

ANNUAL REPORT

for the year ended 30 June 2009

**Including the Director-General of Health's
Annual Report on the State of Public Health**

Citation: Ministry of Health. 2009. *Annual Report for the year ended 30 June 2009 including the Director-General of Health's Annual Report on the State of Public Health*. Wellington: Ministry of Health.

Published in October 2009
by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-478-33915-4 (Print)

ISBN 978-0-478-33916-1 (Online)

HP 4957

This document is available on the Ministry of Health website:

<http://www.moh.govt.nz>



Foreword

This Annual Report outlines the Ministry of Health's key achievements for the 2008/09 financial year, including the Ministry's performance against the outcomes, key initiatives, outputs and measures set out in the 2008–11 Statement of Intent. It also incorporates my annual report as Director-General of Health on the state of public health in New Zealand.

The report is divided into three main parts.

- Part 1 describes our contribution to the health and disability sector outcomes for the 2008/09 year. It outlines what we did and how we performed in contributing to each outcome. It also describes what we have done to strengthen organisational health and capability.
- Part 2 contains our Statement of Service Performance and includes the audited financial statements for the 2008/09 financial year. This Statement describes what we spent and how we performed to deliver our outputs during the year.

Parts 1 and 2 have been produced in accordance with section 44 of the Public Finance Act 1989.

- Part 3 is my annual report on the state of public health for the year ending 30 June 2009. This annual report is a statutory requirement under section 3C(1) of the Health Act 1956.



Stephen McKernan
Director-General of Health
October 2009

Contents

Foreword	iii
Director-General's Overview	1
About Us	4
Part 1: Outcome Performance in 2008/09	5
Our achievements	5
A: A focus on primary health care and prevention	7
B: Strengthening health services we can trust.....	12
C: Enabling a strong, sustainable health sector for the longer term	17
D: Other Ministry operational priorities	20
Our organisation	22
Organisational health and capability	22
Part 2: Service Performance and Financial Summary	25
Statement of responsibility.....	25
Audit Report.....	26
Statement of Service Performance for 2008/09	29
Statement of objectives	29
Departmental output expense: administration of funding and purchasing of health and disability support services.....	30
Departmental output expense: administration of legislation and regulations	32
Departmental output expense: funding and performance of Crown entities.....	35
Departmental output expense: information services	38
Departmental output expense: payment services.....	41
Departmental output expense: servicing of Ministers and ministerial committees.....	42
Departmental output expense: strategy, policy and system performance	45
Financial Statements.....	52
Introduction to the financial reports.....	52
Statement of financial performance for the year ended 30 June 2009.....	55
Statement of movements in taxpayers' funds for the year ended 30 June 2009	55

Statement of financial position as at 30 June 2009	56
Statement of cash flows for the year ended 30 June 2009	57
Statement of commitments as at 30 June 2009.....	58
Statement of contingent liabilities and contingent assets as at 30 June 2009.....	58
Statement of departmental actual expenses against appropriations for the year ended 30 June 2009.....	59
Statement of departmental unappropriated expenditure and capital expenditure for the year ended 30 June 2009.....	59
Notes to the financial statements for the year ended 30 June 2009.....	60
Non-departmental statements and schedules for the year ended 30 June 2009	83
Statement of non-departmental expenses and capital expenditure against appropriations for the year ended 30 June 2009	83
Statement of non-departmental unappropriated expenditure and capital expenditure for the year ended 30 June 2009.....	85
Schedule of non-departmental income and capital receipts for the year ended 30 June 2009.....	86
Schedule of non-departmental assets as at 30 June 2009.....	87
Schedule of non-departmental liabilities as at 30 June 2009	88
Schedule of non-departmental commitments as at 30 June 2009.....	88
Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2009	89
Statement of trust monies for the year ended 30 June 2009	90
Notes to the non-departmental statements and schedules	91
Part 3: Health and Independence Report – The Director-General of Health’s Annual Report on the State of Public Health.....	95
Introduction: Director-General’s overview	95
Health indicator framework.....	95
Health status.....	97
Quality and effectiveness	102
Equity and access.....	113
Efficiency and value for money	115
Patient-centredness and responsiveness.....	117

List of Figures

Figure 1: The Ministry's medium-term outcomes	5
Figure 2: 2008/09 departmental operational appropriations – actual expenditure (\$000s)	53
Figure 3: Comparative data for 2007/08 departmental operational appropriations – actual expenditure (\$000s).....	53
Figure 4: 2008/09 non-departmental operational appropriations – actual expenditure (\$000s).....	54
Figure 5: Comparative data for 2007/08 non-departmental operational appropriations – actual expenditure (\$000s)	54
Figure 6: Independent life expectancy at birth (years) by gender, 1996–2006	97
Figure 7: Independent life expectancy at birth (years) by gender and ethnicity, 2006	98
Figure 8: Life expectancy at birth, by gender and ethnicity, 1996 to 2006	99
Figure 9: Life expectancy at birth, by gender and deprivation (NZDep2006), 2006	99
Figure 10: High or very high probability of anxiety or depressive disorder for adults, by age group and gender (unadjusted prevalence)	100
Figure 11: Age-standardised suicide rates, by gender, 1996 to 2006	101
Figure 12: Age-standardised suicide rates, Māori and non-Māori, 1996 to 2006	102
Figure 13: Ambulatory-sensitive hospital admissions for people aged 0–74 years, age-standardised rate per 100,000, by ethnicity, 2000/01 to 2007/08	103
Figure 14: Cardiovascular disease mortality, all ages, age-standardised rate per 100,000 by gender, 1996 to 2006	104
Figure 15: Cardiovascular disease mortality, all ages, age-standardised rate per 100,000 by ethnicity, 1996 to 2006	104
Figure 16: Five-year relative cancer survival rates in two-year periods, by major cancer site, 1997/98 to 2006/07	105
Figure 17: Five-year relative survival rates (1994–2006), by major cancer site and ethnicity	105
Figure 18: Readmissions rate per 100 discharges (%), all DHBs combined, 1999/2000 to 2007/08	106
Figure 19: Hospital mortality rate per 100 discharges (%), all DHBs combined, 2000/01 to 2007/08	107
Figure 20: Current smoking among those aged 15 years and over, 1983 to 2008 (unadjusted prevalence)	108
Figure 21: Proportion of children and adults who are obese, by age group and gender (unadjusted prevalence), 2006/07	109

Figure 22: Proportion of adults who are obese, by gender, 1997, 2002/03 and 2006/07 (age-standardised prevalence)	110
Figure 23: Proportion of Māori adults who are obese, by gender, 1997, 2002/03 and 2006/07 (age-standardised prevalence)	110
Figure 24: Proportion of Pacific adults who are obese, by gender, 1997, 2002/03 and 2006/07 (age-standardised prevalence)	111
Figure 25: Hazardous drinking among adults, by age group and gender (unadjusted prevalence), 2006/07	112
Figure 26: Hazardous drinking by gender and ethnicity (age-standardised prevalence), 2006/07	112
Figure 27: National immunisation coverage at the 12-month milestone age, by ethnicity, quarterly comparison, 2009	114
Figure 28: National immunisation coverage at the 24-month milestone age, by ethnicity, quarterly comparison, 2009	114
Figure 29: Percentage of day-case procedures, all DHBs, quarterly, December 2001 to March 2009	115
Figure 30: Medical and nursing personnel productivity in DHB provider arms (in medical and surgical services), 2001/02 to 2007/08: outputs and labour cost input growth: indexed to 2001/02 as the base year	116
Figure 31: Medical and nursing personnel productivity in DHB provider arms (in medical and surgical services), 2001/02 to 2007/08: outputs and labour force FTEs input growth: indexed to 2001/02 as the base year	117
Figure 32: International comparison of access to doctor when sick or needing care	118

List of Tables

Table 1: Priority areas for 2008–2011	6
Table 2: Health indicator framework	96
Table 3: Prevalence of disability requiring assistance, by ethnicity and sex, 1996, 2001 and 2006	100
Table 4: Number of elective surgical discharges, 2000/01 to 2008/09	113
Table 5: International comparisons of patient (those with chronic conditions) engagement in care	117

Director-General's Overview

2008/09: A year of challenge and change

This has been a year of challenge and change for the Ministry of Health and the wider health sector. I am pleased to say the Ministry has coped well, and I believe New Zealand has been well served by the Ministry's committed and professional staff.

The change in government brought with it new priorities and targets for the health portfolio. We also faced significant challenges from an influenza pandemic and a global financial crisis which created new pressures and difficult demands on the Ministry.

We will continue to face further challenges and change, and I am confident we now have a strong basis from which to continue improving services while achieving value for money.

Tightening economic conditions

During 2008/09, a global economic recession put considerable pressure on government revenue and necessitated a strong focus on managing government spending. In responding to this pressure, the Government focused its immediate attention on getting full value from public services. This had significant implications for the health sector which represents one of the largest areas of government spending.

The Ministry responded as part of the preparation for Budget 2009 by participating in a wider public service review of government spending. This review identified areas where immediate improvements in efficiency could be made and where low-quality spending could be identified and stopped.

The Ministry undertook its own review of spending by conducting a line-by-line review and implementing spending constraints and contracting improvements to realise total savings of \$178 million in the 2008/09 year and future savings of nearly \$90 million. The Ministry reviewed all areas within its departmental operational control to ensure efficiencies were maximised to support freeing up of resources to the front line.

The Ministry reduced staffing levels in line with the Government's intentions to reduce bureaucracy and shift resources to frontline services. The Ministry's staffing cap as at 31 December 2008 was 1675 full-time equivalents (FTEs). As a result of the above, the Ministry was operating at approximately 200 less staff than its original cap.

The effects of the global recession are likely to last for the foreseeable future, and we will need to maintain considerable vigilance to make sure that we are as effective and efficient as possible. Reviews and refocusing of work will continue to ensure that the Ministry delivers on the Government's priorities while ensuring value for money.

Influenza pandemic

This year the Ministry led New Zealand's response to the Influenza A (H1N1) pandemic. The Ministry, health authorities and other government agencies implemented the New Zealand Influenza Pandemic Action Plan, as well as following international developments and advice from the World Health Organization (WHO). I was impressed with the way we responded to the pandemic. Some of our staff needed to focus immediately on the pandemic response, which required other work and tasks to be reprioritised. Although this created other pressures, the Ministry responded well to the challenges created by the pandemic and we maintained business as usual at a high standard. Thank you to all involved, either directly or indirectly, for your contribution to the Ministry's pandemic response, and the ongoing task of reviewing and revising our preparedness and response plans.

100 days priority actions

The new Government immediately focused on achieving the following specific actions in the health sector within its first 100 days in office:

- prioritise front-line health services rather than growing the bureaucracy
- address hospital waiting lists and service delivery areas
- provide funding for Plunketline
- provide publicly funded 12-month course of Herceptin
- introduce a voluntary bonding scheme to write-off student loans for graduate doctors, nurses and midwives who agree to work in difficult-to-staff areas.

I was pleased at how we responded to the new Government's immediate priorities, all of which were achieved within the first 100 days.

New targets and priorities

The new Government is focused on building and sustaining a strong public health care system to provide better, sooner, and more convenient health services for all New Zealanders. The following Health Targets have been set for the Ministry and sector:

- shorter stays in emergency departments
- improved access to elective surgery
- shorter waits for cancer treatment
- increased immunisation
- better help for smokers to quit
- better diabetes and cardiovascular services.

These Health Targets help us focus our efforts on improving the sector's performance, and to ensure our health system is contributing to maintain and improve health outcomes in these important areas.

I am pleased by the way the Ministry staff and the health sector have responded to the challenges this year and to the priorities of the new Government.

Looking forward

If we are to provide the best quality health care to New Zealanders we need to be innovative and we need to work together. Frontline staff face the pressures and realities of the health sector every day. It is from their experience and their insights that the greatest benefit can be gained for the entire sector.

The future will continue to provide new challenges.¹ I am confident we have the capability and systems to respond as successfully as we have in 2008/09. These challenges bring with them an opportunity for the experienced and committed people working across New Zealand's health sector to step up, challenge their thinking, and deliver even more effective services to the public.

¹ Information on longer-term changes in the focus and direction of the Ministry are available in the Statement of Intent for 2009–2012.

About Us

The Ministry of Health is the primary agent of the Minister of Health in the health and disability system and has overall responsibility for the management and development of that system. We act as the Minister's principal advisor on health policy and as a funder and regulator of health services, and we provide leadership across the system to improve performance.

We are also the Minister's agent in managing the formal relationship with the 21 District Health Boards (DHBs). The DHBs are responsible for meeting the health needs of the people in their districts. They plan, fund and provide health services within their areas, including public hospitals and the majority of public health services.

The current health sector structure was established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). In this legislative environment the strategic direction of the sector has been set within two overarching strategic documents: the New Zealand Health Strategy and the New Zealand Disability Strategy. These two strategies have been supported by other, more targeted, strategies that provide guidance and advice in specific areas, including Māori health, Pacific health and primary health care.

The Ministry's core functions are:

- strategy, policy and system performance – providing advice on improving health outcomes, reducing inequalities and increasing participation, and undertaking nationwide planning, co-ordination and collaboration across the sectors
- monitoring and improving the performance of health sector Crown entities and DHBs, which are responsible for the health of their local communities
- funding and purchasing health and disability support services on behalf of the Crown, including maintenance of service agreements, particularly for public health, disability support services and other services that are retained centrally
- administration of legislation and regulations, and meeting legislative requirements
- administering payments for health benefits and service agreements
- collecting and analysing health information
- servicing Ministers' offices and ministerial advisory committees.

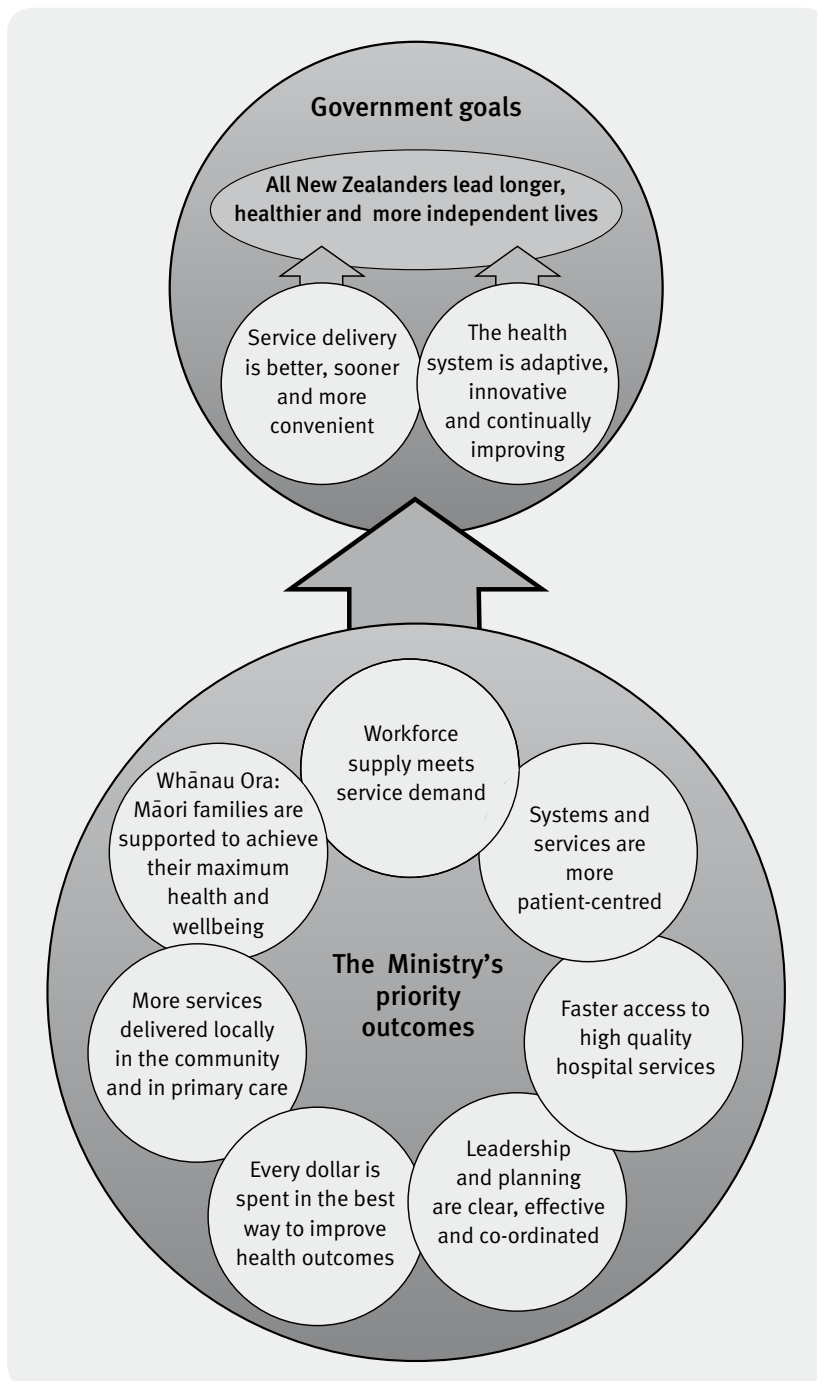
Less than 2 percent of Vote Health funding is spent on the Ministry of Health to deliver these functions in support of the sector and government.

Part 1: Outcome Performance in 2008/09

Our achievements

The 2008/09 year saw a change in government that resulted in the Ministry's activities shifting to support the aim of better, sooner, more convenient services for New Zealanders. The Ministry reflected this shift in its Statement of Intent 2009–12, which contains the first comprehensive overview of the Ministry's outcome framework in a number of years. This new framework, shown below, guided the Ministry's work programme in the latter part of the year and will provide a focus for activities in the year ahead.

Figure 1: The Ministry's medium-term outcomes



To provide an accurate overview of the Ministry's 2008/09 activities, while still meeting the statutory requirements of the Public Finance Act 1989, this Annual Report is based on the 2008–11 Statement of Intent and the 2008 Output Plan, but for completeness, it also incorporates the policy aims and activities of the new Government in the areas reported on. This blended approach provides a richer picture of the Ministry's operations during this year of change. For reference, the framework for priority areas included in the 2008-2011 Statement of Intent is set out below in Table 1.

Table 1: Priority areas for 2008–2011

2008–11 Statement of Intent priority areas
A: Taking public and primary health care to the next level
A1: Getting ahead of the chronic disease burden
A2: Driving forward the Primary Health Care Strategy
A3: Investing in the early years and youth potential
A4: Caring for older New Zealanders
B: Strengthening health services we can trust
B1: Achieving value for money
B2: Actioning the agenda for quality
B3: Strengthening regional and national collaboration among DHBs
C: Enabling a strong, sustainable health sector for the longer term
C1: Strategically developing the health sector workforce
C2: Building seamless health information and communication systems
C3: Optimising capital infrastructure development
D: Other Ministry operational priorities
D1: Improving Māori health
D2: Reducing inequalities
D3: Supporting health and wellbeing through nationally funded services

A: A focus on primary health care and prevention

Our focus on primary health care and prevention is essential to tackling the burden of long-term conditions. The underpinning principle for the Ministry's work programme in the second half of the year was that a comprehensive approach was needed to reduce the incidence and impact of long-term conditions. This work will provide a strong platform for improving health outcomes, and will be achieved through effort in four key areas:

- getting ahead of the chronic disease burden
- primary health care
- early years and youth
- caring for older New Zealanders.

A1 Getting ahead of the chronic disease burden

Better, sooner, more convenient health care

The focus of the Better, Sooner, More Convenient Implementation Plan,² which the Ministry prepared in the early part of 2009, was on moving services closer to home; co-ordinating care, chronic care and social support; and shifting more secondary care to the primary sector. Each of these aspects contributes to improvement in the range and quality of services for people with long-term conditions.

The goals set for this work include:

- developing a more personalised primary health care system
- providing services closer to home
- making Kiwis healthier
- reducing pressure on hospitals.

There have been some recent positive changes, such as:

- the level of unmet need for general practice services has reduced
- management of the risk of cardiovascular disease has improved across all ethnicities, as reflected in the percentage of annual checks in which statins were prescribed
- smoking, cardiovascular disease mortality rates by ethnicity, acute coronary syndrome, stroke and the life expectancy gap between Māori and non-Māori have all reduced.

Despite these recent positive changes, two out of three adults (67 percent) and one in three children (37 percent) had been diagnosed by a doctor with a health condition that lasted, or was expected to last, six months or more. Such long-term conditions and their major risk factors are not distributed equitably among people living in New Zealand. The 2006/07 New Zealand Health Survey³ revealed that people who live in the most deprived neighbourhoods in New Zealand are at greater risk of having long-term conditions, compared with people living in the least deprived neighbourhoods. Similarly, Māori and Pacific peoples are over-represented among those living with long-term conditions.

² Based on the Government's Better, Sooner, More Convenient document.

³ Ministry of Health. 2008. *A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey*. Wellington. Ministry of Health.

Cardiovascular disease

As can be seen in Part 3, the State of Public Health report, rates of cardiovascular disease, including heart attacks and strokes, have reduced steadily over recent years. However, cardiovascular disease remains the leading cause of death in New Zealand, accounting for 40 percent of deaths annually.

Cardiovascular disease is substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Of the eligible population, 2.3 percent had blood tests for cardiovascular disease risk in the five-year period preceding 2008/09, which exceeded the agreed national target of 2 percent. The greatest improvement was made for Pacific peoples.

Diabetes

The number of people with diabetes who participated in the Get Checked free checks in 2008/9 increased by 11,469 people to 100,249 exceeding the national target by almost 2000 people. The proportion of people with diagnosed diabetes using Get Checked is now greatest in Pacific peoples, followed by Māori and then other ethnicities.

In 2008/09, 72 percent of people had ‘satisfactory or better’ diabetes control compared with 71 percent a year earlier. This is slightly below the national average target (73 percent). DHB performance varied, but 11 out of 21 DHBs met or exceeded their targets. Five DHBs exceeded 80 percent.

Long-Term Conditions – Direction for Action

The key primary health care deliverable for addressing the burden of chronic disease for the 2008/09 year was the draft *Long-Term Conditions – New Zealand Direction for Action*⁴ document and supporting documents. The aim of this document is to emphasise proactive, planned and co-ordinated care and prevention which supports people to better manage their health.

A2 Primary health care

To enhance the innovative delivery of primary health care, the Ministry and District Health Boards New Zealand (DHBNZ) agreed on a joint work programme and Primary Health Organisation (PHO) performance programme, and Cabinet approved ‘Strengthening the Health System: Primary Health Care Strategy: Accelerating change’.⁵ Ongoing work has included:

- the calculation of annual adjuster options to inform Very Low Cost Access Practices and Under 6 policies⁶
- work on reasonable increases to general practice fees
- quality improvements in PHO monitoring and reporting
- improvements to the PHO Performance Programme
- initiatives in conjunction with the Royal New Zealand College of General Practitioners, the Rural GP Network and the Independent Practitioners Association Council of New Zealand (IPAC).

4 Ministry of Health. 2009. *Long-Term Conditions – New Zealand Direction for Action* [draft]. Wellington. Ministry of Health.

5 Paper 2, CBC Min (08) 21/33.

6 Some general practices have agreed to set their fees at \$0 for children under six years old. Other practices, known as Very Low Cost Access Practices, set their fees at \$0 for children under six years old and have also agreed to charge a set low fee which is currently \$10.50 for those aged 6 to 17 years old and \$16 for those over 18 years old.

Three initiatives to improve access were implemented in the first half of the year:

- pharmaceutical co-payments for hospital and after-hours prescriptions were reduced
- eleven men's health initiatives were funded through the Men's Health Innovation Fund
- DHBs were invited to submit proposals for improved access to after-hours primary health care services. Eighteen of these were approved during the year.

Twenty-six initiatives were selected for funding from the Primary Health Care Innovation Fund. The Ministry also agreed to fund a pilot extending Healthline services in Taranaki and pilot primary care ambulance services involving Kapiti EMS (Emergency Management Service), Wellington Free Ambulance and Capital and Coast DHB.

More personalised primary health care, closer to home

In the second half of 2008/09, the Ministry focused on the new Government's priority of Better, Sooner, More Convenient care which is focused on more personalised primary care, closer to home, to make New Zealanders healthier and reduce pressure on our hospitals.

The next phase of implementing the Primary Health Care Strategy builds on achievements made to date and will be delivered in an environment where there is enhanced clinical engagement and leadership, and consolidated practices and PHOs.

The ongoing development of primary health care will evolve as a result of:

- the Ministry revising primary health care policy settings, in order to implement Better, Sooner, More Convenient primary health care, through an Expressions of Interest process
- the development of integrated Family Health Centres. These Centres are based on the concept of providing people with access to a more comprehensive range of services which may include social services, services which have been devolved from secondary care settings and Whānau Ora models, as appropriate
- improving the quality of existing programmes.

A3 Early years and youth

Child, youth and maternity

During the past year significant progress has been made implementing new services in response to the new Government's priorities of ensuring all pregnant women, infants, children and youth, across New Zealand, receive effective and well co-ordinated services.

Maternity and Well Child/Tamariki Ora

Maternity services have been facing challenges, with an increasing birth rate and workforce constraints putting pressure on services and lead maternity carers (LMCs) in some areas. One immediate action taken by the new Government in 2008/09 was to provide ongoing support for the Plunketline service.

A draft Maternity Action Plan was released for consultation. This Action Plan will guide health professionals, practitioners and service providers to improve services and outcomes for pregnant women, their babies and their families. The Ministry expects to be able to finalise the Plan in 2009/10.

The new Government set three immediate priorities for maternity services:

- longer stays in maternity facilities
- more co-ordinated services across GPs and LMCs

- more training and upskilling of GPs to increase the LMC workforce and choice for women.

The Government allocated funding in Budget 2009:

- for DHBs to provide women with the option of longer stays in maternity facilities
- to support additional, optional visits in the second and third trimesters for a pregnant woman, her GP and her LMC. Implementation of this will be during 2009/10
- to support additional training and upskilling of GPs and obstetricians.

The Well Child programme, which involves a series of eight contacts with young children and their caregivers, was reviewed and updated, including improving information for parents. A significant focus was placed on the B4 School developmental checks for four year olds. As awareness of this programme grew so did its uptake.

New Government priorities for Well Child included additional visits in the first year of a child's life, and increased co-ordination and smoother transition between providers of maternity services and providers of Well Child services.

The Ministry of Health and the Ministries of Social Development and Education worked in partnership to pilot health and education assessment services in four DHB regions for children and young people entering the care of Child, Youth and Family. The Ministry of Health also worked with DHBs and the Ministry of Social Development to establish a comprehensive health service, funded and delivered by DHBs, for young people in Care and Protection and Youth Justice facilities.

Youth health

The key actions in the area of youth health were the development of a programme of action on youth pregnancy and parenting, and the implementation of school-based youth health services in low-decile schools.

The Government confirmed in May 2009 that these services would continue to be implemented in low decile secondary schools, teen parent units, and alternative education facilities.

National Immunisation Programme Strategy

In New Zealand, 80 percent of two-year-olds are fully immunised. Despite this level of immunisation, outbreaks of preventable diseases, such as measles and whooping cough, occurred during the year because immunisation rates are still too low.

The uptake of the influenza vaccine was significantly higher than last year, partly due to the influenza pandemic. The Ministry purchased additional vaccine for seasonal influenza and also began investigating vaccines for Influenza A (H1N1) 'Swine Flu'.

The Immunisation Strategy was updated to reflect the priorities of the new Government including placing a focus on:

- getting the basic and routine systems working well, and simplifying these where possible
- identifying and understanding the different audiences, and tailoring interventions to suit them.

The Ministry will focus its future work on:

- making the National Immunisation Register work well
- simplifying the Ministry's purchasing arrangements for immunisation services
- better understanding immunisation behaviours.

A4 Caring for older New Zealanders

The Government is focused on ensuring older New Zealanders' care is of a high quality.

The Ministry has given priority to:

- boosting respite care – investing an additional \$5 million a year, specifically targeted at dedicated respite-care beds
- monitoring rest homes – reviewing aged-care residential-care auditing, introducing spot-auditing procedures and making audit results available to the public
- improving certainty of funding – requiring DHBs to index the subsidy paid for older people in care to the annual Forecast Funding Track adjustment
- developing the aged-care workforce – supporting the establishment of an industry training organisation for aged-care that is specific to the sector, and improving the quality of supervision and nursing in rest homes by providing an additional \$18 million a year to help rest homes support and retain nursing staff
- improving home-based care – reviewing inconsistencies in the way DHBs contract for home-based aged-care services, and initiating a stocktake of auditing processes, travel payments, remuneration and training
- preparing for the future – reviewing the costing model for aged-care services as part of a wider plan to make sure sufficient capacity exists to meet the needs of our ageing population.

B: Strengthening health services we can trust

The Government introduced six new health targets:

- shorter stays in emergency departments
- improved access to elective surgery
- shorter waits for cancer treatment
- increased immunisation
- better help for smokers to quit
- better diabetes and cardiovascular services.

Each of these targets has measurable goals attached to them and significant improvements have already been made in several of these areas. For example, the target within elective services was to increase volumes by an average of 4000 cases year-on-year – a target that was significantly out-performed.

B1 Achieving value for money

Throughout 2008/09 the Ministry continued its efforts to get greater value for money from the public health sector. Many of these efforts are described below. A new measure introduced during the year was to get DHBs to describe their efficiency initiatives so that all DHBs can learn from the work undertaken in this area. The results of these efficiency initiatives will be available in 2009/10. The Ministry also evaluated DHB productivity in the 2009/10 round of district annual plans and checked output growth against demographic funding growth. The Ministry followed up with DHBs where output growth appeared poor.

Elective services

Improving access to elective services is a key government priority and reflects the need to fund services that provide the maximum benefit for patients from the funding available. Performance during the last year has been excellent: there has been an increase of 11,800 (10 percent) elective surgical discharges compared with 2007/08. This is a significant improvement on recent years.

The Ministry is also working to implement the Government's goal of 20 new elective surgical operating theatres, in the public sector, to meet future demands for elective services.

Along with increasing the delivery of elective surgery, improving access to specialist care by finding alternative pathways to treatment or outpatient assessment is a core component of the elective services strategy. Progress has been made, in the last year, in supporting primary care direct access to diagnostics, with the funding of 14 pilots and a diagnostic symposium. Work has also been undertaken to support direct access for GPs to elective treatment lists (where appropriate), and the development of alternative first specialist assessment models. In 2008/09 \$10 million was made available to fund additional first specialist assessments and elective procedures in outpatient settings.

There has been a continued focus on improving information supplied by DHBs to the Ministry. This information ensures the Ministry can monitor whether patients are being managed effectively.

There has also been progress implementing improved criteria for clinical prioritisation. In 2008/09, the Ministry has worked with the New Zealand Association of Plastic Surgeons, the New Zealand Society of Otolaryngology, Head and Neck Surgery and the Cardiac Society of Australia and New Zealand – New Zealand Branch, to update national prioritisation tools.

Cancer treatment

The new Government placed significant emphasis on improving services for people with cancer. During the second half of the financial year, the Ministry worked hard to implement several cancer-related initiatives as part of the 100 days of action. Extending publicly funded Herceptin for eligible women with early stage breast cancer was implemented by Christmas 2008. The Ministry also oversaw a programme of work with six DHBs to reduce waiting times for radiation oncology treatment. The Government also boosted funding for hospices.

Diabetes and Cardiovascular Disease Quality Improvement Plan

The Diabetes and Cardiovascular Disease Quality Improvement Plan is a clinically led action plan that identifies priorities and recommends immediate, medium and long-term actions to achieve continuous improvement of services for people with diabetes and cardiovascular disease. A sector steering group was established to oversee implementation of the Plan, and this group identified a number of priorities, which were progressed in 2008/09, the first year of implementation.

One priority was a New Zealand model of diabetes/cardiovascular disease, developed using health system dynamics modelling. In addition, the Ministry updated the Cardiovascular Risk Guidelines Handbook, and PHARMAC began implementation of One Heart Many Lives, a primary prevention programme on cardiovascular disease targeting Māori and Pacific peoples who are at high risk of this disease.

DHB and Crown entity performance

The Ministry closely monitored DHBs' financial and non-financial performances, and compared these performances against their respective district annual plans. As a result of this continual monitoring, the following DHBs had their monitoring status changed in 2008/09:

- Auckland, from Performance Watch to Standard Monitoring
- Otago, from Standard Monitoring to Performance Watch
- Hutt Valley and West Coast, from Performance Watch to Intensive Monitoring.

Quarterly reports for non-DHB health Crown entities were reviewed by the Ministry and reported on to the Minister and Associate Minister, and appropriate actions were taken. These reports provide the formal account of Crown entity performance, which is part of a larger framework of active engagement with entities to improve performance. One example of this is the New Zealand Blood Service financial sustainability project, finalised in October 2008, the results of which are being progressively implemented.

Review of Population-Based Funding Formula

The Ministry completed the policy review of the Population-Based Funding Formula in October 2008, and the results were approved by Cabinet. The Ministry also completed a technical update in November 2008, and this was approved by the Ministers of Health and Finance. The review was completed on time and with no major issues.

Service Planning and New Health Interventions Assessment (SPNIA) framework

The SPNIA framework aids collaborative decision-making between individual DHBs and the Ministry on service-planning changes and the introduction of new health interventions. All SPNIA projects progressed satisfactorily. During the year the National Services Technology Review Advisory Committee completed recommendations for two business cases (photodynamic therapy and transcatheter aortic valve implantation), and recommendations were forwarded to the

Ministry's Executive Leadership Team and DHB chief executive officers for consideration. Work on another four business cases commenced in 2008/09, and these are expected to be completed in 2009/10.

The Ministry supported a review of the SPNIA framework by Professor Stephen Munn, of Auckland DHB. It was completed in June 2009.

DHB and Crown entity ownership advice

The Ministry provided a wide variety of advice on the Government's ownership interest in DHBs and other health Crown entities. This included advice on topical sector issues (such as community laboratory testing in the Auckland region, fraud in the health sector, sector employment relations and the Population-Based Funding Formula) and new government policies (such as the cap in back-office staff at DHBs).

The Ministry also provided advice on accountability documents, such as district annual plans and statements of intent, following significant engagement with DHBs and other health Crown entities. Appointments to DHB and other health Crown entity boards were made, along with advice on strengthening DHB governance, with the goal of improving governance-level performance in the sector.

Other initiatives

Other initiatives were started, including:

- implementation of a 'road map' for improving hospital productivity
- a review of public/private protocol to ensure we can make smarter use of the private sector to work alongside public hospitals. To assist this, the Ministry established a private sector desk and is actively working alongside private providers to encourage better relations.

B2 Improving quality

The Ministry has two main work areas promoting quality and safety for patients and consumers of health and disability services, as well as innovation and improvement of services throughout the health sector.

The underpinning philosophy of this work is that the most important quality improvement activities are frequently those planned and undertaken by frontline staff. DHBs were asked to develop specific outputs and outcomes in their district annual plans (DAPs) for clinical leadership based on the findings of the Ministerial Taskforce's report *In Good Hands*. Because the greatest risks are in the public hospital part of the health care system, the Ministry has initiated a co-ordinated national approach to quality improvement to address public hospital quality and safety issues.

The Releasing Time to Care programme

The Ministry is working with DHBs on the programme Releasing Time to Care – The Productive Ward, which focuses on helping nurses and therapists spend more time on patient care, thereby improving safety and efficiency. Some immediate results were:

- direct patient care time increased from 39 percent to 57 percent in three months
- the reorganisation of ward environments reduced unnecessary staff movements from 18 percent of a nurse's day to 8 percent of a nurse's day in three months. This means 10 percent more time can be spent on patient care
- falls reduction – a DHB ward that had the highest rate of falls in their DHB used the programme and consequently had a 50 percent decrease in falls per month.

The Health Innovation Awards

The Health Innovations Awards were held in November 2008 as part of the INNOV'08 conference, with an increased number of attendees, and many successful innovations and improvements showcased.

Quality Improvement Committee

Health care has become increasingly complex. It is therefore vital to focus on people and quality improvement. To address quality improvement issues, five Quality Improvement Committee improvement projects were implemented during the year. They included optimising the patient journey (patient flows), management of health care incidents, infection prevention and control, safe medications management, and national mortality review systems. They are briefly described below.

- Optimising the patient journey – There are 11 DHB sites piloting the Whai Manaaki/Optimising the Patient Journey methodology and tools. This programme provided six two-day collaborative events that took place at three-month intervals, providing training in methodology, tools and data.
- National health care incident management – The national policy was drafted and is being implemented in DHBs and some other health and disability services. Fourteen DHBs participated in training and education events during the year.
- Infection prevention and control – DHBs were positively engaged in the programme, with about half formally committed to participate. The lead DHB (Auckland) has been implementing a national policy for incident management. There were also several support initiatives, including the development of a website, guidelines, other printed resources, and a PDA-data solution with support.
- Safe medications management – Multidisciplinary working groups were established, with more than 60 clinicians from 21 DHBs. They included consumer and primary health care representation.
- National mortality review systems – The Child and Youth Mortality Review Committee is setting up local review groups, which will soon be operating in 21 DHBs to review the deaths of young persons. Local quality improvement results are already evident, and more are expected as the groups become established.

The Family Violence Death Review Committee has established processes of notification and is currently designing data collection and storage systems. Pilot death reviews have been undertaken, with more planned in 2009/10 to refine the process.

The Perinatal and Maternal Mortality Review Committee produced the second annual report to the Minister of Health, Perinatal and Maternal Mortality in New Zealand 2006. An observational audit of neonatal encephalopathy has been developed and data is being collected on a monthly basis because the Committee has identified this as an area of potential improvement.

The Ministry has postponed the establishment of the Perioperative Mortality Review Committee pending the outcome of the Ministerial Review.

Serious and sentinel events

The Quality Improvement Committee released the second Serious and Sentinel Events Report on health incidents occurring from 1 July 2007 to 30 June 2008. The report was released on 23 February 2009 and received considerable media attention. The Committee plans to release its third report in November 2009 for incidents occurring from 1 July 2008 to 30 June 2009, along with an in-depth analysis of the full data set collected over the last three years.

B3 Strengthening regional and national collaboration among DHBs

Each DHB is accountable for planning and funding services to ensure its resident population has access to the services they require. However, because no single DHB has all the services locally that its population needs, collaborative planning of regional and national services are essential.

The Ministry supports DHB planning by providing strategic leadership, expert advice, tools and information, and by ensuring there are appropriate regional and national structures and processes to support DHB planning.

During 2008/09 the Ministry continued to encourage DHBs to build on and develop regional collaboration. The DAP round is a critical mechanism for encouraging DHBs to further their collaboration. DAPs go through two phases of review and advice by the Ministry, with feedback to and amendment by DHBs, before the DAPs are submitted to the Minister. In the most recent DAP round all DHBs have specifically documented their approaches, which included regional clinical service planning and joint appointments to key positions.

In addition to this the Ministry has an ongoing work programme considering a wide range of issues around health sector collaboration, planning and sustainability. A number of initiatives aimed at strengthening regional and national collaboration were progressed with DHBs in 2008/09, including:

- vulnerable services – assessment and action
- developing of clinical networks – supporting emerging clinical networks and developing policy advice
- supporting DHB activity on regional planning of clinical services
- supporting regional and national service development in priority areas (eg, cardiac surgery, maternal foetal medicine, paediatric rheumatology)
- supporting DHB planning to manage assets
- costing of new models of care (based on the Central Region Clinical Services Plan), which provides information on the impact of costs to inform service planning.

C: Enabling a strong, sustainable health sector for the longer term

A strong and sustainable health sector can only be built through closer relationships within the sector to enable the spread of innovative ideas and practices. The Ministry has focused on sharing innovations and information across the sector to drive capability and innovation by:

- strategically developing the health sector workforce
- building seamless systems for health information and communication
- optimising the development of capital infrastructure.

C1 Strengthening the health sector workforce

The health system's workforce is its greatest resource and accounts for 68 percent of public health expenditure. A strong, sustainable health sector requires a flexible workforce that is able to respond to changing demands.

The Ministry ensures that the policy and regulatory environments support the Government's strategic workforce objectives, and provides leadership to the sector in achieving those objectives. The Ministry's workforce development priorities have changed with the incoming Government. There is a new emphasis on increasing workforce supply to meet service demand and retaining health workers in New Zealand.

As part of the Government's 100 day priority action plan, the Ministry developed and implemented the Voluntary Bonding Scheme to encourage doctors, nurses and midwives to work in hard-to-staff communities and specialties. This scheme offers payments against student loans, or payments directly to those without a student loan, to registrants who work in hard-to-staff areas for three to five years. The scheme was launched on 23 February 2009 and received widespread support across the sector. Registrations exceeded targets, with 115 doctors, 683 nurses and 95 midwives confirmed, against an original target of 100 doctors and a total of 250 nurses and midwives.

Regulations were passed to enable four elected practitioners to be appointed to the Medical Council of New Zealand, and elections were held in February 2009. Regulations are also being made to enable elected membership on the Nursing Council of New Zealand. Elected membership on regulatory authorities will ensure health practitioners have greater input into decisions affecting competence, scopes of practice and safety.

In order to meet the growing demand for health and disability services, greater productivity needs to be achieved by using the workforce more effectively. To do this, unnecessary barriers and constraints to workforce innovation and flexibility must be identified and removed. The Ministry has reviewed all existing Acts of Parliament and identified 59 that contain barriers to workforce innovation. The Ministry will work with clinicians and DHBs to determine which barriers are unnecessary and should be removed.

The review of the operation of the Health Practitioners Competence Assurance Act 2003 was completed and the Director-General's report was tabled in Parliament on 4 June 2009. The review found that the Act is generally operating as intended and is viewed positively by the sector. However, the Director-General recommended 17 legislative amendments to clarify the Act's interpretation and improve its operation. The report includes a number of other recommendations for responsible authorities, the Ministry, DHBs and others to improve the efficiency of processes that have been set up under the Act. A further review of the Act will be carried out in 2012.

Work continued on the Career Framework to include the disability workforce. Consultation with the disability sector confirmed support for the Framework as the preferred conceptual model for workforce development in the disability sector. This model has been used to define career pathways for the disability support workforce, and as a guide for mapping disability support roles and qualifications to a training framework for the care and support workforce.

As part of the Maternity Action Plan, specific actions were focused on ensuring there is a skilled maternity workforce in New Zealand.

C2 Building seamless systems for health information and communication

Information management and information and communication technology (ICT) support the health system. Initiatives undertaken by the Ministry aimed at achieving the outcome of building seamless systems for health information and communication have focused on:

- providing a quality information infrastructure
- ensuring the availability of systems
- developing new business applications.

The following initiatives have contributed to the delivery of outputs aimed at this outcome, and these are described in more detail below:

- the National Systems Development Programme is a four-year initiative to deliver improved and sustainable national payment, information and connectivity systems that interact more efficiently. The initiative consists of the following programmes and workstreams:
 - **Connected health programme** – creating a network to improve the flow of health information and sharing of services and applications
 - **Access and integration worksteam** – providing the infrastructure for the delivery of national systems and secure information exchange between the Ministry and health care providers. A key achievement in 2008/09 was implementing data-hosting centres
 - **Health statistics and reporting** – focusing on key areas of operational risk relating to national data warehouses managed by the Ministry for the health sector. One key achievement is the reduced down time for system recovery (from one to two days to less than two hours) and backup of national data collections (from 27 hours to less than two hours)
 - **Recipient and provider identity services** – ensuring the high quality of the National Health Index, Health Provider Index and address reference data. It also ensures these are accessible across the health system by implementing a modern infrastructure platform, new business processes and support systems
 - **Health payments system** – improving the efficiency and effectiveness of health payment processes, while reducing the risk of fraud. Key achievements for 2008/09 included:
 - developing a single reporting source for 65 percent of payment data, making it quicker and more straightforward for DHBs to carry out analyses
 - reducing monthly payment runs from 200 batches to 40 batches, freeing up 80 operations staffing hours per month
 - enhancing PHARMAC systems to make prescribing generic drugs easier, with potential cost savings of several million dollars per year
 - developing an online platform to allow pharmacists to make payment claims online resulting in reduced administration costs and improved cash-flow for pharmacists

- transaction turnaround times for health payments and agreements transactions were significantly reduced, and the volumes for many payment types increased – with no increase in staffing
- establishing a National Contact Centre to consolidate payment services for health providers and requests for national health data. The Centre produced regular reports to DHBs for monitoring and planning purposes, and responded to requests from researchers and the general public for national health data and statistics. The Centre successfully processed more than 790,000 calls during the 2008/09 year (up 2.7 percent on the previous year).

National Mental Health Information System

Technical components were rolled out to DHBs and non-governmental organisations providing mental health services that will report data to the information system. This will provide a picture of national use and effectiveness of mental health services.

Joint initiatives with other government agencies

The Ministry is working with other government agencies to establish a contract for networking services to replace the government shared network. This service, referred to as One.Govt, is provided by private companies through the Department of Internal Affairs and offers the potential for significant savings across government. It also allows for other agencies (such as DHBs) to join and achieve improved pricing benefits.

The Ministry is working with the Ministry of Economic Development to cover the needs of the health sector on the proposed new broadband investment initiative.

C3 Optimising the development of capital infrastructure

Capital, when in partnership with effective service planning, is a strong driver of improvements in DHB performance. The Ministry has strengthened links between service planning and capital investment. For example, the Asset Management Improvement programme has delivered a framework for asset management that encompasses health service planning.

A national asset management plan for DHBs is on track to be completed in September 2009, in line with The Treasury's capital asset management expectations. Regional asset management plans are due to be finalised in August 2009. An implementation plan for the development of Integrated Family Health Centres has also been completed. Highlights in 2008/09 include:

- approval for a business case to redevelop New Zealand's oral health infrastructure
- collaborating with Australia on the development of health facility design guidelines
- a capital action plan to support the 20 new elective public sector surgical operating theatres.

D: Other Ministry operational priorities

The Ministry has a range of other ongoing operational priorities and outcomes, focusing on:

- improving Māori health
- reducing inequalities
- supporting health and wellbeing through nationally funded services.

D1 Improving Māori health

The Ministry recognises the critical role Māori and mainstream providers play in improving Māori health. Therefore, the Ministry continued its dual focus on strengthening and sustaining the service quality provided by Māori providers, and enhancing the effectiveness of mainstream services to achieve positive gains in Māori health outcomes.

During the year, the Ministry met with a large number of providers to identify priorities for action as well as focusing on implementing the He Korowai Oranga: Māori Health Strategy. The work included:

- funding case studies of whānau ora-based models. Te Toi Hauora Nui project looked at nine Māori providers and the way they worked to support and empower whānau and improve health outcomes, with particular reference to cardiovascular and diabetes care and management. The case studies will be released in the first quarter of 2009/10
- using the Māori Provider Development Scheme to build the capacity and capability of Māori health providers, including supporting workforce development. This included providing 580 Hauora Māori Scholarships covering undergraduate and postgraduate qualifications in nursing, midwifery, medicine, physiotherapy, dentistry, pharmacy and health management
- evaluating the Māori Provider Development Scheme. The evaluation confirmed the effectiveness of the scheme as well as identifying opportunities for consolidating and improving the scheme.

Rongoā – Paepae Matua mo Rongoā (the ‘Collective’)

The Ministry continues to support the development of the Collective in line with Taonga Tuku Iho – Treasures of Our Heritage: Rongoā development plan. The focus in 2008/09 has been to strengthen regional leadership, particularly planning and decision-making processes.

Governance: training and development

The Ministry continues to support governance training and development for Māori members of DHBs, Māori partnership boards, DHB staff, Māori PHO board members, and iwi/Māori health organisations.

Research and evaluation

The Ministry has continued to produce research and statistical information, including an easy-to-use web resource to provide an accessible source of Māori health statistical information (see www.maorihealth.govt.nz). The Ministry also continues to support the Māori health review (see www.maorihealthreview.co.nz), an online monthly publication for disseminating Māori research findings.

Negotiations towards a settlement of the Waitangi Tribunal claim number 692

The Deed of Settlement was signed between the claimants, the Crown and Hawke’s Bay DHB on 3 October 2008. Settlement assets were transferred on or before 2 June 2009, completing settlement of the claim.

Māori mental health and addiction

Implementation of the Forensic Services Future Directions Framework is nearing completion. The report has significance to Māori as more than half of forensic service users are Māori.

D2 Reducing inequalities

As this year's State of Public Health Report (see Part 3) shows, inequality has a major influence on health outcomes. Accordingly, the Ministry has engaged in a variety of activities intended to reduce inequalities. These included raising awareness and understanding of health inequalities, and promoting an intervention framework and health equity tools to complement the framework. Other activities included funding of services to improve access and the reorientation of child and adolescent oral health services. In December 2008, new public health physician training specification and costs were applied.

D3 Supporting health and wellbeing through nationally funded services

Supporting nationally funded services was a priority for the Ministry because of the value, size and scope of the services purchased. The efficient expenditure of \$2.7 billion during 2008/09 on a range of services added enormously to bettering the health and independence of New Zealanders, reducing inequalities, and enhancing trust and security.

In managing the supporting health and wellbeing output through nationally funded services, the Ministry undertook:

- annual service planning
- annual programmes of service development activity
- purchase management
- performance management
- a programme of evaluation.

Depending on the size and scale of each service purchased, service plans of varying detail were prepared that described the generic outcomes to be achieved, key drivers, services to be purchased, specific outcomes and outputs, and the implications for resources. The Ministry used guidelines and standards for these processes to ensure consistency and quality in the management of non-departmental expenditure. The range of services purchased included:

- disability support services for people with a long-term physical, intellectual and/or sensory impairment requiring ongoing support – these were generally for disabled people under the age of 65
- personal and public health services, including immunisation, injury prevention, nutrition, physical activity, tobacco control, elective services, emergency ambulance services, Well Child services and HealthLine
- population screening programmes
- workforce development and provider capability
- developing and disseminating information supporting health and disability support services.

Our organisation

Over 2008/09 the Ministry consolidated the structural changes made in 2007, aimed at improving the quality of advice provided to the Minister of Health, improving its working relationships with DHBs, and providing greater leadership to the sector. The Director-General of Health is supported by eight Deputy Directors-General who lead the following directorates:

- Health and Disability Systems Strategy
- Māori Health
- Population Health
- Sector Capability and Innovation
- Health and Disability National Services
- Sector Accountability and Funding
- Information
- Corporate Services.

The Ministry's Executive Leadership Team has overall responsibility for providing corporate governance, strategic direction and leadership across the Ministry.

The Ministry's staffing levels fluctuated around 1430 full-time equivalent staff throughout the 2008/09 year. This was considerably below the Ministry's establishment level, which was set at 1675 from 31 December 2008 as part of the Government's intention to cap core administration. The Ministry chose to operate at that level and reviewed its work programmes and resource levels in order to achieve its work programme outputs while utilising a lower resource base.

Organisational health and capability

Attraction, commitment and EEO

The Ministry completed a review of costs associated with recruitment and how efficiencies could be gained to assure value for money. This was done by negotiating standard placement fees with all agencies. Cost efficiencies in recruitment also included a review of advertising resulting in savings of over \$1 million. Both these initiatives contributed to ensuring that the Ministry attracted a broad range of applicants for vacant positions.

The recruitment process was also reviewed. New recruitment tools were implemented, which are designed to help hiring managers assess candidates against key selection criteria.

Healthy workplaces

The Ministry has implemented a wellness strategy, which includes initiatives such as Walk the Talk, a programme aimed at employees working in teams to focus on physical fitness. It has also continued other existing Ministry initiatives such as the Influenza Vaccination Programme.

ACC audited the Ministry in August 2008 and the Ministry gained secondary accreditation as part of the ACC Partnership Programme. This programme gives employers significant discounts on their ACC levies in exchange for taking responsibility for employee work injury claims. As first-time achievers of this level within the programme, the Ministry implemented health and safety education programmes, communicated latest thinking bulletins, and drove health and safety as an important aspect of employee engagement.

Learning and development

Implement supporting tools for the Ministry's Management and Leadership Framework

Ministry employees became accredited in the Lominger Framework – an internationally recognised tool for developing employee competencies. This accreditation will enable the Ministry to align its competencies to this framework in 2009/10. The Lominger Framework is recommended by the State Services Commission as the preferred competency model for the public sector. The Ministry also gained accreditation in other management development tools such as DISC, and actively supported a culture of mentoring and career development as a means of increasing the performance of the organisation overall.

Centralising the availability of secondments internally and across the health sector

This initiative is crucial to ensuring the organisation retains key employees and intellectual property. The Ministry has looked for opportunities within the health system and collaborated with public service agencies in an effort to work for the common good. To that end the Ministry seconded 39 employees, including into both internal and external placements into the Ministry and ministerial offices.

Managing in a changeable operating environment

The approach underlying the Ministry's Risk Management Programme is based on the Australia–New Zealand Risk Management Standards (AS/NZS 4360). The key objectives of the Risk Management Programme in 2008/09 were to ensure:

- an environment in which all employees assumed responsibility for managing risk
- risk management practices were embedded in decision-making processes
- risks faced by the Ministry were identified and assessed using a consistent approach
- risks were prioritised and resources for management allocated appropriately.

The Ministry ensures that all risks are identified and managed appropriately so that business objectives and potential opportunities are realised. Mitigation strategies varied depending on each individual risk, and included both existing practices (controls) and planned actions. Sources of risk at the Ministry included: financial, contractual, service delivery, human resource, political environment, public perception, technology, security, natural events and privacy risks.

The Ministry's Executive Leadership Team and the Audit, Finance and Risk Committee had oversight of Ministry-wide risks and were provided risk reports via the Risk Management Programme and its associated reporting structure through the directorates. The Ministry's Risk and Assurance Team provided senior management with independent assurance and information on the governance and stewardship of the Ministry.

The dispersed nature of the assurance activity throughout the Ministry had been identified as a risk. The strategy to manage this risk was to develop an assurance map reporting cycle to provide information and oversight of assurance across the Ministry and how assurance activity was aligned to risk. The first steps in the development of this were made in 2009, and will continue in 2009/10.

The 2006 Ministry Review identified the need for enhanced strategic planning to anticipate future pressures in the health system. As a result, the Long-Term System Framework programme was established, an initial environment scan of the next 20 years was undertaken (in 2008), and ongoing horizon scanning was strengthened.

The Ministry's operational risks were effectively managed, and the policies, practices, procedures and controls were sufficient to reduce operational risks to acceptable levels.

Emergency preparedness

The Ministry met its key statutory and non-statutory emergency preparedness obligations over 2008/09, which required it to:

- be capable of continuing to the fullest extent possible in an emergency
- have the capability and capacity to respond in an emergency as required
- provide leadership and co-ordination for the health sector in planning and preparing for, and responding to, a health emergency
- lead the all-of-government response to a national health emergency, such as a pandemic.

The emergency preparedness work programme is strongly focused on increasing the capability and capacity of the health sector to deal with health emergencies. The Ministry maintains strong links with other government agencies in delivering its emergency management responsibilities.

The health sector has been responding to the impact of the Influenza A, (H1N1) 'Swine Flu' pandemic since April 2009. The Ministry activated the National Health Co-ordination Centre on 25 April 2009 to support operations across the health sector through national co-ordination. As Lead Government Agency, the Ministry has also coordinated the all-of-government response from the Centre. The pandemic has required a significant level of health sector activity at the local, regional and national level in an effort to minimise the impact of the pandemic on New Zealand.

Part 2: Service Performance and Financial Summary

Statement of responsibility

In terms of section 45C of the Public Finance Act 1989, I am responsible, as Director-General of Health, for the preparation of the Ministry's financial statements, statement of service performance and the judgements made in the process of producing those statements.

I have the responsibility for establishing and maintaining, and I have established and maintained, a system of internal control procedures that provide reasonable assurance as to the integrity and reliability of financial reporting.

In my opinion, these financial statements fairly reflect the financial position and operations of the Ministry for the year ended 30 June 2009.



Andrew Bridgman
Acting Director-General of Health
28 September 2009



Richard Morris
Chief Financial Officer
28 September 2009

Audit Report

To the readers of the Ministry of Health's financial statements and statement of service performance for the year ended 30 June 2009

The Auditor-General is the auditor of the Ministry of Health (the Ministry). The Auditor-General has appointed me, Andy Burns, using the staff and resources of Audit New Zealand, to carry out the audit. The audit covers the financial statements and statement of service performance included in the annual report of the Ministry for the year ended 30 June 2009.

Unqualified Opinion

In our opinion:

- The financial statements of the Ministry on pages 52 to 82:
 - comply with generally accepted accounting practice in New Zealand; and
 - fairly reflect:
 - the Ministry's financial position as at 30 June 2009;
 - the results of its operations and cash flows for the year ended on that date;
 - its expenses and capital expenditure incurred against each appropriation administered by the Ministry and each class of outputs included in each output expense appropriation for the year ended 30 June 2009; and
 - its unappropriated expenses and capital expenditure for the year ended 30 June 2009.
- The schedules of non-departmental activities on pages 83 to 94 fairly reflect the assets, liabilities, revenues, expenses, contingencies, commitments and trust monies managed by the Ministry on behalf of the Crown for the year ended 30 June 2009.
- The statement of service performance of the Ministry on pages 29 to 51:
 - complies with generally accepted accounting practice in New Zealand; and
 - fairly reflects for each class of outputs:
 - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance adopted at the start of the financial year; and
 - its actual revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses included in the statement of forecast service performance adopted at the start of the financial year.

The audit was completed on 28 September 2009, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Director-General of Health and the Auditor, and explain our independence.

Basis of Opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Director-General of Health;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Director-General of Health and the Auditor

The Director-General of Health is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Ministry as at 30 June 2009 and the results of its operations and cash flows for the year ended on that date.

The financial statements must also fairly reflect the expenses and capital expenditure incurred against each appropriation administered by the Ministry and each class of outputs included in each output expense appropriation for the year ended 30 June 2009. The financial statements must also fairly reflect the Ministry's unappropriated expenses and capital expenditure for the year ended on that date.

In addition, the Director-General of Health is responsible for preparing schedules of non-departmental activities, in accordance with the Treasury Instructions 2008 that must fairly reflect the assets, liabilities, revenues, expenses, contingencies, commitments and trust monies managed by the Ministry on behalf of the Crown for the year ended 30 June 2009.

The statement of service performance must fairly reflect, for each class of outputs, the Ministry's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses adopted at the start of the financial year.

The Director-General of Health's responsibilities arise from sections 45A and 45B of the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and section 45D(2) of the Public Finance Act 1989.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

Other than the audit, we have no relationship with or interests in the Ministry.



A. P. Burns
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Matters Relating to the Electronic Presentation of the Audited Financial Statements and Statement of Service Performance

This audit report relates to the financial statements and statement of service performance of the Ministry of Health for the year ended 30 June 2009 included on the Ministry of Health's website. The Chief Executive is responsible for the maintenance and integrity of the Ministry of Health's website. We have not been engaged to report on the integrity of the Ministry of Health's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website. The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated October 2009 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.

Statement of Service Performance for 2008/09

Statement of objectives

The generic quantity, quality and timeliness performance measures for all policy advice and briefings supplied by the Ministry of Health follow.

Quantity

Policy advice and briefings will be supplied on the basis agreed between the Minister of Health and the Director-General of Health. Unanticipated briefing requests will be supplied to the Minister as requested.

Quality

Policy advice will comply with the Ministry of Health's standards for policy advice. Briefings and advice will:

- be clear, concise and logical
- be factually accurate, practical and complete
- have a clear statement of purpose
- be presented in the correct format
- consider options and implications
- consider legal, financial and health service implications
- meet Cabinet Office requirements, where relevant
- comment on intersectoral implications
- be peer reviewed
- follow quality processes for briefings, recorded through the use of audit trails.

The quality assurance procedures followed for ad hoc ministerial advice will depend on the type of advice and the timeframe in which it is requested. All advice will be signed out in accordance with delegated authority. This advice includes:

- feedback from the Cabinet Office on compliance with standards for Cabinet papers
- peer review to ensure that standards for policy advice are met
- feedback from the Minister on specific advice tendered
- regular meetings between the Minister and senior staff, and quarterly reports to the Minister on the Ministry's progress against project outputs.

Timeliness

Timeframes for policy projects will be met as agreed between the Minister of Health and the Ministry, unless modified with the Minister's agreement. Short-term and ad hoc ministerial requests will be supplied within the required timeframes. The Ministry manager who is responsible for preparing the request monitors timeliness.

Cost

The out-turn for the year is within budget, in accordance with the Financial Statement of Objectives.

Departmental output expense: administration of funding and purchasing of health and disability support services

This departmental output expense contributes to system and societal outcomes by funding and purchasing health and disability support services on behalf of the Crown. The services funded and purchased include some disability support services, public health services, specified screening services, mental health services, national personal health services, Māori health services, and postgraduate clinical education and training.

In relation to these services, this departmental output expense provides for the Ministry to:

- provide leadership of the broader health sector through implementation of ministerial and Cabinet decisions, policy and strategy development, and enhanced sector accountability
- fund services, including negotiating service agreements, provider audit and monitoring against contracts, and national quality standards
- ensure the effective utilisation of services funding, and analyse expenditure and service trends to inform budget monitoring.

Output	Quantity	Quality	Timeliness
Administration of funding of health and disability support services			
The Ministry will plan, fund, purchase and monitor contracts for mental health and addiction services including problem gambling, alcohol and drugs and primary mental health	An estimated 100	Ministry standard purchasing measure	30/06/09
	Actual: 100	Actual: Achieved	Actual: Achieved
Māori Provider Development Scheme			
Administration of the Māori Provider Development Scheme	Funds allocated to successful applicants across four categories	Decisions on the allocation of funds will be in line with guidelines of the Māori Provider Development Scheme	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Performance management			
For each contract and provider; contract is managed, relationship is managed, issues are managed	100% of contracts	All contracts are monitored; all complaints acted on, active management of relationships with all providers; management of issues as they arise	Ongoing through the life of the contract
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Purchase management			
Services are purchased (repurchased) according to the relevant purchase plan	All funded services as they come up for contract renewal and all new services	Sound contracts awarded through a transparent process that conforms to Ministry standards, and includes the involvement of the relevant users or their representatives and the relevant sector representatives	Services are contracted for according to the timeframes within the relevant purchase plan
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Reduce inequalities			
The incorporation of improved outcomes for disadvantaged groups into the delivery of services	The service plan, service descriptions and purchase plans all identify outcomes and measures for disadvantaged groups	Strategic inequality outcomes and targets are agreed	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Service development			
An annual programme of activity to improve the outcomes of the services that are purchased	One programme of activity with all services being purchased clearly described and with a purchase plan	Purchase plans conform to Ministry standards Relevant users and sector groups will be involved in the process of developing the service specifications	Purchase plans will be completed before service purchasing commences Where they are prompted by a contract expiring a purchase plan will be completed before that expiry
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Cost

Actual 30/06/08 \$000		Actual 30/06/09 \$000	Main estimates 30/06/09 \$000	Supp. estimates 30/06/09 \$000
28,414	Crown Revenue	28,541	32,451	28,541
531	Third Party Revenue	320	21	281
28,945	Total Revenue	28,861	32,472	28,822
28,874	Total Expenditure	27,325	32,472	28,822
71	Net surplus	1,536	-	-

Departmental output expense: administration of legislation and regulations

This departmental output expense contributes to system and societal outcomes by administering legislation and regulations and meeting legislative requirements. This is required to administer and enforce statutory obligations, and to meet health-specific legislative requirements.

In relation to these services, this output expense provides for the Ministry to:

- support passage of the Public Health Bill
- implement and enforce health system accountabilities under the New Zealand Public Health and Disability Act 2000
- develop an enhanced regulatory framework for quality and safety, and oversee its rapid uptake and implementation through the DHB system
- promote improvement in public health and safety through statutory obligations set out in the Health Act 1956 (to be strengthened by the development of the Public Health Bill), the Radiation Protection Act 1965, the Medicines Act 1981, other public health statutes that provide for communicable disease control, and environmental health (including border control)
- lead the whole-of-government response in preparing for, and responding to, health emergencies requiring a government (national) response as described in the Civil Defence and Emergency Management Act 2002
- discharge the obligations and meet the health-specific requirements of statutes
- implement Te Kōkiri through the administration of legislative and statutory obligations and the protection of human rights for those affected by mental illness
- promote continuous improvement in the provision of safe and quality-focused health and disability services through statutory obligations set out in the Health and Disability Services (Safety) Act 2001
- promote improvement in health and disability outcomes for people with severe intellectual disability through statutory obligations set out in the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Output	Quantity	Quality	Timeliness
Administration of New Zealand's international and World Health Organization obligations			
Maintain relationship between the Ministry and OECD, UN, WHO, APEC, Commonwealth Secretariat, AHMC/AHMAC, and Commonwealth Fund, and implement International Health Regulations (IHR) requirements	IHR Implementation Report to WHO	Support New Zealand's membership of WHO Executive Board Effective functioning of national focal point for IHR	Ongoing, as required
	Actual: Achieved	Actual: Achieved	Actual: Achieved
An effective legislative and policy environment for improving, promoting and protecting public health			
Progress Public Health Bill, provide leadership to designated officers in DHBs/PHUs, and strengthen networks/collaboration with other sectors	Provide professional leadership to the designated officers in DHBs/PHUs Provide advice to other key agencies on actions to improve public health	Provide quality and timely advice to the Minister and Health Select Committee to enable progress of the Public Health Bill	As required – subject to Parliamentary process
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Emergency management			
To meet the Ministry's statutory obligations under the National Civil Defence Emergency Management Act 2002, and the National Civil Defence Emergency Management Plan Order 2002	Compliance ongoing due to the ad hoc nature of emergencies, response is as required	Meets the statutory requirements	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Lead and co-ordinate New Zealand's planning and response to a national emergency with a significant health component	At least six interagency meetings held and one plan updated	Evaluation of regular exercises review of emergency plans and standard operating procedure	Ongoing
	Actual: Achieved	Actual: Achieved	Actual: Achieved
HealthCert			
Management of enforcement/complaints made under Health and Disability Services (Safety) Act 2001	An estimated 135 responses (demand driven)	95% of responses responded to within 7 days 95% of reports completed within 30 working days of an investigation audit being completed and obtaining all relevant information obtained	30/06/09
	Actual:189	Actual: Achieved	Actual: Achieved
Legislation and policy			
Administration of legislation, currently these are Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and Part 4A of the NCSP Register	Service capacity is maintained so that services are available for persons subject to compulsory care orders under the Acts	Legislative requirements met	Ongoing, as required by orders of the court
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Radiation protection services and emergency management			
Radiation Protection Act 1965: Licensing of persons to use irradiating apparatus and/or radioactive material	An estimated 3300 licences per year	95% to be completed within 10 days of receipt of all required information	30/06/09
	Actual: 3375	Actual: 99.7%	Actual: Achieved

Output	Quantity	Quality	Timeliness
Regulation of medicine and medical devices			
Evaluate applications to market new and changed medicines and to carry out clinical trials	100% of changed medicines notifications and clinical trial applications will receive response within 45 days New medicines applications received after 21 August 2006 will receive a response within 135 days	Consistency with international standards for the safety, quality and efficacy Medsafe will utilise established peer review procedures and advice from expert committees Medsafe will regulate complementary medicines in a manner that is risk-appropriate and well understood	30/06/09
	Actual: Not achieved ¹	Actual: Achieved	Actual: Achieved

Commentary on performance measures not achieved

1. Of 246 changed medicine notifications, 242 (99.8%) were responded to within 45 days; four changed medicine notifications in June were consented on day 46. Of 265 new medicine applications, 216 (83%) received an initial evaluation within 135 days. However, of 80 changed medicine notifications referred under section 24(5) of the Medicines Act, only 38 (48%) received a response within 135 days. A change in the operation of the external panel required for these evaluations resulted in a number not being processed in the required time. Of 107 clinical trials, 104 (97%) were responded to within 45 days. Three overdue applications were two days or less overdue, while one required consideration by the Gene Technology Advisory Group. New processes are being implemented to ensure that timelines are controlled more effectively.

Cost

Actual 30/06/08 \$000		Actual 30/06/09 \$000	Main estimates 30/06/09 \$000	Supp. estimates 30/06/09 \$000
19,348	Crown Revenue	20,221	20,340	20,221
15,643	Third Party Revenue	17,264	13,419	14,658
34,991	Total Revenue	37,485	33,759	34,879
31,988	Total Expenditure	33,171	33,759	34,879
3,003	Net surplus	4,314	-	-

Departmental output expense: funding and performance of Crown entities

This departmental output expense contributes to system and societal outcomes by providing advice and sector-wide leadership on the ownership and performance of Crown entities.

In relation to these services, this departmental output expense provides for the Ministry to:

(a) DHB and Crown entity performance management

- ensure appropriate system-wide performance management by working with DHBs to reduce inter-DHB variability
- work with DHBs to develop regional and national clinical networks, shared services and other mechanisms to enhance system-wide co-operation and collaboration
- utilise the Monitoring Intervention Framework (MIF) to evaluate, recognise and encourage improved DHB performance
- assist DHB boards to resolve governance issues affecting board performance and the promotion of best governance approaches
- review the ongoing financial and non-financial performance of DHBs and Crown entities and consider any appropriate interventions to achieve performance improvement
- align DHB accountability and monitoring arrangements with the work of the Performance Management and Assessment steering group

(b) DHB and Crown entity ownership advice

- provide advice to DHBs and other Crown entities on how to give effect to key sector-wide priorities and performance targets, and hold these entities accountable for the implementation of this advice
- provide advice on the performance of DHBs and other Crown health entities in delivering the Government's New Zealand Health and Disability Strategies
- develop funding advice to DHBs, incorporating inter-district flows and national pricing and the Population-Based Funding Formula
- provide advice on governance issues affecting DHBs and other Crown entities, including conflicts of interest, succession planning, codes of conduct, delegation policies, and approvals for co-operative and collaborative arrangements
- develop funding advice to other Crown health entities
- develop the planning and reporting requirements for DHBs and other Crown entities, manage the DHBs' Crown Funding Agreements, and review the performance reports on each DHB and other Crown entities
- provide advice on ministerial appointments to the governing bodies of the DHBs and other Crown entity boards and on the expectations of board members
- provide advice on industrial relations across the sector
- provide advice on best practice and policy for DHB elections, and assist DHBs to meet their legislative obligations for DHB elections
- provide support and training for Māori participation in DHB decision-making
- lead the negotiations working towards the resolution of contemporary Treaty of Waitangi claims
- co-ordinate sector capital investment plans through the National Capital Committee and the assessment and management of sector capital business cases.

Output	Quantity	Quality	Timeliness
DHB and Crown entity ownership advice			
Developing advice to DHBs and other Crown health entities on funding and planning	Funding package distributed, and advice provided on all DAPs and SOIs	Robust and timely advice	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Managing DHBs' Crown Funding Agreements	Main agreements updated	Agreements are maintained and that variations are actioned in a timely and effective manner	30/06/09
	Four omnibus rounds completed		
Actual: Achieved	Actual: Achieved	Actual: Achieved	
Managing the DHB non-financial reporting process including Ministry assessment, feedback, reassessment and reporting	Reports are produced to agreed frequency	The process is analytical, robust, effective and delivers balanced information and data	Quarterly through to 30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Advice on ministerial appointments to the governing bodies of DHBs and other Crown entity and on the expectations of board members	Health Reports and verbal briefings as required	Robust and timely advice	As required
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Advice on industrial relations across the sector	Health Reports and verbal briefings as required	Robust and timely advice	As required
	Actual: Achieved	Actual: Achieved	Actual: Achieved
DHB and Crown entity performance			
Conduct DHB reviews and hold DHBs directly accountable for achievement of District Annual Plans (DAPs) and relevant nationwide health policies and targets	Two DHB reviews completed	Credible realistic recommendations for improvement	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Assessing and evaluating DHB performance against the Monitoring and Intervention Framework, by the MIF committee	Ten meetings per year	MIF meetings are held on programme and recommendations dealt with in a timely manner	Regularly
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Elective services			
Ongoing development of national prioritisation tools and implementation of new tools	Work with two clinical services to review and update national tools		Six-monthly review
	Monitor ESPI compliance		
	Six-monthly report on utilisation of prioritisation tools across DHBs		
	Work with DHBs to identify barriers and bottlenecks and provide advice on how these can be reduced, to assist electives uptake and output		
	Actual: Achieved		Actual: Achieved
Monitoring of actual results to elective services target	12 monthly reports	Timely and accurate reporting of target achievement	Monthly through to 30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Cost

Actual 30/06/08 \$000		Actual 30/06/09 \$000	Main estimates 30/06/09 \$000	Supp. estimates 30/06/09 \$000
13,680	Crown Revenue	8,433	13,320	8,433
165	Third Party Revenue	146	10	115
13,845	Total Revenue	8,579	13,330	8,548
12,532	Total Expenditure	8,061	13,330	8,548
1,313	Net surplus	518	-	-

Departmental output expense: information services

This departmental output expense contributes to system and societal outcomes by collecting and analysing health information services.

In relation to these services, this departmental output expense provides for the Ministry to provide:

- custodianship of the Health Information Strategy for New Zealand (HIS-NZ)
- custodianship and operational responsibility for national collections of health and disability information
- custodianship and operational responsibility for national health event summaries
- the collection, processing, maintenance, analysis and dissemination of health data, public health intelligence, statistics and information, including strategies to improve data quality and methods to improve data analysis
- health information to the sector and appropriate information to wider stakeholders
- maintenance and ongoing development of key national systems
- maintenance and ongoing development of national indexes (ie, the National Health Index and Health Practitioner Index) to ensure connectivity to data stored across national collections.

Output	Quantity	Quality	Timeliness
Information services to the Ministry and the sector			
Provide management, direction, development services and operational support for all Ministry information systems	Planned availability exceeds 97%	Unplanned availability is less than 3% (measured monthly)	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
National Health Identifier (NHI)	Planned availability of the NHI exceeds 99.4% (measured monthly)	Unplanned unavailability of the NHI is less than 0.6% (measured monthly) Average transaction response times are less than 3 seconds (measured at the Ministry firewall)	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Health Practitioner Index (HPI)	Planned availability of the HPI exceeds 97% (measured monthly)	Unplanned unavailability of the HPI is less than 3% (measured monthly) Average transaction response times are less than 3 seconds (measured at the Ministry firewall)	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Monitoring the health of New Zealand population			
The New Zealand Health Monitor National Population Health Survey Programme	Main survey and data collection commences for New Zealand adult nutrition, tobacco use and oral health surveys	Milestones and reports delivered within agreed timeframe and budget	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Development programme			
The Connected Health Programme (including implementation of SSC-led broadband provision)	Complete a set of national reference standards, linking infrastructure (including a health directory search engine), procurement framework and governance and management structure	Projects within this programme will be delivered within agreed timeframes and budget and that benefits are realised where appropriate	30/06/09
	Actual: Not achieved ¹	Actual: Not achieved ¹	Actual: Not achieved ¹
Address Information (Recipient and Provider Identity Services)	The Address Service, which will allow the business and other software applications to verify whether a given address is a correct address in New Zealand	Projects within this programme will be delivered within agreed timeframes and budget and that benefits are realised where appropriate	31/05/09
	Actual: Not achieved ²	Actual: Not achieved ²	Actual: Not achieved ²
Pilot implementation of a new online health information framework that will give all health information consumers improved (faster, easier, lower cost) access to health information	New online health information framework implemented	Projects within this programme will be delivered within agreed timeframes and budget and that benefits are realised where appropriate	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Commentary on performance measures not achieved

1. Research to identify the current and future ICT requirements of the health sector was completed. A new internet domain for the New Zealand health sector was implemented. Publication and release of the first version of a *Connected Health Architecture Framework* is starting to be implemented. An electronic business-2-business gateway was implemented. Projects on Critical Mass and Directory Service have been placed on hold, and are awaiting agreement on the strategic direction and requirements for the Directory from the Connected Health Steering Group. A workshop was held with sector representatives to discuss the future direction of Connected Health, and further meetings are to be held before agreement can be reached. The revised due date is 30 October 2009.

2. Four project benefits were signed off in June 2009. Migration requirements were updated to include NHI and HPI address options. This programme has been delayed because the request for proposal processes took significantly longer than planned. Vendor discussions continue and the projects have a new delivery date of 31 December 2009.

Cost

Actual 30/06/08 \$000		Actual 30/06/09 \$000	Main estimates 30/06/09 \$000	Supp. estimates 30/06/09 \$000
66,421	Crown Revenue	61,220	78,591	61,220
900	Third Party Revenue	1,019	408	701
67,321	Total Revenue	62,239	78,999	61,921
66,783	Total Expenditure	61,329	78,999	61,921
538	Net surplus	910	-	-

Departmental output expense: payment services

This departmental output expense contributes to system and societal outcomes by administering and monitoring service agreements and payments for health benefits and service agreements.

In relation to these services, this departmental output expense provides for the Ministry to provide:

- payment and administration of agreements
- payments to health providers for contracted services
- collection of payment clinical data from health provider claims
- information and reports relating to payment and other health data
- audit and counter-fraud processes to ensure health funds are applied legitimately and appropriately
- patient eligibility administration.

Output	Quantity	Quality	Timeliness
Health payments and agreements			
All payments made within KPIs agreed in the Memorandum of Understanding (MOU)	Payments up to a volume of 93,000,000 claims per annum	All appropriately completed claims will be processed within agreed timeframes	Achieve service standard for each claim type as set out in MOU
	Actual: Achieved	Actual: Achieved	Actual: Achieved
All agreements made within KPIs agreed in the Memorandum of Understanding	Agreements up to a volume of 11,000 agreements per annum	All appropriately completed agreements will be processed within agreed timeframes	Five-day turnaround
	Actual: Achieved	Actual: Achieved	Actual: Achieved
A national contact centre will be provided for the health sector for national health information and payments services	All calls to the national contact centre will be answered within the quality and timeliness measures	Abandonment of calls <5% 80% of calls answered within 20 seconds	Calls answered within 20 seconds
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Cost

Actual 30/06/08 \$000		Actual 30/06/09 \$000	Main estimates 30/06/09 \$000	Supp. estimates 30/06/09 \$000
18,346	Crown Revenue	19,897	17,601	19,897
184	Third Party Revenue	213	5	145
18,530	Total Revenue	20,110	17,606	20,042
17,733	Total Expenditure	19,314	17,606	20,042
797	Net surplus	796	-	-

Departmental output expense: servicing of Ministers and ministerial committees

This departmental output expense contributes to system and societal outcomes by providing for servicing of the Minister of Health, Associate Ministers of Health and Parliament.

In relation to these services, this departmental output expense provides for the Ministry to provide:

- a timely ‘no surprises’ policy by consistently informing Ministers in advance of matters of media or public interest that are, or may be, entering the public domain
- advice to the health ministerial team to support enhanced sector-wide leadership and accountability
- other advice to ministers not related to interventions planned for the other departmental output expenses, but which is either requested by ministers or is of such significance that a Minister would be at risk if she/he was not briefed on the matter at hand
- draft responses to ministerial correspondence, parliamentary questions, requests for briefing reports and speeches
- replies to questions asked by the Health Select Committee in relation to the Estimates and Financial Review examinations, responses to petitions, select committee inquiries, and advice to select committees in their consideration of bills
- advice on appointments to ministerial and occupational statutory bodies and committees
- administrative and advisory services to ministerial advisory committees serviced by the Ministry.

Output	Quantity	Quality	Timeliness
Establish strategic frameworks for health workforce			
Leadership and support on workforce planning and development	Develop a National Workforce Strategy for Cabinet approval	Strategy to follow the Long-Term System Framework and be credible with the sector	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Servicing of Ministers, ministerial committees and Parliament			
Draft replies to Parliamentary questions	Provision of an estimated 3000 draft replies to Parliamentary questions	All draft replies peer reviewed and signed out in accordance with delegated authority	95% of draft replies completed within the required time frame
	Actual: 1043	Actual: Achieved	Actual: Not achieved ¹
Provide policy advice to Ministers	As agreed between the Minister and the Ministry	All advice and briefings will meet the quality standards set out in the Statement of Objectives	Advice and briefings completed within the requested time frame
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Draft responses to Ministerial correspondence	Provision of an estimated 4500 draft replies to Ministerial correspondence	All draft replies peer reviewed and signed out in accordance with delegated authority; and 93% of replies signed off at first draft	90% of draft replies to Ministerial correspondence completed within the required time frame
	Actual: 3797	Actual: Achieved	Actual: Achieved
Provide Ministers with briefing papers and speeches	Provision of an estimated 500 briefing requests and speech requests from the Minister	All advice and briefings will meet the quality standards for the provision of policy advice and briefings set out in the Statement of Objectives All draft replies peer reviewed and signed out in accordance with delegated authority	95% completed within the required time frame
	Actual: 705	Actual: Achieved	Actual: Not achieved ²
Provide responses to requests for official information	Provision of an estimated 850 responses to requests for official information	All decisions made in accordance with the provisions of the Official Information Act 1982 All draft replies peer reviewed and signed out in accordance with delegated authority	100% of requests for official information completed within the required time frames
	Actual: 643	Actual: Achieved	Actual: Not achieved ³
Provide responses to written questions from Select Committee	Provision of 350 responses to written questions from the Health Committee relating to the Financial Review and Estimates examinations	All draft replies peer reviewed and signed out in accordance with delegated authority	100% of written responses provided within the time frame requested by the Minister of Health and the Health Committee
	Actual: 234	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Make appointments to Ministerial committees and statutory bodies and committees, and support ministerial advisory committees	An estimated 200 appointments made	All appointments made in accordance with the New Zealand Public Health and Disability Act 2000, DPMC and SSC requirements	30/06/09
	Actual: 113	Actual: Achieved	Actual: Achieved
Communications Management			
Notification of national health stories	90% of national health media stories	Consistent notification to Ministers in advance of relevant issues entering the public domain	Consistent notice in advance
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Commentary on performance measures not achieved

1. The timeliness result was close to target (94%). The timeliness result improved during the financial year.
2. Only 76% of requests for briefing papers and speeches were provided on time. Timeliness was affected by the large number of requests received immediately prior to the Election period. The Ministry's focus has been on ensuring the Ministers' offices were kept informed of delays and that the information was provided before any meeting for which it was required.
3. Only 62% of responses to requests for official information were on time. There were a number of reasons for the late responses: some required redrafting and there were delays associated with the General Election. Closer monitoring of responses is now possible with the new Quill IT system. Monthly results for all ministerial servicing are now included in directorate month reports, which allows closer monitoring of responses by directorate senior management teams. No responses to requests for official information were overdue for the month of July 2009.

Cost

Actual 30/06/08 \$000		Actual 30/06/09 \$000	Main estimates 30/06/09 \$000	Supp. estimates 30/06/09 \$000
21,041	Crown Revenue	15,515	21,191	15,515
807	Third Party Revenue	111	29	114
21,848	Total Revenue	15,626	21,220	15,629
21,629	Total Expenditure	13,863	21,220	15,629
219	Net surplus	1,763	-	-

Departmental output expense: strategy, policy and system performance

This departmental output expense contributes to system and societal outcomes by progressing identified areas of focus.

In relation to these services, this departmental output expense provides for the Ministry to deliver initiatives that progress the Minister's priorities of chronic disease, child and youth services, primary health, health of older people, infrastructure and value for money, and broader or internal priorities of elective services, reducing inequalities and improving Māori health.

Output	Quantity	Quality	Timeliness
A framework for integrative primary care			
A framework developed that outlines the principles and models for the integration of complementary and alternative medicine into mainstream primary health care	Integrative primary care framework	An evidenced-based framework that has sector-wide agreement The framework document meets Ministry standards for publication and is endorsed by the Minister	Interim Report 31/08/08 Final Report 30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Establish strategic frameworks for health workforce			
Review of Health Practitioners Competence Assurance Act 2003	A Health Report to the Minister recommending changes to the Health Practitioners Competence Assurance Act 2003	Report to include findings and recommendations	31/05/08
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Assets and capital strategic framework			
Design and initiate a framework and processes for the strategic management of assets and capital in health	High level framework developed	Specifications for high level framework developed in consultation with the sector	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Health of older people: service cover requirements			
Finalise proposed health of older people service cover requirements	Report provided to the Minister	Consultation undertaken with key stakeholders and final report endorsed by the Minister	30/11/08
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Health Target performance reporting			
Report to Cabinet on progress on achieving Health Targets at a national level	Quarterly	Reviewed annually to measure improved outcomes	30/11/08
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Healthy Eating Healthy Action			
Revision of HEHA implementation plan completed	Comprehensive literature review completed, all DHBs consulted on revised plan, set of specific and measurable targets developed	Evidence based new and innovative interventions incorporated into HEHA plan All DHBs incorporate new interventions in their MAPS DHBs and HEHA sector support the set of targets	30/03/09
	Actual: Achieved	Actual: Not achieved ¹	Actual: Not achieved ¹
Implementation of a strategic framework for Pacific health			
Publish a strategic framework for Pacific health, and complete first year implementation plan	One published document, one completed implementation plan	Outputs agreed and supported by Pacific health sector and Ministry stakeholders	30/03/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Implementation of Cancer Control Strategy Action Plan 2005–2010			
Guidance on referral including overcoming barriers to access to cancer services distributed to funders and primary providers	Guidance document produced	Utilisation of guidance by providers for service improvement	31/12/08
	Actual: Not achieved ²	Actual: Not achieved ²	Actual: Not achieved ²
Feasibility study for national colorectal cancer screening programme commenced	Programme plan for feasibility study completed	Expert advisory group for programme established	31/12/08
	Actual: Achieved	Actual: Achieved	Actual: Not achieved ³
Implementation of Te Kōkiri: The Mental Health and Addiction Action Plan			
Advice to Government on options and recommendations for future funding and service models for primary mental health care	One Health Report to the Minister	Advice to Minister developed through appropriate consultation with key stakeholders	31/12/08
	Actual: Achieved	Actual: Achieved	Actual: Not achieved ⁴

Output	Quantity	Quality	Timeliness
Implementation of the Well Child Review recommendations			
Well Child Review recommendations implemented	Report back to Cabinet; and pilot project in one DHB to address health barriers to learning	Cabinet paper peer-reviewed by external agencies, meets Cabinet Office requirements and approved by the Minister	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Improve the position of the medicines sector to deliver excellent health and disability support outcomes			
Strategic implementation of <i>Actioning Medicines New Zealand</i>	Examine the process for setting the community pharmaceutical budget		30/06/09
	Actual: Achieved		Actual: Not achieved ⁵
Improving diabetes/cardiovascular disease (CVD) Outcomes			
Update evidence-based guidelines for 'Assessment and management of CVD risk' and 'Management of Type 2 diabetes' and disseminate to sector	Guidelines completed	Sector supported to implement updated guidelines	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Development of NZ model of diabetes/CVD utilising health system dynamics modelling	Basic flow model developed	DHBs, clinicians and researchers contribute to model development	30/03/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Improving oral health			
Funding agreements in place with DHBs, implementation commenced and supporting promotional material available to the public	All DHBs have approved funding agreements in place, service re-orientation has commenced, and promotional material is available	All DHBs have agreed project assurance milestones which are being monitored by the Ministry All promotional material aligns with oral health strategic vision and are endorsed by the Oral Health Steering Committee	30/06/09
			Actual: Achieved

Output	Quantity	Quality	Timeliness
Improving quality and innovation			
Establish a Health Initiatives Clearing House to promote innovations within the sector	Clearing House launched	The Clearing House includes information about innovative activities in each DHB	30/06/09
	Actual: Not achieved ⁶	Actual: Not achieved ⁶	Actual: Not achieved ⁶
Long-term conditions programme			
A strategic framework for long-term conditions in New Zealand is developed and released		Framework is endorsed by Partnership Steering Group	31/01/09
		Actual: Achieved	Actual: Achieved
Improve prioritisation of additional funding to Vote Health			
Budget process input includes prioritisation process for new initiatives	Vote Health prioritisation process	New initiatives prioritised considering government and Minister's priorities and Health Targets	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Long-term Sector Systems Framework			
Begin initial implementation of the Long-term System Framework (LTSF)	Develop processes to guide sector development		30/06/09
	Actual: Achieved		Actual: Achieved
Maternity Services Strategic Plan			
Development of a Maternity Services Strategic Plan	Strategic Plan provided to the Minister	Consultation undertaken with steering group and the sector, document meets Ministry standards and is endorsed by the Minister	30/09/08
	Actual: Achieved	Actual: Achieved	Actual: Not achieved ⁷
Monitoring priority areas			
Monitoring of Ministry of Health work programme from an inequalities perspective	Identify resources		30/09/08
	Actual: Achieved		Actual: Achieved

Output	Quantity	Quality	Timeliness
National Alcohol Action Plan			
Development of interagency action plans to guide Government responses to reducing alcohol related harm: (1) a new National Alcohol Action Plan; (2) a new action plan focusing on foetal alcohol spectrum disorder	Two action plans produced	Develop a draft action plan and undertake public consultation prior to seeking Cabinet agreement	30/06/09
	Actual: Not achieved ⁸	Actual: Not achieved ⁸	Actual: Not achieved ⁸
National immunisation programme			
Implementation of mass vaccination programme for human papillomavirus (HPV)	HPV Programme implemented in all regions	Consultation undertaken with key stakeholders and programme implemented to the Minister's satisfaction	31/03/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
National Quality Improvement Programme			
Implement the QIC National Improvement programmes	Service specifications document in the CFA Variations	Completion of work as directed by the Minister of Health following advice from the Quality Improvement Committee (QIC)	Key quality plan 30/10/08
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Primary Health Care Implementation			
Review services to improve access and provide advice on effectiveness and how changes to operational policy settings can improve effectiveness and accountability	Completion of review, sector engagement satisfactory, implementation of agreed recommendations		30/03/09
	Actual: Achieved		Actual: Achieved
Realising the full potential of the Primary Health Care Strategy (PHCS)			
Report on the review of policy framework and funding formulae with recommendations on how to enhance PHCS	A report with recommendations on how to enhance the PHCS provided to the Minister	Review undertaken in collaboration with DHBs and consultation undertaken with key stakeholders, interim report endorsed by Minister	31/08/08
	Actual: Achieved	Actual: Achieved	Actual: Achieved

Output	Quantity	Quality	Timeliness
Tobacco control			
Implementation of DHB tobacco control plans	All DHBs are visited twice to monitor and support progress with implementation	Priority activities in DHB plans are implemented first	30/06/09
	Actual: Achieved	Actual: Achieved	Actual: Achieved
Youth Pregnancy Strategy			
Develop youth pregnancy strategy, including actions to: <ul style="list-style-type: none"> • reduce the number of unintended pregnancies • increase timely access to quality antenatal care and support • provide access to a range of co-ordinated supports following birth 	Final draft strategy provided to Minister	Advice to Minister developed through appropriate consultation with key stakeholders	30/03/09
Youth Health Strategy			
Assist DHBs to develop youth health strategies	Assist all DHBs		30/06/09
	Actual: Achieved		Actual: Achieved

Commentary on performance measures not achieved

1. The Ministry has worked with the Minister to develop a revised implementation plan to address obesity prevention and management that reflects government policy. Further discussions will occur with the Minister in the next financial year.
2. The Ministry revisited its purchasing approach to guidelines development and implementation, and rather than using a preferred provider model decided to utilise a competitive procurement approach prior to finalising this guidance, which reforecast delivery to 30 September 2009. The impacts of this delay were minor. The Suspected Cancer in Primary Care Guidelines will be launched at the Royal New Zealand College of General Practitioners Conference, 9–11 September 2009.
3. Project scoping and advice from the Bowel Cancer Taskforce has reforecast this to 31 March 2011, with implementation commencing in June 2011. The Minister has indicated his support for the new timeframes for the programme.
4. A paper on future funding and service models for primary mental health was sent to the Minister of the previous government in October 2008 seeking permission to release it for sector feedback. That paper would have met the required timeframe. The paper was returned unsigned due to the General Election and was redrafted for the new Minister. There will be further discussion with the Minister in early August 2009. Sector engagement has continued through regional primary mental health networks, and the Ministry is continuing to work with DHBs and PHOs towards the stepped-care model.
5. This work was deferred until 2009/10 in order to meet the Government's priorities, including increasing the pharmaceutical budget in Budget 2009. Timeframes were negotiated with the Associate Minister of Health, Hon Peter Dunne, to undertake this deliverable in 2009/10 to inform the pharmaceutical budget in Budget 2010.
6. The Health Initiatives Clearing House is to be realigned with the productivity work programme, and delivery has been reforecast to 30 September 2009. The delay should result in acceptance of an improved website. Aligning the Health Initiatives Clearing House with the productivity programme will be undertaken in consultation with DHBs.
7. Consultation on the Plan was approved by Cabinet in October 2008.

8. Further direction is awaited in terms of the Ministry reprioritisation process, and a revised due date is still to be determined. Ministry officials have met with the Associate Minister of Health, Hon Peter Dunne, who has indicated a more detailed approach is required. A Health Report has been sent to the Minister of Health requesting approval for a revised framework and approval to resume discussions at Inter-Agency Committee on Drugs (IACD) level over the detail.

Cost

Actual 30/06/08 \$000		Actual 30/06/09 \$000	Main estimates 30/06/09 \$000	Supp. estimates 30/06/09 \$000
31,828	Crown Revenue	47,677	29,668	47,677
367	Third Party Revenue	679	401	476
32,195	Total Revenue	48,356	30,069	48,153
30,704	Total Expenditure	47,775	30,069	48,153
1,491	Net surplus	581	-	-

Financial Statements

Introduction to the financial reports

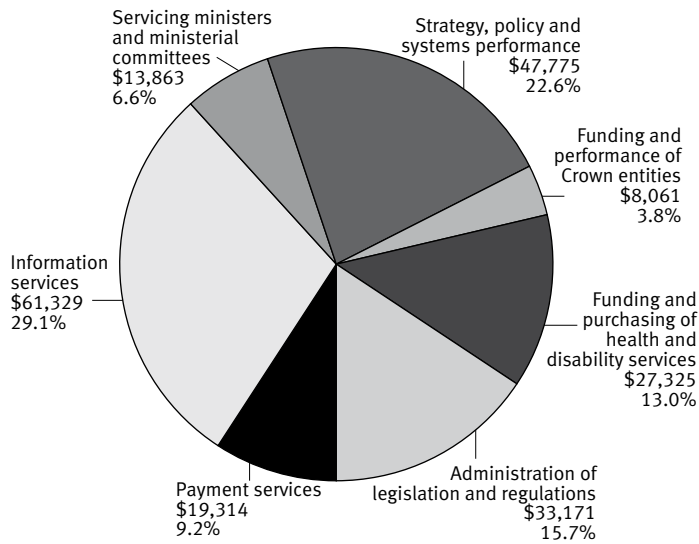
The Ministry receives funding from Parliament for its own operations which is included in its departmental appropriations.

The Ministry also receives and manages significant other appropriations to administer on behalf of the Crown to fund third party service providers including District Health Boards (DHBs) and Non-Governmental Organisations (NGOs). The majority of this funding is for operational purposes with some being appropriated for capital expenditure. All the funding appropriated by Parliament and administered by the Ministry is known collectively as Vote Health.

The Ministry receives additional initiative funding as a health package in the annual budget to implement the Government's new initiatives. A major component of the additional health funding received each year is to recognise the effects of inflation and of demographic changes to the New Zealand population.

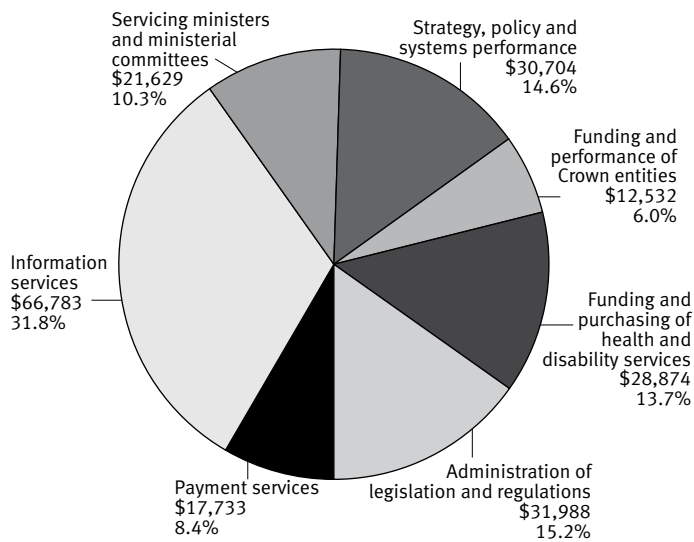
A four-year capital envelope provides a longer time horizon to prioritise and fund capital projects, and is particularly suited to large-scale projects such as those recently completed or being undertaken at some DHBs. With such projects, the certainty of ongoing funding is of considerable benefit to the health and disability sector. The Ministry is able to re-appropriate unspent capital funds in any particular year to a future period due to uncertainty of construction timing and associated costs.

Figure 2: 2008/09 departmental operational appropriations – actual expenditure (\$000s)



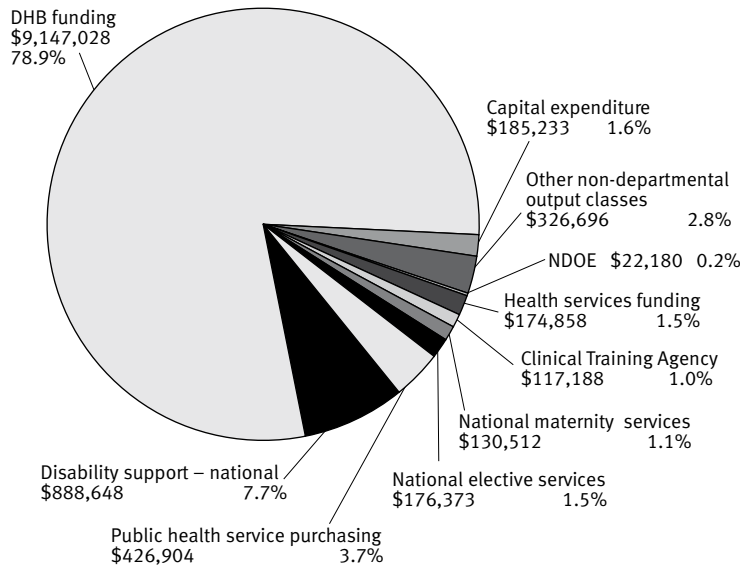
Note: Total actual expenditure \$211.864 million.

Figure 3: Comparative data for 2007/08 departmental operational appropriations – actual expenditure (\$000s)



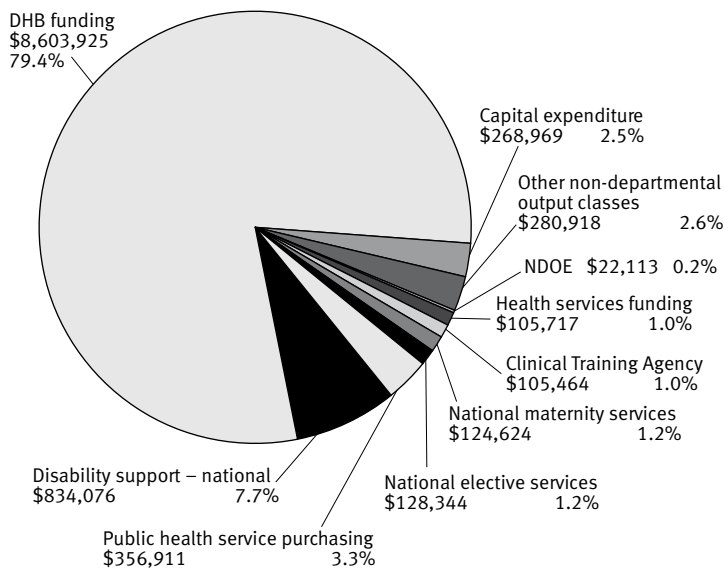
Note: Total actual expenditure \$210.243 million.

Figure 4: 2008/09 non-departmental operational appropriations – actual expenditure (\$000s)



Note: Total actual expenditure \$11.596 billion.

Figure 5: Comparative data for 2007/08 non-departmental operational appropriations – actual expenditure (\$000s)



Note: Total actual expenditure \$10.831 billion.

Statement of financial performance for the year ended 30 June 2009

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000
Income				
199,077		201,504	213,162	201,504
18,549	2	19,752	14,293	16,490
49	3	(9)	–	–
217,675		221,247	227,455	217,994
Expenditure				
124,716	4	126,264	129,415	124,716
8,654		9,674	14,200	14,137
1,402	5	1,498	2,546	2,014
75,471	7	73,402	81,294	59,127
210,243		210,838	227,455	199,994
7,432		10,409	–	18,000

Explanations of significant variances against budget are detailed in note 23.

Statement of movements in taxpayers' funds for the year ended 30 June 2009

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000
18,623		19,973	33,951	19,973
7,432		10,409	–	18,000
1,350		(1,080)	–	–
8,782		9,329	–	18,000
–		12,507	24,578	13,767
(7,432)	12	(10,409)	–	(18,000)
19,973	15	31,400	58,529	33,740

The notes set out on pages 60 to 82 form part of, and are to be read in conjunction with, these financial statements.

Statement of financial position as at 30 June 2009

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000	
Taxpayers' funds					
18,623	General funds	15	31,130	58,529	33,740
1,350	Property, plant and equipment reevaluation reserves	15	270	–	–
19,973	Total taxpayers' funds		31,400	58,529	33,740
Represented by:					
Assets					
Current assets					
9,537	Cash and cash equivalents		9,522	8,395	7,841
15,792	Debtors and other receivables	8	18,261	13,439	20,605
1,202	Prepayments		1,283	540	1,201
26,531	Total current assets		29,066	22,374	29,647
Non-current assets					
22,380	Property, plant and equipment	9	22,117	28,550	26,518
14,982	Intangible assets	10	23,413	28,034	32,062
37,362	Total non-current assets		45,530	56,584	58,580
63,893	Total assets		74,596	78,958	88,227
Liabilities					
Current liabilities					
23,984	Creditors and other payables	11	20,615	7,914	21,418
7,432	Repayment of surplus	12	10,409	–	18,000
3,156	Provisions	13	1,527	5,000	5,676
7,792	Employee entitlements	14	9,213	5,783	7,837
42,364	Total current liabilities		41,764	18,697	52,931
Non-current liabilities					
57	Provisions	13	32	–	–
1,499	Employee entitlements	14	1,400	1,732	1,556
1,556	Total non-current liabilities		1,432	1,732	1,556
43,920	Total liabilities		43,196	20,429	54,487
19,973	Net assets		31,400	58,529	33,740

The notes set out on pages 60 to 82 form part of, and are to be read in conjunction with, these financial statements.

Statement of cash flows for the year ended 30 June 2009

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000
Cash flows from operating activities				
Cash was provided from:				
Supply of outputs to:				
198,726	Crown	199,813	221,162	192,340
2,799	Department	2,628	1,897	1,897
16,914	Others	14,990	12,396	14,593
244	Net GST received/(paid)	(1,177)	–	–
218,683	Total cash provided from operating activities	216,254	235,455	208,830
Cash was disbursed to:				
Produce outputs				
(123,498)	Personnel costs	(133,425)	(129,415)	(124,202)
(75,350)	Operating expenses	(67,492)	(111,294)	(55,290)
(1,402)	Capital charge	(1,498)	(2,546)	(2,014)
(200,250)	Total cash to operating activities	(202,415)	(243,255)	(181,506)
18,433	Net cash inflow/(outflow) from operating activities	13,839	(7,800)	27,324
	16			
Cash flows from investing activities				
Cash was provided from:				
88	Sale of property, plant and equipment	21	240	100
Cash was disbursed to:				
(2,222)	Purchase of property, plant and equipment	(4,516)	(8,145)	(9,705)
(7,982)	Purchase of intangible assets	(14,434)	–	(25,750)
(10,116)	Net cash inflow/(outflow) from investing activities	(18,929)	(7,905)	(35,355)
Cash flows from financing activities				
Cash was provided from:				
–	Capital contribution from the Crown	12,507	24,578	13,767
Cash was disbursed to:				
(457)	Repayment of surplus to the Crown	(7,432)	(9,293)	(7,432)
(457)	Net cash inflow/(outflow) from financing activities	5,075	15,285	6,335
7,860	Net increase/(decrease) in cash and cash equivalents	(15)	(420)	(1,696)
1,677	Add cash and cash equivalents at the beginning of the year	9,537	8,815	9,537
9,537	Cash and cash equivalents at the end of the year	9,522	8,395	7,841

The GST (net) component of operating activities reflects the net GST paid and received with the Inland Revenue Department. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes.

The notes set out on pages 60 to 82 form part of, and are to be read in conjunction with, these financial statements.

Statement of commitments as at 30 June 2009

Actual 2008 \$000		Actual 2009 \$000
	Non-cancellable operating lease commitments	
7,853	Not later than one year	8,902
19,782	Later than one year and not later than five years	20,500
11,584	Later than five years	9,315
39,219	Total non-cancellable operating lease commitments	38,717
	Other non-cancellable commitments	
5	Not later than one year	3,040
–	Later than one year and not later than five years	8,409
5	Total other non-cancellable commitments	11,449
39,224	Total commitments	50,166

The Ministry has medium- to long-term leases on its premises in Auckland, Christchurch, Dunedin, Hamilton, Wanganui and Wellington. The annual lease payments are subject to regular reviews ranging from one year to four years. The amounts disclosed above as future commitments are based on the current rental rates.

The Ministry has entered into non-cancellable contracts for computer maintenance, building services and other contracts for services. These non-cancellable contracts totalled \$11.449 million as at 30 June 2009 (2008: \$0.005 million).

Statement of contingent liabilities and contingent assets as at 30 June 2009

The Ministry had no contingent liabilities as at 30 June 2009 (2008: Nil).

The Ministry had no contingent assets as at 30 June 2009 (2008: Nil).

The notes set out on pages 60 to 82 form part of, and are to be read in conjunction with, these financial statements.

Statement of departmental actual expenses against appropriations for the year ended 30 June 2009

	Actual Expenditure 30/6/09 \$000	Voted [^] Appropriation 30/6/09 \$000
Vote Health		
Appropriations for annual output expenses		
Administration of funding and purchasing of health and disability support	27,325	28,822
Administration of legislation and regulations	33,171	34,879
Funding and performance of Crown entities	8,061	8,548
Payment services	19,314	20,042
Servicing of ministers and ministerial committees	13,863	15,629
Strategy, policy and systems performance	47,775	48,153
Information services	61,329	61,921
Total output expenses	210,838	217,994
Total departmental expenditure	210,838	217,994

[^] These amounts include adjustments made in the Supplementary Estimates.

Statement of departmental unappropriated expenditure and capital expenditure for the year ended 30 June 2009

There was no unappropriated expenditure during the year ended 30 June 2009.

The notes set out on pages 60 to 82 form part of, and are to be read in conjunction with, these financial statements.

Notes to the financial statements for the year ended 30 June 2009

Note 1: Statement of accounting policies for the year ended 30 June 2009

Reporting entity

The Ministry of Health (the Ministry) is a government department as defined by section 2 of the Public Finance Act 1989 and is domiciled in New Zealand.

The primary objective of the Ministry is to act as the Government's agent to fund, administer and monitor the delivery of health services to New Zealanders, rather than making a financial return. Accordingly, the Ministry has designated itself as a public benefit entity for the purposes of New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

The Ministry's financial statements are for the year ended 30 June 2009. The financial statements were authorised for issue by the Director-General of Health on 28 September 2009.

In addition, the Ministry has reported the activities and trust monies that it administers on behalf of the Crown.

Basis of preparation/Statement of compliance

These financial statements have been prepared in accordance with New Zealand Generally Accepted Accounting Practice. They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), NZ IAS 1 Presentation of Financial Statements (issued 2004) paragraphs NZ 13.1(d) and 105(a) and other applicable Financial Reporting Standards as appropriate for public benefit entities.

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the Ministry include the following.

- NZ IAS 1 Presentation of Financial Statements (revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The revised standard gives the Ministry the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). The Ministry intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.

- NZ IAS 23 Borrowing Costs (revised 2007) replaces NZ IAS 23 Borrowing Costs (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. The revised standard will also require borrowing costs to be considered when revaluing property, plant and equipment to fair value based on depreciated replacement cost. Any necessary adjustments to depreciated replacement cost carrying values will have flow on effects to depreciation expense. The Ministry intends to adopt this standard for the year ending 30 June 2010 and has not yet quantified the potential impact of the new standard.

Accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these financial statements.

The measurement base applied to these financial statements is the historical cost basis modified by the revaluation of certain assets and liabilities as described in this statement of accounting policies.

The financial statements are presented in New Zealand dollars being the functional currency of the Ministry. Unless stated otherwise, all values are rounded to the nearest thousand dollars (\$000).

Foreign currency transactions are translated into the New Zealand dollars using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions are recognised in the Statement of Financial Performance.

Monetary assets and liabilities denominated in foreign currency are translated at the rate of exchange applying at balance date. Any unrealised foreign exchange gains or losses resulting from such translation are recognised in the Statement of Financial Performance.

The accrual basis of accounting has been used unless otherwise stated.

Reporting period

The reporting period for these financial statements is the year ended 30 June 2009.

The budget forecast figures (Main Estimates) are the original figures for the financial year as presented in the 2008 Budget on 22 May 2008. The supplementary estimates figures are those budget figures as amended by the Supplementary Estimates (Supp. Estimates) as presented in the 2009 Budget on 28 May 2009 and as adjusted by any transfers made by Order in Council under section 26 of the Public Finance Act 1989.

Judgements and estimations

The preparation of financial statements is in conformity with NZ IFRS and requires judgements, estimates, and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the reporting period in which the revision is made and in any future periods that will be affected by those revisions.

Revenue

The Ministry derives revenue through the provision of outputs to the Crown and for services to third parties. Such revenue is recognised at fair value of consideration received.

Crown Revenue is recognised monthly as the amount of funding required to cover the portion of appropriated output expenses not covered by other third party revenue.

Other revenue from the supply of services is recognised by reference to the stage of completion of the transaction at balance date and only to the extent that the outcome of the transaction can be estimated reliably.

Cost allocation

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with any one specific output.

Direct costs are charged directly to outputs while indirect costs are allocated to outputs based on the level of activity associated with relevant cost drivers.

Depreciation is primarily charged to Business Units on the basis of asset utilisation with the remainder being charged as indirect costs.

There have been no changes in the cost allocation policy since the date of the last audited financial statements.

Taxation

As a Government department, the Ministry is exempt from the payment of income tax in terms of the Income Tax Act 2004. Accordingly, no charge for income tax is recognised.

Taxpayers' funds

The Crown's net investment in the Ministry is shown as taxpayers' funds in the Statement of Movements in Taxpayers Funds and the Statement of Financial Position.

Financial instruments

The Ministry is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, receivables and financial liabilities. Designation of financial assets and financial liabilities into instrument categories is determined by the business purpose of the financial instruments, policies and practices for their management, their relationship with other instruments and the reporting costs and benefits associated with each designation. The designations are reflected in the financial statements of the Ministry.

Financial assets

Receivables and advances have been designated as loans and receivables. Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Loans and receivables are recognised initially at fair value plus transaction costs and subsequently measured at amortised cost using the effective interest rate method. Loans and receivables issued with duration of less than 12 months are recognised at their nominal value, unless the effect of discounting is material. Allowances for estimated irrecoverable amounts are recognised when there is objective evidence that the asset is impaired.

Cash and cash equivalents include cash on hand, cash in transit, and bank accounts.

At each balance date the Ministry assesses whether there is any objective evidence that a financial asset or group of financial assets is impaired. Any impairment losses are recognised in the Statement of Financial Performance.

Financial liabilities

Creditors and payables are recognised initially at fair value less transaction costs and subsequently measured at amortised cost using the effective interest rate method. Creditors and payables to be paid within the following 12 months are recognised at their nominal value, unless the effect of discounting is material.

Derivatives

Derivative financial instruments are recognised both initially and subsequently at fair value. They are reported as either assets or liabilities depending on whether the derivative is in a net gain or net loss position respectively. The Ministry has a non-hedge policy and as such all derivatives are held-for-trading financial instruments with fair value gains or losses recognised in the Statement of Financial Performance.

Property, plant and equipment

Items of property, plant and equipment are initially recorded at cost. Where an asset is acquired for nil or nominal consideration the asset will be recognised initially at fair value, where fair value can be reliably determined. The fair value of the asset received, less costs incurred to acquire the asset, is recognised as revenue in the Statement of Financial Performance.

Revaluations are carried out for the Ministry's land and buildings to reflect the service potential or economic benefit obtained through control of the asset. Revaluation is based on the fair value of the asset, with changes reported by class of asset.

Land is recorded at fair value less impairment losses. Buildings are recorded at fair value less impairment losses and less depreciation accumulated since the assets were last revalued. Valuations are based on either valuation undertaken in accordance with standards issued by the New Zealand Property Institute if available, or valuation conducted in accordance with the Rating Valuation Act 1998 that has been confirmed as appropriate by an independent valuer.

All other asset classes are initially carried at depreciated historical cost, with a review of the carrying values of revalued items performed at each balance date to determine whether any material adjustment is required.

Classes of property, plant and equipment subject to fair value review are revalued at least every three years, or sooner where indicators suggest the carrying amount differs materially to fair value. Unrealised gains and losses arising from changes in the value of property, plant and equipment are recognised as at each balance date. To the extent that a gain reverses a loss previously charged to the Statement of Financial Performance for the asset class, the gain is credited to the Statement of Financial Performance; otherwise gains are credited to the asset revaluation reserve for that class of asset. To the extent that there is a balance in the asset revaluation reserve for the asset class, any loss on revaluation is debited to the reserve to the extent that a balance remains in such reserve. All other losses on property, plant and equipment are reported in the Statement of Financial Performance.

Accumulated depreciation at revaluation date may be either restated proportionately or eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount. The elimination approach is applied unless otherwise indicated.

For each property, plant and equipment asset, project borrowing costs incurred during the period required to complete and prepare the asset for its intended use are expensed.

The carrying amounts of plant, property and equipment are reviewed at least annually to determine if there is any indication of impairment. Where an asset's recoverable amount is less than its carrying amount, it will be reported at its recoverable amount and an impairment loss will be recognised. Losses resulting from impairment are reported in the Statement of Financial Performance unless the asset is carried at a revalued amount in which case any impairment loss is treated as a revaluation decrease to the extent to which that the revaluation relates to the impaired asset class.

Depreciation is charged on a straight-line basis at rates calculated to allocate the cost or valuation of an item of property, plant and equipment, less any estimated residual value, over its estimated useful life. Typically, the estimated useful lives of different classes of property, plant and equipment are as follows:

	Useful life	Depreciation rate
Buildings	40 years	2.5%
Motor vehicles	5 years	20%
Furniture and fittings	5–10 years	10–20%
Machinery	5 years	20%
Leasehold improvements	5–10 years	10–20%
IT equipment	3–5 years	20–33.3%
Scientific equipment	5–10 years	10–20%

Additions

The cost of an item of property, plant and equipment is recognised as an asset if, and only if, it is probable that future economic benefits or service potential associated with the item will flow to the Ministry and the cost of the item can be measured reliably.

Disposals

Gains and losses on disposals are determined by comparing the sale proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the Statement of Financial Performance. When revalued assets are sold, the amounts included in asset revaluation reserves in respect of those assets are transferred to retained earnings.

Intangible assets

Intangible assets are initially recorded at cost. The cost of an internally generated intangible asset represents expenditure incurred in the development phase of the asset only. The development phase occurs after the following can be demonstrated: technical feasibility; ability to complete the asset; intention and ability to sell or use; and where development expenditure can be reliably measured. Expenditure incurred on research related to an internally generated intangible asset is expensed when it is incurred. Where the research phase cannot be distinguished from the development phase, the expenditure is expensed when it is incurred.

Intangible assets with finite lives are subsequently recorded at cost less any amortisation and impairment losses. Amortisation is charged to the Statement of Financial Performance on a straight-line basis over the useful life of the asset. Typically, the estimated useful lives of these assets are as follows:

	Useful life	Amortisation rate
Software – internally generated	3–5 years	20–33.3%
Software – other	3–5 years	20–33.3%
Warranties	3 years	33.3%

Realised gains and losses arising from disposal of intangible assets are recognised in the Statement of Financial Performance in the period in which the transaction occurs.

Intangible assets are reviewed at least annually to determine if there is any indication of impairment. Where an intangible asset’s recoverable amount is less than its carrying amount, it will be reported at its recoverable amount and an impairment loss recognised. Losses resulting from impairment are recognised in the Statement of Financial Performance.

Non-current assets held for sale and discontinued operations

Non-current assets or disposal groups are separately classified where their carrying amount will be recovered through a sale transaction rather than continuing use; that is, where such assets are available for immediate sale and where sale is highly probable. These assets are recorded at the lower of their carrying amount and fair value less costs to sell.

Employee benefits

Employee entitlements to salaries and wages, annual leave, long service leave, retiring leave and other similar benefits are recognised in the Statement of Financial Performance when they accrue to employees. Employee entitlements to be settled within 12 months are reported at the amount expected to be paid. The liability for long-term employee entitlements is calculated on an actuarial basis at the present value of estimated future cash outflows.

Termination benefits are recognised in the Statement of Financial Performance only when there is a demonstrable commitment to either terminate employment prior to normal retirement date or to provide such benefits as a result of an offer to encourage voluntary redundancy. Termination benefits settled within 12 months are reported at the amount expected to be paid, otherwise they are reported as the present value of the estimated future cash outflows.

Obligations for contributions to defined contribution retirement plans are recognised in the Statement of Financial Performance as they fall due. Obligations for defined benefit retirement plans are recorded at the latest actuarial value of the Ministry’s liability. All movements in the liability, including actuarial gains and losses, are recognised in full in the Statement of Financial Performance in the period in which they occur.

Insurance contracts

The Ministry belongs to the ACC Partnership Programme whereby the Ministry accepts the management and financial responsibility for work-related illnesses and accidents of employees.

Under the ACC Partnership Programme, the Ministry is effectively providing accident insurance to employees and this is accounted for as an insurance contract as the Ministry accepts liability for all its claims costs for a period of four years up to a specified maximum. At the end of the four year period, the Ministry pays a premium to ACC for the value of residual claims, and the liability for ongoing claims beyond that point passes to ACC.

The liability relating to the Ministry's ACC Partnership Programme obligations is measured at the present value of expected future payments to be made in respect of the employee injuries and claims, for which the Ministry has responsibility up to the reporting date, using actuarial techniques. Consideration is given to expected future wage and salary levels and experience of employee claims and injuries to date, and may include a risk margin that represents the inherent uncertainty of the present value of the expected future payments. Expected future payments are discounted using market yields applying as at the reporting date based on government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

Lease payments under an operating lease, net of lease incentives received, are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised evenly over the term of the lease as a reduction in rental expense.

Leasehold improvements are capitalised and the cost is amortised over the unexpired period of the lease, or the estimated useful life of the improvements, whichever is shorter.

Provisions

The Ministry recognises a provision, based on probable cost, for future expenditure of uncertain amount or timing where there is a present obligation (either legal or constructive) as a result of a past event.

Provisions are recorded at the best estimate of the expenditure 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. Provisions to be settled beyond 12 months are recorded at their present value.

Contingent assets and contingent liabilities

Contingent liabilities and contingent assets are recorded in the Statement of Contingent Liabilities and Contingent Assets at the point at which the contingency becomes evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote. Contingent assets are disclosed if it is probable that the benefits will be realised.

Changes in accounting policies

Accounting policies are changed only if the change is required by a standard or interpretation or otherwise provides more reliable and more relevant information. All policies have been applied on a basis consistent with the previous year.

Comparative figures

When presentation or classification of items in the financial statements is amended or accounting policies are changed, comparative figures are restated to ensure consistency with the current period unless it is impracticable to do so.

Segment reporting

As a public benefit entity, the Ministry is not required to provide segment reporting.

Goods and Services Tax (GST)

All items in the financial statements are stated exclusive of GST, except for receivables and payables, which are stated on a GST inclusive basis.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) as at balance date is included as part of receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the Statement of Cash Flows.

Note 2: Revenue – other

Actual 2008 \$000		Actual 2009 \$000
9,297	Medicines registration	10,033
4,064	Service fees	3,763
1,721	Annual licence and registration fees	1,886
2,025	State Sector Retirement Saving Scheme recovery	2,204
774	Other departmental revenue	397
668	Other	1,469
18,549	Total revenue other	19,752

Note 3: Gains/(losses)

Actual 2008 \$000		Actual 2009 \$000
49	Net gain on disposal of property, plant, and equipment	(9)
49	Total gains/(losses)	(9)

Note 4: Personnel costs

Actual 2008 \$000		Actual 2009 \$000
111,227	Salaries and wages	116,348
2,506	Employer contributions to defined contribution plans	2,594
704	Increase/(decrease) in employee entitlements	1,322
10,279	Other	6,000
124,716	Total personnel costs	126,264

Note 5: Capital charge

The Ministry pays a capital charge to the Crown on its taxpayers' funds as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2009 was 7.5% (2008: 7.5%).

Note 6: Finance costs

The Ministry has a policy of not entering into finance leases and as such incurs no significant finance costs.

Note 7: Other operating expenses

Actual 2008 \$000		Actual 2009 \$000
277	Audit fees for the financial statements audit	336
19	Audit fees for NZ IFRS transition	–
48	Audit related fees for assurance and related services	210
8,326	Operating lease payments	8,495
8,909	Consultancy	9,172
836	Maintenance	698
–	Net foreign exchange losses	(1)
4	ACC Partnership Programme	(13)
–	Asset write-offs	325
57,052	Other operating expenses	54,180
75,471	Total other operating expenses	73,402

Audit related fees for assurance services were for audit of rest homes and specific health service providers.

Note 8: Debtors and other receivables

Actual 2008 \$000		Actual 2009 \$000
14,187	Debtors – Crown	15,878
1,193	Debtors – departments	672
248	Debtors – other	842
15,628	Net debtors	17,392
164	Accrued revenue	869
15,792	Total debtors and other receivables	18,261

As at 30 June 2009 all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2008			2009		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	15,133	–	15,133	16,532	–	16,532
Past due 1–30 days	58	–	58	45	–	45
Past due 31–60 days	278	–	278	50	–	50
Past due 61–90 days	73	–	73	4	–	4
Past due > 90 days	86	–	86	761	–	761
Total debtors	15,628	–	15,628	17,392	–	17,392

The Ministry has no provision for doubtful debts at 30 June 2009 (2008: Nil). There were no expected losses for the Ministry's pool of debtors, based on analysis of the Ministry's losses in previous periods, and review of specific debtors at balance date.

Note 9: Property, plant and equipment

	Land \$000	Buildings/ leasehold improvements \$000	Furniture plant and equipment \$000	Motor vehicles \$000	Computer hardware \$000	Total \$000
Cost or valuation						
Balance as at 1 July 2007	4,000	7,364	7,791	446	41,465	61,066
Additions	–	437	806	179	798	2,220
Revaluation increase/(decrease)	1,350	–	–	–	–	1,350
Disposals	–	(11)	(221)	(150)	(1,147)	(1,529)
Balance as at 30 June 2008	5,350	7,790	8,376	475	41,116	63,107
Balance as at 1 July 2008	5,350	7,790	8,376	475	41,116	63,107
Additions	–	721	554	138	3,103	4,516
Revaluation increase/(decrease)	(1,350)	270	–	–	–	(1,080)
Disposals	–	(41)	(64)	(38)	(4,524)	(4,667)
Balance as at 30 June 2009	4,000	8,740	8,866	575	39,695	61,876
Accumulated depreciation and impairment losses						
Balance as at 1 July 2007	–	2,939	4,422	325	29,435	37,121
Depreciation expense	–	609	583	49	3,855	5,096
Eliminate on disposals	–	(5)	(221)	(118)	(1,146)	(1,490)
Balance as at 30 June 2008	–	3,543	4,784	256	32,144	40,727
Balance 1 July 2008	–	3,543	4,784	256	32,144	40,727
Depreciation expense	–	649	640	29	2,353	3,671
Eliminate on disposals	–	(21)	(64)	(30)	(4,524)	(4,639)
Balance as at 30 June 2009	–	4,171	5,360	255	29,973	39,759
Carrying amounts						
At 30 June 2007	4,000	4,425	3,369	121	12,030	23,945
At 30 June 2008	5,350	4,247	3,592	219	8,972	22,380
At 30 June 2009	4,000	4,569	3,506	320	9,722	22,117

Land and buildings have been revalued at fair value on 25 June 2009 by an independently contracted registered valuer, W Blake ANZIV/SPINZ, of Simes Limited while having regard for the following:

- reference to evidence of comparative local property sales values
- market capitalisation of comparative local property rental rates
- continuing use by the Ministry.

There are no restrictions over the title of the Ministry's property, plant and equipment nor are any property, plant and equipment pledged as security for liabilities.

Note 10: Intangible assets

	Acquired software \$000	Internally generated software \$000	Total \$000
Cost			
Balance as at 1 July 2007	3,062	24,580	27,642
Additions	3,342	4,640	7,982
Disposals	(242)	(919)	(1,161)
Balance as at 30 June 2008	6,162	28,301	34,463
Balance as at 1 July 2008	6,162	28,301	34,463
Additions	8,680	5,754	14,434
Disposals	–	–	–
Balance as at 30 June 2009	14,842	34,055	48,897
Accumulated amortisation and impairment losses			
Balance as at 1 July 2007	2,015	15,069	17,084
Amortisation expense	1,127	2,431	3,558
Disposals	(242)	(919)	(1,161)
Balance as at 30 June 2008	2,900	16,581	19,481
Balance 1 July 2008	2,900	16,581	19,481
Amortisation expense	2,643	3,360	6,003
Disposals	–	–	–
Balance as at 30 June 2009	5,543	19,941	25,484
Carrying amounts			
At 30 June 2007	1,047	9,511	10,558
At 30 June 2008	3,262	11,720	14,982
At 30 June 2009	9,299	14,114	23,413

There are no restrictions over the title of the Ministry's intangible assets nor are any intangibles pledged as security for liabilities.

Note 11: Creditors and other payables

Actual 2008 \$000		Actual 2009 \$000
3,981	Creditors	4,081
5,676	Income in advance	4,411
11,894	Accrued expenses	10,867
2,433	GST payable	1,256
23,984	Total creditors and other payables	20,615

Note 12: Provision for repayment of surplus to the Crown

Actual 2008 \$000		Actual 2009 \$000
7,432	Net surplus/(deficit)	10,409
–	Retrospective NZ IFRS adjustments added back	–
7,432	Total repayment of surplus	10,409

Note 13: Provisions

Actual 2008 \$000		Actual 2009 \$000
	Current provisions are represented by:	
1,519	Restructuring	489
1,027	Performance incentive	425
592	Project development	583
18	ACC Partnership Programme	30
3,156	Total current portion	1,527
	Non-current provisions are represented by:	
57	ACC Partnership Programme	32
57	Total non-current portion	32
3,213	Total provisions	1,559

Movements in provisions during the year

2009	Restructuring \$000	Performance incentive \$000	Project development \$000	ACC Partnership Programme \$000	Total \$000
Opening balance 1 July 2008	1,519	1,027	592	75	3,213
Additional provision made	130	425	359	44	958
Amounts applied	(882)	(1,027)	(129)	(57)	(2,095)
Unused amounts reversed	(278)	–	(239)	–	(517)
Closing balance 30 June 2009	489	425	583	62	1,559

Restructuring

The restructuring provision arises from costs associated with the completion of the internal restructuring within the Ministry's Information Directorate. It is anticipated that the restructuring will be completed within 12 months of the balance date.

Performance incentive

Performance incentives accrued the actual amount due to employees following individual determinations under the Ministry's remuneration guidelines.

Project development

The provision represents possible impairment of the B4 School Checks system and costs of further development of the Health Practitioners Index System (HPI).

ACC Partnership programme

The liability for the ACC Partnership programme is measured at the present value of expected future payments to be made with respect to employee injuries and claims received up until the reporting date using actuarial calculations. Consideration is given to expected future salary levels and experience of employee injuries and claims history. Expected future payments are discounted using market yields on national government bonds at the reporting date with terms to maturity that match, as closely as possible, the estimated future cash outflows.

The Ministry manages its exposure arising from the programme by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies
- induction training on health and safety
- actively managing work place injuries to ensure employees return to work as soon as practical
- recording and monitoring work place injuries and near miss events to identify risk areas and implementing mitigating actions
- identification of work hazards and implementation of appropriate safety procedures.

The Ministry has adopted a stop loss limit of 160% of the industry premium for the year ended 30 June 2009 (2008: 168%). The stop loss limit meant the Ministry only carried exposure for total cost of claims up to \$223,000 (2008: \$180,554). The stop loss limit will stay at 160% of the industry premium for the 2009/10 financial year.

The Ministry is not exposed to any significant concentrations of insurance risk as work related injuries are generally the result of an isolated event to an individual employee.

An external independent actuarial valuer, Mr Mark Weaver (FIANZ), has calculated the Ministry's liability, and the valuation is effective as at 30 June 2009. The valuer has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

The outstanding claims liability figure is made up of three components, the 'incurred but not reported' (IBNR) claims, reopen claims and open claims. The IBNR claims and the reopen claims numbers are derived using standard ACC factors. These factors make an allowance for discounting anticipated IBNR rates and reopen claims rates by 6.1% and 6.23% respectively (2008: 6.1% and 6.23% respectively). No further adjustments for discounting are considered necessary. Case estimates relating to open claims are neither inflated nor discounted by the Ministry's claims administration provider, meaning that in effect the open claims are discounted at the rate of inflation.

The value of the liability is not material for the Ministry's financial statements. Any changes in assumptions will not, therefore, have a material effect on these financial statements.

Note 14: Employee entitlements

Actual 2008 \$000		Actual 2009 \$000
	Current employee entitlements are represented by:	
5,828	Annual leave	6,556
119	Sick leave	145
628	Retirement and long service leave	782
1,217	Accrued salaries	1,730
7,792	Total current portion	9,213
	Non-current employee entitlements are represented by:	
1,499	Retirement and long service leave	1,400
–	Sick leave	–
1,499	Total non-current portion	1,400
9,291	Total employee entitlements	10,613

The present value of the retirement and long service leave entitlements depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions applied when calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will have significant impact on the carrying value of the liability.

In determining the appropriate discount rate, the Ministry considered interest rates on national government bonds that have terms to maturity 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 the independent actuary.

If the discount rate were to differ by 1 percentage point from the Ministry's estimates, with all other factors held constant, the carrying amount of the total liability would be an estimated average \$47,000 higher/lower.

If the salary inflation rate were to differ by 1 percentage point from the Ministry's estimates, with all other factors held constant, the carrying amount of the total liability would be an estimated average \$48,000 higher/lower.

Note 15: Taxpayers' funds

Taxpayers' funds comprises two components: general funds and revaluation reserve.

Actual 2008 \$000		Actual 2009 \$000
	General funds	
18,623	Balance at 1 July 2008	18,623
7,432	Net surplus/(deficit)	10,409
–	Capital contribution	12,507
	Transfer from revaluation reserve	
(7,432)	Provision for repayment of surplus to the Crown	(10,409)
18,623	General funds at 30 June 2009	31,130
	Revaluation reserves	
–	Balance at 1 July 2008	1,350
1,350	Revaluation gains/(losses)	(1,080)
	Revaluation changes at 30 June 2009	
–	Transfer to general funds	–
1,350	Revaluation reserves at 30 June 2009	270
19,973	Total taxpayers' funds	31,400
	Revaluation reserves consist of:	
1,350	Land revaluation reserve	–
–	Buildings revaluation reserve	270
1,350	Total revaluation reserves	270

Note 16: Reconciliation of net surplus/(deficit) to net cash flow from operating activities

Actual 2008 \$000		Actual 2009 \$000
7,432	Net surplus/(deficit)	10,409
	Add/(less) non-cash items:	
8,654	Depreciation and amortisation expense	9,674
–	Other non-cash items	–
8,654	Total non-cash items	9,674
	Add/(less) items classified as investing or financing activities:	
(49)	(Gains)/losses on disposal of property, plant and equipment	9
	Add/(less) movements in working capital items:	
(165)	(Inc)/dec in debtors and receivables	(780)
(351)	(Inc)/dec in debtor Crown	(1,691)
(661)	(Inc)/dec in prepayments	(81)
1,550	Inc/(dec) in creditors and payables	(3,369)
1,319	Inc/(dec) in provisions	(1,654)
704	Inc/(dec) in employee entitlements	1,322
2,396	Net movements in working capital items	(6,253)
18,433	Net cash from operating activities	13,839

Note 17: Related party transactions and key management personnel

Related party transactions

The Ministry is a wholly owned entity of the Crown. The Government significantly influences the role of the Ministry as well as being its major source of revenue.

The Ministry enters into transactions with other government departments, Crown entities (including DHBs) and other state owned enterprises on an arm's length basis. Those transactions are considered by the Ministry to have occurred within a normal supplier or client relationship on terms no more or less favourable than those which it is reasonable to expect the Ministry would have adopted if dealing with that entity at arm's length in the same circumstances. Such transactions are considered to not be related party transactions and are not disclosed.

The following transactions were carried out with related parties:

- There are close family members of key management personnel employed by the Ministry. The terms and conditions of those employment arrangements are no more favourable than the Ministry would have adopted if there were no relationship to key management personnel.
- During the year the Ministry may purchase advertising space on Samoan Capital Radio, for which the Deputy Director-General – Sector Capability and Innovation is a director. Any advertising

costs and services are supplied on normal commercial terms. There were no direct transactions in the current year (2008: \$3,375).

- During the year the Ministry contracted on behalf of the Crown with Presbyterian Support Services – Northern, for which the Deputy Director-General – Sector Capability and Innovation is a director. The value of services provided under contract during the year totalled \$1,493,342.21 (2008: \$1,159,610) and were negotiated on normal commercial terms. There were no outstanding balances under contracts with this related party as at year end.

No provision has been required, nor any expense recognised, for impairment from related parties.

Key management personnel compensation

Actual 2008 \$000		Actual 2009 \$000
2,393	Salaries and other short-term employee benefits	2,984
–	Termination benefits	–
2,393	Total key management personnel compensation	2,984

Key management personnel include the Director-General of Health, and the eight Deputy Directors-General that form the core of the Ministry's Executive Leadership Team. The increase reflects that all positions were fully staffed for the 12 months following completion of recruitment during the prior year.

Note 18: Events after the balance sheet date

There have been no significant events after the balance sheet date.

Note 19: Financial instrument risks

The Ministry's activities expose it to a variety of financial instrument risks including market risk, credit risk, and liquidity risk. The Ministry has policies in place to manage the risk associated with financial instruments and continually seeks to minimise risk from exposure to financial instruments. These policies do not allow any transactions of a speculative nature to be entered into.

Market risk

Currency risk

Currency risk is the risk that the fair value of future cash flows from a financial instrument will fluctuate as a result of changes in foreign exchange rates.

The Ministry has no significant exposure to currency risk on any financial instruments.

Interest rate risk

Interest rate risk is the risk that the fair value of future cash flows from a financial instrument will fluctuate as a result of changes in market interest rates.

The Ministry has no significant exposure to interest rate risk on any of its financial instruments.

Credit risk

Credit risk is the risk that a third party will default on its obligations to the Ministry, causing the Ministry to incur a loss.

In the normal course of business, credit risk arises from debtors and other accounts receivable, deposits with banks, and derivative financial instruments.

In accordance with New Zealand Treasury policy, the Ministry is only permitted to deposit funds with Westpac Banking Corporation, a registered bank, and to enter into foreign exchange forward contracts with the New Zealand Debt Management Office. These entities have high market credit ratings. With respect to its remaining financial instruments, the Ministry does not have significant concentrations of credit risk.

The Ministry's maximum credit exposure for each class of financial instruments is represented by the total carrying amount of cash, cash equivalents, net debtors and derivative financial instrument assets. The Ministry holds no collateral as security against these financial instruments, including those that are overdue or impaired.

The fair value of all financial instruments is equivalent to the carrying value disclosed in the Statement of Financial Position.

The Ministry held no bank overdraft facilities as at 30 June 2009, or incurred any overdrafts during the 2008/09 fiscal period.

Liquidity risk

Liquidity risk is the risk that the Ministry will encounter difficulty raising liquid funds to meet its payment commitments as they fall due.

In meeting its liquidity requirements the Ministry closely monitors its forecast cash requirements with expected cash draw downs from the New Zealand Debt Management Office. The Ministry maintains a target level of available cash to meet its liquidity requirements.

The table below analyses the Ministry's financial liabilities that will be settled based on the remaining period at the balance date to the contracted maturity date. The amounts disclosed are the contracted undiscounted cash flows.

	Less than 6 months \$000	Between 6 months and 1 year \$000	Between 1 and 5 years \$000	Over 5 years \$000
2008				
Creditors and other payables	23,984	–	–	–
2009				
Creditors and other payables	20,615	–	–	–

Note 20: Categories of financial instruments

The carrying amounts of financial assets and financial liabilities in each of the NZ IAS 39 *Financial Instruments: Recognition and Measurement* categories are as follows:

Actual 2008 \$000		Actual 2009 \$000
	Loans and receivables	
9,537	Cash and cash equivalents	9,522
15,792	Debtors and other receivables	18,261
25,329	Total loans and receivables	27,783
	Financial liabilities measured at amortised cost	
(23,984)	Creditors and other payables	(20,615)

Note 21: Capital management

The Ministry's capital is its equity (or taxpayers' funds) that comprise general funds and revaluation reserves. Equity is represented by net assets.

The Ministry manages its revenues, expenses, assets, liabilities and general financial dealings in a prudent manner. The Ministry's equity is largely managed as a by-product of managing income, expenses, assets, liabilities and its need to both comply with Government Budget processes and New Zealand Treasury instructions.

The objective of managing the Ministry's equity is to ensure the Ministry effectively achieves its goals and objectives, for which it has been established, while remaining a going concern.

Note 22: Memorandum accounts

Since October 2004 the Ministry has, in accordance with the Gambling Act 2003, received an appropriation for problem gambling that over time is intended to be fully funded from the levies collected from the industry, on behalf of the Crown, by the Inland Revenue Department. The following table shows a comparison between the Ministry's appropriation for, and actual expenditure on initiatives in relation to problem gambling and the levies collected to date. The balance in the problem gambling memorandum account at 30 June 2009 is \$4.872 million.

Problem gambling

	Appropriation [^] \$000	Expenditure \$000	Levies collected (IRD) \$000
Transition costs prior to introduction of levy strategy	–	1,291	
Prior years non-departmental amount	64,235	58,781	
Prior years departmental amount	3,044	3,458	
Total to 30 June 2008	67,279	63,530	59,335
2008/09 year non-departmental amount	17,719	16,619	
2008/09 year departmental amount	1,378	1,355	
Total for year ended 30 June 2009	19,097	17,974	21,000
Accumulated totals to June 2009	86,376	81,504	80,335

[^] Appropriation figures include both departmental and non-departmental budgeted amounts and exclude output expense budget amounts carried forward from one year to the following year.

National Radiation Laboratory: Licensing activities

A memorandum account was established on 1 July 1998 for National Radiation Laboratory licensing activities required by the Radiation Protection Act 1965. The following table shows the amounts of revenue and expenses relating to licensing activities.

Actual 2008 \$000		Actual 2009 \$000
	Licensing fees	
305	Balance at 1 July 2008	354
762	Revenue	756
(713)	Expenses	(725)
354	Balance at 30 June 2009	385

Medsafe

Pursuant to the Medicines Act 1981, Medsafe derives third-party fee revenue from the medicines and pharmaceutical industry from licence applications to approve new or changed medicines, and for clinical trials. A memorandum account has been established effective from 1 July 2007 to match accumulated licence revenue collected against the expenses incurred to process applications. This information will be used to ensure that, over time, fees will be set at a level as to ensure revenue collected equates to equivalent levels of costs incurred.

Actual 2008 \$000		Actual 2009 \$000
	Medsafe	
–	Balance at 1 July 2008	1,147
8,999	Revenue	13,314
(7,852)	Expenses	(12,173)
1,147	Balance at 30 June 2009	2,288

Note 23: Explanation of major variances against budget

Explanations for major variances from the Ministry's estimated figures in the Statement of Intent are as follows:

Statement of financial performance

Revenue Crown

Crown revenue was \$11.7 million below budget due to savings identified following the reprioritisation processes during the year.

Revenue other

Revenue from sources other than the Crown was \$5.5 million higher than budget due mainly to higher volumes of medicine applications being processed than anticipated.

Personnel costs

Personnel costs were lower than budget by \$3.2 million due to a reduction in actual to planned staff numbers during the year.

Depreciation

Depreciation costs were lower than budget by \$4.5 million due to a delay in capital expenditure.

Other operating expenses

Other operating expenses were lower than budget by \$7.9 million as a result of savings in consultancy and contractors compared to plan, and savings initiatives instituted as part of the Government's line-by-line savings programme.

Statement of financial position

Revaluation reserves

The 2008/09 value arose from a revaluation of the National Radiation Laboratory, Christchurch property in June 2009.

Cash and cash equivalents, debtors and other receivables

The actual year end current assets were \$6.7 million higher than budget due to a higher debtors level than anticipated and a higher than originally planned Crown debtor, as cash was not required due to underspend at year end.

Property, plant and equipment, and intangible assets

Property, plant and equipment were lower than the main budget due to computer hardware purchases and software implementation being less than anticipated. Progress on the national system development plan and the replacement programme for desktops was delayed as the projects and purchase plans were being assessed.

Creditors and other payables

Creditors, accruals and supplementary budgets were higher compared to mains due to creditors including capital being greater than originally planned. Actual for 2008/09 is similar to but less than, 2007/08.

Repayment of surplus

The repayment of surplus provision reflects the actual surplus generated from savings and constrained hiring and expenditure in the last few months, while at the time of budget setting no surplus figure is assumed to be derived from the year's activities.

Provisions

The decrease of \$3.5 million in provisions over that budgeted is due to restructuring costs and relocation costs not being as large as anticipated when the budget was set.

Statement of cash flows

Cash from operating activities

The decrease is due to the Ministry being underspent at year end following savings in personnel and operating costs.

Cash from investing activities

Purchases of intangible assets (computer software) were \$11 million more than budget due to equity increases not being reflected in the main budget.

Cash from financing activities

As a result of the capital asset additions being funded internally from non cash depreciation and amortisation, part of the budgeted capital contribution of \$10 million was not called upon.

Non-departmental statements and schedules for the year ended 30 June 2009

The following non-departmental statements and schedules record the income, expenses, assets, liabilities, commitments, contingent liabilities, contingent assets and trust accounts that the Ministry manages on behalf of the Crown.

Statement of non-departmental expenses and capital expenditure against appropriations for the year ended 30 June 2009

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000
Vote Health:				
Appropriation for output expenses				
Health and disability support services				
for District Health Boards (DHBs):				
359,499	Northland DHB	389,332	383,484	389,731
956,041	Waitemata DHB	1,012,346	997,874	1,013,278
827,325	Auckland DHB	881,089	872,851	881,337
864,209	Counties Manukau DHB	931,177	915,851	932,041
710,705	Waikato DHB	781,121	769,942	781,745
221,788	Lakes DHB	234,112	228,582	234,294
454,792	Bay of Plenty DHB	491,063	485,464	491,430
107,956	Tairāwhiti DHB	115,404	113,466	115,426
243,144	Taranaki DHB	257,639	253,444	257,887
338,705	Hawke's Bay DHB	357,786	354,798	358,708
161,698	Whanganui DHB	171,453	170,148	172,777
354,710	MidCentral DHB	372,802	368,404	373,103
270,117	Hutt Valley DHB	286,986	283,441	287,506
514,891	Capital and Coast DHB	536,365	530,625	536,775
95,075	Wairarapa DHB	99,868	98,861	99,926
297,505	Nelson-Marlborough DHB	309,489	306,518	309,705
96,127	West Coast DHB	101,682	100,797	101,740
971,608	Canterbury DHB	1,026,481	1,013,312	1,027,024
129,555	South Canterbury DHB	137,705	136,576	137,842
402,886	Otago DHB	418,527	414,879	418,864
225,589	Southland DHB	234,601	232,245	234,756
8,603,925	Total health and disability support services for District Health Boards	9,147,028	9,031,562	9,155,895

Continues next page . . .

Continued from previous page

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000
834,076	National disability support services	–	–	–
–	Disability support services – national	888,648	880,362	889,671
356,911	Public health services purchasing	426,904	547,707	453,201
1,674	Management of residual health liabilities and DHB term debt	1,751	1,751	1,751
105,464	Clinical Training Agency	117,188	120,219	122,271
38,135	National child health services	52,292	41,011	55,443
128,344	National elective services	176,373	192,153	195,198
65,146	National emergency services	68,539	69,053	69,358
8,613	National Māori health services	6,858	9,671	8,562
124,624	National maternity services	130,512	108,128	137,333
53,351	National mental health services	49,041	84,279	55,445
77,814	National contracted services – other	115,471	197,946	123,302
324	National advisory and support services	299	340	340
13,600	Monitoring and protecting health and disability consumer interests	14,641	14,659	14,659
6,487	Meningococcal vaccine	1,177	6,632	2,132
105,717	Health services funding	174,858	421,846	174,869
15,725	Problem gambling	16,627	17,719	17,719
49	Scientific advice to support pest management strategies as they affect public health	–	56	56
10,539,979	Total appropriations for non-departmental output expenses	11,388,207	11,745,094	11,477,205
	Appropriation for other expenses to be incurred by the Crown			
–	Australian Kidney Foundation	–	15	–
2,197	International health organisations	1,908	2,230	3,483
6,043	Legal expenses	1,587	1,778	1,778
13,873	Provider development	18,685	19,289	19,289
22,113	Total appropriations for other expenses to be incurred by the Crown	22,180	23,312	24,550

Continues next page . . .

The accompanying notes on pages 91 to 94 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2009.

Continued from previous page

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000
Appropriation for capital expenditure				
29,800	Deficit support for DHBs	2.8	73,490	– 100,000
73,636	Equity for capital projects for DHBs and the NZ Blood Service	2.9	62,831	158,686
–	Health sector projects		–	3,765 3,765
–	Queen Mary Hospital site	2.10	14,800	– 14,800
80,492	Loans for capital projects	2.11	21,880	38,955 89,923
70,000	Refinance of DHB private debt		–	– –
10,949	Residential care loans	2.12	12,232	15,000 15,000
–	Rollover of Crown Health Funding Authority loans		–	– –
264,877	Total appropriations for capital contributions to other persons or organisations		185,233	216,406 323,406
4,092	Response to significant health emergencies		–	– –
4,092	Total appropriations for purchase or development of capital assets by the Crown		–	– –
10,831,061	Total appropriations		11,595,620	11,984,812 11,825,161

Statement of non-departmental unappropriated expenditure and capital expenditure for the year ended 30 June 2009

There was no unappropriated non-departmental expenditure for the year ended 30 June 2009 (2008: nil).

The accompanying notes on pages 91 to 94 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2009.

Schedule of non-departmental income and capital receipts for the year ended 30 June 2009

Non-departmental revenues and capital receipts are administered by the Ministry on behalf of the Crown. As these revenues are not established by the Ministry nor earned in the production of the Ministry's outputs, they are not reported in the Ministry's financial statements.

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000
Income				
Reimbursement from the ACC⁺				
6,576	ACC – reimbursement of complex burns costs	4,306	6,400	6,400
19,005	ACC – reimbursement of work-related public hospital costs	19,108	21,504	24,522
205,611	ACC – reimbursement of non-earners account	231,073	202,523	230,951
69,782	ACC – reimbursement of earners' non-work-related public hospital costs	74,499	61,636	70,287
53,554	ACC – reimbursement of motor vehicle-related public hospital costs	49,791	51,060	58,227
3,739	ACC – reimbursement of medical misadventure costs	3,116	1,877	2,140
4,487	ACC – reimbursement of self-employed work public hospital costs	4,366	5,871	6,695
362,754	Total ACC reimbursements 2.13	386,259	350,871	399,222
176,116	Payment of capital charge by DHBs 2.14	151,160	199,709	199,709
(29,657)	Net surplus/(deficit) from DHBs*	(159,609)	–	(110,000)
873	Other Crown entities surplus/(deficits)**	(5,079)	–	–
599	Crown health financing agency rental	637	278	278
–	Crown health financing agency interest	–	–	–
12	Miscellaneous	20	–	1,253
510,697	Total non-departmental income	373,388	550,858	490,462
Capital receipts				
11,674	Repayment of residential care loans 2.15	10,928	24,000	24,000
304	Repayment of DHB debt	304	–	–
12,499	Equity repayments by DHBs	47,499	49,445	12,499
24,477	Total non-departmental capital receipts	58,731	73,445	36,499
535,174	Total non-departmental income and capital receipts	432,119	624,303	526,961

+ Accident Compensation Corporation.

* Based on unaudited financial statements of the 21 District Health Boards, and accordingly have not been reflected in the Investments in Crown entities figure within the schedule of non-departmental assets.

** Based on unaudited financial statements of the other non-DHB health sector Crown entities, and accordingly have not been reflected in the Investments in Crown entities figure within the schedule of non-departmental assets.

The accompanying notes on pages 91 to 94 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2009.

Schedule of non-departmental assets as at 30 June 2009

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000	
Assets					
Current assets					
65,312	Cash and cash equivalents	2.16	81,580	33,661	30,735
53,216	Inventory	2.17	72,817	50,738	53,216
Debtors and other receivables:					
58,237	District Health Boards	2.18	37,768	–	–
300,504	ACC	2.18	388,693	113,677	360,619
1,368	Government departments	2.18	–	274	1,487
3,751	Others	2.18	7,094	31	1,753
1,326	Prepayments	2.18	1,012	2,841	3,397
483,714	Total current assets		588,964	201,222	451,207
Non-current assets					
Advances:					
49,103	Residential care loans	2.19	29,893	62,058	54,749
4,547	Other advances	2.20	5,394	–	–
Investments:					
2,631	Leasehold land		2,631	–	2,631
23,725	Other investments	2.21	38,409	29,309	23,725
80,006	Total non-current assets		76,327	91,367	81,105
563,720	Total non-departmental assets		665,291	292,589	532,312

In addition, the Ministry monitors a number of Crown entities (including the 21 DHBs). The investment in those entities is recorded within the financial statements of the Government on a line-by-line basis. No disclosure of investment in Crown entities is made in this schedule.

The accompanying notes on pages 91 to 94 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2009.

Schedule of non-departmental liabilities as at 30 June 2009

Actual 2008 \$000	Note	Actual 2009 \$000	Main estimates 2009 \$000	Supp. estimates 2009 \$000	
Liabilities					
Current liabilities					
Creditors and other payables:					
3,885	District Health Boards	2.22	819	3,463	–
2,064	Other payables	2.22	8,990	–	–
Accrued liabilities and provisions:					
228,156	District Health Boards	2.23	285,198	127,758	314,373
1,300	Other Crown entities	2.23	2,767	–	–
182,447	Other accrued liabilities	2.23	138,282	422,404	173,573
417,852	Total non-departmental liabilities		436,056	553,625	487,946

Schedule of non-departmental commitments as at 30 June 2009

The Crown has the following capital and operating contracts for the supply of goods and services.

Actual 2008 \$000		Actual 2009 \$000
Capital commitments		
422,190	Property, plant and equipment	574,620
530	Intangible assets	–
4,200	Other capital commitments	162,618
426,920	Total capital commitments	737,238
Non-cancellable commitments		
9,763,057	Not later than one year	10,252,440
222,963	Later than one year and not later than five years	242,970
–	Later than five years	1,161
9,986,020	Total non-cancellable commitments	10,496,571
10,412,940	Total commitments	11,233,809

The accompanying notes on pages 91 to 94 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2009.

Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2009

Unquantified contingent liabilities

The Ministry on behalf of the Crown has no unquantifiable contingent liabilities.

Quantifiable contingent liabilities

Actual 2008 \$000		Actual 2009 \$000
40,245	Legal proceedings and disputes	15,863
40,245	Total quantifiable contingent liabilities	15,863

Legal proceedings and disputes

Legal claims against the Crown are mainly seeking recompense in relation to perceived issues regarding treatment and care. The Crown is in the process of defending these claims. In the normal course of events previous experience indicates that any settlements are likely to be significantly less than the claims made.

Contingent assets

The Ministry on behalf of the Crown has no contingent assets at 30 June 2009 (2008: Nil).

The accompanying notes on pages 91 to 94 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2009.

Statement of trust monies for the year ended 30 June 2009

Actual 2008 \$000		Actual 2009 \$000
	District Health Boards Deposit Trust Account*	
83	Balance as at 1 July 2008	635
4,613,868	Contributions	4,981,576
(4,612,558)	Distributions	(4,981,494)
–	Revenue	372
(758)	Expenditure	–
635	Balance as at 30 June 2009	1,089

* This trust account was set up to hold funds received from District Health Boards for the delivery of processing services and disbursements.

Another trust account was set up to hold deposits made by those new medicines applications that have been rejected by the Medicines Assessment Advisory Committee (MAAC). Deposits are made when they request the Medicines Review Committee to consider their objections to recommendations made by MAAC. Once the Medicines Review Committee completes its review, these deposits are refunded to depositors subject to the deduction of any costs ordered by the Committee. There were no transactions during the year ended 30 June 2009 and the balance remains under \$500.

The accompanying notes on pages 91 to 94 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2009.

Notes to the non-departmental statements and schedules

Note 1: Statement of accounting policies for the year ended 30 June 2009

Reporting entity

The Non-departmental statements and schedules for the Crown: Vote Health have been prepared by the Ministry and present the public funds managed by the Ministry that are not incorporated in its financial statements.

The Ministry is responsible for an effective and efficient management of revenue, expenditure, assets and liabilities on behalf of the Crown. These have been produced pursuant to the Public Finance Act 1989.

Measurement system

The Non-departmental statements and schedules have been prepared on an historical cost basis modified by the revaluation of certain assets.

Revenue and receipts

Revenue from ACC recoveries and capital charges from District Health Boards is recognised when earned and is reported in the financial period to which it relates.

Debtors and receivables

Receivables from ACC recoveries are recorded at the value of the contract with ACC. Receivables from capital charges are recorded at estimated realisable value.

Residential care loans

The carrying value of residential care loans was calculated at the nominal value, with a provision for impairment, based on a review of a selection of files. The Ministry believes that the current balance approximates the current fair value of the loan book.

Inventory

Inventories held for consumption in the provision for services are recorded at the lower of cost or current replacement cost. Any write down from cost to replacement cost is recognised in the Statement of non-departmental expenses and capital expenditure against appropriations.

Investments

Investments are recorded in the Schedule of non-departmental assets at historical cost. The carrying value represents the aggregate of equity injections made by the Ministry less subsequent repayments of equity returned to the Crown.

Payables and provisions

Payables and provisions are recorded at the estimated obligation to pay.

Accrued expenses

Accrued expenses are recorded at either the value of funding entitlements owing under Crown Funding Agreements or the estimated value of contracts already started but not yet completed.

Financial instruments

The Crown: Vote Health is party to financial instruments as part of its normal operations. These financial instruments include bank accounts, short term deposits, debtors and creditors. All financial instruments are recognised in the Schedules of non-departmental assets and non-departmental liabilities and all revenues and expenses in relation to financial instruments are recognised in the Schedules of non-departmental revenue and non-departmental expenses.

Goods and Services Tax (GST)

All items in the financial statements are stated exclusive of GST, except for receivables and payables, which are stated on a GST inclusive basis.

Commitments

Future expenses and liabilities to be incurred on contracts that have been entered into as at balance date are disclosed as commitments to the extent that there are equally unperformed obligations.

Contingent liabilities

Contingent liabilities are disclosed at the point at which the contingency is evident.

Changes in accounting policies

There have been no changes in accounting policies.

Note 2: Explanation of major variances against budget

Explanations for major variances from the Ministry's non-departmental appropriations within the Main Estimates are as follows:

Schedule of non-departmental expenses and capital expenditure against appropriations

- 2.1 **Public health services purchasing** decrease in expenditure mainly due to lower than expected costs of the Human papillomavirus (HPV) programme, and delays in drinking water and sewage subsidy payments.
- 2.2 **National child health services** actual is greater than the original budget due to new funding agreed during the year for B4 school checks and increase in well child contacts to reflect an increase in birth numbers.
- 2.3 **National elective services** costs were \$16 million less than budget, due to funding brought forward from earlier years, not contracted. However, total elective volumes delivered by DHBs were greater than the targets set.

- 2.4 **National maternity services** increase of \$22 million in actual expenditure above budget reflects extra funding provided to fund a significant increase in birth rates during the year.
- 2.5 **National mental health services** actual expenditure of \$35 million less than budget was due to funding being devolved/ transferred from Ministry appropriations to DHBs.
- 2.6 **National contracted services – other** actual is less than budget due to financial incentive payments transferred to DHBs (\$43 million) and funding reprioritised and transferred to other appropriations to meet the increased costs of the growth in birth numbers (\$29 million) and other savings identified to support pressures in the Vote.
- 2.7 **Health services funding** was significantly underspent compared to the Main Estimates budget, but expenditure was in line with the Supplementary Estimates budget. This appropriation contains the sector risk reserves and provisions for new initiatives still requiring final approvals and a provision for deficit support that is transferred to capital when DHB plans are finalised. The deficit transfer was \$100 million, \$43 million was returned to budget 2009 from risk reserves and savings from programme implementation delays. \$47 million of indicative funding was transferred to other appropriations for specific services, \$16 million was transferred to capital for oral health youth and adolescence services. \$26 million was re-prioritised to other services in September 2008.
- 2.8 **Deficit support for DHBs** is not finalised until the DHB Annual Plans are agreed. The Budget was increased from zero to \$100 million in supplementary. The underspend of \$26.5 million reflects the cash needs only of DHBs in relation to the current deficit.
- 2.9 **Equity for capital projects for DHBs and the NZ Blood Service** underspend relates to delays in Equity requests made by DHBs for approved capital projects. During the year \$50 million was also transferred to the debt funding appropriation.
- 2.10 **Queen Mary Hospital site** was purchased during the year by CHFA. The Government provided a loan to CHFA, for the purchase, which was not known at the time of the Main Estimates budget. The loan will be repaid when the property is subdivided and sold to the agreed parties.
- 2.11 **Loans for capital projects** underspend relates to delays in loan requests made by DHBs for approved capital projects. During the year \$50 million was also transferred from the equity funding appropriation.
- 2.12 **Residential care loans** appropriation is demand driven and is dependant on the number of eligible clients entering into care facilities.

Schedule of non-departmental income and capital receipts

- 2.13 **ACC reimbursements** increase of actual payments over budget is due to ACC advising higher volumes of acute non earner and non work related costs compared to plan.
- 2.14 **Payment of capital charge by DHBs** actual capital charge paid by DHBs is less than the mains budget, due to lower equity in DHB accounts, as a result of increased deficits and lower than planned equity draw downs.
- 2.15 **Repayment of residential care loans** lower than planned repayments of residential care loans is due to less people exiting the system than anticipated and lower than planned draw downs on the system influenced by higher exemptions and lower property values.

Schedule of non-departmental assets

- 2.16 **Cash and cash equivalents** are above budget due to June payments being lower than expected. Also, the capital drawdown for Child and Adolescence Oral Health was not included in the budget as the majority of the payment profile was only agreed by Ministers in May and June 2009.
- 2.17 **Inventory** increases reflect the current pandemic response, with tamiflu being issued, and further purchases of relenza. There has also been slower than anticipated takeup of the HPV programme and the Pneumococcal Vaccine programme.
- 2.18 **Debtors and other receivables** were above budget due to no payments having been received from ACC for the 2008/09 year. The budget anticipated that payment for the core non-variable portion of the contract would be paid. The payments were delayed due to delays in the contract being finalised. The accrual for ACC at year end was \$388.7 million.
- 2.19 **Residential care loans** is less than budget due to provisions made to adjust the loan account. This recognises the current indepth review of the loan ledger, based on the changes of entitlement following changes to protected equity levels and valuations of property.
- 2.20 **Other advances** were not classified separately within the initial forecast financial position.
- 2.21 **Other investments** were over budget as the Crown agreed during the year to provide a loan facility to CHFA to allow them to purchase the Queen Mary Hospital site from Canterbury DHB.

Schedule of non-departmental liabilities

- 2.22 **Other payables** are greater than anticipated as the number of outstanding days with predominately care facilities was greater than anticipated. This has been offset by lower than budgeted DHB creditors as payments were improved during the year to ensure cash flowed into the sector in a timely manner.
- 2.23 **Accrued liabilities and provisions** increases in District Health Board accruals are due to larger than expected electives accruals and the payment of performance payments for Primary Health Organisations (PHOs) not being finalised at year end. Provisions are lower than anticipated, due to improvements in the payables claiming system.

Part 3: Health and Independence Report – The Director-General of Health’s Annual Report on the State of Public Health

Introduction: Director-General’s overview

This report provides a snapshot of the overall functioning of the health system and fulfils the Director-General of Health’s responsibility under the Health Act 1956 to report on the current state of public health in New Zealand.

New Zealanders have affordable access to a strong public health and disability system, and high-level indicators show that the overall health of the population continues to improve. Furthermore, the gap between Māori and non-Māori life expectancy is narrowing. The challenge is to continue improving the performance and sustainability of the health and disability system against a background of growing community expectation and increasing financial and structural pressures.

Delivering government priorities, as defined through Health Targets, the Minister’s priorities and government objectives, is the priority of the Ministry of Health. The Ministry is central to the development and implementation of a wide range of health initiatives. Our role is to manage and lead the health and disability system and ensure services are planned, funded and delivered in a way that improves productivity and cost effectiveness in an increasingly resource-constrained environment.

The results outlined in this report are a testimony to the professionalism and dedication of people throughout the health and disability services and their commitment to maintaining a strong public health system that provides world-class care.

Health indicator framework

The health and independence indicators are organised in accordance with the indicator framework presented in Table 2.

The selected set of indicators satisfy a number of criteria, including sensitivity to change, statistical soundness, measurability for diverse populations, and sustainability. As a set of indicators they provide a view of the whole health system performance and they cover the spectrum of health issues. Most importantly the indicators were chosen for their ability to provide feedback on where the health system is working well and where there is need for improvement.

Table 2: Health indicator framework

Outcome	Indicators
<p>Health status: All New Zealanders lead longer, healthier and more independent lives.</p>	<ul style="list-style-type: none"> • Health expectancy • Life expectancy • Disability requiring assistance • Mental health status • Suicide
<p>Health system performance: How well is the health system performing in delivering quality health actions to improve the health of all New Zealanders?</p>	
<p>Quality and effectiveness: Health care services are effective, co-ordinated, clinically sound, culturally competent and timely. Health care quality relates to all the other performance dimensions.</p>	<ul style="list-style-type: none"> • Ambulatory-sensitive hospital admissions • Cardiovascular disease mortality • Cancer survival • Hospital readmissions • Hospital mortality • Smoking prevalence and tobacco consumption • Obesity • Hazardous alcohol consumption
<p>Equity and access: Fair access to health services in relation to people’s needs, irrespective of income, physical location, ethnicity, age or sex.</p>	<ul style="list-style-type: none"> • Elective surgery discharges • Immunisation coverage
<p>Efficiency and value for money: Effective care is delivered with the most cost- effective use of resources.</p>	<ul style="list-style-type: none"> • Day-case procedures • Productivity and costs of public hospital services
<p>Patient-centredness and responsiveness: The health system is client orientated and respectful of dignity, confidentiality, participation in choices, promptness and quality of amenities.</p>	<ul style="list-style-type: none"> • Patient engagement • Timely access to medical care

Health status

Strategic outcome: All New Zealanders lead longer, healthier and more independent lives

Health status is profiled using summary measures of population health such as health and life expectancies, disability, as well as mental health status. Health status outcomes are not just influenced by the activities of the health system but also the broader activities of the Government and society.

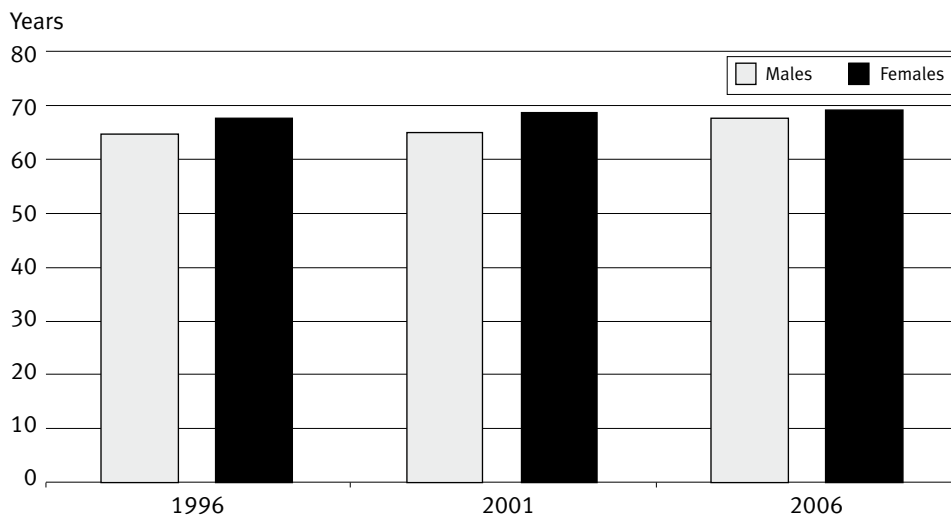
Health expectancy

Health expectancy is the number of years a person could expect to live in good health if current age-specific mortality and morbidity rates persist. The measure of health expectancy used here is independent life expectancy at birth: the number of years expected to be lived without functional limitation requiring assistance.

Health expectancy provides a whole-of-system outcome measure for assessing the performance of the health system, capturing both quantity of life (mortality) and quality of life (morbidity) dimensions of health.

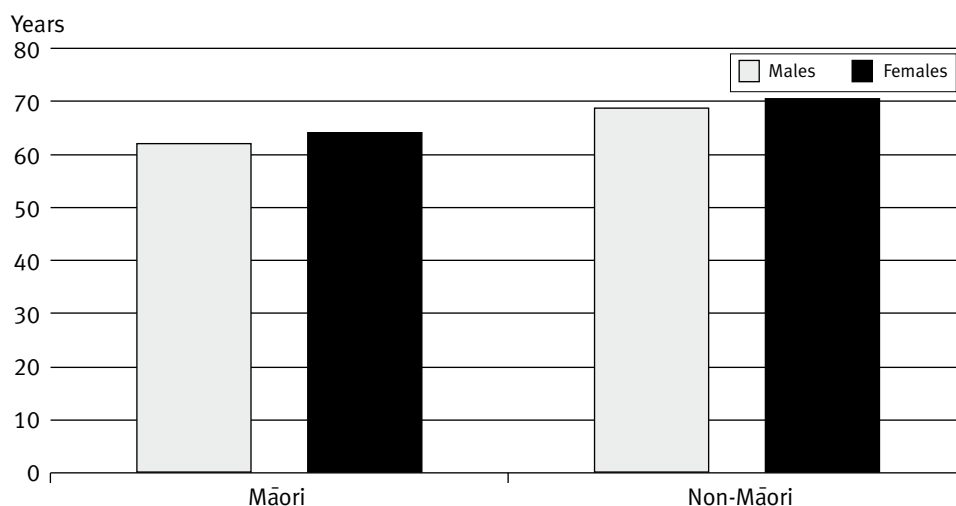
Health expectancy has increased since 1996 and now stands at 67.4 years for males and 69.2 years for females. Health expectancy has increased faster for males than for females over the past decade: males gained 2.7 years and females gained 1.7 years of health expectancy between 1996 and 2006. In particular, significant gains for males occurred between 2001 and 2006 (see Figure 6).

Figure 6: Independent life expectancy at birth (years) by gender, 1996–2006



Source: Statistics New Zealand mortality and population data; Post-censal Disability Surveys 1996, 2001 and 2006; mortality data corrected by the Ministry of Health for ethnic undercount.

Figure 7: Independent life expectancy at birth (years) by gender and ethnicity, 2006



Source: Statistics New Zealand mortality and population data; Post-censal Disability Surveys 1996, 2001 and 2006; mortality data corrected by the Ministry of Health for ethnic undercount.

In 2006 the Māori–non-Māori inequality in health expectancy was 6.8 and 6.2 years for males and females, respectively (see Figure 7). The 1996 and 2001 Disability Surveys were insufficiently powered to provide robust health expectancy estimates for Māori for earlier periods.

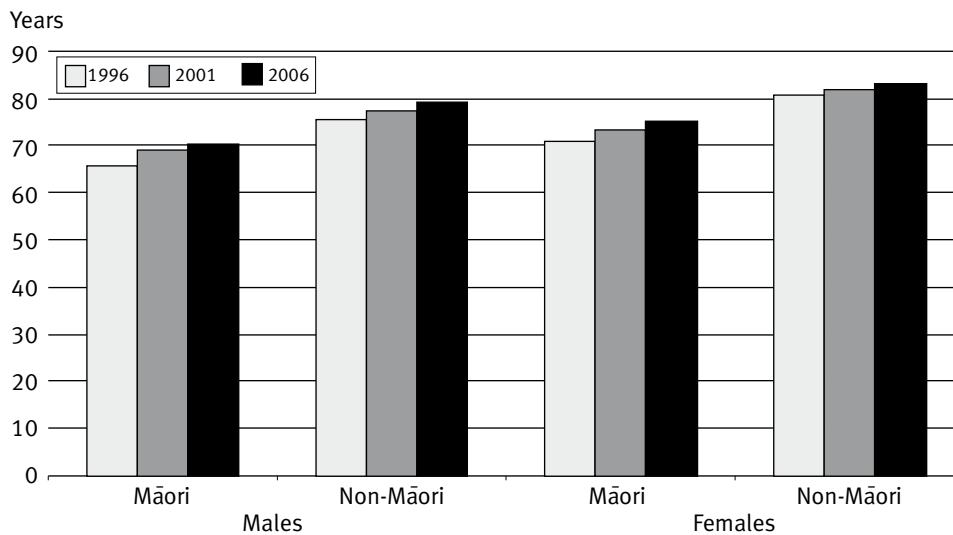
Life expectancy

Life expectancy is the total number of years a person could expect to live, if current age-specific mortality and morbidity rates persist. The indicator used here is life expectancy at birth, which provides a summary measure of the survival experience of the population. It captures the ‘length of life’ dimension of health.

Life expectancy at birth has increased rapidly over the past decade, for both genders and for the Māori and non-Māori ethnic groups (see Figure 8). For males, life expectancy at birth increased from 74.4 years in 1996 to 78.0 years in 2006 (a gain of 3.6 years). For females, life expectancy at birth increased from 79.7 to 82.2 years over the same decade (a smaller gain of 2.5 years). As a result, the gender gap narrowed by over 1 year, decreasing from 5.3 years in 1996 to 4.2 years in 2006.

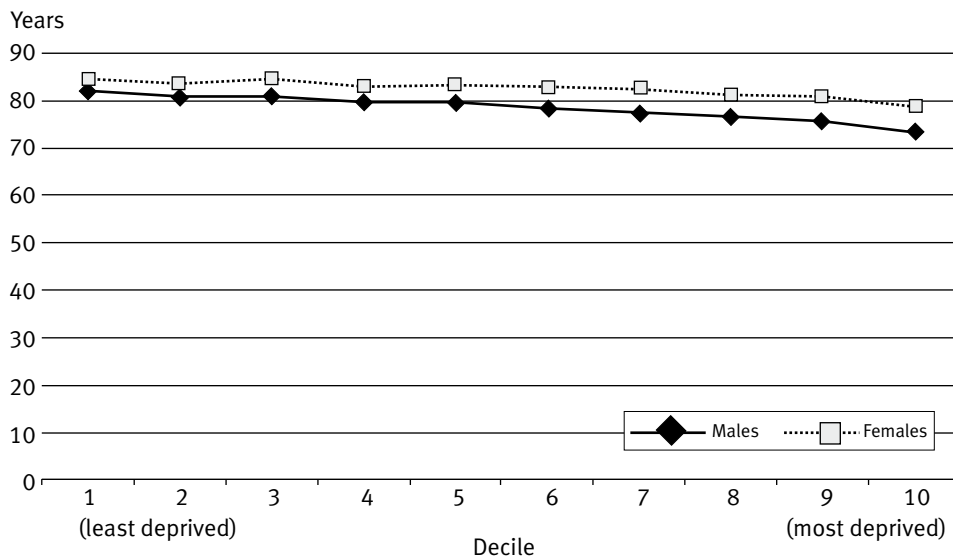
For the Māori population, life expectancy at birth increased from 65.6 to 70.4 years for males (a gain of 4.8 years) and from 70.8 to 75.1 years for females (a gain of 4.3 years) between 1996 and 2006. The gap between Māori and non-Māori narrowed by approximately 1.2 years for males and 2.0 years for females over the decade.

Figure 8: Life expectancy at birth, by gender and ethnicity, 1996 to 2006



Source: Statistics New Zealand; mortality data corrected by the Ministry of Health for ethnic undercount.

Figure 9: Life expectancy at birth, by gender and deprivation (NZDep2006), 2006



Source: Statistics New Zealand; mortality data corrected by the Ministry of Health for ethnic undercount.

Life expectancy at birth decreases with increasing deprivation (see Figure 9). In 2006 the gap in life expectancy at birth between the least deprived decile (NZDep2006⁷ decile 1) and the most deprived decile (NZDep2006 decile 10) was 8.8 years for males and 5.9 years for females.

Disability requiring assistance

The Ministry of Health is directly responsible for funding and planning disability support services for people with long-term sensory, physical and/or intellectual disabilities. Disability requiring assistance is defined as requiring some kind of regular help from other people or technical aids. Approximately 10 percent of New Zealanders had a disability requiring assistance in 2006 (the most recent year for which data is available), a similar proportion to the 1996 and 2001 Disability Surveys (see Table 3).

⁷ The New Zealand Deprivation Index (NZDep) is a small-area census-based measure of social and material deprivation, derived by principal components analysis of 10 socioeconomic variables included in the New Zealand Census.

Table 3: Prevalence of disability requiring assistance, by ethnicity and sex, 1996, 2001 and 2006

	1996			2001			2006		
	Māori (%)	Non-Māori (%)	Total (%)	Māori (%)	Non-Māori (%)	Total (%)	Māori (%)	Non-Māori (%)	Total (%)
Males	13.1	9.3	9.9	13.5	9.9	10.7	10.2	9.6	9.7
Females	13.7	9.5	10.1	14.4	8.9	9.7	10.4	11.2	11.1

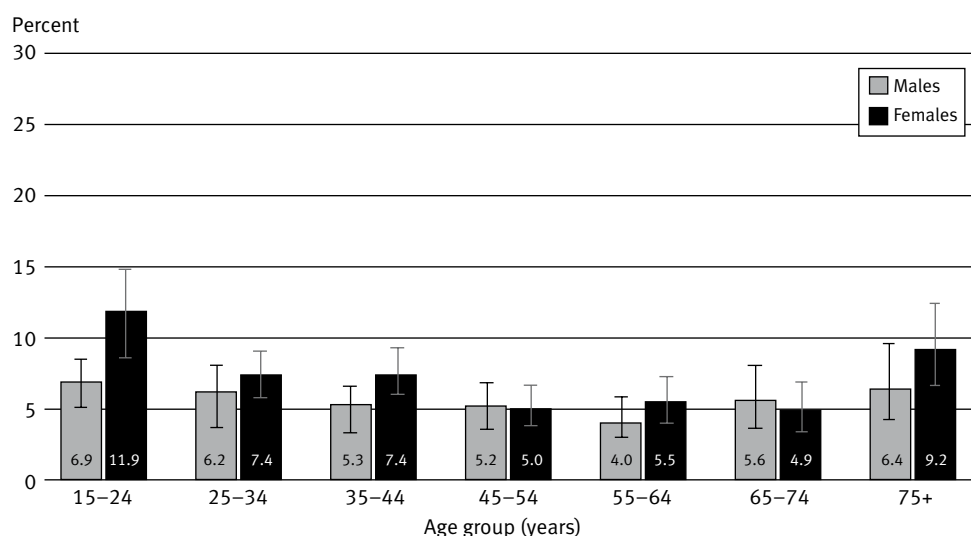
Sources: 1996/97 Disability Surveys; Household Disability Surveys 2001 and 2006; Disability Surveys of Residential Facilities 2001 and 2006.

Mental health status

Poor mental health can cause disability, diminished quality of life and reduced productivity. The Kessler 10-item scale (K10) is a set of questions used internationally to screen populations for non-specific psychological distress and serious mental illness. The scale gathers information about negative emotional states in the four weeks prior to measurement. The results are classified as ‘low’ (little or no psychological distress), ‘moderate’, ‘high’ or ‘very high’ (likely to have a severe mental disorder) probability of an anxiety or depressive disorder.

Psychological distress occurred in all age groups, but the prevalence of a high or very high probability of an anxiety or depressive disorder was highest in women aged 15–24 years, with an increase in prevalence again when women were aged over 75 years. In men, the prevalence of a high or very high probability of an anxiety or depressive disorder remained stable across the age groups with no significant differences by age (see Figure 10).

Figure 10: High or very high probability of anxiety or depressive disorder for adults, by age group and gender (unadjusted prevalence)



Source: 2006/07 New Zealand Health Survey.

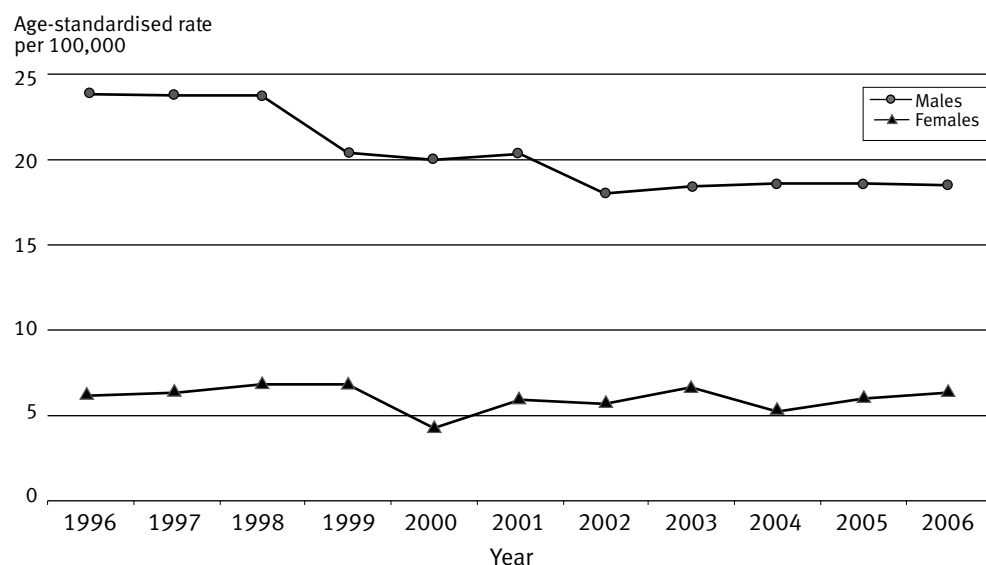
Suicide

Suicide and suicide attempts are an important and serious health issue in New Zealand. Each year approximately 500 New Zealanders die by suicide and it is the sixth-highest cause of avoidable deaths in those aged under 75 years.⁸ In 2006, 524 people died by suicide⁹ in New Zealand. However, suicide rates have fallen by 19 percent since 1998 (see Figure 11).

Males continue to have a significantly higher rate of suicide than females in 2006 (18.5 versus 6.3 deaths per 100,000 population, respectively), and the Māori rate remained significantly higher than the non-Māori rate (17.8 versus 11.0 deaths per 100,000 population, respectively) (see Figures 11 and 12).

For both genders pooled, the highest suicide rate occurred in the 25–29 years age group (21.1 deaths per 100,000 population), although for males the highest rates were observed in 15–24 years age group (31.0 deaths per 100,000 population).

Figure 11: Age-standardised suicide rates, by gender, 1996 to 2006



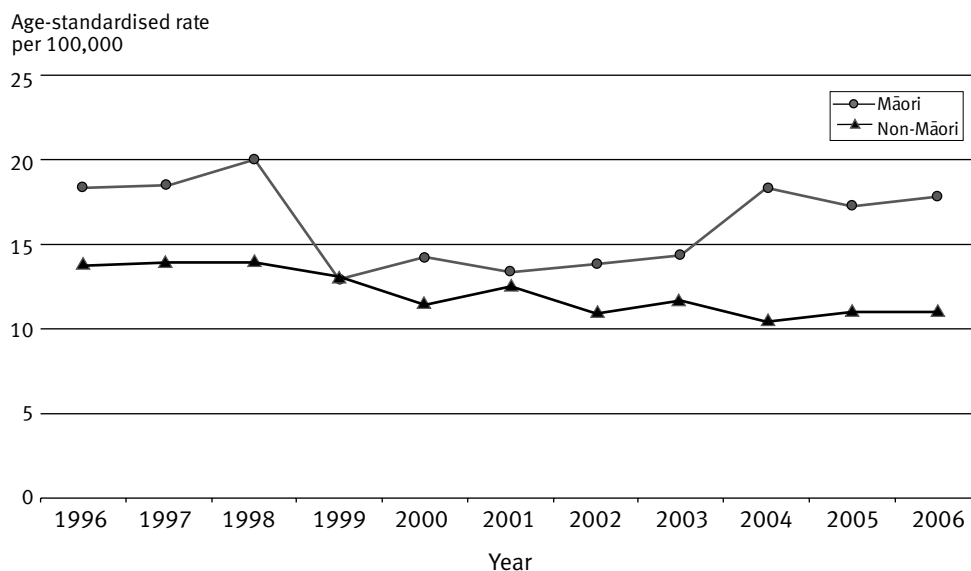
Source: Ministry of Health. 2008. *Suicide Facts: Deaths and intentional self-harm hospitalisations 2006*. Wellington: Ministry of Health.

Note: Rates are age-standardised per 100,000 population (standardised to the World Health Organization standard world population).

⁸ Ministry of Health. 2008. *Suicide Facts: Deaths and intentional self-harm hospitalisations 2006*. Wellington: Ministry of Health.

⁹ A classification of a death as suicide is subject to a coroner's inquiry, and only on completion of an inquest can a death be officially classified as suicide. For this reason, the suicide mortality data reported here is provisional for 2006.

Figure 12: Age-standardised suicide rates, Māori and non-Māori, 1996 to 2006



Source: Ministry of Health. 2008. *Suicide Facts: Deaths and intentional self-harm hospitalisations 2006*. Wellington: Ministry of Health.

Note: Rates are age-standardised per 100,000 population (standardised to the World Health Organization standard world population).

Quality and effectiveness

Strategic outcome: Health care services are effective, co-ordinated, clinically sound, culturally competent and timely.

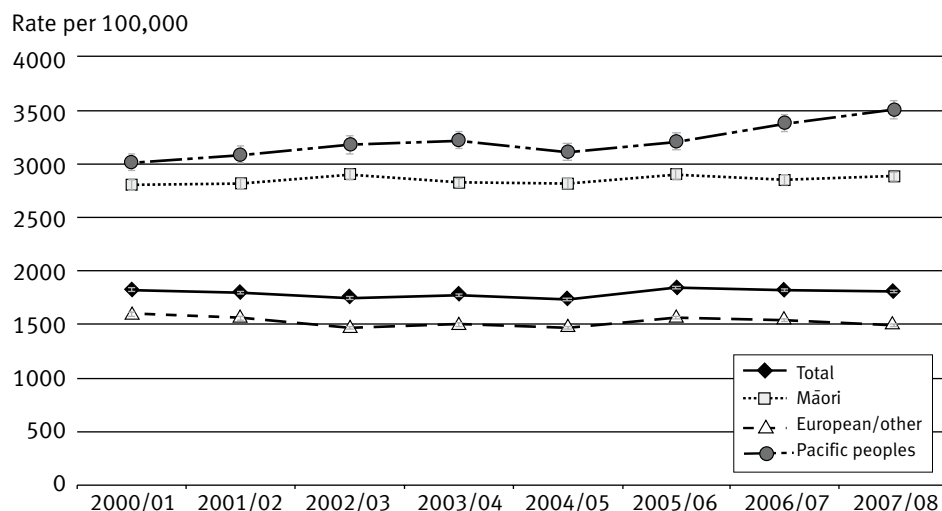
Higher-quality care in all services is an important, common goal. Quality is a multifaceted concept, taking into account performance on a number of dimensions, including effectiveness, patient safety, patient centredness, timeliness, equity and efficiency. Quality in health care can be considered an umbrella concept, encapsulating the need for high performance across all dimensions of the health sector.

Ambulatory-sensitive hospital admissions

Ambulatory-sensitive hospital admissions are admissions that might have been avoided if services had been delivered more effectively or patients had accessed services provided in a community setting, including primary health care. This key health outcome indicator reflects health system effectiveness and access to health care.

Vulnerable populations (Māori and Pacific peoples and people living in areas of high deprivation) have considerably higher rates of ambulatory-sensitive hospital admissions than other people. In 2007/08 Pacific rates were 2.3 times higher than for European/Other people, and Māori rates were 1.9 times higher than those for European/Other people (see Figure 13). Approaches to reducing admissions for Māori and Pacific populations are particularly important and individual DHBs have adopted innovative strategies to reduce ambulatory-sensitive hospital admissions.

Figure 13: Ambulatory-sensitive hospital admissions for people aged 0–74 years, age-standardised rate per 100,000, by ethnicity, 2000/01 to 2007/08



Source: Ministry of Health data 2009

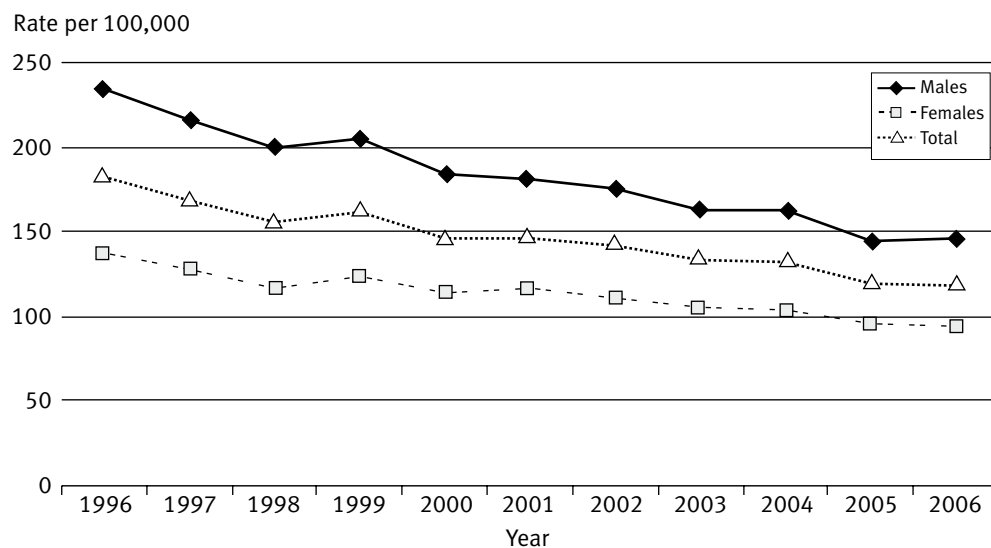
Cardiovascular disease mortality

Cardiovascular disease (CVD: ie, heart, stroke and blood vessel disease) is the leading cause of death in New Zealand, accounting for 40 percent of deaths annually. Of the CVDs, coronary artery disease is the major cause of death, followed by stroke, which is the greatest cause of disability in older people.

CVD mortality has continued to decline steadily in New Zealand. In the 10 years between 1996 and 2006 the rate of CVD mortality declined by 35 percent for the total population, from an age-standardised rate of 235.2 per 100,000 in 1996 to 118.3 in 2006 (see Figure 14).

Males have a significantly higher CVD mortality rate than females, although this gender difference continues to reduce (see Figure 14). There are significant ethnic differences in the CVD mortality rate, with Māori and Pacific peoples having higher CVD mortality rates than the total population (see Figure 15). Improving the percentage of the eligible adult population who have had a CVD risk assessment is a Health Target for 2009/10.

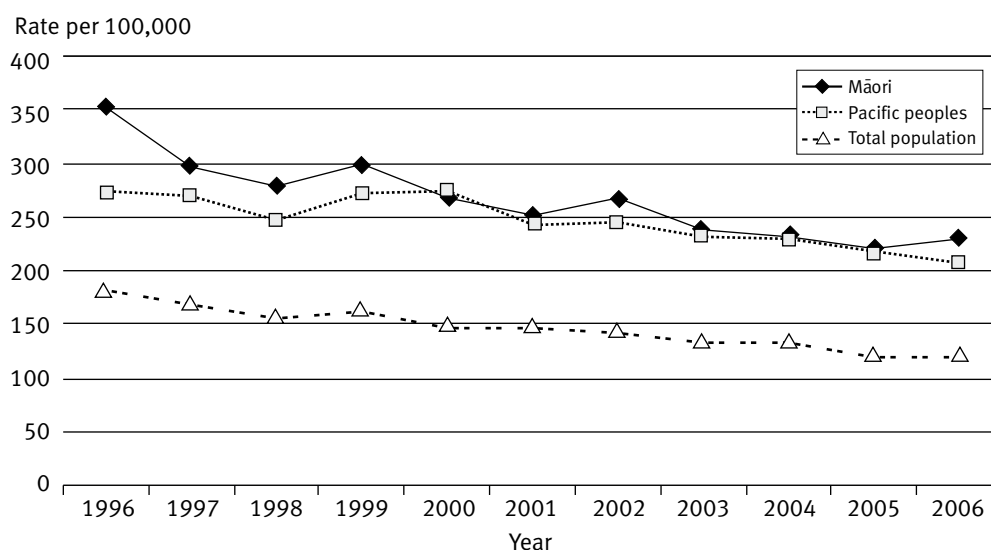
Figure 14: Cardiovascular disease mortality, all ages, age-standardised rate per 100,000 by gender, 1996 to 2006



Source: New Zealand Health Information Service data, 2009.

Note: Rates per 100,000 are standardised to Segi's world population.

Figure 15: Cardiovascular disease mortality, all ages, age-standardised rate per 100,000 by ethnicity, 1996 to 2006



Source: New Zealand Health Information Service data, 2009.

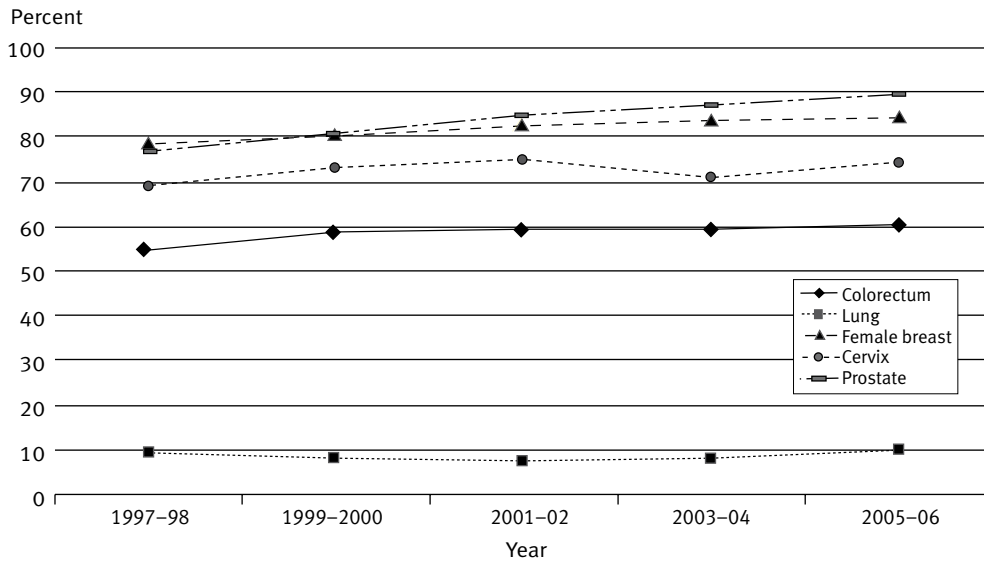
Note: Rates per 100,000 are standardised to Segi's world population.

Cancer survival

Cancer survival is a key outcome measure of cancer control and provides useful insights into the effectiveness of health care in detecting and treating cancer. Five-year cancer survival rates are a direct measure of the effectiveness of the health system in treating cancer.

The five-year relative survival rate has increased for all five major cancer sites featured in Figure 16. This increase was in the region of 5–6 percent for colorectal, breast and cervical cancers and over 12 percent for prostate cancer in the seven years since 1997/98. The survival rate for lung cancer is significantly less than for other cancer sites and has improved the least.

Figure 16: Five-year relative cancer survival rates in two-year periods, by major cancer site, 1997/98 to 2006/07

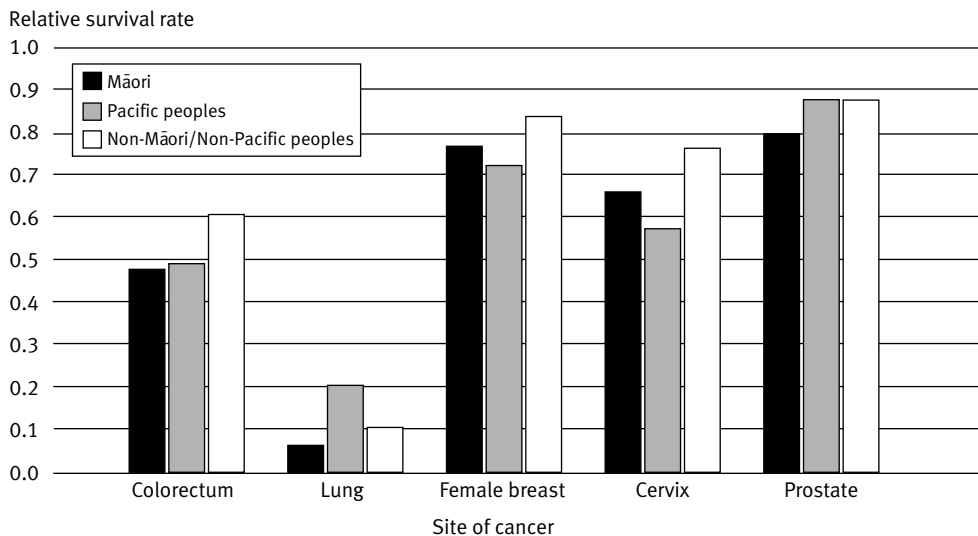


Source: New Zealand Health Information Service data, 2007.

Note: Trends were estimated by examining survival for patients diagnosed in successive two-year intervals by using the period analysis approach.

Five-year relative survival rates show Māori at a marked disadvantage compared with the non-Māori/non-Pacific ethnic group for five selected cancer sites: colorectal, lung, breast, cervix and prostate (see Figure 17). Of all ethnic groups Pacific people show the lowest relative survival rates for female breast and cervical cancers. Efforts to increase the number of Pacific women being screened through cancer screening programmes should help to identify greater numbers of women in need of cancer treatment in the future.

Figure 17: Five-year relative survival rates (1994–2006), by major cancer site and ethnicity



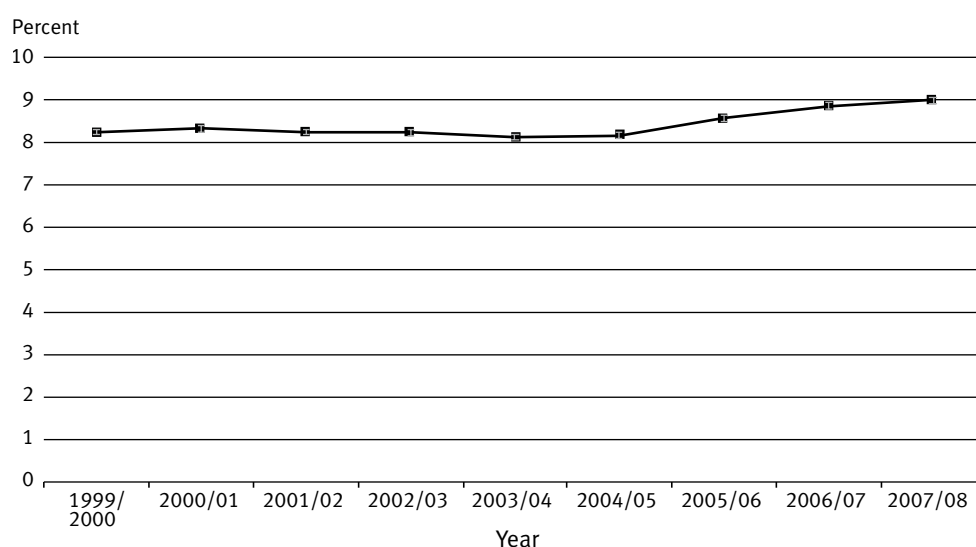
Source: New Zealand Health Information Service data, 2007.

Hospital readmissions

This indicator is a quality check on pressures to reduce the length of stay in publicly funded hospitals and to encourage improvements in service quality. The desired direction of change is a decrease over time. International experience suggests that the indicator is related to the length of stay in hospital, and that where the length of stay decreases over time there can be increases in readmissions rates.

The New Zealand experience indicates that over the past seven years there has been little relative movement in the readmissions rate, which lies within a narrow band between 8.1 percent and 9.0 percent at the overall sector level (the inpatient average length of stay for medical and surgical patients has remained at just over four days). However, in the last three years the readmissions rate is showing a slightly increasing upwards trend of between 0.1 percent and 0.4 percent per annum (see Figure 18).

Figure 18: Readmissions rate per 100 discharges (%), all DHBs combined, 1999/2000 to 2007/08



Source: New Zealand Health Information Service

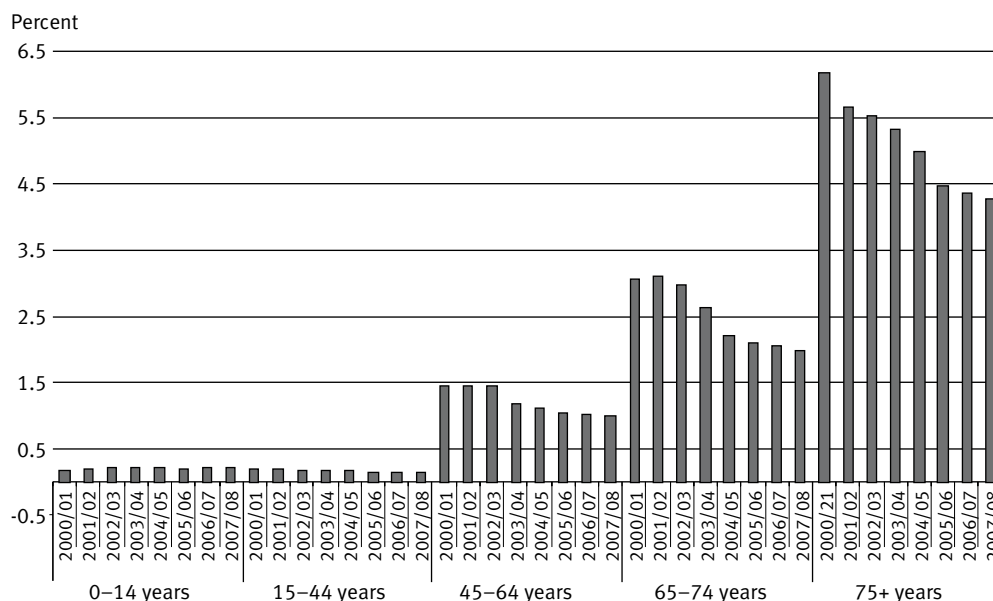
Notes: The readmissions rate is calculated by dividing the number of acute readmissions (to the same or another hospital) within 30 days of the original discharge by the total discharges, and expressing this figure as a percentage. Various exclusions apply, notably: transfers, deaths, planned/unavoidable readmissions, AIDS cases, palliative care cases and long-stay cases.

Hospital mortality

The aim of this quality indicator is to flag patterns of mortality in publicly funded hospitals that are higher than expected, in order to focus on the quality of care. The desired direction of change is a decrease over time.

Trend analysis of hospital mortality rates shows that rates have been declining since 2001/02, indicating improved quality of care on this outcome measure. In 2007/08 the hospital mortality rate was 1.2 percent, a decline of 0.5 percent from the 2001/02 peak of 1.7 percent. There were 2900 fewer in-hospital deaths annually in 2007/08 compared to 2000/01 (see Figure 19).

Figure 19: Hospital mortality rate per 100 discharges (%), all DHBs combined, 2000/01 to 2007/08



Source: New Zealand Health Information Service.

Note: The rate is based on dividing the number of in-hospital deaths by the total discharges and then multiplying by 100.

Smoking prevalence and tobacco consumption

Smoking-related mortality is the single greatest cause of preventable premature death in New Zealand. Each year around 4500 to 5000 people in New Zealand die from smoking (including deaths due to secondhand-smoke exposure). Smoking is the main cause of lung cancer and chronic obstructive pulmonary disease (COPD) and a major contributor to coronary disease and stroke.

The most recent estimate, in 2008, for current adult smoking prevalence is 21 percent, continuing the downward trend noted since 1983 (see Figure 20).¹⁰

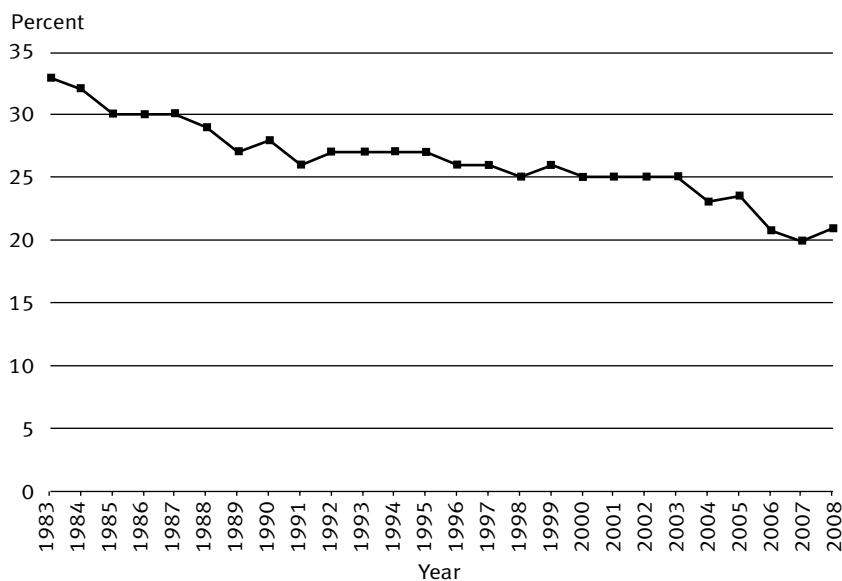
Smoking is a major contributor to inequalities in health. Māori (45.4 percent) and Pacific peoples (31.4 percent) are more likely to be current smokers compared with the total population. People living in the most deprived neighbourhoods were 1.5 times more likely to be smokers than people living in the least deprived areas.

On a positive note, in 2008, half of youth aged 15 to 19 years had never tried smoking. This is significantly higher than in 2006 (39 percent).

Overall, the amount of tobacco products available for consumption in New Zealand fell by around a third between 1997 and 2008, from around 1350 to 1000 cigarette equivalents per capita.

¹⁰ A current adult smoker (daily plus non-daily) is defined as someone aged 15 or more years who has smoked more than 100 cigarettes (or equivalent) in their lifetime and currently smokes at least once a month.

Figure 20: Current smoking among those aged 15 years and over, 1983 to 2008 (unadjusted prevalence)



Source: Ministry of Health. 2009. *Tobacco Trends 2008: A brief update of tobacco use in New Zealand*. Wellington: Ministry of Health.

Obesity

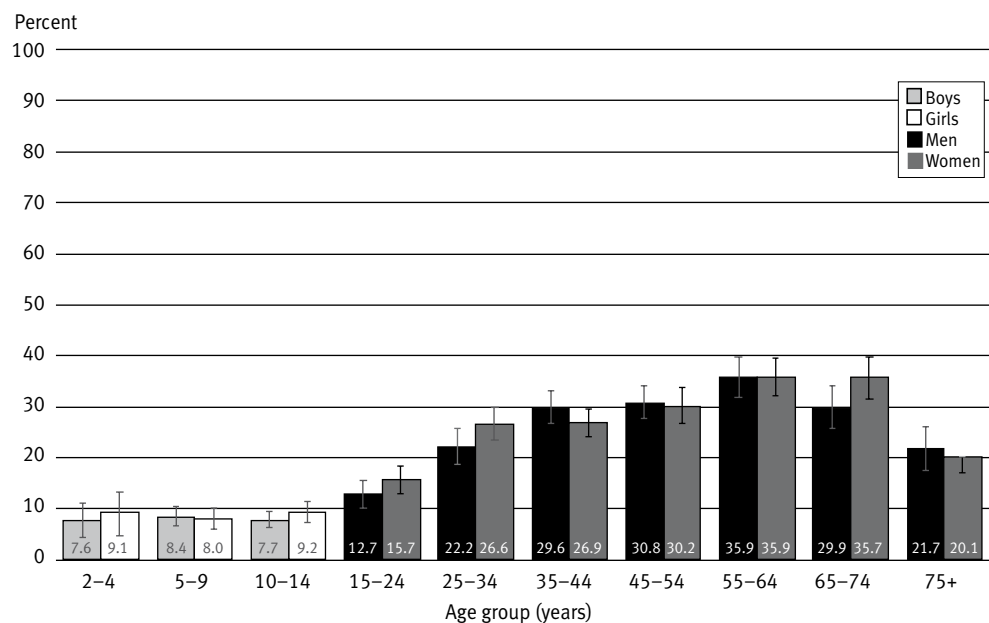
The World Health Organization now describes the prevalence of obesity as an epidemic. New Zealand, like many other countries, is facing the complex issue of high rates of obesity in children, young people and adults. Obesity has severe health effects (eg, cardiovascular disease, some cancers and type 2 diabetes), as well as social and economic effects. Social, cultural and economic changes that influence eating and physical activity patterns have combined to create an obesogenic environment.

Body mass index¹¹ (BMI) is a commonly used indicator of population-level obesity. International BMI cut-off points are used to classify people as underweight, overweight or obese. This report focuses on the proportion of the population who are obese; that is, who have a BMI of 30.00 or over (or the age-appropriate equivalent cut-off point for those aged under 18 years), as measured in the New Zealand Health Survey.

Obesity is not evenly distributed throughout the population. It is related to age, ethnicity and socioeconomic position. In 2006/07 the prevalence of obesity was relatively low for children compared to adults. In adults, obesity increased with increasing age until age 55–64 years in men and 55–74 years in women (Figure 21).

¹¹ Body mass index (BMI) is a measure of weight, adjusted for height, and is calculated by dividing weight in kilograms by height in metres squared (kg/m²).

Figure 21: Proportion of children and adults who are obese, by age group and gender (unadjusted prevalence), 2006/07



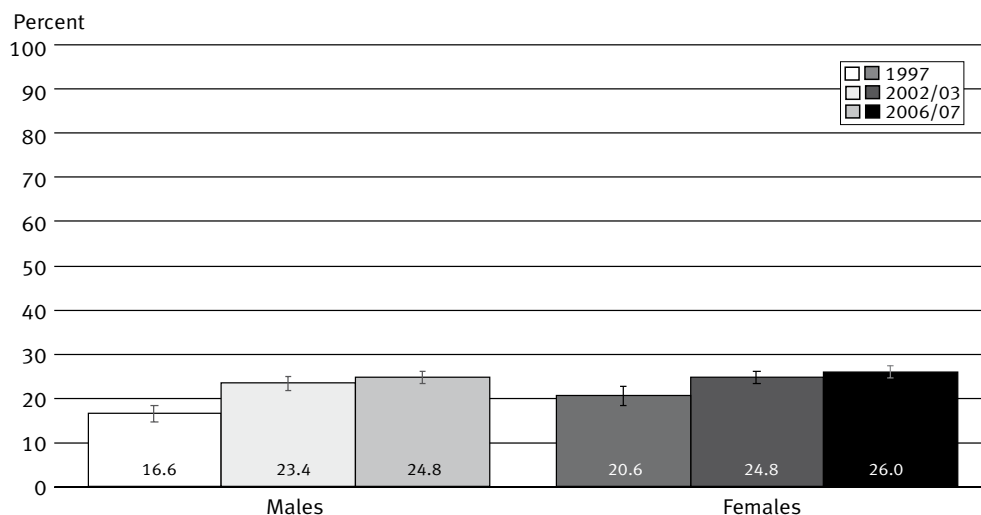
Source: 2006/07 New Zealand Health Survey.

Children and adults who live in the most deprived neighbourhoods (NZDep2006 quintile 5) are significantly more likely to be obese than children and adults living in all of the other four NZDep2006 quintiles.

Adjusted for age, Pacific children and Pacific adults are at least 2.5 times more likely to be obese than all children and all adults in the population. Māori children are 1.4 times and Māori adults 1.7 times more likely to be obese than all children and all adults in the population.

The only data on trends in childhood obesity over time shows that obesity has remained stable from 2002 to 2006/07, at around 9 percent of 5- to 14-year-olds, with no significant change for Māori children (13 percent) and Pacific children (26 percent) over this time. The prevalence of obesity in adults has increased over time in both men and women (Figure 22). However, the increase appears to be slowing, with no statistically significant increase between 2002/03 and 2006/07 for both men and women.

Figure 22: Proportion of adults who are obese, by gender, 1997, 2002/03 and 2006/07 (age-standardised prevalence)

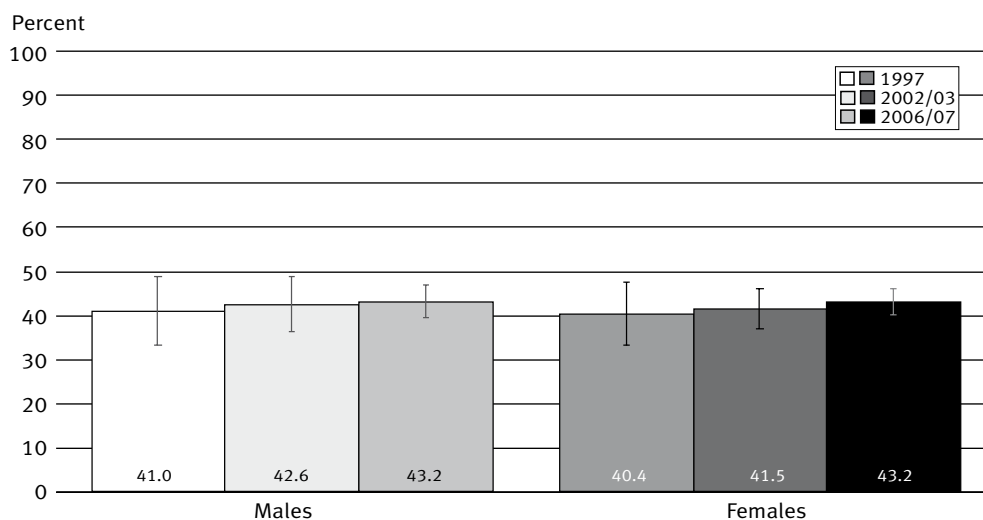


Source: 2002/03 and 2006/07 New Zealand Health Surveys; 1997 National Nutrition Survey.

Note: Data from previous years has been re-analysed to allow for comparability.

There was no significant change in the prevalence of obesity for Māori adults from 1997 to 2006/07 for both men and women (Figure 23).

Figure 23: Proportion of Māori adults who are obese, by gender, 1997, 2002/03 and 2006/07 (age-standardised prevalence)

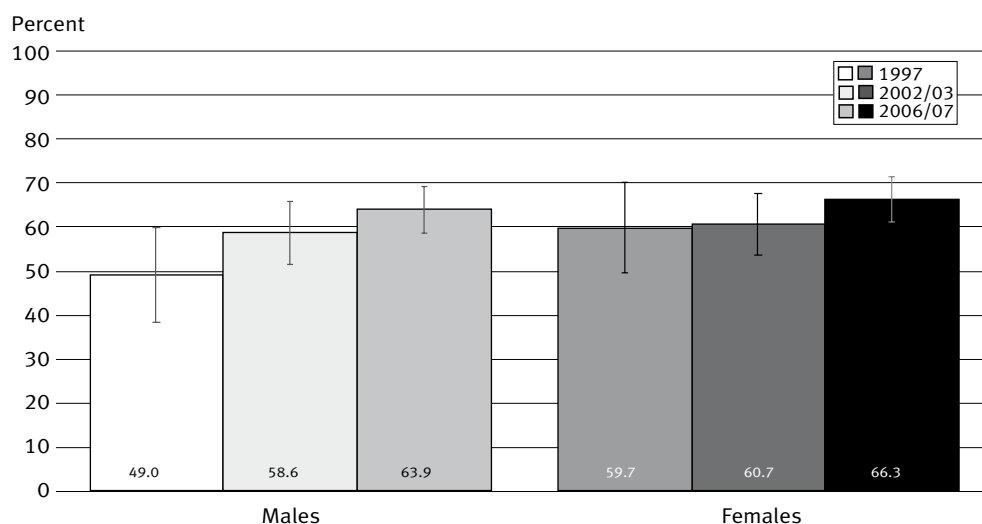


Source: 2002/03 and 2006/07 New Zealand Health Surveys; 1997 National Nutrition Survey.

Note: Data from previous years has been re-analysed to allow for comparability.

For Pacific men there has been a significant increase in the prevalence of obesity from 1997 to 2006/07, while for Pacific women there has been no significant change in the prevalence of obesity over this period (Figure 24).

Figure 24: Proportion of Pacific adults who are obese, by gender, 1997, 2002/03 and 2006/07 (age-standardised prevalence)



Source: 2002/03 and 2006/07 New Zealand Health Surveys; 1997 National Nutrition Survey.

Note: Data from previous years has been re-analysed to allow for comparability.

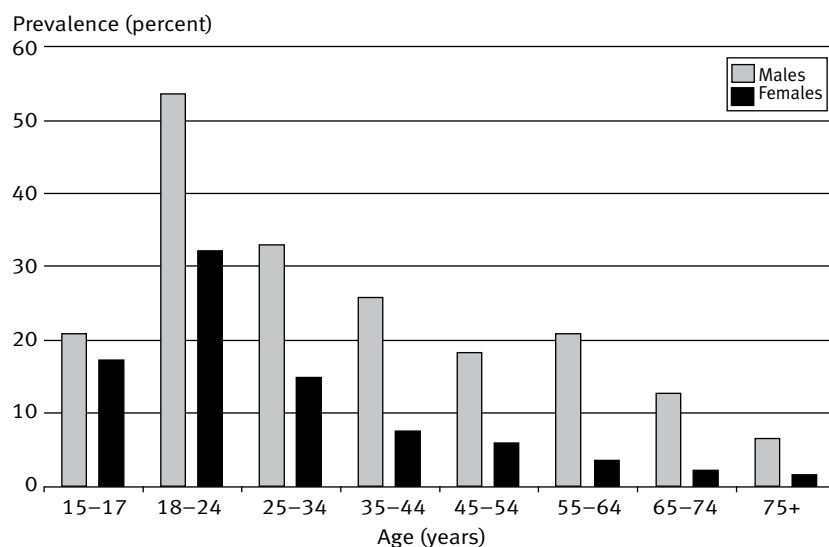
Hazardous alcohol consumption

Hazardous alcohol consumption is associated with elevated risks of intentional and unintentional injury and damage to foetal development, the central nervous system, the gastrointestinal system and the cardiovascular system, and with increased incidence of several cancers. Hazardous drinking refers to an established pattern of drinking that carries a high risk of future damage to physical or mental health. It is defined by a score of 8 or more on the Alcohol Use Disorders Identification Test (AUDIT), developed by the World Health Organization.

The 2006/07 New Zealand Health Survey found that 21 percent of adults who reported having consumed alcohol in the past 12 months had a potentially hazardous drinking pattern. Men in all age groups had a higher prevalence of hazardous drinking than women, with overall twice the prevalence (see Figure 25).

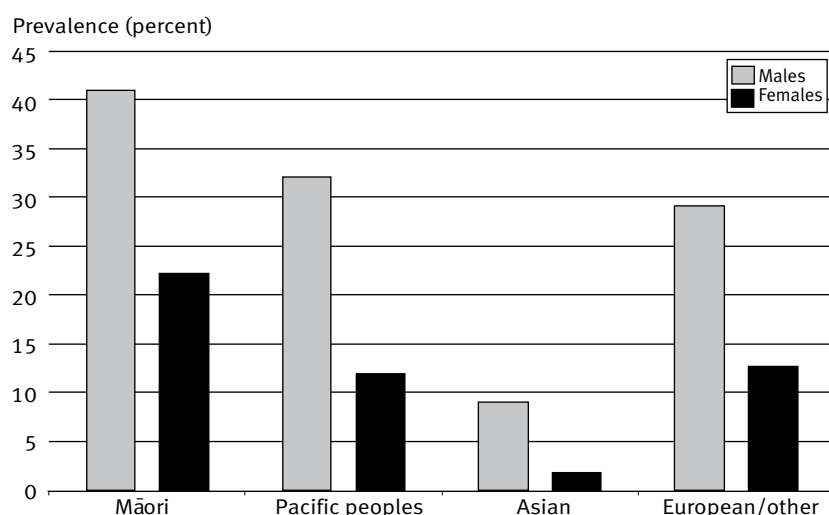
The highest prevalence of potentially hazardous drinking patterns was among those aged 18–24 years, with 54 percent of males and 32 percent of females in this age group meeting the criteria for potentially hazardous drinking (see Figure 25).

Figure 25: Hazardous drinking among adults, by age group and gender (unadjusted prevalence), 2006/07



Source: Ministry of Health. 2008. *A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.

Figure 26: Hazardous drinking by gender and ethnicity (age-standardised prevalence), 2006/07



Source: Ministry of Health. 2008. *A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.

Adjusting for age, the prevalence of potentially hazardous drinking patterns was highest for Māori and lowest for Asian peoples, for both genders (see Figure 26).

Over the period 1996/97 to 2006/07 there was no change in the prevalence of hazardous drinking in the total adult population. However, the age-standardised prevalence rate of hazardous drinking for Māori men increased from 35 percent in 2002/03 to 41 percent in 2006/07.

Equity and access

Strategic outcome: Fair access to health services in relation to people's needs, irrespective of income, physical location, ethnicity, age or sex.

Timely and appropriate access to health care is critical to achieving health gain. The indicators for equity and access are priority areas and feature as Health Targets for 2009/10.

Elective surgery discharges

The elective services policy seeks to ensure that patients are managed in accordance with the principles of clarity, timeliness and fairness. This includes the requirement for DHBs to demonstrate effective management of clinical prioritisation so that patients with the greatest clinical need and ability to benefit are seen first.

The volume of elective surgical discharges increased substantially in 2008/09. Table 4 shows that 129,769 discharges were delivered, an increase of over 11,800 (10%) over the previous year. Increasing the volumes of elective surgery by 4,000 more per annum is a Health Target for 2009/10.

Table 4: Number of elective surgical discharges, 2000/01 to 2008/09

Financial year	Number of discharges
2000/01	107,911
2001/02	106,733
2002/03	104,979
2003/04	106,157
2004/05	106,990
2005/06	105,656
2006/07	113,105
2007/08	117,953
2008/09	129,769

Source: Data extracted from the National Minimum Data Set, Ministry of Health, July 2009.

Notes: This is a dynamic data set and is subject to change as data is updated by DHBs. Updates occur as records are completed or revised.

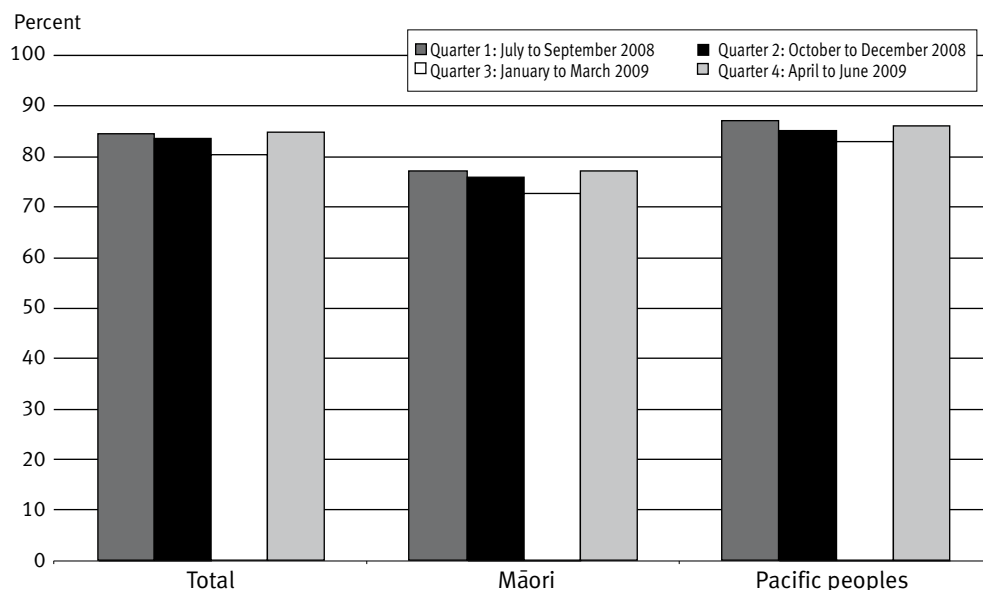
Immunisation coverage

Immunisation is one of the most cost-effective preventive health interventions, and it is an important component of both Well Child and adult preventive health services. Disease transmission will be prevented in a community only when high immunisation coverage is achieved. Achieving high immunisation coverage in all children is particularly important, especially for Māori and Pacific children, who bear a disproportionate burden of vaccine-preventable disease.

The Ministry of Health's long-term goal, adopted from the World Health Organization standard, is to have 95 percent of two-year-olds fully immunised. The Health Target for 2009/10 is to have 85 percent of 24-month-old children fully immunised by July 2010, 90 percent by July 2011, and 95 percent by July 2012.

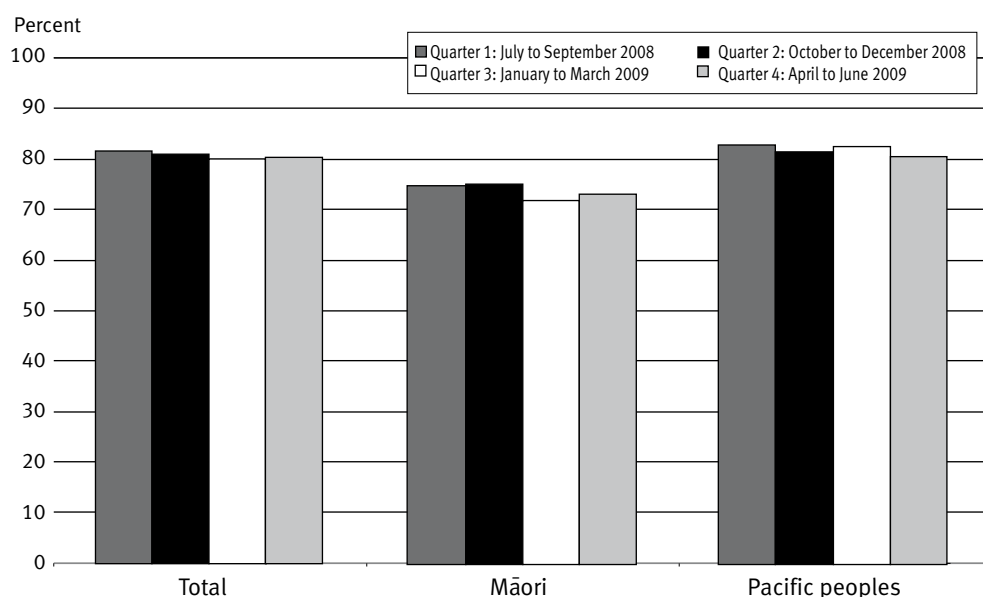
For the 3 months ended 30 June 2009, 85 percent of 12-month-old children were fully immunised (see Figure 27) and 80 percent of 24-month-old children were fully immunised (see Figure 28).

Figure 27: National immunisation coverage at the 12-month milestone age, by ethnicity, quarterly comparison, 2009



Source: National Immunisation Register, Datamart reports.

Figure 28: National immunisation coverage at the 24-month milestone age, by ethnicity, quarterly comparison, 2009



Source: National Immunisation Register, Datamart reports.

Efficiency and value for money

Strategic outcome: Effective care is delivered with the most cost-effective use of resources

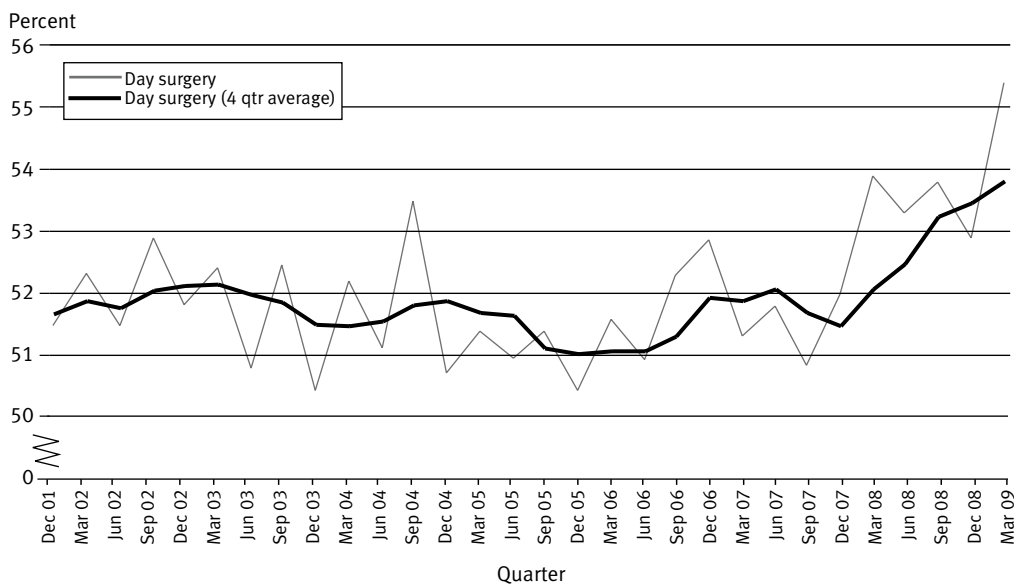
In order to obtain maximum value from the money invested in the health system and to ensure the health system is able to live within the available funding from taxation, it is crucial that ongoing improvements in productivity and efficiency are maintained. Key indicators of health system efficiency and effectiveness are day-case procedures, and productivity and costs of public hospital services, including labour inputs.

Day-case procedures

When surgical procedures can be undertaken on a day-case basis (ie, the patient is admitted and discharged on the same day), the hospital visit results in less disruption for the patient and fewer resources are used. The average case complexity is an obvious influence on the extent to which different specialities can embrace day surgery.

Although the rate of day-case procedures performed fluctuates quarterly, the four-quarter average shows an increasing trend. This indicates hospitals are improving the efficiency of patient management. The four-quarter average to 31 March 2009 is 53.8 percent (measuring day-case procedures as a proportion of all electives, as opposed to all surgeries). This indicates that more than half of the procedures performed allow the patient to be admitted and discharged on the same day (see Figure 29).

Figure 29: Percentage of day-case procedures, all DHBs, quarterly, December 2001 to March 2009



Source: Hospital Benchmark Information, 2009.

Productivity of public hospital services

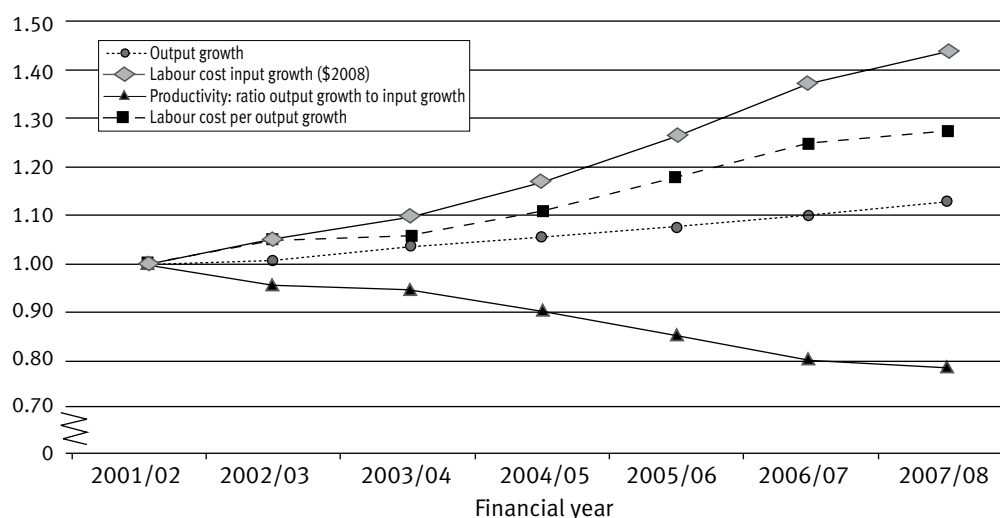
Productivity is a key indicator of whether the most value for money is being achieved for the resources allocated in the health system. Productivity should be viewed within the context of other measures of the quality, effectiveness and efficiency of the health system.

One view of hospital productivity is provided by direct wages and salary input costs per output for medical personnel (staff employed primarily as practicing physicians and/or surgeons) and nursing personnel (all qualified nursing staff, registered and enrolled, and nursing aides) working within medical and surgical services in DHB provider arms.

An output is measured as a case-weighted discharge equivalent (outpatients, emergency department and inpatients combined).

Figure 30 shows that costs per output increased 27% or 4% per annum in real \$2008 during the 2001/02–2007/08 period, corresponding to a period of significant wage settlements for most clinical workforce groups (particularly senior doctors and nurses) employed by DHBs. Outputs also grew over the period but at a slower rate than costs and so there was an overall decline in productivity.

Figure 30: Medical and nursing personnel productivity in DHB provider arms (in medical and surgical services), 2001/02 to 2007/08: outputs and labour cost input growth: indexed to 2001/02 as the base year

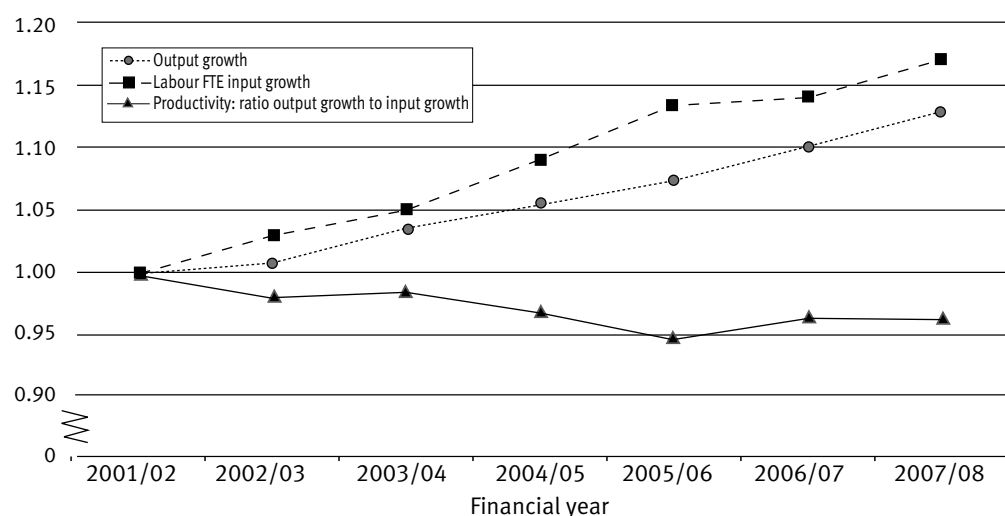


Note: Labour input costs are the direct wages and salary costs for medical and nursing personnel working in medical and surgical services in DHB provider arms. They include outsourced staffing costs for locums and bureau nurses. Labour outputs are medical and surgical case-weighted discharge equivalents (outpatients, emergency department, and inpatient combined). Productivity growth is calculated as the ratio of output growth to input growth.

Source: Ministry of Health, 2009

Figure 31 shows that there was a 5.3% decline in outputs per FTE for medical and nursing personnel working within medical and surgical services in DHB provider arms, from 2001/02 to 2005/06 or an average annual decline of 1.4%. Outputs per FTE then increased by 1.9% between 2005/06 and 2006/07, and remained flat between 2006/07 and 2007/08. On this view of productivity, the productivity of the medical and nursing workforce in terms of outputs per FTE was still lower in 2007/08 than in 2001/02 despite the slight gain in productivity between 2005/06 and 2006/07.

Figure 31: Medical and nursing personnel productivity in DHB provider arms (in medical and surgical services), 2001/02 to 2007/08: outputs and labour force FTEs input growth: indexed to 2001/02 as the base year



Source: Ministry of Health data, 2009.

Notes: Labour costs are medical and nursing personnel direct costs for salaried staff, and they include outsourced staffing costs. Labour outputs are medical and nursing case-weighted discharge equivalents (outpatients, emergency department, and inpatient combined), and efficiency is calculated as costs divided by outputs.

Patient-centredness and responsiveness

Strategic outcome: The health system is client orientated and respectful of dignity, confidentiality, participation in choices, promptness and quality of amenities.

A ‘patient-centred’ and responsive health system is increasingly regarded as crucial for the delivery of high quality care.

Patient engagement

The Commonwealth Fund conducts annual surveys of selected developed countries. The most recent survey in 2008 was of adults with at least one chronic condition. Results show the New Zealand health system has a strong focus on engaging patients in their health care (see Table 5).

Table 5: International comparisons of patient (those with chronic conditions) engagement in care

	Percent							
	AUS	CAN	FR	GER	NETH	NZ	UK	US
Regular doctor always tells you about treatment options and involves you in decisions*	58	56	43	56	63	62	51	53
Your clinician gives you a written plan to manage care at home	42	47	34	31	35	43	35	66

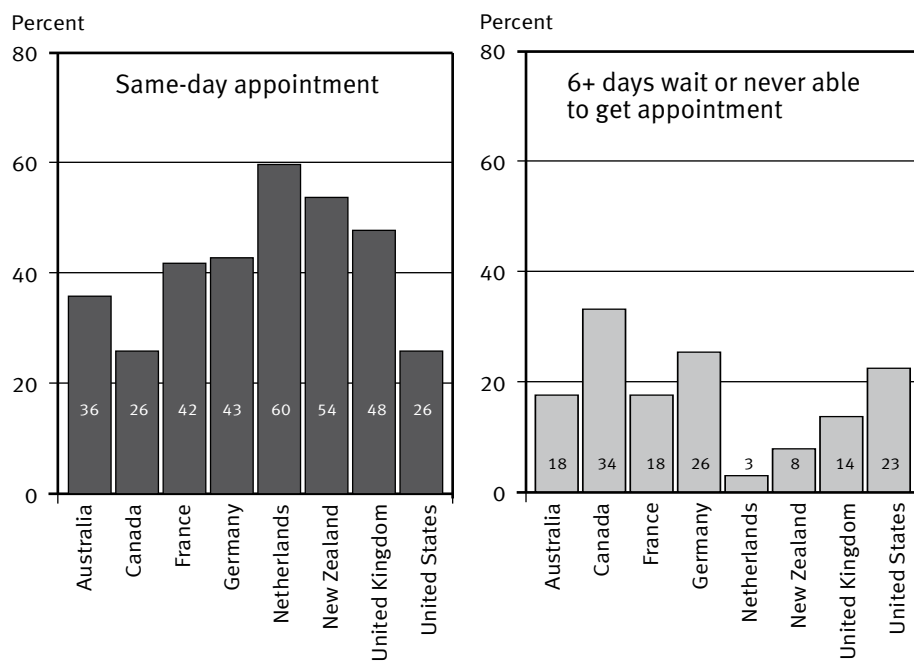
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

* Among those with a regular doctor or place of care.

Timely access to medical care

The 2008 Commonwealth Fund survey of patients with chronic conditions found New Zealand performed well internationally in terms of timely access to medical care, with a high proportion (54 percent) of respondents able to access same-day care, compared to Australia (36 percent) and Canada (26 percent) (see Figure 32).

Figure 32: International comparison of access to doctor when sick or needing care



Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults