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Annual Report

for the year ended 30 June 2017

Ministry of Health

Presented to the House of Representatives
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Director-General's overview

I am pleased to present the Ministry of Health's 2016/17 Annual Report.

The 2016/17 year was a significant one for the Ministry following the launch of the New Zealand Health Strategy. This set the direction of health care for the next 10 years and much of our work during this year was focused on implementing its actions.

This included our co-design work with the disability support sector to develop 'Enabling Good Lives'. This approach will transform the way disability services are delivered and give people with disabilities more choice and control over how they live.

A bowel screening pilot was successfully completed resulting in approval of the National Bowel Screening Programme due to go live from 1 July 2017. This programme aims to reduce waiting times and ensure more New Zealanders get the help they need.

The Ministry continued to work with the primary health care sector to provide more accessible services and develop new models of care in local communities, especially those from priority population groups such as Māori and Pacific peoples.

Improving mental health and addiction services was also a focus . This included working with the wider health sector to develop Nga Taiohi Youth Forensic Inpatient Service, which is the first of its kind in New Zealand and cares for teenage offenders with a mental illness and/or alcohol and drug problems.

The Ministry also achieved some significant milestones as we continued work to deliver on the Government's existing and new Better Public Services targets. I am particularly proud of the Ministry's collaboration with multiple public sector agencies in relation to the care and support workers' pay equity settlement. This was a complex piece of work and involved the Ministry quickly setting up a programme to ensure that 55,000 people, working for 650 providers and covered by 1,100 contracts received the right wages on 1 July.

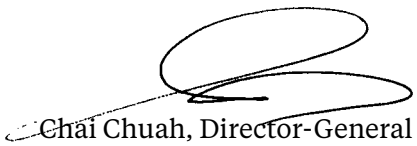
In keeping with the 'smart system' theme of the New Zealand Health Strategy, 2016/17 was also a year that saw technology being used to improve health services and make them more accessible. As well as a number of eHealth initiatives that are in place further developments were made to the Telehealth service, including the introduction of the 1737 number.

While we can reflect on a number of successes I must also acknowledge the things we could do better. Following the errors made in the Budget 2017 funding allocations for district health boards, the Ministry is implementing the recommendations from a Deloitte review so that we can ensure this does not happen again.

We know we need to work differently in a number of ways and 2016/17 was a year of transformation for the Ministry. A lot of the changes we've made are concerned with our stewardship role. We know that many factors affect a person's health and wellbeing and we are committed to working closely with our health and social sector partners to improve system-wide performance.

As we look ahead to the future, I believe that only by continuing to work together with our colleagues across government, the wider health sector, NGOs, local communities and iwi, can we ensure the future sustainability of our health system, helping every New Zealander live well, stay well, and get well.

No reira, tēnā koutou, tēnā koutou, tēnā koutou katoa.



Chai Chuah, Director-General of Health

MINISTRY OF HEALTH
MANATŪ HAUORA

The health and disability system

All New Zealanders live well, stay well, get well

Primary health care

I'll pick up my prescription from my local pharmacy on the way home from work

Secondary and specialist care

Maternal care

Child and family health

Immunisation

I'm taking my baby to our local GP for his six-week immunisation

Pacific health

People-powered Mā te iwi hei kawe

Closer to home Ka aro mai ki te kāinga

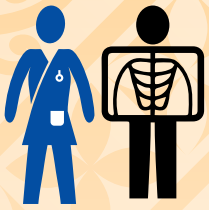
Value and high performance

Touching the lives of all New Zealanders

Feeling anxious, a bit overwhelmed, or do you just 'Need to Talk' to someone? Call or text 1737 anytime

Addictions

Screening



Mental health

Long-term conditions

The Ministry's guidelines for healthy eating and physical activity have really helped me and my family

Disability Support Services

Obesity

I do my weekly grocery shopping with my care worker

Cancer

Residential and community care

I'm proud I've quit smoking with the support of QuitLine and my local Māori health provider

Māori health

As an older person, I'm happy that I receive the support I need to live independently

Contents

List of figures

List of tables

Scope of our Annual Report 2016/17

Our purpose and roles

The purpose of the Ministry of Health (the Ministry) is to lead and shape New Zealand's health and disability system to deliver a healthy and independent future for all 4.7 million New Zealanders.

The Ministry leads a large and devolved health system with many partners. The Ministry takes a national view of the whole of the system that informs sector-wide actions and decisions. The Ministry seeks to deliver better health outcomes for New Zealanders by working in partnership with the sector (including district health boards, primary health care providers and non-government organisations) and other public service agencies, and by engaging with people and their communities in carrying out its key roles. To support all New Zealanders to live well, stay well and get well, the New Zealand health and disability system interacts with hundreds of thousands of customers every day.

The Ministry's work is informed by its strategic direction, including through documents such as the New Zealand Health Strategy (the Strategy), the Ministry's Statement of Intent 2015 to 2019, and the Four-year Plan 2017 to 2021. The Strategy sets the vision for the health system to address the significant challenges and opportunities on its services and the health budget, and emphasises the need for all parts of the health and disability system to work together to make our desired future a reality.

There are leadership roles throughout the health system but the Ministry's role includes being a steward for the health sector. This concept of stewardship is crucial for the health sector – not delivering or controlling everything but making sure the health system works well, at each stage, for every New Zealander. This involves having an overview of the whole health sector and system to ensure it preserves and enhances value through positive outcomes delivered to its customers.

Stewardship also involves recognising that partner organisations will lead and support much of the transformation required in the health sector. It looks at the links between different parts and strengthens these where needed to support a high-functioning health system.

In addition to this stewardship role, the Ministry is also responsible for critical departmental activities that enable the rest of the health sector to fulfil their mandate as per the Strategy.

Context of our annual report

This annual report reflects on how the Ministry has delivered against its strategic intentions, as laid out in the Ministry's Statement of Intent 2015 to 2019 and the Ministry's Four-year Plan 2017 to 2021. The Ministry's Four Year Plan was developed following the release of the New Zealand Health Strategy and aligns the Ministry with the strategic direction of the wider health sector.

New Zealand Health Strategy and associated roadmap of actions

The Government released a refreshed New Zealand Health Strategy in April 2016 to respond to challenges and set a clear future direction for the health system. The Strategy has five strategic themes for the future of the health system: people-powered, closer to home, value and high performance, one team, and smart system.

Released alongside the updated Strategy was a roadmap of actions that identified 27 areas for action over five years to move the health and disability system in the direction of the Strategy. Through the Ministry's 2016/17 work programme, 26 out of the 27 actions contained in the roadmap are being progressed. Of the 104 sub-actions, 91 have activity under way and have progressed to various stages.

Implementation of the Strategy has been a priority for the 2016/17 financial year and is embedded in district health boards' (DHBs) annual planning and reporting processes.

The end of the first full financial year since the updated Strategy was released is a good time to reflect on what has been achieved so far. To this end, the Ministry of Health is working with the wider health sector to gather a combined view of progress. The Ministry also seeks to improve, promote and protect the health and wellbeing of New Zealanders through the work that we deliver with the wider health sector through the development of innovative initiatives to maintain and improve access to quality health services that enhance the value of the services we provide.

Statement of Intent 2015 to 2019

The Ministry's Statement of Intent 2015 to 2019 (SOI) highlights the Ministry's role in delivering on and contributing to Government priorities, cross-and social sector priorities and the Minister of Health's priorities for the health and disability system. Detailed reporting on these areas can be found in Section two.

The SOI also highlights the critical departmental activities (also known as our core work) that the Ministry delivers to preserve value for its customers. These are reported in Section three and include:

- policy advice and ministerial servicing
- purchase of health and disability services
- health sector information systems
- payments service
- regulatory and Enforcement services
- sector planning and performance advice.

Four-year Plan 2017 to 2021

Since the last update of the Ministry's Statement of Intent in 2015, and as part of the process for developing the Ministry's Four Year Plan 2017 to 2021 (following release of the Strategy), six strategic priorities have been identified. These six priorities are actions that the Ministry will need to implement to give effect to the Strategy so that the health system will continue to remain sustainable and improve health outcomes for all New Zealanders.

The structure of our Annual Report

This annual report covers the full scope of our value-enhancing, value-adding and value-preserving work, how we collaborate within the wider government arena, our role in the health sector and our core work within the Ministry.

Section one aligns what we have delivered this year in relation to the Ministry's six strategic priority areas.

Section two details the Ministry's contribution to wider governmental priorities, other priorities as set by the Ministry and the Minister in the Ministry's Statement of Intent 2015–19 including health targets.

Section three focuses on the Ministry's critical departmental activities that preserves value for all its customers.

The remaining sections outline our financial performance and how the Ministry's focus is on fostering a culture of high-performance and customer-orientated service delivery.

The year in review

HealthOne
Shared knowledge - better, safer care

Wins award for **Best Technology Solution** at the **New Zealand Hi-Tech Awards**

Securely contains information for over

800,000

New Zealanders

Pay equity settlement

$2b awarded to **55,000** care and support workers, representing between **15%** to **50%** pay increase

Phase 1 of **project** to make **payments** before 1 July 2017 **implemented** in **10 weeks**

Managed **650 providers** and **1,100 contracts**

National Bowel Screening Programme

Bowel Screening
Check Yourself Out

live from 1 July 2017

Primary objective is to **reduce** the **mortality rate** from bowel cancer

Aim: **62%** of the eligible population will be screened

Mental health and social investment

Launch of service

Need to talk?
24 hours a day
365 days a year 1737

Additional $100m budgeted for cross-government social investment fund

22 initiatives
to reduce childhood
obesity

Developed **new eating and activity guidelines** for adults

Primary health care

98% of children under 6 years old **enrolled with a GP** and receiving free visits

Better access enabled an **increase** in **GP visits:**
15% increase for **Māori children**

11% increase for **Pacific children**

77% disabled people receiving community support up from **67%** in 2016

More choice and **control** for disabled people and their whānau

Disability Support Services

Transformation of the **disability support system**, led by disabled people and the wider disability community

Rongoā Kākāriki
GREEN PRESCRIPTION

Green Prescription turns 20

Positive impact for over

400,000

New Zealanders

73% of **patients noticed positive health changes** from **Green Prescriptions**

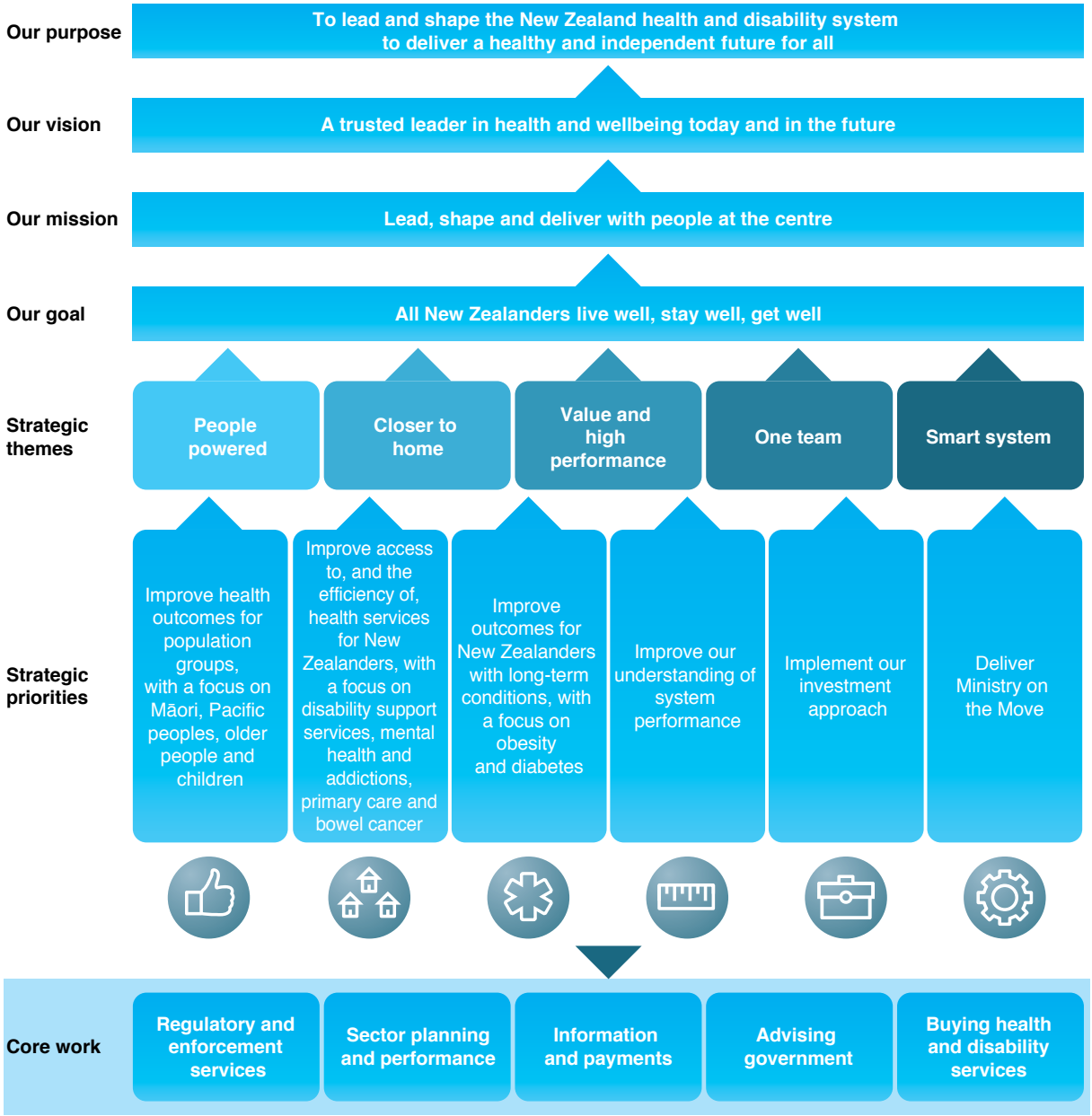
Section one
Delivering our strategic priorities: value-enhancing activities

Delivering our strategic priorities

During the development of the Ministry's Vote Health Four Year Plan 2017 to 2021, six strategic priorities were identified. These six priorities are actions that the Ministry will need to implement to give effect to the the Strategy so that the health system will continue to remain sustainable and improve health outcomes for all New Zealanders. These strategic priorities are:

1. improving health outcomes for population groups with a focus on Māori, Pacific peoples, older people and children
2. improving access to and the efficacy of health services for New Zealanders with a focus on disability support services, mental health and addictions, primary care and bowel cancer
3. improving outcomes for New Zealanders with long-term conditions with a focus on obesity and diabetes
4. improving our understanding of system performance
5. implementing our investment approach
6. delivering on Ministry on the Move transformation programme.

Figure 1: Ministry of Health strategic architecture



Strategic Priority 1: Improve health outcomes for population groups, with a focus on Māori, Pacific peoples, older people and children

The Ministry continues to focus on designing services and models of care that support the achievement of improved health outcomes for Māori, Pacific peoples, older people and children. This includes having a strong focus on developing customer insights and using those insights to inform prioritisation of investment.

Improving health outcomes for Māori

The Ministry undertook many activities aimed at improving health outcomes for Māori. Some highlights from the year are detailed below.

The Whānau Ora Partnership Group

The Whānau Ora Partnership Group seeks to strengthen efforts to support Whānau Ora across Ministerial portfolios. The group identifies opportunities for the Crown and iwi to support shared development, aims and aspirations. It has agreed to a shared Whānau Ora Outcomes Framework (the framework) that takes an aspirational approach to improving whānau wellbeing and self-management. Implementation of the outcomes framework is under way.

The Ministry is focusing on progress in five key health priority areas for the framework: mental health, asthma, oral health, obesity and tobacco. All DHBs are required to respond to the framework by supporting Whānau Ora across priority health areas in their 2016/17 annual plans.

Activities for all five health priority areas are selected based on criteria that support working in a whānau-centred way, reflect known health issues for Māori and Pacific families/whānau and provide a mix of interventions and amendments that can be achieved within four years.

The Ministry will continue to engage with the Whānau Ora commissioning agencies, iwi advisors and across government agencies to work on the priorities identified at the Whānau Ora Partnership Group meetings.

Integrating Māori health plans into DHB annual plans

In an effort to achieve better integration, Māori health plans have been incorporated into the DHB annual plans to strengthen accountability and improve Māori health outcomes. This shift requires DHB chairs and boards to report directly to the Minister of Health on how they have increased accountability for Māori health.

Continuing a targeted approach in key areas

The Ministry continues to address Māori inequities through its targeted approaches in key areas, as described below.

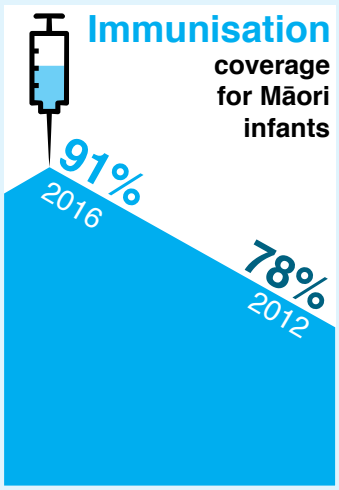
BreastScreen Aotearoa

BreastScreen Aotearoa is addressing inequities in coverage for Māori women through multiple strategies, including monitoring provider initiatives through contracts, data matching with primary health care to identify under-screened women, regional collaboration, DHB Māori health plan activity, redesigned support to screening services contracts and social marketing initiatives.

Better Public Services

Existing targets, such as increasing infant immunisation rates and reducing the incidence of rheumatic fever, have been key work areas over the last five years. In the case of immunisation, coverage for Māori infants has increased from 78 percent in 2012 to 91 percent in 2016. In relation to rheumatic fever, significant reductions have been made in some areas but not all. The Ministry will continue to focus on these areas over the next year.

Māori health year in review

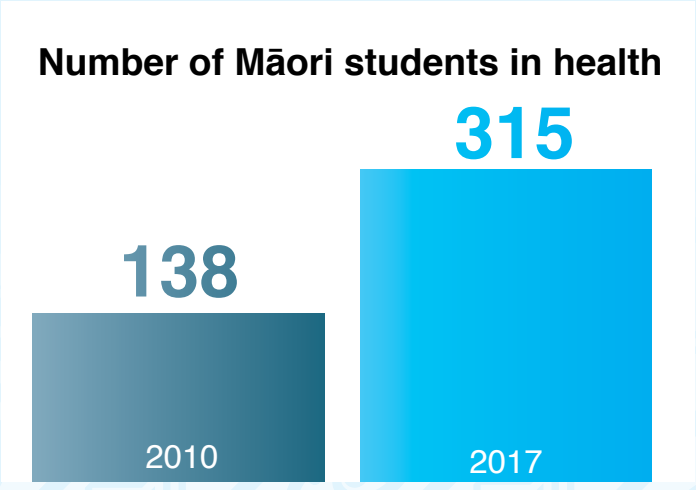


$270m

funding for Māori providers

Māori Provider Development Scheme

The Māori Provider Development Scheme provided funding to assist 111 Māori providers to strengthen their organisations in areas of infrastructure, workforce, governance and management development



~280

Māori health providers working in the **New Zealand health** and **disability system**

National Cervical Screening Programme

Just over 65 percent of the eligible female Māori population (Māori women aged 25–69 years, hysterectomy adjusted) took part in the National Cervical Screening Programme (NCSP) over the last three years. There are inequities in coverage for Māori, Pacific and Asian women, and the NCSP is addressing this through multiple strategies, for example: monitoring provider initiatives through contracts; including cervical screening coverage as a target in the Māori health plans and as a contributory measure in the system-level measures; providing some free smears for priority women; matching data to target under-screened women and taking part in social marketing strategies.

In addition, supports to screening services have been redesigned to improve service access for priority women (Māori, Pacific, Asian, unscreened and under-screened women).

Māori health service improvement

Ensuring there is a continued improvement in Māori health requires opportunities to review and reflect current policies, strategies and programmes. In the last year, the Ministry has reviewed and is developing new strategies, such as Whāia Te Ao Mārama: Māori Disability Action Plan and the New Zealand Suicide Prevention Strategy 2006–2016.

The Ministry also continues to deliver on core activities that: support improving Māori health outcomes; build the evidence base; foster Crown-Māori relationships; support Māori models of care; and support Māori participation, capability and capacity in the health and disability sector.

The highlight was the Waka Hourua: Māori and Pasifika Suicide Prevention programme. Evaluation feedback on the 63 prevention initiatives the programme has funded nationally since its inception in 2014 indicate better recognition of suicidal behaviours and increased knowledge of ways to help people at risk. This evaluation is being used to develop an outcomes framework approved by the National Leadership group.

Other work streams undertaken were programmes funded by the Māori Health Workforce Development Unit and the Hauora Māori Scholarships programme, which awards scholarships to Māori students in health studies.

Māori health development

Treaty of Waitangi Deed of Settlement – Napier Hospital and Health Services Claim, Wai 692

The final implementation of the settlement of the Wai 692 – Napier Hospital and Health Services claim was completed in May 2017. The original settlement signed in October 2008 provided funding (to be paid through Hawke's Bay DHB) for contracts for health services to be delivered to the people of Napier.

Ahuriri District Health Trust (ADH) was created to represent the claimants and assist create service contracts. The DHB and ADH were unable to reach agreement on the terms of service contracts, and the final agreement saw the settlement funds returned by the DHB and paid directly to ADH. ADH will now use the funds to develop capacity as a service provider.

Māori health research reports

Māori health providers report

The Ministry of Health funds Māori health providers to deliver a range of national health services including health workforce training and development, national elective services and national maternity services. The Ministry works with DHBs to ensure all Māori health providers are correctly identified to ensure funding is allocated appropriately.

The Ministry produced its fifth report, *Funding to Māori Health Providers by the Ministry of Health and District Health Boards, 2011/12 to 2015/16,* available at health.govt.nz. The report provides information on Ministry and DHB changes in funding to Māori health providers. It also assesses how these changes compare with changes in total funding for health and disability services (Vote Health). The Ministry uses the information from this report to further develop its understanding of the contribution Māori health providers are making to the health and wellbeing of Māori.

This year's report includes Ministry funding for the first time and noted:

- funding to Māori health providers by the Ministry and DHBs was $270.3m in 2015/16, an increase of $14.4m (5.6 percent) since 2011/12
- funding to Māori health providers by Vote Health decreased from 1.93% to 1.86% between 2011/12 and 2015/16.

The teams within the Ministry who are responsible for contracting providers have been consulted during the process of preparing the report.

Co-designing and testing with Māori about their needs

The Ministry is taking a new approach to gain consumer insight into some of the more difficult problem areas in Māori health. This approach will ensure the design of processes to improve Māori health can better address their needs.

Phase one of this project is complete. A cross-Ministry team applied human-centred design approaches to understand the challenges associated with smoking among young Māori women aged 18–24 years.

The team used Integrated Data Infrastructure (IDI) data and reviewed insights from interviews with more than 50 young Māori women across the country who described the challenges and benefits of smoking in their lives. An external expert advisory group provided additional advice and insights.

The findings from this research have been shared widely through facilitated workshops, technical reports, 'how-to' guidelines and a range of tools. With a better understanding of what the population looks like and why current cessation interventions are not working, a second phase will design and test recommended

Māori child and youth reports

In June 2015, the Ministry again contracted the New Zealand Child and Youth Epidemiology Service (NZCYES) to collate and analyse a range of routinely collected health data on Māori children and young people. This contract was based on a 2010 contract with NZCYES to produce the first series of three 'Te Ohonga Ake' (the Awakening) reports.

The series covers three cyclical topics:

1. chronic conditions and disabilities
2. the determinants of health
3. health status.

The aim of the reports is to provide an overview of the health of Māori children and young people, and it is intended that evidence from the reports will be used to develop programmes and interventions to address child and youth health needs.

Both contracts included an advisory group of Māori health research experts to provide advice and review and select additional indicators for the reports. An advisory group meeting was held in December 2016, and advice and ideas were shared regarding the health status report and health issues for Māori children and young people.

Previous reports (prepared as part of the current second series contract) are: *Māori Children and Young People with Chronic Conditions and Disabilities* released in June 2015 and *The Determinants of Health for Māori Children and Young People* released in March 2016.

Te Ohonga Ake: The Health Status of Māori Children and Young People in New Zealand Series Two was released on 23 June 2017. The publication is funded by the Ministry and produced by NZCYES, University of Otago.

With the release of the last report on health status, the next phase is the dissemination of the results (eg, advertisements in Research Review and press releases). The next immediate steps are to initiate the cross-Ministry conversation (starting with 'Understanding') to explore how Māori child and youth health can be incorporated into the wider Ministry contract with NZCYES without losing the unique focus of the Māori child and youth health contract.

NZCYES has had multiple contracts with the Ministry and individual DHBs, so it is pertinent to explore with NZCYES how future reports can change to enable the Ministry to gather insights and improve data usability.

Series one and two of the Te Ohonga Ake reports can be found on the NZCYES website (www.otago.ac.nz/nzcyes/index.html).

Rheumatic fever impacts

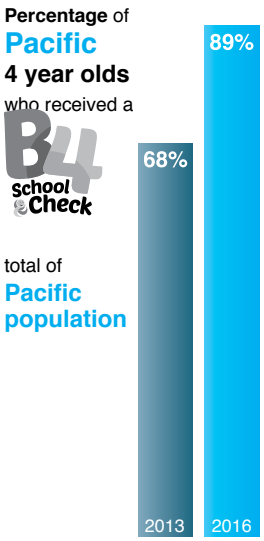
A two-pronged audit and research investigation was completed into the incidence of recurrent rheumatic fever and its impact on patients and their families/whānau. The investigation identified significant variations in practice between DHBs and failings in hand-over processes between primary and secondary health care and on transfer of patients between or within DHBs.

Significantly, research into the patient and family/whānau experience of recurrent rheumatic fever and rheumatic heart disease encountered some of the same difficulties experienced by patients and families/whānau themselves. In particular, the work reinforced the need to design services (or structure research) in forms that meet the needs of the patients rather than the needs of the services (or the research). The work also highlighted the importance of ensuring services are delivered in a culturally safe manner and increasing the participation of Māori and Pacific people in the health workforce.

Due to the complex nature of the health sector not all programmes, plans and projects with a bearing or impact on Māori and Māori health outcomes are discussed here – other sections where Māori health items feature are: 'Closer to Home care' (Section 1) and Sections 2 and 3.

Improving health outcomes for Pacific peoples

‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018



‘Ala Mo’ui: Pathways to Pacific Health and Well-being 2014–2018 is the Government’s national plan for improving health outcomes for Pacific people. It is driven by the vision of achieving health equity for all Pacific people in New Zealand. ’Ala Mo’ui sets out the priority outcomes and accompanying actions that will contribute to achieving this vision.

The four priority outcome areas are:

1. systems and services that meet the needs of Pacific people
2. more services delivered locally in the community and in primary care
3. better support for Pacific people to be healthy
4. Pacific people experience improved determinants of health.

The Ministry monitors progress against ‘Ala Mo’ui indicators at a national and DHB level.

Pacific Provider and Workforce Development Fund

The Ministry of Health administers the Pacific Provider and Workforce Development Fund (PPWDF) to support Pacific health providers to be sustainable and deliver quality health services that best meet the needs of Pacific communities, while also increasing the Pacific health workforce.

Pacific workforce training and development

The Ministry of Health supports Pacific health workforce development through initiatives which are funded through the workforce development aspect of PPWDF. These initiatives include Pacific health science academies in Auckland secondary schools, mentoring of Pacific tertiary students in health-related subjects, and leadership and alumni programmes, one of which is the ANIVA Programme.

The ANIVA programme aims to improve the recruitment, training and on-going professional development of Pacific health workers through a range of initiatives. One of ANIVA’s major initiatives is its Master of Professional Practice (Leadership) programme, which recently had its first cohort of Pacific nurses graduate with Masters of Nursing qualifications.

Another notable workforce development initiative administered by the Ministry of Health is the Pacific Health Scholarship awards. These awards provide financial support to Pacific students in NZQA approved health-related courses, to build the number of Pacific people in the health workforce. In 2017, 192 scholarships were awarded totalling $1.4 million. The priority workforce areas in this cohort included medicine, dentistry, midwifery and nursing.

Pacific Innovation Fund

During the 2016/17 financial year a total of 11 Pacific Innovation projects started or were extended. These projects are spread across the country and are with community, church and provider-led groups delivering services to address diabetes prevention, obesity, health literacy, oral health, antenatal care and suicide prevention.

Five innovation projects are an upscale of previously funded innovation projects and these were able to show that additional benefits could be achieved with the additional funds and time. The remaining six innovation projects are new and have run for six to nine months.

Other work streams involving Pacific peoples include:

- BreastScreen Aotearoa
  - Pacific women aged 45–69 years screened within the last two years, as a proportion of the eligible population was 71 percent (target 70 percent)
- the National Bowel Screening Programme
  - will screen eligible men and women aged 60–74, and provide colonoscopies to participants whose screening test is positive
  - the priority groups are Māori, Pacific, and those in the lowest socioeconomic group
- the number of Pacific women aged 25–69 years (hysterectomy adjusted) who undertook Cervical screening within the last three years as a proportion of the eligible population was 76 percent (target 80 percent).

Improving health outcomes for older people

Supporting the health of older people

During 2016/17, the Ministry worked with older people and their families / whānau, DHBs, primary health care services, service providers, non-governmental organisations (NGOs) and other government agencies to develop a new strategic approach to meet the future health and support needs of older New Zealanders. A new Healthy Ageing Strategy was launched in December 2016, identifying outcome areas, actions and goals for healthy ageing. This strategy sets the strategic direction for the health and wellbeing of older people for the next ten years. Its vision is that:

> 'Older people live well, age well and have a respectful end of life in age-friendly communities.'

The full Healthy Ageing Strategy can be found on the Ministry's website www.health.govt.nz

The Ministry has begun work on an outcomes and measurement framework for determining progress, implementing health-sector and cross-agency governance and ensuring oversight arrangements for monitoring and reporting on progress in healthy ageing area.

The Ministry also developed and released its guidelines for the design of dementia units and continued to work with DHBs to identify future priorities for implementing the New Zealand Framework for Dementia Care.

Moreover, DHBs in partnership with the Ministry initiated a process to review the funding model for aged residential care and for the review sponsors to select a provider.

In partnership with DHBs, providers and older New Zealanders, the Ministry has also initiated work to develop future models of care for home and community support services. This work is aimed at identifying models of care and necessary changes to policy settings that will meet the future care and support needs of a larger and more diverse population of older New Zealanders in a sustainable way.

Pay equity settlement

On 18 April 2017, the Government announced a $2 billion pay equity settlement for 55,000 care and support workers.

The settlement recognises the work carried out by the predominantly female workforce in New Zealand's aged and disability residential care and home and community support services.

The settlement originates from the TerraNova pay equity claim brought by E tū (previously the Service and Food Workers Union) on behalf of care worker Kristine Bartlett. The case successfully argued that a caregiver's pay is less than would be paid to a male with the same skill set in a different occupation due to the fact caregivers are predominantly female.

From July 1 the workforce, who are mostly on or around minimum wage, received a pay rise between 15 and 50 per cent depending on their qualifications and or experience.

The settlement means over the next five years, the workforce will see their wages increase on a range between $19 to $27 per hour. On July 1, the 20,000 workers currently on the minimum wage of $15.75 per hour moved to at least $19 per hour – a 21 per cent pay rise. This resulted in increases to their take home pay of at least $100 a week, or more than $5,000 a year.

This settlement addresses a historic undervaluing of this workforce and will help to support increased qualifications and reduced turnover in the sector, which will result in better care for New Zealanders.

As a result of the settlement, the Ministry, as the lead agency, and in partnership with the ACC, successfully implemented a 10 week project to ensure 55,000 people working for 650 providers and covered by 1,100 contracts received the correct wages from 1st July 2017. During the 10 week project the Ministry worked hard on relationship building and communication, which included holding briefing sessions, developing guidance tools and setting up a helpdesk. The Ministry will continue to manage the payment process and support the sector.

Life and Living in Advanced Age cohort study

Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu/Life and Living in Advanced Age, a Cohort Study in New Zealand (LiLACS NZ), is a longitudinal cohort study of New Zealanders living in advanced age (aged 80 years and over). This world-leading research programme was started in 2010 at the School of Population Health, Faculty of Medical and Health Sciences, at The University of Auckland and is directed by Professor Ngaire Kerse, Professor of General Practice and Primary Health Care. It is the first longitudinal study in the world of an indigenous population in advanced age.

Three reports were released during 2016/17. They are:

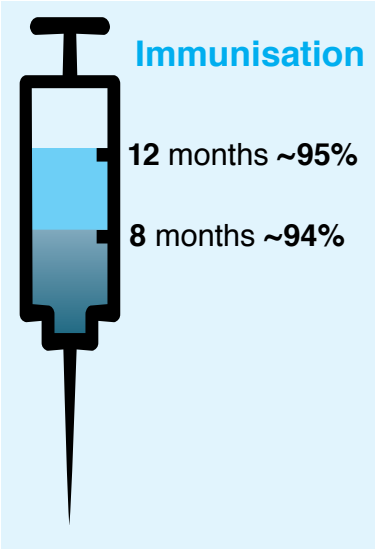
- *Health, Independence and Caregiving in Advanced Age: Findings from LiLACS NZ* (December 2016)
- *Intervals of Care Need: Need for care and support in advanced age: findings from LiLACS NZ* (April 2017)
- *Dementia: Supplementary findings from LiLACS NZ for Section Five, 'Service Use and Common Health Conditions' in the report 'Health, Independence and Caregiving in Advanced Age'* (May 2017).

As a result of these reports, the wider health sector including Māori health providers are able to use the key findings to focus on preventative health care, community support, social care and long-term health planning.

Improving health outcomes for children

The Ministry is actively involved, as part of the wider social sector, in finding a range of solutions to ensure better health outcomes for children and contribute (either as lead or co-lead) to a number of programmes and projects to this end.

Immunisation



Strategies to increase timeliness of vaccinations have been implemented, including providing individual-level data to providers to identify those children who are late for immunisations, earlier referral to outreach services and working across agencies to facilitate locating children who are overdue for immunisations. The reach of communications has been extended by using social media to promote immunisations. Each year, immunisations are also promoted through Immunisation Week, with local and national campaigns to encourage immunisation.

The Better Public Services (BPS) target for 'Increased immunisation' at age 8 months has been maintained at 93–94 percent coverage for the majority of the previous two years, (an increase of 8 percent compared with coverage before the target was introduced). There has been a minor decrease to 92 percent in infant immunisation coverage in the last quarter, but this is not unexpected and reflects usual seasonal variation and other demands on the immunisation sector. By 12 months of age, this coverage generally increases to 94–95 percent, as families/whānau slowly catch up on vaccinations.

Improved service delivery to achieve the target has enabled the National Immunisation Schedule to have maximum impact on the incidence of vaccine-preventable diseases, including invasive pneumococcal disease (IPD) and rotavirus gastroenteritis, the incidence of which have both reduced significantly.

The target has been pro-equity, with greater gains made for immunisation coverage rates for Māori infants compared with the overall population.

Reaching the last few percent of children that are missing out on immunisation will continue to be challenging due a range of complex socioeconomic and cultural barriers.

In an effort to overcome these challenges, the Ministry is focusing its work around immunisation and increased support to vulnerable children and their families/whānau by linking them into wrap-around service strategies that provide seamless service delivery and engagement from pregnancy through to late childhood.

The Ministry has accomplished the 'Increased immunisation' BPS target. Therefore, this target has been discontinued from the end of 2016/17, allowing a shift to new priorities, particularly those identified through social investment. The infant immunisation target will continue to be monitored through the Ministry's Health Target framework, while maternal immunisation will be a focus under the refreshed BPS Result 2: 'Healthy mums and babies'.

Supporting the establishment of a new cross-agency operating model for vulnerable children based on an investment approach

Improving outcomes for vulnerable children has been a long-term priority for the Ministry and the Government. The establishment of the Ministry for Vulnerable Children Oranga Tamariki in 2017, and a desire to drive system-wide improvements to services and outcomes for vulnerable children and their parents and whānau has led to the development of a new cross-agency approach which will require public sector agencies to work towards preventing the early signs of vulnerability from escalating.

The Ministry for Vulnerable Children Oranga Tamariki will rework its existing care and protection services and have a range of new services which include prevention services. The Ministry is working closely with the health and disability sector and other agencies towards supporting this goal of prevention. We are working to improve the accessibility and appropriateness of universal and targeted services, strengthen capacity and practice on the front line, and better understand the needs of vulnerable children and their families/whānau to tailor services and target investment.

We have also:

- undertaken a range of data matching analysis to better understand the health need and service utilisation of children and young people in care
- developed a dedicated workstream to enhancing access for Vulnerable Children and Young People to Universal Services, beginning with early enhancements for children and young people in care
- launched the Fetal Alcohol Spectrum Disorder (FASD) Action Plan, a comprehensive set of cross-government actions to prevent FASD. The Plan includes expanding the pregnancy and parenting services for women with addictions. It includes actions to identify and support children affected by FASD
- made a strong contribution to the development of the first Vulnerable Children's Plan and System Performance Framework.

Reducing the number of assaults on children

The Ministry is closely involved in supporting vulnerable children. This includes the following initiatives.

- A partnership between ACC and the Ministry has been formed to fund and manage the Power to Protect programme, and mandatory reporting on implementation and outcomes are now included in the Crown Funding Agreement with DHBs. The programme reach will also increase as it will be delivered in the community alongside the SUDI (sudden and unexpected death in infancy) Prevention Programme.
- A new online e-learning module has been developed to educate health professionals on the dynamics of family violence (FV). This module allows all health professionals to develop an understanding of the dynamics of FV in their own time before participating in the full Violence Intervention Programme (VIP) training.
- A review of the primary health care VIP guidelines has begun, in consultation with Medical Sexual Assault Clinicians Aotearoa (MEDSAC, formerly Doctors for Sexual Abuse Care).
- All 20 DHBs' VIP policies and procedures are being updated to reflect changes to the Ministry's *Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence.* This guideline, on which the VIP is based, was refreshed to ensure adherence to international best practice and legislation changes in New Zealand.

Other key pieces of work the Ministry has been actively involved in over the previous 12 months include the Ministerial Group on Family Violence and Sexual Violence (MGFVSV) Work Programme. As part of this programme, two DHBs (Waikato and Canterbury) delivered the health component

of individually assessed and customised services to families/whānau who experienced abuse. As a function of the Integrated Safety Response (ISR) programme, DHBs and selected NGOs also deliver interventions for perpetrators of family violence and sexual harm.

Both DHBs report that earlier access to services for victims and perpetrators is making a difference to their engagement with the services and thereby their overall longer-term health and wellbeing.

The MGFVSV work programme is developing rapidly as agencies gain a better understanding of the needs of vulnerable families/whānau and children and the systems shifts required to meet diverse and complex needs.

Rheumatic Fever Prevention Programme

A key challenge has been the lack in decreasing rheumatic fever rates in the Auckland and Waitemata DHB areas although there has been a decrease in rheumatic fever rates at a national level. In particular, there has been no change in rheumatic fever rates in Pacific people (the majority of whom live in the Auckland region).

The Rheumatic Fever Prevention Programme (RFPP) ended on 30 June 2017, but rheumatic fever prevention will continue to be a focus for the 11 DHBs with high incidences of the disease. The government has allocated $5 million per year over the next five years to these 11 DHBs to help them continue to deliver a balanced mix of rheumatic fever prevention activities to address rheumatic fever and reduce rates. The Ministry will continue working closely with these DHBs.

$5m
per annum over
5 years
to 11 DHBs to reduce rheumatic fever =
$25m

The activities undertaken in the three key strategic areas of the RFPP were:

- increasing awareness of rheumatic fever
- improving access to timely, effective treatment for group A streptococcal (GAS) sore throat in primary health care and community settings
- reducing household transmission of GAS bacteria.

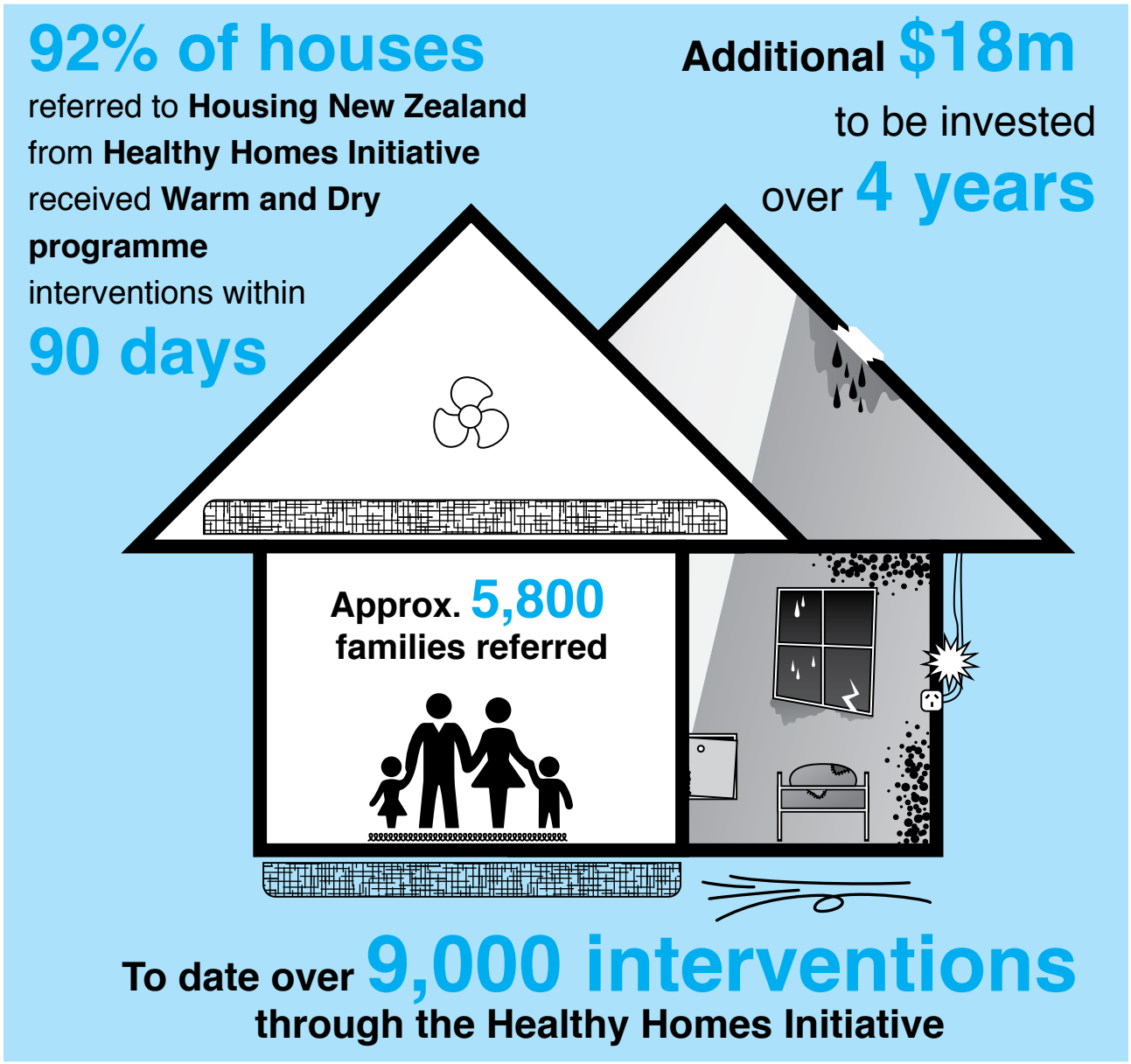
Highlights included:

- delivering the 2017 national Rheumatic Fever Awareness Campaigns, launched on 13 February.
- delivering a youth awareness campaign, a partnership between the ministries of Health and Youth Development (During this time, rheumatic fever youth ambassadors and performers attended festivals and community events and visited more than 50 intermediate schools and high schools. There were 87 young ambassadors recruited from Auckland and 15 from Northland.)
- preparing a pilot of a landlord liaison and minor repair service, in conjunction with Habitat for Humanity New Zealand, to support families/whānau living in privately tenanted properties across the Auckland region.

Healthy Homes Initiative

Healthy Homes Initiatives (HHIs) were established under the Ministry's RFPP from 2013 to support the 11 DHBs with a high incidence of rheumatic fever. The HHIs target families/whānau with children at-risk of getting rheumatic fever who are living in crowded households.

The first HHI launched in Auckland in 2013. Seven more were established in 2015 to cover other DHBs that experience a high incidence of rheumatic fever.



The Budget 2016 investment of $18 million over four years ($4.5 million per annum from 2016/17) for the expansion of existing HHIs, has enabled the HHIs to broaden their original objective of preventing rheumatic fever by reducing household crowding, with a more general focus on warm, dry, healthy housing for vulnerable newborns to five-year-old children. Over the next four years, this expanded service is expected to help around 25,000 families/whānau who live in unhealthy, damp, cold conditions.

The HHIs systematically identify and work with eligible families/whānau to undertake housing assessments and complete individualised plans of action to create warmer, drier, healthier homes. The HHIs then facilitate access to a range of interventions such as insulation, curtains, beds and bedding, and financial assistance.

Low-income target population groups who meet certain eligibility criteria are able to receive support from the HHIs. As at 31 March 2017, almost 5,800 families/whānau had been referred to HHIs. Of these, 4,960 families/whānau were referred through the rheumatic fever eligibility criteria, and 828 families/whānau were referred through the new expanded HHI criteria. Almost 9,000 interventions have been received by families/whānau to reduce household crowding and create warmer, drier and healthier homes.

Options are currently being explored to support HHIs to generate more interventions for families/whānau. Although the current approach is a challenge for HHIs, it has generated innovation in some places such as in the Bay of Plenty where the hope is to establish a voluntary service called a Trade Bank, where tradespeople can volunteer their time and free labour to helping fix minor repairs to homes.

One of the challenges for the HHI providers on the ground is continuing to support families/whānau to navigate or engage with agencies such as Housing New Zealand (HNZ), Ministry of Social Development (MSD), Work and Income (WINZ), etc to get better housing solutions. The Ministry continues to work with these agencies to fine-tune inter-agency working arrangements such as referral and escalation pathways.

The current HHI contracts will be in place until 2020. The Ministry will be working closely with the HHI providers, the DHBs, key government agencies (MSD, HNZ, the Ministry of Business, Innovation and Employment) and other major stakeholders to continue maximising the effectiveness of the HHIs and ensure better outcomes for families/whānau.

Case study: Healthy Homes Initiative

A Waikato home in which a whānau raised more than 80 children needed considerable work. The whānau was referred to the Waikato Healthy Homes Programme, one of the Ministry's HHIs. The home had no power, the whānau prepared meals on portable gas cookers inside, and whānau members slept together in the lounge and garage to keep warm.

The Waikato Healthy Homes Programme facilitated a number of interventions through various partnerships. Immediate interventions included providing four sets of bunk beds, bedding for the whole whānau, curtains and reconnecting the electricity.

One of the key partnerships was with Habitat for Humanity New Zealand, who donated a portion of the labour and materials, facilitated an interest-free loan with affordable repayments for more extensive repairs, such as, full electrical rewiring; replacing rotten weatherboards; providing a new oven and extractor fan; and installing insulation, a heat pump and double-glazed windows, as well as arranging volunteers to paint the exterior of the home.

Publicity about the project led to a local company installing a new roof free of charge.

Maternal and child health

Child and family Maternity Quality Initiative

The Maternity Quality Initiative (MQI) is the Ministry's work programme for increasing quality, safety and the consumer experience of maternity services in New Zealand. The MQI identifies a set of system improvement priorities, under which sit a series of projects. These projects include:

- supporting women who use alcohol and other drugs during pregnancy
- reducing maternal tobacco use

- embedding maternity quality and safety (DHB quality and safety programmes)
- supporting the National Maternity Monitoring Group
- increasing maternity service integration (the maternity clinical information system).

Examples of other projects started in this space are as follows.

- Well Child/Tamariki Ora (WCTO) Quality Improvement Framework and quality indicators provide a mechanism to drive improvement in delivering WCTO services. Ultimately, the framework and indicators aim to support the WCTO programme to ensure all children and their families/whānau achieve their health and wellbeing potential.
- Co-design of a new funding and contracting model for community primary midwifery services, which began in March 2017, is due to produce a draft model by October 2017 and a final model by April 2018.
- Work has started on a further 6 percent increase to all Lead Maternity Care (LMC) modules and a 2.5 percent backfill increase to selected LMC modules.

An action plan for fetal alcohol spectrum disorder

The fetal alcohol spectrum disorder (FASD) action plan, which is a comprehensive set of cross-government actions to prevent FASD, was successfully implemented. As a result, the pregnancy and parenting services for women with addictions has been expanded. The plan includes actions to identify and support children affected by FASD. A stocktake of services and interventions for children with FASD and neurodevelopmental impairment and their families/whānau was completed and included scoping supports, services and care pathways, and gaps.

A New Zealand study to identify children with FASD in the Growing Up in New Zealand (GUiNZ) cohort has commenced, and the first stage of screening to identify children in the pilot group for neurocognitive impairment study has been completed.

Stage two will involve children with neurocognitive delays and their parents being offered the opportunity to participate in the FASD incidence study. In stage 3, the children will be offered a multi-disciplinary assessment by a paediatrician, clinical psychologist and speech/language therapist. The combined multi-disciplinary assessment is expected to provide a definitive diagnosis and strategies and a direction for intervention.

Additionally, five clinicians were supported to complete training in diagnosing children with FASD. A proposal for future governance, steering and working group structures aims to ensure this work is well managed and achieves the desired outcomes.

Sudden Unexpected Death in Infancy Prevention Programme (formerly Safe Sleep Programme)

Since August 2016 the Ministry has been working with paediatric experts to develop a national sudden and unexpected death in infancy (SUDI) prevention programme that ensures every infant and their family / whānau are provided with customised and comprehensive safe sleep information with follow-up support.

A literature review which sought expert advice and consulted nationally with the health workforce regarding SUDI prevention services. Information and consultation from this review was used to design the NSPP under the guidance of an expert advisory panel.

The government announced a plan to dramatically reduce the SUDI toll by 86 percent, and 94 percent for Māori, by 2025 and thus reducing the number of SUDI deaths from 44 to six. To support this plan an additional $2.1 million per annum will be invested in this programme.

Strategic Priority 2: Improve access to, and the efficiency of health services for New Zealanders with a focus on disability support services, mental health and addictions, primary health care and bowel cancer

Keeping New Zealanders healthy and out of hospital requires our health and disability services to support a person's health needs before that person needs to be treated in hospital – it means providing faster, more convenient health care closer to home. For most of us, this translates to receiving appropriate health care in our local community. This includes preventative services that keep people well, treatment services that can be accessed easily and new technologies allowing us to shift some services closer to home.

The aim of the Strategy's theme 'Closer to Home' is to encourage improved health care closer to people's home for acute, rehabilitation/restorative, palliative and home and community support care.

Care 'Closer to Home' encompasses the following programmes.

- Health checks for students at school.
- Support to stay well at home.
- Mental health support in the community.
- Managing medication after a stroke.
- Telemedicine closing the distance (in Ashburton and Opotiki).
- Hooking up to IV drip closer to home.
- Getting back on your feet.
- Taking care of diabetes.

Disability support services

During the financial year 2016/17, a number of disability support services progressed significant pieces of work to improve the quality of their services. These include the development of respite and community residential strategies, a refresh of Whaia Te Ao Mārama: Māori Disability Action Plan, and gaining government approval to start a process of disability system transformation.

Disabled people and their families/whānau have been calling to have more choice and control over support options and their lives. Transformation of the disability support system requires input from disabled people to make sure it meets their needs. To this end, a co-design group was established in 2017 to create a high-level design for a new system that could be rolled out across the country.

People from the disability sector were invited to apply for eight positions in the co-design group. More than 70 people applied. To obtain diversity, five disabled people, two representatives with disabled family members and two from disability service organisations were selected. They were joined by one person from a Needs Assessment Service Coordination (NASC) organisation and three officials from the ministries of Health and Social Development.

Many challenging issues were identified, including designing for the diversity of the disability community, mapping what a good experience in a new system would look like and keeping processes as simple and as straightforward as possible. There were also discussions about how funding

allocations would work, whether the design provided enough flexibility and choice, what was needed to make the system accountable and how to ensure cultural values would be taken into account.

The process was highly collaborative and successful, leading to problems being solved and a clear future vision being developed. The next stage is to develop detailed design plans before the new system is implemented in MidCentral DHB and then rolled out nationally.

Transforming Respite

In 2016, DSS started its journey with the health and disability sector to develop a respite strategy to guide the Ministry in developing future services that would work better for people caring for someone with a disability. The result was *Transforming Respite: Disability Support Services respite strategy 2017 to 2022*.

The finalised strategy supports both the disability system transformation work and the Government's commitment to the Enabling Good Lives approach of empowering disabled people to make their own decisions about the supports they choose for their everyday lives.

The strategy also takes a person-centred approach to respite supports. It recognises the important role that family/whānau carers have in supporting people with disabilities to live a fulfilling life within their communities, iwi and hapū. It invests in developing family/whānau resilience to continue in that caring role and makes it easier for carers of disabled people to take a break.

Transforming Respite draws heavily on the feedback provided by disabled people, their families/whānau, disability organisations, advisory groups and providers about how respite supports can be improved. The strategy is available from the Ministry's website (health.govt.nz).

Community residential strategy

During the 2016/17 financial year, DSS worked with the health and disability sector to develop a community residential strategy.

The Ministry funds community residential services to provide eligible disabled people with the 24-hour support they need to live in a community environment. Services are provided in a range of settings, such as small or large homes and groups of small homes or flats.

The purpose of the community residential strategy is to increase the options for disabled people and their families/whānau to have greater choice, control and flexibility, access to information and less restrictive supports, thus increasing their independence and choice.

The strategy is in its final phase of consultation and will be finalised early in the 2017/18 financial year.

Case study: Enabling Good Lives

Energetic, passionate and determined are three words that describe 29-year-old Alex perfectly. Alex moved from Invercargill late 2016 to start a new life for herself in Hamilton and transferred straight from Accessibility in Southland to Enabling Good Lives.

Since moving to Hamilton, Alex has found a place to live and a part-time job at Nandos, a Portuguese chicken restaurant. Her Connector/Tūhono, Bella, has been assisting Alex with making these important community connections. Through their short time they have built a great friendship as they work together to make sure Alex can really make the most of this opportunity.

Alex's brother is the manager of her Enabling Good Lives direct funding, allowing Alex to focus on building her new life in Hamilton. Whilst Friday to Sunday is taken up with work, she uses the rest of the week to spend time with her support workers, attending her Wintec computer course and also does acrylic painting.

When talking with Alex, you could see how proud of herself she was to be achieving so much in a short amount of time. Alex already has a list of future goals which include increasing her hours at work, and to get her learner's licence.

Whāia Te Ao Mārama: Māori Disability Action Plan

In 2012, the then Associate Minister of Health, Dame Tariana Turia, launched Whāia Te Ao Mārama 2012–2017. This Māori disability action plan developed four high-level priority areas, including:

- improved outcomes for Māori disabled
- better support for whānau
- good partnerships with Māori
- monitoring and reporting on its implementation.

The action plan is in the final stages of a refresh to guide activities over the next five years overseen by Te Ao Mārama Group, a group of external advisors that supports the implementation of Whāia Te Ao Mārama.

Palliative care hospices

Palliative care is care for people of all ages who have a life-limiting or life-threatening condition. It aims to:

- optimise an individual's quality of life until death by addressing the person's physical, psychosocial, spiritual and cultural needs
- support the individual's family / whānau and other caregivers where needed, through the illness and after death.

In March 2017, commissioned a review of 'Adult Palliative Care Services' and the 'Adult Palliative Care Action Plan'.

The review identified challenges and provided strategic direction in meeting future palliative care demands and recommended a refreshed strategic direction for palliative care to meet said demands.

Budget 2015/16 provided additional funding for 54 new positions, including nursing specialists, social workers, medical officers, facilitators, caregivers, trainers and administrative support. The funding also recognises and supports the spiritual element of palliative care. It is now internationally recognised that people have spiritual needs which facing life threatening illnesses.

In May 2017, Te Ara Whakapiri: Principles and guidance for the last days of life and the Te Ara Whakapiri Toolkit were published. This is a New Zealand contextualised, multidimensional, person and family-centric palliative care approach that can be integrated across all settings. It outlines all the essential components and considerations required to promote quality care at the end of life and provides resources to support the implementation of the approach.

The Ministry is working closely with the Palliative Care Advisory Panel, the wider sector, colleges and regional alliances to further develop relationships and engage key stakeholders, communicate key messages and progress priority work.

In-Between Travel Agreement

The In-Between Travel Agreement (IBT) was signed in September 2014. It is an out-of-court settlement between unions, home and community support services (HCSS) providers and DHBs, supported by additional government funding of $36 million in the 2016 financial year and $38.6 million from the 2017 financial year onwards.[1]

The IBT has two parts.

- Part A was implemented from 1 July 2015, when HCSS workers began receiving payments for the time they spent travelling between clients. From 1 March 2016, HCSS received a further contribution towards travel costs.
  - The payment for travel time was formalised in the Home and Community Support (Payment for Travel Between Clients) Act 2016.
- Part B was implemented in part on 1 April 2017, when guaranteed hours of work for 24,000 HCSS support workers commenced as the first stage of workforce regularisation.

An additional $7.8 million to improve the sustainability of the HCSS sector was allocated to 14 DHBs to bring HCSS rates in line with Ministry wage rates from 1 July 2016.

In June 2017, the Ministry co-hosted, with DHBs, a 'co-design future models of HCSS' event, which sought to identify options and opportunities to enable older people to live well at home.

The Healthy Ageing Strategy includes implementation of Part B of the IBT, encompassing the Director-General of Health's Reference Group (DGRG) report recommendations.

As substantial parts of the IBT have been implemented the work programme has transitioned to 'business as usual' and towards the Government's longer-term goals for HCSS.

Mental health

The Ministry has continued to develop and implement critical actions from Rising to the Challenge, which aims to improve outcomes for people who use primary and/or specialist mental health and addiction services. Rising to the Challenge envisages a future where all New Zealanders have the tools to weather adversity, support each other's wellbeing and rapidly access interventions from a range of effective, well-integrated mental health and addiction services. It provides direction to planners, funders and providers of publicly-funded mental health and addiction services on priority areas for service development over the next four years.

1. The total costs of the settlement agreed by Cabinet in 2014 were: $2 million one-off implementation costs in 2014/15, $36 million in 2015/16 and $38.6 million in 2016/17 ongoing [CAB Min (14) 23/22 refers].

Actions include the development of the Mental Health and Wellbeing Outcome Framework and the completion of the Commissioning Framework for Mental Health and Addiction (the Commissioning Framework), the Mental Health and Addiction Workforce Action Plan 2017–2021 (the Workforce Action Plan) and, through the Rural Health Alliance Aotearoa New Zealand (RHAANZ), a Framework to Improve Mental Health and Addiction Outcomes in Rural New Zealand.

DHBs focused on the following six mental health and addiction priority areas for 2016/17:

- Primary mental health
- District suicide prevention and postvention
- Improving crisis response services
- Improving outcomes for children (Supporting Parents, Healthy Children)
- Improving employment and the physical health needs of people with low prevalence conditions
- Improving the quality of the Programme for the Integration of Mental Health Data (PRIMHD).

Rising to the Challenge has driven service development across the mental health sector through DHBs, primary health organisations (PHOs) and NGOs. Service development has included activity to reduce demand on secondary health services, including better primary and secondary health care integration, increased service access for infants, children and youth and increased service options for people with mild to moderate mental health conditions.

The development of a new mental health and addictions strategy is under way as 'Rising to the Challenge' will be replaced from December 2017.

Developing a population-based mental health and addictions outcomes framework

He Tāngata – the Mental Health and Wellbeing Outcome Framework – has been used to focus attention on risk factors and characteristics that impact equity of mental health outcomes for specific population groups and all people in New Zealand.

He Tāngata is a long-term project that will support the mental health system and service transformation. This includes a critical contribution to investment and better outcomes, particularly when used in conjunction with the Commissioning Framework.

Consultation on He Tāngata has been put on hold as critical system development initiatives are undertaken, most notably the development of a new cross-government mental health strategy.

He Tāngata's tools to identify risk factors and segment the population have been applied to system development initiatives (namely, the updated mental health and addiction strategy development and Fit for the Future work).

He Tāngata will continue to be used to support system transformation design, including strategy development, setting national expectations and reviewing performance measurement. It is envisaged that He Tāngata will be publicly consulted on, published and implemented as a tool to support ongoing, long-term system transformation.

Prime Minister's Youth Mental Health Project

180,000+ youths
reached to date via the **Prime Minister's Youth Mental Health Programme**

A comprehensive evaluation by the Social Policy Evaluation and Research Unit (Superu), published in November 2016, found that the Prime Minister's Youth Mental Health Project (YMHP) was a worthwhile financial investment, generating both public and private benefits. As a result, more services and resources have been developed to identify, support and treat youth, with or at risk of developing mild to moderate mental health issues. The Ministry has reached more than 180,000 youths so far.

In July 2016, Cabinet reported that:

- the three most effective initiatives have been continued
- work is under way to increase the reach and impact of a further nine initiatives
- five initiatives have been refocused and two have been reactivated.

Work is currently under way to strengthen data collection and analysis across youth mental health, including work to develop the framework that includes Māori and Pacific outcome measures. This is aligned to data work undertaken by the Social Investment Agency (SIA) as part of the Mental Health Strategy.

Another work stream under way is looking at ways to meet the needs of key populations identified in the evaluation. Examples include a new Pacific initiative and work to investigate the potential for Youth One Stop Shops (YOSSs) to undertake additional projects with key populations. An online guide is being developed to provide practical advice to support teachers and school leaders to meet the needs of lesbian, gay, bisexual, transgender, queer or questioning and intersex (LGBTQI) students.

Suicide prevention

A suicide prevention outcomes framework was developed and has informed the development of the draft suicide prevention strategy. The draft strategy was released for public consultation in April 2017. Public consultation closed in June 2017. During the public consultation period, 15 public consultation meetings were held and nearly 500 submissions were received. This material is currently being analysed.

National Depression Initiative

In October 2016, the National Depression Initiative (NDI) celebrated its 10th anniversary.

Depression.org.nz was updated in 2016 to take a wider view of mental health issues to include distress, anxiety and depression. The expanded site is responsive to the needs of different groups, especially Māori, Pacific peoples, deaf people, men, rural people and LGBTI people.

The Journal, an online self-management tool, helps people with depression and anxiety stay positive by providing information and advice to support problem solving and lifestyle changes. It became available on mobile devices in November 2016.

A TV campaign promoting depression.org.nz ran for two weeks in November to December 2016 and was supported by five weeks of online videos (13 November to 17 December 2016). The campaign used existing Sir John Kirwan advertisements and resulted in a 500 percent increase in visits to the website. Further media placements occurred in two tranches up to the end of the 2016/17 financial year. Work is under way to develop a new campaign. Concepts have been developed with key stakeholders and have been tested in focus group research. The new advertising campaign was due to be aired on television from late August 2017.

Rural mental health and psychosocial recovery post-earthquakes

The Ministry funded RHAANZ to develop a rural mental health and addictions framework, which has been published on the RHAANZ website.

Budget 2016 provided additional psychosocial recovery funding for Canterbury and the Ministry has contracted Canterbury DHB for additional community and secondary mental health and addiction services. In addition, the Ministry has also matched the contribution made by the Christchurch City Council for its earthquake fund to support community-led recovery initiatives.

Additional funding was provided to Canterbury and Nelson Marlborough DHBs after the Kaikoura earthquake. Funding has been used to support psychosocial recovery through additional mental health and addiction services, including working with the two rural support trusts in the affected areas.

Additional
$5m
per annum
for 3 years
for **Canterbury DHB Mental Health Services** for **psychosocial recovery**

Key activities that were funded include:

- All Right? campaign
- Canterbury DHB Mental Health Services; psychosocial recovery through primary and secondary specialist mental health services
- Christchurch City Council fund; community-based recovery grant fund
- a rural mental health initiative.

Youth forensic services (community and inpatient): Increased mental health services to youth justice residences, youth courts and youth units in prisons

Ngā Taiohi Youth Forensic Inpatient Service is the first secure facility of its kind in New Zealand.

The unit has 10 beds dedicated to providing appropriate care for vulnerable young offenders with a mental illness, and, or alcohol and drug problems. Previously youth offenders with mental health issues were treated in adult facilities or in the community with variable care across the country.

Ngā Taiohi will ensure youth offenders with mental health or addiction issues get the care they need. This will also help to address some of the underlying causes of youth offending which is one of the Government's key goals.

To further support youth forensic services, an additional 40 youth mental health positions were created.

There is also an ongoing 'virtual team' for regional youth forensic services that utilises video-conferencing for case management, referral processes and other operational matters.

Addictions

Gambling harm minimisation

The Ministry continues to implement the Strategy to Prevent and Minimise Gambling Harm 2016 to 2019.

Some of the highlights include:

- publishing research on links between gambling harm and family violence
- completing the first stages of a co-design of results-based accountability (RBA) measures for gambling harm service providers
- completing a cross-sector report into multi-venue exclusion from gambling venues and initiating work to implement the findings.

During 2016/2017 the Ministry successfully appealed the High Court's decision which found in favour of the Foundation on the tendering of problem gambling services, with judgement released by the Court of Appeal in December 2016.

The focus has not turned to workforce development, including qualification pathways and training clinical staff in dealing with co-existing problems such as mental health and other addiction issues, along with social issues such as family violence.

National Drug Policy

The high visibility of the Health Promotion Agency's 'Go the Distance' campaign exemplifies the National Drug Policy's harm minimisation approach in action. The campaign aims to change New Zealanders' alcohol consumption behaviour from the current norm of high-risk drinking to one of moderation.

The Ministry is working on regulatory changes to the Misuse of Drugs Regulations 1977 to remove some restrictions to enable easier access to Cannabidiol (CBD) products for therapeutic use. It is anticipated that changes will come into effect by end of 2017.

Tier 1 statistics for alcohol harm were developed and published in November 2016.

The Ministry is also in the process of investigating an early warning system that will:

- enable early identification of emerging psychoactive substances
- inform responses by emergency health care professionals
- coordinate integrated responses across the country
- review the regulation of controlled drugs for legitimate purposes (such as medicines)
- work alongside reviews of the Medicines Act 1981 and other therapeutics legislation
- develop options for further minimising harm in relation to the offence and penalty regime for personal possession within the Misuse of Drugs Act 1975
- commence a review of the policy and operation of the Psychoactive Substances Act 2013.

The Inter-Agency Committee on Drugs will review the progress and evidence to provide advice on a revised set of actions in 2017.

Primary health care

Primary health care relates to professional health care provided in the community, usually from a general practitioner (GP), practice nurse, pharmacist or other health professional working within a general practice. It's called 'primary health care' because, for most of us, it is the first place we turn to for our health needs.

Strengthening primary health care

During the 2016/17 year, the Ministry continued to support the primary health care sector to investigate how it can best contribute to the sustainability of the health system and improve the outcomes for New Zealanders, particularly the most vulnerable populations.

The Ministry supported DHBs' engagement with primary health organisations (PHOs) through the PHO Services Agreement Amendment Protocol Group (PSAAP) meetings, providing advice and guidance on the business rules for funding streams, potential changes to the agreement and interpretation of the agreement in light of government intentions and priorities.

The Ministry provided support to the district-level rural alliances as they determined rural funding allocation decisions and provided timely responses to numerous queries regarding primary health care from the media, the public and politicians.

The Ministry continues to work with the health sector to develop new models of care that improve outcomes, relieve the strain on hospitals, enhance access to services and make the best use of the broad workforce, including nurses and pharmacists, in addition to supporting DHBs as they work with their PHO and other partners to develop actions to meet the two new Better Public Services targets which are:

- reduce the number of hospitalisations for children 12 and under with preventable conditions
- 90 percent of pregnant women register with a Lead Maternity Carer in their first trimester.

Bowel screening

New Zealand has one of the highest bowel cancer rates in the world. Bowel cancer is the second most common cause of cancer death in this country after lung cancer.

Analysis of the bowel screening pilot and with the health sector confirm there is the capability and clinical workforce in New Zealand to deliver the additional colonoscopies required for a progressive roll-out of a national bowel screening programme for people aged 60 to 74 years.

The primary objective of bowel screening is to reduce the mortality rate from this cancer, by diagnosing and treating bowel cancer at an earlier, more treatable stage.

Cabinet approved the National Bowel Screening Programme (NBSP) in August 2016. This enabled the Ministry to set up the National Coordination Centre and work with Waitemata, Hutt Valley and Wairarapa DHBs to start implementing bowel screening in these regions from July 2017.

The milestones for the NBSP were to support Hutt Valley and Wairarapa DHBs to deliver their implementation plans to deliver the NBSP, as well as establish the interim coordination centre at Waitemata DHB.

The challenge for the NBSP is the complexity of rolling out a programme that is delivered across 20 DHBs and involves many stakeholders throughout the participant's journey (eg, primary health care). The roll-out is supported by clear accountabilities each step of the way, an information technology (IT) solution to support delivery and monitoring of the NBSP, development and implementation of robust safety and performance monitoring, and quality standards.

In addition, the Ministry is supporting DHBs with additional funding for colonoscopy services to reduce waiting times and ensure that the progress made on delivering symptomatic colonoscopies is sustained.

Looking ahead, the Ministry will work with Southern and Counties Manukau DHBs to deliver their implementation plans and join the NBSP in 2018, identify the next group of DHBs to join the programme, have the 2018 NBSP business case approved by the Ministers of Health and Finance and successfully conclude the tender process for the national IT solution.

Case Study: Bowel Screening

Aucklander David Vinsen lives in a three generation household, which includes his daughter and two grandchildren.

The 68 year old describes himself as having a portfolio career, which includes owning a property management franchise along with his wife and being the chief executive of the NZ Imported Motor Vehicle Association.

David leads a busy and active life, and it came as a shock when the test he completed through the Waitemata District Health Board bowel screening pilot came back positive.

'I was sent for a colonoscopy, which found an early stage cancer. I was very fortunate that it wasn't invasive and hadn't spread widely,' David says.

'I had major surgery to remove the cancer in February 2015, a colostomy bag for 4 months, minor surgery to connect things up again (basically a plumbing exercise), and a period of recuperation. Not at all a pleasant experience, but far better than the alternative.

'I've just had a battery of tests on the second anniversary of my surgery – and been pronounced clear, as I was last year. My surgeon explained that the difference between a clearance and a cure is that if I go a total of five years with no signs of cancer, I'm considered cured; and I'm absolutely confident that they've got everything.'

David is delighted that bowel screening is going to be available nationwide. He is encouraging those who are invited to do the free bowel screening test to take up the opportunity.

'Do the test; don't be scared about it. It's not at all embarrassing or awkward. There's no inconvenience. All you've got to do is take one small sample at home, post it off in the envelope and that's it.

'And if you are among the small group who are diagnosed with cancer, let those close to you know about it and seek their support. You'll be amazed at the support you get from family, friends and colleagues.

'I also think men, who can sometimes be reluctant to go to the doctor, should consider going for a regular health check-up on or around their birthday.

'We look after our vehicles and have them regularly serviced and inspected. We should do the same for ourselves.'

Strategic Priority 3: Improve outcomes for New Zealanders with long-term conditions, with a focus on obesity and diabetes

Long-term conditions

As the New Zealand population ages, the size of the group with one or more long-term conditions (LTCs) will increase. Enabling people with LTCs to improve their wellbeing requires the health system to better support the prevention, identification and management of LTCs.

The Ministry's LTCs work programme provides support to the Ministry and health sector by providing leadership, evaluating the progress of services, supporting innovation and service improvement and providing tailored support where required.

The LTCs work programme has been supported and enhanced by a clinical advisor. The role encompasses engaging with the sector and supporting the LTCs team, DHBs and primary health care services to deliver outcomes from the Strategy.

A new clinical advisor was appointed in June 2017 and will be involved with the development of the Ministry's LTCs work programme for 2017/18.

The Ministry has worked closely throughout the year with national and regional stroke networks (including encouraging consumer input) and the stroke clinical lead to find innovative ways to support service improvement and delivery. For instance, during the year, the Ministry and the stroke clinical lead visited a number of DHB (with follow-up letters), identifying achievements and where further work is needed.

In line with Roadmap Action 8, from the Strategy (Increase the effort on prevention, early intervention, rehabilitation and wellbeing for people with LTCs), further areas of work will include:

- continuing the three currently funded LTCs research projects, with two additional projects identified for funding
- asking DHBs and their PHO partners to provide feedback on the working draft LTCs outcomes framework and service expectations
- integrating self-management support into general practice based on the outcomes of the self-management support in primary health care project
- continuing to support primary health care practitioners to enable people with LTCs to manage their health.

Other value-enhancing activities undertaken in the last year are as follows:

- an outcomes and service expectations framework has been co-designed with the health sector and is available as a working draft for sector testing.
- LTCs consumer advisory panel has been established to assist with design and evaluation of health services for people with LTCs. This panel can also engage customers directly in the design of more effective health services, systems and support for those affected by LTCs.
- 'more heart and diabetes checks' health target ended in June 2016, but the indicator continues as a performance priority area for DHBs. Nineteen DHBs have included cardiovascular disease (CVD) risk assessment as a contributory measure in the System Level Measures Framework.
- the Ministry also supported a quality improvement initiative to provide national data collection for acute stroke treatment through a centrally held DHB-based electronic register.

- the national FAST (Face, Arm, Speech, Time) campaign was delivered to raise awareness of stroke symptoms and to treat stroke as a medical emergency. Work continued with regional stroke networks and the stroke clinical lead to identify local, at-risk groups and how to reach them. This year's campaign has a particular focus on Māori and Pacific. The FAST message was provided on Māori radio channels in te reo and posters translated into Māori and Pacific languages, such as Samoan, Tongan, and Cook Island Maori.
- Regionally based telestroke 'proof of concept' projects have started. These projects will support the delivery of time-limited acute stroke treatment 24/7, ultimately to all DHBs, ensuring equity of access.
- Thrombectomy, a blood-clot retrieval procedure, currently provided in three tertiary centres, has provided a significant breakthrough in reducing disability for those able to be treated. A health app quality assessment framework and commissioning guidance is being drafted. The New Zealand health App Library was launched to provide quality assessment of health apps for clinicians and consumers.
- The four regional cardiac networks are proactively supporting DHBs to improve services, implement locally appropriate initiatives and support the use of the cardiac registers. The first national report from the New Zealand Cardiac Network, based on information collected in 2015, was published in 2016.

Obesity

Reducing obesity: Childhood Obesity Plan

New Zealand has the third highest adult obesity rate in the Organisation for Economic Co-operation and Development (OECD), and these rates are rising. Almost one in three adult New Zealanders (over 15 years) and one in nine (11 percent) children aged 2–14 years is obese. In October 2015, the Government launched the Childhood Obesity Plan, with 22 initiatives designed to reduce childhood obesity in New Zealand.

Key activities across a number of government agencies, private sector, communities and schools include developing improved public information and resources, encouraging children to be more physically active, supporting children and their families/whānau to be able to make healthier food choices and working with the food and beverage industry to encourage the promotion of healthier alternatives.

Working on a large multi-agency programme has been as challenging as it has been rewarding. There have been a number of successes within the programme, with 9 of the 22 initiatives completed. One programme manager in the Ministry has coordinated the programme, supported by many people actively contributing from different agencies.

The Government is not actively considering a sugar tax at this point in time but has had a watching brief on emerging evidence and practices.

The reducing childhood obesity intervention logic model sets out a number of shared goals, outcomes and indicators for the Childhood Obesity Plan. The model includes four medium-term outcomes to be achieved over the next 4–5 years:

- more children are physically active
- more children eat well
- children's environments support physical activity and healthy eating
- more children have improved health outcomes.

The model includes an agreed set of performance indicators to determine whether the medium-term outcomes are being achieved. Some of the indicators are outcomes focused, while others focus on the drivers of childhood obesity.

The intervention logic model and baseline report for reducing childhood obesity were key cross-agency projects completed in 2016/17. Other highlights are as follows.

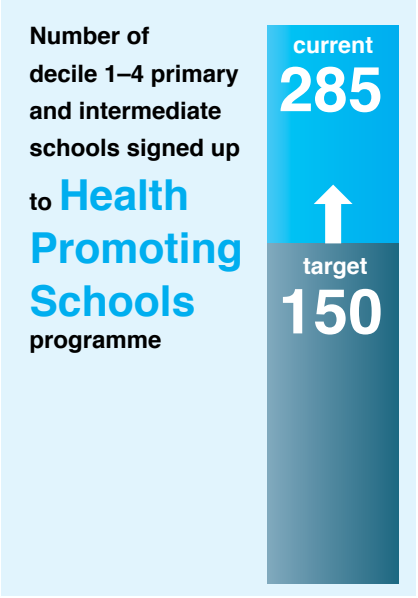
- in the third quarter of the 2016/17 year, 86 percent of obese children identified in the B4 School Check programme were offered a referral to a health professional, with the Ministry's Raising Healthy Kids' health target set at 95 percent by December 2017.
- the Ministry released new guidelines for eating and activity for adults, guidance for healthy weight gain in pregnancy and guidance on gestational diabetes to support health professionals and the public to make healthier choices.
- physical activity guidelines for 5–17 year olds have been updated, and active play guidelines for under-fives have been developed.

All DHBs have become sugar-sweetened beverage free and are working toward implementing the National Healthy Food and Drink Policy.

An awareness campaign that encourages families/whānau to make small changes to help tackle childhood obesity ran again for six weeks during May and June 2017.

The Ministries of Education and Health worked together to encourage schools to become areas where only water and milk are the only drinks consumed. A number of DHBs, Healthy Families New Zealand and Healthy Auckland Together are working with their local councils to encourage them to make their recreation and community facilities 'fizzy drink' free.

To date, 285 new decile 1–4 primary and intermediate schools have signed up to the Health Promoting Schools programme, above the target of 150 schools. Further, Sport New Zealand's Play.sport pilot programme has been expanded from 34 schools to 44 schools across Upper Hutt and Waitakere.



The Healthy Families New Zealand initiative is operating in 10 locations across the country. Below are examples of some of the work to date.

- Go the H20 is a movement initiated by Healthy Families Lower Hutt to make water the first drink of choice in our communities, while the Health Star Rating system continues to expand and is now on more than 2,700 products.
- the Advertising Standards Authority (ASA) has reviewed its advertising codes for children and extended the revised code to apply to young people too.
- the Ministry has worked with the food and beverage industry to develop the Healthy Kids Industry Pledge, which a number of companies have signed and are implementing. Companies will report back later in 2017 against their pledges and the changes they have seen in consumer behaviour and purchasing choices.

More information about each initiative is available on the Ministry's website (health.govt.nz).

Diabetes

Implementing a diabetes plan

An updated version of the Virtual Diabetes Register (VDR) was released in April 2017 and shows that an estimated 241,463 people in New Zealand have diabetes.

The prevalence of diabetes in New Zealand continued to rise between 2010 and 2016, especially in Pacific, Indo-Asian and Māori ethnicities, and those aged 25–50 years, but the rate of increase is slowing.

To date, implementation of the Living Well with Diabetes plan has been managed largely through baseline funding and supported by $12.4 million allocated to DHBs as part of Budget 2013 to support implementation of the Diabetes Care Improvement Package (DCIP). DCIP funding was devolved to DHBs from 1 July 2017.

In partnership with the National Diabetes Leadership Group, the Ministry developed evidence-based advice for health providers on risk-factor management for pre-diabetes.

Some examples of key achievement are described below.

- A review of customer-focused awareness-raising diabetes resources has been completed.
- Several prevention and earlier diagnosis initiatives have been completed. (One PHO's weight management programme is nearing completion. A total of 206 people at risk of developing diabetes or heart disease have been referred by their GPs to enrol in either a three-month or six-month Weight Watchers™ programme.)
- Two DHBs with projects to support people with diabetes and mild to moderate mental health issues are progressing well. The projects include supporting newly diagnosed children with type 1 diabetes and their families/whānau; using a theatre group to support rangatahi with type 1 diabetes; providing a range of supports for adults with poorly controlled diabetes, including kaiāwhina and social workers. These projects will be evaluated by the end of 2017.
- The Healthy Attitudes and Community Engagement project was completed at the end of June 2017. More than 600 people have had HbA1c, blood pressure and blood lipids tests, and referrals have been made to general practices where appropriate. An evaluation measuring changes in clinical outcomes and healthy behavioural changes was due in July 2017.
- In 2016, the diabetes retinal screening guidance was updated and funding was made available to DHBs through elective services in 2017 to improve ophthalmology services, including retinal screening.

Strategic Priority 4: Improve our understanding of system performance

Improving our understanding of how well the health system is performing at a national, regional and local level will allow us to focus our performance monitoring, management and support on issues that matter to people. This work has included streamlining our DHB annual planning process to have a more focused approach on regional and local performance. We have also considered how we can take advantage of new technologies to collect and generate greater amounts of data, enabling us to build a more comprehensive view of the wider health sector. Ultimately this will allow us to develop smart information systems that give us and other users of the information insights into the health of all New Zealanders.

DHB planning

Planning changes have been introduced to ensure that DHB plans are supporting the New Zealand Health Strategy's strategic goals for the future. The streamlined DHB annual plans still need to provide a strong focus on improved performance and access, financial viability, health equity and service quality and delivery to meet legislative requirements. These plans also need to be clearly aligned with the Strategy and all changes to the planning have been made within the current legislative requirements.

DHBs local focus on health equity for priority populations is being strengthened within these annual plans and regional service plans. DHBs have also been asked to ensure there is emphasis on equity of outcomes for each priority area to ensure that there is a continued focus on achieving equitable outcomes for all population groups

New Zealand Digital Health Strategy

The Ministry has begun developing a new digital health strategy (DHS) to guide sector investments in current and emerging technologies that will support delivery of the Strategy. Work commenced with the creation of a health technology vision that will inform the development of the DHS and outline how digital innovation will shape the way health services are delivered in the future.

While the DHS is being developed, sector investment is guided by Digital Health 2020, which replaces the National Health IT Plan. Part of Digital Health 2020 benchmarks the digital maturity of the DHBs against international standards. Targeted investment recommendations have been included in DHB annual plans.

Making the best use of information technology (IT) and ensuring the security of patient records

The health and disability system is using data, information and customer insights to provide better health care that meets people's individual needs. The Ministry expects to build on the successes the sector has achieved on digital health initiatives.

Technology is rapidly changing the way health care is delivered, and its impact is complex and broad. Challenges include predicting how things will change (for example, nanotechnology, synthetic biology and genomics), so that future systems support these new technologies; having IT systems across the sector that can share data and information; minimising the risk of privacy or security breaches; and maintaining and growing data infrastructure.

Digital Health 2020

Digital Health 2020 has been established to progress the core digital technologies presented in the New Zealand Health Strategy. It guides the strategic digital investments that are expected to occur across the health and disability sector in the next five years, 2016–2020. The strategy will encourage health agencies to invest with greater clarity and confidence.

As part of this work, the Ministry has been engaging with the sector to develop a vision of how digital innovation will shape the way health services are delivered in the future.

Digital Health 2020 focuses on enablers such as architecture and standards, information governance, and technology that can be used across the sector and government agencies.

The core components of Digital Health 2020 are:

- **an electronic health record for New Zealanders**
  - this a single longitudinal view of health information accessible to consumers, carers and decision-makers. The electronic health record will support individual health management, delivery of health care and decision-making across the sector. The electronic health record is currently in the Better Business Case (BBC) process. Over 60 workshops and meetings have been held between the Ministry, other government agencies and the wider health sector.
- **health and wellness dataset**
  - this provides access to health data to support government, health organisations and individuals to make evidence-based decisions aligned to the Government's social investment approach. An IT infrastructure is being developed so data can be securely shared between social sector government agencies and some non-government organisations. A Data and Information Governance group within the Ministry is providing strategic leadership for this work, and a working group has been appointed.
- **a preventative health IT capability**
  - information and enabling ICT capability to support and improve the targeting of screening, immunisation and other public health initiatives. Work is progressing on the national bowel screening programme, including identifying potential IT systems.
- **digital hospitals**
  - benchmarking the digital maturity of DHBs to lift the digital capability within hospitals and the integration with the wider sector. Digital maturity investment recommendations have been included in regional service planning guidance for 2017/18 and current regional service plans have been reviewed with a 'digital maturity' lens.
- **regional IT foundations**
  - eHealth foundations that support regional access to health information, delivery of the single electronic health record and lifting digital capability within hospitals. Each region is investing in its IT foundations to support regional access to health information, delivery of the single electronic health record and lifting digital capability within hospitals. A number of projects are under way that provide the foundations for the regional sharing of information.

Other achievements

Information governance	The Health Information Governance Guidelines that provide good practice advice on the safe sharing of personal health information have been completed and approved by the Health Information Standards Organisation (HISO).
Patient portals	Implementation of patient portals by general practices, and use of portals by patients continues to increase. As at June 2017, over 400,000 patients had registered for a portal and nearly 50 percent of general practices had introduced them (over 470 practices).
Clinicians' challenge	There were nearly 50 entries for the Clinicians' Challenge 2016, a competition that encourages clinicians to develop innovative ideas that can make a real difference to the way health care is delivered. Winning innovations related to elective surgery and the taking of TB medication. Planning for the 2017 Clinicians' Challenge is well under way.
Electronic prescribing and administration of medicines (ePA)	Six district health boards are now using ePA, which reduces the risk of medication errors.
National systems	The implementation of various national information systems is progressing. National systems enable the integration of major sources of information on key clinical specialties, such as the national maternity record and newborn hearing screening information.
Regional systems	The Ministry continues to support regions to implement regional systems, such as clinical portals, radiology information and patient management systems.

National Patient Flow

The National Patient Flow (NPF) programme was completed on 30 June 2017. NPF measures the patient journey through secondary health care services and provides information on patients referred for specialist services, the outcome of the referrals and the time it takes patients to access appropriate care. It is the first national collection to utilise SNOMED CT (Systematized Nomenclature of Medicine – Clinical terminology).

Collectively the Ministry and other health services have been:

- submitting, collecting, validating and loading first specialist assessment data into the NPF data mart since July 2014
- publishing developmental prioritisation outcomes of first specialist assessments data for over a year
- gaining Phase 3 compliance and submitting data for the full scope of the collection.

When in full operation, the NPF collection will benefit patients by providing a better understanding of services demand, our capacity to meet that demand and how access varies. It will improve the health sector's knowledge of the complexities of a patient's journey to ensure better links between the necessary services.

Strategic Priority 5: Implement our investment approach

The social investment approach recognises that improving outcomes for New Zealanders spans agency boundaries and interventions delivered by one agency will often have shared benefits well beyond that single agency's scope of influence. The Strategy sets the framework for a social investment approach where all outcomes, analysis and service design are focused on understanding the needs of people who require public services and the impact those services have on peoples' lives.

The Ministry will continue its transformation to enhance its capability as the steward of the health and disability system and drive a social investment approach. This will include growing leadership and working with other stakeholders in the health sector.

Strengthening our understanding of our customers

A core component of the social investment approach is using data and analytics to understand people's needs. The Ministry has undertaken population analytics in the following priority areas:

Mental health

The Ministry has worked with the Social Investment Agency (SIA) to complete draft population analytics for people who have used mental health services. These analytics, along with evidence from other sources, will inform the ongoing development of the cross-government mental health strategy.

Suicide prevention

The Ministry conducted an exploratory analysis into the prevalence of particular factors, such as social service use, in a cohort of people who had either died by suicide or had self-harmed. This analysis, along with further analytics will inform the development of an updated suicide prevention strategy to replace the New Zealand Suicide Prevention Strategy 2006–2016.

Primary health care

The Ministry has been analysing and comparing utilisation patterns of primary and secondary health care across different population groups. The insights from this work will inform ongoing policy work for the future direction of primary health care.

Children and young people in care

The Ministry has worked with the Ministry for Vulnerable Children, Oranga Tamariki to better understand the identified health needs of children and young people undertaking a Gateway Assessment and ensure these needs are being met.

Young Māori women who smoke

Analytics in the Integrated Data Infrastructure (IDI) were used to understand more about the lives of young Māori women who identified as smokers in the 2013 Census. The project served as a test case to apply population analytics and a 'think big, test small and move fast' approach to a discrete issue.

Applying the principles of social investment to our priority areas

In addition to increasing the use of analytics, other principles of social investment have begun to be applied to priority policy projects. These principles include:

- taking a person-centred approach
- understanding people's needs and who is most at risk
- taking a life-course view to maximise prevention and early intervention opportunities
- measuring the impact of health services on outcomes.

The cross-agency mental health strategy, future direction of primary health care, disability support transformation and work programmes to support vulnerable children will continue to embed the principles of social investment as they are developed.

Strategic Priority 6: Deliver Ministry on the Move

The Ministry on the Move transformation programme is about building a Ministry that is better positioned to support the wider health sector in delivering a healthy and independent future for all. To this end, the Ministry continues to focus on building a Ministry that is supported by the right people, in the right places, with the right capability. Furthermore, the Ministry is working to make better use of key enablers such as information technology and governance structures to support its highly skilled and dedicated staff to deliver outcomes that benefit both the Ministry and the health and disability system.

Our transformation story

The Ministry on the Move programme was established in 2015 to inform and implement the Ministry's transformation process with the purpose of enhancing its capability as steward of the system. This includes growing leadership and management capability; culture, values and behaviours; and better management of organisation performance.

People work more effectively and build better relationships (both within the Ministry and with the wider health sector) when they are in an environment which provides them with the right tools to do their job. The relocation of the Wellington offices to a single site in 2016, and co-location with the Ministry of Education in Christchurch are two examples of where the Ministry has made progress in delivering this transformation. Both these projects were delivered under the leadership of the Ministry with support from the Government Property Group within MBIE.

Our people

The Ministry fosters a high-performing, customer-orientated service delivery culture. Some of the ways we do this is through driving results, valuing diversity and being responsive to Māori. We also encourage making informed decisions as a means of building up our organisational performance capability. Cultivating innovation is also an important part of what we do.

As a knowledge-centric organisation, we acknowledge that our most critical resource is our people and recognise that *equality and diversity* are essential for organisational success. Having a diverse workforce increases our capability, performance, productivity, collaboration and staff engagement. The Ministry remains committed to creating a diverse culture with a wide range of skills and perspectives and to employment practices that promote equality and diversity.

Technology

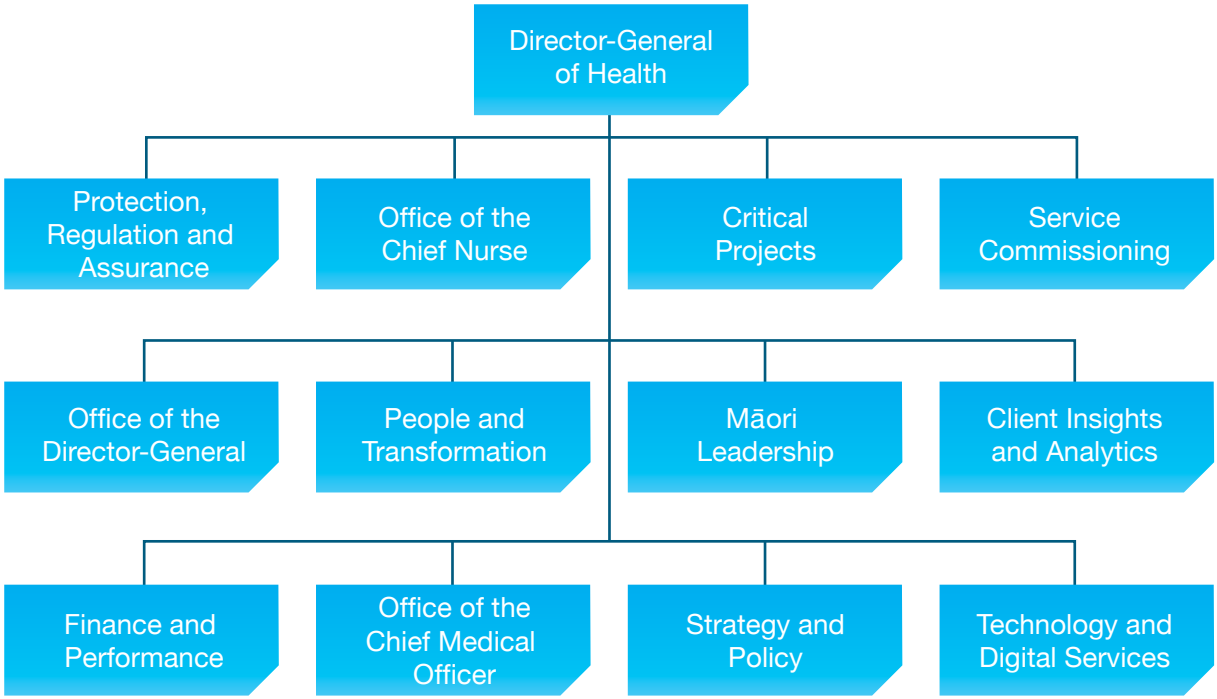
Technology is a key enabler of health. The Ministry's role encompasses advising the government on technology enabled health investments and systems, leading system wide technology and the digital services strategy, developing and implementing core health technology systems and digital services in areas of strategic significance and leading the development of agreed sector architecture and standards. The Ministry's Digital Advisory Board provides strategic advice on emerging and new digital health technologies that will guide decision-making around technologies and encourage innovation in the wider health sector. The Ministry also works across the health and disability system and with other government agencies to optimise the use of the Government's IT Infrastructure as a service and other all-of-government contracts and has undertaken a risk assessment of its current systems and drafted a new corporate IT strategy and a long-term investment plan.

Governance

The Ministry is made up of 12 business units (see our organisational structure below) with a representative on the Executive Leadership Team (ELT) where the Director-General of Health serves as the Chair.

This structure is underpinned by governance and risk management processes which inform ELT's decision-making.

Figure 2: Organisational structure



Section two

Our contribution to wider government, Ministerial and cross-sector priorities: value-adding

Our contribution to wider government, cross-sector and Ministerial priorities

The Government has outlined clear principles for how it expects public services to perform. Realising the Ministry's vision for the health sector requires an approach that aligns with these principles. The Ministry is a results-driven organisation, one that works with other social services to deliver collective impact and pursue innovative approaches.

Wider government priorities

As identified in the Ministry's Statement of Intent 2015-2019, the Ministry contributes to the Government's strategic priorities by:

1. responsibly managing the Government's finances
2. building a more productive and competitive economy
3. supporting the Christchurch rebuild
4. delivering Better Public Services.

Examples of our contribution

1. Responsibly managing the Government's finances

The Ministry is responsible for managing its own funding and ensuring the wider health and disability system is funded and managed efficiently, productively and sustainably. The Ministry works with a number of sector partners to deliver a sustainable health and disability system that delivers value for money.

The Ministry of Health, supported by The Treasury, commenced a Cabinet approved pilot in 2013 to test the concept of social bonds in a New Zealand context. Social bonds are a specific type of social investment where private and not-for-profit organisations invest and partner to deliver approved Government programmes with agreed outcomes which aim to improve the lives of people affected by specific social problems. Investors are paid for the results that they achieve. The pilot programme is expected to conclude in September 2017. As a result of the work undertaken by the Ministry and Treasury, the first social bond which aims to get more people with mental health issues into employment was approved by Cabinet in December 2016 and implemented in February 2017. This bond runs for six years with services being provided in Auckland. The Ministry is also working on implementing a second social bond that is expected to start on 01 October 2017 with the aim of reducing reoffending by children and young persons who have already offended. It is anticipated that 1000 youth will be enrolled in the programme. The success of social bonds allows the Government to explore new ways of funding and delivering social services.

The Ministry of Health is also involved in a number of major hospital redevelopment projects around New Zealand. Construction began at the end of May 2016 on a new hospital and integrated family health centre being built in Greymouth for the West Coast community. The Ministry is responsible for managing the project at a cost of approximately $77.8 million together with the West Coast Hospital Redevelopment Partnership Group which provides governance support for this project. Membership includes representatives from the Ministry of Health, The Treasury, and the West Coast District Health Board. The new facility is expected to open in 2018.

Work also continues to create a single national residential pricing tool model across its disability support services and community and residential care services that will result in consistency, transparency and equity in residential funding across all providers.

2. Building a more productive and competitive economy

Through continuous improvement of its regulatory functions, all New Zealanders have access to safe, high quality care. This ensures a safe and trustworthy regulatory environment in the health and disability sector and this impacts on the economy and the economic growth of New Zealand by contributing to a healthy workforce. We are looking to further contribute to building a productive and competitive New Zealand through our adoption of social investment approaches to health care.

3. Supporting the Christchurch rebuild

The Ministry is working with Canterbury DHB and other agencies to implement the Government's Psychosocial Recovery Strategy and Action Plan which aims to meet the health needs of Cantabrians in response to the ongoing effects of the Christchurch earthquakes. The Ministry of Health is responsible for delivering the Christchurch hospital redevelopment project. The new Burwood Hospital was built at a cost of $215m and was officially opened in August 2016. The rebuild of Christchurch hospitals as part of this overall project is expected to be completed by the end of 2018.

4. Delivering better public services (see also Strategic Priorities 1 and 2 – Section one)

The Ministry is responsible for delivery of the Government's better public services targets within a challenging fiscal environment. Delivery of the targets set in the Better Public Services programme requires the Ministry to work collaboratively across government agencies. Over the last year, the Ministry has been working with its partners in getting a better understanding of the needs of vulnerable tamariki / children and the systems shifts required to meet diverse and complex needs. Focus has been on providing access to timely vaccinations, including providing individual-level data to providers to identify those children who are late for immunisations, earlier referral to outreach services and working across agencies to facilitate locating children who are overdue for immunisations. Existing targets such as increasing infant immunisation rates and reducing the incidence in rheumatic fever have been key work areas over the last five years. In relation to rheumatic fever, significant reductions have been made in some areas.

Cross-sector priorities

The Government expects agencies that deliver social services to work together to deliver the best value for people. Health is a key enabler of better social outcomes. Positive health and independence outcomes are a consequence of activities across the social sector, not just the health and disability system. We know that education, employment status, housing quality, sport and recreation, and public transportation that enables access, all have an impact on the health and wellness of our customers and their families/whānau.

We are working with other government agencies to identify which individuals and community groups have the greatest needs and which mix of services will result in the best outcomes for our customers in the long-term.

The Ministry works across government on a number of initiatives in the health and social sector. These include:

- Supporting vulnerable children (see Section 1, Strategic Priority 1 (page 16)
- The Prime Minister's Youth Mental Health Project (YMHP) (see Section 1, Strategic Priority 2 (page 26).
- Whānau Ora (see Section 1, Strategic Priority 1 (page 7).
- National Drug Policy (see Section 1, Strategic Priority 2 (page 28).

The Minister's other strategic priorities

Improving patient experience and health outcomes through accessible and integrated health care services has been a priority for the Government and the Ministry. Enabling care to be provided closer to home is central to supporting a more effective, efficient and sustainable health system which makes better use of our specialist workforce and technologies to care for New Zealanders with multiple health needs.

Screening

Screening programmes improve health outcomes for people as early detection of disease can prevent premature death and disability. People take part in screening programmes as a preventative health measure.

Health screening programmes

The Ministry's National Screening Unit (NSU) is responsible for delivering safe, effective and equitable screening programmes.

The Ministry launched 'Time to Screen', a new consumer-focused website providing information on breast and cervical screening with a new logo and colours for the breast and cervical screening programmes. The new approach was developed with support from providers. The new website and logo will be supported by a social marketing campaign and over time the aim is to provide information on all population screening programmes.

In consultation with the Ministry and other key stakeholders, the Pan Pacific Nurses Association New Zealand developed the consultation document *National Screening for Healthier Futures 2017–2022* which describes how the Strategy will be applied across the NSU programmes over the next five years. The document reflects the Ministry's commitment to achieving equity and sets targeted actions to make significant gains in this area.

Quality improvement remains a key priority for all programmes and this approach was reflected in a number of initiatives this year, including:

- continuing the antenatal screening programme for Down syndrome and other conditions programme, which supports ultrasound practitioners to further enhance the quality of ultrasound to provide the best possible information to pregnant women and their families/whānau. Early indications are that this initiative is contributing to an improvement in quality for this type of screening
- supporting and monitoring the national quality improvement initiative for Universal-New-born Hearing Screening Programme, which was rolled out in 2016 and includes new equipment and protocol changes. The 20 DHBs involved and the NSU are focused on supporting and monitoring the new approach
- implementing the national breast and cervical screening programme's 'Support to Screening Services'. These new services provide personalised and practical support to women who may need additional support as part of their screening journey. The new service aims to take a more holistic and customer-centred approach to improve screening, in particular for those women who are under-screened or who have never been screened. The Ministry sought sector input into the key challenges of the previous services and the key strengths and opportunities for how services could be reconfigured. This input has been used to reformulate the services to focus on outcomes for women and their families/whānau and to be open to a more diverse range of service provision.

Human Papillomavirus (HPV) screening

The Ministry's NSU is transitioning to human papilloma virus (HPV) screening as the primary test for the National Cervical Screening Programme in 2018. The aim of the programme is to identify pre-cancerous lesions in the cervix so they can be treated to prevent cancer from occurring. The HPV test is a more sensitive test and will further reduce mortality from cervical cancer. The other benefits are that women can be screened every five years and screening will start at age 25.

The key milestones for the year included:

- setting up engagement workshops with laboratories and other stakeholders to better understand the impact of the change to HPV primary screening
- working collaboratively with the bowel screening programme on requirements and procurement for the development of a shared information technology (IT) national screening solution. This approach will support the delivery of HPV primary screening in the longer term as IT is a key enabler of this transition.

The transition to HPV primary screening is a change for the laboratory sector and the Ministry's NSU has been engaging with laboratories to understand the impact and gain insights to inform the development of the future operating model. To overcome challenges in delivering this work the NSU are observing learnings from overseas programmes that have transitioned to HPV primary screening (eg, the Netherlands and Australia) and applying learnings to the New Zealand context.

In preparation for this transition the NSU has continued to engage with the sector on a number of work areas, including:

- development of new clinical guidelines and National Policy and Quality Standards for HPV primary screening
- supporting HPV self-sampling studies which are investigating how self-sampling may work for priority populations in New Zealand.

Cancer

Prostate cancer management

One of the priorities of *Prostate Cancer Management and Referral Guidance* is to provide men and their families/whānau with consistent information on prostate cancer testing and treatment options.

Highlights in this space include the cancer services team's presentation on the progress of the Prostate Cancer Awareness and Quality Improvement Programme (AQIP) to the health select committee.

The new advanced and metastatic prostate cancer sub-group was formed and supports the overall implementation of the AQIP. In particular, the focus has been on developing and implementing clinical guidelines for managing advanced and metastatic prostate cancer.

The Ministry undertook a review of the proposed design of the prostate cancer Decision Support Tool (DST) with key internal and external stakeholders. In September 2016, a series of workshops and presentations were held on prostate cancer grading in Auckland, Hamilton, Wellington, Christchurch and Dunedin.

The review highlighted that the DST would be more appropriate as two separate tools and proposed a public-facing DST designed specifically for men, and their families/whānau as well as a separate DST for GPs, which would guide and support clinical management of men with prostate cancer concerns.

The Ministry website for prostate cancer was revised and updated to reflect current evidence.

Additionally, a single-page customer engagement resource has been developed and distributed to urologists on what to expect if men with prostate cancer decide to be put on active surveillance. Moreover, GP and health care provider training and education information on the prostate cancer has been updated. This information has been disseminated to the Royal New Zealand College of General Practitioners.

Cancer Health Information Strategy

Cancer Health Information Strategy (phase one)

The Cancer Health Information Strategy identifies a number of work streams and three objectives of the Strategy are to:

- improve the quality of clinical information relevant to the cancer pathway by reviewing the lung tumour standards, analysing regional multidisciplinary meetings and working in partnership with Australia New Zealand Gynaecological Oncology Group to develop a simple tool that will improve understanding of ovarian cancer service outcomes across New Zealand
- improve the quality of service delivery information by reviewing of the current cancer stage data. (In addition, a cancer analyst working group has been established to ensure consistency in the data and information collected
- Improve the quality of information provided to cancer patients by appointing cancer nurse coordinators within DHBs and making a country-wide investment in service improvement initiatives including improving the cancer pathway for Māori.

A highlight this year was the launch of the National Radiation Oncology Plan 2017-2021. The Ministry has been working with the radiation oncology sector (both public and private) to improve the way clinical information is collected and used. The aim of the plan is to support service and capacity planning and ensure equitable, high quality care for all cancer patients.

The Cancer Stage Project was established to strengthen and build partnerships across the sector. This project will provide access to cancer stage data across the sector to ensure adherence to privacy and ethics standards.

Cancer Psychological and Social Support Workforce Initiative (phase two)

Psychological services have been working with patients and families/ whānau affected by cancer. The workforce has built strong relationships with existing services, which has assisted in streamlining referrals to the service and have been working closely with cancer nurse co-ordinators to ensure appropriate referrals for psychological and social support.

An external evaluation is currently under way to determine whether the initiative is improving the experience for cancer patients and their families/ whānau, and the overall access, and timeliness of access, to psychological and social support services.

The evaluation started in the northern region and emerging findings suggest that services are meeting the needs of patients, and patients are satisfied with the care they are receiving. Outcomes include a reduction in distress, fear and anxiety, improved day-to-day coping, improved access to transport, finances and other supports. The number of 'Did Not Attends' for treatment have reduced with two patients reporting they would not have had treatment without the support of the service. Results also suggest that ongoing service development is required to improve access to the target population, such as, Māori, Pacific, rural and low socioeconomic communities, and those with high and complex needs.

A successful national workforce forum was held in May 2017 showcasing key successes from across the country and providing an opportunity for DHBs to learn from each other.

This forum led to the publication of *The Model of Care,* which provides key recommendations, particularly to ensure that psychological services meet the needs of Māori. It includes the use of Te Whare Tapa Whā to inform practice, and space for the role of families/whānau to complement cancer care. It is intended to support regions and DHBs to help shape their service to meet local needs and provide service development guidance.

Influenza Immunisation Programme

The Strategy was used as a focus for change to enable access to the funded influenza vaccine by community pharmacists. Implementing this policy change involved multiple organisations working in collaboration towards a shared goal. The introduction of pharmacist vaccinators has broadened access to the influenza vaccine, especially for those who have difficulty accessing general practices.

The Ministry continues to improve vaccine uptake for the annual Influenza Immunisation Programme and during 2016/17 sought to improve access to the influenza vaccine through a number of different levers as described below:

Changing the policy setting by:

- extending the availability of funded vaccine from the 31 July to 31 December of each year for individuals at greater risk from influenza (especially those aged 65 years and over, those aged under 65 years with certain medical conditions and for pregnant women)
- setting policy changes to enable community pharmacists to offer the funded influenza vaccine to individuals 65 years and over and pregnant women. This took effect on 1 April 2017
- supporting the Immunisation Advisory Centre (IMAC) to hold the New Zealand Influenza Symposium.

Improving infrastructure:

- the Ministry developed the ImmuniseNow web application to enable influenza vaccination information to be transferred electronically from a secure site within community pharmacies to the National Immunisation Register (NIR). As of 1 April 2017, all influenza vaccinations given by pharmacist vaccinators are recorded on the NIR
- a variation was made to the Community Pharmaceutical Service Agreement and changes were made to the IT payment systems to ensure pharmacists can claim for the cost of the influenza vaccine and administer the vaccine to an eligible individual
- the Influenza Business Objects report developed in 2016 is being used to monitor influenza immunisation coverage for those aged 65 years and over. From 2017, this report will be used to monitor DHB performance.

Sector communications:

- the Ministry has a contract with IMAC for the promotion of influenza and the Immunisation Team continues to support IMAC to disseminate communications and promotional messages to health professionals and the public about the 2017 Programme
- pharmacists were frequently provided with communications in order to support them in the delivery of the Programme and wider communications were developed for the health sector to inform them of these changes
- the Ministry distributed 1.2m doses of vaccine and this was the sixth year in a row that more than one million doses have been distributed and an estimated 25 percent of the population have been immunised against influenza.

Improving access to the vaccine aims to improve influenza immunisation coverage, reduce hospitalisations and improve health outcomes for vulnerable population groups as in 2016, only 56 percent of those aged 65 years and over were recorded on the NIR as having had an influenza vaccine.

Therapeutic products regulatory regime

The key milestone was the issuing of comprehensive drafting instructions and progressing the drafting of this complex bill.

A further milestone is deciding, with considerable sector involvement, the details of the policy for pharmacy licensing. During the year there has been ongoing engagement with stakeholders on key issues (such as pharmacy licensing) and on the overall project, progress etc. (eg, with the medical device and medicines industries, clinical interest groups, and within Australia).

The Ministry has worked closely with the pharmacy sector, the internal pharmacy network, other government departments and the Minister's Office to ensure that all perspectives are considered and risks are managed as far as possible when addressing pharmacy licensing.

The next steps are to complete a full draft of the bill and a companion discussion document and consult publicly ahead of the bill entering the legislative process in 2018.

Smokefree Aotearoa New Zealand 2025

Smokefree New Zealand 2025 Innovation Fund

Smokefree compliance and enforcement activities continue across the country. The Ministry has co-ordinated training for all appointed Smoke-free Enforcement Officers and provided support when it is required.

The Ministry has initiated a number of prosecutions during the year, mostly related to smoking in an internal part of a licensed premise. Steps to prosecute are also being taken against a company for selling a 'heat not burn' tobacco product in contravention of the Smoke-free Environments Act 1990.

More information on the legal status of 'heat not burn' tobacco products is available on the Ministry's website.

In March 2017, the Ministry prepared a regulatory impact statement regarding e-cigarettes which provided an analysis of options to regulate e-cigarettes and e-liquid as consumer products, as well as analysis of high-level options for the regulation of emerging tobacco and nicotine-delivery products. The Ministry of Health's advice on e-cigarettes and other emerging tobacco and nicotine-delivery products will be kept under review as new evidence emerges.

Other Ministerial priorities

Oral health

Community oral health services

Over the past nine years the Ministry has worked with DHBs to implement a major re-investment programme in child and adolescent oral health. Over this time there has been an encouraging improvement in child oral health outcomes, as well as in COHS enrolment and attendance.

Trend data from December 2007 to December 2015 indicate that the percentage of children who were caries-free at age five increased from 51 percent to 59 percent. The results for Māori five-year-olds increased from 29 percent to 39 percent caries-free, and for Pacific five-year-olds from 29 percent to 33 percent caries-free.

The percentage of preschool children enrolled with the COHS increased from 43 percent to 80 percent.

The average number of decayed, missing and filled teeth (DMFT) per child at school year eight reduced from 1.53 to 0.90. The results for Māori children reduced from 2.31 to 1.31 average DMFT, and for Pacific children from 1.79 to 1.39 average DMFT.

Oral health promotion initiative

A government investment of $10 million over four years has been made for an oral health promotion initiative to promote good oral health for young children. Māori, Pacific and low-income families/whānau are the priority groups, due to their significantly poorer oral health outcomes from childhood to adulthood. The initiative includes development of a social marketing campaign and the distribution of toothbrushes and toothpaste to families/whānau and their young children.

The social marketing campaign was launched in November 2016 and included a television commercial featuring a re-imagined tooth fairy speaking to parents about the need to brush their children's teeth twice a day with fluoride toothpaste. The campaign uses humour to relay the messages and has proved popular with the groups it is seeking to reach.

Against a background trend of increasing dental admissions for children, the success of the Child Oral Health Promotion Initiative and the Electronic Oral Health Record Programme will be critical to the achievement of new Better Public Services results.

Fluoridated drinking-water supplies

In April 2016, Government announced proposed legislative changes to allow DHBs to direct local authorities to fluoridate community water supplies in their areas.

The Ministry developed the Health (Fluoridation of Drinking Water) Amendment Bill to implement these changes by amending Part 2A (Drinking-Water) of the Health Act 1956. The bill was introduced to the House on 17 November 2016 and passed its first reading on 6 December 2016. The bill has been considered by the Health Committee and this included a public consultation process. The final report of the Health Committee was presented to the House at the end of May 2017. The next step is the second reading of the bill.

The Ministry has worked with DHBs and local government to develop operational policy and address other implementation issues. It has also updated the Fluoride Facts website to provide the public with clear and up-to-date information about the safety, effectiveness and cost of water fluoridation. The website includes short videos of experts and community leaders talking about water fluoridation.

Health literacy

In New Zealand, the Ministry of Health has recently published a Framework for Health Literacy.

The Framework describes the characteristics of a health-literate health system; which includes building health literate health organisations and a health literate workforce to support individual and family health literacy.

This is a system which reduces the literacy demands people face and builds the health literacy skills of the workforce, and the individuals and families/whānau who use its services.

A health literate system provides quality services that are easy to access and gives clear and relevant health messages so that people can effectively manage their own health.

More information on the framework and a range of health literacy publications are available on the Ministry's website.

National health targets

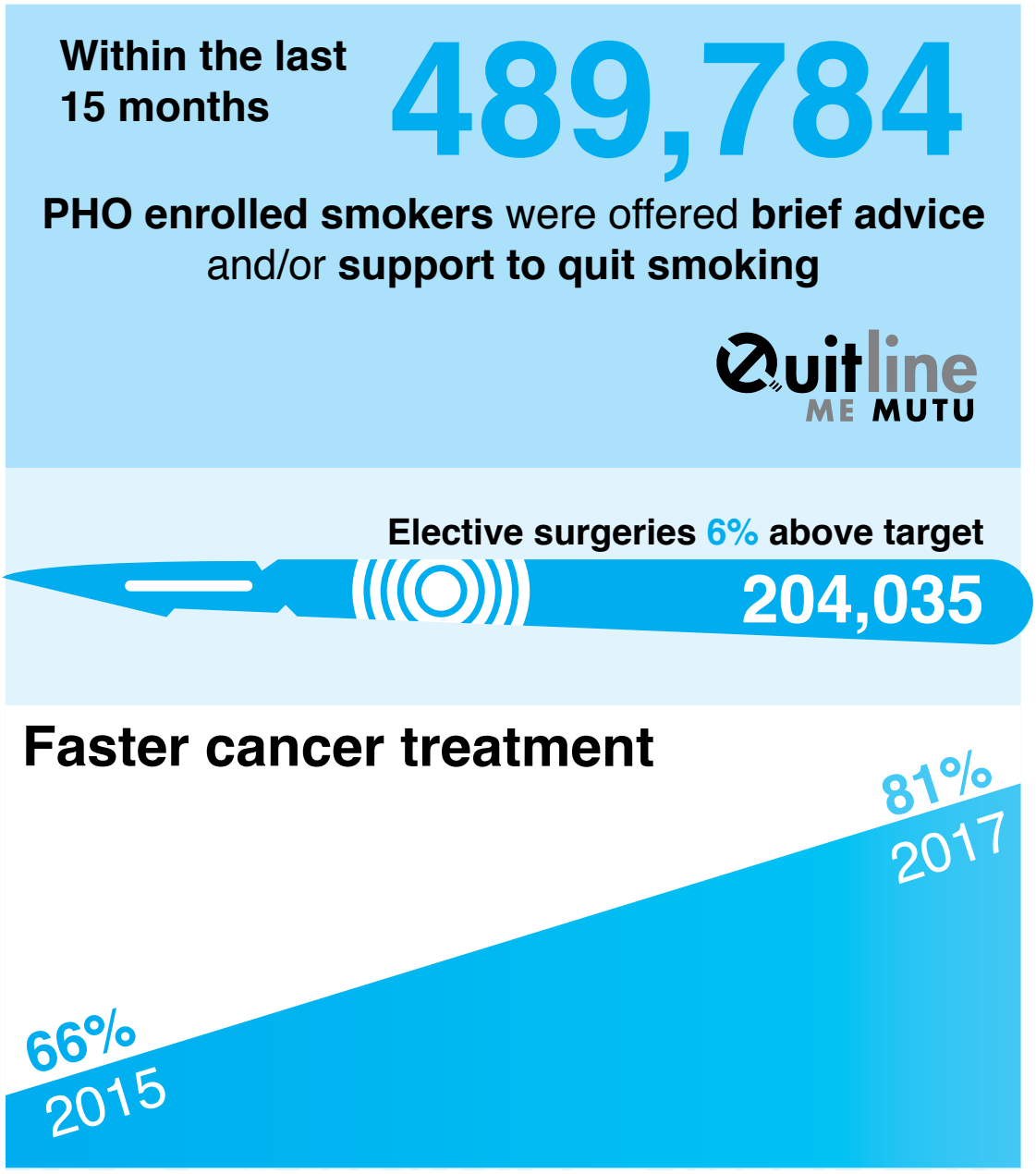
National health targets are a set of national performance measures specifically designed to improve the performance of health and disability services that reflect significant public and government priorities. They provide a focus for action. Meeting these targets makes a practical difference to individuals and their families/whānau by improving their access to services, reducing waiting times and preventing harmful conditions.

Three of the six health targets focus on patient access, and three focus on prevention.

This section reports on the performance of the health targets against the national target and historical performance.

Key national health target achievements

Over the 2016/2017 year, the Ministry, DHBs and the wider health sector continued to deliver strong performances against the national health targets.



Health target: Shorter stays in emergency departments

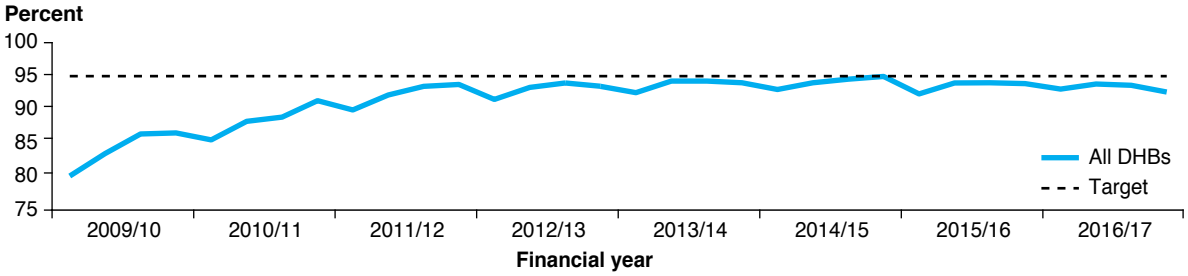
Performance summary

Shorter Stays in Emergency Departments

Between 2009/10 and 2016/17 there has been a noticeable improvement in performance, with the number of patients admitted, discharged or transferred from an emergency department within six hours increasing from 80 to 93 percent, an overall improvement of 16 percent.

Even though at the end of the 2016/17 financial year the result was slightly below target, the result is a continuation of the consistently strong performance during the past eight years, and is the result of the hard work undertaken by the Ministry, DHBs and the wider sector.

Figure 3: Shorter stays in emergency departments



What is the target?

Ninety-five percent of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours. The target indicates how efficiently our acute (urgent) patients are flowing through our public hospitals to get back home again.

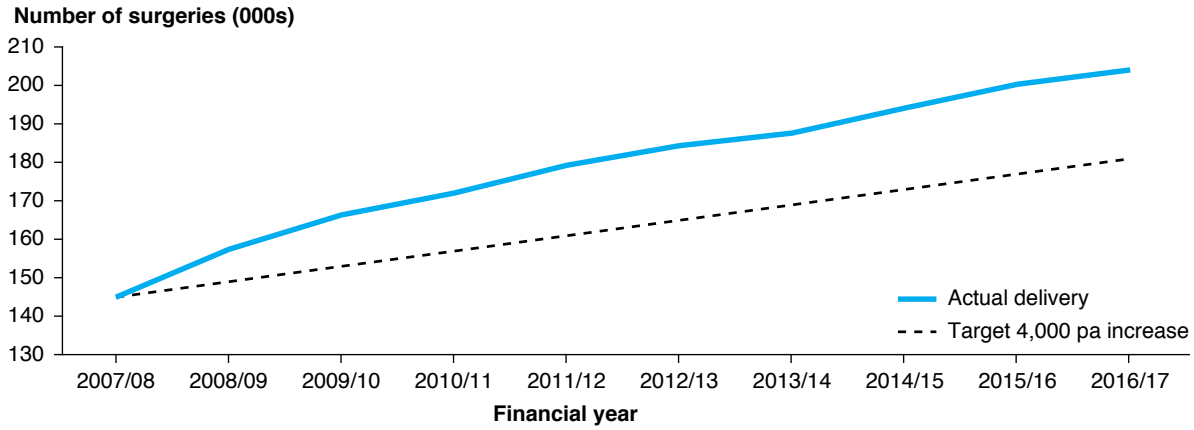
Health target: Improved access to elective surgery

Performance summary

During 2016/17 there were 204,035 elective surgical discharges, up 41 percent from 2007/08, a significant increase.

The 2016/17 result was 6 percent or 11,798 elective surgical discharges above target, thus improving the quality of life for more New Zealanders. 18 of the 20 DHBs positively contributed to this result.

Figure 4: Improved access to elective surgery



What is the target?

The volume of elective surgery will be increased by an average of 4000 discharges per year.

DHBs have negotiated local targets taking into consideration the health needs of their communities. Collectively these targets contribute to a national increase in elective surgery discharges.

Since 2015/16 the target has included elective and arranged in-patient surgical discharges, regardless of whether they are discharged from a surgical or non-surgical specialty (excluding maternity).

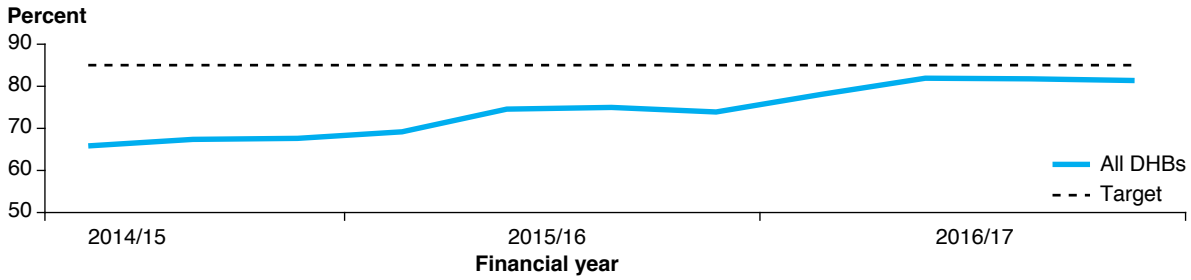
Health target: Faster cancer treatment

Performance summary

Implementing sustainable service improvement can be a challenge and as such exceeding the target for providing faster cancer treatment to patients remains a challenge. However, significant progress has been made, there has been a 20 percent improvement since 2014/15.

The improved performance continued during 2016/17 resulted in a 10 percent increase compared to 2015/16.

Figure 5: Faster cancer treatment



What is the target?

The target is 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

The results for quarter 4 2016/17 cover those patients who received their first cancer treatment between 1 January and 30 June 2017.

Note: from quarter one 2017/18 faster cancer treatment results will be against the new 90 percent target and technical adjustments to the target definition have also been made.

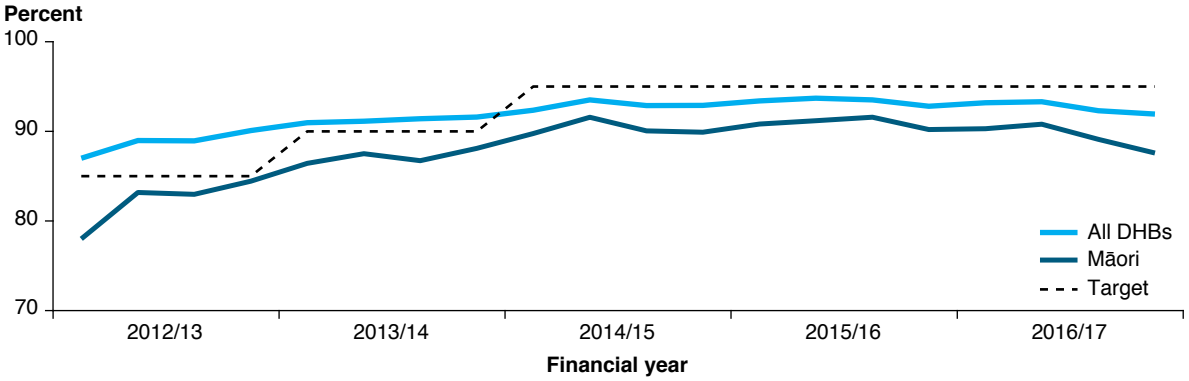
Health target: Increased immunisation

Performance summary

The overall immunisation coverage has been consistently above 90 percent since 2012/13, a very strong result. Of note, the difference in immunisation coverage between the total population and the Māori population has reduced over the past two years.

National immunisation during 2016/17 was 92 percent. Of the 15,316 eligible children aged eight months in quarter four 2016/17, 14,079 were fully immunised.

Figure 6: Increased immunisation



What is the target?

95 percent of infants aged eight months will have completed their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

The quarterly progress result includes children who turned eight months old during the three month period of the quarter and who were fully immunised at that stage.

Health target: Better help for smokers to quit – primary care

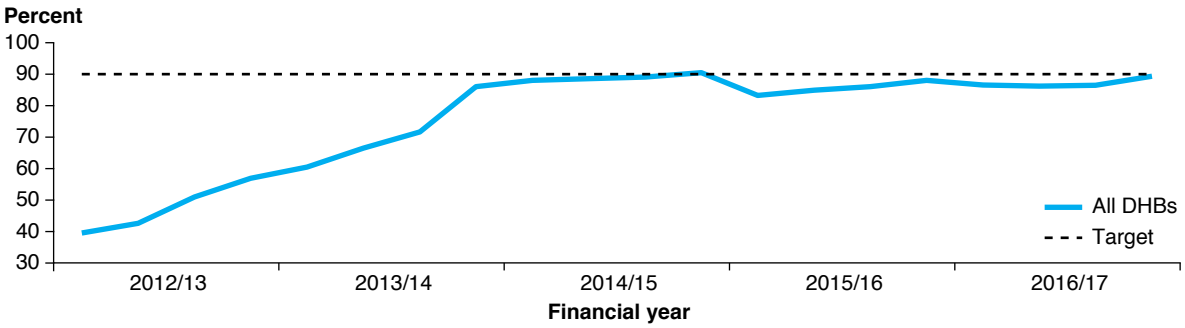
Performance summary

Better Help for Smokers to Quit

Since 2012/13 there has been a 123 percent increase in PHO enrolled smokers who were offered brief advice and/or support to quit smoking, this is an extremely positive result. Since 2014/15 there has been a consistently high level of performance.

The 2016/17 result was 89 percent (92 percent of pregnant woman), meaning that within the last 15 months 489,784 PHO enrolled smokers were offered brief advice and/or support to quit smoking.

Figure 7: Better help for smokers to quit – primary care



What is the target?

- 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.
- 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking[2].

From quarter one 2015/16 the primary care target shifted its focus to the entire enrolled population of people who smoke and not only those seen in primary care, and covers advice provided over 15 months, instead of 12 months.

From quarter one 2016/17 the hospital component of the target is no longer reported as a health target. This change was made after the 95 percent target was met for several consecutive quarters. The hospital target results will continue to be published on the Ministry's website along with the maternity target results.

2 The maternity target remains developmental and reported results cover only a proportion of pregnant women who identify as smokers

Health target: Raising healthy kids

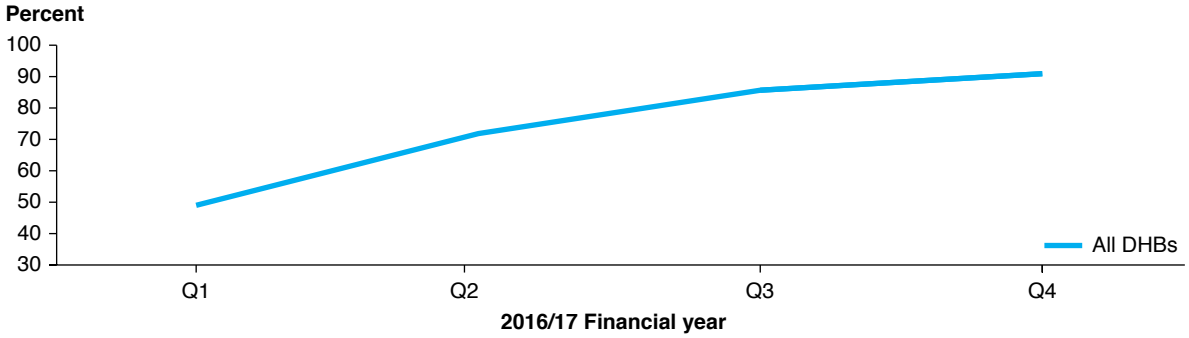
Performance summary

2016/17 was the first year the raising healthy kids health target was reported.

DHBs made excellent progress, and are on track to meet the target of 95 percent by December 2017.

The 2016/17 result was 91 percent up from 49 percent in quarter one.

Figure 8: Raising healthy kids



What is the target?

By December 2017, 95 percent of obese children who were identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Public reporting on the Raising Healthy Kids health target is based all completed B4 School Checks in a six-month period.

The results for quarter 4 2016/17 capture referrals of obese children who had a completed B4 School Check processed in the six-month period from 1 December 2016 and 31 May 2017 and where the referral to a registered health professional was acknowledged within 30 days. It also includes children who were already under care, and referrals declined by the parent/caregiver.

The health target is just one part of the wider childhood obesity plan that includes actions on healthy food policies, working with the food industry, schools and local government.

Section three

Our core business activities: value preserving

Statement of performance

Introduction

This section outlines the Ministry's performance and meets the requirements of the Public Finance Act 1989. Performance measures enable the reporting of the quantity, quality, timeliness and cost-effectiveness of the Ministry's outputs. The measures also provide key information about the Ministry's overall performance and role. The performance measures show the Ministry's outputs against the performance measures from the Estimates.

This section groups and presents the Ministry's performance measure results by appropriation within Vote Health. The Ministry has met or exceeded most of its targets; explanations are provided if the variance is greater, or less than, 10 percent. We also seek to improve, promote and protect the health and wellbeing of New Zealanders through the core work that we deliver. In doing so, we are seeking to preserve and enhance the value of the services we provide to our customers.

Health sector information systems

The Ministry is responsible for managing and operating the technology and digital services that underpins the national data collections and systems used in service delivery within the Ministry and across the health and disability sector. These services enable the health and disability system to undertake local, regional and national planning of resources for current and future service demand.

The Ministry works closely with the sector to develop its technology and digital services, strategies and initiatives.

Across the health sector the following six systems are the most commonly accessed:

- the Ministry's own website
- the National Health Index (NHI)
- the National Immunisation Register (NIR)
- Pharmacy Electronic Claiming (PEC)
- the Oracle financial system
- special authorities.

National infrastructure and systems

Systems, such as the NHI, enable frontline sector staff to identify patients in real time to allow for delivery of the most appropriate services and support.

Table 1: Summary of performance for national infrastructure and systems

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
National infrastructure and systems			
100%	The percentage of time for which the key sector – and public-facing systems are available (Note 1)	100%	99%
14,990	The number of active user logins to national systems (Note 2)	15,893	15,000

Note 1 Key sector- and public-facing systems are National Health Index (NHI), National Immunisation Register (NIR), Online Pharmacy, Special Authorities, Oracle Financials, and web access. Planned outages are not included in this measure.

Note 2 An active user is either an individual user or an organisation. Each login by an active user is counted.

Disruptions to services are unproductive and in 2016/17 all systems were available for almost 100 percent of the time. Information from national systems was available to almost 16,000 external user accounts with log-in access to the systems. An active user is either an individual user or an organisation.

National collections and reporting

National collections provide health information used to support decision-making in policy development, funding, monitoring and research.

Table 2: Summary of performance for national collections

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
National collections			
13	The number of national collection reports produced annually	16	10
100%	The percentage of data submitted by DHBs that is processed within two working days (Note 1)	100%	97%
3,109	The number of requests, for data and/or analysis, responded to in respect of information held within the national collection datasets	3,058	2,900

Note 1 This measure relates to the national minimum dataset and the national booking reporting systems only.

The data collected is a valuable contributor to work undertaken to improve the health outcomes of New Zealanders. It is also used by the Ministry in meeting its reporting functions.

In 2016/17 all data submitted by DHBs relating to the National Minimum Dataset, (NMDS - hospital events) and the National Booking and Reporting System (NRBS - patients waiting for elective surgery) were processed within two working days of receipt. With a commitment to the efficient and accurate processing of data the Ministry also provides information services to the public.

Managing the purchase of services

One of the Ministry's core responsibilities is procuring health and disability services for New Zealanders on behalf of the Crown. In 2016/17 a total of $12.3 billion of funding was provided to DHBs and health and disability Crown entities. The Ministry also spent $2.8 billion in the direct purchasing of non-departmental services.

The performance measure results demonstrates the Ministry's level of performance in negotiating and managing its portfolio of contracts to within its purchasing and pricing frameworks to deliver customer-focused services while ensuring value for money.

Contracting

The following performance measures present the work undertaken to procure services using non-departmental expenditure (NDE) on behalf of the Crown.

Table 3: Summary of performance measures for managing the purchase of services

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Contracting			
4,018	Total number of contracts held by the Ministry for the purpose of purchasing goods and services on behalf of the Crown	4,316	4,300
Achieved	The Ministry's procurement policy is assessed and confirmed to be in line with government standards	Achieved	Achieved
1:105	The ratio of departmental expenditure for the output class against relevant non-departmental expenditure (Note 1)	1:84	1:80

Note 1 The methodology for this measure was updated in 2016/17 to utilise the latest available expenditure data for year-end reporting. The comparable result for 2015/16 using the same methodology would have been 1:88.

The Ministry also holds contracts with other parties on behalf of the Crown. These allow for procuring services from third party service providers and are always paid from NDE appropriations. The scope of this class of contract includes:

- any new, or renewed, contracts supporting national service procurement including services such as the National Screening Unit, disability support services, ambulance services, maternity and public health services
- any new, or renewed, contracts entered into by the Ministry for providing services to external parties using NDE funding.

To ensure compliance with current government standards and expectations the Ministry periodically reviews its internal procurement policies and standards.

Contract management

Contract management performance measures are designed to assess how well the Ministry handles monitoring information. They perform the function of measuring the quality of contract performance management. Through regular feedback to providers the Ministry works to prevent poor performance and to help resolve any performance issues as they arise. This applies to all monitoring reports sent to the Ministry by contracted service providers according to a regular reporting schedule, such as would normally be expected in a contracting arrangement. Reports may be sent monthly, quarterly or according to some other schedule.

Table 4: Summary of performance measures for contract management

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Contract management			
333	Social agencies are required to move NGOs contracts to the streamlined contract framework as they are renewed. The Ministry will move the following numbers of contracts by 30 June 2017 (Note 1)	819	800
95%	The percentage of Ministry feedback to Crown Funding Agreement Variation (CFA) variations monitoring reports that are supplied to DHBs within agreed timeframes	100%	90%
95%	The percentage of complaints from service users received by the National Quality Group, National Services Purchasing and National Health Board that receive a timely initial response from the Ministry	95%	100%

Note 1 Target increases as follows: 2015/16: 320; 2016/17: 800; 2017/18: 840; 2018/19: 900.

The Ministry also contracts with a large number of NGOs to provide health, disability and social services to people in New Zealand.

The streamlined contracting framework creates a new standard contract for a government agency that is purchasing services from a NGO provider. This enables the framework to have the same structure, look and feel no matter which government agency uses it.

A significant amount of contracting activity is carried out using Crown Funding Agreement Variations (CFAV), and these are monitored in a different way to other Ministry contracts, with their own monitoring rules and tracking system. In assessing the performance in this area the Ministry applies performance measures against the feedback it provides to DHBs within agreed timeframes.

The Ministry has an expectation that the national support services it purchases will be of a high quality and takes any complaints about service provision seriously. Through prompt and effective responses to complaints, and a standard response protocol, the Ministry is well placed to manage the service delivery of contracted service providers.

Payment services

The Ministry is responsible for administering core health payment processes for the health and disability system. This includes administering the agreements held between health funding organisations and service providers, managing the payment of funds and capturing and tracking health care users' entitlements and usage.

In addition to performing audit and investigation activities on the payments made across the health and disability system the Ministry also operates telephone contact centres which process queries and service requests from funders, providers and health care consumers in support of the payment services function.

Claim transactions

The Ministry pays a variety of health and disability system providers such as midwives and pharmacists in response to claims from those providers.

Table 5: Summary of performance measures for claim transactions

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Forecast number of claims processed per annum			
1,775,576	The forecast number of claims processed per annum	1,763,068	1,700,000
100%	The number of claims paid on time	100%	95%
99%	The percentage of claims processed accurately*	99%	95%

* The percentage of claims processed accurately is measured based on a 5% sample accuracy assessment of all manual claims

The Ministry's claim processing team pays all claims relating to registrations, invoices and other support claims as efficiently as possible.

The number of claims processed each year is demand driven and a gradual reduction in manual transactions reflects the changing nature of claims.

Agreements

The following performance measures cover agreements administered where a service to the health and disability sector is delivered. It includes contracts between funders (Ministry or DHBs) and the service provider, but excludes CFAs, and their variations, as these are administered outside of the payment services systems.

Table 6: Summary of performance measures for agreement administration

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Forecast agreement administration			
9,123	The number of agreements processed per annum	9,375	9,400
80%	The percentage of all draft agreements prepared for funders within agreed timeframes	87%	95%
97%	The percentage of agreements prepared accurately*	100%	95%

* The percentage of agreements prepared accurately is measured based on a 5% sample accuracy assessment of all agreements processed manually.

Contact centres

The National Contact Centre (NCC) supports the health and disability system and the wider public by responding to health-related enquiries in approximately 60 service areas. This includes calls relating to carer support, the NHI and the Ministry's general telephone line.

Table 7: Summary of performance measures for contact centres

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Contact centres			
454,444	The forecast number of contact centre calls per annum (Note 1)	437,748	500,000
81%	The percentage of calls to contact centres answered within service specifications for timeliness (20 seconds)	81%	80%*
3%	The percentage of calls abandoned by callers prior to being answered by the contact centre	3%	Less than 5%
97%	The percentage of enquiries resolved in under 10 working days	96%	95%

Note 1 This measure is demand driven.

* The budget standard for 2016/17 was adjusted by 10% from 90% to 80% in supplementary estimates.

Ministry-funded, but outsourced, contact-centre services such as Plunketline, Healthline and Quitline are not included in the performance measures reported here.

Financial audit and compliance activities

The Ministry continues to work on improving compliance and preventing fraud in the health sector. This is a cost-effectiveness measure for the Ministry's audit activities on sector financial payments.

Table 8: Summary of performance measures for financial audit and compliance activities.

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Financial audit and compliance activities			
94%	The total dollar value of payments made to those primary health and disability providers who have been subject to audit and compliance activities during the year, expressed as a percentage of the budget for those providers	93%	80%
0%	The total number of Ministry-prosecuted cases against the percentage of those cases that contain adverse judicial comments	0%	Less than 10%

There has been a greater emphasis placed on educational services this year with an aim of preventing fraud and loss of health funding. All North Island DHBs have now received a briefing on fraud awareness and the 0800 Health Integrity Line operated by the Ministry.

In 2016/17, there were three successfully concluded prosecutions, none of which were subject to any adverse judicial comment.

Regulatory and enforcement services

The Ministry is involved in a range of regulatory, leadership and purchasing roles aimed at protecting the public from environmental and disease risk factors that lead to ill health. It is also involved in promoting safe practice and increasing consumer confidence in the products and services they access. This includes interventions to reduce the risks from environmental hazards and communicable diseases, and to manage outbreaks. The Ministry also carries out several key statutory functions related to health and disability protection. These include the roles of the Directors of Public Health and Mental Health, which both carry important leadership and decision-making responsibilities, including the interpretation and administration of any health and disability relevant legislation. The Ministry also supports a range of committees established under statute.

The coordination of public health protection and related regulatory functions includes the appointment of statutory officers under the Health Act 1956, the Hazardous Substances and New Organisms Act 1996 and the Biosecurity Act 1993. The Director-General of Health also appoints statutory officers under a range of other Acts, in particular the Smoke-free Environments Act 1990 and the Hazardous Substances and New Organisms Act 1996. All Directors of Area Mental Health Services appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 also met the criteria set by the Director-General of Health.

The Ministry provides ongoing purchasing and monitoring of border control and environmental health services on behalf of the Crown, exercises regulatory powers that minimise risks to the public, and supports the statutory and clinical leadership role of the Director of Public Health.

The Ministry undertakes a range of activities to coordinate public health protection and related regulatory functions between the DHBs. This includes administering the environmental health-related aspects of legislation and providing advice as required. Six-monthly meetings were convened for DHB public health unit environmental health managers. Statutory officers employed by DHB public health units were provided with manuals, guidelines and training on implementing legislation and policy in areas of border health, drinking-water, hazardous substances, emergency management, legislation, environmental health surveillance and health protection.

The Ministry administered the Burial and Cremation Act 1964, including processing disinterment licences, applications for burials in special places, burial ground/cemetery applications, medical referee appointments and cremator applications. Health officials supported the Law Commission's review of the Burial and Cremation Act 1964.

Regulatory assessment of performance

The Ministry is responsible for a range of core regulatory functions within the health sector. These are listed below:

- The New Zealand Medicines and Medical Devices Safety Authority (Medsafe), which is responsible for the regulation of therapeutic products.
- HealthCERT, which is responsible for ensuring hospitals, aged residential care providers (including rest homes), residential disability care providers and fertility service providers provide safe and reasonable levels of service for consumers.
- The Office of Radiation Safety, which is responsible for the regulation of ionising radiation.
- Medicines Control, which is responsible for regulating the distribution chain of medicines and controlled drugs within New Zealand.
- The Psychoactive Substances Regulatory Authority, which is responsible for the operation of the Psychoactive Substances legislation.
- The Public Health Group, which administers legislation protecting people from communicable disease and environmental health risks.

The Ministry conducts quality audits of pharmacies licensed under the Medicines Act 1981 and reviews any surveillance audits performed by designated auditing agencies for providers certified under the Health and Disability Services (Safety) Act 2001. The Ministry also audits manufacturers and packers of medicines with quality audits used to enable providers of health care services continue to improve the quality of their services beyond formal licensing/certification.

The Ministry receives and responds to complaints made under the Health and Disability Services (Safety) Act 2001 against certified hospitals, rest homes, mental health facilities and residential disability services. Any complaint received by the HealthCERT team in the Ministry is tracked internally with an initial response provided within seven working days. For any complaints made directly to the Health and Disability Commissioner or DHBs, the receiving agency is responsible for providing the initial response to the complainant.

Table 9: Summary of performance measures for regulatory and enforcement compliance activities.

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Compliance activities			
	The number of quality audits of providers conducted or assessed		
275	HealthCert	244	267
361	Medicines Control	361	360
636	**Total**	**605**	**627**

Regulatory administration

A central part of the Ministry's regulatory activities is the licensing of service providers under the requirements of health and disability related legislation. This sees pharmacies and other parties involved in the pharmaceutical supply chain (such as wholesalers and researchers) being licensed to handle medicines and drugs under the Medicines Act 1981 and the Misuse of Drugs Act 1975 and service providers who use and possess radioactive substances having licences issued under the Radiation Safety Act 2016. Issuing certificates is central to the Ministry's regulatory activity.

Hospitals, rest homes, residential disability care providers and fertility providers are certified under the Health and Disability Services (Safety) Act 2001. Under this legislation, the completion of an operator's certification is expected within 20 working days of the Ministry receiving the relevant information and payment of the required fee.

Table 10: Summary of performance measures for regulatory and enforcement implementation activities.

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Regulatory activities			
99%	The percentage of medium- and high-priority quality incident notifications relating to medicines and medical devices that undergo an initial review within 5 working days	99%	90%
91%	The percentage of all certificates issued to providers under the Health and Disability Services (Safety) Act 2001 within target timeframes	87%	90%

91%	The percentage of all licences and authorities issued to providers under the Medicines Act 1981 and Misuse of Drugs Act 1975 within target timeframes	90%	90%
100%	The percentage of all licences and consents issued to radiation users under the Radiation Safety Act 2016 within 10 working days of the receipt of all information and payment of the required fee	99%	90%
78%	The percentage of all New Medicines Applications (for ministerial consent to market) that receive an initial assessment within 200 days	88%	80%
100%	The percentage of all Changed Medicines Notifications (for ministerial consent to market) responded to within 45 days	100%	100%

Support services for statutory committees and regulatory authorities

The Ministry assists the Minister with the process of appointing members to statutory committees and regulatory authorities by sourcing candidates, compiling recommendations for appointment, conducting candidate interviews, and preparing Cabinet documentation concerning appointments.

The Ministry complies with the State Services Commission guidelines when assisting the Minister with appointments and provides the Minister with quality advice in a timely manner before members' terms expire.

Table 11: Summary of performance measures for support services for statutory committees and regulatory authorities

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Support services for statutory committees and regulatory authorities			
Achieved	All statutory officers appointed by the Ministry meet the criteria set by the Director-General of Health and any statutory prerequisites for appointment	Achieved	Achieved
100%	All recommendations for appointments meet the requirements of health legislation	100%	100%
217	The number of appointments to statutory committees and regulatory authorities (Note 1)	81	55
100%	The percentage of recommendations for appointments where recommendations are presented to the Minister prior to expiration of term for current appointee	95%	100%
3.90	Average rating for statutory committee satisfaction with secretariat services provided by the Ministry	4.37	greater than 4.00

Note 1 The performance standard is based on the total number of appointments expected in any given year and is estimated in advance of that year. The actual number of appointments depend on a number of factors such as unexpected vacancies and the operational needs of the board. Appointments vary over a three-year cycle and are estimated to be 55 in 2016/17; 42 in 2017/18; 103 in 2018/19.

Sector planning and performance

The Ministry works with DHBs to create accountability documents outlining the DHBs' deliverables and what can be done to improve their performance. The Ministry monitors the DHBs' service and financial performance over the year against their targets working with the DHB to address any issues that may affect their ability to meet performance expectations.

Planning and funding support systems

To assist Crown entities to plan for the upcoming financial year indicative advice needs to be provided by the end of the calendar year.

Table 12: Summary of performance measures for sector planning and funding support systems

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Planning and funding support systems			
Achieved	Planning and funding advice of the financial year is provided to Crown entities by 31 December	Achieved	Achieved
Achieved	The Ministry provides the Minister with advice on agreement of all DHB annual plans by 30 June	Achieved	Achieved

By working closely and collaboratively with DHBs, the Ministry expects to facilitate agreements on the DHBs' annual plans by 30 June of each year. The timeliness target for agreements between DHBs and the Ministry serves as a proxy measure of the quality of the activities undertaken by the Ministry in support of this aim. In providing assistance in facilitation, feedback and advice on the draft plans the Ministry functions as an advisor in the process with plans being signed off by ministers and the DHB.

Performance monitoring

The Ministry uses a number of performance indicators to set expectations and monitor performance to ensure DHBs appropriately work towards the Strategy's priorities and achieve stated government priorities for performance improvement and health outcomes.

Table 13: Summary of performance measures for performance monitoring activities

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Performance monitoring			
100%	The percentage of monitoring feedback reports about performance supplied to DHBs within agreed timeframes	100%	100%
100%	The percentage of all letters to DHBs, with health target performance tables and supporting information, provided to the Minister within 5 working days of the date for publication	100%	100%
55%	The percentage of quarterly and monthly monitoring reports about DHBs provided to the Minister within agreed timeframes (Note 1)	45%	100%
100%	The percentage of quarterly and monthly monitoring reports about Crown entities (excluding DHBs) provided to the Minister within agreed timeframes	100%	100%

Note 1 Reviewing of reports and requests for further information or clarification has resulted in the reports taking longer to complete. The Ministry is working on solutions to streamline the process.

A vital part of the reporting process is the feedback (assessments) the Ministry gives to DHBs on each of these measures, particularly when improvement on performance is necessary and/or remedial actions are required.

DHBs are accountable for achieving the health targets, and results are published in national and local newspapers and online and early advice on target performance allows DHBs to manage the impact of the publication of the results.

The Ministry is responsible for the funding, monitoring and planning of DHBs and other health Crown entities and as such, it reports to the Minister periodically. in the following performance areas:

- DHB financial performance: a monthly report highlighting where a DHB reports a significant variance against a plan, enabling areas of financial pressure and risk to be identified, as well as best practice within the DHB sector
- DHB performance on health targets: a quarterly report containing detailed results and remedial actions
- overall quarterly report on DHB performance, including non-financial information, information on health target performance and financial information: this provides the Minister with an integrated high-level view of DHB performance
- health Crown entity performance: a quarterly report describing major achievements, performance against planned outputs, financial performance and governance commentary.

Emergency response

The Ministry maintains the capability and capacity to lead and coordinate a national health response to an emergency. In addition, in accordance with the Civil Defence Emergency Management Act 2002, the Ministry has prepared plans to continue functioning during and after an emergency.

These responsibilities include:

- ensuring it is capable of continuing to function to the fullest extent possible in an emergency affecting its operations,
- having the capability and capacity to respond in an emergency that has health implications,
- providing leadership and co-ordination for the health sector in planning and preparing for, and responding to, a health emergency and
- leading an all-of-government response to a national health emergency such as a pandemic.

The all-hazards approach to emergency management across reduction, readiness, response and recovery activities reflects international best practice and aligns with the development of the WHO health emergency risk management framework.

Table 14: Summary of performance measures for emergency response activities

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Emergency response			
100% [Achieved]	Maintain the capability to respond to national emergencies and emerging health threats within 2 hours	Achieved	Achieved
Achieved [100%]	Quarterly regional or national health sector emergency planner meetings held in each region	100%	100%

The Ministry has capability to activate the National Health Coordination Centre (NHCC) within two hours of any emergency event requiring a level of national health coordination. Primary and alternative sites for the NHCC have been identified at Ministry offices. The emergency management information system also allows for the NHCC to be set up at a suitably equipped and service location if required.

During 2016/17 the health sector responded effectively to a range of significant challenges including numerous local events and a number of regional and national events. The Ministry lead and coordinated numerous health sector responses from the National Health Coordination Centre. These included the Havelock North Gastroenteritis outbreak, Kaikoura-Hurunui Earthquake Sequence and Whakatane flooding where the Ministry worked effectively with a range of agencies.

Supporting governance functions

The Minister, in consultation with Cabinet and Caucus, appoints suitable candidates to DHB and other health Crown entity boards. The Ministry assists the Minister with the appointments process by sourcing candidates, compiling recommendations for appointment, conducting candidate interviews, and preparing Cabinet documentation concerning appointments and complies with State Services Commission guidelines when assisting the Minister with appointments and provides the Minister with quality and timely advice before members' terms expire.

Table 15: Summary of performance measures for governance activities

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Governance activities			
100%	The percentage of appointments to DHBs and other Crown entity boards where advice is presented to the Minister prior to the current appointee's term expiring (Note 1)	100%	100%
40	The number of appointments to DHBs and other health Crown entity boards*	130	137

Note 1 The performance standard is based on the total number of appointments expected in any given year and is estimated in advance of the 2016/17 year. DHB elections were held in October 2016 to elect members for 19 of the 20 DHBs.

* Unexpected resignations or departures prior to the expiration of the term is not included.

Ministry of Health – Capital Expenditure PLA

This appropriation is limited to the purchase or development of assets by and for the use of the Ministry of Health, as authorised by section 24(1) of the Public Finance Act 1989.

The Ministry has an approved Five Year Capital Expenditure Plan and all capital spending is included in this plan.

Policy advice and ministerial servicing

Multi-category expenses

This multi-category expense for policy advice and ministerial servicing is intended to provide Ministers with policy advice that appropriately informs them on issues affecting the health portfolio. The ministerial servicing category is intended to provide Ministers with support so that they can discharge their portfolio responsibilities.

The quality of verbal and written advice provided to the Ministry is measured through external assessment and feedback from the Minister on an annual basis.

Table 16: Summary of performance measures for policy advice

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
MCA			
84%	The average score for Minister's overall satisfaction with written and verbal advice*	80%	80%
Policy advice			
7.10	The external score attained by written policy advice as assessed by an external reviewer	7.03	greater than 7.00
$178.98	Total policy function cost per output hour (Note 1)	$186.12	$165–$175

* The Ministry surveys the Minister in regards to whether verbal and written advice provided met his expectations using a five point scoring system on an annual basis. The assessment is done on an annual basis and not a four-monthly basis at the Minister's request.

Note 1 The increase reflects wage inflation and outsourced resources costs.

Ministerial servicing

The Ministry provides a wide range of advice and services to Ministers.

Table 17: Summary of performance measures for ministerial servicing

Actual 30/06/2016	Measure description	Actual 30/06/2017	Budget standard 30/06/2017
Ministerial servicing			
98%	The percentage of responses provided to the Minister within agreed timeframes: for written parliamentary questions and Ministerial letters	97%	96%
94%	The percentage of responses provided to the Minister within agreed timeframes, for requested briefings (Note 1)	85%	96%
99%	The percentage of Ministerial letters that required no revision	99%	98%
89%	The percentage of responses to Official Information Act requests provided to the Minister within agreed timeframes (for requests made to the Minister) or to the requestor within the statutory timeframe, including where extended in line with the Act (for requests made to the Ministry) (Note 1)	84%	95%

Note 1 The Ministry has undergone significant transformation during 2016/17 and is working to improve response times through improved systems, processes and staff development.

During 2016/17 the Ministry responded to 2,597 pieces of ministerial correspondence (made up of direct replies, written parliamentary questions and ministerial letters). Of the 724 requested briefings drafted by the Ministry, 614 were completed on time.

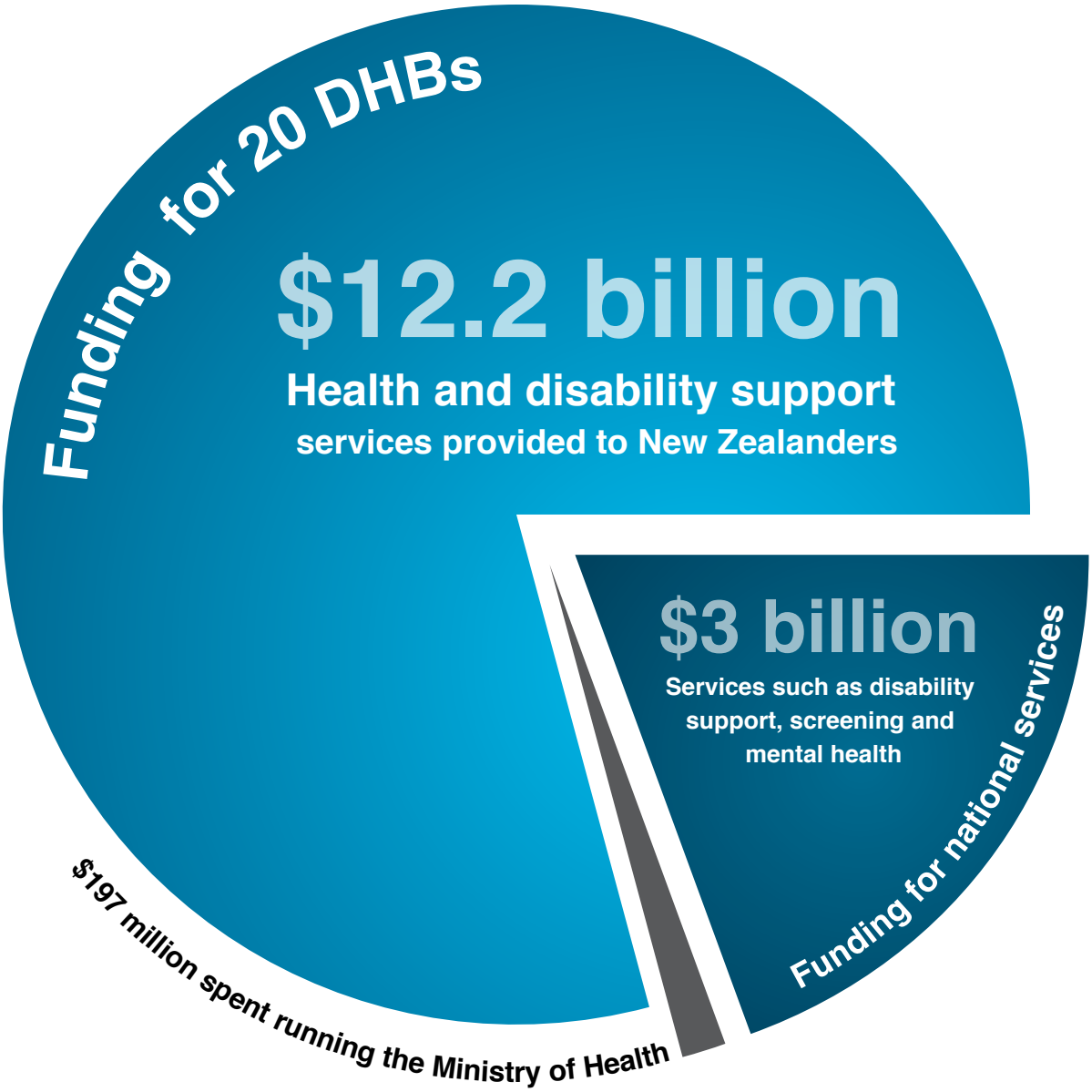
During 2016/17 the Ministry responded to 957 OIA requests, meeting the agreed timeframe for 812. Although the number of OIAs completed decreased by 124 compared to the previous year, the timeliness has continued to decline.

The Ministry is working to improve timeliness of Ministerial and OIA responses by improving systems and processes, and through staff development.

Section four

Financial Statements

How was the **2016/17 health budget* spent**?



*Health operating spend, excluding capital funding ($3b in 2016/17)

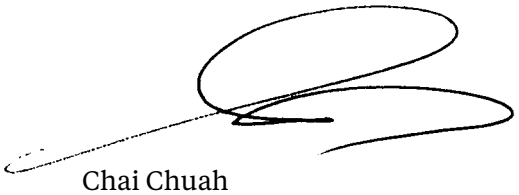
Statement of responsibility

I am responsible, as Director-General of Health and Chief Executive of the Ministry of Health (Ministry), for:

- the preparation of the Ministry's financial statements, and statements of expenses and capital expenditure, and for the judgements expressed in them;
- having in place a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting;
- ensuring that end-of-year performance information on each appropriation administered by the Ministry is provided in accordance with sections 19A to 19C of the Public Finance Act 1989, whether or not that information is included in this annual report; and
- the accuracy of any end-of-year performance information prepared by the Ministry, whether or not that information is included in the annual report.

In my opinion:

- the financial statements reflect the financial statements of the Ministry as at 30 June 2017 and its operations for the year ended on that date; and
- the forecast financial statements fairly reflect the forecast financial position of the Ministry as at 30 June 2018 and its operations for the year ending on that date.



Chai Chuah
Director-General of Health
29 September 2017

Stephen O'Keefe
Chief Financial Officer
29 September 2017

Independent Auditor's Report

To the readers of the Ministry of Health's annual report for the year ended 30 June 2017

The Auditor-General is the auditor of the Ministry of Health (the Ministry). The Auditor-General has appointed me, Stephen Lucy, using the staff and resources of Audit New Zealand, to carry out, on his behalf, the audit of:

- the financial statements of the Ministry on pages 81 to 103, that comprise the statement of financial position, statement of commitments, statement of contingent liabilities and contingent assets as at 30 June 2017, the statement of comprehensive revenue and expense, statement of changes in equity, and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information;
- the performance information prepared by the Ministry for the year ended 30 June 2017 on pages 53 to 72 and 120 to 132;
- the statements of expenses and capital expenditure of the Ministry for the year ended 30 June 2017 on pages 112 to 117; and
- the schedules of non-Departmental activities which are managed by the Ministry on behalf of the Crown on pages 104 to 112 that comprise:
    - the schedules of assets; liabilities; commitments; and contingent liabilities and assets as at 30 June 2017;
    - the schedules of expenses; and revenue for the year ended 30 June 2017;
    - the statement of trust monies for the year ended 30 June 2017; and
    - the notes to the schedules that include accounting policies and other explanatory information.

Opinion

Unmodified opinion on the financial statements, statements of expenses and capital expenditure and schedules of non-Departmental activities

In our opinion:

- the financial statements of the Ministry on pages 81 to 103:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; and
        - its financial performance and cash flows for the year ended on that date; and

- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards.

- the statements of expenses and capital expenditure of the Ministry on pages 112 to 117 are presented fairly, in all material respects, in accordance with the requirements of section 45A of the Public Finance Act 1989.

- the schedules of non-Departmental activities which are managed by the Ministry on behalf of the Crown on pages 104 to 112 present fairly, in all material respects, in accordance with the Treasury Instructions:

    - the assets; liabilities; commitments; and contingent liabilities and assets as at 30 June 2017;

    - expenses; and revenue for the year ended 30 June 2017; and

    - the statement of trust monies for the year ended 30 June 2017.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior years

In respect of the comparative information only, some significant performance measures of the Ministry (including the national health targets relating to increased immunisation and better help for smokers to quit), relied on information from third-party health providers, such as primary health organisations. The Ministry's control over much of this information in prior years was limited, and there were no practical audit procedures to determine the effect of this limited control.

The limited control over information from third-party health providers meant that our work on the affected performance information for the comparative years was limited, and our audit opinion on the performance information for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year. However, the limitation cannot be resolved for the prior years, which means that the Ministry's performance information for the 30 June 2017 year, may not be directly comparable to the performance information of prior years.

In our opinion, except for the matters described above, the performance information of the Ministry on pages 53 to 72 and 120 to 132:

- presents fairly, in all material respects, for the year ended 30 June 2017:

    - what has been achieved with the appropriation; and

    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 29 September 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Director-General of Health and our responsibilities relating to the information to be audited, we comment on other information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Director-General of Health for the information to be audited

The Director-General of Health is responsible on behalf of the Ministry for preparing:

- financial statements that present fairly the Ministry's financial position, financial performance, and its cash flows, and that comply with generally accepted accounting practice in New Zealand.
- performance information that presents fairly what has been achieved with each appropriation, the expenditure incurred as compared with expenditure expected to be incurred, and that complies with generally accepted accounting practice in New Zealand.
- statements of expenses and capital expenditure of the Ministry, that are presented fairly, in accordance with the requirements of the Public Finance Act 1989.
- schedules of non-Departmental activities, in accordance with the Treasury Instructions, that present fairly those activities managed by the Ministry on behalf of the Crown.

The Director-General of Health is responsible for such internal control as is determined is necessary to enable the preparation of the information to be audited that is free from material misstatement, whether due to fraud or error.

In preparing the information to be audited, the Director-General of Health is responsible on behalf of the Ministry for assessing the Ministry's ability to continue as a going concern. The Director-General of Health is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Ministry, or there is no realistic alternative but to do so.

The Director-General of Health's responsibilities arise from the Public Finance Act 1989.

Responsibilities of the auditor for the information to be audited

Our objectives are to obtain reasonable assurance about whether the information we audited, as a whole, is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of the information we audited. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

For the budget information reported in the information we audited, our procedures were limited to checking that the information agreed to the Ministry's Statement of Intent 2015 to 2019 and relevant Estimates and Supplementary Estimates of Appropriations, and the 2016/17 forecast figures included in the Ministry's 2015/16 Annual Report.

We did not evaluate the security and controls over the electronic publication of the information we audited.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the information we audited, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Ministry's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Director-General of Health.

- We evaluate the appropriateness of the reported performance information within the Ministry's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Director-General of Health and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Ministry's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the information we audited or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the

audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Ministry to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the information we audited, including the disclosures, and whether the information we audited represents the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Director-General of Health regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Director-General of Health is responsible for the other information. The other information comprises the information included on pages iii to ix, 1 to 52, 74 to 75 and 133 to 145, but does not include the information we audited, and our auditor's report thereon.

Our opinion on the information we audited does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

Our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the information we audited or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Ministry in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

In addition to the audit we have carried out a probity assurance engagement during the Indicative Business Case phase of the Electronic Health Record Project, which is compatible with those independence requirements. Other than the audit and this engagement, we have no relationship with, or interests, in the Ministry.

S B Lucy
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2017

Actual 2016 $000		Note	Actual 2017 $000	Unaudited budget 2017 $000	Unaudited forecast 2018 $000
	Revenue				
178,920	Revenue Crown		185,484	182,331	185,484
10,688	Other revenue	2	10,367	13,346	13,390
189,608	**Total revenue**		**195,851**	**195,677**	**198,874**
	Expenses				
113,654	Personnel costs	3	113,436	113,063	113,148
11,190	Depreciation and amortisation expense	6,7	7,760	11,000	9,000
2,576	Capital charge	4	2,108	2,587	2,576
62,883	Other expenses	5	73,198	69,027	74,150
(2)	Net (gain)/loss on sale/disposal of property, plant and equipment		5	–	–
190,301	**Total expenses**		**196,507**	**195,677**	**198,874**
(693)	**Surplus/(deficit)**		**(656)**	**–**	**–**
	Other comprehensive revenue and expense				
	Item that will not be reclassified to net surplus/(deficit)				
550	Gain/(loss) on property revaluations		–	–	–
550	**Total other comprehensive revenue and expense**		**–**	**–**	**–**
(143)	**Total comprehensive revenue and expense**		**(656)**	**–**	**–**

Explanations of major variances against budget are detailed in note 16.

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2017

Actual 2016 $000		Note	Actual 2017 $000	Unaudited budget 2017 $000	Unaudited forecast 2018 $000
	Equity				
30,159	Taxpayers' funds		30,159	30,159	30,159
2,590	Property revaluation reserve		2,590	2,590	2,590
1,792	Memorandum accounts		(93)	(93)	(93)
34,541	**Total equity**	**12**	**32,656**	**32,656**	**32,656**
	Represented by:				
	Assets				
	Current assets				
6,423	Cash and cash equivalents		7,758	8,000	5,000
947	Receivables		1,184	1,500	1,146
1,458	Crown debtors		6,764	4,787	2,409
2,153	Prepayments		4,556	2,894	2,894
10,981	**Total current assets**		**20,262**	**17,181**	**11,449**
	Non-current assets				
14,886	Property, plant and equipment	6	10,959	7,184	10,952
34,239	Intangible assets	7	29,929	34,864	34,864
49,125	**Total non-current assets**		**40,888**	**42,048**	**45,816**
60,106	**Total assets**		**61,150**	**59,229**	**57,265**
	Liabilities				
	Current liabilities				
11,731	Payables	8	16,224	16,480	14,038
608	Return of operating surplus	9	1,229	–	–
3,691	Provisions	10	952	1,000	1,000
8,162	Employee entitlements	11	8,613	8,063	8,541
24,192	**Total current liabilities**		**27,018**	**25,543**	**23,579**
	Non-current liabilities				
30	Provisions	10	30	30	30
1,343	Employee entitlements	11	1,446	1,000	1,000
1,373	**Total non-current liabilities**		**1,476**	**1,030**	**1,030**
25,565	**Total liabilities**		**28,494**	**26,573**	**24,609**
34,541	**Net assets**		**32,656**	**32,656**	**32,656**

Explanations of major variances against budget are detailed in note 16.

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2017

Actual 2016 $000		Note	Actual 2017 $000	Unaudited budget 2017 $000	Unaudited forecast 2018 $000
35,292	Balance at 1 July		34,541	32,656	32,656
(143)	Total comprehensive revenue and expense		(656)	–	–
	Owner transactions				
(608)	Return of operating surplus to the Crown	9	(1,229)	–	–
34,541	**Balance at 30 June**		**32,656**	**32,656**	**32,656**

Explanations of major variances against budget are detailed in note 16.

Statement of cash flows for the year ended 30 June 2017

Actual 2016 $000		Actual 2017 $000	Unaudited budget 2017 $000	Unaudited forecast 2018 $000
	Cash flows from operating activities			
188,162	Receipts from revenue Crown	180,178	177,463	182,533
10,884	Receipts from other revenue	9,896	13,016	12,825
(66,622)	Payments to suppliers	(73,713)	(69,347)	(79,945)
(113,281)	Payments to employees	(113,544)	(108,413)	(108,569)
(2,576)	Payments for capital charge	(2,108)	(2,587)	(2,576)
(391)	Goods and services tax (net)	692	–	–
16,176	**Net cash flow from operating activities**	**1,401**	**10,132**	**4,268**
	Cash flows from investing activities			
1,575	Receipts from sale of property, plant and equipment	11,201	15,368	11,319
(5,188)	Purchase of property, plant and equipment	(8,298)	(8,500)	(9,386)
(6,347)	Purchase of intangible assets	(2,361)	(12,000)	(7,624)
(9,960)	**Net cash flow from investing activities**	**542**	**(5,132)**	**(5,691)**
	Cash flows from financing activities			
–	Return of operating surplus	(608)	–	–
–	**Net cash flow from financing activities**	**(608)**	**–**	**–**
6,216	**Net increase in cash held**	**1,335**	**5,000**	**(1,423)**
207	Cash at the beginning of the year	6,423	3,000	6,423
6,423	**Cash at the end of the year**	**7,758**	**8,000**	**5,000**

Explanations of major variances against budget are detailed in note 16.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2017 (continued)

Reconciliation of net surplus/(deficit) to net cash flow from operating activities

Actual 2016 $000		Actual 2017 $000
(693)	**Net surplus/(deficit)**	**(656)**
	Add/(less) non-cash items:	
11,190	Depreciation and amortisation expense	7,760
–	Asset Write off/down	604
11,190	**Total non-cash items**	**8,364**
	Add/(less) items classified as investing or financing activities:	
(2)	Gain/(loss) on disposal of property, plant and equipment	5
	Total items classified as investing or financing activities	
	Add/(less) movements in working capital items:	
486	(Increase)/decrease in receivables	(237)
9,242	(Increase)/decrease in Crown debtor	(5,306)
464	(Increase)/decrease in prepayments	(2,402)
(3,604)	Increase/(decrease) in payables^	3,817
(161)	Increase/(decrease) in provisions	(2,738)
(746)	Increase/(decrease) in employee entitlements	554
5,681	**Total movements in working capital items**	**(6,312)**
16,176	**Net cash flow from operating activities**	**1,401**

Explanations of major variances against budget are detailed in note 16.

^ No payables for capital expenditure have been included when calculating the increase/decrease in the payables movement.

The accompanying notes form part of these financial statements.

Statement of commitments as at 30 June 2017

Capital commitments

Capital commitments are the aggregate amount of capital contracted for the acquisition of property, plant and equipment and intangible assets that have not been paid for or are not recognised as a liability at balance date.

Cancellable capital commitments that have penalty or exit costs explicit in the agreement on exercising that option to cancel are reported below at the lower of the remaining contractual commitment and the value of those penalty or exit costs.

Non-cancellable operating lease commitments

The Ministry leases property, plant and equipment in the normal course of its business. The majority of these leases are for premises and photocopiers, which have a non-cancellable leasing period ranging from three to ten years.

The Ministry's non-cancellable operating leases have varying terms, escalation clauses and renewal rights.

Actual 2016 $000		Actual 2017 $000
	Capital commitments	
368	Intangible assets	126
368	**Total capital commitments**	**126**
	Operating leases as lessee	
	Future aggregate lease payments to be paid under non-cancellable operating leases are as follows:	
7,981	Not later than one year	10,005
29,774	Later than one year and not later than five years	37,922
82,439	Later than five years	81,452
120,194	**Total non-cancellable operating lease commitments**	**129,379**
120,562	**Total commitments**	**129,505**

The Ministry has medium to long-term leases on its premises in Auckland, Christchurch, Dunedin, Hamilton, Whanganui and Wellington. The annual lease payments are subject to regular reviews ranging from one to four years. Amounts disclosed are based on current rental rates.

Statement of contingent liabilities and contingent assets as at 30 June 2017

The Ministry had no contingent liabilities as at balance date (2016: $nil).

The Ministry had no contingent assets as at balance date (2016: $nil).

The accompanying notes form part of these financial statements.

Notes to the financial statements for the year ended 30 June 2017

Notes index

1. Statement of accounting policies

Reporting entity

The Ministry of Health (the Ministry) is a government department as defined by section 2 of the Public Finance Act 1989 (PFA) and is domiciled and operates in New Zealand. The relevant legislation governing the Ministry's operations includes the PFA, the Public Accountability Act 1998 and the New Zealand Public Health and Disability Act 2000. The Ministry's ultimate parent is the New Zealand Crown.

The Ministry's primary objective is to provide services to the New Zealand public. The Ministry funds, administers and monitors the delivery of health services. The Ministry does not operate to make a financial return. In addition, the Ministry has reported on Crown activities and trust monies that it administers in the non-departmental statements and schedules on pages 104 to 112.

The financial statements are for the year ended 30 June 2017 and were approved for issue by the Director-General of Health on 29 September 2017.

Basis of preparation

The financial statements have been prepared on a going-concern basis and the accounting policies have been applied consistently throughout the year.

Statement of compliance

The financial statements of the Ministry have been prepared in accordance with the requirements of the PFA, which include the requirement to comply with New Zealand generally accepted accounting practice and Treasury Instructions.

The Ministry has designated itself as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice. The financial statements have been prepared in accordance with and comply with PBE accounting standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Changes in accounting policies

There have been no changes in the Ministry's accounting policies since the date of the last audited financial statements.

Comparative figures

When presentation or classification of items in the financial statements is amended or accounting policies are changed, comparative figures are restated to ensure consistency with the current period unless it is impracticable to do so.

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

Foreign currency transactions

Foreign currency transactions are translated into New Zealand dollars using the spot exchange rates at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions are recognised in the surplus or deficit.

Cash and cash equivalents

Cash and cash equivalents comprise funds in current accounts with Westpac New Zealand Limited, a registered bank.

The Ministry is only permitted to expend its cash and cash equivalents within the scope and limits of its appropriations.

Receivables

Short-term receivables are recorded at the amount due less any provision for uncollectability.

A receivable is considered to be uncollectable when there is evidence that the amount will not be fully collectable. The amount that is uncollectable is the difference between the carrying amount due and the present value of the amount expected to be collected.

Goods and services tax (GST)

Items in the financial statements are stated exclusive of GST, except for receivables and payables, which are stated on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position. The net GST paid to or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the statement of cash flows.

Income tax

The Ministry is a public authority and consequently is exempt from income tax. Accordingly, no provision has been made for income tax.

Budget and forecast figures

Basis of the budget figures

The 2017 budget figures are for the year ended 30 June 2017 and were published in the 2015/16 Annual Report. They are consistent with the Ministry's best estimate financial forecast information submitted to the Treasury for the Budget Economic and Fiscal Update (BEFU) for the year ending 2016/17.

Basis of the forecast figures

The 2018 forecast figures are for the year ending 30 June 2018, which are consistent with the best estimate financial forecast information submitted to the Treasury for the BEFU for the year ending 2017/18.

The forecast financial statements have been prepared as required by the PFA to communicate forecast financial information for accountability purposes. The 30 June 2018 forecast figures have been prepared in accordance with and comply with PBE FRS 42 Prospective Financial Statements.

The budget and forecast figures are unaudited and have been prepared using the accounting policies adopted in preparing these financial statements.

The Chief Executive is responsible for the forecast financial statements including the appropriateness of the assumptions underlying them and all other required disclosures. The forecast financial statements were approved by the Chief Executive on 24 April 2017.

While the Ministry regularly updates its forecasts, updated forecast financial statements for the year ending 30 June 2018 will not be published.

Significant assumptions used in preparing the forecast financial information

The forecast figures contained in these financial statements reflect the Ministry's purpose and activities, and are based on a number of assumptions on what may occur during the 2017/18 year. The forecast figures have been compiled on the basis of existing government policies and ministerial expectations at the time the Main Estimates were finalised.

The main assumptions, which were adopted as at 24 April 2017, were as follows.

- The Ministry's activities and output expectations will remain substantially the same as the previous year focusing on the Government's priorities.
- Personnel costs were based on current wages and salary costs adjusted for anticipated remuneration changes.
- Operating costs were based on historical experience and other factors that are believed to be reasonable in the circumstances and are the Ministry's best estimate of future costs that will be incurred.
- Estimated year-end information for 2016/17 was used as the opening position for the 2017/18 forecasts.

The actual financial results achieved for 30 June 2018 are likely to vary from the forecast information presented. Factors that may lead to a material difference between information in these forecast financial information statements and the actual reported results include changes to the budget through initiatives approved by Cabinet, technical adjustments to including transfers between financial years and timing of expenditure relating to significant programmes and projects.

2. Revenue

Accounting policy

The specific accounting policies for significant revenue items are explained below.

The Ministry derives revenue through the provision of outputs to the Crown and for services to third parties. Such revenue is recognised at fair value of consideration received.

Revenue Crown

Revenue from the Crown is measured based on the Ministry's funding entitlement for the reporting period. The funding entitlement is established by Parliament when it passes the Appropriation Acts for the financial year. The amount of revenue recognised takes into account any amendments to appropriations approved in the Appropriation (Supplementary Estimates) Act for the year and certain other unconditional funding adjustments formally approved prior to balance date.

There are no conditions attached to the funding from the Crown. However, the Ministry can incur expenses only within the scope and limits of its appropriations.

The fair value of Revenue Crown has been determined to be equivalent to the funding entitlement.

Supply of services

Revenue from the supply of services is recognised by reference to the stage of completion of the transaction at balance date and only to the extent that the outcome of the transaction can be estimated reliably.

Breakdown of other revenue

Actual 2016 $000		Actual 2017 $000
7,788	Medicines registration	8,034
315	Service fees	415
2,042	Annual licence and registration fees	1,723
543	Other revenue	195
10,688	**Total other revenue**	**10,367**

3. Personnel costs

Accounting policy

Salaries and wages are recognised as an expense as employees provide services.

Breakdown personnel costs

Actual 2016 $000		Actual 2017 $000
107,405	Salaries and wages	108,060
3,319	Employer contributions to defined contribution plans	3,372
(746)	Increase/(decrease) in employee entitlements	554
3,676	Other personnel costs	1,450
113,654	**Total personnel costs**	**113,436**

4. Capital charge

Accounting policy

The capital charge is recognised as an expense in the financial year to which the charge relates.

The Ministry pays a capital charge to the Crown on its equity (adjusted for memorandum accounts) as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2017 was 6.0% (2016: 8.0%).

5. Other expenses

Accounting policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease.

Lease incentives are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Other expenses

Other expenses are recognised as goods and services as received.

Breakdown of other expenses

Actual 2016 $000		Actual 2017 $000
376	Fees to Audit New Zealand for audit of financial statements	390
14,071	Contractors and consultants	20,335
19,599	Computer services	20,951
4,404	Travel	3,754
5,536	Communications and couriers	6,703
2,176	Printing and stationery	1,675
7,674	Operating lease payments	9,368
1,755	Occupancy costs other than leases	1,349
4,987	Professional specialist fees	4,579
–	Asset write-offs	234
2,305	Other expenses	3,860
62,883	**Total other expenses**	**73,198**

6. Plant, property and equipment

Accounting policy

Property, plant and equipment consists of the following asset classes: land, buildings, leasehold improvements, furniture and office equipment, and motor vehicles.

Land is measured at fair value and buildings are measured at fair value less accumulated depreciation. All other classes are measured at cost less accumulated depreciation and impairment losses.

Individual assets, or groups of assets, are capitalised if their cost is greater than $4,000.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment, other than land, at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as follows:

	Useful life	Depreciation rate
Buildings	40 years	2.5%
Motor vehicles	5 years	20%
Furniture and fittings	5–10 years	10–20%
Machinery	5 years	20%
Leasehold improvements	5–10 years	10–20%
IT equipment	3–5 years	20–33.3%

Leasehold improvements are capitalised over the shorter of the unexpired period of the lease or the estimated remaining useful lives of the improvements.

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each balance date.

Work in progress
Work in progress is recognised at cost less impairment and is not depreciated.

Additions
The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the Ministry and the cost of the item can be measured reliably.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals
Gains and losses on disposals are determined by comparing the disposal proceeds with the carrying amount of the asset and are included in the surplus or deficit. When a revalued asset is sold, the amount included in the property revaluation reserve in respect of the disposed asset is transferred to taxpayers' funds.

Subsequent costs
Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Ministry and the cost of the item can be measured reliably.

The cost of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Revaluations
Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from their fair value and at least every three years.

The carrying value of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class-of-class asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus of deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Impairment
The Ministry does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets
Property, plant and equipment assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is the present value of the asset's remaining service potential. Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is considered to be impaired and the carrying amount is written down to the recoverable service amount. The total impairment loss is recognised in the surplus or deficit. Reversal of an impairment loss is recognised in the surplus of deficit.

Breakdown of property, plant and equipment

	Land $000	Buildings/ leasehold improvements $000	Furniture, plant and equipment $000	Motor vehicles $000	Computer hardware $000	Total $000
Cost or valuation						
Balance as at 1 July 2015	4,800	10,709	5,070	373	20,309	41,261
Additions	–	5,259	(73)	–	2	5,188
Revaluation increase/ (decrease)	550	–	–	–	–	550
Disposals	–	–	(1,808)	–	(540)	(2,348)
Transfers	–	(630)	–	–	630	–
Balance as at 30 June 2016	**5,350**	**15,338**	**3,189**	**373**	**20,401**	**44,651**
Balance as at 1 July 2016	5,350	15,338	3,189	373	20,401	44,651
Additions	–	8,619	151	–	126	8,896
Disposals	–	(17,967)	(1,399)	–	(1,887)	(21,253)
Balance as at 30 June 2017	**5,350**	**5,990**	**1,941**	**373**	**18,640**	**32,294**
Accumulated depreciation and impairment losses						
Balance as at 1 July 2015	–	5,192	2,168	239	19,154	26,753
Depreciation expense	–	2,435	445	24	853	3,757
Eliminate on disposal	–	–	(208)	–	(537)	(745)
Transfers	–	(600)	–	–	600	–
Balance as at 30 June 2016	**–**	**7,027**	**2,405**	**263**	**20,070**	**29,765**
Balance as at 1 July 2016	–	7,027	2,405	263	20,070	29,765
Depreciation expense	–	871	178	23	281	1,353
Eliminate on disposal	–	(6,511)	(1,393)	–	(1,879)	(9,783)
Balance as at 30 June 2017	**–**	**1,387**	**1,190**	**286**	**18,472**	**21,335**
Total property, plant and equipment including WIP						
At 30 June 2015	4,800	5,517	2,902	134	1,155	14,508
At 30 June 2016	5,350	8,311	784	110	331	14,886
At 30 June 2017	**5,350**	**4,603**	**751**	**87**	**168**	**10,959**
Work in progress (WIP)						
At 30 June 2015	–	1,029	89	–	64	1,182
At 30 June 2016	–	6,148	11	–	6	6,165
At 30 June 2017	**–**	**3,566**	**92**	**–**	**24**	**3,682**

The land at 108 Victoria Street, Christchurch was valued by Knight Frank, an independent valuer. The effective date of the evaluation is 30 June 2017. There has been no change to the value of this land.

There are no restrictions over the title of the Ministry's plant, property and equipment.

7. Intangible assets

Accounting policy

Intangible assets are initially recorded at cost. The cost of an internally generated intangible asset represents expenditure incurred in the development phase of the asset only. The development phase occurs after the following can be demonstrated: technical feasibility; ability to complete the asset; intention and ability to sell or use; and where development expenditure can be reliably measured. Expenditure incurred on research related to an internally generated intangible asset is expensed when it is incurred. Where the research phase cannot be distinguished from the development phase, the expenditure is expensed when it is incurred.

Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the costs of services, software development employee costs, and an appropriate portion of relevant overheads.

Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the software.

Staff training costs, costs associated with maintaining software and costs associated with development and maintenance of the Ministry's website are recognised as an expense when incurred.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit. The useful lives and associated rates of major classes of intangible assets have been estimated as follows:

	Useful life	Amortisation rate
Software – internally generated	3–7 years	14.3–33.3%
Software – other	3–7 years	14.3–33.3%

Impairment
Intangible assets subsequently measured at cost that have an indefinite useful life, or are not yet available for use, are not subject to amortisation and are tested annually for impairment. For further details, refer to the policy for impairment of property, plant and equipment in note 6 as the same approach applies to the impairment of intangible assets.

Critical accounting estimates and assumptions

Useful lives of software
The useful life of software is determined at the time the software is acquired and brought into use and is reviewed at each reporting date for appropriateness. For computer software licences, the useful life represents management's view of the expected period over which the Ministry will receive benefits from the software, but not exceeding the licence term. For internally generated software developed by the Ministry, the useful life is based on historical experience with similar systems as well as anticipation of future events that may impact the useful life, such as changes in technology.

Breakdown of intangible assets

	Acquired software $000	Internally generated software $000	Total $000
Cost			
Balance as at 1 July 2015	20,080	67,265	87,345
Additions	185	6,162	6,347
Disposals	–	(490)	(490)
Balance as at 30 June 2016	**20,265**	**72,937**	**93,202**
Balance as at 1 July 2016	20,265	72,937	93,202
Additions	153	1,944	2,097
Disposals	–	(33)	(33)
Balance as at 30 June 2017	**20,418**	**74,848**	**95,266**
Accumulated amortisation and impairment losses			
Balance as at 1 July 2015	17,220	34,800	52,020
Amortisation expense	1,492	5,941	7,433
Disposals	–	(490)	(490)
Balance as at 30 June 2016	**18,712**	**40,251**	**58,963**
Balance as at 1 July 2016	18,712	40,251	58,963
Amortisation expense	554	5,853	6,407
Disposals	–	(33)	(33)
Balance as at 30 June 2017	**19,266**	**46,071**	**65,337**
Total intangible assets including WIP			
At 30 June 2015	2,860	32,465	35,325
At 30 June 2016	1,553	32,686	34,239
At 30 June 2017	**1,152**	**28,777**	**29,929**
Work in progress			
At 30 June 2015	1	10,997	10,998
At 30 June 2016	57	10,768	10,825
At 30 June 2017	**138**	**11,663**	**11,801**

There are no restrictions over the title of the Ministry's intangible assets.

8. Payables

Accounting policy

Short-term payables are recorded at the amount payable.

Revenue in advance are fees received in advance in relation to new medicine applications.

Breakdown of payables

Actual 2016 $000		Actual 2017 $000
224	Creditors	428
2,167	Revenue in advance	1,931
8,245	Accrued expenses	12,078
1,095	GST payable	1,787
11,731	**Total payables**	**16,224**

9. Return of operating surplus

Actual 2016 $000		Actual 2017 $000
(693)	Net surplus/(deficit)	(656)
	Add:	
1,301	Surplus/(deficit) of memorandum accounts	1,885
608	**Total return of operating surplus**	**1,229**

The return of operating surplus to the Crown is required to be paid by 31 October of each year.

10. Provisions

Accounting policy

A provision is recognised for future expenditure of an uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event
- it is probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation
- a reliable estimate can be made of the amount of the obligation.

Provisions are not recognised for net deficits from future operating activities.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. Provisions to be settled beyond 12 months are recorded at their present value.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has been announced publicly to those affected or implementation has already commenced.

Breakdown of provisions

Actual 2016 $000		Actual 2017 $000
	Current portion	
372	Assets to be written-off	–
1,346	Restructuring	645
1,666	Lease make-good	–
300	Demolition of NRL building	300
7	Other	7
3,691	**Total current portion**	**952**
	Non-current portion	
30	ACC partnership programme	30
30	**Total non-current portion**	**30**
3,721	**Total provisions**	**982**

Movement of provisions

	Lease exit makegood $000	Assets to be written-off $000	Restructuring $000	Other $000	Total $000
Opening balance 1 July 2016	**1,666**	**372**	**1,346**	**337**	**3,721**
Additional provision made	–	–	571	–	571
Amounts applied	(1,666)	(372)	(1,272)	–	(3,310)
Closing balance 30 June 2017			**645**	**337**	**982**

11. Employee entitlements

Accounting policy

Short-term employee entitlements
Employee entitlements that are due to be settled within 12 months after the end of the year in which the employee provides the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, long service leave and retirement gratuities expected to be settled within 12 months and sick leave.

Long-term employee entitlements
Employee entitlements that are due to be settled beyond 12 months after the end of the year in which the employee provides the related service, such as retirement and long service leave have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to employees, based on years of service, years to entitlement, the likelihood that employees will reach the point of entitlement, and contractual entitlements information
- the present value of the estimated future cash flows.

Presentation of employee entitlements
Sick leave, annual leave, vested long service leave, and non-vested long service leave and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Critical accounting estimates and assumptions: long service leave and retirement gratuities

The measurement of the long service leave and retirement gratuities obligations depends on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. A weighted average discount rate of 1.87% (2016: 2.93%) was used. The discount rates and salary inflation factor used are those advised by the Treasury.

If the discount rates were to differ by 1% from the Ministry's estimates, with all other factors held constant, the carrying amount of the liability and the surplus or deficit would be an estimated $99,456 higher/lower.

If the salary inflation rates were to differ by 1% from the Ministry's estimates, with all other factors held constant, the carrying amount of the total liability and the surplus or deficit would be an estimated $133,086 higher/lower.

Breakdown of employee benefits

Actual 2016 $000		Actual 2017 $000
	Current position	
6,354	Annual leave	6,302
383	Sick leave	422
1,007	Retirement and long service leave	1,046
418	Accrued salaries	843
8,162	**Total current portion**	**8,613**
	Non-current position	
1,343	Retirement and long service leave	1,446
1,343	**Total non-current portion**	**1,446**
9,505	**Total employee entitlements**	**10,059**

12. Equity

Accounting policy

Equity is the Crown's investment in the Ministry and is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified as taxpayers' funds, memorandum accounts and property revaluation reserves.

Memorandum accounts

Memorandum accounts reflect the cumulative surplus or deficit on those departmental services provided that are intended to be fully cost recovered from third parties through fees, levies or charges. The balance of each memorandum account is expected to trend toward zero over time.

Property revaluation reserves

These reserves relate to the revaluation of land and buildings to fair value.

Breakdown of equity

Actual 2016 $000		Actual 2017 $000
	Taxpayers' funds	
30,159	Balance at 1 July	30,159
(693)	Surplus/(deficit)	(656)
1,301	Transfer of memorandum account net deficit for the year	1,885
(608)	Return of operating surplus to the Crown	(1,229)
30,159	**Balance at 30 June**	**30,159**
	Property revaluation reserves	
2,040	Balance at 1 July	2,590
550	Revaluation gains on land and building	–
2,590	**Balance at 30 June**	**2,590**
	Memorandum accounts	
3,093	Balance at 1 July	1,792
(1,301)	Net memorandum account deficits for the year	(1,885)
1,792	**Balance at 30 June**	**(93)**
34,541	**Total equity**	**32,656**

13. Memorandum accounts

The memorandum accounts summarise financial information relating to the accumulated surpluses and deficits incurred in the provision of statutory information and performance of accountability reviews by the Ministry to third parties in a full cost recovery basis.

The balance of each memorandum account is expected to trend toward zero over a reasonable period of time, with interim deficits being met either from cash from the Ministry's statement of financial position or by seeking approval for a capital injection from the Crown. Capital injections will be repaid to the Crown by way of cash payments throughout the memorandum account cycle.

Action taken to address surpluses and deficits

A revised fee strategy is currently being developed to ensure that fee structure and associated revenues are in line with the forecast activities.

Capital management

The Ministry's capital is its equity, which comprise taxpayer's' funds, memorandum accounts, and property revaluation reserves. Equity is presented by net assets.

The Ministry manages its revenues, expenses, assets, liabilities, and general financial dealings prudently. The Ministry's equity is largely managed as a by-product of managing revenue, expenses, assets, liabilities, and compliance with the government budget processes, Treasury instructions, and the PFA.

The objective of managing the Ministry's equity is to ensure that the Ministry effectively achieves its goals and objectives for which it has been established while remaining a going concern.

Memorandum accounts

Actual 2016 $000		Actual 2017 $000
	Opening balance	
(516)	Problem gambling	(515)
973	Office of radiation safety	1,019
2,636	Medsafe	1,288
3,093		**1,792**
	Revenue and appropriation	
1,001	Problem gambling appropriation	957
919	Office of radiation safety revenue	582
7,427	Medsafe revenue	7,646
9,347		**9,185**
	Expenditure	
(1,000)	Problem gambling expenditure	(1,172)
(873)	Office of radiation safety expenditure	(970)
(8,775)	Medsafe expenditure	(8,928)
(10,648)		**(11,070)**
(1,301)	**Total deficit for year**	**(1,885)**

Continued

	Closing balance	
(515)	Problem gambling	(730)
1,019	Office of radiation safety	631
1,288	Medsafe	6
1,792		**(93)**

14. Related party transactions

The Ministry is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and condition no more or less favourable than those that it is reasonable to expect the Ministry would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel compensation

Actual 2016 $000		Actual 2017 $000
	Leadership Team including the Chief Executive:	
3,690	Remuneration	4,429
10	Full-time equivalent staff	11

The above key management personnel disclosure excludes the Minister of Health. The Minister's remuneration and other benefits are not received only for his role as a member of key personnel of the Ministry. The Minister's remuneration and other benefits are set by the Remuneration Authority under the Members of Parliament (Remuneration and Services) Act 2013 and are paid under Permanent Legislative authority, not by the Ministry of Health.

15. Events after the balance date

There are no significant events after the balance date.

16. Explanation of major variances against budget

Explanations for major variances from the Ministry's estimated figures are outlined below.

Statement of Comprehensive Revenue and Expense

Revenue Crown

Revenue Crown was $3.2 million higher than the unaudited budget. This was mainly due to additional funding for Information Technology Services $2.2 million and Managing Purchase of Services $1.4 million.

Revenue other
Revenue other was $3.0 million lower than the unaudited budget. This was mainly due to Natural Health Products not generating revenue $0.8 million, lower demand for Product Regulation services $0.7 million and less activity in the Australia NZ Therapeutic Products Authority Transition Agency $0.9 million.

Depreciation
Depreciation and amortisation costs were $3.2 million lower than the unaudited budget due to capital project delays.

Statement of financial position

Current assets
Current assets were $3.1 million higher than the unaudited budget. This was mainly due to Crown debtors $2.0 million and prepayments $1.7 million partially offset by lower cash and receivables $0.6 million.

Property, plant and equipment, and intangible assets
Property, plant and equipment, and intangible assets were $1.2 million lower than the unaudited budget due to capital project delays.

Non-departmental statements and schedules for the year ended 30 June 2017

The following non-departmental statements and schedules record the revenue, expenses, assets, liabilities, commitments, contingent liabilities, contingent assets, capital receipts and trust accounts that the Ministry manages on behalf of the Crown.

Statement of non-departmental expenses and capital expenditure against appropriations for the year ended 30 June 2017

Actual 2016 $000		Actual 2017 $000	Main estimates 2017 $000	Voted^ appropriation 2017 $000
	Non-departmental appropriations			
11,791,121	Health and disability support services for DHB	12,194,581	12,219,915	12,199,848
2,785,840	National services	2,857,750	2,879,536	2,888,142
35,191	Non-departmental other expenses	104,899	28,472	302,492
485,621	Non-departmental capital contributions to other persons or organisations	3,033,039	803,196	3,342,242
15,097,773	**Total non-departmental appropriations**	**18,190,269**	**15,931,119**	**18,732,724**

^ Voted appropriation includes adjustments made in the Supplementary Estimates and under PFA.

Non-departmental other expenses include $2.4 million of expenditure not requiring appropriation as follows:

Residential care loans impairment $1.6 million.

Revaluation of properties $0.8 million.

The GST input expense for the year was $2.272.6 million (2016: $2,203.2 million).

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2017.

Schedule of non-departmental revenue and capital receipts for the year ended 30 June 2017

Non-departmental revenues and capital receipts are administered by the Ministry on behalf of the Crown. As these revenues are not established by the Ministry nor earned in the production of its outputs they are not reported in the financial statements.

Actual 2016 $000		Actual 2017 $000	Main estimates 2017 $000	Supp. estimates 2017 $000
	Revenue			
	Reimbursement from the Accident Compensation Corporation (ACC)			
4,839	Reimbursement of complex burns costs	5,900	4,924	4,924
29,036	Reimbursement of work-related public hospital costs	24,139	29,544	29,544
275,846	Reimbursement of non-earners' account	297,627	280,668	280,668
87,109	Reimbursement of earners' non-work-related public hospital costs	103,499	88,632	88,632
72,591	Reimbursement of motor vehicle-related public hospital costs	52,404	73,860	73,860
4,839	Reimbursement of medical misadventure costs	4,231	4,924	4,924
9,679	Reimbursement of self-employed public hospital costs	4,600	9,848	9,848
483,939	**Total ACC reimbursements**	**492,400**	**492,400**	**492,400**
	Non-departmental revenue			
203,941	Payment of capital charge by DHB*	183,515	224,410	167,238
(55,032)	Net surplus/(deficit) from DHB**	(117,530)	–	–
3,041	Other Crown entities surplus/(deficit)	(240)	–	–
635,889	**Total non-departmental revenue**	**558,145**	**716,810**	**659,638**
	Non-departmental capital receipts			
11,549	Repayment of residential care loans	10,034	15,000	15,000
600	Repayment of DHB debt	600	–	–
12,499	Equity repayments by DHB	12,499	12,499	12,499
24,648	**Total non-departmental capital receipts**	**23,133**	**27,499**	**27,499**
660,537	**Total non-departmental revenue and capital receipts**	**581,278**	**744,309**	**687,137**

* Net surplus or deficit from DHB is based on unaudited financial statements of the 20 DHB. These have not been reflected in the investments in Crown entities figure within the schedule of non-departmental assets.

** Other Crown entities surplus or deficit is based on unaudited financial statements of the other non-DHB health sector Crown entities. These have not been reflected in the investments in Crown entities figure within the schedule of non-departmental assets.

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2017.

Schedule of non-departmental assets and liabilities as at 30 June 2017

Actual 2016 $000		Note	Actual 2017 $000	Main estimates 2017 $000	Supp. estimates 2017 $000
	Assets				
	Current assets				
107,514	Cash and cash equivalents		133,291	95,000	95,000
17,383	Inventory	2.11	12,733	20,558	17,000
	Receivables:				
55	District Health Boards		–	–	19,036
18,552	ACC		414	–	–
1,195	Government departments		282	945	1,195
2,251	Other receivables		2,055	1,962	1,822
33,239	Prepayments		97,184	12,894	33,000
180,189	**Total current assets**		**245,959**	**131,359**	**167,053**
	Non-current assets				
	Advances:				
36,355	Residential care loans	2.12	35,259	40,000	38,360
2,438	Other advances		(116)	1,954	2,554
	Investments:				
314,039	Christchurch and West Coast hospital rebuild project	2.13	258,278	439,912	313,073
33,783	Other investments		28,516	20,910	20,910
386,615	**Total non-current assets**		**321,937**	**502,776**	**374,897**
566,804	**Total non-departmental assets**		**567,896**	**634,135**	**541,950**
	Liabilities				
	Current liabilities				
	Payables:				
20,114	DHB payables		22,017	–	–
35,397	Other payables	2.14	29,847	–	–
	Accrued liabilities and provisions:				
195,423	DHB accrued liabilities		255,976	239,932	212,932
1,147	Other Crown entities		1,278	–	–
158,329	Other accrued liabilities		161,823	178,913	197,188
410,410	**Total non-departmental current liabilities**		**470,941**	**418,845**	**410,120**

The Ministry monitors a number of Crown entities including 20 district health boards. Investment in these entities is recorded in the financial statements of the Government on a line-by-line basis. No disclosure of investments in Crown entities is made in this schedule.

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2017.

Schedule of non-departmental commitments as at 30 June 2017

Breakdown of capital commitments

Actual 2016 $000		Actual 2017 $000
334,349	Property, plant and equipment	265,661
334,349	**Total capital commitments**	**265,661**

Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2017

Breakdown of contingent liabilities

Actual 2016 $000		Actual 2017 $000
1,025	Legal proceedings and disputes	6,885
1,025	**Total contingent liabilities**	**6,885**

Legal proceedings and disputes

Legal claims against the Crown are mainly seeking recompense in relation to perceived issues regarding treatment and care and is in the process of defending these claims. Settlements are likely to be significantly less than the claims made.

Contingent assets

The Ministry had no contingent assets as at balance date (2016: $nil).

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2017.

Problem Gambling Levy Report for the year ended 30 June 2017

In accordance with the Gambling Act 2003, the Ministry receives an appropriation for problem gambling that over time is intended to be fully funded from the levies collected from the industry by IRD. The following report shows the levies collected to date and actual expenditure.

Actual 2016 $000		Non-departmental actual 2017 $000	Departmental actual 2017 $000	Total actual 2017 $000
	Problem Gambling non-departmental expenditure			
(352)	Balance at 1 July	(1,221)	(515)	(1,736)
17,821	Revenue*	19,280	957	20,237
	Revenue adjustment for 2015/16^	694	–	694
(19,205)	Expenses	(14,913)	(1,172)	(16,085)
(1,736)	**Balance at 30 June**	**3,840**	**(730)**	**3,110**

* Revenue is actual levies collect by IRD, less the Departmental revenue based on the "Preventing and Minimising Gambling Harm: Three-year service plan 2016/17–2018/19".

^ Health receives confirmation from IRD of actual levies collected. 2015/16 provision numbers were used for the annual report that understated actual revenue by $694,000. This is corrected in 2016/17.

Statement of trust monies for the year ended 30 June 2017

Actual 2016 $000		Actual 2017 $000
	District health boards deposit trust account	
1,088	Balance as at 1 July	924
7,324,487	Contributions	7,682,773
(7,324,151)	Distributions	(7,682,768)
(500)	Expenditure	465
924	**Balance as at 30 June**	**1,394**

The trust account was established to hold DHB funds received for delivery of processing services and disbursements.

The accompanying notes form part of these financial statements.

For a full understanding of the Crown's financial position and the results of its operations for the year, refer to the consolidated Financial Statements of the Government for the year ended 30 June 2017.

Notes to the non-departmental statements and schedules

Notes index

1. Statement of accounting policies

Reporting entity

These non-departmental statements and schedules present financial information on public funds managed by the Ministry on behalf of the Crown. The financial information is consolidated into the Financial Statements of the Government and therefore readers of these schedules should also refer to the financial statements of the Government for the year ended 30 June 2017.

Basis of preparation

The non-departmental statements and schedules have been prepared in accordance with the accounting policies of the financial statements of the Government, Treasury instructions and Treasury circulars.

Measurement and recognition rules applied in the preparation of the non-departmental statements and schedules are consistent with Crown accounting policies and Tier 1 NZ PBE accounting standards.

Statement of compliance

The financial statements of the Ministry have been prepared in accordance with the requirements of the PFA, which include the requirement to comply with New Zealand generally accepted accounting practice and Treasury Instructions.

The financial statements have been prepared in accordance with and comply with PBE accounting standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Changes in accounting policies

There have been no changes in the Ministry's accounting policies since the date of the last audited financial statements.

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

Revenue and receipts

Revenue from ACC recoveries and capital charges from DHB is recognised when earned and is reported in the financial period to which it relates.

Debtors and receivables
Receivables from ACC recoveries are recorded at the value of the contract and agreed with ACC. Receivables from capital charges are recorded at estimated realisable value.

Residential care loans
An actuarial valuation of residential care loans was carried out in May 2017.

Inventory
Inventories held for consumption in the provision for services are recorded at the lower of cost or current replacement cost. Any write-down from cost to replacement cost is recognised in the Statement of Non-Departmental Expenses and Capital Expenditure against appropriations.

Investments
Investments are recorded in the Schedule of Non-Departmental Assets at historical cost. The carrying value represents the aggregate of equity injections made by the Ministry less subsequent repayments of equity returned to the Crown.

Accrued expenses
Accrued expenses are recorded at either the value of funding entitlements owing under Crown funding agreements or the estimated value of contracts already started but not yet completed.

Goods and services tax (GST)
All items in the financial statements, including appropriation statements, are stated exclusive of GST, except for receivables and payables, which are stated on a GST-inclusive basis. In accordance with Treasury instructions, GST is returned on revenue received on behalf of Crown where applicable.

Input tax deductions are not claimed on non-departmental expenditure. Instead, the amount of GST applicable to non-departmental expenditure is recognized as a separate expense and eliminated against GST revenue on consolidation of the financial statements of the Government.

Commitments
Future expenses and liabilities to be incurred on contracts that have been entered into as at the balance date are disclosed as commitments to the extent that there are equally unperformed obligations.

Budget figures
The budget figures are consistent with the financial information in the Mains Estimates. In addition, these financial statements also present the updated budget information about the Supplementary Estimates.

Payables and provisions
Payables and provisions are recorded at the estimated obligation to pay.

Changes in accounting policies
There have been no changes in accounting policies.

Events after the balance date
There are no significant events after the balance date.

2. Explanation of major variances against budget

Explanations for major variances from the Ministry's non-departmental appropriations within the Main Estimates are as follows.

Schedule of non-departmental expenses and capital expenditure against appropriations

2.1 Health and disability support services for DHB

Variances differ across DHB (net favourable variance of $25.3 million) reflecting a number of changes during the year. These changes include technical changes following the reduction of capital charge costs in the year and DHB Crown debt being converted to equity offset by increased cost with the devolution of Hospice Community Palliative Care from the National Personal Health appropriation administered by the Ministry (refer 2.6 below).

At an individual DHB level, the significant variance, other than above, relates to an unfavourable variance of $27.1 million against the Main Estimates for funding to the Auckland DHB as a result of a transfer of funding from other DHB for paediatric cardiac services. The Auckland DHB provides these services.

2.2 National disability support services

The unfavourable variance of $22.1 million against the Main Estimates is mainly due to a demand increase in disability support services (DSS) including in-between travel (IBT) claimed volumes, volume driven costs for areas such as environmental support services funding, and one-off costs associated with the Pay Equity settlement. In addition to changes reflected in the 2016/17 Supplementary Estimates, a section 26A change increasing the appropriation by $4.5 million was provided to meet residual IBT costs and DSS volume pressures.

2.3 Public health services purchasing

The favourable variance of $14.6 million against the Main Estimates is mainly due to the timing of projects in the Sanitary Works Subsidy Scheme $19.2 million where funding was transferred to 2017/18. This was offset by transfers of funding from other appropriations to better reflect where activities are provided and transfers from 2015/16 for continued work on the Rheumatic Fever Prevention programme $1.7 million.

A residual underspend $7 million against the final Voted appropriation is mainly due to the timing of costs incurred for the Bowel Screening programmes and Refugee, and Migrant services where in-principle expense transfers of $6.8 million are to be carried over to 2017/18.

2.4 National Maternity Services

The unfavourable variance of $7.280 million against the Main Estimates is mainly related to cost pressures relating to high claimed scan volumes, and an increase to the unit price effective from 1 July 2016.

2.5 National Mental Health Services

The unfavourable variance of $5.9 million against the Main Estimates is mainly due to additional funding to meet costs for the Canterbury Mental Health All Right Campaign and to deliver initiatives to expand alcohol and drug treatment, and reduce demand for methamphetamine in Northland. The year-end underspend against final budget $4.8 million is mainly due to the timing of the alcohol and drug treatment programme. An in-principle expense transfer is agreed to be carried over to 2017/18.

2.6 National Personal Health Services

The favourable variance of $16.7 million against the Main Estimates is mainly due to Hospice Community Palliative Care funding being devolved to DHB ($15 million) in 2016/17. The residual relates to funding changes between appropriations that occurred in the year.

2.7 Repayment of District Health Board Loans

No funding was appropriated in the Mains Estimates. The unfavourable variance of $76 million relates to the early repayment at fair value of DHB loans during 2016/17.

2.8 Equity for capital projects for DHBs and Health Sector Crown Agencies

The unfavourable variance of $2,354 million against the Main Estimates is mainly due to an additional $2,392 million in costs associated with DHB debt funding being converted to equity during 2016/17 with the residual relating to the timing of funding required for DHB capital projects.

This appropriation holds capital funds pending DHB drawdown to meet funding requirements for capital projects approved by Cabinet or joint Ministers of Health and Finance. This funding has been carried forward for projects in out-years.

2.9 Health Sector Projects

The favourable variance of $246.1 million against the Main Estimates is due to the timing of funding required for health sector capital projects mainly relating to the Canterbury Hospital Rebuild and the Grey Base Hospital, which are managed or co-managed by the Ministry. This underspend will be carried forward to 2017/18.

2.10 Refinance of Crown Loans

The unfavourable variance of $143.7 million against the Main Estimates mainly reflects an additional costs associated with DHB debt funding being converted to equity during 2016/17.

Schedule of non-departmental assets

2.11 Inventory

Vaccine stocks were $7.8 million less than the Main Estimates due to the write-off of out-of-date emergency stock.

2.12 Residential care loans

Residential care loans were $4.7 million lower than the Main Estimates mainly due to the opening balance being $2.0 million lower than forecast.

2.13 Christchurch and West Coast Hospital Rebuild Project

The Christchurch and West Coast Hospital Project was $181.6 million lower than the Main Estimates due to the timing of the project.

Schedule of non-departmental liabilities

2.14 Other payables

Other payables were not provided for in the Main Estimates.

Appropriation statements

The following statements report information about the expenses and capital expenditure incurred against each appropriation administered by the Ministry for the year ended 30 June 2017. They are prepared on a GST exclusive basis.

Statement of cost accounting policies

The Ministry has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be attributed to a specific output in an economically feasible manner.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation and capital charge are on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes in cost accounting policies since the date of the last audited financial statements.

Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2017

Actual expenditure 2016 $000	Appropriation title	Notes	Actual expenditure 2017 $000	Main estimates 2017 $000	Voted appropriation 2017** $000	Actual expenditure as a % of total Vote	Location of end-of-year performance information
	Departmental output expenses						
31,790	Managing the purchase of services		34,054	33,539	35,164	0.19%	1
22,739	Regulatory and enforcement services		22,042	23,377	22,283	0.12%	1
47,050	Sector planning and performance		48,010	47,915	48,022	0.26%	1
50,110	Health sector information systems		53,501	52,128	54,278	0.29%	1
17,907	Payment services		18,377	17,646	18,418	0.10%	1
169,596	**Total departmental output expenses**		**175,984**	**174,605**	**178,165**	**0.96%**	
	Multi-category expense and capital expenditure						
4,592	Ministerial servicing		4,387	4,720	4,706	0.02%	1
16,113	Policy advice		16,134	16,352	16,003	0.09%	1
	Departmental capital expenditure						
11,535	Ministry of Health – permanent legislative authority		10,659	15,010	17,010	0.06%	1
32,240	**Total multi-category expense and capital expenditure**		**31,180**	**36,082**	**37,719**	**0.17%**	
201,836	**Total departmental output appropriations**		**207,164**	**210,687**	**215,884**	**1.13%**	
201,836	**Total departmental appropriations**		**207,164**	**210,687**	**215,884**	**1.13%**	

Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2017 (continued)

Actual expenditure 2016 $000	Appropriation title	Notes	Actual expenditure 2017 $000	Main estimates 2017 $000	Voted appropriation 2017** $000	Actual expenditure as a % of total Vote	Location of end-of-year performance information
	Non-departmental output expenses						
	Health/disability support services for district health boards (DHB)						
511,786	Northland		536,633	539,583	536,635	2.92%	2
1,349,320	Waitemata		1,391,674	1,399,525	1,391,675	7.57%	2
1,118,297	Auckland		1,195,265	1,168,145	1,195,267	6.50%	2
1,274,349	Counties Manukau		1,321,733	1,329,104	1,321,735	7.19%	2
1,042,740	Waikato		1,088,798	1,096,798	1,088,800	5.92%	2
284,778	Lakes		298,534	300,118	298,534	1.62%	2
638,060	Bay of Plenty		664,889	670,326	664,890	3.62%	2
147,136	Tairawhiti		154,031	154,899	154,032	0.84%	2
318,643	Taranaki		324,724	327,231	324,724	1.77%	2
457,148	Hawke's Bay		470,211	469,504	470,212	2.56%	2
206,464	Whanganui		210,551	211,894	210,551	1.15%	2
467,256	MidCentral		482,762	484,891	482,764	2.63%	2
365,331	Hutt Valley		372,954	375,024	372,955	2.03%	2
690,915	Capital and Coast		702,654	708,924	702,655	3.82%	2
128,179	Wairarapa		130,946	131,668	130,946	0.71%	2
394,740	Nelson-Marlborough		403,401	405,579	403,403	2.19%	2
121,928	West Coast		124,489	125,017	124,489	0.68%	2
1,314,527	Canterbury		1,330,249	1,326,373	1,335,847	7.24%	2
167,795	South Canterbury		171,495	172,374	171,495	0.93%	2
791,729	Southern		818,588	822,938	818,589	4.44%	2
11,791,121	**Total health/disability support services for DHB**	**2.1**	**12,194,581**	**12,219,915**	**12,200,198**	**66.29%**	
	National services						
1,167,483	National disability support services	2.2	1,187,988	1,165,888	1,188,334	6.46%	3
372,112	Public health services purchasing	2.3	386,087	400,644	392,911	2.10%	3
83,559	National child health services		81,764	85,001	81,841	0.44%	3
323,180	National elective services		350,577	355,517	356,205	1.91%	3
95,540	National emergency services		101,033	99,946	101,050	0.55%	3
4,066	National Māori health services		3,010	6,828	3,328	0.02%	3
144,589	National maternity services	2.4	154,047	146,767	154,100	0.84%	3
53,114	National mental health services	2.5	64,848	58,962	69,669	0.35%	3
24,518	National contracted services – other		25,880	37,155	25,907	0.14%	3

Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2017 (continued)

Actual expenditure 2016 $000	Appropriation title	Notes	Actual expenditure 2017 $000	Main estimates 2017 $000	Voted appropriation 2017** $000	Actual expenditure as a % of total Vote	Location of end-of-year performance information
27,510	Monitoring and protecting health and disability consumer interests		28,642	27,596	28,746	0.16%	3
18,205	Problem gambling services		14,900	17,440	19,865	0.08%	3
176,252	Health workforce training and development		184,657	180,014	185,014	1.00%	3
179,615	Primary health care strategy		185,360	186,019	185,794	1.01%	3
105,563	National personal health services	2.6	82,027	98,694	82,638	0.45%	3
10,534	National health information systems		4,369	13,065	5,418	0.02%	3
–	Auckland health projects integrated investment plan		–	–	720	0.00%	4
–	Health sector projects operating expenses		2,561	–	6,252	0.01%	3
2,785,840	**Total national services**		**2,857,750**	**2,879,536**	**2,887,792**	**15.54%**	**3**
14,576,961	**Total non-departmental output expenses**		**15,052,331**	**15,099,451**	**15,087,990**	**81.83%**	
	Non-departmental other expenses						
1,639	International health organisations		1,703	2,030	2,030	0.01%	4
959	Legal expenses		961	1,028	1,028	0.01%	4
22,709	Provider development		23,831	25,414	24,434	0.13%	4
–	Repayment of DHB loans	2.7	75,974	–	275,000	0.41%	4
25,307	**Total non-departmental other expenses**		**102,469**	**28,472**	**302,492**	**0.56%**	

Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2017 (continued)

Actual expenditure 2016 $000	Appropriation title	Notes	Actual expenditure 2017 $000	Main estimates 2017 $000	Voted appropriation 2017** $000	Actual expenditure as a % of total Vote	Location of end-of-year performance information
	Non-departmental capital contributions to other persons or organisations						
14,000	Deficit support for DHB		37,700	50,000	74,624	0.20%	2
41,030	Equity for capital projects for DHB and the NZ Blood Service	2.8	2,539,467	185,299	2,722,345	13.80%	3
162,418	Health sector projects	2.9	156,258	402,397	241,059	0.85%	3
–	Loans for capital projects		85,000	90,000	85,000	0.46%	3
50,000	Refinance of DHB private debt		–	–	–	0.00%	3
207,520	Refinance of Crown loans	2.10	204,214	60,500	204,214	1.11%	3
10,653	Residential care loans		10,400	15,000	15,000	0.06%	3
485,621	**Total non-departmental capital contributions to other persons or organisations**		**3,033,039**	**803,196**	**3,342,242**	**16.48%**	
15,087,889	**Total non-departmental appropriations**		**18,187,839**	**15,931,119**	**18,732,724**	**98.87%**	
15,289,725	**Total Vote: Health**		**18,395,003**	**16,141,806**	**18,948,608**	**100.00%**	

The numbers in this column represent where the end-of-year performance information has been reported for each appropriation administered by the Ministry, as detailed below:

1 Section three 'Our core business activities' of the Ministry's annual report.

2 The DHBs annual reports.

3 The Vote Health Report in relation to selected non-departmental appropriations for the year ended 30 June 2017.

4 Exemptions granted under section 15D of the Public Finance Act 1989

** These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Statement of expenses and capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2017

Expenses and capital expenditure incurred in excess of appropriation: $nil

Expenses and capital expenditure incurred without or outside scope or period of appropriation: $nil

Statement of departmental capital injections for the year ended 30 June 2017

Actual capital injections 2016 $000		Actual capital injections 2017 $000	Approved appropriation 2017 $000
	Vote Public Issues		
1,517	Ministry of Health – Capital injection	–	–

Statement of departmental capital injections without, or in excess of, authority for the year ended 30 June 2017

The Ministry has not received any capital injections during the year without, or in excess, of authority.

Appendices

Appendix 1: Outcome and impact measures

The Ministry has high level outcome and impact measures that support the achievement of the overall outcomes of the health and disability system. These measures are set out in the Statement of Intent 2015–19. All results reported reflect the latest data available.

The change in reporting format of these measures is to ensure that more comparatives are included. The prior year's comparatives are unaudited and are for comparison purposes only.

Outcome measures

<table>
<tr><th>Measure</th><th>Target</th><th colspan="5">Results</th></tr>
<tr><td colspan="7">Health-adjusted life expectancy improves over time</td></tr>
<tr><td rowspan="4">Health-adjusted life expectancy[3] is the number of years a person can expect to live in good health and without an impairment needing assistance.</td><td rowspan="4">Improved results for male/female</td><td colspan="5">People in New Zealand live longer in good health, but spend a higher proportion of their lives with disabilities</td></tr>
<tr><td colspan="5">Health-adjusted life expectancy</td></tr>
<tr><td>Gender</td><td>2015</td><td>2010</td><td>2000</td><td>1990</td></tr>
<tr><td>Female</td><td>71.8</td><td>71.3</td><td>69.8</td><td>68.1</td></tr>
<tr><td></td><td></td><td>Male</td><td>69.9</td><td>69.4</td><td>66.9</td><td>64.3</td></tr>
<tr><td colspan="7">Life expectancy increases over time</td></tr>
<tr><td rowspan="11">Life expectancy at birth as an indicator of the number of years a person can expect to live, based on population mortality rates at each age in a given year/period</td><td rowspan="11">Improved results for male/female and Māori/non-Māori</td><td colspan="5">Life expectancy is a summary measure of mortality and the trend shows New Zealanders are living longer than ever before.</td></tr>
<tr><td colspan="5">Life expectancy at birth[4]</td></tr>
<tr><td>Gender</td><td>2014–16</td><td>2013–15</td><td>2012–14</td><td>2005–07</td></tr>
<tr><td>Female</td><td>83.4</td><td>83.3</td><td>83.2</td><td>82.2</td></tr>
<tr><td></td><td></td><td>Male</td><td>79.9</td><td>79.7</td><td>79.5</td><td>78.0</td></tr>
<tr><td>Ethnicity and gender</td><td>2012–14</td><td>2005–07</td><td>2000–02</td><td>1995–97</td></tr>
<tr><td>Māori males</td><td>73.0</td><td>70.4</td><td>69.0</td><td>66.6</td></tr>
<tr><td>Māori females</td><td>77.2</td><td>75.1</td><td>73.2</td><td>71.3</td></tr>
<tr><td>Non-Māori males</td><td>80.3</td><td>79.0</td><td>77.2</td><td>75.4</td></tr>
<tr><td>Non-Māori females</td><td>83.9</td><td>83.0</td><td>81.9</td><td>80.6</td></tr>
<tr><td colspan="5">Improvements in Māori life expectancy at birth since 1995/97 have narrowed the gap between Māori and non-Māori.</td></tr>
</table>

3 Global Burden of Disease Study 2015 (GBD 2015) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2016. Available from http://ghdx.healthdata.org/gbd-results-tool. This measure is similar to health expectancy which uses a minor variation in the calculation.

4 Statistics New Zealand: Life expectancy, 2017. Available from http://www.stats.govt.nz/browse_for_stats/health/life_expectancy.aspx

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td colspan="3">Decrease age-standardised Disability Adjusted Life Years (DALY) per 1,000 people</td></tr>
<tr><td>One DALY represents the loss of one year lived in full health. DALYs include health losses from premature mortality and years lived with a disability based on severity</td><td>Decrease</td><td>Age-standardised DALY rates per 1,000 population have been steadily decreasing since 1990. The rate of decrease has slowed in recent years. As the population is growing and ageing, the absolute number of DALYs has slowly increased, from 950,000 in 1990 to around 1.1 million in 2013.
Disability adjusted life years (DALY) per 1,000 people
<table><tr><th></th><th>2013</th><th>2010</th><th>2005</th><th>2000</th></tr><tr><td>DALY</td><td>209</td><td>212</td><td>220</td><td>235</td></tr></table></td></tr>
<tr><td colspan="3">Life expectancy by health spending per capita compares well within the OECD</td></tr>
<tr><td>New Zealand maintains its position within the Organisation for Economic
Co-operation and Development (OECD) balancing relatively high life expectancy outcomes with relatively modest expenditure[5]</td><td>OECD position maintained</td><td>New Zealand has maintained its position within the OECD as having relatively high life expectancy for relatively modest expenditure. New Zealand performs well internationally with respect to life expectancy in terms of health spending per capita: it has relatively high life expectancy for comparatively modest health expenditure. In 2015 New Zealand achieved higher life expectancy than could be expected (the 13th highest among 35 countries) given expenditure on health care (19th highest among 35 countries) relative to other OECD countries.
OECD life expectancy and health expenditure
<table><tr><th></th><th>2015</th><th>2010</th><th>2005</th><th>2000</th></tr><tr><td>Life expectancy</td><td>13th out of 35 OECD countries</td><td>13th out of 35 OECD countries</td><td>12th out of 35 OECD countries</td><td>13th out of 35 OECD countries</td></tr><tr><td>Health expenditure</td><td>19th out of 35 OECD countries</td><td>20th out of 35 OECD countries</td><td>23rd out of 35 OECD countries</td><td>20th out of 35 OECD countries</td></tr></table></td></tr>
<tr><td colspan="3">Health spending growth slows over time</td></tr>
<tr><td>The projected rate of growth in health spending lowers when the rate of growth spending between 2000 and 2009 is compared, in the value of 2001 dollars, with the rate between 2010 and 2019</td><td>The projected rate of growth in health spending lowers</td><td>Real health expenditure continues to grow, but the projected rate of growth in health spending between 2010 and 2018 is projected to be lower than the rate of growth between 2000 and 2009. Vote Health spending has remained steady since 2000 at about 5–6 percent of gross domestic product.</td></tr>
</table>

5 Source: OECD Health Statistics, Health Expenditure and Financing, 2015. URL: http://stats.oecd.org/(accessed 15 September 2017)

Impact measures

Impact 1: The public is supported to make informed decisions about their own health and independence

Measure	Target	Results
The results of the burden of disease and health surveys are improved	Improved results	For most risk factors, survey results have continued to improve from 1990.

New Zealand burden of disease study: health loss attributable to selected risk factors, 1990-2015: age-standardised DALY rates per 1,000

Risk factors surveyed	2015 (rate per 1000)	2010 (rate per 1000)	2000 (rate per 1000)	1900 (rate per 1000)
Blood pressure (systolic)	14.8	15	20	31.1
Cholesterol (total blood level)	7.8	7.9	10.9	18.9
Tobacco use	16.1	16.9	22.5	33.2
Alcohol use and hazardous drinking	8.5	9	10	14.3
Insufficient intake of fruit and vegetables	4.5	4.9	6.9	11.1
Insufficient physical activity	5.2	5.4	6.7	9.8
Illegal drug use	4.91	4.85	4.7	4.4

(For more information, please see note 1 below)

Measure	Target	Results
At least 85% of new in the Well Child/ Tamariki Ora (WCTO) programme	Greater than 85%	The Ministry has supported DHBs to improve WCTO service enrolment over 2015/16 and 2016/17. Further work in 2017/18 will target improvement to access and utilisation of WCTO services for vulnerable children and their families/whānau

Percentage of new babies enrolled with Well Child/Tamariki Ora programme

	2016/17	2015/16	2014/15
Percentage	89.0%	88.3%	87.1%

Measure	Target	Results
Daily smoking prevalence falls to 10% by 2018 and Māori and Pacific rates halve from their 2011 levels as part of Smokefree 2025	Prevalence less than 10% Targeted reduction Māori greater than 50% Pacific greater than 50%	The rate of smoking prevalence across the whole population is reducing. However, Māori and Pacific smoking rates have not seen the same level of reduction and the Ministry continues to focus on reducing smoking in these population groups.

Daily[6] smoking prevalence (15 years and over)

	2015/16[7]	2014/15	2013/14	2012/13
Total population	14.2%	15.0%	15.7%	15.6%
Māori	35.5%	35.5%	37.8%	36.2%
Pacific peoples	22.8%	22.4%	22.9%	22.0%

6 Daily smokers (adults aged 15+ years) smoke every day, and have smoked more than 100 cigarettes in their whole life. The 100-cigarette threshold limits the indicator to people with established tobacco use.

7 Most recent results available. Source: https://minhealthnz.shinyapps.io/nz-health-survey-2015-16-annual-update/

Measure	Target	Results			
B4 School Check is provided to 90% of the eligible population	90%	The purpose of the B4 School Check is to promote health and wellbeing in 4-year-olds, and to identify any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school. **Percentage of B4 School Checks provided to eligible population**			
			2015/16	**2015/16**	**2015/16**
		Percentage of eligible population	94%	92%	92%
Suicide rates decline for all ages	Reduced	The Ministry continues to focus on reducing suicide rates and have consulted the public on the draft suicide prevention strategy. Nearly 500 submissions were received and these are being analysed to help develop the future strategy. **Suicide rates (per 100,00 population)**			
			2014[8]	**2013**	**2012**
		15–24 years of age	13.9	17.8	23.0
		25–44 years of age	16.2	14.2	15.8
		45–64 years of age	14.0	16.0	13.1
		65+ years of age	9.5	8.9	9.5

Note 1: The results of the burden of disease and health surveys are improved

Behavioural factors, including poor diet, insufficient physical activity, and use of alcohol and tobacco, as well as the consequences of these behaviours, such as high BMI, blood glucose, and cholesterol are the leading causes of health-loss (measured by Disability Adjusted Life Years) in New Zealand. The major health conditions contributing to health loss include coronary heart disease, respiratory conditions including chronic obstructive pulmonary disease (COPD), depressive disorders, and transport-related injuries. This is consistent with a global trend, known as the epidemiological transition, whereby the leading causes of death and disability are shifting away from infectious causes, and towards chronic conditions. Risk factors are cumulative: in general, the more risk factors present in a person's life, the poorer that person's health outcomes are likely to be over time. Multiple risk factors in one person are associated with earlier and more rapid development of a condition, more complications and recurrence, a greater health loss and disease burden, and a greater need for management of a condition.

8 This is the provisional result for 2014. Time for inquiry and further analysis of case files is required to finalise results for 2014 Source: http://www.health.govt.nz/publication/suicide-facts-2014-data. In 2014, 504 people died by suicide in New Zealand, which equates to an age-standardised rate of 10.7 per 100,000. Data is based on figures for a calendar year.

Impact 2: Health and disability services are closely integrated with other social services, and health hazards are minimised

Measure	Target	Results
The annual influenza programme of 1.2 million influenza vaccins is delivered	1.2m	Influenza is a significant public health issue in New Zealand. Each year it has a large impact on our community, with 10-20% of New Zealanders infected. **Number of vaccines delivered**

	2016/17	2015/16	2014/15
Number of vaccines delivered	1.2m	1.2m	1.2m

Measure	Target	Results
Health and disability services are closely integrated with other social services	Integrated	In Progress: The Ministry has collaborated with other social services on programmes including Whānau Ora, Healthy Homes and Vulnerable Children. The Ministry will continue to work with other social service agencies and providers support programmes designed to deliver against Government and Better Public Services priorities
The incidence of rheumatic fever rates is reduced by two-thirds to 1.4 cases per 100,000 people by June 2017.	1.4 cases per 100,000 people by June 2017	Rheumatic fever is a serious but preventable illness. The Rheumatic Fever Prevention Programme (RFPP) has made progress around reducing the incidence of rheumatic fever (For further information please refer Note 2 below.) **Rheumatic Fever rates per 100,000 population**

	2016/17	2015/16	2014/15
Rate	3.2	2.4	3.0

Note 2: The incidence of rheumatic fever rates is reduced by two-thirds

Although the five year (2012–2017) BPS target to reduce rheumatic fever was not met, by June 2017, rheumatic fever had reduced nationally by 16 percent from 2012 to 3.2 cases per 100,000 population in the 2016/17 financial year. This decrease was driven by a 34 percent decrease in rheumatic fever cases among Māori nationally. Although the Rheumatic Fever Prevention Programme (RFPP) has ended, the Ministry continues to work with all 11 DHBs with a high incidence of rheumatic fever (and in particular, the Auckland region DHBs where the majority of cases are) to ensure a continued focus on reducing rheumatic fever rates.

Impact 3: The public can access quality services that meet their needs in a timely manner, where they need them

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td>Infant mortality rates continue to decrease from a baseline of 4.8 deaths per 1,000 live births in 2009</td><td>Decrease</td><td>Infant mortality continues to be an area of focus for the health sector. In particular there is a sustained focus on reducing early neonatal deaths through improvements in maternity care, and reducing Sudden and Unexpected Death in Infancy (SUDI) and Suden Infant Death Syndrome (SIDS).[9]
Infant mortality rates per 1000 live births
<table>
<tr><th></th><th>2014 (provisional)</th><th>2013</th><th>2009</th></tr>
<tr><td>Māori</td><td>7.2</td><td>5.3</td><td>7.4</td></tr>
<tr><td>Pacific peoples</td><td>7.1</td><td>7.6</td><td>6.0</td></tr>
<tr><td>Asian</td><td>5.0</td><td>4.1</td><td>3.4</td></tr>
<tr><td>Other</td><td>4.6</td><td>4.4</td><td>4.2</td></tr>
<tr><td>Total</td><td>5.7</td><td>5.0</td><td>5.2</td></tr>
</table></td></tr>
<tr><td>Serious and sentinel (adverse) events reduce from a baseline of 374 in 2009/10[10]</td><td>Reduce</td><td>The increase in results from the baseline in 2009/10 reflects significant progress across our health sector to improve the quality and consistency of voluntary serious and sentinel (adverse) events reporting to the Health Quality and Safety Commission New Zealand.
Serious and sentinel events
<table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th>2014/15</th></tr>
<tr><td>General events</td><td>543</td><td>520</td><td>525</td></tr>
<tr><td>Mental health events</td><td>206</td><td>185</td><td>185</td></tr>
</table></td></tr>
<tr><td>There is reduced amenable mortality[11]. The amenable mortality rate measures premature deaths (deaths of people aged under 75) from causes that the health system could potentially have prevented.</td><td>Reduce</td><td>The age standardised amenable mortality rate declined from 144.9 deaths per 100,000 in 2000 to 92.8 deaths per 100,000 in 2013 (reflecting a 36% reduction). This shows that the health system has been successful in reducing amenable mortality. Although the overall rate of amenable mortality is declining, disparities between ethnicities remain.
Amenable mortality rates: deaths per 100,000 population[12]
<table>
<tr><th></th><th>2013</th><th>2010</th><th>2005</th><th>2000</th></tr>
<tr><td>Deaths per 100,000 population</td><td>92.8</td><td>103.7</td><td>119.2</td><td>144.9</td></tr>
</table></td></tr>
</table>

9 The number of fetal and infant deaths in New Zealand is small and may cause rates to fluctuate markedly from year to year. Rates derived from small numbers should be interpreted with caution.

10 Source: www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/

11 Source: Health and Independence Report 2016. http://www.health.govt.nz/publication/health-and-independence-report 2016

12 The latest finalised results available are from 2013. The result reported in 2015/16 shows 2013 provisional results of 92.6% and have been finalised as 92.8%

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td>The service quality score for public services (including health services) continues to improve[13]

The annual Service Quality Scores (SQS) collected in the Kiwis Count survey[14] measure New Zealanders' satisfaction with a range of commonly used services. This includes two health services measures: use of the 0800 health service and receiving outpatient services.</td><td>Overall SQS for public services continues to improve.

SQS for health services (0800 health services phone line and outpatient services) continues to improve.</td><td>The Ministry and the wider health sector are actively engaged in a range of local and national initiatives to make gains in the areas identified in the Kiwis Count survey as being less satisfactory.

Overall SQS for the public sector (including health services)
<table>
<tr><th></th><th>2016</th><th>2015</th><th>2012</th><th>2007</th></tr>
<tr><td>Score</td><td>74</td><td>75</td><td>72</td><td>68</td></tr>
</table>
SQS for using 0800 phone line health information
<table>
<tr><th></th><th>2016</th><th>2015</th><th>2012</th><th>2007</th></tr>
<tr><td>Score</td><td>74%</td><td>79%</td><td>70%</td><td>67%</td></tr>
</table>
SQS for receiving outpatient services
<table>
<tr><th></th><th>2016</th><th>2015</th><th>2012</th><th>2007</th></tr>
<tr><td>Score</td><td>72%</td><td>75%</td><td>73%</td><td>69%</td></tr>
</table></td></tr>
</table>

Note 3: The service quality score for public services (including health services)

The overall Service Quality Score for public sector services has increased six points from 68 in 2007 to 74 in 2016. However, the 2016 result shows a levelling off, with a decrease of one point from 2015 which is an outlier compared to the overall trend. The Service Quality Scores for two health services have increased since 2007; using an 0800 number for health information, and receiving outpatient services. The scores decreased in 2016 from 2015, after record high levels in 2015.

13 This replaces the measure 'overall quality score in the health group continues to improve' due to the Kiwis Count Survey results provides overall quality for public services, including health services but are not specific for the health group.

14 State Services Commission – Kiwis Count Survey. http://www.ssc.govt.nz/kiwis-count

Impact 4: Personalised and integrated support services are provided for people who need them

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td rowspan="3">There is a reduced incidence of falls</td><td rowspan="3">Reduction of in hospital falls that result in a fracture</td><td>Falls continues to be an important focus area and the Ministry is working with partners across the wider social sector on falls prevention programmes.
Falls that result in a fractured neck of femur (hospital)</td></tr>
<tr><td><table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th>2014/15</th><th>2013/14</th></tr>
<tr><td>Number of falls</td><td>77</td><td>65</td><td>88</td><td>92</td></tr>
</table></td></tr>
<tr><td></td></tr>
<tr><td rowspan="8">The prevalence of people in the 65-plus-years age group with a dependent disability has reduced.
The measure has been redefined as follows: a reduction in the proportion[15] of older people requiring residential care; and rate of acute hospital use.</td><td rowspan="8">Reduced prevalence</td><td>A key focus in the health sector is on improving the independence of older people. There is good evidence that older people who continue to live in their own home – with support from home and community support service (HCSS) providers if necessary – experience greater wellbeing. The majority of older adults also prefer to stay in their own home, and this arrangement is also usually less expensive than residential care. The aim is to reduce the proportion of older people requiring residential care services.
Reduced prevalence shown through residential care</td></tr>
<tr><td><table>
<tr><th></th><th>2014/15</th><th>2014/15</th><th>2013/14</th></tr>
<tr><td>Number of older people aged 65+ requiring residential care</td><td>31,288</td><td>30,828</td><td>30,829</td></tr>
<tr><td>Number of older people aged 65+ requiring residential care</td><td>4.6%</td><td>4.6%</td><td>4.8%</td></tr>
</table></td></tr>
<tr><td>The rate of acute hospital use through bed-days is a measure of how effectively health system resources are being used. It may be affected by the quality of primary health care, discharge planning, and ongoing communication about a person's care between hospital and community care. The corresponding aim is to reduce the rate of acute hospital use.
Reduced prevalence shown through acute hospital use[16]</td></tr>
<tr><td><table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th>2014/15</th></tr>
<tr><td>Acute hospital use number of bed days for older people aged 65+</td><td>1.02m</td><td>1.04m</td><td>1.06m</td></tr>
<tr><td>Acute hospital use number of bed days per older person aged 65+</td><td>1.43</td><td>1.51</td><td>1.61</td></tr>
</table></td></tr>
<tr><td>(For further information, please refer note 4 below)</td></tr>
<tr><td></td></tr>
<tr><td></td></tr>
<tr><td></td></tr>
</table>

15 Population data sourced from: http://nzdotstat.stats.govt.nz/wbos/index.aspx

16 Results are for the 12 months ending March each year

Measure	Target	Results
Ethnic health disparities are reduced	Reduce	Reducing ethnic health disparities has remained a key focus across the health sector. The following metrics provide an indication of health disparities that have reduced as health outcomes have improved. However, challenges still exist for future improvement.

Current[17] smokers unadjusted prevalence (percentage of population) of adults aged 15 years or older, by ethnicity[18]

Ethnicity	2015/16	2013/14	2011/12	2006/07
Māori	38.6%	40.9%	40.2%	42.1%
Pacific peoples	25.5%	24.7%	25.9%	27.1%
Asian	8.7%	8.3%	9.4%	11.3%
European and other	14.5%	15.3%	16.5%	18.7%

Immunisation coverage (percentage of eligible population fully immunised for age) for infants aged 12 months, by ethnicity[19]

Ethnicity	2016	2013	2009
Māori	94%	91%	77%
Pacific peoples	97%	95%	88%
Asian	97%	96%	92%
New Zealand European	95%	94%	89%

Ambulatory Sensitive Hospitalisation (ASH) is a proxy measure of avoidable hospital admissions.

ASH (crude rate per 100,000 population by ethnicity for children aged 0-4 years old)[20]

Ethnicity	2016	2015	2014	2013	2012
Māori[21]	7,212	7,690	7,812	7,361	7,782
Pacific peoples	12,168	12,775	13,241	12,267	12,159
Other	5,690	5,505	5,995	5,467	5,686
National total[22]	6,677	6,745	7,132	6,583	6,836

ASH (age-standardised rate per 100,000 population by ethnicity for adults aged 45-64 years old)[23]

Ethnicity	2016	2015	2014	2013	2012
Māori[24]	7,002	6,913	6,972	7,108	7,305
Pacific peoples	8,963	8,730	8,954	8,737	8,876
Other	3,037	3,054	3,066	3,137	3,047
National total[25]	3,739	3,731	3,749	3,801	3,733

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td rowspan="7">The proportion of people with a K10 score greater than 12 is reduced[26].
This measures a person's experience of symptoms such as anxiety, confused emotions, depression or rage in the past four weeks. People who have a score of 12 or more have a high probability of having an anxiety or depressive disorder.</td><td rowspan="7">Reduce</td><td colspan="5">The 2015/16 New Zealand Health Survey found that 7% of adults experienced psychological distress in the four weeks before taking part in the survey. (For more details, please refer note 5).
Percentage of people with a K10 score >12</td></tr>
<tr><td></td><td>2015/16</td><td>2014/15</td><td>2013/14</td><td>2012/13</td></tr>
<tr><td>Males</td><td>5.0</td><td>4.6</td><td>5.1</td><td>5.4</td></tr>
<tr><td>Females</td><td>8.6</td><td>7.6</td><td>7.2</td><td>6.8</td></tr>
<tr><td>Total</td><td>6.8</td><td>6.2</td><td>6.2</td><td>6.1</td></tr>
<tr><td>Māori</td><td>10.5</td><td>9.6</td><td>9.5</td><td>9.7</td></tr>
<tr><td>Pacific peoples</td><td>11.3</td><td>10.2</td><td>13.0</td><td>9.4</td></tr>
</table>

Note 4: There is a reduced prevalence of people in the 65-plus-years age group with a dependent disability

In 2015/16, the number of people aged 65 and over in residential care was 31,288[27] which shows an increase of 2,138 since 2006/07 (up from 29,150). This represents a decrease in the proportion of people aged 65 and over requiring care from 5.6 percent to 4.6 percent. For people aged 75 and over there were 27,899[28] in residential care in 2015/16, an increase of 1,542 since 2006/07 (up from 26,357). This represents a decrease of the proportion of people aged 75 years and older from 11 percent to 10 percent. For people aged 75 years and over, the rate was an estimated 0.72 million bed days in the year ending March 2016. This represents an average of about 2.5 bed days per person for the year. In the year ending March 2017, the rate had fallen to 2.3 bed days per person and 0.71 million total bed days for the year.

Note 5: The proportion of people with a K10 score >12 is reduced

Prevalence of psychological distress varied by sex, age, ethnic group and neighbourhood deprivation, as follows.

- Women were more likely to have experienced psychological distress than men (the rates were 9% and 5% respectively).
- Psychological distress rates decreased with age. Less than 5% of adults aged 65 years and over experienced psychological distress in the previous four weeks. In contrast, more than 8% of adults aged 15–44 years experienced psychological distress in the past four weeks.
- One in nine Pacific and Māori adults (11%) experienced psychological distress in the past four weeks. After adjusting for age and sex differences, Pacific and Māori adults were 1.5 times as likely to have experienced psychological distress as non-Pacific and non-Māori adults respectively.
- The prevalence of psychological distress was higher in the most socioeconomically deprived neighbourhoods (11.5%), than in the least deprived neighbourhoods (3.8%). Those living in the most deprived areas were 3.1 times as likely to have experienced psychological distress as those in the least deprived areas, after adjusting for age, sex and ethnic differences.

17 Daily smokers (adults aged 15+ years) smoke every day, and have smoked more than 100 cigarettes in their whole life. The 100-cigarette threshold limits the indicator to people with established tobacco use.

18 Source: The New Zealand Health Survey. https://minhealthnz.shinyapps.io/nz-health-survey-2015-16-annual-update/

19 Source: National Immunisation Register. Published online at http://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data

20 Source: National Minimum Dataset and Statistics NZ (base population). https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive

21 Although ASH rates for Māori remain higher than for the other ethnicities and at the national total, the decrease of 520/100,000 population is greater for Māori between 2012 - 2016 compared with the rate of decline for other ethnicities at the national total.

22 The national total includes all ethnicities.

23 Source: National Minimum Dataset and Statistics NZ (base population). https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive

24 Although ASH rates for Māori remain higher than for the other ethnicities and at the national total, the decrease of 303/100,000 population is greater for Māori between 2012 - 2016 compared with the rate of decline for other ethnicities at the national total.

25 The national total includes all ethnicities.

26 Source: https://minhealthnz.shinyapps.io/nz-health-survey-2015-16-annual-update/.

27 The Aged Residential Care (ARC) numbers are derived from the Demand Planner that DHBs and providers are able to use to future demand for ARC services. Available at http://centraltas.co.nz/health-of-older-people

28 The Aged Residential Care (ARC) numbers are derived from the Demand Planner that DHBs and providers are able to use to future demand for ARC services. Available at http://centraltas.co.nz/health-of-older-people

Impact 5: Health services are clinically integrated and better coordinated

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td>DHB performance against planned integration activities</td><td>Performed planned integration activities</td><td>The DHB performance planned integration activities include shifting services closer to home, integrated acute demand planning and the development of clinical pathways.
Highlights from integration activity in 2016/17 include:
moving specialist clinics into primary health care so patients can access specialist advice through more convenient services closer to home
upskilling general practitioners (GPs) to provide procedures previously provided in the hospital setting (such as joint injections) to free up specialists to treat higher acuity patients in hospital
funding GPs to better manage specific acute conditions (such as cellulitis through IV antibiotics) to help reduce emergency department (ED) presentations
improving primary health care access to diagnostics such as ultrasounds and CAT scans, allowing patients to be diagnosed and treated sooner
giving GPs access to rehabilitation equipment for the home and respite care for the elderly, keeping people in the community care setting
improving IT support to enable improved communication between health professionals such as shared electronic patient information and patient self-management through the use of patient portals</td></tr>
<tr><td>The number of assaults on children decreases[29]</td><td>Decrease</td><td>This is a Better Public Services priority area and the Ministry is part of a cross-agency project to decrease the number of assaults on children. (For more information, please see note 6 below.)
Number of Assaults on Children<table><tr><th></th><th>2016</th><th>2015</th><th>2014</th><th>2013</th></tr><tr><td>Number</td><td>2,953</td><td>3,118</td><td>3,178</td><td>3,181</td></tr></table></td></tr>
<tr><td>Personal health information is readily available to patients and clinicians no matter where the care is delivered</td><td>Readily available</td><td>In progress:
Sector and regional systems have been established and work is in progress to explore options for a National Electronic Health Record platform to give patients and clinicians access to health information from sector systems in a secure and timely manner. (For more details about progress made in certain sectors and regional systems, see note 7 below.)</td></tr>
</table>

Note 6: The number of assaults on children decreases

The Ministry, working with DHBs, Police and Ministry for Vulnerable Children, Oranga Tamariki, provides for an alert system designed to ensure child welfare concerns are suitably identified, assessed, recorded and report thought the correct channels to allow the appropriate agency to take actions. Concerns raised by DHBs, and other medical practitioners, will generate a flag for the child's medical file, and those of any siblings. For the 2016/17 year there were 8,462 new alerts generated across New Zealand.

29 State Services Commission: http://www.ssc.govt.nz/bps-supporting-vulnerable-children

Note 7: Personal health information is readily available to patients and clinicians
Over 400,000 New Zealanders now have access to their personal health information via a patient portal, and the number continues to grow steadily. All DHBs use clinical workstations to provide shared access to health information for health care providers. The South Island has implemented HealthOne, a portal that brings together patient data for a range of health care providers in hospitals and community care settings in all DHBs.

The National Enrolment Service (NES) has been implemented in general practices and provides a 'single source of truth' for all national enrolment and identity data. A National Maternity Record, that allows sharing of maternity information in hospitals and the community, is being implemented and is in use in five DHBs.

Impact 6: The health and disability system is supported by suitable infrastructure, workforce and regulatory settings

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td rowspan="4">The are 5,000 postgraduate trainees and 1,900 training units</td><td rowspan="4">5000 & 1900</td><td>The Ministry has continued to support the development of the health sector workforce through training programmes.
Number of postgraduate trainees and training units</td></tr>
<tr><td><table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th>2014/15</th></tr>
<tr><td>Post graduate trainees</td><td>5,618</td><td>5,587</td><td>5,369</td></tr>
<tr><td>Training units</td><td>2,149</td><td>1,888</td><td>1,826</td></tr>
</table></td></tr>
<tr><td rowspan="2">Health-related legislation is reviewed and updated as required</td><td rowspan="2">Reviewed and updated</td><td>The Ministry continues to monitor, review and update health legislation as required. (For details on this year's legislation review, please refer note 8 below.)
Health-related legislation reviewed and updated</td></tr>
<tr><td><table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th>2014/15</th></tr>
<tr><td>Result</td><td>Achieved</td><td>Achieved</td><td>Achieved</td></tr>
</table></td></tr>
<tr><td>Integrated IT and security programmes are delivered</td><td>Delivered</td><td>In progress
Digital Health 2020, overseen by the Ministry is working to ensure local, regional and national digital systems are integrated and able to share information across the hospital, primary health care and community sectors.</td></tr>
</table>

Note 8: Health related legislation is reviewed and updated as required
Significant updates to health related legislation include work to replace statutory references to medical practitioners which resulted in eight amendment Acts given Royal Assent on 7 November 2016. The amendments allow suitably qualified health practitioners, including medical practitioners, to perform certain functions – such as issuing sickness certificates. The objective of the work is to make best use of the highly qualified health practitioner workforce and facilitate the provision of timely and efficient services.

Impact 7: quality, efficiency and value for money improvements are enhanced

<table>
<tr><th>Measure</th><th>Target</th><th>Results</th></tr>
<tr><td>DHBs forecasted deficits reduce from a baseline of $23.4 million in 2011/12</td><td>Reduce deficit</td><td>Costs have increased since baseline 2011/12 and the Ministry continues to work with DHBs where appropriate to improve financial performance. (For more details, please see note 9 below.)
DHB forecast deficits
<table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th>2014/15</th></tr>
<tr><td>Deficit</td><td>-$118.9m</td><td>-$55m</td><td>-$68m</td></tr>
</table></td></tr>
<tr><td>DHBs manage within their budgets (collectively)</td><td>Within budgets</td><td>The Ministry has continued to work closely with DHBs to manage individual budgets and collective financial performance. (For more details, please see note 10 below.)</td></tr>
<tr><td>NZ Health Partnerships Limited is established</td><td>Established</td><td>Completed:
NZ Health Partnerships Limited was established 01 July 2015. An independent stakeholder survey conducted in mid-2016 assessed NZ Health Partnerships as well aligned with DHBs.</td></tr>
<tr><td>Ministerial advisory committees' are supported</td><td>Supported</td><td>The Ministry has continued to support advisory committees' and the overall satisfaction with the support provided has remained at an average rating of 4.1 over the last three years.
Committees overall satisfaction with support
<table>
<tr><th></th><th>2016/17</th><th>2015/16</th><th>2014/15</th></tr>
<tr><td>Satisfaction rating</td><td>4.4</td><td>3.9</td><td>4.1</td></tr>
</table></td></tr>
</table>

Note 9: DHB forecast deficits reduced from a baseline of $23.4 million in 2011/12
District Health Boards continue to face increasing cost pressures in areas such as personnel costs, increased use of outsourced services and higher clinical supplies expenses arising from increased acuity and growing demand. A number of significant events have occurred since the baseline was set in 2011/12 which has added cost pressures to DHB budgets (e.g. earthquakes). The Ministry continues to work with DHBs where appropriate to improve financial performance.

Note 10: DHBs manage within their budgets (collectively)
District Health Boards continue to face increasing cost pressures in areas such as personnel costs, increased use of outsourced services and higher clinical supplies expenses arising from increased acuity and growing demand. A number of significant events have occurred since the baseline was set in 2011/12 which has added cost pressures to DHB budgets (eg, earthquakes). The Ministry continues to work with DHBs where appropriate to improve financial performance.

Appendix 2: System Level Measures

The System Measures Level (SLM) Framework commenced from July 2016. SLMs focus on continuous quality improvement as a catalyst to drive health system integration and collaboration. The SLMs have a specific focus on equity, young children, youth and vulnerable populations.

Mirroring the New Zealand Health Strategy's themes of one team, people-powered and smart systems, SLMs provide a mechanism for DHBs, through their district alliances, to work with their primary, secondary and community care providers to improve the health outcomes of their local populations.

Sector involvement in the development of the SLMs, along with a focus on clinically led quality improvement and equity has ensured strong sector and clinical support for the SLMs.

Four SLMs were implemented in July 2016 (refer to figure A2.1):

- ambulatory Sensitive Hospitalisation rates for 0–4 year olds
- acute hospital bed days per capita
- patient experience of care – made up of inpatient and primary care patient experience surveys
- amenable mortality rates.

Each SLM includes: improvement milestones, with a particular focus on Māori and reducing equity gaps; specific activities to drive the improvement milestones; and contributory measures[30]

Figure A2.1: Ministry of Health system level measures

Ambulatory sensitive hospitalisations (ASH) rates per 100,000 children aged 0–4 years (ie, keeping children out of hospital)	
6,789 per 100,000 national mean	Expected trend ↓
Total acute hospital bed days per capita (ie, using health resources effectively)	
413.4 per 1,000 population national meaning	Expected trend ↓
Patient experience of care, measured across four domains via patient survey	
Communication National mean **8.3** (patient score out of 10)	Expected trend ↑
Partnership National mean **8.4** (patient score out of 10)	Expected trend ↑
Coordination National mean **8.4** (patient score out of 10)	Expected trend ↑
Physical and emotional needs National mean **8.4** (patient score out of 10)	Expected trend ↑
Amenable mortality (ie, prevention and early detection)	
90.8 per 100,000 population national mean	Expected trend ↓

30 Contributory measures are front line service measurements of health processes or activity that are tangible and clinically meaningful and can be found in the Measures Library (www.hqmnz.org.nz).

Appendix 3: Legal and regulatory framework

Additional statutory reporting requirements

The Minister of Finance has not specified any additional reporting requirements.

Health Act 1956

The Health Act 1956 requires the Director-General of Health to report annually on the current state of public health. A Health and Independence Report is tabled each year in Parliament by the Minister of Health. The Minister is required to table the report by the twelfth sitting day of the House of Representatives after the date on which the Minister received the report. The Act also requires the Director-General to report before 1 July each year on the quality of drinking-water in New Zealand. Copies of the most recent report are made available to the public through the Ministry's website.

New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability Act 2000 requires the Minister of Health to report annually on the implementation of the New Zealand Health Strategy, the New Zealand Disability Strategy and the National Strategy for Quality Improvement. The Minister must make the report publicly available and present it to the House of Representatives as soon as practicable after the report has been made.

Public Finance Act 1989

Section 19B of the Public Finance Act 1989 requires the Minister of Health to report annually on non-departmental expenditure relating to health sector agencies other than Crown entities. The Vote Health Report, in relation to selected non-departmental appropriations for the year ended 30 June 2017, will be tabled in Parliament by the Minister of Health within four months of the end of the financial year (by the end of October) or, if parliament is not in session, as soon as possible after the commencement of the next session of Parliament. Copies of the report will be made available to the public through the Ministry's website.

Other legislation

Other reporting requirements relate to the following legislation:

- Disabled Persons Community Welfare Act 1975
- Health (Drinking Water) Amendment Act 2007
- Health Research Council Act 1990
- Human Assisted Reproductive Technology Act 2004
- Social Security Act 1964

Legislation the Ministry administers

- Alcoholism and Drug Addiction Act 1966
- Burial and Cremation Act 1964
- Cancer Registry Act 1993
- Care and Support Workers (Pay Equity) Settlement Act 2017
- Disabled Persons Community Welfare Act 1975 (Part 2A)
- Epidemic Preparedness Act 2006
- Health Act 1956
- Health and Disability Commissioner Act 1994
- Health and Disability Services (Safety) Act 2001
- Health Benefits (Reciprocity with Australia) Act 1999
- Health Benefits (Reciprocity with the United Kingdom) Act 1982
- Health Practitioners Competence Assurance Act 2003
- Health Research Council Act 1990
- Health Sector (Transfers) Act 1993
- Home and Community Support (Payment for Travel between Clients) Settlement Act 2016
- Human Assisted Reproductive Technology Act 2004 (in conjunction with the Ministry of Justice)
- Human Tissue Act 2008
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Medicines Act 1981
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Misuse of Drugs Act 1975
- New Zealand Public Health and Disability (Southern DHB) Elections Act 2016
- New Zealand Public Health and Disability Act 2000
- Psychoactive Substances Act 2013
- Radiation Safety Act 2016
- Smoke-free Environments Act 1990
- Social Security (Long-term Residential Care) Amendment Act 2006
- Substance Addiction (Compulsory Assessment and Treatment) Act 2017

Other regulatory roles and obligations

In addition to administering legislation, key personnel within the Ministry (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions under various pieces of legislation.

- Biosecurity Act 1993
- Civil Defence Emergency Management Act 2002
- Education Act 1989
- Food Act 2014
- Gambling Act 2003
- Hazardous Substances and New Organisms Act 1996
- Local Government Act 1974
- Local Government Act 2002
- Maritime Security Act 2004

- Prostitution Reform Act 2003
- Sale and Supply of Liquor Act 2012
- Social Security Act 1964
- Victims' Rights Act 2002
- Waste Minimisation Act 2008.

International compliance

The Ministry helps the Government to comply with certain international obligations by supporting and participating in international organisations such as the World Health Organization. The Ministry also ensures New Zealand complies with particular international requirements, such as the International Health Regulations (2005) and the Framework Convention on Tobacco Control, and a range of United Nation conventions.

Regulations administered by the Ministry can be accessed on the Ministry website: www.health.govt.nz.

Full, searchable copies of the Acts and associated regulations administered by the Ministry can be found at: www.legislation.govt.nz.

Appendix 4: Section 11 committees

Section 12(5) of the New Zealand Public Health and Disability Act 2000 requires that, in every Annual Report, the Ministry must specify the name, chairperson and members of all committees established under Section 11 of the Act[31]. This appendix fulfils that requirement.

Cancer Control New Zealand

Cancer Control New Zealand was disestablished in August 2015 because of the progress made in improving cancer services for New Zealanders.

Health Workforce New Zealand

Professor Des Gorman (Chair)

Ms Helen Pocknall (Deputy Chair)

Mrs Gloria Crossley

Dr David Kerr

Ms Stella Ward

Ms Sally Webb

Professor Tim Wilkinson

Dr Andrew Wong

National Health Board

The National Health Board was disestablished in March 2016 following an independent review as part of the development of the refreshed New Zealand Health Strategy.

National Health Committee

The National Health Committee was disestablished in March 2016 and their functions streamlined into the Ministry of Health.

Northern A Health and Disability Ethics Committee

Dr Brian Fergus (Chair)

Dr Karen Bartholomew

Ms Toni Millar

Dr Catherine Jackson

Ms Rosemary Abbott

Dr Kate Parker (appointed November 2015)

Dr Christine Crooks

Ms Rochelle Style

31 Section 11 committees are not DHB or Crown entity boards

Northern B Health and Disability Ethics Committee

Ms Kate O'Connor (Chair) (appointed December 2015)

Mrs Leesa Russell (appointed December 2015)

Mrs Mali Erick

Jane Wylie

Mrs Phyllis Huitema (to May 2017)

Miss Tangihaere Macfarlane (appointed May 2017)

Mrs Stephanie Pollard

Mr John Hancock

Dr Nora Lynch

Central Health and Disability Ethics Committee

Mrs Helen Walker (Chair)

Dr Cordelia Thomas

Sandy Gill

Dr Patries Herst

Dr Dean Quinn

Dr Peter Gallagher

Dr Angela Ballantyne

Dr Melissa Craig

Southern Health and Disability Ethics Committee

Ms Raewyn Idoine (Chair)

Dr Sarah Gunningham

Dr Nicola Swain

Dr Devonie Eglinton

Dr Mathew Zacharias

Dr Mira Harrison-Woolrych

Dr Fiona McCrimmon

Ethics Committee on Assisted Reproductive Technology

Ms Iris Reuvecamp (Chair)

Dr Deborah Payne (resigned 2017)

Dr Freddie Graham

Dr Carolyn Mason

Ms Jo Fitzpatrick

Dr Paul Copland

Ms Michele Stanton

Mrs Judith Venning Charlton

Mary Birdsall (appointed 2017)

Advisory Committee on Assisted Reproductive Technology

Gillian Ferguson (Chair)

Michael Legge (Deputy Chair)

Jonathan Darby

Kathleen Logan

Sue McKenzie

John McMillan

Catherine Poutasi

Barry Smith

Dr Sarah Wakeman (appointed June 2017)

Colin Gavaghan (appointed June 2017)

National Ethics Advisory Committee[32]

Neil Pickering (Deputy Chair September 2016)

Julian Crane

Adriana Gunder

Maureen Holdaway

Fiona Imlach

Monique Jonas

Kahu McClintock

Wayne Miles

Liz Richards

Hope Tupara

Dana Wensley

Capital Investment Committee

The Capital Investment Committee (CIC) is a section 11 committee which provides advice to the Ministers of Health and Finance on the prioritisation and allocation of funding for capital investment and health infrastructure.

CIC offers a valuable source of independent advice to Ministers on multiple large scale health capital projects under way around New Zealand.

32 The National Ethics Advisory Committee was established under s16 of the New Zealand Public Health and Disability Act 2000. As such, it does not fall under the annual report requirement in s12(5).

Objectives and key tasks

The CIC provides independent advice to the Director-General of Health and the Ministers of Health and Finance on capital investment and infrastructure in the public health sector in line with Government priorities. This includes working with DHBs to review their business case proposals, prioritisation of capital investment, delivery of a National Asset Management Plan, and any other matters that the Minister may refer to it.

Current membership:

Evan Davies (Chair)

Paul Carpinter

Jan Dawson

Des Gorman

Murray Milner

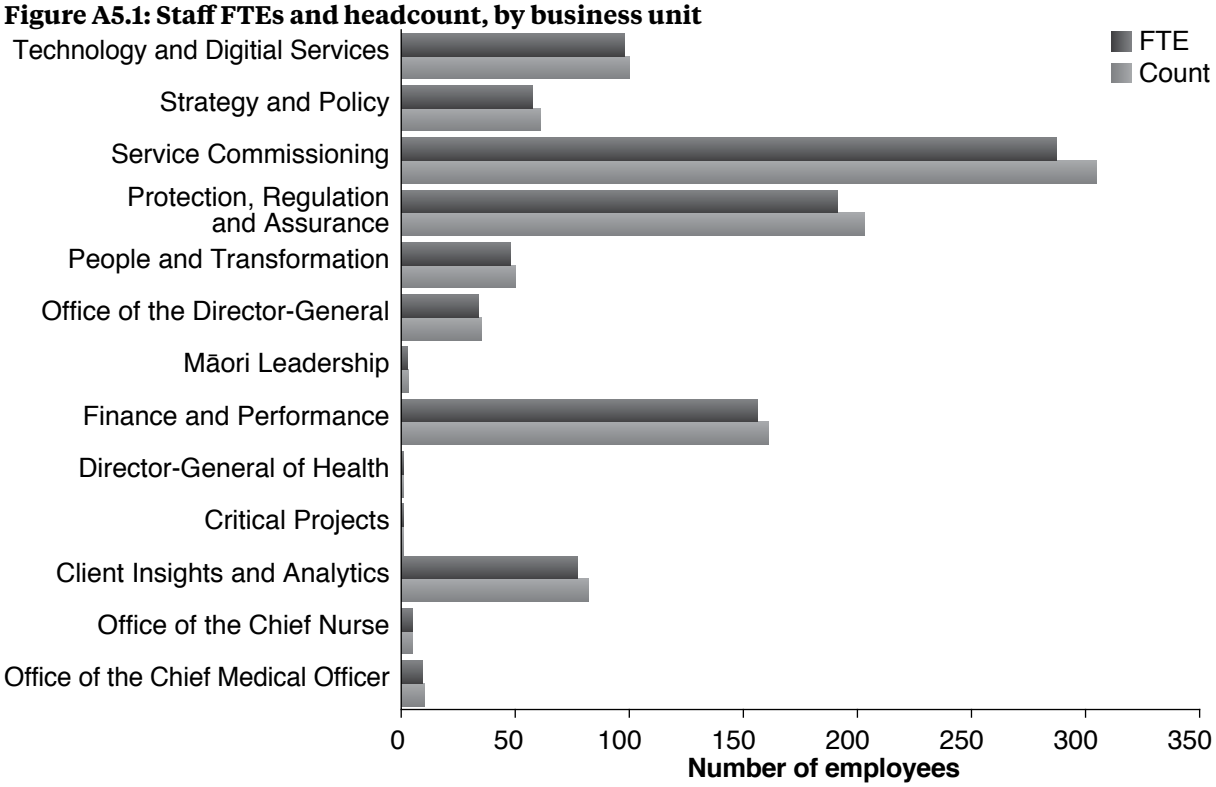
Sally Webb

Margaret Wilsher

Appendix 5: Staff information and Location

Permanent staff

Figure A5.1: Staff FTEs and headcount, by business unit



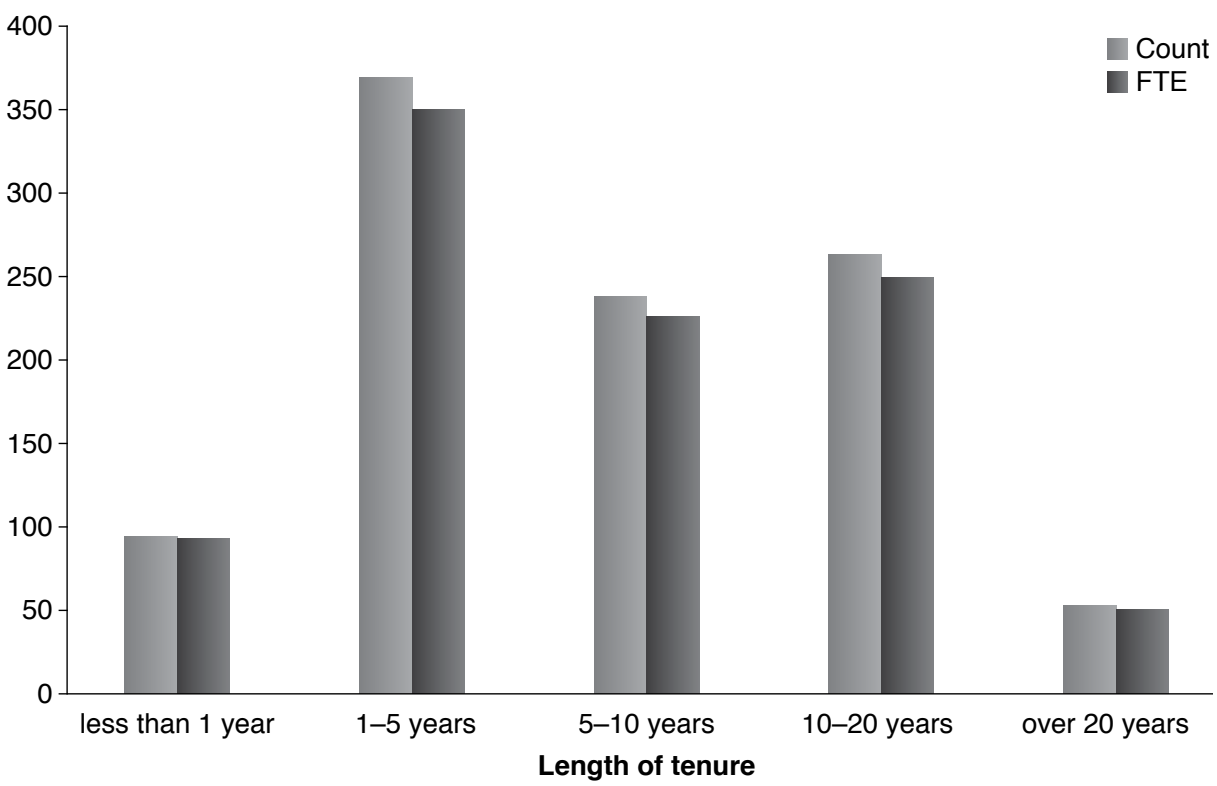
The number of permanent staff at the Ministry as at 30 June 2017 was 969 full-time equivalents (FTEs), or 1017 individuals.

Turnover

The 12-month gross rolling average turnover rate for 2016/17 was 13.60 percent, down from last year's 14.8 percent.

Length of service

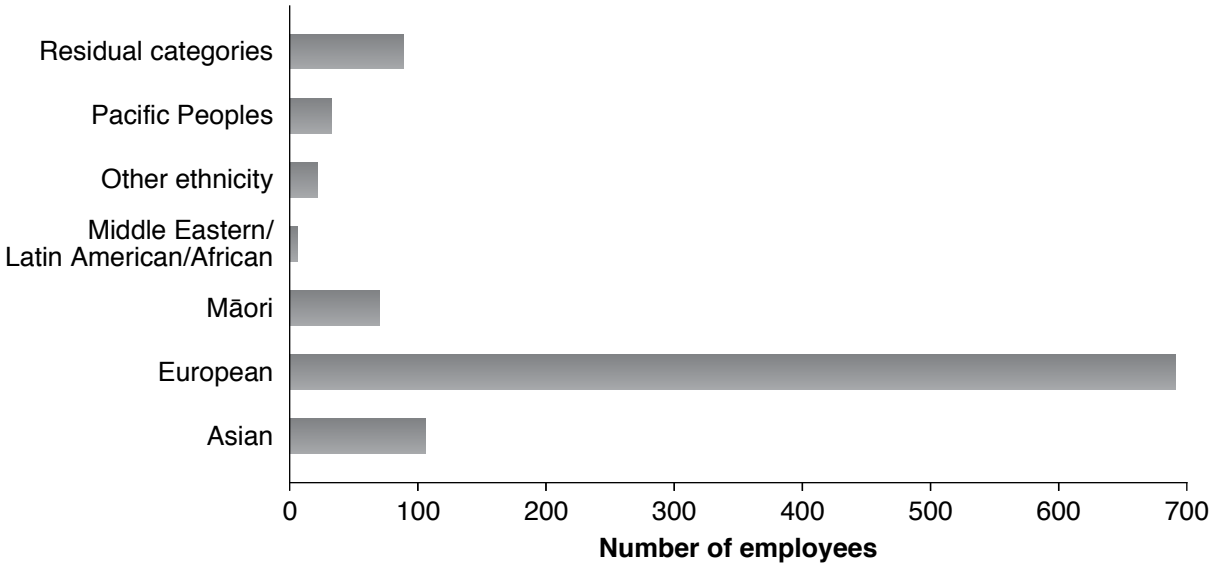
Figure A5.2: Staff numbers, by length of service



The average length of service for Ministry staff is 7.81 years.

Ethnicity

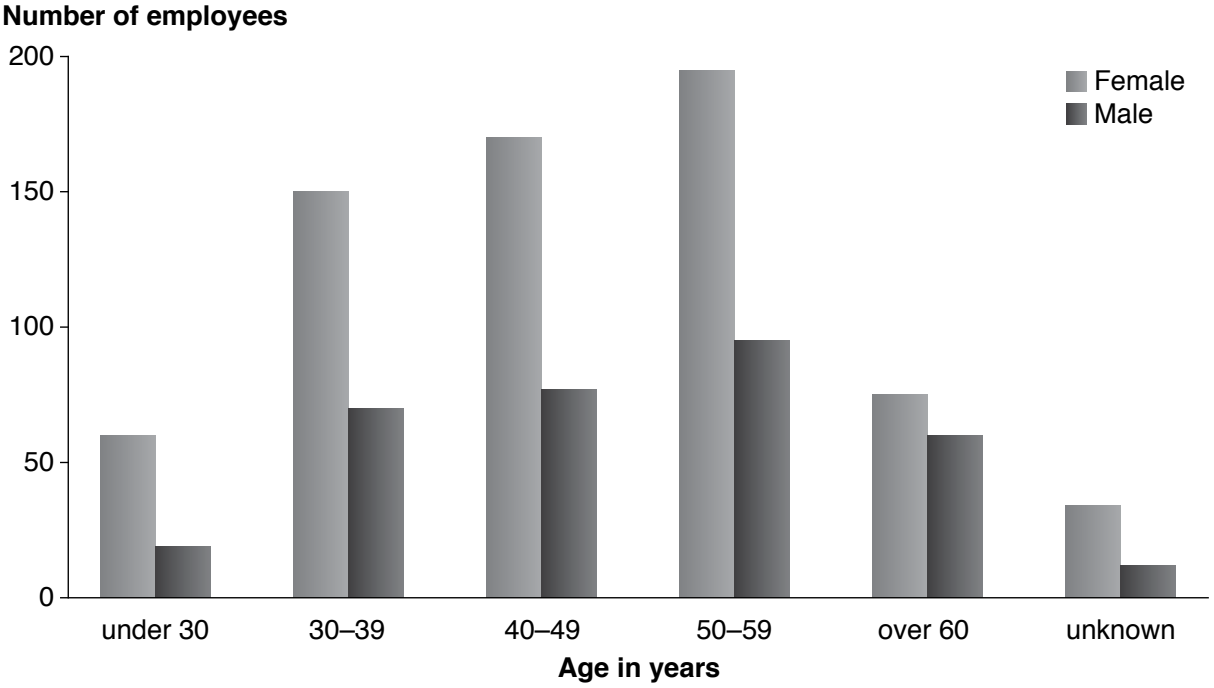
Figure A5.3: Staff ethnicity



The New Zealand European ethnic group is the most dominant group within the Ministry, at 67.94 percent, an increase of 3.94 percent from last year.

Gender and age

Figure A5.4: Staff numbers, by age group and gender



Approximately 67 percent of Ministry staff are female and 33 percent are male.

Figure A5.5: Gender proportion, by age group

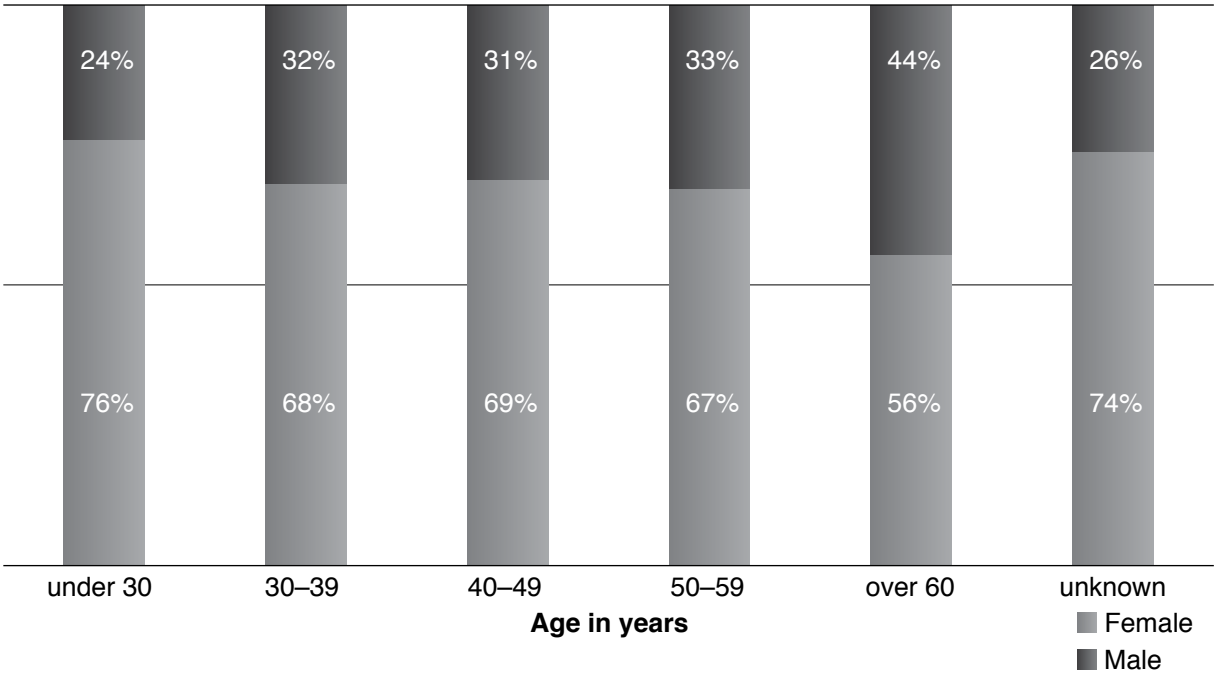
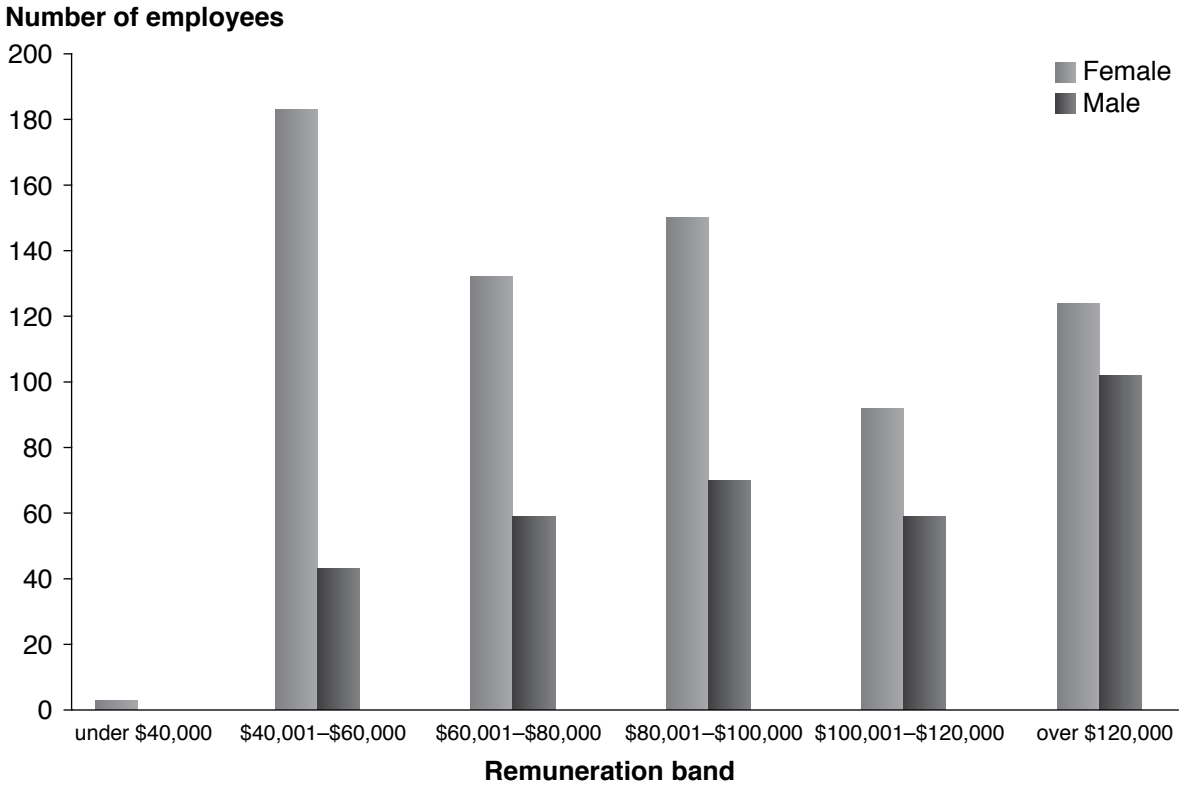


Figure A5.6: Gender and remuneration



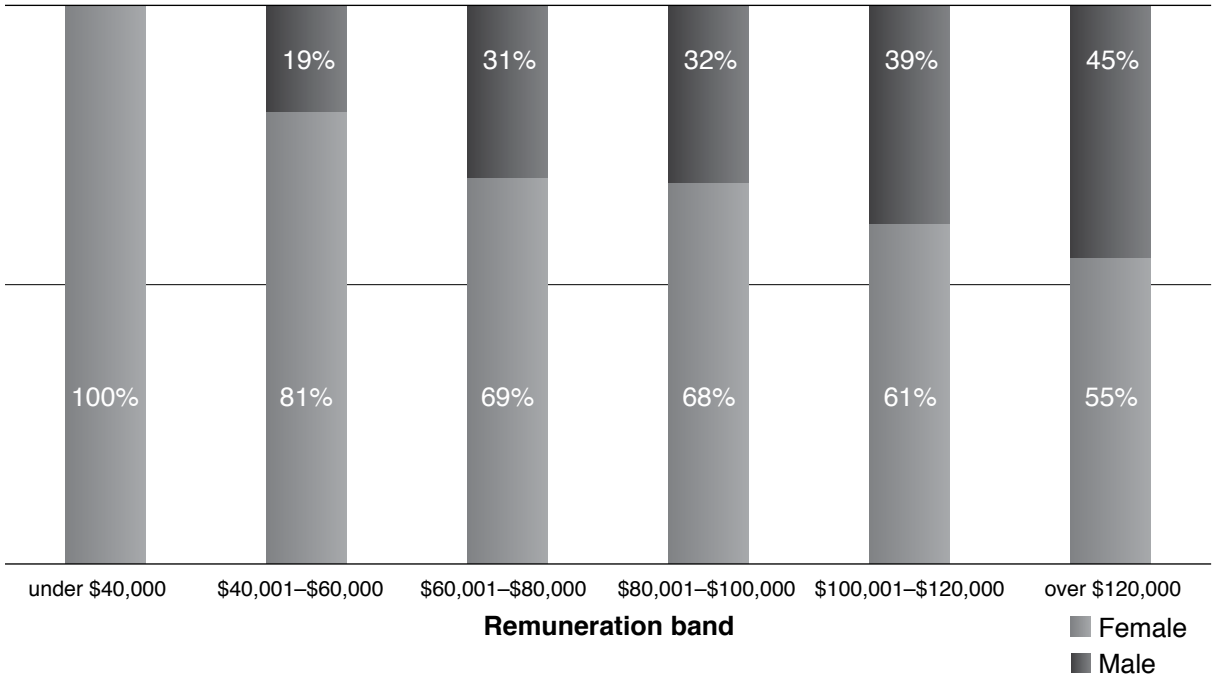
Salary

The average salaries of Ministry staff have increased since 2015/16 from approximately $95,000 to approximately $96,000. This is an increase of 1 percent.

Approximately 37 percent of staff are paid over $100,000 and there is approximately a $19,933 difference between the average salaries paid to male and female staff ($108,442 for male staff and $88,509 for female staff). There are a number of potential factors relating to this difference. A major influence is that more female staff work part time.

The Ministry is an equal employment opportunity employer. The Ministry's remuneration policy ensures that all roles in the Ministry are evaluated using a recognised methodology and that salary bands are set accordingly, ensuring all employees, regardless of their age, gender or ethnicity, are rewarded on an appropriate salary scale.

Figure A5.7: Gender proportion, by salary band



Staff location

Ministry of Health permanent staff are located throughout the country, with the highest concentration of numbers in Wellington.

Figure A5.8: Staff location by headcount