Controller and Auditor-General
Tumuaki o te Mana Arotake

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Parliamentary paper

Health sector: Results of the 2011/12 audits

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Health sector: Results of the 2011/12 audits

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Auditor-General's overview

This is the second year that I am publishing a separate report on audit results for the health sector. This report accompanies my reports on the education and transport sectors, which sit alongside the Crown research institutes, central government, and local government reports.

The performance of the public health system – in particular, the district health boards (DHBs) – is important to us all. Good health is important for us personally and collectively, as a contributor to the social and economic well-being of New Zealand. The health sector is the largest area of central government spending on public services. Ensuring clinical and financial sustainability to meet our current and future health needs is an ongoing challenge for the whole sector.

My previous reporting on the health sector has focused on the results for DHBs. This year, I have broadened this report to include audit results and commentary on other public sector health entities, including shared service agencies working with DHBs, the Ministry of Health, and Crown entities such as the Pharmaceutical Management Agency (Pharmac) and the New Zealand Blood Service.

My auditors found that most DHBs and other health sector entities have sound management control environments and financial information systems. I am also pleased to see continued improvement in service performance reporting. In particular, I note Canterbury DHB and the New Zealand Blood Service, whose service performance reporting we assessed as "very good". Reporting comprehensive and clear performance enables an entity to show what it has achieved, including progress towards improving health outcomes. It also enables the Government and the public to assess value for money.

Last year, I reported that DHBs needed to improve their reporting on efforts to reduce disparities for Māori. My Office intends to follow up on this work and review the DHBs' 2012/13 reporting.

The Canterbury earthquakes continue to have a significant effect, particularly on Canterbury DHB but also more widely in the sector (for example, with insurance costs and the nature of insurance cover, and higher earthquake-strengthening requirements for buildings). Rebuilding Canterbury, including Canterbury DHB, is a priority for the Government.

Clinical and financial sustainability are a focus for the whole sector, which is working to reduce DHB deficits and achieve service and operational efficiencies. DHBs are increasingly operating collaboratively between districts (for example, shared management structures and people), regionally (for example, service and capital planning), and nationally (for example, shared information and management systems).

Health Benefits Limited is leading work aimed at saving DHBs $700 million over five years through initiatives that reduce administrative, support, and procurement costs for DHBs. The associated work programme will mean significant change for the sector and ongoing risk, including risks to the maintenance of service delivery and the delivery of planned savings and efficiencies. I will continue to watch that the reporting of savings is transparent and reflects actual savings.

My Office is working on an approach to financial analysis across the public sector, to assess sector trends and variances and better understand the ability of public entities to respond to potential financial risks. We have analysed the DHBs using this approach. I include our initial findings in this report and welcome discussion on the approach and how to develop it further.

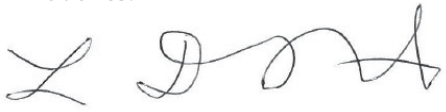
During the past 18 months, I have had a particular focus on visiting health sector entities, including most DHBs. Highlights included the new Ko Awatea education and innovation centre in Counties Manukau DHB and the Wairoa Integrated Family Health Service, which is developing a new model of care to meet the health needs of the Wairoa rural community. These two centres have the potential to make a real difference.

Our ongoing and future work

This year, the theme for my Office's work programme is *Our future needs – is the public sector ready?* The focus is on how public entities prioritise work, develop necessary capabilities and skills, and use information to identify and address future needs. We are reviewing the state of asset management throughout the public sector, including DHB assets.

My Office is also looking at how DHB capital investment aligns with regional service planning, how effectively the public service (health and other sectors) is working towards preventing and reducing child obesity, and how effectively government departments are preparing and planning for the ageing population.

The pace and scale of change in the health sector is increasing through regional collaboration and national initiatives to increase efficiency, save costs, and improve health services and outcomes. I expect there to be full and transparent reporting of performance throughout the health sector, and am considering what further work my Office might carry out on the effectiveness of some of these initiatives.



Lyn Provost
Controller and Auditor-General

10 April 2013

Part 1
Overview of the health sector

1.1 In this Part, we describe the health sector's operating environment, structural changes in the health sector, and the district health board (DHB) environment, including regionalisation and shared services.

The health sector's operating environment

1.2 New Zealand's health and disability services are delivered through a complex network of organisations. The devolved nature of the system means that responsibility and authority for funding and planning exists at national, regional, and local levels. Figure 1 shows the structure of the New Zealand health and disability sector.

1.3 The Government has budgeted more than $14 billion[1] (in Vote Health) for health spending in 2012/13. Health spending is the largest area of public spending on services. Public health spending has increased substantially over the years, both in actual dollars and as a percentage of gross domestic product (GDP), from around 3% of GDP in 1950 to 6.6% in 2011.

1.4 Despite the increased funding, our public health system continues to face significant challenges, including:

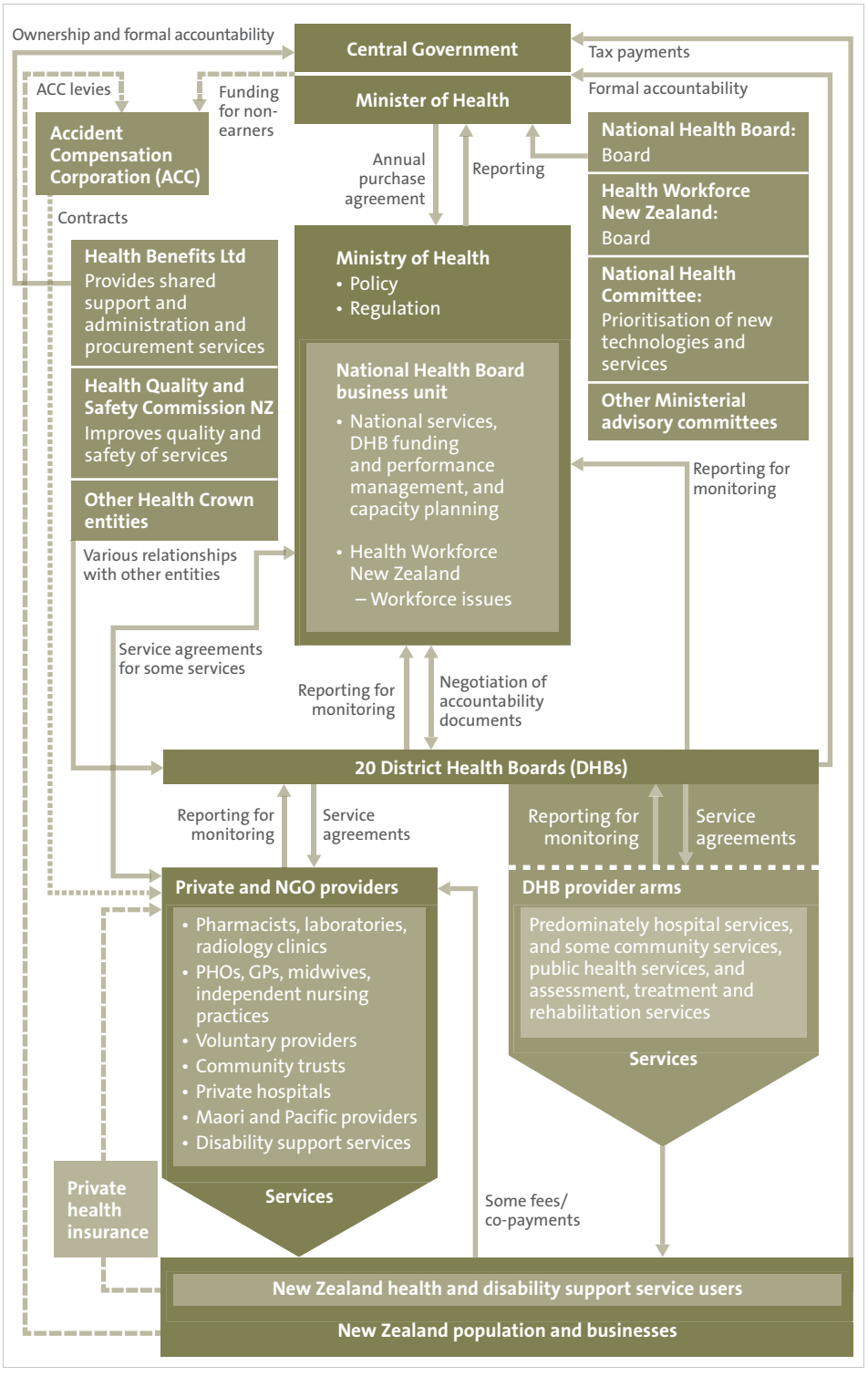
- meeting the needs of our ageing population and a rising prevalence of long-term and chronic conditions;
- responding to increasing demand for services and access to improved technologies;
- reducing disparities in health outcomes for Māori and other population groups;
- supporting vulnerable children; and
- maintaining and developing the health workforce, including attracting and retaining hospital specialists, and ensuring that the workforce evolves to support future models of care and service innovations.

1.5 The Government expects the health sector to continue to provide New Zealanders with high quality health care and lift health outcomes, while ensuring that our health system is sustainable over the long term. There is continued pressure for increased efficiency and reduced costs.

1.6 The Government aims to return to surplus in 2014/15, and it has indicated that it is unlikely that health spending can continue to increase at the rates of past years. It expects the sector to contribute by lifting productivity and improving financial performance each year. DHBs are expected to reduce deficits and break even.

1 The Budget included total appropriations of $14.125 billion in Vote Health for 2012/13.

Figure 1
Structure of the New Zealand health and disability sector



Source: Ministry of Health.

1.7 Increased efficiencies and sector savings are expected from DHBs focusing more strongly on service integration, both within their districts (for example, with community primary care) and by collaborating with other DHBs. Regional collaboration and national initiatives, such as those led by Health Benefits Limited (HBL), are intended to achieve costs savings for the sector. HBL is a Crown-owned company, and has a target of $700 million of savings for the sector over five years (see Part 4).

1.8 The Government continues to focus on lifting performance against the six national health targets. The health targets are national performance measures designed to improve performance in targeted service areas, such as shorter waits for cancer treatment and more heart and diabetes checks.[2]

1.9 As well as these targets, one of the Government's 10 key results for the public sector to achieve during the next five years (announced in June 2012) is a particular focus for the health sector and DHBs. That result is to "increase infant immunisation rates and reduce the incidence of rheumatic fever".

1.10 The Ministry of Health (the Ministry) is the Government's principal advisor on health policy and has overall responsibility for the health and disability sector. The Ministry allocates about $10.5 billion to DHBs to spend on public health services in their districts, including public hospitals and primary health care.

1.11 The Ministry directly purchases just under $2.8 billion of health and disability services (for example, national Māori health, child health, mental health, and maternity services). The Ministry also manages the national planning and funding of information technology (IT), workforce planning, and capital investment in DHBs. DHBs also carry out local and regional planning and management in these areas.

Structural change in the health sector

1.12 A number of advisory committees and bodies have been set up or reconstituted in recent years to work with the Ministry to lead improvements in the health and disability system, including:

- the National Health Board, for whole-of-system planning and advice;
- Health Workforce New Zealand, for health workforce planning;
- the IT Health Board, for IT investment;
- the National Health Committee, for the evaluation of technology investment options; and
- the Capital Investment Committee, for capital investment decision-making.

2 For more information about the health targets, see the Ministry of Health's website, www.health.govt.nz.

1.13 HBL was set up in 2010 to lead DHB shared services and joint procurement, and the Health Quality and Safety Commission was set up to improve service quality and safety.

1.14 Four Crown entities were disestablished with effect from 1 July 2012 – the Crown Health Financing Agency, the Mental Health Commission, the Alcohol Advisory Council of New Zealand, and the Health Sponsorship Council. The functions of the latter two entities were taken over by the new Health Promotion Agency established on 1 July 2012. The functions of the Crown Health Financing Agency and Mental Health Commission were, in the main, taken over by the Ministry. We discuss our final audits of these disestablished entities in Part 2.

1.15 The Pharmaceutical Management Agency (Pharmac) is the Crown entity that decides, on behalf of DHBs, which medicines and related products are subsidised for use in the community and public hospitals. The role of Pharmac continues to expand – for example, by taking on responsibility for managing all medicines used in hospital medicines and medical devices.

1.16 In June 2012, the four largest DHBs – Auckland, Counties Manukau, Waitemata, and Canterbury – set up the New Zealand Health Innovation Hub to collaboratively fast-track new health technologies and service innovations. The Hub is jointly owned by the four DHBs.

District health board environment

1.17 DHBs are responsible for identifying and providing for the health needs of their district. Their funding is largely based on the population of their respective districts. Figure 2 shows each DHB's population at December 2012 and the Vote Health funding for each DHB[3] in 2011/12 and 2012/13, grouped by the four regions. The four largest DHBs were each allocated funding of more than $1 billion for 2012/13.

3 These figures do not represent total income for DHBs because they receive other revenue (for example, from the Accident Compensation Corporation and other DHBs for health services).

Figure 2
Population of district health boards (2012/13 estimates), and funding for 2011/12 and 2012/13

District health board	Population*	2012/13 Budget funding** $million	2011/12 estimated actual funding** $million
All DHBs	4,465,835	10,819	10,500
Northern Region			
Auckland	465,965	1,022.8	992.3
Counties Manukau	512,885	1,172.6	1,122.0
Northland	159,630	461.0	448.1
Waitemata	558,010	1,215.0	1,173.8
Totals	*1,696,490*	*3,871.4*	*3,736.2*
Midland Region			
Bay of Plenty	215,440	583.0	567.7
Lakes	103,340	266.9	259.9
Tairawhiti	46,648	135.8	133.9
Taranaki	110,138	290.5	282.6
Waikato	371,540	952.1	918.9
Totals	*847,106*	*2,228.3*	*2,163.0*
Central Region			
Capital and Coast	299,025	640.0	623.5
Hutt Valley	144,865	341.6	333.3
Wairarapa	40,630	115.7	112.6
Hawke's Bay	156,430	418.1	401.8
MidCentral	170,095	439.2	424.8
Whanganui	62,853	195.4	191.2
Totals	*873,898*	*2,150.0*	*2,087.2*
South Island Region			
Canterbury	509,670	1,199.7	1,179.1
Nelson Marlborough	141,248	357.3	345.8
South Canterbury	56,420	156.1	152.7
Southern	308,133	741.7	723.0
West Coast	32,870	114.5	113.0
Totals	*1,048,341*	*2,569.3*	*2,513.6*

* Ministry of Health, *My DHB*, www.mydhb.health.govt.nz.

** *The Estimates of Appropriations 2012/13*, Vote Health, pages 128 to 130.

Regionalisation

1.18 A 2010 amendment to the New Zealand Public Health and Disability Act 2000 required DHBs to collaborate at local, regional, and national levels for the most effective and efficient delivery of health services to meet local, regional, and national needs.

1.19 DHBs are required to prepare an annual plan and collaborate with other DHBs in their region to produce regional plans for health services and resourcing. This regional planning is reflected in the annual plans of DHBs. This year, 2012/13, is the second full year of regional service plans, and there is increasing emphasis on developing clinical service models, addressing vulnerable services, and capital investment planning in a regional context. Regions are also more focused on shared services.

1.20 We are currently carrying out a performance audit on how DHBs' capital investment aligns with regional service planning and is guided by high quality information about future needs.

1.21 Individual DHBs are held accountable for delivering services. There are still no formal mechanisms for public accountability across entities or regions (for example, collective reporting against regional plans). A DHB can be held to account for its regional responsibilities only to the extent that regional planning is reflected in its annual plan.

1.22 In our view, it is important that accountability arrangements in the health sector keep pace with the regionalisation of planning and delivery of services. We will continue to discuss with interested parties how the sector can best be held to account for effective delivery of health services in an increasingly regionalised and nationalised system and inter-agency environment.

1.23 We will also continue to consider our auditing approach for DHBs in an increasingly regional and sub-regional (see Figure 3) environment.

Figure 3
Sub-regional arrangements

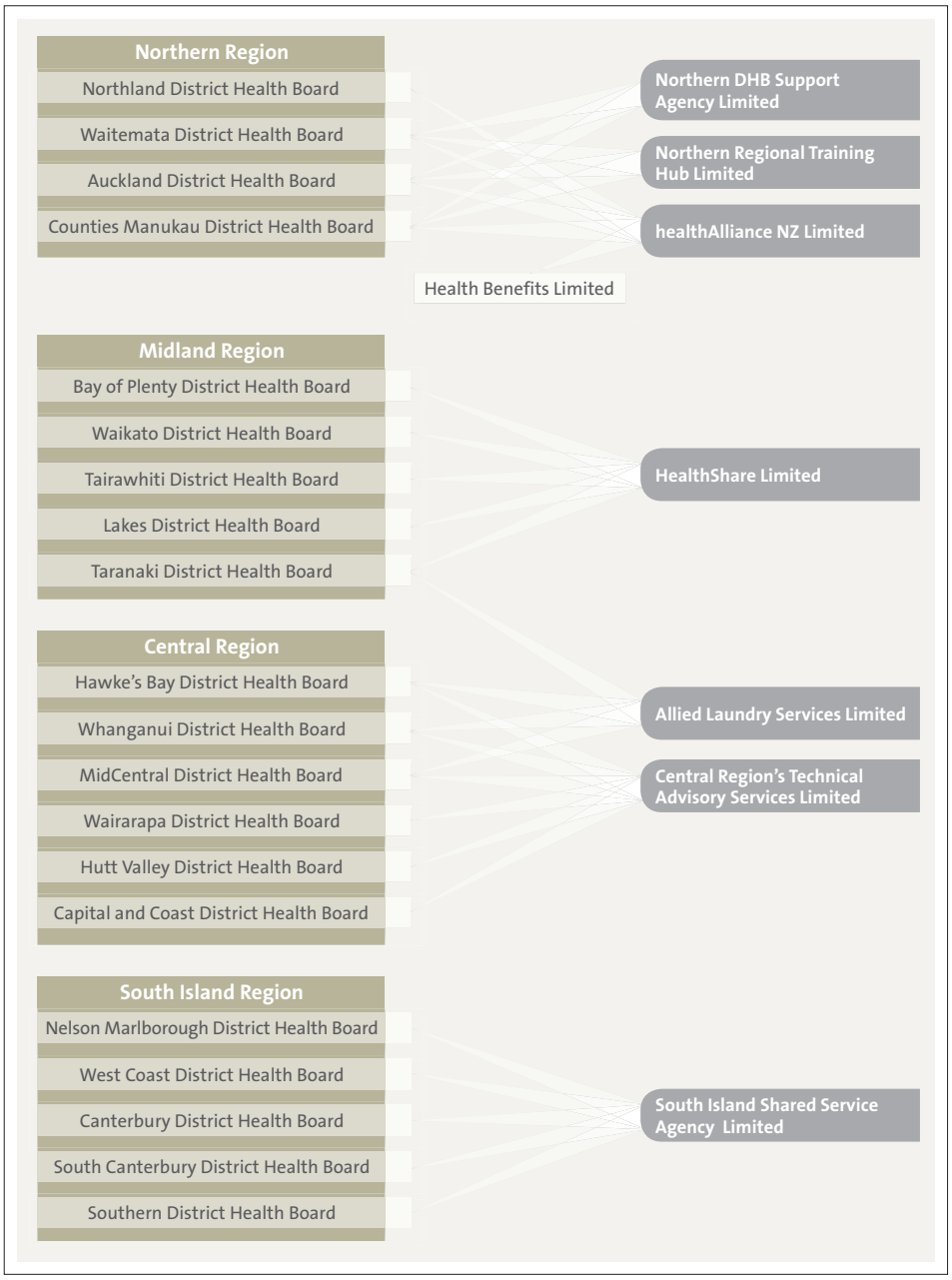
Sub-regional arrangements within some regions are becoming more established as DHBs work more closely together to address service and financial pressures:

- Collaborative governance and management arrangements between Canterbury and West Coast DHBs include shared Board members and a joint Chief Executive Officer since July 2010.
- Three DHBs in the Central Region – Capital and Coast, Hutt Valley, and Wairarapa – continue to work closely together as a sub-region. The three DHBs recently merged planning and funding functions into a single Service Integration and Development Unit. Joint management appointments were made for two of the DHBs (Wairarapa and Hutt Valley), including the appointment of a joint Chief Executive Officer. In 2012, the three DHBs prepared a "3 DHB" plan to achieve a joint net break-even financial result for 2013/14 and the following years.*

* Health Partners Consulting Group Limited, *Achieving a 3 DHB Net Break-even Result: a plan outline as requested by the Minister of Health*, September 2012.

1.24 Figure 4 provides an overview of the regional structure of DHBs and the agencies jointly owned by DHBs to deliver shared services.

Figure 4
Regional structure of district health boards and the agencies jointly owned by district health boards to deliver shared services, as at 30 June 2012



Shared services

1.25 There has been more regional and national collaboration on DHB shared services as the sector seeks efficiencies and cost savings. Figure 3 shows the jointly owned DHB shared service providers for the four regions. HBL is also leading national initiatives for shared service arrangements and initiatives throughout DHBs. We discuss HBL in Part 4.

1.26 Shared service agencies in the sector have continued to evolve – for example, by taking on expanded roles and functions. There have also been structural changes:

- In the Northern Region, healthAlliance N.Z. Limited (healthAlliance) was set up in July 2000 as a joint venture between Counties Manukau and Waitemata DHBs. Its scope and ownership was changed in March 2011, and it is now jointly owned by the four northern DHBs and HBL.
- In the Central Region, the former activities of District Health Boards New Zealand (DHBNZ) were subsumed into Central Region's Technical Advisory Services Limited (TAS), with effect from 1 September 2011. DHBNZ's functions were rebranded as District Health Board Shared Services (DHBSS), which is now a distinct unit in the new TAS.
- From 1 December 2011, South Island Shared Services Agency Limited ceased operating (and is a dormant company). Its operations and staff were transferred to Canterbury DHB and are now managed under the South Island Alliance Programme Office for the South Island DHBs.

1.27 We report our audit results for the regional shared services agencies in paragraphs 2.59-2.77.

Part 2
Audit results for 2011/12

2.1 Under section 15 of the Public Audit Act 2001, the Auditor-General audits the financial statements, accounts, and other information that public entities are required to have audited each year. The purpose of the annual audit is to give assurance that an entity's reports fairly reflect its financial and, where required, non-financial performance.

2.2 Public entities that we audit in the health sector include the Ministry, 20 DHBs and their subsidiaries, other health-related Crown entities, Crown companies, and regulatory authorities. The Auditor-General does not audit primary health organisations because they are not public entities. We include in the Appendix a list of the entities in the health sector that we audit.

2.3 Previously, our reporting on health sector audit results focused on DHBs. This year, we have broadened the coverage of our report to provide a fuller account of the results of our audit work in the health sector.

2.4 In this Part, we discuss the 2011/12 audit results, including:

- our audit opinions;
- our assessment of the management environment, systems, and controls for DHBs and other significant health sector entities; and
- particular areas of audit focus.

2.5 Audit results for the Ministry and non-DHB Crown entities will continue to be included in our central government report, which aggregates results by type of entity.

2.6 We report on DHBs' asset management in Part 3 and DHBs' financial performance in Part 5.

Audit results for district health boards

2.7 In carrying out the audits, our auditors focus on key areas of business and sector risk. The operating environment for DHBs, including increasing regionalisation and shared services, is described in Part 1.

2.8 As part of an annual audit, our auditors consider whether it is appropriate for a DHB to prepare its financial statements on the basis of the "going concern" assumption. That assumption is appropriate when the DHB is expected to be able to operate for the foreseeable future and at least for the next 12 months, taking account of all the available information.

2.9 In 2011/12, the "going concern" assumption for all 20 DHBs was considered valid. Four DHBs required a "letter of comfort" from the Ministers of Health and Finance that the Crown will continue to provide support where necessary to maintain financial viability. Our auditors were able to rely on the letters for those DHBs (Capital and Coast, Southern, West Coast, and Whanganui) to conclude that the going concern assumption was appropriate. In Part 5, we discuss the 2011/12 DHB financial results and our analysis of DHBs' financial statements (over six years) to help understand DHBs' ability to respond to financial risk.

2.10 We modified one DHB audit opinion in 2011/12.[4] As in the past three years, we issued a qualified opinion on Counties Manukau DHB's financial statements, because we disagreed with the DHB's accounting treatment of certain funding (as "income in advance") in the comparative information for the 2010/11 year. We continue to discuss this with the DHB.

2.11 Our auditors also drew attention to particular matters of emphasis in their audit reports (for example, about the uncertainties relating to earthquake-prone buildings for Hutt Valley DHB, which we comment on in paragraphs 2.20-2.21).

Earthquake-related issues

2.12 The Canterbury earthquakes of 2010 and 2011 killed 185 people, damaged more than 100,000 homes, destroyed much of Christchurch's central business district, and badly damaged infrastructure (for example, more than 9000 hospital rooms needed some degree of repair).

2.13 We continue to monitor and report on earthquake-related issues affecting Canterbury and the country more generally. Understandably, Canterbury is the DHB most affected by the earthquakes. However, there are also wider sector issues, such as the effect on insurance costs and the nature of insurance cover, and higher earthquake-strengthening requirements for buildings.

Canterbury DHB

2.14 The effects of the Canterbury earthquakes on Canterbury DHB are ongoing, including damage to facilities (along with associated costs and disruption), displacement of sections of the population, and effects on residents' health needs.

2.15 During the year, the DHB recognised an impairment of its buildings and equipment of $14.3 million, which is in addition to the $33.8 million recognised last year. Insurance is expected to meet most of the reinstatement costs, but it does not cover upgrades required to meet higher building code requirements. The DHB has also identified $28.9 million of specific additional costs as a result of the earthquakes.

4 There are three types of modified opinions: an "adverse opinion", a "disclaimer of opinion", and a "qualified" opinion.

2.16 Before the earthquakes, Canterbury DHB was planning a major redevelopment of Christchurch Hospital to better align its facilities with current models of care and to improve efficiency.

2.17 In September 2012, the Government announced its approval for the redevelopment project to progress to the next stage. A detailed business case was presented to, and approved by, Cabinet in March 2013. The proposed redevelopment is expected to cost more than $600 million and will be the largest and most complex building project in the history of New Zealand's public health service.

2.18 As part of our annual audit, we will continue to consider risks and areas of focus as the project progresses. We have included the Canterbury business case in our performance audit on DHBs' capital investment and regional service planning.

Insurance

2.19 Insurance costs have increased significantly after the earthquakes. At the same time, the nature of cover is changing. In October 2012, we asked public entities about their insurance cover. We intend to report our findings to Parliament this year and will include the results for the health sector, including a case study of HBL's collective insurance arrangement for DHBs.

Earthquake strengthening of buildings

2.20 DHBs have been considering their compliance with building codes and the earthquake strength of their buildings. This has resulted in a number of impairments (or potential impairments) of buildings being recorded in DHB financial statements. Examples of impairments (or potential impairments) reported at 30 June 2012 include:

- Hutt Valley DHB – although significant uncertainty exists, a potential impairment of $21 million was disclosed in the notes to the financial statements;
- Nelson Marlborough DHB – $6.4 million impairment due mainly to low earthquake strength assessment; and
- West Coast DHB – impairment of $2.6 million for buildings that are earthquake-prone.

2.21 In our 2011/12 audit report for Hutt Valley DHB, we drew attention to the uncertainties over the carrying value of certain buildings due to earthquake-strengthening issues. The Board is gathering information on the status of its buildings, including estimates of costs to strengthen buildings, and is expected to make decisions in 2013 about the affected buildings.

2.22 The Ministry is assessing the implications of earthquake-strengthening issues and changes to building codes for the sector. We will continue to monitor the effect of earthquake strengthening of buildings in our audit work.

Procurement

2.23 More than three-quarters ($10.8 billion in 2012/13) of Vote Health is used to fund the health services that each DHB provides directly to its population (for example, hospital services) or indirectly through other providers, including non-government organisations, primary health organisations, or another DHB.

2.24 This means there are two different aspects to DHB procurement and contracting. There are goods and services that the DHB uses itself, and health services that it purchases from other providers. DHBs spend about $5.7 billion each year purchasing supplies and services from other organisations. Managing this spending well is important, to ensure value for money and to minimise risks such as waste, fraud, and conflicts of interest.

2.25 DHBs' procurement policies and practices have been, and will continue to be, an area of interest for our Office. In September 2010, we published a performance audit report, *Spending on supplies and services by district health boards: Learning from examples*. We continue to follow up with DHBs on areas for improvement identified in that report and through our usual annual audit work.

2.26 Regional and national initiatives are key drivers of procurement change, opportunity, and associated risk for the DHB sector. This includes all-of-government initiatives led by government departments, sector initiatives led by HBL, and regional initiatives led by regional shared services agencies.

2.27 Our auditors reported that some DHBs were delaying making changes to systems and processes, pending the outcomes of sector and regional initiatives. We acknowledge that there is activity within the sector on collaborative procurement processes, and this might have contributed to some delays in taking remedial action. DHBs still need to consider the risks associated with delaying when they will make improvements.

2.28 We will continue to focus on DHB procurement and the effect of sector initiatives in our audits.

Contracting relationships

2.29 Last year, we reported that some DHBs had begun using "high trust" and integrated contracts, which can provide more effective and efficient procurement arrangements and can reduce reporting requirements. Figure 5 sets out some important principles of high-trust contracting arrangements.

2.30 Integrated contracts typically bring together multiple funding agreements into one single document that focuses on shared outcomes, with results agreed and described and flexibility about service delivery. The Whānau Ora approach includes an integrated contracting process, and Canterbury DHB's alliancing initiative is another example of a framework for integrated contracts.

2.31 During the last two years, we have reviewed aspects of Canterbury DHB's alliancing initiative. We found that governance and management structures are maturing. We also found that service providers are working:

- together rather than competing with each other;
- with other parts of the health system to determine appropriate models of care; and
- in an open and transparent manner with Canterbury DHB to actively address questions of service efficiency and consistent quality of service delivery.

Figure 5
Important principles of high-trust contracting agreements

With increasing use of high-trust contracting, we highlight important principles to observe in agreements with providers:

- transparency of decision-making processes;
- equity of treatment; and
- demonstrable value for money.

Information systems

2.32 Regionalisation, collaboration, and shared services continue to be themes in the DHB sector's information systems (IS) environment, and are expected to achieve more effective and efficient delivery of health services.

2.33 There is extensive IS planning and development throughout the sector, within DHBs, between regions, and at a national level (for example, led by the IT Health Board[5]).

2.34 IS development priorities include an eMedicines programme, regional information platforms for DHBs to store data and allow sharing of patient information systems throughout regions, and national systems (for example, oncology, cardiac, and InterRAI[6] for aged care assessment).

2.35 Our auditors continue to focus on technology risks for the DHB sector. We highlight the need for:

- alignment of DHB plans against regional and national IS plans, to ensure that priorities are aligned, duplication and waste are avoided, and DHBs and the wider sector gain value for money from investments;
- strong governance and sound understanding by management and the board of major IS risks, and for appropriate regional governance bodies to be in place;
- continued focus on appropriate IS security; and

5 The IT Health Board, a subcommittee of the National Health Board, provides strategic leadership on information systems throughout the sector.

6 InterRAI is a technological system to improve information about quality of care.

- a focus on business continuity planning throughout the DHB and on IT disaster recovery planning, which ensures that key systems are up and running as required. Regional planning provides an opportunity to highlight business and system continuity provisions.

2.36 Our auditors reported that some DHBs were delaying implementing long-term remedial improvements (for example, to activity level controls) because of current and pending regionalisation of IT operations. Delays might be appropriate in some situations, such as when new systems are being considered, but remedial actions should still be implemented if there are significant issues or risks.

2.37 In the Northern Region, healthAlliance provides information services to the four Northern DHBs. In June 2012, the IT assets of the four DHBs were transferred to healthAlliance. For our 2011/12 audits of the four northern DHBs, we carried out integrated audit and reporting through healthAlliance as the service provider. We reported issues and areas for improvement to healthAlliance as the entity responsible for remediation.

Assessing DHBs' management environment, systems, and controls

2.38 As part of the annual audits, our auditors comment on DHBs' management control environment, financial information systems and controls, and service performance information and associated systems and controls. We assign grades that reflect our recommendations for improvement (see Figure 6).

Figure 6
Grading scale for assessing public entities' environment, systems, and controls

Grade	Explanation of grade
Very good	No improvements are necessary.
Good	Improvements would be beneficial and we recommend that the entity address these.
Needs improvement	Improvements are necessary and we recommend that the entity address these at the earliest reasonable opportunity.
Poor	Major improvements are required and we recommend that the entity urgently address these.

2.39 We report each DHB's results to its management and its governing board. We also report the results to the Minister of Health, the Ministry (as the monitoring department), and the Health Committee of the House of Representatives.

2.40 Grades for a particular DHB might fluctuate from year to year depending on several factors, such as changes in the operating environment, standards, good practice expectations, and auditor emphasis. For example, a downward shift in grade might not indicate deterioration – it could be that the entity has not

kept pace with good practice expectations for similar entities between one year and the next. How an entity responds to the auditor's recommendations for improvement is important, and the long-term trend in grade movement is a more useful indication of progress than year-to-year grade changes.

Grades in 2011/12

2.41 Our auditors assessed most of the DHBs as "good" in all three aspects for 2011/12, with service performance reporting still the main area where more improvement could be made (see Figure 7).

2.42 Overall, the grades show that most DHBs have sound management control environments and sound financial information systems and controls.

Figure 7
Summary of district health boards' 2011/12 grades for environment, systems, and controls

District health board	Year audited	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Auckland	2011/12	Good	Good	Needs improvement
	2010/11	Good	Good	Needs improvement
Bay of Plenty	2011/12	Good	Good	Needs improvement
	2010/11	Good	Good	Needs improvement
Canterbury	2011/12	Very Good	Good	Very Good
	2010/11	Very Good	Good	Good
Capital and Coast	2011/12	Needs improvement	Good	Needs improvement
	2010/11	Needs improvement	Needs improvement	Needs improvement
Counties Manukau	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
Hawke's Bay	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
Hutt Valley	2011/12	Good	Needs improvement	Good
	2010/11	Good	Needs improvement	Good
Lakes	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
MidCentral	2011/12	Good	Needs improvement	Good
	2010/11	Good	Needs improvement	Needs improvement
Nelson Marlborough	2011/12	Good	Good	Good
	2010/11	Good	Good	Good

District health board	Year audited	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Northland	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
South Canterbury	2011/12	Very Good	Good	Good
	2010/11	Very Good	Good	Good
Southern	2011/12	Good	Needs improvement	Needs improvement
	2010/11	Good	Good	Good
Tairawhiti	2011/12	Good	Good	Needs improvement
	2010/11	Needs improvement	Needs improvement	Needs improvement
Taranaki	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
Waikato	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
Wairarapa	2011/12	Good	Good	Needs improvement
	2010/11	Good	Good	Needs improvement
Waitemata	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
West Coast	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
Whanganui	2011/12	Good	Good	Needs improvement
	2010/11	Good	Good	Needs improvement

2.43 In 2011/12, four DHBs improved their grades from the previous year. Canterbury and MidCentral DHBs increased their grades for service performance information. Capital and Coast and Tairawhiti DHBs improved their grades for financial information systems and controls from "needs improvement" in 2010/11 to "good". Tairawhiti DHB also had the same improvement in its management control environment grade.

2.44 Southern DHB's grades for financial and service performance information systems and controls went down from "good" in 2010/11 to "needs improvement" in 2011/12. Our auditor noted that improvements were required to the DHB's financial budgeting, monitoring, and forecasting procedures and also recommended improvements to the quality of its service performance reporting, including reporting progress against health outcomes and impacts.

Five-year trends in management control environment and in financial information systems and controls

2.45 Figures 8 and 9 set out our grades for DHBs from the past five years for management control environments and financial information systems and controls.

Figure 8
Grades for district health boards' management control environment, 2007/08 to 2011/12

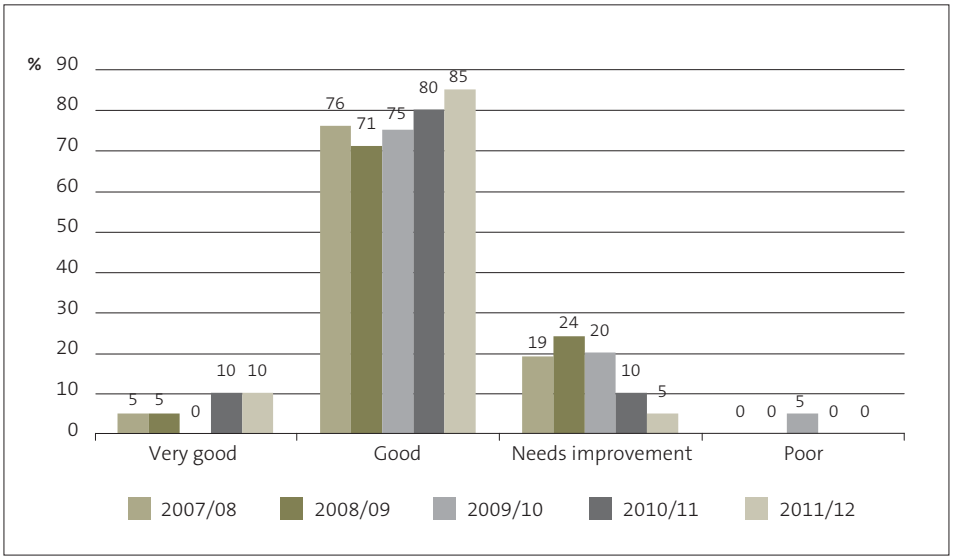
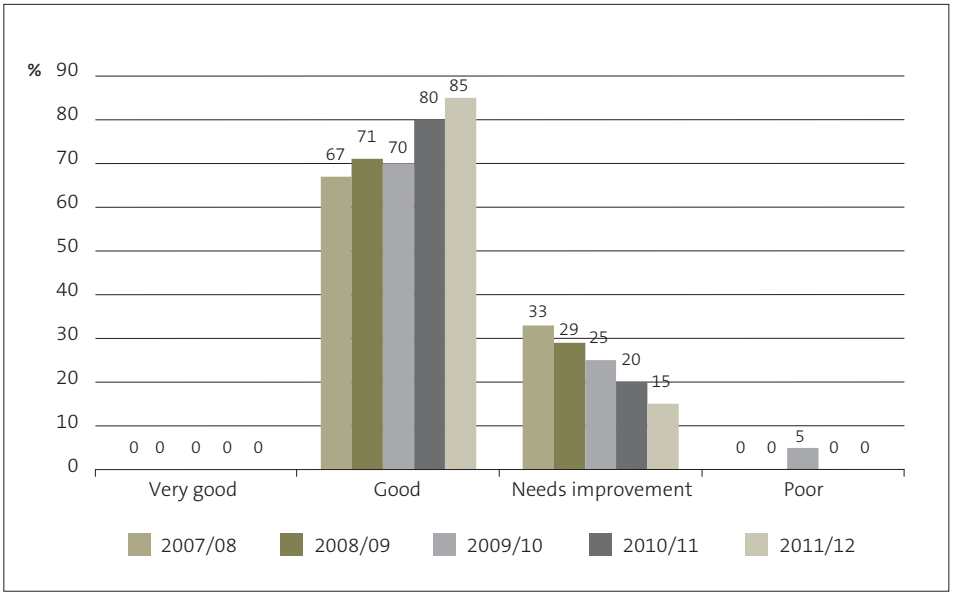


Figure 9
Grades for district health boards' financial information systems and controls, 2007/08 to 2011/12



2.46 The grades for DHBs' management control environments and financial information systems and controls show a steady improvement over the years. The overall number of "needs improvement" grades in these two aspects has been steadily reducing each year, which indicates that DHBs are continuing to maintain and improve their systems and controls.

Service performance reporting

2.47 Service (non-financial) performance reporting is an integral part of our parliamentary accountability system, and helps the Government to seek better efficiency, effectiveness, and value for money from the public sector.

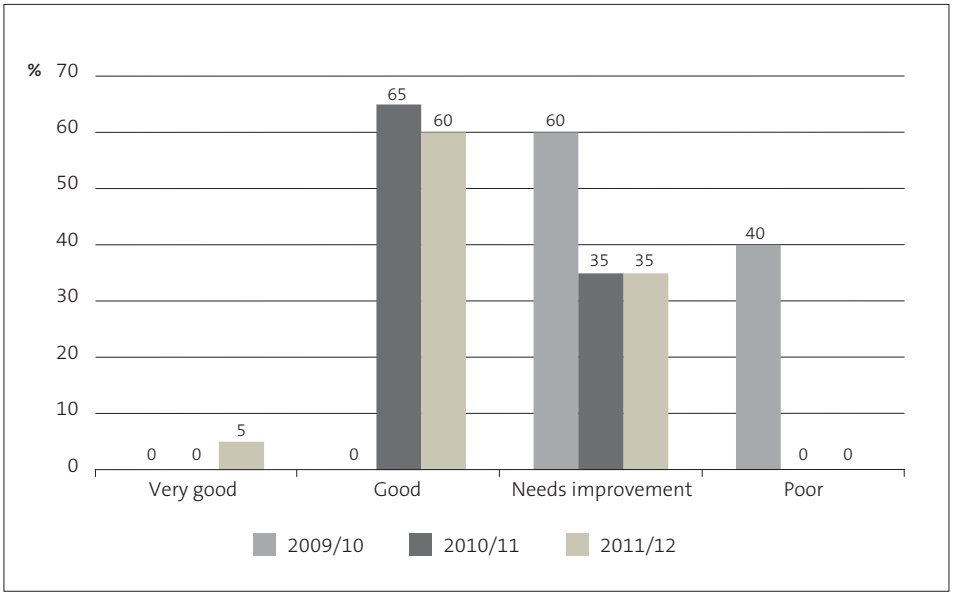
2.48 Since 2006, the Auditor-General has stressed the importance of quality non-financial performance information to explain and help understanding of public sector performance and effectiveness.

2.49 In 2008/09, for the first time, we issued grades for public entities' service performance information and associated systems and controls. At that time, we graded all DHBs as "poor/needs improvement". DHBs did not identify clearly or comprehensively the services that they delivered. Also, the quality of measures for outcomes and for services provided was poor.

2.50 DHBs' service performance reporting improved considerably during the next two years, after significant work by the DHBs individually and regionally, and by the Ministry. We also continued to work with DHBs during this time to recommend areas for improvement.

2.51 Figure 10 shows the grades our auditors gave DHBs for each of the past three years.

Figure 10
Grades for district health boards' service performance information and associated systems and controls, 2009/10 to 2011/12



2.52 Although the overall results for 2011/12 are similar to 2010/11, our auditors reported that DHBs were continuing to improve the quality of their service reporting, including MidCentral DHB, which improved from "needs improvement" to "good".

2.53 Canterbury DHB received a "very good" grade, the first DHB to do so. This is particularly noteworthy because only about 4% of all public entities (government departments and Crown entities) that we assessed in 2011/12 were graded as "very good". Canterbury DHB and Hawke's Bay DHB (which presents an informative performance story in its 2011/12 annual report) provide useful exemplars for other DHBs to help them report fully and comprehensively on their performance.

Applying our revised auditing standard in 2012/13

2.54 In 2012/13, we will apply a revised auditing standard to our audit of DHBs' service performance information. The revised standard requires our auditors to modify their audit opinion if the performance information in the annual report does not, in their opinion, fairly reflect performance for the year.

2.55 Before implementing this revised auditing standard, we have worked with the Ministry and DHBs to help DHBs improve their service performance reporting. Our early focus was on helping DHBs to improve their statements of intent, on the assumption that this will lead to better annual reporting of performance. This included publishing a paper in 2011, *District health boards: Learning from 2010–13 Statements of Intent*.

2.56 In June 2012, we published a companion paper, *District health boards: Quality annual reports*,[7] which assesses and discusses characteristics of non-financial performance reporting in the DHBs' 2010/11 annual reports. The paper is intended to help DHBs improve the quality of their performance reporting.

2.57 One of our main findings was the need for many DHBs to improve their reporting on the effects of their services and other activities towards achieving better health for their communities. The DHBs continued to improve their service performance reporting in 2011/12, but further improvement is still needed. Figure 11 sets out our expectations of DHBs' performance reporting.

Figure 11
Our expectations of district health boards' performance reporting

We expect DHBs to report on their performance in a manner that is clear, logical, and understandable, and that:

- provides a basis for assessing how effectively each DHB responds to its strategic priorities and achieves its intended outcomes;
- links financial information and good quality non-financial performance information to provide a basis for assessing cost-effectiveness; and
- describes its services clearly and concisely, particularly the quality of those services.

2.58 We will continue to work with DHBs and the Ministry to help DHBs to continue to improve their performance reporting as we apply the revised standard to the audits of DHBs in 2012/13.

7 Available on our website, www.oag.govt.nz.

Audit results for regional shared services agencies

2.59 As already outlined, the role and functions of DHB shared services agencies are evolving with the increased focus on regional collaboration and achieving efficiencies and cost savings. There are also a range of national initiatives in the sector, such as those led by HBL, that are interconnected with regional collaboration.

2.60 Figure 3 sets out the regional structure of DHBs, including the jointly owned shared service agencies. We discuss these agencies and our audit results in more detail below. We will continue to report on these agencies, which are playing an increasingly significant role in supporting the sector.

Northern Region

2.61 We issued unmodified audit opinions on healthAlliance, Northern DHB Support Agency Limited, and Northern Regional Training Hub Limited.

2.62 healthAlliance has emerged as a more significant shared services agency for the region and now has more than 500 staff. Its revenue and expenditure more than doubled from $42 million in 2010/11 to $91 million in 2011/12.

2.63 healthAlliance was set up in July 2000 as a joint venture between Counties Manukau and Waitemata DHBs. Its scope and ownership was changed in March 2011, and it is now jointly owned by the four northern DHBs and HBL (they each own 20%).

2.64 The main functions of healthAlliance include finance, information services, some procurement services, and regional internal audit for the DHBs. It also provides business improvement, human resources, and staffing services (such as payroll processing) to some of the DHBs. During 2011/12, all IT assets owned by the northern DHBs were transferred to healthAlliance.

2.65 Northern DHB Support Agency Limited provides regional support functions, including regional service planning and purchasing and contracting functions for specified health services for the northern DHBs.

2.66 Northern Regional Training Hub Limited facilitates the training and education of clinical workforces for the northern DHBs.

2.67 On 1 March 2013, Northern DHB Support Agency Limited and Northern Regional Training Hub Limited were amalgamated and renamed as Northern Regional Alliance Limited.

Midland Region

2.68 We issued an unmodified opinion on HealthShare Limited.

2.69 The role of HealthShare Limited in administering and facilitating regionalisation of Midland DHB clinical services is expanding. In 2012/13, it will be moving into a range of new activities, including regional information systems and internal audit.

Central Region

2.70 We issued unmodified audit opinions on Allied Laundry Services Limited and TAS.

2.71 We also issued an unmodified opinion on DHBNZ, which included an emphasis of matter paragraph drawing attention to the preparation of the financial statements on a dissolution basis.

2.72 The former activities of DHBNZ were acquired by TAS with effect from 1 September 2011. DHBNZ's functions were rebranded as District Health Board Shared Services (DHBSS), which is a distinct unit in the new TAS.

2.73 The amalgamation has meant significant change to TAS's organisational structure, systems, and internal controls. We recommended that TAS review its governance and management structures, and the capability of staff and systems, to ensure that they continue to be appropriate given the significant changes to TAS. We also recommended that TAS improve its internal control environment.

South Island Region

2.74 We issued an unmodified opinion on South Island Shared Services Agency Limited, with an emphasis of matter paragraph drawing attention to the preparation of the financial statements on a realisation basis. This was because the company ceased operating from 1 December 2011 when its operations and staff were transferred to the South Island Alliance Programme Office (SIAPO).

2.75 SIAPO is hosted by Canterbury DHB and will report directly to the South Island Alliance Leadership Team (made up of the South Island DHB chief executive officers).

Future focus

2.76 The expanding size and scope of functions for these agencies – in particular, healthAlliance – can present challenges and risks for the agencies and the DHBs they support. This includes the need to ensure that they have the required capability and capacity, systems, processes, and appropriate governance and oversight to effectively support the DHBs.

2.77 Our auditors will continue to consider these matters in deciding the areas of focus and risk for their annual audits. We are also considering how we can more effectively audit entities that are working collaboratively, with more services and organisational functions being provided by shared service agencies.

Audit results for the Ministry and other Crown entities

2.78 We set out below the audit results for the Ministry and the nine non-DHB health sector Crown entities that we audited in 2011/12.

2.79 The health Crown entities, including entities disestablished in 2011/12, are listed in Figure 12.

Figure 12
Health sector Crown entities and Crown entities disestablished in 2011/12

Health sector Crown entities
Health and Disability Commissioner
Health Quality and Safety Commission
Health Research Council of New Zealand
New Zealand Blood Service
Pharmaceutical Management Agency
Crown entities disestablished in 2011/12
Alcohol Advisory Council of New Zealand
Crown Health Financing Agency
Health Sponsorship Council
Mental Health Commission

2.80 We issued unmodified audit opinions in 2011/12 for all the entities listed in Figure 12. We also highlighted in our audit reports that the financial statements of the four disestablished entities were appropriately prepared on a dissolution basis.

2.81 The role and functions of the Ministry and other Crown entities underwent changes in 2011/12 as the sector continued to evolve. For example, in conjunction with the Crown entities being disestablished, the Ministry took on additional functions and a new Crown entity, the Health Promotion Agency, was set up on 1 July 2012. We will audit the new Health Promotion Agency for the first time in 2012/13.

2.82 The role of Pharmac also expanded as it took on responsibility for managing hospital medicines, the national immunisation schedule, and hospital medical devices.

Ministry procurement and contracting

2.83 The Ministry contracts with a large number of organisations, including health providers within and outside of the Government, to provide health-related services, worth about $2.8 billion annually.

2.84 Although the Ministry has a good overall policy framework, its challenge for some years now has been the consistent application of policy on a day-to-day basis. The Ministry has taken steps to improve compliance, but significant issues remain. To help address this in 2011/12, the Ministry engaged an external reviewer to review national services purchasing and contract management.

2.85 The reviewer recommended improvements in procurement management, contract management, and value for money. We expect the Ministry to prioritise its response and implement improvements, including lifting the level of compliance with procurement policies.

Assessing the management environment, systems, and controls

2.86 In the health sector, we assess and grade the management environment, systems, and controls of the Ministry and other Crown entities, as we do for DHBs. We report each entity's results to its management team and, where applicable, to the governing board. We also report the results to the Minister of Health and the Health Committee of the House of Representatives. We did not grade the four disestablished entities.

2.87 Figure 13 shows grades for 2010/11 and 2011/12 for the three aspects that we grade. It shows improvements in grades for three entities from the previous year: the Ministry, the Health Quality and Safety Commission, and the New Zealand Blood Service.

Figure 13
Summary of other health entities' grades for environment, systems, and controls, 2010/11 and 2011/12

Other health entities	Year audited	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Ministry of Health	2011/12	Good	Good	Good
	2010/11	Good	Good	Needs improvement
Health and Disability Commissioner	2011/12	Good	Good	Good
	2010/11	Good	Good	Good
Health Quality and Safety Commission	2011/12	Good	Good	Needs improvement
	2010/11	Needs improvement	Needs improvement	Needs improvement
Health Research Council of New Zealand	2011/12	Very good	Very good	Good
	2010/11	Very good	Very good	Good
New Zealand Blood Service	2011/12	Very good	Very good	Very good
	2010/11	Very good	Good	Good
Pharmac	2011/12	Very good	Very good	Needs improvement
	2010/11	Very good	Very good	Needs improvement

2.88 The management control environment and financial information systems and controls were all graded as either "very good" or "good" in 2011/12. This means that we do not have any significant concerns. Our appointed auditor recommended improvements that would be beneficial for three of the six entities.

2.89 The Health Quality and Safety Commission improved its grades from "needs improvement' to "good" for both the management control environment and its financial information systems and controls. These improvements reflect the Commission's good progress in developing its control environment since the Commission was established in November 2010.

2.90 We graded the service performance information and associated systems and controls as "good" for three entities and "needs improvement" for two. We continue to work with health sector entities to help ensure that they clearly report their performance so that a reader can understand what the entity did, what it achieved, and the affect it had.

2.91 The New Zealand Blood Service was graded as "very good", which puts it (with Canterbury DHB) among the top 4% or so of public entities that we graded as "very good" in 2011/12.

Final audits for disestablished entities

2.92 We carried out final audits for four health Crown entities that were disestablished from 1 July 2012:

- the Alcohol Advisory Council of New Zealand and the Health Sponsorship Council, whose functions were taken over by the new Health Promotion Agency;
- the Mental Health Commission, whose functions were transferred to the Health and Disability Commission or the Ministry (or discontinued); and
- the Crown Health Financing Agency, whose functions were transferred primarily to the Ministry.

2.93 For all four entities, our audit report included an explanatory note highlighting that the financial statements were appropriately prepared on a disestablishment basis.

2.94 We did not assess and grade the entities' management environment, systems, and controls when we carried out the final audits. This is because the grades reflect our recommendations for improvement, and deficiencies identified during the final audit of a disestablished entity might not be relevant to any new entity or any entity that takes on the disestablished entity's functions.

2.95 However, we did report our audit findings and any significant issues to any new entities and the responsible Minister. Risks facing disestablished entities include potential loss of key staff and capability, and the breakdown of internal controls and organisational performance. Overall, our auditors found that all four disestablished entities maintained sound systems and controls up to the date of their disestablishment.

Audit results for regulatory authorities

2.96 We audit the 16 health-related regulatory authorities whose members are appointed by the Minister of Health under the Health Practitioners Competence Assurance Act 2003 (see Figure 14). We also audit two secretariats that each support two or three of the authorities.

Figure 14
Health regulation authorities and secretariats

Health regulation authorities
Dental Council of New Zealand
Dietitians Board
Medical Council of New Zealand
Medical Radiation Technologists Board
Medical Sciences Council of New Zealand
Midwifery Council of New Zealand
New Zealand Chiropractic Board
New Zealand Psychologists Board
Nursing Council of New Zealand
Occupational Therapy Board of New Zealand
Optometrists and Dispensing Opticians Board
Osteopathic Council of New Zealand
Pharmacy Council of New Zealand
Physiotherapy Board of New Zealand
Podiatrists Board of New Zealand
Psychotherapists Board of Aotearoa New Zealand
Health regulation authority secretariats
Health Regulatory Authorities Secretariat Limited
Medical Sciences Secretariat

2.97 The authorities are responsible for the registration and oversight of health professions. Each authority prescribes scopes of practice and necessary qualifications for its profession, registers practitioners, and issues annual practicing certificates. The authorities are funded by their professions (through membership fees).

2.98 In our audit reports for the 16 authorities and two secretariats in 2011/12, we drew attention to uncertainty about the delivery of office functions of the authorities in the future of the health-related regulatory authorities and secretariats. In February 2011, Health Workforce New Zealand issued a consultation document proposing a single shared secretariat and office function for all 16 regulatory authorities.

2.99 The authorities are working together on a business case for moving to shared administrative secretariat functions. Potential changes could include co-location, shared IT systems, and re-structuring board, management, and staff.

Part 3
District health boards' asset management

3.1 Capital asset management is about effectively managing assets during their economic lives, which includes improving the quality and relevance of information to support decision-making, future service delivery, and asset performance.

3.2 We expect each DHB to:

- know how well its mix of assets meets outcome and service delivery needs, now and in the future (that is, link its asset management to its strategic planning);
- have information reliable enough to support its planning, defined service levels, documented lifecycle management strategies, and complete financial forecasts;
- make good links between asset management planning and its other service and financial planning, with clear responsibility for planning and for having an up-to-date documented plan in place; and
- understand, respond to, and manage demand for its assets and the risks related to them.

3.3 In our high-level review in 2011 of how DHBs manage their assets,[8] we found that most DHBs had not improved how they plan to manage assets since 2009, when the Ministry required DHBs to document their approach to asset management in asset management plans. Few DHBs had documented their policy for managing assets, and their plans typically focused on the capital needed rather than why the asset is needed and when. We also found that most DHBs had not brought together financial forecasts of capital and operational expenditure, did not keep their asset management planning up to date, and had not included a risk register within their plans.

3.4 We have followed up our recommendations with individual DHBs, as part of our annual audits for 2011/12.

3.5 Our auditors reported that nine DHBs still needed to update their asset management plans. In some instances, delays were because of changes and developments at a regional planning level and the need to align the asset management plan with clinical services reviews and regional planning. Our auditors also reported that they had recommended improvements to the asset management plans of three other DHBs.

3.6 We will continue to follow up with individual DHBs on aspects of asset management planning that need to improve.

8 *Health sector: Results of the 2010/11 audits* (Part 4), available at www.oag.govt.nz.

3.7 Since 2009, the Ministry has required DHBs to produce asset management plans and to submit their capital intentions to the Ministry. Business cases for new investment need to integrate service planning – of the individual DHB, between DHBs, throughout a region, and nationally.

3.8 We are carrying out a performance audit to establish whether capital investment planning aligns with DHBs' regional services planning and is guided by high quality information about future needs. The audit will focus on the Ministry and the Capital Investment Committee processes, and two of the four regions (the Northern and South Island regions).

3.9 We intend to present our report to Parliament by the end of 2013.

Profile of district health board assets

3.10 Our work programme in 2012/13 focuses on the question: *Our future needs – is the public sector ready?* As part of this work, we wanted to find out more about the management of significant physical assets in the public sector.

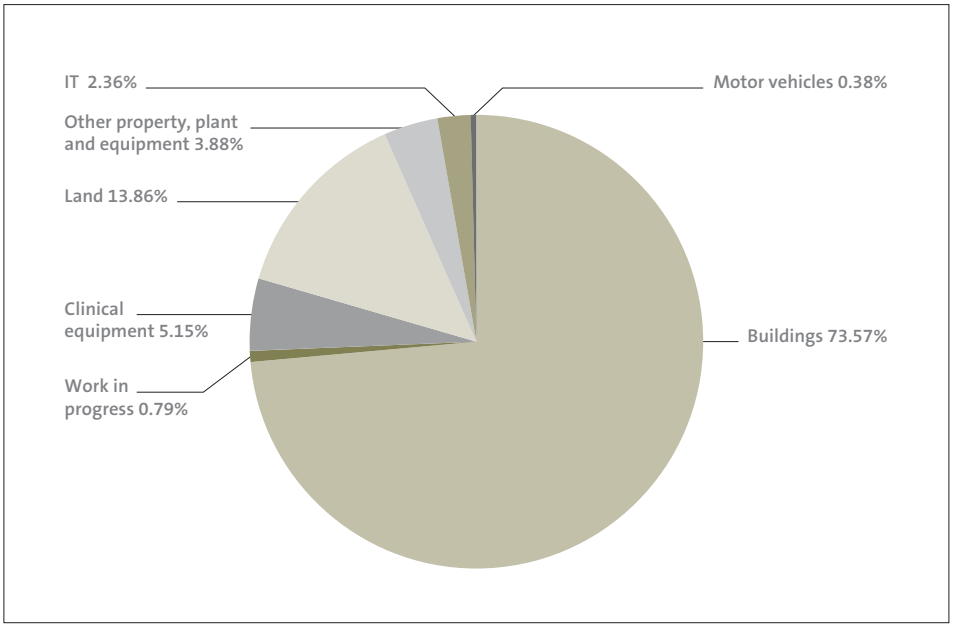
3.11 In October 2012, we asked public entities that had significant assets about the condition of their assets, how well they are maintained, whether enough money is being spent to renew them, and the adequacy of checking and reporting on those assets.

3.12 Our focus was on assets that are significant to the delivery of services. Although assets that are significant to one entity might not be significant to another, the information provided is helping us to compare broad groups within the public sector and to build a picture of the state of the public sector as a whole.

3.13 We received responses from about 350 entities throughout the wider public sector, including all 20 DHBs.

3.14 The responses showed that DHBs hold $5 billion of property, plant, and equipment (excluding intangible assets). Of those assets, $4.3 billion worth of assets are considered significant (see Figure 15). They are largely made up of land and buildings, which together account for 87% of the value of significant assets.

Figure 15
Significant health sector assets



3.15 DHBs spent $575 million on assets in 2011/12, including renewing existing assets and spending on new assets. This equates to 11.5% of the $5 billion of assets held by DHBs. Later this year, we intend to report further analysis to Parliament on asset management in the public sector.

Part 4
Health Benefits Limited

4.1 In this Part, we describe HBL's work programme and its reporting of sector savings.

4.2 HBL was set up on 30 July 2010 and is a Crown company owned by the Ministers of Health and Finance.

4.3 HBL's purpose is to facilitate and lead initiatives that reduce administrative, support, and procurement costs for DHBs. HBL is working with the sector to deliver a target of $700 million of gross savings for DHBs during its first five years.

Work programme

4.4 The HBL work programme gained significant momentum during 2011/12, as it made progress with initiatives and business cases – in particular, for the Finance, Procurement, Supply Chain Shared Systems and Services (the FPSC) work stream.

4.5 During 2011/12, HBL introduced a shared banking service for DHBs. As at 30 June 2012, five DHBs had joined this service. By December 2012, all but one (Taranaki DHB) had joined the service. The service is managed by HBL and includes a banking "sweep" arrangement, where all DHB bank account balances are brought together into one collective account on a daily basis. This arrangement is expected to provide annual benefits of $4 million for DHBs – for example, by obtaining a more favourable interest return than DHBs would achieve individually or, if a DHB is overdrawn, more favourable borrowing rates.

4.6 Other HBL work streams include:

- facilities management and support services, which includes food and laundry services;
- collective procurement, working with Pharmac and the National Health Committee to prepare a co-ordinated strategy for procurement of medical devices (for all DHBs);
- information services;
- ineligible patients; and
- HR/workforce management.

4.7 As part of its procurement work, HBL has continued the previous arrangement operated collectively by DHBs of negotiating a national insurance policy on behalf of all DHBs. This has been a particular challenge in today's insurance market, and we propose to discuss the sector's achievements in a report to Parliament about insurance later this year.

Finance, Procurement, Supply Chain Shared Systems and Services programme

4.8 By the end of 2011/12, HBL had made significant progress with the business case for introducing the FPSC for all DHBs. The first two DHBs are expected to move to the new system by December 2013 and all the rest by December 2014.

4.9 The FPSC is forecast to deliver net benefits of about $138 million over five years (from 2012/13) and about $538 million in the 10 years to 2021/22. Once-only implementation costs are estimated at about $87.9 million.[9]

4.10 Implementing the FPSC involves significant change for the sector. Potential effects on DHBs include changes in staff responsibilities, organisational capability, financial or procurement processes, accounting and reporting, and relationships with suppliers.

4.11 There will be ongoing risks associated with these changes, including risks to the maintenance of service delivery through the transition, delivery of planned savings and efficiencies, and implementing the project on time and to budget.

4.12 Our auditors will continue to consider these and other sector changes when deciding the areas of focus and risk for their annual audits of DHBs and other health sector entities. We are also considering whether we will carry out other work on the effectiveness of these and other sector initiatives.

Reported savings

4.13 HBL's goal is to contribute to gross savings of $700 million for DHBs over five years. The gross savings target does not take into account any associated costs in achieving the savings, such as the $87.9 million investment by DHBs to implement the FPSC.

4.14 HBL reaches agreement with each DHB on the costs and benefits expected from its initiatives. The reporting of savings is based on (unaudited) returns that DHBs submit to HBL.

4.15 HBL reports annual savings based on a sector savings methodology that has been agreed with DHBs. We were told that the methodology is to be reviewed in 2012/13. Under the methodology, savings are categorised as:

- baseline savings that improve the DHB's net operating result (for example, price reductions and rebates);
- value-added savings (for example, cost increases avoided); and
- other procurement and non-procurement savings.

9 Health Benefits Limited, *Annual Report 2012*, page 9.

4.16 HBL reported total sector savings (since it was formed) of $114.6 million as at 30 June 2012. This was made up of sector savings from initiatives measured by HBL totalling $59.6 million in 2011/12 and $55 million in 2010/11.[10]

4.17 During our audit of HBL, we focused on HBL's ability to transparently measure and report savings against cost savings targets (that is, savings achieved by HBL, DHBs, and all-of-government initiatives). We reviewed the reported performance against the cost savings model. Reported savings to date have been based on returns completed and approved by each DHB. These savings have not been the subject of any quality assurance review by HBL. As part of the audit, HBL acknowledged that it intends to introduce additional controls and procedures to verify savings currently reported by DHBs.

4.18 In its 2012 annual report, HBL has disclosed information about the sector savings model and the categories of savings identified above. However, it reported savings in total, rather than breaking down the achievement of savings between categories.

4.19 We recommended that HBL further improve the transparency of its measurement and reporting of savings, including:

- where practicable, estimating and reporting on the associated costs/ investments to achieve savings;
- breaking down reported savings using the three categories identified in the sector methodology – baseline savings, value-added savings, and other procurement savings; and
- reporting this information transparently for each DHB.

4.20 We consider that this will enable better understanding of the nature of the savings reported and provide important benchmarking information so DHBs' national, regional, and individual achievements can be measured over time.

4.21 Our auditors will continue to work with HBL and DHBs to ensure that there are more effective quality assurance systems to verify the savings information reported by DHBs and to improve the transparency of the savings model to reflect actual savings.

10 Health Benefits Limited, *Annual Report 2012*, page 2.

Part 5
District health boards' financial performance

5.1 In this Part, we describe the 2011/12 financial results for each DHB and aggregated deficit, asset, liability, and debt trends for the past six years.

5.2 We also describe our analysis of DHBs' financial statements from the past six years using a set of indicators as a potential way of understanding and prompting discussion about the financial ability of DHBs to respond to short-, medium-, and long-term financial risks.

Financial results

5.3 DHBs had total revenue of $13.332 billion and total expenditure of $13.354 billion in 2011/12. This represents an increase of just over 3% on both total revenue of $12.963 billion and total expenditure of $12.980 billion in 2010/11.[11]

5.4 The aggregate deficit for the 20 DHBs for 2011/12 was $22.4 million compared to $16.1 million in 2010/11. The total deficit was less than half the total planned deficit of $55.1 million.

5.5 Figure 16 sets out financial results for each DHB, by region, for 2011/12. Amounts have been rounded, so surpluses or deficits of less than $50,000 will show as 0.0 (nil).

Figure 16
Summary of 2011/12 financial results for district health boards, by region.

District health board	Revenue* $million	Expenditure* $million	Surplus (deficit)** $million	Planned surplus (deficit)** $million	Variance from plan** $million
All DHBs	13,332.0	13,354.2	(22.4)	(55.1)	32.7
Northern Region					
Auckland	1,788.9	1,788.1	0.7	0.1	0.6
Counties Manukau	1,352.5	1,347.1	5.4	0.0	5.4
Northland	505.9	505.9	0.0	0.0	0.0
Waitemata	1,375.2	1,370.3	4.8	0.0	4.8
Totals	*5,022.5*	*5,011.4*	*10.9*	*0.1*	*10.8*
Midland Region					
Bay of Plenty	639.7	639.7	0.0	0.0	0.0
Lakes	305.2	308.3	(3.1)	(3.2)	0.1
Tairawhiti	154.7	155.0	0.0	0.0	0.0
Taranaki	318.9	318.9	0.2	3.2	(3.0)
Waikato	1,145.4	1,135.9	9.4	11.5	(2.1)
Totals	*2,563.9*	*2,557.8*	*6.5*	*11.5*	*(5.0)*

11 Office of the Auditor-General (2012), *Health sector: Results of the 2010/11 audits*, page 9. Amounts are rounded.

District health board	Revenue* $million	Expenditure* $million	Surplus (deficit)** $million	Planned surplus (deficit)** $million	Variance from plan** $million
Central Region					
Capital and Coast	919.3	939.3	(19.9)	(20.0)	0.1
Hutt Valley	434.3	434.2	0.1	0.0	0.1
Wairarapa	129.3	134.0	(5.4)	(4.4)	(1.0)
Hawke's Bay	464.3	462.4	2.0	2.0	0.0
MidCentral	555.2	548.5	6.7	1.0	5.7
Whanganui	217.8	218.0	(0.2)	(4.9)	4.7
Totals	***2,720.2***	***2,736.4***	***(16.7)***	***(26.3)***	***9.6***
South Island Region					
Canterbury	1,472.3	1,472.4	0.0	(25.0)	25.0
Nelson Marlborough	408.3	413.5	(5.2)	0.1	(5.3)
South Canterbury	174.1	173.8	0.3	(0.5)	0.8
Southern	836.6	849.8	(13.2)	(10.5)	(2.7)
West Coast	134.1	139.1	(5.0)	(4.5)	(0.5)
Totals	***3,025.4***	***3,048.6***	***(23.1)***	***(40.4)***	***17.3***

* From DHBs' 2011/12 annual reports.

** The surplus/(deficit) figure does not include revaluations or impairments of asset value. Also, where the surplus/(deficit) figure is affected by profits from joint ventures or associates, it will not be the same as revenue less expenditure. Rounding can lead to some small differences in the totals and the variances.

5.6 As Figure 16 shows, the Northern and Midland Regions each reported a cumulative surplus, and the Central and South Island Regions each reported a cumulative deficit. The surplus/deficit trends for the past six years for each region are shown in Figure 17.

5.7 Although the overall deficit in 2011/12 was less than planned, the results range from a surplus of $9.4 million (Waikato DHB) to a deficit of $19.9 million (Capital and Coast). Nine DHBs reported surpluses, seven reported deficits,[12] and four broke even (or were very close to break-even).

5.8 Fourteen DHBs met or performed better than planned, and six did not meet their surplus/deficit targets.

5.9 Canterbury DHB essentially "broke even" (reporting a net deficit of $43,000) compared with a budgeted deficit of $25 million. Additional government funding of $10 million and insurance proceeds of $24.7 million helped contribute to this result, and offset some of the additional costs incurred because of the

12 Four of these obtained a letter from the Minister that supported their continuing viability (going concern status, see Part 2).

District health board	Revenue* $million	Expenditure* $million	Surplus (deficit)** $million	Planned surplus (deficit)** $million	Variance from plan** $million
Central Region					
Capital and Coast	919.3	939.3	(19.9)	(20.0)	0.1
Hutt Valley	434.3	434.2	0.1	0.0	0.1
Wairarapa	129.3	134.0	(5.4)	4.4	(9.8)
Hawke's Bay	464.3	462.4	2.0	2.0	0.0
MidCentral	555.2	548.5	6.7	1.0	5.7
Whanganui	217.8	218.0	(0.2)	(4.9)	4.7
Totals	***2,720.2***	***2,736.4***	***(16.7)***	***(17.6)***	***0.9***
South Island Region					
Canterbury	1,472.3	1,472.4	0.0	(25.0)	25.0
Nelson Marlborough	408.3	413.5	(5.2)	0.1	(5.3)
South Canterbury	174.1	173.8	0.3	(0.5)	0.8
Southern	836.6	849.8	(13.2)	(10.5)	(2.7)
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12 Four of these obtained a letter from the Minister that supported their continuing viability (going concern status, see Part 2).

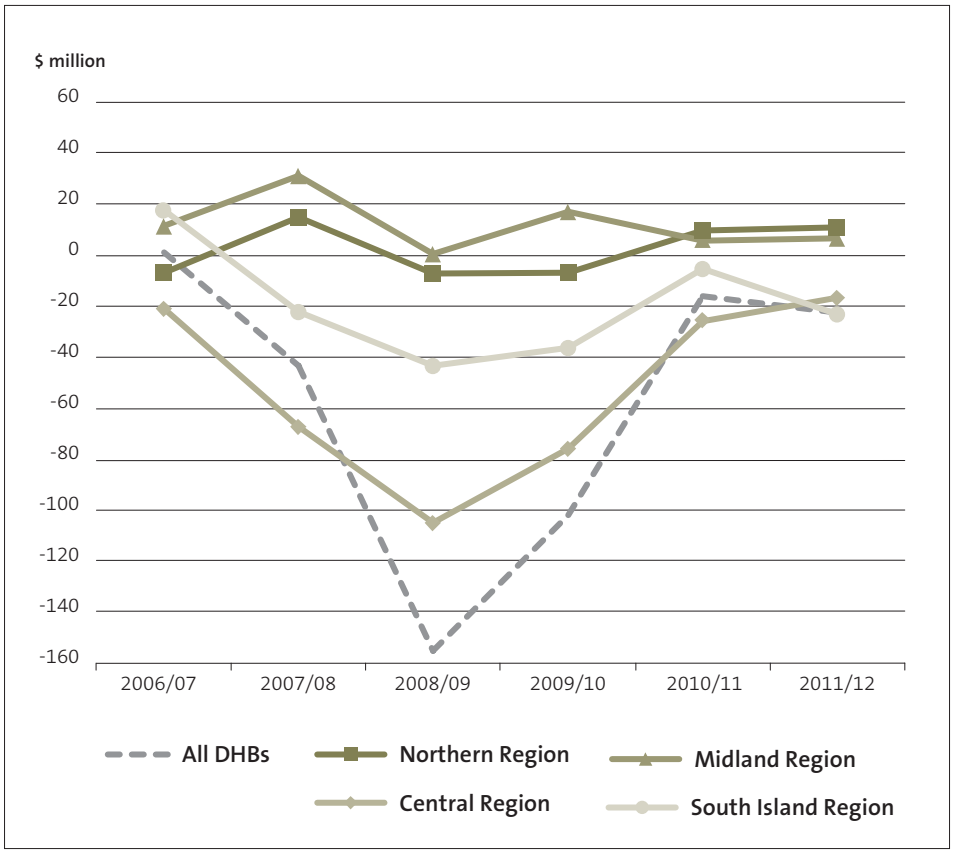
earthquakes. The ongoing effects of the earthquakes are expected to continue to affect the DHB's financial results for the next few years.

5.10 DHBs continue to work to improve their financial performance by seeking increased efficiency and productivity in clinical and support services. This work included increased regional collaboration and national shared services and initiatives led by HBL and others, as discussed in Parts 2 and 4.

Surplus/deficit trends

5.11 Figure 17 shows the total deficit, for all DHBs, from 2006/07 to 2011/12, including a breakdown by the four regions.

Figure 17
Surplus/deficit for all district health boards, 2006/07 to 2011/12



5.12 The regional surplus/deficit trends show the increasing deficit levels, for the Central and South Island Regions in particular, until 2008/09, and then overall improvement to 2010/11. The regional trends were positive from 2010/11 to 2011/12, except for the South Island Region, which increased its aggregated deficit from $5.4 million in 2010/11 to $23.1 million in 2011/12.

5.13 Regional planning and collaboration by DHBs to aid clinical and financial sustainability is resulting in changes to clinical service models and increased shared service arrangements to save costs. An example of closer sub-regional collaboration was in response to the draft 2012/13 annual plans of the three Greater Wellington DHBs (Capital and Coast, Hutt Valley, and Wairarapa DHBs) when the Minister of Health requested that they plan to achieve a sub-regional break-even financial result for 2013/14 and the following years.

Monitoring of district health boards

5.14 The Ministry monitors the performance of DHBs and other health Crown entities. It monitors and supports DHBs through its National Health Board business unit, which also monitors each DHB's financial position. The Crown Health Financing Agency (disestablished with effect from 1 July 2012) also had a role in monitoring risks to the financial performance of the DHBs. The Ministry has now taken over the Crown Health Financing Agency's monitoring functions.

5.15 The Ministry's monitoring framework for 2011/12 continued to use three levels of intervention – standard monitoring, performance watch, and intensive monitoring. There is also a Single Event Monitoring regime, introduced to respond to external events such as the Canterbury earthquakes. The Ministry is currently refining its monitoring framework.

5.16 Briefly stated, under the existing framework, standard monitoring is used when a DHB is in a sound financial position, has supported accountability arrangements in place, and is complying with requirements in a timely manner. DHBs are under a performance watch when there is some non-compliance or deterioration in performance. Intensive monitoring occurs when a DHB continues to be non-compliant or deteriorates in the performance watch requirements, or a single event creates a material risk.

5.17 As at 1 March 2013, 11 DHBs were on standard monitoring and nine were being monitored more closely:

- Taranaki, Whanganui, Hutt Valley, and Nelson Marlborough DHBs were on performance watch;
- Capital and Coast, Southern, Wairarapa, and West Coast DHBs were being monitored intensively; and

- Canterbury DHB had been on a Single Event Monitoring regime since the Canterbury earthquakes.

5.18 As well as monitoring, the Minister of Health can change how a DHB is governed, to help improve its performance. To do this, the Minister can appoint one or more Crown monitors to observe the decision-making processes of the DHB board, to help the board understand the policies and wishes of the Government, and to advise the Minister on any matters about the DHB or its board. If seriously dissatisfied, the Minister can dismiss the board and appoint a commissioner.

5.19 As at 1 March 2013, no commissioners were appointed to DHBs. Capital and Coast and Hutt Valley DHBs had a joint Crown monitor, and Southern DHB also had a Crown monitor.

Using financial statements to understand financial risk

5.20 We are exploring ways of using financial statements to better understand financial risk and financial performance in the public sector. The approach we are developing uses indicators based on information in the financial statements of public entities, which we then report on in groups: local authorities, tertiary education institutions, Crown research institutes, government departments, and other Crown entities, as well as DHBs.

5.21 We describe our approach in the following section and set out observations from applying it to information in DHBs' financial statements over the past six years, from 2006/07 to 2011/12.

5.22 The set of indicators we use is not an "audit test" and is just one possible way of looking at a DHB's financial performance and position, to indicate potential risk to financial sustainability. Financial performance needs to be considered in the broader context and, in particular, alongside non-financial performance information.

5.23 We will work with DHBs, and the Ministry as the monitor of DHB performance, on the applicability and usefulness of this approach for DHBs. We welcome feedback and discussion as we refine it further over time.

Explanation of our approach

5.24 Our approach uses financial statements to assess financial risk or uncertainty in a standardised and comparable way throughout the public sector.[13] We recognise that the Government funds and supports DHBs in the delivery of essential health services. Our analysis is intended to provide an indication of the financial ability of DHBs to respond to short-, medium-, and long-term financial risks.

13 The terms "risk" and "uncertainty" can have different meanings. In this approach, we use the terms inter-changeably to mean the potential for variation from what is expected or considered to be "typical" for the sector.

5.25 Financial statements are important in assessing performance. Although they say little about the non-financial objectives of DHBs and other public entities, they reflect and summarise many of the financial risks faced by a DHB in achieving its objectives.

5.26 Risks for DHBs can arise from many different sources, including economic, political, societal, and structural changes inside and outside a DHB. Our approach does not seek to identify or understand the root causes of risk. Instead, we use the financial statements to help assess the overall effect on three areas that relate to a DHB's financial ability to deliver on its objectives. For DHBs, we have looked at the following three areas:

- The accuracy and consistency of DHB budgeting for its use of financial resources. We have called this *stability*. To assess it, we compare actual performance with budget/forecast information.
- The DHB's financial ability to respond to medium-term unanticipated events, or how well the DHB can "bounce back", without major structural or organisational change. We have called this *resilience*. We look at operating cash flow costs, whether current assets cover current liabilities, and interest costs.
- The financial preparedness of a DHB for long-term uncertainty and to maintain itself in the longer-term. We have called this *sustainability*. We focus on balance sheet items such as assets, liabilities and debt, with related items such as capital expenditure and depreciation.

5.27 To assess the potential financial risks involved in delivering sector objectives we consider:

- whether the average values of the selected indicators are within a reasonable range;
- how they are trending over time – for example, improving, declining, or constant; and
- the distribution of DHBs that lie outside what we consider "typical" for the sector, the extent of variability, and what this might mean for the sector.

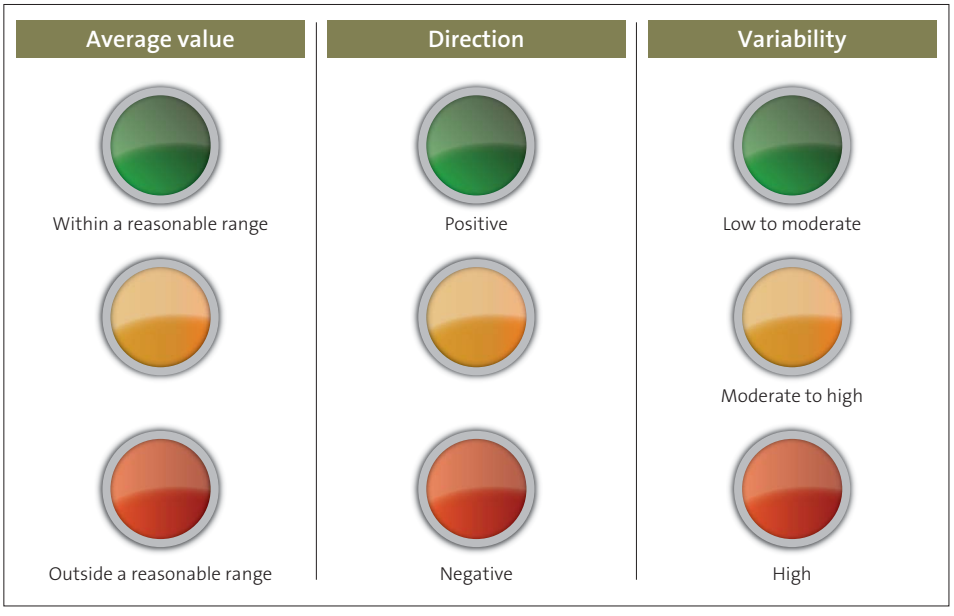
5.28 Figure 18 sets out the indicators we used.

Figure 18
Financial statement assessment framework – indicators for district health boards

Accuracy of budgeting (stability)	Resilience	Sustainability
Budget to actual operational expenditure	Current assets to operating cash flows	Capital expenditure to depreciation (and amortisation)
Budget to actual capital expenditure	Current assets to current liabilities	Retained earnings to total equity
	Interest costs	Debt to total assets

5.29 We have used a traffic light system to summarise the results of our analysis of DHBs, as described in Figure 19.

Figure 19
Traffic light assessment of district health boards' financial performance



5.30 As with all analysis of financial performance, there are limitations to what can be inferred. Our approach does not provide a comprehensive assessment of a sector or entity's performance but focuses on potential financial risk. DHBs outside what is typical for all DHBs are also not necessarily more at risk – they may simply warrant further investigation.

5.31 In this report, we present overall observations for DHBs. We intend to do further analysis to understand which indicators are most useful for understanding the financial risks faced by DHBs, the reasons why some DHBs are outside the typical range, and where further investigation may be needed.

What we found

5.32 Overall, our findings reflect the challenging operating environment and expectations for DHBs. These include increasing demand for services and the continued focus on providing high-quality health care and improving health outcomes. The health sector is also working to ensure that the health system is sustainable. For example, DHBs are expected to reduce deficits and improve their financial performance each year. They are also developing new models of care and more integrated services, both within their districts (for example, with primary care providers) and in their regions (with other DHBs). And, as discussed earlier in this report, there is also increased regional collaboration and national shared service initiatives to increase efficiency and reduce costs.

5.33 Our findings indicate that the potential financial risks are generally moderate to high and that some aspects might warrant further consideration. Of particular note are:

- the negative levels of retained earnings as a result of deficits incurred in previous years, and whether the recent signs of improvement in DHBs' surplus/deficit performance can be maintained;
- the (apparent) limited financial ability for some DHBs to respond to unexpected events in the medium term using their own financial resources – for example, with current assets on average covering only 59% of current liabilities; and
- the consistent under-spending against budget for asset expenditure requirements.

5.34 The reasonably high variability throughout the sector also suggests inconsistency in the financial ability of some DHBs to manage potential short-, medium-, and longer-term financial risks.

The accuracy of district health board budgeting (stability)

5.35 We looked at the accuracy of DHBs' budgeting against actual cash flows for both operational and capital expenditure (on assets and other investing activities).

5.36 Overall, DHBs' accuracy in planning, budgeting for, and delivering their financial resources is mixed, with good accuracy for operating expenses but a consistent under-spending against budget for their capital expenditure needs. Most DHBs are within the typical range. This lower variability could reflect a consistency in management approaches and more uniformity in how financial resources are used.

Budget to actual operational expenditure DHBs' planning and budgeting for operational activities were closely aligned to actual spending throughout the six-year period. A ratio of 1.0 indicates accurate budgeting. The DHB average is consistent at around 0.98.	Average value	Good accuracy with sector average at 0.98
	Direction	Consistent
	Variability	Low to moderate
Budget to actual capital expenditure A ratio of 1.0 indicates capital expenditure in line with budget. The DHB average is consistent at around 1.32, which indicates sizable and consistent under-spending against budget.	Average value	Sizeable over-budgeting, with sector average at 1.32
	Direction	Consistently high
	Variability	Low

The resilience of district health boards

5.37 Overall, DHBs' financial ability to respond to unanticipated events warrants further consideration. Although DHBs' resilience is supported by low interest costs of around 1% of total operating expenditure, their current assets are not enough to cover current liabilities, and would cover operating costs for about only one month. One possible reason for this is that DHBs are largely funded by the Government on a monthly basis, at the beginning of each month, which could explain low cash levels (a part of current assets) at the end of the month.

5.38 There are also quite a few DHBs outside the typical range. This variability could reflect a variety of management approaches and less uniformity in understanding and responding to some of these potential medium-term risks.

Current assets to operating cash flows This indicator shows how long the operational cash flows of a DHB could be supported using only current assets as funding. A ratio above 1.0 indicates current assets would cover cash flows applied to operations for one year. The DHB average indicates current assets range between 0.08 and 0.11. This suggests that, on average, DHBs could support operating cash flow costs for about one month. One possible reason for this is that DHBs are predominantly funded by the Government on a monthly basis, which means that low cash levels (part of current assets) at the end of each month would not be unexpected.	Average value  Current assets cover operating cash flows for one month on average Direction  Consistent low Variability  Moderate to high
Current assets to current liabilities This indicator shows whether the DHBs' current assets could cover their current liabilities in the event of an unexpected change or event. A ratio above 1.0 indicates that current assets are larger than current liabilities. The DHB average indicates that current assets would cover about 59% of current liabilities (a ratio of 0.59), but there are signs of some improvement in current asset coverage in later years.	Average value  Current assets do not cover current liabilities Direction  Improving in recent years Variability  Moderate to high
Interest costs This indicator shows the level of interest costs that cannot be easily changed in response to unexpected events. A ratio close to zero indicates that interest costs represent a small proportion of the costs of operating the DHB. Interest costs are, on average, low for DHBs, representing about 1% (a ratio of 0.01) of total operating expenditure.	Average value  Low interest costs relative to operating expenditures Direction  Consistent Variability  Low to moderate

The sustainability of district health boards

5.39 Overall, DHBs' financial ability to deal with long-term financial risk is also mixed. Positively, DHBs spending on their assets appears encouraging, but the split between renewing existing assets and new asset spend is unknown. Debt levels have steadily increased from 25% of total assets in 2007 to 31% in 2012, which are within a reasonable range and are supported by low interest costs of around 1%

of total operating expenditure, as discussed above. However, the level of retained earnings remains highly negative because of past deficits (see Figure 17).

5.40 Quite a few DHBs are outside the typical range, which could reflect a variety of management approaches and less uniformity in understanding and responding to some of the potential longer-term risks.

Capital expenditure to depreciation This indicator shows the level of investment in assets. This indicator assumes that depreciation and amortisation is a reasonable estimate of the amount of expenditure required to maintain the existing tangible and intangible asset base. Therefore, if capital expenditure is above depreciation, this is positive. However, as capital expenditure also includes spending on new assets, we would expect the ratio to be above 1.0, and possibly well above 1.0 in a sector like the health sector, which has high capital needs. In 2006/07, DHBs' average capital expenditure was around 1.28 times depreciation and amortisation levels, with an increase to 1.57 in 2010/11, and a slight drop to 1.55 in 2011/12.	Average value	Capital expenditure ranges from 1.28 to 1.57 times depreciation and amortisation
	Direction	Consistent
	Variability	Low
Retained earnings to total equity Retained earnings represent the accumulated surpluses and deficits of DHBs over time. A positive and increasing ratio of retained earnings to equity can indicate long-term profitability and/or an increasing proportion of surpluses being retained in the entities. We compared the level of retained earnings to total equity for each DHB from 2006/07 to 2011/12. From 2007 to 2011, DHBs' retained earnings as a percentage of total equity were consistently negative, ranging between -39% and -59%.	Average value	Sizeable negative retained earnings
	Direction	Improving in recent years
	Variability	Moderate to high

Debt to total assets

We compared total debt to total assets for each DHB from 2006/07 to 2011/12. The ratio shows the proportion of the DHB that is funded by debt providers and, while many assets are not easily realisable, the higher the proportion of debt the more important the debt provider's interests become in managing future uncertainties.

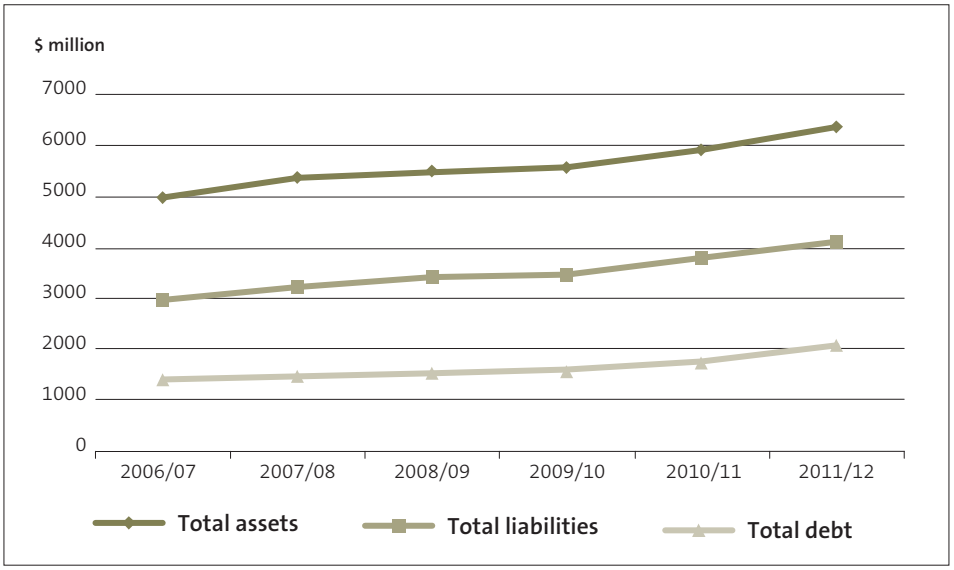
From 2006/07 to 2011/12, the sector average indicates total debt starts at 25% and increases steadily to 31% of total assets.

Average value	Sector average between 25% and 31%
Direction	Steadily increasing
Variability	Moderate to high

5.41 The Crown both owns the equity of DHBs and is the primary provider/holder of DHB debt. This means that the residual risk for both debt and equity lie with the Crown. The Ministry and the Treasury are reviewing the use of debt and equity within DHBs.

5.42 Figure 20 shows trends in total assets, total liabilities, and total debt for the past six years.

Figure 20
Total assets, total liabilities, and total debt, 2006/07 to 2011/12



5.43 Figure 20 shows steadily increasing trends for all three balance sheet aspects (aggregated for all DHBs), with a 28% increase in total assets, a 39% increase in total liabilities, and a 48% increase in total debt. This aligns with the steadily increasing debt to asset ratio discussed above.

Future focus

5.44 We intend to further refine our approach, including assessing which indicators are most useful for better understanding the financial ability of DHBs to respond to financial risk, the reasons why some DHBs lie outside what is considered typical, and where further analysis might be warranted.

5.45 As we refine our approach, it will also be used to inform our audit teams about sector risks and to investigate further any DHBs that are consistently and/or materially outside of what is typical for the sector.

5.46 We welcome feedback and discussion on our approach and our initial findings.

Part 6
Our recent and ongoing work in the health sector

6.1 In this Part, we provide summaries of our recent reports and describe our ongoing and future work in the health sector.

Recent reports

Effectiveness of arrangements to check the standard of rest home services: Follow-up report

6.2 The *Effectiveness of arrangements to check the standard of rest home services: Follow-up report* was completed in September 2012. Our earlier report in 2009 found that the certification process for rest homes did not provide adequate assurance that they had met the criteria in the *Health and Disability Services Standards*. We made nine recommendations in our 2009 report.

6.3 In our 2012 follow-up report, we found that all the recommendations had been met through initiatives introduced by the Ministry to strengthen the certification process, including introduction of the integrated audit approach, higher quality audits, and more frequent audits of high-risk rest homes. We also identified further improvements that could be made, such as using clinical and audit information together to continuously improve the quality of care provided. As a result of our report, the nationwide introduction of a technological system to improve information about quality of care (interRAI) has been accelerated, and additional training on audit methodology (the tracer technique) has been arranged for rest home auditors.

District health boards: Quality annual reports

6.4 In June 2012, we published a paper discussing characteristics of DHBs' annual reports that we consider are good for accountability. We assessed the 2010/11 annual reports of DHBs and highlighted areas of good reporting and where further improvements were needed.

6.5 This paper is intended to help DHBs to improve the quality of their reporting of non-financial performance information. The paper complements our February 2011 publication, *District health boards: Learning from 2010–2013 Statements of Intent*.

Fraud survey results for district health boards

6.6 New Zealand generally has a "clean" image when it comes to fraud. We consistently rank well in surveys that measure public trust in government and the effectiveness of systems and processes that deal with fraud and corruption.

6.7 In 2011, we surveyed almost 2000 people working in the public sector, including DHBs. In April 2012, we published our fraud survey results for DHBs,[14] which included confirmation that most DHBs had a fraud policy and a culture that encouraged staff to raise concerns about fraud.

6.8 However, we cannot afford to be complacent if we are to prevent fraud. It is important that the right systems are in place and that information about fraud incidents is shared internally and externally.

Ongoing work

Scheduled services

6.9 We published our report *Progress in delivering publicly funded scheduled services to patients* in June 2011. Since then, we have met with the Ministry regularly and received reports on its progress in implementing our recommendations.

6.10 We consider that significant improvements have been achieved. A greater proportion of patients now receive their first specialist assessment within six months and treatment within six months.[15] There has also been significant improvement in ensuring that patients needing cardiac surgery are treated in priority order and within the relevant period. At the same time, DHBs have treated more patients. Data has started to be collected about waiting times for some diagnostic tests and DHBs are to progressively work towards providing access to these tests within specific time frames.

6.11 We are continuing to meet with the Ministry to follow progress and will report more fully on this in 2014.

Our future needs work programme

6.12 As part of our work programme for 2012/13, we are carrying out several projects that focus on services and resources that are important to our health needs now and in the future.

DHB regional service planning and capital investment

6.13 We are currently carrying out a performance audit to establish whether capital investment planning aligns with DHB regional services planning and is guided by high-quality information about future needs. Because of the breadth of coverage of the regional services planning, we will focus on the interaction between regional services planning and cancer services. We will also concentrate on two of the four regions (Northern and South Island), because these regions have the

14 See the fraud reports on our website, www.oag.govt.nz/reports/fraud-reports.

15 Since we published our report, DHBs have been required to work towards ensuring that all patients get their scheduled treatment within four months. They have two or three years to achieve this.

greatest need for new capital investment. We intend to present our report to Parliament by the end of 2013.

Child obesity

6.14 Good child health is important for children and families now, and also for continued good health and active contribution to society into adulthood. Almost 30% of New Zealand children between five and 17 years old are classed as obese or overweight. This increases the risks of children developing diseases such as diabetes, heart disease, and asthma as they grow older.

6.15 We are examining the approaches that the Ministry, the Ministry of Education, and Sport New Zealand are taking to combat child obesity, and whether these approaches are informed by the end user. We intend to report on this work later this year.

6.16 We are considering whether we will do further work to examine the effectiveness of service delivery in combating child obesity. For example, we could take a closer look at the "delivery chain" and test the systems, processes, and relationships from government agencies through to the end users.

Ageing population

6.17 The proportion of older people in our population is growing at a faster rate than ever before, resulting in a major shift in our population structure. The number of New Zealanders aged 65 and over will exceed one million by the late 2020s.

6.18 We are carrying out a performance audit to examine whether a cross-section of public entities, including the Ministry, are effectively preparing and planning for the projected growth and composition of older people.

6.19 The *Madrid International Plan of Action on Ageing* (2002) set out to address the opportunities and challenges of ageing in the 21st century. A minimum list of 50 indicators was prepared to track progress in implementing the Madrid plan.

6.20 We are examining the use and usefulness of these indicators, including whether information is available on each of the 50 indicators, what the available information tells us about the status of older people, and how it is used to make improvements or projections.

6.21 We will publish our report in the latter part of 2013. Until then, we will progressively release the interim results for each indicator on our website (www.oag.govt.nz). We hope that the final report will provide assurance and stimulate discussion about the public sector's preparations during the last 20-30 years to deal with an ageing population.

Social media and technology-enabled service delivery

6.22 We are examining the use of social media by public entities to help deliver services. We are particularly interested in innovative social media practice, barriers to using social media, and common learning that can be shared throughout the public sector. We are selecting several case studies, which might include cases from the health sector – for example, the Ministry's breastfeeding community of practice and Waikato DHB's use of social media to promote discussion of vaccination during a measles outbreak.

6.23 The Ministry example demonstrates a cost-effective community of practice for hard-to-reach groups such as Māori and Pacifica. Waikato DHB illustrates a quick and targeted use of social media to prevent a wider outbreak of measles among schoolchildren.

6.24 We are using social media as one way to communicate our findings, and we aim to publish our findings by the end of June.

Future work

6.25 In 2013/14, we will focus our work on service delivery. Areas of focus are likely to include case management, contracting for outcomes, and delivering services in a digital environment. We are still deciding the work programme and which entities and sectors, including health entities, we will focus on. Our annual plan for 2013/14 will set out this work programme.

Reducing health disparities for Māori

6.26 In 2010/11, we reviewed DHBs' 2010/11 annual reports to assess their reporting on reducing health disparities for Māori. We reported our findings in our *Health sector: Results of the 2010/11 audits* report. We found that the combination of lack of information in the annual reports on Māori health needs and on targets to reduce disparities made it hard to gauge DHBs' progress.

6.27 In 2011/12, the Ministry introduced a new structure for DHB Māori health plans. The plans provide a summary of a DHB's Māori population and their health needs. The plan then documents and details the interventions and actions the DHB plans to carry out to address health issues to achieve indicator targets set nationally, regionally, and at district level.

6.28 We intend to carry out follow-up work to assess DHBs' progress in their reporting for 2012/13.

Appendix

Public entities in the health sector audited by the Auditor-General

Government departments
Ministry of Health
Crown entities
Health and Disability Commissioner
Health Promotion Agency (new)
Health Quality and Safety Commission
Health Research Council of New Zealand
New Zealand Blood Service
Pharmaceutical Management Agency
Crown entities disestablished in 2011/12
Alcohol Advisory Council of New Zealand
Crown Health Financing Agency
Health Sponsorship Council
Mental Health Commission
Crown company
Health Benefits Limited

Health regulation authorities
Dental Council of New Zealand
Dietitians Board
Medical Council of New Zealand
Medical Radiation Technologists Board
Medical Sciences Council of New Zealand
Midwifery Council of New Zealand
New Zealand Chiropractic Board
New Zealand Psychologists Board
Nursing Council of New Zealand
Occupational Therapy Board of New Zealand
Optometrists and Dispensing Opticians Board
Osteopathic Council of New Zealand
Pharmacy Council of New Zealand
Physiotherapy Board of New Zealand
Podiatrists Board of New Zealand
Psychotherapists Board of Aotearoa New Zealand
Health regulation authority secretariats
Health Regulatory Authorities Secretariat Limited
Medical Sciences Secretariat

District health boards
Auckland District Health Board
Bay of Plenty District Health Board
Canterbury District Health Board
Capital and Coast District Health Board
Counties Manukau District Health Board
Hawke's Bay District Health Board
Hutt Valley District Health Board
Lakes District Health Board
MidCentral District Health Board
Nelson Marlborough District Health Board
Northland District Health Board
South Canterbury District Health Board

District health board subsidiaries
Allied Laundry Services Limited
Auckland District Health Board Charitable Trust
Biomedical Services New Zealand Limited
Brackenridge Estate Limited
Canterbury Linen Services Limited
Central Region's Technical Advisory Services Limited
Dempsey Trust
District Health Boards of New Zealand Incorporated (dissolved)
Enable New Zealand Limited
HIQ Limited
Health South Canterbury Charitable Trust

Southern District Health Board Tairawhiti District Health Board Taranaki District Health Board Waikato District Health Board Wairarapa District Health Board Waitemata District Health Board West Coast District Health Board Whanganui District Health Board	healthAlliance N.Z. Limited HealthShare Limited Milford Secure Properties Limited New Zealand Centre For Reproductive Medicine New Zealand Health Innovation Hub (new) New Zealand Institute of Rural Health Northern DHB Support Agency Limited Northern Regional Training Hub Limited South Island Shared Service Agency Limited Spectrum Health Limited Tairawhiti Laundry Services Limited The Kaipara Total Health Care Joint Venture The Lakes District Health Board Charitable Trust The Manukau Health Trust Three Harbours Health Foundation Waikato Health Trust
Entities audited under section 19 of the Public Audit Act 2001	
TLab Limited	

Publications by the Auditor-General

Other publications issued by the Auditor-General recently have been:

- Transport sector: Results of the 2011/12 audits
- Local government: Results of the 2011/12 audits
- Draft statement of intent 2013–2016
- Crown Research Institutes: Results of the 2011/12 audits
- Inquiry into decision by Hon Shane Jones to grant citizenship to Mr Yang Liu
- Ministry for Primary Industries: Preparing for and responding to biosecurity incursions
- Inquiry into the Government's decision to negotiate with SkyCity Entertainment Group Limited for an international convention centre
- New Zealand Police: Enforcing drink-driving laws
- New Zealand Defence Force: The civilianisation project
- Effectiveness and efficiency: Stories from the public sector
- Department of Conservation: Prioritising and partnering to manage biodiversity
- Auckland Council: Transition and emerging challenges
- Matters arising from the 2012-22 local authority long-term plans
- Education sector: Results of the 2011 audits
- Response of the New Zealand Police to the Commission of Inquiry into Police Conduct: Third monitoring report
- Annual Report 2011/12

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