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Manatū Hauora

# Annual Report

for the year ended 30 June 2022

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MINISTRY OF HEALTH



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# A message from the Director-General

Kia ora koutou katoa

It is my pleasure to present the Manatū Hauora | Ministry of Health 2021/2022 Annual Report.

Whilst only a few months into the role of Director-General, it gives me great pride to see the progress and achievements over the last year, and I am excited about the opportunities ahead.

It is incredibly humbling to see the vast array of work undertaken by teams within the Ministry, and a chance to reflect on how this mahi improves health outcomes for people and whānau across Aotearoa. The Ministry values of kaitiakitanga, whakapono, manaakitanga and kōkiri ngātahi are evident and woven through every aspect of our work.

I would like to also acknowledge the wider health and disability sector. The selfless dedication, expertise, and kotahitanga you have shown throughout this period of significant change and uncertainty is admirable.

We are entering a new era of health in Aotearoa, with a once-in-a-lifetime opportunity to put equity front and centre. Manatū Hauora is well placed to continue its role as steward of the health system, and build on the progress so far to support the vision of pae ora – healthy futures for all.

Ngā mihi maioha,

Professor Diana Sarfati  
Director-General of Health

# He kupu nā te Tumu Whakarae

Kia ora koutou katoa

Tēnei au e whakarewa atu nei i te Pūrongo ā-Tau 2021/2022 mō te Manatū Hauora.

Ahakoā e torutoru noa ngā mārama e noho nei au i te tūranga o te Tumu Whakarae, e poho kererū atu ana au ki ngā kokenga, ki ngā whakatutukihanga kua taea i te tau ka hori, e hīkaka ana anō te ngākau ki ngā āheinga kei te pae e tata mai rā.

Ka ngākau whakaiti atu ki ngā kaupapa huhua kua tutuki i tēnā tīma, i tēnā tīma o te Manatū, kia mārama ai te hono o ēnei kaupapa ki te ora o te motu e piki nei, e pakari ake nei, huri noa i Aotearoa. Ko ngā uara o te Manatū ēnei, ko te kaitiakitanga, ko te whakapono, ko te manaakitanga me te kōkiri ngātahi, e āta kitea ana, e āta kōtuia ana i roto i ā tātou mahi.

Me mihi atu ki te rāngai hauora, hunga hauā, whānui nei. Mōu i manawa nui mai, i ū mārika mai, i whakaatu atu i te tohungatanga me te kotahitanga, mō ēnei i whakatinanahia e koutou i tēnei wā o te hurihuri, o te mōhio kore, ka whakamīharo atu.

Kua kuhu atu tātou ki te anamata o te hauora i Aotearoa, ki tētahi āheinga rerenga tahi nei ki konei whakamatuahia ai tēnei mea, te mana taurite. E tika ana kia noho mai te Manatū Hauora hei kaitiaki mō ngā ratonga hauora, kia tutuki tonu atu ai ngā whanaketanga kua tīmata nei, hei tautoko anō i a pae ora – kia ora ai te anamata o te katoa.

Ngā mihi maioha

Ahorangi Diana Sarfati  
Tumu Whakarae mō te Hauora

# Farewell reflections from our former Director-General

Kia ora koutou katoa

This was another extraordinary year. While we continued to navigate the challenges of the ongoing COVID-19 pandemic, New Zealand's healthcare system delivered a wide range of care to many New Zealanders and we helped to lay the foundations for the Government's health reforms.

## Responding to the COVID-19 pandemic

New Zealand's response to the ongoing COVID-19 pandemic continues to be one of the best in the world. During 2021/22, we successfully delivered on the most complex vaccination programme in our history achieving high coverage rates across the population.

Our health system responded admirably to the pandemic and the range of additional challenges that resulted. As all countries have experienced, there has been significantly increased pressure on our system and in particular the workforce. I would like to take this opportunity to sincerely thank all health and disability workers for their professionalism, commitment and sheer hard work.

As the situation and science evolved, so too did our response - the launch of the Care in the Community programme is an example of an innovative response to the pandemic. The programme protected people, their whānau and our hospital system by enabling people to safely self-isolate and access health, welfare and

accommodation support through local care coordination hubs.

Our testing and surveillance regime evolved rapidly and with the introduction of Rapid Antigen Tests and technology to support self-notification of results, people were able to test easily and frequently and then isolate if positive.

## Health reforms

As part of our contribution to the health reforms, we've focused on ensuring we deliver well on our role as steward of the health system and establish strong relationships with Te Whatu Ora and Te Aka Whai Ora.

I would like to acknowledge the huge amount of work put in by people across Manatū Hauora, and the wider health and disability system to ensure a smooth and successful implementation of the reforms.

We know this is very much the start and the transformation of the health system will require partnership, time and effort. The goal - Pae Ora - is clear, and is about ensuring equitable access to, experience of and outcomes from care for all New Zealanders to support their health and broader wellbeing.

## Other areas of work

The Ministry sustained a large non-COVID-19 work programme. Among other things, we developed a long-term pathway for mental health and addiction services and continued to increase services through the access and choice

programme; managed and expanded national cancer screening services; and implemented Ngā Parewa, the updated health and disability services standard. Following clear public support for Assisted Dying, we put in place the services and range of safeguards needed to enable safe access to this new service.

We've also worked across the system to support DHBs and improve physical infrastructure – significant projects that opened this year were Te Nīkau Hospital and Health Centre in Greymouth, Waipapa Hospital in Christchurch and Taiao Ora – the integrated stroke unit at Auckland Hospital. Work also commenced on the new Dunedin Hospital build – the largest ever health infrastructure project ever undertaken in New Zealand. We have also overseen significant investment in data and digital infrastructure, much of it in support of the COVID-19 response with a view to creating a significant legacy for the system.

Ko tō tātou waka, he waka eke noa, we are all in this together, without exception.

## Farewell

My term as Director-General of Health and Chief Executive of the Ministry of Health ended on 29 July 2022. It has been a privilege to serve New Zealanders as the Director-General of Health at this time and I can say without reservation that it has been the best job I have ever held.

I am pleased to be handing over to Dr Diana Sarfati who is well placed to lead the Ministry as it refines and develops its role as the Government's chief advisor on health and steward of the health system.

Ngā mihi,

Dr Ashley Bloomfield  
Former Director-General of Health

# He huritao nā te Tumu Whakarae o Mua

Kia ora koutou katoa

He tau whakamīharo anō tēnei. I a tātou e whakaterere tonu nei kia puta i ngā au parata o te urutā Kowheori-19, i rite tonu tā te pūnaha whakarato hauora tiaki i te tini o te tangata i Aotearoa, ā, ka whai wāhi atu anō mātou ki te whakatakoto i ngā whakahounga hauora nā te Kāwanatanga i tohu.

## Hei kaupare i te urutā Kowheori-19

E mōhiotia ana te kounga o tā Aotearoa huarahi karo i te urutā Kowheori-19, puta noa i te ao. I ēnei tau 2021/2022, ka kōkiritia e tātou tētahi hōtaka whāngai rongoā ārai mate, ko tōna nui kātahi anō nei ka kitea i konei, me tōna whātoro atu anō ki ngā tōpito huhua o te motu.

Me whakahīhi ka tika ki te kounga o tā te pūnaha whakarato hauora karo i te urutā, i ngā tini wero anō hoki i puta mai nō muri. Pērā anō i ngā whenua katoa, he nui ngā taumaha kua ūhia ki runga i ō tātou ratonga hauora, otirā, ki ō tātou kaiwhakarato ake. Me āta whakatakoto i aku mihi ki ngā kaiwhakarato hauora, kaiwhakarato hunga hauā, i te ngaio rawa, i te ū mārika, i te whakapau kaha ki ngā mahi.

Ka puta mai he tūāhua, ka tipu mai he mōhio, ka whai atu anō tā tātou kaupare – ko te rewanga o Care in the Community te whakatauiria ake i te kaupapa rangatira hei karo i te urutā. Nā tā rātou hōtaka i tiakina ai te tokomaha, ō rātou whānau, me ō tātou hōhipera, i taea ai te noho taratahi me te kimi tonu i ngā āwhina ā-hauora, ā-oranga, ā-whare, kua whakatōpūngia ki ō rātou hau kāinga.

I tere hangā mai ā tātou mahere kimi, mātakitaki patuero, ā, ka hau mai ko te Mata Whakaari Patuero me te hangarau tautoko i tā te tangata tohu mai i tōna whakataunga ake, i māmā ai te whakamātau ka hiahia ana, me te noho taratahi mēnā i pāngia.

## Ngā whakahou i te ao hauora

Hei whakatutuki i te wāhi ki a mātou i roto i ngā whakahou i te ao hauora, kua āta whai mātou kia tika tā mātou tiaki i te pūnaha hauora, kia rena ai te taura here ki Te Whatu Ora, ki Te Aka Whai Ora anō hoki.

Me mihi atu au ki ngā kaha i whakapauria ai e te tini o te Manatū Hauora, me te whānui anō hoki o te pūnaha whakarato hauora, whakarato hunga hauā i ngāwari ai te whakatū i ēnei whakahounga.

E mōhio ana mātou he tīmatatanga noa tēnei, ā, e tutuki ai tēnei kaupapa me taipoto, me whakapau hāora, me whakapau kaha. Ko te whāinga – arā, ko Pae Ora – e mārāma ana, kia kotahi ai, kia kounga ai tā tātou tiaki i te hauora o Ngāi Aotearoa, hei tautoko i tā rātou hauora, mauri anō hoki.

Ko tō tātou waka, he waka eke noa, kotahi anake taua waka, e kore e rerekē ake.

## He kaupapa anō i tutuki

Kua pīkauria tonutia e te Manatū ētahi atu kaupapa kāore he pānga ki te Kowheori-19. I tua atu i ētahi kaupapa atu anō, kua paraia he huarahi mau roa hei hāpai i te tiaki hinegaro, i te patu

wawara hoki, kua whakakahangia anō ēnei ratonga mā te Access and Choice Programme; kua whānui ake te whakarato i te motu ki ngā ratonga rapu mate pukupuku; kua whakatūria a Ngā Parewa, te paearu hou hei whakarato i te hunga hauā. I te mārāma rawa o te kite e tautoko ana te motu i te mate whakaahuru, i whakatakotohia he ritenga e haumaruru ai te tono i tēnei ratonga.

Kua whānui anō hoki tā tātou tautoko i ngā poari hauora ā-rohe e toka ai te hanga – ko ētahi kawa i tāia ai i tēnei tau, ko te whare hauora o Te Nīkau ki Māwhera, ko Te Hōhipera o Waipapa ki Ōtautahi, me Taiao Ora – te whare mate roro ohotata ki Te Hōhipera o Tāmaki. I tīmata mai rā te hanga i Te Hōhipera o Ōtepoti – kātahi anō ka kitea tētahi hanganga pēnei te nui i te ao hauora o Aotearoa nei. Kua whakapaua anō he pūtea nui ki te tiaki raraunga, tiaki matihiko, ko te nuinga i whakapaua ki te karo i te Kowheori-19, engari kia mau roa ai aua hua, haere ake nei.

## Poroaki

Ka mutu taku noho hei Tumu Whakarae, hei Tumuaki hoki o te Manatū Hauora, hei te 29 Hūrae 2022. Anō te hōnōre nui i riro māku e ārahi a Aotearoa hei Tumu Whakarae mō te Hauora i tēnei wā, me te ngāwari o te whakahua atu ko tēnei tūranga mahi te tūranga rawe katoa kua whakanōhia e au.

E koa ana au kua riro tēnei tūranga i a Tākuta Diana Sarfati, ka toa rawa tana ārahi i te Manatū kia koi ai te mata, kia tipu tonu ai ia hei kaitohutohu matua ki te Kāwanatanga, mō te hauora, mō te tiaki anō i te pūnaha hauora.

Ngā mihi,

Tākuta Ashley Bloomfield  
Tumu Whakarae o Mua mō te Hauora

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# **Who we are and what we do | Ko mātou, me ā mātou mahi**



# About Manatū Hauora

Manatū Hauora (the Ministry of Health) is the chief steward of the health system. Our shared vision is an Aotearoa where all people live longer in good health, have improved quality of life, and where there is equity in outcomes between all groups.

Manatū Hauora makes sure the health system operates fairly and equitably to deliver pae ora (healthy futures) for New Zealanders.

Aotearoa New Zealand moved to a new national health system on 1 July 2022 with the introduction of the Pae Ora (Healthy Futures) Act 2022. Under the changes, the Ministry's role as kaitiaki of the health system has been strengthened, with other functions transferred to new entities such as Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (the Māori Health Authority). This annual report refers to the Ministry's role, priorities and achievements during 2021/22, prior to the enactment of the new legislation.

## Our kaitiaki responsibilities

During 2021/22, as kaitiaki of the health and disability system, we:

- provided free and frank advice about effective interventions
- provided clinical and sector leadership
- funded an array of national services (including disability support services and public health services)
- legislated (including developing new legislation)
- regulated, enforced, measured, monitored and evaluated
- provided ongoing reviews of evidence about effective interventions

- set expectations and accountability requirements
- ensured that we met Aotearoa New Zealand's international health and disability obligations.

As at 30 June 2022, we employed over 800 staff based in 6 locations across Aotearoa New Zealand. Our people worked on a wide range of activities covering policy, regulation, operational matters, readiness and response, innovation, improvement and clinical development to support the health and disability sector.

## Vote Health

Vote Health was and continues to be the main source of funding for the health and disability system in Aotearoa, which includes Manatū Hauora. In 2021/22 Aotearoa New Zealand's DHBs carried out most of the day-to-day business of the health and disability system and administered more than two-thirds of the Vote.

This included funding for:

- primary health care
- hospital services
- public health services
- aged care services
- services from non-governmental health providers, including Māori and Pacific providers.

Almost 17% went of the remaining part of the Vote, towards delivering other health and disability services.

Over 15% of the Vote in 2021/22 was for the health response to COVID-19.

Over 1% of the Vote provided support, oversight, governance and development with the aim of maintaining and enhancing the quality and delivery of the sector. Just over 1% of the Vote was for Ministry operating costs.

## Our priorities for the health and disability system

During 2021/22 our priorities included:

- the Government's COVID-19 response
- the health and disability system reforms
- improving child wellbeing
- improving mental health through preventative measures
- improving wellbeing through preventative measures
- creating a strong and equitable public health system
- providing better primary health care
- ensuring a financially sustainable health system.

### COVID-19 response

We continued to support the Government's ongoing public health response to the COVID-19 pandemic. Some focus areas of the response included:

- coordinating the incident response
- testing and contact tracing
- managing supply chains for vaccinations and medicines
- vaccination and immunisation programmes

- staying on top of emerging science and evidence
- health at the border (including managed isolation and quarantine)
- working on the future strategy and response frameworks for Aotearoa.

### Health and disability system reforms

In 2021/22, we worked with the Health and Disability Review Transition Unit (the Transition Unit; from within the Department of the Prime Minister and Cabinet) to develop a joint work programme progressing the system reforms. The Transition Unit led the actions from the Health and Disability System Review.

Working with the Transition Unit, we:

- developed the Pae Ora (Healthy Futures) Bill (which became law on 1 July 2022)
- provided Cabinet with policy advice
- developed the Government Policy Statement
- planned and implemented our Ministry's new operating model, including the public health system transformation.

In September 2021, the interim agencies Interim Health New Zealand and Interim Māori Health Authority | Te Mana Hauora Māori were established. These agencies worked with us and the Transition Unit so that we were ready for the reforms on 1 July 2022.

The Minister of Health, agreed as appropriation Minister to direct under section 7C(2)(i) of the Public Finance Act 1989, to the Departmental Agency Chief Executives to use the relevant categories of the Health and Disability Systems Reform multi-category appropriation, to clearly delineate the accountabilities of the interim agencies, alongside any funding decisions around localities networks and developing new Hauora Māori programmes. Accordingly, during

2021/22 the Interim Chief executives of the interim Health New Zealand and Interim Māori Health Authority departmental agencies were responsible (instead of the Ministry of Health, as the appropriation administrator) to the Minister of Health for what was achieved with those expenses.

We set up Interim Health New Zealand and Te Mana Hauora Māori | Interim Māori Health Agency as departmental agencies within Manatū Hauora on 1 September 2021.

This made it easier to appoint staff to the interim agencies, including the Chief Executives in mid-February 2022. It also allowed the interim agencies to develop their operating models and prepare the interim New Zealand Health Plan and the New Zealand Health Charter.

We transferred Ministry functions to the interim agencies along with staff. The Ministry of Health led the work to determine which functions would transfer, working with the interim agencies to agree which functions would transfer and how the functions fit in the interim agencies' operating models.

The Joint Transitional Leaders Group made the final agreement of function transfers. This Group consisted of the Director-General of Health, Chief Executives of the interim agencies, and the Lead of the Transition Unit at the Department of the Prime Minister and Cabinet.

Whaikaha | Ministry of Disabled People was established on 1 July 2022. Whaikaha takes on most functions delivered by the Disability directorate within the Ministry of Health, as well as taking on new responsibilities.

Between 1 March and 1 July 2022, 1,560 full-time staff<sup>1</sup> transferred from the Ministry of Health to Interim Health New Zealand, Te Mana Hauora Māori and Whaikaha.

## Improving child wellbeing

We continued to deliver on the priorities in the Child and Youth Wellbeing Strategy.<sup>2</sup> This included work areas from the Government's response to the Well Child Tamariki Ora Review.

In 2021/22 we:

- provided mental health support for primary and intermediate school students
- expanded access to primary mental health and addiction support services
- improved oral health care for children and young people.

## Improving mental health through preventative measures

We progressed work to roll out consistent mental health services across the country, while reflecting the specific needs of local communities. Improving access and choice of primary mental health and addiction services helps ensure New Zealanders can access support when – and where – they need it.

## Improving wellbeing through preventative measures

In 2021/22 we:

- progressed actions under the cross-agency Aotearoa New Zealand Homelessness Action Plan (led by the Ministry of Housing and Urban Development)<sup>3</sup>

1 Where 1.0 FTE (full-time equivalent units) is equal to 40 hours of work per week.

2 Department of the Prime Minister and Cabinet. 2019. Child and Youth Wellbeing Strategy. Wellington: Department of the Prime Minister and Cabinet. URL: [childyouthwellbeing.govt.nz/resources/child-and-youth-wellbeing-strategy](https://childyouthwellbeing.govt.nz/resources/child-and-youth-wellbeing-strategy) (accessed 18 August 2022).

3 New Zealand Government. 2019. Aotearoa/New Zealand Homelessness Action Plan. Wellington: Ministry of Housing and Urban Development. URL: [hud.govt.nz/community-and-public-housing/addressing-homelessness/aotearoa-homelessness-action-plan-2020-2023](https://hud.govt.nz/community-and-public-housing/addressing-homelessness/aotearoa-homelessness-action-plan-2020-2023) (accessed 9 September 2022).

- worked as part of the Joint Venture for Family Violence and Sexual Violence to develop a prevention-based approach to family and sexual violence.<sup>4</sup>
- increased access to our national screening programmes for detectable diseases
- controlled the purchase of tobacco-related products.

## Providing better primary health care

We continued programmes to help us make sure health professionals have the tools they need. For example, we are developing standardised population health data for health professionals to use to plan and take action.

## Ensuring a financially sustainable health system

We are committed to prioritising the sustainability of health system services.

In 2021/22 we worked with DHBs to ensure a long-term view that protects their assets and facilities. The approach aimed to promote trust in our health and disability system by assuring the quality, safety and coverage of health and disability services.

## Our Values | Ngā Uaratanga

Our organisational culture is guided by our values and informed by our rich history, current context and experience of how we work together to solve problems and deliver on our strategy.

Our collectively chosen values guide how we work together within the Ministry, for example, in our recruitment processes, our induction programme and our performance and development

### Our Ministry values | Ngā Uaratanga



**Manaakitanga**

We show care, inclusion, respect, support, trust and kindness to each other.

*"He aroha whakatō, he aroha puta mai"  
If kindness is sown, then kindness you shall receive*



**Kaitiakitanga**

We preserve and maintain an environment that enables the Ministry and our people to thrive.

*"Ka mua, ka muri"  
The past is clearly visible but the future is not  
The future comes out of the past.  
The only constant is change*



**Whakapono**

We have trust and faith in each other to do the right thing.

*"He tangata ki tahi"  
A man who speaks once  
A person who says something and sticks to it*



**Kōkiri ngātahi**

We connect and work together collectively towards a common purpose.

*"He waka eke noa"  
We are all in this together  
"Mā pango, mā whero, ka oti te mahi"  
Many hands make light work*

<sup>4</sup> For more information, please visit the Joint Venture's website, Te Puna Aonui, at [tepunaaonui.govt.nz/our-work](http://tepunaaonui.govt.nz/our-work).

systems. Our values also guide how we work across the health and disability

sector, with our public sector colleagues and with communities.

## Our strategy | Tā Tātou Rautaki

Our organisational strategy Tā Tātou Rautaki sets out how we have worked towards pae ora | healthy futures.

In 2022–23 we will update our strategy Tā Tātou Rautaki. We will also update our Strategic Intentions 2021–2025 to redefine our strategic objectives.

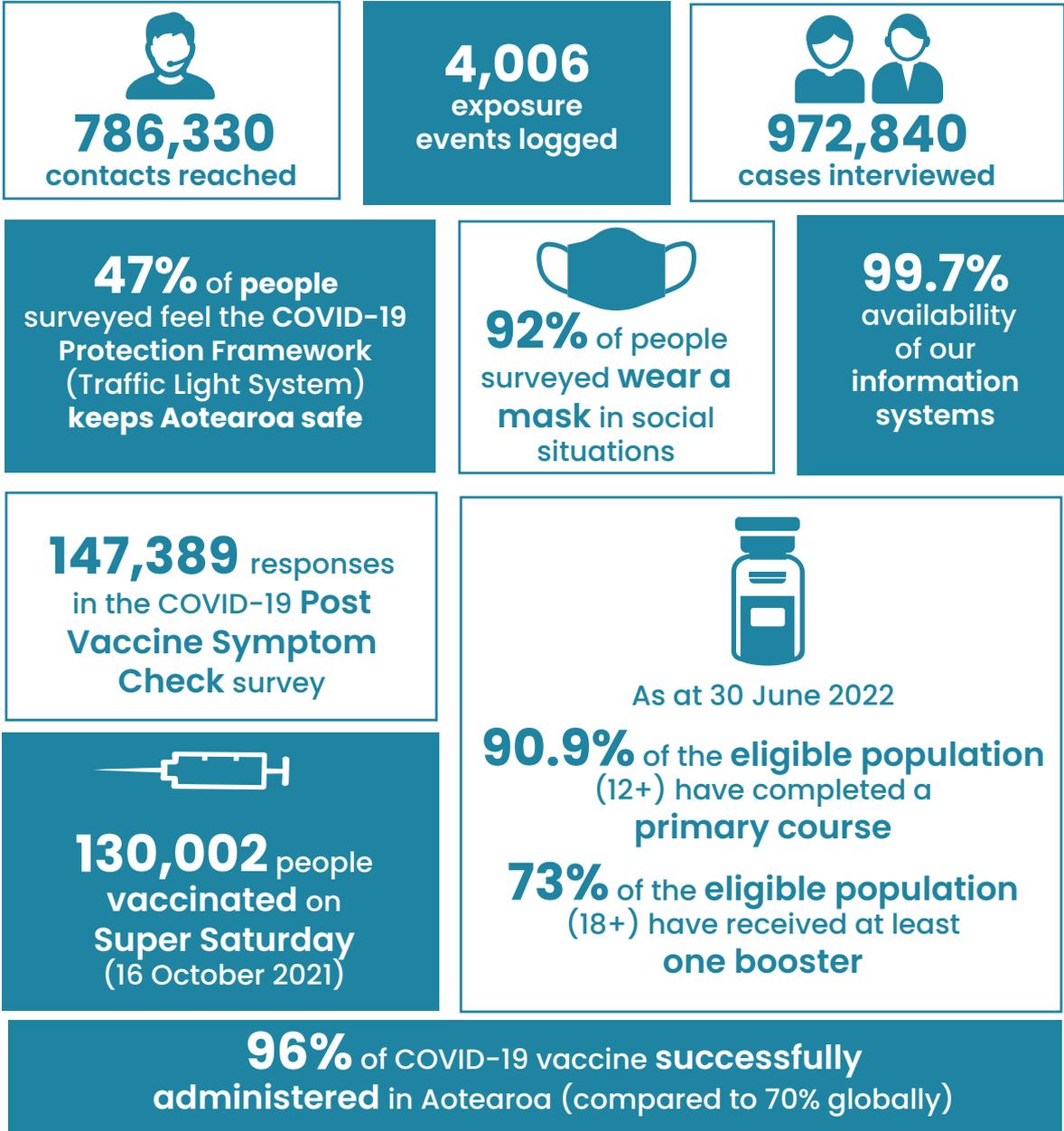


5 Ministry of Health. 2021. *Strategic Intentions 2021 to 2025*. Wellington: Ministry of Health. URL: [health.govt.nz/system/files/documents/publications/strategic\\_intentions\\_2021-2025-withcover\\_9\\_dec.pdf](https://health.govt.nz/system/files/documents/publications/strategic_intentions_2021-2025-withcover_9_dec.pdf) (accessed 18 August 2022).

# Our continued response to the COVID-19 pandemic | Tā mātou kaupare tonu i te urutā Kowheori-19



# COVID-19 information at a glance | He whakarāpopoto kōrero mō te Kowheori-19



More than  
**56,000**  
users trained  
to use COVID-19  
platforms

**2,614**  
vaccination sites  
established

More than  
**20,000**  
vaccinators trained



**4.5 million**  
people accessed  
free RATs

**48,839**  
border workers  
in the Border  
Workforce  
Testing Register

**807,567** COVID-19 tests  
at the border  
99.96% negative COVID-19  
test results at the border



More than  
**804 million**  
total poster scans  
since May 2020

**229,955**  
people returned  
to Aotearoa  
through MIQ  
since March 2020

More than  
**100,000**  
workers and  
**260** businesses  
provided with  
onsite COVID-19  
vaccines

**27** local  
community  
vaccination sites  
established in the  
community

As at 30 June 2022  
NZ COVID Tracer  
app had  
**3.66 million**  
registered devices

**2.4 million**  
users activated  
Bluetooth tracing

**35,761**  
exemption  
applications  
processed for the  
Auckland and Upper  
Hauraki boundaries

# Leading the COVID-19 health response in Aotearoa New Zealand | Te ārahi i te kaupare i te Kowheori-19 i Aotearoa

The COVID-19 response has continued to be one of the most important public health responses nationally and internationally. We are committed to keeping everybody safe and achieving equitable outcomes for the people of Aotearoa New Zealand.

Our public health priorities shaped the response to the COVID-19 pandemic in Aotearoa New Zealand. The Government revised its elimination strategy and the Alert Level system in late 2021, taking into account the new context of a highly vaccinated population and emerging variants of concern. The COVID-19 Protection Framework (CPF) replaced the earlier framework.

The CPF helped in implementing increased deployment of testing, digital technology and vaccination and in promoting mask use. The principles of the CPF allowed us to promote equity, to reduce the impact of COVID-19 on our most vulnerable populations and to protect the health system.

This strategy – alongside the Omicron response plan – guided the shift from ‘elimination’ to ‘protection and minimisation’. It allowed us to implement a ‘care in the community’ model and enabled New Zealanders to reconnect with the world.

Our most effective tool was the COVID-19 vaccination programme. We had never before attempted an immunisation programme of this scale and complexity, yet the programme achieved vaccination of more than 90% of eligible New Zealanders.

These vaccination rates reduced hospitalisation and mortality rates, enabling the health and disability system to better manage COVID-19.

We relied on science and the latest data from both here and overseas with the aim of protecting New Zealanders and our health system. Our COVID-19 response succeeded because we had a unified response across all government agencies, and our public health units and district health boards (DHBs).

Over the 2021/22 year, we continued to provide a dedicated health response to the challenges of COVID-19. We worked hard to coordinate immunisations and to provide integrated, whānau-centred care in the community.

We continued to provide a dedicated and agile health response to the unprecedented challenges of COVID-19. We faced outbreaks of 2 different variants, supported the government's shift from its elimination strategy to one of protection and minimisation, implemented our biggest-ever national immunisation programme and supported the reopening of our borders to the rest of the world.

## Responding to and managing the Delta and Omicron community outbreaks

On **17 August 2021**, after over 100 days of no community transmission of COVID-19, the **first Delta case** was detected in the community in Aotearoa. Because this variant was more severe and had a higher transmission risk, the motu (country) went into an immediate lockdown.

In August 2021, the first community case of the Delta variant in Aotearoa was detected. At the time, approximately 18% of the population was fully vaccinated, and the government was pursuing an elimination strategy under the Alert Level settings. An immediate national lockdown

was imposed – the first in over a year – and we quickly mobilised our response, with testing, contact tracing and border settings kicking into gear.

While in the first month we managed to largely contain the outbreak, Delta eventually began to spread in hard-to-reach populations, and by mid-September community cases had reached over 1,000 in total. We scaled systems and services to support contact tracing and case investigation at pace and supported the implementation of new public health measures to suppress transmission. While working to contain the outbreak, we also implemented our biggest drive to immunise the population.

Cases continued to rise into October and, as our health system faced immense pressures, it quickly became apparent that we needed a new model for managing Delta. By this time, however, we were well into our immunisation programme and had a largely vaccinated population.

The Government signalled the move from its elimination strategy to one of suppression with a focus on vaccinations and a move to caring for community cases in the home. In response, we developed a new care in the community model, bringing together clinical, health and welfare supports grounded in a pro-equity approach, to provide integrated and wrap-around care to individuals and their whānau in the community at the local level.

In December 2021, Aotearoa shifted away from its elimination strategy to the COVID-19 Protection Framework, acknowledging the impacts of COVID-19 had changed because we had a highly vaccinated population.

On **16 December 2021**, the **first Omicron case** was reported in Aotearoa. Compared with Delta, Omicron was predicted to spread at an unprecedented pace in the community.

We responded rapidly with an Omicron response strategy that saw significant operational changes across testing, case investigation and contact tracing. We shifted to using rapid antigen tests (RATs), developed a case self-registration portal for positive RAT results, and made stepwise changes to testing and isolation

requirements for cases, household contacts and close contacts.

There was a focus on encouraging the public to get booster vaccines. The period between receiving the second dose and the booster was reduced from 6 months to 4 months, improving vaccine coverage.

This strategy has continuously evolved and improved, informed by evidence and data, together with the insights and voices of those with lived experience and those responding to and supporting communities on the ground.

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## Timeline: Contact tracing and testing responses

### Burst call centre (August 2021)

In August 2021, the National Investigation and Tracing Centre used existing call providers to scale up our contact tracing service, standing up an additional call centre to meet the surge in contacts resulting from the Delta outbreak. In total, 12 government agencies and one external call provider came together to provide contact tracing resources.

The all-of-government contact tracing centre was set up in 48 hours, with the team responsible for calling contacts of COVID-19 cases. Over a 2-week period, this additional contact tracing centre made 6,566 successful calls, informing New Zealanders of their potential exposure to COVID-19 and giving them advice they could follow to control the spread as quickly as possible.

### Technology (August 2021 onwards)

To manage the extent of this outbreak, digital contact tracing tools were rapidly deployed to assist the response, including the NZ COVID-19 Tracer app and the Locations of Interest website. The use of both of these tools increased significantly during this period and these tools were improved and updated throughout the outbreak.

### Testing response to Delta (August 2021)

In August 2021 the first community Delta case was identified in Auckland. A key part of our response was to set up multiple community testing centres to help with the increase in testing demand. We also pushed out personal protective equipment (PPE) from the

warehouses to meet the increased demand for it. Labs and DHBs were notified to expect an increase in testing demand after Alert Level restrictions began, and testing requirements put in place for people crossing the Alert Level boundaries. We set up multiple saliva drop-off stations at workplaces and close to the boundaries.

In October, working with the private sector we began a RAT pilot. This successful pilot led the way for the distribution of RATs later in 2022.

Demand for polymerase chain reaction (PCR) testing was highest during the Delta outbreak, when up to 50,000 tests a day occurred. All the regions successfully stood up extra testing sites and focused on specific areas that had outbreaks.

## **Border operation response to Delta (17 August 2021)**

On 17 August 2021, following an outbreak of the Delta variant, the country moved to Alert Level 4. On 31 August, Auckland and Northland remained at Alert Level 4 while the rest of Aotearoa, south of Auckland, moved down to Alert Level 3. This split in Alert Levels saw the establishment of a regional boundary and as a result, travel between different Alert Levels became restricted.

The Health Order Exemptions team worked closely with the Data and Digital team to establish a system for assessing exemption requests to allow interregional travel. This work included managing a surge workforce of assessors all trained remotely and working within their own lockdown requirements.

In partnership with the Ministry of Business, Innovation and Employment (MBIE), the Ministry delivered projects that continually improved and refined the efficiency and quality of the health services delivered within Managed Isolation and Quarantine (MIQ).

On 16 December 2021, preparation for the arrival of the Omicron variant in Aotearoa began by putting in place a range of new precautionary measures. From 24 December 2021, the length of MIQ was extended to 10 days and other new public health measures.

## **National Case Investigation Service (November 2021)**

Recognising we needed the ability to scale up our national case investigation capacity, we established the National Case Investigation Service in November 2021. Having a focused case investigation service provided greater system capacity as well as improving efficiencies and enabling public health units to focus on high-risk cases and exposure events.

## **Testing response to Omicron (Mid-January 2022)**

In mid-January, in response to the increasing prevalence worldwide of the Omicron variant, Manatū Hauora prepared a new Testing Plan. The Testing Plan aligned with the Government's Omicron Response Plan, which would see RATs become the main testing method in phase 3 of the Omicron response.

The Testing Plan recognised that, with the Omicron variant outbreak, eliminating COVID-19 would no longer be viable, given expected case numbers were between 5,000 and 50,000

a day, and that prioritising PCR testing would be essential. Under the new Testing Plan, the purpose of testing shifted away from detecting cases to protecting priority populations from severe disease and/or death, ensuring equity and limiting the impact on society by protecting critical infrastructure.

## Contact tracing response to Omicron (February 2022)

The case investigation and contact tracing service underwent comprehensive operational change to manage the number of cases resulting from the Omicron outbreak. During February and March, significant work went into preparing new technology enablers to support the high case volume and align with the Government's COVID-19 Protection Framework. Changes included implementing technology for people to self-report RAT results and an online contact tracing form that digitally enabled communities could use for self-management.

## Border operations response to Omicron (March 2022)

Once the Omicron variant became established in the community and led to a rapid rise in the number of community cases, MIQ settings (ie, the requirements related to entering MIQ from the border for a certain length of time) were progressively reduced to keep the strength of the requirements proportional with the community response. Throughout the first wave of the Omicron outbreak, MIQ facilities served as isolation facilities for community cases that could not safely self-isolate at home or in other accommodation.

On 10 March 2022, the formal decommissioning process of MIQ facilities began. At first, a small number of facilities remained open to respond to demand for isolation accommodation for community cases. As this demand from the community became very low, the final MIQ facilities were deactivated on 30 June 2022.

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## Exploring the use of other medicines to treat COVID-19

As global experience with treating COVID-19 grew, so did knowledge about how to provide effective treatment for severe COVID-19 and which patient groups needed treatment most. Global demand for effective treatments was high and supplies were often short.

The Ministry led a cross-sector approach in which:

- the Ministry's COVID-19 Science and Technical Advisory team conducted horizon scanning and initial product assessment on a rolling basis to synthesise emerging evidence on therapeutic products in development
- the Ministry's COVID-19 Therapeutics

Technical Advisory Group (the Therapeutics TAG) reviewed emerging evidence and potential for clinical use in Aotearoa

- Pharmac reviewed evidence on the risks, benefits, efficacy and safety of therapeutic products with potential use in Aotearoa to clinically evaluate treatments, make funding decisions and determine access criteria
- Pharmac undertook supply chain facilitation and contract management, using COVID-19 funds to acquire supplies for clinical use in Aotearoa, and working with suppliers to ensure they meet regulatory obligations
- the Therapeutics TAG provided information on up-to-date clinical guidance about using therapeutics.

## Delivering the COVID-19 National Immunisation Programme

In 2021, Aotearoa embarked on the largest vaccination programme in its history, aiming to provide 4.2 million eligible people with the opportunity to be double-vaccinated against COVID-19 by the end of the year.

Tasked with building an operational approach to deliver on this goal throughout 2021 and 2022, we dedicated significant resources and health system infrastructure to designing and delivering this vaccination programme.

The first COVID-19 vaccinations were administered on 19 February 2021. Vaccines were then progressively rolled out to the population using a sequencing framework that prioritised the people most at risk of contracting COVID-19 and of experiencing a poor health outcome from infection. This framework meant that when supply was initially limited, vaccinations were delivered to those most at risk.

By 30 June 2022, 95 percent of the population over the age of 12 were double vaccinated, and 73 percent of the eligible population over the age of 18 had received a third 'booster' dose.

By the end of 2021, Aotearoa was one of the world's most highly vaccinated countries for COVID-19, sitting in the top half of the group of OECD nations.

### Meeting the needs of disabled people through priority vaccinations

We worked hard to improve and prioritise health services to better support disabled people as part of our COVID-19 response.

The Ministry established a \$4 million transport fund to support equitable access to vaccination services for disabled people and stood up a disability-focused phone and text service through Whakarongorau Aotearoa. People with lived experience and whānau whaikaha | family of disabled people were the staff of this service, which disabled people could use to ask questions, book transport and request home vaccinations through DHBs.

We worked with our Disability Immunisation Advisory Group, Tātou Whaikaha, to identify disability-specific factors we needed to consider in our immunisation roll-out and operational action plans for our COVID-19 response. Tātou Whaikaha supported us to develop and design processes, campaigns and actions that met the needs of our disabled populations and support them adequately during our response.

We commissioned the Social Wellbeing Agency to create disability indicators on COVID-19 vaccination coverage for disabled people. Analysis of vaccination uptake rates for disabled people was completed in December 2021 and updated to include children in March 2022. We shared the results of this analysis with our delivery partners, including DHBs, to help inform service delivery and outbreak activities.

## Supporting our Pacific neighbours: COVID-19 preparedness and response in Polynesia and Fiji

The Polynesian Health Corridors (PHC) programme, a partnership with the Ministry of Foreign Affairs and Trade, and Polynesian countries, focused on helping

to prepare countries for pandemics, specifically COVID-19, by:

- strengthening outbreak management systems
- planning for and supporting the COVID-19 vaccine roll-out.

Vaccine planning and delivery were at the forefront of PHC’s support to Polynesia during the year.

The PHC programme worked closely with a wide range of stakeholders including (but not limited to):

- the governments of the Cook Islands, Niue, Tokelau, Tonga, Tuvalu and Samoa
- Ministry of Foreign Affairs and Trade
- New Zealand Defence Force
- Medsafe
- Centre for Adverse Reaction and Monitoring
- Immunisation Advisory Centre
- Kuehne & Nagel
- United Nations Children’s Fund (UNICEF)
- The World Health Organisation (WHO).

Its overarching aim was to support the 6 Polynesian countries and Fiji so they were well positioned to deliver a safe and effective pandemic response.

In extending its support to Fiji, the PHC programme procured and delivered 7,000 doses of paediatric Pfizer vaccine and 52,560 adult doses for those aged 12–14 years. PHC also led a technical assistance mission to Suva, along with the Immunisation Advisory Centre, to support and train Fiji’s vaccinator workforce in June 2022.

Through the work across the entire programme, Polynesian countries achieved vaccination rates that were world leading.

In addition to vaccine support, PHC provided Niue, the Cook Islands and Fiji with on-the-ground technical assistance, infection prevention and control training, and case investigation and contact tracing workshops. It also participated in community and public sector engagements to strengthen outbreak preparedness.

Testing capability was central to the COVID-19 response, protecting Pacific communities against COVID-19. The PHC provided 217,040 RATs to Polynesian countries.

**Number of rapid antigen tests donated to Polynesian countries, February 2021 – June 2022**



**357,690** doses of **paediatric and adult Pfizer COVID-19 vaccine** delivered across **Polynesia and Fiji** since April 2021



**383** clinicians attended **COVID-19 professional development workshops**



Over **825** vaccinators trained

**World-leading vaccination rates\***

Cook Islands	98.5%
Niue	94.3%
Tokelau	97.0%
Samoa	93.3%
Tonga	91.0%
Tuvalu	91.3%

\* people aged 12 years and older who have received two doses of Pfizer COVID-19 vaccine

Country	Total RATs donated
Cook Islands	31,680
Niue	4,740
Samoa	91,720
Tokelau	6,840
Tonga	73,240
Tuvalu	8,820
<b>Grand total</b>	<b>217,040</b>

## Demonstrating our commitment to achieving equitable outcomes

Equity for Māori, Pacific, disabled people, and ethnic communities was at the centre of the COVID-19 vaccination programme design and implementation.

A significant amount of work went into responding rapidly to the challenges of COVID-19, including mobilising systems, services and support to meet the needs of priority populations and deliver equitable health outcomes. We especially acknowledge the significant contribution that iwi, Māori and Pacific providers, as well as our frontline workforce, made (and continue to make) during this response.

Locally led solutions helped drive equitable outcomes, supported communities and improved resilience.

Over the year we worked directly with other agencies, engaged frequently with communities and providers, and worked with equity advisory groups to inform a pro-equity COVID-19 response.

Engagement between the National Immunisation Programme equity regional account managers, DHBs and local Māori health providers led to the planning and

delivery of a range of vaccination events, including vaccination sprint events held in Tairāwhiti, Bay of Plenty and South Auckland.

As a result of our close working relationship with the Ministry for Pacific Peoples, we created an effective mechanism to hear from Pacific communities directly through their national, regional and ethnic-specific Zoom fono. These engagements helped us to promote ethnic-specific communication across Pacific communities, leading to an ongoing high level of compliance with public health guidance, including on vaccination and testing measures. Importantly, we were also able to engage with Pacific peoples considered hard to reach.

Ongoing engagement with our lived experience group, Te Kōtuku e Rere, supported us to design and develop approaches that connect with rural Māori, Pacific, mental health and addiction, and disabled populations.

### COVID-19 Māori health response

In July 2021, the Ministry conducted an internal review of the COVID-19 Māori health response. This review highlighted 3 pillars that were essential to this response across 2020 and 2021, and through which funding has been allocated.

Following this, the Ministry published the COVID-19 Māori Health Protection Plan in December 2021. The plan provided an updated monitoring framework to guide the health and disability system actions for Māori through the COVID-19 response in the short to medium term. Informed by Te Tiriti o Waitangi, it aimed to protect whānau, hapū, iwi and hapori Māori from the impacts of COVID-19 by preventing and mitigating those impacts.

As part of the COVID-19 Māori health response, the Ministry published an

evaluation of the Māori Influenza Vaccination Programme, which provided insight into the impact of the programme on Māori influenza (flu) rates and equity.

## Meeting Māori aspirations: Partnership, investing in service providers, and data sharing

The Ministry partnered with Māori health providers, local iwi, kura kaupapa communities, DHBs, local communities and whānau to design initiatives to increase vaccination uptake.

The Ministry also partnered with iwi Māori and Māori providers to establish care coordination hubs under the Care in the Community programme. Some regions established iwi-based hubs, where iwi-Māori took the lead to provide responsive support to their communities.

An additional \$29.6 million was allocated to support Māori health and disability providers to extend the reach of their services for whānau in response to the Omicron outbreak. A focus area for this funding was to provide training, requalify staff who could return to the workforce easily and establish back-up arrangements to maintain services through the Omicron response and vaccination efforts.

The Ministry collaborated internally and externally to improve equity data collection and sharing. We improved our reporting to focus on the underlying causes of inequities that affect Māori, particularly in relation to housing.

From February 2022, the Ministry produced Māori and Pacific COVID-19 data weekly reports.

## Vaccination data sharing

The Ministry began activities to share COVID-19 vaccination data with Māori, iwi and hauora service providers in November 2021. The purpose was to enable communities to support the delivery of the COVID-19 vaccination programmes locally.

To ensure the programme was appropriately responsive to Te Tiriti o Waitangi and the recommendations in the Waitangi Tribunal Haumarū COVID-19 Priority Report, the data-sharing agreements included a clause stating that resourcing and support for this purpose would be available.

To support this mahi, in December 2021 we established a pool of funding to enable partners to increase their technical capacity and capability.

## Meeting the additional service needs of our disabled people

Through hui with disabled people and representative groups, the Ministry heard the voices of disabled people.

This approach led to changes such as making PPE easier to access for disability funded providers and giving them good access to relevant guidance that they could use to support disabled people with the highest needs and maintain service continuity.

The Ministry gave disability providers financial certainty through additional financial support in the form of \$19.3 million surety payments. This surety extended to disabled people and whānau who manage their own budgets. The Ministry funded the storage, supply and distribution of PPE for these people and their whānau, providing them with good access to PPE.

As a response to COVID-19 and its impacts on disabled people and their whānau, we

made access to respite more flexible. For example, disabled people could use Carer Support and Individualised Funding to pay family | whānau | āiga, including those living in the same household, for providing support.

### Supporting our local Pacific communities

The Ministry had a pivotal role in leading and coordinating the Pacific health and disability sector to achieve equitable health outcomes for Pacific peoples in Aotearoa.

In 2021/22, in leading the Pacific COVID-19 response, we:

- successfully sustained the capacity of Pacific health providers to deliver community-led response activities across 2 major outbreaks
- published high-quality research on Pacific peoples’ experiences of COVID-19 to support service planning and design
- provided health information, guidance and communications in a culturally appropriate, consistent and timely way for Pacific communities.

The Ministry’s Testing team created an Advancing Equitable Access 8-point action plan to address testing inequities for Māori, Pacific, disability and at-risk groups. Rural and ethnic minority communities were included in the at-risk group focus.

### Supporting our rural people during the COVID-19 response

The map below shows the distribution of RAT collection sites across Aotearoa New Zealand. In total, 96.5% of the population were within a 20-minute drive of a collection site.

A surge in cases created pressure on the distribution warehouse and courier network. At these times, the Māori Provider Distribution Channel coordinated urgent delivery. The 29 lead iwi-Māori providers who made up this channel were positioned all over the motu and were connected to over 1,000 community partners, including communities in rural/remote settings.

The channel service began in April 2022 and, due to the success of its outreach, the contract has been extended to September.

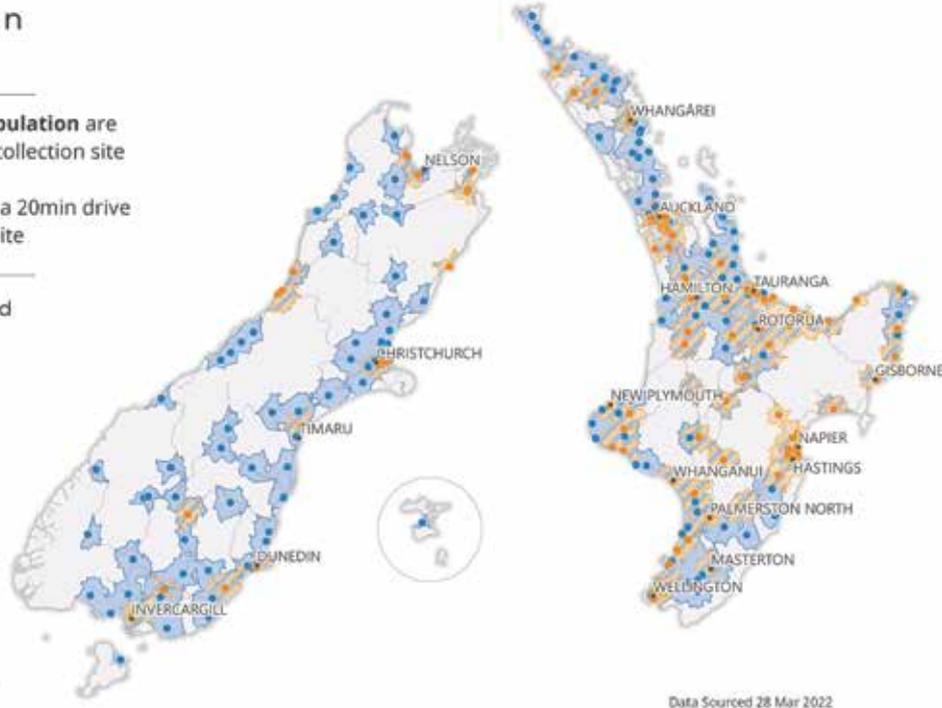
#### RAT collection sites

96.5% of the general population are within a 20min drive of a collection site

95.4% of Māori are within a 20min drive of a collection site

#### RAT collection sites and 20min drive time catchment areas

- Māori providers RAT collection sites
- Māori providers 20min drive time
- RAT collection sites
- RAT collection 20min drive time
- Overlapping 20min drive time



## Ethnic communities

Ethnic communities include migrants and refugees. Making up 20% of the population of Aotearoa, these diverse, ethnic communities include African, Asian, continental European, Latin American and Middle Eastern cultures.

The health network for ethnic communities was not as developed as for the Māori and Pacific Health and disability provider space. For this reason, we needed to focus more on developing cross-sector relationships through the Ministry of Ethnic Communities and Ministry of Social Development to reach their community partner network.

We worked with the community partner network (over 40 groups, trusts and providers) and Ministry of Social Development ethnic community connectors to distribute masks and RATs.

## Collaborating with other agencies during the response

We collaborated across government with agencies, organisations and groups to achieve an effective, robust and equitable response to COVID-19. This was done in part through various channels, ranging from the Border Executive Board to independent advisory groups, that were established to deliver high-quality leadership and advice to our ongoing COVID-19 response.

This cooperation also included our key cross-government partners, such as:

- the Department of the Prime Minister and Cabinet
- the Ministry of Business, Innovation and Employment
- Ministry of Foreign Affairs and Trade
- Ministry of Social Development
- Ministry of Education

- New Zealand Police,
- New Zealand Customs Service
- the Chief Coroner.

All of these partners supported the response to the pandemic both domestically and at the border to protect New Zealanders.

These joint ventures included successful reviews of COVID-19 at the maritime border along with New Zealand Customs and in MIQ facilities with MBIE. As a result of both reviews, we and our partners made recommendations to inform system-wide improvements.

Many operational activities required the network of government agencies to work together. For example, we needed to cooperate over the service of the MIQ facilities, Care in the Community model and the roll-out of RATs nationwide, all of which played important roles in protecting New Zealanders and minimising the impact of widespread COVID-19.

In addition, the successful delivery of crucial work programmes that were integral to bringing back normality to Aotearoa required a huge effort across agencies, including Manatū Hauora. One such programme was the Reconnecting New Zealanders to the World approach, which saw a phased reopening of our borders.

Our work in partnership with agencies and groups was pivotal to the delivery of our operations that have been essential to the COVID-19 response in Aotearoa.

## Planned care: Managing COVID-19 effects

The COVID-19 outbreak and the emergence of long COVID significantly affected planned care delivery in 2021/22. However, planned care services continued, giving priority to patients with the highest

clinical need and urgency, including cancer cases.

In Budget 2020, Cabinet approved \$282.5 million over 3 years for initiatives to reduce planned care waiting lists. It decided on the 3-year timeframe as it acknowledged the recovery process would not be straightforward, given the continued risk that COVID-19 presents to service provision.

The Ministry supported a flexible approach to this funding in 2021/22. DHBs provided targeted plans for how they would use the funding for the year to reduce waiting lists and increase delivery.

In 2021/22, \$10 million was allocated to 63 improvement projects. A proportion of this funding was to be distributed each

year for service improvement projects to futureproof our health service, improve workforce planning and reduce inequities in health outcomes.

While the COVID-19 response delayed some projects, 47 of 69 year one (2020/21) projects are now complete. An evaluation is under way to determine which projects are worthy of national spread or expansion to other regions.

The Ministry also connected with the DHBs regularly throughout 2021/22 to discuss the impacts of the outbreak on planned care. Aspects considered included the regional context, waiting lists and restrictions within the DHBs such as capacity and workforce constraints, including realignment of workforce due to staff absences.



# Our performance story | Tā tātou taki haere i a tātou



# 2021/22 operations at a glance

## He whakarāpopoto i te 2021/22

**Nearly 800,000**

telehealth calls, texts, emails  
and webchats answered

**166**

**Cochlear implants**

funded  
(up from 86 in 2020/21)

**51,297**

**New Zealanders**  
provided with  
**disability support services**



**494,641**

**Ministry contact centre calls**  
(up from 408,000 in 2020/21)

**7,161 WPQs**  
received

**7,123**  
answered

**4,555 OIAs**  
received

**1,969 Ministerial**  
briefings provided



**Influenza equity**  
gap for

**Māori**

aged **65+**

**reduced** from  
8.4% to 4.4%

**325,000+**

screens via the  
**National**  
**Cervical**  
**Screening**  
**Programme**



**1.422 million**  
influenza vaccines  
distributed

Need to Talk? 1737  
service answered  
more than  
**127,000** contacts  
supporting 47,000  
people experiencing  
distress

**235,000+**  
screens through  
**BreastScreen**  
**Aotearoa**  
(1,411 cancers  
detected)

**184,733**  
mental health and addiction service contacts  
answered supporting **73,897** people



**65%**  
of DHB-employed  
health care workers  
vaccinated for  
influenza  
nationwide  
(up from 77% in 2020/21)

**540**  
media releases  
**100**  
media stand-ups  
delivered  
**70**  
ministerial releases

**220,000+**  
screens through  
the **National**  
**Bowel**  
**Screening**  
**Programme**

**5**  
Facebook Live events  
**2,412**  
social media posts  
**95 million**  
visits to health.govt.nz  
**748**  
newsletters sent

# Our achievements | Ā mātou ekenga

Our organisational strategy, Tā Tātau Rautaki, lists four outcomes that helped shape and frame our work during 2021/22.

These outcomes included a focus on equity, sustainability, collaboration and people-centred services:

- 1 Improved equity in health outcomes and independence for Māori and all other people.
- 2 Sustainable and safe health and disability services.
- 3 An integrated, collaborative and

innovative health and disability system.

- 4 People-centred services, support and advice that meet the needs of everyone.

The stories that follow demonstrate the variety, depth and breadth of our mahi during the year, within the context of these four areas.

# 1. Improving health equity for all people in New Zealand

We identified where people faced inequities in health outcomes and created innovative approaches to address them.

People have differences in health and independence that not only are avoidable, but are unfair and unjust. Addressing those differences involves prioritising the health and independence of Māori and other groups who experience inequities, and working together to address the social, economic cultural and environmental determinants of health.

## Māori–Crown Partnerships

Māori–Crown Partnerships envisions a health and disability system where meaningful Māori–Crown relations reflect true partnership, at all levels of the system. Māori health development is increasingly led by iwi and hapū, and relationships are built on mutual trust and confidence.

In 2021/22, we continued to support new and improved relationships with various iwi and Māori groups. We held both Hui Whakaoranga and Wānanga Hauora events across Aotearoa. We also made significant contributions to the drafting of the Pae Ora (Healthy Futures) Bill, which will strengthen the health system's relationships with iwi and Māori groups.

## We progressed Whakamaua: Māori Health Action Plan 2020–2025

Whakamaua: Māori Health Action Plan 2020–2025 puts He Korowai Oranga: Māori Health Strategy into practice. It establishes the system settings necessary to meet obligations under Te Tiriti and achieve the aims of the health and disability system reforms to advance Māori health and wellbeing.

Whakamaua sets out 46 actions to achieve the outcomes that He Korowai Oranga seeks. In 2021/22, we implemented 42 of those actions, while we will begin work on the remaining 4 in 2022/23.

## Monitoring Whakamaua

Whakamaua contains a monitoring framework that has 3 interrelated components:

1. monitoring the delivery of actions
2. reporting on a set of quantitative indicators
3. commissioning an independent evaluation into the overall delivery of the plan.

The insights gained from this monitoring will create an important feedback loop that will be used to identify and address any problems that occur in implementing Whakamaua, and to make changes and improvements as required.

At the end of 2021, the Ministry published an interactive web tool showing a statistical overview of the 13 initial quantitative measures for Whakamaua. The dashboard can be accessed online.<sup>6</sup>

## Addressing racism in the health and disability system – Ao Mai te Rā

Ao Mai te Rā: the Anti-Racism Kaupapa is an action-oriented initiative to support the way the health sector understands, reacts and responds to and addresses racism in all its forms. Ao Mai Te Rā consists of 2 phases that we will implement over the lifespan of Whakamaua: Māori Health Action Plan 2020–2025.

6 Please visit the Whakamaua Dashboard at [minhealthnz.shinyapps.io/whakamaua-monitoring-year-one](https://minhealthnz.shinyapps.io/whakamaua-monitoring-year-one).

Phase one, the discovery phase, began in April 2021. As part of this, we released several outputs that provide the health system with guidance and initial tools for change. These include:

1. a social and digital anti-racism communications campaign specifically for the health system context
2. a position statement, associated literature review and set of working definitions for racism and anti-racism in the health system
3. an anti-racism maturity model (or road map of action) that identifies the key levers for change
4. a series of case studies on good or best-practice anti-racism action already under way in the system.

## Hui Whakaoranga 2021 summary report

Early in 2022, we published the Hui Whakaoranga 2021 summary report.<sup>7</sup> It provides a high-level summary of the key themes and insights from kōrero captured across the hui.

Hui Whakaoranga recognises our kaitiakitanga | stewardship role and serves as a platform for giving practical effect to Te Tiriti – a key action in Whakamaua: Māori Health Action Plan 2020–2025. Hui Whakaoranga 2021 began the process of building effective Tiriti-based partnerships between health sector leaders and their networks at both national and regional levels. These partnerships provide the basis for creating change across a generation.

In 2021 there were 4 regional hui across the motu | country and one national virtual hui. Participants included representatives

from iwi, hapū and hapori Māori, and organisations from across the Māori health and disability sector, including Iwi-Māori Partnership Boards, district health boards (DHBs), Māori health providers, and Māori health workforce and government agencies.

## Ngā take Tiriti: Wai 2575

Our position statement on Te Tiriti o Waitangi, developed in 2020/21, outlined the updated expression of the Crown's Te Tiriti obligations in the context of the health and disability system. In doing so, it adopts the principles of Te Tiriti that the Waitangi Tribunal set out in its Hauora Report (on stage one of the Wai 2575 inquiry).<sup>8</sup>

## Wai 2575: Hauora

Among Māori-Crown Partnerships actions, an explicit priority is to lead and respond to the recommendations of the Hauora Report and to continue to support subsequent stages of the Wai 2575 Health Services and Outcomes Kaupapa Inquiry.

In the past year, we saw considerable progress in actioning the Hauora Report recommendations. Examples include:

- establishing Te Aka Whai Ora
- strengthening the Treaty and Māori health equity provisions in health legislation (Pae Ora | Healthy Futures Act 2022)
- redesigning partnership arrangements, including establishment of Iwi-Māori Partnership Boards.

## Wai 2575: Haumarū

In December 2021, the Waitangi Tribunal held a priority hearing to inquire into the Crown's response to the COVID-19 pandemic, which resulted in the Haumarū

7 Ministry of Health. 2022. *Hui Whakaoranga 2021: Summary report*. Wellington: Ministry of Health. Available at: [health.govt.nz/publication/hui-whakaoranga-2021-summary-report](https://health.govt.nz/publication/hui-whakaoranga-2021-summary-report).

8 Waitangi Tribunal. 2019. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. Wellington: Waitangi Tribunal.

Report.<sup>9</sup> The Ministry has programmes of work to address the findings and recommendations in the Haumarū Report.

In several instances, the recommendations relate to significant longer-term work already under way across government, such as work to:

- improve the monitoring of Māori health outcomes, including by Te Aka Whai Ora | Māori Health Authority
- strengthen the collection and use of health-related ethnicity and disability data
- strengthen our data-sharing capability and capacity.

### Kaupapa inquiries

Manatū Hauora, through our Māori–Crown Relations team, engaged with other Crown agencies who have other active kaupapa inquiries. Those agencies include the Ministry of Housing and Urban Development, Ministry for Women, Ministry of Justice and Te Arawhiti.

Manatū Hauora is one of the Crown parties included in Ngāi Tūhoe: He Tapuae: Service Management Plan 2020 to 2025. The Ministry’s commitments to Ngāi Tūhoe include the commitment to reset and then restore the relationship between the Ministry and Ngāi Tūhoe.

### Developing data handling protocols to collect iwi affiliation and Māori descent data (Tātai)

We began collecting Māori descent and iwi affiliation data through the purpose-built, online portal, Tātai.<sup>10</sup>

The COVID-19 pandemic presented an opportunity for the Ministry to initiate this data set collection due to our extensive engagement with Māori during the vaccination roll-out. We delivered the project in partnership with Māori data experts from Te Kāhui Raraunga, on behalf of the Data Iwi Leaders Group, and with advice from Te Puni Kōkiri, the Ministry of Education and Stats NZ.

As well as the online portal, the project developed protocols for collecting Māori descent and iwi affiliation data in the health sector.<sup>11</sup>

### Wānanga Hauora 2021 summary report

Wānanga Hauora 2021<sup>12</sup> responded to a key action in Whakamaua: Māori Health Action Plan 2020–2025 in the priority area of Māori leadership.

Wānanga Hauora 2021 consisted of 4 regional wānanga across the motu and one virtual wānanga between April and August 2021. The wānanga provided opportunities for leadership networking, professional development, and training for DHB members, Iwi–Māori Partnership Board members and Māori health organisation leaders.

### Equity by Design

The Equity by Design project is a partnership between the Ministry (as of 1 July 2022, Te Aka Whai Ora) and the Health Quality & Safety Commission. The goal is to design practical health equity and Te Tiriti solutions that will influence pro-equity and Tiriti-centred thinking, practice and behaviour across the entire health and disability system.

9 Waitangi Tribunal. 2021. *Haumarū: The COVID-19 priority report*. Wellington: Waitangi Tribunal.

10 For more information, please visit the Tātai portal at [tatai.maori.nz](http://tatai.maori.nz).

11 Ministry of Health. 2022. *HISO 10094:2022 Māori Descent and Iwi Affiliation Data Protocols*. Wellington: Ministry of Health. Available at: [health.govt.nz/publication/hiso-100942022-maori-descent-and-iwi-affiliation-data-protocols](http://health.govt.nz/publication/hiso-100942022-maori-descent-and-iwi-affiliation-data-protocols).

12 Ministry of Health. 2021. *Wānanga Hauora 2021: Summary report*. Wellington: Ministry of Health. Available at: [health.govt.nz/publication/wananga-hauora-2021-summary-report](http://health.govt.nz/publication/wananga-hauora-2021-summary-report).

Phase one (discovery) of the project engaged over 100 people who work across a diverse range of areas in the health system through system wānanga and empathy interviews. When completed this phase will have produced the following discovery artefacts:

- the findings from the Health Equity Assessment Tool (HEAT) review
- a comprehensive stocktake of existing equity and Tiriti tools
- animated user personas to present the various levels of equity and Tiriti maturity in the system
- 6 horizon scans to identify future opportunities.

## Establishing fair regional governing boards that represent all New Zealanders and work collectively toward pae ora

January 2022 saw the establishment of 4 governance groups representing the Northern, Te Manawa Taki (Midland), Central and Southern regions. Their purpose has been to support the growing need for regional solutions to the pandemic response, support a regional approach to ministerial priorities, and maintain the focus on the performance of DHBs at first and then of the new health system structures from 1 July 2022.

These groups provided an additional level of oversight and governance to the pandemic response. The DHB chairs worked collectively to guide regional implementation activity for the response, and to develop regional ways of working.

## Health sector negotiations for pay equity

Four major pay equity claims, covering an estimated 85% of the DHB employed workforce, continued to be progressed

during the year:

- administration and clerical workforce
- nursing workforce
- midwifery workforce
- allied public health, scientific and technical workforce.

### Administration and clerical pay equity settlement

On 16 May 2022, the majority (97%) of union members voted in favour of ratifying the settlement agreement for administration and clerical pay equity.

On 7 June 2022, the parties met to sign the settlement agreement, concluding the pay equity claim process. The administration and clerical claim is the first pay equity claim to settle under the amended Equal Pay Act 1972.

### Nursing pay equity claim

In late December 2021, the parties to the nursing pay equity claim reached an agreement in principle to settle the claim. In April 2022, the union parties to the claim released details of the proposed settlement to members and workers covered by the claim.

Union members then voted in favour of seeking a determination from the Employment Relations Authority on the proposed offer of settlement. Their specific focus was the offer to backdate the pay equity rates to 31 December 2019 (after deduction of any early payments or further base salary adjustments).

### Midwifery pay equity

The midwifery claim reached the bargaining stage of the pay equity claim process during the year. Progress with discussions slowed as the union parties to this claim were waiting for the outcomes of the Employment Relations Authority proceedings on the nursing pay equity

claim. The parties were continuing their discussions and were committed to progressing the negotiations in any way possible.

### Allied public health, scientific and technical workforce pay equity claim

This agreement of the allied public health, scientific and technical workforce was at the early work assessment stage during the year. The parties estimated that the work and remuneration assessment would be completed by the end of the 2022 calendar year.

The claim had not yet established that the workforce it covered had been undervalued historically based on the sex of the workers. The parties had agreed to use their best efforts to develop a Memorandum of Understanding that established a work programme and timeline to conclude the pay equity claim by 29 April 2023.

### Improving community water fluoridation coverage

Community water fluoridation is a safe, effective and affordable public health measure to improve oral health. While it benefits everyone, the benefits are greatest for Māori, Pacific peoples and those living in deprived communities. A 2016 report found that children and adolescents living in areas with fluoridated drinking-water have a 40% lower incidence of tooth decay across their lifetime.<sup>13</sup>

In 2021/22 Manatū Hauora supported the enactment of the Health (Fluoridation of Drinking Water) Amendment Bill 2021, which became Part 5A of the Health Act 1956. The new arrangements, which

came into force in December 2021, gave the Director-General of Health the power to issue directions to local authorities to fluoridate their drinking water supplies.

### Offering free toothbrushes and fluoride toothpaste to preschoolers and their whānau

Whānau with preschool-age children were able to receive free packs of toothbrushes and fluoride toothpaste through Manatū Hauora's child oral health promotion initiative. We made this offer because we recognise that the costs of toothpaste and toothbrushes can be a barrier to good oral health self-care.

### Launching a world-leading Smokefree Action Plan

Associate Minister of Health, Hon Dr Ayesha Verrall launched the Smokefree Aotearoa 2025 Action Plan<sup>14</sup> on 9 December 2021.

The plan set out a bold goal to achieve a Smokefree Aotearoa for all New Zealanders – fewer than 5% of New Zealanders across all population groups smoking daily.

The plan set out 28 actions under 6 focus areas. These actions called for more smoking cessation services, ongoing health promotion and changes to legislation.

In June 2021, the Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Bill was introduced to the House. Its purpose was to:

- significantly reduce the availability of tobacco in retail outlets
- prevent young people now and in the following generations from ever taking

13 Please visit [health.govt.nz/publication/review-benefits-and-costs-water-fluoridation-new-zealand](https://health.govt.nz/publication/review-benefits-and-costs-water-fluoridation-new-zealand) to access the report.

14 Ministry of Health. 2021. *Smokefree Aotearoa 2025 Action Plan – Auahi Kore Aotearoa Mahere Rautaki 2025*. Wellington: Ministry of Health. Available at: [health.govt.nz/publication/smokefree-aotearoa-2025-action-plan-auahi-kore-aotearoa-mahere-rautaki-2025](https://health.govt.nz/publication/smokefree-aotearoa-2025-action-plan-auahi-kore-aotearoa-mahere-rautaki-2025).

up smoking

- reduce the appeal and addictiveness of smoked tobacco products, beginning by reducing nicotine levels.

## Rapidly scaling up the National Immunisation Programme

The main objective of the National Immunisation Programme was to safely deliver a new vaccine, leading to a high-quality vaccination experience for all participants.

To meet this objective, the programme needed to provide new and ongoing guidance to all DHBs and vaccinating providers. The programme's overarching approach was to build provider capability to prevent and detect vaccine and operational process errors to reduce the risk of consumer harm.

The programme maintained a suite of operational, clinical and quality documents and processes. These included COVID-19 vaccine service standards, operating guidelines, operational policy statements, planning guides, an incident management process, incident response toolkits, and incident and detecting failsafe reporting to increase consumer safety.

In 2021/22, we progressed the National Immunisation Programme in several important ways:

### Influenza

Efforts were targeted at rolling out an influenza campaign with widened eligibility to free vaccinations to include Māori and Pacific people aged 55 and over in particular.

### Measles

In response to the 2019 measles outbreak and as part of broader actions to strengthen the immunisation system, the National Measles Immunisation Catch Up

Campaign was launched in July 2020 to address the immunity gap among those born between 1989 and 2004.

The campaign was effectively paused in March 2021 to allow district health boards to reallocate resources to their COVID-19 vaccination programmes, but restarted in December 2021.

## The Medicinal Cannabis Scheme

The purpose of the Medicinal Cannabis Scheme is to improve access to high-quality medicinal cannabis products for patients.

Medicinal cannabis products are only available to patients on prescription from a doctor. They must be verified as meeting the medicinal cannabis quality standards before they can be supplied.

The Misuse of Drugs (Medicinal Cannabis) Regulations 2019 allowed for a transitional period when medicinal cannabis products supplied before 1 April 2020 could continue to be supplied without meeting the quality standards.

The transitional period was extended twice to allow companies more time to submit applications for assessment of their products. The transitional period ended 30 September 2021, and as of 30 June 2022, a total of 18 medicinal cannabis products have been verified as meeting the minimum quality standard of which 5 are cannabidiol (CBD) products.

## Access and Choice: Investing in kaupapa Māori, Pacific, youth and Rainbow services

### Expanding primary mental health and addiction services

The Budget 2019 initiative 'Expanding access to and choice of primary mental

health and addiction support' (Access and Choice) has given people access to primary mental health and addiction support services when and where they need it. These services have no eligibility criteria and are open to anyone whose thoughts, feelings or behaviours are affecting their mental wellbeing.

We continued to roll out services across the motu in general practices as well as kaupapa Māori, Pacific and youth-specific settings.

### Integrated primary mental health and addiction services

As of 31 May 2022, 356 general practice sites across Aotearoa were offering mental health and addiction services as an integrated part of general practice teams. These services have delivered more than 350,000 sessions to date, including over 24,000 sessions in May 2022 alone.

### Kaupapa Māori, Pacific and youth services

We introduced a range of new primary mental health and addiction services for people throughout Aotearoa.

As of 31 May 2022, Aotearoa had:

- 27 kaupapa Māori services that are 'by Māori for Māori' – which we chose using an innovative, award-winning procurement process
- 9 Pacific-specific services in areas with high Pacific populations
- 21 youth-specific services in youth friendly places such as schools and youth one-stop-shops.

Together, these 3 streams have delivered more than 82,500 sessions to date.

## National Telehealth Service – Māori Whānau Virtual Support Network

Prioritising equity was the driving force in the Healthline COVID-19 response to the needs of Māori, Pacific and disability communities.

The development of the healthline Māori Whānau Virtual Support Network followed the co-design of a Pacific approach that identified the need for a more targeted, community-led way to engage with Pacific and other vulnerable communities.

The agencies that ran Māori partner call centres were Te Hau Ora o Ngāpuhi (Kaikohe), Ngāti Whātua (Auckland), Te Arawa Lakes (Rotorua) and Te Taiwhenua o Heretaunga (Hawke's Bay). Māori advisors at the National Telehealth Service provided support.

COVID-19 Pacific and disability pathways were also operational. The Pacific pathway provided ongoing support through the Pacific National Telehealth Service advisor network.

## Child Development Services

Child Development Services (CDS) is an early intervention service, run by allied health professionals for tamariki and pēpē | babies, that is multidisciplinary and community-based.

During the year, CDS supported tamariki and whānau when tamariki face additional challenges to achieve expected milestones and/or had an impairment. The Government allocated an additional \$35 million over 4 years for the CDS Improvement Programme in Budget 2019. The purpose of this funding was to:

- improve health and social outcomes for children who are not meeting developmental milestones

- modernise the CDS model to improve equity of access and align with Enabling Good Lives principles.

During 2021/22, the programme met the target of seeing an additional 1,150 children per year and maintained an increased resource of 77 allied health staff across Aotearoa. The programme also developed a draft service model for the future, which it will further test, develop and implement during 2022/23.

## Launching the National Hepatitis C Action Plan

We developed the National Hepatitis C Action Plan for Aotearoa New Zealand – Māhere Mahi mō te Ate Kakā C 2020–2030.<sup>15</sup>

On 28 July 2021, World Hepatitis Day, Associate Health Minister, Hon Dr Ayesha Verrall launched the Action Plan in Hamilton. The plan responded to the World Health Organization’s call to eliminate hepatitis C by 2030.

An estimated 45,000 New Zealanders are living with hepatitis C infection. The plan aims to improve equitable health outcomes for all New Zealanders living with hepatitis C and to advance the health aspirations of Māori, consistent with Te Tiriti o Waitangi obligations.

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<sup>15</sup> Ministry of Health. 2021. *National Hepatitis C Action Plan for Aotearoa New Zealand – Māhere Mahi mō te Ate Kakā C 2020–2030*. Wellington: Ministry of Health. Available at: [health.govt.nz/system/files/documents/publications/hp7622\\_-\\_hep\\_c\\_action\\_plan\\_v11\\_web.pdf](https://health.govt.nz/system/files/documents/publications/hp7622_-_hep_c_action_plan_v11_web.pdf).

## 2. Making New Zealand's health and disability systems and services safe and sustainable

We preserve trust in the system by assuring the quality, safety and coverage of health and disability services.

To meet current and future needs of the health and disability system, we prioritise health and disability services, clinical and financial sustainability, quality and safety. We are also adopting a long-term view that futureproofs our infrastructure, assets and facilities.

### Ngā Paerewa Health and Disability Services Standard

On 28 February 2022, Ngā Paerewa Health and Disability Services Standard came into effect. Health services certified under the Health and Disability Services (Safety) Act 2001 must comply with Ngā Paerewa.

Ngā Paerewa replaced the Health and Disability Services Standards NZS 8134:2008, the Fertility Services Standard NZS 8181:2007, the Home and Community Support Sector Standard NZS 8158:2012, and the Interim Standards for Abortion Services in New Zealand.

Ngā Paerewa has a strong focus on Te Tiriti o Waitangi and service providers' additional responsibilities to be responsive to the needs of Māori. Ngā Paerewa is outcome-focused, which gives service providers flexibility in how they demonstrate they are achieving the requirements within the context of their service.

### Redesigning the Well Child / Tamariki Ora Programme

We completed phase one of the Well Child / Tamariki Ora redesign in 2021/22.

Phase one strengthened current service

delivery while building the foundations for implementing the recommendations of the Well Child / Tamariki Ora review.

The next step is to review and analyse the findings of phase one with the aim of evolving it into phase two of the redesign. We also need to understand how this work integrates with the direction of the New Zealand Health Plan in the maternity and early years programme, Kahu Taurima.

### Developing a long-term pathway for mental health and addiction

In September 2021, we published *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. This set out the Government's 10-year strategy and action plan for improving mental wellbeing for all, while addressing inequities for specific population groups.

The approach built on the important findings of the 2018 report *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* – and the Government's response to that report. This response included substantial investment in mental health and wellbeing through Budget 2019.

To achieve *Kia Manawanui's* vision of 'Pae ora: An equitable and thriving Aotearoa in which mental wellbeing is promoted and protected', we need collective efforts to address 5 focus areas:

1. building the social, cultural, environmental and economic foundations for mental wellbeing
2. equipping communities, whānau and individuals to look after their own mental wellbeing

3. fostering community-led solutions support in communities
4. expanding primary mental wellbeing
5. strengthening specialist services.

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## Case study: Strengthening the mental health and addiction workforce

As part of the Ministry work to transform the mental health and addiction system, a significant work programme got underway to support the development of a strong, diverse, and sustainable workforce. The mahi in this area focused on both growing and upskilling the existing workforce, as well as developing new workforces.

This work included expanding education and training programmes across a number of professions and competencies, increasing support for Māori and Pacific students, and supporting a broad range of workforces to contribute to mental wellbeing.

As part of diversifying the workforce mix, we established a new opt-in accreditation pathway so that New Zealand Association of Counsellors members who meet specific requirements can be employed as clinical staff in Ministry-funded mental health and addiction services. Counsellors are a self-regulated workforce, which previously precluded this.

The new accreditation pathway provides an important boost to the mental health and addiction workforce, while also ensuring those supporting people with mental health and addiction needs are qualified, practice safely and have appropriate oversight.

We also focused on encouraging more people to work in the mental health and addiction sector. The mental health and addiction nursing recruitment campaign launched in March 2022 is an example of one of these recruitment initiatives.

The 'Are You Ready' campaign aimed to encourage nursing graduates to choose mental health and addiction as a preferred practice area and as a professional career, attract former nurses back into the profession, and increase the number of Māori and Pacific peoples working in this area.

Budget 2019 funded a range of mental health and addiction health workforce initiatives which took place during the year. Examples include:

- 122.5 additional 'new entry to specialist practice' places each year for nurses, social workers and occupational therapists to enter the mental health and addiction workforce, bringing the total funded places to 314.5
- 16 additional clinical psychology internships each year, bringing the total funded placements to 28 and increased funding for interns to 100% of the Multi-Employer Collective Agreement rate

- 365 new training places for postgraduate study each year in specialist practice areas such as cognitive behaviour therapy for children and adolescents, talking therapies, brief interventions and youth addiction
- 70 new bursaries for Māori students pursuing a career in the sector, bringing the total funded to 150
- 65 new scholarships for Pacific mental health and addiction students, bringing the total funded to 125
- over 800 additional places per annum made available on cultural competency programmes to ensure mental health and addiction services better meet the needs of diverse New Zealanders.

## Working towards repealing and replacing the Mental Health Act

We made significant progress in our work to repeal the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) and to replace it with modern, fit-for-purpose legislation that reflects an approach based on human rights. This phased work programme began in 2019 and forms part of the Government response to *He Ara Oranga*.

### Initial amendments to the Mental Health Act

Alongside new guidelines released in September 2020 to improve the application of the Mental Health Act, the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021 (the Amendment Act) was passed in October 2021. The Amendment Act updated the Mental Health Act to improve the protection of individual rights and safety of patients, including by eliminating indefinite treatment orders, while work to fully replace the Act is under way.

### Full repeal and replacement of the Mental Health Act

Following the Amendment Act, focus turned to the full repeal and replacement of the Mental Health Act. From October 2021 to January 2022, we undertook public

consultation on a discussion document, *Transforming Our Mental Health Law*, which asked the public what new mental health legislation should look like. From this we received over 300 written submissions and gathered feedback from more than 500 people who attended over 60 online information sessions and consultation hui.

We received feedback from a range of perspectives: tāngata whaiora | service users and their whānau, Māori, Pacific, Asian and ethnic communities, the mental health sector including non-governmental organisations and clinicians, and the general public. The findings from public consultation will help guide the development of policy proposals for new legislation.

## Ongoing work to improve the health and disability system's infrastructure

Until 30 June 2022, before the formal launch of Te Whatu Ora, the 20 DHBs and Manatū Hauora were responsible for investment in health infrastructure.

The Ministry's Health Infrastructure Unit had oversight of more than 130 health infrastructure projects in various stages of implementation.

In addition, the Ministry itself led some major infrastructure programmes, including the Mental Health Infrastructure

Programme, the Regional Hospital Redevelopment Programme and the new Dunedin Hospital build.

### The Mental Health Infrastructure Programme

The Mental Health Infrastructure Programme actively supported DHBs to improve their mental health infrastructure. The programme comprised 16 projects, with our Health Infrastructure Unit leading one of these.

Five mental health facilities achieved investment approval in 2021/22 (in MidCentral, Lakes, Waitematā, Waikato and Tairāwhiti DHBs), while the others are scheduled to be approved by December 2023. The projects that the programme oversees have a combined value of more than \$300 million.

### The Regional Hospital Redevelopment Programme

The Regional Hospital Redevelopment Programme was established to support the early planning work for the redevelopment of the Nelson and Whangārei Hospitals. Both districts had nearly completed this planning and were expected to have approved business cases in the second half of 2022.

Further hospital sites in Tauranga, Hawke's Bay and Palmerston North have since been added to the programme. Early planning work to identify what these sites require has now begun.

### The new Dunedin Hospital build

The new hospital in Dunedin is the largest health infrastructure project being undertaken in Aotearoa.

The new hospital will be accredited 5-Star Green Star. It will provide 421 beds, more than 16 theatres and 30 intensive care or high-dependency beds.

During 2021/22 the project advanced significantly. Site clearance was

completed ahead of schedule and piling works for the outpatients facility began in June 2022. Work on the inpatients facility advanced, with developed design work under way.

We expect the regional economy will receive an estimated \$429 million boost to its gross domestic product and employ thousands of construction workers over the lifetime of the project, which is due for completion in 2028.

### Healthy Homes Initiative

The Healthy Homes Initiative (HHI) aims to increase the number of children and their whānau who live in warm, dry and healthy homes and in this way to enhance their health and wellbeing.

HHI providers are a referral and navigation service that support whānau by coordinating interventions to make homes warmer, drier and healthier.

Budget 2021 included funding of \$30 million over 4 years to expand the reach and impact of the HHI. Currently HHI providers are in 11 North Island regions.

### DHB Intensive Support Programme

In 2021/22, 7 DHBs participated in the Ministry's Intensive Support Programme. This programme addresses DHB performance and financial sustainability by providing targeted support to optimise available resources, develop efficient and effective models of care, focus on financial management and build system capability.

COVID-19 created unique pressures on DHBs, delaying services and some planned improvements. During 2021/22, we worked with Te Whatu Ora | Health New Zealand to highlight ongoing issues, risks and opportunities that Te Whatu Ora | Health New Zealand should continue to closely support.

### 3. Creating an integrated, collaborative and innovative health and disability system

We build the connections needed to provide an integrated, collaborative and innovative health and disability system.

To do this, we foster effective relationships, advance collaborative ways of working and enable secure, timely, joined-up information to flow through the system.

#### Hira – connecting health information

Hira is a programme that will connect health and wellbeing information and enable this information to be delivered to all New Zealanders where and when they need it. Cabinet endorsed the overarching programme business case for Hira in April 2021. It has since approved the detailed business case for the first tranche of Hira and approved investment of up to \$170 million over 3 years.

In te reo Māori, hira means ‘to have significant bearing on future events; a widespread effect’. This reflects the Hira programme’s role in laying the foundations for a digitally enabled health and disability system that is people-centred, accessible, joined-up and responsive. Hira will transform the way people access, use and share health information.

Over time, Hira will enable people to update some of their health information themselves and choose who they want to share it with. With permission, they will be able to see and help manage whānau health information. Through Hira, people will be able to pull information from different systems to create a single view – a bit like online banking. At the same time, privacy and security are paramount concerns in this programme.

#### Digital Enablement Programme

The Ministry’s Digital Enablement Programme supports new and innovative ways for people to access health care through digital means.

A number of primary and community care providers received support from the programme to help them improve people’s access to general practice and other community health services.

The programme supported providers to test ways that primary and community health care services can be accessed digitally – without people having to leave home or their hometown.

#### Digital tools to assess and inform people, enabling self-management

Using the digital tools we developed, health professionals could quickly triage and assess COVID-19 positive people and whānau. As a result, more people could self-manage their condition, while care and support could focus on those at higher risk of developing COVID-19 complications.

#### Keeping our equipment, systems and data secure and accessible

As we are encouraging digital innovation in the health and disability sector, people across the sector are sharing ever more data. At the same time, the number of cyber-attacks on critical national infrastructure is growing.

In December 2021, we received approval to stand up the National Cyber Security Uplift Programme. Its aims are to improve

our ability to protect our health systems (and the data they contain) against cyber threats and to better enable a rapid response to cybersecurity events when they occur.

The programme has already increased the number of cybersecurity specialists across the health sector, including in primary care, and has implemented tools that protect against cyber-attacks.

## Reporting on national-level analytics

We published a wide range of national-level data sets on our website, including 22 Tier 1 statistics .

At the end of 2021/22, National Collections and Reporting had 14 web tools and another 4 in development.

## Strengthening our nursing workforce

In 2021/22, we supported many initiatives to strengthen our nursing workforce across Aotearoa.

- We invested a total of \$26.7 million over 4 years in the professional development and support for nurses undertaking postgraduate training and graduate nurses entering the workforce in the supported New Entry to Practice programme.
- We funded all 534 applicants for the Voluntary Bonding Scheme's 415 places, making it the biggest intake in more than a decade. Registrations included 70 Māori nurses and 49 Pacific nurses, the highest number in the history of the scheme. A record 179 registrations came from nurses working in mental health and addiction services.
- We allocated funding to support nurses not currently practising to return to the nursing workforce.

- We invested in and supported the development of 2 campaigns – one for general nursing and the other for mental health and addiction nursing.
- Drawing on \$3.325 million allocated to critical care nursing workforce initiatives, we implemented a suite of initiatives to support critical care units to attract, develop and retain critical care nurses.

## Leading the cross-agency work to transform the mental health system

The Government has committed to a whole-of-government approach to improving New Zealanders' mental wellbeing, and Manatū Hauora plays a key leadership role in this.

Many interwoven social, cultural, environmental and economic factors influence the mental wellbeing of individuals and whānau. A joined-up approach across agencies is important to build robust support systems.

The response to COVID-19 demonstrated how government agencies can work successfully together and with communities to support wellbeing.

## Health Sector Agreements and Payments Programme

The Health Sector Agreements and Payments (HSAAP) Programme will progressively replace the legacy systems the Ministry has used to manage agreements and distribute payments on behalf of the Crown.

The new system will provide the flexibility to respond to the changing needs of New Zealanders, the sector and the health and disability system reforms.

The Ministry was responsible for managing agreements between funders and providers of health and disability

community-based care, processing approximately 120 million transactions and distributing over \$12 billion each year in payments for services provided under these agreements.

The HSAAP Programme supports the system reforms by addressing equity issues and improving the availability of agreements and payments data to health system users (including policy and decision-makers). It also removes the growing risk that the current legacy systems will fail.

## Acute care and demand

The Ministry and DHBs collaborated over 2021 and developed an acute care work programme with contribution from DHBs, the ambulance sector, aged care and primary care. The Ministry strengthened its strategic role in guiding the system in its response to acute demand.

The programme has had good engagement from the health sector.

Over the last year, the programme:

- provided support for individual DHBs that had identified issues in acute flow
- shared lessons learned and effective processes across DHBs
- provided national support by developing resources in targeted areas aligned to data and insights
- supported pilot DHB-run programmes that allow change programmes to be developed and rolled out nationally over time (eg, on weekend discharge)
- provided more up-to-date data on emergency department waiting times through weekly reporting of key metrics from emergency departments
- established an acute care advisory group to identify workstreams to support improved acute and wider system flow.

## 4. Providing support and advice focused on the person's needs, for all people in New Zealand

We work collectively with people and communities to make smart, informed and transparent decisions about the design and delivery of services.

We harness the lived experience and expertise in the wider system to improve outcomes and quality of life. This year, we have taken the following actions to make health and disability services safe, sustainable and people-centred.

### Surveying the health of New Zealanders

Each year, the New Zealand Health Survey provides timely, reliable and relevant health information about people's health and wellbeing that cannot be collected as efficiently from other sources. The survey gathers information on population health, health risks and protective factors.

The 2020/21 results were based on data collected between September 2020 and August 2021. They provided some insights into the impact of the COVID-19 pandemic on the health of New Zealanders.

The survey showed that while most Kiwis were in good health, psychological distress had increased since the year before: nearly one in 10 adults reported experiencing it.

Notably, daily smoking rates continued to fall, down to 9.4% from 11.9% the year before, while e-cigarette use had increased. Māori (22.3%) and Pacific (16.4%) adults reported higher smoking rates than other ethnic groups.

The survey also highlighted that obesity had increased since the year before for both adults and children. About 1.5 million New Zealanders were obese in 2020/21.

We use the Health Survey results to inform our initiatives and work programmes to improve the health of New Zealanders in areas such as smoking, hazardous drinking, obesity, mental health and addiction, access to health care, oral health, Māori health, Pacific health and Rainbow community health. The 2021/22 Health Survey results will be published in November 2022.

### Social licence survey on how we should use people's health data

We understand that the health data we hold belongs to New Zealanders. We have a responsibility to provide effective and appropriate kaitiakitanga over that data.

In late 2021, the Ministry commissioned a survey of the public of Aotearoa to understand their views about how we should use their health data. The insights from this mahi will help us to use health data appropriately as we enhance evidence-based decision-making across the health and disability sector.

A total of 2,572 people who had previously responded to the New Zealand Health Survey participated in the online survey. The survey provided clear evidence that a significant majority of New Zealanders are comfortable with us reusing their health data, provided that we meet certain conditions.

### Establishing the Aged Care Commissioner

As part of Budget 2021, the Government announced funding to establish the Aged Care Commissioner. It created the role to provide greater strategic oversight and leadership, monitor system

performance and advocate on behalf of older consumers and their whānau for better health and disability services. The Aged Care Commissioner contributes to providing older people with access to high-quality care. The role is situated as a Deputy Commissioner reporting to the Health and Disability Commissioner.

The inaugural Aged Care Commissioner began in the role in March 2022.

## Assisted dying – end of life choice

The End of Life Choice Act 2019 (the Act) came into force on 7 November 2021. This Act gave eligible people access to the Assisted Dying Service in Aotearoa. The Ministry led the planning of the implementation of the Act during the year up to 7 November.

In the period 7 November 2021 to 31 March 2022, the Assisted Dying Service received 206 applications to access assisted dying. The annual report to the Minister from the Registrar (assisted dying) provides more detail on the statistics for the Service.

As the service is new to Aotearoa, demand for it is difficult to estimate until it has operated for a longer period. We will continue to provide advice and support to applicants and their whānau through the assisted dying clinical pathway.

## Abortion law reform and services

In 2021/22 the Ministry continued its work programme on equitable, accessible, person-centred and high-quality abortion care. This mahi has focused on improving access to primary care provision of early medical abortion (EMA), which includes supporting health practitioners in primary care to deliver a high-quality service.

We also published the Abortion Services Annual Report in October 2021.

The report outlines access, equity of provision and the focus for the year ahead. The data has shown that while the legislative change has enabled earlier access to abortion, work remains to be done to make services equitable, including in terms of their accessibility closer to home.

The development of the Standard for Abortion Counselling in Aotearoa New Zealand started in March 2022. This standard sets the expectation of counselling and ensures that people receive unbiased and skilled abortion counselling, if they ask for it.

## Cochlear implants offering a sense of sound

Cochlear implants are surgically implanted electronic devices that give a person who is severely hard of hearing or profoundly deaf a sense of sound. This innovation significantly improves people's quality of life.

The Government allocated a further \$7.08 million a year, ongoing from 1 July 2021, to increase the number of publicly funded cochlear implants from 86 to 166 per year.

This funding amounts to an additional \$28.32 million over 4 years. As a result, more people waiting for the services have already been able to receive their implant. The waiting list has reduced from 200 to 151 people between 1 July 2021 and 30 June 2022, even though referrals to the service increased at the same time.

## Air and road ambulance services

During the year, the National Ambulance Sector Office (NASO) worked closely with road and air ambulance providers to address the demands of COVID-19.

NASO also focused on securing new road ambulance agreements with both Wellington Free Ambulance and St John.

These agreements reflect the approach that commissioners are adopting more widely as a result of direction from funding agencies.

## Rolling out of the National Bowel Screening Programme

The National Bowel Screening Programme provides free screening to around 835,000 New Zealanders aged 60 to 74 years.

Its aim is to detect bowel cancer at an early, more treatable stage. The national roll-out of this newest cancer screening programme (and the first one to include men) started in July 2017, after more than a decade of preparation and planning. This year was the last in the 5-year implementation journey, making the programme now accessible across the motu.

From July 2017 to the end of June 2022, the programme sent out over one million test kits, identified 1,422 cancers and removed thousands of pre-cancerous polyps.

## Developing a platform for community suicide prevention initiatives

In November 2021, the Suicide Prevention Office launched He Kāpehu Whetū, an online portal of community-based stories and links to suicide prevention initiatives.<sup>16</sup>

The stories are aligned to the strategic intent of the Suicide Prevention Office. They are designed to inspire leaders and communities across Aotearoa who want to address the needs of their local community and take action to develop their own initiatives.

Alongside stories of local suicide prevention initiatives, the website provides a hub for resources including support lines, media guidelines for suicide reporting, and

<sup>16</sup> To access the portal, please visit [hekapehuwhetu.govt.nz](https://hekapehuwhetu.govt.nz).

suicide prevention resources.

## We expanded the Te Ara Oranga methamphetamine harm reduction programme

The Ministry established Te Ara Oranga Methamphetamine Harm Reduction Programme in 2017 as an integrated cross-agency programme targeted at reducing methamphetamine harm. It began in Northland, where the local DHB, New Zealand Police and community agencies led its development and piloting.

The programme works to reduce drug-related harm and support better community health, social and justice outcomes, including improved wellbeing, re-engagement with whānau and employment, and a reduction in family violence and crime. People who use methamphetamine are given the opportunity to receive therapeutic help that takes a culturally appropriate approach and is tailored for people in the local community.

In December 2021, an independent evaluation of Te Ara Oranga concluded that its model of care has been successful in helping those who struggle with methamphetamine-related harm. It also has had positive flow-on effects for whānau and the wider community, with over 3,000 people and whānau supported to date in Northland.

## Working collaboratively to progress the Homelessness Action Plan

The Aotearoa New Zealand Homelessness Action Plan is a comprehensive central government-led cross-agency plan that aims to prevent and reduce homelessness.

Actions centre on transitioning a minimum of 100 people who are homeless (or at risk of becoming homeless) and in mental

health inpatient units into the community over 4 years.

The fourth action, Rapua Te Āhuru Mōwai – Mental Health and Addictions Homelessness Transitions Pilot, is under way. This will address the current urgent

issue of people remaining in inpatient units (despite no longer clinically requiring that level of service) because they have no suitable accommodation to be discharged to.



# How we manage our business | Tā mātou whakahaere i a mātou



# Making the Ministry a great place to work

## Kia rangatira te Manatū hei wāhi mahi

It is an exciting time for the Ministry and health and disability system with the establishment of new health agencies.

For our people in Manatū Hauora, we will be working together to review and shift our operating model, develop our workforce capability and streamline how we work together across different functions to achieve the best outcomes.

We have worked to implement the health and disability reforms, including the establishment of new health agencies, Te Whatu Ora | Health New Zealand, Te Aka Whai Ora | Māori Health Authority and Whaikaha | Ministry of Disabled People.

Our mahi | work and how we collaborate with these agencies will be crucial in achieving an equitable health system that is truly fit for future generations.

We will continue to build on the great mahi from last year to provide a diverse range of opportunities for our people and maintain a people-centric approach in all we do, ensuring Manatū Hauora remains a great place to work.

### Embedding our values

Our people demonstrate Ngā Uaratanga | Our Ministry Values across the Ministry. This is evident, for example, when they acknowledge each other's contribution to the values through the annual Ministry Leadership Awards.

To make Ngā Uaratanga visible and emphasise their importance to our people, we have now firmly embedded them in our recruitment processes, our induction programme and our performance and development systems.<sup>17</sup>

### Flexible working

We have continued to provide an environment that enables an effective balance between work requirements and personal and whānau commitments.

Our Flexible First policy plays a big part in the Ministry's culture and the way we do our mahi. It speaks to all our values and is a key enabler in making the Ministry a great place to work.

Through Flexible First, we adapted seamlessly to equip our people and support them to work flexibly during the COVID-19 Alert Level changes and throughout the response to the pandemic.

<sup>17</sup> For more information on Ngā Uaratanga, please see the first section of this report, 'Who we are and what we do'.

## Performance and remuneration framework

Guided by Ngā Uaratanga | Our Ministry Values, we have implemented a new performance and remuneration framework. Underpinning the new framework are the principles that it will be:

- **equitable**, acknowledging our people's mahi and expertise
- **transparent**, we will communicate it clearly so that all our people understand it
- **consistently applied** with confidence throughout the Ministry
- **affordable and sustainable** to support our role as kaitiaki of the health and disability system.

## Workforce strategy

To achieve pae ora | healthy futures, the Ministry needs the right people doing the right work at the right time. Turuki! Paneke! (our workforce strategy) sets out a high-level, 3-year programme of work to address vulnerabilities and capability gaps in our workforce.

During 2021/22, we have made good progress under the 3 broad domains of capability, capacity and culture. With the introduction of the health and disability system reforms from 1 July 2022, we will need to review Turuki! Paneke! so that Manatū Hauora is well positioned to perform our new role in the system.

## Accessibility Tick

The Accessibility Tick<sup>18</sup> publicly recognises the Ministry's ongoing commitment to being accessible to and inclusive of our employees and customers with disabilities.

We have continued to work collaboratively with our employee-led Disability Network and Accessibility Working Group to deliver on the actions needed to maintain our Accessibility Tick accreditation.

18 For more information, please visit [accessibilitytick.nz](https://accessibilitytick.nz).

Planning is under way to introduce disability confidence training to all managers. We are also engaging with the Disability Network to design a career development toolkit/programme for those with accessibility needs.

## Supporting our people to develop and succeed

At the Ministry, we want to support our people to continue their learning and to offer a variety of development opportunities.

We use the 70/20/10 model to consider different types of development, acknowledging that often the greatest learning comes by experiencing new tasks and challenges on the job or by learning from others.

## Internal formal learning opportunities

In 2021/22, we have supported job-specific development through a series of in-person, one-day workshops to develop capability in writing skills, peer-reviewing and proofreading. Over the past year, 259 of our staff have taken up the opportunity to attend these workshops.

For our leaders, the range of leadership development opportunities includes:

- Leading Edge, our in-house emerging leaders programme
- 360-degree assessment and leadership coaching
- the Leadership Development Centre's programmes (for all levels of leadership).

We have continued to build on our library of e-learning, such as by:

- converting our face-to-face health and safety induction to an online module
- grouping te ao Māori learning at the Ministry under one dashboard

- introducing change support
- updating our leader toolkit
- updating our Hoe Kia Rite (induction programme).

We welcome our new staff with an onboarding programme that offers a series of activities, workshops and modules to build their confidence and competence with the requirements of their new role.

Our new managers attend online manager induction sessions and can access a range of supporting information in the online leader toolkit.

We have also supported our staff to take up career development opportunities through internal and external secondments. These are great opportunities for our staff to grow and enhance their careers, increasing the breadth of their experience across the public and health sectors.

In addition, the Ministry has continued to support our people with external learning and development opportunities. Over the past year, we granted study assistance for 38 staff undertaking tertiary study. This assistance took the form of either partial reimbursement of fees when staff successfully completed their study, or paid study leave.

### Internships and graduate opportunities

We have continued to build on our Early in Career programme. In 2021/22, in our first Ministry-led internship programme, we successfully engaged 11 interns to work at the Ministry between November 2021 and February 2022.

From the programme, 5 interns have remained working with the Ministry, while the other 6 returned to their studies.

In 2021/22, we increased our engagement

with tertiary institutions, giving students opportunities to complete work experience and gain credits towards their qualification. One example was the Victoria University of Wellington's Bachelor of Health internship, which saw the Ministry engage 14 interns in 2021.

We also continued to participate in the Ethnic Communities Graduate programme. In 2021/22, 3 graduates joined the programme.

## Health, safety and wellbeing

Building and sustaining a safe place to work is core to Ngā Uaratanga | Our Ministry Values. In the past financial year, we continued to improve our proactive approach to managing our health, safety and wellbeing risks.

### The psychosocial wellbeing of our people is a key focus

We have increased our efforts in psychosocial risk management, identifying areas of work that pose higher risk of psychosocial harm and collaborating with our people to establish meaningful controls. We refreshed our risk register to reflect our understanding that psychosocial risk can arise in various contexts and each requires a tailored approach. Kia Tu Kaha: Our Wellbeing Plan (2022–2025) was approved by the Executive Leadership Team in late June and sets the direction for wellbeing initiatives under three domains:

- **Whakahaumarū | Protect:** Primary interventions that minimise risks to kaimahi and create an environment where people thrive
- **Whakamana | Empower:** Secondary interventions that give people skills and knowledge when things start to get challenging
- **Āwhina | Care:** Tertiary interventions that

show manaakitanga and aroha when our people need them most.

## We supported our people through COVID-19

We managed our risk of COVID-19 in our work environments through engaging with our workers and subject matter experts and sharing our risk assessments as the circumstances evolved. We empowered our workers with information and skills through online wellbeing workshops and regular updates during alert level changes as the country transitioned to the COVID-19 Protection Framework.

To manage capacity in our offices many of our people continued to engage in a mix of working from home and in the office. Pain and discomfort represented 69% of our incident reports in the past financial year so we have offered a \$400 working from home contribution to our fixed-term and permanent employees to purchase equipment that is ergonomically sound. In addition to this, we offered ergonomics webinars to our workers to better equip them with the tools and knowledge to prevent pain and discomfort.

## We continue to engage with our people

Recognising that worker engagement is key to a safety culture, we refreshed our health and safety award programme, renamed as the Kia Haumarū Awards, meaning 'Let there be safety and protection'. The Awards recognise behaviours that enhance and protect the health, safety and wellbeing of our people and are presented quarterly.

We continue to engage with our workers through regular Regional and National Committee meetings. The National Health and Safety Committee is chaired by the Deputy Director-General Corporate Services and it provides an opportunity for a member of our Executive Leadership

Team to hear directly from our people regarding health, safety and wellbeing issues.

## We have been recognised for our health and safety risk management

In August 2021 we retained our tertiary accreditation with the ACC Accredited Employers Programme. This demonstrates that we provided satisfactory evidence that we have a clear track record of health and safety systems and processes, and are engaged in continuous improvement.

## We are reviewing health, safety and wellbeing governance

Our leaders are continually improving how they maintain oversight of health and safety and are progressing to the establishment of a health, safety and wellbeing subcommittee in the 2022/23 financial year.

# Our commitment to Papa Pounamu | Tā mātou taurangi atu ki Te Papa Pounamu

The Ministry's Whiria te Tangata | Culture and Inclusion Strategy has the Papa Pounamu diversity and inclusion work programme at its foundation.

We are implementing Whiria te Tangata over 3 years. Work is already well under way to create a safe and inclusive environment where all our people can thrive and do their best work.

The Ministry remains committed to the progressing the 5 additional Papa Pounamu focus areas:

1. Te āheinga ā-ahurea | Cultural competence

2. Te urupare i te mariu | Addressing bias
3. Hautūtanga ngākau tuwhera | Inclusive leadership
4. Te whakawhānaungatanga | Building relationships
5. Ngā tūhononga e kōkiritia ana e ngā kaimahi | Employee-led networks.

Below we outline our commitment to Papa Pounamu and list progress we have made in these focus areas. We do not include a section specifically on the fourth focus area, Te whakawhānaungatanga | Building relationships, because all of the activities we discuss contribute to this area.

## Te āheinga ā-ahurea | Cultural competence

In March 2021, the Director-General of Health and the Executive Leadership Team (ELT) committed to Whāinga amorangi | Transforming leadership.

They committed to this mahi so that everyone in the ELT keeps building their own personal capability, and that of our people, across 6 key competencies:

1. Te Tiriti o Waitangi and the history of Aotearoa
2. te reo Māori
3. tikanga/kawa practices
4. understanding racial inequity and institutional racism
5. worldviews and knowledge systems
6. engaging with Māori.

During 2021/22, we have made good progress toward delivering phase one of the plan.

The following are some of the key initiatives achieved over the past year:

- We held 7 **Wall Walk** sessions, with 233 staff participating. The Wall Walks are significant in building staff capability

and understanding of Te Tiriti o Waitangi and Aotearoa's history of inequity and racism.

- We launched a series of online lunchtime **Kai & Kōrero** sessions. The purpose of Kai & Kōrero is to raise visibility of kaupapa Māori initiatives we are delivering internally and provide a platform for our people to learn topics relating to te ao Māori, mātauranga Māori and te reo Māori.
- We launched **Toro Mai**, a 2-part e-learning module covering te reo and tikanga Māori.
- A total of 45 staff participated in **Engaging with Māori introductory workshops**, facilitated by Te Arawhiti. The workshops provided techniques and insights for effectively engaging with Māori, along with a framework and advice on how to apply these in the context of the Māori-Crown relationship.
- Te reo Māori programme (Levels 1 and 2) had 236 participating staff.
- We piloted a tailored learning programme in te reo and tikanga Māori (Te Tupuranga) with 11 of our staff who have Māori whakapapa. The objective of the programme is to create a tūrangawaewae for all Māori to grow and flourish as Māori at Manatū Hauora by connecting holistically through whakapapa and te reo and tikanga Māori.
- Ten members of the ELT completed te reo Māori coaching sessions with the aim of developing their confidence and capability in te ao Māori.

## Te urupare i te mariu | Addressing bias

It is mandatory for all staff to complete unconscious bias e-learning as part of the Ministry's Gender Pay and Accessibility Tick action plans. The training is included in the Ministry's induction programme for new staff and people leaders.

As part of our commitment to developing our people's capability, in line with Whāinga Amorangi: Transforming Leadership Framework, we are working towards an outcome statement 'Institutionalised racism is identified and addressed in Manatū Hauora (the Ministry of Health)'.

## **Hautūtanga ngākau tuwhera | Inclusive leadership**

To complement our leadership development programme, we participated in Tū Mau Mana Moana. Tū Mau Mana Moana is a scholarship programme that provides targeted leadership development for Pacific leaders in the public sector.

## **Ngā tūhononga e kōkiritia ana e ngā kaimahi | Employee-led networks**

Employee-led networks (ELN) are an integral part of our culture and our values. We have continued to work collaboratively with our ELNs and implemented a set of guidelines for starting a network and growing an existing network.

Information has also been provided to people leaders to ensure their ELN members feel safe and supported to contribute to the mahi of an ELN.

Additionally, we hold regular meetings with ELN representatives to share ideas and collaborate on events, such as organising a successful Pink Shirt Day in May 2022.

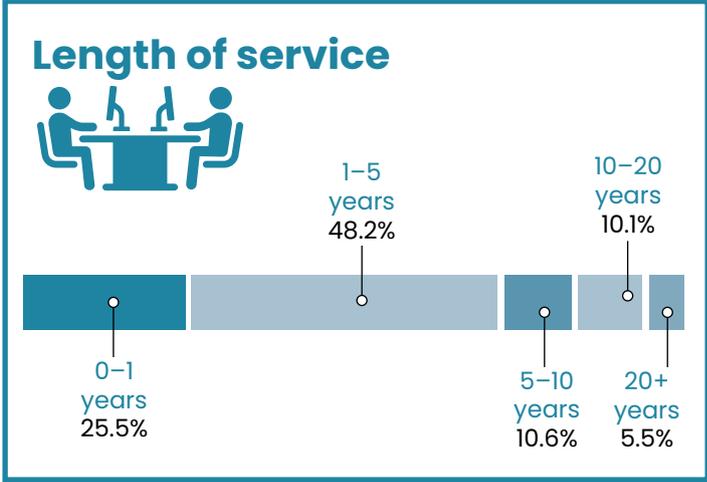
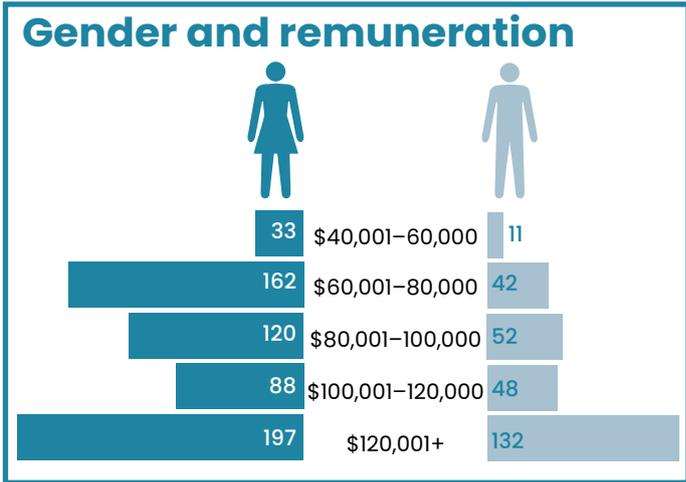


# Our people | Ko mātou



# Snapshot as at 30 June 2022<sup>19</sup>

**885**  
**employees**  
work for Manatū Hauora  
(862.8 FTE)



Average salary  
**\$112,841**  
(+4.8% since 2020/21)

**53.1%**  
staff paid over  
**\$100,000**  
(48.5% since 2020/21)

<sup>19</sup> Data here captures Manatū Hauora (the Ministry of Health) staff only. It excludes staff who work for Te Aho o Te Kahu | Cancer Control Agency and staff that were working within the interim departmental agencies Hauora Aotearoa (interim Health New Zealand) or Te Mana Hauora Māori (interim Māori Health Authority).

### Gender pay gap

**10.7%**

as at  
30 June 2022

**11.4%**

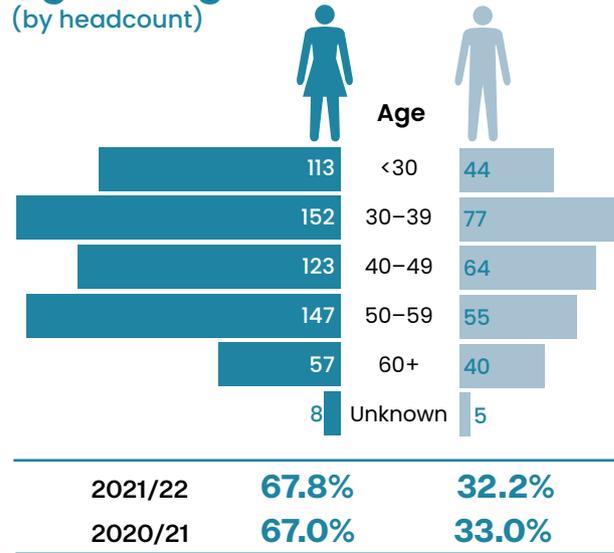
as at  
30 June 2021

**14%**

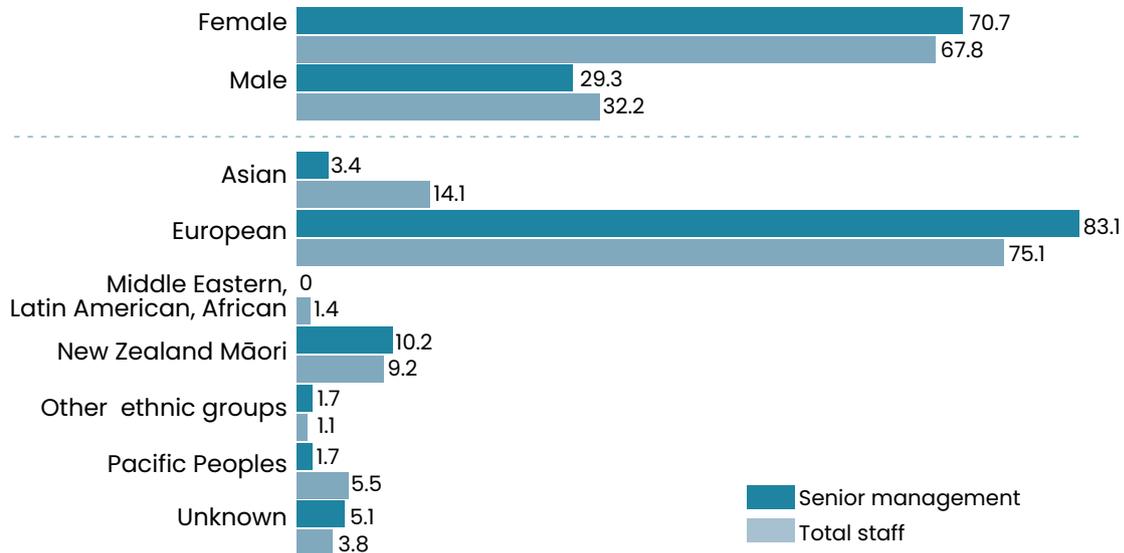
as at  
30 June 2020

### Age and gender

(by headcount)



### Percentage of staff at senior management level compared to the number of total staff



## Number of people who work at the Ministry

- Full-time equivalent (FTE) = 862.82
- Headcount = 885
- Staff transferred (system reforms) = 930 total (915 Hauora Aotearoa | Interim Health New Zealand, 15 Te Mana Hauora Māori | Interim Māori Health Authority)

## Overall headcount and FTEs by year

Data as at 30 June each year.

Year	Headcount	FTE
2022	885	862.82
2021	1,680	1,631.46
2020	1,224	1,186.85
2019	1,205	1,161.71
2018	1,127	1,083.77

## Gender year-on-year comparison

Data as at 30 June each year.

Year	Number		
	Females	Males	Total
2022	600	285	885
2021	1,126	554	1,680
2020	832	392	1,224
2019	824	381	1,205
2018	770	357	1,127

Year	Percentage	
	Females	Males
2022	67.8%	32.2%
2021	67.0%	33.0%
2020	68.0%	32.0%
2019	68.4%	31.6%
2018	68.3%	31.7%

20 Data as at 30 June each year.

## Gender and remuneration

	Females	Males	Total
\$40,001–\$60,000	33	11	44
\$60,001–\$80,000	162	42	204
\$80,001–\$100,000	120	52	172
\$100,001–\$120,000	88	48	136
\$120,001+	197	132	329

## Average salary

\$112,841 (4.8% increase since 2020/21)

## Percentage of staff paid \$100,000 or more

Data as at 30 June each year.

Year	Percentage of staff
2022	53.1%
2021	48.5%

## Gender pay gap

Year <sup>20</sup>	Gender pay gap
2022	10.7%
2021	11.4%
2020	14.0%
2019	11.3%
2018	15.8%

The Ministry is seeing a consistent decline in its gender pay gap. This is analysed on a monthly basis by band and directorate. The Ministry is also committed to Kia Toipoto – the Public Service initiative to close the pay gaps for women, Māori, Pacific peoples and other ethnic groups in the public sector. 'Like for like' analyses are performed yearly to ensure that staff are being fairly paid based on their time in their role.

The higher gender pay gap in 2020 and 2021 occurred as a result of the rapid growth in our workforce during the COVID-19 response.

As a result of this growth, the staff employed on fixed-term contracts expiring during 2021/22, and staff being transferred to Te Whatu Ora and Te Aka Whai Ora before 1 July 2022, has resulted in the overall gender pay gap within the Ministry decreasing – from 11.4% in 2021 to 10.7% in 2022.

## Ethnic pay gap

Ethnicity	2022	2021
Asian	10.0%	14.2%
European	-8.4%	-13.8%
Middle Eastern, Latin American, African (MELAA)	NA	NA
New Zealand Māori	2.5%	1.2%
Other ethnic group	NA	NA
Pacific peoples	12.3%	17.7%
Unknown	NA	NA

Note: NA applies where one ethnic group did not have more than 20 employees.

Where an employee has identified multiple ethnicities, their data is counted within each group declared.

## Modernising the Ministry

### Improving the IT infrastructure of the Ministry

The Ministry upgraded its IT technology and provided staff with the tools they need to work productively in cooperative working environments and built the ability for our staff to be fully mobile. These were important tools to both keep our people safe and to enable working at the different COVID-19 alert levels.

The changes were made under a work programme called Modernising the Ministry. They included:

- Launching and rolling out 'Bring Your Own Mobile'. This enables staff to access their work email, Microsoft Office and Microsoft Teams securely from their own mobile device.
- Introducing Microsoft SharePoint, compliant with the New Zealand Public Records Act, to ultimately replace the Lotus Notes document management system that we have used for the last 27 years. This was done in under four months. A lot of work was also done to prepare for the migration of tens of millions of documents out of Lotus Notes Cabinets to their new destinations within the three new external entities (Health New Zealand, Māori Health Authority, and the Ministry for Disabled People) and the Ministry of Health.
- 'SharePoint 101' training was delivered to over 600 of our staff. Attendees included a significant number of staff who were destined to move to Health New Zealand.
- We started Lotus Notes migration towards the retirement of this software. To achieve this 11 databases were migrated and 54 databases were deleted. There are over 266 databases still to go. Ten applications were re-developed, leaving 40 applications still requiring migration or deletion.
- We were able to reduce the number of Lotus Notes licences from 4,004 licences in May to 2,134 licences by the end of June. This will result in savings of \$500k per year for Lotus Notes software, at contract renewal time at the end of July 2022.
- We replaced CISCO Jabber and deployed Teams External Calling. This software allows our people to make calls to external numbers from Microsoft

Teams. Over 2,150 accounts were set up in the rollout. 900 inactive Jabber licences were removed in the process (with accompanying cost savings).

- Backups of data in our Microsoft cloud tenancy commenced with over 81 million emails, 370,000 folders, and more than 15TB in data was backed up over the Matariki long weekend in June 2022. This was the first use of a significant new backup capability we have implemented.
- We assisted Health New Zealand and other health sector colleagues with multiple different point-to-point migrations of data and information from Ministry of Health repositories to new homes in those agencies (as part of the progress toward implementing the health and disability sector reforms).
- We continued work on getting the most out of our Microsoft 365 investments, and the foundations laid for all three aspects of the significant Lotus Notes migration and retirement work still to do in the coming years.

## Our ongoing investment and technology upgrades

During the year we continued a programme of modernising our internal ICT systems and managed to remove some high-risk areas of legacy IT risk.

Our Modernise the Ministry programme of work has started to upgrade old Lotus

Notes applications into more current technologies provided by Microsoft, reducing our reliance on IBM Notes and increasing our use of cloud-based services.

We made major upgrades to the systems that support our Whanganui-based call centre, which have greatly supported our staff to deal with the huge call volumes from New Zealanders about COVID-19 and to the systems used by our internal service desk.

Our IT Service Centre supported up to 3000+ staff members during the COVID response, a significant increase in workload from the 1200 people we supported at the start of 2020.

A significant achievement was the upgrade of our entire IT security boundary which was about to go out of vendor support.

We have continued to upgrade the infrastructure that support collection of national data and have made savings of millions of dollars in licensing costs by moving to newer transaction processing systems for health payments.

On top of all the significant project work, to keep our systems current, the IT Operations teams have made some significant improvements with automation of the patching of our server fleet, whilst managing a very significant increase in staff IT requests and incident resolution.

# **Our statements of service performance | Ō mātou pūrongo pūtea**



# Performance of Manatū Hauora

This section details the performance of Manatū Hauora (the Ministry of Health) against our output measures and targets specified in Vote Health – Main Estimates of Appropriation 2021/22<sup>21</sup> and (where updated) in Vote Health – Supplementary Estimates of Appropriation 2021/22.<sup>22</sup>

Performance information for selected non-departmental appropriations for the year ended 30 June 2022 is available in a separate Vote Health Report.

This section focuses on our performance, measured by Vote Health’s output classes:

- Policy advice and related services
- Health sector information systems
- Managing the purchase of services
- Payment services
- Regulatory and enforcement services
- Sector planning and performance
- Health and disability system reform (multi-category appropriation (MCA))
- National response to COVID-19 across the health sector (MCA)
- Implementing the COVID-19 vaccine strategy (MCA)
- Ministry of Health – capital expenditure.

Each measure’s Budget Standard (target) for 2021/22 is included to provide context for the 2021/22 actual results. Where applicable, we compare our performance this year against the output measures and results from last year (2020/21).

Within each output class in this section, we use the following symbols to provide a quick check for the 2021/22 results:

Met or exceeded the target	✓
Did not meet the target	✗
Not available   Not assessed	NA

21 *Vote Health – Health Sector – Estimates 2021/22*, available at: [treasury.govt.nz/publications/estimates/vote-health-health-sector-estimates-2021-22](https://treasury.govt.nz/publications/estimates/vote-health-health-sector-estimates-2021-22).

22 *Vote Health – Supplementary Estimates of Appropriations 2021/22*, available at: [treasury.govt.nz/publications/supplementary-estimates/vote-health-supplementary-estimates-appropriations-2021-22](https://treasury.govt.nz/publications/supplementary-estimates/vote-health-supplementary-estimates-appropriations-2021-22).

# Policy Advice and Related Services

This appropriation is limited to the provision of policy advice (including second opinion advice and contributions to policy advice led by other agencies) and other support to Ministers in discharging their policy decision-making and other portfolio responsibilities relating to the health portfolio.

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

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
Average score attained from a sample of the Ministry's written policy advice as assessed using the agreed Department of the Prime Minister and Cabinet (DPMC) framework	3.70	Greater than 3.2 out of 5	3.62	✓
Ministerial satisfaction with the policy advice service	3.9	Equal to or greater than 4 out of 5	4.27	✓
Percentage of responses provided to the Minister within agreed timeframes:				
Ministerial letters (Note 1)	96.2%	95%	95.04%	✓
Written parliamentary questions	100%	95%	98.4%	✓
Ministerial Official Information Act requests (Note 1)	96.5%	95%	95.43%	✓
Percentage of responses provided to the Minister that required no [substantive] amendments:				
Ministerial letters	New measure	95%	99.92%	✓
Written parliamentary questions	New measure	95%	99%	✓
Ministerial Official Information Act requests	New measure	95%	99.42%	✓

Note 1: While still achieving budget standard, the actual results for 2021/22 reflect the volume of work and organisational pressures resulting from the August 2021 lockdown and Omicron outbreak.

## Financial performance

<b>Policy advice and related services</b>	<b>Actual 2020/21 \$000</b>	<b>Main estimates 2021/22 \$000</b>	<b>Voted appropriation 2021/22 \$000</b>	<b>Actual 2021/22 \$000</b>
Crown revenue	34,306	34,259	39,329	39,329
Other revenue	-	-	-	-
Total revenue	34,306	34,259	39,329	39,329
Total expenses	34,144	34,259	39,329	39,056
Net surplus (deficit)	162	-	-	273

# Health Sector Information Systems

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.

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

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
<b>Client insight and analytics</b>				
Percentage of published Tier 1 statistics meet Statistics New Zealand standards within agreed timetable (Note 1)	100%	100%	100%	✓
The National Collections meet the Statistics New Zealand standards for Tier 1 statistics (Note 1)	Achieved	Achieved	Achieved	✓
<b>National infrastructure and Ministry information systems</b>				
The percentage of time for which key sector- and public-facing systems are available (Note 2) (Note3)	98%	99%	99.52%	✓
Number of times that IT systems operated by the Ministry of Health have been compromised by an unauthorised third party	0	0	0	✓
<b>National Health Information Systems</b>				
The percentage of scheduled updates to the New Zealand Formulary, a key sector independent resource, providing healthcare professionals with the clinically validated medicines for patients, delivered in line with contractual requirements	100%	100%	100%	✓

Note 1: National Collections and Reporting published 100% of our Tier 1 statistics to the required standard in 2021/22. During this year there were around 198,000 visits to web pages with National Collections data. Of these, around 153,000 visits were to pages containing our Tier 1 statistics.

Note 2: Key systems include: Proclaim, Special Authority, Health Identity Platform (includes the National Health Index), National Immunisation Register, Financial Management, www.health.govt.nz, Oracle, and National Screening Solution.

Note 3: In 2021/22, the Ministry operated systems to support the COVID-19 health response and the COVID-19 Vaccine and Immunisation Programme. The overall availability of those key systems was 99.65%. The table below is not a performance measure but provides the name of each system, the availability target, and the percentage of time that the system was available.

## Additional performance information: COVID-19 information systems availability (uptime)

COVID-19 health response or COVID-19 vaccination and immunisation programme information systems (Note 1)	Actual 2020/21	Target	Actual 2021/22
National Contact Tracing Solution (NCTS)	99.67%	99%	98.60%
National Border Solution (NBS)	100%	99%	99.94%
National Immunisation Booking Solution (NIBS)	100%	99%	99.65%
Border Clinical Management Solution (BCMS)	99.67%	99%	99.04%
COVID-19 Immunisation Register (CIR)	99.56%	99%	99.99%
COVID Immunisation Consumer Support (CICS)	100%	99%	99.97%
Centre Adverse Reaction Monitoring (CARM)	100%	99%	100%
COVID-19 Vaccination and Immunisation Programme (CVIP)	100%	99%	99.97%
<b>Total</b>	<b>99.86%</b>	<b>99%</b>	<b>99.65%</b>

Note 1: In last year's report (2020/21), a calculation error was made when totalling the availability of the systems listed. The total for 2020/21 was incorrectly calculated as 99.97 percent. The value in the table above has been updated to reflect the correct value, 99.86 percent (0.11 percent less than what was reported last year).

## Financial performance

Health sector information systems	Actual 2020/21 \$000	Main estimates 2021/22 \$000	Voted appropriation 2021/22 \$000	Actual 2021/22 \$000
Crown revenue	106,519	101,647	240,222	240,222
Other revenue	16	-	1,053	712
Total revenue	106,535	101,647	241,275	240,934
Total expenses	93,445	101,647	270,275	196,579
Net surplus (deficit)	13,090	-	(29,000)	44,355

The appropriation actual spend was higher than the original budget to fund increased COVID-19 related technology costs, including managing COVID-19 in the community, additional operational support costs and enhancements to meet increased technology requirements including the integration of other health information technology with My COVID Record.

The underspend against the updated budget is due to COVID-19 related disruptions and delays, such as delays in on-boarding resources due to constraints in the current recruitment market, which pushed some activities into the 2022/23 year.

The Joint Ministers have approved an in-principle expense transfer of up to \$71.235 million from 2021/22 to 2022/23 which will be confirmed as part of the 2022 October Baseline Update.

# Managing the Purchase of Services

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 (i.e. funding is not devolved to another entity).

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 Ministry of Health’s Statement of Strategic Intentions).

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
The Ministry procurement process is in line with government standards	Achieved	Achieved	Achieved	✓
The percentage of Ministry feedback to Crown funding agreement variation (CFAV) monitoring reports that are supplied to DHBs within agreed timeframes (Note 1)	67%	95%	85.3%	✗
The percentage of complaints in regards to Disability Support Services (DSS) that receive either a resolution notification or progress update within 20 working days of DSS receiving the complaint	85.5%	95%	96.6%	✓

Note 1: The achievement of this measure was heavily dependent on the timeliness of the Ministry of Health’s subject matter experts providing feedback in the database within agreed timeframes.

We ensure we give the subject matter experts as many reminders as possible about timeframes and communicate expectations for completing reviews. As the Ministry’s subject matter experts face competing work demands and resource constraints, monitoring feedback to DHBs within agreed timeframes continues to be a challenge.

## Financial performance

Managing the purchase of services	Actual 2020/21 \$000	Main estimates 2021/22 \$000	Voted appropriation 2021/22 \$000	Actual 2021/22 \$000
Crown revenue	71,556	74,185	83,773	83,773
Other revenue	734	1,484	1,484	13
Total revenue	72,290	75,669	85,257	83,786
Total expenses	71,199	75,669	85,257	79,421
Net surplus (deficit)	1,091	-	-	4,365

The underspend against the updated budget is due to the residual work required in 2022/23 to support the ongoing responsibilities of the Ministry in relation to the Health and Disability System Reform, and delays in the enhanced influenza immunisation programme as the COVID-19 vaccine programme remains a top priority.

The Joint Ministers have approved an in-principle expense transfer of up to \$5.145 million from 2021/22 to 2022/23 which will be confirmed as part of the 2022 October Baseline Update.

# Payment Services

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

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.

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
The percentage of claims paid on time	99.9%	98%	99.7%	✓
The percentage of claims processed accurately	95.3%	95%	100%	✓
The percentage of all draft agreements prepared for funders within target timeframes (Note 1)	84.9%	95%	77.4%	✗
The percentage of agreements prepared accurately	100%	95%	100%	✓
The percentage of calls to contact centre answered within service specifications for timeliness (20 seconds) (Note 2)	72.7%	80%	28.2%	✗
The percentage of calls abandoned by callers prior to being answered by the contact centre is less than (Note 3)	4.5%	5%	16.2%	✗
The percentage of enquiries resolved within 10 working days (Note 4)	93%	95%	89.4%	✗
Ratio of financial value of identified recoverable losses from audit and compliance activities against operational costs (Note 5)	New measure	1.8:1	1.6:1	✗
Ratio of financial value of averted losses from audit and compliance activities to operational costs (Note 5)	New measure	4:1	3.9:1	✗

Note 1: High volume of activity and unforeseen challenges, along with the transition to the Te Whatu Ora | Health New Zealand, have impacted the processing capacity. The health sector reforms and the establishment of the new funding entities has created a more complex contracting environment for FY 21/22. Sector Operations has played a central role in supporting the new organisations, which has led to a significant increase in the time spent assisting funders on how to contract as new funder/commissioners rather than simply drafting agreements.

Note 2: Call volumes throughout the year were high due to the pandemic. Demand from New Zealanders was unprecedented as they sought support for COVID related enquiries and clarification on changes to the COVID policy regulations. This put significant pressure on the Contact Centres ability to manage calls in a timely manner. Annually, there was a 18 percent increase in call volumes. From January to June, there was a 27 percent increase in volumes. Staff Covid and winter illness also put significant pressure on the Contact Centre's ability to manage calls in a timely manner.

It has also been identified that there is an issue with the software that calculates the service levels. This is being investigated by the vendor.

Note 3: The high call abandonment percentage is related to the high volume of calls to contact centre (see Note 2), resulting in longer wait times.

Note 4: We did not meet the Budget Standard due to a dip in January 2022 where only 30.4% of enquires were resolved within ten working days due to the holiday period. Since January 2022, we have been meeting/exceeding the Budget Standard due to the increased workforce capacity.

Note 5: The first six months of the year saw the cumulative and ongoing effect of the COVID-19 lockdown along with the diversion of our Audit and Compliance staff to assist with COVID-19 contact tracing. Lockdowns, travel restrictions, assisting with COVID-19 contact tracing, staff sickness and the need to be sensitive with the health providers by not interfering with their delivery of services, have all have impeded the audit and investigative process on-site and the delivery of these targets.

The gradual reduction of COVID-19 related restrictions has enabled audit and investigative services to resume fully. Despite these improvements, the effect of the COVID-19 restrictions over the entire year resulted in these measures being marginally lower than the Budget Standard.

## Financial performance

Payment services	Actual 2020/21 \$000	Main estimates 2021/22 \$000	Voted appropriation 2021/22 \$000	Actual 2021/22 \$000
Crown revenue	18,710	18,430	18,180	18,180
Other revenue	27	-	-	-
Total revenue	18,737	18,430	18,180	18,180
Total expenses	19,600	18,430	18,180	17,653
Net surplus (deficit)	(863)	-	-	527

# Regulatory and Enforcement Services

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.

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

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
The percentage of high priority incident notifications relating to medicines and medical devices that undergo an initial evaluation within 5 working days	New measure	90%	97%	✓
The percentage of all certificates issued to providers under the Health and Disability Services (Safety) Act 2001 within target timeframes (Note 1)	93%	90%	91%	✓
Percentage of licences and authorities issued under the Medicines Act 1981 and Misuse of Drugs Act 1975 within target timeframes	95%	90%	94%	✓
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 (Note 2)	94%	90%	93%	✓
The percentage of all New Medicines Applications (for ministerial consent to market) that receive an initial assessment within 200 days (Note 3)	82%	80%	74%	✗
The percentage of all Changed Medicines Notifications (for ministerial consent to market) responded to within 45 days	100%	100%	99%	✗
Average rating for statutory committee satisfaction with secretariat services provided by the Ministry	3.58	4 out of 5 or greater	4.6 out of 5	✓

Note 1: 334 out of 369 certificates met the required timeframes. While the performance measure was met, the result is lower than it could have been primarily due to HealthCERT audits for healthcare providers being impacted by COVID-19. These impacts resulted in cancellations, delays, and extensions.

Note 2: Considerable effort has gone into issuing licences and consents this year, particularly in the fourth quarter where there was a spike in demand for dental licences. The development of a new Radiation Database will lead to an increased workload in the short to medium term, increasing some of current required work effort.

Note 3: 101 of 136 New Medicines Applications received an initial assessment within 200 days. All new medicine and change medicine applications relating to COVID-19 vaccines and therapies were assigned priority assessments, impacting the timeliness of other applications.

## Financial performance

Regulatory and enforcement services	Actual 2020/21 \$000	Main estimates 2021/22 \$000	Voted appropriation 2021/22 \$000	Actual 2021/22 \$000
Crown revenue	12,795	16,029	16,579	16,579
Other revenue	13,022	15,949	16,334	16,552
Total revenue	25,817	31,978	32,913	33,131
Total expenses	27,994	31,978	32,913	31,013
Net surplus (deficit)	(2,177)	-	-	2,118

The underspend against the final appropriated budget is a result of delays in the build of a new radiation store, a common software platform for regulatory schemes and lower than anticipated activity in relation to the Assisted Dying scheme.

The Joint Ministers have approved an in-principle expense transfer of up \$1.550 million from 2021/22 to 2022/23 which will be confirmed as part of the 2022 October Baseline Update.

# Sector Planning and Performance

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

This appropriation is intended to achieve: 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.

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
Planning advice for the financial year is provided to DHBs by 31 December (Note 1)	New measure	Achieved	Not achieved	✘
Percentage of quarterly reporting output reports delivered to DHBs within 3 months of quarter end (Note 2)	New measure	100%	0%	✘
The percentage of monthly monitoring reports about DHBs provided to the Minister within agreed timeframes (Note 3)	New measure	100%	55%	✘
The percentage of quarterly monitoring reports about Crown entities (excluding DHBs) provided to the Minister within agreed timeframes	New measure	100%	100%	✔
The percentage of appointments to other health Crown entity boards (excluding DHBs) where advice is presented to the Minister prior to the current appointee's term expiring	New measure	95%	100%	✔
Maintain the capability and capacity to respond to national emergencies and emerging health threats (Note 4)	Not achieved	Achieved	Not achieved	✘

Note 1: This performance measure is no longer applicable due to system reforms and disestablishment of DHBs. The planning advice issued to DHBs in December 2021 would have been advice for the development of DHB annual plans for the 2022/23 year. DHBs and DHB annual plans were required under the New Zealand Health and Disability Act 2000. The Act was repealed and DHBs were disestablished on 30 June 2022.

Note 2: Work continued to be re-prioritised due to the response to the outbreak of Omicron, as well as the health and disability system reform work. This delayed the release of these reports. The production of these reports was also delayed due to the availability of data and information where staff in the sector were re-deployed.

Note 3: There were 11 reports due in the year and of these, six were delivered within the required timeframe. Progress was made to streamline the internal sign-off process to enable the reports to be produced in line with expectations. Reports are not provided in July.

Note 4: Since November 2020 the Emergency Management Team has responded to 18 events that required coordination, including four offshore incidents. COVID-19 has directly impacted all systems and had an impact on the sector's ability and resources to update plans, provide training, and conduct preparation exercises. These factors have created capability and capacity challenges that will take some time to recover from.

## Financial performance

Sector planning and performance	Actual 2020/21 \$000	Main estimates 2021/22 \$000	Voted appropriation 2021/22 \$000	Actual 2021/22 \$000
Crown revenue	81,649	72,141	89,785	89,785
Other revenue	2	149	149	2
Total revenue	81,651	72,290	89,934	89,787
Total expenses	73,674	72,290	89,934	84,698
Net surplus (deficit)	7,977	-	-	5,089

Sector planning and performance actual spend was higher than the initial budget due to additional funding required to implement the three work programmes: the National Asset Management Programme, the Mental Health Infrastructure Programme and Facility Service Planning, and additional funding to manage cost pressures for the health and disability system review.

Actual spend was lower than the final appropriated budget as a result of the impact of COVID-19 on the National Asset Management Programme and Mental Health Infrastructure Programme. Good progress is being made with work accelerating, however some work had not progressed as planned. COVID-19 also impacted some integration activities in relation to the health reforms.

The Joint Ministers have approved an in-principle expense transfer of up to \$3 million from 2021/22 to 2022/23 which will be confirmed as part of the 2022 October Baseline Update.

# Health and Disability System Reform

The single overarching purpose of this appropriation is to implement health and disability system reform.

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
<b>Performance for the MCA as a whole</b>				
Ministerial Oversight Group satisfied with progress towards the Health and Disability System Reform deliverables agreed by Cabinet (Note 1)	New Measure	Equal to or greater than 4 out of 5	4	✓
Minister of Health satisfied with progress towards the Health and Disability System Reform deliverables agreed by Cabinet	New Measure	Equal to or greater than 4 out of 5	4	✓

Note 1: The result is based on an average score using responses from 4 of the 5 Ministerial Oversight Group members.

## Interim Health New Zealand responsibilities

### Departmental output expenses – Health New Zealand

This category is limited to the establishment of Health New Zealand, delivery of initial health and disability system reform priorities, and related advice.

Performance measure	Actual 2020/21	Target	Actual 2021/22	At a glance
Ministerial Oversight Group satisfied with progress towards the Health and Disability System Reform deliverables agreed by Cabinet (Note 1)	New measure	Equal to or greater than 4 out of 5	4	✓
Minister of Health satisfied with progress towards the Health and Disability System Reform deliverables agreed by Cabinet	New measure	Equal to or greater than 4 out of 5	5	✓

Note 1: The result is based on an average score using responses from 4 of the 5 Ministerial Oversight Group members

### Non-Departmental output expenses – Locality Networks

This category is limited to developing, implementing and delivering Locality Networks.

Performance measure	Actual 2020/21	Target	Actual 2021/22	At a glance
Funding agreements in place for first phase of Locality Networks (Note 1)	New measure	5–6 locality networks	9	✓

Note 1: Nine letters of agreement for Phase 1 Locality funding were implemented, with funding paid within the FY21/22 year.

## Interim Māori Health Authority responsibilities

### Departmental output expenses – Māori Health Authority

This category is limited to the establishment of a Māori Health Authority, delivery of initial hauora Māori reform priorities, and related advice.

Performance measure	Actual 2020/21	Target	Actual 2021/22	At a glance
Ministerial Oversight Group satisfied with progress towards the Health and Disability System Reform deliverables agreed by Cabinet (Note 1)	New measure	Equal to or greater than 4 out of 5	4	✓
Minister of Health satisfied with progress towards the Health and Disability System Reform deliverables agreed by Cabinet	New measure	Equal to or greater than 4 out of 5	5	✓

Note 1: The result is based on an average score using responses from 4 of the 5 Ministerial Oversight Group members

### Non-Departmental output expenses – Hauora Māori

This category is limited to developing, implementing and delivering hauora Māori services, supporting the development of hauora Māori providers, developing partnerships with iwi, and other related initiatives.

Performance measure	Actual 2020/21	Target	Actual 2021/22	At a glance
Commissioning plan in place for delivery of hauora Māori services	New measure	Achieved	Achieved	✓
Delivery in accordance with the commissioning plan	New Measure	Achieved	Achieved	✓

## Financial performance

<b>Health and Disability System Reform</b>	<b>Actual 2020/21 \$000</b>	<b>Main estimates 2021/22 \$000</b>	<b>Voted appropriation 2021/22 \$000</b>	<b>Actual 2021/22 \$000</b>
<b>Departmental output expenses</b>				
<b>Health New Zealand</b>				
Crown revenue	-	21,495	25,495	25,495
Other revenue	-	-	-	-
Total revenue	-	21,495	25,495	25,495
Total expenses	-	21,495	25,495	22,081
Net surplus (deficit)	-	-	-	3,414
<b>Māori Health Authority</b>				
Crown revenue	-	23,119	24,139	24,139
Other revenue	-	-	-	-
Total revenue	-	23,119	24,139	24,139
Total expenses	-	23,119	24,139	7,660
Net surplus (deficit)	-	-	-	16,479
<b>Non-departmental output expenses</b>				
<b>Hauora Māori</b>				
Total expenses	-	17,396	17,396	8,760
<b>Locality networks</b>				
Total expenses	-	9,642	9,642	-
<b>Total MCA expenses</b>		<b>71,652</b>	<b>76,672</b>	<b>38,501</b>

This multi-category appropriation was established in 2021/22. Its single overarching purpose is to implement health and disability system reform.

Health and disability system reform MCA actual spend was lower than budget due to the longer time taken than initially planned to scope, consult and finalise function transfers on the Interim Health New Zealand and Interim Māori Health Authority work programmes, which is partly driven by disruptions caused by COVID-19.

While the implementation for the work programmes has commenced and the critical changes were in place for the 1 July transfer, there were some residual works required to support the ongoing responsibilities extending into 2022/23.

Further, the work is underway with Iwi-Māori Partnership Boards to create services that could include health education, pūrākau, resource development, and models centred on addressing the wider social and environmental determinants of health in their communities. The provision of these services would extend into 2022/23.

The Joint Ministers have approved in-principle expense transfers from 2021/22 to 2022/23 of up to:

- Health New Zealand - \$9 million
- Māori Health Authority - \$17 million
- Hauora Māori - \$9.642 million
- Locality Networks - \$17.393 million

The in-principle expense transfers will be confirmed as part of the 2022 October Baseline Update.

# National Response to COVID-19 Across the Health Sector

The single overarching purpose of this appropriation is to implement a national response to COVID-19 across the health sector.

This appropriation is intended to provide for the national response to the COVID-19 pandemic across the health sector.

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
<b>Performance for the MCA as a whole</b>				
Ministerial satisfaction with the national response to COVID-19 across the health sector (Note 1)	4	Equal to or greater than 4 out of 5	4	✓

Note 1 Hon Dr Verrall, the Minister for COVID-19 Response was the Minister surveyed for the satisfaction with the national response to COVID-19 across the health sector.

## Departmental output expenses – National health response to COVID-19

This category is intended to achieve the following: To enable the Ministry of Health to maintain the capacity and capability to respond to the COVID-19 pandemic.

Performance measure	Actual 2020/21	Target	Actual 2021/22	At a glance
Ministerial satisfaction with the Ministry of Health's management and coordination of the national response to the COVID-19 across the health sector (Note 1) (Note 2)	4	Equal to or greater than 4 out of 5	4	✓
Mechanisms in place to routinely capture and inform public health science, response operations, intelligence, operational feedback, and public perceptions, concerns and trust (Note 3)	New measure	Achieved	Achieved	✓

Note 1: Hon Dr Verrall, the Minister for COVID-19 Response, was the Minister surveyed for the satisfaction with the national response to COVID-19 across the health sector.

Note 2: This performance measure was not included in the Vote Health estimates. We have included it as additional information.

Note 3: Monitoring any Variants of Concern using Whole Genome Sequencing on shore, scanning of international databases and literature to provide insights into New Zealand's behaviours, attitudes and practices to COVID-19 response measures and decisions.

## Non-departmental output expenses – COVID-19 public health response

This category is intended to achieve the following: Provide for the ongoing public health response to the COVID-19 pandemic.

Performance measure	Actual 2020/21	Target 2020/21	Actual 2021/22	At a glance
Monitoring Border worker testing compliance through the Border Worker testing Register (PCR testing) (Note 1)	New measure	Greater than 90% compliance	89.93%	✘
Minimum of 90% of New Zealanders can access COVID-19 testing within a 20 minute drive to a testing point. This includes priority population groups and people at higher risk of serious illness from COVID-19 (Note 2)	New measure	Achieved	Achieved	✓
Maintain an average of 12-week stock in Ministry's National Personal Protective Equipment (PPE) and Critical Medical Supply Chain	New measure	Achieved	Achieved	✓
The Ministry provides support to MIQ teams with information, guidance and dedicated health services aligned to infection prevention and control protocols (Note 3)	New measure	Achieved	Achieved	✓
Maintain Public Health contact tracing and case management capacity through scalable telehealth services and digital pathways in line with response/pandemic requirements (Note 4)	New measure	Up to 1,000 cases per day	24,100	✓

Note 1: Indicative data between July 2021 and 16 February 2022 shows achieved target of 89.93%. The data only goes until 16 February which is when testing was changed to RATs. As a self-administered and self-reported test that did not align with the Required Testing Order, RAT compliance could not be reliably counted on as a compliance measure from that time. Due to changes in the Maritime Border order, Maritime staff were not required to test from 2 May 2022.

Note 2: Priority population groups are represented by communities disproportionately affected by COVID-19 outbreaks. This includes people with comorbidity, compromised immunity, older people, people in aged care facilities, and population groups with other risk factors.

Measures of success include the number and geographic coverage of priority population groups by community providers contracted by the Ministry to deliver supervised RATs (including Māori providers); the number and geographic coverage of RATs delivered to aged residential care facilities and the disability community etc.

Note 3: Regular audits for Infection Prevention and Control (IPC) were undertaken against the IPC Standard Operating Procedure (SOP) to ensure a level of compliance.

IPC SOPs were readily accessible online to all staff in MIQ. IPC SOPs were regularly reviewed. This occurred when new public health advice was available or changes to IPC protocols were identified as required. After each review, IPC SOPs were distributed to all MIQs via Ministry for Business, Innovation and Employment's (MBIE) MIQ distribution networks.

Note 4: Significant case investigation and contact tracing capacity were increased across the twelve Public Health Units (PHUs) as well as the national telehealth services contracted by the National Investigation and Tracing Centre (NITC) due to the COVID-19 response.

In November 2021, the National Case Investigation Service (NCIS) was stood up to significantly increase the national case investigation capacity, enabling public health units to focus on higher risk exposure events.

In response to Omicron, digital tools (online case investigation forms and text message communications) were developed for the public who are digitally-enabled, further aiding the scalability of the service. These digital pathways, combined with the national case investigation service, offer significant capacity and capability, and the service successfully scaled to respond to ~24,000 case per day at the peak of the Omicron outbreak (March 2022).

## Financial performance

<b>National response to COVID-19 across the health sector</b>	<b>Actual 2020/21 \$000</b>	<b>Main estimates 2021/22 \$000</b>	<b>Voted appropriation 2021/22 \$000</b>	<b>Actual 2021/22 \$000</b>
<b>Departmental output expenses National health response to COVID-19</b>				
Crown revenue	21,711	43,297	89,497	89,497
Other revenue	-	-	-	-
Total revenue	21,711	43,297	89,497	89,497
Total expenses	13,250	43,297	89,497	66,875
Net surplus (deficit)	8,461	-	-	22,622
<b>Non-departmental output expenses COVID-19 public health response</b>				
Total expenses	217,580	850,725	3,772,907	2,406,847
<b>Total MCA expenses</b>	<b>230,830</b>	<b>894,022</b>	<b>3,862,404</b>	<b>2,473,722</b>

The National response to COVID-19 across the health sector actual spend was higher than the initial budget due to additional funding required for:

- meeting the ongoing costs of the public health response to COVID-19 and supporting community-based testing for COVID-19
- supporting the ongoing health system response to COVID-19 including testing, case investigation, contact tracing and to support the transition to the minimisation and protection framework
- supporting the delivery of the COVID-19 Care in the community work programme which devolves responsibility for various parts of the patient journey to appropriate local providers via regional coordination centres
- additional supply of personal protective equipment (PPE) to meet demand requirements.

The Joint Ministers have approved in-principle expense transfers from 2021/22 to 2022/23 of up to:

- National health response to COVID-19 - \$16 million
- COVID-19 Public Health response - \$1,149.268 million

The in-principle expense transfers will be confirmed as part of the 2022 October Baseline Update.

# Implementing the COVID-19 Vaccine Strategy

The single overarching purpose of this appropriation is to implement the COVID-19 vaccine strategy so as to minimise the health impacts of COVID-19.

This appropriation is intended for the purchase of potential and proven COVID-19 vaccines and other therapeutics and the delivery of COVID-19 vaccines through an immunisation programme.

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
<b>Performance for the MCA as a whole</b>				
Ministerial satisfaction with the implementation of the COVID-19 vaccine strategy	5	Equal to or greater than 4 out of 5	5	✓

## Departmental output expenses – Supporting the implementation of the COVID-19 vaccine strategy

This category is limited to advising on the COVID-19 Vaccine Strategy, administering the purchase of COVID-19 vaccines and other therapeutics, and supporting the delivery of an immunisation programme for COVID-19 vaccines.

Performance measure	Actual 2020/21	Target 2021/22	Actual 2021/22	At a glance
Ministerial satisfaction on Ministry advice in relation to the COVID-19 vaccine strategy	New measure	Equal to or greater than 4 out of 5	5	✓

## Non-departmental output expenses – Implementing the COVID-19 immunisation programme

This category is limited to delivering approved vaccines through an immunisation programme as part of minimising the health impacts of COVID-19.

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
Providers are enabled to deliver COVID-19 vaccinations in line with national guidance, operations policies, and service standards (Note 1)	New measure	Achieved	Achieved	✓
Number of approved COVID-19 vaccines administered to individuals in line with the policy settings	Achieved	Achieved	9,967,210	✓

Note 1: The programme released the COVID Vaccine and Immunisation Programme (CVIP) operating guidelines in late February 2021, and the Service Standards in May 2021. The provider requirement is adherence. Conformance to the Service Standards will be assessed in 2022/23.

## Purchasing potential and proven COVID-19 vaccines and other therapeutics

This category is limited to obtaining potential and proven vaccines and therapeutics as part of minimising the health impacts of COVID-19.

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
Number of COVID-19 vaccine doses purchased by Pharmac and received by the Ministry of Health in the central storage facilities (Note 1)	New measure	Achieved	15,340,610	✓
Number of COVID-19 therapeutics purchased by Pharmac and available for treatment of COVID-19 in accordance with guidelines issued by the Ministry of Health (Note 2)	New measure	Achieved	7	✓

Note 1: The Ministry of Health led the purchasing function of COVID-19 vaccine doses until 1 July 2022, when the function transferred to Pharmac. Most of vaccine purchasing was completed via advanced purchasing agreements in 2020.

Note 2: Four of the therapeutics are for use in hospitals. These are Baricitinib, Casirivimab with imdevimab (Ronapreve), and remdesivir. The work for these treatments has been led by Pharmac with input from their clinical advisors. The Ministry has led the production of clinical guidance as needed following the treatments becoming available and Pharmac establishing access criteria.

The remaining three therapeutics are for use in both primary care or hospital these are Nirmatrelvir and Ritonavir (brand name Paxlovid), molnupiravir and the pre-exposure prophylaxis therapy Evusheld.

## Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

### COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

#### HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

#### HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

## Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Aotearoa, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.<sup>23</sup>

## Percentage of the eligible population who have completed their primary COVID-19 vaccination course<sup>24</sup> (HSU 2021 vs HSU 2020)

Year <sup>25</sup>	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	10.50%	11.11%
2021/2022	79.93%	84.55%
<b>Total</b>	<b>90.43%</b>	<b>95.66%</b>

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 90.43%, compared with 95.66% using HSU 2020 as at 30 June 2022..

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

23 <https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology>

24 Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.

25 Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

## COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Aotearoa during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

### COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year <sup>26</sup>	Primary course				Total <sup>27</sup>
	Dose 1	Dose 2	Booster 1	Booster 2	
2020/21	719,402	456,498	1	-	1,175,901
2021/22	3,573,206	3,658,233	2,681,098	21,673	9,934,210
<b>Total</b>	<b>4,292,608</b>	<b>4,114,731</b>	<b>2,681,099</b>	<b>21,673</b>	<b>11,110,111</b>

By 30 June 2022, a total of 11.11 million COVID-19 vaccinations had been administered, of which 89.4% were administered in 2021/22

26 Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1 July–30 June.

27 Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

## COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

### COVID-19 vaccine doses administered by age group<sup>28</sup>

Age group (years) <sup>29</sup>	Primary course				Total <sup>30</sup>
	Dose 1	Dose 2	Booster 1	Booster 2	
0 to 11	264,018	129,996	-	-	<b>394,014</b>
12 to 15	261,252	251,007	145	1	<b>512,405</b>
16 to 19	225,039	224,953	75,408	10	<b>525,410</b>
20 to 24	274,406	276,876	154,605	37	<b>705,924</b>
25 to 29	296,341	299,566	178,804	75	<b>774,786</b>
30 to 34	308,454	313,709	207,833	238	<b>830,234</b>
35 to 39	277,070	283,094	205,372	233	<b>765,769</b>
40 to 44	253,530	259,933	202,661	306	<b>716,430</b>
45 to 49	256,538	263,867	217,857	428	<b>738,690</b>
50 to 54	256,052	268,170	238,404	864	<b>763,490</b>
55 to 59	237,752	254,715	243,168	1,357	<b>736,992</b>
60 to 64	212,843	235,420	240,669	1,933	<b>690,865</b>
65 to 69	150,183	188,942	213,199	3,276	<b>555,600</b>
70 to 74	121,680	161,545	190,295	4,326	<b>477,846</b>
75 to 79	79,834	109,779	137,359	4,017	<b>330,989</b>
80 to 84	54,501	75,376	95,029	2,678	<b>227,584</b>
85 to 89	29,043	39,965	50,584	1,234	<b>120,826</b>
90+	14,670	21,320	29,706	660	<b>66,356</b>
<b>Total</b>	<b>3,573,206</b>	<b>3,658,233</b>	<b>2,681,098</b>	<b>21,673</b>	<b>9,934,210</b>

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

28 Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.

29 Age groupings in this table reflect the age of the person at the time of the vaccination being administered.

30 Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

## COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

## COVID-19 people vaccinated by age group during 2021/22<sup>31</sup>

Age group <sup>32</sup> (years)	Partial <sup>33</sup>		Primary course <sup>34</sup>		Booster course			
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received Second Booster % eligible (50+)
0 to 11	224,700	29%	112,936	14%	-	0%	-	-
12 to 15	226,702	83%	200,925	73%	-	0%	-	-
16 to 19	231,597	91%	229,573	91%	41,730	42%	-	-
20 to 24	275,184	82%	277,833	83%	150,970	51%	-	-
25 to 29	290,716	76%	295,341	77%	173,703	54%	-	-
30 to 34	314,961	78%	322,146	80%	205,206	58%	-	-
35 to 39	285,232	79%	291,982	81%	205,975	64%	-	-
40 to 44	261,537	81%	268,673	83%	204,064	69%	-	-
45 to 49	250,676	77%	258,437	79%	211,241	74%	-	-
50 to 54	263,051	78%	273,944	81%	238,639	77%	814	3%
55 to 59	238,090	73%	253,890	78%	238,890	82%	1,323	5%
60 to 64	223,200	74%	243,831	80%	244,718	86%	1,892	6%
65 to 69	165,556	64%	199,476	77%	217,622	89%	3,098	9%
70 to 74	125,763	57%	165,045	75%	192,534	92%	4,266	13%
75 to 79	90,743	58%	123,418	79%	149,207	94%	4,148	15%
80 to 84	60,174	57%	83,239	78%	101,423	96%	2,830	15%
85 to 89	33,150	59%	45,326	80%	55,422	97%	1,357	14%
90+	18,409	55%	25,856	77%	33,710	101%	738	11%
<b>Total</b>	<b>3,579,441</b>	<b>68.39%</b>	<b>3,671,871</b>	<b>70.16%</b>	<b>2,665,054</b>	<b>72.53%</b>	<b>20,466</b>	<b>9.73%</b>

31 Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021–30 June 2022.

32 Age groupings in this table reflect age of the persons at end of financial year.

33 Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).

34 Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2)..

## COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

### COVID-19 vaccine doses<sup>35</sup> administered by ethnicity<sup>36</sup> (1 July 2021 – 30 June 2022)

Ethnicity (Note 1)	Primary course				Total
	Dose 1	Dose 2	Booster 1	Booster 2	
Asian	580,623	590,465	437,058	1,052	<b>1,609,198</b>
European/other	2,217,281	2,309,673	1,830,969	18,853	<b>6,376,776</b>
Māori	494,988	478,102	243,101	1,270	<b>1,217,461</b>
Pacific peoples	253,571	252,529	146,115	365	<b>652,580</b>
Unknown	26,743	27,464	23,855	133	<b>78,195</b>
<b>Total</b>	<b>3,573,206</b>	<b>3,658,233</b>	<b>2,681,098</b>	<b>21,673</b>	<b>9,934,210</b>

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

35 This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster

36 Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

## COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

### COVID-19 people vaccinated by ethnicity during 2021/22<sup>37</sup>

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster, 50+	Received second booster (% eligible, 50+)
Asian	531,537	76.62%	566,740	81.69%	436,264	73.35%	808	4.84%
Māori	460,097	75.73%	465,397	76.60%	241,978	55.31%	1,158	6.20%
European /other	2,097,891	74.86%	2,245,403	80.13%	1,817,461	77.08%	18,073	11.04%
Pacific peoples	236,854	75.87%	250,002	80.08%	145,626	59.15%	310	3.25%
Unknown	28,362	76.69%	31,393	84.89%	23,725	62.70%	117	7.28%
<b>Total</b>	<b>3,354,741</b>	<b>75.34%</b>	<b>3,558,935</b>	<b>79.93%</b>	<b>2,665,054</b>	<b>72.53%</b>	<b>20,466</b>	<b>9.73%</b>

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

### COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1,2)	Partially Vaccinated 12+	Partially Vaccinated 12+ percentage of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	651,364	93.89%	644,685	92.93%	436,284	73.36%	808	4.84%
Māori	529,789	87.20%	509,003	83.78%	241,978	55.31%	1,158	6.20%
European/other	2,584,879	92.24%	2,553,423	91.12%	1,817,486	77.08%	18,073	11.04%
Pacific peoples	287,323	92.03%	280,248	89.77%	145,631	59.15%	310	3.25%
Unknown	40,172	108.63%	39,106	105.74%	23,728	62.71%	117	7.28%
<b>Total</b>	<b>4,093,527</b>	<b>91.93%</b>	<b>4,026,465</b>	<b>90.43%</b>	<b>2,665,107</b>	<b>72.54%</b>	<b>20,466</b>	<b>9.73%</b>

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

<sup>37</sup> Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)  
Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)  
Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)  
Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)  
50+ age determined as at 30-Jun-2022  
Basis of population is HSU2021 for 12+ years old  
All counts exclude those who died prior to 30-Jun-2022

## Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ<sup>38</sup>:

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
  - a. National population estimates (produced quarterly)
  - b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
  - a. Official national and subnational projections
  - b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

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38 <https://www.stats.govt.nz/methods/population-statistics-user-guide>.

## Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.'<sup>39</sup>

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

## Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

### Comparison of HSU 2021 to the Stats NZ PRP

As at 31 December 2021, there is an estimated 5.2 million health service users in the HSU 2021. This is an increase of 233,000 people from the HSU 2020 (an approximate 4% increase), and 110,000 more people than the Stats NZ PRP for 30 June 2021.

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<sup>39</sup> More information on the findings from the Stats NZ review of the HSU is available at: [stats.govt.nz/reports/review-of-health-service-user-population-methodology/](https://stats.govt.nz/reports/review-of-health-service-user-population-methodology/)

## New Zealand population by ethnicity: HSU 2021 and Stats NZ PRP comparison<sup>40</sup>

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	802,000	875,400	-73,400
Pacific peoples	391,000	352,200	38,800
Asian	834,100	848,800	-14,700
European/other	3,167,400	3,046,200	121,200
Unknown	39,200	0	39,200
<b>Total (Note 1)</b>	<b>5,233,700</b>	<b>5,122,600</b>	<b>111,100</b>

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

## Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

## New Zealand population by ethnicity: HSU 2020 and Stats NZ PRP<sup>41</sup>

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	766,700	854,900	-88,200
Pacific peoples	367,900	346,600	21,300
Asian	734,700	840,300	-105,600
European/other	3,108,400	3,048,400	60,000
Unknown	22,800	0	22,800
<b>Total (Note 1)</b>	<b>5,000,500</b>	<b>5,090,200</b>	<b>-89,700</b>

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

40 HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

41 HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

## COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv<sup>42</sup> and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

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42 EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

## COVID-19 deaths by DHB of residence

The following outlines the total number of deaths associated to COVID-19 in Aotearoa by the DHB of residence at the time of death (as at 30 June 2022).

DHB of residence	No doses	Primary course <sup>43</sup>	Boosted <sup>44</sup>	Partial (single dose)	Total
Auckland	12	27	45	2	86
Bay of Plenty	7	13	32	1	53
Canterbury/ West Coast	29	25	125	4	183
Capital & Coast/Hutt	13	19	70	2	104
Counties Manukau	27	33	44	6	110
Hawke's Bay	3	9	15	1	28
Lakes	4	4	14	3	25
Mid Central	7	11	22	0	40
Nelson Marlborough	5	8	13	0	26
Northland	12	10	18	2	42
South Canterbury	1	1	9	0	11
Southern	12	12	60	0	84
Tairāwhiti	1	2	6	1	10
Taranaki	8	5	23	1	37
Waikato	25	28	69	1	123
Wairarapa	3	1	14	1	19
Waitematā	20	27	64	3	114
Whanganui	4	2	9	1	16
Unknown <sup>45</sup>	1	0	1	0	2
<b>Total</b>	<b>194</b>	<b>237</b>	<b>653</b>	<b>29</b>	<b>1,113</b>

43 'Primary course' is defined as a person receiving two doses of the COVID-19 vaccine.

44 'Boosted' is defined as a person receiving three doses of the COVID-19 vaccine.

45 'Unknown' is defined where the normal place of residence has not yet been identified.

## COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Aotearoa by age group at the time of death (as at 30 June 2022).

Age group (years)	No doses	Primary course <sup>46</sup>	Boosted <sup>47</sup>	Partial (single dose)	Total
<10	0	0	0	0	0
10 to 19	1	1	0	0	2
20 to 29	1	1	0	0	2
30 to 39	3	3	0	0	6
40 to 49	5	8	2	0	15
50 to 59	15	15	19	2	51
60 to 69	23	33	46	3	105
70 to 79	43	57	130	4	234
80 to 89	53	70	259	9	391
90+	50	49	197	11	307
<b>Total</b>	<b>194</b>	<b>237</b>	<b>653</b>	<b>29</b>	<b>1,113</b>

## COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Aotearoa by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	No doses	Primary course <sup>48</sup>	Boosted <sup>49</sup>	Partial (single dose)	Total
Asian	7	17	21	3	<b>48</b>
European/other	122	150	553	13	<b>838</b>
Māori	36	31	50	6	<b>123</b>
Pacific peoples	28	38	28	7	<b>101</b>
Unknown <sup>50</sup>	1	1	1	0	<b>3</b>
<b>Total</b>	<b>194</b>	<b>237</b>	<b>653</b>	<b>29</b>	<b>1,113</b>

46 'Primary course' is defined as a person receiving two doses of the COVID-19 vaccine.

47 'Boosted' is defined as a person receiving three doses of the COVID-19 vaccine.

48 'Primary course' is defined as a person receiving two doses of the COVID-19 vaccine.

49 'Boosted' is defined as a person receiving three doses of the COVID-19 vaccine.

50 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

## Financial performance

<b>Implementing the COVID-19 vaccine strategy</b>	<b>Actual 2020/21 \$000</b>	<b>Main estimates 2021/22 \$000</b>	<b>Voted appropriation 2021/22 \$000</b>	<b>Actual 2021/22 \$000</b>
<b>Departmental output expenses</b>				
<b>Supporting the implementation of the COVID-19 vaccine strategy</b>				
Crown revenue	48,990	23,850	205,786	205,786
Other revenue	–	–	–	–
Total revenue	48,990	23,850	205,786	205,786
Total expenses	44,838	23,850	205,786	191,565
Net surplus (deficit)	4,152	–	–	14,221
<b>Non-departmental output expenses</b>				
<b>Implementing the COVID-19 immunisation programme</b>				
Total expenses	95,438	182,700	797,949	805,283
<b>Purchasing potential and proven COVID-19 vaccines and other therapeutics</b>				
Total expenses	5,567	508,019	1,079,699	566,420
<b>Total MCA expenses</b>	<b>145,843</b>	<b>714,569</b>	<b>2,083,434</b>	<b>1,563,268</b>

Implementing the COVID-19 vaccine strategy MCA actual spend was higher than the original budget due the COVID-19 vaccination programme in 2021/22, the transition to an integrated national immunisation programme, additional costs for the ongoing public health system response to COVID-19, and to support the transfer of functions and resources from Vote Prime Minister and Cabinet to Interim Health New Zealand and Interim Māori Health Authority.

The Joint Ministers have approved in-principle expense transfers from 2021/22 to 2022/23 of up to:

- Implementing the COVID-19 immunisation programme - \$47.278 million
- Purchasing potential and proven COVID-19 vaccines and other therapeutics - \$472.552 million

The in-principle expense transfers will be confirmed as part of the 2022 October Baseline Update.

# Ministry of Health – Capital Expenditure

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

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.

## Performance assessment

Performance measure	Actual 2020/21	Budget Standard 2021/22	Actual 2021/22	At a glance
Expenditure is in accordance with the Ministry of Health’s capital asset management plan	Achieved	Achieved	Achieved	✓

## Financial performance

Ministry of Health – capital expenditure	Actual 2020/21 \$000	Main estimates 2021/22 \$000	Voted appropriation 2021/22 \$000	Actual 2021/22 \$000
Total appropriation	10,110	23,402	37,927	5,245

The actual capital spend reflects the revised expenditure phasing following the Ministry’s updates to the capital expenditure plans. Also, this year, substantial amount initially budgeted as capital was converted into operating expenditure due to the accounting policy changes required for software as a service implementation costs.

# Financial statements | Ngā taurangi pūtea



# Statement of Responsibility | Kupu Whakaū Haepapa

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 2022 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 2022 and its operations for the year ending on that date.



Dr Diana Sarfati  
Director-General of Health  
30 September 2022



Fergus Welsh  
Chief Financial Officer  
30 September 2022

## Independent Auditors Report

### To the readers of the Ministry of Health's annual report for the year ended 30 June 2022

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 106 to 140, that comprise the statement of financial position, statement of commitments, statement of contingent liabilities and contingent assets as at 30 June 2022, 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 2022 on pages 62 to 98 and 162 to 175;
- the statements of expenses and capital expenditure of the Ministry for the year ended 30 June 2022 on pages 150 to 153 and 158 to 159; and
- the schedules of non-departmental activities which are managed by the Ministry on behalf of the Crown on pages 141 to 149 and 154 to 157 that comprise:
  - the schedules of assets, liabilities, commitments, and contingent liabilities and assets as at 30 June 2022;
  - the schedules of expenses, and revenue for the year ended 30 June 2022;
  - 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 106 to 140:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2022; 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 Reporting Standards.
- the performance information of the Ministry on pages 62 to 98 and 162 to 175:
  - presents fairly, in all material respects, for the year ended 30 June 2022:
    - 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 150 to 153 and 158 to 159 are presented fairly, in all material respects, in accordance with the requirements of section 45A of the Public Finance Act 1989.
- the schedules of non-departmental activities which are managed by the Ministry on behalf of the Crown on pages 141 to 149 and 154 to 157 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 2022; and
  - expenses and revenue for the year ended 30 June 2022; and

Our audit was completed on 30 September 2022. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to the HSU population information used in reporting Covid-19 vaccine strategy performance results. 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.

### **Emphasis of matter – HSU population information was used in reporting Covid-19 vaccine strategy performance results**

Without modifying our opinion, we draw your attention to the ‘Further notes on the HSU dataset’ on pages 91 and 92 which outlines the information used by the Ministry to report on its Covid-19 vaccine coverage. The Ministry uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 92. This section outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity, age and District Health Board. The Ministry has provided a table on page 93 that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

### **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; and
- 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 Strategic Intentions 2021 to 2025, Estimates and Supplementary Estimates of Appropriations 2021/22 and 2021/22 forecast financial figures included in the Ministry 2020/21 Annual report.

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

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

- We identify and assess the risks of material misstatement of the information we audited, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Ministry's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Director-General of Health.
- We evaluate the appropriateness of the reported performance information within the Ministry's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Director-General of Health and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Ministry's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the information we audited or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Ministry to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the information we audited, including the disclosures, and whether the information we audited represents the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

## **Other information**

The Director-General of Health is responsible for the other information. The other information comprises the information included on pages iii to xii, 2 to 60, 100 and 176 to 258, 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: International 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 three assurance engagements over procurements and an agreed-upon procedures engagement of the Mental Health and Addictions Ringfence. These engagements are compatible with those independence requirements. Other than the audit and these engagements, we have no relationship with or interests in the Ministry.

A handwritten signature in blue ink, appearing to read 'S B Lucy', is positioned above the printed name.

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

## Statement of comprehensive revenue and expense for the year ended 30 June 2022

Restated actual 2021 \$000		Note	Actual 2022 \$000	Unaudited budget 2022 \$000	Unaudited forecast 2023 \$000
<b>Revenue</b>					
404,790	Revenue Crown	2	845,212	428,452	315,058
13,801	Other revenue	2	17,279	17,582	18,873
<b>418,591</b>	<b>Total revenue</b>		<b>862,491</b>	<b>446,034</b>	<b>333,931</b>
<b>Expenses</b>					
179,947	Personnel costs	3	230,635	205,890	114,689
6,079	Depreciation and amortisation expense	6, 7	5,275	10,519	4,670
2,288	Capital charge	4	2,932	2,951	1,658
200,072	Other expenses	5	482,397	226,674	212,914
<b>388,386</b>	<b>Total expenses</b>		<b>721,239</b>	<b>446,034</b>	<b>333,931</b>
<b>30,205</b>	<b>Net surplus/(deficit)</b>		<b>141,252</b>	-	-
<b>Other comprehensive revenue and expense</b>					
Item that will not be reclassified to net surplus/(deficit)					
965	Property revaluation		-	-	-
<b>965</b>	<b>Total other comprehensive revenue and expense</b>		<b>-</b>	<b>-</b>	<b>-</b>
<b>31,170</b>	<b>Total comprehensive revenue and expenses</b>		<b>141,252</b>	<b>-</b>	<b>-</b>

The accompanying notes form part of these financial statements.

## Statement of financial position as at 30 June 2022

Restated actual 2021 \$000	Note	Actual 2022 \$000	Unaudited budget 2022 \$000	Unaudited forecast 2023 \$000
<b>Equity</b>				
28,338		25,961	63,339	26,087
3,555		3,555	2,590	3,555
(6,002)	12	(7,339)	(6,002)	(7,339)
<b>25,891</b>	<b>11</b>	<b>22,177</b>	<b>59,927</b>	<b>22,303</b>
<b>Represented by:</b>				
<b>Assets</b>				
<b>Current assets</b>				
2,639	14	13,733	7,000	7,000
16,847	14	13,470	5,762	12,200
84,334	14	236,912	7,930	21,794
4,343		9,220	5,000	6,800
<b>108,163</b>		<b>273,335</b>	<b>25,692</b>	<b>47,794</b>
<b>Non-current asset</b>				
9,463	6	9,421	11,879	12,058
14,436	7	14,407	58,849	23,634
<b>23,899</b>		<b>23,828</b>	<b>70,728</b>	<b>35,692</b>
<b>132,062</b>		<b>297,163</b>	<b>96,420</b>	<b>83,486</b>
<b>Liabilities</b>				
<b>Current liabilities</b>				
52,737	8	106,915	22,842	46,302
34,264	9	142,589	–	–
–	10	–	345	1,579
17,328	10	23,760	11,580	11,460
<b>104,329</b>		<b>273,264</b>	<b>34,767</b>	<b>59,341</b>
<b>Non-current liabilities</b>				
1,842	10	1,722	1,726	1,842
<b>1,842</b>		<b>1,722</b>	<b>1,726</b>	<b>1,842</b>
<b>106,171</b>		<b>274,986</b>	<b>36,493</b>	<b>61,183</b>
<b>25,891</b>		<b>22,177</b>	<b>59,927</b>	<b>22,303</b>

The accompanying notes form part of these financial statements.

## Statement of changes in equity for the year ended 30 June 2022

Restated actual 2021 \$000		Note	Actual 2022 \$000	Unaudited budget 2022 \$000	Unaudited forecast 2023 \$000
16,476	Balance as at 1 July		25,891	49,914	22,303
30,205	Net surplus/(deficit)		141,252	–	–
965	Property revaluation		–	–	–
	<b>Owner transactions</b>				
(34,264)	Return of operating surplus to the Crown	9	(142,589)	–	–
12,509	Capital contribution – cash		4,349	10,013	943
–	Capital withdrawal		(6,726)	–	(943)
<b>25,891</b>	<b>Balance as at 30 June</b>		<b>22,177</b>	<b>59,927</b>	<b>22,303</b>

The accompanying notes form part of these financial statements.

## Statement of cash flows for the year ended 30 June 2022

Restated actual 2021 \$000		Actual 2022 \$000	Unaudited budget 2022 \$000	Unaudited forecast 2023 \$000
<b>Cash flows from operating activities</b>				
355,119	Receipts from revenue Crown	692,634	428,357	331,439
4,957	Receipts from other revenue	12,720	17,982	24,433
(167,209)	Payments to suppliers	(450,498)	(237,476)	(237,677)
(174,307)	Payments to employees	(224,323)	(196,523)	(109,220)
(2,288)	Payments for capital charge	(2,932)	(2,951)	(1,658)
(1,462)	Goods and services tax (net)	24,000	–	–
<b>14,810</b>	<b>Net cash flow from operating activities</b>	<b>51,601</b>	<b>9,389</b>	<b>7,317</b>
<b>Cash flows from investing activities</b>				
–	Receipts from sale of property, plant and equipment	28	4,000	4,000
(171)	Purchase of property, plant and equipment	(1,128)	(6,213)	(5,340)
(3,344)	Purchase of intangible assets	(2,766)	(17,189)	(72)
<b>(3,515)</b>	<b>Net cash flow from investing activities</b>	<b>(3,866)</b>	<b>(19,402)</b>	<b>(1,412)</b>
<b>Cash flows from financing activities</b>				
12,509	Capital injection	4,349	10,013	943
–	Capital withdrawal	(6,726)	–	(943)
(27,345)	Return of operating surplus	(34,264)	–	(5,905)
<b>(14,836)</b>	<b>Net cash flow from financing activities</b>	<b>(36,641)</b>	<b>10,013</b>	<b>(5,905)</b>
<b>(3,541)</b>	<b>Net increase in cash held</b>	<b>11,094</b>	<b>–</b>	<b>–</b>
6,180	Cash at the beginning of the year	2,639	7,000	7,000
<b>2,639</b>	<b>Cash at the end of the year</b>	<b>13,733</b>	<b>7,000</b>	<b>7,000</b>

The accompanying notes form part of these financial statements.

## Statement of cash flows for the year ended 30 June 2022 (continued)

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

Restated actual 2021 \$000		Actual 2022 \$000
<b>30,205</b>	<b>Net surplus/(deficit)</b>	<b>141,252</b>
	<b>Add/(less) non-cash items</b>	
6,079	Depreciation and amortisation expense	5,275
3,472	Impairment of work in progress intangibles	–
<b>9,551</b>	<b>Total non-cash items</b>	<b>5,275</b>
	<b>Add/(less) items classified as investing or financing activities</b>	
69	(Gains)/losses on disposal of property, plant and equipment	18
<b>69</b>	<b>Total items classified as investing or financing activities</b>	<b>18</b>
	<b>Add/(less) movements in working capital items</b>	
(9,975)	(Increase)/decrease in receivables	3,377
(49,671)	(Increase)/decrease in Debtor Crown	(152,578)
(325)	(Increase)/decrease in prepayments	(4,877)
29,317	Increase/(decrease) in payables*	52,822
(214)	Increase/(decrease) in provisions	–
5,853	Increase/(decrease) in employee entitlements	6,312
<b>(25,015)</b>	<b>Total movements in working capital items</b>	<b>(94,944)</b>
<b>14,810</b>	<b>Net cash flow from operating activities</b>	<b>51,601</b>

\* Payables for capital expenditure have been excluded when calculating the increase/decrease in the payables movement as they are relating to investing activities.

The accompanying notes form part of these financial statements.

## Statement of cash flows for the year ended 30 June 2022 (continued)

### Reconciliation of net cash flow from financing activities

Actual 2021 \$000		Actual 2022 \$000
	<b>Movement in liability arising from financing activities</b>	
6,919	Increase/(decrease) in return of operating surplus liability	108,325
<b>6,919</b>	<b>Total movement in liability arising from financing activities</b>	<b>108,325</b>
	<b>Non-cash item</b>	
(34,264)	Operating surplus to be paid to the Crown in 2022/23	(142,589)
<b>(34,264)</b>	<b>Total non-cash item</b>	<b>(142,589)</b>
	<b>Add/(less) owner's contribution and withdrawal</b>	
12,509	Capital contribution	4,349
–	Capital withdrawal	(6,726)
<b>12,509</b>	<b>Net owner's contribution and withdrawal</b>	<b>(2,377)</b>
<b>(14,836)</b>	<b>Net cash flow from financing activities</b>	<b>(36,641)</b>

The accompanying notes form part of these financial statements.

## Statement of commitments as at 30 June 2022

### Capital commitments

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

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

### Non-cancellable operating lease commitments

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

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

Actual 2021 \$000		Actual 2022 \$000
	<b>Capital commitments</b>	
1,078	Intangible assets	–
<b>1,078</b>	<b>Total capital commitments</b>	<b>–</b>
	<b>Operating leases as lessee</b>	
	Future aggregate lease payments to be paid under non-cancellable operating leases are as follows:	
10,300	Not later than one year	11,500
35,507	Later than one year and not later than five years	35,832
41,159	Later than five years	32,969
<b>86,966</b>	<b>Total non-cancellable operating lease commitments</b>	<b>80,301</b>
<b>88,044</b>	<b>Total commitments</b>	<b>80,301</b>

Note: Some functions of the Ministry will move to Te Whatu Ora | Health New Zealand and/or Te Aka Whai Ora | Māori Health Authority from 1 July 2022. It is likely that the responsibility for some leased premises where relevant business functions are carried out will also transfer therefore reducing the Ministry's non-cancellable operating lease commitments from 2023 onwards. Refer to note 16 for more details.

The accompanying notes form part of these financial statements.

The Ministry has medium to long-term leases on its premises in Auckland, Christchurch, Dunedin, Hamilton, Whanganui, Palmerston North 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 2022**

The Ministry is defending a small number of legal disputes involving past employees for which a potential liability has not yet been quantified as at 30 June 2022.

The Ministry had no other contingent liabilities as at 30 June 2022 (2021: \$nil).

The Ministry had no contingent assets as at 30 June 2022 (2021: \$nil).

The accompanying notes form part of these financial statements.

# Notes to the financial statements for the year ended 30 June 2022

## 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 and employee entitlements
11. Equity
12. Memorandum accounts
13. Related party transactions
14. Financial instruments
15. Departmental agency results – Cancer Control Agency, interim Te Whatu Ora | Health New Zealand, interim Te Aka Whai Ora | Māori Health Authority
16. Events after balance date

## 1 Statement of accounting policies

### Reporting entity

The Ministry of Health (the Ministry) is a government department as defined by section 5 of the Public Service Act 2020 and is domiciled and operates in New Zealand. The relevant legislation governing the Ministry's operations includes the Public Finance Act 1989 (PFA), Public Service Act 2020, and the New Zealand Public Health and Disability Act 2000. The Ministry's ultimate parent is the New Zealand Crown.

The financial statements of the Ministry for the year ended 30 June 2022 are consolidated financial statements including the Ministry, Cancer Control Agency, interim Te Whatu Ora | Health New Zealand, and interim Te Aka Whai Ora | Māori Health Authority. The Cancer Control Agency (established 1 December 2019), interim Te Whatu Ora | Health New Zealand and interim Te Aka Whai Ora | Māori Health Authority (both established 1 September 2021) are departmental agencies as defined by section 2 of the PFA and section 5 of the Public Service Act 2020, which are hosted within the Ministry. Unless explicitly stated, references to the Ministry cover the Ministry and the departmental agencies (see note 15).

In addition, the Ministry has reported on Crown activities that it administers in the non-departmental statements and schedules on pages 141 to 157.

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 has designated itself as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP).

The financial statements are for the year ended 30 June 2022 and were approved for issue by the Director-General of Health on 30 September 2022.

### **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 GAAP 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).

### **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.

### **Changes in accounting policies**

The policy applied to account for costs to customise and configure a software under as a service (SaaS) arrangement has changed during the year. In April 2021, the International Financial Reporting Interpretations Committee issued final agenda decision on how to account for SaaS-related expenditure. The agenda decision clarified that a customer does not normally recognise an intangible asset based on the requirement of PBE IPSAS 31 Intangible Assets where a supplier controls the application software to which a customer accesses in a SaaS arrangement. The change means that the Ministry's costs to customise and configure a SaaS software should be recognised in surplus or deficit. Prior year results have been retrospectively adjusted to account for this change.

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

Below tables represent the impact of the changes before and after restatement:

### Statement of financial performance for the year ended 30 June 2021

	After restatement \$000	Before restatement \$000	Increase / (decrease) \$000
<b>Expenses</b>			
Depreciation and amortisation expense	6,079	10,864	(4,785)
Other expenses	200,072	193,477	6,595
<b>Changes in net surplus/(deficit)</b>	<b>(206,151)</b>	<b>(204,341)</b>	<b>(1,810)</b>

### Statement of financial position as at 30 June 2021

	After restatement \$000	Before restatement \$000	Increase / (decrease) \$000
<b>Net assets</b>			
Intangible assets	14,436	42,228	(27,792)
<b>Changes in net assets</b>	<b>14,436</b>	<b>42,228</b>	<b>(27,792)</b>

### Statement of changes in equity for the year ended 30 June 2021

	After restatement \$000	Before restatement \$000	Increase / (decrease) \$000
Balance as at 1 July	16,476	42,458	(25,982)
Net surplus/(deficit)	30,205	32,015	(1,810)
Property revaluation	965	965	-
<b>Owner transactions</b>			
Return of operating surplus to the Crown	(34,264)	(34,264)	-
Capital contribution - cash	12,509	12,509	-
<b>Balance as at 30 June</b>	<b>25,891</b>	<b>53,683</b>	<b>(27,792)</b>

### Statement of cash flows for the year ended 30 June 2021

	After restatement \$000	Before restatement \$000	Increase / (decrease) \$000
Payments to suppliers	(167,209)	(160,614)	(6,595)
<b>Changes in cash flow from operating activities</b>	<b>(167,209)</b>	<b>(160,614)</b>	<b>(6,595)</b>
Purchase of intangible assets	(3,344)	(9,939)	6,595
<b>Changes in cash flow from investing activities</b>	<b>(3,344)</b>	<b>(9,939)</b>	<b>6,595</b>

## Statement of cash flows for the year ended 30 June 2021

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

	After restatement \$000	Before restatement \$000	Increase / (decrease) \$000
Net surplus/(deficit)	30,205	32,015	(1,810)
Depreciation and amortisation expense	6,079	10,864	(4,785)
<b>Changes in net cash flow from operating activities</b>	<b>36,284</b>	<b>42,879</b>	<b>(6,595)</b>

### Accounting standard effective 30 June 2022

An amendment to PBE IPSAS 2 Cash Flow Statements require entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash and non-cash changes. The new information required by this amendment has been presented in the reconciliation of net cash flow from financing activities on page 111.

### Standards issued, 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:

#### PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Ministry has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The Ministry has decided not to early adopt the standard.

#### PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with early adoption permitted. The Ministry has determined the main impact of the new standard is that additional information will need to be disclosed and those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

### 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.

Cash and cash equivalents are subject to the expected loss requirements of PBE IFRS 9.

However, no loss allowance has been recognised because the estimated loss allowance for credit losses is considered to be nil or trivial.

## Receivables

Short-term receivables are measured at amortised cost and recorded at the amount less any provision for uncollectability and an allowance for credit losses as per the requirements of PBE IFRS 9. No adjustment for credit losses has been made as the estimated loss allowance is considered to be nil or trivial.

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, Inland Revenue is included as part of receivables or payables in the statement of financial position. The net GST paid to or received from Inland Revenue, 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 2021/22 budget figures are for the year ended 30 June 2022 and were published in the 2021 Annual Report. They are consistent with the Ministry's best estimate at the time for financial forecast information submitted to the Treasury for the Budget Economic and Fiscal Update (BEFU) for the year ended 2021/22.

### Basis of the forecast figures

The 2022/23 forecast figures are for the year ending 30 June 2023, which are consistent with the best estimate at the time for the BEFU forecast financial information submitted to the Treasury for the year ending 2022/23.

The forecast financial statements have been prepared as required by the PFA to communicate forecast financial information for accountability purposes. The 30 June 2023 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 Director-General as Chief Executive of the Ministry 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 14 April 2022.

While the Ministry regularly updates its forecasts, updated forecast financial statements for the year ending 30 June 2023 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 2022/23 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 14 April 2022, were as follows:

- the Ministry's activities and output expectations for 2022/23 have changed substantially reflecting the implementation of the Government's health and disability system reforms which include:
  - the establishment of new agencies: Te Whatu Ora | Health New Zealand, Te Aka Whai Ora | Māori Health Authority
  - the establishment of the Public Health Agency, a distinct business unit within the Ministry
  - the transfer of disability support services related funding to Vote Social Development for the ongoing operation of Whaikaha – Ministry of Disabled People, a new departmental agency within the Ministry of Social Development, to support tangata whaikaha Māori and disabled people
- personnel costs were based on current wages and salary costs adjusted for anticipated remuneration changes and anticipated workforce changes as a result of the impact of the health and disability system reform and new initiatives
- operating costs were based on historical experience and other factors, including the forecast impact of the health and disability system reform, that are believed to be reasonable in the circumstances and are the Ministry's best estimate of future costs that will be incurred
- the estimated year-end closing financial position information for 2021/22 was used as the opening position for the 2022/23 forecasts.

The actual financial results achieved for 30 June 2023 are likely to vary from the forecast information presented and the variance may be material. Factors that may lead to a material difference between information in these forecast financial statements and the actual reported results include changes to the budget that may be approved by Cabinet during 2022/23 and reflected in the Vote Health 2022/23 Supplementary Estimates, technical adjustments to (including transfers between) financial years, material deviation between anticipated and actual business functions and associated assets and liabilities balances that will be transferred to Te Whatu Ora, Te Aka Whai Ora, or Whaikaha, and the 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 the 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 of \$845.212 million (2021: \$404.790 million).

### 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.

### Other revenue

Actual 2021 \$000		Actual 2022 \$000
9,970	Medicines registration	10,092
2,686	Annual licence and registration fees	4,425
1,145	Other revenue	2,762
<b>13,801</b>	<b>Total other revenue</b>	<b>17,279</b>

### Explanation of major variances against budget

Revenue Crown was \$416.760 million higher than budget due to additional operating costs for COVID-19 vaccine strategies and national response to COVID-19 (\$228.136 million), health and disability system reform (\$5.020 million), health sector information systems additional funding (\$168.628 million) for various technology requirements relating to maintenance and enhancement of COVID-19 technology and the development of a number of new information technology initiatives, accounting policy changes on SaaS converting capital to operating costs, development of national immunisation solution, and a number of immaterial funding adjustments. These variances were expected and the changes were outlined and included in the 2021/22 Vote Health Supplementary Estimates (Revised budget).

## 3 Personnel costs

### Accounting policy

#### Salaries and wages

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

### Superannuation schemes

#### Defined contribution schemes

Employer contributions to the State Sector Retirement Savings Scheme, KiwiSaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are expensed in surplus or deficit as incurred.

<b>Actual 2021 \$000</b>		<b>Actual 2022 \$000</b>
166,070	Salaries and wages	214,987
4,879	Employer contributions to defined contribution plans	6,156
5,853	Increase/(decrease) in employee entitlements	6,239
3,145	Other personnel costs	3,253
<b>179,947</b>	<b>Total personnel costs</b>	<b>230,635</b>

### Explanation of major variances against budget

Personnel costs were \$24.745 million higher than the budget due to additional resources required for the health and disability system reform, response to COVID-19, and higher than anticipated annual leave expenses due to COVID-19.

## 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 balance (adjusted for memorandum accounts) as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2022 was 5.0% (2021: 5.0%).

## 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 expenses as goods and services are received.

### Other expenses

Restated actual 2021 \$000		Actual 2022 \$000	Unaudited budget 2022 \$000	Unaudited forecast 2023 \$000
560	Fees to Audit New Zealand for audit of financial statements	665	470	735
–	Fees to Audit New Zealand for other assurance services	136	–	–
242	Payment made for Auditor-General's costs for COVID-19 vaccination report	–	–	–
54,235	Contractors and consultants	150,092	77,564	110,117
9,423	Professional specialist fees	29,373	19,362	10,000
2,351	Sector and public consultations	1,846	7,156	2,000
88,522	Computer services	229,105	76,317	46,562
8,578	Advertising	31,409	416	8,000
13,173	Operating lease payments	15,770	14,769	15,806
3,557	Occupancy costs other than leases	4,269	3,779	4,000
7,705	Communications and couriers	10,334	10,694	8,005
1,809	Printing and stationery	2,384	1,597	3,072
2,786	Travel	3,184	4,006	1,157
3,472	Impairment of work in progress intangibles	–	–	–
69	Net loss on sale/disposal of property, plant and equipment	18	–	–
3,590	Other expenses	3,812	10,544	3,460
<b>200,072</b>	<b>Total other expenses</b>	<b>482,397</b>	<b>226,674</b>	<b>212,914</b>

### Explanation of major variances against budget

Other expenses were \$255.723 million higher than the budget due to additional contractors and consultant (\$72.528 million) required for the health and disability systems reforms including the establishment of the interim Te Whatu Ora | Health New Zealand and interim Te Aka Whai Ora | Māori Health Authority departmental agencies, additional costs (\$30.993 million) required for COVID-19 vaccine strategies including advertising and awareness campaigns, and the development of a national immunisation solution. Information technology costs were \$152.788 million higher than budget to support the implementation of an ecosystem of data and digital services that enables access to a virtual electronic health record (Hira), cyber security, managing COVID-19 in the community, and the changes in SaaS accounting policy which now requires the configuration and customisation costs of a SaaS arrangement to be expensed rather than capitalised.

## 6 Plant, property and equipment

### Accounting policy

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

Land is measured at fair value. 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
Motor vehicles	5 years	20%
Furniture, plant and equipment	5–10 years	10–20%
Leasehold improvements	5–10 years	10–20%
Computer hardware	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.

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 surplus or deficit. When a revalued asset is sold, the amount included in the property revaluation reserve in respect of the disposed asset is transferred to taxpayers' funds.

## Subsequent costs

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

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

## Revaluations

Land is revalued with sufficient regularity to ensure that the carrying amount does not differ materially from its fair value. Land is revalued at least every three years.

The carrying value of the revalued asset is assessed annually to ensure that it does not differ materially from fair value. If there is a material difference, then the off-cycle asset class revaluation is carried out.

Revaluation movement is accounted for on a class-of-asset basis.

The net revaluation result is credited or debited to other comprehensive revenue and expense and is accumulated to an asset revaluation reserve in equity for that class-of-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 surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in surplus or deficit will be recognised first in surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense. A revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs.

## Impairment

Property, plant and equipment 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 surplus or deficit, unless the asset belongs to a class that are measured using the revaluation model. Reversal of an impairment loss is recognised in surplus or deficit.

## Movement of property, plant and equipment

The land which is at 108 Victoria Street, Christchurch was valued by Telfer Young, an independent valuer on 30 June 2021. The building on the land was damaged and had been derecognised as a result of the 2011 Christchurch earthquake.

	Land \$000	Leasehold improvements \$000	Furniture plant and equipment \$000	Motor vehicles \$000	Computer hardware \$000	Total \$000
<b>Cost or valuation</b>						
Balance as at 1 July 2020	5,350	5,271	1,622	373	3,100	15,716
Additions	–	–	467	–	106	573
Revaluation	965	–	–	–	–	965
Disposals	–	–	(114)	(30)	(1,465)	(1,609)
<b>Balance as at 30 June 2021</b>	<b>6,315</b>	<b>5,271</b>	<b>1,975</b>	<b>343</b>	<b>1,741</b>	<b>15,645</b>
Balance as at 1 July 2021	6,315	5,271	1,975	343	1,741	15,645
Additions	–	317	126	242	1	686
Disposals	–	–	(115)	(133)	(470)	(718)
<b>Balance as at 30 June 2022</b>	<b>6,315</b>	<b>5,588</b>	<b>1,986</b>	<b>452</b>	<b>1,272</b>	<b>15,613</b>
<b>Accumulated depreciation and impairment losses</b>						
Balance as at 1 July 2020	–	2,433	1,296	298	2,993	7,020
Depreciation expense	–	527	113	–	63	703
Eliminate on disposal	–	–	(88)	(24)	(1,429)	(1,541)
<b>Balance as at 30 June 2021</b>	<b>–</b>	<b>2,960</b>	<b>1,321</b>	<b>274</b>	<b>1,627</b>	<b>6,182</b>
Balance as at 1 July 2021	–	2,960	1,321	274	1,627	6,182
Depreciation expense	–	488	125	30	47	690
Eliminate on disposal	–	–	(103)	(107)	(470)	(680)
<b>Balance as at 30 June 2022</b>	<b>–</b>	<b>3,448</b>	<b>1,343</b>	<b>197</b>	<b>1,204</b>	<b>6,192</b>
<b>Total property, plant and equipment including WIP</b>						
At 30 June 2020	5,350	2,838	326	75	107	8,696
At 30 June 2021	6,315	2,311	654	69	114	9,463
<b>At 30 June 2022</b>	<b>6,315</b>	<b>2,140</b>	<b>643</b>	<b>255</b>	<b>68</b>	<b>9,421</b>

## Work in Progress (WIP)

As at 30 June 2022 WIP costs incurred to date of \$0.317 million relates to compliance for storage of radioactive waste (2021: \$0.434 million for refurbishing the Whanganui warehouse, these were completed and capitalised in 2021/22).

## Restrictions

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 the 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 surplus or deficit. The useful lives and associated rates of major classes of intangible assets have been estimated as follows:

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

### Impairment

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

## Critical accounting estimates and assumptions

### Useful lives of software

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

### Software as a service

The Ministry exercises judgement in capitalising costs incurred in implementing SaaS. Generally, the costs incurred in configuring and customising software under a SaaS arrangement are expensed in the period they are incurred. SaaS costs that are identifiable, generate future economic benefits and the Ministry can demonstrate control over the asset are capitalised when incurred.

Costs of configuring and customising commercial off-the-shelf software are capitalised.

### Movement of intangible assets

	Acquired software \$000	Internally generated software \$000	Total \$000
<b>Cost</b>			
Balance as at 1 July 2020 (restated)	20,131	82,553	102,684
Additions (restated)	–	1,766	1,766
Impairment	–	(3,472)	(3,472)
<b>Balance as at 30 June 2021 (restated)</b>	<b>20,131</b>	<b>80,847</b>	<b>100,978</b>
Balance as at 1 July 2021 (restated)	20,131	80,847	100,978
Additions	81	4,480	4,561
Disposals	(1,531)	(4,684)	(6,215)
<b>Balance as at 30 June 2022</b>	<b>18,681</b>	<b>80,643</b>	<b>99,324</b>
<b>Accumulated amortisation and impairment losses</b>			
Balance as at 1 July 2020 (restated)	19,629	61,537	81,166
Amortisation expense (restated)	148	5,228	5,376
<b>Balance as at 30 June 2021 (restated)</b>	<b>19,777</b>	<b>66,765</b>	<b>86,542</b>
Balance as at 1 July 2021 (restated)	19,777	66,765	86,542
Amortisation expense	50	4,535	4,585
Eliminate on disposal	(1,524)	(4,686)	(6,210)
<b>Balance as at 30 June 2022</b>	<b>18,303</b>	<b>66,614</b>	<b>84,917</b>
<b>Total intangible assets including WIP</b>			
At 30 June 2020 (restated)	502	21,016	21,518
At 30 June 2021 (restated)	354	14,082	14,436
<b>At 30 June 2022</b>	<b>378</b>	<b>14,029</b>	<b>14,407</b>

## Work in Progress

The Ministry has a number of IT projects in progress, mainly relating to Hira, resulting in work in progress of \$6.269 million (2021: \$2.251 million restated).

## Restrictions

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

## Explanation of major variances against budget

Intangible assets were \$44.442 million lower than budget which reflected the changes in accounting policy for SaaS. Last year's intangible assets were reduced by \$27.792 million while current year SaaS spend was recognised under computer services in other expenses rather than intangible assets.

## 8 Payables

### Accounting policy

Short-term payables are measured at the amount payable.

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

<b>Actual 2021 \$000</b>		<b>Actual 2022 \$000</b>
3,538	Creditors	1,909
3,302	Revenue in advance	3,459
42,754	Accrued expenses	74,404
3,143	GST payable	27,143
<b>52,737</b>	<b>Total payables</b>	<b>106,915</b>

## Explanation of major variances against budget

Payables were \$84.073 million higher than the budget due to higher accrued expenses at the end of the year as a result of higher expenses this year compared to the original budget and suppliers' invoices not received and settled by 30 June 2022. Furthermore, GST payable was higher due to higher Crown revenue recognised at the end of the year and lower expenses than anticipated, therefore GST output materially exceeding GST input.

## 9 Return of operating surplus

<b>Restated Actual 2021 \$000</b>		<b>Actual 2022 \$000</b>
30,205	Net surplus/(deficit)	141,252
	Add:	
2,249	(Surplus)/deficit of memorandum accounts	1,337
1,810	Impact of changes in accounting for SaaS	–
34,264	Total operating surplus/(deficit)	142,589
<b>34,264</b>	<b>Total return of operating surplus</b>	<b>142,589</b>

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

## 10 Provisions and employee entitlements

### 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.

No provision was recognised as at 30 June 2022 (2021: nil).

### 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 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.

<b>Actual 2021 \$000</b>		<b>Actual 2022 \$000</b>
	<b>Current position</b>	
12,910	Annual leave	16,704
865	Retirement and long service leave	1,135
3,553	Accrued salaries	5,921
<b>17,328</b>	<b>Total current portion</b>	<b>23,760</b>
	<b>Non-current portion</b>	
1,842	Retirement and long service leave	1,722
<b>1,842</b>	<b>Total non-current portion</b>	<b>1,722</b>
<b>19,170</b>	<b>Total employee entitlements</b>	<b>25,482</b>

## 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 3.34% (2021: 0.38%) 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 \$19,450 higher/lower (2021: \$13,840 higher/lower).

If the salary inflation rates were to differ by below percentages from the Ministry's estimates, with all other factors held constant, the carrying amount of the total liability and the surplus or deficit would increase/(decrease) by:

	+/-1% \$000	+/-3% \$000	+5% \$000
Movement	+/-28	+/-83	+139

### Explanation of major variances against budget

Employee entitlements were \$12.176 million higher than budget due to additional employees required for the health and disability system reform and higher than anticipated annual leave expenses and lower leave taken due to COVID-19, resulting in increased annual leave, Holidays Act and long service leave liabilities, and accrued salaries.

## 11 Equity

### Accounting policy

Equity is the Crown's investment in the Ministry and is measured as the difference between total assets and total liabilities (net assets).

### Capital management

The Ministry's capital is its equity, which comprise taxpayers' funds, memorandum accounts, and property revaluation reserve.

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, 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

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 reserve

Property revaluation reserve is the result of land revaluation to fair value.

Restated actual 2021 \$000		Actual 2022 \$000
<b>Taxpayers' funds</b>		
17,639	Balance as at 1 July	28,338
30,205	Net surplus/(deficit)	141,252
2,249	Transfer of memorandum account net deficit for the year	1,337
(34,264)	Return of operating surplus to the Crown	(142,589)
12,509	Capital injection	4,349
–	– Capital withdrawal	(6,726)
<b>28,338</b>	<b>Balance as at 30 June</b>	<b>25,961</b>
<b>Property revaluation reserve</b>		
2,590	Balance as at 1 July	3,555
965	Revaluation gains on land	–
<b>3,555</b>	<b>Balance as at 30 June</b>	<b>3,555</b>
<b>Memorandum accounts</b>		
(3,753)	Balance as at 1 July	(6,002)
(2,249)	Net memorandum account deficits for the year	(1,337)
<b>(6,002)</b>	<b>Balance as at 30 June</b>	<b>(7,339)</b>
<b>25,891</b>	<b>Total equity</b>	<b>22,177</b>

## 12 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

To recover the deficit memorandum account balance from fees revenue in future years, the Ministry has undertaken fees reviews, and is completing consultation on proposed fees changes. It is expected new fee schedules will be introduced in 2022/23.

	Problem Gambling*	Office of Radiation Safety	Medsafe	Medicinal Cannabis	Vaping	Total
	\$000	\$000	\$000	\$000	\$000	\$000
Balance as at 1 July 2020	(707)	(675)	(2,485)	114	–	(3,753)
Revenue	–	928	9,577	570	–	11,075
Expenditure	–	(1,670)	(9,695)	(806)	(1,153)	(13,324)
<b>Balance as at 30 June 2021</b>	<b>(707)</b>	<b>(1,417)</b>	<b>(2,603)</b>	<b>(122)</b>	<b>(1,153)</b>	<b>(6,002)</b>
Balance as at 1 July 2021	(707)	(1,417)	(2,603)	(122)	(1,153)	(6,002)
Revenue	–	1,016	9,772	477	1,774	13,039
Expenditure	–	(1,750)	(10,198)	(1,059)	(1,369)	(14,376)
<b>Balance as at 30 June 2022</b>	<b>(707)</b>	<b>(2,151)</b>	<b>(3,029)</b>	<b>(704)</b>	<b>(748)</b>	<b>(7,339)</b>

\* The Problem Gambling memorandum account was disestablished in 19/20. The Ministry is in the process to seek approval from the Crown to close the deficit balance of the account. Revenue collected and expenditure incurred in relation to problem gambling services are disclosed in the 'Problem Gambling Revenue Report' on page 146.

## 13 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 conditions 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 2021 \$000	Actual 2022 \$000
<b>Leadership team</b>	
6,795 Remuneration	7,579
19 Full-time equivalent staff	20

The leadership team also includes the Director General.

The above key management personnel disclosure excludes the Minister of Health and Minister for COVID-19 Response. 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.

The remuneration of the leadership team includes contributions to defined contribution plans and non-monetary benefit provided (car parks). The non-monetary benefit has been measured using the recovery rate that is applicable for other employees who avail car parks in the Wellington office.

## 14 Financial instruments

### Categories of financial instruments

The carrying amounts of financial assets and financial liabilities in each of the financial instrument categories are as follows:

Actual 2021 \$000		Actual 2022 \$000
<b>Financial assets measured at amortised cost</b>		
2,639	Cash and cash equivalents	13,733
16,847	Receivables	13,470
84,334	Debtor Crown	236,912
<b>103,820</b>	<b>Total financial assets measured at amortised cost</b>	<b>264,115</b>
<b>Financial liabilities measured at amortised cost</b>		
46,292	Payables	76,313
34,264	Return of operating surplus	142,589
<b>80,556</b>	<b>Total financial liabilities measured at amortised cost</b>	<b>218,902</b>

### Financial instruments risks

The Ministry's activities expose it to a variety of financial instrument risk, credit risk and liquidity risk. The Ministry has policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow the Ministry to enter into transactions that are speculative in nature.

#### Market risk

##### Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in foreign currency exchange rates.

Foreign currency denominated transactions are not material. Therefore, the impact of the Ministry's exposure to currency risk is minimal.

### Credit risk

Credit risk is the risk that a third party will default on its obligations to the Ministry, causing a loss to be incurred.

In the Ministry's normal course of its business, credit risk arises from Debtor Crown, receivables and cash and cash equivalents.

The Ministry's credit risk is concentrated with the Crown and other government agencies but not with any individual agencies. The carrying amount of financial assets best represents the Ministry's maximum exposure to credit risk at balance date.

### Interest rate risk

Interest rate risk is the risk that the fair value of a financial instrument will fluctuate, or the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

The Ministry has no interest-bearing financial instruments, therefore, it has no exposure to interest rate risk.

### Liquidity risk

Liquidity risk is the risk that the Ministry will encounter difficulty raising liquid funds as they fall due.

As part of meeting its liquidity requirements, the Ministry closely monitors its forecast cash requirements with expected cash drawdowns from the Treasury Capital Markets. The Ministry maintains a target level of available cash to meet liquidity requirements.

### Contractual maturity analysis of financial liabilities

The table below analyses the Ministry's financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows.

	Carrying amount	Total contractual cash flows	Less than 6 months	6 months to 1 year	1-5 years
	\$000	\$000	\$000	\$000	\$000
Payables	76,313	76,313	76,313	-	-
Return of operating surplus	142,589	142,589	142,589	-	-
<b>Balance as at 30 June 2022</b>	<b>218,902</b>	<b>218,902</b>	<b>218,902</b>	-	-
Payables	46,292	46,292	46,292	-	-
Return of operating surplus	34,264	34,264	34,264	-	-
<b>Balance as at 30 June 2021</b>	<b>80,556</b>	<b>80,556</b>	<b>80,556</b>	-	-

## 15 Departmental agency results

### 15.1 Te Aho o Te Kahu | Cancer Control Agency

On 28 August 2019, Cabinet approved the establishment of Te Aho o Te Kahu | Cancer Control Agency as a departmental agency, hosted by the Ministry.

The Order in Council also named the Cancer Control Agency as a department agency within the Ministry under Schedule 1A of the then State Sector Act 1988 with effect from 1 December 2019.

The nature of this arrangement means while the agency is a separate departmental operating unit within the Ministry, it is functionally independent, with separate ministerial reporting lines and Chief Executive. The Ministry's financial statements include the operations of the Cancer Control Agency, and 2020/21 is the first full year of operation for the agency.

The Cancer Control Agency is funded within Vote Health baselines.

In summary its financial performance for the year ended 30 June 2022 was as follows:

Actual 2021 \$000		Actual 2022 \$000
<b>Departmental activities</b>		
11,031	Revenue	10,512
<b>11,031</b>	<b>Revenue Crown</b>	<b>10,512</b>
<b>Expenses</b>		
5,225	Personnel costs	7,325
1,810	Other expenses	972
<b>7,035</b>	<b>Total expenses</b>	<b>8,297</b>
<b>3,996</b>	<b>Net surplus/(deficit)</b>	<b>2,215</b>
<b>Non-departmental activities</b>		
1,795	Appropriation: National personal health services	2,272
<b>1,795</b>	<b>Total non-departmental expenditure</b>	<b>2,272</b>

### 15.2 Interim Te Whatu Ora | Health New Zealand

On 1 September 2021, Cabinet approved the establishment of Te Whatu Ora | Health New Zealand as a departmental agency, hosted by the Ministry.

The Order in Council titled the Public Service (Health New Zealand and Māori Health Authority) Order 2021 named Te Whatu Ora | Health New Zealand as a department agency within the Ministry under Schedule 2, Part 2 of the Public Service Act 2020. Interim Te Whatu Ora | Health New Zealand has been established to undertake detailed planning, organisational work, and consultation in relation to the implementation of the health and disability system reforms.

Te Whatu Ora | Health New Zealand has been established as interim departmental agency within the Ministry until the permanent entity comes into effect from 1 July 2022. The purpose of the interim agency is to help drive the development of the permanent entity and its role within a newly transformed system.

The nature of this arrangement means while the agency is a separate departmental operating unit within the Ministry, it is functionally independent, with separate ministerial reporting lines and Chief Executive.

The Ministry's financial statements include the operations of interim Te Whatu Ora | Health New Zealand.

Interim Te Whatu Ora | Health New Zealand is funded within Vote Health baselines. The appropriation Minister directed under section 7C(2)(c)(i) of the Public Finance Act 1989 for the interim Te Whatu Ora | Health New Zealand to use the relevant categories of the Health and Disability System Reform Multi Category Appropriation (MCA) from 1 September 2021 to 30 June 2022.

In summary its financial performance for the year ended 30 June 2022 was as follows:

### Statement of financial performance for the year ended 30 June 2022

	Actual 2022 \$000	Unaudited budget 2022 \$000
<b>Departmental activities</b>		
Revenue	25,495	21,495
<b>Revenue Crown</b>	<b>25,495</b>	<b>21,495</b>
<b>Expenses</b>		
Personnel costs	3,656	4,855
Other expenses	18,425	16,640
<b>Total expenses</b>	<b>22,081</b>	<b>21,495</b>
<b>Net surplus/(deficit)</b>	<b>3,414</b>	<b>-</b>
<b>Non-departmental activities</b>		
Locality networks	-	9,642
<b>Total non-departmental expenditure</b>	<b>-</b>	<b>9,642</b>

### 15.3 Interim Te Aka Whai Ora | Māori Health Authority

On 1 September 2021, Cabinet approved the establishment of Te Aka Whai Ora | Māori Health Authority as a departmental agency, hosted by the Ministry.

The Order in Council titled the Public Service (Health New Zealand and Māori Health Authority) Order 2021 named Te Aka Whai Ora | Māori Health Authority as a department agency within the Ministry under Schedule 2, Part 2 of the Public Service Act 2020. Interim Te Aka Whai Ora | Māori Health Authority has been established to undertake detailed planning, organisational work, and consultation in relation to the implementation of health and disability system reforms.

Interim Te Aka Whai Ora | Māori Health Authority has been established as an interim departmental agency within the Ministry until the permanent entity comes into effect from 1 July 2022. The purpose of the interim agency is to help drive the development of permanent entity and its role within a newly transformed system.

The nature of this arrangement means while the agency is a separate departmental operating unit within the Ministry, it is functionally independent, with separate ministerial reporting lines and Chief Executive.

The Ministry's financial statements include the financial operations of interim Te Aka Whai Ora | Māori Health Authority.

Interim Te Aka Whai Ora | Māori Health Authority is funded within Vote Health baselines. The appropriation Minister directed under section 7C(2)(c)(i) of the Public Finance Act 1989 for the Interim Te Aka Whai Ora | Māori Health Authority to use the relevant categories of the Health and Disability System Reform Multi Category Appropriation (MCA) from 1 September 2021 to 30 June 2022.

In summary its financial performance for the year ended 30 June 2022 was as follows:

### Statement of financial performance for the year ended 30 June 2022

	Actual 2022 \$000	Unaudited budget 2022 \$000
<b>Departmental activities</b>		
Revenue	24,139	23,119
<b>Revenue Crown</b>	<b>24,139</b>	<b>23,119</b>
<b>Expenses</b>		
Personnel costs	2,894	3,532
Other expenses	4,766	19,587
<b>Total expenses</b>	<b>7,660</b>	<b>23,119</b>
<b>Net surplus/(deficit)</b>	<b>16,479</b>	<b>-</b>
<b>Non-departmental activities</b>		
Hauora Māori	8,760	17,396
<b>Total non-departmental expenditure</b>	<b>8,760</b>	<b>17,396</b>

## 16 Events after balance date

As a result of the health and disability system reform, some functions of the Ministry were transferred to Te Whatu Ora | Health New Zealand, Te Aka Whai Ora | Māori Health Authority and Whaikaha | Ministry for Disabled People from 1 July 2022.

The changes to the health system are considered the most significant and the biggest in 21 years. The Government's intention is to build a stronger health and disability system that delivers for all New Zealanders. Its aim is to strengthen New Zealand's health system into a single nationwide health service which provides consistent, high-quality services for everyone, particularly groups who have been traditionally underserved.

The new health system is intended to provide a better balance of national consistency for hospital and specialist services and local tailoring of primary and community care. It is expected that this will improve care quality and equity, while ensuring the services received by people close to home reflect the needs of the community.

The following changes in the health system were made from 1 July 2022:

- Refocus the role of the Ministry as the chief steward of the health system and the lead advisor to the Government on matters relating to health
- The new organisation, Te Whatu Ora, will take responsibility for day-to-day running of the health system – into which all District Health Boards (DHBs) will be consolidated
- The new entity, Te Aka Whai Ora, intends to ensure that the health system delivers improved outcomes for Māori, and to directly commission tailored health services for Māori
- The Public Health Agency which has been established within the Ministry and a new strengthened, national public health service within Te Whatu Ora | Health New Zealand, is expected to make sure New Zealand is always ready to respond to threats to public health, for example, pandemics
- Whaikaha | Ministry of Disabled People has been established within the Ministry for Social Development to lead the partnership between the disability community and government, and to help drive ongoing transformation of the disability system in line with the Enabling Good Lives approach.

As a result of these changes, in addition to the total operational budget transferring from the Ministry (as outlined in the 2022/23 Vote Health Estimates of Appropriation), the Ministry's assets and liabilities will reduce from 1 July 2022. Below are the expected reduction from the Ministry's net assets.

## Departmental assets and liabilities

	<b>Actual 2022 \$000</b>
<b>Assets</b>	
Receivables and prepayments	1,686
Property, plant and equipment	579
Intangible assets	11,776
<b>Total assets</b>	<b>14,041</b>
<b>Liabilities</b>	
Employee entitlements	9,558
<b>Total liabilities</b>	<b>9,558</b>
<b>Net assets</b>	<b>4,483</b>

## Non-departmental (NDE) assets and liabilities

	<b>Actual 2022 \$000</b>
<b>Assets</b>	
Prepayments	97,144
Inventory	550,231
Residential care loans	48,629
Hospital rebuild projects	298,365
<b>Total assets</b>	<b>994,369</b>
<b>Liabilities</b>	
Payables and accruals*	1,095,154
<b>Total liabilities</b>	<b>1,095,154</b>
<b>Net assets/(liabilities)</b>	<b>(100,785)</b>

\* NDE payables and accruals include the Ministry's payables to DHBs of \$857.539 million which will either eliminate against Te Whatu Ora's | Health New Zealand's receivables or paid by the Crown subsequent to 30 June 2022.

The transfer is expected to be finalised in December 2022. The actual net assets/(liabilities) to be transferred may vary from above depending on the Ministry's final agreement with Te Whatu Ora, Te Aka Whai Ora, and Whaikaha.

# Non-departmental statements and schedules for the year ended 30 June 2022

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.

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 Statement of the Government for the year ended 30 June 2022.

## Statement of non-departmental expenses for the year ended 30 June 2022

Actual 2021 \$000	Note	Actual 2022 \$000	Unaudited budget 2022 \$000	Revised budget 2022 \$000	
17,467,320	Contracted services funding to DHBs (devolved and non-devolved funding, including COVID-19 costs)	2.6, 2.10	20,261,597	18,755,243	19,738,711
34,921	Services from Pharmaceutical Management Agency Limited	2.9	164,512	48,122	163,805
26,987	Services from Institute of Environmental Science and Research Limited		44,923	22,812	39,000
24,276	Services from Health Promotion Agency		19,726	16,048	16,048
14,453	Services from Health Quality and Safety Commission		14,688	16,111	16,084
14,370	Services from the Health and Disabilities Commissioner		16,920	17,828	16,270
2,891	Services from other Crown entities		8,022	15,456	15,456
<b>17,585,218</b>	<b>Total services from Crown Entities</b>		<b>20,530,388</b>	<b>18,891,620</b>	<b>20,005,374</b>
78,654	Workforce training and development services		90,755	117,235	106,560
68,008	Mental health services		103,593	109,345	112,891
1,396,173	Disability support services		1,578,967	1,523,804	1,567,474
211,575	Maternity services		228,978	247,578	245,903
167,643	COVID-19 activities	2.9, 2.10	1,818,027	765,435	4,503,589
758,091	Other services from third parties		576,343	666,271	696,966
56,391	Impairment of inventory (note 2.1)		15,538	–	–
<b>2,736,535</b>	<b>Total services from third parties</b>		<b>4,412,201</b>	<b>3,429,668</b>	<b>7,233,383</b>
<b>20,321,753</b>	<b>Total services</b>		<b>24,942,589</b>	<b>22,321,288</b>	<b>27,238,757</b>
(1,388)	Revaluation adjustment in residential care loans		2,494	–	–
<b>(1,388)</b>	<b>Total revaluation and impairment adjustments</b>		<b>2,494</b>	<b>–</b>	<b>–</b>
<b>20,320,365</b>	<b>Total non-departmental expenses</b>		<b>24,945,083</b>	<b>22,321,288</b>	<b>27,238,757</b>
3,042,575	GST input expense		3,707,343	3,329,349	4,066,662
<b>23,362,940</b>	<b>Total non-departmental expenses GST inclusive</b>		<b>28,652,426</b>	<b>25,650,637</b>	<b>31,305,419</b>

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 Statement of the Government for the year ended 30 June 2022.

## Schedule of non-departmental revenue and capital receipts for the year ended 30 June 2022

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 2021 \$000		Actual 2022 \$000	Unaudited budget 2022 \$000	Revised budget 2022 \$000
<b>Revenue</b>				
<b>Reimbursement from the Accident Compensation Corporation (ACC)</b>				
7,163	Reimbursement of complex burns costs	7,445	7,094	7,445
31,672	Reimbursement of work-related public hospital costs	35,190	34,497	35,190
367,323	Reimbursement of non-earners' account	416,082	407,885	416,082
121,311	Reimbursement of earners' non-work-related public hospital costs	134,786	132,131	134,786
58,746	Reimbursement of motor vehicle-related public hospital costs	65,270	63,985	65,271
3,549	Reimbursement of medical misadventure costs	3,943	3,865	3,943
7,376	Reimbursement of self-employed public hospital costs	8,195	8,034	8,195
<b>597,140</b>	<b>Total ACC reimbursements</b>	<b>670,911</b>	<b>657,491</b>	<b>670,912</b>
<b>Other non-departmental revenue</b>				
249,586	Payment of capital charge by DHBs and NZ Blood Service	304,860	374,638	426,964
12	Fines and penalties	64	–	–
18,792	Miscellaneous	22,500	2,674	13,596
<b>865,530</b>	<b>Total non-departmental revenue</b>	<b>998,335</b>	<b>1,034,803</b>	<b>1,111,472</b>
<b>Non-departmental capital receipts</b>				
16,931	Repayment of residential care loans	14,123	20,000	20,000
12,800	Equity repayments by DHBs	12,474	12,499	12,499
<b>29,731</b>	<b>Total non-departmental capital receipts</b>	<b>26,597</b>	<b>32,499</b>	<b>32,499</b>
<b>895,261</b>	<b>Total non-departmental revenue and capital receipts</b>	<b>1,024,932</b>	<b>1,067,302</b>	<b>1,143,971</b>

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 Statement of the Government for the year ended 30 June 2022.

## Schedule of non-departmental assets and liabilities as at 30 June 2022

Actual	Note	Actual	Unaudited budget	Revised budget
2021		2022	2022	2022
\$000		\$000	\$000	\$000
<b>Assets</b>				
<b>Current assets</b>				
258,941		312,394	343,822	258,941
219,050	2.1	550,231	92,470	219,050
2,476		11,935	2,000	2,000
370	2.2	48,636	32,800	2,000
5,897		6,336	1,000	6,000
7,011		37,598	11,884	6,000
145,494	2.3	178,165	112,972	200,080
<b>639,239</b>		<b>1,145,295</b>	<b>596,948</b>	<b>694,071</b>
<b>Non-current assets</b>				
46,949		48,629	44,114	48,827
195,389		301,515	351,832	276,937
<b>242,338</b>		<b>350,144</b>	<b>395,946</b>	<b>325,764</b>
<b>881,577</b>		<b>1,495,439</b>	<b>992,894</b>	<b>1,019,835</b>
<b>Liabilities</b>				
<b>Current liabilities</b>				
<b>Payables:</b>				
78,189	2.4	97,010	–	–
68,092	2.4	44,782	42,000	42,000
<b>Accrued liabilities and provisions:</b>				
371,119	2.5	768,238	311,545	400,000
220,583		360,963	248,852	242,284
<b>737,983</b>		<b>1,270,993</b>	<b>602,397</b>	<b>684,284</b>

During 2021/22 the Ministry monitored 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 Statement of the Government for the year ended 30 June 2022.

## Schedule of non-departmental commitments as at 30 June 2022

### Capital commitments

Actual 2021 \$000		Actual 2022 \$000
	<b>Capital commitments</b>	
71,948	Not later than one year	56,226
44,571	Later than one year and not later than five years	23,000
70,000	Later than five years	69,703
<b>186,519</b>	<b>Total capital commitments</b>	<b>148,929</b>

There are five projects in progress which are all related to hospital redevelopment.

## Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2022

### Contingent liabilities

Actual 2021 \$000		Actual 2022 \$000
1,000	Legal proceedings and disputes	1,000
<b>1,000</b>	<b>Total contingent liabilities</b>	<b>1,000</b>

### 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.

### Contingent assets

The Ministry had no contingent assets held on behalf of the Crown as the balance date (2021: \$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 Statement of the Government for the year ended 30 June 2022.

## Problem Gambling Revenue Report for the year ended 30 June 2022

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 Inland Revenue. The following report shows the revenue collected to date and actual expenditure.

Actual		Non- departmental actual 2022 \$000	Departmental actual 2022 \$000	Total actual 2022 \$000
2021 \$000				
<b>Problem Gambling nondepartmental expenditure</b>				
7,000	Balance as at 1 July	4,409	(214)	4,195
15,787	Revenue	12,258	990	13,248
(18,592)	Expenses	(17,448)	(1,167)	(18,615)
<b>4,195</b>	<b>Balance as at 30 June*</b>	<b>(781)</b>	<b>(391)</b>	<b>(1,172)</b>

\* The balance represents the accumulated balance of surpluses and deficits incurred in providing problem gambling services. They are not formal assets or liabilities of the Crown.

Revenue is actual levies collected by Inland Revenue based on the *Strategy to Prevent and Minimise Gambling Harm: Three-year service plan 2019/20–2021/22*.

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 Statement of the Government for the year ended 30 June 2022.

# Notes to the non-departmental statements and schedules

## Notes index

1. Statement of accounting policies
2. Explanation of major variances against budget
3. COVID-19 Response Expenditure for the year ended 30 June 2022

## 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 2022.

### 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 generally accepted accounting practice (Public Benefit Entity Accounting Standards) as appropriate for public benefit entities.

### 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, 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:

#### PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Ministry has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The Ministry has decided not to early adopt the standard.

## 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 and New Zealand Blood Service are recognised when earned and is reported in the financial period to which it relates.

### Cash and cash equivalents

Cash and cash equivalents are subject to the expected loss requirements of PBE IFRS 9. However, no loss allowance has been recognised because the estimated loss allowance for credit losses is considered to be nil or trivial.

### Debtors and receivables

Receivables from ACC recoveries are measured at amortised cost and recorded at the value of the contract and agreed with ACC, less an allowance for credit losses as per the requirements of PBE IFRS 9. The estimated loss allowance is considered to be nil. Receivables from capital charges are recorded at estimated realisable value.

### Residential care loans

An actuarial valuation of residential care loans was carried out in June 2022.

### Inventory

Inventories held for consumption in the provision for services are recorded at the lower of cost or net realisable value in accordance with PBE IPSAS 12. Any write-down from cost to net realisable value is recognised in the Statement of Non-Departmental Expenses and Capital Expenditure against appropriations.

### Payables

Payables are measured at amortised cost and are recorded at the estimated obligation to pay per the requirements of PBE IFRS 9. Short-term payables are due within 12 months and are recognised at their nominal value unless the effect of discounting is material. Payables due beyond 12 months are subsequently measured at amortised cost using the effective interest method where applicable.

### 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 the Crown where applicable.

Input tax deductions are not claimed on non-departmental expenditure. Instead, the amount of GST applicable to non-departmental expenditure is recognised 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 2021/22 Mains Estimates for Vote Health. In addition, these financial statements also present the updated budget information reflecting changes made during the year and reported in the 2021/22 Vote Health Supplementary Estimates (Revised budget).

## 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.

## Changes in accounting policies

There have been no changes in accounting policies.

## Events after the balance date

Significant events after balance date are disclosed in note 16 of the Ministry's Departmental financial statements.

## 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 2022. They are prepared on a GST exclusive basis.

## Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2022

Actual expenditure 2021 \$000	Appropriation title	Note	Actual expenditure 2022 \$000	Unaudited budget 2022 \$000	Revised budget* 2022 \$000	Location of end-of-year performance information <sup>A</sup>
<b>Departmental output expenses</b>						
71,199	Managing the purchase of services		79,421	75,669	85,257	1
27,994	Regulatory and enforcement services		31,013	31,978	32,913	1
73,674	Sector planning and performance		84,698	72,290	89,934	1
93,445	Health sector information systems		196,579	101,647	270,275	1
19,600	Payment services		17,653	18,430	18,180	1
8,432	National health response to COVID-19		–	–	–	1
34,144	Policy advice and related services		39,056	34,259	39,329	1
<b>328,488</b>	<b>Total departmental output expenses</b>		<b>448,420</b>	<b>334,273</b>	<b>535,888</b>	
<b>Multi-category expenses</b>						
<i>Implementing the COVID19 vaccine strategy MCA</i>						
44,838	Supporting the implementation of the COVID-19 vaccine strategy		191,565	23,850	205,786	1
<i>National response to COVID-19 across the Health Sector MCA</i>						
13,250	National health response to COVID-19		66,875	43,297	89,497	1
<i>Health and disability system reform</i>						
–	Health New Zealand		22,081	21,495	25,495	1
–	Māori Health Authority		7,660	23,119	24,139	1
<b>58,088</b>	<b>Total multi-category expenses</b>		<b>288,181</b>	<b>111,761</b>	<b>344,917</b>	
<b>386,576</b>	<b>Total departmental and multi-category output expenses</b>		<b>736,601</b>	<b>446,034</b>	<b>880,805</b>	
<b>Departmental capital expenditure</b>						
10,110	Ministry of Health – permanent legislative authority		5,245	23,402	37,927	1
<b>10,110</b>	<b>Total departmental capital expenditure</b>		<b>5,245</b>	<b>23,402</b>	<b>37,927</b>	
<b>396,686</b>	<b>Total departmental output appropriations</b>		<b>741,846</b>	<b>469,436</b>	<b>918,732</b>	
<b>Non-departmental output expenses</b>						
<b>Health and disability support services for district health boards (DHB)</b>						
706,919	Northland		781,159	761,244	783,927	2
1,734,496	Waitematā		1,871,255	1,823,567	1,875,290	2
1,490,114	Auckland		1,617,004	1,568,189	1,621,965	2

Actual expenditure 2021 \$000	Appropriation title	Note	Actual expenditure 2022 \$000	Unaudited budget 2022 \$000	Revised budget* 2022 \$000	Location of end-of-year performance information <sup>A</sup>
1,649,756	Counties Manukau		1,806,882	1,766,037	1,816,318	2
1,404,967	Waikato		1,526,006	1,476,179	1,526,760	2
382,784	Lakes		422,317	411,895	423,745	2
856,609	Bay of Plenty		935,411	922,346	937,589	2
191,226	Tairāwhiti		207,440	202,827	209,240	2
401,127	Taranaki		427,010	415,394	428,481	2
588,092	Hawke's Bay		645,490	628,229	645,513	2
263,542	Whanganui		282,864	276,623	284,171	2
605,941	MidCentral		646,600	630,882	649,207	2
457,895	Hutt Valley		485,771	478,085	487,382	2
876,119	Capital & Coast		943,376	914,098	945,774	2
167,676	Wairarapa		182,817	179,158	183,187	2
518,858	Nelson-Marlborough		561,816	550,718	561,822	2
154,887	West Coast		166,844	162,770	167,870	2
1,648,555	Canterbury		1,772,260	1,719,485	1,781,772	2
207,278	South Canterbury		219,107	214,737	219,120	2
1,035,179	Southern		1,107,904	1,085,842	1,110,404	2
<b>15,342,020</b>	<b>Total health and disability support services for DHBs</b>	<b>2.6</b>	<b>16,609,333</b>	<b>16,188,305</b>	<b>16,659,537</b>	
	<b>National services</b>					
1,658,856	National disability support services	2.7	1,870,172	1,829,569	1,870,440*	3
938,666	Public health service purchasing		484,597	507,220	502,779*	3
109,199	National child health services		120,809	115,883	120,883*	3
466,484	National planned care services		532,131	559,960	574,960	3
169,620	National emergency services		185,219	181,165	189,165	3
10,986	National Māori health services		12,294	8,828	12,416	3
217,091	National maternity services		235,972	254,578	252,903	3
191,236	National mental health services		241,135	243,170	252,451	3
30,262	National management of pharmaceuticals		25,512	25,262	25,512	5
31,347	Monitoring and protecting health and disability consumer interests		35,522	36,172	35,522	6
17,962	Problem gambling services		17,448	19,595	20,245	3
196,333	Health workforce training and development		208,470	234,121	223,446	3

Actual expenditure 2021 \$000	Appropriation title	Note	Actual expenditure 2022 \$000	Unaudited budget 2022 \$000	Revised budget* 2022 \$000	Location of end-of-year performance information <sup>A</sup>
348,765	Primary health care strategy		382,604	403,395	386,895*	3
91,085	National personal health services		67,033	73,601	72,551*	3
4,751	Health sector projects operating expenses		5,346	2,000	58,535	3
29	Auckland health projects integrated investment plan		683	–	720	4
17,282	Health services funding		14,633	21,181	26,512	3
–	Supporting equitable pay	2.8	63,338	–	224,619	4
120,755	Minimising the health impacts of COVID-19		–	–	–	3
–	– Aged Care Commissioner		650	–	650	6
<b>4,620,709</b>	<b>Total national services</b>		<b>4,503,568</b>	<b>4,515,700</b>	<b>4,851,204</b>	
<b>19,962,729</b>	<b>Total non-departmental output expenses</b>		<b>21,112,901</b>	<b>20,704,005</b>	<b>21,510,741</b>	
	<b>Multi-category expenses</b>					
	<i>Implementing the COVID-19 vaccine strategy MCA</i>					
95,438	Implementing the COVID-19 immunisation programme	2.9	805,283	182,700	797,949	1
5,567	Purchasing potential and proven COVID-19 vaccines and other therapeutics	2.9	566,420	508,019	1,079,699	1
	<i>National response to COVID-19 across the Health Sector MCA</i>					
217,580	COVID-19 public health response	2.10	2,406,847	850,725	3,772,907	1
	<i>Health and disability system reform MCA</i>					
–	– Hauora Māori		8,760	17,396	17,396	1
–	– Locality networks		–	9,642	9,642	1
<b>318,585</b>	<b>Total multi-category expenses</b>		<b>3,787,310</b>	<b>1,568,482</b>	<b>5,677,593</b>	
<b>20,281,314</b>	<b>Total non-departmental and multi-category output expenses</b>		<b>24,900,211</b>	<b>22,272,487</b>	<b>27,188,334</b>	
	<b>Non-departmental other expenses</b>					
2,150	International health organisations		2,096	2,230	2,230	4
2,046	Legal expenses		2,695	6,778	3,000	4
36,243	Provider development		37,587	39,793	45,193	3

Actual expenditure 2021 \$000	Appropriation title	Note	Actual expenditure 2022 \$000	Unaudited budget 2022 \$000	Revised budget* 2022 \$000	Location of end-of-year performance information <sup>Λ</sup>
40,439	<b>Total non-departmental other expenses</b>		42,378	48,801	50,423	
	<b>Non-departmental revaluation and impairment adjustments</b>					
(1,388)	Net movement in residential care loans book value		2,494	–	–	4
(1,388)	<b>Total non-departmental revaluation and impairment adjustments</b>		2,494	–	–	
20,320,365	<b>Total non-departmental expenses</b>		24,945,083	22,321,288	27,238,757	
	<b>Non-departmental capital contributions to other persons or organisations</b>					
240,000	Equity support for DHB deficits	2.11	280,000	39,211	280,000	2
966,203	Health capital envelope 2020–2025 (MYA)	2.12	424,961	1,548,255	479,531	3
–	– New Dunedin Hospital 2021–2026 (MYA)	2.13	32,421	–	81,548	3
18,395	Residential care loans – payments		18,210	20,000	20,000	4
–	– Capital investment for services to the Health sector		–	–	300	4
1,224,598	<b>Total non-departmental capital contributions to other persons or organisations</b>		755,592	1,607,466	861,379	
21,544,963	<b>Total non-departmental appropriations</b>		25,700,675	23,928,754	28,100,136	
21,941,649	<b>Total Vote Health</b>		26,442,521	24,398,190	29,018,868	

\* These are the total approved appropriations from the 2021/22 Vote Health Supplementary Estimates, adjusted for any transfers under section 26A of the Public Finance Act 1989.

<sup>Λ</sup> 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 The 'Our performance' section of the Ministry's annual report.
- 2 The DHBs and other Crown Entity annual reports.
- 3 The Vote Health Report in relation to selected non-departmental appropriations for the year ended 30 June 2022.
- 4 Exemptions granted under section 15D of the Public Finance Act 1989.
- 5 Pharmac's annual report.
- 6 Health and Disability Commissioner's annual report.

## 2 Explanation of major variances against budget

Explanations for major variances from the Ministry's non-departmental appropriations against the unaudited budget are as follows.

### Schedule of non-departmental assets and liabilities

#### 2.1 Inventory

Inventory was \$457.761 million higher than budget due to an increase in COVID-19 vaccines, Personal Protective Equipment (PPE), Rapid Antigen Test (RATs), and testing equipment to meet demand requirements offset by an inventory write down primarily due to stock written off as it passed its use by date.

#### 2.2 Receivable from ACC

Receivable from ACC was \$15.836 million higher than budget due to higher than anticipated outstanding ACC unpaid invoices raised closer to 30 June 2022.

#### 2.3 Prepayments

Prepayments were \$65.193 million higher than budget due to deposits for RATs as at 30 June 2022.

#### 2.4 Payables

DHB Payables were not provided for in the main estimate budget as the Ministry's intention was to pay outstanding payables before 30 June 2022. However, material DHB supplier invoices were only received after the year end close off, and paid after balance date.

#### 2.5 DHB accrued liabilities

The DHB accrued liabilities were \$456.693 million higher than budget which reflects increased funding for DHBs health and disability support services, and suppliers' invoices not received by the Ministry before 30 June 2022.

### Schedule of non-departmental expenses and capital expenditure against appropriations

#### 2.6 Health and disability support services for DHBs

Health and disability support services for DHBs was \$421.028 million higher than actual due to additional funding being provided during 2021/22 for pay equity settlements, additional capital charge payments following the revaluation of DHB assets, additional funding to fund surge costs in both critical care and ward beds, devolution of In-Between Travel part A funding and responsibilities to the DHBs from the Ministry, additional work required for the Canterbury Earthquakes Programme, and a number of other small adjustments.

#### 2.7 National disability support services

National disability support services were \$40.603 million higher than budget due to the additional funding required to cover cost pressures on the Government disability support services, including price increases due to inflationary pressures and increases in service volumes due to demand for services, and funding for pay equity settlements.

## 2.8 Supporting equitable pay

Supporting equitable pay with a total spend of \$63.338 million was a new appropriation established and funded during 2021/22 to fund the costs related to supporting equitable pay for nurses, administration and clerical workers.

## 2.9 Implementing the COVID-19 vaccine strategy MCA

Implementing the COVID-19 vaccine strategy MCA was \$680.984 million (of which \$461 million was provided through the DHBs) higher than budget due to:

- additional funding required in 2021/22 to support the COVID-19 vaccination programme and the transition to an integrated national immunisation programme
- additional funding to secure a portfolio of COVID-19 therapeutics through Pharmaceutical Management Agency Limited (\$114 million) and to purchase COVID-19 vaccines
- additional costs for the on-going public health system response to COVID-19.

## 2.10 National response to COVID-19 across the health sector MCA

National response to COVID-19 across the health sector MCA was \$1,556 million (of which \$444 million was provided through the DHBs) higher than budget due to additional funding required for:

- meeting the ongoing costs of the public health response to COVID-19 and supporting community-based testing for COVID-19
- supporting the ongoing health system response to COVID-19 including testing, case investigation, contact tracing and to support the transition to the minimisation and protection framework
- supporting the delivery of the COVID-19 Care in the community work programme which devolves responsibility for various parts of the patient journey to appropriate local providers via regional coordination centres
- additional supply of personal protective equipment (PPE) to meet demand requirements.

## 2.11 Equity support for DHB deficits

Equity support for DHB deficits is \$240.789 million above budget to meet below DHB's sector operating and working capital needs:

- Waikato
- Bay of Plenty
- Taranaki
- Capital & Coast
- Wairarapa
- West Coast
- Canterbury.

## 2.12 Health capital envelope 2020–2025 (MYA)

The capital envelope multi-year appropriation (MYA) was established in Budget 2020 for purchasing of health sector assets, providing capital to health sector Crown entities or agencies for new investments, and reconfiguring DHB's balance sheet. This appropriation is \$1,123.294 million lower than budget which reflects the updated capital expenditure plans, and in particular the timing of drawdowns for individual projects.

## 2.13 New Dunedin Hospital 2021–2026 (MYA)

The New Dunedin Hospital 2021–2026 with a total spend of \$32.421 million is a multi-year appropriation established this financial year to fund capital expenditure on the construction of the new Dunedin Hospital and associated projects.

# 3 COVID-19 response expenditure for the year ended 30 June 2022

In March 2020 the World Health Organisation declared the outbreak of novel coronavirus (COVID-19) a pandemic. In response to the pandemic, total funding of \$10.039 billion has been appropriated to Vote Health for 2019/20 and outyears.

Total expenditure for the year ended 30 June 2022 across the Ministry is \$4.037 billion against a budget of \$5.946 billion. The total spend is made up of \$3.779 billion in non-departmental expenditure and \$258.440 million in departmental expenditure. In August 2022, the Joint Ministers have approved and early confirmed the in-principle expense transfers of \$921.347 million for COVID-19 Health System Response and \$479.508 million for COVID-19 Vaccine and Immunisation from 2021/22 to 2022/23. The final transfer amounts will be confirmed in the 2022 October Baseline Update.

Key spending on initiatives during 2021/22 includes:

- \$201.648 million – Personal Protection Equipment (PPE): For the purchase and use of additional PPE, including protective masks, face shields, gloves, and other protective clothing, for frontline health care workforce and essential services workforce. This cost includes the \$4.874 million impairment of inventory after an assessment was performed at year end on the quality of PPE in accordance with PBE IPSAS 12. Refer to note 2.1 above for inventory balance at year end.
- \$1.216 billion – COVID-19 testing and laboratory capacity: For purchase of testing equipment, consumables associated with processing tests and the delivery of testing services within the community to detect the presence of COVID-19. This amount includes \$746.169 million for the purchase of RATs.
- \$213.102 million in DHB support to respond to the COVID-19 pandemic including costs for incident management, regional coordination services, additional cleaning, and security services as well as other activities associated with the response.
- \$114.332 million – Enhanced border measures – managed isolation and quarantine: To provide health services in our managed isolation or quarantine facilities.
- \$60.426 million – increase in combine Pharmaceutical Budget and Pharmac operating costs: To meet the increase in the price of medicines precured by Pharmac resulting from the disruption to supply.

- \$566.562 million – for the purchase of COVID-19 Vaccines and COVAX agreement.
- \$987.337 million – for the delivery of the immunisation programme including the cost incurred by DHBs' in administering the vaccine, cost of technology to support vaccine delivery, costs associated with delivering equitable outcomes and the costs associated with information campaigns on the vaccine to the public.
- \$422.054 million – Care in the Community: For the costs of providing Care in the Community services, including primary care, pharmacy, and ambulance services.
- \$178.041 million – Contact Tracing: For the costs of providing National Close Contact Services, technology and telehealth services for the managements of COVID-19.

## Statement of budgeted and actual expenses and capital expenditure incurred against appropriations for the year ended 30 June 2022

### Transfers under section 26A of the PFA for Vote Health

The Ministers of Finance and Health as Joint Ministers agreed to support a fiscally neutral adjustment between appropriations in Vote Health under section 26A of the Public Finance Act 1989 for the 2021/22 financial year only, to avoid the risk of unappropriated expenditure at year end. The section 26A transfer is approved by way of an Order in Council prior to 30 June under section 26A of the Public Finance Act.

The approved appropriation includes adjustments made in the Supplementary Estimates and the following transfers under section 26A of the Public Finance Act were made:

	Supplementary estimates 2022 \$000	Section 26A transfers 2022 \$000	Approved appropriation 2022 \$000
<b>Non-departmental output expenses</b>			
National child health services	115,883	5,000	120,883
National disability support services	1,859,440	11,000	1,870,440
Primary health care strategy	395,895	(9,000)	386,895
Public health service purchasing	504,779	(2,000)	502,779
National personal health services	77,551	(5,000)	72,551

# Statement of expenses and capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2022

The Ministry has no expenses and capital expenditure incurred without, or in excess of, appropriation or other authority for the year ended 30 June 2022.

**Expenses and capital expenditure incurred in excess of appropriation**  
 Nil.

**Expenses and capital expenditure incurred without appropriation or outside scope or period of appropriation**  
 Nil.

# Statement of departmental capital injections for the year ended 30 June 2022

Actual capital injections 2021 \$000	Actual capital injections 2022 \$000	Approved appropriation 2022 \$000
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Vote: Health

12,509	Ministry of Health – Capital injection	4,349	10,013
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# Statement of departmental capital injections without, or in excess of, authority for the year ended 30 June 2022

The Ministry has not received any capital injections during the year without, or in excess, of authority.



# Appendices | Ngā āpitihanga



# Appendix 1: Statement of strategic intentions (2021-2025) – Outcome measure results

While the actions and directions of the entities within the public health system of New Zealand are developed and progressed in the short-term, the reformation changes to the system will require us to develop a new set of strategic intentions to guide the mahi during this transitional period.

The new strategic intentions must be produced no later than six months after 01 July 2022, when the new health system structure came into effect. After presenting to the House of Representatives, these will be available on our website, [health.govt.nz](http://health.govt.nz).

## Outcome measures

Please note, the outcome measure ‘independent life expectancy’ has not been reported because results are dependent on data gathered in the Disability Survey which was last undertaken in 2013.

Additionally, 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.

## Health-adjusted life expectancy improves over time

### Measures

Health-adjusted life expectancy is the number of years a person at birth can expect to live at a given age in good health taking into account mortality and disability.

### Target

Improved results for male/female

### Results

People in New Zealand live longer in good health but spend a higher proportion of their lives with disability.

### Health-adjusted life expectancy<sup>51</sup>

	2019 <sup>52</sup>	2018	2017	2016	2015	2010	2000	1990
Female	70.3	70.3	70.4	70.4	70.3	70.0	68.3	66.1
Male	68.9	68.9	69.1	69.1	69.0	68.4	65.9	63.3

51 Results from prior years have been updated as the estimates are recalibrated and re-estimated based on new information, data and methods each year. See: [ghdx.healthdata.org/gbd-results-tool](http://ghdx.healthdata.org/gbd-results-tool).

52 These are the latest results available and are the same as reported in our 2020/21 Annual Report.

## Life expectancy increases over time

### Measure

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.

### Target

Improved results for male/female and Māori/non-Māori

### Result

Life expectancy is a summary measure of mortality and the trend shows New Zealanders are living longer than ever before.

Improvements in Māori life expectancy at birth since 1995–97 have narrowed the gap between Māori and non-Māori.

### Life expectancy at birth (years of life)<sup>53</sup>

	2019–21	2017–19	2012–14	2005–07	2000–02	1995–97
Female	84.1	83.5	83.2	82.2	81.1	79.7
Male	80.5	80.0	79.5	78.0	76.3	74.4

### Ethnicity and sex

	2019–21	2017–19	2012–14	2005–07	2000–02	1995–97
Māori female	N/A	77.1	77.1	75.1	73.2	71.3
Māori male	N/A	73.4	73.0	70.4	69.0	66.6
Non-Māori female	N/A	84.4	83.9	83.0	81.9	80.6
Non-Māori male	N/A	80.9	80.3	79.0	77.2	75.4

Please note, caution should be taken with comparisons to 2012–2014 period life tables, particularly for the Māori ethnic group due to apparent under-estimation of the Māori ethnic group suggested by the revised Māori population estimates.

Life expectancy figures for 2019–2021 are an interim indication of trends from abridged period life tables. All other figures are based on complete period life tables.

53 Data in this table is available at:  
 1995–97 to 2017–19: [stats.govt.nz/information-releases/national-and-subnational-period-life-tables-2017-2019](https://stats.govt.nz/information-releases/national-and-subnational-period-life-tables-2017-2019).  
 2019–21: <https://www.stats.govt.nz/information-releases/births-and-deaths-year-ended-december-2021-including-abridged-period-life-table/>.

## Decrease age-standardised disability-adjusted life years (DALYs) per 1,000 people

### Measure

DALY is an abbreviation for disability-adjusted life year. 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. It allows policymakers, researchers and others to compare very different populations and health conditions across time. DALYs allow us to estimate the total number of years lost due to specific causes and risk factors.

Age standardised DALY rate is the DALY adjusted for differences in the age distribution and size of different populations and is used usually for populations comparisons (for example, between different periods or different countries)

### Target

Decrease

### Result

Age-standardised DALY rates per 1,000 decreased from 1990 until 2019. As the population is growing and ageing, the absolute number of DALYs has slowly increased from 1,039,768 in 1990 to 1,215,774 in 2019.

### Disability-adjusted life years (DALYs) per 1,000 people<sup>54</sup>

	2019 <sup>55</sup>	2018	2017	2016	2015	2010	2000	1990
Female	198	197	197	196	198	204	224	257
Male	217	217	215	215	217	227	267	319
Total	207	207	205	205	207	215	244	286

54 Prior year results have been updated as the estimates are recalibrated and re-estimated based on new information, data and methods each year. Available at: [ghdx.healthdata.org/gbd-results-tool](https://ghdx.healthdata.org/gbd-results-tool) for more information.

55 These are the latest results available and are the same as reported in our 2020/21 Annual Report.

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

### Measure

New Zealand maintains its position within the Organisation for Economic Co-operation and Development (OECD), balancing relatively high life expectancy outcomes with relatively modest health expenditure.

### Target

Maintain OECD position

### Result

New Zealand has improved its position within the OECD as having relatively high life expectancy for relatively modest expenditure on health. New Zealand performs well internationally with the 11th equal-highest life expectancy out of 37 OECD countries while expenditure was only 19th highest of 38 in 2020. New Zealand's improved life expectancy position reflects that many OECD countries saw reductions in life expectancy due to the COVID-19 pandemic. In contrast, New Zealand saw an increase in life expectancy, due in part to our COVID-19 response.

### OECD life expectancy and health expenditure – position out of OECD countries<sup>56</sup>

	2020	2019	2018	2017	2015	2010	2005
Life expectancy	11th equal of 37	16th equal of 38	19th equal of 38	14th equal of 38	14th of 38	13th equal of 38	12th of 38
Health expenditure	19th of 38	19th of 38	19th of 38	19th of 38	19th of 38	20th of 36	21st of 36

56 This data has been obtained from [stats.oecd.org/index.aspx?DataSetCode=HEALTH\\_STAT#](https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#).

This information comes directly from the OECD. The OECD updates prior year results as the estimates are recalibrated and re-estimated based on new information, data and methods each year. Therefore, prior results change as the source data is updated.

The OECD updates data historically for the full set of 38 countries as countries join the organisation and/or when it receives information. The differences in the number of countries in the denominator can be because some member countries have not provided data.

# Appendix 2: Health system indicator framework – High-level indicators

In August 2021, the Government announced a set of health indicators that will be used to hold the new health system to account, ensuring it delivers more equitable health care for all New Zealanders.

## Health system indicator framework: High-level indicators

The following indicators will be used by us to monitor the performance of the reformed health and disability system. While the reforms were not implemented until after the end of the financial year reported within this document, we are providing these indicators proactively.<sup>57</sup>

The following high-level indicators are broken down by Government priority:

- improving child wellbeing
- improving mental wellbeing
- improving wellbeing through prevention measures
- creating a strong and equitable public health system
- providing better primary health care
- ensuring a financially sustainable health system.

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<sup>57</sup> Most high-level system indicators reported here show data since 2019. December 2019 is considered the baseline against most of the indicators where we are tracking against future changes.

# Improving child wellbeing

## Indicator results

### Immunisation rates for children at 24 months of age

#### Indicator description

Percentage of children who have had all their age-appropriate scheduled vaccinations by the time they are 2 years old.

#### Baseline data

14,146 2-year-old children fully immunised (91.9% of children).

#### Results (Percent of children fully immunised at age 24 months for the quarter ending 31 December)

	2019	2020	2021
All Ethnicities	91.9%	89.6%	83.9%
Māori	87.5%	81.9%	69.7%
Pacific	93.8%	90.4%	83.6%

#### Comment

Timely immunisations ensure children are protected against harmful and avoidable diseases. When community immunisation coverage is below 95%, the risk of vaccine-preventable diseases increases, particularly measles and pertussis (whooping cough). The National Immunisation Schedule (the Schedule) is a series of vaccines offered free as part of the National Immunisation Programme, with the aim of protecting children from serious diseases when they are most vulnerable.

This indicator counts those children enrolled on the National Immunisation Register (NIR) who turn 24 months old during the reporting period, that have completed all age-appropriate immunisations according to the Schedule (events currently at 6 weeks, 3 months, 5 months, 12 months and 15 months) by the age of 24 months.

Note: Immunisation status does not indicate whether the vaccinations were given on time, only if a child has had all the vaccinations they should have had by that age.

The drop in coverage seen in the indicator between the baseline 2019 figure and the 2020 and 2021 results shows the impact of changes to the Schedule in late 2020, which included adding the 12-month event and bringing the second dose of MMR forward to 15 months, as well as disruption from COVID-19.

## Ambulatory sensitive hospitalisations (ASH) for children (age range 0–4 years)

### Indicator description

Rate of hospital admissions for children under 5 years old for an illness that might have been prevented or better managed in the community.

### Baseline data

20,240 potentially avoidable stays in hospital for children under 5 years old (6,615 per 100,000 children).

### Results (ASH rate per 100,000 children 0 to 4-year-olds for 12-months ending 31 December)

	2019	2020	2021
All Ethnicities	6,615	4,315	6,079
Māori	7,950	5,044	6,837
Pacific	12,145	7,133	10,716

### Comment

This indicator looks at hospital admissions for a specific set of conditions that could have potentially been avoided through changes in primary, community and hospital ED settings.

As a likely consequence of COVID-19, there was a reduction in the number of ASH events during 2020. To December 2021, there has been an increase in child ASH events across all ethnicities although not to 2019 levels. Inequities for Māori and Pacific populations remain concerning and is a key focus for improvement.

# Improving mental wellbeing

## Indicator results

### Under 25-year-olds able to access specialist mental health services within 3 weeks of referral

#### Indicator description

Percentage of child and youth accessing mental health services within 3 weeks of referral.

#### Baseline data

69.4% of under-25-year-olds able to access specialist mental health services within 3 weeks of referral.

#### Results (Percentage of people being able to access services for the 12 months ending 31 December)

	2019	2020	2021
All Ethnicities	69.4%	67.0%	72.7%
Māori	73.7%	73.4%	79.6%
Pacific	77.7%	77.1%	86.1%

#### Comment

Accessing help for mental health issues for young people is associated with better outcomes and reduced disruption to important developmental tasks such as engagement in education and employment, developing and maintaining supportive peer relationships and taking on the tasks of increasing autonomy.

The indicator measures the time from referral to first in-scope contact with specialist mental health services and so relates to those young people who have the most severe mental health or substance harm issues. Whilst not all young people need to be seen urgently, the measure provides a view of service responsiveness to young people's needs within the resources they have available. Performance against the measure is impacted by a range of factors including workforce supply and capability, funding of services, services connection to other providers in their community and a range of other factors.

Improvement in the overall performance against the measure from 69.4% at 2019 baseline to 72.7% in 2021 is unlikely to be statistically significant for all ethnicities. However, the improvement of 5.9% for Māori and 8.4% for Pacific young people between 2019 – 2021 is encouraging. However, caution should be exercised when considering the implication of these data. The national impacts of the COVID-19 pandemic had impacts on factors such as service provision and young people's reduced school attendance (where mental health issues are often identified). It is therefore likely that some of the improvement is due to fewer young people being seen.

### Access to primary mental health and addiction services

#### Indicator description

In development.

#### Baseline data

In development.

#### Results

2019	2020	2021
N/A	N/A	N/A

#### Comment

This measure is in development. Baseline data is being captured during 2023/24. There is now comprehensive reporting by providers and work is under way to improve data reliability by automating validation processes.

# Improving wellbeing through prevention measures

## Indicator results

### Ambulatory sensitive hospitalisations (ASH) for adults (age range 45–64 years)

#### Indicator description

Rate of hospital admissions for people aged 45–64 years for an illness that might have been prevented or better managed in the community.

#### Baseline data

48,217 potentially avoidable stays in hospital for people aged 45–64 years (3,864 per 100,000 people).

**Results** (Age standardised ASH rate per 100,000 people 45 to 64-year-olds for 12-months ending 31 December)

	2019	2020	2021
All Ethnicities	3,864	3,567	3,602
Māori	7,578	6,915	6,707
Pacific	9,118	7,975	7,569

#### Comment

This indicator looks at hospital admissions for a specific set of conditions that could have potentially been avoided through changes in primary, community and hospital ED settings. As a likely consequence of COVID-19, there was a reduction in the number of ASH events during 2020. To December 2021, there has been an increase in adult ASH events although not to 2019 levels. Inequities for Māori and Pacific populations remain concerning and is a key focus for improvement.

## Participation in the bowel screening programme

### Indicator description

Participation is an important measure for determining the acceptability and reach of a screening programme. Participation is the proportion of invited people during a timeframe that were screened.

As the bowel screening programme invites participants back every two years, participation counts invitations over a two-year period. The invitation period is a rolling 2-year period up to the reporting end date.

The results presented in the table below have yet to be included in the official health system indicator suite/dashboard.

### Target

The bowel screening programme's target is to achieve 60% of eligible people invited return a completed FIT kit and to achieve equitable outcomes for Māori and Pacific peoples.

### Results

	2019	2020	2021
All Ethnicities	61.9%	62.1%	61.3%
Māori	54.9%	54.4%	52.9%
Pacific	41.6%	41.9%	41.7%

### Comment

The National Bowel Screening Programme (NBSP) was rolled out progressively across 20 Districts between 2017 and May 2022. The NBSP is now being offered nationwide. The participation rates provided are overall figures amongst the districts offering bowel screening at the end of May of each year.

The overall participation rate has consistently been above the target of 60% during the period 2019–2021. The participation rates for Māori and Pacific peoples, however, have been lower and have not yet reached the target level and so are an ongoing focus of the programme.

The NBSP has also detected a downward trend in participation rates over the past two years, due to the impact of COVID-19.

To address the impact of COVID-19, and the lower rate of participation amongst Māori and Pacific peoples, the NBSP has several initiatives currently underway. This includes:

- Further refining active follow-up processes with priority populations
- A new community invitation strategy in Tairāwhiti
- An ongoing national awareness raising media campaign
- Use of a recently redesigned bowel screening kit.

All these initiatives, which are intended to improve participation rates, have been designed with a specific focus on improving the equity of the programme through addressing the lower rates of participation amongst Māori and Pacific peoples.

# Creating a strong and equitable public health system

## Indicator results

### Acute hospital bed day rate

#### Indicator description

Number of days spent in hospital for unplanned care, including emergencies.

#### Baseline data

2,067,733 days were spent in hospital for unplanned care, including emergencies (398.6 bed days per 1,000 population).

**Results** (Age standardised rate of acute hospital bed days per 1,000 population for 12-months ending December)

	2019	2020	2021
All Ethnicities	398.6	363.3	397.8
Māori	562.9	519.7	560.7
Pacific	689.0	621.2	646.2

#### Comment

This indicator looks at the demand for acute inpatient services and the burden experienced by our secondary health system. COVID-19 has resulted in a reduction in the number of acute hospital bed days during 2020, however, we have seen an increase in 2021 despite various lockdowns.

We are continuing to monitor this to assess health system performance as well as the degree of integration between community, primary and secondary care.

### Access to planned care

#### Indicator description

People who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the delivery plan.

72,931 people had surgery or care as planned (5.2% more than planned).

**Results** (Number of surgery or planned care for the quarter ending December)

	2019	2020	2021
	72,931 (+5.2%)	81,885 (+14.8%)	79,211 (+10.0%)

#### Comment

Planned care reporting includes both inpatient surgeries and minor procedures which are provided in inpatient and outpatient hospital and community settings.

The COVID-19 lockdown periods and those following were marked by rapid and radical changes in the number of planned care admissions, caused by the necessary postponement of planned care at higher Alert Levels.

As a result of significant deferrals due to COVID-19 cases in the community and in hospitals district health boards (DHBs) under-delivered on planned inpatient surgical discharges. This was primarily a consequence of COVID-19 management including lockdowns, a reduction in planned delivery due to COVID-19 cases in hospital and workforce pressures. Urgent and non-deferrable care continued during lockdown periods.

Reporting indicates there was an over-delivery of minor procedures. While this has skewed overall performance, this is typical and is not a cause for concern. Minor procedures tend to be of low acuity, low complexity and can be undertaken in alternate settings (such as outpatient or community settings).

# Providing better primary health care

## Indicator results

### People report they can get primary health care when they need it

#### Indicator description

Percentage of people who say they can always get primary health care from a GP or nurse when they needed it in the last 12 months.

#### Baseline data (12 months to June 2021)

81% of people reported they could always get health care from a GP or nurse when they needed it.

#### Results

	June 2021 (Baseline)	Jul-Sep 2021	Oct-Dec 2021
All Ethnicities	81%	80%	80%
Māori	75%	74%	76%
Pacific	78%	78%	79%
Non-Māori non-Pacific	83%	81%	81%

#### Comment

Over the last two quarters of 2021, there was no significant difference from baseline in the percent of people reporting they can get care when they needed it. All of the time periods include the COVID-19 pandemic and periods in level 4 lockdown. We know that COVID-19 disrupted normal general practice services, so it is pleasing to see no significant reduction in the percent of patients being able to get care when needed.

There was no significant change in responses by ethnicity from baseline. Māori remain least likely to report being able to access care (76%), followed by Pacific (78%) and non-Māori, non-Pacific (83%).

## People report being involved in the decisions about their health care and treatment

### Indicator description

Percentage of people who say they feel involved in their own care and treatment with their GP or nurse.

### Baseline data (12 months to June 2021)

86% of people report they feel involved in their health care and treatment.

### Results

	June 2021 (Baseline)	Jul-Sep 2021	Oct-Dec 2021
All Ethnicities	86%	87%	86%
Māori	84%	86%	85%
Pacific	85%	86%	88%
Non-Māori non-Pacific	87%	87%	86%

### Comment

Over the last two quarters of 2021, there was no significant difference from baseline in the percent of people reporting being involved in decisions about their care and treatment as much as they wanted to be. This suggests that despite general practice being under pressure during COVID-19, patients' experience of care has not changed.

There was no significant difference by ethnicity from baseline.

# Ensuring a financially sustainable health system

## Indicator results

### Annual surplus/deficit at financial year end

#### Indicator description

Net surplus/deficit as a percentage of total revenue.

#### Baseline data

Annual deficit is 2.2% of revenue excluding one-offs, 3.4% of revenue including one-offs.

**Results** (Net surplus/deficit excluding unbudgeted one-offs for the financial year ended)

2018/19	2019/20	2020/21
-2.5%	-2.8%	-2.2%

#### Comment

One-offs are Holidays Act 2003 provisions and unfunded COVID-19 impacts. This shows how well the health and disability sector has managed the annual cost for providing services relative to revenue. In 2020/21, the sector spent 2.2% more than revenue. When one-off costs associated with the Holidays Act 2003 and COVID-19 that weren't planned for are included, the overspend increased to 3.4% of revenue. This is an improvement on the results for the previous two years.

### Variance between planned budget and year-end actuals

#### Indicator description

Budget versus actuals variance as a percentage of budget.

#### Baseline data

Actual deficit result is worse than the approved plan/budget by \$28 million (11.0%) excluding unbudgeted one-offs and by \$245 million (96.9%) including one offs.

**Results** (Variance against planned budget for the financial year ended, excluding unbudgeted one-offs)

2018/19	2019/20	2020/21
-54.1%	-12.0%	-11.0%

#### Comment

The actual deficit result shows the difference against planned budget. This indicator is intended to show how well the health and disability sector performed against the planned budget for the year, that is, how well did it do what it said it would do. In 2020/21, the actual deficit was 11% worse than planned budget, and when one-off costs associated with Holidays Act 2003 provisions and COVID-19 were included, the deficit was 96.9% worse than planned. This indicator excludes Canterbury DHB, as that DHB's plan/budget was not approved.

# Appendix 3: Delegation of functions or powers

The Public Service Act 2020 requires departments to state where their chief executive’s functions or powers have been delegated to a person outside the public service.

In addition to disclosing any delegations of functions or duties, our annual report must give a detailed description and assessment of how effectively the delegated function or power was performed or exercised.

The following table provides the information and assessments that the legislation requires.

## Delegation of functions or powers

Person delegated to	Function or power delegated	Assessment of how effectively the delegated function or power was performed or exercised
Police Commissioner	<p>The power to appoint enforcement officers at section 18 of the COVID-19 Public Health Response Act 2020 (the Act).</p> <p>These appointments are only for the purpose of authorising enforcement officers to assist with the enforcement of any Alert Level boundary mandated by Order made under the Act.</p>	<p>The delegation of power was used on 3 occasions in 2021/22: on 14, 16 and 17 December 2021.</p> <p>We have determined that the exercised delegation of power – to allow the Police Commissioner to authorise police officers as enforcement officers at section 18 of the Act – and the criteria followed by the Police Commissioner’s appointment documents were performed appropriately and in accordance with the requirements outlined in the Act.</p>

# Appendix 4:

## Legal and regulatory framework

Manatū Hauora (the Ministry of Health) is responsible for overseeing the legal and regulatory framework of the health and disability system in Aotearoa New Zealand.

By administering a wide range of Acts, regulations and other legislative tools (such as orders-in-council), we keep the system safe, equitable and relevant. Regulating the health and disability system helps provide assurance to all New Zealanders that the system is fair and that the services offered can be trusted.

Here we summarise the main pieces of legislation we administer within the health and disability system.

### Legislation administered by the Ministry of Health

In 2021/22, our Ministry administered over 30 pieces of legislation, steering the national health and disability system:

- Burial and Cremation Act 1964
- Cancer Registry Act 1993
- Contraception, Sterilisation, and Abortion Act 1977
- Compensation for Live Organ Donors Act 2016
- COVID-19 Public Health Response Act 2020
- Disabled Persons Community Welfare Act 1975 (Part 2A)<sup>58</sup>
- End of Life Choice Act 2019
- 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

58 This Act is administered by the Ministry of Social Development and the Ministry of Health.

- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Mental Health and Wellbeing Commission Act 2020
- Misuse of Drugs Act 1975
- New Zealand Public Health and Disability (Waikato DHB) Elections Act 2019
- New Zealand Public Health and Disability Act 2000
- Psychoactive Substances Act 2013
- Radiation Safety Act 2016
- Residential Care and Disability Support Services Act 2018
- Smokefree Environments and Regulated Products Act 1990
- Substance Addiction (Compulsory Assessment and Treatment) Act 2017
- Support Workers (Pay Equity) Settlements Act 2017.

## Statutory reporting requirements

### Health Act 1956

The Health Act 1956 sets out the roles and responsibilities of individuals to safeguard public health, including the Minister of Health, the Director of Public Health and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies and the National Cervical Screening Programme.

The Health Act 1956 requires the Director-General of Health to report every year on the current state of public health.

The Minister of Health tables a Health and Independence Report each year in Parliament. The Minister must table the report by the 12th sitting day of the House of Representatives after the date on which the Minister received the report.

The Health Act 1956 also requires the Director-General to report before 1 July each year on the quality of drinking-water in Aotearoa. The public can access the most recent report through the Ministry's website.

### New Zealand Public Health and Disability Act 2000

Please note, on 1 July 2022 the New Zealand Public Health and Disability Act 2000 (NZPHDA) was repealed and replaced by the Pae Ora (Healthy Futures) Act 2022. We have included the NZPHDA in this report as it was in effect during the reporting period 1 July 2021 – 30 June 2022. We will detail the obligations for Pae Ora (Healthy Futures) Act 2022 in the 2022/23 annual report.

The New Zealand Public Health and Disability Act 2000 establishes the structure underlying the public sector funding model and the organisation of health and disability services. It established district health boards (DHBs) and certain health Crown entities and sets out the duties and roles of key participants, including the Minister of Health and ministerial advisory committees.

The New Zealand Public Health and Disability Act 2000 required the Minister of Health to report every year 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 every year on end-of-year performance information on any Vote Health appropriations that third-party health sector service providers with direct funding from Manatū Hauora deliver, where that information is not covered in other reporting to Parliament.

The Minister of Health is responsible for presenting the Vote Health Report on selected non-departmental appropriations for the previous financial year (1 July – 30 June) to Parliament within 4 months of the end of the financial year. If Parliament is not in session during this time, the tabling process must occur as soon as possible after the start of the next session of Parliament.

## Public Service Act 2020

The Border Executive Board was established under the Public Service Act 2020 as an Interdepartmental Executive Board. Its purpose is to ensure the delivery of a safe, integrated and effective border system for Aotearoa.

The New Zealand Customs Service hosts the Border Executive Board. The Ministry of Health's Chief Executive is one of the Board's 6 members. For more information about the Border Executive Board, including membership and publications, please visit [customs.govt.nz/about-us/border-executive-board](https://customs.govt.nz/about-us/border-executive-board).

## Other regulatory roles and obligations

In addition to administering the legislation outlined above, key roles within our organisation (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions contained in other pieces of legislation that we do not administer:

- Biosecurity Act 1993
- Civil Defence Emergency Management Act 2002
- Education and Training Act 2020
- 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
- Public Service Act 2020
- Sale and Supply of Alcohol Act 2012
- Social Security Act 2018
- Victims' Rights Act 2002
- Waste Minimisation Act 2008.

Please note, the legislation listed above are examples illustrating where these powers and functions can be found. This list may not be exhaustive.

## Additional statutory reporting requirements

The Minister of Finance has not specified any additional reporting requirements.

## International compliance

The Ministry helps the New Zealand Government comply with international obligations by actively supporting and participating in international organisations (such as the World Health Organization).

The Ministry also ensures Aotearoa New Zealand complies with international requirements, such as the International Health Regulations (2005) and the Framework Convention on Tobacco Control, as well as a range of United Nations conventions.

## Web resources

To search and access publications we produce, please refer to [health.govt.nz/publications](https://health.govt.nz/publications)

For information on regulations administered by the Ministry, please refer to [health.govt.nz/our-work/regulation-health-and-disability-system](https://health.govt.nz/our-work/regulation-health-and-disability-system)

To view a complete list of searchable copies of the Acts and associated regulations administered by the Ministry, please visit [legislation.govt.nz](https://legislation.govt.nz)

# Appendix 5: Asset performance indicators

The Aotearoa New Zealand Government's Cabinet Office Circular CO(19)6 outlines the expectations of government departments to monitor and report on asset performance indicators in their annual report.

The following table outlines these indicators and provides additional information on the indicators, if applicable.

## Asset performance indicator results for property

Indicator	Indicator type	Actual 2019/20	Actual 2020/21	Target 2021/22	Actual 2021/22	At a glance
Percentage of buildings with a Property Council of NZ Grade of C or better (Note 1)	Condition	89%	91%	>80%	91.7%	✓
Percentage of buildings with an Initial Evaluation Process – New Building Standard Seismic Grade of C or better	Condition	100%	100%	100%	100%	✓
All building warrants of fitness current (Note 2)	Condition	100%	100%	100%	100%	✓
Average occupancy m <sup>2</sup> per head	Utilisation	14.62	11.33	<14 m <sup>2</sup>	11.39	✓
Percentage of buildings with a functionality rating of 3 or better (Note 3)	Functionality	100%	100%	100%	100%	✓
Average power used kWh/m <sup>2</sup>	Functionality	73 kWh/m <sup>2</sup>	84.78 kWh/m <sup>2</sup>	<80 kWh/m <sup>2</sup>	73 kWh/m <sup>2</sup>	✓

Note 1: Property Council New Zealand's quality grading matrix includes the following grades:

Grade A: A landmark office building located in major CBD office markets which is a pacesetter in establishing rents and includes ample natural lighting, good views and outlook, prestige lobby finish, on-site undercover parking, quality access to and from an attractive street setting, and premium presentation and maintenance.

Grade B: High-quality space including good views and outlook, quality lobby finish, on-site undercover parking, quality access to and from an attractive street setting, and quality presentation and maintenance.

Grade C: Good-quality space with a reasonable standard of finish and maintenance. Tenant car parking facilities should be available

Grade D: Office space with lower poor-quality finish. Services fall below the minimum set for a C grade

Note 2: A building warrant of fitness is a building owner's annual statement. It is used to confirm 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). For more information, please visit [building.govt.nz/building-officials/guides-for-building-officials/building-warrants-of-fitness](https://building.govt.nz/building-officials/guides-for-building-officials/building-warrants-of-fitness).

Note 3: Building functionality assesses how fit for purpose or suitable a building is to meet the service needs of its users. The rating scale for this measure is defined as:

1. actively hinders operation
2. not fit for purpose/significant issues
3. fit for purpose/generally fine
4. ideal.

# Appendix 6: Committees

## Section 11 committees

Under section 11 of the New Zealand Public Health and Disability Act 2000 (the NZPHD Act), the Minister of Health had authority to establish any committee that the Minister considered necessary for any purpose relating to the Act, its administration or any services.

For each committee established under section 11 of the NZPHD Act, Manatū Hauora (the Ministry of Health) was required to publish the following information in our annual reports:

- the name of each committee
- the names of the chairperson and members of each committee
- a declaration of whether any of the committees have not reported to the Minister in the period covered by the annual report.

Here we provide details to meet these requirements, covering 1 July 2021 to 30 June 2022.

Please note, on 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act) replaced the NZPHD Act. Section 87 of the Pae Ora Act replaces section 11 of the NZPHD Act, including the requirement to disclose the committee information in our annual report.

## Interim departmental agencies

As part of the health and disability system reforms, the following interim agencies were established as section 11 committees to oversee the creation of the new permanent entities.

## Interim Health New Zealand

The Interim Health New Zealand Board was established on 23 September 2021 to provide independent advice on establishing the permanent entity Te Whatu Ora | Health New Zealand and support the transformation and transfer of functions as the health and disability system reforms take effect.

The interim board was disestablished on 30 June 2022.

### Membership

Mr Rob Campbell (chair)	Hon Amy Adams	Cassandra Crowley
Vui Mark Gosche	Dame Dr Karen Poutasi	Vanessa Stoddart
Dr Curtis Walker	Sharon Shea	

## Te Mana Hauora Māori | Interim Māori Health Authority

The Te Mana Hauora Māori | Interim Māori Health Authority Board was established on 23 September 2021 to help drive the development of the permanent entity Te Aka Whai Ora | Māori Health Authority and its role within a newly transformed system.

The interim board was disestablished on 30 June 2022.

### Membership

Sharon Shea (co-chair)	Tipa Mahuta (co-chair)	Dr Sue Crengle
Dr Mataroria Lyndon	Lady Tureiti Moxon	Fiona Pimm
Awerangi Tamihere	Dr Chris Tooley	

## Pharmac Review Committee

The Pharmac Review Committee was established in March 2021. It examined:

- how well Pharmac performs against its current objectives and whether (and how) its performance against these could be improved
- whether Pharmac's current objectives maximise its potential to improve health outcomes for all New Zealanders as part of the wider health system, and whether and how these objectives could be changed.

The committee was disestablished at the end of March 2022, after completing the review.

### Membership

NA (disestablished).

## 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 work includes:

- working with district health boards to review their business case proposal
- prioritising capital investment
- delivering a National Asset Management Plan
- any other matters that the Minister may refer to the Committee.

### Membership

Evan Davies (chair)	Paul Carpinter	Jan Dawson
Professor Des Gorman	Murray Milner	Dr Margaret Wilsher

## Health Workforce Advisory Board

The Health Workforce Advisory Board was established under section 11 of the NZPHD Act. It provides advice to the Minister of Health on health workforce matters, including strategic direction, emerging issues and risks.

Additionally, the Health Workforce Advisory Board acts as an advisory committee for the health workforce, under section 15 of the NZPHD Act.

### Membership

Dame Professor Judith McGregor (chair)	Dr Grace Wong
Dr Andrew Connolly	Ailsa Claire (ex officio)
Karl Metzler	Faumuina Associate Professor Fa'afetai Sopoaga
Tūraukawa Bartlett	Wesley Pigg
Dr Joanne Baxter	

## Health and disability ethics committees

The health and disability ethics committees are a group of 4 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) being conducted meets, or exceeds, ethical standards established by the National Ethics Advisory Committee.

### Membership: Northern A

Dr Kate Parker

### Resigned (1 July 2021 – 30 June 2022):

Dr Michael Meyer	Dr Karen Bartholomew
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### Membership: Northern B

Kate O'Connor (chair)	Barry Taylor	Leesa Russell
Alice McCarthy		

### Resigned (1 July 2021 – 30 June 2022):

Dr Gabrielle Jenkin	Maxine Shortland	Susan Sherrard
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### Membership: Central

Helen Walker (chair)	Associate Professor Patries Herst	
Albany Lucas	Dr Cordelia Thomas	Sandra Gill
Jessie Lenagh-Glue	Julie Jones	

### Resigned (1 July 2021 – 30 June 2022):

Dr Peter Gallagher

### Membership: Southern

Anthony Fallon (chair)	Amy Henry	
Associate Professor Nicola Swain	Dominic Fitchett	Dr Devonie Waaka
Dr Sarah Gunningham	Dr Mira Harrison-Woolrych	

### Resigned (1 July 2021 – 30 June 2022):

Dr Sarah Gunningham

## Other committees

The Human Assisted Reproductive Technology Act 2004 requires that we publish the chair and membership of the committees associated to the Act in our annual reports.

The following ethics committees have been established to provide advice to the Minister of Health.

### 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

Calum Barrett (chair)	Dr Rosemary de Luca	Dr Karen Reader
Karaitiana Taiuru	Dr Sarah Wakeman	Seth Fraser
Catherine Ryan	Edmond Fehoko	Dr Debra Wilson
Shannon Hanrahan		

#### Resigned (1 July 2021 – 30 June 2022):

Dr Analosa Veukiso-Ulugia      Erin Gough  
Kathleen Logan (resigned as Chair, continued as member)

### 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. The Committee 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 Reuevecamp (chair)	Mania Maniapoto-Ngaia	Judith Charlton
Dr Jeanne Snelling	Associate Professor Michael Legge	
Dr Analosa Veukiso-Ulugia	Dr Emily Liu	
Associate Professor Angela Ballantyne		Richard Ngatai

#### Resigned (1 July 2021 – 30 June 2022):

Dr Mary Birdsall      Dr Tepory Emery

# Appendix 7: Substance Addiction (Compulsory Assessment and Treatment) Act 2017

In February 2018, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 came into effect, replacing the Alcoholism and Drug Addiction Act 1966.

The purpose of the Substance Addiction Act (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act) helps people with a severe substance addiction (or addictions) who have an impaired decision-making capacity to engage in voluntary (or compulsory) addiction treatment services.

The Substance Addiction Act has been developed to be better equipped to protect the human rights and cultural needs of patients and their whānau. The Act places greater emphasis on a mana-enhancing and health-based approaches to substance addiction treatment.

Under section 119 of the Substance Addiction Act, we are required to disclose the following information relating to patients in our Annual Report.

The data below has been extracted from PRIMHD<sup>59</sup> on 8 August 2022 and covers activities that occurred from 1 July 2021 to 30 June 2022.<sup>60</sup>

Over this period:

- 32 people were detained under the Substance Addiction Act
- 30 compulsory treatment orders were made
- 22 compulsory treatment orders were extended
- 28 discharged patients chose voluntary residential treatment and out-patient services
- for individuals who had compulsory treatment orders made (or extended), the average length of detention was 12 weeks (84 days).

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59 Programme for Integration of Mental Health Data (PRIMHD) is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes database for health consumers. The data is collected from district health boards (DHBs) and non-governmental organisations (NGOs).

As the data from PRIMHD is only able to measure mental health and addiction outcomes, these results may not fully encompass or recognise other sources of support people recovering from severe substance addiction are receiving (for example, patients that have received support for access to housing).

60 There may be cases where a person first came under the Substance Addiction Act in June 2022 or engaged the process at the end of June 2022 and continued through 2022. Due to this there may be discrepancies in reporting, where a higher number of people had compulsory treatment orders made (or extended) than were detained under the Substance Addiction Act.

The number of individuals detained under the Substance Addiction Act in 2021/22 by the duration of their detention (measured in weeks).

Number of weeks of detention <sup>61</sup>	Number of individuals
0	0
0-1	0
1-2	1
2-3	0
3-4	0
4-5	2
5-6	0
6-7	1
7-8	4
(greater than) 8	20

Among these patients:

- 28.6% were detained for up to, and including, eight weeks, which is within the first period of compulsory treatment set out in the Act.
- 71.4% of patients were detained for a period of between 8 and 16 weeks, requiring a compulsory treatment order extension.

Data extracted from PRIMHD shows that among service users who were discharged from the Substance Addiction Act during 1 July 2021 – 30 June 2022:

- 23.5% received additional inpatient care
- 82.4% engaged with individual treatments in outpatient services
- 44.1% had family meetings arranged
- 76.5% had Supplementary Consumer Records
- 64.7% had wellness plans.

Please note, if an individual using these services was discharged in late June 2022, they are unlikely to have had enough time to engage with outpatient services during the reporting period.

For this reason, it may be difficult to draw meaningful conclusions about a service user's recovery journey from the information above.

<sup>61</sup> The categories are defined as up to, and including, the upper limit. For example, one week and one day would be in 1-2 weeks; 7 weeks exactly would be included in 6-7 weeks.

# Appendix 8: Carbon Neutral Government Plan – Greenhouse gas emissions 2021/22

At Manatū Hauora, we are committed to playing our part in the Carbon Neutral Government Plan to minimise our environmental footprint by reducing our greenhouse gas emissions.

## Moving to net zero Carbon emissions

In January 2022, we released our Greenhouse Gas Emissions Base Year Report and Inventory. Due to the changing situation that COVID-19 has presented; we have selected 1 March 2019 – 29 February 2020 as our base year. This was determined to be the best representation of our 'business as usual' in recent years.

Our provisional and unverified data for 2021/22 shows we emitted 1147.21 tonnes of carbon dioxide equivalent ( $tCO_2e$ )<sup>62</sup>. These emissions equate to a 41.65 percent reduction from our base year emissions (1966.23  $tCO_2e$ ).<sup>63</sup>

The reduction in emissions can be directly attributed to:

- Reduced domestic and international travel due to restrictions imposed by the COVID-19 pandemic.
- Transitioning our fleet to low emission vehicles (hybrid and electric). In the 2021/22 financial year, the Ministry began the electrification of its automobile fleet through the purchase of one electric vehicle and six hybrid vehicles.
- Modernising our technology platforms to enable our people to work anywhere, on any

<sup>62</sup> Our emissions will be formally audited by a Certified Carbon Auditor before we publish the formal reduction plan in December 2022. As such, the emissions for 2021/22 are considered preliminary.

<sup>63</sup> Following a review of the historic data used to produce the 2021/22 emissions report, the total emissions for the base year (1 March 2019 – 29 February 2020) have been amended – from 1962.84  $tCO_2e$  to 1966.23  $tCO_2e$ .

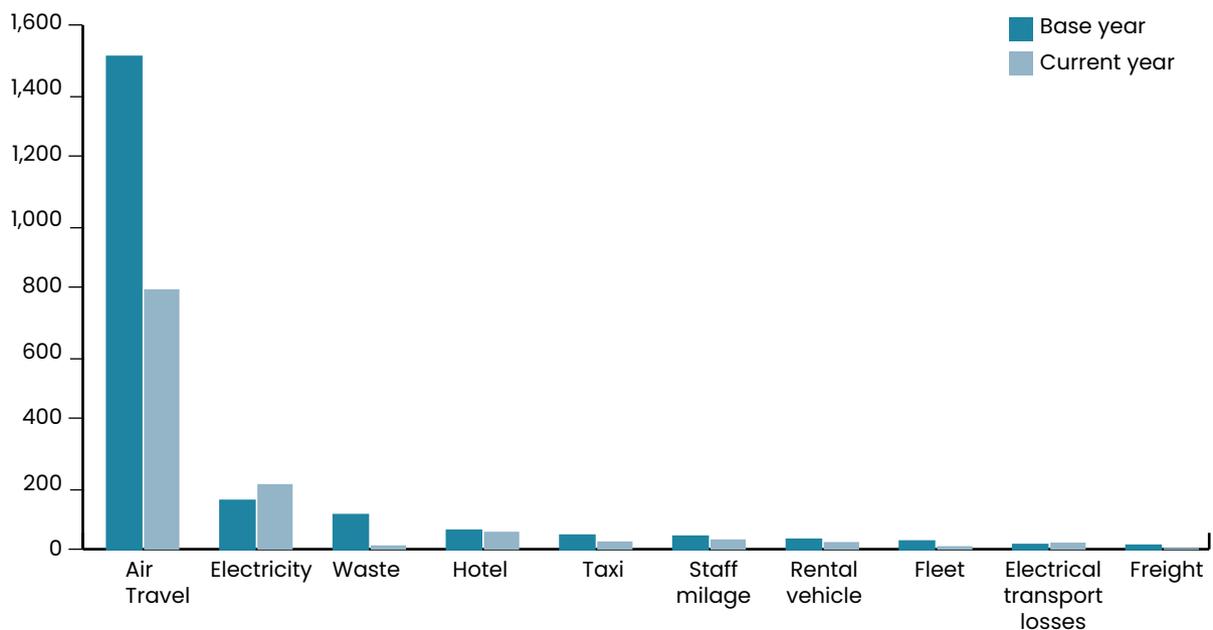
device, at any time, reducing the need for travel and/or face to face meetings.

- Improved data collection techniques for our waste stream, resulting in a significant drop in emissions.

The below figure provides an overview of emissions sources, broken down by source. The emissions in 2021/22 are compared against our base year figures.

In 2021/22 we saw a 33.5 percent increase in emissions derived from electricity. This was directly related to bringing on additional short-term accommodation to support a significant increase in our workforce, as part of our role in the COVID-19 response.

Annual emissions by source: Base year (2019/20) compared to 2021/22.



## Progress towards our 2025 and 2030 targets

In line with the Carbon Neutral Government Programme target to achieve 42 percent reduction in gross emissions, the Ministry has set targets for emitting no more than 1553.3 tCO<sub>2</sub>e for the year 2025, and 1140.4 tCO<sub>2</sub>e for the year 2030.

By 1 December 2022, we are required to publish the Ministry’s inaugural reduction plan. The plan will identify specific reduction initiatives, enabling the Ministry to effectively reach our 2025 reduction target.

During 2021/22, our executive leadership team have committed to focusing on areas where we can make the greatest impact to reduce emissions. The primary areas of focus include:

- Review of internal policies and practices in relation to all modes of travel.

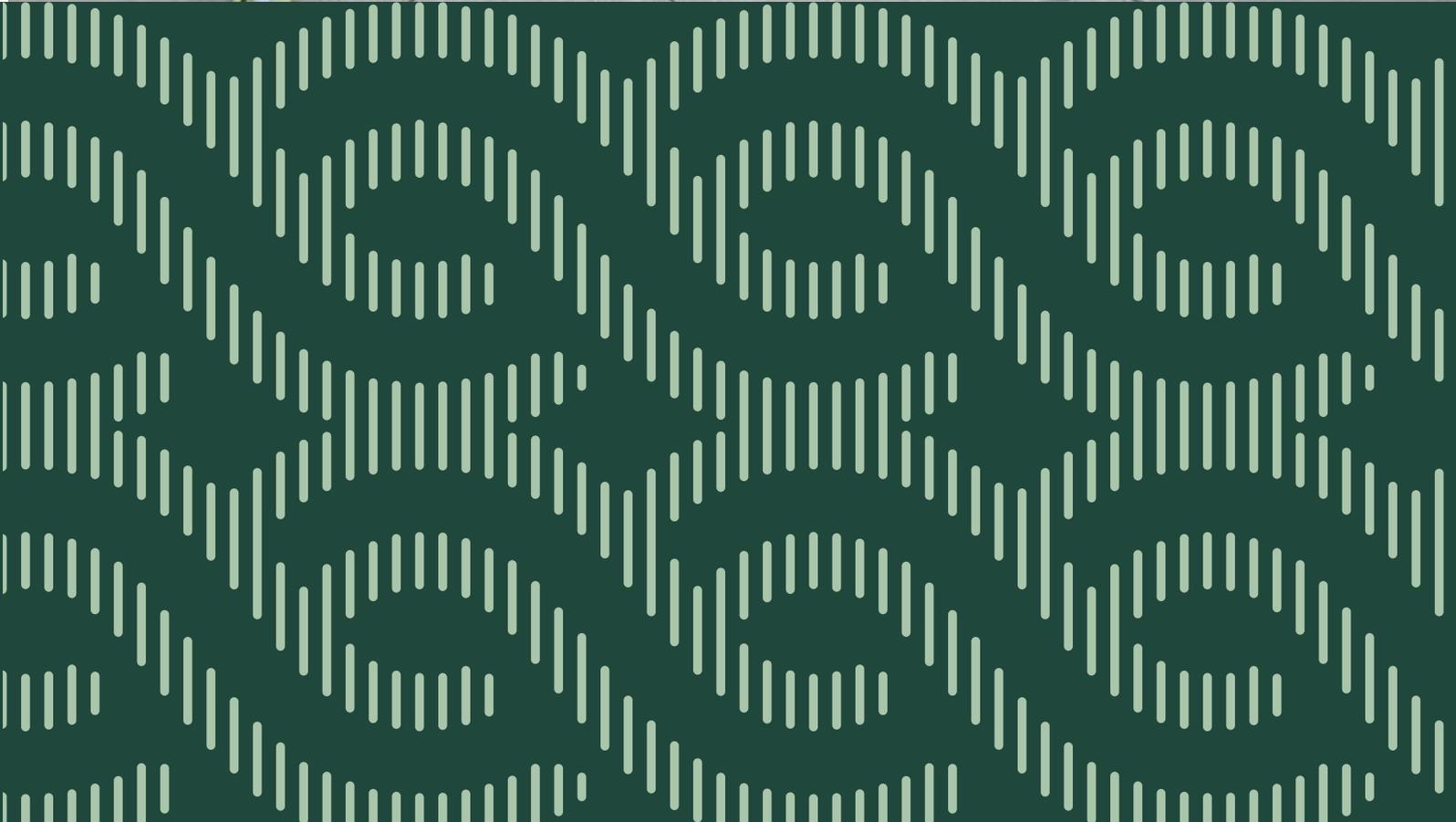
- Ongoing review of our fleet needs and the upgrade of any remaining fleet to electric/hybrid by 2025.
- Feasibility studies on systems that will improve our energy efficiency and reduce our waste streams.
- Where financially prudent, increased capital investment in sustainable long-term initiatives.





TE AHO  
O TE KAHU  
CANCER  
CONTROL  
AGENCY

# Annual Report 2021/22



## Our purpose

We provide strong central leadership and oversight of cancer control. We lead and unite efforts to deliver better cancer outcomes for Aotearoa New Zealand.

## Our work is

- equity led
- knowledge driven
- outcomes focused
- person and whānau centred.



## Our Vision

**Fewer cancers**  
**Kia whakaiti iho te mate pukupuku**

**Better survival**  
**Kia runga noa ake te mataora**

**Equity for all**  
**Kia taurite ngā huanga**

## Who we are

Te Aho o Te Kahu, the Cancer Control Agency is a departmental agency reporting directly to the Minister of Health and hosted by the Ministry of Health.

The agency was created in recognition of the impact cancer has on the lives of New Zealanders and provides a sharp focus on this important health issue.

We have 60 people working for us across six Wellington-based teams and four regional hubs.

# He mihi | Chief Executive foreword

I am very pleased to be able to present the third annual report for Te Aho o Te Kahu, the Cancer Control Agency.

Since the Agency was established, I have enjoyed taking stock of our achievements in each annual report. While there is still much to be done, I am extremely proud of our team and the work they have undertaken over the last 12 months.

We have remained as committed as ever to our vision of:

**Fewer cancers** Kia whakaiti iho te mate pukupuku

**Better survival** Kia runga noa ake te mataora

**Equity for all** Kia taurite ngā huanga.



Over the last year, Te Aho o Te Kahu has shown leadership and consistency throughout a time of change for the health system. The health reforms have provided an exciting opportunity to rethink the way cancer services are delivered in Aotearoa New Zealand, and Te Aho o Te Kahu has taken a leading role in many of the conversations, plans and pieces of work taking place across the motu.

Not only are we building enduring relationships with the new health entities, we are also continuing to foster the connections we have across the cancer sector. The work of He Ara Tangata, our consumer reference group, has been critical over the last year. Our regional hubs have also done an incredible job of connecting with communities across the motu to ensure Te Aho o Te Kahu remains tethered to those on the ground. I also acknowledge the tireless work of our partners Hei Āhuru Mōwai, Māori Cancer Leadership Aotearoa, as we, together, pursue equity in cancer outcomes for whānau Māori.

The ongoing COVID-19 pandemic has continued to influence the work of Te Aho o Te Kahu. We have guided the cancer sector through the Omicron outbreak by providing guidance to clinicians and patients, as well as producing regular monitoring reports of the cancer system. It has been a challenging time for the cancer workforce, and I am incredibly grateful for the dedication of all who have ensured whānau continue to receive the cancer care they need.

Alongside our expanding work programme, we have continued to build a high-performing agency. This was reflected in the 2022 Te Taunaki, Public Service Census, which showed our staff had an elevated level of confidence when engaging with Māori. It also reaffirmed that our staff feel Te Aho o Te Kahu has a culture that celebrates diversity, inclusivity, and acceptance.

I want to take this opportunity to thank all those who work in the cancer sector – you have gone above and beyond for your patients, their whānau and their wider communities in the last 12 months.

Finally, I want to acknowledge those who are living with cancer. You are the focus of our work, and we will continue to do our utmost to ensure Aotearoa New Zealand maintains a world-class cancer care system.

Dr Diana Sarfati

**Chief Executive and National Director of Cancer Control**

**Te Aho o Te Kahu, Cancer Control Agency**

# Anei mātou | Who we are

Te Aho o Te Kahu, Cancer Control Agency (Te Aho o Te Kahu), is a departmental agency reporting directly to the Minister of Health and hosted by Manatū Hauora, Ministry of Health. Te Aho o Te Kahu was created in recognition of the impact cancer has on the lives of New Zealanders and provides a sharp focus on this important health issue.

Cancer presents some unique challenges to the health system.

- The number of people diagnosed with cancer is projected to double over the next two decades.
- The costs and complexity of care and pace of change present major challenges for our health care systems and services.
- Māori and Pacific peoples have worse cancer survival rates than other New Zealanders.
- Cancer survival is improving in Aotearoa New Zealand, but our rate of improvement is slower than rates in other comparable countries, so we are at risk of falling behind.

## Tā mātou aronga | Our purpose: an agency focused on cancer

We provide strong, central leadership and oversight of cancer control. We lead and unite efforts to deliver better cancer outcomes for Aotearoa New Zealand. We are also accountable for ensuring there is transparency in our country's progress towards achieving the goals and outcomes outlined in the *New Zealand Cancer Action Plan 2019–2029*<sup>1</sup>.

In practice, we deliver this leadership and oversight by:

- providing advice to government about the future design and function of cancer services and options for resolving operational issues
- bringing stakeholders together to progress and achieve shared objectives
- undertaking national initiatives to improve cancer outcomes for New Zealanders
- assembling and disseminating cancer data and information to inform decision-making and service delivery
- providing support for cancer service providers when service is, or is likely to be, disrupted or is not meeting demand or expectations.

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<sup>1</sup> Ministry of Health. 2019. *New Zealand Cancer Action Plan 2019–2029 – Te Mahere mō te Mate Pukupuku o Aotearoa 2019–2029*. Revised January 2020 Wellington: Ministry of Health.

# Tō mātou whāinga | Our vision

We strive to achieve fewer cancers, better survival, and equity for all.

We are driven to achieve a work programme aligned to our values.



# Te taonga me te kupu taurangi o te ingoa | Our name: Te Aho o Te Kahu

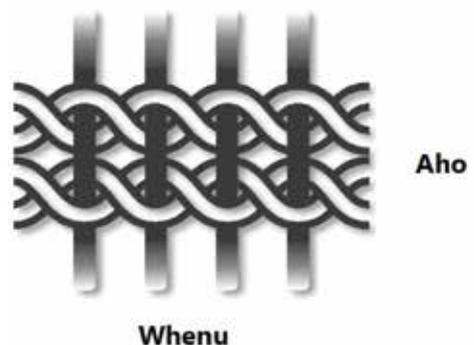
Our te reo Māori name is a taonga, gifted to us by Hei Āhuru Mōwai, Māori Cancer Leadership Aotearoa in June 2020. This name is core to who we are and how we work.

Te Aho o Te Kahu means 'the central thread of the cloak'. This thread (aho) binds the many strands (whenu) into one cloak (kahu) that protects people and their whānau.

**Te Aho:** The central thread symbolises our Agency and our role as a leader and connector across the cancer control continuum.

**Te Kahu:** The cloak symbolises all the services, organisations, communities, and people that work with those affected by cancer.

Equity is not only the priority for us in our role as 'Te Aho'; it is also embedded in our architecture, processes, systems and tikanga.



# Te taonga: Te Kahu Āhuru | Our treasure: Te Kahu Āhuru

Taking inspiration from the vision and name gifted to us, the cloak *Te Kahu Āhuru* was created by kairaranga (weaver) Pip Devonshire and gifted to Te Aho o Te Kahu on 3 August 2021 at Pipitea Marae in Wellington.

This physical embodiment of our purpose is now on display in our Wellington office and is available to be worn by our kaimahi (staff) at events.

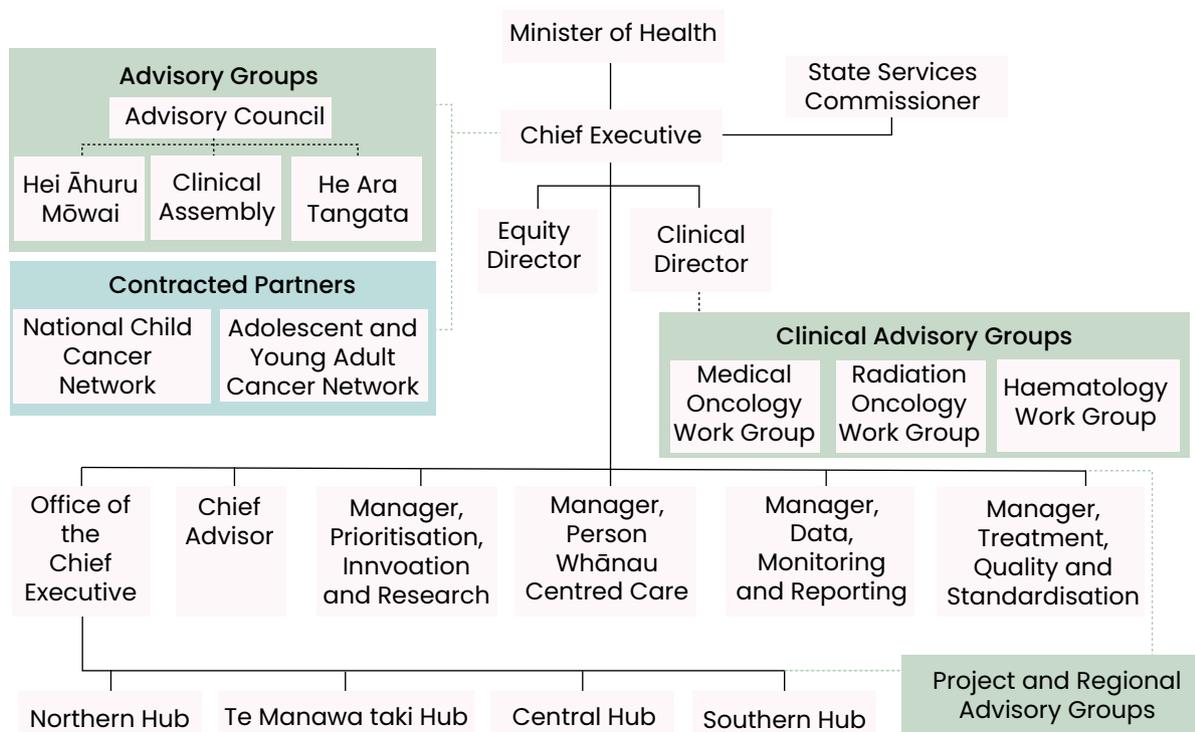


Pip Devonshire explains the raranga (weaving) process while Chief Executive, Dr Diana Sarfati wears Te Kahu Āhuru.

## Ngā rōpū tūhono | Our partners

This year, we have continued to connect with our key partners (shown in green and blue in the organisational structure diagram) to strengthen our work programme and external advice. The role and functions of these groups is regularly reviewed to ensure we make best use of their valuable time and expertise.

### Te Aho o Te Kahu Organisational Structure



## Advisory Council

The Advisory Council supports our chief executive to ensure our organisation has a whole-of-system focus on preventing, treating, and managing cancer. The council also supports our chief executive to oversee system-wide prioritisation and coordination of cancer care in Aotearoa New Zealand. It considers and provides advice on how to get the best value from existing cancer prevention and care investment. As part of our commitment to Te Tiriti in our work the council has 50 percent Māori membership and a Māori co-chair.

## Hei Āhuru Mōwai, Māori Cancer Leadership Aotearoa

Hei Āhuru Mōwai is the Māori cancer leadership group. Its membership brings a range of expertise, including clinical, community care, epidemiology, health services management and research. The Chair of Hei Āhuru Mōwai is also a member of the Advisory Council.

We support the leadership and rangatiratanga of Hei Āhuru Mōwai through operational and project funding, and Hei Āhuru Mōwai works closely with us and provides expertise and support for negotiated strategic work and projects centred on improving Māori cancer outcomes.

## National Clinical Assembly

The National Clinical Assembly provides clinical advice to support us with our long-term strategic direction for reducing cancer incidence and improving cancer services across the cancer continuum. The assembly includes clinicians from a broad range of cancer-related medical, nursing, and allied health specialities.

## He Ara Tangata

He Ara Tangata is the Consumer Reference Group that provides us with advice and solutions for people affected by cancer and their whānau. He Ara Tangata members are embedded on projects across our work programme, and their input ensures our work remains focused on the needs of people across the continuum of cancer care.

## Other advisory groups

To ensure we remain connected with those on the ground, and hear directly from them, we have three primary clinical working groups (Medical Oncology, Radiation Oncology and Haematology) and more than 17 other advisory groups, involving over 200 health professionals and consumers. We meet regularly with these working groups, and their input feeds into our work at all levels.

## COVID-19 response team

As the nationwide COVID-19 pandemic response strategy shifted from 'elimination' to 'endemic' across the course of 2021/22, we reconvened our rapid response team, initially established in March 2020, to ensure we were directly connected to the health sector and could respond to issues and opportunities as they arose. Initially meeting twice weekly, the group now meets on an ad-hoc basis when members indicate there are issues to be discussed.

## Contracted partners

We contract National Child Cancer Network New Zealand (NCCN) and Adolescent and Young Adult Cancer Network Aotearoa (AYA) to deliver care for children and young people with cancer. We collaborate on the direction of their work programmes, meet regularly to discuss progress and issues, and provide support on programme delivery.

## Other external partners

One of our key functions is to liaise with the many parties and organisations involved with cancer prevention and care. In the country's new health system, this includes direct relationships between the chief executives of Te Aho o Te Kahu and Te Whatu Ora, Health New Zealand; Te Aka Whai Ora, Māori Health Authority; Manatū Hauora, Ministry of Health; the Public Health Agency; Pharmac; Health Quality & Safety Commission New Zealand and many more.

The relationship between us and our host, Manatū Hauora, Ministry of Health is particularly important and is supported through co-location and an interdepartmental agency agreement signed in August 2021.

## Being 'Te Aho' – the central thread

In addition to these core relationships, we have developed strong active links with Māori and Pacific health leaders, consumer-led groups, clinical leadership groups, non-governmental organisations and primary health care practitioners. These relationships continue to develop and evolve as the new health system beds in. We are committed to hearing the voices of those across the cancer continuum in Aotearoa New Zealand. There is a wide array of other government entities, sector groups, programmes and projects we contribute to across all workstreams as part of being 'Te Aho' for the cancer continuum.

## Te ū ki Te Tiriti |

### Our commitment to Te Tiriti o Waitangi

We strive to achieve the following four goals of Te Tiriti o Waitangi (Te Tiriti), each expressed in terms of mana.

#### Mana whakahaere

Encouraging effective and appropriate stewardship or kaitiakitanga over the health and disability system. (This goes beyond the management of assets or resources.)

#### Mana motuhake

Enabling Māori to be Māori; to exercise their authority over their lives and to live on Māori terms and according to Māori philosophies, values and practices, including tikanga Māori.

#### Mana tangata

Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.

#### Mana Māori

Enabling ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

The principles of Te Tiriti outlined below, provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work.

#### Tino rangatiratanga

The assurance of tino rangatiratanga provides self-determination and mana motuhake for Māori in the design, delivery and monitoring of health and disability services.

#### Equity

The principle of equity requires the Crown to commit to achieving equitable health outcomes for Māori.

#### Active protection

The principle of active protection requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori.

#### Options

The principle of options requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way.

#### Partnership

The principle of partnership requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services, especially in regard to development and delivery of the primary health system for Māori.

# Ō mātou whānau | Our people

## Personnel

As at 30 June 2022, we had 63 people employed or 60.6 full-time equivalents (FTE), supported by an additional contracted 4.8 FTE.

Of the 60.6 FTE, we have 58.6 FTE employed on permanent contracts, with 1.2 FTE fixed term and 0.8 FTE on secondment.

Eight permanent staff (13 percent) resigned during 2021/22.

## Full-time and part-time staff

Twenty percent of our permanent staff work part time.

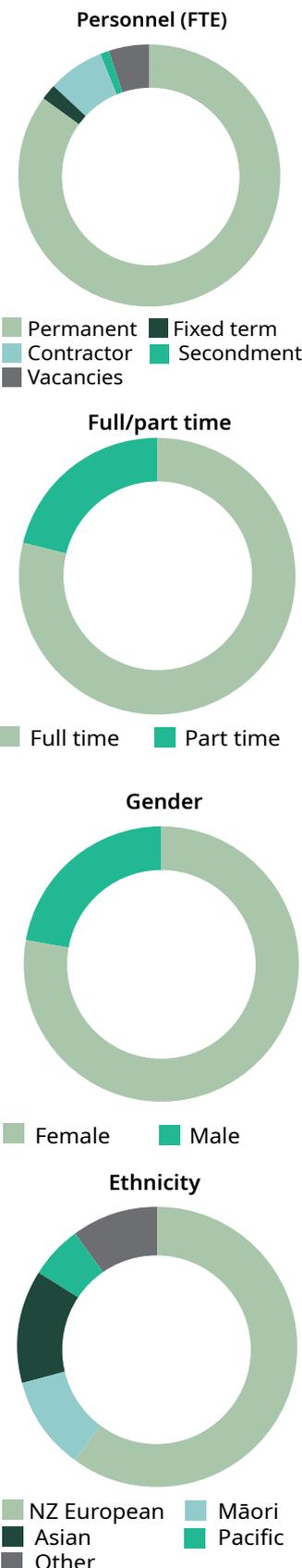
## Gender

The majority of our staff are female (78 percent). No staff identify as gender diverse.

## Ethnicity

We have followed a deliberate strategy to attract and recruit staff who identify as Māori, although this is not without its challenges as there is high demand for Māori staff across the new health entities. Our proportion of Māori staff rose slightly to 11 percent this year (from six staff in 2020/21 to seven in 2021/22). Two of our secondments are Māori also.

At year end, 6 percent of our staff were Pacific peoples, and 40 percent were non-European.



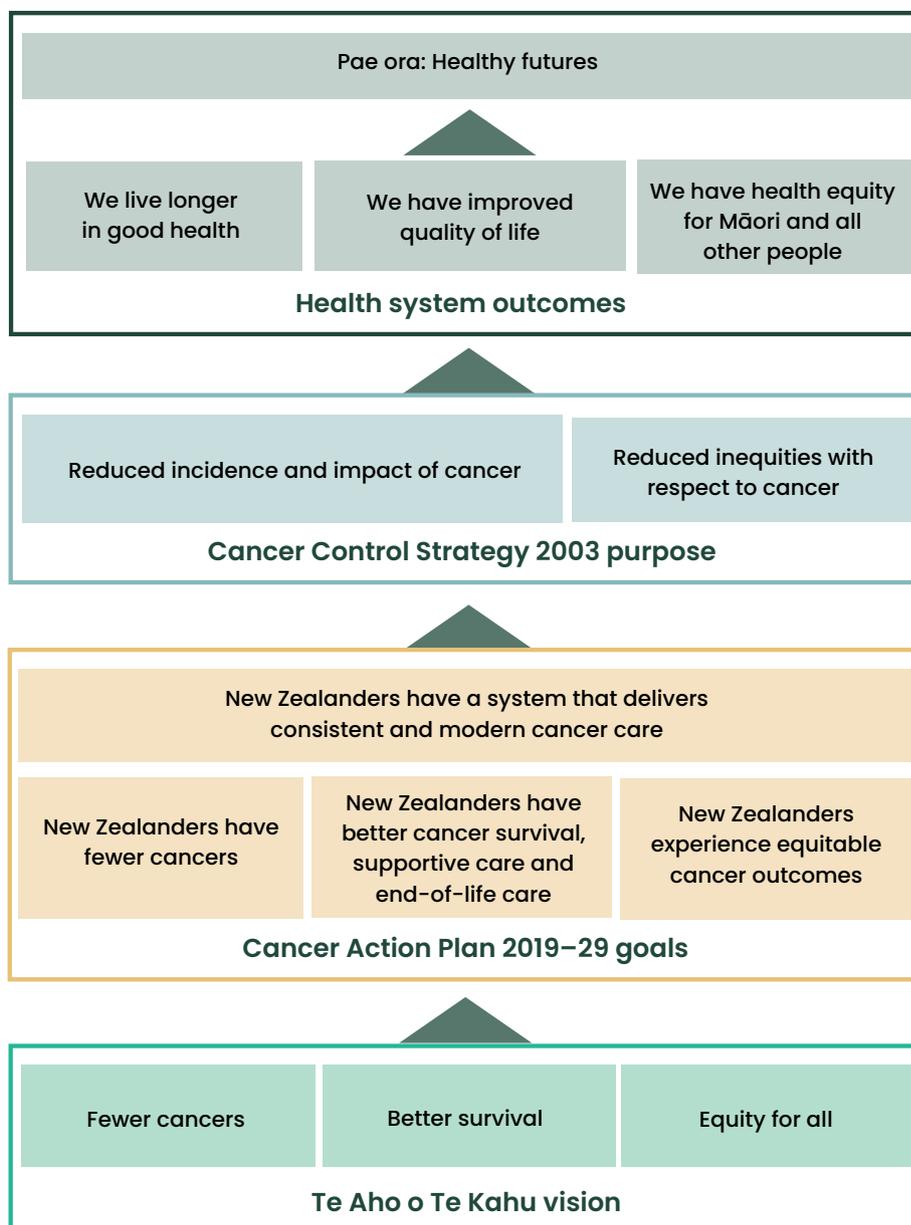
## Diversity and inclusion

We strive to be a diverse and inclusive workplace where all people feel valued. We are a member of Te Kawa Mataaho, Public Service Commission's Diversity and Inclusion Executive Champions Network. Papa Pounamu, the Te Kawa Mataaho diversity programme, identifies five priority areas for development: cultural competence, addressing bias, inclusive leadership, building relationships and employee-led networks. We are engaged across all of these priorities via our Whāinga Amorangi: Transforming Leadership plans and E Tipu E Tipu, our Māori Language Plan (see Tō mātou tutuki | What we have achieved and Tō mātou whakahaere | Our performance sections).

Whiria te Tangata, the Manatū Hauora culture and inclusion strategy outlines a shared overarching approach to diversity and inclusion. Our staff work alongside Manatū Hauora staff in developing, delivering, and participating in Manatū Hauora awareness and celebration events and are encouraged to engage with the many employee-led networks on offer at both Manatū Hauora and the wider public service.

# Ō mātou takune | Our intentions for 2021/22

The strategic direction of Te Aho o Te Kahu is articulated through *The New Zealand Cancer Control Strategy 2003*<sup>2</sup> and the *New Zealand Cancer Action Plan 2019–2029* (the Cancer Action Plan)<sup>3</sup>. Our work is focused on achieving the Aotearoa New Zealand health system goal of pae ora: healthy futures and the three system outcomes – living longer in good health, improved quality of life and equity for all – through delivering our vision of fewer cancers, better survival and equity for all.



2 Minister of Health. 2003. *The New Zealand Cancer Control Strategy*. Wellington: Ministry of Health and the New Zealand Cancer Control Trust.

3 Ministry of Health. 2019. *New Zealand Cancer Action Plan 2019–2029 – Te Mahere mō te Mate Pukupuku o Aotearoa 2019–2029*. Revised January 2020 Wellington: Ministry of Health.

In 2021/22, in recognition that a core function of our agency is to shape the health environment, we adopted a 'shaping strategy'. This strategic approach supports us to work in a way that maximises opportunities to engage and influence.



## Work programme

Our work programme for 2021/22 sought to progress the goals in the Cancer Action Plan and focused on planning for the delivery of cancer care in the new health system.

All aspects of our work programme consider the likely or intended impact on improving equity in access, quality, and outcomes. Our work programme has focused on the following Cancer Action Plan outcomes.

<b>New Zealanders have a system that delivers consistent and modern cancer care</b>	
<b>Te Aho o Te Kahu priorities</b>	<b>Te Aho o Te Kahu work</b>
Supporting a system that delivers consistent and modern care	Building a high-performing agency Commitment to capability building Systems and processes Active health sector support COVID-19
Transforming the future of cancer service delivery	Seven cancer services planning projects
Developing a monitoring framework	Delivering the first monitoring report
Providing better quality, more connected data	CanShare Anti-Cancer Therapies – Nationally Organised Workstreams Structured pathology National radiation oncology collection Faster cancer treatment reporting HISO standards Collaboration across data and digital health
<b>New Zealanders have fewer cancers</b>	
<b>Te Aho o Te Kahu priorities</b>	<b>Te Aho o Te Kahu work</b>
Achieving fewer cancers through a focus on prevention	Cancer Prevention Report Cancer research Primary health care project Advice for primary care
<b>New Zealanders have better cancer survival</b>	
<b>Te Aho o Te Kahu priorities</b>	<b>Te Aho o Te Kahu work</b>
Improving cancer survival	Quality improvement programme Cancer medicines availability analysis Clinical trials
<b>New Zealanders experience equitable cancer outcomes</b>	
<b>Te Aho o Te Kahu priorities</b>	<b>Te Aho o Te Kahu work</b>
Improving equity of cancer outcomes	Māori community hui Embedding equity-led thinking Being equity-led and whānau-centred with data Pacific research project Supporting equity-led work across the sector

# Ā mātou whakatutukitanga | What we have achieved

## He pūnaha manaaki | Supporting a system that delivers consistent and modern care

### Building a high-performing agency

Te Aho o Te Kahu has a reputation, within Government and across the health and disability sector, for responsiveness and delivery. In the 2021/22 year, we continued to strengthen our relationships with stakeholders, grow our staff capabilities and support the wellbeing of our team around the motu – all during a challenging year of COVID-19 disruptions and health system reforms.

We supported the Minister of Health and Associate Ministers by providing high-quality, timely advice across a range of cancer topics through regular meetings, briefing papers and weekly updates. Our communications team has built a strong relationship with the Ministers' secretaries to ensure we can meet the needs of the Ministers' offices as they arise. We have cemented our place as the trusted cancer advisor to Government.

We have bedded in our sector stakeholder engagement this year through regular meetings with our advisory groups (outlined in the section Ngā roopu tūhono | Our partners) and by scaling up the many project and tumour stream advisory groups supporting our work programmes. We have held more than 200 stakeholder meetings and engagements in 2021/22 – with many focused on the work we are doing to design cancer services for the new health system. Engagements will continue as we begin to work with the new health entities to deliver change.

Of note this year is our deepening partnership with Hei Āhuru Mōwai, Māori Cancer Leadership Aotearoa. Hei Āhuru Mōwai members sit on many of our major advisory groups, providing strategic input to our work programme direction, targeted advice towards equitable cancer outcomes for Māori, access to Māori cancer expertise and support for developing Māori capability across our organisation. We have engaged Hei Āhuru Mōwai co-chair Gary Thompson as pou tikanga to provide us with cultural guidance as needed. We support the aspirations of Hei Āhuru Mōwai and its growth as an organisation. We have provided resource to support their priorities, including the development of infographics for whānau with cancer throughout the COVID-19 pandemic. The strength of this partnership has been recognised by Te Kawa Mataaho, Public Service Commission, and we are finalists in its Spirit of Service, Māori Crown Relationship award.

Māori leadership and engagement are evident at every level within our organisation: through proactively recruiting Māori staff, engaging with Māori clinical and lived-experience leaders, holding hui with whānau Māori and Māori communities, partnering with Hei Āhuru Mōwai and ensuring key advisory bodies have 50 percent Māori membership and a Māori chair/co-chair.

The involvement of He Ara Tangata, Consumer Reference Group has also gathered momentum this year, and reference group members are now embedded in projects across our organisation, to provide a critical lived-experience lens to our work.

## Commitment to capability building

Capability building remains a major focus for us. We have an induction process that requires all staff to undertake modules on te ao Māori along with learning about our obligations as public servants. Our staff can access all Manatū Hauora professional development resources, including external workshops and online courses. We also deliver our own bespoke courses, including a two-day 'machinery of government' course, staff forums and information sessions and an annual all-staff capability-building day. Each staff member's professional development plan must contain capability-building goals.

Our commitment to Te Tiriti can be seen in our ambitious programme to build capability to engage with Māori. In 2021/22, we delivered four Whāinga Amorangi: Transforming Leadership plans to Te Arawhiti, The Office for Māori Crown Relations, and these were endorsed without change. Te Arawhiti have directed other Government entities to us to provide guidance on their plans. We have made strong progress against the goals and measures set out in the plans through activities such as a day at Pipitea Marae, a presentation by Meihana Durie on mātauranga Māori, attending The Wall Walk\* (the interactive workshop designed to raise awareness about key events in the history of Aotearoa New Zealand's bicultural relations), hosting a Te Tiriti session, delivering a racial bias workshop, Waitangi, Matariki and Te Wiki o Te Reo Māori activities and twice-weekly waiata sessions. Every staff member is required to have a goal in their professional development plan that relates to Whāinga Amorangi.

Our commitment can also be measured in our progress against our Māori language plan, E Tipu E Tipu. The staff survey showed confidence in speaking te reo has increased across every measure (see Tō mātou whakahaere | Our performance section).

## Systems and processes

We continued to develop our systems and processes in the 2021/22 year, aided by the signing of the departmental agency agreement with our hosts, Manatū Hauora.

We launched a suite of project management templates that have been extremely useful in providing an agency-wide view of national and regional work in progress and created an equity toolkit to support staff to develop equity led thinking at all levels across the Agency.

We have embedded a new leadership group meeting structure, separating out operational, tactical and strategic work and allowing us to streamline our agenda and workflow. We have responded to all ministerial enquiries, Official Information Act requests (OIAs) and pieces of correspondence within expected timeframes.

Our focus on growing and supporting our staff saw the launch of our Leadership Pledge and Wellbeing Strategy this year. The pledge is a compelling reminder of our people leaders' commitment to the wellbeing of their team members, and the strategy outlines how we will prioritise wellbeing using a Te Whare Tapa Whā model.

## The Leadership Group's pledge to Wellbeing

As leaders, we recognise staff wellbeing as a critical aspect of being successful as an agency. We whakamana, give respect to, Te Whare Tapa Whā, which emphasises the connections between our physical, spiritual, mental, emotional, family, and social dimensions of health. These concepts indicate the importance of balance in our lives.

We always want staff to feel comfortable, respected and connected.

As leaders, our responsibility is to uphold this pledge and organisational manaakitanga. We will set positive examples and, by doing so, enhance mana and support for individuals.

### As leaders, we will:

- Promote work life balance, e.g. flexible working
- Provide opportunities for whakawhanaungatanga, to establish relationships in all aspects of work
- Be open to discussions about workload and consider wellbeing when assigning work
- Make space in meetings to discuss wellbeing, e.g. team meetings, leadership meetings, 1:1s
- Dedicate time towards an activity that promotes organisational wellbeing
- Actively take part in training that enables us to develop and support our staff
- Be active and intentional in supporting staff belonging to diverse SOGIESC (sexual orientation, gender identity and expression, and sex characteristics), religious and ethnic communities
- Listen to and consider staff suggestions for enhancing wellbeing
- Be mindful of and adapt to new ways of approaching wellbeing.

We are very proud of our results in the inaugural Public Service Census, Te Taunaki, in 2021. There are over 60,000 public servants across 36 agencies. The results highlight much of the work we are doing, particularly around diversity and inclusion, te reo Māori and Māori Crown relations (see Tō mātou whakahaere | Our performance section).

As yet another validation of our performance, we were thrilled to learn our chief executive was nominated for and selected as one of three global finalists in the Union for International Cancer Control (UICC) Chief Executive Office Award. The winner will be announced at the UICC General Assembly in Geneva in October. We are very proud to support Diana in this nomination.

## Active health sector support

We continue to offer support to the secondary and tertiary cancer sector through our four regional hubs. The hubs are responsible for:

- developing positive working relationships with regional stakeholders
- maintaining links with regional and local governance groups
- working closely with cancer service providers to implement national priorities
- understanding regional and local needs and performance

- promoting a regional perspective and advocating for regional needs
- coordinating responses to regional or local issues or opportunities.

This includes working directly with clinical and operational leadership of cancer services to support service delivery and timely access to diagnosis and treatment. Across the 2021/22 year, that support has been tailored to the needs of each region and affected district. It included providing insight into service performance data and working with clinicians and service staff to identify and support appropriate responses.

## COVID-19

We have provided national leadership for the cancer care sector throughout the COVID-19 pandemic. In 2021/22, we responded promptly in the initial stages of the Delta and Omicron outbreaks and re-issued guidance to the cancer care sector to ensure cancer treatments continued in a safe and effective manner at all alert levels and traffic light settings.

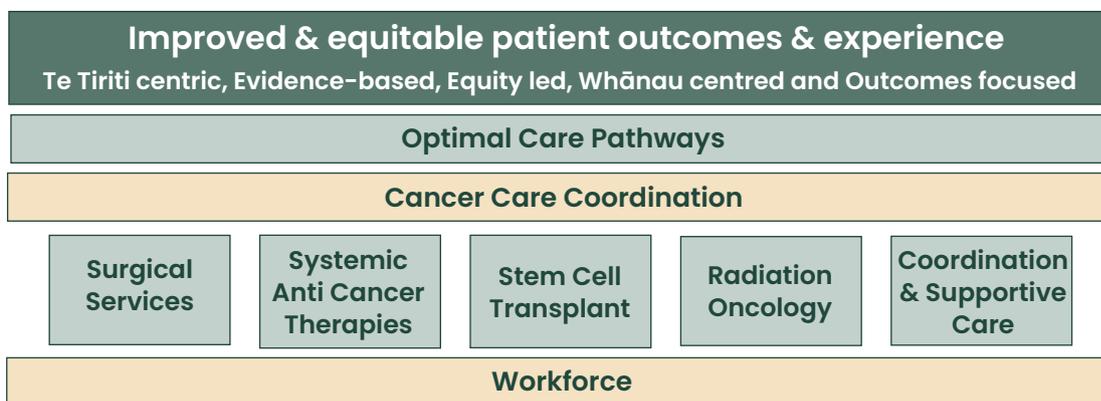
We developed guidelines for clinicians on vaccinating people with cancer and worked alongside cancer care sector partners to ensure key information reached patients. We set up a monitoring framework to identify how cancer services were being impacted by the pandemic and provide an up-to-date picture for the health sector to respond to. The monitoring has shown that, in general, the cancer system operated well during the pandemic and has not worsened any existing inequities or created new ones. Where treatment has been impacted, we have worked with the sector to find solutions, with a particular focus on prioritising Māori and Pacific populations in any catch-up activities.

We are currently supporting Te Whatu Ora to respond to the increased pressure on the health system because of winter illnesses and COVID-19. We provided advice to district health boards (DHBs) on how cancer services should continue and, as part of this, we requested DHBs alert us when there are changes to the availability of cancer surgery or treatment in their services. We continue to support our clinical working groups with COVID-19-related issues, such as the roll-out of new antiviral medications.

## Transforming the future of cancer service delivery

We are currently undertaking a large, proactive programme of work to transform the way cancer treatment services are provided in Aotearoa New Zealand. The aim of this work is to support everyone to access high-quality care, regardless of who they are or where they live. The Cancer Services Planning Programme aims to provide evidence-based guidance to commissioning entities on how to change the way specialist cancer treatment and support services are organised and distributed to achieve optimal, equitable cancer outcomes for all people with cancer in Aotearoa New Zealand.

The design and implementation phase of the programme started in March 2022 and aims to take our thinking beyond what changes need to occur to how the recommendations could be implemented by the new commissioning entities. The outputs from the seven projects within the programme will provide the new entities with a head start on implementing the recommendations. The diagram below (with the seven projects in green) provides a representation of this work. In addition, a second programme of work will soon examine how the services and processes prior to cancer diagnosis could be organised and delivered.



We presented a high-level recommendations summary to the Minister of Health in October 2021. This summary was then shared with the Health System Reform Transition Unit, for input into the interim New Zealand Health Plan of Te Whatu Ora. The full report on the programme *He Mahere Ratonga Mate Pukupuku, Cancer Services Planning: A vision for cancer treatment in the reformed health system* is available on our website.

## 1. Workforce

Addressing the challenges facing the cancer workforce is a priority across the whole Cancer Services Planning Programme. The cancer workforce is struggling to meet current demand much less meet the projected 40 percent increase in new cancer diagnoses between 2020 and 2040. In 2021/22, our focus was on developing an implementation plan that concentrated on immediate short-term actions (subject to available funding). We delivered the plan to Te Whatu Ora and provided advice on utilising existing funding, starting with areas of greatest need – oncology and haematology nursing, the radiation oncology workforce and developing a stem cell transplant workforce model of care. The plan also provided the building blocks for future workforce planning that will continue in 2022/23. We will work with Te Whatu Ora, Te Aka Whai Ora, Māori Health Authority and the Health Workforce Taskforce to ensure there is appropriate cancer workforce capacity and capability to align with future demand for, and changes to, cancer treatment in this country.

## 2. Tumour optimal cancer care pathway

Unwarranted tumour cancer variation in the delivery of cancer care means that some people receive sub-optimal care, and resources are used in ways that do not lead to optimal outcomes. This project supports improvements in cancer care by defining the optimal (evidence-based, best-practice), publicly funded care we should provide. Planning has commenced to develop the optimal cancer care pathways for health care providers and services along the pathway, and for whānau there will be a ‘what to expect’ guide. The pathways will be a tool to help identify and address unwanted variation and inequity, particularly for Māori and Pacific peoples, encourage a proactive response to addressing and eliminating such inequity and drive continuous quality improvement.

## 3. Stem cell transplant

Stem cell transplant services have become fragmented, inequitable, and no longer fit for purpose. This contributes to a cancer services system that does not work equally well for everybody, especially Māori and Pacific peoples. This project aims to design a sustainable future service model for stem cell transplant, at the same time, working to address immediate capacity challenges.

#### 4. Surgical services

Aotearoa New Zealand does not have a national policy to guide how surgery for different cancers should be distributed throughout our country. This means many New Zealanders experience barriers to accessing surgical care, and treatment pathways are inconsistent. The focus of this project is on developing a framework that can help determine how cancer surgical services should be distributed across Aotearoa New Zealand, including the level of centralisation/localisation required for equity of access and quality.

#### 5. Systemic anti-cancer therapies

Care for patients receiving systemic anti-cancer therapies (SACT) – chemotherapy, immunotherapy, targeted therapy and hormone therapy – is becoming more complex, and demand is increasing. Our focus is on addressing immediate capacity challenges while developing new models of care for delivering SACT, looking to enable more SACT to be delivered in the community, where it is appropriate to do so.

#### 6. Radiation oncology

Radiation oncology (RO) in Aotearoa is of high quality but not all population groups are receiving the same access to, or benefit from, it. Currently RO services are managed by six host hospitals operating independently from each other. This project looks to describe and support the move to provide a single RO system of care, operating under a standardised national RO service model. It also focuses on increasing RO workforces and the public Linear Accelerator (LINAC) machine stock and accessibility.

#### 7. Cancer care coordination

We are developing an establishment plan so that cancer care coordination services can be commissioned throughout the country, with the initial focus on supporting Māori and Pacific cancer patients and their whānau. This plan includes strategic advice for the commissioning entities on how they can create cancer coordination services that are broadly consistent and high quality but also tailored to suit local communities and delivered in a range of settings, including primary health care, secondary health care, kaupapa Māori and community health organisations.

### Developing a monitoring framework

The *New Zealand Cancer Action Plan 2019–2029* sets four outcomes and multiple related actions across the cancer control pathway. This year, we have developed a monitoring framework so we can transparently assess our progress towards achieving the aspirations of the Cancer Action Plan.

We will report on 11 broad indicators to give a ‘snapshot’ of the current state of cancer control in Aotearoa New Zealand. Each year, we will calculate the indicators and present the results in a monitoring report to show progress in the cancer control system. The monitoring report will also present activities being undertaken to achieve the outcomes and actions of the Cancer Action Plan. A summary of the first monitoring report is available in *Tō mātou whakahaere*, Our performance section.

## Better quality and more connected data and information CanShare

CanShare is a new national health informatics platform that aims to allow the timely sharing of relevant and accurate cancer data. The primary intent of the CanShare programme is to support clinical and patient decision making at the point of care. Outcomes from this work will include advanced analytics capability supporting up-to-date monitoring of cancer care throughout the country.



This will enable the collection of complete and accurate cancer data, joining currently disparate data siloes and providing a means to share timely clinical cancer information as needed. Over the past year some 200 contributors including health care practitioners, subject matter experts and consumers have been consulted or participated in working groups to advise on CanShare. Alongside the technical aspects of CanShare, we are building the partnerships critical to give effect to Te Tiriti of Waitangi, in particular Māori data sovereignty in the development and use of cancer data. Connections have been established with Te Whatu Ora, a cloud database is being built and there has been much work undertaken in the individual programmes comprising CanShare, as outlined below.

### Anti-Cancer Therapies – Nationally Organised Workstreams

ACT-NOW (Anti-Cancer Therapies – Nationally Organised Workstreams) is a national systemic anti-cancer therapy (SACT) data collection and analytics programme. In 2021/22 stakeholders collaborated to agree on SACT treatment definitions. This has now happened for 90 percent of cancers, meaning that treatment regimens can be compared across the country, outliers investigated, and quality improvement activities instigated.

Implementation of these definitions is underway within the public system, enabling the development of prototype analyses and early insights that can be used as a basis for clinical decision making.

There are multiple projects across our regional hubs now focused on operationalising the benefits of the ACT-NOW programme. Our Central Hub has stood up an ACT-NOW project for the Wellington Blood and Cancer Centre and the Regional Cancer Treatment Service. Functional requirements have been endorsed for the transition to oncology e-prescribing in our Te Manawa Taki Hub. In the Northern Hub, ACT-NOW is integral to the implementation of a new e-prescribing system, with our staff on the implementation working group and steering group.

### **MOSAIQ Oncology software system**

The Southern Hub continues to support the implementation of MOSAIQ across the region. The hub hosted a workshop to continue reviewing and updating Canterbury DHB care plans in MOSAIQ and ensuring alignment with the ACT-NOW project. Clinical staff, supported by Southern Hub staff, updated several existing care plans and created new ones. This will ensure the system is current when other districts come on board. Engagement with Nelson Marlborough and Canterbury DHBs to develop a detailed project plan, including timelines for MOSAIQ implementation, is underway.



Michelle Vaughan, Canterbury DHB medical oncologist and Simon Pointer, Te Aho o Te Kahu national pharmacist at the workshop

### **Multidisciplinary meeting dashboard**

The South Island cancer multidisciplinary meeting (MDM) electronic platform has been a key enabler to streamlining MDM meeting management functions, documentation processes and supporting workflows across the region. One of the key outputs has been the development of a regional power BI dashboard which provides almost real time visibility of MDM resource, volumes and key tumour specific data.

Leveraging off this dashboard, the Southern Hub has supported the development of tumour stream visuals (beginning with the hepato-pancreato-biliary tumour stream) which has combined key surgical, oncology and mortality data to measure patient flow, outcomes and survival. This work is unique to the South Island and will continue to be rolled out to include other cancer tumour streams. These visuals also provide valuable insight into areas which would benefit from quality improvement initiatives.

### **Structured pathology**

Pathology is integral to the diagnosis and treatment of cancer. The ever-increasing complexity of cancer treatment requires a greater level of pathology reporting; however, pathology services are facing major challenges with legacy paper-based data systems and work volumes.

For pathology services to transition to a more connected digital health environment, data standards must be developed. These data standards will identify and describe the clinically relevant data elements, creating consistent workflows for all professionals involved in pathology services.

In 2021/22, we determined a development and release approach to speed up the delivery of data standards and ensure they are robust and meet our Tiriti obligations, including recognising Māori data sovereignty in the development and use of cancer data. In 2021/22, thoracic (lung, pleural and thymic) and breast cancer draft data standards were released, and four more are in development.

### **National radiation oncology collection**

The national radiation oncology collection (ROC) is a national data collection and analytics programme to support efficiencies and improved outcomes for people with cancer receiving radiation therapy. ROC continues to support data-driven improvements to treatment equity, quality, consistency, and efficiency in Aotearoa New Zealand.

ROC has been used as the key data source to underpin national planning to increase treatment capacity and the workforce to support this. This is intended to address inequities by reducing the barriers to access to radiation therapy and support the provision of radiation therapy closer to home for many people.

### **Faster cancer treatment reporting**

Faster cancer treatment (FCT) indicators were introduced by the Government in 2012, requiring DHBs to collect standardised information on patients who had been referred urgently with a high suspicion of cancer. There are two indicators.

- 31-day indicator – patients with a confirmed cancer diagnosis receive their first cancer treatment (or other management) within 31 days of a decision to treat.
- 62-day indicator – patients referred urgently with a high suspicion of cancer receive their first treatment (or other management) within 62 days of the hospital receiving the referral.

We support ongoing FCT data quality improvement by enhancing transactional data business rules and working with DHBs and Manatū Hauora on data quality. We also coordinate FCT data collection, reporting and dissemination.

Throughout 2021/22, our regional hubs continued to support DHBs to improve their performance against FCT measures. Different regions have experienced different needs and challenges, and therefore the support provided by each hub has varied. Collectively, the regional hubs have supported their DHBs with regional FCT analysis, including providing equity-focused reporting, contributing to local DHB cancer service improvement work groups, collating regional narrative reports, and assisting with specific improvement initiatives. Most recently, we have initiated a project to support a consistent interpretation and use of the cancer wait-time business rules to better support service improvements and regional hub project manager knowledge.

### **HISO (Health Information Standards Organisation) standards**

Nationally agreed and HISO endorsed data standards support the vision we share with Te Whatu Ora for a fully interoperable digital health system to facilitate the timely sharing of cancer information for decision making, quality improvement and research. Standards ensure the integrity of collected health information so that systems can ‘talk to each other’. These standards are part of a system in which patients and their whānau have access to and control over their own information.

Two data standards have been published in 2021/22: the structured pathology data standard and the multidisciplinary meetings data standard. More are currently being developed.

## Leadership and collaboration across data and digital health

We have been working alongside Manatū Hauora, Te Whatu Ora and Te Aka Whai Ora to ensure the needs of cancer patients and whānau are considered within data and digital system changes. We now have staff sitting on key digital governance and advisory groups including the Hira programme governance group, the Digital Enablement Oversight Group, the Digital Health Equity Reference Group and Te Rangapū Tiriti, a new co-governance group established by Manatū Hauora to ensure Māori have a voice within the area of data & digital health. We also chair the Cancer Working Group within the New Zealand Telehealth Forum. In 2021/22 we facilitated a New Zealand Telehealth Forum webinar on telehealth in cancer care and took part in two other webinars, Pae Ora and Improving Māori Health Gains.

## Kia whakaiti iho te mate pukupuku | Achieving fewer cancers through a focus on prevention

### Cancer Prevention Report

Te Aho o Te Kahu released *Pūrongo Ārai Mate Pukupuku, Cancer Prevention Report (Cancer Prevention Report)* on 4 February 2022, in collaboration with Te Hiringa Hauora, Health Promotion Agency and the University of Otago Wellington. The Cancer Prevention Report outlines evidence-based interventions to prevent cancer across six key cancer risk factors: tobacco, alcohol, poor nutrition and excess body weight, insufficient physical activity, excessive exposure to sun and chronic infections.

Up to half of all cancers can be prevented by reducing or removing everyone's exposure to the cancer risk factors present in our lives and environments. The purpose of this report is to summarise how Aotearoa New Zealand is doing in each of those risk factor areas and to highlight where we could do better. Our aim was to identify ways to create the environments that help whānau live long healthy lives, free of cancer. We will work alongside Manatū Hauora, the Public Health Agency, Te Whatu Ora and Te Aka Whai Ora as needed in areas that the Government is keen to progress.

### Cancer research

In 2021/22 we teamed up with the Health Research Council of New Zealand (HRC) and Manatū Hauora to provide \$6.2 million in funding for research aimed at addressing the stark inequities in cancer care and survival for Māori and Pacific peoples in Aotearoa New Zealand. There were six recipients with proposals across a range of areas: lung cancer

screening, improving clinical care in lung and uterine cancer and whānau ora navigation within the delivery of cancer care.

## Primary health care

Our Person and Whānau Centred Care team have initiated a project to provide us with an in-depth understanding of the state of primary and community health care in Aotearoa New Zealand with respect to cancer. This is a three-phase project that involves a stocktake of the current state, a literature review and consideration of actions across the continuum of care where primary health care can be better supported/optimised. Stakeholder engagement will be undertaken across each aspect. Focused implementation work will be determined once the initial stocktake and literature review phases are complete.

## Advice and guidance to primary health care

In 2021/22 we commissioned the independent, not-for-profit health professional educational organisation Best Practice Advocacy Centre New Zealand (bpac<sup>nz</sup>) to develop evidence-based packages on the early detection and follow-up and surveillance of lung cancer and melanoma. These information packages are supported by peer group discussion points and a quiz that help both general and nurse practitioners with their ongoing medical education. Around 11,000 health practitioners currently use bpac<sup>nz</sup>, and it is seen as a powerful platform for sharing educational materials with a primary health care audience.

# Kia runga noa ake te mataora | Improving cancer survival

## Quality improvement programme

Quality performance indicators (QPIs) are used to improve the quality of cancer services and deliver better outcomes for people diagnosed with cancer. They enable DHBs to compare their performance with other DHBs. QPIs are selected by an expert working group with consumer representation and a range of clinical experts involved in providing care to cancer patients. To date, we have selected, calculated, and reported on QPIs for bowel, lung, and prostate cancers. Currently, we are working on QPIs for breast and pancreatic cancers.

This year, we worked with the National Bowel Cancer Working Group to recalculate the bowel cancer quality performance indicators that were first published by Manatū Hauora in March 2019<sup>4</sup>. This latest report published QPI data for patients diagnosed with bowel cancer in Aotearoa New Zealand from 2017 to 2019. We released the *Bowel Cancer Quality Improvement Monitoring Report Update 2022* to DHBs at the start of March and published the final report at the end of April.

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4 Ministry of Health. 2019. Bowel Cancer Quality Improvement Report. Wellington: Ministry of Health.

After calling for nominations via our website and through key stakeholders, we convened a national Breast Cancer QPI Working Group late last year. Its role is to work with us to identify potential breast cancer QPIs. Once the breast cancer QPIs have gone through public consultation and been finalised, they will be calculated using data from the New Zealand Cancer Registry and Manatū Hauora national data collections for patients diagnosed with breast cancer in Aotearoa New Zealand from 2017 to 2019.

We also worked with the national Pancreatic Cancer Working Group to finalise the pancreatic cancer QPI descriptions after receiving feedback via the public consultation process in October 2021. The indicators are now being calculated, and we hope to publish the results soon.

## Cancer medicines availability analysis

In April 2022 we released *Mārama Ana ki te Āputa: He tātari i te wāteatanga o ngā rongōā mate pukupuku i Aotearoa | Understanding the Gap: an analysis of the availability of cancer medicines in Aotearoa*, our cancer medicines availability analysis report. The report describes the findings of an analysis that compares the availability of cancer medicines in Aotearoa (medicines publicly funded via Pharmac) with that of Australia – not only in terms of the number of medicines funded but also in terms of clinical benefit.

Cancer medicines are a crucial part of cancer care. In our work, we often hear concerns from patients, their whānau and their health professionals regarding cancer medicines availability. The aim of this work was to provide useful insights to Pharmac, the New Zealand Government, the health sector and to the public. We identified 20 different medicine–indication pair gaps across nine different solid-tumour cancer types where the medicines were publicly funded in Australia and not in Aotearoa New Zealand and where the analysis indicated that the medicine would offer substantial clinical benefit. This analysis was conducted separately to the independent review of Pharmac announced by the Government in March 2021, but we shared the preliminary results of this analysis with the Pharmac review panel.

## Clinical trials

Inadequate and inequitable access to cancer clinical trials has been highlighted by the cancer sector as an area of concern. Manatū Hauora is leading work to improve clinical trial infrastructure for all conditions, including cancer, and this year, we continue to advocate and provide support from a cancer perspective. The teletrials model (implemented in Australia) gives people with cancer who are living away from the major centres the opportunity to participate in clinical trials without needing to travel. In 2021/22, we funded the organisation Cancer Trials New Zealand to develop core infrastructure to support teletrials in Aotearoa New Zealand.

# Te whakapai mana taurite o ngā hua mate pukupuku | Improving equity of cancer outcomes

## Māori community hui

In 2020/21 Te Aho o Te Kahu launched a series of community hui, specifically aimed at whānau Māori who were affected by cancer. The last of these hui was completed in 2021/22, with our team travelling to Southland and Waikato in July 2021. Over 2,800 whānau Māori supported and attended a community hui, helping us gain a deeper understanding of the experiences and issues faced by Māori cancer patients and whānau.

We've been analysing the data and insights shared throughout the hui series and discussing these insights with stakeholders working in Māori health and cancer care. We are in the final stages of producing a report summarising the collective voice of whānau Māori and look forward to sharing the findings back with the communities and contributors. We've also used the insights internally to elevate the patient voice in several key projects, including the Cancer Services Planning Programme.

## Embedding equity led thinking

In 2021/22 we continued to build our focus on equity, with capability development a key area of work. Our Equity team developed a toolkit that included resources and research. This toolkit is designed to educate, inform, and challenge our staff.

We have also incorporated equity frameworks into key business processes and project planning methodology. We established a community of practice, Te Kāhui Mana Taurite, to support equity analysis across the entire Cancer Services Planning Programme. This roopu identified and analysed equity issues across each area of the programme. The voice of patients and whānau was integrated into this analysis, as was national and international literature.

We have also been supporting the equity work of other agencies and organisations. Our Equity team has shared insights with other health and community colleagues, both formally and informally, through guest speaker presentations, various governance and advisory roles, and publication of research papers.

## Being equity led and whānau centred in the development and use of data

We are actively working with our partners to better understand and put into practice our obligations and responsibilities with respect to Māori data sovereignty and governance. We are mindful of the privilege we have in accessing people's cancer data. We understand our obligations to ensure cancer information is timely, sharable, relevant, and accessible, and used appropriately for the purpose for which it was intended. To give effect to Te Tiriti o Waitangi, we treat data as a taonga (treasure) and apply appropriate safeguards to secure and protect Māori data from misuse. We recognise the rights and interests of Māori in the collection, ownership and application of data.

We have developed a position statement on the collection of cancer data and information in Aotearoa New Zealand in relation to hapū and iwi affiliation, Māori descent and ethnicity. Equity impact assessments inform the foundation data programmes of ACT-NOW and structured pathology reporting of cancer. We have started scoping for an overarching equity impact assessment to inform CanShare development and delivery. This will include integrating safeguards in development and use of Māori data for analytics, improvement, and research.

## **Pacific research project**

We have been working with Moana Connect to explore Pacific cancer pathways to diagnosis, treatment, follow-up after treatment, support, and the handover back to primary health care services. We want to understand at what points along the cancer pathway Pacific peoples experience breakdowns in the system or face challenges and barriers and what supports they have received.

This research follows an empowerment approach where Pacific stories and perspectives are championed and, once completed, will inform our work around identifying opportunities to improve cancer coordination and supportive care for Pacific peoples during cancer treatment. We expect to release the findings from this research later in 2022.

## **Supporting equity led work across the cancer sector**

Te Aho o Te Kahu has supported a number of organisations looking to embed equity in their work. This includes the Cancer Society, who have been codesigning a proposed new model of care with equity as a key principle, and the National Child Cancer Network, who have established a roopu and research project focused on better understanding any inequities of experience among families living with child cancer.

We have also collaborated with the New Zealand Telehealth Forum and the University of Auckland to support an internship examining the resources are available to help patients understand and use telehealth and are working with the Forum and Massey University to survey all public hospital cancer clinics on their use of and attitudes towards telehealth in cancer care.

# Tā mātou whakahaere | Our performance

## Agency performance

Performance measure	2020/21	2021/22	Notes
Staff satisfaction	7.3/10	NA	Ministry of Health Kōrero Mai Survey is undertaken every two years. Will be carried out again in Nov 2022.
Sick leave taken	3.1 days	4.7 days ↑	Most staff have taken COVID-19 sick leave across 2021/22 (either contracting COVID-19 themselves or caring for dependents).
Staff turnover	4%	13% ↑	Staff turnover has increased as we have become fully established and are settling into BAU operation.
Percentage Māori staff	8%	11% ↑	Deliberate recruitment focus on Māori staff and capability.
Percentage Pacific staff	0%	6% ↑	Deliberate recruitment focus on Pacific staff and capability, creation of a Pacific Equity role in the Northern Hub.
Percentage Non-European staff	26%	40% ↑	
<b>Diversity and Inclusion</b>			Statements from 2021 Public Service Census
I believe my agency supports and actively promotes an inclusive workplace	93%		Average across the Public Service was 78%
The people in my workgroup behave in an accepting manner to people from diverse backgrounds	91%		Average across the Public Service was 81%
I feel accepted as a valued member of the team	86%		Average across the Public Service was 79%
I am satisfied with my work/life balance	59%		Average across the Public Service was 52%
<b>Te Reo Māori</b>			Statements from 2021 Public Service Census
I use at least some te reo words and phrases	84%		Average across the Public Service was 58%
I hear leaders regularly using te reo words and phrases	93%		Average across the Public Service was 67%
Staff are supported to improve our te reo Māori	84%		Average across the Public Service was 59%
How many staff have never studied te reo	23 people	6 people ↓	From internal Whāinga Amorangi individual capability surveys

Performance measure	2020/21	2021/22	Notes
<b>Māori Crown Relations</b>			Statements from 2021 Public Service Census
I am comfortable supporting tikanga Māori in my agency	87%		Average across the Public Service was 69%
I am encouraged and supported to engage with Māori	91%		Average across the Public Service was 65%
I feel confident in my ability to identify aspects of my agency's work that may disadvantage Māori	89%		Average across the Public Service was 58%
I understand how my agency's Te Tiriti responsibilities apply to its work	89%		Average across the Public Service was 69%
Te Aho o Te Kahu enables me to apply Māori Crown relations skills to my mahi	49%	76% ↑	From internal Whāinga Amorangi individual capability surveys
OIA timeliness	100%	100%	From Ministry of Health data

### Te Aho o Te Kahu Whāinga Amorangi Individual Māori Crown Relations Surveys (baseline in 2021, repeated in 2022)



## Sector performance

The New Zealand Cancer Action Plan 2019–2029 sets four outcomes and multiple actions across the cancer control pathway. In 2021/22 we developed a monitoring framework and are currently in the process of developing the first monitoring report.

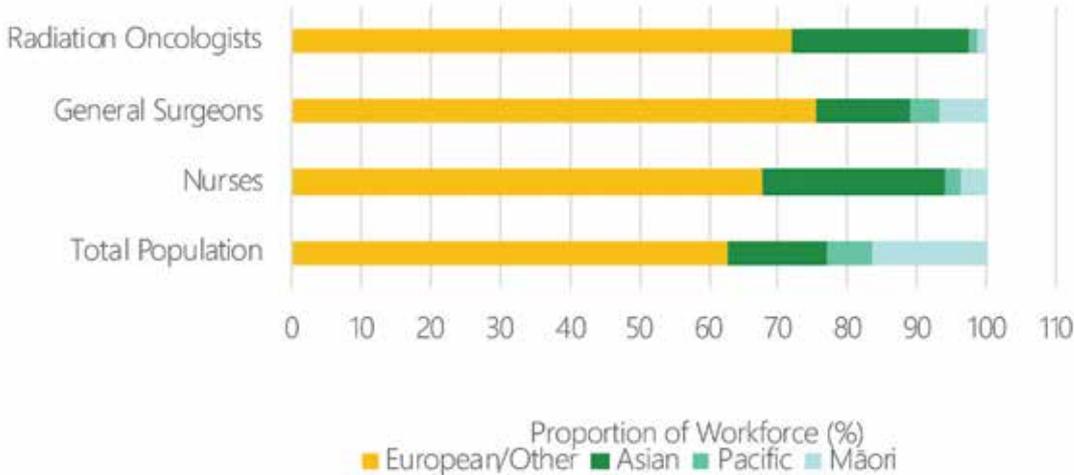
This report presents eleven broad indicators of the current state of cancer control in Aotearoa along with activities being undertaken to achieve the aspirations of the Cancer Action Plan.

Monitoring will take place annually and we will be able to track system change over time. These measures tell us if we are heading in the right direction – however it is important to note, they are not solely attributable to Te Aho o Te Kahu and will likely shift slowly.

# Outcome 1: New Zealanders have a system that delivers consistent and modern cancer care

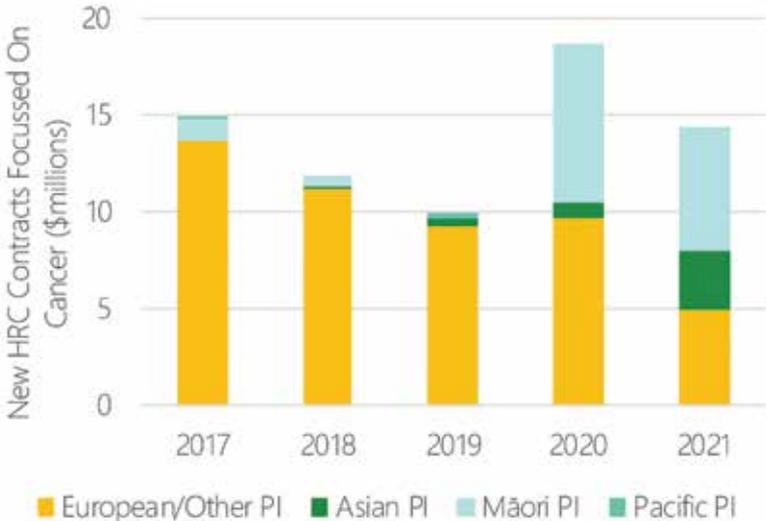
## Indicator 1: Ethnic distribution of the current cancer workforce

Ethnic distribution of radiation oncologists, general surgeons and nurses in 2021, shown alongside the ethnic distribution of the total New Zealand population.



There is a mismatch between the ethnic distribution of the cancer workforce and the general population. Māori and Pacific peoples are underrepresented in the cancer workforce.

## Indicator 2: Government investment in cancer-focused research

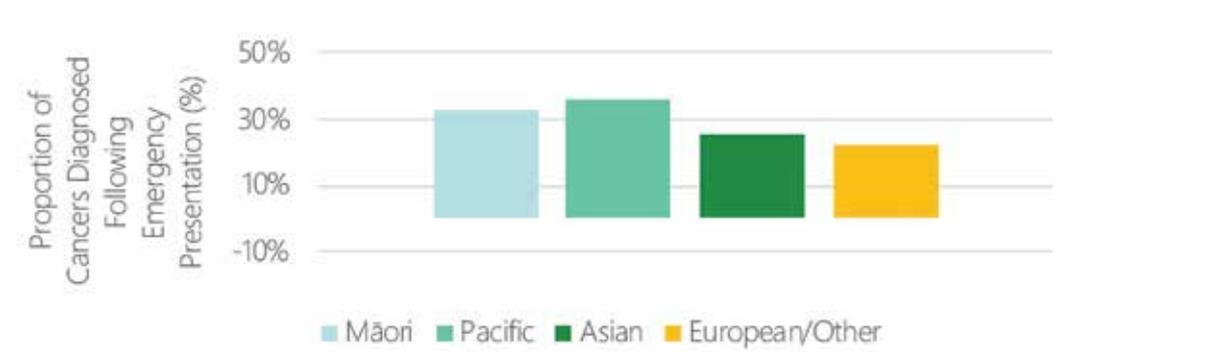


In 2020 and 2021 there has been an increase in diversity, with Māori leading projects worth more than \$6 million and Asian principle investigators leading projects worth more than \$3 million. There are few Pacific-led HRC-funded cancer-focused research.

## Te Aho o Te Kahu-led activities related to Outcome 1

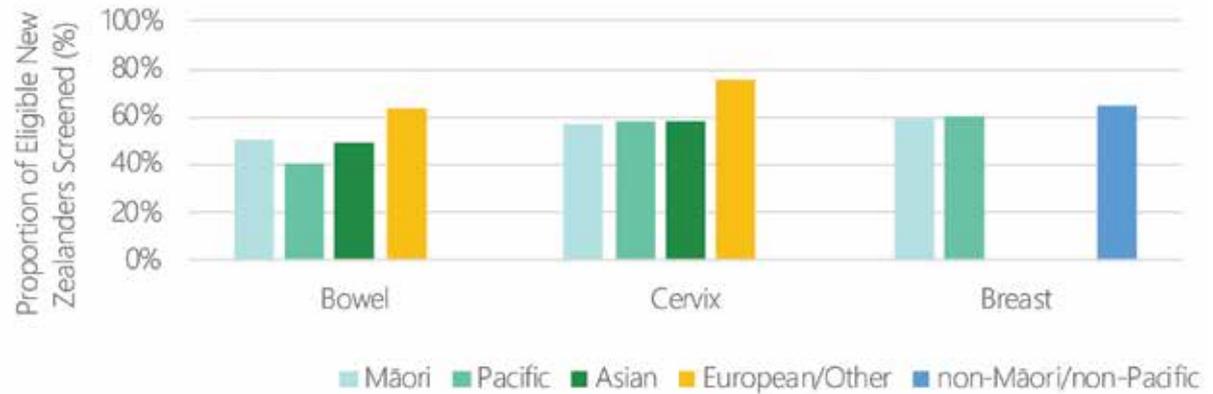
	Te Aho o Te Kahu-led activity	Related Action(s) within the Cancer Action Plan
<b>Outcome 1:</b>  New Zealanders have a system that delivers consistent and modern cancer care	Creation of a cancer control agency for New Zealand	Leadership and governance
	Creation of groups to assist in the governance of cancer care delivery	Leadership and governance
	Partnership with Māori cancer leaders	Leadership and governance
	Building infrastructure to make real-time cancer data sharing a reality	Data and information
	Structured Pathology Reporting of Cancer	Data and information
	MDM Data Standard refresh	Data and information
	New funding for research to drive equitable cancer outcomes	Research and innovation
	Supporting improved access to cancer clinical trials via teletrials	Research and innovation

**Outcome 2: New Zealanders experience equitable cancer outcomes**  
**Indicator 1: Diagnosis of cancer following an emergency presentation**



In 2020, Māori and Pacific peoples were more likely to be diagnosed with cancer following an emergency presentation.

**Indicator 2: Participation in national cancer screening programmes**

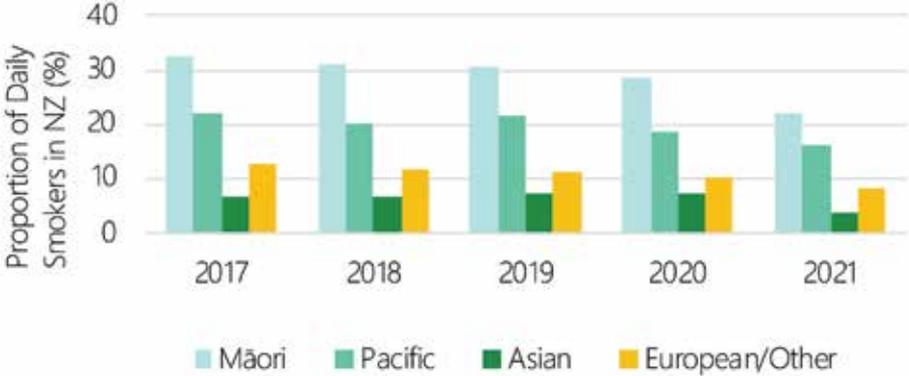


Based on data from 2021, there are strong disparities in access to each of the three national screening programmes between ethnic groups.

**Te Aho o Te Kahu-led activities related to Outcome 2**

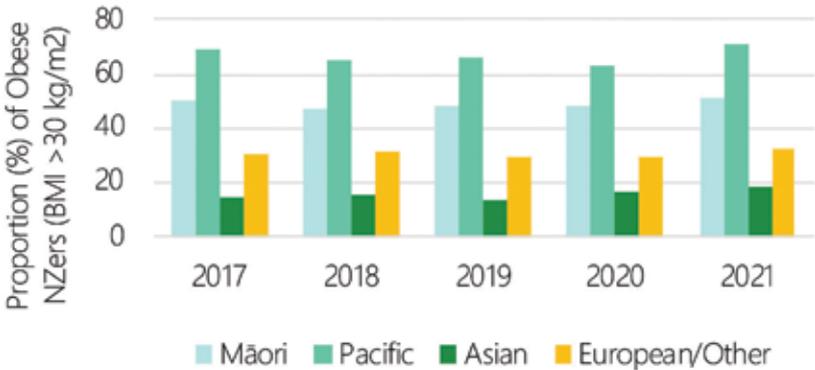
	Te Aho o Te Kahu-led activity	Related Action(s) within the Cancer Action Plan
<b>Outcome 2:</b> New Zealanders experience equitable cancer outcomes	Gathering the voice of the Māori community	Achieve equity by design
	Building Mana Enhancing Relationships with Māori Leaders and Cancer Care Provider	Achieve equity by design
	Project focusing on primary care	Achieve equity by design
	Project on cancer care for Pacific peoples	Achieve equity by design

**Outcome 3: New Zealanders have fewer cancers**  
**Indicator 1: Proportion of New Zealanders who are daily smokers**



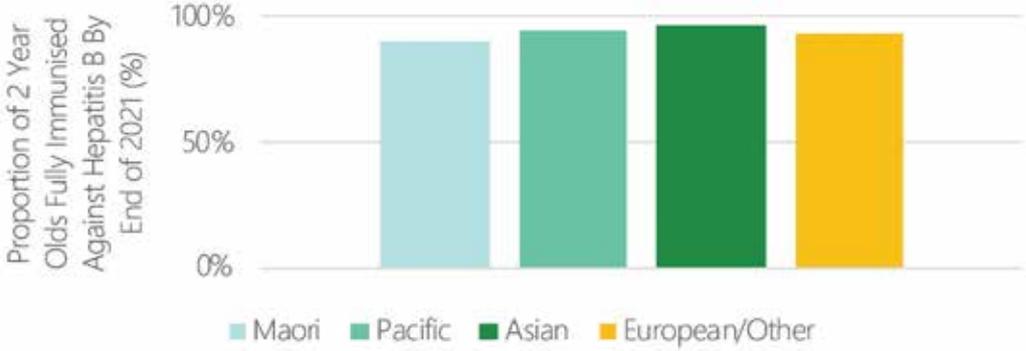
There are strong disparities in daily tobacco smoking between ethnic groups in New Zealand. The rate of daily smoking appears to be reducing for most ethnic groups over time, although there does not appear to have been a change in disparities between ethnic groups.

**Indicator 2: Proportion of New Zealanders who are obese**



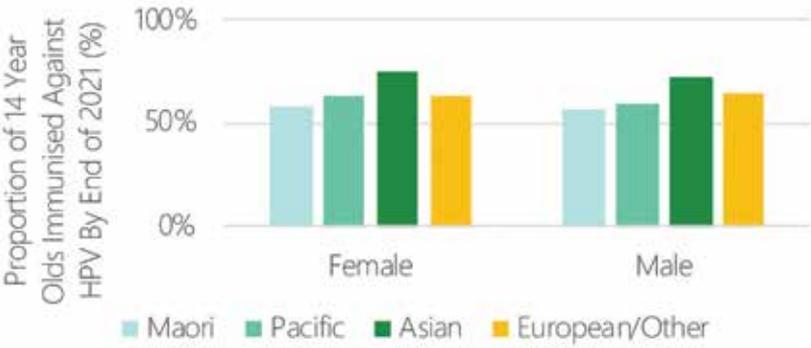
Stark disparities exist in rates of obesity between ethnic groups in New Zealand. The highest rates of obesity are seen among Pacific peoples, followed by Māori, European/Other and Asian peoples. The rates of obesity are not reducing over time for any ethnic group, and disparities between ethnic groups are not changing.

**Indicator 3: Proportion of New Zealand children immunised against hepatitis B**



Less Māori are immunised against hepatitis B than other ethnic groups. Falling rates of childhood immunisation against hepatitis B are particularly important for Māori, since the rate of primary liver cancer is higher for Māori and the incidence of liver cancer is increasing abruptly over time for Māori, but not for non-Māori.

**Indicator 4: Proportion of New Zealand children immunised against HPV**



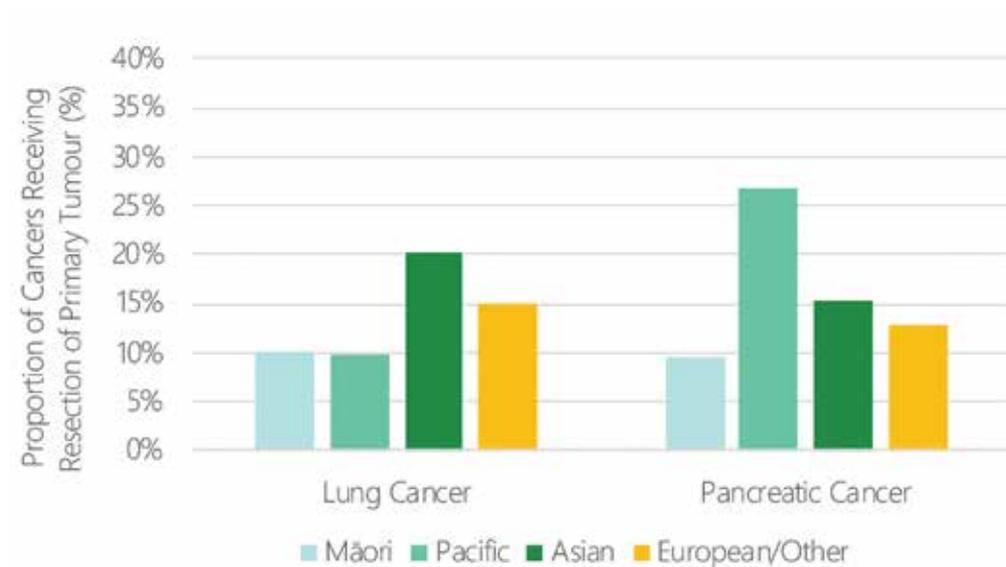
Around 60 percent of New Zealanders who turned 14 in 2021 are fully immunised against HPV. The proportion of fully immunised 14-year-olds is increasing although rates for Māori females have plateaued over the last decade.

**Te Aho o Te Kahu-led activities related to Outcome 3**

	Te Aho o Te Kahu-led activity	Related Action(s) within the Cancer Action Plan
<b>Outcome 3:</b> New Zealanders have fewer cancers	Cancer Prevention Report To view this report, go to <a href="https://teaho.govt.nz/publications/prevention-report">https://teaho.govt.nz/publications/prevention-report</a>	Smokefree by 2025 Encourage and support healthy living Prevent cancers related to infection Reduce the incidence and impact of avoidable skin cancer caused by UVR

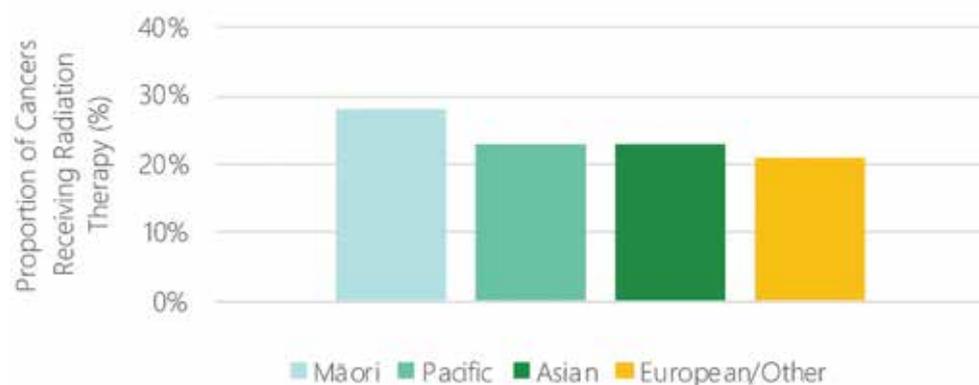
## Outcome 4: New Zealanders have better cancer survival, supportive care and end of life care

### Indicator 1: Proportion of New Zealanders with cancer who received surgical treatment



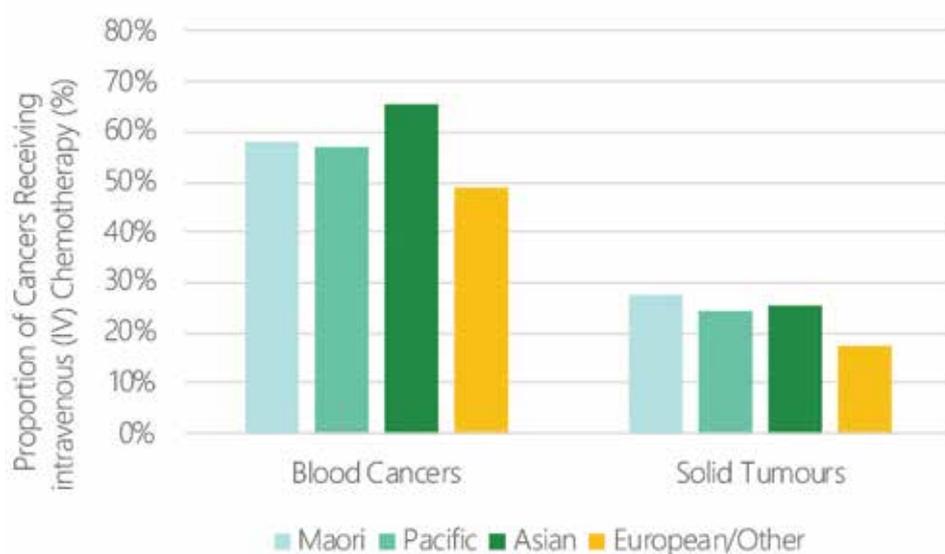
Overall, the rate of surgical resection for both cancers was around 10–15%, with limited evidence of disparities between ethnic groups.

### Indicator 2: Proportion of New Zealanders with cancer who received radiation therapy



Māori appeared more likely to access radiation therapy. While this might suggest that Māori have better access to radiation therapy than other ethnic groups, there is evidence that Māori are more likely to be referred for curative or palliative radiation therapy rather than surgery compared to non-Māori.

### Indicator 3: Proportion of New Zealanders with cancer who received systemic therapy



More than half of blood cancers and around a quarter of solid tumours were treated with IV chemotherapy infusion. European/Other population appeared to access less IV chemotherapy however some private providers do not report data and European/Other access more privately funded care than other groups.

### Te Aho o Te Kahu-led activities related to Outcome 4

	Te Aho o Te Kahu-led activity	Related Action(s) within the Cancer Action Plan
Outcome 4: New Zealanders have better survival	<b>Cancer Medicines Availability Analysis</b> To view the report, go to <a href="https://teaho.govt.nz/publications/cancer-medicines">https://teaho.govt.nz/publications/cancer-medicines</a>	Improve cancer diagnosis and treatment outcomes
	<b>Measuring cancer treatment quality</b>	Improve cancer diagnosis and treatment outcomes
	<b>Cancer service planning</b> To view copy of the report, go to <a href="https://teaho.govt.nz/publications/cancer-services-planning">https://teaho.govt.nz/publications/cancer-services-planning</a> .	Improve cancer diagnosis and treatment outcomes

# Tauākī Haepapa | Statement of responsibility

We are jointly responsible for the accuracy of any end-of-year performance information prepared by Te Aho o Te Kahu, whether or not that information is included in the Annual Report.

In our opinion, the Annual Report fairly reflects the operations, progress, and organisational health and capability of Te Aho o Te Kahu.



Dr Diana Sarfati  
Chief Executive (to end June 2022)  
Te Aho o Te Kahu, Cancer Control Agency  
30 September 2022

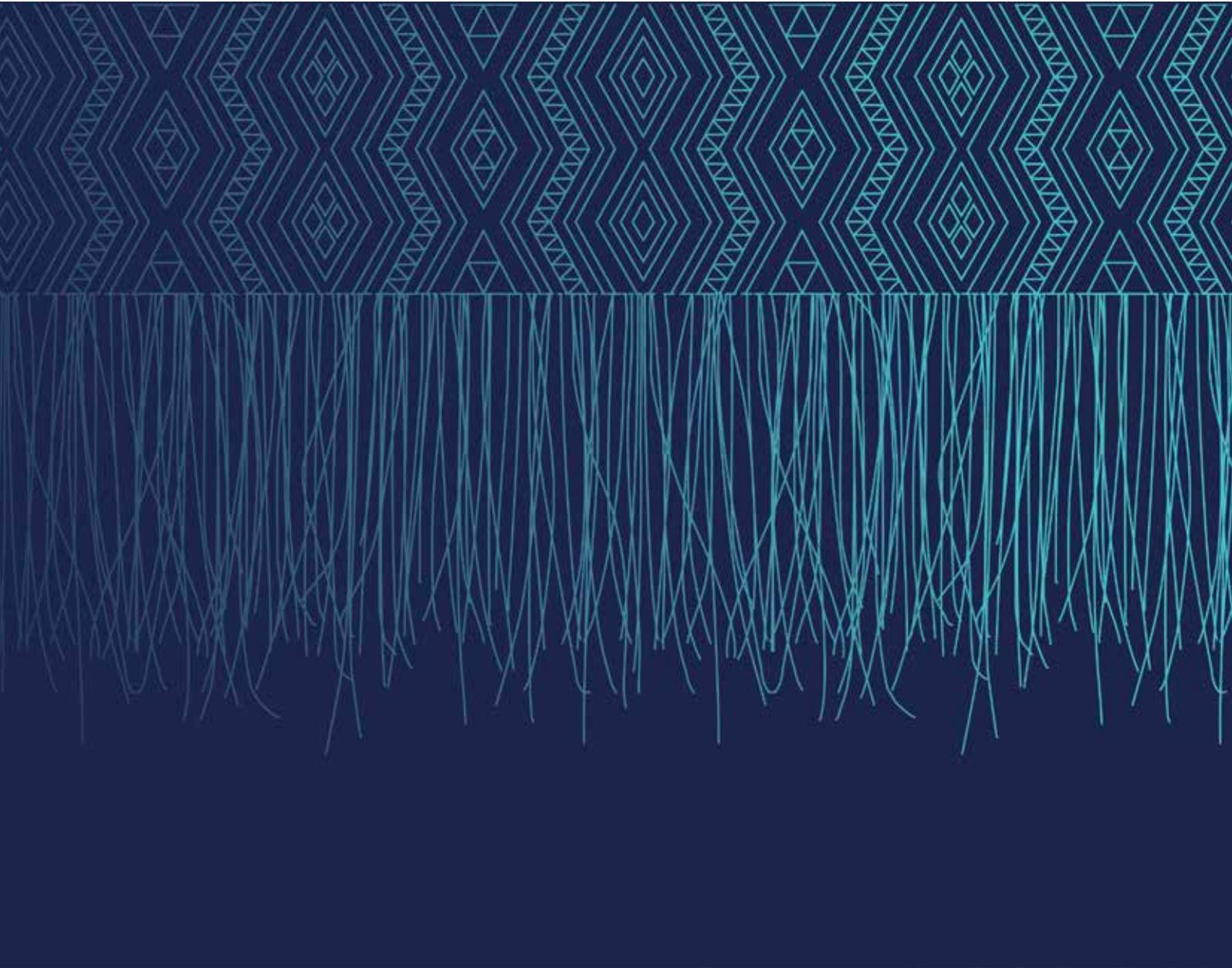


Nicola Hill  
Acting Chief Executive (from July 2022)  
Te Aho o Te Kahu, Cancer Control Agency  
30 September 2022



# **Te Whatu Ora**

Health New Zealand



**Interim Health New Zealand  
Annual Report  
2021/22**

## **NOTE**

Interim Health New Zealand – given its interim status – is exempt from developing a Statement of Performance Expectations (SPE) and Statement of Intent (SOI) until the 2022/2023 financial year when it has become Te Whatu Ora | Health New Zealand.

In lieu of reporting against a SOI/SPE, performance has been reported against the Letter of Expectations sent from the Minister of Health, Hon Andrew Little, to the acting Chief Executive in December 2021.

# Introduction from the Chief Executive

Te Whatu Ora | Health New Zealand was successfully established on 1 July 2022 and is now the largest Crown Entity in Aotearoa with over 80,000 staff all across the motu. This annual report covers our period as interim Health New Zealand and a departmental agency within the Ministry of Health. The interim entity was established to build the foundations for the new organisation and ensure a smooth transition. This was the first step in the Government's Health Reform programme, which aims to achieve 5 key system shifts:

- The health system will reinforce te Tiriti o Waitangi principles and obligations;
- All people will be able to access a comprehensive range of support in their local area to help them stay well;
- When people need emergency or specialist care this will be accessible and high quality for all;
- Digital services will mean that many more people will get the care they need in their homes and local communities;
- Health and care workers will be valued and well trained for the future health system.

When looking back at what we have achieved as interim Health New Zealand in only a matter of months, I feel immensely proud of our work together in preparation for the establishment of our new entity. I would like to thank the members of the interim Health New Zealand Ministerial Committee for their leadership and support over this period. The preparation for 1 July 2022, or 'Day 1', involved a wide

range of professionals who joined and supported interim Health New Zealand in all areas, especially in establishing our corporate abilities, including amalgamating the budgets for 20 District Health Boards (DHBs) and seven Shared Service Agencies and related subsidiaries, transferring staff from the Ministry of Health and many other achievements. We also laid the foundations for changes to come, with the development of Te Pae Tata | Interim New Zealand Health Plan, establishing expert Taskforces and beginning work on our organisational design.

Te Whatu Ora – Health New Zealand, alongside Te Aka Whai Ora – Māori Health Authority, has an ambitious agenda, set by the government, to transform our health system to support all New Zealanders to live longer and have the best possible quality of life. Central to our ambitions is achieving equity of access and outcomes for priority populations who have not been well-served in the previous system, including Māori, Pacific and people living with disabilities. Our establishment during our time as interim Health New Zealand paved the way for success in the next steps in our transition and transformation journey and was a true collaboration of a 'team of teams'.

Fepulea'i Margie Apa  
**Chief Executive, Te Whatu Ora | Health New Zealand**

# Who we are and our role

After the announcement of the health reforms, the Health and Disability Review Transition Unit (Transition Unit) was established by Cabinet in September 2020 following consideration of the Health and Disability System Review / Hauora Manaaki Ki Aotearoa Whānui (the Review). The Transition Unit led the response to the Review, including developing the policy response and design of the system operating model, and providing advice on the establishment of new entities and legislative change.

Interim Health New Zealand was established in September 2021 as a Departmental Agency in the Ministry of Health to act as a precursor to the full Te Whatu Ora – Health New Zealand Crown Entity. This entailed taking on progressive responsibilities in the lead up to 1 July 2022 and beginning the design and set up of the organisation to ensure that it was equipped to fulfil the full role of Health New Zealand as of 1 July (an entity with over 80,000 employees and responsible for nearly \$20 billion of operating expenditure and \$24 billion of assets).

At the same time, the interim Māori Health Authority was also established. The two entities have been working and will continue to work in close partnership to achieve the goals set out by the government and legislated in the Pae Ora (Healthy Futures) Act 2022.

## Vision

The health reforms, as enabled by the Pae Ora legislation, are intended to achieve a fundamental change in how our health system delivers care to New Zealanders. Interim Health New Zealand played a critical role in that change – both in guiding the transition to our future health

system and in taking over leadership of a growing proportion of the system in the lead up to 1 July 2022. In summary, the reforms involve the following changes:

- DHBs consolidated into a single entity – Health New Zealand, later named Te Whatu Ora, which will be responsible for the day to day running of our health system;
- A new Māori Health Authority (later named Ta Aka Whai Ora) will ensure our health system delivers improved outcomes for Māori, and will directly commission tailored and innovative health services for Māori;
- A new Public Health Agency within the Ministry of Health and a strengthened national public health service within Health New Zealand will embed a focus on population health, wellbeing and prevention while ensuring we are always ready to respond to public health threats; and
- Hospital and Specialist Services will be managed as national and regional networks, while primary and community-based care will be commissioned on a locality basis.

Through these reforms, the Government aims to achieve the following five system shifts:

- The health system will reinforce Tiriti o Waitangi principles and obligations;
- All people will be able to access a comprehensive range of support in their local area to help them stay well;
- When people need emergency or specialist care this will be accessible and high quality for all;
- Digital services will mean that many more people will get the care they need in their homes and local communities;

- Health and care workers will be valued and well trained for the future health system.

Interim Health New Zealand was responsible for designing the system and processes to support the establishment of Te Whatu Ora, which included development of an interim New Zealand Health Plan with the interim Māori Health Authority setting out how the system will achieve these shifts.

## Our people

By 30 June 2022, we had directly employed 172.9 full-time equivalent (FTE) staff.

During quarter two and quarter three of the 2021/22 financial year, interim Health New Zealand began to take on operational functions from the Ministry of Health. By 30 June, 2,554.81 FTE (including vacancies) had been transferred from the Ministry of Health to interim Health New Zealand. As staff were transferred, interim Health New Zealand took on formal accountability for those operational functions.

## Policies and processes

During our time as interim Health New Zealand and a departmental agency, we generally adopted the policies and processes of our host agency, the Ministry of Health, including corporate policies. Interim Health New Zealand created a suite of corporate policies in preparation for Day 1, which were enacted from 1 July to apply to Te Whatu Ora | Health New Zealand.

## What we have achieved

In the months prior to Day 1, interim Health New Zealand focused on activity to establish itself in anticipation of a successful transition of functions from existing entities on 1 July. We also began

to take on wider responsibilities over time as functions and staff transferred from the Ministry of Health, as well as progress priority pieces of work such as drafting the interim New Zealand Health Plan.

This report provides an overview of interim Health New Zealand's activities and performance against the Minister's Letter of Expectations and Vote Health Appropriations.

## Accountability and oversight

A Ministerial committee was established under Section 11 of the New Zealand Health and Disability Act 2000 to provide advice on the delivery of interim Health New Zealand's functions and workplan. The committee consisted of a Chair and six members, and a member from the interim Māori Health Authority Ministerial committee. This committee was established to act in the same way as a Board of a Crown Entity.

The committee provided governance oversight and direction during 2021/22. Joint working groups were established with the interim Māori Health Authority committee to produce interim governance products but also in anticipation of formal governance roles post 1 July 2022. They also provided an opportunity for a shared governance perspective and setting the tone for an on-going collaborative relationship between Te Whatu Ora and Te Aka Whai Ora.

An interim Health New Zealand work programme was developed which included all required elements and workstreams to ensure preparedness for Day 1. Assurance reporting against this work programme was provided regularly to the advisory committee. Weekly assurance reporting on progress against the workplan was provided to the

Minister of Health by the Transition Unit. Weekly meetings between interim Health New Zealand and interim Māori Health Authority Chairs and Chief Executives and the Minister were also established to ensure any issues and risks were escalated and addressed. In September 2021, a Transition Programme Assurance Group was established by the Director of the Transition Unit after consultation with the Chief Executive of the Department of the Prime Minister and Cabinet, to provide independent advice on the implementation and transition risks of the reform programme. This group met monthly, received regular assurance reporting and provided implementation and programme advice.

Following the appointment of the Chief Executives of interim Health New Zealand and interim Māori Health Authority, fortnightly Transitional Joint Leadership Group Meetings between the Chief Executives of those entities, the Director-General of the Ministry of Health and the Chief Executive of the Transition Unit provided further oversight and assurance activities to ensure Day 1 preparedness.

## Strategic approach to interim Health New Zealand's functions

The key documents which outline our strategic approach post Day 1 are: Te Pae Tata (Interim NZ Health Plan), Te Mauri o Rongo (Health Charter), and a Memorandum of Understanding between Te Whatu Ora and Te Aka Whai Ora. Interim Health New Zealand initiated the development of these documents in preparation for the establishment of Te Whatu Ora and Te Aka Whai Ora.

Interim Health New Zealand and the interim Māori Health Authority worked

closely together since our establishment in September 2021, laying the foundation for how the entities can work together as Te Whatu Ora and Te Aka Whai Ora. Alongside joint advisory committee activities, a collaborative approach has been taken to developing key documents such as the interim NZ Health Plan to ensure that the plan focuses on embedding Te Tiriti and achieving equity.

We have engaged with the interim Māori Health Authority across all of our major programmes of work as interim Health New Zealand, including representation and collaboration on the Taskforces (Planned Care, Immunisation and Workforce), organisational design, and sharing and collaborating on many organisational policies and procedures to ensure alignment. The two entities shared offices, and do so as Te Whatu Ora and Te Aka Whai Ora, ensuring a culture of collaboration continues as we move through the next stages of change. A Memorandum of Understanding has been signed between Te Whatu Ora and Te Aka Whai Ora based on principles of partnership, transparency, honesty and collaboration in all aspects of our working relationship.

## Key expectations and deliverables

**New Zealanders do not experience disruption to the services they receive and the workforce experiences minimum disruption**

On 1 July 2022 – Day 1, Te Whatu Ora | Health New Zealand assumed the assets, liabilities and roles of previous DHBs, and became primarily responsible for the day to day running of Aotearoa's Health System. Significant preparation was undertaken by interim Health New Zealand, in collaboration with our partners in the interim Māori Health Authority, Transition Unit, Ministry of Health and DHBs in the

months prior to 1 July 2022 to ensure that this transition was smooth and successful.

A key focus of the preparations for Day 1 was risk mitigation and ensuring that New Zealanders did not experience a disruption to the services they receive from the health service. Mitigation plans for risk areas for Day 1 were put in place. Prior to 1 July, interim Health New Zealand communicated clearly to communities that people should continue to seek and receive treatment in the same way they have always done, and that services would continue as normal, which they did from 1 July 2022.

There was extensive engagement at the front line with stakeholder groups and staff. The Chief Executives of interim Health New Zealand and the interim Māori Health Authority engaged with the workforce and the sector to explain the change and what it meant. The Chair of the Ministerial Committee connected with key stakeholder groups, and the Transition Unit led discussions to understand culture as input to the Health Charter. Communication is a continuing focus post 1 July 2022 to ensure everyone understands the background to reform.

Consistent with the Minister's expectations, our focus was on ensuring minimal disruption to our workforce. As such, existing payroll and information technology (IT) systems have continued to be used in all of the former DHBs and Shared Service Agencies from 1 July 2022 to ensure a smooth transition.

While operating as a departmental agency, interim Health New Zealand utilised the systems of its host agency, the Ministry of Health. Teams within interim Health New Zealand worked to ensure a smooth transfer to Te Whatu Ora on 1 July for these 'head office' staff (i.e. those directly employed by interim Health New

Zealand or transferred from the Ministry of Health), including establishing: a payroll system, an Ask HR call centre, recruitment application tracking system, careers website, a new intranet and a new IT environment. The first payment under the newly established payroll system was successfully made to employees on 21 July 2022. As at 1 July 2022, all IT enablers were activated as planned with minimal disruption to head office staff. Key business policies and processes were also developed and implemented from Day 1 to ensure a smooth transition.

The activities undertaken in preparation for Day 1 have set the foundations for the next few months when we will be transferring all 'head office' Te Whatu Ora staff into our new IT environment. Following this, a wider migration of ex-DHB and Shared Service Agency systems has been planned and will be implemented.

### **Health New Zealand established with a culture that encourages and fosters positive, collaborative working from the outset**

It is critical that we move towards a one-system ethos in our future system. This will require the combined efforts and collaboration of all our partner organisations, workforces and communities to deliver an improved system which achieves equitable health and wellbeing outcomes for all New Zealanders. During our time as interim Health New Zealand, alongside building our relationship with the interim Māori Health Authority, we have been engaging and collaborating with other key partners and agencies including unions representing our health workforce, the Public Service Commission, the Ministry of Health, other public sector agencies and partner community organisations.

Our key partnership with the interim Māori Health Authority formed the basis for

our on-going partnership as Te Whatu Ora and Te Aka Whai Ora. The interim Chief Executives will continue to align on key functions and decision making, and undertook a joint approach to welcoming staff from the existing entities and setting a new tone for our relationship going forward.

Interim Health New Zealand established a Change Management Office to support the development of the new operating models and ways of working in Te Whatu Ora. The Change Management office will develop a structured change plan and oversee the change programme, ensuring that the strategic intentions of the reform are reflected in the development and implementation of changes to the health system.

### **Health New Zealand has an interim senior leadership structure that is ready to run the system in a new way**

Initial interim appointments were made to key leadership positions in interim Health New Zealand in December 2021 to 30 June 2022 while the future operating model was developed. The future operating model for Te Whatu Ora's Executive Leadership Team (ELT) was released by interim Health New Zealand in April 2022 (refer Fig.1). Interim appointments were made in May-June 2022 to key positions on the ELT to ensure consistency of leadership post 1 July 2022. Interim Health New Zealand has since begun making appointments to permanent ELT roles. An interim district and regional structure was also established in June 2022 to minimise disruption to the workforce post 1 July 2022 by maintaining district reporting lines while we work through the detailed operating model design work.

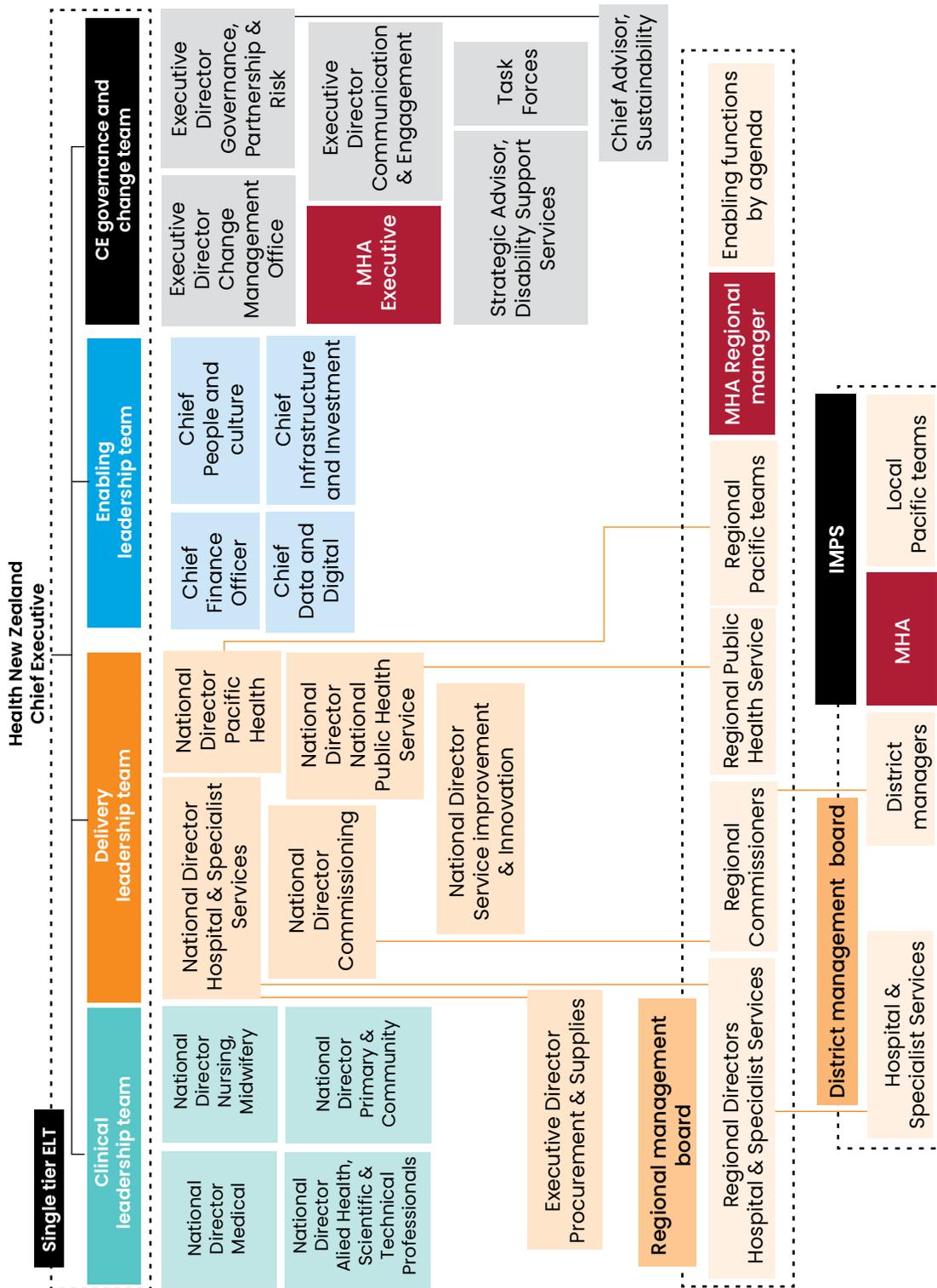
### **Health New Zealand and the Māori Health Authority have determined how they will work together practically to co-commission services**

When interim Health New Zealand developed the interim leadership structure for Te Whatu Ora, a key consideration was ensuring strong Māori leadership is embedded. The ELT structure has a Te Aka Whai Ora representative, which is included to ensure we embed Māori strategic leadership and strong partnership across both organisations, as well working alongside colleagues to strengthen Māori presence and decision making at all levels of the system. The ELT structure also has a National Director – Pacific Health role whose focus will be Pacific commissioning, workforce development, provider development, ensuring localities are effective for Pacific populations and leading provider arm Pacific services. This ELT structure was developed by interim Health New Zealand for implementation post 1 July 2022.

Prior to Day 1, interim Health New Zealand began establishing working groups to commence planning for key Te Whatu Ora functions. These working groups are comprised of subject matter experts and Te Aka Whai Ora representatives and are developing recommendations for national, regional and local operating models, prior to implementation of changes.

Interim Health New Zealand also established design work on a framework for co-commissioning and engagement with stakeholders across Te Whatu Ora and Te Aka Whai Ora. This process is continuing.

Fig 1. ELT structure as released in April 2022



## **Performance against appropriation measures**

The commentary below outlines our performance against relevant measures in the Health Sector – Estimates 2021/22.

## **Ministerial Oversight Group satisfied with progress against delivery of the Health System Reform Implementation Plan agreed by Cabinet**

Prior to 1 July 2022, the Minister of Health provided a final pre-implementation update to Cabinet (including other members of the Ministerial Oversight Group). Based on an external assurance review and progress reports from health entities, the Minister assessed the reforms to be ready for implementation. As such, Cabinet agreed to proceed with legislation to give effect to the reforms from 1 July 2022.

## **Minister of Health satisfied with progress against delivery of the Health System Reform Implementation Plan agreed by Cabinet**

In addition to the above Cabinet report, weekly assurance reporting on progress against the workplan was provided to the Minister of Health by the Transition Unit. Weekly meetings between interim Health New Zealand and interim Māori Health Authority Board Chairs and Chief Executives and the Minister were also established to ensure any issues and risks were escalated and addressed.

## **Funding agreements in place for first phase of Locality Networks**

Locality networks are the new regional basis for organising health services for communities.

A locality coordinator will draw together health providers, iwi, local authority representatives, and social sector agencies to work out what is available

and what is needed at a local level. The purpose of the process is to engage with the relevant community and understand its needs.

The plan that is developed will be agreed with the relevant iwi Māori partnership board and will be tailored to the community covered by the locality. That plan will form the basis of the funding decisions by Te Whatu Ora and Te Aka Whai Ora.

In April 2022, the Minister of Health announced the first nine areas rolling out the locality approach. The areas are:

- Horowhenua
- Ōtara/Papatoetoe
- Hauraki
- Taupō/Tūrangi
- Wairoa
- Whanganui
- Porirua
- West Coast
- Eastern Bay of Plenty.

## **Performance against workplan**

In line with the Minister's expectations, interim Health New Zealand created a workplan in preparation for Day 1. The workplan covered the main elements which were required for the successful establishment of our entity from 1 July 2022 and other key areas of preparation and planning to support the transition and transformation activities post Day 1.

All critical areas of the workplan for Day 1 were delivered, including: corporate transition, procurement and supply chain, finance, data and digital, people, culture and capability, transfers and mergers, commissioning, and national public health service. Some work plan areas were not completed by 30 June 2022. However, these did not hinder overall operations on

Day 1, with mitigation plans in place. Other key areas of the workplan which involved preparation for activities post 1 July are covered in the following sections.

## **Te Pae Tata | Interim NZ Health Plan**

Te Pae Tata, our interim Health Plan, sets out our intentions for action over the next two years to transition our system to be able to meet the ambitions of the Pae Ora legislation and deliver on the interim Government Policy Statement for Health. This work was initiated during our time as interim Health New Zealand, in collaboration with the interim Māori Health Authority, to ensure Te Tiriti and equity are fully integrated and the Māori Health Improvement Plan actions have been agreed and embedded. The plan covers the first two years of Te Whatu Ora's operations and sets out how the system will achieve the five system shifts, improve outcomes for vulnerable populations, strengthen performance, reduce variability and work towards becoming carbon neutral. The first full Health Plan will be completed by June 2024 and will be comprehensive, fully costed, widely consulted and developed in line with the requirements set out in the Pae Ora legislation. Within Te Whatu Ora, our structure, planned activities and reporting will be based around the delivery of Te Pae Tata.

## **Communications and Engagement**

Alongside Transition Unit communications, in the lead up to Day 1, interim Health New Zealand developed a communications plan to ensure staff and communities were kept aware of the transition. We will

continue to take a transparent approach to engagement throughout the coming changes. Our name brand identity for Te Whatu Ora underwent extensive development alongside the interim Māori Health Authority, now Te Aka Whai Ora, and was launched on Day 1, with a phased and pragmatic approach to implementation prioritising digital use of the visual brand.

## **Taskforces**

In May 2022, interim Health New Zealand established three Taskforces to provide advice and recommendations on key issues affecting the health sector: workforce, planned care and immunisation. The role of the Taskforces is to identify key actions that can be taken in the immediate and short term to alleviate pressures in these areas.

## **Te Mauri o Rongo | Health Charter**

Interim Health New Zealand provided input into the draft Health Charter, which will guide the development of the culture, leadership and working environment of the health workforce. The Charter will be supported by a five-year strategic plan which includes a two-year action plan and activities/deliverables for the first 6, 12 and 24 months post 1 July 2022. The development of the plan has included engagement with Tier 1-3 leaders from interim Health New Zealand and the interim Māori Health Authority and with the Combined Trade Unions group. The Charter remains in development.

# Statement of Responsibility

I am responsible, as Chief Executive of interim Health New Zealand, for the accuracy of any end-of-year performance information prepared by interim Health New Zealand whether or not that information is included in the Annual Report.

In my opinion, the interim Health New Zealand Annual Report fairly reflects the operations, progress, and organisational health and capability of interim Health New Zealand.



Fepulea'i Margie Apa  
**Chief Executive, Te Whatu Ora | Health  
New Zealand**

Interim

**MĀORI HEALTH  
AUTHORITY**

**TE MANA  
HAUORA MĀORI**

He hinonga taupua

# **Interim Māori Health Authority**

## **Te Mana Hauora Māori Annual Report 2021–2022**

## Note

The interim Māori Health Authority – given its interim status – is exempt from developing a Statement of Performance Expectations (SPE) and Statement of Intent (SOI) until the 2022/2023 financial year when it has become Te Aka Whai Ora | The Māori Health Authority.

In lieu of reporting against a SOI and SPE, the Treasury have advised to report against the Letter of Expectations sent from the Minister of Health, Hon Andrew Little, to the acting Chief Executive in December 2021.

The Treasury is not expecting this 2021/22 report to cover the full range of additional non-legislative requirements as set out in departmental reporting guidance, such as Carbon Neutral Government Programme and Diversity and Inclusion requirements, given that the agency is interim, of a transitional nature and of very small size, such requirements are impractical.

# A message from the Chief Executive

## Nau mai rā ki interim Māori Health Authority

It is my great pleasure to publish the interim Māori Health Authority Annual Report 2021 -2022 in acknowledgement of our mahi over the past nine months to set up Te Aka Whai Ora | The Māori Health Authority as we operated as a Departmental Agency within Te Manatū Hauora| the Ministry of Health.

This document sets out our responses to the Minister's Letter of Expectations (December 2021) in setting up the initial structures, processes and agreements in place ready for Te Aka Whai Ora Day 1 (1 July 2022). It demonstrates how, supported by the chief stewardship role of Te Manatū Hauora, and in partnership with interim Health New Zealand, we intend to give effect to the waka houora approach to co-design and co-commissioning for the new health system.

In accordance with the expectations of the Minister of Health and Cabinet, the interim operating model will be refined over the coming years as new functions and relationships are established and embedded in Te Aka Whai Ora.

Equity is an underlying principle that has been designed into the core of the operating model. This aligns with our overall transition objectives – to simplify the way we work, unify our teams, make visible the voices of whānau and consumers and embed enablers of equity and sustainability.

The transformation of our health system will take time and will not be achieved without the valued efforts of our health sector workforce. We look forward to working with you to make our health system work better for all New Zealanders – now and into the future.

E hara taku toa i te toa takitahi, engari he toa takitini

Riana Manuel

**Chief Executive /Tumu Whakarae**

**Interim Māori Health Authority**

Te Aka Whai Ora| Māori Health Authority

# Interim Māori Health Authority – who we are and what we achieved

The Health and Disability System Review and its Final Report Pūrongo Whaka Mutunga, recognised that transformational change is needed at all levels of the health system to achieve better outcomes for Māori and eliminate inequities.

The establishment of the interim Māori Health Authority (iMHA) was a direct health reform response to Wai 2575 Health Services, the Outcomes Kaupapa Inquiry<sup>1</sup> and the Health and Disability Review/Hauora Manaaki Ki Aotearoa Whānui.<sup>2</sup>

The Pae Ora (Healthy Futures) Act 2022 outlines the core changes within the health reforms, including the formal, permanent establishment of an independent statutory entity, Te Aka Whai Ora | the Māori Health Authority, from 1 July 2022.

The iMHA was established in September 2021 and operated as a Departmental Agency within Te Manatū Hauora until 1 July 2022. The iMHA was established to design and set up a new independent statutory entity, Te Aka Whai Ora | the Māori Health Authority, to fulfil its strategic partnering, planning, commissioning and development roles as of 1 July 2022 within a newly transformed system.

## Our functions

Our iMHA functions expressed in the Minister's Letter of Expectations December 2021 were to:

- set up the operating functions of the future Te Aka Whai Ora | Māori Health Authority ready for Day One- 1 July 2022 building the base for our operating model; the approaches, frameworks and systems for how the Te Aka Whai Ora | Māori Health Authority will work in future in a detailed workplan.
- establish Te Aka Whai Ora | Māori Health Authority's role as a strategic partner to bring a unique and focused Māori viewpoint to the design and delivery of system policy, strategy, prioritisation, planning and performance. It will be accountable both to the government for succeeding in that role, and to Māori for reflecting their needs and aspirations in how Te Aka Whai Ora gives effect to its functions.
- set up commissioning of hauora Māori services to deliver on a modest initial commissioning budget in the 2021/22 financial year.
- deliver the Pae Tata | interim New Zealand Health Plan working jointly with Health New Zealand to give effect to the initial Government Policy Statement.
- support and engage with Iwi Māori Partnership Boards about their establishment plans.
- other functions, that included working with the Health Reform Transition Unit, Te Manatū Hauora, interim Health New Zealand, and other agencies as required.

1 [waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/](https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/)

2 [systemreview.health.govt.nz/](https://systemreview.health.govt.nz/)

Note: As the iMHA was of a transitional nature and of very small size, exclusions were granted by The Treasury for departmental reporting, such as Carbon Neutral Government Programme and Diversity and Inclusion requirements, as such requirements are impractical.

## Our people

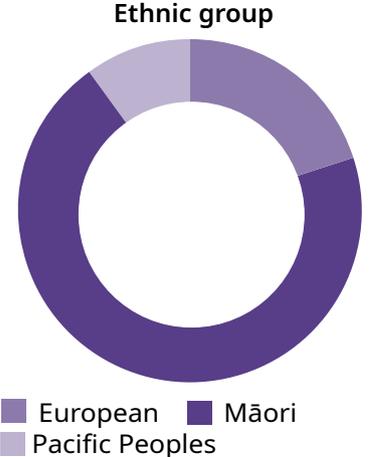
As at 30 June 2022, the iMHA directly employed 10 FTE<sup>3</sup>. The data below excludes staff secondments from other agencies and contractors working in the iMHA. As at 30 June 2022, 60 percent of employed staff identify as female.

Gender	Te Aka Whai Ora	
	Headcount	Proportion
Female	6	60%
Male	4	40%
Total	10	100.0%



As at 30 June 2022, 58.8 percent of employed staff identify as Māori.

Ethnic Group	Te Aka Whai Ora	
	Headcount	Proportion
Other	0	0.0%
European	2	20%
Maori	7	70%
Pacific Peoples	1	10%
Total	10	100.0%



## Policies and processes

The iMHA follows the policies and process of our host agency, Te Manatū Hauora. This includes corporate policies relating to human resources, information on our compliance with our obligations to be a good employer (including its equal employment opportunities programme, procurement, and finance).

We have a Departmental Agency Agreement with Te Manatū Hauora and agreed with the Deputy Public Service Commissioner on the 22nd November 2021.

## Governance and Partners

The iMHA worked closely with the eight advisory committee members appointed to the Hauora Advisory Committee established by the Minister of Health under section 11 of the New Zealand Health and Disability Act, to provide advice on the iMHA functions and work plan. We worked with the committee to ensure it is embedded in the governance of Te Aka Whai Ora.

<sup>3</sup> Payroll data was transferred from Manatū Hauora early July 2022. Headcount and demographic data excludes contractors and secondments from other agencies.

The iMHA Chief Executive<sup>4</sup> was accountable to the Minister of Health for delivery of iMHA's functions, and accountable to the Director of the Health Reform Transition Unit within the Department of Prime Minister and Cabinet in relation to performance management (as delegated by the Public Service Commissioner). Regular formal meetings took place with Chief Executive and Chair of the Hauora Advisory Committee, Director of the Transition Unit and Director General of Health.

The interim Board<sup>5</sup> of the iMHA led by two co-chairs and six Board members was appointed to help drive the development of Te Aka Whai Ora | the Māori Health Authority and its role within a newly transformed system from 1 July 2022.

The iMHA worked closely with its partner the Interim Health New Zealand (iHNZ) to develop the interim Te Pae Tata |the interim New Zealand Health Plan. From 1 July 2022, Te Aka Whai Ora and Te Whatu Ora must give effect to the interim Government Policy Statement and Te Pae Tata when performing their functions.

The iMHA worked with the Health Reform Transition Unit, iHNZ and Te Manatū Hauora on the interim Government Policy Statement measures that we will be used from 1 July 2022 to monitor health system delivery of hauora Māori services delivered by Te Whatu Ora and to provide public reports on the results of that monitoring.

## Performance against our deliverables

The iMHA has deliverables to report on how our funding was invested to deliver our strategic outcomes how our activity is organised and what we use as performance measures. The measures below align with the Treasury's Vote Health Estimates 2021 -2022 Assessment of Performance and the Minister's Letter of Expectations Dec 2021. They provide a simple representation of the services provided by key indicators in our nine months of operation.

The iMHA is required to report against the requirements of the Minister' Letter of Expectations of December 2021. The key requirements are to ensure that by 30 June 2022 that:

- a. capability and resourcing are ready,
- b. strategic frameworks and relationships are developed, and
- c. all iwi Māori Partnership Boards establishment plans ensure the structure of these Boards are representative of Māori Community.

In the past nine months the iMHA has focused on activity to establish Te Aka Whai Ora | Māori Health Authority ready for 1 July 2022. We have also progressed high-priority work to set up the Iwi Māori Partnership Boards that are a key feature of the reformed system, and to transfer to us (as commissioners), the kaupapa Māori contracts from Te Manatū Hauora and district health boards.

The following section reports the iMHA's performance against the Minister's Letter of Expectations December 2021 and Treasury's Vote Health Estimates of Appropriations 2021/22 Budget 2021, page 142.

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4 [www.mha.govt.nz/our-leadership/](http://www.mha.govt.nz/our-leadership/)

5 [www.mha.govt.nz/our-board/](http://www.mha.govt.nz/our-board/)

## Performance against the Minister’s Letter of Expectations

The summary of the Minister of Health’s Letter of Expectations requirements is listed below, followed by results and commentary Developing the Day One Operating model for Te Aka Whai Ora.

Initial Work Plan	Jan 2022 to March 2022	April 22 to 30 June 2022
<p><b>Initial set up confirmation of initial work plan</b></p> <p>Internal capability building early design work on future operating model completed.</p> <p>Initiated relationships with Te Manatū Hauora and iHNZ.</p> <p><b>Detailed workplan</b> for road map to Day One prepared including for:</p> <p>iMHA’s 9 months and at least the first 6 months of Te Aka Whai Ora.</p> <p>Minister provided initial version of this plan by 10 Dec 2021.</p> <p>See Establishment Plan published July 2022.</p>	<p><b>Building base for Māori Health Authority</b></p> <p>Operating model approaches frameworks and systems developed.</p> <p>Engaging initial leadership supporting capability clarifying and developing capability to manage MHA accountabilities in the new system,</p> <p>Initiate design and development of the future partnerships</p> <p>Formalised arrangements with Te Manatū Hauora and iHNZ on key transition planning and activity, policy, planning, and accountability documents Pae Tata  Interim NZ Health Plan and Statements of Intent.</p> <p>Build connections with Māori health sector and Iwi Māori Partnership Boards.</p>	<p><b>Getting ready for Day One.</b></p> <p>Capability and resourcing are ready.</p> <p>Capability, strategic frameworks and relationships developed.</p> <p>All Iwi Māori Partnership Boards establishment plans ensure structure of these Boards are representative of the relevant Māori community.</p>
<p><b>Key expectations and deliverables 1 July 2022 following Pae Ora Act, for the first two years</b></p> <p>Te Aka Whai Ora   Māori Health Authority is a statutory entity responsible for its role in the health system alongside Te Whatu Ora   Health New Zealand and Te Manatū Hauora.</p>		
<p><b>Future governance and leadership</b> at national and regional level</p>	<p>Design for governance and leadership completed.</p> <p>Timetable for recruiting key roles on temp or permanent basis prepared</p>	
<p><b>Internal Operating Model</b> for services and developed with partners.</p>	<p>Design of regional or sub regional arrangements and commissioning function developed with partners and align with Te Whatu Ora models /other public services.</p>	

## Developing the Day One Operating model for Te Aka Whai Ora | Māori Health Authority

The iMHA and iHNZ have been focused on establishment and setting up platforms for transformation. However, Day One, 1 July 2022 signals the beginning of this transformation journey.

Our Te Aka Whai Ora Establishment Plan<sup>6</sup> published in July 2022 sets out the initial structures in place from Day 1 (1 July 2022) and demonstrates how, in partnership with Te Whatu Ora – Health New Zealand, we intend to give effect to the waka houora approach to co-design and co-commissioning for the new health system.

6 Te Aka Whai ora Establishment Plan [www.teakawhaiora.nz/our-work/](http://www.teakawhaiora.nz/our-work/)

'Te Whatu Ora Health New Zealand and Te Aka Whai Ora Māori Health Authority work together' is published on our webpage [www.teakawhaiora.nz/our-work/](http://www.teakawhaiora.nz/our-work/)

Working with Te Whatu Ora and others, Te Aka Whai Ora will ensure these are reflected in the priorities and plans of Te Pae Tata| the interim New Zealand Health Plan, and how health services are designed and delivered to meet those needs, including through the use of Te Ao Māori models and the application of mātauranga Māori. This approach will help build a stronger Māori workforce, support the growth in capability and capacity of hauora Māori healthcare providers, and encourage more innovation in services that deliver better outcomes for Māori.

The iMHA worked with Iwi Māori Partnership Boards, Māori health providers and professionals, iwi, hapū and Māori communities to understand Māori health needs and aspirations across New Zealand. In future, each local community, partnerships between Iwi Māori Partnership Boards, Te Aka Whai Ora and Te Whatu Ora regional and district teams, and the wider community will ensure Māori voices are heard to be embedded in plans and services, and that health equity for Māori is non-negotiable.

The partnership between Te Aka Whai Ora and Te Whatu Ora will invest in services grounded in Te Ao Māori and ensure the wider health system better recognises and is more responsive to Māori needs, alongside that of the wider population.

The Te Aka Whai Ora will work with Manatū Hauora on strategy and policy issues of relevance to Māori, providing direction for the health system, and ensuring that our commitment to Te Tiriti o Waitangi continues to underpin approaches to hauora.

## Key relationships

### Monitoring Relationships

The Pae Ora Act requires us to monitor the delivery of hauora Māori services by Te Whatu Ora and provide public reports on the results of that monitoring; to monitor, in co-operation with Manatū Hauora and Te Puni Kōkiri, the performance of the publicly funded health sector in relation to hauora Māori; and to partner with Manatū Hauora on monitoring overall health system performance for Māori.

It is essential that there is a shared and transparent approach to monitoring the progress of all organisations, and clear lines of accountability for delivery. Te Aka Whai Ora co-monitors delivery of equity for Māori across the health system with Manatū Hauora, and co-monitors equity outcomes with Te Puni Kōkiri across the social sector. Manatū Hauora retains its chief stewardship and monitoring role of the health system. Te Aka Whai Ora also has a role to monitor Te Whatu Ora's delivery in partnership with Manatū Hauora.

The Te Aka Whai Ora monitoring framework that is in development, focuses on accountability in the following areas of the health system, including entity performance, systems performance and service performance.

When services are not performing for Māori, Te Aka Whai Ora and Te Whatu Ora will ensure the issues are quickly identified, and drive service and system improvement. To ensure Te Aka Whai Ora is sufficiently empowered, for instance if the services commissioned

fail to deliver intended outcomes for Māori or to address inequity, there is an escalation pathway for resolution that could ultimately reach the Minister. Discharging the roles of a commissioner, co-commissioning and strategic system monitor will afford Te Aka Whai Ora an unprecedented position with relation to hauora Māori.

We have a range of tools to hold the system accountable for the way it plans, strategises, funds, commissions and procures health services. We can apply consequences and impose penalties for non-performance or non-delivery.

## Interfaces with Iwi Māori Partnership Boards, Districts, Hospitals and Localities

Integration will be facilitated with and through district partners (in the interim, the previous district health board areas). This may be part of the role of regional commissioners to chair and hold local relationships. The iMHA set up the initial basis for how Te Aka Whai Ora will continue to work on the design for its regional operations and commissioning functions.

Iwi Māori Partnership Boards will be enabled to voice the aspirations and priorities of Māori communities within the health system. They will partner in planning around health priorities and services at the Locality level within their rohe or coverage area and agree locality plans embed mātauranga Māori within locality plans, that then influence and inform regional and national planning and influence regionally through their relationship with Te Aka Whai Ora.

Primary and community care will, over time, serve their communities through locality networks. Every locality will have a consistent range of core services, but how these services are delivered will be based on the needs and priorities of local communities.

## Working with Te Whatu Ora

### Chief Executives

Te Aka Whai Ora and Te Whatu Ora chief executives will partner and align on key functions and decisions impacting Māori health gain, including ensuring organisation structures have clear pathways for partnership and 'mirrored' roles across the organisations.

### Regional working

Te Aka Whai Ora and Te Whatu Ora will work together at a regional level. Te Aka Whai Ora will have regional teams, co-located with Te Whatu Ora and embedded in regional management arrangements to ensure partnership, with approval rights for all relevant strategies and plans at the regional and locality level.

Regional managers / leadership will continue to evolve to determine how they will work with their regional counterparts at Te Whatu Ora, including commissioners to shape and form strategy, monitor hospital delivery, and operate cohesively as a region. Te Aka Whai Ora regional managers work with their Te Whatu Ora counterparts to translate national Māori health priorities, support iwi engagement at the regional level, form the direct reporting line for local Iwi Māori Partnership Boards support teams and input priority equity gain initiatives. They also enable regional commissioning of Māori capacity and capability.

## Commissioning

Te Tiriti o Waitangi principles (Wai2575, Whakamaua and Waka Hourua strategic framework) have been used to underpin the iMHA draft Commissioning for Hauora Māori Outcomes Framework. Equity considerations have been included as strategic commissioning and funding principles. An investment logic model was completed for the Budget 2022 Treasury Budget Bid at the end of 2021. The investment logic model ensures the iMHA commissioning investments are part of a broader plan to improve hauora Māori, and test and confirm that the rationale for this proposed commissioning investment is evidence based and sufficiently compelling – and expected to lead to a range of outcomes.

The commissioning terms, outcomes and example measures are intended to assist the strengthening of the Government's relationship with and commitment to Te Tiriti, and guide the shift to a more equitable health and disability system.

Te Aka Whai Ora commissioning functions will directly fund and direct the provision of Te Ao Māori services and other services focussed on whānau and Māori communities, whether directly and/or jointly with Te Whatu Ora. When new services are commissioned or existing services are reviewed, Te Aka Whai Ora will partner with Te Whatu Ora to make sure service design and priorities reflect the diverse needs of the community, including for Māori.

Te Aka Whai Ora will lead nationwide Māori provider development and the expansion of Te Ao Māori services, as well as having a strong mandate to encourage and invest in innovation in delivery of local services and new service models to meet the health needs of Māori.

Te Aka Whai Ora will have co-commissioning functions with Te Whatu Ora in those services that have a significant impact on outcomes for Māori health. This includes, primary health services, population health screening and immunisation programmes. While Te Whatu Ora will lead on operational matters relating to general health service commissioning, this responsibility will clearly entail delivery of improved health outcomes and equity for Māori.

Te Aka Whai Ora will influence and agree these intended outcomes, set services expectations and initiatives to reduce bias, undertake monitoring, engage with iwi/Māori and approve final plans and resource allocation.

# Performance against Treasury's Assessment of Performance.

What is intended to be achieved with each category and how performance will be assessed.

Assessment of Performance	Estimates Standard	2021/22	
		Supplementary Estimates Standard	Budget Standard
<b>Departmental Output Expenses</b>			
Ministerial Oversight Group satisfied with progress towards the Health and Disability System Reform deliverables agreed by Cabinet	Replacement measure	Equal to or greater the 4 out of 5	Equal to or greater the 4 out of 5
Te Manatū Hauora satisfied with progress against delivery of the Health System Reform deliverables agreed by Cabinet.	Replacement measure	Equal to or greater the 4 out of 5	Equal to or greater the 4 out of 5
<b>Non- Departmental Output Expenses</b>			
Hauora Māori			
Commissioning plan in place for delivery of new hauora Māori services.	Replacement measure	Achieved	Achieved
Delivery in accordance with the commissioning plan.	New measure	Achieved	Achieved

Please note, the replacement measure wording change is to ensure scope is applicable to the activity and expected progress that has occurred in the year, rather than delivery of the broader, longer term, reform outcomes.

## Māori Health Authority Departmental Output Expenses

Output	Measured by	Results and examples
The iMHA has the capability and capacity to fulfil its objective and functions, and to be an organisation that is grounded in Te Tiriti o Waitangi to promote hauora Māori. The iMHA has most of the systems and policies for managing finance, human resources, information technology and meeting statutory machinery of government requirements.	By the end of June 2022, systems and controls, infrastructure, operational policies, and processes are in place to enable a fully functioning independent statutory entity and meeting its purpose to set up the Māori Health Authority for 1 July 2022.	<b>Achieved.</b> The iMHA strategic framework, incorporating vision, mission, values, and our strategic priorities, are developed and approved by the iMHA Board.  The iMHA's interim operating model is agreed and adopted.

Te Aka Whai Ora organisational design is published on [www.teakawhaiora.nz/about-us/our-structure/](http://www.teakawhaiora.nz/about-us/our-structure/). Some appointments to key roles have been made, other roles are staffed by secondments, fixed-term employees or contractors.

We are continuing to work on the design of our regional and local structure in partnership with Te Whatu Ora.

### Hauora Māori Commissioning plan is in place for delivery of hauora Māori services and delivery in accordance with the commissioning plan.

Output	Measured by	Results and examples
The iMHA are commissioning hauora Māori services and have determined how we will leverage our partnerships to add value to the system to deliver equity and hauora Māori.	<p>The iMHA draft Commissioning Framework and plans are developed and being implemented according to the commissioning plan.</p> <p>Description of contact in place by 30 June 2022.</p> <ul style="list-style-type: none"> <li>• Contracts with 149 providers, with two extensions in place by 30 June 2022.</li> <li>• The value of contracts in place by 30 June 2022 was: \$12.4m Provider workforce and sustainability and innovation fund.</li> <li>• The expansion of existing rongoā services and to ensure national coverage.</li> <li>• The establishment of a national Rongoā body, Te Kahui Rongoā</li> <li>• Support the Iwi Māori Partnership Boards.</li> </ul>	<p><b>Achieved.</b></p> <p>The evidence based draft Commissioning Framework and commissioning values and practices, and plans are in place and being implemented according to the commissioning plan.</p> <p>The Implementation Plan for Budget 21 has been signed off by the iMHA executive leadership Team 8 February 2022.</p> <p><i>Examples of other procurement:</i></p> <p>\$2m to support the expansion of existing rongoā services and establish four new rongoā services to ensure national coverage.</p> <p>\$800,000 for showcasing Māori Exemplar initiatives (ie, Impact evaluation) to support other areas to work in that way .</p> <p>\$300,000 to support the establishment of a national Rongoā body, Te Kahui Rongoā.</p> <p>\$3.192 million to operationalise the Iwi Māori Partnership Boards.</p>

The investment logic model (renamed the Investment Outcomes Model) has been updated based on discussions and feedback with the iMHA Board. The Investment Outcomes Model is strengths based.

The iMHA commissions to ensure resourcing is equitable to achieve health outcomes and the wider aspirations of whānau, hapū, iwi and Māori. This includes workforce Rongoā Māori, and in the future the range of Mātauranga Māori and Te Ao Māori direct commissioning, co-commissioning and partnered commissioning to deliver on the aspiration of Pae Ora.

The iMHA is working on the operating model development which will reflect how the Commissioning for Hauora Māori Outcomes and Investment Outcomes model will be put into practice within the organisation. An operating model is also being developed for the function of the Iwi Māori Partnership Boards. Both models will need to be strongly linked and aligned to avoid confusion of roles.

The geographical coverage of Rongoā Māori services for 2020/21 has increased. All 20 district health board areas now have at least one Rongoā Māori service that is contracted by iMHA. Prior to Budget 2021 only 16 areas had a Rongoā Māori service. Te Aka Whai Ora have since contracted a Rongoā Māori service in the other four district health board areas (MidCentral, West Coast, South Canterbury, and Auckland.)

Interim

**MĀORI HEALTH  
AUTHORITY**

**TE MANA  
HAUORA MĀORI**

He hinonga taupua

## Statement of Responsibility

I am responsible, as Chief Executive of the interim Māori Health Authority for the accuracy of any end-of-year performance information prepared by the interim Māori Health Authority, whether or not that information is included in the Annual Report.

In my opinion, the Annual Report fairly reflects the operations, progress, and organisational health and capability of the interim Māori Health Authority.



Riana Manuel  
**Chief Executive/Tumu Whakarae**  
**Interim Māori Health Authority**