CONTROLLER AND AUDITOR-GENERAL
Tumuaki o te Mana Arotake

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Health sector: Results of the 2016/17 audits

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Overview

The performance of organisations providing health services, including the district health boards (DHBs), is important for New Zealand's economic and social well-being. In 2016/17, $16.22 billion was spent on health, making it the second largest area of government spending after social security and welfare.

However, financial sustainability continues to be a challenge for DHBs. The total deficit for all 20 DHBs increased significantly in 2016/17 and is expected to have increased further in 2017/18. Continued financial pressure makes it difficult for DHBs to invest for the future. It also affects their resilience and their ability to make investments to deal with significant changes in demand.

DHB-managed assets – generally hospitals and clinical equipment – are essential for providing health services. DHB-managed assets that are not adequately and regularly maintained can have significant consequences for New Zealanders.

During our 2016/17 audits of DHBs, we did not see much progress in addressing the recommendations from our 2016 report, *District health boards' response to asset management requirements since 2009*. Recent reports about the condition of some Middlemore Hospital buildings are a timely reminder of how vulnerable DHB-managed assets can be when maintenance is deferred. In our view, asset management remains a significant risk to future service delivery for the entire health sector. We will continue to focus on asset management in our annual audit work. We are also planning to start a programme of work in 2018/19 that looks at significant new investments in the health sector, starting with major hospital building projects.

In our audits of DHBs, we look at their control environments, particularly their financial and service performance systems and practice. DHBs generally have largely effective systems and controls in place, and these systems and controls are improving. Many DHBs have also improved their performance reporting in recent years, which is important for transparency and accountability. However, further improvements to performance reporting would help demonstrate the difference DHBs are making to the well-being of New Zealanders.

DHBs procure a lot of services from third parties. To get the best value for money and quality of service, DHBs need to manage the procurement process well. Although DHBs have procurement policies and practices in place, particularly for day-to-day transactions, they need to focus more on managing contracts. DHBs often rely on trust rather than actively managing contracts to ensure that third parties deliver services to the required standard.

Careful management of sensitive expenditure, such as travel and expenses, remains crucial to maintaining New Zealanders' trust in the institutions that deliver public services and spend public money. It is particularly important that, as the employer of the chief executive, DHB boards ensure that New Zealanders'

expectations of their senior public servants are met. But I encourage all staff, particularly those in senior positions, to take action – such as talking to their auditor or making use of protections provided by the Protected Disclosures Act 2000 – when they have concerns about financial mismanagement or misuse of funds in their organisations.

As well as our core audit work, we monitor changes and developments in the health sector to inform our audits and to help us focus on important issues.

Since 2016/17, pressures on the health sector have increased. These have included the problems with buildings at Middlemore Hospital, delays in the Bowel Screening Programme after issues with the pilot programme, and issues with ophthalmology services at Southern DHB that were recently reported by the Health and Disability Commissioner. The Havelock North Drinking Water Inquiry found major deficiencies in the drinking-water system and criticised how the Ministry of Health exercised its functions.

In a sector as large and complex as health, issues are to be expected. However, when several significant issues happen at once, there could be an impression that the health sector has fundamental weaknesses and is at risk of more significant failures. Our audits, at least at an institutional level, suggest that public entities in the health sector have the internal controls and systems they need to operate effectively and be accountable for their performance.

The critical decisions for the health sector are about what services to provide, how to provide them, and where. The Ministry of Health plays an important role here. The health sector relies on clear and strong leadership to make the right choices for future services and meet the expectations of New Zealanders. After a period of re-structuring, the Ministry of Health continues to change. A new Director-General started in June 2018. He will be able to draw on a recent Performance Improvement Framework review of the Ministry of Health from the State Services Commissioner, which provides an external perspective on where the challenges are and what changes might be needed.

The Government has recently announced a wide-ranging review of the health sector, which is expected to result in a report by January 2020. We will continue to provide assurance on the health sector's financial and performance reporting where we can, alert entities and governors to risks where we see them, and recommend improvements where they are needed.

Greg Schollum
Deputy Controller and Auditor-General

21 June 2018

Results of the 2016/17 audits of health sector entities

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1.1 In this Part, we discuss our 2016/17 audit results for health sector entities. We focus primarily on district health boards (DHBs) because they fund or provide most health services. We also summarise our performance audit work in the health sector.

1.2 New Zealand's public health system comprises a government department, a number of Crown entities (including DHBs), non-government organisations, and private health providers (see the Appendix for a more detailed overview of the health sector).

1.3 In our view, the most important observations from our audits are as follows:

- Continuing deficits are a challenge for DHBs. We see signs of financial challenges contributing to a climate of pressure that can increase risks to services.
- DHBs need to better manage their assets.
- DHBs procure a lot of services from third parties. Contracts for these services need to be more actively managed.
- Overall, the systems and controls supporting financial and service performance in the health sector are reliable. A significant recent improvement is that most DHBs can now report with confidence the performance results for services that are delivered by third parties.
- There is a greater need for effective scrutiny of sensitive expenditure by DHBs.

Observations from the 2016/17 audits of district health boards

Continuing deficits are a challenge

1.4 DHBs are under pressure to meet an increasing demand for services with the available funding. Living within their means requires careful management. However, DHBs are finding this increasingly difficult.

1.5 The overall deficit for all DHBs increased to more than $119 million in 2016/17. That amount is almost $70 million more than the budgeted deficit. It is also a significant increase from the deficit in 2015/16 (although the 2015/16 deficit was reduced by deficit funding of $16.38 million provided to Canterbury DHB).

1.6 Several DHBs have savings plans and are taking steps to reduce expenditure and/or gain efficiencies. They will need to be clear about which savings are efficiencies and which savings will affect services. This is so that DHB boards can make decisions based on accurate information about the potential effect of these savings.

Why does this matter?

1.7 Operating under financial pressure for a long period of time makes it difficult for DHBs to plan for the future. This could potentially lead to a deterioration of services, which would have significant consequences for New Zealanders.

Financial challenges contribute to a climate of pressure that can exacerbate risk

1.8 To achieve clinical and financial sustainability, DHBs are looking for innovative ways to provide more or better health care for their communities with the resources available to them. These innovations can include changes to workforce utilisation, using technology, and stronger integration between primary and secondary care. Innovation is undeniably important, but DHBs should remember the importance of managing the basics well.

1.9 In our audit of Waikato DHB, we saw information about a procurement process for a way of providing health care through mobile devices, called HealthTap. Although we understood the overall aim, we had concerns about the procurement process that Waikato DHB used.

1.10 We decided to start an inquiry into this procurement. We will publish our findings and any associated recommendations when our inquiry work is complete.

Why does this matter?

1.11 DHB boards and management need to remain mindful of demonstrating value for money by using processes that are appropriate for the nature and size of the procurement. Failing to manage the procurement process effectively can result in DHBs paying more for goods and services, procuring the wrong goods and services, or both. This can lead to a waste of scarce resources.

Contracts with third parties need to be actively managed

1.12 There have been improvements in DHBs' procurement policies and practices, particularly for day-to-day transactions. However, DHBs could strengthen their contract management practices. DHBs contract third parties to provide a lot of health services and often rely on trust rather than actively managing contracts to ensure that these health services are being delivered to the required standard.

1.13 The procurement and contract management environment for DHBs has gone through changes in the last few years, which has heightened risks. Agents such as NZ Health Partnerships Limited, healthAlliance N.Z. Limited, and the Pharmaceutical Management Agency provide procurement services for DHBs. However, recent changes in what each agent is responsible for has led to some confusion among DHB staff about what procurement services are now provided and which agent provides them.

1.14 Also increasing risks, some DHBs' procurement staff have left in anticipation of a greater centralisation of procurement. This means that some DHBs do not have the procurement expertise that they need in-house.

Why does this matter?

1.15 A large proportion of DHBs' spending is through some form of procurement, so it is essential that they properly manage the full procurement process. This includes managing contracts for the delivery of goods and services from third parties.

1.16 DHBs should consider carefully whether they have the capability to carry out their procurement and contract management functions. Even where agents carry out procurement activities on their behalf, DHBs are responsible for ensuring value for money and reliable and high-quality service delivery.

Assets need to be better managed

1.17 Collectively, DHBs own more than $6 billion worth of assets, such as hospitals and clinical equipment. The Ministry of Health (the Ministry) told us that, based on recent insurance assessments, the replacement value is actually in excess of $16 billion. DHBs rely on these assets to provide health services. We looked at DHBs' asset management in our June 2016 report *District health boards' response to asset management requirements since 2009*.

1.18 In general, DHBs' asset management was not as mature as we expect from organisations of their size and with their level of reliance on their assets.

1.19 Our findings included:

- About two-thirds of DHBs were unlikely to have substantively updated their asset management plans since 2009.
- DHBs tended not to specify the levels of service they expect from their assets, resulting in weak asset performance reporting.
- There was limited reporting to governors and senior managers on the performance and condition of assets.

1.20 This raised doubts about how well positioned DHBs are to support future service delivery. DHBs appeared to focus more on short-term results and less on how they would ensure that the assets' ongoing capability would continue to deliver services. We made several recommendations to help DHBs improve this. During the 2016/17 audits, we looked at some DHBs' progress with our recommendations and found that there had been little change.

Why does this matter?

1.21 Without appropriate facilities, DHBs cannot provide effective services. All facilities degrade over time and need to be maintained and/or replaced. Service requirements can also change, which means that different types of facilities are

needed. Because DHBs are large, complex, and asset intensive, they need to use best practice asset management. To date, we have not seen this in DHBs.

1.22 There has been recent media attention on the condition of some buildings in Counties Manukau DHB's Middlemore Hospital campus. However, other DHBs have also previously reported significant failures in important buildings as a result of deferred maintenance. In our view, asset management remains a significant risk to future service delivery for the entire health sector.

1.23 We recommend that DHB boards that have not yet done so review their asset management policies, systems and capabilities, and practices. They should also consider how to implement the recommendations from our report *District health boards' response to asset management requirements since 2009* so that they can improve their longer-term capability. We will continue to focus on asset management in our annual audit work.

Systems and controls are generally reliable

1.24 Our audits provide assurance that DHBs' reporting of financial and service performance fairly reflects actual performance. We look at the relevant systems and controls that entities have in place. We assess and grade the strength of these systems and controls, covering aspects such as the clarity of planning, the quality of financial management practices, and the systems and approaches for reporting on performance.

1.25 In general, DHBs have effective systems and controls in place. The overall quality of these systems and controls improved slightly from 2015/16. However, in the last few years DHBs have made their performance reporting clearer and more comprehensive. This is especially noteworthy because of their complexity and size.

Why does this matter?

1.26 Effective internal controls are critical for organisational performance and accountability. Internal controls are part of an organisation's protection against corruption. New Zealand's position at the top of Transparency International's *Corruption Perceptions Index* is likely to be, in part, because of continual improvement of public entity controls. Weak internal controls can result in problems such as poor decision-making, confused communication, and wasted resources.

1.27 Our audits suggest that, overall, DHBs have the internal controls and systems they need to operate effectively and be accountable for their performance. However, we regularly see where further improvements could be made and we will continue to make recommendations about these.

Greater reliance on performance information reported by third parties

1.28 Some of the performance measures reported by DHBs rely on information from third parties, such as general practitioners and public health organisations. Because these third parties are not public entities, we do not audit them and, in previous years, we have been unable to get assurance that the information they provided was accurate. From 2012/13 to 2014/15, we issued modified audit opinions on all DHBs' performance information because of this.

1.29 The Ministry worked with DHBs and our auditors to develop a methodology that would allow us to audit performance information provided by third-parties. Because some systems and controls for collating the performance information are consistent and centrally performed, the audit work was able to be completed on a national basis rather than for each DHB. This meant that the approach was cost-effective.

1.30 As a result, beginning in 2015/16, we were able to give unmodified opinions on the performance reporting of some DHBs. This was an important development because it means people can rely on the performance information. In 2016/17, 19 DHBs received unmodified opinions for their 2016/17 performance information. Only one DHB declined to use the new methodology, and we will continue to work with that DHB to resolve this.

Why does this matter?

1.31 Performance reporting provides an account of the health services that have been paid for with public money. Improved transparency in DHBs' overall performance, made possible by the new auditing methodology, means New Zealanders can have greater confidence in what is reported and that the services they are paying for have been provided effectively.

The need for effective scrutiny of sensitive expenditure

1.32 During the 2016/17 audit, the then chair of Waikato DHB's board asked us to look into the then chief executive's expenses. We had several concerns, including about the approval process, business purpose, consideration of personal leave, and lack of supporting documentation, particularly for travel. We made several recommendations to improve practices. The State Services Commissioner also conducted an investigation, which was reported on in March 2018.[1]

1.33 Because this matter has already been reported on extensively, we will not go into detail here. However, we do have some general observations to make.

1 State Services Commission (2018), *Inquiry report into allegations of unauthorised or unjustified expenditure, and related matters, at the Waikato District Health Board*. www.ssc.govt.nz/waikato-dhb-inquiry.

1.34 DHB boards employ only one staff member: the chief executive. It is important that boards diligently oversee chief executives, and understand that it is their responsibility for setting the tone and culture at the top of the organisation.

1.35 It is also important that staff raise any concerns about financial mismanagement or misuse of public funds in their organisation with their auditor. They need to do this regardless of the level at which the behaviour occurs. Failing to do so exposes the organisation to risk and compromises the effectiveness of the audit.

1.36 Staff can use the protections of the Protected Disclosures Act 2000. The Auditor-General is an appropriate authority for disclosures made under this Act. Others are listed on the Ombudsman's website. All DHBs should ensure that their policies and processes for protected disclosures are up to date, easily accessed, and understood by their staff.

Why does this matter?

1.37 New Zealanders expect integrity from their public servants. Public trust in government and the public sector can be easily lost. Robust controls, and conscientious application of them, are important to retaining public trust.

Other observations from the 2016/17 audits of district health boards

1.38 As well as these significant observations, our audits identified a couple of other important matters.

Earnings management

1.39 As noted earlier, DHBs operate in a tight financial environment and are under considerable pressure to "live within their means". This has resulted in some DHBs being overly focused on achieving a particular surplus or deficit (often in line with budget). To achieve this, some DHBs have incorrectly accounted for expenditure where a judgement has been necessary to determine the amount and timing of the expenditure. Aspects of particular concern are judgements relating to expenditure accruals, provisions, asset lives, and estimated leave liabilities.

1.40 In previous years' audits, we saw some DHBs making judgements in these categories of expenditure and revenue that could not be supported by the available evidence. The amounts involved were not large enough that we would point them out in our audit report if left uncorrected. This is because, when compared with the overall financial statements, the amounts were not large enough that people would be seriously misled by the financial statements. We reported the errors to boards. However, in many cases they declined to make the corrections we recommended.

1.41 Although there was less of this behaviour in 2016/17, it is unfortunately still happening. DHBs should approach financial year-end cut-offs and valuations consistently and not make judgements that are biased towards a particular result. Our auditors will continue to be alert for biased judgements in the financial reporting process. They will continue to report to DHB boards where they find bias and, if corrections are not made, report to the Minister of Health and to Parliament's Health Committee, to enable them to hold DHBs to account for their financial reporting.

Why does this matter?

1.42 New Zealanders need to have confidence that the financial statements of public entities fairly reflect the actual financial performance of the entities. This assurance is provided by consistent application of accounting standards, but is undermined if entities choose to ignore the standards in pursuit of a short-term financial objective.

Non-compliance with the Holidays Act 2003 still not resolved

1.43 Several organisations in the public and private sector have experienced problems arising from non-compliance with the Holidays Act 2003. These problems occur because pay systems have not been set up to account for different leave entitlements for employees who work non-standard work hours.

1.44 This could potentially be a significant risk for DHBs, which operate 24 hours a day. Although the liability is unlikely to be large enough to affect the audit of any single DHB, the total amount for all DHBs might be large.

1.45 During the last two audits, we asked DHBs what they were doing to understand their risk related to non-compliance with the Holidays Act and how they were accounting for any potential liability. In 2016/17, DHBs commissioned Central Region's Technical Advisory Services Limited to develop a way for DHBs to assess their liability. In the meantime, DHBs have adopted a range of approaches to accounting for a potential liability.

Why does this matter?

1.46 This affects every DHB, which means that there is potential that the combined liability for all DHBs could be a large amount of money. There should be some urgency in removing this uncertainty, especially because the issue has now been known about for two years.

1.47 We expect that DHBs will pick up on the work from Central Region's Technical Advisory Services Limited to identify what liability, if any, they have from non-compliance with the Holidays Act so that this can be properly accounted for.

Shared-service initiatives

1.48 DHBs and other entities in the health sector have been working on sector-wide projects aimed at improving corporate support. The intended benefits of these projects have included reduced costs, increased efficiency, and better use of information throughout the health sector. We looked at these projects because of their scale and their potential benefit to all DHBs.

The National Oracle Solution

1.49 One of the most significant shared-service initiatives in recent years is the National Oracle Solution. This initiative is led by NZ Health Partnerships Limited (Health Partnerships), a subsidiary owned by all 20 DHBs. The National Oracle Solution is a system that is intended to replace DHBs' finance and supply chain systems, many of which are ageing and unsupported. Its expected benefits include enabling smarter sector-wide procurement through better quality data and easier implementation of national contracts.

1.50 The National Oracle Solution replaced the previous Finance, Procurement and Supply Chain project, which was led by Health Benefits Limited, a Crown-owned company that stopped operating in June 2015 and passed its operations onto Health Partnerships. In 2015, we inquired into Health Benefits Limited, including its management of the Finance, Procurement and Supply Chain project.

1.51 Including the period that it was known as the Finance, Procurement and Supply Chain project, the National Oracle Solution has been running since August 2012. The project, which has been funded by DHBs, has been re-scoped (for example, removing shared financial services) and had its delivery time line extended several times. The original budget was $87.9 million, which we understand has been spent.

1.52 In 2016/17, the National Oracle Solution did not achieve any of its performance measures, one of which was to have the first four DHBs begin using it in 2016/17.[2] The programme was re-planned with revised timelines, including a July 2018 date for the first four DHBs. We understand that this re-planned programme, including additional costs, has been approved by all 20 DHBs and that the additional spending is awaiting approval by Ministers.

1.53 Every year, DHBs need to consider whether there has been any impairment of their investment in the National Oracle Solution that should be provided for, which means assessing whether the value of the investment has reduced because it will not be fully realised. In 2016/17, all 20 DHBs concluded that their investment had not been impaired. This conclusion was partly supported by a Health Partnerships-commissioned assessment that the expected benefits still

2 The first four DHBs are Canterbury, Bay of Plenty, Waikato, and West Coast DHBs.

exceed the expected costs of the project. We considered that these assessments were reasonable, based on the information that was available at the time.

1.54 We will continue to follow developments with the National Oracle Solution, including the DHBs' consideration of whether any impairment of their investment needs to be provided for.

Why does this matter?

1.55 DHBs have identified collaboration as an important part of achieving financial and clinical sustainability. Shared back-office systems like the National Oracle Solution were intended to save money and help DHBs to be more effective. The challenges in delivering the National Oracle Solution have raised questions about how effectively DHBs are collaborating, and whether the intended benefits will be achieved.

The National Infrastructure Platform

1.56 Another significant shared-services programme led by Health Partnerships is the National Infrastructure Platform. In 2015, Health Benefits Limited contracted a service provider to move DHBs' local infrastructure to data centres that are more centrally managed to increase information security and reliability. Towards the end of 2015/16, Health Partnerships resolved to end the original agreement with the service provider because of continued delivery problems.

1.57 In 2016/17, Health Partnerships negotiated a new agreement with the service provider that allowed DHBs to procure services from that provider or other providers from the Government's Infrastructure as a Service procurement panel. Under the new arrangement, DHBs lead their own infrastructure transition using tools and templates developed with Health Partnerships, rather than the original centrally led approach.

1.58 Because of the changes to the agreements with the service provider, Health Partnerships needed to consider whether its accounting treatment of funds received by Health Partnerships/Health Benefits Limited in previous years was still correct. This was a complex issue to resolve and, as a result, the financial statements were not finalised before the statutory reporting deadline of 31 October 2017. The final annual report was approved by the board of Health Partnerships on 9 February 2018.

Why does this matter?

1.59 It is important that DHBs have an effective solution for providing timely and secure access to their information, especially because some DHBs have been continuing to run legacy systems while waiting for the National Infrastructure Platform to be delivered. It is also essential that Health Partnerships accounts accurately to DHBs for its revenue and expenditure.

Major hospital building projects

1.60 There are currently several large building projects at different stages, all located in the South Island, which are operating under a relatively new model. The Ministry manages the project and a "partnership" group appointed by the Minister of Health – usually a mix of DHB board members and independent appointments – is responsible for governance.

1.61 Burwood Hospital was the first hospital to be completed under this new model. It was legally transferred to Canterbury DHB in August 2016 at a cost of $215 million.

1.62 The Christchurch Hospital Acute Services Building project, budgeted at $463 million, is scheduled to be completed in 2018.

1.63 Grey Base Hospital on the West Coast is scheduled to open in early 2019 at a cost of $77.8 million. The project is being governed by the West Coast Partnership Group.

1.64 The Ministry and the DHBs involved are still working on the arrangements for transferring assets for the Grey Base Hospital and the Canterbury Acute Services Building to the DHBs.

1.65 In August 2017, Ministers approved the indicative business case for rebuilding Dunedin Hospital at a cost of between $1.2 billion and $1.4 billion. This hospital is expected to be completed in seven to 10 years from June 2017 and will be the largest single investment in the health sector to date. The Southern Partnership Group will govern the project.

1.66 We understand that there are many other potential building projects throughout the health sector. Some facilities are reaching the end of their useful lives. Other facilities are needed to meet population growth, particularly in Auckland.

Why does this matter?

1.67 Hospital building projects are some of the most expensive and complex projects in the public sector. Because there is a long time between concept and completion, and because of the importance of hospitals to New Zealanders, it is important to get the planning right on a national and regional level. This should help ensure that services go where they will deliver the best overall health outcomes.

1.68 We plan to start a programme of work in 2018/19 that looks at this broad area of health sector investment. This is likely to be a multi-year programme of work that will consider a range of activities, from the way the health sector plans its significant investments to the effectiveness of delivering the projects.

Observations from the 2016/17 audits of other entities in the health sector

The Ministry and the other Crown entities

1.69 In our assessment of the Ministry's and the other Crown entities' control environments, the grades were all "good" or "very good" on our assessment scale. "Good" means that the controls were reliable but we identified some improvements that should be made. "Very good" means that the controls were of such a high standard that, based on our audits, we did not consider it necessary to recommend improvements. All entities either maintained or improved their assessments compared with previous audits. Both the Health Promotion Agency and the New Zealand Blood Service received "very good" grades in all three assessment areas. For the Health Promotion Agency, this was an improvement from previous years.

1.70 We recommended that the Ministry update its performance framework to align with the *New Zealand Health Strategy 2016* (the Health Strategy) and so that there are clearer links between the strategic priorities and the Ministry's own measures of success. The Ministry has since published its *Strategic Intentions 2017 to 2021*, which is largely based on the Health Strategy. We understand that the Ministry is continuing to work on its performance framework.

Our performance audit work in the health sector

Mental health

1.71 In May 2017, we published a performance audit report, *Mental health: Effectiveness of the planning to discharge people from hospital*. Our audit looked at how effectively DHBs plan, and implement their plans, for discharging people who have been admitted to hospital with acute mental health problems.

1.72 International evidence shows that good planning for transitioning people from inpatient care to the community is critical in supporting them effectively. We looked at whether the discharge planning was completed as intended, people's needs were met after they left hospital, and the discharge planning was effective.

1.73 Timeliness, quality, and effectiveness of discharge planning are impaired by pressures on inpatient and community services. In some circumstances, discharge planning was late or incomplete and some people were discharged from hospital without a plan for their broader needs. Following up on people after they were discharged was also not as timely as expected. Improvements were urgently needed for discharge planning to be more effective.

1.74 We made five recommendations, two of which were for the Ministry to address with DHBs.

Patient portals

1.75 In November 2017, we published a performance audit report, *Ministry of Health: Supporting the implementation of patient portals*. This audit looked at how well the Ministry supported primary health organisations and general practices in implementing patient portals. Patient portals are secure websites that let people access their health information and interact with their doctor online. Using patient portals supports the Health Strategy's goals of giving people greater access to their health information and encouraging them to be more involved in decisions about their treatment.

1.76 The Ministry plays a support role in the implementation of patient portals because they are created and run by private companies and paid for by primary health organisations and general practices.

1.77 The Ministry worked effectively with organisations throughout the health sector, including the Royal New Zealand College of General Practitioners, in supporting the implementation of patient portals. This helped the Ministry identify, and then work to address, concerns that some doctors had about the patient portals. In our view, the way the Ministry worked with the health sector contributed to increased uptake of patient portals. This was a good example of different parts of the health sector working together to achieve a common goal.

1.78 We did identify an opportunity for the Ministry to provide more value by collecting statistical information that would show the benefits of patient portals, which could encourage general practices that are reluctant to use them.

1.79 As part of our work programme planning, we will be considering whether to follow-up on these performance audits.

Financial performance of district health boards

2

2.1 In this Part, we describe:

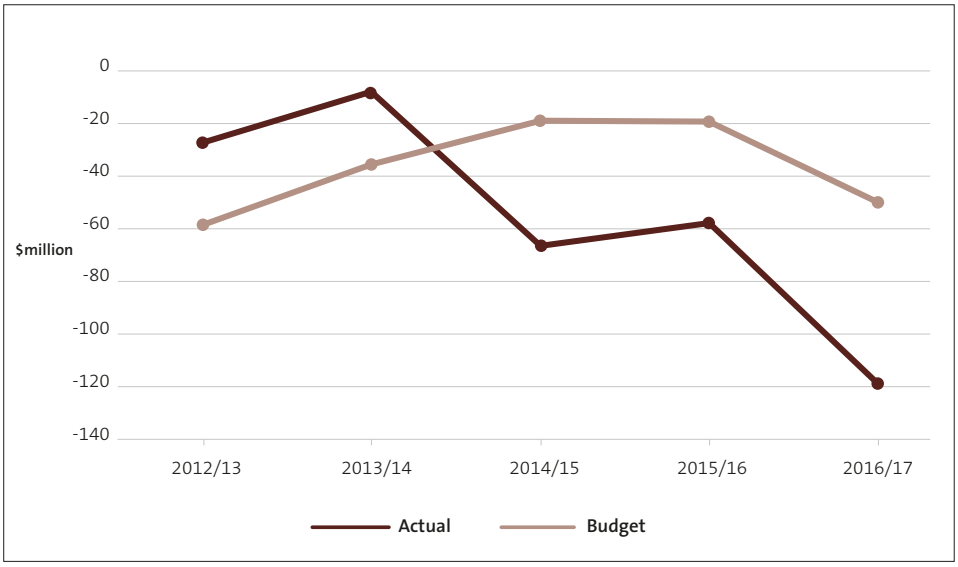
- the 2016/17 financial results for each DHB and the overall financial sustainability of DHBs;
- financial management practices of DHBs; and
- DHBs' spending on contracted services compared with spending on services they provide themselves.

District health boards' financial results

2.2 The second largest Vote in the Government's 2016/17 Budget was Health, with appropriations totalling $16.14 billion ($15.87 billion for 2015/16). In line with the 2016/17 Supplementary Estimates of Appropriations, $12.2 billion went directly to DHBs to provide health services. DHBs received about 4.2% additional funding in 2016/17 (the additional funding in 2015/16 represented a 2.8% increase).

2.3 Figure 1 looks at DHBs' aggregate financial results and compares the actual deficit with what was budgeted. For 2012/13, we excluded insurance payouts of $294.7 million to Canterbury DHB, because this was a one-off event that would have skewed the overall result.

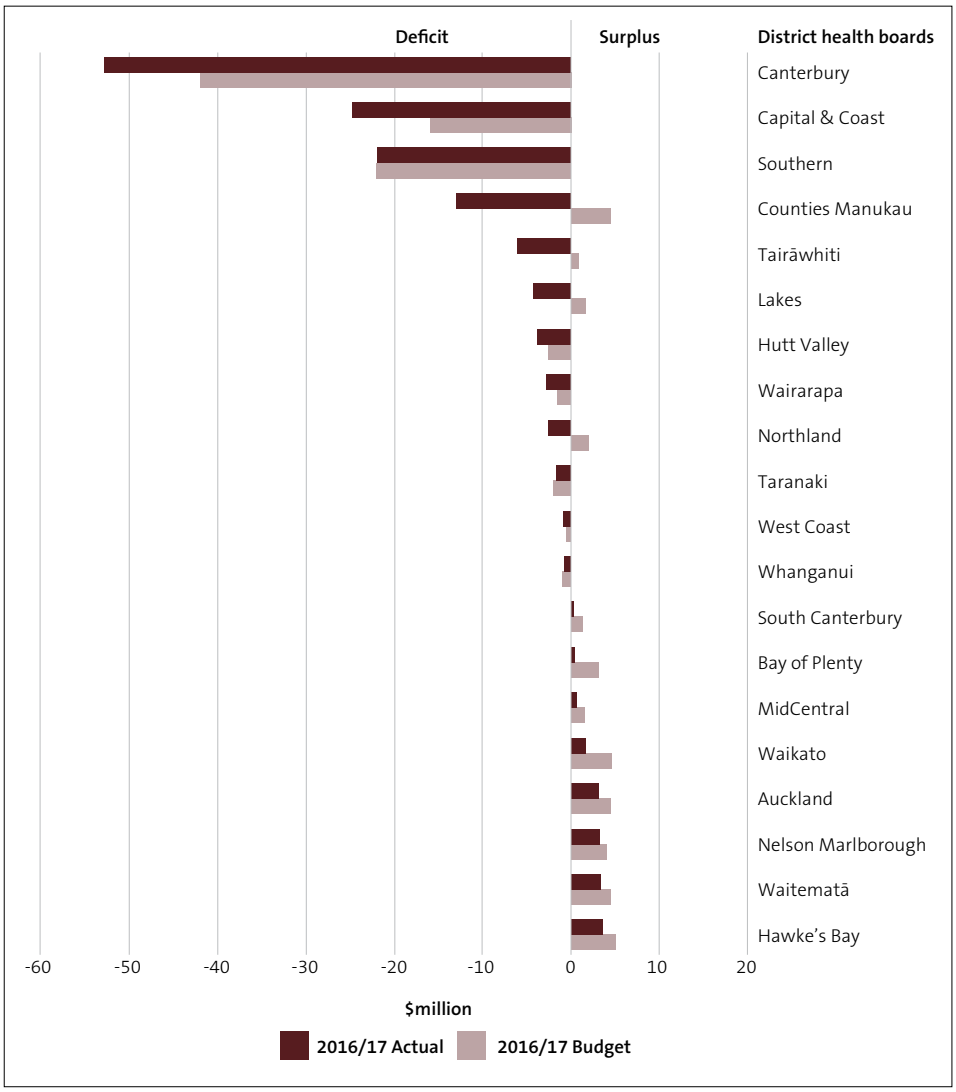
Figure 1
Comparison of district health boards' budgeted and actual deficit (aggregated), 2012/13 to 2016/17



2.4 DHBs' overall financial results have deteriorated since 2012/13, with the actual deficit significantly worse than budgeted in each the last three years. The overall deficit in 2015/16 was reduced by the $16.38 million deficit funding provided to Canterbury DHB in that year. No deficit funding was provided to Canterbury DHB in 2016/17.

2.5 Figure 2 shows the actual and budgeted financial results for each DHB for 2016/17.

Figure 2
Financial results for district health boards, 2016/17



2.6 DHBs with the largest deficits for 2016/17 were Canterbury, Southern, Capital and Coast, and Counties Manukau. Of these, only Southern DHB was within budget. Of the other 16 DHBs, 14 reported results that were worse than budget. Out of all 20 DHBs, 12 DHBs reported deficits in 2016/17. Canterbury DHB's deficit of $52.8 million was partly because of the increased costs, mainly capital charge and depreciation, from the new Burwood Hospital building.

2.7 Each year DHB boards must consider whether their DHB will have the resources to pay its expenses for the coming year. If this is in doubt the DHB might not be able to operate as a "going concern". In 2016/17, five boards concluded that they might not have the required resources for the coming year without further funding from the Government. These boards obtained letters of support from the Ministers of Health and Finance offering further funding if required.

Debt to equity conversion and the cost of capital

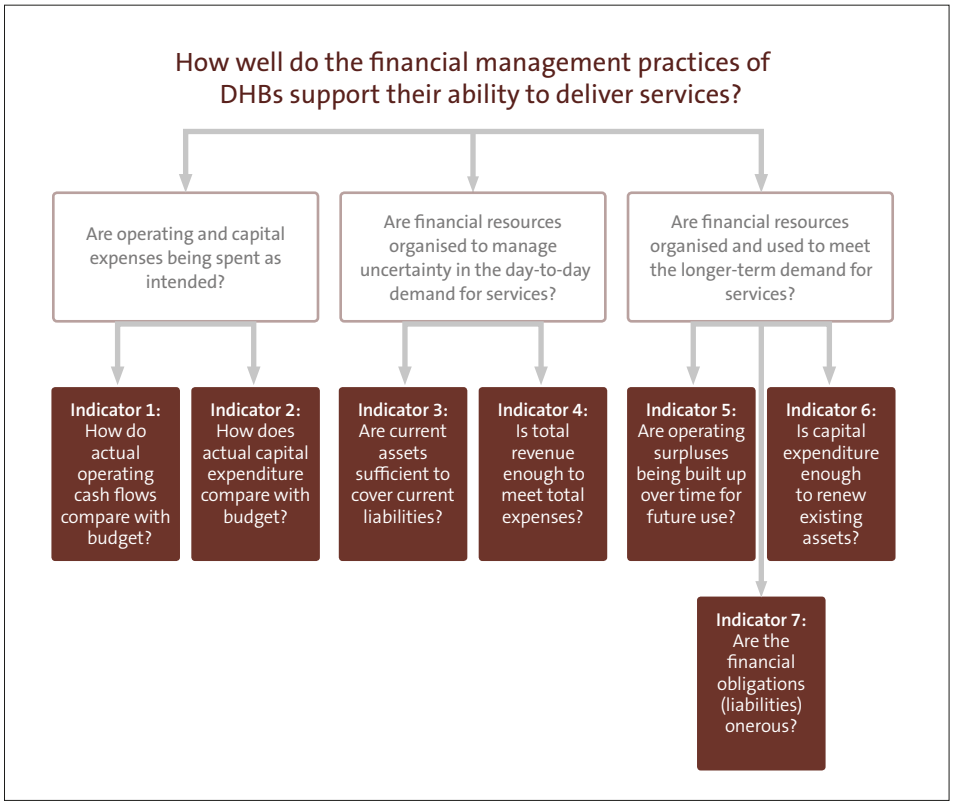
2.8 In 2016/17, the Government converted existing DHB debt to equity and ended DHBs' access to Crown debt funding of capital investment, meaning that DHBs can no longer use debt funding for large investments like new hospitals or expensive equipment. This was a significant change, achieved by providing $2.415 billion to DHBs through the Supplementary Estimates 2016/17. This has improved DHB balance sheets by reducing their liabilities and therefore increasing equity.

2.9 We understand that this change was the first phase in a review of the health capital funding system by the Ministry, in consultation with DHBs. The review is considering a new system to address the issue of affordability of capital investments. In our report *Health sector: Results of the 2014/15 audits*, we looked at the way that one part of the public sector capital funding system, the capital charge, worked in the health sector. We concluded that it was not clear what the capital charge regime is actually achieving in the health sector, and that it might be onerous for some DHBs, particularly those with static or declining populations. It is encouraging to see consideration being given to changes in capital funding for DHBs.

Financial management practices of district health boards

2.10 In our report *Health sector: Results of the 2014/15 audits*, we discussed how well the health sector's financial structure supported the delivery of health services. To do this, we examined several ratios, looking at data from the financial statements of all DHBs. The ratios we looked at (indicators), and the overall questions we wanted to answer by looking at these ratios, are outlined in Figure 3.

Figure 3
Questions and criteria for reviewing district health boards' financial management practices



2.11 For this report, we examined the same ratios for 2015/16 and 2016/17, looking for any significant movements. Rather than repeat our analysis of the full set of ratios, we have summarised our findings.

2.12 In general, there was little change from what we described in our 2014/15 report. Any movement there has been suggests further deterioration for some DHBs. The main points are:

- DHBs are still weak in accurately budgeting for and investing in capital. They tend to underspend on capital compared to their budgets and for the first time in many years, capital expenditure has fallen below depreciation. Depreciation is designed to reflect the progressive using up of the asset over its life. Taken together, this suggests DHBs may not be investing enough in maintaining or updating their assets.
- DHB's resilience and ability to invest for the future has deteriorated. DHBs have faced worsening deficits and declining cash flows in the last three years, which has resulted in a further deterioration in their ability to retain and use financial resources to deal with shocks such as pandemics or significant asset failure.

Providing services directly and contracting others to provide services

2.13 DHBs have two broad categories of spending. The first is to fund services provided directly by the DHB, mainly through hospitals and specialist services (the provider role). The second is to provide full or partial funding for third parties, such as general practitioners, to provide health services (the funder role). One of the challenges for DHBs is to find the right balance between the funder role and the provider role. This can be especially challenging when demand for provider services increases unexpectedly, as it did in some DHBs' emergency departments in 2016/17 or when DHBs are expected to provide expensive new hospital treatments when they become available.

2.14 Parts of the Health Strategy emphasise the importance of more and better care in the community, where effective prevention or management of conditions can reduce the need for expensive intervention in hospitals. We expect to see, over time, more spending allocated to the funder role relative to the provider role – for example, for primary health services.

2.15 In its February 2017 report, *District Health Board Financial Performance to 2016 and 2017 Plans*, the Treasury considered this tension between the funder and provider roles:

> [It] *raises the structural risk that DHBs prioritise funding for their own provider-arms (hospitals) at the expense of externally provided services (for example primary care). This risk may be particularly apparent when DHBs are under pressure to meet hospital output targets and avoid running deficits.*

2.16 With many DHBs facing significant financial pressures, it is important to understand this risk. If DHBs' spending on primary health care is compromised, there could be higher and longer-term hospital costs as a result. Access to primary health services for those on low incomes might also be limited.

2.17 Although DHBs' spending on services from other providers had increased in recent years, the Treasury found that DHBs' spending has fallen slightly as a percentage of total expenditure. It also found that, as a percentage of total expenditure, DHBs spent less on these services than they planned to in 2014/15 and 2015/16.

2.18 We looked at DHBs' financial results for 2016/17 and saw that, again, DHBs tended to overspend on services that they provided directly and underspend on services provided by third parties. For all 20 DHBs, spending was $116.5 million more than planned on their own services and $61.3 million less than planned on services from other providers.

2.19 This shows that, in recent years, DHBs spent less than they originally planned on externally provided services. It is unclear whether these unspent resources were used to meet higher than anticipated demand for hospital services or to avoid or to reduce deficits in financially challenging circumstances.

2.20 We also do not know whether this affects the quality or scope of primary health care or health services. This situation also suggests that there could be barriers to successful implementation of the Health Strategy if spending is not happening where needed to advance some of the Health Strategy's objectives.

2.21 In our view, there would be benefit in more work by the Ministry, the Treasury, and DHBs to determine what is behind this pattern of spending by DHBs and whether it is affecting health outcomes.

Appendix
Overview of the health sector

In this Appendix, we provide an overview of the health sector.

Structure of the health sector

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

Government spending on health in 2016/17 was $16.22 billion, making it the second largest area of government expenditure after social security and welfare.

The broader 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 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 (between $900 million and $1 billion) of health funding each year.

The Ministry of Health

The Ministry is the lead agency in the health 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.

As well as being the principal advisor to the Minister, the Ministry is the steward of, and has overall responsibility for, the management and development of the health and disability system. The Ministry seeks to improve, promote, and protect the health and well-being of New Zealanders through:

- its leadership of New Zealand's health and disability system;
- advising the Minister and the Government on health and disability issues;
- directly purchasing a range of national health and disability support services; and
- providing health sector information and payment services for the benefit of all New Zealanders.

District health boards

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.

DHBs are responsible for providing or funding health services for the populations of their districts. DHBs differ greatly in terms of their population size, density, and demographics. Waitematā DHB has the largest population at about 597,000, and the smallest is West Coast DHB, at about 33,200.

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. 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.

DHBs are governed by a board made up of up to four members appointed by the Minister and up to seven elected members. The one exception to this is Southern DHB, which is governed by a Commissioner. In 2015, following several years of poor financial results, the then Minister dismissed the Southern DHB board and appointed the Commissioner, who is supported by two deputy commissioners. This arrangement is expected to continue until a new board commences following the 2019 elections.

Other Crown entities

Other Crown entities set up under the Act have various roles in the health 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** promotes and protects the rights of consumers, as set out in the Code of Health and Disability Services Consumers' Rights.
- 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 and vaccines to publicly fund in New Zealand. It also negotiates contracts for some hospital medical devices.

Funding the health sector

DHB Funding

The bulk of DHB funding is allocated using the population-based funding formula. The population-based funding formula 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).

Funding provided to DHBs using the population-based funding formula is "devolved" funding, meaning that DHBs determine how best to use the money for the benefit of the people in their districts. In 2016/17, DHBs collectively received $12.2 billion of this devolved funding. DHBs also collectively receive additional funding of about $1.1 billion from the Ministry of Health to provide national health, public health, and disability services.

DHBs provide hospital-based services and purchase services from third parties such as PHOs and residential facilities. Collectively, DHBs spend about $6.2 billion[3] on services from other providers each year.

Other health sector funding

As well as purchasing health and disability services directly from DHBs, the Ministry purchases them from a range of other providers such as the other Crown entities, PHOs, and non-government organisations. Services purchased in this way include health workforce training and development, disability services, ambulance services, maternity services, and some mental health services. In 2016/17, total spending on these services including through DHBs was $2.9 billion.

Finally, there is the role of the Accident Compensation Corporation, which in 2016/17 spent approximately $2.3 billion on injury treatment, emergency travel, care, and support.

3 This is the amount paid by DHBs to all other providers, which includes $1.57 billion paid to other DHBs for inter-district flows – that is, payment for care provided to patients who live in another district.

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