

# Reforming Health New Zealand: confronting crisis, sustaining recovery

Lester Levy, formerly Commissioner and currently Chair of Health New Zealand

## A health system under strain

By the early 2020s, New Zealand's public health system faced deep-seated and widely acknowledged problems. Long before the COVID-19 pandemic, performance on key indicators—from emergency department waits to access to elective surgery—had been declining. These trends reflected structural fragmentation, variable local governance, outdated infrastructure and the absence of a coherent national delivery model.

The 2022 health reforms sought to address these failings by replacing 20 district health boards (DHBs) with a single entity: Health New Zealand – Te Whatu Ora. The ambition was to design a nationally planned, regionally supported and locally delivered system that could reduce unwarranted variation, improve equity and make better use of resources. Eight shared service agencies and key Ministry of Health functions were also integrated into the new organisation. The theoretical advantages were clear: single-point accountability, integrated financial management, economies of scale and the ability to coordinate care across the entire population.

Yet, as is often the case with health reform, the gap between structural change and improved outcomes proved difficult to bridge. The first 2 years of Health New Zealand were marked by deteriorating financial control, widening performance gaps and an erosion of local clinical governance. Centralisation, rather than delivering streamlined decision making, weakened links to frontline knowledge and accountability.

By mid-2024, the organisation was facing a cash crisis, growing deficits and mounting political and public concern that the reforms were failing to deliver. The Government responded by taking its strongest governance intervention—replacing the board with a commissioner.

## The commissioner's mandate

The commissioner's appointment in July 2024

acknowledged that incremental course corrections would not suffice. The remit was explicit: arrest the financial decline, stabilise service performance and lay the groundwork for a sustainable turnaround.

Functionally, a commissioner has the powers of a board but operates more like an executive chair, enabling rapid interaction with the chief executive and senior management. Three deputy commissioners were appointed with focussed remits: financial control, clinical engagement and workplace safety. This structure compressed decision-making timelines and enabled sharper, faster responses.

## Diagnosing the causes of underperformance

Independent reviews commissioned during this period provided a clear, if sobering, diagnosis.

Financial deterioration was attributed to multiple factors:

- Loss of district-level financial oversight after centralisation
- Weaknesses in budgeting and savings plans
- Ineffective financial reporting systems and information flows
- Organisational restructuring that reduced institutional capability
- Delayed responses to issues and emerging risks

This was not simply an accounting failure—it was a loss of control over the levers that determine financial sustainability.

On quality and safety, New Zealand's performance was broadly in line with comparable countries, but long waits for assessment and treatment emerged as the largest source of preventable harm. The patients in greatest jeopardy were those waiting in emergency departments, for first specialist assessments, for diagnostics and for elective surgery.

The review of workplace safety found progress in managing risks but noted that responses were

often reactive rather than preventive, limiting consistency and resilience.

Tellingly, a review of innovation concluded that while world-class healthcare innovators existed within New Zealand, the system lacked the mechanisms to scale their work or to adopt proven global solutions.

## Turning the corner

Over the following 12 months, the commissioners adopted a markedly different governance rhythm. Seventy-three formal commissioner meetings were held in a year—compared with the 11 or 12 typical of a board. This intensity allowed faster governance decisions, enabling the executive to move with urgency.

**Financial recovery** was a central achievement. Between July 2024 and May 2025, the monthly deficit fell by 85%, and by the end of the financial year the organisation was within budget. The projected depletion of cash reserves within 12 months was averted, with the year-end balance at NZ\$1.054 billion. The organisation is now on a credible path to break even by 2026/2027.

**Service performance** also began to improve. Emergency department length of stay metrics reached their best levels in almost 3 years despite a 4% rise in attendances. Cancer treatment timeliness improved to 90% within 31 days, the first time this had been achieved since 2021. Childhood immunisation at 24 months reached 82%—the highest since Health New Zealand's inception.

Waiting lists, which had reached record highs in early 2025, were reduced by over 8,000 patients each for elective surgery and first specialist assessments. The number of patients waiting longer than 4 months for treatment fell by 15.5%, and those waiting for a first specialist appointment by 26.4%.

An internally funded elective surgery boost between February and June 2025 delivered an additional 10,579 cases through partnerships with private providers. This was accompanied by investment in primary care—notably an enhanced capitation initiative and government-funded programmes to strengthen urgent care, 24/7 digital access and workforce development.

**Productivity trends** showed encouraging signs. The long-run decline in hospital productivity, evident since at least 2012, was arrested, with May 2025 recording the highest levels since 2021.

## Why the early reforms faltered

The structural weaknesses that undermined Health New Zealand's first 2 years hold important lessons for health reform globally. Centralisation removed layers of local governance without replacing them with effective regional or clinical leadership structures. In doing so, it severed feedback loops between those delivering care and those setting priorities.

Clinical governance was diluted, and decision making became slower and less aligned with patient needs. National enabling services—finance, IT, workforce planning—became disconnected from the realities of local service delivery. Without robust systems, financial and operational oversight degraded, and pre-existing weaknesses in infrastructure and models of care persisted.

These missteps reflect a broader truth: consolidating governance structures is not the same as integrating care delivery. Structural reform must be accompanied by robust mechanisms for local accountability, clinical engagement and transparent performance monitoring.

## The road ahead: sustaining the gains

The commissioner's 2-year turnaround plan is only half complete. The next 12 months must consolidate financial control, deepen performance improvements and—crucially—move towards the model that was envisaged in 2022 but never realised.

**Devolution** is central to this vision. Decision-making authority and budgets should move progressively from the national centre to regional, district and unit levels, enabling services to respond to local needs while remaining aligned with national priorities. With devolved authority must come clear accountability for outcomes, supported by governance frameworks that allow regions and districts to influence national policy.

**Clinical leadership and engagement** will be equally important. This means embedding clinicians at every level of governance, strengthening clinical networks, aligning service planning with frontline expertise and fostering a culture where quality and safety are paramount. The clinical senate and an expanded clinical innovation network can help ensure that decision making is informed by both best evidence and local context.

**Culture change** will underpin all else. Leadership can set direction and allocate resources, but sustainable improvement depends on the day-to-day decisions of clinicians, managers and support staff. Every operational choice—from workforce planning to service redesign—must be viewed through the lens of patient benefit.

## Lessons for health system reform

Health New Zealand's experience underscores several broader principles relevant to health systems worldwide:

- 1. Structural reform is a means, not an end.** Organisational mergers do not automatically produce integration, efficiency or improved outcomes. Without parallel investment in governance capability, clinical engagement and system intelligence, centralisation can impair performance.
- 2. Financial stability is a prerequisite for reform.** Service innovation and performance improvement are difficult to sustain in the context of fiscal crisis. Restoring financial discipline provides the platform for longer-term change.

- 3. Local accountability matters.** National bodies must remain connected to frontline realities. Devolution, when paired with robust oversight, can align national goals with local responsiveness.
- 4. Culture drives performance.** Systems that engage clinicians as partners, value innovation and align decision making with patient benefit are more likely to achieve lasting improvement.

## Cautious optimism

Health New Zealand has moved from crisis to stability, but it is not yet a high-performing health system. The gains of the past year—in financial control, service access and operational efficiency—are still fresh. The test for the coming year will be to embed these improvements while advancing towards a devolved, clinically led model.

With an experienced clinician as chief executive, strong clinical representation on the board and a workforce committed to patient care, the potential is real. The challenge is to maintain discipline, avoid distraction and deliver a system that is nationally coordinated, locally responsive and unrelentingly focussed on patient benefit.

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**COMPETING INTERESTS**

LL reports the following roles:

Chair, Health New Zealand 24 July 2025 to present.

Commissioner, Health New Zealand 24 July 2024 to 23 July 2025.

Chair, Health New Zealand 1 June 2024 to 23 July 2024.

Chair, Health Research Council 1 January 2016 to present.

Crown Monitor, Canterbury District Health Board 2019 to 2022.

Ministerial Advisory Group Member 2017 to 2019.

Chair, Waitematā District Health Board 2009 to 2018.

Chair, Auckland District Health Board 2010 to 2018.

Chair, Counties Manukau District Health Board 2016 to 2018.

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