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## Health sector: Results of the 2012/13 audits





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# Health sector: Results of the 2012/13 audits

Presented to the House of  
Representatives under section 20 of  
the Public Audit Act 2001

May 2014

ISBN 978-0-478-41071-6 (print)  
ISBN 978-0-478-41072-3 (online)



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# Auditor-General's overview

The performance of the public health system, particularly the performance of district health boards (DHBs), is important to all New Zealanders. Our collective good health is part of the social and economic well-being of New Zealand.

In 2012/13, the government spending on health (through Vote Health) was nearly \$14 billion – 18% of the Government's total expenditure of \$78.6 billion.

The health sector continues to focus on improving its financial performance, including reducing the deficits of DHBs. My Office has analysed financial data from the past seven years to better understand the financial health of public sector entities, and in this report I discuss what that analysis tells us about DHBs.

This report also describes the results of our 2012/13 audits of entities in the health sector and our recent performance audit work to assess the effectiveness of particular aspects of the public health system – in particular, regional services planning. The health and well-being of older people has also been a focus of work for my Office in recent years and I summarise this work and our findings. The work has included identifying where better government data about older people is needed.

## **Public accountability and decision-makers need good performance information**

Collectively, DHBs spend about \$5.7 billion a year on services from third parties, such as primary health organisations and other non-governmental organisations.

In 2012/13, my auditors found that DHBs had limited controls over the performance information reported to them by third parties. For example, DHBs did not check the reported information to ensure that it was reliable. Without adequate evidence to support the reporting, the auditor's opinion on each DHB's third-party performance information was necessarily qualified. The audit of the Ministry of Health was also affected by this issue.

Good quality and reliable performance information is important for decision-makers and for public accountability. I recommended that entities in the sector work together to identify a cost-effective approach to addressing this problem with third-party performance information. There is unlikely to be an easy or quick solution, but the Ministry of Health has taken responsibility to lead the response.

DHBs continue to work more collaboratively, regionally and nationally, to increase their efficiency (such as cutting administrative costs and improving the delivery of

health services). I published a report on regional services planning in November 2013, which looked at the progress that regional services planning had made since 2011. Overall, I found not as much progress as expected, although there were some signs of success. My recommendations included the need to improve the quality of data for planning and reporting. Good information is important in enabling decision-makers to ensure that services are effective and efficient.

There has been improved and clearer reporting by Health Benefits Limited of savings for DHBs. I encourage them all to continue improving this reporting, including ensuring that the reporting is supported by good systems and documentation.

Also, there have been improvements in the 2012/13 reporting by DHBs on reducing Māori health disparities. This is important information for all of us and I encourage DHBs to report more information about the extent of disparities in their population and the progress in reducing those disparities.

DHBs manage assets worth more than \$5 billion. They have made limited progress in asset management planning, with more than half still needing to update or improve their plans. I am aware that some delays are because of pending regional and national plans, and it is important that DHBs manage associated risks in the meantime. I intend to carry out work in 2014/15 to gain more information about their asset management practices.

### **Ongoing change and the importance of effective governance**

The health sector continues to undergo significant change, such as new health technologies and information technology systems, and changes to how services are delivered.

The implementation (led by Health Benefits Limited) of the national Finance, Procurement and Supply Chain (FPSC) shared service and system for DHBs will mean significant change and associated risks for each DHB and for the sector. The risks include, particularly during the transition period, the loss of key staff capability and a breakdown in internal controls and systems, or in the management control environment. Effective project and risk management through the transition is critical.

My auditors found that most DHBs still need to improve their information technology security (such as password controls) and that many did not have business continuity and disaster recovery plans. Business continuity and disaster recovery plans are essential to ensure that critical health services and systems are working in the event of a disaster. DHBs have responded well in recent events

(such as the Canterbury earthquakes), but I am aware that some are waiting for regional systems or the FPSC before making improvements to their plans. It is important that DHBs assess and manage risks in the meantime.

It is also important that there is effective governance in place, with central oversight of major projects and oversight by DHBs as the FPSC is rolled out. In a shared services environment, roles and responsibilities must be clear. It is also critical that shared services agencies undergoing significant expansion, such as healthAlliance N.Z. Limited, ensure that they have the capacity and capability to maintain existing services as well as delivering new ones.

Major infrastructure projects, such as the redevelopment of hospitals in Canterbury, also need effective governance arrangements. The Canterbury DHB hospitals redevelopment is expected to cost more than \$650 million and is the largest ever health-related building project in New Zealand.

There continues to be considerable change in the health sector as it works to ensure clinical and financial sustainability to meet the current and future needs of New Zealanders. In my view, good reliable performance information and effective governance of change are critical enablers for success.



Lyn Provost  
Controller and Auditor-General

19 May 2014



# Part 1

## Overview of the health sector

- 1.1 In this Part, we provide an overview of the health sector to help set out the context for our work, including describing:
- the health sector’s operating environment;
  - district health board (DHB) funding (including the population-based funding formula);
  - regional and national collaboration (including our audit of regional services planning); and
  - legislative changes that affect the public sector.

### Operating environment

- 1.2 The health sector faces complex and ongoing challenges, including an ageing population, people living longer with multiple health conditions, and the increasing costs of new technologies and medicines. Non-communicable diseases, such as cardiovascular disease, diabetes, and cancer, are the leading cause of mortality. Mental health problems, including worryingly high suicide rates, are also a significant issue for New Zealand.
- 1.3 New Zealand’s health and disability services are delivered through a complex network of organisations. Appendix 1 lists the public entities in the health sector. We described the sector’s structure, regional and sub-regional arrangements, and recent structural and non-structural changes in our 2013 report, *Health sector: Results of the 2011/12 audits*. These changes are expected to lead to improvements in various aspects of the capability and infrastructure needed to support the health system and the sustainability of the health sector.
- 1.4 There are two key components of the public health system:
- The Ministry of Health (the Ministry), which advises the Minister of Health and the Government on health issues and leads the public health and disability sector, including monitoring DHBs and other Crown entities.<sup>1</sup> The Ministry also operates regulatory functions, provides health sector information and payment services, and purchases national health and disability services.
  - DHBs, which are responsible for identifying and providing for the health needs of their district. The 20 DHBs are grouped into four regions (Northern, Midland, Central, and South Island).
- 1.5 Government expenditure in Vote Health in 2012/13 was just under \$14 billion, which was about 18% of total government expenditure (\$78.6 billion). More than three-quarters of the health budget is allocated directly to the DHBs in the form of population-based funding.

<sup>1</sup> Associated bodies such as the National Health Board, Health Workforce New Zealand, IT Health Board, and Capital Investment Committee also have a role in advising and leading the sector.

- 1.6 As the second largest area of public spending (after Social Development), health spending plays a key role in government financial sustainability. The challenge is to continue to provide New Zealanders with high-quality health care while ensuring that the health system is sustainable. The previous high rate of annual increases in health spending, particularly since the 1990s, has now started to level off.

### District health board funding

- 1.7 DHB funding is largely based on the population of each district. It is calculated using a population-based funding formula (PBFF). DHBs also collectively receive additional funding of about \$1 billion from the Ministry for national health services (for example, funding to provide national elective services). Other funding sources include other government agencies (most notably Accident Compensation Corporation, or ACC), local government, and private sources, such as insurance and out-of-pocket payments (for example, payments from international patients).

### Population-based funding formula

- 1.8 The PBFF is used to determine the share of funding allocated to each DHB, based on its population, the relative needs of the population, and the costs of providing health and disability services. The formula includes weightings and adjustors for population age and other indicators of high needs, such as deprivation status and ethnicity.<sup>2</sup> These weightings are based on expected average health care costs for each person, such as inpatient, outpatient, maternity, immunisation, mental health, and pharmacy costs, and adjustors for unavoidable costs (such as the higher cost of providing services in rural areas).<sup>3</sup>
- 1.9 The PBFF was developed in 2000 and used population data available at the time. Cabinet approved the formula in November 2002 and directed that it be reviewed every five years to include new data about deprivation from the population census.<sup>4</sup> It is updated each year with population projections from Statistics New Zealand.
- 1.10 The PBFF was introduced in 2003 and was also reviewed in 2003, when 2001 census data became available. The 2003 review<sup>5</sup> did not consider any structural issues, but the PBFF was updated using the 2001 data. The PBFF was also reviewed after the 2006 census, which led to a few minor changes and recalculations. In conjunction with updating the PBFF with new data from the 2013 census, a full policy review of the PBFF is currently being scoped by the Ministry.

2 Ministry of Health (2003), *Population-based Funding Formula*, page vii.

3 Penno E. and Gauld R (2013), "How are New Zealand's District Health Boards funded and does it matter if we can't tell?", *New Zealand Medical Journal*, Vol. 126, No. 1376, page 25.

4 Ministry of Health (2003), *Population-based Funding Formula*, page 1.

5 See [www.health.govt.nz/publication/population-based-funding-formula-2003](http://www.health.govt.nz/publication/population-based-funding-formula-2003).

- 1.11 Funding for DHBs under Vote Health has been increasing annually using demographic and “contribution to cost pressures” adjusters. These increases are intended to help meet inflationary pressures and service demand pressures caused by population changes. There has also been additional funding for specific new initiatives (such as funding for dementia in Budget 2013).
- 1.12 Figure 1 shows the population for each DHB that the Ministry used to determine Vote Health Budget funding for 2013/14, and the actual funding for 2012/13. Further financial information for DHBs, including total revenue and expenditure for each DHB in 2012/13, is set out in Part 4.

**Figure 1**  
**Population of district health boards (2013/14 estimates), and funding for 2012/13 and 2013/14**

District health board	Population*	2013/14 Budget funding** \$million	2012/13 actual funding*** \$million
All DHBs	4,490,851	11,104.4	10,891.0
<b>Northern Region</b>			
Auckland	469,585	1,068.6	1,051.2
Counties Manukau	517,070	1,203.4	1,174.7
Northland	159,765	474.9	465.6
Waitemata	564,755	1,252.8	1,217.9
<b>Northern Region totals</b>	<b>1,711,175</b>	<b>3,999.7</b>	<b>3,909.4</b>
<b>Midland Region</b>			
Bay of Plenty	216,040	593.6	584.8
Lakes	103,110	272.8	268.5
Tairāwhiti	46,715	141.2	137.3
Taranaki	110,773	296.0	290.9
Waikato	374,475	977.9	948.1
<b>Midland Region totals</b>	<b>851,113</b>	<b>2,281.5</b>	<b>2,229.6</b>
<b>Central Region</b>			
Capital and Coast	300,330	661.0	643.5
Hutt Valley	145,410	346.0	342.3
Wairarapa	40,760	119.2	116.0
<b>3 DHB sub-region totals</b>	<b>486,500</b>	<b>1,126.2</b>	<b>1,101.8</b>

District health board	Population*	2013/14 Budget funding** \$million	2012/13 actual funding*** \$million
Hawke's Bay	156,900	430.4	419.2
MidCentral	170,430	447.6	440.5
Whanganui	62,868	198.0	195.7
<b>Central Region totals</b>	<b>876,698</b>	<b>2,202.2</b>	<b>2,157.2</b>
<b>South Island Region</b>			
Canterbury	509,955	1,218.6	1,222.0
Nelson Marlborough	142,075	367.5	359.1
South Canterbury	57,055	160.9	156.1
Southern	309,600	758.0	743.0
West Coast	33,180	116.0	114.6
<b>South Island Region totals</b>	<b>1,051,865</b>	<b>2,621.0</b>	<b>2,594.8</b>

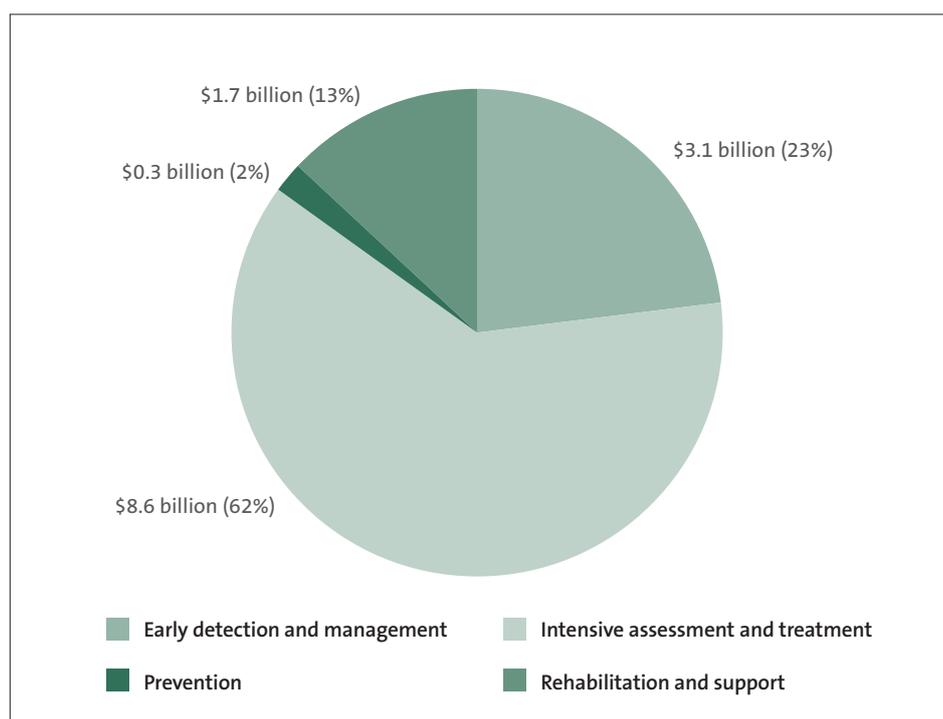
\* Updated data received from the National Health Board (Ministry of Health).

\*\* The *Estimates of Appropriations 2013/14, Vote Health*, pages 130 to 132.

\*\*\* CFISnet.

- 1.13 DHBs deliver hospital-based services and purchase services from third parties, such as primary health organisations (PHOs) and residential facilities. Collectively, DHBs spend about \$5.7 billion on services from third parties each year. We discuss the DHBs' reporting of service performance information in Part 3.
- 1.14 The health services that DHBs provide and purchase are categorised into four output classes (groups of similar services/activities):
- early detection and management;
  - intensive assessment and treatment;
  - prevention; and
  - rehabilitation and support.
- 1.15 Figure 2 shows the distribution of total expenditure for all DHBs in 2012/13 across the four output classes.

**Figure 2**  
Distribution of spending by all district health boards in 2012/13



1.16 In Part 4, we discuss DHBs' financial performance, including their financial results for 2012/13 and our analysis of their financial health.

### Regional and national collaboration

- 1.17 Increased regional and national collaboration is a focus for the sector as further efficiencies and cost savings are sought. There is a current expectation that initiatives led by Health Benefits Limited (HBL) will produce sector savings of \$764 million over five years (from July 2010).
- 1.18 The evolving regional and sub-regional operating environment for DHBs is set out in our 2011/12 report. Shared services agencies, such as healthAlliance N.Z. Limited (healthAlliance), have continued to take on expanded roles, with an increasingly wider scale and scope of functions (see Part 2).
- 1.19 DHB elections were held in October 2013, resulting in changes in board memberships. Those changes included six new chairpersons and six new deputy chairpersons. There are seven chairperson and deputy chairperson cross-appointments, which are intended to encourage greater regional collaboration in the planning and delivery of health services.

- 1.20 Individual DHBs are held accountable for delivering services. Although DHBs are planning regionally, there are still no formal arrangements (other than publishing regional plans) for public accountability about regional service delivery between entities or regions. This is an area of increasing interest for our Office because agencies are increasingly expected to work more collaboratively throughout the public sector.

### Regional services planning

- 1.21 With health spending of just under \$14 billion, it is important that services are designed and delivered without unnecessary waste.
- 1.22 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. Changes to regional services planning were introduced in the health sector in 2011 to support the effective and efficient design and delivery of services.
- 1.23 The expectation was that DHBs would plan together to reduce service vulnerability, reduce costs, and improve the quality of care. We decided to see what progress had been made and so carried out a performance audit on regional services planning. We published our report in November 2013.<sup>6</sup>
- 1.24 We looked at the effectiveness of the planning process in helping to ensure a sustainable health system for the future, including the extent to which the intended benefits were being achieved. We focused on aspects of service delivery, capital investment, and the availability of good quality data to support decision-making.
- 1.25 We found some signs of success but not as much progress as expected, and there were some challenges that needed to be overcome. The Ministry and DHBs had put effort into creating the conditions for success and collaboration had increased but it was still not yet business as usual.
- 1.26 The Ministry was not systematically monitoring and measuring progress, or quantifying the benefits achieved by regional services planning. It was difficult to tell whether the sector was going far or fast enough to achieve what it was trying to achieve.
- 1.27 In our view, the Ministry needed to do better in setting the direction for DHBs and in providing guidance.
- 1.28 Good planning requires good information, based on data that is complete, reliable, consistent, and comparable. In the areas that we looked at, the quality of data used for planning and reporting needed to improve. We recommended that the Ministry and DHBs work together on this.

<sup>6</sup> *Regional services planning in the health sector*, available at [www.oag.govt.nz](http://www.oag.govt.nz).

- 1.29 We made seven recommendations to help the Ministry and DHBs as they continue with regional services planning. We expect to follow up on this work in 2015/16.

### Public sector legislative reform

- 1.30 Three principal statutes governing the management of the State sector and public finances were amended in 2013. The changes support the goals of the Government's Better Public Services (BPS) programme, which is meant to see public entities working more closely together to deliver better results for less money. The legislative changes are intended to provide for:
- greater financial and reporting flexibility; and
  - stronger leadership at the system, sector, and departmental level to achieve the desired change in the performance of the State sector.
- 1.31 The amendments to the Crown Entities Act 2004 were enacted in July 2013. They change aspects of the way in which statutory Crown entities, including DHBs, can present information on their financial and service performance (both forecast information and end-of-year reporting).
- 1.32 The changes also mean that subsidiaries of Crown entities are not required to produce their own annual report (or statement of intent) unless they are directed to by the Minister of Finance (for example, to support public accountability).
- 1.33 We have discussed with the Ministry whether the three significant DHB-owned shared services agencies (healthAlliance, HealthShare Limited, and Central Region's Technical Advisory Services Limited) should continue to produce their own accountability documents. In our view, given the significance of their operations, it would be appropriate for them to do so.



## Part 2

# Audit results for 2012/13

- 2.1 In this Part, we discuss the 2012/13 audit results and our areas of interest, including:
- our audit reports;
  - observations and matters arising from the 2012/13 audits; and
  - our assessment of the management environment, systems, and controls for DHBs and other significant health sector entities.
- 2.2 We discuss DHBs' service performance reporting, including our qualified audit opinions on performance information, in Part 3. We discuss DHBs' financial results and performance in Part 4.

### Overview of our audit reports

- 2.3 There are legislative requirements for government departments, Crown entities (including DHBs), and other public entities to report on their service performance, and for the Auditor-General to audit that reporting. Our audit reports include our opinion on the entity's financial statements and on its performance information.
- 2.4 We set out details about our standard and non-standard audit reports, and timeliness of reporting, in our report, *Central Government: Results of the 2012/13 audits, Volume 2*. In this Part, we provide an overview of audit reports for major health sector entities. Non-standard audit reports include:
- modified audit opinions<sup>7</sup> on the financial statements or performance information; or
  - unmodified opinions that include a paragraph emphasising a matter (an emphasis-of-matter paragraph) or otherwise drawing the reader's attention to a particular matter (an other-matter paragraph).
- 2.5 We summarise our audit reports for significant public entities in the health sector in Figure 3, including a brief explanation of why we issued the non-standard audit reports.

<sup>7</sup> There are three types of modified opinions: an "adverse opinion", a "disclaimer of opinion", and a "qualified opinion". For a plain-English explanation of audit reports, see *The Kiwi guide to audit reports* at [blog.oag.govt.nz](http://blog.oag.govt.nz).

**Figure 3**  
**Summary of 2012/13 audit reports**

2012/13 audit reports	Public entities in the health sector
<p><b>Standard audit reports</b></p>	<p>We issued standard audit reports for:</p> <ul style="list-style-type: none"> <li>• Central Region’s Technical Advisory Services Limited</li> <li>• Health and Disability Commissioner</li> <li>• Health Benefits Limited</li> <li>• Health Promotion Agency</li> <li>• Health Quality and Safety Commission</li> <li>• Health Research Council of New Zealand</li> <li>• healthAlliance N.Z. Limited</li> <li>• HealthShare Limited</li> <li>• New Zealand Blood Service</li> <li>• Pharmaceutical Management Agency</li> </ul>
<p><b>Non-standard audit reports</b></p> <p>These include modified and unmodified audit opinions.</p>	<p><b>Modified opinions</b></p> <p>We issued modified audit opinions for all 20 DHBs, which included:</p> <ul style="list-style-type: none"> <li>• unqualified opinions on each DHB’s financial statements; and</li> <li>• qualified opinions on each DHB’s performance information.</li> </ul> <p>We found that DHBs generally have limited controls over much of the performance information from third-party health providers. We were not able to obtain the evidence needed to express an unqualified audit opinion on all the service performance information reported by each DHB.</p> <p>We also qualified our opinion on particular performance information reported by Lakes DHB and by Wairarapa DHB.</p> <p>We issued an unqualified opinion on the Ministry of Health’s financial statements and a qualified opinion on its service performance information. We explain our qualified opinion about service performance information in Part 3.</p> <p>We qualified our opinion on the Auckland District Health Board Charitable Trust’s financial statements because the Trust had limited control over donations and we could not confirm that all donations were properly recorded.</p> <p><b>Unmodified opinions with an “emphasis of matter” paragraph</b></p> <p>We drew attention to the uncertainty about the delivery of office functions in the future of the 16 health regulatory authorities and the two secretariats.</p> <p>We drew attention to the uncertainty about Allied Laundry Services Limited’s ability to continue as a going concern because of the national restructuring of laundry services being led by Health Benefits Limited.</p> <p>We drew attention to the appropriate preparation of Manukau Health Trust’s financial statements on a disestablishment basis. The Trust is expected to be wound up before the next balance date.</p>

## Observations and matters arising from the 2012/13 audits

- 2.6 A significant matter arising from our 2012/13 audit work was the qualified opinions relating to service performance reporting by DHBs. This is a sector-wide issue that affected the audits of all DHBs and the Ministry. We discuss it further in Part 3.
- 2.7 DHBs continued to operate in a constrained financial environment, with lower increases in funding and a focus on making efficiencies and cost savings. This included the continued focus on developing and implementing regional and shared services initiatives for the DHB sector, including those led by HBL. We considered these and other important matters, such as procurement and DHBs' asset management, in our audit work.

### Information systems and controls

- 2.8 As part of the annual audit, we consider information systems and technology (IT) controls that affect the reliability of the financial statements and service performance reporting. The work includes assessing general information technology controls, business application controls, and data analysis. Matters that auditors focus on include:
- assessing risks related to an entity's activities, such as its IT governance and strategic planning, IT processes and organisation, and how performance is monitored and evaluated; and
  - testing operational effectiveness of management controls, such as data and operations management, problem and incident management, systems acquisition and project management, and security (network and applications).
- 2.9 Balancing IT business requirements with the availability of resources is a continuing challenge for DHBs. We are interested in DHBs' information service risks, particularly the ongoing regionalisation of IT operations, information security, business continuity, emerging technologies, and effective IT governance.

### Effects of regionalisation on the IT environment

- 2.10 Regionalisation, collaboration, and shared services continued to be themes within DHBs' IT environment during 2012/13. There are also ongoing and significant IT developments, such as increased sharing of information between health providers and developing patient portals (for patients to access their health information, book appointments, or communicate directly with their general practitioner).
- 2.11 There are several risks associated with regionalisation that the DHBs need to mitigate, such as conflicts between regional and local priorities, a single point of failure for the regionalised systems, and a lack of standardised operational procedures.

2.12 DHBs need to ensure that their planning is robust, to properly align local priorities with those in regional and national IT plans. We expect the governance of regional activities to be defined and documented in regional information systems plans.

2.13 The roll-out of the HBL-led national Finance, Procurement and Supply Chain (FPSC) system for all DHBs started in April 2014 with the implementation of the finance system in Hutt Valley DHB (see paragraphs 2.30-2.33). This is part of a significant period of change for DHBs and the wider health sector, and there will be an increased inherent risk of a breakdown in controls in the transition period, or possibly a move to an ineffective control environment under the FPSC. Effective governance is critical, including that boards monitor change and risk management processes during the change period. Those risks include the possible loss of key personnel or institutional knowledge, as well as any effect on the control environment.

#### **Information security**

2.14 Work during our annual audits has shown that more than half of the DHBs need to improve their IT security controls. The most common problems were weak password settings, failures to promptly terminate system access (for example, removing access for staff who no longer work for the DHB), the management of user log-on accounts, and a lack of periodic reviews of users' access rights.

2.15 The main reason we were given for why DHBs were not implementing robust password settings was the potential negative effect on the delivery of health services (that is, password log-on procedures could cause a delay in accessing a clinical system). Several DHBs also told us that they were delaying making improvements as they awaited the implementation of regional and national IT systems and operations, such as the FPSC. It is important for DHBs that delay making IT security improvements to manage associated risks in the meantime.

#### **Business continuity and disaster recovery**

2.16 Business continuity and disaster recovery are essential to ensure that vital health services and systems are still working in the event of a disaster. More than half of the DHBs lacked formally documented and tested disaster recovery and business continuity plans. Improvements might be addressed through regional plans and regional operations but, in the meantime, DHBs bear the risk of the absence of formal plans.

#### **Main technology risks for the sector**

2.17 In our feedback to entities in the DHB sector, we highlighted that the main technology risks were to do with:

- aligning local DHB plans with regional and national IT plans to avoid duplication of effort and resources;

- IT governance – DHBs (management and boards) need to ensure that they have an adequate understanding of the main information systems risks through, for example, regular oversight by boards of significant strategic projects;
- business continuity and IT disaster recovery – business continuity must be DHB-wide, and IT disaster recovery is an important component of continuity planning and ensuring that critical systems are working within the required period (regional IT plans provide an opportunity to ensure that continuity provisions are highlighted); and
- information security, which is challenging for the sector (DHBs need to ensure that security policies and initiatives are in place, and that they are implemented).

### Shared services for district health boards

- 2.18 Collaborative regional and national initiatives to improve efficiency and save costs in the DHB sector continued to evolve during 2012/13. In this context, the DHB sector includes the 20 DHBs, the regional shared services agencies (healthAlliance, HealthShare Limited, and Central Region's Technical Advisory Services Limited) and the national agencies – HBL and the Pharmaceutical Management Agency (Pharmac) – leading initiatives for shared services and sector procurement.
- 2.19 The shared services agencies have an increasing role in providing services to DHBs and, in some instances, have been taking on expanded roles and functions. The following sections set out our main findings and risks for the sector.

#### Health Benefits Limited

- 2.20 HBL is a Crown company and was set up on 30 July 2010. Its purpose is to facilitate and lead initiatives that reduce administrative, support, and procurement costs for DHBs. It had an initial target of delivering gross sector savings of over \$700 million.
- 2.21 HBL is dealing with a substantial change agenda for the sector in a range of programme areas.<sup>8</sup> It is important that HBL has robust programme and risk management and regular, timely reporting to the board and to the sector, to enable it to meet its objectives effectively and efficiently.
- 2.22 We note that HBL's programme management arrangements are evolving as the programmes progress beyond the initiation phases of the project life cycle. Although some of these changes have arisen as a result of the State Services Commission's Gateway review of the FPSC in December 2012, the changes also reflect a growing maturity of what is a relatively young organisation. The recent establishment of a project management office by HBL will assist with ensuring

<sup>8</sup> We described HBL's work programme in our 2013 report on the health sector – see *Health sector: Results of the 2011/12 audits*, Part 4.

consistency throughout HBL in terms of programme management requirements, practices, and documentation.

### Reporting sector savings

- 2.23 In our 2013 report on the health sector,<sup>9</sup> we described HBL's savings methodology and recommended that HBL continue to improve the transparency of its measurement and reporting of savings.
- 2.24 HBL reported cumulative (gross) sector savings of \$213.5 million to 30 June 2013 and has forecast reaching \$764.9 million by 30 June 2016.
- 2.25 Overall, HBL has improved its reporting of savings, including disclosing the definitions used for the various categories of savings reported. HBL is also providing a better breakdown of the benefits achieved in these savings categories.
- 2.26 HBL has also revisited its savings methodology, in partnership with the DHBs. HBL will, in 2013/14, report benefits under the categories "budget-impacting" and "non-budget-impacting":
- **Budget-impacting** savings are those that have a clearly defined effect on the DHB "bottom line" (that is, in the Statement of Comprehensive income, including any depreciation effect).
  - **Non-budget impacting** benefits are those that do not meet the definition of "budgetary". They can include increases in costs that are avoided, benefits carried forward from previous years (budgetary or non-budgetary), and qualitative improvements (such as reduced complexity or reduced clinician time in administration).
- 2.27 Our 2012/13 audit of HBL also reviewed the assurance processes put in place by HBL to satisfy itself as to the validity of DHB-reported benefits. That review confirmed that the work performed by HBL to date was not yet sufficiently documented or detailed enough for us to rely on. It is important that HBL has confidence in the quality of the savings data in its annual report. We believe that some level of sample verification by HBL would be appropriate, both to satisfy the board that its information is valid and also to identify any common issues that could beneficially be communicated to all DHBs.
- 2.28 We also recommended that HBL improve its systems for reviewing the savings data that DHBs provide to it. It is important that DHBs ensure that they have appropriate documentation to support their reporting of savings to HBL, which will also support HBL's reporting of savings.
- 2.29 We will check whether the reporting of savings is adequate and reflects the new benefit definitions referred to above. We are also considering what future work

we might do to assess the effectiveness or benefit realisation of sector shared services or procurement initiatives, such as those led by HBL.

#### **National Finance, Procurement and Supply Chain**

- 2.30 During 2012/13, HBL has continued to make progress with national systems and services for the FPSC.
- 2.31 Last year, we reported that the first two DHBs were expected to move to the new system by December 2013 and the rest of the DHBs by December 2014. The FPSC is now expected to be gradually released to the DHBs over two to three years, starting in April 2014. We encourage HBL to communicate regularly to DHBs on progress and changes to the timetable for implementation.
- 2.32 There can be good reasons to delay implementing new systems to make sure that the systems and sector are ready for implementation. However, the extended timetable also heightens the need to manage associated risks in an extended period of uncertainty. These can include the loss of key staff, declining staff morale, potential system breakdowns or loss of controls, and a greater risk of fraud. We encourage the sector to keep these risks under review before and during the transition phase.
- 2.33 Hutt Valley DHB has been the first to move to the new system, followed by Capital and Coast and Wairarapa DHBs. Implementing the FPSC will also be divided into functional phases, such as rolling out the finance system first (this includes the general ledger, accounts payable, and accounts receivable, but does not include payroll), followed by the procurement and supply chain functions.

#### **healthAlliance N.Z. Limited**

- 2.34 healthAlliance has been selected as the future provider of the FPSC shared services to all 20 DHBs.
- 2.35 healthAlliance was established in 2000 as a joint venture to provide support functions (including procurement, supply chain, finance, information technology, and payroll processing) to Counties Manukau and Waitemata DHBs. In 2011, its scope and ownership was changed to be jointly owned by, and provide shared services to, all four northern DHBs and HBL.
- 2.36 As the FPSC service is rolled out, healthAlliance will assume responsibility for providing financial transaction processing, financial accounting, and reporting services to successive groups of DHBs. It will also assume responsibility for purchasing and receiving goods and for payments to suppliers. A subsidiary company, healthAlliance (FPSC) Limited, was established in September 2013 to carry out these functions.

- 2.37 healthAlliance (the parent company) will continue to provide support services to the four northern DHBs until they receive the national FPSC service. Operating in regional and national environments will add complexity and challenges for the healthAlliance Group (the parent and its new subsidiary) because it will be operating in two different environments for an extended period of time.
- 2.38 This is expected to put a strain on resources. A disruption to service continuity could therefore become a risk for DHBs in the Northern Region. It is important that the DHBs keep this risk under review.
- 2.39 The expanded role is significant for healthAlliance, and its risk profile has changed and continues to change.
- 2.40 Capability and capacity are significant risks for the healthAlliance Group, as is the increased risk of control breakdowns, fraud, and loss of productivity. In our audit, we highlighted the need for healthAlliance to ensure that it has the processes, systems, controls, and resources required for its changing and expanding role.
- 2.41 Effective project management and risk management through the transition is critical. It is also important that healthAlliance works closely with HBL and DHBs to make sure that roles and responsibilities are clear, in particular to avoid overlaps and gaps.
- 2.42 Although DHBs will be relying on the controls within the shared service centre, the responsibility for effective internal control remains with each DHB's board. It will be important for DHBs, and other entities that receive shared services, to understand and obtain assurance that controls at the shared services centre are appropriate and operating as intended.
- 2.43 Evolving shared services also present challenges and opportunities for how we audit DHBs and other agencies in a shared services environment. We will continue looking at how we can increase our audit efficiency and improve our effectiveness as these changes develop.

### **Procurement in the health sector**

- 2.44 More than three-quarters (\$10.9 billion in 2012/13) of Vote Health was used to fund services that each DHB provided directly to its population (for example, hospital services) or indirectly through other providers, including non-governmental organisations, PHOs, or another DHB.
- 2.45 Procurement in the health sector involves billions of dollars and is a major activity for many entities. This includes DHBs' purchasing of services from third-party health service providers (such as rest homes, Māori health providers, and PHOs),

worth more than \$5.7 billion, collective procurement in DHB regions by shared services agencies, and centralised procurement for all DHBs by Pharmac and HBL. In 2013/14, the Ministry will also directly purchase about \$2.8 billion worth of health and disability services.

- 2.46 We have an ongoing interest in whether procurement policies, practices, and systems are current, effective, and fit for purpose. We are also interested in the changing procurement environment of the DHB sector and the achievement of the intended benefits from new initiatives.
- 2.47 Procurement services provided through the FPSC will cover only some of the DHBs' procurement, such as hospital supplies. DHBs will still carry out significant procurement activity, including purchasing health services from third parties.
- 2.48 Our auditors continue to make recommendations to DHBs where improvements are needed to procurement policies or practices. It is important that DHBs ensure that they have up-to-date and good-practice procurement policies and practices to cover their own procurement activities, and which also address procurement in a shared services environment.

#### **Ministry contracting and procurement**

- 2.49 The Ministry contracts with a large number of organisations, including health providers within and outside the public sector, to provide health-related services, worth about \$2.8 billion annually.
- 2.50 In previous audits, we have recommended that the Ministry improve the consistent application of, and compliance with, its procurement policies. To help address this in 2011/12, the Ministry engaged an external reviewer to review national services purchasing and contract management.
- 2.51 In March 2013, the Ministry established a Procurement Optimisation Programme. The objectives of the Programme are to enhance procurement practices within the Ministry, provide a greater strategic view, and demonstrate value for money. We will follow the progress of this Programme with interest.

#### **Pharmaceutical Management Agency**

- 2.52 Pharmac is a Crown agency that decides, on behalf of DHBs, which medicines and related products are subsidised for use in the community and public hospitals. It was created in 1993 to actively manage government spending on medicines. Pharmac reported that, from 2000 to 2013, it saved DHBs more than \$5 billion.
- 2.53 In recent years, Pharmac has experienced significant change and growth as a result of its increased responsibilities and functions. It is now responsible for managing the national immunisation schedule, establishing the national

hospital medicines list, working with HBL, and managing all hospital medical device procurement on behalf of DHBs (by mid-2015). Our auditors reported that Pharmac maintained an effective control environment, and associated internal controls, while it took on these expanded responsibilities in 2012/13.

### Asset management by district health boards

- 2.54 At 30 June 2012, DHBs collectively held about \$5 billion of property, plant, and equipment. Many of these assets – \$4.3 billion worth – are considered significant (mostly land and buildings). At 30 June 2013, DHBs' property, plant, and equipment had increased to \$5.4 billion and their total assets were worth nearly \$7 billion (see Part 4).
- 2.55 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.
- 2.56 We have an ongoing interest in effective asset management by DHBs and have reported regularly on our work. In 2011, our high-level review of how DHBs manage their assets<sup>10</sup> found that most DHBs had not improved how they plan to manage their assets since 2009. In the past two years, we have followed up on our recommendations with individual DHBs as part of our annual audits.
- 2.57 In June 2013, we published *Managing public assets*, which reported our findings from gathering information about asset management practice from 340 public entities (those owning assets worth more than \$2 million). We gathered information about the regularity of reporting of asset condition information to decision-makers, the extent of deferred maintenance or deferred renewals, and whether the entities had asset management plans.
- 2.58 We found that 90% of DHBs:
- check the condition of their buildings regularly;
  - had documented information on their significant assets; and
  - documented maintenance and/or renewal profiles for their buildings.
- 2.59 We also found that 80% of DHBs carry out planned maintenance or renewal of their buildings.
- 2.60 However, many DHBs still do not have up-to-date asset management plans. In 2012/13, our auditors reported that more than half of the DHBs needed to update or improve their asset management plans and practices. Some DHBs had delayed updating their plans pending regional asset management plans and a national plan. If a DHB decides to delay updating its asset management plan, then in the meantime it needs to ensure that there is still high-quality and relevant

<sup>10</sup> Health sector: Results of the 2010/11 audits, Part 4.

information to support decision-making, future service delivery, and asset performance.

2.61 We expect decision-makers in DHBs to have good information about their assets and future asset needs. We plan to carry out more in-depth work on DHB asset management in our 2013/14 audits. This will include a focus on building and clinical equipment asset classes. Both types of assets are critical to the delivery of public health services.

2.62 The work will allow us to improve our inventory of asset management information, including information about practices for valuation and depreciation, the extent and reliability of physical asset knowledge, asset condition, and asset performance. We intend to report to Parliament on this work.

#### **Canterbury District Health Board's hospitals redevelopment**

2.63 The redevelopment of Christchurch and Burwood hospitals is expected to cost more than \$650 million and is the largest ever health-related building project in New Zealand. Burwood Hospital is being rebuilt first, including the construction of a new 230-bed facility, and is expected to be finished in stages from mid- to late-2015. There is an expected overlap when construction at Christchurch hospital starts in 2015.

2.64 A Hospitals Redevelopment Partnership Group was established in September 2012 to prepare the final business case for the redevelopment of Christchurch hospitals, which was approved by the Government in March 2013.

2.65 The Partnership Group, with representatives from Canterbury DHB, government departments, including the Ministry, and others in the health sector, is overseeing the project.

2.66 We will continue to maintain our interest in effective governance arrangements for this large and complex project.

#### **Our assessments of public entities' management environment, systems, and controls**

2.67 As part of annual audits, our auditors comment on the 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 4).

**Figure 4**  
**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.

- 2.68 We include the results of our assessments in our audit reporting to management and governing boards. We also report the results to the Minister of Health, the Ministry (as the monitoring department), the three central agencies,<sup>11</sup> and Parliament's Health Committee.
- 2.69 Grades for a particular entity can 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 a grade might not indicate deterioration – it could be that the entity has not kept pace with good practice for similar entities between one year and the next. How an entity responds to an auditor's recommendations for improvement is important, and the long-term trend in grade movement is a useful indication of general progress.
- 2.70 Appendix 2 sets out the 2012/13 and prior year grades for each DHB and the other health sector entities that we grade.

### Grades for district health boards

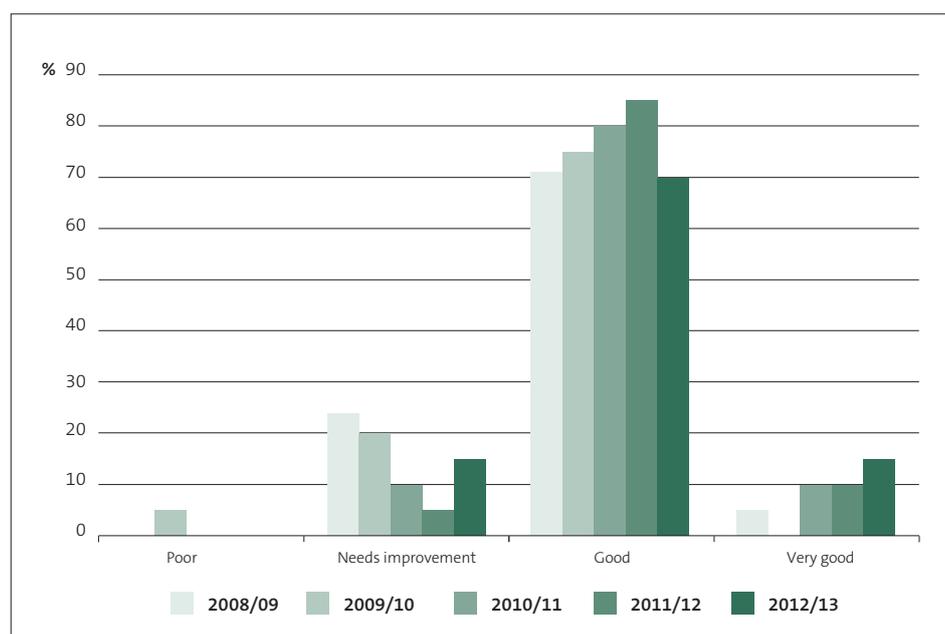
- 2.71 In this section, we discuss the 2012/13 grades and five-year trends in grades for DHBs' management control environment and financial information systems and controls. Part 3 discusses grades and trends in grades for DHBs' service performance information and associated systems and controls.

#### Management control environment

- 2.72 Figure 5 sets out our grades for DHBs' management control environments for the past five years.

<sup>11</sup> The three central agencies are the State Services Commission, the Treasury, and the Department of the Prime Minister and Cabinet.

**Figure 5**  
**Grades for district health boards' management control environment, 2008/09 to 2012/13**



- 2.73 The grades for DHBs' management control environments show a steady overall improvement in the years to 2011/12, followed by a slight drop in 2012/13. Although one more DHB was graded as "very good" in 2012/13 than in 2011/12, two more DHBs were graded as "needs improvement" in 2012/13 than in 2011/12.
- 2.74 The grade for Bay of Plenty DHB's management control environment improved from "good" in 2011/12 to "very good" in 2012/13. Two other DHBs (Canterbury and South Canterbury) were also graded "very good" in 2012/13, which is consistent with their 2011/12 grades.
- 2.75 In 2011/12, one DHB (Capital and Coast) was graded as "needs improvement" and in 2012/13 three DHBs were graded "needs improvement" (Capital and Coast, Lakes, and Southern).
- 2.76 We changed the grade for Lakes DHB's management control environment from "good" to "needs improvement" because of deficiencies in the control environment, identified after an investigation by the internal auditor.
- 2.77 The investigation identified that a senior manager and a subordinate colluded with IT suppliers to obtain false invoices. The false invoices were to support

accruals for work that had not been done. The manipulation of the accruals was intended to preserve a department's unspent budget in 2012/13. The actions were not in keeping with accounting standards or the expected behaviour of staff members or suppliers. There was no identified personal gain to staff or suppliers and no loss incurred by the DHB. The amount involved was about \$316,000, which was corrected prior to the finalisation of the DHB's financial statements.

2.78 The DHB dealt with the staff members involved in keeping with their employment contracts and the DHB's policies.

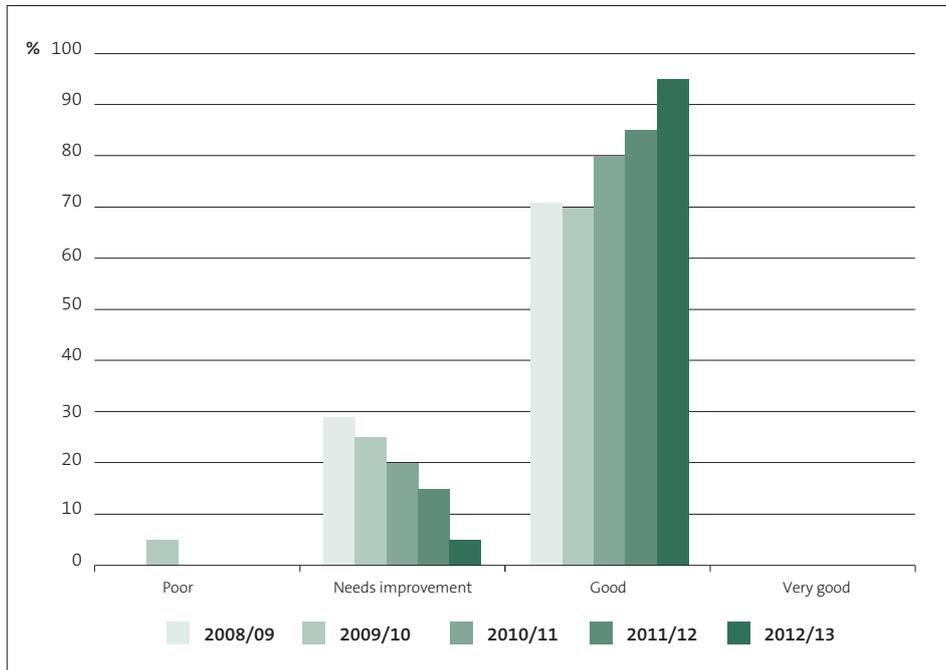
2.79 We changed the grade for Southern DHB's management control environment from "good" to "needs improvement" in 2012/13 because of deficiencies in the control environment:

- The DHB has used one-off accounting adjustments to secure the deficit position that it agreed with the Ministry, rather than a focus on sustainable solutions to the budgetary position. In 2012/13, an adjustment was used that was not consistent with accounting standards (relating to asset depreciation), which had the effect of reducing the DHB's reported deficit by \$3.4 million (from \$15.3 million to \$11.9 million).
- There was an ongoing and historical dispute between the DHB and South Link Health (SLH), which had not been resolved at the time of our audit. The dispute was about the use of money thought to be held by SLH (possibly about \$5 million). The matter was brought to the attention of our auditors, including an allegation that there could be fraud involved. We recommended that, if the DHB considered that there is evidence of fraud, then it should refer the matter to the Police. If not, it should reach an agreement with SLH on future actions. The DHB has since engaged forensic accountants to investigate.

### Financial information systems and controls

2.80 Figure 6 sets out our grades for DHBs' financial information systems and controls for the past five years.

**Figure 6**  
**Grades for district health boards’ financial information systems and controls, 2008/09 to 2012/13**



- 2.81 The grades for DHBs’ financial information systems and controls show a steady improvement over the past five years, with only one DHB graded as “needs improvement” in 2012/13.
- 2.82 We changed the grade for West Coast DHB’s financial information systems and controls from “good” in 2011/12 to “needs improvement” in 2012/13. Internal controls and processes in the main financial systems had not been consistently applied during the year because of several staff changes within the financial team and because resources were stretched.
- 2.83 We increased the grade for three DHBs (Hutt Valley, MidCentral, and Southern) from “needs improvement” in 2011/12 to “good” in 2012/13. These DHBs continued to strengthen their financial information systems and controls.
- 2.84 DHBs’ financial information systems and controls will undergo significant change as they move to the FPSC. Clarity about roles and responsibilities is important. DHBs and service providers need to be clear about what each agency is responsible for in a shared services environment.
- 2.85 Maintaining the capability of financial and other staff during the transition period is also a potential challenge for DHBs. They will need to manage risks, such as the potential loss of staff and reduced staff morale.

### Grades for the shared services agencies

- 2.86 In our 2013 report on the health sector,<sup>12</sup> we included audit results and observations for HBL and the DHBs' regional shared services agencies because of their increasing role in providing services to DHBs.
- 2.87 Appendix 2 sets out the grades for HBL and Central Region's Technical Advisory Services Limited. For healthAlliance and HealthShare Limited, our auditors provided feedback to management and the boards about the control environment, systems, and controls, and about what improvements were needed. We will grade these entities as part of our 2013/14 audits.
- 2.88 We discussed our main audit observations and risks for the DHB sector earlier in this Part. They included the need to maintain effective control environment and systems, and that there is appropriate capacity and capability and effective governance for the increasing scope and functions of these agencies in providing services to DHBs.

### Grades for the Ministry and other Crown entities

- 2.89 The grades for the Ministry and the health sector Crown entities were all "good" or "very good" in 2012/13. This means that, overall, these entities maintained robust systems and controls during 2012/13, and that our auditors did not identify any significant concerns. For entities assessed as "good", we recommended improvements.
- 2.90 The grades for the Ministry, Health and Disability Commissioner, Health Research Council, and New Zealand Blood Service were all unchanged from 2011/12. Of particular note is the New Zealand Blood Service, which was graded "very good" for all three aspects for the second consecutive year.
- 2.91 The Health Quality and Safety Commission improved two of its grades, from "good" to "very good" for the management control environment and from "needs improvement" to "good" for service performance information and associated systems and controls. This is the second consecutive year that the Health Quality and Safety Commission has improved two of its grades. This reflects continued steady progress in developing its control environment since the Health Quality and Safety Commission was established in November 2010.
- 2.92 The Health Promotion Agency was established on 1 July 2012 from the merger of the Alcohol Advisory Council and the Health Sponsorship Council. The Health Promotion Agency also took on some health promotion functions previously delivered by the Ministry.

<sup>12</sup> See *Health sector: Results of the 2011/12 audits*, Parts 2 and 4.

- 2.93 When entities merge to create a new organisation, there is an inherent risk of an ineffective control environment or a breakdown in internal controls. In our first audit of the Health Promotion Agency, we found that the Agency had managed its change programme effectively and that it had an effective control environment. We graded the management control environment as “very good”, and the financial information systems and controls, and the service performance information and associated systems and controls as “good”.

### **Audit results for regulatory authorities**

- 2.94 We audit the 16 regulatory authorities (see Appendix 1) whose members are appointed by the Minister of Health under the Health Practitioners Competence Assurance Act 2003. We also audit two secretariats that each support two or three of the authorities.
- 2.95 The regulatory 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).
- 2.96 In February 2011, Health Workforce New Zealand issued a consultation document proposing a single shared secretariat and office functions for the 16 authorities. In late 2012, it funded a detailed business case for establishing a shared secretariat organisation.
- 2.97 In our audit reports for the 16 regulatory authorities and the two secretariats in 2012/13, we drew attention to uncertainty about the delivery of office functions for the authorities because of a proposal to combine the secretariats and office functions of the regulatory authorities.
- 2.98 We have drawn attention to this uncertainty in our audit opinions for the past two years. We note the length of time that this uncertainty has remained. Extended periods of uncertainty can elevate risks for entities, such as the risk that staff will leave or that capability might decline, if decisions to upgrade or maintain systems or infrastructure are delayed.
- 2.99 We understand that the regulatory authorities are now considering other options for improving their co-operation.



## Part 3

# Service performance reporting

- 3.1 In this Part, we discuss DHBs' service performance reporting, including our audit opinions in 2012/13 and the sector-wide issue about the reporting of third-party performance information, which affected the audit opinions of all DHBs and the Ministry.

### About service performance reporting

- 3.2 Service performance reporting is an important part of Parliament's accountability system and helps demonstrate effectiveness, efficiency, and value for money in the public sector. It also enables organisations to manage performance more effectively, and supports good decision-making.
- 3.3 There are long-standing legislative requirements for DHBs and many other entities in the public sector to report on their service performance, and for the Auditor-General to audit that reported information.
- 3.4 Since 2006, we have stressed the importance of high-quality performance information to aid people's understanding of the public sector's effectiveness. We have reported extensively to public entities and Parliament on the need to improve service performance reporting, and the quality of reporting has improved significantly in recent years.<sup>13</sup>
- 3.5 We have also been improving our approach to auditing service performance information, which includes progressively implementing a revised auditing standard on auditing performance information. The standard requires auditors to report on whether an entity's reported performance complies with generally accepted accounting practice and fairly reflects actual performance for the year. To do this, auditors verify material aspects of the reported service performance and make sure that the reporting appropriately covers the entity's activities, and the effect of those activities.
- 3.6 We have been working with DHBs to help improve performance reporting since 2008/09. Our early focus was to help improve the quality of statements of intent, given that performance is reported against information in those statements. More recently, our focus has been on DHBs continuing to improve the appropriateness, clarity, and reliability of their reported information.
- 3.7 In the 2012/13 audits, we applied the revised auditing standard to DHBs' service performance reports for the first time. DHBs were among the last Crown entities to have this auditing standard applied to the audit of their service performance reports. There are a few remaining public entities, such as subsidiaries of DHBs, that are still to have this standard applied to their audits.

<sup>13</sup> Our publications about performance reporting are available at [oag.govt.nz/reports/performance-reporting](http://oag.govt.nz/reports/performance-reporting).

## The 2012/13 audits

- 3.8 Audit work is planned and performed to obtain evidence on a sample basis, because public entities carry out too many transactions for an auditor to look at them all. Auditors use their professional judgement to assess the evidence and ensure that they have reasonable assurance that there are not material misstatements in the financial statements and service performance information.
- 3.9 Auditors assess whether an entity has systems and controls that the auditor can rely on. This assessment includes testing these systems and controls to confirm their reliability. If there are not reliable systems and controls, then auditors must perform substantive testing of data to confirm its reliability.
- 3.10 The 2012/13 audits of DHBs' performance information included evaluating the national health targets.<sup>14</sup> These targets report performance from DHBs' hospital services and services that DHBs purchase from third parties, such as PHOs and other non-governmental organisations.
- 3.11 DHBs generally have reliable systems and controls over the performance information that they report for their hospital services, with two exceptions, which we discuss in paragraphs 3.25-3.29. However, DHBs generally have limited controls over much of the performance information that they report from third-party health providers.

## Third-party performance information

- 3.12 DHBs could not demonstrate how they know that they can rely on third-party performance information. DHBs did monitor how performance was tracking against targets, but could not provide us with evidence that they were checking that the information reported to them by third parties was reliable.
- 3.13 It appeared that DHBs and other entities, such as the Ministry, either assumed someone else was checking the data or they largely operated on trust.
- 3.14 There were no practical audit procedures we could use to determine the effect of this limited control. For example, the primary care measure that includes providing smokers with advice and support to quit relies on information from general practitioners that we are unable to independently test. It is not our role to audit the third-party health providers. Our role is to check that the reported performance information fairly reflects the actual performance of each DHB.
- 3.15 As a result, we were not able to obtain the evidence needed to express an unmodified opinion on all of a DHB's performance information. For the third-party performance information, the scope of the audit was limited.

<sup>14</sup> See "How is my DHB performing?" at [www.health.govt.nz](http://www.health.govt.nz).

3.16 All DHBs' audit opinions for 2012/13 were qualified because of this problem with third-party performance information.

3.17 Our qualified opinion does not mean that the health target performance reporting by DHBs was wrong, or that there was a failure of DHBs' service delivery, or any wrongdoing or false reporting by DHBs, or that the information reported from general practitioners was wrong. It simply means that we were unable to verify some important performance information.

**A sector-wide issue**

3.18 The qualification on third-party performance information is a sector-wide issue that has affected the audits of all DHBs and the Ministry.

3.19 The Ministry reports national health target information as its impact measures. This information is reported to the Ministry by DHBs. We qualified the Ministry's audit opinion because we were not able to gain sufficient assurance about the health targets at the time that we completed our audit of the Ministry, which has a statutory reporting date a month earlier than the date for DHBs.

3.20 A significant amount of health funding is spent on third-party services, about \$5.7 billion, and it is important that there is reliable performance information about these services to support decision-making and public accountability.

3.21 The audits have shed light on the limited control of DHBs over much of the performance information provided by third-party health providers. The limited control is an issue that we expect DHBs to address.

3.22 We recommended that the Ministry and DHBs work together, and with other relevant organisations, to identify a cost-effective approach for the sector to get sufficient assurance over the performance information from third parties. Because this is a sector-wide issue, we are encouraging the sector as a whole to consider whether the introduction of additional controls is appropriate and cost-effective and, if so, how best to introduce them.

3.23 We are aware that an Integrated Performance and Incentive Framework is being developed for primary care, and that there is already considerable audit activity in the health sector, both of which may provide opportunities to help address this issue.

3.24 By early 2014, limited progress had been made. Short-term approaches are being considered alongside longer-term ones. Our 2013/14 audits might also be affected by the limited control over third-party performance information. We will continue to work with the sector to help address this issue.

### Other qualifications

- 3.25 As well as the qualification on third-party performance information, we further qualified our audit opinions on Lakes and Wairarapa DHBs. These matters were also related to performance information reporting.
- 3.26 In our audit of Lakes DHB, we found inconsistencies (between paper and electronic records) in the recorded times for the discharge of patients in the DHB's reported performance for the "shorter stays in emergency departments" measure. We were unable to quantify the extent of any misstatement in the reported performance so we could not rely on the reported performance.
- 3.27 As a result, we qualified our opinion and recommended that Lakes DHB improve its system for recording discharge times for patients in the emergency department.
- 3.28 In our audit of Wairarapa DHB, we found that the reported performance was materially overstated for the hospital performance measure for "smokers seen in hospital are offered advice and support to quit". Our testing identified an error in the data extracted to calculate the reported results. We were unable to quantify the extent of the overstatement so we could not rely on the reported performance. We therefore qualified our audit opinion.
- 3.29 We recommended that the DHB implement a robust system to ensure that appropriate evidence is retained to support the results of reported performance and that there is a system to check and monitor the accuracy and completeness of results.

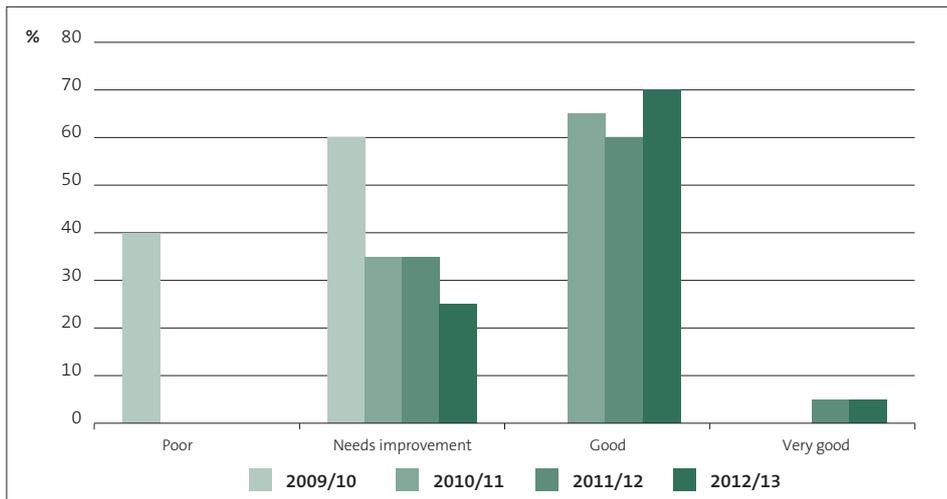
### Assessing service performance information and associated systems and controls

- 3.30 In Part 2, we discussed our assessments and grades of management control environments and financial information systems and controls. In this section, we discuss our grading of service performance information and associated systems and controls for DHBs. Appendix 2 sets out the grades for each DHB for 2012/13 and the prior year.
- 3.31 DHBs have made steady progress (see Figure 7) with improving their performance reporting in recent years, including:
- preparing appropriate performance frameworks to show what they do (services or outputs) and the difference they make (impacts and health outcomes);
  - reporting performance against performance measures and targets to show what was achieved and how well they performed; and

- reporting on the health status of their population to show progress in achieving improved health outcomes for their districts, including for population groups such as Māori, who have disparities in health outcomes (see Part 5).

- 3.32 Canterbury DHB provides a good example of a full and informative performance story in its 2012/13 annual report.
- 3.33 Our assessment and grading of service performance information in 2012/13 excluded the sector-wide issue with third-party performance information.
- 3.34 The grades reflect the auditor’s recommendations for improvement based on what is considered best practice for the entity and how far short an entity is from an appropriate standard of best practice. Because this was a sector-wide issue affecting all DHBs, there is no standard of best practice for DHBs to be assessed against yet.
- 3.35 Figure 7 shows the grades that our auditors gave DHBs for each of the past four years.

**Figure 7**  
**Grades for district health boards’ service performance information and associated systems and controls, 2009/10 to 2012/13**



- 3.36 Three DHBs (Auckland, Bay of Plenty, and Whanganui) improved their grades from “needs improvement” in 2011/12 to “good” in 2012/13.
- 3.37 Lakes DHB’s grade changed from “good” to “needs improvement” because it needs to improve its system for recording the discharge times for emergency department patients.

- 3.38 We will continue to exclude the sector-wide issue with third-party performance information from our assessment and grading of service performance information in our 2013/14 audits, to allow time for the sector to address this issue. We will review our approach for the 2014/15 audits.
- 3.39 We will continue to work with DHBs and the Ministry to help DHBs to continue to improve their performance reporting, including their reporting of third-party performance information.
- 3.40 We will also consider the effect of changes that may result from the amended Crown Entities Act (see Part 1) on performance information reporting.

## Part 4

# Financial performance of district health boards

- 4.1 In this Part, we describe:
- the 2012/13 financial results for each DHB;
  - monitoring of district health boards; and
  - our analysis of DHBs' financial statements from the past seven years to better understand their financial health.

### Financial results

- 4.2 We described DHBs' funding in Part 1 and set out the amount of funding that they are directly allocated under Vote Health. DHBs also receive income from other sources, including the Ministry, ACC, and insurance payments. Figure 8 sets out the total revenue for each DHB.
- 4.3 Collectively, DHBs had total revenue of \$14.0 billion (\$13.7 billion excluding Canterbury DHB's insurance income of \$295 million, explained below) and total expenditure of \$13.7 billion in 2012/13. Excluding the insurance income, this represents an increase of nearly 3% on 2011/12.<sup>15</sup>
- 4.4 The aggregate DHB deficit (excluding Canterbury DHB) for 2012/13 was \$19.3 million, compared to a planned deficit of \$18.5 million, and an aggregate deficit of \$22.4 million in 2011/12.<sup>16</sup> DHBs continue to work in a financially constrained environment, with nine DHBs reporting deficits and the remainder breaking even or reporting surpluses.
- 4.5 Figure 8 sets out financial results for each DHB, by region, for 2012/13. Amounts have been rounded, so surpluses or deficits (actual and planned) of less than \$50,000 will show as 0.0 (nil).

<sup>15</sup> *Health sector: Results of the 2011/12 audits*, page 43. Amounts are rounded.

<sup>16</sup> The figures for 2011/12 include Canterbury DHB. Its deficit in 2011/12 was effectively zero, so its inclusion does not affect this comparison.

**Figure 8**  
Summary of 2012/13 financial results for district health boards, by region

District health board	Revenue \$m	Expenditure \$m	Surplus (deficit)* \$m	Planned surplus (deficit)* \$m	Variance from plan \$m
All DHBs	14,006.4	13,739.6	(19.3)	(18.5)	(0.8)
<b>Northern Region</b>					
Auckland	1,820.1	1,820.1	0.2	0.1	0.1
Counties Manukau	1,405.7	1,402.6	3.0	3.0	0.0
Northland	523.2	523.1	0.1	0.0	0.1
Waitemata	1,423.4	1,416.6	6.8	2.0	4.8
<b>Totals</b>	<b>5,172.4</b>	<b>5,162.4</b>	<b>10.1</b>	<b>5.1</b>	<b>5.0</b>
<b>Midland Region</b>					
Bay of Plenty	656.7	656.7	0.1	0.0	0.1
Lakes	316.2	318.0	(1.8)	(0.8)	(1.0)
Tairāwhiti	158.9	160.9	(1.5)	0.0	(1.5)
Taranaki	326.7	326.9	0.0	2.7	(2.7)
Waikato	1,184.9	1,183.0	2.1	1.0	1.1
<b>Totals</b>	<b>2,643.4</b>	<b>2,645.5</b>	<b>(1.1)</b>	<b>2.9</b>	<b>(4.0)</b>
<b>Central Region</b>					
Capital and Coast	959.2	970.0	(10.8)	(10.0)	(0.8)
Hutt Valley	442.9	445.9	(3.0)	0.0	(3.0)
Wairarapa	133.2	136.6	(3.4)	(3.1)	(0.3)
Hawke's Bay	474.9	472.8	2.1	3.0	(0.9)
MidCentral	582.9	576.5	6.4	1.5	4.9
Whanganui	222.7	224.6	(1.9)	(2.9)	1.0
<b>Totals</b>	<b>2,815.8</b>	<b>2,826.4</b>	<b>(10.6)</b>	<b>(11.5)</b>	<b>0.9</b>
<b>South Island Region</b>					
Canterbury**	1,791.9	1,505.0	-	-	0.0
Nelson Marlborough	420.4	423.4	(2.9)	0.1	(3.0)
South Canterbury	178.0	177.2	0.7	(0.5)	1.2
Southern	849.7	861.3	(11.9)	(11.0)	(0.9)
West Coast	134.8	138.4	(3.6)	(3.6)	0.0
<b>Totals</b>	<b>3,374.8</b>	<b>3,105.3</b>	<b>(17.7)</b>	<b>(15.0)</b>	<b>(2.7)</b>

Rounding can lead to small differences in the totals and variances. Figures are from DHBs' 2012/13 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.

\*\* Revenue includes insurance receipts. Surplus/deficit is recorded as nil, as explained in paragraph 4.8.

## Canterbury DHB

- 4.6 Canterbury DHB's total income of \$1.8 billion for 2012/13 includes just under \$295 million that came from the final settlement of its earthquake damage claim.
- 4.7 Canterbury DHB's insurance policy for earthquake-damaged buildings had a cap of \$320 million. The estimated cost of the damage (more than \$500 million) is well in excess of the cap. The DHB received \$25 million of insurance income in 2011/12. The balance of \$295 million is recognised in the 2012/13 financial statements. The bulk of this money (\$287.5 million) was part of the final settlement agreed in September 2013, and was a post-balance date adjustment to the DHB's income.
- 4.8 This insurance income resulted in the DHB reporting a surplus of \$286.9 million for 2012/13. Ignoring the additional insurance income, the DHB effectively "broke even" (after receiving additional funding of \$35 million from the Ministry for additional earthquake costs and lower revenue because of estimated population reductions). We have therefore reported a nil result for Canterbury DHB in Figure 8.

## Regional financial performance

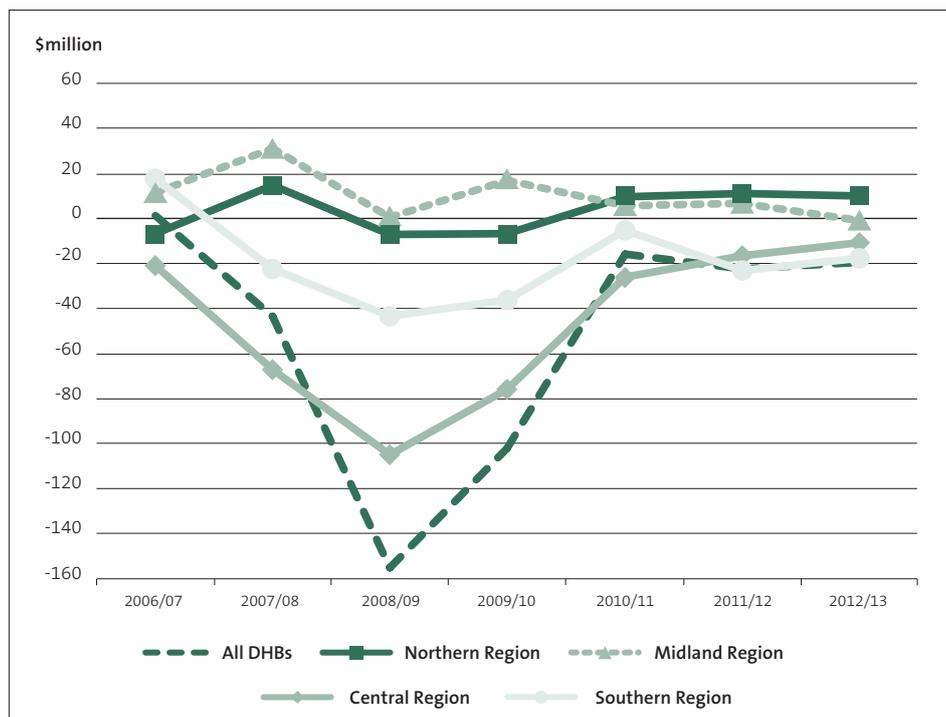
- 4.9 As Figure 8 shows, the Northern Region reported a cumulative surplus and the other three regions reported cumulative deficits. The surplus/deficit trends for the past seven years are shown in Figure 9.
- 4.10 All four Northern Region DHBs reported surpluses for 2012/13, resulting in a cumulative surplus for the region of \$10.1 million, just down from the cumulative surplus of \$10.9 million in 2011/12.
- 4.11 Two Midland Region DHBs (Lakes and Tairāwhiti) reported deficits in 2012/13. The Midland Region had a combined deficit of \$1.1 million in 2012/13, compared to a regional surplus of \$6.5 million in 2011/12.
- 4.12 The main difference was Waikato DHB's result in 2012/13, a surplus of \$2.1 million compared to a surplus of \$9.4 million in 2011/12.
- 4.13 Four of the six Central Region DHBs reported deficits resulting in a cumulative deficit of \$10.6 million compared to a cumulative deficit of \$16.7 million in 2011/12.
- 4.14 The main difference was in the result for Capital and Coast DHB, which reported a deficit of \$19.9 million in 2011/12 and a deficit of \$10.8 million in 2012/13. However, the DHB's total income of \$959.2 million includes a building revaluation gain of \$20.3 million. This was one of four revaluation gains recognised since 2004 that have cumulatively reversed a \$65.9 million revaluation loss recognised in 2002. Without this one-off gain, the DHB's deficit in 2012/13 would have been \$31 million.

- 4.15 The combined deficit for the South Island Region (excluding Canterbury DHB) was \$17.7 million, which is an improvement on the combined deficit of \$23.1 million in 2011/12 (Canterbury DHB's result was nil in 2011/12).
- 4.16 However, we note that Southern DHB's reported deficit was reduced by \$3.4 million because of the incorrect accounting treatment of a depreciation expense (see paragraph 2.79).
- 4.17 DHBs continue to work to improve their financial performance by seeking efficiency and productivity gains in clinical and support services. This includes a focus on regional collaboration and national shared service initiatives, such as those led by HBL and others, as discussed in Parts 1 and 2.

**Surplus/deficit trends**

- 4.18 Figure 9 shows the total deficit, for all DHBs, from 2006/07 to 2012/13, including a breakdown by the four regions.

**Figure 9**  
**Surplus/deficit for all district health boards, and the four regions, 2006/07 to 2012/13**



- 4.19 The total surplus/deficit trends show a general convergence towards zero and “break-even” for the sector. However, the Midland Region went into a regional deficit for the first time in 2012/13.
- 4.20 DHBs spent more than \$13.7 billion in 2012/13 (see Figure 8). They are dependent on continuing Crown funding, which is provided monthly. They are also subject to close monitoring of their financial performance and position by the Ministry.

### Monitoring of district health boards

- 4.21 The Ministry monitors the performance of DHBs and other Crown entities. It monitors and supports DHBs through its National Health Board business unit, which also monitors each DHB’s financial position.
- 4.22 The Ministry’s monitoring framework uses 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.
- 4.23 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 their 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.
- 4.24 As at 1 March 2014, 10 DHBs were on standard monitoring and 10 were being monitored more closely:
- Taranaki, Waikato, Hutt Valley, and Whanganui DHBs were on performance watch;
  - Capital and Coast, Wairarapa, Nelson Marlborough, Southern, and West Coast DHBs were on intensive monitoring; and
  - Canterbury DHB has been on a Single Event Monitoring regime since the Canterbury earthquakes.
- 4.25 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.
- 4.26 As at 1 March 2014, Southern DHB had a Crown monitor and no commissioners were appointed to DHBs.

## Using financial statements to understand financial health

- 4.27 Last year, we reported on our analysis of DHB financial statements to better understand financial risk and financial performance.<sup>17</sup> We have continued this analysis to better understand the financial health of DHBs and their ability to deliver on their objectives. We report elsewhere on our analysis of other central government entities (government departments, Crown research institutes, and other Crown entities).<sup>18</sup>
- 4.28 We examined the audited financial statements of DHBs over seven years, to assess three accounting relationships:
- **Ability to operate as planned.** We examined the relationship between planned expenditure and actual expenditure for operational and capital spending. We also examine the likelihood of DHBs spending more than they receive.
  - **Ability to manage uncertainty.** We examined the ability of DHBs to cover their current liabilities and adjust their operations in times of change.
  - **Ability to invest for the future.** We examined the general level of expenditure on capital assets and the level of total liabilities the DHB is responsible for.
- 4.29 Figure 10 summarises the accounting relationships we examined to better understand the financial health of DHBs.

**Figure 10**

### Accounting relationships examined to better understand the financial health of district health boards

Ability to operate as planned (stable services)	Ability to manage uncertainty (resilient services)	Ability to invest for the future (sustainable services)
Budgeted to actual operational spending	Current assets to current liabilities (working capital)	Spending on capital compared to depreciation
Budgeted to actual capital spending	Ongoing operating expenses* to total operating expenses	Total liabilities to total assets
Net operating cash flow (excluding depreciation and amortisation) to total cash flow received		Retained earnings to total assets

\* By ongoing (or fixed) operating expenses, we mean employee benefits, interest, depreciation, and amortisation.

<sup>17</sup> *Health sector: Results of the 2010/11 audits*, Part 5.

<sup>18</sup> See our 2014 report, *Central government: Results of the 2012/13 audits (Volume 2)*.

## Sector overview

- 4.30 Overall, our findings reflect the challenging operating environment and expectations for DHBs to deliver quality health services and improve health outcomes in financially constrained times. DHBs are working to improve their financial performance and to “live within their means”. The aggregated sector deficit for 2012/13 and trend during the past seven years shows a decreasing sector deficit since 2008/09.
- 4.31 Our findings show a sector with a strong focus on delivering short-term results, particularly in the planning and budgeting of operational activities. However, many of the longer-term ratios also suggest that the adequacy and alignment of financial resources may limit the ability of DHBs to respond to unexpected events or exploit future opportunities without recourse to the Crown.
- 4.32 Figure 11 summarises the financial health of DHBs, using data from the past seven financial years. Fewer than half of all DHBs have indicators at levels that would characterise good financial health and their results have been consistent for the last seven years. There is sizeable over-budgeting of capital spending, low levels of working capital, and moderate to high liabilities compared to assets. The high liabilities include debt associated with previous operating deficits and spending on capital items.

**Figure 11**

**Summary of the financial health of district health boards, using data from the past seven financial years**

Ability	Financial statement items we compared	Variance	Comment
to operate as planned	Budgeted and actual operational spending	Less than 5%	The small variance suggests that the sector is generally good at spending what it plans to spend on its operational activities.
	Budgeted and actual spending on capital	20% to 50% less than budgeted	The large variance suggests that the sector is not generally good at spending what was planned.
	Operational income and spending	2% higher or lower	This ratio suggests that the sector is generally good at spending what it receives in funding but has little left over as reserves.

Ability	Financial statement items we compared	Variance	Comment
to manage uncertainty	Current assets and current liabilities	50% to 70%	This ratio suggests that the sector could experience difficulty in paying its current liability obligations in times of change and/or uncertainty.
	Ongoing operating expenses and total operating expenses	30% to 50%	This ratio suggests that the sector has the ability to adjust its spending patterns in times of change. However, we note that a sizeable proportion of DHB spending is contracted through other health service providers.
to invest for the future	Capital spending and depreciation	100% to 150%	This ratio suggests that the level of capital expenditure across the sector is likely to be enough to replace existing assets (although the figure also includes spending on new assets).
	Total liabilities and total assets	50% to 100%	This ratio suggests that the sector's liabilities could restrict management's focus on, and capability for, investing in longer-term assets.
	Retained earnings and total assets	-5% to -20%	This ratio reflects historical operating deficits and suggests that the sector has limited reserves.

## The ability to operate as planned

### How likely are DHBs to over- or under-forecast their operational spending needs?

- 4.33 Overall, the financial statements show that DHBs' operational spending is generally in line with their operational budgets. This result is consistent with the tight financial environment that DHBs operate in and their aim to manage within their means and break even.
- 4.34 For cash flows, the difference between budget and actual operational spending has been consistently small among DHBs. As a group, DHBs have consistently kept within 5% of their budgeted operational spending in recent years as they focus on managing within their operating budgets.

### **How likely are DHBs to over- or under-forecast their capital spending needs?**

- 4.35 Our analysis of financial statements shows that the difference between budget and actual capital spending has been consistently large among DHBs. The variances relate to over-budgeting (or under-spending) on capital assets.
- 4.36 Capital asset management is about effectively managing assets during their economic lives. Good asset management planning underpins accurate capital budgeting and spending. We discussed DHBs' asset management in Part 2, including the need for many DHBs to update or improve their asset management plans and practices. Some DHBs have delayed updating their plans, pending the development of regional plans. Given this context, it is difficult to know whether budgeted capital spending by DHBs as a group is in keeping with DHBs' current asset management plans.

### **How likely are DHBs to spend more than they receive on their operations?**

- 4.37 In most instances, the difference between what is received and what is spent on DHBs' operational costs has ranged from between a 2% surplus and a -2% deficit (excluding depreciation and amortisation funding received). This shows that the funding that DHBs receive for their operational expenses is reasonably consistent with the level of their operational costs.
- 4.38 DHBs continue to work hard to manage within their means, reduce deficits, and, where possible, "break even". The financial results for 2012/13 (see Figure 8) show that, as a group, DHBs had total expenditure of more than \$13.7 billion and a collective deficit variance of \$0.8 million, which is very small given the level of expenditure.

## **The ability to manage uncertainty**

### **Could DHBs find it difficult to cover their current liabilities, with current assets, if needed?**

- 4.39 DHBs receive funding based on their population profile (see Part 1) to provide health services to their population. This amounted to about \$11 billion for all DHBs in 2012/13. Collectively, they also received about \$1 billion from the Ministry for nationally funded health services.
- 4.40 DHBs regularly deal with low levels of uncertainty, responding to peaks in demand for health services (such as high rates of influenza or increased demand for emergency department services) and working with inter-district funding flows. Inter-district funding flows provide a means for a DHB to pay another DHB for providing health services to people from its population (for example, for specialist health services or for patients needing care when out of their own district).

- 4.41 DHBs can generally manage minor fluctuations in inter-district funding flows or service demands but more significant fluctuations can affect their ability to meet their short-term financial responsibilities. DHBs would expect to manage major events, such as a pandemic or a natural disaster, with the support of the Government (for example, Canterbury DHB received additional support of \$35 million in 2012/13 after the Canterbury earthquakes).
- 4.42 DHBs' levels of current assets might not be sufficient to cover current liabilities, if required. A result of 100% means that the value of current assets equals the value of current liabilities. For DHBs, the results were in the range of 50% to 70%. There is a moderate risk that DHBs' levels of current liabilities could be onerous in times of uncertainty.
- Could DHBs find it difficult to adjust operations in times of change?**
- 4.43 Funding for DHBs is adjusted each year to reflect demographic changes, increased demand for services, inflationary pressures, and new government initiatives (see Part 1). However, the rate of annual increases has reduced in recent years as the Government works to "bend the curve" of health spending and focus on financial sustainability. DHBs are expected to manage their budgets within constrained funding increases and lift productivity and health outcomes for New Zealanders.
- 4.44 Where DHBs have a high proportion of ongoing (or fixed) expenses (employee benefits, interest, depreciation, and amortisation), the ability to adjust and adapt in times of change could be limited. We note that a sizeable portion of DHBs' spending is contracted to third-party health providers.
- 4.45 Overall, the financial statements indicate that DHBs' levels of current liabilities and ongoing costs are not onerous, given the surety of their revenue, and would not adversely affect their ability to manage uncertainty in times of change.

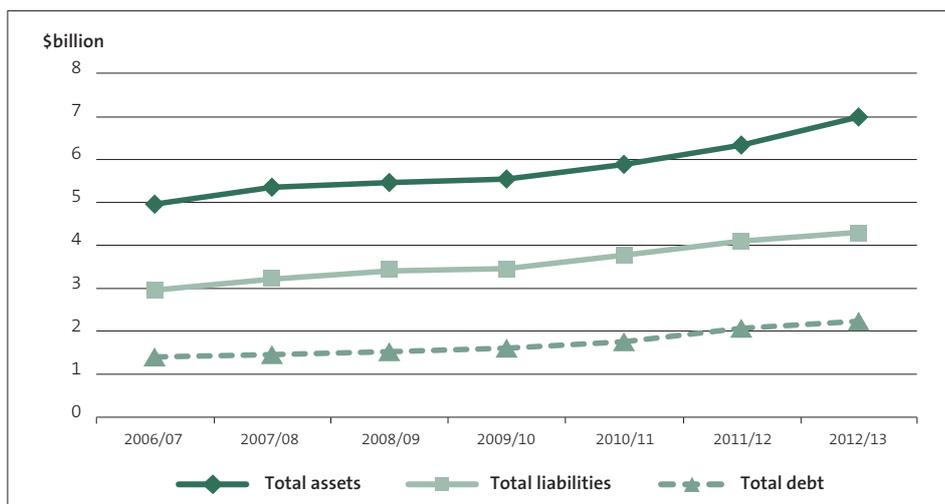
## The ability to invest for the future

### How likely are DHBs to be underinvesting in their assets?

- 4.46 Figure 12 shows steady increases in total assets, total liabilities (including total debt), and total debt over the past seven years. The increase from 2011/12 to 2012/13 was most notable for total assets, an increase of more than 10%, followed by an increase of nearly 8% in total debt and just under 5% in total liabilities.

**Figure 12**

**District health boards' total assets, total liabilities, and total debt, 2006/07 to 2012/13**



- 4.47 There has been some significant capital investment in recent years, with a number of hospital redevelopments (including at Waikato DHB and Capital and Coast DHB). The pending redevelopment of Canterbury DHB hospitals is expected to cost more than \$650 million and will be the largest ever health-related building project in New Zealand.
- 4.48 Maintaining the operational capacity of DHB assets is fundamental to the long-term sustainability of health services. Comparing an entity's capital expenditure to its asset consumption (as measured by depreciation) is one way of understanding the level of investment in an entity's capital assets. A result of 100% would mean that levels of capital expenditure were equal to depreciation – in other words, new and replacement assets were equal to assets used up.
- 4.49 We would expect a result of more than 100% because capital expenditure includes not only replacing existing assets but also spending on new assets

and the health sector has high capital needs. Our comparison for DHBs results in an average of 100% to 150%. This could indicate a low to moderate risk of underinvestment in DHBs' capital assets. It is worth noting that the ratio does not distinguish between spending on existing or new assets.

#### **Are total liabilities becoming onerous?**

- 4.50 Overall, DHBs have a high level of total assets compared to their total liabilities. Too many liabilities can reduce future funding options and distract management from a focus on the long-term assets of the DHB.
- 4.51 Our analysis showed a moderate risk of DHBs being restricted by too many liabilities. The result for all DHBs ranged from 50% to 70% (when 100% would mean that total liabilities were equal in value to total assets). This indicates that levels of total liabilities would not adversely affect the overall ability of DHBs to invest for the future. However, this might not be so for an individual DHB, if it had high levels of debt or persistent deficits.

#### **Could DHBs find it difficult to manage within their means in the long term?**

- 4.52 Figure 9 shows that DHBs have reported significant collective deficits since 2006/07, but there has been some improvement in more recent years.
- 4.53 Retained earnings reflect historical accumulated surpluses or deficits. Low or no retained earnings indicates that DHBs are operating in a tight financial environment. This can result in, and it has for some DHBs, contributions from the Crown to offset these losses. In our analysis, a result of 100% would mean that retained earnings were equal in value to total assets. The average result for DHBs during the past seven years ranged from -5% to -20%.

#### **Conclusion**

- 4.54 Overall, our analysis of DHBs' financial statements shows that, collectively, DHBs are generally managing within their means. This includes managing in a more constrained financial environment in recent years, with lower rates of annual increases in funding. Although nine DHBs reported deficits in 2012/13, the remainder were breaking even or reporting surpluses.
- 4.55 Financial and service sustainability, including investing in health infrastructure and assets to planned levels to meet future needs, is an ongoing challenge for DHBs.

## Part 5

# Reporting on reducing Māori health disparities

- 5.1 In this Part, we provide an update on our 2010/11 review<sup>19</sup> of the quality of DHBs' reporting on how they are reducing Māori health disparities.
- 5.2 In our 2010/11 review, we found that a lack of information made it hard to gauge DHBs' progress in reducing disparities for Māori. Information was lacking about the size of the disparity for most DHBs' Māori populations, the initiatives that DHBs were taking to address disparities, and the measures and targets used to assess progress in reducing disparities.
- 5.3 We reviewed the 2012/13 annual reports of DHBs to re-assess this reporting. There has been a significant improvement in the 2012/13 reporting. We saw a notable increase in the number of Māori-specific performance indicators, and better linking of Māori health plans to performance reporting in the annual reports.
- 5.4 However, several DHBs still need to provide better information about the extent of disparities for their Māori population, the initiatives and programmes to reduce disparities, and the progress that has been made in reducing those disparities. This is important information for New Zealanders and should be clearly set out for readers of the DHBs' annual reports.

### Requirement to reduce Māori health disparities

- 5.5 Under section 22(1)(e) and (f) of the New Zealand Public Health and Disability Act 2000, DHBs have a statutory objective to reduce (with a view to eliminating) health outcome disparities "by improving health outcomes for Māori and other population groups". DHBs are expected to prepare, and put into effect, services and programmes to do so.
- 5.6 The Ministry also requires each DHB to produce an annual Māori health plan, describing the DHB's efforts to improve Māori health in its district and reduce inequalities.<sup>20</sup>
- 5.7 The Ministry has a template for the Māori health plans that it regularly reviews. For 2012/13, the template required DHBs to report against a set of 15 indicators in nine health areas. Seven of these areas (access to care, maternal health, cardiovascular disease, diabetes, cancer, smoking, and immunisation) relate to health services, with some overlap with the National Health Targets, while two (workforce and data quality) relate to organisational capability. DHBs assess and report their performance against these plans directly to the Ministry.

<sup>19</sup> See *Health sector: Results of the 2010/11 audits*, Part 5.

<sup>20</sup> The Ministry's requirement for Māori health plans is set out in the Operational Policy Framework. Clause 21.5 of SOC Min (10) 15/2 states that DHBs' annual plans are to include Māori health plans.

- 5.8 We do not audit the Māori health plans. However, we do have a strong interest in the accountability of public entities. DHBs' annual reports play an important role in enabling public accountability for how effective DHBs are in reducing disparities.
- 5.9 Where the disparity in health status for Māori is significant, we expect to see measures and targets for Māori, with trend information showing progress, in the annual report of the DHB.

### Our review

- 5.10 To assess the progress in the quality of DHB reporting since our review two years ago, we decided to review each DHB's 2012/13 annual report. We assessed how the DHB reported on:
- the extent of the district's Māori health disparities, including Māori population and health status information;
  - initiatives that the DHB was taking to reduce disparities and to respond if it failed to achieve its targets for Māori; and
  - the effect of those initiatives on Māori health (that is, progress against the measures and targets, including trend data).

### Extent of Māori health disparities

- 5.11 We expect DHBs to identify in their annual report any particular health disparities for their Māori population, to give an idea of the extent of the disparities (in terms of severity and areas of disparity), and to use this as a basis for planning services to meet the needs of Māori.
- 5.12 If Māori health disparities are a priority for a DHB, this should be clear in the annual report. Linking the DHB's Māori health plan (which contains detailed information on the population profile of the district, including the size and age distribution of the Māori population and the leading health issues affecting Māori) to the performance reporting in the annual report is an important way for the DHB to be publicly accountable about how it is reducing disparities for Māori.

### What we found

- 5.13 There has been an improvement from 2010/11 in how well DHBs identify the extent of Māori health disparities, but there is room for further improvement.
- 5.14 In 2010/11, DHBs typically made a general statement (without describing particular health disparities or providing data) that Māori health was a priority.

The relative importance of the issue for the district was not made clear, and typically the Māori health plan was not linked to the annual report.

- 5.15 In 2012/13:
- seven DHBs (Auckland, Counties Manukau, Hawke’s Bay, Northland, Waikato, Wairarapa, and Waitemata) reported the extent of the overall disparity in Māori health by reporting trends in the life expectancy rates for Māori people in their district compared to other population groups; and
  - a further six DHBs (Hutt Valley, Taranaki, Canterbury, South Canterbury, Southern, and West Coast) reported the results of specific disparities between Māori and non-Māori performance and how disparities are changing over time.
- 5.16 However, the amount of trend information for disparity areas varied widely between the DHBs, and more commentary is needed for graphs to explain the severity of, or change in, the disparities for Māori.
- 5.17 The DHBs’ Māori health plans contain detailed information on the population profile of their district, including the size and age distribution of the Māori population and the leading health issues affecting Māori.
- 5.18 However, this information was generally not included in the annual report, with 11 DHBs not stating the percentage of their district’s population represented by Māori. We consider that this information is essential in providing context to the reader as to the importance of the issue of Māori health disparities in the district.
- 5.19 Taranaki DHB provided a good example of alignment with its Māori health plan. It prepared a table that reports the results for Māori and non-Māori for each of the measures in its Māori health plan, with a column that states the disparity percentage as well as reporting on the DHB’s progress towards the outcomes in the plan.

### Initiatives to improve Māori health

- 5.20 We expect DHBs to report what they have done specifically to address the disparities that they have identified.

#### What we found

- 5.21 In the 2010/11 annual reports, descriptions of the initiatives to address disparities were general rather than specific. They were more focused on improving the participation of Māori in the health workforce than health services initiatives.

5.22 In 2012/13, 14 DHBs included some discussion in their annual report on initiatives to reduce disparities in Māori health, with the number of initiatives discussed varying widely.

5.23 DHBs still tended to be somewhat vague about the initiatives they implemented. Counties Manukau DHB is one exception. Its annual report provided good descriptions for a number of specific health service initiatives for Māori.

### Reporting progress in reducing disparities

5.24 We expect DHBs to use measures and targets by which their performance in reducing those disparities can be measured, and to report against these in its annual report.

#### What we found

5.25 In the 2010/11 annual reports, half of the DHBs had five or fewer indicators about Māori in their statement of service performance.

5.26 By contrast, in the 2012/13 annual reports, three-quarters of the DHBs included 10 or more measures for measuring achievements for Māori in the statements of service performance.

5.27 For the seven areas in the Māori health plan related to health services (access to care, maternal health, cardiovascular disease, diabetes, cancer, smoking, and immunisation):

- four DHBs reported results for all seven areas in their annual report; and
- seven DHBs (including the four South Island DHBs, with relatively small Māori populations) reported results for fewer than five of the areas.

5.28 Eight DHBs (Capital and Coast, Hawkes Bay, Hutt Valley, MidCentral, Tairāwhiti, Wairarapa, Whanganui, and South Canterbury) reported that there is no longer a disparity for Māori in the immunisation national target, because Māori immunisation levels are now on a par with those of non-Māori.

5.29 Most DHBs had indicators of Māori achievement as well as the seven considered a focus for Māori health nationally. All DHBs apart from one had oral health indicators and 17 DHBs had mental health indicators.

5.30 Where there is a single target for the whole population, with the intended goal of equality in the long term, progress should, in our view, still be reported against milestones toward eliminating any existing disparities. Twelve DHBs reported trend information to show their results for the Māori health indicators, often

separately reporting the Māori and non-Māori results on the same graph so the reader could see the size of the disparity and any changes in it over several years.

- 5.31 In our view, there is still room for improvement in reporting on the effectiveness of initiatives in reducing Māori health disparities. This is particularly so in setting targets and reporting trend information as the DHB moves toward achieving those targets.
- 5.32 More commentary with trend graphs would help readers better understand the results, and what the DHB intends to do to reduce any remaining disparities.

### **District health boards' partnership arrangements**

- 5.33 Sixteen DHBs clearly reported in 2012/13 on the processes in place to allow Māori to take part in, and contribute to, strategies for improving Māori health. This is a slight improvement on 2010/11, when 14 DHBs reported this.
- 5.34 However, the amount of detail in the information varied widely. Some included only the statutorily required information. Other DHBs reported on their relationship with iwi partners and set out whether they had representatives on the board to contribute to the governance and development of the strategic direction for Māori.

### **Other population groups**

- 5.35 As well as improving the health outcomes of Māori, the New Zealand Public Health and Disability Act also requires reporting on other population groups.
- 5.36 Eleven DHBs reported results of performance indicators for their districts' Pacific population. For the remaining DHBs, we confirmed that the size of their Pacific population was not large, at less than 4% of the district's total population.
- 5.37 Results from the DHBs' service reporting indicated that the Pacific population experience the same level of health disparities as Māori. However, very little was reported on the specific initiatives in place targeted at reducing inequalities for the Pacific population.
- 5.38 It is important that DHBs report on the extent of disparities in the health status of Māori and other population groups in their annual reports so that it is clear to Parliament and the public what disparities exist and what is being done to address them. This includes describing initiatives, with measures and targets to reduce disparities, and reporting on the effect of those initiatives, so that progress in reducing disparities can be assessed.



## Part 6

# Health and well-being of older people

6.1 In this Part, we:

- discuss why our work programme has focused on older people;
- list our reports, since 2007, that have focused on older people;
- discuss what our work has told us about older people's health and well-being; and
- indicate areas of potential future interest.

### Why our work programme has focused on older people

6.2 The structure of New Zealand's population is changing, but the main change is that it is ageing. In 2006, there were two children for every older person. In 2023 – only nine years from now – we could have more people aged 65 or older (older people) than we have children under 15. The 2013 census found that females outnumbered males in all age groups from 25 to 29 years onwards, and 64% of people aged at least 85 years were female. There were 607,032 older people (14% of the total population) and 73,000 of this group were aged at least 85 years.

6.3 One way or another, many public resources will be committed to responding to our ageing population. We expect that governments will spend more on superannuation, healthcare, and social support care (such as home-based support services and aged residential care). Spending on other services might decrease.<sup>21</sup>

6.4 Maintaining and improving older people's health and welfare is important for everybody. Individuals' health and well-being in older age is affected by current behaviours and practices, but is also affected by their health at younger ages. For example:

- Prenatal nutritional deficits and impaired growth during pregnancy and infancy represent a significant risk factor for type-two diabetes, heart disease, stroke, osteoporosis, and high blood pressure in later life.
- Non-communicable diseases are of long duration and potentially slow progression. The four most common of these diseases (cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes) all share the same risk factors, which are tobacco use, physical inactivity, harmful use of alcohol, and unhealthy diets.<sup>22</sup>

21 The Treasury has considered the effect of New Zealand's ageing population on the country's financial sustainability in its 2013 report *Affording Our Future: Statement on New Zealand's Long-term Fiscal Position*. Our report on the Treasury's Statement is available at our website: [www.oag.govt.nz](http://www.oag.govt.nz).

22 Health Committee (2013), *Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age: Volume 1*, pages 45-46, New Zealand House of Representatives, [www.parliament.nz](http://www.parliament.nz).

- 6.5 Improving the health and well-being of children and younger adults will produce benefits for those individuals in older age. Society also benefits because healthier older people can participate more fully in the business and affairs of the wider community.

## Our reports

- 6.6 Since 2007, we have published a range of reports that fully or partly focused on the health and well-being of older people. We decided to bring together the findings from our work to get an overview of how public entities have been meeting the needs of older people. Figure 13 lists our reports by year along with the relevant follow-up reports.

**Figure 13**  
Reports of performance audits and follow-up reports, by year of publication

Year	Title
2007	<i>Ministry of Health and district health boards: Effectiveness of the “Get Checked” diabetes programme</i>
2010	<i>Effectiveness of the Get Checked diabetes programme, which aimed to help DHBs make further improvements in implementing the programme</i>
2008	<i>The Accident Compensation Corporation’s leadership in the implementation of the national falls prevention strategy</i>
2010	<i>Performance audits from 2008: Follow-up report, which included an article on ACC’s progress in responding to the Auditor-General’s recommendations</i>
2009	<i>Effectiveness of arrangements to check the standard of services provided by rest homes</i>
2012	<i>Effectiveness of arrangements to check the standard of rest home services: Follow-up report</i>
2010	<i>District health boards: Availability and accessibility of after-hours services</i>
2014	<i>Forthcoming – an article following up on progress in responding to the Auditor-General’s recommendations</i>
2011	<i>Progress in delivering publicly funded scheduled services to patients</i>
2013	<i>Delivering scheduled services to patients: Progress in responding to the Auditor-General’s recommendations</i>
2011	<i>Home-based support services for older people</i>
2014	<i>Forthcoming – an article following up on progress in responding to the Auditor-General’s recommendations</i>
2013	<i>Using the United Nations’ Madrid indicators to better understand our ageing population*</i>

\* Many of the Madrid indicators are health related, but there are also indicators for other sectors, such as social development, justice, and transport.

## What we have learned about older people's health and well-being

- 6.7 Our work using the United Nations' Madrid indicators shows that, as a group, older people generally experience good health and well-being, and mortality rates from common non-communicable diseases are improving. However, not all older people experience improvements uniformly. Women, Pākehā, and people on higher incomes often (but not always) benefited more than men, non-Pākehā, and people on lower incomes.
- 6.8 There are some relatively small groups of vulnerable older people, such as those in residential care and those receiving home-based support. We found that progress in introducing systems that will collect reliable data about the quality of these services is slow.<sup>23</sup>
- 6.9 We also found that public entities use different definitions of elder abuse, neglect, and exploitation, and that no single agency collects data on this subject. Therefore, little is known about the extent of this issue and no one can really know whether current prevention programmes are effective.

### Improvements in health and well-being

- 6.10 Most older people (90% in 2010) were satisfied or very satisfied with their quality of life. In 2011/12, only 5% had experienced any recent psychological distress. An increasing proportion assess their own health as good to excellent.
- 6.11 Mortality rates for older people<sup>24</sup> are decreasing for non-communicable diseases (especially circulatory diseases), though mortality rates from external causes (accidents, injuries, and poisoning) have increased. Disability rates for older people are decreasing.<sup>25</sup> Seven per cent of older disabled people needed daily help with a range of everyday tasks.
- 6.12 In 2011/12, about 7% of people aged 65-74 years and 4% of people aged at least 75 years reported that cost was a barrier to accessing primary health services.<sup>26</sup>
- 6.13 Access to elective (or scheduled) surgery has improved for older people faster than for younger age groups.<sup>27</sup>

23 In 2011 and 2013, we described how the reporting on progress towards achieving the objectives of the *Health of Older People Strategy* (2002) was not complete, reliable, or comparable. Data collected was not analysed to provide a national report on progress.

24 The available data is for people 60 and over, not 65 and over, and is from 2000 to 2009.

25 From data available to 2006.

26 This data was collected for the first time in 2011/12. The results were lower than for younger adults.

27 The Ministry of Health data that we used was extracted from the National Minimum Data Set (surgery only) on 4 February 2013 for data up to 2011/12. The 2012/13 data was extracted on 12 August 2013.

### Areas where progress has been slow or has worsened

- 6.14 Obesity rates have doubled for people aged 65-74 years between 2002/03 and 2011/12, and overweight (but not obese) rates have increased slightly, too. Obesity is linked to diabetes, the rate of which is increasing.
- 6.15 Older people are disproportionately affected by falls. There has been a national focus since 2001 on reducing the incidence and harm of falls, but the rate of falls for every 100,000 population, aged at least 60 years, increased from 37 in 2000 to 53 in 2009.<sup>28</sup>
- 6.16 Findings for some of the Madrid indicators showed that outcomes for health and disability services for older Māori, Pacific, and, increasingly, Asian ethnicities were worse than for Pākehā.
- 6.17 In 2008/09, about 9% of older people were believed to be receiving home-based support services from the health and disability sector (excluding services funded by the Ministry of Social Development and ACC). Some older people living in the community are potentially more vulnerable than others. In 2006, a higher proportion of older disabled people lived alone (one-third) than disabled people in other age groups (one-quarter).

### Other areas for improvement

#### Lack of data

- 6.18 A high proportion of older people live in the community and may receive support from whānau, family, friends, neighbours, churches, charities, and state agencies. Reliable trend data on the number of older people receiving home-based support services is not collected by the Ministry of Health. Reliable data on the number of older people receiving home-based support services should be available once interRAI<sup>29</sup> is fully implemented.
- 6.19 Also, an estimated 31,305 older people were living in residential care in 2013. We found that the Ministry and DHBs do not have reliable information about the quality of residential and home-based support services received by older people. Progress in implementing our recommendations about this has been slow and depends on the successful implementation of interRAI.

<sup>28</sup> The Health Quality and Safety Commission has introduced a programme to reduce the incidence and harm from falls in hospital and residential care settings.

<sup>29</sup> The interRAI Organization is a collaborative network of researchers in more than 30 countries, committed to improving care for persons who are disabled or medically complex. In practice, the term “interRAI” is used to refer to the organisation’s clinical assessment tool. Data collected by health professionals using the tool is stored in an information technology system.

- 6.20 It is not yet clear how and when the data collected from interRAI will be used to improve nationwide equity of access, improve quality, and evaluate the effectiveness of policy settings for aged residential care and home-based support services.<sup>30</sup>

### **Elder abuse**

- 6.21 Our Madrid indicators work showed that public entities use different definitions of elder abuse, neglect, and exploitation (abuse), and that no single agency collects data on this subject. The size and scope of the problem and the main risk factors are unknown and it is difficult to evaluate the effectiveness and efficiency of current prevention programmes and legislation.
- 6.22 However, some data is available and it indicates that the size of the problem is larger than might be generally understood. Data about reported cases of abuse comes mainly from Age Concern, which received an average of 3.6 reports per calendar day from 1 July 2010 to 30 June 2012 (an average of 1,314 each year).<sup>31</sup> Using a low prevalence range from other countries of 2%-5%<sup>32</sup> and 2013 census data, we estimate that 12,141-30,352 older people might have experienced abuse in 2013. In 2011, we reported that nine out of 20 (45%) DHBs had yet to involve Age Concern's Elder Abuse and Neglect Prevention co-ordinators to empower older people to complain about abuse.
- 6.23 Older people report a higher rate of victimisation than the narrower definition of abuse. The 2008 New Zealand Crime Survey found that 20% of people aged at least 60 years had been victims of a crime or felt they were at risk of being a victim. Fifteen per cent of retired people had been victims, or felt they were at risk of being a victim.

### **Areas of potential future interest**

- 6.24 There are many uncertainties about the effects of a changing population structure on individuals and on society as a whole. Having the right kind of data available is important in managing for those uncertainties and preparing for the future. Accurate, relevant data can be used to identify improvements or adverse consequences as the result of changes in society and in government policy, and helps support accountability and transparent decision-making.

30 The New Zealand Health Survey asks respondents questions about their experience with general practitioners, practice nurses, after-hours doctors, emergency department doctors, and medical specialists, but not home-based support services.

31 Data reported to public entities, such as the Health and Disability Commissioner, the Ministry of Health and district health boards, the New Zealand Police, or the Financial Intelligence Unit, is not included in Age Concern's data.

32 These rates were used in Ferrino, April (2013), *Improving the quality of age-related residential care through the regulatory process*, page 55, Ian Axford (New Zealand) Fellowships in Public Policy, [www.fulbright.org.nz](http://www.fulbright.org.nz).

- 6.25 We expect the public entities involved in improving the health and well-being of older people to be clear about the intervention logic for policy and programmes, and collect relevant data to identify the effectiveness and efficiency of actions taken. We expect interventions to be based on a good understanding of how to change people's behaviour for the better, and incentives to be focused on promoting progress towards achieving the desired outcomes.
- 6.26 We will continue to monitor the progress made by the Ministry and DHBs in improving their knowledge of the quantity and quality of home-based support and rest home services through the introduction of interRAI and how that data is used to make improvements.
- 6.27 Allied to this, we expect public entities to work with service providers to understand the size and scope of the elder abuse problem and the main risk factors involved, and evaluate the effectiveness and efficiency of current prevention programmes and legislation.

# Appendix 1

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

Government departments	Health regulation authorities
Ministry of Health	Dental Council of New Zealand
<b>Crown entities</b>	Dietitians Board
Health and Disability Commissioner	Medical Council of New Zealand
Health Promotion Agency	Medical Radiation Technologists Board
Health Quality and Safety Commission	Medical Sciences Council of New Zealand
Health Research Council of New Zealand	Midwifery Council of New Zealand
New Zealand Blood Service	New Zealand Chiropractic Board
Pharmaceutical Management Agency	New Zealand Psychologists Board
<b>Crown company</b>	Nursing Council of New Zealand
Health Benefits Limited	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
	<b>Health regulation authority secretariats</b>
	Health Regulatory Authorities Secretariat Limited
	Medical Sciences Secretariat

District health boards	District health board subsidiaries
Auckland District Health Board	Allied Laundry Services Limited
Bay of Plenty District Health Board	Auckland DHB Charitable Trust
Canterbury District Health Board	Biomedical Services New Zealand Limited
Capital and Coast District Health Board	Brackenridge Estate Limited
Counties Manukau District Health Board	Canterbury Linen Services Limited
Hawke's Bay District Health Board	Central Region's Technical Advisory Services Limited
Hutt Valley District Health Board	Dempsey Trust
Lakes District Health Board	Enable New Zealand Limited
MidCentral District Health Board	HIQ Limited
Nelson Marlborough District Health Board	Health South Canterbury Charitable Trust
Northland District Health Board	healthAlliance N.Z. Limited
South Canterbury District Health Board	HealthShare Limited
Southern District Health Board	Manukau Health Trust
Tairāwhiti District Health Board	Milford Secure Properties Limited
Taranaki District Health Board	New Zealand Centre For Reproductive Medicine
Waikato District Health Board	New Zealand Health Innovation Hub Limited Partnership
Wairarapa District Health Board	New Zealand Health Innovation Hub Management Limited
Waitemata District Health Board	New Zealand Institute of Rural Health
West Coast District Health Board	Northern Regional Alliance Limited*
Whanganui District Health Board	South Island Shared Service Agency Limited
	Spectrum Health Limited
	Tairāwhiti Laundry Services Limited
	The Kaipara Total Health Care Joint Venture
	The Lakes District Health Board Charitable Trust
	Three Harbours Health Foundation
	Waikato Health Trust

\* Northern DHB Support Agency Limited merged with Northern Regional Training Hub Limited on 1 March 2013 and was renamed Northern Regional Alliance Limited.

## Appendix 2

# Environment, systems, and controls grades for 2011/12 and 2012/13

The following tables set out the environment, systems, and controls grades assigned by our auditors in 2012/13 and 2011/12 for DHBs, their shared service agencies, and the Ministry and other health sector Crown entities.

### District health boards

District health board	Year audited	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Auckland	2012/13	Good	Good	Good
	2011/12	Good	Good	Needs improvement
Bay of Plenty	2012/13	Very Good	Good	Good
	2011/12	Good	Good	Needs improvement
Canterbury	2012/13	Very Good	Good	Very Good
	2011/12	Very Good	Good	Very Good
Capital and Coast	2012/13	Needs improvement	Good	Needs improvement
	2011/12	Needs improvement	Good	Needs improvement
Counties Manukau	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
Hawke's Bay	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
Hutt Valley	2012/13	Good	Good	Good
	2011/12	Good	Needs improvement	Good
Lakes	2012/13	Needs improvement	Good	Needs improvement
	2011/12	Good	Good	Good
MidCentral	2012/13	Good	Good	Good
	2011/12	Good	Needs improvement	Good
Nelson Marlborough	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
Northland	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
South Canterbury	2012/13	Very Good	Good	Good
	2011/12	Very Good	Good	Good

District health board	Year audited	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Southern	2012/13	Needs improvement	Good	Needs improvement
	2011/12	Good	Needs improvement	Needs improvement
Tairāwhiti	2012/13	Good	Good	Needs improvement
	2011/12	Good	Good	Needs improvement
Taranaki	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
Waikato	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
Wairarapa	2012/13	Good	Good	Needs improvement
	2011/12	Good	Good	Needs improvement
Waitemata	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
West Coast	2012/13	Good	Needs improvement	Good
	2011/12	Good	Good	Good
Whanganui	2012/13	Good	Good	Good
	2011/12	Good	Good	Needs improvement

**DHBs' shared service agencies**

	Year audited	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Central Region's Technical Advisory Services Limited	2012/13	Good	Needs improvement	Needs improvement
	2011/12	Needs improvement	Needs improvement	Needs improvement
Health Benefits Limited	2012/13	Good	Good	Needs improvement
	2011/12	Very good	Good	Needs improvement

Note: healthAlliance N.Z Limited and HealthShare Limited will be graded in 2013/14.

**Ministry of Health and Crown entities**

	Year audited	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Ministry of Health	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
Health and Disability Commissioner	2012/13	Good	Good	Good
	2011/12	Good	Good	Good
Health Promotion Agency	2012/13	Very good	Good	Good
	2011/12	N/A	N/A	N/A
Health Quality and Safety Commission	2012/13	Very good	Good	Good
	2011/12	Good	Good	Needs improvement
Health Research Council	2012/13	Very good	Very good	Good
	2011/12	Very good	Very good	Good
New Zealand Blood Service	2012/13	Very good	Very good	Very good
	2011/12	Very good	Very good	Very good
Pharmac	2012/13	Very good	Very good	Good
	2011/12	Very good	Very good	Needs improvement



# Publications by the Auditor-General

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

- Schools: Results of the 2012 audits
- New Zealand Customs Service: Managing Trade Assurance capability risks
- Draft annual plan 2014/15
- Central government: Results of the 2012/13 audits (Volume 2)
- Additional work on Solid Energy New Zealand Limited
- Inquiry into property investments by Delta Utility Services Limited at Luggate and Jacks Point
- The Auditor-General's Auditing Standards 2014
- The Treasury: Learning from managing the Crown Retail Deposit Guarantee Scheme
- Department of Internal Affairs and grants administration
- Maintaining a future focus in governing Crown-owned companies
- Delivering scheduled services to patients
- Continuing to improve how you report on your TEI's service performance
- Central government: Results of the 2012/13 audits (Volume 1)
- Department of Corrections: Managing offenders to reduce reoffending
- Public entities in the social sector: Our audit work
- Immigration New Zealand: Supporting new migrants to settle and work
- Summary: Inquiry into the Mangawhai community wastewater scheme
- Inquiry into the Mangawhai community wastewater scheme
- Regional services planning in the health sector
- Effectiveness and efficiency of arrangements to repair pipes and roads in Christchurch

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