



Heart health, for this generation and the next

Development of a national
heart health action plan

Heart Foundation White Paper
July 2026







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A renewed call for a national heart health action plan

Heart disease remains the single leading cause of death in Aotearoa New Zealand and progress towards reducing it has stalled. Recovering progress requires a coordinated national strategy for cardiovascular diseases that affect the heart and circulation.

Over the past 50 years, rates of cardiovascular deaths have declined substantially, reflecting improved prevention, treatment and acute care. However, recent declines have slowed from 2% per year in the early 2000s to less than 1% by 2020. There are signs rates may be increasing again.^{i,ii}

Declining smoking rates are being offset by other risks. Dietary risks and obesity now contribute more to cardiovascular burden than smoking. New drug treatments expand the opportunities for obesity treatment, and strengthening the prevention system is vital to reduce the future impact on New Zealanders.ⁱⁱⁱ

Despite major advances in treatment, unequal access and a strained health workforce are hindering progress. Hypertension (high blood pressure) remains underdiagnosed and undertreated, new treatments such as weight-loss drugs are slow to reach New Zealanders, and barriers to healthcare still prevent those at highest risk from seeking treatment until it's too late.

Stalled progress is not equal; gains for Māori and Pacific Peoples have been markedly slower. Inequities in heart health outcomes have widened over the past 10 to 15 years, with little to no improvement in avoidable mortality.^{iv} Māori and Pacific Peoples are still receiving suboptimal rates of diagnosis and care and experience persistently lower access to effective medication.^v

Health system reforms and changes in leadership have further impacted progress, contributing to poor continuity and a lack of sustained action.

Assuming current trends and population growth, the number of cardiovascular deaths is likely to increase by more than 25% from around 10,000 a year in the early 2020s to over 13,000 by 2040. For Māori and Pacific Peoples, it is likely to increase by more than 70%, from 1,260 to around 2,200 for Māori, and from 520 to more than 900 for Pacific Peoples.*

We can reverse the lack of recent progress, but it requires focus and accountability for better outcomes.

This can be achieved if New Zealand acts urgently to establish a national plan that sets a clear vision for cardiovascular health and prioritises and delivers evidence-based action. Our white paper sets out why this is more urgent than ever, and the immediate and sustainable action to secure the future heart health of all New Zealanders.

The number of cardiovascular deaths by 2040

+25% for all
New Zealanders

+70%
for Māori and
Pacific Peoples

* Trends estimated using methodology in appendix 2.

Summary of priorities

This 2026 white paper proposes seven high-level priority areas. All are necessary, and we propose them in order of impact, from those that will see immediate benefits to those required for sustainable long-term gains.

Change the current trajectory

1. Early detection and management of cardiovascular risk

Systematic risk assessment for cardiovascular disease, combined with proactive management of risk, in particular hypertension.

2. Timely and equitable access to care and treatment

Improving access to timely, evidence-based treatment – including existing and emerging medicines and specialist services regardless of where people live.

3. A focus on obesity as a leading contributor to cardiovascular disease

Recognising obesity as a chronic, complex disease that needs a consistent clinical approach to assessment, diagnosis, treatment and care.

4. Increase survival for out-of-hospital cardiac arrest

Targeted improvements in community response including CPR and defibrillation.

Sustain mid- to long-term gains and reduce future burden

5. Build a strong and sustainable prevention system

A strong prevention system is essential to reduce future cardiovascular disease. This includes improving access to healthy food, increasing physical activity, and sustaining low smoking rates.

6. Grow and sustain a world-class health workforce and strengthen the research-to-practice pipeline

Turn research into practice and deliver timely, world-class care by strengthening workforce capacity, improving representation and access, and ensuring sustainability over the long-term.

Ensure oversight and accountability, and measure success

7. Establish national oversight and accountability for heart health

A national oversight group must assume accountability for a clear vision and road map to deliver better outcomes for heart health. Oversight should operate independently of politics to provide continuity and long-term sustainable action for years to come.

The burden of cardiovascular disease on New Zealand

Including hypertension, almost one million New Zealanders live with cardiovascular disease every day.^{vi}

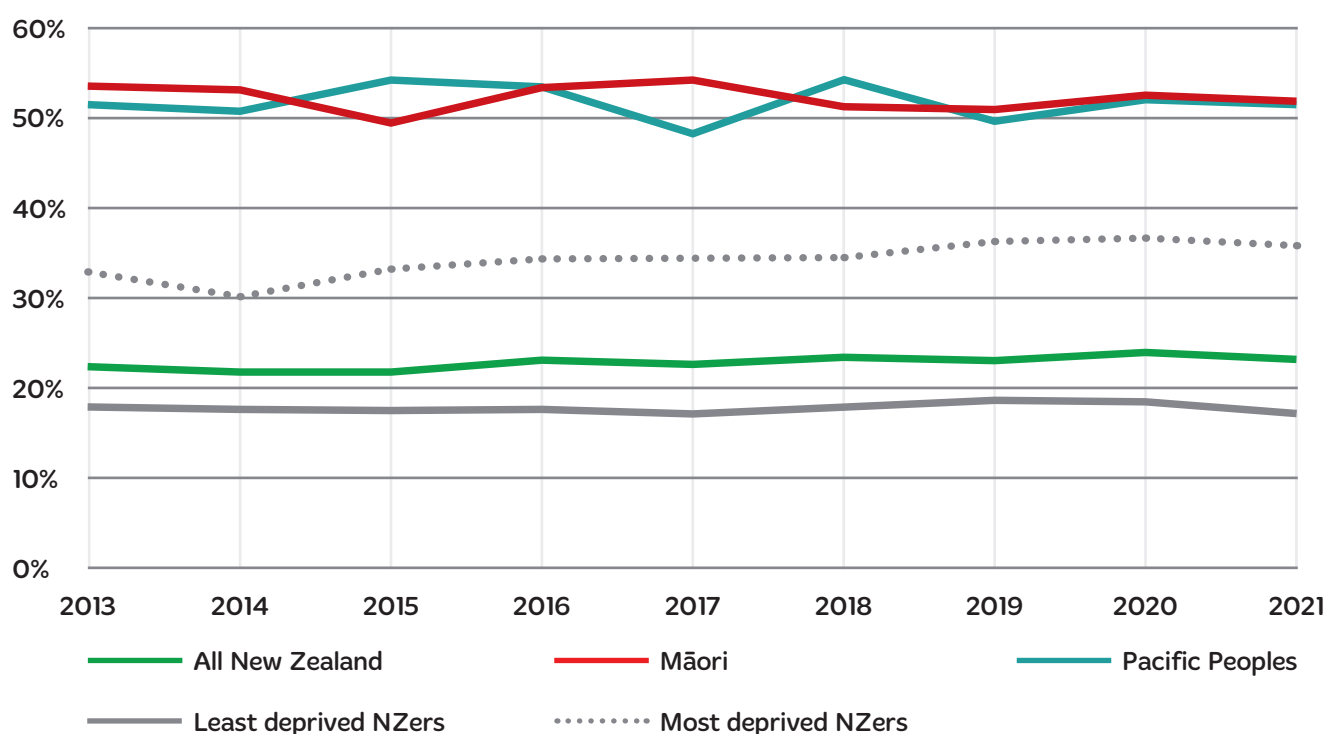
Each year around 10,000 New Zealanders lose their lives to cardiovascular diseases, accounting for three in 10 deaths. Heart disease remains the single biggest killer of New Zealanders.ⁱ

Approximately one-quarter of deaths from cardiovascular disease each year in New

Zealand are avoidable. This means they are premature (under age 75) and preventable or treatable. For Māori and Pacific Peoples, around half of cardiovascular deaths are avoidable, and for those living in the most deprived communities, approximately one in three are avoidable.^{vii}

These patterns have remained largely unchanged for over a decade, indicating a persistent failure to deliver prevention and treatment equitably.

Percentage of cardiovascular deaths that are avoidable 2013-2021

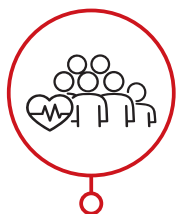


Cardiovascular disease drives the life expectancy gap

The impact of these inequities is profound. Avoidable cardiovascular disease is the single largest contributor to the life expectancy gap between Māori and non-Māori, accounting for

almost a quarter of the six years' difference in life expectancy.^{viii} This exceeds the contribution of cancer, diabetes, suicide and road traffic injuries combined.

Cardiovascular disease in New Zealand



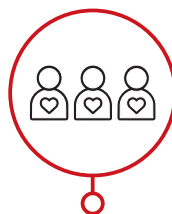
1 million

New Zealanders
living with CVD



10,000

deaths each year



3 in 10

of all deaths are
from CVD



Heart disease

remains NZ's single
leading cause of death

Each year CVD results in



\$3.3 billion

in cost to health system



\$720 million

in lost income
(3 x economic burden
associated with cancer)



1 in 6

hospital bed days
(more than cancer and
respiratory disease combined)

The cost of living with cardiovascular disease

In New Zealand, heart disease and stroke account for almost 15% of health lost to disability. This has a profound impact on the economic and social wellbeing of families and communities.

People living with cardiovascular disease represent an estimated \$720 million in lost income each year for New Zealanders, approximately three times the economic burden associated with cancer.^{ix}

This burden falls disproportionately on Māori and Pacific Peoples, and those on lower incomes. Almost half of Māori and Pacific deaths from heart disease are premature (before the age of 75), with a far greater proportion of the disability and deaths among people who are still working age and have dependent families.

The cost to the health system

The approximate cost of heart disease and stroke to the health system is over \$3.3 billion a year.^x One in six hospital bed days are taken

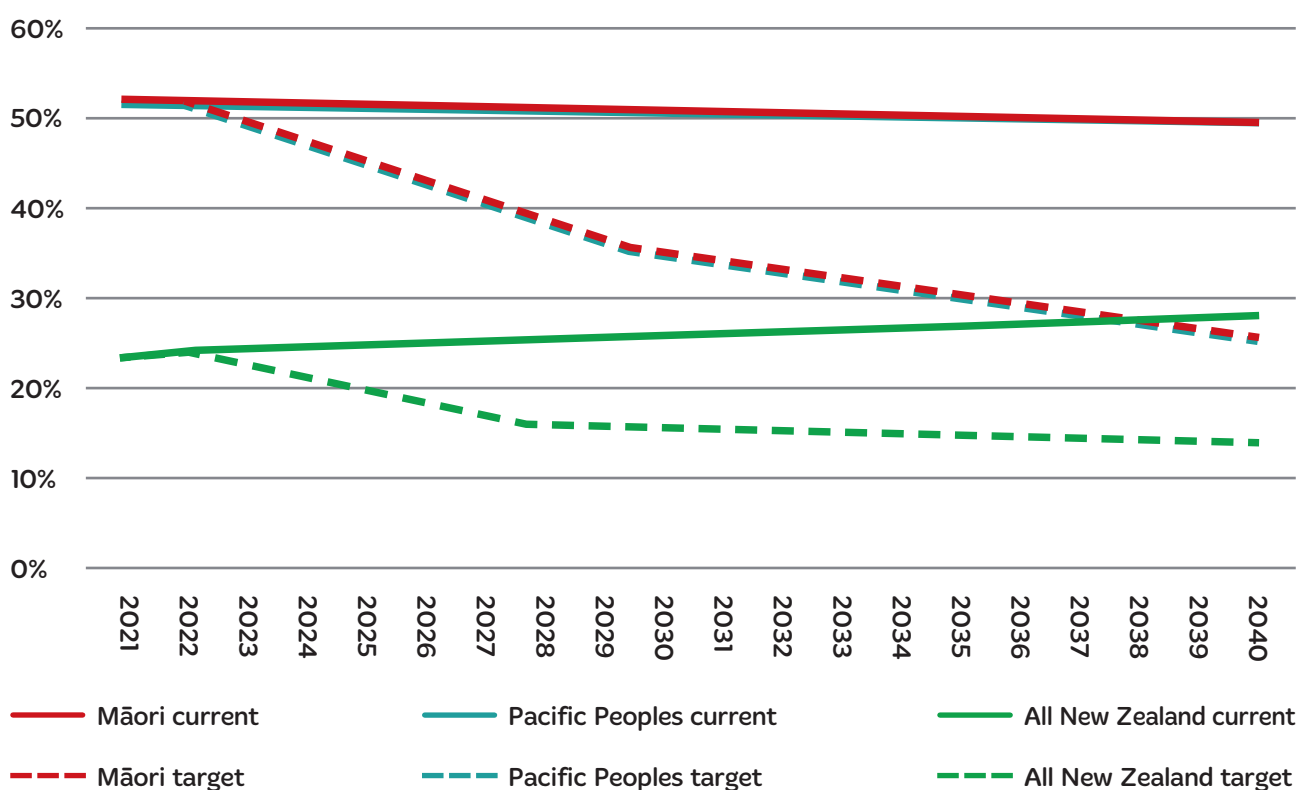
up by heart disease and stroke, more than cancer and respiratory disease combined.^{xi}

A goal to prevent 20,000 avoidable deaths by 2040

We propose targets to:

- reduce avoidable cardiovascular deaths for all New Zealanders by 30% by 2035 and 40% by 2040
- reduce avoidable cardiovascular deaths for Māori and Pacific Peoples by 40% by 2035 and 50% by 2040

Projected % of CVD deaths that are avoidable (current — vs target - -)



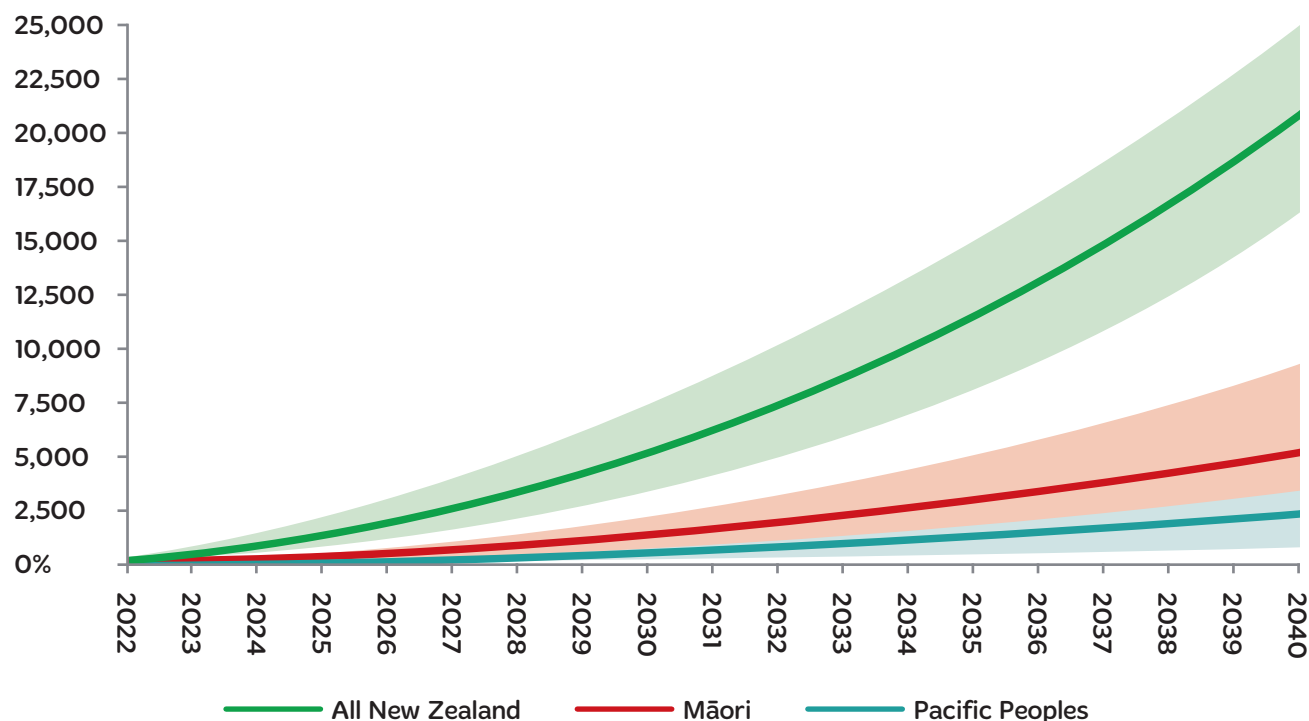
Proposed targets are informed by international evidence demonstrating that large reductions in avoidable cardiovascular mortality can be achieved through combinations of hypertension control; improved access to healthcare, treatment and prevention; and strengthened emergency response systems.

Achieving the proposed targets could prevent the premature loss (before age 75) of around 20,000 lives by 2040 compared with current trends.

This estimate only includes avoidable deaths before age 75, with large additional benefits likely among older age groups through improved treatment and prevention.

This represents one of the most significant opportunities to improve population health outcomes in Aotearoa New Zealand, particularly for Māori and Pacific Peoples, who experience a disproportionate share of avoidable mortality.

20,000 premature deaths averted by 2040



These gains are achievable. Evidence suggests that a relatively small number of well-targeted interventions can have a large and rapid impact on reducing avoidable deaths from cardiovascular disease, particularly when delivered at scale and equitably.

Realising this opportunity requires coordinated action across the full continuum

of cardiovascular health – from prevention and early detection, through to timely treatment and emergency response. We propose actions in order of impact, starting with those that can shift the trajectory of cardiovascular outcomes in the short term, supported by a system that sustains those gains in the long term.

Goals and actions to achieve priorities



Change the current trajectory

Priority 1: Early detection and management of cardiovascular risk

Improving the detection and management of risk is the most immediate way to reduce cardiovascular mortality over the next decade.

Hypertension is the leading modifiable risk factor for heart disease and stroke, contributing to an estimated 45% of cardiovascular deaths in New Zealand.^{iii,xii}

Improving detection and control of high blood pressure represents the single largest opportunity to reduce avoidable mortality in the near term. Controlling hypertension is one of the most cost-effective and immediate interventions to prevent cardiovascular disease.^x

However, almost a third of New Zealanders with high blood pressure remain undiagnosed, and two-thirds remain untreated and inadequately controlled. We lag well behind comparable health systems in other countries, including Canada, where 64% are controlled, double the New Zealand rate.^{xii}

Goal 1: Increase hypertension control to 50% by 2035

Recent estimates indicate that approximately 69% of New Zealanders with hypertension

have been diagnosed, and of those, only 32% have their blood pressure effectively controlled. Increasing control to 50% by 2035 could avert more than 12,000 deaths by 2040.^{xii}

Goal 2: Ensure systematic cardiovascular risk assessment and management

Approximately 500,000 New Zealanders are due for a cardiovascular disease risk assessment (CVDRA) each year, with an additional 75,000 becoming newly eligible annually. A systematic approach is required to identify, assess and manage high-risk individuals early.

Why this matters

Improving targeted detection and management of cardiovascular risks prevents the progression to chronic disease, reduces heart attacks, strokes and renal failure, and can significantly reduce heart health inequities.

Key actions

- Prioritise and mandate a Hypertension Taskforce to rapidly increase awareness, earlier detection, and more effective treatment and sustained control of elevated blood pressure, especially for highest risk populations.
- Ensure systematic cardiovascular disease risk assessment and management for eligible populations, similar to other national screening programmes.

Expected impact

Improving cardiovascular risk detection and management, especially hypertension control, is expected to deliver the largest and most immediate share of the projected reduction in avoidable deaths by 2040.

Priority 2: Timely and equitable access to care and treatment

Delays in accessing care remain a major contributor to avoidable morbidity and mortality.

Improving access to timely, evidence-based care is critical to reducing avoidable cardiovascular deaths. There are many barriers to care including financial and physical, not knowing when to seek help, and the availability of health services.

Māori and Pacific patients are more likely to present later in the disease pathway and experience worse outcomes, reflecting barriers to early diagnosis, specialist care and ongoing management.

New treatments are often slow to reach New Zealanders or receive regulatory approval and funding. For example, approval of SGLT2 inhibitor drugs for heart failure in New Zealand came more than four years after the European Union and the USA.

Cardiometabolic drugs (GLP-1 receptor agonists often referred to as “weight-loss drugs”) have proven benefits beyond reducing weight. ^{xiii} They are now considered important medicines for preventing cardiovascular events and wider access is likely to improve outcomes for many New Zealanders.

Use of cardiovascular disease medications for secondary prevention remains inconsistent leaving many people undertreated. As of December 2025, only 44% of eligible patients were receiving optimal therapy for cardiovascular disease after a heart attack, with significantly lower rates observed among Māori, women, higher deprivation and younger patients. ^{xiv}

Goal 3: Reduce delays in access to specialist cardiology care

Timely access to specialist assessment and treatment is essential for preventing the progression of heart disease and avoiding acute events. Since 2020, the proportion of patients waiting more than four months for a cardiology appointment has increased substantially, rising from around 10% to approximately 25% in 2025. ^{xv}

“Since 2020, the proportion of patients waiting more than four months for a cardiology appointment has increased substantially, rising from around 10% to approximately 25% in 2025.”

Goal 4: Expedite access to evidence-based treatment

Timely authorisation and funding for medicines which prevent cardiovascular disease complications will impact the lives of many New Zealanders. Medsafe and Pharmac processes should expedite decision-making and access for cost-effective efficacious treatments. These should include:

- fixed-dose combination preparations for hypertension management
- PCSK9 Inhibitors for dyslipidaemia management
- SGLT2 inhibitors for heart failure with preserved ejection fraction
- obesity management medications where adequate weight reduction cannot be achieved by behaviour changes alone.

Funded access to these treatments is available across many comparable OECD countries, and New Zealanders often face delayed access.

Goal 5: Urgently address undertreatment for secondary prevention

All eligible patients who have had a cardiovascular event should be systematically offered and supported to remain on guideline-directed secondary prevention therapy.

Why this matters

Improving awareness of and access to timely care and treatment will reduce avoidable hospitalisations and more serious complications for thousands of patients. For those with heart disease, it will improve survival and quality of life.

Key actions

- Expand community-based services to improve access for high-need populations.
- Provide sustained and systematic population-level campaigns and community education on when to access heart healthcare.
- Strengthen primary and secondary care integration to support earlier intervention, and systematic provision of best practice treatment options.
- Ensure the medicines approval and funding system keeps up with evidence-based treatments for cardiovascular disease.
- Support access to evidence-based pharmacotherapy as indicated for cardiovascular health.

Expected impact

Increased and more equitable uptake of evidence-based care and treatments will reduce avoidable hospitalisations and premature deaths, improve quality of life, and narrow persistent inequities in heart health outcomes for Māori and other underserved populations.

Priority 3: Focus on obesity as a leading contributor to cardiovascular disease

Obesity is a major and growing contributor to cardiovascular disease in New Zealand and should be recognised as a core cardiovascular health priority.

New Zealand has the third-highest obesity rate in the OECD, with more than one-third of adults classified as obese. The burden is not equally distributed, with substantially higher prevalence among Māori and Pacific Peoples and people living in the most deprived neighbourhoods. ^{vii}

While New Zealand has clinical guidance relating to diabetes, cardiovascular risk, and weight management, there is currently no comprehensive national obesity and cardiovascular guidance integrating prevention, chronic disease management, pharmacotherapy and equity-focused care.

Obesity is a chronic, complex disease requiring long-term management rather than short-term weight-loss interventions alone. Effective management includes early identification, comprehensive behavioural and lifestyle support, and when appropriate, access to evidence-based pharmacological and surgical treatment options.

When appropriate, pharmacological, surgical or other therapeutic options can support effective disease management. Care should also address the prevention and treatment of obesity-related complications and comorbidities.

Recent advances in obesity treatment, particularly incretin-based therapies such as GLP-1 receptor agonists and dual GIP/GLP-1 receptor agonists (also referred to as “weight-loss drugs”), have significantly changed the treatment landscape. They are now considered important medicines for preventing heart attacks and wider access is likely to improve cardiovascular outcomes for many New Zealanders. These medicines can achieve clinically meaningful weight loss while also improving glycaemic control and cardiometabolic risk factors. ^{xvi}

“Recent advances in obesity treatment, particularly incretin-based therapies, also referred to as “weight-loss drugs”, have significantly changed the treatment landscape.”

Goal 6: Adopt a consensus position to guide clinical practice on obesity management and treatment

The Australian Heart Foundation has recently published an evidence-based consensus statement on obesity and cardiovascular disease.^{xviii} It is recommended that this be adopted and adapted to New Zealand.

Why this matters

Addressing obesity represents one of the largest opportunities to reduce future cardiovascular disease burden in New Zealand. Earlier intervention and equitable access to effective treatment could

reduce rates of diabetes, heart failure, stroke, coronary disease and avoidable hospitalisations. It also offers an opportunity to reduce long-standing inequities experienced by Māori and Pacific communities.

Without a coordinated national approach, obesity-related cardiovascular disease is likely to continue increasing pressure on the health system, workforce and wider economy.

Key actions

- Integrate obesity management into existing cardiovascular disease assessment and management, as recommended in the Australian Heart Foundation consensus position on obesity.
- Ensure timely assessment, approval and funding pathways for evidence-based obesity medicines with proven cardiovascular benefit.

Expected impact

A stronger national response to obesity would reduce future cardiovascular disease burden, improve quality of life and decrease avoidable morbidity and mortality. Improved access to effective obesity treatment and prevention strategies would also help reduce inequities in cardiovascular outcomes, particularly for Māori and Pacific Peoples, while reducing long-term pressure on the health system.

Priority 4: Increase survival for out-of-hospital cardiac arrest

Improving and enabling better community responses to out-of-hospital cardiac arrests (OHCA) represents a high-impact opportunity to save lives.

Rapid intervention, including CPR and defibrillation, significantly improves survival rates. For every minute without CPR and defibrillation, the chance of survival falls by 10 to 15%. ^{xviii}

Almost 2,500 New Zealanders are treated for a cardiac arrest at home or in the community each year, and only around 12% survive to 30 days post-event. OHCA mortality rates for Māori and Pacific are double those of non-Māori non-Pacific New Zealanders.

New Zealand has relatively high rates of bystander CPR, with around 80% of cases being attended, but early defibrillation is low, often because of inequitable access,

outdated registries, and inaccessibility of AEDs (automated external defibrillators) out of hours or in residential areas. ^{xix} A recent audit found only 7% of AEDs in one major city were available to the public 24/7, and rural access is even more limited. ^{xx}

This results in significant inequalities, with women, Māori, Pacific, rural and Asian patients all less likely to receive defibrillation. ^{xxi}

There is also substantial inconsistency across New Zealand health professions. Less than half of health practitioner regulatory bodies require mandatory CPR training for registration. ^{xxii}

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A recent audit found only 7% of AEDs in one major city were available to the public 24/7, and rural access is even more limited.”

Goal 7: Double community defibrillation rates by 2030

Currently, only around 6% of people experiencing an OHCA receive defibrillation from a community responder. Increasing this to at least 12% by 2030 would significantly improve survival outcomes. ^{xix}

International experience demonstrates that targeted investment in community response systems can rapidly increase defibrillation rates and survival. ^{xxii, xxiii}

Why this matters

Rapid intervention, including CPR and defibrillation, more than doubles the chance of survival. For every minute without CPR and defibrillation, the chance of survival falls by 10 to 15%. Improved access can reduce inequalities in emergency outcomes.



Key actions

- Expand access to publicly available defibrillators in high-need areas.
- Establish and maintain a national, real-time AED registry.
- Integrate first responder systems with emergency services.
- Introduce mandatory CPR and AED training in schools.
- Standardise CPR training requirements across health professions.

Expected impact

Improved community response to cardiac arrest has the potential to more than double survival rates, particularly for populations currently underserved by emergency response systems.

Sustain mid- to long-term gains and reduce future burden

Priority 5: Build a strong and sustainable prevention system

A strong prevention system is essential to reduce the future burden of cardiovascular disease.

While treatment improvements can reduce mortality in the short term, long-term gains depend on reducing the incidence of disease through prevention.

Dietary risk factors are second only to hypertension as a preventable risk factor for cardiovascular disease in New Zealand. In particular, they contribute to obesity, high cholesterol and hypertension itself. ⁱⁱⁱ

Recent trends indicate worsening risk factors for diet and exercise. The proportion of New Zealanders meeting daily fruit and vegetable intake recommendations fell from 6.5% in 2022 to 4.2% in 2025. Rates of physical inactivity have also continued to increase. ^{vii}

Increasing costs continue to put a strain on families purchasing healthy food, with more than half reporting they have cut back fruit and vegetables as a result. This rises to almost two-thirds of Pacific families and single parent families. ^{xxiv}

Smoking rates have declined significantly in recent years, demonstrating that sustained public health action can deliver large population-level gains. Increased numbers of people have vaped to quit, and an initial uptake of vaping by young people now appears to be slowing and declining. ^{xxv} Although less harmful than smoking, vaping nicotine is not risk-free and this requires ongoing monitoring. ^{xxvi}

Goal 8: Reverse the declining trends in consumption of healthy food and physical activity and achieve minimal smoking for all populations

Reversing current trends requires large-scale systemic action. This includes making healthy food options more accessible and affordable, and addressing the impact of cheap, highly marketed unhealthy foods, especially on children. Low smoking rates must be sustained.

Why this matters

A strong prevention system benefits multiple conditions and will continue to reduce future incidence of preventable cardiovascular disease. Addressing the social determinants is vital to reverse persistent unfair outcomes and inequities.

“The proportion of New Zealanders meeting daily fruit and vegetable intake recommendations fell from 6.5% in 2022 to 4.2% in 2025.”



Key actions

- Reduce barriers for families to access affordable healthy food, and increase food reformulation to reduce sodium and sugar consumption.
- Limit marketing of unhealthy foods, particularly to children.
- Support healthier, affordable options in early learning services, schools, workplaces and communities.
- Increase active transport through urban design that favours investment in walkable, bikeable communities and public transport, particularly in lower income areas, to make daily activity the default.
- Achieve adult smoking rates of less than 5% for all populations and sustain youth smoking rates under 1%. Increase successful quitting for older adults who are still smoking and at greatest risk of heart disease.

Expected impact

Prevention measures will deliver sustained reductions in cardiovascular disease over time and are essential to maintaining long-term improvements in population health by supporting future generations to grow up with healthy options as the default.

Priority 6: Grow and sustain a world-class health workforce and strengthen the research-to-practice pipeline

Meeting the needs of existing patients and putting research into action requires a high-quality workforce and adequate resources for implementation.

Aotearoa New Zealand has world-class heart research programmes, both domestically and through international collaborations.

Currently New Zealand faces a future health workforce shortage. In 2023, there were around 160 cardiologists practising in Aotearoa New Zealand. By 2025, this was estimated to be down to 154, of whom only 2% are Māori or Pacific, and 15% are women. In 2025, there were 21 unfilled vacancies for cardiologists in New Zealand. These risks are increasing as the existing cardiology workforce is ageing, and New Zealand is experiencing a loss of newly qualified cardiologists to Australia and the USA. ^{xxvii}

Evidence suggests that lower ratios of cardiologists per population are associated with significantly lower mortality. Best outcomes are observed when this ratio is around one cardiologist per 10,000 to 15,000 people. ^{xxviii} Only Auckland currently comes close with around one cardiologist per 20,000 people. This is three times more cardiologists per head of population than Canterbury or Lakes, and almost four times more than Taranaki. The national ratio is one per 34,000. ^{xxviii}

“

In 2023, there were around 160 cardiologists practising in Aotearoa New Zealand. By 2025, this was estimated to be down to 154, of whom only 2% are Māori or Pacific, and 15% are women.”



Goal 9: Strengthen the research-to-practice pipeline

Develop stronger pathways from research to practice and close the evidence to action gap, ensuring that New Zealanders benefit from developments in prevention, treatment and care.

Goal 10: A sustainable and equitable workforce

The attrition of the cardiology workforce requires urgent reversal. The incoming and newly qualified workforce is not large enough to meet demand. Women, Māori and Pacific professionals remain substantially underrepresented.

Goal 11: Match international best practice of one cardiologist per 10 to 15,000 people

The current cardiology workforce is under-resourced and inadequately distributed with significant proportions of the country facing a shortage of care.

Why this matters

A representative and well-distributed workforce capable of meeting demand will ensure timely delivery of healthcare and improve equitable access to evidence-based treatments.

Key actions

- Develop stronger pathways from research to practice and close the evidence to action gap to ensure benefits to New Zealanders.
- Promote and incentivise heart health as a career pathway, to build a sustainable, skilled and diverse workforce that represents the Aotearoa New Zealand population.
- Support and incentivise cardiology and allied workforce development, especially in areas where there is high unmet need for heart health services.

Expected impact

Having a workforce capable of meeting future demand and enabling delivery of evidence-based treatment is a critical success factor.



Ensure oversight and accountability, and measure success

Priority 7: Establish national oversight and accountability for heart health

Success requires clear goals for prevention, risk identification and management, treatment and outcomes, together with adequate resourcing and incentives to achieve them, and clear accountability for delivery.

New Zealand currently has no systematic and transparent reporting on cardiovascular health. While we can measure risks such as smoking, system measures such as wait lists, and outcomes such as hospitalisations and deaths, are disparate and often unrelated. There are limited goals and measures specified for tangible actions that will reduce heart disease.

The health system has faced considerable upheaval and change in the last few years, and this has disrupted continuity, planning and implementation. Support is needed across the political spectrum for an independent, evidence-based and accountable approach.

Goal 12: By the end of 2026 establish a national oversight group accountable for a clear vision and road map for cardiovascular health

Cardiovascular disease causes an enormous burden on individuals, families, and the New Zealand health system but lacks equivalent strategic governance to other chronic long-term conditions such as cancer, diabetes and mental health. A national oversight group is needed to assume accountability for a clear vision and road map for cardiovascular

health. Oversight must be strategic, not clinical, and be accountable to the public and policymakers. It must be able to act independently of politics in order to provide continuity and sustainable action.

A national oversight group should be responsible for:

- A clear vision and road map to:
 - reduce avoidable cardiovascular deaths
 - reduce persistent inequalities in cardiovascular care and outcomes.
- Alignment and coordination with existing strategies and plans that overlap. For example, diabetes, mental health and cancer.
- Systematic and transparent reporting on heart health.

A national heart health plan and oversight are crucial to move from the status quo of fragmented action to a coordinated, resourced and effective approach to improving New Zealand's heart health.

Appendix 1. About the Heart Foundation

The Heart Foundation exists to stop all people in New Zealand dying prematurely from heart disease and enable people with heart disease to live full lives.

The Heart Foundation is New Zealand's heart charity, leading the fight against our country's single biggest killer – heart disease. We provide nationwide programmes, support, and resources to individuals and families in every community across New Zealand.

In 1968, a small group of cardiologists and business people joined forces to address New Zealand's growing heart disease crisis. Their vision was clear: to create a national organisation dedicated to tackling this issue

through education and research. In 2026, we celebrated the milestone of \$100 million invested into life-saving heart research.

Over the past five decades there has been a 75% reduction in deaths from heart disease. But one preventable death is still one too many.

That's why we continue to work tirelessly to stop people in New Zealand from dying prematurely of heart disease, and to ensure those living with heart conditions can live full lives.

Appendix 2. Methodology for estimating lives saved

Future cardiovascular disease (CVD) mortality trends in Aotearoa New Zealand were estimated using an age-specific projection model combining observed mortality, avoidable mortality and official population projections by five-year age group and ethnicity.

Historical CVD mortality data for 2013 to 2021 was sourced from the Ministry of Health by age, sex and ethnicity. Data was coded by ICD-10 code, and using methodology from Walsh and Grey (2019) ^{vii} avoidable deaths were calculated by five-year age bands and ethnicity. Calculated avoidable deaths were linked to median projected population estimates for 2022 to 2040 sourced from Stats NZ Tatauranga Aotearoa.

Age-specific mortality rates were calculated for each year by dividing observed deaths by the corresponding population. Recent mortality patterns (2017–2021) were used as the baseline period to predict future trajectories. Recent years were favoured to reduce instability from single-year variation and better reflect recent mortality conditions.

Two projection scenarios were developed. The first was an “ageing-only” scenario. Recent age-specific mortality rates for people under 75 were held constant and applied to projected future populations.

This scenario isolates the effect of demographic change, particularly population ageing on future premature mortality burden.

The second was a business-as-usual (BAU) scenario in which recent trends in age-specific mortality rates observed between 2013 and 2021 were extrapolated forward and applied to future population projections. A slight increase in avoidable mortality was predicted in the BAU scenario as significant growth was predicted in the 60- to 74-year-old population.

Avoidable CVD mortality was modelled separately for people aged under 75 years using the same approach. Projections were modelled towards a target of 30% reduction

in avoidable mortality by 2035 and 40% by 2040. Māori were modelled to a target of 35% by 2030 and 25.8% by 2040.

BAU and modelled avoidable mortality rates

Year 20-	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
BAU NZ%	23.9	24.1	24.3	24.5	24.8	25.0	25.2	25.4	25.6	25.8	26.0	26.2	26.4	26.6	26.8	27.0	27.3	27.5	27.7
Target NZ %	23.9	22.6	21.3	20.0	18.6	17.3	16.0	15.8	15.7	15.5	15.3	15.2	15.0	14.8	14.7	14.5	14.3	14.2	14.0
BAU Māori %	51.7	51.6	51.4	51.3	51.2	51.1	50.9	50.8	50.7	50.6	50.4	50.3	50.2	50.1	49.9	49.8	49.7	49.6	49.4
Target Māori %	51.7	49.6	47.5	45.4	43.4	41.3	39.2	37.1	35.0	34.1	33.2	32.3	31.3	30.4	29.5	28.6	27.7	26.8	25.9
BAU Pacific %	51.2	51.1	51.1	51.0	50.9	50.8	50.7	50.6	50.5	50.4	50.3	50.2	50.1	50.0	49.9	49.8	49.8	49.7	49.6
Target Pacific %	51.2	49.2	47.1	45.0	43.0	40.9	38.8	36.8	34.7	33.8	33.9	32.0	31.1	30.2	29.2	28.3	27.4	26.5	25.6

Future BAU age distributions were cross-checked against observed 1996 to 2022 trends in combined Ischaemic Heart Disease (IHD), stroke and other heart disease mortality. The modelled 2040 age structure was constrained to remain consistent with these long-run trends, allowing continued ageing while avoiding implausibly rapid shifts into the oldest age groups.

Assumptions and limitations

The modelling assumes that recent age-specific mortality trends provide a reasonable basis for future projections under BAU conditions. Future changes in major risk factors, treatment effectiveness, screening practices, health service access, economic conditions or public health policy are not explicitly modelled. The target scenario therefore represents a simplified counterfactual based on reductions in avoidable mortality rather than modelling the impact of specific interventions.

Because avoidable mortality was restricted to deaths under 75 years, potential reductions in mortality among older populations were not directly incorporated and the model will therefore underestimate the total population benefit.

Several limitations should be considered when interpreting the projections. Historical avoidable mortality was only used from a relatively short period (2013–2021) for the core CVD modelling, limiting the ability to estimate long-term cohort effects or structural breaks in mortality trends.

Projections are sensitive to uncertainty in future population estimates, which use the median growth scenario from Stats NZ Tatauranga Aotearoa projections. Projections should be interpreted as plausible future scenarios designed to inform planning and policy discussion rather than precise forecasts of future mortality.

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