Controller and Auditor-General
Tumuaki o te Mana Arotake

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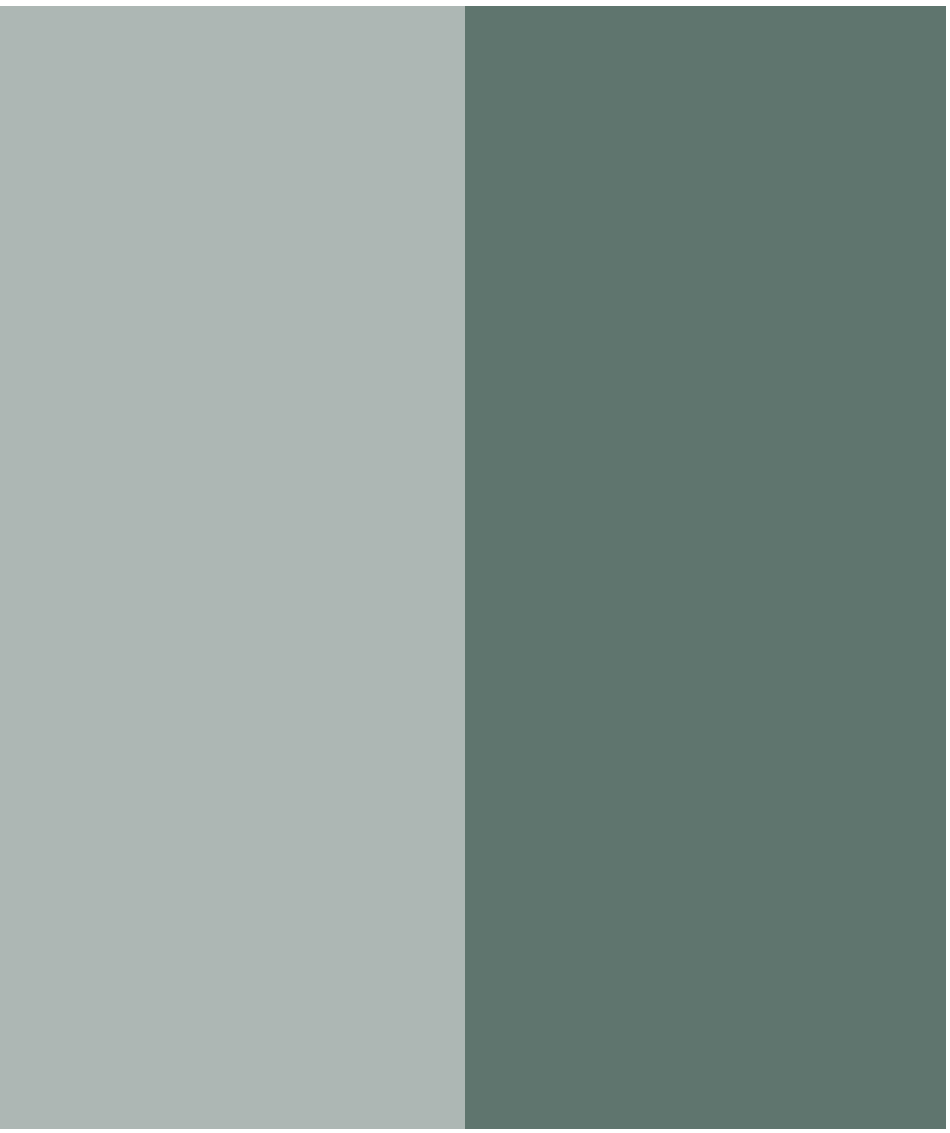
Health sector: Results of the 2014/15 audits



Health sector: Results of the 2014/15 audits

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Auditor-General's overview

The performance of the health sector greatly affects New Zealand's overall social and economic performance, and thus the quality of life for all of us.

Its importance is reflected in the amount the Government spends on health. In 2014/15, this was just over $15 billion, which is the second-highest area of spending after social security and welfare.

Financial sustainability has been a challenge for district health boards (DHBs) for a long time. Previously, we had seen some improvements in the overall financial results, with deficits decreasing in the last few years. That trend reversed significantly in 2014/15, although much of the increase in deficits came from just two DHBs: Southern and Canterbury.

In general, DHBs are doing reasonably well at marshalling their resources for current operational needs. However, our analysis of their financial statements for successive years suggests that their planning for the future and ability to deal with uncertainty or changing circumstances is limited.

We saw indications in our 2014/15 audits that some DHBs are especially focused on achieving a particular financial result, and are basing their decisions on how they account for expenditure and revenue on this objective. This suggests that there is too much focus on the "bottom line", which could detract from other important objectives, such as sound asset management and financial resilience.

Among the many costs contributing to financial pressure on DHBs is the capital charge that the Government places on DHBs' net equity. It is not clear to me what the capital charge regime is actually achieving in the health sector. If anything, it appears to be giving DHBs an incentive to use debt funding.

Other financial stresses result from the overall pressures the DHBs are operating under. These pressures include growing demand from population growth and demographic change, particularly the ageing of the population. A strategic response to such change is the updated *New Zealand Health Strategy*, which the Minister of Health launched in April 2016. The Strategy notes that maintaining services as they are currently provided will probably become unaffordable, and that an increased emphasis on maintaining health and illness prevention is needed. As the sector carries out the new strategy, it will need to continue controlling its finances carefully and maintain service quality as it moves to new ways of doing things. This will not be easy.

There were two significant structural changes in the sector in 2014/15. One was the replacement of the Southern DHB board with a commissioner, after several years of poor financial results from the DHB. We set out the main findings from our audit of Southern DHB in this report.

The other major change was the winding-down of Health Benefits Limited (HBL) and its replacement with a DHB-owned entity. In 2015, we inquired into HBL. We found that developing shared services for multiple entities is difficult and creates both risks and opportunities. We noted 11 lessons that are applicable to any shared-services programme, which I recommend to any agency developing programmes involving multiple entities.

DHBs collectively manage physical assets worth $5.7 billion. Many of these assets, such as hospital buildings and clinical equipment, are essential to providing healthcare. We have found several areas of weakness in the way DHBs manage their assets and associated capital expenditure. They appear to be unduly focused on delivering short-term results. In my view, DHBs need a longer-term perspective on managing assets and related capital investment. I will continue to monitor this closely.

The role of information and information technology in the provision of health services continues to grow. This places an increasing obligation on the sector to manage its information responsibly and securely. In our 2014/15 audits, we found that DHBs had made slow but steady improvements to their information technology security, which I encourage them to continue. I am still concerned about the adequacy of DHBs' business continuity and information technology disaster recovery planning. Some DHBs may be delaying the development of these plans because they expect national initiatives to provide solutions, but it is important that DHBs manage such risks in the meantime.

The health sector faces many challenges, and our audits reveal some weaknesses and matters that need to be worked on. But we also see much that is positive, and many significant achievements and improvements despite the challenging environment. I hope that the findings from our audits are used by the sector to continue this progress.

Lyn Provost
Controller and Auditor-General

3 August 2016

1 Introduction

1.1 In this Part, we provide an overview of the health sector to set out the context for our work, describing:

- the sector's operating environment and the principal entities in the sector;
- how the sector is funded, including the funding of district health boards (DHBs) through the population-based funding formula; and
- changes in the sector, including an update of the *New Zealand Health Strategy*.

The health sector's operating environment

1.2 New Zealand's public health system is administered under the New Zealand Public Health and Disability Act 2000 (the Act). The Act establishes the DHBs and some other Crown entities, setting their purpose, functions, governance arrangements, and reporting obligations. It also establishes certain responsibilities of the Minister of Health (the Minister).

1.3 Government expenditure on health in 2014/15 was $15.06 billion, making it the second-largest expenditure after social security and welfare.

1.4 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 that we audit.

1.5 The public health system has three main components:

- The Ministry of Health (the Ministry) advises the Minister and the Government on health issues, leads the public health and disability sector, and monitors DHBs and other Crown entities. The Ministry also performs regulatory functions, provides health sector information and payment services, and purchases national health and disability services.
- DHBs are responsible for providing for the health needs of their district. They do this through various activities, including providing secondary and tertiary health services in their hospitals, and funding other organisations and groups to provide primary health services. DHBs are supported by shared-services agencies, which provide administrative, financial, and information systems and services.
- Primary health organisations (PHOs) are not-for-profit organisations funded by DHBs to deliver primary health care services. People generally receive these services by visiting general practices, most of which belong to PHOs. PHOs are not public entities, and so are not audited by the Auditor-General, but their general practices are the part of the health system that most people have contact with most often. PHOs receive a large amount (about $1 billion) of health funding.

Ministry of Health and associated bodies

1.6 The Ministry is the lead agency in the sector. The Director-General of Health is the chief executive of the Ministry and has statutory responsibilities under the Act and the Health Act 1956.

1.7 The Government established the National Health Board (NHB) in November 2009. The NHB was made up of a ministerially appointed board and a business unit in the Ministry. The board was responsible for overseeing the NHB's work programme, which included:

- funding and monitoring the planning and performance of DHBs; and
- planning and funding specified national services, such as child health and emergency services.

1.8 The NHB had two subcommittees: the Capital Investment Committee and the National IT Health Board. Their responsibilities related to the planning and approval of investments in the sector. In March 2016, the NHB was disestablished. The Capital Investment Committee was reconstituted as a statutory advisory committee to the Minister. The National Health IT Board is now accountable to the Director-General of Health. The Ministry has absorbed the other functions of the NHB into other business units.

1.9 Health Workforce New Zealand is a statutory advisory committee to the Minister, supported by the Ministry, with responsibility for planning and development of the health workforce.

District health boards

1.10 DHBs were established by the Act, which sets out the objectives that DHBs must work towards. The objectives, as set out in section 22 of the Act, include the following:

- to improve, promote, and protect the health of people and communities;
- to promote the integration of health services, especially primary and secondary health services; and
- to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs.

1.11 DHBs are responsible for providing or funding health services for the people of their districts. The 20 DHBs differ greatly in terms of their population size and density, and their demographics. Waitemata DHB has the largest population of about 583,000, and the smallest is West Coast DHB, with a population of about 33,700.

1.12 Each DHB prepares an annual plan, which is agreed with the Minister, and, for those DHBs deemed to be at high financial risk, the Minister of Finance also. The plan includes budget and performance measures. DHBs are organised into four regions: Northern, Midland, Central, and South Island. Since 2011, regulations have required DHBs to prepare plans showing how they will operate regionally, as well as their individual plans.

Other Crown entities

1.13 Other Crown entities set up under the Act have various roles in the sector:

- The Health Quality and Safety Commission works with clinicians, providers, and consumers to improve health and disability support services.
- The Health and Disability Commissioner investigates and reports on complaints about health or disability service providers to ensure that the rights of consumers are upheld.
- The New Zealand Blood Service provides the health system with access to blood and tissue products, and related services.
- The Health Promotion Agency was formed on 1 July 2012 by merging the Alcohol Advisory Council and the Health Sponsorship Council. It leads and supports work in a number of areas, including the promotion of health, well-being, and healthy lifestyles, and provides advice and research on alcohol issues.
- The Pharmaceutical Management Agency (Pharmac) decides which medicines, medical devices, and related products are to be subsidised. DHBs provide the funding for the subsidies.

Funding for the health sector

1.14 Government spending on health has increased from $13.13 billion to $15.06 billion since 2009/10. The rate of increase in expenditure on health over this period has levelled off compared with previous years. For example, in the five years to June 2015, government expenditure on health increased by 9.5%, whereas in the five years to June 2010, it increased by 37.5%.

1.15 The challenge is to continue to provide New Zealanders with high-quality health care while ensuring that the health system is financially sustainable.

District health board funding and expenditure

1.16 The bulk of DHB funding is allocated using the population-based funding formula (PBFF), which we describe below. DHBs also collectively receive additional funding of about $1 billion for national health, public health, and disability services.

1.17 DHBs provide hospital-based services and purchase services from third parties such as PHOs and residential facilities. Collectively, DHBs spend about $5.9 billion on services from other providers each year.[1]

1.18 The health services that DHBs provide and purchase are grouped into four output classes:

- early detection and management;
- intensive assessment and treatment;
- prevention; and
- rehabilitation and support.

Population-based funding formula recently reviewed

1.19 The PBFF is used to calculate the share of funding allocated to each DHB, on the basis of its population, the population's needs, and the costs of providing health and disability services. The formula includes weightings and adjustors for population age and other indicators of need, such as deprivation status and ethnicity. 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 "rural" adjustors to reflect the higher cost of providing services in rural areas).

1.20 Funding for DHBs under Vote Health has been increasing annually through the Budget process, reflecting relative priorities across government. Assumptions about annual demographic changes are based on Statistics New Zealand's population projections. Additional funding has also been provided for specific new initiatives.

1.21 The PBFF was devised in 2000, using 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.

1.22 The Ministry completed the latest full review of the PBFF in late 2015. The review looked at whether the PBFF was still fit for purpose, and considered matters including whether the core model's weightings and the adjustors should be changed.

1.23 The review recommended no structural change to the PBFF model, but it has resulted in technical changes to each of the components of the model, such as updated inputs. The biggest change is to the rural adjustor, which affects the underlying model used. This is likely to result in slightly larger funding increases for DHBs with high rural populations, such as Southern DHB, than more densely

1 This is the amount paid by DHBs to all other providers, which includes $1.48 billion paid to other DHBs for inter-district flows – that is, payment for care provided to patients who live in another district.

populated DHBs such as Auckland. The changes to funding resulting from these changes to the model will start in 2016/17.

1.24 Figure 1 shows the population figure for each DHB that the Ministry used to calculate Vote Health Budget funding for 2014/15, and the actual, "fully devolved" funding for 2014/15. The fully devolved funding is funding that each DHB can determine how best to spend in order to meet the health needs of the people in its district. In addition to this funding, DHBs receive funding for specified services (for example, additional elective surgeries). Further financial information on DHBs is set out in Part 3, where we discuss DHBs' financial performance and set out our analysis of their financial health.

Figure 1
Population of district health boards (2015/16 estimates), and fully devolved funding for 2015/16 (Budget) and 2014/15 (actual)

District health boards	Population*	2015/16 Budget funding $million**	2014/15 actual funding $million***
Northern region			
Auckland	482,015	1,115.6	1,092.3
Counties Manukau	524,505	1,268.5	1,246.4
Northland	169,035	509.3	487.9
Waitemata	582,765	1,342.1	1,311.8
Northern region totals	**1,758,320**	**4,235.5**	**4,138.4**
Midland region			
Bay of Plenty	222,235	633.6	614.4
Lakes	103,920	283.5	278.3
Tairāwhiti	47,603	146.8	144.3
Taranaki	118,560	317.7	304.2
Waikato	391,770	1,040.1	1,002.4
Midland region totals	**884,088**	**2,421.7**	**2,343.6**
Central region			
Capital and Coast	301,170	689.6	678.8
Hawke's Bay	160,735	457.1	435.5
Hutt Valley	144,550	363.6	357.8
MidCentral	171,250	465.9	458.0
Wairarapa	43,880	127.8	122.5
Whanganui	62,453	205.6	202.3
Central region totals	**884,038**	**2,309.6**	**2,254.9**

South Island region			
Canterbury	529,905	1,281.4	1,268.4
Nelson Marlborough	146,270	393.2	378.2
South Canterbury	59,043	167.4	164.6
Southern	313,050	789.6	776.5
West Coast	33,685	121.5	119.6
South Island region totals	**1,081,953**	**2,753.1**	**2,707.3**
All district health boards	**4,608,398**	**11,719.9**	**11,444.2**

* Data provided by the Ministry of Health.

** The Treasury (2015), *The Estimates of Appropriations 2015/16*.

*** Ministry of Health (2015), *Annual Report for the year ended 30 June 2015*.

Changes in the health sector

Updating the *New Zealand Health Strategy*

1.25 One of the responsibilities of the Minister as set out in section 8 of the Act is to determine a strategy for health services, called the *New Zealand Health Strategy* (the Strategy), and to report each year on progress in implementing it.

1.26 The previous Strategy was approved in December 2000. In November 2014, the Minister announced that the Ministry would be reviewing the Strategy. Public consultation on a draft strategy began in October 2015, and the Minister launched the finalised Strategy in April 2016.

1.27 The Strategy sets out the global challenges facing the health system:

- providing health and social services to increasing numbers of older people who are living longer;
- a growing burden of long-term conditions, such as heart disease, diabetes, depression, and dementia;
- how to afford new technologies and drugs and meet rising expectations;
- a highly mobile global workforce;
- the emergence of new infections and antibiotic resistance; and
- the health and social consequences of climate change.

1.28 Other challenges in New Zealand include reducing health disparities for Māori and other population groups, and maintaining and developing the health workforce. The Strategy clearly signals that significant changes will be needed in models and approaches to health care provision.

1.29 The Strategy notes the likelihood that maintaining services as they are currently provided will become unaffordable, with the proportion of gross domestic product needed to fund these services rising from 7% now to 11% in 2060.[2] It says that a change to the system is needed to put more emphasis on prevention and less on treatment. The Strategy will require everyone involved in health care delivery, including the Ministry and DHBs, to make the necessary changes and exercise the flexibility to be effective within financial constraints.

1.30 Towards this change, the Strategy specifies five strategic themes with associated objectives, and includes a "roadmap" of actions to be completed within five years. The updated Strategy is likely to result in a period of sustained change as the sector carries it out. An early indication of this is an extensive restructure of the Ministry now in progress, to position it to carry out the Strategy.

1.31 An example of an innovative approach already being taken to service delivery is Whānau Ora, which we reported on in 2015.[3] We found that, despite some gaps in communication and inconsistency between the agencies involved, Whānau Ora has produced some benefits for many families and whānau who have been directly supported, and their communities. However, we noted that the Ministry had no plans then to make any changes to take advantage of the work already done, or to improve the Whānau Ora funding model.

Using information and information technology to support health services

1.32 Effective use of information is essential to maintaining and improving the public health system. In our work, we consider how the Ministry and other agencies gather clinical and quality information on performance for reporting and for supporting decision-making.

1.33 The National Health IT Board has the role of leading and co-ordinating information and information technology (IT) development in the health sector. This role includes setting the sector's strategic direction, and providing advice to the Director-General of Health or the Minister on requests by DHBs to make IT investments exceeding a specified amount.

1.34 In November 2015, the National Health IT Board released a revised five-year work plan to 2020. The plan specified four priority areas:

- a single national electronic health record for every New Zealander, with a working target date of mid-2018 for establishing a base electronic health record;
- a standard for the use of digital solutions by hospital and specialist services;

2 Ministry of Health, *New Zealand Health Strategy*, page 11.

3 *Whānau Ora: The first four years*, available at www.oag.govt.nz.

- a preventative health IT platform to capture information relating to population screening programmes for individuals; and
- data to support health and social investment.

1.35 Working towards these priorities will require entities in the sector to work together closely and carefully manage investments in IT to allow the sharing and exchange of information that these priorities will require.

1.36 In our recent progress report about how the Ministry and DHBs deliver scheduled services to patients,[4] we noted the introduction of the National Patient Flow Collection, a new national patients' information system, which will eventually allow patients to be followed from referral to scheduled services to the outcome of the referral, between services in a DHB, and between DHBs. This new system is expected to provide comprehensive information on patient "pathways" at individual, DHB, and national levels.

1.37 In our *Annual plan 2016/17*, we state our intention to look at work to improve patient information systems. This work will focus on the Patient Portals programme. Patient portals are online sites, provided by general practitioners, which enable patients to get their health information and interact with their general practice.

Changes at agency and sector level

1.38 There were two major changes in the health sector in 2014/15.

Southern DHB's board replaced by a commissioner

1.39 Southern DHB is the southernmost, and geographically the largest, DHB. It was formed in May 2010 as the result of the merger of Southland and Otago DHBs. It has reported deficits every year since 2011/12. It recorded its largest deficit, of $27.2 million, in 2014/15.

1.40 In June 2015, the Minister, using powers provided by section 31 of the Act, dismissed the Southern DHB board and replaced it with a commissioner. In his statement announcing the decision, the Minister noted long-standing financial problems at Southern DHB, and his lack of confidence that the existing governance arrangements were suitable for delivering the changes needed.

1.41 The commissioner started on 18 June 2015, and has been joined by three deputy commissioners. The original term for the commissioner was until December 2016, at which point a new board would have started its term after the elections in October 2016. Legislation enacted in May 2016 cancelled the 2016 election for

4 *Delivering scheduled services to patients – Progress in addressing the Auditor-General's recommendation*, available at www.oag.govt.nz.

Southern DHB, allowing the commissioners' appointments to be extended beyond the original December 2016 deadline.

1.42 Southern DHB has the challenge of achieving financial sustainability without repeated recourse to the Crown for additional support. Its planned deficit for 2015/16 is $35.9 million. We discuss Southern DHB further in Part 2.

Health Benefits Limited and New Zealand Health Partnerships

1.43 Health Benefits Limited (HBL), was a Crown-owned company set up to prepare national programmes in partnership with the health sector to reduce the costs of non-clinical support services to DHBs, by using a centralised shared-services model. However, after difficulties and delays in delivering some of HBL's programmes, the Government decided to wind down its operations and replace it with a DHB-owned entity. HBL's last day of operation was 30 June 2015.

1.44 A Transition Interim Governance Group was established to oversee the transition from HBL to a new entity that will continue HBL's work. The group included representatives from DHBs, the Ministry, the Treasury, and HBL.

1.45 The new entity, NZ Health Partnerships Limited (NZHP), started on 1 July 2015 as a Crown subsidiary owned by all the DHBs. NZHP works with DHBs and other entities to "... enable DHBs to collectively maximise shared-services opportunities for the National Good".[5] It is led, supported and owned by the 20 DHBs.

1.46 NZHP continued the programmes begun by HBL and started some new work. Programmes still operating include a sector procurement strategy, a common financial management information system, a shared information technology infrastructure to replace separate infrastructure in each DHB, and food services for both hospitals and Meals on Wheels.

Our inquiry into Health Benefits Limited

1.47 In November 2014, Hon Annette King MP asked the Auditor-General to look into the performance of HBL, the decision to wind it down, what it had cost the health sector, and what benefits it had achieved. We looked into the costs and benefits of HBL's work in the health sector, seeking lessons about shared-services programmes. We also looked at:

- how HBL managed relationships with health sector entities;
- the approach and processes that HBL used in business cases; and
- the governance and management arrangements for delivering HBL's programmes.

5 See www.nzhealthpartnerships.co.nz/operating-model/.

1.48 By the end of June 2014, HBL had reported total gross savings of $301.8 million on behalf of the sector, of which $71 million was attributable directly to HBL. As well as savings, other benefits resulted from HBL's work, such as improvements to DHBs' data integrity and the sharing of good practice in administrative and support services.

1.49 HBL's most ambitious programme was the Finance, Procurement and Supply Chain (FPSC) programme. It was intended to provide a common financial management information system for all DHBs, a centralised procurement function performed by healthAlliance N.Z. Limited (healthAlliance), and a redesigned supply chain. The original completion date was November 2014. However, the programme encountered delays and was paused in 2014 so that it could be revised.

1.50 HBL encountered several problems with the FPSC programme. They included inadequate communication with DHBs, which contributed to a lack of commitment from some DHBs, and DHBs not supplying timely and accurate information to HBL's board. HBL also had no programme management office for maintaining project management discipline, and there were weaknesses in the programme's governance structure. The budget for the FPSC programme was revised more than once to accommodate costs that were not budgeted for. By March 2015, it had spent $80 million of the budgeted $92.1 million, and was not yet complete.

1.51 At the time of our inquiry, it was too soon to assess the benefits of the FPSC programme, which we found to be ambitious, complex, and risky. We will continue to monitor the programme in the course of our annual audit work of NZHP.

1.52 We included 11 lessons in our report on HBL about managing new programmes for a sector. Lessons for sector-wide initiatives include:

- ensuring open two-way communication with the parties to align the programme with DHBs' objectives, and to gain commitment to and understanding of requirements, especially that of providing good information;
- ensuring that solutions are scalable; and
- establishing sound governance and management structures for programmes, including comprehensive planning for change.

2 Audit results for 2014/15

2.1 In this Part, we discuss the 2014/15 audit results, including:

- observations and matters arising from the 2014/15 audits; and
- our assessment of the management control environment, systems, and controls for DHBs and other health sector entities.

2.2 The main matters arising from our audits relate to:

- the non-standard audit reports for all DHBs and the Ministry regarding performance information derived from third parties;
- shared services and other initiatives to increase cost-effectiveness and savings;
- procurement and contract management;
- the earnings management practices of some DHBs;
- information systems and controls;
- the transition to public benefit entity accounting standards;
- DHBs' performance reporting on appropriations;
- the Canterbury hospital rebuild projects; and
- DHBs' asset management.

2.3 We discuss DHBs' financial results and performance in Part 3.

Observations and matters arising from the 2014/15 audits

Non-standard audit reports because of third-party performance information

2.4 In 2014/15, we issued non-standard audit reports for all DHBs and for the Ministry of Health because some important performance measures used by the DHBs, including some of the national health targets, rely on information from third-party health providers, such as PHOs. The DHBs' control over much of this information was limited, and we could not obtain evidence to assure us of the reliability of the information from third parties that was used by DHBs to report.

2.5 We first issued non-standard audit reports for all 20 DHBs over this matter in 2012/13. We reported on it in detail in our health sector report for that year.

2.6 Our non-standard audit reports do not mean that the health target performance reporting by DHBs was incorrect, or that the DHBs' service delivery failed, or any wrongdoing or false reporting by DHBs, or that the information reported by general practitioners was wrong. It means that we could not verify some important performance information because we do not audit PHOs.

Performance reporting by district health boards still reliant on unaudited third-party reporting

2.7 DHBs report their performance against a number of measures. Because DHBs have overall responsibility for health services to the people in their districts, they report not only on the performance of the services they deliver themselves through their hospitals, but also on some services provided by others, such as general practitioners and PHOs.

2.8 For example, the measure for the national health target for smoking prevention is the percentage of smokers offered brief advice and support to quit smoking when being seen by a health professional in a PHO or a public hospital.

2.9 The primary smoking prevention measure relies on information from general practitioners. We could not test this information independently because our audit mandate does not extend to information held by general practitioners or PHOs. Also, the DHBs could not give us evidence that they were checking that the information reported to them by third parties was reliable.

A sector-wide issue affecting all district health board audits

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

2.11 The Ministry reports the results against national health targets as measures of its impact. This information is reported to the Ministry by DHBs. We qualified our audit opinion for the Ministry for the same reason that we qualified those of the DHBs.

2.12 DHBs pay about $5.9 billion to other providers of services, of which $4.4 billion is to third parties such as PHOs and general practitioners, and it is important that there is reliable performance information about these services to support decision-making and to ensure public accountability.

Work to address this issue is continuing

2.13 In our audits, we recommended that the Ministry and DHBs work together, and with other relevant organisations, to devise a cost-effective way to get sufficient assurance over performance information from third parties. Because this is a sector-wide issue, we encourage the sector as a whole to consider whether the introduction of additional controls is appropriate and would be cost-effective, and, if so, how best to introduce them.

2.14 The Ministry has taken the lead in trialling an approach that might be helpful. The Ministry developed a methodology for auditing the data that general practitioners provide to PHOs, which the PHOs then report to the DHBs. We are pleased to see this progress. It is too early to say whether solutions will be available in time to affect the results of the 2015/16 audits.

Other non-standard audit reports

2.15 As well as the qualification relating to third-party performance information, we further qualified our audit opinions on Wairarapa DHB, and Capital and Coast DHB. These qualifications related to performance information reporting for their hospital services, and applied to the 2013/14 comparative information only – that is, we issued qualified opinions for the DHBs for certain measures in 2013/14. These results were reported again in 2014/15 so that readers could compare performance of the DHBs from one year to the next. Our audit opinion for Lakes DHB was also qualified for these measures in 2013/14, but the DHB chose not to report the comparative information in 2014/15. We were pleased to see that the problems that had led to these qualifications had been resolved by the DHBs for the 2014/15 performance information.

Shared services – initiatives to increase cost effectiveness and savings

2.16 Considerable efforts continued in the sector to increase effectiveness and achieve savings by using shared-services agencies. Below are summaries of the results of our audits of these entities.

Health Benefits Limited

2.17 HBL's financial statements were prepared on a non-going-concern basis, as its assets and liabilities were transferred to a new company, NZ Health Partnerships Limited (NZHP) on 1 July 2015.

2.18 HBL reported savings of $72.6 million in the sector for 2014/15. This makes cumulative sector savings of $374.4 million since HBL began reporting them.

2.19 In previous years, we found that HBL had difficulty securing verifiable information from DHBs about the benefits that were being realised and then reported on by HBL. We made recommendations for improving the transparency of HBL's reporting, and over time we have observed some improvements in this area, including the enhanced checking of savings reported by DHBs.

2.20 In 2014/15, HBL further improved their reporting of benefits by providing, for the first time, a breakdown of benefits from applying its savings methodology. This allowed it to report "budget-impacting" and "non-budget-impacting" savings separately. The two kinds of savings are defined as follows:

- Budget-impacting savings: those with a clear effect on the DHB's "bottom line" (that is, in the Statement of Comprehensive Revenue and Expense, including any depreciation effect).
- Non-budget-impacting savings: those that do not meet the definition of budgetary. They may include increases in costs that have been avoided, benefits that have been carried forward, and qualitative improvements (such as reductions in complexity or clinicians' time spent on administration).

2.21 Both types of benefits are reported as dollars saved. In 2014/15, budget-impacting savings were $20.1 million, and non-budget-impacting savings were $52.5 million.

2.22 Despite the improvements we note above, HBL still found it difficult to report benefits in 2014/15. There was a notable deterioration in some DHBs' communication with HBL, with long delays in providing HBL with information about savings they had realised. Four DHBs did not respond to requests for confirmation of benefits to be reported. Delays in establishing the National Infrastructure Programme also resulted in benefits initially recorded for the programme being removed from the final annual report.

2.23 Because of these challenges and delays, HBL breached section 156(1) of the Crown Entities Act 2004. This requires HBL to forward its annual financial statements and certain other information to the Auditor-General within three months of the end of the financial year, and to forward its annual report in time to allow the Auditor-General to review it and provide an audit report within four months of the end of the financial year.

2.24 HBL's successor, NZHP, will clearly need to work hard to establish and maintain effective communication channels with DHBs. This is vital to the successful delivery of shared-services programmes. As part of our audit, we made a number of recommendations on ways to improve matters.

healthAlliance N.Z. Limited

2.25 healthAlliance N.Z. Limited (healthAlliance) is owned by the four northern region DHBs. It was established to provide "back office" functions (procurement, supply chain, finance, information systems, and payroll processing) to generate efficiencies and savings for the shareholding DHBs.

2.26 In July 2014, healthAlliance (FPSC) Limited, a subsidiary of healthAlliance, began running the National Procurement Service, which is available to all 20 DHBs. This service provides a national catalogue of goods and services, with a view to reducing costs and increasing savings for DHBs. Goods and services made available in this way include clinical supplies and non-clinical support services.

2.27 healthAlliance (FPSC) Limited also manages the Oracle financial management platform for Hutt Valley DHB. When Hutt Valley DHB started using the platform in April 2014, it was the first (and remains the only) DHB to do so.

2.28 healthAlliance has expanded to take on these new functions while continuing to provide services to its established clients in the northern region. The resulting challenges have been further complicated by the disestablishment of HBL and its replacement by NZHP. We noted the uncertainty affecting healthAlliance (FPSC) Limited while NZHP decides how to continue the programmes it inherited from HBL.

Pharmaceutical Management Agency

2.29 The main role of the Pharmaceutical Management Agency (Pharmac) is to manage the list of subsidised medicines formally known as the Pharmaceutical Schedule. Since 2010, the Government has expanded Pharmac's area of responsibility to include helping DHBs to purchase vaccines, and medicines and medical devices for hospital use.

2.30 Pharmac is well established in the management of the Combined Pharmaceutical Budget and has had notable success in securing savings on pharmaceuticals. But it is still developing its approaches in its newer areas of responsibility, which could take several years to reach similar maturity.

2.31 To secure the greatest possible savings for DHBs, Pharmac expects to progress to full budget management of the purchase of hospital medicines and medical devices, of the kind it currently exercises over the Combined Pharmaceutical Budget. However, making this transition will require Pharmac to have access to accurate purchase and usage data from DHBs.

2.32 Our audit did not find any negative effect on the control environment and associated internal controls from Pharmac's growth and expanded responsibilities. We noted that Pharmac is working closely with stakeholders to help it achieve the best outcome.

Procurement and contract management

2.33 DHBs spend a large portion of their funding on procuring goods and services. Each DHB needs to carefully manage a number of major contracts to ensure that the DHB and the public receive what is being paid for. Many DHBs are engaged in large projects or programmes that also need sound procurement and contract management processes.

2.34 Procurement in the DHB sector is complex because of the role of other parties in helping the DHBs manage procurement. On a day-to-day basis, the Ministry provides the important service of processing the DHBs' payments for nationally contracted services. A number of regional and national initiatives also involve other parties providing procurement services for the DHBs – for example, the national procurement service run by healthAlliance (FPSC) Limited.

2.35 For some years now, our audits of DHBs have identified potential improvements in aspects of procurement and contract management, such as updating procurement policies and practices to ensure that they are in line with the Government Rules of Sourcing and with good procurement practice. In general, DHBs have been slow to address these findings. We understand that DHBs have possibly deferred improvements because they were expecting national and regional initiatives for procurement services to provide solutions, or to change processes to the extent that improvements made now would need to be redone.

2.36 Although shared services and systems will have an increasing role in DHB procurement, it remains the individual DHB's responsibility to ensure that they have robust and effective procurement and contract management. DHBs need to be confident that their policies and processes provide sufficient assurance. We will continue to monitor this and tell DHBs where we consider improvements are needed.

Earnings management practices at district health boards

2.37 As we have reported in previous health sector reports, DHBs are very focused on meeting their forecast financial targets.

2.38 During our 2014/15 annual audits, we observed that some DHBs seemed overly focused on achieving a particular "bottom line" result. Our auditors noted that DHBs are managing their financial results carefully with the objective of reporting close to break-even results or budgeted surpluses or deficits. We noted that a number of DHBs could not support the way they had accounted for some revenue and expenditure, because of judgements made about accruals, provisions, asset lives, and estimated leave liabilities. Some DHBs chose not to adjust for misstatements that we found, if adjusting would significantly affect their financial positions relative to their budgeted positions. Where we found this was happening, we reported it to the DHB and included it in our reporting to the Minister and to Parliament.

2.39 Although this "bottom line" focus and financial pressure on DHBs has been present for a number of years, it seemed to be more evident in the 2014/15 audit round.

2.40 In no instance did our auditors consider these issues serious enough to affect the audit opinion. Nevertheless, DHBs need to approach financial year-end cut-offs and valuation assumptions consistently, without bias toward the desired year-end result.

2.41 We will continue to focus on this issue in 2015/16 and beyond.

Information systems and controls

2.42 In our annual audits, we consider IT controls that affect the reliability of the financial statements and service performance reporting. This involves assessing general IT controls, business application controls, and data analysis.

2.43 Balancing IT business requirements against the availability of resources is a continuing challenge for DHBs. We are interested in DHBs' information service risks, particularly in the regionalisation of IT operations, business continuity and disaster recovery, information security, emerging technologies, and the role of IT in governance.

Progress in addressing risks of regionalisation and collaboration for the IT environment

2.44 In our previous health sector report,[6] we discussed the potential risks to DHBs' information controls in an environment of increasing regionalisation, collaboration, and shared services. These risks arise from conflicts between regional and local priorities, a single point of failure in a regionalised or national system, and a lack of standardised operating procedures.

2.45 We have recommended that DHBs plan carefully, to align local priorities properly with those in regional and national IT plans, and that governance arrangements for regional activities be clearly defined in information systems plans.

2.46 In the last year, we observed a marked improvement in this area. Although the risks we note remain, we are satisfied (after our 2014/15 audits) that the sector has reasonable processes and controls for ensuring that significant risks relating to regionalisation are promptly recognised, mitigated, and reported. We were pleased to see this progress in response to our recommendations.

Business continuity and disaster recovery still a risk

2.47 The lack of formal disaster recovery plans remains a risk for DHBs. Close alignment is needed between the disaster recovery plan and the expectations set out in business continuity plans. Provisions for business continuity planning must be seen as a DHB-wide initiative rather than as a task for the IT department. IT disaster recovery is a key component of continuity planning, to ensure that crucial systems are up and running in the required time.

2.48 The sector's disaster recovery systems can potentially benefit from NZHP's development of the National Infrastructure Platform. To use the platform, DHBs are expected to move their data to two data centres that meet government standards for information security and resilience, in line with the "Information as a Service" model developed by the Government's Chief Information Officer. However, this programme will take some years to complete. In the meantime, DHBs need to consider how to manage their disaster recovery risks.

DHB governance – better strategic understanding of IT needed

2.49 The reliance of DHBs on information systems and technology for effective and efficient delivery of healthcare services is increasing. Now more than ever, executive management and boards need to ensure that they understand the information systems risks a DHB faces. We encourage boards to regularly examine strategic IT projects and related risks, as routine good governance practice.

6 *Health sector: Results of the 2012/13 audits*, available at www.oag.govt.nz.

Information security needs closer attention

2.50 DHBs need to devote more attention to information security, particularly at the network level. We continue to note issues, including weak password settings and a lack of periodic review of user access rights. This is particularly important given the large amount of sensitive information that DHBs are responsible for. These observations have been consistent for the last five years.

2.51 Some DHBs have formal information security arrangements, but most DHBs' information security arrangements are on a "best efforts" basis. We continue to recommend that DHBs work at improving the security of their information.

2.52 However, we have seen some improvement in this area. The number of security-related issues we have found in the DHB sector declined in the last three years. Although the pace is slow, the trend is positive.

2.53 We note that the topic of information security is gradually gaining attention outside of IT departments. Given its importance to entities that manage large amounts of sensitive information, a whole-of-entity approach to information security is needed.

The transition to public benefit entity accounting standards

2.54 The 2014/15 year was the first in which DHBs were required to comply with public benefit entity (PBE) accounting standards. These standards have been developed recently by the External Reporting Board[7] for entities whose primary objective is to provide goods or services for community or social benefit, and where equity has been provided to support the pursuit of this primary objective rather than a financial return. The new standards require DHBs to consider how they account for revenue and expenditure, using new definitions. Because we were aware that this could require some time and effort on the part of DHBs, we reminded them of the need to prepare for the new standards.

2.55 In general, we found that DHBs were poorly prepared for the transition to the PBE accounting standards, and additional time and effort were needed in the audit to ensure that DHBs accounted for their revenue appropriately.

2.56 It is essential that public entities apply accounting standards correctly so that people can rely on the accuracy of their reported information, and can compare the performance of one entity with another.

2.57 Despite these problems, the transition to the new PBE accounting standards did not much affect the DHBs' financial results. The transition had no opinion implications, and all DHB audits were completed on time.

7 The External Reporting Board is an independent Crown entity responsible for developing and issuing accounting and auditing and assurance standards in New Zealand.

2.58 This will remain a focus for auditors in 2016, but we expect it to become routine as DHBs become more familiar with the new standards.

District health board reporting on appropriations

2.59 Some changes to the Public Finance Act 1989 and Crown Entities Act 2004 came into effect in 2014/15. One of them was the requirement, under section 19C of the Public Finance Act, for some Crown entities to report information about appropriations if this was required explicitly in the Estimates of Appropriation. The Estimates for DHBs are set out in Vote Health, which specified DHBs as performance reporters for some appropriations.

2.60 As the appropriation administrator for Vote Health, the Ministry is responsible for ensuring that the relevant health-related entities are aware of their reporting obligations. During 2014/15, the Ministry did not communicate adequately with DHBs about their obligations to report. As a result, DHBs did not report the required information. However, the aggregated information for all DHBs is included in the Minister's reporting (as required by section 19B of the Public Finance Act). The Ministry's annual report also includes a reference to where the information can be found.

2.61 DHBs disclosed the non-reporting in their annual reports and also stated where the information could be found.

2.62 We recommended that the Ministry ensure that it communicate adequately with DHBs in future on their reporting requirements, so that they can report the information required by legislation.

Canterbury District Health Board Facilities Development Project – new governance model

2.63 The Canterbury District Health Board Facilities Development Project, which includes redevelopment at Burwood Hospital and the construction of the Acute Services Building at Christchurch Hospital, is the largest single investment in public health facilities ever made in New Zealand. The overall cost is expected to be about $650-700 million.

2.64 The Government established a Hospital Redevelopment Partnership Group, which includes representation from Canterbury DHB and the Ministry, and independent members to provide governance oversight of the project. The Ministry is taking a central role in management of the project. Previously, hospital building construction projects were managed and governed by DHBs.

2.65 When this role was given to the Ministry in 2013, it was a new role. The Ministry has had to build this capability and will need to continue to build capacity to reflect the additional projects it is delivering. We understand that the Ministry will soon hand over the completed Burwood Hospital to Canterbury DHB.

2.66 In our report *Governance and accountability for three Christchurch rebuild projects*, we examined the new governance model as it applied to the construction of the Acute Services Building. The project appeared to be progressing well, but significant risks were caused by a lack of clarity about roles and responsibilities in the new arrangements, which had been brought together hastily. We recommended that the Ministry ensure that lessons from this project and elsewhere in the public sector are applied to other projects using this model.

2.67 The construction of the new Grey Hospital for West Coast DHB currently under way and the planned Dunedin Hospital build for Southern DHB are also using this model. We will continue to monitor the governance arrangements for these projects and the Ministry's response to any recommendations arising from the review.

Asset management

2.68 DHBs rely heavily on physical assets, such as hospital buildings. DHBs have $5.7 billion invested in physical assets and plan more than $6 billion of capital expenditure in the next 10 years. During our audits in 2014/15, we noted that a number of DHBs had started or were planning major asset replacements. In at least one instance, the Dunedin Clinical Services Building belonging to Southern DHB, the replacement work was considered urgent because of difficulty maintaining the building at appropriate standards for delivering services. We also noted that some other DHBs were obliged to manage their accommodation needs carefully because they owned buildings that required earthquake strengthening.

2.69 The Ministry started requiring DHBs to prepare asset management plans in 2009. At that time, our auditors looked at how DHBs responded to the requirements. Since then, we have reported concern about whether DHBs have the asset management information they need to support the delivery of health services that depend on assets.

2.70 We decided to take a more in-depth look into the state of DHB assets and the approach that DHBs are taking to manage them. To inform our work, we analysed all DHBs' reported financial results and forecasts that were relevant to how they managed their assets. We also collected, as part of our 2013/14 audits, information about how DHBs manage two classes of assets: their buildings and clinical equipment. We also analysed information provided by the Ministry and the Treasury from recent initiatives to improve asset management.

2.71 Effective asset management begins with a good understanding of each DHB's population, current asset base, and future service needs – and a sound asset management plan to support future service delivery.

2.72 Among our findings were that:

- about two-thirds of DHBs have not substantively updated their asset management plans since 2009;
- DHBs tend not to specify the levels of service they expect from their assets and, as a result, reporting on asset performance is generally weak;
- DHBs generally do not systematically collect, maintain, analyse, and use asset information, particularly on clinical equipment; and
- there is limited reporting to governors and senior managers about the performance and condition of assets.

2.73 We also looked at capital expenditure management in DHBs, because of its connection with asset management. We found that:

- there has been sizable over-budgeting or under-spending of capital, suggesting that the DHBs might not be investing the capital needed to continue to deliver their services in the future; and
- almost half of all capital expenditure is funded externally rather than from DHBs' operating cash flows, indicating that DHBs rely heavily on funding from the Crown to renew and replace assets.

2.74 These results lead us to ask how well DHBs are positioned to support future service delivery and financial decision-making. Our audit results depict DHBs focused on delivering short-term results. In our view, the DHBs will need to take a longer-term perspective on health services and associated capital investment and asset management.

2.75 We expect DHBs to give more attention to their asset management, and a number of them have told us of their commitment to improving in this respect. DHB asset management practitioners told us about the part that they expect the Health Asset Management Improvement Group, formed in 2015, to play in this.

2.76 We also recommended that the Ministry and the Treasury provide support to help DHBs to improve, and consider how to provide incentives for DHBs to balance short-term results with longer-term service and asset management needs. We were told that complying with the 2015 Cabinet Office Circular on *Investment Management and Asset Performance in the State Services* is an important component of this. We will continue to monitor DHBs' asset management.

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

2.77 In annual audits, our auditors comment on the management control environment, financial information systems and controls, and performance information and associated systems and controls. We assign grades for each of these three aspects to reflect the scale of our recommendations for improvement. The grades are based on the accountability documents relating to the particular year. They are not an assessment of overall management performance, or of an entity's effectiveness in achieving its financial and service performance objectives. Figure 2 provides explanations for each grade we assign.

Figure 2
Grading scale for assessing public entities' environment, systems, and controls

Grade	Explanation of grade
Very good	We have made no recommendations for improvement.
Good	We have recommended that some improvements be made.
Needs improvement	We have recommended that major improvements be made at the earliest reasonable opportunity.
Poor	We have recommended that fundamental improvements be made urgently.

2.78 Overall, the grades assigned show that the health sector entities have generally maintained sound management and financial controls, and have improved their performance information and associated controls.

2.79 Figure 3 shows the spread of grades for DHBs against all three aspects in 2014/15.

Figure 3
Environment, systems, and controls grades for district health boards, 2014/15

Grade	Management control environment	Financial information systems and controls	Performance information systems and controls
Very good	2	0	1
Good	16	18	17
Needs improvement	2	2	2
Poor	0	0	0

2.80 We include the results of our assessments in our audit reporting to management and governing boards. We also report the results to the Minister, the Ministry (as the monitoring department), the three central agencies,[8] and Parliament's Health Committee.

2.81 Grades for a particular entity can fluctuate from year to year depending on several factors, such as changes in the operating environment, applicable standards, good practice expectations, or the auditor's emphasis. For example, a downward shift in a grade might not show deterioration – the entity might have simply not kept pace with good practice in similar entities from one year to 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.

2.82 Appendix 2 sets out the grades for 2014/15 and the previous year for each DHB.

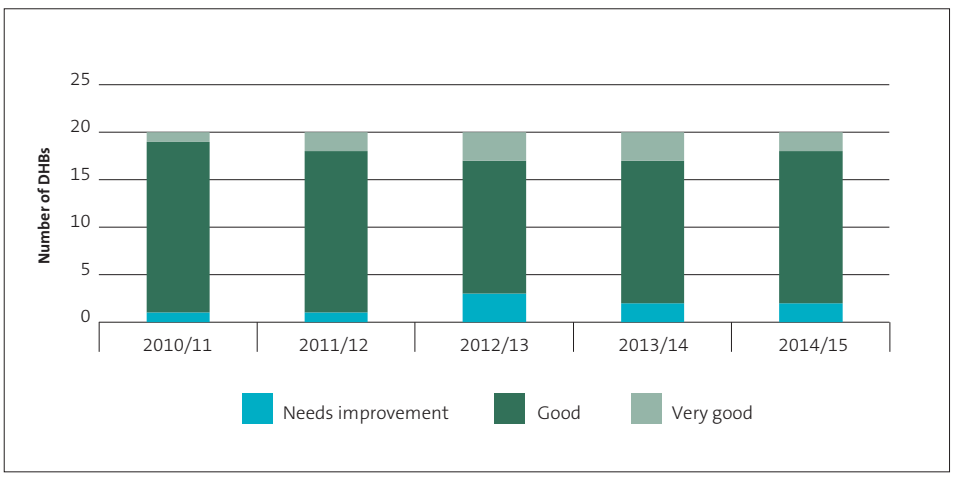
Grades for district health boards

2.83 In this section, we discuss the 2014/15 grades and five-year trends in grades for DHBs' management control environment, financial information systems and controls, and service performance systems and controls.

Management control environment

2.84 Figure 4 sets out the grades for the DHBs' management control environment for the last five years.

Figure 4
District health boards' management control environment grades, 2010/11 to 2014/15



8 The three central agencies are the State Services Commission, the Treasury, and the Department of the Prime Minister and Cabinet.

2.85 The grades for DHBs' management control environment show reasonably consistent results with small changes over the five years covered. The number of DHBs graded as "very good" has fallen from three to two in 2014/15, with a corresponding rise in the number graded as "good", from 15 to 16. Two DHBs were graded "needs improvement".

2.86 We changed the grade for Canterbury DHB from "very good" to "good" because we noted some improvements that should be made. They included revisiting the budget assumptions from the earthquake repair programme and facilities rebuild, and management reviewing and obtaining board approval for the capped inter-district flow agreement with West Coast DHB, which sets the cost that Canterbury DHB charges for clinical services provided to West Coast residents.

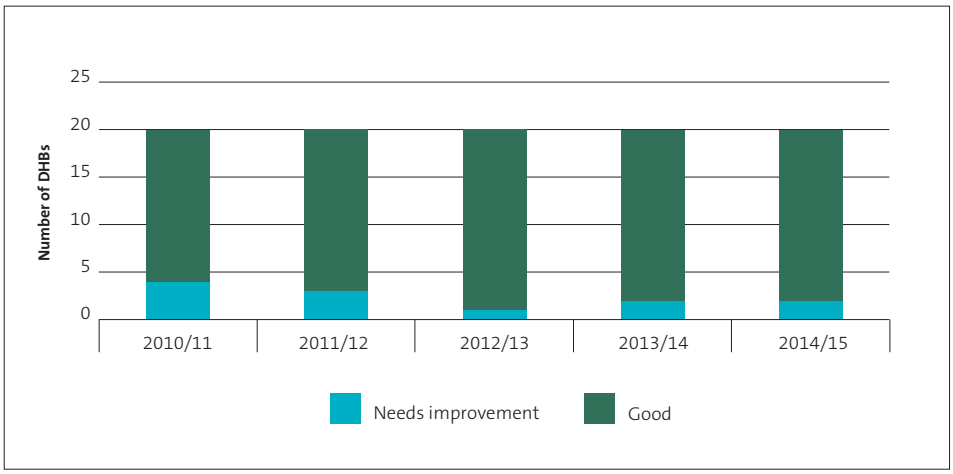
2.87 All other grades remained the same as in 2013/14.

2.88 The most common recommendations were for DHBs to improve their policies and processes for procurement and contract management, ensuring that they have adequate reporting frameworks for contracted providers of healthcare services. Recommendations also included reviewing and monitoring contracts to ensure reporting on quality as well as quantity; training staff in formal processes for procurement and contract management; and strengthening controls to mitigate risk of conflicts of interest, internal or with contracted parties.

Financial information systems and controls

2.89 Figure 5 sets out our grades for DHBs' financial information systems and controls for the last five years.

Figure 5
District health boards' financial information systems and controls grades, 2010/11 to 2014/15



2.90 The grades for DHBs' financial information systems and controls have shown improvements since 2011, with the number of "needs improvement" grades falling from four to two. All the DHBs retained their grades from 2013/14 to 2014/15.

2.91 Two DHBs, Southern and Wairarapa, were rated as "needs improvement".

2.92 For Southern DHB, we noted serious weaknesses in the budget and forecasting processes. We also observed that the very long time it has taken to finalise budgets with the Ministers of Health and Finance contributes to these weaknesses. Its annual plan for 2014/15 was not signed by the end of 2014/15, and its 2015/16 annual plan was not signed until March 2016.

2.93 We recommended that Southern DHB make major improvements to its financial systems and controls as soon as reasonably possible.

2.94 We made other recommendations to DHBs for improving their financial systems and controls:

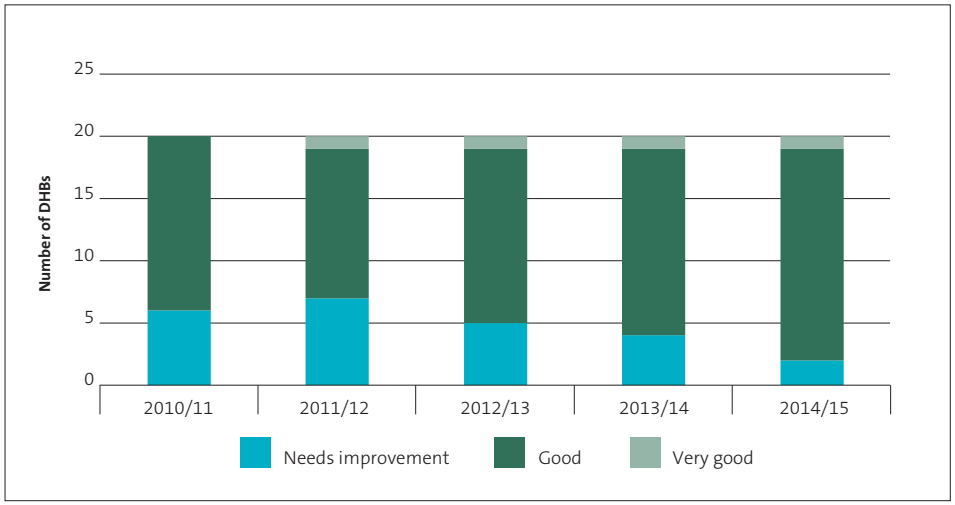
- we advised some DHBs in shared-services arrangements to consider additional reporting or assurances, to enable the board and management to maintain appropriate controls over expenditure and delivery of services.
- we recommended that some DHBs review their processes to ensure that provisions and accruals are accurately disclosed in the draft financial statements and that the amounts are in line with the supporting documents.
- we noted gaps in some DHBs' disaster recovery and business continuity planning and processes.
- We continued to note some basic IT issues with user-access controls in some DHBs.

2.95 We noted a particular risk for Wairarapa DHB, which has no support for its current financial management information system. Wairarapa DHB is expecting to move to a new system as part of NZHP's National Oracle System, but delays in completing that project has extended the period of risk substantially. We consider that other DHBs should take note, and ensure that they have measures in place to mitigate the risks should a similar transition situation arise.

Performance information and associated systems and controls

2.96 Figure 6 sets out our grades for DHBs' performance information and associated systems and controls for the last five years.

Figure 6
District health boards' performance information and associated systems and controls grades, 2010/11 to 2014/15



2.97 Our consideration of DHBs' performance information and associated systems and controls excluded the third-party performance information matter that resulted in a non-standard audit report for all DHBs. We excluded this from our consideration because it is a sector-wide matter, and we did not feel that any one DHB could make the improvements that are needed.

2.98 The third-party performance information matter aside, this is the most improved aspect of DHBs' control environment and information in the last five years. There was further improvement in 2014/15, with two more DHBs moving from "needs improvement" to "good". Wairarapa and Tairāwhiti DHBs remained at "needs improvement". For Wairarapa DHB, this was because of the lack of evidenced controls that we could rely on in auditing its performance information. In the case of Tairāwhiti DHB, we identified improvements that the DHB could make to the way it reports on outcomes, impacts, and outputs, so that readers of its annual report can gain a better understanding of its performance.

2.99 All the other DHBs retained the grading they received in 2013/14.

Grades for the Ministry and other Crown entities

2.100 The grades for the Ministry and the health sector Crown entities were all "good" or "very good" in 2014/15. This means that, in general, these entities maintained robust systems and controls during 2014/15, and that our auditors did not find any major concerns. For entities assessed as "good", we recommended improvements. We excluded the sector-wide issue about third-party performance information reporting from our grading of performance information and associated systems and controls when assessing the Ministry.

2.101 The grades for the Ministry, the New Zealand Blood Service, and the Health Promotion Agency were unchanged from the previous year. The New Zealand Blood Service maintained "very good" grades for all three aspects for the fourth consecutive year.

2.102 The Health Research Council moved from "very good" to "good" for its financial systems and controls because we assessed the new system the Council uses to manage research contracts, which went live in September 2014, as needing some additional processes.

Audit results for regulatory authorities

2.103 We audit the 16 regulatory authorities (see Appendix 1) whose members are appointed by the Minister under the Health Practitioners Competence Assurance Act 2003. We also audit two secretariats, which each support two or three of the authorities.

2.104 The regulatory authorities are responsible for the registration and oversight of health professions. Each authority prescribes scopes of practice and required qualifications for its profession, registers practitioners, and issues annual practising certificates. The authorities are funded by their professions through membership fees.

2.105 In our previous health sector report, for 2012/13, we discussed the lengthy period of uncertainty for the authorities as they considered a proposal to establish a shared secretariat organisation. We considered that both the prolonged uncertainty and any eventual transition created risks to the entities' control environments, which would need to be managed carefully.

2.106 We understand that the authorities have decided not to proceed with the shared secretariat option.

2.107 The three regulatory authorities with June or September balance dates began using the new PBE accounting standards in 2014/15. They were well prepared and the audits went smoothly as a result.

3 Financial performance of district health boards

3.1 In this Part, we describe:

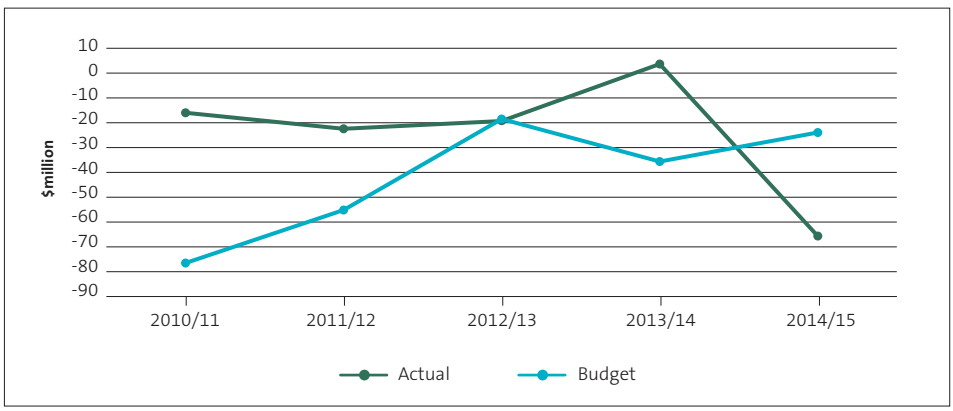
- the 2014/15 financial results for each DHB, and the overall financial sustainability of DHBs;
- the monitoring of DHBs;
- our analysis of DHBs' financial statements from the last seven years to understand their financial health; and
- our consideration of the effect of DHBs' fixed costs of capital.

Financial results

3.2 Vote Health 2014/15 was the second largest Vote in the Government's Budget, with appropriations totalling $15.6 billion ($14.7 billion in 2013/14). The total budget for the provision of health services fully devolved to the DHBs for 2014/15 was $11.5 billion ($11.2 billion in 2013/14) as per the 2014/15 Supplementary Estimates of Appropriations. DHBs received about 2.3% additional funding from the Ministry of Health in 2014/15 (the additional funding in 2013/14 was a 3.5% increase.)

3.3 Figure 7 shows the aggregate financial results for the DHBs over the last five years, comparing the actual surplus/deficit with that budgeted for each year. The 2012/13 figure excludes insurance pay-outs to Canterbury DHB in that year of $294.7 million, as this was a one-off event that would have distorted the overall result.

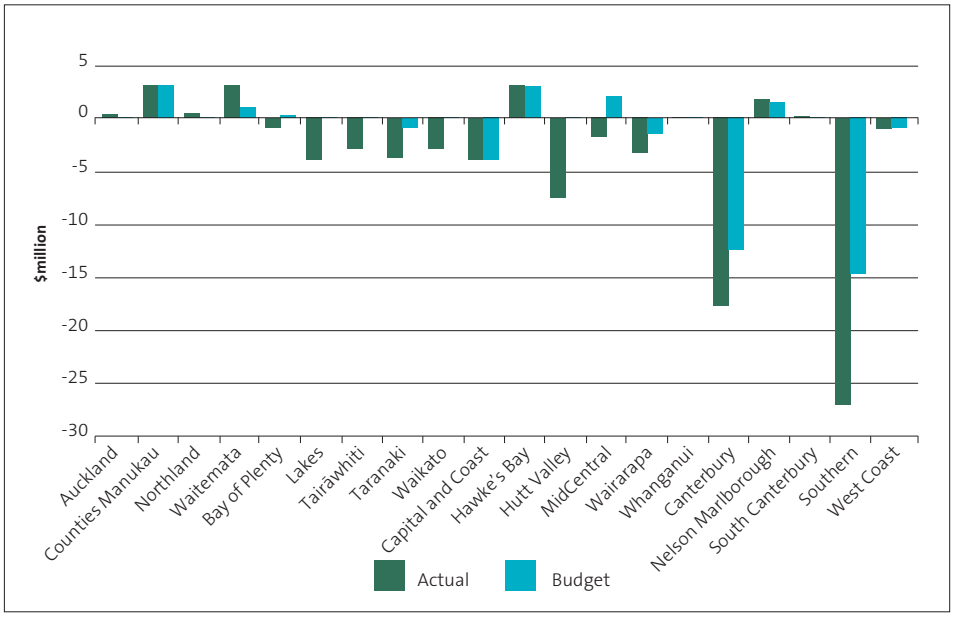
Figure 7
Comparison of district health boards' budgeted and actual surplus/deficit (aggregated), 2010/11 to 2014/15



3.4 The financial performance of DHBs was relatively stable between 2010/11 and 2013/14, with actual aggregate results better than or close to budget in each year. This deteriorated significantly in 2014/15, when the aggregate result was a much higher deficit than budgeted. The main contributors to this deterioration were the results for Southern DHB and Canterbury DHB. The larger deficit in 2014/15 for Canterbury DHB is partly due to the Government's decision to fund the budgeted deficit through additional equity rather than as revenue as it had in 2014, enabling Canterbury DHB to break even that year.

3.5 Figure 8 shows the budgeted and actual financial results for each of the DHBs for 2014/15.

Figure 8
Financial results for district health boards, 2014/15



3.6 Figure 8 shows some variability, but results were generally worse than budget. The two largest deficits were those of Southern DHB ($27.2 million) and Canterbury DHB ($17.9 million).

3.7 Financial sustainability remains an ongoing concern, given the ageing population, ongoing staff salary negotiations, and generally higher public expectations regarding service. DHBs are under pressure to deliver more during a period of constrained increases in funding.

3.8 DHBs reported an overall deficit of $65.6 million for 2014/15 against a budgeted deficit of $23.9 million. Appendix 3 sets out the financial results of each individual DHB for 2014/15.

3.9 DHBs are expected to make efficiencies through collaboration with other DHBs – for example, regionally and sub-regionally – and by using shared service agencies such as NZHP. They are also expected to increase service delivery in many areas – for example, to meet the national health targets.

3.10 The pressure on DHBs to achieve a break-even position creates continuing business and audit risks for many DHBs.

3.11 Although the deficits of some individual DHBs are decreasing compared with previous years, a number of DHBs remain under significant financial pressure. Having said this, we included an emphasis of matter paragraph relating to going-concern status in only one DHB's audit report. That was Southern DHB, which has a deteriorating financial position. Some other DHBs had received a letter of support from the Ministers of Health and Finance, which in some cases was a factor in our assessment of their going-concern status, but was not significant enough to require specific mention in the audit report.

Monitoring of district health boards

3.12 The Ministry grades each DHB according to the intensity of the "watch" on which it has placed the DHB. This is primarily (but not entirely) a reflection of the financial performance of the DHB. Figure 9 shows the Ministry's latest risk gradings of each DHB.

Figure 9
Ministry of Health's risk gradings of district health boards, April 2016

Northern region	
Auckland	Standard Monitoring
Counties Manukau	Standard Monitoring
Northland	Standard Monitoring
Waitemata	Standard Monitoring
Midland region	
Bay of Plenty	Standard Monitoring
Lakes	Performance Watch
Tairāwhiti	Standard Monitoring
Taranaki	Performance Watch
Waikato	Performance Watch
Central region	
Capital and Coast	Intensive
Hawke's Bay	Standard Monitoring
Hutt Valley	Intensive
MidCentral	Performance Watch
Wairarapa	Intensive
Whanganui	Standard Monitoring

South Island region	
Canterbury	Single Event
Nelson Marlborough	Standard Monitoring
South Canterbury	Standard Monitoring
Southern	Intensive
West Coast	Intensive

Source: Ministry of Health

3.13 Financial sustainability will continue to be an area of audit focus in 2015/16.

Financial structure of district health boards

3.14 In our last two health sector reports, for the results of the 2011/12 and 2012/13 audits, we reported on the financial health of DHBs using information from the audited financial statements. In both reports, we noted that DHBs were operating in a challenging environment. In our last report, we stated that the focus on delivering short-term results might limit the ability of DHBs to respond to unexpected events or exploit opportunities without recourse to the Crown.

3.15 Since publishing those two reports, we have seen serious financial difficulties experienced by Southern DHB and, to a lesser extent, by Canterbury DHB. Our recent report on DHBs' asset management also questioned how well DHB's asset management practices support future service delivery and financial decision-making.[9]

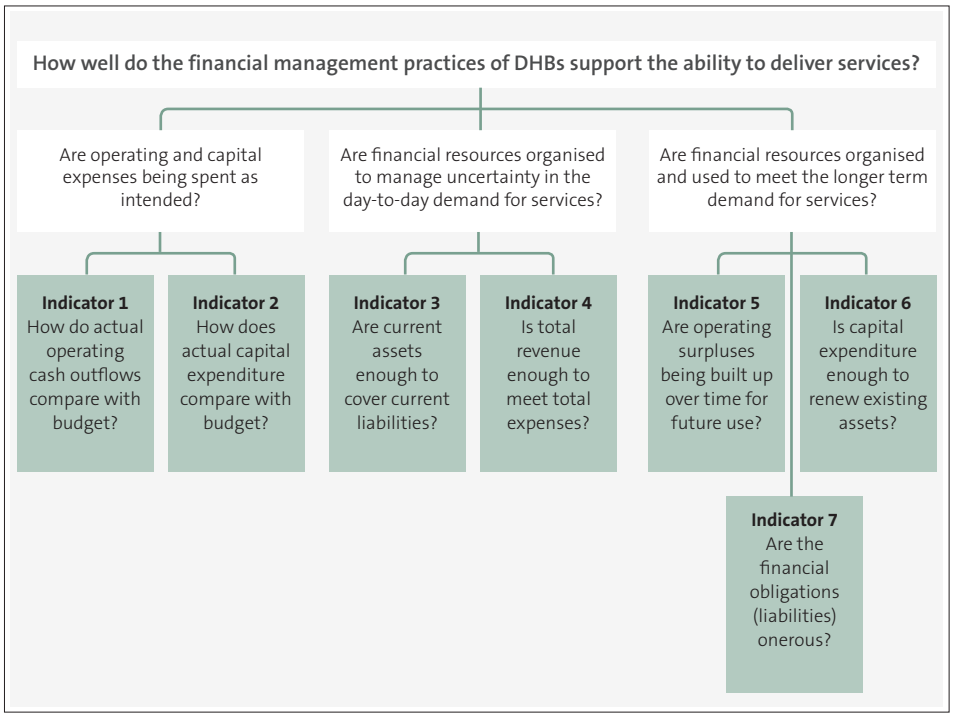
3.16 In this report, we again examine parent data[10] in the audited financial statements of DHBs for the last seven years to find out how well the sector's financial structure supports the delivery of health services. By financial structure, we mean the way financial resources are planned for, organised, and allocated.

3.17 Although the sector's financial resources are only one part of the service delivery chain, if they are not well planned for, organised, and allocated, the ability to provide a resilient and enduring service could be constrained in times of uncertainty and change. Figure 10 sets out the questions we asked to inform our review.

9 *District health boards' response to asset management requirements since 2009*, available at www.oag.govt.nz.

10 In a few instances, where no parent data is available, we use group data.

Figure 10
Questions and criteria for reviewing DHBs' financial management practices



3.18 This approach is consistent with our previous health sector reports, except that Indicator 4 (whether total revenue covers total expenses) replaces an earlier indicator of ongoing (or fixed) costs in the review of DHBs' ability to manage uncertainty. The change reflects the importance of having an operating buffer in times of uncertainty, and the difficulty in assessing what costs are fixed, as a large proportion of DHB spending is contracted through other health service providers.

3.19 Our analysis for each indicator is summarised using graphs, which we present in Figures 12-18. Each dot represents one DHB for a particular year. We chose to present the results in this way to show how the DHBs move over time as a group, and whether the outliers show significantly different results. We can show this outlier effect more clearly when we present the results in this way.

3.20 The graphs cover the period from 2008/09 to 2014/15. In preparing our graphs, we specified ranges within which we consider it reasonable to expect entities to function. For example, Indicator 1 compares actual operating expenditure with budgeted operating expenditure. For this indicator, we have set less than plus or minus 5% as our "reasonable" range, and more than plus or minus 10% per cent as outside our reasonable range. Ratios that are between 5% and 10% are difficult to apportion as being either within or outside a reasonable range and are therefore uncertain. Figure 11 summarises these ranges for each indicator.

Figure 11
Target ranges for our review of the financial structure of district health boards

Indicator	Outside a reasonable range	Uncertain (neither within nor outside)	Within a reasonable range
1. Actual versus budget operating cash outflows	More than +/-10%	Between +/-5% and +/-10%	Less than +/-5%
2. Actual versus budget capital expenditure	More than +/-20%	Between +/-10% and +/-20%	Less than +/-10%
3. Current assets to current liabilities	Below 50%	Between 50% and 90%	Above 90%
4. Net income to total revenue	Below 0%	Between 0% and 1%	Above 1%**
5. Retained earnings to total assets	Below 0%	Between 0% and 10%	Above 10%
6. Capital expenditure to depreciation*	Below 100%	Above 200%	Between 100% and 200%
7. Total liabilities to total assets	Above 70%	Between 50% and 70%	Below 50%

* Ideally, we should compare depreciation with renewals-related capital expenditure only, but this information is not available in the financial statements of DHBs.
** If net income to total revenue becomes too high, this may also be a sign of poor planning or control.

3.21 The ranges are based on general accounting relationships and might not always be appropriate for a particular DHB at a particular point in time. However, throughout the sector and over time, they provide an indication of management's focus on and control over the way financial resources are being planned for, organised, and allocated. For example:

- a high "Total liabilities to total assets" ratio (above 70%) suggests that management might need to spend a disproportionate amount of time managing these liabilities; and
- a "Net income to total revenue" ratio of less than 0% suggests that the annual expenses of DHBs were greater than the annual revenue they received. This position is not sustainable over time.

How well are the district health boards operating as planned?

3.22 Overall, the indicators suggest that the sector's ability to operate as planned is mixed.

3.23 Figures 12 and 13 summarise how well the sector is operating as planned. Indicator 1 (actual versus budget operating cash outflows) shows how well operating expenditure is budgeted for and spent throughout the sector. Indicator 2 (actual versus budget capital expenditure) is similar to Indicator 1, but instead shows how well capital expenditure is budgeted for and spent throughout the sector. For both indicators, a ratio of 0% shows that DHBs spent exactly what

they budgeted for in that year. This is a change to our previous health sector reports, where we showed budget as a proportion of actual expenditure. We made this change for consistency with our recent reports on other sectors, and because it enables us to show very low expenditure against budget, as can be seen particularly in Figure 13.

Figure 12
How district health boards' actual operating cash outflows compare with budget, 2008/09 to 2014/15

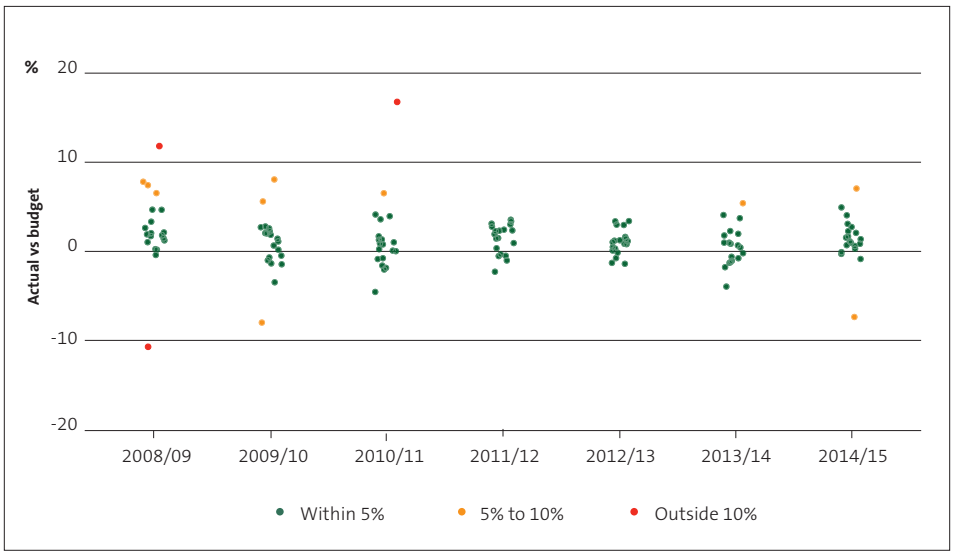
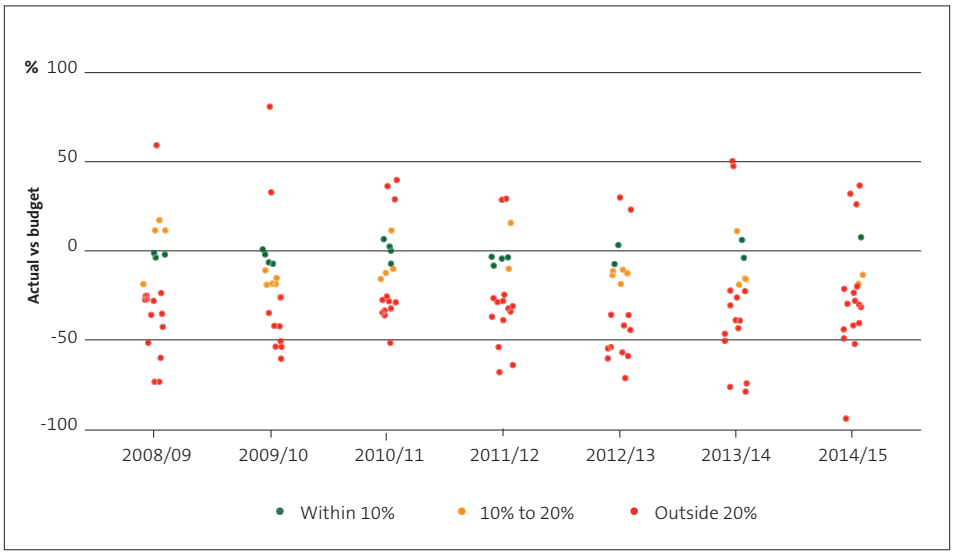


Figure 13
How district health boards' actual capital expenditure compares with budget, 2008/09 to 2014/15



3.24 As we have found in our previous health sector reports, DHBs are generally good at budgeting their operating expenditure but consistently under-spend on (or over-budget for) their capital expenditure programme. In 2014/15, there were two relatively large under-spending (operating and capital) outliers, both at West Coast DHB and both relating to the hospital redevelopment in Greymouth, which did not go ahead as expected during 2015.

3.25 In 2014/15, Counties Manukau DHB reportedly over-spent its capital budget, spending about $16 million more than expected on property, plant, and equipment and intangible assets. In the DHB's financial statements, this line item also included sales of assets, which are normally disclosed separately but in this case offset (reduced) the reported budgeted capital expenditure line. These sales mainly related to a potential sale of land that had been budgeted for, and reporting a separate budgeted number for asset sales would have been commercially unwise. The year-end variance was because the sale of this land did not occur during 2014/15 because the necessary clearances could not be obtained.

How well can district health boards manage uncertainty?

3.26 Overall, the indicators relating to managing uncertainty suggest that DHBs' resilience has declined slightly in the last two years.

3.27 Figures 14 and 15 summarise DHBs' ability to manage uncertainty. Indicator 3 (current assets to current liabilities) shows whether current assets (such as cash, or accounts receivable) are enough to cover current liabilities (such as accounts payable, or current portion of debt). A ratio of less than 90% means it may be difficult for current assets to cover current liabilities. Indicator 4 (net income to total revenue)[11] shows whether annual revenue is sufficient to cover annual expenses. A ratio of less than 0% means that annual revenue was not sufficient to cover annual expenses.

11 Net income is calculated as revenue less expenses and is before comprehensive income (which includes revaluation gains and losses).

Figure 14
District health boards' current assets to current liabilities range, 2008/09 to 2014/15

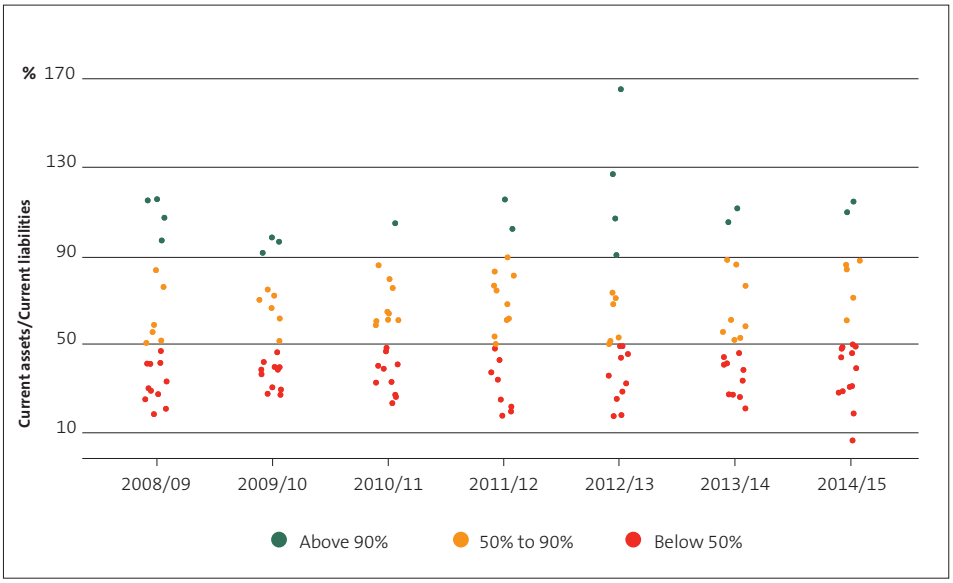
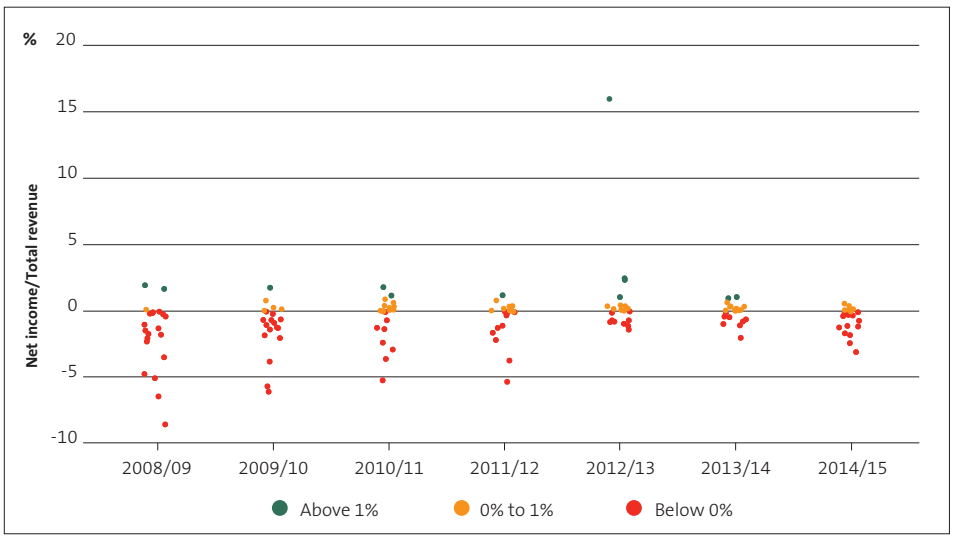


Figure 15
District health boards' net income to total revenue range, 2008/09 to 2014/15



3.28 The ability of the sector to cover its current liabilities with current assets has declined slightly over the last two years, and management of working capital remains an area of focus for most DHBs.

3.29 In 2014/15, Tairāwhiti DHB's current assets could cover only about 7% of its current liabilities. The low current asset position arose because of an unexpected cash flow deficit, which was financed with a short-term loan through HBL.

3.30 From 2008/09 to 2012/13, DHBs' overall net surplus/deficit steadily improved, but in the last two years, DHBs have largely moved back into deficit again.

3.31 In 2014/15, 13 of the 20 DHBs had net deficits for the year. In the last three years, Southern DHB has had the largest deficit in the sector – in 2014/15 this was 3.1% of its total revenue. The large net surplus outlier in 2012/13 was the result of a one-off insurance receipt by Canterbury DHB.

How well can district health boards invest for the future?

3.32 Overall, these indicators suggest that DHBs' ability to invest for the future continues to be limited (without recourse to the Crown).

3.33 Figures 16-18 summarise how well DHBs are able to invest for the future. Indicator 5 (retained earnings to total assets) shows the accumulated surpluses or deficits that the DHBs have incurred over time. A ratio of less than 0% suggests that no savings are available for future projects or programmes.

3.34 Indicator 6 (capital expenditure to depreciation) shows whether the level of capital expenditure matches the estimated consumption of, or the cost of using up, assets (that is, depreciation). When capital expenditure is less than depreciation over time, this can suggest insufficient spending on the renewal or replacement of existing assets. When capital expenditure is more than depreciation over time, this can reflect large new capital expenditure programmes. When it is considerably more, this is more uncertain and could also reflect limited long-term planning.

3.35 Indicator 7 (total liabilities to total assets) shows the level of liabilities DHBs are exposed to. A ratio of more than 70% means that management might need to spend a disproportionate time managing liabilities.

Figure 16
District health boards' retained earnings to total assets range, 2008/09 to 2014/15

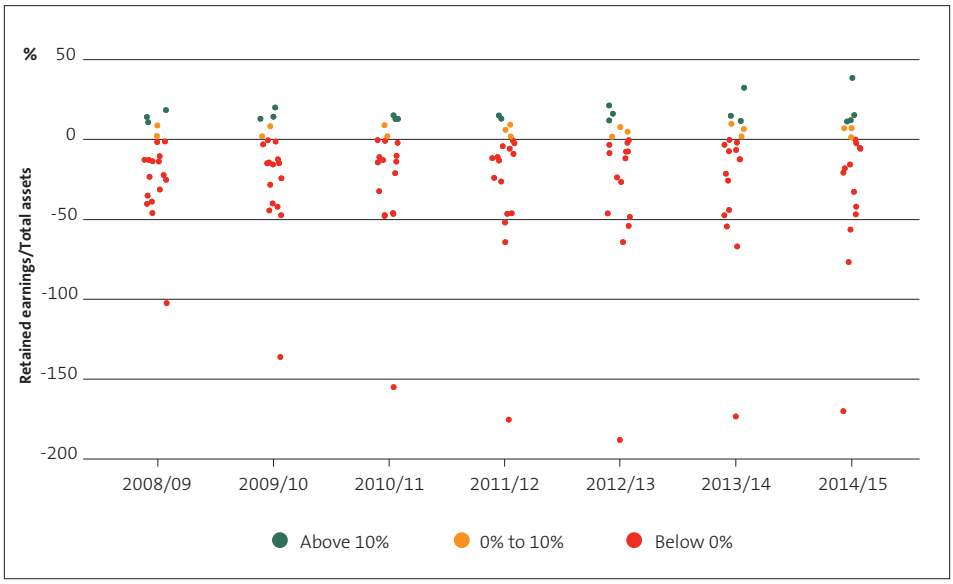


Figure 17
District health boards' capital expenditure to depreciation range, 2008/09 to 2014/15

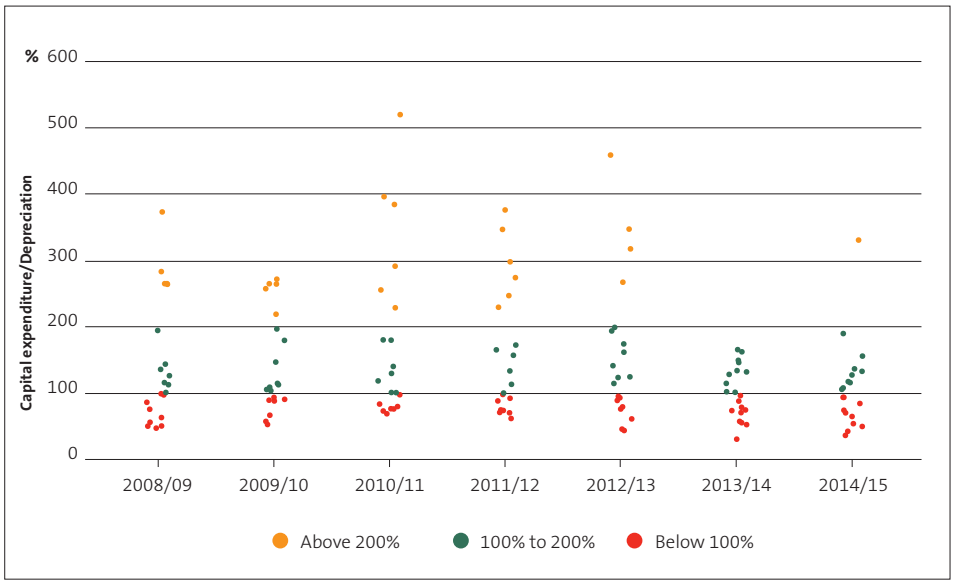
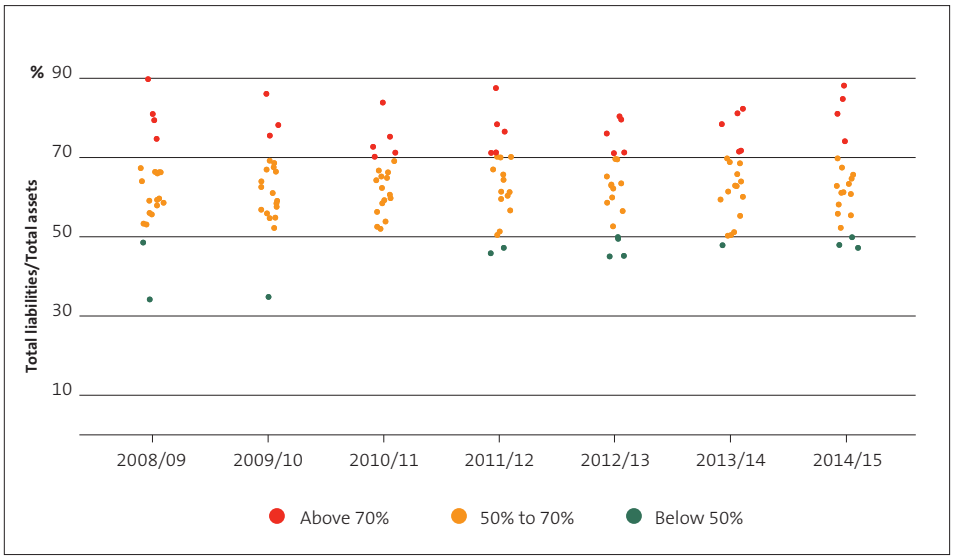


Figure 18
District health boards' total liabilities to total assets range, 2008/09 to 2014/15



3.36 The proportions of DHBs' retained earnings and liabilities have not changed materially since our previous health sector report. Most DHBs continue to fall outside what we would consider a reasonable range. We show that the magnitude and volatility of capital expenditure relative to depreciation is quite high for many DHBs from 2008/09 to 2012/13. For example, for each year from 2008/09 to 2011/12, at least five DHBs had capital expenditure levels that were more than 200% of depreciation. For 2013/14 and 2014/15, the indicator has stabilised but has also fallen largely outside of what we would consider a reasonable range.

3.37 Every year since 2008/09, Wairarapa DHB has had the highest proportion of liabilities compared with assets among DHBs, most of which are long-term loans from the Crown. Every year since 2008/09, West Coast DHB has had the lowest proportion of retained earnings to assets in the sector.

Managing fixed costs of funding

3.38 There are two fixed costs that DHBs must pay to Government for the use of funds provided by the Government. The first is a capital charge levied on the Crown's investment (that is, DHB equity or total assets less total liabilities) in each DHB at a rate of 8% per annum. The second is the interest charged on loans provided by the Government, including the refinancing of private sector debt in the early 2000s. The interest rate reflects New Zealand Government Bond rates, which vary. In 2015 it was about 3%.

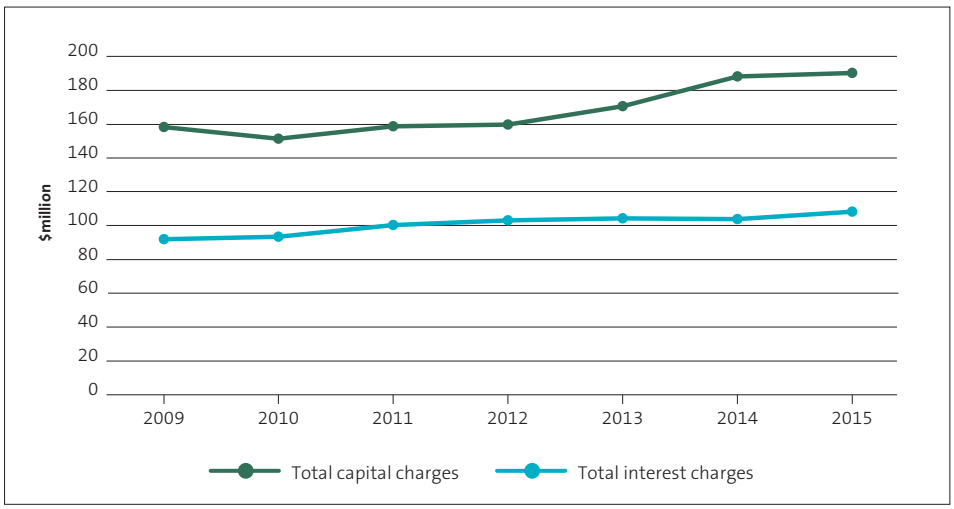
3.39 For DHBs, the presumption is that any additional capital charges associated with new Crown funding or any operating surpluses will be funded from DHBs' existing baselines. Additional funding is automatic for increases associated with rate changes, revaluations, and accounting policy changes.

3.40 The Treasury states that charging for the use of Crown funding can be an effective tool to improve capital management and transparency.[12] However, a review of various reports and commentaries suggest that the effectiveness of charging for Crown capital remains uncertain[13] and we are unaware of any published review of the effectiveness of Crown-based debt funding of DHBs.

3.41 Our observations and commentary below is provided to encourage more debate about how the charging for Crown funding is affecting the financial and asset management practices of DHBs. It is not a full and detailed review of the capital charge regime or the use of Crown-based debt funding.

3.42 Figure 19 shows how much the DHBs paid the Government in capital charges and interest from 2008/09 to 2014/15.

Figure 19
District health boards' annual costs of capital (capital charge and interest payments), 2008/09 to 2014/15



12 See the Treasury's report T2010/1569 *Outstanding issues with capital charge*, page 9.

13 For example, see the Treasury (2006), *Capital Asset Management Review*, pages 23 and 62; State Services Commission (2010), *Charging for Capital*, available at www.ssc.govt.nz; Rose Anne MacLeod (2010), "Charge Down", available at www.gaaaccounting.com; and Office of the Auditor-General (1995), *Third Report of the Controller and Auditor-General*, pages 104-105.

3.43 Over this period, DHBs' annual interest payments have increased by about $16 million (on average about 3% each year). The annual capital charge has increased by about $32 million (on average about 3.5% each year over this same period).

3.44 Compared to the total amount of debt and equity of all DHBs, the overall annual cost of funding has reduced from about 7% (in 2008/09) to about 6.1% (in 2014/15). This reduction mainly reflects:

- the greater use of debt funding (instead of the more expensive equity funding) to finance investments in DHB capital assets; and
- a fall in the interest rate charged on that debt. The 10-year Government Bond rate reduced from about 5% (in 2008/09) to about 3% (in 2014/15).

3.45 In 2014/15, the largest costs of funding paid were by Auckland DHB (about $56 million) and the smallest by West Coast DHB (about $1.5 million).

Are the objectives aligning with practice?

3.46 The capital charge regime was first introduced into central government in the early 1990s as one part of a wider policy to emulate market forces within government.[14]

3.47 The objectives for applying a capital charge are to ensure that "... prices for goods and services produced by government departments reflect full production costs; allows comparison of the costs of output production with those of other producers (whether in the public or private sector); and creates an incentive for departments to make proper use of working capital and to dispose of surplus fixed assets."[15]

3.48 The use of debt financing by the DHBs was seen as complementing the Crown's equity support. Much of it arose from the Crown taking over health sector debt from the private sector from the early 2000s.[16]

3.49 A 1998 article on the effects of capital charges on capital expenditure decisions in core government concluded that "great difficulties arise in applying a system of real capital charges within the core government".[17] These difficulties included:

14 See Marc Robinson, "Capital charges and capital expenditure decisions in core government", *Journal of Public Budgeting, Accounting and Financial Management*, 10(3), 354-374 (Fall 1998), page 356.

15 See *Treasury Instructions 2014*, page 35.

16 See Hon Annette King, Memorandum to Cabinet Health and Social Policy Committee 1 August 2000, "District health Board Investment and Balance Sheet Management: Further work"; and Crown Health Financing Agency *Annual Report 2005,* page 2. (The Crown Health Financing Agency was tasked with refinancing private debt.)

17 See Marc Robinson, "Capital charges and capital expenditure decisions in core government", *Journal of Public Budgeting, Accounting and Financial Management*, 10(3), 354-374 (Fall 1998), pages 361 and 364-369.

- imperfect information about the quantity and quality of each output and whether an efficient production cost can be calculated;
- the relatively fixed and consistent nature of the capital charge in an environment of uncertainty;
- conflict between two different approaches to managing entities' balance sheets in a decentralised context– a capital charge regime (a price-signalling approach) and ongoing centralised capital rationing (a quantity-rationing approach); and
- the potential bias of entities towards projects that improve cost efficiency, which helps offset the capital charge, rather than those that improve the quality of services, which does not.

3.50 The main potential benefit of the capital charge to the financial management of DHBs is to support better balance sheet management. However, where the capital charge is largely fully funded, the incentive to support better balance sheet management is limited. Furthermore, in those cases where the capital charge is not fully funded, the ability to adjust net assets in response to changing capital charges is also limited because DHBs have little surplus assets to make a capital repayment (such as cash) and their larger capital assets (such as hospital buildings or clinical equipment) cannot be easily reduced in size or value.

What is happening in other countries?

3.51 We understand that, in the United Kingdom, capital charging still applies in the National Health Service[18] but that it was removed from departments' budgets and accounts in 2009/10 because "... although the cost of capital charge was an important step when first introduced, other incentives ... have now become more significant in promoting improved asset management."[19]

3.52 In Australia (at federal and state levels), the capital charge was largely discontinued over the period from 2003 to 2007. The Western Australia Government's Department of Treasury and Finance (DTF) noted in 2006 that the capital user charge (CUC) "... has proved a difficult concept to apply in the public sector, as evidenced by the removal of the CUC by all other Australian jurisdictions except Victoria ... and ... the charge has not led to noticeable improvements in the asset management practices of agencies. The charge has also proved to be administratively burdensome from both an agency and DTF perspective."[20]

18 See the National Audit Office report *The financial sustainability of NHS bodies*, November 2014, pages 37-38.

19 HM Treasury March 2009 "Alignment (Clear line of sight) project", page 43.

20 Victoria State Government's Department of Treasury and Finance, Discussion Paper, Replacement of the Financial Administration and Audit Act by the Financial Management Act and the Auditor General Act, November 2005, page 9; and Department of Treasury and Finance, provision of additional information, 17 February 2006, page 11. (excerpts taken from Department of Treasury and Finance to the Public Accounts Committee Report 3, 2006).

3.53 Western Australia's reasons for discontinuing its capital charge regime are similar to the reasons given for discontinuing the scheme at the Commonwealth and other state government levels.

3.54 In 2006, the Western Australia Office of the Auditor General also noted that the capital user charge "... increased the risk of agencies manipulating their cash balances to minimise their exposure to this charge."[21]

What are we observing in New Zealand?

3.55 It is clear that DHBs devote considerable time to managing the implications of the capital charge on Crown equity and interest costs on Crown loans. For example:

- In 2005, Wairarapa DHB originally budgeted for a Crown equity drawdown of $3.9 million to fund the Wairarapa Hospital redevelopment. However, in its annual report, the DHB noted this was not required as the DHB was able to draw down debt at a lower interest rate than the capital charge rate at the time.[22]
- The 2010/11-2012/13 Statement of Intent for Taranaki DHB said, "... expenditure ($1.44M towards capital charge and depreciation) incidental to the revaluation of assets ... carried out on 30 June 2008 continues to be charged against the hospital provider. This extraordinary expenditure has had a material impact on [Taranaki DHB's] financial and cash positions."[23]
- PricewaterhouseCoopers noted in its 2015 financial review of Canterbury DHB that the DHB avoided an increase in capital charges by transferring earthquake insurance proceeds to the Ministry and repaying equity from its reserves as a contribution to a particular project rebuild.[24]
- In Auckland DHB's *Health Improvement Plan 2006 to 2010*, the DHB sought to change its existing loan financing arrangements in a way that would "have the effect of delaying and reducing the requirement for equity injections from the Crown and consequently reduce capital charges".[25]

3.56 Various reviews also suggest that DHBs, particularly those with large capital investment programmes, face added financial management pressures because of (among other things) capital charges and interest costs.[26]

21 Submission No 2a from Office of the Auditor General, 20 February 2006, page 4.

22 Wairarapa DHB, Well Wairarapa: *Annual Report 2005*, page 16.

23 Taranaki District Health Board, *Statement of Intent 2010/11–2012/13,* page 53.

24 See PricewaterhouseCoopers (2015), *Canterbury District Health Board: Stage One Financial Review*, page 26.

25 Auckland District Health Board (2006), Health Improvement Plan 2006 to 2010, page 56.

26 See PricewaterhouseCoopers (2015); Crown Health Financing Agency (July 2009), DHB Financial Sustainability, page 5; and Office of the Auditor-General (June 2015), Briefing to the Health Committee: Vote Health, paragraph 2.2.

3.57 We have also seen a bias towards funding projects with Crown loans rather than using DHB equity. This is because, in the current environment, the interest cost (when using debt) is significantly lower than the capital charge (when using equity).

3.58 Whether the time spent on managing these costs (including the Treasury's time in administering the capital charge regime) could be better spent elsewhere would be an important part of any future review of these Crown costs of funding.

Are these costs of funding increasingly onerous?

3.59 There have been various accounts over the years of DHBs' experiencing difficulty managing interest and capital charges, and in our recent work on DHB asset management we heard from commentators that the capital charge was making investment decisions increasingly challenging. PricewaterhouseCoopers' financial review report for the Ministry of Health on Canterbury DHB also noted regarding "deficit drivers" that "a significant movement in depreciation and future capital charges over the next 5 years as the rebuild or new assets are transferred onto [Canterbury DHB's] books has a very material effect."[27]

3.60 To understand whether these costs of funding could be affecting DHBs, we looked at whether they had increased or decreased in the last seven years, as a proportion of DHB debt and equity, and revenue.

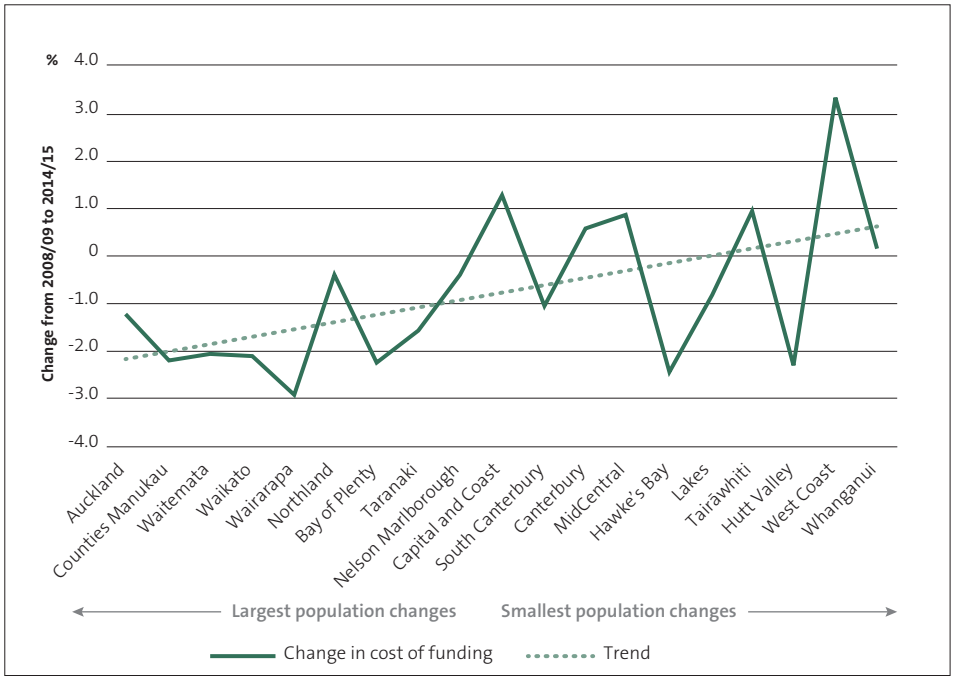
3.61 In the last seven years, the sector had seen a small reduction in these costs of funding relative to total debt and equity, and little change compared to revenue. However, when DHBs are ordered by how fast their populations have grown from 2008/09 to 2014/15 (although there was some variability), our findings suggest that:

- many DHBs in faster-growing areas had lower growth (or declines) in their costs of funding relative to debt and equity, or revenue; and
- many DHBs in slower-growing areas had higher growth in their costs of funding relative to debt and equity, or revenue.

27 See PricewaterhouseCoopers (2015), *Canterbury District Health Board: Stage One Financial Review*, page 7.

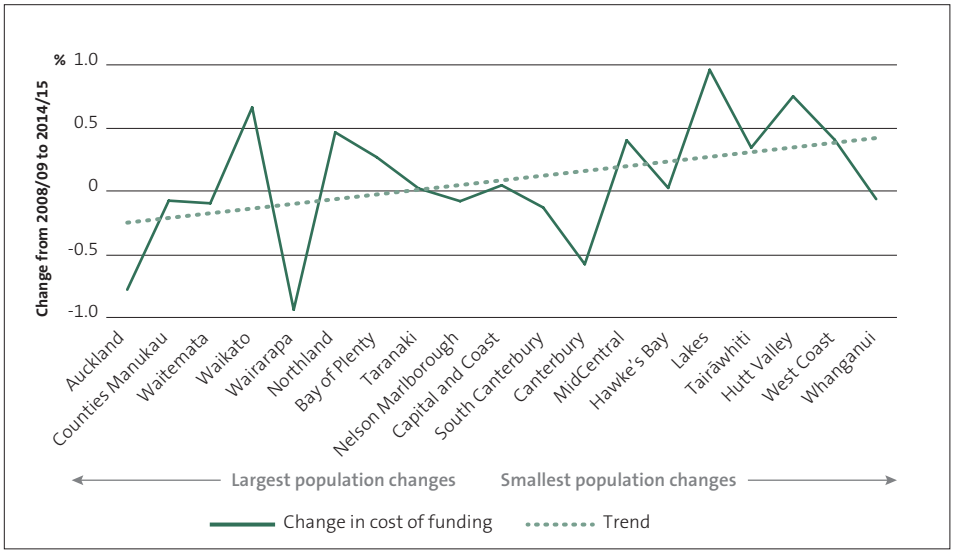
3.62 Figures 20 and 21 show these costs of funding across DHBs.

Figure 20
Changes in district health boards' costs of funding as a proportion of total debt and equity, 2008/09 to 2014/15



Note: We excluded Southern, Southland, and Otago DHBs from this analysis because Southland and Otago DHBs were merged into Southern DHB in 2010.

Figure 21
Changes in district health boards' costs of funding as a proportion of revenue, 2008/09 to 2014/15



Note: We excluded Southern, Southland, and Otago DHBs from this analysis because Southland and Otago DHBs were merged into Southern DHB in 2010.

Summary

3.63 The sector's fixed costs of funding have increased significantly since 2008/09 – particularly the capital charge. Although at a sector level, this growth is largely in line with the growth in DHB debt and equity, and revenue. It also appears that DHBs in slower-growing areas may be experiencing greater increases in the costs of funding when compared to DHBs in faster-growing areas.

3.64 Although interest on debt and the capital charge regime focuses management on the costs of the funds they use, the effectiveness of these fixed charges on capital asset decision-making remains uncertain. It would appear that, in some circumstances, considerable time is being spent on managing these fixed charges and possibly on administering the capital charge regime.

3.65 Overall, it isn't clear what the capital charge regime is achieving in the health sector. It appears to be giving DHBs an incentive to use debt funding rather than equity funding due to the higher capital charge rate. In the absence of DHBs being able to generate operating surpluses, they will need to continue to take on debt in order to fund their operating and capital needs.

3.66 There is also the possibility that changes in regional demographics are making these fixed charges increasingly onerous for DHBs in slower-growing areas, and that this may be affecting their future financial sustainability.

Appendix 1
Public entities in the health sector audited by the Auditor-General in 2014/15

Government departments
Ministry of Health
Crown entities
Health and Disability Commissioner
Health Promotion Agency
Health Quality and Safety Commission
Health Research Council of New Zealand
New Zealand Blood Service
Pharmaceutical Management Agency (Pharmac)
Crown company
Health Benefits Limited (disestablished 2015 – function taken over by NZ Health Partnerships Limited)

Health regulation authorities
Dental Council of New Zealand
Dieticians Board
Medical Council of New Zealand
Medical Radiation Technologists Board
Medical Sciences Council of New Zealand
Midwifery Council of New Zealand
New Zealand Chiropractic Board
New Zealand Psychologists Board
Nursing Council of New Zealand
Occupational Therapy Board of New Zealand
Optometrists and Dispensing Opticians Board
Osteopathic Council of New Zealand
Pharmacy Council of New Zealand
Physiotherapy Board of New Zealand
Podiatrists Board of New Zealand
Psychotherapists Board of Aotearoa New Zealand

Appendix 1
Public entities in the health sector audited by the Auditor-General in 2014/15

District health boards	District health board subsidiaries
Auckland District Health Board	Allied Laundry Services Limited
Bay of Plenty District Health Board	Auckland District Health Board Charitable Trust
Canterbury District Health Board	Brackenridge Estate Limited
Capital and Coast District Health Board	Central Region's Technical Advisory Services Limited
Counties Manukau District Health Board	Dempsey Trust
Hawke's Bay District Health Board	Enable New Zealand Limited
Hutt Valley District Health Board	healthAlliance N.Z. Limited
Lakes District Health Board	healthAlliance (FPSC) Limited
MidCentral District Health Board	Health South Canterbury Charitable Trust
Nelson Marlborough District Health Board	HealthShare Limited
Northland District Health Board	Milford Secure Properties Limited
South Canterbury District Health Board	Spectrum Health Limited
Southern District Health Board	New Zealand Health Innovation Hub Limited Partnership
Tairāwhiti District Health Board	New Zealand Health Innovation Hub Management Limited
Taranaki District Health Board	New Zealand Institute of Rural Health
Waikato District Health Board	The Kaipara Total Health Care Joint Venture
Wairarapa District Health Board	The Lakes District Health Board Charitable Trust
Waitemata District Health Board	Three Harbours Health Foundation
West Coast District Health Board	Waikato Health Trust
Whanganui District Health Board	Wilson Home Trust
Health regulation authority secretariats	
Health Regulatory Authorities Secretariat Limited	
Medical Sciences Secretariat	

Appendix 2
Environment, systems, and controls grades for district health boards, 2014/15 and 2013/14

	2014/15		
District health boards	**Management control environment**	**Financial information systems and controls**	**Performance information and associated systems and controls**
Auckland	Good	Good	Good
Bay of Plenty	Very good	Good	Good
Canterbury	Good	Good	Very good
Capital and Coast	Needs improvement	Good	Good
Counties Manukau	Good	Good	Good
Hawke's Bay	Good	Good	Good
Hutt Valley	Good	Good	Good
Lakes	Good	Good	Good
MidCentral	Good	Good	Good
Nelson Marlborough	Good	Good	Good
Northland	Good	Good	Good
South Canterbury	Very good	Good	Good
Southern	Needs improvement	Needs improvement	Good
Tairāwhiti	Good	Good	Needs improvement
Taranaki	Good	Good	Good
Waikato	Good	Good	Good
Wairarapa	Good	Needs improvement	Needs improvement
Waitemata	Good	Good	Good
West Coast	Good	Good	Good
Whanganui	Good	Good	Good

Appendix 2

Environment, systems, and controls grades for district health boards, 2014/15 and 2013/14

	2013/14		
District health boards	**Management control environment**	**Financial information systems and controls**	**Performance information and associated systems and controls**
Auckland	Good	Good	Good
Bay of Plenty	Very good	Good	Good
Canterbury	Very good	Good	Very good
Capital and Coast	Needs improvement	Good	Needs improvement
Counties Manukau	Good	Good	Good
Hawke's Bay	Good	Good	Good
Hutt Valley	Good	Good	Good
Lakes	Good	Good	Needs improvement
MidCentral	Good	Good	Good
Nelson Marlborough	Good	Good	Good
Northland	Good	Good	Good
South Canterbury	Very good	Good	Good
Southern	Needs improvement	Needs improvement	Good
Tairāwhiti	Good	Good	Needs improvement
Taranaki	Good	Good	Good
Waikato	Good	Good	Good
Wairarapa	Good	Needs improvement	Needs improvement
Waitemata	Good	Good	Good
West Coast	Good	Good	Good
Whanganui	Good	Good	Good

Appendix 3
Financial results for district health boards, 2014/15

District health boards	Revenue $000	Expenditure $000	Surplus/(deficit)		
			Actual $000*	Budget $000*	Variance $000
Northern region					
Auckland	1,917,421	1,917,066	355	27	328
Counties Manukau	1,485,966	1,482,949	3,017	3,007	10
Northland	555,698	555,582	116	0	116
Waitemata	1,541,136	1,538,118	3,018	1,000	2,018
Northern region totals	**5,500,221**	**5,493,715**	**6,506**	**4,034**	**2,472**
Midland region					
Bay of Plenty	697,513	698,503	(990)	251	(1,241)
Lakes	330,741	334,786	(4,045)	0	(4,045)
Tairāwhiti	165,014	167,988	(2,974)	0	(2,974)
Taranaki	343,402	347,189	(3,787)	(935)	(2,852)
Waikato	1,256,473	1,258,888	(2,415)	(28)	(2,387)
Midland region totals	**2,793,143**	**2,807,354**	**(14,211)**	**(712)**	**(13,499)**
Central region					
Capital and Coast	996,227	1,000,209	(3,982)	(4,000)	18
Hawke's Bay	462,348	469,888	3,054	3,000	54
Hutt Valley	140,144	143,480	(7,540)	0	(7,540)
MidCentral	496,420	493,366	(1,854)	2,049	(3,903)
Wairarapa	601,189	603,043	(3,336)	(1,491)	(1,845)
Whanganui	231,953	231,917	36	0	36
Central region totals	**2,928,281**	**2,941,903**	**(13,622)**	**(442)**	**(13,180)**
South Island region					
Canterbury	1,558,651	1,576,587	(17,936)	(12,550)	(5,386)
Nelson Marlborough	443,253	441,536	1,717	1,500	217
South Canterbury	189,748	189,568	180	67	113
Southern	883,905	911,085	(27,180)	(14,800)	(12,380)
West Coast	139,861	140,908	(1,047)	(1,000)	(47)
South Island region totals	**3,215,418**	**3,259,684**	**(44,266)**	**(26,783)**	**(17,483)**
All district health boards	**14,437,063**	**14,502,656**	**(65,593)**	**(23,903)**	**(41,690)**

Note: Figures are for the DHB group in each case.

* The surplus is before other comprehensive revenue and expense.

Appendix 4
Our recent reports relevant to the health sector

Since we published our previous health sector report in May 2014, we have published several reports on or including matters relevant to the health sector.

We published three reports relating to health, three articles reporting entities' progress on recommendations included in previous reports, and an inquiry report. We also included commentary on health sector issues in the Auditor-General's reflections reports on our recent yearly themes, *Service delivery* (2013/14) and *Governance and accountability* (2014/15), and in our report on the timeliness of public sector reporting.

All of these reports are available on our website, www.oag.govt.nz:

- *Collecting and using information about suicide* (2016)
- *Home-based support services for older people: Follow-up audit* (2016)
- *District health boards' response to asset management requirements since 2009* (2016)
- *Reflections from our audits: Governance and accountability* (2016)
- *Being accountable to the public: Timeliness of reporting by public entities* (2015)
- *Reflections from our audits: Service delivery* (2015) and its companion report, *Changes in the delivery of public services* (2015)
- *Whānau Ora: The first four years* (2015)
- *Governance and accountability for three Christchurch rebuild projects* (2015)
- *Delivering scheduled services to patients – progress report* (2015)
- *Home-based support services for older people – progress report* (2014)
- *Inquiry into Health Benefits Limited* (2015)
- *District health boards: Availability and accessibility of after-hours services – progress report* (2014)
- *Accident Compensation Corporation: Using a case management approach to rehabilitation* (2014)
- *Accident Compensation Corporation: How it deals with complaints* (2014).

Although the Accident Compensation Corporation is not usually considered to be part of the health sector, we include the last two reports listed because the topics relate to clients with health issues.

Publications by the Auditor-General

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

- Annual Plan 2016/17
- Energy sector: Results of the 2014/15 audits
- Collecting and using information about suicide
- Home-based support services – follow-up audit
- Crown Fibre Holdings Limited: Managing the first phase of rolling out ultra-fast broadband
- District health boards' response to asset management requirements since 2009
- Education for Māori: Using information to improve Māori educational success
- Immigration New Zealand: Supporting new migrants to settle and work – Progress in responding to the Auditor-General's recommendations
- Effectiveness and efficiency of arrangements to repair pipes and roads in Christchurch – follow-up audit
- "Joining the dots" – Insights from the 2014/15 audits
- Response to query about Housing New Zealand's procurement processes
- Reflections from our audits: *Governance and accountability*
- Local government: Results of the 2014/15 audits
- Department of Conservation: Prioritising and partnering to manage biodiversity – Progress in responding to the Auditor-General's recommendations
- Public sector accountability through raising concerns
- A review of public sector financial assets and how they are managed and governed
- Improving financial reporting in the public sector

Website

All these reports, and many of our earlier reports, are available in HTML and PDF format on our website – www.oag.govt.nz.

Notification of new reports

We offer facilities on our website for people to be notified when new reports and public statements are added to the website. The home page has links to our RSS feed, Twitter account, Facebook page, and email subscribers service.

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