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Parliamentary paper

## Health sector: Results of the 2010/11 audits

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# Health sector: Results of the 2010/11 audits

Presented to the House of  
Representatives under section 20 of  
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# Auditor-General's overview

The performance of district health boards is important for our health, and our health is vital to the economic well-being of New Zealand. The health sector is one of the largest areas of central government spending on public services.

The health sector is doing better at managing within its means, and has reduced its overall deficit. Further pressures, though, are expected – especially as a result of the Canterbury earthquakes.

Last year, I included my reporting on health with my reporting about the annual audits in central government. This year, I have decided to publish separate reports on the health and education sectors, as well as two volumes on the wider central government sector.

In all four reports, I note the ongoing importance for public entities of continuing to improve their performance reporting. Improvements in information about performance enable an entity to focus on initiatives that will improve the outcomes it seeks, and are relevant to all health providers and public entities. I am particularly pleased at the improvement in service performance reporting by district health boards – but they still need to improve their reporting on efforts to reduce disparities for Māori.

I am also aware that the health sector faces particular challenges because its performance reporting is entity-by-entity in a sector that is increasingly operating collaboratively, between districts, regionally, and nationally. Accountability arrangements need to keep pace with the regionalisation of planning and services.

In my view, there is still room to reduce the compliance burden for hard-pressed service providers in the health sector. I continue to encourage district health boards to explore procurement arrangements that provide for good accountability but have simplified reporting requirements.

The health sector is now focused on service efficiencies. There could be savings made through better recovery of the costs of providing health services to patients ineligible for free health services. It is an aspect of DHBs' efficiency that Health Benefits Limited is working with DHBs to improve. I will watch the progress that Health Benefits Limited makes with this.

We have reviewed DHBs' asset management planning, and concluded that the health sector needs to improve. I am currently considering asset management planning as one of the aspects that our audits will focus on during the next 12-18 months.

I have some concerns about district health boards' reporting of progress in reducing health disparities for Māori. I am also considering whether child health – and, in particular, disparities in the health status of Māori children – will be part of our work for the next 18 months on our theme, *Our future needs – is the public sector ready?*

A handwritten signature in black ink, appearing to read 'Lyn Provost', written in a cursive style.

Lyn Provost  
Controller and Auditor-General

1 March 2012

## Part 1

# Overview of the health sector

- 1.1 In this Part, we discuss the health sector's operating environment, including some recent structural changes and the shift to regional planning and accountability. We also set out the funding of district health boards (DHBs) and the population in each district.<sup>1</sup>
- 1.2 In the rest of this report, we discuss the financial performance of DHBs in 2010/11 (Part 2), the audit results for 2010/11 (Part 3), our review of DHBs' management of their assets (Part 4), DHBs' reporting of their efforts to reduce health disparities for Māori (Part 5), and our recent and ongoing work in the health sector (Part 6).

### The health sector's operating environment

- 1.3 The public health system faces serious challenges from a rising demand for services and for access to improved technologies, exacerbated by an ageing population. There are international shortages of skilled clinical specialists, remuneration pressures, and significant building and clinical equipment replacement costs, which are unlikely to reduce in the short term.
- 1.4 The Canterbury earthquakes have affected and will continue to affect the services and infrastructure of DHBs, particularly Canterbury DHB (see Part 4). Our earlier report on the 2011 annual audits of central government discusses the effects of the earthquakes in more detail.<sup>2</sup> For DHBs, one particular effect has been suspension of the 2011 capital round. This has led to delays in approvals for business cases, because resources have been redirected to Canterbury DHB.<sup>3</sup>
- 1.5 Vote Health continues to increase, but the Government expects increased financial pressure on the health services and has indicated a tightening of funding increases during the next several years. Vote Health had appropriations of nearly \$14 billion for 2011/12.
- 1.6 About three-quarters of Vote Health is funding for the health services that DHBs provide, based on the Government's spending priorities, the size of the district's population, and socio-economic factors. The funding covers the health and disability services that the DHB provides directly to its population or indirectly through another provider – such as another DHB, a not-for-profit primary health organisation (PHO), or a private for-profit or not-for-profit provider such as a non-government organisation.

1 The structure of the sector is outlined in the Ministry's briefing to the Minister of Health, *The New Zealand Health and Disability System: Organisations and Responsibilities* (2011), Wellington, page 2 and pages 19-26.

2 Office of the Auditor-General (2011), *Central government: Results of the 2010/11 audits (Volume 1)*, Part 2, Wellington.

3 National Health Board (2011), *Capital Investment Committee Update*, Wellington.

- 1.7 The Ministry of Health (the Ministry) oversees almost \$10.5 billion of public funds that DHBs spend on public hospitals and primary health care.<sup>4</sup> It also manages the national planning and funding of all information technology, workforce planning, and capital investment in DHBs.
- 1.8 Although there have continued to be increases in the Budget for Vote Health (against the trend for most other sectors), the amount for new initiatives is less now than it was in 2009/10. Then, there was almost \$723 million for new operating and capital initiatives (as well as \$86 million reprioritised from existing areas). In 2011/12, there was \$516 million for new operating and capital initiatives (plus \$109 million reprioritised from existing areas). Much of the increase for Vote Health has been to keep up with demographic and cost changes in the sector.<sup>5</sup>
- 1.9 The sector is under pressure to provide better, more timely, and more convenient health services. The Government continues to review expenditure to identify funding that could be better used in other areas, particularly in frontline health services rather than “back office” functions.

### Structural changes in the health sector

- 1.10 In July 2010, Health Benefits Limited (HBL) was set up to reduce DHBs’ costs by increasing the effectiveness and efficiency of administrative, support, and procurement services.<sup>6</sup> HBL is tasked with contributing to \$700 million of savings for DHBs during its first five years.<sup>7</sup>
- 1.11 In December 2010, the Health Quality and Safety Commission was set up to examine and improve the quality and safety of health and disability support services and achieve better value for money. The Commission took over the mortality review functions set out in the New Zealand Public Health and Disability Act and responsibility for rolling out the Safer Medication Management Programme.
- 1.12 The number of PHOs continues to reduce: there were 55 at 31 January 2011 and 32 at 31 July 2011. This figure does not include South Canterbury DHB’s Primary and Community Services unit, which replaced the district’s only PHO in May 2010. The 32 PHOs vary widely in size and structure.

4 *Health Sector Information Supporting the Estimates of Appropriations for the Government of New Zealand for the year ending 30 June 2012*, Volume 6, page 8.

5 *Health Sector Information Supporting the Estimates of Appropriations for the Government of New Zealand for the year ending 30 June 2010*, and *Health Sector Information Supporting the Estimates of Appropriations for the Government of New Zealand for the year ending 30 June 2012*, Volume 6, pages 12-13 for each year.

6 Health Benefits Limited was a dormant company, reactivated to carry out these functions.

7 Health Benefits Limited, *Annual Report 2011*, page 2.



- 1.13 Further structural changes have been signalled for the health sector. Parliament is considering disestablishing the Crown Health Financing Agency at the end of 2011/12. This would affect DHBs in particular because it lends money to DHBs and is involved in property disposal. The Ministry would take over its functions. Disestablishment of the Health Sponsorship Council and the Alcohol Advisory Council of New Zealand is also being considered (to form a new agency, the Health Promotion Agency), as well as disestablishment of the Mental Health Commission (with its functions moved to the Office of the Health and Disability Commissioner).

### Population and funding of district health boards for 2010/11

- 1.14 There have been across-the-board increases in the population-based funding of DHBs since 2009/10. Figure 1 shows each DHB's population at 30 June 2011 and its 2010/11 and 2009/10 funding.

**Figure 1**  
**Population of district health boards at 30 June 2011, and funding for 2010/11 and 2009/10**

District health board	Population*	2010/11 funding** \$m	2009/10 funding*** \$m
Auckland	458,120	961.8	930.1
Bay of Plenty	213,970	544.3	523.2
Canterbury	513,960	1,128.5	1,079.1
Capital and Coast	295,640	597.5	569.2
Counties Manukau	500,770	1,058.4	1,004.8
Hawke's Bay	155,750	393.0	378.2
Hutt Valley	145,070	320.1	308.6
Lakes	103,600	252.0	244.6
MidCentral	169,320	409.9	396.9
Nelson-Marlborough	139,605	334.0	324.1
Northland	159,100	431.0	418.0
South Canterbury	56,220	148.4	143.4
Southern	304,185	701.7	681.5
Tairāwhiti	46,835	128.4	124.0
Taranaki	109,750	275.4	266.2
Waikato	368,500	877.2	840.5
Wairarapa	40,295	108.2	105.0
Waitemata	547,560	1,124.7	1,047.7
West Coast	33,010	109.8	106.8
Whanganui	63,520	185.6	180.5
<b>Total</b>	<b>4,424,780</b>	<b>10,089.9</b>	<b>9,672.6</b>

\* Statistics New Zealand estimate, 30 June 2011.

\*\* Total Budget, *Supplementary Estimates of Appropriations for the year ending 30 June 2011*, pages 443-444.

\*\*\* Total Budget, *Supplementary Estimates of Appropriations for the year ending 30 June 2010*, pages 128-130.

## Regional planning and accountability

- 1.15 DHBs are responsible for identifying and providing for the health needs of their district.
- 1.16 In our earlier report on the 2010/11 audits of the central government sector as a whole, we commented that:
- It is not easy to combine the existing appropriation and reporting requirements, which are annual and based on individual entities, with the more collective and longer-term governance needs of the [central government] sector.<sup>8</sup>*
- 1.17 One of the main changes to accountability arrangements in the health sector has been the establishment of regional planning requirements. Some DHBs (particularly those in greater Auckland) already had mechanisms for regional planning and collaboration. Under a 2010 amendment to legislation, each DHB is now required to prepare an annual plan and collaborate throughout its region to produce regional plans for health services and resourcing, which are reflected in the annual plan. Together, these replace the former district annual plan and the district strategic plan. There are four regions: northern, midland, central, and southern.
- 1.18 Despite requirements for regional planning, the requirements for reporting still focus on individual DHBs. There are no mechanisms for collective public reporting. Further, services are increasingly being rationalised regionally and nationally, and inter-agency service collaboration is increasingly encouraged. To the extent that regional planning is reflected in an individual DHB's annual plan, the DHB can be held to account for its regional responsibilities.
- 1.19 In our view, it is important that accountability arrangements in the health sector keep pace with the regionalisation of planning and services. We will continue to discuss with interested parties how the sector can best be held to account for effective delivery of health services in an increasingly regionalised and nationalised system and within an inter-agency environment.

<sup>8</sup> Office of the Auditor-General (2011), *Central government: Results of the 2010/11 audits (Volume 1)*, Wellington, page 81.

## Part 2

# Financial performance of the district health boards

2.1 In this Part, we discuss the financial performance of DHBs for 2010/11, the financial sustainability of DHBs, and the arrangements for monitoring them.

### Financial performance in 2010/11

2.2 Figure 2 sets out the financial performance of the 20 DHBs for the year ended 30 June 2011.

**Figure 2**  
Summary of district health boards' 2010/11 financial performance

District health board	Revenue* \$m	Expenditure* \$m	Surplus (deficit)* \$m	Deficit as % of revenue	Planned surplus (deficit)** \$m	Variance from plan <sup>§</sup>
Auckland	1,821.1	1,821.0	0.1	N/A	0.1	0.0
Bay of Plenty	614.1	614.1	0.1	N/A	(0.5)	0.5
Canterbury	1,405.7	1,405.8	(0.1)	0.0%	0.0	(0.1)
Capital and Coast	885.3	916.9	(31.6)	3.6%	(40.1)	8.5
Counties Manukau	1,296.2	1,291.3	4.9	N/A	0.0	4.8
Hawke's Bay	448.0	442.7	5.3	N/A	0.0	5.3
Hutt Valley	420.3	423.2	(2.9)	0.7%	(3.0)	0.1
Lakes	300.7	304.0	(3.3)	1.1%	(3.5)	0.2
MidCentral	532.5	522.9	9.6	N/A	(3.7)	13.4
Nelson-Marlborough	395.8	395.5	0.2	N/A	(0.7)	0.9
Northland	489.7	489.3	0.4	N/A	0.0	0.4
South Canterbury	171.5	170.4	1.1	N/A	(0.2)	1.3
Southern	814.3	814.2	0.2	N/A	(14.9)	15.1
Tairāwhiti	149.7	153.2	(3.2)	2.2%	0.0	(3.2)
Taranaki	311.8	310.4	1.5	N/A	(2.3)	3.8
Waikato	1,114.3	1,103.7	10.6	N/A	8.0	2.6
Wairarapa	127.4	131.0	(3.6)	2.8%	(2.2)	(1.4)
Waitemata	1,321.6	1,317.3	4.3	N/A	0.0	4.3
West Coast	130.7	137.5	(6.8)	5.2%	(7.2)	0.4
Whanganui	212.6	215.4	(2.8)	1.3%	(6.3)	3.5
<b>Total</b>	<b>12,963.3</b>	<b>12,979.9</b>	<b>(16.1)</b>	<b>N/A</b>	<b>(76.5)</b>	<b>60.4</b>

N/A "Not applicable".

\* From DHBs' annual reports. The surplus/deficit figure does not include revaluations. Also, where the surplus (deficit) figure is affected by profits from joint ventures or associates, it will not be the same as revenue less expenditure. Rounding may lead to some small differences in the total.

\*\* From DHBs' annual reports.

§ Because of rounding, there may be some small differences between the surplus/deficit minus planned surplus/deficit reported here and the actual variance from plan.

## Financial sustainability

- 2.3 DHBs continue to work to make savings and set up a sustainable model of service delivery that will allow them to achieve a break-even position. Last year, it appeared unlikely that this would be achieved soon.<sup>9</sup> However, DHBs' financial performance for 2010/11 was better than their 2009/10 performance and better than the budgeted position for 2010/11. DHBs might achieve a break-even result earlier than expected, although we are aware that the effects of the Canterbury earthquakes could still adversely affect DHBs' financial performance.<sup>10</sup>
- 2.4 In 2009/10, the deficit was \$102.1 million.<sup>11</sup> Figure 2 shows that, individually, 12 of the 20 DHBs had budgeted for a deficit for 2010/11, with an aggregate budgeted deficit of \$76.5 million. In fact, only eight DHBs recorded a deficit in 2010/11, with an overall deficit for DHBs in 2010/11 of \$16.1 million.
- 2.5 Of the eight DHBs that recorded a deficit in 2010/11, only four DHBs had a deficit that was more than 2% of revenue. The overall deficit was highly influenced by the result for Capital and Coast DHB, with its deficit of \$31.6 million, although this was \$8.5 million better than its budgeted deficit of \$40.1 million. No other DHB's deficit was more than \$6.8 million.
- 2.6 As part of our normal audit process, we will continue to monitor the effectiveness and efficiency with which DHBs manage their resources to provide enough high-quality health and disability services to meet current and future needs.

## Monitoring arrangements

- 2.7 The Ministry is the monitoring department for DHBs, and monitors and supports DHBs through its National Health Board business unit.
- 2.8 The Ministry's monitoring regime for 2010/11 had three different levels of intervention – standard monitoring, performance watch, and intensive monitoring. There was also a Single Event Monitoring regime, introduced to respond to external events such as the Canterbury earthquakes.<sup>12</sup>
- 2.9 As well as intensive monitoring, the Minister of Health can change how a DHB is governed, to help improve its performance. To do this, the Minister can appoint one or more Crown monitors to observe the decision-making processes

9 Office of the Auditor-General (March 2011), *Central government: Results of the 2009/10 audits (Volume 2)*, page 26.

10 See also, *Central government: Results of the 2010/11 audits (Volume 1)*, December 2011, Part 2.

11 Office of the Auditor-General (March 2011), *Central government: Results of the 2009/10 audits (Volume 2)*, page 25.

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

of the DHB board, to help the board understand the policies and wishes of the Government, and to advise the Minister on any matters about the DHB or its board. If the Minister is seriously dissatisfied with the governance of a DHB, they can dismiss the board and appoint a commissioner.

- 2.10 There has been little change in the last 12 months in the number of DHBs that have required special monitoring or governance arrangements. As at 31 December 2011:
- Capital and Coast, Southern, Wairarapa, West Coast, and Whanganui DHBs were being monitored intensively;
  - Taranaki DHB was on performance watch;
  - Capital and Coast and Hutt Valley DHBs had a joint Crown monitor, and Southern DHB had a Crown monitor; and
  - there were no commissioners in place.
- 2.11 Since the Canterbury earthquakes, Canterbury DHB has been on a Single Event Monitoring regime.
- 2.12 The Ministry also monitors specific DHB functions. For example, the Ministry requires and monitors the DHBs' implementation of Māori health plans for improving the health of, and reducing health disparities for, Māori. We discuss this further in Part 5.

### **Crown Health Financing Agency's monitoring of DHBs' financial performance**

- 2.13 The Crown Health Financing Agency also monitors risks to the financial performance of all DHBs.<sup>13</sup> In its report on the DHBs' (unaudited) 2010/11 results, the Crown Health Financing Agency commented on DHBs' favourable performance, with only two DHBs performing "materially unfavourable to plan"<sup>14</sup> (see also Figure 2).
- 2.14 However, the Crown Health Financing Agency also commented on the understatement of the aggregate deficit, given the large once-only asset revaluation at Capital and Coast DHB and the delays in planned capital investment for DHBs. It advised a continued strong focus on cost control and deficit reduction.<sup>15</sup>
- 2.15 The Crown Health Financing Agency also noted an expected increase in the deficit for 2011/12, affected to a large extent by the forecast deficit for Canterbury DHB.

<sup>13</sup> There is legislation being considered that would disestablish the Crown Health Financing Agency and pass its monitoring functions to the Ministry of Health from 1 July 2012.

<sup>14</sup> Crown Health Financing Agency (2011), *Annual Credit Review of District Health Boards October 2011*, Wellington, page 3.

<sup>15</sup> Crown Health Financing Agency (2011), *Annual Credit Review of District Health Boards October 2011*, Wellington, page 3.

In the Crown Health Financing Agency's view, DHBs have an underlying deficit of \$30 million, although it rates this as insignificant when compared with DHBs' revenue.<sup>16</sup>

- 2.16 The Crown Health Financing Agency rated five DHBs as being "not stable", in that they were generally projecting deficits. They would also require support to meet planned operating costs and capital plans with, possibly, other aggravating factors, such as aggressive cost growth assumptions, optimistic efficiency targets, or a poor history of performance issues. The five DHBs were Capital and Coast, Southern, Tairāwhiti, Wairarapa, and Whanganui.<sup>17</sup>

16 Crown Health Financing Agency (2011), *Annual Credit Review of District Health Boards October 2011*, Wellington, page 4.

17 Crown Health Financing Agency (2011), *Annual Credit Review of District Health Boards October 2011*, Wellington, page 6.

## Part 3

# District health boards' audit results for 2010/11

- 3.1 Under section 15 of the Public Audit Act 2001, the Auditor-General audits the financial statements, accounts, and other information that each of the 20 DHBs and their subsidiaries are required to have audited each year. The Auditor-General does not audit PHOs because they are not public entities. The purpose of the annual audit is to give assurance that an entity's reports fairly reflect its financial and non-financial performance and do not mislead the reader.
- 3.2 In this Part, we discuss the 20 DHBs' audit results for 2010/11, including the audit opinion and our assessment of the environment, systems, controls, and non-financial reporting. During the year, we reviewed procurement practices and policies and examined DHBs' reporting of non-resident debt. We also report on these in this Part.
- 3.3 We report on the major work we carried out on DHB asset management in Part 4 and on DHB reporting on the reducing of health disparities for Māori in Part 5.

### Non-standard audit reports

- 3.4 Three of the audit reports we issued in 2010/11 were non-standard.<sup>18</sup>
- 3.5 For the third time, we issued a modified opinion on Counties Manukau DHB's financial statements, for the way in which the DHB had treated "income in advance". We also issued reports with an "emphasis of matter" paragraph on a valuation issue for MidCentral DHB, and on Whanganui DHB's financial difficulties.
- 3.6 We have raised these matters with the DHB, the Minister, and the monitoring departments.

### "Going concern" considerations

- 3.7 As part of an audit, appointed auditors consider whether it is appropriate for a DHB to prepare its financial statements on the basis of the "going concern" assumption. That assumption is appropriate when the DHB is expected to be able to operate for the foreseeable future, and at least for the next 12 months, taking account of all the available information. For 2010/11, there was significant concern about the ability of five DHBs to continue to operate for the foreseeable future – Capital and Coast, Southern, Wairarapa, West Coast, and Whanganui DHBs. Those DHBs and our auditors relied on a "letter of comfort" from the Ministers of Health and Finance in concluding that the going concern assumption was appropriate to use when preparing the financial statements.

<sup>18</sup> A non-standard audit report is one that contains a modified opinion and/or an "emphasis of matter" or an "other matter" paragraph. There are three types of modified opinion (an "adverse" opinion, a "disclaimer of opinion", and a "qualified opinion"). An adverse opinion is the most serious type of non-standard audit report.

## Assessing the environment, systems, and controls

- 3.8 As part of the annual audits, our auditors comment on DHBs' management control environment, financial information systems and controls, and service performance information and associated systems and controls. We assign grades that reflect the recommendations for improvement that we make (see Figure 3).

**Figure 3**

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

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

- 3.9 Our auditors assessed most of the DHBs as "good" for the management control environment and for financial information systems and controls for 2010/11. Thirteen DHBs were assessed as "good" for their service performance information and associated systems and controls (see Figure 4).



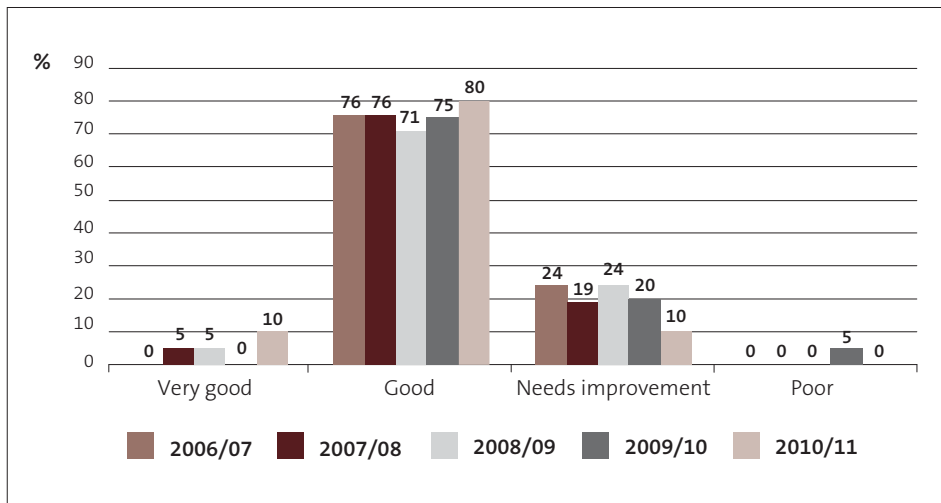
**Figure 4**  
**Summary of district health boards' 2010/11 grades for environment, systems, and controls**

District health board	Management control environment	Financial information systems and controls	Service performance information and associated systems and controls
Auckland	Good	Good	Needs improvement
Bay of Plenty	Good	Good	Needs improvement
Canterbury	Very Good	Good	Good
Capital and Coast	Needs improvement	Needs improvement	Needs improvement
Counties Manukau	Good	Good	Good
Hawke's Bay	Good	Good	Good
Hutt Valley	Good	Needs improvement	Good
Lakes	Good	Good	Good
MidCentral	Good	Needs improvement	Needs improvement
Nelson-Marlborough	Good	Good	Good
Northland	Good	Good	Good
South Canterbury	Very Good	Good	Good
Southern	Good	Good	Good
Tairāwhiti	Needs improvement	Needs improvement	Needs improvement
Taranaki	Good	Good	Good
Waikato	Good	Good	Good
Wairarapa	Good	Good	Needs improvement
Waitemata	Good	Good	Good
West Coast	Good	Good	Good
Whanganui	Good	Good	Needs improvement

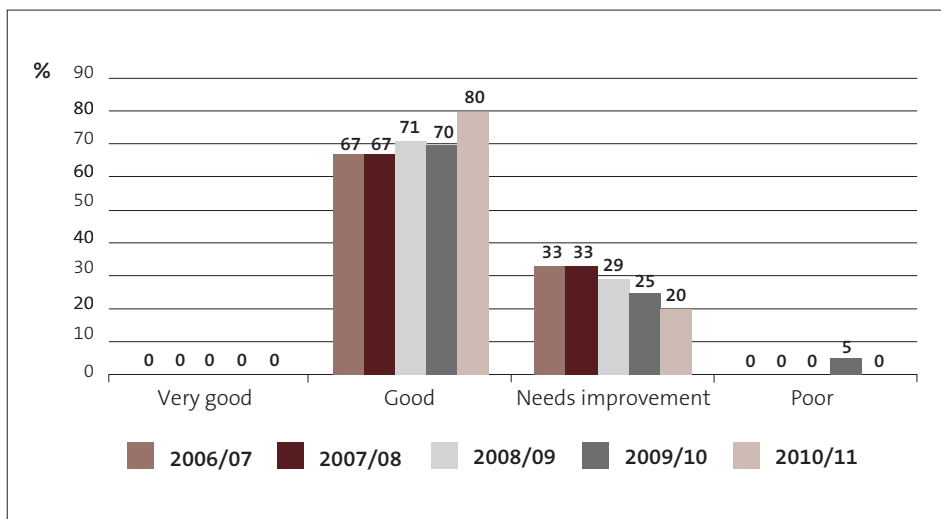
### Trends in management control environment and in financial information systems and controls

- 3.10 In the last five years, there has been a slight trend toward improved grades in the management control environment and in financial information systems and controls. Figures 5 and 6 set out our grades for DHBs' management control environment, and financial information systems and controls, for the year ended 30 June 2011 and the four previous years.

**Figure 5**  
**Grades for district health boards' management control environment, 2006/07 to 2010/11**

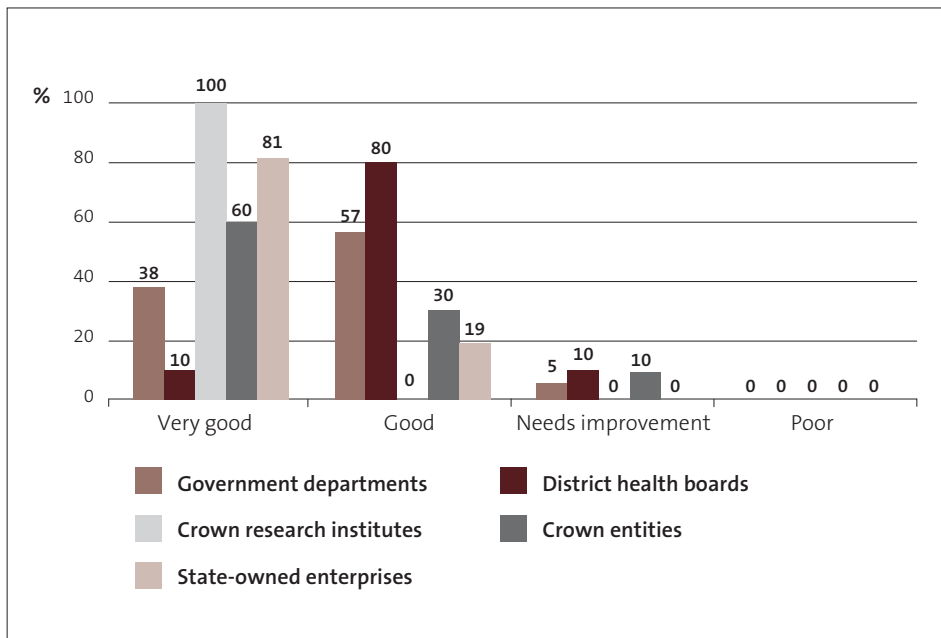


**Figure 6**  
**Grades for district health boards' financial information systems and controls, 2006/07 to 2010/11**



- 3.11 DHBs are now graded better in these two aspects than at any other time since 2006/07. We note that grades for a particular DHB can fluctuate from year to year, reflecting the circumstances of each DHB in each financial year. Some of the factors that can cause fluctuations include changes in the operating environment, standards, good practice expectations, audit emphasis, and whether the DHB has kept pace with good practice expectations between one year and the next. Nevertheless, there has been a fairly consistent move toward better grades.
- 3.12 We note that government departments, Crown research institutes, State-owned enterprises, and other Crown entities have achieved better grades than DHBs, in 2010/11 and for earlier years. Between 38% and 81% of other types of public entities achieved a “very good” grade for their management control environment for 2010/11. Only 10% of DHBs did (see Figure 7).

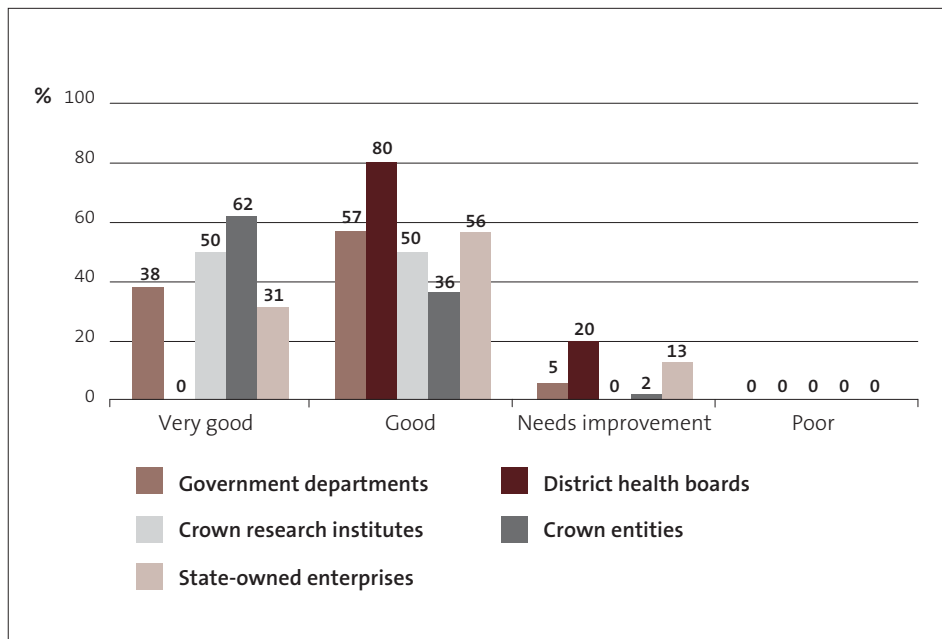
**Figure 7**  
**Grades for management control environment by type of entity, 2010/11**



Note: The “Crown entities” included here are those categorised as statutory entities under the Crown Entities Act 2004, excluding DHBs.

3.13 Between 31% and 62% of other types of public entities were graded “very good” for financial information systems and controls for 2010/11. By comparison, no DHBs were graded “very good” (see Figure 8).

**Figure 8**  
Grades for financial information systems and controls by type of entity, 2010/11



Note: The “Crown entities” included here are those categorised as statutory entities under the Crown Entities Act 2004, excluding DHBs.

### Non-financial performance reporting

3.14 In 2008/09, we issued a grade for entities’ service performance information and associated systems and controls for the first time. We graded all DHBs as “poor/needs improvement”. DHBs did not identify clearly or comprehensively the services that they delivered. The quality of measures for outcomes and for services provided was poor.

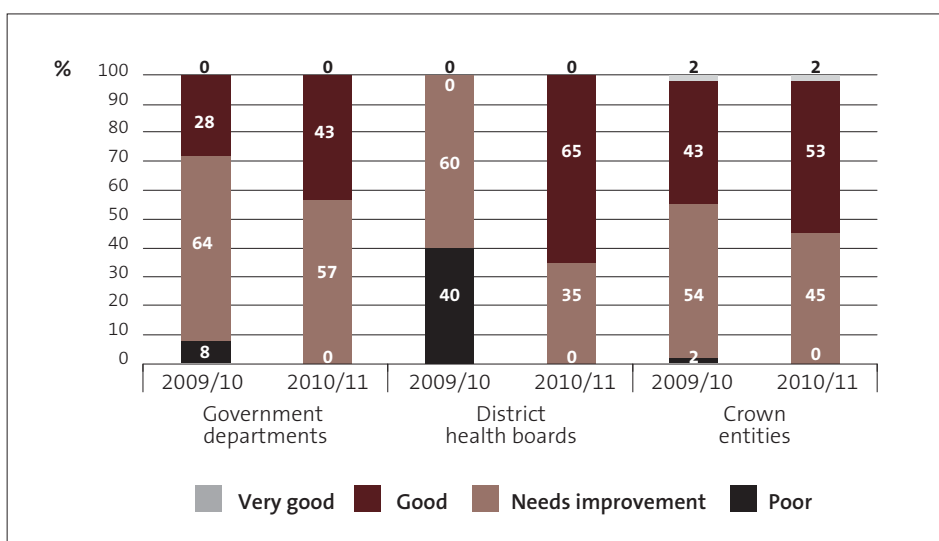
3.15 DHBs’ non-financial reporting improved considerably during the last two years, after significant work by the DHBs individually and regionally, and by the Ministry. Figure 9 shows the audit results for 2008/9, 2009/10, and 2010/11.

**Figure 9**  
**Grades for district health boards' service performance information and associated systems and controls, 2008/09 to 2010/11**

Grade	Number (%) of DHBs		
	2008/09	2009/10	2010/11
Very good	0	0	0
Good	0	0	13 (65%)
Needs improvement	–	12 (60%)	7 (35%)
Poor	–	8 (40%)	0
Poor/needs improvement	21 (100%)	–	–

3.16 The 2010/11 results are a marked improvement from 2009/10, when no DHBs were graded “good”. DHBs now lead the other Crown entities and government departments in the proportion of entities rated “good” for service performance information and associated systems and controls (see Figure 10).

**Figure 10**  
**Grades for service performance information and associated systems and controls by type of entity, 2009/10 and 2010/11**



Note: The “Crown entities” included here are those categorised as statutory entities under the Crown Entities Act 2004, excluding DHBs. Percentage figures have been rounded and might not add up to 100.

- 3.17 Our auditors have worked with individual DHBs, and we have provided the Ministry and DHBs with comparative information on performance information reporting by DHBs. We have also published good practice examples from the previous year's statements of intent (see our 2011 publication, *District health boards: Learning from 2010-13 Statements of Intent*).
- 3.18 We continue to focus on whether each DHB's service performance information presents a performance story that is clear, logical, and understandable, and that:
- provides a basis for assessing how effectively the DHB responds to its strategic priorities and achieves its intended outcomes;
  - links financial information and good quality non-financial performance information to provide a basis for assessing cost-effectiveness; and
  - describes its services clearly and concisely, particularly the quality of those services.
- 3.19 During the past three years, we have focused on helping DHBs to improve their statements of intent, on the assumption that better annual reporting of performance will follow. DHBs need to continue to work on this. We will apply a revised auditing standard to DHBs' performance reporting in 2012/13.
- 3.20 We intend to provide examples of good practice in annual reporting to help DHBs with their ongoing improvement.

## Procurement

### The procurement environment

- 3.21 DHBs carry out much procurement and that carries with it risks to DHBs' effectiveness and efficiency. In July 2010, the Government established Health Benefits Limited (HBL) to improve DHBs' procurement processes (among other matters).
- 3.22 In past years, our auditors have reviewed DHBs' procurement policies and practices. In September 2010, we published *Spending on supplies and services by district health boards: Learning from examples*, which identified areas for improvement and provided guidance to enhance the effectiveness and efficiency of procurement in contributing to a DHB's business. During our 2010/11 audit, we followed up that report by looking at whether DHBs had prepared a plan and/or systems to improve their procurement practices. We found that, although improving, procurement practices continue to be an area of risk.
- 3.23 DHBs use about half of their funding to pay other organisations to deliver health services. These third parties are often not public entities. Usually, the DHB

manages its risks in these third-party arrangements through a chain of “back-to-back” contracts<sup>19</sup> to ensure that services of the right quality are delivered as and when required.

- 3.24 In the audits for 2010/11, we considered whether “back-to-back” contracts for health services were ensuring that health resources were not wasted and that the required services were provided to the specified standards and in a publicly acceptable way. At the same time, we identified whether the DHB was using “high trust” contracting<sup>20</sup> to reduce the compliance burden of contracting.
- 3.25 Below, we summarise where, in a “third party” environment, DHBs can improve further on their procurement practice and procurement generally.

### Enhancements needed in procurement

- 3.26 DHBs could further improve their procurement practice by:
- *Taking a more strategic approach.* A procurement strategy would draw together policies and approaches and provide a framework that allows procurement to better contribute to corporate objectives. Several DHBs have been awaiting clarity about the services that will fall under the control of HBL, and procurement leadership from HBL. In our view, there is a risk in their waiting, and DHBs ought to have a procurement plan for 2011/12 to show which of the main issues in procurement they intend to address. We note that DHBs have been working together to achieve a more strategic procurement planning approach.
  - *Co-ordinating procurement management arrangements.* In our view, greater co-ordination across the organisational arms of each DHB would improve the quality of procurement activity, as would entity-wide reporting backed by a sound procurement review process. DHBs must consider whether they have enough skilled staff to carry out the procurement function effectively and efficiently.
  - *Considering ethics and legality.* DHBs need to ensure that they have sufficiently assessed and investigated potential conflicts of interest, especially where former staff have been appointed as contractors.

19 A “back-to-back” contract is where the DHB passes its own responsibilities to health service users to the provider of those health services (which the DHB funds). By enforcing the contract, the DHB can ensure that its responsibilities and obligations can and will be met.

20 A “high trust” approach is now being taken in contracts of the Ministry of Social Development and in the Whānau Ora initiative. It typically consists of:

- a simple funding agreement of no more than three pages;
- funding paid up front in one annual instalment;
- meaningful annual reporting focusing on outcomes, with results agreed and described, and flexibility about service delivery; and
- a customised approach to meeting the holistic needs of families.

### Procurement in a “third party” environment

- 3.27 Our auditors did not report any difficulties with DHBs' management of “back-to-back” contracts.
- 3.28 We are aware that small-scale health service providers believe that DHBs could use “high trust” and integrated<sup>21</sup> contracts to better effect. Our auditors reported little evidence of “high trust” contracts, some remarking that the DHB had only recently begun using them. However, we are aware that Whānau Ora developments in the wider government sector, in which the health sector has a major role, are beginning to affect the contracting environment, with more use of “high trust” and integrated contracts.
- 3.29 In our view, DHBs could continue to explore more effective and efficient procurement arrangements, such as reducing reporting requirements, perhaps through more and better use of “high trust” and integrated contracts with third-party providers, whether or not this is within a particular Whānau Ora initiative.
- 3.30 In our view, the Ministry needs to continue to encourage DHBs' efforts to do so. We will maintain our focus on the issue in future audits.

### Managing the debt of ineligible patients

- 3.31 Health or disability services in New Zealand's public hospitals are generally free or subsidised for New Zealand residents, and some other categories of eligible people who meet certain clinical and other assessment criteria.<sup>22</sup>
- 3.32 If DHBs fail to identify or collect payment from ineligible patients, the DHB must meet the costs of their treatment (reducing the funds available for other services). These costs ultimately fall on the New Zealand taxpayer.
- 3.33 We have been told that there is some anxiety in the community that DHBs might, in trying to identify ineligible patients, place a burden of proof on patients that is unreasonable. The concern was that, for example, health service providers might start asking vulnerable patients (such as frail elderly New Zealanders with no proof of residency immediately on hand) for proof that they are eligible for free or subsidised treatment.
- 3.34 It was in this context that, in 2010/11, HBL “worked closely with DHBs to improve revenue collection from patients ineligible for free healthcare, by reviewing practices to build a best practice guide”.<sup>23</sup> The guide was distributed in May 2011 to the DHB teams that deal with matters of patient eligibility.

21 The Ministry of Social Development developed integrated contracts to merge several agencies' contractual requirements of a service provider, with the aim of reducing the compliance burden.

22 Eligibility criteria are explained on the Ministry's website, [www.health.govt.nz](http://www.health.govt.nz).

23 Health Benefits Limited *Annual Report 2011*, page 6.



- 3.35 HBL reported that, at the time of its 2010/11 annual report, it had not yet determined whether its targeted additional saving from improved collection of non-resident revenue had been achieved. This was because DHBs do not routinely report specific data about revenue collected from and owed by ineligible patients, and the relevant data from DHBs was not available at that time.<sup>24</sup>
- 3.36 However, HBL said that 2010/11 data collected from the northern region showed a net gain of about \$6.5 million in revenue collected from ineligible patients, as a result of a wide range of activity and initiatives.<sup>25</sup> Therefore, it appears that there are savings to be made in this area, although HBL was not able to determine the aggregate amount for 2010/11.
- 3.37 We also had difficulty gathering this data for 2010/11. DHB revenue was not detailed by source (eligible/ineligible patients) in DHBs' annual reports. Neither, in general, did DHBs report on the level of revenue, debt, or debt write-off, by type (non-resident).
- 3.38 HBL told us that it has asked DHBs to report ineligible patient and non-resident revenue, and associated bad debts, each month from 1 July 2011, and that arrangements have been made to record this information.
- 3.39 Collection of debt is not the sole focus of debt management. There is also the question of whether DHBs are identifying ineligible patients correctly, and, if not, what barriers to correct identification there are.
- 3.40 HBL told us that it is producing further best practice material for DHBs. Also, the Ministry has been working on improving data-matching to increase the accuracy of identifying non-resident patients. This work indicates that there may be a large issue with providers receiving per capita subsidies for patients who are non-resident and ineligible. The Ministry is taking action on this issue. At the same time, as we have noted above, there is a need for an approach to identifying who is eligible and who is not that does not place an unreasonable burden of proof on vulnerable New Zealanders.
- 3.41 We will continue to monitor the Ministry's and HBL's progress in helping DHBs to improve identification and recovery of the cost of treatment and/or subsidy of ineligible patients, in a way that is effective but not onerous for New Zealand citizens, especially the vulnerable.

<sup>24</sup> Health Benefits Limited *Annual Report 2011*, page 12.

<sup>25</sup> Health Benefits Limited *Annual Report 2011*, page 12.



## Part 4

# Managing district health boards' assets

- 4.1 In this Part, we detail the findings of our high-level review in 2011 of how DHBs manage their assets.
- 4.2 Our review covered:
- the overall approach to planning;
  - strategy;
  - the fundamentals of asset management;
  - organisational factors; and
  - the specialist areas of demand and risk management.
- 4.3 In our view:
- DHBs need to see asset management planning as a core part of their own service and financial planning, and to regularly update their plans (to improve them and keep them relevant). There is scope for the Ministry to encourage DHBs in this.
  - Information about all of a DHB's assets and their condition needs to be brought together and linked to asset lifecycle management strategies, with a clear rationale for any work that is planned on assets.
  - Links need to be clearer between the assets, models of care, required service levels, demand for health services, and the outcomes sought.

### Background

- 4.4 Asset management is an essential part of public sector governance, and should be part of an organisation's strategic, corporate, service, and financial planning.
- 4.5 A complex range of property, plant, and equipment assets underpins DHBs' services. These assets need to be managed so that services are effective and efficient. Asset management means thinking about assets in the context of the services they are supporting, not only now but in the future, and being clear why an asset is held.
- 4.6 We expect each DHB to:
- know how well its mix of assets meets its outcome and service delivery needs, now and in the future (that is, include its asset management in its strategic planning);
  - have information about its assets and their condition that is reliable enough to support its planning, defined service levels, documented lifecycle management strategies, and complete financial forecasts;

- ensure that there are good links between asset management planning and its other service and financial planning, with clear responsibility for planning and for having an up-to-date documented plan in place; and
- understand, respond to, and manage demand for its assets and the risks related to them.

4.7 An entity's approach to asset management forms part of our management control environment assessment in each annual audit. In 2011, we carried out a high-level review of how DHBs manage their assets, as a follow-up on work in previous audits. Our findings are set out below.

### Overall approach to planning

4.8 In 2009, the Ministry required DHBs to formally document their approach to asset management in an asset management plan. In response to that requirement, all DHBs produced an asset management plan in 2009. Regional asset management plans were also produced then.

4.9 Since 2009, the Ministry has required DHBs to submit their capital intentions (as part of applying for capital funding). By the end of July 2012, the Ministry must provide to the Treasury a report on its capital intentions that links individual, regional, and national plans. The Ministry requires DHBs' business cases for new investments to link to local and regional service and asset plans.

4.10 In our view, most DHBs have not improved how they plan to manage assets since 2009. However, there have been discernible improvements in some, notably Auckland, MidCentral, Capital and Coast, and Hutt Valley DHBs. In these DHBs, asset management planning is a core part of service and financial planning, and there is evidence that they regularly update their plans to improve them and keep them relevant. Canterbury DHB is also noteworthy for the integration of its planning for assets with its service and financial planning (see paragraphs 4.41-4.44).

4.11 We consider that there is scope for the Ministry to further encourage and support the other DHBs to see asset management planning as a core part of their service and financial planning, and to produce regional, "joined up" asset management. At the same time, the Ministry needs to ensure that business cases for capital investment are fully integrated with service planning, for the individual DHB, between DHBs, throughout a region, and nationally.

## Strategy

### What we expected

- 4.12 Asset management planning needs to be a main element of strategic planning for health services. It should be done before budgets have been set, and after approaches to meeting health needs have been determined. It has to happen within the DHB's planning cycle.

### What we found

- 4.13 Links between asset management planning and DHBs' other service and financial planning are variable. The DHBs that have updated their planning (for example, Auckland and Capital and Coast DHBs) have gone further than a simple summary of assets. They have defined their outcomes and service delivery needs, completed a structured assessment of asset functionality, capacity, and performance, and linked this to models of care, demand for health services, and the outcomes sought (even if they have had to make assumptions about some of this).
- 4.14 In the wider group of DHBs, which is still relying on 2009 planning, the links between the assets, models of care, demand for health services, and the outcomes sought are typically either not documented or out of date. For example, Southern DHB (formed from the merger of Otago and Southland DHBs) is yet to produce an integrated Southern DHB asset management plan. An integrated plan would enable the DHB to have a better overview of its assets and its relative priorities and needs.
- 4.15 Few DHBs have documented their policy for managing assets. Each DHB should be clear on the appropriate level of sophistication for its asset management practices, proportionate to the scale and risk of its assets, so that services are supported effectively. We agree with international guidance on infrastructure management<sup>26</sup> that the best place to set this out is in a brief corporate policy statement.
- 4.16 Apart from formal plans to manage assets, many DHBs are substantially redeveloping their assets to better meet service needs. This leaves these organisations well placed to take a more strategic view.

<sup>26</sup> *International Infrastructure Management Manual* (NAMS, 4th edition, 2011). We note that, although this guidance is international, it was produced in New Zealand and is highly relevant.

## Fundamentals of asset management

### What we expected

- 4.17 The four aspects that we consider to be fundamental to asset management, and that we assessed, were whether:
- asset information supports strategic planning;
  - information about levels of service is integral to the asset management plan;
  - lifecycle strategies to manage assets cover acquiring, procuring, operational planning, repairs and maintenance, renewal, capital upgrades, responding to growth, and disposal; and
  - there are financial forecasts of operational, maintenance, renewal, and new capital work that are based on explicit assumptions, are precise and reliable, and are supported by up-to-date valuations and a clear, plausible approach to funding work on the assets.

### Information about assets

- 4.18 Most DHBs' asset management plans – whether they date from 2009 or are more recent – provide a summary of assets owned, but that information typically focuses on the age and a description of assets, without information about their condition and performance.
- 4.19 Typically, two factors hamper asset management planning:
- Information on different assets is usually held in separate systems – for example, buildings information is held separately from clinical equipment and vehicle information – making it difficult to consider planning as a whole.
  - Most DHBs' data contains information about equipment that has been fully depreciated and is beyond the end of its (theoretical) useful life, but is still in use.
- 4.20 This latter factor is particularly unhelpful in asset management planning. For example, if asset A is at the end of its theoretical life, but has been assessed to be in good condition and performing well, we would expect the remaining life to be extended to reflect its actual remaining life. Conversely, if asset B, with theoretically five years of useful life left, becomes obsolete, it actually has no useful life left. Unless these useful lives are adjusted to match reality, a profile of remaining life will not match the renewal needs of the DHB. It will wrongly show assets as needing renewal when actually they continue to function adequately, or conversely show assets as having useful life left when actually they need replacing.

- 4.21 This makes it difficult to distinguish between equipment whose useful life has proved longer than originally estimated, and equipment whose appropriate renewal has been deferred, perhaps because of funding shortfalls.
- 4.22 We would expect renewal forecasting to be based on analysis of remaining useful life, condition, and performance. The lack of these aspects of information about some assets makes this difficult.

### Linking assets to levels of service

- 4.23 “Levels of service”, which define the standards of a DHB’s health services, are at the heart of good asset management.<sup>27</sup> Defining service levels helps to put asset management planning in the context of supporting service delivery.
- 4.24 In our 2011 review, we found some good examples of planning based on levels of service. Capital and Coast DHB has defined an initial set of levels of service linked to the assets required to deliver them, and has begun what it calls a “staged introduction of levels of service philosophy”. Similarly, Auckland DHB, in dedicated sections of its 2010 and 2011 asset management plans, refers specifically to “asset service levels”. Although its service levels are defined at a relatively high level, they do cover the breadth of asset groups.
- 4.25 It is clear that other DHBs have standards, expectations, performance measures, and other information that could form the basis of defining asset-related service levels. In our view, pulling them together to support planning should be a priority for these DHBs.

### Lifecycle strategies

- 4.26 We expect lifecycle management strategies to clearly set out the rationale for any work that is planned on assets. Instead, we found that DHBs’ plans typically focus on the capital needed, not on why the asset is needed and when.
- 4.27 Most DHBs’ plans contain good discussion of growth and other demographic change. Auckland DHB’s asset management plan stands out by linking this analysis to capital, maintenance, and operational costs. This positions Auckland DHB well to take a whole-of-lifecycle view to maintaining or renewing its assets.
- 4.28 Without a lifecycle strategy that a DHB follows, maintenance or renewal might be deferred to a point that is a risk to the DHB’s services. The level of risk will depend on the level of service required. More importantly, deferred maintenance and renewal can lead to a shortening of the useful lives of key assets and, in the longer

27 One of the basic tenets of sound asset management practice is: “To provide the levels of service the current and future community want, and are prepared to pay for, in the most cost-effective way”, NAMS (2007), see [www.nams.org.nz](http://www.nams.org.nz).

term, increased costs. Deferred maintenance and renewal of assets may lead to equipment breakdowns, and health services being unavailable.

- 4.29 Many DHB asset management plans refer to deferred maintenance and renewals, without saying how much deferred maintenance there is, or what service levels are expected to be delivered using those assets.

### Linking capital and operational forecasts

- 4.30 The Ministry requires a statement of capital intentions from each DHB. Although important, it is only one aspect of financial planning.
- 4.31 We found that most DHBs have not brought together financial forecasts of capital and operational expenditure. This is a weakness in financial planning for DHBs' assets.

## Organisational factors

### What we expected

- 4.32 We expected DHBs:
- to have a complete, up-to-date asset management plan in place;
  - to be clear how asset management planning is linked to other operational service and financial planning, such as annual budgeting processes; and
  - to be clear how asset-related service delivery is organised, with responsibility for asset management at management and governance levels, supported by access to suitably qualified experts where needed.

### What we found

- 4.33 Most DHBs do not keep their asset management planning up to date. Some DHBs state that they are working to a three-year asset management planning cycle, with an update due in 2012.
- 4.34 In our view, a three-year asset management planning cycle can be appropriate once asset management planning is mature and established as part of business as usual. However, most DHBs are not in this position. A more appropriate approach is to update and improve planning incrementally in the early years. This was the approach taken by Auckland, MidCentral, Capital and Coast, and Hutt Valley DHBs, for example.
- 4.35 As noted above, links between asset management plans and other planning need to be strengthened. In particular, planning cycles need to be better aligned.



- 4.36 One of the better examples is Auckland DHB's asset management plan, which is well integrated with the DHB's capital and other budgeting processes. The mix of outsourcing and in-house work is explained and justified. Responsibility for asset management is clear at the operational and governance levels.

### Managing demand and risks

- 4.37 Most DHBs have documented the factors that influence demand on their assets, with explicit and detailed growth and demand assumptions.
- 4.38 To help manage risks, some DHBs have followed good practice by formally identifying certain assets as critical to service delivery. Capital and Coast DHB has a risk framework and is applying a risk-criticality model to all its assets to identify potential effects on business deliverables. Formally identifying critical assets allows them to be prioritised for inspection, maintenance, and renewal as appropriate.
- 4.39 Auckland DHB's plan outlines the corporate approach to risk management, using a web-based event (incident) reporting system. Risk and asset criticality are addressed throughout the plan, showing that asset-related risks are well considered.
- 4.40 However, most DHBs have not included within their asset management plans a risk register of major asset-related risks and approaches for managing those risks. As a result, the approach to managing risk or dealing with disaster is not clear. The lack of clarity weakens this aspect of DHB management.

### Effect of the Canterbury earthquakes on asset management

- 4.41 In 2009, Canterbury DHB prepared a plan for a significant realignment of health services followed by a redevelopment of facilities. Asset analysis and appraisal was one of the three components of its plan. The other two aspects were clinical services planning and the concept master plan. Canterbury DHB told us that a business plan was submitted to the Government in November 2010 for building work at Christchurch and Burwood Hospitals.
- 4.42 The recent earthquakes have caused substantial damage. Canterbury DHB continues to assess damage after significant aftershocks. It has prepared some temporary provisions to enable service delivery to be maintained, and has taken care to ensure that these temporary developments are aligned to the overall direction of service delivery and effective asset management in line with the concept master plan.

- 4.43 To ensure that Canterbury DHB's asset planning is also aligned to provide more complex hospital services and meet regional needs, it is working with colleagues across the southern region to prepare a regional asset management plan that is aligned with projected clinical needs.
- 4.44 This planning work will be based on:
- future clinical demands;
  - its current assets, their current state, and whether they are fit for purpose;
  - an analysis of the gap between what the DHB has and what its future needs are expected to be; and
  - asset developments in line with overall clinical need across the South Island.
- 4.45 We expect that there will be wider repercussions for DHBs from the Canterbury earthquakes. Upgrading buildings to meet existing building codes, and the possibility of more rigorous codes, introduce new challenges for DHBs.<sup>28</sup>

### **Our focus for future audit work on asset management**

- 4.46 To follow up on the findings of our review, we are currently considering whether DHB asset management will be one of the topics focused on in our audit work in 2012/13. The focus of our work would be the more general issue of whether the public sector, and DHBs in particular, are well prepared to meet future service needs.
- 4.47 We will continue to encourage the Ministry, in its work with DHBs on asset management planning, to get DHBs to see it as a core part of their service and financial planning, and to work on regional, "joined up" asset management. At the same time, the Ministry needs to ensure that business cases for capital investment that it manages nationally are fully integrated with service planning, for the individual DHB, the district, the region, and nationally.

<sup>28</sup> See Part 2 of Office of the Auditor-General (December 2011), *Central government: Results of the 2010/11 audits (Volume 1)*.

## Part 5

# Reducing health disparities for Māori

- 5.1 In this Part, we discuss the requirement for DHBs to improve the health of Māori and reduce health disparities for Māori, and how DHBs monitor and report this.
- 5.2 In our view, the combination of lack of information in the annual reports on Māori health needs and on targets to reduce disparities makes it hard to gauge DHBs' progress.

### Requirement to reduce health disparities for Māori

- 5.3 Under section 22(1)(e) and (f) of the New Zealand Public Health and Disability Act 2000 (the Act), DHBs have a statutory objective to reduce (with a view to eliminating) health outcome disparities “by improving health outcomes for Māori and other population groups”. DHBs are expected to prepare and put into effect services and programmes to do so.
- 5.4 Under the Act, DHBs must also establish and maintain processes enabling Māori take part in, and contribute to, strategies for improving the health of Māori. He Korowai Oranga is the Government’s strategy for improving Māori health and reducing health inequalities for Māori.
- 5.5 In 2009, a Ministry assessment of DHBs’ Māori health plans<sup>29</sup> found that all DHBs had such plans (seven of which were jointly prepared by the DHB in partnership with Māori and 12 of the others by the DHB), and that almost all of the plans were in line with the DHBs’ district annual plans and He Korowai Oranga.<sup>30</sup> Although most plans had a strategic focus, only some included actions, and the duration of the DHBs’ Māori health plans varied (three-, five-, or ten-year plans). There tended to be a lack of clarity in the plans about who would monitor and evaluate the plan’s effect and when and how they would do it.
- 5.6 In 2011/12, the Ministry required every DHB to produce an annual Māori health plan describing how the health of Māori in its district will be improved and inequalities reduced.<sup>31</sup> The Māori health plan should be in line with the DHB’s annual planning document and He Korowai Oranga. The Ministry expects there to be governance-level (usually partnership) relationships (what the Ministry calls a Māori relationship board) with local Māori communities, which would help assess achievements against the Māori health plan.
- 5.7 As a result of the lack of clarity noted in its 2009 assessment, the Ministry introduced a template for the plans and now requires DHBs to report against a set of 15 indicators in nine health issue areas. Seven of these (access to care, maternal

29 Information provided by the Ministry of Health, 12 January 2012.

30 The annual plan and regional plans have replaced district annual plans and district strategic plans.

31 The Operational Policy Framework empowers Ministry requirements for Māori health plans. Clause 21.5 of SOC Min (10) 15/2 states that annual plans of DHBs are to include Māori health plans.

health, cardiovascular disease, diabetes, cancer, smoking, and immunisation) relate to services, while two (workforce and data quality) relate to organisational capability. DHBs can consider regional and district priorities in the plans by including additional indicators. The Ministry also requires DHBs with high rates of rheumatic fever and/or sudden infant death syndrome to include them in their local indicator set.

- 5.8 DHBs are expected to internally assess their own progress on the Māori health plans. The Ministry will monitor DHBs to ensure that DHBs evaluate and review progress to achieve the desired outcomes. In doing so, the Ministry has certain expectations, central among them that:
- there are targets, milestones, and actions that can be measured; and
  - the DHB makes changes if indicator targets are not being achieved.
- 5.9 The new structure for Māori health plans introduced for 2011/12 is intended to provide a more effective planning mechanism for reducing inequalities and improving the health of the Māori population.

### Our review

- 5.10 We do not audit the Māori health plans. However, we do have a strong interest in the accountability of public entities. Each year we audit DHBs' performance reporting (the statement of service performance in the annual report).
- 5.11 We expect that each DHB in whose district the health status of Māori differs significantly from the population in general will, in its accountability documents, report meaningfully on what the disparities are and how it has improved the health of, and reduced disparities for, Māori.
- 5.12 For 2010/11, we decided to review each DHB annual report to assess whether the DHB reported there on:
- the extent of the district's health disparities for Māori;
  - initiatives, with measures and targets, that the DHB is taking to reduce disparities and to respond if it fails to achieve its targets for Māori; and
  - the effect of those initiatives on Māori health (that is, whether measures, targets, and trends for effects are reported, and to what extent).
- 5.13 We also noted whether the DHB had in place processes for Māori to contribute to strategies for improving the health of Māori in their community.

## The extent of health disparities for Māori

- 5.14 We expected DHBs to identify in the annual report any particular health disparities for its Māori population, to give an idea of the extent of the disparities (in terms of severity and areas of disparity), and to use this as the basis for its planning of services to meet the needs of Māori.
- 5.15 DHBs are also expected to have this information in their Māori health plans. Acknowledging this, we still expect that if Māori health disparities are a priority for a DHB, this will be clear in the annual report by the DHB, as it is held to account through this document.

## What we found

- 5.16 DHBs' stated general intent to achieve health equity is not usually accompanied by any detailed information about disparity in the district or the size of the disparity for Māori.
- 5.17 Four DHBs did not describe in their annual report the district's health disparities for Māori (that is, they either mentioned only the statutory requirement about addressing disparities or did not mention or quantify district-specific Māori health disparities).
- 5.18 The other DHBs typically made a general statement that Māori health is a priority, described the nature of the partnership arrangements in the district, and described initiatives for improving staff capability and capacity. They did not, generally, describe the particular health disparities between Māori and other groups in the district, or the relative importance of the issue for the district.
- 5.19 It is possible that DHBs expect people to read the Māori health plans to get this information. The Ministry's 2009 assessment found that all DHBs had such plans and that most DHBs provided information in the Māori health plans on the needs and priorities of Māori within their district.
- 5.20 We found it difficult to locate the Māori health plans of four of the DHBs. We question whether an interested reader of the DHB's annual report would have gone to the lengths we did to find the Māori health plans of those DHBs.
- 5.21 Some Māori health plans were easier to access. Counties Manukau DHB's *Whaanau Ora Plan 2006–2011*, for example, was available on the DHB's website.<sup>32</sup>
- 5.22 Māori health plans, being plans and not reports, do not give the kind of information needed to hold the DHB to account for reducing disparities for Māori. However, if these plans were linked to statements of intent and statements of service performance, it would be possible to provide this information.

32 Available at [www.cmdhb.org.nz/About\\_CMDHB/Planning/Maori-Health-Plan/WhaanauOraPlan.pdf](http://www.cmdhb.org.nz/About_CMDHB/Planning/Maori-Health-Plan/WhaanauOraPlan.pdf).

- 5.23 Counties Manukau DHB's *Whaanau Ora Plan 2006–2011* has measures<sup>33</sup> but no report (because it is a plan) of progress toward those outcomes during the five years for which the plan was in place. However, Counties Manukau DHB reported on a comprehensive range of Māori-specific performance indicators in its 2010/11 statement of service performance, with some close matches between the *Whaanau Ora Plan 2006–2011* measures and the performance results. Among these were avoidable hospitalisations: in the plan the aim was to “reduce potentially avoidable hospitalisations 0-14 years and 15+ years”, and the reported result (on page 74 of the *Annual Report as at 30 June 2011*) was set out for the age groups 0-4, 45-64, and 0-74 years. Also, in the plan was the aim to “increase the number of children who are fully immunised at 2 years of age”, and this was reported on page 71 of the *Annual Report as at 30 June 2011*.
- 5.24 In our view, this linking of plans to performance reporting is a necessary step in reducing disparities for Māori. Unless information about the actual district Māori health disparities and initiatives taken by the DHB is available in the statement of service performance, there is no formal mechanism to hold the DHB to account. We expect the DHB's accountability documents to identify any significant Māori health disparities and the annual report to detail progress to reduce disparities.

### Specific initiatives to improve Māori health

- 5.25 In the preamble to their annual report, 14 of the 20 DHBs mentioned initiatives that they were taking to address disparities for Māori. However, descriptions were usually general rather than specific, and usually involved workforce, governance, or process initiatives (such as training support for providers of services for Māori), not health service initiatives. Lakes DHB's annual report is an exception in its descriptions of both governance and health service initiatives for Māori.
- 5.26 Again, the Māori health plans might outline specific initiatives. We found that the Counties Manukau *Whaanau Ora Plan 2006–2011* has a section on “service development strategies” (page 36). However, these tend to be inputs and processes (such as “risk management”) rather than health service initiatives.

### Measuring how effective initiatives are in reducing health disparities for Māori

#### Indicators of progress

- 5.27 Although all DHBs had indicators that measured achievements for Māori, the number of such indicators varied widely, with half having five or fewer in their statement of service performance.

33 It has sections outlining medium-term priorities, outcomes, and measures (pages 20-21 and 26-29).

- 5.28 It was not clear why some DHBs that said they had high disparities for Māori had few indicators for those disparities.
- 5.29 The Ministry's reporting requirements for the Māori health plans (introduced in 2011/12) include national and regional indicators, with the DHB expected to establish district-specific indicators as appropriate. The Ministry also expects DHBs to report data for Māori against 15 indicators (including 13 service performance indicators) quarterly, six-monthly, or annually to the Ministry. We see this as a positive move.

### Targets and trends

- 5.30 The result that New Zealanders want is for differences in health between Māori and non-Māori to be as small as possible or, better still, none at all. Setting targets helps the DHB to see the results of the work it is doing to reduce disparities.
- 5.31 Where the disparity in health status for Māori is significant, we expect to see measures and targets for Māori, with trend data, in the annual report of the DHB.
- 5.32 The national Māori health plan indicators reflect National Health Targets for immunisation, smoking, cardiovascular disease, cancer, and diabetes, as well as maternal health and access to care (percentage of Māori enrolled in PHOs, and avoidable hospitalisations).<sup>34</sup>
- 5.33 Most of the National Health Targets are set very high and are being met, so it is unlikely that disparities for Māori would be evident. If there are still disparities for Māori in these health areas, we expect to see measures and targets for Māori in the annual reports of the DHB.
- 5.34 Where DHBs had indicator measures for Māori in their annual report, all had specific targets. In some instances, targets were set at the same level as for other population groups. In others, targets for Māori were lower, even considerably lower. There was usually little trend data to show progress toward the target, or toward reduced disparity. Most DHBs showed only baseline data for the indicator, not the trend.
- 5.35 In some DHBs (for example Bay of Plenty DHB), the same targets were set for all population groups (an "aspirational" target), and the Ministry has taken this approach through the Māori health plan template. "Aspirational" targets, coupled with trend data to guide specific action plans year by year toward the target, may be more effective than setting low targets with no specific initiatives.
- 5.36 In our view, more work needs to be done on the effect of the level of the target on the likelihood, and time taken, to reduce significant disparities for Māori.

<sup>34</sup> There is flexibility for the regional and district indicators to reflect regional and district health needs. However, priorities for affected DHBs include indicators for rheumatic fever and sudden infant death syndrome.

- 5.37 Public reporting (for example, in annual reports) could also be helpful in achieving change. Māori and Pacific peoples' immunisation rates have improved,<sup>35</sup> arguably as a result of setting the targets at the same levels for these groups as for others and publicly reporting the results.
- 5.38 We were unable to form a view about how well DHBs use information about Māori health status to focus on their next steps, because DHBs tended to be vague about what they intended to do. For example, one DHB said that "A range of initiatives are being undertaken to meet this target which is expected to lead to improved results."

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

- 5.39 Some DHBs, such as Lakes DHB, clearly state partnership arrangements in accountability documents. In Lakes DHB, the Māori partners have the status of a governance body, signing off the DHB's statement of intent and annual plan.
- 5.40 This is not so for all DHBs. In six of the DHBs' annual reports, it was not clear what processes were in place to allow Māori to take part in, and contribute to, strategies for improving Māori health. Again, the DHBs concerned might have expected readers of their annual reports to access this information through the Māori health plan or their website.

### **Our focus for 2011/12**

- 5.41 As one aspect of our audit focus on service performance reporting for 2011/12, we intend to pay attention to the quality of DHBs' reporting of their efforts to reduce health disparities for Māori.
- 5.42 We consider that there are clear and sensible reporting requirements (in the form of the Ministry's Māori health plan template for 2011/12). In our view, better information about the disparities and about trends for the main indicators of those disparities would help DHBs to shape their health initiatives. Reporting against the Ministry's health indicators in the annual report would be helpful. We will discuss the monitoring and reporting of DHBs' Māori health initiatives with the Ministry.
- 5.43 We are considering, for our audit work in 2012/13, whether to focus on child health initiatives throughout the public sector in the medium to long term, and how well those initiatives address the future needs of New Zealanders. An important aspect of this would be the effectiveness of DHBs' initiatives to reduce disparities for Māori.

35 Information provided by the Ministry of Health, 2 February 2012.



## Part 6

# Our recent and ongoing work in the health sector

### Recent reports

#### *District Health Boards: Learning from 2010–2013 Statements of Intent*

We published a good practice guide in February 2011 on DHBs' statements of intent (SOIs). It was written to help DHBs as they prepared their 2011-14 and future SOIs.

Feedback from the DHBs has indicated that this was a very useful guide, and further good practice guidance has been requested. This is being prepared for publication shortly. In our view, the gains that have been made in performance reporting by DHBs in the last three years can be attributed in no small part to the good practice guidance that DHBs have had from our auditors and from our publications.

#### *Progress in delivering publicly funded scheduled services to patients*

We published a report in June 2011 in which we assessed progress made in achieving the government strategy "Reduced Waiting Times for Public Hospital Elective Services". We found that there had been good progress over 10 years but there was more to do to ensure that patients were assessed in a nationally consistent way, and seen and treated in priority order. We meet regularly with the Ministry to assess progress against our recommendations. At these meetings, the Ministry provides us with progress updates.

#### *Home-based support services for older people*

In July 2011, we published our report on home-based support services for older people. We carried out a performance audit to establish how effective the Ministry of Health and district health boards were in ensuring that, where appropriate, people aged 65 and over got the care and support they needed to remain living independently at home. We will meet regularly with the Ministry to assess progress against our recommendations. The Ministry has agreed to provide us with progress updates at these meetings.

#### *New Zealand Blood Service: Managing the safety and supply of blood products*

We have just published (14 February 2012) our report on managing the safety and supply of blood products by the New Zealand Blood Service. We found that the Blood Service effectively supplies safe blood and blood products to patients in our health system. This is a "good news" story. The Blood Service is a high-performing organisation and we had no recommendations to make.

## Ongoing work

We are considering focusing in our health sector work for the next 18 months on DHBs' asset management, building on the review discussed in Part 4 of this report. This would be incorporated into a work programme that examines the readiness of the public sector to meet the needs of New Zealanders in the medium to long term.

We are also considering a focus on child health, which would involve a wide range of entities, the DHBs and Ministry, and core health service providers, as well as the many entities in the public sector whose services contribute to the well-being of children: the social services, housing and justice sectors in particular. Part 5 of this report looked at one aspect of child health; the contribution of DHBs to reducing disparities in the health status of Māori. It would be the basis for a more in-depth examination of how well the public sector is prepared to ensure the future well-being of our children.

# Publications by the Auditor-General

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

- Central government: Results of the 2010/11 audits (Volume 2)
- New Zealand Blood Service: Managing the safety and supply of blood products
- Central government: Results of the 2010/11 audits (Volume 1)
- Education sector: Results of the 2010/11 audits
- Managing the implications of public private partnerships
- Cleanest public sector in the world: Keeping fraud at bay
- Annual Report 2010/11
- Transpower New Zealand Limited: Managing risks to transmission assets
- The Treasury: Implementing and managing the Crown Retail Deposit Guarantee Scheme
- Managing freshwater quality: Challenges for regional councils
- Local government: Improving the usefulness of annual reports
- New Zealand Transport Agency: Delivering maintenance and renewal work on the state highway network
- Government planning and support for housing on Māori land
- Inquiry into the use of parliamentary travel entitlements by Mr and Mrs Wong
- The Emissions Trading Scheme – summary information for public entities and auditors
- Planning to meet the forecast demand for drinking water in Auckland
- Appointing public sector auditors and setting audit fees
- Home-based support services for older people
- New Zealand Customs Service: Providing assurance about revenue
- Inland Revenue Department: Making it easy to comply
- Central government: Cost-effectiveness and improving annual reports
- Annual Plan 2011/12

## Website

All these reports are available in HTML and PDF format on our website – [www.oag.govt.nz](http://www.oag.govt.nz).

Most of them can also be obtained in hard copy on request – [reports@oag.govt.nz](mailto:reports@oag.govt.nz).

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