

Annual Report for the year ended 30 June 2018

Ministry of Health

Presented to the House of Representatives pursuant
to section 44 of the Public Finance Act 1989

Citation: Ministry of Health. 2018. *Annual Report for the Year Ended 30 June 2018: Ministry of Health*. Wellington: Ministry of Health.

Published in October 2018 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-98-853992-8 (print)
ISBN 978-1-98-853993-5 (online)
HP 6932



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Director-General's overview

Kia ora koutou katoa

I am pleased to present the Ministry of Health's 2017/18 Annual Report.

New Zealand has one of the best public health systems in the world. It's our collective challenge to ensure that the system is strong, responsive and sustainable, and ensure it meets the needs of all New Zealanders into the future.

The Ministry has a fundamental role in ensuring leadership and stewardship of the health sector and the health system. During the 2017/18 year we have strengthened this leadership through working closely and collaborating with the sector to deliver better health care, and improved and more equitable health outcomes.

Our focus is on delivering the Government's goals of a strong public health care system and improved and more equitable outcomes for New Zealanders. We have responded to the Government's 100-day plan and priorities of mental health and addictions, primary care, child wellbeing and public provision of health services to achieve more equitable health outcomes for priority population groups. Our contributions include providing analysis and policy advice to support the development and implementation of this work.

The Ministry has achieved some significant milestones during the 2017/18 year. We have worked with sector representatives, cross agency partners, and disabled people and their families to initiate a transformation of the disability support sector services; implemented workforce settlement agreements (pay equity for care and support workers); supported the Crown's response to the Waitangi Tribunal Kaupapa Inquiry into Health Services and Outcomes; implemented the National Bowel Screening Programme to five DHBs; and supported the Government response to the Havelock North Drinking-Water Inquiry.

We have also supported the Ministerial Review of the New Zealand Health and Disability System announced on 29 May 2018, which will develop recommendations to the Government for ensuring our public health service is equitable and sustainable, and delivers the health care that New Zealanders expect and deserve.

Other reviews commenced in 2017/18 will directly inform our future work programme, including the Government's Inquiry into Mental Health and Addiction, the Bowel Cancer Screening Review, the Productivity Commission Report, a review into water regulation (led by the Department of Internal Affairs), work with other government agencies and Crown entities to deliver a 'wellness approach' to the delivery of services, and the review of the 2008 Health and Disability Standards.

The State Services Commission's 2017 Performance Improvement Framework (PIF) review of the Ministry identified specific areas for improvement; in terms of both our

sector leadership and stewardship, and our own organisational performance. In response to the review, we developed an interim response, including current, short-term and medium-term initiatives to improve our performance. We are now making the changes needed to deliver that response.

As effective system stewards our focus now, and into the future, is on working closely with our colleagues across government, the wider health sector, non-government organisations (NGOs), local communities and iwi to ensure there is clear direction and commitment to delivering a sustainable and equitable health system for New Zealanders.

Ngā mihi

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

Dr Ashley Bloomfield
Director-General of Health

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Section A:

Our year in review

New Zealand has one of the best public health systems in the world. Like any effective system, ongoing improvement is needed to ensure it continues to be strong, responsive and sustainable, and ensure it can meet the needs of all New Zealanders into the future. The Ministry plays a fundamental role in achieving this.

This year, the Ministry has continued to provide leadership and stewardship of the health sector and the health system and in doing so has focused on providing more equitable health outcomes for New Zealanders. A summary of our key goals, priorities and core work is provided in Figure 1.

In addition to delivering our core services and commitments in 2017/18, we also responded to the Government's 100 day plan and priorities of mental health and addictions, primary care, child wellbeing and public provision of health services to achieve more equitable health outcomes for priority population groups.

We have delivered a number of significant milestones during 2017/18, many of which we have worked on with our wider health and disability sector peers. This has included, but is certainly not limited to:

- developing a Māori health performance story
- supporting the Crown's response to Wai 2575 Kaupapa Inquiry into Health Services and Outcomes
- implementing the Health Ageing Strategy
- implementing workforce settlement agreements
- launching free online resources aimed at getting children aged five and under to play regularly and get quality sleep
- launching a new sudden and unexpected death in infants prevention programme
- transforming the disability support sector services
- extending the National Bowel Screening Programme
- launching the first phase of online death certification for doctors and nurse practitioners
- supporting the Government response to the Havelock North drinking-water inquiry
- developing a People Plan that provides a pathway to enhance the culture, leadership and capabilities of the Ministry.

We are making good progress towards addressing the specific areas identified for improvement by the State Services Commission in our most recent Performance Improvement Framework (PIF) review. Notably, we have launched a number of short-term and medium-term initiatives to lift our performance. These include in the areas of

governance, leadership and stewardship, our relationships, the way we work, how we manage data, analytics and the voice of the customer. They also include how we manage our systems and processes, boost our culture, capability, and the sustainability of the health system. We provide further commentary about our work in this report.

Figure 1: Key goals, priorities and core work



About this report

While the Ministry is looking forward, this annual report is necessarily backward-looking. In accordance with the Public Finance Act 1989 this annual report provides a report of our performance against the commitments we made in our Statement of Strategic Intentions (SOSI) 2017–2021.

Section B:

About us

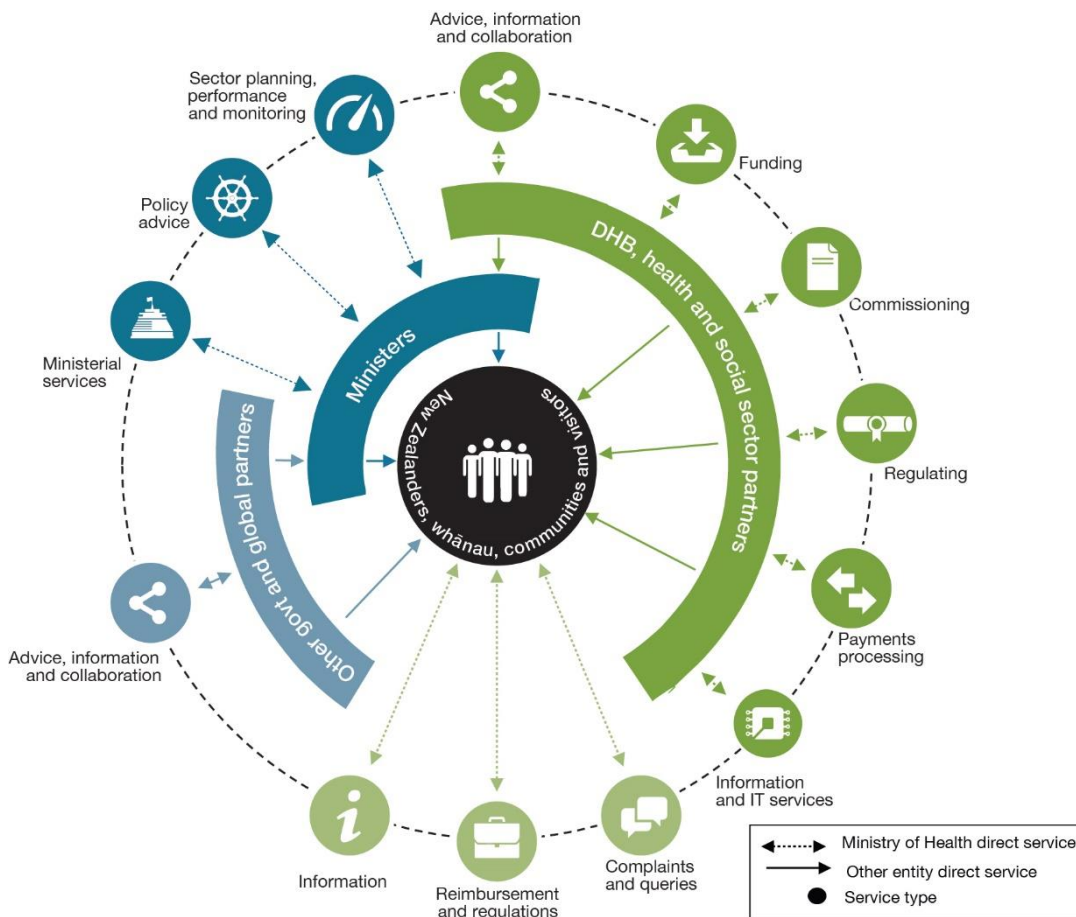
Our roles

The Ministry's core work (refer Figure 2) promotes, protects and improves the health and wellbeing of New Zealanders by:

- providing evidence-informed advice on health and disability matters to the Government, the Minister of Health, Associate Ministers of Health, and other stakeholders
- providing clinical and technical advice on a range of health and disability policies
- commissioning and monitoring a wide range of national health and disability services on behalf of the Crown
- providing advice and support to District Health Boards (DHBs) and other organisations in the health and disability sector on their planning and accountability functions
- managing national information systems and providing a payments service to support the health and disability system
- administering legislation and regulations to ensure safety of health products and services
- providing support services to committees established under statute or appointed by the Minister.

Further information about our core work can be found in Section E: Our performance.

Figure 2: What we do and the services we provide



Organisation structure, health and capability

Our organisation

The Ministry supports and advises the Minister and Associate Ministers of Health.

We work across the health and disability sector with our partners, DHBs, Crown entities and agencies, and non-governmental organisations to improve health outcomes and address health inequities for New Zealanders.

Director-General of Health

The Director-General of Health (Director-General) is the appointed chief executive of the Ministry of Health under the State Sector Act 1988. The statutory responsibilities of the Director-General are wide ranging and include:

- stewardship of the Ministry of Health, including its medium and long-term sustainability, organisational health, capability, and capacity to offer free and frank advice to ministers and successive governments
- performance of the Ministry's functions and duties including upholding of legislation administered by the Ministry
- efficient and economical delivery of the Ministry's outputs, and our contributions to the intended outcomes
- stewardship of the assets and liabilities on behalf of the Crown that are used by, or relate to, the Ministry.

The Director-General's functions, duties and powers are collectively delivered by the Ministry with roles shared across our business units.

Our business units

The Ministry has 11 business units led by an executive team leader who reports directly to the Director-General (refer Table 1).

Table 1: Our business units

Business unit	Roles
Office of the Director-General	Provides administrative support to the Director-General, ministers, the Executive Leadership Team (ELT), and the Chief Science Officer Provides ministerial services, internal and external communications, and assurance and risk management
Strategy and Policy	Provides policy advice on the health and disability system Develops strategy for the health and disability system Supports the health and disability system to implement policy and strategy
Chief Medical Officer	Provides key point of contact for clinical leadership and advice to the Ministry, ministers, and the health and disability sector Supports professional development within the Ministry and the clinical workforce
Chief Nursing Officer	Provides key point of contact for clinical leadership and advice to the Ministry, ministers, and the health and disability sector Supports professional development within the Ministry and the clinical workforce
Service Commissioning	Manages the relationships between the Ministry and health and disability service providers for funding, purchasing, performance management, commercial advice and contractual arrangements Works closely with the Strategy and Policy, and Finance and Performance units to design, plan and fund health and disability initiatives Works closely with the Protection, Regulation and Assurance unit on day-to-day operations

Business unit	Roles
Protection, Regulation and Assurance	<p>Ensures New Zealanders have a trusted, safe and effective health and disability system by:</p> <ul style="list-style-type: none"> • protecting New Zealanders from public health risks, supporting people to make healthy choices, and promoting risk management • regulating to ensure safe products, services and premises • ensuring that international and legal obligations are met <p>Works closely with the Service Commissioning unit and DHBs to ensure high quality and safe service delivery</p>
Māori Leadership	<p>Leads the Ministry's and health and disability sectors focus on improving Māori health outcomes and reducing Māori health inequalities, and acts as the poutoko manawa (backbone) for the Ministry and sector efforts to promote, protect and partner with Māori</p> <p>Builds strong relationships within the health and disability sector, and government agencies and with iwi</p>
Technology and Digital Services	<p>Provides technology and digital services to the health and disability sector and the Ministry</p> <p>Assesses the potential impact of and supports the development of existing and emerging health technology</p> <p>Works closely with Strategy and Policy, the Chief Medical Officer and the Chief Nursing Officer to develop and implement the technology and digital strategy for the health and disability sector</p>
Finance and Performance	<p>Provides financial systems and expert advice on financial performance, non-financial performance, and risk management for the health and disability system</p> <p>Manages payments to the health and disability sector</p> <p>Provides Ministry services for finance, planning, risk and assurance, audit and compliance, and portfolio management</p>
People and Transformation	<p>Provides advice on sector workforce matters</p> <p>Provides Ministry services for human resources, internal organisational strategy, facilities and business services, health and safety, and security</p>
Critical Projects	<p>Oversees and manages critical priority projects</p>

Our people

Our people are vital to building a high performing, responsive health and disability system. Accordingly we seek to attract, develop and retain people who are engaged and passionate about making contributions to our purpose and vision.

Key statistics about our people are provided in Appendix 4.

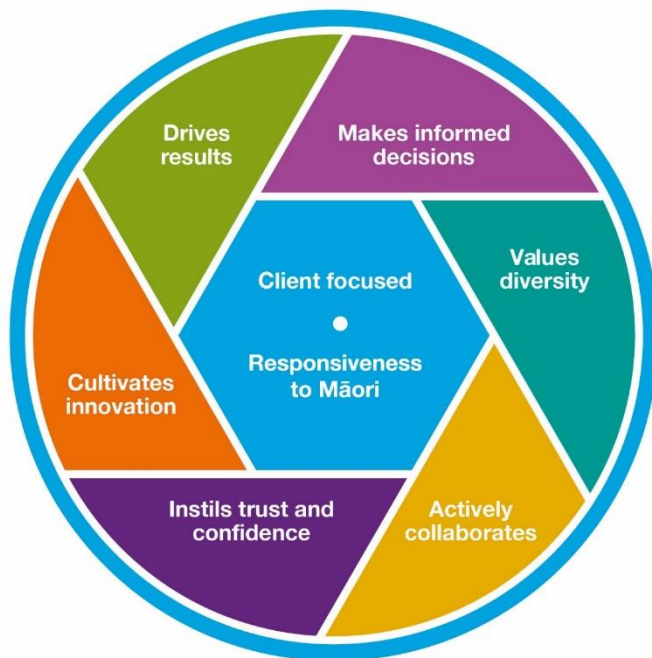
Our People Plan

During the year we developed a People Plan for the Ministry. The Plan focuses on four key areas: engaging culture; great leadership; right capability; and people excellence. The Plan provides a pathway for the Ministry to improve moving forward.

Our behaviours

Our behaviours were developed collaboratively across the Ministry and reflect how we like to work and act every day (refer Figure 3). They are formalised into our recruitment and performance management processes.

Figure 3: Our behaviours



Equal employment opportunities

The Ministry is committed to equal employment opportunities (EEO) and is committed to identifying and removing barriers that disadvantage any person or groups of

people. Our equal employment policy and hiring practices are designed to advance equality and diversity, while also ensuring appointment on merit.

Our EEO policy around diversity, inclusion and disability is incorporated into all employment agreements. It is reviewed regularly and the Director-General takes an active lead in communicating and monitoring the policy.

Diversity and inclusion

Our health and disability system needs to be inclusive for every New Zealander. We recognise health services touch the lives of every New Zealander in some way. Accordingly at the Ministry we need to be able to understand and consider a wide range of perspectives in our work. We treat people fairly and inclusively regardless of individual differences such as disability, race, ethnic origin, age, gender, sexual orientation, marital status, ethical or religious beliefs, or family responsibilities.

We are committed to the achieving diversity and inclusion goals in our workplace and articulating these in our Diversity and Inclusion Plan. During the year we engaged an independent reviewer to assess the Ministry's current state of diversity and inclusion. The review provided useful recommendations, which are being built into our Diversity and Inclusion Strategy.

Responsiveness to Māori

We are committed to improving health outcomes and achieving health equity for Māori, which will be supported through building Māori capability and capacity at the Ministry.

Our Māori Leadership group has developed two resources that outline how we can all build Āheitanga Māori (Māori capability) at the Ministry:

1. The Te Reo Māori and Tikanga Framework is a way to develop our competency in four areas (Te Reo Māori, Karakia/ Waiata, Kawa and Tikanga, and history of mana whenua and local iwi)
2. Āheitanga Māori (Māori capability), identifies four key areas (Mātau Hauora Māori, Ngā Kawa o te Manatū, Te Tūhonotanga ki ngā kaimahi and Ngā Rauemi, to help build understanding and knowledge of āheitanga Māori.

Gender pay equity

As at 30 June 2018, the Ministry's average gender pay gap, adjusted for like-for-like roles, was less than one percent. The unadjusted gap is 17 percent (compared to the average public sector gap of 12.5 percent¹) due to a high number of women in lower-paid support roles. For example, 96 percent of staff in administration roles at the Ministry are women.

¹ Available at: www.ssc.govt.nz/sites/all/files/public-service-workforce-data-2017-v2_0.pdf

The Ministry will make further improvements to close the gap by:

- incorporating gender pay equity in the Diversity and Inclusion Strategy
- providing greater visibility of gender disparity to guide decision-making
- increasing the number of women in senior leadership roles
- continuing to actively support and encourage flexible working practices
- exploring opportunities for increased flexible resourcing.

Health, safety and wellbeing

The Ministry is committed to looking after our people's health, safety and wellbeing. Our Health and Safety Policy promotes a continuous improvement approach to prevent injury and keep our people safe and well.

The Executive Leadership Team (ELT) is responsible for reviewing and approving the health and safety objectives and work programme on an annual basis. The National Health and Safety Committee consists of members from ELT and is chaired by an ELT representative appointed by the Director-General. We monitor performance and progress against our objectives regularly as part of health and safety committee meetings.

We completed our Health and Safety Transition Project in 2017/18. The purpose of the project was to ensure the Ministry's health and safety management system meets the requirements of the Health and Safety at Work Act 2015.

The project culminated in a series of workshops for health and safety representatives to:

- increase understanding of why health and safety is important in our workplace
- provide an overview of the health and safety legal requirements
- ensure representatives had an understanding of the Ministry's health and safety management system.

Protected disclosure

The State Services Commission recently communicated expectations about the ability of staff in the state services to raise their concerns without fear of punishment or reprisal through its model standards document *Acting in the Spirit of Service: Speaking up*.² In response, the Ministry published *Acting in the Spirit of Service: Speaking up at the Ministry of Health* to incorporate policies for protected disclosure.

² Available at: www.ssc.govt.nz/sites/all/files/Model%20Standards.PDF

Section C:

Our strategy

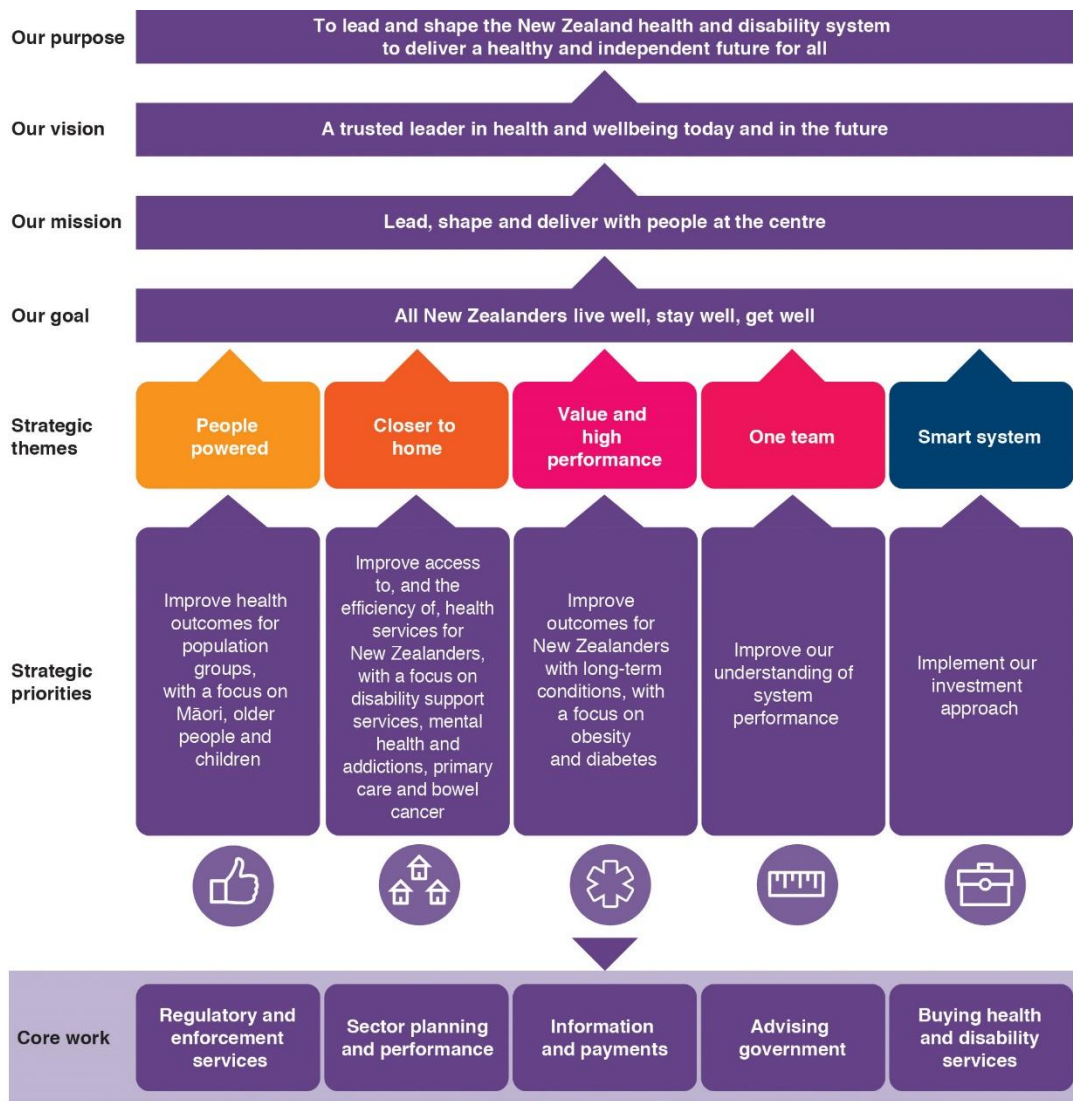
About our strategy

In April 2016, we released a refreshed New Zealand Health Strategy (the Health Strategy). The Health Strategy sets the direction for the health and disability system and outlines how, as a sector, we can work together to improve health outcomes for all New Zealanders. The Health Strategy was developed through extensive engagement with the public and in collaboration with our partners in the health, disability and social sectors.

The Ministry's SOSI sets out the outcomes we aim to achieve, the associated linkages with the themes of the Health Strategy and how, through our core work, we will support delivery of our strategic priorities (see Figure 4). Our 2017/18 performance is reported against the five strategic priorities in the SOSI:

1. improve health outcomes for population groups, with a focus on Māori, older people and children
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 care and bowel cancer
3. improve outcomes for New Zealanders with long-term conditions, with a focus on obesity and diabetes
4. improve our understanding of system performance
5. implement our investment approach.

Figure 4: Strategic architecture



Strategic priority 1: Improve health outcomes for population groups

with a focus on Māori, older people and children

The health and disability system is serving most New Zealanders well. However, some population groups experience poorer health outcomes than others. This year the Ministry has continued to work in collaboration with our partners in the health and disability sector as well as wider sectors to improve health outcomes for population groups, with a focus on Māori, older people and children.

Improving health outcomes for Māori

Health statistics show that Māori adults have higher rates of cardiovascular disease, psychological distress, arthritis, asthma, diabetes and chronic pain compared with non-Māori adults. Māori children also have higher rates of asthma, eczema and poor oral health than non-Māori children.

During 2017/18, we strengthened our strategic approach and analytical insights into health inequities for Māori and other high need demographic groups including the Pacific Island population. This provides us with a foundation for working with the sector to design models of care and implement services that will improve health outcomes and reduce health inequities.

Development of a Māori health performance story

The final draft of the Māori health performance story was completed this year. This provides a high-level assessment of Māori health using statistics around key health conditions such as heart disease, stroke, cancer, mental health and oral health, child health indicators for immunisation, and sudden and unexpected death in infants.

Primary health care

Māori encounter greater barriers to, and have greater levels of unmet need for, primary health care services than other population groups. This was the basis of the Waitangi Tribunal's Kaupapa Inquiry into Health Services and Outcomes (Wai 2575), which will hear all claims concerning grievances relating to health services and outcomes and which are of national significance.³ The Ministry collated extensive information to inform this inquiry, and will work with DHBs on the Crown's response.

³ Available at: www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/

Māori Oral Health Quality Improvement Group

The Ministry continued to support the Māori Oral Health Quality Improvement Group (QIG). The QIG represents Māori oral health providers and works with DHBs and the wider health sector to deliver better oral health outcomes for Māori. A key piece of work has been the QIG position statements, based on clinical research, on community water fluoridation and dietary sugar intake.

Māori Women's Smoking Project

Smoking rates among Māori remain high. In 2017/18, the Ministry commissioned an extensive programme of research to investigate barriers that prevent reductions in smoking among Māori women aged 18–24 years.

The research found that social environmental factors play a major part in smoking habits. In response, the Māori Women's Smoking Project has taken a 'start small, think big and move fast' approach to address the complex problem of smoking among young Māori women.

The project has provided the Ministry with a deeper understanding of smoking in the lives of young Māori women. This deeper understanding, together with evidence and insights drawn from phase one of the project, will allow us to test and evaluate new approaches to determine how services can better reach and enable young Māori women to reduce harm, stop smoking and quit for good.

Improving health outcomes for older people

New Zealand's population is changing. Our population is becoming more ethnically diverse and living longer. This creates both new opportunities and challenges for the health and disability system.

The Ministry's approach to supporting our older people to live well and stay healthy is through early intervention and better models of care centred around the patient's needs.

Implementing the Healthy Ageing Strategy

The Healthy Ageing Strategy was launched in December 2016.⁴ This year marked the first full year of implementation of priority actions of the Healthy Ageing Strategy.⁵ Of the 48 actions identified as priorities for implementation within the first two years of the Strategy's launch, 45 are under way and progressing well.

⁴ Available at: www.health.govt.nz/publication/healthy-ageing-strategy

⁵ Available at: www.health.govt.nz/our-work/life-stages/health-older-people/healthy-ageing-strategy-update/healthy-ageing-strategy-implementing-strategy

Key milestones reached include work towards the establishment and World Health Organization certification of New Zealand's first age-friendly city in Hamilton, and implementation of strength and balance programmes in both the community and homes.

Implementing workforce settlement agreements

In April 2017, the Government announced a \$2 billion pay equity settlement for 55,000 care and support workers.⁶ This followed the settlement announced in late 2014 that funded the travel of in-home support workers. Both settlements deliver improved remuneration, conditions, training and, therefore, capability in the care and support workforce. During 2017/18 we worked closely with providers and DHBs to manage the payment processes and support the wider sector to implement both settlements.

National framework for home and community support services

The Healthy Ageing Strategy emphasises the need to develop more efficient models of home and community care for the future. In 2017/18, DHBs and the Ministry led engagement with the sector and consumers to identify principles and core components of high-quality and sustainable home and community support. We will build on this work in 2018/19 to complete a national framework for home and community care services, and consider options for implementation through DHBs.

Aged residential care

The Ministry and DHBs commissioned a review of the funding model for aged residential care in 2017/18. EY (formerly Ernst and Young) is undertaking the review to consider the relevance of the funding model in light of current and likely future demand. The scope of the review is to look at both policy and funding relationships between aged residential care providers and health services such as general practice, pharmacy and allied health services. The results, expected in December 2018, will be used to help develop and prioritise options for a future funding model.

Improving health outcomes for children

The time between pre-conception to age five and especially the first three years are key for healthy brain development and lifelong physical and mental health. New Zealand's universal services, which have a high and growing enrolment (for example Well Child/Tamariki Ora, community health and immunisation programmes and B4 School Checks) provide children with high-quality universal services at every point between birth and five years to support good health and development.

While we are providing services for an increasing number of children, some children are still missing out. The Ministry is committed to removing barriers to access and

⁶ Available at: www.health.govt.nz/new-zealand-health-system/pay-equity-settlements/care-and-support-workers-pay-equity-settlement

finding solutions to keep up with demand to further improve health outcomes for children.

Reducing childhood obesity

Children with obesity face greater risk of developing health problems, including long-term health conditions. Maintaining a healthy weight is important in childhood to support healthy growth and development.

The Ministry's ongoing work in this area in partnership with other agencies aims to reduce childhood obesity through school and community-based programmes to educate and promote healthy choices and, where necessary, lifestyle changes.

Obesity rates are higher among Māori and Pacific children. In May 2018, the Ministry launched a package of free online resources developed in collaboration with Toi Tangata aimed at getting children aged five and under to play regularly and get quality sleep. The resources complement the Ministry's *Sit Less, Move More, Sleep Well: Active Play guidelines for under-fives*.⁷ They are uniquely themed for New Zealand children and families/whānau, using a kaupapa Māori approach to communicate key messages. The resources are written in both te reo Māori and English, and include two downloadable videos on moving like mokomoko (lizards) and pūngāwerewere (spiders). Our future work is focused on creating a five-year roadmap for reducing childhood obesity.

Sudden and unexpected death in infants (SUDI)

Sudden and unexpected death in infants (SUDI) is an umbrella term used to describe sudden unexpected death in infancy, which includes sudden infant death syndrome (SIDS), unintentional suffocation, and previously unidentified diseases in affected infants.

The Ministry launched a new national SUDI prevention programme (NSPP) in October 2017. This programme targets the two key risk factors for SUDI: exposure to tobacco smoke during pregnancy and bed sharing with a baby. The programme was developed and implemented through collaboration between the Ministry and cross-government agency representatives, academics and service providers and aims to reduce the SUDI rate to 0.1 in every 1,000 births by 2025.

Child wellbeing

Child wellbeing is a key priority for the Government and the Ministry. The Department of Prime Minister and Cabinet (DPMC) is leading this work through its Child Wellbeing Unit.

⁷ Available at: www.health.govt.nz/publication/sit-less-move-more-sleep-well-active-play-guidelines-under-fives

The Ministry is supporting DPMC to lead continuous improvement of the health sector systems and services that support the health and development of infants, children and youth. During the year we held workshops with DHBs to develop plans and measures to progress this work.

Working with others to keep children safe

During 2017/18, the Ministry continued working with other agencies, including Oranga Tamariki and the Ministry of Justice, to support cross-agency programmes of work to improve services for children most at risk of harm.

The Ministry is a signatory to a memorandum of understanding (MoU) between New Zealand Police, DHBs and Oranga Tamariki that governs the working relationships and decision-making processes between agencies where child abuse and neglect have been identified or suspected.

Under the MoU, Oranga Tamariki social workers are based at DHBs for a 12-month period. Having Oranga Tamariki social workers based in health settings has enabled breaking down of inter-sector barriers and supported collaborative, child-centred practice.

The MoU provides a framework to implement the Child Protection Alert System. This system provides a flag on the National Medical Warning System to alert a treating clinician where, in the case of a particular child, another health professional has previously reported child protection concerns to Oranga Tamariki.

The Ministry also supports a Violence Intervention Programme Coordinator to work with each DHB to facilitate its Violence Intervention Programme. In addition, DHBs train staff to safely and effectively screen, assess and respond appropriately to victims of suspected or diagnosed child abuse and neglect.

Extending free general practitioner visits for children

Under-13-year-olds currently have access to free general practitioner visits and prescriptions. As part of the Budget 2018 announcement for new primary care initiatives, the Government announced that it would extend zero fees for general practitioner visits to include those aged under-14-years, with effect from 1 December 2018. The Ministry has been working with key providers on the implementation of this initiative.

Strategic priority 2: Improve 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

New Zealanders receive a range of health services throughout their lives, and whilst most people are able to access more services and the quality of services has improved, barriers make services out of reach for certain groups, particularly those in lower socioeconomic areas. The Ministry continues to work with our health sector peers to improve access and provide equitable health outcomes.

Our work in disability support services, mental health and addictions, primary care and bowel cancer programmes continues to focus on building a health and disability system that improves health outcomes for all New Zealanders through targeted early intervention and support.

Improving health and disability services

A wide-ranging review designed to future-proof our health and disability services was announced in May 2018. The review will investigate health equity issues for Māori and Pacific peoples, the impact of increasing long-term conditions and the effects of a growing and ageing population on the health and disability system. It has a strong focus on primary and community-based care as early intervention and prevention will help alleviate pressure on hospitals and specialist services. The review will also take into account the results of the Government Inquiry into Mental Health and Addiction, the work of the Ministerial Advisory Group on Health and the Waitangi Tribunal Wai (2575) Health Services and Outcomes Kaupapa Inquiry.

Key activities in 2017/18 focused on improving access to disability support services

In New Zealand in 2013, 1.1 million people (24 percent of the population) reported some form of disability or long-term impairment.⁸ The Ministry, in partnership with DHBs and the disability community, plays a key role in pursuing objectives in the New Zealand Health Strategy and New Zealand Disability Strategy to ensure disabled people have the highest attainable standards of health and wellbeing, and that

⁸ Available at:
http://archive.stats.govt.nz/browse_for_stats/health/disabilities/DisabilitySurvey_HOTP2013.aspx

disabled people and their family/whānau have equitable access to high-quality, inclusive and culturally responsive support services and information. A 'one size fits all' approach to services creates challenges. Together with the disability community, we are working to address these challenges.

Strategies and action plans

In March 2018, the Ministry launched the *Where I Live; How I Live – Disability Support Services Community Residential Support Services Strategy 2018 to 2020*. The strategy follows the enabling good lives (EGL) principles, which support people with disabilities to make decisions about the kind of life they want. It aims to improve options for disabled people whose complex support requirements present challenges for the delivery of a sustainable service.

The strategy guides the operations of the Ministry's Disability Support Services to enable disabled people and their families/whānau and residential service providers to achieve the following outcomes:

- greater choice, control and flexibility for disabled people over where and how they live
- access to information and support to enable disabled people to make well-considered choices about where and how they live and receive support
- increasing independence and choice, supported by service providers.

The Ministry published *Whāia Te Ao Mārama 2018–2022: Māori Disability Action Plan* in April 2018.⁹ It builds on *Whāia Te Ao Mārama 2012–2017*, and focuses on supporting tāngata whaikaha (Māori with disabilities) and their whānau following the principles of te Tiriti o Waitangi (the Treaty of Waitangi). It also reflects New Zealand's obligations to the United Nations Convention on the Rights of Persons with Disabilities (2007).

Transforming the disability support system

The Ministry is co-developing the detailed design for new disability support system with disabled people, their families/whānau, disability sector representatives and officials from across government. The focus areas of the design include network building, safeguarding, market stewardship, provider capability and analysis, responsiveness to Māori, implications for people with high and complex needs, and equipment and modifications. It also included the perspectives of disabled Māori and Pacific people, in line with *Whāia Te Ao Mārama 2018–2022: The Māori Disability Action Plan* and *Faiva Ora 2016–2021: National Pasifika Disability Plan*.¹⁰

The outputs from the co-design working groups were reviewed through virtual testing groups, which were open for anyone to join and provide feedback. We are working to implement a prototype of the transformed system in the MidCentral DHB region to bring to life the key features of the new system, which are based on the EGL vision and

⁹ Available at: www.health.govt.nz/publication/whaia-te-ao-marama-Māori-disability-action-plan-disability-support-services-2012-2017

¹⁰ Available at: www.health.govt.nz/publication/faiva-ora-2016-2021-national-pasifika-disability-plan

principles. Key features will include disabled people and their families/whānau being welcomed into the system in multiple ways, access to connectors/ kaitūhono,¹¹ easy to use information and tools, a straightforward funding process and capability funding.

The Ministry is finalising the monitoring and evaluation approach for the prototype, capturing detailed data through a baseline study, evaluation of the system outcomes and impacts and cost-benefit analysis. The next steps include developing a policy and legislation work programme to support the transformed system.

Improving mental health and addiction outcomes

The Ministry's work in mental health and addiction services focuses on protecting the human rights and safety of individuals and communities. We administer legislation that governs how mental health services operate and provide advice to the Government.

Demand for mental health and addiction services is rising, and specialist mental health services are under increasing pressure. Approximately 47 percent of New Zealanders experience a mental health disorder and/or an addiction at least once in their lives.¹² Each year approximately 20 percent of New Zealanders use mental health services and the prevalence of mental illness among Māori is significantly higher than it is among non-Māori.¹³

More than 500 people die by suicide each year and New Zealand's youth suicide rate is one of the highest among countries in the Organisation for Economic Co-operation and Development (OECD).¹⁴

The societal impacts of mental illness are significant. Mental distress, mental illness and addiction are often associated with other poor life outcomes, such as unemployment, poor physical health, interaction with the justice system, low levels of education, and housing instability.

Supporting the Government Inquiry into Mental Health and Addiction

The Ministry provided advice and assistance to establish the Government Inquiry into Mental Health and Addiction. This included preparation of information, input into draft terms of reference in consultation with the Department of Internal Affairs and later a

¹¹ Connectors/Kaitūhono are available to walk alongside disabled people and family/whānau, to help them identify what they want in their lives, how to build their lives, and the supports that are available to live their lives.

¹² Available at: www.hpa.org.nz/what-we-do/mental-health

¹³ Available at: www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/mental-health-data-and-stats?mega=Health%20statistics&title=Mental%20health

¹⁴ Available at: www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/understanding-suicide-new-zealand

formal submission. Feedback from the inquiry is due in October 2018, and will inform new models of care.

Legislation update sets high threshold for compulsory treatment

The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 came into force in February 2018. The Act aims to enable people to receive compulsory treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired. Its focus is on restoring an individual's capacity to participate in voluntary treatment. The Director of Addiction Services has appointed nine area directors, whose powers and responsibilities include clinical oversight and statutory administration. Area directors will normally act as the main points of contact between the Director and addiction treatment centres to oversee the delivery of these services.

Improving primary health care

Primary health care serves as the first point of contact for most people seeking health services and plays a key role to facilitate access to wider primary and secondary services.

Our primary health workforce includes general practitioners, nurses, pharmacists, midwives, community health workers, ambulance workers and allied health workers (for example physiotherapists and podiatrists).

International research has found health systems that prioritise primary health care have lower per-capita costs, better health outcomes and lower rates of premature mortality. A strong primary health care sector can reduce overall demand on health services by treating health problems before they escalate and improving coordination of care across the wider health and disability system.

Our primary health care system is central to improving the health of all New Zealanders. The Ministry continues to work with sector peers to reduce access barriers and unmet demand, particularly for vulnerable population groups, through innovative and collaborative models of care.

Budget 2018 primary care initiatives are under way

The Ministry has continued work with the primary health care sector to investigate how it can best contribute to the sustainability of the health system and improve outcomes for New Zealanders; particularly for Māori and Pacific peoples.

As part of Budget 2018, the Government announced its commitment to improving access to primary health care with initiatives to reduce the cost of visiting a general practice for under-14-year-olds and Community Services Card (CSC) holders. From 1 December 2018 all CSC holders, and their dependents, will be eligible for Very Low

Cost Access (VLCA) level co-payment fees.¹⁵ The current maximum co-payment fee for adults in the VLCA scheme is \$18.50.¹⁶

The Ministry is undertaking further work to strengthen the impact of the primary health care system, including scoping of a free annual health check, including an eye check, for all SuperGold Card holders.

Bowel cancer and other screening services

Screening services play an important role in our health and disability system to enable early detection and intervention of illnesses.

New Zealand has one of the highest rates of bowel cancer in the developed world. Bowel cancer is often treated successfully if caught in the early stages. The National Bowel Screening Programme (NBSP) is free to men and women aged 60 to 74 years who are eligible for publicly funded health care and has been successfully implemented in five DHBs.

The National Cervical Screening Programme (NCSP) plans to transition to Human Papillomavirus (HPV) primary screening from 2021. In consultation with our stakeholders, the Ministry developed clinical pathways and guidelines for HPV primary screening.

The Ministry has continued to work closely with BreastScreen Aotearoa (BSA) providers to develop a funding model for the provision of national breast screening services with a focus on improving equity and improving re-screening rates.

Non-Invasive Prenatal Testing (NIPT) is a method of screening for certain chromosomal abnormalities in a developing baby that is not currently publicly funded. We have been investigating the advantages and disadvantages of bringing NIPT into the publicly funded antenatal screening programme.

The National Bowel Screening Programme

Five DHBs currently offer free bowel screening under the National Bowel Screening Programme (NBSP). The Government has approved an extension for the NBSP to 2021. Over the next four years, approximately \$67.1 million of operating funding will enable:

- extension of the programme to a further 15 DHBs
- a progressive increase of the services provided by the national coordination centre and four bowel screening regional centres to support the entry of more DHBs into the programme

¹⁵ Available at: www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/community-services-card

¹⁶ Available at: www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/very-low-cost-access-scheme

- development of a national IT solution to support the screening programme.

The first set of NBSP safety and monitoring indicators were rolled out and the national coordination centre went live ahead of schedule in November 2017. The coordination services are performing well to support DHBs to provide bowel screening services.

The initial planning and design phase of the new NBSP IT system is under way and is expected to be completed at the end of August 2018. This IT system known as the National Screening Solution (NSS) is a long-term strategic technology solution that will support planning, assist with managing participants, monitor safety and quality and enable on-going evaluation of the NBSP programme nationally. It is also intended to improve the patient experience for New Zealanders.

Other initiatives in 2017/18 to improve access to and the efficacy of health services

The Ministry has been actively involved in a wide range of additional initiatives to improve access to and the efficacy of health services, including services for Rainbow New Zealanders, gender-affirming care, maternity, planned care and modernising air ambulance services.

Improving access to and efficacy of health services for Rainbow New Zealanders

The Ministry is actively involved in improving health outcomes for Rainbow New Zealanders. Rainbow refers to diversity in terms of sexuality, sex and gender identity.

All health care providers are obliged to provide inclusive health care. Protections set out in legislation and service standards support Rainbow New Zealanders' right to access safe and welcoming health care, but we acknowledge that there is more work to be done to ensure this.

Gender-affirming care

Transgender/tāhine people currently face barriers to accessing public care that assists in affirming their gender identity. The Ministry is developing advice on how to improve the delivery of gender-affirming care, and to improve care pathways in this area. We have recently been able to assess more people and we expect to see an increase in the number of people receiving surgery in 2018/19.

Refreshing the approach to planned care

The Ministry supports DHBs to improve access to planned care (including elective services), through applying patient-centred principles of:

- clarity – patients know whether or not they will receive publicly funded services

- timeliness – where services can be delivered within the available capacity, patients receive them in a timely manner (four months or less)
- fairness – DHBs direct available resources to those with the greatest need and ability to benefit.

The Ministry, in partnership with a Sector Advisory Group, commenced a priority work programme to refresh the approach to 'planned care', including elective services. The goal is to take a more comprehensive approach, and to design services around expanded principles of equity, quality, access, timeliness and experience. We are actively working with DHBs to implement new models of care that are effective regardless of the delivery setting.

Maternity care programme

The Ministry has continued working with the broad whole-of-maternity sector to develop a more equitable and sustainable service to address long-standing workforce challenges. We are investigating both short and longer term solutions to deliver better outcomes and resolve workforce shortage and conditions.

Modernising air ambulance services

The National Ambulance Sector Office (NASO), DHBs and the air ambulance sector recognise that the existing operating model for the air ambulance helicopter service is not sustainable. Together with ACC and DHBs, NASO is developing a 10-year programme to modernise services, ensuring that every community has access to an effective air ambulance helicopter service.

Our aim is to provide a modern air ambulance service that is safer through improved clinical resourcing, better linked with other emergency services through national integration that can cover all of New Zealand, and provide round-the-clock availability.

Strategic priority 3: Improve outcomes for New Zealanders with long-term conditions

with a focus on obesity and diabetes

Day-to-day decisions influence our health and wellbeing. Poor nutrition, insufficient exercise, excessive alcohol intake, obesity and smoking are key risk factors that cause the greatest health loss and put people at risk of developing long-term health conditions.

Long-term conditions are ongoing or recurring conditions that have a significant impact on peoples' lives. They include diabetes, cancers, cardiovascular diseases, respiratory diseases, mental illness (including depression and anxiety), chronic pain, chronic kidney disease, and musculoskeletal conditions. In 2016, long-term conditions were the leading cause of health loss in New Zealand (87 percent).¹⁷

Adults living in areas of the highest socioeconomic deprivation experience significantly poorer health outcomes. They have higher rates of poor cardiovascular health, psychological distress, diagnosed mood and/or anxiety disorders, arthritis, asthma, diabetes and chronic pain than those living in areas of low socioeconomic deprivation. Māori and Pacific adults have higher rates of diabetes than other population groups.

The Ministry is focused on increasing prevention activities and developing integrated models of care. We share knowledge with the wider health sector including our NGO partners and provide resources and input into designs for new models of care to improve the management of long-term conditions. Prevention is a key focus to improve health and wellbeing, and also reduces the cost to our health system.

Obesity

New Zealand has the third-highest adult obesity rate in the OECD, and these rates are rising. The New Zealand Health Survey 2016/17¹⁸ found that 32.2 percent (1.2 million adults) were obese, up from 28.6 percent in 2011/12. Children living in the most socioeconomically deprived neighbourhoods were 2.5 times more likely to be obese than children living in the least deprived neighbourhoods, after adjusting for age, sex and ethnic differences.

Poor diet and obesity are the two top causes of health loss in New Zealand. The Global Burden of Disease 2016¹⁹ study showed that high body mass index (overweight and

¹⁷ Available at: www.health.govt.nz/system/files/documents/publications/health-and-independence-report-2017-v2.pdf

¹⁸ Available at: www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey

¹⁹ Available at: ghdx.healthdata.org/gbd-2016

obesity) accounted for 8.9 percent of health loss in New Zealand and poor diet accounted for 8.6 percent of health loss.²⁰ Poor diet and obesity are key risk factors for many long-term conditions including cardiovascular disease and type 2 diabetes.

A strategic approach to managing obesity

International evidence supports a multi-pronged approach to healthy eating, growth and development: no single action is effective by itself. The Ministry is working to identify the best combination of actions for the New Zealand context.

The Minister of Health has asked a working group of food and beverage industry representatives to propose innovative actions that will contribute to reducing population overweight and obesity. We are supporting this engagement to find appropriate solutions.

The Minister has also indicated that regulatory actions could be required if voluntary actions do not go far enough to reduce obesity. We are assessing potential regulatory and non-regulatory actions taking into consideration both international and New Zealand-based research, initiatives and evaluations.

Diabetes

Diabetes is a chronic condition caused by the body's inability to control blood glucose. If this chronic condition is not well managed, diabetes can cause kidney failure, eye disease, foot ulceration and increased risk of heart disease.

Implementing the Living Well with Diabetes Plan

As at the end of the 2017 calendar year, an estimated 245,680 people in New Zealand had been diagnosed with diabetes.²¹ The rate of increase in diabetes prevalence has slowed over the last few years. The rate of amputations from diabetes has remained relatively stable. However, the rate of people with diabetes requiring renal replacement has been declining since 2010.

With support from the Ministry, DHBs are implementing *Living Well with Diabetes Plan: A plan for people at high risk of or living with diabetes 2015–2020*, and collaboration between primary care, secondary care, and community services is increasing. Now that we are halfway through the plan, the Ministry has asked DHBs to self-audit their performance against the Quality Standards for Diabetes Care. Results will be used to determine priority areas for improvement.

²⁰ Please note: these figures are not designed to be added directly to give a cumulative percentage of health loss.

²¹ Available at: www.health.govt.nz/our-work/diseases-and-conditions/diabetes/about-diabetes/virtual-diabetes-register-vdr

Other initiatives for improving outcomes for long-term conditions

Medicinal cannabis

As part of its 100-day plan, the Government announced that it would introduce legislation to make medicinal cannabis available for people who are terminally ill, based on the principles of fairness, quality and safety and compassion. The Ministry immediately started work on this urgent priority and the Misuse of Drugs (Medicinal Cannabis) Amendment Bill was introduced in Parliament in December 2017.

The Ministry is preparing for the implementation of the proposed regulatory schemes, which includes formalising a medicinal cannabis scheme and developing technology solutions.

Managing acute demand

Long-term conditions collectively represent 87 percent of New Zealand's disease burden.²² Preventing long-term conditions, and supporting people who live with them, requires ongoing focus, prioritisation and effort, especially in the context of New Zealand's growing and ageing population.

How long-term conditions are managed directly impacts acute demand. In June 2018, the Ministry published *Top Tips for Improving Your Acute Demand Management*, designed to help our sector to identify gaps in their local acute service delivery and change models of care to improve health outcomes for those with long-term conditions. Further work is well underway to develop a longer term strategy for acute demand in relation to management of long-term conditions.

²² Available at: www.health.govt.nz/system/files/documents/publications/health-and-independence-report-2017-v2.pdf

Strategic priority 4: Improve our understanding of system performance

As steward of the health system, the Ministry needs clear oversight on how the health system is performing, where the pressures are and how to use these insights to inform a sustainable growth path for the system. Robust frameworks for performance management, system analytics, customer insights (including changing expectations and demand patterns) and strong partnerships with the sector are critical components to understanding health system performance. This has been a key area of focus for the Ministry during 2017/18.

Strengthening our performance story

The Ministry collects a wealth of information from the health sector, but in the past has faced challenges turning this information into meaningful insights. Information about our health sector's performance is critical to decision making and helps ensure appropriate resource allocation by showing linkages in expenditure to service volumes and the flow on impact on service quality and health outcomes. It also helps the Ministry to better understand how our sector is balancing local health needs and national priorities.

This year we have been using analytics to build an understanding of the impact of our investment in health including the effectiveness, efficiency, and outcomes we are achieving from that investment. These insights are the starting point for our health system performance story.

Refreshing our approach to DHB performance monitoring

During 2017/18, we commenced a preliminary programme of work, in conjunction with DHB representatives and The Treasury, to refresh the approach for DHB performance monitoring and intervention. This work helps improve our understanding and oversight of system performance, forecast demand, and workforce requirements.

Clarity, execution and measurement of our strategy

The New Zealand Health Strategy sets the direction of health services to improve the health of people and communities. The Strategy identifies productive ways of working to achieve its objectives, ie, 'the how'. In 2017/18, we clarified the outcomes and

changes we are seeking to achieve across the health system, ie, 'the what'. This will aid with implementation of the strategy. We have summarised these into the following system shifts:

- **better health maintenance:** to reduce the risk of mortality and death across our population
- **targeted investment:** signalling a general shift in investments to early intervention and less acute settings
- **lower acuity in the system:** to reduce the cost of acute care through effective early interventions and lower prevalence of chronic conditions
- **greater equity:** to focus more on those who do not have access to services they need or who are experiencing poor health outcomes, especially Māori, Pacific peoples and vulnerable groups
- **sustainability:** to ensure the health and disability system delivers sustainable outcomes through investment in and management of our workforce and infrastructure, including physical equipment, property and technology.

In 2017/18, we started developing an outcomes-tracking framework and an implementation framework to support execution and measurement of the strategy.

Fit-for-purpose systems

Fit-for-purpose and well-functioning systems and technologies are crucial enablers of stewardship of the health system. They are key to creating a more sustainable, high-performing and digitally enabled health system.

We acknowledge that we need to upgrade our systems (including IT systems) and processes, which are the basic building blocks of an effective organisation capable of leading the system.

This year we have focused on:

- improving our core business (eg, official correspondence, planning and budgeting processes, and reporting)
- implementing Infrastructure as a Service for the Ministry and Ministry-delivered sector systems
- establishing supporting functions (eg, an Enterprise Portfolio Management Office)
- upgrading our financial systems.

Our long-term work programme addresses how we ensure that we work more efficiently and effectively, and appropriate prioritisation of investment in both national systems and Ministry systems.

Data, analytics and the voice of the customer

The success of our health system depends on applying analytics, insights and the voice of the customer. This year the Ministry developed a vision for our analytics function, piloted population-based analytics and modelling for some of our strategic priorities, and began implementation of the QlikSense business analytics tool.

New Zealand Digital Health Strategy

The New Zealand health and disability sector and the rapidly changing digital landscape are complex. The Ministry's Digital Health Strategy helps us navigate this complexity by guiding sector investment in, and use of, digital technologies. We developed the Strategy through engagement with clinical and non-clinical stakeholders in the Ministry and the sector (including DHBs, primary care organisations and NGOs), and other stakeholders such as the government Chief Digital Officer, consumers, academia and industry partners. We also developed, in collaboration with the sector, the Vision for Health Technology, to support the New Zealand Health Strategy, and outline how we see technology shaping the way New Zealanders 'live well, stay well and get well' in 2026.

We created the website digital.health.nz as a digital channel allowing us to engage with a broad range of stakeholders. We have published the Vision for Health Technology on the website, and will publish the Digital Health Strategy there following approval.

Strategic priority 5: Implement our investment approach

Over the last year, the Ministry has been working on developing our social investment approach to health, which takes a systematic view of the effectiveness of health services (refer Figure 5). We are testing an analysis model to provide an evidence base for our decision-making.

Our approach to social investment

Implementation of a social investment approach is underpinned by commitments in the New Zealand Health Strategy. Our approach will also address the Government's focus on wellbeing.

The Health Strategy is, in essence, a social investment strategy. It is concerned with using analysis, outcomes and service design to understand the needs of people requiring public services and the impact those services have on peoples' lives.

We are working with the Social Investment Agency on a mental health and addictions test case, to understand whether services that meet people's mental health and addiction needs create fiscal, individual and social benefits outside the health system.

Figure 5: Our social investment approach



Why we are taking a social investment approach to health

The health of New Zealanders is generally improving. However, rates of improvement are not equal. Some groups are missing out on universal services, and do not get the same level of benefits, in terms of health outcomes, when they do get them. For example, preventable health loss (through unhealthy lifestyle and environment) is a significant issue that affects some population groups more than others.

The current lack of this systematic view makes it difficult to prioritise investment based on expected returns and benefits.

In some areas we know a lot about cost-effectiveness and efficacy. In others we do not, and this is problematic where costs are high.

Our ability to quantify the impact of health interventions on other social outcomes is limited. Our ability to measure performance of the sector in achieving the population outcomes we are seeking, and reducing projected demand/pressure is also limited. Our social investment approach, therefore, needs to address these current limitations.

How we are taking a social investment approach to health

The Ministry has developed a prototype model to forecast the incidence and prevalence of disease. The model predicts the likely cost-growth and burden of disease for the population based on several major health conditions. Our focus in 2017/18 was simulating the incidence and prevalence of cardiovascular disease and diabetes. In 2018/19, this focus will expand to include other major health conditions such as mental health and cancer.

Analysis was also completed on the following priority areas:

- mental health service users, to examine the pathways people take through mental health services, and identify risk factors for self-harm and suicide
- primary health care service use, to determine patterns of use and the impact on the health outcomes of people with identified long-term conditions
- the impact of different models of care in primary health care.

To complement this, we have worked alongside Oranga Tamariki to develop disability indicators for the child wellbeing model, and to test the assumptions and application of the model for policy and practice.

We have also worked alongside other social sector agencies to identify populations that would be most likely to benefit from collective action,²³ and determine where we could use existing service interactions to provide additional support.

²³ Collective action is an approach to health that takes account of the interrelationship between the individual and the environment, based on a view that health is largely determined by factors outside individual control.

Section D:

Tracking sector performance

System level measures

The System Level Measures (SLMs) Framework aims to improve health outcomes by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. Sector involvement in the development of the SLMs, along with a focus on local clinically-led quality improvement, has ensured strong sector and clinical support for the framework.



Four SLMs were implemented in July 2016 (refer to Table 2):

- 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.

Two additional SLMs were introduced from 1 July 2017 and will be reported on in future reports:






- babies living in smokefree homes (a healthy start)
- youth access to, and use of, youth-appropriate health services.

Table 2: System level measures²⁴

System level measure	Expected trend	Results	Comments
Ambulatory sensitive hospitalisations (ASH)²⁵ rates per 100,000 children aged 0–4 years			
6,789 per 100,000 national mean		6,748 per 100,000 national mean March 2018 results	The 12-month rolling average for the first six months of the financial year (to December 2017) showed a downward trend for Pacific and total populations. However, the 12-month rolling average to March 2018 shows an upward trend for Māori and total populations, while the Pacific rate maintained a downward trend. There has been a prominent equity gap for the Pacific population for the past five years; DHBs have been focusing their activities to reduce these rates.
Total acute hospital bed days per capita			
413.4 per 1,000 national mean		391.4 per 1,000 national mean	The 12-month rolling average showed a downward trend for hospital bed day use, with a national mean of 423.6 to March 2016, 401.7 to March 2017 and 391.4 to March 2018. The rate for Māori and Pacific populations remains significantly high when compared to the national mean. The Pacific population continues to have the highest hospital bed day use (685) compared to the national mean (391.4), Māori (557), and non-Māori and non-Pacific rates (352).

²⁴ At the time of this Annual Report, the latest available results are from March 2018.

²⁵ Ambulatory-sensitive hospitalisations are defined as hospitalisations of people less than 75 years old resulting from diseases sensitive to prophylactic or therapeutic interventions that are deliverable in a primary health care setting.

System level measure	Expected trend	Results	Comments
Patient experience of care			
Communication			
National mean 8.3 (patient score out of 10)		8.2 (patient score out of 10) February 2018 survey results	At the national level, survey scores started to change in quarter 3 of 2017/18 after remaining constant for two years. Scores for the communication and coordination domains have slightly decreased, while scores for physical and emotional needs domain have increased slightly.
Partnership			
National mean 8.4 (patient score out of 10)		8.4 (patient score out of 10) February 2018 survey results	These changes are not universal across the DHBs. Considering that in quarter 2 of 2017/18, scores in all domains increased, it is too early to say this is a significant shift. The national response rate has increased to around 26%, compared to 23% previously.
Coordination			
National mean 8.4 (patient score out of 10)		8.2 (patient score out of 10) February 2018 survey results	The primary care patient experience survey was piloted in February 2016 and is now being implemented by over 700 general practices across the country. During the 2017/18 quarter 4 survey, approximately 99,000 patients were invited to participate in the survey, and about 22,000 completed it (a response rate of about 22%).
Physical and emotional needs			
National mean 8.4 (patient score out of 10)		8.5 (patient score out of 10) February 2018 survey results	
Amenable mortality²⁶			
90.8 per 100,000 national mean – 2015 data		2016 data not available yet	The time lag in data availability is due to waiting for the outcome of coronial inquiries. Amenable mortality rates have been declining over the last 10 years, and we expect this trend to continue. The rates for Māori and Pacific populations have reduced over the last 10 years, in particular for Māori. However, the equity gap between rates for Māori, Pacific people and the total population has remained.

²⁶ Amenable mortality means deaths from those conditions for which variation in mortality rates (over time and across populations) reflects variation in the coverage and quality of health care (preventative or therapeutic services) delivered to individuals.

Health targets

Reporting on health targets

Health targets are a set of national performance measures specifically designed to track the performance of health and disability services that reflect significant public and government priorities. Table 3 outlines the health target results for 2017/18.

Table 3: Health target results 2017/18

Target area	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Shorter stays in emergency departments	95%	91.2%	93.1%	91.3%	91.3%
Improved access to elective surgery ²⁷	100%	103.6%	102.3%	102.3%	103.2%
Faster cancer treatment (see note 1)	90%	92.3%	93.2%	91.4%	91.0%
Increased immunisation	95%	92.3%	92.2%	91.7%	91.2%
Better help for smokers to quit	90%	88.8%	88.3%	88.6%	89.7%
Raising healthy kids	95%	92.2%	97.5%	98.5%	98.5%

Note 1: From 1 July 2017, adjustments to the faster cancer treatment target were introduced, including an increase of the target from 85 percent of patients expected to receive their first cancer treatment within 62 days to 90 percent, and technical adjustments to allow for breaches that are appropriate for patients.

Table 4: Health target results 2016/17

Target area	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Shorter stays in emergency departments	95%	93.1%	93.8%	93.6%	92.6%
Improved access to elective surgery ²⁸	100%	104.9%	103.4%	103.8%	106.1%
Faster cancer treatment	85%	78.0%	81.9%	81.8%	81.4%
Increased immunisation	95%	93.2%	93.3%	92.3%	91.9%
Better help for smokers to quit	90%	86.6%	86.2%	86.5%	89.3%
Raising healthy kids	95%	49.0%	71.9%	85.7%	90.9%

²⁷ The target is to increase the volume of elective surgeries by an average of 4000 discharges per year (4000 is equivalent to 100%).

²⁸ The same conversion of the target to percentage applies to 2016/17 as explained above in footnote 27 for 2017/18.

Development of new health measures

The Ministry has embarked on a programme of work to develop a new set of performance measures to improve health outcomes for New Zealanders. We aim to have the new measures in place early in the 2019 calendar year.

Better Public Service results

In January 2018, the Government announced that it would not be continuing the Better Public Service (BPS) programme. Accordingly, this report does not include the 2017/18 BPS results. However, the BPS Result 3: Keeping kids healthy by reducing avoidable hospitalisations for children is reported as part of the above system level measures framework.

Section E:

Our performance

This section outlines the measures used by the Ministry to assess our performance in delivering our outputs. Our outputs are specified in the *Vote Health – Health Sector Estimates 2017/18*²⁹ and, where relevant, have been updated in *the Health Sector – The Estimates of Appropriations*.³⁰

Health sector information systems

Scope of appropriation

This appropriation is limited to the provision of information technology services and the publication of data and information derived from these services to the health and disability system.

What is intended to be achieved with this appropriation

This appropriation is intended to provide information technology services and infrastructure to support the operation of New Zealand's health services.

Our role

The Ministry is responsible for the technology and digital services that underpin the national data collections and systems used 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.

Key systems include:

- the Ministry's website
- the National Health Index (NHI)

²⁹ Available at: www.treasury.govt.nz/publications/vote-health-health-sector-estimates-2017-2018-html

³⁰ Available at: www.treasury.govt.nz/publications/budgets/health-sector-estimates-appropriations-government-new-zealand-year-ending-30-june-2018

- the National Immunisation Register (NIR)
- Pharmacy Electronic Claiming (PEC)
- the Oracle financial system
- special authorities.

Our achievements in 2017/18

New Zealand Digital Health Strategy

The Vision for Health Technology was developed in 2017 in collaboration with the sector to support the New Zealand Health Strategy. The vision outlines how we see technology shaping the way New Zealanders 'live well, stay well and get well' in 2026.

Acknowledging the complexity of the health and disability sector and the rapidly changing digital landscape, the New Zealand Digital Health Strategy guides sector investment in, and use of, digital technologies: see 'Strategic priority 4' in Section C for further information.

Sector CyberSecurity

The Ministry has been developing the Health Sector Cyber Event Response Plan in consultation with the health sector and central agencies. We will be publishing it in early 2018/19. This will be a living plan that we will continue to update.

Establishment of Emerging Health Technology Group

The Ministry established a new group within its Technology and Digital Services unit, the Emerging Health Technology Group, to engage with the Ministry and the sector on how emerging health technology can be brought into health services with more impact, and faster than the sector has been capable of in the past. This team focuses on building networks and knowledge about emerging health technology and on providing advice on developing and implementing emerging health technology in partnership with the sector.

Online death certification

The Ministry is working with the Department of Internal Affairs to make it simpler for health practitioners to complete medical documents after someone dies. Doctors and nurse practitioners are now able to complete the necessary forms online via the new Death Documents platform.

The project is currently in its first phase, and launched on 1 March 2018. A group of medical practitioners around the country has started completing the medical certificates of cause of death and cremation forms online. More than 370 cause-of-death and cremation certificates had been completed online by 30 June 2018.

Electronic Health Record

The Ministry continues to work on the national Health Information Platform (National Electronic Health Record) business case. We have completed the indicative business case and are seeking Cabinet approval to proceed to the detailed business case stage.

Performance assessment

Actual 2016/17	Performance measure	Actual 2017/18	Budget standard 2017/18
Client insight and analytics			
See note 1	Percentage of published Tier 1 statistics meet Statistics New Zealand standards within agreed timetable	100%	100%
See note 1	Respondent satisfaction with how the Health Survey is conducted is greater than	98%	90%
National infrastructure and Ministry information systems			
100%	The percentage of time for which key sector- and public-facing systems are available (see note 2)	99.9%	99%
See note 1	Number of security breach incidents	0	0

Note 1: New performance measure for 2017/18; comparable information has not previously been reported.

Note 2: Key sector- and public-facing systems are the National Health Index (NHI), National Immunisation Register (NIR), Online Pharmacy, Special Authorities, Oracle Financials, and Web Access.

Financial performance

Actual 2016/17 \$000	Health sector information systems	Actual 2017/18 \$000	Budget 2017/18 \$000	Revised budget ³¹ 2017/18 \$000
54,278	Crown revenue	52,845	51,618	52,845
27	Third-party revenue	0	0	0
54,305	Total revenue	52,845	51,618	52,845
53,501	Total expenditure	52,840	51,618	52,845
804	Net surplus	5	0	0

³¹ These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Managing the purchase of services

Scope of appropriation

This appropriation is limited to purchasing services for the public and health and disability sector on behalf of the Crown, for those services where the Ministry has responsibility for the purchasing function (ie, funding is not devolved to another entity).

What is intended to be achieved with this appropriation

This appropriation is intended to achieve the administration of health and disability services, purchased on behalf of the Crown in line with Government priorities and the Ministry of Health's strategic intentions (as outlined in the SOSI).

Our role

The Ministry is responsible for procuring health and disability services for New Zealanders on behalf of the Crown. This appropriation covers the Ministry's costs.

In 2017/18, the Ministry provided a total of \$12.7 billion of funding to DHBs. It also spent \$3.3 billion on direct purchasing of non-departmental services and non-DHB Crown entities. The Ministry also holds contracts with other parties on behalf of the Crown. These allow for procuring services from third-party service providers. 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 services and public health services
- any new, or renewed, contracts entered into by the Ministry for providing services to external parties using non-departmental expenditure funding.

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

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

The Ministry has a range of measures that assess the quality of the Ministry's contract performance management. Through regular feedback to providers, the Ministry works to prevent poor performance, and help resolve any performance issues as they arise. This applies to all monitoring reports contracted service providers sent to the Ministry according to a regular reporting schedule, such as would normally be expected in a contracting arrangement.

A significant amount of contracting activity takes place under Crown funding agreement variations (CFAV). The Ministry monitors these a different way to other Ministry contracts, with a specific set of monitoring rules and a tracking system.

The Ministry expects that the national support services it purchases will be of a high quality and takes any complaints about service provision seriously.

Our achievements in 2017/18

The performance assessment results (below) demonstrate the Ministry's level of performance in negotiating and managing its portfolio of contracts in 2017/18.

Performance assessment

Actual 2016/17	Performance measure	Actual 2017/18	Budget standard 2017/18
Achieved	The Ministry procurement process is in line with government standards	Achieved	Achieved
1:84	The ratio of departmental expenditure for the output class against relevant non-departmental expenditure (see note 1)	1:75	1:107
819	Social agencies are required to move contracts with non-government organisations (NGOs) to the streamlined contract framework as they are renewed. The Ministry will move the following numbers of contracts	840	840
100%	The percentage of Ministry feedback to Crown funding agreement variation (CFAV) monitoring reports that are supplied to DHBs within agreed timeframes (see note 2)	100%	95%
95%	The percentage of complaints in regards to disability support services (DSS) that receive either a resolution notification or progress update within 20 days of DSS receiving the complaint	100%	95%

Note 1: There was a large one-off departmental expenditure cost for implementing the pay equity settlement agreement.

Note 2: When a monitoring report is received by the Ministry, it is logged into an electronic system. This generates an automated letter to say the Ministry has received the report. The 'formal response' is the next contact the Ministry has with the provider, when necessary. The formal response could be a phone call, email, formal letter or site visit.

Financial performance

Actual	Managing the purchase of services	Actual	Budget	Revised budget³²
2016/17		2017/18	2017/18	2017/18
\$000		\$000	\$000	\$000
34,963	Crown revenue	43,368	36,213	41,973
	Third-party revenue	28		
34,963	Total revenue	43,396	36,213	41,973
34,054	Total expenditure	43,368	36,213	41,973
909	Net surplus	28	0	0

³² These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Payment services

Scope of appropriation

This appropriation is limited to the administration and audit of contracts and payments on behalf of the Crown and Crown agencies.

What is intended to be achieved with this appropriation

This appropriation is intended to provide for timely and appropriate payments to be made to eligible parties (including eligible health service providers and consumers) and contracts to be audited and processed efficiently and effectively.

Our role

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.

Agreements

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

Contact centres

The Ministry operates a contact centre that manages queries and service requests from funders, providers and health care consumers in support of the payment services function. The contact centre also supports the health and disability system and the wider public by responding to health-related enquiries in approximately 60 service areas. This includes queries relating to special authority, the NHI and eligibility for publicly funded health services.

The performance measures below do not cover Ministry-funded, but outsourced, contact-centre services such as Plunketline, Healthline and Quitline.

Financial audit and compliance activities

The Ministry performs audit and investigation activities on the payments made across the health and disability system.

Our achievements in 2017/18

Financial audit and compliance activities

The Ministry concluded two significant investigations in 2017/18. One resulted in civil recovery action, and the other was not referred for prosecution, in line with the Solicitor-General's Prosecution Guidelines.

Performance assessment

Actual 2016/17	Performance measure	Actual 2017/18	Budget standard 2017/18
100%	The percentage of claims paid on time	99.8%	98%
99%	The percentage of claims processed accurately	98.9%	95%
87%	The percentage of all draft agreements prepared for funders within target timeframes (see note 1)	85.1%	95%
100%	The percentage of agreements prepared accurately (see note 2)	100%	95%
81%	The percentage of calls to contact centres answered within service specifications for timeliness (20 seconds)	81.2%	80%
3%	The percentage of calls abandoned by callers prior to being answered by the contact centre is less than	3.8%	5%
96%	The percentage of enquiries resolved in under 10 business working days	96.1%	95%
See note 3	Court written decisions and findings relating to concluded Ministry of Health Audit & Compliance initiated prosecutions contain no adverse judicial comment in regards to the evidential basis of the prosecutions	0	0
See note 3	Percentage of Health Integrity Line complaints that are evaluated within 10 working days of complaint being received is greater than or equal to	97%	95%

Note 1: Not achieved due to the high demand of agreement requests from funders at the start of the financial year. The average agreement processing time was five working days.

Note 2: All information is deemed to be processed accurately if agreements are legally binding and purchase order information is correctly entered.

Note 3: New performance measure for 2017/18; comparable information has not previously been reported.

Financial performance

Actual	Payment services	Actual	Budget	Revised
2016/17		2017/18	2017/18	budget³³
\$000		\$000	\$000	2017/18
				\$000
17,918	Crown revenue	15,840	17,340	15,840
	Third-party revenue	28		
17,918	Total revenue	15,868	17,340	15,840
18,377	Total expenditure	15,838	17,340	15,840
(459)	Net surplus	30	0	0

³³ These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Regulatory and enforcement services

Scope of appropriation

This appropriation is limited to implementing, enforcing and administering health- and disability-related legislation and regulations, and provision of regulatory advice to the sector and to Ministers, and support services for committees established under statute or appointed by the Minister pursuant to legislation.

What is intended to be achieved with this appropriation

This appropriation is intended to ensure that health and disability services are regulated so that appropriate standards are followed.

Our role

The Ministry has multiple regulatory, leadership, protection and purchasing roles. We protect New Zealanders from public health risks (such as environmental and disease risk factors that lead to ill health). We also regulate to ensure safe products, services and premises in health products and services and provide advice and leadership to ensure we meet international and legal obligations.

Support services for statutory committees and regulatory authorities

The Ministry assists the Minister with appointments of members to statutory committees and regulatory authorities.

Appointing and supporting statutory officers

The Director-General of Health appoints statutory officers under several Acts of Parliament, including the Health Act 1956, Hazardous Substances and New Organisms Act 1996, Biosecurity Act 1993, and Smoke-free Environments Act 1990.

Providing sector coordination and support

The Ministry coordinates public health protection and related regulatory functions between the DHBs. This includes administering the environmental health-related aspects of legislation and providing advice, manuals, guidelines and training.

Burial and Cremation Act

The Ministry administers the Burial and Cremation Act 1964, including through processing disinterment licences, applications for burials in special places, burial ground/cemetery applications, medical referee appointments and cremator applications.

Delivery of regulatory functions

The Ministry is responsible for delivering regulatory functions, and supporting committees established under statute. Its key regulatory functions include:

- the **Director of Public Health** and **Director of Mental Health**, who have leadership and decision-making responsibilities, including the interpretation and administration of health and disability-related legislation
- 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. The Ministry receives and responds to complaints made under the Health and Disability Services (Safety) Act 2001 against certified providers
- 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
- the **Psychoactive Substances Regulatory Authority**, which is responsible for the operation of psychoactive substances legislation
- the **Public Health Group**, which administers legislation protecting people from communicable disease and environmental health risks.

Appendix 3 provides a full list of committees supported by the Ministry.

Licensing and certification

The Ministry's licencing and certification roles include:

- licencing pharmacies and other parties involved in the pharmaceutical supply chain, such as wholesalers and researchers (under the Medicines Act 1981 and the Misuse of Drugs Act 1975)
- licencing service providers who use and possess radioactive substances (under the Radiation Safety Act 2016)

- certifying hospitals, rest homes, residential disability care providers and fertility providers (under the Health and Disability Services (Safety) Act 2001).

Our audit functions support our licensing and certification roles, and also seek to improve the quality of services beyond formal licensing/certification requirements.

Contracting for health-related border control

The Ministry purchases and monitors health-related border control and environmental health services on behalf of the Crown, and exercises regulatory powers in this area to minimise public risk.

Outbreak management

The Ministry's role includes oversight of interventions to reduce the risks from environmental hazards and communicable diseases, and to manage outbreaks.

Key achievements in 2017/18

Havelock North Drinking Water Inquiry

The Ministry provided support for developing the Government's response to the Havelock North Drinking Water Inquiry, which released its stage 2 report in December 2017. The Inquiry investigated the widespread outbreak of gastroenteritis in Havelock North in August 2016, during which more than 5,000 people were estimated to have fallen ill. Up to four deaths were associated with the outbreak.

The Ministry undertook some immediate actions in response to the Inquiry, including the following:

- the Director-General issued a formal statement on 20 December 2017 asking district health boards to remind water suppliers of their statutory responsibilities to provide safe water – including considering treating water treatment – set out in the Health Act 1956
- we issued updated guidance and training to drinking-water assessors, medical officers of health and health protection officers.

The Ministry has provided further information on compliance and enforcement to public health officers, specifically by:

- establishing a Drinking-water Advisory Committee with expertise across a range of relevant disciplines to provide advice on supplying safe drinking-water, including revisions to the Drinking-water Standards
- ensuring the accountability arrangements for drinking-water assessors are clear, and improving communication channels between assessors

- providing advice and guidance to drinking-water assessors and drinking water suppliers to help them improve risk assessment and management of drinking-water supplies
- commissioning the Institute of Environmental Science and Research (ESR) to update the Ministry's water safety plan framework and supporting 39 guidance documents
- encouraging public health units to set up collaborative arrangements with water suppliers in their regions to promote information sharing and cooperation at local levels to improve the safety of drinking-water.

Misuse of Drugs (Medicinal Cannabis) Amendment Bill

The Ministry provided legal and regulatory advice on the Misuse of Drugs (Medicinal Cannabis) Amendment Bill, including supporting select committee consideration (see section C: Our strategy).

Government Inquiry into Mental Health and Addiction

The Ministry provided input and advice to assist the Government Inquiry into Mental Health and Addiction (see section C: Our strategy).

Reviewing standards

In collaboration with Standards New Zealand, the Ministry is reviewing the mandatory Health and Disability Services Standards (2008) and the Fertility Services Standards (2007).

Implementing substance addiction legislation

The Ministry is implementing the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (see section C: Our strategy).

Funeral-sector regulation

The Ministry is considering options for regulating the funeral sector.

In 2015, the Law Commission reported on *Death, Burial and Cremation in New Zealand* and made 127 recommendations to improve the law on death certification, cemeteries and crematoria, the funeral sector, and burial decisions.

The scope of the Law Commission's recommendations involves multiple agencies. The Ministry is leading policy work to develop options for implementing the recommendations. To this end, we are working with the Department of Internal Affairs, the Ministry for the Environment, Te Puni Kōkiri, the Ministry of Justice, the Ministry of Business, Innovation and Employment and Local Government New Zealand to address the Law Commission's recommendations.

Climate change: Draft Health Planning Guide

The Ministry has a responsibility to ensure that DHBs, public health units and other organisations effectively prepare for periods of high heat associated with climate change. We are developing heat health plan guidelines to encourage and guide relevant organisations to prepare heat health plans. Consultation on the draft guideline started in 2017/18.

Outbreak management

The Ministry provides clinical leadership and advice for management of localised and national outbreaks of communicable diseases.

In 2017/18, we worked closely with public health units and ESR to manage outbreaks of mumps and measles. We are closely monitoring increased rates of pertussis, syphilis and meningococcal diseases and are working with health care providers to ensure communities are taking practical steps to prevent the further spread of these communicable diseases. We have contracted ESR to provide reference and specialist testing services, scientific support services and agreed special communicable disease projects.

Performance assessment

Actual 2016/17	Performance measure	Actual 2017/18	Budget standard 2017/18
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%
87%	The percentage of all certificates issued to providers under the Health and Disability Services (Safety) Act 2001 within target timeframes	90%	90%
90%	The percentage of all licences and authorities issued to providers under the Medicines Act 1981 and Misuse of Drugs Act 1975 within target timeframes (see note 1)	84%	90%
99%	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	90%	90%
88%	The percentage of all new medicines applications (for ministerial consent to market) that receive an initial assessment within 200 days	85%	80%
100%	The percentage of all changed medicines notifications (for ministerial consent to market) responded to within 45 days	100%	100%
4.37	Average rating for statutory committee satisfaction with secretariat services provided by the Ministry	4	greater than 4 out of 5

Note 1: Performance was lower than projected due to a significant increase in applications for new premises, and increased demand-driven work relating to auditing, medicinal cannabis and industrial hemp activity.

Financial performance

Actual	Regulatory and enforcement services	Actual	Budget	Revised budget³⁴
2016/17		2017/18	2017/18	2017/18
\$000		\$000	\$000	\$000
9,192	Crown revenue	11,363	10,653	11,363
10,184	Third-party revenue	10,336	14,041	13,458
19,376	Total revenue	21,699	24,694	24,821
22,042	Total expenditure	24,820	24,694	24,821
(2,666)	Net surplus	(3,121)	0	0

³⁴ These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Sector planning and performance

Scope of appropriation

This appropriation is limited to advising on and coordinating health sector planning and performance improvement; and funding, monitoring, and supporting the governance of, health sector Crown entities, and sector coordination.

What is intended to be achieved with this appropriation

This appropriation is intended to ensure health sector services are appropriately planned, funded, and monitored; health sector Crown entities, agencies, and companies are appropriately governed; and sector co-ordination is encouraged and assisted.

Our role

Supporting governance functions

The Minister, in consultation with Cabinet and Caucus, appoints suitable candidates to DHBs and other health Crown entity boards. The Ministry assists the Minister with the appointments process.

Health provider planning and performance

The Ministry is responsible for the funding, monitoring and planning of DHBs and other health Crown entities.

We work with DHBs to create accountability documents outlining their deliverables and what can be done to improve their performance. We also monitor their service and financial performance over the year against their targets, and work with them to address any issues that may affect their ability to meet performance expectations. DHB performance is reported periodically to the Minister.

We support planning and performance for non-DHB Crown entities. We also provide advice to the Minister on Crown entity planning (eg, statements of intent and output agreements) and reporting (eg, quarterly and annual reports).

Planning and funding support systems

We assist Crown entities to plan for the upcoming financial year. We work closely and collaboratively with DHBs and give advice to the Minister on DHB annual plans by 30 June 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 assisting with facilitation, feedback and advice on the draft plans, the Ministry functions as an advisor in the process; ministers and the DHBs sign off the plans.

Performance monitoring

We use several performance indicators to set expectations and monitor performance to ensure DHBs appropriately work towards agreed priorities for performance improvement and health outcomes.

A vital part of the reporting process is the feedback the Ministry provides to DHBs on delivery of these measures, particularly when improvement is necessary.

We provided the following reports to the Minister:

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

Emergency response

We maintain the capability and capacity to lead and coordinate a national health response to an emergency. This includes maintaining plans to continue functioning during and after an emergency, in accordance with the Civil Defence Emergency Management Act 2002.

Our responsibilities include:

- ensuring we are capable of continuing to function to the fullest extent possible in an emergency that affects our 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
- leading an all-of-government response to a national health emergency such as a pandemic.

We maintain the capability to activate an emergency response within two hours of notification of an emergency event requiring national coordination, including activation of the National Health Coordination Centre (NHCC). We have identified primary and alternative sites for the NHCC, and our system also allows for the NHCC to be set up at an alternate location, if required.

Our achievements in 2017/18

Pandemic Influenza Planning: Completion of Exercise Pomare

The Ministry leads the all-of-government response for human health emergencies, including pandemics. The New Zealand Influenza Pandemic Plan (2017) provides the all-of-government framework and measures to prepare for, and respond to, an influenza pandemic.

We led Exercise Pomare, a national inter-agency exercise series, between October 2017 and May 2018 to familiarise government agencies with their role and responsibilities before, during and after a pandemic response. The exercise series will inform updating the Plan and further pandemic planning across agencies.

World Health Organization Emergency Medical Team classification for the New Zealand Medical Assistance Team

The Ministry has a responsibility to ensure that the health and disability sector has sufficient capability and capacity to respond to health emergencies, including disasters in the Pacific.

Our New Zealand Medical Assistance Team (NZMAT) is a multidisciplinary team of health specialists with the necessary skills, qualifications and training to support a health emergency response within New Zealand or the southwest Pacific.

The World Health Organization classified the NZMAT in September 2017, officially acknowledging that the team has the capacity and capability to meet agreed international guiding principles and minimum technical standards for safe, effective and ethical health care delivery as an emergency medical team.

Performance assessment

Actual 2016/17	Performance measure	Actual 2017/18	Budget standard 2017/18
Achieved	Planning and funding advice for the financial year is provided to Crown entities by 31 December (see Note 1)	Not Achieved	Achieved
Achieved	The Ministry provides the Minister with advice of all DHB annual plans by 30 June (see Note 1)	Not Achieved	Achieved
100%	The percentage of monitoring feedback reports about performance supplied to DHBs within agreed timeframes	100%	100%
45%	The percentage of quarterly and monthly monitoring reports about DHBs provided to the Minister within agreed timeframes (see note 2)	40%	100%
100%	The percentage of quarterly and monthly monitoring reports about Crown entities (excluding DHBs) provided to the Minister within agreed timeframes	100%	100%
Achieved	Maintain the capability and capacity to respond to national emergencies and emerging health threats (see note 3)	Achieved	Achieved
100%	The percentage of appointments to DHBs and other health Crown entity boards where advice is presented to the Minister before the current appointee's term expiring (see note 4)	78%	100%

Note 1: Timeframes were delayed to enable more time for detailed planning discussions and analysis with the Minister of Health and this had a flow on impact on the planning process with DHBs.

Note 2: Timeframes were impacted by the need to collect and analyse additional information (including variance analysis) and the subsequent preparation, review and approval of the resulting information. Parts of the reporting processes are beyond the Ministry's control, and further work is underway to improve reporting timeframes with DHBs.

Note 3: Capability and capacity to respond means the Ministry has the necessary systems, procedures, facilities and staffing to initiate and manage the health response to a national emergency or emerging health threat at the national level.

Note 4: Unexpected resignation or departure prior to expiration of a term is not included from this measure. The year end result was outside of the Ministry's control. The Ministry was unable to provide advice on the expiry of two out of nine board members whose terms expired in 2017/18, due to these terms expiring in the period of restraint leading up to, and following the outcome of, the 2017 general election.

Financial performance

Actual	Sector planning and performance	Actual	Budget	Revised budget³⁵
2016/17		2017/18	2017/18	2017/18
\$000		\$000	\$000	\$000
48,423	Crown revenue	48,315	47,277	48,315
157	Third-party revenue	1	149	149
48,580	Total revenue	48,316	47,426	48,464
48,010	Total expenditure	48,464	47,426	48,464
570	Net surplus	(148)	0	0

³⁵ These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Policy advice and ministerial servicing

The purpose of this multi-category expense appropriation is to provide policy advice and other support to Ministers in discharging their policy decision-making and other portfolio responsibilities.

Scope of appropriation: departmental output expenses

Ministerial servicing

This category is limited to the provision of services to Ministers to enable them to discharge their portfolio responsibilities other than policy decision-making.

Policy advice

This category is limited to the provision of advice (including second opinion advice and contributions to policy advice led by other agencies) to support decision-making by Ministers on government policy matters.

What is intended to be achieved with this appropriation

This appropriation is intended to ensure that Ministers are supported and advised so they can discharge their portfolio responsibilities.

Ministerial servicing

This category is intended to ensure Ministers are provided with support so that they can discharge their portfolio responsibilities.

Policy advice

This category is intended to ensure Ministers are provided with policy advice that appropriately informs them on issues affecting the health portfolio, Government priorities, and when otherwise appropriate.

Our role

The Ministry provides a wide range of advice and policy services to Ministers including preparing draft correspondence, providing briefings, and preparing responses to Official Information Act (1982) (OIA) requests as well as providing advice on policy matters.

Our achievements in 2017/18

Ministerial servicing

In 2016/17 the Ministry identified issues with ministerial servicing timeliness and quality. In response, we completed a project to address these issues and clear the backlog of work and in doing so, improved our capability and capacity.

Policy advice

The Ministry has continued to provide quality policy advice to support decision-making by Ministers. We have further enhanced our processes through adoption of the Department of Prime Minister and Cabinet Policy Project tools.

Performance assessment

Actual 2016/17	Performance measure	Actual 2017/18	Budget standard 2017/18
Ministerial servicing			
97%	Percentage of responses provided to the Minister within agreed timeframes; for written parliamentary questions and ministerial letters (see note 1)	89%	96%
85%	Percentage of responses provided to the Minister within agreed timeframes, for requested briefings (see note 1)	88%	96%
99%	Percentage of Ministerial letters that required no revision (see note 1)	NA	98%
84%	Percentage of responses to Official Information Act requests provided to the Minister within the agreed timeframe (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) (see note 1)	84%	95%
Policy advice			
7.03	The average score attained by written policy advice as assessed by an external reviewer ³⁶	7.23	greater than 7 out of 10
\$186.12	Total policy function cost per output hour	\$182.81	\$175–\$185

Note 1: The Ministry identified process and quality issues with previous processes and completed a project to address these issues. This has addressed the backlog of work and improved our OIA capability and capacity. We are working with the Minister's Office to improve ministerial correspondence processes. We did not collect data for ministerial letters that require no revision. However, we will resume reporting in 2018/19.

³⁶ The external review was completed by New Zealand Institute of Economic Research (NZIER).

Financial performance

Actual 2016/17 \$000	Multi-category expenses: Policy advice and ministerial servicing	Actual 2017/18 \$000	Budget 2017/18 \$000	Revised budget³⁷ 2017/18 \$000
	Policy advice			
16,003	Crown revenue	15,389	16,289	15,389
	Third-party revenue			
16,003	Total revenue	15,389	16,289	15,389
16,134	Total expenditure	15,385	16,289	15,389
(131)	Net surplus	4	0	0
	Ministerial servicing			
4,706	Crown revenue	5,202	4,702	5,202
	Third-party revenue			
4,706	Total revenue	5,202	4,702	5,202
4,387	Total expenditure	5,201	4,702	5,202
319	Net surplus	1	0	0

³⁷ These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Ministry of Health – capital expenditure

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.

What is intended to be achieved with this appropriation

This appropriation is intended to achieve the renewal, upgrade, or redesign of assets to support the delivery of the Ministry of Health’s core functions and responsibilities.

Our role

The Ministry manages the renewal, upgrade, or redesign of assets used in the delivery of the Ministry of Health’s core functions and responsibilities.

Performance assessment

Actual 2016/17	Performance measure	Actual 2017/18	Budget standard 2017/18
Achieved	Expenditure is in accordance with the Ministry of Health’s capital asset management plan	Achieved	Achieved

Financial performance

Actual 2016/17 \$000	Ministry of Health: capital expenditure	Actual 2017/18 \$000	Budget 2017/18 \$000	Revised budget ³⁸ 2017/18 \$000
10,659	Total expenditure	7,163	8,000	9,929

³⁸ These are the appropriations from the supplementary estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

Section F: Audit report and financial statements

Statement of responsibility

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

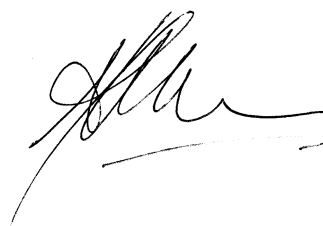
- the preparation of the Ministry's financial statements, and statements of expenses and capital expenditure, and for the judgements expressed in them
- having in place a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting
- ensuring 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
- 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 2018 and its operations for the year ended on that date
- the forecast financial statements fairly reflect the forecast financial position of the Ministry as at 30 June 2019 and its operations for the year ending on that date.



Dr Ashley Bloomfield
Director-General of Health
28 September 2018



Fergus Welsh
Chief Financial Officer (Acting)
28 September 2018

Independent Auditor's Report

To the readers of the Ministry of Health's annual report for the year ended 30 June 2018

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 70 to 94 that comprise the statement of financial position, statement of commitments, statement of contingent liabilities and contingent assets as at 30 June 2018, 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 2018 on pages 33 to 62, and 110 to 119; and
- the statements of expenses and capital expenditure of the Ministry for the year ended 30 June 2018 on pages 106 to 109; and
- the schedules of non-departmental activities that are managed by the Ministry on behalf of the Crown on pages 95 to 105 that comprise:
 - the schedules of assets; liabilities; commitments; and contingent liabilities and assets as at 30 June 2018;
 - the schedules of expenses; and revenue for the year ended 30 June 2018; and
 - the notes to the schedules that include accounting policies and other explanatory information.

Opinion

In our opinion:

- the financial statements of the Ministry on pages 70 to 94:
 - present fairly, in all material respects:
 - its financial position as at 30 June 2018; 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 performance information of the Ministry on pages 33 to 62, and 110 to 119:
 - presents fairly, in all material respects, for the year ended 30 June 2018:
 - 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.
- the statements of expenses and capital expenditure of the Ministry on pages 106 to 109 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 that are managed by the Ministry on behalf of the Crown on pages 95 to 105 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 2018; and
 - expenses; and revenue for the year ended 30 June 2018.

Our audit was completed on 28 September 2018. 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 audit 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.

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 Strategic

Intentions 2017 to 2021, Estimates and Supplementary Estimates of Appropriations 2017/18 for Vote Health, and the 2017/18 forecast financial figures in the Ministry's 2016/17 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 iii to vi, 1 to 32, 63 to 64, and 120 to 131 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 over the Electronic Health Record Project and a review of the process followed by the Ministry in its engagement of a consultant to review the National Oracle Solution programme. Other than the audit and these engagements, 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 2018

Actual	Note	Actual	Unaudited	Unaudited
2017		2018	budget	forecast
\$000		\$000	\$000	\$000
Revenue				
185,484	Revenue Crown	192,322	184,092	193,853
10,367	Other revenue	10,392	14,190	13,607
195,851	Total revenue	202,714	198,282	207,460
Expenses				
113,436	Personnel costs	115,728	115,292	114,687
7,760	Depreciation and amortisation expense	8,219	7,581	8,216
2,108	Capital charge	1,875	2,576	2,108
73,198	Other expenses	80,095	70,833	80,560
5	Net (gain)/loss on sale/disposal of property, plant and equipment	(1)	-	-
196,507	Total expenses	205,916	196,282	205,571
(656)	Surplus/(deficit)	(3,202)	2,000	1,889
Other comprehensive revenue and expense				
<i>Item that will not be reclassified to net surplus/(deficit)</i>				
-	Gain/(loss) on property revaluations	-	-	-
-	Total other comprehensive revenue and expense	-	-	-
(656)	Total comprehensive revenue and expense	(3,202)	2,000	1,889

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 2018

Actual		Note	Actual	Unaudited budget	Unaudited forecast
2017			2018	2018	2019
\$000			\$000	\$000	\$000
Equity					
30,159	Taxpayers' funds		30,385	33,472	33,583
2,590	Property revaluation reserve		2,590	2,590	2,590
(93)	Memorandum accounts		(1,521)	(1,521)	(1,521)
32,656	Total equity	12	31,454	34,541	34,652
Represented by:					
Assets					
Current assets					
7,758	Cash and cash equivalents		6,203	5,000	7,000
1,184	Receivables		1,213	1,146	1,146
6,764	Crown debtors		7,418	1,990	5,218
4,556	Prepayments		1,889	2,894	2,894
20,262	Total current assets		16,723	11,030	16,258
Non-current assets					
10,959	Property, plant and equipment	6	10,048	11,371	9,241
29,929	Intangible assets	7	30,255	34,864	33,850
40,888	Total non-current assets		40,303	46,235	43,091
61,150	Total assets		57,026	57,265	59,349
Liabilities					
Current liabilities					
16,224	Payables	8	16,337	10,203	10,895
1,229	Return of operating surplus	9	-	608	1,889
952	Provisions	10	-	2,372	2,372
8,613	Employee entitlements	11	7,810	8,168	8,168
27,018	Total current liabilities		24,147	21,351	23,324
Non-current liabilities					
30	Provisions	10	-	-	-
1,446	Employee entitlements	11	1,425	1,373	1,373
1,476	Total non-current liabilities		1,425	1,373	1,373
28,494	Total liabilities		25,572	22,724	24,697
32,656	Net assets		31,454	34,541	34,652

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 2018

Actual	Note	Actual	Unaudited	Unaudited
2017		2018	budget	forecast
\$000		\$000	2018	2019
		\$000	\$000	\$000
34,541	Balance at 1 July	32,656	34,541	34,652
(656)	Total comprehensive revenue and expense	(3,202)	2,000	1,889
	Owner transactions			
(1,229)	Return of operating surplus to the Crown	-	(2,000)	(1,889)
	Capital contribution - cash	2,000	-	-
32,656	Balance at 30 June	31,454	34,541	34,652

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

Statement of cash flows for the year ended 30 June 2018

Actual		Actual	Unaudited	Unaudited
2017		2018	budget	forecast
\$000		\$000	2018	2019
		\$000	\$000	\$000
	Cash flows from operating activities			
180,178	Receipts from revenue Crown	191,668	184,511	194,448
9,896	Receipts from other revenue	10,752	14,190	13,607
(73,713)	Payments to suppliers	(79,897)	(75,412)	(86,230)
(113,544)	Payments to employees	(115,629)	(110,713)	(108,991)
(2,108)	Payments for capital charge	(1,874)	(2,576)	(2,108)
692	Goods and services tax (net)	(184)	-	-
1,401	Net cash flow from operating activities	4,836	10,000	10,726
	Cash flows from investing activities			
11,201	Receipts from sale of property, plant and equipment	1	-	-
(8,298)	Purchase of property, plant and equipment	(577)	(1,000)	(50)
(2,361)	Purchase of intangible assets	(6,586)	(7,000)	(8,787)
542	Net cash flow from investing activities	(7,162)	(8,000)	(8,837)
	Cash flows from financing activities			
-	Capital Injection	2,000	-	-
(608)	Return of operating surplus	(1,229)	(2,000)	(1,889)
(608)	Net cash flow from financing activities	771	(2,000)	(1,889)
1,335	Net increase in cash held	(1,555)	-	-
6,423	Cash at the beginning of the year	7,758	5,000	7,000
7,758	Cash at the end of the year	6,203	5,000	7,000

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 2018 (continued)

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

Actual 2017 \$000		Actual 2018 \$000
(656)	Net surplus/(deficit)	(3,202)
	Add/(less) non-cash items:	
7,760	Depreciation and amortisation expense	8,219
604	Asset Write off/down	116
8,364	Total non-cash items	8,335
	Add/(less) items classified as investing or financing activities:	
5	(Gains) on disposal of property, plant and equipment	(1)
-	Non-cash transaction - adjustment to depreciation	160
5	Total items classified as investing or financing activities	159
	Add/(less) movements in working capital items:	
(237)	(Increase)/decrease in receivables	(29)
(5,306)	(Increase)/decrease in Crown debtor	(654)
(2,402)	(Increase)/decrease in prepayments	2,667
3,817	Increase/(decrease) in payables [^]	(634)
(2,738)	Increase/(decrease) in provisions	(982)
554	Increase/(decrease) in employee entitlements	(824)
(6,312)	Total movements in working capital items	(456)
1,401	Net cash flow from operating activities	4,836

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.

Statement of commitments as at 30 June 2018

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.

The accompanying notes form part of these financial statements.

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 2017 \$000		Actual 2018 \$000
	Capital commitments	
126	Intangible assets	680
126	Total capital commitments	680
	Operating leases as lessee	
	Future aggregate lease payments to be paid under non-cancellable operating leases are as follows:	
10,005	Not later than one year	9,319
37,922	Later than one year and not later than five years	37,580
81,452	Later than five years	73,233
129,379	Total non-cancellable operating lease commitments	120,132
129,505	Total commitments	120,812

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 2018

The Ministry had no contingent liabilities as at balance date (2017: \$nil).

The Ministry had no contingent assets as at balance date (2017: \$nil).

The accompanying notes form part of these financial statements.

Notes to the financial statements for the year ended 30 June 2018

Notes index

1. Statement of accounting policies
2. Revenue
3. Personnel costs
4. Capital charge
5. Other expenses
6. Plant, property and equipment
7. Intangible assets
8. Payables
9. Return of operating surplus
10. Provisions
11. Employee entitlements
12. Equity
13. Memorandum accounts
14. Related party transactions
15. Events after the balance date
16. Explanations of major variances against budget.

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 95 to 105.

The financial statements are for the year ended 30 June 2018 and were approved for issue by the Director-General of Health on 28 September 2018.

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.

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the Ministry are:

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards. Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of the Ministry adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1 January 2021, with earlier application permitted. The main changes under the standard relevant to the Ministry are:

- new financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- a new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. The Ministry will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The Ministry has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the Ministry anticipates that the standard will not have a material effect on the Ministry's 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.

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 2018 budget figures are for the year ended 30 June 2018 and were published in the 2016/17 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 2017/18.

Basis of the forecast figures

The 2019 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 2018/19.

The forecast financial statements have been prepared as required by the PFA to communicate forecast financial information for accountability purposes. The 30 June 2019 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 2018.

While the Ministry regularly updates its forecasts, updated forecast financial statements for the year ending 30 June 2019 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 2018/19 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 2018, 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 2017/18 was used as the opening position for the 2018/19 forecasts.

The actual financial results achieved for 30 June 2019 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 2017 \$000		Actual 2018 \$000
8,034	Medicines registration	7,616
415	Service fees	427
1,723	Annual licence and registration fees	2,264
195	Other revenue	85
10,367	Total other revenue	10,392

3 Personnel costs

Accounting policy

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

Breakdown personnel costs

Actual 2017 \$000		Actual 2018 \$000
108,060	Salaries and wages	110,358
3,372	Employer contributions to defined contribution plans	3,521
554	Increase/(decrease) in employee entitlements	(825)
1,450	Other personnel costs	2,674
113,436	Total personnel costs	115,728

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 2018 was 6.0% (2017: 6.0%).

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 2017 \$000		Unaudited		
		Actual 2018 \$000	Budget 2018 \$000	Unaudited Forecast 2019 \$000
390	Fees to Audit New Zealand for audit of financial statements	416	385	385
20,335	Contractors and consultants	21,042	13,251	21,408
20,951	Computer services	22,516	22,150	23,150
3,754	Travel	3,456	3,187	3,187
6,703	Communications and couriers	6,351	5,783	6,783
1,675	Printing and stationery	1,410	1,510	1,510
9,368	Operating lease payments	11,669	11,341	11,287
1,349	Occupancy costs other than leases	3,154	3,428	3,482
4,579	Professional specialist fees	6,709	6,455	4,297
234	Asset write-offs	116	-	-
3,860	Other expenses	3,256	3,343	5,071
73,198	Total other expenses	80,095	70,833	80,560

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 costs 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 or 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 or 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 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
Balance as at 1 July 2017	5,350	5,990	1,941	373	18,640	32,294
Additions	-	48	27	-	91	166
Disposals	-	(240)	(307)	-	(12,096)	(12,643)
Balance as at 30 June 2018	5,350	5,798	1,661	373	6,635	19,817
Accumulated depreciation and impairment losses						
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
Balance as at 1 July 2017	-	1,387	1,190	286	18,472	21,335
Prior year adjustment	-	160	-	-	-	160
Depreciation expense	-	552	131	12	105	800
Eliminate on disposal	-	(201)	(233)	-	(12,092)	(12,526)
Balance as at 30 June 2018	-	1,898	1,088	298	6,485	9,769
Work in progress (WIP)						
At 30 June 2016	-	6,148	11	-	6	6,165
At 30 June 2017	-	3,566	92	-	24	3,682
At 30 June 2018	-	-	11	-	41	52
Total property, plant and equipment including WIP						
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
At 30 June 2018	5,350	3,900	573	75	150	10,048

The land at 108 Victoria Street, Christchurch was valued by Bayleys Valuations Limited, an independent valuer. The effective date of the evaluation is 30 June 2018. 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	3–10 years	14.3–33.3%
Software – other	3–10 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 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
Balance as at 1 July 2017	20,418	74,848	95,266
Additions	22	7,723	7,745
Disposals	(320)	(3,142)	(3,462)
Balance as at 30 June 2018	20,120	79,429	99,549
Accumulated amortisation and impairment losses			
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
Balance as at 1 July 2017	19,266	46,071	65,337
Amortisation expense	262	7,157	7,419
Disposals	(320)	(3,142)	(3,462)
Balance as at 30 June 2018	19,208	50,086	69,294
Work in progress			
At 30 June 2016	57	10,768	10,825
At 30 June 2017	138	11,663	11,801
At 30 June 2018	2,488	6,833	9,321
Total intangible assets including WIP			
At 30 June 2016	1,553	32,686	34,239
At 30 June 2017	1,152	28,777	29,929
At 30 June 2018	912	29,343	30,255

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 2017 \$000		Actual 2018 \$000
428	Creditors	3,578
1,931	Revenue in advance	2,320
12,078	Accrued expenses	8,832
1,787	GST payable	1,607
16,224	Total payables	16,337

9 Return of operating surplus

Actual 2017 \$000		Actual 2018 \$000
(656)	Net surplus/(deficit)	(3,202)
	Add:	
1,885	(Surplus)/deficit of memorandum accounts	1,428
1,229	Total operating surplus/(deficit)	(1,774)
1,229	Total return of operating surplus	-

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 2017 \$000		Actual 2018 \$000
	Current portion	
645	Restructuring	-
300	Demolition of NRL building	-
7	Other	-
952	Total current portion	-
	Non-current portion	
30	ACC partnership programme	-
30	Total non-current portion	-
982	Total provisions	-

Movement of provisions

	Restructuring \$000	Other \$000	Total \$000
Opening balance 1 July	645	337	982
Amounts applied	(645)	-	(645)
Unused amounts reversed		(337)	(337)
Closing balance 30 June	-	-	-

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

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 1.77% (2017: 1.87%) 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 \$92,172 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 \$123,037 higher/lower.

Breakdown of employee benefits

Actual 2017 \$000		Actual 2018 \$000
	Current position	
6,302	Annual leave	6,218
422	Sick Leave	-
1,046	Retirement and long service leave	759
843	Accrued salaries	833
8,613	Total current portion	7,810
	Non-current position	
1,446	Retirement and long service leave	1,425
1,446	Total non-current portion	1,425
10,059	Total employee entitlements	9,235

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 2017 \$000		Actual 2018 \$000
	Taxpayers' funds	
30,159	Balance at 1 July	30,159
(656)	Surplus/(deficit)	(3,202)
1,885	Transfer of memorandum account net deficit for the year	1,428
(1,229)	Return of operating surplus to the Crown	-
-	Capital Injection	2,000
30,159	Balance at 30 June	30,385
	Property revaluation reserves	
2,590	Balance at 1 July	2,590
-	Revaluation gains on land and building	-
2,590	Balance at 30 June	2,590
	Memorandum accounts	
1,792	Balance at 1 July	(93)
(1,885)	Net memorandum account deficits for the year	(1,428)
(93)	Balance at 30 June	(1,521)
32,656	Total equity	31,454

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 taxpayers' 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		Actual
2017		2018
\$000		\$000
	Opening balance	
(515)	Problem gambling	(730)
1,019	Office of radiation safety	631
1,288	Medsafe	6
1,792		(93)
	Revenue and appropriation	
957	Problem gambling appropriation	990
582	Office of radiation safety revenue	1,126
7,646	Medsafe revenue	7,309
9,185		9,425
	Expenditure	
(1,172)	Problem gambling expenditure	(869)
(970)	Office of radiation safety expenditure	(1,359)
(8,928)	Medsafe expenditure	(8,625)
(11,070)		(10,853)
(1,885)	Total deficit for year	(1,428)
	Closing balance	
(730)	Problem gambling	(609)
631	Office of radiation safety	398
6	Medsafe	(1,310)
(93)		(1,521)

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 2017 \$000		Actual 2018 \$000
	Leadership Team including the Chief Executive:	
4,429	Remuneration	5,165
11	Full-time equivalent staff	12

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 \$8.2 million higher than the unaudited budget. This was mainly due to additional funding during the year reflecting an in-principle transfer from 2016/17 for National Bowel Screening solution (\$1.8 million); additional funding to meet costs associated with Pay Equity implementation (\$5.1 million); and work on very low cost GP visits for Gold Card holders (\$1.5 million).

Revenue other

Revenue other was \$3.8 million lower than the unaudited budget. This was mainly due to Natural Health Products not generating revenue (\$1.3 million) and lower demand for Product Regulation Services (\$2.5 million).

Depreciation

Depreciation and amortisation costs were \$0.6 million lower than the unaudited budget due to timing of the completion of some capital projects.

Other expenses

Other expenses are higher than the unaudited budget by \$9.3 million. This was mainly due to higher contractor and consultancy costs for Pay Equity (\$3.9 million) and National Bowel Screening Programme (\$2.0 million) and a number of operating areas (\$1.9 million). The balance of \$1.5 million is due to marginally higher costs across most other expenditure types.

Statement of financial position

Current assets

Current assets were \$5.7 million higher than the unaudited budget. This was mainly due to higher Crown debtors (\$5.4 million) and cash (\$1.2 million) partially offset by lower prepayments (\$1.0 million).

Property, plant and equipment, and intangible assets

Property, plant and equipment, and intangible assets were \$5.9 million lower than the unaudited budget due to timing of the completion of some capital projects.

Payables

Payables were \$6.1 million higher than the unaudited budget. This was mainly due to GST and PAYE (\$1.6 million) not due to be paid until the following month, higher Therapeutics Revenue in Advance (\$0.5 million), higher inter-agency payables (\$0.3 million) and generally higher Ministry payables (\$3.5 million).

Non-departmental statements and schedules for the year ended 30 June 2018

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 2018

Actual 2017 \$000		Actual 2018 \$000	Budget 2018 \$000	Revised budget 2018 \$000
	Non-departmental appropriations			
12,194,581	Health and disability support services for DHB	12,711,847	12,682,765	12,717,147
2,857,750	National services	3,236,303	3,200,179	3,247,254
104,899	Non-departmental other expenses	22,196	27,347	22,410
3,033,039	Non-departmental capital contributions to other persons or organisations	341,338	656,496	503,225
18,190,269	Total non-departmental appropriations	16,311,684	16,566,787	16,490,036

Revised budget includes adjustments made in the Supplementary Estimates and under PFA.

There was no non-departmental other expenses not requiring appropriation in 2018. (2017: 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 \$2,448.5 million (2017: \$2,272.6 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 2018.

Schedule of non-departmental revenue and capital receipts for the year ended 30 June 2018

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		Actual	Budget	Revised
2017		2018	2018	budget
\$000		\$000	\$000	\$000
	Revenue			
	Reimbursement from the Accident Compensation Corporation (ACC)			
5,900	Reimbursement of complex burns costs	6,092	5,091	5,091
24,139	Reimbursement of work-related public hospital costs	24,920	30,546	30,546
297,627	Reimbursement of non-earners' account	307,260	290,184	290,184
103,499	Reimbursement of earners' non-work-related public hospital costs	106,849	91,637	91,637
52,404	Reimbursement of motor vehicle-related public hospital costs	54,100	76,364	76,364
4,231	Reimbursement of medical misadventure costs	4,368	5,091	5,091
4,600	Reimbursement of self-employed public hospital costs	4,749	10,182	10,182
492,400	Total ACC reimbursements	508,338	509,095	509,095
	Non-departmental revenue			
183,515	Payment of capital charge by DHB	325,984	239,591	254,059
675,915	Total non-departmental revenue	834,322	748,686	763,154
	Non-departmental capital receipts			
10,034	Repayment of residential care loans	11,220	15,000	15,000
600	Repayment of DHB debt	-	-	-
12,499	Equity repayments by DHB	12,499	12,499	12,499
23,133	Total non-departmental capital receipts	23,719	27,499	27,499
699,048	Total non-departmental revenue and capital receipts	858,041	776,185	790,653

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 2018.

Schedule of non-departmental assets and liabilities as at 30 June 2018

Actual	Note	Actual	Budget	Revised budget
2017		2018	2018	2018
\$000		\$000	\$000	\$000
Assets				
Current assets				
133,291		162,949	95,000	95,000
12,733	2.8	8,518	17,000	17,000
Receivables:				
-		591	-	415
414		443	19,036	-
282		465	1,195	282
2,055		6,156	1,962	1,822
97,184		48,248	33,000	33,000
245,959		227,370	167,193	147,519
Non-current assets				
Advances:				
35,259		38,357	38,360	37,264
(116)		(116)	2,554	-
Investments:				
258,278	2.9	492,131	647,975	544,426
28,516		29,008	20,910	20,910
321,937		559,380	709,799	602,600
567,896		786,750	876,992	750,119
Liabilities				
Current liabilities				
-		-	-	-
Payables:				
22,017		19,048	-	-
29,847	2.10	31,330	-	-
Accrued liabilities and provisions:				
255,976		254,854	212,932	278,848
1,278		1,543	-	-
161,823		173,126	177,237	209,698
470,941		479,901	390,169	488,546

The Ministry monitors a number of Crown entities including 20 DHBs. 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 2018.

Schedule of non-departmental commitments as at 30 June 2018

Breakdown of capital commitments

Actual 2017 \$000		Actual 2018 \$000
265,661	Property, plant and equipment	110,632
265,661	Total capital commitments	110,632

Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2018

Breakdown of contingent liabilities

Actual 2017 \$000		Actual 2018 \$000
6,885	Legal proceedings and disputes	7,610
6,885	Total contingent liabilities	7,610

Legal proceedings and disputes

Legal claims against the Crown are mainly seeking recompense in relation to perceived issues regarding treatment and care, and the Crown 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 the balance date (2017: \$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 2018.

Problem Gambling Levy Report for the year ended 30 June 2018

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	Non-departmental actual	Departmental actual	Total actual
2017 \$000	2018 \$000	2018 \$000	2018 \$000
Problem Gambling non-departmental expenditure			
(1,736) Balance at 1 July	3,840	(730)	3,110
20,931 Revenue	19,560	990	20,550
(16,085) Expenses	(15,997)	(869)	(16,866)
3,110 Balance at 30 June	7,403	(609)	6,794

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".

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 2018.

Notes to the non-departmental statements and schedules

Notes index

1. Statement of accounting policies
2. Explanation of major variances against budget.

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 2018.

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.

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the Ministry are:

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards. Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of the Ministry adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1 January 2021, with earlier application permitted. The main changes under the standard relevant to the Ministry are:

- new financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- a new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. The Ministry will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The Ministry has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the Ministry anticipates that the standard will not have a material effect on the Ministry's 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 DHBs 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 2018.

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 DHBs

Variances differ across DHBs (net unfavourable variance of \$29.1 million) reflecting a number of changes during the year. These changes include technical changes such as changes to capital charge costs in the year (\$14.5 million) and equity to revenue changes (\$4.0 million). Additionally there were devolution of funding from appropriations administered by the Ministry, for alcohol and other drug treatment services from the National Mental Health Services (\$3.4 million) and devolving responsibility for guaranteed hours of work for the home and community support sector from National Disability Support Services (\$3.8 million).

2.2 National disability support services

The unfavourable variance of \$47.2 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 community care, residential services, and equipment services. There was also a transfer of funding during the year to DHBs (\$3.8 million as noted above). In addition to changes reflected in the 2017/18 Supplementary Estimates, a Section 26A change increasing the appropriation by \$5.0 million was provided to meet residual IBT costs and DSS volume pressures. However, growth in the last quarter was higher than expected and there was a \$12.9 million (1.02 percent) overspend against the final voted appropriation. This is being addressed through Section 26B of the Public Finance Act.

2.3 Public health services purchasing

The favourable variance of \$41.2 million against the Main Estimates is mainly due to the timing of projects in the Sanitary Works Subsidy Scheme (\$18.6 million) and in the Bowel Cancer screening programme rollout (\$9.3 million), with funding carried forward into 2018/19. Funding was also carried forward into 2018/19 for the Fluoridisation of Water Supply Assistance scheme (\$3.0 million) as this programme is awaiting enabling regulation change.

2.4 National Maternity Services

The unfavourable variance of \$19.7 million against the Main Estimates is related to cost pressures due to higher claimed volumes, and a 6 percent increase to the unit price of Lead Maternity Care Section 88 Notice modules implemented during the year.

2.5 Mental Health Pay Equity Settlement

The Crown negotiated a pay equity settlement for mental health and addictions support workers in 2018, with \$23.45 million of costs incurred in 2017/18. The settlement costs cannot be met from the existing 2017/18 appropriation – Supporting Equitable Pay for Care and Support Workers, where the scope of expenditure incurred against this appropriation was limited to funding costs incurred as a result of legislation giving effect to the pay equity settlement with care and support workers, and are therefore incurred without appropriation. Approval for unappropriated expenditure is being sought under Section 26C of the Public Finance Act.

2.6 Equity for capital projects for DHBs and Health Sector Crown Agencies

The favourable variance of \$277.6 million against the Main Estimates is mainly due to 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.

2.7 Health Sector Projects

This appropriation funds health sector capital projects that are Ministry led. Funding is appropriated to Health before the projects begin, but actual expenditure depends on the projects needed and the timing of those projects. In 2017/18 the appropriation mainly funded the Canterbury hospitals rebuild and the West Coast projects.

The favourable variance of \$54.7 million against the Main Estimates will be carried forward to 2018/19.

Schedule of non-departmental assets

2.8 Inventory

Vaccine stocks were \$8.5 million less than the Main Estimates due to the write-off of out-of-date emergency stock.

2.9 Christchurch and West Coast Hospital Rebuild Project

The Christchurch and West Coast Hospital Project was \$155.8 million lower than the Main Estimates due to the timing of the project.

Schedule of non-departmental liabilities

2.10 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 2018. 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 2018

Actual expenditure 2017 \$000	Appropriation title	Actual expenditure 2018 \$000	Budget 2018 \$000	** Revised budget 2018 \$000	Actual expenditure as a % of total Vote	Location of end-of-year performance information
	Notes					
Departmental output expenses						
34,054	Managing the purchase of services	43,368	36,213	41,973	0.26%	1
22,042	Regulatory and enforcement services	24,820	24,694	24,821	0.15%	1
48,010	Sector planning and performance	48,464	47,426	48,464	0.29%	1
53,501	Health sector information systems	52,840	51,618	52,845	0.32%	1
18,377	Payment services	15,838	17,340	15,840	0.10%	1
175,984	Total departmental output expenses	185,330	177,291	183,943	1.12%	
Multi-category expense and capital expenditure						
4,387	Ministerial servicing	5,201	4,702	5,202	0.03%	1
16,134	Policy advice	15,385	16,289	15,389	0.10%	1
Departmental capital expenditure						
10,659	Ministry of Health - permanent legislative authority	7,163	8,000	9,929	0.04%	1
31,180	Total multi-category expense and capital expenditure	27,749	28,991	30,520	0.17%	
207,164	Total departmental output appropriations	213,079	206,282	214,463	1.29%	
Non-departmental output expenses						
Health/disability support services for district health boards (DHB)						
536,633	Northland	564,287	557,165	564,289	3.41%	2
1,391,674	Waitemata	1,464,456	1,450,808	1,464,458	8.86%	2
1,195,265	Auckland	1,252,079	1,239,980	1,252,081	7.58%	2
1,321,733	Counties Manukau	1,375,690	1,377,805	1,375,692	8.33%	2
1,088,798	Waikato	1,150,494	1,134,739	1,150,497	6.96%	2
298,534	Lakes	314,710	310,096	314,712	1.90%	2
664,889	Bay of Plenty	694,747	694,230	694,749	4.20%	2
154,031	Tairāwhiti	160,653	160,113	160,655	0.97%	2
324,724	Taranaki	335,661	338,959	335,663	2.03%	2
470,211	Hawke's Bay	482,423	484,193	482,426	2.92%	2
210,551	Whanganui	218,554	218,859	218,556	1.32%	2
482,762	MidCentral	494,251	499,456	494,253	2.99%	2
372,954	Hutt Valley	384,878	388,121	384,880	2.33%	2
702,654	Capital and Coast	735,631	738,901	735,633	4.45%	2
130,946	Wairarapa	135,248	136,657	135,250	0.82%	2
403,401	Nelson-Marlborough	418,361	418,304	418,363	2.53%	2
124,489	West Coast	128,075	128,823	128,077	0.78%	2
1,330,249	Canterbury	1,378,248	1,375,372	1,383,508	8.34%	2
171,495	South Canterbury	177,017	178,097	177,019	1.07%	2
818,588	Southern	846,384	852,087	846,386	5.12%	2
12,194,581	Total health/disability support services for DHB	12,711,847	12,682,765	12,717,147	76.93%	

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 E "Our performance" 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 2018.
- 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 budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2018 (continued)

Actual expenditure 2017 \$000	Appropriation title	Notes	Actual expenditure 2018 \$000	Budget 2018 \$000	** Revised budget 2018 \$000	Actual expenditure as a % of total Vote	Location of end-of-year performance information
National services							
1,187,988	National disability support services	2.2	1,255,530	1,208,374	1,242,680	7.61%	3
386,087	Public health services purchasing	2.3	364,314	405,471	373,967	2.20%	3
81,764	National child health services		82,170	85,001	82,501	0.50%	3
350,577	National elective services		354,104	346,517	356,145	2.14%	3
101,033	National emergency services		108,162	109,958	110,118	0.65%	3
3,010	National Māori health services		2,149	6,828	2,750	0.01%	3
154,047	National maternity services	2.4	166,508	146,767	166,667	1.01%	3
64,848	National mental health services		65,090	62,183	65,356	0.39%	3
25,880	National contracted services - other		24,892	28,720	25,020	0.15%	3
28,642	Monitoring and protecting health and disability consumer interests		29,844	28,746	29,846	0.18%	3
14,900	Problem gambling services		15,997	17,521	17,821	0.10%	3
184,657	Health workforce training and development		186,609	186,745	186,745	1.13%	3
185,360	Primary health care strategy		192,531	195,405	193,405	1.17%	3
82,027	National personal health services		79,176	84,057	79,207	0.48%	3
4,369	National health information systems		4,701	8,236	5,028	0.03%	3
-	Auckland health projects intergrated investment plan		-	650	370	0.00%	4
2,561	Health sector projects operating expenses		5,270	-	10,328	0.03%	3
-	Equitable Pay for Care and Support Workers		275,806	279,000	299,300	1.67%	4
-	Mental Health Pay Equity Settlement	2.5	23,449	-	-	0.14%	
2,857,750	Total national services		3,236,303	3,200,179	3,247,254	19.58%	
15,052,331	Total non-departmental output expenses		15,948,150	15,882,944	15,964,401	96.51%	
Non-departmental other expenses							
1,703	International health organisations		1,819	2,030	1,843	0.01%	4
961	Legal expenses		1,972	1,028	2,028	0.01%	4
23,831	Provider development		18,405	24,289	18,539	0.11%	3
75,974	Repayment of DHB loans		-	-	-	0.00%	
102,469	Total non-departmental other expenses		22,196	27,347	22,410	0.13%	
Non-departmental capital contributions to other persons or organisations							
37,700	Deficit support for DHB		69,300	50,000	86,924	0.42%	2
2,539,467	Equity for capital projects for DHB and Health Sector Crown Agencies	2.6	25,811	303,388	120,639	0.16%	2
156,258	Health sector projects	2.7	233,375	288,108	280,662	1.41%	3
85,000	Loans for capital projects		-	-	-	0.00%	
204,214	Refinance of Crown loans		-	-	-	0.00%	
10,400	Residential care loans		12,852	15,000	15,000	0.08%	3
3,033,039	Total non-departmental capital contributions to other persons or organisations		341,338	656,496	503,225	2.08%	
18,187,839	Total non-departmental appropriations		16,311,684	16,566,787	16,490,036	98.71%	
18,395,003	Total Vote: Health		16,524,763	16,773,069	16,704,499	100.01%	

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 E "Our performance" 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 2018.
- 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.

Transfers under section 26A of the PFA for Vote Public Issues

The approved appropriation includes adjustments made in the Supplementary Estimates and the following transfers under section 26A of the PFA.

	Supp estimates 2018 \$000	Section26A transfers 2018 \$000	Approved appropriations 2018 \$000
Departmental output expenses			
Payment services	16,440	(600)	15,840
Managing the purchase of services	42,523	(550)	41,973
Health sector information systems	53,395	(550)	52,845
Sector planning and performance	47,474	990	48,464
Regulatory and enforcement service	24,111	710	24,821
Non-Departmental output expenses			
National personal health services	82,707	(3,500)	79,207
Public health service purchasing	375,567	(1,600)	373,967
National child health services	83,001	(500)	82,501
National contracted services - other	25,220	(200)	25,020
National disability support services	1,237,680	5,000	1,242,680
National mental health services	64,556	800	65,356

Statement of expenses and capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2018

	Expenditure after remeasurements 2018 \$000	Approved appropriation 2018 \$000	Unappropriated expenditure 2018 \$000
Vote Public Issues			
Departmental Output Expenses			
Managing the purchase of services	43,368	41,973	1,395
Non-Departmental Output Expense			
National services			
Disability Support Services	1,255,530	1,242,680	12,850
Mental Health Pay Equity Settlement	23,449	-	23,449

The Ministry of Health has two instances where expenditure has exceeded the approved appropriation. In addition one instance of expenditure was incurred without appropriation. The Disability Support Services appropriation will be managed under Section 26B of the Public Finance Act 1989. Managing the Purchase of Services and Mental Health Pay Equity Settlement will be managed under Section 26C of the Public Finance Act 1989. The reason for the unappropriated expenditure is detailed in the following paragraphs.

Expenses and capital incurred in excess of existing appropriation and approved by the Minister of Finance under Section 26B of the Public Finance Act 1989

For Disability Support Services, the Ministry of Health has incurred costs that were higher than appropriated mainly due to additional equipment claims, additional residential care services costs and growing demand for individualised funding services. This resulted in actual costs exceeding those appropriated by \$12.85 million.

Expenses and capital incurred in excess of existing appropriation and approved by the Minister of Finance under Section 26C of the Public Finance Act 1989

The settlement of the Mental Health and Addictions Support Workers' Pay Equity Claim and associated costs were agreed after finalisation of the 2017/18 Supplementary Estimates. Two instances of unappropriated expenditure arose as a consequence of the settlement.

The settlement costs totalling \$23.45 million cannot be met from the existing 2017/18 appropriation – Supporting Equitable Pay for Care and Support Workers, where the scope of expenditure incurred against this appropriation was limited to funding costs incurred as a result of legislation giving effect to the pay equity settlement with care and support workers, and are therefore incurred without appropriation.

The implementation costs totalling \$1.395 million associated with this that were incurred in the 2017/18 financial year have resulted in the Managing the Purchase of Services appropriation to exceed the total authority.

Statement of departmental capital injections for the year ended 30 June 2018

Actual capital injections 2017 \$000	Actual capital injections 2018 \$000	Approved appropriation 2018 \$000
Vote Public Issues		
- Ministry of Health - Capital injection	2,000	2,000

Statement of departmental capital injections without, or in excess of, authority for the year ended 30 June 2018

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 commenced developing a new outcomes and tracking framework in the last quarter of 2017/18 to clearly articulate the health outcomes we are seeking across the health and disability system.

As this new framework is still being developed, we selected the following high-level impact and outcome and measures to show the progress the health and disability system is making. All results reported reflect the latest data available at the time of writing.

Outcome measures

Table 5: Outcome measures³⁹

Measure	Target	Results																																											
Health-adjusted life expectancy improves over time																																													
Health-adjusted life expectancy is the number of years a person can expect to live in good health and without an impairment needing assistance	Improved results for male/female	<p>People in New Zealand live longer in good health, but spend a higher proportion of their lives with disability.</p> <p>Health-adjusted life expectancy⁴⁰</p> <table border="1"> <thead> <tr> <th>Gender</th> <th>2016</th> <th>2015</th> <th>2010</th> <th>2000</th> <th>1990</th> </tr> </thead> <tbody> <tr> <td>Female</td> <td>71.8</td> <td>71.8</td> <td>71.4</td> <td>69.8</td> <td>67.9</td> </tr> <tr> <td>Male</td> <td>69.8</td> <td>69.8</td> <td>69.3</td> <td>66.9</td> <td>64.2</td> </tr> </tbody> </table>	Gender	2016	2015	2010	2000	1990	Female	71.8	71.8	71.4	69.8	67.9	Male	69.8	69.8	69.3	66.9	64.2																									
Gender	2016	2015	2010	2000	1990																																								
Female	71.8	71.8	71.4	69.8	67.9																																								
Male	69.8	69.8	69.3	66.9	64.2																																								
Life expectancy increases over time																																													
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	Improved results for male/female and Māori/non-Māori	<p>Life expectancy is a summary measure of mortality and the trend shows New Zealanders are living longer than ever before.</p> <p>Life expectancy at birth⁴¹</p> <table border="1"> <thead> <tr> <th>Gender</th> <th>2015–17</th> <th>2014–16</th> <th>2013–15</th> <th>2012–14</th> <th>2005–07</th> </tr> </thead> <tbody> <tr> <td>Female</td> <td>83.4</td> <td>83.4</td> <td>83.3</td> <td>83.2</td> <td>82.2</td> </tr> <tr> <td>Male</td> <td>80.4</td> <td>79.9</td> <td>79.7</td> <td>79.5</td> <td>78.0</td> </tr> </tbody> </table> <p>Ethnicity and gender⁴²</p> <table border="1"> <thead> <tr> <th></th> <th>2012–14</th> <th>2005–07</th> <th>2000–02</th> <th>1995–97</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>Improvements in Māori life expectancy at birth since 1995-97 have narrowed the gap between Māori and non-Māori.</p>	Gender	2015–17	2014–16	2013–15	2012–14	2005–07	Female	83.4	83.4	83.3	83.2	82.2	Male	80.4	79.9	79.7	79.5	78.0		2012–14	2005–07	2000–02	1995–97	Māori males	73.0	70.4	69.0	66.6	Māori females	77.2	75.1	73.2	71.3	Non-Māori males	80.3	79.0	77.2	75.4	Non-Māori females	83.9	83.0	81.9	80.6
Gender	2015–17	2014–16	2013–15	2012–14	2005–07																																								
Female	83.4	83.4	83.3	83.2	82.2																																								
Male	80.4	79.9	79.7	79.5	78.0																																								
	2012–14	2005–07	2000–02	1995–97																																									
Māori males	73.0	70.4	69.0	66.6																																									
Māori females	77.2	75.1	73.2	71.3																																									
Non-Māori males	80.3	79.0	77.2	75.4																																									
Non-Māori females	83.9	83.0	81.9	80.6																																									

³⁹ The outcome measures for 'independent life expectancy' have been removed to reduce confusion with the 'health adjusted life expectancy' results. The difference between these are minor technical amendments in the calculation useful for detailed health research purposes. The outcome measure for decrease in the 'rate of growth in health spending over time' has been removed due to changes in the government priorities and strategic focus for the health sector.

⁴⁰ Prior year results have been updated as the estimates are re-calibrated and re-estimated based on new information, data, and methods each year. Available at: ghdx.healthdata.org/gbd-results-tool.

⁴¹ Available at: www.stats.govt.nz/information-releases/new-zealand-abridged-period-life-table-201517-final

⁴² These are the latest results available and are the same as reported in our 2016/17 Annual Report.

Measure	Target	Results
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Decrease age-standardised Disability Adjusted Life Years (DALY) per 1,000 people

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

Decrease

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 people⁴³

	2016	2013	2010	2005	2000
Male	244	236	238	243	257
Female	226	222	223	228	233
Total	234	229	230	235	245

Life expectancy by health spending per capita compares well within the OECD

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

Maintain OECD position

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 2016 New Zealand achieved higher life expectancy than could be expected (the 13th highest among 33 countries) given expenditure on health care (19th highest among 36 countries) relative to other OECD countries.

OECD life expectancy and health expenditure – position out of OECD countries⁴⁴

	2016	2015	2010	2005	2000
Life expectancy	13th of 33	14th of 36	13th of 35	12th of 35	13th of 35
Health expenditure	19th of 36	19th of 35	20th of 35	23rd of 35	20th of 35

⁴³ Prior year results have been updated as the estimates are re-calibrated and re-estimated based on new information, data, and methods each year. Available from ghdx.healthdata.org/gbd-results-tool

⁴⁴ 2016 data: Three OECD countries did not report life expectancy data for 2016. 2015 data: This figure differs from what was published in our 2016/17 Annual Report – the change in our 2015 ranking results are from the updated life expectancy data to include results from Canada. Source: OECD Health Statistics, Health Expenditure and Financing, 2015. Available from: <https://stats.oecd.org> (accessed 16 August 2018).

Impact measures

Table 6: Impact measures

Measure	Target	Results																																													
The results of the burden of disease and health surveys are improved	Improved results	Survey results have continued to improve from 1990 for most risk factors. Health loss attributable to selected risk factors based on age-standardised DALY rates per 1,000 people⁴⁵																																													
		<table border="1"> <thead> <tr> <th>Risk factors surveyed</th> <th>2016 (rate per 1,000)</th> <th>2010 (rate per 1,000)</th> <th>2000 (rate per 1,000)</th> <th>1990 (rate per 1,000)</th> </tr> </thead> <tbody> <tr> <td>High blood pressure (systolic)</td> <td>13.0</td> <td>13.9</td> <td>21.0</td> <td>33.2</td> </tr> <tr> <td>High cholesterol (total blood level)</td> <td>6.4</td> <td>7.0</td> <td>11.5</td> <td>20.5</td> </tr> <tr> <td>Tobacco use</td> <td>14.6</td> <td>16.2</td> <td>22.4</td> <td>32.4</td> </tr> <tr> <td>Alcohol use and hazardous drinking</td> <td>10.1</td> <td>10.3</td> <td>11.2</td> <td>17.2</td> </tr> <tr> <td>Insufficient intake of vegetables</td> <td>2.5</td> <td>2.6</td> <td>3.7</td> <td>5.4</td> </tr> <tr> <td>Insufficient intake of fruit</td> <td>3.0</td> <td>3.3</td> <td>4.5</td> <td>6.2</td> </tr> <tr> <td>Low physical activity</td> <td>2.1</td> <td>2.3</td> <td>3.3</td> <td>5.0</td> </tr> <tr> <td>Illegal drug use</td> <td>4.3</td> <td>4.3</td> <td>4.2</td> <td>3.7</td> </tr> </tbody> </table>	Risk factors surveyed	2016 (rate per 1,000)	2010 (rate per 1,000)	2000 (rate per 1,000)	1990 (rate per 1,000)	High blood pressure (systolic)	13.0	13.9	21.0	33.2	High cholesterol (total blood level)	6.4	7.0	11.5	20.5	Tobacco use	14.6	16.2	22.4	32.4	Alcohol use and hazardous drinking	10.1	10.3	11.2	17.2	Insufficient intake of vegetables	2.5	2.6	3.7	5.4	Insufficient intake of fruit	3.0	3.3	4.5	6.2	Low physical activity	2.1	2.3	3.3	5.0	Illegal drug use	4.3	4.3	4.2	3.7
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⁴⁵ Prior year results have been updated as the estimates are re-calibrated and re-estimated based on new information, data, and methods each year. Available at: ghdx.healthdata.org/gbd-results-tool
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.

Measure	Target	Results																								
At least 85% of new babies are enrolled with Plunket in the Well Child/Tamariki Ora (WCTO) programme	Greater than 85%	<p>The Ministry works to support DHBs to improve WCTO service enrolment to target improvement to access and utilisation of WCTO services for at risk children and their families/whānau.</p> <p>New babies enrolled with Well Child/Tamariki Ora programme⁴⁶</p> <table border="1"> <thead> <tr> <th></th> <th>2017/18</th> <th>2016/17</th> <th>2015/16</th> </tr> </thead> <tbody> <tr> <td>Percentage</td> <td>85.4%</td> <td>89.0%</td> <td>88.3%</td> </tr> </tbody> </table>		2017/18	2016/17	2015/16	Percentage	85.4%	89.0%	88.3%																
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Daily smoking prevalence falls to 10% by 2018 and Māori and Pacific rates halve from their 2011 levels as part of Smokefree 2025 ⁴⁷	Prevalence less than 10% Targeted reduction: <ul style="list-style-type: none"> • Māori greater than 50% • Pacific greater than 50% 	<p>The rate of smoking prevalence across the whole population is reducing. However for Māori and Pacific populations smoking rates have not seen the same level of reduction and the Ministry continues to focus on reducing smoking in these population groups.</p> <p>Daily smoking prevalence (15 years and over)⁴⁸</p> <table border="1"> <thead> <tr> <th></th> <th>2016/17</th> <th>2015/16</th> <th>2014/15</th> <th>2013/14</th> <th>2012/13</th> </tr> </thead> <tbody> <tr> <td>Total population</td> <td>13.8%</td> <td>14.2%</td> <td>15.0%</td> <td>15.7%</td> <td>15.6%</td> </tr> <tr> <td>Māori</td> <td>32.5%</td> <td>35.5%</td> <td>35.5%</td> <td>37.8%</td> <td>36.2%</td> </tr> <tr> <td>Pacific</td> <td>21.8%</td> <td>22.8%</td> <td>22.4%</td> <td>22.9%</td> <td>22.0%</td> </tr> </tbody> </table>		2016/17	2015/16	2014/15	2013/14	2012/13	Total population	13.8%	14.2%	15.0%	15.7%	15.6%	Māori	32.5%	35.5%	35.5%	37.8%	36.2%	Pacific	21.8%	22.8%	22.4%	22.9%	22.0%
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Pacific	21.8%	22.8%	22.4%	22.9%	22.0%																					
B4 School Check is provided to 90% of the eligible population	90%	<p>The B4 School Check (B4SC) is a free health and development check for all four-year-old children. By identifying health or development problems early, children are able to be connected to and access support services before they start school. The B4SC includes hearing, eyesight, height, weight and oral health assessments.</p> <p>Percentage of B4 School Checks provided to eligible population</p> <table border="1"> <thead> <tr> <th></th> <th>2017/18</th> <th>2016/17</th> <th>2015/16</th> </tr> </thead> <tbody> <tr> <td>Percentage of eligible population</td> <td>93%</td> <td>94%</td> <td>92%</td> </tr> </tbody> </table>		2017/18	2016/17	2015/16	Percentage of eligible population	93%	94%	92%																
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⁴⁶ Results only include services provided by Plunket. DHBs also provide these services. The result will be updated for the 2018/19 annual report to include all providers.

⁴⁷ The Government has set a goal of making New Zealand an essentially smokefree nation by 2025. This is supported by the Ministry of Health's goals for 2018 to reduce the daily smoking rate. Available at: www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey/improving-health-new-zealanders#1

⁴⁸ Daily smokers (adults aged 15+ years) smoke every day, and have smoked more than 100 cigarettes in their whole life. Smoking rates. Sixteen percent of adults were current smokers (smoke at least monthly) and 14% of adults were daily smokers in 2016/17. Both current and daily cigarette smoking rates have decreased since 2006/07, when 20% of adults were current smokers and 18% of adults were daily smokers. Thirty-two percent of Māori and 22% of Pacific adults were daily smokers in 2016/17. Available at: www.minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/_w_e0ad63aa/#!/explore-indicators

Measure	Target	Results																														
Suicide rates decline for all ages	Reduced	<p>The Ministry continues to focus on reducing suicide rates. In 2015, 525 people died by suicide in New Zealand, which equates to an age-standardised rate of 11.1 per 100,000.</p> <p>Suicide rates (per 100,000 population)⁴⁹</p> <table border="1"> <thead> <tr> <th></th> <th>2015</th> <th>2014</th> <th>2013</th> <th>2012</th> </tr> </thead> <tbody> <tr> <td>15–24 years of age</td> <td>16.9</td> <td>14.1</td> <td>17.8</td> <td>23.0</td> </tr> <tr> <td>25–44 years of age</td> <td>14.4</td> <td>16.3</td> <td>14.2</td> <td>15.8</td> </tr> <tr> <td>45–64 years of age</td> <td>14.4</td> <td>14.2</td> <td>16.0</td> <td>13.1</td> </tr> <tr> <td>65+ years of age</td> <td>9.5</td> <td>9.5</td> <td>8.9</td> <td>9.5</td> </tr> </tbody> </table>		2015	2014	2013	2012	15–24 years of age	16.9	14.1	17.8	23.0	25–44 years of age	14.4	16.3	14.2	15.8	45–64 years of age	14.4	14.2	16.0	13.1	65+ years of age	9.5	9.5	8.9	9.5					
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The annual influenza programme of 1.2 million influenza vaccines is delivered	1.2 million	<p>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.</p> <p>Number of vaccines delivered (million)</p> <table border="1"> <thead> <tr> <th></th> <th>2017/18</th> <th>2016/17</th> <th>2015/16</th> <th>2014/15</th> </tr> </thead> <tbody> <tr> <td>Number of vaccines delivered</td> <td>1.29</td> <td>1.20</td> <td>1.20</td> <td>1.20</td> </tr> </tbody> </table>		2017/18	2016/17	2015/16	2014/15	Number of vaccines delivered	1.29	1.20	1.20	1.20																				
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Infant mortality rates continue to decrease from a baseline of 4.8 deaths per 1,000 live births in 2009	Decrease	<p>Infant mortality is an ongoing 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 sudden infant death syndrome (SIDS).⁵⁰</p> <p>Infant mortality rates per 1,000 live births</p> <table border="1"> <thead> <tr> <th></th> <th>2015</th> <th>2014</th> <th>2013</th> <th>2009</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>4.9</td> <td>7.2</td> <td>5.3</td> <td>7.4</td> </tr> <tr> <td>Pacific peoples</td> <td>7.1</td> <td>7.1</td> <td>7.6</td> <td>6.0</td> </tr> <tr> <td>Asian</td> <td>4.3</td> <td>5.0</td> <td>4.1</td> <td>3.4</td> </tr> <tr> <td>Other</td> <td>3.2</td> <td>4.6</td> <td>4.4</td> <td>4.2</td> </tr> <tr> <td>Total</td> <td>4.3</td> <td>5.7</td> <td>5.0</td> <td>5.2</td> </tr> </tbody> </table>		2015	2014	2013	2009	Māori	4.9	7.2	5.3	7.4	Pacific peoples	7.1	7.1	7.6	6.0	Asian	4.3	5.0	4.1	3.4	Other	3.2	4.6	4.4	4.2	Total	4.3	5.7	5.0	5.2
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⁴⁹ Data is based on figures for a calendar year. Results from previous years as reported in the 2016/17 Annual Report have been updated to reflect changes in the source database, which is maintained on a live basis. Available at: www.health.govt.nz/publication/mortality-2015-data-tables

⁵⁰ The number of fetal and infant deaths in New Zealand is small and may cause rates to fluctuate markedly from year to year and, accordingly, should be interpreted with caution. Figures included in the 2016/17 Annual Report were provisional. These results presented are the final results.

Measure	Target	Results																																												
<p>There is reduced amenable mortality.</p> <p>The amenable mortality rate measures premature deaths (deaths of people aged under 75) from causes that the health system could potentially have prevented.</p>	Reduce	<p>The age standardised amenable mortality rate declined from 144.9 deaths per 100,000 in 2000 to 90.7 deaths per 100,000 in 2015 (reflecting a 37 percent 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.</p> <p>Amenable mortality rates: deaths per 100,000 population⁵¹</p> <table border="1"> <thead> <tr> <th></th> <th>2015</th> <th>2014</th> <th>2013</th> <th>2010</th> <th>2005</th> <th>2000</th> </tr> </thead> <tbody> <tr> <td>Deaths per 100,000 population</td> <td>90.7</td> <td>92.6</td> <td>92.8</td> <td>103.7</td> <td>119.2</td> <td>144.9</td> </tr> </tbody> </table>		2015	2014	2013	2010	2005	2000	Deaths per 100,000 population	90.7	92.6	92.8	103.7	119.2	144.9																														
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Deaths per 100,000 population	90.7	92.6	92.8	103.7	119.2	144.9																																								
<p>The service quality score for public services (including health services) continues to improve.</p> <p>The annual service quality scores (SQS) collected in the Kiwis Count survey measure New Zealanders' satisfaction with a range of commonly used services. This includes a public health sector score and three specific health services measures: stayed in a public hospital; used the 0800 health service phone line; and received outpatient services (including accident and emergency).</p>	<p>Overall SQS for public services continues to improve</p> <p>SQS for health services (0800 health services phone line and outpatient services) continues to improve</p>	<p>The Ministry and the health sector are 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.</p> <p>Public health sector level SQS score⁵²</p> <table border="1"> <thead> <tr> <th></th> <th>2017</th> <th>2016</th> <th>2015</th> <th>2012</th> </tr> </thead> <tbody> <tr> <td>Score</td> <td>73%</td> <td>73%</td> <td>76%</td> <td>72%</td> </tr> </tbody> </table> <p>Stayed in a public hospital</p> <table border="1"> <thead> <tr> <th></th> <th>2017</th> <th>2016</th> <th>2015</th> <th>2012</th> </tr> </thead> <tbody> <tr> <td>Score</td> <td>74%</td> <td>73%</td> <td>76%</td> <td>73%</td> </tr> </tbody> </table> <p>Used 0800 health phone line</p> <table border="1"> <thead> <tr> <th></th> <th>2017</th> <th>2016</th> <th>2015</th> <th>2012</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Score</td> <td>73%</td> <td>74%</td> <td>79%</td> <td>70%</td> <td>67%</td> </tr> </tbody> </table> <p>Received outpatient services (including accident and emergency)</p> <table border="1"> <thead> <tr> <th></th> <th>2017</th> <th>2016</th> <th>2015</th> <th>2012</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Score</td> <td>72%</td> <td>72%</td> <td>76%</td> <td>73%</td> <td>69%</td> </tr> </tbody> </table>		2017	2016	2015	2012	Score	73%	73%	76%	72%		2017	2016	2015	2012	Score	74%	73%	76%	73%		2017	2016	2015	2012	2007	Score	73%	74%	79%	70%	67%		2017	2016	2015	2012	2007	Score	72%	72%	76%	73%	69%
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⁵² Source: State Services Commission – Kiwis Count Survey. Available at: www.ssc.govt.nz/kiwis-count

Measure	Target	Results																											
Reduction in the proportion of older people requiring residential care; and rate of acute hospital use	Reduced prevalence	<p>The health sector is focusing on improving the independence of older people. The aim is to maintain, or slow the decline of, the health of older people so they do not deteriorate to the point where they are better off in residential care. The majority of older adults also prefer to stay in their own home.</p> <p>Reduced prevalence shown through residential care⁵³</p> <table border="1"> <thead> <tr> <th></th> <th>2016/17</th> <th>2015/16</th> <th>2014/15</th> <th>2013/14</th> </tr> </thead> <tbody> <tr> <td>Number of older people aged 65+ requiring residential care</td> <td>31,454</td> <td>31,288</td> <td>30,828</td> <td>30,829</td> </tr> <tr> <td>Proportion of older people aged 65+ requiring residential care</td> <td>4.4%</td> <td>4.6%</td> <td>4.6%</td> <td>4.8%</td> </tr> </tbody> </table> <p>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.</p> <p>Reduced prevalence shown through acute hospital use⁵⁴</p> <table border="1"> <thead> <tr> <th></th> <th>2016/17</th> <th>2015/16</th> <th>2014/15</th> </tr> </thead> <tbody> <tr> <td>Acute hospital use number of bed days for older people aged 65+</td> <td>1.04m</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>1.45</td> <td>1.51</td> <td>1.61</td> </tr> </tbody> </table>		2016/17	2015/16	2014/15	2013/14	Number of older people aged 65+ requiring residential care	31,454	31,288	30,828	30,829	Proportion of older people aged 65+ requiring residential care	4.4%	4.6%	4.6%	4.8%		2016/17	2015/16	2014/15	Acute hospital use number of bed days for older people aged 65+	1.04m	1.04m	1.06m	Acute hospital use number of bed days per older person aged 65+	1.45	1.51	1.61
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⁵³ Available at: www.nzdotstat.stats.govt.nz/wbos/index.aspx

⁵⁴ Results are for the 12-month period ending March each year for 2014/15 and 2015/16. Results for 2016/17 are for the year to June 2017.

Measure	Target	Results																																																												
Ethnic health disparities are reduced	Reduction	<p>Reducing ethnic health disparities continues as a key health sector focus. The following metrics provide an indication of health disparities that have reduced as health outcomes have improved. However, challenges still exist for future improvement.</p> <p>Current smokers unadjusted prevalence (percentage of population) of adults aged 15 years or older⁵⁵</p> <table border="1"> <thead> <tr> <th>Ethnicity</th> <th>2016/17</th> <th>2015/16</th> <th>2013/14</th> <th>2011/12</th> <th>2006/07</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>35.3%</td> <td>38.6%</td> <td>40.9%</td> <td>40.2%</td> <td>42.1%</td> </tr> <tr> <td>Pacific peoples</td> <td>24.5%</td> <td>25.5%</td> <td>24.7%</td> <td>25.9%</td> <td>27.1%</td> </tr> <tr> <td>Asian</td> <td>8.2%</td> <td>9.1%</td> <td>8.3%</td> <td>9.4%</td> <td>11.3%</td> </tr> <tr> <td>European and other</td> <td>14.2%</td> <td>14.5%</td> <td>15.3%</td> <td>16.5%</td> <td>18.7%</td> </tr> </tbody> </table> <p>Ambulatory Sensitive Hospitalisations (ASH) crude rate per 100,000 population for children aged 0–4 years old⁵⁶</p> <table border="1"> <thead> <tr> <th>Ethnicity</th> <th>2017</th> <th>2016</th> <th>2015</th> <th>2014</th> <th>2013</th> </tr> </thead> <tbody> <tr> <td>Māori⁵⁷</td> <td>7,292</td> <td>7,290</td> <td>7,691</td> <td>7,791</td> <td>7,348</td> </tr> <tr> <td>Pacific peoples</td> <td>11,213</td> <td>12,175</td> <td>12,737</td> <td>13,157</td> <td>12,221</td> </tr> <tr> <td>Other</td> <td>5,582</td> <td>5,735</td> <td>5,487</td> <td>5,966</td> <td>5,418</td> </tr> <tr> <td>National total⁵⁸</td> <td>6,545</td> <td>6,730</td> <td>6,729</td> <td>7,101</td> <td>6,541</td> </tr> </tbody> </table>	Ethnicity	2016/17	2015/16	2013/14	2011/12	2006/07	Māori	35.3%	38.6%	40.9%	40.2%	42.1%	Pacific peoples	24.5%	25.5%	24.7%	25.9%	27.1%	Asian	8.2%	9.1%	8.3%	9.4%	11.3%	European and other	14.2%	14.5%	15.3%	16.5%	18.7%	Ethnicity	2017	2016	2015	2014	2013	Māori ⁵⁷	7,292	7,290	7,691	7,791	7,348	Pacific peoples	11,213	12,175	12,737	13,157	12,221	Other	5,582	5,735	5,487	5,966	5,418	National total ⁵⁸	6,545	6,730	6,729	7,101	6,541
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⁵⁵ Current smokers are adults aged 15+ that have smoked more than 100 cigarettes in their lifetime and currently smoke at least once a month. The results for 2015/16 for Pacific peoples were updated. Available at: www.minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/_w_557d88bb/#!/home

⁵⁶ The national total includes all ethnicities. Results from previous years (as reported in 2016/17 Annual Report) have been updated. The datasets are updated regularly to take into account of updates or corrections from inpatient records reported by DHBs. Source: National Minimum Dataset and Statistics New Zealand (base population). Available at: www.nsfh.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive

⁵⁷ 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 and 2016 compared with the rate of decline for other ethnicities at the national total.

⁵⁸ Source: National Minimum Dataset and Statistics NZ (base population). Available at: www.nsfh.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive

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The proportion of people with a K10 score greater than 12 is reduced. 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.	Reduce	<p>The 2016/17 New Zealand Health Survey found that 7% of adults experienced psychological distress in the four weeks before taking part in the survey.</p> <p>Percentage of people with a K10 score ≥ 12⁶¹</p> <table border="1"> <thead> <tr> <th></th> <th>2016/17</th> <th>2015/16</th> <th>2014/15</th> <th>2013/14</th> <th>2012/13</th> </tr> </thead> <tbody> <tr> <td>Males</td> <td>6.4</td> <td>5.0</td> <td>4.6</td> <td>5.1</td> <td>5.4</td> </tr> <tr> <td>Females</td> <td>8.7</td> <td>8.6</td> <td>7.6</td> <td>7.2</td> <td>6.8</td> </tr> <tr> <td>Total</td> <td>7.6</td> <td>6.8</td> <td>6.2</td> <td>6.2</td> <td>6.1</td> </tr> <tr> <td>Māori</td> <td>11.5</td> <td>10.5</td> <td>9.6</td> <td>9.5</td> <td>9.7</td> </tr> <tr> <td>Pacific peoples</td> <td>11.8</td> <td>11.3</td> <td>10.2</td> <td>13.0</td> <td>9.4</td> </tr> </tbody> </table>		2016/17	2015/16	2014/15	2013/14	2012/13	Males	6.4	5.0	4.6	5.1	5.4	Females	8.7	8.6	7.6	7.2	6.8	Total	7.6	6.8	6.2	6.2	6.1	Māori	11.5	10.5	9.6	9.5	9.7	Pacific peoples	11.8	11.3	10.2	13.0	9.4
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⁶⁰ Although ASH rates for Māori remain higher than for the other ethnicities and the national total, the decrease of 303/100,000 population is greater for Māori 2012–2016 compared with the rate of decline for other ethnicities at the national total.

⁶¹ Available at: www://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/_w_557d88bb/#!/home

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 6% respectively).
- Psychological distress rates decreased with age. Fewer than 5% of adults aged 75 years and over experienced psychological distress in the previous four weeks. In contrast, more than 8% of adults aged 15–34 years experienced psychological distress in the past four weeks.
- 12% of Pacific and Māori adults 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 (4.8%). Those living in the most deprived areas were 2.9 times as likely to have experienced psychological distress as those in the least deprived areas, after adjusting for age, sex and ethnic differences.

Appendix 2: 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 12th 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 public 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 Minister of Health will table the Vote Health Report, in relation to selected non-departmental appropriations for the year ended 30 June 2018, in Parliament 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.

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

The Ministry of Health administers the following legislation:

- 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, including under the following Acts:

- 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 Nations conventions.

Web resources

Ministry of Health publications are available at health.govt.nz/publications

Regulations administered by the Ministry can be accessed on the Ministry website: www.health.govt.nz/our-work/regulation-health-and-disability-system

Full, searchable copies of the Acts and associated regulations administered by the Ministry can be found at: legislation.govt.nz

Appendix 3: Committees

Section 11 committees

The Minister of Health has the authority to establish committees under section 11 of the New Zealand Public Health and Disability Act 2000 for any purpose relating to the Act, or its administration and services. Section 12(5) of the Act requires the Ministry of Health to list the name, chairperson and members of each of these committees.⁶²

Capital Investment Committee

The Capital Investment Committee 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.

Membership

Evan Davies (chair)
Paul Carpinter
Jan Dawson
Des Gorman
Murray Milner
Sally Webb
Margaret Wilsher

Expert Review Panel for Health

The Minister of Health appointed the Expert Review Panel for Health on 28 May 2018. The term of office started on 28 May 2018 and will end on 31 January 2020.

Membership

Heather Simpson (chair)
Shelly Campbell
Professor Peter Crampton
Dr Lloyd McCann
Dr Margaret Southwick
Dr Winfield Bennett
Sir Brian Roche

⁶² Section 11 Committees are not DHBs or Crown entity boards.

Health Workforce New Zealand

Health Workforce New Zealand is responsible for national coordination and leadership on workforce issues to ensure the health system has the right people in the right place with the right skills to provide the safest care and best outcomes for New Zealanders. Their purpose is to provide advice on workforce development and regulation, gather workforce data and intelligence and invest in health workforce training.

Membership

Professor Des Gorman (chair)
Helen Pocknall (deputy chair)
Gloria Crossley
Dr David Kerr
Professor Tim Wilkinson
Charmeyne Te Nana-Williams
Dr Lance O'Sullivan (June 2017 to June 2018)

Health and Disability Ethics Committees

The Health and Disability Ethics Committees are a group of four regionally based ethics committees (Northern A, Northern B, Central and Southern). Their purpose is to check that health and disability research (such as clinical trials) meets or exceeds ethical standards established by the National Ethics Advisory Committee.

Membership: Northern A Health and Disability Ethics Committee

Dr Brian Fergus (chair)
Dr Christine Crooks
Dr Karen Bartholomew
Dr Kate Parker
Toni Millar
Dr Catherine Jackson
Rochelle Style

Membership: Northern B Health and Disability Ethics Committee

Kate O'Connor (chair)
Maliaga Erick
Stephanie Pollard
Tangihaere Macfarlane
Jane Wylie
Leesa Russell
Dr Nora Lynch
John Hancock

Membership: Central Health and Disability Ethics Committee

Helen Walker (chair)
Dr Cordelia Thomas

Sandy Gill
Dr Patries Herst
Dr Dean Quinn
Dr Peter Gallagher
Dr Melissa Craig

Membership: Southern Health and Disability Ethics Committee

Raewyn Idoine (chair)
Dr Devonie Eglinton
Dr Sarah Gunningham
Dr Nicola Swain
Dr Mira Harrison-Woolrych
Dr Fiona McCrimmon
Dr Anna Paris

Ministerial Advisory Group for Health

The Minister of Health established the Ministerial Advisory Group for Health for a period of two years (18 December 2017 to 17 December 2019) to provide strategic advice on the future direction of health services and provide advice to the Minister of Health.

Membership

Sir Brian Roche (chair)
Professor David Tipene-Leach
Dr Karen Poutasi
Dr Lester Levy
Muriel Tunoho

Other committees

The following ethics committees, established under the Human Assisted Reproductive Technology Act 2004, provide advice to the Minister of Health. The Act requires the Ministry to publish information about these committees and its membership in our annual report.

Advisory Committee on Assisted Reproductive Technology

The Advisory Committee on Assisted Reproductive Technology (ACART) formulates policy and provides independent advice to the Minister of Health. It also issues guidelines and provides advice to the Ethics Committee on Assisted Reproductive Technology (ECART). ACART is a ministerial committee established under section 32 of the Human Assisted Reproductive Technology Act 2004. The Minister of Health appoints members.

Membership

Gillian Ferguson (chair)
Associate Professor Colin Gavaghan
Jonathan Darby
Dr Kathleen Logan
Sue McKenzie
Professor John McMillan
Dr Karen Reader
Dr Barry Smith
Dr Sarah Wakeman

Ethics Committee on Assisted Reproductive Technology

The Ethics Committee on Assisted Reproductive Technology (ECART) considers, determines and monitors applications for assisted reproductive procedures and human reproductive research. It can only consider applications for procedures that ACART has issued guidelines for. ECART is a ministerial committee established under section 27 of the Human Assisted Reproductive Technology Act 2004. The Minister of Health appoints members.

Membership

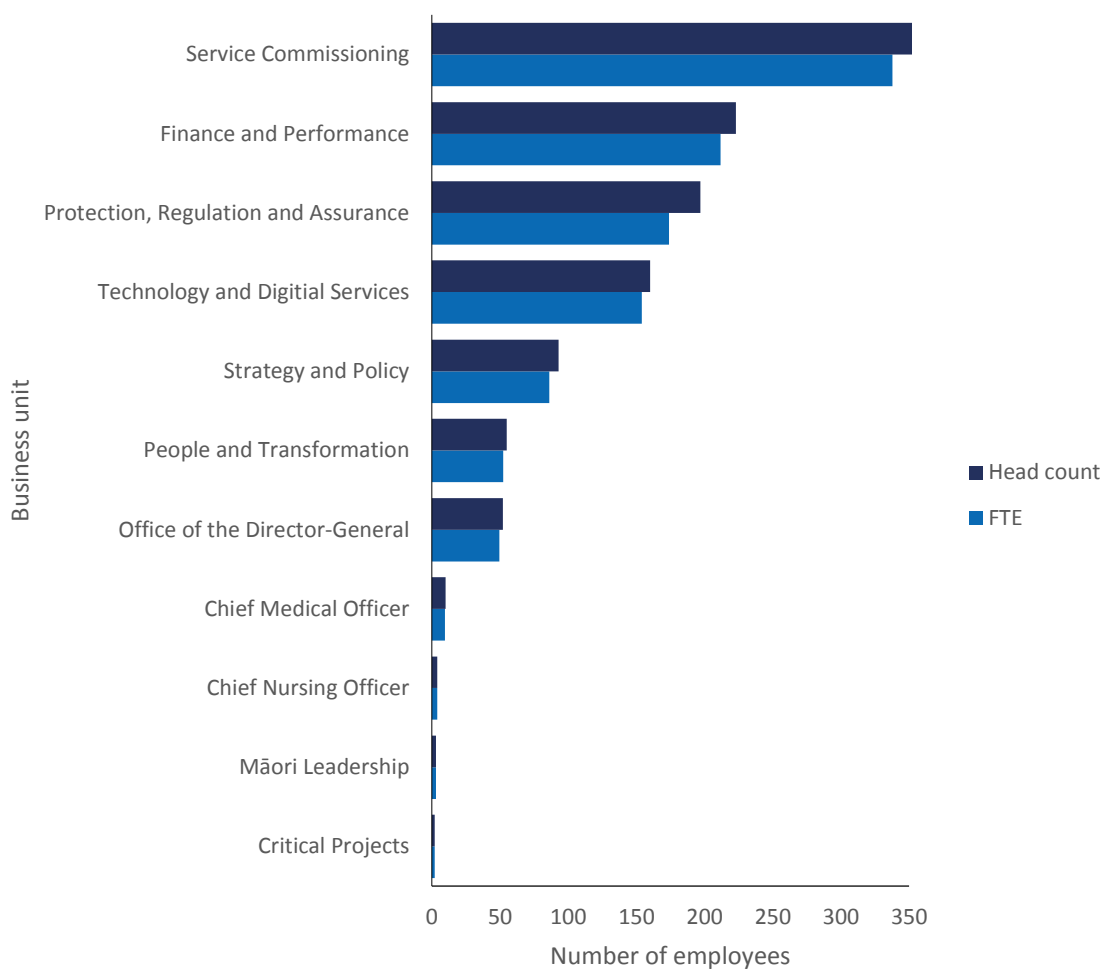
Iris Reuvecamp (chair)
Dr Carolyn Mason
Dr Freddie Graham
Dr Paul Copland
Michèle Stanton
Judith Charlton
Dr Mary Birdsall

Appendix 4: Staffing information

Permanent staff

As at 30 June 2018, the number of permanent staff at the Ministry was 1,011 full-time equivalents (FTE), or 1,051 individuals. This compares with 969 FTE, or 1,017 individuals in June 2017. Figure 6 provides a breakdown by business unit.

Figure 6: Staff FTE and headcount, by business unit



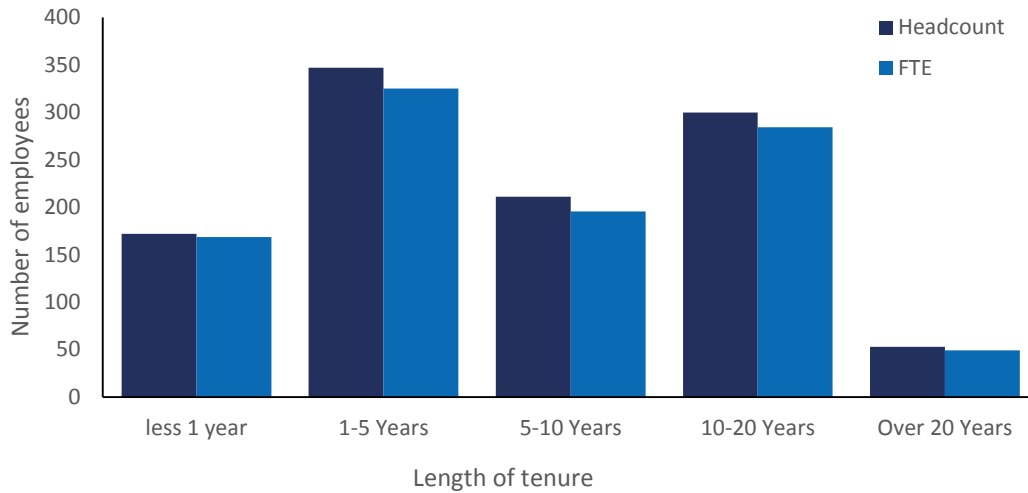
Turnover

The 12-month rolling average turnover rate for 2017/18 was 13.17 percent. In 2016/17, it was 13.6 percent.

Length of service

The average length of service for Ministry staff is 7.45 years. This is slightly down from 7.81 years in 2016/17. Figure 7 provides a breakdown of staff numbers by length of service.

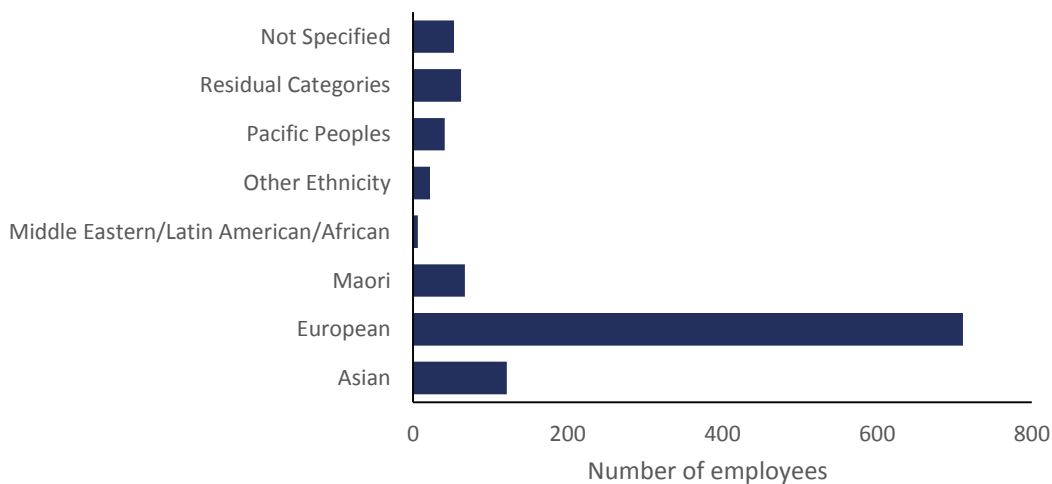
Figure 7: Length of service



Ethnicity

The New Zealand European ethnic group is the most dominant group within the Ministry, at 65.7 percent. This is a decrease of 2.2 percent from last year. Figure 8 provides a more detailed breakdown.

Figure 8: Ethnicity



Gender and age

Approximately 69 percent of Ministry staff are female and 31 percent are male (compared to 67 percent female and 33 percent male last year). Figure 9 provides a breakdown by age group. Figure 10 provides a breakdown by remuneration band.

Figure 9: Gender and age-group

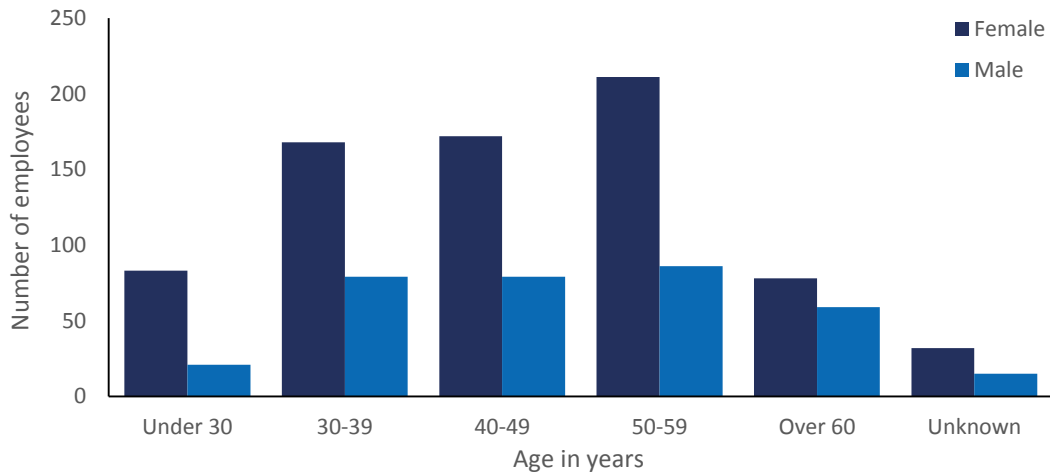
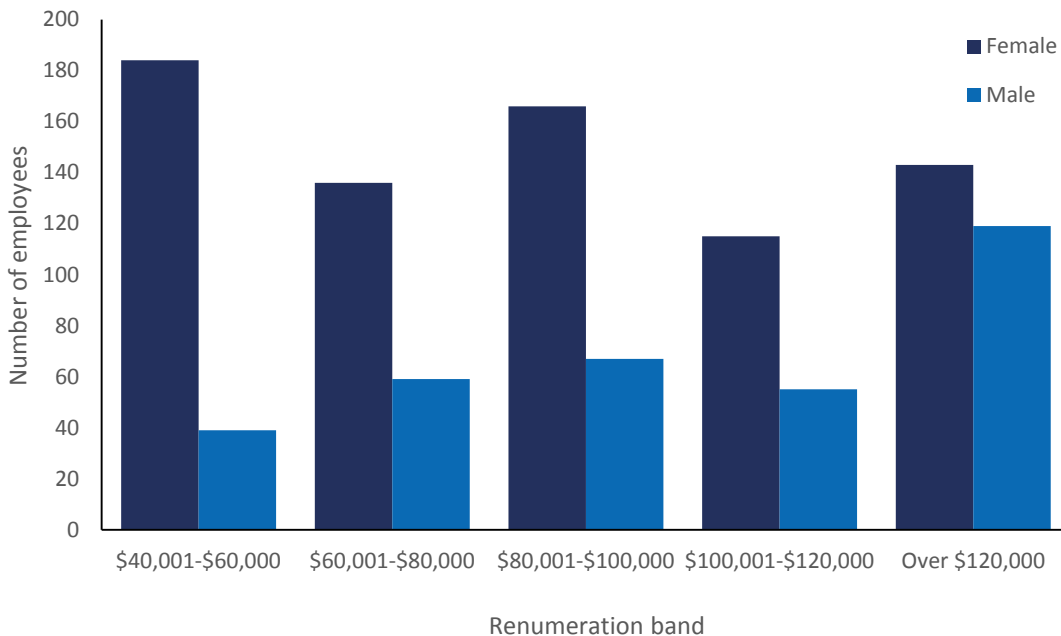


Figure 10: Gender and remuneration band



Salary

The average Ministry salary has increased 1.5 percent since 2016/17, from approximately \$96,000 to approximately \$97,500.

Approximately 39 percent of staff are paid over \$100,000.

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.

Staff location

Our permanent staff are located throughout the country, with the highest concentration of numbers in Wellington. Table 7 provides a breakdown by location.

Table 7: Staff location and headcount

Location	Head count of staff	
	30 June 2017	30 June 2018
Whanganui	46	41
Auckland	59	57
Christchurch	36	34
Dunedin	60	60
Hamilton	11	8
Wellington	805	851
Total	1,017	1,051

Appendix 5: Asset performance indicators

Table 8: Asset performance indicators

Indicator	Indicator type	Actual 2017/18	Target 2017/18
Property			
Percent of buildings with a Property Council of NZ Grade ⁶³ of C or better	Condition	88%	>80%
Percent of buildings with an Initial Evaluation Process – New Building Standard ⁶⁴ Seismic Grade of C or better	Condition	100%	100%
All Building Warrants of Fitness ⁶⁵ current	Condition	100%	100%
Average occupancy m ² per head	Utilisation	13.9m ²	<14m ²
Percent of buildings with a functionality rating ⁶⁶ of 3 or better	Functionality	100%	100%
Average power used kwh/m ²	Functionality	73kwh/m ²	<80kwh/m ²
ICT			
Availability of five key ICT applications including internal MOH and sector systems (see note 1)	Availability	99%	99%
Availability of key sector and public facing systems (see note 1)	Availability	99%	99%
The number of active sector user logins to national systems	Utilisation	14,876	15,000

Note 1: This measures the total time that an application was able to perform its required functions as a percentage of available time over total time the system should be made available. The five key ICT applications are National Health Index (NHI), National Immunisation Register (NIR), Special Authorities, Proclaim, and the Ministry of Health website. The key sector and public facing systems are National Health Index (NHI), National Immunisation Register (NIR), Online Pharmacy, Special Authorities, Oracle Financials, and Web Access.

⁶³ Available at: https://www.propertynz.co.nz/sites/default/files/uploaded-content/website-content/quality_grading_matrix.pdf

⁶⁴ Further information can be found at: https://www.mbie.govt.nz/info-services/building-construction/documents-and-images-library/safety-quality-epb/copy_of_questions-and-answers-may-2016.pdf

⁶⁵ A building warrant of fitness is a building owner's annual statement confirming the specified systems in the compliance schedule for their building have been maintained and checked for the previous 12 months, in accordance with the compliance schedule. Further information can be found at: <https://www.building.govt.nz/building-officials/guides-for-building-officials/building-warrants-of-fitness/>

⁶⁶ Building functionality assesses the fitness for purpose or suitability of the building to meet the service needs of the users. Rating scale for this measure is defined as: 1 being actively hinders operation, 2 being not fit for purpose/significant issues, 3 being fit for purpose/generally fine, and 4 being ideal.