.6%	62.7%
Central Te Ikaroa	63.2%	58.3%	74.5%	84.7%	74.7%	75.8%
Te Waipounamu	72.7%	63.4%	80.5%	88.8%	84.0%	82.4%
All New Zealand	58.9%	49.4%	74.7%	85.9%	73.0%	73.4%

**Rurality status is unknown for 33 (0.06%) out of the 53,360 total eligible pregnant women registered with a lead maternity carer

● Target Achieved

● Partially Achieved

● Not Achieved

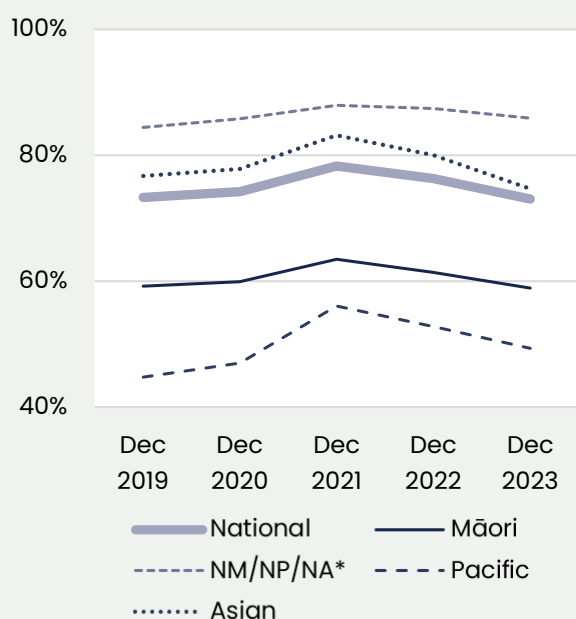
(0.1-5% away from target)

(>5% away from target)

Regionally, the percentage of registrations during the first trimester was lowest in Tairāwhiti (51.9%) followed closely by Counties Manukau (55%), while West Coast (88.1%), Canterbury (85.5%) and Southern (83.2%) reported the highest levels of early registrations. Te Waipounamu as a region exceeded the baseline percentage of early registrations.

Early registration with a Lead Maternity Carer in the first trimester is influenced by factors such as awareness of pregnancy and maternity services, ease of access to LMCs (different districts have variation in availability of access), cultural safety, and trust in the health system. Social determinants like income, housing, and previous healthcare experiences also play a significant role in when and how women engage with maternity care.

Longer-term trend (rolling 12-month period)

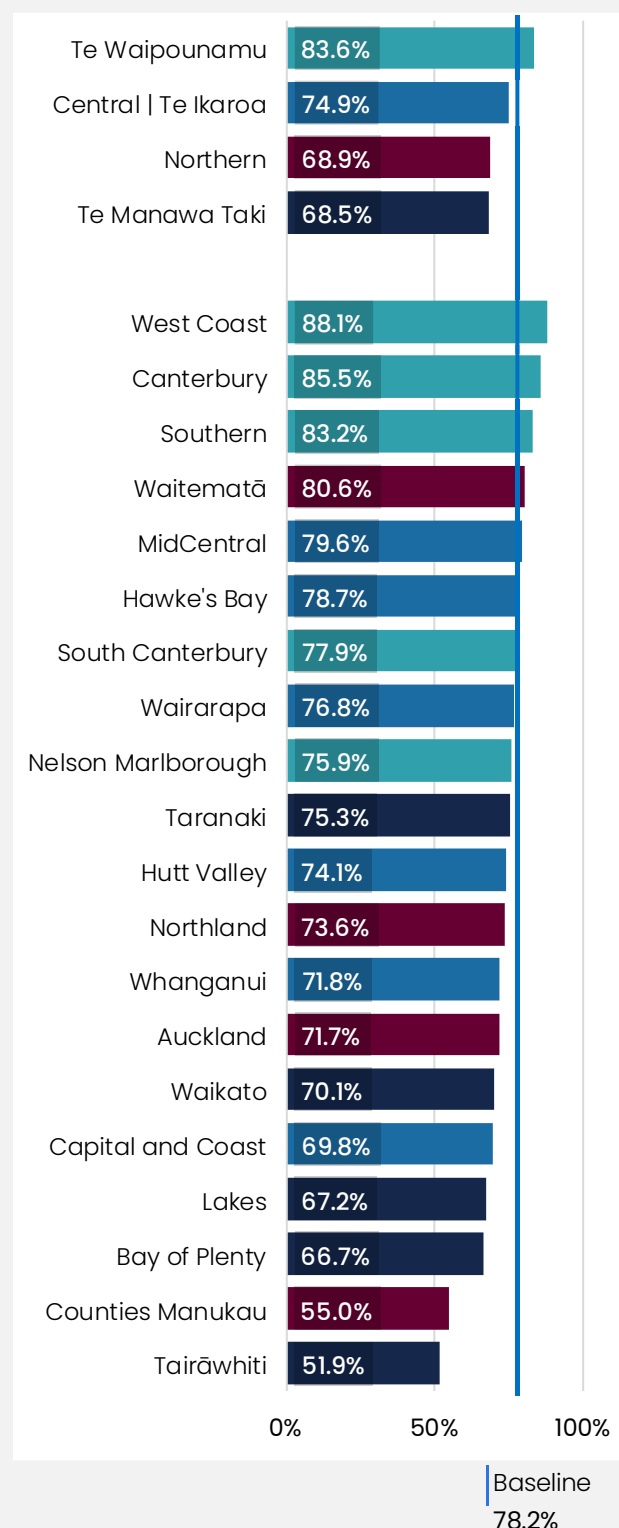


Supporting the midwifery workforce is a priority for Health NZ. The Health NZ workforce plan has emphasised midwifery as a crucial focus area, with efforts directed at expanding the workforce by attracting and supporting new midwives, valuing and retaining existing midwives, and encouraging those who have left the profession to return.

Notes to the measure:

- Data for this measure is only available a year in arrears. Latest available is the 2023 calendar year.
- The baseline for this measure has been updated from the SPE 24/25 figure of 94.9% to correct an error in drafting where the wrong value was recorded for this measure.

Results by Region and Districts



Launch of Diabetes Retinal Screening pilot programme

The new AI enhanced Diabetes Retinal Screening (DRS) pilot programme launched at Baderdrive Doctors on 27 February 2025.

The pilot aims to improve access and care for people living with diabetes. By using AI for real-time image grading, larger data volumes are able to be processed thus boosting efficiency across the programme.

Seven South Auckland primary care providers are trialling the DRS image capture supported by primary care assistants, including the Kaiāwhina workforce (non-regulated health roles). Retinal images taken at local clinics are immediately assessed by AI, with high-risk cases referred to specialists. This efficient service aims to improve timely access to care and allow specialists to focus on core clinical duties.

The pilot is a key part of the holistic 'by Pacific, for Pacific' South Auckland pilot programme to relieve the burden of diabetes and specifically to help reduce the risk of people with diabetes developing sight-threatening diabetic eye disease.



Outcome measures

Ref	Measure						
P2-22	Rate of Ambulatory Sensitive Hospital (ASH) admissions (per 100,000) for children aged 0-4 years						Desired Trend ↓
	Baseline	Target	2023/24 Result	2024/25 Result		Yearly for the last 3 years	
Overall	7,752	see below	7,325	7,471	●	7,841	7,471
Māori	8,192		8,129	8,510	●	8,253	8,510
Pacific	14,639		14,327	15,110	●	14,89...	15,110
Asian	6,616		6,195	6,585	●	6,617	6,585
NM/NP/NA*	6,616		5,774	5,446	●	6,573	5,446
Northern			7,941	8,392	●	8,519	8,392
Te Manawa Taki			7,801	7,232	●	7,762	7,232
Central Te Ikaroa			7,576	7,862	●	8,160	7,862
Te Waipounamu			5,502	5,697	●	6,409	5,697

*Non-Māori, non-Pacific, non-Asian

Target: Decrease from baseline

Baseline: 2022/23 FY

This measure is recorded in the Vote Health: Supplementary Estimates with a target of “Improve from baseline as at June 2024”, result is partially achieved.

2024/25	Prioritised Ethnicity				Rurality	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	9,392	15,848	6,385	5,642	8,314	7,058
Te Manawa Taki	8,441	11,711	6,572	5,850	7,719	5,926
Central Te Ikaroa	8,512	15,953	8,073	5,884	8,201	6,185
Te Waipounamu	6,877	11,502	6,052	4,709	6,188	4,458
All New Zealand	8,510	15,110	6,585	5,446	7,783	5,705

● Target Achieved

● Partially Achieved

● Not Achieved

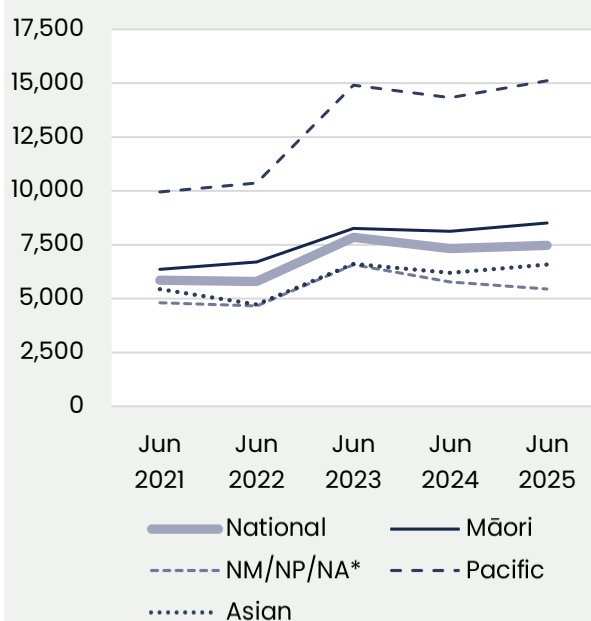
(0.1-5% away from target)

(>5% away from target)

ASH rates for 0-4 year olds have increased slightly over the last 12 months at a national level. However, there have been improvements across the 3-year timeframe (2023-25) in the national rate, from the 2022/23 baseline. This means the overall ASH target for children aged 0-4 years is met.

There are higher ASH rates for Māori and Pacific children compared to non-Māori, non-Pacific, non-Asian children, particularly for Pacific children at 15,110, which follows a longstanding trend.

Longer-term trend (rolling 12-month period)

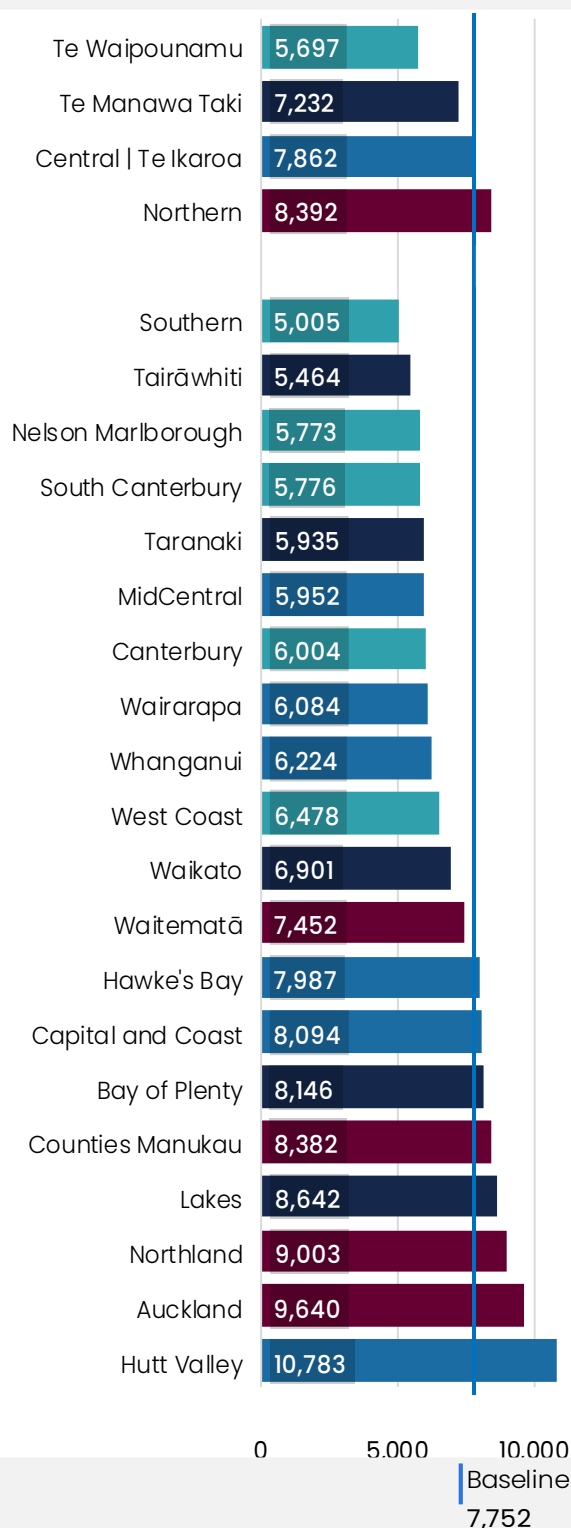


Regional ASH rates for 0-4 year olds are higher for Māori and Pacific Peoples across all four regions, compared to Non-Māori, Non-Pacific, Non-Asian children. There is less regional variation according to rurality

Notes to the measure:

- Regional comparisons: the national 2023/24 FY baseline has been used as the baseline for regional target comparisons
- The calculation uses those aged 0-4 who have been discharged after an acute inpatient event (numerator) as a proportion of the Stats NZ's Estimated Resident Population (denominator), which is updated annually and this 2023/24 values may be different from what was published last year, per 100,000.
- Please note that with population projections there is an inherent uncertainty in the numbers, this is due to their reliance on assumptions about future fertility, mortality, and migration trends, which can change over time.
- An ambulatory sensitive hospitalisation (ASH) is a hospital event for a condition that the hospitalisation could potentially have been avoided by the provision of appropriate health interventions and early disease management, normally delivered in primary care and community-based care settings

Results by Region and Districts



Ref	Measure						
P2-23	Rate of Ambulatory Sensitive Hospital (ASH) admissions (per 100,000) for people aged 45-64 years						Desired Trend ↓
			2023/24	2024/25		Yearly for the last 3 years	
	Baseline	Target	Result	Result			
Overall	3,739	see below	3,821	3,782	●	3,770	3,782
Māori	6,981		7,276	7,284	●	6,960	7,284
Pacific	8,127		8,257	8,101	●	7,856	8,101
Asian	1,994		2,215	2,096	●	2,136	2,096
NM/NP/NA*	1,994		3,089	3,075	●	3,114	3,075
Northern			4,103	4,117	●	4,071	4,117
Te Manawa Taki			4,290	4,051	●	4,264	4,051
Central Te Ikaroa			4,219	4,233	●	4,101	4,233
Te Waipounamu			2,695	2,691	●	2,653	2,691

*Non-Māori, non-Pacific, non-Asian

Target: Decrease from baseline

Baseline: 2022/23 FY

This measure is recorded in the Vote Health: Supplementary Estimates with a target of “Improve from baseline as at June 2024”, result is achieved.

2024/25	Prioritised Ethnicity				Rurality	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	8,160	8,808	2,325	3,139	4,134	3,759
Te Manawa Taki	7,456	6,280	1,476	3,206	4,008	4,186
Central Te Ikaroa	7,411	7,629	2,309	3,583	4,338	3,773
Te Waipounamu	4,721	4,586	1,393	2,583	2,852	2,135
All New Zealand	7,284	8,101	2,096	3,075	3,872	3,321

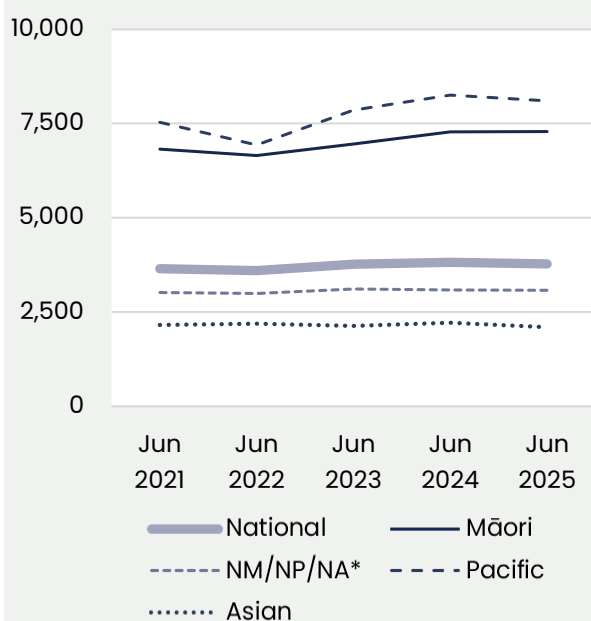
Rurality status is unknown for 100 (0.01%) out of the 1,297,825 total eligible people aged 45-64 years

● Target Achieved
 ● Partially Achieved (0.1-5% away from target)
 ● Not Achieved (>5% away from target)

National and regional ASH rates for 45–64-year-olds remained stable over the last 12 months. The national ASH rate for 45-64 year-olds over the 2024/25 FY is 0.1-5% over the 2022/23 FY baseline, which means the ASH target for this age group is partially achieved.

Māori and Pacific populations aged 45-64 years experience substantially higher ASH rates than other groups, which are long-standing trends. The ASH rates for Māori aged 45-64 years over the last 12 months are above the baselines set for these measures and is partially achieved..

Longer-term trend (rolling 12-month period)

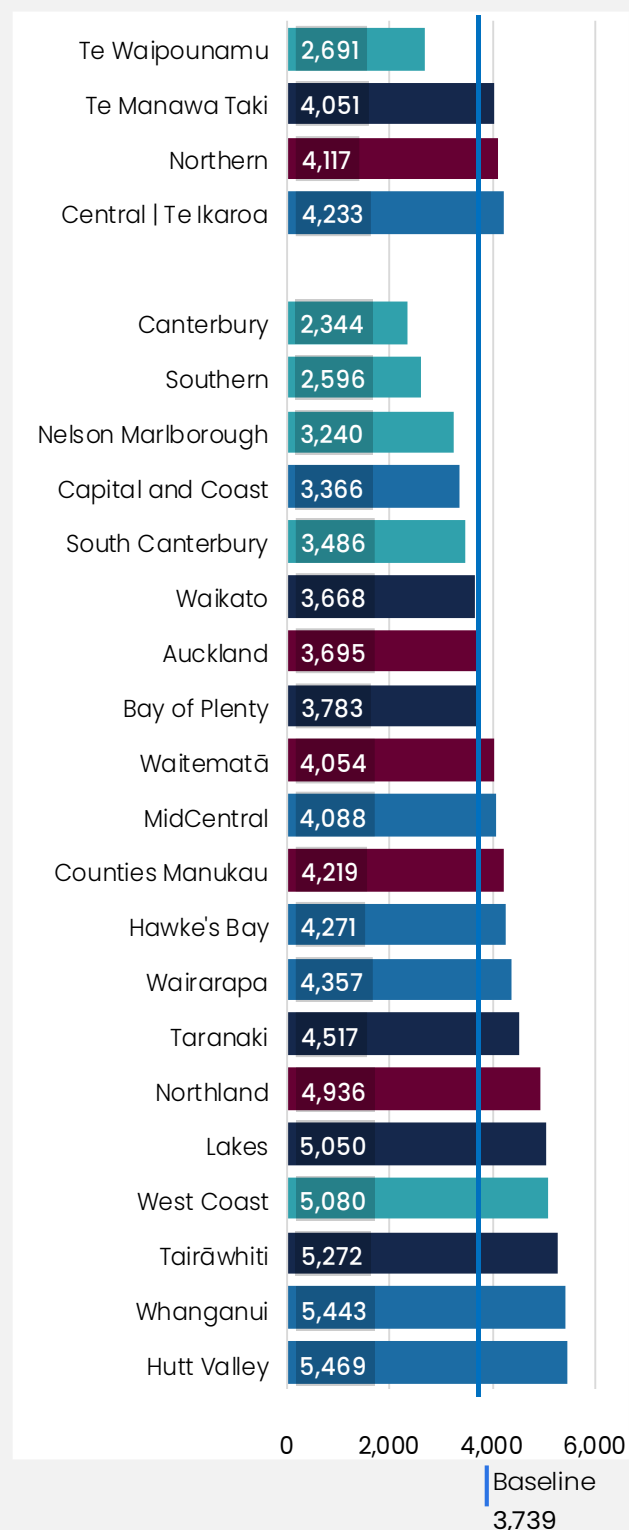


There is variability in regional ASH rates by ethnic group and rurality in people aged 45-64 years.

Notes to the measure:

- Regional comparisons: the national 2023/24 FY baseline has been used as the baseline for regional target comparisons
- The calculation uses those aged 45-64 who have been discharged after an acute inpatient event (numerator) as a proportion of the Stats NZ's Estimated Resident Population (denominator), which is updated annually and this 2023/24 values may be different from what was published last year, per 100,000.
- Please note that with population projections there is an inherent uncertainty in the numbers, this is due to their reliance on assumptions about future fertility, mortality, and migration trends, which can change over time.
- An ASH is a hospital event for a condition that the hospitalisation could potentially have been avoided by the provision of appropriate health interventions and early disease management, normally delivered in primary care and community-based care settings.

Results by Region and Districts



Ref	Measure						
P2-184	Ambulatory sensitive hospitalisations (ASH) for cardiovascular conditions per 100,000 in those aged 45-64 years						Desired Trend 
			2023/24	2024/25			
	Baseline	Target	Result	Result	Yearly for the last 3 years		
Overall	1,569	see below	1,558	1,536		1,569	1,536
Māori	2,564		2,633	2,687		2,564	2,687
Pacific	3,252		3,228	3,068		3,252	3,068
Asian	1,092		1,129	1,055		1,092	1,055
NM/NP/NA*	1,325		1,289	1,275		1,325	1,275
Northern			1,707	1,709		1,725	1,709
Te Manawa Taki			1,700	1,545		1,710	1,545
Central Te Ikaroa			1,784	1,823		1,791	1,823
Te Waipounamu			1,035	1,037		1,049	1,037

*Non-Māori, non-Pacific, non-Asian

Target: Improve from baseline (trend to decrease)

Baseline: 2022/23 FY

2024/25	Prioritised Ethnicity				Rurality	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	3,116	3,333	1,162	1,330	1,414	1,610
Te Manawa Taki	2,652	2,614	766	1,252	1,458	1,630
Central Te Ikaroa	2,804	2,827	1,284	1,614	1,721	1,694
Te Waipounamu	1,619	1,681	608	1,007	1,043	833
All New Zealand	2,687	3,068	1,055	1,275	1,399	1,360

Rurality status is unknown for 100 (0.01%) out of the 1,297,825 total eligible people aged 45-64 years

 Target Achieved
  Partially Achieved
  Not Achieved
 (0.1-5% away from target) (>5% away from target)

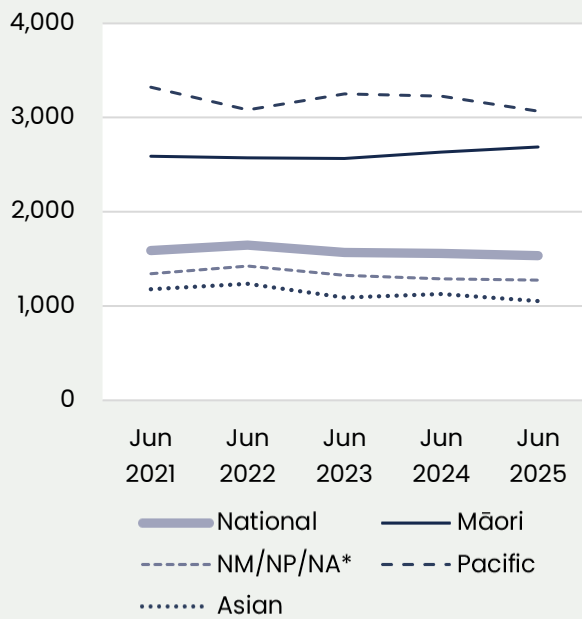
ASH rates for cardiovascular conditions for adults aged 45-64 years are incrementally improving. There have been improvements for all ethnic groups except for Māori.

Nationally, the rate is below the national 2022/23 FY rate which acts as the baseline rate. This means the ASH target for cardiovascular conditions in this 45-64 year age group is achieved.

Regional ASH rates are higher for Māori and Pacific Peoples across all four regions, compared to both Asian and Non-Māori, Non-Pacific, Non-Asian groups.

Reducing ASH rates is a focus for all regions.

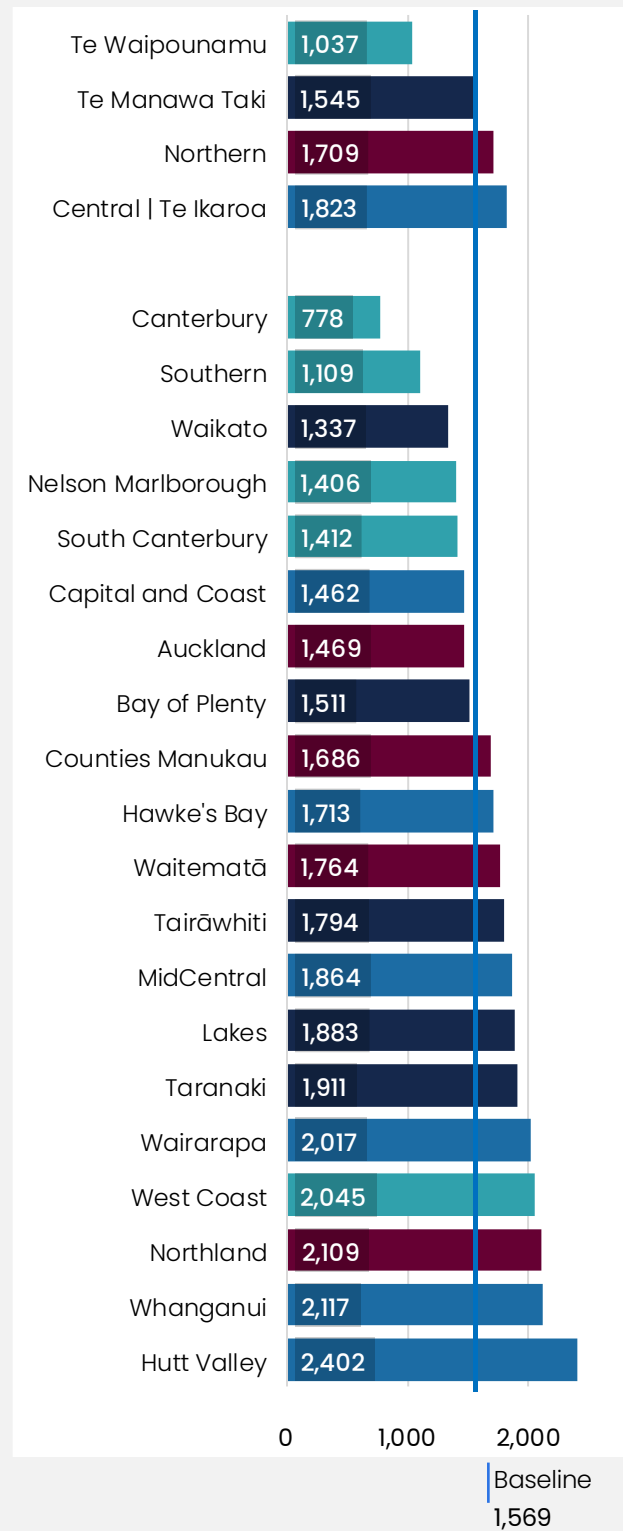
Longer-term trend (rolling 12-month period)



Notes to the measure:

- a) Regional comparisons: the national 2023/24 FY baseline has been used as the baseline for regional target comparisons

Results by Region and Districts



Ref	Measure						
P2-185	Ambulatory sensitive hospitalisations (ASH) for respiratory conditions per 100,000 in those aged 0-4 years						Desired Trend 
	Baseline	Target	2023/24 Result	2024/25 Result		Yearly for the last 3 years	
Overall	4,999	see below	4,437	4,316		4,999	 4,316
Māori	5,195		4,803	4,813		5,195	 4,813
Pacific	9,602		8,815	8,852		9,602	 8,852
Asian	4,113		3,684	3,754		4,113	 3,754
NM/NP/NA*	4,266		3,587	3,220		4,266	 3,220
Northern			4,744	4,900		5,291	 4,900
Te Manawa Taki			4,877	4,195		5,121	 4,195
Central Te Ikaroa			4,617	4,508		5,201	 4,508
Te Waipounamu			3,272	3,207		4,170	 3,207

*Non-Māori, non-Pacific, non-Asian

Target: Improve from baseline (trend to decrease)

Baseline: 2022/23 FY

2024/25	Prioritised Ethnicity				Rurality	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	5,382	9,200	3,725	3,407	3,610	3,842
Te Manawa Taki	4,915	6,795	3,604	3,453	3,776	3,322
Central Te Ikaroa	4,537	9,896	4,540	3,570	3,891	2,988
Te Waipounamu	3,851	6,621	3,345	2,665	2,843	2,025
All New Zealand	4,813	8,852	3,754	3,220	3,549	2,946

**Rurality status is unknown for 100 (0.01%) out of the 1,297,825 total eligible people aged 45-64 years

 Target Achieved

 Partially Achieved

 Not Achieved

(0.1-5% away from target)

(>5% away from target)

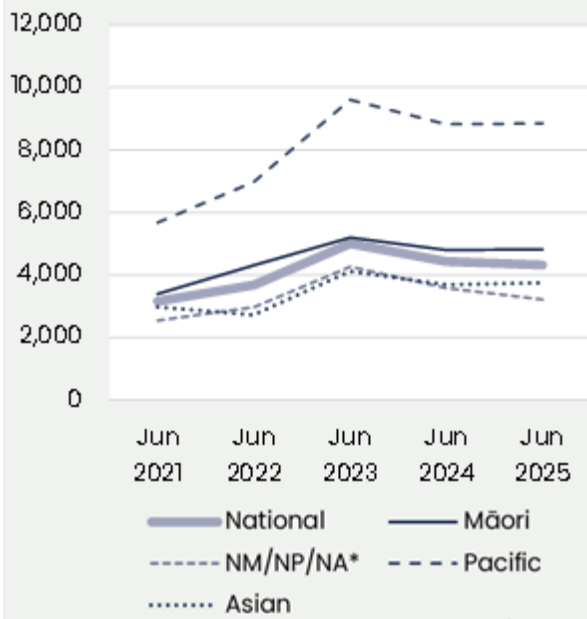
ASH rates for respiratory conditions for children aged 0-4 years are incrementally improving. There have been improvements for all ethnic groups.

Nationally, the rate is below the national 2022/23 FY rate which acts as the baseline rate. This means the ASH target for cardiovascular conditions in this 0-4 year age group is achieved.

Regional ASH rates are higher for Māori and Pacific Peoples across all four regions, compared to both Asian and Non-Māori, Non-Pacific, Non-Asian groups (apart from Central | Te Ikaroa for Asian)

Reducing ASH rates is a focus for all regions.

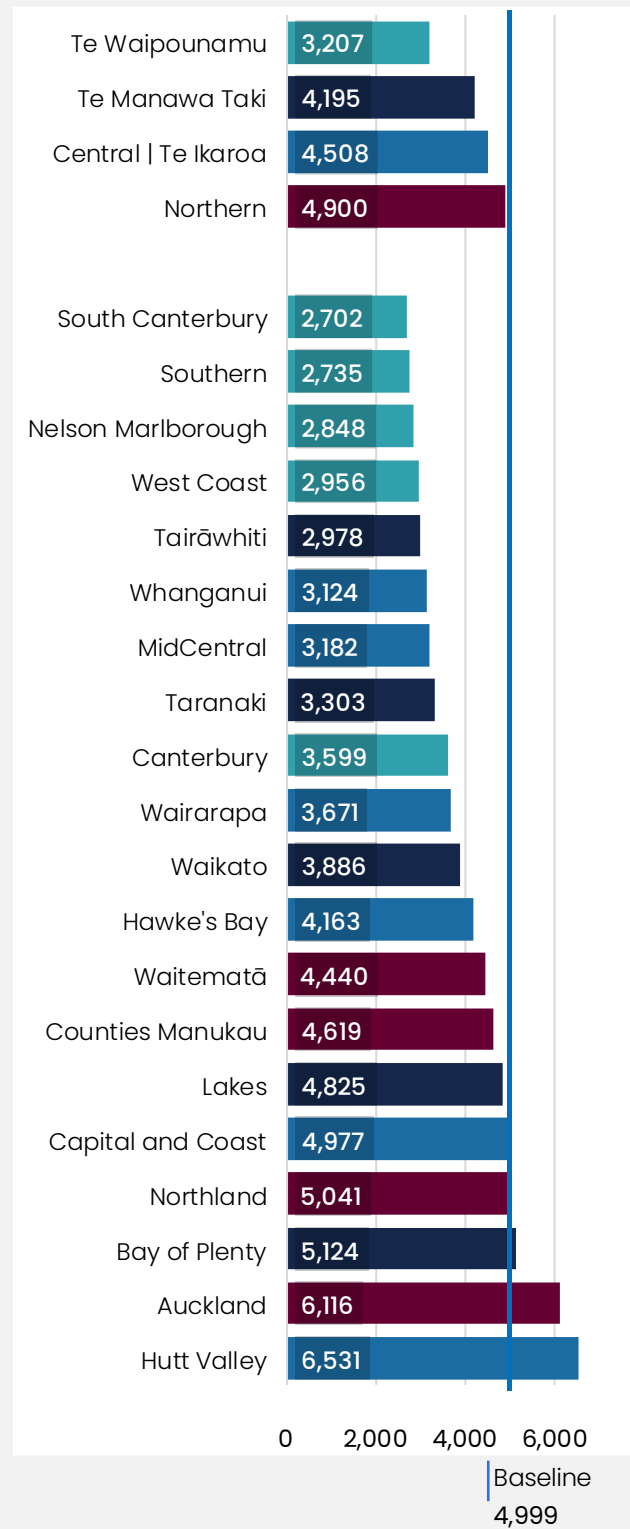
Longer-term trend (rolling 12-month period)



Notes to the measure:

- a) Regional comparisons: the national 2023/24 FY baseline has been used as the baseline for regional target comparisons

Results by Region and Districts



Ref	Measure						
P2-186	Ambulatory sensitive hospitalisations (ASH) for respiratory conditions per 100,000 in those aged 45-64 years						Desired Trend
	Baseline	Target	2023/24 Result	2024/25 Result		Yearly for the last 3 years	
Overall	648	see below	633	666		648	666
Māori	1,610		1,666	1,756		1,610	1,756
Pacific	1,398		1,402	1,505		1,398	1,505
Asian	206		229	218		206	218
NM/NP/NA*	483		447	475		483	475
Northern			645	672		662	672
Te Manawa Taki			724	806		779	806
Central Te Ikaroa			704	747		685	747
Te Waipounamu			483	479		492	479

*Non-Māori, non-Pacific, non-Asian

Target: Improve from baseline (trend to decrease)

Baseline: 2022/23 FY

2024/25	Prioritised Ethnicity				Rurality	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	1,839	1,564	237	440	615	672
Te Manawa Taki	1,823	1,385	168	547	788	863
Central Te Ikaroa	1,928	1,530	218	516	767	636
Te Waipounamu	1,147	1,068	176	432	518	344
All New Zealand	1,756	1,505	218	475	653	608

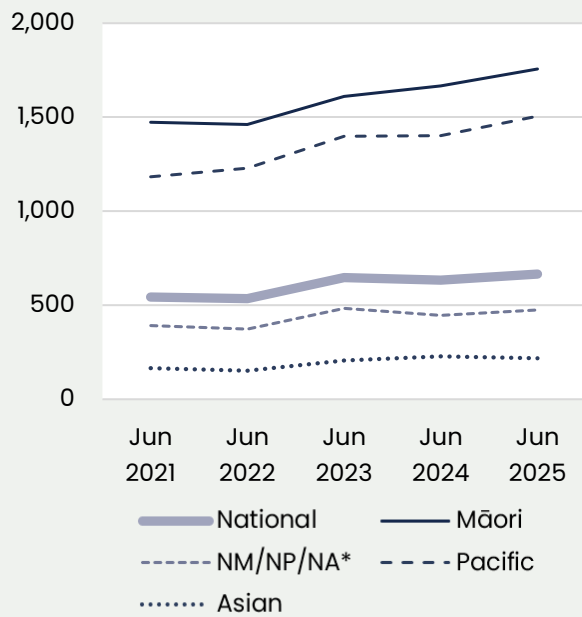
**Rurality status is unknown for 100 (0.01%) out of the 1,297,825 total eligible people aged 45-64 years

Target Achieved
 Partially Achieved
 Not Achieved
 (0.1-5% away from target) (>5% away from target)

ASH rates for respiratory conditions for adults aged 45-64 years have fallen below the baseline for most categories. There has been an improvement for non-Māori, non-Pacific, non-Asian and the Te Wai Pounamu region, with a number of others falling into a partial achievement.

Nationally, the rate is above the national 2022/23 FY rate which acts as the baseline rate. This means the ASH target for cardiovascular conditions in this 45-64 year age group is not achieved but falls within the 5% partial achievement category.

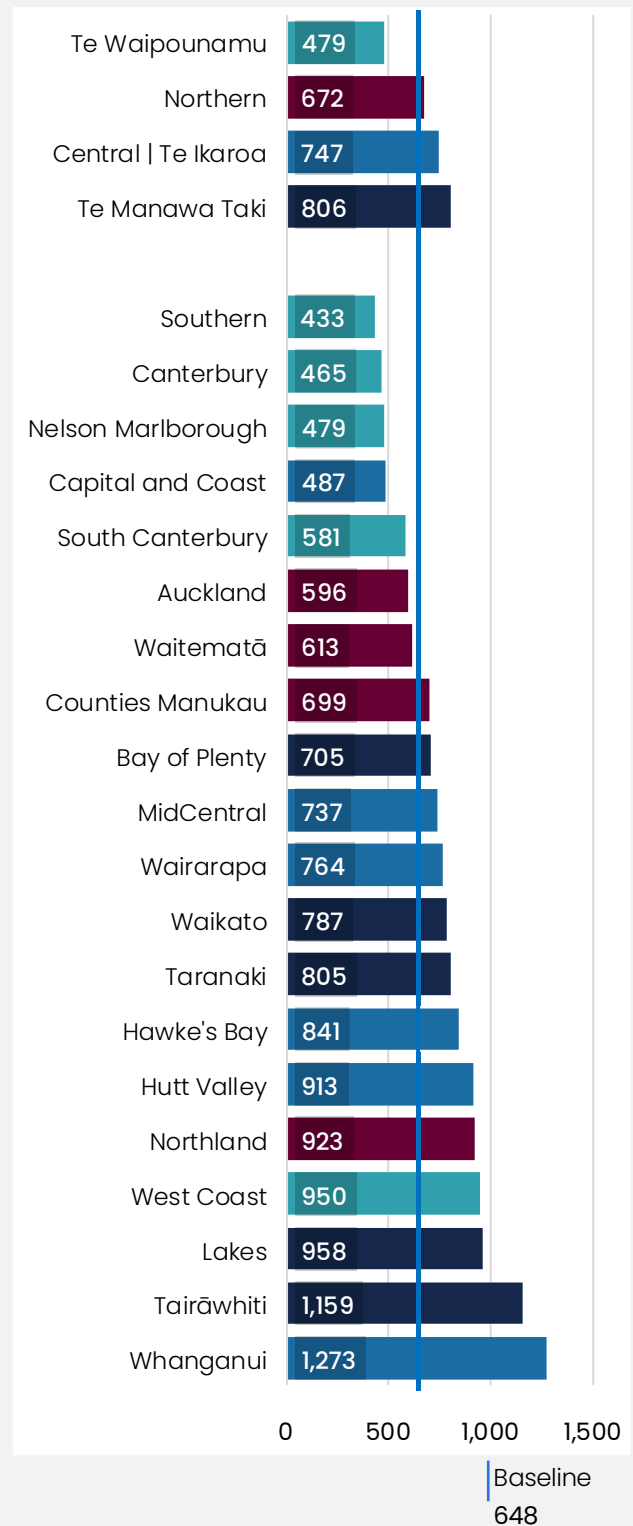
Longer-term trend (rolling 12-month period)



Notes to the measure:

- a) Regional comparisons: the national 2023/24 FY baseline has been used as the baseline for regional target comparisons

Results by Region and Districts





GP Practices

Health New Zealand contracts with approximately 30 Primary Health Organisations (PHOs), which are responsible for engaging around 956 general practices across New Zealand, forming the cornerstone of our health system.

General practices, which may operate one or more facilities, provide first-contact, continuous, and comprehensive care to individuals and whānau. Their services include - but are not limited to – delivering immunisation and screening services, diagnosis, treatment, long term condition management, and care coordination.

Many practices work in partnership with Māori health providers, and community organisations to deliver culturally responsive and locally tailored care. Increasingly, they are supported by multidisciplinary teams – including nurses, pharmacists, physiotherapists, and social workers – who work together to address complex health needs and reduce pressure on hospital services.

They also play a vital role in keeping people well and treating illness early, contributing significantly to the overall health and wellbeing of communities and to the efficient operation of the health system



Locations in New Zealand



Region	Total number of Practices
Northern	391
Midland Te Manawa Taki	172
Central Te Ikaroa	143
Southern Te Waipounamu	250
Total	956



Pharmacies

Health NZ contracts with just under 1,100 community-based pharmacies nationwide, which are integral to the delivery of accessible, safe, and effective healthcare.

These pharmacies not only dispense medications and some medical devices but also provide clinical advice and increasingly offer a broader range of health services – including vaccinations, minor ailment consultations, and medication reviews.

Located in urban centres, rural towns and remote communities, community pharmacies are among the most accessible points of care within the health system.

Pharmacists are instrumental in supporting medicine adherence, managing long-term conditions, and reducing medicine-related harm.

Many pharmacies now operate under collaborative care models, working closely with general practices and other healthcare providers to ensure continuity of care.

Their contribution to public health – particularly during outbreaks and vaccination campaigns – has been critical in improving health outcomes and addressing health inequities.



Locations in New Zealand



Region	Total number of Pharmacies
Northern	430
Midland Te Manawa Taki	190
Central Te Ikaroa	181
Southern Te Waipounamu	260
Total	1,061



Aged Residential Care



Locations in New Zealand

Health NZ contracts with just under 700 aged residential care (ARC) facilities across the country, supporting the delivery of long-term care to older New Zealanders.

These facilities include rest homes, continuing care hospitals, and dementia units. They offer 24-hour clinical care, support with daily living, and a safe, dignified environment for residents.

ARC providers are a vital part of the health sector's continuum of care, particularly for those with complex health needs or limited ability to live independently.

ARC providers work in partnership with general practice teams, allied health professionals, and families to ensure residents receive person-centred care that respects their preferences and cultural values.

Many facilities also offer palliative care and rehabilitation services, helping residents maintain quality of life and independence for as long as possible.

As New Zealand's population ages, ARC will continue to play a central role in meeting the needs of older adults and supporting their wellbeing.



Regions	Total number of ARC facilities
Northern	213
Midland Te Manawa Taki	140
Central Te Ikaroa	134
Southern Te Waipounamu	207
Total	694

Maintaining access to residential care beds across the region

This year our Central | Te Ikaroa region identified increasing demand for higher levels of residential care. A reconfiguration scope was completed in December 2024 to increase the number of available dementia and psychogeriatric beds in ARC facilities. Having more beds available shortens wait times for admission to ARC, resulting in expedited discharges from hospitals (supporting flow) and/or lessening the risk of hospital admission due to carer stress.

By 30 June 2025, the work programme added 40 additional dual use beds (rest home or hospital level care), 15 hospital-level care and 30 dementia care beds across the region. Of these 85 beds, 18 were new and the remainder reconfigured from existing rest home or dual use beds. These initiatives reflect a collaborative, service-wide approach to improving outcomes and efficiency across the region.

Tairāwhiti after-hours service

Following an open procurement process, a new weekend and public holiday after-hours healthcare service in Tairāwhiti called Tātai Whānau launched on Saturday 3 May, 2025.

Health NZ, in partnership with the Te Rōpū Matua collective through Ngāti Porou Oranga, has restored and expanded access to healthcare for the people of Tairāwhiti. The service replaces previous arrangements between general practices and is delivered from the clinic at Ngāti Porou Oranga, Puhī Kaiti Medical Centre.

The service includes:

- A walk-in or phone-first service with access to a nurse, nurse practitioner, or doctor;
- A local nurse-led phone line operating during the same hours as the clinic;
- Health navigation services to help patients access the right care.

The service launched positively and operates at full capacity during weekends with 30 to 40 face-to-face consultations per day. While weekday services have not yet been introduced, planning is underway to align future service hours with the Urgent Care and After-Hours framework, specifically the addition of evening hours (5-8 pm).

The service was established primarily to ensure consistent access to primary care during weekends and public holidays in Gisborne; a goal it has successfully met. It has also contributed to strengthening collaborative models of care. Although it is too early to measure the impact on Gisborne Hospital's Emergency Department (ED), efforts are being made to promote access to appropriate services for clinical needs, thereby supporting redirection of appropriate patients away from the ED.

Proactive Care in the Community

Care@Home is a collaborative initiative that began in Nelson in August 2024, designed to support people who may be at risk after visiting the ED. It was created in response to growing concerns about overcrowding, long waiting times, and an increase in people leaving the ED before receiving care. Concerns were raised nationally in July 2024 that there was a rise in mortality among people who self-discharged, prompting urgent action.

Rather than waiting for people to return to the ED, Care@Home reaches out to those who may need extra support — whether they left before being treated or were discharged with complex medical or social needs. Care@Home aims to offer timely, personalised care that helps people stay well in their homes and communities.

In the first year, Care@Home connected with over 1,000 people and in 80% of these community interactions, further follow up occurred. For context, over the same period Nelson's ED saw around 33,000 people. Examples of follow-up actions after a Care@Home interaction include nurse practitioner reviews, referrals for aged care, enrolment with a general practice or Hauora Māori provider, or help accessing medical, housing and social support.

Many people have expressed gratitude for the follow-up, saying things like: "Thank you for following up, it shows you really care". Clinicians have also praised the initiative, with one ED staff member calling it: "Invaluable for the ED and community."

Local Community Coordinators for Care@Home are based within primary care at Nelson Bays Primary Health and the Marlborough PHO. The service is helping to build a more connected, compassionate health system, one that puts people and their wellbeing at the centre.

Output Class 3: Hospital and specialist services

This output class secures hospital and specialist services for people eligible for publicly funded health services in New Zealand in line with Ministerial service coverage expectations.

Specialist services are typically situated in intensive health service environments such as 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.

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.

Why is this important?

The focus for hospital and specialist services is to ensure all eligible 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.

Summary of Performance

Health NZ's overall performance for 2024/25, for this output class was:

	Total	Achieved	Partially achieved	Not achieved	Not Reported/No Target
Number of measures	20	6	11	2	1
% of Total measures	100%	30%	55%	10%	5%

This summary does not tell the story of improvement since 2023/24. Further, because we must report on our annual result (which for many measures reflects an average of our full year performance), the overall results do not fully tell the story of progress that occurred during the year. For that story we invite you to read the narrative for each measure and review the spark lines and long-term trend lines which visualise the movement in performance over time.

Overall, the number of people waiting longer than 4 months for first specialist appointments decreased to 73,000 by end of June 2025, and 63.9% of patients were waiting less than four months for elective treatment by 30 June. These results reflect our focus on planned care performance, treating the right patients in the right order based on clinical need and total time waiting. Improving patient flow through hospitals has been a key area of focus leading to tangible improvements for patients

The proportion of medical appointments delivered by telehealth increased to 7.2%, 2.8% short of the target, with the biggest improvement for Māori (0.6%), and Te Waipounamu region leading at 10.1% of total appointments, 13% for those in rural areas.

This year showed we have some work to do with our target for the Consumer Engagement Quality and Safety Marker, which was not achieved in any region. Missed first specialist appointment rates increased nationally, with rates for Māori (15.2%) and Pacific peoples (17.1%) remaining a concern. Performance for timely cancer management was just 0.3% under target nationally, with some groups (Māori - 87.3%) and regions (Central | Te Ikaroa region - 86.8%) exceeding the target.

Results for output class measures

The following sections present all the measures classified, in accordance with our performance framework, by whether they are an input, output, impact or outcome measure.

Inputs: Summary of Financials

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

Expected revenue and proposed expenditure	2024/25	2024/25	2024/25	2023/24
	Actual \$ million	Budget \$ million	Variance \$ million	Estimated Actual \$ million
Revenue – Crown	12,816	13,248	(432)	12,856
Other revenue	1,664	1,868	(204)	1,703
Total operating revenue	14,480	15,116	(636)	14,559
Total operating expense	15,823	15,966	143	15,303
Surplus/(deficit)	(1,344)	(850)	(494)	(744)

Input measures

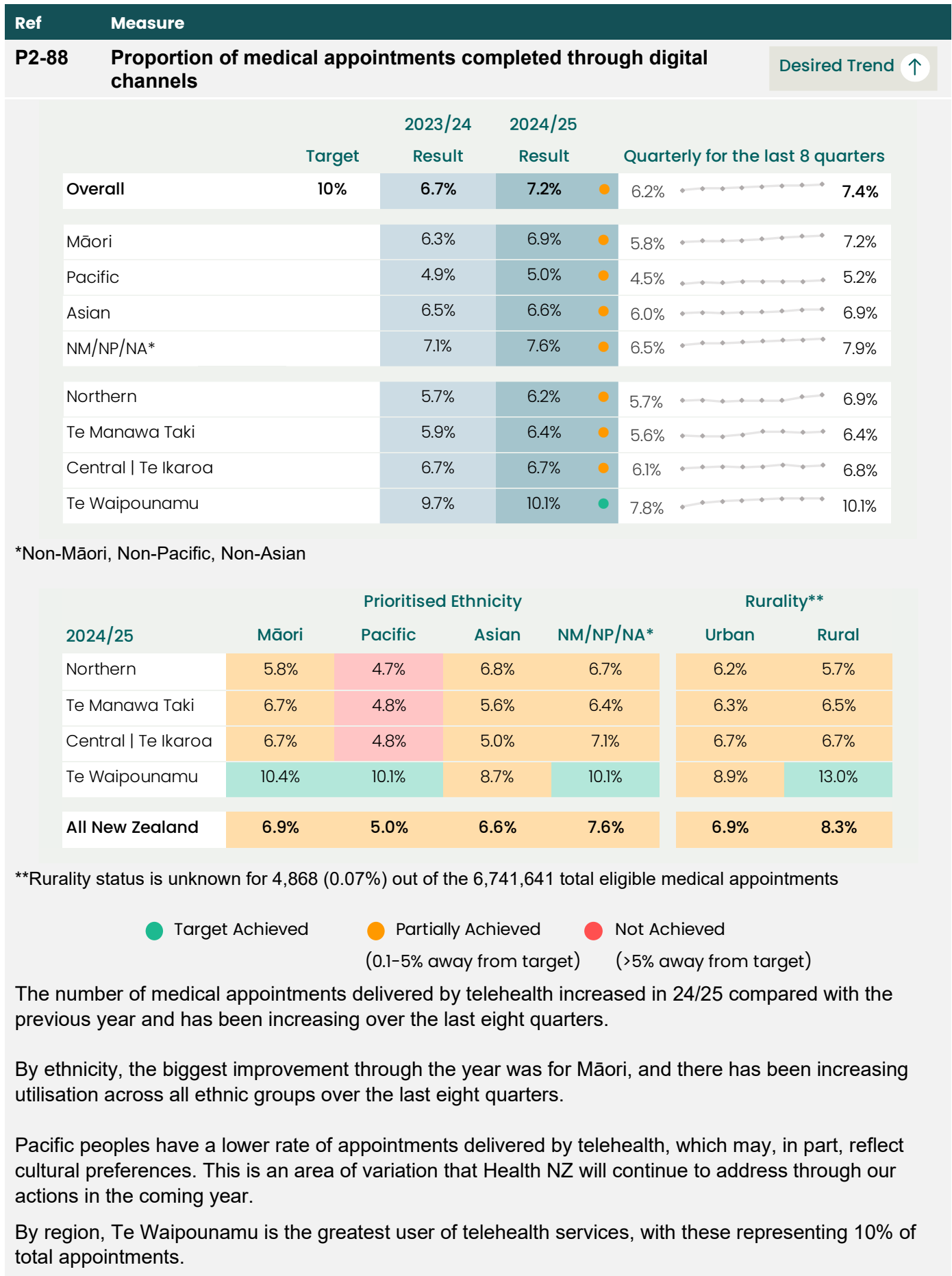
Ref	Measure
P2-85	High-quality asset manager Results for this measure can be found in the Physical Infrastructure section of this report.
P2-90	Hospital redevelopment project meets milestones Results for this measure can be found in the Physical Infrastructure section of this report.

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-93	Percentage of drawdowns repaid in 10 business days or less	Achieved	Has not been required	Has not been required	N/A
	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.				

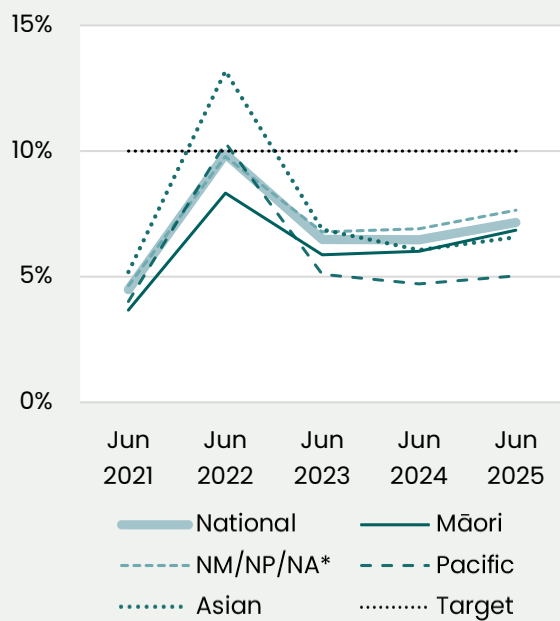
Ref	Measure	Target	2023/24 Result	2024/25 Result	Status																				
P2-36	Health New Zealand has self-assessed all regions against the Consumer Engagement Quality and Safety Marker at a minimum of Level 3	Achieved	Not Achieved	Not Achieved	●																				
In 2024/25, Health NZ transitioned to regional reporting against the Consumer Engagement Quality and Safety Marker (QSM). Opportunities within the new regional structures were leveraged to enhance understanding of, and compliance with, the code of expectations. This included strengthening capability and supporting continuous improvement, as reflected in the QSM reporting. As at March 2025, none of the regions had self-assessed at level 3 (Involvement) or 4 (Partnership and Shared Leadership) in the QSM. <table><tr><th>Region</th><th>Responsiveness</th><th>Engagement</th><th>Experience</th></tr><tr><td>Central Te Ikaroa</td><td>Level 2 (Consultation)</td><td>Level 2 (Consultation)</td><td>Level 2 (Consultation)</td></tr><tr><td>Northern</td><td>Level 2 (Consultation)</td><td>Level 2 (Consultation)</td><td>Level 2 (Consultation)</td></tr><tr><td>Midland Te Manawa Taki</td><td>Level 2 (Consultation)</td><td>Level 2 (Consultation)</td><td>Level 2 (Consultation)</td></tr><tr><td>Southern Te Waipounamu</td><td>Level 2 (Consultation)</td><td>Level 1 (Minimal)</td><td>Level 2 (Consultation)</td></tr></table> Notes to the measure: a) The QSM is currently reported every six months. The next reporting period is April to September 2025 and should be submitted in October/November 2025. b) For more information please visit the HQSC website.						Region	Responsiveness	Engagement	Experience	Central Te Ikaroa	Level 2 (Consultation)	Level 2 (Consultation)	Level 2 (Consultation)	Northern	Level 2 (Consultation)	Level 2 (Consultation)	Level 2 (Consultation)	Midland Te Manawa Taki	Level 2 (Consultation)	Level 2 (Consultation)	Level 2 (Consultation)	Southern Te Waipounamu	Level 2 (Consultation)	Level 1 (Minimal)	Level 2 (Consultation)
Region	Responsiveness	Engagement	Experience																						
Central Te Ikaroa	Level 2 (Consultation)	Level 2 (Consultation)	Level 2 (Consultation)																						
Northern	Level 2 (Consultation)	Level 2 (Consultation)	Level 2 (Consultation)																						
Midland Te Manawa Taki	Level 2 (Consultation)	Level 2 (Consultation)	Level 2 (Consultation)																						
Southern Te Waipounamu	Level 2 (Consultation)	Level 1 (Minimal)	Level 2 (Consultation)																						

Output Measures

Ref	Measure	
P2-129	Total annual emissions	Results for these measures can all be found under Sustainability on page 204.
P2-130	Emissions profile	
P2-131	Change in total emissions	
P2-132	Staffing - full-time equivalents	
P2-133	Total expenditure HNZ	
P2-135	Progress towards 2025 and 2030 targets	
P2-136	Emissions Initiatives	
P2-238	Holiday's Act remediation commenced	Results for these two measures can be found under Holidays Act Remediation Programme on page 216.
P2-91	Holiday's Act remediation - current employee	
P2-87	Capital Investment benefits met	Results for this measure can be found under Our physical infrastructure on page 195

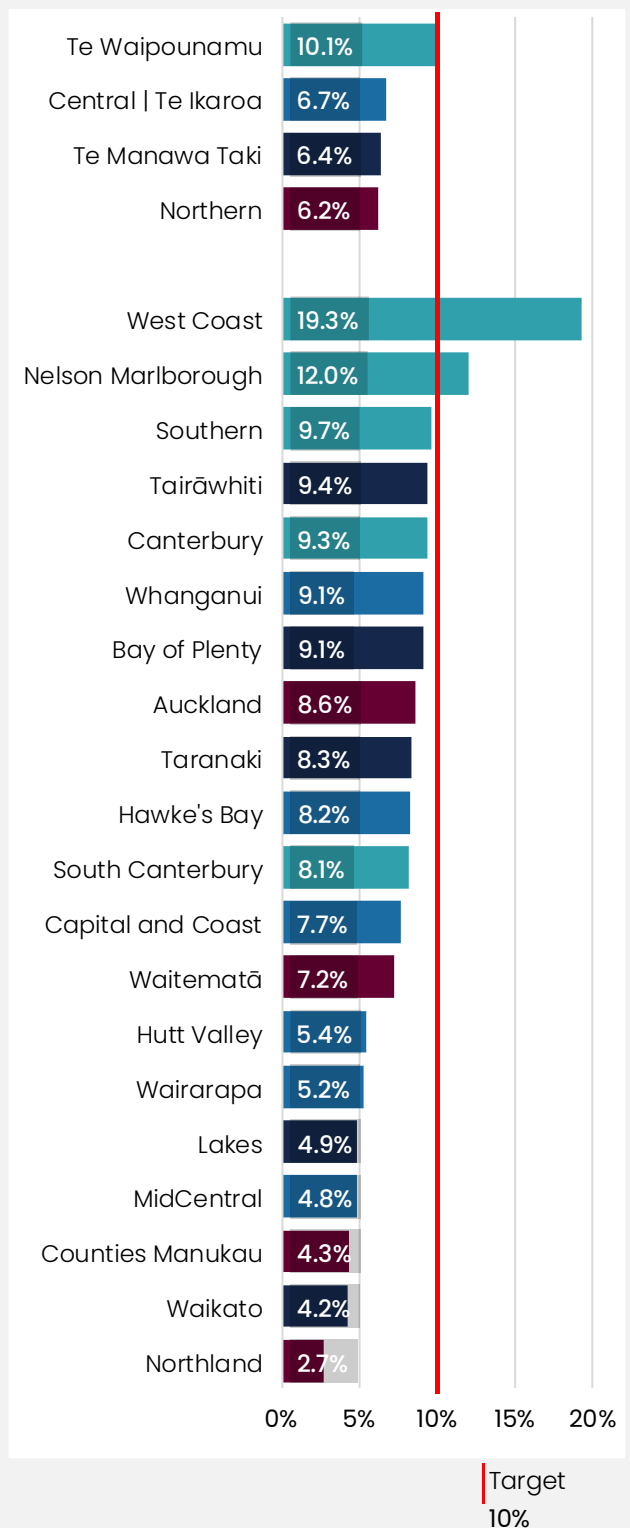


Longer-term trend (rolling 12-month period)



Te Waipounamu makes good use of this method of providing care, particularly for patients living in more rural and remote areas.

Results by Region and Districts



Ref	Measure																																																																					
P2-43	Number of planned care interventions delivered including: - Inpatient surgical discharges - Minor procedures - Non-surgical interventions	Desired Trend 																																																																				
Inpatient surgical discharges		Minor procedures																																																																				
<table><tr><th>Baseline</th><th>2023/24</th><th>2024/25</th></tr><tr><td>158,693</td><td>Result</td><td>Result</td></tr><tr><td>Overall</td><td>182,710</td><td>189,766 </td></tr><tr><td>Māori</td><td>28,927</td><td>30,739</td></tr><tr><td>Pacific</td><td>12,625</td><td>13,020</td></tr><tr><td>Asian</td><td>16,359</td><td>18,019</td></tr><tr><td>NM/NP/NA*</td><td>124,799</td><td>127,988</td></tr><tr><td>Northern</td><td>67,290</td><td>69,395</td></tr><tr><td>Te Manawa Taki</td><td>39,652</td><td>41,242</td></tr><tr><td>Central Te Ikaroa</td><td>37,820</td><td>38,366</td></tr><tr><td>Te Waipounamu</td><td>37,948</td><td>40,763</td></tr></table>		Baseline	2023/24	2024/25	158,693	Result	Result	Overall	182,710	189,766 	Māori	28,927	30,739	Pacific	12,625	13,020	Asian	16,359	18,019	NM/NP/NA*	124,799	127,988	Northern	67,290	69,395	Te Manawa Taki	39,652	41,242	Central Te Ikaroa	37,820	38,366	Te Waipounamu	37,948	40,763	<table><tr><th>Baseline</th><th>2023/24</th><th>2024/25</th></tr><tr><td>138,572</td><td>Result</td><td>Result</td></tr><tr><td>Overall</td><td>156,121</td><td>149,813 </td></tr><tr><td>Māori</td><td>10,969</td><td>11,480</td></tr><tr><td>Pacific</td><td>7,786</td><td>7,690</td></tr><tr><td>Asian</td><td>11,154</td><td>11,196</td></tr><tr><td>NM/NP/NA*</td><td>126,212</td><td>119,447</td></tr><tr><td>Northern</td><td>46,483</td><td>43,159</td></tr><tr><td>Te Manawa Taki</td><td>35,881</td><td>37,163</td></tr><tr><td>Central Te Ikaroa</td><td>31,795</td><td>31,777</td></tr><tr><td>Te Waipounamu</td><td>41,962</td><td>37,714</td></tr></table>			Baseline	2023/24	2024/25	138,572	Result	Result	Overall	156,121	149,813 	Māori	10,969	11,480	Pacific	7,786	7,690	Asian	11,154	11,196	NM/NP/NA*	126,212	119,447	Northern	46,483	43,159	Te Manawa Taki	35,881	37,163	Central Te Ikaroa	31,795	31,777	Te Waipounamu	41,962	37,714
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*Non-Māori, non-Pacific, non-Asian Target: Improve from baseline, trend to increase Baseline: July 2021 – June 2022		The data shows a positive trend, with improvements across all three areas compared to baseline. Inpatient surgical discharges have increased 19.5% from baseline, indicating improved access. 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. While minor procedures have fallen overall from last year, 2024/25 shows improved access for Māori (4.6%) and Asian peoples (0.3%) compared to previous year. Non-surgical interventions, decreased across all categories year on year but still exceed the baseline period. Notes to the measure: a) Results for 2023/24 have changed from previously reported values due to improvements in completeness and accuracy of national collections data. b) The SPE 2024/25 target of “Deliver in line with planned volumes” cannot be reported as we used case-weighted discharges (CWDs) as a basis for planning in 2024/25. CWDs cannot be mapped to the categories in this measure, so the previously reported 2021/22 baselines have been used.																																																																				
 Target Achieved		 Partially Achieved		 Not Achieved																																																																		
		(0.1–5% away from target)		(>5% away from target)																																																																		

Impact measures

Ref	Measure	Desired Trend 
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P2-170

Lower limb amputation hospitalisations, age-standardised per 100,000 ethnic specific population with diabetes

			2023/24	2024/25	
	Baseline	Target	Result	Result	
Overall	113	see below	126	114	
Māori	168		185	183	
Pacific	123		156	126	
NM/NP*	91		94	84	
Northern			111	99	
Te Manawa Taki			142	157	
Central Te Ikaroa			134	130	
Te Waipounamu			140	93	

*Non-Māori, non-Pacific, non-Asian

Target: Improve from baseline (trend to decrease)

Baseline: 2020/21 FY

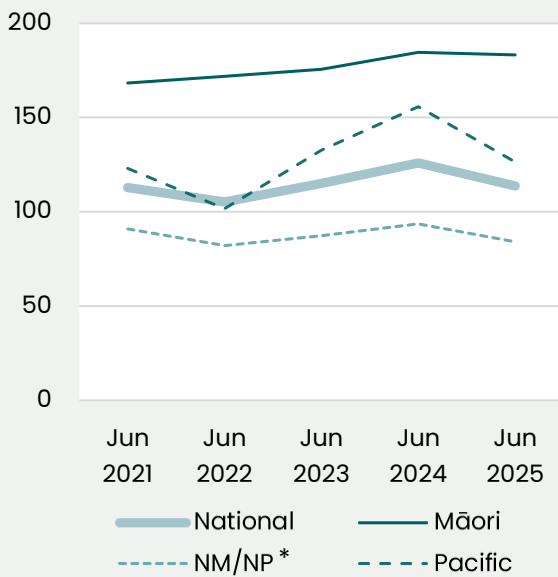
	Prioritised Ethnicity			Rurality**	
2024/25	Māori	Pacific	NM/NP*	Urban	Rural
Northern	181	111	61	96	135
Te Manawa Taki	281	89	119	141	204
Central Te Ikaroa	207	144	83	132	119
Te Waipounamu	75	100	95	101	62
All New Zealand	183	126	84	111	137

**Rurality status is unknown for 1,895 (0.54%) out of the 350,275 total eligible people with diabetes

 Target Achieved
  Partially Achieved
  Not Achieved
 (0.1–5% away from target) (>5% away from target)

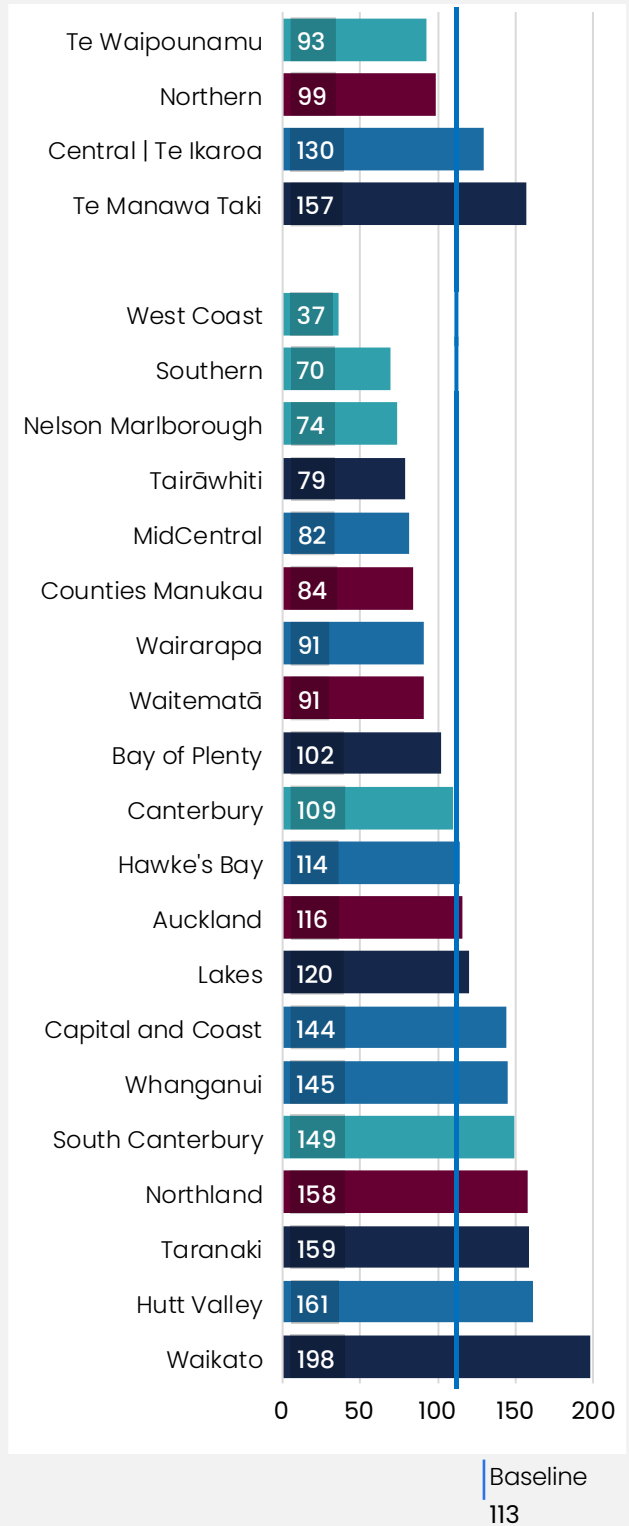
The age-standardised rates of hospitalisations for lower limb amputations for people with diabetes have varied around a relatively stable mean since the 2020/21 baseline for Pacific and non-Māori, non-Pacific groups, but increased for Māori. Māori and Pacific rates are higher than non-Māori, non-Pacific, especially the rate for Māori, and the disparities are increasing. Variance between urban and rural populations varies across regions.

Longer-term trend (rolling 12-month period)



Non-traumatic amputation is largely due to diabetes and is considered a marker of the quality of long-term diabetes care and management. Many lower-limb amputations are considered to be preventable through early detection, management of diabetes, supporting efforts to be smokefree, and timely interventions for foot ulcers and vascular issues.

Results by Region and Districts



Ref	Measure				
P2-196	Rate of renal failure hospitalisations, age-standardised per 100,000 people with diabetes				Desired Trend ↓
			2023/24	2024/25	
	Baseline	Target	Result	Result	
Overall	3,380	see below	2,546	2,422	●
Māori	5,374		3,817	3,761	●
Pacific	5,363		4,160	4,135	●
NM/NP*	2,317		1,767	1,580	●
Northern			2,588	3,026	●
Te Manawa Taki			2,948	2,465	●
Central Te Ikaroa			2,372	2,216	●
Te Waipounamu			2,162	1,725	●

*Non-Māori, Non-Pacific, Non-Asian

Target: Improve from baseline (trend to decrease)

Baseline: June 2022

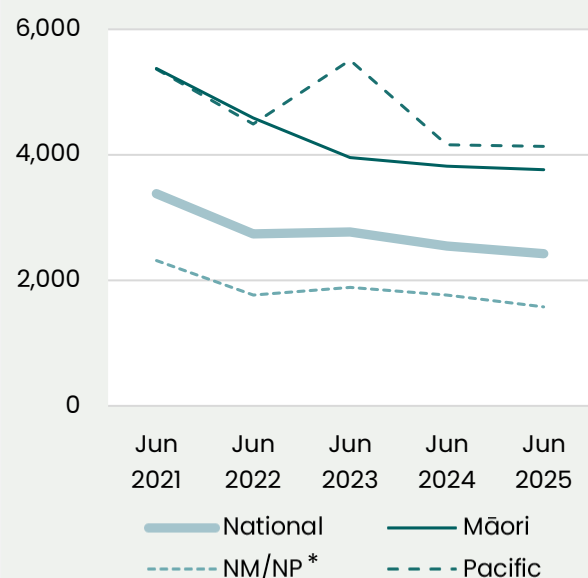
	Prioritised Ethnicity			Rurality**	
2024/25	Māori	Pacific	NM/NP*	Urban	Rural
Northern	4,722	4,065	1,908	3,072	2,512
Te Manawa Taki	3,664	5,520	1,556	2,369	2,813
Central Te Ikaroa	3,169	4,053	1,542	2,339	1,759
Te Waipounamu	2,575	3,202	1,498	1,856	1,358
All New Zealand	3,761	4,135	1,580	2,507	2,110

**Rurality status is unknown for 1,895 (0.54%) out of the 350,275 total eligible people with diabetes

● Target Achieved ● Partially Achieved ● Not Achieved
(0.1–5% away from target) (>5% away from target)

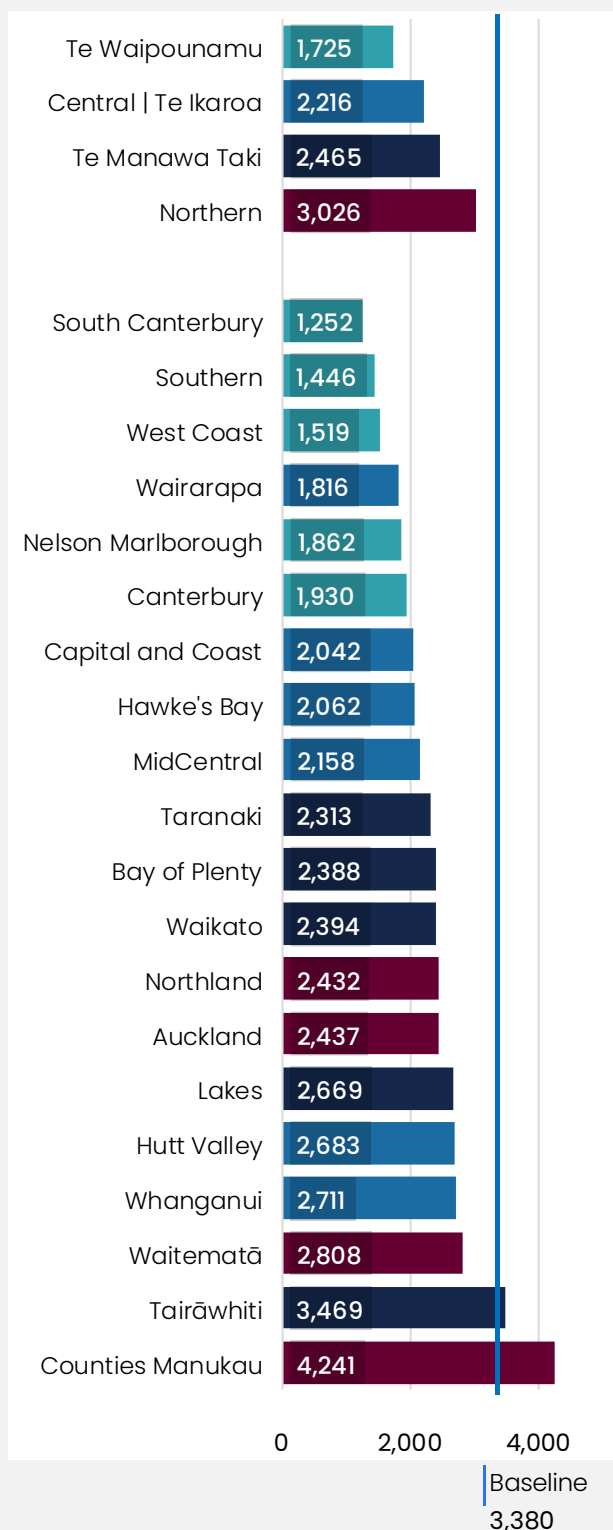
Renal failure hospitalisations are one element of a wider picture about the impact of renal disease in people living with diabetes. While the overall age-standardised rates of hospitalisations with renal failure for people with diabetes have reduced both over the last year and from the 2020/21 baseline, underlying trends in clinical markers of renal disease and patterns of need for dialysis remain of concern. Rates of renal failure hospitalisations in people with diabetes are substantially higher for Māori and Pacific Peoples compared with non-Māori, non-Pacific groups. Variance between regions, and urban and rural populations, likely reflects at least in part the differences in the ethnic mix of their communities.

Longer-term trend (rolling 12-month period)



Kidney disease in those with diabetes is a leading cause of end-stage renal disease in New Zealand. Preserving renal function in people with diabetes requires regular monitoring, management of risk factors, including blood sugar levels and blood pressure, and using medications that can slow the progression of kidney disease.

Results by Region and Districts



Ref Measure

P2-39



Percentage of patients who wait less than four months for a first specialist appointment

Desired Trend ↑

	2024/25 Milestone	2030 Target	2023/24 Result	2024/25 Result		Monthly for the last 24 months
Overall	62%	95%	63.4%	60.4%	●	67.3% → 62.0%
Northern			62.7%	62.4%	●	65.9% → 64.3%
Te Manawa Taki			59.2%	55.8%	●	64.1% → 59.8%
Central Te Ikaroa			71.5%	64.3%	●	75.5% → 65.7%
Te Waipounamu			62.6%	58.3%	●	66.5% → 56.7%

This measure is also in the Vote Health: Estimates /Supplementary Estimates 2024/25 with the same target.

● Target Achieved

● Partially Achieved

● Not Achieved

(0.1–5% away from target)

(>5% away from target)

Performance to the FSA health target deteriorated in 24/25 a year-on-year comparison with the previous year. This was, in large part, related to a deterioration in FSA delivery and performance in the third quarter, which resulted in total FSA waitlists, and the number of patients waiting more than four months peaking in early February 2025. Health target performance also reached its lowest point at this time.

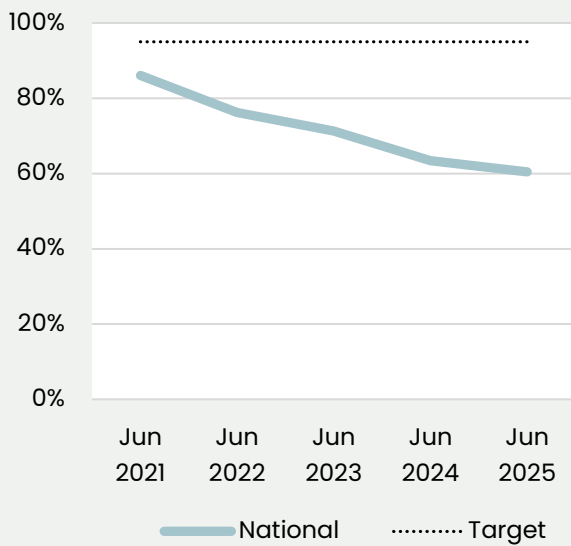
In response, Health NZ initiated a nationally integrated planned care programme, with the goal of ensuring that FSA delivery and target performance achieved the 62% improvement trajectory milestone by 30 June 2025.

Key activities within the programme included increasing delivery (ensuring clinics are fully booked, additional weekend and extended hours clinics), improving our booking performance with a focus on long waiters, releasing nationally consistent outpatient waitlist management guidelines for the first time, and validating our waitlists, with a particular focus on contacting all patients waiting more than four months for FSA.

As a result of these activities, the total FSA wait list reduced from a peak in early February of over 206,000 to 197,000 by the end of June 25, a 4.8% improvement. More importantly, the number of patients waiting more than four months for FSA reduced at a much faster rate. At the February peak, more than 88,000 patients were waiting more than four months. By the end of June, this had reduced to 73,000, a 17% improvement.

As the number waiting more than four months reduced at a faster rate than the total waitlist, health target performance improved consistently between February and June 25, such that Health NZ achieved the annual 24/25 milestone of 62% of patient waiting less than four months for an FSA on 30 June 2025.

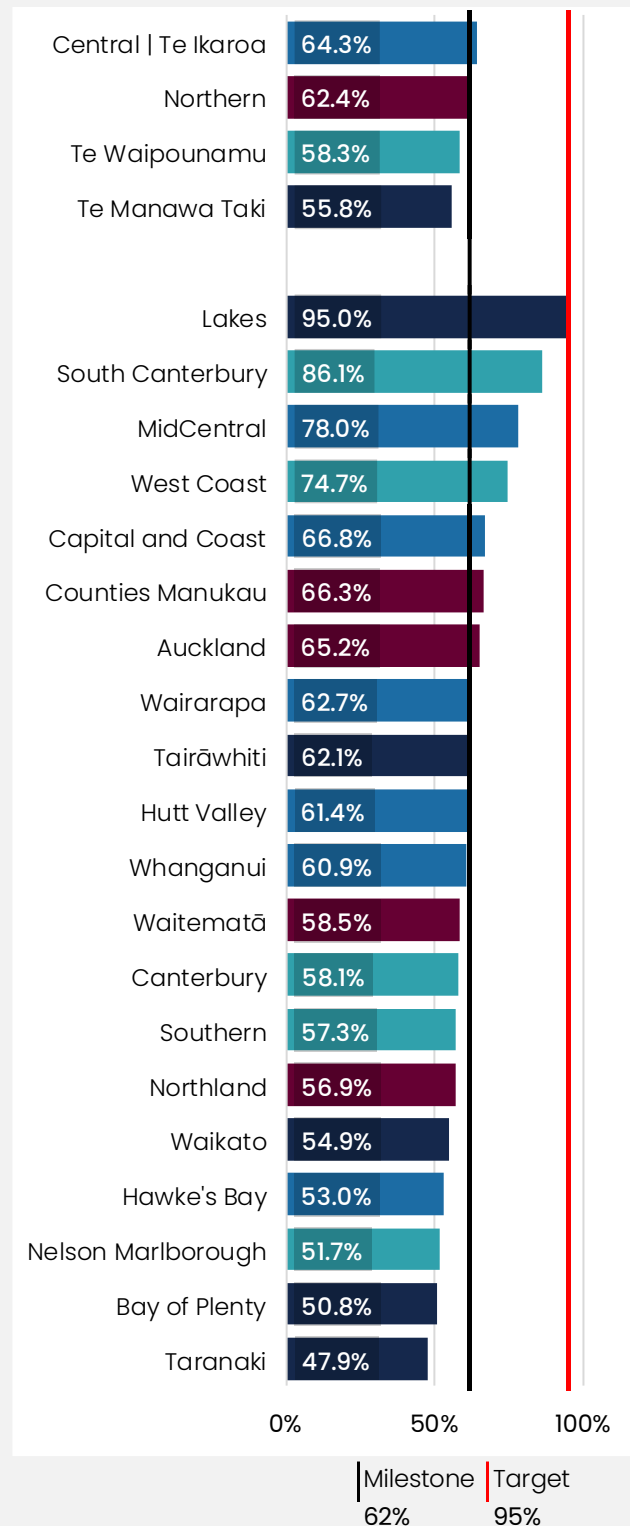
Longer-term trend (rolling 12-month period)



Notes to the measures:

- The data is not available at the patient level, so we are unable to report on ethnicity or rurality.
- The annual figure was calculated using 12 monthly snapshots of the number of people at the end of each month who had been waiting for less than four months (numerator) as a proportion of everyone waiting (denominator) and these results were used to create an annual average performance. These monthly figures may include the same person through several months from referral to first specialist appointment. Due to the fact the data is not available at a patient level (as per note a above) we are unable to determine who was seen within 4 months out of the total waitlist during the year.
- Measurement of the result and red/amber/green rating is against the 2024/25 milestone.
- To be included on a waiting list an individual has to be accepted for a specialist appointment but not yet seen by a specialist. The measure counts, on a monthly basis, every person on a waitlist for less than four months as a proportion of every person on a waitlist on the last day of each month.
- Referrals made but not accepted are excluded from the measure. Referrals may be rejected as the wrong service has been selected or the specialist is unable to perform the service requested.

Results by Region and Districts



Ref Measure

P2-40



Percentage of patients who wait less than four months for elective treatment

Desired Trend ↑

	2024/25 Milestone	2030 Target	2023/24 Result	2024/25 Result		Monthly for the last 24 months
Overall	63%	95%	62.2%	60.9%	●	61.9% → 63.9%
Māori			60.1%	59.2%	●	60.2% → 62.7%
Pacific			60.8%	54.5%	●	62.7% → 55.4%
Asian			63.5%	58.6%	●	65.0% → 61.4%
NM/NP/NA*			62.7%	62.6%	●	61.9% → 65.8%
Northern			63.2%	57.0%	●	64.1% → 59.3%
Te Manawa Taki			62.0%	66.3%	●	59.5% → 69.3%
Central Te Ikaroa			66.2%	65.1%	●	65.6% → 69.4%
Te Waipounamu			57.1%	60.0%	●	57.7% → 63.3%

*Non-Māori, non-Pacific, non-Asian

This measure is also in the Vote Health: Estimates 2024/25/Supplementary Estimates 2024/25 with the same target.

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	54.7%	52.2%	55.7%	59.7%	57.1%	55.9%
Te Manawa Taki	63.5%	65.9%	68.0%	67.2%	66.4%	66.0%
Central Te Ikaroa	61.9%	62.6%	65.5%	66.2%	64.4%	68.0%
Te Waipounamu	57.9%	59.5%	61.9%	60.2%	60.2%	59.5%
All New Zealand	59.2%	54.5%	58.6%	62.6%	60.6%	61.9%

**Rurality status is unknown for 672 (0.06%) out of a total of 1,191,988 elective treatment patients on waitlist.

● Target Achieved

● Partially Achieved

● Not Achieved

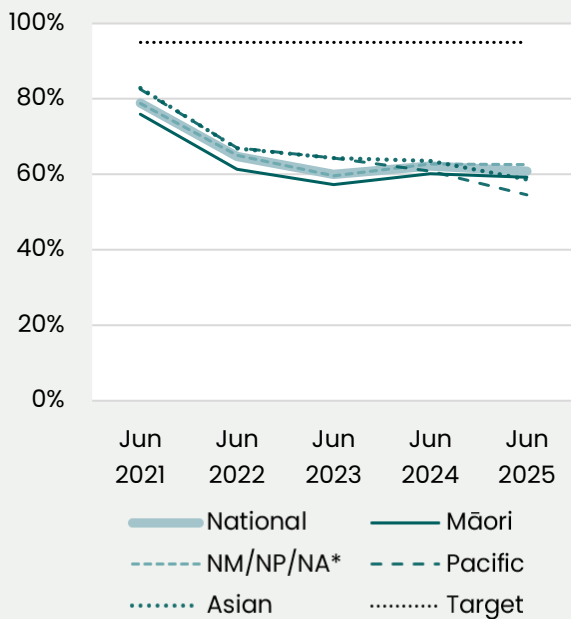
(0.1–5% away from target)

(>5% away from target)

Performance to the elective treatment health target deteriorated in 24/25 in a year-on-year comparison with the previous year. This was, in large part, related to a deterioration in internal and outsourced delivery and performance in the third quarter, which resulted in total treatment waitlists, and the number of patients waiting more than four months, peaking in early February 2025. Health target performance also reached its lowest point at this time.

In response, Health NZ launched the Electives Boost in late February 25, with the goal of providing an additional 10,579 outsourced procedures, targeted to long-waiting patients as a priority, by 30 June 25.

Longer-term trend (rolling 12-month period)



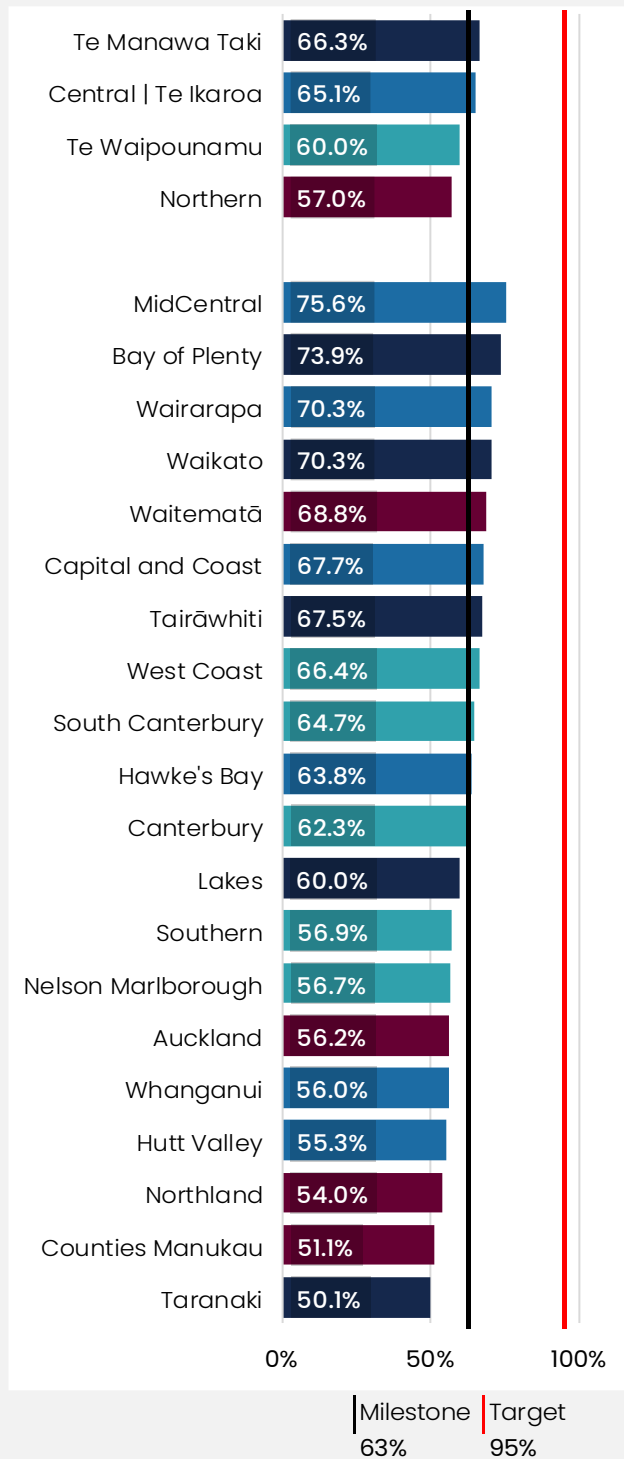
Alongside this Health NZ also put significant focus on improving booking performance – treating the right patients in the right order, improving internal theatre productivity and theatre list scheduling and validating our waitlists by contacting patients waiting longer than four months for surgery.

Delivery through the Electives Boost exceeded expectations, with over 16,000 additional outsourced treatments provided. As the focus for the Boost was on long-waiting patients, this supported the significant reduction in long waiters, and a corresponding improvement in health target performance. Health NZ exceeded the 24/25 target improvement trajectory milestone of 63% by 30 June, reaching 63.9% of patients waiting less than four months for elective treatment (page 25).

Notes to the measures:

- The annual figure was calculated using 12 monthly snapshots of the number of people at the end of each month who had been waiting for less than four months (numerator) as a proportion of everyone waiting (denominator) and these results were used to create an annual average performance. These monthly figures may include the same person through several months from referral to receiving treatment. Due to the fact the data is not available at a patient level (as per note a above) we are unable to determine who was treated within 4 months out of the total waitlist during the year.
- Measurement of the result and red/amber/green rating is against the 2024/25 milestone.
- To be included on a waiting list an individual has to be accepted for treatment, but not been treated. The measure counts, on a monthly basis, every person on a waitlist for less than four months as a proportion of every person on a waitlist on the last day of each month. Referrals made but not accepted are excluded from the measure.

Results by Region and Districts



Ref	Measure	
P2-41	Rate of acute bed nights spent in hospital per 1,000 population	Desired Trend 

			2023/24	2024/25				
	Baseline	Target	Result	Result		Yearly for the last 3 years		
Overall	429	see below	455	439		458		439
Māori	415		651	642		633		642
Pacific	484		789	750		743		750
Asian	428		283	259		285		259
NM/NP/NA*	428		426	411		433		411
Northern			497	480		493		480
Te Manawa Taki			470	454		486		454
Central Te Ikaroa			439	427		432		427
Te Waipounamu			397	381		408		381

*Non-Māori, Non-Pacific, Non-Asian

Target: Decrease from baseline

Baseline: 2022/23 FY

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	689	850	278	460	485	449
Te Manawa Taki	658	552	237	407	458	443
Central Te Ikaroa	612	584	212	406	423	444
Te Waipounamu	546	427	208	373	402	329
All New Zealand	642	750	259	411	449	405

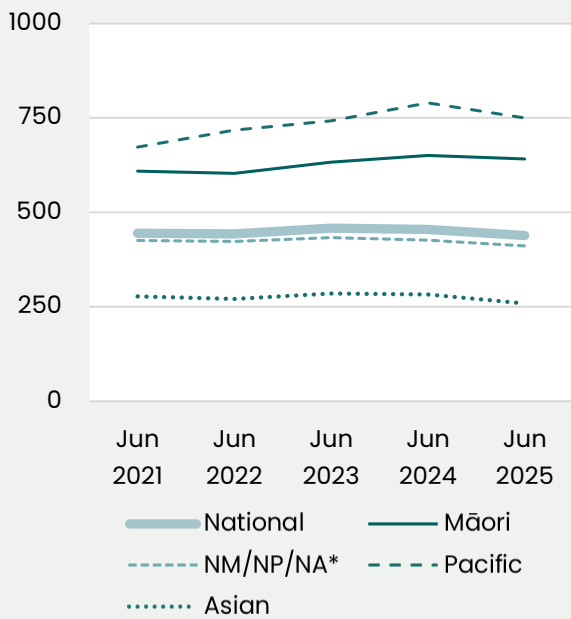
**Rurality status is unknown for 360 (0.01%) out of the 5,379,040 total eligible population

 Target Achieved
  Partially Achieved (0.1-5% away from target)
  Not Achieved (>5% away from target)

Acute bed days are the number of days a person spends in hospital, following an acute admission. The acute bed days rate is presented as the number of bed days for acute hospital stays per 1,000 population, age standardised.

This measure is intended to reflect demand for acute inpatient services on the health system. Nationally, the number of acute bed days per 1,000 population decreased from 455 in the 23/24 financial year to 439 in the 24/25 financial year.

Longer-term trend (rolling 12-month period)



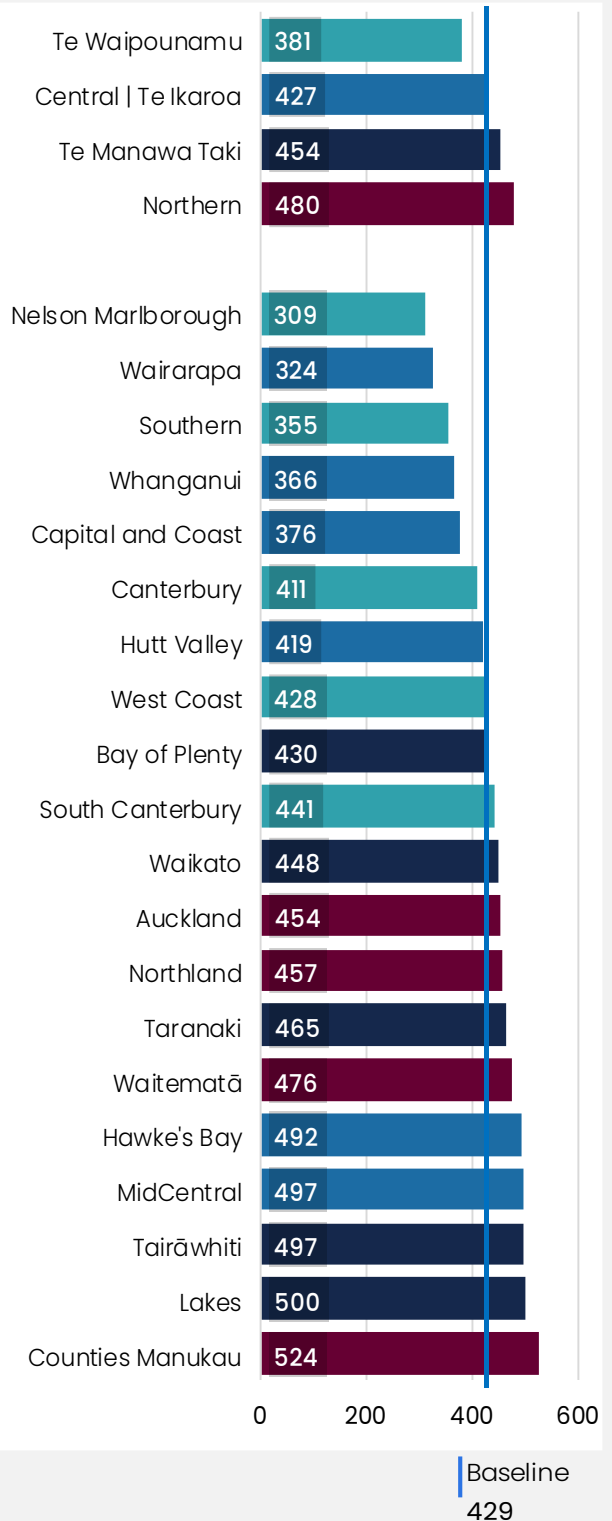
Hospital flow programmes continue to focus on reducing delays in discharge and moving patients through the system in a timely way.

The capacity and availability of services in the community, including primary care and aged residential care, are important to prevent the need for extended acute hospital stays.

Notes to the measure:

- a) For information on the methodology, please refer to Accountability Performance Measures Specifications September 2025.

Results by Region and Districts



Measure

P2-44

Inpatients – the percentage of patients who reported they were involved as much as they wanted to be in making decisions about their treatment and care

Desired Trend 

	Baseline	Target	2023/24 Result	2024/25 Result		Quarterly for the last 8 quarters	
Overall	81.8%	see below	81.5%	82.3%		81.2%	 82.8%
Māori	80.4%		80.2%	81.0%		78.2%	 82.3%
Pacific	85.9%		83.8%	87.6%		86.9%	 86.2%
Asian	88.7%		87.6%	89.4%		85.1%	 87.0%
NM/NP/NA*	81.1%		81.0%	81.3%		81.2%	 82.1%
Northern			80.7%	82.2%		80.0...	 82.8%
Te Manawa Taki			80.8%	80.3%		78.3%	 81.5%
Central Te Ikaroa			82.7%	82.5%		84.2%	 81.8%
Te Waipounamu			82.4%	84.9%		83.6...	 85.0%

*Non-Māori, Non-Pacific, Non-Asian

Target: Maintain Baseline**Baseline:** 2022/23 FY

Prioritised Ethnicity

2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	80.9%	87.7%	87.3%	79.7%
Te Manawa Taki	79.1%	87.7%	90.8%	79.6%
Central Te Ikaroa	82.4%	86.1%	92.3%	81.6%
Te Waipounamu	85.7%	90.2%	94.3%	84.3%
All New Zealand	81.0%	87.6%	89.4%	81.3%

 Target Achieved Partially Achieved

(0.1–5% away from target)

 Not Achieved

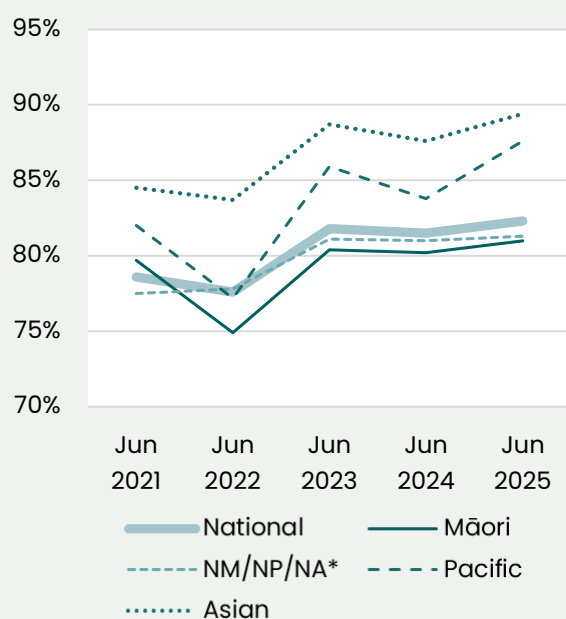
(>5% away from target)

The percentage of patients who reported they were involved as much as they wanted to be in making decisions about their treatment and care has increased in the last year.

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.

Longer-term trend (rolling 12-month period)

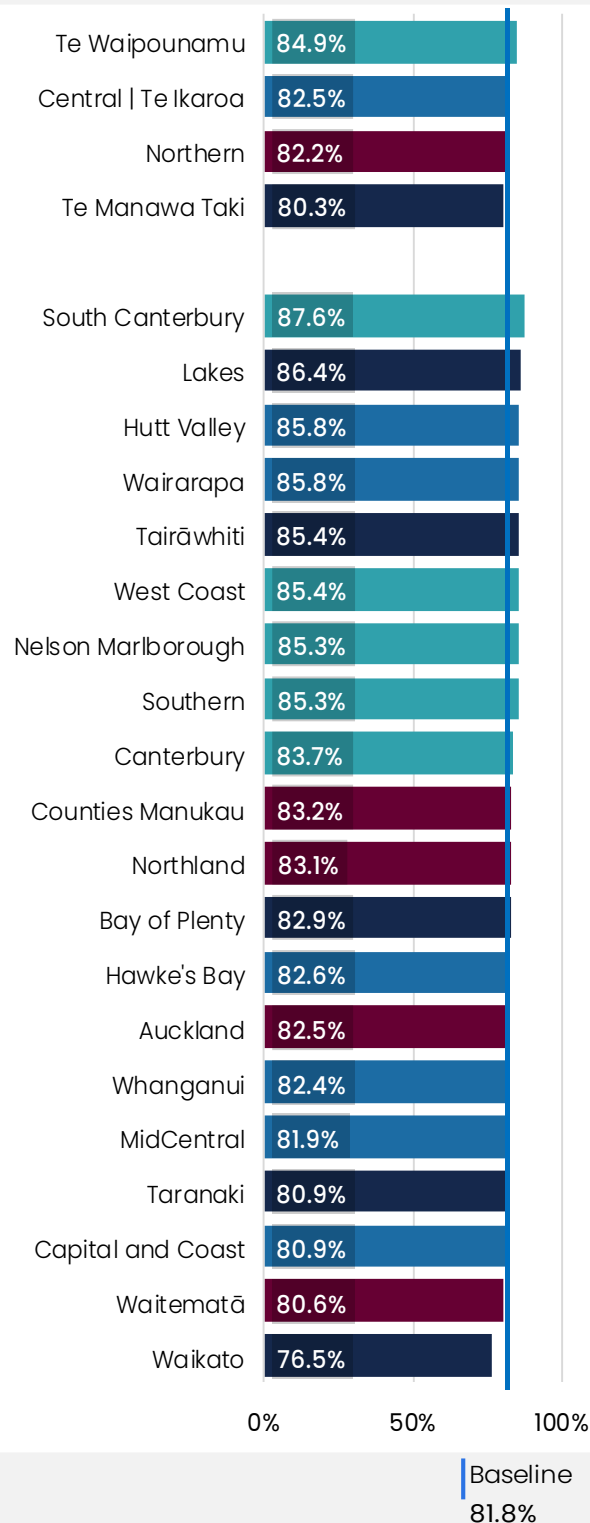


When comparing the current reporting period with the previous annual reporting period, a similar pattern emerges. Asian patients and whānau report the highest involvement, while Māori report lower involvement.

Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- Further details on the survey methodology can be found at: www.hqsc.govt.nz/our-data/patient-reported-measures.

Results by Region and Districts



Ref Measure

P2-45



Percentage of patients admitted, discharged or transferred from an emergency department within six hours

Desired Trend

	2024/25 Milestone	2030 Target	2023/24 Result	2024/25 Result		Quarterly for the last 8 quarters
Overall	74%	95%	69.7%	72.0%		67.6% 73.9%
Māori			74.1%	75.8%		71.6% 77.8%
Pacific			68.1%	69.6%		65.0% 71.3%
Asian			72.3%	74.0%		69.8% 76.2%
NM/NP/NA*			67.8%	70.4%		66.0% 72.4%
Northern			69.2%	70.6%		65.0% 72.5%
Te Manawa Taki			73.3%	74.7%		71.4% 76.8%
Central Te Ikaroa			58.4%	61.7%		55.1% 65.3%
Te Waipounamu			74.6%	77.9%		75.6% 78.9%

*Non-Māori, Non-Pacific, Non-Asian

This measure is in the Vote Health: Supplementary Estimates 2024/25. The target and result are the same.

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	74.9%	68.2%	72.8%	68.6%	69.1%	82.0%
Te Manawa Taki	79.0%	77.9%	76.7%	71.7%	72.1%	79.4%
Central Te Ikaroa	67.5%	62.2%	64.3%	59.0%	62.3%	58.2%
Te Waipounamu	79.7%	79.5%	82.0%	77.0%	76.4%	81.5%
All New Zealand	75.8%	69.6%	74.0%	70.4%	70.2%	77.7%

**Rurality status is unknown for 10,470 (0.78%) out of the 1,341,270 total eligible patients presented at an emergency department

Target Achieved

Partially Achieved

Not Achieved

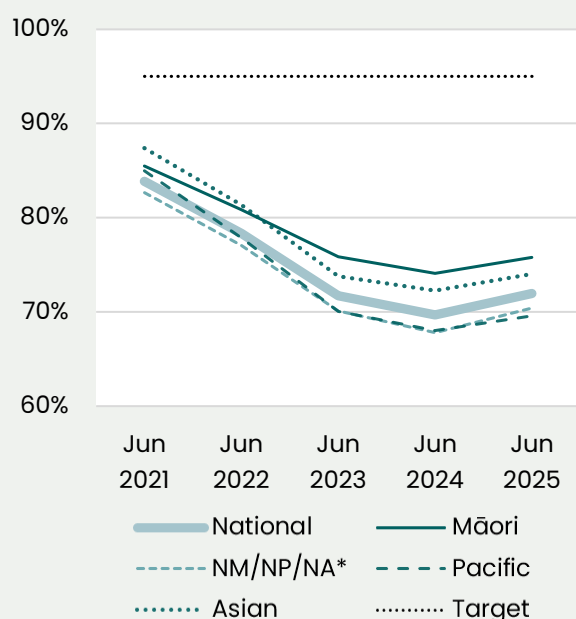
(0.1-5% away from target)

(>5% away from target)

People admitted, discharged or transferred from an ED within 6 hours is 72.0%, an improvement on the 2.3% from last year. Total performance remains below 2024/25 milestone of 74% and below 2030 target of 95%. However, the milestone was achieved for Māori and Asian populations nationally and for the Midlands | Te Manawa Taki and South Island | Te Waipounamu regions.

Improvement has been seen across all areas as Health Target implementation plans continue to be rolled out and championed by our clinical staff.

Longer-term trend (rolling 12-month period)



The traditional 'dip' in performance was observed in Q1, reflecting the change in presentation types with more viral illness in winter driving more acute medical admissions. Hospital performance is also impacted by staffing levels, with staff illness over winter another important factor in performance.

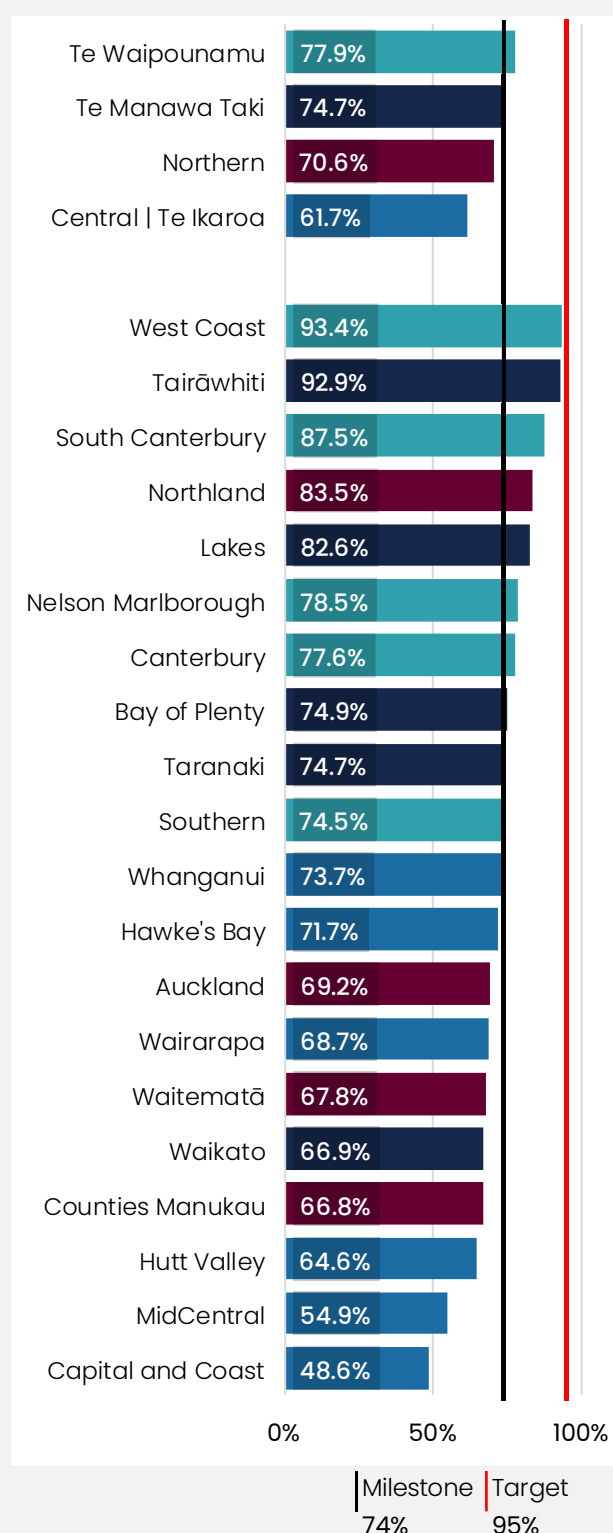
By ethnicity, all groups have improved in 24/25 compared to the previous year. Notably, Māori and Asian achieved the milestone target. All ethnicities demonstrated an improvement >6% during the 24/25 year through to end of quarter 4.

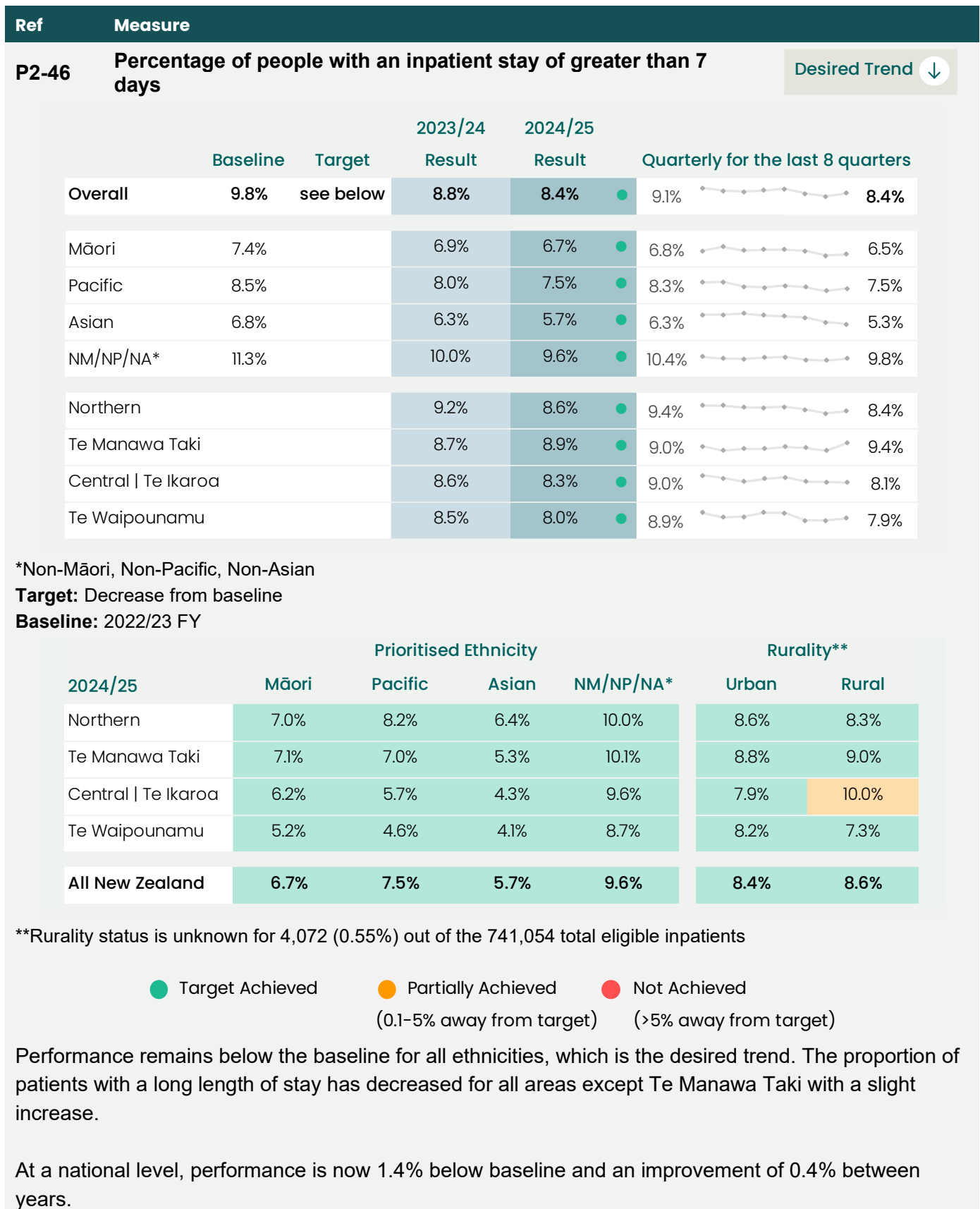
Based on the performance average over the year, there was a 3.3% improvement for Central and Te Waipounamu when compared to the 2023/24.

Notes to the measure:

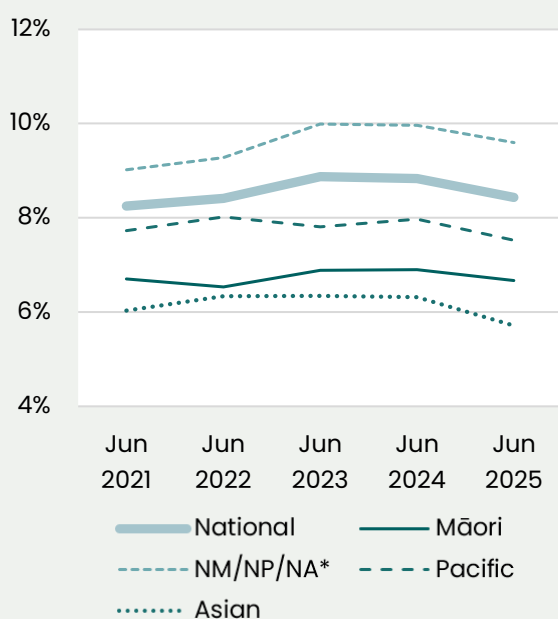
- This result is a 12-month rolling average of performance to 30 June 2025 and differs from the Quarter 4 result on page 25.
- Measurement of the result and red/amber/green rating is against the 2024/25 milestone.
- This measures the time from first contact between a patient and triage nurse/clerical staff within ED (whichever comes first) and either (1) admission to an inpatient ward (including ED observation units or inpatient assessment units) (2) discharge to the community, or (3) transfer to another facility outside of the ED.

Results by Region and Districts





Longer-term trend (rolling 12-month period)



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.

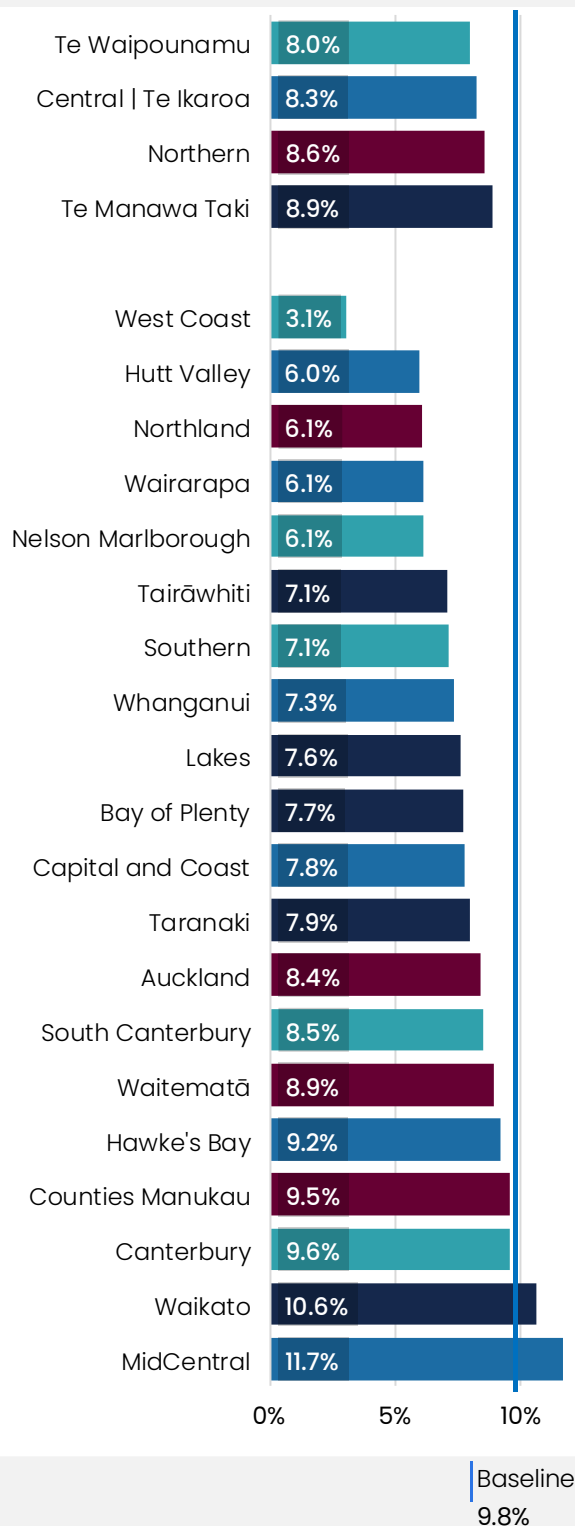
Health NZ is working across the system to put plans in place to keep people well at home and ensure safe and timely discharge following a hospital admission.

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) For information on the methodology, please refer to Accountability Performance Measures Specifications.

Results by Region and Districts



Ref Measure

P2-51



Percentage of patients receive cancer management within 31 days of the decision to treat

Desired Trend ↑

	2024/25 Milestone	2030 Target	2023/24 Result	2024/25 Result		Quarterly for the last 8 quarters
Overall	86%	90%	84.2%	85.7%	●	85.1% 86.3%
Māori			84.6%	87.3%	●	85.9% 86.9%
Pacific			80.3%	82.6%	●	79.2% 82.0%
Asian			83.5%	85.5%	●	81.8% 88.5%
NM/NP/NA*			84.5%	85.7%	●	85.7% 86.3%
Northern			83.5%	85.6%	●	83.7% 85.1%
Te Manawa Taki			83.9%	85.9%	●	85.7% 92.4%
Central Te Ikaroa			84.6%	86.8%	●	84.1% 86.0%
Te Waipounamu			85.2%	84.7%	●	87.3% 83.7%

*Non-Māori, Non-Pacific, Non-Asian

This measure is in the Vote Health: Supplementary Estimates 2024/25. The target and result are the same

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	86.8%	81.0%	85.0%	86.4%	85.4%	86.5%
Te Manawa Taki	88.3%	89.4%	80.2%	85.4%	86.8%	84.1%
Central Te Ikaroa	87.1%	84.7%	88.6%	86.8%	86.8%	87.0%
Te Waipounamu	86.5%	89.0%	89.3%	84.3%	84.8%	84.6%
All New Zealand	87.3%	82.6%	85.5%	85.7%	85.8%	85.4%

**Rurality status is unknown for 15 (0.08%) out of the 19,359 total eligible cancer patients with a health professional's decision to treat

● Target Achieved

● Partially Achieved

● Not Achieved

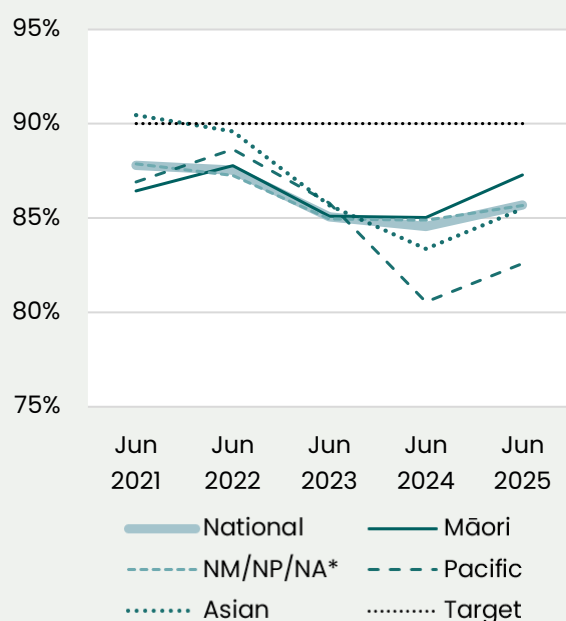
(0.1-5% away from target)

(>5% away from target)

Performance to the 31-day Faster Access to Treatment (FCT) health target has improved through FY 24/25. Based on performance averaged over the year, there was a 1.5% improvement compared to 23/24, with performance nationally just below the 24/25 milestone of 86%.

Performance by quarter shows that FCT performance has been making steady improvements through the year, and Health NZ achieved 86.3% at the end of the fourth quarter.

Longer-term trend (rolling 12-month period)



By ethnicity, all groups improved in 24/25 compared to the previous year. Notably, Māori have made the most significant improvement this year and were the best-performing ethnic group in all regions.

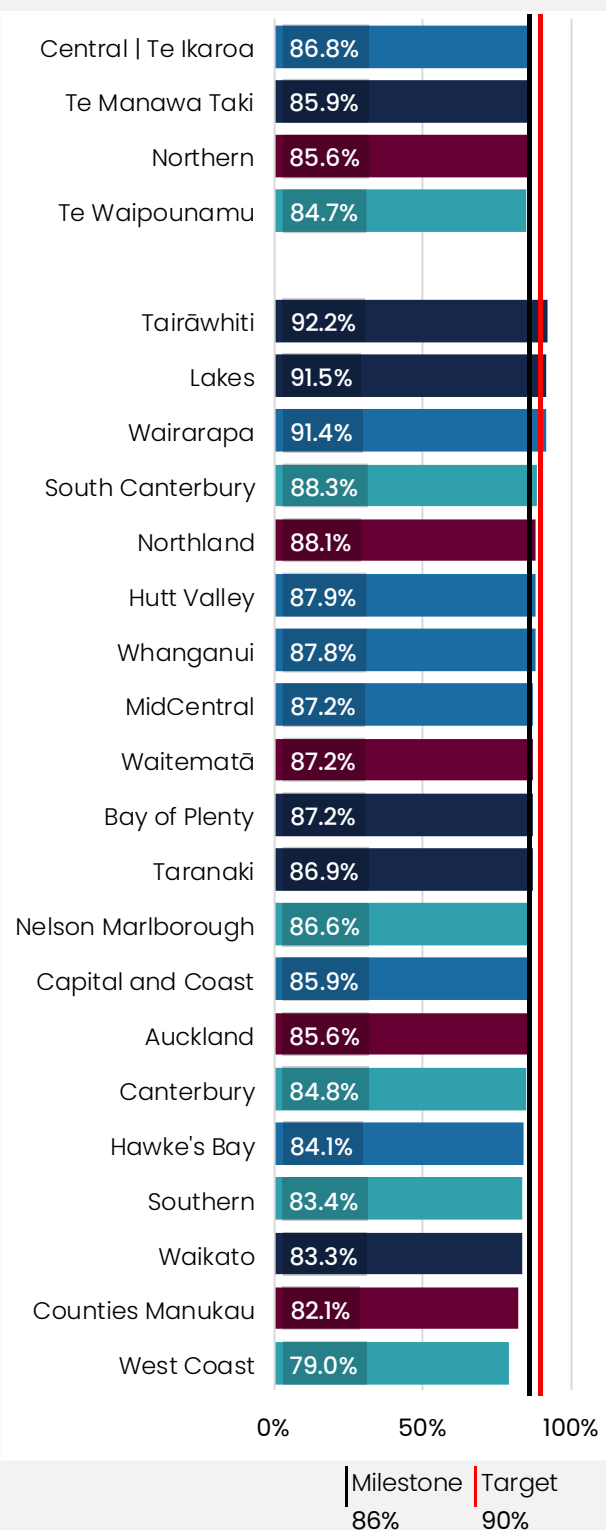
Regionally, the most significant progress was in the Te Manawa Taki region which achieved 92.4% in quarter four.

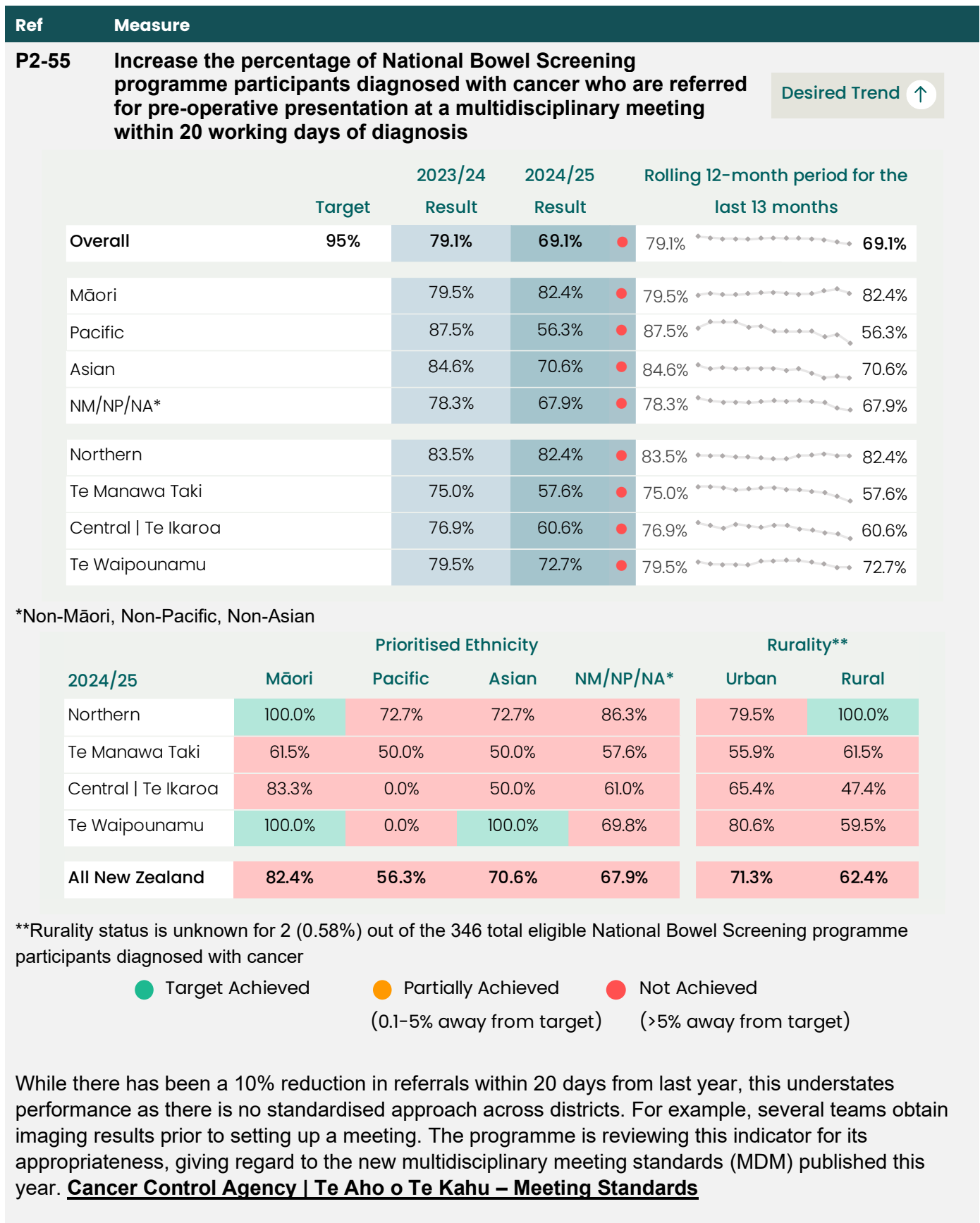
The region has established a forward-looking patient tracking approach and identifies potential breaches for immediate action at 20 days. District and regional cancer teams coordinate with surgical bookers and other support, including patient navigation and assistance, to ensure that patients receive treatment within 31 days. This means that more patients are getting access to the care they need faster. Following the success of this approach in Te Manawa Taki, it will be rolled out to all regions in 25/26.

Notes to the measure:

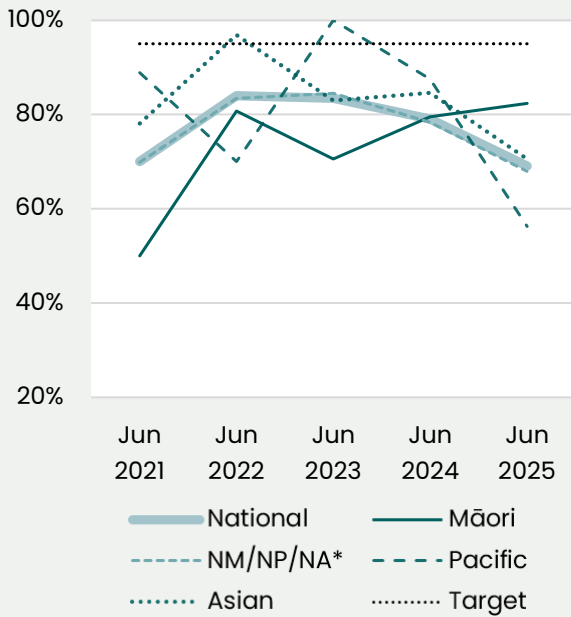
- This result is a 12-month rolling average of performance to June 30, 2025, and differs from the Quarter 4 result on page 25
- Measurement of the result and red/amber/green rating is against the 2024/25 milestone.
- 31 days is the maximum length of time a patient should wait from the decision to treat date to receiving first treatment (or other management) for cancer.
- The 31-day indicator includes all patients who received their first treatment irrespective of how they were referred. Decision-to-treat is the date on which the treatment plan was agreed between the patient and the clinician responsible for treatment. It does not include patients who have been waiting over 31 days but have yet to receive their first treatment.

Results by Region and Districts





Longer-term trend (rolling 12-month period)

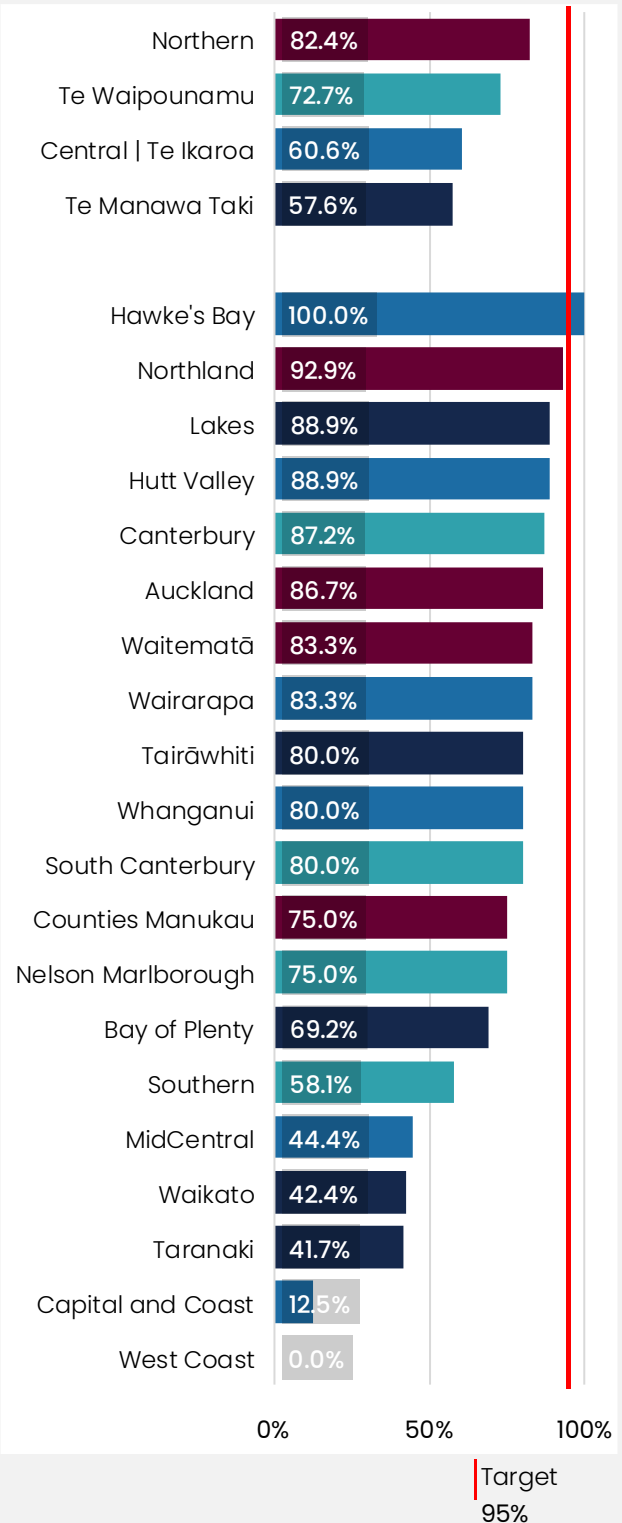


Performance against this measure has declined over the last year. Some district and regional differences are due to processes adapted for local clinical needs e.g. waiting for staging imaging to be completed prior to presentation at the MDM. As many cancers diagnosed in the screening programme are earlier stage, when there is pressure on the number of cases requiring MDM discussion, clinical prioritisation is required and where considered appropriate, MDM discussion is deferred until post-surgery. MDMs are an important quality process and while the timeliness standard is not currently met, the NBSP is satisfied that all cases are discussed. We note the 2024 Standard for high-quality cancer MDMs in New Zealand does not have a timeliness component for when cases are discussed.

Notes to the measure:

a) Results for 2023/24 have changed from previously reported values due to improvements in completeness and accuracy of national collections data.

Results by Region and Districts



Ref	Measure	
P2-56	Percentage of cardiac patients waiting >120 days for treatment	Desired Trend ↓

	2023/24	2024/25		Monthly for the last 24 months
	Target	Result		
Overall	25%	16.9%	26.7%	19.2% 26.0%
Māori		18.6%	34.8%	17.1% 25.9%
Pacific		16.7%	43.4%	3.4% 46.8%
Asian		13.0%	31.3%	0.0% 30.6%
NM/NP/NA*		17.1%	19.5%	22.5% 19.9%
Northern		11.8%	32.6%	2.7% 34.6%
Te Manawa Taki		27.4%	23.9%	35.9% 0.0%
Central Te Ikaroa		18.6%	26.7%	20.0... 12.1%
Te Waipounamu		14.3%	9.1%	27.5% 16.3%

*Non-Māori, Non-Pacific, Non-Asian

In the Vote Health: Supplementary Estimates 2024/25 this measure was updated to focus on <120 days and was given a target of 75% to bring it into line with the planned care health targets. It is partially achieved.

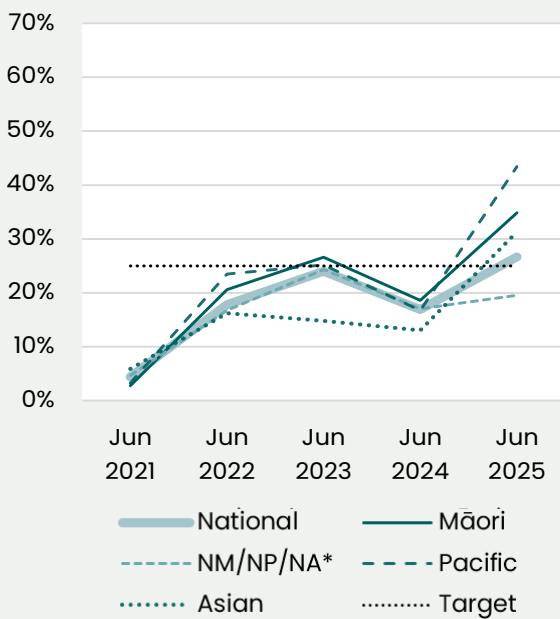
	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	44.4%	43.5%	33.4%	22.5%	33.8%	24.9%
Te Manawa Taki	26.3%	44.4%	25.0%	22.3%	24.5%	22.9%
Central Te Ikaroa	27.0%	47.4%	27.5%	24.4%	29.4%	14.4%
Te Waipounamu	6.7%	33.3%	0.0%	8.3%	9.4%	8.7%
All New Zealand	34.8%	43.4%	31.3%	19.5%	28.9%	17.9%

** Rurality status is unknown for 11 (0.22%) out of a total of 4,963 cardiac patients on waitlist.

● Target Achieved
 ● Partially Achieved (0.1-5% away from target)
 ● Not Achieved (>5% away from target)

The percentage waiting less than four months for the 2024/25 financial year has seen a 9.8% increase compared to 2023/24. Throughout the year the five districts have focused on long waiting patients where possible. The decrease is a result of the continual growth in demand in 2024/25 (approx.+5%) in conjunction with the factors listed below.

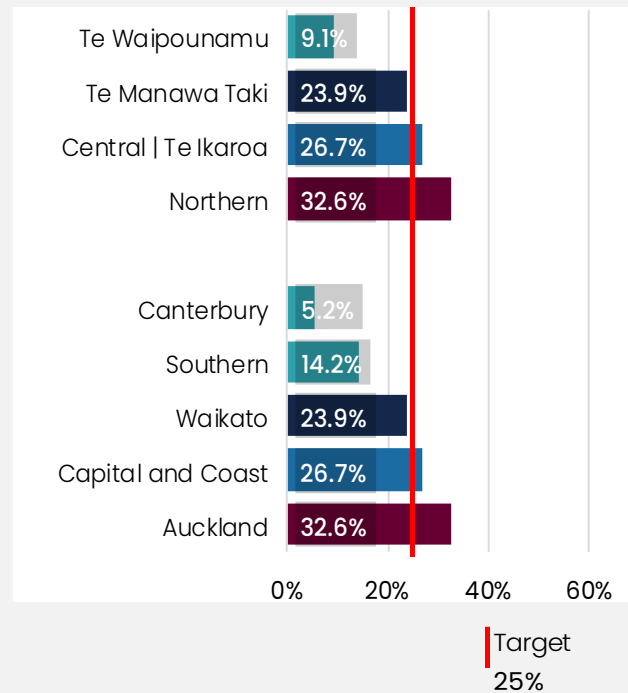
Longer-term trend (rolling 12-month period)



Over the last seven years, nationally cardiac surgery waiting lists have grown beyond a level where they can be managed within a patient's clinically 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.

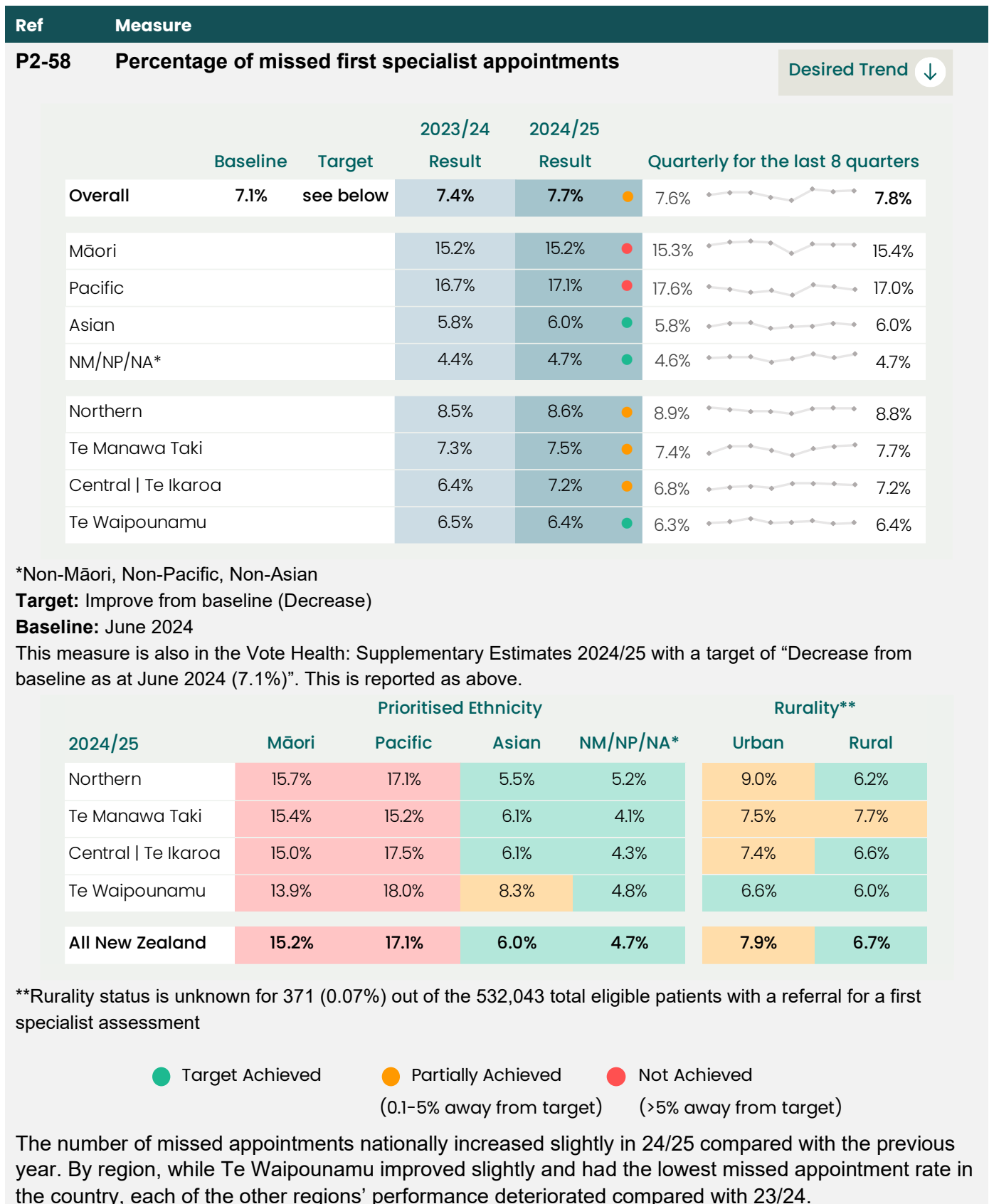
When possible, a concentrated effort to address patients waiting over 120 days and applying an equity lens across ethnicities continues to be undertaken by the five public hospitals providing cardiac surgery. These are Dunedin Public Hospital, Christchurch Public Hospital, Wellington Regional Hospital, Waikato Hospital and Auckland City Hospital

Results by Region and Districts

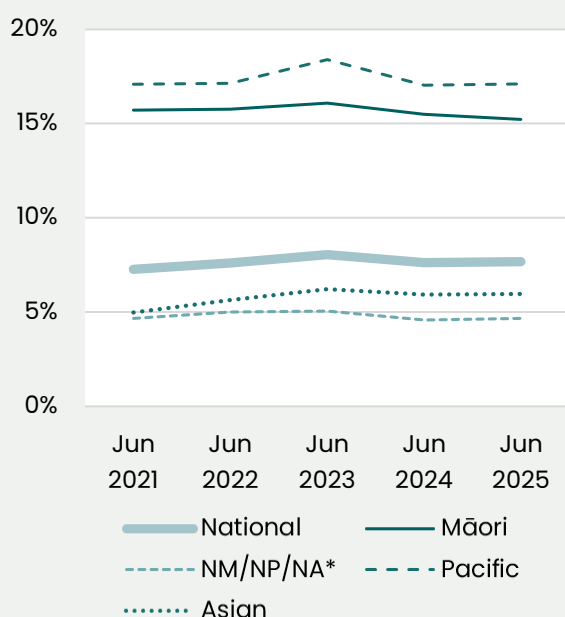


Notes to the measure:

- The annual figure was calculated using 12 monthly snapshots of the number of people at the end of each month who had been waiting for longer than four months (numerator) as a proportion of everyone waiting (denominator) and these results were used to create an annual average performance. These monthly figures may include the same person through several months from referral to receiving treatment.
- Results for 2023/24 have changed from previously reported values due to improvements in completeness and accuracy of national collections data.
- To be included on a waiting list an individual has to be accepted for treatment, but not been treated. The measure counts, on a monthly basis, every person on a waitlist for longer than four months as a proportion of every person on a waitlist on the last day of each month. Referrals made but not accepted are excluded from the measure. This measure excludes all patients under the age of 16.



Longer-term trend (rolling 12-month period)



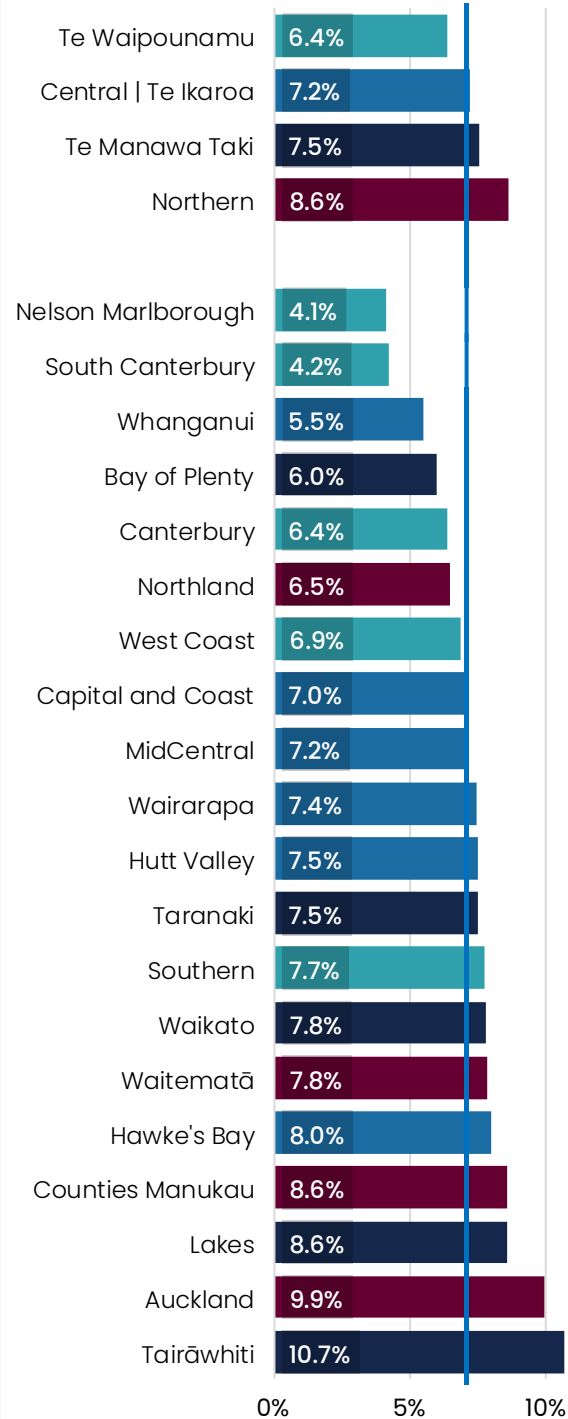
Notably, significant differences in missed appointment rates for Māori and Pacific peoples, are of concern. Māori missed appointment rates have remained static, while rates for Pacific peoples have increased slightly in 24/25. This pattern is noted across each region.

Health NZ is committed to reducing missed appointments and providing care that is accessible for all. Our regions are working to reduce this rate and increase support for patients to attend appointments. Health NZ is also working to bring care closer to home or delivered in more convenient ways, such as by telehealth, or for example, by mobile surgical services which provide Dental and other services to patients in more rural areas or areas of higher deprivation around the country. This year Health NZ also launched initiatives such as a mobile Ear, Nose and Throat service in the Northern region to take care to communities where the need is greatest.

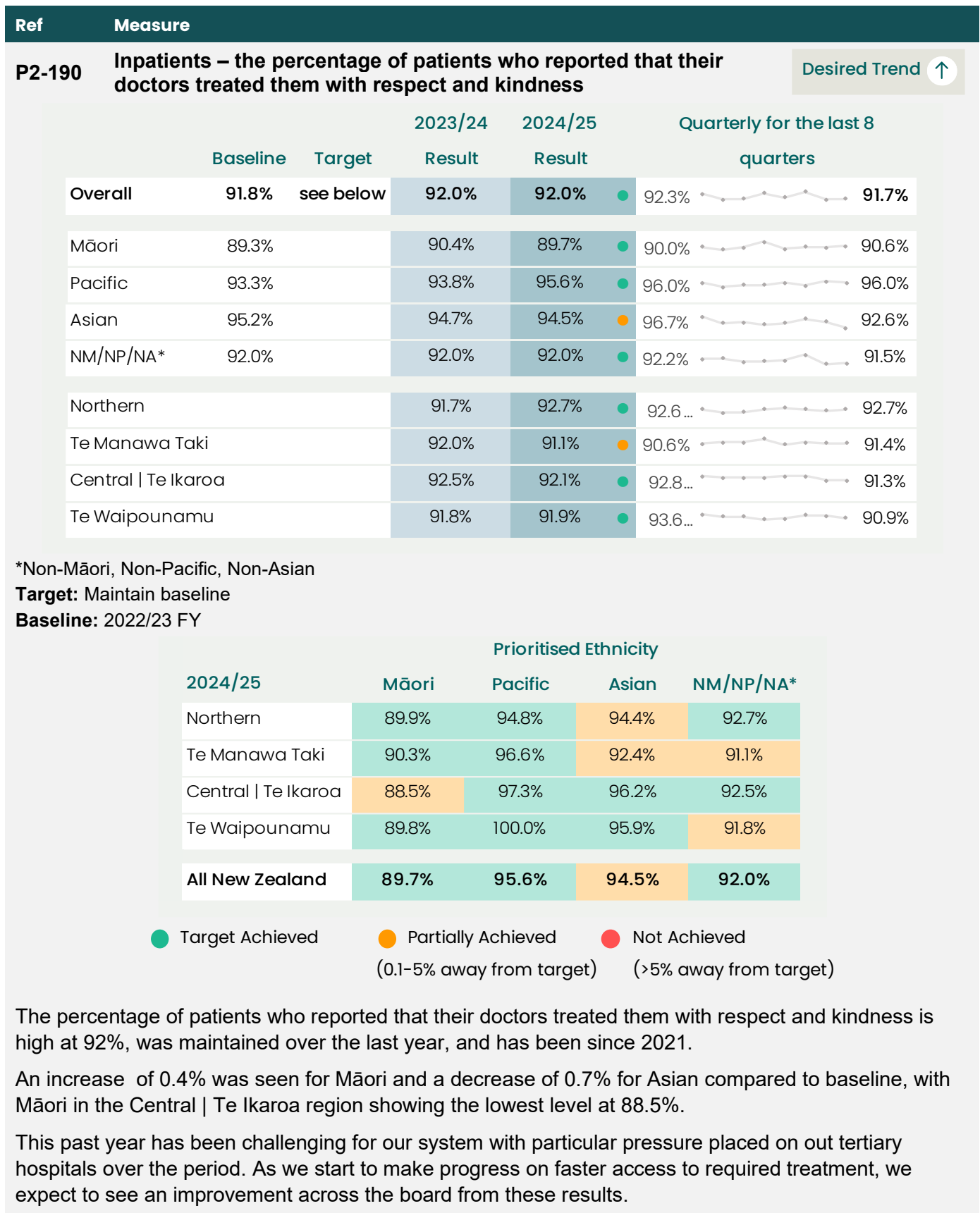
Notes to the measure:

- a) In the Statement of Performance Expectations 2024/25, this measure was published with 2022/23 baselines. These baselines were updated through the Vote Health: Supplementary Estimates 2024/25 to present a single national baseline target as presented above.

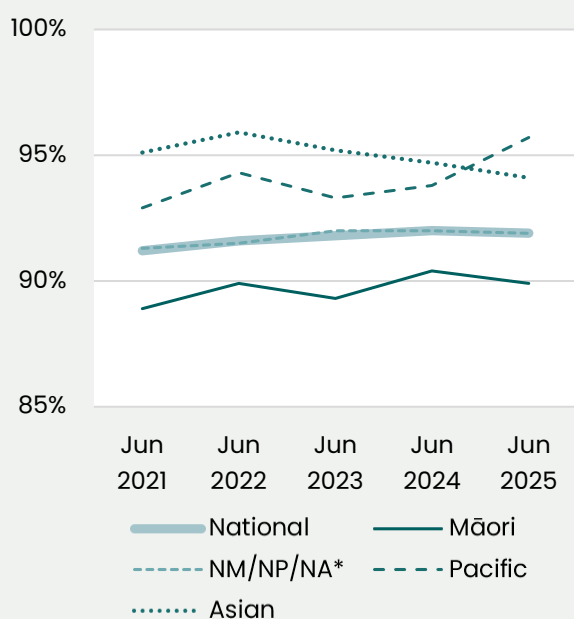
Results by Region and Districts



Baseline
7.1%



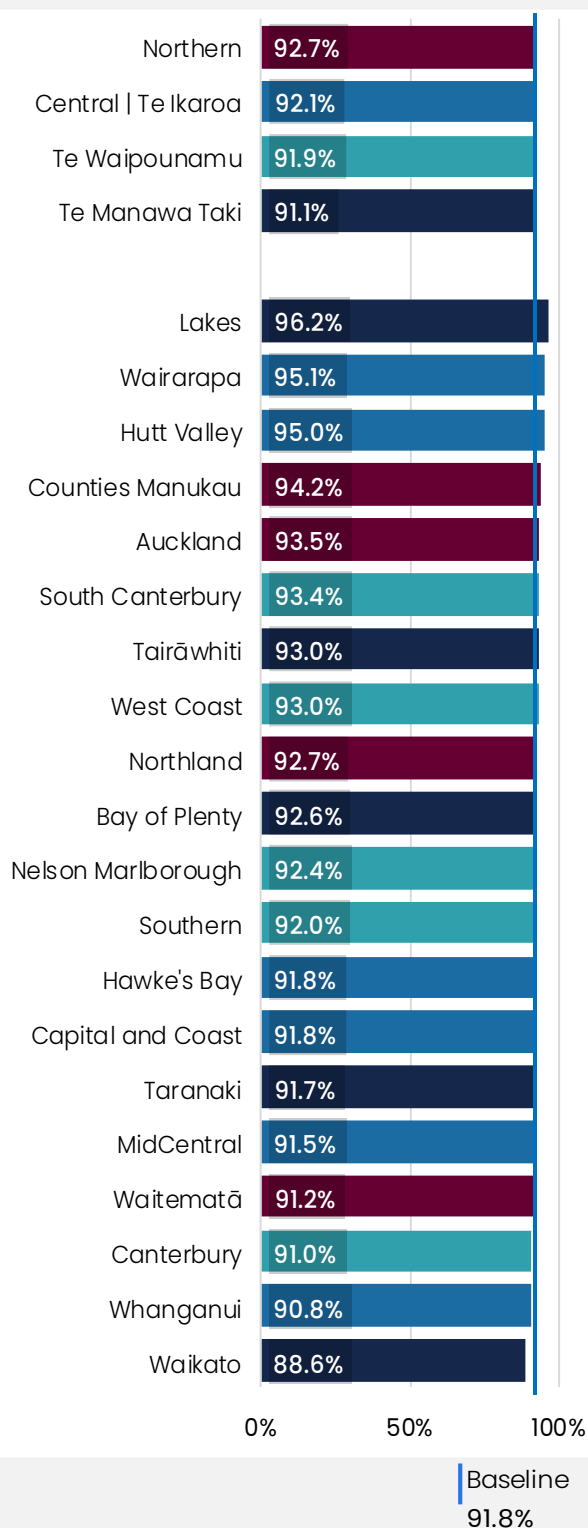
Longer-term trend (rolling 12-month period)



Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- Further details on the survey methodology can be found at: www.hgsc.govt.nz/our-data/patient-reported-measures.

Results by Region and Districts



Ref	Measure					
P2-42	Decrease in rate of acute readmissions within 28 days of discharge					
		Desired trend 				
	Target	2023/24 Result	2024/25 Result	Rolling 12-months for the last 3 periods		
Overall	12%	12.8%	13.0%		12.8%	13.0%
Māori		13.3%	13.5%		13.5%	13.5%
Pacific		12.7%	13.1%		12.9%	13.1%
Asian		12.2%	12.3%		12.3%	12.3%
NM/NP/NA*		12.7%	12.9%		12.7%	12.9%
Northern		12.8%	13.0%		12.9%	13.0%
Te Manawa Taki		12.8%	12.9%		13.0%	12.9%
Central Te Ikaroa		13.0%	13.3%		12.9%	13.3%
Te Waipounamu		12.6%	13.0%		12.6%	13.0%

*Non-Māori, Non-Pacific, Non-Asian

This measure is also in the Vote Health: Estimates 2024/25/Supplementary Estimates 2024/25 with the same target.

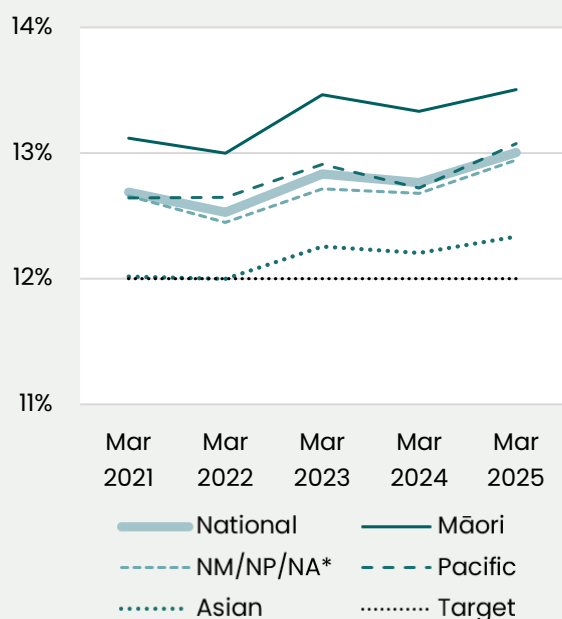
2024/25	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	13.7%	13.1%	12.2%	13.0%	13.1%	12.4%
Te Manawa Taki	13.2%	13.0%	11.7%	12.8%	12.7%	13.3%
Central Te Ikaroa	13.3%	13.4%	12.8%	13.3%	13.5%	12.2%
Te Waipounamu	14.4%	12.7%	13.5%	12.7%	13.4%	11.7%
All New Zealand	13.5%	13.1%	12.3%	12.9%	13.1%	12.5%

**Rurality status is unknown for 3,665 (0.35%) out of the 1,052,540 total number of stay discharge

 Target Achieved
  Partially Achieved
  Not Achieved
 (0.1-5% away from target) (>5% away from target)

Performance has remained partially achieved over the past 12 months across all categories. 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.

Longer-term trend (rolling 12-month period)

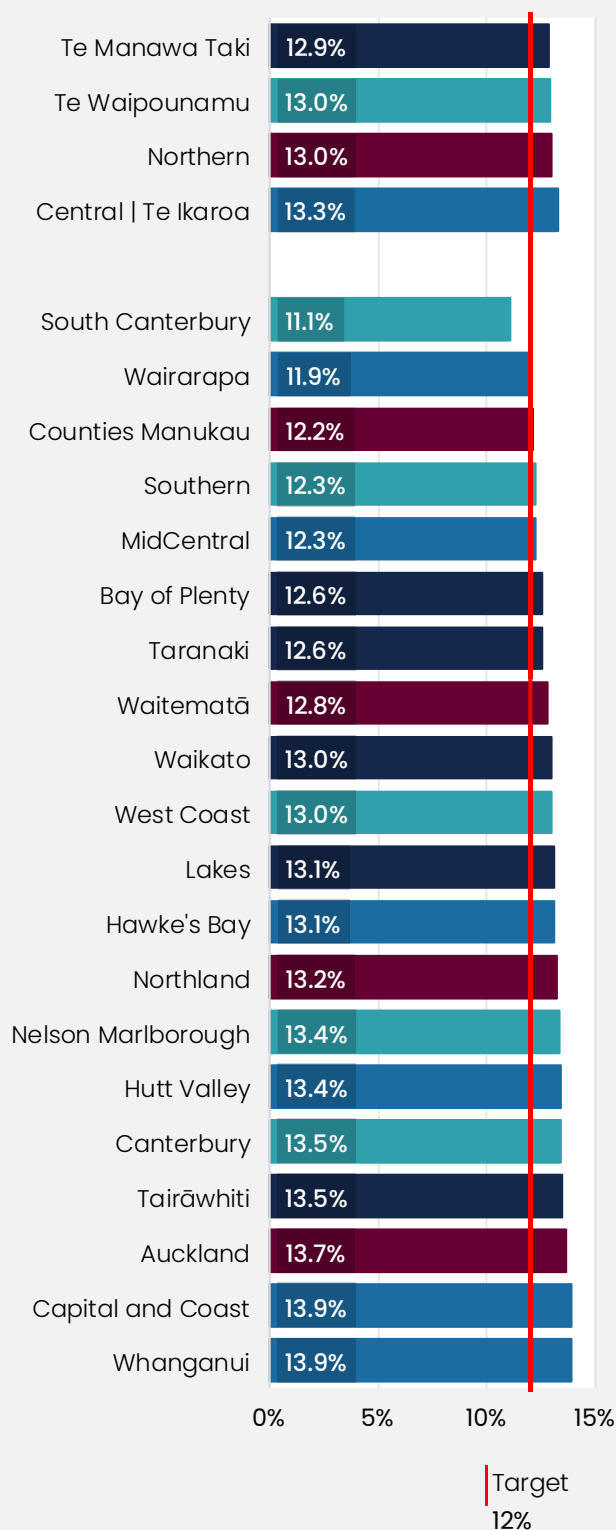


All regions and ethnicities have had a slight deterioration in this performance measure (0.1-0.4%). Two subgroups have reached the target of 12%, Te Manawa Taki Asian, and Te Waipounamu Rural, both at 11.7%.

Notes to the measure:

- Acute readmission standardised rates are derived by calculating a predicted number of acute readmissions for each district and then comparing their actual number with the predicted number to arrive at a ratio. The ratio is standardised to the most recent period's national crude rate for comparison.
- Reporting for the full financial 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 middle of August or further for some inpatient events. In the Health NZ annual report for 2023/24, the measure was reported for the 12 months to March 2024. This reporting period has been repeated – for the 12 months to 31 March 2025.
- The index (first) stay must be an inpatient short stay at the emergency department (ED), palliative care, cancer treatments, paediatric services, geriatric services, long-term conditions, mental health events (except when a stay started with the first event being a mental health event), overseas patients, or assessment, treatment, and rehabilitation services
- The readmission must be within 28 days and not be a non-acute stay (the first event has a non-acute admission type) or maternity services. Additionally, deceased patients and those not discharged at the end of the reporting period are excluded from the first stays but included in the readmission stays. Outpatient stays (non-admitted patients) are excluded from both the index and readmission stays

Results by Region and Districts





Public Hospitals

Health NZ owns 87 sites with nearly 11,100 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.



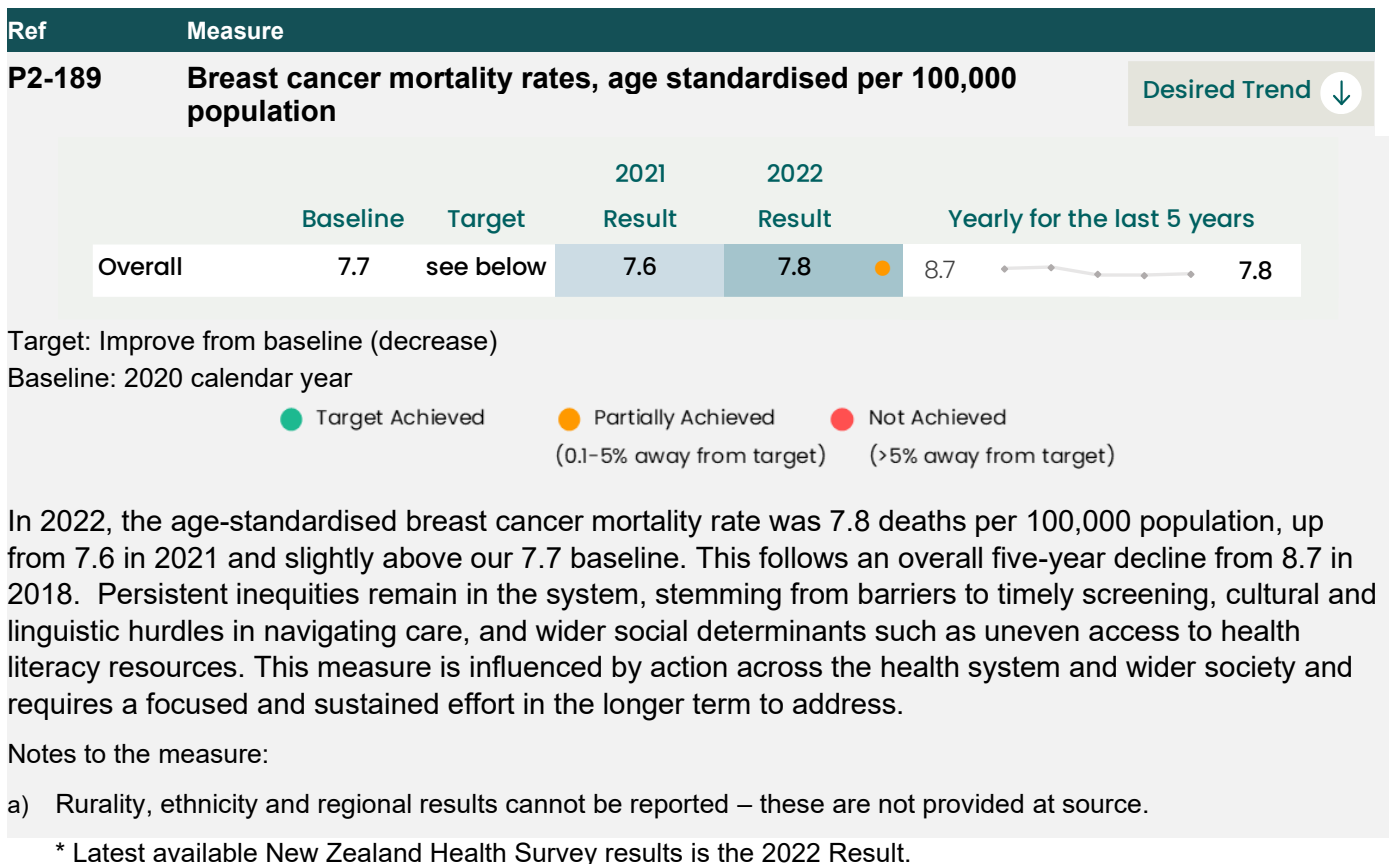
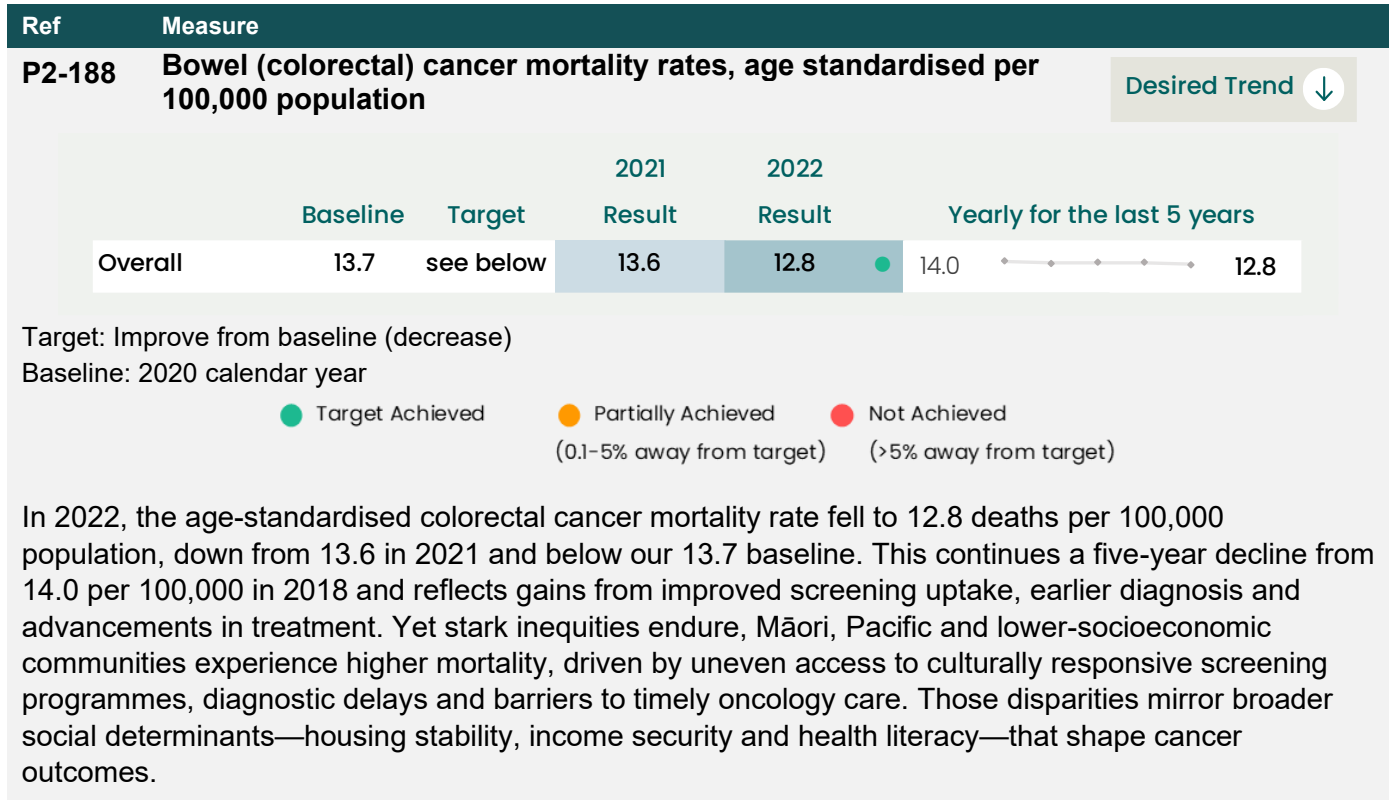
Locations in New Zealand



Regions	Total number of beds*
Northern	4,185
Midland Te Manawa Taki	2,077
Central Te Ikaroa	2,070
Southern Te Waipounamu	2,760
Total	11,092

* 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.

Outcome Measures*



Acute Flow – Transition and Discharge Lounge initiatives

These lounges help to improve the patient journey across the hospital by enabling ward bed access earlier in the day for ED patients who need hospital admission.

In the Northern region, Transition Lounges are now in place in each district with the establishment of new lounges in Whangarei and North Shore Hospitals in the past year. Existing lounges in Middlemore and Auckland City Hospitals continued to improve their standards processes to ensure timely and effective patient handovers, discharge papers and transfers.

When patients are medically well enough to be discharged out of hospital, they move to the lounge and wait in a comfortable space while their medications and paperwork are finalised. Lounges are conveniently located for whānau to collect patients, and for more efficient transfer between hospital sites.

We have seen marked benefits for patients in the new Whangārei Hospital Transit Lounge with an average of 16 patients a day completing their inpatient stay. This is double the number of patients they were previously managing and is expected to continue to increase as more clinical services use lounge facilities for patient discharges.

Output Class 4: Mental health and addiction services

Mental health and addiction services provide support and treatment across the continuum of mental distress/mental illness and addiction. They include primary, secondary and tertiary services which support prevention (including suicide), early intervention, recovery and maximise outcomes. Some people can get appropriate clinical care through strengthened primary care practices that can provide a comprehensive approach to health and wellbeing.

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. 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.

Why is this important?

Mental health and addiction services make a positive difference to people's health and wellbeing by supporting them through mental illness. 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.

Summary of Performance

Health NZ's overall performance for 2024/25, for this output class was:

	Total	Achieved	Partially achieved	Not achieved	Not Reported/No Target
Number of measures	12	8	1	3	0
% of Total measures	100%	67%	8%	25%	

This summary does not however tell the story of improvement since 2023/24. Further, because we must report on our annual result (which for many measures reflects an average of our full year performance), the overall results do not fully tell the story of progress that occurred during the year. For that story we invite you to read the narrative for each measure and review the spark lines and long-term trend lines which visualise the movement in performance over time.

While the target for the number of people who accessed primary mental health and addiction services through the Access and Choice programme was not achieved, 2024/25 saw a greater number of people able to access these services through Integrated Primary Mental Health and Addictions services (IPMHA). IPMHA services provide timely access to

mental health and wellbeing support within general practice and community settings, often on the same day.

The number of people seen per year by each Access and Choice service has increased steadily over the last five years. This will continue to track upwards with the focus on reaching 325,000 per year in 2026/27.

We also saw increases in the number of people accessing Kaupapa Māori, Pacific and Youth IPMHA services through the Access and Choice programme, apart from a small decrease in the Northern region. There was significant growth in the number of people seen by Pacific Access and Choice services, due to ongoing work to improve and embed services.

Targets were achieved for the following three measures, with the first two having achieved their 2030 target during 2024/25:

- The percentage of people accessing primary mental health and addiction services through the Access and Choice programme seen within one week
- The percentage of people accessing specialist mental health and addiction services who are seen within three weeks.
- The percentage of young people seen within three weeks from a mental health referral

Mental health expenditure slightly exceeded the ringfence, largely driven by extra spending on hospital and specialist services.

The target for the number of brief only interventions delivered was not achieved. Since late 2023, there has been an increased focus on ensuring those with more severe concerns are prioritised for support. Planned improvements include strengthening provider performance monitoring, improving referral pathways and service promotion.

Results for output class measures

The following sections present all the measures classified, in accordance with our performance framework, by whether they are an input, output impact or outcome measure.

Input: Summary of Financials

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.

Expected revenue and proposed expenditure	2024/25 Actual \$ million	2024/25 Budget \$ million	2024/25 Variance \$ million	2023/24 Estimated Actual \$ million
Revenue – Crown	2,669	2,683	(14)	2,285
Other revenue	50	0	50	0
Total operating revenue	2,719	2,683	36	2,285
Total operating expense	2,756	2,683	(73)	2,305
Surplus/(deficit)	(37)	0	(37)	(21)

More funding in the communities

In the year, Health NZ allocated an additional \$12.4 million, supplementing the \$114 million* already allocated for service funding within the Midlands | Te Manawa Taki region.

This new investment supported the expansion of mental health and addiction services, with a particular focus on strengthening peer-led initiatives in emergency care and crisis response, as well as enhancing services for infants, children, and youth.

Funding was also directed towards growing access to primary mental health and addiction support, ensuring earlier intervention and better continuity of care across the system.

These initiatives reflect a continued commitment to building a more connected, culturally responsive, and community-informed mental health system that meets the diverse needs of the Midlands | Te Manawa Taki region.

*Excludes Access and Choice and Hauora Māori Services funding

Input measures

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-154	Mental health expenditure ringfence expectations are met	Achieved	Achieved	Achieved	●
	Mental health expenditure exceeded ringfence expectations which was largely driven by extra spending on hospital and specialist services. In the 2024/25 financial year there was \$2,756m in operating expenditure against a budgeted (ringfence expectation) \$2,683m. In Health NZ's Statement of Performance Expectations 2024/25, this measure is listed under all five output classes, in this Annual Report we have chosen to report this measure under this output class only.				

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-198	Train additional mental health and addiction professionals each year (2030 target is 500)	Establish Baseline	N/A	457[#]	●
	This measure is one of the Government Targets for Mental Health & Addiction Services, newly established from 1 July 2024. #The 2024 academic (calendar) year result was 457. 349 people started training in semester one of the 2025 academic year. This is a partial result as it represents only the first semester intake for the 2025 academic year, and some professions also have a second semester intake (starting July/August 2025). The full result for this measure will be reported in Q2 2025/26 (and in the 2025/26 Annual Report). The Mental Health and Addiction Workforce Plan 2024-2027 contains focused initiatives to support workforce development and achieve the health target. Notes to the Measure: This measure is also in the Supplementary Estimates 2024/25 with a target of "500". The 2024/25 result is not achieved against this target				

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-200	Percentage of mental health and addiction investment allocated towards prevention and early intervention (2030 Target is 25%)	Establish Baseline	24.4%	24.4%	●
	This measure is one of the Government Targets for Mental Health & Addiction Services, newly established from 1 July 2024. The prevention early intervention target is an annual measure and reflects the amount of funding budgeted, not the amount spent. The increased focus on this prevention and early interventions is shown through the Mental Health and Addiction Community Sector fund which provides \$10 million over two years to support innovative time-limited initiatives aimed at improving mental health outcomes. Further, a nationwide mental health promotion campaign was recently launched. The "Top Up" campaign draws on the evidence-based '5 Ways to Wellbeing' to support people to take simple, everyday actions which can have a positive impact on mental wellbeing. Notes to the Measure: Prevention includes mental wellbeing promotion and suicide prevention. Early intervention includes both services that intervene early during distress (such as primary MH&A) and services that intervene early in the life course (such as maternal, infant, child and youth specialist services). This measure is reported annually, with the 2024/25 result first reported in the quarter two report. The information to report on this measure is unable to be automatically derived from our financial systems so the result has been manually extracted for the 2024/25 year. As a result, data is not reliable, and the reported result is a best estimate. Improving the reliability of results will require improved connectivity of data across our information systems. Work is underway to scope improvements and develop an action plan. Results are likely to shift as data accuracy improves. In the Vote Health: Supplementary Estimates 2024/25 this target was updated to 23.9% and is achieved.				

Output measures

Ref	Measure	
P2-137	The number of people accessing support from problem gambling services	Desired Trend 

			2023/24	2024/25	
	Baseline	Target	Result	Result	
Overall	5,768	6,750	7,696	7,095	
Māori			2,451	2,367	
Pacific			1,139	867	
Asian			1,599	1,697	
NM/NP/NA*			2,507	2,164	
Northern			3,553	2,974	
Te Manawa Taki			899	1,438	
Central Te Ikaroa			1,581	1,353	
Te Waipounamu			1,415	1,321	

*Non-Māori, Non-Pacific, Non-Asian

Baseline: 2024/25 Estimates

	Prioritised Ethnicity			
2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	630	465	1,203	676
Te Manawa Taki	1,003	50	83	302
Central Te Ikaroa	543	242	108	460
Te Waipounamu	188	110	302	721
All New Zealand	2,367	867	1,697	2,164

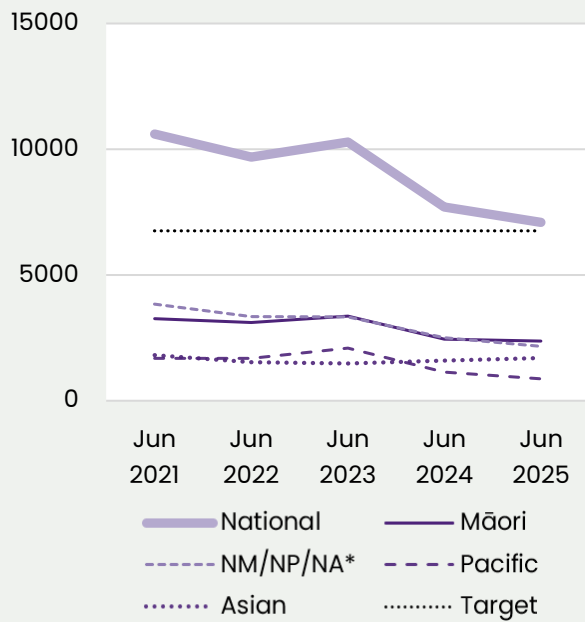
 Target Achieved  Partially Achieved  Not Achieved
(0.1-5% away from target) (>5% away from target)

This measure tracks the number of individuals accessing support from problem gambling services (excluding national gambling helpline). It reflects the reach and accessibility of specialist addiction counselling for those experiencing gambling-related harm.

There are ongoing issues with the existing data quality and capture which have resulted in an estimated 4.7% underreporting for 2024/25.

While the data suggests a decline in service use, this trend commenced several years prior. Anecdotal evidence from providers indicates that they are seeing clients with more acute gambling harm issues, as well as co-morbidities (e.g. other mental health, addiction and social issues). Each client therefore may be provided with more intensive support than historically thus leading to fewer clients being seen overall.

Longer-term trend (rolling 12-month period)



Gambling harm is a highly stigmatised issue, and is often not perceived as a health issue, which makes it challenging for providers to reach people who experience gambling harm.

Improvement pathway: A review of provider performance is planned, alongside efforts to improve the data collection and reporting system.

Notes to the measure:

- Rurality and district cannot be reported - lowest level of granularity for gambling harm data is Territorial Local Authority (TLA), we require patient level granularity to generate rurality.
- Users of this service can be anonymous so may not have a TLA recorded. The National / All New Zealand figure includes clients from unknown domicile of 248 in 23/24 and 9 in 24/25.
- Gambling Harm volumes for 23/24 are incomplete for Jan to Jun due to new providers not submitting activity records - they account for around 25% of activity, therefore 12.5% annualised.
- Gambling Harm volumes are around 4.7% understated for 24/25 due to ongoing data collection issues.
- Volumes have decreased significantly since 2022/23. New contracts were put in place from Jan 2024 with some existing providers exiting and new providers coming on board. The net effect has been a reduction in activity.

Result for 2023/24 have changed from previously reported values due to improvements in completeness and accuracy of data.

Ref	Measure	Desired Trend 
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P2-138 The number of brief only interventions delivered

		2023/24	2024/25
	Target	Result	Result
Overall	6,000	5,214	3,180 
Māori		1,936	1,615
Pacific		666	190
Asian		1,066	831
NM/NP/NA*		1,546	544
Northern		2,120	934
Te Manawa Taki		583	1,037
Central Te Ikarooa		1,386	828
Te Waipounamu		858	377

*Non-Māori, Non-Pacific, Non-Asian

	Prioritised Ethnicity			
2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	217	73	531	113
Te Manawa Taki	872	33	55	77
Central Te Ikarooa	466	71	72	219
Te Waipounamu	57	13	172	135
All New Zealand	1,615	190	831	544

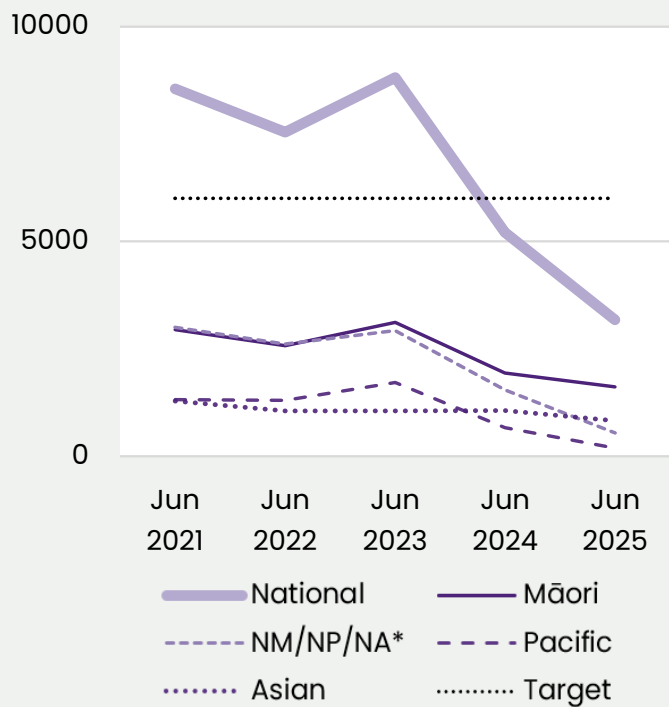
 Target Achieved
  Partially Achieved (0.1-5% away from target)
  Not Achieved (>5% away from target)

This measure captures the number of brief interventions delivered by specialist services—typically short, early-stage engagements aimed at motivating further help-seeking for people who may be experiencing gambling harm. It excludes brief interventions that may be delivered by other services providers and in other contexts.

Since late 2023, there has been an increased focus on ensuring those with more severe concerns are prioritised for support. There are also data quality and capture issues with underreporting estimated at 4.7%.

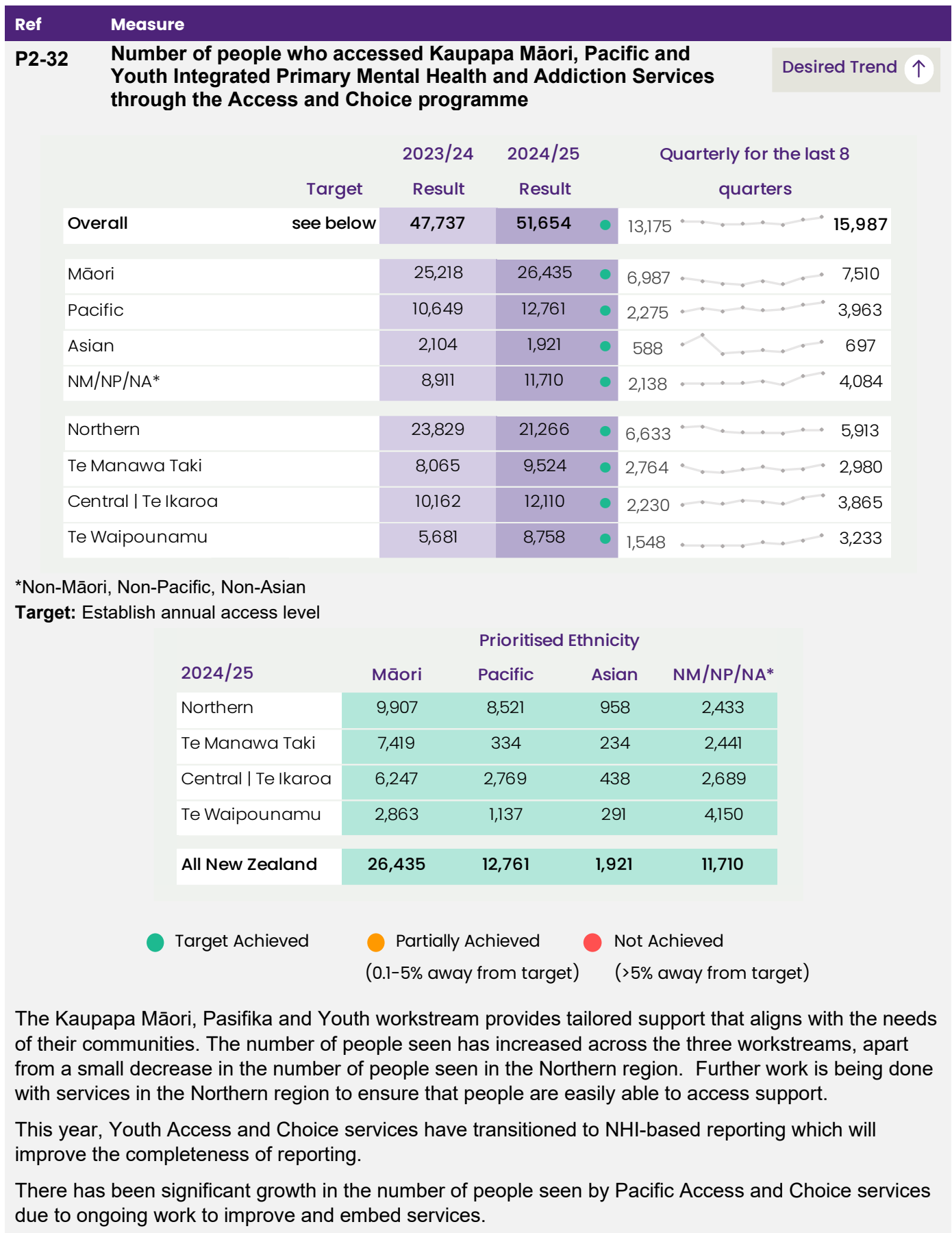
Improvement pathway: Planned improvements include strengthening provider performance monitoring, improving referral pathways, service promotion.

Longer-term trend (rolling 12-month period)

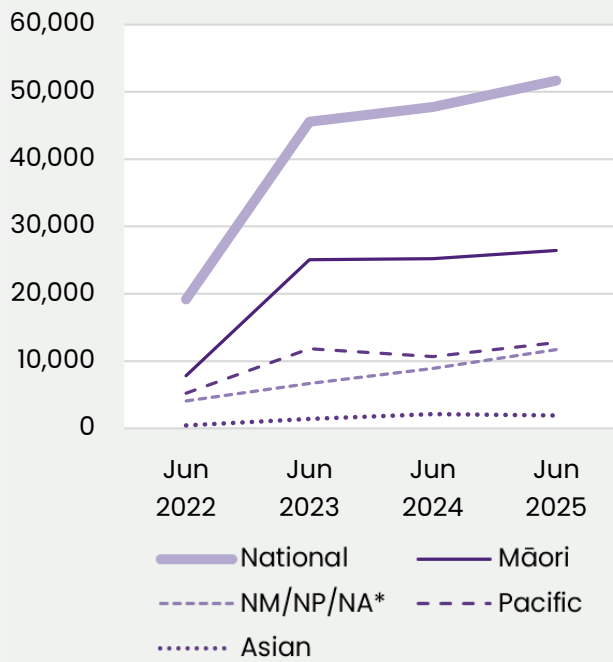


Notes to the measure:

- Rurality and district cannot be reported - lowest level of granularity for gambling harm data is Territorial Local Authority (TLA), we require patient level granularity to generate rurality.
- Users of this service can be anonymous so may not have a TLA recorded. The National / All New Zealand figure includes clients from unknown domicile of 248 in 23/24 and 9 in 24/25.
- Gambling Harm volumes for 23/24 are incomplete for Jan to Jun due to new providers not submitting activity records - they account for around 25% of activity, therefore 12.5% annualised.
- Gambling Harm volumes are around 4.7% understated for 24/25 due to ongoing data collection issues.
- Volumes have decreased significantly since 2022/23. New contracts were put in place from Jan 2024 with some existing providers exiting and new providers coming on board. The net effect has been a reduction in activity. No status by region in heatmap. This decision was taken given the data quality issues noted above.
- Result for 2023/24 have changed from previously reported values due to improvements in completeness and accuracy of data.



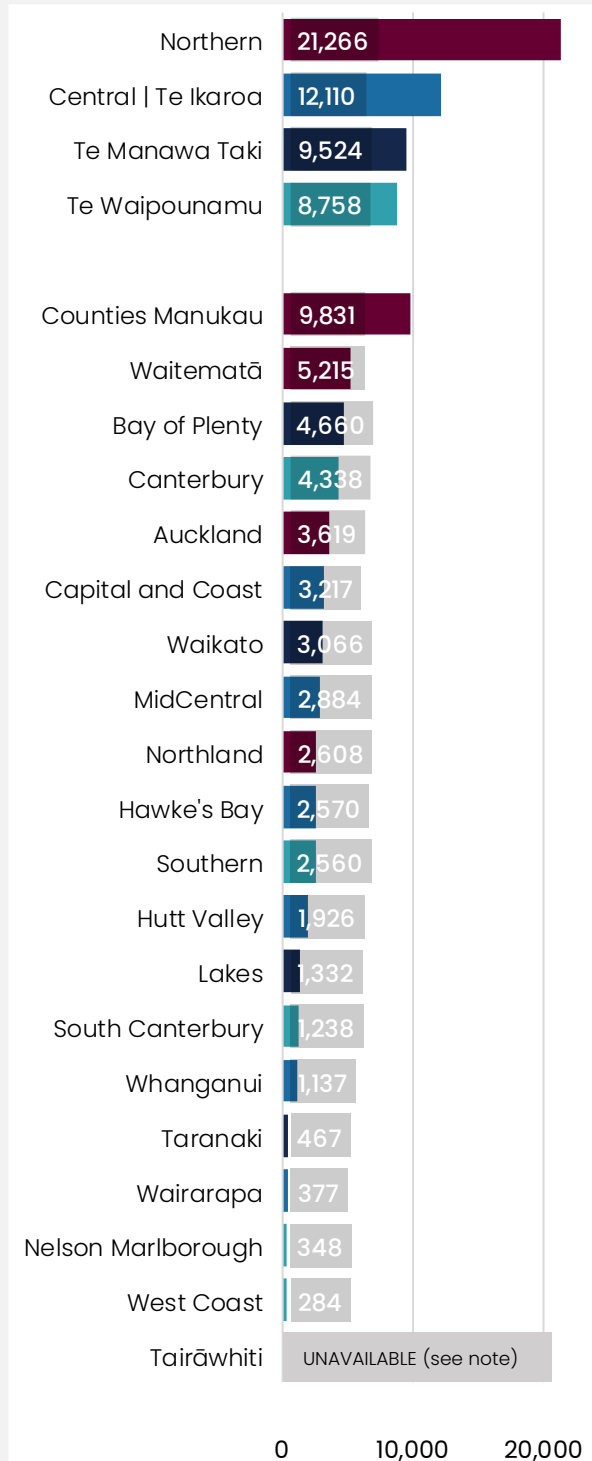
Longer-term trend (rolling 12-month period)



Notes to the measure:

- a) Ruralty cannot be reported - it is not recorded for non-IPMHA services.
- b) Tairāwhiti is not part of the Access and Choice programme.
- c) Overall results do not equal the sum of individual categories - each provider reports the number of distinct people they have provided access for, but those people may have also received services from another provider

Results by Region and Districts



Ref	Measure					Desired Trend 
P2-37	Number of people who accessed primary mental health and addiction services through the Integrated Primary Mental Health and Addiction Services					
		2023/24	2024/25			
		Target	Result	Result	Quarterly for the last 8 quarters	
Overall	see below	159,862	182,845		51,528 	62,305
Māori		30,445	35,306		10,377 	12,671
Pacific		12,081	13,765		3,981 	4,727
Asian		17,113	22,044		5,132 	7,341
NM/NP/NA*		100,473	111,979		32,08... 	37,594
Northern		56,959	66,466		18,716 	22,540
Te Manawa Taki		19,364	24,969		6,254 	10,080
Central Te Ikaroa		31,471	32,876		10,370 	11,053
Te Waipounamu		52,234	58,756		16,197 	18,644

*Non-Māori, Non-Pacific, Non-Asian

Target: Establish annual access level

2024/25	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	11,760	9,839	14,458	30,522	58,487	8,096
Te Manawa Taki	8,404	595	1,179	14,820	19,886	5,156
Central Te Ikaroa	7,855	1,796	2,141	21,116	26,884	6,069
Te Waipounamu	7,363	1,539	4,276	45,651	43,920	14,985
All New Zealand	35,306	13,765	22,044	111,979	149,027	34,280

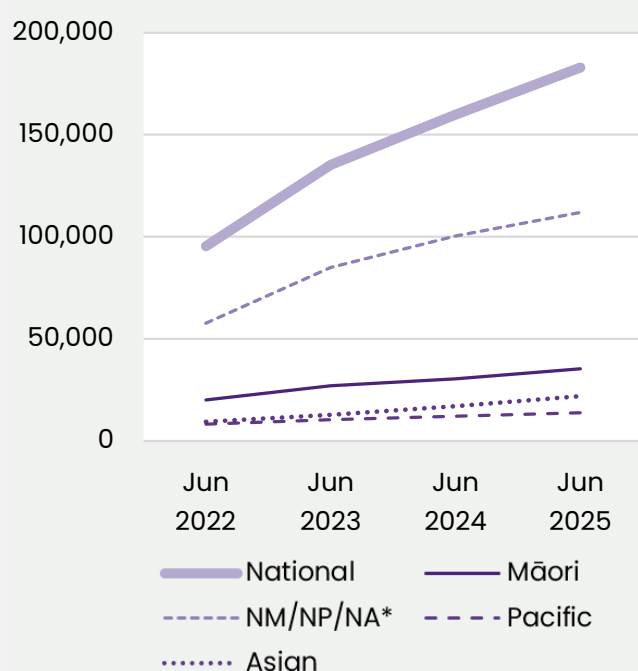
**Rurality status is unknown for 196 (0.11%) out of the 182,845 total eligible people who accessed primary mental health and addiction services through the Integrated Primary Mental Health and Addiction Services

 Target Achieved
  Partially Achieved
  Not Achieved
 (0.1-5% away from target) (>5% away from target)

Integrated Primary Mental Health and Addiction (IPMHA) services is one of four Access and Choice workstreams. IPMHA services provide timely access to mental health and wellbeing support within general practice and community settings, often on the same day.

Under the IPMHA service, programme, Health Improvement Practitioners, Health Coaches and/or Support Workers work in an integrated way with general practice teams and can offer evidence-based interventions and wellbeing support for people whose behaviours or actions are negatively impacting their mental health and wellbeing.

Longer-term trend (rolling 12-month period)



IPMHA services are available to over 3.55 million people, surpassing the original goal of the service (70% of those enrolled with general practice).

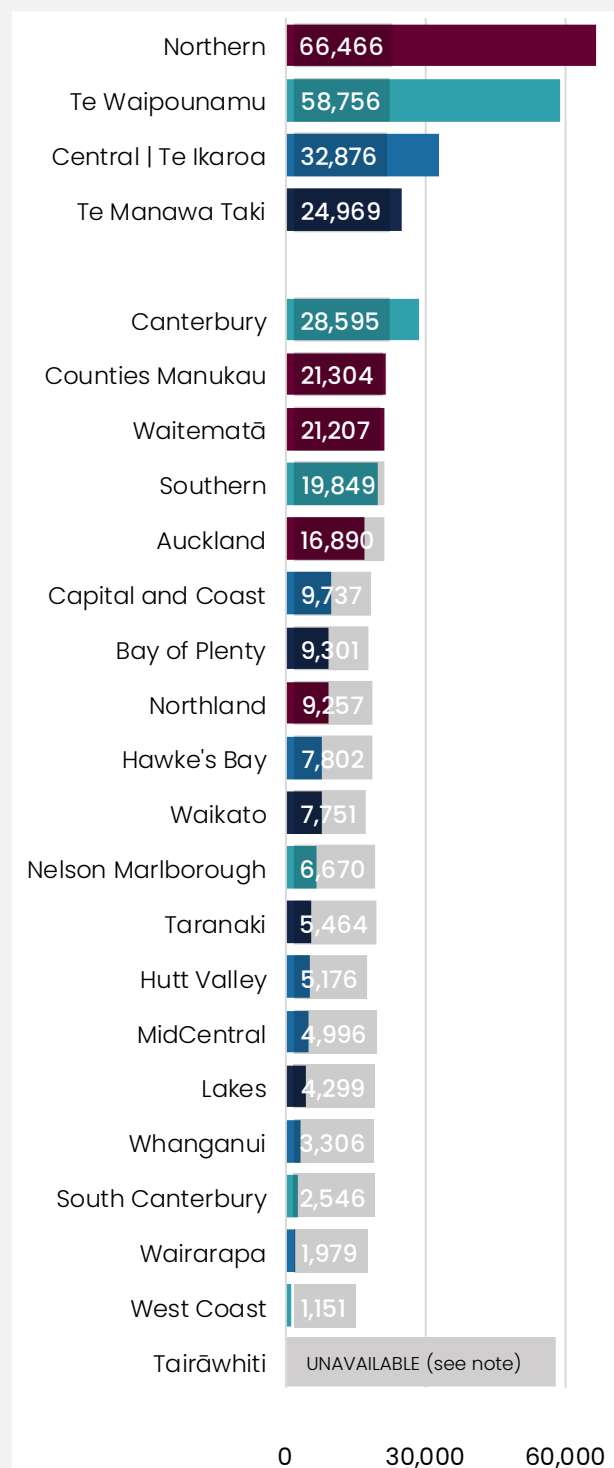
The number of people accessing IPMHA services continues to increase each year across all ethnicities and regions, with an overall 12.5% increase from 2023/24 to 2024/25.

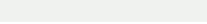
The implementation of IPMHA services is nearing completion with the focus shifting to ongoing service improvement and promotion to increase the number of people accessing services.

Note to the measure:

- Tairāwhiti Access and Choice reporting is not included as an integrated service is delivered across the Access and Choice workstreams. Reporting requirements do not align with other Access & Choice reporting. Work is underway to align reporting for 2025/26.
- No status by region in heatmap. This decision was taken given the data quality issues noted above

Results by Region and Districts



Ref	Measure				Desired Trend 
P2-199	Number of people who accessed primary mental health and addiction services through the Access and Choice programme				
		2023/24	2024/25		
	Target	Result	Result	Quarterly for the last 8 quarters	
Overall	325,000	207,482	233,943 	64,703 	78,105
Māori		55,601	61,593	17,364 	20,137
Pacific		22,727	26,505	6,256 	8,685
Asian		19,208	23,923	5,720 	8,028
NM/NP/NA*		109,333	123,345	34,221 	41,550
Northern		80,788	87,606	25,349 	28,418
Te Manawa Taki		27,294	34,437	9,018 	13,037
Central Te Ikaroa		41,629	44,931	12,600 	14,902
Te Waipounamu		57,933	67,198	17,745 	21,762

*Non-Māori, Non-Pacific, Non-Asian

Baseline: 325,000, based on the 2023/24 aspirational target in the [Wellbeing Budget 2019](#).

This measure is in the Vote Health: Supplementary Estimates 2024/25 with a target of "meet annual access level established for 2024/25".

	Prioritised Ethnicity			
2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	21,628	18,350	15,396	32,899
Te Manawa Taki	15,805	929	1,412	17,224
Central Te Ikaroa	14,080	4,565	2,576	23,775
Te Waipounamu	10,159	2,666	4,549	49,580
All New Zealand	61,593	26,505	23,923	123,345

 Target Achieved

 Partially Achieved

(0.1–5% away from target)

 Not Achieved

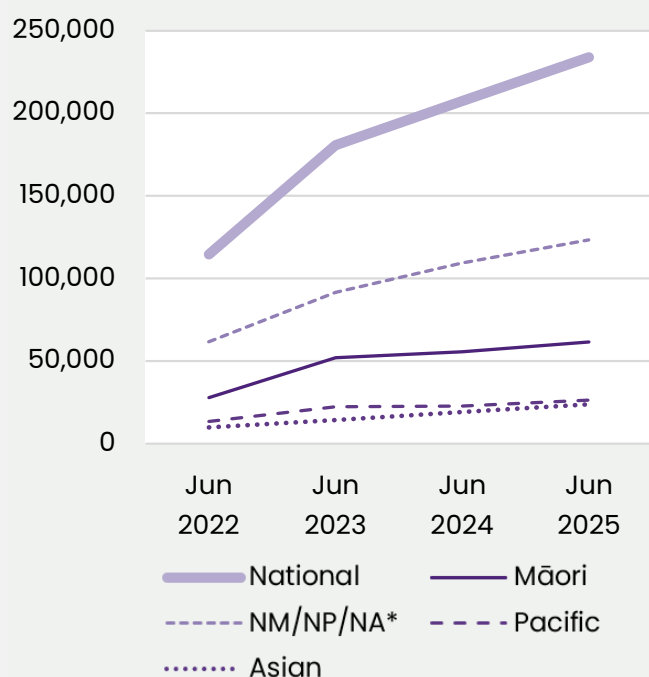
(>5% away from target)

The Access and Choice programme provides free, accessible and flexible primary mental health and addiction support for people with mild to moderate needs. The programme is delivered through four workstreams: Integrated Primary Mental Health Addiction (IPMHA) services delivered through general practice, Kaupapa Māori, Pacific and Youth.

The number of people seen per year by each Access and Choice service has increased steadily over the last five years. In 2024/25 the Access and Choice Programme provided over 780,000 sessions to nearly 234,000 people.

This will continue to track upwards with the focus on reaching 325,000 per year in 2026/27. IPMHA services are available to over 3.55 million people, surpassing the original goal of the service (70% of those enrolled with general practice).

Longer-term trend (rolling 12-month period)



Kaupapa Māori and Youth services are available in all 20 districts, and Pacific services are available in the nine districts that were planned to have them.

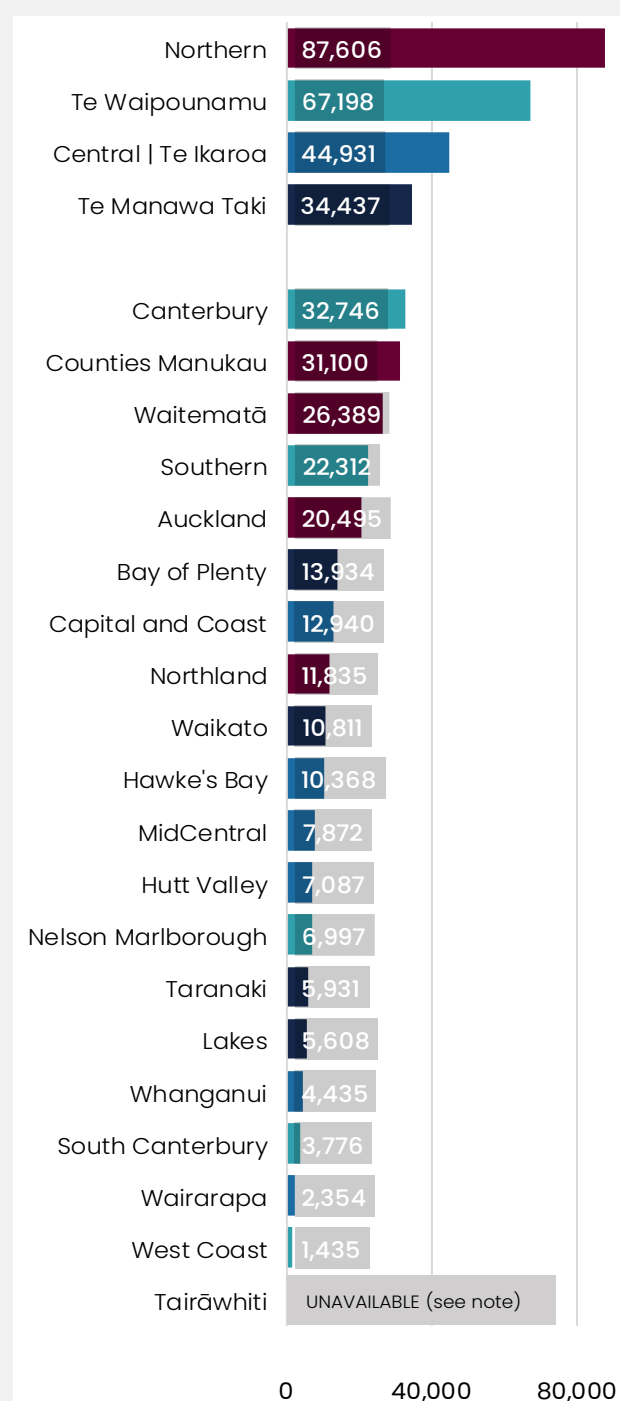
The workforce growth has kept pace with the expansion of the services, with close to 90% of the contracted full-time equivalent (FTE) staff in place at the end of June 2025.

The implementation of Access and Choice services is nearing completion with the focus shifting to ongoing service improvement and promotion to increase the number of people accessing services.

Notes to the measure:

- Rurality cannot be reported - it is not recorded for non-IPMHA services.
- Longer-term trend reported from June 2022 to June 2025 - data only goes back four years.
- Tairāwhiti Access and Choice reporting is not included as an integrated service is delivered across the Access and Choice workstreams. Reporting requirements do not align with other Access & Choice reporting. Work is underway to align reporting for 2025/26.
- Overall results do not equal the sum of region or ethnicity - each provider reports the number of distinct people they have provided access for, but some people may have also received services from other providers using different demographics.
- Baselines are not currently available by ethnicity or region, performance against target is the only possible at a national level.

Results by Region and Districts



- Measure P2-199 in the Health New Zealand Quarterly Report (MHA access, Integrated Primary) represents the unique count of people accessing Access & Choice IPMHA services. It does not include Youth, Kaupapa Māori and Pacific Access & Choice services. Measure P2-199 in the Annual Report includes IPMHA, Youth, Kaupapa Māori and Pacific Access & Choice services.

Impact measures

Ref	Measure				Desired Trend ↑	
P2-201	Percentage of mental health and addiction-related emergency department presentations are admitted, discharged or transferred from an emergency department within six hours					
						
	2024/25 Milestone	2030 Target	2023/24 Result	2024/25 Result	Quarterly for the last 8 quarters	
Overall	74%	95%	65.8%	66.2%	●	64.4%  69.4%
Māori			67.1%	68.0%	●	64.9%  70.6%
Pacific			56.2%	54.9%	●	52.8%  57.5%
Asian			60.6%	58.9%	●	55.0%  61.5%
NM/NP/NA*			66.7%	67.1%	●	66.6%  70.8%
Northern			54.6%	52.8%	●	52.8%  58.1%
Te Manawa Taki			74.8%	76.7%	●	75.5%  78.1%
Central Te Ikaroa			54.5%	54.1%	●	53.1%  56.6%
Te Waipounamu			85.0%	85.0%	●	85.8%  86.1%

*Non-Māori, Non-Pacific, Non-Asian

This measure is in the Vote Health: Supplementary Estimates 2024/25. The target and result are the same.

2024/25	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	52.9%	49.0%	49.5%	54.7%	52.1%	63.4%
Te Manawa Taki	81.5%	71.4%	75.0%	73.0%	77.4%	74.4%
Central Te Ikaroa	60.8%	54.6%	49.4%	50.8%	54.9%	49.4%
Te Waipounamu	85.5%	84.5%	87.5%	84.8%	86.7%	76.2%
All New Zealand	68.0%	54.9%	58.9%	67.1%	66.0%	67.7%

**Rurality status is unknown for 150 (0.61%) out of the 24,647 total eligible mental health and addiction-related emergency department presentations

● Target Achieved
 ● Partially Achieved (0.1–5% away from target)
 ● Not Achieved (>5% away from target)

The shorter mental health and addiction-related stays in ED (MH&A SSED) target is new. Since its introduction in this financial year, the target has shown a slight upward trend; however, data quality issues and the absence of reliable historical data prevent a definitive assessment of progress at this stage. Nationally, the target has not achieved its 74% milestone.

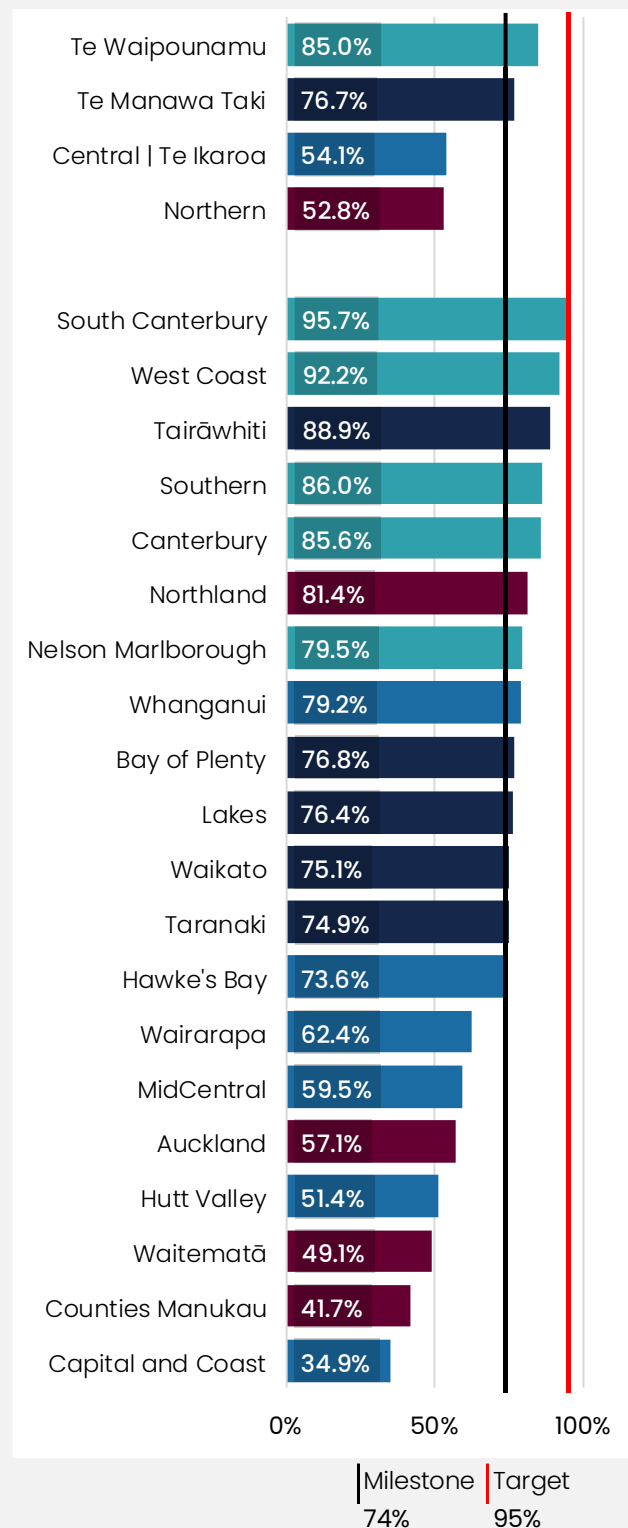
Te Manawa Taki and Te Waipounamu have achieved the milestone, noting that both regions had been performing above the milestone since the target's introduction. In contrast, the Northern and Central regions did not meet the milestone but showed some early signs of improvement, particularly in specific districts.

The trend exhibited with the MH&A SSED targets mirrors that of the wider SSED target (the cohort measured in the MH&A SSED is a subset of the SSED target) – in line with this, going into the 2025/26 financial year, the focus will be on lifting SSED and MH&A SSED performance in the most challenged districts, along with supporting patient flow through hospitals and into the community. Over the past year, the system has continued to mature its approach to target improvement, focusing on disseminating practices and processes to improve MH&A ED flow and efforts to improve SNOMED data quality.

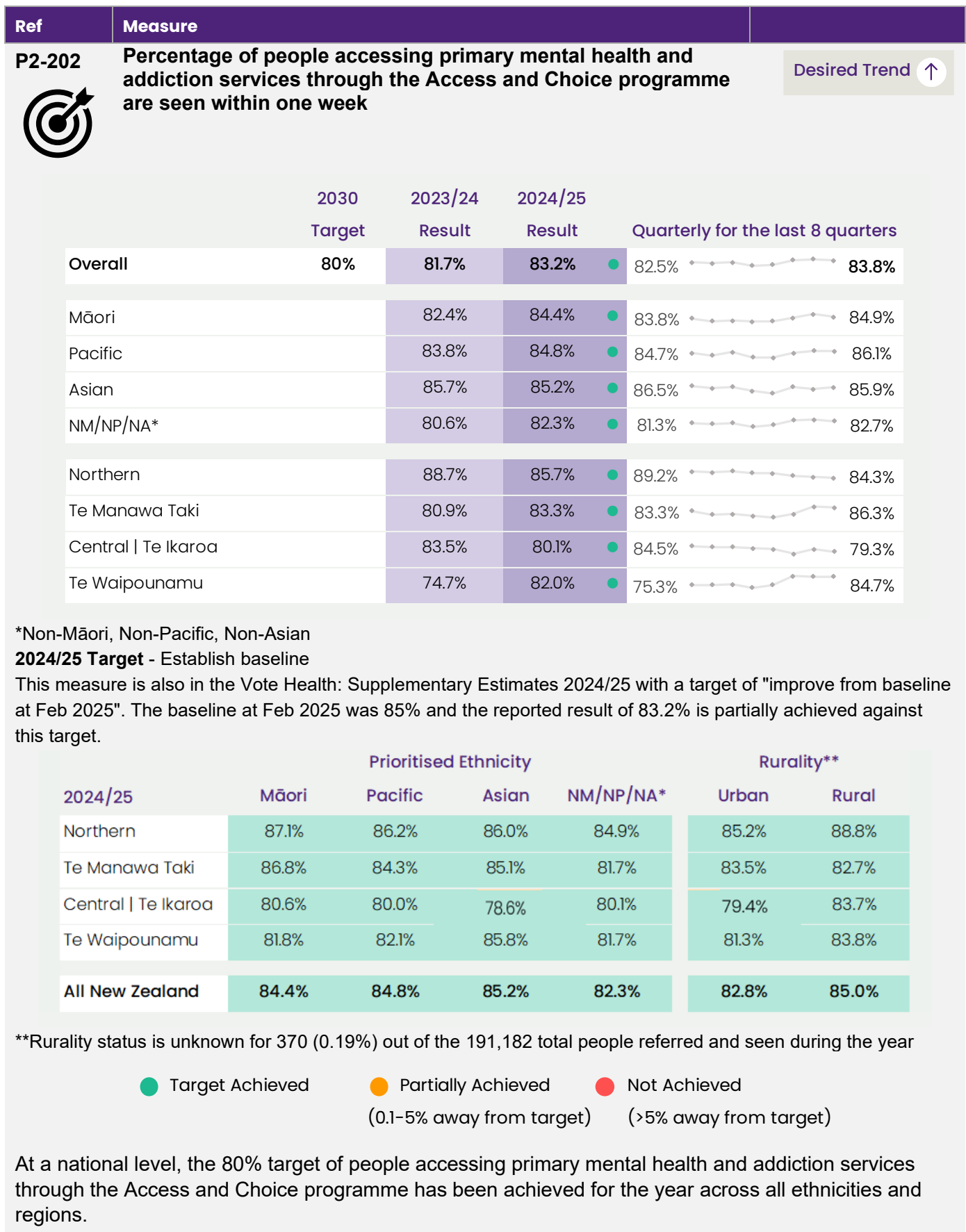
Notes to the measure:

- This measure is based on a subset of 8 of the 158 presenting complaint SNOMED (Systematised Nomenclature of Medicine) codes (abnormal behaviour, aggression, anxiety, crisis, insomnia, mental health issue, self-harm, and suicidal ideation). The subset of codes includes patients who do not require secondary mental health services and excludes some who do. This measure does not reliably identify any addiction-related events. ED staff enter a SNOMED code for presenting complaint at the triage stage of an ED presentation. It does not account for the complexities of acute presentations, for example people presenting with combinations of physical and mental symptoms, or presentations where the actual problem is not immediately obvious.
- No longer-term trend - 2023/24 was the first financial year that all districts were reporting SNOMED code. SNOMED has not been fully implemented at all EDs. Some districts provide this detail through a hierarchical mapping exercise involving recorded symptoms, discharge diagnosis and ICD diagnoses fields, which makes comparisons between districts difficult.
- Tairāwhiti was a late adopter to recording SNOMED codes for ED presentations. Data for Tairāwhiti is reported from the June 2024 quarter onwards.
- This result is a 12-month rolling average of performance to 30 June 2025 and differs from the Quarter 4 result on page 25.

Results by Region and Districts



- This measure is subset of P2-45 and measured on the same basis.



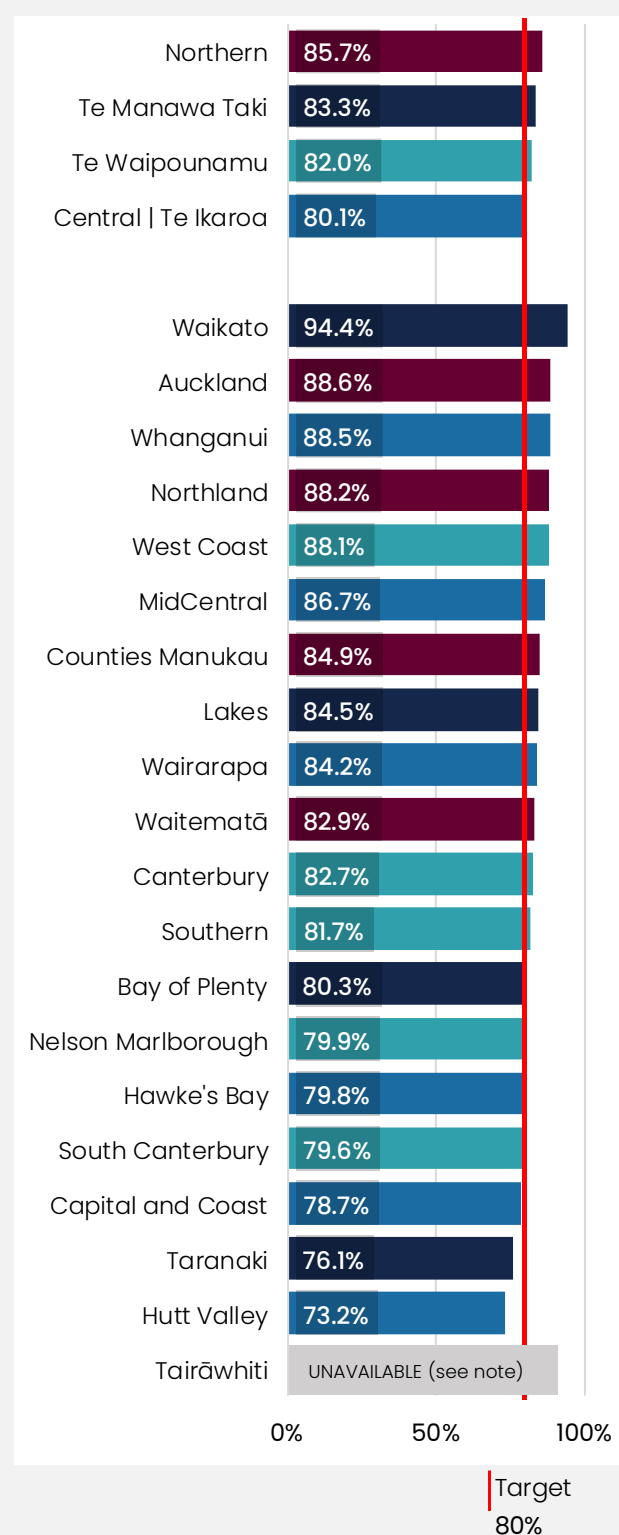
There is ongoing work to ensure timely access and increase utilisation of Access & Choice services.

It should be noted that this is a new measure and the reporting of referral dates became mandatory with consistent definitions and guidelines from 1 October 2024.

Notes to the measure:

- Inclusion of referral date was mandated in October 2024. As such, data prior to Q2 2024/25 is incomplete and does not use consistent definitions of referral date. Data quality improved through Q1 and Q2 2024/25, however Health NZ is still developing systems and controls to support the completeness and accuracy of the reported result, including assurance processes to ensure the accuracy of underlying data provided by IPMHA service providers.
- Data is a subset of the Access and Choice programme and only includes the Integrated Primary Mental Health and Addiction (IPMHA) workstream. This represents approximately 70 percent of Access and Choice activity. Youth, Māori, Pacific, and Tairāwhiti Access and Choice providers are not included in the results as they are not yet submitting data at a national health index level. From 2025/26 through to 2026/27 there is a staged plan to improve the types of data submitted to Health NZ and to expand the coverage for this measure to include other Access and Choice providers' (including Youth, Māori, Pacific, and Tairāwhiti Access and Choice providers).
- This result is a 12-month rolling average of performance to 30 June 2025 and differs from the Quarter 4 result on page 25.
- Measurement of the result and red/amber/green rating is against the 2024/25 milestone.
- A referral can be from a variety of sources including self-referred, from clinical staff or other allied health professions.
- The waiting time is the number of days from the date a patient was referred to an access and choice provider and the date the patient was first seen by the service. This measure only captures patients who have been referred and seen by an access and choice provider in the period

Results by Region and Districts



Ref	Measure	
P2-203	Percentage of people accessing specialist mental health and addiction services who are seen within three weeks	Desired Trend 



	2030 Target	2023/24 Result	2024/25 Result		Quarterly for the last 8 quarters
Overall	80%	79.8%	81.5%		80.8%  80.3%
Māori		82.3%	83.8%		82.3%  81.8%
Pacific		85.5%	85.7%		86.1%  84.6%
Asian		82.8%	84.4%		83.5%  82.8%
NM/NP/NA*		77.5%	79.3%		79.0%  78.7%
Northern		83.3%	84.1%		82.4%  81.3%
Te Manawa Taki		80.6%	82.3%		80.0%  82.0%
Central Te Ikaroa		79.1%	80.1%		79.4%  80.8%
Te Waipounamu		73.2%	77.0%		79.8%  76.2%

*Non-Māori, Non-Pacific, Non-Asian

2024/25 Target - 80%

This measure is also in the Vote Health: Estimates/Supplementary Estimates 2024/25 with the same target

	Prioritised Ethnicity				Rurality**	
2024/25	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	84.7%	87.6%	86.9%	82.0%	84.6%	78.7%
Te Manawa Taki	84.8%	84.9%	82.3%	80.2%	82.2%	82.3%
Central Te Ikaroa	82.5%	79.0%	76.4%	78.9%	79.7%	81.3%
Te Waipounamu	81.3%	79.2%	79.6%	75.6%	77.6%	74.8%
All New Zealand	83.8%	85.7%	84.4%	79.3%	81.8%	79.3%

**Rurality status is unknown for 739 (0.49%) out of the 151,096 total people referred and seen during the year

 Target Achieved
  Partially Achieved
  Not Achieved
 (0.1–5% away from target) (>5% away from target)

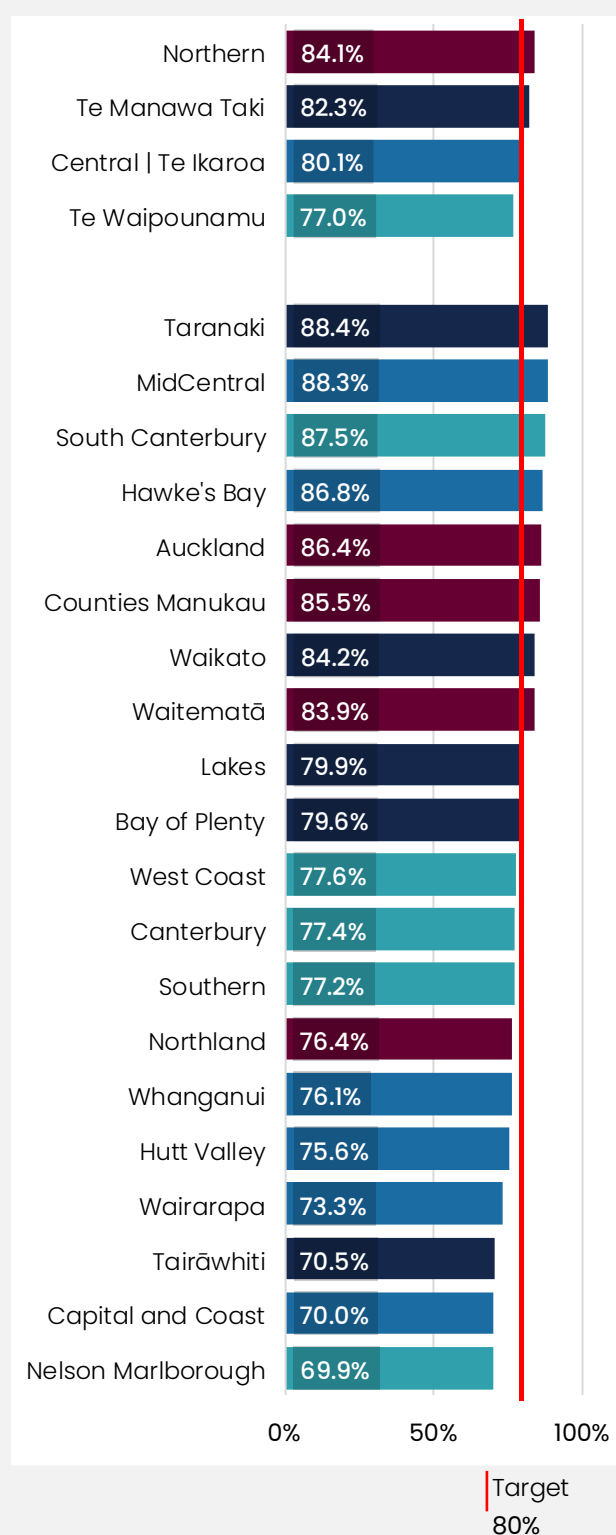
Although the target for faster access to specialist services is newly introduced, historical data—previously unpublished—are available. These data indicate a decline in the proportion of people seen within three weeks by specialist mental health and addiction services, falling from above 80% to below the target over the three years leading up to 2024/25. In 2023/24, performance declined to 79.8%, followed by an improvement in the current year.

The Central and Te Waipounamu regions continue to face the greatest challenges, though both have shown improvement this year. Te Waipounamu recorded a notable 3.8 percentage point increase, despite remaining below target. Performance across service types is not uniform: services delivered by Health NZ's specialist mental health teams are exceeding the target, while Alcohol and Other Drug (AOD) services—delivered by both Health NZ and Non-Governmental Organisations—are below target. Given the patterns of performance across service types and districts, for example, Te Waipounamu's overall performance below target is impacted by its AOD service performance. A focus on understanding drivers and potential barriers to accessing AOD services is underway. Similarly, in Northern, a regional approach to faster access to AOD services is being established.

Notes to the measure:

- Measurement changed in 2024/25 to support more current and inclusive monitoring. All ages, referrals (including inpatient admissions), and addiction services are now included. Our focus is on waiting time to individual teams rather than new episodes/access to services.
- Referrals that have not yet had contact (not seen) are not counted in this measure.
- This result is a 12-month rolling average of performance to 30 June 2025 and differs from the Quarter 4 result on page 25
- Addiction services provided by community providers are included.
- Mental health services delivered by community providers are excluded.
- The PRIMHD submission for the Northland region was lower than expected owing to a system upgrade and resourcing constraints.
- The waiting time is the number of days from the date a patient was referred to a mental health or addiction service and the date the patient was first seen by the service. This measure only captures patients who have been referred and seen by a specialist mental health service in the period. Referrals that are subsequently declined or patients that are referred but have not yet been seen are not included in the measure.

Results by Region and Districts



Ref	Measure				
P2-69	Percentage of young people seen within three weeks from a mental health referral				
		Desired Trend 			
	Target	2023/24 Result	2024/25 Result	Quarterly for the last 8 quarters	
Overall	80%	72.7%	75.5%		73.0%  75.4%
Māori		78.1%	80.1%		78.0%  78.7%
Pacific		82.4%	82.9%		82.9%  83.2%
Asian		74.6%	79.1%		73.1%  75.8%
NM/NP/NA*		67.7%	70.9%		68.5%  72.0%
Northern		74.9%	80.3%		72.9%  78.7%
Te Manawa Taki		72.9%	72.9%		71.4%  72.0%
Central Te Ikaroa		73.7%	75.0%		75.2%  75.8%
Te Waipounamu		66.8%	69.4%		71.8%  71.6%

*Non-Māori, Non-Pacific, Non-Asian

The Vote Health: Supplementary Estimates 2024/25 set a target of 72% to align to the agreed value in the Mental Health and Addiction Targets Implementation Plan. The 2024/25 result is achieved against this target.

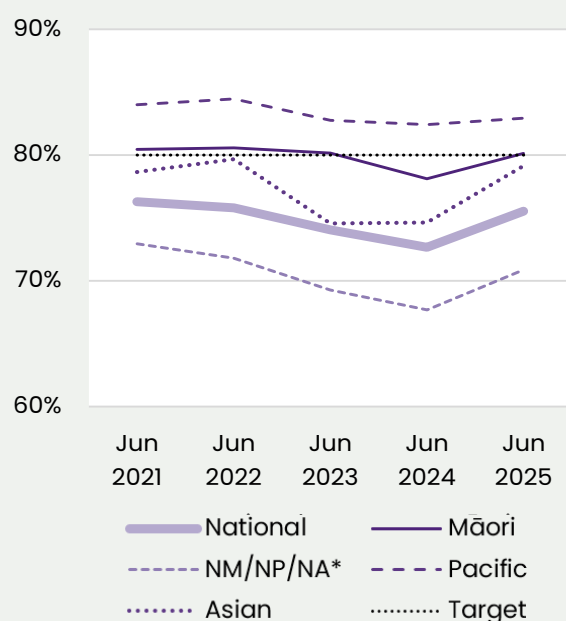
2024/25	Prioritised Ethnicity				Rurality**	
	Māori	Pacific	Asian	NM/NP/NA*	Urban	Rural
Northern	82.4%	85.6%	83.1%	76.2%	80.9%	74.2%
Te Manawa Taki	78.8%	76.5%	70.0%	67.6%	73.8%	69.9%
Central Te Ikaroa	79.7%	75.3%	66.5%	72.2%	74.9%	75.1%
Te Waipounamu	77.9%	75.2%	73.3%	65.6%	71.2%	64.0%
All New Zealand	80.1%	82.9%	79.1%	70.9%	76.6%	70.4%

**Rurality status is unknown for 137 (0.30%) out of the 45,917 total eligible young people with a mental health referral

 Target Achieved
  Partially Achieved (0.1–5% away from target)
  Not Achieved (>5% away from target)

Historical data shows that performance had consistently fallen short of the 80% headline target and deteriorated further this financial year. Three regions—Northern, Central, and Te Waipounamu—have shown improvement this year. Northern recorded the most significant gain (5.4%), followed by Te Waipounamu (2.6%) and Central (1.3%). Te Manawa Taki maintained its performance

Longer-term trend (rolling 12-month period)

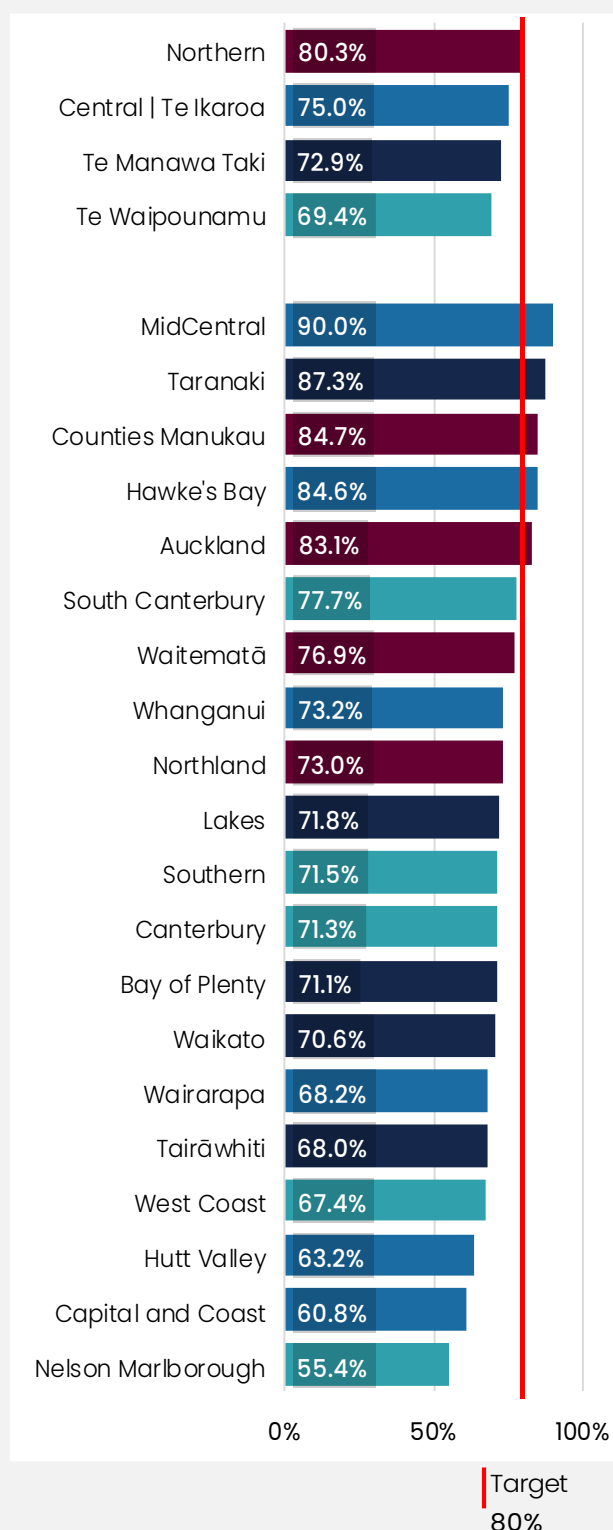


Compared to the all-ages faster access to specialist services target, performance between service types within the under-25 cohort measure shows a different pattern. Alcohol and Other Drug services (delivered by both Health NZ and Non-Governmental Organisations) are performing close to the 80% target, Services delivered by Health NZ's specialist mental health teams are performing below the 80% target. Notably, Health NZ's infant, child, and adolescent mental health services (ICAMHS) are performing well below the 80% across all regions but have demonstrated the most significant improvement since the introduction of the target for faster access to specialist services. Given the patterns of performance across services and age cohorts, there is a significant focus on supporting improvements in ICAMHS in all regions.

Notes to the measure:

- Measurement changed in 2024/25 to support more current and inclusive monitoring. We have moved from a 12-month rolling average to measuring 'seen dates' each quarter and including all ages and addiction services.
- Referrals that have not yet had contact will not show.
- All referrals (including inpatient admissions) are included. Our focus is on waiting time to individual teams rather than new episodes/access to services. Urgent and non-urgent referrals are included and grouped together. Whānau-only face-to-face contacts are now included as in-scope activities.

Results by Region and Districts



Mental Health & Addiction services

Access and Choice is a nationally funded programme that aims to strengthen primary mental health and addiction support through integrated services delivered in general practice, as well as kaupapa Māori, Pacific, and youth settings. One of the five mental health & addiction targets focuses on increasing the percentage of people accessing timely support via this programme.

The Te Manawa Taki region has deliberately focused efforts on lifting access rates to ensure individuals and whānau can receive early support, closer to home. Previously, the regional access rate sat around 83.3% for 2024/25, but it is now tracking around 86% for 2025/26, reflecting sustained improvement.

Key success factors include:

- Strengthened partnerships between general practices, iwi and community providers;
- Investment in the primary mental health workforce, including Health Improvement Practitioners, Health Coaches, and Support Workers;
- Tailored approaches that reflect the needs of Māori, Pacific peoples, youth, and rural communities;
- Consistent focus on timely, culturally responsive, and whānau-centred care.

These gains reflect a collective regional commitment to shifting mental health support upstream, improving wellbeing, reducing pressure on specialist services, and building trust through accessible and equitable care.

Output Class 5: Hauora Māori services

Hauora Māori services are a mix of services, including kaupapa Māori, that have been developed to improve Māori health outcomes and reduce health inequities. This output class provides for the development, implementation and delivery of hauora Māori services, and the development of hauora Māori partners, including partnerships with iwi and IMPBs (Iwi Māori Partnership Boards).

This output class enables commissioning for integrated outcomes and implementation of hauora Māori actions as set out in the NZ Health Plan. While this output class focuses on Māori, the services purchased within it are accessible to, and accessed by, all New Zealanders. Equally, 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 to health services for Māori.

Why is this important?

This output class is intended 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 wellbeing models that draw on the particular context and experiences of Māori to ensure our health system offerings can be designed in a manner that continues to respond to the needs of all people eligible for publicly-funded health services in New Zealand.

Summary of Performance

Health NZ's overall performance for 2024/25, for this output class was:

	Total	Achieved	Partially achieved	Not achieved	Not Reported/No Target
Number of measures	8	7	0	0	1
% of total measures	100%	88%	0%	0%	12%

This year Hauora Māori partners (contracted under the 'Immunising our Tamariki' initiative) delivered more than 93,000 vaccinations, including approximately 32,000 scheduled childhood immunisations for pēpi under 24 months that directly counted towards the Government health target.

The percentage of Māori patients who reported that hospital staff included family, whānau or someone close to the patient in discussions about the care they received was higher than in 2023/4 by 1.3%

Overall, the percentage of Māori patients who reported having trust and confidence in their treatment provider was slightly lower than previous year by 0.3%

Results for output class measures

The following sections present all the measures classified, in accordance with our performance framework, by whether they are an input, output, impact or outcome measure.

Inputs: Summary of Financials

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 \$6M in 2024/25.

Expected revenue and proposed expenditure	2024/25 Actual \$ million	2024/25 Budget \$ million	2024/25 Variance \$ million	2023/24 Estimated Actual \$ million
Revenue – Crown	544	576	(32)	174
Other revenue	5	2	3	0
Total operating revenue	549	578	(29)	174
Total operating expense	444	578	134	203
Surplus/(deficit)	105	0	105	(28)

Input measures

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-205	Percentage of Hauora Māori partners that are meeting their contracted outcome targets as defined in the new outcomes-based contracts	50%	New Measure	88%	
Assessment of Quarter four reporting from Hauora Māori Partners showed 88% achievement of client outcomes across all partners and domains.					
Achievement by domain:					
Domain		Examples of outcomes			
Health enablers	78%	Improved: access to services, education, employment; financial literacy and capability; living conditions.			
Whānau health	89%	Improved: health and wellbeing of māmā and pēpi; long-term conditions; medication management.			
Te ao Māori	89%	Greater quality of life, strengthened cultural identity.			
Whānau leadership and empowerment	83%	Improved: navigation of the health system; health literacy.			
Whānau relationships	80%	Improved quality of care and treatment of whānau, reduction in experiences of racism, stigma, discrimination.			

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-208	Percentage of Iwi Māori Partnership Boards that participate in setting strategic priorities for commissioning in Health New Zealand Te Whatu Ora	80%	New Measure	80%	
12 out of 15 Iwi Māori Partnership Boards submitted final versions of their Community Health Plans that met all expected criteria to inform priorities for commissioning, meeting the 2024/25 target for this measure. Following extensive engagement both within Health NZ and with Iwi Māori Partnership Boards, national and regional processes for integrating Iwi Māori Partnership Boards into Health NZ business planning were established. We are considering the implications of the Government's announcements on 17 June and the subsequent release of the Healthy Future (Pae Ora) Amendment Bill 2025 for Iwi-Māori Partnership Boards and the Hauora Māori Advisory Committee, as well our role in supporting the new arrangements.					

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-237	Support Iwi Māori Partnership Boards in fulfilling their functions as outlined in s30 of the Pae Ora (Healthy Futures Act) 2022	Achieved	New Measure	Achieved	
15 Iwi Māori Partnership Boards have agreements in place which cover administrative support, analytical support, financial support, and support for arranging and funding regional and national forums or meetings. Regular forum and engagements continued to be hosted for Iwi Māori Partnership Boards, relevant data shared and information requests responded to. As per P2-208 a significant focus in 2024/25 was supporting Iwi Māori Partnership Boards to complete their Community Health Plans and be in a position to influence strategic priorities for commissioning in Health NZ.					

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-239	Percentage of Hauora Māori partners that have moved to integrated or outcomes contracts by 30 June 2025	Increase from baseline (2023/24)	New Measure	44%	
The result for this measure was achieved in quarter one with 44% of Hauora Māori Partners moving to integrated outcome contracts. Representing a significant change to the way services are commissioned, from a traditional contracting methodology to a more whānau-centred and outcomes-focused approach, Hauora Māori Partners were supported to implement this new approach and to meet the reporting requirements for their outcomes-based agreements. A performance monitoring framework to enable aggregate reporting on outcome data, was also developed. A further 4% of Hauora Māori Partners, with contracts expiring at 30 June 2025, were also transitioned to outcome-based contracts to commence in 2025/26.					

Output measures

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-110	Percentage of Māori scholarship grants offered under the Hauora Māori Services appropriation that are taken up	100%	New Measure	100%	
An annual initiative specifically designed to address the low rate of Māori in health-related employment, Te Pitomata provides a one-off grant to students currently enrolled in a relevant healthcare study. This year's round launched and closed in March 2025. 1,373 applicants were successful and took up their grant, an increase on the 1,218 funded last year. The 2025 grants are supporting students studying for undergraduate, postgraduate and Rongoā qualifications. Te Pitomata grant funding enables an increase in the capacity and capability of the Māori health workforce. By supporting the attainment of qualifications across the Māori health workforce pipeline, this initiative helps build a sustainable healthcare system that can better serve all New Zealanders.					

Impact measures

Ref

Measure

P2-207

Percentage of people reporting that their family/whānau or someone close to them were involved in discussions about the care received

Desired Trend 

			2023/24	2024/25		Quarterly for the last 8	
	Baseline	Target	Result	Result		quarters	
Overall	77.6%	see below	78.6%	79.0%		79.7% 	77.4%
Māori	76.8%		77.9%	79.2%		78.5% 	77.0%
Pacific	84.0%		85.2%	85.4%		83.4% 	78.8%
Asian	86.5%		85.3%	86.0%		82.6... 	82.5%
NM/NP/NA*	76.4%		77.4%	77.4%		79.3% 	76.7%
Northern			77.7%	78.8%		77.7% 	77.2%
Te Manawa Taki			77.3%	77.1%		77.6% 	75.9%
Central Te Ikaroa			80.1%	80.0%		81.8% 	76.8%
Te Waipounamu			80.1%	81.0%		82.7% 	80.0%

*Non-Māori, Non-Pacific, Non-Asian

Target: Increase from baseline

Baseline: 2022/23 FY

This measure is also in the Vote Health: Supplementary Estimates 2024/25 with a target of 'Improve from baseline May 2024 Overall 90.3%' – This has not been achieved.

Prioritised Ethnicity

2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	77.0%	86.6%	85.5%	75.0%
Te Manawa Taki	79.1%	84.6%	84.7%	75.2%
Central Te Ikaroa	82.8%	75.1%	90.3%	78.4%
Te Waipounamu	77.6%	95.2%	85.2%	80.8%
All New Zealand	79.2%	85.4%	86.0%	77.4%

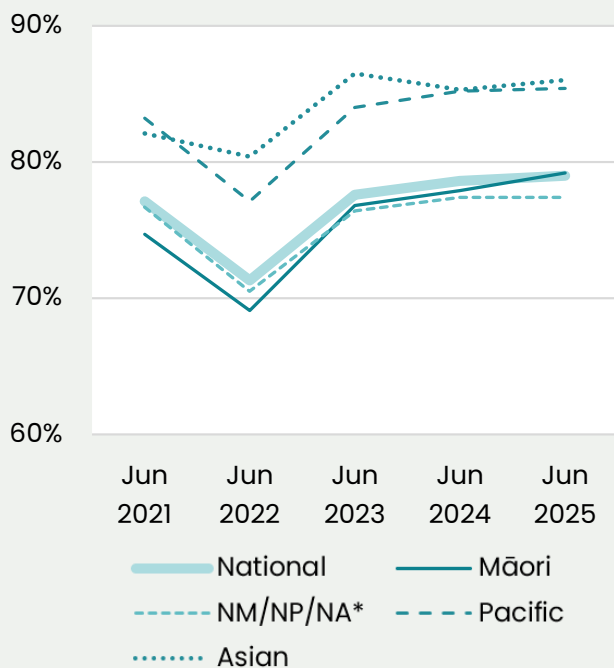
 Target Achieved

 Partially Achieved
(0.1-5% away from target)

 Not Achieved
(>5% away from target)

Overall, the percentage of patients who reported that hospital staff included family, whānau or someone close to the patient in discussions about the care they received was similar to the previous year. Asian and Pacific peoples continue to report higher rates of involvement in discussions than other ethnic groups. However, Asian people seen a decline of 0.5% from baseline and thus a partial achievement.

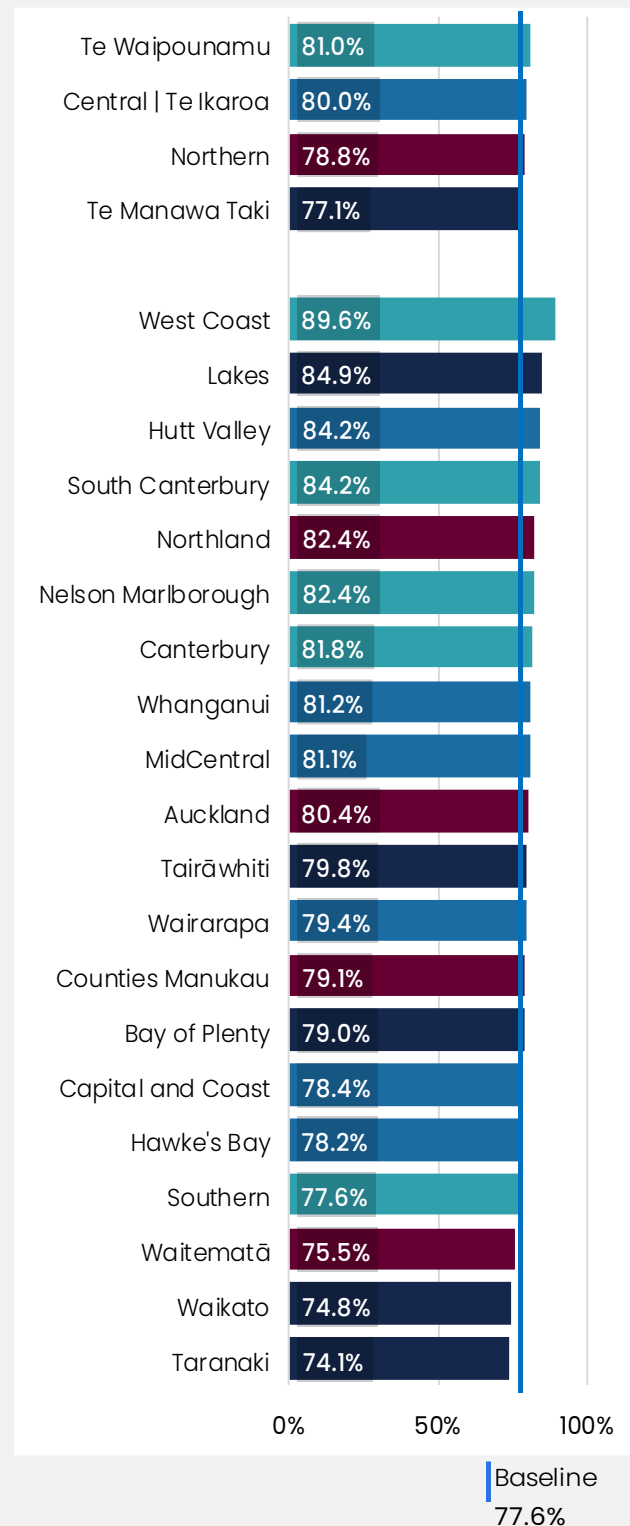
Longer-term trend (rolling 12-month period)



Notes to the measure:

- a) rurality cannot be reported - this is not provided at source
- b) Sparklines represent 8 quarters to May 2025.
- c) Further details on the survey methodology can be found at: www.hqsc.govt.nz/our-data/patient-reported-measures.

Results by Region and Districts



Ref	Measure						
P2-210	Percentage of people reporting that they had trust and confidence in their treatment provider					Desired Trend 	
			2023/24	2024/25	Quarterly for the last 8		
	Baseline	Target	Result	Result	quarters		
Overall	85.9%	see below	87.9%	87.6%		87.2% 	88.1%
Māori	84.5%		85.8%	85.5%		83.7% 	85.6%
Pacific	86.2%		88.2%	89.2%		86.7% 	89.5%
Asian	85.8%		88.4%	87.4%		86.9... 	87.7%
NM/NP/NA*	86.1%		88.2%	87.9%		88.0% 	88.5%
Northern			88.6%	88.4%		88.1% 	88.8%
Te Manawa Taki			87.7%	87.2%		86.7% 	87.8%
Central Te Ikaroa			86.6%	86.7%		85.6... 	87.4%
Te Waipounamu			88.1%	87.4%		87.7% 	87.8%

*Non-Māori, Non-Pacific, Non-Asian

Target: Increase from baseline

Baseline: 2022/23 FY

This measure is also in the Vote Health: Supplementary Estimates 2024/25 with a target of 'Improve from baseline May 2024 Overall 88.4%' – This has been partially achieved.

Prioritised Ethnicity				
2024/25	Māori	Pacific	Asian	NM/NP/NA*
Northern	85.8%	89.2%	87.3%	89.1%
Te Manawa Taki	85.7%	87.5%	87.1%	87.6%
Central Te Ikaroa	85.1%	90.2%	86.7%	86.8%
Te Waipounamu	85.1%	89.1%	88.5%	87.5%
All New Zealand	85.5%	89.2%	87.4%	87.9%

 Target Achieved

 Partially Achieved

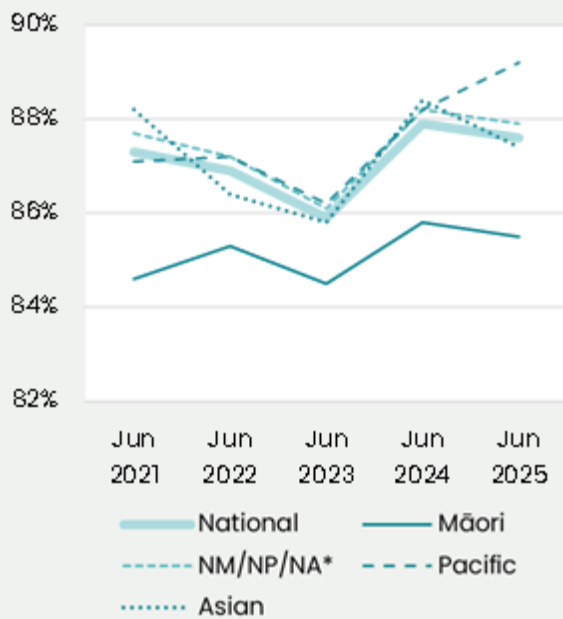
 Not Achieved

(0.1–5% away from target)

(>5% away from target)

Overall, the percentage of patients who reported having trust and confidence in their treatment provider was slightly lower than previous year by 0.3%. However, we seen positive results compared to baseline, with all ethnic groups and regions increasing form baseline..

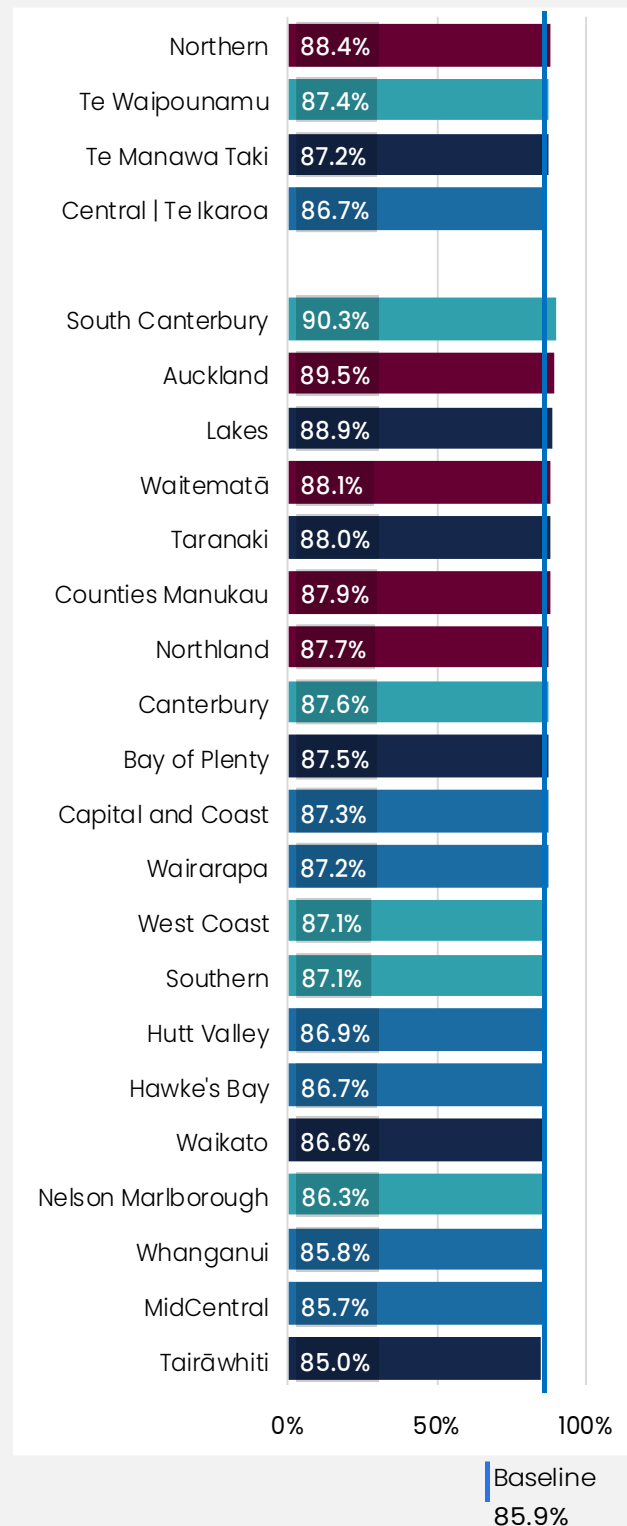
Longer-term trend (rolling 12-month period)



Notes to the measure:

- Rurality cannot be reported - this is not provided at source.
- Further details on the survey methodology can be found at: www.hqsc.govt.nz/our-data/patient-reported-measures.
- Regional comparisons: the national 2023/24 FY baseline has been used as the baseline for regional target comparisons

Results by Region and Districts



Māori Health Outcomes

Our vision for Māori health

Improving health outcomes for Māori remains a priority for Health NZ, with a focus on the key areas that contribute to the difference in life expectancy between Māori and other New Zealanders.

The vision of a health system that delivers the services that whānau and community need is central to *Pae Ora*: Mauri ora | healthy individuals, Whānau ora | healthy families, Wai ora | healthy environments.

The health system as a whole shares responsibility for improving health outcomes for Māori, ensuring health services are timely, easy to access, and of a quality that continues to meet the needs of all New Zealanders. Health NZ acknowledges the contributions of its many partners, including Iwi Māori Partnership Boards (IMPBs) and its Hauora Māori partners, in shaping its understanding of local priorities and the approaches that best advance Māori health aspirations. The 15 Community Health Plans we have received from IMPBs will play a key part in tailoring our services to where they are most needed.

Activities to improve Māori health

As we work to improve Māori health outcomes, we have focused over the past year on those factors that make the greatest contribution to health loss for Māori including:

- a) Cancer
- b) Long-term conditions - cardiovascular disease, diabetes, stroke, chronic respiratory disease
- c) First 2,000 days of life for pēpi
- d) Mental health and Addictions

Cancer care coordination contracts

2024/25 saw 20 Hauora Māori partners provide cancer co-ordination services - supporting whānau to access cancer services from prevention, through to diagnosis, treatment and survivorship, as well as end-of-life care.

Related services to tackle cancer, including education on cancer risk factors and programmes such as smoking cessation, healthy eating, and exercise, were also provided by our hauora Māori partners with over 6,400 whānau members supported with care across the cancer continuum. During quarter three alone, 2,132 people received help to access cancer prevention services, including screenings and vaccination, and diagnosis and cancer treatment.

In June 2025, the number of partners providing this service was increased to expand services from mid-October 2025. These will be in Tāmaki Makaurau (two services), Waikato, Tairāwhiti, Hawke's Bay, Taranaki and Whanganui. They will be delivered through a kaupapa Māori approach and will be available to everyone.

Long term conditions through primary and community care

Taking services to community settings, identifying and contacting whānau who were not engaged with a primary care practice and running free clinics, were a hallmark of the

support provided by our hauora Māori partners throughout 2024/25. Underpinned by a focus on the prevention, early detection and self-management of long-term conditions key examples of these services included:

- Hauora education and promotion activities in community settings
- Nurse support to attend appointments and maintain treatment programmes
- Diabetes-specific initiatives that support whānau through screening, medication management, diet and exercise.

Noticeable achievements reported by whānau included: enhanced self-management skills and confidence, better adherence to medication and treatment plans, improved overall wellbeing and quality of life.

Community-based mental health and addictions initiatives

Significant 2024/25 achievements across our Oranga Hinengaro programmes included:

- Reshaping Oranga Hinengaro services for Māori in the wake of the publication of He Arotake - a Suicide Prevention and Postvention Review in July 2024.
- Influencing the rollout of Peer Support Specialists (PSS) within Emergency Departments to implement approaches that draw on lived-experience and whānau-led practice.
- Supporting the establishment of Te Hurihanga - a mix of community-based and respite residential support to address the 'gap' in local service provision across Southern | Te Waipounamu and to reduce the use of crisis and acute services in the lower South Island.
- Delivering kaupapa focused services and support:
 - To over 27,000 people engaged in Kia Piki Te Ora suicide prevention programmes in the six months from January to June 2025
 - By way of over 115,000 Access and Choice sessions to people with mild to moderate mental health and addiction needs throughout Aotearoa.

Kahu Taurima

Supporting locally-designed kaupapa Māori models of maternity and early years care, our Kahu Taurima programmes are delivered by 34 hauora Māori partners across Aotearoa. On a mission to align innovative, integrated care models that embed Te Ao Māori principles with sound clinical practice, our partners each provide a model of care shaped by whānau, with services tailored to their needs and aspirations. Over 30,000 whānau members were engaged in Kahu Taurima Te Ao Māori models of care over the last 12 months.

Grounded in mātauranga and tikanga Māori, these services include antenatal and postnatal support, parenting education, mental health and wellbeing care, child development services and wānanga for pregnant women. All of which are designed to improve outcomes for mothers, babies and whānau in a way that is culturally-affirming and mana-enhancing.

Other Te Ao Māori Solutions

In 2024/25, a further 30,000 whānau members were also supported to access a range of other hauora funded Te Ao Māori solutions.

These included:

- Iwi-designed and taiao-based wānanga hauora series for rangatahi
- Home and hauora assessments for kaumātua in rural communities
- Combining learning modules, peer groups, and kōrero to support rangatahi achieve hauora and employment goals through mātauranga māori
- Helping rangatahi connect with their whakapapa, whānau, marae and famili
- Supporting whānau with complex quadriplegia to access the support and services they need to manage their condition
- Supports for tāngata turi (deaf) whānau, included advocating for increased tri-lingual interpreter training and supporting tāngata turi to host a national turi conference
- Specialised wānanga for whānau māori who have a child with takiwātanga (autism)
- Disability transport for kaumātua and tāngata whaikaha to attend specialist and primary care appointments

Additional services and programmes to maintain wellbeing including health-centred wānanga, mirimiri and rongoā, and te ao Māori focused exercise programmes were taken-up by more than 27,000 whānau members.

Mātauranga Māori

Drawing on a mix of a proactive, holistic, wellbeing-led approaches, our Hauora Māori partners engaged with over 60,000 whānau members in 2024/25 to deliver mātauranga Māori focused health and wellbeing support, including for example:

- Traditional rongoā healing practices
- Plant based traditional rongoā / medicines
- Healthy lifestyles
- Mahinga Kai development.

Workforce contracts

Investments to support Māori workforce development in 2024/25, have focused on opportunity, and leadership pathways for Māori across the workforce pipeline. This resulted in initiatives to promote Science, Technology, Engineering, and Mathematics (STEM) and pre-tertiary education to rangatahi interested in pursuing health sciences as a career, and tertiary support to enhance tauira (student) success and employment pathways. This year:

- 1,373 Te Pitomata grants were awarded to support tauira across health qualifications.
- Leadership programmes exceeded expectations with 103 graduates, including 85 nurses and 18 midwives.
- Māori enrolment at Otago University's Division of Health Sciences reached 1,065 students (16.2% of total), with enrolments in Medicine, Dentistry, Oral Health, and Radiation Therapy exceeding population parity.

- Pūhoro Māori STEM engagement with 1,371 rangatahi, surpassed its year two target of 750.
- Te Rau Puawai provided support to 146 mental health students, Whakapike Ake at Auckland University supported 462 rangatahi and whānau through eight interventions.

These initiatives demonstrate sustained growth in Māori participation, leadership, and support within the health workforce pipeline, with further work planned to maintain this positive trajectory.

The 2025 Te Pitomata grant allocations supported 1,373 grants across undergraduate, postgraduate and Rongoā Māori categories of study and training. The Te Pitomata Grants 2025 were broadly distributed with the highest numbers in Southern | Te Waipounamu (395) and Te Tai Tokerau (355). Midland | Te Manawa Taki (287) and Central | Te Ikaroa (246) received comparatively fewer grants.

Immunising our tamariki

In 2024/25, Hauora Māori partners contracted under the 'Immunising our Tamariki' initiative delivered more than 93,000 vaccinations, including approximately 32,000 scheduled childhood immunisations for pēpi under 24 months, that directly counted towards the Government's 'Improved immunisations' health target.

The 'whole of whānau' approach offered immunisations and other support to tamariki whānau who might not otherwise engage with vaccination services. The outreach programme works in whānau-based settings and offers manaaki-care and support (taking time to listen, learn, educate and address concerns).

Foetal Alcohol Spectrum Disorder

Investments to support whānau affected by Fetal Alcohol Spectrum Disorder (FASD) are making a positive impact. They have increased whānau access to support, building knowledge through workforce development, addressing the need for prevention and improving navigation of the available services.

Initiatives during 2024/25 included:

- Community-led programmes to support whānau affected by FASD, with anti-stigma and de-escalation strategies, and education sessions on respite care, among the offerings.
- Training our workforce to recognise and respond to FASD.
- A health promotion campaign drawing attention to the risks of alcohol during pregnancy and the impacts of harm.

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 2024-2028, the 2024-25 Statements of Performance Expectations, Vote Health: Estimates of Appropriations 2024/25, and Vote Health: Supplementary Estimates 2024/25.

To further the achievement of equity in health outcomes, performance results in this report provide ethnic breakdowns for Māori, Pacific Peoples, Asian Peoples and the population that is non-Māori, non-Pacific, non-Asian aligned with the Statement of Performance Expectations 2024/25 where possible.

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 2024/25 is shown for selected 'material' measures. We will also disaggregate material measures by rurality, meaning if the person lives in a rural or urban area, to examine equity of access.

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.

Data collection disclosure

During the year, Health NZ continued to migrate from a data collection system that was managed by the previous 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 years 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 2024 through to May 2025 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.

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.

With reference to **P2-176 Increase in percentage of Māori, Pacific, Asian, and other people who say they receive care from a GP or nurse when they need it** (see Output Class 2: Primary and community care services), the following is the survey size, response rate, and confidence interval for the question

The 'Response included' column shows the total number of respondents for the question. The 'Response rate' column shows the percentage of total invited respondents (210,000) who answered the question. Unweighted results were used here because whole numbers make more sense.

	Response included (for survey)	Response rate	Confidence interval (for relevant question)
Q1 2024/25 August 2024	31,931	15.8%	+/- 0.5 percentage points
Q2 2024/25 November 2024	32,277	15.5%	+/- 0.5 percentage points
Q3 2024/25 February 2025	32,441	15.8%	+/- 0.5 percentage points
Q4 2024/25 May 2025	35,090	16.0%	+/- 0.5 percentage points

Organisational Health and Capability



Clinical leadership

Effective and high-performing clinical governance across the whole of Health NZ is essential to ensuring excellent quality and safe care delivery and experience for all patients and whānau. We have a national team that ensures clinical input and professional expertise is engaged in decision-making about strategy, service design and delivery at all levels of Health NZ – nationally, regionally and locally. It also:

- provides professional leadership, including scopes of practice, performance, conduct and professional development of clinical staff.
- provides system-wide support for clinical governance, quality management systems, and patient safety initiatives to ensure the use of processes, frameworks and practices that drive continuous improvement and effectively manage clinical risk.
- leads the development of national core standards, thresholds, guidelines, and models of care to define expectations and, through national clinical networks, guides Health NZ toward consistent, best-practice healthcare delivery nationwide.
- works in partnership with Hauora Māori, Pacific and Disability leaders to ensure that decision-making focuses on equitable outcomes.
- drives clinical partnership to support health target planning and achievement.

During 2024/25, Health NZ established its permanent national clinical leadership team and consulted on and embedded consistent district-level clinical leadership in medical, nursing, allied health, scientific & technical, and midwifery professions.

New Zealand Clinical Senate

The Senate is a multidisciplinary group that has been established to provide constructive, independent, impartial strategic advice to the Board on system-wide issues that affect quality, affordable and efficient patient care.

District and Regional expressions of interest for Senate issues in May 2025 resulted in 208 EOIs received from across districts and regions. Membership was confirmed in August 2025, see <https://www.tewhatauora.govt.nz/corporate-information/about-us/expert-groups/new-zealand-clinical-senate>.

The first Senate meeting is scheduled for October 2025 with the inaugural Senate report expected to be completed by December 2025.

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 through the development of national standards and models of care.

Networks provide clinical leadership and advice on national service configuration within their specialty. This includes informing decisions on national service specifications and role

delineation. Additionally, they identify areas of unwarranted variation in healthcare delivery within their specialty and solutions to address these issues.

At 30 June 2025, there were 13 National Clinical Networks operating, with Pathology in the process of being established as a new network.

- | | |
|------------------------------|---------------------------------------|
| 1. Cancer | 8. Mental health and addiction |
| 2. Cardiac | 9. Oral health |
| 3. Diabetes | 10. Radiology |
| 4. Eye health | 11. Renal |
| 5. Infection services | 12. Rural Health |
| 6. Maternity | 13. Stroke |
| 7. Trauma | |

Quality and Patient Safety

Nationwide-wide support is critical for Health NZ's clinical governance, quality management systems, and patient safety initiatives, to drive continuous improvement and effectively manage clinical risk.

National Events, Feedback and Risk Management System

Work commenced in 2024/25 to establish a single national system for recording and managing events (incidents – includes staff H&S and patient events), consumer feedback and risk management. This work is expected to be completed by early 2027 and involves moving all regions and districts onto a system already in use in Te Waipounamu Region.

The national system will standardise categories, which will enable comparative reporting at national, regional and local levels, providing better information to inform risk management, quality improvement, decision-making, and reduction of harm.

Clinical Governance Framework

During 2024/25 Health NZ worked collaboratively, including with consumer representatives, to develop a national Clinical Governance Framework (it was finalised in August 2025).

The framework provides structure and accountability for clinical governance, as well as four quality domains which outline the main activities that are required to monitor and improve quality and safety within health services: Consumers and whānau are active partners; engaged, effective and clinically-effective healthcare; and system safety and learning.

We would like to acknowledge the Health Quality & Safety Commission | Tāhū Hauora for its work in developing **Collaborating for Quality: A framework for Clinical Governance**, which formed the basis of our work.

Meeting the code of expectations for Consumer Engagement

By June 2024, Health NZ had established four regional consumer councils, along with a framework and policies to guide their operations. The aim of the councils is to strengthen engagement with consumers we work together to plan, develop and monitor health services and to help share consumer knowledge and experience consistently with Health NZ's leaders at a regional level.

While members do not represent specific groups, the selection process ensured a diverse membership from throughout each region, featuring urban/rural, ethnic, disabled and rainbow voices. During 2024/25 significant milestones achieved include publishing their Terms of Reference and contact details (see <https://www.tewhatuora.govt.nz/corporate-information/about-us/expert-groups/regional-consumer-councils>), finalising membership and resourcing, councils meeting regularly online or in-person, identifying key work programme priorities, and engaging with their respective Health NZ regional directors regularly.

The Quality Safety Marker (QSM) for consumer engagement is a self-assessment reporting framework, coordinated and published by Health Quality Safety Commission. It gathers examples of consumer engagement activities to demonstrate how agencies are meeting the Code of Expectations. Reporting against the QSM measure (P2-36 in Output Class 3 – Hospital and specialist services) is found in the Statement of Service Performance section of this report.

This year, following a change from district to regional QSM reporting, Health NZ has leveraged opportunities within its new regional structures to enhance understanding of, and compliance with the Code. Achieving nationally consistent improvement in self-assessed results over time is proving a challenge, so Health NZ and HQSC are discussing how to better align effort and impact, taking into account the resources available to do this work.

Māori Crown Relations

Health New Zealand | Te Whatu Ora (Health NZ) works closely with the Ministry of Health in upholding and fulfilling the Crown's health-sector obligations within Treaty settlements.

In 2024/25, we completed a comprehensive stocktake of all inherited Treaty settlement commitments, including Iwi-Crown Accords, Relationship Agreements and former District Health Board (DHB) Memorandums of Understanding with Iwi. This has enabled us to centrally manage these responsibilities through a national working database, including processes to ensure our legal obligations continue to be met.

Health NZ also works closely with Te Puni Kōkiri | Ministry of Māori Development and Te Tari Whakatau | the Office of Treaty Settlements to maintain accurate records in Te Haeata, the Crown's Treaty settlement portal. Health NZ reports on 72 Treaty settlement commitments across seven settlements, comprising both cultural and commercial redress.

As at 30 June 2025:

- **Cultural commitments**

Completed: 40% (two commitments across two settlements). Health NZ has completed the actions required to deliver the commitment(s).

Yet to be triggered: 60% (three commitments across one settlement). Health NZ is yet to start delivery of the commitment(s). It may be conditional on other commitments or is to be delivered at a certain time in the future.

- **Commercial commitments**

Yet to be triggered: 100% (comprising 67 commitments across five settlements). Health NZ is yet to start delivery of the commitment(s). All relate to land owned by Health NZ which are subject to, for example, a Right of First Refusal (RFR). An RFR can be triggered at such time that Health NZ deems the lands surplus to requirements.

In late-June 2025 Health NZ, alongside the Ministry of Health, agreed to enter into three new Relationship Agreements with Iwi approaching settlement with the Crown. The actual number of commitments Health NZ will be assigned via these settlements is not yet determined, so is not accounted for above.

In response to the Office of the Auditor-General's recommendations, we are strengthening our systems to monitor, report and give effect to these commitments. Importantly, we recognise also that Iwi Māori Partnership Boards (IMPBs), while a key mechanism for Māori engagement, do not replace the direct Treaty relationship between Iwi and the Crown.

Iwi Māori Partnership Boards

Established under the Pae Ora Act as one of a number of mechanisms to enable Health NZ to give effect to Te Tiriti o Waitangi, Iwi Māori Partnership Boards (IMPBs) play a key role in ensuring that local priorities inform and shape services in a way that optimises outcomes for Māori whānau.

Throughout 2024/25, Health NZ worked with IMPBs to design, commission and deliver services that both offered choice and responded to Māori needs. IMPBs also maintained a role in monitoring the performance of the health sector in their communities - assessing how well the system works for Māori and how services might be improved to best serve those communities.

The strong networks and working relationships that have been established regionally, with IMPBs engaging with local health providers, clinical leaders and Health NZ commissioners, provide a sound foundation for our work into the future, with a collective focus on achieving agreed hauora outcomes for Māori.

Pacific Health

Health NZ works in partnership with providers, agencies, and communities to ensure Pacific peoples have access to high-quality, culturally-responsive care close to home. Our aim is to ensure the publicly funded health sector delivers services and care that meets the needs of Pacific families and contributes to closing the life expectancy gap for Pacific communities.

Pacific Peoples Health Outcomes and Life Expectancy

Despite some progress over recent years, improvements in life expectancy for Pacific Peoples have plateaued, and significant disparities in health outcomes persist. Currently, there remains a six-year life expectancy gap between Pacific Peoples and non-Māori, non-Pacific populations. This gap is predominantly attributed to preventable premature deaths.

For the year ending 30 June 2025, data highlights concerning rates of potentially preventable acute hospitalisations among Pacific communities:

- Pacific children aged 0–4 years experienced 15,110 hospitalisations per 100,000, significantly higher than the 5,446 per 100,000 among non-Māori, non-Pacific, non-Asian children.
- Pacific adults aged 45–64 years had 8.101 hospitalisations per 100,000, compared to 3,075 per 100,000 observed in non-Māori, non-Pacific, non-Asian adults.

Chronic health conditions remain a substantial challenge for Pacific Peoples. There are high prevalence rates of diseases such as gout, diabetes and cardiovascular conditions, often with individuals managing multiple chronic illnesses simultaneously. Alarming, these conditions tend to manifest at younger ages within Pacific communities compared to the general population.

Addressing these disparities is critical to improving health equity and life expectancy outcomes for Pacific Peoples. Our ongoing commitment focuses on preventive care, culturally-tailored interventions, and community partnerships to reduce avoidable hospitalisations and manage chronic diseases more effectively.

Initiatives to Strengthen Pacific Health Outcomes

Pacific Outreach contracts enable the work of 31 Pacific providers across the country, delivering services in immunisations, family-centred care, health education and long-term condition management. These providers ensure culturally-responsive, community-led healthcare that increases access and choice for Pacific families. Pacific providers use trusted, community-based models to deliver care and referrals, which are highly valued by the communities they serve.

Pacific providers, including the Pacific Regional Coordination Hub, delivered 11,891 vaccinations for Pacific children under 24 months during FY 2024/25 – out of a total of 16,919 vaccinations for children of all ethnicities in that age group¹.

Thanks to the targeted, community-led efforts during the last quarter of 2024/25 by Pacific providers in the Northern region, in that region milestone coverage for Pacific children at

¹ Previous data on childhood vaccinations delivered by Pacific providers was underreported due to incorrect mapping of providers to the Pacific provider type group. This issue has now been corrected in the Aotearoa Immunisation Register.

24 months has surged, jumping 10.5% from 70.6% in June 2024 to 81.1% in June 2025 (when comparing rolling 3 month data). In Counties Manukau, where Pacific communities are highly represented, Pacific providers achieved a significant 8.6% increase in performance, lifting coverage from 75.7% in June 2024 to 84.3% in June 2025 (when comparing rolling 3 month data). These results reflect the strength of Pacific providers' culturally-responsive models of care.

Pacific Provider Development Funding

The Pacific Provider Development Fund is a vital investment in strengthening Pacific health providers across New Zealand. By supporting organisational growth and workforce development, the fund ensures providers are well-equipped to deliver high-quality, sustainable health and disability services that are culturally appropriate and tailored to the needs of Pacific communities.

Through this investment, Pacific health providers grow in strength, capability and reach - resulting in an increase in the number of providers and broader service delivery to Pacific families. This expansion empowers families with greater choice and access to services that reflect a distinct Pacific focus and supports the delivery of high-quality, sustainable health services that are 'by Pacific, for Pacific' and tailored to the needs of Pacific communities.

The Fund also contributes to a more sustainable and accountable health system, fostering environments that support equitable health outcomes for Pacific peoples. Providers are increasingly able to demonstrate their models of care and the health outcomes they achieve.

As a result of these strengthened services, it is intended that Pacific families can experience improved health literacy and self-management, including:

- Higher vaccination rates
- Increased participation in health screening
- Better management of long-term conditions
- Greater focus on overall wellbeing
- Enhanced preparedness for emergencies.

Health of disabled people

Achieving equity of health outcomes and equitable access to healthcare for disabled people in a measurable and meaningful way requires a systemic approach to improving and being responsive in the way we deliver services.

A picture of disability health

Monitoring and reporting on health outcomes for disabled people is a longstanding challenge due to the historic lack of disability data in the health system. Efforts over the past year to find and collate available data from health surveys, map patient journeys and care pathways for disabled people, engage with the community and assess organisational capability have resulted in a clearer picture of the current state for disability health.

Disabled people have the same healthcare requirements throughout their lives as non-disabled people and interact with all health services, often at a higher rate than non-disabled people. At the same time, many disabled people also have complex health needs, including high levels of co-occurring health conditions and chronic health conditions, as well as any specific healthcare needs related to their disability. Disabled people comprise a high proportion of patient flow across health services, especially emergency services.

Health services are frequently not meeting the needs of disabled people, with one in three (29%) reporting unmet need for health services despite this population having more contact with health care providers. Disabled people are less likely to report good health, more likely to present to emergency departments (54% in the last year), and more likely to be admitted with longer hospital stays. Despite this greater contact and broader range of requirements, disabled people are less likely to be investigated, referred or offered treatment. See the [2023/24 New Zealand Health Survey](#) and [Household Disability Survey 2023](#) for more information.

Low capability in our workforce on disability matters and inaccessible healthcare pathways for disabled people contribute significantly to poor health outcomes and system inefficiencies, driving down system performance and health target achievements.

Regular Disability Capability assessments to measure and inform targeted organisational capability uplift indicated that in 2024/25 our organisational disability maturity baseline score dropped from 1.58 to 1.41 out of a possible four, which means our capability state remains between 'nil or basic' and 'reactive'. This baseline score informs the prioritisation of actions for Health NZ to uplift our disability capability maturity to a score of four ('innovative') by 2027.

Key Activities in 2024/25

In 2024/25, Health NZ advanced several foundational initiatives to improve system responsiveness and equity for disabled people. A major focus was on disability data, where inconsistent collection continues to limit our ability to monitor participation and improve outcomes. To address this, Health NZ is collating existing data and leading the development of a Patient Profile NHI (PPNHI), which will introduce a disability identifier and capture access needs at point of care. Phase 2 of the PPNHI project, completed this

year, focused on discovery and design, with Phase 3 set to scope implementation and pilot delivery in FY26.

Alongside data improvements, work was progressed on Disability Models of Care to embed equity and accessibility across the services we fund and deliver. These models are patient-focused and system-integrated, supporting universal access to assistive services and inclusive practices. Key initiatives included the development of the Purple Envelope—a communication tool for residential disability support services and emergency departments—now in final design following extensive community consultation. Accessibility of health information was also enhanced, with NZ Sign Language and alternate formats introduced for public health campaigns and radiotherapy journeys. Procurement processes were updated to embed disability equity in service contracts, and a training plan is underway to support kaimahi in applying disability considerations across the commissioning cycle.

To strengthen workforce capability we launched 12 new disability e-learning, integrated disability education into orientation programmes, and expanded Disability Health Study Days to a wider national audience online. Tools such as “Hello, I’m Deaf” cards were redistributed to support accessible communication in clinical settings. Finally, regional policy reviews were undertaken using the Policy Review Guide, resulting in disability being formally included in policy due diligence processes alongside Māori, Pacific and Legal considerations.

Consumer and whānau voice

Health NZ commissioned work to seek feedback and insights from the disability community, and this showed high level of dissatisfaction with the consistency and proactivity of our existing engagement and communication with the community; particularly the lack of accessible information, points of contact and feedback pathways, and “frustrating and circular” processes.

These findings and associated recommendations were incorporated into a disability communication and engagement plan, and informed the development of two priority actions to improve and embed engagement with the disability community: Incorporating a disability question in feedback processes to identify if feedback or complaints relate to disability, identify themes and respond systemically; and Establishing a dedicated point of contact for disabled people in Patient Administration Services to enable disabled people to ask questions, request assistance, or find the right person to talk to.

Health NZ also prioritised the establishment of community partnerships, networks and engagement across collaborative projects, including:

- a disability partnership group and disability community testing to guide Patient Profile NHI (PPNHI) development
- engagement with Disability Residential Services and key Disability NGOs on the Yellow envelope redesign to ensure the product will be fit for purpose both across emergency department and residential services.
- ensuring disability community representation in Regional Consumer Council membership

Our digital infrastructure

Improving access, outcomes and productivity

Health NZ is focused on sustaining and maintaining our most critical digital services, especially those supporting clinical service delivery. The current digital landscape is complex, fragmented and fragile. To date we have identified approximately 615 critical, i.e. category 1 and 2 systems (with categorisation of all systems not yet completed).

These systems have varying levels of regional consolidation. There is a high number of district-specific applications often used by few end users, and we have over 6,000 applications in use. Digital system limitations and regular outages impact the patient experience, clinical productivity and the quality of care.

Our improvements include a combination of regionally/clinically-focused initiatives and work to address urgent critical infrastructure issues, to 'manage convergence' towards fewer yet better and more modern systems, and to lift the performance of the inherited legacy environment.

We now manage our digital services nationally, with resultant economies of scale and the ability to deploy modern digital platforms and capabilities, in partnership with the regions. As at 30 June 2025, 552 projects and initiatives were completed, with a total investment value of \$257.12 million. These projects range from minor updates, enhancements and life-cycle management to significant IT programmes, with a focus on maintenance and establishing clinical solutions.

Enhancing the experience and productivity of clinical staff

Digital tools can support standardised clinical workflow, improve user experience, increase efficiency, and enhance the flow and utility of information between care settings. In 2024/25 we:

- Delivered an electronic medication management system, Medchart, in Southern, Waitaha | Canterbury, and MidCentral districts. By reducing medication errors, facilitating real-time updates, and integrating with the NZ ePrescription Service (NZePS) and Medicines Data Repository (MDR), MedChart optimises prescription and pharmacy processes and reduces administrative workload. This upgrade also addresses cyber security risks, reduces technical debt and overhead costs.
- A long-awaited replacement of the mental health system in Northland. Regional Collaborative Community Care is a wide-ranging application designed to support Addiction and Community Health Services, replacing a paper-based system with digital tools and processes. This enables efficiencies for district nurses and other clinicians.
- Delivered a national Service Desk platform so that kaimahi can access help when they need it, now used by 12,003 of our clinical staff. This enables staff to access applications required from a single device.
- Deployment of new devices – we replaced around 8,881 desktop / laptops, thin clients, and iPads; 3,717 monitors; and 1,458 'other' aged devices for clinical staff.

Improving health service access and outcomes

We are empowering people to connect into services in lower-cost settings of care, receive care closer to home and utilise data to make informed decisions.

- Te Puna, our online breast screening system, enables enrolment and appointment bookings online, nationwide. Te Puna sends a secure personalised link or QR code via email, text or letter to women when they become eligible or are due for a screen. This has significantly improved access to breast screening services – particularly for wāhine Māori, Pacific women, and women who are under-screened or unscreened.
- Email validation functionality in the Te Waipounamu Patient Administration System is complete. The region was printing approximately 1.1 million letters per year - emailed PDF letters will now enable most hospitals in the region to avoid risks to patients associated with limited postal mail delivery and realise savings in avoiding postage costs and reduced staff effort.

Building sustainable and resilient digital foundations

We are creating a technical environment that is less complex and more stable, focused on 'next generation' solutions and infrastructure. In 2024/25 we have:

- Replaced old technology with modern, cloud-based digital systems to give clinicians a unified view of the patient journey. The South Island, Northern Region, Auckland and Central Districts are now connected through their respective Patient Administration Systems. These complex multi-year projects have replaced dated and fragmented technology with fit-for-purpose, connected and supported technology. They will create workflow efficiencies for clinicians and will improve patient, staff and whānau experience.
- Completed further rollouts towards a national maternity and neonatal system with a single care record shared between system users. BadgerNet Maternity is now operational in 12 districts (14 hospitals) and 19 primary birthing units, with 43% of community-led maternity carers also using the system. BadgerNet Neonatal is implemented at two hospitals and currently being implemented at Counties Manukau. This means smoother/real time data sharing and record-keeping, enabling better care for pregnant women/people and newborns. Further rollouts are funding dependent.
- Delivered a new Radiology Information System (RIS) and a new Picture Archiving and Communication System (PACS) in Te Manawa Taki region. This upgrade aligns radiology services across all five districts: Waikato, Lakes, Bay of Plenty, Taranaki, and Tairāwhiti. It fosters a more collaborative and inclusive way of working.
- A national digital facility framework to support major builds. This will be used for Dunedin Hospital and will inform upgrades in Nelson, Whangarei and beyond.
- Added meningococcal, mumps, and other diseases to the National Disease Management System, enabling coordinated case and contact tracing for communicable diseases at a local, regional and national level.
- Cyber Security Operations national approach. Our investment continues to reduce incidents, speed up recovery and enable smarter responses. We improved data loss prevention with a new Data Protection Tool. This reduces accidental sharing of large

volumes of personal information by identifying external emails that contain a high volume of NHI numbers and asks senders to check data and recipients.

- The Health sector agreements and payments programme builds systems that enable a modern and flexible approach to how we procure services from external providers. It will enable changing funding models and different contractual mechanisms.

Managing a complex IT environment

Digital infrastructure and services are a critical enabler and change catalyst for improving health service access and health sector productivity. Despite efforts to improve our systems, the inherited patchwork of IT systems can still impede better patient care, frustrate our employees and impact productivity.

- ~75% of hospitals use paper-based medication prescribing and administration, which can increase medication errors;
- ~80% of our hospital diagnostics are using paper-based ordering processes which increases unnecessary orders by ~5%;
- ~75% of hospitals using paper-based vital sign recording and escalation of early deterioration warnings meaning we find errors later which created harm we could have prevented
- ~65% of hospitals are using paper-based progress notes which can add time when a clinician wants to document care.

The long-term underinvestment and poorly focused historical investment in digital infrastructure) has resulted in a large amount of technology that is no longer fit for purpose and out of vendor support.

We have made significant progress to simplify and unite the digital landscape. With further improvement opportunities and as resources allow our focus is on prioritising the digitisation of paper processes. However, the complex landscape means that simplification and standardisation is challenging. In some cases, an upgrade towards a national system is either not the highest value option or will require significant investment.

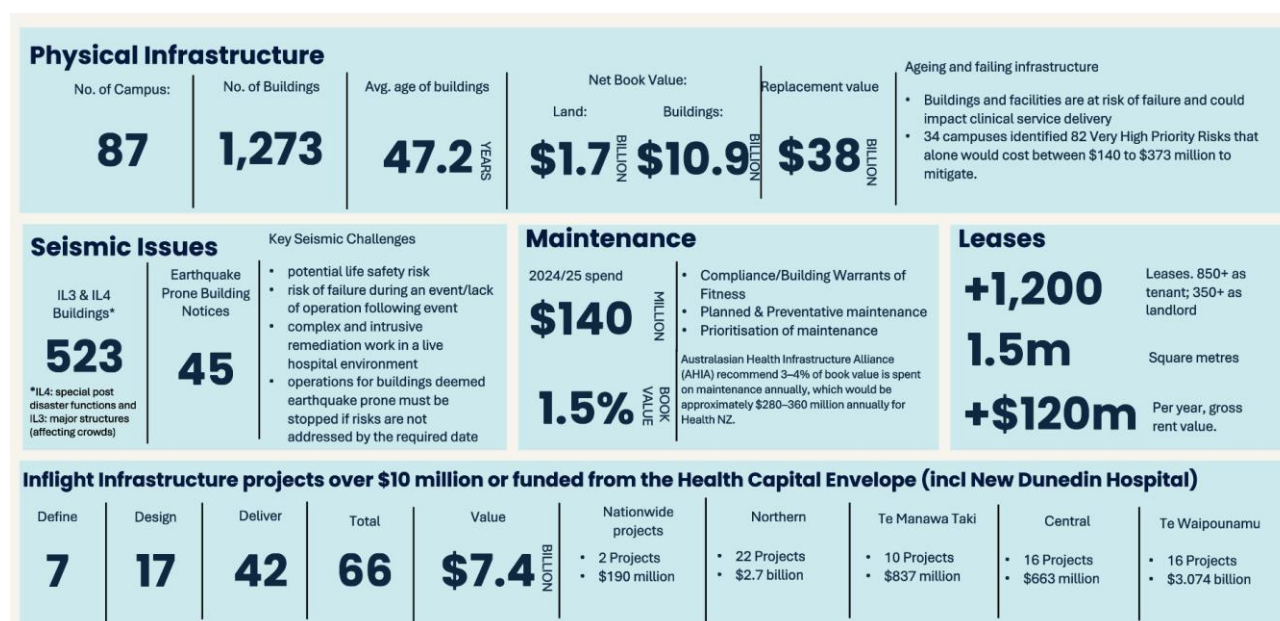
Our Digital Investment Plan (DIP), in development, describes the strategy for investment to drive and support high-quality, sustainable healthcare. The investments outlined in the DIP will enable the delivery of a sustainable digital infrastructure portfolio, stabilising and enhancing our digital services to meet a growing population with changing needs and is designed to respond to new models of care.

Our physical infrastructure

Safe, fit for purpose health facilities, sites and equipment are essential for a well-functioning health system to improve the health of all New Zealanders.

Health NZ has brought our public hospital buildings together into one portfolio, to ensure that the health estate supports the delivery of services. The portfolio has over 1,200 buildings across 87 campuses with an average age of 47 years, totalling a net book value of \$10.9 billion (replacement value \$38 billion).

We ensure health facilities, sites and equipment with the highest need of investment are prioritised and standardise how these are maintained, refurbished or redeveloped.



Summary of Physical Health Infrastructure

Some significant physical health infrastructure projects that reached practical completion² during the 2024/25 financial year include:

- Replacement of Linear Accelerators at Auckland City Hospital
- Upgrade of the Rotorua Women, Child and Family Facility
- Upgrade of the Acute Mental Health and Addictions Facility (Te Whare Awhiora), Gisborne Hospital
- Surgical Services Expansion Project, Hawke's Bay Hospital
- Upgrade of the Nelson Mental Health Inpatient Unit (Wahi Oranga)
- Purchase and fit-out of Manaia House community mental health facility in Whangarei.

² Practical completion refers to the stage in a construction project when the building and fit-out are complete, except for minor omissions and defects that do not prevent the property from being used for its intended purpose. It is a key milestone marking the point at which the infrastructure component is considered complete. Operational go-live is when the facility is being used.

Investment and Planning

The Health Infrastructure Plan (The Plan)

The Plan was approved by Cabinet in March 2025 and published in April 2025 **Health Infrastructure Plan – Health New Zealand | Te Whatu Ora**.

It outlines a comprehensive, phased programme of hospital and facility developments across the country to be delivered in three to four stages. This includes major new builds and expansions including new acute services buildings, inpatient units, expanded emergency departments and wards, and upgraded facilities.

The Plan is underpinned by the Nationwide Clinical Service and Campus Plan, which seeks to deliver more health services in the community and reduce demand on hospitals. Health NZ has submitted the key priority investments planned for assessment in Budget 2026 in the Infrastructure Priorities Programme.

Standardised design and consistent functional requirements

Health NZ is developing a nationally standardised approach towards establishing requirements for health infrastructure and designs for use across facilities, including:

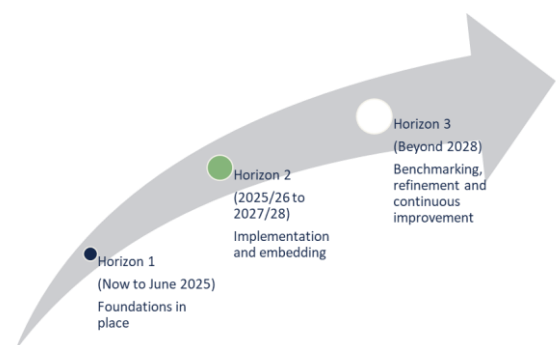
- Demand and capacity modelling for forecasting future health needs so that hospitals are responsive to current and future need;
- Functional Design Briefs and Schedules of Accommodation to promote consistent, high-quality hospital design, streamlining processes and facilitating meaningful clinical input;
- Modular elements based on the Australasian Health Facility Guidelines to support efficient and quality planning and design.

National Asset Management Strategy

Supporting the Health Infrastructure Plan, the National Asset Management Strategy (NAMS) was published in April 2025 **National Asset Management Strategy - Infrastructure – Health New Zealand | Te Whatu Ora**.

The NAMS contains a roadmap to lift asset management practice across the health estate. The NAMS is about improving the practices and tools that Health NZ needs to better manage all public health infrastructure. In practical terms, it provides a forward plan and the ability to manage health facilities so they operate effectively and efficiently, enabling clinical service provision 24/7.

Achieving the desired uplift in asset management practice is a multi-year journey. The diagram shows the three horizons. Health NZ has delivered Horizon 1: foundational activities.



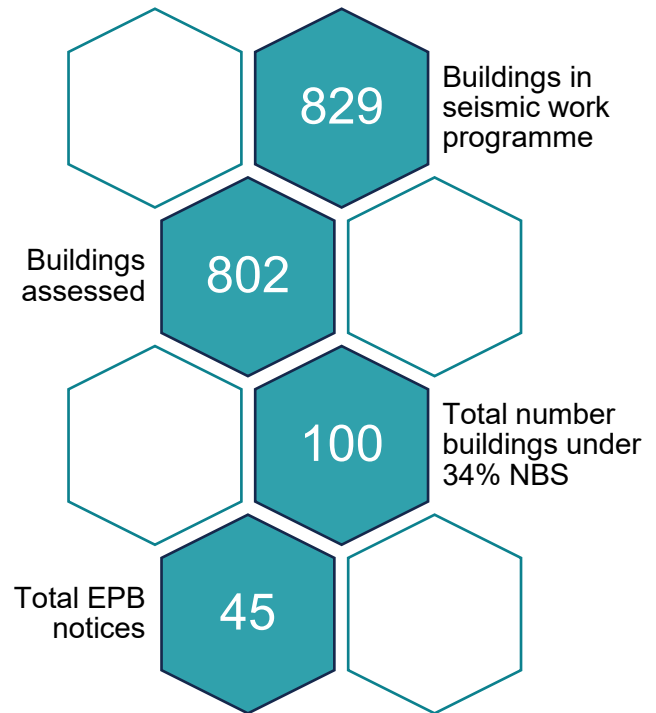
Seismic work programme

Health NZ has 45 buildings that are considered Earthquake Prone Buildings (EPB). Buildings with the highest seismic risk are being considered for investment as part of a prioritisation process.

Seismic resilience is taken seriously, guided by MBIE Seismic Risk Guidance and the Health and Safety at Work Act 2015. Expert engineers advise on risk, and interim safety measures are implemented where needed.

Health NZ has developed and implemented:

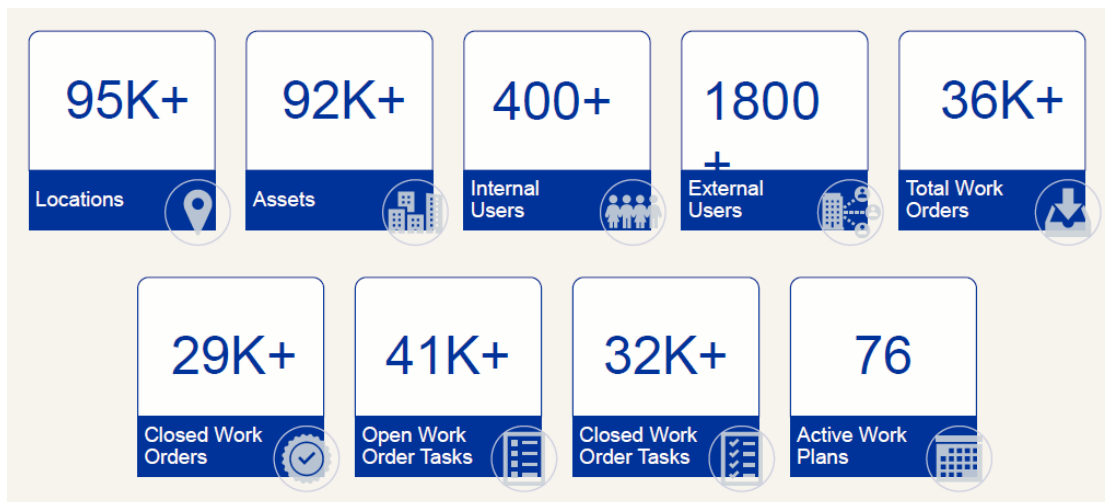
- A Seismic Policy and Strategy
- An externally legally reviewed occupancy risk evaluation process
- Guidance for the design of new hospital buildings
- Post-earthquake response arrangements to address the 'do we stay or go decision' following an earthquake
- A process to assess the level of seismic restraint in our buildings
- Reporting dashboards to ensure national visibility



Asset Management Information System

The initial roll out of a new national Asset Management Information System was completed in June 2025, with the successful migration of all campuses on to the tool for reactive maintenance. This is a national system to manage our assets more effectively for buildings, plant, infrastructure, land and property. This helps us to see the big picture and make strategic decisions on our asset management.

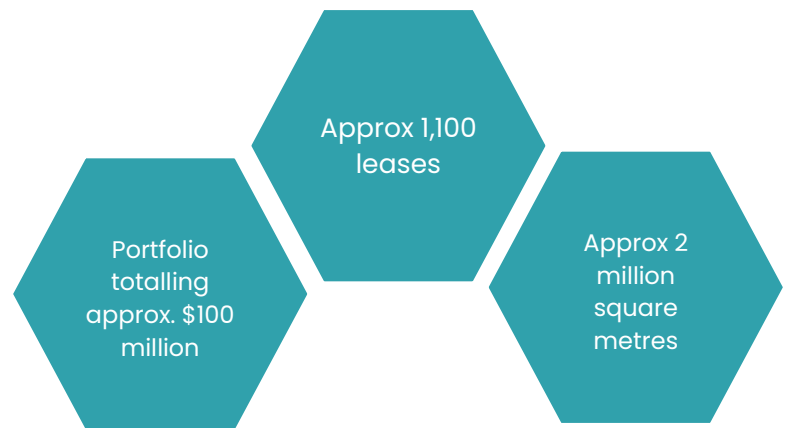
A snapshot of the numbers



Land and Property

Health NZ maintains approximately 1,100 leases, covering about two million square metres across the country, and has undertaken a large amount of work on streamlining processes in relation to its land portfolio and leased estate.

Approximately 40 land parcels have been identified as being potentially surplus to operational requirements and are now being assessed under the Property Acquisition and Disposal Policy.

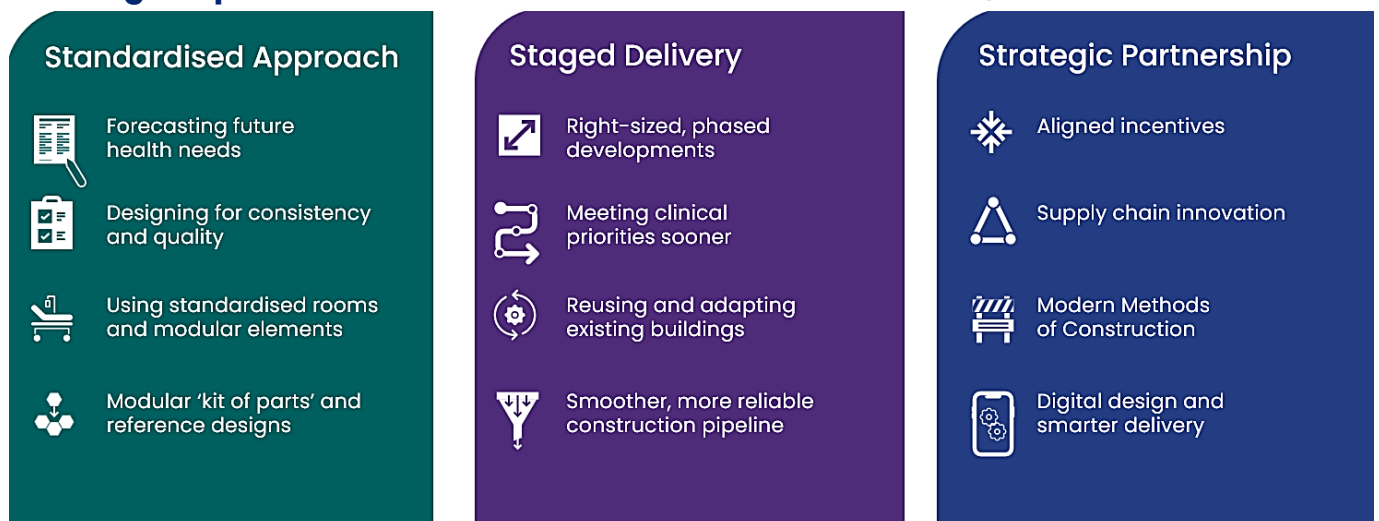


This includes:

- Finalising a Leasing Policy and developing a standard suite of lease instruments;
- Reviewing leased spaces and consolidating offices/spaces;
- Ensuring appropriate land use zoning and titles free from encumbrances;
- Providing advice and input into the reform of the Resource Management Act;
- Reviewing Health NZ parking to inform a Parking Policy;
- Seeking private sector funding for management and development of carparks;
- Identifying opportunities for asset recycling.

Improving project delivery

Building Hospitals Better: Better Value Health Infrastructure, Delivered Faster



Health NZ is delivering a new generation of nationally-coordinated health facilities across the country using our 'Building Hospitals Better' approach which is built on three pillars:

This is our approach for the Nelson Hospital and Whangārei Hospital redevelopments.

Major Inflight Programmes

The top ten major health infrastructure projects by value that Health NZ is delivering are:

- Pihi Kaha Whangārei Hospital: replacement of a large section of the main hospital block to address building issues and increase capacity;
- E Tū Wairua Hinengaro – Forensic Psychiatric Services Facilities Replacement, Mason Clinic: the facility will be built on the northern end of the Mason Clinic campus to accommodate people who currently reside in units;
- Facilities Infrastructure Remediation Programme Tranche 1: remediation of urgent infrastructure at Auckland City Hospital and Greenlane Clinical Centre;
- Facilities Infrastructure Remediation Programme Tranche 2: new central plant, tunnels and integration at Auckland City Hospital and Greenlane Clinical Centre;
- Manukau Superclinic expansion and planned care capacity increase Manukau Health Park: improving accessibility, communication, technology, facilities and staff capacity;
- Project Maunga – Taranaki Base Hospital: a new building housing core clinical services including ED, radiology, laboratory, maternity services, neonatal and ICU;
- Wellington Hospital Emergency Department Refurbishment: shifting and expanding ED while also delivering expanded acute services;
- Whangatupuranga Nelson Hospital: addressing seismic vulnerabilities, increasing patient demand and outdated facilities;
- Christchurch Hospital Redevelopment, Tower 3: provides five wards, creating space for a further 160 inpatient beds;
- New Dunedin Hospital: The first tranche of enabling works for the Inpatient Building started in June 2025. A Crown Manager was appointed to oversee the delivery of the Inpatient Building which is expected to be completed in early 2031.

Continuing to deliver care to patients

While new major infrastructure projects are underway, Health NZ ensures it can continue delivering care to patients by rolling out four new deployable relocatable inpatient units across the country. Each unit will provide between 28 and 32 beds, delivering a rapid uplift of at least 112 inpatient beds nationwide.

The relocatable units will be designed and built to meet relevant design standards, with a design life of up to 50 years. These units can be moved between sites depending on clinical need and demand, providing a flexible and future-proof solution.

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-85	Health New Zealand 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%	38-40%	Not achieved	

The Asset Management Information System project has successfully migrated all campuses to the new national tool. This is first being used for reactive maintenance and will progressively be used for planned maintenance as the asset register is updated with existing data.

Underpinning the National Asset Management Strategy, Health NZ intends to implement the draft National Maintenance Strategy and the draft Asset Criticality Framework to enhance the prioritisation of maintenance and renewal activities at a national level.

Ref	Measure	Target	2023/24 Result	2024/25 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	Achieved	Achieved	Achieved	

Benefits realisation remains on track overall, with continued focus on ensuring all the closure and post-implementation activities are completed in a timely manner. These are project management activities that provide evidence to confirm whether anticipated benefits outlined in the business case are realised.

Based on post-implementation review (PIR) documentation submitted during 2024/25, the majority of benefits outlined in the approved business cases were fully realised or on track to be realised in line with agreed benefit measures, KPIs, and targets. Not all projects completed during 2024/25 have submitted PIR documentation yet, and some benefits can only be assessed via Post-Occupancy Evaluations which are undertaken 12 months after occupancy, so our assessment is based solely on PIRs received.

Regular Health Capital updates are provided to the Minister by Health NZ summarising benefits achieved and Health NZ also contributes to Treasury Quarterly Investment Reporting.

This measure in the Vote Health: Estimates 2024/25 has a target of 80%. 98% of benefits were achieved based on reporting to the Minister during 2024/25.

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-90	Hospital redevelopment project meets project milestones	90%	Milestone report	Achieved	

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 Outpatient Building is on track for operational commissioning in October 2026. The first tranche of enabling works for the Inpatient Building commenced in June 2025. Completion of the Inpatient Building is expected to be early 2031.

This is a measure under the Vote Health: Estimates of Appropriation for New Dunedin Hospital 2021-2026 (M36) (A21).

Health Technology Assets (Clinical Equipment)

“Medical devices save lives, improve health and quality of life, and are indispensable for the prevention, diagnosis, treatment, and management of all medical conditions, diseases, illnesses, and disabilities. Medical devices, and in particular, assistive devices, also are important for rehabilitation and enable people with disabilities to continue to function. Without medical devices, routine medical procedures – from bandaging a sprained ankle, to diagnosing HIV/AIDS or implanting an artificial hip – would be impossible.” (World Health Organization, 2011).

Health NZ established a new Health Technology Management (HTM) function towards the end of 2023, effectively bringing together the resources to manage clinical equipment across the motu at a portfolio level. While there is still more to do to fully implement the operating model, outstanding progress has been made during the establishment phase of this new approach, with the following highlights this year:

- Over 400 new clinical equipment compliance requirements reviewed, while actively supporting Health NZ’s Health Technology Evaluation Pathway and Technology Advisory Groups to ensure safe, effective, and future-ready technology adoption across Health NZ.
- Established the national Clinical Asset Management Information System (NCAMIS), successfully rolling it out to 75% of districts by 30 June 2025. As at end July 2025, 245,000 (94%) of clinical equipment assets have been captured in NCAMIS, with full national deployment on track for completion by the end of October 2025. NCAMIS will unify asset data across the motu, replacing legacy systems, improving data quality, and enabling risk-based capital planning and long-term investment decisions. Continued progress will require further resourcing to fully realise system benefits and support business-as-usual operations.
- A significantly improved and more integrated approach has been in place across the three business functions managing major capital portfolios — HTM, the Infrastructure Investment Group, and Digital Services. A suite of national guidance documents was developed and distributed to strengthen capital planning capability and improve the quality of submissions across the motu.
- Established a Health Technology Delivery and Deployment function, focused on ensuring timely, consistent, and high-quality delivery of health technologies across the motu. Key appointments include regional Delivery Managers in all four regions.
- Brought together 217 clinical engineering specialists and support staff under a single HTM Operations function. This function collectively supports the safe, reliable, and cost-effective management of approximately 261,000 reusable medical devices across their lifecycle to enable high-quality, technology-enabled healthcare delivery.

Current Position of Health Technology Assets

The health technology (clinical equipment) assets owned by Health NZ have been summarised in the table below to inform their purpose, capacity, and relevant values.

Asset Portfolio	Asset Purpose	Quantity/Capacity (Nationally)	Book Value (Nationally)
Health Technology (Clinical Equipment) Assets	To enable the delivery of high-quality, timely clinical services through the availability of equipment that meets required clinical and safety standards	Major Capital Items: 24 x Linear Accelerators 32 x Magnetic Resonance Imaging (MRI) Systems 65 x Computerised Tomography (CT) scanners ³ ~261,000 items of Clinical Equipment (in-hospital and limited community-based items) ⁴	Calculated Book Value of assets is \$1.376 billion ⁵ Calculated Replacement Value of assets is \$2.142 billion ⁶

³ The CT scanner fleet has increased by 11 scanners (20%) from the 23/24 annual report. This reflects the focus on increasing the asset fleet as part of the capital planning process. Equipment data has been included where the scanners are under the control of Health NZ sites and being used to deliver services funded by Health NZ, regardless of the ownership model.

⁴ Includes mainly in-hospital devices that are managed by HTM Operations 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 across the motu. The data will be confirmed as data is migrated to NCAMIS (see previous page).

⁵ The overall book value was calculated using the overarching 'Clinical Asset' portfolio, which may be incomplete and includes other asset classes which are not clinical equipment and may not all meet the financial definition of an asset. The data will be more reliable when the roll-out of NCAMIS is completed and data quality validation has been completed towards the end of FY25/26. Health NZ's migration to a single Financial Procurement Information Management (FPIM) system will also enhance data quality.

⁶ The overall replacement value was calculated using the overarching clinical asset portfolio, which includes other asset classes which is not medical equipment. The data will be further refined when the roll-out of NCAMIS is completed towards the end of October 2025 and further refined towards the end of 25/26.



Asset Performance Indicators

The relevant asset performance indicators for the Health Technology (Clinical Equipment) Assets highlight the need to ensure these assets are in acceptable condition, are well utilised, and comply with regulatory requirements.

Safe clinical service delivery requires that all 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 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	2024/25 Average Target ⁷	2024/25 Average Actual ⁸
Major Assets			
24x Linear Accelerators	Availability/Uptime ⁹	98%	98.7%
36x Magnetic Resonance Imaging (MRI) Systems	Availability/Uptime	98%	99%
67x Computerised Tomography (CT) Systems	Availability/Uptime	95.5%	99%
Minor Assets			
~261,000 Minor medical equipment (in-hospital and community based)	Condition-Performance Verification ¹⁰	93%	80% ¹¹

⁷ The target is based on the Service Level Agreements (SLAs) KPI’s established with the service providers and does not consider any utilisation targets set by individual hospitals.

⁸ The actual is an average of the SLAs KPI’ results, across all machines, as reported by the service providers.

⁹ The Availability/Uptime 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.

¹⁰ 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).

¹¹ This actual is based on an average of the available results (n=18) and only focused on in-hospital. The target of 93% was not achieved mainly due to capacity constraints (e.g. vacancies and resourcing) within HTM Operations. The next phase of establishment for the HTM function will be a more detailed realignment of resources and teams and work to identify any capacity gaps.

Sustainability

Health NZ’s activities generate significant greenhouse gas emissions and incur other environmental impacts. Climate change and more frequent severe weather events will increase stress on our health systems and the health of the community. We continue to make good progress across our key sustainability workstreams:

- Decarbonising the health system
- Environment in all practices
- Health system resilience and adaptation to climate change
- Integrating sustainability into core strategies and culture.

These workstreams aim to implement opportunities to become a more sustainable and resilient organisation by reducing emissions, protecting the natural environment and better understanding and responding to climate risks and impacts. Sustainability initiatives have associated co-benefits such as reducing operating costs or supporting improved health outcomes. Further information on our projects is available on our [website](#).

Carbon Neutral Government Programme

Health NZ is part of the Carbon Neutral Government Programme (CNGP), 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.

Our emissions reporting aligns to the CNGP requirements and international reporting standard ISO 14064-1:2018. This reporting has been independently audited by Toitū Envirocare and is available on our [website](#).

Our total annual emissions and sources

Our largest emissions sources relate to the 24-hour, year-round operation of health facilities, together with emissions from staff air travel and funded patient travel. In 2024/25, we emitted a total of 192,105 tonnes of carbon dioxide equivalent (CO₂e) across all measured emissions sources. This is approximately a 15% reduction from our 2022/23 baseline and 2% below last year.

The performance data below explains our emissions and uses measures prescribed by the CNGP for reporting departments and agencies.

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-129	Total annual measured emissions for financial year (tCO ₂ e)	25% reduction over two years	196,501 tCO ₂ e	192,105 tCO ₂ e	●
Total measured emissions reduced by 2.2% or 4,396 tCO₂e between 2023/24 and 2024/25. Refer to P2-136 for clarifications regarding this reduction. In 2022/23, emissions were 237,822 tCO₂e. Note: Results for 2023/24 have changed from previously reported values due to improvements in completeness and accuracy of data.					

Ref	Measure			
P2-130	Emissions profile broken down by emissions source/scopes (tCO₂e)			
Category	2022/23 Base year	2024/25	Decrease (increase)	% change
Category 1: Direct emissions	102,413	77,678	24,735	-24%
Category 2: Indirect emissions from imported energy	41,705	37,006	4,699	-12%
Category 3: Indirect emissions from transportation	67,930*	65,917	2,013	-3%
Category 4: indirect emissions from products or services used by Health NZ	13,361*	11,504	1,857	-14%
Total	225,409	192,105	33,304	-15%

Emissions profile broken down by emissions source/scope (tCO₂e).

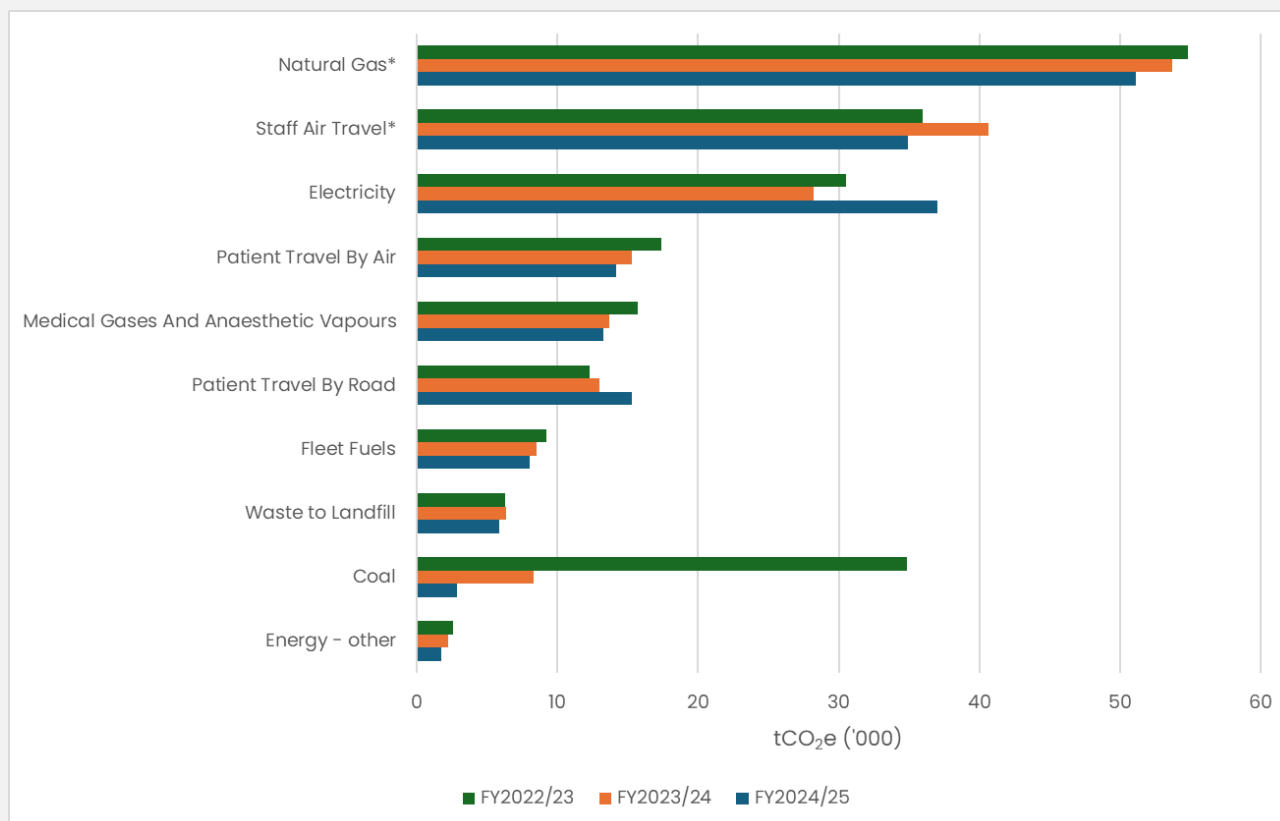
* Result for 2022/23 have changed from previously reported values due to improvements in completeness and accuracy of data..

Ref	Measure	Target	2022/23 Result	2023/24 Result	2024/25 Result	Status
P2-132	Full-time equivalent of staff (FTE) in the reporting period	N/A	74,971	82,923	80,231	N/A
As reported elsewhere in this Annual Report. Linking FTE with emissions as an emissions intensity metric this continues to reduce from a baseline year of 3 tCO ₂ e/FTE to, 2.4 tCO ₂ e /FTE in 2023/24, to 2.4 tCO ₂ e/FTE in 2024/25.						

Ref	Measure	Target	2022/23 Result	2023/24 Result	2024/25 Result	Status
P2-133	Total expenditure in the reporting period	N/A	\$26.7 billion	\$27.90 billion	\$29.02 billion	N/A
As reported elsewhere in this Annual Report. Linking expenditure with emissions as an emissions intensity metric this continues to reduce from a baseline year of 8.45tCO ₂ e/\$m to, 7.05 tCO ₂ e/\$m in 2023/24, to 6.62 tCO ₂ e/\$m in 2024/25.						

Ref	Measure	Target	2022/23 Result	2024/25 Result	Status
P2-131	Base year period and total emissions. Change in total emissions each subsequent year compared to the base year	N/A	225,382 tCO ₂ e	192,105 tCO ₂ e	N/A

Total measured emissions reduced by 14.7% or 33,277 tCO₂e between the baseline year (2022/23) and 2024/25. Refer to P2-136 for clarifications regarding this reduction.



*Data in this graph corrects information contained in the previously published inventories for 2022/23 and 2023/24 relating to air travel emissions and for gas consumption in 2023/24.

Results for 2022/23 have changed from previously reported values due to improvements in completeness and accuracy of data.

Ref	Measure	Target
P2-134	2025 and 2030 gross emissions reduction targets (%)	25% reduction of Category 1 and 2 emissions between 2022/23 and 2024/25
The NZ Health Plan Te Pae Waenga sets a target to achieve a 25 per cent reduction of Category 1 and 2 emissions by the end of 2024/25.		
The Emissions Reduction Plan (ERP) 2024/25 to 2026/27 sets a midpoint science-based aligned target to reduce total measured emissions (Categories 1, 2, 3 and 4) by 24% by end of FY2026/27. Any 2030 targets will be set as part of preparing the next three-year ERP.		

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-135	Progress towards 2025 and 2030 targets	25% reduction of Category 1 and 2 emissions between 2022/23 and 2024/25	15%	20%	
Health NZ achieved a combined 20% reduction in Category 1 and 2 emissions by the end of 2024/25. Respectively, Category 1 emissions fell by 24% and Category 2 emissions dropped by 11%. The energy transition away from direct emissions (Category 1), in particular a historical reliance on coal boilers for some facilities, will inevitably lead to an increase in Category 2 electricity consumption. However, by implementing energy efficiency projects across our facilities electricity consumption has only increased by 2% from the baseline year. A more significant factor impacting Category 2 emissions has been the drop in the percentage of grid electricity supplied by renewables during 2024/25. The emissions intensity of grid purchased electricity increased by 37.8% compared to last year. If this had remained constant our combined Category 1 and 2 reduction would be 27.5%.					

Ref	Measure
P2-136	Commentary on results: - 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. A summary of key emissions reduction initiatives undertaken and our plans for improvement over time are covered in the section below. Not all of our emissions are currently measured. As outlined in the Emissions Reduction Plan, Health NZ uses the terms 'footprint' and 'footprint plus' to distinguish between measured and unmeasured (currently excluded) emissions. Our footprint emissions include some emissions sources not required to be reported under the GNGP. Footprint plus emissions include sources such as staff commuting, patient and visitor private travel, purchased goods and services (including commissioned healthcare services), and the embodied emissions arising from capital works, such as new buildings and major refurbishments. These sources currently lack sufficiently robust data sources or collection methodologies to provide reasonable assurance of their accuracy. Work is planned to consider bringing such sources into our emissions reporting and they nonetheless remain a priority for reduction activities. In collating the 2024/25 data a previous double-counting issue in relation to air travel emissions was identified. In addition, some gas consumption data, equivalent to 2,961 tCO₂e, was omitted from 2023/24 reporting. Both issues have been rectified in the data contained herein to enable more accurate comparisons between reporting years in the above chart. This means that the figures in this Annual Report will differ from last year's report and from the previously published emission inventories for 2022/23 and 2023/24.

Demonstrating our sustainability

Health NZ has implemented several emissions reduction initiatives that have contributed to significant reductions against our baseline:

- Removing coal boilers from all but one site, including partnering with a supplier of steam to switch boilers to biomass sources – resulting in a 92% reduction or 31,999 tCO₂e;
- Ongoing delivery of the Phase 1 Energy Transition Programme, comprising energy efficiency projects anticipated to reduce emissions by 11,000 tCO₂e/yr and save at least \$2.5m per annum;
- Improving management of medical gases and anaesthetic vapours – resulting in a 15% reduction or 2,409 tCO₂e;
- Selecting hybrid and battery electric vehicles alternatives as part of lifecycle replacement of fleet vehicles - resulting in a 13% reduction or 1,213 tCO₂e.

Further initiatives are outlined in Health NZ's first Emissions Reduction Plan, covering the period through to the end of 2026/27, available on our website:

<https://www.tewhatauora.govt.nz/publications/emissions-reduction-plan>.

Some key collaborative achievements and milestones during 2024/25 include:

- Health NZ partnered with a waste management provider to recycle expired Personal Protective Equipment (PPE) and rapid tests secured during the Covid-19 pandemic or convert them into fuel used for cement production (replacing coal).
- A new Health NZ Asset Management Strategy and End of Trip Facilities Guidance ensure decision-making supports environmental and wellbeing outcomes. The new Tōtara Haumaru (The Sheltering Tōtara) hospital facility at North Shore Hospital features New Zealand's first large-scale indoor healing garden, which provides a place of calm for patients, whānau and staff.
- Engagement with medical professionals through national clinical networks across Health NZ to raise awareness and support the integration of sustainability within respective clinical practices and models of care. This included the preparation of draft sustainability guidance and worksheets to be trialled and refined for final adoption.
- Collaboration and support to the Ministry of Health | Manatū Hauora enabled the development and publication of the Health National Adaptation Plan (HNAP) and subsequent commissioning of a Vulnerability and Adaptation Assessment, due to be finalised in 2025/26.
- Establishment of a National Medical Gas Governance Committee and a Climate Risk Advisory Group to ensure effective cross-organisation coordination and implementation.
- several organisation-wide staff awareness weeks and months in support of national campaigns. Recycling Week in October, Sustainability Month in April and Energy Awareness Month in June showcased action being taken across Health NZ. Staff sustainability engagement is supported through bi-monthly all-staff hui.

Occupational Health, Safety and Wellbeing

Health NZ is the single largest employer in New Zealand, with a workforce of over 100,000 people. Health NZ continues to advance its commitment to creating a safe, inclusive and supportive environment for all staff and patients. A Health and Safety strategy, launched in February 2025, sets a clear vision for nationally-coordinated, regionally-supported, and locally-implemented systems and processes that prioritise continual improvement, proactive risk management, and collaborative engagement.

Strategic Direction and Governance

The strategy is underpinned by four pillars: Promoting a Safe Culture, Managing Our Risks, Resilient and Responsive in Emergencies, and Supportive Systems. These pillars guide our national work programme and inform the development of a three-stage Horizon delivery plan through to 2028. Horizon One, which runs until June 2026, includes measurable targets and quarterly reporting to ensure accountability and progress.

Governance was provided by a Health, Safety and Wellbeing Executive Governance Group, with oversight aligned to officer due diligence obligations under the Health and Safety at Work Act 2015. At the district level, Health, Safety and Wellbeing committees have been successfully established, meeting quarterly - in alignment with the Worker Participation Agreement. These meetings provide a structured forum for discussing district-specific health and safety matters and progressing actions that support safe and effective local management and delivery of health services.

National Policy Implementation

In the past year, we released national policies to strengthen our occupational health and safety and wellbeing framework. These include policies on hazardous substances management, health and safety at work, health surveillance, managing health challenges at work, occupational hygiene, risk management, verification and assurance, and work-related injury and rehabilitation. Each policy is supported by guidance, templates and targeted training to ensure consistent understanding and implementation.

In addition, we updated Health and Safety handbooks for officers and people leaders to reinforce leadership accountabilities and safe practice expectations. These resources provide tailored guidance to support leaders in fulfilling their health and safety responsibilities and promoting a culture of safety within their teams.

Workforce Development and Training

We made meaningful progress in building workforce capability across health and safety and occupational health. Training programmes for hazardous substances and violence and aggression have been implemented. A key focus remains on equipping all front-facing staff with de-escalation training to help prevent serious harm from incidents involving violent or aggressive behaviours. The Prevention First e-learning training module introduces staff to practical de-escalation techniques and situational awareness and has been completed by over 30,000 front-facing staff. This work is supported by the ED Security Improvement Programme, funded through Budget 2024, which has delivered

violence reduction training to eight priority EDs (see Significant investments from Budget 2024 on page 30).

Several additional national training programmes are currently being finalised, including moving and handling, and a nationally-aligned health and safety training module. These are scheduled to be offered to staff in the first quarter of 2025/26, further strengthening our commitment to consistent and high-quality health and safety education across the organisation.

Systems and Assurance

Work is underway to develop a nationally consistent digital incident management system that will support standardised reporting and assurance across Health NZ. Health and safety escalation guidance and verification templates have been introduced to ensure emerging risks are identified and addressed promptly.

As part of our health and safety system assurance programme, the ACC Accredited Employer Programme (AEP) self-assessment and audit process was used to evaluate practices across high-risk services. This work supports our national verification approach and contributes to strengthening consistency and alignment with best practice across the organisation.

Health NZ has made significant progress in strengthening assurance across its capital projects and facilities. Key achievements include the endorsement and implementation of the IIG Health and Safety Roadmap, the establishment of a national team with regional leads, and the development of a Critical Risk Management Framework covering 20 8 endorsed risks areas. The team has also launched a national asbestos management group, issued Safety Alerts & Learns following incident investigations, and began structured site visits and audits to verify control effectiveness.

To support consistency and compliance, the team has initiated work on standardised templates, contractor prequalification processes, and health and safety performance indicators for major projects. These efforts align with recommendations from both the HSE Global and CHASNZ reviews and reflect a commitment to continuous improvement, proactive risk management, and national alignment in health and safety practices.

Union Collaboration and Worker Engagement

Our partnership with unions remains central to our approach. The Worker Participation Agreement, signed in 2024, has laid a strong foundation for collaborative decision-making and programme design. We continue to work closely with union representatives to ensure our initiatives are fit for purpose and responsive to frontline realities.

Emergency Management

The health system responds to a significant number of emergency events each year, working in close partnership with local government, civil defence and other government and social agencies to protect communities and maintain continuity of care. Emergency management within Health NZ is not only critical to safeguarding health services, it is also a legislated responsibility. This ensures that our role in readiness, response and recovery is embedded as a core function of the health system.

To deliver on this obligation, we have established a nationally-led approach to emergency management, with dedicated resources at local, regional and national levels. This

structure ensures that health services are prepared to respond effectively to both everyday disruptions and large-scale emergencies.

In the last financial year alone, Health NZ supported and managed responses to severe weather, power outages, water shortages and wildfires — each posing real risks to the delivery of health care. We also ran and participated in local and national exercises, including Exercise Rū Whenua, a national all-of-government exercise led by the National Emergency Management Agency designed to test systems and decision-making in a nationally-significant emergency.

These real-world responses and exercises demonstrate the necessity of a robust emergency management system within health. The lessons we take from them directly strengthen our preparedness and response capability, ensuring that Health NZ can continue to deliver critical health services under pressure and contribute strongly to the wider national response effort.

Workforce

Equal Employment Opportunities

Paid employment status	Employee count	Contracted FTE	% Employee count
Permanent	85,817	73,752.7	85.2%
Fixed term	5,384	4,787.2	5.3%
Others	9,471	1,691.7	9.4%
	100,672	80,231.6	

Employee gender

	Gender	Employee count	Contracted FTE	% Employee count
Permanent	Female	66,968	56,444	78.04%
	Male	18,774	17,244	21.88%
	Gender diverse	36	31	0.04%
	Unknown	39	34	0.05%
		85,817	73,753	
Fixed term	Female	3,635	3,146	67.51%
	Male	1,743	1,636	32.37%
	Gender diverse	S*	S*	
	Unknown	S*	S*	
		5,384	4,787	
Others	Female	8,039	1,637	84.88%
	Male	1,420	53	14.99%
	Gender diverse	S*	S*	
	Unknown	S*	S*	
		9,471	1,692	
Combined	Female	78,642	61,228	78.12%
	Male	21,937	18,933	21.79%
	Gender diverse	41	31	0.04%
	Unknown	52	40	0.05%
		100,672	80,231.6	

Employee ethnicity

People can and do identify with multiple ethnicities. However, the 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	% Employee count
Permanent	Māori	7,367	6,381.7	8.58%
	Pacific	4,323	3,907.7	5.04%
	Asian	24,755	22,166.1	28.85%
	European/Other	45,562	37,958.2	53.09%
	Unknown	3,810	3,339.0	4.44%
	Total	85,817	73,752.7	
Fixed term	Māori	504	439.1	9.36%
	Pacific	238	223.1	4.42%
	Asian	1,434	1,327.9	26.63%
	European/Other	2,961	2,570.8	55.00%
	Unknown	247	226.4	4.59%
	Total	5,384	4,787.2	
Others	Māori	878	137.0	9.27%
	Pacific	465	65.3	4.91%
	Asian	2,486	656.4	26.25%
	European/Other	5,110	758.5	53.95%
	Unknown	532	74.5	5.62%
	Total	9,471	1,691.7	
Combined	Māori	8,749	6,957.7	8.7%
	Pacific	5,026	4,196.1	4.99%
	Asian	28,675	24,150.4	28.48%
	European/Other	53,633	41,287.5	53.27%
	Unknown	4,589	3,639.9	4.56%
	Total	100,672	80,231.6	

Health NZ reports demographic data for its employed workforce quarterly on its website, see <https://www.tewhatauora.govt.nz/for-health-professionals/health-workforce-development/health-workforce-initiatives/health-workforce-information-programme>.

Data caveats

- Data is a snapshot in time as at 30 June 2025 and reflects the entire Health NZ workforce, including those based in districts, regions, and the national office. Any employee who has an employment end date entered before 30 June 2025 is excluded, since they left employment before the end of the reporting period.
- Employee count is a distinct count of individual employees. There is the potential for individuals to be counted more than once if they have roles in more than one Occupation Group.
- Contracted FTE is calculated using a 2,086-hour annual contract.
- 'Others' are those without contracted hours and includes employees on parental leave and Leave without Pay and Casuals.
- *S = Suppressed; When reported results are five or below for either employee count or contracted FTE the entire row is suppressed to protect privacy.

Wellbeing feedback

Designed specifically for healthcare workers, the Wellbeing Index (WBI) is a validated screening tool delivered through an app. It helps identify which parts of our workforce are thriving and which are at risk of distress across six dimensions of workplace wellbeing. The WBI app was launched nationally in July 2024 for all Health NZ staff. It assesses risk of distress and connects users to appropriate mental health support resources. The tool also offers repeated longitudinal measurement to monitor workforce wellbeing over time. This provides vital data to support evidence-based practices that enhance staff wellbeing and resilience.

To increase engagement and awareness, targeted communications campaigns and on-site visits were conducted throughout 2024/25 across several districts, with activities continuing into the next quarter. Between 1 July 2024 and 30 June 2025, 2,869 registrations were recorded for the WBI app. In Q4 (1 April to 30 June 2025), 1,833 staff used the app, and among these users, 25% were identified as struggling, 35% as at risk, 24% as doing okay, and 16% as thriving.

Change Processes

Health NZ is undergoing changes to bring decision-making and resources closer to where care is delivered. This approach recognises that those closest to where care is delivered are best placed to organise and deliver it. Clinical leadership and partnership will play an increasingly important role in guiding these changes. A clear operational plan has been developed and will be refined throughout 2025, with full implementation expected by mid-2026.

In Q3 of 2024/25, the PSA lodged compliance orders with the Employment Relations Authority on behalf of members affected by Health NZ's change processes. In Q4, Health NZ and the PSA reached agreements, and proceedings were withdrawn for the National Public Health Service, Data and Digital, Pacific Health, and Planning, Funding and

Outcomes. Hearings for Service Improvement and Innovation and for Procurement and Supply Chain reached determinations confirming Health NZ has met all contractual and statutory obligations. Proceedings remain active for Finance, Communications and Engagement, People and Culture, and Audit, Assurance and Risk, with mediation scheduled for the next quarter.

As at August 7, consultation has closed and decision documents have been published for Government Services; People and Culture; Finance; Communications and Engagement; Audit, Assurance and Risk; Hauora Māori Service; Procurement, Supply Chain and Health Technology Management; Planning, Funding and Outcomes; Pacific Health; and Digital Services.

Health Workforce Plan Implementation

Published in December 2024, the Health Workforce Plan outlines Health NZ's initiatives to build a sustainable workforce pipeline and strengthen the healthcare system. The plan focuses on five priorities: (1) Get our workforce basics right; (2) Work differently for productivity and better care; (3) Keep people well, close to home through primary care; (4) Address workforce needs to hit targets; and (5) Build a workforce that reflects community needs. As at Q4 2024/25, all activities across these priorities are on track.

Collaboration with education providers and agencies remained strong throughout the year, supporting the development and maintenance of training pathways. Pilot implementation of the NZQA-approved Level 4 Foot Care Assistant qualification commenced in Q4.

Enrolments increased notably in key programmes, including Radiation Therapy at Otago, which nearly doubled to 43 compared to 23 last year, and the Perioperative Practitioner Programme in Auckland, where enrolments grew by 28%.

Efforts to improve clinical placements have been underway, culminating in the signing of the National Clinical Student Placement and Access Agreement, effective January 2025. This established a consistent national approach to placements across all education providers working with Health NZ. Complementing this, a Student Placement Coordination Tool is being piloted to better organise placements and improve coordination and visibility of placement capacity and demand. This year, the tool secured 221 placements for anaesthetic technicians for semester one.

Targeted funding remains crucial for early-career workforce development. 400 funded employment support opportunities were made available for graduate registered nurses in primary and community settings. Additionally, 925 newly qualified professionals from 2024, across a range of roles, including nurses, midwives, anaesthetic technicians, general practice trainees, pharmacists, dentists, oral health therapists, radiation therapists and sonographers, have been accepted into the Voluntary Bonding Scheme that will enable them to receive financial support following completion of their bonded period.

While the domestic workforce pipeline continues to strengthen, Health NZ continues to focus on international recruitment to meet demand across all regions and districts. From 1 July 2024 to 6 July 2025, applications from over 8,000 expressions of interest and directly sourced candidates were received. More than 1,600 were referred to recruitment teams, resulting in 462 new professionals offered roles or commencing work, a conversion rate of approximately 28 %. Recruits span a range of medical, nursing, allied health and technical roles.

Holidays Act Remediation Programme

The Holidays Act Remediation Programme (HARP) is a nationwide initiative aimed at ensuring compliance with the Holidays Act 2003 by correcting historic payroll errors related to holiday pay entitlements. As New Zealand’s largest employer, Health NZ employs over 90,000 staff across numerous districts and services. The programme represents a commitment to address legacy payroll issues, ensuring fair and accurate pay for all employees.

Payments for Auckland, Counties Manukau, and Waitematā were completed in 2023.

Significant milestones were achieved during this reporting period (June 2024 – June 2025). Since the programme’s inception, approximately two-thirds of the current workforce have been remediated.

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-91	Remediate all current employees for each Te Whatu Ora - Health New Zealand District, and the New Zealand Blood and Organs Service, within agreed timelines	Completed by 30 June 2025	Not Achieved	Not Achieved (25%)	
As of 30 June 2025, since HARP began, Health NZ has paid \$524 million to 71,000 current employees. Payments made during 2024/25 are set out in the table below. Most of the remaining districts (Tairāwhiti, Canterbury, West Coast, MidCentral), and top-up remediations in districts that received interim payments, are scheduled to be completed by December 2025 with final payments for Lakes and Whanganui in early 2026. The revised schedule 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.					

Current employees remediated July 2024 – June 2025

District	Payment Date	Payment Status	Amount Paid in million	Staff paid
Waikato	June 2025	Interim	38.8	5,219
Southern	June 2025	Full	40.9	5,589
Capital and Coast	May 2025	Full	52.9	7,430
Hutt Valley	April 2025	Full	24.8	2,399
Nelson Marlborough	April 2025	Full	20.6	3,088

Northland	April 2025	Interim	31.1	3,776
Wairarapa	March 2025	Full	4.7	645
Bay of Plenty	December 2024	Interim	32.6	4,299
Taranaki	December 2024	Full	18.6	2,422
South Canterbury	December 2024	Interim	3.9	1,029
Hawke's Bay	November 2024	Interim	15.2	3,566
Total			284.1	39,462

Progress towards remediation for the first group of former employees commenced in Taranaki in late 2024/25, with payment targeted for August 2025. Payments to former employees are expected to continue until 30 September 2026.

Ref	Measure	Target	2023/24 Result	2024/25 Result	Status
P2-238	Payments for former employees who have registered on the national employee portal and whose information has been validated will commence in 2024/25	Achieved	New measure	Not Achieved	
Owing to ongoing complexity of configuring payroll systems to calculate and pay entitlements for the current employees of Health NZ, there has been a knock-on effect in this project. It is planned that the first payments to former employees will commence in August 2025 and payments will continue throughout 2025/26 financial year.					

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 Tapatahi¹², alongside NZ Council of Trade Unions and affiliated health unions, and Kāhui Kōkiri¹³, 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.

¹² strategic level engagement forum, including NZ Nurses Organisation and other affiliated unions.

¹³ national level operational engagement forum, including all unions

Risk Management

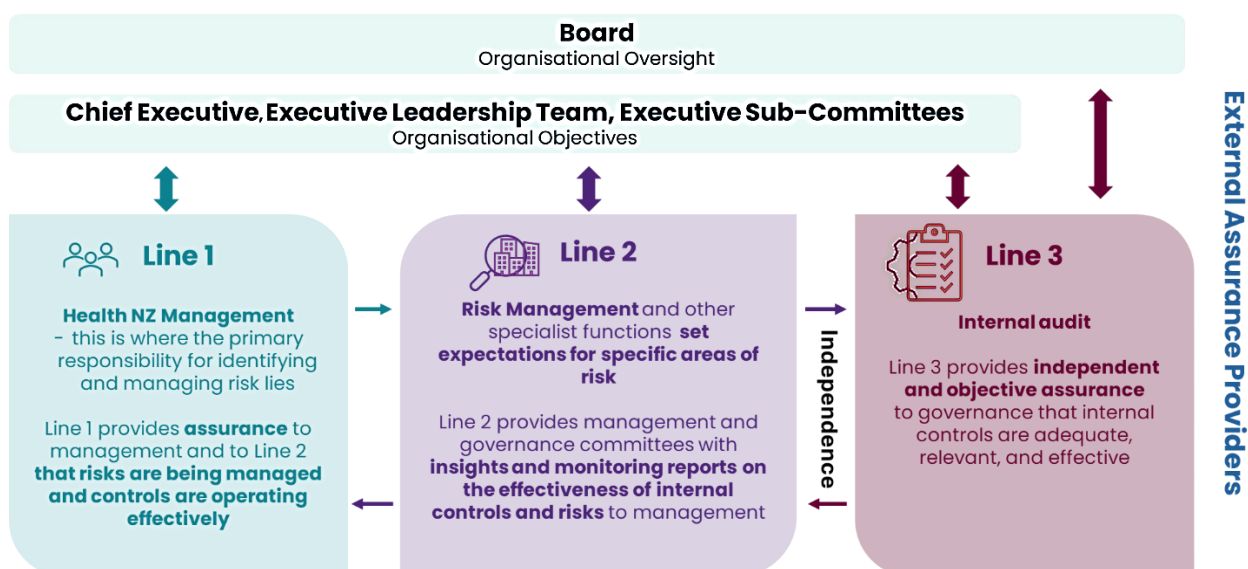
Effective risk management helps us maintain the quality of our service, and deliver appropriate healthcare efficiently, within our resources. We cannot remove all risk from the delivery of healthcare, so are committed to embedding robust risk management into our daily decision-making and operations. Our management of risk reflects the scale, complexity, challenges and opportunities of our work.

How we manage risk at Health NZ

We enable our people to manage risks that could prevent the achievement of our objectives. To do this, we have clear guidance provided by our Risk Management Policy and associated framework and process, all of which were refreshed or developed during 2024/25.

The Risk Management Policy and associated framework and process are based on the ISO 31000:2018 Risk Management Guidelines and set the requirements for how risks are to be managed at Health NZ. The risk framework and process inform the organisation how to give effect to the Risk Management Policy's requirements in a clear and consistent way, by outlining the roles and responsibilities that our people have for managing risk.

Health NZ has adopted the internationally-recognised Three Lines Model (as shown below) to structure our risk and assurance activities. The Model defines clear risk management roles and responsibilities and provides flexibility as Health NZ's operating environment changes.



At Health NZ we categorise risks by type – Strategic (risks with long-term and significant consequences), Operational (risks managed by our people every day), and Project and Programme (risks specific to project or programme delivery).

Each risk type has risk categories and sub-categories based on the source of risk. Categories are used to assist with analysis, insight, communication and subsequent monitoring and reporting.

Key things we are working on

In the past year we reviewed and updated our Risk Management Policy and associated framework and developed our risk management process which we are now implementing. We also reviewed the structure of the national Risk Management team. We are now in the process of increasing the team's capacity and capability which will enable us to further embed a consistent approach to risk management across the organisation, increasing our overall risk maturity towards the targeted level.

An important element of increasing our risk maturity is setting a risk appetite, which is the amount of risk an organisation is willing to pursue or retain to achieve its objectives. We are progressing our work on risk appetite, which we intend to discuss and set with the Board during the 2025/26 financial year. Risk appetite statements will be our reference point when making decisions and determining which risks to prioritise in our risk management process.

Another enabler of the uplift of risk maturity is the proposed introduction of a single national system for recording and managing risks. The system will bring greater consistency to how risk information is captured, managed and reported across all levels of Health NZ, supporting clearer insights and more informed decision making. Implementation will take place during the 2025/2026 financial year, with completion expected in the 2026/2027 financial year.

Privacy

Ensuring people's personal information is treated with care is fundamental to delivering our healthcare services. Every day, people trust us with some of their most sensitive and private information. Our role is to ensure this information is collected appropriately, used responsibly and kept safe and secure.

We take a consistent, nationwide approach to protecting privacy. Our national Privacy Policy and supporting practices are applied at local, regional, and national levels.

During the last financial year some of our key privacy focus areas have been:

- **Safeguarding personal information** – providing robust and clear guidance to our staff on the safe collection, use, sharing and storage of personal and health information.
- **Responding to breaches and complaints** – managing privacy breaches and complaints promptly and fairly, and working closely with clinical, legal, digital and other teams to protect people impacted by the breach and attempt to reduce harm.
- **Embedding privacy into services and technology** – embedding privacy protections into new and evolving systems and services, ensuring privacy risks are identified and mitigated early.
- **Continuing to build a healthy privacy culture** – building an environment where privacy is understood, valued and embedded in everything we do by delivering training, awareness messaging and ongoing education for staff.

Our responsibility as guardians of people's personal and health information means we are committed to:

- **Being transparent** – we publish a public-facing Privacy Statement that explains, in plain language terms, how personal and health information is collected, managed and protected. This statement helps people understand what they can expect from us in relation to their information. We encourage staff to discuss information concerns with people in an open, respectful way, so questions can be addressed at the point of care.
- **Responding to access and correction requests** – we support people to exercise their right to access and correct their health records. We ensure requests are responded to fairly and promptly.
- **Informing people of privacy breaches** – when a privacy breach occurs, our teams work together collaboratively and act quickly to contain, assess and reduce any risk of harm. We keep those affected informed and communicate with them openly and compassionately. We support our teams to strengthen processes and undertake staff education to prevent similar occurrences in future.
- **Responding to privacy complaints** – privacy complaints are an important way to hear directly from patients and whānau about their experiences. Every privacy complaint is treated with respect, acknowledged promptly and considered fairly. Where

concerns are upheld, we take action to put things right. We use insights to identify themes and improve privacy practices across Health NZ.

- **Conducting privacy assessments** – we carry out privacy assessments whenever new or changes to technologies, systems, services or processes are proposed. This is based on the scale of change, the sensitivity of the information involved, and the potential impact on individuals' privacy. We look closely at how information will be collected, stored, used and shared. We ensure these technologies, systems, services and processes align with people's privacy rights and that any potential privacy risks are identified and addressed before changes are put in place. We do this alongside digital, clinical, legal and operational teams ensuring safeguards are in place.

Protecting privacy is not just about compliance. It is about ensuring that individuals trust that their personal and health information will be respected, used responsibly and safeguarded. By building strong privacy practices across Health NZ, we support safe and connected care, protect individuals from harm, and strengthen confidence in our health system.

Annual Financial Statements

Statement of comprehensive revenue and expense for the year ended 30 June 2025

			Group	
	Notes	Actual 2025 \$m	Budget 2025 \$m	Actual 2024 \$m
Revenue				
Crown funding (from the MoH)	2	24,296	24,810	23,483
Other funding from the Crown/Crown Entities	2	2,759	2,556	2,560
ACC contract revenue		476	460	428
Interest revenue		119	78	159
Other revenue	2	427	393	550
Total revenue		28,077	28,297	27,180
Expenditure				
Personnel costs	3	11,928	12,466	11,742
Outsourced personnel		432	270	538
Outsourced services		800	752	846
Clinical supplies	6	2,518	2,483	2,486
Depreciation and amortisation costs	10, 11	904	888	846
External service providers		10,111	10,235	9,189
Capital charge	4	486	529	470
Interest expense		6	7	7
Infrastructure, non-clinical supplies and other	5	1,839	1,767	1,778
Total expenditure		29,024	29,397	27,902
Surplus/(Deficit)		(947)	(1,100)	(722)
Other comprehensive revenue and expense				
Gain/(Loss) on property revaluations		1,678	-	-
Total other comprehensive revenue and expense		1,678	-	-
Total comprehensive revenue and expense		731	(1,100)	(722)

The budget figures included in these financial statements are from the Statement of Performance Expectations dated 14 November 2024.

Explanations of major variances against budget are provided in note 21.

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2025

	Notes	Group		
		Actual	Budget	Actual
		2025	2025	2024
		\$m	\$m	\$m
Balance at 1 July		9,612	9,614	9,313
Capital contributions from the Crown		2,072	3,234	957
Capital contributions returned to the Crown		(12)	(12)	(12)
Net assets transferred on amalgamation of Māori Health Authority	22	-	-	77
Movements in trusts and special funds		8	-	3
Movements in minority interests		6	-	(4)
		11,686	12,836	10,334
Comprehensive Income				
Surplus/(Deficit) for the year		(947)	(1,100)	(722)
Other comprehensive revenue and expense				
Gain/(Loss) on property revaluations	10	1,678	-	-
Total comprehensive revenue and expense for the year		731	(1,100)	(722)
Balance at 30 June	16	12,417	11,736	9,612

Explanations of major variances against budget are provided in note 21.

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2025

			Group	
	Notes	Actual 2025 \$m	Budget 2025 \$m	Actual 2024 \$m
Assets				
Current assets				
Cash and cash equivalents	7	1,056	31	840
Receivables	8	427	426	409
Prepayments		129	106	105
Investments	9	37	33	393
Inventories		186	165	184
Assets held for sale		3	-	5
Total current assets		1,838	761	1,936
Non-current assets				
Prepayments		5	6	6
Investments	9	128	121	121
Investments in associates and joint ventures		6	3	3
Property, plant and equipment	10	16,133	15,169	13,782
Intangible assets	11	539	354	539
Total non-current assets		16,811	15,653	14,451
Total assets		18,649	16,414	16,387
Liabilities				
Current liabilities				
Payables and deferred revenue	12	1,809	1,809	2,027
Borrowings	13	10	11	11
Employee entitlements	14	3,816	2,194	4,250
Provisions	15	114	212	85
Total current liabilities		5,749	4,226	6,373
Non-current liabilities				
Borrowings	13	89	147	97
Employee entitlements	14	362	300	300
Restricted funds	7	2	2	2
Provisions	15	30	3	3
Total non-current liabilities		483	452	402
Total liabilities		6,232	4,678	6,775
Net assets		12,417	11,736	9,612
Equity				
	16			
Crown equity		6,131	7,324	4,102
Accumulated surpluses/(deficits)		(2,710)	(2,835)	(1,735)
Revaluation reserves		8,851	7,173	7,175
Trusts and special funds		136	72	67
Minority interests		9	2	3
Total equity		12,417	11,736	9,612

Explanations of major variances against budget are provided in note 21.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2025

		Group		
	Notes	Actual 2025 \$m	Budget 2025 \$m	Actual 2024 \$m
Cash flows from operating activities				
Funding from the Crown/Crown Entities		27,364	27,826	26,493
Interest received		119	78	161
Other revenue		578	393	643
Payments to employees		(12,285)	(14,616)	(12,521)
Payments to suppliers		(15,815)	(15,488)	(14,685)
Capital charge		(486)	(529)	(470)
Interest paid		(7)	(7)	(6)
GST (net)		(86)	-	85
Net cash flows from operating activities		(618)	(2,343)	(300)
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		-	5	18
Receipts from sale or maturity of investments		348	1,108	1,886
Investment in restricted and trust funds		-	-	(3)
Funds placed on short term deposit >3months		-	(750)	(2,222)
Purchase of Property, Plant and Equipment		(1,452)	(2,028)	(1,445)
Purchase of Intangible assets		(114)	(63)	(185)
Net cash flows from investing activities		(1,218)	(1,728)	(1,951)
Cash flows from financing activities				
Capital contributions from the Crown	16	2,073	3,235	957
External Borrowings		-	50	-
Capital contributions returned to the Crown	16	(12)	(12)	(12)
Other Equity movements		-	-	-
Private sector debt repaid		(9)	(11)	(10)
Net cash flows from financing activities		2,052	3,262	935
Net (decrease)/increase in cash and cash equivalents				
		216	(809)	(1,316)
Cash and cash equivalents at the start of the year				
		840	840	2,019
Cash transferred in on amalgamation of the Māori Health Authority	22	-	-	137
Cash and cash equivalents at the end of the year	7	1,056	31	840

Explanations of major variances against budget are provided in note 21.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2025 (continued)

Reconciliation of reported net surplus/(deficit) with net cash inflow/(outflow) from operating activities

	Notes	Group	
		Actual	Actual
		2025	2024
		\$m	\$m
Reported Net Surplus/(Deficit) for the Year		(947)	(722)
Add Non-Cash Items:			
Depreciation and amortisation expense	10, 11	904	846
Unrealised (gain)/loss on investments		(12)	-
Total non-cash items		892	846
Add Items Classified as Investing Activities:			
Gains on disposal of property, plant and equipment		-	(5)
Investments in Associates		-	4
Total items classified as investing or financing activities		-	(1)
Add Movements in Statement of Financial Position Items:			
Decrease in Debtors and Other Receivables		(18)	157
Decrease/(increase) in Prepayments		(22)	(11)
Decrease in Inventories		(2)	198
Increase/(Decrease) in Creditors and Other Payables		(191)	105
Increase in Provisions		48	(62)
Increase/(Decrease) in Employee Entitlements		(378)	(810)
Net movements in working capital items		(563)	(423)
Net Cash Inflow from Operating Activities		(618)	(300)

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 2025

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 2025 comprise Health NZ (the parent entity) and its subsidiaries, together referred as the "group". Its interests in associates and joint ventures are equity-accounted for in the group financial statements. Health NZ's subsidiaries, associates and joint ventures listed below are incorporated and domiciled in New Zealand.

Subsidiaries – 100% owned

Three Harbours Health Foundation
Auckland Hospitals Research and Endowment Fund
Auckland Hospital Foundation
Waikato Health Trust
Taranaki District Health Trust
Spectrum Health Limited
The Lakes District Hospitals Charitable Trust
Tairāwhiti Laundry Services Limited
Enable New Zealand Limited
Canterbury Linen Services Limited
Brackenridge Services Limited
Allied Laundry Services Limited
New Zealand Health Innovation Hub Management Limited - General Partner for New Zealand Health Innovation Hub Limited Partnership

Subsidiaries – less than 100% owned

Kaipara Total Health Care Joint Venture (54%)

Associates

TLab Limited (50%)
Gisborne Laundry Services (50%)
Streamliners NZ Limited (20%)

Joint ventures

HealthOne (2021) Limited Partnership (50%)

Joint operations

Awhina Waitakere Health Campus
Manawa Health Research and Education Facility arrangement
Compounding facility and services with Slade Health

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 2025 and were approved for issue by the Board chair and the chair of the Finance and Audit Committee (as delegated by the Board) on 31 October 2025.

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.

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

1 Statement of accounting policies for the year ended 30 June 2025 (continued)**BASIS OF PREPARATION (continued)***Going Concern*

The financial statements have been prepared on a going concern basis. The Board, after making enquiries, has a reasonable expectation that Health NZ will have adequate cash resources to continue operations for the foreseeable future. The Board has reached this conclusion having regard to circumstances which it considers likely to affect Health NZ during the period of one year from the date of signing the 2024/25 financial statements, and to circumstances which will occur after that date which could affect the validity of the going concern assumption.

The key considerations are set out below:

- Health NZ's approved 2025/26 Statement of Performance Expectations (SPE) deficit of \$200m.
- The SPE closing cash is \$343m. Going concern financial forecasts show a higher closing cash balance of \$550m reflecting the higher actual closing cash balance at 30 June 2025 and lower Holidays Act payments than previously forecast. The cash position forecast for 31 December 2026 is \$531m.
- Focus for 2025/26 is on delivering measurable improvements to achieve health targets; ensuring timely care and preventative treatment; stabilising Health NZ governance, organisational teams and accountability; and improving timeliness and transparency of reporting on performance to targets, performance to budgets and service delivery. Focus will also be on ongoing improvements to financial discipline and enhancing controls across the organisation. This will ensure that Health NZ stays within budget and continues to improve value for money through productivity, efficiencies and reducing waste. Health NZ will:
 - Continue to strengthen operating models, empowering regional decision-making, clinical leadership, strengthen regional financial accountability, regional efficiencies and removing duplication. This will support more effective prioritisation and responsiveness to regional, district and local needs within available funding.
 - Continue to work with existing and new providers and the community sector, to maximise service delivery and improve outcomes to achieve results.
 - Make better use of capacity in hospital and specialist services, optimising service delivery and continuing to build partnerships with private hospitals.
 - Continue to progress financial discipline and efficiency initiatives including strategic procurement, contract management and other workforce related or digital enabled efficiencies.
 - Monitor and report on financial and non-financial performance including productivity improvements, health targets, workforce metrics and forecasts.
 - Monitor capital expenditure performance, tracking funding for approved programmes and ensuring operational affordability of projects.
 - Monitor cash reserves and liquidity to ensure Health NZ financial obligations are met as and when they fall due.
- Health NZ will receive Health Capital Envelope (HCE) equity from the Crown for approved capital projects. This is planned at \$1.658bn for 2025/26. Additional HCE funding of circa \$522m is forecast for the first half of 2026/27 per going concern financial forecasts.

1 Statement of accounting policies for the year ended 30 June 2025 (continued)**BASIS OF PREPARATION (continued)***Going Concern (continued)*

- Health NZ is required to settle the Holidays Act remediation liabilities as disclosed in note 14 of this report. Until remediation projects are completed for all Health NZ components, there remains uncertainty as to the actual amount Health NZ will be required to pay to current and former employees. The liability required for remediation has been reassessed at \$1.4bn. Crown equity funding amounting to circa \$945m is forecast for 2025/26 and an additional \$187m in the first half of 2026/27.
- The Crown (Minister of Health and Minister of Finance) has provided a letter of comfort to the Board 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).

New standards, amendments and interpretations adopted

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 has been adopted in the preparation of these financial statements.

Other changes in accounting policies

There have been no other changes in the group's accounting policies since the date of the last audited financial statements.

Standards, amendments, and interpretations issued but not yet effective and not early adopted**2024 Omnibus Amendments to PBE Standards**

2024 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 2027:

- PBE IPSAS 1 *Presentation of Financial Reports – Classification of Liabilities as Current and Non-current liabilities with Covenants*

Health NZ's adoption of the revised standard is not expected to have a significant impact on Health NZ's financial statements.

1 Statement of accounting policies for the year ended 30 June 2025 (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

The group financial statements are prepared by adding the 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.

Investments in subsidiaries, associates, and joint ventures*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 investments are 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.

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.

1 Statement of accounting policies for the year ended 30 June 2025 (continued)**Investments in subsidiaries, associates, and joint ventures (continued)***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.

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.

Restricted Funds

Funds held for specific purposes (mostly research) that are not available for Health NZ operating costs.

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.

Budget figures

The 2024/25 budget figures are derived from the Statement of Performance Expectations dated 14 November 2024. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

1 Statement of accounting policies for the year ended 30 June 2025 (continued)

Critical judgements in applying accounting policies

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

- Classification of Leases – refer to note 13.
- 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.

Critical accounting estimates and assumptions

The Board 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 – refer to **Note 10**
- Measuring the liabilities for Holidays Act 2003 remediation, long service leave, retirement gratuities, sabbatical leave, and continuing medical education leave – refer to **Note 14**
- Estimated useful life of property, plant and equipment – refer to **10**
- Estimated useful life of intangible assets – refer to **Note 11**
- Provision for expected credit losses – refer to **Note 8**

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. Health NZ considers that there are no conditions attached to the funding, and it is recognised as revenue at the point of entitlement. This is considered to be the start of the appropriations period that the funding relates to. 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 the Crown/Crown entities

Health NZ receives funding from the Ministry of 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 of 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 provided to third parties on commercial terms 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.

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.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when Health NZ 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.

Research revenue

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)**Funding from the Crown/Crown Entities**

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Crown funding – health services	24,296	23,245
Crown funding - Covid-19 response	-	238
Total Crown funding (from the Ministry of Health)	24,296	23,483
Pharmac funding	2,381	2,151
Ministry of Disabled People	314	323
Other	64	86
Total other funding from Crown/Crown Entities	2,759	2,560

Other revenue

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Gain on sale of property, plant and equipment	2	5
Donations and bequests received	26	25
Rental and accommodation revenue	27	30
Direct charges revenue	41	40
Drug trial revenue	11	14
Research grants	40	35
Other revenue (insurance claims, retail sales, carpark, laundry, pathology, equipment rental, training and consultancy fees)	280	401
Total other revenue	427	550

Non-cancellable leases as a lessor

The future aggregate minimum lease payments to be received under non-cancellable operating leases:

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Not later than one year	23	11
Later than one year and not later than five years	16	21
Later than five years	8	8
Total non-cancellable operating lease commitments as lessor	47	40

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 2025 \$m	Actual 2024 \$m
Salaries and wages	11,558	12,004
Defined contribution plan employer contributions	364	363
Movement in employee entitlements liability	97	(649)
Movement in Holidays Act remediation liability	(110)	80
Movement in restructuring provision	19	(56)
Total personnel costs	11,928	11,742

3 Personnel costs (continued)

Board and independent Committee member remuneration

	Group	
	Actual	Actual
	2025	2024
	\$000	\$000
Board member/Commissioners' remuneration – in thousands		
Professor Lester Levy (Board Chair 1 June 2024 to 23 July 2024, Commissioner to 23 July 2025)	333	33
Roger Jarrold (Board member 29 March 2024 to 23 July 2024, Dep. Commissioner to 23 July 2025)	265	84
Ken Whelan (Dep. Commissioner from 5 August 2024 to 23 July 2025)	183	-
Kylie Clegg (Dep. Commissioner from 23 August 2024 to 23 July 2025)	169	-
Dame Dr Karen Poutasi (Board Chair, resigned 31 May 2024)	-	201
Naomi Ferguson (resigned 9 July 2024)	-	88
Hon Amy Adams (resigned 8 July 2024)	-	70
Dr Jeff Lowe (resigned 9 July 2024)	-	68
Ms Tipa Mahuta (Waikato, Maniapoto, Ngāpuhi) (from 1 July 2023 - 30 June 2024)	-	35
Ms Vanessa Stoddart (resigned 8 July 2024)	-	85
Dr Curtis Walker (Te Whakatōhea rāua ko Ngāti Porou) (resigned 9 July 2024)	-	25
Total board member remuneration	950	689
Independent committee members – in thousands	\$000	\$000
Alan Brown – Health Infrastructure Committee	8	-
Katrina Van Houtte - Health Infrastructure Committee	8	-
Norman Wong – Finance Risk & Assurance Committee	14	-
Jonathan Oram (to July 2024)	-	1
Lale Ieremia (to 30 June 2024, committee discontinued)	-	12
Marc Rivers (to 30 June 2024, committee discontinued)	-	33
Mei Fern Johnston (to 11 Sept 2024, committee discontinued)	2	5
Michal Noonan (to 30 June 2024, committee discontinued)	-	13
Professor Marie Bismark (to 30 June 2024, committee discontinued)	-	12
Scott Pritchard (to 30 June 2024, committee discontinued)	-	9
Tevita Funaki (to 30 June 2024, committee discontinued)	-	7
Vena Crawley (to 30 June 2024, committee discontinued)	-	19
Total independent committee members	32	111

Health NZ has provided a deed of indemnity to the Commissioners 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.

3 Personnel costs (continued)

Board and independent Committee member remuneration

On 22 July 2024 the Minister of Health Dr Shane Reti announced the appointment of Professor Lester Levy as Commissioner for a 12-month term, replacing the Health NZ Board. No Board members received compensation or other benefits in relation to cessation (2023/24: nil).

The Health NZ board was re-established, and the appointed members assumed their roles on 24 July 2025 after the Commission ended.

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 2025 was 5.00% (2023/24: 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.

5 Infrastructure, non-clinical supplies and other expenses (continued)

Breakdown of infrastructure, non-clinical supplies and other expenses

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Audit New Zealand fees for audit of financial statements	5	5
Rental expenses including operating leases	97	91
Software - annual license fees	231	233
Information and communication technology expenses	144	116
Allowance for credit losses on receivables (note 8)	29	22
Board member fees	1	1
Loss on disposal of property, plant and equipment	2	4
Loss on disposal of intangible assets	-	8
Impairment of work in progress	21	11
Food, cleaning and laundry services	343	298
Utilities	115	110
Maintenance	97	118
Other facilities expenses	100	105
Compliance and corporate	188	199
Transport and travel	70	77
Other expenses (retail COGS, minor equipment, repairs, office costs, staff training and support)	396	380
Total infrastructure, non-clinical supplies and other expenses	1,839	1,778

In addition to the Audit New Zealand audit fees above, there were fees paid to Audit New Zealand for: 1) \$0.73m (\$0.93m 2023/24) for the audits of the New Zealand Health Plan for 1 July 2025 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) nil (2023/24: \$0.01m) 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 \$0.49m (2023/24: \$0.45m).

5 Infrastructure, non-clinical supplies and other expenses (continued)

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:

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Not later than one year	82	87
Later than one year and not later than five years	141	194
Later than five years	36	62
Total non-cancellable operating lease commitments as lessee	259	343

6 Clinical Supplies

This includes inventories recognised as an expense during the year of \$1.732m (2023/24: \$1.720m).

This includes a \$nil (2023/24: \$103m) write-down of Covid-19 inventories that have expired or will become obsolete. The 2023/24 write-down was calculated based on product expiry dates (\$39m and expired stock on hand) and the expected future usage given the current national pandemic response settings (\$64m excess stock on hand).

In the current year there was a reversal of previously written off inventory amounting to \$5.3m (2023/24 \$nil) due to the extended distribution of Covid-19 inventory into the community.

No inventories are pledged as security for liabilities. However, some inventories are subject to retention of title clauses.

7 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.

7 Cash and cash equivalents (continued)

Breakdown of cash and cash equivalents and further information

	Group	
	Actual	Actual
	2025	2024
	\$m	\$m
Current assets		
Bank balance and cash on hand *	56	284
Health NZ BNZ Cash Offset Balance	1,000	556
Total cash and cash equivalents in the statement of cash flows	1,056	840

* includes \$nil (2023/24: \$236m) of term deposits with original maturities of < 3 months. Also includes \$2m of restricted funds relating to the sale proceeds on an endowment property held on interest earning deposit, which are to be used in conjunction with Health NZ Auckland Treaty partner, Ngati Whatua.

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 Combining 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 Participating Combining 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.

8 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 possess 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.

8 Receivables (continued)**Accounting Policy (continued)**

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 2025 \$m	Actual 2024 \$m
Receivables	190	170
Other accrued income *	284	265
Less: Allowance for expected credit loss	(47)	(26)
Total receivables	427	409

* Includes \$235m accrual for Pharmac funding (2023/24: \$218m).

The ageing profile of trade receivables at year end is detailed below:

	Group			
	Gross 2025 \$m	Expected credit loss allowance 2025 \$m	Gross 2024 \$m	Expected credit loss allowance 2024 \$m
Receivable days past due				
Not past due	359	(1)	339	(1)
Past due 0-30 days	27	(3)	32	(3)
Past due 31-90 days	19	(5)	14	(3)
Past due 91-360 days	36	(12)	27	(11)
Past due more than 1 year	33	(26)	23	(8)
Total	474	(47)	435	(26)

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.

8 Receivables (continued)**Movements in the allowance for expected credit losses**

	Group	
	Actual	Actual
	2025	2024
	\$m	\$m
Balance 1 July	(26)	(24)
Additional allowances (made)/released	(29)	(22)
Written off during year	8	20
Balance at 30 June	(47)	(26)

9 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/endowed 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 is transferred from/to trust funds in equity.

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 2025 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 2025.

Equity investments

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.

9 Investments (continued)

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 2025 \$m	Actual 2024 \$m
Current assets		
Short term deposits > 3 months < 12 months	37	389
Investment portfolios with fund managers – trusts and special funds	-	4
Total current portion	37	393
Non-Current assets		
Term deposits	22	28
Investment portfolios with fund managers – trusts and special funds	42	35
Residential Care Loans	61	55
Other investments – trusts and special funds	3	3
Total non-current portion	128	121
Total Investments	165	514

The carrying value of investments approximates their fair value.

10 Property, plant and equipment

Accounting Policy

Property, plant, and equipment consist of the following asset classes: land, buildings (all improvements including building structure, services and fitout, leasehold improvements, site 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.

10 Property, plant and equipment (continued)

Accounting Policy (continued)

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.

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.

10 Property, plant and equipment (continued)

Accounting Policy (continued)

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.

10 Property, plant and equipment (continued)

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings 2025

The most recent valuations were performed as at 30 June 2025. Health NZ engaged the independent district valuers to perform full valuations or desktop assessments of the land and building assets.

Independent valuer	District(s)	Valuation approach	Carrying value of land (\$m)	Carrying value of buildings (\$m)
CBRE	Auckland	Full valuation	398	1,071
	Canterbury	Full valuation	172	2,326
	Taranaki	Desktop Assessment	17	250
	Waitemata	Full valuation	348	985
	Whanganui	Desktop Assessment	6	106
RS Valuation Limited	Bay of Plenty	Desktop Assessment	51	434
	Counties Manukau	Full valuation	284	1,247
	Lakes	Desktop Assessment	25	276
	Mid Central	Desktop Assessment	24	346
	Northland	Desktop Assessment	26	415
	Waikato	Full valuation	101	1,158
Colliers	Capital and Coast	Full valuation	52	661
	South Canterbury	Desktop Assessment	7	69
CBRE Limited	Hutt Valley	Desktop Assessment	36	298
	Wairarapa	Desktop Assessment	5	52
Beca	Southern	Desktop Assessment	137	395
	Nelson Marlborough	Desktop Assessment	46	214
Added Valuation Limited	Hawkes Bay	Desktop Assessment	19	271
JLL	Tairāwhiti	Desktop Assessment	6	110
Coast Valuations Limited	West Coast	Desktop Assessment	9	199
Total			1,769	10,883

Full valuations were undertaken for the six largest Health NZ districts comprising 65% of the previous 2023 building portfolio valuation. Some small value outlying locations and minor buildings at the six largest districts were assessed on an indexed basis.

Desktop assessments were undertaken for the 14 smaller districts.

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.

10 Property, plant and equipment (continued)

Critical accounting estimates and assumptions (continued)

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.
- 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.

10 Property, plant and equipment (continued)

Critical accounting estimates and assumptions (continued)

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 require 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.

10 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

	Group							
	Land	Buildings	Clinical Equip.	Other Equip.	IT/ITC	Motor Vehicles	Work in Progress	Total
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Cost								
Balance at 1 July 2024	1,731	9,751	2,028	293	435	109	1,850	16,197
Transfers from WIP	1	611	176	47	73	5	(913)	-
Additions to WIP	-	-	-	-	-	-	1,400	1,400
Impairment Losses	-	-	-	-	-	-	-	-
Disposals/transfers between classes	-	-	(62)	10	(17)	(3)	(33)	(105)
Transfers from Intangibles	-	-	-	-	-	-	85	85
Revaluation (note 16)	37	581	-	-	-	-	-	618
Balance at 30 June 2025	1,769	10,943	2,142	350	491	111	2,389	18,195
Depreciation and impairment losses								
Balance at 1 July 2024	-	580	1,271	145	325	83	11	2,415
Depreciation	-	543	168	20	54	7	-	792
Impairment Losses/reversals	-	-	-	-	-	-	(11)	(11)
Disposals/transfers between classes	-	(3)	(63)	9	(12)	(5)	-	(74)
Transfers to Intangibles	-	-	-	-	-	-	-	-
Reversal of accum depn on revaluation (note 16)	-	(1,060)	-	-	-	-	-	(1,060)
Balance at 30 June 2025	-	60	1,376	174	367	85	-	2,062
Carrying Amount								
At 1 July 2024	1,731	9,171	757	148	110	26	1,839	13,782
At 30 June 2025	1,769	10,883	766	176	124	26	2,389	16,133

10 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

	Group							
	Land	Buildings	Clinical Equip.	Other Equip.	IT/ITC	Motor Vehicles	Work in Progress	Total
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Cost								
Balance at 1 July 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	-	-	-	-	-	-	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 1 July 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 depn on revaluation	-	-	-	-	-	-	-	-
Balance at 30 June 2024	-	580	1,271	145	325	83	11	2,415
Carrying Amount								
At 1 July 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

Work in progress

Property, plant and equipment under construction by class of asset are detailed below:

	Group	
	Actual 2025	Actual 2024
	\$m	\$m
Buildings	2,216	1,651
Clinical equipment	102	132
Information technology	51	37
Motor Vehicles	5	4
Other equipment	15	15
Total work in progress	2,389	1,839

10 Property, plant and equipment (continued)

Leased assets

Health NZ has entered 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 13**.

Capital commitments

	Group	
	Actual	Actual
	2025	2024
	\$m	\$m
Property	903	1,071
Intangible assets and other equipment	176	153
Total capital commitments	1,079	1,224

11 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
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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.

11 Intangible assets (continued)

Breakdown of intangible assets and further information

2025	Group		
	Computer Software	Work in Progress	Total
	\$m	\$m	\$m
Cost			
Balance at 1 July 2024	1,118	248	1,366
Additions from WIP	212	(212)	0
Additions	-	201	201
Transfers to Property, plant and equipment	-	(85)	(85)
Disposals	(12)	-	(12)
Balance at 30 June 2025	1,318	152	1,470
Accumulated depreciation and impairment losses			
Balance at 1 July 2024	828	-	828
Amortisation	112	-	112
Disposals	(9)	-	(9)
Balance at 30 June 2025	931	-	931
Carrying amount 1 July 2024	292	247	539
Carrying amount 30 June 2025	387	152	539

2024	Group		
	Computer Software	Work in Progress	Total
	\$m	\$m	\$m
Cost			
Balance at 1 July 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 1 July 2023	748	-	748
Amortisation	85	-	85
Disposals	(5)	-	(5)
Balance at 30 June 2024	828	-	828
Carrying amount 1 July 2023	284	145	429
Carrying amount 30 June 2024	291	248	539

12 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 2025 \$m	Actual 2024 \$m
Payables under exchange transactions		
Creditors	1,476	1,618
Deferred revenue	46	45
Total payables under exchange transactions	1,522	1,663
Payables under non exchange transactions		
GST, WHT, PAYE & FBT payable	287	364
Total payables under non exchange transactions	287	364
Total payables and deferred revenue	1,809	2,027

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.

13 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.

13 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 2025 \$m	Actual 2024 \$m
Current		
Finance Leases	9	10
Other	1	1
Total current portion	10	11
Non-current		
Finance Leases	87	95
Other	2	2
Total non-current portion	89	97
Total borrowings	99	108

13 Borrowings (continued)

The net carrying amount of leased items within each class of property, plant, and equipment is included in **Note 10**. 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 2025 \$m	Actual 2024 \$m
Minimum lease payments payable:		
No later than one year	15	16
Later than one year and not later than five years	40	47
Later than five years	104	112
Total minimum lease payments	159	175
Future finance charges	(63)	(70)
Present value of minimum lease payments	96	105
Present value of minimum lease payments payable:		
No later than one year	13	14
Later than one year and not later than five years	34	39
Later than five years	49	52
Total present value of minimum lease payments	96	105

The carrying value of finance lease liabilities approximates their fair value.

14 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, sick leave and expected voluntary bonding scheme claims.

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.

Voluntary bonding scheme payment claims not expected to be settled wholly before 12 months after the end of the reporting period are calculated based on the historical retention performance and claims volumes.

14 Employee entitlements (continued)

Accounting Policy (continued)

The calculations are based on:

- 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.
- likely future voluntary bonding scheme claims are based on extrapolations of historical retention performance and claims volumes.

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, retirement gratuities and voluntary bonding scheme claims 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 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 30 June 2025 and range between 3.14% and 5.99% (2023/24: 4.57% and 5.28%). The salary inflation factor is 2.5% (2023/24: 3.0%) which is Health NZ's best estimate forecast of salary increments.

If the discount rate were to differ by $\pm 1\%$ 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 \$23.5m higher / \$20.3m lower (2023/24: \$29.9m higher / \$21.5m lower).

If the salary inflation factor were to differ by $\pm 1\%$ 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 \$20.9m lower / \$24.4m higher (2023/24: \$22.1m lower / \$30.1m higher).

14 Employee entitlements (continued)

Critical accounting estimates and assumptions (continued)

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 and for calculation of minimum entitlements to remediate any historical non-compliance from 1 May 2010 (the agreed start of the remediation period).

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.

Determining the quantum of expected future payments to current and former employees is complex and, until detailed calculations have been performed for each employee, judgements and assumptions are involved in making an estimate of the liability.

The liability transferred to Health NZ when it was established on 1 July 2022 had been estimated using remediation scripts (where 100% of the population is recalculated) or a sample and extrapolation approach across the population. Modelling was undertaken in 2022/23 and 2023/24 to estimate the increase required to the provision where there was ongoing non-compliance (i.e. where payroll systems had not been rectified and remediation payments to current employees had not been made).

As at 30 June 2025, detailed remediation calculations have been modelled for employees of some districts. In these cases, the amount included in the provision is based on the output of the remediation payment models. Where detailed remediation calculations have not been completed, generally for former employees, an estimate of the liability has been made using remediation models completed for, or actual payments made, to current employees. For a small number of smaller districts, an estimate of the liability has been made using national average remediation rates.

As better information has become available, the estimate of the liability has been adjusted and \$189m of the provision has been released/reversed in 2024/25 (2023/24: \$153m).

Payments to settle this provision commenced in July 2023, with \$284m paid to employees in the year ended 30 June 2025 (2023/24: \$240m). Payments made are deducted from the provision.

A further amount of \$61m (2023/24: \$107m) was deducted from the provision for the revaluation of annual leave balances for the remediated employees to reflect the leave rates agreed to be used for calculating annual leave entitlements as part of the remediation project. When these employees receive remediation payments, the leave revaluation amount is transferred to the annual leave balance.

The liability recognised has been estimated using the best available information at both 30 June 2025 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 are likely to differ from the financial liability estimate recorded.

14 Employee entitlements (continued)*Holidays Act 2003 remediation (continued)***Breakdown of employee entitlements**

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Current		
Accrued salaries and wages	351	296
Annual leave	1,674	1,593
Holidays Act 2003 remediation	1,356	1,825
Continuing education leave and expenses	274	312
Sick leave	26	33
Long service leave	58	62
Retirement gratuities	64	60
Voluntary Bonding Scheme	8	-
Other employee entitlements	5	69
Total current portion	3,816	4,250
Non-current		
Long service leave	89	76
Retirement gratuities	171	168
Voluntary Bonding Scheme	29	-
Other entitlements	73	56
Total non-current portion	362	300
Total employee entitlements	4,178	4,550

Movements in Holidays Act 2003 Remediation Provision

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Opening Balance 1 July	1,825	2,101
Additional provision made	79	233
Paid to employees	(284)	(240)
Kiwisaver and ACC paid	(14)	(9)
Leave revaluation transferred to staff liabilities	(61)	(107)
Unused amount reversed	(189)	(153)
Closing Balance 30 June	1,356	1,825

15 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”.

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.

From 1 April 2024 Health NZ is liable for all claim costs for a period of four years (2024: two years) after the end of the cover period in which the injury occurred. At the end of the cover 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. Previously individual HNZ districts had varying no high claims limits.

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 to possible, the estimated future cash outflows.

Holidays Act Remediation Project

The provision is for the costs expected to complete the remediation project works.

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.

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.

15 Provisions (continued)

Breakdown of provisions and further information

	Group	
	Actual	Actual
	2025	2024
	\$m	\$m
Current		
ACC Accredited Employers Programme	22	19
Holidays Act Remediation Project	73	66
Restructuring	19	-
Total current	114	85
Non-current		
ACC Accredited Employers Programme	26	1
Other	4	2
Total non-current	30	3
Total provisions	144	88

Movement for each class of provision

	Group	
	Actual	Actual
	2025	2024
	\$m	\$m
ACC Accredited Employers Programme		
Opening balance 1 July	20	16
Discount unwind and changes in assumptions	7	-
Increase full self-cover to 4 years (2024: 2 years) and no limit high value claims	21	-
Additional provisions made	22	14
Amounts used	(22)	(10)
Closing balance 30 June	48	20
Holidays Act Remediation Project		
Opening balance 1 July	66	66
Additional provisions made	49	48
Amounts used	(42)	(48)
Closing balance 30 June	73	66
Restructuring Provision		
Opening balance 1 July	-	56
Amount unused and reversed during the year	-	(56)
Additional provisions made	63	-
Amounts used	(44)	-
Closing balance 30 June	19	-

15 Provisions (continued)**Movement for each class of provision (continued)**

	Group	
	Actual	Actual
	2025	2024
	\$m	\$m
Other		
Opening balance 1 July	2	4
Additional provisions made	4	-
Amounts used	(2)	(2)
Closing balance 30 June	4	2

16 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. Equity is disaggregated and classified into the following components:

Crown Equity

Accumulated surpluses or deficits

Revaluation reserves

Trusts and special funds

Contributions from/(repayment to) the Crown

This relates to funding from the Crown for Crown approved capital projects, Holidays Act remediation, and deficit support for pay equity payments.

Revaluation reserves

These reserves relate to the revaluation of land and improvements to fair value.

Trusts and special funds

The receipt of donations, bequests, and investment revenue earned on these funds is recognised as revenue and then transferred to the reserve. Application of funds on the trusts' specified purposes is recognised as an expense.

This reserve records the unspent amount of trusts and special funds provided to Health NZ.

16 Equity (continued)

Breakdown of equity and further information

	Group	
	Actual 2025 \$m	Actual 2024 \$m
<i>Crown Equity</i>		
Opening balance 1 July	4,102	3,080
Capital contributions from the Crown – capital projects	1,399	682
Capital contributions from the Crown – Holidays Act remediation	256	275
Equity contribution from the Crown – deficit support	419	-
Capital contribution returned to the Crown	(12)	(12)
Reclassification to trusts and special funds	(33)	-
Maori Health Authority – equity on amalgamation	-	77
Balance at 30 June	6,131	4,102
<i>Accumulated surpluses/(deficits)</i>		
Opening balance 1 July	(1,735)	(1,013)
Surplus/(deficit)	(947)	(722)
Reclassification to trusts and special funds	(28)	-
Balance at 30 June	(2,710)	(1,735)
<i>Revaluation reserves</i>		
Opening balance 1 July	7,175	7,175
Revaluations (refer to note 10)	1,678	-
Transfers to accumulated surplus/(deficit) on disposal	(2)	-
Balance at 30 June	8,851	7,175
<i>Trusts and special funds</i>		
Opening balance 1 July	67	64
Movements in trusts and special funds	8	3
Reclassification from equity and accumulated surplus/(deficit)	61	-
Balance at 30 June	136	67
<i>Minority interests</i>		
Opening balance 1 July	3	7
Movements in minority interests	6	(4)
Balance at 30 June	9	3
Total Equity	12,417	9,612

16 Equity (continued)**Breakdown of equity and further information**

	Group	
	Actual 2025	Actual 2024
<i>Revaluation reserves consist of</i>		
Land	1,677	1,640
Buildings	7,174	5,535
Total revaluation reserves	8,851	7,175

17 Contingencies**Contingent Liabilities**

Unquantifiable contingent liabilities as at 30 June 2025

- 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 was acting for the Attorney-General on behalf of the Crown in *Stafford v Attorney-General*, in which it was 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 sought the return of land they said the Crown held on trust for the successors of the original owners and compensation, or other relief. This extended to land 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 High Court Judgment was issued on 31 October 2024. The judgement granted relief in the form of specified land, a monetary amount commensurate with the loss of beneficial use of the land, and an interest component. The Court agreed that Crown entity land, including Health NZ’s Nelson Hospital site, was not available as a remedy.

Health NZ is a party to a variety of legal proceedings and disputes. As at the balance date, we do not consider that the possible financial impact of any of these legal proceedings or disputes, including the legal costs to be incurred in connection with any such legal proceedings or dispute, is material. Because of this, these legal proceedings and disputes are not individually disclosed.

18 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 1**).
- Key management personnel and their close family members. Key management personnel are Board Members/Commissioner and Deputies, the Leadership Team, and their close family members are their spouses, children and dependants.
- Entities in which Board members/Commissioners and Deputies, 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 2025	Actual 2024
Board Members		
Remuneration	\$0.06m	\$0.69m
Full-time equivalent members	0.06	1.50
Commissioner and Deputies		
Remuneration	\$0.89m	-
Full-time equivalent members	1.81	-
Leadership Team		
Salaries	\$9.60m	\$8.29m
Cessation payments	\$1.68m	-
Final Payments for leave & in lieu of notice	\$2.01m	-
Total leadership team remuneration	\$13.29m	\$8.29m
Full-time equivalent members	15.84	13.98
Total key management personnel remuneration	\$14.24m	\$8.98m
Total full time equivalent personnel	17.71	15.48

18 Related party transactions (continued)**Key management personnel compensation (continued)**

The Leadership Team comprises the Chief Executive Officer and Executive Team Members. Various changes to the Executive Leadership Team members occurred throughout 2024/25.

The full-time equivalent for Board members has been determined based on the frequency and length of meetings and the estimated time to prepare for meetings.

The full-time equivalent for the Commissioner and Deputy Commissioners has been determined based on the expectation of hours as advised by the Minister of Health.

An analysis of respective remuneration is provided in **Note 3**.

19 Financial Instruments**Carrying amounts of finance assets and liabilities**

The carrying amounts of financial assets and liabilities in each financial instrument category are:

	Group	
	Actual 2025 \$m	Actual 2024 \$m
<i>Financial assets measured at amortised cost</i>		
Cash and cash equivalents	1,056	840
Receivables	427	409
Term deposits	59	514
Total financial assets measured at amortised cost	1,542	1,763

Fair value hierarchy disclosures

	Group	
	Actual 2025 \$m	Actual 2024 \$m
<i>Financial assets measured at fair value through surplus or deficit</i>		
Portfolio investments	42	39
Residential care loans and other	64	58
Total financial assets measured at fair value through surplus or deficit	106	97
<i>Financial liabilities measured at amortised cost</i>		
Payables (excluding revenue in advance and taxes payable)	1,477	1,618
Borrowings and finance leases	99	108
Restricted funds	2	2
Total financial liabilities measured at amortised cost	1,578	1,728

19 Financial Instruments (continued)

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.

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			
	Total	Quoted market price	Observable inputs	Significant non-observable inputs
	\$m	\$m	\$m	\$m
Group 30 June 2024				
Financial Assets				
Portfolio investments	39	-	39	-
Residential care loans and other	58	-	58	-
Group 30 June 2025				
Financial Assets				
Portfolio investments	42	-	42	-
Residential care loans and other	64	-	64	-

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.

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.

19 Financial Instruments (continued)

Financial Instrument risks (continued)

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 2024 and 30 June 2025, 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.

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 2024 and 30 June 2025, 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. Pharmac 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.

19 Financial Instruments (continued)

Credit risk (continued)

	Group	
	Actual 2025 \$m	Actual 2024 \$m
Counterparties with credit ratings		
Cash, cash equivalent and bank term deposits		
All of Government banking service providers	1,115	1,257
Total counterparties with credit ratings	1,115	1,257
Counterparties without credit ratings		
Portfolio Investments - no defaults in the past	42	39
Residential care loans and other - no defaults in the past	64	58
Receivables		
Existing counterparty with no defaults in the past	427	409
Existing counterparty with defaults in the past	-	-
Total counterparties without credit ratings	533	506

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.

	Group					
2025	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	1,476	1,476	1,476	-	-	-
Borrowing & finance leases	99	162	16	13	29	104
Total	1,575	1,638	1,492	13	29	104

19 Financial Instruments (continued)

Liquidity risk (continued)

2024	Carrying amount \$m	Contractual cash flow \$m	Group			
			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

20 Events after balance date

On 7 July 2025, the Minister of Health announced the re-establishment of the Board of Health NZ and the Board commenced their role on 24 July 2025. The Board took over from the Commissioner (Professor Lester Levy) and Deputy Commissioners previously appointed with effect from 24 July 2024 under section 62 of the Pae Ora (Healthy Futures) Act 2022.

21 Explanation of major variances against budget

The budget figures included in the financial statements are from the 2024/25 Statement of Performance Expectation (SPE) and the actual financial results are compared against this budget.

The major variances in the Statement of Comprehensive Revenue and Expenses

Revenue Variances:

Crown Funding revenue received was less than budget by \$514m due to:

- \$440m of budgeted funding (not received as costs have not been spent) is to be transferred to 2025/26 and future years through the In Principle Expense and Capital Transfer (IPECT) process and is subject to confirmation in the 2025 October Baseline Updates. IPECTs are used to ensure that funding aligns with the timing of expenditures for budget initiatives/programmes.
- \$74m overbudgeted reimbursement for capital charge (driven by timing of costs for major capital projects) and for Pay Equity in the current year.

Other Funding from the Crown/Crown Entities was more than budget by \$203m, mainly:

- \$192m Pharmac revenue reflecting higher demand for funded medicines and wash-ups from the prior year.

Expenditure Variances:

Personnel costs were less than budget by \$538m due to the following factors:

- \$145m variance due to expenditure not incurred for budget initiatives with funding (and associated costs) transferred forward through IPECTs;
- \$189m from the release of the provision for the Holidays Act liability that was determined as no longer required following reassessment of the residual liability; and
- \$204m from other factors, principally (i) budgeted personnel price uplifts not realised mainly due to Collective Agreements that remained unsettled at year end and, (ii) lower internal personnel costs, which were offset by higher outsourced personnel costs (as noted below).

Outsourced personnel costs were greater than budget by \$162m due to use of contingent workforce to cover staffing requirements (e.g. leave, additional rosters, short-term resources required for funded projects and initiatives).

External Service provider costs were less than budget by \$124m, reflecting \$263m costs not realised which have funding transferred forward through IPECTs. These are offset by above budget pharmaceutical costs not funded by Pharmac.

21 Explanation of major variances against budget (continued)

The major variances in the Statement of Financial Position

Cash and Cash Equivalents are \$1bn above the budget mainly driven by:

- Crown equity funding received in September 2024 (\$419m) from the Ministry of Health to compensate Health NZ for pay equity settlement payments made to Allied Health and midwifery staff in 2023/24 for which operational funding had not been received in that year.
- Health Capital Envelope Crown equity funding received in September 2024 (\$275m) to reimburse Health NZ for capital costs incurred in prior years that had not been claimed in 2023/24.
- Delays in progressing remediation payments for the Holidays Act liability reduced the unfunded cash contribution from Health NZ (the 2024/25 budget had assumed full remediation payments would be made in the year).
- Collective Agreements not settled in the year when the budget had assumed full settlement.

Property, Plant and Equipment value is greater than budget by \$964m mainly due to impact of land and building asset revaluations completed as at 30 June 2025 (circa \$1.64bn) and the balance is from asset additions, net of depreciation for assets not revalued.

Employee Entitlements were \$1.62bn above the budget mainly due to budget assumptions for the Holidays Act liability where the SPE budget assumed that all remediation payments would have been completed by 30 June 2025. Due to complexity of the programme, there have been delays in finalising payment calculations, resulting in lower than planned payments made during the year.

Total equity was \$680m above budget mainly due to a gain from revaluation of land and buildings of \$1.68bn plus a favourable result compared to budget of \$153m, offset by lower equity received for capital projects funded by the Crown (due to major capital projects progressing at a slower pace than planned) and lower Crown equity claimed for the Holidays Act liability (due to programme delays).

The major variances in the Statement of Cash Flows

Funding from the Crown/Crown Entities was less than budget mainly due to IPECT transfers to future years, net of additional above budget funding received from supplementary budget announcements.

Payments to Employees were less than budget mainly due to the budget having assumed full remediation costs for the Holidays Act liability and settlement of all Collective Agreements during the year, which did not eventuate.

Payments to Suppliers were above budget reflecting expenditure uplift in line with the baseline and budget initiatives funding uplift. Other underlying variances include increased pharmaceutical costs (partially offset by additional funding) and increased outsourced costs.

Capital charge payments were less than budget as the budget assumed the full capital plan to be implemented as planned, but actual costs incurred were less and equity claims against the Health Capital Envelope for Health NZ funded projects were also lower.

22 Amalgamation of Te Aka Whai Ora | Maori Health Authority (MHA)

On 1 April 2024, the majority of the roles and functions of the MHA were amalgamated with Health NZ.

The combination was 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 was accounted for using the pooling of interest's method, which results in the assets and liabilities of MHA measured at their carrying amounts being as of amalgamation date combined with Health NZ assets and liabilities at that 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	5
Prepayments	8
Total Current Assets	150
Total Assets	150
Current Liabilities	
Trade payables and deferred revenue	91
Employee entitlements	4
Total Current Liabilities	95
Total Liabilities	95
Net Assets	55

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.

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. Immediately prior to the amalgamation date, assets of \$172m, liabilities of \$95m, and net assets of \$77m were reported by the MHA.

Additional Disclosures - Employee Remuneration

The number of Health NZ employees receiving remuneration over \$100,000 on an annualised basis.

Remuneration range	Actual 2025	Remuneration range	Actual 2025
\$100,000 - \$109,999	7,810	\$620,000 - \$629,999	11
\$110,000 - \$119,999	7,947	\$630,000 - \$639,999	10
\$120,000 - \$129,999	7,643	\$640,000 - \$649,999	13
\$130,000 - \$139,999	6,396	\$650,000 - \$659,999	5
\$140,000 - \$149,999	4,485	\$660,000 - \$669,999	5
\$150,000 - \$159,999	2,858	\$670,000 - \$679,999	5
\$160,000 - \$169,999	1,881	\$680,000 - \$689,999	10
\$170,000 - \$179,999	1,405	\$690,000 - \$699,999	7
\$180,000 - \$189,999	970	\$700,000 - \$709,999	11
\$190,000 - \$199,999	777	\$710,000 - \$719,999	2
\$200,000 - \$209,999	585	\$720,000 - \$729,999	3
\$210,000 - \$219,999	481	\$730,000 - \$739,999	9
\$220,000 - \$229,999	415	\$740,000 - \$749,999	5
\$230,000 - \$239,999	376	\$750,000 - \$759,999	1
\$240,000 - \$249,999	341	\$760,000 - \$769,999	3
\$250,000 - \$259,999	360	\$770,000 - \$779,999	6
\$260,000 - \$269,999	343	\$780,000 - \$789,999	4
\$270,000 - \$279,999	311	\$790,000 - \$799,999	3
\$280,000 - \$289,999	284	\$800,000 - \$809,999	3
\$290,000 - \$299,999	284	\$810,000 - \$819,999	1
\$300,000 - \$309,999	256	\$830,000 - \$839,999	2
\$310,000 - \$319,999	238	\$840,000 - \$849,999	2
\$320,000 - \$329,999	221	\$850,000 - \$859,999	3
\$330,000 - \$339,999	204	\$860,000 - \$869,999	2
\$340,000 - \$349,999	210	\$870,000 - \$879,999	1
\$350,000 - \$359,999	201	\$880,000 - \$889,999	1
\$360,000 - \$369,999	179	\$890,000 - \$899,999	5
\$370,000 - \$379,999	187	\$900,000 - \$910,000	2
\$380,000 - \$389,999	177	\$910,000 - \$919,999	1
\$390,000 - \$399,999	145	\$920,000 - \$929,999	4
\$400,000 - \$409,999	140	\$930,000 - \$939,999	1
\$410,000 - \$419,999	129	\$950,000 - \$959,999	1
\$420,000 - \$429,999	126	\$960,000 - \$969,999	2
\$430,000 - \$439,999	127	\$970,000 - \$979,000	1
\$440,000 - \$449,999	102	\$1,000,000 - \$1,009,999	3
\$450,000 - \$459,999	110	\$1,020,000 - \$1,029,999	2
\$460,000 - \$469,999	71	\$1,030,000 - \$1,039,999	2
\$470,000 - \$479,999	66	\$1,040,000 - \$1,049,999	1
\$480,000 - \$489,999	62	\$1,070,000 - \$1,079,999	2
\$490,000 - \$499,999	61	\$1,110,000 - \$1,119,999	1
\$500,000 - \$509,999	36	\$1,150,000 - \$1,159,999	1
\$510,000 - \$519,999	44	\$1,160,000 - \$1,169,999	1
\$520,000 - \$529,999	53	\$1,190,000 - \$1,199,999	1
\$530,000 - \$539,999	43	\$1,210,000 - \$1,219,999	1
\$540,000 - \$549,999	34	\$1,240,000 - \$1,249,999	1
\$550,000 - \$559,999	29	\$1,280,000 - \$1,289,999	1
\$560,000 - \$569,999	27	\$1,380,000 - \$1,389,999	1
\$570,000 - \$579,999	19	\$1,410,000 - \$1,419,999	1
\$580,000 - \$589,999	21	\$1,540,000 - \$1,549,999	1
\$590,000 - \$599,999	15	\$1,590,000 - \$1,599,999	1
\$600,000 - \$609,999	22	\$1,620,000 - \$1,629,999	1
\$610,000 - \$619,999	12	\$1,730,000 - \$1,739,999	1
Total			49,487

In the year 1,822 employees received compensation/other benefits related to cessation and retention totalling \$63,888,043. Annualised salaries have increased due to the impacts of Holidays Act remediation payments, additional duties and MECA step changes.

Independent Auditor's Report

Independent Auditor's Report

To the readers of the Health New Zealand | Te Whatu Ora Group annual financial statements and performance information for the year ended 30 June 2025

The Auditor-General is the auditor of the Health New Zealand | Te Whatu Ora group (the Group). The Auditor-General has appointed me, Stephen Lucy, using the staff and resources of Audit New Zealand, to carry out, on his behalf, the audit of:

- the annual financial statements of the Group that comprise the statement of financial position as at 30 June 2025, 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 on pages 223 to 274; and
- the performance information that consists of:
 - the Group's statement of performance for the year ended 30 June 2025 on pages 35 to 181, 200, 216, 217 and 289 to 292; and
 - the end-of-year performance information for appropriations for the year ended 30 June 2025 included within pages 35 to 181, 200, 216, 217 and 289 to 292.

Opinion

Unmodified opinion on the annual financial statements

In our opinion, the annual financial statements of the Group:

- fairly present, in all material respects:
 - its financial position as at 30 June 2025; 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.

Qualified opinion on the performance information

In our opinion, except for the possible effects of the matter described in the *Basis for our opinion* section:

- The statement of performance of the Group fairly presents, in all material respects, the Group's service performance for the year ended 30 June 2025. In particular, the Group's statement of performance:

- provides an appropriate and meaningful basis to enable readers to assess the actual performance of the Group for each class of reportable outputs, determined in accordance with generally accepted accounting practice in New Zealand; and
 - fairly presents, in all material respects, for each class of reportable outputs:
 - the actual performance of the Group;
 - the actual revenue earned; and
 - the output expenses incurred; and
 - compared with the forecast standards of performance, the expected revenues, and proposed output expenses included in the Group's statement of performance expectations for the financial year; and
 - complies with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.
- The end-of-year performance information for appropriations:
 - fairly presents, in all material respects:
 - what has been achieved with each appropriation; and
 - the actual expenses or capital expenditure incurred in relation to each appropriation as compared with the expenses or capital expenditure that were appropriated or forecast to be incurred; and
 - complies with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Our audit was completed on 31 October 2025. This is the date at which our opinion is expressed.

Basis for our opinion

Performance information: Our work was limited in respect of the performance measure on the timeliness of access to primary mental health and addiction services

An important aspect of the Group's performance information is reporting on the timeliness of access to mental health and addiction services. As disclosed on page 161, the Group is still developing systems and controls to support the completeness and accuracy of the result reported for the performance measure: *percentage of people accessing primary mental health and addiction services through the Access and Choice programme seen within one week*. As a result, our work was limited and there were no practicable audit procedures we could apply to obtain sufficient appropriate evidence that the reported performance for this measure is materially correct.

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards, the International Standards on Auditing (New Zealand), and New Zealand Auditing Standard 1 (Revised): *The Audit of Service Performance Information* issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the *Responsibilities of the auditor* section of our report.

Independent Auditor's Report

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements and the performance information of the Group for the current period. In applying our professional judgement to determine key audit matters, we considered those matters that are complex, have a high degree of uncertainty, or are important to the public because of their size or nature.

These key audit matters were addressed in the context of our audit of the annual financial statements and performance information of the Group as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the Basis for our opinion section of our report, we have determined the matters described below to be the key matters to be communicated in our report.

Description of key audit matter	How we addressed this matter
Service performance information	
Achieving better health outcomes and reducing undesired variability in access to services are important objectives of the health system in New Zealand. Reporting clear, accurate, and informative service performance information enables readers to assess the performance of the Group and the progress towards system targets and objectives, and improved health outcomes. Numerous different clinical information systems are used across the organisation to collect, record, and report performance information, which creates complexity in reporting on the performance of the Group to New Zealanders. We considered the service performance information to be a key audit matter due to the complexities of the reporting systems and the importance of the performance information to the public.	We have: - assessed whether the performance framework provides an adequate basis for reporting the Group's performance; and - identified performance measures that, in our view, are the most significant to readers of the Group's service performance information. For the performance measures we considered to be significant, we have: - understood the systems and controls the Group has in place to capture, collate, and report service performance in a consistent and accurate manner across the Group; - assessed the reasonableness of the measurement bases underlying the performance reported and confirmed that they have been consistently applied; - verified reported performance to underlying data and tested the integrity of the data on a sample basis. This included: - inspection of supporting documentation; - reperformance of calculations; and - reviewing underlying data for omissions.

Description of key audit matter	How we addressed this matter
	Our work also included assessing whether the service performance information was appropriate and meaningful based on our knowledge of the Group's overall performance and priorities. This included considering whether reported performance provided sufficient information based on location and ethnicity to highlight variability. As a result of the above procedures, except for the measure described in the Basis for our opinion section we are satisfied that the performance information of the Group fairly presents, in all material respects, the Group's service performance and achievements for the year.
Holidays Act 2003 remediation provision	
As outlined in note 14, the employee entitlements liability includes a \$1.356 billion 'Holidays Act 2003 remediation' provision for amounts owing to current and former employees who have been paid less than their legal leave entitlements under the Holidays Act 2003 (Holidays Act). Determining the quantum of expected future payments to current and former employees is complex and, until detailed calculations have been performed for each employee, judgements and assumptions are involved in making an estimate of the liability. We considered this to be a key audit matter due to the significant amount of public money involved, and the judgements and assumptions involved in estimating the liability. The provision is also of significant interest to the public, given the impact on many thousands of current and former health sector employees.	We have: - considered the progress made during the year in calculating the amounts owed to, and paying out, affected employees; and - agreed payments made during the 2024/25 financial year to payroll system data. In respect of the provision recognised at 30 June 2025, we have evaluated whether the provision recorded has been estimated using the best available information. Where detailed remediation payment calculations have been completed, we have compared the provision balance recorded to results of the remediation models. Where management has engaged an expert to complete the modelling, we have: - evaluated the competence and objectivity of the expert, and the appropriateness of the expert's work; and - reperformed a sample of the expert's work. Where detailed remediation payment calculations have not been completed, we have assessed the reasonableness of the estimate of the liability made. This involved: - obtaining an understanding of the method, data and assumptions used to estimate the liability and assessing the method for

Description of key audit matter	How we addressed this matter
	compliance with the requirements of PBE IPSAS 39, <i>Employee Benefits</i>; • considering the appropriateness and reasonableness of key judgements made and assumptions applied; and • testing the source data used and calculations. We have also assessed whether the Group has adequately addressed estimation uncertainty, including making appropriate disclosures in the financial statements. As a result of the above procedures, we are satisfied the Holidays Act remediation provision in the Group's financial statements is reasonable, supportable, and appropriately disclosed.
Valuation of buildings	
The Group's portfolio of building assets was valued at \$10.883 billion as at 30 June 2025, a valuation increase of \$1.641 billion, as discussed in note 10 to the financial statements on pages 245 to 253. Full valuations were undertaken for most buildings owned by the six largest districts and desktop valuations or indexed movements were used to record valuation changes for all other buildings. These valuations were carried out by independent valuers. 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. The accuracy of the valuations depends on the completeness and accuracy of the underlying asset information, and the appropriateness of the judgements made and assumptions involved in determining the fair value. The key judgements and assumptions for these valuations relate to useful lives and remaining useful lives and replacement costs. We considered the valuation of buildings to be a key audit matter because of the financial significance of the asset balance and the	We have: • obtained an understanding of the controls over the revaluation process; • examined the instructions provided to the valuers and the valuation reports and as required, held discussions with valuers to confirm our understanding of the valuation methods and source data used, key judgements made, and assumptions applied in the valuations; • assessed the expertise of the valuers and other experts for the work and their objectivity; • assessed the valuation methods and disclosures in the financial statements for compliance with the requirements of PBE IPSAS 17, Property, Plant and Equipment; • reviewed the source data for errors and omissions and assessed the reasonableness of key judgements made and assumptions applied, including estimates of useful lives and remaining useful lives and unit rates for replacement costs; • assessed the appropriateness of price indices used and confirmed movements to the indices; • tested the calculations in the valuations and assessed whether the valuation movements

Description of key audit matter	How we addressed this matter
judgements and assumptions involved in determining fair value.	have been correctly calculated and accounted for; - assessed the overall valuation changes and sought explanations from the valuers for any significant or unusual changes in value; and - determined whether impairments and reversals of impairment have been appropriately considered as part of the revaluation process. As a result of the above procedures, we are satisfied the value of building assets held at fair value in the Group's financial statements is reasonable and supportable.

Emphasis of matter – Going concern is dependent on a letter of comfort

Without further modifying our opinion, we draw attention to Note 1 on pages 229 and 230, 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 deficit of \$947 million was incurred for the current year (see page 223), and an operating deficit of \$200 million is forecast for the financial year ending 30 June 2026. The Group's current liabilities also exceed its current assets by \$3.911 billion (see page 225).

The Board therefore obtained a letter of comfort 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 to maintain viability.

Responsibilities of the Board for the Group's annual financial statements and the Group's performance information

The preparation of the financial statements and performance information of the Group is the responsibility of the Board.

The Board is 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. This includes preparing performance information that provides an appropriate and meaningful basis to enable readers to assess what has been achieved for the year.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare Group annual financial statements, a Group statement of performance, and the end-of-year performance information for appropriations that are free from material misstatement, whether due to fraud or error.

In preparing the Group's annual financial statements, the Group statement of performance, and the end-of-year performance information for appropriations, the Board is responsible, on behalf of the

Group, for assessing the Group's ability to continue as a going concern. The Board is 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 Board's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the Group's annual financial statements and the Group's performance information

Our objectives are to obtain reasonable assurance about whether the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out 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 the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations.

For the budget information reported in the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations, our procedures were limited to checking that the information agreed to the Group's statement of performance expectations or to the Estimates and Supplementary Estimates of Appropriations for the Government of New Zealand for the year ending 30 June 2025.

We did not evaluate the security and controls over the electronic publication of the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the Group's financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations, 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 our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We 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.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate whether the Group's statement of performance and the end-of-year performance information for appropriations:
 - provide an appropriate and meaningful basis to enable readers to assess the actual performance of the Group in relation to the forecast performance of the Group (for the statement of performance) and what has been achieved with each appropriation (for the end-of-year performance information for appropriations). We make our evaluation by reference to generally accepted accounting practice in New Zealand; and
 - fairly present the actual performance of the Group and what has been achieved with each appropriation for the financial year.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board 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 we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the information we audited or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations, including the disclosures, and whether the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations represent the underlying transactions and events in a manner that achieves fair presentation.
- We plan and perform the group audit to obtain sufficient appropriate audit evidence regarding the financial information, the service performance information, and the end-of-year performance information for appropriations of the entities or business units within the group as a basis for forming an opinion on the group annual financial statements, the group statement of performance and the end-of-year performance information for appropriations. We are responsible for the direction, supervision and review of the audit work performed for the purposes of the group audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises all of the information included in the annual report, but does not include the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations, and our auditor's report thereon.

Our opinion on the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the Group's annual financial statements, the Group's statement of performance, and the end-of-year performance information for appropriations or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. As described in the *Basis for our opinion* section above, we could not obtain sufficient evidence to confirm the performance information relating to the timeliness of access to primary mental health and addiction services. Accordingly, we are unable to conclude whether or not the other information that includes related information is materially misstated with respect to this matter.

Independence

We are independent of the Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners (including International Independence Standards) (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board.

We use publicly funded health services on the same basis as others. This has not impaired our independence.

In addition to the audit of the annual financial statements and performance information of the Group, we have carried out audits of the New Zealand Health Plan for 1 July 2025 to 30 June 2027 and the annual performance reports against the interim New Zealand Health Plan for 2022/23 and 2023/24 combined, which are compatible with those independence requirements. Other than the audits, we have no relationship with, or interests in, the Group.



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

Appendices

Appendix 1: Glossary

Term	Definition	Term	Definition
ACC	Accident Compensation Corporation	IMPB	Iwi Māori Partnership Board
AI	Artificial Intelligence	IPMHA	Integrated primary mental health and addiction services
AIR	Aotearoa Immunisation Register	IPSAS	International Public Sector Accounting Standard
ARC	Aged Residential Care	MBIE	Ministry of Business, Innovation & Employment
ASH	Ambulatory sensitive (avoidable) hospital admissions	MECA	Multi-Employer Collective Agreement
CNGP	Carbon Neutral Government Programme	MHA	Māori Health Authority
CT	Computerised Tomography	MH&A	Mental health and addictions
DHB	District Health Board (no longer in operation)	MRI	Magnetic Resonance Imaging
DMFT	Decayed Missing Filled Teeth	N/A	Not available
DRS	Diabetic retinal screening	NAMS	National Asset Management Strategy
ED	Emergency Department	NBSP	National Bowel Screening Programme
FASD	Fetal Alcohol Spectrum Disorder	NCSP	National Cervical Screening Programme
FIT	Faecal immunochemical test	NGO	Non-government organisation
FSA	First specialist assessment	NHI	National Health Index
FTE	Full Time Equivalent	NPHS	National Public Health Service
FY	Financial year	NZQA	New Zealand Qualifications Authority
GP	General Practice	PBE	Public Benefit Entity
GPS	Government Policy Statement on Health	PPE	Personal Protective Equipment
HCE	Health Capital Envelope	PPHNI	Patient Profile National Health Index
HDP	Health Delivery Plan	QSM	Quality and Safety Marker
HNZ / Health NZ	Health New Zealand	SBIP	School based immunisation programme
HPV	Human papilloma viruses	SNOMED	Systematised Nomenclature of Medicine
ICAMHS	Infant, child, and adolescent mental health services	SPE	Statement of Performance Expectations
ICU	Intensive Care Unit		

Term	Definition
SSSED	Shorter stays in Emergency Departments
SSP	Statement of Service Performance
STEM	Science, Technology, Engineering, and Mathematics
WBI	Wellbeing Index

Te reo Māori

Term	Description
hauora	health and wellbeing
iwi	extended kinship group, tribe, nation
Kahu Taurima	The name 'kahu taurima' has many connections to maternity and early years. 'Kahu' speaks to the korowai (cloak) of services and support that wraps around whānau as well as an alignment with He Korowai Oranga: Māori Health Strategy. 'Taurima' means caring, nurturing, and fostering our most cherished pēpi, tamariki and whānau
kaiāwhina	helper, assistant, contributor, counsel, advocate
kaumātua	Māori elder
kaupapa	topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative
kōrero	conversation, discussion or meeting
mahinga kai	traditional food and resources
mana	spiritual power, authority, influence
mana motuhake	separate identity, autonomy, independence
manaaki	to support and take care of

Term	Description
mātauranga	knowledge, wisdom
mauri ora	healthy individuals
mirimiri	traditional healing and massage practice
motu	country
Oranga Hinengaro	mental wellbeing
pēpi	baby, infant
rangatahi	youth, younger generation
rongoā	holistic healing
taiao-based	Interconnectedness of the environment with human wellbeing
takiwātanga	autism
tamariki	children
tāngata turi	people with deafness
tāngata whaikaha	people with disabilities
tauirā	student
Te Ao Māori	Māori world view
tikanga	customs and traditional values
wai ora	healthy environments
wānanga	seminar, conference, forum
whakapapa	a line of descent from one's ancestors
whānau	extended family, family group
whānau ora	healthy families

Appendix 2: Performance measures unable to be reported

Output class 2: Primary and Community Care Services

Ref	Measure	Target per SPE / Vote	2023/24 Result	2024/25 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%	Unable to report	Unable to report	N/A
Baseline: Māori 49%, Pacific 18%, non-Māori, non-Pacific 33% The status against target is 'unable to report' for 2024/25. 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. We will likely review this measure as part of the 2025/26 Supplementary Estimates process.					
P2-33a	Increase in percentage of pregnant women who register with a Primary Maternity Carer in the first trimester of their pregnancy of all registrations	Increase from baseline	New Measure	Unable to report	N/A
Baseline: 76.40% The status against target is 'unable to report' for 2024/25. Data is only available for 5 districts in New Zealand and more work will be required to address this which is underway. Please refer to P2-33b Increase in percentage of pregnant women who register with a Lead Maternity Carer in the first trimester of their pregnancy of all registrations.					

Output class 5: Hauora Māori services

Ref	Measure	Target per SPE / Vote	2023/24 Result	2024/25 Result	Status
P2-60	Increase in expenditure by kaupapa Māori primary, community, public and population health service providers, compared with the average of the last five financial years	Achieved	Unable to report	Unable to report	N/A
Given that Health New Zealand has been in existence for only 3 years, and this is the first year following the transition of Te Aka Whai Ora into the entity, we are unable to calculate this measure as described. This measure was removed in the Estimates 2025/26 and this is reflected in the SPE 2025/26.					

Appendix 3: Measures included in the 23/24 annual report and removed during the year

The following measures were previously reported by Health NZ in last year's annual report but they have been removed from reporting this year via changes to our SOI and SPE or Vote Health measures. These changes have been made to:

- better align to our organisational priorities such as ensuring timely, quality health services, strengthening equity and workforce, modernising infrastructure, and ensuring stronger accountability,
- replace measures with more appropriate measures of performance with better data quality e.g. replacing P2-08 Positive FIT Bowel Screening tests with Screening rates,
- reflect the cessation of some appropriations, e.g. National Response to Covid-19.

The following measures were discontinued through the Vote Health Estimates 2024/25

ID	Performance Measure
P2-10	Providers are enabled to deliver COVID-19 vaccinations in line with national guidance, operations policies, and service standards
P2-11	COVID-19 MCA: Number of approved COVID-19 vaccines administered to individuals in line with the policy setting (see Note 2)
P2-12	COVID-19 MCA: Number of COVID-19 vaccine doses purchased by Te Pātaka Whaioranga - Pharmac and received by Te Whatu Ora - Health New Zealand in central storage facilities
P2-26	Increase in expenditure by kaupapa Māori hospital and specialist service providers, compared with the average of the last five financial years
P2-29	Increase in rongoā consultations for rongoā Māori clients provided in terms of both total volumes and spread across the country
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,
P2-31	Decrease in proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area, compared with the 12 months to 30 June 2019
P2-34	Expenditure is consistent with budget for the appropriation against key line items and overall
P2-35	Proportion of total expenditure directed to mental health and addiction meets agreed level
P2-52	Percentage of patients prioritised using approved national recognised processes or tools
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
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
P2-59	Decrease in the rate of diabetes complications for Māori, Pacific, Asian and other people

ID	Performance Measure
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, as compared with 12 months prior to 30 June 2022
P2-63	Increase in proportion of Māori and other under-represented groups in the unregulated health workforce employed by Health New Zealand compared with the proportion of the total population, in the 12 months prior to 30 June 2022
P2-64	Increase in proportion of Māori and Pacific people in leadership and governance roles in Te Whatu Ora - Health New Zealand, compared with 2022/23
P2-66	Proportion of total expenditure directed to mental health and addiction meets agreed level
P2-81	Deliver a national asset management strategy and capital investment strategy and investment plan by 31 December 2023.
P2-86	Health New Zealand Te Whatu Ora provides an annual update to the Ministers of Health and Finance on the improvement programme's enhancement of the asset and investment management framework
P2-89	Maintain an average of 12-week stock in Health NZ's National Protective Equipment (PPE) and Critical Medical Supply Chain
P2-92	Establish a national portal to facilitate the identification and remediation of former Te Whatu Ora - Health New Zealand and New Zealand Blood and Organ Service employees, and commence the remediation payments process for former employees by 31 December 2023
P2-128	Maintain Public Health contact tracing and case management capacity through scalable telehealth services and digital pathways in line with response/pandemic requirements
P2-139	Te Whatu Ora - Health New Zealand makes progress towards establishing itself and operating with appropriate infrastructure

The following measures were discontinued through the Statement of Intent 2022-2024 which incorporates the 2022-23 Statement of Performance Expectations

ID	Performance Measure
P2-01	Establish a nationally integrated public health service with consistent operating models
P2-02	Continue COVID-19 response and integrate into business as usual
P2-06	Percentage spend of Health NZ's total budget on public health
P2-13	Localities are established
P2-14	Provider networks are established
P2-15	Percentage of children enrolled with an oral health service
P2-24	Improve digital access to primary and mental healthcare to improve access and choice including virtual after-hours and telehealth with a focus on rural communities
P2-47	Number of mental health bed nights
P2-48	Colonoscopies per 100,000 people

ID	Performance Measure
P2-49	First specialist assessments per 100,000
P2-50	Percentage spend of Health NZ's total budget on mental health
P2-65	Percentage spend of Health NZ's total budget on specialist and hospital services
P2-68	People served by specialist MH&A services per 100,000 people (both Te Whatu Ora and NGO delivered specialist services)
P2-70	Number of people accessing integrated primary mental health and addiction services per 100,000 people
P2-71	Total number of mental health contacts
P2-72	People served by specialist and NGO mental health services per 100,000 people
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
P2-77	Deliver the approved digital capital projects in line with Business Cases
P2-78	Develop and implement a national plan to create consistency in data and digital capability across Te Whatu Ora.
P2-82	Deliver the information solution strategy, requirements and road map for procurement and supply chain
P2-83	Establish the centre-led, nationally, regionally, and locally delivered procurement and supply function building on the existing operations

The following measures were discontinued through the Vote Health Estimates 2023/24:

ID	Performance Measure
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 (95% target)
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
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
P2-142	Budgeted to fully spend the \$1.208 billion received from the Capital Appropriation in 2023/24

Appendix 4: 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) – Air travel international	25,350
Scope 1 – Biofuel (fossil fuel emissions and N ₂ O and CH ₄ component for the biofuel portion)	-	Scope 3 (mandatory) – Business travel other (eg. taxi, hotel, rental cars)	2,570
Scope 1 – Biomass (fossil fuel emissions and N ₂ O and CH ₄ component for the biofuel portion)	10	Scope 3 (mandatory) – Freight	-
Scope 1 – Forestry – harvest/deforestation	-	Scope 3 (mandatory) – Staff working from home	-
Scope 1 – Refrigerants, medical and other gases	15,682	Scope 3 (mandatory) – Transmission and distributions losses (electricity)	1,810
Scope 1 – Other	-	Scope 3 (mandatory) – Transmission and distributions losses (natural gas)	1,821
Scope 1 – Stationary combustion – coal	7,718	Scope 3 (mandatory) – Waste (to landfill)	6,368
Scope 1 – Stationary combustion – natural gas and LPG	49,684	Scope 3 (mandatory) – Wastewater	2,712
Scope 1 – Stationary combustion – other (e.g. diesel)	1,497	Scope 3 (mandatory) – Water	210
Scope 1 – Transport fuels – aviation	-	Scope 3 (other material) – Emissions from purchased goods and services	15,347
Scope 1 – Transport fuels – other (e.g. shipping fuel)	-	Scope 3 (other material) – Emissions from purchased capital goods	-
Scope 1 – Transport fuels – vehicle fleet	8,493	Scope 3 (other material) – Other (e.g. staff commuting, investments, leased assets)	8,655
Scope 2 – Electricity	26,425	Scope 1 Biogenic emissions – Biofuel CO ₂ component (considered carbon neutral)	-
Scope 2 – Other (e.g. purchased steam)	586	Scope 1 Biogenic emissions – Biomass CO ₂ component (considered carbon neutral)	27,942
Scope 3 (mandatory) – Air travel domestic	30,329	Removals – Forest growth removals	-

